

Minutes of the RSA Workforce Advisory Group Meeting
24th July 2009
Hilton Hotel Melbourne Airport

Present

(ST) Shelley Tranter - NSW
(SH) Sandra Handy - WA RSA Member
(KN) Kate North- WA RSA Member
(DG) Debbie Gregory – RSA Federal Chairperson
(AR) Andrea Rolfe - QLD
(BC) Barbara Cottell - Victoria
(PW) Pam Woods - NT
(PB) Paul Bennett - SA
(SR) Sue Robertson - Tasmania

Apologies

Agenda as sent

Introductions

Shelley Tranter– Representing NSW

Like to know more Labour Govt groups of clinicians (GMT) DOH 20 groups
1 on renal (?equivalent to Renal Clinical Network) Manager manages executive of 9
people. Shelley is nurse representative and chair of work force committee (WET) Chair
of subgroup (WET nurses) WET – a bit hard how many nurses (done in Paul’s survey).
What sort of work force do we need? We do not have any base line data at present –
compiling now but nothing on acuity just staff ratios, survey on education last year. NSW
plenty of education available for RN’s (particularly on line courses, appears to be no gap)
there is a gap for EN’s and strategies are been worked on regarding scope of practice
issues, survey next week and develop structure for EN’s.

Acuity tool – Newcastle Woolongong HD patient categorizing (not validated) all
different things for different purposes. Models of care work. Professor Mary Chiarella
structured work shops – evaluate in September, Models of Care No 2. Aim is to think of
ways of working within resources and improving nursing care how do we manage
patients. Need baseline data to take to DOH. Renal Unit 50 RN’s and 2 EN’s possibly
introduce Assistants in Nursing (AIN). This is of course a cheaper option but they do not
replace the RN AIN’s will do basic care. In NSW there is a rule that all NSW
procedures/policies need to be state wide. Presently there are no renal techs in NSW.

Andrea Rolfe representing QLD

Main issues are because of the 3 zone structure each zone has a renal network then there
is a statewide network. All operate independently – historically this has ment different
use of funding as individual funding decisions are made, gaps appear to grow bigger

between areas. Staff models – ratio based but some on acuity. 2009 expected review possibility of a state side modeling system – being undertaken by the statewide renal network.

Renal Units – predominately staffed by RN's – no consistency across the state, no AIN's at moment – almost no technicians. State wide issues – geographical issues, staff required to travel double up for visits to ensure staff safety.

Question - SR asked – What context are we in – renal, HD, PD or HD first then move onto PD????

QLD have no statewide model 1:3 staff to patient ratio is the accepted norm, this has been documented in previous state studies. But this is not validated nothing in place for renal wards. Limited evidence for ratio. TREND modeling used – how do we know that it is correct? – not used by all facilities in the state.

No opportunity for additional funding, growing population base, ageing work force how do we retain staff. There is a QLD transition to nursing program renal

Co-ordinated out of Brisbane, utilization rates vary across the state, dependent on local renal education support so it is not so accessible to some staff.

Sue Robertson representing Tasmania

Nurse Practitioner (NP) is a long way away believes Tasmania is running far behind.

There are 3 area health services all areas have renal units 2 areas have renal funding from Northern. CEO of each area have own funding. North and South work independently/individually this is historical. George Institute is working on a plan (as no plan) looking at state wide at the moment there is no infrastructure, managed at micro level this is not sustainable, huge inequity of resources.

Question – Are we talking purely HD?

Southern areas – Hobart has specific roles North West manages everything on the 1:4 ratio except now have PD nurse it is a case of working smarter but it is not going to last. Do want a statewide director – need appropriate funding. There are no privately run renal units. Huge challenges. What is actually done within the ratio? What are we including? There is no time for research.

Question PB – What is the George Inst doing?

Draft plan not really Tasmania specific have a nurse per hour model. Renal model never been looked at or validated. There is such a division of services they do their best at a micro level. A company may support a position but is this possible? In Tasmania there are only RN's in renal. .4 educator in south but nothing in north. Govt looking at possibility of AIN's – these are not a replacement for RN's.

DG stated that there is a lack of funding everywhere. Do all transplants go across to mainland – Yes.

There is a big divide between north and south – interesting historical – 2 directors. There are some bonuses of this set up.

Pam Wood representing Northern Territory

Top End – One service divided in 2 – top and central large differences in the needs for both. Darwin set up explained – see presentation.

There is a big push for return to country for patients.

Alice Springs – 28 chairs – biggest HD unit in southern hemisphere. Private unit planned – department of health will pay for patients to attend this unit.

Tennant Creek – 8 chairs.

Infrastructure will not be able to manage by next year. There are lots of remote nurses managing the CKD program. 5 year strategy in force now reviewing this they have gone past the patient growth prediction – how are they going to manage??

Challenges – distance, transient staff – staff move around but patients don't! Traveling nurses who are not skilled in renal. Home HD in remote areas – HD cannot be put into local clinics due to the issues when a patient dies.

Burolooda opening a HD unit soon.

Night Cliff staff structure see presentation. 85% indigenous patients. Normally takes 3-6 months to train for HHD with a carer, indigenous carers hard to find – reasons include not wanting to leave home town. HHD nurse will not be sustainable as getting rather busy. Positives – have a separate social worker/dietician. Courses at Charles Darwin Uni can be full or part time provides a 6 week HD training program for nurses (in house training) More educators is desirable there is another PD educator starting soon for 6 months.

Hours per patient ratio – general nursing done but not renal it is difficult to assess for renal, trying to get managers to see renal but it is seen as all too hard.

For acute patients 1:2, for patients that can help themselves 1:5, visiting HHD patients do not require a nurse. Assistance is required with nurse to patient ratio's.

DG – Where do aboriginal health workers (AHW) fit in?

PW – try to encourage AHW's unfortunately education level is lower and difficulties have been encountered, some funding was available but this has now gone – finding the right people is very difficult.

Batchelor Institute running an RN course with a renal component have 1 indigenous RN at present. Govt pushing for more but people hard to find – rare to find people that want to live in city they want to be home.

Problems with HHD patients when things go wrong or patient dies – pay back and blaming issues – big problems. HHD – patients not keen there is a lot of work going on to see how can change the perception.

Transplant nurse has to look after a huge area and population.

DG commented that despite the resources NT do a great job.

Barbara Cottell Manager at Dandenong representing Victoria

Victorian workforce planning – working group was developed in 2007 Sue Evans involved there was a workshop in 2008.

All acute dialysis done in and around Melbourne, if transplant patient needs to move from country to metro area.

DHS review outcome push more home therapies.

Rural programs – starting to get some acute patients in country such as CAB but not renal. Hubs and nodes – Bendigo is an example of a node.

Each unit varies in set up – acuity of patients not really different. Barbara has 1:3 but has no administration support so that 1 nurse does a wide variety of roles.

SR commented that it is difficult to get the accountants to see what is nurse's role.

ST asked well what is the nurse's role?

Recruitment and retention – how do we attract nurses? How do we break down the barriers?

Some positives – Registration now available for Div 2 EN's to cannulate.

SR – stated that there is no IV medication authority for Div 2 nurses in Tasmania.

There are so many different terms for nurses we need to be aware of who is who in each state. If we are going to have more technicians who will govern this group of health care providers?

Kate North representing WA

Did a survey in 2008 renal workforce committee asked for a review. There are many private/public satellites and just approved for 2 more this year. No private dialysis in WA. PPT's – private companies. If patients travel to WA then the health fund pay. Private health funds will pay for such things as fistula formation but not dialysis. WA looking at introducing AIN's – Fremantle was doing a pilot but no funding left. For the specialist staff these are attached to the teaching hospitals. When Kate recruited 10 new staff only 1 had renal experience so 9 had to be trained (2 were youngish) all are very happy.

Sandra – Centre of Excellence discussed.

Paul Bennett representing SA

Paul went to CKD conference yesterday all networks spoke. SA active have senior nurse group developed a lot of things. Adelaide easier to get around – collegial group. Policies and procedures done but not really addressed work force. Do have work force group but not done anything as yet.

Question – Is there a structure for this workforce group ?

We cannot change the states structure – funding and governments are something we have no control over, but maybe Federal RSA would be a powerful body to suggest changes etc.,

Present networks – how can we use them? We should embrace all states resources/ideas/processes.

RSA renal workforce survey – it was Federal RSA who came up with idea to have a baseline national information report – Roche assisted with some funding.

What is happening? No data on dialysis work force. How do we define a nephrology nurse? We can only capture a dialysis nurse – how do we define a dialysis nurse/professional/carer?

What is a renal qualification? What is your perception?

Need to include dialysis technicians in the renal health care provider group.

In the survey the actual number of nurses is not specified it is the FTE. New Zealand south do have technicians.

Question – what is it that nurses give to dialysis?

Is it a waste to have RN's as in in the number of RN's doing sometimes what patients can and will do. Full time is classed as more than 30 hours per week.

How does renal nursing compare to general nursing as in full and part time ratios ?

There appears to be no trend – no previous data. More EN's coming - EN role will increase therefore what is a dialysis set of skills for RN's, EN's or technicians.

Average age of renal nurses between 40-50 years. Do we have to worry about our work force? If we have nurses in their 40's starting that is good – will they stay? Renal nurses less likely to have back issues, less strain than ward work although there is now more nursing care involved in dialysis patient care.

Renal qualifications section remains a little grey still. South Australia has had a more hospital based renal course for many years hence SA has more RN's and EN's with post registration renal qualifications.

PW – asked if EN's do the same course as the RN's – it is a different course but the outcome is the same = a skilled dialysis nurse.

ST – NSW course does not exist anymore used to have it hopefully get it back some time.

PW commented that in the past nurses had to do the renal course if they wanted to work in renal.

ST commented that there are now lots of courses available on line and these are very good.

It would be interesting to look at how general nurses qualifications compare to renal qualifications (RN's only) there is no data from New Zealand (NZ) or Northern Territory (NT).

DG mentioned that as nurses do the renal course they feedback and talk with enthusiasm to others which is good.

BC commented that it really helps when nurses get the theory in what they are doing in practice helps people realize and understand more what they are doing and why, it encourages studying.

Everyone discussed the possible barriers to study and the question was asked about how recent the recorded qualifications (in the data) were.

With the renal qualifications why is there different rates and what can be done? Do renal qualifications improve patient care?

Linda Aitken has done lots of research regarding whether more qualifications lead to better outcomes, does a certain qualification improve outcomes. How would we research this?

ST mentioned that they are just so many variances – each component would need to be done separately, each state or territory also has its individual variances.

Questions – What is the more qualified nurse doing? Has outcomes been looked at?

Patient to staff ratio (per nurse = FTE's) compared to ANZ data on patients works out at 3.8 patients to each staff member (this is all of dialysis), however in WA worked out to 4.6 – differences can correspond to more HD etc.

There is an influence of dialysis modality on a regional basis – 9% increase in Home HD or home therapies there is a decline then in patient nurse ratio of 1.

PB stated that transplant patients are classified as home patients so when you add transplant to home patients all pretty much the same – comes out that we are doing fairly well. Graham Russ adds the figures together.

Questions – What best describes dialysis unit staff levels? Is this a true reflection of what is happening – this is only a snapshot in time and many say they are OK when asked.

Paul commented that lots of units have the same staffing levels and people tend to comment that they happy and stable, this suggests that most places are OK. Where do we go from here? Do we have a workforce issue? We do need to plan and strategize for the future.

Limitations to the survey – Important findings and recommendations – see Paul's presentation.

Questions - There are some reasons for variations do we need to explore more? Do we explore the role of the EN, the role of the technician and the role of the RN in more detail in each unit? This would be costly and how do we get funding for another study then do we explore every year? How often do we need the information? What is it in nursing which needs to be in dialysis?

DG stated that it was not probably possible for the group to come up with a statement today, need to look at the small steps in the process of achieving an outcome. Need to aim to have a statement ready for the next meeting by the time of the national conference.

ST – we need a project plan, need to look at the scope of roles is it dialysis? PD? HD? Or anything what are the resources that we require? Shelley had listed some additional questions:-

What is it as an RN that they do? Looking at the RN, the EN, the technician, the Assistant in nursing (AIN) what is each scope of practice? What are the differences?

The EN policy is different in every state will this bring barriers to what ever it done?
We (the RSA) cannot manipulate health bodies at this point in time unless we lobby as a federal body in the future.
What are the influences in respect of work that we want to create?
Need to look at the context – what is HD in center versus satellite?
Practice contexts this will assist us in knowing – we need to get the names right and the titles right – nomenclature.
Available acuity tools – is there a toll already available? Can we validate it? Kate devised one and piloted it – this is research.
What effect does current contexts of care have on all what we discussed?
Consumers/recipients.
What issues do we need to address – differences in generations, skills and qualifications?
We can omit the age issue now as we have covered that.
What are the barriers to the work that we do?
What else is happening which may impact or influence our work? (Consider federally funded healthcare, KHA, national registration etc.)
What support staff are available?
Where is the equality/equity?
Hospital versus private funding – think.
How do nurses provide care, which models do they use? Are they using case management model?
How are renal inpatients how is their care structured?
All of this can impact the rural services.
What influence do we have in making a recommendation for example for staffing requirements?
Is it related to the “magnet hospitals” concept?
Benchmarking – mentoring other hospitals/units as in the Centre of Excellence program.
IMPORTANT big question – how can we network the networks?

RSA can advise – should we have a representative for the work force in every state network? Yes we more or less already do – we need a representative and a proxy for each state.

KN – has a self care philosophy passion. Kate asked why is it that nurses traditionally what to do everything for patients once they are on dialysis? We don't seem to promote self care enough.
ST stated that she uses the Orem self care model of nursing.
SR commented that nurses should stop doing so much as we create rods for our own back at times.
PW highlighted that the NT promote self care very strongly, literacy skills are a bit of a problem as these are very low in the NT patient population – however patients get a reward and a certificate for been active and self caring sometimes they tell the nurses off if they try to help them. Kate added that 38% of her patients are indigenious and they all do something to help themselves.

Sandra

Again the scope of nursing role for PD and HD was mentioned and what tools do we need to assist in determining patient to staff ratios?

PW commented that we need to look at renal as a whole.

SR asked if we needed to approach trade to assist. It was agreed that this was not necessary at this moment in time.

PB – start on process – look at what has been done already – why reinvent the wheel. There is lots of information especially from UK. There has been a lot of money invested in the research and projects we would never be able to do this.

Do we go away from the actual acuity? Is it about ratio's what? What does this mean? Need to be inclusive approach – each network has to ensure that they are talking to each other.

What is the scope of practice? Process, scope, resources.

What resources are there?

KHA (not really nursing) Networks in each state, trade, ANZSN, RCNA, ANF possibly the health departments.

SR – back to the original question about acuity – we need a position statement from the RSA around recommended ratios for patients/nurses.

WA, QLD and NSW all doing their own things.

DG – should we review each state first? The recruitment and retention group was an RSA idea; this is separate from the DHS network groups.

What sort of structure do we want?

KN highlighted that it is really important that we feed the networks – these are who have the teeth to do anything.

AR agreed – we need to work collectively.

We do have some reasonable templates with Wendy Washington's work and the UK information. Most of us looking for ratio guidelines how can we staff our services?

ACORN is not evidenced based – expert evidence only.

KHA is not a nursing body. CARI mentioned as this could be an avenue for some guidelines.

How do we formalize our ratios?

Dialysis nurses role has evolved over the years – everyone works differently, Paul doesn't think we can capture this it is far too much.

Need to address the acuity – some units nurse to patient ratios could be questioned and challenged.

It is complex/conceptual UK discuss all roles when they describe the work force there to a certain extent.

KN what needs to be done for a dialysis patient? Is it different in every unit – this has to be done to a point but not related to workforce necessarily.

PW – hours per patient care no guidelines for renal looked at WA but wasn't reflection of NT needs but no minimum standard from say the RSA is currently available.

PB- we live in a world of numbers we need figures. What is our biggest group of people we want to affect? Target an issue – which issue?

ST – dependency tool? Would this tool help us ascertain our workforce needs, this is a very complex issue.

Should we attach all the information we currently have onto the website?

Need to gather resources from every state put these out for all to see and utilize. Need to open up the website need to network – we need a national approach. Although we still have differences within the states. We could use the tool – get a score – score can assist in applying a ratio.

RSA can offer resources but cannot dictate how to do. RSA can offer resources on website and this work force group can develop and gather resources, this may stimulate others research/ideas to apply certain KPI's.

Another webpage on the website will probably be a minimal cost. Work force page can be modified it can be a dedicated page. Maybe there will be sub committees for the work force like there is for the journal.

Questions – Do we have the commitment to do this?

Are any ideas worth it?

We really need a statement that reflects the RSA Mission.

Do we as a group want to continue?

If we do then we need to start with something simple so that it is achievable and a positive experience.

Victoria and Tasmania do not have a work force group at the moment.

Maybe we need an RSA person and a network person?

NT needs someone from central and top end to be represented. Pam will ask Jill Gorham to be a representative along with herself. Pam will see if she can encourage a central person to represent the central area. NT has quarterly meetings already and has a very good communication network set up. Next meeting is in Mid August.

Kate is already on the workforce party in WA.

Suggestion that there is a dedicated person and a proxy for each state.

QLD – has its own networking, they have a statewide clinical governance could bring in from this group. Andrea will approach Wendy Washington ask if there is any commitment and if they want to be involved.

ACT – it was questioned does ACT have a representative? We do need someone from ACT who will follow this up?

Overall this group who met today is committed.

BC – commented that she is an RSA member but not involved in any workforce group, is keen to be involved though.

SR – keen to be involved but would like some direction.

Again question was asked – do we need to involve industry? Should we just use utilize the international data and colleagues work? Not for workforce but maybe for education.

Chair Person appointed – Andrea Rolfe

PB – committed to assist in any way keen to get Fiona Donnelly involved as she is the work force group Chair in SA.

Do we need a Co Chair was asked but it was thought that a chair person - one person to keep track and lead would probably be much better.

New Zealand and ACT need a representative. Possibly Jo Wilkinson from Tasmania to get involved.

Terms of reference were discussed.

What do we do?

- Advise RSA on renal work force issues
- Facilitate access to work force related resources
- Promote renal work force research
- Collaborate with regional health authorities and other professional bodies on renal work force issues

What we do not do?

- Uniform nomenclature (although we do need a consistent language)
- Control home dialysis therapies and transplantation

What next?

What is our work force?

Compile a statement for the next meeting

Chair of this work force group to present at federal board meetings, this will be part of the reporting process.

Meeting schedule

Next meeting will be a teleconference – something will be required to feedback to the RSA in June next year.

There needs to be a statement to present to the board meeting in November 2009.

Need to approach Jen Severn to modify website. These minutes will need to go on the work force page.

Have 1 person from each state to attend meetings also have a proxy ready.

Name of group will be Work Force Advisory Group (WAG)

To do – collate all possible tools and information. Look at what is of value from the already obtained information that would be good for the website. Add links to different networks to the web page. Maybe we need the word acuity on the web page.

Get membership right

All presentations from today please send to Sandra Handy so can be distributed to the group and referred to. Sandra_handy@baxter.com