EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 16 OCTOBER 2002

SESSION FOUR

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

DA COSTA, MS NANCY
Clinical Nurse Manager (Community Health),
Bentley Health Service,
examined:

The CHAIRMAN: Thank you for attending today. This committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of the Parliament. Have you completed the "Details of Witness" form and do you understand the notes attached to it?

Ms Da Costa: Yes.

The CHAIRMAN: Did your receive and read the detailed "Information for Witnesses" briefing sheet, regarding giving evidence before the parliamentary committee?

Ms Da Costa: Yes.

The CHAIRMAN: You have made a submission, and we would like you to elaborate on some of the points, so we have asked you to come in and talk about the three basic points you made. Is there something that is a burning issue, that you are passionate to discuss? You can begin with that.

Ms Da Costa: The main issue is community health nursing in general, but the reason I wrote to the committee was that we have some big issues with the increased complexity of the students that we are looking after in the school health system. Over the last four to 10 years, the number of students with disabilities, different kinds of diseases or conditions, or just general complexity, has been increasing in the general school community. In particular, I have a passion about special education schools, but before moving to that topic, I point out that there is no allowance in the funding for the school nurses' sick leave, relief and long service leave. That is my main problem, because nurses are entitled to those benefits in their award, and we must give them to the nurses when they require them. When they are sick or on long service leave, particularly in special education schools, we cannot leave those schools without a service, because those children need a nurse. If they are away for half an hour, an hour, all day or for a whole month, they must be relieved. To relieve them we must take from the district school nurses. If one of them is not available, it goes out to the high school nurses, or, as the last resort, child health nurses. Somewhere along the line we have to fill positions, so all those different services get upset and feel they have lost their nurse. It is a sort of ripple effect.

Special education schools are particularly vulnerable. We have three such special education schools in the Bentley Health Service catchment area. I suppose that makes our problem three times bigger than that of any other health service area. There are eight of these schools in the metropolitan area, as far as I know. There are two in the north metropolitan area, one in Armadale, two in Fremantle and one in the Kalamunda area. We have three. You can see the increased magnitude. Bentley is the smallest health service in terms of funding and things like that.

Mr M.F. BOARD: When you have finished giving us a bit of an idea of the issue, we will ask you a few questions to elaborate. This is a friendly inquiry - we are not on a witch hunt to put pressure on anyone or any area - but what we are particularly

looking at is the way in which we can improve the delivery of health services. There are emerging trends around the world for changing occupations, the way people enter them, the way they train, and the way they relate to one another. The committee particularly wants to look at that emerging trend and where the pressure points are for the existing occupations, where they might need additional assistance, or where the training institutions might need additional support. You are already starting to touch on these issues.

Ms Da Costa: To illuminate the complexities, I would like to talk about one of our special education schools at Kenwick. I have talked to the school, the staff know that I am here, and everyone is quite comfortable with this information being public. The school is in the Cannington school district, but it is serviced by the Bentley Health Service. I will provide a snapshot of the job of a registered nurse working at Kenwick. There are 85 students, of whom 26 are epileptic, and many are unstable. Nine are asthmatic, some quite severely so. Some students have rare degenerative disorders, and have to be fed by oral-gastric tubing, or through a button in their tummy, called intra-gastric. This week, there are 11 oral-gastric feeds a day. In the previous term, they had 21 a day, but there was a death at the end of the last term. That is a whole different scene. That child had been at that school for six years, and the school was very intimately involved with the family and the child. There was a lot of grief with that, but that is another story. A lot of these children have swallowing difficulties and require suctioning to maintain their airways while they are at school; some really frequently. The nurse also manages frequent seizures, because of the children with epilepsy. One child has had three seizures in the past two days. Sometimes they are calling 000 for an ambulance, to get a child admitted to hospital. This happens several times in a term. I do not like to give a number, but it happens quite frequently. There are 13 administrations of medication every day. One child has a rare disorder. I do not want to pick out one child, but these children have quite special disorders. They have behavioural issues. The school will often take a child that will not be accepted anywhere else, because of either reduced levels of intelligence, if they have an intellectual disability, or disruptive behaviour. Those children are often boisterous and knock other children down, or are aggressive because of their condition. Then the nurses are treating the staff with cold packs for bruising, and fractures and so on.

Immunisation is a huge issue for these students. Trying to take an ordinary child for immunisation is hard enough, but to go to the general practitioner with a kid with disabilities is much harder. They may be disruptive, having to wait a long time to get in to see the doctor. It is really difficult for the parents. The local government authority has pulled out of providing immunisation services in that area, so our community nurse has organised within our health service for a service to be given at the school. That is not funded, we just do it. A lot of liaison is necessary with other agencies on behalf of the child, with the staff and the parents. I am sure committee members know this, but in the case of a lot of parents of children with intellectual disability, either or both parents also have an intellectual disability, so their understanding of good health issues is not necessarily the best, or it takes time and they do not understand it. The nurse spends a long time with that. Broadly speaking, more complex situations are also arising in the district feeder and high schools that flow on from district primary schools because as we mainstream more children with difficulties and disabilities, the level of complexity and disadvantage spirals.

Mr M.F. BOARD: Obviously a trend is emerging and there has been a move to do more things in the community rather than accommodate more of these students in general classrooms as well as special education schools. You are on the ground in charge of a certain area. What would be the best way for the committee to assist in this area?

Ms Da Costa: As a manager I would like the funds to be available so that when these nurses take long service or sick leave I can replace them without taking funds from other services. That leave is covered in the on-costs for child health nurses or general nurses. It is part of the funding we get from the department. It is not available for school nurses and I do not know why that is the situation. I am presently managing this problem and it is too difficult.

Mr M.F. BOARD: What about the training aspect?

Ms Da Costa: Do you mean training at the outset or when we get the nurses in place?

Mr M.F. BOARD: Training as part of nursing education and transitional programs.

Ms Da Costa: At present there is no obligation for school health nurses to have anything other than a basic registered nurses qualification, which is considerable. However, we need more qualified nurses in the light of the complexity of the work. There is not enough training in counselling, for example. It is not considered to be a basic requirement; it is an extra qualification achieved subsequent to nursing. The problem with special education nurses is that we cannot allow them staff development time on a week day. They must be relieved entirely. They are fairly special people themselves in terms of their ability. We cannot take on any old agency nurse who has not dealt with the complexities that special education nurses face. Not only is it difficult to find relief for them but also funding is insufficient.

The CHAIRMAN: Schools are open for four terms, and for 12 or 14 weeks a year schools are not open. Is it not possible for nurses to be trained or up-skilled at that time?

Ms Da Costa: They have one day with Princess Margaret Hospital for Children, where the staff development training is excellent, at the beginning of term. They do it in their own time.

The CHAIRMAN: It is done in their own time. Are you saying that when schools are not open they are not employed?

Ms Da Costa: School nurses are contracted under school conditions. Their salary is annualised, so they are paid commensurate to the time they work. For the 12 weeks they are on holiday they get part of the salary they have earned throughout the term. We also provide education on a pupil free day, when they must update their compulsory requirements. They update their cardiopulmonary resuscitation, risk management etc.

Mr P.W. ANDREWS: How many high school nurses operate under your auspices?

Ms Da Costa: The Bentley Health Services covers four high schools. There are five nurses because one is a job-sharing situation.

Mr P.W. ANDREWS: Therefore, you have four full-time equivalents. What are the names of the high schools?

Ms Da Costa: Belmont City College, Cannington Community College, Kent Street Senior High School and Como Senior College.

Mr P.W. ANDREWS: Would nurses not take their long service leave from December to February, for example?

Ms Da Costa: That is their basic entitlement for annual leave. They take their vacation during the school holidays. Long service leave is equivalent to work time; therefore, if they took it on a full-time basis, it would be a term.

Mr M.F. BOARD: Is it the same contract as teachers work under?

Ms Da Costa: Yes.

The CHAIRMAN: Can they take half pay over six months?

Ms Da Costa: Yes, but they must still be replaced full time.

Mr R.A. AINSWORTH: You referred in your submission to a conflict between education and health and the role of the school nurse? Can you elaborate on that?

Ms Da Costa: From our perspective, the role of the school nurse is to screen the children to ensure that they are developmentally progressing satisfactorily. There should be surveillance of children who have been referred or who have on-going conditions, and it should be ensured that things are followed up and the children are looked after. A primary part of our job is health promotion and health education. School health nurses also act as mentors and as resource people, and as advocators for students with parents or other agencies. We think that is our role. The school thinks our work involves first aid; for example, if someone is hurt in manual arts we provide a cold pack to stop bleeding. That is very important and we like to do that. However, in our opinion, it is not the overriding reason we are there. We think education health promotion, advocacy and mentoring are our priorities.

Mr R.A. AINSWORTH: Does the conflict about your role differ among schools or is it fairly general across the system?

Ms Da Costa: There will always be a principal who is much more in touch and up to date witservices. Some principals are very supportive; for example, certain principals are happy to let nurses attend developmental courses and even support them by paying fees. One of the schools paid for the school nurse to attend the recent Community Health Nursing Conference. I am speaking generally. There is a conflict.

Nurses at district schools is a different issue altogether. They have sporadic contact with the schools. The district school nurse at Belmont is responsible for 15 schools. She cannot be in every one of those primary schools every week or fortnight. She might get there two or three times a term. Her primary objective is to get all of the children screened and to arrange referrals to ensure that children's health needs are met.

The CHAIRMAN: It is a hell of a job is it not?

Ms Da Costa: I come from a child health background, and am now responsible for school nurses, diabetes educators, Aboriginal health workers and others across the board. I have been very concerned about the position of school health nurses and their funding. That is why I wrote the submission.

The CHAIRMAN: Do you see another part of the health service profession emerging specifically to run school health?

Ms Da Costa: I would not like to lose school health because it is a great educator for the rest of the people involved in population health, as we now call it. As I said, I

would like to get some sense of the funding being resolved to ensure they are supported.

The CHAIRMAN: You would like recognition for their work.

Ms Da Costa: I guess so. I could be a school nurse. I am a registered nurse, I have raised three children and I live around the corner. In 2002 that does not reflect the situation. Nurses are extremely skilled and very valuable and they are not valued. School health nurses are not allowed to work in their role without a senior first aid certificate. However, at Bentley we cannot pay for these staff to sit for their certificate. They must pay for it. Every day they must deal with children having seizures, for example. Not only registered nurses are involved but also enrolled nurses. They work five hours a day. They do the certificate in their own time and pay for it themselves, yet we expect them to have it. I do not feel very good as a manager telling that to people whom I value and support.

There is a postgraduate course at Curtin for school nurses. I think it is called postgraduate certificate - I am not sure - but it is to be changed to a postgraduate diploma, which is good. People who want to be school nurses can do core units and further study. People who want to be generalists or undertake migrant health can study for it. I am told that program should take off next year. The cost of studying for that is prohibitive. Can the people whom we hope to get into these jobs afford to do this? Some sort of supportive scholarship would be good and very welcome.

You also asked about career paths. Due to the independent nature of the work community nurses do, they come into the system at level 2 under the Australian Nursing Federation award as clinical nurses. We have no level 1s because these people need to work on their own in a school, a child health centre or the community. They must work independently. A registered nurse with much experience is probably a midwife. If she is doing child health, she will have a bachelor of nursing. One of our generalists also has a postgraduate diploma in primary health and recently finished a postgraduate diploma in mental health. She is a level 2 and cannot be promoted to a higher level. She is very experienced and concentrates on migrant and culturally linguistically diverse health. We cannot give her any more money. We cannot promote her because there is no stream in community health for clinical nurse specialists. If she worked in mental health, she could advance to become a clinical nurse specialist. There are no positions in our field. She could go into management as I have done. However, there are five positions in the east metropolitan area for clinical nurse managers. There is not really anywhere for her to go. There is nowhere for the clinical nurse to go. I know of one research position at level 3 at Fremantle Health Service and they are very fortunate to have that. In the east metropolitan division we are looking at the roles and responsibilities of the senior nurses. We are well supported by the new population health unit at the East Metropolitan Health Service.

I am doing a project at the moment, looking at the roles. We are bringing back two level 4s, which is the old Australian Nursing Federation coordinator level. That is a blessing, which will happen and it will be great. There is one level 4 in Fremantle, and no others in the rest of the metropolitan area. Over the past 10 years, seven coordinator positions in community health have disappeared. If a nurses wishes to become a co-director or a director of nursing, or something like that, she must move out of the specialty, because there is nowhere to go. There is no career path to speak of at the moment.

The CHAIRMAN: Thank you very much for coming. It was extremely good to hear your evidence. The issue is very important and the more information we have the more productive and constructive this inquiry will be. The committee really appreciates your time. You will receive in the mail a copy of the transcript. We would like you to have a look at it. If you wish to make any alterations, will you please return it to us within 10 working days.

Committee suspended from 12.18 to 12.45 pm