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An investigation of nurse education service models in acute care metropolitan hospitals across Australia

Carolyn Keane  
*The University of Notre Dame Australia*

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# Chapter 1: Introduction

*Education is not the filling of a pail, but the lighting of a fire*

-Yeats-

## 1.1 Introduction

The provision of continuing professional development is necessary to support nursing staff in their delivery of safe patient care and to ensure they remain current with the rapidly changing healthcare environment in which they work (International Council of Nurses, 2015). Employing healthcare organisations have a responsibility to ensure that a range of professional development activities is available to staff to allow them to participate in continuing professional development and lifelong learning opportunities (Australian Nursing and Midwifery Federation, 2013).

Nurse education services within hospitals support nursing practice through the provision of ongoing high-quality education and training for nursing staff (Horner, 1995). They offer a range of services focussing on education, clinical support and professional development. Services offered by nurse education services within hospitals usually include continuing education courses, postgraduate specialist programs and coordination of graduate nurse programs and undergraduate students (Swansburg, 1995).

Most hospitals in Australia provide some form of nurse education service. These services can be delivered within the organisation in a number of ways. The aim of this study is to investigate nurse education service models in acute care metropolitan hospitals across Australia and to develop recommendations for future service delivery. This research study used a mixed methods approach with the research strategy containing three phases, commencing with a tertiary teaching hospital in Perth,

Western Australia (W.A.) before expanding to include acute care metropolitan hospitals in W.A. and then across Australia.

## **1.2 Background**

Staff development refers to the processes, programs and activities by which organisations develop, enhance and improve the skills, competencies and performance of their employees (Narayanasamy & Narayanasamy, 2007). Within healthcare settings, however, the term ‘staff development’ is often used to refer to a specific nursing education department or education service that functions within the organisation. These departments have multifaceted roles that include induction and orientation of new staff, competency management and training to support continuing professional development and safe patient care (Haggard, 2006a).

The terminology used to identify nurse education services and staff within healthcare organisations can vary widely between countries, states and even employing institutions (Conway & Elwin, 2007). Some of the terminology used in W.A. to name the nurse education department within hospitals includes the Learning and Organisational Development Unit, the Education Centre and the Staff Development Service. Nurse educator titles also vary between organisations and include Staff Development Educator, Staff Development Nurse, Program Coordinator and Program Facilitator. In addition to the title, the role, qualifications and scope of practice can also vary considerably. For example, nurse educators in the United Kingdom (UK) and the United States (US) often work both within academia and in the clinical environment, in comparison with nurse educators in Australia, who are solely employed by the hospital and work primarily in the clinical practice setting (Sayers & DiGiacomo, 2010).

In Western Australia, under the Department of Health and Australian Nursing Federation Industrial Award junior nurse educators are level two registered nurses (RNs) employed in education roles. An RN at this level is required to perform in the stream of clinical, management, research, or staff development duties delegated by a Senior Registered Nurse (SRN). The level 2 RN’s role includes delivering

comprehensive nursing care to a specific group of patients; providing support, direction, orientation and education; being responsible for planning and coordinating services; acting as a role model; assisting in the management of research projects/quality improvement programs and policy development; being responsible for education and training in relation to clinical practices and being responsible for the clinical supervision of nurses at Level 1 and/or enrolled nurses (Western Australia Health Department & Australian Nursing Federation, 2010).

In Australia, junior nurse educators working within hospitals may be required to undertake a variety of functions as part of their role, including participating in the hospital induction program and managing area-specific orientation for new nursing staff; planning, implementing and evaluating education and training programs to enable staff to achieve and maintain competency in clinical performance; and delivering area-specific and hospital mandatory competencies (McAllister, Oprescu & Jones, 2014). Junior nurse educators also provide clinical support and supervision to nurses who require performance management, assist with the supervision and development of undergraduate nursing students and undertake activities to identify and address nurse training and development needs (Conway & Elwin, 2007). This direct supervision encompasses the educator being present and personally observing, working with, guiding and directing the staff member or student being supervised (Australian Nursing and Midwifery Council, 2007).

In Western Australia, under the Department of Health and Australian Nursing Federation Industrial Award senior nurse educators are Level 3 SRNs employed in education roles. An SRN at this level is responsible for an expanded professional practice role, which may include, a role as team leader of health professionals; clinical/professional responsibility for a ward/ unit, an expanded role of clinical practice and/or management/leadership and the use of advanced problem solving strategies that influence, manage and coordinate patient care (Western Australia Health Department & Australian Nursing Federation, 2010).

Senior nurse educators working within hospitals are required to undertake a variety of functions as part of their role. These can include coordinating the development and

delivery of education and training programs to meet operational objectives and the learning needs of staff, and supporting the development of evidence-based standards and policies (Narayanasamy & Narayanasamy, 2007). Senior nurse educators are also responsible for human resource management and providing leadership, professional support and guidance for nursing staff (Conway & Elwin, 2007). This guidance may be in the form of assistance and advice given to nurse unit managers or junior nurse educators about their performance at work (McAllister, Oprescu & Jones, 2014).

### **1.2.1 History of Nurse Education in Hospitals**

Nurse education services and educators were first formally recognised in 1860 when Florence Nightingale established the first nurse training school at St Thomas' Hospital in London. The Nightingale School of Nursing revolutionised and professionalised nursing education, making nursing a viable and respectable option for women who desired employment outside the home. Following the establishment of the Nightingale School of Nursing, the Nightingale model of nurse education was quickly adopted worldwide by supervisors of public health institutions (Brooks, 2007).

The first nursing school in Australia commenced in 1868 when Florence Nightingale sent Lucy Osburn and five other English sisters to the Sydney Infirmary and Dispensary to improve the standards of the hospital. Osburn was successful in improving the standards of nursing, with the other sisters eventually taking up positions as matrons at other hospitals, which spread the Nightingale teaching model across the hospital system of the colony (South East Health, 2005).

The transfer of undergraduate nurse education from hospital-based training to university education commenced in the early 1980s and was completed in the 1990s. The initial qualification was developed at diploma level but soon progressed to a Bachelor's Degree and subsequently to Honours-level qualifications (Russell, 1990). Within healthcare organisations, specific nursing positions whose focus was education were created and implemented within the different career structures throughout the states of Australia (Henderson & Winch, 2008).

### **1.2.2 Continuing Nursing Education**

From the beginning, Florence Nightingale believed that continuing nurse education and lifelong learning were an important part of nursing practice. She stated that education did not finish with graduation and that nurses should never consider their training finished, as there was no end to what they may be learning every day (O'Shea, 2002).

Organised continuing nurse education efforts in hospitals have been traced to the depression years of the 1920s and 1930s. As the availability of work in nursing patients in their homes declined, nurses moved into staff positions in hospitals. This transition from private practice into group practice in an institutional setting was supported by orientation and training programs to acquaint new staff members with equipment, procedures and regulations (Poole, 1974). During World War II, the scope of nurse education expanded to include skills training to refresh inactive nurses returning to practice and to provide on-the-job training for volunteers and non-nursing workers. As professional needs grew over the years, nurse education services within hospitals grew in response, encompassing continuing education, leadership and management training, enhancing nurses' professional growth (O'Connor, 1986).

In reviewing the literature, three different models of nurse education services within hospitals were identified. These are described as centralised, decentralised and combination models. These different models are briefly described below but are examined in more detail in Chapter 2. When describing the structure of the different service models, it is clear that each model's structure supports specific advantages and disadvantages in how the service operates (Haggard, 2006b).

### **1.2.3 Centralised Model**

A centralised nurse education service model is one in which there is an organisation-wide approach to nurse training, where a central authority or department has the responsibility of meeting nurses' training requirements. In a centralised model, all education staff, even those placed within the clinical areas, report centrally to the

education department and coordinator of the education service (Cummings & McCaskey, 1992)

In a centralised model, there is a coordinator of the service who directs and influences all of the training being delivered across the site. In hospitals with this model, junior nurse educators may be based in clinical areas but report to senior nurse educators based in the central education department, outside the clinical area. The senior nurse educators and any other staff involved in the delivery of education, such as administration staff, all report to the coordinator of the nurse education service. In a centralised model, all of the educators have a reporting line to the education service and are also costed to this service (Haggard, 2006a).

#### **1.2.4 Decentralised Model**

Unlike the centralised model, in a decentralised nurse education service model there is no central training department, as educators within individual clinical areas are responsible for meeting the training needs of staff within their areas and report directly to the nurse unit managers. The nurse unit managers direct the nurse educators and have governance over education (Cummings & McCaskey, 1992)

In a decentralised nurse education service model, the junior and senior nurse educators are attached to individual clinical areas and report to the nurse unit manager of that area. There is no education and training service that operates across the organisation and no official reporting lines or relationships between the educators located within the different clinical areas (Haggard, 2006a). The individual nurse unit managers of each clinical area identify a need for a nurse educator and initiate the recruitment and selection process independently of other areas. In a decentralised nurse education service model, there is no overarching education department that delivers training across multiple areas or conducts hospital induction. Instead, all orientation, education and training needs are met in the individual clinical areas by the nurse educators employed in those areas.

### **1.2.5 Combination Model**

In a combination nurse education service model, there is a centralised education department delivering education and training across the organisation as well as clinically placed educators who are managed by the nurse unit managers and are independent of the education service. There is no relationship or reporting lines between the education department and the nurse educators managed by the nurse unit managers. A combination service model allows for the use of different aspects of the centralised and decentralised models. Some functions are delivered by the education service across the organisation, such as orientation and record keeping, while others are delivered in individual clinical areas by the nurse educators employed and managed by the nurse unit managers, such as unit-specific training (Cummings & McCaskey, 1992).

A combination service model can address the many conflicting demands placed on the nurse education service, such as maintaining ongoing routine programs such as hospital orientation, while also being able to respond rapidly to local unit needs that can emerge at short notice. A combination model allows nurse educators attached to the education service to focus on the delivery of programs across the organisation, such as graduate nurse programs and study days. The nurse educators employed by the clinical areas report to the nurse unit manager and can concentrate on delivering area-specific training with no connection to the education service (Cummings & McCaskey, 1992).

## **1.3 Topic and Purpose**

As outlined above, a number of different nurse education service models are used within acute care hospitals around Australia, including centralised, decentralised and combination models. All of these models have advantages and disadvantages that can affect service delivery, quality of service and cost.

In Perth, the capital city of W.A., there are a number of tertiary, general and specialist hospitals that are a mix of public and private organisations. All of these facilities have

nurse education departments that vary in size and function. In the 1960s and 1970s, all of these hospital nurse education services used a similar model, with the education staff reporting to a centralised education department and coordinator. However, in the 1980s and 1990s, a number of events occurred that directly affected the structure and function of these nurse education units.

These events included one of the hospitals in Perth changing the structure of its staff education service so that it delivered training across multiple hospitals within the one health service. A new national nursing staffing structure was also introduced that included junior and senior nurse education positions for the first time. In addition, new clinical divisions were developed within W.A. hospitals with services realigned under a new directorate structure. The result of this was that by the end of the 1990s the nurse education services within the hospitals in Perth had changed to a variety of service models (Sue Davies, personal communication, 15 May 2013; Gavin Leslie, personal communication, 4 June 2013; Spillman, 2008).

### **1.3.1 Significance of the Study**

The World Health Organization (WHO; 2013) estimates that the world will be short of 12.9 million health-care workers by 2035; with the shortage currently standing at 7.2 million. In regards to the nursing, it is predicted that 40% of nurses will leave health employment in the next decade worsening an already depleted workforce. In Australia nursing associations have identified significant shortages in the next 10 years, linked to the ageing population and the increasing complexity in health needs (Patty, 2016). The exodus from the nursing profession is expected to rise in the next few years with many surveys showing nurses are fed up with demanding workloads they are expected to take on (Health Times, 2015). Education and training for nursing staff is crucial to support the delivery of quality patient care by developing nurses' knowledge and skills to support their transition from novice to expert practitioner. However, continuing education is not just about addressing professional requirements for the job; it is also about developing other skills that allow for the promotion of both personal and professional growth (Sayers, DiGiacomo & Davidson, 2011).

Offering high-quality staff education can be one of the best ways to attract, motivate and retain talented people within the organisation. If an organisation has a good reputation for education and support, staff may choose to work there over other organisations and stay longer (Darbyshire, Downes, Collins & Dyer, 2005). Continuing nurse education is also a mandatory requirement of remaining registered with the national nursing regulatory body, the Nursing and Midwifery Board of Australia, which states that nurses must remain competent after registration and undertake continuing professional development of at least 20 hours each year (Nursing and Midwifery Board of Australia, 2010).

Continuing nurse education is required now more than ever. Nursing is under significant pressure with increases in the number, age and co-morbidities of patients, the rapid rise of technology and the emergence of new roles (Garrett, 2012; Henderson & Winch, 2008). However, it can often be difficult for nurse education departments to justify their existence when their activity and outcomes can be difficult to quantify. As the nurse education service is a support service within the organisation, in times of financial pressure the hospital executive can see education as something that can be cut to reduce costs. It is imperative that the nurse education department function as effectively and efficiently as possible and can produce measurable outcomes for the organisation to justify its cost in regard to the organisation's financial bottom line (Lindy & Reiter, 2006).

Another consideration is the Activity Based Funding (ABF) system, which commenced operation in W.A. in July 2010. Over time, ABF will extend to every aspect of the Australian public health system (Department of Health Western Australia, 2013). In 2009, the National Health and Hospitals Reform Commission recommended that the cost of clinical education be funded specifically in all relevant payment streams for public hospitals. This was prompted by a concern that without specific funding, education and training runs the risk of being squeezed out. The development of an ABF model for education and training is still in the planning phases, with work being undertaken to classify all of the elements of teaching and training, including scope, outputs and costs, to enable a model to be launched in 2018. This capturing and costing

of education as a separate activity in the future will have significant implications for healthcare organisations that will need to re-examine the structure, function and output of their education services (Council of Australian Governments, 2011).

Although numerous discussion articles have been published within the area of nurse education in healthcare facilities over the years, these papers appear to address specific aspects within the field, such as student and graduate nurse training and the development of specific clinical programs, with only a limited number focussing on the structure or model of nurse education services. In searching the literature, there appears to be only one American and one Canadian study that have undertaken research in the area, with their findings being weak and difficult to generalise. This study addresses this by looking specifically at nurse education service models and using a robust methodology to ensure the findings are generalisable.

No studies appear to have been conducted in Australia within this area, so it is unclear what nurse education service models are being used or the frequency of their use. This study addresses this gap by investigating the types of nurse education service models in use across Australia, the frequency of their use and the perceptions of the different models by nurse educators working within them. It also examines the factors perceived to have influenced the type of model adopted, as well as nurse educators' views regarding future priorities for nurse education. This study, undertaken within Australia using a robust methodology, adds to the existing body of knowledge and provides recommendations that will assist nurse education departments, which will need to be able to clearly define their business and demonstrate the direct results of their service on patient care outcomes to ensure the sustainability of nurse education services within healthcare organisations into the future.

### **1.3.2 Research Questions**

The purpose of this study is to investigate the different nurse education service models that are being used within hospitals across Australia to evaluate the efficiency and effectiveness of the different model types. To assist healthcare organisations to deliver on outcomes in the most cost-effective manner, it is imperative that research is

conducted into the various nurse education service models to demonstrate which is the most efficient and effective. The few studies that have been undertaken in this area to date have provided only weak evidence and are difficult to generalise. In light of the opening of a number of new hospitals across Australia, it is important to conduct further study in this area to inform the future models of nurse education services being developed for organisations to ensure the sustainability of the service into the future.

The research area of study is nurse education, with the research topic being nurse education services in acute metropolitan hospitals across Australia. The aim of the study is to investigate nurse education service models in acute care metropolitan hospitals across Australia and develop recommendations for future service delivery.

The research questions are:

1. What nurse education service model is used at Hospital One in Perth, W.A.?
2. What nurse education service models are used in other acute care metropolitan hospitals across W.A.?
3. What nurse education service models are used in acute care metropolitan hospitals across Australia?
4. What are the perceived factors that influence which nurse education service model is used at different acute care metropolitan hospital sites?
5. What are the views of nurse educators about the different nurse education service models used in acute care metropolitan hospitals across Australia?
6. What are the views of nurse educators about future nursing education priorities and services?

This research project contains three phases. Phase one focusses on Hospital One, a tertiary teaching hospital in Perth, W.A.; phase two expands the focus to acute care metropolitan hospitals in W.A.; and phase three includes all acute care metropolitan hospitals across Australia.

## **1.4 Summary**

This thesis presents a research project investigating nurse education service models across Australia. The research conducted in this area to date remains scarce and does not include the Australian context. This research project comprises three phases. Phase one focusses on one tertiary teaching hospital in Perth, W.A.; phase two expands the focus to include acute care metropolitan hospitals in W.A.; and phase three includes all acute care metropolitan hospitals across Australia.

This thesis comprises six chapters. Each chapter provides the reader with an understanding of the research, its findings, implications and conclusions. The aim of Chapter 1 has been to describe the background information for the research topic and research questions in relation to nurse education service models. Chapter 2 outlines the literature related to the area of nurse education and the different service models. Chapter 3 discusses the methodology of the research project, including the mixed methods approach and the methods of data collection and analysis across the three phases of the study. Chapter 4 provides an explanation of the qualitative and quantitative findings, including the demographics of the participants. Chapter 5 compares the study's findings with the literature and discusses the new knowledge gained from the study. Chapter 6 concludes by summarising the study and making recommendations for the future.