Second level nurses: a critical examination of their evolving role in New Zealand Healthcare

By

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Abstract

The role of the enrolled nurse in New Zealand healthcare has seen constant change and uncertainty over the last 30 years (Wilson, 2000). Positions have disappeared, the regulatory body of the Nursing Council of New Zealand has imposed disadvantageous regulations and there has been a wide-held view that enrolled nursing is at the bottom of the professional ladder (Waitere, 1998). Enrolled nurse training was disestablished in 1993 and re-introduced in 2003, but at the same time the title was changed and the scope of practice diminished. It is therefore difficult to understand why anyone would choose this level of entry into nursing. Yet, for Maori, it appears to have been a viable option because proportionately, there are a greater number of Maori in enrolled nursing that in any other health profession.

Enrolled nursing has evolved in a more equitable way in Britain, where it is not the qualification, but the job role that defines the scope of practice. This paper examines the evolution of the enrolled nurse in New Zealand from my perspective as a registered nurse who has worked with enrolled nurses in both Britain and New Zealand settings and who values the contribution that enrolled nurses make to healthcare outcomes to patients. I have analysed key documents from a critical perspective to draw conclusions about the positioning of enrolled nurses in New Zealand and make recommendations for a more equitable and emancipated future for enrolled nurses.

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Chapter 1

Introduction

This research project is a critical examination of the evolving role of the second level nurse in New Zealand healthcare; from the original inception of the Nurse Aid role in 1939, through to the Nurse Assistant role of 2008. It will be examined through the lens of a British trained Registered Nurse, whose work role combines both professional leadership and operational management. This weaving of roles creates tensions when those in positions of responsibility strive to ensure evidence-based, quality nursing care provision within the constraint of tight budgetary controls. This first chapter will begin with an overview of what second level nursing is including an international perspective, to show why I have chosen this important area of nursing for this project.

Three types of nursing activity are recognized by the International Labour Organization (Warr, Gobi, & Johnson, 1998). The term first level nurse denotes a professional registered nurse (RN) who has completed a 3-4 year preparatory education programme, leading to registration on a Nursing Council register. Second level nurses studied for between 12 and 24 months and were awarded the title enrolled nurse, while untrained nursing aides are classed as third level practitioners. Within this project the terms enrolled nurse and nurse assistant are both used to denote a second level nurse in New Zealand. The title of nurse assistant has been in use since September 2004.

My personal interest

The role of the second level nurse has been of personal interest since my early nursing days in the United Kingdom when *pupil* nurses (trainee enrolled nurses) trained alongside *student* nurses (trainee registered nurses). When I arrived in New Zealand in 2003 I discovered that the way second level nurses are positioned within the New Zealand health system was quite different to the positioning of second level nurses in the United Kingdom. Recently, as an employer, my interest has risen further due to the chronic shortage of registered nurses in Rotorua and the announcement that the Polytechnic in Rotorua (Waiariki Institute of Technology) is offering a nurse assistant programme. This is in addition to the undergraduate registered nursing degree that they already offer. While in discussion with the polytechnic regarding accepting student nurse assistants on practicums, it was expressed that most of the students who undertake the course are local to Rotorua and in search of future employment in the Rotorua area. This was of particular relevance as I am the manager of a large retirement village and care home facility. The first programme planned for 2009, will have a rehabilitation/care of the older person endorsement. This course will complement the six other educational institutions (North Tec, Christchurch Polytechnic Institute of Technology, Southern Institute of Technology, Manukau Institute of Technology, UNITEC New Zealand and Whitireia Polytechnic) who have been accredited by the Nursing Council of New Zealand to provide nurse assistant education programmes.

With the current national and international shortage of first level or registered nurses the debate around the second level nursing workforce to support registered nurses is an important issue for healthcare. This was acknowledged by the previous New Zealand Labour government; with the setting up of an Advisory Committee on the Clinical Workforce to support Registered Nurses in 2008 (Ministry of Health, 2007).

This research project will compare United Kingdom, Australian and New Zealand perspectives on the second level nurse's role. While all three countries have very similar second level nurse origins, they have diverged into three distinct pathways, all of which have an impact on the situation in New Zealand. It is important to include the Australian perspective due to the significance of the Trans Tasman Mutual Recognition Act 1997, and the way that Australian enrolled nurses are recognized in New Zealand (News Update April 2008). In brief, the United Kingdom ceased training second level nurses in the late 1980s, while Australia has continued to provide second level training, with the role being further developed, (Milson-Hawke & Higgins, 2003; Milson-Hawke & Higgins, 2004; Duckett, 2005). In New Zealand training ceased in 1993 and recommenced in 2002. This project argues that second level nurses have a pivotal role in the healthcare system in New Zealand. They are a valuable and untapped resource that have much to contribute to providing safe, effective and regulated nursing care.

New Zealand, along with a number of other countries is experiencing nursing workforce shortages (Boelen & Kenny, 2009) with an increase in the non-regulated workforce (Buchan & Dal Poz, 2002). There is an important debate to be had over the training of second level nurses and their subsequent employment, particularly in the current healthcare climate where there are acute shortages of first level registered nurses. The tradition of second level nurses filling the gap at times of registered nurse shortage is not a new phenomenon (Webb, 2000). Raising the status of second level nurses so that they are a defined workforce to be reckoned with would go some way to removing their image as simply a poor substitute for a registered nurse.

Aim of the research

The aim of this project is to critically examine the evolution of the enrolled nurse role in New Zealand over the last 30 years through a personal, gender and cultural safety lens.

Focus and method

According to Higgs, Richardson and Dahlgren (2004, p. 67), using a critical research paradigm allows us to generate emancipatory knowledge which enhances our awareness of how our thinking is socially constructed and how this limits our actions. Particular attention will be paid to the Clinical Workforce to Support Registered Nurses, draft document published in July 2008 by the Nursing Advisory Committee for the Ministry of Health. This is an important document as its recommendations will shape the future second level workforce. According to the Nursing Advisory Committee the registered nursing and second–level clinical workforce is a product of government policy, the regulatory system, clinical safety standards, the interests of training and education providers, health service requirements and the local and global health workforce market (Ministry of Health, 2007a).

Other key documents I examined are the Nursing Workforce Strategy (Green, 2006), the seminal PhD research thesis by Alison Dixon *Critical case studies as voice: The difference in practice between Enrolled and Registered Nurses* (1996*),* which gives a comprehensive account of the industrial and political action taking place regarding second level nurses from the 1970s to the 1990s and Adamson's action research thesis of 1997, *The journey from Enrolled Nurse to registration and beyond: Discovering a process to promote self-efficacy and professional development.* Other documents that will be referenced to this work include the views from the professional bodies representing nursing, the Nursing Council of New Zealand, the New Zealand Nurses Organization and the College

of Nurses, Aotearoa, while the the Raranga Tupuake: Maori Health Workforce Development Plan – 2006 (Ministry of Health, 2006), provides the strategic framework for the development of the Maori health and disability workforce over the next 10-15 years. These documents are supported with additional New Zealand research and research from the United Kingdom and Australia.

The Treaty of Waitangi

The Nursing Council of New Zealand sets specific guidelines for the practice of cultural safety, the Treaty of Waitangi and Maori Health (Nursing Council of New Zealand, 2005). As a New Zealand registered British trained nurse, my practice is overseen by the Nursing Council of New Zealand. Therefore this research project will respect the need to uphold the principles of the Treaty of Waitangi, ensuring the concept of kawa whakaruruhau (cultural safety) and affirming that Maori as *tangata whenua* hold a unique position in this country. Tangata whenua is a Maori term and literally means "people of the land". It has become a New Zealand English term and holds a specific and important legal status whereby under the Treaty of Waitangi, Iwi are accorded special rights and obligations under New Zealand law. While New Zealand law is based in British Common Law, a richness is added when indigenous concepts that stem from a completely different ancestry is combined. I have sought guidance from reading the Guidelines on Ethics in Health Research (Health Research Council, 2005) and the Guidelines for Researchers on Health Research Involving Maori (Health Research Council, 2008*)*. While this research does not use individual participants and is purely a review of documents, I need to be mindful that people of different cultures may hold differing basic beliefs and that due recognition of the indigenous culture of Maori must be acknowledged. Part of providing culturally safe nursing practice, is recognizing that the process to attain cultural safety is underpinned by communication, recognition of the diversity in its worldviews and the impact of colonization processes on minority groups. Further discussion on the position of Maori nurses is developed within this project.

This first chapter has introduced the concept of the second level nurse, explained my personal interest and has set the scene for Chapter 2, which will commence with an explanation about how this research will use a critical social theory framework to critique the fundamental ideologies underpinning a second level nursing workforce. Through a literature search, a historical overview will be given to set the scene for this project, while themes related to the social, political and professional issues of having a second level nursing workforce will be established and examined in detail, pursing the relevance to current healthcare practices in New Zealand.

Chapter 2

Background

The beginning point for this research was a literature search using a variety of on line nursing and healthcare databases, accessed through the Waikato institute of Technology (WINTEC) library site and the medical library at Lakes District Health Board. Keywords were: enrolled nurse, nurse assistant, second level nurse and nursing skill mix. Despite using multiples of each key word, I was disappointed to find a lack of research available in the category of second level nurses' roles. Many papers focused on enrolled nurse conversion to first level (Allan & McLafferty, 1999; Iley, 2004; Kenny, & Duckett, 2005) or why enrolled nurses choose not to convert (Webb, 2001) or the careers of enrolled nurses after completing conversion courses (McLafferty, 1999). Papers looking at skill mix appeared to focus on the role of the registered nurse and the nurse aide or unregulated workforce (McKenna, 1995; McGillis Hall, 2003; Lee, Yeh, Chen & Lien, 2005). Surprisingly, the amount of research on the nurse aide/healthcare assistant and unregulated healthcare workers appears to far exceed those for the category of second level nurse and perhaps gives an indication of the level of interest in this section of the nursing workforce. In the data-base searches that I performed I, uncovered very few papers that were of New Zealand origin, with most coming from Australia (where enrolled nurses are still trained and are very much part of the healthcare workforce) and from the United Kingdom. However, these papers tended to be from a historical perspective only. Of note is the fact that the majority of papers on unregulated healthcare workers comes from the United Kingdom (Hancock & Campbell, 2006; Warr, Gobbi, & Johnson, 1998; Thornley, 2000; Warr, 2002). Of the available New Zealand papers, the majority are from the College of Nurses, Aotearoa and the New Zealand Nurses Organisation. I also uncovered valuable research information through doing a hand search through *Kai Tiaki: Nursing New Zealand* journals from the 1990s and early 2000s.

This study is limited to a document review which is an appropriate research methodology. A more substantial and longer study could have included interviews with second level nurses. This would have added to the richness of this project. The voices of those nurses who have lived and worked through these changes recounting their personal stories, contributes so much to our own understanding of past events. For example, Wendy Johnson, an enrolled nurse who was made redundant along with 85 other enrolled nurses from their jobs at Hawkes Bay District Health Board in January 1998, says:

> *I feel so many things have been stolen from me over the last few months….I feel my life has been turned upside down and it was never my choice. I was comfortable with being an EN and my ambitions were satisfied through my work with NZNO….I miss the satisfaction of helping people get better or at least get comfortable. I miss the conversations with patients and the knowledge I gained from hearing their stories. I have been a nurse for 21 years and thought I'd done a really good job. I believed I was an effective member of the health team and gave the best I could to nursing (Kai Tiaki: Nursing New Zealand. March 1998. p.7).*

Johnson chose not to bridge to registered nurse status and left nursing altogether.

This was where I came in. As an employer, I needed to examine what role I could play in the education of nurse assistants who would be studying at Waiariki Polytechnic in Rotorua, the local tertiary institute. My role as a manager in the local service provider was to provide practicum placements for nurse assistant trainees and develop their roles once they were employed.

Critical Social Theory

This project uses a critical social theory framework, so that social, historical, political and professional perspectives can be examined in the context of questioning the creation and role of a second tier of nursing workforce. Critical social theory examines the overt and covert structural relationships between power, control and dominance. Critical ways of knowing emanate from the Marxist-orientated Frankfurt school of German scholars, from liberation movements such as feminism and the revolutionary thinking of Paulo Freire (1921-1997) who worked with the underprivileged and dispossessed. Paul Freire (Matheson & Bobay, 2007), created a model of oppression based on the observations of Brazilians, who had been taken over and dominated by Europeans, consequently the values of the dominant group were internalized as part of the Brazilian culture. Freire believed that education was a means whereby oppressed groups could become aware of their subjugated status and the myths perpetuated by their oppressors, hence paving their way to emancipation, consequently the values and norms of the dominant group are viewed as the *right ones* in society, while the characteristics of the oppressed group are negatively valued, creating low self esteem and the development of self hatred. This also reinforces the belief in the dependant role of oppressed groups. This bears significant similarities to New Zealand culture, due to the post colonial relationship between the Maori (indigenous New Zealanders) and Pakeha, the European New Zealanders. Within New Zealand, the dominant culture in health remains that of the traditional Western biomedical model (Richardson, 2003), while an unspoken assumption of the benefits of a scientific knowledge base, together with its role as an arbitrator of reality has allowed for this dominance of the positivist paradigm in health care. Consequently, this has lead to the marginalization of those who hold a different world view, namely Maori, whose beliefs encompass the concept of a community, societal based level of responsibility for individual wellbeing. With fundamentally different world views, this inevitably creates conflict, when the individual opposing sides attempt to

communicate. Richardson goes on to argue that the impact of colonization and cultural impositions are invariably linked to poor Maori health statistics, lower life expectancy, lower birth weight and a greater likelihood of belonging to a low socioeconomic group.

Critical social theory is often connected philosophically and methodologically with the work of Freire who followed a Marxist tradition. He believed that people must emancipate themselves and overcome oppression, that the key to resolution must be grounded in a grassroots effort from the oppressed group. Habermas of the Frankfurt school is considered the most notable modern or second generation critical theorist. Habermas described emancipation as a process achieved through mutual understanding, critical reflection and communicative competence. This critical focus is required to reveal exposed dominance and oppression. The underpinning conviction that supports this philosophy is that no aspect of social phenomena can be understood unless related to the structure and history in which it is found (Fulton, 1997).

Critical social theory in nursing is often seen as being generated by emancipatory action (McCormack, Manley, Kitson, Titchen & Harvey, 1999), while Mooney and Nolan (2006), expressed the view that critical social theory is a means to frame enquiry with the aim of liberating groups from constraints that interfere with balanced participation in social interation. However as critical social theory concerns itself with ways of seeing the world and its systems, it can be used with a variety of research approaches that enable individuals to address constraining factors that have hindered change and creativity. Ball (1992) used a critical social theory approach for her research into adult education and the anti-racist feminist praxis, while the work of Fontana (2004) seeks to clarify the confusion surrounding a critical methodology within nursing research, by defining critical science within nursing and by synthesizing seven common processes seen in critical research. These foundation processes are consistently seen in critical studies; critique, context, politics, emancipatory intent, democratic structure,

dialectic analysis and reflexivity. Fontana goes on to state that when each of these processes is present and the study grounds itself or at least in part with the critical tradition, the study can be considered critical. These processes are not to be considered as steps to follow, rather it is the synthesis of these processes that constitute a critical methodology for nursing research (Fontana, 2004). It is parts of this approach that I wish to demonstrate through this project.

Feminist perspective

This project also embraces underpinnings from a feminist perspective, as essentially nursing remains a female orientated profession. According to Webb (1993), while feminist and critical approaches share many assumptions; emacipatory goals of research, variety of methods, the recognition that the knowledge is socially constructed and acknowledgement of the oppressive nature of social structures, gender is not the central concern of critical theorists. In contrast feminist theory places gender central to the research, respects and values feeling and experiences, calls for more equal partnerships and claims the importance of making feminist writings accessible to all. Gender has significant implications for the roles, responsibilities and capabilities of the individuals, with nursing intrinsically linked to the dynamics of power that affect women within our culture (Clifford, 1992). In New Zealand, over 40,000 women and less than 3,500 men hold Annual Practising Certificates (News Update December 2007).

Influences in nursing

According to Smith and Mackintosh (2007), nursing has traditionally been a profession dominated by class hierarchy, reflected in nurses' positions and locations. This is supported by Fletcher (2006), who states that the practice of nursing today has been strongly influenced by the historical development of the practice, within hierarchical, autocratic, and oppressive institutions. Fletcher goes on to state that groups are oppressed when forces outside themselves control them, that these controlling groups have greater prestige, power and status than

the oppressed group. Power within nursing has been defined as having control, influence or domination over something or someone (Chandler 1992). However, this view contrasts with that of Ryles (1999) who believed that power can be an infinite force that helps to establish the possibility that people can free themselves from oppression. Historically nursing was seen as subservient to the male dominated medical profession. Nurses trained under Nightingale were required to be “trained and disciplined” (Daly, Speedy & Jackson 2000, p 13), while the tradition of doctors providing lectures to trainee nurses continued until at least the 1980s in the UK. This is supported by French (2001) who outlined the unequal power and knowledge between nursing and medicine, as historically knowledge was imparted to nurses from doctors, who also exerted control over practice, particularly through their influence on legislation. In New Zealand the state nursing examination from its inception in 1901 until 1937 was written and marked by the medical profession with an absence of nursing input. Sargison (2001) noted that the nursing profession was shaped by the medical profession, who asserted themselves as social and political leaders. This image or self concept of women was marked by sexism and subservience to male domination without autonomy and in most instances led women not to assume leadership positions (O’Bryan Doheny, Cook & Stopper, 1997, p 63).

Within nursing, social and cultural influencing factors have their origins in the view of nursing being women’s work. Nursing has always had a gendered identity, as traditionally most of its recruits are female and a number of nursing skills are seen as natural female attributes, rather than competencies that are developed through professional education (Iley, 2004). Although the perception of nursing as women’s work is criticized by nurses, it continues (Department of Health, 1999). This gender issue also explains why nurse are so keen to undertake technical male dominated medical tasks, which often obscure the value of traditional nursing care skills. Of particular note is the fact that men were not permitted until 1939, when the *Nurses and Midwives Act (1925),* was

amended, that men were permitted to register on the male nurses register (Gade & Hornblow, 2007)

Due to the complex nature of critical social theory and the brevity of this research report, while race and class are aspects to be considered, this report is going to concentrate of gender and ethnicity.

Chapter 3

The tradition of nursing

This chapter will commence with a historical overview of nursing and the emergence of the second level workforce leading up to the current position. The whole history of nursing has its roots in the works of religious nursing orders which existed in the middle ages and was viewed as a vocation for nuns, whose ambition was to alleviate the suffering of sick people (McGough & McGough, 1998). Florence Nightingale's role in shaping modern nursing was to create a respectable profession for upper middle-class women in the mid 19th century. A model of nurse training evolved to train matrons as leaders of bedside nurses, as it has been suggested that care work was regarded as lower class and carried out under the moral leadership of upper class women. Central to nursing is the delivery of direct patient care; however this seems to be constantly sidelined from the core of professional practice (Smith & Mackintosh, 2006).

My United Kingdom experience

In the United Kingdom, enrolled nurse training began in response to the Nurses Act 1943 which allowed for the training of second level nurses to assist first level nurses in the delivery of nursing care (Cockayne, Davis, & Kenyon, 2007). In New Zealand second level nursing began in 1939, as a response to the shortage of registered nurses created by the Second World War. This was a two year course leading to registration as a nurse aid with the name changing to enrolled nurse in 1977. In the United Kingdom, entry to the two year enrolled nurse course was by passing two, rather than the five General Certificate of Education (GCE) O levels that were pre-requisites for training as a registered nurse. Hallam (2002) comments that the two levels of nurse training were viewed at the time as one way of alleviating the chronic nursing shortage, as it allowed entry requirements to be lower, giving a greater number of potential applicants. The

training which was hospital based was designed to be practical in nature. According to Swaffield (1991) candidates for nurse training were informed by nurse teachers that there was no difference between the roles of RN and EN, this is supported by Foong and Mackay (1996) who stated that once trained the EN often undertook the same functions as the RN and depending on staffing levels, they were responsible for managing wards

At the hospital that I trained at in the United Kingdom, pupil nurses completed the same clinical placements as student nurses during their two years. They shared tutorials and lectures, with slight differences in the academic assignments they were required to pass. Pupil and student nurses wore the same white uniform, distinguished only by a pale green strip for pupils and a pale blue strip for students on their caps. This issue of differentiating rank by the colour of uniform or cap is an interesting example of the imprinting of a hierarchical system and is noted by both Kenny (1993) and Mackenzie (1997), who notes that “unlike first-level nurses whose work-wear differs widely on a national scale, enrolled nurses’ uniforms were noted to be always be green, to which the wearers attached the symbolic meaning of naiveté, incompetence and a lack of experience”.

At the end of the second year the pupil nurses sat their final exams and were awarded enrolled nurse entry to the nursing register (McGough & McGough, 1998). Student nurses who left during the third year of training or who completed the third year of training and then failed their final exams could be granted the award of enrolled nurse as they had fulfilled the requirement of two years of training. The enrolled nurse qualification was also awarded to healthcare staff in some of the long-stay hospital institutions, after the completion of fifteen years of service. This gave them a qualification by virtue of long service. In the UK it was common place for EN’s to then go on and convert to a registered nurse status by completing the third year of training. This third year of training for general nurses consisted of placements in mental health, maternity and paediatrics (all areas that also had their own specialist training) and then a management block,

designed to equip the soon-to-be staff nurse with the skills to effectively and efficiently manage a ward. Second level training was also divided up in to sub-specialties, (as with RN training), general/adult, mental health and learning disabilities/mental sub-normality. Once enrolled nurse training ceased in the UK, all EN's were encouraged to convert to first level registration and a variety of opportunities were made available (Allan & McLafferty, 1999). Flexible open learning courses were developed and the number of years' experience and where that experience had been gained were taken into consideration, with many EN's having to complete a reduced conversion course of months rather than a whole year. While in New Zealand, the one year second level training was a stand-alone, requiring the EN to complete almost a whole three years to become a registered nurse. In Australia enrolled nurse training varies in length from state to state but is between one and two years, with a flexible approach to converting to first level registration (Boelen & Kenny, 2009).

New Zealand training

As mentioned previously, New Zealand second level training began in 1939. This two year hospital-based training programme led to registration as a nurse aid, while the changes to the Nurses and Midwives Act in 1965 saw the introduction of an 18 month practical programme. These nurses were called community nurses in the expectation that rather than working in the hospital sector they would work in the community (They could also do further 6 month endorsements in medical or surgical nursing). Unfortunately, this was not the case and by 1977 the title was changed to enrolled nurse with a reduction in the length of the training programme to one year. It appears to me that this position of community nurse was a genuine attempt to create a valued and professional working group, with a clearly defined role, yet I have been unable to clearly ascertain the reason for the devolution of this position, other than the introduction of the 1977 Nurses Act.

Direction and Supervision

In 1983, amendments to the Nurses Act (1977) brought in the requirement that enrolled nurses were required to practise under the direction and supervision of a Registered Nurse or Medical Practitioner. At the time (1983), there were two major stakeholders in the nursing profession, the New Zealand Nurses' Association (NZNA) – now known as the New Zealand Nurses Organization (NZNO) and the Chief Nurse of New Zealand, who was the spokesperson for the Department of Health. By statute both NZNA and the Department of Health were represented on the Nursing Council of New Zealand and it would not have been possible for the changes to the Nurses Act 1977, with regard to the need for enrolled nurses to be under the direction and supervision of a registered nurse, without the support of these stakeholders. According to Dixon (1996), even though the law changed the tensions between registered nurses and enrolled nurses remained unabated. It was felt at the time that the Nurses Act (1977) and Amendments had little relevance to nurses in their daily lives until something went wrong; with the Amendment creating new problems for the profession, due to its lack of clarity and definition. What exactly did supervision and direction really mean? A Nursing Council of New Zealand position paper *Direction and Supervision, 1999* offered guidelines to clarify the requirements; however it was acknowledged that the application of direction and supervision varied within different settings with much debate being had about levels of delegation and supervision, whether it be indirect or direct. Feedback from the 1996 NZNO Conference (Kai Tiaki, October, 1996 p.18), stated that NZNO no longer supported enrolled nurses having to work under the direction and supervision of a registered nurse. The 1996 NZNO Conference passed a remit, with minimal debate, from the enrolled nurses' national committee stating that enrolled nurses:

- Protect and promote the wellbeing of the patient/client at all times
- Practice safely and competently within their sphere of knowledge and experience
- Provide nursing care in co-operation with other health professionals.

The conference feedback went on the state that, Committee chairperson Margaret Pink was thrilled the remit had passed, saying it had taken a lot of hard work over a number of years to reach this point. They needed to get rid of the direction and supervision clause, which was never in the original Nurses Act, but in an Amendment in 1983. However, the content of this remit was never enacted by employers and the nursing Council and the direction and supervision clause remains in the scope of practice for enrolled nurses.

It is not until June 2008 and the publication by the Nursing Council of New Zealand *Guideline:direction and delegation (2008),* which replaced the 1999 Direction and Supervision paper, that some clarity is given to the meaning of delegation and direction. Yet interestingly, enrolled nurses and nurse assistants are not named in this document. Its focus appears to be the unregulated healthcare workers. Is this yet another way to marginalize the second level workforce? Is it a way of reducing their role to that of an “untrained worker”? While it is acknowledged there is a rise in the number of untrained workers in the health workforce, there still remains a significant number of second level nurses who work under the direction of registered nurses. Registered nurses need to be aware of their role in delegation. Indeed it is a competency requirement under the Health Practitioners Competency Assurance Act (2003), so, would it not have been prudent for Nursing Council to have at least mentioned by name the second level workforce within this document? Although it must be acknowledged that under the principles of direction and delegation the registered nurse must take into account the level of knowledge, skill and experience of the person to perform the delegated activity. Is this the catch all phrase to incorporate second level nursing?

Accountability

On the other side of the debate surrounding direction and supervision, is the issue of accountability, with each registered nurse, midwife and enrolled nurse remaining individually accountable for their practice, with being accountable meaning being answerable, chargeable, culpable, liable and responsible. Enrolled nurses are not able to delegate his or her nursing care duties to unregulated health care assistants, with the responsibility of carrying out the assigned nursing duties firmly remaining with the enrolled nurse. Increasingly health care assistants are being employed, and where the registered nurse delegated duties to them, the registered nurse accepts responsibility for those tasks. This even applies when the family are assisting with the care of the client/patient/resident/woman.

A single level of practice

Internationally, in the late 1980s there was much debate around there being only a single level of nurse that of the professional registered nurse, with advancement towards attaining professional status for nursing being well documented (Dingwall, Rafferty & Webster 1988, Webb, 2000). According to Parkin (1995), professionalization can be described as a political process, with issues of power and control central to achieving this. White (1985) acknowledges that while Enrolled Nurses have been essential to the workforce numbers, they have been a “thorn in the side” of those who wish to advance the occupation of nursing towards attaining professional status.

The view that there should only be a single level of nurse has long been held by the College of Nurses Aotearoa. Their position paper on “The Current proposal to reinstate Enrolled Nurse training in New Zealand”, August 2000, clearly states that:

> “the College considers the proposal to re-introduce training of a second level person who is called a nurse will undermine the development of professional nursing in New Zealand”

This they claim is supported by the International Council of Nurses, who at its 1985 conference made a strong case for the term nurse to mean registered nurse only (College of Nurses Aotearoa. 2000).

The demise of the Enrolled Nurse

In New Zealand, hospital based enrolled nurse training ceased in 1993. Recommendations following a workshop facilitated by the Department of Health in 1989, put forward that Area Health Boards should decide their own service needs in terms of the number of trainee enrolled nurses it would accommodate. The responses varied greatly, with some looking to increase trainee numbers, others reducing trainee numbers, while others looked to cease training due to budgetary constraints. With the support of the then Minister of Health and the Crown Health Enterprises, in 1994 Nursing Council revoked hospital schools of nursing. The Ministry’s justification for this was stated as “sector driven”. According to Dixon (2001), while enrolled nurses were trained to work under the supervision and delegation of registered nurses by providing care to patients with relatively stable and predictable health outcomes; due to the health reforms of the 1990s, very few patients in the public health system could have been classified in this way. Added to this was a tighter level of fiscal control, which was a contributing factor, as an experienced enrolled nurse was paid more than a beginner practitioner registered nurse. Employing a beginner practitioner was seen as more cost effective, due to the limitations on the scope of practice of the enrolled nurse (Oliver, 1997).

The picture from the United Kingdom (UK)

The two separate levels of practice continued in the UK until 1986. It had been argued by the United Kingdom Central Council that the role of enrolled nurse was no longer fit for purpose, stating that staffing and recruitment levels could be maintained through higher education and the development of the unqualified and less expensive healthcare assistant (Cockayne, Davis & Kenyon, 2007).

From my own experiences of nursing in the UK during the 1990s, there was the overwhelming concern that with the demise of Enrolled Nurse training and the development of Project 2000 which saw nurse education transfer to higher education institutions and the emergence of Diploma and Degree educated nurses, would those RN's who held hospital level training, be perceived as the *"new version"* of the second level nurse? So what did happen? Certainly there was no visible division that many hospital-certificate level nurses had so feared. At the coal face of nursing, nursing registration was equal whatever the educational background. Fears of Registered Nurses having to differentiate by uniform colour as to certificate, diploma or degree educated simply did not occur.

The biggest change, in my view, came within the nursing management structure. Where once career progression was linked frequently to *time served* and who was *next in line* for the role of such as Sister. Job advertisements started to request that potential candidates hold English Nursing Board (ENB) certificates. Examples of these included; Clinical Teaching (ENB 998) and a whole host of nursing specialities such as the Care of the Elderly (ENB 741). Toward the end of the 1990s, these certificated papers were accredited to a points system and could be used as Accreditation of Prior Learning towards the Diploma in Nursing and the Degree in Nursing. While a full degree was 240 points, 60 points were awarded to certificate/hospital trained nurses toward attaining a diploma or degree. While these ENB papers were being studied by Registered Nurses,

Enrolled Nurses were also eligible to apply and there were also specific Enrolled Nurse papers available separately.

One of the significant moves in the United Kingdom to remove the barrier between Registered Nurses and Enrolled Nurses was the introduction of the Clinical Grading system in the 1990s. This system Graded the job rather than the person. Enrolled Nurses, who chose not to convert to Registered Nurse status, frequently held higher grades through experience or post enrolment professional development. In practice this gave Enrolled Nurses the ability to be senior to Registered Nurses, as there was no directive, as is the case in New Zealand that UK Enrolled Nurses have to work under the direction and supervision of a Registered Nurse. This system reinforced the hierarchy system, yet at the same time allowed the development of a defined career pathway. Importantly it linked specific roles to expectations of responsibility, with everyone being aware of who was in charge/the most senior member of staff at all times. Unfortunately a significant negative of the grading was the animosity (frequently between colleagues) during the original grading exercise, with many disgruntled nursing staff appealing their grades. This grading system has now been succeeded by the Agenda for Change directive and the Grading is now a numerical one.

Nursing New Zealand style

At first I found the *flat* system of general ward nursing within the District Health Board system, to be confusing, with automatic yearly salary progression, irrespective of additional training or ability. In my experience the number of years qualified did not denote the ability to lead or direct a team, it merely demonstrated (particularly with a few staff) *sticking power.* Having worked with many enrolled nurses who held senior positions in the UK, I brought with me an assumption that New Zealand EN's would be equally positioned, however from my first observations it was clear that their scope of practice was significantly less with low status attached to Enrolled Nurses at ward level. According to

Alexander (2003) the removal of Enrolled Nurse from working in mental health and acute care environments, appeared to be little more than a knee jerk reaction to a high profile report on the care of Mark Burton, while a mental health inpatient at Kew Hospital in Invercargill. While yet more was taken from Enrolled Nurses recently, with their removal from working night duty in one Wellington hospital (and general national discussion that they should be removed from night duty in all District Health Board hospitals), following the death of a patient and a subsequent Health and Disability Commissioner enquiry. Again this appears to be an unqualified knee-jerk reaction towards Enrolled Nurses, where various other options could have been explored, that are more positive and constructive. On examination, this was a complicated enquiry, with no direct blame being apportioned to the Enrolled Nurses in question, yet the very sector of the nursing profession to suffer the most is those least able to defend themselves, those working at the lowest level of the nursing hierarchy. Once again this demonstrates the power issues within nursing. This in particular was a complicated complaint, involving several different shifts of both nursing and medical staff, with complicating factors linked to staff shortages, poor communication and a complex patient. The solutions put forward to prevent this type of incident occurring again are also complex and a simple approach to stop Enrolled Nurses working night duty is naive in the least.

However this is not the first time that Enrolled Nurses have seen their roles evaporate before them. In 1996 Taupo, as part of the Lakeland Health Crown Health Enterprise (CHE), greatly reduced the number of Enrolled Nurses.

> *NZNO members feel it is extremely sad and shortsighted on the part of the CHE to prefer RN and multi-skilled health assistants (MSHAs) as the skill mix rather than using skilled and professional ENs* (Kai Tiaki November 1996, p 25).

This was again echoed by Health Care Hawkes Bay, by replacing Enrolled Nurses with unlicensed *clinical associates*. Brenda Wilson, NZNO national directors view was

> *that this was against the public interest to deny patients the qualified nursing care provided by ENs,*

while Craig Walsham stated:

> *the CHE would pay the ENs, disguised as clinical associates, considerably less than they now receive. The CHE wants to use the ENs vast experience but doesn't want to pay for it. EN's don't want their experience and their qualifications downgraded.* (Kai Tiaki February 1997, p.7)

These changes were also happening in other areas of New Zealand.

On commencing working in New Zealand, I discovered that Enrolled Nurses were unable to administer medication other than those given orally and could not sign for controlled drugs. Having been used to Enrolled Nurses being up-skilled and proactive, I felt the Enrolled Nurses I came across in 2003 when I arrived in New Zealand to be little more than *glorified health care assistants*. The two I was working with had both been qualified for more than 25 years, had extensive experience and had both previously worked in acute areas (this was an Assessment, Treatment and Rehabilitation ward), with one of the nurses having worked in several other countries over the years. I found it particularly disheartening and patronizing when new graduate nurses were allocated as their *senior nurse.* There was also a level of confusion when allocating patients at the commencement of each shift. Under the system of patient allocation, whereby each nurse is allocated 4-6 patients for whom they deliver total patient care, there was frequently a tone of animosity from Registered Nurses, who expressed the view they were *picking up* additional work, by supervising the Enrolled Nurse

and carrying out any nursing tasks that were outside of their scope of practice. One beneficial change for Enrolled Nursing was the change from patient allocation to team nursing. This nursing system allowed appropriate delegation of nursing tasks within a supportive rather than antagonistic environment. It re-enforced the notion of the right person for the most appropriate job and allowed the Enrolled Nurses to once again provide appropriate nursing care within their defined scope of practice. It could be argued that in times such as Registered Nursing shortages, here was an experienced and regulated workforce, not being utilized to their full capacity, where opportunities for increased patient outcomes could be achieved.

Oppression in nursing

Historically, there has always been a defined hierarchy within nursing, stemming back to the already defined class system within the UK. O'Brien (2007) argued that a constant of the nursing experience is that professional hierarchies are structured and restructured in a large part on the social divisions of class, gender and race, as played out through different types of education, management structures, institutional hierarchies, behaviors and the *pecking order* of specialties. These hierarchies give rise to the major characteristics of oppressed groups, a dominant group's ability to control a lower, submissive group. Roberts, as long ago as 1983, was able to identify that nurses demonstrated oppressed group behaviours. She argued that dependent and submissive behaviours of nurses have evolved throughout history in response to the domination of more powerful groups, such as hospital administrators and doctors. Not only do enrolled nurses have the oppression brought about by their low placing in the structure of nursing, they are also further marginalized by their low volume of numbers.

Allan (2007), expressed the view that the division and disadvantage within nursing is also closely linked to the debates around "centrality of care" as a valid

activity for professional nurses, as while direct patient care is understood rhetorically to be central to nursing, it appears to be constantly sidelined, in Allan's view from professional practice. In New Zealand the debate around professionalism within nursing began in the 1970s, through the acceptance that a fundamental restructuring of nursing education was required. In 1971, the landmark Carpenter Report recommended the transfer of basic nursing training from hospital schools to education colleges. This was the same year that the Nurses' Association launched *Operation Nursing Education*. With the support of the then government a process began to transition from hospital schools providing nurse *training* to a system of comprehensive *education*, which was established in polytechnics across the country. This move of pre-registration nursing training under a hospital based apprenticeship model (funded through Vote Health), to that of inclusion under the tertiary education sector brought with it a fundamental shift in nursing education, philosophy and policy. This placed nursing firmly in line with other health professionals such as physiotherapists and dentists, whose educational preparation to practise had long been within the tertiary sector. While all this was occurring for Registered Nurses, the Enrolled Nurse continued to be *trained* under hospital based programmes until they ended in 1993. 2000 saw government initiatives to see the return of the Enrolled Nurse programme, with the first polytechnic Enrolled Nurse programme commencing in 2002 at Northland Polytechnic.

The College of Nurses, which was established in 1992 and represents registered nurses professionally, has been active throughout the 1990s and into the new millennium, on the debate on the role of second level nursing, and had developed a

> *clear position in which it does not support the re-instatement of enrolled nurse training.*

Even though second level training has been available for a couple of years, the views of the College of Nurses does not appear to have altered, with Executive Director Jenny Carryer continuing to believe that an RN/unregulated caregiver workforce would be potentially much safer than an RN/EN workforce because there would be less potential for confusing public expectations around the role of nurses (O'Connor, 2009). This is an interesting concept put forward by Carryer and despite a comprehensive search of the NZ literature during the 80s and 90s, I was unable to find any information to substantiate this as a reason for the role of enrolled nurses to be discontinued. From my own personal experience, where the majority of clinical staff tend to wear scrubs or scrubs-like clothing, with only a credit card sized name badge, it is very difficult to differentiate the individual roles, yet if confusion does exist, then surely it would be safer to confuse an educated and regulated enrolled nurse with an RN than a unregulated care giver? There is also confusion over roles when gender is added to the mix, as testified by both my husband and son who are both RNs. There is a patient assumption irrespective of the uniform that as men they are the doctor rather than the nurse.

The views of the College of Nurses, is in direct contrast to the New Zealand Nurses Organization, which in many ways is quite understandable when we consider who each of the organizations are representing. From my many years working as a RN in the UK, I had never encountered a negativity towards enrolled nurses from registered nurses, yet within a short time of arriving in New Zealand I heard from a senior District Health Board manager, that an Enrolled nurse, was not a *real nurse*. This was not to be the only time that I heard the view that Enrolled Nurse training counted for nothing.

As an experienced nurse I can appreciate the opposing arguments that the two professional nursing bodies present. While NZNO needs to be mindful of those Enrolled Nurse who are its membership, all be it a dwindling membership, it still needs to represent them. Looking in from outside and having experienced

Enrolled Nursing in the United Kingdom, Enrolled Nursing has not been and is not an attractive option for anyone wanting to work in health in New Zealand. This is a nursing position that is even marginalized by others in their own profession of nursing.

At the 1995 Enrolled Nurse convention in Wellington, the opening message from nursing lecturer Joy Bickley was clear

> *Enrolled nurses have been ridiculed, discriminated against, humiliated and treated dismissively by a wide range of people including Registered Nurses, doctors the former NZNA, the Nursing Council and crown health mangers.* (Cited by Waitere, 1998).

This was a view echoed two years later by Enrolled Nurse Rhoda Waitere who said at the 19th NZNO convention in 1997

> *Enrolled Nurses are seen as an oppressed group because they are controlled by external forces with greater power and prestige. These forces included senior nurses, doctors, crown health enterprise management, the Nursing Council and some within NZNO.* (Kai Tiaki Nursing New Zealand June 1997, p27).

In both of the above articles by Rhoda Waitere, she discusses the concept of horizontal violence, a term she first heard at the 1995 National Enrolled Nurse conference, when Victoria University Lecturer Joy Bickley described it as a situation where oppressed people, i.e. groups who were dominated by other groups, tend to hit out at each other, rather than at the origin of their oppression. This closely linked with “colonization” of ENs by registered nurses, whereby RNs forced their values regarding accountability, the importance of education, the title “nurse” and registration on the lesser group. This confirms the powerlessness of

the enrolled nurse, whereby not being able to be heard, they stop trying to be heard.

Nothing had changed for Enrolled nurses in the years 1995-97. So was ending Enrolled Nurse training and the devolution of the role potentially a good thing after all? After all this was not an attractive career option at the time. Would this create the solution to having a single level of practice? According to Dingwell et al 1988, who stated that in the course of history demographic and economic arguments have always prevailed against the aspirations of the profession. While Edwards, (1997) noted that within health the wage bill for nursing has always represented a considerable expenditure, making it unlikely that the profession's call for an all qualified and preferably all graduate workforce will be heeded.

By mid 2000 the re-introduction of Enrolled Nurse training moved a step closer. This reintroduction was part of the Labour Party promises, as part of their election campaign that year. Yet there was much debate around the format of this training. The Ministry of Education's espousal of a vocational training model and the philosophy of life-long learning suggested a way forward, while NZNO's professional nursing advisor Eileen Brown declared at the time that

> *this building block approach to education, linked to practical experience, fits in very well with how ENs have been trained in the past.* She also went on to add*, "a new EN programme would need to be based on an analysis of current health needs and be placed on the New Zealand Qualifications Authority (NZQA) framework….. a modular approach would enable ENs to move onto a degree programme* (Kai Tiaki June 2000, p7).

At the same time that Enrolled Nurse training ceased in the UK, moves were afoot to create a *trained* but unqualified level of staff. In 1986 the healthcare assistant (HCA) initiative was proposed, with the aim that these HCA would provide support for qualified nurses (Stokes & Warden, 2004). This it appears is

becoming a common scenario within health, removing one layer of nursing and replacing it with a cheaper unregulated and unqualified substitute. We also need to consider the issue of taking away a career choice by ending Enrolled Nursing. Would this really promote more Maori and Pacific people into Registered nursing as a career? Unfortunately this has not been the case. In Counties Manukau where 18% of the population identify as Maori and 22% as Pacific people and where over 1900 nurses working for the District Health board only 3% or 60 are Maori and 4.7% or 88 are Pacific nurses (O'Connor, 2008).

Maori and Enrolled Nursing

One of the important positions to be considered in any research into the second level workforce must be the impact of these changes for Maori. According to O'Connor (1997), 8% of Enrolled Nurses identified as Maori, the highest representation of Maori in any health profession. While Maori accounted for just 2.7% of Registered Nurses. It was felt at the time (1997) by NZNO policy analyst Hugh Oliver that

> *Enrolled nursing can be seen as the first steps on a nursing career path. Over the years many ENs have undertaken "bridging" courses to RN status. Consequently the demise of the EN training represents not only a withdrawal of funding for the training of Maori health professionals, but also represents the removal of the first rung of a career ladder for Maori.*

This view was firmly supported by Te Runanga chairperson Dianne Irwin, who said

> *If EN training is not restarted in some form, opportunities for Maori to enter nursing will be lost".* Irwin went on to state *With more services being moved into the community, more and more Maori ENs are looking for opportunities to work there, particularly in areas where it is predominantly*

> *Maori accessing health services – where their heart are.* (Cited by O'Connor 1997)

While NZNO would argue that

> *Second level nursing is a stepping stone opportunity for those who are impacted upon by structural social inequity, including many Maori* (NZNO Feedback to the nursing advisory committee 2008).

This view is vehemently opposed by the College of Nurses, who believe that

> *Energy would be best put into increasing the Maori and Pacific Island representation into registered nursing. We should be mindful to the reasons for the higher rates of attrition from education from those groups.*

The College of Nurses claim this view was formed after consideration by the Maori Caucus of the college and a recent Hui that also express that this is the view of the Council of Maori Nurses, who they quote as having made

> *An unequivocal statement that they do not wish to support the re-introduction of enrolled nurse training as a desirable option for Maori who are interested in nursing. (College of Nurses Aotearoa, 2000).*

In personal email correspondence with the National Council of Maori Nurses, they state that

> *They have long believed that entry into nursing should be via the RN qualification, and that the name Nurse be protected to include those people who have completed the 3 year RN qualification"* they also went on to state *"Historically Maori have been directed towards second level nursing because they are so good with their hands. We reject this notion*

that Maori prefer to do the hands on nursing and leave the intellectual thing to others as a legacy of our education system.

Raranga Tupuake –Maori Health Workforce Development Plan (2006), is a key Ministry of Health document, that sits under the umbrella of the New Zealand Health Strategy, He Korowai Oranga: Maori Health Strategy and the New Zealand Disability Strategy, with Raranga Tupuake providing a strategic framework for the development of the Maori health and disability workforce over the next 10-15 years (Raranga Tupuake, 2006). The vision being to build a competent, capable, skilled and experienced Maori health and disability workforce, with three goals to achieve this vision.

1. Increase the number of Maori in the workforce
2. Expand the skill base of Maori in the workforce
3. Enable equitable access for Maori to training opportunities.

In the case of nursing and in line with following the above goals, surely the introduction of a second level nursing workforce would be seen as an in road to a career in health, as Enrolled Nursing had the highest level of Maori participation in a health discipline. If this is the route in, then it is the educational system which should change to embrace the future opportunities it could offer to Maori. Hyltons 2005 study into the transition from EN to degree RN at a New Zealand satellite campus, clearly demonstrates that the Maori students recognized that there were no cultural differences in the learning abilities between the Maori and Pakeha students, however what was apparent was the different approach they utilized to meet the challenges they faced.

<u>Enrolled Nurse – all change</u>

In 1999 Nursing Council's policy regarding recognition for prior learning was changed to reflect the move in the educational preparation of nurses from Diploma to Degree level, which is at levels 5, 6 and 7 over the three years of the

programme. This subsequently saw the old style Enrolled Nursing training as equating approximately to level 3 on this framework (Kirkpatrick, 2001). For the forthcoming reintroduction of Enrolled Nurse training, it would have seemed prudent, if a stepping stone, modular approach was to be utilized to enable progression to first level Registered Nurse status that this should be at level 5 on the NZQA framework. What actually happened was the newly introduced second level training was at level 4. Here was an opportunity to create a new tier of nursing, one where there was a true ability to staircase on to Registered Nurse training, instead it created a narrow role at a very basic level, which gave no impetus to go on to further training. Adding to the confusion the Nursing Council in 2004 decided to change the qualifying title from Enrolled Nurse to Nurse Assistant for the 137 enrolled nurses who graduated or trained between 2000 and September 2004. The impact of this was described by several of the affected nurses as

A kick in the guts, unethical, belittling and underhanded (Cassie, 2007).

For many the impact was not just about losing that feeling of being valued as a nurse, but the financial impact. Many of those in Northland were particularly hard hit, losing their community scope, losing their jobs and struggling to get second level work. While some had lost their jobs, others were downgraded to nurse aids, adding to the angst already felt by allowing employers to have qualified nurses and paying them caregiver wages.

However due to the immense public and professional pressure and the Regulations Review Committee recommending that the Council amend its 2004 decision, the decision was made to reinstate the title Enrolled nurse for those who qualified between 2000 and September 2004. Those who started second level training after 18th September 2004 would retain the title Nurse Assistant. NZNO chief executive Geoff Annals,

> *While the re-instatement of the title for the affected nurses vindicated their grievance, it had not resolved the confusion over titles and essentially had added more (Cassie, 2007).*

In Cassie's article in the Nursing Review, she quotes Jenny Carryer, the executive director of the College of Nurses and a long time campaigner for scrapping of second level nursing as saying

> *The re-instatement of the title for some new second level nurses was a mess, confusing and a tragedy. How can we ever expect the public to know what a nurse is.*

This was certainly true, not only was it confusing for the public, but employers alike. Along with Registered Nurses, there were three forms of second level nurse, those trained prior to 1993, those who trained during the period 2000-September 2004 and those post September 2004. Many had conditions placed on their scopes of practice as to where they could work. In 2007 I received a CV from an Australian Enrolled Nurse, her training had been for 18 months and she had over 10 years experience in an acute hospital setting. She had registered with the New Zealand Nursing Council and given the title Nurse Assistant, there was no conditions placed on her scope of practice. Yet despite severe nursing shortages I was unable to make a job offer to her. The DHB that I worked for was unable to sort an appropriate job description and there was great reluctance to take a second level nurse onto an acute ward environment, due to a lack of understanding around the scope of practice for a Nurse Assistant, as opposed to an Enrolled Nurse. This it seemed was a familiar tale to this nurse who had approached two other DHB's. Her last email to me said she would be staying in Australia. Up until late 2008 there was no provision for employing second level nurses at this DHB, although there were a still a couple employed there, who had been there for more than 10 years. With all this confusion it is surprising that anyone should wish to complete this level of nursing study.

CHAPTER 4

New generation second level nurse

This chapter will look at the current state of second level nursing. This *new generation* of second level nurses can have endorsements in the following scopes of practice, Long term care and rehabilitation, Medical/surgical, Perioperative care, Acute care – general and Acute care-medical surgical nursing (News Update September 2008, p4). Unlike the Enrolled Nurse scope of practice which requires that the nurse work under the direction and supervision of a Registered Nurse, to implement nursing care for people who have stable and predictable health outcomes, the Nurse Assistant's scope allows them to assist Registered Nurses to deliver nursing care, by performing delegated interventions from the nursing care plan, in community, residential and hospital settings. Nurse Assistants may be required to work in specific areas based on their educational programme and designated on their practicing certificate. In theory this gives Nurse Assistants a broader scope of practice than Enrolled Nurses and that their area of practice is governed by their educational preparation.

The current Nurse Assistant education programme in New Zealand requires that applicants complete a programme meeting the standards, legislative requirements and expected competencies as sanctioned by Nursing Council. The programme length would be 1000 hours usually spread over two semesters in a single academic year.

Module	Focus	Theory Hours	Practice Hours
1	General	250	400
2	Specific	100	250
		350	650

Module 1 has a general focus and develops the generic knowledge, skills and attitudes required to undertake a nurse assistance role, while module 2 has a specialty focus, preparing students to work in a specific area of practice. The above hours outlined are the minimum practice hours required and providers can include more practice hours. The qualification of Nurse Assistant sits at level 4 of the New Zealand Qualifications Authority, while Registered Nursing sits at levels 5, 6 and 7 over the three years of the programme.

Currently three education providers offer training leading to a scope of practice for Nurse Assistants in acute care. Again noted in Nursing Review, was data from several education providers, who had seen increased applications for the Acute scope of practice and a marked decline in the number of applications for the rehabilitation and long term care scopes of practice. While many employers may have liked the idea of a second level workforce, this means clearly defining roles and providing job descriptions.

The workforce statistics from Nursing Council for the year ending 31 March 2007, show that 44,520 nurses held practising certificates.

	Men	Women	Total
Nurse Practitioner	3	29	32
Registered Nurse	2,877	37,987	40,864
Nurse Assistant	15	142	157
Enrolled Nurse	118	3,419	3,537

These figures show that 70 nurses are registered in more than one scope of practice. 55.6% of all New Zealand nurses are employed by District Health Boards, 11.2% in Primary Health Care, 9.2% in rest homes/residential care, 8.5% in private or non-public hospitals, 5.3% in *other* areas of practice and 1.9% in educational institutions. (News update December 2007, page 4). As can clearly be seen from the above figures, the second level workforce makes up a small

proportion of the total nursing workforce. Since the majority of second level nurses would have registered before 1993, when the *old style* enrolled nurse training ceased, the majority of second level nurses bring with them a wealth of years of clinical experience.

Chapter 5

Gender and culture

This chapter will examine the enrolled nurse role from a gender and cultural perspective. As can be seen from the data included earlier in this research report, the majority of enrolled nurses are female, with only 117 men recorded as holding enrolled nurse registration in 2007, while I am unable to supply Australian data I can give anecdotal information around the number of men who worked as enrolled nurses in the UK. With the tradition of separate male and female wards in the UK and despite nursing remaining a traditional female role, men were still attracted to the work and it was not unusual for men to staff the male patient wards. Likewise the majority of Registered Nurses are also female, however women still remain the oppressed gender group in society. Roberts (2000) stated that women felt a devaluation of their worth, because they were not like the valued persons in society - men. While Matheson and Bobay (2007) argue that oppressed groups, such as women, assimilate the norms and values of the dominant group, in the belief that they will gain power and control if they become more like their oppressor, while leaders in the oppressed group who are successful at assimilation, become marginal in that they do not belong to either group. This adoption of the values and norms of the more powerful group by nurse leaders, can be viewed as a method of improving their own status and power and as such, it rarely results in the subsequent empowerment of lower ranked nursing staff. They go on to state, that while there is a much written on power and empowerment in nursing, most studies focus on those who already are in positions of power, there is a tremendous gap in the nursing literature on empowerment at staff nurse (Registered Nurse) level or enrolled nurse level. Each woman who enters nursing will carry with them, their own personal story of why they chose the route they did, how their own personal circumstances influenced their choices, but also how for some choosing enrolled nursing may have been a compromise. The ability to complete a professional nursing

qualification in 1 year, may not meet with the realities of the real world once the study is completed. If education providers are paid on a “bums on seats” basis, they too must be part of the process of making the qualification a worthwhile one.

If it is accepted that nursing is “predominantly” a female profession, are enrolled nurses simply an oppressed group due to their gender? A short answer to that would be no, as women also make up the majority of registered nurses, however what can be clearly articulated is that enrolled nurses, irrespective of their gender are a subordinate group to registered nurses.

If culture is added into the discussion, then we must determine what made enrolled nursing an attractive option for Maori to enter into healthcare this way. Why of all the professions within health, has enrolled nursing had the greatest level of participation? According to Durie (2005 p 207), attempts to recruit Maori into the health professions have been made for several years, with current registration figures remaining relatively low and that those who identify as Maori should have access to further training, so that their effectiveness among Maori can be enhanced. Wouldn’t it therefore seem a reasonable suggestion that support should be given to the development of the enrolled nurse position by Maori in a position of influence? If we look at inequalities, it was the Pakeha dominated world view that ceased enrolled nurse training in the first place, under the guise of wanting an all degree registered nurse workforce and the need to cut costs. This brings with it an elitist approach, yet this is exactly what happened. Those in senior nursing positions allowed this to happen.

Examining enrolled nursing from a gender and cultural position gives us some indication of the oppression within enrolled nursing, however it does not explain the whole picture, but gives us an indication of two of the areas to be focused on in order to empower enrolled nurse. In the following chapter the future of the enrolled nurse will be examined, giving recommendations towards the emancipation of the role.

Chapter 6

The future

This chapter will examine the future of the second level workforce, the work that is going on under the Clinical Workforce to support Registered Nurses, draft document (Ministry of Health, 2008) and my own personal views based on my past experience and my vision for the future of nursing.

What was concluded by the Nursing Workforce Strategy (Green, 2006), was that future Registered Nurses are likely to be supported by a changing mix of Nurse Assistants, regulated and non-regulated healthcare workers to maintain workforce and service sustainability.

One of the action points within the Nursing Workforce Strategy document is the development of a position paper on the second level regulated role to support Registered Nurses in their practice with a non-regulated workforce. The rationale for doing this being, that agreement with key stakeholders is required on the shape of this second tier workforce supporting Registered Nurses is central to the best use of nursing expertise and sustainable health services. In early 2008 the Minister of Health requested that the Ministry of Health provide advice on the clinical workforce required to support services provided by Registered Nurses, hence the Nursing Advisory Committee on the clinical workforce to support Registered Nurses was established. The objective of this Advisory Committee was to provide the Director-General of Health with relevant and practical advice on the options for a clinical second –tier workforce. They would be examining questions around regulation for such a workforce, potential options for this level of workforce and suggested actions to enable the establishment of such a workforce. An Independent Chair – Candis Craven chaired the first committee meeting on 1st April 2008. Members include the likes of District Health Board Directors of Nursing, General Managers, Planning and Funding staff,

representatives from the New Zealand Nurses Organisation and Nursing Council. In July of 2008 a draft recommendations paper was distributed for feedback, while the final version was expected to be released in October of that year. In personal email correspondence with Mark Jones, Chief Nurse at the Ministry of Health, on the 1st of December 2008, he informed me that although the recommendations were put forward to the previous Minister of Health (New Zealand held a general election in November 2008), they were not signed off prior to the election and they are now with Minister Ryall, who will determine what he considers to be the optimum way forward. Until that happens, the Ministry of Health can not make the final recommendations available. However, key issues identified by the Advisory Committee, include:

- Issues related to registered Nurses – the lack of Registered Nurses to direct and delegate second level nurses and non-regulated staff and the potential need for specific training in delegation, supervision and leadership.
- Issues related to current second level nurses – the shortage of second level nurses and their current scopes of practice.
- Issues related to the non-regulated workforce – risk to the public, range of titles, lack of training and career pathways, re-numeration, retention and recruitment, shortages and the financial impact.

This committee examined how other countries addressed the second level workforce and made recommendations, specifically four overarching principles.

1. Second level regulated nurses are the key second level clinical support for registered nurses.
2. There should be the promotion of a team approach to the delivery of care, with registered nurses having the overall responsibility.
3. The development of an education career pathway for second level nurses and the non-regulated health workforce.
4. A national campaign to promote the new programmes to employers and to attract people into the new education programmes.

One of the significant recommendations from this draft paper is under principle one, where it recommends a broader scope of practice, the qualification be nationally consistent with the NZQA framework and be at level 5 with entry at level 4, is aligned to other countries' workforces where possible, cover the full range of community/clinical needs and meets current and future health and disability sector workforce demands.

As 2008 ends, the recommendations are still not yet signed off and the various education providers are continuing to provide NZQA level 4 Nurse Assistant training. I can appreciate that these providers run as businesses and the hold up in directing the future direction of the workforce to support Registered Nurses, would be equally frustrating for them in how they plan their programmes and how they attract their students.

In adopting a team approach to nursing care delivery the notion of the "the most appropriate person for that job" can truly be actioned. There are skills associated with nursing care delivery that only registered nurses can do, which include, the assessment, planning and evaluation of care, high-level technical skills and the co-ordination of the care. While the majority of "hands on" care being delivered can easily be delegated to a second level workforce, such examples would include: preparing elective patients for theatre, following a wound-care regime and recording observations. There is even room for unregulated healthcare workers to assist within a team model approach, in carrying out all the domestic style tasks that nursing currently does, such as bed making, handing out food, and re-stocking equipment.

An education pathway should be established for the regulated and non regulated workforce, in a staircase model with recognized exit points, that lead to a final exit with a registered nurse qualification, with the first year of this programme at level 5 and that exit at this point would give a foundation certificate in health.

There would be so many benefits to this first year of study being multi-disciplinary and not just for nursing students, but for those studying all health disciplines. This shared academic commonality would increase the links of multi-disciplinary/holistic healthcare even further.

By far the greatest challenge to the second level nursing workforce, is the education of and acceptance of potential employers of this role. Without the commitment of employers, the vision is one of history repeating itself. A national campaign to raise employer awareness and also changes in the legislation governing private care homes would see the elevation of this role within society and the profession. While there are recognized nursing shortages within the acute sector, these are also evident in the private care home sector, where issues with underfunding and high regulatory costs mean that nursing wages are often significantly lower than the public sector, increasing the difficulty in attracting and retaining nurses. Would this not be an ideal career pathway for Nurse Assistants with the rehabilitation/older persons endorsement? Could they take charge on a shift?

Until the recommendations are published, I can only hope that those reviewing the draft document can see the potential health benefits to the nation of a well developed second level workforce. This would create a workforce that embraces Maori who can use this qualification as a stepping stone to other positions within healthcare. It is clear that second level nurses are an oppressed group, not only from the education providers, the Nursing Council and nursing in general, but from the lack of employment prospects once they are in the labour market.

There is much that needs changed if second level nurses are to overcome the oppression enforce on them by nursing itself. A starting point would be in raising the qualification level to Diploma and creating a specific role for them. Within the older persons endorsement this could be their ability to work as the nurse in charge within care home facilities. This would not only create a defined career

pathway, but also assist with reducing the number of nursing vacancies in this employment sector. Having nurses specifically educated in a speciality, e.g. rehabilitation/older people, can improve the health status for those clients.

If the enrolled nurse route was once the main entry point for Maori into a career in health, surely by re-instating this role it will once again encourage Maori to take up a career in nursing? What needs to tie in with this, is the ability to easily climb the ladder to Registered Nurse and the support mechanisms made available to those who wish to do so.

The second level nurse role has created a huge debate, not only within nursing itself, but at a ministerial level. Through the work of both the unions and the Nursing Council, the voice of the second level nurse must continue to be heard. Having second level nurses holding prominent positions within these organizations and being a voice on the ministries discussion table would assist in again raising the profile of these nurses, while the development of a national “Champion” for the role, would create a media front, extolling the role to both prospective nurses and employers.

Rather than looking to create a new solution, perhaps New Zealand should look to Australia, where the role of the second level nurse has flourished and there is an ability to staircase to Registered Nurse status. By using a proven system, we should be able to replicate the success of the Australian system and go one step nearer improving the health status of all New Zealanders, by embracing and actively encouraging Maori to once again use second level nursing as a way to reduce the health inequalities faced by so many Maori.

Completing this research project has been a tremendous personal journey for myself. Coming from a “colonial” background, and bringing with it pre-conceived ideas about how New Zealand enrolled nurses should be positioned based on my UK experience, has meant that my view point has changed significantly. While New Zealand has degree level educational preparation, this emphasizes

the gap between enrolled and registered nurse, however my fundamental view is that the most appropriate group to support the registered nursing workforce, remains that of a regulated second level nursing workforce.

References.

Adamson, M.J. (1997). *Action research: the journey from enrolled nurse to registration and beyond. Discovering a process to self-efficacy and professional development*. MA Thesis. Victoria University of Wellington, New Zealand.

Alexander, G. (2003). Protecting the position of enrolled nurses. *Kai Tiaki Nursing New Zealand,* May, p 11.

Allan, I., & McLafferty, I. (1999). The road to conversion for enrolled nurses: A literature review. *British Journal of Nursing, 8*(6), 356-360.

Allan, H. (2007).The rhetoric of caring and the recruitment of overseas nurses: the social production of a care gap. *Journal of Clinical Nursing*, *16*, 2204-2212.

Ball, W. (1992). Critical social research, adult education and anti-racist feminist praxis. *Studies in the Education of Adult, 21*, 1.

Boelen, M.G., & Kenny, A. (2009). Supporting Enrolled Nurse conversion – the impact of a compulsory bridging program, *Nurse Education Today*, *29*, 553-537.

Bolton, K., & Carryer, J. (2000). Not all nurses support EN comeback in New Zealand. *Nursing Standard, 15*(7), 31.

Buchan, J., & Dal Poz, M.R. (2002).Skill mix in the health care workforce: reviewing the evidence. *Bulletin of the World Health Organization, 80*(7), 575-580

Cassie, F. (2007). Nurses call for an apology. *New Zealand Nursing Review, 8* (8), *1-2.*

Chandler, G.E. (1992). The source and process of empowerment. *Nursing Administration Quarterly, 16*(3), 65-71.

Clifford, P.G. (1992). The myth of empowerment. *Nursing Administration Quarterly,16*(3), 1-5.

Cockayne, D., Davis, G., & Kenyon, L. (2007). Two levels of practice: meeting professional or workforce needs. *Nursing Standard*, *21*(27), 44-47.

College of Nurses Aotearoa. (2000). *The current proposal to re-instate Enrolled Nurse training in New Zealand.* College of Nurses Aotearoa:New Zealand. Retrieved January 22, 2008 from http://nurse.org.nz/leadership/ls_reinstate_en.htm

Daly, J., Speedy, S., & Jackson, D.(2000). *Contexts of Nursing.* Sydney: Maclennan & Petty.

Department of Health. (1999). *Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare.* HMSO: London.

Dingwall, R., Rafferty, M., & Webster, C. (1988). *An introduction to the social history of nursing.* England: Routledge.

Dixon, A. J. (1996). *Critical case studies as voice: The difference in practice between enrolled and registered nurses* (PhD Thesis) Flinders University of South Australia: Adelaide.

Dixon, A.J. (2001). Second level nurse, *International Journal of Nursing Practice*, *7*(5), 360.

Duckett, S.J.(2005), Health workforce designs for the 21st century. *Australian Health Review, 23*(4), 201-210.

Durie, M. (2005). *Whaiora Maori Health Development (*2nd ed.). South Melbourne: Oxford University Press.

Edwards, M. (1997). The nurses' aid: Past and future necessity. *Journal of Advanced Nursing, 26*(2), 237-245.

Fletcher, K. (2006) Beyond dualism: Leading out of oppression. *Nursing Forum, 41*(2), 50-59.

French, P. (2001). Nursing registration: A time to celebrate. *Kai Tiaki Nursing New Zealand*, *7*, 17-19.

Fontana, J.S. (2004). A methodology for critical science in nursing. *Advances in Nursing Science, 27*(2), 93-101.

Foong, A.L.S., & Mackay, G.F. (1996). An exploration of the psychosocial perspectives on educational/developmental opportunities for enrolled nurses: the forgotten species? *Nurse Education Today,16*(1), 94-97.

Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing, 26*, 529-536.

Gade, J. D., & Hornblow, A.R. (2007). Development of the New Zealand nursing workforce: Historical themes and current challenges. *Nursing Enquiry, 14*(4), 330-334.

Green, J. (2006) DHBNZ, Nursing workforce strategy, (December 2006), *Future Workforce*, Wellington: DHBNZ.

Hallam, J. (2002). Vocation to profession: Canging images of nursing in Britain, *Journal of Organizational Management*, *15*(1), 35-47.

Hancock, H., & Campbell, S.(2006). Developing the role of the healthcare assistant. *Nursing Standard, 20*(49), 35-41.

Health Research Council. (2002). *Guidelines on Ethics in Health Research (Revised 2005).*: Wellington: HRC.

Health Research Council. (2008). *Guidelines for Research on Health Research Involving Maori*. Wellington: HRC.

Higgs, J., Richardson, B. & Dahgren, M.A. (Eds) (2004).*Developing practice knowledge for Health Professionals.* London:Butterworth Heinmann.

Hylton, J. A. (2005). Relearning how to learn: Enrolled Nurse transition to degree at a New Zealand rural satellite campus. *Nurse Education Today, 25*(7), 519-526.

Iley, K. (2004). Occupational changes in nursing: the situation of enrolled nurses. *Journal of Advanced Nursing*, *45*(4), 360-370.

Kai Tiaki Nursing New Zealand. (1998). *The human face of enrolled nurse redundancies. 4*(2), 7.

Kai Tiaki Nursing New Zealand (1998). *Policy on enrolled nurses change*. *2*(9), 18.

Kai Tiaki Nursing New Zealand. (1996).*Tairawhiti nurses' collective contract settled. 2*(10), 25.

Kai Tiaki Nursing New Zealand. (1997). *Campaign to save EN positions in Hawke's Bay, 3(*1), 7.

Kai Tiaki Nursing New Zealand. (1997). *EN's speak out against discrimination, 3*(5), 27

Kai Tiaki Nursing New Zealand (2000). *Support grows to restart EN training, 6*(5), 7.

Kenny, A.J., & Duckett, S. (2005). An online study of Australian Enrolled nurse conversion. *Journal of Advanced Nursing*, *49*(4), 423-431.

Kenny, C. (1993). Enrolled nurses: Why are they devalued? *Nursing standard*, *5*(18), 28-31.

Kirkpatrick, J (2001). Policy reflects change from Diploma to Degree preparation *Kai Tiaki Nursing New Zealand*, March, 20

Lee, T. Y., Yeh, M.L., Chen, H.H., & Lien, G.H. (2005). The skill mix practice for nursing: Measuring outcome. *Journal of Advanced Nursing, 51*(4), 406-413.

Mackenzie, J. (1997). 'A thorny problem for feminism': An analysis of the subjective work experiences of enrolled nurses. *Journal of Clinical Nursing*, 6, 365-370.

Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviours in nursing. *Journal of Professional Nursing, 23*(4), 226-234.

McCormack, B., Manley, K., Kitson, A., Titchen, A., & Harvey, G. (1999). Towards practice development – a vision in reality or a reality without a vision? *Journal of Nursing Management*. 7, 255-264.

McGillis Hall, L. (2003). Nursing staff mix models and outcomes. *Journal of Advanced Nursing, 44*(2), 217-226.

McGough, G. & McGough, S. (1998). Enrolled nursing: evaluating the role. *Nursing Standard, 12*(33), 49-56.

McKenna, H.P. (1995). Nursing skill mix substitutions and quality of care: An exploration of assumptions from the research literature. *Journal of Advanced Nursing, 21*(3), 452-459.

McLafferty. A.I. (1999). The careers of enrolled nurses following completion of conversion courses. *Nursing Standard. 2*(13), 32-36.

Milson-Hawke, S., & Higgins, I. (2003). The scope of enrolled nurse practice: a grounded theory study. *Contemporary Nurse, 17* (1-2), 44-62.

Milson-Hawke, S. & Higgins, I. (2004). The scope of enrolled nurse practice: a review of the literature. *Contemporary Nurse, 14*(2), 129-137.

Ministry of Health. (2006). *Raranga Tupuake Maori Health Workforce Development Plan.* Wellington: MoH.

Ministry of Health (2007). *A career framework for the health workforce in New Zealand.* Wellington: MoH.

Ministry of Health (2007a) *Clinical Workforce to Support Registered Nurses*, Draft 10 July 2008, Wellington: MoH.

Ministry of Health. (2008). *Clinical Workforce to support Registered Nurses*, draft document. Wellington: Ministry of Health.

Mooney, M., & Nolan, L. (2006). A critique of Freire's perpective on critical social theory in nursing education. *Nurse Education Today, 26*, 240-244.

News update. (2007, December). *Workforce statistics.* Wellington: Nursing Council of New Zealand.

News update. (2008, April). *Memorandum of understanding with Australia.* Wellington: Nursing Council of New Zealand.

News update. (2008, September). *NA Programmes.* Wellington: Nursing Council of New Zealand.

New Zealand Nurses Organization. (2008) *Feedback to the nursing advisory committee on the workforce to support registered nurses*. Wellington: NZNO.

Nursing Council of New Zealand. (2005). *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice.* Wellington: Nursing Council of New Zealand.

Nursing Council of New Zealand (2008). *Guideline: direction and delegation.* Wellington: Nursing Council of New Zealand.

O'Brien, T. (2007). Overseas nurses in the National Health Service: A process of de-skilling. *Journal of Clinical Nursing, 16*, 2229-2236.

O'Bryan Doheny, M., Benson Cook, C. & Stopper, M.C (1997). *The discipline of nursing, and introduction* (4th ed). Connecticut: Appleton & Lange Stamford.

O'Connor, T. (1997). Training for enrolled nurses. *Kai Tiaki Nursing New Zealand, 3*(2), 20-22.

O'Connor, T. (2008) Boosting Maori and Pacific nursing numbers. *Kai Tiaki Nursing New Zealand 14*(12), 20-21.

O'Connor, T.(2009). Minister's action backs enrolled nurses. *Kai Tiaki Nurisng New Zealand, 14*(10), 11.

Oliver, H. (1997). From ENs to RNs – five nurses' stories. *Kai Tiaki Nursing New Zealand*, 3(3) 26-27.

Parkin, P. (1995). Nursing the future: a re-examination of the professionalization thesis in light of some recent developments. *Journal of Advanced Nursing, 21*, 561-567.

Richardson, S. (2003). Aoteaoroa/New Zealand nursing: from eugenics to cultural safety. *Nursing Inquiry, 11*(1), 35-42.

Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science,* 21-30.

Roberts, S.J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science, 22*, 71-82.

Ryles, S.M. (1999). A concept analysis of empowerment: Its relationship to mental health nursing. *Journal of Advanced Nursing, 29*(3), 600-607.

Sargison, P.A. (2001). *Essentially a woman's work: A history of general nursing in New Zealand*. PhD Thesis, University of Otago, Dunedin.

Smith, P., & Mackintosh, M. (2006). Profession, market and class: migration and the remaking of division and disadvantage. *Journal of Clinical Nursing, 16*(12), 2213-2220.

Stokes, J., & Warden, A. (2004). The changing role of the health care assistant. *Nursing Standard, 18*(51), 33-37.

Swaffield, L. (1991). Labeled second- class? *Nursing Times, 87*(12), 48-49.

Thornley, C. (2000). A question of competence? Re-evaluating the roles of nursing auxiliary and health care assistants in the NHS. *Journal of Clinical Nursing, 9* (3), 451-458.

Waitere, R. (1998). Coping with horizontal violence. *Kai Tiaki: Nursing New Zealand, 4*(2), 24.

Warr, J. (2002) Experiences and perceptions of newly prepared health care assistants (Level 3 NVQ). *Nurse Education Today, 22*(3), 241-250.

Warr, J., Gobbi, M., & Johnson, S. (1998). Expanding the nursing profession. *Nursing Standard, 12*(31), 22-28.

Webb, B. (2000). Enrolled nurse conversion: a review of the literature, *Journal of Nursing Management, 8*, 115-120

Webb, B. (2001). An exploratory study in a community National Health Service Trust to understand why enrolled nurses choose not to convert to first-level registration. *Journal of Nursing Management, 9*(6) 343-352.

Webb, C. (1993). Feminist research: Definitions, methodology, methods and evaluation. *Journal of Advanced Nursing. 18*, 416-423.

White, R. (1985), Political regulators in British nursing. *Political Issues in Nursing: Past, Present and Future, 1,* 19-43.

Wilson, B. (2000). Support grows to restart EN training. *Kai Tiaki Nursing New Zealand, 8*(5), 7.