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Spotlight Skill Recognition Report

A report into the work of nurses and midwives that identifies, names and classifies the 'invisible skills' used by those workers

for

Gordon Legal

Re: AM2024/11: Application to vary the *Nurses Award 2020* – work value case

Author: Dr Lisa S. Heap

Research Into Action

16th March 2026

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1.0 Introduction & Summary

1.1 Statement

1. My name is Dr Lisa Susanne Heap, of [REDACTED] Victoria, Australia.
2. I refer to a letter from Gordon Legal dated 28 October 2024 (see copy at Annexure one) in which I was asked to
 - (1) apply the “*Spotlight*” skill-recognition tool to the work of Registered Nurses and Midwives, Enrolled Nurses, and Assistants in Nursing working outside of aged care;
 - (2) based on application of that tool, produce an independent expert report identifying, naming, and classifying the “*invisible skills*”, if any, used by those workers in their work (“Report”).
3. My opinions and the facts and information upon which I base my opinions in relation to the application of the Spotlight skill recognition tool to the work of nurses and midwives are contained in this report.
4. Research Into Action (RIA) engaged several people to assist in the preparation of this report (‘Project Personnel’).
5. Both I and all project personnel were provided with a copy of the Federal Court of Australia Expert Evidence Practice Note (GPN-EXPT). I, and each of the project personnel have read, understood and agreed to be bound by the practice note and both I and all project personnel have complied with it in preparation of my report.
6. The contents of my report reflect my specialist knowledge gained through training, study, research, practice and experience (see below). The conclusions and opinions expressed in my report are mine. In preparing this report, I made all the inquiries I believed were desirable and appropriate and no matters of significance which I regard to be relevant have been deliberately withheld from the Fair Work Commission.
7. Attached to this report is a
 - a) copy of my resume, at Annexure two
 - b) copy of a letter of instruction from Gordon Legal dated 28 October 2024, at Annexure one
 - c) summary of the relevant expertise of those project personnel who were engaged by RIA to assist me in the preparation of my report at Annexure three.

1.2 Expertise

8. I am a founding Director of Research Into Action (RIA) an independent research organisation. I have been a Director of RIA since 2024 when the organisation was established. In my role at RIA I conduct research related to measures to increase gender equality in society (Australia and worldwide). RIA also conducts commissioned research in a variety of fields. I am also concurrently employed as a Senior Researcher at the Centre for Future Work (‘the Centre’), a

research centre focussing on economic issues facing working people, including the future of jobs, wages and income distribution, skills and training, sector and industry policies, the role of government and public services, and inequalities and discrimination at work. I commenced employment with the Centre in February 2024. In my role at the Centre, I provide economic and social policy analysis of labour issues with a research focus on gender and inequalities at work, work health and safety, and the regulation of work.

9. Prior to establishing RIA and taking up the position at the Centre, I was a PhD Candidate and Sessional Lecturer at RMIT University. My doctoral thesis (completed in 2023) was entitled *Preventing Gender-based Violence and Harassment at Work: A Study of the Potential of New Regulatory Approaches*. In this research I identified and addressed the dimensions of the gender regimes that operate at work and in society that create and sustain gender inequality at work. I examined contemporary regulatory approaches designed to eliminate and prevent gender-based violence and harassment at work. Finding limitations in each of these contemporary regulatory approaches I proposed an alternative—the transformative gender regimes model.
10. Prior to undertaking my doctoral research, I held senior positions in the union movement and in industry. I have over 30 years' experience as a labour lawyer and industrial relations practitioner.
11. I hold a PhD in Law from RMIT University, a Graduate Diploma in Applied Human Rights from RMIT University, a Bachelor of Laws (Hons - First Class) from Latrobe University, and a Bachelor of Arts (Political Science/Industrial Relations) from the University of Western Australia. I am admitted to practise as a Barrister & Solicitor in the Supreme Court of Victoria & High Court of Australia.
12. I have substantial expertise in addressing gender and inequalities at work, including gender pay inequality. From 2015-2018 I was engaged by the Victorian Trades Hall Council (VTHC) to establish the Victorian Women's Rights and Safety Unit. This unit, based at Trades Hall, investigated the experiences of Victorian working women and advised the Victorian and national union movements on initiatives designed to eliminate gender inequality at work. In this role I led action research projects that produced evidence-based legal and policy reforms.
13. Between 2015-2021, I was the principal adviser on equal pay to the New Zealand Public Service Association (NZPSA). In this role I advised the National Secretary and the Board of the NZPSA on legal and policy initiatives designed to achieve equal pay for members of the NZPSA. I also represented the NZPSA in tripartite work assessment processes to address legal claims for pay equity for clerical and administrative employees in District Health Boards (DHBs) and for clerical and administrative employees in the public sector. In the DHB claim I was a member of the joint Work Assessment Panel that assisted the claimants and male

comparator roles. This involved interviewing workers, developing role profiles, assessing the skills, responsibilities, and working conditions of clerical and administrative workers (and male comparators), conducting a points factor evaluation of the work of claimants and comparator roles, and documenting the conclusions from this analysis. In the public sector claim I advised on the processes for gathering data and assessing the work of claimants and comparators. I trained interviewers engaged by the State Services Commission (SSC) who interviewed workers to gather the data for the assessment process. I also provided technical support and advice to NZPSA officials negotiating pay equity claims for workers in other sectors including claims for pay equity for allied health professionals within DHBs and for library assistants in Local Government. In the library assistants claim I trained union and employer representatives on how to conduct gender-neutral work assessments.

14. In 2020 I was jointly appointed (by the NZPSA) and Social Services Providers Aotearoa (SSPA), a peak body representing social services providers (employers), to chair the Work Assessment Panel for the pay equity claim for social workers and social work team leaders employed in non-government organisations in New Zealand. In this role I chaired a committee of representatives appointed by employers and unions who assessed the work of social workers and social work team leaders to identify and classify, the skills, responsibilities, and working conditions associated with this work.
15. In 2022-2023 I was engaged by the New Zealand Nurses Association (NZNO) and the NZPSA as an adviser for the Nursing Pay Equity claim which covered health care assistants and hospital aides, mental health assistants, enrolled nurses, obstetric nurses, karitane nurses, community nurses, registered nurses, senior nurses and nurse practitioners, employed in public health. In this role I provided advice in relation to the outcomes of the work assessment process used by the unions and employers to assess nursing work. I also provided technical advice to the unions regarding the work assessment outcomes and the valuing of nursing roles during proceedings before the New Zealand Employment Relations Authority and during the mediation process which resulted in an agreed settlement of that claim.
16. I am recognised, within Australia and overseas, as an expert on gender at work, gender pay (in)equality and gendered violence at work. I am currently the Chair of the Victorian Government's Equal Workplaces Advisory Council (EWAC). EWAC consists of 12 experts from public and private sector organisations appointed by the Minister for Industrial Relations. EWAC advises the Victorian Minister for Industrial Relations on policy designed to achieve gender pay equity and increase women's workforce participation. I am also currently a Director of Gender Equity Victoria. Gender Equity Victoria is the independent peak body for organisations and individuals seeking to advance gender equity in Victoria.

17. In 2019 I was commissioned by the Victorian Government to draft Victoria's first strategy to attract, recruit, and retain women workers within the building and construction industry— *Building Gender Equality: Victorian Women in Construction Strategy 2019-2022*. From 2017-2020 I was a member of the Victorian Ministerial Council on Women's Equality, a body appointed to advise the Minister for Women on initiatives to promote gender equality in Victoria, including at work.
18. I have been involved in the negotiation of two international Conventions related to gender at work. In 2019- 2020 I was appointed as a Technical Adviser to the Worker's Group, Standard Setting Committee, ILO Convention C190 – Violence and Harassment Convention. In 1999-2000 I was the Australian Worker's Representative, Standard Setting Committee, ILO Convention C183 – Maternity Protection.
19. In 2008-2009 I acted on behalf of the Queensland Services Union in the Queensland Industrial Relations Commission (QIRC) in proceedings to address gender-based undervaluation in the Queensland Social and Community Services Award (the QLD SACS pay equity case).¹
20. More details of my relevant experience are contained in my resume at Annexure two.

1.3 Basis of this Report: Primary Material and Secondary Material

21. The Primary Material on which this Report is based is as follows
 - a) Transcripts of 29 interviews with Registered Nurses (RNs), Midwives (MWs), Enrolled Nurses (ENs) and Nurse Practitioners (NPs), totalling 600,000 words, based on the recording of those interviews. Each interview ran for 1.5 – 2 hours.
 - b) Coding of interview transcripts using a coding framework based on the Spotlight skills taxonomy. There were several rounds of coding to cross-check results. The research approach used in this study is set out in chapter two of this report.
 - c) Analysis of the data collected using the Spotlight skills taxonomy and the typology of invisibility (see chapters four - eight).
22. The Secondary Material relied upon is included in chapter three and the Reference List.

1.4 The Spotlight tool & invisibility

23. In this report I have been asked to apply the Spotlight skill recognition tool (Spotlight tool) to the work of nurses and midwives and, based on the application of that tool, to identify, name and classify the 'invisible skills' used by those workers.
24. The Spotlight tool is a job and skills analysis tool. It is designed to assist in naming and classifying skills that are unrecognised or undervalued based on gendered assumptions of skills in traditional approaches to job evaluation.

¹ *Queensland Services, Industrial Union of Employees AND Queensland Chamber of Commerce and Industry Limited, Industrial Organisation of Employers and Others (A/2008/5)*, 6 May 2009.

25. 'Invisible' in this context means 'hidden', 'under-defined', 'under-specified' or 'under-codified' (FWC, 2022, Aged Care Decision Stage 1 [43]); Junor 2021, [3]). This is sometimes referred to as the typology of invisibility. Spotlight skills are defined as 'invisible' when they are used singly or in combination as follows

Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work 'behind the screens' or 'behind the scenes'

Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations

Under-specified skills — skills that are often misdescribed as 'soft', 'natural' or 'innate personal traits', or described as 'emotional labour' or 'emotional intelligence' or 'teamwork'—terms which need to be unpacked

Under-codified skills — integrative skills used in organising work processes, 'getting things done', bringing together and applying a range of other skills, and/or interweaving one's own work activities with others' to create an overall workflow (Junor 2021 [33]).

26. More details about the Spotlight tool and the typology of invisibility are set out in chapter two.

1.5 Organisation of the report

27. In chapter two I set out the research approach taken to produce this report. Details are provided on the Spotlight tool and the application of that tool in this research. Information is provided about the participants who were interviewed for the study, how data was gathered, and how the data from the interviews was analysed through a coding process.
28. In chapter three I position this study in the broader context of nursing and midwifery in contemporary Australia. The chapter includes a summary of the demographics of the nursing and midwifery workforce, their qualifications and training, professional regulation and scope of practice. The chapter includes a discussion of the literature on the issues, challenges and opportunities facing nurses and midwives in contemporary Australia. This review of the literature informed the analysis of the data on each of the four classifications to which I applied the Spotlight skills recognition tool. I conclude the chapter with a brief review of the literature on the undervaluation of work in female dominated occupations.
29. Chapter four is a presentation and analysis of the data gathered from **17** RNs who participated in the study. The results of the coding of interview transcripts are summarised in a 'skill profile' in the form of a Heat Map, a table showing the relationship between the work activities identified in the Spotlight assessment and the typology of invisibility, and work activity examples from the RN participants illustrating the performance of each of the nine Skill Elements in the Spotlight tool. Each Skill Element is elucidated with examples from RNs at various Skill Levels. The chapter also includes three work activity case studies of the clustered and simultaneous deployment of multiple Spotlight skills by RNs.

30. Chapter five is a presentation and analysis of the data gathered from **3** MWs who participated in the study. The results of the coding of interview transcripts are summarised in a 'skill profile' in the form of a Heat Map, a table showing the relationship between the work activities identified in the Spotlight assessment and the typology of invisibility, and work activity examples from the MW participants illustrating the performance of each of the nine Skill Elements in the Spotlight tool. Each Skill Element is elucidated with examples from MWs at various Skill Levels. The chapter also includes three work activity case studies of the clustered and simultaneous deployment of multiple Spotlight skills by MWs.
31. Chapter six is a presentation and analysis of the data gathered from **5** ENs who participated in the study. The results of the coding of interview transcripts are summarised in a 'skill profile' in the form of a Heat Map, a table showing the relationship between the work activities identified in the Spotlight assessment and the typology of invisibility, and work activity examples from the EN participants illustrating the performance of each of the nine Skill Elements in the Spotlight tool. Each Skill Element is elucidated with examples from ENs at various Skill Levels. The chapter also includes three work activity case studies of the clustered and simultaneous deployment of multiple Spotlight skills by ENs.
32. Chapter seven is a presentation and analysis of the data gathered from **4** NPs who participated in the study. The results of the coding of interview transcripts are summarised in a 'skill profile' in the form of a Heat Map, a table showing the relationship between the work activities identified in the Spotlight assessment and the typology of invisibility, work activity examples from the NP participants illustrating the performance of each of the nine Skill Elements in the Spotlight tool. Each Skill Element is elucidated with examples from NPs at various Skill Levels. The chapter also includes three work activity case studies of the clustered and simultaneous deployment of multiple Spotlight skills by NPs.
33. In chapter eight, in conclusion, I document the dimensions of the roles in nursing and midwifery, drawing together my findings from the analysis of the Primary Materials. I also set out some further findings regarding the skills, responsibilities and demands on nurses and midwives and the contextual complexity within which they perform their work. I believe the complexities of the contemporary circumstances within which nursing and midwifery work is undertaken requires an intense application of the invisible skills identified in my Spotlight analysis.

1.6 Key findings

34. In summary my opinions and the facts and information upon which I base my opinions are set out in this section. Chapters four to eight contain the evidence and analysis of the Primary Material that I rely upon for my opinions. Chapter three contains the Secondary Materials which have also informed these opinions.

35. The skills I identified using the Spotlight methodology are the following nine skills, organised into three Skill Sets

A: Contextualising: Building and shaping awareness

- A1. Sensing contexts or situations
- A2. Monitoring and guiding reactions
- A3. Judging impacts

B: Connecting — Interacting and relating

- B1. Negotiating boundaries
- B2. Communicating verbally and non-verbally
- B3. Working with diverse people and communities

C: Coordinating

- C1. Sequencing and combining activities
- C2. Interweaving own activities smoothly with those of others
- C3. Maintaining and/or restoring workflow

36. In the Spotlight framework, each skill is identified as being exercised at one of five levels

- Orienting
- Fluently performing
- Solving new problems as they arise
- Sharing solutions/deploying expertise
- Creating a system

37. In my expert opinion based on the information and analysis contained in this report there is significant evidence of the nurses and midwives who participated in this study utilising all nine Spotlight skills. The Primary Materials furnished an average (rounded) of 140 reported uses of the nine Spotlight skills for each RN, 160 for MWs, 85 for ENs and 176 for NPs.

38. I note the Skill Element counts set out above are lower than that in other studies (e.g. for nursing in the *Aged Care Work Value Case*) where the Spotlight tool has been applied. This is because in this study no additional score (loading) was allocated for criticality or frequency across any Skill Element for any classification. The Spotlight methodology allows for each instance of a Spotlight Skill Element to be counted. A loading can also be added to this count for wherever a participant has indicated that the work activity (and therefore the skills associated with it) are frequent and/or critical. Thus, one instance of an activity which is both frequent and critical could be given a count of 3. In this study I decided not to apply the loading for frequency and criticality. I made this decision after reviewing the transcripts of interviews. I believed that the issue of frequency and criticality had not been discussed consistently enough across the interviews to allow for these loadings to be included in the count. Whilst the numbers of instances of the use of Spotlight skills counted is lower in this

study, due to my decision not to apply additional counts for frequency and criticality, the patterns of utilisation across the Skill Elements and the levels at which the skills are deployed are similar to those for nurses in the *Aged Care Work Value Case*.

39. The deployment of Spotlight skills was at a high level of proficiency – for EN's mainly Skill Level 2 (fluently performing) and Skill Level 3 (problem-solving). For RNs, MWs and NPs mainly Skill Level 3 (problem-solving) and Skill Level 4 (solution-sharing). There were also examples provided at Skill Level 5 (creating-systems), particularly for NPs.
40. In my expert opinion there is considerable evidence (set out in chapters four to seven) that the work of nurses and midwives in this study contains examples where Spotlight skills were deployed in 'clusters' simultaneously. The clustered use of skills requires a complex combination of thinking, feeling and acting. Further, the capacity to apply several skills at the same time is itself an 'under-codified higher-level skill'; increasing the effort required to perform the role and adding to work intensity (Junor 2021).
41. The use of Spotlight skills (either singly or in combination) by nurses and midwives in this study informs my findings that these skills are likely to be 'invisible' in that they are skills that are often 'hidden', 'under-defined', 'under-specified' or 'under-codified' and therefore under-recognised.
42. Based on the evidence set out in chapters four to eight and the Secondary Materials referred to in chapter three I am of the opinion that the lack of recognition for the formal and informal learning that happens 'on the job' is likely to be another factor that contributes to the skills, developed and exercised by nurses and midwives, being undervalued or overlooked.
43. Based on the evidence set out in chapters four to eight and the Secondary Materials referred to in chapter three I am of the opinion that nurse and midwives are involved in delivering relationship-based care. This approach to nursing and midwifery requires the deployment of high levels of interpersonal and contextual awareness, negotiation, communication and connecting skills. These skills are often 'hidden', 'under-defined', 'under-specified' or 'under-codified' and therefore under-recognised.
44. Based on the evidence set out in chapters four to eight and the Secondary Materials in chapter three I am of the opinion that the increasing complexity and diversity of the Australian community, and the increasing complexity in their health needs, intensifies the use of Spotlight skills used by nurses and midwives and is placing further demands on nurses and midwives.

2.0 Research approach

45. I was asked by Gordon Legal to
- a) apply the ‘Spotlight skill-recognition tool’ to the work of Registered Nurses and Midwives, Enrolled Nurses, and Assistants in Nursing working outside of aged care; and
 - b) based on application of that tool, produce an independent expert report identifying, naming, and classifying the ‘invisible skills’, if any, used by those workers in their work.
46. To apply the Spotlight tool and produce this expert report I established a research project team to investigate the dimensions of the work of nurses and midwives. Whilst I was originally asked to include Assistants in Nursing in this investigation, I was subsequently advised that I was no longer required to investigate that classification of workers.
47. In this chapter of the report, I set out the research approach used to conduct this study.

The research team

48. An investigation of this nature requires considerable resources. As the Lead Investigator I maintained oversight of, and responsibility for, the conduct of this research. I am the sole author of this report and the views, findings and opinions contained in this report are mine alone.
49. To support me in this investigation I engaged a team of experienced researchers and technical personnel. The following is a list of members of this team and their role

Table 2.1: Research team for the Spotlight research project on nurses and midwives

Team Member	Role
Dr Lisa Heap	Director of Research into Action, Lead Investigator, interviewer, coder and report author
Dr Michael Victory	Director of Research into Action, Project Manager, coder
Ms Susan Kenna	Interviewer, coder and research assistance
Ms Christine Ross	Interviewer
Ms Sue O’Shea	Interviewer
Mr Vincent Victory	Excel database developer

50. Details of the relevant experience of each team member is contained at Annexure three.
51. There is a community of practice of researchers and practitioners who have experience in using the Spotlight tool for job analysis. During the conduct of this investigation, I was able to draw on this community of practice. Prior to the commencement of the project, I convened a meeting with Honorary Associate Professor Anne Junor (UNSW), Honorary Professor Ian

Hampson (UNSW) and Associate Professor Nikola Balnave (Macquarie University) to discuss the design of the research project and the use of the Spotlight tool.

52. Honorary Professor Hampson provided input during the development of the Spotlight workbook. Honorary Associate Professor Anne Junor peer reviewed coding of transcripts and provided insights on the application of the Spotlight tool. Professor Emerita Sara Charlesworth (RMIT University) provided advice related to gender, work and the identification of skills.
53. I am grateful to the research team and to the expert members of the community of practice who supported this project.

Information on which I base my opinion

54. The **Primary Material** on which this report is based is set out in chapters four through seven of this report. It consists of information gathered and data generated from research participants who were a sample of Registered Nurses (RNs), Enrolled Nurses (ENs) Nurse Practitioners (NPs) and Midwives (MWs).
55. In this study I addressed NPs as a separate category from RNs as I determined that the NP role was sufficiently distinct from the work of RNs to warrant investigating this role separately (a more detailed discussion of this is set out below in section 3.1).
56. The Primary Material on which this Report is based is as follows
 - a) Transcripts of 29 interviews with Registered Nurses, Midwives, Enrolled Nurses and Nurse Practitioners totalling 600,000 words based on the recording of those interviews. Each interview lasted between 1.5 – 2 hours.
 - b) Coding of interview transcripts using a coding framework based on the Spotlight skills taxonomy. There were several rounds of coding to cross check results.
 - c) Analysis of the data collected using the Spotlight skills taxonomy and the typology of invisibility (see chapters four - eight).
57. The Spotlight workbooks which included
 - a) Participant details form
The details collected from participants included registration and endorsements, job title, job domain (e.g. acute care, palliative care, midwifery, rehabilitation, disability care, primary health care, community health care, mental health care etc), job setting (e.g. metropolitan, regional, rural, remote), whether they worked in private or public sector, classification level (if known), qualifications, the state or territory in which they were employed, their employer (later de-identified), main workplace, length of time in current job and length of time in nursing.
 - b) A list of open-ended questions

Completion of written responses to these questions was optional. The questions were discussed in the participant interviews.

c) Notes in relation to work activity descriptors

These descriptors were used as triggers for the conversation in the interviews.

58. A sample copy of the Workbook is contained at Annexure four.
59. The **Secondary Material** relied on for this study consists of academic literature and published reports related to nursing and midwifery work, the role of nurses and midwives in Australia, gender regimes and processes at work, and the recognition and valuing of skills. The material informs the conclusions in chapter eight. The full range of Secondary Material is contained in the Reference List.

2.1 The Spotlight tool

60. In this section of this report, I provide information regarding the Spotlight tool that was used to gather and analyse the data collected from workers (Junor, Hampson et al 2009).
61. It is not my intention in this report to go the development of the Spotlight tool in detail. The literature, evidence and methods relied on to develop the tool were extensively documented in the Report of Honorary Professor Anne Junor in the *Aged Care Work Value Case* (Junor 2021). For the purposes of this report, I refer to the evidence set out in the report of Honorary Professor Junor regarding the development of the Spotlight tool.
62. The Spotlight tool is used “as an aid in identifying, naming and classifying ‘invisible skills’ used in undertaking service work processes that are not directly observable” (FWC, 2022, Aged Care Decision Stage 1 [43]). ‘Invisible’ in this context means skills that are hidden, under-defined, under-specified or under-codified² (FWC, 2022, Aged Care Decision Stage 1 [43]). These categories of invisibility, and the literature they were devised from, are set out in detail in the report of Honorary Professor Junor (Junor 2021). Further information regarding the nature of ‘invisible skills’ is set out later in this chapter.
63. I also use the term under-recognised skills. In her report Honorary Professor Junor describes under-recognised skills as being invisible by reason of falling within one or more of the preceding four types of skills, or through otherwise being taken for granted (for example through lack of a formal qualification), skills may be omitted from duty statements or

² In the formatting of this report from hereon in, the following conventions have been used, single quotation marks have been used for ‘invisible’ or ‘invisible skills’ to denote the specific meaning in the Spotlight ecosystem and underlining has been used for the ‘invisible skill’ classifications being hidden, under-defined, under-specified, under-codified. Underlining has also been used for under-recognised skills, an all-encompassing term for these skills used in the ‘Junor Report’. Where not underlined, the word ‘hidden’ retains its conventional meaning.

classification standards. The job size may therefore be larger than appears in a duty statement. On-the-job or in-service training, or knowledge acquired through learning networks, may be required but not recognised. Absence of skill documentation may be a historical legacy of social status based on gender and age, or of location in a “secondary”, non-career labour market, with skills acquired inside or outside the workplace taken for granted and not recognised as skills. (Junor 2021 Annexure 8 p. 6).

64. One of the advantages of the Spotlight tool is that rather than identifying a list of skills that may be present in a particular form of work, it is designed to profile skills needed to perform particular work within the context (environmental, social, cultural and organisational) in which the work is performed (Junor, Hampson, Smith, & Ewer, 2007, p. 52).
65. The Spotlight tool, through its emphasis on how skills interact and are deployed in different contexts (‘clustered’³), provides the opportunity to better assess the nature and utilisation of these skills (Junor & Hampson, 2024).

Spotlight taxonomic framework

66. The Spotlight taxonomic framework (the Framework) is the central component of the Spotlight tool (Junor, Hampson, Barnes and Smith 2009; Ministry of Business, Innovation, and Employment 2009a).
67. The Framework provides a structured mechanism to identify, name and classify skills. The focus of the Framework is on those skills that may be overlooked or ‘invisible’. In particular the Framework seeks to overcome the limitations in traditional job evaluation processes and tools that make assumptions about the nature and value of work in jobs that are mainly done by women. Thus, the Framework is designed to ensure there is accurate and comprehensive job data to support equitable valuation processes.
68. The Spotlight taxonomic framework is included at Annexure five.

Skill Sets

69. The Framework identifies three different Skill Sets upon which a range of overlooked or ‘invisible’ complex work process and activities depend. These three Skills Sets are
 - I. Skill Set A - Conceptualising - building and shaping awareness skills, including the ability to perceive, ‘read’ and interpret the significance of workplace situations and contexts

³ Formatting conventions have also been applied. Single quotation marks have been used to show when ‘cluster’, ‘clustering’, ‘skills cluster’ or ‘cluster of skills’ have been used with the specific meaning given to them in the Spotlight ecosystem.

- II. Skills Set B - Connecting - interacting and relating skills, including negotiating interpersonal, organisational and intercultural relationships
- III. Skill Set C - Coordinating - the ability to organise one's own work, link it into to the overall workflow and deal with disruptions.
- IV. The Spotlight taxonomic framework is included at Annexure five.

Skill Elements

70. The Framework subdivides these Skill Sets into nine Skill Elements, as follows
- A. Contextualising - Building and Shaping awareness, including the ability to
 - A1 Perceive contexts or situations
 - A2 Monitor and guide reactions
 - A3 Judge impacts
 - B. Connecting - Interacting and relating, including the ability to
 - B1 Negotiate boundaries
 - B2 Communicate verbally and non- verbally
 - B3 Connect across diverse cultures and communities
 - C. Coordinating – including the ability to
 - C1 Sequence and combine activities
 - C2 Interweave one's activities with others'
 - C3 Maintain or restore workflow.

Skill Levels

71. The Framework maps the skills identified at five levels of proficiency. These levels of proficiency go beyond minimum entry level requirements, i.e. those required for the attainment of a qualification. The Framework identifies skills at the novice level through to that of problem-solving practitioner and further to a level where a shared development of practical approaches innovations is embedded in how work is carried out (Department of Labour 2009, pp.13-14)
72. The five levels of proficiency are
- a) Orienting - Building experience through practice, reflection and learning to work with others
 - b) Fluently performing - Applying experience in a practiced and self-reliant way
 - c) Solving new problems - Providing resourceful solutions to problems as they arise in the course of work activity
 - d) Sharing solutions -Sharing developed expertise with colleagues or team
 - e) Expertly creating systems - Embedding new solutions in work processes

2.2 Application of the Spotlight tool in this research

73. In this research the Spotlight tool was used to both gather data and analyse that data.

Data gathering

74. The Spotlight tool was used in the processes for gathering data. The principal means of gathering primary evidence for this research was via individual interviews with participants performing nursing and midwifery work. To facilitate these interviews participants were given a Spotlight workbook (see example at Annexure four) prior to attending the interview. The workbook included open-ended questions and a set of matrices of work activities grouped in accordance with the Spotlight framework.
75. The purpose of the workbook was to allow participants to prepare for the interview, providing them with an overview of the matters that would be discussed and encouraging them to think of examples of work activities that described their work.
76. The Spotlight workbook included 13 open ended questions that the interviewer and the participant discussed at length in the interviews. In addition to discussing the open-ended questions participants discussed the work activities grouped in the matrices in the workbook.
77. Participants identified those activities that applied to their work. Where they identified an activity that applied to their work, they were then asked to provide examples that demonstrated that application. The discussion regarding the work activities in the workbook formed part of the recorded interview.
78. In this research the activity descriptors included in the Workbook were adapted from those used in the Spotlight workbook in the *Aged Care Work Value Case*.

Data analysis

79. The second application of the Spotlight tool in this research was in the analysis of the data collected. The components of the Spotlight framework were incorporated into a code book or 'frame' against which the evidence from the interviews was coded. This is a form of closed coding used in qualitative research practice. The aim of closed coding in this way is to use theory-informed approaches to understand the data (Bingham and Witkowsky 2022; Crabtree and Miller 1999; Lincoln and Guba 1985; Miles, Huberman and Saldaña 2020)
80. The process for coding the transcripts of interviews is described in section 2.5 of this chapter. Coding the data against the coding frame assists in identifying, naming and classifying the Spotlight skills (invisible skills) present in the examples given by the participants.

2.3 Research participants

81. There were 29 workers who participated in this research project. The socio-demographic details for these participants are set out in this section of the report.

Selection of participants

82. In 2024 (and with some additional names provided in 2025) Gordon Legal referred 57 nurses and midwives to Research Into Action as potential participants for this study.
83. The processes used by Gordon Legal to identify the potential participants is set out in correspondence from them dated 29th January 2026. A copy of that letter is contained at Annexure six.
84. The list contained the name, contact details, occupational classification, the field of nursing work, the name of their current workplace and the experience for each of the 57 potential participants. The cohort for participation in this research was chosen from this pool of 57 potential participants using the processes described in the paragraphs below.
85. The selection of the final group of workers to participate in this research was made considering the following factors
 - a) When selecting occupational classifications (RN, EN, MW, NP), consideration was given to the proportion of the total nursing workforce represented by that occupational classification.
 - b) The nominated state/territory of each participant was considered.
 - c) Consideration of geographic location extended to the nominated work location of the potential participants. I used a grouping of just four locations: metropolitan, regional city, rural or remote.
 - d) Consideration was given to the years of experience of the potential participants as indicated on the information supplied by Gordon Legal. The final selection included participants with experience ranging from 6 years to 44 years. The selection was based on the participants' answer to the question of how many years of nursing experience they held. Data was also available on the number of years the person had been in their current role. This factor was given only secondary consideration in the selection process.
 - e) Consideration was also given to the current workplace as indicated by the potential participants on the information supplied by Gordon Legal. An attempt was made to choose a sample of participants who best reflected the wider nursing and midwifery workforce. Consideration was given to whether the person worked in acute care, primary health care or mental health. Within those broader groups I made choices to include, where possible, nurses and midwives employed in private and public hospitals, GP clinics and other medical clinics, local government services, and community and not for profit health services.
 - f) Consideration was given to the field of work that each person had nominated on the list supplied by Gordon Legal. I used the OSCA classification of nursing

occupations to assist in this selection process (Australian Bureau of Statistics. 2024b). The purpose of this was to choose participants who, as far as possible, reflected the diverse fields of work of the wider nursing workforce. In practical terms, this criterion was only applied to RNs as the sample size of the other three classifications was smaller. Other considerations prevailed for ENs, MWs and NPs (e.g. state/territory location, years of experience, geographic work location and employment provider).

86. I selected an initial group of 30 participants for this study. I decided on this number after
 - a) Reviewing the approach taken in previous investigations using the Spotlight tool
 - b) Considering the data and literature regarding the make-up of the nursing and midwifery workforce in Australia
 - c) Considering the different contexts and settings within which the nursing and midwifery workforce is employed
 - d) Considering the timeframe and resources available to me.
87. Out of the final 30 potential participants selected by me, 29 accepted the invitation to participate in this study.
88. After conducting interviews and reviewing the transcripts of those interviews I determined that I had sufficient evidence from the 29 participants to conduct my analysis and produce this report.

Demographics of research participants

89. In the following series of tables and graphs I set out the information about the demographics of the research participants. Some comparisons are made to the demographic data presented in the analysis of Secondary Materials in chapter three of this report

Table 2.2: Research participants by occupation classification

	Participants	% of participants (rounded)
Enrolled Nurse	5	17
Registered Nurse	17	59
Midwife	3	10
Nurse Practitioner	4	14
	29	

90. When compared with the demographics of the nursing and midwifery cohorts across Australia (see chapter three of this report), I note the following
 - a) The proportion of ENs in this study (17%) is fairly comparable to the proportion of ENs as a percentage of all nurses (15%)

- b) This study has a slightly greater proportion of MWs (10%) than the proportion of MWs across the nurses and midwives registered with the NMBA (7%)
- c) This study has a significantly higher proportion of NPs (14%) compared to the proportion of NPs across the full RN cohort (less than 1%).
- d) Those with RN registration only (not including those with dual registration) comprise 76.0% of the total cohort of midwives and nurses registered with NMBA. This is greater than the proportion (59%) of RNs in this study.

Comparison figures compiled from data in Annual Report of NMBA 2023/2024 (Nursing and Midwifery Board of Australia 2024a)

Participants by sex

- 91. One participant (RN) in this study identified as male.

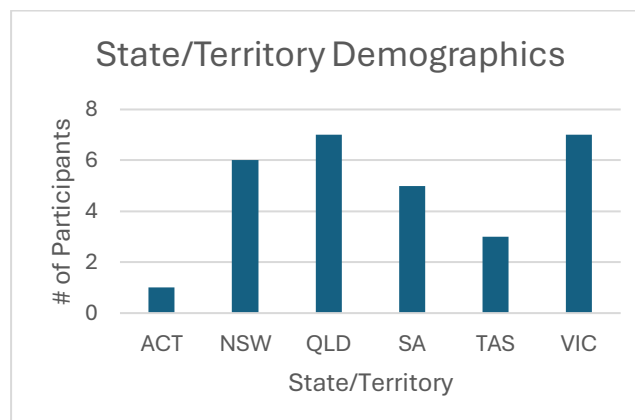
Aboriginal and Torres Strait Islander identification

- 92. One participant in this study identified as a person of Aboriginal and Torres Strait Islander descent.

Participants by state/territory

- 93. The distribution in Figure 2.1 below shows that the highest number of participants for the study came from the three most populous states (QLD, NSW & VIC).

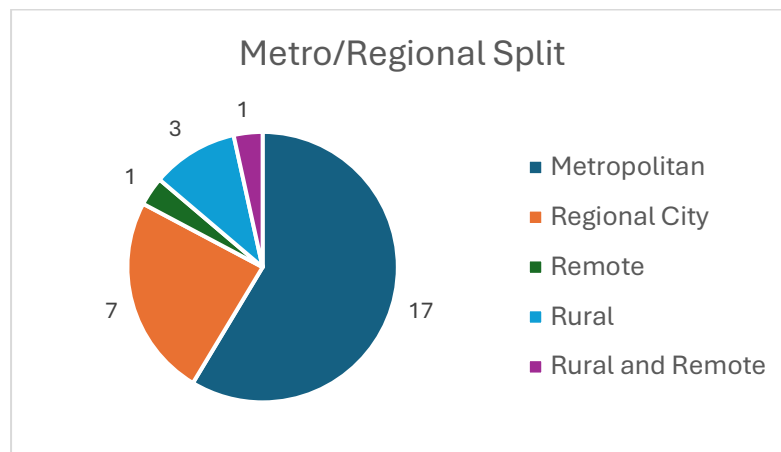
Figure 2.1: State/territory of research participants by residence n=29



Participants by geographic distribution

- 94. Given the participant details I had access to I have represented the geographic distribution of their primary place of work as one of four categories – metropolitan, regional city, rural or remote, or as in the case of one participant a combination of these locations.

Figure 2.2: Metropolitan and regional location of participants by workplace location

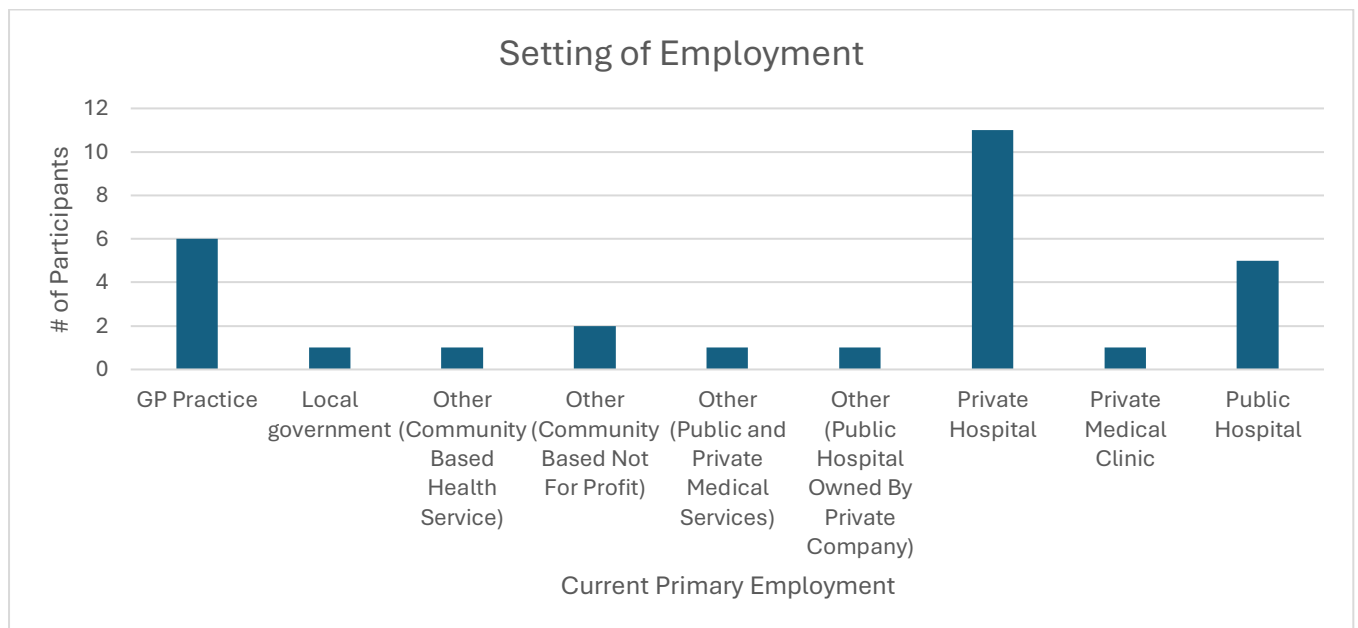


95. Figure 2.2 shows a concentration of participants in this study from metropolitan centres; 59% (rounded) of the participants. This percentage is below the proportion of nurses and midwives across Australia employed in metropolitan settings - 73% for nurses and 70% for MWs as at June 2023 (Nursing and Midwifery Board of Australia 2023c and 2023d). In this study there is a higher proportion of participants from regional, rural and remote locations than the wider cohort of nurses and midwives. One other comparison that can be reasonably made is that this study draws 24% of its participants from regional cities. In the broader cohort of nurses, 10% of all nurses were employed in regional cities, and 10.5% of midwives as at June 30 2023 (Nursing and Midwifery Board of Australia 2023c and 2023d).

Setting of Employment

96. In Figure 2.3 below I identify the setting where each participant is employed (their primary place of employment). There are nine different settings represented in the sample of participants for this study. In the literature I reviewed I was unable to access a comparative set of data for the distribution of the nursing and midwifery cohort across Australia.

Figure 2.3: Setting of employment for each research participant n=29

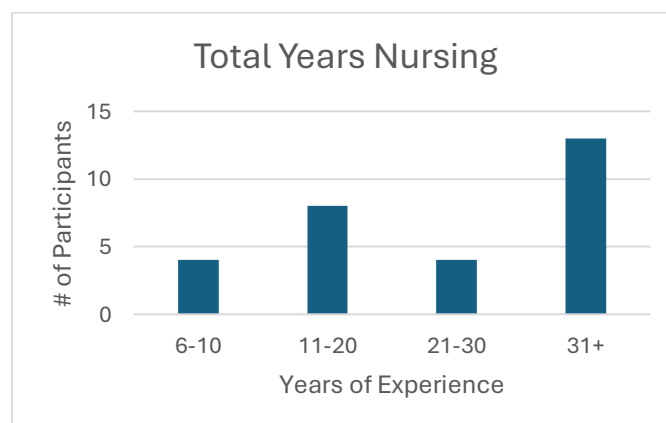


97. Without access to comparative data but recognising the number of hospitals in Australia which has been reported as 633 private hospitals and 704 public hospitals (Australian Institute of Health and Welfare, 2026), it is apparent that the number of participants employed in private hospitals is overrepresented in the study sample compared to the wider nursing and midwifery population. This was not a deliberate choice, but rather the product of the sequence of choices I made in choosing the sample according to the methodology set out in section 2.4 of this chapter.

Experience

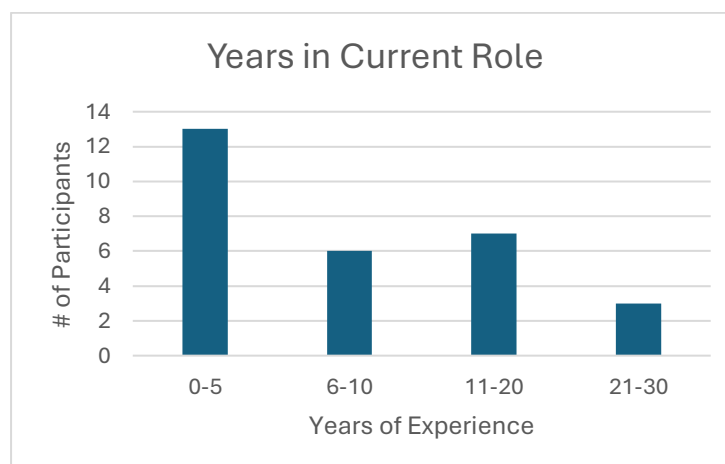
98. Figure 2.4 below provides information on the years of nursing and midwifery experience as self-reported by the participants. The data should be considered a general representation of the experience of the group rather than a definitive record, as there were variations in how participants interpreted the question.

Figure 2.4: Years of experience in nursing and midwifery of the research participants n=29



99. Figure 2.5 gives a different perspective on the years of experience of the study participants. They were asked to nominate how many years they had been in their current role. Once again the data is self-reported and should be viewed as a general representation of the experience of the group in their current role. Variations in employment patterns make it likely that participants will have had different interpretations in answering the question.

Figure 2.5: Years in current role for participants in the study n=29



Qualifications

100. Information on the qualifications of research participants has been grouped by occupation classification and is presented in the relevant chapter for each classification.

2.4 Data gathering

101. The process of selecting participants for this study is set out in section 2.4 of this chapter. Once identified and selected, research participants were invited to participate in the study. An invitation was sent from Research into Action (RIA). A Participant Information and Consent Form (PICF) was sent to, and signed and returned by each person invited to be involved in the study. A copy of the PICF is included at Annexure seven.
102. Those participants who agreed to take part in the study were forwarded a Spotlight workbook. The components of the workbook are discussed in section 2.3 in this chapter. A copy of the Spotlight workbook is attached at Annexure four. Participants were asked to fill out this workbook by
- a) completing the additional demographic information
 - b) reviewing the open-ended questions and as an option answer those questions in preparation for the interview
 - c) reviewing the matrices of work activities contained in the workbook and indicating which work activities applied to their work.
103. I consulted with Associate Professor Anne Junor and her colleague Honorary Professor Ian Hampson on the construction of the Workbook.

Pilot program

104. I conducted a pilot round of interviews using the Zoom video conference platform in late January 2025 with four participants from the study. The pilot was designed to
- a) test the applicability of the workbook to this group of nurses and midwives
 - b) check the usability of the relevant forms and communication material and processes for clarity and efficiency
 - c) trial the interview process
 - d) test the quality of transcripts generated automatically through Zoom.
105. The four pilot participants were invited to provide feedback on the materials. No changes were recommended to the materials or the processes arising from the pilot. Although one clear recommendation from the participants (and myself as the interviewer) was that the interviews should be limited to 90 minutes.
106. I reviewed the automatically generated transcripts from Zoom. I also invited Dr Victory, who attended each of the four pilot interviews, to review the transcripts. We agreed that the Zoom transcripts were of high quality and an accurate capture of the interview, albeit with minor errors particularly when technical health terms and acronyms were used and a tendency to repeat words in sentences where a speaker might have paused for a short time. I determined that these transcripts were of sufficient quality to be used in the study.

Interviews with participants

107. The interviews were conducted over the period January to May 2025. They were conducted through Zoom video conferencing for a duration of approximately 90 minutes (with one interview extending to 120 minutes across two sessions). Interviews were conducted by me and three experienced interviewers—Ms Christine Ross, Ms Sue O’Shea and Ms Susan Kenna.
108. I conducted three briefing sessions with the initial interview team (Ross and O’Shea) –one face to face and two online. The fourth interviewer, Ms Kenna, was added to the interview team later. Ms Kenna had the same level of briefing provided to the initial interview team. Dr Victory sat in on the pilot interviews and on several other interviews to provide technical support and to monitor the interview processes to ensure consistency in approach.
109. Pseudonyms were allocated to each participant prior to the interview. At the commencement of the interview participants changed their ‘Zoom name’ to the pseudonym, so all transcripts have only the pseudonym of the participant.
110. The open-ended questions and matrices in the Spotlight workbook were used as prompts for the interview. All participants were asked the open ended questions. Participants were also asked to respond to the activity statements on the matrices. Through this process a rich picture emerged of the work of each of the participants which was captured in the interview transcripts. One additional issue that arose in many early interviews was the impact of COVID

on the work of nurses and midwives. The impact of COVID on nursing and midwifery work then became a common question for interviewers to ask about.

111. Participants were invited to submit to RIA any further comments or materials following the interview; these might include role descriptions or additional material that they thought may be of interest to the research. Not all participants were able to fully complete the workbook prior to the scheduled interview. This challenge was overcome by the interviewer screen sharing the workbook and inviting comment from the participant (which was then captured on transcript).
112. At the conclusion of the interviews RIA held approximately 45 hours of audio recording of the participant interviews.
113. All 29 interviews were transcribed automatically by the AI function in Zoom. Following each of the 29 interviews, the interview transcript was downloaded and forwarded to the interviewer for a first review. The interviewers had access to the audio recording of the interview and used this to assist in reviewing the auto generated transcript. The purpose of this review was
 - a) To read through the full interview transcript to identify any obvious examples of incorrect transcription
 - b) To read in detail for technical health terms or acronyms that could be more accurately presented
 - c) To carefully check for any potentially mis-transcribed words, correlate with the audio file and correct the transcript.
114. Information that could identify the person or their specific work location was redacted.
115. The reviewed transcripts were returned to RIA and stored securely by the Project Manager. At this point prior to the commencement of coding, RIA held 29 interview transcripts totalling approximately 600,000 words from nurse and midwife participants.

2.5 Data analysis

Coding frame

116. Following the method developed by Honorary Associate Professor Anne Junor and colleagues, statements made by a participant in the interview and in written responses to the open-ended questions in the Spotlight workbook were assigned a code using a coding frame. The coding frame is based on the Spotlight framework and is set out below in Table 2.6.

Table 2.6: Coding frame for data analysis

Skill Elements	Orienting	Fluently performing	Problem Solving	Sharing solutions	Expertly creating a system
Contextualising/Building and Shaping awareness					
A1 Perceive contexts or situations	A1.1	A1.2	A1.3	A1.4	A1.5
A2 Monitor and guide reactions	A2.1	A2.2	A2.3	A2.4	A2.5
A3 Judge impacts	A3.1	A3.2	A3.3	A3.4	A3.5
Connecting/ Interacting and relating					
B1 Negotiating Boundaries	B1.1	B1.2	B1.3	B1.4	B1.5
B2 Communicating verbally and non-verbally	B2.1	B2.2	B2.3	B2.4	B2.5
B3 Connect across diverse cultures and communities	B3.1	B3.1	B3.3	B3.4	B3.5
Coordinating					
C1 Sequence and combine activities	C1.1	C1.2	C1.3	C1.4	C1.5
C2 Interweave one's activities with others	C2.1	C2.2	C2.3	C2.4	C2.5
C3 Maintain or restore workflow	C3.1	C3.2	C3.3	C3.4	C3.5

117. Coding, using the above coding frame, was the principal method used to identify, name and classify the Spotlight Skill Elements and levels present in the description of work activities provided by participants. Statements from participants were also considered in relation to the typology of invisibility (hidden, under-defined, under-specified, under-codified, under-recognised) discussed in section 2.1 of this chapter.
118. This form of content analysis using 'closed coding' is a commonly used in qualitative research practice. Past Spotlight projects have used this practice of closed coding.

Coding process

119. The coding process involves allocating a code or several codes, that correspond with the coding framework and thus the Spotlight tool, to the examples of work activities provided by participants. The description of a work activity by one of the participants may have a single

code allocated e.g. C1.3 if in the view of the coders it represented an example of the person operating at the problem-solving level as they sequenced and combined their activities.

120. In this study it was common for the description of a work activity to have multiple codes allocated. A common coding pattern saw an activity being coded at A1.3, B1.3 and C1.3. The interview participant will have described an activity where they had to piece together information from a patient to solve a problem (A1.3). They may then have described how they gained the trust of the patient by explaining to them each step of a process that the patient would be involved in, and the purpose of that process (B1.3). Finally, the participant, in their nursing or midwifery role, may have had to reprioritise their own tasks and routines to meet the new demands arising from solving the problem for this particular patient (C1.3).
121. A subset of the research team was involved in coding interview transcripts and written responses to open-ended questions in the workbook. I also accessed the expertise of Honorary Associate Professor Junor to inform the coding process. She reviewed a sample of coded transcripts for each of the classifications (RN, EN, NP and MW).
122. I conducted two initial moderation sessions with the coding team. The purpose of moderation sessions was to build consistency of interpretation of the codes and to enhance inter-rater reliability. I conducted two further online review sessions with the coding team as we moved through the coding process.
123. The original coding of each transcript was reviewed by another member of the coding team and differences in approaches to coding discussed. A final process of review and verification was conducted by me. Therefore, all transcripts were triple coded.
124. At the end of the coding process there were over 4,000 codes allocated to statements across the 29 interview participants. The coding of the statements in this way identifies, names and classifies the skills involved in the work activities described by the participants.

Representing the data

125. A member of the research team custom designed an Excel database to capture the codes and related statements from the transcripts and written responses. The Excel database contains a profile of each individual participant. The quotes describing the work activities of the individuals were included in the database along with the code/s that tagged to that quote.
126. The process of coding and the analysis available from using the Excel database support the development of skill profiles for each participant and for each classification of work. Spotlight skills profiles consist of the counts of instance of the use of each Spotlight Skill Element at each level. Through averaging the counts in individual profiles within a classification, a skills profile or Heat Map can be produced for each classification.
127. In the chapters for each occupation (chapters four to seven) the evidence supporting my findings is presented in four formats

- a) A skills profile in the form of a Heat Map tallying all codes allocated to work activities for each occupation classification at level
 - b) A Table showing the dominant skill elements for the occupation classification at level, using the wording from the Spotlight framework. In this table the link between the work activities, the Skill Elements in the Spotlight framework and the typology of invisibility of skills is set out
 - c) Work activity examples from participants' interview transcripts aligned with the Spotlight framework Skill Elements and Skill Levels
 - d) Case Studies that provide examples of work activities showing participants deploying 'clusters' of Spotlight skills.
128. In presenting the evidence of work activities and the alignment with the Spotlight framework and the typology of invisibility for each of the four classifications in chapters four to seven I have provided examples of work activities for each Skill Element at level. Whilst an example has been used to illustrate a single Skill Element, this does not mean that this example is only illustrative of that Skill Element. An example drawn from the Primary Material may have been coded to multiple skill elements. Examples showing the clustered deployment of Spotlight skills are contained in the case studies in the relevant section of chapters four to seven.
129. I note that many of the participant work activities had multiple codes allocated as they contained more than one Skill Element.
130. A Heat Map is a graphical representation of a data set in which more dominant features are coloured or shaded to represent that dominance. In the case of this report the Heat Maps are structured to show in darker colours the higher average incidence of a coded activity per person in each classification. The Heat Maps generated from applying the Spotlight tool show the relative intensity of the demand for the use of various Spotlight Skill Elements at a particular level in each job classification. This report includes a Heat Map for each classification (RN, EN, MW and NP) in chapters four to seven.
131. The Spotlight methodology allows for each instance of a Spotlight Skill Element to be counted. A loading can also be added to this count for whenever a participant has indicated that the work activity (and therefore the skills associated with it) are frequent and/or critical. Thus, one instance of an activity which is both frequent and critical could be given a count of 3. In this study I decided not to apply the loading for frequency and criticality. I made this decision after reviewing the transcripts of interviews. I believed that the issue of frequency and criticality had not been discussed consistently enough to allow for these factors to be included in the count. While this has led to lower Skill Element counts in the Heat Maps than other Spotlight analyses, because no score was allocated for criticality or frequency across

any Skill Element for any classification, internal consistency has been maintained and the relativity of scores within and across classifications remains valid.

132. In addition to the Excel database being used to create individual skills profiles and classification skills profiles, the verbatim quotes within the database can be used to support thematic analyses or to identify responses on specific issues across participants. The themes or specific issues that were relevant to this study were drawn from the Secondary Material set out in chapter three of this report.
133. The findings and conclusions drawn from the analysis of the data collected are set out for each classification (RN, EN, MW and NP) in chapters four to seven with final integrated conclusions being set out in chapter eight of this report.

2.6 Summary of research approach

134. In summary, I have applied the following approach to gathering and analysing data upon which I have based my opinion in this report
 - a) I was provided with a list of 57 potential participants by Gordon Legal.
 - b) I developed selection criteria that, in my expert judgement, would provide the most comprehensive and diverse sample of each of the four classifications (EN, RN, MW, NP) from the pool of participants to whom I had access. Ultimately 29 nurses and midwives participated in interviews.
 - c) I consulted with Honorary Associate Professor Anne Junor and Honorary Professor Ian Hampson, authors of the Spotlight taxonomic framework, as well as Associate Professor Nicola Balnave who has employed this framework, to develop the tools required to undertake the research.
 - d) Following that consultation I finalised the documentation to be used in this study including the Spotlight workbook given to participants.
 - e) I assembled an experienced research team to support me in conducting this study.
 - f) Interviews of approximately 90-minutes duration were conducted with 29 participants who agreed to participate in this study.
 - g) The transcripts from the interviews and the written answers to open-ended questions contained in the workbook were coded using a coding frame aligned with the Spotlight taxonomic framework.
 - h) I analysed the 4,000 identified Skill Element codes from the 600,000 words of transcript from the 29 interviews. In this process I used a custom designed Excel database to assist in the data analysis.
 - i) Throughout the process of selecting, interviewing, coding and data analysis I engaged with the relevant academic literature and published reports.

135. I believe I have taken all the necessary steps to ensure that the research approach adopted in this study is comprehensive and the results are reliable.

3.0 Nursing and midwifery in contemporary Australia

136. The focus of this research is the skills of nurses and midwives which can be characterised as ‘invisible’. The term ‘invisible’ has been applied to skills in female dominated areas of work that have been, and continue to be, overlooked and undervalued in the mechanisms that assess and value work – including traditional job evaluation processes and the processes and decision making of industrial tribunals. Overlooking and undervaluing these skills has contributed to gender-based undervaluation of female-dominated areas of work. Further details about gender-based undervaluation and ‘invisible skills’ are set out later in this chapter.
137. In this research I applied the ‘Spotlight skill-recognition Tool’ (forthwith - Spotlight tool and Spotlight framework) to identify, name and classify the ‘invisible skills’ present in the work of nurses and midwives. Prior to presenting the Primary Material, I present an overview of nursing and midwifery in Australia drawn from the Secondary Material. This allows me to place my expert evidence on ‘invisible skills’ in context.
138. This overview is not exhaustive. The literature I have focussed on is contemporary academic literature and published reports that could be reasonably applied to a nurse or midwife working anywhere in Australia. Therefore, I have not gone to the differences between the states and territories on nursing and midwifery practice. I reviewed one international meta-analysis (Jackson et al 2021) and refer briefly to international studies that provide insights into the Australian context and those that reference internationally qualified nurses and midwives currently working in the Australian health system. I have limited my focus to literature on nursing and midwifery in the context of the contemporary health workforce and health care delivery in Australia. The overwhelming majority of the references and the discussion are from publications on nursing and midwifery since 2000.
139. This chapter is set out in four sections
- 3.1 Overview of nursing and midwifery professions in Australia
 - 3.2 Contemporary issues impacting on nursing and midwifery
 - 3.3 (Under)valuing female dominated areas of work
 - 3.4 Summary of nursing and midwifery in contemporary Australia

3.1 Overview of nursing and midwifery professions in Australia

140. Nurses and midwives make up the majority (54.8%) of all registered health practitioners in Australia (Nursing and Midwifery Board of Australia 2024a) and more than 40% of the national health workforce (Department of Health and Aged Care 2024a, p.6). In June 2023 there were approximately 500,000 people in Australia who held registration as a nurse or midwife (Nursing and Midwifery Board of Australia 2024a).

141. The focus of this research and report is on Enrolled Nurses (ENs), Registered Nurses (RNs), Nurse Practitioners (NPs) and Midwives (MWs). The Nursing and Midwifery Board of Australia (NMBA)⁴ describes nursing and midwifery roles. I have included a summary of the different classifications drawn from the NMBA descriptions. I do not suggest these summaries describe the full detail of the work of any of the classifications.

Enrolled Nurses (ENs)

142. ENs provide nursing care as part of a team. They work under the supervision of a Registered Nurse or Nurse Practitioner. Examples of core EN activities include
- a) providing personal care and hygiene needs such as showering, dressing and assisting with meals
 - b) recording and interpreting clinical observations including
 - temperature, pulse and blood pressure
 - urinalysis
 - blood glucose and other tests used in specific areas of practice
 - c) recognising and communicating changes in the person's condition to the RN and, with the RN, formulate the next steps of care
 - d) providing basic care for those with acute and chronic physical and mental health needs
 - e) providing basic wound care in line with an agreed plan of care
 - f) administering and monitoring medicines and intravenous therapy
 - g) supporting basic nutrition advice and education responding to people's health and care needs (Nursing and Midwifery Board 2025b).

Registered Nurses (RNs)

143. RNs are accountable for the management of people in their care. They conduct comprehensive assessments, develop care plans and coordinate other health workers and resources to provide nursing care. RNs apply critical thinking and analyse nursing practice, providing safe, appropriate and responsive quality nursing practice. RNs provide information and education to enable people to make decisions and take action in relation to their health and well-being. RNs supervise, and when appropriate, delegate care to ENs, student nurses and other healthcare workers. Examples of core RN activities include
- a) responsibility for the assessment, planning and delivery of care to people who have acute and/or chronic physical and mental health issues
 - b) developing, reviewing and maintaining nursing care plans and other health records

⁴ The NMBA is the body that regulates nursing and midwifery in Australia.

- c) the ongoing monitoring and evaluation of the nursing care provided and identification where care may need to be escalated or altered due to the changing health of the person
- d) performing treatments, commencing administering and monitoring medication and IV therapy
- e) interpreting diagnostic test results and reports
- f) educating people about treatment plans, their follow up care, and any referrals to specialist services that have been made
- g) providing emotional and psychological support to people and their families
- h) supervising nursing students
- i) participating in medical or surgical procedures as part of a multi-disciplinary team (for example in surgical wards and operating theatres)
- j) working with a nursing focus with other healthcare providers (Nursing and Midwifery Board 2025b).

Nurse Practitioners (NPs)

144. NP practice is primarily a clinical role. NPs integrate theoretical and advanced practice knowledge to apply to diagnostic reasoning to formulate diagnoses. NPs have authority to practise independently and collaboratively in multi-disciplinary teams, at an advanced practice level. NPs supervise ENs, nursing and NP students and other healthcare workers. Depending on the individual scope of practice, the NP may have the ability and authority to work at an extended or specialist level. This includes providing or assisting with medical or surgical procedures, or advanced care in range of specialist and/or generalist clinical areas. Examples of core NP activities include many registered nursing activities, and in addition
- a) advanced health assessment that includes ordering and interpreting diagnostic tests (pathology and medical imaging)
 - b) diagnosing and treating acute and/ or chronic physical and mental health conditions
 - c) independent prescribing of scheduled pharmacological and non- pharmacological interventions
 - d) independent referral to general practitioners, medical specialists and allied health practitioners
 - e) establishing healthcare delivery
 - f) a strategic role to improve, manage or prevent health issues
 - g) support meeting the need of community health using contemporary research to provide evidence-based care
 - h) policy development initiation and quality improvement activities (Nursing and Midwifery Board 2025b).

A note on NPs in this study

145. NPs are RNs for the purposes of registration (discussed in more detail in the next section of this chapter). In this study I have reviewed the work activities of NPs separately to those of RNs. My reasons for doing so are

- a) Nurse Practitioner is a protected title in the same way as Enrolled Nurse, Registered Nurse and Midwife
- b) The NMBA has developed a separate scope of practice for NPs, which is different than that for RNs
- c) NPs have a compulsory additional qualification requirement for endorsement
- d) Nurse Practitioner is listed by the NMBA as one of four education pathways for nurses and midwives, the others being Registered Nurse, Enrolled Nurse and Midwife
- e) The NMBA have developed separate Nurse Practitioner Standards (Nurse and Midwifery Board of Australia, 2025c)
- f) NPs are a distinct classification in the *Nurses Award 2020*.

For these reasons I decided to investigate the NP role as one separate from RNs.

Midwives

146. Midwives work in partnership with women. Midwives supervise student midwives and other healthcare workers and delegate activities from a midwifery plan of care. Examples of core midwife activities include

- a) antenatal care including abdominal palpation, performing clinical observations on mother and unborn baby
- b) reviewing and ordering diagnostic and/or screening tests, and risk assessments from a clinical, health, lifestyle and psychological perspective
- c) intrapartum care including monitoring and support of women during labour, monitoring the foetus during labour and medication management
- d) birthing the baby, identifying variances to normal birth and escalating as necessary to specialist staff
- e) managing medication and IV therapy within the context of midwifery practice
- f) managing the third stage of labour, perineal assessment and suturing, facilitating initial mother and baby interaction, including skin to skin and breastfeeding support
- g) advising and supporting parents on the daily care of their newborn babies
- h) identifying where there may be concerns about the health and wellbeing of the mother and the newborn baby
- i) offering breastfeeding and nutritional support

- j) supporting parents who experience miscarriage, termination, stillbirth and neonatal death
 - k) women's health, reproductive and sexual health, and child and family health care
- (Nursing and Midwifery Board of Australia, 2023a).

Snapshot of nurses and midwives and where they work

147. In the following section I provide key data regarding the composition of the nursing and midwifery workforce in Australia.

Composition of the nursing and midwifery workforce by division⁵

148. RNs are by far the largest division across the nursing and midwifery workforce. The Table below shows that those with single RN registration alone comprise more than 80% of the nurses and midwives whose registration is active. Of those who hold registration as a MW, 76% hold dual registration as a nurse and a midwife. Table 3.1 sets out the breakdown of nurses and midwives by divisions.

Table 3.1 Number of Nurses and Midwives by division (2024)

Classification division	Nos
Enrolled Nurse	70,769
Enrolled Nurse and Registered Nurse (dual registration)	12,268
Registered Nurse	394,785
Practising Midwife (standalone qualification – not dual registered as a nurse – author calculation)	7,131

The following groups of nurses are subsets of the ENs and RNs above	
Nurse Practitioner (included with RNs)	2,900
EN and midwife (included with ENs)	116
EN & RN & Midwife (included with those who have dual registration)	110
RN and midwife (included with RNs)	26,001

Source: Table compiled from data in Annual Report of NMBA 2023/2024 (Nursing and Midwifery Board of Australia 2024a)

Health care settings and fields of work

149. The Australian health care system is large and complex with nurses and midwives employed in multiple settings across the nation. The Australian Institute of Health and Welfare in its most recent summary of data on hospitals in Australia reports that there were 633 private hospitals

⁵ There are multiple organisations that gather data about the health workforce generally and the nursing and midwifery workforce specifically. This leads to variations in the numbers of nurses and midwives across different sources and reports. One of the observations made in the final report of the Scope of Practice Review is the need for nationally consistent health workforce data collection and collation (Department of Health Disability and Ageing, 2024).

and 704 public hospitals (Australian Institute of Health and Welfare, 2026). Information from the Productivity Commission notes, there are about 7000 accredited GP clinics in Australia (Productivity Commission 2024b).

150. In any year around 80% of Australians visit one of the 7,000 GP clinics, 38% of the population will visit a specialist, and 15% will attend a hospital emergency department (ED). Of those that visit a GP more than once, just over one quarter report attending more than one general practice (Productivity Commission 2024b).
151. I found it useful to draw on the Occupation Standard Classification for Australia (OSCA)⁶ as it applies to nurses and midwives (Australian Bureau of Statistics, 2024b). OSCA also provides data on how many nurses and midwives are employed in the different settings of work.
152. OSCA has four fields of work for ENs and RNs, to which I refer to in this report. They are
 - a) Acute Care – which can include public and private hospitals. This expert report includes evidence from nurses and midwives working across a full range of hospitals.
 - b) Primary Health Care – such as General Practice and emergency medical clinics, community and public health settings including maternal and child health services, and private clinics e.g. skin care clinics. This expert report contains evidence from nurses and midwives working in a diverse range of primary health care settings.
 - c) Mental Health - settings where specialised services are provided to those who are experiencing psychiatric or psychosocial illness. This expert report includes evidence from those working in mental health.
 - d) Aged Care.
153. Table 3.2 presents the total head count of nurses, both RN and EN, working in each of the identified fields. I note that nurses working in Acute Care and Primary Health Care comprise over 88% of the nurses employed across the Australian health sector.

⁶ Formerly ANZSCO. OSCA is a standardised framework for processing occupational related data by the Australian Bureau of Statistics (ABS).

Table 3.2: Number of Nurses by fields of work (2024)

Nurses (includes RN, EN and NP)	Head Count¹	% of nurses employed in each sector (rounded)
Nurses working in Acute Care	213,405	66
Nurses working in Primary Health Care	71,568	22
Nurses working in Mental Health	28,567	9
Nurses working in other settings	7,828	3
	321,368	

Source: (Department of Health and Aged Care 2024d).

¹Figures includes some projections of entries and exits to employment and not final data.

154. Table 3.3 below shows the distribution of midwives across various fields of work. Data on the fields of work for midwives is less accessible than for nurses. I was unable to locate data that showed a breakdown of the full midwifery workforce. Rather, the numbers in this table are taken from a survey of 2460 midwives, (just under 10% of the number of registered MWs).

Table 3.3: Number of Midwives by fields of work (2024)

Location of work	Number	% of midwives employed in each sector (rounded)
Hospital based	1396	57
Of those working in hospitals some midwives work in Midwifery Group Practice and Team Midwifery	190	
Private Practice	101	4
Child and family health and maternal child health roles as a midwife	147	6
Other including policy, education and research roles	821	33

The data for this table is drawn from a workforce survey undertaken for the Midwifery Futures Project (Homer et al., 2024, p. 51)

Gender mix of the nursing and midwifery workforce

155. There has been a steady increase in the number of males taking up nursing and midwifery, and that trend is predicted to continue (Department of Health and Aged Care 2024d). However, most of the workforce is female.

Table 3.4: Number of Nurses and Midwives by sex (2024)

Classification	Female	Male
Nurses	88.0%	12.0%
Midwives including those holding dual registration as a nurse	99%	1.0%

(Nursing and Midwifery Board of Australia 2024a)

Regulation of nursing and midwifery

156. Nurses and midwives in Australia are regulated in accordance with the National Regulation and Accreditation Scheme (NRAS) for Health Professionals (Department of Health Disability and Ageing, 2025a). Under the NRAS each profession has a national board that regulates the profession, registers practitioners and develops standards, codes, and guidelines for the profession. In the case of nurses and midwives this is the Nursing and Midwifery Board of Australia (NMBA). The Australian Health Practitioner Regulation Agency (Ahpra) administers the NRAS and supports the national boards.
157. Nurses and midwives must be registered by the Nursing and Midwifery Board of Australia (NMBA) and must meet the NMBA's professional standards to practice (Nursing and Midwifery Board of Australia, 2025d).
158. The NMBA regulates
 - a) registration of nursing and midwifery practitioners and students
 - b) standards, codes and guidelines for the nursing and midwifery profession
 - c) notifications, complaints, investigations and disciplinary hearings
 - d) the assessment of overseas trained practitioners who wish to practise in Australia
 - e) approving accreditation standards and accredited courses of study (Nursing and Midwifery Board of Australia, 2025a)
159. While there are no additional state or territory requirements for registration, nurses and midwives are required to comply with state and territory legislation in their own jurisdiction and wherever they practice.
160. The four classifications, Enrolled Nurse, Registered Nurse, Nurse Practitioner and Midwife are all 'protected titles' meaning that only those registered or endorsed by the NMBA can use these titles in Australia (Nursing and Midwifery Board of Australia, 2025d)
161. Many nurses and midwives hold dual qualifications. The most common dual qualification is to be a Registered Nurse and a Midwife.
162. The data on registration numbers is contained in Table 3.1(above).
163. The regulatory schemes that nurses and midwives must have knowledge of comply with is comprehensive and includes policies, professional standards, guidelines, frameworks and position statements issued by the NMBA.

Education, training, qualifications and professional recognition

164. In this section I describe the formal qualifications and training, and non-accredited training required or typically available to each of the four classifications in this study. Prior to setting out what is currently required, I briefly explore the significance of the shift from hospital based to university training.

The shift to tertiary training and qualifications

165. Nursing education in Australia began moving from hospital-based apprenticeship style programs to tertiary education in universities and vocational institutions in 1973. The transition, known as *Project 2000* was completed by 1993 with all nursing and midwifery students entering a tertiary education pathway from 1st January 1994 (Lowe, 2020). All nursing and midwifery courses are independently accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) on behalf of the NMBA.
166. Hospital trained nurses are still engaged in health service delivery today. Eleven of the participants in this study identify as having been hospital trained. For this reason, I have chosen to record, if briefly, the reasons for, and the outcomes of the transition from an apprenticeship style system to a tertiary model of training.
167. Changes in approaches to training nursing and midwives have been traced back to shifts in the political, social and economic environment post the Second World War. Global influences prompted changes in Australia's approach to health service delivery which in turn shifted the expectations of the Australian community about the delivery of health services (Bryant, 2022; Lowe, 2020). Australia was an original signatory to the Universal Declaration on Human Rights (UDHR) in 1948. The UDHR includes a right to social security, education and health. This is credited with having a significant impact on nursing in Australia (Bryant, 2022). Bryant, who was the first Commonwealth Chief Nurse and Midwifery Officer, argues that societal changes through the 1960s and 1970s e.g. introduction of Medibank in 1975 (as Medicare was originally known) led to an expansion of health services across the country in which nurses played a significant role. Bryant describes the change for nurses
- The role of the nurse intensified, and nurses needed to deliver care which was more than providing comfort. They needed to become technically competent and move to a plane where nursing diagnosis and interventions contributed to patient outcomes (Bryant, 2022, p. 1).
168. The move towards tertiary training for nurses was occurring internationally including in Scotland at the University of Edinburgh in 1956 and New Zealand in 1967. A 1978 Commonwealth Inquiry into Nurse Education and Training identified
- a disconnection between classroom and clinical teaching, sub-optimal workplace preparation and insistence on an improved model of nurse training and education (Lowe, 2020).
- Nurses were being required to, “assess, plan, implement and evaluate nursing care and accept professional responsibility and accountability for their practice” (Lowe, 2020, n.p.).
169. Factors that raised expectations for nurses included
- a) expanding health research which nurses were expected to understand (Sax, 1978)

- b) increasing technological change, particularly in the introduction of new diagnostic tools (Bryant, 2022)
 - c) nurses and midwives were increasingly required to operate as members of health care teams with highly skilled practitioners as practices evolved (Sax, 1978).
- 170. Legislation to support the transition to tertiary based training was passed in 1984, with the final stage being completed in 1993, in readiness for all education qualifications to be undertaken in tertiary settings from 1st January 1994.⁷
- 171. Two issues, germane to this study on 'invisible skills' in nursing and midwifery can be identified in the debates that led to the transition to tertiary education. The first relates to the type of care to be delivered by nurses. Rosemary Bryant (AO), had this to say about the reasons for the transition

If nurses were to maintain their role in patient care they had to become educated in the care of patients through enhanced treatments and resist the rise of technicians who cared for specific aspects of a patient's care. **Wholistic care was paramount.** (emphasis added) (Bryant, 2022, p. 1)
- 172. In "wholistic care" we can see the antecedent of 'person-centred care' (discussed later in this chapter) and the need for the skills and knowledge of nurses and midwives to be developed to support this approach to patient care.
- 173. The second issue relates to the claim from nurses themselves that the status of their role required appropriate recognition. Bryant notes

Nurses became more aware of their centrality to the health system and demanded rightly to be properly remunerated. Cases for salaries and conditions which were more in line with similar occupations in the wider community continued at both state and national levels throughout the 1980s and 1990s (Bryant, 2022, p. 2)
- 174. There was opposition to the change in nurses training and education, with a key argument (including from some unions) being that 'girls' from lower socio-economic families would not be able to afford to undertake nursing courses, as they were not being paid, unlike the existing apprenticeship model, meaning that nursing would become an elite profession denying many women the opportunity to enter into this career (Bryant, 2022). The legislation was debated at state and territory level, but in Bryant's view the changes were swept along with other changes to higher education taking place at the time (Bryant, 2022, p. 2).

Theory & practice – an ongoing discussion

- 175. There are some concerns expressed in the literature and in reports about nursing practice regarding the effectiveness of the current university curriculum to prepare graduates

⁷ *States Grants (Nurse Education Transfer Assistance) Act 1985, Parliament of the Commonwealth of Australia*

adequately for work in clinical settings (see for example the discussion in Department of Health and Aged Care 2024b). These concerns revolve around how to achieve an adequate balance between education in the theory of nursing practice and person-centred care on the one hand, and the capacity to operate effectively in clinical situations on the other.

176. A review of the skills taught in registered nursing preparation programs in Australia in 2015 noted that there was

[a] sense of disappointment with the product of contemporary nursing programs in that new RNs (i.e. individuals who have recently completed accredited courses and are eligible for licensure/registration as a nurse) are often referred to as not being 'competent' by clinically based colleagues. (Brown & Crookes, 2016, p. 1)

177. Whilst there are few who question the appropriateness of tertiary qualifications as a minimum requirement, addressing the gap between learning in theory and the ability to apply skills and knowledge in context when delivering health care warrants attention. The consultation process for the National Nursing Workforce Strategy captured this concern

Transitioning from theoretical learning to practical application in placements is recognised as a significant challenge. Consultation participants noted that while academic preparation and simulation is essential, it does not fully equip students for the realities of clinical work. Some nurses and students explained that encountering real patients with complex needs can be overwhelming when they have had limited hands-on experience. Some personally pay to do short courses in specific skill areas in order to feel more prepared when they go out on placement, which is only an option for those with enough disposable income. (Department of Health and Aged Care 2024a, p. 39)

178. The above quote recognises the complexities involved in applying the technical skill of nursing to the 'real patient'. It is the skills that are involved in this real-world application that the Spotlight tool, used in this study, is designed to identify (Junor 2021).

Initial qualifications of nurses and midwives

179. There have been modifications to the requirements for nurse education since 1994, but in summary, nurses complete a formal tertiary qualification. That qualification ranges from a Diploma for an Enrolled Nurse to a Bachelor of Nursing degree for a Registered Nurse (or a Master's degree after completing a relevant Bachelor degree). For Nurse Practitioners a Master's degree is part of the requirement for endorsement. Midwives require a Bachelor degree but may also follow a pathway that includes a Masters.
180. It is difficult to access data on the number and types of qualifications, beyond that required as minimum entry to the professions.⁸ As the demographic data set out in this chapter shows,

⁸ I reiterate the observation made earlier in this chapter that multiple organisations collect data on health professionals but there is a need for nationally consistent health workforce data collection and collation

most midwives have dual recognition (RN and Midwife) and in that case they will also have dual tertiary qualifications. NPs are required to have a Master's degree. Senior nurses, mental health nurses, nurses and midwives in management may have additional post-graduate qualifications, including a specialty post-graduate diploma or Master's degree.

181. Australian nursing qualifications have national recognition under the Australian Qualifications Framework. Table 3.4 below sets out in more detail the entry level qualifications required for each of the nursing classifications and midwifery.

(Department of Health Disability and Ageing, 2024). I was unable to find any central point of collection of data on post entry qualifications by nurses and midwives.

Table 3.4: Summary of entry qualifications for nurses and midwives in Australia

Classification	Qualification	AQF level	Requirements	Clinical placement hours
Enrolled Nurse	Diploma of nursing	AQF 5	Minimum 18 months within the vocational education training (VET) sector, delivered by Registered Training Organisations (RTO)	Minimum of 400 hours in a variety of settings
Registered Nurse	Bachelor of Nursing	AQF 7	Three years full time (or equivalent) at university	Minimum of 800 hours in a variety of settings
	Master of Nursing	AQF 9	Two years full time (or equivalent) at university following a relevant Bachelor degree	
Nurse Practitioner	Master of Nurse Practitioner	AQF 9	18 months to 2 years at university, including 300 hours of supernumerary clinical practice in addition to holding registration and qualifications as an RN	5,000 hours of advanced practice
Midwife	Bachelor of Midwifery	AQF 7	Three years full time (or equivalent) at university	Students complete a minimum of 10 continuity of care episodes (antenatal, labour and postnatal care) with women and their families
	Master of Midwifery	AQF 9	Two years full time (or equivalent) at university in addition to a relevant Bachelor degree	
	Graduate Diploma of Midwifery	AQF 8	12 months full time (or equivalent) for current RNs seeking midwifery registration	
Mental Health Nurse	Graduate Diploma of Mental Health Nursing	AQF 8	12 months full time (or equivalent) at university in addition to a relevant Bachelor degree	
	Master of Mental Health Nursing	AQF 9	Two years full time (or equivalent) at university in addition to a relevant Bachelor degree	
	Graduate Certificate in Mental Health and an additional specialist Certificate (for example, drugs and alcohol; eating disorders)	AQF 8	This pathway is for those who already have RN registration. Duration of courses varies. There are also transition courses for ENs to achieve recognition as a Mental Health nurse.	12 weeks working in a mental health setting

Source: Table developed by author based on information from (Nursing and Midwifery Board of Australia, 2023a; Nursing and Midwifery Board of Australia 2025b)

182. Despite all tertiary nursing courses being approved by Australian Nursing and Midwifery Accreditation Council (ANMAC), there can be variation in tertiary degrees. Accreditation of courses does not extend to prescribing specific content and therefore providers will each explore what they perceive to be the highest quality course they are able to deliver within the scope of resources to which they have access.

Registration Requirements

183. Nurses and midwives are eligible for registration with NMBA on completion of an accredited course. (This differs to teaching, for example, where upon completion of an accredited course a graduate teacher achieves provisional registration. Further steps are required for full registration). It is common for nursing and midwifery graduates to complete a supported transition to practice program, though this is not mandatory (Department of Health and Aged Care 2024b, p. 51). In addition to educational standards, registration requirements for both nurses and midwives include a criminal history check and meeting an English language standard (Nursing and Midwifery Board of Australia, 2025e).
184. Nurses and midwives renew their registration by 31 May each year. After initial registration, nurses, midwives and nurse practitioners must also complete required annual amounts of Continuing Professional Development (CPD) to maintain their registration (Nursing and Midwifery Board of Australia, 2025e).

What nurses and midwives are expected to know on commencement

185. The educational outcomes that will be achieved by any person who is judged to have successfully completed their qualification as determined by the NMBA are set out below for each nursing classification and midwives. These educational outcomes make comment on the skills that a nurse or midwife is expected to have on the first day they walk into a health service delivery setting.

a) Enrolled nurses

ENs graduate from a competency-based education framework with essential knowledge to manage and complete nursing care under the supervision of an RN, NP or midwife. The supervision can be direct or indirect. ENs are educated with the essential knowledge required to effectively provide nursing care that is person centred, informed by evidence, complete delegated care, manage tasks and manage contingencies in the context of the role. ENs recognise normal and changing health conditions of people in their care.

b) Registered nurses

RNs graduate as generalists with a person-centred approach to practice and an integrated theoretical and practice-based knowledge of care across the lifespan and across all body systems. RN practice is person centred and evidence-based. During their education RNs develop critical thinking skills that are transferable across the many contexts where RNs work. RNs have an in-depth scientific knowledge that includes the administration, supply and quality use of medicine. RNs have foundational skills in communication, relationships and management.

c) Nurse practitioner

NPs graduate with advanced health assessment skills and diagnostics skills, with a person-centred approach underpinned by clinical research and practice improvement methods. NPs are educated and authorised to diagnose, prescribe scheduled medicines and order diagnostic investigations. NPs have advanced skills in communication, research, leadership and clinical practice. (Nursing and Midwifery Board of Australia 2024c)

186. There is a separate statement to describe the education outcomes for MWs.

a) Midwives

Midwives graduate with a woman-centred approach to practice and an integrated theoretical and practice-based knowledge of care across the childbearing continuum. Midwives have an in-depth scientific knowledge that includes the administration, supply and quality use of medicine relevant to midwifery practice. Midwives have foundational skills in communication, relationships and management (Nursing and Midwifery Board of Australia, 2023a)

187. The above statements for ENs, RNs and MWs provide some insight into the technical knowledge and skills that a nurse or midwife is required to have when they commence their first day of work in health service delivery as described by the NMBA. There is no further qualification period or additional education required to achieve registration and to be employed as a nurse or midwife. The statements reflect the reality that to be registered, a nurse or midwife is expected to have foundational skills that are expected to deepen as they gain further on the job experience. The statement for NPs is different. It reflects the fact that NPs have advanced skills and experience through practice on the job and additional education.
188. These statements hint at, but do not articulate in any detail, the Contextualising, Connecting, and Coordinating skills that the Spotlight tool is designed to identify which underpin the ability of nurses and midwives to deploy technical knowledge and skills in action (Junor, Hampson, Barnes & Smith 2009).

Continuing Professional Development (CPD)

189. A practicing RN, EN or MW must complete a minimum of 20 hours of Continuing Professional Development (CPD) each year. The NMBA states that CPD is how nurses and midwives maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (NMBA 2021).
190. Additional hours are required for various endorsements and for those seeking to maintain dual registration. A NP is required to complete a total of 30 hours of CPD each year. The standard 20 hours as an RN and then an additional 10 hours for their NP endorsement.⁹

⁹ Nursing and Midwifery Board Registration Standard: Continuing Professional Development, 1 June 2016.

191. The NMBA encourages nurses and midwives to spread their CPD learning over the year as part of their ongoing development. The form and content of CPD can be broad and varied. The NMBA website notes
- CPD may include formal and informal learning activities. Participation in certain professional activities can also contribute to meeting your CPD requirements. CPD activities must be relevant to your area of professional practice and have clear aims and objectives that meet your self-assessed requirements. (Nursing and Midwifery Board of Australia, 2021a)
192. As an example, one of the most prominent providers of CPD is the Australian Nursing and Midwifery Federation (ANMF). A review of the ANMF (Victorian Branch) website in April 2025, showed the ANMF Training and Education Centre had 286 short courses available. These included Diabetes training, Infectious Diseases training, Family Violence training, and training in Community and Primary Health Care, Clinical Practice, Aged Care, Cancer Nursing, Ethics, and Aphra Requirements. The ANMF also offers Accredited Courses such as Certificate IV qualifications in Work Health and Safety, Training and Assessment and First Aid (Australian Nursing and Midwifery Federation -Victorian Branch, 2025).
193. Nurses and midwives can complete their CPD through professional reading, and self-directed study or research, or through attending courses and conferences of their own choice.
194. One of the issues raised in the consultations for the National Nursing Workforce Strategy is that nurses and midwives who are pursuing CPD and further study options are doing so at their own expense (Department of Health and Aged Care 2024b).
195. CPD requirements can be met through employer directed training, or on the job training. The consultations for the National Nursing Workforce Strategy included the observation that
- some hospitals and health services have taken the responsibility for providing ongoing education, believing they offer greater control of content and overall higher quality because they can often support the training in familiar onsite or face-to-face environments. (Department of Health and Aged Care 2024b, p. 55)
196. Nurses and midwives pursue post graduate qualifications to build a specialisation (this is discussed in more detail later in this section). However, the consultation process for the development of the National Nursing Workforce Strategy noted that these additional skills may be ignored by the system. It was noted that
- if a nurse in Australia acquires a new skill outside their workplace, there is a high possibility that they might be prohibited from applying that skill in their workplace. The literature also indicates that they would be required to demonstrate their competency through an assessment before being permitted to apply the newly acquired skill. (Department of Health and Aged Care 2024b, p. 55)

197. The Draft National Nursing Workforce Strategy has identified the need to “develop a national professional development framework” (Department of Health Disability and Ageing, 2024a, p. 10). At the time of writing no change had been made to CPD requirements nor any final plan published for a national framework.

Standards

198. To be registered nurses and midwives must be assessed as meeting professional standards. The NMBA has standards for nurses and midwives. Professional standards define the practice and behaviour of nurses and midwives. Each of the four classifications included in this study have their own separate standards. These standards have accompanying assessment criteria framework for assessing standards of practice (formerly known as competency standards) and a Code of Conduct (Nursing and Midwifery Board of Australia, 2025d).

Scope of practice

199. Nurses and midwives work to their scope of practice. A scope of practice is the area within which a nurse or midwife can be expected to competently work. A scope of practice is not fixed in any setting, nor to any person. While the scope of nursing and midwifery practice is governed by national standards, it is influenced by local context, the health needs of the patient, employer policy, education and training and individual skills. The onus is on the individual nurse or midwife to ensure that what they are doing at any particular time fits within their scope of practice. The introduction to the Fact Sheet on Scope of Practice and Capabilities of nurses reads

... the scope of practice of individual practitioners is influenced by the settings in which they practice. This includes the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider. As the nurse gains new skills and knowledge, their individual scope of practice changes. (Nursing and Midwifery Board of Australia 2025b) (Emphasis Added)

200. The NMBA publishes a Decision-Making Framework (DMF) designed to support nurses and midwives to make professional judgements about when an activity is within their scope of practice and, when it is not (Nursing and Midwifery Board of Australia, 2023b).
201. Scope of practice is a source of conversation in reviews of nursing and midwifery. The summary of consultations regarding the development of the National Nursing Workforce Strategy includes the following commentary

In almost every form of consultation, ‘scope of practice’ emerged spontaneously as a significant concern among nurses and stakeholders ... nurses across all nursing roles are advocating for a more defined and expanded scope of practice that aligns with their qualifications, skills and the evolving needs of healthcare delivery. (Department of Health and Aged Care 2024a, p. 48).

202. The Report also records that 95% of nurses are familiar with the term ‘scope of practice’ and in the judgement of the Report’s authors nurses have an extremely good understanding of their scope of practice (Department of Health and Aged Care 2024a).
203. Barriers that have been identified to achieving the aim of a more clearly defined and expanded scope of practice for nurses include legislation and regulation, employer practices and settings, education and training, funding policy and technology. (Department of Health Disability and Ageing, 2024b). Nurses appear to be frustrated with the limitations
- Nurses understand their scope of practice well but cite a lack of opportunity or lack of recognition of their skills from their colleagues or workplaces that is preventing them from operating at their optimal scope of practice. (Department of Health and Aged Care 2024a, p. 48)

Specialisations

204. There appears to be less regulation of nursing specialisations. Nurses may describe themselves as having a nursing specialisation e.g. a critical care specialist. It is not always evident to a lay person where a nurse specialisation might differ from a regulated endorsement such as Nurse Practitioner or a MW with endorsement for scheduled medicines.
205. There are a number of training organisations that offer specialist training. The Australian College of Nursing (ACN) is an Institute of Higher Education and is registered and accredited by the Tertiary Education Quality and Standards Agency (TEQSA) for the delivery of 19 Graduate Certificates in various nurse specialisations. The (ACN) also offers accredited vaccination related courses. One commercial provider lists over 50 nursing specialisation certificates (<https://lerna.courses/australia/>).
206. The NMBA researched this issue of specialisation in 2014 but concluded that no action was required on their part to further regulate nursing specialisations. Their findings included
- a) a variety of mechanisms are employed internationally to recognise and regulate speciality practice, including licensure, endorsement, credentialing, validation and certification
 - b) formally regulating speciality groups for purposes of registration did not reduce risk to the public
 - c) there was a lack of significant evidence that regulation of speciality practice improves patient/client outcomes.

The research identified that organisations representing speciality nursing groups in Australia have developed processes for recognising speciality practice. This provides a sufficient means of acknowledging specialist nursing practice in Australia and may be recognised by employers and the health industry at large (Nursing and Midwifery Board of Australia, 2024b).

207. From the searches I have conducted, it is not apparent to me whether gaining 'specialisation' through the attainment of Graduate Certificates leads to any recognition in terms of career advancement or additional remuneration. (This does not refer to 'endorsements' such as NP).
208. A tertiary focus for nurse education, the ready availability of Graduate Certificate specialisations and the annual CPD requirement for registration promote a culture of ongoing education and ongoing learning for nurses and midwives. The continuing development of skills and knowledge are seen as critical to success in these roles (Department of Health and Aged Care 2024a).

3.2 Contemporary issues impacting on nursing and midwifery

209. The draft findings from the initiative of the Australian Government Department of Health and Aged Care, Safer Care Victoria and the Victorian Department of Health to create a National Nursing Workforce Strategy¹⁰ set out the challenges facing the Australian health and aged care system and nursing in Australia

The health and aged care system is facing challenges from a range of factors. These include an ageing population, increasingly complex and chronic diseases, geographically dispersed population, the impacts of climate change and advancements in technology. These challenges have a significant impact on demand for the nursing workforce. In addition, the COVID-19 pandemic placed additional stress on the nursing workforce both highlighting and exacerbating the issues the profession faces (Department of Health Disability and Ageing, 2024a, p. 2).

210. Following is an overview of the major challenges that are currently impacting, and likely to continue to impact, on the work of nurses and midwives in contemporary Australia.

Attraction and retention to nursing and midwifery

211. There is a predicted shortfall of nurses. The national nursing supply and demand study makes the following observation

The baseline projections across all sectors show an undersupply of 70,707 FTE [nurses] by 2035 with around 79,473 nurses needed to fill the gap (Department of Health and Aged Care 2024b, p. 7).

212. To meet demand for nurses Australia needs to grow the nursing workforce by 21.9% by the year 2035, using the 2022 figure of 362,855 nurses registered and employed as the baseline (Department of Health and Aged Care 2024d, p. 3). That translates to an increase in nurse registrations and employment of 2.1% over and above the current rate of new entries to the nursing profession. This figure presumes that the current exit patterns for nurses remains

¹⁰ Note the strategy does not specifically include midwives other than where a nurse holds dual registration as nurse and midwife.

constant. Any acceleration of retirements, resignations and departures from the nursing workforce will exacerbate this shortage.

213. The supply and demand study uses five categories to divide the nursing workforce
- a) Aged care nurses - a shortage of 17,551 full time equivalent (FTE) is predicted by 2035
 - b) Acute care nurses -a shortage of 26,665 FTE is predicted by 2035
 - c) Primary health care nurses – a shortage of 21,765 FTE is predicted by 2035
 - d) Mental health nurses -a shortage of 1,918 FTE is predicted by 2035
 - e) Other – a shortage of 2,808 FTE is predicted by 2035
- (Department of Health and Aged Care 2024d, p. 8)
214. These figures show that 71% of the predicted nursing shortage is in health care delivery in acute care, primary health care and mental health care.
215. The Draft National Nursing Workforce strategy, takes a positive view about the attraction of nursing as a profession for workers and for those completing their final years of schooling
- Nursing in Australia has been an attractive career choice for many decades. Nurses are leaders and key decision-makers in health care. They influence, manage and institute change and deliver exceptional care in all circumstances (Department of Health Disability and Ageing, 2024a, p. 10)
216. The projections for the midwifery workforce are more complex as there is no nationally consistent approach to workforce planning. The most recent Commonwealth Department of Health modelling for the midwifery workforce models a slight excess of midwives by 2030 (Homer (AO) et al., 2024, p. 17). However, the Midwifery Futures report expresses serious concern about the accuracy of the modelling. The modelling was undertaken in 2019, prior to COVID. Since that modelling, data has already been reported that midwives per 100,000 population has dropped by 4% (Homer (AO) et al., 2024).
217. The data collected for the Midwifery Futures project report shows that 11% of recent midwifery graduates are not working in midwifery. The average age of registered midwives is 47 with 34.8% being aged 55 or older. In a survey conducted for the Midwifery Futures report one third of midwives are considering leaving the profession prior to retirement (Homer (AO) et al., 2024, p. 49) The potential for a shortage is exacerbated in remote and very remote areas where there was a decline of 6.5% and 6.8% respectively in the midwifery workforce from 2018/19 to 2022/23 (Nursing and Midwifery Board of Australia 2023c).
218. In the survey of midwives reported at Table 3.3 (above), 54.7% of midwives reported they were based in hospitals (acute care). There were 12.1% based in private practice or child and family health and maternal child health roles as a midwife, which I have defined as primary health care settings. None reported that they were working in a mental health setting.

219. While there is no breakdown of the shortage of midwives in these areas, the Midwifery Futures Project survey data showed that, if given their first preference for work
- 33.3% of midwives would choose standard hospital care
 - 23.6% would choose private midwifery practice
 - 37.5% would choose midwifery group practice. (Homer (AO) et al., 2024, p. 11)
220. These last two figures generated concern for the Midwifery Futures project. The last two preferences represent Continuity of Care models which is the preferred model promoted by the midwifery profession. Currently just 10.8% of midwives are employed using this model of care (3.1% in private practice and 7.7% who operate under this model in a hospital setting), and yet over 60% of current midwives would prefer to work in this form of care (Homer (AO) et al., 2024, p. 69). There are too few vacancies to accommodate these preferences which has led the authors of the Midwifery Futures report to express their concern about whether midwives will remain in the profession if they cannot work under their preferred model of care (Homer (AO) et al., 2024, p. 69).

Solutions to attraction and retention

221. The nursing demand and supply study highlights some interesting trends in terms of attracting new participants to the profession. It is predicted that there will be a slight increase in males being attracted to the profession with growth from 12.2% of the nursing workforce in 2022 to 13.4% in 2035 (Department of Health and Aged Care 2024d, p. 3).
222. There is projected to be a substantial increase in nurses arriving from overseas. The report projects that nurses with an initial qualification from overseas will grow from 20% in 2022 to 28% by 2035 (Department of Health and Aged Care 2024d, p. 4). Whether this projected growth is from short term visa entry or through permanent migration is not stated in the report. The Midwifery Futures project has recommended further recruitment of overseas trained midwives (Homer (AO) et al., 2024).
223. The average age of the nursing workforce is predicted to decline from an average age of 43 for female nurses to an average age of 42 by 2035. For males it is projected to remain at its current level of an average age of 42 years (Department of Health and Aged Care 2024d, p. 3). This suggests an exit of experienced nurses at the top of the age bracket from the profession, and the loss of their skills and knowledge in health service delivery. However, it also suggests that caution should be exercised in describing nursing as an ageing profession.
224. In the report, one of the interesting strategies raised to limit the projected shortfall of nurses is to promote an increase in hours worked by nurses in the profession. The modelling projects that if nurses who currently work less than 0.75 FTE (and are under the age of 65) were encouraged to work one extra shift per fortnight this would reduce the projected shortage to 50,434 FTE; a reduction of 20,364 in the projected shortage (Department of Health and Aged

Care 2024d, p. 11). The average FTE for nurses working in acute care was 0.89 FTE in 2022 and for those in primary health care it was 0.85 FTE (Department of Health and Aged Care 2024d, p. 9). In the material I consulted I could not find any studies that suggested nurses were looking to expand their hours of employment.

225. A similar, if less detailed approach, was suggested by the Midwifery Futures project in suggesting that midwives working an additional 4 hours per week could overcome some of the predicted shortage of midwives, however, to accomplish this outcome the following would be needed
- Improved workplace flexibility
 - Adequate working conditions
 - Enhanced career pathways (Homer (AO) et al., 2024, p. 9)
226. The Draft National Nursing Strategy does not deal with remuneration as an important driver of attraction and retention in the nursing and midwifery professions. Goodare (2017) in his review of the literature on why nurses leave the profession, draws on four historical studies to arrive at the conclusion that for many nurses remuneration drives mobility. Nurses perceive themselves as well educated, highly skilled professionals who, in an era defined by cost of living pressures, are willing to change professions to seek higher pay and improved working conditions (Goodare, 2017).
227. The Draft National Nursing Workforce Strategy makes the following observation
- Retaining dedicated, diverse and high performing nurses in all health and aged care settings is key to the ongoing sustainability of the nursing workforce. Valuing flexibility and supporting healthy work-life balance is vital. Development of national nursing frameworks encompassing career development, transition to practice and professional development will be important to achieve this priority ... Supporting nurses to work to their optimum scope of practice will also drive improved retention. (Department of Health Disability and Ageing, 2024a, p. 10)
228. The frameworks, the career development, the professional development in which nurses and midwives operate, as referenced by the Draft National Nursing Workforce Strategy and the Midwifery Futures project should all be informed by recognition of the full range of skills that nurses and midwives bring to their role including identifying and valuing those skills that have been 'invisible' and therefore contributed to undervaluing the work.

Competition for nursing skills to meet the needs of an ageing population

229. According to the most recent Intergenerational Report (2023) which makes projections about the Australian community and budget through to 2063

Demographic ageing alone is estimated to account for around 40 per cent of the increase in Government spending over the next 40 years. Ageing and a growing population are

driving strong growth in health and aged care spending (Commonwealth of Australia, 2023, p. 143).

230. The Intergenerational Report also notes

From 2022–23 to 2062–63, real total health spending on those aged over 65 years is expected to increase around six-fold. Over the same period, real total health spending on those over 85 years is expected to increase around nine-fold. People aged 65 or older currently account for around 40 per cent of health spending, despite being about 16 per cent of the population. Combined with population growth, this will play a significant role in increasing future health costs. Demand for access to the highest standards of care and rapid technological innovation will also place pressure on the Government to increase expenditure (Commonwealth of Australia, 2023, p. 149).

231. The implication of the ageing population and the increased demands on the Australian health system, when expressed in terms of GDP, show that the increase in total health spending (not including aged care) will increase by 0.4% of GDP (Commonwealth of Australia, 2023, p. 146). Importantly the increased spending on the health needs of the ageing population is not just a projection of the future. There is almost two decades of data showing a substantial increase in the budget spending on older Australians. One estimate is that the ageing of the population and meeting their more complex health requirements accounted for about 20-30% of the growth in real per-capita healthcare spending between 2000-2001 and 2018-2019 (Productivity Commission 2024a).
232. Increases in spending on older Australians in the provision of aged care will increase the demand for nurses. The Australian Institute of Health and Welfare, drawing on data from the 2021 census, estimates that approximately 46,440 people representing 18% of the aged care workforce are RNs and ENs (Australian Institute of Health and Welfare 2024b). Any increase in demand for nurses for aged care will necessarily bring about an increase in demand for nurses and increase the competition for nursing skills between aged care and acute, primary and mental health service delivery.
233. In addition to this increase in requirements for aged care brought about by the demographics of the Australian population, recent Commonwealth Government policy innovations require more RNs in aged care.¹¹
234. Not only might there be a significant increase in competition for nursing skills between aged care, primary care and acute care but the skills required may also change significantly between different health care settings. With the demographic shift to an older population will come not only increased demand for nursing in aged care but an increased requirement to

¹¹ See <https://www.gen-agedcaredata.gov.au/topics/aged-care-workforce> accessed on 23 July 2025); <https://www.health.gov.au/our-work/care-minutes-registered-nurses-aged-care/24-7-rns>

manage chronic diseases and an increase in palliative care, which may be delivered in aged care settings, acute care settings or at home by nurses who are primary care practitioners. There will also be an increase in demand for developing and monitoring long term health plans, a service generally provided by nurses in primary care settings.

Increase in number and complexity of patient presentations

- 235. This expert report focuses on the role of nurses and midwives working *outside* of aged care settings. The principal settings of nurses and midwives work outside of aged care are acute care, primary health care, and mental health nursing. I also note the delivery of health care, such as palliative care and care to an ageing population in the home, or in community, which the participants in this study were engaged in.
- 236. Any change in the general health of the Australian population and/or increases in hospital admissions or attendance at GP practices and medical clinics will impact on the work performed by nurses and midwives.

Chronic illness and multimorbidity

- 237. The life expectancy of Australians has trended upwards in the last two decades suggesting improved levels of health (AIHW 2023a). Along with this upward trend in life expectancy there has also been an increase in Australians living through those years with chronic conditions and an increase in the number of Australians living with multi-morbidities (where a person has 2 or more chronic conditions at the same time). In 2007-08 16.5% of Australians were living with 2 or more chronic conditions. By 2022 this had increased to 21.9% (Australian Institute of Health and Welfare, 2024a). In the last 20 years, the total number of years that Australians have lived with disability due to chronic conditions rose from 1.6 million in 2003 to 2.5 million in 2023 (Australian Institute of Health and Welfare, 2024a).
- 238. People living with multimorbidity have more complex health care needs and report poorer overall quality of life than those without multimorbidity. (Australian Institute of Health and Welfare 2025b)
- 239. Primary care, that is a person's local or regular General Practice clinic, or where available, a medical clinic, is likely to be the first place that a person attends for the prevention and diagnosis of a chronic condition. They are also likely to be a key player in managing chronic conditions, though this will be shared across the hospital sector, depending on the condition. While it is acknowledged that there is a need to improve the quality of data collection across practices, the available data show that chronic conditions make up a substantial proportion of General Practice activity. In 2022–23, 60% of people (10.2 million) who visited a GP in the last 12 months had a long-term health condition (Australian Institute of Health and Welfare 2025b). This is an upward trend. The use of Medicare subsidised GP services per person is

increasing in both total volume and in the average number of visits per person even after accounting for the ageing population. (Australian Institute of Health and Welfare, 2024a).

240. The demand on primary health care settings is clearly increasing and will continue to do so as chronic illness and multi-morbidity increases in Australia. This will have an impact on the knowledge and skills required of nurses currently working in primary health care. It is likely to raise issues about scope of practice and role clarity between nurses, NPs and GPs.

Increased hospital admissions

241. Data released by the Australian Institute of Health and Welfare in May 2025, shows that hospital admissions in Australia have increased over the past decade. The raw figures show that in 2014-2015 there were 10.2 million hospitalisations. This increased to 12.6 million hospitalisations in 2023-2024. An increase would be expected given population growth in Australia; however, the rate of hospitalisation has increased by 4% over that decade, moving from 405 admissions per 1,000 population to 421 per 1,000 population (Australian Institute of Health and Welfare 2025a)
242. The overwhelming majority of admitted patient hospitalisations (91%) were episodes of acute care, and this is an upward trend

Between 2022–23 and 2023–24, the number of acute care hospitalisations increased by 4.9% for public hospitals and by 2.6% for private hospitals (Australian Institute of Health and Welfare 2025a).

These data show that workloads in hospitals are clearly increasing.

Covid 19, its after effects and the risk of future pandemics

243. The health sector and its workforce were at the forefront of responding to the COVID 19 pandemic. Such was the magnitude of this event across the world that it will have impacted on policy and practice in all health settings, and therefore a significant impact on the work of nurses and midwives across all settings. The full impact of the pandemic will continue to be a focus for researchers for many years.
244. While there is a need to look to preparing for a future where pandemics may become more common, that cannot override the need to respond to the still ongoing demands of the COVID 19 pandemic. There were 4,981 deaths involving COVID in Australia in 2024 (Australian Bureau of Statistics 2025).
245. The Australian Institute of Health and Welfare reports on the impact of responding to COVID 19 on other dimensions of health care in Australia since 2020. The rise of long COVID as a new chronic illness is one development. Studies report that for those with long COVID there are increased health-care use and costs as well as patient reports of limitations on their daily activities and a reduced quality of life (Australian Institute of Health and Welfare, 2024a).

246. It is also likely there will be a long lasting impact on the health of the Australian community as a result of interruptions to regular health services during the pandemic period. These include people delaying appointments with doctors, delays in non-urgent surgery and disruption of national screening programs such as Bowel, Cervical and Breast screening programs (Australian Institute of Health and Welfare, 2024a)
247. The literature on the impact of COVID led me to add an additional question to the interviews conducted with participants for the research for this expert report. Participants were asked a direct question about the impact of COVID 19 on their work.

Climate change

248. There are plentiful examples of the impact of climate change induced acute events on the health of people in the Australian community, with increased frequency and severity of bushfires and floods being the most obvious examples. What is less apparent to many in the Australian community is the wider impact of climate change on the health of Australians, and its potential to have a serious impact on the health of many people in the community. The Australian government has seen the need to act and in 2023 released a National Health and Climate Strategy (<https://www.health.gov.au/our-work/national-health-and-climate-strategy>).
249. Health practitioners involved in health service delivery are already fully aware of the current impact and likely future problems. The Australian Medical Association (AMA) has regularly updated its position on climate change, first published in 2004. It is unequivocal in its reporting of the increasing negative impact on the health of Australians of climate induced changes such as increased heat, food and water borne diseases, vector borne diseases and indirect impacts including on mental health. The AMA identifies those most at risk
- The most marginalised groups will disproportionately feel the overwhelmingly negative health impacts of climate change, including: rural Australians; low-income individuals and families; people with chronic diseases; children and elderly people; physical and outdoor workers; tourists; and indigenous Australians (Australian Medical Association, 2015).
250. Nurses and midwives as the frontline workers in acute care and primary health care will be the most exposed to the health issues arising from climate change. Whether this is realised through further increases in chronic illnesses such as diabetes, kidney disease or heart disease; or there are increased critical climate incidents resulting in asthma and respiratory events; or the spread across a wider geographic region of viruses such as Ross River virus. Any and all of these incidents will require an increase in knowledge and skill from nurses and midwives, where they may not currently be responding in type, or volume to these illnesses.

Advancing person-centred care

251. The move to models of care that focus more directly on the person or patient holistically including their needs and desires, require different skills from nurses and midwives. Person-

centred care¹² is now the standard in Australian health care delivery. The person-centred care approach underpins the Australian Charter of Health Care Rights and the Australian Safety and Quality Framework for Health Service Standards (NSQHS). It has been adopted by the National Health Service (UK), the World Health Organisation (WHO) and significant health lobby groups such as the International Alliance of Patients' Organisations (Kitson et al., 2013).

What is person-centred care?

252. A person-centred approach to health care begins with the person and not the illness or medical condition. The NSQHS describes the broad aim of patient centred care as
- ...[treating] each person respectfully as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care.
- (Australian Commission on Safety and Quality in Health Care, 2025)
253. Person-centred care can be contrasted with a bio-medical approach to care based on signs and symptoms of illness in which the clinician determines the actions that will be taken to achieve improved health. It was (and remains in some places) an 'approach that was medically dominated and disease orientated' (Delaney, 2018, p. 121). There is evidence that person-centred care can lead to improvements in safety, quality and cost-effectiveness of health care, as well as improvements in patient and staff satisfaction (Australian Commission on Safety and Quality in Health Care, 2025).
254. There is not a single accepted definition of person-centred care in the models being implemented across global health delivery. The Australian definition as developed by the Australian Commission on Safety and Quality in Health Care is
- Patient-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care (Australian Commission on Safety and Quality in Health Care, 2011, p.1)
255. McCance and McCormack have been influential in the development of a theoretical model of person-centred care (Kitson et al., 2013). Through several publications they have developed a framework and practical applications for person-centred care in health service delivery. According to McCance and McCormack person-centred care has the following domains
- a) Prerequisites: which focus on the attributes of the nurse
 - b) The care environment: with a focus on the context in which the care is delivered

¹² The terms 'person-centred care' and 'patient-centred care' are used interchangeably in the nursing literature.

- c) Person centred processes: that focus on the delivering care through a range of activities
 - d) Expected Outcomes: which is the result of effective person centred nursing.
- (McCance & McCormack, 2025; McCance, 2003; McCormack & McCance, 2006)
256. The role of the nurse (and by implication the midwife in maternity hospitals/units)¹³ is central to the delivery of effective person-centred care. McCance and McCormack identify the demands made on nurses in the effective implementation of person centred care as follows
- a) In the prerequisite domain, person-centred care requires of nurses that they are “professionally competent, having developed interpersonal skills, being committed to the job, being able to demonstrate clarity of beliefs and values and knowing self”
 - b) In the care environment domain, nurses become one of the contributors to an overall environment that requires (an) appropriate skill mix; systems that facilitate shared decision-making; power sharing; effective staff relationships; organisational systems that are supportive; the potential for innovation and risk taking and the physical environment
 - c) In the person centred domain, processes required of nurses are to be such that they enable, connections between nurses, patients and others significant to them in their lives through the constructs of, working with persons beliefs and values; engaging authentically, being sympathetically present; sharing decision making and providing holistic nursing care (McCance & McCormack, 2025, p. 51)
257. Person-centred care was first included in the NSQHS standard for health service delivery in Australia in 2011. Delaney acknowledges, that “providers have grappled with the implementation” of person-centred care (2018, p. 120). However, it remains the standard expected by the Australian Commission on Safety and Quality in Health Care.
258. In midwifery, Continuity of Care is the favoured model. The Midwifery Futures report describes this model as providing “mothers with a continuous midwife relationship across health care settings and is strongly associated with optimal consumer outcomes and improved experience” (Homer (AO) et al., 2024, p. 25).
259. The Midwifery Futures report also describes some barriers to the implementation of this model of care. These relate to restrictions on the MWs scope of practice “being inconsistently recognised by different health services at which they work” (Homer (AO) et al., 2024, p. 25). This prevents MWs from working across different settings and providing continuity of care to the women they are working with.

¹³ While the framework language uses the word ‘nurse’ in the discussion the authors refer also to the work of midwives.

260. Birthing on country is another model of midwifery care that has been designed to meet the needs of Aboriginal and Torres Strait Islander women. The principles of this model are the co-design with First Nations communities of maternity services that value Aboriginal and Torres Strait Islander ways of being and knowing, provides for inclusion of traditional practices and culturally competent service delivery. The model includes connections with land and country and takes a holistic definition of health (Homer (AO) et al., 2024, p. 81).

Interdisciplinary teamwork

261. Person-centred care has a wider impact than just the direct service delivery role of nurses and midwives. The need for health professionals to work together as a team of carers for each person is acknowledged in the very definition of person-centred care which requires, “information and communication, continuity and transition, care coordination” (Australian Commission on Safety and Quality in Health Care, 2011, p.1). In their model McCance and McCormack reference the necessary collaboration in the domains of the care environment and expected outcomes (McCance & McCormack, 2025).
262. Person-centred care is a wholistic approach to health service delivery that relies on interdisciplinary teams working in collaboration with each other and the patient to achieve the best health outcomes.
263. The research base exploring the link between person-centred care and implementation of interdisciplinary teams is evolving (Michielsen et al., 2023; Ngangue et al., 2021; Walton et al., 2021). Nurses have taken collaborative approaches with patients to improve health outcomes and the skills required for this have been studied (Delaney, 2018; McCance, 2003; Stein-Parbury, 2021).
264. Delaney sets broad parameters for how nurses work may change to meet the requirements of working in interdisciplinary teams within a person-centred care setting. She identifies the need for transformational leadership, innovative practices and collaborative approaches. She describes the shift required in nursing as one in which “the critical humanistic role of nurses in collaborating with patients and promoting and advocating for their patients’ choices and represent a need to move beyond technical competences in the provision of health care” (Delaney, 2018, p. 121).
265. A Dutch study that drew on papers from Australia, New Zealand, Canada, USA, UK and English and Dutch speaking European countries (Michielsen et al., 2023), identified four groups of competencies that were required for the successful implementation of interdisciplinary team work in a person-centred care approach. The four broad groupings are
- a) interprofessional communication
 - b) collaborative teamwork
 - c) leadership

- d) acquisition of competencies required to offer person-centred integrated care.
266. Effective implementation in primary care settings, which were the subject of the Michielsen review demonstrated the importance of moving from a hierarchical structure that relies on subordination to one of “complementarity” (Michielsen et al., 2023, p. 10). The review of articles identified specific skills that were observed in effective implementation of person-centred care. Without being exhaustive of those described in the paper, they include
- a) The capacity to engage in two way open dialogue in both team meetings and bi-lateral communication with other health professionals and patients
 - b) An openness to understanding the professional backgrounds, strengths and boundaries and areas for mutual reinforcement with other health professionals
 - c) An intrinsic motivation to cooperate with others
 - d) The interpersonal communication skills to share pertinent information and knowledge about patients and their goals for their own health
 - e) The ability to recognise diverse personal perspectives and the capacity to develop a shared language that enables a collaborative approach to working across these diverse perspectives and experiences
 - f) The presence of leaders who model and advocate for sustainable and effective collaboration in interprofessional teams
 - g) An approach to on the job education that promotes interprofessional education in which “two or more professions learn with, about and from each other to enable effective collaboration and improve health outcomes in patients”
 - h) Role clarity and an understanding of the competencies of each of the health care professions involved (Michielsen et al., 2023, p. 9).
267. The authors of the review focus in on the communication skills required for interdisciplinary teamwork in person-centred care. They note that the communication competencies required for interprofessional communication are the same as those required for patient-centred communication. They list as some of the specific skills to be acquired
- a) the need to learn how to ask open-ended questions and to use those questions
 - b) listening skills
 - c) the ability to recognise non-verbal signs
 - d) the ability to adjust to the level of understanding of the patient.
- (Michielsen et al., 2023, p. 10)
- I note that these are all skills aligned with Skill Elements in the Spotlight tool.
268. A Canadian paper, Ngangue et al (2021), reviewing the implementation of interdisciplinary patient-centred care in primary care settings focused on the organisational complexity of such implementation. The review acknowledges the “inconsistency between the ideals of patient centred care and the reality of the [Canadian] health care system which is oriented to the bio-

medical model” (Ngangue et al., 2021, p. 6). Their literature review identified the importance of nurse leadership in promoting and implementing change and innovation in patient care.

269. The authors present the views of two managers of primary settings to juxtapose the tension in the implementation of patient-centred care

... it puts the overall competence of the nurse in the foreground both at the evaluative level, the teaching level and at the collaborative level. It positions nursing ... in its pivotal role (Ngangue et al., 2021, p. 4)

They contrast this statement with the frustration of a second nurse manager

They [doctors] still tend to say ‘I am the doctor, I know what you need. I will tell you what you need, then apply it’ (Ngangue et al., 2021, p. 5)

270. Walton et al (2021) conducted a single site study in a Sydney hospital, drawing on the experiences of 77 clinicians (including nurses, allied health officials and medical officers) working in interdisciplinary teams to deliver patient centred care. The study identified that the three enablers of effective interdisciplinary teamwork were

- a) effective communication
- b) a shared understanding of patient goals
- c) clarity of the clinical roles within the team.

271. Participants described a successful interdisciplinary team. They spoke about a clear and specific plan that was communicated clearly to all members of the team and the importance of the contribution of each member of the team being valued. Echoing the findings from the Michielsen paper, participants indicated that the successful interdisciplinary teams had role clarity for each of the contributors, those roles were understood by all in the team and there was a defined and effective leader (Walton et al., 2021).

272. Effective person-centred care as defined by the standards of Australian Commission on Safety and Quality in Health Care requires interdisciplinary teamwork. In this model collaboration across the health professions involved in the delivery of health care is what is required to deliver effective health outcomes. The review of the literature on interdisciplinary teams operating in person-centred care has identified the skills that are required for interdisciplinary teams to be effective. Many of these skills are aligned with Skill Elements in the Spotlight tool.

273. McCance and McCormack describe person-centred care in any health service setting

[it] emphasises the contextual, attitudinal and moral dimensions of caring practices
...[requiring] nurses who have the ability to manage numerous contextual and attitudinal factors that exist in care environments, to engage in processes that keep the person at the centre of caring interactions (McCance & McCormack, 2025, p. 57)

The skills that McCance and McCormack describe for person-centred care are skills that align with the Skill Elements in the Spotlight framework. Person-centred care requires the development and use of skills by nurses and midwives that are hidden, under-defined, under-

specified and under-codified. The evidence for this proposition is set out in chapters four to seven of this report.

Use of digital technology (including AI) in health service delivery

274. Technological developments, including the use of Artificial Intelligence (AI) are changing, and will continue to change health service delivery. The most readily identifiable change for most in the Australian community will be the rapid expansion of telehealth following the COVID pandemic. Others will have experienced the introduction of wearable health monitoring devices and online Apps as services being offered by traditional health providers and new private entries to the health service delivery field. Increasingly there is use of AI as an aid in clinical diagnosis. Perhaps underpinning all of these innovations is the movement toward Electronic Medical Records (EMR).
275. The scope for Electronic Medical Records (EMR) is vast in an advanced medical system such as that which operates across Australia. There has been a significant movement in the EMR direction with 96% of General Practitioners now using digital records and there is an increasing use of EMR in hospitals (Productivity Commission 2024b, p. 16). The complexity of the health system with thousands of providers across GP clinics, medical specialists, emergency care clinics, hospitals, diagnostic imaging centres, pathology collection and analysis and pharmacies has, perhaps inevitably, seen the development of multiple EMR systems, not all of which communicate with each other.
276. People, particularly those with chronic illnesses and multi-morbidities will attend numerous service providers. Where EMR systems are not integrated then this can lead to delays in the delivery of health care and has the potential for inaccuracies occurring in treatment plans. The federal government sponsored My Health Record was designed as a solution to this fragmented system, “but despite an investment of more than \$2 billion, it continues to be plagued by incomplete records and poor usability” (Productivity Commission 2024b, p. 21). Those working and potentially transferring between different types of health care providers, such as nurses and midwives, are likely to have to learn, and use multiple EMR systems.
277. Telehealth, whether by phone or online virtual platforms, has expanded considerably since the COVID pandemic. Prior to 2020, when COVID was first diagnosed in Australia and the community moved through the various lockdowns and restrictions, less than 1% of GP and specialist appointments funded by Medicare were telehealth appointments (Productivity Commission 2024b, p. 36). In comparison in 2023 nearly one in five Medicare-funded General Practitioner appointments took place over the phone or by video, as did more than one in ten Medicare funded specialist consultations (Productivity Commission 2024b, p. 36)
278. The regulations governing telehealth allow for the provision of telehealth services by nurses, nurse practitioners and midwives (Australian Government Department of Health, 2021).

Telehealth requires new knowledge and the exercise of new skills from nurses, midwives and nurse practitioners. The literature on the new skills to be developed is still evolving, however one recent Australian study makes the following observation on the use of telehealth across a variety of health practitioner roles

Areas for skill development include communicating effectively via digital platforms, conducting virtual assessments, identification of services safe to provide via telehealth ... and issues relating to privacy (Ashley et al., 2023, p. 8)

279. The same study references international studies that have called for the development of practice standards specific to telehealth and the inclusion of “telehealth education in undergraduate and postgraduate training programmes” (Ashley et al., 2023, p. 8). Australia currently has The National Safety and Quality Digital Mental Health (NSQDMH) Standards which aim to improve the quality of digital mental health service provision, and to protect service users and their support people from harm. There does not appear to be a standard that encompasses the provision of telehealth in acute or primary health care settings.
280. Artificial Intelligence (AI) is leading to major changes in the Australian workforce, including the health sector. There is no question that the work of nurses and midwives will be influenced by the increasing implementation of AI into the health sector.
281. The literature suggests that the work of nurses and midwives is likely to be changed by technological innovation. It will and has already required nurses and midwives to develop and use new skills. The evidence for this change is set out in chapters four to seven. There remains a question about whether the technological innovation will enhance or detract from the human element in caring that is valued by the Australian community.

Contextual challenges for nurses and midwives

282. Australia’s geography and demographics create an unequal distribution of health service delivery. There are significant challenges in providing the same quality of service that is found in major urban centres in rural and remote Australia, to Aboriginal and Torres Strait Islander communities and to those who are from a cultural and linguistically diverse background.

Rural and remote

283. The delivery of health care to rural and remote communities is a particular challenge to the Australian health system. Vast distances, sparse populations and poor transport infrastructure to remote communities all create barriers in the delivery of health services. The majority of Australia’s leading health services are located in the major metropolitan centres with good services in regional cities. These centres are attractive to health professionals as places to access quality training and professional development, strong peer networks, mentoring from experienced health leaders, tertiary facilities and career opportunities.

284. The primary contact point for health service delivery remains the local General Practice or medical clinic (Australian Bureau of Statistics, 2024c). It is important then to consider access to GPs in locations across the country. In metropolitan centres there were 112 GPs per 100,000 population. This declined to 82.6 GPs per 100,000 population in small rural towns and 72.4 per 100,000 population in very remote communities (Department of Health Disability and Ageing, 2025b). It is nurses, midwives and nurse practitioners who bridge the gap in health service provision in rural and remote settings. According to the Draft National Nursing Workforce strategy, “While the nursing profession is the best distributed health workforce in comparison to other professions, more nurses are needed in rural and remote areas” (Department of Health, 2024a, p.11).
285. Limited health infrastructure, lack of diagnostic tools and testing centres, no ready access to complex pharmaceuticals and few peer support networks or training and development opportunities increase the demands on the knowledge and skills of nurses, midwives and nurse practitioners in rural and remote areas. Goodare (2017) nominates these issues as reasons for workforce attrition in rural and remote locations.

Access for First Nations People

286. Aboriginal and Torres Strait Islander people experience a double disadvantage in accessing health services. As well as cultural, language and social barriers, they are more likely to live in regional and remote areas and experience the challenges of accessing services in those regions that all Australians experience living in those locations. Drawing on Australian Bureau of Statistics figures the Productivity Commission estimates that the share of Aboriginal and Torres Strait Islander people living in regional areas and remote areas are 43.8% and 15.4% respectively. The estimated shares of the rest of the population are 25.2% and 1.4% respectively (Productivity Commission 2024b, p. 8)
287. Aboriginal and Torres Strait Islander people experience different access to health service delivery compared to the rest of the Australian population. The Closing the Gap report for 2025 makes the following observation
- Colonisation and government policies have disrupted Aboriginal and Torres Strait Islander ways of living and suppressed cultural practices and expression, leading to harmful effects on wellbeing. The ongoing trauma and marginalisation resulting from colonisation continues to affect Aboriginal and Torres Strait Islander health and wellbeing through a range of interrelated stressors. These include the presence and impact of institutional racism and discrimination in mainstream services as well as social and economic inequalities such as access to adequate housing, education, income and employment. The result is higher health risk factors. (Productivity Commission, 2025, p. 20)
288. The Closing the Gap Report reports on progress on the targets and strategies set by the Federal government to improve the lives of Aboriginal and Torres Strait Islander people, to

close the deficits in their life experience compared to the wider Australian population. From that report (Productivity Commission, 2025) I have drawn a selection of health data to highlight the deficits in health service delivery to Aboriginal and Torres Strait Islander people. The particular data sets represent likely points of interaction for nurses and midwives

- a) Suicide rates among Aboriginal and Torres Strait Islander communities increased from 23.6 per 100,000 people in 2018 to 30.8 per 100,000 people in 2023.
- b) In 2024, 33.9% of Aboriginal and Torres Strait Islander children were assessed as being developmentally on track. This is a decline from 35.2% in 2018.
- c) Of the Aboriginal and Torres Strait Islander babies born in 2022, 89.2% were of healthy birthweight, a decrease from 2021. In addition, it is worth noting that in remote areas, the proportion of healthy birthweights decreased from 88.2% to 85.6% between 2017 and 2022.
- d) There is a downward trend in Aboriginal and Torres Strait Islander people accessing General Practice and chronic disease management services.

289. I want to draw attention to the suicide data, to draw a direct link to its impact on mental health nurses. The Closing The Gap Report notes the following

Access to health professionals, including doctors, counsellors and other health professionals or the reasons for not accessing them, highlight barriers that can prevent people from getting support when needed ... The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is determined by a multitude of factors beyond the mental or physical health of the individual. Concepts of autonomy and empowerment, connection to family, culture and Country, as well as employment and educational opportunity all contribute to social and emotional wellbeing. (Productivity Commission, 2025, pp. 38–39)

290. There are challenges for mental health nurses in both providing health care to Aboriginal and Torres Strait Islander people who may be living in remote areas and the further challenge of providing mental health support in the context of specific cultural expectations, institutional racism and post-traumatic stress disorders from the ongoing effects of colonisation. It requires deep knowledge and a broad skill set to provide the level of mental health support that is required by this group of Australians.

291. Across all health professionals, including nurses and midwives, there is a need to develop cultural competencies to deliver effective health care to Aboriginal and Torres Strait Islander people. The NMBA has developed principles of culturally safe care which are embedded in the standards for practice for RNs, ENs, NPs and MWs (Nursing and Midwifery Board of Australia 2025d).

292. Ahpra developed a national Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025¹⁴. According to that strategy to ensure culturally safe and respectful practice, health practitioners must
- a) Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
 - b) Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices to provide care that is holistic, free of bias and racism
 - c) Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare driven by the individual, family and community
 - d) Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues. (Australian Health Practitioners Regulation Agency 2022)
293. Implementation of culturally safe and respectful practice requires health practitioners to develop cultural competence. Sharifi et al (2019) reviewed 43 international journal articles and developed a 6 point framework of the skills required of nurses to be culturally competent
- a) Cultural awareness – understand the effects of one’s own culture and thus avoiding the imposition of that culture on others
 - b) Cultural knowledge – ongoing learning about others especially how culture impacts on a person’s response to illness and treatment (author – in Australia this is likely to be critical in dealing with First Nations people who have experienced the trauma of colonialism and ongoing racism in health service delivery)
 - c) Cultural sensitivity – learning to value, respect and admire cultural diversity – to better understand a patient’s attitudes and viewpoints
 - d) Cultural skill – the ability to establish effective communication with individuals from other cultures (author – and in an Australian context communication with those who do not have proficiency in the English language)
 - e) Cultural proficiency – the acquisition and the transfer of new knowledge from ongoing education, reading and research (author –in Australia often linked to advocacy for change and improvement of health service delivery)

¹⁴ The Australian Government Department of Health has published, National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031. <https://www.health.gov.au/sites/default/files/documents/2022/03/national-aboriginal-and-torres-strait-islander-health-workforce-strategic-framework-and-implementation-plan-2021-2031.pdf> This plan will influence the Ahpra definition of cultural safety but at the time of writing no change had been made to the definition by Ahpra.

- f) Dynamicity – building cultural competence through frequent encounters with patients from different cultural backgrounds (Sharifi et al 2019 pp.3-4)

The skills of cultural competence are reflected in the Spotlight Tool. They are a particular focus of Skill Set B – Connecting – ‘interacting and relating’. They are readily identified in Skill Elements B2.3, B3.2, B3.3, B3.4 and B3.5. The evidence that nurses and midwives are applying these skills is contained in chapters four to seven. These are skills that are identified as under-recognised, under-codified and hidden. They are ‘invisible’ and as such it is highly improbable that they have been accurately valued when assessing work value.

294. The Draft National Nursing Workforce Strategy lists a goal to build the Aboriginal and Torres Strait Islander population in the nursing workforce to achieve parity with the proportion of Aboriginal and Torres Strait Islander people in the Australian population (Department of Health Disability and Ageing, 2024a). The NMBA annual report records that currently 1.6% of midwives and 1.5% of nurses identify as Aboriginal or Torres Strait Islander (Nursing and Midwifery Board of Australia, 2024a). The ABS reports that in 2021, 3.8% of the total Australian population identify as Aboriginal or Torres Strait Islander (Australian Bureau of Statistics 2023) The Nursing Strategy will require detailed plans to reach the goal it has set.
295. The Aboriginal Community Controlled Health Organisations (ACCHO) are leaders in providing and advocating for the expansion of digital health services in remote communities (Productivity Commission, 2024b, p. 4). Contributors to the Commission’s report described many advantages of implementing digital health services, such as a reduction in travel time and therefore time away from work and home; a reduction in costs to access services and importantly the presence of a person from the ACCHO to provide support.
296. The combination of acquiring the skills to provide digital services and working with Aboriginal and Torres Strait islander people in remote communities demands new skills and skill combinations from nurses and midwives. The evidence that they are beginning to exercise these skills is evident in the Primary Material that is discussed in chapters four to seven of this report. This is a tangible example of where the work of nursing and midwifery continues to expand to incorporate new skills. These skills are likely to be under-recognised and ‘invisible’ to job assessments because of their relative recency (particularly post COVID).

Access for CALD communities

297. The final dimension of the specific contexts which I review is the provision of health care to Culturally and Linguistically Diverse (CALD) members of the Australian community. The ABS reported from the 2021 census that 27.6% of the Australian population had been born overseas. Importantly for addressing the issue of health service delivery, 22.8% of the Australian population reported speaking a language other than English at home (Australian

Bureau of Statistics, 2022). It is important to note that this figure includes refugees and asylum seekers who are among the most vulnerable people in the Australian community.

298. Diversity in culture, language, religion and social values makes it more difficult to access health care (Khatri & Assefa, 2022, p. 2). Khatri and Assefa identify three types of barriers that impact on access to health care
- a) Individual and family level issues
 - b) Community and organisational issues e.g. conflicting sociocultural values, language and communication problems
 - c) Systems and policy level issues e.g. inadequate inclusion of migrants and refugees in regional health organisations.

The issues were most acute during the recent pandemic when, “COVID 19 deaths in Australia revealed a three-fold higher mortality rate among CALD groups than the general population” (Khatri & Assefa, 2022, p. 2).

299. The figures regarding CALD communities’ access to health services raises questions about what is expected of nurses, midwives and nurse practitioners when seeking improved health outcomes for almost 30% of the patients with whom they are dealing. These patients may have a different first language, different sociocultural values and increasingly different values about gender roles. Some options for improvement identified in the literature (Khatri & Assefa, 2022) include
- a) Improved communication by health services e.g. timely referral in response to risk factors, and appointment reminders
 - b) Opportunistic screening (e.g. screening of breast and cervical cancers) in GP clinics and advice about follow-up were found in one study to be effective in identifying multimorbidity
 - c) Pre-arranged group appointments by Maternal and Child Health Nurses were found to increase engagement and participation with the health system
 - d) Professional training and development to support health practitioners to identify cultural variations and recognise cultural differences to minimise stigma and discrimination
 - e) Recruiting health workers from CALD communities to adequately elicit and address patients’ needs.

300. Nurses and midwives are essential to many practices described in the literature as supporting improved health outcomes for people from CALD backgrounds. The Primary Material discussed in chapters four to seven shows that nurses and midwives are exercising new skills to engage with people from CALD backgrounds. They are skills identified in the Spotlight tool as under-recognised and ‘invisible’ in the performance of the work. It is taken for granted that nurses and midwives possess these skills even though the literature (Australian Health

Practitioners Regulation Agency 2022, Khatri & Assefa, 2022, Sharifi et al 2019) makes it clear that the development of cultural competence requires intensive training and support.

Advanced Practice Nursing

301. All nursing and midwifery education programs are accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC). Once a person has satisfactorily completed an ANMAC accredited course they are eligible for registration as a nurse or midwife. Beyond those accredited pathways, there is a wide range of options open to nurses and midwives to continue their training and development. However, there appears to be limited opportunity for nurses to construct career progression based on increasing their education, their knowledge and skills. One concept of structured development for nurses and midwives that is emerging is Advanced Practice Nursing. Currently Nurse Practitioners are the only recognised Advanced Practice Nurses in Australia.
302. The literature is plentiful on the concept of Advanced Practice Nursing (Bouchoucha et al., 2022; Duffield et al., 2009; Gardner et al., 2016; Masso & Thompson, 2017; Parker & Hill, 2017; Scanlon et al., 2018; Thoun, 2011). The concept emerged in Australia in the 1990s, later here than in some other comparable western countries, e.g. it was introduced in the USA in 1965. Despite its later development of the concept of Advanced Practice Nursing, Australia has moved more quickly than other comparable countries to establish a definition for what it means for a nurse to have developed their practice to an advanced level (Parker & Hill, 2017).
303. The NMBA now includes a definition of Advanced Practice Nursing
- Nurses practising at an advanced practice level incorporate professional leadership, education, research and support of systems into their practice. Their practice includes relevant expertise, critical thinking, complex decision-making, autonomous practice and is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex healthcare requirements. Advanced practice in nursing is demonstrated by a level of practice and not by a job title or level of remuneration. (Nursing and Midwifery Board of Australia, 2024b).

The definition provides a foundation for how nurses and midwives can develop their skills to attain this level of recognition, but there is wide agreement that there is much more development to undertake to create an accepted culture of Advanced Practice Nursing.

304. Despite the fact that Advanced Practice is in demand by health service providers (Gardner et al., 2016), there is a concurrence of views both internationally and here in Australia that there remains ambiguity and confusion over how Advanced Practice should be developed, recognised and rewarded (Bouchoucha et al., 2022; Gardner et al., 2016; Parker & Hill, 2017). Gardner et al describes the implementation in Australia over the past 30 years as “incremental and discordant” (2016, p. 69). Their study found that there were over 70

position titles that had been linked to Advanced Practice (Gardner et al., 2016). These titles included Clinical Nurse Consultant, Clinical Nurse Specialist, Nurse Educator, Nurse Manager, Clinical Nurse Coordinator and Nurse Practitioner.

305. Bouchoucha makes the point that some of the roles involve clinical leadership while others such as Nurse Manager provide “leadership and management” mainly in hospital settings (2022, p. 104). Of the 70 different roles and titles, only one, Nurse Practitioner, is formally recognised by the NMBA. I have given particular consideration to this role later in this section of this review. One important progression in the discussion about Advanced Practice nursing is the claim by Gardner et al that their research demonstrates “that advanced nursing practice is measurable as a level of nursing practice rather than being identified as a collection of roles and titles” (Gardner et al., 2016, p. 68).

306. Recognition of Advanced Practice Nursing is being considered. The Draft National Nursing Workforce Strategy lists the following goals

Career and education infrastructure enable nurses to progress their careers and lead and participate in research and innovation in the way they choose. (Department of Health Disability and Ageing, 2024a, p. 4) and Post graduate nursing qualifications are accredited and recognised, contributing to career progression and satisfaction. (Department of Health Disability and Ageing, 2024a, p. 8)

That there is currently no systematic accreditation of specialist skills, other than Nurse Practitioner, raises questions about these skills being overlooked and undervalued.

Nurse Practitioners

307. One form of Advanced Practice Nursing in Australia that is formally recognised with an Apha endorsement is Nurse Practitioner. The first NPs were authorised to practice in December 2000 (Bouchoucha et al., 2022). It is generally agreed that the NP role developed as a response to the shortage of medical practitioners in rural and remote Australia and in particular in remote Aboriginal and Torres Strait Islander communities (Bouchoucha et al., 2022; Duffield et al., 2009; Parker & Hill, 2017).

308. Since those first appointments the requirements for endorsement and the breadth of practice have evolved. The NMBA now defines the role as

A nurse practitioner is a registered nurse endorsed as a nurse practitioner by the NMBA. The nurse practitioner practices at an advanced level, meets and complies with the *Nurse practitioner standards for practice*, has direct clinical contact and practices within their scope under the legislatively protected title ‘nurse practitioner’ under the National Law. (Nursing and Midwifery Board of Australia 2024b).

The requirements to reach endorsement were outlined earlier in this chapter.

309. Scanlon et al (2018) report that Nurse Practitioners are predominantly employed within the public health system, with 28% in the private sector. In total 46% work in hospital settings. The majority hold a clinical appointment in the emergency departments of those hospitals.
310. The implementation of Nurse Practitioners was not without opposition. Both the Australian Medical Association and the Royal Australian College of General Practitioners opposed the creation of the Nurse Practitioner role. (Duffield et al., 2009). The initial opposition has diminished with the Scanlon et al survey of Nurse Practitioners reporting that 96% had the support of their physicians with patient care decisions, 89% felt valued by their physician colleagues, and 90% felt that were part of a collaborative team (2018, p. 416).
311. There is agreement in the literature that NPs have demonstrated their value to the Australian health care system (Bouchoucha et al., 2022; Duffield et al., 2009; Scanlon et al., 2018).

Bouchoucha writes

studies have looked at patient satisfaction, comparable care, length of stay, and adverse events and they have all shown that NPs are able and competent to provide safe and efficient care to a diverse range of patients and contribute positively to healthcare services in Australia. (2022, p. 106)

However, as with many innovations, progress is not always linear and positive.

312. Nurse Practitioners still report they face barriers to practicing to the full extent of their scope, some interprofessional difficulties and their reimbursement per hour is the lowest of all health professionals working in the mental health space (Bouchoucha et al., 2022). The COVID 19 pandemic provided just one example of where Nurse Practitioners confronted difficulty in exercising their full scope of practice. Despite already being approved, and have included in their scope of practice, the capacity to roll out vaccination programs in aged care settings and in outreach services, Nurse Practitioners were initially only able to issue COVID-19 vaccinations to the general public if supervised by a General Practitioner or suitably qualified health professional (Bouchoucha et al., 2022).
313. The future use of NPs is unclear. Duffield et al (2009) notes the appeal of NPs to government and health authorities. Access to health services can be increased while offering costs savings to the funding authorities. However, Duffield et al (2009) also observe that there are also risks to the development of the role and indeed the development of Advanced Practice Nursing if the focus of the discussion remains about funding and not the unique contribution that Advancing Nursing can make (2009, p. 58).

Leadership

314. The final consideration in this section is the development of leadership skills among nurses and midwives. Here I take the view that there are two distinct approaches to leadership that need to be considered, what Bouchoucha (2022) referred to as “clinical leadership” and

“leadership and management”. For the purposes of this expert report, to create greater differentiation between the two types of leadership, I will refer to the second form as ‘organisation leadership’. This is not to suggest that the two skill sets need to be separated or that one person or one role cannot encompass both dimensions of leadership. Indeed, Masso reported that many NPs lead a health service, thus creating some difficulty in separating out “the leadership role of the nurse practitioner, as distinct from the clinical care component of the nurse practitioner role” (2017, p. 284). The literature does suggest, However, that there are different skills developing for each dimension of leadership in nursing.

315. The Australian College of Nursing White Paper on Nurse Leadership identifies many of the clinical leadership skills that might be expected of clinical leaders in health service delivery. I have divided those skills into system and patient skills.
316. In system skills, clinical nurse leaders
 - a) make connections between challenges at the local level and the broader political, economic and social context
 - b) understand the factors that have shaped the current health system and are able to look beyond day-to-day challenges to develop long-term strategies to drive improvements in patient and population health outcomes
 - c) contribute to shaping the design and delivery of new models of care, as well as driving the changes that will be required for their implementation (Australian College of Nursing, 2015, p. 4).
317. At the patient level, the skills expected of a clinical leader include
 - a) delivering and monitoring evidence-based practice, evaluating outcomes within a continuous improvement framework, assessing and mitigating risks to individual patients, improving efficiency and coordination at the point of care and advocating for patients
 - b) engaging with patients in the context of the care and taking account of the patient’s social, cultural and economic environment
 - c) facilitating strong communication and collaboration with patients and within the multidisciplinary team they are able to recognise and address gaps in patients’ care as well as systemic issues of concern (Australian College of Nursing, 2015, p. 7).
318. The Draft National Nursing Workforce Strategy envisions a role for nurses to work in partnership with other health professionals, health providers and the university sector to build a more skilled nurse workforce, through nurse led research, to better meet prevention and treatment of all Australians (Department of Health Disability and Ageing, 2024a).
319. The literature on organisation leadership across all industries is vast, complex and growing, and it does not form an essential part of this expert report. Rather the focus in this report is a

narrower, on the skills that might be demonstrated by, or be required of a nurse or midwife who is working in an organisational leadership role in a health delivery setting. The Australian College of Nursing White paper on Nurse Leadership is a helpful source (Australian College of Nursing, 2015). In the White Paper the authors address the complexity of organisation leadership. They do not always distinguish clearly between executive leaders who may be in role such as Directors of Nursing and those who might be in roles of more relevance to this expert report such as Nurse Unit Managers or Assistant Nurse Unit Managers.

320. The White Paper identifies skills that are definitively attributed to managers at the Unit level.

These skills include

- a) driving change in nursing units, including both cultural and practice change
- b) role modelling behaviours such as mentoring and demonstrate their commitment to creating a learning environment by valuing feedback from patients and staff and encouraging professional development
- c) leading improvements in service delivery which support a shared interdisciplinary focus on the patient's goals rather than a siloed approach to care delivered by different interprofessional groups (Australian College of Nursing, 2015, p. 9).

321. The White Paper further expands on the role of Unit managers in exploring the attributes of successful leaders as

- a) emotionally intelligent leaders may be able to address dysfunctional workplace relationships by modelling organisational values and managing conflict
- b) those who focus on outcomes and targets to the exclusion of people and relationships may be slower to address a culture of bullying and are more likely to attribute workplace conflict to individuals rather than organisational practices and policies
- c) they may change workplace culture by modelling professional behaviours, socialising new members, using effective conflict resolution techniques (Australian College of Nursing, 2015, p. 9).

Nurse and midwife health and wellbeing

322. As front line health workers nurses and midwives have always had complex work environments to manage. Depending on their role they may be confronted by infectious diseases and serious illnesses; multi-morbidity or chronic illness; significant physical and/or mental trauma; and death, whether in acute situations or in palliative care. They have the highest contact rates of any of the health professions in acute care and in remote settings (Department of Health Disability and Ageing, 2024a). Their work is performed across

unsociable hours; for those in acute care settings it is likely to include the additional stress of shift work and weekend rosters (Day et al., 2007).

323. There is growing evidence that significant and negative changes to nurses and midwives, have occurred as a result of the COVID-19 pandemic, and they may be ongoing. The negative impact on the health and wellbeing of nurses and midwives includes higher levels of stress, distress, anxiety and fear (Jarden et al., 2023). The shortage of nurses (as discussed earlier in this chapter) has been exacerbated by the COVID-19 pandemic with resignations by nurses and midwives as a result of the pandemic. The shortage is world-wide and COVID-19 is seen as a major contributing factor (Buchan et al., 2022). The shortage of nurses has had an impact on the ability of the health care workforce to maintain quality patient care and to meet their regulatory role requirements (Jarden et al., 2023). There has been an impact on nurses physical and psychological health as a result of “care left undone” (Jarden et al., 2023, p. 2485). Some of the major reasons that nurses have given for resigning from their role include fears for personal safety, uncertainty about their ongoing role, workload, rostering and not feeling supported, respected and valued (Jarden et al., 2023, p. 2488).
324. Investigating what motivated nurses to stay in their role Jarden et al (2023) identified five themes across participants. These themes became apparent through questions about reasons for joining and leaving the organisation, what made a great day, and finally what might have prompted them to stay with the organisation. The five themes are
- a) Relationships
 - b) Communication
 - c) A desire to learn and develop
 - d) Work-life balance
 - e) Providing quality patient care.
325. In their study Delgado et al (2022) point to the relational nature of the work of mental health nurses that requires them to engage in emotional labour. They are required to
- Regulate their emotions, and manage their emotional expression and related behaviour at work to maintain the professional demeanour required to meet others’ needs. (Delgado et al., 2022, p. 1261)
326. The mental health nurses interviewed by Delgado et al in this qualitative study had developed a series of strategies to build and maintain their own resilience. The nurses in the study described being “attuned to self and others” and “maintaining psychological equilibrium through pro-active self-care”. A third strategy for maintaining resilience was “having a positive mindset grounded in purpose” (Delgado et al., 2022, p. 1263). The authors of the study focus in on this strategy to observe that the nurses
- ... engaged in a process of reflection about their professional role and responsibilities ...
- (their) sense of purpose seemed connected to altruistic values including compassion,

kindness, hope, service and making a difference ... and maintaining a positive connection to others (emphasis added) (Delgado et al., 2022, p. 1264).

327. This study suggests that coping with complex emotional labour such as that required of mental health nurses in the wake of the COVID-19 pandemic requires an increased focus on interpersonal relationships not only with patients but with their colleagues. The authors conclude with the observation that

The ongoing emotional labour of mental health nursing work cannot remain invisible if mental health nurses are to make a meaningful difference in others' lives (Delgado et al., 2022, p. 1273).

Emotional labour is a term used to describe the work of those in caring professions. However, as Junor (2021) notes, it is a term that needs to be unpacked to fully understand the skills that are utilised when terms such as 'emotional labour' or 'emotional intelligence' are used. They are typified as under-specified skills. They are skills that are likely to be 'invisible' in the workplace; it is taken for granted that nurses and midwives will possess 'emotional intelligence', but a full understanding of the skills behind 'emotional intelligence' and 'emotional labour' may not be recognised in job classification processes (c.f Junor 2021).

Perceptions of nurses in the community

328. There is value in considering how both community perceptions and nurses and midwives' own perceptions of their work may have shaped the work, the knowledge and skills they have developed and the ways in which the knowledge and skills associated with nursing and midwifery are valued. What we think of nursing and midwifery work is socially and culturally determined (Jackson et al., 2021, p. 7). As a female dominated profession with strong historical links to "visions of heroism and self-sacrifice what is expected of nurses is dictated by gendered social norms and the social expectations of women's work" (Jackson et al., 2021, p. 7).
329. Within the Australian community, nurses are generally held in high regard. People's experience of nurses is often as the "the first point of contact in a healthcare setting and the last health professional they interact with before discharge, highlighting the integral role nurses play throughout the healthcare journey" (Department of Health and Aged Care, 2024a, p. 19). They are frequently encountered as the people who provide not only nursing care but also emotional support to the patient and their families. Words such as 'compassionate', 'trustworthy' and 'dedicated' are typically used to describe nurses. (Department of Health and Aged Care, 2024a).
330. The consultation on the national workforce strategy for nurses summarised the reasons people became nurses in the following words

Nurses are generally proud of the role they fulfil in the community. They believe the community holds them in high regard and that their peers, friends and family are highly supportive of their career choice. The COVID-19 pandemic reminded them that despite the significant challenges of their roles, many continue to feel a strong sense of pride when they tell others *'I'm a nurse'*. (Department of Health and Aged Care, 2024a, p. 24).

- 331.** In a regular community survey about the ethics of a range of professions nurses have been rated highly, recording third place in 2023, higher than GPs and second only to pharmacists in the health sector. Although the same report notes that there has been a decline in the net score for nurses over the previous 2 years since the COVID-19 pandemic (Department of Health and Aged Care, 2024a). For several previous surveys nurses had been rated the highest of all health practitioners.
- 332.** The COVID-19 pandemic (and acknowledging that it remains an ongoing health issue) may have altered perceptions of nurses. During the lockdown periods across the globe, there were regular community events and activities to acknowledge the work of nurses, midwives and other health professionals who worked long hours in personally risky and tense situations, often with inadequate resources. Nurses were highly praised for their contributions. However, some nurses believe the reputation of the profession has been tarnished following the peak of COVID-19 pandemic, with the belief that “the community perceives nurses to be stressed, burnt out, overworked and underpaid” (Department of Health and Aged Care, 2024a, p. 25). The perception is that the role is challenging and difficult.
- 333.** Perceptions are important. There may be some in the community who identify nurses as altruistic, female, ‘angels’ and ‘handmaidens’, rather than qualified professionals. The perception of nursing may also be shaped by a focus on acute care settings and therefore not recognising the full breadth of nursing work including many roles where nurses work, including rehabilitation nurses, primary care nurses, mental health nurses, as well as those in nurse education roles, research and government, where nurses can influence policy and contribute to healthcare improvements (Department of Health and Aged Care, 2024a).
- 334.** The consultation papers for the development of the National Nursing Workforce Strategy addresses the issue of the undervaluation of the nursing profession. The paper suggests that the community has a low level of knowledge about nursing. The low level of knowledge leads to undervaluation and constraints on the profession, and
- negatively influences attitudes towards nursing and the potential for it to offer an interesting and rewarding career path. (Department of Health and Aged Care, 2024b, p. 33)

- 335.** The Draft National Nursing Workforce Strategy had this to say about community perceptions of nursing expressed during its consultations
- The nursing profession is recognised for its commitment and the ability of nurses to manage care with a human touch, particularly in areas like mental health and cancer care. They are viewed as the essential intermediary between doctors and families, providing empathy, information and answers to queries (Department of Health and Aged Care, 2024a, p. 20).
- 336.** The skills associated with key components of nursing work as described in the above quote – “human touch, being the intermediary, providing empathy, information and answers” are among the skills that are often under-recognised leading to undervaluation of the work of nurses and midwives. It is these skills of Contextualising, Connecting and Coordinating that the Spotlight tool, being applied in this study, seeks to make visible to enable the full valuation of the skills of nurses and midwives to take place.
- 337.** Some nurses find it frustrating that their work is seen as providing ‘angelic care’ because this perception does not recognise, “the nursing profession as highly educated, evidence-based and scientific healthcare professionals” (Department of Health and Aged Care, 2024c, p. 10). The community narrative of nurses as ‘angels and heroes’ is the subject of a research paper (Stokes-Parish et al., 2020) written in the early months of the COVID-19 pandemic. The paper identifies several global examples of where nurses have been portrayed as ‘angels and heroes’ for their work in caring for patients, those with and without COVID. The authors note
- As an angel, the nurse is viewed as a caring, comforting, female servant of god ... as a hero the nurse is envisaged as an individual with divine powers or ancestry (Stokes-Parish et al., 2020, p. 463).
- 338.** As ‘angels and heroes’ nurses are seen to possess qualities such as moral integrity, bravery, self-sacrifice and compassion. These are admirable attributes, but they may mask essential skills performed in the role. The authors argue that the ‘angels and heroes’ narrative “creates a perception that skill, education, knowledge and discipline are unimportant (or of low importance)” when thinking about nursing (Stokes-Parish et al., 2020, p. 463).
- 339.** One element raised in the Secondary Material and of relevance to this expert report is the community perception that nurses being ‘caring’ and ‘morally valuable’ embeds a view of nursing as a feminine profession. This is often accompanied by a view that nurses are “mere assistants to doctors ... with media representations and dramatisations often reinforcing these narrow views” (Department of Health and Aged Care, 2024a, p. 25). Where these perceptions are strong, it appears that men are less likely to choose nursing as a career, “reinforcing the image that nursing is a female profession” (Stokes-Parish et al., 2020, p. 464).

Nurses' own perceptions of their role in society

- 340.** The report from the research and consultation during the development of the Draft National Nursing Workforce Strategy provides a helpful lead in what nurses say and value about the profession and their role in society. I have identified three key themes of relevance to this expert report from the broader discussion in the Draft Strategy (Department of Health and Aged Care, 2024a, pp. 23–24)
- a) Nursing can provide a deep sense of personal fulfillment and role satisfaction. The direct impact nurses have on the lives of their patients, through both critical and routine care, offers a tangible sense of accomplishment. This career enables nurses to witness the immediate effects of their care and support, from alleviating pain and suffering to providing comfort and encouragement during recovery processes.
 - b) The nursing profession offers significant opportunities for professional autonomy, development and advancement. Nurses are critical thinkers, required to make quick, informed decisions about patient care. A career in nursing is seen as diverse and varied, with many career opportunities and specialisations.
 - c) Nurses spoke of their passion for the dynamic and ever-evolving nature of health care, which requires them to be lifelong learners and adapt to new technologies and treatments. This aspect of nursing can be particularly appealing to those who seek a career that will challenge them mentally and offer opportunities for growth and advancement.
- 341.** From the above summary, nurses do have a view of themselves as altruistic, i.e. their work serves the needs of and improves the lives of others. However, in contrast to the community perceptions about the attributes of the people in the role, such as being empathetic and compassionate, the language from nurses focuses on the skills and knowledge required to be professional in the role. They use terms such as critical thinking, informed decision making, and identify the intellectual or cognitive skills required to adapt to new technology and treatments and the opportunity to advance their knowledge and skills through specialisation. These and many other skills are evident in the work activity descriptions of nurses and midwives in the Primary Material analysed in chapters four to seven.

Professional identity

- 342.** One gauge of the identity that nurses and midwives project into the community can be found in the proliferation of professional bodies and networks that they have formed to build their professional practice, skills and knowledge. Earlier in this chapter I outlined the role of the regulatory bodies (NMBA and Ahpra) that govern nursing and midwifery and which nurses and midwives are required to join as an essential element of their practice. However, nurses and midwives have created and maintained multiple organisations that support their

professional practice. The Council of National Nursing and Midwifery Organisations (CoNNMO) has 58 member organisations. CoNNMO, which operates under the auspices of the Department of Health Disability and Ageing

enables national nursing and midwifery professional organisations in Australia to come together to share information, learn from each other, support and mentor one another in building capacity, and, at times, to act as a conduit to influence and give voice on matters of mutual concern for the nursing and midwifery professions

(<https://connmo.org.au/members/>).

343. A strong voice for the combined groups, both nurses and midwives is the Australian Nursing and Midwifery Federation (ANMF). Through its affiliated state and territory bodies it is both the largest professional nursing and midwifery organisation and also the largest union in Australia. As well as representing the industrial and political interests of its members, the ANMF also has as a key objective the advancement of the professional interests of its members. The ANMF includes in its statement of aims that it exists to “provide professional opportunities to help all our members deliver best practice care, fulfil their professional goals and achieve a healthy work-life balance” (www.anmf.org.au).
344. The most readily identifiable of the professional bodies are the Australian College of Nursing (ACN) and the Australian College of Midwifery (ACM). The ACN identifies its purpose as supporting “nurses to uphold the highest possible standards of integrity, clinical expertise, ethical conduct, and professionalism through our six pillars of Education, Leadership, Community, Social Impact, Advocacy and Policy” (www.acn.edu.au). The ACM is dedicated to leading, educating, connecting and fostering the growth of midwives across the nation, with four aims, “to lead, educate, connect and grow” (www.midwives.org.au). I also note given the focus of this expert report there is also an Australian College of Mental Health Nurses and an Australian College of Nurse Practitioners. Each of these is a professional body seeking to promote and extend the skills of the nurses from each of these fields of nursing work.
345. The full list of CoNNMO members (<https://connmo.org.au/members/>) reveals the formation of professional groups of nurses and midwives who coalesce around a particular issue, specialisation or field of work to develop their skills and expertise to meet those specialist needs. The group of 58 organisations includes
- a) those linked to particular cultural communities e.g. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
 - b) those organisations representing the development of skills and knowledge of nurses and midwives by their specific field of employment e.g. The Australian Primary Health Care Nurses Association (APNA) and the National Enrolled Nursing Advisory Council
 - c) those nurses and midwives whose work is so specialised as to have unique characteristics experienced by a small number of nurses and midwives e.g. Flight

Nurses Australia, and CRANaplus which has been established by members to support nurses and midwives working in rural and remote Australia

- d) by far the largest group are those organisations who have been formed to develop the skills of nurses and midwives who have chosen to follow a specialisation in health service delivery e.g. Cancer Nurses Society of Australia (CNSA), Nursing Midwifery in Digital Health.

346. I briefly emphasise the Australian College of Perioperative Nurses (ACORN) as participants interviewed in the research phase of this expert report referenced ACORN in their interviews. The Australian College of Perioperative Nurses (ACORN) describes itself as Australia's peak body of perioperative nursing and the largest specialist nursing college. Its functions include providing funds for research, professional development and patient safety resources. It states "Our work is to advocate for safe, quality perioperative care for every patient on every occasion" and "When our work is done, we will have delivered safe, quality perioperative care that protects the health and wellbeing of every patient and nurse" (www.acorn.org.au).

347. ACORN also publishes standards for perioperative nursing practice. These standards operate in addition to the NMBA Standards. In the interviews for this report the ACORN standards were referenced by three participants as part of their work. The standards are clearly important to those who work in that nursing specialisation.

348. What I note here is that these are additional standards imposed voluntarily by the members of this professional group as they seek higher levels of skill and knowledge in the performance of their duties. Because these skills are imposed by voluntary professional associations they are likely to be under-recognised and 'invisible' leading to undervaluation of the work.

An international perspective on nursing

349. One international paper reviewed for this study proffered a meta-narrative review and integrated framework to define the work of nursing that is worthy of discussion in this report (Jackson et al 2021). Following a review of 121 academic papers on the work of nursing the authors conclude that "nursing work can be understood as a model of physical, emotional, cognitive and organisational labour" (Jackson et al., 2021, p. 1).

350. The authors describe the physical labour of nursing as incredibly demanding, requiring long hours of standing, lifting and walking long distances. They include in this form of labour nurses' constant use of visual and aural cues, such as patient observation and listening for alarms, and nurses using their own body as a form of communication. Finally, the reviewed papers show that nurses manage the bodies of patients as part of their work. Some of the

studies identify how this work can be taken for granted and how the language used makes nurses' physical work invisible e.g. 'a bed was made' compared to 'the nurse made the bed'.

351. The review includes the sociological concept of emotional labour such as when nurses project something different to what they feel (projecting calm in a crisis). The authors argue from the review of papers that emotional labour is central to nurses' work, helping nurses focus on people not tasks. Despite this centrality the literature suggests that emotional labour goes unrecognised and unsupported. In an intriguing observation the review also finds that the literature suggests that nursing students struggle to learn emotional labour norms.
352. Organisational labour is defined as arranging essential activities for a patient, their families, and the organisation, ensuring patient flow through the healthcare system. It is work performed mostly by nurses and is generally unrecognised even by nurses themselves. It is evident in the completion of 'paperwork' and managing the flow of information across a wide number of people and departments ensuring safe management of the patient through the system. Nurses' coordinate disjointed activities into a coherent process for the patient.
353. Cognitive labour has emerged more recently in the literature. It describes how nurses learn while they work. They develop expertise in clinical practice on the job over time after the completion of initial education. Nurses are engaged in a variety of forms of thinking, e.g. critical thinking, critical reasoning, problem solving, clinical judgement and clinical decision making. Nurses carry significant cognitive load in their working memories, allowing them to manage multiple tasks and deal with constant interruption and demands on their time.
354. I conducted a comparison between the Spotlight framework and the Jackson framework which is set out in Table 3.6 below. This analysis identifies the alignment between the Spotlight framework and contemporary international literature on understanding the work of nursing.

Table 3.6 Comparison of Jackson et al framework with Spotlight Skill Elements and levels

Physical Labour (Jackson)	Spotlight Skill	Emotional Labour (Jackson)	Spotlight Skill Elements
Nursing is physically demanding		Nurses project calm in a crisis	C1.3, C3.3, C3.4, C3.5
Nurses use visual and aural cues	A3.3 B1.3, B3.3, B3.4	Nurses display genuine compassion	A2.3 C2.3, C3.3
Nurses use their own body to communicate	B2.3, B3.3	Nurses focus on people not just tasks	A2.3, A3.3, B1.3, B2.3, B3.3, C3.3
Nurses manage the bodies of others	A2.3, A3.3	Emotional labour can be exploited	A3.4 B1.3
Organisational Labour (Jackson)	Spotlight Skill	Cognitive Labour (Jackson)	Spotlight Skill Elements
Nurses manage the flow of information for patient safety	A1.4, A1.5, A2.4 B2.4, B3.3, B3.5 C1.4, C2.4	Nurses learn while they work	A2.4, A3.4, B1.4 C1.4, C2.5, C3.4
		Nurses engage in a variety of forms of thinking	A2.5, A3.5, B3.4 C3.4 And L3 for all 9 Skill Elements
Nurses bring coordination to what can be disjointed activities	A3.4, B2.4, C1.4, C2.3, C3.4 And L5 for all 9 Skill Elements	Nurses hold and respond to simultaneous priorities	A2.4, A2.5, B1.5, B3.4 C1.3, C1.5, C2.4, C3.4
		Nurses manage interruptions and constant demands	A1.3, B3.3, C1.3, C3.4, C3.5

3.3 (Under)valuing female dominated areas of work

355. Undervaluation of female-dominated work has been widely documented in academic literature, particularly within the fields of sociology, economics, industrial relations, and gender studies. This literature consistently identifies systemic, structural, and cultural drivers of wage inequality and occupational devaluation in roles where women are overrepresented. It is not my intention to address this vast body of literature regarding current and historical undervaluation of female dominated work. Rather I provide an overview of key aspects addressed in this literature as it relates to the work of nurses and midwives.

Gender based undervaluation

356. The concept of gender-based undervaluation has been used to describe the outcome of gender biased social norms that have undervalued women's capabilities and rights in society (UNDP 2023). The structure of gender relations in society can be referred to as the gender order (Connell 1987). The structure of gender relations in a particular institution, including for example the labour market work, the family, households and the law, is referred to as the 'gender regimes' (Acker 1989, 1990, 2006).
357. In Australia a patriarchal gender order (Connell 1987, 2012) has shaped the structure of gender relations in society, within the home, and at work. This structure of gender relations has reinforced the concept of the 'male-breadwinner' and 'female-care-giver' thus designating the public domain (work) as the province of men and the home and the tasks and

activities associated with it as the responsibility of women. This framing of paid work as male has an historical legacy in how the work that women perform is viewed and valued. The ongoing gender pay gap, the primary responsibility that women have in relation to care and household tasks and the predominance of women in part-time and insecure employment are all reflections of, and outcomes from, this historical framing of work (Charlesworth, 2024).

Gender segregation

358. Divisions within the labour market and at work reinforce the gender order (Acker 1989; 1990, 2006). Segregation can be vertical referring to the imbalance between women and men in leadership categories (occupational hierarchies) where men dominate in management and decision making and higher valued roles and women are concentrated in lower paid non-management positions. Segregation can also be horizontal referring to an over representation of women and men in an occupation or industry/ies (Senate Standing Committee on Finance and Public Administration, 2017:38). Gender segregation is both an outcome of the gender order and gender regimes operating in society and at work and a reinforcing factor that sustains the gender order (Austen et al 2020, 363). In feminised sectors such as in health care both vertical and horizontal segregation are present (WHO 2024).
359. Whilst many factors may drive gender pay gaps gender segregation has been identified as one of the key drivers (Cortis et al 2023; Rubery and Grimshaw 2007). Where female dominated areas of work involve the application of skills that have been historically associated with the roles women have played in the home such as domestic and care work undervaluation of this work is apparent (Grimshaw and Rubery, 2007; Macdonald and Charlesworth, 2021; Charlesworth and Smith, 2018).

The FWC approach to addressing gender-based undervaluation in female dominated areas of work

360. In Australia our institutions of work including the federal industrial relations tribunal have under-estimated the gender-based undervaluation of female dominated areas of work in the way they have considered the skills associated with this work (Charlesworth and Heap 2020). However, recently the Fair Work Commission has recognised and accepted that
- as a general proposition work in feminised industries, including care work, has been historically undervalued and that the reason for that undervaluation is likely to be gender based.¹⁵
361. The Full Bench in the Aged Care Decision – Stage 1 accepted several principles that are applicable to assessing the impact of gender based occupational segregation and the gender based undervaluation of work including that

¹⁵ (2022] FWCFB 200, (355)-(356).

- a) The valuation of work is influenced by social expectations and gendered assumptions about the role of women as workers. In turn these social practices influence institutional and organisational practices
- b) Undervaluation occurs when work value is assessed with gender-biased assumptions. The reasons for gender-based undervaluation in Australia include the continuation of occupational segregation, the weaknesses in job and work valuation methods and their implementation, and social norms, gender stereotypes and historical legacies
- c) Gender-based undervaluation in the employment context occurs when work value is assessed with gender-biased assumptions which means the skill level of occupations, work or tasks is influenced by subjective notions about gender and gender roles in society. Skills of the job occupant are discounted or overlooked because of gender
- d) Gender-based undervaluation of work in Australia arises from social norms and cultural assumptions that impact the assessment of work value. These assumptions are impacted by women's role as parents and carers and undertaking the majority of primary unpaid caring responsibilities. The disproportionate engagement by women in unpaid labour contributes to the invisibility and the under recognition of skills described as creative, nurturing, facilitating or caring skills in paid labour
- e) The barriers and limitations to the proper assessment of work value in female dominated industries and occupations include
 - I. changes in the regulatory framework for equal pay and equal remuneration applications and the interpretation of that framework.
 - II. procedural requirements such as the direction in wage-fixing principles that assessment of work value focus on changes in work value and tribunal interpretation of this requirement.
 - III. conceptual considerations including the subjective notion of skill and the "invisibility" of skills when assessing work value in female-dominated industries and occupations
- f) The approach taken to the assessment of work value by Australian industrial tribunals and constraints in historical wage fixing principles have been barriers to the proper assessment of work value in female dominated industries and occupations¹⁶

¹⁶ [2022] FWCFB 200 (758).

362. In 2022 the Fair Work Act 2009 (Cth) (FW Act) was amended in ways that support the tribunal to address gender inequality at work.¹⁷ These amendments include a requirement that the Commission's assessment of work value is to be free of assumptions based on gender and to include consideration of whether historically the work has been undervalued because of assumptions based on gender (s1572B). The modern awards objective and the minimum wages objective, in ss 134(1) and 284(1) respectively, were also amended to include the need to achieve gender equality as a matter required to be considered by the Commission.

Invisibility of skills

363. The Fair Work Commission has identified that the subjective (and historically male dominated) view of skill and the 'invisibility of skills' when assessing work value in female dominated industries and occupations has led to undervaluation of female dominated areas of work. Invisible in this context means skills that are "hidden", "under-defined", "under-specified" or "under-codified".¹⁸

364. Honorary Associate Professor Junor set out the meaning of each of these categories on 'invisibility' in her report in the *Aged Care Work Value Case* as follows

- a) Hidden skills — skills that are diplomatically kept unnoticed or downplayed because they involve work "behind the screens" or "behind the scenes"
- b) Under-defined skills — skills that are hard to 'pin down' in words because they are used in non-verbal or rapidly changing situations
- c) Under-specified skills — skills that are often misdescribed as defined as "soft", "natural" or innate personal traits, or included in the portmanteau term "emotional labour" and need to be unpacked
- d) Under-codified skills — integrative skills used in organising work processes, "getting things done", bringing together and applying a range of other skills, and/or interweaving own work activities with others' to create an overall workflow i.e. performing "articulation work" (Junor 2021, p. 9)

365. I also use the term under-recognised skills. In her report Hon Associate Professor Junor describes under-recognised skills as being invisible by reason of falling within one or more of the preceding four types of skills, or through otherwise being taken for granted (for example through lack of a formal qualification), skills may be omitted from duty statements or classification standards. The job size may therefore be larger than appears in a duty statement. On-the-job or in-service training, or knowledge acquired through learning

¹⁷ Fair Work Legislation Amendment (Secure Jobs, Better Pay) Act 2022 (Cth).

¹⁸ Ross, 2022, Aged Care Decision Stage 1 [43]).

networks, may be required but not recognised. Absence of skill documentation may be a historical legacy of social status based on gender and age, or of location in a “secondary”, non-career labour market, with skills acquired inside or outside the workplace taken for granted and not recognised as skills (Junor 2021 Annexure 8 p. 6 of 43).

3.4 Summary of nursing and midwifery in contemporary Australia

366. Nursing and midwifery are professions that are highly regulated in Australia. The NMBA and Ahpra control initial registration to practice and annual registration, issue statements that describe core elements of the work, Scope of Practice and Standards for each occupation classification, Codes of Conduct, frameworks and guidelines. The question raised in the discussion in this chapter is whether those descriptions, standards and the Scope of Practice provide sufficient detail about the work of these four occupations to inform job descriptions and job evaluation processes, and underpin award classification structures. Specifically, whether these standards, statements, codes, frameworks and guidelines capture the invisible skills involved in nursing and midwifery work.
367. All nurses and midwives in Australia require tertiary qualification for initial registration. While the need for a tertiary qualification is not questioned there continues to be concerns about how to achieve the balance between theory, clinical practice and person-centred care in context, (and for midwives continuity of care) in how nurses and midwives are trained. Understanding the full range of skills and knowledge required by nurses and midwives to perform in their role in context is a critical component of achieving that balance. The Spotlight framework can be used to illuminate the full range of skills by identifying those skills performed by nurses and midwives that are ‘invisible’ and historically overlooked in female dominated areas of work.
368. There will be an increase in the breadth and depth of skills required by nurses and midwives, along with new skills to be acquired to deal with changes in the demography of Australia and the health of Australians. The ageing population and the growth in chronic illnesses will increase the demand on nursing skills. The escalation in hospital admissions and people with multi-morbidities will increase the demand on nurses and midwives’ skills. The rise in the Australian population from a CALD background is, and will, continue to require new skills in cultural competence from nurses and midwives.
369. The likelihood of further pandemics, similar to COVID 19, and a predicted increase in acute and chronic conditions arising from the impact of climate change will also make new and complex demands on nurses and midwives. As frontline workers nurses and midwives will be exposed to critical climate incidents and longer term issues such as the spread of viruses arising from floods and extreme climate events.

370. The ongoing implementation of person-centred care across health service delivery is demanding new skills from nurses as is continuity of care for midwives. There is widespread agreement and commitment to these models but the research is also showing the new demands on nurses and midwives to implement these models. I have set out the research which documents the many skills required to work in interdisciplinary teams, an essential element of successful person-centred care and continuity of care. These skills are aligned with the Spotlight framework.
371. Nurses and midwives will be required to learn new technology skills. While there appears to be some reluctance on the part of some nurses and midwives to engage with new technology and a similar caution among the Australian community to have too much technology in their health care, there seems little doubt that governments will continue to invest in and promote technology solutions in the health industry. Growing pressure on health budgets will lead to searches for innovation and cost saving measures. Nurses and midwives seem unlikely to be significant beneficiaries of the time saving being touted by those promoting AI as a mainstream health service innovation.
372. Nurse and midwives have a commitment to developing their professional knowledge and skills. They have a regulated requirement for annual hours of CPD. There is also evidence of widespread ongoing learning and education through tertiary courses including Graduate Certificates, commitment to voluntary professional networks and codes of practice, employer provided training and self-directed learning. I was unable to identify any coordinated or systematic recognition for nurses and midwives for the completion of CPD and additional education. There does not appear to be any systematic approach to measuring, recognising and rewarding the growth in skills and knowledge of nurses and midwives or development of career pathways. (The NP role is an exception discussed in the next paragraph.)
373. In developed western countries with which Australia might compare itself (USA, Canada, UK, European Union countries) there is an active debate about Advanced Practice Nursing. The only recognised Advanced Practice Nurse classification in Australia is the Nurse Practitioner. There is a clear pathway described to reach this classification. The NP role was first recognised Australia wide in 2000. There are approximately 2500 registered NPs employed in Australia.
374. Nurses and midwives perceive themselves as well educated and skilled professionals. Many consider themselves mobile professionals who are willing to change professions in search of higher pay and improved working conditions. The literature presented in this chapter suggests a degree of frustration among nurses and midwives that their skills and knowledge are undervalued by the Australian community. It is not that nurses and midwives themselves are undervalued, regular community surveys show the opposite. However, the public image of nurses, captured in the dual metaphor of 'angels and heroes' is, in the view of nurses and midwives, a metaphor that undermines their expertise. The literature also suggests that the

dominant image of nursing and midwifery is that they are feminised professions. The high proportion of female nurses (88%) and midwives (98.8%) is not denied, but the more that the image of the profession is described as feminised the more it appears to be 'women's work' to which fewer men are attracted. Thus, potentially reinforcing the cycle of undervaluation that has accompanied female dominated areas of work.

375. I discussed one meta narrative review of nursing (Jackson et al 2021), which reviewed 121 international papers. The authors concluded that nursing is a combination of physical, organisational, emotional and cognitive labour. I compared the Jackson framework and the Spotlight framework that I was asked to use to identify the 'invisible' skills used in nursing and midwifery for this study. I have concluded that the Spotlight tool continues to have a strong alignment with contemporary literature on the work of nursing.
376. Gender-based undervaluation of work in Australia arises from social norms and cultural assumptions that impact the assessment of work value. These assumptions are impacted by women's role as parents and carers and that they continue to undertake the majority of primary unpaid caring responsibilities. The disproportionate engagement by women in unpaid labour contributes to the invisibility and the under recognition of skills described as creative, nurturing, facilitating or caring skills in paid labour. Such descriptions are frequently applied to nursing and midwifery.

4.0 Registered Nurses

4.1 Introduction to Registered Nurses

377. I have been asked to apply the Spotlight tool to the work of Registered Nurses (RN) to “identify, name and classify the ‘invisible skills’” used by RNs who participated in this study. To do this I conducted a Spotlight analysis, the details of which are set out in chapter two of this report, drawing on the descriptions of work activities provided by RNs who were interviewed for this study. This chapter includes the facts and information gathered from the 17 RNs interviewed on which I have relied to support my findings. Where relevant I have also incorporated information from Secondary Material referred to in chapter three of this report.
378. The analysis in this chapter draws from the information about work activities provided by participants who were interviewed for this study. The transcripts from these interviews were reviewed and analysed against the Spotlight taxonomy. A coding framework that corresponds with the Spotlight taxonomic framework was developed to assist in coding the work activities described in the interviews with participants. Using this coding framework codes were allocated to the descriptions of the work activities provided by participants. Sometimes several codes may have been allocated to a work activity. Through this coding process the Spotlight skills that are present in the participants work were identified. The activities (and the skills associated with them) were named and grouped in relation to the Skill Element that they relate to in the taxonomic framework. An assessment of the Skill Level at which the skills were being performed was then made. (The research approach is set out in chapter two)
379. Drawing on the evidence and analysis set out in this chapter I conclude that the work of RNs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. A substantial volume of the work of RNs interviewed requires they use skills that are hidden, under-recognised, under-defined, under-specified, under-codified and therefore likely to be under-valued on gender grounds.
380. The highest area of skill intensity was in Contextualising skills (Skill Set A). There was also a high incidence of Coordinating skills recorded (Skill Set C). RNs in this study are exercising the Spotlight skills mainly at the levels of problem solving (L3) and sharing solutions/applying expertise (L4). However, there are also instances of skills being deployed to create systems (L5). The exercise of skills at levels 3 and above is underpinned by the consolidation of skills and expertise through experience reflected in the instances recorded at level 2 which is the level of fluency in performing work activities.
381. The chapter is set out as follows:
- 4.1 Introduction to Registered Nurses
 - 4.2 A brief review of the profile of RNs in Australia that draws on a literature review
 - 4.3 A snapshot of the demographics of the RNs interviewed for this study

4.4 A representation of the data analysis of the RN interviews in the form of a Heat Map and a Skills Table

4.5 Selected examples of work activities provided by the RN participants in this study aligned with each of the nine Skill Elements of the Spotlight framework, and a discussion of the identifying, naming and classifying of these skills

4.6 Case studies showing the clustered deployment of Spotlight skills that provides further insight into the complex combinations of skills utilised by RNs.

4.7 Conclusion

4.2 Profile of RNs in Australia

382. The Nursing and Midwifery Board of Australia (NMBA) reported that in 2024, 394,785 people held RN nursing registration (Nursing and Midwifery Board of Australia 2024a). Of that group, 26,001 also held dual registration as a midwife and 110 held registration as an EN, midwife and RN. In addition to that number 12,268 held dual registration as EN and RN (Nursing and Midwifery Board of Australia 2024a).
383. Australia changed its nursing qualification and training structure in 1994. From that date all people commencing a RN qualification were required to enter a Bachelor of Nursing course as a minimum qualification (see chapter three for a discussion of this change). This degree qualification is delivered by a university and is typically completed over 36 months; and must include a minimum of 800 hours of clinical practice. In the group of 17 RNs interviewed for this study, seven were 'hospital trained' i.e. they commenced their training prior to 1994 when a tertiary qualification was not required. Of that group of seven, 4 had a qualification awarded at the end of their training (Diploma or Certificate depending on the state); 1 person received a similar qualification and has since upgraded with a degree qualification; and 2 did not specify anything about their qualifications.
384. RNs must be registered with the NMBA and are required to renew that registration annually. One of the requirements for renewal is the completion of 20 hours of Continuing Professional Development (CPD).
385. The OSCA classification system used by the Australian Bureau of Statistics (ABS) and Jobs and Skill Australia (JSA) provides additional insights into the RN workforce (Australian Bureau of Statistics, 2024b). In the classification system, RNs are included under the classification, 'Midwifery and Nursing Professionals' along with Midwives (MW) and Nurse Practitioners (NP). OSCA further differentiates the specialisations in which RNs work as Acute Care, Primary Health Care, Mental Health and Aged Care.
386. NPs are identified in OSCA as a specialisation of RNs (Australian Bureau of Statistics, 2024b). In this study, for reasons argued elsewhere (see chapter three) I have treated NPs as a distinct

classification and analysed the data for them separately. I note that NPs are a separate classification within the *Nurses Award 2020* (see clause A.7).

387. Within the category of RNs in this study there are persons who are classified as Assistant Nurse Unit Managers (ANUMs) and Nurse Unit Managers (NUMs). These RNs hold positions of responsibility within the organisations that employ them that require these RNs to manage the staff and resources of a section of the organisation (for example a hospital ward). NUMs may be responsible for front-line human resources related activities including staff allocations and staffing rosters, staff development and performance management, and workplace health and safety. The NUM in this study was involved in cross-hospital initiatives related to patient care including representing the clinical nursing perspective on committees.

388. The Nursing and Midwifery Board provides a description of the core work and activities of RNs

RNs are accountable for the management of people in their care. They conduct comprehensive assessments, develop care plans and coordinate other health workers and resources to provide nursing care. RNs apply critical thinking and analyse nursing practice, providing safe, appropriate and responsive quality nursing practice. RNs provide information and education to enable people to make decisions and take action in relation to their health and well-being. RNs supervise, and when appropriate, delegate care to ENs, student nurses and other healthcare workers. Examples of core RN activities include

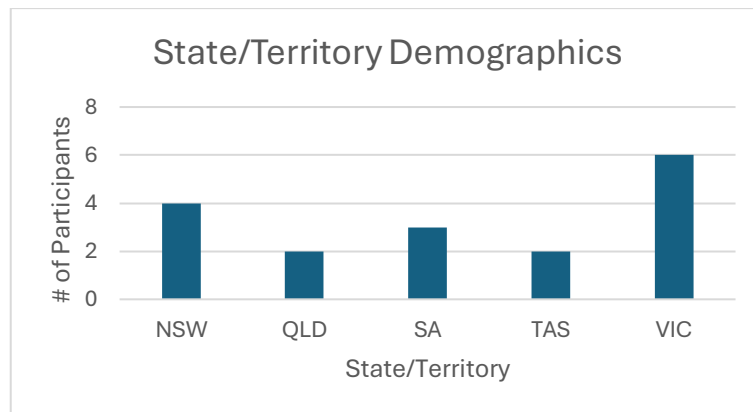
- a) responsibility for the assessment, planning and delivery of care to people who have acute and/or chronic physical and mental health issues
- b) developing, reviewing and maintaining nursing care plans and other health records
- c) the ongoing monitoring and evaluation of the nursing care provided and identification where care may need to be escalated or altered due to the changing health of the person
- d) performing treatments, commencing administering and monitoring medication and IV therapy
- e) interpreting diagnostic test results and reports
- f) educating people about treatment plans, their follow up care, and any referrals to specialist services that have been made
- g) providing emotional and psychological support to people and their families
- h) supervising nursing students
- i) participating in medical or surgical procedures as part of a multi-disciplinary team (for example in surgical wards and operating theatres)
- j) working with a nursing focus with other healthcare providers (Nursing and Midwifery Board 2025b).

4.3 Profile of RNs in this study

389. Seventeen (17) RNs were interviewed for this study. Of the group, 16 identified as female and one as male.

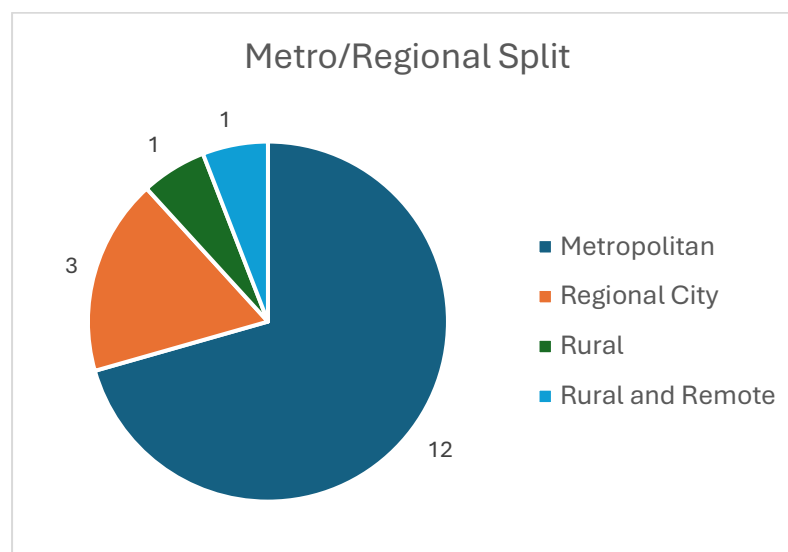
390. The following figure shows the spread of RN participants by state.

Figure 4.1: Distribution of RNs in this study by Australian state



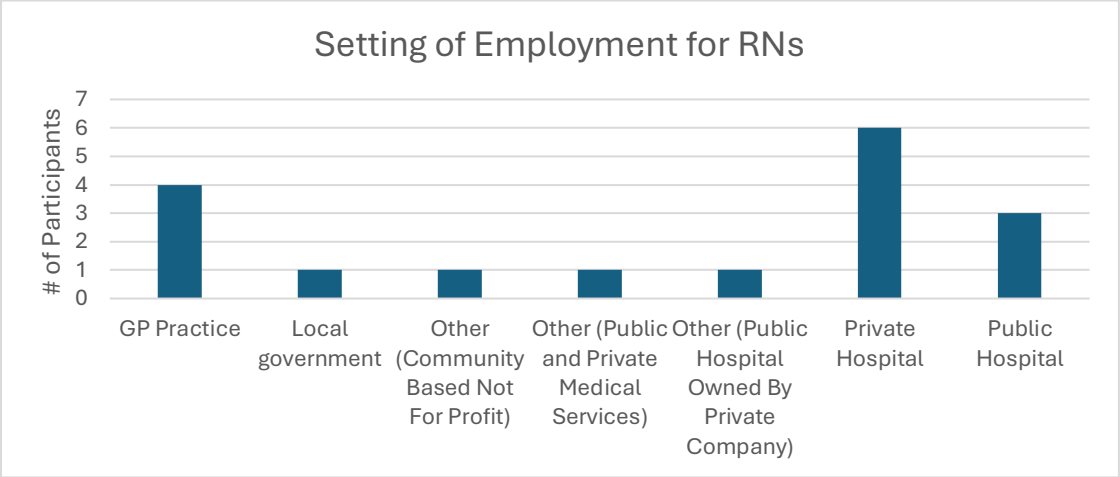
391. Most of the RN participants (12) were working in metropolitan health services but there was also representation from regional cities and rural and remote communities.

Figure 4.2: Geographic distribution of RNs in this study by location of work



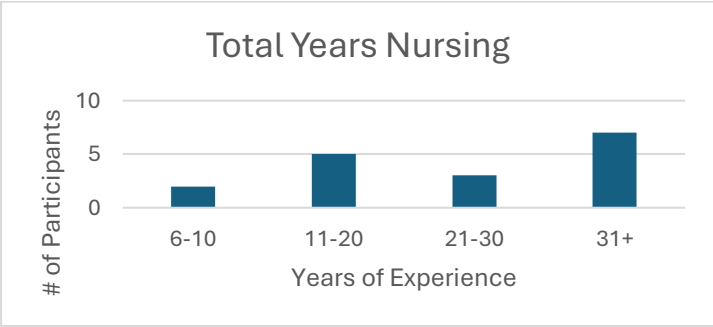
392. Most of the RN participants (10) were employed in acute care (in hospital settings). Four were employed in GP clinics and two in other settings which can be defined as primary health care settings. One of the interviewed RNs worked in mental health care. The spread is shown in Figure 4.3.

Figure 4.3: Setting of employment for RNs in this study



393. There was a spread of experience working as nurse, ranging from 6 years to 44 years. The distribution of years in nursing is displayed in Figure 4.4.

Figure 4.4: Total years in nursing for RNs in this study



394. The group of 17 RNs have a wide array of qualifications, experience and endorsements. Table 4.1 sets out the information provided by participants about their field of nursing, aligned (as closely as possible) with OSCA (Australian Bureau of Statistics, 2024b). Matching the information provided by participants with the OSCA classifications was complicated by the transition from ANZSCO to OSCA¹⁹ and further complicated by the RNs self-defining their role. Their own categorisation of their work did not directly align with the OSCA classifications. The information in Table 4.1 was provided by the RNs and has not been separately verified, but I have no reason to question its veracity.

¹⁹ Formerly ANZSCO, the ABS has revised its classification structure and is now known as OSCA, the new standardised framework for processing occupational related data.

Table 4.1: Field of nursing work for RNs in this study

RN classification (relying on OSCA terminology)	Number of RNs in this study
Acute Care	
Critical care/Emergency/Intensive care	2
Medical	2
Surgical/Peri-operative	5
Not otherwise defined	1
Primary Health Care	
Practice Nurse at GP clinic	4
Maternal and Child Health	1
Community Health	1
Mental Health	
Child and Adolescent Mental Health	1

395. Table 4.2 sets out the qualifications and endorsements held by RN participants. Many of the RNs have dual or multiple qualifications.

Table 4.2: Qualifications and endorsements for RNs in this study

Qualification or endorsement	Number
Masters degree in a nursing field	2
Bachelor of Nursing or Bachelor of Midwifery (one with honours)	12
Postgraduate Diploma in a nursing related field	3
Postgraduate Certificate in a nursing related field	8
Hospital trained nurses	7
Bachelor equivalent	1
Diploma of Health Science in Nursing	3
Certificate of Nursing	1
Not specified	2
Unspecified Certificate qualification (not including mandatory employer requirements)	5
Currently enrolled in a postgraduate course	2
Initially qualified as an Enrolled Nurse and upgraded to RN	2
Nurse immunisation endorsement	4
Scheduled medicines endorsement (rural and remote)	1

396. The RN participants had a spread of leadership responsibilities in the settings where they worked. Table 4.3 (below) sets out the leadership roles that RNs in the study held. The information in Table 4.3 was provided by the RNs and has not been separately verified, but I have no reason to question its veracity.

Table 4.3 Leadership roles held by RNs in this study

Leadership role at the time of interview (except the final row)	Number of RNs in this study
Substantive role as a Nurse Unit Manager NUM	1
Substantive role as a Practice Manager of a GP clinic	1
Substantive role as Triage Shift Coordinator	1
Job title includes Clinical Nurse Specialist	2
Performing Team Leader roles on a regular or relieving basis	5
Held substantive NUM or ANUM roles in positions that they have left in the last 12 months	2

397. The RNs in this study were spread across a diverse selection of work roles and settings. The information provided by the RNs in interviews produced rich data regarding the work of RNs across the various roles and settings. After examining the transcripts of interviews and applying the Spotlight tool to this information gathered in this study, I was confident that I had sufficient data to draw the conclusions contained in this report regarding the nature of 'invisible skills' present in RN work.

4.4 The Spotlight framework and work activities of RNs in this study

398. In the following section I set out the incidence of reported activities using each Spotlight Skill Element at each level. The method of identifying and classifying these activities is discussed in chapter two of this report.

Spotlight Heat Map and analysis

399. The Heat Map (below) visually shows the patterns of intensity and complexity of Spotlight skills utilised. The Heat Map was compiled by tallying the incidences of Spotlight Skill Elements (at level) present in the work activities of each RN participant and then averaging that number across the 17 RNs in the study.

Table 4.4: RNs Spotlight Skills Profile

Registered Nurses Spotlight Skills Profile						
Skill Element	1. Orienting	2. Fluently Performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising	0.1	8.7	20.9	24.2	3.9	57.8
A1. Sensing contexts or situations	0.0	5.4	10.2	11.1	1.8	28.5
A2. Monitoring and guiding reactions	0.1	1.4	7.6	6.2	0.5	15.8
A3. Judging impacts	0.0	1.9	3.1	6.9	1.6	13.5
Total B: Connecting	0.1	7.5	17.4	13.7	0.8	39.5
B1. Negotiating boundaries	0.0	3.8	7.7	11.1	0.4	23.0
B2. Communicating verbally and non-verbally	0.0	2.6	6.6	1.0	0.1	10.3
B3. Working with diverse people and communities	0.1	1.1	3.1	1.6	0.4	6.2
Total C: Coordinating	0.1	6.4	20.1	15.4	1.4	43.2
C1. Sequencing and combining activities	0.1	4.0	7.6	4.3	0.3	16.2
C2. Interweaving your activities smoothly with those of others	0.0	1.9	8.7	6.9	0.5	18.1
C3. Maintaining and/or restoring workflow	0.0	0.5	3.8	4.1	0.5	8.9
Average per Participant Incidence	0.2	22.7	58.3	53.2	6.1	140.5

400. Table 4.4 shows the average incidence of the Spotlight Skill Elements drawn from the description of work activities given by RN participants in their interviews. The incidences set out in Table 4.4 show that the work of RNs involved the use of skills across the 9 Skill Elements of the Spotlight framework. This incidence reflects high levels of the application of

Contextualising, Connecting, and Coordinating skills (the three Skill Sets in the Spotlight framework).

401. The Skill Set where the most instances were recorded was Skill Set A, Contextualising (Building and Shaping Awareness) with an average of 57.8 incidences per person. This was followed by Skill Set C, Coordinating with an average of 43.2 incidences per person. The final Skill Set B, Connecting (Interacting and Relating) had an average incidence per person of 39.5. The dominant Skill Levels were level 3 - Solving Problems, and level 4—Applying Expertise/Sharing Solutions. There were also examples of the use of level 5—Creating Systems Skills. This was particularly the case where RNs, either formally or informally, were required to take on responsibility for managing areas of work.
402. RNs demonstrated situational awareness, reading the context in which they were operating. The highest average incidence for any Skill Element across the RN group is at A1.4 where they averaged 11.1 incidences per person. At this level, the RNs were applying their expertise to sharing new approaches to interpreting situations that they, or the group they were working with were experiencing. These skills of sensing context and situations are skills that are typically under-defined. When skills are under-defined they can be ‘invisible’.
403. The incidences in Skill Set A show a density flowing from A1.3 and A1.4, into A2.3 (7.6 incidences per person), A2.4 (6.2 incidences per person) and A3.4 (6.9 incidences per person). The A2 and A3 skill elements have a focus on the personal and social environment, that is the ability to monitor and guide one’s own reactions and those of others and to judge the impact of your actions on others. These are skills of personal awareness and the ability to see the self in context, including seeing oneself as others do. These skills are often grouped under phrases like ‘emotional intelligence’, a generic description of complex skills that are typically under-specified. As with under-defined, when skills are under-specified they can be ‘invisible’.
404. RNs interviewed were ‘keying’ into the behaviour of others—patients, peers and medical specialists, seeking to understand behaviours and responses, and maintaining a sensitivity to the self-respect and independence of others. The ability to key into others and understand the underlying reasons for difficult behaviours requires skills of diplomacy and are hidden or assumed to come naturally, therefore are under-specified skills. When judging the impact of actions, whether their own or that of the work group (see A3.3 and A3.4) RNs were engaging in diplomatic efforts to maintain a cordial working environment. It is an example of the hidden skills in the typology of invisibility; this work occurs behind the scenes and therefore may not be valued in job assessment processes. Relationship building is often taken for granted as a ‘natural trait’ in caring occupations. When a skill is considered a ‘natural trait’ it leads to it being under-specified; it is not unpacked to identify the skills that go into relationship building. When a skill is under-specified it is likely that it is ‘invisible’.

405. The second highest skill set for RNs, when measured by average incidence, is the Coordinating Skill Set C with an average of 43.2 incidences per person averaged across all RN participants. The demonstration of 'interweaving activities with others' by RNs (C2) and 'sequencing and combining one's own activities' (C1) were among the top four average incidences across the nine Spotlight Skill Elements with average incidences of 18.1 and 16.2 respectively.
406. Across Skill Set C, level 3 (problem solving) was the dominant Skill Level. Across the RN group the averages are 7.6 incidences per person of C1.3, and 8.7 incidences of C2.3, and finally 3.8 incidences per person for C3.3. These incidence scores show that RNs, who occupy the middle space in most health service hierarchies, were required to both make adjustments and solve problems in relation to their own work and apply problem solving skills in relation to interweaving their work with others. RNs demonstrated an ability to think quickly on their feet, reprioritise, focus on the required steps in a procedure to ensure the safety of co-workers and patients, and manage conflicts between legal requirements, organisational rules and patient need. The ability to organise and negotiate work organisation, and think whilst doing, and multi-task are all integrative skills that are often under-codified and thus 'invisible', even in the workplace as the skills are performed.
407. In the final Skill Set B the Heat Map shows an average of 39.5 incidences per person across the three Skill Elements. Negotiating boundaries B1 had the second highest overall average for a single Skill Element at 23.0 per person, with the level 4 activity in that Skill Element B1.4 having the equal highest score for a single level of any of the nine elements at 11.1 average incidences per person.
408. In Skill Set B the grouping of high scores is around B1.3 and B1.4 (negotiating boundaries) and B2.3 (communicating verbally and non-verbally). The Primary Material shows that a key part of RNs work was the ability to build trust by explaining processes (once again the depth of knowledge they possess to problem solve) and finding ways to refuse requests that could not be met, whilst still negotiating for the quality of care for patients. Historically relationship building skills, particularly in female dominated care-based work, have been undervalued in job evaluation and work-value processes as they have been characterised as innate traits and thus often under-specified and rendered 'invisible'.
409. The RNs in this study were required to adapt their communication to meet the needs of people who may have been vulnerable and who may have had impaired listening skills. The RNs interviewed were dealing with patients with chronic and complex needs, including those in ICU and those requiring palliative care. The work of the RNs interviewed involved the use of verbal cues and body language to identify and respond to the needs of people with varying levels of understanding. The use of verbal and non-verbal cues in the Primary Material are examples of under-defined skills.

410. The work descriptions provided by RNs included examples of RNs dealing with the death of patients, with the after effect of attempted suicides, with visible and unpleasant cancers (of the mouth and genitals) and with drug and alcohol abuse. These subjects are difficult to discuss and to analyse. Because these subjects may be taboo there is the potential for the skills involved in this work to be overlooked and remain hidden. In the analysis that follows I have refrained from presenting some of the more confronting examples provided by the RNs interviewed to limit the possibility of triggering negative reactions for readers and because the circumstances may mean that these examples are identifiable to persons involved, their families or to others in the community. Whilst not included as examples in this report these examples have been incorporated in my analysis.

Spotlight skills and the typology of invisibility

411. To provide an overview of the link between RNs work activities, Spotlights skills and the typology of invisibility I have included Table 4.5. This Table provides examples of work activities engaged in by the RNs illustrating the use of Spotlight skills by RNs. The relationship of these activities to the typology of invisibility is also noted. The average incidences of the Spotlight skills at each level, for each Skill Element is also used. (In section 4.5 of this chapter more detailed examples of these work activities are included.)
412. Table 4.5 below provides examples of activities illustrating RNs' use of Spotlight skills across the 9 Skill Elements.

Table 4.5 Selected activities illustrating the use of Spotlight skills – RNs

Skill Element	1. Orienting	2. Fluently performing	3. Solving problems	4. Sharing solutions	5. Expertly creating a system
A1. Sensing contexts or situations	0.0	5.4	10.2	11.1	1.8

- L3 Piece together information and perspectives from various sources to solve a problem (UD)
 L3 Use knowledge of the job and its internal and external contexts to anticipate and avoid problems (UC)
 L4 Use techniques for exchanging rapid situational updates with colleagues (UD)
 L4 With colleagues share approaches to solving problems relating to patients or technology (UC)
 L5 Use the understanding of the organisation's priorities to influence policies and help shape systems (H)

A2. Monitoring & guiding reactions	0.1	1.4	7.6	6.2	0.5

- L3 'Key in' to others' ways of thinking to filter information according to how it will be received (US)
 L3 Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain, fear, shame (US)
 L3 Work in sensitive situations to help people maintain composure, self-respect or independence (H, US)
 L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)

A3. Judging impacts	0.0	1.9	3.1	6.9	1.6

- L3 Pick the moment to convey unwelcome news, judging from reactions determine how much to say (H, US)
 L3 Help patients feel at ease whilst you are carrying out activities that may worry or distress them (UD)
 L4 Help create a supportive context for giving and receiving feedback (H, US)
 L4 Constructively challenge practices that may compromise the safety or dignity of others (H, US)
 L5 Predict and analyse impacts of decisions on other parts of the organisation and other agencies (UC)

B1. Negotiating boundaries	0.0	3.8	7.7	11.1	0.4

- L3 Gain others' trust and consent by explaining each step of a process and its purpose (US)
 L3 Find a way to refuse requests that cannot be met, or are unreasonable or dangerous (UR)
 L4 Share knowledge and experience to guide people, including those who do not accept your authority (H)
 L4 Constructively give and receive feedback in unequal power situations (H)

B2. Communicating verbally & non-verbally	0.0	2.6	6.6	1.0	0.1

- L2 Use active listening, reflecting and using silence to allow people to talk through their concerns (US)
 L3 Pitch your use of language and body language to people with varying levels of understanding (H, US)
 L3 Overcome communication problems by 'translating' (e.g. specialised terms), between experts, patients, family members and people of different ages and experiences (UC)

B3. Working with diverse people & communities	0.1	1.1	3.1	1.6	0.4

- L3 Anticipate and act to minimise problems created by intercultural and disability barriers (US, UC)
 L3 Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or similar conditions (H, UD, UC)
 L4 Work with relevant communities to incorporate elements of the cultures of patients and families into your work practices (UC)

C1. Sequencing & combining activities	0.1	4.0	7.6	4.3	0.3

- L2 If interrupted, carry the idea and get back quickly to the same point (UC)
 L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC)
 L3 As new demands arise, frequently reprioritise tasks to keep within deadlines whilst attending promptly to medication times, bell calls etc. (UC)
 L4 Exchange ideas with colleagues for more effective management of workflow (UC)
 L4 Utilise methods for recording key events as they happen, share information to allow effective follow-up (UC)

C2. Interweaving activities smoothly with others	0.0	1.9	8.7	6.9	0.5

- L3 Check your own and co-workers' safety in responding to difficult situations (UC)
 L3 Carry out all steps to ensure legal and safe procedures in a rapidly changing situation (UC)
 L4 Develop and use shared information exchange systems (UC)
 L4 Have in place, and be able to activate, support networks for quick and calm response to emergency or other changing contingencies (H, UC)

C3. Maintaining &/or restoring workflow	0.0	0.5	3.8	4.1	0.5

L3 Manage conflict between legal requirements and/or organisational rules and patient need (H, UC)

L3 Make time for caring listening and interactions amidst intense work pressures (US, UC)

L4 Quickly notice and adapt to changes in the workflow, cooperating to prevent or de-escalate stressful or dangerous situations (UC)

L4 Bring routines and lines of work back together after they have been disrupted by an emergency (UC)

Legend:	H	Hidden Skills
	UD	Under-defined skills
	US	Under-specified skills
	UC	Under-codified skills
	UR	Under-recognised skills

4.5 Aligning RN work activities with Spotlight Skill Elements and Levels

413. In this section I have used examples drawn from the Primary Material from the RNs interviewed, to illustrate the relationship between their work activities and the Spotlight framework. Whilst an example has been used to illustrate a single Skill Element this does not mean that this example is only illustrative of that Skill Element. An example drawn from the Primary Material may have been coded to multiple skill elements. Examples showing the clustered deployment of Spotlight skills are in the Case Studies at section 4.6 of this chapter.

A1- Sensing contexts or situations

414. The first skill group is Skill Set A which involves contextualising and shaping awareness. This refers to the ability of a worker to understand, perceive and respond to context, monitor and guide reactions (the workers' and others), and judge what is happening and consider the implications, impacts, outcomes or consequences of particular circumstances or contexts. These complex skills of sensing context and situations are often under-defined.

415. The focus of skill element A1 is on the ability of the worker to perceive, interpret or read work or social contexts and situations. These contexts and situations include workplace and social roles, rules, resources, regulations, risks, conditions and emergency situations. Activities coded at levels 3 and 4 within the Spotlight framework were the most frequent for RNs in this study. These level 3 and 4 activities were underpinned by the RNs fluent use (L2) of knowledge of the role and the context within which the role is performed.

A1 - Level 2 - Fluently performing

416. All RNs in this study demonstrated the capacity to fluently perform the tasks associated with their role (L2). The ability to adapt and apply skills and knowledge to the needs of the patient, as well as the ability to understand outside developments and remain up to date with changes in regulatory context are part of fluently performing the RN role.

417. There were several examples where RNs had to apply skills of adaptability. The ability to be flexible, adaptable and ready to meet what was encountered each day was central to the role as reflected by this statement from Samantha (RN) working in an Intensive Care Unit (ICU)

Well, first of all, there is no such thing as an average day, because every day is different. It depends on what's come through your doors. – Samantha, Registered Nurse

418. Yolanda (RN) working in a theatre in a private hospital described the set-up of her shift

Well, from the start of the day we're preparing the anaesthetic equipment, doing the safety and functional checks on an anaesthetic machine. We are planning for the day ahead, looking at the list for the day, and what that might look like in terms of plan A, B, C, D. We are liaising with the anaesthetist and surgeon about what we are going to do. - Yolanda, Registered Nurse

419. The experience of Tanya (RN) also in a metropolitan private hospital provided another example of the preparedness required which is a feature of a RN's capacity to judge what is needed for their work

Then we check where we are allocated for the day. So which theatre we're in, and which surgeon that we'll be working with. We then go and prepare the setups for the day ... We load up the equipment trolley with all the instruments and all what we call consumable items, and then we wheel it around to the theatre where we will be working. Once we've made it to the theatre, we ensure that it is set up appropriately. So, we liaise with the perioperative team. We make sure that all the tech equipment is inside the theatre and that the theatre is clean and essentially ready to use. We then start setting up for the first case of the day. So, there's a lot going on in that first half an hour of the day. - Tanya, Registered Nurse

420. There were several examples in the Primary Material where RNs noted a tension between the need to maintain skills and to meet training requirements. From the information provided by the RNs in this study it was apparent that there is an expectation that RNs will complete required training and integrate new skills and knowledge from this training into their practice. The acquisition and utilisation of new skills without those skills being formally recognised is an example of under-recognised 'invisible skills'.

A1 - Level 3 - Solving new problems

421. The ability to problem solve (L3) through piecing together information and perspectives from various sources, along with the ability to apply knowledge of both the job and the internal and external contexts to avoid problems, were skills present in the work of RNs in this study.
422. Information may be pieced together in the context within which nursing is taking place. As Ivy (RN) working in a General Practice described

And it's learning the skills of a practice nurse which is vastly different to the hospital. We do so many different things. We do ear syringing. We do a lot of wound care. We do

health assessments on 75-year-olds, 45 year olds, Aboriginal Torres Strait Islander patients. We do chronic disease care plans for people. And so the little nuances. - Ivy, Registered Nurse

The “little nuances” Ivy (RN) described includes knowledge of both individual patients and the context within which they are situated which makes a difference in how care can be delivered. This understanding of nuance reflects skills of interpretation and analysis, awareness of difference and cultural competence that are under-defined and ‘invisible’.

423. When asked about what is important in her role, Megan (RN) also in a General Practice setting, highlighted how knowledge of individual circumstances of the patient and of the broader health system is critical

I think the clinical skill that we bring in patient education around their complex disease, around their complex wounds around this and identifying social need is big. So finding out that you know patients cannot afford the allied health that they’ve been referred to, and then working with them to find more affordable options and trying to tap into some of the community based or [name of state] health based options that are now available in our community that doesn’t get any sort of recognition or time allocated to it.- Megan, Registered Nurse

Megan’s reflection that the time she spent on navigating the system to source more affordable alternatives for her patients is not given recognition or time allocation is symptomatic of work that is under-recognised and yet is central to the health outcomes of Megan’s patients. The ‘invisibility’ of the work to the management of the practice leads to an unreasonable workload for Megan (RN).

424. The evidence of Natalie (RN) a Maternal and Child Health nurse (MCH) was that MCH nurses are often working alone. They required the ability to piece together information and apply knowledge of context to make quick assessments alone, sometimes in complex circumstances

You're an autonomous practitioner. You're responsible for making quick decisions constantly, you know, throughout the day, and quick assessments. So, I think that's the day-to-day challenge. I think the thing I really don't like dealing with in my role is the family violence and the child abuse elements of the surveillance that we do. And I guess that wasn't part of maternal and child health, really, when I started in 2009. I'm not saying it's right or wrong that it's included, but it's definitely a component of the work that carries with it significant responsibility. - Natalie, Registered Nurse

425. In surgery, the application of knowledge and problem solving when interpreting context may occur as part of a team in emergency circumstances. The Primary Material shows that adapting to different styles and approaches of various surgeons was part of reading the context within which work was being performed. Sonny (RN) described this context

... surgeons can be a difficult group of people to work with and can be extremely set in their ways of how things are done. So, for us nursing staff, particularly scrub nurses, we

tend to communicate with someone what's going to potentially upset them [the surgeons]. So, what to avoid and you know what to do that will make an operation and procedure smooth, go quite nicely and smoothly without yeah, upsetting the apple cart, so to speak. - Sonny, Registered Nurse

Sonny's description of sharing information amongst the nurses and adopting and adapting practices to "make an operation and procedure smooth" is an example of hidden skills that go unacknowledged because to do so would mean having to call out the potential difficult behaviour of the surgeons.

426. The evidence from RNs was that sensing and responding to the context or situation during surgery required adaptability and responsivity. Tanya (RN) also a scrub nurse (or scout) described what happened when equipment and techniques were organised for one type of procedure and how that shifted when complications arose

So, from a scrub scout perspective if it's in an instance where something's bleeding, we would automatically get the stuff that we know we need in a bleeding case. So, your haemostatic agents, your gauze and your sponges, and all those sorts of things ... so it would often just turn into, Right we've got to open up this patient and find where they're bleeding from. So then, from a scrub nurse perspective, you don't have the equipment for an open case. You've got the [laparoscopic] stuff open. So, then you're like frantically getting all that open and ready. And yeah, yeah, so everyone sort of has their role in those situations. - Tanya, Registered Nurse

In this example Tanya (RN) provided insights into the seamless transitions that were required as people took up their 'known' roles to address the unexpected development of the patient bleeding. The ability to do this work involved both anticipating and resolving problems on the spot. This 'thinking while doing' and the seamless transitions and interweaving of work with others is an example of under-codified skills.

427. Sonny (RN) and Tanya (RN) made multiple rapid autonomous decisions in response to changing circumstances to allow a procedure to continue apparently seamlessly, both demonstrating integrative skills. That the work continues seamlessly without interruption can mean that the skills are taken for granted and the depth of the skills utilised may not be fully explored when job assessments are undertaken.
428. Aaron (RN) who is a NUM in a public hospital described the variety of considerations he undertook to maintain staffing levels

I guess it's balancing staff expectations and organisational need as well. And over the last, like 6 to 12 months I've been seeing an increase in staff, wanting to work weekends because of penalty rates. And some of them have expressed quite frankly to me it's cost of living related. But I can't put all of my staff all weekends. And then there are other people that require weekends because of caring responsibilities. And you know, which is also understandable, ... and some of those caring responsibilities are obviously a little bit more

long standing than the cost of living. So, I have a number of staff that are on flexible work arrangements that I also have to review and make sure they fit in with their rostering. And you know, do the best to meet all the criteria. - Aaron, Registered Nurse

The example shows how Aaron (RN) was required to balance the expectations of staff, acknowledging and responding to the social context (cost of living and caring responsibilities), the legal parameters (flexible work agreements and shift provisions) and the organisations expectations. What might be recorded on a position description or task list as “prepare and maintain rosters” involves a consideration of several complex factors, whilst for Aaron (RN), it was trying to do the right thing by his staff as well as the hospital. He was considering the internal and external contexts that impact on these decisions.

429. Natalie (RN) and Aaron (RN) in quite different contexts also showed integrative skills. They absorbed new knowledge, family violence regulations for Natalie (RN), and individual staffing requirements for Aaron (RN) and integrated these seamlessly into their work routines. The skill they were utilising was the ability to reflect on and modify their actions, even in the midst of carrying them out, thinking back to purposes and ahead to outcomes. These are under-codified ‘invisible’ skills.

A1 - Level 4 - Sharing solutions

430. The skills involved at level 4 involve sharing new approaches when interpreting and understanding contexts. This may involve activities such as exchanging rapid situational updates and exchanging information with colleagues. Sharing approaches to solving problems relating to patients or technology may also be work activities at L4. Activities at this level also include maintaining internal and external networks, keeping up with developments relevant to RNs work. There was a high number of instances of work activities at level 4.
431. In the General Practice context Megan (RN) explained the role of RNs in interpreting context, sharing information and managing situations. In the following example she explains how she was required to share information with colleagues in her practice to rectify what she believed was inappropriate action by a General Practitioner (GP) at her clinic. In this example the inappropriate action was the administration of vitamin shots where there was no medical need. The GP, who previously worked in a solo practice, was providing these shots to patients regardless of their medical situation

He's been doing it in his little solo practice for years, and his patients love it. They think it gives them real health benefits, but to administer a medication that is a prescription only medication there must be a medical need. None of these patients are vitamin deficient. And he's [GP at the clinic] also asked for them to walk in off the street and ask the nurses to administer it without being seen by general practitioners at the same time. The management who are not clinical think that this is fine. So, this has been a real problem. So, I've had to get one of the doctors on side with me, so we've had to look at all the RACP

guidelines. We've had to look at the Therapeutic Goods Act. We've had to look at the Poisons Act. I've had to explain to him [the GP] that putting 2 ampules in a specimen bag with needles and syringes for people to take home cannot be done on a prescription medication, nor am I qualified to dispense. So, it's going to be a big education program to bring this guy on board now. I can't do it on my own, because I'd be low hanging fruit, and he could well take against me, and you know you've got to pick your hill to die on, so I've had to work behind the scenes with the other GPs to bring them on board to show them that this is what's happening. And now the ball's in their court. - Megan, Registered Nurse

In this example Megan (RN) and her colleagues worked collaboratively to seek out information ensuring they were on solid ground to tackle a difficult problem. Megan (RN) was conscious of the fact that patients had been used to receiving the vitamin injection and that they were going to want to continue that practice. She demonstrated an ability to judge her impact in seeking a solution to the problem.

432. Techniques for sharing information and situational updates can be important to ensure continuity of care and for managing the resources of the organisation. Saania a RN clinical nurse specialist working in a mental health ward in a metropolitan public hospital described the processes involved

So, one would be a handover with, I guess the treating team. So, letting them know, I guess in the last 24 hours what has occurred? What the flash points are, and I guess you know priorities of who to review first. [Being] able to formulate a plan. There was also a thing we call a bed meeting. So that's meeting with all the other nursing charges within all the other wards of the hospital and the hospital manager would be there. So, it's sort of just updating the wider hospital about how many beds are available, how many beds you have open, how many of those beds are occupied? If they're high care, or not. Your staffing profile, and if there's any sort of expected admissions, discharges things like that. - Saania, Registered Nurse

The skills required when participating in meetings like the “bed meeting” may be disregarded as they occur daily. This includes being underplayed by the workers themselves, Saania (RN) uses the phrase “just updating”. However, in the description provided by Saania (RN) we can see that the gathering and synthesis of the material provided at these meetings engaged critical thinking and analytical skills about both the patient context and also the overall organisational priorities. An important aspect of these meetings is that they provided insights into the availability of beds which was a significant issue for the hospital.

433. The ability to read context and use techniques to manage a situation was apparent in an example provided by Layla (RN) who was a shift co-ordinator in the Emergency Department (ED) of a metropolitan private hospital. The ED closed at 10pm and all patients needed to have been attended to—either discharged or moved to another part of the hospital by that time. Layla’s role involved triaging all the patients

The ED would be full by 9 o'clock and we would have patients out by 10 o'clock, all patients out. It's just the way we communicate with the receiving departments. ...Yeah, and just getting doctors to complete their notes in a timely manner, and just being upfront. You know we need this done, we need that done. ...Also being here at the same time. Yes, hands on. It's very important teamwork, and that's very important. It's never gonna get done if nurses work on their own, you have to help each other out. – Layla, Registered Nurse

Layla (RN) referred to the work as “just managing the patient flow”. Her example demonstrates skills of decision-making (triaging patient need), negotiating with doctors to ensure they have their parts of the process complete and synthesising and processing information to provide situational updates to other departments within the hospital. Underpinning her work were the skills required to maintain a sense of teamwork. Teamwork is an under-specified skill. To accurately value a role that promotes ‘teamwork’ requires an unpacking of the skills that comprise that umbrella term. When this is done the role can be more accurately valued.

434. In the General Practice context maintaining networks was important for patient care. Fatima (RN) in a regional city described how when conducting health assessments, she interacted with the aged care system

... we're in continual process when we do healthcare assessments or care plans that we're making help make decisions on for the patient in order to get agencies or my aged care to assess them ... we mediate between them, and we mediate a lot between community nursing for dressings and wound care and things like that with nursing referrals, and also to make sure, if a patient did have any different cultural needs, that there was a nurse or interpreter informing the patient what was going on. So, the doctor does all the nurse referrals and then, if they can't get this sorted, it comes back to the nurse to sort it out.- Fatima, Registered Nurse

This example shows how the RN was piecing together a system of care through making and maintaining networks and contacts and mediating on behalf of patients.

435. In the examples at L4 we can observe the demonstration of teamwork. Teamwork of the nature described above comprises the use of multiple under-codified skills. Saania (RN) in mental health and Layla (RN) in an ED provided clear examples of when they were required to process and synthesise information and apply critical thinking and analysis to that information so that a team of people could work effectively.

A1 - Level 5 - Expertly creating systems

436. Work activities at L5 involve participating in setting up shared processes for monitoring contexts. This may include applying knowledge of the organisations priorities to influence policies and shape systems. It could include developing systems for sharing informing about

new internal or external developments and/or bringing together people to address issues for patients or the organisation. Whilst there was a lower average of instances where RNs were undertaking activities at L5 there were some important examples of work at this level.

437. The Primary Material shows that where RNs were in positions of additional responsibility activities that demonstrate skills at L5 were more likely to be exercised. For example, Aaron (RN and NUM) in a public hospital explained his involvement in providing the nursing perspective on hospital wide committees

I'd normally be involved in a number of committees ... The organisation sets up a committee, and there's always a NUM representative that they want, because nursing is the biggest workforce that we have. So, I sit on our Electronic Medical Record (EMR) Governance Committee, which is one of several that I sit on. ... And you know there's things that I would advocate for from a nursing perspective, there's you know, some general opinions I might have as an individual, but generally advocating for nursing. ... Through involvement in that committee I have been put on the tender evaluation for our mobile computers that we use around the hospital to go to our patients. So, I've been put on that ... I'm bringing in my understanding about EMR and the clinical aspect on, you know the specifications that we require in these new devices. That will help, in that sense, shape the system of work that my staff are working within to make sure that aligns better than our current resource, which it doesn't anymore - Aaron, Registered Nurse

438. Melissa (RN) was also involved with the doctors and a practice manager in policy development for her General Practice clinic

Being a new practice, we have been working towards becoming an accredited practice. So going through an accreditation process ... So, within those standards are expectations around things like infection control within the practice, cold chain vaccine monitoring within the practice. How you manage your recalls of patients who might have abnormal results by the practice. So, they're all things that I'm involved in, and yes, writing the policy on how the practice manages those important aspects. That's just something that I've done is write those policies up to be submitted for the accreditation process and for us to work under. - Melissa, Registered Nurse

439. Saania (RN) described an innovation, in the mental health context. She and her colleagues designed a safety improvement when dealing with patients who had difficult behaviours

So, a big thing that me and a few of the other senior staff members sort of instilled was it's something called a proactive safety huddle. So, what that entails is that you have somebody that's coming in with, I guess a behaviour of concern or a challenging presentation and you get people together. And it's this formulated list of you know, what the person's come in for? What are the challenges? What are the triggers? What are the risk factors? And then how we mitigate that ... any of the nurses could sort of say, I want to implement a proactive safety huddle for my patient, because XYZ. I've got these risk concerns. So, it would get everybody coming together. It was really collaborative as well,

which I really enjoyed ... it was something that was really helpful within the mental health sector again, just to sort of have that continuity of care. Everybody was on the same page, and there was a plan as well. ...I was part of the planning [for that]. The instigating of that was more our clinical nurse consultant - Saania, Registered Nurse

440. In each of the examples set out above for L5, RNs led or contributed to innovations applying their expertise as RNs to system level changes. Their ability to read the context (internal and external) within which these changes were occurring was important. The examples show how applying their comprehensive understanding of work processes, gained through experience on the job, has benefited the organisations that employ them and the patients in their care. In the examples the ability to collaborate with others was key to the success of the outcomes.

A2 - Monitoring and guiding reactions

441. The focus of Skill Element A2 is on the ability of the worker to monitor and guide their own and others' reactions. Activities coded at Skill Level 3 within the Framework were the most numerous for RNs in this study. Instances of activities at Skill Level 4 were also present in the work of RNs, along with instances of level 5 activities.

A2 - Level 3 - Solving new problems

442. Work activities at level 3 involve the ability of a worker to solve new problems in monitoring and guiding reactions. This may involve keying into other's ways of thinking, considering how information will be received and using insights into difficult behaviour to resolve problems. Working in sensitive situations and helping others to maintain composure, self-respect, and independence are activities that demonstrate L3 skills of monitoring and guiding reactions.
443. The Primary Material shows that 'keying in' to patient behaviour is a critical part of the work of RNs. This can involve anticipating how individual patients may respond in a particular context. Katherine (RN) described the behaviour of patients post operation and the need to understand where the patient is coming from

It is critical, particularly in in my department, where I work with patients that wake-up post anaesthesia and surgery quite often... they're emotional. They're upset. There's a lot of underlying anxiety that is diagnosed in patients. So yeah, I think I've developed some skills over my years. Just, I guess, naturally, through learning about life myself, but also at looking a little bit more into the psychology of patients and using that and those skills to help patients who are in situations where they're, you know, anxious and upset. -

Katherine, Registered Nurse

In this example Katherine (RN) refers to having developed skills "naturally, through learning about life". This is a good example of how the skills involved in nursing are often overlooked even by the workers themselves. In her description Katherine (RN) hovers between acknowledging that she has "developed some skills over my years" but then also suggests these skills are just "naturally through learning about life myself". This characterisation of

these skills (even by the worker themselves) is an example of under-specified skills, where learned capabilities are dismissed as ‘natural’ or innate’.

444. The Primary Material in this study shows that building a relationship with patients is part of the role of RNs. The requirement to consider the underlying factors that are impacting on patients and their behaviours was captured in the following example from Megan (RN) who worked in an inner-city General Practice clinic

...Every time you interact with someone you have to take on board their history and where they're coming from, because it's really building up a relationship and a partnership. And that's not gonna happen if you come and say right now, you're doing this, this, this and this and that's it ... You have to be able to understand where people are coming from. We've got one GP, that does a lot of mental health. We have a large number of chronic schizophrenics coming in for their regular medication, and they can demonstrate a couple of them can display quite challenging behaviours. And you do need to be sympathetic to this, and to be able to manage it and create and to provide a really safe space so that they'll keep coming back. - Megan, Registered Nurse

In this example from Megan (RN) the need to create a “safe space” for patients was part of working in partnership with the patient in a person-centred approach. Applying sophisticated analytical and emotional skills, Megan (RN) understood that working in a hierarchical manner – telling the patient they are “doing this, this and this” – had the potential to undermine the dignity of the patient and may have resulted in them not returning for necessary treatment. The skills exercised by Megan (RN) are difficult to measure and as a result are typically under-recognised and ‘invisible’.

445. The interviewed RNs were conscious of how their communication (including body language) and the information they were imparting, could be interpreted in sensitive circumstances

Yes, so your body language is really important. Because you've got a patient lying in a bed, and you're standing over them. And that can be really intimidating. Plus, we work with very, very vulnerable people where I am, and they might have had some really bad news. They might be in there to have cancer operation. So, you would use your body language. You might hold their hand, you might stroke their head. You might give them intense eye contact. You might change the tone of your voice. You might change your lingo. You might take out some of the bigger words and use more simple words if say it was a child, or if it was a person that was a little bit confused. You might have to be prepared to say it 10 or 15 times in a row. Yeah, you instinctively change how you speak and how you react. There are some people that don't like to be touched. They are uncomfortable with touch. So then you would withdraw to maybe a bit more of a distance. You might get a seat and sit down to their level. - Sienna, Registered Nurse

In this example Sienna (RN) referred to her ability to understand and respond to her patients’ needs as “instinct” and thus it may be overlooked as something that is a personal trait of hers

when in fact Sienna (RN) assessing and adjusting her approach is an example of analytical skills, reflexivity, and emotional awareness. These are under-specified 'invisible' skills.

446. Teaching patients to undertake their own care required RNs in this study to adjust their approach to information sharing. In the following example Ivy (RN) explained her processes

So I try and develop ways that I can understand the patient and then work out how I can teach them to understand what I'm trying to tell them, and how to look after themselves better. I know some people like handouts and they can read the handouts, and that's fine, whereas others need to see, touch, hear, feel. So, yes, it's working those little systems.

She continued

It's looking and listening and trying to find the unsaid words. There are times when I will ask a patient a question, and they'll pop out an answer. But you know I don't know whether it's a look on their face or just a slight reaction that there's something more to that answer, so you can probe a little bit more. - Ivy, Registered Nurse

We can see the application of skills to assess what communication will work best with different patients. Ivy (RN) refers to this as "working those little systems". She uses analytical skills when considering if the patient's answer is fully correct. She explains how she "probe[d]" to find out what was really happening for the patient. These are complex processes that Ivy (RN) deployed which engaged several learned skills.

447. Assessing and starting where the patient is at, was also a feature in MCH

Whenever I see a family, I often try and see what their point of view is first on the solutions because there are so many ways to do things I like to make sure that they feel valued and heard, and that the advice I give is consistent with something that they think that they would implement – Natalie, Registered Nurse

In the following example Natalie (RN) explains the process she used to assess and provide useful information to families

Well, you've got a list of information you need to provide families, and you're continually assessing where the family is at. What their values are and how they will receive the information that you're going to give. And to give them that information in a constructive as possible way that meets their needs. It's this constant sort of tussle between what you have prescribed for the session and what they bring to the session. And, as I said, just this, multiple layers of assessment and decision making in a really short space of time. And then you do that. And the next person's waiting at the door - Natalie, Registered Nurse

This example shows the speed with which she is assessing where the parents were at and what might be useful for them. This all occurred in a short space of time and with the pressure of other families waiting to meet with her. Natalie's (RN) reflexivity and ability to make assessments whilst performing her role is an example of the deployment of under-codified skills which may be overlooked. A significant part of the interaction with patients in

the above example is the underlying objective that Natalie has of making the families feel heard and valued and thus building their confidence as parents. The skills of diplomacy involved in this process are often hidden and 'invisible'.

448. The Primary Material in this study shows that having difficult conversations is part of the work of RNs. This was particularly apparent in cases of serious illness or where a patient was dying. In these circumstances the RN needed to adjust the level and type of information they shared to the needs of the patient and their families

I've had so many you know really difficult conversations with families about death and dying ... I looked after this man who'd had his eye removed from cancer. I didn't know his eye was removed and I went to do the first dressing change and took this dressing off and there's this massive big hole in his head ... the doctor had told him that he could go and have like some plastic surgery and have a flap you know skin flap put over it. And I said I'm really sorry to tell you, but that is not true. That's not something that you can cover or fix. You know, I used to say to people ...I'm happy to tell you what I know, I'm happy to tell you the reality. Things that I know you don't get told by your doctors, your oncologists ...and even surgeons. People go for a five minute consultation they don't get the full picture. Some of these really serious operations that they have. You know, I used to be always like, okay, do you really want to know the bigger picture? If you don't, that's fine. But if you do, I'm happy to tell you. - Cassandra, Registered Nurse

In this example Cassandra (RN) had to counter misinformation provided by another health professional and provide the bad news to the patient with frank compassion. The work activity allows us to juxtapose the person-centred care and skills from Cassandra (RN) with what I will call the bio-medical model of the surgeon. She is exercising skills that are hidden. They are performed 'behind the scenes' to get things done on behalf of the person who was nominally responsible – the surgeon. The Primary Material provided many similar examples where RNs operated in these sensitive situations enabling a person to restore their independence or maintain their self-respect. These additional responsibilities fell to RNs rather than to the medical practitioners. These additional dimensions of the work and their qualitative nature mean that it is unlikely they are fully valued in job assessment processes.

449. The evidence also shows that asking the difficult questions in a compassionate manner is part of the work of RNs

I don't think I've done one [an assessment] that hasn't been quite confronting, as far as mental health issues that they've dealt with. Their PTSD, their alcohol substance abuse that's come out of not being able to cope with some of the things. I think as an experienced nurse, I'm quite good at anticipating and at accepting these things, and how to deal with these things. I doubt that someone who doesn't have experience would be okay with some of these confronting things that they might tell you. Not that I delve into it. That's not my job to delve into it. But you have to still do the questions around—have

you ever thought about hurting yourself? Have you ever thought about hurting somebody else? You know, assessing their drug use, assessing their alcohol use. So yeah, just in doing that can come some challenges, I guess, as to how to process that information that you sometimes get met with. - Melissa, Registered Nurse

In this example Melissa (RN) was required to confront the difficult life circumstances of patients. During this exchange Melissa (RN) showed compassion for the patients whilst at the same time maintaining a level of professional distance so that she could retain her focus on the quality of the information she was providing and how to best provide it to the patient.

450. There was evidence in the Primary Material that RNs experience a level of tension where the nature of the care that is needed doesn't afford the dignity that a RN would like to provide

Yeah, there's no dignity in intensive care a lot of the time, and as much as we'd really try as nurses to maintain that when someone's really, really sick, you just go into a horrible mode, really, where you just do whatever you need to do. And if they're uncovered and they're exposed, and you kind of try. But you try to make them feel, make people feel okay. But your primary goal at that point is just to do the best for them in the interest of preserving life. But we do, we do try? Yeah. - Samantha, Registered Nurse

The example provided by Samantha (RN) shows the complex processes RNs are working through when they believe they are unable to meet their desire to provide the quality of care and the level of respect for the dignity of the patient that they would like. In the ICU unit there are more pressing priorities for RNs than looking to the dignity of the patient; their life may be at risk. But the RNs still noticed and did what they could.

451. What is evident from the Primary Material is that the ability of RNs to manage their own emotions in building connections with patients and clients is key (L3). Natalie (RN) made complex decisions about building parental confidence with one client while the next client was waiting outside the door. Cassandra (RN) took responsibility, avoided by other medical professionals, to be honest with a patient about their prognosis. Samantha (RN) had to manage the internal tension between protecting a patient's dignity and saving their life. RNs managing themselves in life changing scenarios for their patients and clients is about the skill of emotion management. The examples set out above show the performance of skills that are under-specified and hidden 'invisible' skills.

A2 - Level 4 - Sharing solutions

452. Work activities at level 4 involve the ability of a worker to share solutions to monitoring and guide reactions. Level 4 work activities may involve awareness of the emotional pressures, strength and weaknesses of colleagues and also working with others to identify and handle underlying difficulties.
453. The Primary Material in this study shows a very strong culture of support for one another amongst the RNs. RNs described using experience and skills to support junior or new

colleagues who had not yet fully developed the knowledge or skills for the context in which they had been placed. The context in which support was provided included caring for critically ill patients, complex theatre operations and the death of patients. All of these contexts required management of emotions, engaging skills that are often under-specified.

454. Katherine (RN) who held an elected Work Health and Safety (WHS) role used the positional authority of the role and her own experience and skills to support younger colleagues

I am, you know, often providing that emotional support to all of my colleagues, particularly our young, my younger colleagues. As an example we had over our Christmas period we had unfortunately, some pretty nasty traumas that were occurring out there in the community, and patients were needing to come in to us, and some of the outcomes weren't great for those patients, and some of those nurses who'd been involved in those back to back were really feeling that emotional burden of those traumas and they had tried to speak with managers about how they were feeling in terms of trying to get some just some time off to decompress, and it wasn't received very well, so that though that person reached out to me and I was able to offer them some advice, and support around that, and how they should raise that with management. - Katherine, Registered Nurse

In this example Katherine (RN) showed an alertness to the emotional pressures on her co-workers and then she used her experience to negotiate supports for them. When rebuffed she maintained her composure, guiding her own reactions, and moved to a contingency plan to find a solution for those colleagues.

455. Cassandra (RN) in community nursing also supported colleagues new to the role

we had a new staff member, she hadn't been with us very long and she went to see a patient and she found him dead you know at the side of the house ... You know, I talked to her about whether she wanted to go home, whether she wanted the rest of the day off. But no, she didn't. She was happy to keep working and then like we got her some flowers and just kind of kept an eye on it - Cassandra, Registered Nurse

This example shows where context is important in the work of RNs. Cassandra (RN) described her colleague as new to the role (not necessarily as new to nursing). As a community nurse her colleague was visiting people in their own homes, working autonomously and therefore exposed as an individual to traumatic events, without the immediate presence of other colleagues as is likely in a hospital or General Practice clinic. Cassandra (RN) consulted with her colleague, comparing mental notes drawn from her own experience and continued to monitor her colleague for any future signs of difficulty.

456. In the following example contextual experience (in ICU) and alertness to the drivers of difficult behaviour is apparent

Some people say it's really hard, but often if there's a particular difficulty or a family that have difficult boundaries you would try not to put one of your softer, I don't want to use the word soft because we're not soft, but more gentle nurses in an environment where

they're not going to be protected, where that family may be either particularly intense or particularly draining...It is something that we're really aware of, but it's sometimes unavoidable. - Samantha, Registered Nurse

In describing what was needed as an RN in the ICU Samantha's example shows the use of active listening and observational skills that enabled her to detect the early warning signs that things were not going well for the patient or family member, and her insights into and understanding of the reasons for difficult behaviour. She has learned to manage her own reactions, and this enabled her to focus on others (patient or family). Because she has developed these skills, she can prepare patients and families for the complexity of the transitions that occur in ICU, if you like the ups and downs, and even the death of patients. These skills have developed over time and with experience in the ICU. They are examples of the under-defined and under-specified skills that can be 'invisible' in this context. They are taken for granted until they are not evident, hence the decision to allocate some of the more "gentle nurses" to other patients.

457. In the Primary Material there was evidence of RNs sharing solutions on how to monitor and guide their own and other's reactions. RNs spoke of the need for quality debriefing as an important pillar of support after distressing events, but also as a technique for exploring improvements in how processes are enacted. There were also examples where debriefing was not provided, to the detriment of the people involved.

458. Sienna (RN) acting in a WHS role lobbied for regular debriefing to support staff

I might wander in and go and have a look at that group of people and see that they are struggling with their emotions, and I then might go and talk to the manager and say, Look, you know, they probably need a clinical, a critical debrief. Now we've got systems in place to do that, but my hospital is very reluctant to do that, because it costs money to bring in someone from the EAP, a counsellor or so on, to come in and talk to this group of people and make sure they're okay in their mind. So, I've often tried to push for a critical debrief from a group of people that I can see are damaged and been refused, because, say, the person has decided it can't be justified. - Sienna, Registered Nurse

459. Saania (RN) in mental health care described managing a critical incident. She worked through each of the required steps and in ensuring she had a solution to the problem sought feedback from a trusted colleague, in this instance her manager. She followed through the process to keep everyone safe, but was disappointed not to get the support of her manager for a timely structured debrief about the incident

So for that [presence of a weapon], you need to call a code black. In that sense, police get involved as well to be a part of that, just because obviously it's an armed threat. So we had one of those instances on the unit where somebody had bought in a razor blade to harm with, but they also expressed, seeing that if a nurse tries to take it off me, I'm going to use it to hurt them as well. So obviously. Yes, absolutely so obviously needed to take

that escalation. We did that. I had emailed my manager to advise them. This, is what happened during the shift, and, mind you, the staff were there till about 11.00pm. You know, finishing their notes, doing all that. I provided I guess more of an informal debrief. Just being like, is everybody okay? How? What can I do to support you? I'll put in your overtime absolutely. But in this moment I'll reach out to get you guys, you know, some more formal debriefing. So, you can talk about this incident. I reached out to my manager was like this incident happened. It was, you know, pretty heavy. You know, Staff were working overtime. I think that would really benefit from a debrief. Debrief wasn't offered until a week later and that really bothered me. - Saania, Registered Nurse

In the description Saania (RN) identifies both the immediate needs of the staff that she has responsibility for and the potential future needs for ongoing support. She lobbies for the debrief as soon as possible after the event. She was required to manage her own reaction and disappointment when the debrief was delayed by a week.

460. The diplomacy exercised by Sienna (RN) and Saania (RN) in lobbying for effective debriefing for colleagues involves hidden skills. This is work that is performed 'in the gaps' in their regular work routine. In these examples both Sienna (RN) and Saania (RN) deploy their skills to maintain the workflow of the group as a collective endeavour when it has been interrupted by a significant event (under-codified skills). That neither felt successful in their efforts does not detract from the skills used.

A2 - Level 5 - Expertly creating systems

461. Level 5 instances occurred where RNs were involved in introducing new systems, significant system improvements, policy proposals or innovations.
462. Expertly creating or refining a system can make a significant difference to patient outcomes. Megan (RN) a senior practice nurse in a GP clinic described how she initiated a system improvement to correct what she described as miscommunication. The internal system for following up medical test results was being applied inconsistently by doctors and gaps were emerging in follow up calls to patients. This could have had serious consequences if the patient needed follow up treatment after a test result

We've got a section when they get a result called 'doctor to advise' and there's been real misinterpretation about that from the doctors. Does that mean the doctor rings them? Or that they, the patients, know to make an appointment to get the advice on that result. Over the last few months we've had a number of patients ringing up, saying, Look, I had these results done, and I haven't heard anything. When you go back and check it's 'Doctor to advise', and no one's advised them. We looked at that communication system and decided that the best way to do it, is to block that option for them. So, it's either they have to either phone call that patient and let them know what those results are, and they can put back leave, or they send it to the nurses, and we can do it. If the results are okay and there's no further intervention, then we'll ring them and say, Look! The doctors

looked at your results. Everything's normal. Or are there any particular ones that you want me to discuss with you? And I can send them to you? ... That will clear up a lot of miscommunication. It's something that's slipped in lately, and a couple of the doctors use it a lot, and it's being badly used. So, I did initiate that. - Megan, Registered Nurse

What Megan (RN) described as a miscommunication required her to gather information about what was happening, analyse the information to identify the source of the problem; consider various options to solve the problem; consult with key players who enter and use the information; decide on a solution; and then communicate the system change and the reason for the change across the Practice. During this process Megan (RN) was aware of the reactions from people across the hierarchical structure of the Practice and how the systemic improvement would affect their work. Megan's RN clinical skills meant that she understood the clinical implications of failing to provide the proper follow up to test results. In this example there is an interweaving of skills of contextual awareness, building and shaping awareness and being attuned to the reactions of others.

463. Katherine (RN) who held the elected positions of WHS representative and union representative used the structures provided by these positions to contribute to proposed system changes

You know, we have an ever changing environment sometimes. And with that there's, you know, our nursing leaders, you know, change not changing policies, but implementing new policies. Suggesting changes that can be made to our work patterns or the way that things are being done, so I always like to make sure that that they're being done in line with any of our industrial agreements. And sometimes that's not always the case. So, I would in, you know, in my role as an HSR and as a union delegate in my workplace. If any issues are brought to me by other members, or in something that I may read as a policy proposal, I will have that communication with my managers to raise any concerns that might be coming from that. - Katherine, Registered Nurse

In this example Katherine (RN) engaged in consultation with her co-workers and drew on sources of information such as industrial agreements and WHS legislation. She communicated with her managers about the changes. In these processes there is monitoring of her own and other's reactions as she advocates for herself and co-workers. This 'behind the scenes' work of consultation, research and analysis on behalf of her colleagues, to ensure that proposed changes do not have a negative impact in the workplace is an example of hidden skills.

464. Aaron (RN) in his role as NUM tried to bring about a system change in managing the use of equipment. He remained focused on the importance of the change; sought to overcome resistance in the implementation, but in the end had to let go of the change

But I think it's really important to understand the importance of a change that you're trying to introduce. So sometimes the change isn't as important and you're getting resistance. So, it's time to let that go and focus on the things that are more important or

going to get an outcome that is better for staff or patients. You know, the way we store certain equipment so it doesn't get damaged and I changed the process. And no one really adhered to that ... I persevered with that for about 2 months. And it was not changing, and I could not bring that change on with my staff. So, I put that system back in place the way it was originally and the equipment damage is there. But it's not as bad as when I tried to change it. – Aaron, Registered Nurse

This is an example of a manager making a judgement about when it is in the best interests of the organisation to move on and leave behind a change process that is not delivering the goal for which the change was introduced. In this instance Aaron (RN) demonstrated his ability to assess the situation, understand the underlying factors including resistance to the change that were undermining the implementation of his new approach. He demonstrated reflexivity in his decision-making to let go of the innovation given the potential problems that persisting with the change may bring. The ability to assess the reactions of others to change and how this might impact on the capacity to deliver quality care and to knowing when to let go of change involves skills that are both hidden and under-codified and thus 'invisible'.

A3 - Judging impacts

465. The focus of Skill Element A3 is on the ability of the worker to judge the impact of their work. For RNs that impact may be on patients or on their colleagues or on systems. Judging impact is one of the Skill Elements grouped under, Contextualising, so it involves judgement of actions in the context of the work, not in isolation from the day-to-day performance of the work. Among the RNs interviewed for this study there was a spread of instances across levels 2, 3, 4 and 5 with the most dense concentration around L4.

A3 - Level 2 - Fluently performing

466. All RNs in this study demonstrated the capacity to fluently perform the tasks associated with their role (L2). The ability to note early warning signs of a problem for a patient or colleague, to be able to reduce the fear or stress of others with careful explanations, and the ability to prepare each patient for key transitions were part of fluently performing the RN role.
467. Cassandra (RN) a community nurse in a regional setting spoke of the importance of relieving anxiety in patients

... just talking to them and you know listening to them and how they feel about it and, you know, make sure their pain is managed before you start the procedure as well because if they're anxious and then they're in pain, it's not going to be pleasant at all. So those things are really important that the procedure is not going to cause him any more pain. - Cassandra, Registered Nurse

Cassandra (RN) noted that an anxious patient is more likely to experience pain and complications during, or because of a medical procedure. The seriousness, invasiveness and the foreign nature of many medical procedures can create anxiety for people undergoing the

treatment. The ability of an RN to act to reduce fear or stress is a skill that is often described as natural or innate to those in caring roles. It is an under-specified 'invisible' skill.

468. Sonny (RN) who worked in a surgical ward in a metropolitan private hospital trained herself to listen for cues in a patient's answers that may provide a warning sign of a problem

We ask a range of questions, and sometimes it's when you have a conversation with somebody, they will give you a snippet of something that makes you a little like a light bulb of oh, hang on! I'm going to go down that track because I think they're going to give me something important that will have an impact on how we care for them ... it's just those little, I don't know there's certain things that people say to you. I think that comes from experience, though as well. How and what to ask people to gain that information from them. - Sonny, Registered Nurse

In this example Sonny (RN) analysed her own skills - the learned skill of what and how you ask people to gain information, and the careful listening that is performed that converts "a snippet of something" into a change to "how we care for them".

A3 - Level 3 - Solving new problems

469. At level 3 of the Spotlight framework, RNs are engaged in solving unfamiliar problems part of which includes judging the impact of actions, one's own and others. This can relate to choosing how and when to provide difficult or confronting information, putting patients at ease and testing and evaluating solutions to a problem through reflective practice. It includes judging impacts in the workplace.

470. Cassandra (RN) working as a community nurse was reflexive in conveying information

you know, a lot of the older generation were like, you're the nurse, you just do what you've got to do. You know, they didn't always feel like they had a say in things. Whereas now it's patient centred. You know, everybody has a say and especially when you're going into people's houses. You have a say in what happens to you. So yeah, just trying to suss people out and kind of follow the cues a bit on how you handle the situation, I guess. I'd probably you know ask have they had the procedure done before do you know what happening [or] if they haven't had it done before figure out how to approach somebody so that they're not going to be really embarrassed - Cassandra, Registered Nurse

In this example as well as demonstrating her reflexivity in "sussing out" what was going on Cassandra (RN) also reflected on how community expectations have changed and therefore how her role has changed over time. Cassandra (RN) also referenced patient-centred care in a further nod to how approaches to nursing care have changed her role and the skills she was required to develop and implement.

471. Yolanda (RN) explained her vision of quality patient care

... patient care, quality, patient care is what is why we are a nurse, isn't it? It's what we do. It's what we love. I like to advocate for my patient and support them. Going into theatres, you know. It's a very scary thing for a patient. To support them and just be there for them

when they're in their most vulnerable time. It's a big thing to go into theatre, and I like to know that I've helped them feel safe and supported. I guess. - Yolanda, Registered Nurse

In the description Yolanda (RN) is very confident about her role, but potentially underestimates her own skills, by wrapping them in the language of, "well we are nurses that is what we do". She put herself 'in the shoes of the patient' seeking to understand how they felt about the procedure and seeking to put them at ease by reassuring them about the operation. Historically relationship building skills, such as those demonstrated by Yolanda (RN), particularly in female dominated care-based work, have been undervalued in job evaluation and work-value processes as they have been characterised as innate traits. To be able to 'do what nurses do' Yolanda (RN) was engaging complex skills of assessment, engagement and exercising judgement about what was needed to settle the patient. This included judging how what she is doing may impact on the patient. It is a good example of under-defined skills in nursing. These skills include tactile skills such as having a feeling for patients when they are nervous or even afraid of a procedure and the ability to ease that fear. Nurses themselves may be unaware of the complexity of the skill having achieved operational fluency or developed tacit knowledge from long immersion in the situation.

472. Natalie (RN) working in MCH reflected on balancing the needs of nursing mothers with the time and resource constraints she was working with

... if the visits at the end of the day I would just to stay longer and help them with a breastfeed knowing that that could be a turning point in their breastfeeding journey for me to invest that time with them, and that's something that it's again empowering for the woman, I think, to have a greater sense of control over that. But that comes at a cost to me and my family that I'm the one that then can't make it to basketball training on time. So, I think there are choices that you make to try and fulfill your role to the best of your ability, that sometimes aren't the best for you. And it's really people could say, Well, you make a decision to. It's very hard when you're in the moment, and you've got a crying woman, and you're saying I'm going to leave you just how you are on a Friday afternoon - Natalie, Registered Nurse

In this example we see a RN with a deep understanding of the potential positive impact of her work on others, along with a sense of the frustration that she was unable to put in place all the strategies that were needed. Natalie (RN) almost glosses over the tension in achieving a balance between her work life and her home life. She briefly acknowledges there would be a cost to her family, "I'm the one who can't make it to basketball training on time". This is an example of a RN balancing obligations to the nursing mother whilst at the same time wanting to maintain a reasonable workload for herself. Her awareness of the impact of her decision making, "I'm going to leave you just how you are on a Friday afternoon" is front and centre in this example. Natalie's work activity is an example of under-specified skills, because they are

under-specified, what is required of her to provide care and support for the new mothers is 'invisible'. It leads to an unreasonable workload and the tension she experiences between her professional and her home life.

A3 - Level 4 - Sharing solutions

473. At Level 4 RNs are sharing solutions to judge impacts of their own actions and their work group. Skill Element A3.4 had one of the highest average incidences per person across the RNs who were interviewed. Skills performed at this level of this Skill Element are typically under-specified, under-codified and hidden. In the examples set out below, drawing from the Primary Materials for this study, I build a picture of what 'judging impacts' means at the 'sharing solutions' level with examples from RNs in diverse situations.

474. Sharing solutions can involve checking in with colleagues to test one's own understanding of what is happening in the context

if there is something that I'm not sure of, or something that's been implemented or there is you know, there's discrepancy in something I would just always wanna touch base and check to see where everybody else you know their thoughts and what they think is happening to, just for different perspectives on what it might be. To make sure that you know [you are] not going rogue, with my own understanding of what it is. - Katherine, Registered Nurse

475. Fatima (RN) took a similar approach in the General Practice context

... a patient that's got chronic wound care. And I'm not happy with how it's going with the patient, and it's all broken down, and I've thought of everything I can think of for that patient. I would get the next nurse's input. And we do this regularly ... We'd always converse with one another if we had any problems for the best patient's needs. - Fatima, Registered Nurse

476. In both examples above the RN summarised their understanding or checked in with others about the solution.

477. Sharing solutions can also involve creating an environment in which feedback can be given and received. Aaron (RN) had both responsibility and the authority as a NUM to build a supportive environment. His modelling of debriefing practice set a tone for the practice he was encouraging within the Unit

... staff get quite overwhelmed and consumed which is rightly so, and I spend a bit of time debriefing, organising, you know, and there's been a number of times I've organized reflective practice sessions with our mental health nurses to come in and support my team and really managing staff expectations, family expectations around this as well. - Aaron, Registered Nurse

Aaron (RN) demonstrated his ability to judge many factors that were affecting the welfare of his staff - the impact of the staff's clinical responsibilities, staff expectations and the

expectations of family. He not only had the ability to address things in less formal “debriefing” processes he also judged where more was needed brought in assistance to provide this.

478. The information in the Primary Materials shows that RNs do not require a management role to create a supportive environment

I think it's challenging for new staff that are put in situations where the skill mix is not what it should be due to the staff on the day. Yeah, sometimes with any new job you only know what you know, and then you can read all you like about it in a book, but it's not until you put in that situation it's going to be very scary, I guess. Just having that knowledge behind you to speak up and call out, This isn't safe. I'm above my head. This is out of my scope. – Yolanda, Registered Nurse

In this example Yolanda (RN) pointed to the transition of new staff from their formal learning environment to the contextualised learning on the job. As Yolanda (RN) highlighted it was a leap to move from the textbook to the lived experience of dealing with a patient in recovery from a procedure. (This ‘leap’ was a familiar refrain in the Primary Material.) Yolanda's reflexivity had her aware of the need for an environment in which new staff could express doubts about their capacity to fulfil all elements of the role at that stage of their career.

479. Consciously building an environment for giving and receiving feedback is an example of the use of under-specified skills. Those who benefit may be unaware of the skills that have created the environment and in the same way the skills can be missed in job evaluation processes, because the skills are seen to be innate or just part of the character of the person. Aaron (RN) modelled the behaviours he is encouraging his staff to adopt, checking in with them about his understanding of what was happening and what was needed. This is an under-codified skill. Yolanda's (RN) experience and tacit knowledge enabled her to recognise when a new staff member might have been out of their depth. She closely observed her colleague's progress being open to any expression of being overwhelmed.
480. The creation of feedback environments can also be built into the structure of the workplace. Sienna (RN) was the elected WHS representative for her location. She provided an example of her focus on solutions through the health and safety processes

If I notice a dangerous practice I will then use the hospital system to make an online awareness of it. I will take photographs. I will meet. I will contact the work Health Safety Department directly. I will let them know if we need to stop unsafe work, or where I think it is, how important it is. And obviously I cannot be ignored because legislation supports me to do that role. So, I can then give them suggestions from experience of what I might know happens in other workplaces to try and solve a solution, and quite often these things will then turn into a policy. - Sienna, Registered Nurse

In this example Sienna (RN) used her knowledge of safe work practices, the boundaries of her role as a WHS representative and the appropriate procedures for raising concerns, to resolve

WHS problems. Whilst the role and responsibility of a WHS representative are formally recognised in legislation, in the example given by Sienna (RN), it can be observed how she successfully navigates the various levels of interactions to achieve a positive outcome. These are the diplomacy and communication skills that are hidden or under-specified. It is work that is done behind the scenes, or through roles that might not be considered by some as 'nursing work' e.g. WHS responsibilities, and thus may be 'invisible'.

481. Layla (RN) who had some authority as a Shift Coordinator challenged the behaviour of doctors, raising issues with hospital authorities

We have doctors that are really bossy and think that they are above us ... if we bring patients in, they will come and question, why are you bringing this patient in? ... So, it's very embarrassing and challenging, because I'm interviewing the patient, and they come chomping on me, like overlooking me. I do approach them and say, you know, that was inappropriate ... It does happen often, and we've reported it to the manager or the emergency director. - Layla, Registered Nurse

482. Melissa (RN) in a General Practice clinic was also frustrated with the behaviour of doctors

So safety and dignity of others, especially when it comes to your patients. That's like a massive part of what the role of the nurse is to be an advocate, for your patient is like right in the top of the list of stuff that we should be doing, and I've quite often named up issues, such as GPs presuming they can just burst into a treatment room if they need something off a shelf, or without knocking on the door, or you know the use of privacy curtains or you know things like that. So, I have challenged things like that. - Melissa, Registered Nurse

483. Both of these examples above (Layla and Melissa) show the skills of the RN. Each has observed an issue of concern and has considered whether it is an issue that needs to be raised directly with the person or escalated. The evidence from the RNs shows that it is a challenging task to take a workplace matter further when inappropriate behaviour has occurred; behaviour that may impact on the privacy or dignity of patients. It required each of these RNs to draw on their workplace credibility and the skills and capacity that comes with qualifications and knowledge to engage in those challenging conversations. In these examples the experience of both RNs supported their ability to call out inappropriate practice and seek a change in that practice. The skills are examples of hidden skills. They are exercised with diplomacy to minimise embarrassment or to prevent escalation of conflict. They are not made explicit as they are dealing with errors, mistakes or bad behaviour but in the workplace if these problems are not challenged then workflows and teamwork can break down. As hidden skills they may be rendered 'invisible' in job evaluation processes.

A3 - Level 5 - Expertly creating systems

484. At level 5 of the Spotlight framework, RNs are engaged in creating and improving systems.

This can mean setting up robust evaluation processes, predicting and analysing impacts of decisions and creating systems for monitoring outcomes of the organisation's action.

485. The Primary Materials show that Aaron (RN) who is also the NUM for his unit was frequently involved in system level interactions. His knowledge of the clinical work of nursing enabled him to analyse the impacts of decisions made whilst managing his Unit. He was also able to consider impacts across the organisation. Aaron (RN) had developed systems that enabled him to monitor outcomes and evaluate those outcomes for his Unit. He had the analytical and predictive skills to design systems that would bring improvement in patient outcomes. In the interview Aaron (RN) provided multiple examples at L5 of judging impacts. Short excerpts from the interview with Aaron (RN) illustrate the L5 skills he was applying in his NUM role

I'm also responsible for ensuring quality initiatives, implement auditing, reviewing audit results of various audits, whether I've performed them myself or all my team members through delegation have performed them on my behalf. I then review those outcomes and results and then look at quality improvement initiatives.

I was looking at a couple of quality initiatives, and some data that we've been collecting around some patient falls and some interventions that we've kind of refreshed with our team and just some reminders and just looking at some trend data in there and seeing how we're progressing.

[I] had done a little bit of investigating the previous day. I just needed to get back there. To just actually have some one-on-one conversation. I've gone through the clinical notes I've read medical, sorry some radiology reports and pieced together the outcomes for the patient. I just wanted to get any further information and check on the welfare of staff following those incidents.

Our policies are for review every 3 years. So, whether they're in their normal review cycle or someone's wanting to change it in between ... I sit on a committee that reviews that on behalf of nursing as well.

I put in place quality projects and initiatives in my ward, and I'm working across a number of wards actually, with my peers to implement the projects on trying to increase our patient flow, in particular in the morning. - Aaron, Registered Nurse

486. In the above examples Aaron (RN) was operating at a sophisticated level integrating multiple skills whilst maintaining workflow in the Unit. He was utilising the following skills, and it is not an exhaustive list: consulting with staff, applying his knowledge of nursing within the context of system changes, organising schedules to follow up on procedures, advocating for the work

of nurses, and successfully exchanging information across work groups. These are the integrative skills that are required for people to interweave their work in complex environments and maintain or improve workflow. They are under-codified skills and can be difficult to measure. Because there is no definitive measure of allocating value to the skills they may be overlooked in job evaluation processes.

487. Melissa (RN) who had a senior role at a metropolitan GP clinic, turned her attention to different systems that had an impact on the people employed at that clinic

it's nice to think that you can sit there for hours and talk to somebody about their mental health problems, or their inability to walk their dog or whatever. But the reality is that general practice needs to pay for itself. There are bills to pay. There are wages to pay, and there are other patients to see, and your appointment book is full. So being able to utilise the Medicare rebates that are available and really getting those systems working well means that we can get paid by Medicare to do these reviews on patients. And yeah, utilising those rebates as an opportunity to get the people in and giving them time. But yeah, also getting that necessary, unfortunately, necessary money into the organisation to be able to support itself so very, very mindful that time is important. There are bills to be paid. I cost money as well. I've got to be efficient, and I've got to be productive in my role, but at the same time meet the needs of the patients as well. So it's just that nice balancing act, I guess. - Melissa, Registered Nurse

In this example Melissa (RN) applied robust evaluation skills—analysing the impact of decisions made in one part of the clinic on other parts of the clinic and building a system for monitoring outcomes of the organisations actions. She was required to be pragmatic in her approach but all the time judging the balance between the economic viability of the General Practice clinic and the needs of patients. The skills being displayed by Melissa are typically under-codified, as they are the integrative skills that lead to system improvement. It is these improvements in workflow that enable other workers to perform their jobs more effectively, whilst the organising skills and judgement calls behind the improvement are ‘invisible’.

B1 - Negotiating Boundaries

488. The focus of skill element B1 is on the ability of the worker to draw and respect boundaries for themselves and for others. This includes the ability to support, negotiate, persuade, de-escalate, advocate and influence. Those with whom boundaries are being navigated include peers, people in authority, people under one’s care and people outside a worker’s line of authority. Activities coded at L4 within the framework were by far the most numerous for RNs in this study, followed by those at L3.

B1 - Level 2 - Fluently performing

489. At this level of fluently performing, an RN may be seeking to build cordial relations with people to gain their cooperation.

490. Samantha (RN) working in an acute care setting, specifically an ICU ward, was building trust with patients and more particularly their families

you're spending one-on-one time for up to 12 hours a day with your patient, and if the patient is asleep or unconscious you're spending 12 hours with their families, sometimes with their families around the clock. So, you know an awful lot about them really big intricacies about their lives because you're standing there ... And it's actually quite well recognised in intensive care that that does happen, and that there are some nurses that deal with those things better than others. - Samantha, Registered Nurse

Samantha's (RN) communication comes from knowledge of the likely path the family will be following as intensive, possibly life-threatening treatment is provided to their family member. Samantha (RN) does not necessarily recognise her own skills, in dealing with people in these complex health scenarios, but in her statement "some nurses deal with thing better than others" she is acknowledging it is not innate for every person. In female dominated care-based work, skills have often been considered as innate traits thus undervaluing the skills involved in the work. The skills to manage patients and families in ICU are learned capabilities that are often under-specified.

B1 - Level 3 - Solving new problems

491. At L3 of this Skill Element RNs are solving problems in/by negotiating boundaries. This may involve RNs explaining procedures to patients, step by step if necessary, to build a trusting relationship. It may also involve finding ways to refuse requests all whilst maintaining goodwill and standards of patient care.
492. The Primary Materials show that RNs accept their role as the interface with patients. They know the procedures and can find ways to explain them to the patients, whilst taking a relational approach to their work—a person-centred care approach (see chapter three for a discussion of this model of nursing care).
493. The RNs in primary health care settings in this study accepted the role of being the one who provided informed communication to patients about the procedures that lay ahead

So, if you've got a patient with a new diagnosis going to a specialist, they may well ask you, what's that specialist going to do? So, you do need to have an indicator, have an idea... Yes, you can probably expect to have some imaging done. There's some minor procedures, you know like a cystoscopy or a colonoscopy, or some of that. And you need to be able to tell them what that involves, what they should expect. So, there's a lot of your time spent doing that ... certainly improve the patient experience, and certainly improve the patient's confidence, as you know, moving forward with new diagnoses and things. - Megan, Registered Nurse

In this example, Megan (RN) was consciously working to build the confidence of the patient through giving them the information of what to expect in the next stage of any process.

Megan (RN) relies on knowledge of the medical procedures and she takes time to inform the patient. This is one example of how person-centred care has modified the nursing profession; there is an expectation that this time will be given. It is less clear from the Primary Material whether the additional time has been considered in workload allocations.

494. In a MCH setting, Natalie (RN) made conscious choices about explaining a process in a way that would lead to eventual acceptance by the new mother

I guess it's again that careful communication about assessing where they are at and what they would be willing to take on, and that small steps forward are better than no steps forward So maybe a good topic would be someone who's chosen not to vaccinate their child. Now I have a duty of care to make sure that they have had a conversation with somebody else ... I think, that probably demonstrates that sharing the knowledge and experience, when people don't accept your opinion. - Natalie, Registered Nurse

It is apparent that Natalie (RN) was aware of the boundaries she was negotiating. She demonstrated skills in assessing “where they are at”. She was aware that parents may hold to a view that they make the decision about the interests of their child and are unwilling to have regulations imposed on them. Natalie (RN) accepted this and chose to progress carefully—“small steps forward are better than no steps forward”. In doing this she was establishing a relationship of trust with the parent that may build over time. She was also balancing this approach with her own awareness of the duties she had to both the parents and the community. This ability to assess and communicate with parents and be attuned to their needs is an example of skills that may be under-specified when simply defined as ‘emotional intelligence’ or ‘ability to communicate’ in job classification or job evaluation processes. These terms need to be unpacked to gain an appreciation of the full range of skills they represent.

495. The Primary Material also shows that RNs have a role in advocating on behalf of the patient even to family and doctors. Samantha (RN) working in ICU related this work activity, where she was negotiating for the patient with doctors and family members

Quite a quite a lot of emotional stuff comes out in there in regards to goals of care for patients, and the reality of it is that you know many of our patients are not going to survive their stay in intensive care. So, it's being realistic with those doctors and with families and setting goals of care to make sure that we're all on the same page, so that the expectations of those that we're meeting the expectations of the families. But we also have to advocate for the patient. And I mean, some families can be sometimes very unrealistic. And it's not because they're stupid. It's just because they're emotional. They're distressed, and they're not educated. There's a bit of a feeling sometimes in intensive care that because our family members come into intensive care that we can fix them, and we often can't fix them, and it doesn't matter what we do. There's no fixing them. It's maintaining them for a little while. – Samantha, Registered Nurse

Samantha (RN) was dealing with critically ill patients, who she knew from experience, were unlikely to live through the treatment process. Yet, she was understated about her negotiating role. The Primary Material shows that the nurses themselves do not trumpet the importance and complexity of what they are doing, and this contributes to the skills being under-recognised or hidden. In this example Samantha (RN) was empathic with the family (“they’re distressed, and they’re not educated”). She was negotiating to get common agreement between parties with very different interests and power - the family, the doctor and herself about what was a realistic prognosis (“setting goals of care to make sure we are all on the same page”). She was also drawing on her experience to inform the conversations (“we often can’t fix them”) and she was negotiating for the best interests of the patient (“it’s maintaining them for a little while”).

496. Sienna (RN), working as a peri-operative nurse in a private hospital described some of the scenarios where she found herself advocating and negotiating boundaries for patients

these sorts of advocacy roles that we play, are not really deeply recognised. I don't believe so. That might be a cultural advocacy. It might be a consent advocacy. It might be looking at your patient going—Oh, my God! Your husband died a week ago, and here you are in my hospital, having an operation. You are clearly overwhelmed, and we need to try and work out how we can support you. I shall contact the social worker on your behalf. It's these sorts of instinctive things that you do as a nurse when you're looking after a vulnerable human being, depending on your experience and depending on, I suppose, your level of commitment to the advocacy role, it can be quite intense. - Sienna, Registered Nurse

Sienna (RN) unconsciously hides the skills she is applying in supporting the woman whose husband has died by using the phrase, “instinctive things that you do as a nurse”. Skills described as instinct are often under-specified and as in this example ‘invisible’ even to the people who exercise those skills. They are not instinctive but learned skills that are practiced and developed through experience. There is an irony in Sienna (RN) unconsciously hiding her own skills, as she had said in the first line of her description of this work activity that the advocacy role in nursing “is not really deeply recognised”.

B1 - Level 4 - Sharing solutions

497. B1.4 had the equal highest average incidence, 11.1 per person, across the nine Skill Elements at level. At L4 RNs are sharing solutions in/by negotiating role boundaries. This may involve sharing knowledge and experience, building and maintaining networks outside of the work group and constructively giving and receiving feedback in unequal power relationships.
498. The Primary Material shows that a RNs knowledge may may be contested. In the following example Aaron (RN & NUM) explains the processes he used during a multidisciplinary case conference when family were not prepared to accept the cognitive decline of an elderly

patient (their father) and what might be involved in ongoing care. Aaron (RN) was responding to an interviewer question about his role as NUM in multi-disciplinary meetings

So often it is around bringing the nursing care needs of the of the person we're talking about. You know maybe the family members say Oh, I can manage XY and Z. I can go in and say, well, it takes 3 of my nursing staff to provide this. It's just you at home. How? How can we accommodate that? ...and then maybe working with them [family member] to identify some time to come in when the nursing staff are doing that, and then they can either observe the nurses, or they can try and do it with nursing support to step in when they need to. Or sometimes it's around taking feedback from that meeting back out to my nursing team and going well, these are some of the concerns. Can we try and address XYZ that the family is concerned about because that sits within our realm.

Aaron continues

It really depends on the family. But often it may be about brokering what you know. You need to see the care that's required, or to address some care concerns, because sometimes some of these meetings things come out that we weren't aware of this or weren't aware of that, or it's actually being able to address complaints and concerns. Sometimes they do come up in family meetings that it may not be something that I can fix or resolve, but I can at least have a discussion with the family at that point. - Aaron, Registered Nurse

Aaron (RN) demonstrated how he worked through a series of potential solutions, “brokering”, to help the family members come to terms with what may be needed even when those family members may not accept his knowledge and advice. Aaron (RN) remained open to the concerns of the family members indicating he was prepared to receive feedback and take this out to his team to see what they could do to accommodate the needs of the family. All the time he is making certain that what was being proposed was within the parameters of quality patient care. This exchange of giving and receiving feedback with the patient’s family engages the skills of tact and diplomacy which are hidden ‘invisible’ skills.

499. The information in the Primary Materials shows that RNs are the conduit between patients, their family and the doctors and may therefore be put in the position of clarifying and justifying the care plan in circumstances even where their authority is not accepted

[I] explain to the patient this is what's happening to that change of plan. This is what the doctor wanted And so, then a family member would come and won't be happy with the plan. So I would explain it to them. It's like, so this is what the doctor suggested, and they would question so how do you know? It's like, they always come up with, But Google says this, and I was like yeah, no. This is what the doctor recommends. ... And then if they're not happy... because this was actually discussed in front of the patient, and the patients agreed to that. So, if you're not happy with that we can get in touch with the doctor, and you can speak to them. - Jacqueline, Registered Nurse

In this example not only is Jacqueline (RN) having to navigate attacks on her professional standing through statements such as, “Google says”, but she is also defending the doctor and the patient’s agreement to the care plan. She maintains her professional position and provides the family member with an option for them to pursue any concerns they have. Managing this exchange in a manner that doesn’t escalate or cause difficulties for the patient requires tact and diplomacy and is an explicit example of the application of hidden skills.

500. Building networks, both internal to create a strong team culture, and external to promote exchange of information are skills which the RNs in this study appeared to excel

... you’ve got people that have come from all different backgrounds and all different cultures. And they’re not just nurses. They’re people themselves. So they’ve got a lot going on. We work very much in a team where you’ve got doctors and nurses and other different types of professionals, and they all need to be on the same page. They need to understand what the issue is. It’s always patient centred so at the end of it. There’s always a patient at the end of this. So it’s about working together with other specialists and letting them know what the problems, are listening to their ideas, swapping your ideas. Having some discussion as to what may or may not work, and then influencing that decision – Sienna, Registered Nurse

Sienna (RN) was embedded in the team in theatre but had the capacity to stand outside of her role to engage in a feedback process with those with greater authority and those with lesser authority to collaboratively solve the problems that the team was experiencing. The shared value across the group that Sienna (RN) used to unite them was the focus on patient-centred care. This allowed her to influence the conversations.

501. Exchange of information between colleagues is more complex when the exchanges involve unequal power situations, for example between doctors and medical specialists and nurses. The following examples drawn from the Primary Material illustrate some of the different styles of feedback that occurred in conversations when there was a power imbalance.

502. Sonny (RN) working in a surgical ward in a metropolitan private hospital, encountered the doctor-nurse hierarchy, age, experience and gender disparities in her feedback exchanges

... when you have a junior doctor in in the facility and it just giving them advice and the information of what should happen and things like that, and sometimes unfortunately, even though they're new to the area, they sometimes feel that they know more. I tend to find, unfortunately, it tends to be a little bit of a male thing, so particularly with our young surgeons. – Sonny, Registered Nurse

With 20+ years of nursing experience in surgical wards, Sonny’s (RN) interactions emerged from her own confidence, based on her qualifications, knowledge and development of skills across those years of experience. In this example her skills did not appear to be recognised by her less experienced, if more qualified, male colleague.

503. Megan (RN) working in a metropolitan GP clinic and with 30+ years of experience showed the nuanced communication that comes with one-to-one interactions with an older doctor

We've got an older general practitioner who's quite has some quite fixed views, particularly about wound care. Initially and for quite some time my suggestions were met with derision, and I had to accept that for his patients the way he wanted to do it was the way that it had to be done. But I can actually say that he has realised that the way we care for wounds is better than the way he does it, and he is changing. But I had to at first not go in all guns blazing. Just accept his authority, and then just work around. Sometimes, you know softly, softly, killer monkey, isn't it? Just like you're trying to get patients on side, gotta get the doctors on side, too. - Megan, Registered Nurse

Megan's "softly, softly" approach towards both the doctor and the patients demonstrated complex skills of reflection and negotiation. She persuaded, influenced, cajoled and used her own knowledge to bring about a change in practice from one fixed in his ways, resulting in improved treatments for patients. This is an example of the deployment of hidden skills, where diplomacy is exercised by the RN to protect the ego of the older medical practitioner.

504. The evidence of the RNs in this study was that they exercise considerable skill in managing the hierarchical relationships that exists between nursing staff and medical practitioners. Ivy (RN) in a General Practice provided insights into how RNs supported less experienced doctors

we also supervise the registrars, so not supervise in a formal sense. But if they are undertaking certain procedures, we're normally there to assist with the procedures. So, we see things that they shouldn't be doing. And the challenge is trying to say to them, you shouldn't be doing it this way. But have them respect you at the same time. - Ivy, Registered Nurse

505. In the examples provided in this study RNs used language that downplayed the skill in 'managing up', particularly with junior doctors. Samantha (RN) provided an example

Often, we would have a junior doctor who would come with us a lot of the time. But I use the word junior doctor fairly. They're junior doctors. They look at us a lot like what will I do? So, they need a bit of love as well, and they often get a bit panicky. It's often their first rotation through ICU, or they haven't had a lot of exposure. So, there's education, and it's not just education. It's almost like being a Mum sometimes to them. Do you know what I mean, because they're quite important, and they need they need a lot of emotional support as well. - Samantha, Registered Nurse

In this example Samantha (RN) referred to the knowledge exchange that is occurring between the experienced RNs and the junior doctors. Because of the hierarchy this exchange was being handled carefully (the junior doctors are important). Beyond the knowledge exchange Samantha (RN) was assisting junior doctors to manage their own emotions and giving them "emotional support" to boost their confidence. Referring to these complex exchanges as "giving a bit of love" or RNs "being a mum" not only reflects the gendering of the RN role it

hides the complex emotion management that RNs are undertaking (under-specified skills) and the negotiation, tact and diplomacy skills involved (hidden skills).

506. In the examples above we see a range of RNs managing the power hierarchy in diverse settings. It is a good body of evidence of the negotiation skills, the tact and the diplomacy that form part of the role of being a RN. These skills are typically hidden to avoid embarrassing another part of the medical profession, being doctors and medical specialists, and so these skills of the RNs are effectively 'invisible'.

B1 - Level 5 - Expertly creating systems

507. At L5 level five RNs in this study were involved in implementing shared processes for negotiating role boundaries. This may include carrying forward a proposal for system change.
508. Katherine (RN) identified a problem, researched the solution and then carried a proposal forward by getting key stakeholders on side. She undertook this work while employed in her normal duties in the surgical ward of a public hospital in a regional city. Katherine's (RN) description of the work activity is an example of under-codified skills

I identified that we weren't really applying clinical based recommendations around preventing and managing a condition that's known as inadvertent perioperative hypothermia within patient groups. And I implemented a quality improvement activity for that. And through that process, that is, looking at that issue and addressing it. But I've also had to bring together a lot of people to enable that so a lot of my nursing leaders to affect any change down the track I've had to, you know, get them on board with what it is what it means for our patients and how we need to improve the management of what we're currently doing around addressing that complication. - Katherine, Registered Nurse

B2 - Communicating verbally and non-verbally

509. The focus of Skill Element B2 is on the ability of the worker to communicate verbally and non-verbally. This can include deploying empathy, emotion work, using aesthetic communication styles, touch etc. (under-defined and under-specified skills). For RNs that communication will be with patients and their families, and with colleagues internal to the workplace, with management of the workplace, and with peers and others who are external to the workplace.
510. The highest average incidences per person for B2 is at level 3, problem solving by effective verbal and non-verbal communication with an average of 6.6 incidences per person. In the following section I have concentrated on L3 examples.

B2 - Level 3 - Solving new problems

511. Level 3 of the Spotlight framework moves into communication (verbal and non-verbal) for problem solving. This can include the ability of the RN to adapt the content of communication to the needs of the patient or co-worker. It may also involve overcoming communication problems through translating between experts and patients/family members.

512. In the first example Francis (RN) described experiences with patients where she varied her non-verbal language to meet the needs of the patient she was working with

with more elderly patients, especially if they've been given sort of bad news, or they think that the news that they might receive once they get to wherever they're going, is going to be bad, sometimes I'll put out their hand for you to hold it. I know with little children they're always grabbing for you. Babies often just want to be held. So, you're often trying to comfort people in different ways and forms, and it's regardless of age. Actually, I've had pregnant women that have broken down, you know, and you just sit there and comfort them and talk to them about their experience or let them talk about their experience. - Francis, Registered Nurse

The actions and reactions that Francis (RN) incorporated into her approach to different patients is encouraged under a person-centred care model, focussing on the patient experience, not just the treatment response (see chapter three for a discussion of this approach to nursing care). This is one more example from the Primary Material of where person-centred care is changing the skill requirements for nurses. The skills involved in knowing when and how to provide comfort to patients may be overlooked or regarded as being innate or natural to some workers, typically females, and thus under-specified despite being critical communication skills.

513. Sienna (RN) outlined why body language was important so that patients who had been through surgery were not intimidated

Yes, so your body language is really important. Because you've got a patient lying in a bed, and you're standing over them. And that can be really intimidating. Plus, we work with very, very vulnerable people where I am and they might have had some really bad news. They might be in there to have a cancer operation. So, you would use your body language. You might hold their hand. You might stroke their head. You might give them intense eye contact. You might change the tone of your voice. You might change your lingo. You might take out some of the bigger words and use more simple words if say it was a child, or if it was a person that was a little bit confused, you might have to be prepared to say it 10 or 15 times in a row. Yeah, you instinctively change how you speak and how you react. There are some people that don't like to be touched. They are uncomfortable with touch. So, then you would withdraw to maybe a bit more of a distance. You might get a seat and sit down to their level. - Sienna, Registered Nurse

Sienna's description of her work activity moved through the use of body language to translating medical language for the patient and then back to an acute awareness of her own physical presence in relation to the person she was working with. This is another example of the reflective practice of nurses—carefully thinking through their own physical actions, their verbal responses, and reactions to the other even as they implement their normal clinical practice. Their verbal and non-verbal communication is fully integrated into, not separate

from the performance of their work. Sienna (RN) spoke of “instinctively” knowing how to do this. Sienna (RN) herself does not recognise the complexity of the skills that she is applying. The Spotlight tool seeks to make these under-specified and under-codified skills used by Sienna (RN) and her peers, visible to ensure that their work can be accurately valued.

514. In an example provided by Katherine (RN) in an operating theatre, she described how she deftly switched from verbal communication to non-verbal communication, as a patient began to feel the impact of an anaesthetic

when I'm in the role of an anaesthesia nurse, I'm there when the patient goes off to sleep. One thing I always do in my practice is I place my hand on their shoulder and let them know that that's me there. I'm a person. I've got you. I'm touching you, ... sometimes patients don't feel that you're focusing on them when there's all this noise, so that reassuring hand on their shoulder, I feel goes a long way. - Katherine, Registered Nurse

What might be discounted as being an act of simple kindness is in fact a demonstration of support and respect for the patient. Katherine (RN) provided a good explanation of the skills that she used and why she used them; reinforcing patient dignity and giving them confidence as they go through surgery. The skills are rendered ‘invisible’ when such actions are described as personality traits such as kindness. They are under-specified skills.

515. Samantha (RN) adapts her communication to ensure that families understood what was happening in ICU, and were reassured that things were working as they should be

There's a lot of explanation required for families and it's obviously pretty overwhelming for families. They come in it's very confronting, especially if their relative is connected to a lot of equipment. So, it's explaining what that equipment is, and it's explaining it in terms that's not frightening for them. We try and make everything sound like this is what we would expect to happen. And these are the things that we would not expect to happen, and sort of prime them for that. You then would have to assess, based on the patient and what we know about the patient and on the family. - Samantha, Registered Nurse

Samantha's (RN) ability to assess and adapt how and what she communicated was built from her experience of knowing that families in this context have a reduced attention span and their capacity to listen and understand is altered by emotions. She was empathic observing and interacting with the family using skills learned from her own previous attempts at communicating with people in similar scenarios.

516. The information in the Primary Materials shows that RNs in this study act as a conduit between the patient and the doctors and medical specialists. Megan (RN) explained the task for a RN working in a GP clinic

I think what happens for nurses in general practices is they hold it all together. So they're a really good conduit between the doctors, the reception staff, the practice management staff and the patients. ... if there is a problem, inevitably it goes first to the nurses and we

know whether to escalate it to the treating doctor, escalate it to the team as a whole, or manage it within the practice manager and the reception - Megan, Registered Nurse

517. Megan (RN) also commented on the need to translate

we also have to put that language, that knowledge in language, that the receptionist can understand that the patients can understand, and that the non-clinical managers can understand. - Megan, Registered Nurse

518. The examples above, of the exercise of Spotlight skills judged to be Skill Element B2 level 3 focus on RN communication skills. The Primary Materials show a breadth and depth of communication skills utilised by RNs in their role. The Spotlight framework and typology of invisible skills highlight that the communication skills being used by RNs are under-specified and under-codified skills. These skills may be mis-characterised as 'natural' or 'innate' personal traits. To bring these skills to greater visibility I have listed some of the skills (not an exhaustive list) exercised by the RNs in the above examples provided above for B1.3

- a) the ability to draw on similar experience from the past and apply to the present
- b) the ability to observe patients and families and assess their receptiveness to information
- c) the ability to assess and respond to patient and family emotional states
- d) the ability to adopt practices which align with models of person-centred care and recognition of the RN role within that model and how that should impact on their communication
- e) capacity for reflexivity about the impact of their own verbal and non-verbal language
- f) the ability to manage their own emotions and reactions to limit negative impact on patients and their families
- g) capacity for reflexivity about their power in the relationship with people in vulnerable situations and the ability to adapt their communication accordingly
- h) the ability to adapt their communication quickly in high pressure situations
- i) a deep knowledge of illnesses and medical issues and treatments and an ability to translate that knowledge and the communication of doctors and medical specialists for those without the same level of knowledge.

B3 - Working with diverse people and communities

519. The focus of Skill Element B3 is on the ability of the worker to connect across different cultures and work with people from diverse communities. Some RNs are embedded in workplaces where they are dealing with many dimensions of diversity including First Nations status, CALD patients, age and disability. For other RNs that were interviewed they had limited experience in working across cultural boundaries.

B3 - Level 3 - Solving new problems

520. At level 3 RNs are solving problems of inter-cultural communication. This may involve anticipating and acting to minimise problems created by intercultural or disability barriers. It may also involve interacting effectively with patients using a range of communication, mobility or health care technologies.
521. World events can have an impact on the context within which patient care is delivered. In the following example Megan (RN) working in a General Practice clinic in a suburb with a large Orthodox Jewish population provided an example of her actions when international affairs had an impact on medical care

Set aside prejudgments and manage your own reactions to difficult, disturbing situations.

That is an integral part of dealing with people who are in emotionally and physically difficult stages. You know. It is a really big part. We've just as I said. You know, primarily, our patients are Jewish. We've just gone through, we are going through Israel's actions in Gaza. There is a lot of lot of high emotion about that. You can hear things in your daily workplace which probably don't align with how you think about the world, and you know you've got to put that aside and keep doing your job and we've heard some pretty confronting things, and that's affected all of us that work there. You do have to coach and talk to others. You know working with younger nurses, saying, Look, when you're doing this procedure or doing these immunisations, it's best not to make too much of it....

[don't] take more and more time to do the procedure, just get in, do it, and then you can talk about it, because the longer it takes the harder it can be. - Megan, Registered Nurse

It is a clear example of how the work of RNs is affected by the social context in which they are operating, and how, as a result they are required to develop and exercise new skills in 'emotion management'. Megan (RN) was conscious of the demands on herself and the staff with whom she was working and acted to provide clear direction to them about managing the relationship with people who may have had strong and different political views. The ability to manage one's emotions so as not to compromise patient care is a learned skill, evidenced by Megan's (RN) need to "coach and talk to others" about how to manage the situation.

Management of one's emotions is an under-specified 'invisible' skill.

522. The Primary Material shows that one of the more complex encounters for RNs is engaging with patients who do not have the skills, or capacity, or the desire to engage with cultural difference. Layla (RN) encountered this as the Triage Shift Coordinator in a metropolitan hospital emergency ward. It was further complicated when Layla reveals, she is herself a person of colour. Her decision making occurs under the pressure of that environment

... there's one we had where the patient did not want a person of colour looking after them. Like really bad. So, what do we do? We calmly just tell the nurse explain, like, you know, these things often happen, but we will swap you over to another patient. Some patients, it's just better just swapping them around, because if a patient doesn't want to

be looked after by a person of colour. We explain that. And I'm a person of colour. So even worse. - Layla, Registered Nurse

It is an example of Layla (RN) demonstrating communication skills but also skills in monitoring and controlling her own emotions, staying focussed on resolving the problem. In moving the nurse from the patient she was anticipating problems and acting to minimise any fall-out.

523. RNs in this study engaged with cultural differences that were beyond language, religious and national cultures and included class, age and sexuality, disability and other aspects of a person's life. Melissa (RN) was working in a metropolitan General Practice clinic with a diverse patient profile, which she explained in her work activity description. Her challenge in working with this patient profile was to promote a culture of safety for people who felt at risk

That's quite a lot of what I do, I guess, as a nurse is to be able to come up with other language, non-medical language to explain things that we're doing. Being in the CBD, being a new practice, being actually open to new patients means that we get a lot of people who've just moved here from other countries. We also are seen to be a very safe place when it comes to transgender patients. People need a very open way of communicating, I guess, and we've got it. But we've got illiterate people as well, who have, you know, who are on the streets, lower socioeconomic people. So, it's quite a range of people that we have. All those people need an imaginative way to communicate for various reasons ... It's part of what you do. Drawing a lot of pictures and to explain things, giving it to them to take home - Melissa, Registered Nurse

Creating a safe space as described by Melissa (RN) required an understanding of the needs of the patients and the ability to create a culture that responded to the need. She spoke of having open communication. She described processes that she adopted to assist those groups who attend the clinic to engage in solving their health issues. She uses the phrase "imaginative communication", as a metaphor for how she experimented with different approaches to communication, including the use of media, to build and sustain the relationships with all patients.

524. Cassandra (RN) working in regional setting described how she resolved a communication problem for a patient who had become non-verbal due to mouth cancer

We had another man that had mouth cancer too and he couldn't speak. And we used to make him little signs because he used to get really angry and frustrated with people because he could kind of speak but people would get really frustrated with him. I mean, he'd get really angry because people couldn't understand him. So, we made him little signs to say, if you've got to go to hospital, this is your sign. And I've got this and this and I need this done. And yeah, so yeah, just try and, work out the way that works I guess - Cassandra, Registered Nurse

The skills exercised by Cassandra (RN) are under-specified skills. There is an assumption that nurses will find a way to communicate with patients, but that does not recognise the

sophisticated skills that Cassandra applied in these situations. She adapts her whole approach to communication to be non-verbal to interact effectively with those with limited communication. They may be a low technology technique but the skills lie in being able to respond to unpredictable events such as that which Cassandra (RN) has described and then utilising imagination or previous experience to craft a solution. It also requires the skills to incorporate the changed practice into routine interactions with the patient.

B3 - Level 4 - Sharing solutions

525. At L4 RNs are sharing solutions for intercultural communication. This may involve listening and observing attentively to key into what are often the unspoken elements of working with different cultural groups, to continue to solve health problems.
526. Aaron (RN and NUM) implemented a nuanced approach, based on his own knowledge that a national culture is not homogenous and that careful listening is required to understand differences between people and therefore how treatment plans might be developed
- ... the way that the families interact are really, you know, dependent on culture. But then, you know, not everything is, you know, cultural as well. You can have two families from the same cultural background, and they'll both interact in different ways. And I think that's something that's really important to be aware of. But also having a bit of an understanding of some of the cultural sensitivities and expectations in particular around putting family members into residential, aged care. Or you know some cultures it seems to be through my experience, are less likely to want additional support, to come into the home from an external provider, or things like that. So, when we're sitting through meetings and even preparing for family meetings or having discussions with family, its having an understanding that this might not be something that they want. So, ...let's have a backup plan. That's you know, so that that might be option one. But if that doesn't work for you, and that doesn't suit these are some of the other options we do have that we might be able to support you with. - Aaron, Registered Nurse

Aaron (RN) was listening and observing attentively for cues that would help him devise the most appropriate treatment plan. He had also considered and sought to anticipate any problems in advance. His awareness of the cultural factors that may impact on how the family accepted and interpreted the advice they would receive is also apparent. These are under-codified skills performed by RNs.

527. There were examples in the interviews of RNs describing their engagement with cultural training for the dominant cultural groups in their area. In the example from Ivy (RN) what stood out was her commitment to engaging in different ways and sharing the knowledge in an attempt to bring about improved care and services for a particular community
- Another thing I did was join the focus group for the Yazidi refugees. We have the biggest population in [city]. So I joined the focus group to work out how we can support these refugees and help them to understand how health in Australia works, basically. And then,

whatever information I gather from these places, I'll share amongst the clinic staff, both the doctors and yeah, and the reception. - Ivy, Registered Nurse

Ivy (RN) gives up her time and voluntarily commits to this focus group so that she can build her understanding of the community and provide better and more specific health care. This is an example of an under-recognised skill. A duty statement will not list 'attend voluntarily out of hours activities to increase cultural understanding'. Ivy's (RN) commitment to growing her knowledge about this community group was in response to needs she identified at the clinic. The job she was performing was larger than would appear on a duty statement.

528. The evidence of RNs working in rural and remote communities was that they were required to deal with the tension between western medical culture and First Nations culture

I noticed a lot of women you'd bring them in, and they'd say they don't want to come. They've got no family there, or their family is not going to be there till next week. Sometimes you'd bring them in, and they'd actually get a flight back to their community, and you would bring them in again. And it's because we're trying to change. Our culture conflicts with theirs, whereas they want to birth with their family surroundings in their community. But we say there's no facilities out there to you for you to safely birth. You need to come in and have these specialist services around you. And so, it's a conflict of what's normal to each other you know. So, you're often bringing things that you know from experience they don't feel that that's normal for them. And so yeah, it's quite difficult sometimes because it's what you expect It's what the system expects. But it's not culturally what they expect. - Francis, Registered Nurse

In this example Francis (RN and also a registered MW) demonstrated a commitment to respecting the culture of First Nations people. She sought ways to communicate the benefit of taking the best from both approaches; a traditional approach familiar to the First Nations women and the skills of western medicine practitioners and the resources that they can bring to childbirth. This requires the ability to connect across both cultures to provide the best level of care. It is an example of an under-codified skill where the worker seeks to rectify barriers or breakdowns in processes to maintain or restore workflow.

529. Through the examples in L4 I have demonstrated that RNs actively sought to build their knowledge about diverse communities and then adapted their own practice to better meet the needs of those communities. The skills evident in the work of the RNs responding to different cultures are skills that are typically under-codified skills. These skills are the integrative skills used in organising work processes to meet the needs of patients. In this case the RNs are required to do several things at once. They will provide the treatment that is required for the patient whilst at the same time having to interweave their activities with the work of translators, community members and specific cultural, social or religious requirements, including those communities and individuals who have experienced trauma.

C1 - Sequencing and combining own activities

530. The focus of Skill Element C1 is on the ability of the worker to sequence and combine their own activities. This may involve reprioritising their own work to meet changed circumstances or switching and linking their activities with other events occurring in the workplace. For the RNs in this study the highest average incidences for C1 was at L3 with 7.6 per person. There was also 4.3 incidences per person at L4.

C1 - Level 2 - Fluently performing

531. At L2 RNs can fluently link their own work tasks into a smooth work process.
532. During the interviews RNs raised many examples of the necessity for them to be able to respond quickly to changes in the workflow. They needed to sequence and combine activities to perform their duties and achieve the best outcome for patients. Megan (RN) working in a metropolitan General Practice clinic describes her mental preparation for the day

Yeah, it's pretty much every day. You never know what's going to come through the door. Even if you think you know what's going to come, you don't. So, you just have to really be prepared, I think. And that's I think that's the challenge. How do you manage just what walks through the door every day

Then Megan (RN) carried out a routine work activity, giving immunisations. She automatically moved into patient education mode to build vaccine awareness across the community

We would see anything up to 7 or 8 infants for their routine immunisation. So that's checking that they're well, doing all their measurements. Are they meeting all their milestones, educating the parents about the vaccines, what they're receiving, what drug, what diseases. We're trying to prevent the implications of those diseases. So, you have to have disease knowledge what those diseases are, because as you know, most people have never known one. I know, I have never seen a child with diphtheria. Nobody can understand what tetanus is. We've now got an outbreak, an increasingly large outbreak of measles. There's been 10 cases of measles in [state], all of them in the [name of city] area since February.

Megan (RN) sequenced her activities through the day, even with little control of the workflow. She adapted to the needs of multiple GPs who relied on her to complete patient treatments

That's a really big part of the nurses work, you know. In a 15 minute consultation doctors may not have enough time, but then they'll say, Go and see Megan and you know, let's talk to the next stage. So I'll say, all right. You're going for this appointment now. But before you do that, you've got to have this scan, this scan and this scan. These are the medications you're prescribed. It's really important that you do this, this and this with those medications to make sure you're getting the best outcome. So, there's a lot of that in general practice. - Megan, Registered Nurse

533. This narrative provides a snapshot of an RN moving through different activities fluently, confidently and competently. In this snapshot an RN working in primary health is mentally prepared for the unexpected and adjusts their sequence of activities accordingly. The RN had some prescribed tasks (in this example immunisation) combined other tasks with that (patient education) and interwove activities with other health practitioners to ensure that treatment plans for patients were finalised and understood. In each of these tasks as well as organising her own work, the RN was utilising a full range of assessing, reprioritising and communication skills. The confident, fluent performance of these skills can lead them to being under-recognised; they are taken for granted and may be omitted from duty statements or classification standards.

C1 - Level 3 - Solving new problems

534. At L3 RNs are involved in solving new problems in scheduling and managing their work. This may involve assessing the urgency and importance of simultaneous calls on their attention. It can require frequent reprioritising of tasks to keep within deadlines and thinking quickly on their feet when new problems arise.
535. The RNs who were interviewed and who worked in primary health care, dealt with life and death decisions. Fatima (RN) described the intensity of simultaneous calls on her attention
- [You have a patient with] chest pain and you've got another patient with wound care and another one with a vaccination, say, because we've got 3 [nurses], as I said and sometimes it will take 2 nurses to sort out the patient if we have got an emergency. Because you can't leave the patient if they're breathless, or whatever, the other one [nurse] has to go and get the trolley and things. You have to leave your other 2 patients because they're still stable. They still need their work done, needs met, but we would leave them. And just say, we've got an emergency at the moment we will be back with you. We'd sort out the other patient. The doctor comes in. We ring the ambulance, we get all that sorted once the patient's stable. Then we go back to the other patients. That happens constantly. - Fatima, Registered Nurse

Fatima's work activity is typical of examples from RNs in the Primary Material. Following a crisis they just "go back to the other patients". This ability to handle disruptions in workflow, moving from crisis back into normal practice is an example of organising skills that are under-codified skills. Fatima's example is also an example of reflexivity. She explains how she thinks through all of the processes, and the options, and anticipates the outcomes whilst still maintaining continuity of work processes. The ability of a RN to bring their own emotional state under control, to return to equilibrium and to continue making a sequence of decisions, some of which may be critical are under-codified 'invisible' skills.

536. The evidence in the Primary Material is that RNs were faced with unplanned and unpredictable scenarios that required critical decision making in the midst of other routine

work activities. The evidence of the RNs who were interviewed showed their ability to prioritise and then re-prioritise to meet deadlines and patient needs. A patient with chest pain was the prompt for Melissa (RN) in a primary health care setting to re-prioritise

You've got your book that's pretty much filled with your appointments, and then something else comes in, walks in through the door without an appointment, or sits down with the GP and says, Oh, by the way, I've got this chest pain, or something like that. And then that sort of does throw things a fair bit. Even today I went in, and I was going to be purely in an admin role. And there was the nurse who was working today doing a procedure, and yes, another GP saying, oh, but I've got this patient that needs this, not planned, but needs it done now. So, I was dressed like this, not in uniform. And I said, yeah, sure I'll do that. - Melissa, Registered Nurse

537. In cases of re-prioritising there is rarely going to be a checklist or Standard Operating Procedure. It requires nurses to think quickly on their feet, a phrase which itself can mask the skills and knowledge behind the rapid decision making that RNs who were interviewed were performing. This is an under-codified skill where continuity of action is maintained whilst at the same time the worker is reflexively considering how to adapt to meet the changing situation and anticipating what might happen and how to prepare for a new scenario.

538. The following example from an emergency ward is from the perspective of the Team Leader who is a RN. The capacity of the RN (and in this case the doctor) to bring their own emotions under control, to rebalance and continue their work were important skills in the scenario

... if we've had a patient that was unwell and not necessarily passing away, but needed to go to critical care, and it's like sort of like a resuscitation where everybody's hands on bringing this patient back to life. And there's lots of It's just like a near death and the department is messy. Yeah, we would give that person time. Okay, we'll seal off that cubicle, and then we'll get somebody to clean and let the person go. Whoever was involved just go get a quick cup of tea, and then come back and just debrief about the situation. And like, while yeah, fresh stuff, if it's anything we could have done differently, or you know as a Team Leader. And there's also the doctor ... that is involved in the resuscitation. But it's mainly like the Team Leader needs to make sure that everybody's okay. Emotionally and physically, they are okay to go on. - Layla, Registered Nurse

539. Sienna (RN) working in an operating theatre, had to make a critical decision in a team of people with greater power. From previous experience she knew that some would not appreciate her decision. She was thinking on her feet responding to what was happening and doing so under the pressure of knowing what might come from other sources

we also have emergency procedures we can put into place. So, call on our managers to come onto the floor, stop theatres, make theatres stop so that we can get our area safe. There's a lot of pressure doing that because they don't like doing it. But keep their patients in; don't come out to recovery, because we've run out of room. And a lot of

emotions come along with that from surgeons. It's like, Well, sorry we don't do bunk beds here, so you'll just have to wait. Yeah. So ...you have to be quite assertive. As a nurse. it doesn't matter what your personality type, like there are certain times, if you're in that position, that you have to be brave enough to go and say No you're not doing it, and then deal with the poor behaviours that follow from your doctor colleagues. - Sienna, Registered Nurse.

The ability to think on one's feet, and under extreme pressure is an under-codified skill. It is the capacity by the RN to do several things at once and be thinking about the purpose of the work even as the tasks are being performed. In this case the purpose is the care and safety of the post-operative patients that had to be prioritised. Sienna (RN) was also aware of the tension that existed in maintaining workflow and the need for theatre procedures to continue. The exercise of the skill in this example from Sienna (RN) is magnified by her having to initiate the process to cease theatre procedures in an unequal power situation.

540. The need and the capacity to think quickly also extends to the decisions made about staffing and what can reasonably be expected of a nurse at a given stage of their career. Underlying this decision making was knowledge about the scope of practice of a RN. Tanya (RN) provided an example of why that quick thinking is so important

Experience in this area of nursing is very much a matter of life or death. So, a new nurse who's unfamiliar with the theatre environment would not be able to anticipate what is required. And when it's required. For example, using that case of a patient bleeding, they wouldn't know where to start. So, what do I do first? What do I prioritise first? You've got to get the haemostatic agents prepared. You have to ensure that all the appropriate equipment is available and opened in a timely manner. You have to pre-empt a lot of things that you just wouldn't know to do if you've never been in that sort of environment. - Tanya, Registered Nurse

541. The work activity descriptions from Tanya (RN), Sienna (RN) and Layla (RN) provided examples of how RNs took responsibility for the management of workflow in their workspaces. They had a thorough understanding of the tasks and the ability of colleagues to meet the needs of those tasks (e.g. Tanya). They adapted and thought quickly on their feet putting in place a sequence of activities to ensure workflow was maintained (e.g. Layla). These skills are typically under-codified and as a result may not be fully valued in job grading and evaluation. There is also an example of how diplomacy is required with colleagues to maintain the workflow (e.g. Sienna who talked about being "brave" and "assertive" to protect patient wellbeing). These are the skills of maintaining a group work process across time and space, skills that enable the interweaving multiple lines of work. These are 'invisible' skills.

C1 - Level 4 - Sharing solutions

542. At L4 an RN will be sharing new approaches to organising work roles. This may involve exchanging ideas with colleagues for more effective management of workflow, flagging new arrangements and utilising methods for recording key events to allow for effective follow-up. A key difference with L3 is that there is planned activity by RNs to improve workflow where there are known issues. The focus is on sharing solutions and implementing new processes; a step beyond problem solving in the moment.
543. Following are six examples from diverse nursing situations where RNs were active in finding and sharing solutions to issues. Megan (RN) and Melissa (RN) were in General Practice clinics, Sienna (RN) and Yolanda (RN) working in acute care, Natalie (RN) was in community health and Saania (RN) in mental health.
544. There was evidence of RNs managing multiple sources of information, organising and creating systems and processes to manage patient needs

Things like somebody who's planning to go overseas, who needs a complicated travel vaccination schedule, working that out. There's a guideline and there are you know, what accelerated schedules can we use? How do we structure all that? In what appointments do they need to make? Who do they need to see? In the meantime, working all, and that can be quite complicated, you know, children arriving from overseas, who have had some vaccinations appropriate to the country that they've got their origin but not ours. How do we catch them up. How do we make sure they're completely up to date? People who have got a new diagnosis and need urgent, urgent appointments? How do we put a case to the receptionist of different specialties to say, you need to see this patient sooner rather than later. - Megan, Registered Nurse

545. The evidence showed how experience assisted RNs in developing and applying new processes ... being involved in the setup of a new organisation, bringing with me things that have worked previously that I've developed over the years. Certainly in my area of vaccinations, ordering stock. You know, stock management and things like that. I've developed checklists and systems around how many vaccines to order. You know what works in the practice. [It includes] what to put in the doctor's emergency bag to how to set up the emergency trolley to you know the flow of sterilising instruments. Yeah, all of those sorts of things have all been embedded. - Melissa, Registered Nurse
546. There was evidence in the interviews of RNs learning from experience and creating 'teaching moments' to share information

If we had a critical event we might use that information, taking off the confidential aspect of it as a teaching tool. Yeah, to teach other nurses. If this is a scenario this is this is what we had. What would you do. How would you solve that? We're now going to change it because we found out this is unsafe and we think a better way to go is to do this procedure. Here, try this, and we're going to use it as a trial and see if that works better

for us. And then we're going to go back, and if we like it, we're going to change policy. -

Sienna, Registered Nurse

547. The evidence from the Primary Material is that RNs were active participants in team meetings discussing resourcing and sharing ideas for organising personal work roles

... like team meetings contributing to discussions around extra programs that could be delivered that would support common themes that you might see evolving in patients that you're seeing or the fact that there's not enough funding for extra visits? You know, is there a creative way that we can work around patients or clients that need more frequent appointments than what the framework allows and justify them. - Natalie, Registered Nurse

548. Saania (RN) in a mental health setting described her role in leading team meetings

I stepped in as a leader. For the majority of the role that I was in. I found that collaborating with the team was really important to help run the shift with a bit more routine ease and flow. I think when you have your whole team involved in those discussions there is better management of how the shift goes if everybody's on the same page. So that consistency and maintaining that, that's something that I definitely prided myself in doing. ...although I was a leader, it wasn't like here's what I say, and what I say goes. It's like here's what I'm thinking, what other input does everyone else have? Let's work together so very much work within that sort of team dynamic with all ideas welcome and formulating that plan to ensure that it was consistent, and it flowed just a lot nicer. - Saania, Registered Nurse

549. In the interviews there were many examples of approaches to handover of patients in acute care settings from the team on one shift to the next, from one procedure (e.g. theatre) to another (e.g. recovery). However documentation occurred, whether through technology or manual processes, RNs recognised the importance of the process in aiding patient health outcomes. Quality handovers included sharing solutions to issues being experienced by the patient. Yolanda (RN) was succinct and direct in her summary of handover

We need to provide a handover when we are taking patient to recovery, and it needs to be recorded in a timely way that people are aware of what has just happened. I mean, this is a patient that's just gone through a procedure. They need to know the recovery staff need to know what they're looking after. Be clearly documented if there was anything that happened, that's not routine. - Yolanda, Registered Nurse

550. In each of the six examples, RNs are engaged in articulation work, exercising skills that are regularly under-codified. Articulation work is the work which enables complex processes to appear to operate smoothly. Where multiple people are involved in complex tasks, it requires coordination. That is work taken on by RNs in these examples. Where breakdowns occur in a process then RNs are leading the activity to share solutions. In each of these examples RNs take responsibility for the finding solutions to problems. It is under-codified skills that can

lead to undervaluation of a role. If the work is not fully described and the skills identified then the full dimensions of the role performed in context cannot be understood or valued.

C1 - Level 5 - Expertly creating systems

551. Among the RNs interviewed for this study, there those with deep and wide experience of many nursing contexts. Their experience was valued in setting up or improving systematic approaches to integrating individual work activities, both L5 skills.

552. Francis (RN), a flight nurse was called on to design a new system

I was brought on board to help set that up [a paediatric retrieval service] with my retrieval experience. And so a lot of our policies are from me starting that job. So, I've done an awful lot of processes and policies. And they centre around what the role of the retrieval nurse is in [name of regional city]. I sent through the position descriptions of both jobs, flight nurse and a retrieval nurse. And it was just outlining what we need to set up the retrieval service what we need for ongoing. And now we're 6 years on to the retrieval service being in operation. And so, it's future proofing it to be sustainable for the future. So, they're the sort of policies that I've covered. - Francis, Registered Nurse

553. For Aaron (RN and NUM) working within a large metropolitan public hospital, the focus was on how he could improve systems for the longer term benefit of patients, through his leadership and managerial role. While he does not describe it in these terms, Aaron (RN) was effectively putting in place an action research project to test his system for improving health outcomes for the patients in the Unit he was managing

So, some of our longer-term trends for me, it's looking at our risk stuff. So, looking at falls and delirium, and how we prevent falls and delirium, and a lot of what we talk about related to support for patients maintaining their interest and improving mental and physical function. Looking at what programs we can put in place in hospital ... So, I'm implementing a program that would improve their physical function. We've got some resources that we've put together, and I continue to maintain around mental and cognitive cognition maintenance in hospital to prevent delirium. You know, just provide some mental stimulus. So we have activities that we try and a lot of them are self maintained activities with the patient, but have the resources that they can sit there, and they can do some ... And then, looking backwards, you know the last 6 to 12 months, as we maintain those programs, see how many patients engage, because not every patient can engage in some of our programs due to being medically unwell and not being able to. We then see how that those programs and changes to those programs may have positive impacts. - Aaron, Registered Nurse

554. Melissa (RN) in primary health care was focussed on establishing a new system for the GP clinic to manage those patients with chronic health conditions. In this particular case she was working with veterans and was focused on a long-term plan of improvement for them

Look, it's a big part of chronic disease management as well as that of veterans care that I was talking about. Having systems in place to get the patients back in. I'll do a chronic disease management plan and you know these are the sorts of things that might be helpful. I'll do a referral to an exercise physiologist because you're having these falls and you're losing some of your condition. So, let's refer you off. You've got your goals of being able to walk to the mailbox to check your mail or take your dog for a walk, or and you're going to do these things. Let's get you back in time in 3 months, time and review. How that's going for you. Is this working for you? Is there anything else that you need and having a system in place to send an automated text message inviting them to come back for a review of their care plan, or inviting them to come back to talk about how they're going. As a veteran who's got health issues. All of those sorts of things are a big part of an important part of what I do. - Melissa, Registered Nurse

Melissa (RN) was analysing the immediate health needs of the patients to help design a new treatment plan that would be sustainable and more effective in the long term. She was using analysis, prediction, planning, clinical skills and organisation skills to develop a new system.

555. In two of these examples, Aaron (RN) and Melissa (RN) have leadership responsibilities, and they used their positions to pursue system improvement. Francis (RN) because of her vast experience, 35+ years, found herself in a position of designing a system for a new organisation. In each case they exercised skills of analysis and prediction, of planning and organising, all overlaid with their clinical expertise. They were designing and improving complex systems that enabled improvements in workflow and worker performance of their duties. When these integrative skills used in organising work processes are under-codified then the full scope of the RN role is unlikely to be fully valued.

C2 - Interweaving activities with those of others

556. The focus of skill element C2 is on the ability of the worker to get things done by liaising with others to weave activities together. It may involve tracking systemised work processes and balancing conflicting demands. For the RNs in this study the highest average incidences for C2 was at L3 with 8.7 per person and then L4 with an average of 6.9 incidences per person.

C2 - Level 3 - Solving new problems

557. At L3 RNs solve problems in and by interweaving their activities with others. This may involve considering WHS issues in responding to difficult situations and carrying out steps to ensure legal and safe procedures are enacted in difficult circumstances. It may also involve monitoring group work processes to ensure resources are available.
558. A feature of the work of RNs in this study was their work within nursing and multidisciplinary teams. The Primary Material shows a commitment by RNs to using teamwork to gets things done, particularly when resources were stretched. As a NUM Aaron (RN) is not required to

take on a patient load, however, he makes himself available to do this when workload suggests to him that it would be helpful for staff and patients

But you know whether they don't have any patient allocated, and you've got a colleague who's drowning. I'll take a couple [of patients] at least. It's that goodwill that all nurses have to try and help each other out. Especially when I work in a team of only 5 on a night shift compared to 10 during the day. You kind of feel you need to support each other a little bit more, because there is less to support you with. - Aaron, Registered Nurse

559. The following example from Layla (RN) captures the multi-tasking that was evident from many of the RNs that were interviewed

And also just staff engagement—mentoring, facilitating. So basically, whatever I do is very important and also supporting the manager. So, it's like, I said, it's a small emergency department, and we do everything, everything is included. And I don't think anything really gets overlooked. - Layla, Registered Nurse

560. One of the features of 'teamwork' that is under-codified is reflexive practice. We see in the examples from Aaron (RN) and Layla (RN) that they are consciously thinking through the situation they are in as they are doing the work that is required of them. They are consciously thinking through how the team is operating as it seeks to deliver quality patient care while they themselves are involved in the delivery of those services.

561. The Primary Material shows that when RNs recognise that resources are constrained they were prepared to commit the time to meet the legal obligations of their institutions e.g. duty of care or staff ratios. There was also evidence of tension about the additional workload

And I also find it challenging when we're getting towards the end of the day, and we don't have staff to relieve us for the end of our shift, and we're then forced to do overtime because, as you have a duty of care, if you're a primary nurse for a patient, you can't just go—well, yeah, my shift, my shift is finished, bye, see you later. I think we get into a bit of trouble. [Interviewer: How often would that sort of thing happen.] Oh, that's daily. - Katherine, Registered Nurse

The tension evident in Katherine's (RN) description can arise when workers believe that the scope of their work is not fully understood; that some of the skills are in fact 'invisible'. In this instance the commitment by the worker to meet legal obligations does not seem to be matched by the institution providing sufficient resources – itself likely to be caused by the 'invisibility' of the skills involved.

562. There was evidence in the Primary Material of RNs expressing the need to not let the team down which could also take its toll on the health of the worker

We always had what we called a float nurse, who could be just for those occasions if a person was sick and needed to leave. If a person was overwhelmed and needed some time out. If a person needed education, if a nurse needed to go and attend a meeting, we always had a float nurse. We always had that person available. There was always a process

in place where we could make a phone call, and we could get more hands-on deck. So that was the first thing. We don't have those abilities anymore. We do not have enough nurses. So, if you need to attend a meeting quota, or anything like that, or even leave early. It is to the detriment of your team and nurses are very aware of that, which is why you'll often find nurses coming in to work sick or not. They shouldn't be there because they're emotional. And they're or they're exhausted, and they are there because they don't want to let their team down. - Sienna, Registered Nurse

There are several examples in the Primary Material of nurses and midwives bemoaning the reduction of staffing levels (loss of “float nurse” and “supernumerary” was common). This has happened despite what is clear evidence of increasing workloads for nurses and midwives in hospitals and in health service delivery (see chapter three). Among many other reasons is the likelihood that the changing nature and complexity of the skills required in the role are not well understood by those making resourcing decisions. The skills required to perform effectively as an RN (or MW, EN, NP) are ‘invisible’.

563. Sienna (RN) spoke of looking for clues to see how colleagues were travelling

So, I think instinctively, as a nurse, you look at your colleagues, and you look at prompts like physical prompts. Such as are they getting teary? Are their hands shaking? Is their voice shaking? Do they look uncomfortable with the situation? Have they stopped talking to you. And it's at that time when you start encouraging your colleagues to talk about what's going on, and you might not always be able to do it at that time. You might need to get someone else to step in. Hold that patient, take them [colleague] to one side for 5 minutes. Say, are you okay, do you need a break? You're looking very stressed. How are you feeling without judgment so that they can comfortably in a safe place say ... I don't want to look after this patient anymore. I need some time away from this patient. So that's the sort of things that you would do, I suppose. Yeah, you're just constantly looking at people for their reaction. So I guess in a way you're using your experience as not just a nurse, but a human being. - Sienna, Registered Nurse

In this example Sienna (RN) used complex skills of observation, reflection, evaluation and communication to both identify a potential problem and then respond to the problem when it was clear that her colleague needed support. In this context Sienna's use of the term “instinctively” and her assessment that she is using her experience “not just as a nurse but as a human being” is interesting as she herself is underestimating the skills involved. It has long been the case that female dominated care-based work has been undervalued because skills are misdescribed as innate traits, even by the female workers themselves. Sienna's description of her work is a good example of the under-specified skill of emotion management that is required of RNs but which historically has not been well understood or valued in job assessment processes.

564. Sienna (RN) reflected on the impact that it can have when you are injured at work

Recently I had to attend the accident emergency because someone [a patient] hurt my shoulder. So I popped down there. It wasn't serious, but it was upsetting. And I was actually in tears. Yeah, because I actually felt emotional for me. I got a bit scared that time. You get a bit older. You don't move as quickly. - Sienna, Registered Nurse

Occupational violence was mentioned regularly in the interviews across all nursing categories. In this example from Sienna (RN) whilst she acknowledges the impact that the incident had on her she is also almost dismissive, “You don’t move as quickly”. The presence of violence should never be accepted however it is clear that RNs regularly meet violence in the workplace. In this example we observe that it took Sienna (RN) considerable effort to manage her own response to the incident. It is another example of the under-specified skill of emotion management which is critical to the performance of the duties of an RN.

565. RNs provided evidence of implementing processes for teamwork and consistent workflows

We're lucky that anaesthetists are very, very helpful in that department, you know. It helps them [anaesthetists] if we know what to do or have the plan, A,B,C, and the knowledge behind us to just know what to do in those situations that we can't predict. Looking at a list, you know, it's always the ones you think—Oh, this is going to be a straightforward case, and then doesn't always go that way. - Yolanda, Registered Nurse

The use of the phrase “helping” the anaesthetist by Yolanda (RN) masks the skills she has developed in having back-up plans and being able to seamlessly address changes in circumstances. The focus on getting things done and maintaining the workflow by problem solving is an example of an under-codified skill. Typically, value is placed on the skills of the medical specialist, but what is ‘invisible’ are the skills exercised by nursing staff to ensure that the specialists’ skills are optimised in that context on that day with that patient.

566. Processes are important in Emergency Departments where it is the role of the RN to ensure a consistent throughput of patients. Layla (RN) was asked to explain more about her role as both triage nurse and Shift Coordinator

So the triage person triages all patients that present to the emergency department. So, you've got to prioritise them in order of category, who sees, who needs to see the doctor within 10 min, 30 min, an hour, or 1.20. You manage that workflow, and you just allocate them to a certain base. - Layla, Registered Nurse

This process of triage requires Layla to have a perspective on the patient needs and as Shift Coordinator she also needs to consider her colleagues and the physical resources (equipment, rooms, beds etc) that will be required to support the workflow. There is a complex interweaving of staff, patients and resources to maximise the workflow and patient care – all skills that are typically under-codified.

567. At L4 RNs share approaches to interweaving individual and team activities. This may involve developing and using shared information exchange systems, having in place and being able to activate support networks for calm responses in emergency circumstances and making decisions about whether to persist with processes or move on from using them.
568. The RNs provided examples of using formalised structured programs to support their work. Samantha (RN) provided an example of a process used in ICU when a patient goes into cardiac arrest. The aim is to minimise errors in critical incidents by having a decision making process and training staff to follow that process. Effectively the interweaving of activities is pre-determined by the structured process. Samantha an RN with 30+ years of experience working in ICU, described the advantages of this approach

That's why we have those things like I was talking about with COACHED, and where they try and teach us to have an autopilot response to things. It's very good, the way it's done to be honest. That's one thing I can say is that there's a such a standardised process and that we all are on the same process that nobody has to make decisions outside of that process. There's an algorithm. And you follow that damn algorithm, do you know what I mean? So, I think that's how that's I think that's actually one, a very good protective factor for us is to have really clear pathways like that. – Samantha, Registered Nurse

569. The process described by Samantha (RN) is designed to 'make routine' the response to a life threatening emergency in order to minimise the chance of error. It would be easy to mistake this as removing the skill level from the process and reducing it to a basic linear process. Without consciously recognising it, Samantha (RN) reveals the importance of staff systematically internalising the process so that it becomes an automatic routine
- "they teach us to have an auto pilot response" - this is complex training to deliver and absorb as you are training people away from a natural 'fight or flight' instinct
 - "we are all on the same process" - it requires a high level of training and ongoing practice to have a team function smoothly in such a high pressure situation
 - "you follow that damn algorithm" - which can only happen if the staff involved have a deep understanding of the series of steps in the algorithm and why each step might be required. Should some glitch occur the staff need to be able to respond to a variation in the algorithm

The description of the procedure as routine or an "algorithm" masks the interweaving of activity of many people in a high pressure situation, a potential life or death experience. The physical actions, the interweaving of bodily movements of a number of people, the coordination of activities and communication with others, the focus on the sequence to be performed all need to be successfully integrated for this process to be implemented. The integration is an example of an under-codified 'invisible' skill.

570. Melissa (RN) described how information exchange took place in the metropolitan GP practice where she worked and how it led to sharing of solutions to issues

Every bit of correspondence that comes in, every pathology test that comes in, every X-ray result that comes in gets flagged as either needing no action, or needing a follow up appointment, or needing some advice given to them from the nurse ... Well, I feel that only just now, with lots of good communication and things like that, that we've got a sense of how that can work well for our practice and our patients. And that's just with a lot of work and a lot of discussion with every part of the team. But yes, lots of involvement in that process. - Melissa, Registered Nurse

Melissa (RN) hides some of the skills required behind phrases such as “lots of good communication”. Behind that phrase is hidden the following skills: knowledge of the current process; analysis of the problems being encountered; design and testing of alternative approaches; a proposal to change the process; advocacy for the new process and persuading key decision makers to adopt it; consultation skills to engage the staff who will implement the new process; and persuasion to have those staff see the benefit in implementing the new system, including convincing any staff who were reluctant to come on board with the change. These are ‘invisible’ skills.

571. The Primary Material provided evidence that sharing solutions only works when networks exist with whom the solutions can be shared (and adopted) and when relationships have been built and trust established. In those environments health practitioners can depend on each other for support in emergencies and other changing contingencies. Samantha (RN) gave her perspective on this issue of networks needed to support an ICU nurse

Well for my role in particular for example, to look after a patient holistically, it involves a whole host of different professionals, whether it be doctors, nurses, speech therapists, occupational therapists, wound specialists, anaesthetists, a theatre team, like we liaise with a lot of people. A lot of people. So you've got to have really good networks with people ... knowing when to reach out, and who to reach out to when you've got different things, as there's too many things in critical care for one person to be an expert of all things ... That's something that we do all the time. - Samantha, Registered Nurse

In this example from Samantha (RN) an important element of her practice was the ability, or skill, to make judgement calls as to when and who to reach out to when it was clear that extra expertise might be needed.

572. The RNs provided evidence of the importance of perseverance when exploring and enacting solutions. They also provided evidence of occasions when it was time to let things go. Making the decision in that grey area was difficult but important. Flight Nurse Francis (RN) described pushing through tiredness to do a review of the case the team had just completed. She provided an insight into the type of conversations that take place

When you're probably returning to base with your doctor. If you're not just absolutely shattered, you'll sit there and just talk about various things and you often go through like a checklist. Oh, I didn't do that. Did you do that? Oh, I thought you were doing that or you know, when I walked in on this conversation I was busy getting the ventilator ready. But I heard the doctor say to you. What was he speaking about, or I didn't quite catch what happened there - Francis, Registered Nurse

These debriefing or reflective processes can help eliminate errors and promote more effective interweaving of activities across the team. This was particularly important in Francis' (RN) context as there was a high level of staff rotation through the different roles required for medical flight services. Interweaving activities is more complex when a work colleague is new and therefore their work patterns unfamiliar. Francis (RN) has learned to manage her own reactions, and was thus able to focus on her peers. Because she has developed these skills, she can recognise when and how to debrief with the staff she has worked with. These skills are developed over time and with experience. They are examples of under-codified skills.

C2 - Level 5 - Expertly creating systems

573. At L5 the RN is creating or improving systematic approaches to integrative teamwork activities. This may include creating systems for sharing innovations or policies and developing systems for maintaining long-term records. Incidences were more likely to occur where the RN held formal management responsibility.
574. Aaron (RN and NUM) had significant responsibility for building and/or maintaining systems that promote effective performance by the staff under his direction. He described the scope of the work that he saw as his responsibility

So I have about 80 people in that EFT (equivalent full time) that report to me directly as their line manager. And I'm responsible for managing, I guess, from a resource and people perspective all of their leave entitlements, their performance management, their coaching of, you know, performance management issues. But also, you know, in some regards to mentoring and providing, you know that positive and developmental feedback that we all need. - Aaron, Registered Nurse

Managing 80 people and coordinating them into effective teams that can deliver the required health care is a complex task. There are many skills that make up the activities required for that level of management. I have limited my discussion to the skills that Aaron (RN) refers to in his example. Initially he accepts that he has a responsibility for the workers in the team (it is not just a title and salary). His responsibility includes coordinating physical and people resources, with the latter including meeting legal obligations for things like leave records and also for effective performance of duties by each person. Aaron (RN) puts a focus on positive feedback, "which we all need".

575. What is interesting, and possibly alarming, is that Aaron (RN) remarked in his interview on the lack of formal leadership and management education that has been made available to support him. In part to make up for this shortfall he has built a network of people in similar roles with whom he exchanges ideas, resources and policies that enable them to be more effective in their role and therefore provide better support to staff in their unit

So, I reached out to some NUMS that I knew. I still do. I think all of us very openly say we don't know everything, anyway. So we do have that kind of attitude around there's no stupid question but the number of questions that I ask that decreases over time. But it's really, you know, Where do I find this? Do you have a position description? I need to advertise? How do I advertise this? - Aaron, Registered Nurse

C3 - Maintaining and/or restoring workflow

576. The focus of skill element C3 is on the ability to work around obstacles, keep things on track, rectify mistakes and restore and stabilise workflows after an interruption or emergency. It may not necessarily be a crisis but may include activities that maintain the stability of the organisation as it moves through cycles of pressure and overload. For the RNs in this study the highest average incidences per person for C3 was at L4 with 4.1 incidences and then L3 with an average of 3.8 incidences per person.

C3 - Level 3 - Solving new problems

577. At L3 RNs are solving problems in maintaining and restoring workflows. This may include identifying minor issues that may grow into bigger problems and acting to prevent this. Managing conflict between legal requirements, organisation policy and patient need may also be a requirement as is taking time for caring for patients amidst work pressures.
578. The RNs in the study, reported examples of managing the conflict between the legal obligations imposed by authorities, health institutions and their own scope of practice and the needs of the patient(s) with whom they were working. Sienna (RN) described the conflicts faced by nurses in a metropolitan private hospital

And see the thing with nurses is we can't always be decision makers because you don't have complete control of your patient, due to the fact that you've got doctors that have responsibility and hospitals that have responsibility. You can't be independently practising. So all of the decisions that are patient centred have to take into account what the rules are in the hospital as long as what is best clinical practice. So there has to be a balance there which means that you have to constantly talk to other people. When you've got a problem. - Sienna, Registered Nurse

In the example she stresses the hospital rules and the doctor's responsibility. The tension with her own person-centred approach is evident in phrases such as, "as long as what is best clinical practice" and "there has to be a balance". Sienna (RN) sought to resolve the tension by "constantly talk[ing] to other people". She was committed to problem solving to maintain the

workflow, but it was not volume of patients or throughput, but rather a commitment to safety, to procedure and to patient outcomes that motivated Sienna's practice. This was a commonly expressed value across the Primary Material.

579. In the ED of a metropolitan private hospital and under the pressure that comes with managing emergencies, Layla (RN) made the time for patients. In her approach to her work, patient care remained part of the workflow

you have to find time. You need to have, because you need to have time in between those pressures of work, because patients they need to be felt cared for all the time. - Layla, Registered Nurse

580. Layla (RN) took a similar view in coordinating and working with the staff

So just listening, if somebody is like really struggling or just being attentive to what they need. Their needs are at that time and like, if you're the Team Leader all the responsibilities on you, because everybody's going to come to you. So you got to have strong shoulders, and you got to be very fit and mentally prepared to come in on your shift. - Layla, Registered Nurse

Layla (RN) recognised the need to be physically and mentally prepared for the role. The physical and mental preparation for the role underpinned the other skills that Layla (RN) applied. Skills at this level of this Skill Element are typically under-codified. Under-codified skills are those integrative skills in which a worker appears to do several things at once; rapidly sequencing, switching and combining activities. The delivery of those skills relies on the worker's physical and mental preparation for the role. It is evident that both types of fitness are essential for a nurse to complete their duties including the simultaneous performance of multiple skills that is evident from the Primary Material in this study.

C3 - Level 4 - Sharing solutions

581. At L4 the RN is sharing approaches to stabilising workflow. This may include the ability to de-escalate stressful and dangerous circumstances, sharing techniques for making safe decisions under high pressure or in sensitive and/or ambiguous circumstances and bringing routines and lines of work back together after emergencies.
582. Aaron (RN) was articulate in describing the work activities that comprised his role as NUM. He was prepared to make changes to the workflow of the Unit in response to what had been shared with him in the safety huddle, with the intention of preventing stressful situations, caused by staffing issues, over which he had some control

We have our organisational huddle that I sit in, and I'm required to sit in and listen to. I guess the challenges and across the organisation. And then how we performed yesterday, and how we looking at for the next day. And then I use that information to assist making decisions for the rest of the day, you know, if we if we don't have casual staff to fill vacancy in the afternoon, I'm starting to chase up some of my own staff to see if anyone's

available, which in my mind is a bit of a challenge when we've got the right to disconnect.

– Aaron, Registered Nurse

Aaron (RN) displayed his knowledge of the working conditions of the staff with his reference to the “right to disconnect” laws.

583. Sienna (RN) in her perioperative role described the workflow in an operating procedure describing how to de-escalate a potentially dangerous situation. Sienna's (RN) comment is in answer to an interviewer question of what an experienced RN might be able to do that may be beyond a new RN

... assessing an airway, for example. So when I'm holding an unconscious airway which is a human being in my hand. and I'm making sure that they're breathing and that they're ventilating, that it's effective if they start to decline and you'll have them connected to a monitor. So if that monitor starts alarming, and these numbers come up which are alarming, and the person's not breathing, or they're making all sorts of noise, that can be very stressful for a new one because it's not always obvious. It comes with experience to stay calm and to manage the situation calmly. If you lose control of the situation sometimes it's hard to know what your limitations are when you're not experienced ... to stop yourself from panicking and keep calm. You don't just, you're not taught to keep calm. Yeah. - Sienna, Registered Nurse

This is an experienced theatre nurse working in a specific context under immediate life and death pressure to make good decisions and implement the skills that she has been taught and has practised. The “staying calm” arises from a confidence in those skills, a deep knowledge of the solution to the problem unfolding with the patient and many years of experience encountering similar issues. A phrase such as “staying calm” effectively masks the skills required to maintain control over one's emotions while a life-saving action is performed. The skills are under-specified ‘invisible’ skills.

584. Sienna (RN) provided examples of the flow on effect when complications arose in a theatre and the skills required to manage that overflow

So I've got ten theatres pouring into one recovery room. Patients are coming out too quickly. I'm running out of beds, and I'm running out of staff. We need to adapt to that situation immediately by getting someone to go around to all the theatres. Look at the theatres which people can keep their patients in there and telling them to phone before they come out. Don't just come out, otherwise we will make them return their patient to theatre and recover that patient in theatre until we're safe. So this could happen at anytime. - Sienna, Registered Nurse

And another example related to a death in the theatre

So you might have a theatre list. And there might be, say, eight people on that list. And if one of those persons dies on the table, there's going to be a big delay. Because these things take time to sort out. So not only is that the person dying taking up time, it also

upsets people. ... But you still need to get on with the day you've got all these other patients that need to happen. So you're either going to have to cancel them or delay them. But you need to communicate that to everybody, and you need to find out that the staff are safe to continue. Sometimes they might be fatigued, and they might not be able to continue. - Sienna, Registered Nurse

Sienna's (RN) pragmatic explanation of the problem once again partially conceals the skills that were involved in not only maintaining her own sense of calm and focus on patients, and the need to communicate with them but also acknowledging and addressing the vulnerability of staff in this context. These are example of the under-specified skill of emotion management required of RNs to perform their duties.

585. The interviews revealed how RNs were integral to restoring stability and balance to the workflow after an emergency. In the examples provided below, workflow relates to the procedures that keep patients alive. Samantha (RN) was working in an ICU ward and used very casual language to cover the seriousness and intensity of having to enact "advanced life support mode", which in Samantha's (RN) language became "a bad day" and on one occasion "a really bad day". Advanced Life Support mode means performing CPR on a patient

we would have to go into a scenario of advanced life support, which is a very bad day when it happens, but it's something that we do. It's often a nurse that will run that protocol and organize who's in what role. And we have a particular format that's used right across the country. It's called COACHED. And it's a senior nurse who would run that. And it's basically who's doing what? When drugs are going to be given when shocks are going to be delivered. For how long CPR goes on, and you'll put people in those roles and make sure that that is flowing. So as a senior nurse. That's also part of your that would be part of your role. - Samantha, Registered Nurse

And Samantha continued a little later in the interview

... it's rinse and repeat for the rest of the day, usually, unless something goes catastrophically wrong, and then you go into ... advanced life support sort of mode. Should they arrest, or should they bleed unexpectedly, or something happen? It's giving you a really bad day. It's a bad day for the patient. It's a bad day for us, and obviously we need to be prepared for any of those circumstances that can happen which they regularly do. And then, once that's done again, it's re-assess and how do we move forward? - Samantha, Registered Nurse

Samantha (RN) retains the same casual language with her sentence about 'reassessing and moving forward'. Whatever the crisis for one patient there remained several others who still require intensive support. Her "moving forward" involved looking to the care of those others. Once again the RN brought their own feelings and emotions under control and continued to perform the required duties to keep the remaining patients safe. These are the skills of emotion management that are under-specified and often 'invisible'. The capacity to control

one's own emotions is not innate to a particular type of person, it emerges from experience and is a practised skill. Historically the skills have not been well understood or accurately valued in job assessments of work performed in female dominated care work.

586. In her role as a MCH nurse Natalie (RN) described the disruptions that she has to address. In her interview she used the term 'micro-emergencies' contrasting her dilemmas with emergencies that other RNs might be dealing with

You do have to bring things back together after the schedule has been disrupted by an alarming incident, so to speak, but that might be that someone's had an Edinburgh postnatal depression score of 18 or 19 and all. They're feeling suicidal. And then you need to bring that back together, to be able to bundle it all up, sort of and move it forward, and then keep going with the day - Natalie, Registered Nurse

Natalie (RN) downplayed the significance of being in communication with someone who is "feeling suicidal" and the impact that may have had on her. She "bundles it up" and carries on with the day. Once again it was an example of the skill of emotion management that is required of RNs to perform their duties.

C3 - Level 5 - Expertly creating systems

587. At L5 RNs are involved in creating systems for stabilising workflow. This may include working to develop shared mutual support systems, building and maintaining back-up systems and establishing systems or maintaining continuity and being responsive to change.
588. As the NUM, Aaron (RN) had responsibility for staffing rosters. He showed in his example that this was more than an administrative task, it required a knowledge of the patients in the unit, an awareness of their likely needs and a close relationship with the nursing staff to understand their strengths and weaknesses in meeting those needs. These are just some of the elements that contributed to the system Aaron (RN) sought to put in place to manage the resources of the unit and to maintain continuity and stability of care

So we budgeted to at least meet those minimum ratios and in some cases we may have some additional budget. But I need to make sure that I work within that budget that I manage my annual leave amongst my staff; replacement of staff; making decisions around whether or not we require additional nurses to work with some patients that might have some safety concerns. Whether it's their high falls risk [or] they may have mental health conditions that require some additional supervision. Working with my team, I'll make the final decision around whether or not we request additional nurses. And I say request, because at times that's not being able to be provided. - Aaron, Registered Nurse

589. Saania (RN) working in mental health care was asked by the interviewer, what gave her satisfaction in her role. Her response showed both a commitment to the emotional skills required to develop the relationship connections with the young people she was working with, and a commitment to improvement in the system and advocacy for the young people

Despite everything, the most meaningful part of my work is making young people feel seen, heard, and safe. Even brief moments of connection—a calm conversation after an outburst, a smile from a previously withdrawn teen, or a family expressing relief—remind me why I do this work. I also find fulfilment in mentoring others, advocating for systemic change, and pushing back against injustice. Even when the system falls short nurses are the constant, and I take pride in being that anchor, especially for those whose lives have been marked by instability and trauma. - Saania, Registered Nurse

Saania's (RN) use of the "anchor" metaphor is quite striking, a symbol of stability and constancy for those whose lives are affected by instability and trauma.

590. In section 4.5 above, I have taken examples of work activities described in the interviews by RNs and aligned them to each of the nine Spotlight Skill Elements. When combined with the Heat Map in section 4.4 showing the frequency of incidences of skills, these examples illustrate that RNs use all skill elements intensely across their working activities.
591. It is also timely to reiterate the point made earlier in this discussion that the performance of a skill element at the higher levels e.g. level 3 or 4, will necessarily have lower level skills embedded in the performance of that higher level skill.

4.6 RN Skill Cluster case studies

592. It may be that a Skill Element is exercised singularly by a RN. In practice it is more likely, and indeed evident in the interviews that were conducted, that several skills across the nine Skill Elements are performed simultaneously in a work activity undertaken by a nurse or midwife. The Spotlight framework describes that phenomena as 'clusters of skills'. Interweaving, or deploying 'clusters of skills' requires a complex combination of thinking feeling and acting. Further, the capacity to apply several skills at the same time is itself an 'under-codified higher level skill'; increasing the effort required to perform the role and adding to work intensity. (Junor 2021 – Annexure 6, page 3 of 22)
593. The skill of deploying complex 'clusters' of Spotlight skills has the following characteristics
 - a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities
 - b) It is the 'thinking' element of multi-tasking
 - c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges
 - d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to rebuild and work on. (Junor 2021 Annexure 6 page 3 of 22)
594. I have chosen to analyse RNs exercise of 'clusters of skills' through three case studies. The case study approach allows me to illustrate in considerable depth how unpacking a work activity and the 'cluster of skills' evident in that work activity reveals the full range of

‘invisible’ skills in that work activity. The three case studies are typical work activities performed by RNs, allowing for the broad range of roles that are performed by RNs. Once case study is from a NUM in a large metropolitan public hospital, another a RN in a GP clinic, and the third, a post-operative RN in a private hospital.

RN Case Study One: Managing the safety of staff

595. Aaron is a RN and a NUM in a large metropolitan public hospital. The selected work activity is a crisis response to a threat by a family member of a patient on Aaron’s ward. The relative has threatened to kill one of the doctors. It is not a routine activity for a nurse or for a NUM, however, in the interviews for this study, almost every person interviewed across the four classifications (RN, EN, MW, NP) raised the issue of their experience of aggression or threatened violence from patients and/or their partner or families in the course of their work. It was common to hear in the interviews that aggression had increased in recent years.
596. In this case study it is possible to observe the lived working experience of implementing all three Skill Sets - Contextualising, Connecting and Coordinating at a high level, mostly at level 4. As the NUM Aaron (RN) has a legislated obligation to act for the safety of the staff he is responsible for. The case study demonstrates the simultaneous deployment of a cluster of thinking, relational and coordinating skills to respond to a crisis that threatens the safety of the nursing staff.
597. Aaron (RN), who opens the description with “not too long ago”, is a manager who is in control of his reactions, who is making careful considered judgements about the impact of his actions in cooperation with the emergency coordination team, and who is constantly aware of the situation that is unfolding for the Unit he manages and the wider hospital environment. The presence of the police in that coordinating group is an indication of the seriousness of the threat that the hospital is dealing with. Throughout the activity Aaron (RN) maintains a focus on the safety of the nursing staff in his own Unit for whom he has responsibility and the wider group of employees such as the doctors for whom he does not have direct responsibility.
598. Aaron (RN) proved to be reflexive about his decision making and his own feelings throughout the interview conducted for this study, but in describing this work activity he was succinct and matter of fact in his description.
599. In his interview Aaron (RN and NUM) described the work activity thus

Not too long ago, there's a relative that called up and threatened to kill the doctors on the ward. So, working with the director of our department or the medical director working with my manager, our security team, the police and having multiple phone calls and communications around what we were doing to ensure safety of the doctors that I work very closely with, but also if someone came in to kill the doctors my nurses are everywhere as well. There's more of my nurses than there are the doctors, so there's more targets. So, I guess you know, having a general situation understanding, and

communicating also with my nurses, to make sure that they were kept as safe as the doctors were as well. - Aaron, Registered Nurse

600. I have described the case study as 'Managing the safety of staff', capturing the management role that Aaron (RN) has, and the priority he places on staff safety throughout his description. In the profile of the RNs in this study, Aaron (RN) was the only one who identified as having a substantive role as a NUM, one other was a Practice Manager in a GP clinic. At least 8 other RNs had some form of leadership or management responsibility e.g. Shift Coordinator, senior nurses who act in Team Leader roles at different times.
601. In viewing this work activity description through the lens of the Spotlight framework, I observe that Aaron (RN) excels in his reading of the context in which the work activity is unfolding. A close reading of his description reveals up to 10 instances of Skill Set A, Contextualising, (see the table below). The focus of Skill Set A is on the ability of the worker to perceive, interpret or read work or social contexts and situations. These contexts and situations include workplace and social roles, rules, resources, regulations, risks, conditions and emergency situations. Contextualising also has a focus on the capacity of the worker to monitor and guide their own reactions and to judge the impact of their actions on others. These skills are all performed at multiple levels and simultaneously by Aaron (RN) in the work activity he describes. The ability to interpret context and share information and rapid situational updates can be critical to keeping patients and staff safe.
602. Aaron's (RN) description of his handling of this emergency reflects the use of complex communication and analytical skills. He demonstrated the ability to read the immediate threat (to doctors) and to understand the implications for the staff he was responsible for (nurses), should that threat develop. He is communicating with multiple stakeholders and with his staff in real time whilst the situation is unfolding. The threat brings increased pressure on Aaron (RN) to structure communication to meet the needs of the audience, who are likely to have heightened anxiety because of the threat situation. Aaron (RN) is sharing knowledge and experience to guide others, knowledge about the context of his unit and about the staff who work there. He was also required to share knowledge with his own staff and to gain their trust through a step by step explanation of how the emergency was being managed. He may have already had their trust as a manager for routine and clinical events, but this will have required a renewal of the terms of the relationship with the staff; many of whom will have been frightened, in the face of the threat, and the risk to themselves.
603. Aaron (RN) is interweaving his work with the emergency coordination group, and the staff in the unit. While it is not stated by Aaron (RN), in the example it is likely that he will have consulted with his ANUMs prior to speaking to the staff as a whole group. Through his

interview Aaron narrated many examples of consulting and working with his ANUMs to get the best outcomes for patients and staff in the Unit.

604. A count of the codes allocated in the table below, shows that Aaron's (RN) description of this work activity was assessed by a team of coders to have had 27 instances of the nine Skill Elements from the Spotlight framework. The skills are performed simultaneously as Aaron (RN) manages the emergency situation that is unfolding in the Unit. It is an example of how Spotlight framework skills are rarely exercised in isolation but are performed in clusters.
605. The 'cluster of skills' demonstrated in this example are A1.4, A2.4, A3.4, B1.4, C2.3. In the following Table the example given by Aaron is broken down to show the skills being performed simultaneously.

Table 4.6: RN Case Study One: Managing the safety of staff

Phrases and sentences from Aaron's statement	Spotlight coding	Illustrative statements from Spotlight workbook (abbreviated)	Observation
<i>there's a relative that called up and threatened to kill the doctors on the ward</i>	A1.4 C2.3	exchanging rapid situational updates with colleagues And Check your own and co-workers' safety	At this point hospital emergency procedures have commenced and rapid situational updates are being made by people in key roles including Aaron as the Unit Manager. Aaron was already thinking about the safety of his staff (evident in later comments).
<i>working with the director of our department or the medical director working with my manager, our security team, the police</i>	A1.4 A3.4 B1.4 C2.4	share approaches to solving problems And Regularly summarise your understanding of what is going on And Build and maintain networks of working relationships And activate, support networks for quick and calm response to emergency	Here Aaron was engaged with key stakeholders internal and external to the hospital. He shared information about his Unit in response to specific questions. This involves regularly checking his understanding of what was happening as he followed the steps of the hospital emergency procedure. The involvement of the police is a key indicator of the seriousness of the threat.
<i>having multiple phone calls and communications</i>	B1.4 B2.3	Share knowledge and experience to guide people And Adapt the content of your communication to the varying attention spans of different listeners	Aaron was sharing situational updates requiring him to adapt his communication to meet the requirements of stakeholders e.g. police

<i>what we were doing to ensure safety of the doctors</i>	A1.3 A2.4 A3.4	Solve problems by sifting key issues from all the detail And Be alert to and help manage co-workers' emotional pressures And Regularly summarise your understanding of what is going on	He does not have management responsibility for doctors but he was drawn into the overall coordination of the response, and here we see that he was sifting through the detail to get to the key issue of workers safety. Twice in the description he mentions the priority of the safety of the workers.
<i>I work very closely with</i>	A2.3 B1.4	'Key in' to others' ways of thinking And Build and maintain networks of working relationships	This statement arises from his empathy for the doctors with whom he works closely, 'keying into' how they will be feeling. They are people with whom he has built networks.
<i>if someone came in to kill the doctors my nurses are everywhere as well, there's more of my nurses than there are the doctors, so there's more targets</i>	A1.4 A2.4 A3.4 C2.3	convey information from a range of sources And Be alert to and help manage co-workers' emotional pressures And Regularly summarise your understanding of what is going on And Check your own and co-workers' safety in responding to difficult situations, whilst avoiding pressures to react before thinking	This focus of the stakeholders coordinating the emergency response is on the direct threat to the doctor. Aaron with primary responsibility for the nursing staff alerted the emergency coordination team to the risk. Aaron is displaying his situational awareness under extreme pressure; his consciousness of how his co-workers might be experiencing the emergency. He acts for their safety.
<i>having a general situation understanding</i>	A1.3 A1.4 A3.3 B1.4 C2.3	share information about developments relevant to your work area And Test your solution to a problem, by listening, observing and reflecting And Share knowledge and experience to guide people And Carry out all steps to ensure legal and safe procedures in a rapidly changing situation	This simple statement masks knowledge and skills that Aaron was exercising: • He was reading the situation in his own unit and across the hospital • He was monitoring and guiding his own reactions • He was judging the impact of what he is saying to the emergency coordination team

			• He was sequencing his own activities to meet his legal responsibilities to his staff • He was interweaving his activities with the emergency coordination team and communication with his staff .
<i>communicating also with my nurses to make sure that they were kept as safe as the doctors were as well</i>	A2.3 A3.4 B1.4 B2.3 C2.3	'Key in' to others' ways of thinking And Regularly summarise your understanding of what is going on And Share knowledge and experience to guide people And Adapt the content of your communication to the varying attention spans of different listeners And Carry out all steps to ensure legal and safe procedures in a rapidly changing situation	His final act in the description of the work activity was the communication with the nursing team. It will have involved complex communication – working through, with them the steps necessary to maintain their own safety and that of their colleagues and patients. Evidence from across the course of his interview suggest that he was watching carefully the reactions and body language of the staff adapting his communication to decide what and how much to say.
What is left unsaid in this example from Aaron • Throughout the communication about the threat Aaron was managing the potential conflicts, at least internally, between his legal obligation to protect the staff, the organisational procedures being implemented to respond to the threat, and the needs of the patients whose treatment may be interrupted as the process unfolds (C3.3) • Aaron was also required to bring routines and lines of work back together after the communication of the threat and any lockdown procedures enacted (C3.4).			

RN Case Study Two: Well informed and anticipatory action

606. Megan (RN) is the senior practice nurse in a large metropolitan General Practice clinic. This case study provides an example of the skills deployed simultaneously by an experienced RN working in primary health care with coordination responsibilities. Megan (RN) brings her clinical knowledge as an RN to the coordination work that she undertakes. There is a seamless

integration of reading the context of the clinic, interweaving activities with clinic staff to meet patient and organisational needs, and adapting communication for the team at the clinic.

607. In Megan's (RN) work activity she demonstrates skills from each of the three Spotlight Skill Sets – Contextualising, Connecting and Coordinating. As with the wider cohort of RNs, she performs these skills at the higher levels of the framework, levels 3 and 4. Her strengths are in sensing contexts and situations and interweaving activities smoothly with others.

608. Megan (RN) described the work activity in her interview thus

I think what happens for nurses in general practices they hold it all together. So they're a really good conduit between the doctors, the reception staff, the practice management staff and the patients. And they are the problem shooters. If there is a problem, inevitably it goes first to the nurses and then we know whether to escalate it to the treating doctor, escalate it to the team as a whole, manage it within the practice manager and the reception? Or is it something the nurses have done. And then how do we manage that? So, there's lots of problem solving. There's lots of rapid situational updates. Things change all the time and things, can, you know, like, if we're sending someone to hospital, or we're trying to get an urgent appointment for someone, or we want to try and fit someone. You know, we're always juggling and trying to keep everybody informed of what's happening. And the organisation's priorities. And this comes in when you're a bulk billing practice. The organisation's priority is to keep you all in jobs and to keep you all employed, and to keep the company healthy, and that that has an impact on us as well when we can't fit patients. - Megan, Registered Nurse

609. I have titled the case study, 'Well informed and anticipatory action'. In the title I have sought to capture the way that Megan (RN) uses her contextual knowledge to plan and prepare actions to be taken by the whole team at the General Practice clinic to meet the needs of the patients. Megan's (RN) skill is in her capacity to respond effectively to the unpredictability of the clinic. What contributes to her effectiveness is her problem-solving capacity, her communication within the clinic and her ability to juggle tasks and priorities without losing focus on the primary goals. Her use of the metaphor, "conduit", is apt for the role she plays at the clinic in being the connection point between its many moving parts. In the last lines of the description, we see that her communication and her coordination and interweaving of activities is about moving people toward the priorities of the organisation.

610. This description from Megan (RN) shows how RNs in the General Practice context operate as a fulcrum around which information sharing and working on solutions to improve patients' outcomes pivots. Complex decision making occurs around whether issues are escalated to doctors or whether the issue reflects the need for a whole of practice response. Megan's (RN) explanation also highlights how a RN utilises their knowledge and understanding of the system (a bulk billing practice) and the priorities of the organisation (keep the workers in jobs and the company healthy). This sits with the requirement to provide access for patients. Her

reference to “always juggling and keeping everyone informed” reflects skills of critical thinking, strategic decision making, communication, and adaptability.

611. The skills that Megan (RN) is exercising are not performed in a simple linear progression. They are ‘clustered’ in each aspect of the work activity that she narrated in her interview. The Table below shows Megan’s (RN) full work activity broken into eight sections. In 7 of the 8 sections there is a ‘clustering’ of two or more skills.

612. In this example from Megan (RN) the overriding skills that were observed were coded as A1.4, B1.3, B2.3, C1.3, C2.4, C3.3. The full range of coding that makes visible the ‘clustered’ deployment of Spotlight skills in the work activity description is set out in the Table below.

Table 4.7: RN Case Study Two: Well informed and anticipatory action

Phrases from Megan’s statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>for nurses in general practices they hold it all together</i>	A1.3 C1.3	anticipate and avoid problems And frequently reprioritise tasks to keep within deadlines whilst attending promptly to medication times, bell calls etc	In Megan’s experience it is the nurse, and typically the RN (who also supervises any ENs in the clinic), who is reading the situation across the practice and sequencing their activities to promote a steady workflow.
<i>they’re a really good conduit between the doctors. the reception staff, the practice management staff and the patients</i>	A1.4 B1.3 B2.3 C2.4	exchanging rapid situational updates with colleagues and to convey information from a range of sources And Gain others’ trust and consent by explaining each step And Adapt the content of your communication to the varying attention spans And activate, support networks for quick and calm response to changing contingencies	The word “conduit” as expressed here is rich with meaning. Megan is the focal point for information and will exchange situational updates across all workers in the practice. We learn later that her communication is adapted for each of the different groups, nurses, doctors, reception and management, and will interweave people in a way that they can respond to changing contingencies.
<i>they are the problem shooters</i>	A1.3	Use knowledge of the job and its internal and external contexts to anticipate and avoid problems.	She identifies her view of the work of RNs as being the people who can both identify issues and then solve the problem
<i>If there is a problem, inevitably it goes first to the nurses and then</i>	A1.4 B1.3	share approaches to solving problems	There is a subtle shift in Megan’s language as she uses “we”, flagging

<i>we know whether to escalate it to the treating doctor, escalate it to the team as a whole, manage it within the practice manager and the reception</i>	B2.3 C2.4	And Negotiate (e.g. for patients) And Adapt the content of your communication to the varying attention spans And use shared information exchange systems	that the decision making path that she follows is done in consultation with others. That pathway means an interweaving of the work of multiple people and negotiating the boundaries between the groups so that people are all acting within their scope.
<i>Things change all the time and things, can, you know, like, if we're sending someone to hospital, or we're trying to get an urgent appointment for someone or we want to try and fit someone</i>	A1.4 B1.3 C1.3	exchanging rapid situational updates with colleagues And Negotiate (e.g. for patients) And frequently reprioritise tasks to keep within deadlines And Think quickly on your feet as new problems arise during an activity	Megan is acutely aware of the situation at the practice and its dynamic nature. She manages the sequence of her own activities to ensure that urgent appointment can be confirmed, either at the hospital or the clinic. That has required negotiation with people with whom she has already built a network (e.g. reception staff at specialists, hospitals or her own clinic).
<i>we're always juggling and trying to keep everybody informed of what's happening And the organisation's priorities.</i>	A1.4 B1.2 C3.3	create and maintain internal and external networks And Communicate clear and consistent limits in a way that gains acceptance And adapt to changes in the workflow	Megan is reading the situation; maintaining stability of the organisation (she is focussed on the organisation's priorities), despite the juggling. She recognises the importance of clear communication across the team in the clinic, because as we note in the next two sentences there may be an impact on patients.
<i>And this comes in when you're a bulk billing practice</i>	A1.3	Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems	Megan is fully aware of the limits of the situation in which they are working. She knows the Medicare funding processes and is very conscious of that funding level.
<i>The organisation's priority is to keep you all in jobs and to keep you all employed, and to keep the company healthy, and that that has an impact on us as well when we can't fit patients</i>	A1.3 A2.3 C3.3	Piece together information and perspectives from various sources to solve a problem And Work in sensitive situations to help people maintain	We see Megan in pragmatic mode here. She knows the situation of the clinic. In the previous sentence she has addressed the funding source and here she shows her awareness of the outgoings for the practice; the

		composure, self-respect or independence And Manage conflict between legal requirements and/or organisational rules and patient need	expenditure on staffing. She knows the importance of keeping those two elements in balance and the implications if they are not balanced. The clinic must remain open to maintain access for patients. As a person with clinical knowledge and (from her first statement) one who “holds it all together” she takes a lead in managing the conflict between organisational priorities and patient need.

RN Case Study Three: Empathic alertness and communication

613. The final case study of the clustering of skills by RNs draws from the interview with Sienna (RN). Sienna (RN) is a post-operative nurse working in a private hospital in a metropolitan setting. She is one of a group of ‘hospital trained’ RNs who participated in this study. She commenced her training in 1983. With a career that included working outside of health care, she estimates at least 30 years of active nursing. In the work activity that is the subject of the case study, Sienna (RN) refers on several occasions to what her experience enables her to do and understand with this patient.
614. In the example we can observe the use of Spotlight Skill Sets—Contextualising and Connecting, both performed primarily at level 3. Sienna (RN) demonstrates all three Contextualising Skill Elements; sensing contexts or situations, monitoring and guiding reactions, and judging impacts, on multiple occasions in this work activity. She is providing resourceful solutions to problems as they arise. There is a demonstration of the deployment of a cluster of skills from Skill Set A; 18 incidences are identified in the Table below. It can be observed that Sienna (RN) is demonstrating level 3 of negotiating boundaries and communicating verbally and non-verbally.
615. In the work activity description Sienna (RN) is responding to a clarification question from the interviewer about how she knows how patients want to be treated at any point in time
- You just instinctively know, you just know, because you're a nurse. It's just things that you pick up. I think what happens is that we are a patient advocate. So, we're very tuned into when our people are upset or we hear some bad news, and from experience we know that is bad news. From experience we know that we can expect tears, or whatever from that. And you know it's to us it's sort of like 101. It's just basic like we would struggle for someone not to get it but it's amazing how many doctors don't get it, you know. They just come and drop a bombshell on a patient and say, Oh, okay, well, you know, that's come

back. That's malignant. We're gonna have to start chemo tomorrow, and then off they go. And then you've got this person who's in a state of absolute shock thinking I've just found out I've got cancer. I knew Chemo might have been on but he's just said, we're starting it tomorrow. So, what does it mean? So you have to break that right down into simple language. Simple routine work when the person's been a bit overloaded. Come back to the conversation. If you're not capable of the conversation. Then make that call. What can we do? Let's get a relative in so that they can listen as well. So, you've got two sets of ears getting the information ... we can problem solve from there. - Sienna, Registered Nurse

616. I have titled the case study, 'Empathic alertness and communication', to capture the skills that Sienna (RN) demonstrated in firstly being able to walk in the shoes of the patient, or empathise with them, and secondly in structuring and adapting her communication to meet the altered state of the patient who is grappling with the information that has been given to her by the doctor. Sienna (RN) sees the events from the perspective of the patient and has the skills to adapt to the patient's needs.
617. The case study makes visible the 'clustered' deployment of the Spotlight skills that a RN demonstrates when they undertake what is described as a core activity of their work, "providing emotional and psychological support including advocating for a person throughout their treatment" (Nursing and Midwifery Board 2025b). The primary sentence in Sienna's (RN) description of the work activity is, "It's just basic like we would struggle for someone not to get it but it's amazing how many doctors don't get it". The juxtaposition between the nursing staff and the doctors in terms of their situational awareness of the patient shines a light on the 'invisible skills' being exercised by RNs.
618. Within the Connecting Skill Set Sienna's work was also judged to be at the problem solving level for both negotiating boundaries and communicating verbally and non-verbally, so B1.3 and B2.3. She moved through the process, negotiating for the best outcomes for the patient given the news that had been revealed. She built trust with the patient by explaining the steps in what is now required, constantly engaged in active listening and observation to determine how she needs to adapt her communication to meet the needs of the patient. The observation leads her to change her communication approach to adapt to the shift in the attention span of the patient. Sienna (RN) is very conscious of translating the doctor's advice into terms that the patient can absorb and understand.
619. In the coding of the transcript only the overriding codes are allocated. In this case A1.3, A2.3, A3.3, B1.3, and B2.3 are the codes that were collated and incorporated into the Heat Map for RNs. The table below breaks down Sienna's (RN) work activity description showing the skill of deploying a complex 'cluster of skills' in carrying out this work activity.

Table 4:8: RN Case Study Three: Empathic alertness and communication

Sentences from Sienna's statement	Spotlight coding	Illustrative statements from Spotlight workbook (abbreviated)	Observations
<i>You just instinctively know, you just know, because you're a nurse. It's just things that you pick up.</i>	A1.3 A2.3	Piece together information and perspectives from various sources And 'Key in' to others' ways of thinking	Several RNs used the word 'instinctively' in their descriptions. This phrasing potentially masks the skills they utilise in their work.
<i>I think what happens is that we are a patient advocate.</i>	A2.3 B1.3	'Key in' to others' ways of thinking And Negotiate (e.g. for patients)	Sienna has a clear view of how she sees herself in her role and therefore how she performs the role.
<i>So we're very tuned into when our people are upset or we hear some bad news, and from experience we know that is bad news.</i>	A1.3 A2.3 A3.3	Use your knowledge to anticipate and avoid problems And using insights into reasons for difficult behaviour And Pick the right moment to convey unwelcome news	Sienna uses the phrase "tuned in". She uses active listening and then her accumulated experience to judge the impact of her work on the patient who may be distressed. We see her empathy with the patient.
<i>From experience we know that we can expect tears, or whatever from that. And you know it's to us it's sort of like 101. It's just basic like we would struggle for someone not to get it.</i>	A1.3 A2.3 A3.3	Use your knowledge to anticipate and avoid problems And Work in sensitive situations to help people maintain composure And Test your solution to a problem, by listening, observing and reflecting	Sienna is active in sensing the context anticipating the problem, "we can expect tears"; monitoring her own reaction to the needs of the patient, "it's sort of like 101" and solving the problem through listening, observing and reflecting, "it's just basic like we would struggle for someone not to get it".
<i>But it's amazing how many doctors don't get it, you know. They just come and drop a bombshell on a patient and say, Oh, okay, well, you know, that's come back. That's malignant. We're gonna have to start chemo tomorrow, and then off they go.</i>	A2.3 A3.2 C3.3	using insights into reasons for difficult behaviour And note early warning signs of an impending disturbance or that an approach is not working And Identify minor issues that have the potential to grow into bigger problems and act to prevent this	This is the comment that puts the 'invisible skills' that are evident in this work activity description into context. Sienna describes the skills as "instinctive" and a "struggle for someone not to get it". But in her view many doctors "don't get it", which is the clue that the skills are not instinctive, but learned and practiced

			because they are important to the nursing profession and to patients.
<i>And then you've got this person who's in a state of absolute shock</i>	A2.2 A3.2	pick up on and respond to small changes or early warning signs And note early warning signs of an impending disturbance or that an approach is not working	There is a clear expression of empathy for the patient; Sienna has seen this before.
<i>I knew Chemo might have been on but he's just said, we're starting it tomorrow. So, what does it mean?</i>	B2.2	Use active listening, reflecting and using silence to allow people to talk through their concerns	Having focused on the situation and the context, people's reactions and the impact of actions, Sienna moves into the communication phase. She needs to explain to the patient the processes that they will now move through and justify the timing.
<i>So you have to break that right down into simple language. Simple routine work when the person's been a bit overloaded.</i>	A3.2 A3.3 B2.3	note early warning signs of an impending disturbance or that an approach is not working And Test your solution by listening, observing and reflecting And Overcome communication problems by 'translating' (e.g. specialised terms), between experts, patients	She is observing the patient, carefully, noticing when her communication is not working, judging how to better communicate the significance of the unwelcome news and breaking down (or translating) the procedures into components that the patient can understand in their "overloaded" state.
<i>Come back to the conversation. If you're not capable of the conversation. Then make that call. What can we do? Let's get a relative in so that they can listen as well. So, you've got two sets of ears getting the information.</i>	A1.3 A3.3 B1.3 B2.3	Piece together information and perspectives from various sources And Pick the right moment to convey unwelcome news And Gain others' trust and consent by explaining each step of a process and its purpose And Adapt your communication	The culmination of the work activity is in the recognition from close observation that the patient is still not absorbing the meaning of the communication. This happens when the RN is keyed into how the patient is receiving the information. After reflection Sienna shifts and changes the communication pattern including bringing in another person.
<i>And then we can problem solve from there.</i>	C3.4	Bring routines and lines of work back together after they have been disrupted by an emergency	The denouement, as it is almost always in the examples we heard from RNs in the interviews, is how to get back to routine procedures

620. The use of the word 'instinct' is worthy of comment. It is a word that was used frequently by RNs during interviews. Referring to the ability to read and interpret situations and apply a range of skills as 'instinct' masks the skills that RNs exercise by suggesting that they are innate or natural. The nurses themselves may fail to recognise the skills that they have developed. From the analysis in Table 4.8 above I have compiled a short summary of the skills and knowledge that are 'instinctive' to Sienna in this work activity description

- Anticipation of the problem based on experience
- Reference back to past experiences to develop a plan
- Empathy with the patient's feelings about the news
- The capacity to provide answers to challenging questions about treatments
- Recognition that the patient may not be processing all the input
- Making a judgement call to bring in a relative to help.

4.7 Conclusions about RNs and Spotlight skills

621. Relying on the primary evidence set out in this section and from secondary sources included in chapter three I find that the work of RNs involves substantial incidence of the use of Spotlight skills across the 9 Skill Elements of the Spotlight framework. These skills have historically been overlooked and undervalued ('invisible') in job evaluation, job grading or work value assessments. Some skills, those included in the Spotlight framework, those that are particularly evident in female dominated care-based work, have been undervalued in job evaluation and work-value processes as they have been characterised as innate traits and thus often hidden, under-specified, under-defined, under-codified and under-recognised and thus rendered 'invisible'.
622. The Skill Set where the most instances were recorded was A, Conceptualising. Within Skill Set A the Skill Element with the most instances recorded for RNs was A1, sensing contexts or situations, with an average of 28.5 instances per participant. This reflects the requirement of RNs to play close attention, and respond to, the contexts (clinical, technical and social) within which their work is performed. This involves both sending and reading cues and signals and adapting knowledge of formal rules related to their work as well as the application of knowledge of social norms and rules. The ability to interpret cues and signals which is a feature of skill element A1 is an example of skills that are hidden, under-defined or under-recognised and thus 'invisible'.
623. The level at which Skill Element A1 was being exercised was most frequently at either problem solving (A1.3) or solution sharing (A1.4). These skill levels reflect that RNs are frequently required to interpret contexts to solve unfamiliar problems; piece together information and perspectives from various sources and use their knowledge of the job and the job context to anticipate and avoid problems. RNs work with colleagues to share

- techniques and information and approaches to interpreting contexts. Problem solving and solution sharing in this way involves skills that may be under-codified and thus 'invisible'.
624. The next highest level of recorded instances of activities was Skill Set C, Coordinating. Within that group of skills, sequencing and combining activities (C1) and interweaving activities with others (C2) were the Skill Elements with the most instances recorded for RNs (with averages of 16.2 and 18.1 instances per participant respectively). This reflects the key contribution the RNs in this study made to maintaining workflows; their own, others or the team. The ability to adjust one's own work, re-prioritise activities and to amend work arrangements more generally to get things done is a feature of Skill Elements C1 and C2. The skills associated with the ability to facilitate, (re)schedule, accommodate change and disruptions, track and systematise work are often overlooked as 'just doing the job'.
625. The ability to make these necessary adjustments is central to the role of RNs in this study. The levels at which Skill Elements C1 and C2 were being exercised was most frequently at either problem solving (L3) or solution sharing (L4). This reflects the role played by RNs in assessing the urgency and importance of relative calls on demands for their and others attention and reprioritising, all whilst ensuring safety standards and legal requirements are being adhered to. Sometimes referred to as the capacity to 'think quickly on ones' feet' these problem solving skills (L3) associated with work tasks and workflows are often under-codified and thus 'invisible'. They are integrative, bringing together the application of skills knowledge and experience to allow for seamless adjustments.
626. The RNs in this study were also involved in sharing methods for organising workflow and interweaving individual and team activities, using methods for recording and sharing information and contributing to the development of systems and the sharing of information. These are judged to be at level 4 of Skill Element (C1). Skills associated with adapting to changes in workflow, being effective in an emergency and creating opportunities for information exchanges are often under-codified and thus 'invisible'.
627. The work activities described by RNs in this study also showed high instances of the need to negotiate boundaries, Skill Element B1. For this Skill Element the data shows an average of 23.0 instances per participant. This Skill Element was exercised mainly at the level of problem solving (L3). Building a rapport and gaining trust with others whether they be other health care professionals, patients and their families was a feature of the work of RNs. At the same time as creating this rapport RNs also demonstrated the requirement to maintain boundaries that enabled them to say no to requests, whether from patients or from other health professionals that may be unreasonable or dangerous. Building rapport, being empathic or using diplomacy may be overlooked as skills being seen as something that comes naturally or be attributed to an individuals' personal attributes when in fact the ability to do this is an exercise of skills that are under-specified.

628. It was also apparent in the interviews with the 17 RNs across acute care, primary health care and mental health settings that the skills performed in the course of their duties are frequently clustered, i.e. skills are deployed not in isolation and in linear form but in combination and simultaneously. Three examples of this clustering are presented; the first 'Managing the safety of staff', the second 'Well informed and anticipatory action' and the third, 'Empathic alertness and communication'. As an example of the intensity of skills demonstrated by RNs, it is worth noting that in the first case study involving Aaron (RN and NUM), a team of trained coders identified 27 occurrences of Spotlight Skill Elements in Aarons description of his role in managing an emergency issue for the staff in the hospital Unit he manages. In the description the coding team identified 5 different Skill Elements at level 3 and a further 5 different Skill Elements at level 4, with multiple occurrences of many of those Skill Elements at those levels.
629. Work activities performed by RNs rely on the combined deployment of clusters of these under-recognised skills in combination with each other. Combining multiple skills simultaneously involves higher level thinking and reflexivity skills; engaging in these complex higher order tasks while performing physical tasks is itself an under-recognised skill.
630. The three different approaches to the data analysis; being a Heat Map, alignment of work activities with Skill Elements, and the Skill Cluster case studies show the hidden, under-defined, under-specified, under-codified and under-recognised skills, or in totality the 'invisible skills', that are demonstrated by RNs in the performance of their duties. Table 4.5 showing the relationship between the Spotlight skills and the typology of invisibility is the most obvious representation of the relationship.

5.0 Midwives

5.1 Introduction to MWs

631. I have been asked to apply the Spotlight tool to the work of Midwives (MW) to “identify, name and classify the ‘invisible skills’” used by MWs who participated in this study. To do this I conducted a Spotlight analysis, the details of which are set out in chapter two of this report, drawing on the descriptions of work activities provided by MWs who were interviewed for this study. This chapter includes the facts and information gathered from the 3 MWs interviewed which I have relied on to support my findings regarding the application of the Spotlight taxonomic framework to the role of MWs, the Primary Material. Where relevant I have incorporated information from Secondary Material referred to in chapter three.
632. The analysis in this chapter draws from the information about work activities provided by participants who were interviewed for this study. The transcripts from these interviews were reviewed and analysed against the Spotlight taxonomy. A coding framework that corresponds with the Spotlight taxonomic framework was developed to assist in coding the work activities described in the interviews with participants. Using this coding framework codes were allocated to the descriptions of the work activities provided by participants. Sometimes several codes may have been allocated to a work activity. Through this coding process the Spotlight skills that are present in the participants work were identified. The activities (and the skills associated with them) were named and grouped in relation to the Skill Element that they relate to in the taxonomic framework. An assessment of the Skill Level at which the skills were being performed was then made. (the research approach is set out in chapter two)
633. Drawing on the evidence and analysis set out in this chapter I conclude that the work of MWs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. A substantial volume of the work of MWs interviewed requires the use of skills that are hidden, under-recognised, under-defined, under-specified, under-codified and therefore likely to be undervalued on gender grounds.
634. The dominant skill when measured by intensity of incidences was Skill Set A - Contextualising. This was followed by Skill Set B – Connecting and close to that in terms of the intensity of incidences described was Skill Set C - Coordinating. The Heat Map provided below show the numbers of incidences in each Skill Set and Skill Element at level as coded from the transcripts of the interviews with the MW participants. The work activities described in the interviews showed MWs operating primarily across level 3 and level 4 of the Spotlight framework. Level 3 activities are characterised as ‘solving new problems’ and level 4 as ‘sharing solutions/applying expertise’. There was also evidence from the interview participants of MWs ‘expertly creating a system’ or operating at level 5 of the Spotlight framework. This higher level was most apparent in the Contextualising and Coordinating Skill Sets.

635. The limited examples of orienting and fluently performing skills is a reflection of the experience of the MWs who were interviewed. Each has moved beyond the orienting and fluently performing stages to problem solving and the higher levels. The exercise of skills at the higher levels is underpinned by the consolidation of skills and expertise at the lower levels which arises from learning about the dimensions of the role as experiences accumulate.
636. The chapter is set out in the following sequence
- 5.1 Introduction to MWs
 - 5.2 A brief review of the profile of MWs that draws on the detail in chapter three
 - 5.3 A snapshot of the demographics of the MWs interviewed for this study
 - 5.4 A representation of the data from the MW interviews in the form of a Heat Map and a Skills Table
 - 5.5 Selected examples of work activities provided by the MW participants aligned with the nine Skill Elements and levels of the Spotlight framework
 - 5.6 A discussion of the clustered deployment of skills that provides further insight into the complexity of the work undertaken by MWs.
 - 5.7 Conclusion

5.2 Profile of MWs in Australia

637. The Nursing and Midwifery Board of Australia (NMBA), reports that in 2024 there were 33,258 people who held registration as a MW in Australia (Nursing and Midwifery Board of Australia 2024a). Many MWs hold dual registration as set out in Table 5.1 below

Table 5.1: NMBA active registrations as MW

Practising Midwife (standalone qualification – not dual registered as a nurse) (Author calculation based on NMBA tables)	7131
EN and midwife (dual registration)	116
RN and midwife (dual registration)	26,001
Total registered with NMBA as MW	33,258

(Nursing and Midwifery Board of Australia 2024a)

638. Table 5.1 shows that the majority of registered MWs (78.2%) hold dual registration as a Registered Nurse (RN).
639. Australia changed its nursing and midwifery qualification and training structure in 1994. From that date all people commencing a MW qualification were required to complete a tertiary qualification from a university (see chapter three for a discussion of this change). Of the group of three midwives who participated in this study, two commenced nursing/midwifery training in the previous hospital based system. Both have since completed tertiary qualifications in

midwifery. The third participant qualified under the post 1994 system. There are multiple pathways to achieve registration as a midwife as set out in Table 5.2

Table 5.2: Pathways to achieve a MW qualification for NMBA registration

Midwife	Bachelor of Midwifery	AQF 7	Three years full time (or equivalent) at university	Students complete a minimum of 10 continuity of care episodes (antenatal, labour and postnatal care) with women and their families
	Master of Midwifery	AQF 9	Two years full time (or equivalent) at university in addition to a relevant Bachelor degree	
	Graduate Diploma of Midwifery	AQF 8	12 months full time (or equivalent) for current RNs seeking midwifery registration	

640. MWs must be registered with the NMBA and are required to renew that registration annually. One of the requirements for renewal is the completion of 20 hours of Continuing Professional Development (CPD). Those with dual registration must complete the required hours of CPD for each form of registration (e.g. 20 hours for MW registration and 20 hours for RN registration). An additional 10 hours of CPD is required for those who are endorsed MWs, as is one in the group of three.
641. The OSCA classification system used by the Australian Bureau of Statistics (ABS); and Jobs and Skill Australia (JSA) provides some limited additional information about the MW workforce (Australian Bureau of Statistics, 2024b). MWs are grouped with Registered Nurses (and Nurse Practitioners) as 'Midwifery and Nursing Professionals'. OSCA further differentiates specialisations for MWs as Clinical Midwife, Clinical Midwife consultant, Midwife Specialist and Endorsed Midwife. One of the MWs interviewed was an Endorsed Midwife. No other specialisations were reported by participants in the interviews.
642. At the time of writing the ABS was not reporting employment numbers in each of these OSCA midwifery specialisations. Jobs and Skills Australia draws data from different sources to the NMBA, at different times, and using different criteria, so there are discrepancies between the numbers reported by each organisation. It is not my intention to explore those differences here, but to provide the JSA data to further illustrate the profile of MWs in Australia. JSA reports that there are 21,100 MWs in employment in Australia. Of those 99% are female and the median age is reported as 42. Of those employed, 52% are working part time (Jobs and Skills Australia 2026).
643. In the literature I reviewed I was unable to identify national data for the care settings for MWs. In chapter three I reported the results of a study of the midwifery workforce that had

approximately 10% of registered MWs participating and which included data on the setting in which MWs worked (see Table 3.3).

644. The distribution of MWs across the country by state and territory and by geographic location is consistent with the general spread of population (detailed data is included in chapter three). The three most populous states, NSW, VIC and QLD, and coincidentally the three states represented by the MWs in this study, have 76.6% of registered MWs. Moving to geographic distribution, 69.8% of registered MWs report that they work in a metropolitan centre and 10.5% in a regional city. The remaining 19% are spread across rural, regional and remote settings. With a sample of three in this study the percentages carry little weight, but for the record, 66.6% work in metropolitan areas and 33.3% in regional cities.

Scope of Practice

645. The Nursing and Midwifery Board of Australia (NMBA) introduces the Scope of Practice Fact Sheet for MWs with the following

MWs graduate with a woman-centred approach to practice and an integrated theoretical and practice-based knowledge of care across the childbearing continuum. MWs have an in-depth scientific knowledge that includes the administration, supply and quality use of medicine relevant to midwifery practice. MWs have foundational skills in communication, relationships and management (Nursing and Midwifery Board of Australia 2023a)

646. The NMBA also provides a description of the work of MWs, including core activities

MWs work in partnership with women. MWs supervise student MWs and other healthcare workers and delegate activities from a midwifery plan of care. Examples of core midwife activities include

- antenatal care including abdominal palpation, performing clinical observations on mother and unborn baby,
- reviewing and ordering diagnostic and/or screening tests, and risk assessments from a clinical, health, lifestyle and psychological perspective
- intrapartum care including monitoring and support of women during labour, monitoring the foetus during labour and medication management
- birthing the baby, identifying variances to normal birth and escalating as necessary to specialist staff
- managing medication and IV therapy within the context of midwifery practice
- managing the third stage of labour, perineal assessment and suturing, facilitating initial mother and baby interaction, including skin to skin and breastfeeding support
- advising and supporting parents on the daily care of their newborn babies
- identifying where there may be concerns about the health and wellbeing of the mother and the newborn baby
- offering breastfeeding and nutritional support

- supporting parents who experience miscarriage, termination, stillbirth and neonatal death
- women's health, reproductive and sexual health, and child and family health care. (Nursing and Midwifery Board of Australia 2023).

5.3 Profile of MWs in this study

647. Three MWs were interviewed for this study, all were female. All participants held dual registration as MW and RN. All have multiple qualifications. As it is a small sample size I have set out the qualifications of each of the participants.

MW one

- Certificate qualification after hospital based nurse training
- Postgraduate Diploma in Midwifery
- Masters in Midwifery

MW two

- Hospital based nurse training (did not indicate if a Certificate was awarded)
- Diploma of Registered Nursing
- Graduate Diploma of Midwifery

MW three

- Bachelor of Nursing/Bachelor of Midwifery
- Masters of Primary Maternity Care

648. Two of the MWs in the group commenced their careers in nursing and midwifery prior to the introduction of compulsory tertiary qualification in 1994. Both have since added tertiary qualifications to their resume.

649. In addition to initial training and qualifications, one of the MWs is an endorsed MW authorised among other things to administer scheduled medicines. One MW is currently employed as an Associate Nurse Unit Manager (ANUM).

650. Three states are represented, being the three most populous states, Queensland, New South Wales and Victoria. Two of the MWs work in large metropolitan hospitals and the third works in a regional community setting, though employed by the public hospital system.

651. The group have diverse experience across public and private hospital settings. While in the interview they were asked to focus on their current role, there is little doubt that they brought to their current role the experience, knowledge and skills from previous roles. Once again because the sample size is small I have listed the work settings and years of experience for each of the three participants. It provides a good snapshot of the diversity of the group and the wealth of their experience.

MW one (40 years since commencing nursing/midwifery – active for 30 years)

- 9 years of nursing in public and private hospitals (no further details)
- 21 years in current MW role in a large private metropolitan hospital
- 15 years as a MW in public hospitals concurrent with work in the private hospital (recently exited that position).

MW two (44 years of nursing and midwifery experience)

- 22 years at a 'private facility' with 6 of those years as a NUM
- 9 years as a MW at a private hospital with primary responsibility for antenatal classes
- 13 years in current role as a MW in a large private metropolitan hospital, including the last 2 years as an ANUM.

MW three (8 years in nursing and midwifery)

- 6 years in public hospitals (not specified if nursing or midwifery or both)
- 2 years as a MW in a private midwifery practice
- Less than one year in current role working in a regional community based clinic, operated by the public hospital system.

652. There are over 33,000 people with MW registration with the NMBA. They represent 6.9% of the total nursing and midwifery workforce. The three MWs in this study brought to the interviews an extraordinary breadth and depth of experience across multiple care settings; public hospitals, private hospitals, private practice and a midwifery group practice. There is a combined total of 82 years of nursing and midwifery experience across the three MWs, with the great majority of that time in midwifery practice. Two of the group have 30+ years of experience, the third has 8 years. Within the group the presence of a MW employed as an ANUM and another who is an endorsed MW enriches the narratives brought to the interviews. All three have tertiary qualifications including two with Master's degrees, which suggests a deep theoretical knowledge to accompany their practical experience.

653. Two of the three MWs in this study currently work in hospital settings. The third works in a community clinic but is employed by the state hospital system. None of the group are currently working in private practice, though one was working in such a role until the end of 2024. None of the MWs interviewed for this study reported having worked in family and maternal child health roles or in policy, education or research roles, which are the other typical places of employment for MWs.

5.4 The Spotlight framework and work activities of MWs in this study

654. In the following section I set out the incidence of reported activities for each Spotlight Skill Element at each level. The method of identifying and classifying these activities is discussed in chapter two.

Spotlight Heat Map and analysis

655. A Heat Map is presented below to visually show the patterns of intensity and complexity of ‘invisible skills’ utilised. The Heat Map was compiled by tallying the incidences of Spotlight skills (at level) present in the work activities of each MW participant and then averaging that number across the three MWs in the study.

Table 5.3: MW Spotlight Skills Profile

Midwife Spotlight Skills						
Skill Element	1. Orienting	2. Fluently Performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A Contextualising	0.0	8.7	32.7	21.7	3.7	66.7
A1. Sensing contexts or situations	0.0	5.0	12.0	10.3	2.0	29.3
A2. Monitoring and guiding reactions	0.0	2.3	10.7	6.7	1.0	20.7
A3. Judging impacts	0.0	1.3	10.0	4.7	0.7	16.7
Total B Connecting	0.0	3.3	19.0	26.3	1.0	49.7
B1. Negotiating boundaries	0.0	2.0	11.3	20.0	0.3	33.7
B2. Communicating verbally and non-verbally	0.0	1.3	6.0	2.0	0.0	9.3
B3. Working with diverse people and communities	0.0	0.0	1.7	4.3	0.7	6.7
Total C Coordinating	0.0	4.3	24.7	12.7	2.0	43.7
C1. Sequencing and combining activities	0.0	3.0	9.3	2.0	0.3	14.7
C2. Interweaving your activities smoothly with those of others	0.0	1.0	8.3	6.3	0.7	16.3
C3. Maintaining and/or restoring workflow	0.0	0.3	7.0	4.3	1.0	12.7
Average per Participant Incidence	0.0	16.3	76.3	60.7	6.7	160.0

656. Table 5.3 shows the average incidence of the Spotlight skills drawn from the description of work activities given by MW participants in their interviews. The incidences set out in Table 5.3 show that the work of MWs involves performing work activities across the nine Skill Elements of the Spotlight framework. Each of the nine Skill Elements from the Spotlight framework is evident in the work activities described by the MWs who were interviewed.
657. The dominant Skill Set when measured by intensity of incidences described was Contextualising, with an average of 66.7 incidences per person. This was followed by Connecting with 49.7 incidences per person and close to that in terms of the intensity of incidences described was Coordinating at 43.7 per person. The work activities described in the interviews showed MWs operating primarily across level 3 and level 4 of the Spotlight framework. These levels are classified as 'solving new problems' (L3) and 'sharing solutions/applying expertise' (L4). More than 85% of the incidences described by the MWs were coded at these two levels. There was also evidence from the participants of MWs engaged in 'expertly creating a system' judged to be at level 5 of the Spotlight framework, with an average incidence of 6.7 per person at L5.
658. The Heat Map shows a heavy concentration of incidences at levels 3 and 4 of the Contextualising Skill Set, with all three Skill Elements, 'sensing contexts and situations', 'monitoring and guiding reactions' and 'judging impacts', being in the top four for average incidences per person, 29.3, 20.7 and 16.7 respectively. These three Skill Elements represent over 40% of the average incidences per person across all 9 Skill Elements. That data suggests that it is frequent work for MWs to be reading the context for their work including the physical environment, the social connections between people, including colleagues and patients, and the clinical events for the ante-natal, birthing and post-partum women.
659. Further the Heat Map shows that the three MWs who were interviewed were applying these skills at a high level; they were 'problem solving' and 'sharing solutions' with colleagues, having moved beyond level 1 'orienting', and level 2 'fluently performing'. At these higher levels of performance MWs are using their knowledge to piece together information enabling them to anticipate and avoid problems. They are listening, reflecting and observing in search of solutions to problems and making judicious choices about when to intervene. MWs also move into sharing solutions through building networks, creating environments for feedback and being open to challenge issues with which they disagree. They are alert to the needs of the emotional pressures on co-workers.
660. This skill set of Contextualising is particularly important given the unpredictability of a Maternity Unit and the unpredictability of the arrival of a baby (on most occasions). MWs need to be constantly on alert for changes in the stage of a woman's pregnancy and the health of the baby. In the work activity examples provided in section 5.4 of this chapter, I

present examples of MWs conducting ‘corridor assessments’ of women entering a hospital, of MWs sitting with a woman for a few minutes and being able to assess at what point she was in her labour; and another where a simple change in the sound of a woman in labour was an indicator of a new stage. These are living working examples of the ‘invisible skills’ exercised by MWs who are sensing the contexts and situations in which they are operating.

661. Table 5.4 below shows that the skills being performed by MWs that were coded against Skill Set A - Contextualising are under-recognised, under-codified, under-specified, under-defined and hidden, all examples of skills that are ‘invisible’ in job evaluations.
662. The second highest average incidence of skills was in Skill Set B - Connecting. The Heat Map shows an average of 49.7 incidences per person across the three Skill Elements in this set. The highest overall average for a single Skill Element was for B1 - ‘negotiating boundaries’ with an average of 33.7 incidences per person. The Heat Map shows an intensity of occurrence around levels 3 and 4 for the Skill Element – ‘negotiating boundaries’, and level 3 for the Skill Element - ‘communicating verbally and non-verbally’. This suggests that MWs are regularly using communication skills at a high level to solve new problems and share solutions through the application of their own expertise.
663. In Table 5.4 below, we can observe that the skills exercised by MWs at Skill Element B1 are classified as under-specified, under-codified and hidden.
664. The final Skill Set - Coordinating, has an average of 43.7 incidences per person. The spread across the three Skill Elements in this group was relatively even. The Skill Element C1 - ‘sequencing and combining activities’, averaged 14.7 incidences per person while Skill Element C2 - ‘interweaving activities with others’, averaged 16.3 incidences per person. The final Skill Element C3 - ‘maintaining and/or restoring workflow’, averaged 12.7 incidences per person. There is a density of incidences at level 3 across all three Skill Elements. There is also a relatively high incidence per person of 6.3 at level 4 of ‘interweaving your activities smoothly with others’, (C2.4).
665. This coding outcome for Skill Set C suggests that MWs are assessing the urgency of calls on their time, reprioritising and thinking quickly on their feet. They are checking that legal and safe procedures are being used and monitoring each step of a process. They are checking on the safety of their co-workers. When maintaining or restoring workflow is considered, then MWs are identifying minor issues that may grow into bigger problems, they are managing the conflict between organisation requirements and patient needs and making time for caring listening and interactions amidst intense work pressures.
666. The skills at level 3 of Coordinating are under-codified, under-specified and hidden. These are typically the skills that allow a person to interweave all of the other skills required to perform a task. (This will become more evident in the case studies of ‘clustering skills’ that are set out

in section 5.6 of this chapter). MWs will rapidly sequence, switch and combine activities even in the midst of carrying them out. When skills are under-specified, under-codified or hidden they may be ‘invisible’ when assessing the value of a work role. However, to the pregnant and post-partum women they are essential skills to enable the safe delivery of a child and the health of the woman. They are also the skills that describe the support that MWs provide to women who have pregnancies terminated or whose babies do not live. Some of these examples are from the MWs are also recorded in section 5.5 of this chapter.

Spotlights skills and the typology of invisibility

667. To provide an overview of the link between MWs work activities, Spotlights skills and the typology of invisibility I have included Table 5.4. This Table provides examples of work activities engaged in by the MWs illustrating the use of Spotlight skills by MWs. The relationship of these activities to the typology of invisibility is also noted. The average incidences of the Spotlight skills at each level, for each Skill Element is also used. In section 5.5 of this chapter more detailed examples of these work activities are included.

Table 5.4: Typology of invisible skills and Spotlight Skill Elements for MWs

Skill Element	1. Orienting	2. Fluently performing	3. Solving problems	4. Sharing solutions	5. Expertly creating a system
A1. Sensing contexts or situations	0.0	5.0	12.0	10.3	2.0

L2 Adapt to the interaction styles and needs of each different patient (UR)

L3 Use knowledge of the job and internal and external contexts to anticipate and avoid problems (UC)

L4 Use techniques for exchanging rapid situational updates with colleagues and to convey information from a range of sources (UD)

L5 Use understanding of the organisation's priorities to influence policies and help shape systems (H)

A2. Monitoring & guiding reactions	0.0	2.3	10.7	6.7	1.0

L2 Quickly pick up on and respond to small changes or early warning signs in, patients, carers or family members or work colleagues (H)

L3 'Key in' to others' ways of thinking to filter information according to how it will be received (US)

L3 Solve problems by using insights into difficult behaviour, e.g. responses to pain, fear, shame (US)

L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)

A3. Judging impacts	0.0	1.3	10.0	4.7	0.7

L3 Test your solution to a problem, by listening, observing and reflecting (UR)

L3 Help patients feel at ease whilst carrying out activities that may worry or distress them (UD)

L4 Constructively challenge practices that may compromise the safety or dignity of others (H, US)

B1. Negotiating boundaries	0.0	2.0	11.3	20.0	0.3

L2 Provide support unobtrusively to help others maintain composure and independence (H)

L3 Gain others' trust and consent by explaining each step of a process and its purpose (US)

L4 Build and maintain networks of relationships with people outside immediate work group (UC)

L4 Constructively give and receive feedback in unequal power situations (H)

B2. Communicating verbally & non-verbally	0.0	1.3	6.0	2.0	0.0

L3 Adapt the content of your communication to the varying attention spans of different listeners, interpreting-cues to pace information (US)

L4 Help non-experts solve administrative or technical problems by providing explanations using familiar examples and language (H)

B3. Working with diverse people & communities	0.0	0.0	1.7	4.3	0.7

L3 Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or similar conditions (H, UD,UC)

L4 Listen and observe attentively to key into the unspoken aspects of interactions based on diversity including another language, culture, sexuality, ability etc. (UC)

C1. Sequencing & combining activities	0.0	3.0	9.3	2.0	0.3

L2 Work out slotting each activity into the day, attend to a number of tasks or patients at once (UC)

L3 Think quickly on your feet as new problems arise during an activity (UC)

L4 Exchange ideas with colleagues for more effective management of workflow (UC)

C2. Interweaving activities smoothly with others	0.0	1.0	8.3	6.3	0.7

L3 Check your own and co-workers' safety in responding to difficult situations, whilst avoiding pressures to react before thinking (UC)

L4 Have in place, and be able to activate, support networks for quick and calm response to emergency or other changing contingencies (H, UC)

L4 Develop and use shared information exchange systems, such as mental maps, flow-charts, coding systems, templates or automated spreadsheets (UC)

C3. Maintaining &/or restoring workflow	0.0	0.3	7.0	4.3	1.0

L3 Make time for caring listening and interactions amidst intense work pressures (US, UC)

L4 Quickly notice and adapt to changes in the workflow, cooperating to prevent or de-escalate stressful or dangerous situations (UC)

L5 Build and maintain backup systems in case of system breakdown (UC)

Legend: H	Hidden Skills
UD	Under-defined skills
US	Under-specified skills
UC	Under-codified skills
UR	Under-recognised skills

668. Table 5.4 provides examples of activities illustrating MWs' use of Spotlight skills across the 9 Skill Elements.

5.5 Aligning MW work activities with Spotlight Skill Elements and Levels

669. In this section I have used examples drawn from the Primary Material to illustrate the relationship between the work activities and the Spotlight framework. Whilst an example has been used to illustrate a single Skill Element this does not mean that this example is only illustrative of that Skill Element. An example drawn from the Primary Material may have been coded to multiple skill elements. Examples showing the clustered deployment of Spotlight skills by MWs are contained in the case studies at section 5.6 of this report.

670. MWs work in partnership with women from the ante-natal stage through the delivery and the immediate post-natal phase. They are the coordinator and link person across the health services that a woman will need during pregnancy, delivery and post delivery. Amy (MW) captured the centrality of the role

So the midwife will look after the women antenatally, intrapartum, through labour and postnatally. So they are the lead providers in that scenario. So they will do absolutely everything. Now, if it varies from the normal, there will be medical input. So yeah, the midwife does everything like she was able to ... we're the main contact with the patients and the women and their families. That is given to us to deal with, because we're the main contact with the patient ... other colleagues, other health care workers. Yeah, everything seems to be coordinated by the midwife - Amy, Midwife

A1 Sensing contexts or situations

671. The first skill group is Skill Set A which involves contextualising and shaping awareness. This refers to the ability of a worker to understand, perceive and respond to context, monitor and guide reactions (the workers' and others), and judge what is happening and consider the implications, impacts, outcomes or consequences of particular circumstances or contexts.

These skills of sensing context and situations are often under-defined and thus invisible in classification structures and job evaluation processes.

672. The focus of Skill Element A1 is on the ability of the worker to perceive, interpret or read work or social contexts and situations. These contexts and situations include workplace and social roles, rules, resources, regulations, risks, conditions and emergency situations. Activities coded at levels 3 and 4 in the Spotlight framework were the most numerous for MWs in this study. For MWs this can include knowing the detail of what should or should not be happening through pregnancy, delivery and post-partum experiences, and 'reading' the women for whom they are providing care. These level 3 and 4 activities were underpinned by MWs fluent use (L2) of knowledge of the role and the context in which the role is performed.

A1 - Level 2 - Fluently performing

673. MWs fluently performing in their role (L2) adapt and apply knowledge gained in and outside of the workplace and adapt their interactions to the needs of each woman. MWs responded to a wide differential between women's knowledge about pregnancy, birth and general health

I've found that people ring more than they used to. Women have higher expectations of you – especially about you being present at their birth. I find more people want more information/education than previously which makes appointments tend to be lengthier. There is also more and more medical intervention in pregnancy and birth. More women are requiring more scans and tests which need to be monitored. They are also being induced more often, which tends to be longer birth suite shifts. - Amanda, Midwife

674. At the other end of the spectrum, some women had low levels of knowledge about their own body and health literacy which called for a different approach by the MWs

I mean I haven't been in the profession that long, but I even in my time I feel like it's getting worse ... they seem to understand less and less their own bodies. Which is, I find, fascinating because you know more information ... people have been having babies for like aeons, you know, like, I had to explain to someone about, you know, the fact that their vagina and the urethra aren't in the same spot, you know, like things like that. But even things like nutrition, you know, like somebody thinks that because they deep fried their chicken nuggets at home and didn't buy them at McDonald's it's healthier. - Amanda, Midwife

Meeting the needs of women across this spectrum has increased the demands on MWs.

Changing requirements in a work role can lead to skills being under-recognised.

A1 - Level 3 - Solving new problems

675. Building knowledge about each woman and adapting to their needs also applies in the delivery room as Amanda (MW) explained

You go in there knowing the woman, you know what she wants, and then you know what's generally out of character for her or whatever, so that definitely helps when you're

in that kind of vulnerable moment with them. But the birth suite's a big example of reading someone, and I think that's what makes MWs invaluable is that you can sit there in a room and assess someone without having to do anything which is not what doctors do ... we can sit there and watch someone for 10 minutes and we kind of have a good idea of what's happening. - Amanda, Midwife

In this work activity Amanda (MW) pieced together information to meet the health needs of this woman. She drew on her knowledge of the woman from previous encounters (pre-natal appointments) and she drew on her knowledge and experience – “you can sit there in a room and assess someone without having to do anything”, to understand what is happening. This is an example of an under-defined skill. Amanda's ability to read the patient is a skill that has been initiated through her tertiary study, developed and refined from her years in the role and her willingness to learn from others, but it must still be exercised in the context of each individual woman. This is a complex task to assess a woman at this stage of labour. The tactile skills and tacit knowledge that allow it to happen are difficult to measure and so may be ‘invisible’ when MW job assessments are undertaken.

676. In another example Amy (MW) was explicit about the problem solving path that she followed

If you get a woman coming with some abdominal pain, you know, we sort of have to gather pieces of information. Basically by clinical examination, you know, examining the woman's abdomen and obviously getting her history, which is not always very accurate. Sometimes when women are in pain, they're not very accurate with their stories because they're finding it hard to concentrate and give specific detail. So once we get all that, the obvious clinical signs, we may perform tests like urine analysis. Say she came in with abdominal pain, we did a urine analysis to see whether she's got something else that's making her uterus irritable. See if her tummy is soft all those sort of pieces, and we put them together to solve the issue of what is actually going on. - Amy, Midwife

In this work activity example, Amy (MW) solved the problem by sifting through the details of clinical tests enhanced by her own observations, to identify the issue for the woman.

A1 - Level 4 - Sharing solutions

677. Amy (MW) described an activity that was characteristic of level 4 of the Spotlight framework

... obviously, we would get input from other colleagues and tests that we can perform on the spot, because we've got to make a pretty quick assessment of what's going on, because it could be something quite dire or sinister that needs immediate action and monitor the baby, etcetera, and then obviously input from the obstetrician. So we gather all that information first, and then we would contact an obstetrician and escalate that and say, this is what we found. What do you want to do? - Amy, Midwife

Having made a judgement, and shown awareness of the context, “it could be something quite dire or sinister”, Amy (MW) then exchanged information with two peers. Initially she obtained

input from a colleague, looked at possible solutions, and then she consulted with an obstetrician shared the situational update and sought advice about next steps. Seeking and sharing solutions in specific contexts i.e. the situation of this particular woman is an under-codified skill. The MW is rapidly sequencing, switching and combining activities under the cloud of there being something “dire or sinister that needs immediate action”.

A1 - Level 5 - Expertly creating systems

678. Amy (MW) has more than 30 years of nursing and midwifery experience, including 21 years in her current role. She had a good understanding of how things should be in that setting and what effective operation should look like. When issues arose that were of concern, Amy (MW) escalated those issues to the Director level to bring about system change

I've actually been down to the Director of Clinical Services and spoken to her about ways of changing things, and they've taken those on board because we've had a lot since we lost our manager and birth unit. There's been a lot of problems with the task she did, and about redistribution of the task she did to MWs already on the floor, which has increased our workload. So I've been down to address issues with workload. - Amy, Midwife

Amy (MW) used her knowledge of the organisation to influence a policy change to help staff manage workload. Work activities coded to this Skill Element (A1) and this level are typically hidden skills. Work is done behind the scenes, in this case by a very experienced MW, to bring about change in procedures and systems to improve workflow across the Unit; in this particular case to rectify issues created by a previous manager. The process is hidden. Amy (MW) has sufficient informal authority to go straight to the Director of Clinical Services to propose the change. The skills are hidden because unspoken workplace conventions prevent this type of skill being included in a job evaluation process. However, if the skills were not performed then staff would continue to suffer under a problematic workload.

A2 Monitoring and guiding reactions

679. The focus of Skill Element A2 is on the ability of the worker to monitor and guide their own and others' reactions. Midwifery offers a particular relationship between midwife and the woman, a close relationship that is unlike any other in the provision of health care. The MWs interviewed explained that to be truly effective in their role they needed a deep understanding of the women they work with and their responses and reactions. They needed to monitor and guide their own reactions in complex scenarios, whilst also looking to the needs of their colleagues. These measured interactions all occurred as they worked toward solutions to complex ante-natal, delivery, and post-natal experiences.

A2 - Level 2 - Fluently performing

680. Level 2 activities, where a midwife is fluently performing her duties include being alert to the needs of each woman they work with, picking up on small cues even from the first encounter

Every person that walks into the room is different. And I think what makes a good midwife is knowing what they need from you like some women, they will need absolutely bare minimum. They just want you there and like, I just hang out and I do a lot less. Other women, they need me in a far more intensive capacity. Some of them I have to provide a lot more emotional support. Every single person is different. - Amanda, Midwife

That apparently relaxed demeanour, “I just hang out”, should not be mistaken for not being acutely aware of the events happening in the room. This work activity is another example of Amanda (MW) exercising a skill that is under-defined. Amanda (MW) plays down the skill, even as she describes making very careful observations about the woman and her progress through labour. There were also formal observations and Amanda (MW) would have noted and interpreted those. What is under-defined is the capacity to adjust accepted procedures to care for the particular needs of the woman, each and every woman that a MW engages with. Amanda’s description gives an insight into the application of midwifery skills in the context of the lived experience of a metropolitan hospital.

681. Amy (MW) highlighted the importance of responding calmly to small changes and early warning signs

So you just need to really be very attentive and not miss anything, and I think sometimes they're [MWs new to the profession] not aware what the repercussions are of some subtle changes that you might not act on them, but you need to know. You've seen it before. You think, Oh, I'm not happy about this. They don't recognise that. And the skills, I guess to me it's second nature. The skills are required and the actions required. When I have an adverse event or something not going with that pathway. I just go into that cycle.
- Amy, Midwife

Amy (MW) framed this work activity in terms of the difference between how an experienced MW acts and responds and the signs that might be missed by a MW who is new in the role. Amy’s own language about her work suggests that even the people who perform the skills do not always recognise the skills nor can they explain what they do. She describes her response as ‘second nature’. When this happens, skills are under-specified; they are accepted as natural or innate and not ‘unpacked’ to identify the range of skills that are being performed. Amy (MW) follows up by saying, “I just go into that cycle” and her own language hides the knowledge and skills that she possesses. Skills are made ‘invisible’ by this language.

A2 - Level 3 - Solving new problems

682. The Primary Material shows the MW keying into the experience of the woman they were working with. This building of empathy with the woman is represented on level 3 on the Spotlight framework. Amanda (MW) related this example about a woman who initially wanted a home birth, but changed her mind

I managed over the course of her pregnancy, to build trust in me, in that I will provide the care, the way that she needed it. Luckily she was low risk, and there was no problems, because that would have been an absolute nightmare. But I managed to get her to trust me and build trust in me, so that she did come into hospital and have a baby in the hospital rather than at home by herself. - Amanda, Midwife

- Amanda (MW) built a relationship with this woman, a relationship of trust. She mentions 'trust' three times in this example. The trust emanates from active listening to what the woman wants from the birth experience and considered communication on Amanda's part to keep the woman informed about the benefits of all options. This is an example of an under-specified skill. Amanda (MW) through patience and persistence built trust that ultimately led to this woman making a decision that was safer for herself and her child. The relationship skills used by Amanda (MW) have, particularly in female dominated care-based work such as midwifery, often been undervalued in job evaluation and work-value processes. They have been characterised as innate traits and thus often under-specified and rendered 'invisible'.
683. MWs listened for issues that were not directly related to the pregnancy but may have had an impact on the woman and her child. Amanda (MW) was solving problems using insights into reasons for behaviours

... every booking and visit you have to ask them about there's little tools that we use that screen them for sort of domestic violence and all that kind of stuff. But it feels a little unknown, because this is person you've never met before, you know, and I don't know that I would tell everyone my deepest darkest secrets so often what we use some of those tools throughout the pregnancy, and you have some people that you just know you're not going to get the right answer, you know, day one. So sometimes you revisit them throughout the pregnancy, particularly if you have concerns. - Amanda, Midwife

Amanda (MW) used "tools" to make subtle inquiries of the woman about her situation, looking closely for any reactions that might give Amanda more information about the presence of domestic violence. Her experience guides her, prompting her to come back to this conversation over time. At the same time her reflexivity leads her to acknowledge that she would be reluctant to reveal her 'darkest secrets'. The "tools" that Amanda (MW) references require skills to be implemented. These skills include among others active listening, observation, deep knowledge from training, experience with signs of gendered violence, persistence, and a commitment to the wellbeing of the women and her child. When phrases such as "use tools" are not unpacked in job evaluation processes then the skills that are utilised, such as those I have listed above remain 'invisible'. Because they are under-specified they can be mischaracterised as innate personal traits.

684. The Primary Material shows that each encounter is a two way encounter between the MW and the woman. It is particularly important for the MW to constantly monitor themselves. Amy (MW) projected an image of calm for the pregnant woman, but also modelled this behaviour for junior staff she was working with

I guess a more junior midwife you know, they're gonna be really really stressed, I mean, don't get it wrong. I'm really stressed, too, sometimes. But I don't act stressed. I always look like I'm calm, a skill I've developed. - Amy, Midwife

In this example Amy (MW) explicitly acknowledges that the calm is “a skill I have developed”. It is a more complex skill than simply making a decision to be calm. Amy (MW) is exercising the skill of emotion management. She is managing her own emotions to create the safest environment for the women and in this case the junior midwife. The projection of calm to reduce anxiety for patients is an under-specified skill. When a skill is under-specified and complex to measure it may lead to the work being undervalued.

685. MWs who were performing at level 4 of this Skill Element demonstrated an alertness to, and helped manage co-workers emotional pressures, strengths and needs. This is an aspect of midwifery which according to Kate (MW) changes with experience and has changed over time, as she described in the following examples

They (junior staff) don't want to communicate with the medical staff, they're quite scared of their medical staff and I actually encountered this last night where a junior member of staff wouldn't even ring a doctor for a basic drug order because she was scared of the doctor. - Kate, Midwife

Something that's happened in recent times is the increase in mental health issues with our staff, not just our patients, but our staff and some of them don't cope with certain situations, and we've had to manage those staff during a shift to get them through the shift and get them back on track. - Kate, Midwife

686. Given the pressure and the potential risks to women and babies through all stages of the delivery process, it is essential for MWs, as the health practitioner directly supporting the woman through the full birthing experience, to be fully focussed. Experienced MWs such as Kate (MW) accept responsibility for monitoring their colleagues to ensure they are switched on to all aspects of their work. This is an example of the integrative skills performed by MWs that are under-codified ‘invisible’ skills. The ability to look out for the other, to interweave tasks with a colleague who is experiencing difficulty and needs support; these are the integrative skills that allow workflow to continue and in this case pregnant and birthing women to be cared for safely.

A3 Judging impacts

687. The focus of Skill Element A3 is on the ability of the worker to judge the impact of their work. For RNs that impact may be on patients and/or on their colleagues. Judging impact is one of the Skill Elements grouped under Contextualising, so it involves judgement of actions in the context of the work. There are many ways to judge impacts but reflexivity, or the ability to reflect on your own practice, is at the core of this Skill Element in the Spotlight tool.
688. The work activity from Amy (MW) showed her performing at multiple levels of the A3 Skill Element. At each level there was a reflexive element. In the description Amy (MW) reflected on her practice, almost rehashing a conversation she had had with junior staff members. Her reflection demonstrated movement through the Spotlight levels

So I go through that with some of the junior staff, or the students, that we've got to make decisions very quickly. Sometimes the obstetrician, you know, you might have called them for the birth, and they're not there, and sometimes that's fine, and you know the baby comes out. It's all good. That's fine. A midwife can deliver a baby, so that's no issue. Sometimes there's complications, you know, and you've got no doctor there. The baby's, you know, sitting on the peritoneum for too long, and you've got to make a call, you know. You perform an episiotomy. You know I did that other week performed episiotomy, and lucky I did, because she had a big vaginal wall tear, and that would have been even worse if I hadn't done that. And you've just got to make those decisions sometimes. You know, you've got a woman involved, too ... - Amy, Midwife

Amy's practice began at level 2 where she noted early warning signs, "we've got to make decisions". The recognition of the early warning signs is an example of an under-defined skill, Amy had reached operational fluency as a MW and her tacit knowledge and immersion in the work meant that the complexity of the skills she exercised were not fully explained in the description. In her own words, "It's all good. That's fine". Her own confidence in her skills is an example of the performance of judging impacts at level 3, the level of problem solving. Amy (MW) says, "A midwife can deliver a baby, so that's no issue". At some stage she was going to have to communicate the potentially unwelcome news to the birthing woman, that the obstetrician was not going make it to the birth, and at the same time reassure her that as a midwife she could deliver the baby safely. She knew the importance of putting the patient at ease. Amy's description shows examples of under-specified and under-defined 'invisible' skills. Amy (MW) also described actions that were coded at level 4. She summarised her own understanding of what was happening for the woman. Typically, she would have "called the obstetrician" before making a decision to act. She described how she was required to intervene in a complicated birth. She narrated the activity in the interview as if she was sharing solutions with her colleagues, the junior midwives. Throughout the activity she was conscious of ensuring that her own projection of calm protected the woman from distress;

captured in her statement “You know, you've got a woman involved, too”. The skills she demonstrated are examples of hidden and under-codified skills. Amy herself hides the skills behind her statement ‘A midwife can deliver a baby, so that's no issue.’ The knowledge and the skills behind this understated comment about midwifery are ‘invisible skills’.

A3 - Level 3 - Solving new problems

689. I observed similar skills exercised by Amanda (MW) in these two activities

... obviously detecting things early is ideal, because then you can hopefully either stop it before it happens. But also it gives you time to kind of discuss with the woman that, Hey, I'm a little bit concerned about this. Nothing to worry about at the moment. But I'm going to just tell the doctors, because something might happen. You can kind of introduce those early kind of conversations. - Amanda, Midwife

And

... trying to stay as calm as I can, detecting things as early as I possibly can, and getting the people involved that need to be involved as early as I possibly can, as well as having really good open communication with the woman and her family. To try and keep them kind of in the know of what's happening. You know, the last thing you need is to be sitting on something you're worried about, and then having to press a big red button and a thousand people walk in right? Well, I mean, that's gonna be scary for any family. But if you do that kind of work a little bit earlier. They can kind of understand and comprehend why? - Amanda, Midwife

The capacity to project calm in difficult circumstances engages a complex set of skills—to note and act on early warning signs, know how to prepare a woman for key transitions, have the emotional maturity to empathise with the other person and therefore make good decisions about what, to know how and when to communicate unwelcome news or information about procedures that may be likely to distress the person. These are also skills developed from the reflective practice that is evident in the description from MWs that were interviewed. There were multiple examples of MWs reviewing practice collectively in pursuit of improvement (an example follows in the L4 examples of this Skill Element). Work activities such as those relayed by Amanda (MW) need to be unpacked to define the skills that are being implemented. It is common to describe the work as ‘innate’ or ‘natural’ meaning that the skills are under-specified ‘invisible’ skills. Using terms such as ‘innate’ or ‘natural’, particularly ‘natural for women’ has led to the undervaluation of jobs where women are the majority as with midwifery where 99% of MWs are female (Jobs and Skills Australia 2026).

A3 - Level 4 - Sharing solutions

690. The evidence from the MWs who were interviewed is that MWs work collaboratively to achieve the best outcomes for the women with whom they are working. The collaboration extends to medical specialists as Amy (MW) explained

So the consultant we would call them and get instruction on what they wanted to do after we'd assess the patient. So we always assess women first, and then we ring the obstetrician and ask them what other [indistinct] they would like, or what actions they would like. - Amy, Midwife

691. At other times, MWs create supportive environments in which they give and receive feedback in pursuit of better practice among their own peers

We're always discussing patients that have come in. And we're always interested in what happened to them and what worked and what didn't work. And we're always sort of networking on that between each other. Some of us go on workshops or you know, develop our skills. And we share those ideas to try and share ideas at work, too, about things that we find things that don't. We have safety huddles every day, and we find that certain things are not working within our workspace. So we network that and we come up with a better solution for that problem rather than continue on with the same old thing that's not working - Amy, Midwife

Amy (MW) emphasised the constant learning that was occurring among the MW teams through the exchange of information and reflection on “what worked and what didn’t”. The MWs were open to changing practice where it was demonstrated that a change would improve outcomes. Judging one’s impact in sharing solutions is an example of an under-codified skill. The ability of a person to reflect on and modify their own actions thinking back to purpose and ahead to outcomes can be ‘invisible’, yet it was the most common form of learning and prompt for improving practice that I observed in the MW interviews.

A3 - Level 5 - Expertly creating systems

692. The Primary Materials provided evidence that for MWs the pursuit of improvement in practice can go beyond their own procedural techniques to focus on improvement at a system level. Amy (MW) spoke of her experience

I've been monitoring the bookings at our hospital. I do these things. They're not my job, but I do them because I'm interested in improving our service ... so we're already struggling with staff and skill mix and for some reason our bookings have gone up and this is gonna have a huge impact on our organisation and our flow through. But they have no, plan to deal with this and I asked them, in fact, I had a meeting with the chief nurse of our organisation because of some adverse outcomes we had, and I escalated it. And I got myself a meeting with her. And I said, our numbers are going up like 30% for the next 3 months. What is the plan? - Amy, Midwife

As an experienced MW, Amy took responsibility for promoting improvements. Initially she evaluated the workflow and the staff allocations in the Unit. She identified a problem and then advocated for change. She persisted in the face of passive resistance from those in charge of these systems. This is an example of skills that are under-recognised. The activity

described by Amy (MW) was unlikely to appear on a job description, among other things, it was work done on her own initiative. But it was this activity by Amy (MW) that led to the identification of “adverse outcomes”. Her persistence led to a meeting with a decision maker, the chief nurse, where she was able to present the case for change to prepare for the shifting population dynamic. The sequence of skills demonstrated by Amy (MW) to bring about the system improvement under-recognised ‘invisible skills’.

B1 Negotiating boundaries

693. This Skill Element of the Spotlight framework investigates how workers negotiate boundaries between patients, co-workers and management; it explores the skills of interacting and relating. This Skill Element had the highest average incidence per person of the nine Skill Elements demonstrated by MWs. It is a skill that MWs exercise frequently.

B1 - Level 3 - Solving new problems

694. The MWs in this study identified themselves as being the central health practitioner in the service provided to women. It is the MW who coordinates, navigates and negotiates a pathway through the system for the women for whom they are caring. Amanda (MW) described her understanding of her role advocating and negotiating for women

So for me, building rapport with women is getting to the crux of what it is that they need. And then I look at myself as kind of like a bit of like a what's the word? A middle ground between the woman and the system. So I can kind of liaise for her on her behalf, and, you know, tap in and tap out for her as she needs. You know navigate that with her, so that you know they get what they need. - Amanda, Midwife

There were many examples in the interviews of MWs using similar language, suggesting that this conception of their work as the “middle ground” or liaison person is deeply embedded in the practice of MWs and in the performance of their own work.

695. MWs described negotiating with medical specialists on behalf of the pregnant woman, negotiating for the outcome desired by the woman

I try and come at it from the woman's perspective. So whilst I may not always agree with what they're doing or what they're choosing to do. As long as the woman is educated, then it's her decision to make. Sometimes what I find happens in what I do is when MWs and doctors clash, it's a clash of values and perspectives, whereas if you can take it back and say, Hey, this is actually about the woman and bring it back to the woman and her needs and her safety. Sometimes it takes the emotion out of it a little bit. And it's less of ‘me versus you’. It's more of like a let's actually just change the focus here from us to the woman. That's how I try and navigate the tricky situations with doctors in particular. But I guess you could probably apply that to colleagues as well when there's a clash of opinions as well. - Amanda, Midwife

These conversations with doctors and medical specialist were complicated by relationships imbued with a strong hierarchical structure. Amanda (MW) skilfully structures her communication to get the desired outcome. She begins with the principled position of the “woman and her needs” (even if she does not agree with the woman’s approach). She can then frame any difference with doctors as a values clash, moving the discussion away from ‘doctor-midwife’ conflict, away from a ‘me-versus-you’ conflict. She focuses on the woman’s needs and her safety as an element of the negotiation. It is a carefully considered structured approach to the negotiation.

696. Amanda’s example details some of the skills of MWs that are often hidden and under-recognised. The skill can be masked by language such as “MWs graduate with a woman-centred approach to practice” (Nursing and Midwifery Board of Australia 2023a). If the language is not unpacked to understand the skills required to take a “woman-centred approach” then the work of MWs may be undervalued.
697. Similar negotiation skills are evident in the next four examples from Amanada (MW) and Kate (MW). As with the previous example from Amanda (MW) each of the following involves MWs utilising skills that are hidden, under-recognised and under-codified
698. Amanda (MW) described negotiating with a woman who did not want doctors involved. It required careful negotiation to maintain the relationship with the woman without giving way on the quality of care

Yeah, whereas she was adamant, she didn't want any doctors near her. It was one of the things like, Hey, the doctor doesn't have to come in if you come to the hospital. Doctor doesn't have to come in, but they have to know you're here in case we need them, you know. So it was able to kind of negotiate where the hard line was which I think a lot of people when you actually like, get to the bottom of it. They're not unreasonable. -
Amanda, Midwife

Amanda (MW) did not refuse the request from the woman to exclude doctors from her care, but found a way to convince the woman having a doctor in the hospital who was aware of her presence was an essential part of the experience.

699. Kate (MW) described a relatively new development where MWs were negotiating with women who had a ‘google education’ about pregnancy and birth

Patients not accepting medical advice? That's becoming a new issue with Google ... But now we have people that argue the point with us, and we've got medical, you know science to prove what we're saying to them, and they won't listen. - Kate, Midwife

MWs that were interviewed described this as a growing phenomenon, with additional examples provided in the interviews. The job of MWs is changing and the skills demanded of them are increasing because of the widespread use of technology and access to social media.

New skills required in jobs can remain under-recognised in job evaluation processes. The duties of the role expand but the processes to assess the growth in the job lag behind.

700. Negotiating a path through the birthing and post-partum experience extends beyond the woman to include her partner and family. In the interviews with the MWs, there were examples of having to negotiate with partners

since COVID, we've had increasing, we were having issues prior to that, but since COVID, we seem to have had many more challenging issues with people's visitors and the patients. We get abused verbally. When I started nursing there were visiting hours and you listen to the nurse and you do what you were told, and if you were told to leave you left. Now it's like, Well, you don't have a right to kick me out and things like that, and they will get quite nasty and aggressive, and sometimes physically aggressive. - Kate, Midwife

This example introduces a new dimension into the negotiation process, that is the potential for aggression from a woman's partner. The challenge for the MW was to negotiate a solution to the problem that had arisen while continuing to focus on the quality of care for the woman. In addition to the aggression being unacceptable the skills to maintain quality care for the woman whilst negotiating with others such as partners, is an under-codified skill.

701. An increase in threats of violence and aggression was a consistent theme across all four classifications (EN, RN, MW and NP) interviewed for this study.

B1 - Level 4 - Sharing solutions

702. MWs were engaged in negotiation with their organisation over patient ratios, resourcing, scheduling of patients and availability of doctors. For Amanda (MW) her push for procedural changes was exercised in lobbying to work to her full scope of practice

I've been pushing to get midwives working with their endorsement within the public system. Currently I'm not allowed, despite the fact, I was doing it in private practice. I'm not allowed to use my endorsement in my current role. Which is silly. So I've been spearheading that, and now there's a committee being made to try and implement it so that we can work to full scope. - Amanda, Midwife

Amanda (MW) extended the advocacy beyond herself to include colleagues outside of her immediate work group. She wanted the change to apply across the public system.

703. The evidence from MWs was that collaboration for change extended beyond the hospital or immediate work location to external networks

[I] particularly enjoy networking with other hospitals, and I'm certainly in chat groups with other [Name of network of hospitals] hospitals within my organisation. And we talk about what goes on at different facilities, and what works, and get ideas from that as well, which is probably not part of my role. I'm not a manager of the birth unit or the unit at all. But I think all us MWs are interested in providing the best experience we can for the women we care for, so we're pretty passionate about it. - Amy, Midwife

Amy (MW) built networks to improve her skills. Her focus was on 'providing the best experience for women', and she recognised that building networks and relationships outside of the immediate work environment would lead to better midwifery practice.

B2 Communicating verbally and non-verbally

[Note: this section contains descriptions that may be triggering for any reader who has experienced loss in connection with giving birth or as a partner in the same situation]

704. This Skill Element of the Spotlight framework places the focus on clarity of communication. The work activity examples set out below cover the full range of verbal and non-verbal communication that takes place under pressure and often in complex circumstances. Speaking may be explaining or 'translating' complex concepts and procedures. Listening may be to understand the desire of a woman for a particular approach to birthing.
705. I have focussed on level 3 as this level had the highest average incidence per person (6.0).

B2 - Level 3 - Solving new problems

706. The sophisticated communication skills of MWs were perhaps most evident, and most needed, at times of loss in the birthing process, including unanticipated foetal death and planned medical terminations. In the first of three examples Amanda (MW) described supporting a woman through a medical termination

I've been with women through medical terminations. I had a woman last year who was, you know, she was 28 weeks, and that was no fault of her own. That's how long it took to appropriately diagnose this condition that the baby was incompatible with life. And so whilst it's nice to go through that with someone that she knew obviously, that I think that actually almost makes it harder for the midwife, because it is someone that you know that, you know, and you're with them when they go through that. That can be really tough. - Amanda, Midwife

707. Amanda (MW) described supporting a woman whose baby died not long after birth

... it's not uncommon for, you know a baby to be born and having to do resuscitation on a baby. Thankfully I haven't been a part of too many awful resuscitations. But you know I've been with a woman whose baby did pass after a week, and that wasn't very nice, either. – Amanda, Midwife

708. Amy (MW) described a very late term foetal death in utero

... a poor woman that's lost her baby. you know, foetal death in utero at 38 weeks, nearly ready to have a baby and is hysterical like you know. You have to change how you provide that information, don't you? So you know she's not going to be listening to me. I just have to listen to her, - Amy, Midwife

Amy (MW) was reflexive about her communication. She adapted what and how she communicated knowing that the woman was not in any condition to listen or understand. She interpreted the cues to pace information, acknowledging that at that moment her role was to

listen. In the earlier examples from Amanda (MW) the emotional impact on her is obvious. Her own actions and communication are hidden behind phrases such as “I’ve been with a woman whose baby did pass after a week” and “you’re with them when they go through that”. It is in the “being with” the woman that the verbal and body language is adjusted to meet the needs of the other.

709. The reflexivity of the MWs about their own work practice and their ability to manage their own emotions and adapt their communication in these extreme circumstances are examples of the skill of ‘emotion management’. Management of oneself to allow the workflow to continue, to allow care for the woman to continue is a skill that is under-specified. The exercise of the skill of emotion management in these specific contexts can also be hidden skills. They are rendered ‘invisible’ by the unspoken conventions of keeping termination and foetal death away from public spaces.

710. In the discussion at B1.3 I cited an example of MWs having to negotiate with the partners of the women for whom they were providing care. The evidence from MWs also referred to the increasingly complex and important communication skills required of them in the relationship with partners and families. MWs are having to adapt their communication to meet the needs of the partners and families who are also involved in the birth process. There were examples of the communication happening in a positive environment

Generally they're [partners] around for most of the appointments and things like that. So they're present for the education. And we kind of work as a team, generally depending on the woman in a situation. Obviously, sometimes that's not their kind of relationship. But yes, generally I work with them as well, and provide particular education to them around, like how to be supportive in labour and birth, and that kind of thing. - Amanda, Midwife

711. MWs also spoke of communicating with partners whose behaviour was inappropriate

You get some situations where partners can become verbally abusive, and you need to really de-escalate the situation. And yeah, don't react. And to think very carefully and considered about what you're going to say to de-escalate the situation and do more listening and understanding. - Amy, Midwife

To de-escalate the situation, Amy (MW), moved to doing more listening and understanding and minimising her reactions. This happened in the shadow of the potential for physical abuse. It is completely inappropriate behaviour but as indicated previously it is an increasing phenomenon faced by health practitioners in the delivery of health care.

712. The growth of managing patient, partner and family aggression remains an under-specified and hidden skill. The rapid growth in these phenomena means that the skills developed by MWs (and other health professionals) are likely to ‘invisible’ to job evaluation processes by virtue of their recency. This may be ameliorated where the evaluation processes includes consultation with workers from the floor - increased aggression was raised unprompted by

most participants in this study. The skills that have enabled MWs to adapt their practice to meet this new demand on them are under-specified. There is an expectation that MWs will get on with the task of caring for the woman and the child. However, that requires MWs to skilfully manage their emotions. This could be managing fear for their own safety or that of their colleagues, fear for the safety of the woman and child, concerns about their own job security should a complaint develop from an incident with a partner and ultimately a questioning about whether this is a job in which they want to remain. These emotions need to be managed for the MW to continue to provide care for the woman and the child.

B3 Connecting across cultures

713. The focus of Skill Element B3 is on the ability of the worker to connect across different cultures and work with people from diverse communities. The diversity and cultural mix of the Australian population means that MWs will encounter women from culturally and linguistically diverse backgrounds; very likely they will encounter women from a First Nations background, those who come from different socio-economic backgrounds to themselves, and increasingly people who identify as non-binary. The challenge for MWs is not in the simple encounter with diversity, but in how they adapt their practice to better meet the needs of the diverse people they meet in their work.

B3 - Level 2 - Fluently performing

714. The Primary Material provided evidence of MWs connecting with people from other cultures through an empathic approach, being able to 'stand in the shoes' of another to see one's work from their perspective

... that's a conversation I have with all my clients before they birth. And that's the beauty of the care, the model of care that I work in is, I can have those conversations because whilst it's good to know about a generalised population, not everybody, that is, you know, Indian will want all of the Indian birthing practices and if we look at our First Nations, women, they come from all different mobs which do little nuanced things depending on where they're from. So I try and have those conversations before the day, so that I can be aware of what the kind of things that they do, and don't want. - Amanda, Midwife

Amanda (MW) sought knowledge and adapted to meet the needs of women from different cultural backgrounds, recognising that those cultures are not homogenous. Each woman still had her own wishes (and plan) about pregnancy and birth.

B3 - Level 3 - Solving new problems

715. Amy (MW) was honest about her need to learn and adapt to the needs of people who were non-binary or transgender

We're getting more transgender couples and I really need help with this ... obviously I've not being living under a rock, but it is quite tricky, the language. I don't want to offend

anyone, and they've got partners. The other week we had a transgender female transitioning to a male, but had a baby, so went off drugs had a baby, and the partner was male transitioning to a female, but they were non-binary as well. They didn't want the baby identified as any particular sex. I really had to rely on some colleagues and one of the obstetricians to get that all in place we had to make a plan for that ... I need to actually talk to colleagues about how the situation's going, and many a time I had to talk to obstetricians, not about things like that, but about to explain situation like you know, what would they do? And even in the clinical scenarios, what would the choice be medically? And you know I'm always learning stuff. - Amy, Midwife

There is evidence from Amy (MW) of active listening and adaptation to minimise problems for individuals or couples who are operating outside of the normative patterns she has experienced as a MW. She is active in learning how to minimise problems that may arise for people of diverse sexuality and gender. The skills required to problem solve with people from different cultural backgrounds (widely interpreted) are under-specified and under-codified skills. It requires skills in emotion management to work in partnership with people whose lives are outside of your own experience and knowledge. Despite her own insecurity about her responses to transgender and people who were non-binary, Amy's (MW) years of midwifery experience led her to begin with the skill of active listening.

716. MWs in this study shared the challenges they had faced in supporting pregnant women with learning disabilities to deliver a baby. The challenges included patterns of communication and consideration of moral issues such as consent to a procedure or procedures

It can be really tricky when we think when we talk about informed consent. Because, you know, people's understanding is varied, so that can be really tricky. And I think morally can be really difficult, because you know as much as you might try and explain something to someone if you know you're there up against that, then their capacity can be diminished, and then you wonder are they truly consenting to this, or are they not ... I will often talk about it before the event. So if I have women who do have learning disabilities, I will essentially tell them about how birth can go. and I will step out, each in different scenarios ... so we can try and hopefully get a little bit more of a level and understand, like high level of understanding in those kinds of moments. - Amanda, Midwife

The evidence from Amanda (MW) is that a skilled midwife anticipates issues for a woman with a learning disability and engages in planning for solutions around consent to treatments, well before those issues arise.

717. The Primary Material shows that building a trusting relationship with the pregnant woman and also monitoring and guiding one's own responses assists the MW to anticipate and avoid problems for women who have experienced complex social lives as Amanda (MW) narrated

She had quite a rough history. She used to do IV drugs, and she was quite a rough character, but had kind of somewhat steadied her life a little bit, but she was petrified of

needles, and so she just refused, like any blood tests, any vaccinations, anything like that. And it was really impacting on her care. And it got to the point where she was actually avoiding my calls and appointments, and not showing up, and things like that, because she was so scared of that sort of stuff which she didn't tell me to start with, but when we finally got to the bottom of that I negotiated with her ... just getting down to what it was that she actually was worried about. She was fine after that. Actually she was really lovely. She turned up to all her appointments. She did all the things that she needed to do. And she was fine. - Amanda, Midwife

Amanda (MW) varied her communication, found a way to interact effectively, built trust and found solutions to the problems being experienced. This is aided by the MW beginning from a point of view of respect for the other, and as result seeking to build an empathic relationship.

718. In these three examples of level 3 of this Skill Element the ability of MWs to manage their own emotions in building connections with patients and clients can be clearly observed. Amy (MW) recognised her own need to learn and adapt to meet the needs of non-binary and transgender people who were giving birth and or their partners, whilst still delivering high quality midwifery care. Amanda (MW) was reflexive in her practice when dealing with a woman with a learning disability. She reflected on the question of consent even as she carried out a procedure. Amanda (MW) anticipated and acted to avoid a problem in supporting a woman with a complex social history. MWs managed themselves in scenarios that were life changing for the women who were delivering babies. The work activity descriptions involved the skill of emotion management, an under-specified 'invisible' skill.
719. It is these relationship building skills, particularly in female dominated care-based work, that historically have been undervalued. They have been under-recognised 'invisible skills', often mischaracterised as innate traits.

B3 - Level 4 - Sharing solutions

720. MWs were active in seeking solutions for groups operating outside of standard procedures for cultural reasons. Amanda (MW) described her negotiation on behalf of a First Nations woman and her community when there was a clash between hospital procedures and cultural expectations for the birthing woman

They were only allowed 2 women to support people. But you know we were working with First Nations, women who culturally require often lots of people, because it's definitely more of a community women's business. So that didn't work for our clients, and their cultural needs. So that was a constant struggle. Because you know, we were coming in saying, no, we're not going to do that. This is culturally important for this woman and her family. But the hospital they quite like their rules and regulations, so things like that often cause a bit of rub. - Amanda, Midwife

Amanda (MW) advocated for the woman, seeking to incorporate cultural practices into the birthing experience. It is not clear whether Amanda (MW) succeeded each time that she encountered the conflict between the needs of the patient and hospital rules but the nuance in her language suggests that she found and shared a solution.

B3 - Level 5 - Expertly creating systems

721. There were also examples where MWs were contributing to improving systems that would deliver better outcomes for First Nations women

with First Nations, families, and I've worked with women there who they were having their 7th children, and all 6 of the previous ones had been removed. But because they had a wraparound services with appropriate support networks implemented into their care like they were those kids. That kid wasn't being taken away from them. It was the first time that they were ever able to parent and like for me being a part of that is probably one of the most rewarding things. - Amanda, Midwife

Amanda (MW) has contributed to a system improvement, the wraparound service that enabled this woman to overcome systemic barriers. After the removal from her care of 6 children, Amanda (MW) was hopeful that everything was in place for the woman to care for her 7th child. This is an example of an under-codified skill. Amanda's (MW) work enabled the interweaving of various people and groups that may then have made a life changing difference for this woman. It is an example of articulation work that typically is invisible in job evaluation processes. Articulation work is that which enables complex processes to appear to operate smoothly. Where multiple people are involved in complex tasks, it requires coordination. That is work undertaken by Amanda (MW) in this example.

C1 Sequencing and combining activities

722. The focus of skill element C1 is on the ability of the worker to sequence and combine their own activities. This may involve reprioritising their own work to meet changed circumstances or switching and linking their activities with other events occurring in the workplace. A consistent theme presented in the MW interviews was the unpredictability of the work. Amanda (MW) described it this way, "so birth can be quite unpredictable. It's pretty much like the ED of the maternity world", and Amy (MW) in these words, "Well, yeah, there's multiple things also going on in the birth unit which you have to do as well. So yeah, multitasking".

C1 - Level 2 - Fluently performing

723. Kate (MW) spoke about how the sequencing of all care activities extended into the post-natal period for mother and baby. She noted how the work of MWs has changed and intensified

So the biggest one would be gestational diabetic babies ... they were always sent to the nursery for monitoring for at least 24 hours, and then, if everything was fine, they would be released back to the mums. And now that's being managed on the ward. ... So that

means that we, the girls need to be more mindful that they need to watch them more. They need to make sure they're feeding better, whereas in the past, they were always in the nursery, and they were monitored more closely. So that's increased the workload quite dramatically on postnatal. It's made it very difficult and challenging. - Kate, Midwife

Fluently performing midwifery work at level 2 of this Skill Element of the Spotlight framework is typically under-codified. MWs seamlessly sequence and combine activities to get tasks done, so seamlessly that the skills required to do the work become 'invisible'. They notice what needs to be done and they get the job done, working out ways of fitting all tasks into the day. This is evident in Kate's (MW) example where she provides a clear description of work intensification. Other than acknowledging it is "challenging and difficult" there is no suggestion that the work will not be incorporated into routine procedure. Thus do the additional skills required for the new work become 'invisible'.

C1 - Level 3 - Solving new problems

724. MWs constantly assessed whether they were on the cusp of an emergency and should request medical specialist intervention. This was complicated by the availability (or unavailability) of the medical specialist, with the decision about that call resting with the MW

We can get the obstetrician to come in. But that's around about half an hour away. And our theatre team. We don't have theatre team there at night. So that's half an hour away, too. So yeah, we just have to call the obstetrician. If we have concerns. It's a lot of responsibility ... I asked obstetricians to come in, and you know they're not very happy about being woken up at night. But I say, You need to sort this out, like that's my obligation as a midwife. I can't, it's beyond my skill set. They should know. Most are good. They'll just come. They know if I ring them it's a problem. But you know, some push back a bit, lately I found they want to push back a bit, but you know I just feel sorry for the younger MWs, you know if they're pushing back on me, who is quite senior. What are they doing to younger MWs, - Amy, Midwife

Amy's (MW) work activity description shows the deployment of 'clusters' of Spotlight skills. I explore this concept in more detail in section 5.6 of this chapter. However, it would be remiss of me not to briefly highlight the simultaneous use of a 'cluster of skills' in this example. Amy (MW) sequenced her own work, assessing birth schedules for the women, calculating travel distances and times for obstetricians or doctors, and thinking on her feet as the situation changed (C1.3). She was using contextual knowledge and past experience to make the judgements about calling the medical specialist (A1.3). She was monitoring her own reactions to the medical specialists and reflecting on how it might be for her junior colleagues (A2.3 and A2.4). She was negotiating boundaries about responsibility and scope of practice with the specialists with whom there was an unequal power relationship (B1.4) and she was adapting

her communication for each doctor and each occasion (B2.3). What appeared to be a routine activity for Amy (MW) involved the deployment of a complex 'cluster' of Spotlight skills.

C1 - Level 4 - Sharing solutions

725. The evidence from the interviews was that MWs would take the lead in conversations with medical practitioners in proposing solutions to problems. Amy (MW) provided this example

I'm not an expert on everything, and they certainly have a lot more extensive training than I do but I did have an experience the other night where I used my experience. I was on a night duty on a Saturday night, and I had a very junior midwife with me and the obstetrician. The baby's heart rate was very abnormal, and she said, Oh, it's not bad enough for a Caesar, but she needs to have a baby, and she wanted to be put this hormone drip up Syntocin. Well, it was a very small baby, and she was 36 weeks. It was a bit prem, and she said, put some up and she can have a baby, and I actually refused. I said, No, there's a 99% chance that baby is not going to tolerate that. And the theatre team are half an hour away. You're half an hour away, and I've got a very junior midwife with me, and I had other things going on in the birth unit as well. My experience told me. I mean, maybe someone else might have said, Oh, okay, the doctor said to do it, but I said, No, I'm not prepared to do it. She wasn't very happy, she said, are you going to ring me all night about it? And I said, No, I'll monitor it. If it gets worse I'll be ringing you. But I won't be putting some Syntocin up ... Sometimes I have to know what I think is safe just because she's a doctor doesn't mean that I'm gonna do something that I think is unsafe, or feel unsafe. - Amy, Midwife

Amy (MW) was reprioritising and thinking on her feet even as she spoke with the medical specialist. Integrated into this example were high level negotiation and communication skills being used by Amy (MW), made more complex by the unequal power situation in play with the doctor. She challenged the doctor on what she believed was an unsafe practice. Amy (MW) had developed the relationship with the woman in labour. She advocated for what she believed was in the best interests of the woman and her baby. Amy (MW) was exercising skills that are under-codified. A duty statement might read "identifying variances to normal birth and escalating as necessary to specialist staff", but if such a statement is not unpacked then the skills performed by MWs will remain 'invisible'. For example, in Amy's (MW) description she is reflecting on and modifying her own actions whilst on the phone to the specialist and working through a solution to the problem, including challenging the treatment plan proposed by the specialist, as she was exchanging information.

C1 - Level 5 - Expertly creating systems

726. Kate (MW) described implementing audits of practice across the maternity Unit to improve systems. The important thing to note is that it was a self-directed initiative

It depends on what we're auditing. Sometimes it's just auditing checking procedures and make sure people are doing it. So that's not a lot of time-consuming time, but it, you know, we graph it and put it out there. But we do it in our own time a lot of the time. And not in work time ... we do it after hours, or we will take it home and graph it at home. Things like we also have audited, like families, responses to things, and patient feedback and even visiting hours, things like that. So again, it's stuff that we do outside of our work hours, so we very rarely can do it within our work hours. - Kate, Midwife

In the example Kate (MW) notes that much of the work was done after hours in her own time. It is an example of skills that are under-recognised. The activity described by Kate (MW) will not appear on a job description. She was voluntarily exercising a skill that was beyond what might have been the core requirement of "auditing". The work of Kate (MW) and others in analysing results and extending the scope of the audit will have benefitted the hospital administration and the staff. However, the work would likely have remained 'invisible' in assessing the value of the role, given that it was performed voluntarily in her own time.

C2 Interweaving activities smoothly with others

727. The focus of skill element C2 is on the ability of the worker to interweave their tasks and activities with others. This skill element is about teamwork, about observation and prediction, about flexibility and adaptability.

C2 - Level 2 - Fluently performing

728. The Primary Material shows MWs fluently performing their duties and working effectively in teams to reduce duplication of work. There is evidence of MWs noticing when a colleague needed help and standing in for others at short notice. Amanda (MW) displays job knowledge and interweaving of tasks with others when describing the planning of staffing routines

So we generally work in a small team. We as the primary midwife for that woman who she's known will do the 12 hours, hoping that they have a baby in that time, and if they don't, then one of the MWs that we work with will come and relieve us at 12 hours, and hopefully, if we've planned it out right that midwife will have met that woman at some point in her antenatal period, so that she's not completely unknown to her. - Amanda, Midwife

C2 - Level 3 - Solving new problems

729. Collaborating, supporting and interweaving with others (L3) can involve checking on the safety of co-workers, and minding your own safety when responding to difficult situations. Kate (MW) did this but also elevated her concerns when the intervention did not deliver the required outcome. She narrated an incident where there was a threat to a colleague and she implemented the hospital safety procedure. Kate (MW) remained calm and focused and achieved a solution to the emergency

We have a code that we can call. But sometimes that's difficult to get someone up there before the situation's gone out of hand, because they have to come from another part of the hospital, so they will send security. But and sometimes they don't manage it very well either, and we find sometimes that we've had an instance where we had a father who was being quite aggressive and standing over a midwife threatening her. And I called Code, and they came up and actually made the matter worse, and made it sound like the midwife had done something wrong, and they appeased him, and they let him stay. And I said, he needs to be removed from the hospital. And he continued on with this behaviour, and in the end he was removed from the hospital, but it didn't sort of support the staffing. So that's quite challenging that if you you're told to report it, and when you report it you don't get support. - Kate, Midwife

Looking to the safety of colleagues and acting in difficult situations is an example of an under-codified skill. In this example Kate (MW) noted the aggression directed at a colleague, acted to prevent the aggression and then had to challenge the inadequate response by the security responders. She demonstrated the integrative skills that are required in a workplace to maintain workflow (in this case care of pregnant, birthing and post-partum women). I heard and read transcripts of interviews across all four classifications in this study, noting that this type of aggression is increasing in health service delivery.

730. MWs in this study were conscious of carrying out all steps to ensure legal and safe procedures. This was important given the unpredictability and rapidly changing circumstances in a maternity Unit. Deep knowledge and understanding of process enabled MWs to act quickly and calmly. They were mindful in ensuring all necessary resources were at hand

So there's the Australian College of Midwives consultation and referral guidelines have a big list of things, and they categorise risks either as an A B or C, and then depending on which category they fell into that would determine who we had to refer to, if and who we had to refer to. So if someone was a category A, they'd be considered low risk. We could case conference with another midwife. However, if they were a B or a C, well, C, definitely, it's a referral to obstetrics. A or B was in certain conditions consult with obstetrics. - Amanda, Midwife

Amanda (MW) was well versed in the procedure from her professional organisation for making decisions about establishing a treatment plan for each woman. There is no doubt that she was capable of carrying out all of the legal steps should there be a change in the situation for any of the women. Describing a process as routine should not minimise the value of the work. Making complex decisions routine is about having staff who have been trained to systematically internalise the process so that it becomes automatic. However, what is also evident from the interview evidence is that MWs have highly developed observational skills and the ability to respond to unpredictability. So while a 'routine procedure' may be followed, in combination with observational skills, what is evident are the integrative skills that enable

the work to be performed according to procedure but with an eye to the care and safety of the women. It is an under-codified skill.

C2 - Level 4 - Sharing solutions

731. At level 4 of the Spotlight framework the interweaving of tasks is about shared information exchanges and building the support networks that enable quick and calm responses to emergencies. This was demonstrated by MWs describing handover of pregnant women from one midwife to another. Amy (MW) showed the criticality of that work activity

Today, for instance, this woman has delivered the baby that was stillborn, and she's gone home. But she's coming back tomorrow to see the baby, and you know, there's important information like that. And unfortunately, it's verbal. So we have to pass that on from team leader to team leader ... we have our little systems - Amy, Midwife

732. MWs interviewed for this study maintained networks and exchanged information with parties external to the hospital/birthing facility. This enabled them to extend the care for a woman beyond the hospital/birthing facility, particularly where they had concerns about the ongoing wellbeing of the woman

... we also liaise with maternal child health quite a lot. If we see an issue that's coming up we will actually contact maternal health... if there's a mental health issue, if they're not coping, if we foresee there's a strange dynamic between the mother and the father. We liaise that to them things like that. Although we don't see a lot of them after they've left, we do set up processes that allow a longer term care for that patient. - Kate, Midwife

Kate (MW) had established a network with the MCH nurses in her region (she is based in a regional city). We know this when she says they do this “quite a lot”. In this instance when dealing with sensitive issues for the patient (mental health and/or potential family violence) those networks helped her to have a nuanced conversation with the MCH nurse about concerns that she had for a woman. This is an example of the under-codified skills in the work of MWs. They are the skills of maintaining care for a woman that extends across the space for which the MW has direct responsibility (e.g. the maternity Unit) and beyond the time that the woman is under their direct care. The MWs cut across lines of work and institutional boundaries to ensure the best care for the women.

733. MWs interviewed for this study were working to improve systems and processes related to the ongoing health of the pregnant and post-partum women

Childbirth education was another thing as well. It sort of all went online. And we've now started bringing back face to face. It was shut down over COVID, and it's been well received by the hospital, and it's been well received by the patients. So I think, yeah, those long-term work goals we've done through that way. So changing the way the department works. - Kate, Midwife

For Kate, in the post COVID era there was a reintroduction of in-person childbirth education courses. She glosses over the skills that she would have used to make this system change. Having moved to online during COVID, it was now necessary to change the established practice. Achieving this change will have involved consultation with colleagues, development of a policy proposal, cost analysis and influencing and persuading key decision makers. At each step of the process, she would have been interweaving her work with others. Kate (MW) was demonstrating the integrative skills that enable change and improvement to take place even as existing practices are maintained. Integrative skills are under-codified 'invisible skills'.

C3 Maintaining and/or restoring workflow

734. The focus of Skill Element C3 is on the worker contributing to maintaining or restoring workflow after an interruption or emergency. It may not necessarily be a crisis but may include activities that maintain the stability of the organisation as it moves through cycles of pressure and overload. The skills within this element are about the knowledge of processes, the ability to control one's own emotions and project calm and confidence, and to have good processes for clear decision making when under pressure.

C3 - Level 3 - Solving new problems

735. It was evident from the interviews with MWs that in maternity settings, even with the best planning, the unexpected is a common occurrence. MWs were required to manage conflicts in the routines they would normally implement. They needed to make time to listen, respond to, and care for the arrival of a pregnant woman for whom delivery was unpredictable. Kate (MW) provided an example in which those skills were at work

The coordinating of a manageable workload can sometimes be very challenging. Sometimes you've got too many inductions, you just get lots of people walking in. And it's diabolical at times, because we only have 6 birth suites. We had a situation a few weeks ago, where we had 12 women in labour. So they had them all over the place, and they were triaging who was in further along in their labour than others ... So you end up looking after 2 or 3 labouring women, which is extremely challenging. - Kate, Midwife

736. The Primary Material showed that when resources were not available it fell back on the knowledge and skills of the experienced MWs to manage the conflict between the unavailability of the required resources and the needs of the women for whom they were caring. Amy (MW) was one of those experienced MWs

... in my hospital, because it's in the private sector, we don't have the resources they do in the public ... certainly on weekends and night duty it's just the MWs. We're in a major private hospital in a metropolitan area, and it seems unbelievable that if I press an emergency buzzer the only doctors in my hospital are an ICU intensivist who knows nothing about obstetrics. If I have a maternal collapse ... I can get out the MWs, but I can't get a doctor to come and help me. MWs have to deal with it on our own. - Amy, Midwife

The lack of availability of an appropriate medical specialist placed significant additional responsibility on the skills and knowledge of the MWs. There are limitations on their scope of practice and when an emergency situation presented itself, it was a significant dilemma for the MWs. Amy (MW) was required to consider whether with her experience she was more or less suited to undertake a procedure than a medical specialist from another discipline? MWs were faced with answering complex questions to maintain workflow, i.e. in providing quality care for women.

C3 - Level 4 - Sharing solutions

737. The Primary Material showed that restoring workflow relied on the MWs being in control of their own emotions under pressure

I think it's really important that I stay level headed because it's often not the emergency [but] being heightened in that room, that heightens the woman. And so I make a point to make sure that I'm calm. - Amanda, Midwife

Decisions in an emergency need to be made from a position of emotional calm and regulation. This is an example of the under-specified skill of emotion management that is constantly required of MWs.

738. In the interviews MWs provided examples of responding to emergency situations. In the following example Amy (MW) reflected on being adaptable and making the best choice

we create a system for you know what we're going to do in a Caesarean section, and the resuscitator is not working. That's just a clinical situation. We just have to be very adaptable we have to call on other midwives to help us out. We have to think of another way. I guess it's solving a problem or another system that'll work if something's not working. I guess it's part of reanalysing things. When you're on your feet we just have to find the best solution at the time. ... you know, resuscitation of a baby and stuck down in theatre on your own. You've got to just think of a different way. - Amy, Midwife

As an experienced MW Amy will have encountered many emergency situations. Her description highlights her skills such as noticing that there is a problem and then working through alternatives to ensure that the situation does not become dangerous. A key response is to call on “other midwives” to exchange solutions for responding to the emergency. The L4 skills evident in this description are under-codified skills. They are the integrative skills that enable MWs to restore workflow when there has been a breakdown in the process.

739. Amanda (MW) provided another example of implementing strategies to bring the routines of work back together after an ‘interruption’

So if there is identified that there's been a traumatic birth, we'll often do a debrief like a hot debrief with the woman and with everyone that was there, including the doctors and all that sort of stuff. - Amanda, Midwife

A structured debrief enables people to express emotions and process their feelings. When done well it will set out a process for restoring workflow. In this maternity setting there will be other women who require attention of MWs, doctors and other staff, so workflow needed to be restored. There is skill in maintaining workflow across the group when there has been a breakdown of routine as happens when there is a traumatic event such as described by Amanda (MW). In the interviews with MWs it was evident that the responsibility for restoring workflow was work undertaken by MWs. It is an under-codified skill.

C3 - Level 5 - Expertly creating systems

740. Following a system break down, Kate (MW) worked with a team to develop a back-up system in the event of any future system interruptions

So we actually did have a situation one night where our whole system went down, and we didn't know what to do. So we had no drug system. We had no birth system, nothing. So we actually developed a backup package, so that if that happened we could continue to monitor the ladies, you know, birth and everything on paper, because they'd moved away from it ... So we've now developed a package where, if that happens which is rare, but it does happen. We now have a proper backup solution to ... I was in the role when that happened. I was doing the temporary birth suite role. So we developed a package to make sure that if that ever happened when you exactly where to go, grab it and just continue on with the care. - Kate, Midwife

Kate (MW) had to respond and lead when “the system went down”. She was in a management role where she had the authority to develop a “package” response to be implemented in the event that systems went down again. She actively created a system to ensure continuity of workflow could be maintained in an emergency. Building this back-up system is an example of an under-codified skill. Even a limited unpacking of the skills exercised by Kate (MW) shows that she reflected on the impact of what happened when the systems went down, identified what was interrupted, developed and consulted on alternative approaches if the automated systems were not working, refined those alternative approaches and worked through the process to have them approved for any future interruption.

5.6 MW Skill Cluster case studies

741. It may be that a Skill Element is exercised singularly by a MW. In practice it is more likely and indeed evident in the interviews that were conducted that several skills across the nine Skill Elements are performed simultaneously in a work activity undertaken by a nurse or midwife. The Spotlight framework describes that phenomena as ‘clusters of skills’. Interweaving, or deploying ‘clusters of skills’ requires a complex combination of thinking feeling and acting. Further, the capacity to apply several skills at the same time is itself an ‘under-codified higher level skill’; increasing the effort required to perform the role and adding to work intensity. (Junor 2021 – Annexure 6, page 3 of 22)

742. The skill of deploying complex 'clusters' of Spotlight skills has the following characteristics
- a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities
 - b) It is the 'thinking' element of multi-tasking
 - c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges
 - d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to rebuild and work on. (Junor 2021 Annexure 6 page 3 of 22).
743. I present three case studies that show in detail how work activities described in interviews by MWs demonstrate the simultaneous use of skills in the performance of their work.

MW Case Study One: Responding, referring, reflecting

744. One of the core work activities performed by MWs is assessing a pregnant woman who appears to be moving toward the onset of labour. The MW will be dealing with inputs from the woman herself and where possible the MW will use visual cues and audio cues to help her make an assessment. In this case study from Amy (MW) she describes how the inputs are provided from women via a telephone call, with information transferred to Amy (MW) by colleagues, which may bring additional complexities.
745. From a phone call it may be possible to make an assessment and decide on a course of action, or more information may be required. Whichever of those paths is followed there is the beginning of a relationship between the pregnant woman and the MW. The MW is now central, deciding about the next step, which may include referral to a medical specialist such as an obstetrician. What is evident in the example below is that primacy is given to responding to the women being assessed. It was not just a clinical assessment by the MW of the women, but a shared endeavour, with the relationship building commencing at this first contact. The MWs that were interviewed in the study spoke of being collaborators, working to bring about a successful outcome for women. This is evident in this case study.
746. The other element of the work activity described in this example is the commitment to reflection on practice among MWs. Initially Amy (MW) described consultation with colleagues as an assessment is made but later in the description, she describes networking with colleagues to share and reflect on what happened in each birthing process and what could be learned from what worked and what didn't work.
747. In the interview, Amy (MW) described the following work activity
- For instance, we will get a phone call to triage a woman with certain symptoms and whatever. And you know, well maybe you know, I want a second opinion on it, or maybe it's more junior midwife that's not really sure. It's very important whether we invite the woman in or not. We don't want to leave her home when she may develop into having a

serious issue. So we'll certainly use our problem solving. We will consult with other colleagues, or sometimes even escalate it to an obstetrician if we're unsure. And call the woman back. And obviously, if they're on site we certainly solve problems using technology. It's a lot of equipment we use. One of them I've been talking about a bit is continuous monitoring of the baby's heart rate. That tells us a lot about what's going on. So we certainly use that and ultrasound to and to share these solutions. We're always discussing patients that have come in. And we're always interested in what happened to them and what worked and what didn't work. And we're always sort of networking on that between each other. Some of us go on workshops or you know, develop our skills. And we share those ideas to try and share ideas at work. We have safety huddles every day, and we find that certain things are not working within our workspace. So we network that and we come up with a better solution for that problem rather than continue on with the same old thing that's not working or inconvenient. - Amy, Midwife

748. I have described the case study as 'Responding, referring and reflecting', capturing the three phases of the assessment performed by Amy (MW). Her words show her focus on the importance of responding to the women, her openness to referring to an obstetrician, and finally the reflection that occurs after the event, which promoted learning and improved practice among her and her colleagues. In addition to the observation about reflection and ongoing learning, I note that Amy (MW) has over 30 years experience as an active nurse and midwife, with 21 years in her current midwifery role.
749. In viewing this anecdote through the lens of the Spotlight framework the overriding Skill Elements are within Skill Set A – Contextualising, and demonstrate Amy (MW) performing at level 4, (solution sharing). At level 4 of this Skill Set, Amy (MW) is demonstrating skills such as 'exchanging rapid situational updates with colleagues, conveying information from a range of sources' She is also alert to 'helping manage co-workers emotional strengths pressures and needs'. Nested in 'solution sharing' are level 3 skills of 'problem solving'. At the conclusion of the work activity, she moves into reflection with her colleagues, where the creation of a supportive context for giving and receiving feedback can be observed.
750. Amy (MW) is also using skills from the Skill Set B - Connecting. She was judged to be working at level 4 of the Spotlight framework for negotiating boundaries. At this level typical descriptions of communication include 'sharing knowledge and experience to guide people', (evident in her focus on "calling the woman back"). We also see 'building and maintaining networks of relationships with people outside the immediate work group' (evident in her reference to "safety huddles").
751. Amy (MW) is also working at level 4 of Skill Set C - Coordinating, particularly in her smooth interweaving of activities with others. At this level she can be observed 'activating support networks for quick and calm responses to emergencies or other changing contingencies'. An

analysis of her interweaving from one phone triage process, showed that she consulted with colleagues about the initial assessment, and then considered whether to escalate the issue to an obstetrician or engage in further assessment of the woman through the available technology and therefore with those who support the use of this technology. Finally, she gathered with her colleagues to reflect on the outcome.

752. In the work activity in this case study, the coding team allocated the following codes, A1.4, A2.4, A3.4, B1.4 and C2.4. They are the codes represented in the Heat Map in section 5.4 of this chapter. As has been said on a number of occasions in this report, the performance of a higher level of a skill presumes that lower level skills have been mastered to enable the higher level of skill to be performed. Lower level skills may be 'nested' into the higher level skills.

Table 5.5: MW Case Study One: Responding, Referring and Reflecting

Selected sentences from Amy's statement	Spotlight coding	Illustrative statements from Spotlight workbook (abbreviated)	Observation
<i>we will get a phone call to triage a woman with certain symptoms and whatever</i>	A1.2	Adapt and apply knowledge and skills gained in and outside this workplace	Amy describes a standard function of midwifery – assessing information about a woman's pregnancy.
<i>maybe you know, I want a second opinion on it</i>	A1.4	Use techniques for exchanging rapid situational updates with colleagues and to convey information from a range of sources	Amy has information from the phone call, possibly direct or from another midwife (see next sentence). Having heard the symptoms she is already open to input from others to make the assessment.
<i>maybe it's a more junior midwife that's not really sure</i>	A2.4	Be alert to and help manage co-workers' emotional pressures, strengths and needs	Amy is aware of the knowledge and skills of her colleague, 'maybe a junior midwife' and factors that into her assessment. This will be a person she is likely to include in the reflection described later in the activity, where the focus is on developing skills.
<i>it's very important whether we invite the woman in or not</i>	A1.3	Solve problems by sifting key issues from all the detail	Amy has multiple points of information, now she sifts through the detail to determine the key issue, whether the woman needs to come in for further assessment.

<i>We don't want to leave her home when she's she may develop into having a serious issue</i>	A1.3 A2.3	Use your knowledge to anticipate and avoid problems And 'Key in' to others' ways of thinking	Amy is determining whether a problem is likely to arise (or if things are proceeding as they should) and is also understanding the mindset of the woman who may well be in a state of heightened anxiety.
<i>So we'll certainly use our problem solving</i>	A1.3 A2.3 A3.4	Piece together information and perspectives from various sources to solve a problem And Work in sensitive situations to help people maintain composure And Regularly summarise your understanding of what is going on to check that others agree	Confirmation that Amy is fully aware and reflexive about the processes she is undertaking. Her problem solving has included summarising what she knows and checking with others. The use of the pronoun 'we' is also noted. It is a shared endeavour by the MWs on duty.
<i>We will consult with other colleagues or sometimes even escalate it to an obstetrician if we're unsure</i>	A1.4 A2.4	With colleagues and associates, share approaches to solving problems And Prepare for a key event by going through all the steps and gaining feedback from a trusted colleague	Amy utilises her networks, both peers and medical specialists to ensure that the best assessment of the woman has been made.
<i>And call the woman back</i>	B1.4	Share knowledge and experience to guide people,	Here is the focus on the relationship with the pregnant woman. The importance of calling back is emphasised in Amy's description.
<i>if they're on site and we certainly solve problems using technology. It's a lot of equipment we use</i>	C2.4	Have in place, and be able to activate, support networks for quick and calm response to changing contingencies	Amy's assessment includes consideration of the options available to her should they suggest the woman comes into the hospital. Her knowledge extends to all of the options that might be required to interweave into the assessment.
<i>We're always discussing patients that have come in. And we're always interested in what</i>	A2.4	Compare notes with others, to identify underlying causes	Here Amy has moved into reflection mode with colleagues sharing solutions for future assessments.

<i>happened to them and what worked and what didn't work</i>		of difficulties and share approaches to handling them	
<i>And we're always sort of networking between each other</i>	B1.4 A3.4	Build and maintain networks of working relationships And Help create a supportive context for giving and receiving feedback	The sharing about difficulties can only be effective if the relationships or networks have been built to encourage that level of communication. It also requires the creation of an environment in which feedback can be given and received; and it will be supportive.
<i>Some of us go on workshops or you know, develop our skills we share those ideas to try and share ideas at work,</i>	A1.4	Keep up to date with and share information about developments relevant to your work area	MWs seek out information from external networks (workshops) and on return to the workplace they share new knowledge with others.
<i>We have safety huddles every day, and we find that certain things are not working within our workspace</i>	B1.4	Build and maintain networks of working relationships with people outside your immediate work group	Safety huddles were an activity raised in several interviews by MWs and nurses. They are opportunities to raise and discuss issues that need to be resolved at a work location.
<i>So we network that and we come up with a better solution for that problem rather than continue on with the same old thing that's not working or inconvenient</i>	C2.4	Develop and use shared information exchange systems And Decide when people or processes need more time, and when to 'move on'	Amy views her contribution to the safety huddles as another opportunity to continue to improve processes across the work location.

MW Case Study Two: Coordinating system improvement

753. Kate (MW) is an Assistant Nurse Unit Manager (ANUM) in a large metropolitan private hospital. This case study provides an example of the deployment of a 'cluster of skills' by a MW in the performance of her role which includes management responsibility. An ANUM will perform tasks, understood generally as management tasks, but continues to have a role in the delivery of the core care; in this case being the care of pregnant women, the birthing process and the post-partum period. In this work activity description, Kate (MW) was acting in a role above her substantive ANUM position.

754. Kate describes the change she made to practices in the birth suite

It was an initiative of mine. I actually did the birth suite manager role for 3 months last year, and we were having a lot of issues. Because our bookings increased quite

considerably, and we were having issues with people. A lot of bookings in the morning, and they were still labouring in the afternoon, and then we would get 2 or 3 more that would come in early in the afternoon for their inductions, and we either had no beds, no staff and people delivering as they were walking in the door. It made it very unmanageable to work that workload. We had this rule that nobody was actually implementing, that inductions had to come in from 6 o'clock. We had a doctor that was really pushing back on that, and said it didn't suit her lifestyle, and she'd have to get childcare and things like that. And I said if you want your care of your patients being safe and having staff available to do it, we have to have this happen. So it's taken us a while, but she's the only one that gives us push back. Everyone else is toeing the line now. and it works really well, and the flow of the unit now runs quite well. - Kate, Midwife

755. I have described the case study as 'Coordinating system improvement'. It is an example of workplace change that is driven from the experience of performing and understanding the core work. Kate (MW) was required to deploy a complex 'cluster of skills'.
756. In bringing about the change in the process in the birthing suite Kate is exercising skills from Skill Set C - Coordinating, demonstrating all three Skill Elements in this group at a high level. There are several examples of Kate (MW) sequencing her own work to share solutions to the issue of patient flow that is occurring in the birth suite. She has the capacity, enhanced by her role as the acting manager, to create and implement a new system. Kate (MW) does this, interweaving her role with that of others across the birth suite; creating the system has also required her to problem solve and share her solutions with others. In this endeavour of sharing solutions she encounters one obstacle. From her description it appears that she has been successful in improving the workflow in the birth suite through her initiative to revitalise a hitherto ignored policy, thus re-establishing continuity and stability.
757. The underpinning skills that enabled the sequencing and interweaving of activities that restores workflow were Kate's (MW) communication skills. These skills are captured in Skill Set B - Connecting. Her network of relationships with her peers and other colleagues enabled her to work through the process for the change to be implemented. We also see that the process required her to give and receive feedback in situations of unequal power.
758. Kate (MW) has solved a significant workload problem for the staff in the maternity Unit. To achieve that outcome, she deployed a 'cluster of skills' across the Connecting and Coordinating Skill Sets. The main Skill Elements that were coded for this case study were C1.4, C2.5, C3.5 & B1.4. A further breakdown of the Skill Elements and Skill Levels can be seen in the Table below. This case study provides an example of how the lower level skills are nested into the higher Skill Levels.

Table 5.6: MW Case Study Two: Coordinating System Improvement

Phrases from Kate's statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>It was an initiative of mine. I actually did the birth suite manager role for 3 months last year</i>	C1.4	Clearly and briefly flag new arrangements	Kate assumes responsibility for putting in place (or as is evident below - returning to) an arrangement to improve workflow.
<i>we were having a lot of issues</i>	A1.3	Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems	Kate brings to the management role her knowledge of the context and situation of the birthing suite.
<i>our bookings increased quite considerably, and we were having issues with people. A lot of bookings in the morning, and they were still labouring in the afternoon</i>	C3.3	Identify minor issues that have the potential to grow into bigger problems and act to prevent this	Kate has identified the problem and foresees the potential for it to become a bigger problem over time.
<i>then we would get 2 or 3 more that would come in early in the afternoon for their inductions we either had no beds, no staff and people delivering as they were walking in the door</i>	C3.3	Manage conflict between legal requirements and/or organisational rules and patient need	Kate can see the conflict between the way the processes of the suite are designed and the needs of the birthing women.
<i>so it made it very unmanageable to work that workload</i>	C2.3	Check your own and co-workers' safety in responding to difficult situations And Carry out all steps to ensure legal and safe procedures	Kate is prompted into action by concern for her colleagues, who have an unmanageable and unsafe workload.
<i>We had this rule that nobody was actually implementing that inductions had to come in from 6 o'clock</i>	C2.5	Develop shared policy approaches to addressing resource constraints	Kate identifies an opportunity for system change by focussing on a policy that existed but was being ignored; a policy that would address the issue of resource constraints.
<i>we had a doctor that was really pushing back on that, and said it didn't suit her lifestyle</i>	C1.4	Clearly and briefly flag new arrangements (or the need for them) to affected parties in a timely way	Kate's knowledge of all of the parties connected to the birth suite enables her to identify a potential problem with reverting to the ignored policy.

			She flags the 'new' arrangement with the doctor.
<i>And I said, if you want your care of your patients being safe and having staff available to do it, we have to have this happen</i>	B1.4 C1.4	Constructively give and receive feedback in unequal power situations And Exchange ideas with colleagues for more effective management of workflow	Kate has exchanged the idea of the change with the doctor and has had to manage a difficult conversation, in a situation where the doctor still holds considerable power.
<i>So it's taken us a while</i>	B1.4 C2.4	Build and maintain networks of working relationships And Decide when people or processes need more time, and when to 'move on'	Kate's statement here, when unpacked, shows that she has persevered in her quest for change, and has been successful. Time has been given for people to adapt to the change and it has happened.
<i>She's the only one that gives us push back. Everyone else is toeing the line now and it works really well</i>	B1.4 C3.5	Establish systems for maintaining continuity and stability as well as responsiveness to change	Kate has worked with people to build a commitment to this systemic change. It has changed the unmanageable workload for herself and her colleagues and improved the outcome for the women. Kate's comment about the one doctor suggests that she is implementing the procedure, but not willingly.
<i>and the flow of the unit now runs quite well</i>	C3.4	Bring routines and lines of work back together after they have been disrupted	Kate has successfully implemented the solution and the change in procedure has improved the workflow for all.

MW Case Study Three: Catering to diverse needs

759. The final case study of the deployment of a 'cluster of skills' by MWs focuses on how they cater to the diverse needs of the women with whom they work. Amanda (MW) was working in community clinic in a regional city. As she was employed under the state hospital system, the clinic accepted all women who arrived at the clinic for support. In this example the diversity arises from the socio-economic differences between women. Amanda (MW) juxtaposed the disadvantage of one woman with the relative advantage of another. She was reflexive, naming the disadvantage as she talked about her work in the interview. The

challenge as she revealed in her work activity description was to know and understand and adapt to how socio-economic background affects a woman's approach to childbirth.

760. Amanda (MW) described the work activity

What I'm doing now is less about educating and empowering. It's more about holding people together. You know I've worked with some people who, they're not interested in writing a birth plan because they're worried about feeding their kids that night. The care that I provide is different and more kind of like wraparound services and liaising with social workers. You know, we're not talking about acupuncture points and relaxing breathing techniques, we're not doing that sort of stuff. But then it's interesting sometimes you've got people who focus on that, you know, and that's all they want and all they need. I think it's that disadvantage right? You know there are people out there who can afford to go and do hypnobirthing course and then they want to talk you through their breathing techniques and all that sort of stuff. So I feel like the range of what I do now is bigger, because the range of people I see in their level of disadvantage is so much bigger. - Amanda, Midwife

761. I have titled the case study, 'Catering to diverse needs'. One of the key principles that was expressed consistently by the MWs who were interviewed was that the role is to support every woman, to advocate for every woman to have the birth experience that they wanted. This is the principle that we see underpinning Amanda's work with the diversity of these two women. At times MWs were required to find a way to refuse requests that were unreasonable or unsafe, but that did not deter from the goal of providing support without judgement.

762. The 'cluster of skills' deployed by Amanda (MW) in this case study align with the Contextualising and Connecting skill groups. The skills that were coded were at A1.2 and A2.3 of Contextualising, and B1.4 and B3.4 of Connecting.

763. In Amanda's (MW) description, she demonstrated how she fluently performs the Skill Element of 'sensing contexts or situations'. She had 8 years of experience as a midwife in three different contexts. She was confident in her own skills and knowledge. In terms of the Spotlight framework, she was performing at level 2 'adapting and applying knowledge and skills gained in and outside of the workplace' and 'adapting to the interaction styles and needs of each different patient'. Amanda (MW) was also engaged in 'monitoring and guiding reactions', Skill Element A2.3 the 'problem solving' level. At this level Amanda (MW) was 'keying into others' ways of thinking to filter information according to how it would be received'. I observed Amanda's (MW) own reflection about needing to interact with each woman differently but equally, using her understanding of the woman's needs.

764. Within the Connecting Skill Set Amanda (MW) was adept at negotiating boundaries B1. Her work activity was judged to be at level 4, 'sharing solutions'. At this level of this Skill Element, Amanda (MW) was 'sharing knowledge and experience to guide others'. That sharing of

knowledge and guiding of others needs to be filtered by the cultural context of the person with whom one is interacting. In the example Amanda (MW) was describing the different cultures that emerged from diverse socio-economic backgrounds and how she responded to those different cultures (Skill Element B3). At level 4 of the Spotlight framework for this Skill Element Amanda (MW) was listening and observing attentively to unspoken aspects of interactions with the other person. In the example she evaluates her experiences with one particular woman who was most worried about feeding her kids that night. This changed how Amanda (MW) supported that woman. That is juxtaposed with another woman who had attended a course and was keen to discuss breathing techniques.

765. Accepting all women into the public hospital system means that MWs will encounter the full diversity in the community. Amanda adapts her practice to meet the needs of the women she encounters and in doing so deploys a 'cluster of skills' simultaneously.
766. In the coding of the transcript the main codes were A1.2, A2.3, B1.4 and B3.4. They are the codes that were collated and incorporated into the Heat Map. In Table 5.8 the work activity is broken down in detail and shows lower level codes for some of the skills exercised by Amanda in carrying out this aspect of her work.

Table 5.7 MW Case study three: Catering to diverse needs

Selected sentences from Amanda's statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>What I'm doing now is less about educating and empowering it's more about holding people together</i>	A2.3	Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain, fear, shame or grief	Amanda has a view about her role as a MW but uses her insights into people and adjusts her practice to what women need at the time.
<i>I've worked with some people who, they're not interested in writing a birth plan</i>	A1.2	Adapt and apply knowledge and skills gained in and outside this workplace	Amanda knows that all women are encouraged to have a birthing plan describing how they want their care during and after the birthing process. Amanda accepts for some women that is not important.
<i>they're worried about feeding their kids that night</i>	A1.2	Adapt to the interaction styles and needs of each different patient	Here is the evidence of having listened to the woman. From here Amanda adapts her practice to meet that women's needs i.e. she does not have the woman prepare a birthing plan.
<i>The care that I provide is different</i>	A2.3	Key in' to others' ways of thinking to filter information	In the absence of a birthing plan, Amanda thinks through how she can

		according to how it will be received	best provide care for this woman, recognising that it may be very different from many other births that she supports.
<i>more wraparound services and liaising with social workers</i>	B1.4 B3.4	Share knowledge and experience to guide people, And Informally interpret or mediate between work associates and members of diverse communities	Amanda knows the services that can be made available to the woman; services not directly related to the birthing process. Amanda shares the information and then appears to mediate between the woman and the providers of those services.
<i>You know, we're not talking about acupuncture points and relaxing breathing techniques like, we're not doing that sort of stuff</i>	A2.3	'Key in' to others' ways of thinking to filter information according to how it will be received	Implicit knowledge is expressed here by Amanda, even in the negative, about the pain relief solutions that can be enacted for birthing women. The statement recognises the need to empathise with each woman and to understand their needs.
<i>sometimes you've got people who focus on that, you know, and that's all they want and all they need</i>	A1.2	Adapt to the interaction styles and needs of each different patient	Amanda understands the need to adapt her practice to the needs of each woman.
<i>I think it's that disadvantage right?</i>	B3.3	Work effectively with people who have a different sense of time, or similar conditions	Amanda names the social situation that she is encountering in working with the woman. It is a different social experience to many who come to Amanda's clinic.
<i>you know there are people out there who can afford to go and do a hypnobirthing course. And then they want to talk you through their breathing techniques and all that sort of stuff</i>	B1.4 B3.3	Share knowledge and experience to guide people And Work effectively with people who have a different sense of time, or similar conditions	While the focus of the early part of this work activity description is on a woman experiencing socio-economic disadvantage, Amanda is at the same time working with women who have economic advantages. She shares her knowledge equally, if differently, with woman who do have the time to focus on breathing techniques.
<i>So I feel like the range of what I do now is bigger, because the range of people I see in their level</i>	B1.4 B3.4	Share knowledge and experience to guide people And	Amanda sums up her work activity description with her own learning and recognition of how her work is

<i>of disadvantage is so much bigger</i>		Listen and observe attentively to key into the unspoken aspects of interactions based on diversity	changing. She is required to be attentive and shift her communication to the needs of each woman, not just the clinical needs but also, in this example the needs that emerge from socio-economic backgrounds.

5.7 Conclusions about MWs and Spotlight skills

767. There are over 33,000 MWs across Australia with NMBA registration. Of this group 78% hold dual registration as a MW and RN. In this chapter I have presented evidence from detailed interviews with three MWs, all of whom hold dual registration as RNs. The work activity descriptions that have been coded and presented in a Heat Map in section 5.4 and aligned with the Spotlight Framework in section 5.5 are the lived working experience of MWs.
768. The years of experience of the MWs in this study spanned 8-44 years of nursing and midwifery work. Notwithstanding the considerable years of experience of the MWs in this study, I do not consider that they have provided information about their work that is exceptional or goes beyond the activities that an experienced MW would be required to carry out. The study was rewarded with three participants who were articulate about the theory and the practice of midwifery. They were interviewed about their current role however, they also proved to be reflective about the experience of MWs across the profession and the varied settings in which MWs work. From the evidence gathered I have drawn conclusions about the 'invisible skills' demonstrated by the MWs in this study.
769. The Heat Map in section 5.4 shows the dominant skill when measured by intensity of incidences was Skill Set A - Contextualising, with an average of 66.7 incidences per person. This was followed by Skill Set B - Connecting, with an average of 49.7 incidences, and close in terms of the intensity of incidences was Skill Set C - Coordinating, with 43.7 per person.
770. The work activities described in the interviews showed MWs operating primarily across level 3 and level 4 of the Spotlight framework, represented by the descriptions 'solving new problems' and 'sharing solutions/applying expertise'. It was L3 'solving new problems' of the Spotlight framework, that showed the highest overall incidence of work activities with an average of 76.3 per person. There was evidence from the interview participants of MWs 'expertly creating a system', operating at L5 of the Spotlight framework. This higher level was most apparent in the Contextualising and Coordinating Skill Sets. The highest average for a single Skill Element was B1, negotiating boundaries, with 33.7 incidences per person.
771. MWs frequently demonstrated the Spotlight skills in 'clusters'. Three case studies were presented each showing the simultaneous deployment of Spotlight skills, with one case study

from each of the three participating MWs. The first case study, 'Responding, referring, and reflecting' shows the deployment of a 'cluster of skills' from the Contextualising Skill Set. The case study reflects the data in the Heat Map where there is a density of skills recorded at level 3 and level 4 of the three Skill Elements in Contextualising. The second case study, 'Coordinating system improvement', shows the deployment of a 'cluster of skills' around the Coordinating Skill Elements at levels C1.4, C2.5 and C3.5. The case study is of a midwife, who is an ANUM, and who implemented system improvement in the workflow management of delivery suites in a maternity Unit. The third case study, 'Catering for diverse needs', shows the deployment of a 'cluster of skills' around the Contextualising Skill Elements at levels A1.2 and A2.3, and the Connecting Skill Elements at levels B1.4 and B3.4. The ability of, and need for MWs to perform skills simultaneously is made visible by the Spotlight framework.

772. The three different approaches to the data analysis; being the Heat Map, the alignment of work activities with Skill Elements, and the 'Skill Cluster' case studies show the hidden, under-defined, under-specified, under-codified and under-recognised skills, or in totality the 'invisible skills', that are demonstrated by MWs in the performance of their duties on each shift that they work. These skills, 'invisible' in the valuation of the work of MWs are the very skills that are valued by the pregnant, birthing and post-partum women whom the MWs are supporting.

6.0 Enrolled Nurses

6.1 Introduction to ENs

773. I have been asked to apply the Spotlight Tool to the work of Enrolled Nurses (EN) to “identify, name and classify the ‘invisible skills’” used by ENs who participated in this study. To do this I conducted a Spotlight analysis, the details of which are set out in chapter two of this report, drawing on the descriptions of work activities provided by ENs who were interviewed for this study. This chapter includes the facts and information gathered from the 5 ENs interviewed which I have relied on to support my findings regarding the application of the Spotlight taxonomic framework to the role of ENs (the Primary Material). Where relevant I have also incorporated information from Secondary Material referred to in chapter three.
774. The analysis in this chapter draws from the information about work activities provided by EN participants who were interviewed for this study. The transcripts from these interviews were reviewed and analysed against the Spotlight taxonomy. A coding framework that corresponds with the Spotlight taxonomic framework was developed to assist in coding the work activities described in the interviews with participants. Using this coding framework codes were allocated to the descriptions of the work activities provided by participants. Sometimes several codes may have been allocated to a work activity. Through this coding process the Spotlight skills that are present in the participants work were identified. The activities (and the skills associated with them) were named and grouped in relation to the Skill Element that they relate to in the taxonomic framework. An assessment of the Skill Level at which the skills were being performed was then made. (the research approach is set out in chapter two)
775. Drawing on the evidence and analysis set out in this chapter I conclude that the work of ENs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. A substantial volume of the work of ENs interviewed requires the use skills that are hidden, under-recognised, under-defined, under-specified, under-codified and therefore likely to be under-valued on gender grounds.
776. The highest area of skill intensity was Skill Set A - Contextualising. This was followed by Skill Set C - Coordinating and close to that in terms of the intensity of incidences described was Skill Set B - Connecting. The work activities described in the interviews showed ENs operating primarily across level 2 and level 3 of the Spotlight framework, represented by the descriptions ‘fluently performing’ and ‘solving new problems’. It was the latter, ‘solving new problems’, that showed the highest overall incidence of reported work activities. There was also evidence from the interview participants of ENs operating at level 4 of the Spotlight framework, ‘sharing solutions/applying expertise’. This higher level was most apparent in the Contextualising and Connecting Skill Sets. This data is set out in section 6.4 of this chapter.

777. The limited examples of orienting skills is a reflection of the experience of the group of ENs who were interviewed; they had an average of 15.4 years of nursing experience. The ENs interviewed have moved beyond the orienting stage to fluently performing and the higher levels. The exercise of skills at the higher levels is underpinned by the consolidation of skills and expertise at the lower levels which arises from learning about the dimensions of the role as experiences accumulate.
778. The Heat Map at section 6.4 of this chapter displays the average number of coded incidences for each Skill Element at each level. An explanation of the development of the Heat Maps and how they represent the data from the coding of the interviews can be found in chapter two of this report. I have also presented three case studies that demonstrate how the Spotlight skills are commonly deployed in clusters. See section 6.6 of this chapter for these case studies.
779. The chapter is set out as follows
- 6.1 Introduction to Enrolled Nurses
 - 6.2 A brief review of the profile of ENs in Australia that draws on a literature review
 - 6.3 A snapshot of the demographics of the ENs interviewed for this study
 - 6.4 A representation of the data analysis of the ENs interviews in the form of a Heat Map and a Skills Table
 - 6.5 Selected examples of work activities provided by the EN participants in this study aligned with each of the nine Skill Elements of the Spotlight framework, and a discussion of the identifying, naming and classifying of these skills
 - 6.6 A discussion of the deployment of 'clusters of skills' that provides further insight into the complexity of the work undertaken by ENs.
 - 6.7 Conclusion

6.2 Profile of ENs in Australia

780. The Nursing and Midwifery Board of Australia (NMBA), reports that in 2024 there were 70,769 people who held EN nursing registration. Of that group, 116 also held dual registration as a midwife. In addition to the total number who held EN registration, a further 12,268 people held dual EN and RN registration (Nursing and Midwifery Board of Australia 2024a).
781. Australia changed its nursing qualification and training structure in 1994. From that date all people commencing an EN qualification were required to enter a Diploma of Nursing as a minimum qualification. This qualification is delivered in Australia by Registered Training Organisations and Universities. The qualification is typically completed over 18 months; and must include a minimum of 400 hours of clinical practice. I note the date of the introduction of the tertiary qualification for a purpose; in the group interviewed for this study, one EN identified as being 'hospital trained'. The term is used to describe how nurses were trained prior to the compulsory qualification.

782. ENs must be registered with the NMBA and are required to renew that registration annually. One of the requirements for renewal is the completion of 20 hours of Continuing Professional Development annually (CPD).
783. In the literature that I reviewed for this report, there is little differentiation between the information provided on ENs and Registered Nurses (RN); in most papers they are grouped as 'nurses'. I have included in this chapter, information about ENs only where it is clear that the data or literature is referring only to ENs. More detailed information on nurse demographics is set out in chapter three.
784. The OSCA classification system used by the Australian Bureau of Statistics (ABS); and Jobs and Skill Australia (JSA) provide some additional insights into the EN workforce (Australian Bureau of Statistics, 2024b). In the OSCA classification system, ENs are included under the classification, Health Support Workers and Assistants. The other three classifications in this study, RNs, Midwives (MW) and Nurse Practitioners (NP) are included in the classification, Midwifery and Nursing Professionals. OSCA further differentiates the specialisations in which ENs work as Acute Care, Primary Health Care, Mental Health and Aged Care. JSA does not currently report employment numbers for those specialisations.
785. JSA draws data from different sources to the NMBA, at different times, and using different criteria, so there are discrepancies between the numbers reported by each organisation. It is not my intention to explore those differences here, but to provide the JSA data, to further illustrate the profile of ENs in Australia. JSA reports that there were 41,600 enrolled nurses in employment in Australia. Of those 89% were female and the median age was reported as 43. Of those employed, 59% were working part time (Jobs and Skills Australia 2026a).
786. The Nursing and Midwifery Board of Australia (NMBA) introduces the Scope of Practice Fact Sheet for ENs with the following:
- ENs graduate from a competency-based education framework with essential knowledge to manage and complete nursing care under the supervision of an RN, NP or midwife. The supervision can be direct or indirect. ENs are educated with the essential knowledge required to effectively provide nursing care that is person centred, informed by evidence, complete delegated care, manage tasks and manage contingencies in the context of the role. ENs recognise normal and changing health conditions of people in their care (Nursing and Midwifery Board of Australia 2025b).
787. The NMBA, the registering body, also provides a description of the work of ENs, including examples of core activities which I have set out below
- ENs provide nursing care as part of a team, contribute to the development of plans of care while working under the supervision of an RN or NP. ENs have the knowledge and skills to gather and interpret data using observation, interview, physical examination and measurement. ENs are accountable in providing care that has been delegated to them by

an RN or NP, according to the health needs of the person, and that is within their competence. ENs work as part of a multi-disciplinary team and collaborate with other healthcare workers.

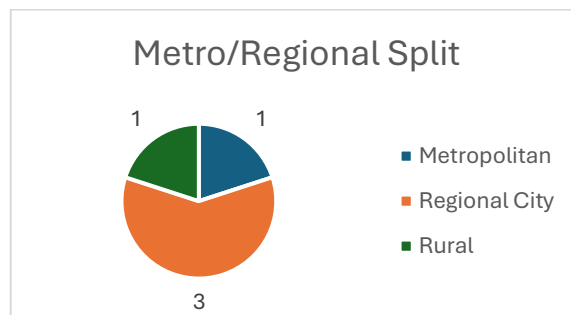
Examples of core EN activities include

- a) providing personal care and hygiene needs such as showering, dressing and assisting with meals.
- b) recording and interpreting clinical observations including
 - temperature, pulse and blood pressure
 - urinalysis
 - blood glucose and other tests used in specific areas of practice
- c) recognising and communicating changes in the person's condition to the RN and, with the RN, formulate the next steps of care
- d) providing basic care for those with acute and chronic physical and mental health needs
- e) providing basic wound care in line with an agreed plan of care
- f) administering and monitoring medicines and intravenous therapy
- g) supporting basic nutrition advice and education responding to people's health and care needs. (Nursing and Midwifery Board 2025b).

6.3 Profile of ENs in this study

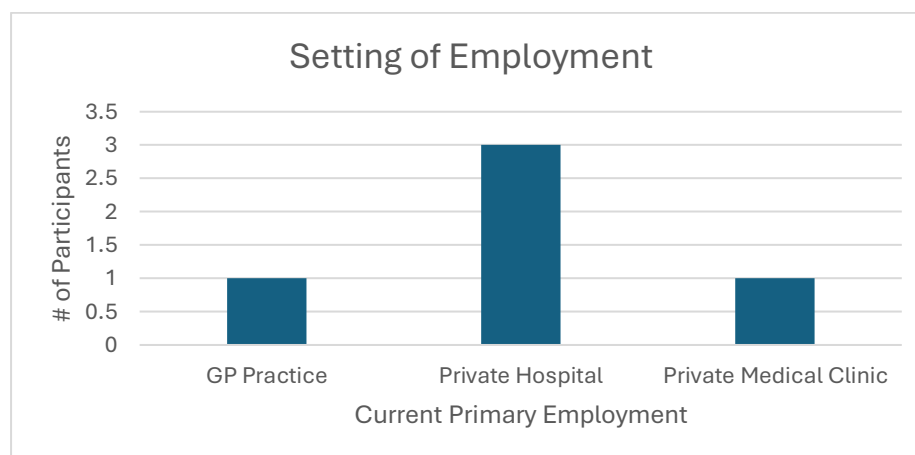
788. Five ENs were interviewed for this study, all were female. Four of the five have completed a Diploma of Nursing, with one of those four also completing a Bachelor degree in a health related field, another is currently studying to upgrade their qualification to become a RN. One of the five was 'hospital trained'. That person described themselves as having 36 years' experience, so it is likely they undertook the hospital training around 1989, among the last few intakes before the move to tertiary qualifications that was required from 1994.
789. Two states are represented across the group. Three ENs were from Queensland and two from South Australia. There was a reasonable spread of geographic locations across those two states to provide diverse perspectives as represented in Figure 6.1 below.

Figure 6.1: Geographic distribution of ENs in this study



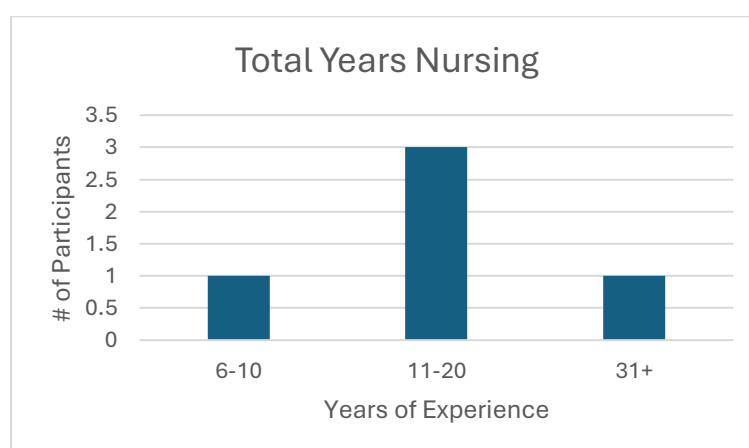
790. Four of the five ENs were working in acute care settings and one in a primary health care setting. The four working in acute care gave varied descriptions of their roles including theatre nurse in a clinic, acute health care for surgical and medical patients, anaesthetic nurse, and endoscopy and surgical admission nurse. All five were employed by private employers i.e. none were in the public system. The spread is show in Figure 6.2 below

Figure 6.2: Setting of employment for ENs in this study



791. There was a spread of experience working as an EN ranging from 6 years to 36 years, with the average at 15.4 years of experience and the median at 11 years. When asked about how long they had been in their current role, three responded with 11 years, including two who were in the same role as when they started their nursing career. One of the ENs was in her first year in the role and the EN working in primary health care had been in that role for 2 years. The distribution of years in nursing is displayed in 6.3 below.

Figure 6.3: Years in nursing for ENs in this study



792. There were over 70,000 ENs working across all states and territories, and across acute care, primary health care, mental health and aged care (out of scope of this report). I have calculated from NMBA data that ENs represented 14.6% of all nurses and midwives who held current registration with NMBA (Nursing and Midwifery Board of Australia 2024a). In this study ENs comprise 17% of all participants (n=29).

793. The ENs in this study were spread across a diverse selection of EN work roles and settings. The information provided by the ENs in interviews produced rich data regarding the work of ENs across the various roles and settings. After examining the transcripts of interviews and applying the Spotlight tool to the information gathered in this study, I am confident that I have sufficient data to draw the conclusions contained in this report regarding the nature of 'invisible skills' present in EN work.

6.4 The Spotlight framework and the work activities of ENs in this study

794. In the following section I set out the incidence of reported activities using each Spotlight Skill Element at each Skill Level. The method of identifying and classifying these activities is discussed in chapter two. I also show the relationships between Skill Elements as performed by ENs and the typology of invisible skills (details of this typology are set out in chapter two).

Spotlight Heat Map and analysis

795. A Heat Map is presented below to visually show the patterns of intensity and complexity of invisible skills utilised. The Heat Map was compiled by tallying the incidences of Spotlight skills (at level) present in the work activities of each EN participant and then averaging that number across the 5 ENs in the study.

Table 6.1: ENs Spotlight Skills Profile

Enrolled Nurse Spotlight Skills Profile						
Skill Element	1. Orienting	2. Fluently Performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising	0.6	17.0	16.4	6.6	0.0	40.6
A1. Sensing contexts or situations	0.4	12.2	9.0	3.2	0.0	24.8
A2. Monitoring and guiding reactions	0.0	2.4	5.2	2.0	0.0	9.6
A3. Judging impacts	0.2	2.4	2.2	1.4	0.0	6.2
Total B: Connecting	0.2	8.0	9.8	2.0	0.0	20.0
B1. Negotiating boundaries	0.0	4.0	3.8	2.0	0.0	9.8
B2. Communicating verbally and non-verbally	0.0	3.2	4.0	0.0	0.0	7.2
B3. Working with diverse people and communities	0.2	0.8	2.0	0.0	0.0	3.0
Total C: Coordinating	0.6	7.8	12.4	4.4	0.0	25.2
C1. Sequencing and combining activities	0.2	4.2	4.4	1.8	0.0	10.6
C2. Interweaving your activities smoothly with those of others	0.2	2.8	4.0	1.4	0.0	8.4
C3. Maintaining and/or restoring workflow	0.2	0.8	4.0	1.2	0.0	6.2
Average per Participant Incidence	1.4	32.8	38.6	13.0	0.0	85.8

796. Table 6.1 shows the average incidence of the Spotlight skills drawn from the description of work activities given by EN participants in their interviews. The incidences set out in Table 6.1 show that the work of ENs involved performing work activities across the nine Skill Elements of the Spotlight framework. Each of the nine Skill Elements from the Spotlight tool was evident in the work activities described by the ENs who were interviewed for this study. The dominant Skill Set when measured by intensity of incidences described was Contextualising, with an average of 40.6 incidences per person. This was followed by Coordinating with 25.2

incidences per person and close to that in terms of the intensity of incidences described was Connecting at 20.0 per person. The work activities described in the interviews showed ENs operating primarily across level 2 and level 3 of the Spotlight framework, represented by the descriptions 'fluently performing' and 'solving new problems'. More than 44% of the incidences described by the ENs were coded at level 3 of the Spotlight framework. There was also evidence from the interview participants of ENs 'sharing solutions/applying expertise', judged to be at level 4 of the Spotlight framework. This higher level was most apparent in the Contextualising and Coordinating Skill Sets.

797. All five of the ENs in this study operated in environments where they were required to exercise autonomy and judgement. That judgement included situational awareness in which they were reading the context in which they were operating which is reflected in Skill Set A - Contextualising. The highest average incidence for any Skill Element across the five ENs was at level 2 - sensing contexts and situations (A1.2) where they averaged 12.2 incidences per person. At this level, the ENs were adapting and applying knowledge to new contexts, they were adapting to the needs of each patient, and frequently to the needs of the medical specialist whom they were supporting. The Heat Map shows that they move into problem solving, evident in the second highest average score of 9.0 incidences for level 3 of sensing contexts or situations (A1.3), and level 3 of monitoring and guiding reactions (A2.3) with the third highest score of 5.2 incidences per person. At this level the skills being exercised include piecing together information from various sources and sifting key issues from the detail to solve problems. ENs are 'keying' into the behaviour of others including patients, peers and specialists, seeking to understand behaviours and responses, and maintaining a sensitivity to the self-respect and independence of others. The capacity to read the situation, both the physical and social context, requires the demonstration of skills that are regularly hidden, under-defined, under-specified, under-codified and under-recognised and hence 'invisible'. These terms are explained in chapter three of this report.
798. The second highest coding Skill Set score for ENs, when measured by average incidence was Skill Set C – Coordinating with an average of 25.2 incidences per person across each interview transcript. The ENs demonstration of 'sequencing and combining their own activities' (C1) had the second highest average incidence across the nine Skill Elements with a score of 10.6 incidences per person. Once again for ENs, the grouping of incidences in this Skill Set was at its highest across level 2 and level 3. There is a consistency of outcome at the problem solving level (L3) in this Skill Set. The Skill Elements in this group include 'sequencing and combining one's activities' (C1.3) with an average of 4.4 incidences per person; 'interweaving your activities smoothly with those of others' (C2.3) with an average of average of 4.0 incidences per person; and 'maintaining and/or restoring workflow' (C3.3) with an average of 4.0 incidences per person.

799. At this problem solving level ENs are organising their own work, which includes assessing the urgency and importance of simultaneous calls on their attention, reprioritising their tasks to meet new demands and thinking quickly on their feet as new problems arise (C1.3). Each of these skills requires independent and autonomous thinking by ENs. However, as they were frequently working as part of team, their own work had to interweave with that of others. The Skill Element C2 at level 3 includes the skills of checking the safety of their co-workers, carrying out the legal and procedural steps they are required to follow, and also monitoring each step of a process to make sure the necessary resources are at hand. ENs who were interviewed were also conscious of the overall workflow and maintaining the integrity of that workflow when problems arose. The skills that were demonstrated include identifying minor issues before they become a major problem, managing conflict between legal requirements and patient need, and making time to listen and care for patients despite the intensity of the work. These are judged to be Skill Element C3 at level 3. The skills at level three of Coordinating are regularly under-codified in assessing job value and therefore 'invisible'.
800. In the next section I set out detailed examples from ENs performing against the nine Skill Elements, but here I note what was heard from ENs working in surgical theatres. Four of the five ENs interviewed were working in theatre or surgery related roles. There were several examples of ENs describing how they needed to understand all of the steps in an operating procedure, all of the variations of the procedure, all of the potential complications that could occur, and all of the vagaries in the way that a particular medical specialist (e.g. surgeon or anaesthetist) might handle a procedure. This knowledge was required as the EN had to prepare all of the equipment that may be required for that procedure, and under pressure respond to, even anticipate, the next step that a medical specialist would take, in order to be efficient in maintaining the workflow in that theatre (and therefore the success of the procedure for the patient). These were examples of the under-codified skills being performed by ENs in one of their work roles.
801. The Primary Material shows a gender segregation in the work undertaken in operating theatres and surgical clinics. All the ENs interviewed in this study were female, and across all ENs 89% are female (Jobs and Skills Australia 2026a). In the interviews ENs consistently referred to specialist medical staff and surgeons as males. Gender segregation has been identified as one of the drivers of the undervaluation of female dominated areas of work such as nursing (see a full discussion in chapter three of this report).
802. In the Skill Set B - Connecting, the Heat Map shows an average of 20.0 incidences per person across the three Skill Elements. Negotiating boundaries (B1) had the third highest overall average for a single Skill Element (9.8 incidences per person). Once again, the grouping for ENs is around fluently performing (L2) and problem solving (L3). At level 2 of negotiating boundaries (B1.2), ENs are demonstrating clear and consistent communication that sets

limits, they are building cordial relations with people across the workplace and providing unobtrusive support and care. At level 2 of communicating verbally and non-verbally (B2.2), they are interpreting the needs of others, using active listening and making effective use of body language. These are the skills that most in the community would reasonably expect of a nurse who was in direct contact with patients (the skills we would want to experience ourselves if in need of nursing assistance). They are expected skills, but they remain under-specified skills for ENs. Because they are 'expected', they can be described as 'natural' or 'innate skills' and as a result they can become 'invisible' as work skills and less valued.

803. At Level 3 of negotiating boundaries (B1.3), the problem solving level, there was an average of 3.8 incidences per person. This rises to an average of 4.0 incidences when we move to the Skill Element - 'communicating verbally and non-verbally' (B2.3). At this level of these Skill Elements nurses are demonstrating the capacity to build trust by explaining processes, (once again there is a depth of knowledge that they must possess to problem solve); finding ways to refuse requests that cannot be met but still negotiating for the quality of care for patients. They adapted their communication to the diversity of people and experiences they were dealing with, pitching verbal and body language to people with varying levels of understanding. They played a significant role in translating medical information for patients and families. These skills are hidden and under-specified, as they often involve the exercise of diplomacy to protect the reputation or independence of another e.g. protecting the reputation of a medical specialist who has limited skills in breaking down complex medical terminology; or at the patient level it may mean identifying a person with limited language skills, or one who is extremely vulnerable, and maintaining their dignity in what may be a confusing and disorienting environment.

Spotlight skills and the typology of invisibility

804. To provide an overview of the link between ENs work activities, Spotlights skills and the typology of invisibility I have included Table 6.2 (below). This Table provides examples of work activities engaged in by the ENs illustrating the use of Spotlight skills by ENs. The relationship of these activities to the typology of invisibility is also noted. The average incidences of the Spotlight skills at each level, for each Skill Element is also used. In section 6.5 more detailed examples of these work activities is also included. More detail on the typology of 'invisible' skills is contained in chapter three.

Table 6.2 Typology of invisible skills and Spotlight Skill Elements for ENs

Skill Element	1. Orienting	2. Fluently performing	3. Solving problems	4. Sharing solutions	5. Expertly creating a system
A1. Sensing contexts or situations	0.4	12.2	9.0	3.2	0.0
L2 Adapt to the interaction styles and needs of each different patient (UR, H)					
L3 Piece together information and perspectives from various sources to solve a problem (UD)					
L3 Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems (UC)					
L4 With colleagues, share approaches to solving problems relating to patients or technology (UC)					
A2. Monitoring & guiding reactions	0.0	2.4	5.2	2.0	0.0
L2 Quickly pick up on and respond to small changes or early warning signs in, patients, carers or family members or work colleagues (H)					
L3 'Key in' to others' ways of thinking to filter information according to how it will be received (US)					
L3 Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain, fear, shame (US)					
L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US)					
A3. Judging impacts	0.2	2.4	2.2	1.4	0.0
L2 Prepare each patient individually for key transitions (US)					
L3 Help patients feel at ease whilst you are carrying out activities that may worry or distress them (UD)					
L4 Constructively challenge practices that may compromise the safety or dignity of others (H, US)					
B1. Negotiating boundaries	0.0	4.0	3.8	2.0	0.0
L2 Build/maintain cordial relations with people outside one's authority, thereby gaining co-operation (UC, H)					
L3 Gain others' trust and consent by explaining each step of a process and its purpose (US)					
L4 Build and maintain networks of working relationships with people outside your immediate work group (UC)					
B2. Communicating verbally & non-verbally	0.0	3.2	4.0	0.0	0.0
L2 Use active listening, reflecting and using silence to allow people to talk through their concerns (US)					
L3 Adapt the content of your communication to the varying attention spans of different listeners, interpreting cues to pace information (US)					
L3 Pitch your use of language and body language to people with varying levels of understanding (H, US)					
B3. Working with diverse people & communities	0.2	0.8	2.0	0.0	0.0
L2 See your own and your work team's behaviour from the perspective of someone from another cultural or ability group (UR)					
L3 Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or similar conditions (H, UD, UC)					
C1. Sequencing & combining activities	0.2	4.2	4.4	1.8	0.0
L2 Work out ways of slotting each activity into the day, to attend to a number of tasks or patients at once (UC)					
L3 Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis (UC)					
L3 Think quickly on your feet as new problems arise during an activity (UC)					
C2. Interweaving activities smoothly with others	0.2	2.8	4.0	1.4	0.0
L3 Check your own and co-workers' safety in responding to difficult situations, whilst avoiding pressures to react before thinking (UC)					
L3 Monitor each step of a group work process to ensure that necessary resources are at hand (UC)					
L4 Have in place, and be able to activate, support networks for quick and calm response to emergency or other changing contingencies (H, UC)					
C3. Maintaining &/or restoring workflow	0.2	0.8	4.0	1.2	0.0
L3 Manage conflict between legal requirements and/or organisational rules and patient need (H,UC)					
L3 Make time for caring listening and interactions amidst intense work pressures (US, UC)					

Legend:	H	Hidden Skills
	UD	Under-defined skills
	US	Under-specified skills
	UC	Under-codified skills
	UR	Under-recognised skills

805. Table 6.2 provides examples of activities illustrating use of Spotlight skills across the 9 Skill Elements by ENs.

6.5 Aligning EN work activities with Spotlight Skill Elements and Levels

806. In the following section I provide examples of EN work activities mapped against the Spotlight framework from ENs interviewed for this study drawn from the Primary Material.

807. I have used examples drawn from the Primary Material to illustrate the relationship between the work activities and the Spotlight framework. Whilst an example has been used to illustrate a single Skill Element this does not mean that this example is only illustrative of that Skill Element. An example drawn from the Primary Material may have been coded to multiple skill elements. Examples showing the deployment of ‘clusters’ of Spotlight skills are contained in the case studies at section 6.6 of this chapter.

A1 Sensing Contexts or Situations

808. The first skill group is Skill Set A which involves contextualising and shaping awareness. It refers to the ability of a worker to understand, perceive and respond to context, monitor and guide reactions (the workers’ own and others), and judge what is happening and consider the implications, impacts, outcomes or consequences of particular circumstances or contexts.

809. The focus of Skill Element A1 is on the ability of the worker to perceive, interpret or read work or social contexts and situations. These contexts and situations include workplace and social roles, rules, resources, regulations, risks, conditions and emergency situations. Activities coded at levels 2 and 3 were the most numerous for ENs in this study. The examples show ENs performing fluently in their role and solving unfamiliar problems in their context.

A1 - Level 2 - Fluently performing

810. All five ENs in this study demonstrated the capacity to fluently perform the tasks associated with their role (L2). The ability to adapt and apply skills and knowledge to the needs of the patient is part of fluently performing the RN role.

811. Theatre nurse, Jessica (EN), with over 30 years of experience had a well refined situational awareness (A1.2) She ensured that all equipment that may have been needed for an operation was prepared in advance and she did so unassisted. She knew and understood in some depth each procedure that was scheduled for the day and she prepared the necessary equipment and the materials that might be needed

So if you have the equipment there for the anaesthetist before he asked for it. So you're going to be able to do that. The more experience you have because you've been through some stuff, and you know what can happen. And you just pick things up a lot quicker. Guess you're a lot more situationally aware. - Jessica, Enrolled Nurse

812. The importance of this preparation was emphasised later in her interview when Jessica (EN) described an interaction with a medical specialist

They [the patient] can aspirate. So we have to make sure that the suction equipment is there. That that's all available for the anaesthetist, because you know most of the time they're standing there, and he's just like, Give me this. Give me this. So we just need to be thinking before about what could happen. And make sure that all that equipment, emergency equipment's there. - Jessica, Enrolled Nurse

In phrases such as “need to be thinking before about what could happen”, and “make sure that all of the emergency equipment’s there” an experienced EN can be observed applying her experience and fluently performing, undertaking complex tasks without direction.

813. At this level of sensing contexts and situations (A1.2) ENs were adapting to the needs of each patient. ENs were looking at clinical signs for each patient, using formulas and cues to look for signs of anxiety or stress which may have brought complications to the procedure

Then we call for the patient and the patient comes down. You go through the checklist. the pre anaesthetic checklist, and then you also have to be gauging the patient. You know how, if they're stressed, just gauging them and looking at them and being situationally aware of where they are - Jessica, Enrolled Nurse

814. Tamara (EN) in a similar role in a theatre used similar skills

So we're there from the moment they come into theatre to the moment they leave theatre. So you learn what a patient wants quite easy if someone walks in and they start talking. You know that they're quite anxious. And they want to be like, they want to chat throughout. And you also learn if someone just wants to lay there and be quiet until it's done. - Tamara, Enrolled Nurse

815. Both Tamara (EN) and Jessica (EN) were applying close observation of the patients, reading signs and being prepared respond to any needs. They understood that each patient would express those needs differently. The situational awareness and the capacity to respond to the needs of each individual patient that is evident in these descriptions from Tamara (EN) and Jessica (EN) are under-recognised skills. Both ENs demonstrated skills that are more than applying standard procedures (e.g. checklists), they are picking up on cues from patients about how to adapt their practice to better meet patient needs. In preparing the equipment for theatre they had thought through the possible contingencies and prepared for them.

A1 - Level 3 - Solving new problems

816. The ability to problem solve (L3) through piecing together information and perspectives from various sources, along with the ability to sift key issues from all the detail to avoid problems are skills present in the work of ENs in this study.

817. The Primary Material shows that at level 3 ENs were piecing together information to anticipate and avoid problems for patients. Jessica (EN) notes the gaps between an experienced EN and a “new person”

Once you have a lot of experience, and you pick up things that you never would have picked up as a new person, because you have the experience. And you've been through, you know some things, and you're very aware of what situations can crop up. And so you're scanning and observing and watching the patient and the anaesthetist all the time.

- Jessica, Enrolled Nurse

818. Jessica (EN) reads the high pressured atmosphere of an operating theatre, anticipating the thinking of the specialist medical team

Okay? So you're thinking, what's? Why are they worried about this? What do they think. What are they worried about? What's going on? And the more that you've been in there, the more you automatically, subconsciously pick things up like the way that the sats probe sounds. You just pick up things that you know fluctuations or when things start to happen, it's sort of like a subconscious thing. - Jessica, Enrolled Nurse

819. In this latter example Jessica (EN) is using knowledge of the job to anticipate and avoid problems. These are under-codified ‘invisible’ skills. They are skills that Jessica (EN) herself has not fully recognised. She describes it as something that is “automatic”, despite the fact that in her description she describes her skills of reading the expressions of the theatre team, listening for sounds, and observing fluctuations in the rhythm of the movement of people. She was anticipating what might be required of her should something change.

820. Jacinta (EN) was also reading the patient, using accumulated knowledge to prevent harm

So you have to be able to recognize when your patient is deteriorating, and that is not something that just comes to you, you do have to learn and recognize about. If your patient is deteriorating or not. You're looking at the rise and fall of the chest. You're looking at the colour of the patient. You're looking before you even look at your machine.

You are looking at all of these. - Jacinta, Enrolled Nurse

Jacinta (EN) was explicit about learning skills; they are not “something that just comes to you”.

821. In the examples provided above by Jessica (EN) and Jacinta (EN) they describe the progress in knowledge and skill development that they have made since they commenced in the EN role. Experience and further learning have helped them develop the skills to recognise what is happening in a procedure, or for a patient that they would not have recognised when they first commenced in the role. The skills they have developed are under-codified, being the

integrative skills that enable the workflow to continue such as Jessica's (EN) first example of being able to respond to the demands of the anaesthetist. Jessica (EN) and Jacinta (EN) were interweaving their work with that of others to maintain workflow.

822. Lauren (EN) working in a rural General Practice clinic, brought together her local knowledge of patients, doctors and geography. Operating at level 3 of 'sensing context and situations', she sifted through the detail about the patients to identify a particular issue. Lauren (EN) described the scenario at the practice

... because people travel a long way to come to this clinic, and it can be an hour and a half for some people; older people, frail people, ill people. - Lauren, Enrolled Nurse

She continued, giving the reason why the travel time is significant

So pressure cooker, because the patient sitting in the waiting room, they know that that doctor won't see them if we run late, so I have to take time out of their appointment for their Care Plan to make sure that we stay on time for the doctor. [He] won't see them, he will send them away and let them come back. And that's not ideal obviously. - Lauren, Enrolled Nurse

Lauren (EN) considered the health requirements of the patient and the social context. She knew the doctor was particular about his schedule, refusing to see patients who were late (even if it is because they were with the nurse). Lauren (EN) knew which patients had travelled long distances, so she adapted her schedule of doing Care Plan assessments (also an example of a C1 skill) with the patient, to meet the demands of the doctor and to prevent a problem. Lauren (EN) took responsibility for interweaving her work with others to maintain workflow. This is an example of the integrative skills that are under-codified.

A1 - Level 4 - Sharing solutions

823. The skills at level 4 may involve activities such as exchanging rapid situational updates and exchanging information with colleagues. Sharing approaches to solving problems relating to patients is also a L4 work activity.

824. Nina (EN) exchanged situational updates with the Nurse Unit Manager (NUM) to share solutions about staff allocations, drawing on her knowledge of the patients and the staff

... if there's two new staff members or two staff members not usually from our ward you can identify the fact that that's going to be an issue straight up. So you need to make sure the skill mix of the nursing team is appropriate. That's usually with regards to allocating in the book, you know they might and the NUM might do it ... It might be somebody who's not normally on the ward who does the allocation you can identify with them, and kind of say, look, I think you need to change this team up. - Nina, Enrolled Nurse

The sharing of a solution by Nina (EN) is a level 4 skill. She knew the skill of each staff member, who was new and who was not. She knew the patients in the Unit, "you need to make sure the skill mix of the nursing team is appropriate". She knew that the NUM did not

hold all of that knowledge. Having read the situation in the Unit, Nina provided a situational update to the NUM, sharing an approach to solving the problem before it became manifest in patient treatment. Being proactive sharing solutions with colleagues is an under-codified skill. Nina's intervention allowed for a better interweaving of staff to improve workflow.

825. In the examples at level 3 and 4 we can observe the demonstration of teamwork by Jessica (EN) and Jacinta (EN) in theatre situations, Nina (EN) in a hospital Unit and Lauren (EN) in a General Practice clinic. The teamwork arises through the ENs adapting their routines and tasks to meet the practices of others. They are integrative skills, developed through experience and knowledge that enable workflow to continue and patient care needs to be met. If the ENs had failed to adapt their practice then patient care would have been compromised. The most striking example is Lauren (EN) adapting her routine to accommodate the practice of the GP with a rigid view about management of his own time, regardless of circumstances. These are examples of under-codified 'invisible' skills.

A2 Monitoring and Guiding Reactions

826. The focus of Skill Element A2 is on the ability of the worker to monitor and guide their own and others' reactions. Activities coded at level 3 within the Spotlight framework were the most numerous for ENs in this study with instances of activities at level 4 also present.

A2 - Level 2 - Fluently performing

827. At level 2 ENs are performing fluently in their role. They will be quickly picking up on small changes in patients, their families or colleagues. ENs will also be conscious of their own reactions to changing situations around them.
828. Jessica (EN) was aware of her impact on others, and self-monitored to ensure that the work could still be performed fluently, even as differences arose with colleagues in a theatre

Well, I guess people are just where they are ...[it] doesn't mean that I'm gonna like it. I guess I just have to be more tolerant of where people are. I guess that's probably what I learned from that situation. And also I mean, I don't even know if this is correct or not. I just think it's really important to be honest and communicate ... I'm very direct, and not everybody can cope with that, or you know, maybe it depends on your tone of voice. I just always haven't been aware of those things, and I've just learned over time to be aware, of how the other person communicates. - Jessica, Enrolled Nurse

Jessica (EN) acknowledged that it is a skill that she has learned to be aware of how her communication affects other people. She has also learned that she will "have to be more tolerant". There is a skill in guiding or adapting your own behaviours whilst working with others. Jessica (EN) showed awareness of her behaviours, recognised the impact, and chose a new path. Her reflexivity about her own work practice and her ability to manage her emotions in her relationships with colleagues are examples of the skill of emotion management. Management of oneself to allow the workflow to continue is a skill that is under-specified. The

ability to control one's own emotions is not innate to a particular type of person, even if it has been mischaracterised as a personal quality. The skills of 'emotion management' are under-specified and historically have not been accurately valued in job assessments.

A2 - Level 3 - Solving new problems

829. Work activities at level 3 involve the ability of a worker to solve new problems in monitoring and guiding reactions. This may involve keying into other's ways of thinking, considering how information will be received and using insights into difficult behaviour to resolve problems. Working in sensitive situations and helping others to maintain composure, self-respect, and independence are activities that demonstrate L3 skills of monitoring and guiding reactions.

830. The ENs that were interviewed had developed strategies to meet the diverse approaches of medical specialists. This understanding of the 'other' enabled them to problem solve as they moved through the procedures to support the medical specialists. There was an emphasis on maintaining one's own composure in pressured environments

Well, depending on the person most of the time you can't say anything because they get offended, you just have to put up with it most of the time. - Jessica, Enrolled Nurse

Jessica (EN) understood the high pressure environment of an operating theatre. She accepted, if reluctantly, that she just had to put up with "it". She had insight into the reasons for the difficult behaviour demonstrated by others in the team. She exercised judgement saying that she would put up with it "most of the time". That phrase does suggest there were times she did challenge inappropriate behaviours. This is another example of the skill of emotion management by an EN, an under-specified 'invisible' skill.

831. There was evidence in the interviews of ENs 'keying' into the way of thinking of others. This helped ENs to problem solve. They chose to filter information considering how it might be received by the medical specialists

How I think something should work is different to how a doctor thinks something should work. And learning it might work for a certain doctor, but it doesn't work for another doctor. So just knowing when to drop it, and leave it for that certain doctor, because there is things that you would love to take into theatre with another doctor that another doctor has showed you. - Tamara, Enrolled Nurse

Tamara's (EN) example demonstrates how she adapted her behaviour and communication to meet the different needs of each of the doctors that she worked with. She recognised her own 'reaction' i.e. she had new knowledge had to hold back to meet the needs of the doctor she was working with. She exercised judgement, "knowing when to drop it". Tamara (EN) was exercising tact and diplomacy in her relationships with others in the medical hierarchy. Diplomacy such as this, that preserves the reputation of members of the medical profession, is a hidden skill that may be 'invisible' when assessing the full range of skills performed by ENs.

832. The Primary Material showed ENs bringing reassurance to patients, helping them maintain their composure and their dignity in sensitive situations

So we do procedures on genitals underneath you on your breasts as well. We've done quite a lot of procedures maintaining dignity. Then we have quite a few patients that are wheelchair bound total body photography being one of those things that you do have to stand and move and be able to do this and do that. We have a couple of patients who are in their wheelchair, so they can't stand to do that. So being able to kinda adjust the rules and take certain photos so that they can be included. And they can have that protection, as well. - Tamara, Enrolled Nurse

Tamara (EN) adapted her practice when performing procedures in which people were exposed or vulnerable. She had to solve problems that arose because of the limitations of some patients. She helped patients maintain their composure and their self-respect. Her language shows care for each patient. In acting to preserve the dignity of patients, reducing the stress on a patient and modifying the screening process for people with a disability, Tamara (EN) was utilising multiple skills. They are skills that are often described as 'natural' or 'innate' to those in caring roles such as nursing. They are under-specified 'invisible' skills.

833. Even in a limited analysis of the skills, Tamara (EN) can be observed performing the following
- a) demonstrating a sound knowledge of the purpose and regulations for the screening procedure,
 - b) making informed judgement about what could be adapted, and how to adapt the process to meet the needs of individual patients
 - c) demonstrating a sound knowledge of the requirements for the screening process
 - d) the experience to know how to position the patient for the screening
 - e) communication skills that enabled her to move each patient into the modified position
 - f) the empathic skills to recognise when someone's dignity might be compromised

When a skill is under-specified possibly appearing in a statement such as 'modify procedures for those with a disability', if the skill is not unpacked this can lead to an undervaluation of the skills performed in the role.

A2 - Level 4 - Sharing solutions

834. Work activities at level 4 involve the ability of a worker to monitor and guide reactions in sharing solutions. These activities may involve awareness of the emotional pressures, strength and weaknesses of colleagues and actively working with others to identify and handle underlying difficulties.
835. There was a range of peer relationships evident across the five ENs who were interviewed. They were alert to the needs of their colleagues as in this example from Tamara (EN)

Theatre can be quite daunting to new nurses. We have a few. I do have a colleague who doesn't work very well under pressure. So when something blows up in theatre she doesn't know how to handle it, or if something's out with the books for the day she gets quite emotional and just being able to sit there and explain like, it's okay, like, we'll figure it out like we will work through the day. - Tamara, Enrolled Nurse

This is an example of where an experienced EN had developed skills that a colleague has not yet developed. Without knowing the detail of this specific incident but in reviewing the remainder of Tamara's (EN) interview transcript, I observed that she has detailed knowledge about the complex procedures in a theatre setting. She has knowledge about the different people working in the theatre team and she has the skill of emotion management to control her own responses when others may be volatile in the intensity of an operating theatre. She demonstrated the skill to maintain control of those emotions when problems arose in a procedure. She described preparing the equipment for multiple contingencies if things were to go wrong and as a result described instances where she was able to act to support the medical specialists as they adapted procedures to accommodate a problem. These are not innate skills. They are skills developed by Tamara (EN) through experience and training. In evaluating the work of ENs, these are under-codified and under-specified skills. Tamara (EN) herself does not appear to recognise fully that she has developed these skills. She explains away her colleagues' reactions as "not working well under pressure", rather than not having yet developed the skills.

836. Nina (EN) was alert to her co-worker's emotional pressures, strengths and needs:

... you can see when a co-worker is under a lot of pressure. You know, there's a lot of tears in eyes things like that. So you just basically provide support. Say, go up to them and say, what can I do to help your workload at the moment, - Nina, Enrolled Nurse

The sensitivity to work colleagues allowed Nina (EN) to work toward solutions for the individual and team. Being alert to co-workers needs and then acting to provide support is about monitoring and guiding reactions and enabling the sharing of solutions to maintain workflow. This is the exercise of skills that are under-specified 'invisible' skills.

837. The Primary Material shows ENs working collaboratively comparing notes and observations to identify issues and underlying causes with patients, and moving to solutions

So we get together in the treatment room where the doors are closed and we can talk privately. And just, you know, kind of identify. Okay, there's something going on with this patient. I can't put my finger on it. But what do you think? You know this is one idea that I've got, you know, things like that. - Nina, Enrolled Nurse

As well as working toward a solution, Nina (EN) also showed respect for the patient by moving to "where the doors are closed". It is an example of self-awareness and guiding her own actions in the interests of the patient. Nina (EN) is demonstrating an under-codified skill of reflexive practice, where continuity of care is maintained whilst she is reflecting with

colleagues on how to better meet the needs of this patient, including anticipating what might need to change and the consequences of those changes.

838. Nina (EN) was aware of the pressure on her colleague, understands the complexity of the relationship between them, but works to build trust so that the issues can be resolved

... last week I was teamed up with a grad nurse, a new grad nurse. We did have a busy shift with a few post Ops. The grad nurse and I worked well as a team to get through the night, and we actually had time at the end of the night to sit down and do our updates. Which is something that you know ... like she was nervous. She's a grad nurse, you know. She is an RN. So basically I work underneath her. But her being a new grad nurse and me being the experienced EN we were able to identify issues dealt with them together as a team ... We've done everything to the tee. We've filled our job requirements together as good team. I mean grad nurses have got to learn And we've all started somewhere. And we've all been that new person. - Nina, Enrolled Nurse

In this situation, as Nina (EN) points out, the graduate was a RN, so had seniority. However, Nina as an experienced EN had greater knowledge in the context in which they were operating. Nina (EN) chose to share her knowledge and expertise. She was engaged in solution sharing even though typically she would have been directed by the RN. The willingness to lead the solution sharing is an example of a hidden skill being exercised by Nina (EN). It cannot appear on job descriptions because her scope of practice requires her to be directed by the RN. However, the reality is that workflow would have been interrupted if Nina did not have the diplomatic skills to engineer this solution to the problem of completing the treatment notes.

A3 Judging Impacts

839. The focus of Skill Element A3 is on the ability of the worker to judge the impact of their work. That impact may be on patients and/or on their colleagues. Judging impact is one of the Skill Elements grouped under Contextualising, so it involves judgement of actions in the context of the work, not in isolation from the day to day performance of the work.

A3 - Level 2 - Fluently performing

840. At this level of this Skill Element ENs will be performing fluently, will be preparing each patient for transitions, noting early warning signs of an impending disturbance and acting to reduce fear or stress.
841. Nina (EN) described how she consciously implemented practices to create a safe environment for patients with dementia as they transitioned through the phases of their day
- I suppose, with dementia patients. You know they might be fine during the day, like the day staff kind of say, Oh, yeah, they've been good. They've been fine. But then you kind of quickly identify that the sundowner is going to kick in. So yeah, so we have had to make sure that you know things that staff are aware of it. And to keep a close eye, and usually

they're put into a double room as well, which is right beside the nurses station, which is why we put them there. - Nina, Enrolled Nurse

A3 - Level 3 - Solving new problems

842. At Level 3 of the Spotlight framework, ENs engage in judging impacts in solving unfamiliar problems. This can relate to choosing how and when to provide difficult or confronting information, putting patients at ease and testing and evaluating solutions to a problem through reflective practice. It can include judging impacts of colleagues in the workplace.

843. Jessica (EN) was acutely aware of the importance of patients being as relaxed as possible before a procedure, and she had techniques to help patients achieve that relaxed state

... we had a young girl the other day who just had no control. She was 15. She just had absolutely no control over her emotions whatsoever, and she was just totally engulfed in fear, and her mother was standing beside her, seemed to be feeding the whole process, and then that that then had a ricochet effect on the anaesthetist, and he just wasn't coping. I've learned that, you know, there's techniques that you can use, which I did do. I came in, and because he was like struggling to get the IV in, and the fact that she was reacting the way that she was making it. And so I came in and use one of those techniques. I got her to take her mind off what was going on, and concentrate on her breathing. It was difficult for her in the beginning, but she was able to do it, so I calmed the whole situation down just purely using that technique. – Jessica, Enrolled Nurse

Jessica's description shows awareness of the impact of people's actions across multiple relationships in this work activity. The girls' impact on the anaesthetist, and his impact on her as he struggled to insert the IV, the mother's impact on the girl (or lack of impact) and the impact of the three people on Jessica (EN). Jessica (EN) applied her skills to manage the situation. She emphasised in her description that she had learned "techniques" that she successfully applied. In this example we can observe Jessica's demonstration of the under-specified skill of emotion management, including managing the emotions of a stressed patient.

844. It is Jessica (EN) who is the person to calm the girl despite being the junior in the hierarchical medical relationship. The anaesthetist "just wasn't coping". It is an example of where the skills of those lower in the medical hierarchy can be under-specified. In this example carrying out the clinical procedure is only possible because of the relationship skills exercised by Jessica (EN). Historically relationship building skills, particularly in female dominated care-based work, have been undervalued in job evaluation and work-value processes as they have been characterised as innate traits and thus often under-specified and rendered 'invisible'.

A3 - Level 4 - Sharing solutions

845. At Level 4 ENs are judging their own impact and the impact of the actions of their work group on others and on processes, and they are sharing solutions about how to modify that impact in the interests of better workflow and patient care.

846. Tamara (EN) checks in with a colleague on her understanding of a patient issue and then works collaboratively to constructively challenge a practice that may have compromised the safety of patients. She is operating at level 4 of the Spotlight framework

We also add sodium bicarb to our local to stop the sting as much as we can, and we had a doctor who started, who didn't understand that, and was drawing up in a way that just made us nurses a little bit uncomfortable because it wasn't the correct dosage. So we did our own research. Went back through things, spoke to a couple of doctors, spoke to management about this, who then reiterated it back to him that it's like it's not how it should be drawn up. - Tamara, Enrolled Nurse.

847. The Primary Material showed ENs encountering people at their most vulnerable, their most anxious and most fearful. The examples in this section show ENs being a key contact with patients and exercising the skills required to reduce fear and stress and to help patients feel at ease. They were setting patients at ease, using skills that are under-defined and under-specified. There has been a perception that these are innate personal traits of women rather than skills that are learned and practiced. They are described as the soft skills such as empathy and kindness that are 'natural to women', leading to undervaluation of occupations in which women form the majority.

B1 Negotiating boundaries

848. The focus of skill element B1 is on the ability of the worker to draw and respect boundaries for themselves and for others. This includes the ability to support, negotiate, persuade, de-escalate, advocate and influence. Boundaries are navigated with peers, people in authority, people under one's care and people outside a worker's line of authority.

B1 - Level 2 - Fluently performing

849. At the level of fluently performing, an EN may be building cordial relations with people to gain their cooperation and communicating clear and consistent limits to gain acceptance.

850. Lauren (EN) navigates an incident made more complex by factors outside of her control
- a lady that I have come in for her diabetes care plan. She's got custody of her 3 year old granddaughter and she brings the granddaughter to the Care Plan meetings, which is fine. This little girl is like a bag of fleas. She does not sit still. She's into everything. She's on your lap. She's banging on your keyboard. She's back down again. So in my drawer in my office now I have colouring in pencils and some printed sheets for the granddaughter. When she comes in she can sit on the floor and colour. - Lauren, Enrolled Nurse

Lauren (EN) built a relationship with the young girl, by having appropriate play materials for her. On the surface it is a simple solution, but it allows Lauren (EN) to do the important work of preparing the care plan for the grandmother. It is a good example of the integrative skills that are under-codified in nursing work. Lauren (EN) integrates multiple tasks, i.e. care for the child to enable the workflow to continue whilst completing the Care Plan for the

grandmother. Lauren's description makes these integrative skills appear routine, but the impact is obvious when one considers what would happen if a health practitioner refused to provide the service until the child was accommodated elsewhere (c.f. the time focussed GP in the same clinic in an example described under Skill Element A1 level 3 in this chapter).

851. In the rural General Practice clinic, Lauren (EN) builds relationships that lay the foundation for communicating clear and consistent limits with patients

I'm now seeing the same people every 3 months or so often for their care plans. So I'm getting to know them quite well, and what to expect, what to anticipate from each individual person where their health literacy is at where their level of interest is at where their priorities are at, and it's becoming much easier. to provide a good consult for people. I know their pressure points. I know where the things are hard for them, and that kind of thing. I can adapt my techniques. - Lauren, Enrolled Nurse

Lauren (EN) builds a detailed profile of each person that she treats at the clinic. In an iterative process she asks questions, learns more about the person that enables her to ask more at the next appointment, thus building both the profile and trust with the person. She can then adapt the treatment plan to best meet the needs of the person. It is a good example of skills required in a person-centred approach to health service delivery that is discussed in chapter three.

B1 - Level 3 - Solving new problems

852. At level 3 ENs are solving problems in/by negotiating boundaries. This may involve explaining procedures to patients, step by step if necessary, to build a trusting relationship. It may involve refusing requests whilst maintaining goodwill and standards of patient care.
853. Nina (EN) in a hospital setting gained trust through careful explanation of processes, enabling her to solve a difficult problem

So something like giving or I should say, doing a VAC machine, you know, that can be a bit daunting when people see them. So explaining why we do it. The fact that it enhances things like wound healing but also to explaining to the patient, because they can be quite painful when we put them on, explaining to the patient that we will prepare for that by giving them pain relief prior to us doing the VAC machine application. Also explain to them that the reason why they're good is because they can be left for 3 to 4 days. So basically, you're only doing wound dressings 3 to 4 days rather than every day, if we didn't have the VAC machine. So yeah, and just walking them through what happens, they usually sit there and watch us do it. And as I'm as I'm getting everything ready and preparing the site. I tell them what we're doing and why? - Nina, Enrolled Nurse

Nina (EN) has thorough knowledge about the purpose, operation and benefits of the wound management technique. She engaged in a step by step explanation of the procedure to help put the patient at ease as she did the work. Trust was built by removing surprises for the patient, "it can be quite painful" and by Nina (EN) operating with knowledge and calm

confidence. When an EN scope of practice reads, 'providing basic wound care in line with an agreed plan of care' (Nursing and Midwifery Board 2025b), what is not written and is under-specified, are the contextual relationship skills that are required for attending to the person who needs the wound care.

854. The negotiation of boundaries with management is also important and may require a high level of skill to refuse a request. Tamara (EN) working in a private clinic described her experience

... you need to be able to know what's within your scope, because, like our bosses that aren't from a nursing background, either. So we need to be able to say, this can't be done as an enrolled nurse. - Tamara, Enrolled Nurse

In this example Tamara (EN) highlighted the tension that can exist between an ENs obligation to observe her scope of practice with the pressure that arises in a private medical clinic that may have objectives in addition to patient safety and be managed by people without nursing or medical qualifications. Nurses working outside of their scope of practice can be a risk to the safety of patients and therefore must be observed. The diplomacy involved in 'refusing requests that cannot be met', is a hidden skill exercised by ENs in negotiating boundaries.

B1 - Level 4 - Sharing solutions

855. This level may involve sharing knowledge and experience, building and maintaining networks outside of the immediate work group and constructively giving and receiving feedback in unequal power relationships.

856. There was evidence in the EN interviews of the challenge for health practitioners trying to persuade people to accept a treatment procedure when that person did not necessarily accept the authority of the practitioner. Examples were provided by ENs such as this example from Lauren (EN) in a rural General Practice clinic

That's about kind of reading the person's attitudes as you're there with them. I know I can share all I like, the patient doesn't have to do what I say. I'm not the boss of them, or their mother, and equally they don't have to do what the doctor says, either. It's entirely up to them. But it is part of my role to share knowledge and experience, what the patient does with that is entirely up to them. - Lauren, Enrolled Nurse

857. The ENs interviewed were very conscious of the unequal power relationship with medical staff, but examples were provided where they persevered to share a solution to a problem

I've worked with that same doctor when he looked after residents, and so I've known him a long time. I know how to get around him. There's another doctor that comes from one of the other towns where there's a hospital and a clinic. He also has patients in this facility, he is a tricky customer. Very tricky customer. He's in his seventies. He's extremely knowledgeable. But if you don't manage him you won't get anything that you want out of him. He will, not participate. - Lauren, Enrolled Nurse

Lauren (EN) had built a relationship with a doctor who chose to exercise power in particular ways. She learned to work “around” him. She mentioned a second doctor and described him as a “tricky customer”. In unpicking some of these phrases that Lauren uses we can observe her patience in communicating with these doctors to build trust, her reading of their current mood, her knowledge of their past behaviours and established practices. She “manages him”, meaning she is constructively giving feedback. Lauren (EN) applied her skills to ensure that the best possible care was provided to the patients. These are examples of the hidden skills exercised by ENs that are unlikely appear on duty statements and therefore likely to remain ‘invisible’. Diplomacy requires that the work undertaken by nurses to manage the behaviour of doctors and medical specialists not be documented in job evaluation processes.

B2 Communicating verbally and non-verbally

858. The focus of Skill Element B2 is on the ability of the worker to communicate verbally and non-verbally. This can include deploying empathy, emotion work using aesthetic communication styles, touch etc. That communication will be with patients and their families, and with colleagues internal to the workplace, with management of the workplace, and very likely with peers and others who are external to the workplace.

B2 - Level 2 - Fluently performing

859. At level 2 of this Skill Element ENs will be using active listening with people using both verbal and non-verbal language in that process. They will be interpreting signs from others and reflecting on the meaning of the various communication cues.

860. The evidence of ENs was that it is in communication with the patients that they see the value of their own work. In the first example Jessica (EN) applied active listening and nuanced non-verbal communication with patients

Yeah, holding a hand, and you know, telling her concentrate, take your mind off what’s going on, and concentrate on your breathing, just talking to her like that, and being you know, kind and understanding. And she was a young girl, and it was just really difficult for her. She was like, just really frightened. She was frightened. – Jessica, Enrolled Nurse

861. The young and frightened and the confused elderly need support as Nina’s description reveals

I had a patient return to ward, and he was a bit upset. He identified with me why he was upset. His wife had just recently passed so basic. So all I did basically was hold his hand. And he appreciated that. And yeah, just simple things like that ... He was worried about how his surgery went, and obviously all the emotions come to the top so simple as holding a hand, you know. – Nina, Enrolled Nurse

862. In both examples the EN read the signs of fear and worry, interpreted the needs of the person who at that point in time was not able to communicate clearly. There was active observation of the non-verbal signs, and then in Nina’s (EN) example active listening to the verbalised concerns of the older man and the simple touch of holding his hand. Jessica (EN) used

reassuring language to minimise fear for the young girl. They are examples of under-specified skills. The work activity of ENs may not be unpacked fully to understand the skills and knowledge exercised by ENs as in these examples from Jessica (EN) and Nina (EN) leading to undervaluation of the role. Relationship building and empathy with another have historically been considered as personal traits or defined as 'natural', particularly for women. Consequently, female dominated care based work has been undervalued in job evaluation and work value processes.

B3 - Level 3 - Solving new problems

863. Level 3 of the Spotlight framework moves into communication (verbal and non-verbal) for problem solving. This can include the ability to adapt the content of communication to the needs of the patient. It may also involve overcoming communication problems through translating between experts and patients and family members.

864. The Primary Material shows ENs playing a role in ensuring that the patients have the best chance of understanding the communication from medical staff

... we have a couple of doctors that have a little bit of a language barrier. And some patients just don't understand that. And sometimes we're the ones that have to be like. This is what they're trying to say and get that through. - Tamara, Enrolled Nurse

In this case Tamara (EN) was interpreting language difficulties, possibly heavily accented speech, which she had adjusted to. Tamara (EN) recognised that the patient may not have adjusted to the accent. She accepted responsibility for adapting the doctor's communication for the patient. It is a simple but obvious example of an under-codified skill. It was the EN who had the responsibility of ensuring there was understanding on the part of the patient. In this example the doctor did not exercise that skill.

865. One of the skills that was evident across the groups of ENs interviewed for this research was their capacity to adapt their communication to meet the needs and solve problems for the patients they were working with. It was exemplified by Nina (EN) in her description of working with patients with communication difficulties

on our ward because we do ENT, [and] we have paediatric patients. So basically, you're looking at their pain and through their face, I suppose, and their actions and their emotions. We have had patients before with limited English speaking skills. So yeah, you know, we've had to adapt to that as well, and we have had a patient before who was unable to speak. So we put together a board at the end of his bed we had a clipboard with paper. He was able to write his instructions, and we were able to write our instructions down, so we adapted to written conversation with this patient because he had no voice at all. So you adapt through that. But a lot of the time. It's through facial expressions and emotions. And you know, that you can't what you can. I suppose it's just experience that you kind of identify, Okay, there's an issue here. - Nina, Enrolled Nurse

In this example Nina (EN) described adapting her communication for paediatric patients, for those without fluency in English, and in the final instance with a person who had lost the ability to speak. She had become very skilled in reading non-verbal language, “through facial expressions and emotions”. Nina (EN) understates the level of her own skill when she says, “I suppose it is just experience”, when in fact it has been the development of skills and knowledge through her years of experience, and the application of those skills across various contexts to solve problems. This is an example of an under-codified ‘invisible’ skill.

B3 Connecting across cultures: Working with diverse people and communities

866. The focus of skill element B3 is on the ability of the worker to connect across different cultures and work with people from diverse communities. Across the five ENs that were interviewed for the research, we heard examples of ENs adapting to the needs of patients who had physical impairments e.g. wheelchair bound, those who came from a culturally or linguistically diverse background, and increasingly those whose ‘culture’ was one of a different sense of time brought on by confusion or anxiety such as those patients with dementia. I have focussed on level 3 as it had highest average incidence in this Skill Element.

B3 - Level 3 - Solving new problems

867. At level 3 RNs are solving problems of inter-cultural communication. This may involve anticipating and acting to minimise problems created by intercultural or disability barriers. It may also involve interacting effectively with patients using a range of communication, mobility or health care technologies.
868. Nina (EN) described a work activity in a hospital setting, where she put in place procedures to work effectively with people who had dementia
- If they've got dementia we do basically half hour observation on them to make sure that they are where they're supposed to be in their bed, that they haven't wandered off, or anything like that. If they're a known wanderer. we do have what's called a special allocated to them where they're basically monitored all the time. - Nina, Enrolled Nurse
869. Lauren (EN) related a similar example of supporting dementia patients in a primary health care setting in a rural community
- I've taken people with dementia to appointments and things. and they can be the same. They can't really participate in the appointment, but it's about them. But they need something to do. You know, while we're there, or while we're waiting, you have to have, you know, a finder words, or a magazine to read, or pencils, and a piece of paper. You have to have that ready to go. - Lauren, Enrolled Nurse
870. Both Nina (EN) and Lauren (EN) provided examples of working with people who ‘have a different sense of time or who are displaying confusion, anxiety or similar conditions’. They learned to anticipate and act to minimise problems to meet the needs of this ‘cultural’ group.
871. Jacinta (EN) in a regional private hospital provided a snapshot of patients that she supported

Yeah, so we have a few patients that come in that either, like, I say, sometimes they'll have very bad Alzheimer's, or very bad dementia ... Sometimes you have to do a syringe for a patient with disabilities. It's also knowing what's going to make them comfortable as well. We had a patient that was paraplegic. So he needed a hoist to his procedure. So I haven't done hoisting for some time? And I said to him, Okay, this is the sling I've got. Would this be the sling that you would use at home like a large, medium, or whatever he said. Yes, I said, How would you like me to do this? I'm communicating with my patient the whole time I'm asking if he's comfortable, and then, when he's actually on the bed, I'm making sure that he's comfortable. And I said to him, If you do need the nurses at all. I popped you in a bay where we can watch you. But if you need to be repositioned, then you just need to buzz. - Jacinta, Enrolled Nurse

Jacinta (EN) adapted her communication to interact effectively with people with a range of impairments, physical and cognitive and across the age spectrum. She anticipated and acted to minimise problems by changing her language. Jacinta (EN) checked in with the patient with paraplegia knowing he had more knowledge about the technology that was needed, and she described ongoing repartee with the patient to ensure that he was at ease through the pre-admission phase for a procedure.

872. The skills exercised by Nina (EN), Lauren (EN) and Jacinta (EN) with patients with dementia and Alzheimer and those with disabilities are skills that are under-specified and under-codified. Their adaptations to improve the communication with patients who were experiencing the world differently enabled the workflow and patient care to continue.

C1 Sequencing and Combining Activities

873. The focus of skill element C1 is on the ability of the worker to sequence their own activities. This may involve reprioritising their own work to meet changed circumstances or switching and linking their activities with other events occurring in the workplace. ENs work at the direction of an RN and support the work of medical specialist. The ENs interviewed described having significant responsibility for managing the sequencing of their tasks for the day.

C1 - Level 2 - Fluently performing

874. At Level 2 ENs can fluently link their own work tasks into a smooth work process.
875. Jacinta (EN) when asked to describe a typical day gave a fluent and detailed record of how she sequenced her work to slot in all activities

In an endoscopy list you either do anaesthetic or assisting, if anaesthetic first you set up your room this includes the anaesthetic machine the cannulas for the doctors the airways for the patient and the drugs for the doctors to use. Checking in patients making sure consents and paperwork are correct. Once patient is in the room applying observation equipment and oxygen to patient, watching patients' airway and doing the paperwork. Handing over to recovery when finished the procedure. If assisting you will set up your machines and the equipment you will need for the list, getting your scopes, doing a check

in with patient in the room to make sure you have correct patient, checking consent is correct. Then assisting the doctor with taking specimens and correctly labelling them and making sure the anaesthetic nurse has the correct specimens written down in the paperwork. Writing up specimens in the correct pathology book. Handing over to recovery, taking out charts. - Jacinta, Enrolled Nurse

The fluency with which Jacinta (EN) narrated this description of her day in the interview is evidence of a person who was fluently performing in the role, knowing how to sequence the complex tasks required of her during the day and having experience in the implementation.

C1 - Level 3 - Solving new problems

876. At level 3 ENs are involved in solving new problems in scheduling and managing their work. This may involve assessing the urgency and importance of simultaneous calls on their attention. It can require frequent reprioritising of tasks to keep within deadlines and thinking quickly on their feet when new problems arise.

877. The evidence of the ENs interviewed was that new demands were made of them while performing a work sequence, requiring them to reprioritise tasks to meet those new demands. Nina (EN) described the pressures to sequence her work in looking after the patients in a hospital Unit. In her description she can be observed assessing the urgency of the calls on her time and thinking quickly on her feet as new problems arose

... the wards get busy. You've got patients you're looking after, say, 10 to 12 patients at a time, with all different needs. You've got Post Ops returning back to the ward as well. Sometimes you need to prioritise somebody in an 8 out of 10 pain. You need to deal with that before somebody with a 5 out of 10 pain. ... So you've got your post-ops, which are very important and they're constantly happening. You identify any issues, post anaesthetic or if there's any bleeds or anything happening with the wounds or anything like that ... the importance of what's happening at that time. It changes so often, it's just like a roller coaster constantly changing from minute to minute. - Nina, Enrolled Nurse

Nina (EN) described it as a roller coaster, implying speed, fast turns and rapid changes of direction with the occasional slow climb to the top of a crest. It seems a good metaphor, and to continue the metaphor, it is not a runaway roller coaster. In Nina's (EN) description what can be observed is her skills at work; making clinical assessments about the highest priority need, (8 out of 10 pain before 5 out of 10), and knowing to look for bleeds in post-op patients. She also knew the pattern; post-ops were constantly happening, even if she could not know the problems that might arise with those patients. She projected calm confidence and the ability to think quickly on her feet and solve problems as they arose. The clinical skills demonstrated by Nina (EN) were essential for the performance of the EN role, but it was the skills of projecting calm confidence, thinking quickly on her feet and solving problems as they arose, that enabled the clinical skills to be performed in context. It is those skills that are under-

codified. It is a skill to project calm thereby keeping patients calm even whilst underneath one might be feeling rushed around the rollercoaster. It can also mean that skills exercised by ENs are 'invisible' to those who manage resources in health service delivery.

878. The Primary Material provides evidence of ENs reprioritising their tasks whilst under workload pressure. The literature reviewed in chapter three shows increasing pressure on the skills of all nurses and midwives to meet the challenges of increasing chronic illnesses and co-morbidities. ENs described increasing pressure and intensity of their work to meet the demands of the changing health needs of the population. Nina (EN) working in a private hospital described her experience

The patient's needs are getting higher with regards to their comorbidities. You know, a lot more mobility issues things like that. Private hospitals we don't have that [enforced patient ratios] so we could be looking after more patients than nurses in the public sector.

We are looking after more patients on a day to day basis. - Nina, Enrolled Nurse

879. The skills performed by ENs in reprioritising and thinking quickly on their feet as demands changed in the workplace, and adapting to new demands to meet the health needs of a changing population are examples of skills that are under-codified 'invisible' skills. There can be a lag between actions required of ENs on the floor and job evaluation processes.

C1 - Level 4 - Sharing solutions

880. At level 4 an EN will be sharing new approaches to organising work roles. This may involve exchanging ideas with colleagues for more effective management of workflow, flagging new arrangements and utilising methods for recording key events to allow for effective follow-up.

881. Jessica (EN) in a regional private hospital had actively raised her concerns at a formal level about workload and its impact on staff

There was a Fair Work Commission hearing, because we weren't being listened to at work.

I gave evidence at a Fair Work Commission hearing. All the systemic problems that I could see, the lack of staff, lack of resources, unrealistic expectation that was being put on people. What they're expected to do. You know what lists and how many cases, and not getting meal breaks, and all that sort of thing. - Jessica, Enrolled Nurse

Jessica (EN) was keen to see her colleagues have manageable workloads and appropriate breaks. In committing to giving evidence at the Fair Work Commission, she was seeking solutions to the problems that she had identified.

882. One of the additional activities raised by ENs that were interviewed, was the increased complexity and pressure on record keeping. In the following work activity description from Nina (EN) she provided evidence of her involvement in exchanging ideas with colleagues to allow for effective handover as an essential part of managing workflow

... you have an opportunity to write down what we call a variance. So if you put on the pathway that there's a variance to somebody's care, you have to put a note into the

clinical chart, and in the clinical chat you identify the issue that arose. Then the doctors, the treating medical officer, will usually have a look at any nursing notes when they come to review their patient. And then the other thing is that you identify that onto the clinical path handover sheet. So we've got a handover sheet, and you identify that for the next staff member as well - Nina, Enrolled Nurse

Handover is an important element in minimising patient complications. It was recognised by ENs as a critical part of patient care (the importance of handover in health service delivery is discussed in chapter three and also discussed in the work of RNs in chapter four). Effective sharing and exchange of information is an under-codified skill. Making time for quality handovers and preparing accurate and personalised treatment notes promotes the continuation of effective patient treatment and care plans.

883. I will leave the last sentence in this section to Lauren (EN) who with humour captures the uncertainty but critical importance of nurses being able to change their routine, change the sequence of planned activities and reprioritise

What you think you might be doing can change in the blink of an eye. It's no point doing somebody's diabetes plan if they're having a cardiac arrest. - Lauren, Enrolled Nurse

C2 Interweaving activities smoothly with others

884. The focus of skill element C2 is on the ability of the worker to get things done by liaising with others to weave activities together. It may also involve tracking systemised work processes and balancing conflicting demands.

C2 - Level 2 - Fluently performing

885. When fluently performing their role at this level of this Skill Element ENs will be noticing when a colleague needs help and acting to support that colleague and they will be interweaving tasks based on familiarity with the overall work processes.

886. Jacinta (EN) was interweaving her role with that of others in an operating theatre

you try and work as a team in the [operating] room. So if I'm doing assisting, and my anaesthetic nurse is having a very difficult time holding an airway, or I'm having a very difficult time breathing, we stop what we're doing. So if I'm assisting this, I will stop what I'm doing. I will go and assist my anaesthetic nurse. If she's doing jaw support, I will go and get the machine ready for her. I will then be helping her and the anaesthetist to help that patient maintain an airway, and vice versa. If I'm doing a colonoscopy, and my patient is bleeding, or I'm having a lot of trouble getting to or around the Colon or to reach the [indistinct], my anaesthetic nurse will step in and help as well, making sure that my patient is also safe on the anaesthetic side, making sure the doctor is there to basically take over the care of that patient's airway. - Jacinta, Enrolled Nurse

Jacinta (EN) was proactive in identifying where she might be needed. She liaised with other members of the team and was able to request help from others to ensure the safety of the

patient. All of this was done in a complex and pressured environment where there were life and death risks for a patient.

887. Jacinta (EN) described effective teamwork in the work activity. In unpacking the meaning of 'teamwork' in this context I found

- a) multiple examples of detailed observations of own and others' work
- b) understanding the prioritisation of patient need
- c) skills in "maintaining the airway"
- d) rapid synthesising and processing information to allow for decision-making in response to issues that arise
- e) knowledge of the skills of each member of the team e.g. the role of the doctor.

These were some of the skills exercised by Jacinta (EN) in this example of 'teamwork'. These are under-codified skills that remain 'invisible' if words like 'teamwork' are not unpacked in job evaluation processes.

C2 - Level 3 - Solving new problems

888. At Level 3 ENs solve problems in/by interweaving their activities with others. This may involve considering work health and safety (WHS) issues in responding to difficult situations and carrying out steps to ensure legal and safe procedures are enacted in difficult circumstances. It may also involve monitoring group work processes to ensure resources are available.

889. Patient safety is important to all, but ENs in this study revealed the different ways in which they were involved in assuring patient safety, typically at a cost to themselves. Jacinta (EN) was expected to stay until the theatre list was completed, regardless of her shift finish time

unfortunately, if your list goes long, you just can't leave ... it's paid depending on who is the floor coordinator, or the person in charge. On the day they will come and ask you ...

You are just normally expected to stay. - Jacinta, Enrolled Nurse

Jacinta (EN) experienced the request to work additional hours as a requirement. I know from other examples that Jacinta (EN) shared in her interview that she had a commitment to the needs of the patient and also a commitment to ensuring that all legal and safe procedures were followed. The commitment to legal and safe procedures, in this case remaining on duty to provide care, is an under-recognised skill.

890. The tension evident in Jacinta's (RN) description arises when workers believe that their work is not fully understood, and that some of their skills are 'invisible'. In this instance the commitment by the worker to meet legal obligations is not matched by the hospital providing sufficient staff – itself likely to be caused by the 'invisibility' of the skills exercised by the ENs

C2 - Level 4 - Sharing solutions

891. At this level, ENs share approaches to interweaving individual and team activities. This may involve developing and using shared information exchange systems.

892. Jacinta (EN) provided an example where ENs acting on their own initiative developed a system for shared information exchange to help them meet the different requirements of the medical specialists with whom they were working thus enhancing patient safety

So we have a little cheat book, as we call it. It has the assisting or the proceduralist doctor, your gastroenterologist, and then we have your anaesthetists. So we have a little cheat, sheet, or book that has our doctor's preferences in, so say our proceduralist likes a certain type of snare or a certain type of clip, and will like high flow, but well, not high flow, and then certain cannulas. So it's little cheat sheets for us. - Jacinta, Enrolled Nurse

This resource was a solution for the ENs to meet the different demands of the various medical specialist with whom they worked. This is an example of an integrative skill, where workers combine to develop approaches to ensure that workflow is maintained. Having knowledge of the peculiarities of each medical specialist they worked with enabled ENs to interweave their work effectively with that of each specialist. Maintaining group work processes across the different requirements of specialists, involved the collective work by ENs to interweave their efforts to prevent interruptions to workflow i.e. patient care and treatment plans. It is an under-codified 'invisible' skill.

C3 Maintaining and/or Restoring Workflow

893. The focus of skill element C3 is on the ability to work around obstacles, keep things on track, rectify mistakes and restore and stabilise workflows after an interruption or emergency. It may not necessarily be a crisis but may include activities that maintain the stability of the organisation as it moves through cycles of pressure and overload.

C3 - Level 3 - Solving new problems

894. At L3 ENs are solving problems in maintaining and restoring workflows. This may include identifying minor issues that may grow into bigger problems and acting to prevent this.
895. ENs provided examples of stepping in for a colleague who was experiencing some difficulty
- if your colleague is having a personal issue, you need to be able to notice that, and you need to be able to speak to your managers or speak to your other staff members and say, Hey, are you able to step in for so and so she can step out for 10 minutes and have a breather and a little bit of a reprieve so they can get themselves together. - Jacinta, Enrolled Nurse

Jacinta (EN) a perioperative nurse showed awareness of what colleagues might be experiencing and the potential for that to escalate and impact on the workflow. She described how she would act to prevent the problem escalating. Interweaving with others to maintain workflow is only effective when all workers are functioning effectively. Recognising that a colleague needs to take time to get themselves together and finding a solution to absence of the person is an example of the integrative skills needed to get things done in complex work

such as the delivery of health care. Maintaining workflow and patient safety by looking to the safety of colleagues is an under-codified skill.

C3 - Level 4 - Sharing solutions

896. At level 4 an EN is sharing approaches to stabilising workflow. This may include the ability to de-escalate stressful and dangerous circumstances, sharing techniques for making safe decisions under high pressure or in sensitive and/or ambiguous circumstances and bringing routines and lines of work back together after emergencies.

897. Jacinta (EN) in an operating theatre adapted to a sudden change in the workflow
you are thinking quickly on your feet to try and stop that bleeding to make sure that that patient doesn't have any adverse reactions, making sure that you are also aware of all your bleeding equipment, and that can be Hema Spray, that can be clips, that can be bands all sorts of things. So you're needing to understand your equipment as well as where it is in the room as well, because our rooms are all set up differently, unfortunately. You need to be able to know where it is and how to use it. Yeah. - Jacinta, Enrolled Nurse

In response to the sudden change (the bleed) Jacinta (EN) worked through a mental visual picture of the equipment that might have been required. She had set this up prior to the procedure and now acted quickly to access the equipment for herself and the medical specialist to prevent the situation escalating for the patient. Each operating theatre is different, so there was also a physical context to her actions.

898. It is after a crisis that the capacity to return to routine is most demanding. Nina (EN) described her response after any emergency in her Unit

Depending on what's going on at that stage, we will just basically get back to what needs to be done on the ward at that time ... you might have a debrief at the end of the shift with your NUM. If it's something that's you know, pretty full on. You might have the debrief before you get back to the ward. So yeah, so it just depends on the situation, but you just basically keep going. You don't have time to stop, you know, you just keep going. Reflection time happens later. But yeah, it's you know, if the patients say taken to ICU, or something like that. Then you just keep going on looking after your other patients. - Nina, Enrolled Nurse

This is an example of the exercise of under-codified skills. Nina (EN) herself does not recognise, or does not articulate, what is required of her when she describes her role to “just basically keep going”. I heard in the interviews and read in the transcripts about emergencies from cardiac arrests to threats and aggression from a patient, through to patient deaths.

Nurses, in this case ENs, exercised the following skills in emergencies

- a) managed their own emotions and did so internally, so as to project outward calm
- b) considered the impact on their colleagues and patients
- c) prepared to respond to the reactions of others

- d) refocused on the routines that were required to maintain care for all patients
- e) reconciled the new demands on their time to fulfil patient based care with less time available as a result of the emergency and potentially less staff as some were called away to continue to manage the emergency.

In Nina's (EN) word this is "just keeping on going looking after your other patients". When that statement is unpacked, even in the limited way I have done here, it can be observed how skills performed by ENs in emergencies are under-codified skills and may remain 'invisible'.

899. Health service delivery is unlike a production line which can be stopped while a review of a problem is undertaken, a solution developed and then implemented, thus enabling the workflow to be restored. The interviews for this research provided examples of how ENs maintained workflows and looked to the interests of patients even as a major problem unfolded. They described how they managed significant interruptions to routines without losing focus on patient care; and how they restored workflow after a crisis. The capacity to do those things does not arise simple as a matter of course, it involves the development and exercise of skills and knowledge to achieve a new balance. ENs exercise skills in maintaining and restoring workflow that may 'invisible' to their colleagues.

6.6 EN Skill Cluster case studies

900. It may be that a skill element is exercised singularly by an EN. In practice it is more likely and indeed evident in the interviews that were conducted that several skills across the nine Skill Elements are performed simultaneously in a work activity undertaken by a nurse or midwife. The Spotlight Framework describes that phenomena as 'clusters of skills'. Interweaving, or deploying 'clusters' of Spotlight skills requires a complex combination of thinking feeling and acting. Further, the capacity to apply several skills at the same time is itself an 'under-codified higher level skill'; increasing the effort required to perform the role and adding to work intensity (Junor 2021 Appendix 6 page 3 of 22).
901. The skill of deploying complex 'clusters' of Spotlight skills has the following characteristics:
- a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities
 - b) It is the 'thinking' element of multi-tasking
 - c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges
 - d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to rebuild and work on. (Junor 2021 Appendix 6 page 3 of 22).
902. I have chosen to analyse ENs deployment of 'clusters of skills' through three case studies. The case study approach allows me to illustrate how unpacking a work activity and the 'cluster of skills' evident in that work activity reveals the full range of 'invisible' skills in that work

activity. The three case studies are typical work activities performed by ENs, allowing for the broad range of roles that are performed by ENs. Once case study is from an EN tasked with communicating to patients about a significant delay in operating theatre procedures, another is about an interaction between an EN and a medical specialist and the third, an EN managing patients in a post-operative Unit in a private hospital.

EN Case Study One: Empathic Alertness

903. The ENs that were interviewed, cited examples of being the member of the team who was called on to communicate news that may increase a patient's discomfort or create further inconvenience for them. In a busy workplace this task can be diverted to the person who is perceived to have the least critical role in a process. In the example below Jacinta (EN), who as an EN would have been among the lowest in the hierarchy of an operating theatre, described what she did when there was a delay in the operating theatre schedule. In Table 6.4 I have unpacked that statement using the skills from the Spotlight framework. I have also used statements from the Spotlight workbook to enhance the understanding of what the passage says about the skills that Jacinta (EN) displays.

904. In the interview, Jacinta (EN) described the following work activity

when we have list changes and our patients, unfortunately, are not first anymore. They might be 4th or 5th ... it's about communication, I think, with your patients. The doctors never go out, but the nurses do so. The nurses are the ones who have to speak to those patients and say, I'm very sorry about the long wait. Would you like us to make a phone call for you, or would you like to make a phone call? It is going to be a lot longer. Most patients are more than happy to wait, and especially if they get that phone call. But it's just about the communication, and then they're a lot more cooperative, and unfortunately, you're being done at 7 o'clock tonight instead of one o'clock in the day. -
Jacinta, Enrolled Nurse

905. I have described the case study as 'Empathic Alertness'. It captures two important aspects of Jacinta's description, her alertness to the situation in which the activity took place and her ability to stand in the shoes of the 'other', in this case the patients who were waiting for procedures that were delayed.

906. The Skill Element that is most obvious in her description is that of 'maintaining and/or restoring the workflow', a Coordinating skill in the Spotlight framework. It is aligned with level 3 of the framework, 'problem solving' (C3.3). She was required to advise the patients waiting for admission to the theatre of delays; operations were being re-scheduled and there would be some hours before they were admitted to theatre. She knew that the delay in admission times to the theatre was likely to frustrate patients and create a bigger problem. She needed to craft her communication carefully. In her description of her actions, I observed how she took time for caring listening and interactions with the waiting patients, made more

remarkable by the fact that she had just stepped out of the intense pressure of an operating theatre. Embedded in this level 3 work activity is also the level 2 skill, 'fluently performing'.

907. This work activity description shows Jacinta (EN) piecing together information and perspectives from various sources to solve the problem (A1.3). She had knowledge about the activity happening in the operating theatre, and the people who were undertaking that work. She knew the admission procedures required for the remaining patients and estimated how much time each procedure might take. She was sensing the mood and emotions of the patients still waiting, be that anxiety, stress, restlessness, impatience or some other emotion. These are some of the perspectives that Jacinta (EN) integrated into the task she performed.
908. The third Skill Element of this task is the actual communication that took place between Jacinta and the waiting patients. Jacinta (EN) was fluently communicating verbally, and non-verbally with patients, in both delivering the message and then noting or 'receiving' communication from the waiting patients. This was coded at B2.2.
909. In examining the dominant Skill Elements we find Jacinta (EN) deploying a 'cluster' of three of the nine Skill Elements in communicating the message (A1.3, B2.2 and C3.3). I have unpacked the full range of skills that Jacinta (EN) exercised in the work activity that she provided. This case study provides an example of how lower level skills are nested into the higher levels.

Table 6.4: EN Case Study One: Empathic Alertness

Sentences from Jacinta's statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>The doctors never go out but the nurses do</i>	C3.2	Find ways to get patient cooperation when you must react to a sudden change in priorities	Jacinta has been through this process previously and understands what is required.
<i>when we have list changes and our patients, unfortunately, are not first anymore. They might be 4th or 5th</i>	A1.3	Use your knowledge of the job and its internal contexts to anticipate and avoid problems	Jacinta thinks through the implications for the waiting patients.
<i>it's about communication, I think, with your patients</i>	B1.2	Communicate clear and consistent limits in a way that gains acceptance	From experience she knows the impact of the delay and that there are limited solutions.
<i>I'm very sorry about the long wait</i>	B2.2	Use active listening, reflecting and using silence to allow people to talk through their concerns	She makes a choice to apologise for the delay, not to blame anything or anyone.
<i>Would you like us to make a phone call for you, or would you like to make a phone call?</i>	B2.2 C1.3 C3.3	Interpret the needs and intentions of people And	Jacinta is doing multiple things here- from past experience she knows the importance of the phone call. She is

		As new demands arise, frequently reprioritise tasks And Make time for caring listening and interactions amidst intense work pressures	also using language that shows she is listening to people's needs, despite the intense work pressures. She is also offering to reprioritise her tasks to organise for phone calls to be made.
<i>Most patients are more than happy to wait, and especially if they get that phone call.</i>	A1.3 B2.2	Piece together information and perspectives from various sources to solve a problem And Solve problems by using insights into reasons for difficult behaviour	Aware of patient needs from previous experiences she has already factored in the phone call as one way of solving the problem for those who are stressed by the delay – she understands why some people may not be happy to wait.
<i>But it's just about the communication, and then they're a lot more cooperative</i>	B2.2	Use active listening, reflecting and using silence to allow people to talk through their concerns	Jacinta knows that being clear in her communication will help to get cooperation.
<i>And unfortunately, you're being done at 7 o'clock tonight instead of one o'clock in the day</i>	A3.3	Pick the right moment to convey unwelcome news, judging from reactions about to determine how much to say	It appears that she does not say this out loud, rather keeps this information to herself judging that it may not be helpful at this time.
Then there are the unstated actions that follow this description of her work activity: • Returning to the theatre to communicate to her colleagues the outcome of her conversation with the patients about the delay (B1.2) • Quickly returning to her theatre duties following this interruption (C1.2)			

EN Case Study Two: Reflexive Communication

910. In the second case study the setting is again an operating theatre, but the focus is on the communication between Jessica (EN) and the medical specialists with whom she was working. It was common for ENs to speak about adapting their communication to meet the needs of the different medical specialist who they were supporting in operating theatres.

911. In the interview, Jessica (EN) made the following observation in response to an interviewer question about what it was that she was 'reading' in an operating theatre

Their body language, you know, whether they're stressed or not. Cause a lot of lot of doctors they get stressed working with new people, you know. So I guess you have to sort of try and take that into consideration. Just situational awareness, I guess, is really the

thing just really being aware and watching what's going on. And you know. yeah, that's really basically what it comes down to. I guess. - Jessica, Enrolled Nurse

912. I have described this case study as 'Reflexive communication'. Jessica (EN) was reading the signs from the medical specialist and in that process was actively and consciously reflecting on her own communication, how she was responding and reacting to what is happening in front of her. She was reflexive, meaning that she was attentive to the physical and social environment that she was in; she was conscious of how her responses might impact on other people and that environment.
913. The dominant Skill Elements that are demonstrated are in Skill Set A- Contextualising, specifically 'sensing contexts and situations', and Skill Set B - Connecting, both 'negotiating boundaries' and 'communicating verbally and non-verbally'. In this example it is the non-verbal communication that is evident in Jessica's (EN) description.
914. In the first instance Jessica (EN) applied the knowledge she had gained in and outside of the workplace and adapted it to the relationship with the medical specialist (A1.2). She read the body language of this medical specialist to gain information about how that person was acting and therefore what might be needed from her in support (B2.2).
915. She was actively building trust with this person to ensure a cooperative working relationship in the theatre. She showed an understanding of the specialist and responded according to the lead that person was providing (B1.3). A key phrase in Jessica's (EN) example is "working with new people". She read the non-verbal language of the specialist, noting their stress because Jessica (EN) was new to that specialist. There is no room for Jessica (EN) to be stressed even though the specialist is new to her. She moves on with fluently performing her role, "taking that into consideration".
916. Jessica is deploying a 'cluster of skills' simultaneously with an emphasis on communication (A1.2, B1.3 and B2.2). Table 6.4 provides unpacks all of the skills exercised by Jessica (EN) in this work activity description.

Table 6.4: EN Case Study Two: Reflexive Communication

Phrases from Jessica's statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>Their body language, you know, whether they're stressed or not.</i>	B2.2	Make effective use of body language e.g. to convey or gain information And Interpret the needs and intentions of people who have restricted language	Jessica was reading the body language of the specialist for signs of their emotional state. The specialist does not have the emotional language or chooses not to communicate with Jessica at that time about their level of stress, so Jessica interprets body language.

<i>Cause a lot of lot of doctors. They get stressed working with new people, you know.</i>	A1.2	Adapt and apply knowledge and skills gained in and outside this workplace	Her experience of working in theatres with many specialists is evident; she has seen the stress previously. What sits underneath this comment is that the medical specialist is new to Jessica, but Jessica needs to manage any stress she is feeling about that.
<i>So I guess you have to sort of try and take that into consideration.</i>	B1.3	'Gain others' trust and consent	Here is the beginning of building trust – she stands in the shoes of the other person, accepting how they are feeling and adjusting her response. Jessica trusts the specialist to perform the procedure and accepts the onus is on her, whatever the mood of the specialist, to ensure that the specialist can trust Jessica. This is Jessica in reflexive mode, thinking through how her responses will affect the social environment in the theatre.
<i>Just situational awareness</i>	A1.2	Adapt to the interaction styles and needs of each different patient [or colleague]	Jessica plays down her role with the word 'just' – but the situational awareness is her adapting to the needs of this medical specialist at that time and by implication (and indeed in evidence provided elsewhere during the interview) to each specialist on each occasion.
<i>I guess, is really the thing just really being aware and watching what's going on</i>	B2.2	Use active listening, reflecting and make effective use of body language e.g. appropriate and respectful touch, to reassure, or to convey or gain information	Once again Jessica glosses over the skills she is applying. Her skill is seeing warning signs and making changes. That is based on knowledge of what those signs are and the implications of the changes. She is actively listening and looking for body language as communication.
<i>that's really basically what it comes down to</i>	A1.2	Adapt to the interaction styles and needs of each	Jessica downplays the skills she has brought to the activity. She has

		different patient [or colleague]	adapted her work processes to meet the needs of the specialist.

EN Case Study Three: Combining interaction with monitoring and problem solving

917. In the final case study, I use a work activity from Nina (EN) who was working in a post-surgical ward and explained how she approached the many dimensions of her role. She referred to dealing with pain management in response to patients, and the regulations governing those drugs that she needed to observe.

918. Nina (EN) described her work activity

Yeah, I suppose with regards to pain management, if somebody's in a lot of pain. And obviously the doctor has charted medications, we kind of explain to the patient. Okay, yes, You still have a 7 out of 10 pain. We've given the medication that the doctor has charted on the request form, what we call the PRNS, which is patient, you know request, I suppose. We explain to them why because they don't know. Obviously the doctors have to provide a limit for S8 drugs, which are dangerous drugs. So we don't want to have a look at things like overdose and so forth. I then go through the process of them. Let's find alternative issues to your pain. Ice packs. Things like that, or it could even be a heat pack. So yeah, we try that. Then if we need to, we identify (indistinct). We might bring the doctor in, you know the doctor who's looking after the patient. So yeah, but obviously with S8 drugs there's a limit that you can have - Nina, Enrolled Nurse

919. In this work activity description, the dominant Skill Sets are Contextualising and Connecting. Nina's description shows the Skill Element of 'sensing contexts or situations' at the problem solving level (A1.3). It also shows the Skill Element 'monitoring and guiding reactions' at the problem solving level (A2.3). Nina (EN) was monitoring a patient who was experiencing pain. She was aware of the person's condition and the treatment plan provided by the treating doctor. Her knowledge of the treatment included an understanding of the regulations and possible effects of the medication prescribed for the patient. In this situation no more of the medication could be provided and Nina (EN) moved into problem solving mode in exploring other pain management options. In her description she was acting independently in her assessment of the patient and in finding solutions. She was open to contacting the treating doctor if her interventions did not solve the problem. Right through the description Nina (EN) described herself communicating with the patient, exercising empathy and explaining each step she was undertaking, effectively negotiating the consent of the patient as she moved through the problem solving. These actions align with level 3 of the Spotlight Skill Element, 'negotiating boundaries' (B1.3). My assessment is that in this work activity Nina is primarily deploying Skill Elements A1.3, A2.3 and B1.3.

920. In Table 6.5 I have identified the range and levels of Skill Elements being performed simultaneously by Nina (EN) in her description of her work. This case study provides an example of how lower level skills are nested into the higher levels.

Table 6.5: EN Case Study Three: Combining monitoring and interaction with problem solving

Phrases from Nina's statement	Spotlight coding	Illustrative statement from Spotlight workbook	Observation
<i>Yeah, I suppose with regards to pain management, if somebody's in a lot of pain.</i>	A1.3	Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems	Nina is observing the patient, recognising the signs of difficulty and preparing to respond.
<i>And obviously the doctor has charted medications, we kind of explain to the patient. Okay, yes, You still have a 7 out of 10 pain.</i>	A2.3 B1.2	Key in' to others' ways of thinking And using insights into reasons for difficult behaviour, e.g. responses to pain And help people maintain composure And Communicate clear and consistent limits in a way that gains acceptance.	Nina applies her experience, her knowledge, her skills and her empathy with the patient. Nina lets the patient know she understands what she is experiencing but that there is a limitation on the drugs that have been prescribed.
<i>We explain to them why?</i>	B1.3	Gain others' trust and consent by explaining each step of a process and its purpose	Nina knows the regulations and what is possible but explain so the patient understands, and through that Nina hopes to build the patient's trust in the care Nina is providing.
<i>Obviously the doctors have to provide a limit for S8 drugs, which are dangerous drugs.</i>	B1.3	Understand the significance of the regulatory framework governing your work And Find a way to refuse requests that cannot be met, or are unreasonable or dangerous	Nina is effectively refusing the patients request for more medication and does so in a way that the patient is most likely to accept. Nina is up to date with the regulations about the S8 drugs, even though she is not responsible for prescribing them.

<i>So we don't want to have a look at things like overdose and so forth</i>	A1.3	Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems	Nina's knowledge extends to the reasons for the regulations and the risks to the patient. Even if she calls the doctor at this stage he/she is unlikely to administer more of the S8 medication.
<i>I then go through the process of them</i>	B1.3	Gain others' trust and consent by explaining each step of a process and its purpose	This is the second time Nina refers to an explanation of the treatment with the patient. She is taking time with the person and building the trust that will be required over the next period of treatment.
<i>Let's find alternative issues to your pain. Ice packs. Things like that, or it could even be a heat pack. So yeah, we try that. Then if we need to, we identify (indistinct) We might bring the doctor in, you know the doctor who's looking after the patient.</i>	A2.3 A3.3 C1.3	Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain And Help patients feel at ease whilst you are carrying out activities that may worry or distress them And Think quickly on your feet as new problems arise during an activity	Nina knows the person is in pain and she sets out to solve the problem with alternative treatments to pain medication. Nina sequences a treatment plan – showing her capacity to think quickly on her feet in response to the situation that she is confronted with. Nina reassures the patient that she has different options at the same time she is thinking internally about the problem solving path she will follow.
<i>So yeah, but obviously with S8 drugs there's a limit that you can have</i>	A1.2	Understand the significance of the regulatory framework governing your work	Nina reiterates this point at the end of the anecdote. Clearly this is important knowledge. It serves to emphasise the skills that she has developed in alternative approaches to pain management for patients.

6.7 Conclusions about ENs and Spotlight skills

921. Relying on the Primary Material in this section and Secondary Material included in this report I find that the work of ENs involves substantial incidence of the use of Spotlight skills across the 9 Skill Elements of the Spotlight framework. These skills have historically been overlooked and undervalued ('invisible') in job evaluation, job grading or work value assessments.
922. ENs demonstrate the intensive use of skills across the nine Spotlight Skill Elements. The evidence for this is in the data in the Heat Map (section 6.4) and the alignment of work

- activity descriptions from the interviews with the Skill Elements in the Spotlight framework (section 6.5). That evidence is enhanced in the presentation of three case studies of the deployment of 'cluster of skills' in the work performed by ENs (section 6.6).
923. The dominant Skill Set when measured by intensity of incidences described was Contextualising, Skill Set A, with an average of 40.6 incidences per person. This was followed by Coordinating, Skill Set C, with an average of 25.2 incidences per person and close to that in terms of the intensity of incidences described was Connecting, Skill Set B, with 20.0 incidences per person. To be clear, 40.6 incidences per person means that in the transcript of a 90 minute interview, a team of trained coders identified, on average, 40.6 occurrences of the performance of one of the three Skill Elements grouped under Contextualising ... and so on for the other two Skill Sets.
 924. The work activities described in the interviews showed ENs operating primarily across level 2 and level 3 of the Spotlight framework, represented by the descriptions 'fluently performing' and 'solving new problems'. It was the latter, 'solving new problems', that showed the highest overall incidence of reported work activities with an average of 38.6 incidences per person. There was also evidence from the interview participants of ENs 'sharing solutions/applying expertise', judged to be at level 4 of the Spotlight Framework. This higher level was most apparent in the Contextualising and Connecting Skill Sets.
 925. It was also apparent ENs frequently deployed Spotlight skills in 'clusters', i.e. they are deployed not in isolation but in combination. Three examples of 'skill clusters' were presented; the first 'Empathic alertness', the second 'Reflexive communication' and the third, 'Combining interaction with monitoring and problem solving'. As an example of the intensity of skills demonstrated by ENs, one description of a work activity by Jessica (EN) (that totalled just 137 words), showed 8 skills being applied simultaneously to complete that activity.
 926. Work activities performed by ENs rely on the use of 'clusters' of these under-recognised skills in combination with each other. Combining multiple skills simultaneously involves higher level thinking and reflexivity skills. Engaging in these complex higher order tasks while performing physical tasks is itself an under-recognised skill.
 927. The three different approaches to the data analysis; being a Heat Map, alignment of work activities with Skill Elements, and the Skill Cluster case studies show the hidden, under-defined, under-specified, under-codified and under-recognised skills, that are demonstrated by ENs in the performance of their duties. These are 'invisible skills' in job evaluation processes. Table 6.2 showing the relationship between the Spotlight skills and the typology of invisibility is the most obvious representation of the relationship. Should ENs stop performing any of these 'invisible' skills for which they are not currently recognised then the delivery of health care in the situation where they work would decline and patient health outcomes would become poorer.

7.0 Nurse Practitioners

7.1 Introduction to NPs

928. I was not specifically asked to however I applied the Spotlight Tool to the work of Nurse Practitioners (NPs) to “identify, name and classify the ‘invisible skills’” used by NPs who participated in this study. To do this I conducted a Spotlight analysis, the details of which are set out in chapter two of this report, drawing on the descriptions of work activities provided by NPs who were interviewed for this study. This chapter includes the facts and information gathered from the 4 NPs interviewed which I have relied on to support my findings regarding the application of the Spotlight taxonomic framework to the role of NPs (Primary Material). Where relevant I have also incorporated information from Secondary Material referred to in chapter three.
929. The analysis in this chapter draws from the information about work activities provided by participants who were interviewed for this study. The transcripts from these interviews were reviewed and analysed against the Spotlight taxonomy. A coding framework that corresponds with the Spotlight taxonomic framework was developed to assist in coding the work activities described in the interviews with participants. Using this coding framework codes were allocated to the descriptions of the work activities provided by participants. Sometimes several codes may have been allocated to a work activity. Through this coding process the Spotlight skills that are present in the participants work were identified. The activities (and the skills associated with them) were named and grouped in relation to the Skill Element that they relate to in the taxonomic framework. An assessment of the Skill Level at which the skills were being performed was then made. (the research approach is set out in chapter two)
930. Drawing on the evidence and analysis set out in this chapter I conclude that the work of NPs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. A substantial volume of the work of NPs interviewed requires the use of skills that are hidden, under-recognised, under-defined, under-specified, under-codified and therefore likely to be under-valued on gender grounds.
931. The highest area of skill intensity for NPs was in Skill Set A - Contextualising. There was also a high incidence of Skill Set B - Connecting. NPs in this study were exercising the Spotlight skills at the levels of problem solving (level 3) and sharing solutions/applying expertise (level 4). However, there are also significant instances of skills being deployed to create systems (level 5). Level 4 and level 5 skills make up more than 50% of the incidences of skills recorded. The exercise of skills at L4 and L5 are underpinned by the consolidation of skills and expertise through experience, reflected in the instances recorded at level 2 and level 3. These levels are categorised as fluently performing work activities and problem solving.
932. The chapter is set out in the following sequence

- 7.1 Introduction to NPs
- 7.2 A review of the profile of NPs in Australia that draws on a literature review
- 7.3 A snapshot of the demographics of the NPs interviewed for this study
- 7.4 A representation of the data analysis of the NP interviews in the form of a Heat Map and a Skills Table
- 7.5 Selected examples of work activities provided by the NP participants in this study aligned with each of the nine elements of the Spotlight framework
- 7.6 A discussion of the deployment of 'clusters' of Spotlight skills in three case studies providing further insight into the skills performed by NPs in this study.
- 7.7 Conclusion.

7.2 Profile of NPs in Australia

- 933. A NP must be registered with the Nursing and Midwifery Board of Australia (NMBA) as a RN before an application can be submitted for NP endorsement. The NMBA reports that in 2024, 394,785 people held registration as a Registered Nurse (RN). Of that group 2900 were endorsed as NPs (Nursing and Midwifery Board of Australia 2024a).
- 934. Australia changed its nursing qualification and training structure in 1994. From that date all people commencing a RN qualification were required to enter a Bachelor of Nursing course as a minimum qualification (see chapter three for a discussion of this change). This degree qualification is delivered by a university and is typically completed over 36 months; and must include a minimum of 800 hours of clinical practice. To make application for NP endorsement, a RN is required to complete an additional tertiary qualification, Master of Nursing Science (Nurse Practitioner). This is a university level qualification generally completed across 18 months to two years of study. That qualification must include 300 hours of supernumerary clinical practice. A RN, before seeking endorsement must also have completed 5,000 hours of practice judged to be at an advanced level.
- 935. RNs must be registered with the NMBA and are required to renew that registration annually. NPs follow the same procedure, with a 'Nurse Practitioner' endorsement being attached to their registration. One of the requirements for renewal of RN registration is the completion of 20 hours of Continuing Professional Development. To maintain NP endorsement an additional 10 hours of CPD is required annually in areas that reflect the additions to the scope of practice of NPs (Nursing and Midwifery Board of Australia 2025e)
- 936. The OSCA classification system used by the Australian Bureau of Statistics (ABS) and Jobs and Skill Australia (JSA) provides additional insights into the nursing and midwifery workforce (Australian Bureau of Statistics, 2024b). NPs are identified by OSCA as a specialisation of RNs and included under the classification, 'Midwifery and Nursing Professionals' along with Midwives. No further breakdown of the NP role is undertaken in the OSCA system. In this

study, for reasons I have set out in chapter two, I have treated NPs as a distinct classification and analysed the data for them separately.

937. Jobs and Skills Australia draws data from different sources to the NMBA, at different times, and using different criteria, so there are discrepancies between the numbers reported by each organisation. It is not my intention to explore those differences here, but to provide the JSA data, as presented on its website to further illustrate the profile of NPs in Australia. JSA reports that there are 2500 NPs in employment in Australia. Of those 83% are female with the median age reported as 48. Of those employed, 36% are working part time (Jobs and Skills Australia 2026b). There are some interesting differences between NPs and the broader group of RNs to which they belong. The median age for NPs is 9 years older than RNs (39 years). The difference is likely explained by the requirement for additional qualifications and hours of clinical practice. In considering sex, 17% of NPs are male compared to 13% for all RNs (Jobs and Skills Australia 2026b).
938. In the literature I consulted there were few significant data sets available that differentiated the demographics of NPs from RNs. The examples that I did identify are in chapter three.

A brief history of the NP role

939. The first NPs were authorised to practice in December 2000 (Bouchoucha et al., 2022). It is generally agreed that the NP role developed as a response to the shortage of medical practitioners in rural and remote Australia and in particular in remote Aboriginal and Torres Strait Islander communities (Bouchoucha et al., 2022; Duffield et al., 2009; Parker & Hill, 2017). Since those first appointments the requirements for endorsement and the breadth of practice have evolved. The NMBA now defines the role as

A nurse practitioner is a registered nurse endorsed as a nurse practitioner by the NMBA.

The nurse practitioner practices at an advanced Level, meets and complies with the *Nurse practitioner standards for practice*, has direct clinical contact and practices within their scope under the legislatively protected title 'nurse practitioner' under the National Law.

(Nursing and Midwifery Board of Australia 2024b)

940. Scanlon et al (2018) report that NPs are predominantly employed within the public health system, though there are 28% in the private sector. In total 46% work in hospital settings. The majority hold a clinical appointment in the emergency departments of those hospitals.
941. There is agreement in the literature that NPs have demonstrated their value to the Australian health care system (Bouchoucha et al., 2022; Duffield et al., 2009; Scanlon et al., 2018) Bouchoucha writes

studies have looked at patient satisfaction, comparable care, length of stay, and adverse events and they have all shown that NPs are able and competent to provide safe and efficient care to a diverse range of patients and contribute positively to healthcare services in Australia. (2022, p. 106)

The NP role is relevant to the health needs of the Australian population; it has been formalised in its definition and scope of practice which are also aligned with international practice. (Scanlon et al., 2018).

942. To further illustrate the role of NP, given its shorter history than the other classifications in this study (RN, EN and MW) I have set out in the words of the NPs that were interviewed for this study examples of how they view their role. The NPs were asked, “What is the role of NPs and how is it different to a RN?” (being mindful that all NPs are also RNs)

I write a lot of scripts for opioid medications and medications, the palliative care medications. So yeah, lots and lots of scripts. I order CT scans sometimes. I order ultrasounds dopplers ultrasounds of breasts and order quite a few tests. Order lots of bloods. And then I have to review those results and act on them. That's my responsibility. It doesn't go to someone else. So they're my results. I've got to look them up and work out what we do with those results. They do help with diagnosing certain things. But other times, you know, I order blood transfusions. IV fluids. - Nadine, Nurse Practitioner

... if someone comes in and they've got a urinary tract infection. Registered nurses can do the history. They can do the observations. They can check their urine, and they know that they've got a urinary tract infection. But they're not authorised to organise pathology they're not authorised to prescribe. Nurse Practitioners can order tests relevant to what we are clinically assessing. - Kelly, Nurse Practitioner

... with Nurse Practitioners, there's the 4 domains, there's a clinical, there's the education, there's leadership, and there's research. And so you know, things like research are never reflected in the job description, but that's very much a part of what we are expected to do. - Matilda, Nurse Practitioner

... at least 50% [is not in my role description] All that clinical reasoning and decision making at high levels. All the collaborating, working with different teams. - Nadine, Nurse Practitioner

NPs Scope of Practice

943. The Scope of Practice for NPs has been established by the NMBA. It is important to note that the scope of practice for any nurse or midwife is not fixed in any setting, nor to any person. It is influenced by local context, the health needs of the patient, employer policy, education and training and individual skills. The onus is on the individual nurse or midwife to ensure that what they are doing at any time fits within their scope of practice. I have provided the NMBA Scope of Practice for NPs below

NP practice is primarily a clinical role. NPs integrate theoretical and advanced practice knowledge to apply to diagnostic reasoning to formulate diagnoses. NPs have authority to

practise independently and collaboratively in multi-disciplinary teams, at an advanced practice level. NPs supervise ENs, nursing and NP students and other healthcare workers. Depending on the individual scope of practice, the NP may have the ability and authority to work at an extended or specialist level. This includes providing or assisting with medical or surgical procedures, or advanced care in range of specialist and/or generalist clinical areas. Examples of core NP activities include many registered nursing activities, and in addition

- a) advanced health assessment that includes ordering and interpreting diagnostic tests (pathology and medical imaging)
- b) diagnosing and treating acute and/ or chronic physical and mental health conditions
- c) independent prescribing of scheduled pharmacological and non-pharmacological interventions
- d) independent referral to general practitioners, medical specialists and allied health practitioners
- e) establishing healthcare delivery
- f) a strategic role to improve, manage or prevent health issues
- g) support meeting the need of community health using contemporary research to provide evidence-based care
- h) policy development initiation and quality improvement activities (Nursing and Midwifery Board 2025b).

7.3 Profile of NPs in this study

944. Four NPs were interviewed for this study. All four are female. One of the four identified as being of Aboriginal and Torres Strait Islander heritage.

Geographic distribution

945. Four states/territories are represented across the four NPs.

946. Two NPs work in organisations based in metropolitan regions, one of those two also does outreach work into remote locations. One other NP works in a rural location and the fourth works in remote locations on a fly-in fly-out basis.

Work settings

947. One of the four works in a GP clinic where she also has some management responsibility. Another is employed in a public hospital and consults across several institutions in that region. A third is employed by a not-for-profit community health service. The final person is undertaking short term contracts with community based medical services.

Experience, training and qualifications

948. All NPs interviewed for this study have more than 35 years of experience in nursing. It is likely they were hospital trained to gain their initial nursing qualification (though none explicitly said this in the interview). The years of experience were cited as 35, 43, 46 and 48 years.
949. NP endorsements for each of the four were achieved in the following years, 2003, 2007, 2009, and 2011. That gives a spread of 11-22 years working as Nurse Practitioners.
950. There is a high level of qualifications across the group.

NP One

Master of Nursing Science (Nurse Practitioner)

NP Two

Bachelor of Education

Postgraduate Certificate in General Practice Nursing

Postgraduate Certificate in Intensive Care

Postgraduate Certificate in Midwifery

Master of Nursing Science (Nurse Practitioner)

Authorised immuniser

NP Three

Diploma of Applied Science (Nursing)

Bachelor of Nursing

Graduate Certificate in oncological nursing

Master of Nursing Science (Nurse Practitioner)

Currently enrolled in a PhD

NP Four

Bachelor of Nursing

Master of Nursing Leadership

Master of Nursing Science (Nurse Practitioner)

Doctor of Philosophy

7.4 The Spotlight framework and work activities of NPs in this study

951. In the following section I have set out the average incidence of reported activities using each Spotlight Skill Element at each level. The method of identifying and classifying these activities is discussed in chapter two of this report.

Spotlight Heat Map and analysis

952. A Heat Map is presented in Table 7.1 to visually show the patterns of intensity and complexity of invisible skills utilised. The Heat Map was compiled by tallying the incidences of Spotlight skills (at level) present in the work activities of each NP participant and then averaging that number across the 4 NPs in the study.

Table 7.1: NPs Spotlight Skills Profile

Nurse Practitioner Spotlight Skills Profile						
Skill Element	1. Orienting	2. Fluently Performing	3. Solving new problems	4. Sharing solutions/ Applying expertise	5. Expertly creating a system	Totals
Total A: Contextualising	0.0	6.3	30.3	29.5	12.0	78.0
A1. Sensing contexts or situations	0.0	3.0	13.3	14.8	7.3	38.3
A2. Monitoring and guiding reactions	0.0	2.0	11.3	7.3	1.5	22.0
A3. Judging impacts	0.0	1.3	5.8	7.5	3.3	17.8
Total B: Connecting	0.0	4.3	20.8	22.8	7.8	55.5
B1. Negotiating boundaries	0.0	2.3	9.0	16.5	3.0	30.8
B2. Communicating verbally and non-verbally	0.0	1.3	8.8	0.8	1.3	12.0
B3. Working with diverse people and communities	0.0	0.8	3.0	5.5	3.5	12.8
Total C: Coordinating	0.0	2.3	22.8	12.8	5.0	42.8
C1. Sequencing and combining activities	0.0	1.0	10.0	4.3	1.8	17.0
C2. Interweaving your activities smoothly with those of others	0.0	1.3	9.3	7.0	2.5	20.0
C3. Maintaining and/or restoring workflow	0.0	0.0	3.5	1.5	0.8	5.8
Average per Participant Incidence	0.0	12.8	73.8	65.0	24.8	176.3

953. Table 7.1 (above) shows the average incidence of the Spotlight skills drawn from the description of work activities given by NP participants in their interviews. The table shows that the work of NPs involves the use of skills across the 9 Skill Elements of the Spotlight framework. They are demonstrating these skills across levels 2, 3, 4 and 5 of the Framework, with more than 50% of recorded incidences being at L4 or L5. The Spotlight framework highlights the Contextualising, Connecting and Coordinating skills of Nurse Practitioners; skills that are typically ‘invisible’.

954. The highest number of incidences were recorded for Skill Set A - Contextualising with an average of 78.0 incidences per person. This was followed by Skill Set B - Connecting which had an average incidence per person of 55.5. Skill Set C - Coordinating had an average of 42.8 incidences per person. The dominant skill levels were level 3 - solving problems, and level 4 - applying expertise/sharing solutions. Nurse Practitioners also demonstrated level 5 skills at the highest rate of all classifications interviewed, with an average of 24.8 per person. To

- express this in different language, in a 90 minute interview, an NP was, on average, describing the creation of a system or influencing a system change every 3-4 minutes. That is the frequency with which that level of skill occurs in the normal flow of their work activities.
955. The NPs in this study worked in complex environments where they frequently operated autonomously and were constantly exercising leadership in their work. Only one of the four has a formally designated leadership role, however the evidence from the Primary Material is very clear about the leadership role played by NPs across the communities where they work.
 956. NPs regularly encounter new work environments and contexts requiring them to be constantly alert to the context in which they are working. Their capacity to move into those environments and perform their role is reflected in the data with the highest average incidence for any individual Skill Element being A1 - 'sensing contexts or situations' with 38.3 incidences per person, including 7.5 incidences per person at L5. At this level of performance NPs are bringing people together to address issues for patients and organisations and embedding new solutions to problems into work processes. The skills exercised at level A1.5 of the Spotlight framework are hidden, under-codified and under-recognised.
 957. There is a density of incidences around A2.3 (13.3 average per person) and A2.4 (7.3 average per person) showing frequency in the Skill Element - 'monitoring and guiding reactions'. NPs interviewed were engaged in the most challenging fields of health service delivery. In their interactions in these extreme environments there was a need to carefully monitor their own responses and to be able to quickly develop an empathic relationship with people who may be on the margins of society, as was the case with 3 of the 4 NPs interviewed in this study.
 958. The density continues through A3, which has a focus on 'judging the impacts of one's work and that of others'. The NPs recorded an average of 7.5 incidences per person at A3.4, and 3.3 incidences per person at A3.5. Characteristic of L5 activity is setting up processes for evaluation of the impact of the organisation's work using a range of different methods and resources and analysing the impact of the organisation's work on other agencies. Each of the NPs interviewed was involved in policy development, accreditation procedures and/or providing advice to government. At the system level of Skill Element A3, NPs were utilising skills that are under-codified and 'invisible'.
 959. The capacity to constantly read the social context in new environments and to operate effectively in those work locations requires skills in self-awareness and management, social awareness and relationship connection. These are the skills of Contextualising in the Spotlight framework. They are hidden, under-defined, under-specified and under-codified skills.
 960. The second highest skill set for NPs, when measured by average incidence was Skill Set B - Connecting. Negotiating boundaries (B1) had the second highest overall average for a single

- Skill Element (average 30.8), with the level 4 activity in that skill element having the highest average incidence for a single Skill Level of any of the nine Skill Elements at 16.5 per person.
961. The NP group had the highest average across all classifications (EN, RN, MW and NP) for Skill Element B3, 'working with diverse people and communities', with an average of 12.8 incidences per person.
 962. At levels 3, 4 and 5 of the Skill Set - Connecting, NPs were interacting with and relating to people who were marginalised, living remotely and therefore isolated from specialised health resources, or experiencing the most complex health problems. The skills they were exercising are hidden skills, they are under-specified, as they frequently involve working with patients and communities who are hidden from the mainstream Australian community. The people are hidden by their remote location, hidden by their unstable lifestyle and homelessness, from which mainstream Australia prefers to avert its gaze, and they are hidden by virtue of the complexity of their terminal illness which sees them house bound or hospital bound, and therefore away from the public gaze.
 963. The Primary Material shows that the relationships that were built by NPs with people in remote, disadvantaged and marginalised communities involved careful explanation and reassurance for people who had been victims of trauma in health service delivery. NPs negotiated for quality care, even having to refuse requests that could not be met whilst still maintaining relationships with the patients. Relationship building skills, particularly in female dominated care-based work, have in the past been undervalued in job assessments and work-value processes as they have been characterised as innate traits and thus often under-specified and rendered 'invisible'.
 964. In those situations where NPs were working in cooperation with doctors and medical specialists there was evidence from NPs of the additional negotiation required to overcome a lack of understanding about their role, despite the classification having been established for 26 years. This required of NPs nuanced conversations in unequal power situations. Typically, NPs held greater knowledge of the social context, but did not always have the medical authority, despite their expanded scope of practice, to authorise specific treatments. NPs provided examples of when they were required to persuade and influence doctors and medical specialist to obtain the best outcome for the patient living in a particular context with different patterns of social behaviour that were not well understood by the doctors and medical specialists. That type of negotiation where a nurse is required to challenge the decision of a medical practitioner is typically hidden and therefore 'invisible'. Diplomacy requires that the interests and reputation of medical practitioners is protected.
 965. In Skill Set C - Coordinating, NPs recorded an average of 42.8 incidences per person across each interview. The density of incidences was strongest at the Skill Element of 'interweaving

activities smoothly with those of others' (C2). At the 'problem solving' level of this Skill Element (C2.3), there was an average incidence of 9.3 per person, and at the 'solution sharing' (C2.4), it was 7.0 per person. At C2.5, it was 2.5 incidences per person. At these levels of this Skill Element, the NPs are interweaving person-centred care with an awareness of safety for co-workers and patients, whilst maintaining the workflow in complex environments. They are also extrapolating from individual examples issues that are system wide, and they are addressing those issues through innovations to bring about long term improvements. The interweaving or integrative skills demonstrated by NPs are regularly under-codified and therefore 'invisible'. Maintaining workflow, allowing others to perform their roles, but weaving it all together into a coherent process was described by NPs in their work activities. The term "articulation work" (Junor 2021) is applied to the exercise of these integrative skills.

Spotlight skills and the typology of invisibility

966. To provide an overview of the link between NPs work activities, Spotlights skills and the typology of invisibility I have included Table 7.2. This Table provides examples of work activities engaged in by the NPs illustrating the use of Spotlight skills. The relationship of these activities to the typology of invisibility is also noted. The average incidences of the Spotlight skills at each level, for each Skill Element is also displayed.
967. Table 7.2 (below) provides examples of activities illustrating use of Spotlight skills by NPs across the 9 Skill Elements.

Table 7.2 Typology of invisible skills and Spotlight Skill Elements for NPs

Skill Element	1. Orienting	2. Fluently performing	3. Solving problems	4. Sharing solutions	5. Expertly creating a system
A1. Sensing contexts or situations	0.0	3.0	13.3	14.8	7.3
L3 Piece together information and perspectives from various sources to solve a problem (UD) L4 Use techniques for exchanging rapid situational updates with colleagues (UD) L4 With colleagues share approaches to solving problems relating to patients or technology (UC) L5 Use your understanding of the organisation's priorities to influence policies and help shape systems (H) L5 Bring together people with knowledge and experience to help find ways of addressing issues for patients and the organisation (UC)					
A2. Monitoring & guiding reactions	0.0	2.0	11.3	7.3	1.5
L3 'Key in' to others' ways of thinking to filter information according to how it will be received (US) L3 Work in sensitive situations to help people maintain composure, self-respect or independence (H, US) L4 Be alert to and help manage co-workers' emotional pressures, strengths and needs (US) L5 Foresee potential difficulties with a policy proposal and find ways of addressing them in advance (H)					
A3. Judging impacts	0.0	1.3	5.8	7.5	3.3
L3 Pick the right moment to convey unwelcome news, judging from reactions about to determine how much to say (H, US) L4 Regularly summarise your understanding of what is going on to check that others agree (UC) L4 Constructively challenge practices that may compromise the safety or dignity of others (H, US) L5 Set up processes for robust evaluation of the impact of the organisation's work, using a range of methods and feedback sources (UC, UR)					
B1. Negotiating boundaries	0.0	2.3	9.0	16.5	3.0
L3 Gain others' trust and consent by explaining each step of a process and its purpose (US) L3 Negotiate in a way that maintains goodwill, without giving way on quality patient care (H, UC) L4 Share knowledge and experience to guide people, including those who do not accept your authority (H) L4 Constructively give and receive feedback in unequal power situations (H) L5 Carry forward a proposal for system change by networking with stakeholders and testing with people (H, UC)					
B2. Communicating verbally & non-verbally	0.0	1.3	8.8	0.8	1.3
L3 Pitch your use of language and body language to people with varying Levels of understanding (H, US) L3 Overcome communication problems by 'translating' (e.g. specialised terms), between experts, patients, family members and people of different ages and experiences (UC) L4 Help non-experts solve administrative or technical problems by providing explanations using familiar examples and language (H)					
B3. Working with diverse people & communities	0.0	0.8	3.0	5.5	3.5
L3 Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or similar conditions (H, UD, UC) L4 Listen and observe attentively to key into the unspoken aspects of interactions based on diversity including another language, culture, sexuality, ability etc (H, UD) L4 Work with relevant communities to incorporate elements of the cultures of patients and families into your work practices (UC) L5 Work at a systems Level to ensure diverse groups are provided with partnership, participation and protection of their interests (UC)					
C1. Sequencing & combining activities	0.0	1.0	10.0	4.3	1.8
L3 As new demands arise, frequently reprioritise tasks to keep within deadlines whilst attending promptly to medication times, bell calls etc. (UC) L3 Think quickly on your feet as new problems arise during an activity L4 Exchange ideas with colleagues for more effective management of workflow (UC) L5 Maintain a range of longer-term initiatives, particularly relating to support for patients in maintaining their interests and improving mental or physical function (UC)					

C2. Interweaving activities smoothly with others	0.0	1.3	9.3	7.0	2.5

L3 Check your own and co-workers' safety in responding to difficult situations (UC)

L3 Carry out all steps to ensure legal and safe procedures in a rapidly changing situation (UC)

L4 Have in place, and be able to activate, support networks for quick and calm response to emergency or other changing contingencies (H, UC)

L5 Develop shared policy approaches to addressing resource constraints to meet longer-term restorative and/or rehabilitation goals for patients (H, UC, UR)

C3. Maintaining &/or restoring workflow	0.0	0.0	3.5	1.5	0.8

L3 Manage conflict between legal requirements and/or organisational rules and patient need (H, UC)

L4 Quickly notice and adapt to changes in the workflow, cooperating to prevent or de-escalate stressful or dangerous situations (UC)

Legend:	H	Hidden Skills
	UD	Under-defined skills
	US	Under-specified skills
	UC	Under-codified skills
	UR	Under-recognised skills

968. Table 7.2 provides examples of activities illustrating use of Spotlight skills across the 9 Skill Elements by NPs

7.5 Aligning NP work activities with Spotlight Skill Elements and Levels

969. In this section I have used examples drawn from the Primary Material to illustrate the relationship between the work activities of NPs and the Spotlight framework. Whilst an example has been used to illustrate a single Skill Element this does not mean that this example is only illustrative of that Skill Element. An example drawn from the Primary Material may have been coded to multiple Skill Elements. Examples showing the deployment of 'cluster' of Spotlight skills are contained in the case studies at section 7.6 of this chapter.

A1 Sensing Contexts or Situations

970. The focus of skill element A1 is on the ability of the worker to perceive, interpret or read work or social contexts and situations. These contexts and situations include workplace and social roles, rules, resources, regulations, risks, conditions and emergency situations. Activities coded at levels 3 & 4 of the Framework were the most numerous for NPs in this study, with a substantial coding of skills at level 5. These higher level activities were underpinned by the NPs fluent use (L2) of knowledge of the role and the context in which the role is performed.

A1 - Level 2 - Fluently performing

971. The Primary Material showed that an experienced NP has the knowledge and skills to make an assessment of the context in which they are working. They bring accumulated knowledge from inside and outside of the organisation, including knowledge of regulatory frameworks to

assess how they can be most effective in meeting the needs of patients and other colleagues in that environment. Luna (NP) described her arrival in a remote community

When you have emergencies or fast paced things that have to happen for a patient. If you haven't orientated yourself to what's available, what you can use, who can help you who has the skills within their scope of practice, then you'll fail the patient every time. So as soon as you get to a place, orientation isn't just knowing where the tea room is, it's about knowing where the emergency trolley is, where the drugs are kept, where safe spaces that you can manage a patient with a mental breakdown, with a cardiac arrest, with a birth, with anything. So, knowing what you've got on hand, and where you are in remote settings is one of the most essential. Where are the drugs? How do you prescribe them? How do you write them out of a book? How do you protect yourself legally by giving out drugs of addiction? ... the same rules apply to you whether you're there for 2 weeks or 10 years, so it becomes routine to look at those things. - Luna, Nurse Practitioner

Luna (NP) was required to 'read' the social and the work context rapidly to be fully prepared to operate in her role across multiple unfamiliar settings.

A1 - Level 3 - Solving new problems

972. NPs in the study sifted through details to piece together information to find a way forward in the treatment of patients, acting always in the best interests of that person

So this client had been managed by us but also been managed by a couple of other providers. And was being managed differently by all of them in terms of her treatment. And I said, Look, you know, we've got to stop. We've got to stop testing this person because she keeps getting mixed messages and she keeps starting and stopping her treatment. And what will happen is that she will develop resistance to the treatment and there's not ever going to be anything else to treat her with, because there's no further research happening in this particular area there's no nobody. The multinational drug companies are no longer interested in finding treatment for that small number of people who will become resistant to this virus, and I'm talking about [name of virus redacted to preserve anonymity] And so I said, You know, that makes this person really vulnerable. So the best thing we can do is basically just pull out. - Matilda, Nurse Practitioner

Matilda (NP) was applying knowledge of both the patient and the context which made a difference in how care could be delivered for the person. She reached an informed position that she argued was in the best interests of the patient. Her approach reflected knowledge of the health system and skills in interpretation and analysis.

973. NPs in the study demonstrated the capacity to anticipate and avoid problems. This developed from an understanding of, and experience in the context in which they were operating

So when you're looking at aboriginal communities across Australia, there are endemic health issues that are particular to a different mob so far north, West Queensland, Northern Territory and Western Australia. There's a huge amount of rheumatic heart

disease in children, so understanding that where you would not normally look at a child to see if they've got heart problems. You would look at that in those areas, understanding that in [name of state], in some of the communities, there's high drug, use hepatitis, STDs, so you would look at those, even in a younger population than you would normally do in urban settings. So it's applying that knowledge and the skills that you've gained within each setting and understanding. You do get things very differently to a highly educated group of affluent children in Sydney you would be looking differently for chronic diseases in those children from aboriginal communities, and looking at the endemic problems to each community and applying that knowledge to there. - Luna, Nurse Practitioner

Luna (NP) uses community knowledge, an example of situational awareness, and incorporates that into her approach to clinical diagnosis.

974. The problem solving skills applied by Luna (NP) and Matilda (NP) in these two work activities are skills that are typically under-codified 'invisible' skills.

A1 - Level 4 - Sharing solutions

975. The Primary Material shows that the additional study and training, and the years of experience enabled NPs to build networks and allowed them to exchange rapid situational updates with colleagues. The network of NPs was a valuable source of solutions for problems

I would network with a lot of nurse practitioners in like-minded organisations within the community. You know, for example, there is a homeless health service over on the south side of [city], and they have a nurse practitioner and a couple of candidates. So we would liaise quite a lot and run some joint clinics and programs. you know anything and everything. If we felt that there was a need. Yeah, we would try to respond to that. - Matilda, Nurse Practitioner

976. Each of the 4 Nurse Practitioners interviewed for this research described examples of delivering lectures or training courses, attending and presenting at conferences and writing papers. Kelly (NP) captures the approach evident across the four NPs interviewed

Last year I presented, I think, at 3 different conferences talking about our urgent after hours model, and how nurse practitioners and paramedics can see a wide range of patients clinically, safely and efficiently, and looking at hospital avoidance and also freeing up ambulances for emergency care. I've got another conference in May presenting to rural health, which is mostly GPs on this model, and how it can support GPs sustainability in general practice ... We've also got an abstract in for an international conference of paramedicine speaking about the nurse practitioner role and the community paramedic working together in the middle of the year. - Kelly, Nurse Practitioner

977. NPs have 'education' as one of their four domains of practice; defined as "uses knowledge and skills to educate those receiving care, peers and colleagues" (Nursing and Midwifery Board of Australia 2025c). The work activities above show the additional networking (Matilda) and the innovation (Kelly) that extends the meaning of education in the work of NPs. The

growth in knowledge and support for and from others enables NPs to interweave with others and maintain workflow in disadvantaged, remote and marginalised communities. The work activities contain examples of under-codified and under-recognised 'invisible' skills.

A1 - Level 5 - Expertly creating systems

978. NPs provided examples of how they were shaping systems through innovation; advocating for system improvements, including prompting legislative change; bringing people together to find ways of addressing issues; and developing systems for information exchange. The following examples show NPs operating at level 5 of the Spotlight framework. Nadine (NP) changed the palliative care system across a whole region

I developed a program called Palliative Care Needs Rounds. Which, if you looked it up we ended up doing a randomised control trial with Palliative Care Needs Rounds. So older people who live with multi morbid conditions and high level of disability weren't getting access to specialist palliative care. So we kind of said, well, we're going to walk through the front door, cross over that funding barrier, and we did a randomised control trial with our intervention, and we saved 1.7 million for the State government. So they said, yes, you can provide services to that Commonwealth funded service. - Nadine, Nurse Practitioner

979. Matilda (NP) worked through a systems change approach with multidisciplinary teams to bring about change for homeless people and in correctional facilities

we formed a collaboration with another two organisations and conducted an outreach clinic, where we went into a service that looked after homeless people, and we all came from a different perspective. It was interesting from a systems change perspective, in that we moved out of our silos. And looked collaboratively. Yeah, which you know, we're in the process of writing up. We do that on a number of occasions. We've done that going into correctional facilities. We've written that up. So it's that collaboration. And you know, just by overcoming those barriers that are often set in place where, you know you've got public private and different health service sectors and just managing to navigate those and overcome them to provide something that's really great. - Matilda, Nurse Practitioner

980. The two examples of L5 activity show how NPs applying their comprehensive clinical skills and understanding of work processes, gained through experience on the job, benefited the organisations in which they work and the patients for whom they care. They demonstrated skills applied in context. In the second example, Matilda's ability to envisage a new approach to collaboration with others was key to the success of the initiative. These level 5 skills are typically under-recognised and hidden. The initiative to develop new systems by Nadine (NP) and the work to build a collaborative interdisciplinary team by Matilda (NP) are likely to be taken for granted rather than listed as a requirement of performing their role.

A2 Monitoring and Guiding Reactions

981. The focus of Skill Element A2 is on the ability of the worker to monitor and guide their own and others' reactions. In this Skill Element NPs had high average incidences of activities coded at level 3 and 4, along with a small number of instances of L5 activities.

A2 - Level 2 - Fluently performing

982. The NPs interviewed were experienced nurses and picked up on small changes and early warning signs in their patients

... early warning signs like somebody's ankles are starting to swell, and you know they've never had a heart check or something, even if they're in their late twenties, their ankles are swelling. Suspect the worst back from there? Do they have heart failure? Are carers or family members who start coming in and saying, Oh, my dad has got an infected leg! Can I get some antibiotics? It may be cellulitis. It may be something much more for the fact that them to come in. Why hasn't he come in, or something like that? And so it's important to recognise all those little signs that something more may be wrong. - Luna, Nurse Practitioner

This example is an important reminder that NPs whilst frequently working at the higher levels of solution sharing and system development maintain their core clinical nursing skills.

A2 - Level 3 - Solving new problems

983. The NPs provided examples where empathising with the person under their care helped in understanding difficult behaviours that confront health practitioners. The interviewed NPs were dealing with patients in some of the most difficult, complex and challenging scenarios from cancer therapy to palliative care, drug and alcohol dependency, and conducting health clinics in remote communities. Matilda (NP) articulated what was required in her NP role

that's just all part of being negotiable, trying to meet people where they're at and not taking it personally. You know, and people are often in pain, or fear, or in shame. You know they're very common themes in in the workplace and just acknowledging that. Yeah, that's where your communication skills come in. - Matilda, Nurse Practitioner

984. Kelly (NP) working in a rural GP clinic described a similar scenario with different clientele, and how she allowed each person to come to their own independent decision about their health

... understanding the cycle for behaviour change ... we see people with chronic disease that have issues with weight or smoking, or, you know, having too much alcohol, or whatever I think it's just a matter of, you know keep doing what we're doing until you know evidence, research finds a better way of doing it. We can do all the quick programs and do all that preventative health. But until the person wants to do it, you're fairly blocked. - Kelly, Nurse Practitioner

985. Matilda (NP) shared her reflection on the people she was working with who have substance addictions and frequently are homeless. In her reflection is the empathic approach that was

characteristic of the approach of NPs in the study. Matilda (NP) was fully aware of the sensitivity of the situation in which treatment was taking place, sensitive to the history of the person and sensitive to the complexities of health care for the person

But clients need more than just tablets. They need a whole host of other things. you know. Quite often you're the only healthcare provider that they see or you're the only healthcare provider that they trust. And so there can be a number of other issues that you need to address, not just the one that they present with. - Matilda, Nurse Practitioner

986. At L3 of this Skill Element NPs are 'keying' into how others are thinking and showing a deep appreciation of the contexts. They build a relationship with the other person based on empathy. They communicate difficult and complex information to patients as Matilda (NP) described. At this level (L3) NPs manage their own emotions and show respect for the patient's decision making as Kelly (NP) articulated. NPs managing themselves and displaying empathy for their patients is about the skill of 'emotion management'. It is an under-specified skill, often assumed to be a natural trait or characteristic associated with women workers and historically undervalued for those reasons. Because it is under-specified the skills and knowledge that comprise emotion management can be 'invisible'.

A2 - Level 4 - Sharing solutions

987. The Primary Material shows NPs relying on collaborative approaches to provide health care. Luna (NP) working in remote locations began to rely on new technology, particularly telehealth for exchanges of information with peers

Quite a few of the specialists will allow us to ring them and tell us what to do in a situation as you're doing it in [name of state]. When I was working there we would have a telehealth. So we would have emergency doctors that could be telling us how to do a procedure that was out of my scope, because it had to be done there and then. - Luna, Nurse Practitioner

988. The NPs in the study were focussed on how to operate most effectively in the interests of the patient and their needs as they moved through different health stages

If we're palliating, if we're looking after somebody who's terminal at home, sometimes you'll go within office hours if it's possible, and other times you might have to go after hours to try and manage somebody on medications and different things at home if they need it, that it's very tricky, and there's no set way other than you can't go alone. And it's staff dependent - if you can get somebody to go with you. - Luna, Nurse Practitioner

989. The examples above show the integrative skills that enable the interweaving of tasks and the monitoring of reactions by those involved (including the NP themselves). The examples show the NPs reflecting on and modifying their own actions even as they are carrying out a task. Luna (NP) in the first example is guided through a procedure that is out of her scope via

- telehealth because of the urgency. In the second example she balanced provision of care with her own safety. Skills performed by Luna (NP) in these examples are under-codified.
990. The NPs raised examples of being alert to the emotional pressures, strengths and needs of their co-workers. They were looking to the needs of co-workers and caring for them when required and implementing strategies to improve safety when they identified a problem. Matilda (NP) spoke about her work with the homeless and street people, noting both care for her co-workers and also how self-care was poorly managed among those co-workers
- I always felt I always felt an allegiance to my coworkers ... we've had coworkers that have died from an accidental overdose. And dealing with that, I mean, it was really interesting, because they were all quite blunted, and said, You know, I was really upset, and they were all going, Matilda, just drink a cup of concrete, you know, it goes with the territory. And I'm going we should be doing better than this, guys. We should be doing better than this. - Matilda, Nurse Practitioner
991. Kelly (NP) working in primary health care in a rural setting narrated this example
- I might have finished seeing a patient. So my doors open, so someone's been wanting to ask me a question, and then they'll come in, and then they want to talk and debrief, and I can see that they really need it. And so then I have to take a breath and think you know what's more important, and then close the door and give them, you know, listening time and help them reset, and then me reset. - Kelly, Nurse Practitioner
992. Luna (NP) working in remote communities spoke about mental health and the need to be alert to signs that someone was not coping
- it's really hard ... Some of the nurses that I've had out, and if they've been there for a while they start to withdraw, and they're not engaged, and they're sticking to their room, and that and it can be that they're suffering personally from being away from home and being out there, or that they don't feel safe, or that they're so, it's just important looking at changes in behaviour of your work colleagues ... it's a big issue staff watch staff all the time. - Luna, Nurse Practitioner
993. Nadine (NP) reported the complexity of co-workers responding to families in palliative care
- I had a family not long ago that really was unhappy. They just were so unhappy, and said that the man died really badly, and even though none of us felt that, you know, we did everything, absolutely everything we could. That family was never gonna be satisfied with anything we did. So supporting my colleagues around that is really important. You don't want people to hang out and dry on their own. - Nadine, Nurse Practitioner
994. The four examples above (one from each NP) demonstrate active listening and skills and close observation of colleagues. An important element in sharing solutions is the capacity for the NP to initially recognise that there is a problem, manage their own reactions and thereby enable a focus on supporting co-workers. Typically, under-specified skills, care for co-workers

has been seen as a natural trait of some people who find it easy to apply. However, it is a learned and complex skill to manage one's own emotions while supporting a colleague.

A2 - Level 5 - Expertly creating systems

995. Level 5 of this Skill Element is about initiating system changes. Kelly (NP) working in a rural GP practice, was seeking to introduce an innovation in how the clinic responded to after hours medical requests. She knew it would be resisted by some GPs

So with our urgent and after hours we know that GPs are reluctant to respect and trust other health professionals. So, knowing that when we introduced the service, we approached all the GPs and said, this is what we're doing, and would you like to be involved? So, raising it with them first, and they said, No, they didn't want to be involved. So we foresaw that the difficulty with a change in how things were going to be done, and giving them the option of joining or not joining - Kelly, Nurse Practitioner

Kelly (NP) leads the process applying change management strategies, identifying potential barriers to the innovation and working around those barriers to find a solution. In this example she has anticipated negative responses from GPs (it is a rural town), kept control of her own reactions to the negativity, and worked to find allies to support the proposal. These are sophisticated skills but are hidden skills. It is work that happens behind the scenes to make system improvements and is likely to be 'invisible'.

A3 Judging Impacts

996. The focus of Skill Element A3 is on the ability of the worker to judge the impact of their work. For NPs that impact may be on patients and/or on their colleagues. Judging impact is one of the Skill Elements grouped under Skill Set A - Contextualising. It involves judgement of actions in the context of the work being performed in a particular location or environment.

A3 - Level 2 - Fluently performing

997. Kelly (NP) reflected on her early experience as a NP. Her judgement about her impact on clients was enhanced with growth of confidence through experience, her willingness to consult with others as she learned, and by practice

So when you qualify as a nurse practitioner suddenly you're able to prescribe medication. And for me that was like, Oh, my God! Now I can prescribe. What if I kill somebody? And they have an allergic reaction. And then I'm on the front page of the newspaper going. So when you first start as a nurse practitioner, it's really quite scary. ... I was scared to have the responsibility for looking after a child, and so I would assess them, and when I first started I would call the GP. Who would come in and do the same. And after a while I realised that my clinical skills were the same as their clinical skills. And my assessment was the same as their assessment. I proved to myself that I was okay and competent, because I'd just taken the time to practice and practice and practice - Kelly, Nurse Practitioner

A key element of Kelly's reflection is her commitment to "practice and practice and practice". This is evidence that the skills required for the NP are not innate to a type of person but are skills that are learned and developed over time with attention to practice.

A3 - Level 3 - Solving new problems

998. Luna (NP) working in remote communities, some of the most complex areas of health delivery in Australia spoke of learning about the context to judge her impact and solve problems

So the lessons I've learned are that you have to begin very early in these remote, and it's for indigenous and non-indigenous, because they're all living together in these small communities ... I didn't understand at first that that you may only see that person one in every 6 months, because they might work out on big cattle stations and only come to town. But you have to do everything. Otherwise you've missed your opportunity to find things. - Luna, Nurse Practitioner

999. In the second situation she learns the limits of the impact she can have when dealing with a teenager where the family has full influence over the decision making

This is a very tricky thing. You know that the 17 year old is 2 weeks away from death, and the parents won't send her down for a valve replacement, and the girl doesn't want to go herself, understanding that they are the bosses they've called the shots. It's not your right to override it that you've explained it the best you can, and keep explaining it ... But you are not the boss. You're given the best advice you can, you've explained, but ultimately it is the patient's decision. And they're making a decision based on all the information and their understanding. So that's a very hard thing to do. So all you can do is inform, and hope they've understood your side of it, and go from there. - Luna, Nurse Practitioner

Luna (NP) however difficult it seems, respects the independence of the family's decision making and holds back her own views in that process. She had to manage her emotions.

1000. There were examples from the NPs acting to reduce fear, embarrassment or stress for patients as treatment progressed

He said he wanted to go home. He smoked marijuana. That was the only thing that he had in his day that gave him some peace, and then he wanted to get home, and that he lost trust in the whole system. No one could care for him and so I said, if you know, if I made a plan where we could get your pain under control and get you home tomorrow with the support of home-based palliative care. Would you trust me to give me those 24 hours? And he said, yes, so I started an infusion of Methadone using a syringe driver so prescribed that. - Nadine, Nurse Practitioner

Nadine (NP) has situational awareness about the patient and his condition, she has knowledge about what she can do legally, and she makes a judgment about the impact she can have in negotiating an outcome for this patient.

1001. NPs are dealing with very complex health scenarios often in isolated or remote settings and working on their own. Judging one's own impact on patients, communities and colleagues is

complex when isolated. The essential capacity to solve problems by making challenging decisions and being able to judge the impact of those decisions are skills that are under-specified and under-defined. In the final example Nadine's skill in gaining the trust of the patient and making a clinical decision that no one else would make, may sound like operating on 'gut instinct,' but it is a skill developed through experience in nursing and advanced nursing practice and additional study and qualifications.

A3 - Level 4 - Sharing solutions

1002. Where the context allows NPs were constantly checking in with others to summarise their understanding and to determine a solution. It was not always straightforward when co-workers come from different backgrounds and with different skills sets. Matilda (NP) working with the homeless and those with drug and alcohol addictions provided the following example

I was always really proactive at tracking people down and finding them and staying in touch. But I know that sometimes the support workers and the harm reduction workers would see that as stalking. And saying, You know these people, these people make their own choices and you go, but I need to make sure that those choices they make, are completely informed that they know the consequences of not having treatment. And they're entitled to it. They're absolutely entitled to it. So there was often a lot of that. Often a lot of that interaction about justifying and trying to encourage them to be more proactive about staying in touch with clients. You know they'll come back when they're ready. It just it wasn't always as straightforward as that, - Matilda, Nurse Practitioner

There are similar examples across this chapter where Matilda (NP) is grappling with, and in some cases succeeding in bringing together professions with different cultures to agree on a treatment plan. She consciously created environments in which feedback could take place. This included challenging practices which affected the dignity or safety of the client and eventually deciding on the best strategy to support the person who was seeking assistance.

1003. Kelly (NP) spoke about the feedback environment created between colleagues receiving negative feedback from a patient, is quite confronting as a practitioner, and I knew that he [the GP] would be devastated, that he'd had this feedback, but on the letter he'd acknowledged the way he'd written it, and the self-reflection showed a lot of integrity, and I was really impressed by that, and so for the feedback for him, I sent a letter back, saying how impressed I was on his reflection of the situation and reflection of his part in it, and what he was going to do differently, and said that I was looking forward to working with him for a long time ... I was very mindful of giving him that positive feedback that he was valued as a team member. - Kelly, Nurse Practitioner

1004. The creation of an environment in which feedback can be given and received as in the examples from Kelly (NP) and Matilda (NP) is an under-specified skill. These skills can often be

given the label of 'leadership' or 'people skills', but failing to unpack those terms, means that the full range of skills may remain 'invisible'.

1005. Luna (NP) had the opportunity to establish a health care service in a greenfield site and created a feedback culture that promoted responsibility by patients for their own health

So when I first went up north, we were the first primary health care service in one of these communities, large communities. They never had a GP service, you know, as such, or a primary health service, because there was no GP. And nobody wanted to engage they had never had it. They didn't know what to expect. And then, by the time I'd left there we had everyone in town enrolled, and I had regulars coming in for, and improvement in, diabetes, improvement, regression of their kidney disease, and so people becoming health seekers, I think, and return visits, and engaging in their health care, I think, is the greatest satisfaction you can ever get. - Luna, Nurse Practitioner

1006. What Luna (NP) does not do in this example is describe the skills that she exercised in building this environment. Those skills include respect for the culture of the community and the individuals, empathy for the individuals in that community, active listening and learning about the people and their health conditions, respectful communication about the health procedures being introduced, creation of relationships in the local community to engage support staff e.g. reception staff for the clinic and training of those staff. These are just some of the skills masked behind her words, "by the time I'd left there we had everyone in town enrolled, and I had regulars coming in". Many of the skills exercised by Luna (NP) have been mischaracterised in job evaluation processes as innate personal traits that are a strength of women. It has been the case that these skills have been undervalued in gender segregated occupations that include nursing and midwifery. Gender segregation is one of the drivers of the undervaluation of female dominated areas of work (see discussion in chapter three). The skills required to establish such a clinic remain hidden and under-specified.

A3 - Level 5 - Expertly creating systems

1007. At level 5 of this Skill Element is the creation and development of robust evaluation mechanisms to measure the impact of an organisation's work and/or to improve those organisational systems. Matilda (NP), working on health programs for those with alcohol and drug addiction, provided an example that demonstrated the need for an evaluation process

That was something that I was always mindful of working in the organisation is that we would do some really great initiatives, really great initiatives but we would never evaluate them. And it got to the stage where I was sick of it. and said, We have to demonstrate outcomes from these. It's a great initiative. It works. But we have to put in a robust system to demonstrate that it does work, because otherwise we're never going to get ongoing funding and people are never going to see our work as being valuable. So that's a work in progress, and slowly, and a lot of that comes with the presentation at conferences, too,

and engaging the universities, which is what I set about doing as well. - Matilda, Nurse Practitioner

Matilda (NP) initiated an important work activity; an evaluation process that was to explore more than just clinical outcomes. She identified this as important to the ongoing sustainability of the organisation. In section 7.6 of this chapter, I use an example of Matilda (NP) leading an accreditation program for this organisation to show the deployment of a 'cluster of skills'.

1008. Kelly (NP) led a General Practice clinic through the review cycle for accreditation. She articulated the iterative nature of policy development and review. It was an ongoing process of improvement to meet compliance requirements and more importantly to ensure quality of treatment for patients

Accreditation happens every 3 years. It goes through all your systems and your whole business, which is really good because it identifies areas where you can improve. And I love making things better. So that that's a once every 3 years activity. So I would work with our practice manager and our lead nurse on the detail of that, and being available on the day for the auditors or the accreditation people to be interviewed on all the areas of our business and quality control and safety ... twice a year we have our whole of practice meeting, so I tend to drive that, looking at the culture of our practice and making sure that our code of conduct and our ethics are being adhered to. - Kelly, Nurse Practitioner

Kelly (NP) interweaves complex skills to complete the accreditation. It is a process that is all encompassing of the activities in the workplace, moving beyond just the clinical. The complexity of the skills exercised by Kelly to maintain the workflow while completing the accreditation are skills that are under-codified 'invisible' skills.

B1 Negotiating boundaries

1009. In this Skill Element of the Spotlight framework, the skills being investigated are those related to negotiating boundaries between patients, co-workers and management; it explores the skills of interacting and relating. This Skill Element demonstrated by NPs at level 4 had the highest average incidence per person of any of the Skill Elements at any level (16.5 incidences per person). That average suggests it is a skill that NPs exercise frequently at a high level.

B1 - Level 3 - Solving new problems

1010. Activities at level 3 of the Spotlight framework for Skill Element B1, focus on negotiating with others to build trust, finding a way to refuse a request that is unreasonable or dangerous without generating conflict and negotiating through challenges for quality patient care. Nadine (NP) spoke about building trusting relationships through detailed explanations of a clinical decision and how she influenced health practitioners to accept her plan

At the same time I had to line up an admission with the home based palliative care team, and it really would have fallen down if they said no. So I had to talk to doctors and nurses over in the home-based palliative care team and explain why this discharge needed to

happen tomorrow. And all of those reasons. So there's quite a bit of negotiation around that methadone is a medicine that has very long half life, and not many practitioners feel safe in prescribing that medication, especially sort of one day prior to discharge. So there was lots of convincing on my part that this was safe enough for him to go home on, and I explained that actually, if we didn't get him home on this new medication, he would discharge against medical advice. - Nadine, Nurse Practitioner

Nadine (NP) succeeded in negotiating an outcome, which she acknowledged had risks, but was a plan that she was committed to because it was in the best interests of the patient.

1011. Luna (NP) demonstrated her thorough knowledge of medications and legislation along with sophisticated communication skills and empathy with the patients

Every day I get so many people come in because they want to self medicate because of just incredible trauma in their lives anxiety and depression that they want opioids, or Endone, or drugs of addiction. I have to say to them, I will not prescribe it. You do not have pain that requires this. I will give you Panadol and Nurofen, and I'll give you those ... So it's about refusing patients for their own good, but recognising that sometimes they're not crying wolf, and they do have something. But about then giving them a limited supply, so that you can't be cruel if they've got genuine issues. But it's a very common thing to say to refuse requests for things that are not needed. - Luna, Nurse Practitioner

1012. The ability to diagnose a patient and then to refuse a request for a particular treatment or drug or conversely to risk a novel treatment requires careful communication with the patient and being attuned to their needs. In each of these examples the context exacerbates the complexity of the task – palliative care and a trauma affected community. The skills exercised are typically under-specified when simply defined as 'high level communication skills'. They may also be hidden because they occur in contexts outside the gaze of the mainstream – home based palliative care in Nadine's (NP) case and remote communities for Luna (NP).

B1 - Level 4 - Sharing solutions

1013. A consistent theme from the interviews with the NPs was how they frequently negotiated to establish their credentials with others and shared knowledge about their capacity and their scope of practice. Matilda (NP) emphasised the unique knowledge held by NPs

I find that I'm often explaining and justifying what nursing is and what it has to offer. Particularly from a nurse practitioner stance, where it's easy for people to just see you as a substitute doctor, and you go, that's not all I am. You know, nursing has a lot to offer these clients. And trying to not so much to use my authority. It's about the value of what we have to offer. - Matilda, Nurse Practitioner

Matilda's challenge is to negotiate the barriers that might prevent her from the full exercise of her scope of practice. Her comment, "that's not all I am" is an interesting insight into how she perceives her role in the mix of health practitioners in her organisation. Similarly, her

comment that that people “just” see you as a “substitute doctor” is an inversion of the classic doctor-nurse hierarchy. NPs in the interviews expressed an aversion to being seen as some form of “junior doctor” simply because they can prescribe drugs and order tests. There is a strong belief among the NPs who were interviewed that they were bringing advanced nursing skills to their role; skills which were not to be compared with doctors and medical specialists, but which were not lesser than what medical practitioners bring. NPs view their role as having a strong commitment to holistic care, which is enhanced by the additional capacity to diagnose and treat patients accorded them by their NP endorsement.

1014. Luna (NP) makes a point in describing how she gives and receives feedback in what is an unequal power situation with a GP

... one by one, working with a GP showing them how you work and clearing up misunderstandings because there's been a lot of propaganda that we don't do things well, and I've seen such changes in us being embraced by many doctors over the last 22 years. And so, and it's always clearing up misunderstandings that I'm not working out of my scope. And indeed, even asking the GP. What is your scope of practice? Do you deliver babies, or you don't? Do you do mental health, or you haven't done the course? So they're the same as us. We all have strengths, and we all have weaknesses. And so it's about one by one, clearing up misunderstandings. - Luna, Nurse Practitioner

Luna (NP) was negotiating the barriers that prevented her exercising her full scope of practice.

1015. NPs had success in building networks outside of their immediate work group. Luna (NP) described a cooperative relationship with another NP with whom she works. There were variations in their scope of practice, and they formed a partnership to extend the support they could provide to patients

I'm working with a women's maternal health nurse practitioner. So when I have one of her patients present, I ring her up and ask her what tests she would like done. She'll be back in a few days, you know. What would she like done? And so I can facilitate those tests, and that without crossing my line. So yes, very good. Nurse practitioners are extremely good. We've worked under collaborative arrangements. We also know exactly where our scope ends and begins, and when we need help. - Luna, Nurse Practitioner

1016. The skills exercised by Luna (NP) in these two examples where she sought to build and maintain networks and to give and receive feedback in unequal power situations are examples of hidden and under-codified skills. External networking that allowed for the integration of services across time and space as Luna (NP) partnered with the NP from “women’s maternal health” is an under-codified skill. The negotiation with the GP in the first example is a hidden skill. Negotiating with a medical practitioner to establish her credibility to perform procedures is unlikely to appear on a duty statement but the performance of those skills was critical to patients in the remote communities that Matilda serviced.

B1 - Level 5 - Expertly creating systems

1017. There were examples of NPs working at the system level to find improvements in practice to deliver better outcomes across organisations. This involved networking with key stakeholders

... the expert advisory panel we would meet once every couple of months, and then I'd report back to them, and we'd discuss things like what direction the service was heading in. What research proposals might be of use? What are the trends? How do we need to, maybe readdress our service provision. We'd see a lot of clients, but as time went on we were perhaps seeing less clients. But the clients we were seeing were much more complex. So you know, we'd have a discussion about that. - Matilda, Nurse Practitioner

Matilda (NP) worked with the stakeholder advisory panel to identify current or potential issues. She led a consultation process to explore possible solutions to a current problem, 'clients we are seeing are more complex'. Matilda (NP) also understood the composition of the advisory panel (it is known from another work activity example that the panel includes researchers) and sought out their assistance to map trends and any information the group may already have had from existing research.

1018. There were examples of NPs building a sense of direction for an organisation or system and energising others in their day to day interactions with their colleagues. Nadine (NP) provided a very clear example of a work activity aligned with level 5 of Spotlight framework

And I think that breaking down hierarchy has been really important to me in energising others. Because if you look at the hierarchy, especially in the biomedical model, and with doctors they kind of get bashed down from each other from the big ones. Well, I wanted to say, I'm not, you know. You're welcome to come to our palliative care needs rounds and have end of life discussions, all of us. This is all of our work. I'm a nurse practitioner, you're an assistant in nursing. We're all equally as important. We just do different jobs. So that actually helped to energise others, and it was felt when I was doing this project over a couple of years. It just felt like we were all catching the wave together. - Nadine, Nurse Practitioner

1019. Nadine (NP) and Matilda (NP) in their work activity narratives are describing "articulation work", (Junor 2021). These are the integrative skills that enable the interweaving of tasks and the maintenance of workflow. They are under-codified skills. Skills need to have been named and made visible before they can be measured in job evaluations or work value assessments.

B2 Communicating verbally and non-verbally

1020. This Skill Element of the Spotlight framework places the focus on the clarity of communication of the NP. The work activity examples set out below covers the full range of verbal and non-verbal that takes place under pressure and often in complex circumstances. Speaking may be explaining or 'translating' complex concepts and procedures. The listening

may be to understand the end of life requests of a patient. The examples show the value of non-verbal communication to and from the patient.

B2 - Level 2 - Fluently performing

1021. In the following example Luna (NP) used body language, was open to silence as a form of communication, and applied active listening, even when few words were spoken

I had a guy come in, and he sort of sort of limped in a bit, and I said, Oh, did you hurt your leg! And again, no, no, no! I said, what do you reckon like? What's your big problem that's brought you in, just a bit short of wind, and knowing that a lot of men don't want to talk to women for him to present and to know this it is that he is really disturbed by this is a bit short-winded. And so you've got to understand that that you really need to act on this man, and it ended up that he had a pulmonary embolus. He's just one example. They'll often come in and eyes downcast, and say, I got pain in my tummy, and it can be appendicitis. It can be quite excruciating. So you never palm off that the person is quietly spoken, or it's just understating what they really need. It's important that you try and make them feel comfortable, but respond to the little they say. - Luna, Nurse Practitioner

1022. Matilda (NP) demonstrated how NPs use non-verbal language in their response to patients

You know, people like to have a hug. Things like that. They like to be touched. I find some, you know, and you can read. You can read the signals. - Matilda, Nurse Practitioner

She reassured the person with touch but perhaps the most complex skill is manifest in the last few words, when she says “you can read the signs”. That is an experienced NP, fluent in her work and solving problems with unobtrusive non-verbal communication. These skills are typically under-specified, being described as ‘people skills’ or ‘communication skills’ with little if any unpacking of the depth of acquired skills and knowledge to be able to fluently perform the tasks described in these work activities by Luna (NP) and Matilda (NP).

B2 - Level 3 - Solving new problems

1023. At level 3, NPs are problem solving. In Matilda’s example it is possible to observe the depth of understanding that she had of the people that she was working with. In her final line is evidence of the persistence that she had demonstrated in her communication with her patients. After 18 months she gets them to where they need to be

clients that you know, that you can treat and treat very easily and very quickly, and cure them. Yet their self-esteem is just so eroded that they don't see themselves as being worthy of treatment. And trying to convince them that they are, that can sometimes take me 18 months. Sometimes they're just so bloody chaotic that it can take 18 months to get them there. - Matilda, Nurse Practitioner

1024. Matilda (NP) adapted her communication for these clients, taking a long term view (18 months) of what was required to bring people into a treatment and care plan. She had a deep understanding of her audience, “their self esteem is just so eroded”. It is easy to observe

personal qualities such as dedication and persistence in her description, but those personal qualities do not capture the underlying communication skills that sustained the relationship over 18 months. Those communication skills need to be unpacked to fully appreciate the the work that Matilda is undertaking. Typically, they are under-specified 'invisible' skills.

1025. In an insightful, if whimsical, analysis Matilda (NP) gave an insight into the empathy required to maintain effective communication in the complex environment in which she was operating

Well, you've got to have a bit of street cred in this job. I don't know. It's just I don't know.

Maybe these are my people. Maybe in another life I was a substance user or a sex worker or something like that. But like I said to you, I just, I like the clients. I like their resilience, and I admire it. - Matilda, Nurse Practitioner

1026. NPs interviewed also spoke of the need to translate complex ideas for people with little understanding of the medical issues they faced. Luna (NP) working in remote communities captured many of the required skills in this description of working with patients. She supported their reading literacy, their health literacy, and literally translates medical language into common terms for people

So not only do I interpret the literacy of a letter they may have received. So it might say, your appointment is on this, and they've got no idea how to read it or complete this pre-op form. They've got no idea. So you interpret the literacy of the content and help them complete it. They've got no idea on health literacy, not even urine. Urine is a difficult word for many of them. They pee, they piss. And so it's talking in a language that they understand, and there's no use saying you've got a kidney infection, and they go. What's a kidney? So it is talking to in the most simplistic terms and interpreting what a specialist may have said. or interpreting everything you're talking about in a way that they'll understand. So, interpreting what the specialist has asked them to do, and actually told them, interpreting what doctors say, interpreting test results or anything - Luna, Nurse Practitioner

1027. Luna (NP) described solving the problems of explaining various medical communication. The activities seem routine and straightforward until one asks the questions about why Luna (NP) was required to translate the information and why was it not the responsibility of the medical specialist to ensure that the patient understood the diagnosis/treatment plan. It is because it is a skilled activity to translate technical information into language that can be understood by people who do not have English as a first language and who are not members of mainstream western cultural traditions. Luna (NP) was exercising skills that are under-codified and hidden. It is unlikely that a duty statement would be written suggesting it is the role of NPs to overcome skill gaps of medical specialists; diplomacy demands otherwise. When not listed in duty statements the skills may not be visible.

B2 - Level 4 - Sharing solutions

1028. Nadine (NP) worked with a patient in palliative care, engaged in dialogue with the patient, listened carefully and read cues to decide on the next step

I said, What do you think's happening? And she said, I'm dying, and I said, How long do you think you've got? And she said, 2 weeks. And I said, I agree with you. What do we need to do. How, where do you want to be cared for?

She continued

And when I spoke to the oncologist she was very surprised that I thought that she was dying. She said. Why, why do you think she's dying? What's she going to die of? This person, I had asked her if she had any visitors, and she'd told me that she'd had some visions of her mother coming to see her, and this is actually and it's not in the literature, but it's a prognostic indicator ... Care is mind, body stuff. So that's that can be interesting. When discussing with doctors, and even surgeons can be difficult. They don't see where you're coming from. So yeah, you have to get good at having those conversations and gaining acceptance and trust, I suppose, from different people within the system. -

Nadine, Nurse Practitioner

Nadine (NP) applied her expertise in palliative care. She accepted what she described as the “mind, body stuff” and shared this with the oncologist. It would in Nadine’s view inform the next stage of treatment. Nadine carefully structured her communication with the medical specialists to move to the next stage of the palliative care plan for this patient.

B2 - Level 5 - Expertly creating systems

1029. The NPs interviewed provided examples that were judged to be at level 5 of the Spotlight framework. Their communication capacity made significant contributions to establishing and maintaining systems. Matilda (NP) provided an example of energising a community to become self-sufficient in meeting their need for a system

... that involved as many people as we could within that community and geeing them up to take this on. And they would, you know, like everybody would say. ‘But, Matilda, what if we can just find the money to get you to keep on coming going, you know’. No, no, no, you know, like I can't keep on coming. You need to do this yourselves. You need to take this on, you know it's the best way. It's the best way. It's the only way for it to be sustainable. So that took a lot of effort. It took a lot of effort. It really did. - Matilda, Nurse Practitioner

Matilda’s (NP) approach to this situation included knowledge of the local community and that informed her communication. Her goal was to create a sustainable program that did not rely on her presence. Twice she repeated that it “took a lot of effort”, hinting at what must have been a persistent flow of communication to reach the desired goal. Matilda (NP) is exercising what are under-codified skills which can also be referred to as articulation work (Junor 2021).

Articulation work is where multiple people are involved in complex tasks which requires coordination. Articulation work enables complex processes to appear to operate smoothly, but beneath the surface, as in this example from Matilda, they take “a lot of effort”.

B3 Connecting across cultures

1030. The focus of Skill Element B3 is on the ability of the worker to connect across different cultures and work with people from diverse communities. The data collated in the Heat Map shows that NPs had the highest incidence for this Skill Element across the four classifications (EN, RN, MW and NP). The average per person was 12.8 for NPs.

B3 - Level 2 - Fluently performing

1031. In the group of four NPs interviewed for this report, one NP was working in remote communities with Aboriginal Medical Services, another while located in an urban setting also worked with remote communities and the third worked in a rural General Practice clinic and had established a partnership with the local First Nations community.

1032. Luna (NP) described a scenario where she was working with First Nations communities. It was empathy and building knowledge about the community that enabled health practitioners to perform their work as Luna (NP) explained

Always seek out local knowledge on local traditions. Look at the work teams behaviour from that perspective. We have a new nurse at the moment, and her work routine is driving patients away because she's brash and loud and never listens. And so you can see it stand out a mile away when you have somebody who's not in tune with listening and stuff. So yep identify the correct contact people, always local staff elders. Don't explore any of the surrounds that you're in without permission, because you wouldn't walk around somebody's house or yard, or a stranger's house that you just were called in with somebody else. It's always about asking permission. - Luna, Nurse Practitioner

1033. Kelly (NP), working in rural context speaks about her path to learning the importance of knowing and using local protocols, and her openness to continue learning

with our communication with our local [name of state based organisation] we have a nurse practitioner that works in our practice who is indigenous herself, and we've got a grant from the Australian Primary Healthcare Nurses Association to work on a collaborative project with people with diabetes that have high risks of having hyper or hypothermia. And that situation has taught us that people who are non-indigenous think about trying to work with indigenous people without doing cultural training and safety, that we often get it quite wrong. So even now, we can actually do a lot more into improving that. - Kelly, Nurse Practitioner

1034. In these examples from Luna (NP) and Kelly (NP) they demonstrated empathy, or ‘standing in the shoes of another’ and seeing things from their perspective. This allows a person to show respect for the ‘other’ as in Luna’s (NP) example and not be deterred by making mistakes as in

Kelly's (NP) example. Empathy is a complex and a learned skill. It is often mischaracterised as a natural skill held by some people, typically women, and is under-codified.

B3 - Level 3 - Solving new problems

1035. Operating at L3 of the Spotlight framework for this Skill Element, Luna (NP) anticipated and acted to solve problems. She identified a major problem with health communications, anticipated problems and then acted to minimise those problems

doing your recalls for those patients that you need to come back in, and that's a bit more complex in remote, because a lot of people can't read. So a letter isn't good enough. You might have to get a driver to go out and see if they can find the person to come in. So recalls are a bit more complex in remote settings ... we just all chip in and we do it because it's part of the legal process that you must do your ... the recalls must be done. So it's a team effort. – Luna, Nurse Practitioner

Luna (NP) was managing multiple issues in this example. Initially there was a question of literacy, the person was unlikely to be able to read the letter. Secondly, there was an issue of remoteness and getting access to the person. Thirdly she had networks to activate to solve the problem -having the driver find and bring the person in. Finally, there was a legal obligation to complete the recall so putting the matter aside was not an option. Luna (NP) accepted the responsibility for initiating the recall process. The skills she exercised in this example are under-specified - she adapted her communication to meet the context in which she was operating. She also used integrative skills to ensure that the workflow happened, drawing in multiple people and actions to meet a legal requirement; these are under-codified skills. It is an example of where the context is critical to understand the requirements of a role. To conduct recalls in remote clinic requires very different skills to performing the 'recall tasks in a metropolitan clinic. There is strong evidence in chapter three of the increasing demand for nurses and midwives to meet the needs of people in remote communities and First Nations people. This example provides insight into the additional skills that need to be developed and utilised in meeting that demand.

1036. The Primary Material provides evidence of NPs working with people with language difficulties, including for those for whom English is not their first language, or those with disability, or those who have had limited success in the education system. For people in these groups a health diagnosis can lead to great confusion and anxiety. They may not have the capacity to fully understand health communication. In the example below Luna (NP) demonstrated skills in communicating with patients to minimise confusion and anxiety

... it's really important to key into how the people think and how they'll filter the information. So, for example, asking a patient to telling them that they've got kidney failure. and they need to see a specialist. They'll automatically remember their mum, who died of renal failure, who went and saw a kidney specialist, and they go. No, I'm not going

because they just know that they're going to die like their mum did. And so it's really important with that history of understanding. Then how do you say it? Your opening statement might be, hey? You've got some kidney problems, but we're pretty sure we can make it better. And so you've got to give people hope, and you might have to go see the specialist but just once, and we could even do it on the telehealth here. So it's understanding the fear, the racism that they may have experienced. And it's so alive and well in many places. - Luna, Nurse Practitioner

Luna (NP) exercised a diverse range of skills which under the typology of invisible skills are under-specified, under-defined and under-codified. When job skills have not been named and defined then they can be 'invisible' in work value assessments.

B3 - Level 4 - Sharing solutions

1037. The Primary Material shows that NPs were often working in places and contexts where they were dealing with the most complex and potentially difficult clients. Nadine (NP), described this palliative care scenario, demonstrating skills aligned with level 4 of the Spotlight framework for this Skill Element

I was looking after a woman who was indigenous. So a Ngunnawal elder and she was living in her home that was considered unsafe because she injected drugs, and she smoked inside as well, and she had lung failure and heart failure and some cognitive impairment and communication problems. More difficulties and the home-based palliative care service wouldn't go in because the service her home was deemed unsafe. So I got everyone together in a you know online chat thing. Everyone who was involved in her care and her NDIS worker said, I'm her long suffering NDIS case coordinator. And then, you know, other people were saying not so very nice things. And to actually get that woman to have good, safe end of life care was massive because it's not only kind of the challenge of culture wasn't only like a racial culture or where was someone born culture. - Nadine, Nurse Practitioner

1038. Luna (NP) demonstrated how it was possible to incorporate elements of the culture of the patient into the treatment plan. It was a skilled practitioner at work, communicating across cultural, age, knowledge and gender backgrounds to achieve the best health outcome

... so one man was getting cellulitis of his leg, and he goes, 'I'm not going to stop using the sandalwood leaves'. He makes a tea out of it and puts it on. And so I used, I said, could I put a big handful of salt in in that. and we work together because, my Nan, you know she used to. She was at the mission at [place], and she used to do that, but she used different leaves, and he said, Oh, all right. So you're working together with his medicine and your medicine, and the salt is helping to clean that wound, and then saying. Look, we could just give you an antibiotic, and you can still use your medicine and use an antibiotic. And so it's about delivering in a way that they're still at the centre. They're still calling the shots. They're still allowed to have their fears. But you're negating those and embracing their

ways of doing things and getting the management that you feel is needed, and that they feel is needed. - Luna, Nurse Practitioner

1039. In navigating through cultural barriers and negotiating to overcome resistance (from peers and patients) Luna (NP) and Nadine (NP) were utilising active listening and observational skills that enabled them to find and share solutions to what may have seemed to be intractable problems. In the process both had to manage their own reactions to focus on others (patient or peers). Having developed these skills both Luna (NP) and Nadine (NP) were able to implement treatment plans for the two patients. These skills have developed over time and experience working with people from diverse cultures. They are examples of under-defined and under-codified 'invisible' skills.

B3 - Level 5 - Expertly creating systems

1040. I found it be characteristic of NPs to include in their work constant endeavours to introduce new practices to improve systems. Implementing a work activity, judged to be at level 5 of the Spotlight framework, Luna (NP) described her work in building partnerships, participation and protection for Aboriginal and Torres Strait Islander people at the highest level of government. She pursued a change in regulations about scope of practice and funding policies to enable improvements in the delivery of health care in remote communities:

I get involved through the Congress of Aboriginal and Torres Strait Islander nurses at the [Australian College of Nurse Practitioners], and the Australian Primary Health Care Nurses Association. So I guess I don't know when to back off, but I certainly still go with it trying to get changes so that we can sign off on Close the Gap initiatives so that we can sign off on health things. So yeah, I'd like to say to let go of the system. But I think that I keep working under the current system. But I'm still trying to persevere and change systems for the better, particularly when it's predominantly nurse practitioners in many areas supplying remote service to people. Medicare has got to be about people, not about the GPs, not about the GPs and their money. It's got to be about service to people, and they shouldn't be restricted because they're seeing a nurse practitioner. and you're the only one available. - Luna, Nurse Practitioner

Luna (NP) demonstrated the integrative skills necessary to ensure workflow continued even as she sought to make improvements to the system in which she was operating. Luna's (NP) apparent lack of success in her advocacy does not detract from her demonstration of the skills. Integrative skills are under-codified 'invisible' skills.

C1 Sequencing and Combining Activities

1041. The focus of skill element C1 is on the ability of the worker to sequence and combine their own activities. This may involve reprioritising their own work to meet changed circumstances or switching and linking their activities with other events occurring in the workplace.

1042. All four NPs interviewed were experienced nurses and have held Nurse Practitioner endorsement for several years. All were skilled at managing their own time and sequencing their activities for the context in which they were working. The NPs provided examples of assessing the urgency and importance of simultaneous calls on their time. Luna (NP) described what she was confronted with at a clinic

I do health assessments. So I do all their pathology first, and it can be somebody who's withdrawing off opioids. And so I prescribe, you know, Methadone and Buprenorphine to help them come off, so giving them their counselling. Somebody presents with a cut, and I've got a suture it. A woman wants an implant put in her arm. So I have to do the minor surgical procedure to put that in her arm, so she doesn't become pregnant. Oh, my goodness! Anything and everything! Vaginal infections wound infections. Anything diagnosing a new person with diabetes, finding somebody has kidney disease managing their kidney disease, finding cancers in the last 3 months we've found 8 people with cancers in this new place I'm working at, and so it can be anything I never know. It's a normal clinic. You've got a huge population with broad range of ages. And so it's whatever they present with. 'I've got no energy', and so you do all the investigations you find they've got no iron, and they're anaemic. So organising for iron transfusions. And it can be anything. - Luna, Nurse Practitioner

Luna (NP) worked through the list presented to her at the clinic and the walk-ins, making constant decisions about the clinical priority to be given to any case. She was effectively working as a triage coordinator in many of the clinics that she attends. These are under-recognised skills for a NP. Triage coordination is a specialist skill. In this example Luna (NP) is simply expected to be able to deal with "anything and everything".

1043. Kelly (NP) described setting a plan for her day but remained prepared to reprioritise as things changed in the presentations to the General Practice clinic

I print out my day sheet, which has a list of patients that is on that for me to see, and I use that as a tool to manage my time for the day. I then check my results box for any results of blood tests or imaging that are there. I also check any other practitioners that are away or work part time. I check their results as well, and allocate those to our receptionist to follow through if needed. Then I check the 'best practice' messages. So they're a clinical note system between the team, between doctors and nurses, and admin on the ground. So there might be some messages there that I'll need to check and action. And then I'll check my emails because that that has clinical and management ramifications. - Kelly, Nurse Practitioner

One key aspect to note from her description is the level of autonomy Kelly (NP) exercises over the sequence of her own day. She has autonomy, but not necessarily control, as she takes responsibility for the work of colleagues who had unscheduled time away from work.

1044. Nadine (NP) explained how quickly a day could be disrupted, and the need for NPs to think quickly on their feet and reprioritise their activities

Yesterday my clinic didn't go so well because the man came in, and he had atrial fibrillation, and he was really sick. So I actually had to get him to the emergency department, which isn't a normal part of my job. But you just never know what's gonna happen. So yeah, I couldn't feel his pulse. And when I did his assessment I just went. Yep, you're not okay and had to get him in a wheelchair, had to get him transported over. And I actually had to take him over to ED. - Nadine, Nurse Practitioner

It appears that Nadine's (NP) clinic is operated by herself or with minimal assistance. She took responsibility for getting the patient to the emergency department. Nadine (NP) made a judgement that she had to act and had to reprioritise. It was fortunate for the patient that she had the clinical skills to diagnose the issue. Solving problems through reprioritising and thinking quickly on one's feet are skills that are typically under-codified. These are the skills performed by workers, in this case NPs, that enable them to do several things at once by rapidly sequencing, switching and combining activities. It involves the application of a variety of skills and knowledge, under significant pressure and typically includes projecting calm authority. These skills are under-codified and 'invisible'.

C1 - Level 4 - Sharing solutions

1045. Each of the four NPs were communicating and sharing solutions to problems in the delivery of health services; activities aligned with level 4 of the Spotlight framework. Kelly (NP) articulated the careful documentation process that she implemented

Each patient would have a welcome they'd have you know, How can I help you today go through listening to their history, documenting, taking and documenting their observations, doing a clinical assessment that might be an abdominal examination for someone with abdominal pain. For example, then I would document that while the patient regroups, and they know that I'm listening to them. Then we'll talk together about what my assessment is and what the plan of action for them and for me going forward will be. Then we disengage. I usually take them to reception and follow up with them any follow up appointments that I want made. Get them to book in for any pathology. Do the billing, go back in, finish my notes, and then do the next person"- Kelly, Nurse Practitioner

Recording key events with good documentation allows for effective follow up by Kelly (NP) or by doctors in the clinic or medical specialists in the event of a referral. Given Kelly's (NP) seniority in the clinic it was also an example of modelling good practice for others.

1046. Luna (NP) described her advocacy with colleagues to introduce a new solution that would lead to better health outcomes for patients

... getting them to change that policy so that the patient sees the nurse practitioner first, so that I can order the pathology, act on it, complete the physical exam, so that when the

locum doctor turns up they've got everything prepared for them, whereas policy in the past was, they had to see a health worker and a GP. At the same time showing them that by seeing a nurse practitioner, it's far more comprehensive with the pathology done, and you get that better internal look at how's their thyroid? How's their kidney functioning? Everything. - Luna, Nurse Practitioner

1047. An issue common across all four NPs interviewed and evident in this example from Luna (NP), was the difficulty in establishing credibility. NPs described having to establish their credentials with colleagues and also with patients. Luna's (NP) description suggests she was successful in establishing her credentials and as a result was able to improve patient flow at the clinic. The exchanging of ideas, the development and implementation of new arrangements and improved methods for recording health results are examples of the integrative skills that NPs bring to the health care where they work. They have the skills to plan and create improvements in overall workflow. These are under-codified skills.

C1 - Level 5 - Expertly creating systems

1048. Luna (NP) paid close attention to detail in following a long term health care plan designed to bring improved health outcomes for more patients. It was a simple but effective innovation using coloured bands on graphs, for people who did not have fluency in English and likely had low levels of formal education

... so it's about follow up and screening and assessing the patient. It could be that we've diagnosed kidney problems, so it's recalling them again, engaging with them, monitoring the effectiveness of the treatment you put them on, or what the specialists put them on, and looking and showing them. With some of our patients with things like that, we plot graphs so they might not understand the numbers, but we put a band. We got very good with this in one location of putting a band of colour that was good, and then we show them how they're now dipping into the good band. And so they see that as a very positive thing, and that engages people for a long term to come back. So you don't have to give people complex things to show them how they're doing health wise. You can do simple things that show them that they're achieving what we want to achieve, and that they're getting better. - Luna, Nurse Practitioner

1049. It is creativity in establishing these micro-systems that improves health outcomes in communities. That creativity and the skills that support the development and implementation of an innovation are under-codified 'invisible' skills.

C2 Interweaving activities smoothly with others

1050. The focus of skill element C2 is on the ability of the worker to interweave their tasks and activities with others. This Skill Element is about teamwork, about observation and prediction, about flexibility and adaptability. The data in the Heat Map shows this skill element as one of the biggest demands on NPs and a skill that they performed at a high level. The Heat Maps

show that this Skill Element had the third highest average incidence per person across all nine Skill Elements, with high average incidences across levels 3, 4 and 5. When interweaving their activities with others, there were examples of NPs integrating their activities with those who had limited health service training. NPs were often in informal leadership roles with the groups with whom they are working.

C2 - Level 3 - Solving new problems

1051. Working at the problem solving level by interweaving activities with others meant for Luna (NP) relying on local community drivers to advise on safety. If she was required to treat a patient in their home, she may have faced significant safety risks, but she managed the risk with local knowledge. Some of what Luna (NP) and her colleagues experienced was quite distressing and so I have provided a truncated version of her description

It's not safe. You're going out to houses where there could be a lot of alcohol consumption, and there's 20 to 30 people living in a house. So no, they're not safe. There are dogs. The dogs will attack you and things. So no, these areas are unpredictable, while I say that the majority are absolutely fine. You've got a small amount who are not, and you can't predict whether that's going to be a safe house or not. So that's why we'll often have the driver, and I will take somebody in with me, and we try and use local knowledge to know if that's safe to go into that place on our own. - Luna, Nurse Practitioner

1052. Kelly (NP) initiated a procedure to respond to safety issues at the General Practice clinic.

There was a focus on ensuring the legal and safe steps were followed

We have an outdoor meeting place. And if we have someone that is abusive, then we have a code, and we have people that you know, either evacuate the building or stay in their room with door locked. So I think, having planning and doing practices like having the drills, and like not so much patient safety. But we've been practicing recently with doing our CPR drills so that this is your job. You'll call the ambulance. You're going to do this. I'm going to do that. And so because when you know, we can all react when there's a difficult situation before thinking we all can't stay cool, calm, and collected - Kelly, Nurse Practitioner

Kelly (NP) designed the procedure to be followed in her workplace when there was a risk to employee safety or a critical incident with a patient.

1053. One of the features of solving problems by interweaving your activities with others (often described as teamwork) that is under-codified is reflexive practice. Luna (NP) and Kelly (NP) were consciously thinking through issues of safety even as they planned for and carried out their work. They were consciously thinking through who in the team might enhance the delivery of the required health service or how people needed to respond to particular events.

1054. NPs interviewed provided examples that were aligned with level 4 of the Spotlight framework. Luna (NP) triaged the patient flow between herself and the GP in a remote community, and organised the workflow for patient treatment to get the best outcomes in a limited time frame

.. if we do have a doctor we set them up with appointments, so they see around 14 patients a day, and we try and give them the more complex patients so they can spend time with them. And I will see walk-ins. So I'll see anywhere up to 30 -35 patients a day as walk-ins. More acute presentations, you know, kids with sore ears, suturing things like that. - Luna, Nurse Practitioner

One of the key elements of her statement is “if we have a doctor”. In the interview Luna (NP) spoke of the inconsistency of the presence of a GP attending clinics. This required adaptability on her part to work with the local staff to continue to provide the health service.

1055. Kelly (NP) built long term relationships with two other organisations to support the local indigenous community when the COVID pandemic began

We also have a strong relationship with the South Eastern [state] Aboriginal Corporation ... where I am. we have the highest indigenous population in [the state], so we have a nice collaborative arrangement and working relationship with [State organisation], and we do joint projects together. For example, when the COVID vaccinations first came out, we used their bus to go and collect people and bring them to the practice and had their team helping us and us helping them - Kelly, Nurse Practitioner

This is an example of a NP leading the integration of activities across two organisations. This is an under-codified skill that is also hidden. The work performed by Kelly (NP) occurred in the background, relying on her previous networking and relationship building.

1056. Nadine (NP) described her networking and advocacy to achieve better outcomes for patients in palliative care. She expressed the frustration that came with having to move on when the advocacy did not have the desired impact

Often talking around probably the same things over and over again in different years, with different people around the problems, accessing palliative care in [name of city] and trying to work through that and trying to change. That has been quite time consuming and a little bit sad, because it never really went anywhere ... I was always on those groups. I was always part of those groups, always put my hand up for those groups which had multiple different names. So I suppose I was representing palliative care nurse practitioners - Nadine, Nurse Practitioner

In earlier examples provided by Nadine (NP) she spoke of developing a region wide approach to palliative care that improved care and funding arrangements. In this example she had continued her advocacy and representation for palliative care nurses but was also pragmatic

in judging that on this occasion it was better to move on. The ability to assess the reactions of others and how this might impact on the capacity to deliver quality care and knowing when to let go of change involves the engagement of skills that are both hidden and under-codified and are likely 'invisible' even in the organisations where they the skills are enacted.

C2 - Level 5 - Expertly creating systems

1057. The NPs interviewed were active in working with others to create and improve systems. Luna (NP) was involved in working with governments to bring about system change

And like, I said before, work at systems level to ensure diverse groups are provided with partnership. Like, I've said, I've worked at the Federal level, and still contribute to so many programs at a State and Federal level to get changes for us to access Close the Gap, initiatives and everything else for our patient's sake. It doesn't give me any more money in my pocket or anything. It's only for our patients. So I work through professional organisations to help get that done. - Luna, Nurse Practitioner

1058. Matilda (NP) was also involved in system change that demonstrated the interweaving of activities within and across multi-disciplinary groups. Matilda's (NP) example is the subject of a detailed examination in section 7.6 of this chapter. It is the third 'skill cluster' Case Study titled, 'Information Management'. The skills involved in advocating for and bringing about system change are under-recognised 'invisible' skills.

C3 Maintaining and/or Restoring Workflow

1059. The focus of Skill Element C3 is on the worker contributing to maintaining or restoring workflow after an interruption or emergency. It may not be a crisis but may include activities that maintain the stability of the organisation as it moves through cycles of pressure and overload. The skills within this element are about the knowledge of processes, the ability to control one's own emotions and project calm and confidence, and to have good processes for clear decision making when under pressure.

C3 - Level 3 - Solving new problems

1060. Activities described in the interviews that align with level 3 of the Spotlight framework for this Skill Element included Luna (NP) managing the conflict between legal requirements and the best interests of her patient

So it's very tricky in some ways. Why didn't that mother bring that baby, and now it's covered in sores from its hips all over its legs and everywhere with scabies and sores. Well, you've got to think there's never been a primary health service. This is the first year of its service. They've had no other way to treat it until you've started this service. It's about education, it's not about reporting and thinking that the problem will go away. It's a balance of the problem is we need to treat and fix that now, and we need to educate them. And we need to engage them. So yeah, it's a tricky balance when you're in those places balancing what the law says you should do if something's being mistreated, but

when they're not being mistreated intentionally, and it's through a lack of understanding and a lack of health, resources and things. And you it's a balance, a constant balance. -

Luna, Nurse Practitioner

Making a judgement in this situation described by Luna (NP) relied on her having a deep knowledge of the current context and the historical context for that community. It was a complex decision, but she navigated her way through based on a set of core principles that she held, perhaps captured by her sentence that it's "about education, it's not about reporting and thinking the problem will go away". But the judgement was complex – at the end of the work activity description, twice she expressed the weight of the decision in repeating "balance". Luna (NP) in making the judgement call was exercising 'emotion management'. She was controlling her own emotions; she was considering the implications for the patient and factoring in the legal obligations. The complexity of the skills required to make these judgements are under-specified. The tacit knowledge that informed the decision and the considered balancing of responsibilities are difficult to measure and so may be 'invisible' when job assessments are undertaken.

1061. Matilda (NP) takes time to explain to one of her clients why a health decision has been made. It does not appear that the person(s) who made the decision had taken the time to explain, at least not in a way that the patient understood or accepted. It is Matilda (NP) who took the time to listen and detail the decision

... you know people wanting to have certain surgery done, and you know their default position can often be well, they just want to put me on the scrap heap because I'm an old junkie, and then no, it's not that. It's that your liver is in such a bad way. They need to be sure that you know your body will tolerate an anaesthetic and the surgery. You might think first do no harm. You know they can't just take you to theatre because you want to have the operation. They need to know that you'll be able to tolerate and trying to convince people of that. - Matilda, Nurse Practitioner

Matilda (NP) took time from her busy schedule to listen to the person and sought to understand the concern. She attempted to explain in a meaningful way why the decision was made. She sought to keep the person connected to the health service to maintain support for this person. Making time for caring listening and interactions amidst intense work pressures are under-specified and under-codified skills that may not be visible within the organisation (no other person is present in the consultation) or even to the client who is involved who may just take for granted that this is the work of the NP.

C3 - Level 4 - Sharing solutions

1062. The interviews revealed how the NPs were involved in sharing solutions to maintain and restore workflow. Luna (NP) in remote communities cooperated with the local team and whoever was available on that day

It can be anywhere that you're on your own with a receptionist. You might have another RN or two. It depends how big the township is, and what staff they have in place when you get there. So I've worked in places where I've had a health worker and an RN. I've worked in places where I just have an RN. And some places where you might turn up, and you are on your own. Maybe with a receptionist or a practice manager, so it can vary and so there's no exact recipe for any one place. - Luna, Nurse Practitioner

Luna (NP) has learned adaptability. She has no control over the situation so moved her actions into providing whatever health service was possible given the resources. She does not turn people away from the clinic. Her ability to maintain workflow given whatever resources were available required the use of integrative skills. She was required to rapidly sequence, switch and combine activities depending on just who was available to provide support at the clinic for that day. Integrative skills such as this are under-codified 'invisible' skills.

C3 - Level 5 - Expertly creating systems

1063. The NPs narrated examples of building and maintaining systems when issues had arisen that threatened the ongoing stability of the organisation. Matilda (NP) describes bringing expertise, "external stuff", to help the staff focus on the purpose of the organisation

I like to think that when I go to work I actually contribute some external stuff as well. It's not just the immediate work. But it's more about being a part of the organisation and being a part of the team. You know that that multidisciplinary team and us all working towards similar the same goal. You know the same thing. - Matilda, Nurse Practitioner

In this work activity Matilda (NP) took a long term view of the work. She brought knowledge and skills from outside the organisation and sought to blend with existing skills and knowledge to enable the team to continue building toward the same goal.

1064. Luna (NP) focused on maintaining continuity of workflow in the face of significant challenges

you have to begin very early in these remote, and it's for indigenous and non-indigenous, because they're all living together in these small communities. So it begins that you have to understand how you do things differently ... You might have all these skills in ultrasounding when you walk out of a hospital. Like I could ultrasound. I could do all these fancy things, use dialysis, machines, apheresis machines. But when you hit a community, all you've got is a blood pressure machine, a glucometer, a stethoscope, and a CoaguChek machine. You've got those 4 things, and if you don't know how to take a good history, do a good examination and use those things as well as the pathology test. Then you'll fail. So you have to become very good at the few things you have. - Luna, Nurse Practitioner

Luna (NP) provided the best possible care for the communities where she was working. She did not have the resources available in a larger centre but her knowledge and skills enabled her to provide a quality service using the tools that she had access to. She developed a back-up system to replace the technology that was not available in remote settings.

1065. In this section I have represented work activity descriptions as being aligned with one skill element (even though they are likely to have been coded to multiple skill elements). I chose to represent my analysis in this format to bring clarity to the relationship between the Spotlight framework, the 'invisible skills', and work activities of the NPs who participated in the study. The format makes evident the breadth of 'invisible skills' performed by these NPs.
1066. It is also timely to reiterate the point made earlier in this discussion that that the performance of a skill element at the higher levels e.g. level 4 or 5, will necessarily have lower level skills embedded in the performance of that higher level skill.

7.6 NP Skill Cluster case studies

1067. It may be that a skill element is exercised singularly by an NP. In practice it is more likely and indeed evident in the interviews that were conducted that several skills across the nine Skill Elements are performed simultaneously in a work activity undertaken by a nurse or midwife. The Spotlight Framework describes that phenomena as 'clusters of skills'. Interweaving, or deploying 'clusters' of Spotlight skills requires a complex combination of thinking feeling and acting. Further, the capacity to apply several skills at the same time is itself an 'under-codified higher level skill'; increasing the effort required to perform the role and adding to work intensity (Junor 2021 Appendix 6 page 3 of 22).
1068. The skill of deploying complex 'clusters' of Spotlight skills has the following characteristics
- a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities
 - b) It is the 'thinking' element of multi-tasking
 - c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges
 - d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to rebuild and work on. (Junor 2021, Annexure 6, p.3)
1069. I have set out below three case studies that are illustrative of how work activities described in interviews by NPs demonstrate the deployment of 'clusters of skills' in the day to day performance of their work.

NP Case Study One: Balancing legalities and patient need in palliative care

1070. In this case study I have selected an example from an NP whose work is in palliative care. The NP and her colleagues consult across several hospitals in a metropolitan hospital region. The work activity involves Nadine (NP) negotiating between the needs of the patient who has a "terrible cancer", the wishes of the family, and her legal obligations.
1071. In the case study there is evidence of Nadine's (NP) lived working experience of all three of the Skill Sets - Contextualising, Connecting and Coordinating being performed simultaneously.

The case study shows the exercise of level 3 – ‘problem solving’ and level 4 – ‘sharing of solutions’. Elsewhere in her interview, Nadine (NP) spoke of the system wide improvements that she was involved in through her advocacy work for palliative care (L5).

1072. In the interview, Nadine described the following work activity

So the man came in. He was diagnosed with a terrible cancer, and only 23rd of November. Sorry December last year, and then, you know, he died about a month ago. So that's very, very, very, very fast with that. With that death. The family basically wanted him to die very quickly. And were very, very concerned that we didn't realize that. You know that's what we wanted that they wanted, and that they wanted him to have no pain, and legally, voluntary assisted dying is not legal in [name of state]. So we had to work under the law that we've got right now. Which is, we're allowed to give the amount of pain and pain relief and relief from suffering to people, even if they lack capacity in palliative care. We can use medications to do that, but we just can't give one medication. We can also do a thing called palliative sedation. And we were trying to talk with this family and saying, that's the thing that we need to do. It was really really hard and really difficult, and there was about 6 of us involved, and the family was just really unhappy and wouldn't agree with anything. They wanted to read all the policies themselves, and so that was really tough. - Nadine, Nurse Practitioner

1073. I have described the case study as ‘Balancing legalities and patient need in palliative care’ capturing the two things that are pre-eminent for Nadine (NP). She had legal obligations to meet about the drugs that could be administered and knew from her training the impact of the quantities of those drugs when prescribed. Secondly her focus was on the patient’s needs. The pivot point may well have been her sentence in the work activity description that, “we're allowed to give the amount of pain and pain relief from suffering to people, even if they lack capacity in palliative care”. That is a judgement call by Nadine (NP), and other NPs in similar roles.

1074. Nadine (NP) is in control of her own reactions and is calm in response to the reactions of others throughout the work activity. The case study reveals how she had to navigate the complexities of the palliative care plan for the patient and the law, whilst also addressing the concerns of family that she did not bring about that death soon enough. As Nadine narrated the experience it is possible to observe the multiple skills that she demonstrated simultaneously as she has sought to provide appropriate care for the patient.

1075. Nadine (NP) is confident in her judgement but still found the experience “tough” and “difficult”.

1076. The case study demonstrates the deployment of a ‘cluster of skills’ predominantly the Contextualising Skill Set and the Coordinating Skill Set. The skills are performed simultaneously by Nadine in providing palliative care to this patient.

1077. In the work activity in this case study, the coding team allocated the following codes, A1.4, A2.3, A3.3, B1.4, C1.3, C3.3. They are the codes represented in the Heat Map in section 7.3. I have further unpacked the example in Table 7.3 below showing how at each sentence of Nadine's (NP) description the 'cluster of skills' being deployed. The sentences from Nadine's (NP) work activity description have been paraphrased for the Table below.

Table 7.3: NP Case Study One: Balancing legalities and patient need in palliative care

Sentences from Nadine's statement (edited)	Spotlight coding	Illustrative statements from Spotlight workbook (abbreviated)	Observation
<i>So the man came in. He was diagnosed with a terrible cancer, and only 23rd ... December last year,</i>	C1.3	As new demands arise, frequently reprioritise tasks	Not clear that the man had an appointment – but Nadine reprioritises – she knows the person and the seriousness of the case.
<i>he died about a month ago So that's very, very, very, very fast with that. With that death.</i>	A2.3 C1.3	Work in sensitive situations to help people maintain composure, self-respect or independence And Assess urgency and importance of simultaneous calls on attention	The man had a palliative care plan that Nadine developed and revised as the man's condition deteriorated more quickly than expected.
<i>The family basically wanted him to die very quickly. And were very, very concerned that we didn't realize that. You know that's what we wanted that they wanted, and that they wanted him to have no pain</i>	A3.3 B1.3 B1.4 C3.3	judging from reactions about to determine how much to say And Find a way to refuse requests that cannot be met, or are unreasonable or dangerous And Share knowledge and experience to guide people, including those who do not accept your authority And Make time for caring listening and interactions amidst intense work pressures	Nadine feels the tension between listening empathically to the wishes of the family, looking to the patients interests and knowing that there are legal standards that she cannot cross which may mean saying no to the family. Nadine was making decisions about what it is appropriate to tell the family at what point in time. She is using "we", so the decisions are in concert with colleagues, which is confirmed in a later sentence.
<i>legally, voluntary assisted dying is not legal in [name of state]. So we had to work under the law that we've got right now. Which is, we're allowed to</i>	A1.4 A2.3 A3.3 C1.3 C3.3	keep up to date with and share information about developments relevant to your work area And	Nadine is aware of her legal responsibilities and the options that are available. She anticipates the conflict that is emerging that she will need to manage. She has an eye to the patient's needs and also to the

<i>give the amount of pain and pain relief and relief from suffering to people, even if they lack capacity in palliative care</i>		Work in sensitive situations to help people maintain composure, self-respect or independence And Pick the right moment to convey unwelcome news And Think quickly on your feet as new problems arise during an activity And Manage conflict between legal requirements and/or organisational rules and patient need	family's wishes- and is working to ensure both can maintain their composure, but in the end she will have to convey news to the family that they do not want to hear. It requires deftness on her part to navigate through the complexities. A key phrase is her reference to what she can do even if the patient "lack(s) capacity in palliative care".
<i>We can use medications to do that, but we just can't give one medication. We can also do a thing called palliative sedation.</i>	A1.4	With colleagues share approaches to solving problems relating to patients	The health practitioners are discussing treatment options and the right path forward. The "also" is an indication that there is not a fixed path to solve the problem.
<i>we were trying to talk with this family and saying, that's the thing that we need to do. It was really really hard and really difficult, and there was about 6 of us involved, and the family was just really unhappy and wouldn't agree with anything. They wanted to read all the policies themselves, and. So that was really tough</i>	A1.4 A2.3 A3.3 B1.4 C3.3	With colleagues and associates, share approaches to solving problems relating to patients And Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain, fear, or grief And Test your solution to a problem, by listening, observing and reflecting And Share knowledge and experience to guide people, including those who do not accept your authority And Make time for caring listening and interactions amidst intense work pressures	We can observe the simultaneous activities: - The health practitioners continue to check in with each other to explore solutions - They are listening to the families wishes with empathy, reflecting on what they are experiencing - They are sharing their own knowledge with the family, which is not accepted.

NP Case Study Two: Combining cultural awareness with focussed communication

1078. Luna (NP) worked in rural and remote communities. She operated on a fly-in fly-out basis. She was undertaking short term contracts with Aboriginal Medical Services (AMS) meaning that she was mostly servicing very remote communities where the population was predominantly Aboriginal and Torres Strait Islander. Luna (NP) had more than 30 years of nursing experience. She was endorsed as Nurse Practitioner in 2003.

1079. In the case study Luna was reflecting on her work in remote communities. That work was often undertaken in conjunction with doctors and medical specialists. She also described occasions when she arrived at a clinic and she was the only health practitioner and proceeded to run the clinic with the help of a receptionist only. In this example Luna (NP) had been working a clinic with a medical specialist. Luna (NP) described the work activity:

We get all the specialists coming out to all the areas, and they got their suits on and ties, and as if to say, you will listen to me. They don't speak in plain English. They've [local people] got no idea what they've said. When they've come and gone they ask you. And so I think this is one of the most brilliant thing nurses do we translate the literacy part, we translate the health literacy part, we translate the meaning behind what they're doing. We don't talk in hyperbole. He's just trying to say, if you take this you won't have a heart attack in 20 years. But basically you might say to them, if you take this now, you might not get that heart pain when you're walking down to the river. You bring it back to today and the benefits. And this is what nurses do all the time. We're translators in every aspect, whether it's language or health, literacy language, the meaning of the treatment that they're to undergo and the impacts of that treatment. Look, this might cost you but don't worry. We're going to apply to this mob to see if they'll help pay. You need to store it in the fridge, but we can do it up here, because I know you haven't got a fridge, and you can just come out and get 2 doses, one for today and one for tomorrow each day. Or we'll get the driver to go down with it. You facilitate it. Nurses do this all the time. The doctor spends 6 minutes, writes a script and thinks that's the end of the story, and it's only the beginning. Who do they think actually makes it happen? Gets the patient to swallow? Who monitors if there's a reaction, or if it's actually working, or if it's costing the patient, or if it's a danger to the children, or if it's anything? This is what we do. Nurses do this all the time, and it's just so hidden. And they think they're God. Because oh, that tablet worked, and they've got no idea on the background that went behind silently, so that we make it happen. And there's no credit given to the fact that we make it happen. So the fact that people come back that you've made them feel that comfortable that's just such a win. And what it's about, it's making them the centre, the most important person, and making their family the most important people, and helping them to realize they could be

better with this treatment, but whether they're going to be better or not, we're going to be there to catch them. - Luna, Nurse Practitioner

1080. I have titled the case study, 'Combining cultural awareness with focussed communication'. The intent is to capture Luna's (NP) deep appreciation of the health needs of First Nations people living in remote communities and her skill in adapting her own practice to meet the unique needs that arise from the remoteness and a history of abuse and neglect. It captures her skill as a communicator in bridging the gap between the words of the specialist and the experience of First Nations people.
1081. Luna (NP) experienced the frustration of a values clash. She had a commitment to the long term health of the people in each of the remote communities. Their physical health is essential to maintain a reasonable life. She was frustrated with "suits and ties" who "come and go" and do "6 minute" consultations and believed that was "the end of the story". In her description of the work activity she showed her understanding of the additional complexity of working with people from a different cultural and language background and the need to take more time, build more knowledge and apply a greater level of skill to support them through health challenges and treatment plans.
1082. Luna's (NP) work activity demonstrated the performance of skills across all three Skill Sets - Contextualising, Connecting and Coordinating. All three Skill Elements of the Connecting Skill Set are demonstrated with 'connecting across cultures' being demonstrated at the system level (B3.5). While only C1, 'sequencing and combining activities' is represented from the Coordinating Skill Set it is also demonstrated at level 5. The case study shows Luna performing at level 3 and level 4 of five Skill Elements and level 5 of two further Skill Elements (A1.3, A2.3, A3.3, B1.4, B2.3, B3.5, C1.5). The table below breaks down Luna's work activity description showing the full 'cluster of skills' being deployed by her in carrying out this aspect of her work.
1083. It is clear that Luna is not operating in a linear and sequenced mode, utilising one skill at a time. Skills are 'clustered' in each aspect of the work activity that she has narrated. In Table 7.4 I have separated Luna's example into eight sections and in all but one of the sections the application of several skills simultaneously can be observed.
1084. In Table 7.4 I have paraphrased both Luna's (NP) description and the statements from the Spotlight workbook.

Table 7.4: NP Case Study Two: Combining cultural awareness with focussed communication

Sentences from Luna's statement (edited)	Spotlight coding	Illustrative statements from Spotlight workbook (selective and abbreviated)	Observation
<i>We get all the specialists coming out to all the areas, and they got their suits on and ties, and as if to say, you will listen to me. They don't speak in plain English</i>	A1.3	Use your knowledge of the job to anticipate and avoid problems	Luna shows contextual awareness in her realisation that the specialists have not adapted to the needs of the situation.
<i>They've [local people] got no idea what they've said when they've come and gone, and they ask you.</i>	A2.3 B1.3 B2.2	'Key in to others' ways of thinking to filter information according to how it will be received And Gain others' trust and consent by explaining each step of a process and its purpose	Luna's language suggests that she is anticipating a problem for patients to understand the treatment prescribed by the doctor. Her experience in remote communities means that she is 'keyed' into the people and will be able to explain step by step what is now required. She has their trust.
<i>this is one of the most brilliant thing nurses do we translate, we translate the literacy part, we translate the health literacy part, we translate the meaning behind what they're doing.</i>	A2.3 A3.3 B1.4 B2.3 B3.4	Work in sensitive situations to help people maintain composure, self-respect or independence And Overcome communication problems by 'translating' (e.g. specialised terms), between experts & patients, And Informally interpret or mediate between work associates and members of diverse cultural or language communities-	There is communication issue – Luna (and she references other nurses doing a similar role) must understand what the doctor has said and communicate that to the patient in a way that the patient understands. The translation has a cultural context; the treatment needs to be understood within a unique cultural and linguistic context. Both skills are performed with an overarching goal of ensuring the that the patient(s) retain their own self-respect and independence by having Luna explain the meaning or purpose of the treatment.
<i>He's just trying to say, if you take this, you won't have a heart attack in 20 years. But basically you might say to them, if you take this now, you might not get</i>	A2.3 B1.4 B2.3 B3.4	Share knowledge and experience to guide people And Adapt the content of your communication	Luna is knowledgeable about the harm that First Nations people have suffered in the health system (expressed elsewhere in the interview). She breaks the doctor's

<i>that heart pain. When you're walking down to the river.</i>		And Listen and observe attentively to key into the unspoken aspects of interactions based on diversity	advice into smaller components and uses local scenarios, "walking down to the river". She seeks to provide reassurance.
<i>You bring it back to today and the benefits. And this is what nurses do all the time. We're translators in every aspect, whether it's language, or health literacy, language, the meaning of the treatment that they're to undergo and the impacts of that treatment.</i>	A2.3 A3.3 B1.4 B2.3 B3.5	'Key in' to others' ways of thinking to filter information according to how it will be received And Help patients feel at ease And ensure diverse groups are provided with partnership, participation and protection of their interests	Luna shows her skill in the communication process focussing in on the benefit for the person, while providing the meaning of the treatment and its impact. At a system level she is describing the role that nurses play in building partnerships with First Nations communities. Nurses, in her view, do not just 'come and go' as the medical specialists do.
<i>Look, this might cost you but don't worry. We're going to apply to this mob to see if they'll help pay. You need to store it in the fridge, but we can do it up here, because I know you haven't got a fridge, and you can just come out and get 2 doses, one for today and one for tomorrow each day. Or we'll get the driver to go down with it.</i>	A1.3 A2.3 B1.3 C1.3	Piece together information from various sources to solve a problem And Work in sensitive situations to help people maintain self-respect And negotiate for patients And Think quickly on your feet as new problems arise during an activity	Inside this sentence is Luna's knowledge of the local community and her skills including: - This patient cannot afford the medicine nor has the resources to store it - She knows people who may be able to assist with payment and will negotiate with them for the patient - She expresses it in way that allows the person to save face - She is able to think on her feet to find two options to overcome the storage issue.
<i>The doctor spends 6 minutes, writes a script and thinks that's the end of the story, and it's only the beginning. Who do they think actually makes it happen? Gets the patient to swallow? Who monitors if there's a reaction, or if it's actually working, or if it's costing the patient, or if it's a danger to the children, or if it's</i>	A1.3 A3.3 B2.3 B3.4 C1.4	Piece together information from various sources to solve a problem And Test your solution to a problem, by listening, observing and reflecting And	Luna sees doctors engage in a short consultation, devise a treatment for the clinical symptoms (a script) and move on. She articulates the steps that must be taken that involve the NPs and nurses to ensure the treatment is followed. She flags if the treatment is not suitable ('if there's a reaction' and "danger to the child"). The exasperation of,

<i>anything? This is what we do. Nurses do this all the time, and it's just so hidden ... and they've got no idea on the background ... And there's no credit given to the fact that we, we make it happen.</i>		Clearly and briefly flag new arrangements (or the need for them)	“who makes it happen”, masks the process that Luna has worked through to test solutions for the patients (see the fridge example above).
<i>So the fact that people come back that you've made them feel that comfortable that's just such a win. And what's it about, it's making them the centre, the most important person, and making their family the most important people, and helping them to realize they could be better with this treatment, but whether they're going to be better or not, we're going to be there to catch them.</i>	B1.4 B3.5 C1.5	Share knowledge and experience to guide people And ensure diverse groups are provided with partnership, participation and protection And longer-term initiatives, to support patients in maintaining their interests and improving mental or physical function	Luna’s frustration is understandable in light of her final sentences in describing this work activity. She is committed to, and practices in her daily work, establishing systems that enable the people in remote communities to feel that the health care exists to help them improve their lives. It is a long term focus on maintaining person-centred care.

NP Case Study Three: Information management

1085. The final case study of NPs draws from the interview with Matilda (NP). Matilda (NP) was working with a community based not-for-profit organisation which supported people with substance abuse and sexual health issues. She had been with that organisation for 8 years following 15 years in a similar organisation. She had over 40 years of nursing experience and was endorsed as a Nurse Practitioner in 2007. Her role combined clinical work (80%) with grant writing, policy review and advocacy (20%).
1086. I have set out additional information about the organisation, garnered from Matilda’s (NP) interview, as it is directly relevant to the case study. The organisation was primarily funded by state government but has over 30 additional funding streams through various contracts and partnership arrangements. It is a complex and fluid organisation, perhaps akin to a network, with branches and sub-branches across the state, from metropolitan to rural. They were doing outreach work in remote locations. They established partnerships with local community groups, moving on from the community once the local team was sustainable or the funding agreement expired. There was a substantial crossover with various mental health services. Matilda (NP) estimated the organisation had between 100 and 250 employees. The organisation had established an expert advisory panel which was multi-disciplinary, and included consultant doctors, consumers, representatives from related agencies, staff from

Corrections and also Harm Reduction Services. This snapshot informs the case study which focuses on Matilda (NP) leading an accreditation process for the organisation.

1087. Matilda described how she was given the task of heading up the accreditation process for a complex and multi-disciplinary community based not for profit health service

We've just been through a whole series of accreditation which was a requirement from our funding body, [state health service]. I was given the task of heading that up. There was a lot of that stuff that went on in the background that became very much a part of my role, and that was to get us up to speed with accreditation and to marshall everybody. I was the chair of the meeting. We have an oversight advisory expert panel for the program where we have stakeholders, and you know alternate stakeholders involved and consumers. So there was a lot of there was a lot of involvement in that. These are the sorts of things that you generally don't see in a position description, and you generally don't think of as part of a nursing role. So I guess what it would be is a lot of leadership. -
Matilda, Nurse Practitioner

1088. I have titled the case study, 'Information management' to capture the scope of the task that Matilda (NP) coordinated. Compliance with accreditation processes in health service delivery spread across a vast network required the implementation of a sophisticated system for gathering information, identifying issues, resolving those issues, and sending out communication to staff. Ongoing compliance monitoring was occurring throughout the accreditation cycle but the renewal of accreditation brought concentrated activity related to policy renewal, evaluation of deliverables and scrutiny of operations. This was what Matilda (NP) coordinated using skills that are unrecognised and hidden.
1089. In the example Matilda (NP) used all three Spotlight Skill Sets – Contextualising, Connecting and Coordinating, all performed at L5, the 'creating a system level'. The case study shows Matilda's (NP) strength in Contextualising - building and shaping awareness of the situation, with two Skill Elements, 'perceiving the context' and 'judging impacts' represented at level 5. Similarly, in the Skill Set – Connecting, two of the three Skill Elements - 'negotiating boundaries' and 'connecting across diverse communities' are also performed at level 5.
1090. The deployment of so many Skill Elements at level 5 by Matilda (NP) is remarkable, but not unique among the NPs. All were involved at the system level, whether in policy review, accreditation processes, system creation or advocacy for system change. The Heat Map for NPs shows an average of 24.8 incidences of L5 activity per person. This case study highlights the capacity of NPs to function at a system level across the nine Skill Elements. The concentration of L5 activities can be considered the product of the additional qualifications and training required to achieve NP endorsement, the accumulated experience of years in nursing, and years of working as an NP. Being confronted in their daily work by challenging

and complex health scenarios has fostered the development of high level skills and the integration of these skills in the completion of a work activity.

1091. This case study reveals the extent to which NPs demonstrate the integrative skills that enable complex tasks to be completed in an organisation. Matilda (NP) integrated people into the accreditation process who were outside her direct authority. She brought people together to focus on the accreditation process even though it was not within their normal scope of activities. Maintaining a group work process such as she described involved the interweaving of multiple lines of work, interweaving diverse multi-disciplinary teams and bringing together numerous partnerships into a coordinated stream of activity to meet the accreditation requirements. That capacity to do this is an under-codified 'invisible' skill.
1092. In the coding of the transcript the codes A1.5, A3.5, B1.5, B3.5 and C2.5 were allocated. They are the codes that were collated and incorporated into the Heat Map. The table below breaks down Matilda's work activity description showing the full 'cluster of skills' being deployed by her in carrying out this aspect of her work including lower level skills.

Table 7.4: NP Case Study Three: Information management

Sentences from Matilda's statement	Spotlight coding	Illustrative statements from Spotlight workbook (selective and abbreviated)	Observation
<i>We've just been through a whole series of accreditation which was a requirement from our funding body, [state health service].</i>	A3.5 B1.5 C2.5	Set up processes for robust evaluation of the impact of the organisation's work And Create channels to ensure that relevant information is shared across units And Develop a system for maintaining long-term key records as an aid to compliance	Matilda's responsibilities include policy development and review across the organisation and work on funding applications. Both knowledge sets contribute to the accreditation process. Accreditation is cyclical and Matilda has made a contribution to the review and communication processes in the accreditation cycle.
<i>I was given the task of heading that up</i>	A1.5 B1.4 C2.5	Bring together people with knowledge and experience And Constructively give and receive feedback in unequal power situations And	With 8 years in the organisation and 18 years as a Nurse Practitioner, Matilda was invited to lead the review.

		Develop shared policy approaches	
<i>there was a lot of that stuff that went on in the background that became very much a part of my role, and that was to get us up to speed with accreditation and to marshall everybody</i>	A1.5 B1.5 C2.5	Use your understanding of the organisation's priorities to influence policies and help shape systems And Create channels to ensure that relevant information is shared across units And Develop shared policy approaches to addressing resource constraints	Matilda highlights both formal and informal work to be done ('in the background'). Her language emphasises the communication skills required, negotiating persuading, influencing, to get people to support the processes and policy reviews required for accreditation ("marshall everybody"). This requires knowledge of the people and their work across the multi-disciplinary organisation and the skill to communicate across those disciplines.
<i>I was the chair of the meeting</i>	A1.5 B1.5 C2.5	Develop a system for regular information exchange And Provide a sense of direction that energises others And Develop a system for maintaining long-term key records as an aid to compliance	As chair of the meetings, Matilda must implement a formal structured process. The preparation, operation and follow-up from those meetings requires systematic processes, the skill to drive the process forward and careful record keeping for the compliance element of accreditation.
<i>We have an oversight advisory expert panel for the program where we have stakeholders, and you know alternate stakeholders involved and consumers</i>	A3.5 B3.5 B3.4 C2.5	Create a system for monitoring outcomes of your organisation's actions And Work at a systems Level to ensure diverse groups are provided with partnership, participation and protection of their interests And Develop a system for maintaining long-term key	Working with the advisory group draws from Matilda a different skill set. The advisory group is outlined in the introduction to this case study. It involves stakeholders and clients/consumers. It is a participation and partnership model. Matilda's role includes the systemisation of records and processes for compliance and the longer term.

		records as an aid to compliance	
Matilda provides her own succinct summary. Leading an accreditation process for an organisation of 100-250 staff is not in NP job descriptions or scope of practice. The skills exercised by Matilda in this work activity are hidden from job evaluation as it would not generally be considered clinical nursing work. However, it is evident in her description of the work activity that Matilda is drawing on many of the Contextualising, Connecting and Coordinating skills that she has developed as a Nurse Practitioner. It is an exercise in health leadership that draws on skills that are largely 'invisible' in assessing the value of the work of Nurse Practitioners. <i>These are the sorts of things that you generally don't see in a position description, and you generally don't think of as part of a nursing role. So I guess what it would be is a lot of leadership.</i>			

7.7 Conclusions about NPs and Spotlight skills

1093. The Nursing and Midwifery Board of Australia recognise in their registration system, 2900 RNs who are endorsed as NPs (Nursing and Midwifery Board of Australia 2024a). Four were interviewed for this study. The interviews with those four NPs reveal a group of nurses working at the highest level of their profession. Each of the four NPs in this study had a significant number of years of experience in both nursing and as NPs. It is to be expected, given the requirements for registration as an NP, that those holding this endorsement would be some of the most experienced nurses in Australia. Notwithstanding the years of experience of the participants in this study, I do not believe that the work activities they each described were extraordinary or beyond those expected of an experienced NP.
1094. The incidences set out in Table 7.1 and in section 7.5 show that the work of NPs involves the use of skills across the 9 Skill Elements of the Spotlight framework. They are demonstrating these skills across levels 3, 4 and 5 of the Framework, with more than 50% of recorded incidences being at L4 or L5. The Spotlight framework highlights the Contextualising, Connecting and Coordinating skills of NPs; skills that may be 'invisible' to job evaluation, job grading and work value assessments.
1095. It is evident from the four interviews with NPs in this study that NPs play an important role in the Australian health care system. The NPs in this group have worked to build the foundations for health service delivery in under resourced pockets of the Australian community. Their work has enabled systems to flourish in those environments and for significant gains to be made in the delivery of health care in those communities. The interviews provided evidence of NPs documenting practice, developing and recording systemic procedures, and leading accreditation reviews. These are foundational work activities that enable effective exchange of information, cross fertilisation of ideas, and the flourishing of health systems.
1096. The highest number of incidences were recorded for Skill Set A - Contextualising with an average of 78.0 incidences per person. This was followed by Skill Set B - Connecting which had

- an average incidence per person of 55.5. Skill Set C - Coordinating had an average of 42.8 incidences per person. Performance at skill level 3 – ‘solving problems’, and level 4 – ‘applying expertise/sharing solutions’ had the two highest average incidences per person at 73.8 and 65.0 respectively. Nurse Practitioners also demonstrated L5 skills at the highest rate of all classifications interviewed, with an average of 24.8 per person. To express this in different language, in a 90 minute interview, an NP was talking about creating or influencing a system change every 3-4 minutes. That is the frequency with which that level of skill demonstration occurs in the normal flow of their work activities.
1097. The NPs in this study regularly encountered new work environments and contexts requiring them to be constantly alert to the context in which they are working. Their capacity to move into those environments and perform their role is reflected in the data with the highest average incidence for any individual Skill Element across the NP group being ‘sensing contexts or situations’ with 38.3 incidences per person, with 7.5 of those incidences per person at L5. At this level of performance NPs are bringing people together to address issues for patients and organisations and embedding new solutions to problems into work processes. This Skill Set is exemplified in the case study, ‘Information Management’ in section 7.5, where in leading an accreditation process, Matilda (NP) demonstrates five Skills Elements of the Spotlight framework at Level 5 (A1.5, A3.5, B1.4, B3.5 and C2.5) in one work activity description.
1098. There is a density of incidences around A2.3 (13.3 average per person) and A2.4 (7.3 average per person) showing frequency and skill in ‘monitoring and guiding reactions’. The NPs were engaged in the most challenging fields of health service delivery. In their interactions in these extreme environments they needed to carefully monitor their own responses and to quickly develop an empathic relationship with people who were often on the margins of society. The density continues through A3, which has a focus on judging the impacts of one’s work. The NPs recorded an average of 7.5 incidences per person at A3.4 and 3.3 per person at A3.5. Characteristic of L5 activity is setting up processes for evaluation of the impact of the organisation’s work using a range of different methods and resources and analysing the impact of the organisation’s work on other agencies.
1099. The capacity to constantly read the social context in new environments and to operate effectively in those work locations requires skills that are under-defined, under-specified and under-codified, hence ‘invisible’.
1100. The second highest skill set for NPs, when measured by average incidence was Skill Set B - Connecting. Negotiating boundaries (B1) had the second highest overall average for a single Skill Element (average 30.8), with the level 4 activity in that Skill Element having the highest average incidence for a single level of any of the nine Skill Elements at 16.5 per person. The

NP group had the highest average incidence across all four classifications (EN, RN, MW and NP) for Skill Element B3, working with diverse people and communities, with an average incidence of 12.8 per person. At Levels 3, 4 and 5 of Skill Set B - Connecting, NPs are interacting with and relating to people who are marginalised, living remotely and therefore isolated from specialised health resources, or experiencing the most complex health problems. We heard from each of the NPs how they needed to negotiate through these barriers before they could even get to clinical diagnosis.

1101. The skills of working with the marginalised in the community are hidden skills and they are under-specified, as they frequently involve working with patients and communities who are out of sight from the mainstream Australian community. They are hidden by their remote location, hidden by their unstable lifestyle and homelessness from which mainstream Australia prefers to avert its gaze and hidden by virtue of the complexity of their terminal illness which sees them house bound or hospital bound, and therefore away from the public.
1102. The leadership of the NPs in health practice in diverse cultural settings emerges from their capacity to empathise with the people they are working to support. They are active in engaging with people in communities rather than reacting only to identified illnesses and ill-health. In the examples presented in section 7.5, NPs respect the decisions and the independence of the people they are working with even as they encourage behaviour change for better health outcomes. Acceptance of the 'other' and how they are living is integral to the value system of people who work with people from diverse cultures and in challenging environments. Empathy arises from building knowledge about other people.
1103. These are the skills of Skill Element B3, for which NPs were coded as having an average of 12.8 incidences per person, more than double any of the other three classifications in this study. The skills described in Skill Element B3 – 'connecting across cultures' are hidden skills, and under-codified skills. As noted in chapter three, people from 'other cultures' make up more than 30% of the Australian population. For health professionals engaging with diverse cultures is essential to their work and not a choice.
1104. To appreciate the value of empathy in connecting with other cultures it is worth juxtaposing the empathic skills exercised by NPs, with the behaviour of one who had not developed the same skill of empathy. Luna (NP), who did not always narrate examples with the guarded diplomacy of some of her peers, provided a contrasting example of working with a medical practitioner in a remote community

... he'd come out, and he'd say, this patient is going to start their insulin again. I've told them to and they said they will. And I said, yeah, that's not going to happen. They tell all of you what you want to hear, so that they can get out of there. He will not start it. And I said, the other thing is, that patient has no refrigerator in their house. There's nowhere to store that insulin, and even if they gave it to themselves, it would be ineffective. I don't

say it in a bad way, but I list the issues, and I go so it won't happen. What's your plan B, and make them think, because they believe so much that their hierarchical position, the patient will just do what they say, that they don't ever consider that the patient won't. So yes, I always try to give that constructive feedback, and I go, and next time you come, perhaps not wear a suit coat. just sit and yak to the person even - Luna, Nurse Practitioner

1105. In the final Skill Set - Coordinating, the density of incidences was strongest for the Skill Element - 'interweaving activities smoothly with those of others'. At the problem solving level of this skill (C2.3), there was an average incidence of 9.3 per person. At the solution sharing (C2.4), it was 7.0 per person. At C2.5, it was 2.5 incidences per person. At these levels of this Skill Element, the NPs are interweaving person centred care with an awareness of the safety of co-workers and patients, whilst maintaining the flow of work in complex environments. The interweaving or integrative skills demonstrated by NPs are under-codified 'invisible' skills.
1106. Interweaving activities by NPs extended beyond the immediate work group crossing lines of work and occupational norms. Kelly (NP) commenced a trial to improve emergency out of hours care in a rural GP clinic through an innovative partnership with the local paramedic
- I'm working alongside a community paramedic. I'm actually training him up in a new role. It's an innovative model of care that we're developing at [town] family practice. So, as well as me seeing patients, I'm also supervising him in the patients that he sees, so he will see people and work within his knowledge. Then, if they need something like if he's assisted them, and they've got, say, a urinary tract infection. Then he'll need to come and talk to me and get a pathology form, and I'll need to prescribe antibiotics, and I'll go and see the patient with him. Have a read through his notes, ask him if he's got any questions or concerns and mentor, and train him up to be competent, moving into extending his knowledge and skills - Kelly, Nurse Practitioner
1107. NPs combine Contextualising skills with Coordinating skills at a high level (L5). The demonstration of skills at A1.5 includes understanding the organisation's priorities and influencing policies to help shape systems, implementing systems for regular exchange on developments inside and outside the organisation and bringing together people with knowledge and experience to help find ways of addressing issues for patients and the organisation. At C2.5 it is interweaving people and activities to create systems for sharing of innovations or policies to solve intractable problems. It is developing shared policy approaches and addressing resource constraints to meet longer-term restorative and/or rehabilitation goals for patients, and it is developing systems for maintaining long-term key records as an aid to compliance and organisational development.
1108. Matilda (NP) working in community based not-for-profit health care was aware of the complexity of meeting funding requirements. She combined her knowledge of what was

happening 'on the ground' with strategic thinking about the viability of organisations that have short term funding contracts

... it's about informing those priorities and saying, you know, we need to hit the reset button here, because this is what we're seeing out in the field. And yeah, and sort of you know where we're going to be in a couple of years as well. Very much looking into the future as well. Because it's always about how can we survive? We need to constantly reinvent ourselves, because our funding, you know, goes anywhere from 3 to 5 years -
Matilda, Nurse Practitioner

1109. For NPs the additional qualifications and training, the experience in working across very complex environments, brings with it a confidence to advocate for systemic change. Fortright advocacy for change by Matilda (NP) in contacting senior departmental bureaucrats produced (eventually) a project in community based health where she worked

[It] wasn't unusual for me to just pick up the phone and talk to the manager of Communicable Diseases in [state] Health. I didn't have much of a filter, and I'd ring them up and say, You know what can we do about this? How can we address this? ... And that would provide, you know, some ideas, some solutions or possible solutions. But often they'd say, Yeah, we know, Matilda, and there's nothing we can do about it. We don't have any money. you know. And then, you know, maybe 18 months down the track, you'd suddenly see a project that had started up and think, oh, that's because I had that conversation with, you know, with [name of official], and he's actually held on to that. -
Matilda, Nurse Practitioner

The skills exercised by Matilda (NP) in this work activity description showed the skills of NPs that are hidden, under-recognised and under-codified.

1110. Bringing about system level change is a feature of the contribution that NPs make to the Australian health system. It is represented in the Spotlight framework at level 5 of Skill Set C - Coordinating. There was an average of 5.0 incidences per person at this level across the four NPs. System improvement requires skills of assessing the current context, identifying where improvements can be made, applying knowledge and skills from experience to develop a new way, the communication skills to navigate a proposal through barriers and resistance and finally the capacity to evaluate the change.
1111. It is the credibility of being an advanced practice nurse when engaging with other professionals that has helped NPs advance systemic change. In the examples presented in section 7.5 of this chapter, the work locations of NPs offered less institutional barriers to change but they experienced significant resource constraints requiring of the NPs greater adaptability and resourcefulness. Perhaps Nadine (NP) captures the spirit of NPs approach to change when she said in her interview, "we're going to walk through the front door, cross over that funding barrier".

1112. The Spotlight framework has made visible through the coding process the skills demonstrated by NPs in leading a holistic person-centred approach to healthcare. Person-centred care has connection as its point of difference. There is a relationship between the person and the carer – not between the carer and the illness. The leadership is evident in the clustering of skill exercised by NPs. They ‘share knowledge and experience’ (B1.4), only after they have ‘listened and observed attentively to key into the unspoken aspects of interactions based on diversity’ (B3.4). They ‘constructively give and receive feedback in unequal power situations’ (B1.4), typically exercised as ‘mediating between work associates and members of diverse communities’ (B3.4). NPs have limited power but they exercise that power in resisting the inappropriate interventions of colleagues who do not take the time to listen and learn. They choose not to exercise power over patients; they work with patients by showing respect.

1113. Kelly (NP) provided an example of the respect that NPs accord to the people for whom they provide care. Kelly (NP) is open to learn from her own patients when the system creates a problem for a person with a disability. Kelly (NP) works with the family to improve the person-centred care that seeks to provide in the General Practice clinic

So, what we've started to work on health assessments for people with disability, and we have a patient who has down syndrome and his mum works for the NDIS, and she's raised my awareness of how we can do things better there. And we're looking at the language and the questions that is, on the template for people, the health assessment for people with disabilities to make it a more realistic experience for the person with a disability. -
Kelly, Nurse Practitioner

1114. NPs are committed to sharing their knowledge of improved practice in an endeavour to see other organisations and systems flourish from their experience. Matilda (NP) has completed her PhD, on Nurse Practitioners, and written several peer reviewed articles for nursing and health journals. Each of the four NPs had been engaged to speak at conferences. NPs occupy a unique space in the nursing profession as the only recognised and endorsed advanced nursing classification (at the time of writing) and having the space, the skills and training to contemplate and then act to achieve system improvement.

1115. The NPs interviewed in this study have utilised their positions to become innovators in the Australian health care system. The skills required by NPs to generate innovation include using contextual awareness to identify a gap in care, gathering information from observation and consultation, analysing the information, exploring alternatives through research and creative thinking, choosing alternative approaches and applying critical thinking to select the best option, negotiating, influencing and persuading to overcome barriers, trialling and testing the solution, reflecting and observing the outcomes and modifying as required.

1116. Nadine (NP) approached the interview with the confidence of one who had already delivered significant innovation. Her expertise in palliative care and her networks through government

and senior health bureaucrats enabled her to lead a change in funding arrangements between federal and state authorities for palliative care

Through Palliative Care Australia, talking to the government of the time in 2018, which was the Liberal government. And just saying, Look, this is this is something that's really working and improving death and dying for older people living in nursing homes in Australia, so that our research actually influenced funding through the 2018 at the Federal budget. And so a program called the Comprehensive Palliative Care in Aged Care Program started, which is now part of the Palliative Care Australia program from the Commonwealth, and a partnership agreement was formed with every State and Territory, and it's been refunded, and there's 57 million has now gone into that. So that nursing research changed policy and funding arrangements to improve care across Australia. - Nadine, Nurse Practitioner

1117. One skill consistently applied by the NPs in this study was their capacity to 'look up and out'. They were able to separate themselves from the immediate tasks to look at the wider context and to look to the future. In being able to do that they could see new possibilities, they could see resolutions to problems, they saw the need to build the skills of others, they could see how to overcome barriers. The capacity to look up and out and into the future enables system improvement, system building and innovation.

8.0 Conclusions: Documenting the dimensions of nursing & midwifery work

1118. I was asked to apply the Spotlight skill recognition tool to the work of nurses and midwives and based on the application of that tool to identify, name and classify the ‘invisible skills’ used by those workers. The Spotlight tool is a job and skills analysis tool. It is designed to assist in naming and classifying skills that are unrecognised or undervalued based on gendered assumptions of skills in traditional approaches to job evaluation and in industrial instruments. ‘Invisible’ in this context means ‘hidden’, ‘under-defined’, ‘under-specified’ or ‘under-codified’ (FWC, 2022, Aged Care Decision Stage 1 [43]); Junor 2021, [3]). This is sometimes referred to as the typology of invisibility.
1119. In this chapter I set out my findings and conclusions based on the Primary Material contained in chapters four to seven of this report, and the Secondary Materials in chapter three.
1120. This chapter is in two parts. The first part (Part A) sets out the findings from the application of the Spotlight Tool to the work of nurses and midwives – identifying, naming and classifying the invisible skills. Part B sets out some further findings regarding the work of nurses and midwives and the contextual complexity within which they perform that work that may be overlooked (and therefore undervalued) or that I believe have increased the intensity and complexity of nursing and midwifery work.

Part A: Naming, identifying and classifying the invisible skills

1121. I have applied the Spotlight tool to interviews conducted with workers in each of the four classifications of Enrolled Nurse (EN), Midwife (MW), Nurse Practitioner (NP) and Registered Nurse (RN) – 29 in total. In chapters four to seven I have identified, named and classified the Spotlight skills utilised by the nurses and midwives in this study. The coding identified 4003 incidences of the utilisation of Spotlight skills across the 29 participants in this study.
1122. Based on the information in the Primary Materials and my analysis in chapters four to seven I am of the opinion that there was significant evidence of nurses and midwives who participated in this study utilising all nine Spotlight skills and that these skills and the way they are utilised are likely ‘invisible’.
1123. The deployment of these skills was at a high level of proficiency – mainly Skill Level 3 (problem-solving) and Skill Level 4 (solution-sharing). There are also examples at Skill Level 5 (creating-systems), particularly for NPs.
1124. The highest level of incidences of skill utilisation was in Skill Set A –Contextualising – building and shaping awareness. These are skills of interpersonal and contextual awareness and shaping reactions. They relate to the ability to sense the context within which work is performed, monitor and guide one’s own reactions and those of others, and judge the impact

of one's work. All four classifications recorded Skill Set A as the highest average incidence of the three Skill Sets. All except MWs had the highest average incidence for a single Skill Element at A1 – sensing context or situations. For MWs A1 was the second highest average incidence with the highest average incidence for a single Skill Element being B1 – negotiating boundaries.

1125. There were different patterns across the four classifications for the Skill Set B and Skill Set C. MWs and NPs both had Skill Set B – Connecting, as the set with the second highest average incidence. These are the skills of influencing, negotiating, communicating verbally and non-verbally and connecting and building relationships with those from diverse cultures. For both MWs and NPs Skill Element B.1 – negotiating boundaries, had the highest average incidence per person for Skill Set B.
1126. ENs and RNs both recorded their second highest average incidence per person for Skill Set C – Coordinating. These are the skills of sequencing and organising work, interweaving work with others, and maintaining and restoring workflows. For ENs the Skill Element with the highest average incidence was C1 – sequencing and combining activities. Whilst for RNs the Skill Element with the highest average incidence was C2 – interweaving activities with others.
1127. The pattern of average incidences across the four classifications in this study is set out in the Heat Map at Table 8.1. The Table shows the average of coded incidents per person for each Skill Set for each of the four occupational classifications. It also shows the main Skill Level at which each of the skills in the Spotlight framework was deployed for each classification.

Table 8.1: Average incidence for each Skill Element by occupational classification

Average incidence for each Skill Element by occupational classification				
Spotlight Skill Sets & Elements	Enrolled Nurse	Registered Nurse	Midwife	Nurse Practitioner
Total A: Contextualising - Building and shaping awareness	40.6	57.8	66.7	78.0
A1. Sensing contexts or situations	24.8	28.5	29.3	38.3
A2. Monitoring and guiding reactions	9.6	15.8	20.7	22.0
A3. Judging impacts	6.2	13.5	16.7	17.8
Total B: Connecting - Interacting and relating	20.0	39.5	49.7	55.5
B1. Negotiating boundaries	9.8	23.0	33.3	30.8
B2. Communicating verbally and non-verbally	7.2	10.3	9.3	12.0
B3. Working with diverse people and communities	3.0	6.2	7.0	12.8
Total C: Coordinating	25.2	43.2	44.3	42.8
C1. Sequencing and combining activities	10.6	16.2	14.7	17.0
C2. Interweaving your activities smoothly with those of others	8.4	18.1	17.0	20.0
C3. Maintaining and/or restoring workflow	6.2	8.9	12.7	5.8
Overall incidences (average/person)	85.8	140.5	160.7	176.3
Main Skill Levels	L2/L3	L3/L4	L3/4	L3/4¹

¹NPs scored a high number of L5 incidences (Expertly creating a system/s) which was not evident for the other three classifications

1128. The breadth of the utilisation of skills across the 9 Skill Elements within the Spotlight framework is apparent in Table 8.1. It is clear that for each classification investigated in this study all Spotlight Skill Sets and Skill Elements were engaged. This engagement was largely beyond proficiency level (L2), with skills being deployed predominantly at levels 3 and above.

1129. In chapter two I explained why the count of incidence of Spotlights skills is lower than that for aged care nurses in the Spotlight analysis conducted by Adjunct Associate Professor Junor in the *Aged Care Work Value Case* (Junor 2021 Annexure 5). It is useful to note that whilst the numbers of instances of the use of Spotlight skills counted is lower in this study due to my decision not to apply additional counts for frequency and criticality, the patterns of utilisation across the Skill Elements and the levels at which the skills are deployed are similar to those for nursing in the *Aged Care Work Value Case*.
1130. The case studies for each of the classification contained in chapters four to seven provide evidence of the way that nurses and midwives utilise the skills within the Spotlight framework in practice. This deployment of skills to manage competing demands, responsibilities and relationships is described as ‘articulation work’ (Hampson et al 2009; Cunningham et al 2014). Articulation work is
- attending and sequencing simultaneously a range of different competing demands; responding to contingencies, and working around obstacles. It involves negotiating relationships within and across authority lines, organisational boundaries and cultural groups; interweaving team members’ own activities into overall work-flow; and keeping work processes on track.” (Cunningham et al 2014, 592) (emphasis added).
1131. The case studies in chapters four to seven highlight this concept of articulation work containing examples of the use of Spotlight skills in ‘clusters’. These cases studies are not exhaustive but serve as illustrations of the complex inter-related use of Spotlight skills by nurses and midwives. The deployment of skills in ‘clusters’ increases job size. The ‘clustered’ use of Spotlight skills adds to work intensity and increases the effort required. It requires complex combinations of thinking, feeling and acting. The capacity to deploy skills in this ‘clustered’ way is an ‘under-codified’ higher level skill in itself (Junor 2021 [106-108]).
1132. I am of the opinion that there is considerable evidence (set out in chapters four to seven) of nurses and midwives in this study deploying Spotlight skills in a ‘clustered’ way.
1133. In each of chapters four to seven I have linked the evidence of the utilisation of Spotlight skills with the typology of invisibility showing how the skills utilised by the nurses and midwives in this study may be under-recognised and therefore undervalued due to them being hidden, under-defined, under-specified, or under-codified. I am of the opinion there is significant evidence of nurses and midwives constantly utilising and integrating these ‘invisible skills’ with other aspects of their work. In fact, these ‘invisible skills are at the heart of what makes nursing and midwifery what they are.
1134. In the following sections I summarise the findings for each of the four classifications examined in this study.

8.1 Registered Nurses

1135. There were 17 RN participants in this study. Ten RNs were working in acute care roles, six in primary health roles and one RN was working in mental health care.

Interpersonal and contextual awareness

1136. The evidence in chapter four shows the dominant Skill Set for RNs in this study was Skill Set A - Contextualising - building and shaping awareness with an average of 57.8 incidences per person.
1137. The dominant skill levels for Skill Group A were Level 3 (solving problems), and Level 4 (applying expertise/sharing solutions). There were also examples of the use of Level 5 skills (creating systems). This was particularly the case where RNs, either formally or informally, were required to take on responsibility for managing areas of work. (One RN had a substantive position as a NUM, others described relieving as ANUMs or had other Team Leader roles).
1138. The highest average incidence for any Skill Element at level across the RN group was at A1.4 where they averaged 11.1 incidences per person.
1139. The Primary Materials in chapter four contain examples where the requirement to read people and contexts, pick up on cues and piece together information from a variety of sources to find solutions to changes in context (A1.4) was part of the work of RNs. All RNs in this study demonstrated the ability to adapt and apply skills and knowledge to the needs of the patient as well as the ability to understand outside developments and remain up to date with changes in regulatory context (A1.2). These skills of interpersonal and contextual awareness are often under-specified and under-codified and therefore 'invisible'.
1140. The evidence in chapter four also shows numerous examples of the complex contexts that RNs are required to navigate, including regular experiences of death of patients, the after effect of attempted suicides, and providing care to patients with visible and unpleasant cancers (of the mouth and genitals). These areas of patient care are particularly sensitive and, in some instances, remain taboo subjects not openly discussed. Dealing with issues that are hidden from the public, or which the public choose to avert their attention required RNs in this study to utilise tact, diplomacy and negotiation skills. The fact that the subject matter is hidden or taboo contributes to the skills RNs are utilising in this context being 'invisible'.
1141. The A2 and A3 Skill Elements where RNs also have high average incidences (15.8 and 13.5 respectively) focus on the personal and social environment, i.e. the ability to monitor and guide one's own reactions and those of others (A2) and to judge the impact of one's own actions on others (A3). The evidence in this study was that RNs were 'keying' into the behaviour of others—patients, peers and medical specialists, seeking to understand behaviours and responses (A2.3) and maintaining a sensitivity to the self-respect and

independence of others (A2.3). Having difficult conversations (A2.3) and managing one's own emotions when building connections with patients (A2.3) were key parts of the role of RNs in this study. The ability to key into others and understand the underlying reasons for difficult behaviours and to judge the impact of oneself and others can require careful diplomacy which are often under-specified or hidden skills and therefore 'invisible'.

RNs as the glue—Delivering person-centred care

1142. The RNs in this study were central to the delivery of patient-centred care. RNs occupy the middle space in most health service hierarchies. The RNs in this study had their own metaphors to describe their role. In interviews the terms 'the conduit', 'nurses tend to be the glue' and 'nurses hold it all together' were used by RNs themselves when discussing their work. See for example Megan in RN Case Study Two in chapter four.
1143. Doctors and medical specialists may continue to respond from a bio-medical approach to health care, based on signs and symptoms of illness in which the clinician determines the actions that will be taken to achieve improved health. It is an approach that is "medically dominated and disease orientated" (Delaney, 2018, p. 121). RNs in this study were focussed on delivering person-centred care. This model emphasises the person and not the illness or medical condition requiring treatment (Australian Commission on Safety and Quality in Health Care, 2025). A discussion of person-centred care is contained in chapter three.
1144. There is evidence in this study of RNs having to navigate the differences in approaches (bio-medical and person-centred approaches) and manage the potential relationship tensions that arose from those differences (A1.4, A3.4). This navigation requires skills of diplomacy and tact (hidden skills) and adds to the complexity of the work.
1145. There is evidence in the Primary Materials of RNs challenging the practice of doctors and medical specialists where they perceive a threat to the safety or dignity of patients (A1.3, A2.3). This is also an example of negotiating boundaries (B1.3). Examples included where doctors were not familiar with current practices on wound care or injections (Megan - B1.4). There were also instances where doctors in GP Clinics sought the advice of senior practice nurses and of these RNs providing that advice in tactful ways that didn't embarrass those doctors (Melissa – A3.4). Samantha an experienced RN in the ICU also relayed how it was part of her role to support doctors in their first rotation in the ICU

Often, we would have a junior doctor who would come with us a lot of the time ... They're junior doctors. They look at us a lot like what will I do? - Samantha, Registered Nurse

In each of these examples the onus was on the RN to manage the dynamic to ensure what they believed was in the best interests of the patient.

1146. An example of the person-centred focus of RNs in acute care settings is to be found in RN Case Study Three: Empathic alertness and communication, in chapter four, in which 24

incidences of Spotlight skills were identified and counted. The majority were for Skill Set A. In the case study Sienna (RN) described her role as being a 'patient advocate' 'tuning in' to the needs of the patient and picking up the pieces after they were informed they had cancer.

Leading by doing

1147. There is evidence in chapter four of RNs taking 'leadership' in health care systems deploying strategic thinking skills, working to develop and maintain quality health care and healthy work environments (A1.4, A1.5, A2., A2.5, A.3.4, A3.5). Leadership was exhibited both by those in structured, or formal leadership roles and by RNs who were not in these formal positions but by virtue of their role and the context in which it was performed demonstrated the application of leadership skills.

1148. Leadership may involve galvanising people around a common purpose or goal, and this was evident in the example from Saania (RN) working in mental health. She described a work activity where she gathered the resources required to improve the post discharge support available to young indigenous people

I was part of creating an indigenous safety plan. So having it a bit more focus on our indigenous community, providing resources that were beneficial for indigenous communities as well, once they were discharged. So that was something that I was quite proud of, and that I felt really helped our indigenous cohort of young people, and it was a bit more catered to them in their culture as well. So, I have a big passion of indigenous culture. So very much. I do my own sort of like readings and research, because I think it's really important to sort of understand our First Nations people and be culturally sensitive to them, especially within health care settings, because we are trying to close that gap within health care with, you know, allowing our First Nations people to feel safe within healthcare, Westernized healthcare. - Saania, Registered Nurse

In this example Sannia (RN) motivated others to contribute to the plan (A1.4, B1.3), potentially inspired by her own example of researching and committing to a greater understanding of the problem that was being experienced (B3), skills described as hidden in the typology of invisibility. She linked the work to the Closing the Gap strategy, an example of high-quality critical thinking about the contribution that the service could make to broader societal goals (A1.5) and skills that are under-specified.

1149. Leadership can also include making change to systems. As Practice Manager and senior nurses in GP clinics, Melissa (RN), Ivy (RN) and Megan (RN) each described their involvement in coordinating administrative tasks and contributing to strategic planning and financial decisions (A1.5, A3.5).

1150. RNs were leading activities across all settings, acute care, primary health care and mental health care. At times this arose from their positional role, such as Aaron (RN) in his NUM role or Layla (RN) as a Triage Shift Coordinator. More frequently it was because they played the

advocate for the patient (A1, A2, B1, B2) whether that be as the face of the delivery of the service, preparing patients for operations, or being the one to rest their hand on the shoulder of the patient as the anaesthetic took hold and when they staffed the recovery rooms. They were at the bedside of the ICU patient for 10-12 hours per day and they were the “traffic lights” in the GP clinic.

1151. In my opinion RNs can be described as playing the role of a fulcrum or conduit around which quality person-centre healthcare is delivered. This requires RNs to deploy sophisticated skills, including high levels of interpersonal and contextual awareness – monitoring and guiding the reactions of others judging the impact of their work and that of others on patients, families, colleagues, and the delivery of healthcare more broadly. These skills are often hidden, under-codified or under-specified in job evaluation processes and in industrial instruments.

Dynamic workflow management

1152. The evidence in chapter four shows the second highest Skill Set for RNs, when measured by average incidence, was Skill Set C -Coordinating with an average of 43.2 incidences per participant. The demonstration of interweaving activities with others by the RN group (C2) and sequencing and combining one’s own activities (C1) were among the top four average incidences across the nine Spotlight Skill Elements with average incidences of 18.1 and 16.2 respectively. Dynamic workflow coordination is a feature of RN work.

Thinking on your feet

1153. In the Primary Materials there were numerous examples of RNs multi-tasking, prioritising and reprioritising to meet changes in work demands (C1). This included responding quickly to workflow changes in GP clinics (Megan - C1.2). The ability to organise and negotiate work organisation, think whilst doing, and ‘multitask’ are all integrative skills that are often under-codified and thus invisible.
1154. The examples in the evidence show how it is commonplace for RNs to utilise a range of skills of assessing, reprioritising and communicating with patients and other health professionals throughout the course of the day. This can also include having to do this assessing and reprioritising in emergency circumstances requiring RNs to ‘think on their feet’ (Fatima - C1.3, Sienna - C1.3, Tanya - C1.3, Sienna - C1.3 and Layla – C1.3). On some occasions thinking on one’s feet included RNs taking the required steps in a procedure to ensure the safety of co-workers and patients and manage conflicts between legal requirements and organisational rules and patient need (C1.3, C2.3).
1155. There was evidence in the Primary Materials of RNs operating at C1 - level 4 (finding solutions) and C1 - level 5 (creating and improving systems) when finding solutions or reviewing systems to address issues of individual workflow management. This reflects the level of experience of those RNs in this study who had worked across many contexts and who

were engaged in improving systems. This included Francis (RN) who set up a paediatric retrieval service, Aaron (RN) who as a NUM led the initiative to improve health outcomes for patients experiencing delirium and Melissa (RN) who in her GP clinic set up a system for improving health care for veterans with long term chronic diseases.

Interweaving

1156. The evidence in the Primary Materials shows that RNs were required to interweave their work (C2) with doctors and medical specialists with whom they have limited formal influence, and work with others over whom they had a supervisory responsibility e.g. ENs. As a result, they were adjusting and solving problems in relation to their own work (A1, C1) and applying problem solving skills in relation to interweaving their work with others (A1, C2). A feature of the work of RNs in this study was their work within nursing and interdisciplinary teams (C2.3). The capacity to work in this way requires interpersonal skills, collaborative teamwork, leadership and competencies around person-centred integrated care (Michielson et al., 2023). These skills associated with teamwork are often under-codified.
1157. There was evidence in the Primary Materials of RNs implementing processes to ensure teamwork and consistent workflows. This include bringing lines of work back together after emergencies (see Aaron C3.4, Sienna C2.4, Samantha C3.4 and Natalie C3.4).
1158. The ability to seamlessly manage these interruptions or alterations and rectifying workflow engages integrative skills (C1, C2, C3) which are under-codified and thus 'invisible'.

Negotiating boundaries and communication

1159. In the Skill Set B – Connecting, the evidence in chapter four shows an average of 39.5 incidences per person across the three Skill Elements. RNs were negotiating boundaries (B1) and demonstrating a high level of communication skills, both verbal and non-verbal (B2). Their communication skills, whether that be with other staff or with patients, were an important part of building trust (B2). Activities at level 4 within the framework were the most numerous for RNs in this study. Level 4 requires skills of developing solutions when connecting and negotiating boundaries. Communicating effectively and building relationships of trust may be described by some as innate traits. In this way the skills can be under-recognised in job evaluations and under-specified in job descriptions and thus 'invisible'.
1160. RNs work to a scope of practice that includes working as part of a team with peers, doctors and medical specialists (Nursing and Midwifery Board of Australia 2025b). Delivering person-centred care in a bio medical model requires RNs to negotiate boundaries (as described above) with other medical professionals, sometimes in unequal power situations (B1.4). This requires 'managing up' tactfully, engaging skills that are hidden, as it is considered important to protect the egos and authority of those further up the hierarchy.

1161. RNs reported providing advice to doctors in their practice. This occurred in primary health care settings such as General Practice clinics and acute care settings such as hospitals. Conversations in which advice was given generally took place in informal settings and not part of any structured workplace procedure.
1162. There was evidence from RNs in this study of the role they play in picking up the pieces after an adverse diagnosis (A2.3, B1.3 - hidden and under-specified) and being the translator of information between doctors and patients (B2.3 - under-specified)
- doctors don't get it, you know. They just come and drop a bombshell on a patient ... and then off they go. And then you've got this person who's in a state of absolute shock ... So, you have to break that right down into simple language. Simple routine words when the person's been a bit overloaded. - Sienna, Registered Nurse
1163. There was also evidence of RNs being the conduit between patients, their families and doctors, clarifying and justifying care plans even when their authority was not accepted (Jacqueline - B1.4).
1164. In my opinion the extent and regularity of boundary management that RNs in this study were undertaking represents an under-recognised responsibility.
1165. The Primary Materials show a breadth and depth of communication skills that RNs utilise in their role. This includes adapting styles and methods of communication to the needs of the patient (B2.3). The depth of skills required to communicate effectively with patients has increased as the complexity of patients has increased (see examples in section 4.5 at B3).

Conclusion RNs

1166. Drawing on the evidence and analysis set out in chapter four and above I am of the opinion that the work of RNs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. These skills are largely being deployed at levels 3-5. A substantial volume of the work of RNs interviewed required the use of skills that are 'invisible' - hidden, under-defined, under-specified, under-codified and therefore likely to be under-recognised and undervalued.

8.2 Midwives

1167. Three midwives were interviewed for this study. Two worked in maternity wards in private hospitals and the third was employed in the public sector but worked in a community midwifery clinic. All three were active in pre- and post-natal support for women and with birthing women.

Interpersonal and contextual awareness

1168. The evidence in chapter five shows the dominant Skill Set for MWs in this study was Skill Set A -Contextualising, with an average of 66.7 incidences per person. The MWs in this study had a high number of incidences across the three Skill Elements in Skill Group A.

1169. The MWs in this study were deploying skills primarily across level 3 and level 4 of the Spotlight framework in Skill Group A. Proficiency at these levels showed the MWs problem solving (L3) and sharing solutions (L4) with colleagues. At these levels of proficiency MWs were using their knowledge to piece together information about the context within which they were working enabling them to anticipate and avoid problems related to the context within which their work was performed. They were listening reflecting and observing in search of solutions to problems and making judicious choices about when to intervene whether that be in pre-natal processes to support women to make choices for a healthy pregnancy or during the birth.
1170. MWs also moved into sharing solutions as part of a community of practice with other midwives or with hospital resources which they may have needed to call on during difficult births (A1.4). The interviews indicated patterns of building networks, creating environments for feedback and being open to challenge issues with which they disagreed, including with others who were in higher positions in the hospital hierarchy such as obstetricians.
1171. The ability to perceive contexts and situations (A1) required paying close attention, reading cues and signals and reading risks and potential emerging situations. These skills which are often under-codified, and thus 'invisible' are central to midwifery practice.
1172. Contextualising skills (those in Skill Set A) are particularly important given the unpredictability of a maternity ward and the unpredictability of the arrival of a baby, (on most occasions). The evidence of the MWs in this study showed that those interviewed needed to be constantly on alert for changes in the stage of a woman's pregnancy and the health of the baby. In the work activity examples of MWs set out in chapter five there are several examples of the observational and listening skills of MWs; skills which enable them to make rapid situational assessments of a woman and the state of her pregnancy, thus allowing prompt responses and changes to birthing plans to keep both the woman and her child(ren) as safe as possible.
1173. These observational skills observed in the interviews included picking up on verbal and non-verbal cues and using experience and knowledge (intuition) to 'read' the progress of a birth or the 'state of mind' of a pregnant woman (A1.3, A2.3, A3.3, A3.4). These are examples of hidden and under-specified skills.
1174. Responding to changes in context (the birth) may include co-ordinating rapid changes in workflow, such as in the case of emergency caesarean (C1, C2, C3).
1175. Experienced MWs were skilled in assessing a pregnant woman and her progress through the birth process by applying these skills. Amanda (MW) gave a practical example
- You go in there knowing the woman, you know what she wants, and then you know what's generally out of character for her or whatever, so that definitely helps when you're in that kind of vulnerable moment with them. But the birth suite's a big example of reading someone, and I think that's what makes MWs invaluable is that **you can sit there**

in a room and assess someone without having to do anything which is not what doctors do ... we can sit there and watch someone for 10 minutes. And we kind of have a good idea of what's happening. - Amanda, Midwife (emphasis added)

1176. To sit and “not do anything” emerged as a key skill mastered by experienced MWs. Those observation skills, the listening skills, may not be measurable, but it was how MWs operated. These contextualising and sensing skills, monitoring, and judging circumstances are often under-codified, under-specified and under-recognised and thus invisible.

Negotiating Boundaries and communication

1177. For MWs in this study the evidence shows that the second highest average incidence of skills was in the Skills Set B – Connecting, with 49.7 incidences per person on average. The highest overall average for a single Skill Element for MWs was for Skill Element B1 - negotiating boundaries with 33.7 incidences. These skills were being deployed at levels 3 and 4.
1178. The work of MWs in this study required them to develop strong relationships with expectant mothers and potentially also other family members. At level 3 of Skill Element B1, a MW is building trust by working with women in each step of the process. They are finding ways to refuse unreasonable requests, whilst at the same time negotiating for quality care for the women. At level 4 of the Skill Element they are drawing on deep wells of knowledge about pregnancy and birth to support the women and using their networks for support when troubled by an aspect of the pregnancy or birth.
1179. The evidence in the Primary Materials shows that the midwives in this study deployed skills of negotiation and boundary management as they worked in partnership with obstetricians and specialists (B1.4). In the examples provided by the midwives in this study there was considerable complexity in navigating the boundaries between the ‘woman centred focus’ that was essential to their practice and the bio-medical model within which the rest of the health system operated. Navigating these boundaries required managing frustrations

I find it very frustrating that I've been in my industry for 40 years, and some of these doctors have been there for a lot less, and probably weren't born when I started mine, and that they don't listen to your opinion on things because they're the doctor, and you're just a midwife. So, I find that's quite frustrating. - Kate, Midwife

1180. In the scope of practice of MWs they have as their primary focus the care of women (Nursing and Midwifery Board of Australia 2023a). The MWs spoke of pregnancy and childbirth as a normal part of life, beginning with a view that pregnant women are ‘well women’

Doctors can be tricky sometimes because we just come from different lenses when it comes to maternity care. We come from a well centred kind of lens in that pregnancy is a normal process, and so we try and protect the normal as much as we possibly can. Given that, obviously there is risk that comes with that, whereas medicine they're taught to pathologise and understand the pathology to then treat, which doesn't always work in

obstetrics. So often when you come from that different perspective, there's a bit of rub sometimes with our medical colleagues. - Amanda, Midwife

1181. There remained a concern among MWs that doctors and obstetricians can revert too quickly to medical intervention

Yeah, and there's a lot more obstetric involvement because we work around doctors a lot more whereas private MWs they work in collaboration with doctors, however, they don't always need them, whereas the doctors are around in the public system so often are more involved than they sometimes necessarily need to be. - Amanda, Midwife

1182. I found in the examples provided by MWs in this study that the responsibility to find a resolution of a work around to these differences in approaches between the women centred and the bio-medical model rested with the midwives. They were aware that they had less power in the medical hierarchy and had to negotiate their way through those structures for themselves, and on behalf of the women they are supporting (A3.4, B1.4). This required the deployment of considerable skills to 'diplomatically' navigate the bio-medical context whilst remaining true to midwifery practice objectives. These skills involved in diplomatically navigating difficult circumstances are often hidden and under-codified and thus invisible.

1183. MWs in this study were also negotiating with the partners and families of the women they were supporting (B1.3). This added to the complexity of the relationships particularly where there were concerns regarding family and domestic violence (A1.3, A2.3, B1.3).

1184. MWs in this study also spoke of the impact on women and their partners, family and friends having access to more information through online sources. Whilst information is important, the midwives in this study indicated that information overload also created complexity where there was misinformation or where the information did not apply in the circumstances of a particular woman. This resulted in MWs having to spend more time building relationships of trust with women and their partners (B1.3) and finding tactful ways of refusing approaches that may not be safe (B1.3)

1185. The evidence from the MWs who were interviewed shows that they experienced women and partners who operated with a greater sense of entitlement. This example from Amy (MW) makes the point about the boundaries that MWs are negotiating

But we seem to get tied up a lot in catering tasks which we don't have time for. I think the major issue with doing these extra things, and of course you do them if it helps with the patient's comfort but a) We don't have time and b) It tends to confuse the women and their partners as to what our role is. - Amy, Midwife

1186. The MWs in this study were clear that a 'women centred approach' did not imply that MWs focus was to meet every need expressed by a woman or her partner. MWs had to negotiate the parameters of the relationships with women and their partners and claim the territory for which they were qualified, skilled and experienced to perform. This requires considerable tact

and diplomacy, typically hidden skills, as well as a strong sense and confidence in the parameters of their own role. Amy's example (above), whilst only one example, reflects the gendered assumptions that may be present for some in relation to the role of MWs.

Dynamic workflow management

1187. MWs also had a high average incidence for Skill Set C – Coordinating with an average of 44.3 incidences per person. The density of incidences occurred around Skill Elements C1- Sequencing and combining activities (14.7), and C2- Interweaving (17.0). The MWs interviewed described the skills required to assess the urgency of calls on their time between the many women in the maternity ward. They described reprioritising and thinking quickly on their feet in response to frequent changes in the rate at which different women were progressing through stages of labour (C1.3, C2.3). MWs described their constant exercise of responsibility for checking that legal and safe procedures were being used and monitoring each step of the process for a woman (C2.3). Evidence was also provided of MWs checking on the safety of their co-workers, with particular concern being expressed for “junior midwives” (C2.3). MWs managed the conflict between organisation requirements and patient needs, making time for caring listening and interactions amidst intense work pressures (C3).
1188. Coordinating skills are typically under-codified. These are the integrating skills that allow a person to interweave all the other skills required to perform a task. MWs in this study described rapidly sequencing, switching and combining activities even whilst carrying them out. This is an example of the ‘articulation work’ referred to earlier in this chapter. Whilst the skills may be ‘invisible’ in job evaluation processes, they are essential to enable the safe delivery of a child and the health of the woman or to support to women who have pregnancies terminated or whose children do not live.

Conclusion for MWs

1189. Drawing on the evidence and analysis set out in chapter five and that above I am of the opinion that the work of MWs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. These skills are largely being deployed at levels 3-4. A substantial volume of the work of MWs interviewed required the use of skills that are ‘invisible’ being hidden, under-recognised, under-defined, under-specified, and under-codified and therefore likely to be undervalued on gender grounds.

8.3 Enrolled Nurses

1190. Four of the five ENs interviewed for the study worked in acute care settings and of those four, three were in roles where their predominant work was in surgery or an operating theatre. The fifth EN worked in a rural GP clinic.

Interpersonal and contextual awareness

1191. The Skill Set with the most incidences recorded was Skill Set A - Contextualising with 40.6 incidences per person on average. Within Skill Set A the highest incidences of skills deployed was for Skill Element A1 – Sensing contexts and situations with 24.8 incidences per person. These skills were deployed at levels 2 & 3.
1192. The evidence in the Primary Materials shows that ENs in this study were adapting and applying knowledge to new contexts, they were adapting to the needs of each patient, and frequently to the needs of the medical specialist whom they were supporting.
1193. ENs used close observation skills to read patients looking for clinical signs reading cues to pick up on signs of anxiety and stress that can impact on the effectiveness of procedures (see Jessica A1.2 and Tamara A1.2). The skills involved go beyond the application of checklists. They were responsive to the needs of each patient and adapted their practice accordingly. The ability to read these cues and adapt to the needs of each patient are examples of under-recognised skills.
1194. The evidence in the Primary Materials shows the ENs in this study were also problem solving by piecing together information and perspectives from various sources and using that knowledge to anticipate and avoid problems. This was particularly evident in the examples from those ENs working in acute care setting. The work activity examples in chapter six show ENs anticipating the needs of the surgeons they were working with, picking up on non-verbal and verbal cues. They had prepared the theatre for all possibilities and were able to respond with equipment at hand to meet the needs of different surgeons (A1.3). These are under-specified skills.
1195. In chapter six I have set out many examples where ENs in this study, were using deep knowledge of not just the processes related to procedures, but also of the preferences of different surgeons and anaesthetists (A1.2, A1.3). Their prompt actions contributed to good patient outcomes. See for example the work of Jessica (EN) who worked as a theatre nurse and anticipated the needs of an anaesthetist
- They [the patient] can aspirate. So we have to make sure that the suction equipment is there. That that's all available for the anaesthetist, because you know most of the time they're standing there, and he's just like, Give me this. Give me this. So we just need to be thinking before about what could happen. And make sure that all that equipment, emergency equipment's there. - Jessica, Enrolled Nurse
1196. The evidence in chapter 6 shows that ENs had an average of 9.6 incidences per person at Skill Element A2 – Monitoring and guiding reactions. This reflects their ability to monitor and guide behaviours including through keying into and filtering the way others are thinking and solving problems by using insights into reasons for difficult behaviour (A2.3)

How I think something should work is different to how a doctor thinks something should work. And learning it might work for a certain doctor, but it doesn't work for another doctor. So just knowing when to drop it, and leave it for that certain doctor, because there is things that you would love to take into theatre with another doctor that another doctor has showed you. - Tamara, Enrolled Nurse

1197. There were examples in the Primary Materials where ENs were monitoring and guiding their own reactions to the medical specialists with whom they were working, understanding the quirks of their behaviour (A1.2, A1.3, A2.3)

Well, depending on the person most of the time you can't say anything because they get offended, you just have to put up with it most of the time. - Jessica, Enrolled Nurse

1198. In the above example Jessica (EN) understood the high-pressure environment of an operating theatre. She accepted, if reluctantly, that she just had to put up with “it”. She had insight into the reasons for the difficult behaviour demonstrated by others in the team. She exercised judgement saying that she would put up with it “most of the time”.

1199. There were also examples in the Primary Materials of ENs understanding the need to bring reassurance to patients in sensitive situations to assist patients to maintain their dignity

So we do procedures on genitals underneath you on your breasts as well. We've done quite a lot of procedures maintaining dignity. Then we have quite a few patients that are wheelchair bound total body photography being one of those things that you do have to stand and move and be able to do this and do that. We have a couple of patients who are in their wheelchair, so they can't stand to do that. So being able to kinda adjust the rules and take certain photos so that they can be included. And they can have that protection, as well. - Tamara, Enrolled Nurse

In this example Tamara (EN) adapted her practice when performing procedures in which people were exposed or vulnerable.

1200. These skills of ‘reading signs’, ‘interpreting cues’, and anticipating needs are vital to support the smooth delivery of patient care and yet they often go unrecognised because they are done tactfully and are hidden skills. They can be perhaps associated with a personal trait and so under-specified or become subsumed under conglomerate terms like ‘being a good team player’, also leading to being under-specified.
1201. I am of the opinion that ENs in this study were required to pay close attention to the context within which they were performing their role. This required them to deploy skills of observation – paying close attention and monitoring (A1, A2). The ability to pay close attention, monitor a situation or context are skills that are often under-recognised and under-codified and thus ‘invisible’. ENs were also required to utilise skills of monitoring and guiding their own behaviour and actions and that of others. These skills of managing thoughts, feelings and behaviours sensitively are often hidden and under-specified and thus ‘invisible’.

Dynamic workflow management

1202. The second highest Skill Set for ENs, when measured by average incidence was C - Coordinating with 25.2 per person. The highest Skill Element here was C1 - Sequencing and combining their own activities with 10.6 incidences. This was the second highest average incidence for ENs across all the nine skill elements. The ENs in this study were deploying these skills at levels 2 and 3. ENs deployed skills to organise their own work, which includes assessing the urgency and importance of simultaneous calls on their attention (C1.3), reprioritising their tasks to meet new demands (C1.2) and thinking quickly on their feet as new problems arise (C1.3). Each of these skills required the ENs to exercise independent and autonomous thinking. This is the 'articulation work' referred to earlier in this chapter.
1203. ENs were required to reprioritise their work to meet changed circumstances and to switch and link their activities with other events in the workplace. This involved liaising closely with others to interweave activities, varying their practice from systemised work processes and balancing conflicting demands. What the Primary Material revealed is that while ENs work under the supervision of RNs or NPs, they described having significant responsibility for managing the sequencing of their tasks for the day (see for example Jacinta - C1.2)
1204. Nina (EN) described the need to constantly reprioritise in a hospital Unit as being like a 'roller coaster constantly changing from minute to minute'. The ability to remain calm, to consider the needs and requirements of those with whom they were working – both patients and work colleagues enabled ENs to perform their clinical skills in context, even when that context was the high-pressure demands of an operating theatre. These skills are under-codified. It is a skill to project calm and to keep patients and work colleagues calm whilst there are rapid actions occurring in emergency like situations and when the EN themselves may be feeling pressured.
1205. There was evidence in the Primary Materials of a greater number of patients presenting with comorbidities, increasing the intensity and complexity of record keeping, accentuating the need for effective handovers, and requiring greater attention to workflow management by ENs to ensure effective patient care (C1.3, C1.4). The effective sharing and exchange of information is an under-codified skill.
1206. The ENs who were interviewed in this study were consistently working as part of a team. They were interweaving their work with that of others (C2.3). There was an average incidence of 8.4 reported for Skill Element C2. The Primary Material has evidence of ENs considering the safety of their co-workers when organising and sequencing activities (C2.3). They also demonstrated the ability to apply their knowledge of legal and procedural steps they were required to follow in context and monitor each step of a process to make sure the necessary resources were at hand (A1.2, C2.3). Examples of effective teamwork (Jacinta - C2.3) in the context of an operating theatre required the engagement of multiple Spotlight skills to

maintain workflow and patient safety. These skills are under-codified and will be 'invisible' if words like 'teamwork' are not unpacked.

1207. The ENs who were interviewed in this study provided examples where they were required to maintain or restore workflow after that flow had been disrupted (C3). There was an average incidence of 6.2 reported for Skill Element C3.

Negotiating Boundaries and Relating

1208. In the Skill Set B - Connecting, there was an average of 20.0 incidences per person across the three Skill Elements. Negotiating boundaries (B1) had the third highest overall average for a single Skill Element (9.8 incidences per person). The ENs in this study were deploying these skills at levels 2 (fluently performing) and level 3 (problem solving).
1209. There is evidence in the Primary Material that ENs respected the boundaries between themselves and their colleagues and between themselves and patients. They were able to navigate these boundaries successfully enabling them to be effective team members and to provide quality patient care.
1210. The success of ENs in negotiating boundaries with work colleagues arose from their highly developed communication skills. They were active listeners, reading the communication of the other person both verbally and non-verbally. It is a skill set that enabled them, even in circumstances where they were on a lower level in the medical hierarchy to influence processes to bring about quality patient outcomes (B1.4). There were examples of ENs doing this with people who were in supervision roles over them, people for whom they were providing care and for people outside of their direct influence.
1211. In both acute care and primary health care settings ENs in this study were engaged in professional relationship with RNs, NPs, MWs, allied health practitioners, doctors and medical specialists. They demonstrated use of connecting, interacting and relating skills with their peers, including negotiating boundaries (B1.2, B1.3), reading non-verbal language and communicating clearly (B2.2, B2.3).
1212. There was a degree of sensitivity associated with this when interacting with those who were in positions of greater authority
- And so sometimes you'll see things that the anaesthetist won't see. So, it's really important to talk to him about it and say, Look, did you see the blood pressure? Or did you see the sats, or did you see the whatever? - Jessica, Enrolled Nurse
1213. In the above example Jessica (EN) exercises the skills of diplomacy and tact which are often hidden because the skills include avoiding embarrassing those in higher order positions.
1214. There were examples in the Primary Materials of ENs delivering training to RNs, highlighting their use of high level communication skills to navigate the relationships

So, I do a lot of education, or a lot of training as an enrolled nurse for my registered nurses, in equipment in the setups and also in how to use the specific scopes as well. - Jacinta, Enrolled Nurse

1215. If not formal training, there were examples of ENs openly sharing practice and guiding the work of less experienced RNs, requiring ENs to navigate the hierarchies sensitively (A1.3, A2.3, B1.2, B1.3)

The grad nurse and I worked well as a team to get through the night, and we actually had time at the end of the night to sit down and do our updates ...like she was nervous. She's a grad nurse, you know. She is an RN. So, basically I work underneath her. But her being a new grad nurse and me being the experienced EN we were able to identify issues dealt with them together as a team ... I mean grad nurses have got to learn. And we've all started somewhere. And we've all been that new person. - Nina, Enrolled Nurse

1216. The ENs in this study deployed skills in their interacting and relating, making constant decisions about when to intervene in a conversation or process with an observation and when to hold back. This deployment of these skills is explored in detail in the Skill Cluster case study, EN Case Study Two: Reflexive Communication in chapter six.
1217. The Primary Materials show evidence of ENs using empathy with patients. They had the ability to stand in the shoes of the other (B1.2). There were many examples of verbal and particularly non-verbal communication by ENs to bring comfort, calm and reassurance to patients (B2.3). There was active observation of the non-verbal signs, and then in response the simple touch of holding a hand or a touch on the shoulder. These are examples of under-specified skills. Relationship building and empathy with another have historically been considered as personal traits or defined as 'natural', particularly for women. Therefore, in female dominated care-based work, skills of empathy and relational awareness or 'emotional intelligence' have been undervalued.

Conclusion ENs

1218. Drawing on the evidence and analysis set out in chapter six and that above I am of the opinion that the work of ENs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. These skills are largely being deployed at Levels 2 -3. A substantial volume of the work of ENs interviewed required the use skills that are 'invisible' – being under-recognised, under-defined, under-specified, under-codified and hidden and therefore likely to be under-valued on gender grounds.

8.4 Nurse Practitioners

1219. Four NPs were interviewed for this study. One NP was working in remote communities populated predominantly by Aboriginal and Torres Strait Islander people. Another specialised in palliative care services. The third had a management role in a rural GP clinic. The fourth

worked for a community not for profit organisation with a network of support centres for those with substance abuse issues, sexual health issues and/or who were homeless.

1220. The evidence in the Primary Materials shows that that Nurse Practitioners were operating across all nine Skill Elements from the Spotlight framework. The Skill Set with the most incidences recorded was Skill Set A – Contextualising, with an average of 78.0 incidences per person. This was followed by Skill Set B – Connecting, with 55.5 incidences per person on average. Skill Set C – Coordinating, had an average of 42.8 incidences per person.
1221. The evidence in the Primary Materials shows NPs recorded the highest number of instances at level 3 of the Spotlight framework with an average of 73.8 incidences per person at this level. NPs in this study recorded more than 50% of the incidences of Spotlight skills at level 4 and level 5 with a combined total of 89.8 incidences per person. This is a very high level of operation on the Spotlight framework.

Interpersonal and contextual awareness to shape systems

1222. The evidence in the Primary Materials in chapter seven shows that NPs regularly encountered new work environments and contexts requiring them to be constantly alert to the unfamiliarity in which they were working (A1.3). The ability of the NPs in this study to move into those environments and perform their role is reflected in the highest average incidence for any individual Skill Element across the NP group being A1 - Sensing contexts or situations with 38.3 incidences per person.
1223. The ability to constantly read the social context in new environments and to operate effectively in those work locations requires skills in self-awareness and self-management (A2), social awareness (A1, A2) and building relationships and connections (A1, A2, B1). These skills are often under-defined, under-specified and under-codified skills, and 'invisible'.
1224. The following example from Matilda (NP) demonstrates how she works in multidisciplinary teams to bring about change for homeless people and in correctional facilities
- we formed a collaboration with another two organisations and conducted an outreach clinic, we went into a service that looked after homeless people, and we all came from a different perspective. It was interesting from a systems change perspective, in that we moved out of our silos and looked collaboratively. Yeah, which we're in the process of writing up. We do that on a number of occasions. We've done that going into correctional facilities. We've written that up. So it's that collaboration. And you know, just by overcoming those barriers that are often set in place where, you've got public private and different health service sectors and just managing to navigate those and overcome them to provide something that's really great. - Matilda, Nurse Practitioner
1225. Matilda's ability to envisage a new approach to collaboration with others was key to the success of the initiative. The relationships skills and interpersonal and contextual awareness

skills that sit behind the ability to build a collaborative interdisciplinary team are likely to be 'invisible' in job evaluation processes.

1226. The NPs in this study were engaged in the most challenging fields of health service delivery. In their interactions in these challenging environments there was a need to carefully monitor their own responses and to be able to quickly develop an empathic relationship with people who were often on the margins of society. The capacity to constantly read the social context in new environments and to operate effectively in those work locations requires skills that are under-defined, under-specified and under-codified, hence 'invisible'.

Advocating for change for marginalised communities

1227. The evidence in the Primary materials shows that NPs had an average incidence per person for Skill Set B – Connecting with 55.5 incidences per person, the highest across the four classifications in this study. Those incidences were also coded at the higher levels of the Spotlight framework with 22.5 incidences per person at level 4 and 7.8 incidences per person at level 5 of Skill Set B.
1228. The evidence in the Primary Materials shows that the NPs in this study were interacting with and relating to people who were marginalised or living remotely and therefore isolated from specialised health resources or experiencing the most complex health problems. The NPs advocated for improved health system delivery on behalf of these communities (B1.5).
1229. The skills of negotiating these contextual boundaries often needing to persuade reluctant patients or advocate on behalf of those who were marginalised are hidden and under-specified skills, as they frequently involve working with patients and communities who are hidden from the mainstream Australian community. They are hidden by their remote location, hidden by their unstable lifestyle and homelessness from which mainstream Australia prefers to avert its gaze, and they are hidden by virtue of the complexity of their terminal illness which sees them house bound, or hospital bound, and away from the public.
1230. Nadine (NP) demonstrated a deep understanding of the circumstances of one marginalised patient and an empathy for her situation. She applied her knowledge of health delivery systems and negotiated for a shared solution for this patient that could be applied to others

I was looking after a woman who was indigenous. So a Ngunnawal elder and she was living in her home that was considered unsafe because she injected drugs, and she smoked inside as well, and she had lung failure and heart failure and some cognitive impairment and communication problems. More difficulties, and the home-based palliative care service wouldn't go in because the service her home was deemed unsafe. So I got everyone together in a you know online chat thing. Everyone who was involved in her care and her NDIS worker said, I'm her long suffering NDIS case coordinator. And then, you know, other people were saying not so very nice things. And to actually get that woman to have good, safe end of life care was massive because **it's not only kind of the**

challenge of culture wasn't only like a racial culture or where was someone born culture. - Nadine, Nurse Practitioner (emphasis added)

In her final statement about “culture” Nadine (NP) is suggesting that it is not only the culture of the patient that needs to be considered but the culture of health service delivery.

1231. Another example from Luna (NP) who established a health care service in a remote community where none had previously existed. She measured her own success by noting the increased responsibility that people took for their own health outcomes

So when I first went up north, we were the first primary health care service in one of these communities, large communities. They never had a GP service, you know, as such, or a primary health service, because there was no GP. And nobody wanted to engage they had never had it. They didn't know what to expect. And then, by the time I'd left there we had everyone in town enrolled, and I had regulars coming in for, and improvement in, diabetes, improvement, regression of their kidney disease, and so people becoming health seekers, I think, and return visits, and engaging in their health care, I think, is the greatest satisfaction you can ever get. - Luna, Nurse Practitioner

1232. In the above example Luna (NP) underplays the skills that she exercised in building this clinic. Those skills include (not an exhaustive list) respect for the culture of the community and the individuals (B1.4, B3.5), empathy for the individuals in that community (A2.3), active listening with respectful communication about the health procedures being introduced (B3.3), creation of relationships in the local community to engage support staff e.g. reception staff for the clinic and training of those staff (B3.5). These are just some of the skills masked behind her words, “by the time I'd left there we had everyone in town enrolled, and I had regulars coming in”. The skills required to establish such a clinic remain hidden and under-specified.

Negotiating Boundaries

1233. The evidence from NPs in this study is that they had sophisticated negotiation skills to perform their role. The highest individual incidence of a Skill Element for NPs in this study was B1.4 with 16.5 incidences per person. At this level for this Skill Element, NPs were typically sharing solutions by sharing knowledge and experience with those who did not accept their authority, they were building and maintaining relationships beyond their immediate work group and constructively giving and receiving feedback in unequal power situations.
1234. The skills exercised at B1.4 of the Spotlight framework are typically skills that are ‘invisible’ in job evaluation processes. In the typology of ‘invisible skills’ they are described as hidden. They are skills that are required for the performance of NP duties, but they are performed behind the scenes on behalf of someone who is nominally responsible for the work. It was most evident in the examples from NPs when discussing relationships with medical practitioners. There were also examples of negotiating with patients.

1235. Kelly (NP) had to respond to a GP who did not fully appreciate her skills (or those of other colleagues at the clinic)

We had a doctor say to our practice manager, I'm not comfortable having the COVID immunisation clinic here on a Friday afternoon, because I'm the only doctor here. I went back to the doctor, and I said, 'Okay, I said, you're the only doctor, but we have a paramedic who's trained to treat anaphylaxis. We have a nurse practitioner here who's trained to treat anaphylaxis. We have an emergency nurse here who's trained to treat anaphylaxis we have an authorised nurse immuniser, registered nurse here who can treat anaphylaxis. Which one of these health professionals don't you trust to have to manage an anaphylaxis? There's 5 of us here. What is the problem?' [Interviewer: And did you have the clinic open for immunisations on the Friday afternoons after that] Yes. - Kelly, Nurse Practitioner

1236. There were examples in the Primary Materials of NPs negotiating to establish their credentials with others and sharing knowledge about their capacity and their scope of practice. Matilda (NP) emphasised the unique knowledge held by NPs that that can help guide others

I find that I'm often explaining and justifying what nursing is and what it has to offer. Particularly from a nurse practitioner stance, where it's easy for people to just see you as a substitute doctor, and you go, that's not all I am. You know, nursing has a lot to offer these clients. And trying to not so much to use my authority. It's about the value of what we have to offer. - Matilda, Nurse Practitioner

1237. Matilda's comment that people "just" see you as a "substitute doctor" is an inversion of the classic doctor-nurse hierarchy. In this instance Matilda (NP) was sharing her knowledge seeking to guide patients so that they could understand her role and receive the benefit of the healthcare that she could offer. This approach engaged negotiating and influencing skills and tact to build and maintain relationships with these patients. These are skills that are often hidden in job evaluation processes.

1238. The complexity for an NP working in palliative care is explored in NP Case Study One in chapter seven. In this work example Nadine (NP) had the difficult job of navigating a number of relationships at a critical life stage. This involved negotiations with patients, families, and other health practitioners (B1.4).

1239. There was evidence in the Primary Materials that NPs were conscious of how gender impacted on perceptions of their role

I'm a woman working in a male dominated acute care service that mostly are men and doctors. And I'm prescribing medications and ordering tests which is mostly done by doctors. So, there's has been a lot of negotiation around you know; What is my job? Where do I fit? Where does it stop and start? What are my responsibilities? - Nadine, Nurse Practitioner

1240. In situations where NPs in the study were working in cooperation with doctors and medical specialists there were examples where additional negotiation was required to overcome a lack of understanding about the role of NPs despite the classification having been established for 25 years. This required of NPs nuanced conversations in unequal power situations (B1.4).

Dynamic Workflow

1241. The evidence in the Primary Materials shows NPs coordinating their own work and working with others, including outside of their own organisation and in the broader community. Skill Set C - Coordinating had an average of 42.8 incidences per person. The dominant skill levels were level 3 - solving problems, and level 4 - applying expertise/sharing solutions.
1242. Coordinating with others included managing safety risks by drawing on local resources and knowledge to support the NPs work (Luna - C2.3). It also included adopting and developing safety practices for the team (Kelly - C2.3). It also involved working with others to create system level improvements as discussed in the next section below.
1243. Kelly provided an example of how through the development of long term relationships she was able to lead the interweaving of workflow with two other organisations to support the local indigenous community (C2.4). These interweaving skills are under-codified and therefore more likely to be invisible.

Innovating systems

1244. The evidence in the Primary Materials shows that NPs in this study were advocating for systems change to improve health care for those patients they were working with. This ability to 'look up and out', separating oneself from the immediate tasks to look at the wider context and to look to the future requires the deployment of a combination of contextual awareness, relational, advocacy and coordination skills.
1245. The Primary Materials show NPs in this study working to overcome barriers and bring about system change in the interests of health outcomes. NPs in this study had the highest average per person of incidences at level 5 with 24.8 incidences across all three Skill Sets. Systemic improvement and change required the application of skills from across all three Skill Sets of the Spotlight framework.
1246. Nadine (NP) shaped a system through innovation and advocacy prompting legislative change
- I developed a program called Palliative Care Needs Rounds. Which, if you looked it up we ended up doing a randomised control trial with Palliative Care Needs Rounds. So older people who live with multi morbid conditions and high level of disability weren't getting access to specialist palliative care. So we kind of said, well, we're going to walk through the front door, cross over that funding barrier, and we did a randomised control trial with our intervention, and we saved 1.7 million for the State government. So they said, yes, you can provide services to that Commonwealth funded service. - Nadine, Nurse Practitioner

1247. Luna (NP) described her work in building partnership, participation and protection for Aboriginal and Torres Strait Islander people at the highest level of government. She pursued a change in regulations about scope of practice and funding policies to enable improvements in the delivery of health care in remote communities

I get involved through the Congress of Aboriginal and Torres Strait Islander nurses at the [Australian College of Nurse Practitioners], and the Australian Primary Health Care Nurses Association. So I guess I don't know when to back off, but I certainly still go with it trying to get changes so that we can sign off on Close the Gap initiatives so that we can sign off on health things. So yeah, I'd like to say to let go of the system. But I think that I keep working under the current system. But I'm still trying to persevere and change systems for the better, particularly when it's predominantly nurse practitioners in many areas supplying remote service to people. Medicare has got to be about people, not about the GPs, not about the GPs and their money. It's got to be about service to people, and they shouldn't be restricted because they're seeing a nurse practitioner. and you're the only one available. - Luna, Nurse Practitioner

1248. The example in NP Case Study Three: Information Management shows how Matilda (NP) was interweaving activities across a multidisciplinary group to implement processes for accreditation for her complex organisation (A1.5, A3.5, B1.5, B1.4, B3.4, B3.5, C2.5).
1249. The examples cited in this section show the deployment of 'clusters' of Spotlight Skills at high levels of proficiency. The deployment of skills in this 'clustered' way increases job size. It requires complex combinations of thinking, feeling and acting. The capacity to deploy skills in this 'clustered' way is an 'under-codified' higher level skill in itself.

Conclusion of NPs

1250. Drawing on the evidence and analysis set out in chapter seven and that above I am of the opinion that the work of NPs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements. There was evidence of the NPs operating at the highest level of proficiency (L5). A substantial volume of the work of NPs interviewed required the use skills that are 'invisible' - under-recognised, under-defined, under-specified, under-codified and hidden and therefore likely to be under-valued on gender grounds.

Part B: Contextual complexity in the application of Spotlight skills by nurses and midwives in contemporary Australia

1251. In this section I discuss some issues of contextual complexity that I believe further contribute to the under-recognition and therefore the potential undervaluation of the skills involved in nursing and midwifery in contemporary Australia.
1252. In this section I draw on the evidence contained in the Primary Materials and on the Secondary Materials in this report including perspectives on the impact of significant contextual factors on how work is performed and how these impact on the skills, effort and responsibilities required in nursing and midwifery in Australia today.

8.5 The acquisition of skills ‘on the job’

Nurses and midwives develop their practice through ongoing learning

1253. In female dominated areas of work skills may be ‘invisible’ because these skills are acquired in context on the job or through structured and unstructured learning that is not associated with a formal credential or qualifications. Where the acquisition of skills is not measured or recognised there is more chance that these skills will be overlooked.
1254. Based on the evidence set out in chapters four to seven and the Secondary Materials referred to in chapter three, I am of the opinion that there is considerable evidence of nurses and midwives developing their practice through the acquisition and application of skills via on the job experience and extensive further training and education (formal and informal). The lack of formal credentials for this on the job training and skill acquisition and development may lead to these skills being ‘invisible’ and thus undervalued. In the following paragraphs I set out examples to support this opinion.
1255. RNs MWs and ENs are eligible for registration to practice upon completion of a recognised qualification relevant to their respective professions (as set out in chapter three). NPs must hold RN registration, complete a designated Master’s qualification, and have accumulated 5,000 hours of advanced practice to be eligible for endorsement as a NP.
1256. However ongoing registration with NMBA requires the completion of extensive amounts of Continuing Professional Development (CPD) on an annual basis. RNs, ENs and MWs are required to complete 20 hours of CPD annually. A NP must complete the 20 hours to maintain their RN registration and an additional 10 hours per year to maintain their NP endorsement. For any person with dual registration e.g. RN and MW, they are required to complete the CPD requirement for both registrations. For the RN and MW example it is 40 hours annually.
1257. In the evidence in the Primary Materials, it was common for nurses and midwives to exceed the statutory minimum hours of CPD. They do this through a variety of internal and external structured courses, internal and external informal learning, and through their own self-directed learning. Megan (RN) described her CPD commitment for “last year”

I would do 2 to 3 hours a week on extra training every week. We've got to do 25 hours for our continuing professional development. But I did 125 hours last year. - Megan, Registered Nurse

1258. It was not uncommon for nurses and midwives to complete the CPD hours in their own time. For a person holding registration as a RN and MW (over 25,000 have dual recognition) this equates to more than one working week per year to complete CPD requirements to maintain registration. From Ivy (RN)

So, a lot of the things that we do have to be done out of business hours and through our own finances and what not, because there's not a lot of time in our day to do external activities. Because obviously, our patients are our number one priority. But if we want to do any training or CPD or anything like that. We do that out of our own pocket and on our own time. - Ivy, Registered Nurse

1259. The evidence in the Primary Materials is that building and maintaining networks and the use of these networks to share knowledge and develop skills (A1, A2, A3) was common for nurses and midwives. Nurses and midwives have formed multiple professional associations (see chapter three for further details). The evidence from the Primary Materials is that professional associations were used by nurses and midwives to further the development of their skills through structured learning opportunities such as workshops, online seminars and conferences. The professional associations also created networking opportunities for the exchange of ideas and informal learning occasions. Megan (RN) narrated her experience of these professional associations

I do maintain networks. I'm very involved in the primary health network. And I'm also involved in the immunisation coalition. So, I do maintain those out of work out of my initial relationships. And we do talk to the nurses in other practices in our practice group. - Megan, Registered Nurse

1260. In some instances, professional associations create additional standards. See for example Australian College of Perioperative Nurses (ACORN), which publishes standards for perioperative nurses (see chapter three).

1261. The nurses and midwives involved in this study also participated in employer provided Professional Development. This introduced new skills such as learning how to use new equipment, learning technological advances in existing equipment or learning how to use new documentation systems. Natalie (RN) working in Maternal and Child Healthcare was provided with a learning package of 15 hours to support the rollout of a new framework.

1262. There was evidence of pressure from employers to exceed standard CPD requirements

It's a requirement at my particular hospital. They have probably about 20 to 30 competencies that they want you to do. And it's a requirement that you do them. And look, I'm talking about probably 40-50 hours' worth of work. In theory you can do it in

your downtime, in paid time at work, but the access to the computer and your learning needs and the interruption and then making a mistake and being locked out ... And now it's been tied into the web that if you actually haven't done them, they can deem you as noncompliant, and not give you further shifts until such a time as you can prove it. -

Sienna, Registered Nurse

1263. Employer provided training may be developed and delivered by a colleague. In the following example, Jacinta an EN, prepared and provided training on specific equipment for RN colleagues. It is an example of the skill development of ENs, and the wider respect it generated from RN colleagues

I do a lot of education, or a lot of training as an enrolled nurse for my registered nurses, in equipment in the setups, and also in how to use the specific scopes as well, because they're slightly different ... a lot of where I work is on the job training. - Jacinta, Enrolled Nurse

1264. Jacinta (EN) worked with "senior staff members" to assess retraining if skill deficiencies were identified

[if] new staff members that aren't quite picking up anaesthetics ... we then compare notes with a few of the more senior staff members that have been there for a little bit longer, and we will have a chat with our new staff members and asking them how would they like to proceed? Because sometimes they actually do need more time in theatre to be able to gather the skills to be able to do their job properly. - Jacinta, Enrolled Nurse

1265. There is evidence in the Primary Materials that nurses and midwives took seriously their professional responsibility to share new learnings with colleagues and established informal communication networks for that purpose (A1). In the following example Layla (RN) shared her learning from a company training session

We get training. We get knowledge from reps that come and explain certain products to us. And then we take that information back and we take it back to the on ward level, and we educate. We filter through the other department to the other nurses, making sure that they are providing care to the patient that's within those guidelines and standards. - Layla, Registered Nurse

1266. Workplaces provided opportunities within normal workplace structures for case conferences, for which one of the aims was progressing clinical knowledge and skills. Amanda (MW) explained the process in a maternity unit

So, in a case conference generally we talk from a clinical perspective, and it's the expectation that everyone goes, even if you don't have women that you're presenting because when you hear about other women not only do you learn ... you can be like Oh, well, I wouldn't have done it that way, and you can kind of nut out why, and you know someone can come from a different lens of what research is out there, but particularly in clinical stuff in these continuity models. - Amanda, Midwife

1267. Sienna (RN) in the private hospital where she worked had a structured education role, though she noted there was no recognition nor allowance for the work

My role is very much taken up with guiding and educating constantly my colleagues. It would be expected of me to do that in my appraisal. It would be expected that as a senior nurse doing a senior working in that environment, that I would guide and I would educate, and I do educate constantly. It's not recognised. I get no qualification allowance for that. It's a role I do quite passionately ... if I've got someone a nurse that needs more confidence or needs more help, I will support them more. - Sienna, Registered Nurse

1268. Note in the above example the use of the terms 'guiding and educating' which involve skills of influence, negotiation and communicating verbally and non-verbally (B1). Also significant in this example is how conscious Sienna (RN) is of doing 'senior nurse work' to educate and guide others. Guiding and educating others is assumed to be part of what a senior nurse does and thus may be overlooked.

1269. Nurses and midwives in this study also undertook their own individual learning programs to pursue specialisations and to keep up to date with regulatory changes. Tamara (EN) used her own initiative to keep up to date with skin cancer research to ensure she was "giving the correct information" (A1). Nina (EN) in a surgical ward in a hospital was conscious of the need to be up to date with changing regulations

Obviously, we've got to be professional. We've got legal requirements. We've got so many laws and bylaws and regulations that we have to stick to at work. And that are always constantly there. - Nina, Enrolled Nurse

1270. The regulation of nursing specialisation has been researched, but further regulation was deemed unnecessary (Nursing and Midwifery Board of Australia 2024b). It remains unclear to me whether gaining specialist recognition in the current environment leads to career advancement or recognition through additional remuneration.

1271. On the job learning, or side-by-side learning was common across the nurses and midwives in this study. They learned with and from each other as they worked together. This was an informal learning process, typically occurring between peers; an essential process for contextual learning (A1, B1, B2). When extended to include reflexive practice it was a powerful form of learning

... the reality is that I learned far more actually being in a room and standing next to somebody who had already had those skills and being taught hands on. I like to read a lot of research, and I'll do all those sorts of things. But until I actually see it in the flesh and go. Oh, hang on and see how things correlate. It's not something that really stays in my brain if I can't make it real. - Samantha, Registered Nurse

Reflexive Practice

1272. There is evidence in the Primary Materials that experienced nurses and midwives engage in reflexive practice which enhances learning. Reflexive practice is the constant and open monitoring of the actions performed by a person (Giddens, 1984). It includes an expectation that colleagues will be engaged in the same practice, i.e. I constantly reflect on my own actions, I share those reflections with others and as a collective we reflect on the actions we carried out in the work activities in which we were involved. Samantha (RN) coins a catch phrase that succinctly captures reflexivity

I must have had this like **emergency meeting in my own brain** of, okay, then, well, this is a really awful situation. But maybe something good can come out of this - Samantha,
Registered Nurse (emphasis added)

1273. There is evidence in the Primary Materials of Nurses and midwives gathering informally to review practice. This was reflexive practice at work. The examples provided in the interviews occurred without consideration of hierarchy i.e. they included ENs and RNs and other staff.

1274. The nurses and midwives in this study were often dealing with life and death issues, including palliative care. Nurses and midwives constantly reviewed their practice to look for improvements in how to support patients. I have provided several examples to indicate the breadth of this practice. For example

I mean, we're always getting together as a team experience to find ways of addressing issues for patients ... Get together with a couple of the other nurses, and we might identify an issue. One of the things could be, you know, looking back together through the patient's history. We might be identifying issues - Nina, Enrolled Nurse (A1)
...and there is a lot of sharing. It is very one of the things I really like about working in general practice is, it's generally collegiate. The GP may involve other general practitioners. We might have a clinical problem, and they'll say, 'Well, what would you do?' And you know there's a lot of problems solving in a group atmosphere. - Megan,
Registered Nurse

And yeah, it was really interesting, because we know each of us knows what our strengths are, like, I'm more of that sort of leadership policy, innovation, kind of thing, whereas my other colleague is just the bees' knees when it comes to clinical stuff, and I'm just in awe of her - Matilda, Nurse Practitioner

1275. Reflexivity leads to better decision making and patient care because it encourages a focus on 'why' and 'how' questions rather than only 'what does this process require?'. Sienna (RN) shared her reflections when working with patients in pre- and post-theatre situations

Yes, so your body language is really important. Because you've got a patient lying in a bed, and you're standing over them. And that can be really intimidating. You might hold their hand; you might stroke their head. You might give them intense eye contact. You might change the tone of your voice. You might change your lingo. You might take out some of

the bigger words and use more simple words if say it was a child, or if it was a person that was a little bit confused. You might have to be prepared to say it 10 or 15 times in a row. Yeah, you instinctively change how you speak and how you react. - Sienna, Registered Nurse

1276. The interviews revealed examples where the learning of nurses and midwives clearly moved beyond compliance and maintenance of currency with skills to be a deliberative exercise in extending skills and their scope of practice. This was common for NPs, but for Luna (NP) working in remote areas, it was particularly important, because it broadened her ability to provide treatment, where she was the only health practitioner

I learned a lot of lessons, and that's why I've constantly expanded my scope. That chronic disease starts with a kid with a chronic infected ear or rotten teeth that are infected, and then they get strep infections, and they get heart disease. So, I had to learn to expand out to all these other simple things. I've done dental courses. I've done everything to try. I didn't realise that at first I was very naive. I thought I could just take my knowledge from the big city hospital take it out, and it would be applied everywhere. But it's learning these things. - Luna, Nurse Practitioner

1277. In the final sentences of the above example, Luna (NP) acknowledges that learning, knowledge and the application of skills in nursing is highly contextualised to place, people, patient and self.
1278. The lack of recognition for the formal and informal learning that happens 'on the job' may be another factor that contributes to the skills being developed and exercised by nurses and midwives being undervalued or overlooked. There is a danger that these skills may be ignored by the system (Department of Health and Aged Care 2024b, p.55).

8.6 Evolution of practice

1279. Based on the Primary Materials analysed in chapters four to seven and the Secondary Materials referred to in chapter three I am of the opinion that there is extensive evidence of nurses and midwives extending and deepening skills held with experience and the application of these skills in context.
1280. The evidence provided by nurses and midwives in this study reveals that skills evolve and deepen with further practice and the application of skills in context. This evolution and deepening of skills present in experienced practitioners reflects
- a) the application of skills and knowledge in context
 - b) the ability to assess patients through observation and active listening
 - c) the capacity to have multiple contingencies if a treatment plan needs revision
 - d) the ability to anticipate and avoid problems
 - e) capacity to act with fluency, maintaining emotional control under high pressure
 - f) high level problem-solving and solution sharing skills

These skills present in the work activity of experienced nurses and midwives (which cover the range of Spotlight skills) go beyond those acquired through formal training alone. In the following paragraphs I set out some examples to support this opinion.

1281. A MW with 40 years' experience described the complexity of the examination of a pregnant woman and why practice and experience is important

... skills in vaginal examination takes you forever to become skilled at what you're feeling and what you know and what part of the baby's presenting, and whether it's normal. That takes a number of years. Really. Sometimes I've even had mine checked. You know you go in there, and you think you think in your head what you know, you're gonna feel. And then it's completely different, is it? Oh, no, I'm really confused now. And I get someone else to do it. So yeah...you need a mix of experience. And it's good for junior midwives to experience things they've never experienced before. But they need support."

- Amy, Midwife

1282. An EN with more than 10 years' experience described the need to be alert to the context of each patient and the need to apply skills in that individual context

We're dealing with a range of people. We're dealing with people at their most vulnerable we're dealing with a heap of complex different scenarios. No one patient is the same so basically, that our professional communication, I suppose, has to adapt to all of that. You know, in a way that it's each client. - Nina, Enrolled Nurse

1283. Amanda (MW) with 10 years' experience described assessing a woman through observation and active listening, applying skills built through one to one on the job learning, reflection on experiences and constant checking in with peers

we call them corridor assessments when you someone walks in and you kind of assess them to see whether they're in labour without kind of doing anything about it. In, particularly in birth suite it's super powerful like you can tell the way that someone grunts. You can tell whether they're kind of ready to have a baby. There's a change in the sound. There's also when women are transitioning to fully dilated, ready to have a baby that's often when they lose the blood. That's often when you get the I can't do this, I want to go home, give me the epidural and like. There's a lot of things like that which we as midwives, kind of learn in the trajectory of our careers. - Amanda, Midwife

1284. As an EN with direct care for patients before and after surgery, Nina (EN) observed closely and was internally reflexive about the treatment options depending on the patient's needs

... with regards to pain management, if somebody's in a lot of pain and ... We've given the medication that the doctor has charted on the request form ... I then go through the process of let's find alternative issues to your pain. Ice packs. Things like that, or it could even be a heat pack ... we're not saying, suffer in silence. We're trying to come up with alternatives in a way. And we have rung doctors before and they said, No, sorry. They're not getting any more pain management. So, we've had to let the patient know that. And

that's when we try to negotiate with regards to alternatives, you know. positioning, do we move your position, see if that's gonna help, - Nina, Enrolled Nurse

1285. Jessica (EN) with 36 years' experience, much of it as an anaesthetic nurse read the warning signs and was constantly reviewing and (internally) questioning and anticipating problems in the operating theatre

You just pick up things that you know fluctuations or when things start to happen, it's sort of like a subconscious thing. You just pick it up or if it's not happening, you pick it up ... Why haven't we heard the blood pressure? Why haven't we heard the sats Probe? Stuff like that. You've just got so many things to think about when you first go in there, and it's such a learning curve. You can only learn it one step at a time, there's just no way that you could pick those things up. - Jessica, Enrolled Nurse

1286. Sienna (RN) with more than 30 years' experience provided an insight into her decision making in a theatre emergency. She begins with knowing she has a human being "in my hand" but does not panic. She has learned to remain calm and assess the situation. She knows her limits

when I'm holding an unconscious airway which is a human being in my hand and I'm making sure that they're breathing and that they're ventilating, that it's effective if they start to decline and you'll have them connected to a monitor. So, if that monitor starts alarming, and these numbers come up which are alarming, and the person's not breathing, or they're making all sorts of noise that can be very stressful for a new one. It comes with experience to stay calm and to manage the situation calmly. Whereas you know a lot hit an emergency button. If you lose control of the situation sometimes it's hard to know what your limitations are when you're not experienced. You don't want to feel foolish, but you also don't want to lose the airway. - Sienna, Registered Nurse

1287. Experienced nurses and midwives have developed the capacity to integrate tasks to manage competing demands, responsibilities and relationships which can be described as 'articulation work' (Hampson et al 2009). For newly registered nurses it is not just about learning a task fluently, it is learning the integration of multiple tasks at the same time and then interweaving those tasks with the work of others, either nurse and midwife colleagues or medical practitioners. Layla (RN) described what an experienced nurse can do

Managing their patient load, which includes prioritising, multitasking because it's a lot involved. It's not just looking after patients that are admitted in the ward. We have to do everything from scratch. So, it's quite challenging when they have to multitask, prioritise, because as patients come in, you gotta consider the medication. You got to consider patients to go to the bathroom. You got to see the patient needs to go to CT. So, you got to escort. It's a lot of things in one. Yeah. It's a lot this way. We got to train them how to do it, and what takes priority over the other one. - Layla, Registered Nurse

1288. Skills and knowledge acquired through learning enabled nurses and midwives to fluently adapt to the changing requirements of medical practitioners or patients. Samantha (RN) described her experiences

You've got to be really adaptable ... it can be anything from a medical type scenario that you need to work with the consultants and things to try like different things that you wouldn't ordinarily do. Things that are outside of the realms of normal, like you get some weird, wonderful thing that you've got to try and manage ... - Samantha, Registered Nurse

1289. There was evidence in the Primary Materials that the skill and knowledge gap between experienced and new nurses and midwives can change how Units operate. Layla (RN) provided an example of having to make judicious choices about staff to patient allocations in an emergency ward. Samantha described a similar process in ICU where consideration is given as to which patients will be cared for by "juniors"

We often give our junior staff the most stable of patients, and say, 'Here you go this is yours for the day, and I'm right here, if you need me.' Even the most stable person in ICU can, their wheels can fall off, and then it's supporting those junior staff and mentoring them through those situations. - Samantha, Registered Nurse

8.7 Building relationships to implement person-centred care

1290. Based on the evidence set out in chapters four to seven and the secondary materials referred to in chapter three I am of the opinion that nurse and midwives are involved in delivering relationship-based care. This approach to nursing and midwifery requires the deployment of high-levels of interpersonal and contextual awareness, negotiation, communication and connecting skills.

1291. In this section I have referred the terms 'patient-centred care' or 'continuity of care' however nurses and midwives in this study were more inclined to talk about relationship-based care.

1292. The NSQHS describes the broad aim of patient-centred care as

...[treating] each person respectfully as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care. (Australian Commission on Safety and Quality in Health Care, 2025).

1293. The Midwifery Futures report describes the model of continuity of care as providing "mothers with a continuous midwife relationship across health care settings and is strongly associated with optimal consumer outcomes and improved experience" (Homer (AO) et al., 2024, p. 25).
1294. The literature reviewed in chapter three of this report describes the evolution of the concept of person-centred care and the model of continuity of care (see Kitson et al 2013; Delaney 2018). The role of the nurse and midwives is central to the delivery of effective person-centred care. The demands on nurses (and midwives) are substantial in this model of care

delivery. McCance & McCormack have articulated lists of capabilities that nurses (and midwives) need in this model of care. These include developed interpersonal skills, being able to demonstrate clarity of beliefs and values and knowing self, shared decision-making, power sharing, innovation and risk taking, enabling connections between nurses, patients and others working with persons beliefs and values, engaging authentically, being sympathetically present, and sharing decision making (McCance & McCormack, 2025, p. 51). There is congruence between these skills and those contained in the Spotlight framework.

1295. There were numerous examples in the Primary Materials of nurses and midwives consciously implementing the practice of person-centred care /relationship-based care/continuity of care and, in doing so, engaging multiple Spotlight skills and the ‘clustered’ use of these skills. In the following paragraphs I provide some examples across the four classifications and in different contexts.

1296. In different contexts nurses spoke about their work in terms of building connection and relationship with the people for whom they are providing care

patient care, quality, patient care is what is why we are a nurse, isn't it? It's what we do. It's what we love ... It's a big thing to go into theatre, and I like to know that I've helped them feel safe and supported. - Yolanda, Registered Nurse

And for Saania (RN) in mental health care, relationship-based care is

... the most meaningful part of my work is making young people feel seen, heard, and safe. Even brief moments of connection—a calm conversation after an outburst, a smile from a previously withdrawn teen, or a family expressing relief—remind me why I do this work. - Saania, Registered Nurse

1297. Amanda (MW) articulated what relationship-based care means to her in her midwifery work

Well, essentially, women will seek us out, because they want to know the person that's going to be there when they give birth. So, they want to build a relationship with you so that you can build that trust so that when they are in that space it's someone that they know. So, they're really seeking out that continuity of carer which generally includes building a rapport and a relationship with them. - Amanda, Midwife

1298. Nurses and midwives in this study spoke about advocacy as being part of relationship-based care. Yolanda (RN) described her role as being one where she “advocate[s] for my patient and support them”. Saania (RN) in mental health care used a metaphor to describe her role, “nurses are the constant, and I take pride in being that anchor”. Sienna (RN) clearly articulated her advocacy role

So, your experience and your ability to see when a patient needs you to step forward and speak for them, or defend them, or find out if their choices are consented to choices or to intervene. When you think that they are agreeing to something they actually don't want to do. That takes a certain amount of strength and experience. - Sienna, Registered Nurse

1299. Relationship based care is perhaps best understood when compared with alternative models, with the bio-medical approach being the best known (Delaney 2018). This model revolves around a clinician determining a treatment plan for an illness based on their reading of the signs and symptoms of an illness. In the bio-medical model the relationship appears as between the clinician or carer and the illness, not with the person

Having the skills and knowledge to do things differently and creatively, and you know do that person centred care which nursing enables us to do that holistic person centred creative individual care ... I don't actually want to work in the biomedical model of medicine. I don't want to work that way. I think we are as nurses. We really have the ability to be much more creative and reflective and really try to put patients first. And that comes with a lot of knowledge and a lot of energy to work against systems that don't necessarily do that. - Nadine, Nurse Practitioner

1300. The relationship-based model of care requires not just competency but the deployment of substantial problem solving and innovation skills building connection with patients as part of the delivery of quality care. Amanda (MW) spoke about her experiences

... no one teaches you that like there's no policy that says, ask these questions to find out what this woman needs. It's just through that relationship-based care building rapport with that person which comes from just seeing them regularly [and] providing care to them and talking to them, which you know is totally not within that kind of small scope. When you ask me what you do in an antenatal clinic, it's not their blood pressure or their foetal heart rate like ... [it] happens in that kind of **weird grey area**. That's my job. But like, I can't tick a box to say that I did it. You know what I mean. I think, is exactly the point of what we're doing right is that bit you can't capture, and **that bit's been taken for granted in women's work**. - Amanda, Midwife (emphasis added)

1301. In the above example the skills that Amanda deploys include asking questions, building rapport, organising consistent catch ups, actively listening while other functions are performed. These skills are sensing the context for that woman, knowing her social and physical situation and the relationship she needs from the MW. Amanda (MW) calls what in fact are skills of active listening, reading and interpreting verbal and nonverbal communication and building relationships of trust as the “weird grey area”. It is not something that appears on a form or in a policy. She notes that part of the reason that she believes what she does is ‘invisible’ is because it is “taken for granted in women’s work”.
1302. In palliative care context understanding the past, the present and the future of the person may be part of delivering quality end of life health care. This goes beyond understanding the clinical history

I start my clinic, and I try to learn a little bit about the person, and then I call them in, and then I assess them, so I do their observations. What's important to them. We might have goals of care discussion. We might have discussions around benefits and burdens of

treatments. And whether, you know, they'd prefer to go to Central Australia for a week rather than having chemotherapy and being tied to a hospital. There's lots and lots of discussions around how long do I have. Nobody will tell me. No one will talk to me about that. No one will give me the information, and I'm trying to plan. - Nadine, Nurse Practitioner

1303. In the above example Nadine is balancing the clinical requirements with the goals of patient. She is handling difficult conversations “how long do I have”. In doing so she is ‘reading’ the patient (beyond observations) picking up on cues, building a relationship of trust.
1304. Applying active listening skills (A1.3, A2.3, B1.3, B2.2) and centring the desires of the patient (A3.3) is part of delivering patient-centred care

My priorities aren't their priorities. What I think they should be managing their diabetes better. But that's my business. I don't need to project that onto the patient. They can have completely different priorities, and there's no point having conversations with people and wasting time when their priority is something completely different. - Lauren, Enrolled Nurse

So, key into other ways of thinking. Whenever I see a family, I often try and see what their point of view is. First on the solutions because there are so many ways to do things I like to make sure that they feel valued and heard, and that the advice I give is consistent with something that they think that they would implement - Natalie, Registered Nurse

A lot of the older generation were like, you're the nurse. You just do what you've got to do. You know, they didn't always feel like they had a say in things. Whereas you know, we all know it's patient centred. You know, everybody has a say and especially when you're going into people's houses. You have a say in what happens to you. So yeah, just trying to Yeah, suss people out and kind of follow the cues a bit on how you handle the situation - Cassandra, Registered Nurse

1305. There was evidence in the Primary Materials that NPs in this study were delivering holistic relationship-based care in difficult contexts.
1306. Matilda (NP) interacted with people with substance abuse issues. She committed to lifting them up, refusing to bow to their lack of self-esteem, remaining constant with them. Matilda (NP) provided two examples demonstrating that person-centred care begins with valuing a connection with the person, persevering until trust is established, and facilitating the best possible care (A1.2, A2.3, B2.3).
1307. Luna (NP) shared her thinking about providing what was person-centred care in a remote community

Yeah, that that is just so hard. You might want to mandatory report some mother, because the child hasn't been fed. But you've got to understand she hasn't been fed, and she's in a domestic violence situation, and what you can do is you're cranky at her because the child

hasn't been fed, but what can you do to feed them? ... mandatory report doesn't solve anything. It doesn't feed that child. So, it's very tricky in some ways. Why didn't that mother bring that baby, and now it's covered in sores from its hips all over its legs and everywhere with scabies and sores. Well, you've got to think there's never been a primary health service. This is the first year of its service. They've had no other way to treat it until you've started this service. It's about education. It's not about reporting and thinking that the problem will go away. It's a balance of the problem. We need to treat and fix that now, and we need to educate them. And we need to engage them. So yeah, it's a tricky balance when you're in those places balancing what the law says you should do if something's being mistreated, but when they're not being mistreated intentionally, and it's through a lack of understanding and a lack of health resources and things. - Luna, Nurse Practitioner

1308. In this example from Luna (NP) she demonstrated skills from each of the three Spotlight Skill Sets at level 3. She was monitoring her own reactions and that of others, she was seeking to solve problems across cultural barriers, and she was maintaining workflow (in this case person-centred care for the woman) whilst internally grappling with complex health, cultural and legal issues. These are under-specified and under-codified skills, the integrative skills where a person multi-tasks to maintain workflow in health service delivery.

1309. In settings like palliative care cases can be complex and communication may be difficult

Making sure people who I am seeing or spending time with patients are feeling safe. And an example of that is with my communication. I always let people lead me to places that are safe for them, so I'd never say something like, what do you think about dying or something? I'd always go - What do you think's happening? And you know I wait for them to bring up the dying word ... I don't ever want to do harm to anyone. You know, I want people to feel okay in my care. So yeah, just get always get them to lead the conversation.

- Nadine, Nurse Practitioner

1310. In the above example Nadine showed her reflexive awareness of her own communication when dealing with conversations about death. Her commitment to person-centred care in palliative situations required verbal and non-verbal communication skills to reflect the level of understanding of the other person. These are skills that are under-specified and under-codified.

8.8 Increasing contextual complexity

1311. I am of the opinion that the evidence in the Primary Materials shows that nurses and midwives are deploying high level but under-recognised levels of skills, responsibility and effort in increasingly difficult circumstances.

1312. Nurse and midwives experience first-hand demographic, social or cultural changes across Australia. Change in society are ultimately reflected in the delivery of health care. There are

significant changes having a strong and immediate impact on the work of nurses and midwives.

Greater diversity in those seeking care

1313. There is evidence in the Primary Materials that nurses and midwives were adapting their practice to meet the needs of a more diverse community. In some cases practice is evolving to address this diversity. This diversity requires the engagement of high level interpersonal and contextual awareness (A), connecting (C), interacting and relating skills (B) and considerable effort. There is now an expectation that nurses and midwives will be 'trauma informed' in their delivery of health care. Some people in the community cope with trauma through the consumption of drugs, alcohol and abuse of other substances.
1314. Nurses and midwives in this study also highlighted the change in the information level sought by patients when they presented for health care. Some people came with well researched questions that required more time and effort from nurses and midwives. Whilst others who attended for health care were poorly informed about their own bodies and with very low levels of health literacy.
1315. There were multiple examples provided by nurses and midwives of patients misinformed by Google and other social media platforms.
1316. Nurses and midwives are also experiencing the shift among some people away from vaccine science to vaccine scepticism. They have taken on responsibility for educating people about the importance of immunisation. Natalie (RN) moved between negotiator and educator with parents for what would once have been a routine maternal and child health activity,

Delivering health care to First Nations people

1317. Across all health professionals, including nurses and midwives, there is a need to develop cultural competencies to deliver effective health care to Aboriginal and Torres Strait Islander people. The NMBA has developed principles of culturally safe care which are embedded in the standards for practice for RNs, ENs, NPs and MWs (Nursing and Midwifery Board of Australia 2025d). These standards are discussed in chapter three.
1318. Implementation of culturally safe and respectful practice requires of health practitioners to develop cultural competence. There was evidence in the Primary Materials that nurses and midwives are engaged in understanding the cultural context in the communities where they operate and extending their skills to learn new methods of communicating. Those who are engaged in working with First Nations people openly acknowledged that they are still learning about how to engage in ways that will deliver quality health care (for example Luna NP).
1319. The delivery of health care to First Nations people in remote communities is made more complex by remoteness and the lack of services particularly high-quality frequent transport

If I saw you in the city I'd give you a script off you'd go. If you're in remote, and I give you the script, and we don't carry that medication, I have to contact the pharmacy. I have to organise for flights. The medication comes out in flights. It'll come out 4 days later, even though you needed it today, and then I have to get it. I have to organise for delivery and for the person to come in. I have to explain it. I have to label it so. Everything we do in remote is just so complex. - Luna, Nurse Practitioner

- 1320. Aboriginal and Torres Strait Islander people have experienced racism and trauma in the health system and can be reluctant to engage with health care providers this requires nurses and midwives to establish relationships of trust (B1.3) and understand what is driving reluctance to seek care (B1.4)**

... telling them that they've got kidney failure and they need to see a specialist. They'll automatically remember their mum, who died of renal failure, who went and saw a kidney specialist, and they go, No, I'm not going because they just know that they're going to die like their mum did. And so it's really important with that history of understanding ... So, it's understanding the fear, the racism that they may have experienced. And it's so alive and well in many places. - Luna, Nurse Practitioner

- 1321. In mental health care Saania (RN) was responsible for an innovation to improve health care for First Nations people. It arose from her research and commitment to improved outcomes**

I was part of creating an indigenous safety plan. So having it a bit more focus on our indigenous community, providing resources that were beneficial for indigenous communities as well, once they were discharged. So that was something that I was quite proud of, and that I felt really helped our indigenous cohort of young people come through, and it was a bit more catered to them in their culture as well. So, I have a big passion of indigenous culture. So very much. I do my own sort of like readings and research, because I think it's really important to sort of understand our First Nations people and be culturally sensitive to them, especially within health care settings, because we are trying to close that gap within health care with, you know, allowing our First Nations people to feel safe within healthcare, Westernized healthcare. - Saania, Registered Nurse

- 1322. Kelly (NP) working in a rural General Practice clinic established a program with an indigenous NP in the clinic to improve outcomes for people with diabetes**

we have a nurse practitioner that works in our practice who is Indigenous herself, and we've got a grant from the Australian Primary Healthcare Nurses Association to work on a collaborative project with people with diabetes that have high risks of having hyper or hypothermia. And that situation has taught us that people who are non-indigenous think about trying to work with indigenous people without doing cultural training and safety, that we often get it quite wrong. So even now, we can actually do a lot more into improving that. - Kelly, Nurse Practitioner

1323. One of the interesting developments has been in combining bush and western medicines. They are cautious first steps, but nurses and midwives are learning how to introduce western medicines that complement traditional medicines. Luna (NP) described her experience
- ... one man was getting cellulitis of his leg, and he goes, 'I'm not going to stop using the sandalwood leaves'. He makes a tea out of it and puts it on. And so I said, could I put a big handful of salt in in that, and we work together because, my Nan, she was at the mission at [place], and she used to do that, but she used different leaves, and he said, Oh, all right. So, you're working together with his medicine and your medicine, and the salt is helping to clean that wound, and then saying. They're still allowed to have their fears. But you're negating those or embracing their ways of doing things and getting the management that you feel is needed, and that they feel is needed. - Luna, Nurse Practitioner
1324. There remains tension between the traditional approach and the western medical approach. The evidence in the interviews was that nurses and midwives are learning how to communicate more effectively and how to bring the two approaches into closer alignment.

Increasing chronic illnesses and co-morbidities

1325. The life expectancy of Australians has trended upwards in the last two decades suggesting improved levels of health (AIHW 2023a). Along with this upward trend in life expectancy there has also been an increase in Australians living through those years with chronic conditions and an increase in the number of Australians living with multi-morbidities (where a person has 2 or more chronic conditions at the same time). In 2007-08 16.5% of Australians were living with 2 or more chronic conditions. By 2022 this had increased to 21.9% (Australian Institute of Health and Welfare, 2024a).
1326. The increase in co-morbidities has had a direct and indirect impact on General Practice clinics. The indirect impact is on the pressure for hospital beds. If they are not available and/or where hospitals increase day procedures, then people are treated at home by their doctor and the staff of a clinic including in many cases an RN. Megan (RN) narrated her experience
- People live at home with really debilitating chronic illnesses, and with a large amount of medical management, and you need to be across it. You know people have chemotherapy as a day only patient now, and you know, then go home, and then the post chemotherapy symptoms. You have to manage the whole introduction of immune modulators into medicine from everything, from eczema to migraines to IBS to Crohn's. You've got to know all of that. The management of osteoporosis of menopause, of contraception. It's just more complicated, much more complicated. And we are seeing patients who are much sicker in general practice than once upon a time. - Megan, Registered Nurse
1327. Katherine (RN) provided an insight into her thinking about the challenges of increasingly complex patients. In her view, it is not a case of more tasks, so an increase in workload, it is a different approach to the work involving critical thinking and considered judgement

... there's more focus around critical thinking and having that expertise not just being a jack of all trades. But you know you have to be a master and an expert in what you do know to be able to provide that patient care. That comprehensive, patient care. Because you know patients, their health conditions are becoming more complex. They're living longer. So yeah, there's definitely more of a requirement to possess that expertise and knowledge and not just be task focused. - Katherine, Registered Nurse

1328. The complexity of a patient may not be an illness, but a neurological condition, that affects the treatment plan for that person. Jacinta (EN) described the situation for surgical admissions. She applied her knowledge of the drug regime in making decisions about what steps could be taken with a patient with a neurological condition

There's a lot more ADHD and ADD, and all that stuff. So, a lot more children are now on medications as well. We do a lot of dental where I work for children and ENT, so that makes it a lot more complicated for the anaesthetist and complicated for us when we're trying to admit, especially if the anaesthetist would like a pre-medication for a patient. Sometimes it's just not possible. - Jacinta, Enrolled Nurse

1329. The challenge of dealing with increasing chronic illnesses and co-morbidities reaches to the NUM level in hospitals. Aaron (RN) as the NUM recognises the challenges to staff welfare arising from the increasing complexity of patients

Some of the most [complex] challenges, probably staff welfare. So, we in my space, in addition to having the really complicated and multi factorial, patient or multi morbid patients with multiple of their conditions. We also have we care for mentally unwell patients with eating disorders. - Aaron, Registered Nurse

1330. Aaron (RN) allocates time to support families negotiating complex hospital processes that may involve multi-disciplinary teams when a family member has complex health needs

Working with families can be really challenging, especially with patients with really complex conditions or conditions where families aren't accepting. Sitting down with the multidisciplinary team having family meetings. - Aaron, Registered Nurse

1331. Women with complex health conditions present to Maternity Units, where MWs can be challenged in providing the care required and supporting the woman through the birth and then dealing with illness following the birth

So, we're finding now we've got more diabetes. We've got more high blood pressure. We've got women who are quite obese and therefore have other issues before they get pregnant and that just complicates the whole situation. It's difficult to monitor people who are very overweight. Their blood pressure issues are ongoing when they've had their babies. They seem to be rebounding back in quite often with rebounding blood pressures after they've birthed. Diabetes obviously is well documented that it's increasing in society, and they're becoming diabetic after their babies as well. Their needs are increasing in that

respect as well. Even some mobility of the people like they're not as mobile. They're not as fit, so they don't labour well. - Kate, Midwife

1332. The illnesses are changing routines and increasing the intensity of work for MWs.

The ageing of the Australian population

1333. The Australian population is ageing with medical science and improved care extending the lives of people, enabling them to live longer with illnesses. In health care this is evident in the increased need for palliative care and dementia care. Health service providers, outside of the aged care system, are caring for people with age related health issues and for those with dementia. It is requiring of nurses to be better informed about these conditions and to change practice to meet the needs of an ageing community and those with dementia.

1334. Cassandra (RN) was working in community nursing where she had seen an increase in dementia patients being cared for at home, by spouses with some medical support

[I am] looking after quite a few dementia patients. That are still, you know, maybe living at home their spouse or whatever. And, you know, their reality is very different. - Cassandra, Registered Nurse

1335. In acute care settings, dementia and related conditions of cognitive decline can be complicated by the wishes of the family. In those cases, they can be elevated to the NUM. In this example from Aaron (RN) he drew on a full range of communication skills and committed time to support this family to reach a resolution

Recently we had a patient who was with us for about 2 weeks, while the family were coming to terms with the cognitive impairment of their father, and really struggling with realizing that his cognitive function was declining, and as a smart man and high achieving all of his life ... anytime staff went in the room they were being abused by the family ... we're sitting with family and working with staff to try and communicate effectively with family but also to then have other space to step away and just vent a little bit as well. So, trying to support staff in all of that is probably one of the biggest challenges of my role, and often can be quite time consuming. - Aaron, Registered Nurse

1336. Nadine (NP) was working full time in the field of palliative care; her specialisation. Even with her skill, knowledge and networks, she had to navigate and negotiate her way through the many complexities of palliative care. It required her to engage in influencing and persuasion to put into effect the wishes of the person being supported. She provided this example

At the same time I had to line up an admission with the home-based palliative care team, and it really would have fallen down if they said no. So, I had to talk to doctors and nurses over in the home-based palliative care team and explain why this discharge needed to happen tomorrow. And all of those reasons. So, there's quite a bit of negotiation around that. Methadone is a medicine that has very long half-life, and not many practitioners feel safe in prescribing that medication, especially sort of one day prior to discharge. So, there

was lots of convincing on my part that this was safe enough for him to go home on, and I explained that actually, if we didn't get him home on this new medication, he would discharge against medical advice. - Nadine, Nurse Practitioner

1337. With a different patient, Cassandra (RN) found herself caught between the wishes of a patient in palliative care and a doctor who was the final decision maker. It appears that there was either a clash of values about end of life or a difference in opinion in what quantity of which drugs could be legally prescribed. The description shows common traits of the interactions of nurses and midwives. Nurses and midwives provide person-centred care to the patient – they spend the time with the person. However, they rarely have the final say about the clinical treatment. Typically, that is in the hands of the medical practitioner. Cassandra (RN) learns from this experience to be very careful in making any promise to a patient

And this man, his wife was a nurse. He wanted to die at home, and he could have died at home, but he needed mega amounts of morphine because he'd been on opioids long term. And the doctor he got to a certain dose of morphine, and he said, no, he's not having any more. It was disappointing because he ended up, he had to come into hospital and this poor man like begged me twice, you know, you need to help me die. And it was just really sad because in the end they you know they dosed him with anaesthetic drugs and stuff it just wasn't handled very well. I struggled because I used to always say to patients, don't worry, I'll get you sorted kind of thing. And I couldn't say that anymore because I realised I was just a nurse, and you know the doctor has the final say. - Cassandra, Registered Nurse

1338. The negotiation in palliative care was not always with the medical practitioners. Cassandra (RN) stepped her way through the complexity of the wishes of the patient, the desire of the family, her own obligation to treat the patient and, in the background the law, about what was permissible. It was complex as Cassandra (RN) explained

The man was dying. He was in pain. He wanted more morphine. His wife said, I don't want him to have any more morphine. And I said, look, I'm sorry, but it's not your decision, it's his decision. If he wants more pain relief, he's having it. She didn't want him to get more tired, and those things and I said, well, you know, his pain's got to be managed. The patient's had enough of chemo and treatment, and you know the spouse is like, no, you've got to keep having more. So having to explain to family members that we have to provide what the patient wants ... you've got you know to try and de-escalate just trying to keep yourself calm, trying to keep your voice calm. Trying to keep your body language calm you know not pointing. There's probably days where you feel like you want to say what you think, but you can't you've just got keep calm - Cassandra, Registered Nurse

1339. What is evident from these palliative care examples is that person-centred care was creating new challenges for nurses who were caring for people with very complex illnesses. To advocate for the patient was to find themselves in conflict with family and peers. These

people are often out of sight for mainstream Australians. Nurses do the work of palliative care, behind curtains, bringing deep knowledge, refined skills and informed ethical decision making to very complex care arrangements.

Rise in aggression toward nurses and midwives

1340. Nurses and midwives in this study reported a rise in aggression and harassment from patients and their families. There were seen to be varying causes and different responses depending on the context and setting. Saania (RN) painted a picture from her perspective in mental health care

It's just become more dangerous, and like it's, it's emotionally exhausting. There's a rise in aggression and high-risk behaviours ... So, you know, you're a crisis responder. You need to deescalate. You're essentially a counsellor. You become a legal advocate as well. You know you're going through mental health paperwork, understand the mental health and wellbeing act as well. - Saania, Registered Nurse

1341. In mental health, dealing with young people who threaten violence was seen as an inevitable part of the job to be dealing with young people who threaten violence. The mental health dimension makes it more understandable but not acceptable. Saania (RN) advocated for change and for proper debriefing for staff.

1342. Nurses and midwives working in acute care in hospitals reported many examples of aggression or threatened aggression from patients and/or families. One hospital wide example was presented as a case study of 'skill clusters' in chapter four, section 4.6.

1343. The most frequent examples raised by nurses and midwives were threats, aggression and harassment from patients and/or their partners and families. Nurses described developing de-escalation communication strategies to respond. Few of those who reported feeling threatened indicated that there was any response from the employer

The most challenging ones are patients who are like family members. That's very aggressive. I understand, they get frustrated because sometimes they want it right now. Yeah, that that sort of thing like they want it right now. And you try to explain it to them. But it's not enough. So, they get very, very aggressive. - Jacqueline, Registered Nurse

1344. Threats of aggression and harassment were also present in Maternity Units

since COVID, we seem to have had many more challenging issues with people's visitors and the patients. We get abused verbally. Quite often people seem to think that, you know when I started nursing, you know, there were visiting hours, and you listen to the nurse and you do what you were told, and if you were told to leave you left but now it's like, Well, you don't have a right to kick me out, and things like that, and they will get quite nasty and aggressive, and sometimes physically aggressive. - Kate, Midwife

1345. Nurses and midwives can be required to respond to instances of family violence which not only interrupts workflow but require skills in de-escalation.

8.9 Overall conclusion

1346. The purpose of this report was to identify, name and classify the ‘invisible skills’ used by Registered Nurses, Enrolled Nurses, Nurse Practitioners and Midwives by applying the Spotlight Skill Recognition Tool.
1347. In chapters four to seven in this report, I have set out the material that shows how I have applied the Spotlight skill recognition tool to the work of Registered Nurses, Enrolled Nurses, Nurse Practitioners and Midwives. In these chapters I have, in a systematic way, itemised the use of the nine skills in the Spotlight taxonomy in the work of those nurses and midwives who participated in this study. I have also identified, named and classified the ‘invisible skills’ present in the descriptions of the work activities of the nurses and midwives in this study.
1348. I conclude that evidence has been provided of the extensive and intensive use of the skills in the Spotlight taxonomy. This evidence in chapters four to eight documents the use of these skills at high levels of complexity (Levels 3-5).
1349. This itemisation of Spotlight skills catalogues the range, content and level of skills used by the experienced nurses and midwives in this study. It includes examples of how these skills are used in combination in the work of nurses and midwives. Combining the use of a range of skills is itself a higher-order coordination skill.
1350. In this chapter (eight) I have also identified (through the evidence in the Primary Materials and the Secondary Materials) further issues that I believe contribute to the under-recognition and therefore also the potential undervaluation of the skills employed in nursing and midwifery in contemporary Australia. These issues include the lack of recognition of both the extensive development of nursing and midwifery skills ‘on the job’, and through the extensive ongoing learning (formal and informal) that nurses and midwives undertake that is not credentialled.
1351. I have identified the impact of significant contextual factors on how work is performed and how these factors impact on the skills, effort and responsibilities involved in nursing and midwifery in Australia. These factors include: the further development of person-centred care (nurses) and continuity of care models (midwives) which require extensive contextualising, connecting, and coordinating skills from nurses and midwives. There is also the increasing complexity and diversity of the Australian community and their health needs, which intensifies the skills needed for care and places further demands on nurses and midwives.
1352. The work of nurses and midwives is of high impact and is extremely important to the Australian community. This work engages a depth and range of skills that have been brought to light in this study using the Spotlight framework. I consider that the Primary Materials, set out in chapters four–seven, and further in this chapter, contain evidence of the intensive, and

extensive use of Spotlight skills which are under-recognised (because they are 'hidden', 'under-defined', 'under-specified' or 'under-codified) and are therefore invisible.

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10.0 Annexures

Annexure One: Letter to Dr Heap from Gordon Legal 28/10/2024

28 October 2024

Research Into Action
Dr Lisa Heap
Mr Michael Victory



Nick White

Partner

E: nwhite@gordonlegal.com.au

Angelica Nippard

Lawyer

E: anippard@gordonlegal.com.au

Legal Administrator: Lana Dennis

E: ldennis@gordonlegal.com.au

Our Ref: 011 692

Dear Dr Heap

AM2024/11: Application to vary the *Nurses Award 2020* – work value case
Letter of instructions to produce expert report

1. We continue to act for the Australian Nursing and Midwifery Federation ("ANMF").
2. We confirm that we are instructed to engage you, via "Research Into Action", to:
 - (1) apply the "Spotlight" skill-recognition tool to the work of Registered Nurses and Midwives, Enrolled Nurses, and Assistants in Nursing working outside of aged care;
 - (2) based on application of that tool, produce an independent expert report identifying, naming, and classifying the "invisible skills", if any, used by those workers in their work ("Report").

The nature of your report

3. Your Report must be in the nature of independent expert opinion evidence. That kind of evidence must have the following characteristics, which are highly relevant to the drafting of your Report:
4. *First*, you will need to establish your expertise—i.e., the training, study, and/or experience on the basis of which you have specialised knowledge in relation to the subject matter of the Report. So, please provide, in your Report, details of your training, study, and experience generally, and in particular identify how it is that the training, study, and experience provides you specialised knowledge in relation to the subject matter of the Report. Please also attach to your report a copy of your *curriculum vitae*.

5. *Second*, you must establish the facts and information upon which you base your opinion in a manner which enables the reader to understand your reasoning process. And:
 - (1) if you are expressing an opinion which relies upon scientific literature, or some particular training, study, or experience, then we ask that you provide sufficient references to identify those matters (such as in footnotes, endnotes, and/or a bibliography);
 - (2) when you express an opinion, please provide reasons for the opinion sufficiently to enable the reader to understand the basis for your opinion and your reasoning process.
6. *Third*, please acknowledge that you have read and agree to be bound by the *Harmonised Expert Witness Code of Conduct ("Code")*, found in the Federal Court's Expert Evidence Practice Note (GPN-EXPT). We attach a copy of the Practice Note, including the Code. You are instructed to comply with the Code, and we ask you to acknowledge that by including the following statement in your report:

"I have read and complied with the Harmonised Expert Witness Code of Conduct set out the Federal Court's Expert Evidence Practice Note (GPN-EXPT), and I agree to be bound by it. My opinions set out in this report are based wholly or substantially on specialised knowledge arising from my training, study or experience."

Please note particularly that the Code states matters that are relevant to the drafting of your report (see in particular paragraph 3). Please have regard to these matters in drafting your report. In particular, please ensure that you are in a position to make the declaration set out in 3(i), and make that declaration in that report.

Assistance from project personnel

7. We note that you will require assistance in producing your Report. In respect of any person RIA engages to assist you ("**Project Personnel**"), please ensure that each of the Project Personnel is provided with, and reads, a copy of the Code, and please include as annexures to your Report copies of the *curriculum vitae* of the Project Personnel.
8. Of course, while you will receive assistance from Project Personnel, any opinions and conclusions you express in your Report are to be your opinions and conclusions, and you are instructed to review the work of your assistants to the degree you consider necessary in order to form your own opinions and conclusions.

Next steps

9. Please contact me if you require any further documents or information in order to commence work.

10. We ask you to note that your report is confidential and subject to legal professional privilege of the ANMF. For this reason, we ask that this letter, any other materials provided to you, and any working notes or papers of consequence prepared by you, be maintained in a dedicated file marked as being confidential and subject to legal professional privilege.

Yours faithfully



Nick White
Partner
Accredited Specialist (Workplace Relations)
Gordon Legal

Annexure Two: Resume of Dr Heap

Lisa Heap

Qualifications

- PhD (Law), RMIT University
- Graduate Diploma in Applied Human Rights – Vice Chancellor's Honours List, RMIT University
- Bachelor of Laws (Hons -First Class), Latrobe University
- Bachelor of Arts (Political Science/Industrial Relations), University of Western Australia
- Admitted to practise as a Barrister & Solicitor in the Supreme Court of Victoria & High Court of Australia.

Employment

2024 (ongoing) Senior Researcher, Centre for Future Work

2022 - 2023 Technical Adviser Pay Equity, New Zealand Nurses Organisation & New Zealand Public Service Association (Consulting)

2018 - 2024 Doctoral Candidate & Sessional Lecturer, RMIT University

2015 - 2021 Principal Adviser Pay Equity New Zealand Public Service Association (Consulting)

2015 – 2018 Lead - Women's Rights and Safety at Work, Victorian Trades Hall Council

2007 - 2015 Executive Director, Australian Institute of Employment Rights

2007 - 2015 Legal Officer, Civil Air Operations Officers Association (Part-time)

2005 - 2007 Assistant Branch Secretary, ASU Victorian Authorities & Services Branch

2002 - 2005 National Co-ordinator Legal & Industrial Services Australian Services Union (National)

2000 - 2002 Articled Clerk/Solicitor, Slater & Gordon Lawyers -Industrial & Public Interest Unit

1996 - 2000 Federal Women's Officer, Australian Education Union

1994 -1996 National Industrial Officer, Australian Services Union (National)

1992 – 1994 Branch Industrial Officer, Australian Services Union (Victorian Authorities & Services Branch)

1991 – 1992 Industrial Advocate, State School Teachers Union of Western Australia

1988 – 1991 Industrial Officer, Construction Mining and Energy Worker's Union (WA Branch)

Commissioned research

- *Building Gender Equality: Victoria's Women in Construction Strategy 2019-2022*, Victorian Government, (2019).
- *Documenting the Dimensions: An examination of the work, contextual complexity, and expectations of the roles of Principals and Deputy Principals in Western Australian Public Schools*, Australian Institute of Employment Rights, (2013).

Publications

Published journal articles (Peer Reviewed)

Jericho G., **L. Heap**, C. Joyce, F. Macdonald, J. Stanford (2024) 'Commonwealth Budget 2024-2025: Important progress, missed opportunities' *Journal of Australian Political Economy*, No. 93, June 2024, 135-151

Popa T. C., Platz, K., Jakowski, K., Young, **L. Heap**, Y. Luo (2024) "A Big Nebulous, Multifaceted Concept": Reflections from Victorian Personal Injury Lawyers on Wellbeing, Burnout and Vicarious Trauma', *Psychiatry, Psychology and Law* (2024) 31 (3), 417-439.

Charlesworth S. & **Heap L.** (2020) 'Redressing gendered undervaluation in New Zealand aged care: Institutions, activism, and coalitions' *Journal of Industrial Relations* 62(4), 608-629.

Heap L., Barnes T. & Weller S. (2018) 'De facto informality? Rethinking the experience of women in the formally regulated workplace', *Labour & Industry: a journal of the social and economic relations of work*, 28:2, 115-129.

Barnes, T. W., Roose, J. M., **Heap, L.** & Turner, B. (2016). 'Employment, spill overs and 'decent work': Challenging the Productivity Commission's auto industry narrative' *Economic and Labour Relations Review*, 27(2), 215-230.

Heap L (2008) 'Working Together to achieve a New National Industrial Relations System: A review of the Content and Potential Impact of the Williams Inquiry Report' 21 *Australian Journal of Labour Law*, 70-81.

Heap L (2008) 'The Australian Charter of Employment Rights: Setting the Standard for New Legislation and Good Practice' *Journal of Industrial Relations* 50(2), 349-353.

Submissions & Reports

Heap L (2025) *Briefing Paper: Restoring public sector capability through investment in public service employees*, Centre for Future Work at the Australia Institute.

Heap L & Peetz D (2024) *Submission to Industrial Relations Victoria Inquiry on Restricting Non-Disclosure Agreements (NDAs) in Workplace Sexual Harassment Cases*, Centre for Future Work at the Australia Institute.

Heap L (2024) *Doing it tough: How Australians are experiencing the cost of living crisis*, Centre for Future Work at the Australia Institute.

Macdonald F & Heap L (2024) *Submission to the House of Representatives Standing Committee on Employment, Education and Training Inquiry into the Digital Transformation of Workplaces*, Centre for Future Work at the Australia Institute.

Heap L (2024) *No Blood-No Job: Australia's privacy laws and workers' rights*, Centre for Future Work at the Australia Institute.

Heap L (2022) *Submission to the Australian Parliament Joint Standing Committee on Treaties Inquiry into the International Labour Organization Convention concerning the elimination of violence and harassment in the world of work (No. 190)*.

Heap L (2017) *Inquiry into Gender Segregation in the Workplace*, Senate Finance and Public Administration Committee, VTHC.

Heap L (2016) *Stop Gendered Violence at Work*, VTHC.

Heap L (2016) *Hear My Voice: The Experiences of Victorian Women at Work*, Parliamentary Library & Information Service, Department of Parliamentary Services, Parliament of Victoria.

Heap L (2015) *Submission on the Victorian Government Gender Equality Strategy*, VTHC.

Heap L (2012) *Howe Inquiry into Insecure Work*, Australian Institute of Employment Rights.

Heap L (2012) *Workplace Culture and Bullying - A submission by Australian Institute of Employment Rights to the Standing Committee on Education and Employment*, Australian Institute of Employment Rights

Books and Book Chapters

Heap L (ed) with Macdonald F and Joyce C (2025) *Solving the Crisis: Raising the living standards of Australian Workers*, Centre for Future Work at the Australia Institute.

Heap L & Stanford J (2025) Introduction in Heap et al (eds), *Solving the Crisis: Raising the living standards of Australian Workers*, Centre for Future Work at the Australia Institute.

Heap L (2025) Living the Crisis: Australian workers' experience of the living standards crisis, in Heap et al (eds), *Solving the Crisis: Raising the living standards of Australian Workers*, Centre for Future Work at the Australia Institute.

Heap L (2015) 'Promoting an Understanding of Labour Rights as Human Rights' in *Employment Rights Now Reflections on the Australian Charter of Employment Rights*, Hardie Grant Books.

Heap L (2013) 'Taking the High Road: A Future that Works for Australian Workers' in *Pushing Our Luck: Ideas for Australian Progress*, Centre for Policy Development.

Jerrard M & **Heap L** (2009) 'Ensuring Equal Rights: The role of trade unions' in Strachan G, French E and Burgess J (Eds) *Managing Diversity in Australia*, McGraw Hill Australia Pty Ltd.

Professional Leadership

2024 -2025 Secretary, Association of Industrial Relations Academics Australia and New Zealand (AIRAANZ)

2018 & 2019 Technical Adviser -Worker's Group, Standard-Setting Committee, ILO Convention C190

2017-2020 Member Victorian Ministerial Council on Women's Equality

2015-2017 Parliamentary Library Fellow – Victorian Parliamentary Library

2014-2020	Professor (Adjunct) Australian Catholic University
2009	Technical Adviser ILO – Multi-National Enterprises Initiative, ILO Geneva
1999 & 2000	Australian Worker’s Representative – Standing -Setting Committee, ILO Convention C183

Community & Industry Governance

2024 (ongoing)	Chairperson, Victorian Government Equal Workplaces Advisory Council (EWAC)
2024 (ongoing)	Member, Board of Directors, Gender Equity Victoria (GenVic)
2007 - 2013	Treasurer, Board of Directors, Big West Festival

Annexure Three: Profile of Project Personnel

1. An investigation of this nature requires considerable resources. As the Lead Investigator I maintained oversight of, and responsibility for, the conduct of this research. I am the sole author of this report, and the views, findings and opinions contained in this report are mine.
2. To support me in this investigation I engaged a team of experienced researchers and technical personnel. The following is a list of members of this team, their role and a summary of their relevant experience.
3. I am a Director of Research into Action. I am the Lead Investigator for the study upon which this report is based. I carried out interviews, coding, data analysis and am the author of the report. My full resume is at Annexure three.
4. Dr Michael Victory is a Director of Research Into Action and the Project Manager for this project. Dr Victory also contributed to the coding of interview transcripts and provided research assistance. Dr Victory was awarded his PhD from Victoria University in 2019. His thesis was in the field of education using a Narrative Inquiry methodology. Narrative Inquiry is a qualitative methodology that relies on the coding and analysis of transcripts and texts; using a process and skills that are transferable to the coding and analysis required in the use of the Spotlight tool. Michael is a published author with his most recent book 'Saint Paul and the Education Encounter' published by Springer Nature in 2022.
5. Susan Kenna contributed to the project through interviewing participants, coding transcripts and research assistance. Susan holds a degree in Political Science and a Master's degree in Industrial and Employee Relations. Susan has an extensive employment history in skills analysis, work value and gender pay equity. She conducted a skills analysis of female dominated occupations (home care and school crossing supervisors), that was published by the (then) Department of Education, Employment and Training. At the Finance Sector Union, Susan instigated two joint pay equity projects with National Australia Bank. This work was published by Industrial Relations Victoria as a case study on pay equity. Susan prepared submissions to the House of Representatives Inquiry into Pay Equity and Associated Issues (2008/09) and Review of the Equal Opportunity for Women in the Workplace Act (2009). In 2012 Susan appeared before the Senate Education, Employment and Workplace Relations Committee in respect to the *Gender Equality Bill* (2012). Susan was a long term member of ACTU Women's Committee and was a union representative on the Standards Australia Gender Inclusive Job Evaluation Standard Committee.
6. Christine Ross contributed to the report through interviewing participants. Christine holds a Bachelor degree in political science and international politics, and a Master's in Development Studies from Victoria University (NZ). She has held senior positions with the United Nations on Gender Governance in Pacific countries. From 2019 -2024 Christine contributed to several

projects across New Zealand on job evaluation and pay equity, using a variety of tools. Her work included interviews with, and job assessments for nurses and midwives, clerical workers, and care and support workers. Her most recent work included reviewing interviews with and then writing job profiles for, Nurse Practitioners, Clinical Nurse Leads, Registered Nurses, Enrolled Nurses and Health Care Assistants in New Zealand.

7. Sue O'Shea contributed to the report through interviewing participants. Sue has a Bachelor degree in Psychology and Education (with Honours), a Postgraduate Diploma in Education and a Master's degree in Public Policy. As an advisor and Senior Specialist at the NZ Human Rights Commission she authored several publications on equal opportunity and pay equity. Sue was the Campaign Manager for Equal Pay at the NZ Council of Trade Unions. From 2018 to 2024 she was contracted by several organisations to conduct interviews and research and deliver training for pay equity claims in New Zealand.
8. Vincent Victory developed a customised Excel database that enabled coders to access and sort data and to create the Heat Map representations of the data. Vincent holds a Bachelor of Science (Bio-Medicine) and Master's of Biotechnology from the University of Melbourne.

Annexure Four: Spotlight Workbook

Investigating the dimensions and less visible aspects of nursing work

Thank you for volunteering to take part in this project. Your participation in the project has three components.

1. A Participant Information Consent Form (sent to you separately – to be signed and returned)
2. This workbook (to be filled in and returned)
3. An interview with a researcher from the Research Into Action team

Participant Information Consent Form

You have been sent a Participant Information Consent Form via separate email. By completing this Workbook and participating in an interview with our researchers you are consenting to take part in this project. However, at any point in the process you may withdraw your consent to participate. At that time, you can request that all information provided by you be destroyed and not used in the project or you can give permission for your information to be retained as part of the research project results.

Privacy and Confidentiality

Research Into Action will maintain your information confidentially. Your identity, responses and work location will be de-identified, and pseudonyms will be used. However, please be aware that information obtained during this project may be subject to inspection by relevant authorities including the Fair Work Commission (for the purpose of verifying the procedures and the data). By consenting to participate in this research project, you authorise release of, or access to this confidential information, to the relevant regulatory authorities, if required by law.

This Workbook

There are three key parts to the Workbook:

1. Gathering basic information about you and your role
2. A series of introductory questions about your work (these are questions asked in the interview)
3. A series of checkbox matrices about your work

You will need to return the completed workbook to Research Into Action.

The Interview

Research Into Action will contact you to arrange a suitable time for an online interview with a researcher. The interview will take approximately 90 minutes. We are asking you to prepare for the interview with the researcher by thinking about the introductory questions. The interviewer will have a copy of your completed workbook. During the interview, the researcher will go through each section of the workbook with you:

- to discuss, and where necessary, clarify your answers
- to ask for further examples or details that may assist in understanding your work in more detail.

I look forward to working with you on this important project.

Dr Lisa Heap
Director Research Into Action
and Lead Investigator for the project
February 2025

Research into Action

Research Into Action (RIA) is an independent research organisation. It is a new organisation formed in 2024. The two Directors of the organisation, Dr Lisa Heap and Dr Michael Victory, both have established reputations as researchers, writers, and educators across many organisations. In particular, Dr Heap has been responsible for leading several projects in Australia and New Zealand exploring the dimensions of work skills and knowledge.

RIA has been commissioned by Gordon Legal working on behalf of their client, the Australian Nursing and Midwifery Federation, to conduct research, using the Spotlight Tool, in relation to the work of Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing working outside of aged care.

Should you have any questions of Research into Action about the project or want to raise any concerns please contact the Project Manager, and Director of RIA, Michael Victory – [REDACTED].

More information about this project and Research Into Action is available from our website (*in development as of February 2025*).

Research Into Action – Spotlight Workbook for Nurses Project

Nurses Spotlight Project – Personal Details

B	Full Name	
C	Email Address <i>(This will be our primary source of contact with you to arrange the interview and for any follow up)</i>	
D	Mobile Phone Number <i>(Your mobile will only be used if we need to contact you at short notice to change an interview time or other similar reason)</i>	
	It would be helpful if you could nominate some days of the week (including weekends if that is your preference) and some times of the day/evening that would suit you for an interview. RIA will follow up with you to confirm the day and time	

Please let us know in the space below if there are issues that are helpful for us to know in contacting you, e.g. you may prefer phone contact, or if you are doing shift work and there are times you do not want to be contacted.

It would also be very helpful for us to know if you have any conditions that we should allow for in an interview setting e.g. hearing issues

When you have completed the Workbook please save a copy for yourself and then email to

RIA Project Manager, Michael Victory at



Research Into Action – Spotlight Workbook for Nurses Project

Nurses Spotlight Project - Participant Details

Please fill out the details below as best you can. This information will be supplied to the researcher who conducts the interview with you. You will be able to clarify your answers with the researcher if there is any confusion or complexities in your responses that need further explanation.

The pseudonym will be used to so that your own name is not linked to your answers. RIA will maintain a list cross-referencing your name, the pseudonym and the completed workbook. That information will be stored on a password protected computer. The completed Workbook and any personal information provided will be stored securely and confidentially as set out in the Participant Information Consent materials.

A	Assigned pseudonym/code (RIA to assign)	
B	<i>Left blank deliberately</i>	
C	<i>Left blank deliberately</i>	
D	<i>Left blank deliberately</i>	
E	Registration and Endorsements – please write in all registrations and/or endorsements that you hold (e.g. Registered Nurse, Enrolled Nurse, Midwife, Nurse Practitioner) or if you are an Assistant in Nursing.	
F	Job Title	
G	Job Domain (e.g. acute care, palliative care, midwifery, rehabilitation, disability care, primary health care, community health care, mental health care etc)	
H	Job Setting (e.g. metropolitan, regional, rural, remote)	
I	Public or Private Sector	
J	Classification level (if known)	
K	Qualifications	
L	State/Territory	
M	Employer (will be de-identified)	
N	Main workplace - where you spend most of your work time (will be de-identified)	
O	Other workplaces – if applicable (will be de-identified)	
P	How long have you been in this job?	
Q	How long have you worked in nursing work?	

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Questions for discussion at the interview

We would like to learn more about you, your experience and what your work entails. The following questions are designed to start this conversation. **You can fill in responses to these questions below or just think about them in advance and we will talk about them at the interview.**

1. How long have you been in your current role?
2. Did you hold another position within this organisation – for how long?
3. Have you done this job or worked in this occupation elsewhere – where? For how long?
4. Do you have a job or position description. If so, when was it last updated? **(please provide a copy if available)**
5. Are there aspects of your job that you think are important but not in your job or position description?
6. What does a normal day at work look like for you? /What do you do from the start until the end of your day?
7. What other tasks do you do that only come up from time to time or occasionally?
8. What are the most challenging aspects of your work? Please describe a challenging incident that has arisen in the course of your work. How did you respond to it?
9. In this work, what would an experienced person be able to do that would be challenging for someone just starting?
10. Have you had to acquire new capabilities via on-the-job learning, formal external training, or in-house training?
11. Is the learning recognised by certificates of attainment, or qualifications?
12. Has nursing work changed since you started? How?
13. What gives you a sense of satisfaction in doing your job well?

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Please save your responses as you go – we recommend saving after you have completed your responses to each matrix.

Part A. Contextualising: Building and shaping awareness

In Part A we would like to know about:

- A1 - Sensing contexts or situations (perceive, interpret or 'read' work or social contexts or situations)
- A2 - Monitoring and guiding reactions (monitor and guide your own and others' reactions to your own and others' actions)
- A3 - Judging impacts (evaluate your own or team's impacts within the workplace, or on clients or community)

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A1. Sensing contexts or situations (perceive, interpret or ‘read’ work or social contexts or situations)

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Build up understanding of worksite, resources, contacts, roles and rules as well as terms and technology used by higher-level staff/specialists ☐	Adapt and apply knowledge and skills gained in and outside this workplace ☐	Piece together information and perspectives from various sources to solve a problem ☐	Use techniques for exchanging rapid situational updates with colleagues and to convey information from a range of sources ☐	Use your understanding of the organisation’s priorities to influence policies and help shape systems ☐
Build up a general understanding of terms and technology used by higher-level staff/specialists in the work area ☐	Adapt to the interaction styles and needs of each different patient ☐	Use your knowledge of the job and its internal and external contexts to anticipate and avoid problems ☐	With colleagues and associates, share approaches to solving problems relating to patients or technology ☐	Develop a system for regular information exchange on new developments inside and outside the organisation ☐
Learn about each patient’s needs and about job contexts by observation, questions, reading and reflection ☐	Understand the significance of outside developments, remaining up-to-date with the regulatory framework governing your work ☐	Solve problems by sifting key issues from all the detail ☐	By helping create and maintain internal and external networks, keep up to date with and share information about developments relevant to your work area ☐	Bring together people with knowledge and experience to help find ways of addressing issues for patients and the organisation ☐

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A2. Monitoring and guiding reactions (monitor and guide your own and others' reactions to your own and others' actions)

Please place an **X** in the box for **ALL** statements that apply to your work. (*You can do this by double clicking on the box – if you make mistake a third click will usually remove the X*). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn to set aside pre-judgments and manage your own reactions to difficult or disturbing situations ☐	Use cues or formulas to guide and coach others in how to behave in given situations ☐	'Key in' to others' ways of thinking to filter information according to how it will be received ☐	Be alert to and help manage co-workers' emotional pressures, strengths and needs ☐	Know when to persevere and when to let go of a system change you are seeking to introduce ☐
Learn to interpret subtle unspoken needs and responses of people who lack verbal means of expressing them ☐	Quickly pick up on and respond to small changes or early warning signs in, patients, carers or family members or work colleagues ☐	Solve problems by using insights into reasons for difficult behaviour, e.g. responses to pain, fear, shame or grief ☐	Compare notes with others, to identify underlying causes of difficulties and share approaches to handling them ☐	Monitor perceptions of an initiative and find a way to clear up misinterpretations ☐
Learn to recognise provocations and avoid responding to them ☐	Through close listening and watching, sense the point at which people are becoming uncomfortable with your words or actions ☐	Work in sensitive situations to help people maintain composure, self-respect or independence ☐	Prepare for a key event by going through all the steps and gaining feedback from a trusted colleague ☐	Foresee potential difficulties with a policy proposal and find ways of addressing them in advance ☐

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A3. Judging impacts (evaluate your own or team's impacts within the workplace, or on clients or community)

Please place an **X** in the box for **ALL** statements that apply to your work. (*You can do this by double clicking on the box – if you make mistake a third click will usually remove the X*). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn to predict the flow-on effects of your work activity on patients, families and colleagues ☐	Quickly note early warning signs of an impending disturbance or that an approach is not working ☐	Pick the right moment to convey unwelcome news, judging from reactions about to determine how much to say ☐	Regularly summarise your understanding of what is going on to check that others agree ☐	Set up processes for robust evaluation of the impact of the organisation's work, using a range of methods and feedback sources ☐
Learn to screen worrying or unsettling work processes from patients or their carers or families ☐	Act to reduce the fear, embarrassment or stress of others e.g. by explaining actions or delays ☐	Help patients feel at ease whilst you are carrying out activities that may worry or distress them ☐	Help create a supportive context for giving and receiving feedback ☐	Predict and analyse impacts of decisions on other parts of the organisation and other agencies ☐
Learn to 'read' a situation and consider consequences before responding ☐	Prepare each patient individually for key transitions ☐	Test your solution to a problem, by listening, observing and reflecting ☐	Constructively challenge practices that may compromise the safety or dignity of others ☐	Create a system for monitoring outcomes of your organisation's actions ☐

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B. Connecting, Interacting and relating

In Part B we would like to know about:

B1 - Negotiating boundaries (influence, establish or negotiate within and across boundaries between patients, co-workers and management)

B2 - Communicating verbally and non-verbally (respond to and use verbal and non-verbal communication aptly and/or creatively)

B3 - Connecting across cultures: Working with diverse people and communities (building relations with people from diverse backgrounds based on First Nations status, ethnicity, class, disability, age, gender, or sexuality)

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B1. Negotiating boundaries (influence, establish or negotiate within and across boundaries between patients, co-workers and management)

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn to establish the boundaries of your role when responding to requests from patients, carers or family members or colleagues ☐	Communicate clear and consistent limits in a way that gains acceptance. ☐	Gain others' trust and consent by explaining each step of a process and its purpose ☐	Share knowledge and experience to guide people, including those who do not accept your authority ☐	Carry forward a proposal for system change by networking with key stakeholders and testing with key people ☐
Learn ways of calming and gaining co-operation of patients who are upset ☐	Build/maintain cordial relations with people outside one's authority, thereby gaining co-operation ☐	Find a way to refuse requests that cannot be met, or are unreasonable or dangerous ☐	Build and maintain networks of working relationships with people outside your immediate work group ☐	Create channels to ensure that relevant information is shared across units ☐
Learn to gain patient or co-worker understanding and consent by clearly and appropriately explaining each step of a process ☐	Provide support unobtrusively to help others maintain composure and independence ☐	Negotiate (e.g. for patients) in a way that maintains good-will, without giving way on quality patient care ☐	Constructively give and receive feedback in unequal power situations ☐	Provide a sense of direction that energises others, e.g. by reflecting their aspirations ☐

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B2. Communicating verbally and non-verbally (respond to and use verbal and non-verbal communication aptly and/or creatively)

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn to interpret other people's tone of voice and body language e.g. monitor patients' mood ☐	Interpret the needs and intentions of people who have restricted verbal language — e.g. monitor for signs of pain ☐	Adapt the content of your communication to the varying attention spans of different listeners, interpreting-cues to pace information ☐	Help non-experts solve administrative or technical problems by providing explanations using familiar examples and language ☐	Use apt or memorable language or images to energise diverse listeners, viewers or readers ☐
Learn to use conversation or tone of voice to put people at ease, keep their spirits up or allow closure ☐	Use active listening, reflecting and using silence to allow people to talk through their concerns ☐	Pitch your use of language and body language to people with varying levels of understanding ☐	Coin motivating or operationally important catchphrases that will serve as a shared guide to action – e.g. a single word for a lockdown ☐	Use understanding of community issues to gain acceptance for ideas and approaches by a range of audiences, readers or viewers ☐
Learn to set out concepts clearly and logically in written and spoken language and other media ☐	Make effective use of body language e.g. appropriate and respectful touch, to reassure, or to convey or gain information ☐	Overcome communication problems by 'translating' (e.g. specialised terms), between experts, patients, family members and people of different ages and experiences ☐	Use resources and media to build a stimulating or reassuring environment ☐	Help build a consistent, aesthetic and ethical communication style for the organisation ☐

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B3. Connecting across cultures: Working with diverse people and communities (building relations with people from diverse backgrounds based on First Nations status, ethnicity, class, disability, age, gender, or sexuality)

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn the language and behavioural rules for interacting appropriately in inter-cultural situations ☐	See your own and your work team's behaviour from the perspective of someone from another cultural or ability group ☐	Anticipate and act to minimise problems created by intercultural and disability barriers ☐	Listen and observe attentively to key into the unspoken aspects of interactions based on diversity including another language, culture, sexuality, ability etc. ☐	Work with diverse people and communities to help overcome systemic barriers ☐
Learn to interact easily and respectfully with diverse people and communities ☐	Identify the correct contact people for the communities and cultures with which you interact ☐	Work effectively with people who have a different sense of time, or who are displaying confusion, anxiety or similar conditions ☐	Work with relevant communities to incorporate elements of the cultures of patients and families into your work practices ☐	Work at a systems level to ensure diverse groups are provided with partnership, participation and protection of their interests ☐
Learn respectful protocols for speech register, dress, eye contact and physical distance to facilitate smooth interaction across diverse cultures and communities ☐	Fluently use protocols for acknowledging and respecting First Nations and/or other diverse cultures ☐	Interact effectively with patients using a range of communication, mobility or complex health care technologies ☐	Informally interpret or mediate between work associates and members of diverse cultural or language communities ☐	Develop the expertise to build culturally and disability-inclusive programs ☐

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C. Coordinating

In Part C we would like to know about:

- C1 - Sequencing and combining activities (organising your own work by prioritising, switching, combining and linking activities)
- C2 - Interweaving your activities smoothly with those of others
- C3 - Maintaining and/or restoring workflow (maintain, balance and restore workflow, including when work processes break down)

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C1. Sequencing and combining activities (organising your own work by prioritising, switching, combining and linking activities)

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn techniques for monitoring of care assessments and tasks, and for timely reporting and documentation of activities ☐	Notice what needs to be done and automatically do it, e.g. when a patient is unattended ☐	Assess urgency and importance of simultaneous calls on attention, any of which could become a crisis ☐	Exchange ideas with colleagues for more effective management of workflow ☐	Embed useful elements of your own systems and codes in the organisation's programs ☐
Learn to incorporate new tools and techniques into work processes, such as safe care of tubes, catheters, stoma etc. ☐	Work out ways of slotting each activity into the day, to attend to a number of tasks or patients at once ☐	As new demands arise, frequently reprioritise tasks to keep within deadlines whilst attending promptly to medication times, bell calls etc. ☐	Clearly and briefly flag new arrangements (or the need for them) to affected parties in a timely way ☐	Maintain a range of longer-term initiatives, particularly relating to support for patients in maintaining their interests and improving mental or physical function ☐
Learn to sort your own tasks according to importance and urgency. ☐	If interrupted, carry the idea and get back quickly to the same point ☐	Think quickly on your feet as new problems arise during an activity ☐	Utilise methods for recording key events as they happen, and sharing information to allow effective follow-up ☐	Map long-term work goals, to help align them with organisational realities and resource constraints ☐

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C2. Interweaving your activities smoothly with those of others

Please place an **X** in the box for **ALL** statements that apply to your work. (You can do this by double clicking on the box – if you make mistake a third click will usually remove the **X**). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Make a habit of checking to prevent duplicating the work of others ☐	Automatically check to prevent duplicating the work of others ☐	Check your own and co-workers' safety in responding to difficult situations, whilst avoiding pressures to react before thinking ☐	Develop and use shared information exchange systems, such as mental maps, flow-charts, coding systems, templates or automated spreadsheets ☐	Create systems for sharing of innovations or policies that will help solve intractable problems ☐
Learn the best timing and approach in interrupting others and when not to interrupt ☐	Notice when a colleague needs help — e.g. in moving bed- or chair-bound patients or assisting and supervising mobility ☐	Carry out all steps to ensure legal and safe procedures in a rapidly changing situation ☐	Have in place, and be able to activate, support networks for quick and calm response to emergency or other changing contingencies ☐	Develop shared policy approaches to addressing resource constraints to meet longer-term restorative and/or rehabilitation goals for patients ☐
Learn to ensure that accurately recorded information is conveyed to relevant people in a timely way ☐	Use familiarity with the overall work process to interweave tasks or stand in for others at short notice ☐	Monitor each step of a group work process or meeting agenda to ensure that necessary resources are at hand ☐	Decide when people or processes need more time, and when to 'move on' ☐	Develop a system for maintaining long-term key records as an aid to compliance and organisational development ☐

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C3. Maintaining and/or restoring workflow (maintain, balance and restore workflow, including when work processes break down)

Please place an **X** in the box for **ALL** statements that apply to your work. (*You can do this by double clicking on the box – if you make mistake a third click will usually remove the X*). Where relevant to your work please type an **F** for activities that are very **FREQUENT**, and a **C** for activities that, even if not frequent, are **CRITICALLY IMPORTANT**. Do this by adding an **F** or **C** after the last word in the relevant boxes. At the interview we will ask you for examples to clarify those activities you have indicated apply to your work.

Orienting	Fluently performing	Solving new problems	Sharing solutions	Expertly creating a system
Learn to patch up minor misunderstandings before they escalate ☐	Address things that have not been followed through, without undermining others ☐	Identify minor issues that have the potential to grow into bigger problems and act to prevent this ☐	Quickly notice and adapt to changes in the workflow, cooperating to prevent or de-escalate stressful or dangerous situations ☐	Work to develop a shared mutual support system for maintaining empathy and morale, for example in palliative care situations ☐
Learn to rebalance and refocus quickly after something goes wrong ☐	Manage the conflict between needing to maintain routines by doing something 'right now' and the distress of a patient or family who is 'not ready' ☐	Manage conflict between legal requirements and/or organisational rules and patient need ☐	Share techniques for making safe decisions under high pressure, or in very sensitive or ambiguous situations ☐	Build and maintain backup systems in case of system breakdown ☐
Learn to follow the approved steps and recognised procedures to deal calmly and effectively with an emergency ☐	Find ways to get patient cooperation when you must react to a sudden change in priorities (e.g. 'please hold this; I'll be back very soon') ☐	Make time for caring listening and interactions amidst intense work pressures ☐	Bring routines and lines of work back together after they have been disrupted by an emergency ☐	Establish systems for maintaining continuity and stability as well as responsiveness to change ☐

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D. Anything you would like to add?

Would you like to add anything else about your role that we haven't addressed in the Workbook? Please feel free to add your comments:

Thank you for completing this Workbook. We look forward to discussing this further at the interview. Please save a copy for your records and email a copy to

RIA Project Manager Michael Victory at [REDACTED]

If you would like any further information, please contact Michael Victory at [REDACTED]

Annexure Five: Spotlight Taxonomic Framework

The Spotlight taxonomic framework

The Spotlight skill sets and their elements	The Spotlight skill levels				
	Orienting	Fluently performing	Solving new problems as they arise	Sharing solutions/Applying expertise	Expertly creating systems
	Building experience through practice, reflection and learning to work with others	Applying experience in a practiced and self-reliant way	Providing resourceful solutions to problems as they arise in the course of work activity	Sharing developed expertise with colleagues or team	Embedding new solutions in work processes
Examples of work activities enabled by each skill at each skill level (illustrative only)					
A. Contextualising/ Building and Shaping awareness Capacity to: A1 Perceive contexts or situations A2 Monitor and guide reactions A3 Judge impacts	Map unfamiliar job contexts	Consistently monitor job contexts and situations	Solve unfamiliar problems in interpreting contexts	Share new approaches to interpreting situations	Set up shared processes for monitoring contexts
	Learn to monitor & guide own and others' reactions	Consistently monitor and fluently guide own and others' reactions	Solve new problems in monitoring and guiding reactions	Share solutions to monitoring and guiding own and others' reactions	Introduce new approaches to monitoring and guiding reactions
	Learn to judge impacts	Consistently judge impacts	Solve unfamiliar problems in judging impacts	Share solutions to judging impacts	Establish new methods for evaluating impacts
B. Connecting/ Interacting and relating Capacity to: B1 Negotiate boundaries B2 Communicate verbally and non-verbally B3 Connect across diverse cultures and communities	Find ways to negotiate work roles and boundaries	Negotiate work roles and boundaries effectively	Resourcefully solve problems in/by negotiating roles & boundaries	Share solutions in/by negotiating role boundaries	Implement shared processes for negotiating role boundaries
	Learn effective methods of verbal & non-verbal communication	Effectively communicate, verbally and non-verbally	Solve problems of/by effective verbal and non-verbal communication	Share solutions for effective verbal and non-verbal communication	Implement shared approaches to communication or relationship-building
	Learn to communicate across cultures	Communicate effectively across cultures	Solve problems of inter-cultural communication	Share solutions for inter-cultural communication	Establish systems for building inter-cultural relationships
C. Coordinating Capacity to: C1 Sequence and combine activities C2 Interweave one's activities with others' C3 Maintain or restore workflow	Develop methods for organising your own work	Fluently link up your own tasks into a smooth work process	Solve new problems in scheduling and managing own work	Share new approaches to organising personal work roles	Create or improve systematic approaches to integrating individual work activities
	Develop ways of linking into the overall workflow	Interweave your activities fluently with those of colleagues	Solve problems in/by interweaving your activities with those of others	Share approaches to interweaving individual & team activities	Create or improve systematic approaches to integrating team work activities
	Learn approaches to preventing/ dealing with disruptions	Deal fluently with potential or actual workflow disruptions	Solve problems in maintaining/ restoring workflow	Share approaches to stabilising workflow	Create systems for stabilising workflow

Annexure Six: Letter to Dr Heap from Gordon Legal 29/1/2026

29 January 2026

Research Into Action
Dr Lisa Heap

Nicholas White

PARTNER

E: nwhite@gordonlegal.com.au

Nick Perica

ASSOCIATE

E: nperica@gordonlegal.com.au

Our Ref: 011692

Dear Dr Heap,

Spotlight Report re AM2024/11 — application by the Australian Nursing and Midwifery Federation to vary the Nurses Award 2020

1. We refer to our letter to you dated 28 October 2024 engaging you to:
 - (1) apply the “Spotlight” skill-recognition tool to the work of Registered Nurses and Midwives, Enrolled Nurses, and Assistants in Nursing working outside of aged care;
 - (2) based on application of that tool, produce an independent expert report identifying, naming, and classifying the “invisible skills”, if any, used by those workers in their work (“**Report**”).
2. As you know, in 2024 and 2025 we referred 57 nurses and midwives to Research in Action as persons who had indicated preparedness to participate in the preparation, by you, of your Report. The object of this letter is to explain to you the process by which those persons were sourced, so that you may take that information into account in drafting your Report, so far as you consider it necessary to do so.
3. We are instructed that the process was as follows. Please inform us if you require any information additional to what is set out below.

Queensland, New South Wales, South Australia, Tasmania

4. The **Queensland, New South Wales, South Australian and Tasmanian** Branches of the ANMF each distributed a newsletter and survey to their respective memberships. We **enclose**:
 - (1) a copy of the Queensland bulletin and survey;

- (2) a copy of the New South Wales bulletin and survey;
 - (3) a copy of the South Australian bulletin and survey; and
 - (4) a copy of the Tasmanian bulletin and survey.
5. In the case of **Queensland, New South Wales, and South Australia**, the persons who were referred to Research in Action were persons who had completed the survey. Such persons were then contacted by officers in the relevant Branch. Where a person was a suitable candidate—meaning that they had experience performing work that is or was covered by the *Nurses Award 2020* and they were willing to participate, especially if the Branch thought they would likely be a good participant (e.g., because of being helpful and reliable)—they were referred to Gordon Legal, and then to Research in Action.
6. In the case of **Tasmania**, persons who responded to the survey were not then able to be contacted. So, the persons who were referred were contacted directly by the Branch, either being known to the Branch or having been referred by other ANMF members. Persons were selected for direct approach on the basis of the Branch thinking that they might be suitable candidates—meaning that it was thought they might have experience performing work that is or was covered by the *Nurses Award* and might be willing to participate, especially if the Branch thought they would likely be a good participant (e.g., because of being helpful and reliable). Where a person was a suitable candidate—meaning that they had experience performing work that is or was covered by the *Nurses Award* and they were willing to participate, especially if the Branch thought they would likely be a good participant (e.g., because of being helpful and reliable)—they were referred to Gordon Legal, and then to Research in Action.

Victoria, Australian Capital Territory

7. In **Victoria and the Australian Capital Territory**, persons referred were persons who were known to (and contacted directly by) Branch officials. Persons were selected for direct approach through the Branch's known networks and membership database on the basis of the Branch thinking that they might be suitable candidates—meaning that it was thought they might have experience performing work that is or was covered by the *Nurses Award* and might be willing to participate, especially if the Branch thought they would likely be a good participant (e.g., because of being helpful and reliable).

8. Where a person was a suitable candidate—meaning that they had experience performing work that is or was covered by the *Nurses Award* and they were willing to participate, especially if the Branch thought they would likely be a good participant (e.g., because of being helpful and reliable)—they were referred to Gordon Legal, and then to Research in Action.

Western Australia, Northern Territory

9. There were no referrals from **Western Australia** or the **Northern Territory**.

Additional classifications, practice areas, and workplace settings

10. From time to time, additional participants were sought from **New South Wales**, **Queensland**, and **South Australian** in particular classifications, practice areas, or workplace settings. Such persons were sought by direct approach on the basis that it was thought they might be suitable candidates (as described above). Where a person was a suitable candidate (again, as described above), they were referred to Gordon Legal, and then to Research in Action.

Conclusion

11. The foregoing describes the process by which 57 nurses and midwives were referred to Research in Action. We shall be grateful if you would, in your Report:
 - (1) describe how it was that you selected, from that cohort, the workers who ultimately participated in the preparation of your Report; and
 - (2) identify how, if it all, the process of cohort referral, and your selection of workers from that cohort, bears on the opinions you have expressed in your Report, including:
 - (a) whether it is necessary to qualify or limit the conclusions you have expressed in some way; and
 - (b) if so, what is that qualification or limitation.
12. Please do not hesitate to contact us if you require any further information.

Yours sincerely,



Nick White
Partner
Gordon Legal



Private Sector Update

17 June 2024

We need your help to lift wages in the Private Sector

You may have already seen our update that the Queensland Nurses and Midwives' Union's (QNMU) national body, the Australian Nursing and Midwifery Federation (ANMF), have filed a landmark application with the Fair Work Commission (FWC) to increase the minimum Award wages for nurses and midwives working in private hospitals and the diverse sector.

The Application

The application is designed for nurses and midwives working in various private healthcare settings, such as acute care, palliative care, midwifery, rehabilitation, disability care, primary health care, community health, and mental health. These professionals operate in metropolitan, regional, rural, and remote areas.

We understand that a significant portion of our members terms and conditions are set by an Enterprise Bargaining Agreement (EBA). While any increase to the minimum Award wages would not directly affect those covered by an EBA, it would raise the minimum wage floor that the FWC must consider whenever an EBA is approved.

What do we need

To secure the best possible outcome in this important work value case, we need members from our diverse and private hospital sectors to give evidence about their work, skills, qualifications, the conditions in which they work, and how those things have changed over the years.

If you are passionate about contributing to this landmark case for nurses and midwives, please complete [this form](#). Your input can make a real difference.

After you complete the form, an ANMF Industrial Officer will contact you to ask further questions about your work. They will use this information to draft a witness statement which you will need to sign. Members giving evidence about the complexity of their work is a crucial part of our case with the FWC.

As a witness, you may be asked questions about your statement in the FWC hearing. Where a witness is required to answer questions in the hearing, each witness is allocated approximately 30 minutes. It is likely to be done by videoconference, so you won't need to leave your home or travel. ANMF officials will guide you through this process, provide support and answer any questions you may have.

What next

If you have any further questions, please email industrialfeedback@qnmU.org.au.

Private and Diverse Sector

Work Value Case Member Questionnaire

1. What qualifications do you currently hold and/or are studying towards?

Comment

2. What you do in current your role? What are the tasks, skills and duties required?

Comment

3. What are the previous roles you have held (relevant to nursing/midwifery)?

Comment

4. What are the previous roles you have held (relevant to nursing/midwifery)?

Comment

5. What are the total years of nursing experience you hold?

Comment

6. How has the healthcare industry and your roles changed from your perspective (for better or for worse)?

Note: This could include pay, the type of work or complexity of the work and/or patients.

Comment

Name

QNMU Membership Number

Best Contact Number

Private Email Address

Job Title

Employer

Location (e.g Brisbane)

Join our fight. Raise your voice.

Email not displaying correctly?

[View it in your browser.](#)



NSWNMA member number: {{Recipient.Member_Number__c}}

Dear {{Recipient.FirstName}},

Earlier this year the NSWNMA's national body, the Australian Nursing and Midwifery Federation (ANMF), [filed a landmark application with the Fair Work Commission](#). It aims to lift the minimum Award wages for nurses and midwives working in private hospitals, and in primary care.

This covers those working outside public health and aged care, including acute care, palliative care, midwifery, rehabilitation, disability care, primary health care, community health, Aboriginal health, and mental health. The work of professionals in these areas is felt right across metropolitan, regional, rural, and remote areas of our state. That is why this case is so important.

What you can do

To help secure meaningful improvements, we need members from private hospitals, affiliated health organisations and the primary health sector to speak up and provide insights into their role, skills, qualifications, and the reality of the conditions at work.

Your evidence can make a real difference, and it will help illustrate how your work has changed over time. This is essential to making a compelling argument for improvements to pay and conditions.

If you would like to join us in this fight, please take a moment to [complete this short questionnaire](#).

The next steps

After completing this form, an ANMF Officer may be in touch to discuss your work. They will explain the next steps and help draft a witness statement that will be put forward as formal evidence in our campaign for improvements for you and your colleagues.

{{Recipient.FirstName}}, it is members just like you who know the reality of the challenges facing private hospital and primary health care workers.

[Click here to take our short questionnaire.](#)

Standing together

We know many of our members' working conditions are set by an Enterprise Bargaining Agreement (EBA). Though any increase to the minimum Award wages would not have a direct impact on those covered by an EBA, including AHOs, it would see a rise in the minimum wage floor that the Fair Work Commission must consider whenever an EBA is approved. This is key to strengthening our ongoing fight for better pay and conditions.

If you have any questions, or would just like to know more about this process, please email Marika: mdevecchis@nswnma.asn.au

Together we can highlight the essential work of nurses and midwives working in private hospitals, primary care and AHOs.

In union,

Shaye Candish

General Secretary, NSWNMA

Branch Secretary, ANMF NSW

RN, BN, Grad Cert Nursing (Emergency)



Copyright © {{Current_Year}} NSW Nurses and Midwives' Association, All rights reserved.

You are receiving this because you are on the NSWNMA membership database.

Our mailing address is:

NSW Nurses and Midwives' Association

50 O'Dea Avenue Waterloo, NSW 2017

Authorised by S.Candish, General Secretary, NSWNMA and Branch
Secretary, ANMF NSW Branch

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courses.*

To opt out of these emails, [visit this link](#) to update subscription preferences. .

Join our fight. Raise your voice.

Email not displaying correctly?

[View it in your browser.](#)



NSWNMA member number: {{Recipient.Member_Number__c}}

Dear {{Recipient.FirstName}},

Earlier this year the NSWNMA's national body, the Australian Nursing and Midwifery Federation (ANMF), [filed a landmark application with the Fair Work Commission](#). It aims to lift the minimum Award wages for nurses and midwives working in private hospitals, and in primary care.

This covers those working outside public health and aged care, including acute care, palliative care, midwifery, rehabilitation, disability care, primary health care, community health, Aboriginal health, and mental health. The work of professionals in these areas is felt right across metropolitan, regional, rural, and remote areas of our state. That is why this case is so important.

What you can do

To help secure meaningful improvements, we need members from private hospitals and the primary health sector to speak up and provide insights into their role, skills, qualifications, and the reality of the conditions at work.

Your evidence can make a real difference, and it will help illustrate how your work has changed over time. This is essential to making a compelling argument for improvements to pay and conditions.

If you would like to join us in this fight, please take a moment to [complete this short questionnaire](#).

The next steps

After completing this form, an ANMF Officer may be in touch to discuss your work. They will explain the next steps and help draft a witness statement that will be put forward as formal evidence in our campaign for improvements for you and your colleagues.

{{Recipient.FirstName}}, it is members just like you who know the reality of the challenges facing private hospital and primary health care workers.

[Click here to take our short questionnaire.](#)

Standing together

We know many of our members' working conditions are set by an Enterprise Bargaining Agreement (EBA). Though any increase to the minimum Award wages would not have a direct impact on those covered by an EBA, it would see a rise in the minimum wage floor that the Fair Work Commission must consider whenever an EBA is approved. This is key to strengthening our ongoing fight for better pay and conditions.

If you have any questions, or would just like to know more about this process, please email me at: fusherwood@nswnma.asn.au

Together we can highlight the essential work of nurses and midwives in private hospitals and primary health care.

In union,

Frances Usherwood

Primary Care Sector Coordinator, NSWNMA

Work Value Case Questionnaire

Q1 First name

Q2 Last name

Q3 Membership number (if known)

Q4 Mobile number

Q5 Email

Q6 Workplace

Q7 Workplace postcode and suburb

Q8 Employer

Q9 What is your classification?

Q10 Do you give permission for the NSWNMA to update your records to reflect your details in this survey? This will help us with our advocacy and campaigning around issues that may affect you or your workplace.

Q11 How many years of nursing/midwifery experience do you have in total?

Q12 What qualifications do you currently hold and/or are studying towards?

Q13 What do you do in current your role? What are the tasks, skills and duties required?

Q14 What are the previous roles you have held (relevant to nursing/midwifery)?

Q15 What did you do in your previous roles? What were the tasks, skills and duties required?

Q16 How has the healthcare industry and your role within it changed over time?

Q17 Can you please explain why you gave that rating? This could include changes in pay, the type or complexity of work, or the nature of patient care.

Bulletin



Member name: [REDACTED] | Member number: [REDACTED]

17 July 2024

Dear [REDACTED]

Attention: All RN/M, EN and AIN Members in the **Private Sector**

Help Lift Wages in the Private Sector

As you are likely aware, the Australian Nursing and Midwifery Federation (ANMF) federally has filed a landmark application with the Fair Work Commission (FWC) to increase the minimum wages under the Nurses Award 2020, which applies to members working in relevant classifications in the private sector in South Australia.

The application is designed for nurses and midwives working in various private health care settings outside of aged care (noting that aged care rates have been separately considered in the ANMF's Aged Care Work Value Case). This includes acute care, palliative care, midwifery, rehabilitation, primary health care, community health, and mental health, in metropolitan, regional, rural, and remote areas.

Most ANMF members' employment conditions are set by an Enterprise Agreement (EA). While any increase to the minimum Award wages would not directly affect those covered by an EA, it would raise the minimum wage floor that the FWC must consider whenever an EA is approved.

To secure the best possible outcome in this important Work Value Case, we need members from our private sector to give evidence about your work, skills, qualifications, the conditions in which you work, and how those things have changed over the years.

If you are passionate about contributing to this landmark case for nurses and midwives, please complete [this form](#). Your input can make a real difference.

After you complete the form, an ANMF Industrial Officer will contact you to ask further questions about your work. They will use this information to draft a witness statement for you to sign. Members giving evidence about the complexity of their work is a crucial part of our case with the FWC.

As a witness, you may be asked questions about your statement in the FWC hearing. Where a witness is required to answer questions in the hearing, each witness is allocated approximately 30 minutes. It is likely to be done by videoconference, so you won't need to leave your home or travel. ANMF officials will guide you through this process, provide support and answer any questions you may have.

Staff who are not yet members are strongly encouraged to join ANMF online at www.anmfsa.org.au.

If you require further information, please contact ANMF Officer Claire Victory via email at claire.victory@anmfsa.org.au or via phone on 0439 990 243.

Please circulate this information to staff in your area who do not have access to email. Please print and display on appropriate notice boards.

A printable version of the bulletin can be downloaded [here](#).

Authorised by: Adj Associate Professor Elizabeth Dabars AM, Branch Secretary ANMF South Australian Branch

We Are Stronger Together

anmfsa.org.au | enquiry@anmfsa.org.au | 8334 1900 |
191 Torrens Road, Riddleyton, SA 5008 | PO Box 861, Regency Park, SA 5942



Private Sector

Work Value Case Member Questionnaire

1. **What qualifications do you currently hold and/or are you studying towards?**

Comment

2. **What is your current role? What are the tasks, skills and duties required?**

Comment

3. **What are the previous roles you have held (relevant to nursing/midwifery)?**

Comment

4. **How many years of nursing/midwifery experience to you have, in total?**

Comment

5. **Over the course of your career in nursing/midwifery, how has the healthcare industry and your role/s changed from your perspective (for better or for worse)?**

Note: This could include pay, the type of work or complexity of the work and/or patients.

Comment

Name

ANMF Membership Number

Best Contact Number

Private Email Address

Job Title

Employer

Location (e.g. Adelaide)

From: ANMF Mailout Replies
Sent: Monday, 1 July 2024 2:59:38 PM
To: Organiser Support
Subject: ANMF Newsflash We Need Your Help to Lift Wages in the Private Sector

[View this email in your browser](#)

ANMF Newsflash

We Need Your Help to Lift Wages in the Private Sector

Hi Member,

You may be aware that as a national body, the Australian Nursing and Midwifery Federation (ANMF) has filed a landmark application with the Fair Work Commission (FWC) to increase the minimum Award wages for nurses and midwives working in private hospitals and the diverse sector.

The Application

The application is designed for nurses and midwives working in various private healthcare settings, such as acute care, palliative care, midwifery, rehabilitation, disability care, primary health care,

community health, and mental health. These professionals operate in metropolitan, regional, rural, and remote areas.

We understand that a significant portion of our members' terms and conditions are set by an Enterprise Agreement (EA). While any increase to the minimum Award wages would not directly affect those covered by an EA, it would raise the minimum wage floor that the FWC must consider whenever an EA is approved.

What do we need

To secure the best possible outcome in this important work value case, we need members from our diverse and private hospital sectors to give evidence about their work, skills, qualifications, the conditions in which they work, and how those things have changed over the years.

If you are passionate about contributing to this landmark case for nurses and midwives, please complete the following survey:

<https://www.surveymonkey.com/r/PrivateandDiverseSectorWorkValueCaseMemberQuestionnaire2024>

.

Your input can make a real difference.

What next

After you complete the survey, an ANMF Tasmanian Branch Industrial Officer will contact you to ask further questions about your work. They will use this information to draft a witness statement which you will need to sign. Members giving evidence about the complexity of their work is a crucial part of our case with the FWC.

As a witness, you may be asked questions about your statement in the FWC hearing. Where a witness is required to answer questions in the hearing, each witness is allocated approximately 30 minutes. It is likely to be done by videoconference, so you won't need to leave your home or travel. ANMF Tasmanian Branch officials will guide you through this process, provide support and answer any questions you may have.

If you have any further questions, please contact ANMF Industrial Officer Luke O'Connor via email:

Luke.O'Connor@anmftas.org.au.

The ANMF Tasmanian Branch is 8000 plus members strong! Supporting nurses, midwives, and care workers as the only union in Tasmania employing nurses and care workers to represent members. This is why our Organisers and Member Support Team are uniquely positioned to understand your experiences, represent you in your workplace, and offer industrial advice that's relevant to you.

DOWNLOAD THE PDF HERE

COMPLETE THE SURVEY HERE

Authorised by Emily Shepherd, ANMF Tasmanian Branch Secretary

1 July 2024.



Australian
Nursing &
Midwifery
Federation
Tasmania





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You are receiving this email as an ANMF Tasmanian member. We email to send occasional notices including member meetings and newflashes.

Contact us

Australian Nursing & Midwifery Federation (Tas Branch)
182 Macquarie Street, Hobart, TAS 7000 Australia

(03) 6223 6777 or 1800 001 241 (outside Hobart area)

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Private and Diverse Sector Work Value Case Member Questionnaire

The ANMF's privacy policy is available here: <https://anmftas.org.au/2019/10/privacy/>

1. What qualifications do you currently hold and/or are studying towards?

2. What you do in current your role? What are the tasks, skills and duties required?

3. What are the previous roles you have held (relevant to nursing/midwifery)

4. What are the total years of nursing experience you hold?

5. How has the healthcare industry and your roles changed from your perspective (for better or for worse)?

Note: This could include pay, the type of work or complexity of the work and/or patients.

6. Please provide the below information.

Name

Member Number

Best Contact
Number

Private Email
Address

Job Title

Employer

Location (e.g
Moonah)

Thank you for taking the time to complete this survey.

Emily Shepherd
Branch Secretary
ANMF (Tasmanian Branch)
1 July 2024

Annexure Seven: Participant Information and Consent Form

Research Project: Investigating the dimensions and less visible aspects of nursing work

Participant Information and Consent Form

Introduction

This research project aims to identify the less visible dimensions of nursing work. The project results will be included in a project report that will be used to provide expert opinion evidence to the Fair Work Commission in proceedings related to an application by the ANMF to vary the Nurses Award 2020.

You have been invited to take part in the research project as you may be able to provide us with insights into your work that are relevant to the project.

This Participant Information and Consent Form tells you about the research project, and what is involved. Before you decide whether you wish to participate it is important for you to understand why the research is occurring and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

If you decide you want to take part in this research project, you will be asked to confirm that you consent to participate. By confirming you are telling us that you:

- Understand what you have read
- Consent to take part in the research project.
- Consent to the use of de-identified data provided by you and other participants in a report that may be provided to the Fair Work Commission in proceedings related to the variation of the Nurses Award 2020.

The Research Organisation

The research project is being undertaken by Research Into Action. Research Into Action (RIA) is an independent research organisation. It is a new organisation formed in 2024. The two Directors of the organisation, Dr Lisa Heap and Dr Michael Victory, both have established reputations as researchers, writers, and educators across many organisations. In particular, Dr Heap has been responsible for leading several projects in Australia and New Zealand exploring the dimensions of work skills and knowledge.

RIA has been engaged by Gordon Legal working on behalf of their client, the Australian Nursing and Midwifery Federation, to conduct research, using the Spotlight Tool, in relation to the work of Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing working outside of aged care.

Should you have any questions of Research into Action about the project or want to raise any issues please contact the Project Manager, and Director of RIA, Michael Victory – mvictory@bigpond.net.au.

More information about this project and Research Into Action is available from our website (*in development as at March 2025*).

Project Information

What is the purpose of this research?

This research is designed to find out about the less visible dimensions of nursing work. We are also interested in how nursing work may have changed over recent years.

Why are you inviting me to participate in this research?

As a Nurse, Midwife or as an Assistant in Nursing you will have important insights into what is needed to do your role, the demands of your role, and ways in which it may have changed since you began. If you are relatively new to the work, you may be able to provide insights into unexpected challenges and rewards in the work of which the general public may be unaware.

What does participation in this research involve?

You will be asked to do three things:

- 1) Read this information and consent form and if you agree to participate, sign and return it to Research into Action. This is a critical step for your involvement.
- 2) Complete a Workbook in which you identify a range of work activities that you undertake in your role.
- 3) Take part in a one-to-one interview with an RIA researcher. The interview will focus on the Workbook which you will have completed and your work role and may include for example your daily routine and tasks, changes since you started in the role, rewarding and challenging aspects of the job.

The interview will be online, using Zoom. The interview will be recorded for data analysis but will be anonymised, using an RIA chosen pseudonym.

Do I have to take part in this research?

Participation in this research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the research team.

What are the possible benefits of taking part?

There will be no direct personal benefits to you. However, the information collected in the project may be used as evidence to inform deliberations about the appropriate recognition and remuneration for nursing work.

What are the possible risks and disadvantages of taking part?

The main drawback for you will be the time commitment. We estimate it will take one to two hours to complete the workbook and think about the questions in that workbook. The online interview may take up to 90 minutes.

One of the questions we will discuss with you will relate to the most challenging work event you have experienced. If you do not wish to answer that question, you may skip it and go to the next question or stop immediately. If remembering the experience is distressing, you are encouraged to contact Lifeline on 131 114 or beyondblue on 1300 22 4636 at any time.

What if I want to withdraw from this research project?

If you do consent to participate, you may withdraw at any time without having to provide a reason. Please be assured that if you withdraw, it will not affect your relationship with the researchers. If you

decide to withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the research team.

If you decide to leave the research project, the researchers will not collect additional personal information from you. You will have the option of requesting, either that the information you have provided up to the point of withdrawal be deleted from the project files or giving permission for it to be retained as part of the research project results.

Will I have an opportunity to check the use made of the information I provide, and its accuracy?

Yes, we will discuss your Workbook responses with you, providing an opportunity to clarify interpretations. You will be provided with a copy of the final report.

What will happen to information about me?

Once you consent to participate, we will allocate an invented pseudonym for you. We will also assign an invented pseudonym to your workplace. It is these pseudonyms that will be used to identify your completed questionnaire and the transcript of the interview. The researchers will be aware of your identity via your email address but the cross-referencing between this information and your pseudonym will be securely stored and not shared further without your consent.

For the wider community to benefit from the research, we plan to publish and/or present the results of this research project in a variety of forums. We will ensure that in any publication and/or presentation, all information will be presented in a non-identified and summary form, and that any quotation of your words will be identified only by your pseudonym. Similarly, workplaces and localities will be identified only by invented names.

Information obtained during the research study may possibly be subject to inspection (for the purpose of verifying the procedures and the data) by relevant authorities including the Fair Work Commission. By consenting to participate in this research project, you authorise release of, or access to this confidential information to the relevant regulatory authorities, if required by law.

The information collected for this research will be retained for 5 years after the most recent publication or presentation and will be destroyed at the completion of this data retention period.

Who is organising and funding the research?

This research is being conducted by:

Dr Lisa Heap – Director Research into Action, Lead Investigator

Dr Heap will be assisted by a research team including:

- Dr Michael Victory, Director RIA and Project Manager
- Ms Christine Ross (Independent Consultant), Interviewer
- Ms Sue O'Shea (Independent Consultant), Interviewer
- Ms Susan Kenna (Independent Consultant) Interviewer

The Australian Nursing and Midwifery Federation (ANMF) is funding the research.

Further information and whom to contact

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact:

Name	Dr Lisa Heap
Position	Director RIA/Lead Investigator
Phone	██████████
Email	████████████████████

OR

Name	Dr Michael Victory
Position	Director RIA/Project Manager
Phone	██████████
Email	████████████████████

Participant Consent Form

Research Project title: Investigating the dimensions and less visible aspects of nursing work

Lead Investigator: Dr Lisa Heap

Declaration by the Participant

- I have read the Participant Information Sheet.
- I understand the purposes, tasks and risks of the research described in the project.
- I have had an opportunity to ask questions, and I am satisfied with the answers I have received.
- I freely agree to participate in this research study as described and understand that I am free to withdraw at any time during the project and that withdrawal will not affect my relationship with any of the named organisations and research team members.
- I understand that I will be given a signed copy of this document to keep.

Participant Signature

Name of Participant:

Digital signature of Research Participant:

Declaration by Researcher

I have explained the research project, its activities and risks and I believe that the participant has understood that explanation.

Lead Investigator: Dr Lisa Heap

Digital signature of Lead Investigator