THE UNION FOR
QNU
NURSES AND MIDWIVES

QUEENSLAND NURSES' UNION

003

Submission to The Finance and Administration Committee

Work Health and Safety and Other Legislation Amendment Bill 2014

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Introduction

The Queensland Nurses' Union (QNU) thanks the Finance and Administration Committee (the Committee) for providing the opportunity to comment on the *Work Health and Safety and Other Legislation Amendment Bill 2014* (the Bill).

The purpose of our submission is to highlight the specific characteristics of the nursing and midwifery[1] workforce that dictate the need for workplace health and safety laws that provide adequate protection our members.

The QNU is the principal health union in Queensland. Nurses are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU covers all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 50,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Our submission addresses specific aspects of the Bill that will withdraw existing workers' rights, deny unions the ability to consult over changes to codes of practice, enable employers to temporarily address unsafe conditions and ultimately erode workplace health and safety standards. The Attorney-General is apparently determined that 'the practice of unions using safety to hijack sites and bully contractors on work sites will end' (Hansard, 2014). The QNU is very concerned that this legislation continues to demonstrate a pattern not only of poor public policy, but also hypocritical, petulant and immature behaviour. This includes the dismissal of the informed comments of the Office of the Queensland Parliamentary Counsel (OQPC).

The Attorney-General continues to adopt a flawed and inconsistent logic in his approach to industrial regulation, choosing to 'harmonise' Queensland legislation selectively with the *Fair Work Act 2009* when he perceives an advantage for employers or his own agenda, and then actively disregarding the federal legislation when it does not suit his purpose.

[1] Throughout this submission the terms 'nurse' and 'nursing' are taken to include 'midwife' and 'midwifery' and refer to all levels of nursing and midwifery including Registered Nurses and Midwives, Enrolled Nurses and Assistants in Nursing.

The Nursing Workforce

Nurses are the most geographically dispersed health professionals in Queensland and indeed Australia, working independently or collaboratively to provide professional and holistic care in a range of circumstances.

Nurses work to promote good health, prevent illness, and provide care for the ill, disabled and dying. Most nurses and midwives work in an area of clinical practice such as medical and surgical, aged care, critical care, perioperative, midwifery, emergency, general practice, community health, mental health, family and child health, rehabilitation and disability, rural and remote health and occupational health and safety.

Nurses advocate for the patient as a whole person within a complex health system. At every site and level of the nurse-patient relationship nurses facilitate and mediate the competing demands of patients, families, carers, the environment at points of immediate care, the system and society to achieve the best possible outcomes. They conduct research into nursing and health related issues and participate in the development of health policy and systems of health care management.

Queensland Nursing Workforce Profile

Nursing and midwifery is the largest workforce within the clinical streams.

- As at 30 June 2013, 66,795 nurses and midwives were employed in Queensland, with 49 per cent employed by Queensland Health (Nursing and Midwifery Board of Australia, 2013).
- Queensland Health employs approximately 77,000 staff, including 32,000 nurses (Queensland Government, 2013a).
- The Queensland Health nursing workforce comprises 42 per cent of the entire workforce and 61 per cent of the clinical workforce (Queensland Government, 2013a).
- Registered nurses in Queensland Health (Nurse Grade 5 and above) equate to 83 per cent (20,823 full-time equivalents) of the nursing workforce (Queensland Government, 2013a).

Nursing Work

Nurses work in a unique occupational environment that can require rotating and night shifts, long hours, prolonged standing, lifting, and exposure to chemicals, infectious diseases, x-ray radiation and other hazards (Lawson, Whelan, Hibert, Grajewske, Spiegelman & Rich-Edwards, 2009).

According to the Department of Justice and Attorney-General (Previously the Department of Employment and Industrial Relations) (2007), hospitals and nursing homes[2]

- have an above average non-fatal claim rate (21.2 claims per 1,000 workers) and *one of the worst musculoskeletal disorder and disease claim rates across all industry sub-sectors*. The majority of injuries occur in hospitals followed by nursing homes.

- have a disease rate of 2.5 claims per 1,000 in 2005-06 after a 4% decline over the preceding three years. Overall work pressure caused 36% of claims and other people caused 31%. In 58% of cases, the psychological system in general was affected. Registered nurses were mostly affected.

- were responsible for 84% of all musculoskeletal disorder claims in the health services industry sector. The musculoskeletal disorder claim rate was 15.8 claims per 1,000 workers in 2005-06. Injuries were most frequently caused by handling objects, in particular people.

Hazardous manual tasks can contribute to musculoskeletal injuries which can be permanent and impact on a person's working ability and quality of life as well as the productivity and economic performance of their employer. Musculoskeletal injuries include:

- muscle strains and sprains;
- ligament or tendon rupture;
- prolapsed intervertebral discs;
- tendonitis of the shoulders and elbows;
- carpal tunnel syndrome (Workplace Health and Safety Queensland, 2014)

[2] The industry sub-sector consists of hospitals, psychiatric hospitals and nursing homes.

Hazardous manual tasks involve one or more of the following:

- repetitive or sustained force;
- high or sudden force;
- repetitive movement;
- sustained or awkward posture;
- exposure to vibration.

The nursing workforce is an ageing one. Between 2008 and 2012, the average age of all employed nurses was around 44 years, however the proportion aged 50 and over grew from 35.1% to 39.1% (Australian Institute of Health and Welfare, 2013).

The ageing process and the nature of the work combine to place nurses at a significant risk of workplace illness and injury (Cohen, 2006; National Occupational Health and Safety Council, 2005). The workplace health and safety of nurses is intrinsic to ensuring patient safety. The following snapshot indicates nursing's important contribution to health outcomes.

Work environment	• Poor work environments contribute substantially to nursing turnover which is estimated to cost QUD $150,000 per nurse (Chan et al., 2004). • Because nurses work extended, unpredictable hours with a lack of regular breaks they are more likely to experience elevated fatigue levels. Night duty rotations are common, particularly in specialist units where nurses must maintain careful and astute observations of their vulnerable patients. Fatigue can negatively affect nurses' health, quality of performance and thus patient care. The effects of fatigue may be exacerbated for nurses over 40 years of age (Muecke, 2005).
Nurse staffing	• A decrease in nurse staffing is associated with increased health care costs of 40% (McCloskey et al., 2005) and inadequate nurse staffing is associated with adverse events which were estimated to cost AUD$4 billion in 2007.

	• Short staffed units have higher costs and patients have longer lengths of stay (McCue, Mark & Harless, 2003). • Increasing nurse staffing by one registered nurse hour per patient day may cost US$659 per case, but when compared with the cost per case of adverse events (US$2,384 per case), investing in nurse staffing can lead to a saving (Pappas, 2008). • It is estimated 26.7% of all infections could be avoided by appropriate nurse-to-patient ratios (Hugonnet, 2007).
Nursing workload	• Reducing nursing workloads by one patient per nurse (from five to four patients per nurse) is associated with one life saved per 1,000 admissions, at a cost of US$136,000 per life saved. Compared to the cost of other health care interventions, such as routine cervical screening (which costs $432,000 per life saved) implementing nurse to patient ratios of 1:4 is cost-effective (Rothberg, 2005).
Nursing skill-mix	• A clinically appropriate proportion of registered nurses on medical-surgical units has been associated with reduced medication errors and wound infections (McGillis et al., 2004). • A multi-disciplinary team which includes registered nurses reduces in-patient mortality (Kane et. al., 2007; Needleman et al., 2006; Dall et al., 2009; Estabrooks et al., 2005; Person et al., 2004). • A clinically appropriate proportion of registered nurses in the mix of providers has been associated with shorter lengths of stay, lower rates of shock and cardiac arrest, urinary tract infections, pneumonia and respiratory failure (Department of Health and Ageing, 2009; Needleman et. al., 2002). • The presence of registered nurses in long-term care facilities has been associated with reduced adverse outcomes, including pressure ulcers, hospital admissions, urinary tract infections, weight loss and deterioration in ability to perform activities of daily living (Horn et al., 2005). • Registered nursing care is positively associated with reducing pneumonia, a complication which adds five days to a patient's average length of stay and is estimated to cost US$4,000 - $5,000 per additional day (Cho et al., 2003). Pneumonia is responsible for increasing length of stay by 75%, as well as a 220% increase in the probability of death, and an 84% increase in costs (Cho et al., 2003).

Co-ordinating care	• When operating as part of a multi-disciplinary team, registered nurses assist in reducing waiting times and providing timely access to care by increasing the number of entry points to care, co-ordinating care and assisting patients in navigating the healthcare system (Canadian Nurses Association, 2012).

Source: Data cited in Armstrong (2009) and Queensland Health (2013b).

Despite the evidence indicating nurses are at risk in the workplace, the Bill (amongst other matters) withdraws current provisions in the *Work Health and Safety Act 2011* (the Act) that enable unions and workplace delegates to monitor and protect nurses from unsafe practices and environments.

In doing so the Attorney-General has decided to ignore the advice of the OQPC (2014), the body responsible for drafting all Queensland Acts and subordinate legislation, and proceed with a raft of changes in the full knowledge that they will increase the risk of exposure to unsafe workplaces for many workers. The *Work Health and Safety and Other Legislation Amendment Bill 2014* Explanatory Notes (2014) are unequivocal in highlighting the OQPC's valid concerns regarding the withdrawal of workers' rights.

The Bill

The Bill will amend the legislation to:

- **require at least 24 hours notice by WHS entry permit holders before they can enter a workplace to inquire into a suspected contravention to align with the other entry notification periods in the Act and the *Fair Work Act 2009*;**
- **require at least 24 hours notice before any person assisting a health and safety representative can have access to the workplace;**

The QNU strongly opposes the removal of section 119 from the Act. Although we have been judicious in acting under this provision[3], we have relied on the ability to enter a workplace because an incident or risk has required immediate action on our part and that of the employer. This is an important workplace right that allows workers who are exposed to injury or illness the opportunity to have the situation assessed and rectified.

[3] Similarly s90I of the previous *Workplace Health and Safety and Other Acts Amendment Act 2006.*

We supply the following case studies to demonstrate the significance of these provisions.

Case Study 1

The QNU became aware of an incident at a facility where a nurse had sustained significant injuries as a result of a fall. A QNU official sought entry to the facility from the employer to view the location where the incident occurred.

The official met with the facility manager who, together with three other staff, accompanied him to the Pan Room. Pan rooms house machinery for washing and sterilising bed pans and urinals. In this instance, the room contained a non-slip mat with bevelled edges in front of the sanitiser. At the back of the sanitiser was a bowl containing clear liquid situated directly below an outlet from the sanitiser and it appeared to have overflowed on to the floor.

Neither the facility manager nor any of the other staff claimed any knowledge of the bowl. The official requested testing of the sanitiser and there appeared to be no leakage on that occasion.

A review of information provided by the employer Indicated that there had been previous occasions where there had been water on the floor in the pan room from a leaking sanitiser, and that the incident had been reported to the regulator without any follow up action.

The QNU requested immediate repair of the leaks and recommended that proper drainage for any overflow would be the higher order control in eliminating the hazard rather than non-slip mats.

As our case study shows, union officials and workplace representatives need to be able to act quickly when an injury has occurred or may be likely to occur. Had the manager been given 24 hours notice of the official's visit, it would not have been difficult to rectify the unsatisfactory arrangements to deal with the leaking sanitiser by removing the bowl from under the outlet. This would have then given the appearance that no hazard existed. Furthermore, total reliance on the regulator does not always mean issues are investigated.

Case Study 2

The QNU became aware that members were being exposed to an occupational violence hazard as a result of a 'blind spot' in the annex area of a medium secure unit of a mental health facility after a patient had violently assaulted a nurse. In this instance the nurse was subject to action by the employer because she had entered the area and could not be observed properly.

When an official arrived at the premises he noticed a number of internal memos, notices etc. were pasted across the glass viewing pane thus obscuring parts of the annex area holding mentally ill patients. The assault had occurred in part because the nurse could not immediately be observed interacting with the patient. It Is a fundamental principle in minimising occupational violence hazards to be provided with clear lines of sight to reduce risk.

The QNU requested the removal of the material and notified the employer of their failure.

Case Study 3

The QNU became aware that members working in an endoscopy unit may have been exposed to glutaraldehyde, a hazardous substance used in the sterilisation/cleaning process. As a result of this exposure a member experienced a range of symptoms which resulted in her having to cease employment. The union sought immediate access to the site and evidence from the employer that proper risk assessment, training and procedures had been carried out. In the first instance the employer refused entry to the QNU until the regulator intervened.

The QNU continued to monitor the situation and noted that training records obtained using the relevant legislation indicated that workers received training on glutaraldehyde use *after* the union's initial request to enter the premises and *prior* to finally receiving permission to come onsite.

The employer has since changed the chemicals and equipment used for sterilisation.

- **remove the power of health and safety representatives to direct workers to cease unsafe work;**

The Bill proposes to delete Section 85 of the Act which currently provides health and safety representatives with the right to direct cessation of unsafe work. The Attorney-General has given no specific reason for this amendment either in the Parliament or the Explanatory Notes so we assume he has simply applied the same unsound reasoning as he has to the rest of the Bill.

Section 85 is a comprehensive provision that not only enables the actions of the health and safety representative, it also prescribes the conditions upon which they may make decisions, their obligations to inform the person conducting the business or undertaking and the requirement that they have completed training prescribed in the regulations. These are not frivolous decisions. If the representative must be qualified to act under these provisions, then they clearly do so based on information and training.

To completely withdraw this right undermines the basis of the Act itself because it can only operate effectively when the parties it covers adhere to standards and due process. Randomly amending and deleting sections of the Act to suit a political agenda interferes with its internal balances and operation.

- **remove the requirement under the Act for a person conducting a business or undertaking to provide a list of health and safety representatives to the Work Health and Safety regulator;**

Neither in the parliament nor the Explanatory Notes has the Attorney-General given any explanation for deleting section 74(2) (List of Health and safety representatives) from the Act. Again we must assume the Attorney-General's frequent catchcry of 'reducing red tape' only applies to employers and only in those circumstances that inject rigour into the regulatory process to protect workers' rights. If a person conducting a business or undertaking is no longer required to provide an up-to-date list of health and safety representatives to the regulator, then it becomes more difficult for the regulator to monitor workplace incidents. The regulator should be aware of the names of those individuals who are trained to act in each workplace in accordance with work health and safety legislation to ensure ongoing compliance.

- **allow for codes of practice adopted in Queensland to be varied or revoked without requiring national consultation as required by the WHS Act**

In the Explanatory Notes (page 4), the OQPC points out that the removal of the requirement for the Minister to consult with the Commonwealth, State and Territory governments, unions and employer organisations before varying or revoking a code of practice may reduce the opportunities for workers and employers to participate in decisions on codes of practice. We concur with this view.

Although in Queensland consultation on codes of practice takes place with the Work Health and Safety Board and Industry Sector Standing Committees, the Bill omits section 274(2) giving the Minister a unilateral right to vary or revoke codes of practice without recourse to stakeholders. Here, the Minister is abrogating any legislative responsibility to consult at any level.

- **increase the maximum penalty that can be prescribed for offences in the *Electrical Safety Regulation 2002* to 300 penalty units.**
- **increase penalties for non-compliance with WHS entry permit conditions and introduce penalties for failure to comply with the entry notification requirements;**

We note the Attorney-General's preference for punishment rather than co-operation.

Conclusion

Again, in this government's haste to demonise unions and prevent them from carrying out their legitimate role, this Bill exposes nurses to unnecessary workplace risk. We remind the Attorney-General that **unions are the workers** despite his misplaced conception that the two are separate entities. The QNU considers any attempts to restrict or withdraw current rights will disadvantage nurses and undermine their important role In maintaining the health of *all* Queenslanders.

Recommendation

Based on the evidence presented in this submission, the QNU recommends:

- that the Committee seeks withdrawal of the Bill from the parliament. It is the responsibility of employers and government to ensure nurses have safe workplaces.

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