HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Dr CAC Rowan MP
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP

Staff present:

Ms D Jeffrey (Research Director)
Ms E Booth (Principal Research Officer)

PUBLIC HEARING—INQUIRY INTO THE HOSPITAL AND HEALTH BOARDS (SAFE NURSE-TO-PATIENT AND MIDWIFE-TO-PATIENT RATIOS) AMENDMENT BILL 2015

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 10 MARCH 2016

Gladstone

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Committee met at 1.42 pm

BURTON, Mr Grant, Regional Organiser, Queensland Nurses Union

GRAY, Ms Tina, Registered Nurse/Midwife

LAWSON, Mr Damien, Nurse Manager

CHAIR: Good afternoon, ladies and gentlemen. Thank you for coming today. Before we start can I request that mobile phones be turned off or switched to silent. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 open.

I would like to acknowledge the traditional owners of the land upon which we meet today and also acknowledge their elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The members joining me here today are Christian Rowan, the deputy chair and member for Moggill; Mr Aaron Harper, member for Thuringowa; Ms Ros Bates, member for Mudgeeraba; Mr Joe Kelly, member for Greenslopes; we have an apology from Steve Dickson, member for Buderim, who is unavailable to attend the hearing today; and also we have apologies from local member Glenn Butcher, member for Gladstone, who was actually flying in to be a part of the hearing today but his flight was cancelled so he unfortunately could not be here. Thank you for your attendance here today. The committee very much appreciates you giving up your time to assist us with our inquiry.

The committee is holding three public hearings in regional Queensland this week—the first was in Townsville, yesterday we were in Cairns and today, of course, we are in Gladstone—to receive information from stakeholders about the bill which was referred to the committee on 2 December last year and there will also be a public hearing in Brisbane on 16 March.

The main objective of the bill is to establish a legislative framework to ensure safe nursing and midwifery staff numbers and improve patient outcomes through mandating nurse-to-patient and midwife-to-patient ratios and workload provisions in public sector health service facilities. A few procedural matters before we start: the committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a non-partisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. You have previously been provided with a copy of the instructions for witnesses so we will take those as read. Hansard will record the proceedings and you will be provided with a transcript. I would like to invite you to make an opening statement if you would like.

Mr Burton: Committee members, thanks for listening to us today. I am the QNU regional organiser for Rockhampton and surrounding districts which includes Central Queensland Hospital and Health Service, Central West Hospital and Health Service and all private and aged care facilities in between—approximately 197 facilities in total. I am a proud enrolled nurse with 23 years clinical experience in areas of surgical, medical, aged care, private practice and perioperative. Prior to commencing my nursing in 2003 I commenced in the health industry as an orderly and an assistant in nursing in 1993. Further for noting, I am a third generation Central Queenslander with family dating back to the 1920s so I have been around this region for some time and have a gist of what is entailed.

With me today is Damien Lawson, a director of nursing, and Tina Gray, a midwife, each of whom will provide a statement to the committee with some information on their clinical role and the importance of maintaining minimum nurse-to-patient and midwife-to-patient ratios. Also with us today we do have a sign of the nurses and midwives that couldn't be here because they are providing immediate care and could not get time off. Thank you.

CHAIR: Thank you very much.

Mr Lawson: I am no longer a director of nursing. I would like to make that clear. I am now a nurse manager. Good afternoon and thank you for allowing me to address this hearing today. I am a registered nurse and undertook the role of director of nursing at Gladstone Hospital from September 2013 until June 2014. I am an experienced registered nurse. I have over 10 years experience in senior and executive roles both within Queensland and interstate. I have postgraduate qualifications at the masters level, both in health science and health service management.

I do not feel that I need to highlight to the inquiry today the wealth of evidence that supports patient safety and the quality healthcare outcomes as a result of that. What I need to talk to you about is the need for increased nursing hours for patient day and the implementation of nurse-to-patient and midwife-to-patient ratios. The benefits to patients and healthcare systems speak for themselves. However, what I feel I need to talk to you about or bring to the forefront today is the clinical management and governance issues that registered and enrolled nurses in Queensland currently face.

I have spent 21 years of my life in Gladstone—my first 21 years. I was born at the hospital, I was educated here, I did my trade here and I can out-trump Grant: I have about four generations in the Gladstone district. Therefore, having the opportunity to give something back to the community of Gladstone as the director of nursing was a unique, gratifying and challenging experience for me, both from a personal and professional perspective. You could say that I had a vested interest in achieving safety and quality health outcomes for the Gladstone community.

I thought the greatest challenges in the director of nursing role would be relocating my young family from Brisbane to Gladstone. However, I did not think it would be from the profession itself. I thought nursing and nursing management was universal across Queensland and that the safeguards of the public healthcare system in Queensland and the business planning framework would protect nurses, nursing workloads and patient safety. I can say from my experience this was not always the case. At Gladstone Hospital, and indeed across the Central Queensland Hospital and Health Service, I encountered a dearth in nursing and midwifery resources and skill mix across all areas of nursing. I was frequently told by nurses and midwives from various units that they felt they were unable to deliver a level of care to their patients that they expected due to the workloads they encountered. I had registered nurses and midwives inform me that they did not work on in-patient units at Gladstone Hospital any more due to the unrealistic and sometimes unsafe workloads and skill mix that they incurred.

I further discovered a fragmented healthcare system in Central Queensland. It had been shattered by the voluntary redundancy programs of the Newman government which had abolished key nursing positions at Gladstone Hospital, including the CNC of infection control, further depleting the nursing workforce available to Gladstone Hospital as well as the actual loss of invaluable knowledge and experience that those nurses possessed. There was a culture of budgetary constraints despite the HHS posting a surplus into the tens of millions for the preceding year, a hospital budget that was formulated with little nursing input and what appeared to be a disregard for the business planning framework, despite nurses being the dominant health profession in the workforce and the member of the healthcare team most likely to identify deteriorating patients and initiate interventions that minimised the impact of adverse effects and prevent negative outcomes for patients. There was a culture of health bureaucracy which was compounded by the competing market forces of health service interest between Gladstone and Rockhampton hospitals. There was ever increasing patient numbers and activity and thus increasing nursing workloads. There was a predominantly locum medical workforce that continuously impacted on the nursing and the nurse unit managers' workloads, the overall hospital budget and on the quality of healthcare outcomes and patient safety.

There was a culture among some of the key leadership roles that accepted substandard clinical outcomes through obvious systems failings in regard to clinical incident management and thus patient safety, as stated in the findings of the Vanguard health report for Central Queensland Hospital and Health Service's clinical incident review in February 2014. I do not believe Gladstone Hospital is unique in some of these issues highlighted, but rather shares commonality with the issues of other regional health services across the state.

Implementing nurse- and midwife-to-patient ratios is a positive initiative that will work towards ameliorating the endemic issues compounding nursing workloads, build a culture based on quality and safety and provide the outcomes for people of this region. Thanks.

Ms Gray: I will not trump either of you. I grew up in Brisbane. I work as a registered nurse/registered midwife in the Rockhampton Hospital within the maternity unit. This is a great move to adequately staff units. However, there are specific factors that need to be taken into account when

determining a nurse-to-patient or a midwife-to-patient ratio. This includes the specialty of care provided within that unit. For example, the midwife-to-patient ratio cannot be substituted for a registered nurse or an enrolled nurse. In a maternity unit, they cannot provide holistic care to our women. The higher the acuity of the patient the greater the workload the midwife encounters. And again within a maternity unit, a patient that is seen as one is indeed two patients. Whether the baby is in utero or born, that baby requires foetal wellbeing monitoring to make sure it is okay. A well born baby also needs observation. The ward accepts patients straight from the community. A minimum staffing level should be set and not deviated from a patient number or acuity level. Our patient numbers, our acuity levels within a maternity unit, are unpredictable and can change from a well organised shift to a chaotic shift where staff are stretched beyond capacity. If staff are redeployed to other areas of the hospital it puts patient safety at risk. If staffing within the unit is inadequate to provide immediate safe care within an emergency, again patient safety is at risk.

Midwifery care is unpredictable no matter what shift. Clinical guidelines over the last 10 years have continually been revised and more introduced. This has increased continual observations and assessments of our women and their babies and neonatal care has increased the workload of midwifery staff threefold. However, no extra staff have been provided to maternity units in this time. We must remember that these clinical guidelines are gold standard care and to meet them correct levels of clinical practice staff must be maintained. When midwifery staffing numbers and skill mixes are inadequate it results in less surveillance and assessment within the pregnancy, postnatally and intrapartum. This allows midwives less time for education and can lead to mistakes when staff are too busy. Workload models should reflect the clinical need, remembering 50 maternity patients is indeed 30. If midwife-to-patient ratios are adequate, health costs will actually decrease as surveillance and education will minimise adverse outcomes during the intrapartum and postnatal period thus reducing the patient's length of stay. Identifying and educating mothers with babies who are at risk can also reduce admissions to special care nursery, again reducing health costs.

CHAIR: Thank you very much for your opening statements and thank you very much for having us in Central Queensland. You are obviously very proud. We all did comment flying in that it was very green and very beautiful.

Mr Burton: There is a bit of water lying around at the moment. It is great.

CHAIR: We heard some of the areas we came through were flooded yesterday. Thank you for having us in your home town. I will hand over to the deputy chair, the member for Moggill, to ask some questions.

Dr ROWAN: Thank you for your submissions and also for coming along today. The first question I wanted to ask you particularly, Grant, is in relation to your views in relation to the proposed one as to four on morning shifts and afternoon shifts and then one as to seven in the evenings. Do you have any view that that is the right ratio or whether it should be one as to five or one as to eight or one as to three or one as to six? So those particular figures of one as to four for morning and afternoon and one as to seven, do you think that is the right number or do you think there should be flexibility or are there other numbers that should be looked at?

Mr Burton: To determine those ratios we need to incorporate the appropriate use of the BPF. That is the bottom line. The BPF looks at the service profile, what care is needed. If that is appropriately used then that should determine it. One to four, one to four and one to seven is at this stage the minimum standard, the minimum that should be reflected on any unit or any facility, to ensure adequate nurse-to-patient ratios.

Dr ROWAN: In relation to skill mix ratios, ENs to RNs, do you have any views around whether that should be mandated as well as part of that process?

Mr Burton: Again that is determined by the service profile in the BPF. We just must ensure that there is adequate skill mix to ensure the patient's safety.

Dr ROWAN: I come to you, Damien. With some of your evidence just now outlining your experiences from a management perspective and a clinical governance role as well in your previous executive roles, as part of all this having nurse-to-patient ratios potentially implemented into hospitals, there is a complex ecosystem of other things that need to occur in their holistic system to ensure good clinical outcomes, things like your clinical incident risk management system, your credentialing processes, as you said, around medical staffing and having locums versus permanent staff, leadership and management, clinical data review, all of those things. When we are looking at nurse-to-patient ratios, what else needs to be looked at as part of the implementation of that to ensure successful good clinical outcomes for patients?

Mr Lawson: That is a very broad question. How do we answer that? I think it is about looking at having a system that is a cohesive system to start with. There is much fragmentation at the moment within Queensland Health and within health alone. I think things like the clinical incident management framework or whatever else they might be using, PRIME, for example, in Queensland Health, there is not that clear link between the users that are actually inputting the information and the feedback from health managers or health service managers back to the clinician. We can see that from Central Queensland, and some of the outcomes that have occurred in Central Queensland are a clear result of this. The Vanguard report clearly articulates that there has been a lack of action by some service managers within the health service in actually following up the clinical outcomes that have come as a result of PRIME. I mean, going back to Gladstone Hospital, for example, during my time there, there was over an 80 per cent medical locum workforce. That was unsustainable and not safe for patients. We cannot run a functioning healthcare system with a great patient and safety agenda when we have got an 80 per cent locum doctor workforce. The problem was with the fragmentation there that there may have been a clinical incident during that time, however, the surgeon, the medical officer, was long gone and the outcomes around those were lost in translation, I think. I think that is the reason why a lot of recommendations around RCAs were not implemented within Central Queensland.

Furthermore, there is that ecosystem. It is demonstrated that if we put more registered nurses on the floor patient safety increases. We are the most prolific healthcare provider within the healthcare system. Increasing nursing numbers obviously will increase patient safety. I think that is the one thing we need to look at. But I think it is also about the substitution of roles. Getting rid of vital positions such as clinical nurse consultant for infection control has flow-on effects. Getting rid of that position means that the nurses on the floor do not have that clinical support from those specialist roles. There are other positions. There is also things like the director of nursing for Central Queensland does not sit on all committee meetings in relation to nursing. Decisions are made about nursing and patient outcomes that are not made by healthcare professionals. A perfect example of that would be doing the budget work up in Gladstone Hospital. As the director of nursing I was not invited to the budget workup meeting.

CHAIR: If we can keep comments and questions relevant to the bill. The bill is about ratios, if I can reclarify that. I appreciate all the issues raised would be of importance, but the committee can only report back on those that are relevant to the bill before it.

Dr ROWAN: Tina, can I ask you about your current workload and that of your colleagues at the moment; so the number of patients that you would look after?

Ms Gray: It is not uncommon within our unit to have one midwife on our 15-bed ward. That is one midwife essentially responsible for 30 patients and your help is a registered nurse or even an EN. It is a 15-bed ward. I worked it the other night with an RN. They cannot assess the women. They cannot help the women with their babies. It is a lot of responsibility for that midwife. Our special care nursery can be staffed exactly the same way. I have worked in there with a CPAP baby, eight babies and pool staff with no neonatal qualifications at all. Patient safety is at risk then because you cannot get around to check what they are doing.

Dr ROWAN: Who is currently rostering it that way at the moment? Is it a clinician or an administrator? Who is doing it?

Ms Gray: Our nurse unit manager. Quite often it is sick leave and they cannot replace the midwife once there is sick leave. It is sometimes rostered that way because we do not have the staff in our unit to adequately staff the unit.

Dr ROWAN: So the clinical nurse manager is rostering it that way at the moment because they cannot find staff or there are staff on sick leave?

Ms Gray: Yes.

Dr ROWAN: So there is really a second or third position that would be normally rostered but they cannot fill it?

Ms Gray: I do not know how many midwives we are down, but we are down quite a few midwives at the moment.

Mr Burton: Just to jump in there on Tina's statement. It has been reported recently that we are equivalent of 6.63 FTE midwives down within maternity services. That is not in relation to any sick leave, back leave, maternity leave or ongoing leave. It is certainly the staffing side of things. With workloads I guess there is a bit of a magnetic effect and people do not want to come to the area. Ensuring the safe midwife-to-patient ratios and ensuring we have adequate numbers again picks the staff up and encourages them to say, 'This is a great place to work. Please come to the area to work.'

Ms Gray: They are burning staff out in Rockhampton. I have worked shifts where I am actually the senior in the nursery within the hospital. I have worked shifts where we have had a busy ward, had sick leave and I have been moved out of the nursery as the only midwife on the ward. I have been told to shift coordinate and supervise the transition RN in the nursery. That is an RN on a neonatal learning program. You ring management and say, 'I am not accepting this,' and they say, 'Too bad; there are no staff.'

Mr Burton: This comes back to Damian's point that there are senior positions in management giving direction and identifying the requirements for the nurses who have no health background. We have had executives who have been engineers and so forth. They are providing direction about the health care of the community and where the nursing staff and the medical staff—all the health staff—should direct their care to. How can you do it? Ensuring the safe ratios, having adequate numbers of staffing there and having the BPF implemented correctly they cannot second guess that then. That is what is required. That is the bottom line. It does not come down to funding then, which is currently what is happening.

Dr ROWAN: Would it be a fair reflection to say in the BPF that it should be front-line clinical managers, for want of a better term, who are determining the appropriate staffing based on complexity and acuity on an individual clinical ward or clinical area?

Mr Burton: There is a policy currently within Queensland Health, B5, which encourages participation from all staff with the nurse unit manager, managers and executive nursing directors to identify the service profiles and adequately implement those. That is not happening currently. The bottom line is—and to really simplify it—nurse unit managers and nursing directors are saying, 'This is the requirement we need for staffing numbers to adequately and safely staff our wards,' and financial officers are saying, 'Sorry we do not have the money, you cannot do that.'

Mr Lawson: Can I make two points there. The first point is that there is also professional judgement. The registered nurse is an accountable healthcare professional. They have a professional judgement. However, that judgement is frequently overridden on the direction of executives who are not nurses or are not healthcare workers. For a chief financial officer to make it a decision on professional judgement and whether a nurse says they can or cannot safely care for a patient is unacceptable. That is something that frequently occurs.

I no longer work in the Central Queensland health service. I now work in the Gold Coast health service. It is a problem that is endemic across the whole of Queensland and the whole of Australia. It is something that really needs to change. I think patient ratios would achieve this.

Dr ROWAN: To effectively implement nurse-to-patient ratios and midwife-to-patient ratios there needs to be a review of management processes and structures and culture for that to be effectively implemented?

Mr Lawson: For sure.

Mr Burton: There needs to be a form of clear leadership for the specific areas. There needs to be nursing leaders for nursing, medical leaders for the medical field and allied health leaders for allied health. At the end of the day, they know what is required of the service they provide not an executive level manager who is an engineer, for example.

Ms Gray: Just to back up what Grant said, an example of that was 10 days ago when we were at capacity. They wanted to transfer babies to us. We did not have the staff. We did not have the beds. The executive overrode clinical staff on the floor and forced us to take two more babies into our nursery when we did not have the staff or the beds to accept those babies.

Dr ROWAN: So management can be an effective barrier to the safe implementation of nurse-to-patient ratios and midwife-to-patient ratios?

Mr Burton: It can be, but again if you have the adequate ratios—midwife- and nurses-to-patient ratios—that is going go a long way to stopping that from happening.

Mr KELLY: Can I say thank you to Grant, Tina and Damian for your presentation thus far. Just picking up some of the thoughts from the member for Moggill, I particularly direct this question to Damian, but Tina perhaps it is applicable to midwives as well. I am assuming, given the level you are at in Queensland Health, that you have gone through introducing all of the systems and processes to support the changes to way we manage deteriorating patients—the colour coded obs charts, the starting of the rapid response teams rather than code blue, the retraining of nurses? You have been through all that, have you?

Mr Lawson: Yes.

Mr KELLY: That seems like a pretty simple change when you say we are just going to rearrange the obs charts so the respiratory rates are up the top and we are going to put colour coding in place. There were obviously a lot of system changes that went into supporting that simple change, is that correct?

Mr Lawson: I would say that there needed to be a lot of system changes. Putting a square peg into a round hole does not work. It is great. There is the response from ADDS charts and things like that. There is a clear pathway to follow in those things. However, when there is not a medical officer to follow-up that deteriorating patient, that is when you get into trouble.

Mr KELLY: There is going to be change if we get this legislation through. There are going to be multiple factors that have to be taken into consideration in implementing that change. You have been through that experience before and the outcome that we achieved then was based on evidence. You have got a good background not just in clinical nursing but also in the book learning part of the world as well. You said you did not want to talk about the evidence. I think it is important that you step us through it. In your opinion, the evidence that you have seen for the ratios, is it strong?

Mr Lawson: It is very strong. I think the evidence is irrefutable, not just from a theoretical point of view, but from a practical point of view. We know that the more nurses on the floor the greater the outcomes achieved. For example, I work now as an after-hours nurse manager in Queensland Health. We know that in the units that have high acuity and low nurse numbers more potential patient harm happens. There is underreporting and overreporting within Queensland Health within clinical incident reports as well. Subjectively there is more harm that occurs in those units that have higher acuity and low numbers of registered nurses. When we increase the nursing workforce base, whether it is ENs or RNs, but mainly RNs, it is demonstrated that we can reduce potential harm to patients.

Mr KELLY: As an after-hours nurse manager, if there was legislation that dictated ratios how would that affect your decision-making process in terms of managing staffing?

Mr Lawson: It would simplify the system a lot. At the moment I would be the one on the end of the phone with Tina who is saying, 'We need more staff to safely look after this ward.' It is hard to pull a staff member at 2 am when there has been an influx of patients into a ward or when they have had 12 admissions. It maybe that the nurse manager or the executive have said, 'Close those beds on that ward. We do not need to pay extra nursing staff,' and then patients come in. That is when it is compromising patient safety. It is compromising the integrity, from a professional point of view, of the nurses as well. It is putting the accountability back on those nurses.

Mr KELLY: Tina, you are an RN as well as a midwife. Do you have a speciality area? Do you work as an RN?

Ms Gray: I work within the maternity unit. I spend most of my time in the special care nursery.

Mr KELLY: You mentioned patient education. When you are doing a shift, like the one you just described, where you have one midwife for 15 mothers and 15 or possibly more babies with an RN or EN with you, how easy is it for you to get to the patient education that you feel you need to provide?

Ms Gray: You do not get to the patient education.

Mr KELLY: What do you think the implications of that are for mothers and babies?

Ms Gray: The mothers are not establishing their feeding at all because you cannot get to them and stay with them to help them breastfeed and educate on that. Those mothers end up going home bottle feeding. As research shows, bottle fed babies have more illnesses than breastfed babies. That is going to impact on health costs.

You cannot do any of your discharge education with the mothers or even just sit with a mother and teach them how to settle their baby by wrapping et cetera. You end up taking the baby off them and telling the RN or EN to nurse the baby and put it to sleep because you cannot stay with that mother.

Mr KELLY: That must be quite stressful for midwives who have a high level of professionalism and understand what the implications are?

Ms Gray: Within our unit the midwives are feeling quite demoralised by this. We are very task orientated at the moment because we are just too stretched.

Mr KELLY: How do you think a ratio would impact on your capacity to educate patients?

Ms Gray: If we had a midwife-to-patient ratio within our unit we would be able to educate our mums and send them home breastfeeding competently, knowing how to settle their babies, knowing what to look for postnatally to know whether they are going to have a secondary PPH or what is going

to happen. You are going to have time to do that and you are going to be confident to send them home and know that they are able to cope once they go home.

Mr KELLY: Grant, you travel right across Central Queensland by the sound of it. You must deal with a lot of nurses. Do you come across many people, I think you mentioned it, who have left the system because they are feeling overwhelmed or because the workloads have driven them out of the system?

Mr Burton: Absolutely. There is probably not a week that goes by that I do not come across someone who is contemplating leaving or has actually left. What is even more concerning from my travels around is talking with students and talking with postgraduate nurses who have come into the service, come into the system and within a couple of months have decided that that is enough, 'I need to get out. I need to leave.' That is a shame after three years of study and at the beginning of their career.' It is not only the workloads but because of the support not being able to given on the education side of things because the educators are on the floor working clinical hours and not doing their actual role.

Mr KELLY: Damian, both in your current role and in your role as the director of nursing in Gladstone, the nurses whom you were managing would you characterise that they were able to do the sorts of things that a registered nurse, from a professional's perspective, would like to be able to do—patient assessments, skin assessments, nutritional assessments, behavioural assessments, discharge planning, patient education? Are those the things that people are getting to or are they having to reprioritise?

Mr Lawson: They would get to them, but it would not be to the quality that they would want or that I would expect if I were a patient. I think that is the issue. As I said in my opening statement, I have had experienced, senior registered nurses say to me, 'I am no longer willing to work in an inpatient unit because I cannot give the care that I think the patients expect and that patients expect. I am drowned by the paperwork. I am drowned by the process of it. I am drowned by the politics that is associated with nursing now and the clinical care component that I cannot give.'

It is a shame. Some of those nurses are being picked up in other community sectors or things like that. I think it is a generation of nurses we are losing as a result of this.

Mr KELLY: Because of the workloads people are currently not able to get to those basic things that we should be able to do as professionals. As a director of nursing working with NUMs—I do not know how many wards you have got or how many units you have at the Gladstone hospital, but I am assuming you have a few—

Mr Lawson: There are a couple.

Mr KELLY: I assume there are often quality improvement activities or initiatives that you might have been able to spot as a director of nursing that you would have liked to have worked through with your NUMs. How able were you to put those in place given current workloads?

Mr Lawson: I have to say there was not. Always the basics were done. As any health care professional will tell you it was airway, breathing and circulation. That is the focus of any health care professional. The basics would be done. It would be the things that would improve the quality of care or the quality of outcomes or even the safety to some extent. It would be: yes, we have done the checklist, but have we checked everything? You would be second-guessing yourself all the time. We have seen from SAC 1 events in Rockhampton in previous years that even though all the checks and crosses were done, mistakes can still happen.

Mr KELLY: The notion that NUMs or team leaders, either in midwifery or in general, acute and surgical wards, are best placed to make decisions around immediate staffing needs, how do you feel about that?

Mr Lawson: Can you repeat the question?

Mr KELLY: The notion that NUMs or team leaders in either midwifery or nursing situations are best placed to make decisions about localised staffing, how do you feel about that statement?

Mr Lawson: I think that is right. There are two parts to that question. From the NUM there is the business planning framework that is supposed to support the unit and the service build-up around that. That is one thing, and that is I think where the NUM should be taking the lead on that in consultation with the staff. There is also that thing called professional judgement, and the professional judgement of the people on the ward changes. People are dynamic; health care is dynamic. It changes in the blink of an eye, and we have to have safeguards in the system to ensure that we can adequately provide safe and quality patient care.

Mr KELLY: Would that process of localised decision-making be facilitated and made easier by a nurse-to-patient ratio?

Mr Lawson: I can tell you now as a director of nursing and as a nurse manager in my current position that it would make it easier.

Ms Gray: Yes. If you look at the dynamics of a regional maternity unit, it is not just a postnatal ward or a birth suite or a nursery: it is all in one unit. You can imagine the change in that unit. It can go from a beautiful shift to a chaotic, out-of-control shift in no time. You just need one emergency. We do not even have the staff for our labouring women to have one-on-one care. Our women do have a midwife that is looking after two labouring women plus outpatients that come through, and that experienced midwife might have a graduate midwife with her who she is also supposed to then support. She can also be a shift coordinator. If we had a midwife-to-patient ratio, there is a minimum staffing there that they need to put on that floor which is going to allow those women to be supported properly, educated properly and our junior staff to have support.

This year I have seen two of our grads leave already within our unit because our workloads are so great. We have a student who is refusing to work in the birth suite and is organising to do her birth suite hours elsewhere because we do not have enough staff for that student to be supported one on one in the birth suite and we do not have a full-time educator. As Grant said, when they are on shift they are pulled to work clinical so they are not there to support our staff. If it was legislated that we had to have one to four, one on one in the labour ward and one to four in the nursery, management then have to staff us safely to look after the women of our community.

Mr Burton: To add something extra to that to further support it, the nurse unit managers currently within the organisations here are actually doing clinical hours, so they are more often than not on a weekly and sometimes daily basis doing clinical hours, so they are not even there to lead their team. It is important with the ratios that the nurse unit managers, the team leaders, the educators and clinical facilitators are not part of these ratios.

Ms Gray: We have a clinical facilitator, and I think if you looked at her shifts as clinical facilitator you could count them on one hand over the last two years.

Mr Burton: It is important they do not have a load there. They are to support the team and to educate the students, so they definitely are not counted within the ratios. The ratios are for the clinicians that are on the floor in direct patient care.

Ms BATES: Thank you all for appearing today. Damian, welcome to the Gold Coast. Whereabouts are you going to be?

Mr Lawson: At the Gold Coast University Hospital.

Ms BATES: I am sure that I will bump into you at some stage. Damian, you were the acting DON or the DON?

Mr Lawson: I was a temporary secondment for a nine-month period.

Ms BATES: Just so my colleague at the end knows, it is a 69-bed hospital, is that right, if you add your chairs and your renal unit et cetera together.

Mr Lawson: It fluctuates. I think the maximum could have been 75 on the hospital profile.

Ms BATES: I want to go through the process so that we understand. If you are a nurse on the ward or a nursing unit manager and you believe that there is inadequate staffing based on patient acuity, if you could just step me through the process. I will touch on your comment about getting more staff in, given the fact that we all know that midwives are a rare breed. Certainly in country areas it is very difficult to attract them. If you are the director of nursing and you have a NUM who says, 'I have a problem. I have too many patients here. I do not have the right skill mix,' what was the process for you as acting DON?

Mr Lawson: This was a very difficult situation that I was faced with a lot. I think it is the difference between management and clinical management in that I would actually go to the ward. I had to work in theatre. I had to work in emergency looking after a paediatric patient because there was no-one else to look after that patient. As the director of nursing I was taken away from my strategic objectives to go and do the grassroots basic patient care when there was not enough staff. That did not happen all the time, but it happened. We would take nurses from midwifery that were registered nurses and midwives and take them down to the emergency department or take them down to ward 1A or wherever they needed to go to ensure patient safety at that time. As you know, it is the flux, the ebb and flow of how we have to do it. Sometimes it would mean pulling them out

onto the floor to deal with those situations. It was the clinical facilitators, it was whoever could adequately do that at the time and safely do that at the time to maintain patient safety.

Ms BATES: Correct me if I am wrong, but in country areas often you have a shortage of nurses anyway. I know we have a terrible shortage of midwives. Even with a nurse-patient ratio there is no guarantee that you would be able to fill that ratio in some areas because of either the lack of staff that are around in the first place or the inability to attract them. I think you mentioned that you had to move your family to come and work here. Do you think it is also a mix of not just the fact that you would like to have ratios so it is safer for patients, but also it is difficult to attract staff to certain areas?

Mr Lawson: That is endemic across the whole of regional Queensland. When you get outside the south-east corner that is the reality; however, I think there are other issues at the forefront here. It is a poor culture. Culture is the basis of everything and if we are not respecting our health professionals, whether it is nurses, doctors, midwives or allied health, we are not going to attract them. Some of the reasons why Central Queensland fail to fill and attract vacancies is because of the culture that exists. In saying that, there are also budgetary constraints. You could put the submission and paperwork in to say that we need to fill this vacancy, and it was sent back to you saying, 'Due to budgetary constraints, we are not filling this position.' As the director of nursing, this is what I thought was the safest and needed to occur. Our industrial framework supports this; however, the executive or the bureaucracy within Queensland Health failed the system in these instances. I think that changing the culture of nursing will bring those nurses back. I can tell you now that I could name more than a dozen nurses in Gladstone alone who do not work in the health care system because of those reasons. I was talking to a nurse manager this morning who told me that people do not want to pick up extra shifts because of the workloads that are there, because of the cultures that exist. I think respecting the profession, respecting the patient and bringing that patient and quality agenda to the table will change the way that we attract nurses to regional areas. I think if it is standard across the board whether I am working at the Gold Coast in surgery or whether I am working in surgery here in Gladstone, I know as a registered nurse the standard will be the same for workloads.

Ms BATES: Prior to looking at nurse-patient ratios if you had an emergency situation in your hospital and you needed to put on extra staff, you are the DON so what did you do to make that happen? If you could not make it happen, why couldn't you make it happen?

Mr Lawson: I have to say that I had to fight. Operating theatres in Gladstone did not have enough FTE. I use the word crudely that Gladstone Hospital FTE and nursing was 'raped'. It was literally raped with the numbers and the people that were given redundancies. Giving those people redundancies left huge vacancies there.

Ms BATES: They were voluntary redundancies, weren't they?

Mr Lawson: Not all positions were voluntary redundancies. The people that took them may have taken them voluntarily, but the positions that they were in were not the voluntary things. Some of the things that were taken left huge holes in the system, so I had to fight to get enough FTE to work in the operating suite. The way I did that was going to an agency, and the number of loopholes that I had to jump through to maintain patient safety and to maintain a safe working platform for the registered nurses that worked in theatre, along with the locum workforce that was there as well, to have to fight to get the minimum number of nurses you need on the floor should not happen.

Ms BATES: Do you think those casual nurses would come back and work if there is a designated nurse-to-patient ratio?

Mr Lawson: I think so.

Ms BATES: They would then be permanent part-time rather than casual.

Mr Lawson: I think there is the protection there. Currently the BPF is an industrial instrument, hence the application of it comes down to bean counting rather than patient safety and I think that is the issue. When we have bean counters making decisions about the business planning framework which nurses have put up as the flexible standard that we need to provide patient care, I think that is the issue.

Ms BATES: I totally agree that nurses should be running hospitals. Nobody else should be running them because nurses know what is happening on the floor, so I get your point about that and you certainly have my support as far as that goes. I cannot let it go because you did make a comment about the Newman government, but in February 2014 you did get, from what I remember, five new grad nurses which—

Mr Lawson: Sorry?

Ms BATES: In February 2014 you were in the *Gladstone Observer*—

Mr Lawson: I certainly was, and we actually got 10. There were five FTE, and I can tell you the only reason we got 10 was using strategy in the way that we got it. We had nothing to attract registered nurses to Gladstone. There is a poor work culture and as a result of that the word gets out.

Ms BATES: The work culture was bullying and intimidation, or what?

Mr HARPER: I do not think that is relevant.

Ms BATES: He has raised the issue about culture.

CHAIR: Yes, it is relevant to workload.

Mr Lawson: Yes, the culture is bullying and intimidating and the culture is about money. The culture is not about patient safety: it is about money. The way that we got those 10 graduate nurses for Gladstone at part-time hours is that I applied for rural funding. Gladstone is not a rural hospital, however, rural GPs run the hospital in their locum positions. The way I did that is as the director of nursing I am also responsible for the Boyne Valley Primary Health Care Clinic, which is a rural clinic and midwifery group practice which goes to rural areas such as Mount Larcom and Turkey Beach and other rural areas. I applied to the chief nursing officer to get rural funding and we attracted $10,000 a grad. I think that was the number off the top of my head and from memory. We got $10,000 for every rural graduate nurse that we could employ. How we attracted them is by offering more support with the nurses. We put it into clinical facilitating hours. We got a dual registered nurse midwife, and what we did is used the temporary clinical facilitator hours to support that graduate nurse and give her the platform to become a great midwife.

Ms BATES: That is great. Because you were quoted as saying, 'We are growing our workforce with tailored training to meet our needs and those of our patients'—

Mr Lawson: I can tell you now that was not Central Queensland Health Service that was pushing for that: that was me.

Ms BATES: That is terrific. That is probably where I was going with my questions about when you, as the director of nursing, were told by your staff 'We are in crisis', you went to the management of the hospital.

Mr Lawson: Yes.

Ms BATES: The CEO of the hospital?

Mr Lawson: I would say the executive director in Gladstone. As the director of nursing I reported to the executive director, who was also the director of medical services, and that is who I would report to.

Ms BATES: Is that the same executive director who is there now?

Mr Lawson: No. The position has now been split, I believe.

Ms BATES: In the interim, because obviously this legislation will more than likely pass, has it improved since that executive director left to now?

CHAIR: How does that relate to the ratio bill before the House?

Ms BATES: It is about whether or not they have been able to prosecute the argument whether it was 12 months ago or now.

Mr Burton: To jump in and answer that for Damian, right now I would say absolutely not. There have been numerous changes in the executive director role.

Ms BATES: But no change in what you need.

Mr Burton: It is hard to determine that because there has not been a continuous person within the executive director role here to provide that leadership, so to say that they have had an input or an increase into providing more staff I do not think is accurate. The executive role has not been there to determine it. If there is an increase in staff, that is because of the existing nursing governance. It is because of the director of nursing that that has happened.

Ms BATES: I am not having a crack at all; I am just asking whether anything has changed in the last 12 months other than the nursing advocacy.

Mr Lawson: I cannot comment on that. I have not worked there since September 2014.

CHAIR: I always allow latitude, but if it does not relate to the bill then the question should not be asked and the answer does not need to be provided.

Mr HARPER: Thank you, Grant, Tina and Damian. Before us we have a broad array of experience. I want to start by acknowledging the work that you each do in your respective areas and the huge amount of respect that should be paid to all nurses in Central Queensland, Gladstone and the departments in which you work.

I am probably going to give my age away here, but I started in 1985 as an AIN through to an orderly before I started—this is definitely going to give my age away—in the QATB. I am coming from a different perspective. In 2000 I completed the intensive care program and was based in helicopters for the last 15 years, so 25 years. I can see some parallels here. I can see some challenges. This is about patient safety. Getting that skill mix is absolutely about patient safety, and everything you are saying today has been taken on board.

There is really good evidence based data, not just around the world in the UK and the US, but also here in Australia. The evidence stacks up and the evidence is in. If you get the numbers right on the nurse-to-patient ratio, there are a number of things I have observed in the submissions that I have read where length of stay is decreased. Patient safety is obviously paramount. It has been interesting to listen to whether this would address people going off with stress, absenteeism and bringing people back into the workforce.

The Victorian experience and the people that we spoke with down there, I think it was in 2003 they mandated nurse-to-patient ratios. They had something like 3,000 staff come back into the workforce, of which 1,400 were from agencies, so it actually attracted them back in. That was the Victorian experience. I would hope that with this objective that is before us now we could do the same thing and bring the core nurse-to-patient ratios back to Queensland if it gets through.

Have any of you in your time seen a patient deteriorate because of low work numbers on the ward? Whether that is a hypoglycaemic patient, a patient fall, a set of obs not being done and a patient has deteriorated, have you in your time experienced that because the workload has been too much? Can you touch on any of those particular experiences?

Ms Gray: We had a baby earlier this year who deteriorated over a night duty and no-one looked at that baby or saw it. When the day staff came on they looked at this baby—this baby is actually lucky to be alive—it was ventilated and sent to Brisbane, and it was simply because the workload was too great on the ward. There was again one midwife with pool staff with no experience, and they just had not recognised that if they had done proper observations on this baby they would have noted its tone, it was floppy, its colour was bad, its profusion was bad, and I believe it should have had blood sugar monitoring that it was not done either, and it was directly related to poor staffing.

Mr Burton: Apart from jumping on the internet and going back through coronial inquiries for probably the last five years—and you will see a number of cases there—certainly in my experience in my previous role outside of the QNU the comments that are made by the patients, that is the evidence: 'You must be busy because I have been wanting this for a while.' Or 'I have not had my medication. No-one has come and seen me for the last four hours.' Those comments were real. They happened all the time.

Mr HARPER: We did hear that, and we heard of patients apologising to nurses because they did not want to bother them. I see a lot of nodding.

Mr Burton: Correct.

Ms Gray: They will not buzz for your help because they know you are so busy.

Mr Burton: That does happen. I have had that happen quite a lot. You continually say, 'Don't worry about that. We're here to care for you. Please buzz.' That is what it is. Regardless of the workload that you have you are always saying, 'Don't worry, you're not going to bother me. We're happy to care for you.'

Mr Lawson: I think this question is a broad question again. Nurses are not the only caregiver to a patient, so once again I have seen a failure of the system that allows a patient to deteriorate. They have not seen an individual health care professional allow that to occur as much as their own professionalism would allow it to happen.

Mr HARPER: Because you always do your best, no matter what.

Mr Lawson: No matter what. As I said before, airway, breathing and circulation are the basics of any health care professional in keeping a patient alive; however, subjectively I would say yes.

Mr HARPER: Some of my experiences have been working around smaller hospitals like Charters Towers, Ingham and Ayr outside of Townsville. I have to touch on being an acting officer in charge of a large station and having to argue with a chief financial officer over how many defib pads

you have to get. I get the frustration with that. Going back to those smaller areas in regional hospitals, when you take someone out I imagine you would have some road escorts as well with an ambulance, so when you take someone out of the hospital system that would again impact on—

Mr Lawson: I will use the perfect example. There are no mental health inpatient facilities in Gladstone, and that is an issue in itself; however, nurses would have to be taken off the floor to transfer patients to Rockhampton to the inpatient facility, leaving nursing workloads at a higher ratio than it would normally be within the department.

Mr Burton: That is one of the arguments, but it is happening internally in their facilities as we go now. We have seen the privatisation of radiology services within the Central Queensland Hospital and Health Service. What was not taken into consideration was that there was a nursing pool in that radiology service, but when it was privatised there is no nursing pool so now nurses have to stay with patients when they go down to the radiology department within their own facility to have an MRI which may take an hour or two. That is effectively taking them off the floor and increasing the workload for their colleagues.

Mr HARPER: I guess at the end of the day I see broad support for getting the balance right and improving patient safety across the board. I want to say again thank you very much for your contribution not only to your profession, but here today as well. It has been outstanding.

CHAIR: As part of the inquiry I have certainly had the opportunity, as we all have, to read the extensive body of research around ratios and experiences internationally. I think, Damian, you used the word 'irrefutable'. The research is irrefutable. Much of that research talks about a correlation between having a safe ratio and patient outcomes, and some research talks about a causal link that is very strong. I certainly have not met a nurse who does not talk about having a base and a safety net that can provide them with a sense of security on a shift that they at least have that minimum. Everything that we have heard today has been consistent with that, and I appreciate that.

I wanted to ask about some of the flow-on effects of having nurses working in situations where they feel so stressed. You raised a really important point that I am aware of but had not thought about, and that is the fact that we are losing student nurses because perhaps their expectation have not been met because they have not had support. It has been interesting to hear some of the testimony of student nurses in my own electorate who have talked about how they went in with such dreams and hopes about helping and supporting patients and then were frightened because they were unrewarded, felt the sense of responsibility and privilege in being with people who are at a significantly vulnerable time and maybe did not feel confident. They do not have the wisdom of someone like Joe, who has obviously been a nurse for a long time, and have not seen things like that. Losing students and the wisdom that they would bring into the system in the longer term—can you talk a little bit about the emotional impacts of when you go home or when you are seeing nurses coming off a shift that not having a safety and security net to support them has on their overall practice? Yes, you talked about leaving, but what does that do to them generally?

Mr Burton: Apart from being involved with my members and certainly recently with some matters that have occurred, having nurses in tears about not being able to address their workloads, personally—and I can relate it personally because my wife is a nurse as well. She is only recently out of her study—within two years. I still do spend some time now counselling her on her workloads and ratios. She comes home and feels like, 'I didn't do this,' or, 'I didn't accomplish this. Have I harmed the patient? Have I inadvertently done something wrong?' By no means has she done anything wrong, but that is the feeling that she is getting because she has not got the support; there has not been enough people, and I can relate to that. My wife came home recently and said, 'I was left in recovery by myself. No-one else was around because they were busy handling everyone else.' It is not completely au fait or correct to do that; there should be two nurses for the one patient. These are the things that the staff are being put under pressure for and then coming home. So they have to rely on their partners and family. I certainly saw it sometimes when she was studying—and I could relate and I apologised to her for if I behaved like that. It comes out not only onto me but onto the kids as well—my family, my children. They see that, too. They get that sense of, 'Why would I want to be a nurse? Why would I want to follow in my mother's or father's footsteps because this is what they come home like because they are stressed because they cannot give 110 per cent care to the patient?'

CHAIR: The evidence talks a lot about making that link of improved patient safety and quality outcomes and fewer adverse effects. It gives a lot of data and information around that. What is harder to measure is having a safety net. Would it be fair to say that that empowers a [workforce to feel safer on a ward? What are some of the other positive benefits that you think would flow—if you feel 'empowers' is a fair word—from having an empowered nursing workforce?

Mr Burton: An empowered nursing workforce, apart from the better outcomes for the patient, would result in better outcomes for mentoring the student nurses. It is that sense that you have fulfilled what you wanted to do; you have cared for these patients. At the end of the day, nurses are holding hands with patients when they are born and they are holding hands with patients when they die. That is the reality. There are always tragedies along the way. There are always events that are out of your control. That is nature; that is life. What it does is give them something to fall back on, to know, 'I'm not alone here. I have colleagues I can call on.' Having that skill mix and that minimum ratio to run back on, you know you have someone who would be there; you may not have been through it, but they have been. It is the support; it is that collegial support that you are going to get from your colleagues that you cannot get from—

Mr Lawson: Can I jump in there? I think the holding hands thing is the really important analogy here. The nurses are not around at the moment to hold their hands; that is the problem. You asked about an experience of other people currently in our workforce who suffer as a result of workloads. I had a graduate nurse who was distraught the other night because she was not there when her patient died, and we supported that nurse. She was not there to help them. She could not provide the care that she felt she needed to provide to that dying patient as well as their family. There is the impact of that as well. As a result of that, workloads were affected in other parts of the hospital. I had to take that nurse off the floor, counsel that nurse and make sure that she was okay. In making sure that her patient load was fine, I had to deploy a nurse from another area to make sure of that, leaving that workload force. There is that ever competing ebb and flow of where is the greatest need in trying to get this to occur.

CHAIR: When you have nurses working in an environment where they feel that there is an appropriate safety net and they are operating in a safe environment for their own scope of practice, what is your opinion about how that affects culture in the workplace?

Mr Lawson: Can I take that point on? I came from an operating theatre background. I can tell you now the ACORN standards are very clear in the staffing. Theatre does not go ahead unless the ACORN standards are there to support it. I can tell you now the workforce culture in theatre—nurses want to work in theatre; they do not want to work on the wards. That is because they know what their workload will be when they go there. They know that they will have an anaesthetic nurse. They know that they will have a scrub nurse. They know that they will have a scout nurse to support them in their workloads. When you go to the ward, no-one knows what it is going to be from day-to-day. You do not know whether you are going to have six patients, 15 mothers and 15 babies, or what it is going to be. I think that is the real difference. That improves culture. The culture in theatre around that is the reason why they can attract nurses. It is the same with ICU; you can attract nurses to ICU. They might not be skilled, but people want to go and work there. On a medical ward or a surgical ward it is very hard to attract nurses due to that culture that surrounds nursing workforces, the not knowing what you are going to have how many patients or whatever it is.

Ms Gray: Just to add to that, at the moment we have three grads in our ward. One of the grads is so scared to come to work that she actually gets on the computer and looks to see what the staffing is for each shift. She knows, 'I've got that whole ward to myself as a graduate midwife and there are only five staff rostered. There should be seven. That means I'm going to get staff that don't know what they're doing.' She is stressed from the time she goes home from that shift to the next shift to the point where the other night I said to her, 'Darling, I will move you. Let's move staff around so you can feel at least a little bit supported.' If she came to work knowing each shift she was supported—there was someone there to support her, to help her with her practice and grow—she would not feel that way.

Dr ROWAN: Damian, to your knowledge, have there been any local clinical incidents or complaints that have been reported to the Health Ombudsman in relation to perceived or actual deficiencies in current nursing staffing and currently applied nurse-to-patient ratios?

Mr Lawson: Are you saying during my time in Gladstone?

Dr ROWAN: Yes.

Mr Lawson: Were there issues that I knew about that were reported to the Health Ombudsman? Yes, there were.

Dr ROWAN: Can you give us an idea of how many there would have been through that period?

Mr Lawson: I cannot because I personally did not report them through the Health Ombudsman. But I know that staff members have been reporting through to the Health Ombudsman because of patient safety failures—not just nursing, but health care.

Dr ROWAN: Were those directly related to actual or perceived staffing inadequacies or ratios?

Mr Lawson: I do not think it is just about numbers; it is about the skill mix as well. It could have been that there were not enough nurses on the floor. It could have been the skill mix of nurses who were on the floor as well. It could have been the number of doctors who were or were not in the hospital as well. For example—and I know time is of the essence—I can tell you now that it was frequent that Gladstone would have an obstetric service without having the ability for the patients to have an epidural during their service. If they needed an emergency caesarean, they would have to have a general anaesthetic—and not a regional anaesthetic such as a spinal anaesthetic—to have their procedure because there were not the doctors around as well. I do not think it is just about nursing here; it is about the whole [workforce, but it is about who supports nurses in this situation.

Ms Gray: To add to that, last year Gladstone downgraded their obstetric service. More of those women are now having to relocate to Rockhampton to birth and have their babies. These are babies that normally need blood glucose monitoring or some sort of care afterwards. That is just impacting on another service's ability to safely care for these women and babies.

CHAIR: Our time has expired. Can I thank the three of you very much for being so gracious with your time this afternoon and also with your experiences in coming before the committee. Thank you to those in the public gallery for making the time to come and watch today. I now declare the hearing closed.

Committee adjourned at 2.48 pm