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

WEDNESDAY, 16 MARCH 2016

Brisbane

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Committee met at 9.45 am

CHAIR: Good morning, ladies and gentlemen. Before we start, I request that all mobile phones be switched off or to silent. I now declare open 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.

I would like to acknowledge the traditional owners of the land upon which we meet today and pay my respects to their elders—past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee here today are Dr Christian Rowan, deputy chair and member for Moggill; Mr Joe Kelly, member for Greenslopes; Ms Ros Bates, member for Mudgeeraba; Mr Aaron Harper, member for Thuringowa; and Mr Steve Dickson, member for Buderim.

I thank you for your attendance here today. The committee appreciates you making the time to come before us. The bill was referred to the committee on 2 December 2015. 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- and midwife-to-patient ratios and workload provisions in public sector health service facilities. The purpose of this hearing is to receive additional information to assist us in our examination of the bill. We received a briefing from the Department of Health on 17 February and travelled to Townsville, Cairns and Gladstone last week to listen to the experience of regional nurses.

I have 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 nonpartisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. 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 copy of the transcript. This hearing will also be broadcast.

For any media present, I ask that you adhere to my directions as chair at all times. I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. In this regard, I remind members of the public that the public may be admitted to or excluded from the hearing at the discretion of the committee. Please note that this is a public hearing and you may be filmed or photographed. I formally welcome our first witnesses from the Queensland Nurses' Union.

MOHLE, Ms Beth, State Secretary, Queensland Nurses' Union

PICKER, Ms Lauren, Registered Nurse, Queensland Nurses' Union

PURCELL, Ms Moira, Registered Nurse, Queensland Nurses' Union

TAYLOR, Ms Janelle, Registered Nurse and Midwife, Queensland Nurses' Union

VEACH, Ms Kate, Professional Research Officer, Queensland Nurses' Union

CHAIR: Thank you for appearing this morning. Would you like to make a brief opening statement?

Ms Mohle: Thank you for the opportunity to present at this hearing today. My name is Beth Mohle and I am the Secretary of the Queensland Nurses' Union. I wish to make some brief opening remarks about the important milestone the bill and the regulation represent in the provision of public health services to Queenslanders. The legislation of minimum nurse-to-patient and midwife-to-patient ratios acknowledges the crucial role nurses and midwives play in delivering safe, high-quality health care for all Queenslanders.

Establishing and maintaining safe workloads has long been a long-term priority for nurses and midwives in Queensland. There are currently no laws in Queensland governing how many patients can safely be allocated to a single nurse or midwife. The absence of such laws has resulted in nurses and midwives frequently experiencing unsafe workloads and expressing concern for patient safety.

In a recent survey, QNU members reiterated concerns regarding their capacity to maintain a safe environment for patients due to overwhelming workloads caused primarily by insufficient staffing numbers, inadequate skill mix and an unsupportive clinical practice environment. According to our members, the main effects of unmanageable workloads include lack of time to comprehensively complete patient care, poor motivation and staff morale, increased levels of stress, fatigue and burnout, high error rate when making clinical decisions, difficulty in fully complying with protocols and procedures, and unintended disruptions to other clinical staff and departments.

National and international studies have irrefutably shown that staffing numbers, skill mix and practice environment directly affect the safety and quality performance of health services. I must point out that there is no evidence to suggest that ratios do not improve patient safety and the quality of nursing and midwifery care delivered. Health services with a higher percentage of registered nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and fewer adverse events such as failure to rescue, pressure injuries and infections.

The following statistics give a snapshot of the important correlation between nursing and midwifery workloads and patient outcomes. Every one patient added to a nurse's workload increases the likelihood of an inpatient dying by seven per cent. Every 10 per cent increase in bachelor educated nurses decreases the likelihood of an inpatient dying by seven per cent. Every one patient added to a nurse's workload increases a medically admitted child's odds of readmission within 15 to 30 days by 11 per cent and a surgically admitted child's likelihood of readmission by 48 per cent.

The benefits of nurse-to-patient and midwife-to-patient ratios are numerous. We expect the improvement in staffing numbers and skill mix will contribute to improving organisational productivity, hospital efficiency and continuity of patient care by increasing staff satisfaction, decreasing attrition rates, reducing adverse patient events and minimising unnecessary service variation. If the committee requires further clarification or more information regarding the evidence contained in our submission, the QNU is happy to provide this. We have a folder full of information that we will provide today and table for the committee which has some additional information that may be of interest.

The implementation of minimum ratios in Queensland Health will be distinct from other ratio models applied in Australia and around the world. This is because Queensland Health will be implementing minimum ratios in conjunction with the industrially mandated and validated tool for managing nursing and midwifery workloads known as the business planning framework, or the BPF. The BPF is a comprehensive planning process that customises the workloads of nurses and midwives beyond the legislated ratio to suit the individual circumstances of their clinical environment. It takes into account patient activity and acuity as well as other human factors that affect nursing and midwifery workloads such as training and technology.

The combination of guaranteed minimum ratios and the BPF will allow the number of patients allocated to a single nurse or midwife to be adjusted above the stipulated ratio in accordance with variables such as patient activity, acuity and staff experience. For so very long our members have been calling for this guarantee. We strongly believe the combination of ratios and BPF will deliver Queensland Health a staffing methodology that truly engages front-line nurses and midwives in decision-making and is responsive to the dynamic healthcare environment. Research tells us that having enough nurses and midwives to provide care of reasonable quality is fundamental to driving improvements in culture and the workplace environment and that this is central to ensuring patient safety.

The QNU is confident that the implementation of guaranteed ratios will result in significant workforce planning improvements through the attraction, recruitment and retention of nurses and midwives. This was clearly the experience in Victoria. Members repeatedly advise that the main reason for leaving the profession they love is the loss of intrinsic rewards. They no longer feel able to deliver the quality of care they know they are capable of providing because the necessary staffing numbers and skill mix are not available. This is the source of significant ethical distress for our members.

In our enterprise bargaining process we are currently working with Queensland Health to improve the clinical practice environment in preparation for ratios implementation. This will primarily involve establishing genuine consultative arrangements to give nurses and midwives a meaningful

say at work, strengthening organisational processes in support of proper application of the BPF, using an interest based problem-solving approach to deal with workplace challenges, and developing an integrated workplace framing project to ensure the sustainability of healthcare services. It is anticipated the implementation of ratios will be supported by improvements in the clinical practice environment contained in the pending enterprise agreement.

Another essential component of the implementation of ratios will be the establishment of a robust and independent evaluation process. We understand it has recently been determined that this research will be led by the world renowned expert in the field, Professor Linda Aiken from the University of Pennsylvania. Professor Aiken's team will initially gather baseline data and then will evaluate the impact of the implementation of minimum ratios. This is the first time this exceptional team will conduct research in Australia and shows a real commitment to transparency and being evidence driven by all involved in this important policy initiative.

The legislation provides a cornerstone for the state government's commitment to improve patient safety by ensuring safe workloads for nurses and midwives. However, a number of opportunities exist to refine or enhance aspects of the legislation in order to increase the likelihood of successful and consistent implementation of ratios across Queensland Health. As outlined in our detailed submission to this inquiry, we would like the committee to consider providing greater clarity and certainty around the following issues: explicitly identifying those units captured by phase 1 of implementation and providing further direction around future phasing beyond those wards and facilities outlined in section 30(b) of the regulation; guaranteeing the maintenance of existing skill mix levels along with committing to supporting the application of contemporary nursing and midwifery research findings relating to patient safety and workload management, in particular, only direct-care nurses should be counted in ratios—nurse unit managers, nurse educators and other similar roles should not be included in the ratios; including consistency with respect to the legislation and industrial provisions relating to appropriate workload management; including consistent use of definitions and processes relating to operational compliance and escalation processes; incorporating provisions that provide the application of ratios to speciality areas such as mental health and midwifery along with futureproofing to support contemporary models of care and innovation; and providing further detail and direction around the evaluation of ratios implementation and subsequent public reporting.

In summary, minimum ratios will provide a reliable and enforceable workload management methodology for nurses and midwifes in Queensland public health facilities. Public reporting, ensuring adequate skill mix levels and focusing on patient outcomes will strengthen the implementation of ratios and provide a level of transparency not seen before in the health system. Incorporating ratios into the existing BPF will improve compliance with workload methodology through minimising complexity and maximising compliance.

The QNU regards this legislation as a historical commitment by the state government to safety and quality in health care. We applaud its introduction and will continue to work with Queensland Health to ensure it meets the needs of the Queensland public and the nurses and midwives who work so tirelessly to keep our health system safe. I would now like to hand over to Janelle Taylor, Lauren Picker and Moira Purcell, who will each make a short statement.

Ms Taylor: Good morning and thank you for inviting us. I am the nurse unit manager of the cardiology ward at Prince Charles Hospital and a QNU member. The ever-increasing organisational imperatives that are induced on a daily basis inevitably land on the nurses. As the largest healthcare workforce, we are where the buck always stops. On the whole, these obligations are designed to improve patient care and make hospitals safer places but, unsurprisingly, take nurses away from the bedside. This is where all the i's are dotted and all the t's are crossed. This is where we are audited and judged on our nursing care.

Patients will not complain that they feel ignored or scared. They see how busy nurses are and are reluctant to stop a nurse in flight because they need to ask a question or need some reassurance. Providing safe care is a minefield that nurses need to navigate each day. Patients are staying in hospital for shorter periods of time. Their care is streamlined. They go home quickly and often unpredictably. Current nurse-to-patient ratios do not support these contemporary practices. Improved ratios will mean that nurses are able to spend more time with patients and families, facilitate better patient education, better understanding of their conditions and prevention of readmissions.

The importance of job satisfaction cannot be underestimated here either. Every day nurses in our unit express concerns that they have not had enough time to provide their patients with the attention they deserve. This constant rushing means we cannot spend time with patients to answer their questions or deal with their anxieties. The inability to do our jobs as we know we should goes against the very nature of individuals who choose nursing as a career.

Before I came here today I asked my colleagues what would be improved in our work if nurse-to-patient ratios were improved. There was a common thread in their answers. Student nurses and graduate nurses would be better supervised and better prepared for their role as an RN as credentialed nurses would have more time for supervision and education. They would be able to consolidate their practice in a supported environment and ultimately be better practitioners. When off-the-ward nursing escorts or clinical emergencies tie up any number of nurses on a shift, safe workloads and patient safety could be maintained. These emergencies can leave clinical areas short of staff on the ground and pose risks to patient safety.

I want to finish by saying that a wise nurse academic said to me once, 'The only reason a person stays in hospital is because they require nursing care. Everything else can be done as an outpatient.'

Ms Picker: I was an enrolled nurse, but as of this week I am a registered nurse. I am here today to fight for safer working conditions for nurses and midwives. I currently work for the Darling Downs health service at the Toowoomba Hospital.

It is my hope that implementing nurse-to-patient ratios will improve the quality of care provided to patients by affording nurses the time to perform their duties to an optimal standard that is consistent with safe patient centred care delivery. The complexity of care has increased dramatically over the past decades. The prevalence of chronic diseases such as diabetes and obesity, the ageing population and substance abuse have placed higher demands on nurses. The acuity of today's patient is much higher and patients have a higher severity of illness which increases the intensity level of the care required.

One of my greatest concerns is seeing nurses finishing their shifts distressed and in tears, with the guilt of not being able to provide safe nursing care. Some feel they have been emotionally and physically damaged by the very system they work within. They will often stay behind to complete the increased amounts of paperwork now required. None of this takes into consideration the often high expectations that are displayed by some patients and their families in relation to their care, placing further undue stress on the nurse.

There is only so much we can do with the resources available to us. Unfortunately, it is the nurse who also absorbs the brunt of these related stresses. Nursing is a physically and mentally exhausting profession. We do our jobs out of love and compassion to keep our patients safe. However, we need the time to give quality care to each and every one of them.

CHAIR: Thank you and congratulations, Lauren.

Ms Purcell: I am here today speaking as a registered nurse with 35 years experience across a variety of ward and specialist areas. My last post, a hospital wide after-hours clinical nurse—a very busy and valued position—was cut as one of the 5,000 front-line nursing positions abolished under the previous government's severe and drastic cuts to health care.

I am also here to speak of my experience as a patient—once before the nursing and midwifery job cuts were made by the previous government and once after. As both nurse and patient I can say that in all my years of nursing I have never come across the horrendous workloads that healthcare workers and nurses in particular are currently being faced with. Across-the-board, nurses are stressed to breaking point and patient care is suffering dangerously as a result. Under the previous government 5,000 front-line nursing positions were abolished.

Why are nurses important? In hospital no professional spends as much time with the patient as does the nurse. A nurse assesses, plans, delivers the care required, monitors and evaluates. A nurse is the patient's advocate, ensuring that prescribed treatment orders are delivered safely and appropriately. A nurse often is the first to identify problems or be told of them by the patient. The nurse is then in a privileged and key position to liaise with medical and other allied health professionals.

Extreme pressures are being put on this relationship, to the detriment of the patients in our care. Because of the cuts, the service is running on adrenalin and in constant crisis management mode. This cannot continue. Nurses are burning out and mistakes are being made. There is no room or time for anything other than basic, routine care. Even this is compromised.

Nurses care; we want to deliver the best care. We often sacrifice tea, lunch and toilet breaks and work a considerable amount of unpaid overtime to keep our patients safe. We are often stretched so thin we simply cannot do this. Patients see how busy nurses are. They try to lessen our workload, often by withholding vital communications and sometimes by attempting to mobilise themselves, sometimes with disastrous and costly consequences.

Just last Friday I had an elderly, confused patient who launched off impetuously without his walker and still attached to the wall oxygen, knocking drinks et cetera over in his haste to get to the bathroom. Luckily, I was close enough in this instance to avert an inevitable fall. The increase in the elderly population exacerbates the overstretched workload of nurses, working under extremely pressurised conditions already.

What have the government's cuts done to this vital service? They have led to a cull of experienced nurses with many years of skill and knowledge. These experienced nurses are being replaced by new graduates, straight out of university, with little knowledge of the reality of the practical outworkings of nursing and few to mentor them. Aside from the danger to patients, the stress on these young nurses is unbearable. Many leave, unable to bear the strain. Recently I met a young woman who had left nursing to push people in wheelchairs at the airport. What a waste of the financial investment in university study and training.

Understaffed and overworked, the wards are now in crisis. Proper care is impossible. Proper monitoring and communication are impossible. Mistakes and dangerous outcomes are inevitable. The dam wall cracks where the stress is the greatest.

In working relations between team members, unsurprisingly team dynamics are often toxic. How do I state this with such certainty? I experience it every day I am at work. I, too, experienced it from a patient's point of view this time last year as I underwent my second knee replacement. The first I had had done prior to the government's cuts, and the difference in care was astounding. This last time, I experienced severe complications as a result of being discharged inappropriately and without the necessary checks. I actually had to manage my own readmission and my own management back on the ward. This current situation is untenable. We have to address this matter of workloads and registered nurse-to-patient ratios as a matter of urgency.

CHAIR: Can I thank each of you for your opening statements and say that what you have said mirrors much of what the committee has heard from nurses throughout the state, both in written form and in verbal form. I take this opportunity to thank you, Beth, and the Queensland Nurses' Union for the considered submission that you made to the committee, which has been of assistance in our deliberations.

I also take this opportunity as the chair of this committee but also as a member of this House and a member government, on behalf of my electorate, as the wife of a nurse and as somebody who has treated by nurses—not only do we have nurses in front of us but there are a number of nurses in the gallery—to thank you for the considerable contribution you make to the wellbeing of Queenslanders and for your service to our community. As a committee we very much understand that you make great sacrifices in the service of many sick people across Queensland.

Beth, I wanted to ask you a number of questions. If anybody else wants to throw in then that would be most welcome. There has been some criticism of the ratios in the legislation being considered—that they are too prescriptive and that having minimum ratios will mean that you cannot deal with emergent situations in the best way possible. Can you provide a response to that?

Ms Mohle: Yes, certainly. The thing we have to recall with regard to how we are approaching this in Queensland is that the ratios provide the floor—the guarantee that nurses really want that you will have no more than one to four on an early and a late and one to seven on night duty. The critical component is the BPF that is applied on top of that.

As I said in my presentation, that absolutely allows you to take into consideration the circumstances of a particular unit. Kate and Janelle might want to add some points. I know that Janelle has spent many years working out what is known as the service profile, which is part of the BPF. It is done every year. You review what has changed in terms of the service that has been provided.

This is a belt and braces approach, having the guarantee. That is what our members want. We have had reports from our members who say that they literally call the night before to find out what staffing is on because they are so concerned that there are gaps on the rosters and people will not be coming in. They are so distressed that they will not have the bare minimum required to provide safe care.

The BPF, applied in conjunction with the ratio, is what will add the nuance. For example, areas such as intensive care or speciality areas such as paediatrics will have much higher ratios than one to four. They might have one on one, one to two or one to three. The BPF works all of that out. It actually provides not only staffing numbers but also skill mix and takes into consideration other factors such as technology and the like.

We already have a robust methodology that is available. The difficulty with the BPF is that it has been inconsistently applied. That is the problem. That is why we need the guarantee. We certainly do find that when budgets get tight chief financial officers come in and they actually adjust the BPF according. The poor nurse unit managers will work up a very detailed document saying, 'This is what is required to safely deliver care for this unit for the coming year,' and more often than not it is adjusted because of financial considerations. That is why we think it is so important to have the guarantee of the ratio and the application of the BPF on top of that.

As I said before, there is nowhere else in the world that has this sort of approach. We are unique. We are very well served by the fact that we have jointly done that work over 10 years ago in developing that tool. The difficulty is not with the tool—it is robust and sophisticated. Even chief financial officers have given it the tick in terms of its robustness. It is a lack of applicability across-the-board that is the problem with the BPF, not the tool itself.

Ms Taylor: I would like to give a personal example of what has previously happened with the BPF. Up until about the last three years I wrote a service profile every year for maybe the last 10 or 12 years and I was the only one who read it. That was until the last three years. I have a very good business manager now. Last year when I sat down to do the budget with him, I told him what I needed. He said, 'There is no way you are going to get that.' I said, 'I am telling you that I want you to submit what I have asked for and then I will take up the fight.' He clearly could not fight for it.

One of the biggest problems that I find is that from Monday to Friday between the hours that I am there things are okay. Nobody will try to challenge my clinical judgement about how many staff I need. The minute I walk out the door, for the other two shifts a day plus all weekend, the bullies appear to come out of the woodwork and try to force unrealistic nurse-to-patient ratios onto the staff in the wards because they do not have anyone to support them.

Having a mandated nurse-to-patient ratio would mean that nurses who are in charge after hours and on the weekends would also have something to back up the BPF to say, 'We cannot possibly accept any more patients.' It would give them the evidence to use when the bullies come out and say, 'Just take on more work. You can do it. What is one more patient? What is another patient?'

My personal experience has always been that—we have had the BPF for a very long time. One of the business managers actually said it is just a guide. They are never on the floor. They do not have any idea what it is like. Because people are so committed to looking after their patients and getting their work done, the things that suffer, as Moira said, are toilet breaks, lunch breaks and meal breaks. Up until six months ago I had three nurses on night duty for the whole time that I have been the NUM of this ward for 30 patients. Just in the last six months we got an extra staff member on night duty. Prior to that, I was forcing the nurses to record every shift on which they did not get a meal break. They were saying to me, 'Janelle, we don't care about the overtime. We need that break. We need to get off the floor.' It was never about the money; it was just about the constant workloads, and they have increased so much and we have not caught up with the increases.

CHAIR: Janelle, something you said then leads into my second question and that was mentioning clinical judgement. I have a further question around mandating ratios. Criticism for doing so has been that it takes flexibility and decision-making from the floor or ward where it should be and it should be based on clinical judgement and actually giving a prescribed ratio which reduces the ability for that clinical judgement to be used. What would be your response to that criticism?

Ms Taylor: My response to that would be that the ratios are already better than what we have for a start. Secondly, it is very difficult to find people who understand and adhere to the BPF now. I feel that the nurses would be empowered enough to speak out if they thought there were too many patients allocated. I think there would be an opportunity—like Beth was saying about intensive care and coronary care, the ratios are going to be higher. If we ever have to have a nurse-patient special or something like that, it would have to be in addition for patient safety reasons. Clinical judgement should always be something that is put above anything. Even with the BPF, your clinical judgement still overrides that.

CHAIR: Beth, of all of the nurses that you have contacted or spoken to about the proposed legislation, how many have indicated they are opposed to it?

Ms Mohle: I have not heard from any who have indicated opposition. We have been inundated by member feedback to say this is so overdue. As we have provided to the committee, we have received a cross-section of around 700 submissions from members to say what a difference it would make to their daily working life, how it would keep them in nursing and midwifery, the professions that they love. I have not been made aware of any people who oppose it.

CHAIR: I would concur with that. The committee has not heard from anybody as part of these deliberations, either, but I wanted to ask.

Dr ROWAN: Thank you to all of you for the submissions today, particularly to you, Lauren, for achieving your registered nurse status. Congratulations as well. I will go to you first, Beth, just talking about the current proposed ratios of one to four in the mornings and one to four in afternoons and one to seven in the evenings. What are your views about whether they are the right numbers, or should it be one to three, one to six, one to five or one to eight? Specifically, do you have any comments around the numbers themselves?

Ms Mohle: Certainly it is the case in California, for example, that they have one to four on all shifts—mornings, earlies, lates and night duties. That is what happens in Victoria. This is what has been demonstrated from the research done by Linda Aiken and her team. That is what they have evaluated it on: the basis of one to four, one to four and one to four. We have made an adjustment to that based on our research, too, in terms of the experience interstate, in Victoria and New South Wales. That is the really critical component of actually having the evaluation process that we have factored into this. We are not assuming that one to four, one to four and one to seven is necessarily correct. That is why we are so excited about having Professor Aiken's team come in to take the baseline before 1 July and then to do the evaluation. We are absolutely committed to being evidence driven on this. That is why the evaluation and research platform is so critical.

As I said before, if more than one to four, one to four and one to seven is necessary, that is determined by the BPF. I might hand over to Kate Veach to add some comments in relation to the numbers.

Ms Veach: In terms of the one to four, one to four and one to four that is used in California, research has shown that the one to four has provided the best in terms of reduced mortality rates as well as reduced adverse events for patients when compared to other rates such as one to six and one to eight. The variability in health care in terms of nursing hours per patient is quite extensive. It is not just happening here in Queensland; it is happening in other countries across the world. Linda Aiken's work has proven that in the NHS, which is something that we often compare ourselves to, there is a ratio difference of one to 5.2 patients all the way up to one to 10.7—I think her work has shown—with a mean being around one nurse to 7.8 patients. She has had the opportunity over that time to look at the distinguishing differences between the ratios and the outcomes for patients. The work has shown that, in terms of a one to four, not only does it provide the best patient mortality rates but it also provides reduced adverse events, increased staff satisfaction and decreased burnout.

There is also a level of affordability around that level. Obviously, Dr Rowan, you could look at going underneath the one to four in particular areas and, as Beth said, we are very open to the evidence coming in and telling us what the experience here in Queensland will be. However, we already know that there will be some areas around our critical care areas, paediatric areas and oncology areas that require a different ratio. I think the beginning stages of one to four, one to four and one to seven are a really good start. It aligns us to what is happening in Victoria and New South Wales. It also aligns us with what some of the international evidence is saying. With the evaluation happening here, it will only go towards adding to that lovely world-wide evidence that is gathering around what is the right ratio in particular circumstances.

Dr ROWAN: My next question is around the business planning framework, and I understand at the moment that process is being used to adjust staffing for patient acuity and complexity. In your experience, is the current business planning framework process an effective mechanism to adjust nurse staffing so as to factor in differing acuity and complexity, given that that will be the mechanism that not only continues into the future but also has been used until this point in the absence of ratios? Can you tell me a little bit about your experiences with that?

Ms Mohle: I will start off with an answer and hand over to Kate, who is somewhat of an expert on the BPF. The difficulty has been, as I said before, that it has been inconsistently applied. It has been evaluated—we are now up to the fifth edition of the BPF and it is continually refined and enhanced with each edition. The problem is the fact that some people think it is optional, even though it is industrially mandated. That is the problem. The problem is not with the tool; it is with its application.

As part of EB negotiations that we are currently involved in as well, we have been focusing very much on ensuring that things like the escalation process when there is a difficulty around maintaining safe workloads is improved and that we actually are enshrining the steps that were outlined in the BPF in our industrial instruments so it is much clearer. We have been doing a lot of really intensive work over the last 12 months on improving and streamlining the manual that goes

with the BPF in preparation for the implementation of ratios because they go hand in hand. We do not want to have any inconsistencies with what applies in our industrial instrument as opposed to what is contained in the act, the regulation and the standard that will apply. Kate might want to add some more points to that.

Ms Veach: With consideration of the business planning framework, we have had it around for a very long time. As Beth said, it has been improved and that is a process that will continue into the future. I suppose the value of the business planning framework is that it is a bottom-up approach, and I mean a true bottom-up approach. It is done at the ward level with the nurse unit manager or the midwifery unit manager in charge of the process. It is done in consultation with nurses and midwives on the unit as well as some of the other specialty services that might support what we do, because we do not work in isolation; we work in integrated teams and we provide services with other disciplines.

The environmental analysis that is undertaken within the service profile, which involves an internal environmental analysis which looks at HR processes and a whole range of things that are happening within the internal environment, also looks at the external environment—about what is happening in legislation, policy and what is happening with the economic environment. It is quite a comprehensive tool. It allows nurses and midwives at the coalface to look at what they need and to be part of that, so they are brought into the process right from the beginning. I suppose that is what is disappointing when I hear what Janelle was saying. This takes a lot of time. Anyone who has done a business plan would know it is not an easy process; it takes a bit of time. You put in all the work and sometimes because of budgetary requirements and austerity measures it does not quite happen the way that you think it needs to happen.

In terms of the business planning framework, yes, it is a very important part and it works really well in terms of working in conjunction with an instrument like the ratio, which will provide a floor. There is something else above all of this and that is our professional judgement. Our nurses and midwives award here in Queensland validates the use of professional judgement as a good criterion for judging what you need in your unit or ward. If you are in a situation whereby you have your business planning framework and you have your service profile that has denoted a particular ratio for your unit and you are finding yourself in a bit of a distressed situation, either with maybe a decrease in skill mix or an increase in patient acuity, it still comes down to the professional judgement of the nurse or midwife to make the call about what is safe for that unit. Nurses and midwives do not make that call by themselves; they make it in conjunction with their team members. Sometimes those team members will be from other disciplines as well. It is not a tool that will exclusively make nurses and midwives the people in charge of what they do. Of course, they are in control of their work, but it is an instrument by which we can collaborate with other disciplines as well.

Dr ROWAN: In relation to unintended consequences, one of my concerns in relation to mandated ratios is that in some individual hospital and health services managers, chief financial officers or others might use the minimum ratios as maximum staffing within their business planning framework processes. Do you have any comments around that?

Ms Mohle: Yes, we certainly do. That is I think one of the strengths of actually having ratios in conjunction with the application of the BPF. The one to four could soon become all you are going to get, even though you might demonstrate that you need one to two or one on one. That is why it is so important that you cannot separate the BPF from the ratio, because the BPF will give you the evidence that is required to actually show that you need more than the one to four. It is a belt and braces approach. As I say, other jurisdictions in the country do not have that methodology. That has been validated again and again and it has been in place for over a decade. The difficulty has been not with the tool but with its proper application.

Dr ROWAN: I have just one final question around your views on mandating the skill mix of nurses in all clinical areas—RNs to ENs. What are your views on that?

Ms Mohle: What we are seeking is to have a baseline taken as at the time prior to the implementation ratios and to ensure that we do not go beneath what currently exists. We think that is something that needs to be factored into the evaluation process in relation to the work that Professor Aiken and the team is going to do. That is the view that we have. Kate might have something to add.

Ms Veach: We are pretty fortunate here in Queensland that we have quite a rich registered nurse skill mix already. We have just under 84 per cent registered nurse skill mix. Unfortunately, most of that sits here in our south-east corner, as we see with some of other clinical disciplines as well. I think it is really important to understand the recruitment and retention issues that are experienced in our regional and remote areas. Having a baseline would allow those areas to establish something

that they do not ever want to fall underneath again and they have an objective in terms of a workforce plan to try to improve as natural attrition and other processes occur if they expand. We should be very proud of the 84 per cent skill mix. It is something at which Queensland has done very well.

Mr HARPER: Can I just start by echoing the chair's earlier comments. I thank each of you for your contribution today and for your contribution to your profession. You have a lot of supporters, quite obviously, in the public gallery. From a fellow healthcare professional—I will declare 25 years as an intensive care paramedic—I know that nurses are the backbone of the healthcare system in Queensland. I just want to acknowledge the fantastic contribution you do each make in your profession.

We have heard it. The evidence is in. Wherever we have been, whether that be in Victoria where the ratios have been introduced, or through the regions, increasing the nurse-patient ratio will have a positive effect on decreasing the length of stay, on increasing morale importantly, and decreasing the fatigue, as you have articulated today. There was some emotion evoked from the Townsville hearing—my home town—where a nurse of 35 years, very similar to you, could articulate some of the burden of worry and stress when they could not fix something, or where an adverse event happened. Can any of you touch on any of that in your experience? I am not trying to evoke emotion here, but it is really important to get the warts-and-all story—the facts. If you have seen something where you believe that nurse-patient ratios, or mandating the increase in numbers, would make it safer, can you give us an example?

Ms Taylor: I will refer to the night duty again, because that has been the biggest issue for us. I work in a cardiology ward. We have the busiest cath lab in Australia, I think. We do not get a lot of patients back to the ward until 10 o'clock at night when the cath lab staff go home. One particular night I can remember—I think it was last year or the year before. We had an elderly gentleman in a single room who was in his 90s, but spritely. He lived alone. He was doing really well. He was going home the next day. As usual, the cath lab closed at 10 o'clock. All of the patients roll out of the cath lab into the ward right on handover time. Then we also get admissions from the emergency room. It was an hour and a half after the shift started before the nurses got to do the round because of everything that had happened and this gentleman was found on the bathroom floor. He had been cleaning his teeth. We do not know how long he had been there. No-one could get near them. It is often these kinds of things that you hear about night duty, particularly when you are on skeleton staff—one nurse to 10 patients on night shift. I do not think you can undervalue the implications of having a high patient ratio on one shift—how it carries on to the next shift as well. It impacts on the whole day if you have something like that. The difference in our workloads that just getting the extra person on night duty has made is unbelievable.

Ms Purcell: I can give an example that happened just yesterday. We have a lot of new graduates. In the time that I have had off, which was only eight months between my two surgeries, there has been a complete and utter turnover on the ward and I would say that 80 per cent of them are now new graduates. Yesterday it was pointed out that some vital observations had not been done. We have patients on prostacyclin infusions—continuous infusions—that are needed to maintain their heart function. That infusion cannot stop by any equation. They have to have a spare pump beside them so that if there is any problem suitably qualified staff can change it over immediately; otherwise it becomes a life-threatening situation for the patient. It is very important that we maintain observations, both of the patient and of the equipment, to make sure that everything is functioning as it should and delivering the drug at the rate that it should be done. Because of the high number of new-graduate staff who were unfamiliar with the importance of this drug, vital observations were missed and vital documentation was missed as well. In this instance, luckily there was no adverse patient effect, but it is good luck rather than good management. Senior staff on the ward now to mentor these young graduates and new staff are missing. It is just a disaster waiting to happen.

CHAIR: I will just give Lauren a brief opportunity. I do not want to cut short your opportunity to talk about your experiences, but if you could make it brief. I am just mindful of the time. Thank you.

Ms Picker: I will just reflect on my afternoon shift yesterday where I had an anastomotic leak. He was placed on the emergency theatre list. I then had a post-op patient. I then had a patient who was on an insulin infusion, which requires hourly blood sugars. I then had another patient who required two bags of blood who also had a fall that evening and required an IDC insertion. So that is five. My sixth patient had a rectus sheath infusion, which required lots of pain relief and had a drain in situ and an IDC on hourly measures. So I had a very stressful shift. That is the stuff that we have to deal with regularly. Thank you.

CHAIR: I am just mindful of the time. We have an academic who is going to teleconference in to give us some evidence and she is time constrained. Can we pass to the member for Mudgeeraba to ask her questions and then do that teleconference. Are you able to stay so that our remaining members can ask you questions? Thank you very much.

Ms BATES: Thank you for attending today and for your presentations. One of the issues that has been raised as we have been travelling around the state, and in submissions as well, is that lower nurse-to-patient ratios have virtually no effect on hospitals that have a poor work environment. Would any of you like to comment on that—even if you had a nurse-patient ratio to increase safety? If there are intrinsic issues—I think Janelle mentioned people being bullied after hours, after you have gone—do you think the nurse-patient ratio on its own is going to make a difference if we do not change the culture in hospitals?

Ms Taylor: In our organisation we are fairly lucky. I do not think we have any issues that are significant. What I mean by 'bullies' is that, when you have a duty nurse manager who is sitting there and who has an ED full of patients, they are going to take whatever route they can to deal with what is in front of them at that particular time, not really being able to grasp what is going on on the floor. I would hope and I would like to think that—and judging by the amount of feedback that I get whether I want it or not—the nurses in our area are particularly empowered and feel strong enough to speak up.

The only way I can say this is that most nurses at the moment have trouble getting out of the day that they are in. I find that everyone will commit their eight hours to doing their patient care. They will be at the bedside doing their patient care. Their documentation and everything else that they have to do is happening in their own time after hours. I think increasing the nurse-patient ratios will probably give people time to breathe. In situations where you are saying that there is a bad culture, I think the culture is coming from the fact that they are just struggling to get their work done. I have had nurses say to me, 'I can't come to work tomorrow. I can't do this again tomorrow,' and have taken sick leave, saying that to me—and I am their manager—'I can't do this again tomorrow.' I think the culture is probably coming from the overwork rather than the other way around.

Ms BATES: You also mentioned some of the processes. There are other external factors that affect your workload—things like you mentioned, patients coming out at 10.30 at night from the cath lab. I have had nurses talk to me about surgeons still operating, knowing that they do not have an intensive care bed and then the least sick patient is put out into the ward and then you have adverse patient outcomes. Apart from just the nurse-patient ratio, do you believe that there are other factors in your day-to-day workload that need to be addressed as well to make your job easier so that you do not have patients in unsafe circumstances due to other processes?

Ms Mohle: I will take the question first and then hand over to the others just to highlight the fact that this is exactly the issue that we are concentrating on in our EB—the environment, the context that we are operating in and how we improve the culture and the environment to support the proper application of BPF. It is acknowledged that there is work that needs to be done, but it starts in adopting an interest based problem-solving approach across teams, too. It is not only in nursing. As you highlight, so many things that impact upon nurses and midwives are as a result of what other occupational groups might be doing. So we need to really home in on that. That is something that we are concentrating on in our EB negotiations right now. I will hand over to the others for comment.

Ms Purcell: Can I just say that, having worked at a number of hospitals around the Brisbane area and in the UK, Prince Charles Hospital had a higher staff-to-patient ratio when I first started working there 14 years ago and that was maintained right up until 2012. It was the happiest hospital that I have ever worked in and everybody knew that to get to work at Prince Charles was a really good achievement, because it had such a good reputation. In 2012 everything changed. With the increasing pressures that staff are under now—everybody, not just nurses; it goes right across-the-board from the kitchen staff, the wardies, right up to the medical staff—it has affected everybody's interpersonal relationships. The working environment has become unpleasant and it was never that way when there was good support and good ratios.

CHAIR: Thank you very much. We are now going to see if we can get Professor Duffield on the teleconference. You are welcome to stay there and then we will resume your questioning, thank you.

DUFFIELD, Professor Christine, Professor of Nursing and Health Services Management, University of Technology Sydney and Edith Cowan University (via teleconference)

CHAIR: Professor Duffield, thank you very much for appearing via teleconference before the Queensland Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. Just to give you some context, you are appearing before the committee. All of the members are here with me now. You are speaking to Leanne Linard. I am the chair of the committee and the member for Nudgee. We are in a large chamber, so I apologise if the sound is an issue for you. We have a public gallery with many nurses present and the Queensland Nurses' Union present as well, who have just been appearing before the committee.

Thank you for your submission to the committee. We very much appreciate your expertise and I have your submission here in front of me. I also very much appreciate that you would appear before the committee to add to that submission. I just wanted to give you an opportunity to make an opening statement and then there are a number of questions that the committee has. I appreciate your time is very valuable and you need to go by 11. Would you like to make a brief opening statement?

Prof. Duffield: Yes, I am happy to do so. Thank you for inviting me to speak. You have now probably heard a lot about nurse staffing, so I do not need to teach you how to suck eggs but there are some important aspects that, certainly in the past few years, have come to light in staffing. The first is the number of staff that we have and that is, of course, what nurse-to-patient ratios is about. That is critical. Equally as critical is the skill mix—the proportion of registered nurses to other staff. If I had to pick one, I would probably pick that as slightly more important than numbers. I could put all of you, including the visitors sitting in the public gallery, onto a ward and we might have the right number of staff, but would we have the right mix of staff? No, because many of you would not have a clinical background. Therefore, skill mix becomes critical.

The third aspect that is increasingly more important is the work environment. With work environment, I think we need to put it into a context of what we mean as researchers when we use it, because there is a particular tool that we use that measures five different domains. The one that we have found most significant is the leadership on the unit and the leadership in the hospital, particularly nursing leadership, and resource adequacy. In staffing there is some science—and I have given you some evidence of some of the science—and then there is the art of nurse staffing, which is how you assign staff to which patients or which patients to which staff and how the nurse or the midwife in charge of the unit creates an environment that is positive for the staff working there. It is an art and it is a science. We can talk about the science and we can legislate for that. The art of nurse staffing is a bit more difficult.

CHAIR: Thank you very much for those comments.

Dr ROWAN: Thank you, Professor Duffield, for appearing today. I want to come to measuring the clinical and cost effectiveness of mandated nurse-to-patient ratios and midwife-to-patient ratios. Obviously, from a workload perspective and a job satisfaction perspective, there has been evidence given that mandated ratios would improve those metrics; however, when it comes to improving clinical outcomes or patient outcomes, I wanted to get a sense of your evidence related to all of those other factors that come into the mix. You have already alluded to skill mix but also design, equipment, information technology and management structures. What roles do those things play above and beyond a mandated ratio?

Prof. Duffield: You want to know about things like design and technology and how they impact on patient safety, as well as ratios?

Dr ROWAN: One of the premises for the introduction of nurse-to-patient ratios has been that it will improve clinical outcomes, in other words patient outcomes. I want to understand, through your research and the evidence that you can provide to the committee, how much of that is a factor versus all of the other things around skill mix, design, equipment, information technology systems and management structures, leading to improved outcomes for patients.

Prof. Duffield: The research, both in this country and internationally, is absolutely on the same page. There is no doubt that nurse-to-patient ratios improve patient outcomes. That is really a bit of a no-brainer. There is no question about it. Every single piece of research ever done in any country, including now increasingly in the Asia-Pacific area, indicates that the more patients a nurse has the less good are the patient outcomes. That is really related to surveillance. If you have eight patients to look after and you have to provide surveillance for those eight patients, that is a much more difficult issue than providing surveillance to four patients. That research is done in so many countries and we

now have integrated reviews and meta-analyses that indicate the same across the country. I do not think there is any question about that. There is also robust evidence about skill mix, so I think those two are absolutely definitively defined in the science.

In terms of design and some of the other aspects that you asked about, there is less research on that. Certainly there are other aspects of what is happening in health systems that impact on staffing that, to date, probably are not as well researched. For example, I have a student who has just finished her PhD and demonstrated that the number of patient transfers on a ward averages about four—that is, each patient is moved about four times between wards. That is a significant churn factor that certainly impacts on workload and will have an impact on outcomes. There is some research on what the outcomes for that are, but it is less definitive at the moment. I am not sure if that answers your question, but hopefully it does.

Dr ROWAN: To further clarify, regardless of leadership and management structures, culture, IT systems, equipment or the physical design, having ratios and looking at skill mix—you are saying there would be an improvement in clinical outcomes for patients?

Prof. Duffield: Absolutely. The role of leadership is certainly significant. Have we absolutely tied the role of the nurse or the midwife in charge of the ward to patient outcomes? Yes, we have, because when we talk about work environment one of the subskills and the tool that we use is leadership, and it is the leadership at the ward level with a little bit of what certainly comes from the hospital type leadership. We certainly have made links between higher scores on the leadership subscale and patient outcomes. Leadership certainly is important. The other features that you have mentioned I cannot speak to because I have not looked at them in my research, but there is less research done in those areas because the big-ticket item is to get two things: the right numbers of staff and then the right mix.

Dr ROWAN: Just to add in all of those other things and measure the effectiveness, given that one of the recommendations being considered is to measure the clinical and cost effectiveness of this over a period, are there any specific recommendations that you would have that we could consider for that type of research and how that should be done, captured and reported upon?

Prof. Duffield: There is some Australian work done on the cost of the nurse-sensitive indicators. There are some Australian costs. I think, from memory, in the evaluation some of that was certainly going to be picked up. That is a significant aspect. There was some modelling done in Michigan, probably 10 years ago now, because they went through the same argument about ratios. They modelled the projected increase in staff that would have to occur with the introduction of staff against the costs of the adverse events that would go down because there were nurse-sensitive indicators. It is a while since I looked at it and I cannot remember what the breakpoint was, but it was something like within one to two years the increased costs of staffing were more than met by the decreased costs of adverse events.

Dr ROWAN: Would you have a copy of that or would you be able to access it so that the committee could look at that health economic information? You can take that on notice.

Prof. Duffield: One of the documents you would have, because Di Twigg has given you the article on the Australian costs. I would have to dig out the Michigan one. I would have to have a look for it. It is a long time since I have seen it, but I will have a look.

Dr ROWAN: Thank you, Professor Duffield.

Mr KELLY: Professor Duffield, thank you for your contribution to nurses over many years. I am a registered nurse myself but, sadly, as a hospital trained nurse I did not get the opportunity to be involved in research until later in my career. I greatly appreciate the opportunity to talk to any nursing researchers. I am not sure, Professor, if you had an opportunity to read the other submissions that came before our committee?

Prof. Duffield: I have read the Queensland Nurses' Union one, yes, and certainly I have spoken to Di Twigg, because I am sitting at Edith Cowan as we speak, but that is all I have seen. I have just come back from overseas, so I do apologise.

Mr KELLY: Please give her our regards. It was great to meet her in Western Australia. I know you have been through this with Dr Rowan, but I want to be very clear: other submissions have indicated that there is no research that links nursing ratios to better patient outcomes. In your professional opinion as a researcher of many years experience, the research is very strong and supports the theory that patients will achieve better patient outcomes if we have lower nurse-to-patient ratios; is that correct?

Prof. Duffield: Absolutely.

Mr KELLY: You talked about three things: leadership, ratios and the skill mix. Are you suggesting to the committee that all of those things need to be in place to achieve better patient outcomes?

Prof. Duffield: Yes. Nurse-to-patient ratios are the first step. You need to get the right number of staff and then you would need to ensure we do not follow the UK model where, yes, we might have the right number of staff but more than half of those are unregulated workers, which is how we ended up with the Francis inquiry. You need the right mix of staff. I can demonstrate from our research that if you do not have a good nurse or midwife in charge of the unit to organise those resources then, no, you will probably find yourself with some adverse events. There have certainly been attempts in this country and in other countries to say that we do not need a nurse in charge of the ward and that we can have a business manager, because really there is very little decision-making that is required. We have gone down that road in this country and every once in a while it raises its head again. That would be absolutely fatal. The same would be true of not having a director of nursing responsible for the whole of the nursing service, because somebody needs to understand what is actually happening down at that clinical unit.

I think we have a sense perhaps that staffing this ward is the same as staffing that ward, because these are medical patients and those are medical patients but they are not; they are different patients and they are different staff. I think one of the critical things that is different between nurses and doctors is that doctors follow their patients around the hospital. Nurses are on a ward and whichever patient goes to that ward is the patient the people they must care for. That requires a different set of skills, because they may not be in that clinical specialty; they might be an outlier. That requires judgement from the person in charge of the ward. Yes, we may have a one-to-four ratio on this ward, but it may be that you have five patients because of they are less ill and I have only three and in the end we still balance out at one to four. That is the clinical judgement that is required of the person who is in charge of the unit.

Mr KELLY: So ratios do not interfere with that clinical judgement?

Prof. Duffield: No.

Mr KELLY: Do they facilitate it?

Prof. Duffield: They are only a floor. Unfortunately, they sometimes act as a ceiling, but they are only the floor beyond which you cannot go in staffing. That does not mean that you may not, because of clinical need, need more staff on this particular shift or on this particular day. They should always be considered the floor, not the ceiling.

Mr KELLY: When you talk about skill mix, you are not just talking about putting together a list of letters such as EN, RN, CN or whatever on the floor. You are actually looking at the relative skill mix within those groups as well. Two RNs are not always necessarily going to be the same. Is that where you are suggesting we need that local leadership?

Prof. Duffield: That is exactly right. When I talk about skill mix, I am talking specifically about the proportion of registered nurses to all other staffing. That is quite right: the notion that a registered nurse is a registered nurse is a registered nurse is not true. That would become part of the clinical judgement of the nurse or the midwife in charge of the unit: 'What patients can I safely give to this nurse?' as opposed to 'What patients can I safely give to that nurse?' and how many are those, bearing in mind that for my ward the ratio might be one to four or one to three or whatever is determined.

Mr KELLY: What about ratios helps us to move towards a point where we get the skill mix right, to improve the skill mix?

Prof. Duffield: Ratios do not give you the skill mix but my understanding is that the BPF does. I certainly know in the Victorian legislation they have mandated a skill mix that does not go below 80 per cent registered nurses. You are quite right: ratios do not give you the skill mix. They do give you the numbers, which is a starting point.

Mr KELLY: This is my final question, as I have been told to wrap up, which is sad for me. There is the notion that an RN is not an RN and an EN is not an EN. To my mind, what separates different RNs is the level of development and support that you have had over your career. How is that facilitated by improving staffing ratios?

Prof. Duffield: If you have the right number of staff and the right mix then you will have a balanced workload and staff will be more satisfied in their jobs. There is a very strong link—and there is Australian evidence but also overseas evidence—between job satisfaction and intention to leave. Job satisfaction has an impact on intention to leave which also then translates into turnover. I think in

our study here the cost of replacing one registered nurse is something like $49,000, so it is not an insignificant cost. If you have more satisfied staff, they are more likely to stay. If they are more likely to stay, you are less likely to have staff turnover, which we have already demonstrated impacts negatively on patient outcome. It is a chicken and egg situation.

CHAIR: Professor Duffield, my apologies. It was remiss of me when I introduced you not to introduce your position. Professor Duffield, you are the Professor of Nursing and Health Services Management at the University of Technology Sydney and Edith Cowan University.

Prof. Duffield: Yes, I am.

CHAIR: You obviously work closely with Professor Twigg, whom my colleague mentioned we met recently when we travelled to Perth and Melbourne to look at what they are doing in those jurisdictions. Her evidence, as yours, has been very beneficial to the committee and will be of great assistance to us in both crafting our written response and also our responses in the House during debate on the bills. I thank you very much for your time and your expertise in this area.

Prof. Duffield: Thank you.

MOHLE, Ms Beth, State Secretary, Queensland Nurses' Union

PICKER, Ms Lauren, Registered Nurse, Queensland Nurses' Union

PURCELL, Ms Moira, Registered Nurse, Queensland Nurses' Union

TAYLOR, Ms Janelle, Registered Nurse and Midwife, Queensland Nurses' Union

VEACH, Ms Kate, Professional Research Officer, Queensland Nurses' Union

CHAIR: Thank you very much for your patience. I now invite the member for Greenslopes to commence his questioning.

Mr KELLY: I have been waiting patiently for the opportunity to ask you some questions. I welcome you to parliament as professional colleagues and I acknowledge all of my professional colleagues in the gallery. Lauren, congratulations. In my experience as a nurse you meet many people who start as AINs and ENs and move into very advanced positions in their career. It is an important step for you. You have spent a lot of time learning the theory of nursing. You have learned many idealised things. You probably have a fairly good picture in your mind of what it means to be a registered nurse and to deliver best practice care. Given the current workloads, how do you feel you are going to be able to meet the guidelines of meeting best practice care?

Ms Picker: As an enrolled nurse, I have always worked within my scope as an enrolled nurse. Now that I am a registered nurse there is a higher expectation on me. I have found it hard to access education at this stage. When educational days have been booked in, I have been called off and put on the floor due to staff shortages. I am very keen and willing to upskill, but I have found it difficult to do that.

Mr KELLY: I wanted to talk about the scope of practice questions. When you were talking before, you said that yesterday you had six patients. Obviously you were still working as an enrolled nurse then. Over your career as an enrolled nurse or even when you have been a student doing placements on the wards, have you found that the staffing levels have made it difficult for you to seek the support from the registered staff that you felt you needed as either as an EN or as a student nurse?

Ms Picker: Yes, definitely because they are very stressed and they are spread thin. When I was a student I have been left sitting at the desk while they have had to go and deal with things, because having a student and trying to teach them in an emergency situation just was not going to happen.

Mr KELLY: My next question is for any of the three of you there. I want to talk about some specifics and practicalities around what the ratios might mean. I think about something that we do every day, like skin care. I am a little out of practice at the moment, unfortunately. On a regular day you would need to assess a patient's skin. You would like to be able to do some education on a daily basis. You would like to be able to, as the research suggests, moisturise twice a day. Particularly with older patients, you will have people who get skin tears that require dressings et cetera. All of those things take time. Given your current workloads, how often do nurses in your experience get to do all of the things they need to do around an issue like skin care?

Ms Taylor: As I said before, as you know, nurses prioritise patient care as the most important thing. It is actually the meal breaks and getting home that suffers. I would hesitate to say that people are not doing their work. It is that they are just not getting out of the door for an hour after their shift finishes because that is when they have to do the paperwork, write their reports and do the computer work.

Listening to the dialogue about skill mix, I would like to say that it would be great to have a ward full of experienced people to look after patients, but that is never going to happen in the real world. It is a very unlikely scenario because eventually everyone has to retire at some point. We try to aim for the best skill mix that we possibly can. I think we do pretty well in most cases. It needs to be pointed out that if we have better ratios we will not be losing a lot of skilled nurses because the skilled nurses are the older nurses and they are the ones who are finding it hard to keep up with those workloads. I think skill mix and the ratios work hand in hand there. People are not going to be walking out the door because they cannot keep up with the pace any longer. I wanted to say that because of the dialogue that has been going on about skill mix.

Mr KELLY: Moira, you have come from being in a specialist role to moving back to being a registered nurse, as you outlined in your evidence. Have you come across situations now, because you have been operating at a more advanced level, where you have come back to being an RN and you have seen opportunities for quality improvement or to apply research that you are aware of that have been frustrated by the workload that you are dealing with?

Ms Purcell: I have been struck by how much my colleagues have suffered from not having the extra support. In the role I was in, we dealt with hotspots all around the hospital. Staff were able to call on that resource to help them. That is gone. I made an inquiry of my nurse unit manager recently as to what research activities were going on in our unit. He said that really there was nothing at the moment because time just did not allow it. This is what I mean. We have gone back to just complete and utter basic care, and even that is not always being met to the standard it should. There just is not the scope for any in-depth research at the moment.

Mr KELLY: Something struck me, Janelle, in your evidence. You talked about the unexpected discharges. Certainly that has been my experience over the years—having six to eight to 10 patients, trotting along and working out your plan for the day and suddenly you are told three of them are going home and you have to have them in the discharge lounge in half an hour. How does that impact on your capacity as a registered nurse or a clinical nurse or an EN to do patient education prior to discharge?

Ms Taylor: It has a huge impact. Often the patient is gone before we even know. We have a 30-bed ward. It is not unusual for us to have a turnover of between 15 and 17 patients in a day. We also have this added delight where, because we are constantly full of patients—we never have empty beds—on an evening shift the nursing director and the doctor in charge do a round and identify patients that can be moved out if the emergency room becomes full and we have to make a bed. We worked out that to move a patient out of the ward takes an hour per patient and sometimes we have to do that for two or three or four patients on an evening shift when we are already on reduced staff. That is a new one that has just come up in the last year that has had a huge impact. Often the next day we get those patients back again because the surgical wards do not want them, so we start all over again.

Mr KELLY: Often the bully that you referred to before is the person with greater needs lying in the emergency room demanding that bed. In general, how important is discharge planning for patients and what impacts does it have if we do not get to that? If we prioritise ABC, E does not come into the equation.

Ms Taylor: I do the discharge planning because no-one else has time. I do the discharge planning. I do the interhospital transfers. I do everything. I do the ambulance bookings because nobody else has time.

Mr KELLY: If we do not get to patient education, readmissions are likely and complications are likely.

Ms Taylor: And sometimes even when we do get to it.

Mr KELLY: As a nurse unit manager, you must be able to spot quality improvement activities that you would like to do or you must have clinical nurses or registered nurses or enrolled nurses saying, 'Here is a way we could improve our practices or improve our ward.' Do you find yourself in a situation where you see lots of great ideas but you simply cannot pursue them because of the workloads?

Ms Taylor: Not only can we not pursue quality activities, which I have a list of that I would like to get to, but we have difficulty even getting people to their training for the year. We have mandatory competency days which seem to be the only way we could manage to get people to training because to get them away from the ward was impossible. At the moment no-one has touched that, but anything on top of that we cannot get people to. We get our grads their orientation and we have the one-day mandatory competency for the year and pretty much that is it. Despite what we are budgeted, we are never able to get people off the floor for whatever reason. Anything that is additional to just getting through the day is impossible to do. Like I was saying, just trying to get through the day is what we do.

Mr DICKSON: Ladies, thank you so much for coming in. Beth, it is good to see you again. I thank the nurses upstairs for coming along. I would like to make this statement to start. Mother Teresa has just been made a saint. All of you fall just underneath her—that is, the doctors, nurses and the ambos. We all know that. In a perfect world, we would have a one-to-one ratio. That would be perfect, but we have this little problem and this is where I have a problem: the finances of the state. The health

system chews up 26 per cent of the state's budget. In terms of the economy as far as we see it into the future, income is dropping and expenditure is growing. We have to come to a situation where we can help you and help ourselves at the same time and help all of the constituents throughout Queensland. We need to do more with less.

Beth, as one of the ladies spoke earlier, we are in a situation where possibly middle management is giving direction to you and you do not have the numbers on the floor but I am sure there must be many numbers in middle management. Is that where our problem lies? Where does our problem actually lie? If there are not enough nurses on the floor and you are getting direction from the bean counters saying, 'Get on and do a better job, work more hours and kill yourselves,' what is the solution?

Ms Mohle: There are two aspects to this. There is a short-termism that is really quite dangerous where people do not think about the return from investing in issues such as safe staffing. Having this continual focus on the dollar bottom line at the expense of everything else is one thing. The other aspect of it is that they are not taking into consideration a full economic analysis that incorporates the cost of adverse outcomes. If you just invest in it up-front and have the proper staffing numbers and skill mix, you will save money through decreasing adverse outcomes and getting better patient outcomes, as has been demonstrated repeatedly by the international research. I think it goes hand in glove. It is about trying to reframe the debate so that it is not just about the short term—the budget for this week, the budget for this month—but about looking at it holistically so that we incorporate the significant cost that is involved with adverse outcomes. It is a proper economic analysis.

Mr DICKSON: Beth, I agree with you to a point. This is a $29 million problem which we want to overcome and continue to move forward. I do not think $29 million is a whole lot of money in the Queensland government's health system. I would love to see that relocated from somewhere within the health system. I am possibly looking at middle management. We all know what is happening in the state of Queensland. I think it is a problem within a whole lot of areas within the Queensland government. I want to see you looked after. What I have heard from all of the nurses—we have travelled throughout Western Australia and Victoria and I have heard from you all—is that you need help, and I am sure the government is going to give that to you, but we have to find where those savings are going to come from.

Ms Veach: I will give you some extra information around the adverse events and that might help you put some context around the cost of adverse events and how many we have in Queensland. I will give you quickly some old statistics that I have; I do not have the latest ones. In 2012-13 there were 63,653 adverse events in Queensland public hospitals. That works out on average to be about six out of 100 separations. That is quite a high number. Very conservatively, research tells us that at least 50 per cent of those are considered preventable. They are adverse events that are caused from the hospital environment that we could have stopped.

Professor Di Twigg, whom you have spoken to before, has done some research and she has looked at one particular adverse event alone, and that was something called failure to rescue. Failure to rescue means that as a registered nurse I did not have the time or the opportunity to provide appropriate surveillance, I was not able to detect an issue that came up and I was not able to intervene early enough and the person has consequently died. That is a failure to rescue. In Western Australia, increased nursing hours have resulted in 1,088 life years gained based on prevention of failure to rescue adverse events only. The cost per life year gained was about $8,907, which is well below the reasonable cost-effective threshold in Australia of something between $30,000 and $60,000. That was from the intervention of increasing nursing hours per patient day in Western Australia. They did a retrospective study of what was happening before the change and what happened after the change. That is a little insight into just one adverse event—and we have many—of the way that someone here in Australia has contextualised the advantages of reducing adverse events by increasing nursing hours, putting the investment in at the front for the long-term event.

CHAIR: The time for questions has now expired. I thank you for being very generous with your time. You have remained an hour past what we had proposed. You have brought significant experience and expertise and testimony to our hearing today. I am sure that the many nurses in the gallery could also have added significant experience and value to the committee today regarding safe workloads and patient safety. I thank them again for coming. Thank you again for your submission. It has been a very interesting process for the committee to travel throughout Queensland and interstate hearing about this important legislation. I declare the hearing closed.

Committee adjourned at 11.18 am