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 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

TUESDAY, 8 MARCH 2016

Townsville

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Committee met at 12.33 pm

CHAIR: Good afternoon. 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 acknowledge the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. I am Leanne Linard, the chair of the committee and the member for Nudgee. The other members of the committee here with me today are: Dr Christian Rowan, the deputy chair and member for Moggill; Mr Aaron Harper, the member for Thuringowa; Ms Ros Bates, the member for Mudgeeraba; and Mr Joe Kelly, the member for Greenslopes. We have an apology from Mr Steve Dickson, the member for Buderim, who is unavailable to attend the hearing today. Can I please make special mention of our local members who are here today. We have Aaron Harper, whom I have mentioned, the member for Thuringowa. We also have Coralee O'Rourke, who is watching the proceedings today, the member for Mundingburra and the Minister for Disability Services, Minister for Seniors and Minister Assisting the Premier on North Queensland. Mr Scott Stewart, the member for Townsville, gives his apologies for not attending the hearing today.

Thank you for your attendance. The committee very much appreciates you giving up your time to assist us with this inquiry. The committee is holding three public hearings in regional Queensland this week—in Townsville, Cairns and Gladstone—to receive information from stakeholders about the bill which was referred to the committee on 2 December 2015. There will also be a public hearing in Brisbane on 16 March. The main objective of the bill that we are considering today 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.

There are 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 subject to Legislative Assembly's standing rules and orders. You have previously been provided with a copy of instructions to witnesses so we will take those as read. Hansard will record the proceedings and you will be provided with a transcript.

For any media present, I ask that you adhere to my directions as chair at all times. I remind all those in attendance at the briefing today that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings.

GILES, Ms Katrina, Registered Nurse, Townsville Hospital

O'SULLIVAN, Ms Robyn, Registered Nurse and Midwife, Ayr Hospital, Townsville Hospital Maternity Services

TURNBULL, Ms Kaylene, Regional Organiser, Queensland Nurses' Union

WATT, Ms Deb, Registered Nurse, Townsville Hospital

CHAIR: I formally welcome you all. Thank you for giving your time to come before the committee and to answer some questions. Would anyone like to any make any opening statement or comments?

Ms Turnbull: I am the QNU regional organiser based in the Townsville office. From there we cover not only Townsville but also Mackay and Mount Isa, spanning from Cardwell in the north down to Sarina out to Clermont and across to Mount Isa and up to Mornington Island and part of the gulf. Each of the women with me today will read a statement providing the committee with some information on their clinical role and the importance of maintaining minimum nurse- or midwife-to-patient ratios.

Nurses and midwives are a vital part of the healthcare system. Their work not only supports those with particular healthcare needs but also underpins the social structure in our communities. I worked in various facilities across Queensland in the public, private and aged-care sectors as an enrolled nurse and later as a registered nurse for 25 years prior to commencing employment with the QNU. As a regional organiser, I am regularly in touch with nurses and midwives working in a range of facilities across the public, private and aged-care sectors. Organisers are primarily responsible for the facilitation of QNU member workplace activity in the pursuit of industrial and professional advancement for nurses and midwives. We represent members individually and collectively in workplace issues.

The two most important concerns in the majority of workplaces I visit are unsafe workloads and patient safety. These two matters are inextricably linked and are caused by a number of factors including insufficient numbers of staff and an inadequate skill mix. Nurse- and midwife-to-patient ratios in Queensland public health facilities will be implemented in conjunction with the industrial mandated business planning framework known as the BPF.

The BPF is a comprehensive planning process that customises the workload of nurses and midwives to suit the individual circumstances of their clinical environment. It takes into account the human factors that affect nursing and midwifery workloads beyond ratios. The BPF was jointly developed by Queensland Health and the QNU and has been regularly reviewed and enhanced since it was first introduced in 2001. The combination of the BPF and minimum nurse- and midwife-to-patient ratios will allow the number of patients allocated to a nurse or midwife to be adjusted above the legislated ratio in accordance with variables such as patient acuity and activity.

The QNU anticipates the legislated minimum ratio underpinned by the BPF will assist in many of the long-term workload and patient safety concerns held by nurses and midwives. There is extensive and compelling evidence supporting the benefits of ratios for patients, staff and health services. Increased nurse hours, a higher proportion of registered nurses and better practice environments improve patient satisfaction, lower mortality, decrease readmission rates and reduce adverse incidents such as infections, pressure injuries and post-operative complications. This means people are likely to spend less time in hospital and receive more personal nursing and midwifery care than they would presently.

I thank the committee for this opportunity to present on behalf of our members and ask you to consider thoughtfully the comments of the nurses and midwives who have taken the time to come to this hearing today so they can advocate for safer patient care. I now pass over to Debbie, Katrina and Robyn who will tell the committee about their experiences in very busy hospitals.

Ms Watts: To all of the members and officials of parliament, other interested parties and constituents, welcome to Townsville. I wish to speak to the bill that has been presented on nurse-to-patient ratios. I am a registered nurse currently working in the emergency department of the Townsville Hospital. I have worked in this area for 18½ years. Last year my emergency department saw over 75,000 presentations. That equates to more than 200 presentation in any 24-hour period. I am proud of what I do and am also proud of my longevity in working there in that I am still happy to be a registered nurse.

Legislation for nurse-to-patient ratios will not only add to the quality of care to be able to be delivered to patients but also give greater personal job satisfaction to all nurses and midwives. I can deliver a litany of stories of horror shifts and workloads, not only from my personal experience but also from that of colleagues and friends who work across all sectors and all career ranks in the nursing profession. Nurses get to the end of their shifts and feel like they have accomplished nothing because of the frenzied pace and attention to detail of specific presentations and then apologise for what they supposedly think they have not done.

You walk into the area after hand over and you see that on the work trolleys the equipment is depleted. You also know that they were stocked at the beginning of the shift so it has been busy. You see left over stock and implements and equipment that have not yet been returned to their rightful places. Then you walk past a bin and it will be full of dirty, bloodied swabs. You know that they have had a busy day and they will still apologise for not being able to get that done by the end of their day.

Colleagues of mine have explained to me that there have been instances of night duty shifts in a local aged-care facility where there has been one nurse to 59 residents. That is outrageous and scandalous.

Unlike other industries and professions, health impacts everybody in this room—if it is not you it is your spouse, children, parents, friends and neighbours, whether this be through accidents, medical conditions, acquired illnesses or just plain bad luck. I am not going to continue to speak about the hardship of the nursing profession. I would rather talk to how decent and appropriate workload allocation can lead to great outcomes.

Recently I was allocated to a six-bed area which is routinely staffed with two nurses as per normal allocation in ED and my colleague was also allocated to the resus team and, alas, it turned out to be one of those shifts. I only saw my colleague for about three-quarters of an hour because presentation after presentation required her to be in the resus room. The shift coordinator was mindful not to allocate me more than four patients at any one time. I did not see all four patients all shift. I might have seen 10 or 12. I have no idea, but they only filled the spaces of four beds so that I could manage my workload. A patient presented with a secondary complication to his medical condition and his notes were charted previously that he had been aggressive and abusive to nursing staff. This was a middle-aged single man who had been well and healthy for most of his life and knowledge about his condition was limited and he was very, very scared. On that occasion, because of the allocation of just four beds—four patients per time—I had enough time with this patient to answer a lot of questions to help him. He genuinely thanked me for doing this and admitted that he was scared and also admitted that he had previously been nasty with nurses because he did not understand. Having decent patient time did not take away from any of my other patients' care in that time either. I got good time and this happens all too rarely some days. It is very satisfying to give holistic care and to be thanked on a day. It is really, really good. In conclusion, I advocate for you to support the legislation for nurse-patient ratios. Nursing involves caring for sicker or older or more complex individuals with expert knowledge needed for equipment, drugs and techniques in a rapidly changing world. Please give nurses the tools to give the best care that we can. Thank you.

Ms O'Sullivan: Good afternoon. I am a registered nurse and midwife. I have worked at the Townsville Hospital for 15 years. The last four years I have worked for Maternity Services. As registered practitioners, the regulator requires us to report unsafe work situations as our duty of care to patients. Workload reporting forms supplied by the QNU are for this purpose. Unfortunately, I have found it necessary at times to escalate my workload concerns to the unit manager when I have been allocated 12 to 14 patients along with their babies on a maternity ward when my colleague would be a casual RN or a student in nursing. Just to clarify, a student in nursing is an undergraduate double-degree student doing their registered nurse or registered midwife qualification. That is what a student in nursing is. In mid-2015 approximately 20 midwives notified the Townsville Hospital management team of escalating problems related directly to untenable working loads where limited qualified staff were working with undergraduate nursing staff. I just want to say that when there are enforceable midwife to patient ratios qualified midwives will be present at all births and intrapartum mothers with epidurals and oxytocin infusions that require continuous CTG monitoring, which is under our statewide guidelines, will receive the appropriate level of care. Proper staffing levels will prevent unsafe situations from occurring such as post-partum patients walking from the birth suite to the maternity ward without being escorted by a midwife and without the midwives getting handover.

Advances in fertility medicine have increased the activity and acuity of maternity services as older women are now conceiving who are more likely to have comorbidities and have a higher potential of having multiple foetuses, so we have triplets and twins quite regularly, as well as lots of maternal complications because women from 38 to 48 are having babies. Technology advances are not capable of dealing with post-partum haemorrhages, labour obstructions, cord prolapses, incorrect foetal presentations, hypertensive women, preeclampsic women, complications from comorbidities, bariatric women—most of our women have BMIs above 40 when they actually get pregnant—or unwell women in preterm labour. Maternity care is complex and requires midwives to manage a number of diverse clinical situations such as high-risk inductions, emergency C-sections, foetal tachycardia, maternal assaults, motor vehicle accidents, unexpected and unrelated surgical events while pregnant and mental health and child safety issues—very current issues in maternity services. Hence, women need visual surveillance and monitoring by a qualified midwife throughout their pregnancy, during their labour and in the period post birth. Trained experienced staff are the only safety net women and babies have. A major component of midwifery care is education. Excessive workloads cause midwives to burn out, leaving these areas staffed by nurses and midwifery graduates who have minimal experience in relation to general and emergency obstetric care.

Mothers are the only patients counted in the patient numbers. Babies are registered as unqualified when on the birthing suite and maternity wards. This causes a great deal of concern to midwives as under Queensland maternity statewide guidelines many babies require observations

including blood sugar protocols, meconium observation, prolonged rupture of membrane observations, baseline observations and visual observations for intercostal recession, respiratory effort, colour and turgor. Babies should be counted as separate qualified patients to their mothers in order to allow for adequate midwifery hours and an appropriate staff skills mix to be made available. Midwives provide babies with assistance in feeding, hygiene care such as baths and nappy changes, physical observations, vaccinations, hearing and neonatal screens. Jaundiced babies require blood collection, testing and treatment by midwives with the use of phototherapy beds. When midwives cannot meet all these needs in a timely manner, women, partners and family members become upset and even hostile, which has resulted in some women discharging themselves and their babies against medical advice. These women are often followed up by the chronically understaffed home midwifery program.

Adequate midwife to patient ratios will reduce the likelihood of situations like this occurring because midwives will have a greater capacity to monitor, assess and provide the most appropriate maternity care at the right time to mothers and their babies. Our national accreditation standards take time at the bedside to maintain. To successfully achieve national standards such as breastfeeding, a qualified midwife is required to provide education, supervision and advice related to the mother and the baby. The paperwork associated with this standard is extensive and requires a significant amount of midwifery time to complete. For example, breastfeeding friendly accredited hospitals such as the Townsville Hospital require a three-page document to be discussed and signed by mothers prior to artificial formula being provided, and that would even be if the baby's blood sugar was 1.8 when it should be at least above 3.2, and all these things take time to explain. Without minimum ratios midwives are often experiencing unmanageable workloads which need escalation each time they occur. As midwifery is a specialised service requiring formal training and experience, there is limited availability of pool staff to assist when workloads become unsafe. We often find that call-in staff cannot come in or cannot provide assistance as they are too fatigued from frequently being called in.

A recent survey of the midwives in the maternity unit aimed to gather their opinions on staffing levels. The following general comments were made about how to improve the working conditions in this unit. Incidentally, I did not contribute to this survey so any of these comments are actually not mine. Comments were ensure staff get their breaks, do not count student in nursing in the numbers, provide funding to hire more midwives or staff will burn out, acknowledge when the unit is understaffed with high acuity, make the recruitment process shorter and smoother, provide more education opportunities, bring back facilitators, improve staff morale and job satisfaction through better working staff conditions, do not count the shift coordinator in the numbers as far as patient allocations, establish a patient ratio of one to four in maternity, admit babies if they require nursing care, and do not ask midwives to accept responsibility for 12 mothers and their babies as it is unfair for the midwives and the students to take half of that load. The midwife is responsible for the 12 patients with their babies, so if you add that up you have 24 charts and you have an undergraduate working with you. It is really just very unsafe. Other comments were expect poor morale when midwives are overworked and provide more permanent core positions. People will not move from other cities for a temporary contract. We need to offer permanent work. As a mother of two children who were born at the Townsville Hospital, I just want to say that giving birth is the most important time in a women's life. She expects the safe delivery of her baby as well as assistance with breastfeeding and adequate care for her child. Where would we be without our child's safe delivery into this world? With the rise in postnatal depression, who is teaching mothercraft skills to our mothers? As a midwife who has worked under very difficult conditions, I find it unreasonable that a large regional training hospital should be so understaffed. I no longer work at Maternity Services at the Townsville Hospital.

Ms Giles: Good afternoon. I have been a nurse for 34 years. I work at birth suite, maternity, hyperbarics and I am a clinical nurse in the emergency department of the Townsville Hospital. As a clinical nurse in a busy emergency department which sees between 230 and 250 patients a day, I regularly see the impact that insufficient staffing and skill mix has on patients in my care. I am constantly shocked at the condition of some nursing home patients who present to the emergency department with pressure area illnesses and contractures that could be avoided if proper nursing care in terms of numbers and skill mix were provided. The cost to the healthcare system will only increase unless more registered nurses are employed in the aged-care sector with an appropriate nurse to patient ratio. When transferring patients from the emergency department to the ward, I have witnessed ratios of one nurse to eight patients. Our workload is intense and makes it difficult for nurses to provide safe, high-quality care on a constant basis. We have to remember that the majority of patients admitted to inpatient wards these days will have multiple medical conditions and physical constraints that require more nursing hours and high levels of nursing skill mix.

While technological advances greatly assist nurses in providing care like taking physical observations and maintaining skin integrity, it cannot replace the critical thinking and analytical processes undertaken by nurses that lead to the development of holistic care plans for each patient. It is unfortunate that when service demands exceed the capabilities of available nursing resources the little things have to give way. Nurses need to take more time to undertake hygiene care, feeding, drug administration, pressure area care, continuation of physiotherapy, organising special procedures or tests, and showing empathy for the psychological needs of the patient. I find it greatly distressing that my colleagues feel like they are compromising the care they are delivering due to excess workloads, especially as their motivation is to do the very best they can for their fellow human beings in their time of need. Similar stressful situations are occurring in our maternity services as well. I also work casual shifts in the birth suite and maternity ward to maintain my skills required for my registration as a midwife. I do this cautiously as I know I am frequently placed in situations where I am looking after six mothers and their babies. Some of these babies have complications as a result of birth or maternal conditions that require close monitoring to avoid adverse outcomes. This means I actually have anything up to 12 patients, including mothers and babies.

I am beginning to ask myself if I want to maintain my registration as a midwife, when over the years what was once a joyful experience of helping new mothers start down the path of a wonderful experience of motherhood—sorry, this really upsets me—has become somewhat jaded. The pressure of caring for up to six mothers and their babies means I am frequently unable to sit down with new mothers and teach them how to care for their newborn or answer any questions they have. It is not a very satisfying experience. My time is increasingly taken up completing the paperwork that is recorded to look after anything up to 12 patients, as well as the digital records I have to get and the access to a computer. There are times when I am not able to have a break and this can affect my energy levels and ability to concentrate.

Again, advances in maternity technology have helped in terms of the quick obtainment of physical vital signs of both mothers and newborns. However, midwifery is a hands-on area and there is no way technology can replace the physical and psychological contribution midwives give. I want to do my job properly and impart the best care I can for my patients, but workload that is placed on me does not allow this to happen.

In birth suite, the ratio should be one-to-one as this is a time when support of the mother and close monitoring of the newborn is critical. It is the midwife's skill in assessing the mother and the child that produces a safe outcome. Too many times I find myself attending to more than two mothers at once, and this is not only unsafe for them but it may compromise my registration. Yes, there is a cost for the employment of more nurses and midwives, but this will produce shorter stays in hospital, less complications, increased patient safety and long-term benefits for the organisation. Thank you.

CHAIR: Katrina, thank you very much. Katrina, Robyn, Kaylene and Deb, thank you all very much for sharing your practical experiences with us this morning. I will ask one brief question and then I will hand over to Joe and then the deputy. Many of you may be aware that there is a lot of medical expertise on the committee. We have Dr Rowan, we have a nurse in Joe Kelly, we have a paramedic in Aaron, we have a nurse in Ros and then you have me. The closest I come to it, I am sorry, is being married to a registered nurse. There was a comment in one of the submissions that you may or may not recognise and I was really struck by it as I read through it because it is a comment I have certainly had conveyed to me by my husband and by many other nurses—that is, 'Patients often apologise for being an inconvenience as they see how busy we are rushing around all the time.' That seemed to me to encapsulate the opening comments you have each made—and you are all nodding. Normally, I would ask some questions but I will hand over to Joe who is a registered nurse.

Mr KELLY: Can I start by saying thank you very much for taking the time to come and give your presentations here today. As a nursing colleague, I know we are not generally used to standing up in committees and public forums and expressing ourselves, but it is really important that you have taken the time to do that today. I am really interested in your commentary around patient education, as it is an area I am particularly passionate about. If the government was to move down a path of legislating nurse to patient ratios, do you have an opinion on the capacity that nurses would have to improve the level of patient education they currently engage in? Any of you can answer that question.

Ms Turnbull: I am happy to answer it first. If the ratios were installed as the minimum and your BPF is calculated on top of that, there would be the time for nurses to be able to provide that education to ensure that the patients actually understand. There are a variety of different patients—we have some Indigenous members of the community who often need extra time to have things explained to them and to make sure they fully understand and are informed. It is our view that nurses would be able to do that appropriately with ratios in place and the BPF implemented appropriately on top.

Mr KELLY: I know under the national quality frameworks there are a range of important things we do now—such as monitoring skin integrity every day, monitoring medications, basic care planning. How do you think those sorts of things are impacted by the current workloads?

Ms Turnbull: From discussing it with members on the floor, I can report that many nurses say that people are not getting turned in the time frames that they should be turned, they are not getting changed when they are incontinent as soon as they should be. These things can be addressed through ratios and the BPF being applied appropriately. That would drastically bring down the incident rate of pressure areas being experienced with patients whilst they are in hospitals.

Mr KELLY: For the emergency nurses, obviously we need good patient education in relation to skin integrity and a good education for people with diabetes around foot care and monitoring their sugar. Have you had experience of people returning to hospitals because they have simply missed out or have not had appropriate education during their acute care phase?

Ms Giles: Because we have the four-hour turnaround of patients with the NEAT, your time is very limited with the patients because you are actually trying to get all of the pathology, X-rays and everything processed so they can either go to the wards or be discharged. The opportunities to be able to do education for your diabetic patients or your cardiac patients, if they are able to go home, are very limited.

Mr KELLY: Kaylene, you cover a very large area of Queensland and you obviously work in a large tertiary hospital like TTH, but you also go to many of the smaller country hospitals. Could you comment on the experience of workloads in those smaller country hospitals?

Ms Turnbull: In a lot of the smaller or actually more remote areas, it is difficult to get the skilled staff to be able to adequately assess wounds and do wound care. There is difficulty in being able to get the diabetic patients in for their regular checks and their clinic appointments. If there are people who are off sick, it is much, much harder to try to replace them and people end up doing double shifts. Sometimes that happens day after day. By the time you get to the end of the week, those nurses are exhausted and then they are having to take sick leave. It just revolves around that there is constantly that fatigue there.

From my personal nursing experience, my nursing background was around renal, acute strokes and diabetes education. By the time many patients actually got into the service and got their wounds sorted out, a lot of the time they were up to amputations. That sort of thing really needs to be avoided and addressed—if people had the time to be able to educate and get all those wounds done within the time frame that they are supposed to be done. A lot of the time when nurses are flat strapped, it comes down to trying to get your dressings done. Often on a morning shift, the nurses will not get time for that so then they will be handing over to the afternoon shift with, 'I've not had a chance to get to so-and-so's dressing.' Sometimes they are not done in the time frames that they should be done, which then causes further complications for that patient. In regional communities, it is much harder because they have fewer resources and fewer people to call in when they are trying to cover deficits.

Mr KELLY: Just out of interest, many of you have mentioned what you consider to be unsafe workloads. What has been the response of management if you have tried to raise those issues?

Ms O'Sullivan: I will put a comment forward about that. Quite a bit of my statement was actually edited for my own safety. I had a list of things that occurred to me because I did stand up and say things. Thankfully, I finished up in maternity services in November 2015. It was in June that we all approached the management. One day I could not go into work anymore. I just could not do it so I went on sick leave for two weeks and I tried to go back into work and I just physically could not go back. I had been getting quite wound up for some time because I was so frightened for my registration that something terrible would happen, so I ended up putting myself on the rural pathway. I am working as a registered nurse/midwife in Ayr so I can still work as a midwife down there.

I have seen disgusting behaviour—that is probably the best way to say it. I must say my director in Ayr has been very supportive of me. Working in a rural centre, I think definitely for ratios in the major hospitals—like in these big hospitals—and when the patients are extremely acute, you really must have one to four in maternity services. I do not work in ED all the time, but you certainly would not want more than one to four in the emergency department where you are there with those bays.

One thing I would like to say is that I would like to see a little bit of leeway for the rural sector. For instance, where I am I often get nine patients with an EN and I might get a few antenatal or postnatal ladies coming into the area I might see. With those nine patients, I might have, say, five plus four. It is a little bit different. Sometimes we might lose a staff member on a road transport for a few hours. The patients are certainly not as acute, generally speaking. If they are that acute, we fly them out or we take them by road.

I think that negotiation has to be done carefully with the rural areas. I did go and speak to the director when I started down there and she told me what her staffing was and I thought, 'That's pretty generous.' Often it is. We can even have four patients to two staff sometimes and we actually get time to restock things and check different things. On another shift, it might be 10 patients between the two of us. I must say I have not felt unsafe down there. It has been different.

You mentioned education. A lot of our patients in any hospital are on clinical pathways—whether it be a surgical clinical pathway, a maternity pathway or a neonatal pathway. All of those pathways are already in place with all of the education listed, and we are meant to go through each day pretty well for each condition a certain amount of education. It is actually all in place we just need to have the time to present that education.

Dr ROWAN: To Deb, Kaylene, Robyn and Katrina, thank you very much for your submissions and all the preparation you have done coming today. I also thank you for the great work you do as nurses and midwives in our hospital system. As a medical practitioner, I can say that I do not think doctors could do their jobs at all—let alone as effectively as they do—without all of the support of other staff in our hospitals, whether that be our nurses, midwives or allied health practitioners. Congratulations on all the work you do. I first want to ask about the current quality assurance environment that you work in. What I mean by that is if there is a perceived lack of staff on any particular clinical shift you are working in—so a perceived or actual deficit in clinical staffing from that perspective—and an incident takes place, is that reported into a monitoring system? How is that evaluated in your experience?

Ms Turnbull: There are a couple of different ways. If it is a workload incident, it goes on a workload reporting tool and there is a Queensland Health workload form to complete and there is a QNU one to complete as well. There is also the PRIME system. If it is an incident directly involving a patient or an outcome of a patient, that gets reported and that then gets reviewed and escalated through management and then a report back on that type of incident. So it is fully investigated.

Dr ROWAN: Coming to that into the PRIME system, there would be a range of things that are reported into there around clinical incidents and other things. I wanted to ask in terms of individual clinical areas again and getting your experience in your current work environment. Is data looked at as far as length of stay versus national average length of stay? If there is an increasing number of pressure incidents or rates of DVTs or unplanned admissions to ICU or returns to theatre—all of those things along with other incidents that may take place through perceived or actual problems with staffing—is all of that looked at at an individual clinical unit level?

Ms Turnbull: Some of those details come back to the nursing and midwifery consultative forums because some of those issues are on what is known as the score card that goes back that they report on the amount of pressure area incidents et cetera, but not all HHSs actually provide that information. In my experience attending meetings for North West Hospital and Health Service, Townsville Hospital and Health Service and Mackay Hospital and Health Service, Mackay is the only one that provides that information on a regular basis. I do not think each particular unit gets that information or that feedback. It is not actually provided to them. I think some of that information would be very interesting to be able to have a look at because I am sure there are improvements that could be made in regard to that.

Dr ROWAN: I guess that is what I am coming to. If you have a ratio that exists or a ratio that is implemented, you would want to be looking at a change that has happened there either positively or negatively. That is what I wanted to ask, particularly around these baseline ratios of one to four in the morning and in the afternoon one to seven. Why should it be those specific numbers, in your view, as opposed to one to three, one to five or one to seven or one to eight? Why specifically the one to four and one to seven? Why those numbers across-the-board as opposed to a different set of numbers.

Ms Turnbull: That relates back to evidence and research that has been done in regard to ratios. For a standard unit, the average would be one to four. With the BPF, it looks at the supply and demand, it looks at the acuity and in many areas the ratio is different from that. Those ratios are to establish a minimum. The BPF and the supply and demand is then looked at, and for those particular areas a ratio or number of staff is determined.

What concerns a lot of people on the floor at the moment with the BPF is that a lot of sites are not implementing the BPF as they are supposed to and they put notional ratios on the wall. The notional ratio often will include the team leader, the nurse unit manager and facilitator, and it looks lovely and rosy on the wall but it is not the ratio that the staff on the floor are working to. It is the staff on the floor who have responsibility for those patients. It is incorporating the people who are actually providing the clinical care—the ratio of those staff to the nurse, not including all the other staff.

Dr ROWAN: Factoring in acuity, complexity and other factors such as equipment, geographical design and those things, there needs to be flexibility within the arrangements of the BPF; is that what you are saying?

Ms Turnbull: Yes, and one to four is the minimum. There are certain areas such as the ICU which is one to one, but one to four should be the absolute minimum.

Dr ROWAN: In smaller facilities like Richmond Hospital or Hughenden Hospital—10-bed hospitals with 10 patients—how would this, in your experience, be implemented?

Ms Turnbull: They operate on minimum staffing so there have to be at least two of them there. They then have a person on call if they have to do escorts et cetera. Because their patient numbers can change at any time and they do not know what is going to come in the door they have minimum safe staffing. In all of those places they have two on each shift as a minimum.

Dr ROWAN: In relation to skill mix—RNs versus ENs at any particular facilities—do you have any comments in relation to whether there should be a mandated skill mix in clinical units?

Ms Turnbull: I think it depends on the clinical unit, because usually if there has to be an escort an RN has to go with that patient. They both have different roles. An enrolled nurse has a totally different scope from a registered nurse. The evidence around ratios is in regard to registered nurses to patients.

Dr ROWAN: Are there any risks or unintended consequences of nurse to patient ratios in your experience?

Ms Turnbull: Not in any of the evidence or research that I have read.

Dr ROWAN: Deb, I think in the emergency department there are about 200 patients every 24 hours; is that correct? What is the current nurse to patient ratio there on any routine day?

Ms Watt: It will depend on the acuity of the patient. If the patient comes in and they are a cat 1, they have been retrieved by ambulance from a car accident, they are unconscious and they have a lot of physical damage, it will be a full resuscitation team. There will be doctors and nurses. There will be more than one nurse taking on different aspects—an airway nurse, for example. A patient who comes in because they have fallen over and hurt their foot which is a bit swollen can still wait there. They will be put out into our fast-track area where there are three nurses to eight beds. There are doctors and nurses so there is enough time for them to have their analgesia, painkillers, X-rays, assessments and whatever else they need, whether they need crutches or they need to be admitted to ortho. I will not say ED is like a ward. It will be on the acuity of the presenting patient. There might be a full resuscitation team. If someone has not been breathing very well, once they have been sorted out by the resuscitation team, a couple of hours later they will come out to the floor and they will go one to one.

Dr ROWAN: Who is determining that staffing at the moment on a day-by-day basis?

Ms Turnbull: The staffing for the ED unit is done on the BPF and they work it out on the time for each occasion of service. They then benchmark with similar facilities as to how long each presentation would take. They look back on what the categories were for the previous year—how many cat 1s, cat 2s and cat 3s—and they determine staffing. What would happen in the ED is they would have a set number of staff for the morning shift, but, if there was a major incident like a bus crash or if there was an emergency, staff would be pulled from other areas to deal with that. There might have been two to six patients in one area of the ED, and they will pull one from there and move them over here. It is a bit like rearranging the deck chairs on the *Titanic* at times: you are pulling from pillar to post to try to line them all up.

Ms Watt: We do not do ratios per se. We have set numbers for mornings, evenings and nights, and we have to deal with whatever comes through the door unless there is a major disaster and we can call extras in. If we need to, if there are major incidents, we can have deployment from the wards. On occasion, not very often, you will walk in on a Sunday morning and there will be one nurse or three nurses and nobody on a bed. That never lasts long.

Dr ROWAN: I want to ask about the flexibility. Who is determining that? Is that the executive, the director of nursing of the unit or the clinical director?

Ms Watt: That is our hours per patient day and they are worked out—

Ms Turnbull: Yours is occasions of service and it is worked out in the service protocol through the BPF. Ultimately, it is signed off by the clinical directors and the directors of nursing, but previously—and I believe it is about to change—the finance department would have the last say on the BPF. They would shave a little bit off here and a little bit off there, and this is what you would get

and you had to manage with that. I believe at the Townsville HHS the decision is going back to the executive director of nursing because she has the clinical experience to be able to say, 'This area needs this number of staff to be able to manage with the clinical requirements.'

Dr ROWAN: Your view would be that a clinical person is the most appropriate person—

Ms Turnbull: Yes.

Dr ROWAN:—to have the flexibility to determine what the required staffing needs to be at any particular clinical unit or on any particular day?

Ms Turnbull: Yes.

Ms Watt: Including a registered nurse. If you work on the wards, you have the right to fill out the workload tool to say that due to acuity and too many patients we need more nurses. You report that to your immediate supervisor or line manager, and you can have that dealt with when you first walk in and feel that if you are unsafe. We have the ability to do that on any given day.

Ms Giles: As a clinical nurse in the emergency department, I also do the position of shift coordinator for the day. If we have continuous resuscitations coming through, it often leaves one nurse to a six-bed bay. If the acuity of those patients in those six beds gets to be beyond the ability of one nurse, my responsibility is to shuffle what remaining staff there are in the unit to help out these other nurses who are getting overwhelmed, and that can often be very tricky.

Mr HARPER: Welcome each and every single one of you. I must declare before the committee that, as a committee member, I absolutely wanted a hearing here in Townsville. I believe the regions need to be heard, particularly on nurse to patient ratios. It is International Women's Day, and I congratulate each of you and the people in the audience. Together you represent close to 90-odd years of nursing. I commend and congratulate you for your contribution to your profession. You have each given very good through to emotional statements today about your profession and how the nurse-patient ratio hinges on patient safety and outcomes. I wanted to start by saying thank you.

With the nurse-patient ratios, on those rare occasions where you get more nurses and fewer patients, what is the general feel? Conversely, what happens within the departments or wards when you are overworked and you have more patients to care for? What is the general feel? Anyone can answer this.

Ms Turnbull: I think it would be quite rare from what I have seen, but on those rare days most of the registered nurses or clinical nurses have portfolios that they are supposed to do in their units and are supposed to educate junior staff in their teams. There are also mandatory training requirements every year. Some of those are online. That gives them an opportunity to get to some of that mandatory training and get it done on time. They also then have the time to do audits to make sure that all the tasks are being done each day and it is all recorded. They also have the opportunity to sit down with their patients and discuss with them how things are going, prepare better for discharge and ensure they have support at home. You can plan so much better if you even have just a couple of hours. I do not think any nurse would not utilise that time to make sure they are educating patients, they are restocking, they are educating themselves and doing their mandatories. That time is rare but when it does arise it is very well used.

Ms Watt: And we can be deployed even in the ED, which does not often happen. Deployment means you get assigned to another ward. ED is particular in that the minute we get busy you are recalled, but quite often nurses from other areas are deployed to ED when we are busy. Then you have an issue with skill mix. You will get somebody who comes from kids ward who is not au fait with adult procedure—not that they do not know how to look after adults; it will be procedure and protocol. If we are ever sent to the kids ward, all your double-checking and everything is different in different wards. Do not send me to a surgical ward. I would not know one end of a vac drain to another.

There is also deployment and that is where skill mix is an issue. Even though you get another set of hands, they will try their hardest and do their job as a nurse but they will not be aware of what is needed in their skill set to be in an area that they are not normally in. You can do education; you can do anything you like. You can fill your time because you do not often get that time, and you can get deployed.

Mr HARPER: Do you think the closer interactions that you have with free time improves morale for nursing staff and for patients?

Ms Watt: Yes. Getting a cup of tea and a biscuit for a little old lady who has just spent four hours on one of our trolleys in ED, making sure that she is warm and has enough blankets is half your job some days. By making sure people are fed, warm and comfortable, and feel they can

approach you when they have issues, you find out all the other stuff in their lives such as, 'My daughter is taking all of my money because she is using drugs.' That is where you find the other half of your nursing is. It is a people's job, and the other half of what you do is finding out about a person's life. Not only have they come in with a sore foot; you are having to call a social worker or somebody else because their daughter is taking their money off them. This is how you get to know your patients with time. It is not just about your skills and your job; it is about everything you do every day for them. There is lots of other stuff that you find.

Mr HARPER: I probably contributed to those 200 presentations every day, bringing patients into the emergency department. Thank you for putting up with me for the last 25 years in that medical arena.

Ms BATES: Thank you, ladies. I have three sisters who are in the system right now: a CNC in ED and a CTC and a NUM. So I am well aware of a lot of the issues that you have to face on a regular basis. I have also been in every hospital in Queensland more than once over the last 7½ years. One of the things that I picked up, Robyn, is that it is not just the lack of nurses, or the lack of staff being rostered on; it has also a lot to do with the culture. From where I have been, most people say to me that there is not a lack of nurses; there is just a lack of nurses who want to work for Queensland Health. That is just across-the-board; it does not matter where I go. Deb, this question would probably go to you. How much of the problem of nurses' workload do you think, particularly in your busy ED, is based on a lack of skill mix rather than a number ratio? For instance, if we bring in a ratio that is one to four, or one to three, or one to five, there is no guarantee that you are going to get the nurses back into the workforce who currently do not want to work for Queensland Health and you may end up with a junior staff mix where you have people who are not competent. I can give you an example down at the Gold Coast University Hospital, where they have CNs acting up to CNCs who probably are not quite ready for that role and that their skill mix that they have to work with on a daily basis is not as competent as one would like to have. Can you give me some thoughts on that? I do not believe that just getting the numbers is the answer. I think that we need to have the right skill mix of nurses. Dr Rowan was talking about making sure that it is not just about numbers; it is about the quality of staff and patient acuity as well.

Ms Watt: If you had your ratios and you had enough staffing, you would have time to educate and bring these people in under a decent education program. You have to teach your own. You have to feed your own and encourage your own. So if you are given the appropriate numbers, you can do your part of the job as mentor and educator to junior staff. You can identify junior staff sometimes just by their practice. So you take the time out to go and do education with them, or they are identified to your CNC educator—'Oh, maybe they just need a little bit of a looking at.' You can do this nicely; it does not have to be bullying and harassment. But that is part of your job. If you had the ratios and you had your numbers, you are able to teach your staff, keep your staff.

Ms BATES: Do you think that that would fix the culture?

Ms Watt: That is a whole different issue. I am quite happy to say that bullying and harassment in Q Health is rife and running proud. It has been for a long time. We have had the recent memo come out from the DG about this. It is nice to have a memo. It does not fix the problem.

Ms BATES: No. That is right. In your area as well you raise concern about patient safety. I have been in your ED a number of times and in Cairns. I think as far back as 2009 I was calling for additional security and even police beats in your EDs because of the presentations that you have. Whilst we are looking at areas such as yours, do you think that we should be looking not just at nurse-patient ratios but also the safety of your staff to be able to do their job?

CHAIR: I think we need to make sure that questions and comments are relevant to the bill before the House and the bill is about ratios—

Ms BATES: It is about the safety of patients.

Ms Watt: Just in that for ratios, TTH has been proactive in that we have all of our new policies and procedures for code grey. Have you got a code grey team? There is a whole series of people. We have upgraded our security. We have more security staff who are not nurses—plain security staff. We also have a whole heap of policies and procedures that are now being implemented so that we are safe and the rest of the patients in the department are safe as well.

Ms BATES: Can you just explain what a code grey is as well?

CHAIR: Again, this is not relevant to the bill.

Ms BATES: She is talking about being able to do their jobs safely.

Ms Turnbull: It is about more security in the emergency department. Townsville Hospital was having quite a few issues with aggressive people in the emergency department. They ended up putting more people from security into the emergency department, but not in the security uniform. They were wearing different coloured shirts, I believe, in the department, or they were doing something different. It was about bringing in more people into the emergency department for staff safety. Staff safety in emergency departments is a whole other issue compared with ratios and I do not believe—

Ms BATES: It makes it very difficult to do your job if you are having to deal with violent patients as well.

Ms Turnbull: That is the case, but if you have the right ratio of staff there to be able to provide the service, if you know that you have certain instances happening you use your BPF and you increase the staff further to that. The HHSs have to ensure that there is adequate security in place to be able to respond to any aggressive behaviour.

Ms BATES: I have just a final one about patient ratios. I know that you have your PRIME system and also the rule—

Ms Watt: Ryan's Rule.

Ms BATES: Ryan's Rule. Do those sorts of incidents then get sent on to the Health Ombudsman? The reason I am asking is that he came and spoke to us on 3 June 2015 and I asked him if he could specifically recall a PRIME incident or a Ryan's Rule being called where it was stated specifically that the health service was somehow deficient because of a deficiency in nurse-patient ratios. He said no. Is there another way to justify a nurse-patient ratio by using those sorts of reports to the OHO, because he is not getting them? He said that, of all of the complaints that he has had in Queensland since he has been the OHO, none of them have been attributed to a lack of a nurse-patient ratio, or a lack of nurses.

Ms Watt: I think the institution of Ryan's Rule, other than at one of your outer places—Dajarra or somewhere like that—would not only be for nurses but they would be for nurses, doctors and anybody else who is involved in that care. I cannot answer that properly, but do not forget that Ryan's Rule in a major tertiary hospital is not only just nurses; it is a multidisciplinary undertaking.

Ms BATES: He was saying that people are making Ryan's Rule complaints and a complaint to the OHO at the same time before it was looked at at an HHS level.

Ms Watt: We have our mechanisms, we have our PRIME—

CHAIR: Sorry, we are just straying from the—

Ms BATES: No, it is about nurse-patient ratios.

CHAIR: That is totally off track. You are tying it to a comment about patient ratios. It is not relevant.

Ms BATES: No, I asked a specific question. The Health Ombudsman said that he had not received any complaint from any hospital in Queensland based on the deficiency in nurse-patient ratios. So I just wanted to let you know that that is what he said—unless you read *Hansard.* That is what his version of events is.

CHAIR: What was the question? That was a statement. Thank you for that statement.

Mr KELLY: The Health Ombudsman is triggered by individual patient complaints. One of the investigations might be that you end up with a patient ratio issue being the trigger for what caused the issue.

Ms BATES: But he has not had any.

Mr KELLY: You are not going to have a diminished ratio and suddenly trigger an automatic referral through the Office of the Health Ombudsman.

Ms BATES: I am just making the point that he has had none.

Mr KELLY: Ryan's Rules are a totally separate mechanism whereby any patient can use that to escalate concerns.

CHAIR: Do you have any final questions?

Mr KELLY: I do have a final question.

CHAIR: I know that the member for Greenslopes has a final question and then our time will have expired.

Mr KELLY: We work as health professionals in a system where we work beside many other health professionals. In your experience as nurses, when other health professionals come to see a patient they have time to assess the patient; is that correct?

Ms Watt: Yes.

Mr KELLY: They have time to plan out what care they are going to deliver?

Ms Turnbull: Yes.

Mr KELLY: They have time to evaluate the care that they are going to deliver to those patients and document that?

Ms Turnbull: Yes, they do.

Mr KELLY: In my experience other health professionals do not move forward unless they can go through methodically each of those steps; is that correct? In your opinion as nurses, under the current workloads do you have the capacity to work your way through that nice orderly, logical sequence of assessment through to an evaluation and a documentation system as things currently stand?

Ms Turnbull: No, I do not believe that they do.

Mr KELLY: Would you believe that ratios, if they were legislated, would assist to improve that scenario?

Ms Turnbull: Yes.

Mr KELLY: Thank you.

CHAIR: The time allocated for this public hearing has expired. Thank you for your attendance today. The committee appreciates your assistance and I declare this hearing closed. Can I again apologise for the drilling—I know that you could not hear in the public gallery—and the sound issues, but I assume that, again, this environment of four nurses and five members of parliament is still an easier environment and ratio than you have in your workload. So thank you very much for coming today. Thank you.

Committee adjourned at 1.38 pm