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

WEDNESDAY, 9 MARCH 2016

Cairns

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Committee met at 9.48 am

BISHOP, Mrs Krissie, Regional Organiser, Queensland Nurses Union

CARLTON, Ms Debbie, Clinical Nurse, Mareeba District Hospital

LAAS, Ms Rachel, Clinical Nurse, Queensland Health

CHAIR: I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's inquiry into the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 open. I would like to acknowledge the traditional owners of the land upon which we meet this morning and pay my respects to 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 with me today are: Dr Christian Rowan, deputy chair and the member for Moggill; Mr Joe Kelly, the member for Greenslopes; Ms Ros Bates, the member for Mudgeeraba; Mr Aaron Harper, the member for Thuringowa; and we have an apology from Mr Steve Dickson, the member for Buderim, who is unavailable to attend this morning.

Thank you for your attendance here today. The committee very much appreciates you giving up your time to assist us with the inquiry. The committee is holding three public hearings in regional Queensland this week—one yesterday in Townsville, one today in Cairns and tomorrow in 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 here to talk about 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.

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. You have previously been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a transcript. For any media present, I ask that you adhere to my directions as chair at all times, but we have already spoken, so welcome. I remind all those in attendance at this briefing today that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings, but I thank you for your attendance today to witness these proceedings.

I now formally welcome Debbie Carlton, Rachel Laas and Krissie Bishop. Thank you for coming and being willing to be a witness at the inquiry before the committee today. Would you like to make an opening statement before we open it up for the members to ask questions?

Mrs Bishop: My name is Krissie Bishop and I am the QNU regional organiser for Cairns, the Torres Strait and the cape. I cover south to Cardwell, north up to Thursday Island and the outer islands including Saibai and across to Forsythe and Croydon. I have lived in Cairns and the far north for the past 28 years and I have worked as an RN, a CN and a CNC. Until recently I worked across a range of disciplines including general, medical and surgical to intensive care and theatre in both metro and rural facilities.

Each facility I visit has the same No. 1 priority, which is patient safety, followed by quality care and correct application as per the business plan framework. Without fail, whether I am speaking to a senior nurse or a student nurse on placement, they all answer 'patient safety is my priority', but they feel that they are failing their patients because they do not get to spend quality time with them.

Cairns hospital is the only tertiary referral centre in the Far North area with Townsville Hospital, over 340 kilometres away, the next tertiary facility. There is nowhere else to take patients within the catchment area. The regional hospitals have a diverse caseload which can range on any shift from a cut foot or broken arm to snakebites and multiple car accidents. If there is a snakebite, one nurse is then away from the hospital for four hours minimum taking the patient to Cairns.

The staff want to be able to provide safe quality care to every person that attends their facility, knowing that on each shift they have a guaranteed safe workload and correct skill mix determined by using the BPF. Only yesterday I had a nurse who has come from Victoria to work tell me, 'What have I done? Send me back to Victoria. At least I will be guaranteed a safe patient workload.' The QNU anticipates that legislated minimum ratios, along with the correct application of the BPF, will assist with many of the workloads and patient safety concerns held by the nurses and midwives that I speak to every day.

With me today are Rachel Laas and Deb Carlton. They will each read a statement containing information on their clinical roles and the importance of maintaining minimum nurse-to-patient or midwife-to-patient ratios. I thank the committee for this opportunity, and I ask you to consider the comments of the nurses and midwives who have taken the time to come to this hearing today to advocate for safer patient care.

Ms Laas: My name is Rachel Laas. I am a registered nurse and I currently work on the surgical south ward of the Cairns hospital. Although I have worked in a few roles in the hospital, I have been based on this ward since I graduated six years ago. It is a 32-bed ward with a high turnover of patients. We care for patients pre- and post-operatively. The ward admits patients who have urology issues, burns, bowel surgery, plastic surgery and general surgery. We currently have ratios of one to five on a morning shift, one to five or six on a late shift, and we have recently changed from one to six or seven on a nightshift.

We are finding that the acuity of patients on the ward is increasing primarily due to their existing co-morbidities and the more complex surgeries being done. At present the staff on duty are just barely covering the wide range of care required for these patients. Our workloads become even more intense when registered nurses are replaced with a student nurse, as this adds extra pressure to the experienced nurse allocated for that shift.

Decreasing the amount of patients per nurse will allow the nurse to assist patients to complete their activities of daily living like brushing their teeth, helping them dress and other care requirements. As we have just moved to a computerised system for our records, this involves extra time to enter patient information. Amongst many other matters, reduced nurse-to-patient ratios will ensure that documentation is effectively completed for each patient. We expect the proposed ratios will give nurses more time to check medications and ensure that it is administered correctly. There will be less pressure placed on the staff to complete every task before they leave their shift, and this in turn will decrease the amount of stress related sick leave. There will be more time for education of staff on the ward as well as time for learning for the new graduates and casual staff members.

Treating the whole patient is a key element of nursing and one that is increasingly being eroded through time constraints. The minimum nurse-to-patient ratios will provide more time to talk to patients to assess and monitor their needs, discuss their condition and to gather information relevant to discharge planning. Importantly, it will allow the nurse to become more patient focused rather than task focused.

Ms Carlton: My name is Debbie Carlton. I am a clinical nurse at Mareeba District Hospital. We are a small rural hospital with limited resources and services. We are especially stretched on weekends, evenings and nights. Our responsibilities are vast and not all major events occur during business hours. Many happen in the evenings, overnight or on weekends. I am going to describe a typical after-hours shift and the responsibilities of a team leader so the committee might understand how important it is that only nurses or midwives who are rostered to provide direct care to patients should be included in the ratios. Nursing positions such as mine should not be taken into account when determining the nurse-to-patient ratio.

On every shift I work in the hospital in a nursing team leader capacity, half of our patient admissions happen on an evening shift or nightshift when there is minimal staff, so it is not uncommon for five to seven patients to be admitted to the ward after three pm. Often I will come to work and be individually responsible for at least four patients as well as manage, coordinate and delegate the nursing care of at least 25 patients between junior registered nursing staff, enrolled nurses and an assistant in nursing. I supervise enrolled nurses and an assistant in nursing to administer nursing care. I mentor and support junior registered nurses to problem solve and learn time management skills. I also have at least one nursing student from a local university or TAFE to support and nurture.

I answer most phone inquiries, as I am the only person who has had the complete handover of all 25 patients and there is no secretary after 3 pm, overnight or on weekends. I often spend at least two hours on the phone trying to replace nurses who have called in sick, as we are a rural hospital

with no casual pool of nursing staff. I liaise with Cairns hospital med records, as it can take up to two hours to organise new patients to be put on our computer system for data entry. I organise acute hospital transfers to Cairns hospital, utilising at least one of our registered nurses to transfer, knowing that they are going to be off the hospital grounds or at least four hours out of their eight-hour shift or even longer if they are ramped at Cairns hospital or if the ambulance has been diverted to an accident.

There is no on-site pathology service at Mareeba, so every blood test requires 15 minutes off the ward in an emergency to process it, refrigerate it and have it waiting for a courier to collect. I respond to clinical emergencies in all hospital areas assisting with stabilisation and transfer of patients, which can take you off your home ward for hours. We have no on-call pharmacists after hours, so when the hospital runs out of essential drugs it is my responsibility to source them. When the hospital runs out of linen and towels, it is my responsibility to organise access to the laundry to get more. When the hospital runs outs of face masks on Friday night in the middle of an influenza epidemic, it is my responsibility to get more. When all of the O negative blood has been used due to an accident, it is my responsibility to replenish stock and organise transporting it to the hospital.

Nursing team leaders in a rural hospital are responsible not just for patient care, they are also responsible for the hospital grounds. We respond to all fire alarms that occur within every section of the hospital grounds. This includes checking the nurses' quarters to ensure that doctors and nursing staff are evacuating the building and even checking the dental clinic, as they are all linked to the hospital fire board.

Nursing team leaders have to provide access to the nurses' quarters when swipe cards are deactivated by live-in staff or they have locked themselves out of their rooms whilst using the communal toilet. Nursing team leaders often have to organise allocation of rooms at the nurses' quarters when an influx of nursing, medical and allied health students arrive on Sunday afternoon to commence work on Monday. Nursing team leaders call in maintenance when the nurse call bell system will not turn off, hospital air-conditioning stops, burst water pipes occur, toilets in the nurses' quarters are blocked or power switches in the nurses' quarters are tripped and there is a high temperature alarm in the morgue. Not to mention assisting doctors with rounds and performing minor procedures on the ward with them all requires a senior registered nurse or nursing team leaders to help.

In a rural setting it is essential that team leaders and nursing unit managers are not included in direct care in patient-nurse ratios. Only a limited delegation of nursing team leader tasks can occur if you are lucky enough to be rostered with another senior registered nurse or if they are not off the hospital grounds on an escort. It is the registered nurse who assesses and plans patient care. An enrolled nurse can collect data for the registered nurse to formulate a plan, but it is outside the enrolled nurse's scope of practice to plan care. Assistants in nursing also work under the direct supervision of a registered nurse even for such tasks as bathing patients. These are just a few of the tasks I perform as a clinical nurse, but what about the patients? They are our priority.

For the health and safety of our patients it is essential that nursing team leaders, nurse unit managers or any nurses not directly involved with patient care are not given a patient load within the nurse-patient ratios. Thank you for listening to my concerns.

CHAIR: Thank you, Debbie, Krissie and Rachel for the contribution that you are making to the Queensland health system by being nurses. Certainly there is tremendous respect on the panel for what nurses do, given that we have two nurses on the panel in Joe Kelly and Ros Bates, a medical doctor, Dr Rowan, and a paramedic in Aaron Harper. I am sure my fellow members will convey the same thing, but thank you very much for your contributions.

My questions are to the panel, so please feel free to comment. How will mandating minimum nurse-to-patient ratios practically improve or benefit patient safety?

Mrs Bishop: Practically patients will get quality care. At the moment they are getting the minimum care because there is not enough staff on the wards to safely care for the patients. As Rachel indicated, just brushing their teeth is not a task that is a priority, but it is a priority for the patient. It makes them feel better. It is part of their daily living.

CHAIR: One of the things that I have read in the significant body of evidence around mandating ratios—and I have also heard from nurses, both in the inquiry and externally—is that pressure and wound care is a significant area of concern for nurses because you do not have the time potentially to focus on that and also there are significant adverse effects if that is not dealt with. Is that a fair statement to make? Is that one of the key concerns?

Mrs Bishop: That is a very fair statement. I speak to nurses every day and they tell me that they have to organise to find another nurse just to go and give out pain management tablets. 'We have to turn this patient or they are going to get a pressure sore.' 'I have to do this or that.' They do not have the other staff there to say, 'We need to do this.' Instead they come back three hours later.

CHAIR: Drawing on your comments there, will mandating the minimum ratio proposed, being one to four in the morning and afternoon and one to seven at night, be an improvement on the workload that you are experiencing now?

Ms Laas: Absolutely.

Ms Carlton: Absolutely.

Mrs Bishop: Without question.

CHAIR: I ask that too because one of the comments that I have heard is that in many situations the ratio is now already above that, so what does that achieve? That has been one of the things that I have heard. What you are saying is that it will give you an improved environment in which to work.

Ms Carlton: Absolutely.

Mrs Bishop: I would really like to see where the ratios are above. There are a lot of places that I am aware of where the ratios are severely below.

CHAIR: Thank you, that is very good feedback. Some of you have touched on this, but is there a physical and emotional impact of high patient workloads? If so can you give me a bit of an idea, as someone who is not a nurse, of those sorts of environments?

Ms Laas: I worked during the Ravenshoe disaster and we had nine burns patients on the ward. Some of those patients were burnt all over; some of them were just burnt on their hands. For a burns patient it can take two nurses off the ward for two to three hours just for one patient, but during that time we hardly got any extra assistance which put pressure on the nurses working on that ward. It meant that people felt like they had to come in and do extra work because it was a strain on the other staff members, which increased the sick leave because people do not want to go when it is horrible on the ward. I think more staff would be so beneficial. That is a disaster; it is a big thing to happen.

Mrs Bishop: But every day there are gaps in the rosters. I had a nurse yesterday who said that she was the 18th person called and they offered to buy her a box of chocolates to come in on her day off to work to fill the gap. It is not an uncommon thing; it happens every day with the clinical nurse numbers. They are just trying to fill the gaps because the sick leave is incredibly high due to staff being so tired.

CHAIR: They are obviously feeling extended and pushed to do that over time.

Mrs Bishop: Yes.

Ms Carlton: We have no casual pool of nurses, so we all just sit there and beg our permanent part-timers to come in. They will come because they have been in our shoes, because they have been on where someone has rung in sick and we have not been able to get help, or they will come because they will self-sacrifice for their work colleagues.

Mrs Bishop: And their patients.

Mrs Carlton: And their patients, yes.

CHAIR: The statement from the minister when he introduced the legislation, that it is expected that around 250 additional nurses will be needed to be recruited just to introduce these ratios, is obviously very positive news for each of you.

Ms Carlton: Absolutely, and for the patients too. They will not be as frustrated because we will be able to spend time to educate them and give them the time that we should without doing any of the other external stuff we get dragged to.

CHAIR: Have you received feedback from patients that they feel they want more time from the nursing staff?

Ms Carlton: Absolutely.

Mrs Bishop: Yes. They feel guilty they are taking up our time, and that is just so wrong.

Ms Carlton: They will not ring the bell because 'You look too busy. We don't want to disturb you.' That has detrimental effect on them.

Dr ROWAN: To Deb, Rachel and Krissie, thank you for all the hard work that you do as nurses and for patient care in our Queensland hospital system. I come to you first, Krissie, just in relation to your evidence that there needs to be flexibility in ratios as far as factoring in complexity and acuity. With that occurring in the business planning framework, who should determine that in your view and experience?

Mrs Bishop: Who should determine the business planning framework, or the complex acuity and the numbers?

Dr ROWAN: The flexibility of ratios, factoring in complexity and acuity in individual hospitals or health care settings in the business planning framework, who is the best person or best people to determine that?

Mrs Bishop: In my experience it is the nurses on the floor.

Dr ROWAN: In relation to mandating skill mix ratios, RNs to ENs, do you believe that should also apply, or how would you factor in skill mix?

Mrs Bishop: You factor in your skill mix depending on the acuity of your patient.

Dr ROWAN: Should that be mandated? Apart from a ratio, should the skill mix RNs to ENs or ENs to RNs be mandated?

Mrs Bishop: No, because it can change depending on the acuity on a daily basis. I would mandate that the RNs would be the ratio and your ENs would be your skill mix, depending on the acuity of your patients.

Dr ROWAN: Should ratios also apply to nurse navigators?

Mrs Bishop: I would not know. I would have to take that question on notice.

Dr ROWAN: If you could take it on notice that would be good. I guess my next question comes back to if nurse-to-patient ratios are implemented, will that allow for multidisciplinary ward rounds to occur in Queensland hospitals as well with doctors, nurses and allied health people together having a round collaboratively?

Ms Carlton: I know at Mareeba we have a morning meeting, and all the multidisciplinary teams get together and they discuss each patient basically as a collaborative thing. Allied health touch base with the doctor, and they will go out and discuss it—not together in front of the patient, but in between the rounds and in between each allied health person—holistically together how each service will benefit the patient between the doctor, the physio, the speech therapist or whatever, because of this morning meeting that we have every day at Mareeba.

Dr ROWAN: I wanted to get an understanding of the quality assurance framework, and I will ask Deb and Rachel. In your individual clinical units when particular incidents take place they would be entered into your clinical incident risk management system, PRIME, and if there are incidents that take place in relation to staffing or other things, presumably it is entered into that. As an individual clinical unit do you get to look at those and evaluate them along with other data in relation to your individual clinical unit, like the national average length of stay versus the length of stay of patients in that unit, or the occurrences of pressure ulcers and DVTs and unplanned readmissions to your unit? Do you get all of that data on a regular basis to have a look at and evaluate?

Mrs Bishop: Most of that is dealt with at the nurses' consultative forums and the health consultative forums, and the delegates then disseminate that information back to the staff.

Dr ROWAN: With the information that is being evaluated through those forums, is there any evidence that if there are additional staff or lack of staff, either perceived or actual, that that is dealt with at that level? Is that what is currently happening at the moment, or how is that dealt with through those forums?

Ms Carlton: Are you asking when you do out of PRIME, are the staffing issues captured on the PRIME? Is that what you are saying?

Dr ROWAN: If there is perceived or actual lack of staffing as outlined today and then there is a problem on the clinical unit as far as increasing length of stay or clinical incidents that take place, how is the individual hospital and health service at the moment dealing with that? In other words, if there is a lack of staffing and there is an adverse outcome, how are they adjusting for that? Those forums that were outlined, is that being dealt with at that level now?

Mrs Bishop: That is not something that as nurses we can answer because that is not something that we deal with on the floor.

Dr ROWAN: No, but it is being dealt with at those forums as you outlined.

Mrs Bishop: In the forums it is discussed and it is then dealt with by the managers, depending on how the discussions progress. But all we can say is that Linda Aiken's evidence is very clear and we urge you to look at the QNU's submission.

Dr ROWAN: Yes, but if there is perceived inadequate staffing now and there are adverse events, is management actually—

Mrs Bishop: There is no adequate staffing now. That is what we are saying.

Dr ROWAN: Is the hospital and health service in Cairns then rectifying that as of today, or are patients being put at risk because of inadequate management—

Mrs Bishop: We are not saying there is inadequate management. We are saying there is inadequate staffing on the wards.

Dr ROWAN: Is that being addressed today but in a real-time way? In other words, if the hospital and health service—

Mrs Bishop: You would have to ask the managers if they are addressing inadequate staffing. You cannot ask us as nurses who work on the floor whether they are addressing inadequate staffing.

Dr ROWAN: I was asking through those delegate forums whether that is being addressed—

Mrs Bishop: It gets addressed at those forums, but whether anything tangible comes out of that being addressed is not very clear as to whether we are getting extra staff. It all comes down to the money and how much money is allocated to each BPF for each area.

Dr ROWAN: The other thing I wanted to ask about was apart from ratios, is there anything else from a health system perspective that you would like to see addressed? We talked about some of the inefficiencies, and I think Deb was outlining that with respect to entering new patients on the clinical information system it can take a long period of time and sometimes there are issues that have to be dealt with around consumables and medications. Are there any other things that you would like to see addressed apart from the proposed ratio in relation to clinical design, equipment, technology or other matters?

CHAIR: The only thing I would say is that needs to relate to the ratios.

Dr ROWAN: As part of the proposed implementation of nurse-to-patient ratios, is there anything else that can be additional things that could be of assistance if it was to be implemented?

Ms Carlton: I think rural places are very small—we have limited resources and limited services. We have no pathology. That is a huge thing. Everything has to be put in an esky, sorted round a courier and sent to Cairns. That impinges on patient care. It can take up to 12 hours for those results to get back, whereas because Cairns has on-site pathology those results will come back within a couple of hours. Do you know what I mean? Because we have limited resources, it does impinge upon the patients.

Mr KELLY: Thank you, Deb, Rachel and Krissie, for your presentations. Just picking up on some of those discussions around PRIME and the reporting systems, having filled out quite a few of those myself, in my experience—and I wonder if it is true in your experience—would it be true to say that because the staffing level is the staffing level it is not something you consider when you are filling out PRIME? Usually you are looking at things that have occurred that have led to that patient being on the floor or that medication being given incorrectly or that pressure sore developing without picking it up, so you do not factor staffing into the thinking around that? Is that correct?

Ms Laas: Yes.

Ms Carlton: Yes. There are no prompts in PRIME when you are really, really busy to go, 'Hang on. So and so is down the hill. Our patient ratios are huge—more than one is to four—because I have Joe Blogs down the hill doing an escort.' With PRIME, if you had some sort of prompt in there to say, 'Hey, look at staffing'—do you know what I mean? There are no prompts in PRIME for that.

Mr KELLY: Krissie, you have referred to some research there. You have read some research or you are familiar with research that suggests that if we increase ratios we will have an impact on reducing nurse sensitive outcomes such as pressure sores, falls and hospital acquired pneumonia.

Mrs Bishop: Yes, definitely. We also do not need to read research to understand that, if you can get to your patient and give them the care that they deserve in the time that you should be giving them that care, it is going to reduce the complications that can occur. It is a no-brainer.

Mr KELLY: Is it fair to say that on an average day at work you have to make some really difficult decisions about the types of care that you can deliver and you have to almost go through the ABC algorithm to work out what is the most important? Is that fair to say?

Mrs Bishop: Yes, that is very fair to say.

Mr KELLY: What do you think the long-term impacts of poor oral health care are for a patient?

Ms Carlton: They are just going to re-present again. If we send them home too early, they are going to re-present and then it is the same circle every time.

Mr KELLY: We know that poor oral health care leads to poor general health care. Is that correct?

Ms Carlton: Yes.

Mr KELLY: As a rehab nurse myself, I am sure you are all aware by the sounds of it in the environments that you work in that helping people with basic care is really one of those things that we have to do if we are going to get people home successfully.

Mrs Bishop: Yes.

Mr KELLY: If you cannot shower, if you cannot care for your teeth, if you cannot feed yourself, if you cannot dress yourself, what is going to be the outcome of those things?

Mrs Bishop: Even sitting down and discussing their medication that they are taking home with them—we find people are readmitted because they do not fully understand how to take that medication.

Mr KELLY: Yes. I am assuming you would like to be able to do a full skin assessment on patients every day?

Mrs Bishop: It would be a luxury.

Mr KELLY: Every shift?

Mrs Bishop: It should be a given, not a luxury. Unfortunately, we do not get that time.

Mr KELLY: For those patients that you have assessed as being at nutritional risk, you would like to be able to somehow monitor their nutritional intake?

Ms Carlton: Absolutely.

Mr KELLY: For those patients who are deemed to be at a high-fall risk, you would like to be doing extra monitoring of those patients and education for the families? Is that correct?

Mrs Bishop: Exactly.

Mr KELLY: Are those the sorts of things that you have to make tough decisions about when you do not have adequate staffing levels?

Ms Carlton: Absolutely.

Mrs Bishop: Yes.

Mr KELLY: You talked about patient education around medications. How important do each of you think that patient education is in terms of really preventing people from re-presenting back to hospital and breaking the cycle?

Mrs Bishop: It is imperative. It is highly important.

Ms Carlton: Absolutely.

Mrs Bishop: Also, it is about nurses being educated to educate those patients. We lost a lot of our nurse educators over the last couple of years. We are struggling to get the senior experienced nurses back into the workforce.

Mr KELLY: As people particularly age and their bodies change, we need to educate them about things like skin care, medication, bowel care—those things that will all lead someone back into hospital and things that you would like as a nurse to put your time into in terms of education. In the ABC scenario, where does education fall if you do not have adequate staffing?

Ms Carlton: To the bottom.

Mrs Bishop: Completely.

Mr KELLY: Compare this day that I am going to describe to the day that you often face in your workplace. You get to come to work and you get a good handover. You get to assess your patients properly. You get to introduce yourself properly. If they have family there, you get to talk to the family. You get to do a good skin assessment. You get to do a good sharing and ADL assessment. You get to make sure that the patient adequately intakes the food that they need for the day. You get to make sure that the patient gets out of bed and mobilises to the level of their ability. You get to spend some time generally shooting the breeze with the patient, making sure that psychologically they are okay.

You get to make sure you check their wounds, if they have them. You get to sit down and think about what you need to do in terms of discharge planning and patient education for these people. How does that compare to the day that you are normally dealing with at the moment, Rachel?

Ms Laas: That day sounds fantastic.

Ms Carlton: I would like that day.

Ms Laas: It does not happen at all.

Mr KELLY: Do you think introducing ratios would lead to the possibility of that day occurring more frequently for you in your work situation?

Ms Laas: I think the ratios would allow at least half or three-quarters of that to happen. Just shooting the breeze with a patient, finding out what is concerning them and what we can do for them right now, is going to help them tomorrow or the next day or in the future. That would be the best thing on the day.

Mrs Bishop: I would go so far as to say that if we introduced one nurse to four patients, especially on the general medical surgical ward, that would happen. In a more specialised area like Rachel's, when they take in the skill mix and they have the other nurses to help her then that what would happen. That is where the acuity and the BPF comes in. Because she is more specialised with the burns, it takes up more time. That is when you would apply that to ensure that she has that extra skill mix to make that happen.

Mr KELLY: Krissie, you have worked at the CNC level.

Mrs Bishop: Yes.

Mr KELLY: How often have you seen opportunities for quality improvement activities in your wards that you simply do not feel that you would have the time to get to because the staffing levels are inadequate?

Mrs Bishop: Very often. The majority of the time I have to put the audits on the backburner because patient safety and care come first.

Mr KELLY: In terms of developing those skills for nurses to educate patients, those things take time and take staffing.

Mrs Bishop: Yes. The education of the nurses has severely impacted on the quality of staffing.

Mr KELLY: Thank you very much.

Ms BATES: Deb, I really appreciate your role as a team leader. It is similar to a position in a private hospital where you get to be all things to all people—travel agent, social worker, maintenance worker, problem solver. Thank you for the hard work that you do in our regional and rural hospitals. I picked up when you said you have problems covering sick leave now, that you do not have a casual pool of staff at all. My question is: if you do have a nurse-to-patient ratio, what difference is that going to make for you to cover sick leave when you cannot cover it now? How is that going to change?

Ms Carlton: People are exhausted because they are doing double shifts. A lot of that is fatigue and they are ringing in sick. If you have patient-nurse ratios you have less fatigue. People will want to come to work because they are not fatigued. They are not doing double shifts. The other thing is you will attract more staff with patient-nurse ratios to come and want to work because of the environment they are in. They can do their patient care. They can spend time.

Ms BATES: You do have a finite number of staff that you can call on at the moment. Often in country areas it is difficult to attract staff. I am just wondering whether the nurse-patient ratio on its own is actually going to attract more people to Mareeba, for instance. You have other issues in Mareeba apart from just staffing matters. It is the tyranny of distance and families having to move out there and all of that sort of thing.

Ms Carlton: We have nurses' quarters on site, so that is really attractive. People will come for a short period of time.

Mrs Bishop: There are staff who commute from other areas and there are also nurses in the community who are not working at the moment but have told me on numerous occasions they would be willing to consider coming back to work if they will get a safe patient workload.

Ms BATES: We did a trip to Perth and Victoria last week. One of the things that was raised was, when ratios were introduced in Victoria, all the nurses who were casual effectively had to go on to permanent part-time or they did not get shifts. How do you think that would impact the nurses' choices in areas where a large degree of the workforce in Queensland nursing now prefer to work either permanent part-time or casual? Have you had conversations with casual nurses about how that might impact them?

Ms Carlton: No.

Mrs Bishop: That has not come up in conversation. We have not heard that.

Ms BATES: Do the nurses understand that if we introduce the nurse-patient ratio and it is similar to what the ANF introduced in Victoria you really do not have a choice of being casual? You have to go on to permanent part-time.

Mrs Bishop: How will that be that they will have to go on to permanent part-time?

Ms BATES: That is the way they did it in Victoria.

Mrs Bishop: Just because they did it in Victoria does not mean it is going to happen here.

Ms BATES: No. I am just saying that it is modelled on the same people that you are talking about.

CHAIR: Member for Mudgeeraba, some of that is beyond the scope of the bill. I do not recall that statement either. If we can make sure we talk to the bill—

Ms BATES: I said it earlier. Look at the Hansard. My next question—

CHAIR: We do not have a Hansard for this morning.

Mr HARPER: To reflect on your statement, member for Mudgeeraba, in Victoria—and I highlighted this fact—3,400 nurses returned between 2001 and 2003.

Ms BATES: I do understand the figures. Thank you very much. That is not my question. My question was about if the nurse-patient ratios are brought in has anyone spoken to the staff who are casual at the moment who do not want to work permanent part-time and have they been consulted?

Ms Carlton: I think too you are comparing Perth to Mareeba.

Ms BATES: No, to Victoria.

Ms Carlton: Sorry. I think there would be more flexibility because, even if you brought it in and you are comparing a big capital hospital, people—

Mrs Bishop: I know the staff who wish to stay casual will get work.

Ms Carlton: They will because we have no casual pool.

Mrs Bishop: Not just in Mareeba. In the Cairns hospital there is a big casual pool that is relied upon heavily to fill the gaps in the roster right now. I know that the casual staff who do not wish to go permanent part-time—there is an awful lot who would like to go permanent part-time, so they would welcome the chance to become permanent part-time.

Ms BATES: There is a culture of bullying and intimidation in Queensland Health. It is well known everywhere I have been. I have been in every hospital in Queensland. Do you think that the nurse-patient ratios will remedy this? Do you think it will help with what is going on?

Mrs Bishop: Sorry. I do not know what bullying has to do with ratios.

CHAIR: I warn the member for Mudgeeraba too that that is a fine line in regard to the bill and if we can ask questions rather than make ranging statements about bullying in the whole of Queensland Health.

Ms BATES: Sure. Nurses have spoken about that culture. Do you think that that culture will dissipate if there are nurse-patient ratios and there are more staff? A lot of the complaints that I have received have been about the fact that there have not been enough staff on and that people were fated with shifts or those sorts of things. Do you think that the nurse-patient ratio will assist in that culture that we all know occurs in Queensland Health now?

CHAIR: I think you can certainly answer the question in relation to do you feel that nurse-to-patient ratios will have an effect on culture, but you do not have to make any comment on the assertion that the member has made about the nature of that culture.

Mrs Bishop: I do believe that nurse-patient ratios will positively affect culture because people will be less tired. They will be less concerned about their patients' safety. They will be able to deliver patient care. That is what they went into nursing to do. Therefore, there would be a happier workforce because they are delivering the care the patients deserve.

Ms BATES: Just to go back to your comments in answer to Dr Rowan before, do you believe that the nurses on the floor are the ones who are most able to judge the skill mix of their staff and the acuity of their patients that they are looking after?

Mrs Bishop: I believe the senior nurses on the floor who are working daily trying to deliver that care and supervise the other nurses are the ones who have the most experience on deciding about the staff, the allocation and the care.

Mr HARPER: I start by acknowledging your contribution to your professions over the years. It is significant. Picking up on some of the things that you said, Rachel, about the Ravenshoe disaster and your particular ward, your 32-bed ward obviously has high acuity when faced with those types of incidents. I commend the work that you and your peers have done through that particular disaster.

Ms Laas: Thank you.

Mr HARPER: I was concerned, though, that you did say in the six years since you qualified you have observed stress and absence of staff. Can you articulate more? Is it because of the workload? I think you started touching on it too, Deb, so all jump in if you like. Is it due to those back-to-back shifts or the workload that impacts mentally? You mentioned stress related leave, as well. You may have to take it on notice, but I would certainly like to have an idea of what the absenteeism rates are, particularly if you can dial them down to stress related.

CHAIR: Queensland Health can provide that. They do not have to take that on notice. They can just make comment on that.

Mr HARPER: If you want to comment, that is fine.

Ms Laas: I cannot tell you what the ratios are for stress or with absentee leave, but I can tell you that double shifts ruin you. You can pull a double shift and you can run that entire shift. I am not going to come in tomorrow because I am too tired from my double shift yesterday. That is exactly how it works. People are coming in—I went in yesterday on my day off for four hours to do a burns bath because there was no-one else who would possibly come in. I have done a lot more over my quota of shifts this week, but I felt bad because my other staff members would have had to be pulled off the floor from their patients to do this job. That is just going to make them run even more, because they have to look after this thing and then they have to go back to their patients. There is just not enough time to do everything.

Mrs Bishop: Dissatisfaction at not being able to deliver the holistic care the patients deserve is one of the big factors of staff being sick and staff fatigue. They cannot get to do the basics of care for every patient on every shift.

Mr HARPER: Certainly something that we picked up in the Victorian discussions is that morale did improve and you had a happier workforce. There have been some studies and good bodies of evidence in the UK and the US that support that high morale. Would you comment on that? Could you foresee a similar trend? We have had some good studies out of Western Australia, as well. Would that be the way to go, improving the ratios?

Mrs Bishop: Definitely. The fact that I have people saying they are willing to consider returning to the workforce when they left because they were fatigued, because they did not have the satisfaction, they did not have the staff there to help them, but they would consider returning if they had mandated minimum patient ratios— that says something.

Mr HARPER: At the end of the day this is about patient safety, so it is getting those ratios right. Some of the other interesting data that I read was about reducing length of stay; getting your patients through the patient journey, from the front door and back home quicker. Do you have any comments?

Mrs Bishop: Yes, and less readmissions.

Mr HARPER: Anyone feel free to comment on this: do you have any examples where an inappropriate nurse-to-patient ratio may have resulted in an unintended consequence for either the patient or the nurse?

Mrs Bishop: I would have to take that on notice, but I could definitely find—

Mr HARPER: Quite often we have heard that, because of the ratios, you have not got the nurses on staff and a fall may have been prevented. Say an aged care patient stumbled out of bed or something like that. Some of the examples that we have read about are along those lines. I was seeing if there was anything—

Mrs Bishop: I think it comes down to the fact that if you have patients who are unable to feed themselves, by the time that you get to the third or fourth patient their food is stone cold and they are not going to want to eat it. If you had enough staff, you would be able to feed all those patients while their food was hot and palatable. It is things such as that. That happens every day.

Mr HARPER: Or a diabetic patient with hypoglycaemia and the nurse has been delayed. Deb, I really do get, just from your observations in Mareeba and particularly my time in the ambulance and working in those smaller centres, that once you take that nurse resource out it impacts on your ability to continue to function.

Ms Carlton: Absolutely and it is usually a senior nurse. In the supervisory role, your own patient suffers.

Mrs Bishop: That happens with every hospital in this catchment area. They all have to transfer to Cairns, the more serious sicker patients, and they all then remove the senior nurses from the floor. There is no-one then to back that up. To go to Cairns, that is it.

Dr ROWAN: I have two final questions. Krissie, assuming that the legislation is passed, do you have any recommendations with respect to measuring the clinical effectiveness of nurse-to-patient ratios in Queensland? In other words, how should it be done, by whom and where should be it reported to?

Mrs Bishop: That is not something that I can answer as a nurse. I am just a clinical nurse. That is not something that I would be even thinking about or dealing with. I would just be happy if I walk on that ward knowing that I have my safe patient ratio.

Dr ROWAN: What I am trying to ask is this: measuring the clinical effectiveness unit by unit, at that sort of level, what would you like to see into the future to understand what is actually happening clinically? Nurses on an individual ward would want to—

Mrs Bishop: What would I like to see? I would like to see less readmissions. I would like to see more education, for staff and patients. I would like to see less preventive complications. That is what I would like to see, and staff morale and patient happiness. That is what I would like to see and that is what I would base mine against. That is how I would manage it and look at it, from now to when they get mandated, as to how the care is improving and how the patient satisfaction is improving.

Dr ROWAN: If that data was collected, presumably you would believe that you would see improvements in all of those things?

Mrs Bishop: Definitely. Without question.

Dr ROWAN: Finally, with the ratios obviously you want to see that for public patients and aged care patients?

Mrs Bishop: Definitely.

Dr ROWAN: And private patients?

Mrs Bishop: Definitely.

CHAIR: You do not need to comment on that, because these questions are clearly outside the purview of the bill and the member knows that, because I have ruled previously on that.

Dr ROWAN: Madam Chair, I would say that there are private patients in public hospitals. So I am asking the question—

Mrs Bishop: Whether there are private patients in public hospitals or not, they all get treated the same.

Dr ROWAN: For all patients in all public hospitals, whether they be public patients or private patients, you would like to see the ratio apply to all of those patients?

Mrs Bishop: I would like to see the ratios applied so that nurses have safe working areas and patients are safe and they get the care that they deserve at the end of the day. That is what I would like to see.

Mr KELLY: On a day-to-day basis, do you have any awareness of which patients have elected to be treated as a private patient?

Ms Carlton: At Mareeba we have private patients with us, because it is to the hospital's advantage to use your private health. When that happens everyone is treated basically the same.

Mrs Bishop: But half the time you would not know if they were a private patient or not when they hit the bed.

Ms Carlton: You do not know. We treat them all the same. There is nothing that would signify that they are private as opposed to public. Nothing.

Mr KELLY: I was very interested in your description of your work as a team leader, having fulfilled that role myself. I think I was with you up until about the point where you had to get people back into their nurses quarters after they went to the communal toilets.

Ms Carlton: Yes. It is very common.

Mr KELLY: I want to pick up on the discussion that we have had this morning around nurses at the bedside and the unit level being best placed to allocate staff. As a team leader myself, I think that is a reasonable statement. What are your thoughts around that?

Ms Carlton: I think the nurse on the floor has to be the person to allocate staff, because they are working as a working peer. They know their level of skill. They know how they respond in a stressful environment. We just know. We know what their shortcomings are. We know, because we work with them.

Mr KELLY: As a team leader, you have a pretty high level of understanding of the acuity of the patients.

Ms Carlton: Absolutely.

Mr KELLY: You have a good understanding of not just the skills mix of the staff but also the other things that go on that affect people's performance, if they are having some difficulties at home and so on.

Ms Carlton: Absolutely.

Mr KELLY: If they have had some illness recently, you are aware of all those things. Do you factor all those things into your decision making when you are making decisions about staffing allocations?

Ms Carlton: Absolutely. If you know that someone has had a miscarriage, you would not put them in with pregnant women; do you know what I mean? You know because you have that working relationship with them.

Mr KELLY: A patient's situation can change quite dramatically throughout a shift.

Ms Carlton: Absolutely.

Mr KELLY: During a shift, you can have people deteriorate who were very low care and suddenly they become very high care.

Ms Carlton: Absolutely. You would have an idea from handover who was high care and who was low care, so you would do the best fit with the nurse and the nursing resources you have to allocate the patients around.

Mrs Bishop: It changes on the shift. You can allocate a low-care patient who then becomes a high-risk patient. You would have to reallocate accordingly. That is part of the job, as well, and the experience of being on the floor.

Mr KELLY: I do not know, Rachel, whether you have had those experiences as well, but certainly, Krissie and Deb, you obviously have. Would it be fair to say that you would much rather be making those allocated decisions with a ratio in place that has a much—

Ms Bishop: Definitely.

Ms Carlton: Absolutely.

Mr KELLY: How would that affect your decision making as a nurse?

Ms Carlton: I would put this senior registered nurse with those four patients knowing that if this man went from low to high, then her experience would cover that.

Mrs Bishop: That is the only four patients she is going to have. She is not going to go and look after another seven on the other side.

Ms Carlton: Then I know that nothing is going to drag her from that. She is not going to have another two patients come in after three o'clock and one of them has just been revived from some diabetic incident or whatever. You know that she is going to have that capacity to deal with the here and now and she does not have to extend herself to another three unknowns who may come through the door. She can organise her time better.

Mr KELLY: Stepping away from the team leader role back to your role as nurses at the bedside, regardless of whether you have one patient, two patients, six patients, eight patients or 10 or 12, as we have all had at various times, as the individual registered nurse or enrolled nurse who is allocated a patient load you have to make decisions about how you allocate your time amongst those patients; is that fair to say? You have to make some difficult decisions about what you do for what patients at what time?

Ms Carlton: Yes.

Mr KELLY: Will those decisions be made easier if you are not spreading those over 12 patients, but you are spreading those decisions over four patients?

Ms Carlton: Absolutely.

Mrs Bishop: I would not have to make that decision, because I would have enough time for each patient at the end of the day.

Mr KELLY: Thank you very much.

CHAIR: Thank you very much. There being no further questions, we will conclude the hearing. I thank Krissie, Rachel and Deb for taking the time out to speak to us today. It looks like you are in your uniform, Deb. I am not sure if you are going to or from.

Ms Carlton: Yes, I have to go up the hill.

CHAIR: Certainly the committee has received a significant body of evidence supporting what I consider to be very historic laws that we are talking about introducing in Queensland. I thank you, not only for the contribution that you are making in the health services but also for the contribution that you have made to our consideration of this bill. Thank you very much. I now declare the hearing closed.

Committee adjourned at 10.42 am