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THE UNION FOR QNU NURSES AND MIDWIVES

Submission to the Health and Ambulance Services Committee



Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015

Hospital and Health Boards Amendment Regulation (No. ..) 2016

February 2016

"The primary function of nurses is to provide early surveillance and to detect problems that could lead to death and other complications. If there aren't enough nurses at the bedside with visual contact with patients, nurses don't have a chance of making those decisions".

Linda Aiken, Professor of Nursing, Pennsylvania State University

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Executive summary

The *Hospital and Health Boards (Safe Nurse-to-patient and Midwife-to-patient Ratios) Amendment Bill 2015* (the Bill) and the *Hospital and Health Boards Amendment Regulation (no. ..) 2016* (the Regulation) (refer to attachment 1) represents an important milestone in the provision of public health services to Queenslanders. The Queensland Nurses' Union (QNU) thanks the Health and Ambulance Services Committee (the Committee) for the opportunity to comment on the Bill and the Regulation. We welcome the state government's acknowledgement of the crucial role nurses and midwives play in delivering safe, high quality health care for Queenslanders through the commitment to legislate minimum nurse-to-patient and minimum midwife-to-patient ratios.

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

We point out however, that the dearth of law in this area contrasts sharply with the abundance of evidence demonstrating the benefits of nurse-to-patient ratios. A substantial body of research clearly demonstrates that nurse-to-patient ratios and endorsed skill mix levels (the proportion of Registered Nurses providing care) are economically sound methods to save lives and improve patient outcomes.

National and international studies have irrefutably shown that the number, skill mix and practice environment of nurses directly affect the safety and quality performance of health services. Health services with a higher percentage of Registered Nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and less adverse events such as failures to rescue, pressure injuries and infections.

The following statistics give a snapshot of the important correlation between nursing workloads and patient outcomes:

- Every one patient added to a nurse's workload increased the likelihood of an inpatient dying by 7% [1].
- Every 10% increase in bachelor-educated nurses decreased the likelihood of an inpatient dying by 7% [1].
- Every one patient added to a nurse's workload increased a medically admitted child's odds of readmission within 15-30 days by 11% and a surgically admitted child's likelihood of readmission by 48% [2].

Nurse/midwife-to-patient ratios will contribute to organisational productivity, hospital efficiency and continuity of patient care by increasing staff satisfaction, decreasing attrition rates, reducing patient readmission and adverse events, limiting service variation and improving equality across the healthcare sectors.

The implementation of minimum ratios in Queensland public health facilities will be distinct from other ratio models applied in Australia and around the world. Queensland Health (QH) will be implementing minimum ratios in conjunction with the industrially mandated and validated tool for managing nursing and midwifery workloads known as the Business Planning Framework (BPF).

The BPF is a comprehensive planning process that customises the workloads 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. QH introduced the BPF in 2001 as a matter of priority following a recommendation of the Ministerial Taskforce on Nursing Recruitment and Retention to address areas of critical importance to the nursing and midwifery workforce including workloads, skill mix, patient acuity/complexity and staff training/development needs. The BPF was jointly developed by QH and the QNU and has been regularly reviewed and enhanced since its introduction to ensure its currency.

The combination of the BPF and minimum nurse/midwife-to-patient ratios will allow the number of patients allocated to a nurse/midwife to be adjusted above the stipulated ratio in accordance with variables such as patient activity and acuity.

We point out that while there is significant national and international research validating the benefits of nurse/midwife-to-patient ratios, there is no evidence to suggest ratios do not improve patient safety. The case for ratios as a means of managing nursing and midwifery workloads and thus patient safety has been unequivocally established. Introduction of nurse/midwife-to-patient ratios in Queensland now requires vision and the willingness to act. These are the characteristics of good government where investment in the nursing and midwifery workforce will pay long-term dividends for the population's health.

This submission assesses the contents of the Bill and the Regulation as they relate to the evidence available, QH strategic directions and the organisational values of the QNU. The QNU has also applied a number of implementation success factors, which include prioritising patient safety, correct use of definitions, application in speciality services, suitability of compliance measures, appropriateness of escalation processes and the framework for public reporting.

The QNU considers the proposed legislation supports the state government's approach to improve patient safety by guaranteeing safe workloads for nurses and midwives. However, we have identified a number of opportunities to enhance the Bill and the Regulation, which are broadly outlined below and provided in more detail within the submission.

The QNU recommends:

- incorporating provisions acknowledging the state government's commitment to legislating ratios across Queensland public health facilities including policy directions identifying the number and duration of phases and the health services to be involved beyond those wards and facilities outlined in section 30B of the *Hospital and Health Boards Amendment Regulation (No. ..) 2016;*
- incorporating provisions that support contemporary nursing and midwifery research findings relating to patient safety and workload management such as endorsed skill mix levels;
- incorporating provisions that align with existing workload management resources such as industrial instruments and policies to improve the accuracy of definitions and processes relating to operational compliance and escalation;

- incorporating provisions that improve the application of ratios in speciality services and support contemporary models of care and prospective innovations ; and
- incorporating provisions that provide more detailed operational direction and support a consultative process in reaching agreement regarding the evaluation of ratios implementation and subsequent public reporting.

Recommendations for the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient) Amendment Bill 2015* (the Bill)

To ensure there is consistency of interpretation and implementation of ratios by the 16 Hospital and Health Services (HHS) the QNU believes the Bill would be enhanced by providing further details as set out below.

We recommend the Bill:

- consistently uses the term 'minimum' as a prefix to the phrase nurse-to-patient and midwife-to-patient throughout the document including the title;
- includes the definition of 'nurse' that aligns with the *Health Practitioner Regulation National Law Act 2009* to highlight the difference between Division 1 Registered Nurses and Division 2 Enrolled Nurses and references these terms accordingly;
- includes a definition of 'patient';
- prescribes a requirement about the minimum number of nurses, of a stated division or midwives who must be directly engaged in delivering a health service according to the number and complexity of patients receiving the service;
- incorporates provisions acknowledging the state government's commitment to legislating ratios in Queensland public health facilities including policy directions identifying the number and duration of phases and the health services to be involved;
- incorporates provisions to extend ratio implementation in further phases beyond those wards and facilities outlined in section 30B of the *Hospital and Health Boards Amendment Regulation (No. ..) 2016*;
- explicitly provide commitment to support contemporary nursing and midwifery research findings relating to patient safety and workload management;
- incorporates a provision requiring the Department of Health and HHS to publish temporary exemption notices granted by the Minister for Health and Minister for Ambulance Services (the Minister) and his/her reasons on the department's and HHS's website within 14 days of determining the notice;
- incorporates a provision requiring the Minister to consider the capability of a HHS to comply with both the Regulation and the Standard;

- incorporates a provision requiring mandatory evaluation and reporting processes including the direction for public reporting; and
- incorporates a provision outlining compliance expectations in regards to the regulation and standard.

Recommendations for the *Hospital and Health Boards Amendment Regulation (No. ..) 2016* (the Regulation)

To ensure there is consistency in interpretation and implementation of ratios by the 16 Hospital and Health Services (HHS) the QNU believes the Regulation would be enhanced by providing further details as set out below.

We recommend the Regulation:

- consistently uses the term 'minimum' as a prefix to the phrase nurse-to-patient and midwife-to-patient throughout the document;
- indicates that the definitions of morning, afternoon and night shifts are only to be used for determining the minimum nurse-to-patient or midwife-to-patient ratio;
- includes a provision requiring the Nursing and Midwifery Implementation Group (NaMIG) to develop an agreed evaluation process that is carried out at least every two years to inform future phases.
- clearly defines that only nurses/midwives who are rostered to provide 'direct' care to patients should be included in the ratios;
- includes a provision directing the nominated public sector health service facilities to establish skill mix baselines in each ward at 1 July 2016 to maintain the statewide average;
- adopts standard mathematical rounding conventions for calculating ratios i.e. 1.5 rounds up to 2;
- identifies the individual wards within the nominated facilities allocated as 'medical' or 'surgical';
- provides for a grievance or escalation process when there is dispute regarding the application of the medical/surgical allocation methodology for those wards that are multi-purpose or delivering hybrid models of care, including those with more than one specialty service;
- aligns definitions with contemporary clinical practices and environments. This includes the definitions of 'medical', 'surgical', 'mental health' and 'maternity' units and 'patient'; and
- includes a definition of 'direct care' and 'indirect care' nurses/midwives.

We recommend the Department of Health:

- includes maternity services in phase one of the implementation of ratios for the purposes of identifying any unintended consequences or requirements for special consideration when establishing minimum midwifery staffing levels in phase two;
- undertakes a review of the selected mental health wards to assess their suitability for inclusion in phase one based on their capacity to demonstrate positive culture, contemporary practice environments and compliance with the BPF; and
- issues a directive to all HHS that compliance with the Bill and Regulation must not be achieved through reductions in access to essential auxiliary services such as, but not limited to, health practitioners, operational or administration staff that fundamentally support nursing and midwifery. ■

Introduction

The Queensland Nurses' Union (QNU) welcomes the Queensland government's commitment to legislate nurse-to-patient and midwife-to-patient ratios as acknowledgement of the crucial role nurses and midwives play in delivering safe, high quality health care for Queenslanders [3, 4].

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including Registered Nurses, Registered Midwives, Enrolled Nurses and Assistants in Nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 53,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry-level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNU. ■

Nurses and midwives in Queensland

Nurses and midwives are a vital part of the health care system. The work they do not only supports those with particular healthcare needs but also underpins the social structure in our communities [5]. Queensland nurses and midwives are registered under a national system, which consists of two divisions of regulated nurses, Division 1 Registered Nurses/Registered Midwives and Division 2 Enrolled Nurses.

The Registered Nurse is bachelor qualified and uses critical thinking and analysis to practise independently or interdependently while providing delegations to Enrolled Nurses and Assistants in Nursing (AINs) and Health Care Workers [6]. They provide evidence-based care to all people in the form of promotion and maintenance of health and prevention of illness for individuals with physical or mental illness, disabilities and rehabilitation need, as well as end of life care [6]. The Registered Nurse assesses, plans, implements, and evaluates nursing care in collaboration with members of the interdisciplinary team and is a leader in the coordination of healthcare within and across different health/social contexts [6].

The Registered Midwife is bachelor and/or masters qualified and is responsible and accountable professional who works in partnership with women to provide support, care and advice during pregnancy, labour and after birth [7]. Midwifery care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child and the accessing of medical care when necessary [7]. A midwife may practise in any setting including the home, community, hospitals, clinical or health units and is able to delegate and supervise when required [7].

Enrolled Nurses are diploma-qualified associates to the Registered Nurses who demonstrate competence in the provision of patient-centred care [8]. Enrolled Nurses work under the direction and supervision of the Registered Nurse. Core responsibilities include recognition of normal and abnormal in assessment, intervention and evaluation of individual health and functional status, monitoring the impact of nursing care and maintaining communication with Registered Nurses [8]. Enrolled Nurses also assist with medication administration, activities of daily living and providing support and comfort to individuals [8].

AINs are not currently licensed by the national system and are therefore unregulated. The QNU has long argued that the failure to license these workers is a significant flaw in the regulatory system and we will continue to lobby for their inclusion in this framework. Many AINs hold a Certificate III or IV qualification but this is not a mandatory requirement. The AIN assists with nursing and works under the direct supervision of the Registered Nurse [9]. ■

Nursing and midwifery workload management in Queensland

Establishing and maintaining safe workloads has been a long-term priority for nurses and midwives in Queensland. There are currently no laws governing how many patients can be safely allocated to a single nurse/midwife. The absence of such laws has resulted in nurses and midwives frequently experiencing unsafe workloads and expressing concerns for patient safety [10, 11]. Attachment 2 provides a summary of over 600 responses from nurses and midwives in Queensland explaining how unmanageable workloads affect their ability to provide safe nursing and midwifery care.

The implementation of ratios in Queensland public health facilities will be distinct from other ratios models currently applied in Australia and around the world. This is because ratios in Queensland will be implemented in conjunction with the industrially mandated *Business Planning Framework: a tool for nursing workload management* (BPF).

The BPF is a comprehensive planning process that customises the workloads 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. For example, while technology advancements cannot replace nurses and midwives they often provide enhancements to workplaces that enable staff the opportunity to reinvest in care delivery.

QH introduced the BPF in 2001 as a matter of priority following a recommendation of the Ministerial Taskforce on Nursing Recruitment and Retention to address areas of critical importance to the nursing and midwifery workforce including workloads, skill mix, patient acuity/complexity and staff training/development needs. The BPF was jointly developed by QH and the QNU and has been regularly reviewed and enhanced since its introduction to ensure its currency.

The combination of the BPF and minimum nurse/midwife-to-patient ratios will allow the number of patients allocated to a nurse/midwife to be adjusted above the legislated ratio in accordance with variables such as patient activity and acuity. This complementary action is vital for nurses and midwives to help mitigate current inconsistencies in the application of the BPF and poor compliance with workload escalation processes, both of which have been especially pronounced from 2012 to 2015.

Legislated nurse/midwife-to-patient ratios are vital, as they will form the 'floor' in the delivery of safe, high quality nursing and midwifery while the BPF will be the mechanism for staff to reach above the 'floor' staffing levels to match the individual demand of their clinical service. The QNU anticipates the state government's direction to underpin the BPF with legislated ratios will alleviate many of the long-term workload and patient safety concerns held by nurses and midwives employed in HHS. ■

Delivering safe nursing and midwifery

The QNU is committed to using an evidence-based approach to help ensure the delivery of safe, high quality patient centred health care in Queensland. Current research has proven safe nurse-to-patient ratios in conjunction with a higher proportion of Registered Nurses and better practice environments improves patient satisfaction, lowers mortality rates, decreases readmission rates and reduces adverse events such as infections, pressure injuries and postoperative complications [1, 2, 12, 13, 14, 15, 16, 17, 18, 19]. Hence, health care services wanting to operate at optimal levels must have an adequate supply of nurses/midwives and skill mix to effectively and efficiently meet patient demands.

Nursing and midwifery supply

The amount of direct care provided to a patient is proportionate to the number of nursing/midwifery hours rostered. According to research, health care services with an adequate supply of nurses/midwives will produce the safest clinical environment capable of delivery high quality care. Whereas, health care services with an inadequate supply of nurses/midwives are compromised due the inability of staff to provide patients with appropriate surveillance [20].

> *"One more patient isn't going to hurt you. One then becomes two and so on until even a seasoned veteran in this field such as myself, with a strong knowledge base and great time management skills, can't provide the level of care QLD patients deserve" (Clinical Nurse, Brisbane)*

The tables below demonstrate the difference in nursing time available per patient when additional patients are added to a nurse's workload. A significant reduction in the number of nursing/midwifery hours per patient day (N/MHPPD) is seen when as little as one or two extra patients are added.

The scenarios apply three different sets of nurse-to-patient ratios to a medical ward with 20 beds and 100% patient occupancy.

Scenario one depicts the nurse-to-patient ratio proposed in the Bill of morning shift 1:4, afternoon shift 1:4 and night shift 1:7. A patient admitted in this scenario will receive on average 5.2 hours of nursing care during a 24-hour period.

Scenario two depicts a nurse-to-patient ratio with one additional patient allocated to a single nurse on each shift – morning shift 1:5, afternoon shift 1:5 and night shift 1:8. Patients admitted under this scenario will receive on average 4.4 hours of nursing care over a 24-hour period. This means each patient will receive 48 minutes (15.39%) less nursing care per day when compared with the nurse-to-patient ratios in scenario one.

Scenario three depicts a nurse-to-patient ratio with two additional patients allocation to a single nurse on each shift – morning shift 1:6, afternoon shift 1:6 and night shift 1:9. Patients admitted under this scenario will experience the lowest number of nursing hours per patient. This means each patient will receive 3.2 hours of nursing care during a 24-hour period, which equates to 120 minutes (38.46 %) less nursing care over a 24 hours period when compared with the nurse-to-patient ratios in scenario one. Refer to Figure 1 for the comparison of hours.

TABLE 1 NURSE-TO-PATIENT RATIO 1:4, 1:4 AND 1:7 OVER 24 HOURS

Ratio	AM 1:4	PM 1:4	ND 1:7	Total hours/ day
No. of nurses	5	5	3	NA
Total shift hours	40	40	24	104
			NHPPD	5.2

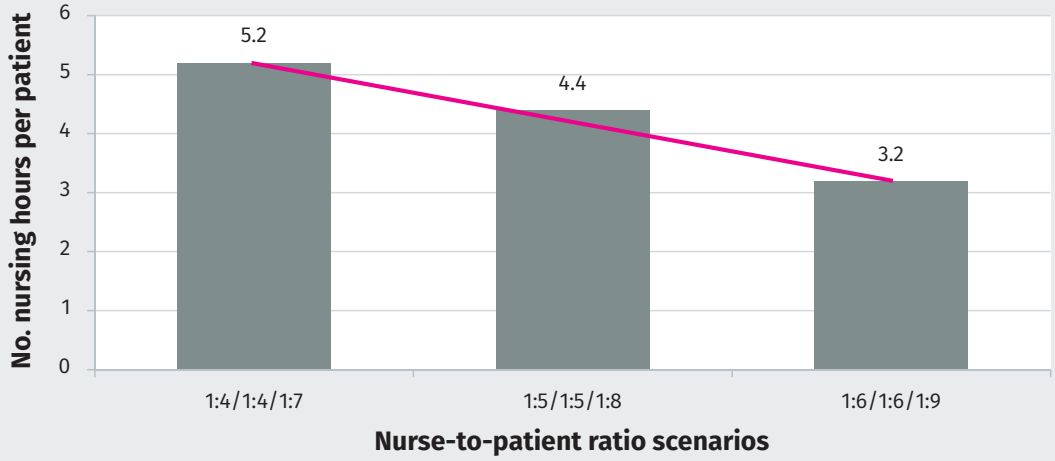
TABLE 2 NURSE-TO-PATIENT RATIO 1:5, 1:5 AND 1:8 OVER 24 HOURS

Ratio	AM 1:5	PM 1:5	ND 1:8	Total hours/ day
No. of nurses	4	4	3	NA
Total shift hours	32	32	24	88
			NHPPD	4.4

TABLE 3 NURSE-TO-PATIENT RATIO 1:6, 1:6 AND 1:9 OVER 24 HOURS

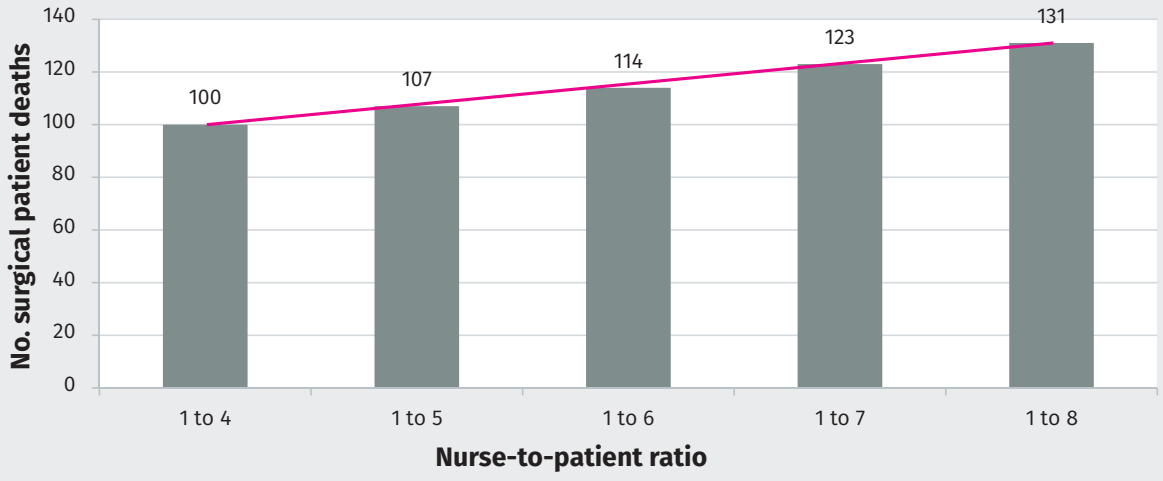
Ratio	AM 1:6	PM 1:6	ND 1:9	Total hours/ day
No. of nurses	3	3	2	NA
Total shift hours	24	24	16	64
			NHPPD	3.2

FIGURE 1 SCENARIO COMPARISON OF NURSING HOURS PER PATIENT PER DAY



One of the most significant outcomes of decreased nursing time per patient is the increase in patient mortality. Figure 3 demonstrates the impact of how one extra patient added to a nurse's workload increased an inpatient's mortality by 7% [1]. This evidence was sourced from an extensive study of discharge data for 422,730 patients in 300 hospitals, across nine European countries [1].

FIGURE 2 SURGICAL MORTALITY ASSOCIATED WITH NURSE-TO-PATIENT RATIOS [1]



Nursing and midwifery skill mix

Research has indicated that nursing and midwifery skill mix is equally as important as having an adequate supply of nurses and midwives in the delivery of safe, high quality health care.

> *"Not only workloads, but also poor skill mix contributes to poor outcomes and decreased consumer satisfaction. Senior staff [...] have difficulty managing their own workload. Some staff are not taking their meal breaks and are working back to complete their tasks and documentation" (Registered Midwife, Townsville)*

Australian studies have examined the relationship between nursing hours, skill mix and adverse events and found a higher proportion of Division 1 Registered Nurses produced statistically significant decreased rates of pressure ulcers, gastrointestinal bleeding, sepsis, shock, physiological or metabolic derangement, pulmonary failure, failure to rescue[1] and falls [21]. Increasing Registered Nurse hours by as little as 10% resulted in the decreased incidence of the following adverse events [21]:

- 45% reduction in central nervous system complications
- 37% reduction in gastrointestinal bleeding
- 34% reduction in urinary tract infections
- 27% reduction in failure to rescue
- 19% reduction in pressure ulcers
- 15% reduction in sepsis
- 11% reduction in pneumonia

Furthermore, international studies have proven that a 10% increase in bachelor-educated Registered Nurses is associated with a 7% lower mortality for inpatients [1]. While Australian studies have shown that increasing nursing skill mix in aged care is associated with reductions in hospital admissions, readmission rates, presentations to emergency departments and improvement in management of end of life care [22]. ■

1 Failure to rescue refers to a death of a patient after a treatable complication has occurred.

Consequences of unsafe nursing and midwifery workloads

Unsafe nursing and midwifery workloads occur in situations where the supply and/or skill mix of staff simply does not meet the patient demand. The lack of balance between supply and demand is frequently associated with suboptimal patient care outcomes because of the consequences that result from high workloads. The consequences of unsafe workloads for staff are often interrelated and include insufficient care time, lack of motivation, escalation of job stress and burnout, diminished decision-making ability, increased number of work-arounds and a reduced capacity to assist fellow clinicians.

Independent, longitudinal studies of Queensland nurses and midwives commencing in 2001 and continuing every three years thereafter indicate ongoing concern around workloads and skill mix [11]. In the 2013 study, the qualitative themes reinforced the findings of the quantitative data. Specifically, the research noted there were fewer nurses employed to work shifts (particularly in the public acute sector) resulting in compromised patient care, increases in workload and increased stress.

There was a decrease in the number of nurses who believed they could complete their work to their satisfaction. The data also found that only 50% of nurses believed the skill mix was adequate, and that this was mostly caused by the large numbers of inexperienced staff now employed [11]. These findings are reliable, independent and consistent over time and strengthen the existing research that nursing and midwifery workloads are directly related to safe, quality patient care.

The following table provides examples of the possible consequences associated with heavy nursing and midwifery workloads.

TABLE 4: EXAMPLES OF CONSEQUENCES ASSOCIATED WITH HEAVY NURSING WORKLOADS [23]

Consequences	Description	Examples
Lack of time	Nurses/midwives with a heavy workload do not have the time to perform tasks safely, apply safe practices, monitor patients appropriately or communicate effectively with members of the multi-disciplinary team.	Nurses/midwives are unable to provide a full end of bed clinical handover or complete all cares required by the patient.
Motivation	A higher level of job dissatisfaction is associated with heavier nursing/midwifery workloads, which can directly affect overall unit performance.	Limited staff compliance with documentation required for organisational patient safety programs.
Stress and burnout	Nurses/midwives experiencing heavier workloads may suffer from higher levels of stress and burnout, which can negatively influence individual and unit performance.	Higher than expected levels of staff absenteeism.
Errors in decision-making	High cognitive workloads can lead to inattention, which contributes to errors due to a diminished capacity to make decisions.	Making an error when calculating the dose of medication for a patient.
Work-arounds	Heavier nursing/midwifery workloads can make it very difficult to follow organisational policies, procedures and guidelines, which are designed to deliver safer, higher quality care.	Nursing/midwifery staff not taking their allocated breaks to accommodate patient health care needs.
Systematic/organisational impact	Heavier workloads in any nursing/midwifery category can negatively impact another clinician's ability to undertake their responsibilities in care delivery, which compromises the quality of patient care.	A Registered Nurse/Midwife may not be available to assist Enrolled Nurses with their patients' needs due to their heavy workload. ■

Minimum nurse-to-patient and midwife-to-patient ratios

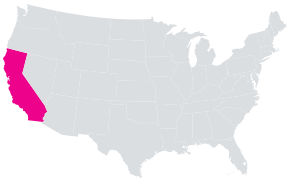
The Bill and the Regulation represent an important milestone in the provision of public health services to Queenslanders. The implementation of minimum nurse-to-patient and minimum midwife-to-patient ratios and endorsed skill mix levels in Queensland will provide safer, higher quality health services that reduce adverse events, save lives and improve hospital efficiency [1, 12, 24, 14, 15, 25]. Queensland will be among the few jurisdictions that have legislation, or intend to legislate nurse-to-patient ratios and midwife-to-patient ratios.

VICTORIA

Victoria was the first Australian state to industrially mandate nurse-to-patient ratios in public hospitals in 2001. Recently, the Victorian parliament enshrined their commitment to patient and staff safety through the introduction of the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* and the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Regulation 2015.*

NEW SOUTH WALES

New South Wales industrially mandated nurse-to-patient ratios in 2011 and is currently seeking a wider application of the ratios methodology across health care services.



CALIFORNIA

California was the first jurisdiction worldwide to legislate minimum nurse-to-patient ratios in 1999.

WALES

Wales introduced the *Safe Nurse Staffing Levels (Wales) Bill* in 2014 seeking to ensure staffing levels within the Welsh National Health Service are sufficient to provide safe, effective and quality nursing care to patients at all times. A parliamentary committee has completed consultation for this Bill and is currently considering evidence regarding the Bill [26]. ■

Benefits of nurse-to-patient ratios

There is extensive and compelling evidence supporting the benefits of ratios for patients, staff and health services.

Patient benefits

Increased nursing hours, higher proportion of Registered Nurses and better practice environments improve patient satisfaction, lower mortality, decrease readmission rates and reduce adverse events such as infections, pressure injuries and postoperative complications [1, 2, 12, 24, 14, 15, 16, 17, 18, 19].

For Queenslanders, this means they are likely to spend less time in hospital and receive more personal nursing/midwifery care than they would now.

- Every one patient added to a nurse's workload increased the likelihood of an inpatient dying by 7% [1].
- Every 10% increase in bachelor-educated nurses decreased the likelihood of an inpatient dying by 7% [1].
- Hospitals with higher nurse staffing had 25% lower odds of being penalised for excessive readmissions compared to otherwise similar hospitals with lower staffing [24].
- Every one patient added to a nurse's workload increased a medically admitted child's odds of readmission within 15-30 days by 11% and a surgically admitted child's likelihood of readmission by 48% [2].

Staff benefits

Improving staffing numbers and skill mix through ratios results in increased staff satisfaction and decreased attrition rates. Nursing turnover is costly and adversely influences organisational productivity and efficiency due to poor continuity of care and costs associated with recruitment [19, 27].

For nurses and midwives, this means a better working environment, improved rosters and less overtime.

- Every one patient added to a nurse's workload is associated with a 23% increase in nurse burnout and a 15% increase is job dissatisfaction [28].
- A Queensland study showed 50% of nurses in the aged-care sector, 32% of nurses in the public sector and 30% of nurses in the private sector experience the inability to meet patient demand due to insufficient staffing. Many of these nurses indicated they were planning to leave the nursing profession [10].

Health Service benefits

Mandating ratios and skill mix levels in Queensland will reduce healthcare variation and deliver economic benefits through reducing adverse patient outcomes and improving healthcare equality across the sectors.

For health services, this means the delivery of direct patient care based on sound staffing methodologies is more achievable and affordable.

- In Western Australia, increased nursing hours have resulted in 1088 life years gained based on prevention of 'failure to rescue' adverse events. The cost per life year gained was $8907, which is well below the reasonable cost-effective threshold in Australia of $30-60,000 per life year gained [14].
- A study of Victorian and Queensland public hospitals estimated hospital acquired complications such as pneumonia and urinary tract infections added 17.1% cost to a hospital admission [20]. Improved nurse staffing and skill mix levels will reduces these types of adverse events and minimise unnecessary costs [1, 12, 14].
- Increased nursing skill mix in aged care is associated with reductions in hospital admissions, readmission rates, presentation to emergency departments and improvement in management of end of life care [22]. ■

Recommendations for the Bill and the Regulation

The recommendations made within this submission focus on the accuracy and applicability of the Bill and the Regulation as they relate to a number of principles the QNU considers as vital to the successful implementation of minimum nurse-to-patient and midwife-to-patient ratios in QH. It is QNU's opinion that the principles applied meet the combined requirements of evidence-based practice, QH strategic directions and the organisational values of the QNU and appropriately exemplify the following themes:

- improving patient outcomes;
- ensuring short and long term achievability,
- applying the available evidence;
- evaluating the benefits for patient, staff and organisation;
- engaging in risk management processes;
- empowering nurses and midwives;
- improving the quality of service delivery; and
- sharing data in an open and transparent manner.

The QNU has also considered a number of success factors that have been deemed by members as essential in accomplishing the operational roll out of ratios in HHS, such as:

- prioritising patient safety;
- correct use of definitions;
- requirements of specialty services;
- ability to monitor compliance;
- establishing a robust and timely escalation process;
- initiating public reporting; and
- committing to future phases. ■

Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015

The QNU supports amending Part 6, Safety and Quality, of the *Hospital and Health Boards Act 2011* to make provisions for the phased implementation of nurse-to-patient and midwife-to-patient ratios in Queensland public health facilities. This amendment fulfils the state government's pre-election commitment made within the Nursing Guarantee to put patient safety first by legislating safe nurse-to-patient ratios and midwife-to-patient ratios and workload provisions such as the BPF [4].

The QNU recommends that the patient safety intentions of the original commitment be reflected in the title of the Bill and the term 'minimum' is used consistently as a prefix to nurse-to-patient and midwife-to-patient ratio to acknowledge the role of the BPF in determining staffing level in addition to the ratio.

Hence, the QNU recommends the Bill:

- consistently uses the term 'minimum' as a prefix to the phrase nurse-to-patient and midwife-to-patient in the title and whenever used throughout the document.

Section 138A Definitions for division 4

The QNU supports aligning the definition of nurse with the *Health Practitioner Regulation National Law Act 2009* (the National Law) to highlight the difference between Division 1 Registered Nurses and Division 2 Enrolled Nurses [29]. Differentiating between the divisions is relevant to ensure safe workloads for nurses and midwives are maintained by appropriately distributing skill mix to match patient acuity. We note the definitions set out in the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* recently passed by the Victorian parliament make a clear distinction between the nursing divisions.

Hence, the QNU proposes section 138A (b) be amended to:

Nurse means a person registered under the Health Practitioner Regulation National Law -

- in the Registered Nurse Division 1 or Enrolled Nurse Division 2 of the nursing and midwifery profession.

In preparation for further ratio implementation phases across Queensland public health facilities, the QNU suggests the definition of 'patient' be included to facilitate health services provided directly or indirectly to become involved. A broad definition of patient will support the inevitable and necessary creation of health innovations beyond the inpatient environment to ensure improvements in the effectiveness and efficiency of our health system continue [30].

Hence, the QNU proposes the following definition of patient is included in section 138A:

- 'Patient' means a person receiving a nursing and/or midwifery service either directly or indirectly from a facility listed in the Regulations.

This will also require a consequential amendment to Schedule 2 (Dictionary) to include:

- ***patient,*** for part 6, division 4, see section 138A.

Section 138B Prescription of minimum nurse-to-patient and midwife-to-patient ratios

The National Law applies the terms Division 1 and Division 2 to distinguish between Registered Nurses/Registered Midwives and Enrolled Nurses as per the feedback provided in respect of section 138A. To align with the National Law and to ensure consistency within the Bill the term 'division' should be used when categorising nurses and midwives.

This distinction is important because the nursing roles and scopes of practice of Registered Nurses are quite different from those of Enrolled Nurses. Further, the number of Enrolled Nurses present on the ward has a direct impact upon the Registered Nurse's workload and responsibility to assess, delegate to and supervise the Enrolled Nurse.

Hence, the QNU recommends section 138B (1) be amended to include:

- a requirement for the regulation to prescribe the minimum number of nurses, of a stated division or midwives who must be directly engaged in delivering a health service according to the number and complexity of patients receiving the service.

When determining the prescription of minimum nurse-to-patient and minimum midwife-to-patient ratios it is crucial that the correct number and skill mix of direct care nurses/midwives are available to safely manage patient demand [31]. Only nurses/midwives who are rostered to provide direct care to patients should be included in the ratios as opposed to including nurses/midwives who are not rostered but are available to become involved. Therefore, compliance measures with the regulation need to ensure indirect nursing and midwifery positions such as Nurse/Midwifery Unit Managers, Clinical Educators and in-charge nurses/midwives are not included in the nurse-to-patient and midwife-to-patient ratios [31].

Section 138B (3) be amended to:

- For this section, a nurse or midwife taken to be engaged in delivering a health service is one who is:

  a) physically present where the health service is being delivered; and

  b) is rostered directly in the delivery of the service.

Currently, there are no provisions within the Bill for further implementation of ratios beyond the initial phase. The QNU considers acknowledgment of the government's commitment to legislate ratios throughout QH public facilities is essential within the Bill to progress the patient safety and quality care agenda [3]. Additional policy direction is required to clearly establish the government's intentions for future ratio implementation including identifying the number and duration of phases as well as the health services to be involved. This action will proactively facilitate any planning and preparation necessary to achieve the wider roll out of ratios in QH in a timely manner.

Hence, the QNU recommends section 138B (2) include a new subsection(c):

- include the proposed plan to extend ratio implementation in further phases beyond those wards and facilities initially included in the Regulations.

Section 138C Temporary exemptions

The QNU welcomes the commitment to transparency in relation to the publication of the Minister's temporary exemptions from compliance with a nursing and midwifery regulation on the department's website. To enhance this commitment and in the context of the decentralised health system in Queensland, the QNU suggests the reasons for the temporary exemptions are included in any publications and that the information is also published on the relevant HHS website. Furthermore, the QNU proposes that a publication timeframe is determined within the Bill to ensure information about the exemption is readily available to members of the local community and HHS staff at the time the decision is made.

Hence, the QNU recommends section 138C (1) be amended to:

- The Minister may, by written notice given to a Service and published on the department's and the relevant Hospital and Health Service websites within 14 days of determining the notice, grant a temporary exemption from compliance with a nursing and midwifery regulation.

Furthermore, the QNU recommends an additional section 138C (7) be added:

- The Minister's reasons for granting the temporary exemption will also be published on the department's and relevant HHS's website.

The QNU considers the reference to a temporary exemption being varied so it imposes a lesser requirement in section 138C (2)(b) as unnecessary and in conflict with the substantial evidence base that directly links the number and skill mix of nurses to the level of safe, quality care provided.

Hence, the QNU recommends section 138C (2)(b) be amended to:

- A temporary exemption may –
  Vary the application of a nursing and midwifery regulation to a Service.

Section 138D Matters for Minister to consider

Section 138D directs the Minister on matters that he/she must consider before making a nursing and midwifery regulation or granting a temporary exemption. The QNU recommends reference to a Service's capability to comply with the Standard is also included in this section. This action will establish the relationship between the Regulation as the minimum staffing requirement and the Standard as the resolute staffing requirement both of which the Minister must consider the capability to comply.

Hence, the QNU recommends section 138D (2) be amended to:

- The Minister must consider the Service's capability to comply with the regulation and the likely effects of compliance including the proper application of the standard.

Section 138E Standards about nursing and midwifery workload management

The primary objective of implementing minimum nurse-to-patient and minimum midwife-to-patient ratios is to improve the safety and quality of health care for patients by ensuring safe workload for nurses and midwives. To measure the success of this objective, an extensive evaluation framework is required to monitor the progress and report on outcomes of ratios implementation. The framework should evaluate the outcomes achieved for patients, staff, health services and government and outline how the results will be made publicly available. In the QNU's opinion this requirement must be evident within the Bill and any subordinate legislation.

Hence, the QNU recommends section 138E (3) be amended to:

- The standard must include requirements about reporting nursing or midwifery workload management information to the chief executive for the purposes of open reporting to the public.

The QNU considers the establishment of the connection between the Regulation and the Standard as fundamental in achieving optimal patient safety and quality of care outcomes though compliance with ratios and the BPF. Section 138E (9) provides a brief statement of compliance expectations and the proposed default position should an inconsistency arise between the Standard and the Regulation. However, this section does not promote the optimal application of the legislation. To increase compliance with legislation and minimise any disputation with industrial instruments the QNU recommends a separate section be added to the Bill. The purpose of the additional section is to strengthen the understanding of compliance and provide a practical example of application.

Hence, the QNU recommends a new section 138G - Compliance with Regulation and Standard - be added:

- **138G - Compliance with Regulation and Standard**

  (1) The application of a requirement under a standard is not limited by a requirement about the same matter under a regulation.

  Example: In relation to the provisions of a particular health service, a nursing and midwifery regulation requires at least one Registered Nurse for every four patients and a standard requires at least one Registered Nurse for every three patients.

  To comply with both the regulation and the standard in the above example, a Service must ensure there is at least one Registered Nurse for every three patients.

  (2) However, if a standard is inconsistent with a regulation, the regulation prevails to the extent of the inconsistency.

  (3) The standard and the *Queensland Health Nurses and Midwives Award – State 2012* (the 'Award') applies to all services. ■

Hospital and Health Boards Amendment Regulation (No. ..) 2016

The QNU supports the Regulation offering operational flexibility for the prescription and application of ratios during the phased implementation to manage any challenges that may arise while legislated ratios and workload provisions are being introduced. Monitored flexibility will accommodate the requirements of wards and facilities with unique models of care or those initiating innovative clinical practice changes within their services. Moreover, when aligned with a public reporting framework, the effectiveness of these flexible arrangements can be used to inform the evidence-base for further innovations in other services.

As per the feedback submitted for the Bill, the QNU seeks the consistent use of the term 'minimum' as a prefix to nurse-to-patient and midwife-to-patient throughout the Regulation.

Hence, the QNU recommends the Regulation:

- consistently uses the term 'minimum' as a prefix to the phrase 'nurse-to-patient' and 'midwife-to-patient' throughout the document.

Part 6A Nurse-to-patient and midwife-to-patient ratios
Section 30A References to shifts

To minimise confusion with the definitions of morning, afternoon and night shifts in the Award, the QNU recommends clarifying that the application of definitions within the Regulation are for the sole purpose of determining the minimum nurse-to-patient or midwife-to-patient ratio.

Hence, the QNU recommends section 30A (2) reads:

- However, for no other purpose than determining the minimum nurse-to-patient and midwife-to-patient ratio –

  a) if a shift falls equally ...

Section 30B Nurse-to-patient and midwife-to-patient ratios applying to particular acute wards – Act, s 138B

Research has irrefutably proven the skill mix of nurses and midwives is just as important as staffing numbers on affecting the safety and quality of health services [1, 2, 12, 24, 15, 16, 17]. Health services with a higher proportion of Registered Nurses combined with higher nursing hours per patient experience lower mortality rates, reduced length of stay and less adverse events such as failures to rescue, pressure injuries and infections [1, 17, 25].

The QNU is seeking assurance within the Regulation that the current statewide nursing and midwifery skill mix of approximately 84% Registered Nurses will not be diluted in order to achieve full ratio implementation.

Hence, the QNU recommends section 30B includes a new subsection (5) that reads:

- At 1 July, 2016, each ward will establish a skill mix baseline for the purposes of maintaining the statewide average.

At this time, we note the Regulation has no reference to an agreed evaluation process and/or review schedule to monitor the progress and outcomes of ratio implementation for the purposes of refining and expanding the Regulation beyond those wards initially outlined in section 30B. The QNU therefore recommends the Regulation include the establishment of an agreed evaluation process through the Nursing and Midwifery Implementation Group (NaMIG) with reviews taking place at least every two years.

Hence, the QNU recommends section 30B includes a new sub-section (6) that reads:

- The NaMIG will develop an agreed process for evaluating the implementation of nurse-to-patient ratios and midwife-to-patient ratios with reviews taking place every two years.

In keeping with the explanation we provided previously under section 138 of the Bill, section 30B (2) requires a reference to the allocation of direct care nurses or midwives in the delivery of health services.

Hence, the QNU recommends section 30B(2) be amended to read:

- The minimum number of direct nurses or midwives who must be engaged in delivering direct clinical health services to patients in the ward is - ...

The QNU also recommends section 30B(2) is amended to clarify the exclusion of indirect nurses and midwives such as Nurse Unit Managers, Nurse Educators and In-charge nurses/midwives from being included in the ratio.

Hence, the QNU recommends section 30B(2d) is added:

- nurses/midwives who are rostered to support clinical processes, such as but not limited to, Nurse/Midwifery Unit Managers, Nurse/Midwifery Educators and In-charge nurses/midwives must not be included in the direct clinical care ratio.

The QNU notes the *Hospital and Health Boards Amendment Regulation (no. ..) 2016 Explanatory Notes* [32] refers to the methodology for calculating the minimum number of nurses or midwives. In cases where this calculation does not result in a whole number, the number of nurses or midwives is rounded up or down. The Explanatory Notes give the example of 1.25 as rounding down to 1, however it incorrectly states that if the number is 1.5 this also rounds down to 1. Under standard mathematical conventions, 1.5 rounds up to 2. This must be clarified under section 30B (4).

Hence, the QNU recommends section 30B (4) be amended to read:

- Otherwise, if the number worked out under subsection (2) is not a whole number, the number must be rounded to the nearest whole number (rounding one-half *upwards*).
- *Example –*
  For the morning shift in a ward with 7 patients, the number worked out under subsection (2)(a) is 1.75, so the minimum number of nurses or midwives required is 2.

  and include the additional example:

  Where the number calculated under subsection (2)(a) is 1.5, the minimum number of nurses or midwives required is 2.

The QNU recommends the Regulation clearly identifies the individual wards within the nominated facilities allocated as 'medical 'or 'surgical'. In addition, the Regulation must provide a grievance or escalation process when there is a dispute in the allocation methodology for those wards considered multi-purpose or are delivering hybrid models of care, and which include more than one specialty service.

Hence, the QNU recommends:

- Each of the public sector health service facilities outlined under Section 30B(1) clearly specifies the individual wards allocated as 'medical' or 'surgical';
- Section 30B includes a new section (7) indicating the grievance or escalation process to follow when a dispute is raised regarding the allocation methodology for wards that are considered multi-purpose or delivering hybrid models of care and which include more than one specialty service.

To reduce the possibility of ambiguity or inconsistent interpretation, the QNU proposes the inclusion of two new Sections:

- 30C titled 'References to Wards' to provide definitions of wards; and
- 30D titled 'References to Direct and Indirect Nurses and Midwives'.

30C References to Wards

(1) A 'maternity ward' is:

- A hospital ward in which public sector health services provide care for women during pregnancy and childbirth as well as for newborn infants.

(2) A 'medical ward' is:

- A hospital ward in which public sector health services are provided to treat patients -
  a) for an immediate episode of illness; or
  b) for an injury caused by accident or other form of trauma.

(3) A 'mental health ward' is:

- A hospital ward in which public sector health services [relating to mental health] are provided to patients.

(4) A 'surgical ward' is:

- A hospital ward in which public sector health services are provided to treat patients –
  a) being assessed and prepared for surgery; or
  b) recovering from surgery.

30C References to Direct and Indirect Nurses and Midwives

(1) 'Direct care' nurses/midwives are:

- nurses/midwives who are rostered to and provide care directly to the patient.

(2) 'Indirect Care' nurses/midwives are:

- nurses/midwives who are rostered to support clinical processes, such as but not limited to, Nurse/Midwifery Unit Managers, Nurse/Midwife Educators and In-charge nurses/midwives.

The inclusion of these definitions will require a consequential amendment to Schedule 6 (Dictionary).

The Dictionary should insert the following additional terms:

***maternity ward**, for part 6A see section 30A(1)*

***medical ward**, for part 6A see section 30A(2)*

***mental health ward** for part 6A see section 30A(3)*

***surgical ward** for part 6A see section 30A(4)*

***direct care nurses/midwives** for part 6A see section 30A(5)*

***indirect care nurses/midwives** for part 6A see section 30A(6)*

Additionally, the QNU requests the Minister consider issuing a service directive outlining ratios compliance will not be achieved through reductions in access to essential auxiliary services such as, but not limited to, health practitioners, operational or administration staff, which fundamentally support nursing and midwifery.

Hence, the QNU recommends:

- the Minister issues a directive to all HHS that compliance with the Bill and Regulation must not be achieved through reductions in access to essential auxiliary services including, but not limited to, health practitioners, operational or administration staff.

Maternity Services and Mental Health wards

Although the Regulation identifies two hospitals where ratios will be introduced in mental health wards (Royal Brisbane and Women's Hospital and Princess Alexandra), there are no maternity services included.

The QNU has written to the Minister urging him to consider the allocation of specific resources to trial the establishment of minimum midwifery staffing levels for maternity services in QH and that key stakeholders including the QNU and relevant midwifery organisation should be involved in the establishment, monitoring and evaluation of the trial. The QNU ask the Committee to make a similar recommendation, as we believe it is necessary to trial implementation of minimum midwife-to-

patient ratios in at least one maternity unit order to identify any unintended consequences, especially those relating to the potential for undermining continuity of care models.

Midwife-led continuity models focus on providing woman-centred care and involve a primary midwife who delivers care from early in pregnancy, throughout pregnancy, labour and birth, to six weeks post-partum [33]. They have been proven to significantly contribute to the quality and safety of maternal and infant health [34]. These models can exist independently or in conjunction with core midwifery models and operate by assigning a caseload of up to 40 women per annum to one full time equivalent (FTE) midwife [33].

Core midwifery models on the other hand are located within the acute hospital environment and operate 24 hours per day using a roster with a set number of staff allocated to a variety of shifts. Based on service delivery method, core midwifery models are more suited than the caseload-driven continuity models to the specific ratios framework outlined in the draft Regulation.

Without appropriate explanation and examples about implementing ratios in wards using combined models of care, there is potential for maternity services to prioritise the regulated ratios and shift resources to them in pursuit of compliance. This action may inadvertently constrain the application and/or progress of midwife-led continuity models in maternity services, which is why QNU's has requested at least one maternity ward to be included in phase one to better understand the workload needs of maternity services[2].

Hence, the QNU recommends:

- the inclusion of maternity services in phase one of the implementation of ratios for the purposes of identifying any unintended consequences or requirements for special consideration when establishing minimum midwifery staffing levels in phase two.

In regards to mental health, the QNU recommends the Department of Health reviews the capacity of the wards selected in the Regulation to ensure the most constructive information is gathered for the wider implementation of ratios in phase two. The QNU considers the wards selected must demonstrate a positive nursing culture, be applying and/or be planning to apply contemporary models of care with differing workload arrangements and be compliant with the application of the BPF. This type of readiness assessment supports an evidence-based approach and will assist in capturing relevant information about workload management processes in these specialty services.

Hence, the QNU recommends:

- the Department of Health undertakes a review of the selected mental health wards to assess their suitability for inclusion in phase one based on their capacity to demonstrate positive culture, contemporary practice environments and compliance with the BPF. ■

2 Maternity services demonstrating service profiles with plans to achieve 50% continuity of care within three years would be deemed as having capacity to trial the implementation of ratios.

Conclusion

The true value of nursing and midwifery's significant contribution in health services is fully recognised when there are adequate numbers of appropriately skilled nurses/midwives to meet patient demands.

The QNU considers the direction of the legislation to be supportive of the state government's commitment to improve patient safety by ensuring safe workloads for nurses and midwives. However, a number of opportunities exist to refine and enhance the accuracy and applicability of the Bill and the Regulation to increase the likelihood of successful and consistent implementation of ratios in Queensland public health facilities.

Minimum nurse-to-patient and midwife-to-patient ratios will provide a reliable and enforceable workload management methodology for nurses and midwives in Queensland's public health facilities. Public reporting of ratios, skill mix levels and quality outcome will strengthen the implementation and provide a level of transparency not seen before in the health system. Incorporating minimum nurse-to-patient and midwife-to-patient ratios into the existing BPF will improve compliance to workload methodology by minimising complexity and maximising compliance.

The QNU regards this legislation as a landmark in the state government's commitment to safety and quality in health care. We applaud its introduction and will continue to work with QH to ensure it meets the needs of the Queensland public and the nurses and midwives who work so tirelessly to keep the health system safe. ■

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Hospital and Health Boards Amendment Regulation (No. ..) 2016

Explanatory notes for SL … No. …

made under the

Hospital and Health Boards Act 2011

General Outline

Short title

Hospital and Health Boards Amendment Regulation (No. ..) 2016

Authorising law

Section 138B of the *Hospital and Health Boards Act 2011*.

Policy objectives and the reasons for them

The *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Act …* amended the *Hospital and Health Boards Act 2011* (the Hospital and Health Boards Act) to implement a legislative framework to enable nurse-to-patient and midwife-to-patient ratios and workload provisions to be mandated in public sector health service facilities.

The amendments enable minimum nurse-to-patient and midwife-to-patient ratios, and requirements relating to the skills and qualifications of the nurses and midwives included in ratios, to be prescribed by regulation ('a nursing and midwifery regulation'). The amendments also enable a nursing and midwifery regulation to prescribe ratios by stated Hospital and Health Services (Services); by stated public sector health service facilities, or parts of facilities; and at stated times and circumstances.

This approach has been adopted to ensure the legislative framework provides sufficient operational flexibility to enable ratios to be gradually implemented in Services through a phased implementation model.

The Government has endorsed ratios of one nurse or midwife to four patients (1:4) for morning and afternoon shifts, and one nurse or midwife to seven patients (1:7) for night shifts. The ratios will apply to prescribed acute wards, units or departments within prescribed public sector health service facilities. It is proposed that ratios will be gradually implemented in Services, in a phased manner, from 1 July 2016.

Achievement of policy objectives

To implement safe nurse-to-patient and midwife-to-patient ratios, the *Hospital and Health Boards Amendment Regulation (No. ..) 2016* (the Amendment Regulation) amends the *Hospital and Health Boards Regulation 2012* to prescribe operational details of the ratios scheme for the purposes of Part 6, Division 4, of the Hospital and Health Boards Act.

The Amendment Regulation inserts new part 6A into the *Hospital and Health Boards Regulation 2012*. Part 6A prescribes nurse-to-patient and midwife-to-patient ratios; prescribes the public sector health service facilities (hospitals), and acute wards in those facilities, to which ratios will apply from 1 July 2016; and contains defined terms to support the interpretation and application of the ratio provision.

The Amendment Regulation prescribes that the minimum nurse-to-patient and midwife-to-patient ratios are:

- one nurse or midwife to four patients for the morning shift, or
- one nurse or midwife to four patients for the afternoon shift, or
- one nurse or midwife to seven patients for the night shift.

The terms 'morning shift', 'afternoon shift' and 'night shift' are defined in the Amendment Regulation by reference to a nominal spread of hours for each shift as follows:

- morning shift: the shift ordinarily worked by nurses or midwives in a ward that mostly falls between 7am and 3pm;
- afternoon shift: the shift ordinarily worked by nurses or midwives in a ward that mostly falls between 3pm and 11pm; and
- night shift: the shift ordinarily worked by nurses or midwives in a ward that mostly falls between 11pm and 7am.

The Amendment Regulation also includes a rounding methodology for calculating the correct number of nurses or midwives required on a shift when the application of the required ratio to the number of patients on a prescribed ward does not result in a whole number.

In accordance with the phased implementation approach, the Amendment Regulation prescribes specific acute wards in 28 public sector hospitals.

Consistency with policy objectives of authorising law

The regulation is consistent with the policy objectives of the *Hospital and Health Boards Act 2011*.

Inconsistency with policy objectives of other legislation

No inconsistencies with the policy objectives of other legislation have been identified.

Alternative ways of achieving poiicy objectives

The Amendment Regulation is the only effective means of prescribing the ratios and the public sector health facilities, and parts of those facilities, to which the ratios will apply.

Benefits and costs of implementation

Implementation of the mandated ratios will cost approximately $25.9 million in the first year, to be funded from within existing Service budget allocations.

Consistency with fundamental legislative principles

The Amendment Regulation is consistent with the fundamental legislative principles, as set out in section 4 of the *Legislative Standards Act 1992.*

Consultation

Targeted consultation on the Amendment Regulation was undertaken by providing an exposure draft to the following stakeholders:

- Hospital and Health Services
- Queensland Nurses' Union
- Australian Workers' Union
- Together Union
- Australian College of Nursing
- Australian College of Midwives
- Australian College of Nurse Practitioners
- Australian College of Mental Health Nurses
- Australian Medical Association Queensland
- Health Ombudsman
- Schools of Nursing and Midwifery (Australian Catholic University, Griffith University, James Cook University, Queensland University of Technology, University of Sunshine Coast, University of Queensland, University of Southern Queensland)
- Private Hospitals Association of Queensland
- Brisbane North Private Hospitals Network
- Anglicare Southern Queensland
- Mater Health Services
- Uniting Care Health
- Pindara Private Hospital Ramsay Health
- Ramsay Health Greenslopes Private Hospital
- The Wesley Hospital Uniting Care Health
- Friendly Society Private Hospital
- Maternity Choices Australia
- Midwifery and Maternity Provider Organisation Australia
- BUPA
- Royal Flying Doctor Service Queensland

Stakeholder feedback was considered during the development of the Amendment Regulation and, where appropriate, incorporated into the Amendment Regulation.

Notes on provisions

Short Title

Clause 1 provides the short title of the regulation.

Regulation amended

Clause 2 provides that the regulation amends the *Hospital and Health Boards Regulation 2012*.

Insertion of new pt 6A

Clause 3 inserts new part 6A comprising new sections 30A and 30B. This part prescribes the specific nurse-to-patient and midwife-to-patient ratios; prescribes the public sector health service facilities, and acute wards in those facilities, to which ratios will apply; and defines terms to support the interpretation and application of the ratio provision.

New section 30A clarifies what is meant by a 'morning shift', 'afternoon shift' and 'night shift', for the purpose of new section 30B. The hours referred to in the shift definitions do not represent actual shift hours, and start and finish times, that must be worked by nurses or midwives on prescribed wards. Rather, they represent a nominal spread of hours for the purpose of applying ratios, having regard to the differing shift arrangements that can occur across public sector health service facilities. For example, if a shift ordinarily worked by nurses or midwives in a prescribed ward in a prescribed facility is 1pm-8.30pm then, for the purposes of applying ratios, that shift would be designated as an afternoon shift because the majority of the shift ordinarily worked falls between the hours of 3pm and 11pm.

New section 30B prescribes minimum nurse-to-patient and midwife-to-patient ratios; and prescribes the public sector health service facilities (hospitals), and acute wards within those facilities, to which ratios will apply from 1 July 2016.

New section 30B also prescribes the methodology for correctly calculating the minimum number of nurses or midwives required when the application of the required ratio to the number of patients on a ward does not result in a whole number. If the number of nurses or midwives calculated is less than one, then the number is taken to be one. If the number of nurses or midwives calculated is not a whole number then the number must be rounded to the nearest whole number (rounding one-half downwards). For example, if the number calculated is 1.25 then the number is one; if the number calculated is 1.5 then the number is one; and if the number calculated is 1.75 the number is two.

Amendment of sch 6 (Dictionary)

Clause 4 amends the dictionary in schedule 6 to include definitions for new terms relevant to new part 6A.

Queensland

Hospital and Health Boards Amendment Regulation (No. ..) 2016

Subordinate Legislation 2016 No. ...

made under the

Hospital and Health Boards Act 2011

Contents

1 Short title

This regulation may be cited as the *Hospital and Health Boards Amendment Regulation (No. ..) 2016*.

2 Regulation amended

This regulation amends the *Hospital and Health Boards Regulation 2012*.

3 Insertion of new pt 6A

After part 6—

insert—

Part 6A Nurse-to-patient and midwife-to-patient ratios

30A References to shifts

(1) In this part—

(a) the ***morning shift*** for a ward is the shift ordinarily worked by nurses or midwives in the ward that mostly falls between 7a.m. and 3p.m.; and

(b) the ***afternoon shift*** for a ward is the shift ordinarily worked by nurses or midwives in the ward that mostly falls between 3p.m. and 11p.m.; and

(c) the ***night shift*** for a ward is the shift ordinarily worked by nurses or midwives in the ward that mostly falls between 11p.m. and 7a.m.

(2) However—

(a) if a shift falls equally across the periods mentioned in subsection (1)(a) and (b), it is taken to be an afternoon shift; and

Example—

A shift from 11a.m. to 7p.m. is an afternoon shift.

(b) if a shift falls equally across the periods mentioned in subsection (1)(b) and (c), it is taken to be a night shift; and

(c) if a shift falls equally across the periods mentioned in subsection (1)(a) and (c), it is taken to be a morning shift.

30B Nurse-to-patient and midwife-to-patient ratios applying to particular acute wards—Act, s 138B

(1) This section applies in relation to the following acute wards in the following public sector health service facilities—

(a) Atherton Hospital—each medical ward and surgical ward;

(b) Bundaberg Hospital—each medical ward and surgical ward;

(c) Caboolture Hospital—each medical ward and surgical ward;

(d) Cairns Hospital—each medical ward and surgical ward;

(e) Caloundra Hospital—each medical ward;

(f) Gladstone Hospital—each medical ward and surgical ward;

(g) Gold Coast University Hospital—each medical ward and surgical ward;

(h) Gympie Hospital—each medical ward;

(i) Hervey Bay Hospital—each medical ward and surgical ward;

(j) Innisfail Hospital—each medical ward;

(k) Ipswich Hospital—each medical ward and surgical ward;

(l) Logan Hospital—each medical ward and surgical ward;

(m) Mackay Hospital—each medical ward and surgical ward;

(n) Mareeba Hospital—each medical ward;

(o) Maryborough Hospital—each medical ward and surgical ward;

(p) Mount Isa Hospital—each medical ward and surgical ward;

(q) Nambour Hospital—each medical ward and surgical ward;

(r) Princess Alexandra Hospital—each medical ward, surgical ward and mental health ward;

(s) Queen Elizabeth II Jubilee Hospital—each medical ward and surgical ward;

(t) Redcliffe Hospital—each medical ward and surgical ward;

(u) Redland Hospital—each medical ward and surgical ward;

(v) Robina Hospital—each medical ward and surgical ward;

(w) Rockhampton Hospital—each medical ward and surgical ward;

(x) Royal Brisbane and Women's Hospital—each medical ward, surgical ward and mental health ward;

(y) Prince Charles Hospital—each medical ward and surgical ward;

(z) Toowoomba Hospital—each medical ward and surgical ward;

(za) Townsville Hospital—each medical ward and surgical ward;

(zb) Warwick Hospital—each medical ward and surgical ward.

(2) The minimum number of nurses or midwives who must be engaged in delivering health services to patients in the ward is—

(a) for the morning shift—the number of patients divided by 4; or

(b) for the afternoon shift—the number of patients divided by 4; or

(c) for the night shift—the number of patients divided by 7.

(3) If the number worked out under subsection (2) is less than 1, the number is taken to be 1.

(4) Otherwise, if the number worked out under subsection (2) is not a whole number, the number must be rounded to the nearest whole number (rounding one-half downwards).

Example—

For the morning shift in a ward with 7 patients, the number worked out under subsection (2)(a) is 1.75, so the minimum number of nurses or midwives required is 2.

4 Amendment of sch 6 (Dictionary)

Schedule 6—

insert—

afternoon shift, for part 6A, see section 30A(1)(b).

morning shift, for part 6A, see section 30A(1)(a).

night shift, for part 6A, see section 30A(1)(c).

ENDNOTES

1 Made by the Governor in Council on . . .

2 Notified on the Queensland legislation website on . . .

3 The administering agency is Queensland Health.

THE UNION FOR QNU NURSES AND MIDWIVES

Attachment 2

What are Queensland's nurses and midwives saying about ratios?



February 2016

Queensland's nurses and midwives want to deliver safe, high quality health care to their patients and residents.

But a growing population with increasingly complex care needs, along with recent significant cuts by the previous government to frontline nursing and midwifery positions, has left our nurses and midwives struggling to meet demand in all sectors, including public, private and not-for-profit facilities, including aged care.

As a result, patient safety is at risk.

Through surveys conducted by the Queensland Nurses' Union, members across all sectors have identified unmanageable workloads because of inadequate staffing as their most significant workplace issue.

QNU members were asked to explain what is currently happening in their workplaces as a result of inadequate staffing, as well as why legislated minimum nurse/midwife-to-patient ratios are important to ensure safe, high quality health care is delivered.

667 nurses and midwives responded from all sectors. The majority of responses told of the impact of unmanageable workloads on patient care and safety, as well as low staff morale.

The following pages are a sample of responses from Queensland's nurses and midwives to a series of questions we posed.

What happens in workplaces with unmanageable workloads?

"A sick fearful feeling in the pit of your stomach."

"Ultimately there is a point at which it is not humanly possible or safe to manage a large number of patients with a variable skill mix. Healthcare consumers should be demanding more in terms of service expectation before the healthcare system erodes to unacceptable standards of care. Nurses play a pivotal role within the healthcare system and should not be treated as disposable commodities to affect a financial budget outcome or short-fall."

Registered Nurse, Private Hospital

"I can't tell you how many patients have said to me they feel guilty for taking up time by having a chat or feel that we are too busy to attend to their needs. They often apologise for being an inconvenience as they see how busy we are rushing around all the time... It is not fair to expect one nurse to manage 18 patients on a night shift without patient falls or other serious adverse incidents occurring. Quite often the nurses in my previous ward were asked to work overtime if one of the night or afternoon staff called in sick and I believe this to be dangerous for both patients and nurses, in view of their registration, should a serious incident occur due to tiredness or lack of concentration."

Enrolled Nurse, Private Hospital

"When workloads are unreasonable, patients get left in toilets and showers because staff cannot get back to them in a reasonable timeframe. These are often the patients who shouldn't be left alone, and they try to get up by themselves, which increases the number of preventable falls."

Registered Nurse/Midwife, Queensland Health

"I have nursed for 32 years. In the beginning there was time to provide quality holistic care. Today I find there is barely time to provide the basics. Nurses through necessity have to cut corners and prioritise time, which mean that only paperwork and very basic nursing care can be provided. I rarely feel that I have provided the best care for my patients and regularly finish my shift feeling deflated and frustrated."

Registered Nurse/Midwife, Nambour Hospital

"[Patients] often apologise for being an inconvenience as they see how busy we are rushing around all the time..."

"Many times having finished a shift being exhausted, deflated and really upset that you had not been physically able to do what you know needed to be done. A sick fearful feeling in the pit of your stomach. Running through the shifts, not being able to take your entitled breaks ... I also know of two other experienced and very capable staff members who have got to their car following the end of their shift and cried with frustration, exhaustion."

Enrolled Nurse, Hervey Bay Hospital

"As a patient safety coordinator my role is to review clinical incidents where patients may have been harmed or died and the harm or death is not reasonably expected as an outcome of healthcare - in my experience the risk for any of the above to affect the outcome for the patient is real and occurring not just in Qld Health but all over Australia - therefore all of the above can apply."

Clinical Nurse Consultant, Queensland Health

"The patients are NOT looked after with dignity and compassion. Patients that are not mobile without assistance are left to soil their pants due to not enough staff to take them to the toilet when they want to go. This is a disgrace to aged care and I know it will be happening in nearly every aged care due to unmanageable workloads. Some wings have 15 patients with just one nurse to watch over all of them. UNACCEPTABLE in this day and age."

Enrolled Nurse Advanced Practice, Aged Care Facility

"There is a mentality among the nursing management team of the just one more. One more patient isn't going to hurt you. One then becomes two and so on until even a seasoned veteran in this field such as myself, with a strong knowledge base and great time management skills, can't provide the level of care QLD patients deserve ... It breaks my heart when I walk away from work feeling all my time was dedicated to running from one fire to another rather than optimising my patients' outcomes and preparing them for discharge. I see it as a waste of time. Poor nursing patient ratios means patients stay longer, have poorer outcomes, decreased patient satisfaction of cares and there is no financial benefit in poor nurse patient ratios due to patients extended stays."

Clinical Nurse, Queen Elizabeth II

"There is a mentality among the nursing management team of the just one more. One more patient isn't going to hurt you."

"I come to work and go home each day scared."

"I have been nursing for 40 years and have been a NUM for 15 years. I come to work and go home each day scared. I have never felt this way before. As we have had our team leader role cut at the same time as our ratios have increased, there is little to no support for the junior staff who are drowning. The senior staff are doing the best they can but with the patient load they carry, there is little time to help. I feel it is only a matter of time before a serious error occurs. I have always been proud of the high standard of nursing care my ward provides, but not anymore."

Nurse Unit Manager, Mater Hospital

"As an individual who started as an AIN and progressed through to NUM I have experienced the impact of unmanageable workloads as a nurse providing direct patient care through to a manager having to fight for every full-time-equivalent of nursing staff. Nursing used to be the caring profession however the increasing reliance on ever advancing technologies, the societal ideal that every error is a lawsuit and the associated excesses of documentation now required and the ever declining health of society as a whole has meant nurses are doing a lot more with no increase in resources."

Nurse Unit Manager, Queensland Health

"I'm not happy in my performance and my job and in my life as a person, due to not able to give the care and the time that I used to love giving to the elderly, and have lost the insight of my reason to be a nurse. Now I have become a robot in my job."

Enrolled Nurse, Residential Aged Care Facility, Townsville

"Staff become very stressed and fatigued. Sick leave escalates as nurses become too tired to cope. Morale plummets and patient safety comes second to just getting through the day ... Meal breaks are missed and staff are blamed for having poor time management skills. Staff who dare to use workload forms are targeted for retribution."

Registered Nurse, Gold Coast University Hospital

"...I have become a robot in my job."

"Patients get less than optimal care. Hygiene care is placed last on priority list - understandable, but not good enough for a developed country. Nurses suffer 'burnout' which is evident in errors made, which can and do contribute to a less than satisfactory outcome for patients. Fatigue leads to decreased emotional reserve to deal with the needs of patients, not to mention increased sick leave, and decreased morale."

Registered Nurse, Kingaroy Hospital

"My personal experience with excessive workloads has unmotivated my interest in nursing, the staff become irritable, patient care decreases, working hours increase to cover the work load."

Assistant in Nursing, Aged Care Facility

"As I work in a small rural Health Service, and there is only minimal staff on every shift, there may be only a small number of inpatients but they may require a lot of nursing care. However the outpatients that come through the door require urgent medical attention which takes staff off the floor into A and E and therefore leaves only one staff member on the floor. This can be quite a dangerous practice and most of the time it is the ENs that are trying to assist the RN, nurse the inpatients, and after hours attend to the paper work and all of the computer work."

Enrolled Nurse, Queensland Health, rural health service

"I never finish on time, I miss breaks and patients become annoyed to the point of abusing me when I cannot help them immediately. Stress between other staff members is at a high thus causing a lot of nurses to take sick days which puts pressure on everyone else as we quite often have to work double shifts get called in on our days off or do overtime."

Acting Clinical Nurse, Maryborough Hospital

"The focus of my work is patient care & this is severely compromised, especially emotional support. With inadequate staffing only the essential tasks are done & sometimes not even that. There is no acuity tool used for staffing & being a senior nurse, I get the sickest pts & on top of that I help & support junior staff. I often don't get my scheduled breaks & in my workplace alone, the fatigue & stress has led to a major amount of sick leave. The support of junior staff is essential so that we can stem the flow of disillusioned women leaving the profession."

Registered Nurse, Holy Spirit Northside

"Observations are missed, medications are late, hygiene (ie incontinence pads) remain unattended for unacceptable periods of time, dressings may be left for next shift."

Enrolled Nurse, Toowoomba Hospital

"In workplaces with unmanageable workloads, management typically tell staff that they need to 'improve their time management skills' instead of addressing the issue by closing beds or hiring more staff."

Registered Nurse, Nursing Agency

"I have noticed patient care not complete and staff making mistakes. I have heard patients' families talking about suing Queensland Health in regards to these issues. We need better patient ratios to provide safe care."

Anonymous, Queen Elizabeth II

"Being unable to answer call buttons for up to half an hour. Staff become stressed and may take this out on fellow staff which breaks down morale. Staff not having time to spend with patient in order to answer questions, reassure, or educate."

Registered Nurse, Toowoomba Health Service

"Morale hits rock bottom when staff feel they cannot do their job competently, mistakes are made because you are rushing to do the next job. Frustration becomes anger because you cannot get to all your patients."

Registered Nurse, Goondiwindi Health Service

"Many nurses take great pride and have a sense of achievement when providing care of their patients and mentoring staff. When they are unable to provide the level of care that a patient requires or see peers struggling it becomes very stressful and frustrating with work becoming unsatisfying and patient care suffers. Patients who feel that their nurse is too busy also tend to delay reporting of problems to their nurse, or feel guilty that they are taking up their valuable time."

Hospital Coordinator, Private Hospital

"I do not work in area directly affected by patient nurse ratios however I have concerns for my fellow nurses who work in ward environments. I have heard them talk of the stresses, fatigue, constant fear of missing something and inability to nurse their patients as they want to. They are tired and disappointed, they want management to listen so they can work safely. Legislated minimum ratios would certainly assist my workmates to nurse as they would like to nurse."

Registered Nurse, Toowoomba Hospital

"There is absolutely no "meat" in the current staffing levels so if someone goes off sick and cannot be replaced then the situation intensifies. I work in an Emergency Department where the pressure of work is causing staff to consider alternative job options, retiring earlier or cutting down their hours. I have been a nurse for over 40 years and in my early days sick leave was at a minimum and it was virtually unheard of for doctors to call in sick."

Nurse Practitioner, Queensland Health

Why are legislated minimum ratios so important to you and your patients and residents?

Prevent missed patient care

"If you erode ratios, you erode care; you erode morale; you erode the standard of our health system and you almost certainly ensure an increase in unplanned readmissions AND/OR workforce attrition."

Registered Nurse, Nursing Agency

"Our ability to respond appropriately with additional staffing in cases where patients deteriorate or escalate in behaviour is almost non-existent... We are not robots, we do not have an inbuilt Turbo mode! Please, for the sake of all nurses and patients, I beg you to listen to our pleas!"

Registered Nurse, Mackay Base Hospital

"Nursing is a people oriented profession and requires time to communicate with the client. If the time is rushed due to workloads, many clients will feel they are a burden and not communicate their needs. These needs can be acute or chronic but either way can lead to reduction in patient safety and self-worth, particularly in the elderly."

Registered Nurse, Blue Care

"In the Recovery Room many of our patients must be cared for one-on-one as immediately post-operative is a critical time. When an RN is given more than one patient, a very dangerous stage is set for patient deterioration and possibly even death. With the increasing workload in our Unit, I have witnessed patient ratios increase and dangerous ratios occurring."

Registered Nurse, Public Hospital

"Patient care and health is put at risk when workloads are too heavy. It is vital for the safety of our patients and the physical and mental welfare of nurses that workloads are realistic and safe."

Clinical Nurse, The Wesley Hospital

"When I have six acutely unwell patients on a day shift I don't have time for the simple cares like showering and taking the time to chat to them. Patients need to feel like they matter and are more than a body in a bed. Having six patients to care for means they are reduced to a number, unfortunately."

Registered Nurse, North West Hospital Health Service

"It is vital for the safety of our patients and the physical and mental welfare of nurses that workloads are realistic and safe."

Ensuring patient and staff safety through minimum ratios

"Hospitals are not factories where people come in, are processed, and then discharged in as short a time as possible. Quality care should be a priority and patients should not feel "guilty" or "bad" for pressing the nurse call buzzer when they have a legitimate concern. Something needs to change and now is the time to implement ratios so that healthcare is something that people speak positively about."

Registered Nurse/Midwife, Private Medical Centre

"Numerous times I have seen first-hand the negative consequences of not enough staff – with some very tragic consequences, unnecessary patient suffering and staff burnout. Because costs will always put pressure on budgets, legislated minimum ratios are important. The temptation to expect those at the coal face to cope with the pressure of not having enough staff to do the work they are registered to do is dangerous and unfair to everyone involved and devalues the lives of human beings."

Undergrade Nursing Student, University Sector

"It is so important to me as I would like to return to clinical nursing after my maternity leave however the thought of entering a workplace with horrendous nurse to patient ratios makes me want to find a new profession. I love nursing but cannot continue to watch patient safety dwindle and nurses burnout."

Clinical Nurse, Mackay Base Hospital

"Legislated ratios would help prevent undue client aggression and stressful situations for both clients and staff. Prevent errors in decision making and greatly improve staff morale, reduce verbal and physical abuse toward staff."

Assistant in Nursing, Cairns Base Hospital

"Minimum ratios ARE important as it simply comes down to patient safety. Patients see how run off our feet nurses are and may hesitate to ask for assistance or tell staff if they become unwell. Staff cannot give the standard of 'quality care' they so desperately want to give each of their patients. With an aging population of baby boomers, retiring and developing health issues, work demands on health professionals are only going to increase. We want to retain staff, not lose them! An improved nurse-patient ratio would certainly improve quality care for each patient. This will lead to positive effects on staff performance and morale, which in turn can impact our patients, health, attitude and length of stay."

Registered Nurse, The Prince Charles Hospital

"I love nursing but cannot continue to watch patient safety dwindle and nurses burnout."

"These ratios will allow nurses and midwives to actually care for patients, not just bandage, then wait for readmission. The workload is just too much with the added paper work, etc and by the end of the week I am shattered. With continuous shift work it is exhausting but with [improved] ratios, this will help with job satisfaction, less errors due to overwork and less readmissions in the future."

Registered Nurse/Midwife, Logan Hospital

"I see the broad view within my facility, of the impact of 'time-poor' staff on patient care and outcomes. Patients deserve to receive the level of care they require, and nurses deserve to be given the capacity to provide this level of care. Nurses become distressed and disheartened when they can only provide suboptimal care due to excess workloads."

Clinical Nurse Consultant, Royal Brisbane Women's Hospital

"Even though legislated minimum ratios will not be rolled out in mental health facilities until after successful introduction to medical/surgical wards, I regard a ratio of 4 patients per staff member in acute mental health wards to be essential. Such a ratio would enable nursing staff to properly care for the patients who are so dependent on professional mental health nurses."

Registered Nurse, Ipswich Hospital

"Minimum ratios are vital to the effective and safe functioning of workloads. Improved nurse/patient ratios facilitate better results, minimise relapses in healthcare and prevent burnout in nursing staff."

Registered Nurse, Logan Hospital

Improved morale and job satisfaction

"I had the pleasure of working under ratios in Victoria. I now work in Queensland and have seriously thought about leaving the profession due to the stress and feeling devastated when I am not able to meet my patients individual care needs due to time constraints and unmanageable workloads."

Registered Nurse, Bundaberg Base Hospital

"I want to feel as though being a nurse is making a difference to people's lives and experiences in hospital, their time of need. Not just doing the bare minimum and going home in tears because this is not what nursing is meant to be like! I want good healthcare for patients and satisfied families."

Registered Nurse, Ipswich Hospital

"The whole industry is the same regardless of where you work and nurses are getting burnt out. This in turn leads to all kinds of things such as errors, falls and accidents, depression, fatigue, family issues due to the high demands of the job. Ratios are very important and need to be regularly reviewed and updated as needed. We nurses do this job for love and to help those who can't help themselves but we are not machines, we are human beings and so are those we care for."

Assistant in Nursing, Private Aged Care Facility

"We feel like failures because we can't give appropriate timely and safe patient care. Patients get minimal care and we feel that what is seen as a caring profession is turning into a harried, exhausting and unsafe profession ... Please let us NURSE our patients and allow us to do it in a safe caring environment."

Clinical Nurse, Queensland Health, rural hospital

"...we are not machines, we are human beings and so are those we care for."

"Without these ratios quality nursing care is simply not possible for me to achieve..."

"Without these ratios quality nursing care is simply not possible for me to achieve and I will avoid working in areas which have unreasonable patient loads. I think the potential for errors and omissions is very high in these circumstances, and nurses and patients will suffer as a consequence."

Registered Nurse, Toowoomba Base Hospital

"The level of stress nurses are working under and the lack of patient safety in the private/public hospitals has to change... Let's bring life back into nursing."

Enrolled Nurse, Private Hospice

"It will be important for me, as I will soon be a new graduate who will have to learn how to negotiate a busy work environment, learn the workplace culture and support networks on top of refining and learning new skills. If ratios are legislated then the pressure to care for a large number of high acuity patients will be drastically decreased."

Undergrad Nursing Student, University Sector

Midwifery

"In the area of maternity I feel we are sending women home without the skills necessary to feel confident with early parenting because we can't spend the time with them as we barely have time to do basic cares... Legislated ratios will help to ensure an appropriate standard of care that will benefit patients and communities. Patients deserve the best of care not substandard care."

Registered Nurse/Midwife, Royal Brisbane Women's Hospital

"They think it's ok if we look after up to 13 women and babies per midwife. It's not ok! It's unsafe. It's stressful. I can't give the great care I want and the mums and bubs can't get the great care they deserve (and pay for). It left me feeling unsatisfied as a midwife."

Registered Midwife, Logan Hospital

"I will be able to provide education and support to new mothers and families. I will be able to give my whole self, 100% undivided attention to that woman and her needs. I will be able to make the woman feel important and not just a number. I often hear, 'I didn't buzz for help, you look really busy'. I will be able to provide care that each woman deserves."

Registered Midwife, Logan Hospital

"For our patients, they would be better prepared physically and mentally for their journey into parenthood, confident in their ability to love, nurture and care for their babies. Improved workload management may also improve our statistics in relation to perinatal morbidity and mortality. Behind those stats are the faces of real people with real problems and real emotions that may not realize the conditions under which you may be working."

Registered Midwife, Townsville Hospital

"If we have legislated minimum ratios we will be able to provide safer care for the women and babies we look after, staff morale will be improved, patient outcomes will improve, and less errors will occur. We will have better ongoing community health if we can educate women whilst they are in our care."

Registered Midwife, Greenslopes Private Hospital

"To ensure safety of women and babies. To ensure good outcomes for them. To increase breastfeeding rates. To help keep nurses and midwives in the workforce that are now burning out too early and leaving midwifery and nursing. I would love to see more staff and less red tape and bureaucracy. 1:4 would be wonderful. Proposed night duty rates of 1:7 are still too high 1:6 would be better."

Registered Midwife, Toowoomba Hospital

Aged Care

"To enable nurses, Assistants in Nursing and Personal Carers to look after their patients in a compassionate, timely manner with dignity and proper caring when needed. Not what we have now in most aged care facilities – they are like a production line with no time to care properly, shower, dry, cream and asses skin, give drinks when needed. Duty of care is not being done and a ratio will certainly address this huge problem especially in aged care where the problem is way out of hand due to no legislation on ratios."

Enrolled Nurse Advanced Practice, Private Aged Care Facility

"I love my job, and I won't give up, but I work in a facility with a ratio of 1 nurse to 75 residents. Like come on. That is ridiculous. How am I meant to look after all those residents? They are here for us to look after, but we don't have the money to put more staff on. It's very dangerous in a sense multiple things could go wrong and I have to prioritise which resident needs me more. That isn't fair on them."

Enrolled Nurse, Private Aged Care Facility

"It would ensure the safe number of nurses required to attend to residents' needs, without rushing whilst giving them the time and contact they need and deserve. Injuries such as skin tears and falls would decrease. Life and work quality would improve for residents and staff."

Clinical Nurse, Aged Care Facility

"...they are like a production line with no time to care properly..."

Private Hospitals

"Every day when I walk out I think could I have made a mistake today? EVERYDAY. I fear of losing my registration every shift... On any given day I have 12+ patients between me and another endorsed nurse. That means we prioritise our patients' needs meds before showers. That means your loved one is lying in a bed of urine in the morning. Is this fair? NO, do we feel horrible? YES."

Registered Nurse, Greenslopes Private Hospital

"Most days I am pulling my hair out and I leave my workplace feeling deflated, thinking, feeling and knowing I have NOT cared for my patients the way I would love to because of the facilities' expectations and demands that are constantly placed on nurses to do MORE with LESS."

Registered Nurse, St Andrew's Private Hospital

"Nurses shouldn't have to go to work stressed out and feeling as though their patients are unsafe and as though they are risking their registration every shift. Nurses are going without meal breaks and working double shifts because we are so busy. This in turn increases the risks to the patients because they are being cared for by nurses that are so tired it is the equivalent of working under the influence of drugs or alcohol."

Registered Nurse, Allamanda Private Hospital

"There has been a constant erosion of hours per patient for years, as nursing is a soft target for budget restrictions. We are not really improving patient care/safety as much as we would like because we are ignoring the fundamental contribution of adequate staffing."

Registered Nurse, The Wesley Hospital

"Most days I am pulling my hair out and I leave my workplace feeling deflated..."

Cost benefits and creating a more efficient health system

"Patients who do not receive appropriate care have a greater length of stay in hospital, blowing costs out, adding unnecessarily to bed block and waiting lists."

Registered Nurse, Gold Coast University Hospital

"All Australians will feel confident that they will get the care and attention that they pay for through their taxes. This applies across the board, both public and private funded patients. The Government keeps advertising what a great health care system we Australians have here, But "under the bed clothes" it is a different story. Legislation must be improved within this sector as at one time everyone in this country will need the nurses and midwives to care for them or their family."

Registered Midwife, Cairns Hospital

> *"Less money spent on fixing mistakes that should never happen"*

"Improved patient outcomes are the result of nurses having the time to nurse proactively instead of reactively. Unfortunately nursing wages are the largest single item in any modern hospital's budget. Short sighted managers can "show" a short term result by cutting staff. Healthcare responds poorly to this "penny wise, pound foolish" approach. Spend the money on professional nurses and reap the rewards."

Registered Nurse, Robina Hospital

"In the end better ratios means better care for patients, which often means a shorter stay in hospital (which of course means less cost to the state)."

Registered Nurse, Toowoomba Hospital

"Less money spent on fixing mistakes that should never happen and would not happen if staffing is adequate for the variety of patient acuity that exists at any one time."

Registered Nurse, Mater Hospital

"It's time for the government to put patient and staff safety as a primary concern. Staff are leaving and looking for alternative jobs due to burnout and workplace stress, and it has to stop."

Registered Nurse/Midwife, Cairns Hospital

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