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Government

Metro North
Hospital and Health Service

Ms Leanne Linard MP
Chair
Health and Ambulance Services Committee
Parliament House
George Street
BRISBANE QLD 4000

By post and by email: hsac@parliament.qld.gov.au

Dear Ms Linard MP

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

Thank you for the opportunity to submit feedback on the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* (Amendment Bill) due 12 February 2016.

The feedback contained within this response is informed through consultation with relevant nursing and midwifery (NM) colleagues within Metro North Hospital and Health Service (MNHHS) who have demonstrated expertise in the clinical application of workforce management. NM MNHHS is supportive of the intent of the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* as a methodology to implement minimum staffing ratios in clinical services to improve safe sustainable workloads and safe patient outcomes.

The existing legislation, *Queensland Health Business Planning Framework: Nursing Resources (BPF)*[1] is the current methodology applied to determine safe NM staffing levels, and is supported by considerable resources to assist NM in the governance of a safe competent nursing workforce. In the proposed legislation under paragraph 138E of the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* it is identified that the Chief Executive is empowered to:

> "…make a standard about nursing and midwifery workload management by Services, including how a Service-
> (a) calculates its nursing and midwifery human resource requirements; or
> (b) develops and implements strategies to manage nursing and midwifery resource supply and demand; or
> (c) evaluates the performance of its nursing and midwifery staff."

[1] Industrially mandated under the Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012.

Metro North Hospital and Health Service
Level 14, Block 7
Royal Brisbane and Women's Hospital
Herston, Queensland 4029 Australia

Telephone +61 7 3647 9501
Fax Number: +61 7 3647 9709
www.health.qld.gov.au

It is requested that *The Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* provides further detail in relation to how the mandated nursing and midwifery staffing levels will be applied and the association of NM in respect to the application of the standards and the devolution of implementation. As such, NM MNHHS offer the following comments and recommendations for consideration in relation to implementation of the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015*.

Definition of a Nurse

It is identified that paragraph 138A defines the terms 'midwife' and 'nurse' as the following:

'Nurse is defined to mean:

> '...a person registered under the Health Practitioner Regulation National Law –
>
> a) to practice in the nursing and midwifery profession as a nurse, other than as a student; and
> b) in the registered nurses division or enrolled nurses division of that profession'

Assistant in Nursing

The above definition paragraph 138A does not delineate the Assistant in Nursing (AINs) classification. Therefore it is unclear if this existing classification of nursing workforce is excluded from the ratio calculation. In the Queensland Health Business Planning Framework *(BPF) a tool for workload management 4th edition*[2] AINs are identified as direct patient care workforce and as such have been included in existing notional ratios. In MNHHS AINs comprise a significant component of the nursing and midwifery workforce and a successful succession management approach has been used to attract, retain and recruit Undergraduate Students employed as AINS as workforce ready new graduates and build capacity in skill mix to provide safe patient care. Undergraduate nursing students are employed as AINS gain ready access to clinical experience which supports workforce readiness as a new graduate. NM MNHHS is concerned that excluding the AIN cohort from the nurse-to-ratio calculation will have a significant negative impact on new graduate recruitment and will reduce the capacity and capability of the future workforce.

Recommendation 1
The Queensland Government consider the inclusion of the AIN classification in providing direct safe quality patient care to patients. The definition in 138A is amended to include AINs as part of the nurse-to-patient ratio calculation.

Shift Co-ordinators

The Bill provides requirements that the skills or qualifications of the nurses or midwives may be prescribed in a regulation (para. 138B). However, the tabled draft *Amendment Hospital and Health Boards Regulation (No. ..) 2016* does not identify specific skill or qualification mix when determining ratios within Services. It is noted that the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015*, Explanatory Notes provide the following additional information in relation into the intent of Section 138B[3]:

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[2] Queensland Health Business Planning Framework a tool for nursing workload management Resource manual 4th edition, July 2008

[3] Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015, Explanatory Notes, p.6

"The intent of this provision is to give Services the flexibility to determine appropriate staffing solutions in response to health service requirements by utilising the skills and abilities of nursing and midwifery staff such as shift co-ordinators, when required."

Whilst the example of Shift Coordinators is appreciated no other reference to the parameters/nature of skills and qualifications of any other nursing/midwifery classification was located.

The explanatory note under 138B gives the impression that shift coordinators will be excluded from the ratio calculation and that this resource can be utilised to provide flexibility in management of services as a staffing solution. Therefore, inclusion or exclusion of shift coordinators in the ratio calculation is unclear in the Bill. Currently in MNHHS a variety of models of care are applied and thus there is adaptation in the application of shift coordinators in relation to inclusion or exclusion in staffing numbers aligned to service needs and safe patient care outcomes.

Recommendation 2

The Queensland Government consider wider flexibility for the inclusion or exclusion of shift coordinators in the ratio calculation and provide examples in *Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015.* Expansion on the intent of section 138B[4] to include scope for Services to have the flexibility to determine that shift coordinators may be included or excluded in the minimum ratio calculation and can utilise shift coordinator skills and abilities to meet safe patient outcomes.

Flexibility in application of ratios

The Bill outlines that minimum ratios will be prescribed through regulation under para 138B. While the tabled draft *Amendment Hospital and Health Boards Regulation (No. ..) 2016* prescribes the following minimum ratios[5]:

"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."

The ratio of 1 nurse/midwife for every 4 patients between 7 am and 3 pm is provided as an example within the Bill: para 138B (2). The mandate of ratios such as 1:4 lacks consideration of professional judgement and flexibility in application to respond to fluctuating patient acuity.

For example the 1:4 nurse / midwife-to-patient ratio is unclear in respect to the degree of flexibility that can be applied as illustrated in the following examples:

- Nursing care partnership model (where 2 nurses / midwives share a patient load of 8) and utilise a best practice standard to build capacity in skill mix and support variation in skill sets to provide safe patient care. The Bill is unclear if the successful existing care partnership model can be applied within a minimum ratio.

[4] Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015, Explanatory Notes, p.6
[5] Hospital and Health Boards Amendment Regulation (No. ..) 2016 para 30B (2)

- There is also lack of clarity how ratios would be applied in the instance where two high acuity patients require the care by one nurse/midwife. It is unclear if there would be the expectation that another nurse/midwife would care for the other six lower acuity 'stable' patients safely within a care partnership.

It is noted in the provisions of *Safe Patient Care, (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Vic)* it is mandated that flexibility is a consideration in the application of ratios in order to evenly distribute the workload with consideration for the level of care required by patients in a ward as illustrated in the following example.[6]

> "…in a ward with 8 patients and a 1:4 ratio, if 3 patients require a higher level of care and 5 patients require a lower level of care then one nurse may be assigned to care for the 3 patients requiring the higher level of care and the other nurse to the other 5 patients."

It is unclear in current form of regulation (138B) if there is provision for flexibility in allocating workforce to address care needs as opposed to legislated ratio. For example, 1 nurse/midwife to care for 2 high acuity patients whilst the other nurse cares for 6 low acuity stable patients or do the ratios have to be applied to the 6 low acuity patients.

Recommendation 3

The Queensland Government consider The *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* to mandate a broader range of minimum ratio applications to accommodate care provision based on patient needs such as those provided in previous examples. For example increase flexibility in application of prescribed ratios to accommodate fluctuations in patient acuity and variations in models of care e.g. care partnerships.

Occupancy

The Bill currently does not make provision in respect to the alignment of nursing / midwifery resources with occupancy when health service activity fluctuates and impacts on occupancy. This fluctuation will be a significant determinant of the number of nursing / midwifery resources required to meet minimum ratios. There is expressed concern that nursing/midwifery workforce will be recruited to actual average occupancy which does not accommodate peak seasonal fluctuations. For example while a health service as a single entity may operate at an average occupancy of 92% for the year, a facility within the health service may demonstrate occupancy of 91% with potential to increase to 100% occupancy within eight hours on the same day. Application of the minimum ratio (1:4) potentially will require a hospital to maintain a flexible workforce available to respond to hour by hour changes in occupancy. Essentially this could mean that hospitals will be required to staff each shift based on full occupancy which will be unachievable in respect to budget integrity.

Recommendation 4

The Queensland Government consider providing explanation and examples in legislation to maintain capacity of nurse / midwife workforce to align resources with activity across the continuum of occupancy and comply with *The Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015.*

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[6] Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Clause 9)

Rounding

The Bill provides a rounding methodology prescribed in regulation 138B. This methodology is to be used for calculating the required number of nurses and midwives when the result is not a whole number[7]:

> "(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."

Whilst rounding calculations are clear on the application of ratios there is concern that use of this methodology within clinical services will cause confusion and workload concerns. For example on night duty in a ward with 14 patients, 2 nurses/midwives are required. As patient admissions increase on night duty the number of patients will be divided by 7 to determine accurate minimum ratios as follows:

Patients	Nurses/Midwives	Ratio Number Rounded
14	2	2
15	2.1	2
16	2.3	2
17	2.4	2
18	2.6	3

It is noted that the increase in staffing numbers occurs when there is 18 patients before the staffing level must increase from 2 to 3. Application of the methodology will be complex and is likely to be misunderstood by clinicians providing direct patient care particularly in situations where patient admissions increase from 14 to 15 there may be an expectation from a nurse / midwife that an additional nurse / midwife resource will be required. Greater clarity through examples in the application of rounding in a ward/unit scenario would assist to calculate accurate minimum ratios and mitigate confusion that may arise in clinical services.

Recommendation 4

The Queensland Government consider providing more examples that apply the rounding methodology in a ward context in the legislation as outlined above.

[7] Hospital and Health Boards Amendment Regulation (No. ..) 2016 para 30B (3) and (4)

Skill Mix

The Bill identifies that enrolled nurses and registered nurses / midwives are included in mandated ratios[8]. The Bill further provides that a requirement for the skills or qualification of the nurses or midwives will be prescribed in a regulation (138B). There is no specific reference to the skill or qualification mix within the mandated ratios. Although, the minimum number of nurses/midwives is one influencing component in the provision of safe quality care, further consideration for the skill mix of the workforce is fundamental to high quality care. There is concern that an unsafe allocation of enrolled nurses or nurses / midwives could be applied. For example applying a minimum ratio using predominantly enrolled nurses will not be able to provide safe patient care.

Recommendation 5

The Queensland Government consider The *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* includes the mix of skills and qualifications of nurses and midwives prescribed within the minimum ratio.

Minimum Ratio Applied According to Service Capability

It is of note that The *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* applies a minimum ratio without consideration to the complexity of services that are provided by a hospital. It is noted that under the Safe Patient Care (Nurse to Patient and Midwife to Patient) Act 2015 (Vic) applies a tiered approach to ratio application according to the level of hospital service provision as illustrated in the following example:

> **"15 Level 1 hospitals**
> The operator of a level 1 hospital must staff a general medical or surgical ward as follows—
> (a) on the morning shift or the afternoon shift—
> (i) one nurse for every 4 patients; and
> (ii) one nurse in charge;
> (b) on the night shift, one nurse for every 8 patients.
>
> **16 Level 2 hospitals**
> The operator of a level 2 hospital must staff a general medical or surgical ward as follows—
> (a) on the morning shift—
> (i) one nurse for every 4 patients; and
> (ii) one nurse in charge;
> (b) on the afternoon shift—
> (i) one nurse for every 5 patients; and
> (ii) one nurse in charge;
> (c) on the night shift, one nurse for every 8 patients."

[8] Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 para 138A

Recommendation 6

The Queensland Government consider integrating a tiered approach to apply minimum ratios aligned to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities v3.2, 2014 (CSCF).

Excluding RBWH Mental Health

The Bill provides that minimum ratios will be prescribed in a regulation (Section 138B). The tabled draft *Amendment Hospital and Health Boards Regulation (No. ..) 2016* prescribes public health sector facilities to be included[9]:

> "(r) Princess Alexandra Hospital—each medical ward, surgical ward and mental health ward;
> (x) Royal Brisbane and Women's Hospital—each medical ward, surgical ward and mental health ward;"

The scope of areas for inclusion within the ratio legislation has been widely discussed regarding the choice of acute surgical and acute medical wards only. It is unclear how RBWH Mental Health was determined to be in scope for the first implementation of the ratios. To support successful implementation of ratio legislation into the acute surgical and acute medical wards, further consideration for the opportunity to exclude Mental Health (section 2A) from initial first round of ratio implementation is sought.

Recommendation 7

The Queensland Government consider excluding RBWH Mental Health from the initial implementation of ratios.

Yours sincerely

Adj. Prof. Ken Whelan
Chief Executive
Metro North Hospital and Health Service

15 / 02 / 2016

[9] Hospital and Health Boards Amendment Regulation (No. ..) 2016 para 30B (1r) and (1x)