

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

Report No. 18

**Health, Communities, Disability Services and
Domestic and Family Violence Prevention
Committee**

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Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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Abbreviations

ACMHN	Australian College of Mental Health Nurses
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Federation
APHA	Australian Private Hospitals Association
Bill	Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015
BPF	Business Planning Framework
the Committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
the Department	Department of Health
ED	Emergency Department
EN	Enrolled Nurse
FLP	Fundamental legislative principle
HHS	Hospital and Health Service
NHPPD	Nursing Hours Per Patient Day
NUM	Nurse Unit Manager
POQA	Parliament of Queensland Act 2001
QLS	Queensland Law Society
Ratios	Nurse-to-patient and midwife-to-patient ratios
RN	Registered Nurse

Chair's foreword

This Report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015*.

The Committee's task was to consider the policy outcomes to be achieved by the legislation, as well as the application of fundamental legislative principles – that is, to consider whether the Bill had sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

The purpose of the Bill is to establish a legislative framework to ensure safe nursing and midwifery staff numbers and improve patient outcomes, through mandating nurse-to-patient and midwife-to-patient ratios and workload provisions in public sector health service facilities.

The Committee sought written submissions, held a public departmental briefing, held public hearings in Brisbane, Cairns, Townsville and Gladstone and travelled to Perth and Melbourne to consider their comparative provisions. The Committee received 18 submissions and spoke with numerous stakeholders during the course of its inquiry.

The Committee was unable to reach agreement on whether to recommend that the Bill be passed. The Government Members strongly supported the intent and progression of the Bill. The Non-government Members considered that they could not support the Bill in its current form.

The Committee was able to agree on the contents of the report, which contains details of the evidence provided to the Committee and the views of both government and non-government Members, for consideration by the Parliament during the second reading debate.

On behalf of the Committee, I would like to thank those individuals and organisations who lodged written submissions and appeared at the Committee's public hearings. Many of the submitters were Registered Nurses and Midwives, and I take this opportunity to formally acknowledge the significant contribution that these health professionals make to Queensland's healthcare system.

The Committee also thanks Professor Di Twigg, Dean, School of Nursing and Midwifery, Edith Cowan University in Perth; and the Department of Health and Human Services and the Australian Nursing and Midwifery Federation – Victorian Branch for meeting with the Committee when it travelled to Perth and Melbourne.

The Committee also wishes to acknowledge the assistance provided by the Department of Health, Queensland Parliamentary Library and Research Service, Hansard, Scrutiny of Legislation secretariat staff, and the Committee Secretariat.

Finally, I would like to thank my fellow Committee Members for their active contributions during examination of the Bill.

I commend this report to the House.



Leanne Linard MP
Chair

1 Introduction

1.1 Role of the Committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) is a portfolio committee of the Legislative Assembly. The Committee was formerly known as the Health and Ambulance Services Committee which commenced on 27 March 2015 under the *Parliament of Queensland Act 2001* (POQA) and the Standing Rules and Orders of the Legislative Assembly.² On 16 February 2016, the Parliament agreed to amend Standing Orders, renaming the Committee and expanding its area of responsibility.

The Committee's primary areas of responsibility include:

- Health and Ambulance Services;
- Communities, Women, Youth and Child Safety;
- Domestic and Family Violence Prevention; and
- Disability Services and Seniors.

Section 93(1) of the POQA provides that a portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation;
- the application of fundamental legislative principles; and
- for subordinate legislation – its lawfulness.

Section 92 of the POQA provides that a portfolio committee is to also deal with an issue referred to it by the Legislative Assembly or under another Act, whether or not the issue is within its portfolio area.

1.2 Referral

On 1 December 2015, the Minister for Health and Minister for Ambulance Services introduced the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife to Patient Ratios) Amendment Bill 2015 (the Bill) into the Legislative Assembly.

In accordance with Standing Order 131, the House referred the Bill to the Committee to consider. The Committee is required to report to the Legislative Assembly by 29 April 2016.

1.3 Inquiry process

The Committee's consideration of the Bill included calling for public submissions, holding a public departmental briefing, four public hearings, including three in regional Queensland, reviewing relevant research and legislation in other jurisdictions and travelling to Perth and Melbourne to meet with relevant stakeholders.

The Committee also sought additional written advice from the Department of Health (the Department), including a written briefing and a response to issues raised in submissions.

The Committee considered expert advice on the Bill's conformance with fundamental legislative principles (FLP) listed in Section 4 of the *Legislative Standards Act 1992*.

² *Parliament of Queensland Act 2001*, section 88 and Standing Order 194

1.4 Submissions

The Committee wrote to stakeholders and subscribers to inform them of the inquiry and invite written submissions. Eighteen were received by the closing date of 12 February 2016.

A list of individuals and organisations that made submissions is contained in Appendix A. Submissions authorised by the Committee have been published on the Committee's webpage and are also available from the Committee secretariat.

1.5 Public departmental briefing

The Committee wrote to the Department seeking advice on the Bill. The Committee received this written advice on 14 January 2016.

Officers from the Department provided a public briefing on 17 February 2016. A list of officers who gave evidence at the public departmental briefing is contained in Appendix B. The transcript of the briefing has been published on the Committee's webpage and is also available from the Committee secretariat.

Subsequent to the briefing, the Committee sought further written advice from the Department in response to matters raised during the hearing and response to submissions. This response was received on 10 March 2016.

1.6 Public hearings

On 8, 9, 10 and 16 March 2016 the Committee held public hearings in Townsville, Cairns, Gladstone and Brisbane respectively. Details of the witnesses is contained in Appendix B. Transcripts of the hearings are published on the Committee's webpage and are available from the Committee secretariat.

The Committee also sought additional written information from stakeholders subsequent to the hearing.

1.7 Interstate meetings

The Committee travelled to Perth and Melbourne from 29 February to 2 March 2016 as part of its inquiry into a number of matters, including the *Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015*.

The Committee met with Professor Di Twigg, Dean, School of Nursing and Midwifery, Edith Cowan University in Perth; and the Victorian Department of Health and Human Services and the Australian Nursing and Midwifery Federation (ANMF) – Victorian Branch in Melbourne.

1.8 Policy objectives of the Bill

The objectives of the Bill are to establish a legislative framework to ensure safe nursing and midwifery staff numbers and improve patient outcomes, through mandating nurse-to-patient and midwife-to-patient ratios and workload provisions in public sector health service facilities.³

1.9 Consultation on the Bill

The explanatory notes detailed that representatives from 12 Hospital and Health Services (HHS) and the Queensland Nurses' Union (QNU) provided the Department with advice and support on the development of the Bill.

³ Explanatory Notes, page 1

Explanatory notes state this group:

*...reviewed the development and implementation of the project, the communication and engagement strategy and the evaluation for the project including the mechanisms for monitoring and reporting.*⁴

Staff from a number of HHSs assisted with particular aspects of the project, and the Nursing and Midwifery Program Steering Committee provided strategic advice. This Steering Committee is comprised of representatives from public and private health services and health industry leaders.⁵

Exposure drafts of the Bill, regulation and workload management standard were provided to a number of organisations, whose feedback was considered during the development of the Bill and, where appropriate, incorporated into the Bill.⁶ In the Department's response to questions taken on notice at the public briefing, it identified some of the stakeholders that were consulted:

*Exposure drafts of the legislation were distributed to a range of stakeholders including Hospital and Health Services (HHSs); the nursing and midwifery professional colleges; Queensland schools of nursing and midwifery; private sector health organisations; relevant unions including the Queensland Nurses' Union; and the Australian Medical Association (Queensland).*⁷

In its written briefing to the Committee the Department noted:

*While stakeholders proposed a range of amendments to the suite of draft legislation, most were generally supportive of mandated ratios. The Private Hospitals Association of Queensland and the Friendly Society Private Hospital oppose the proposal to legislate for ratios. However, it should be noted that mandated ratios are not proposed for the private sector in the legislation.*⁸

Non-Government Members raised the apparently broad scope of the consultation for the Bill which was conducted by the Department, but noted no documents or submissions in relation to the consultation had been provided to the Committee. The Department indicated it would take the question on notice and seek the Director-General's approval for the release of the documents. The Department did not provide the working documents.

Government Members noted the information provided in the explanatory notes regarding consultation undertaken by the Department in development of the Bill, cited above. Government Members also noted the additional information provided by the Department in their response to the question taken on notice which outlined who had made submissions to the Bill consultation and what their position was on the proposed legislation. Government Members felt that this response from the Department was more than adequate and that it is not normal practise for Departments to release internal working documents.

1.10 Outcome of Committee considerations

Standing Order 132(1) requires that the Committee determine whether or not to recommend the Bill be passed.

⁴ Department of Health, written briefing, 14 January 2016, p4

⁵ Department of Health, written briefing, 14 January 2016, p4

⁶ Explanatory Notes, page 1

⁷ Department of Health, response to questions taken on notice, 9 March 2016, p3

⁸ Department of Health, written briefing, 14 January 2016, p4

During its consideration of the Bill it became apparent that the Committee would be unable to reach agreement on this issue. The Government Members strongly supported the intent and progression of the Bill. The Non-Government Members did not support the Bill in its current form.

The Committee as a whole could agree on the significant contribution that all nurses across Queensland make to the health and wellbeing of the community. The Committee supports adequate nurse staffing levels and acknowledges that inadequate staffing can result in adverse outcomes.

Government Members recognise the extensive research undertaken over the last 20 years in over 32 countries examining the effects of nurse-to-patient ratios on patient outcomes. The evidence strongly supports that safe nurse-to-patient ratios lead to significant improvements in patient outcomes. Evidence also indicates that appropriate staffing numbers benefits the nursing workforce by reducing work-related injuries, absenteeism and turnover and increasing job satisfaction. Government Members also noted the significant evidence of economic benefits, in addition to improved patient outcomes, achieved through the implementation of a safe nurse-to-patient ratio. The Bill should proceed as an evidence based approach that will address the issues raised by inquiry participants, when implemented in conjunction with the Business Planning Framework and accompanied by an independent evaluation process.

The Non-Government Members questioned whether the Bill would meet its stated objectives given the scarcity of research into a minimum fixed ratio. Non-Government Members believe the Bill cannot be seen in isolation. The Bill must be considered in conjunction with the draft regulation which was tabled with the Bill, which stipulates a fixed minimum ratio across 28 public hospitals in Queensland and has been referred to in public hearings in relation to the Bill.

Non-Government Members are of the view that a ratio already exists in public hospitals based on the Business Planning Framework formula which has not been shown to be ineffective. At the same time no evidence has been provided to establish, clinically, a need for a fixed minimum ratio.

Non-Government Members support change based on evidence, but cannot support the fixed minimum as is the intention of the Government to implement if the Bill is passed.

2 Background to nurse staffing levels

This chapter provides an overview of what the Bill does; how this is different to what currently occurs; what happens in other jurisdictions; and briefly summarises the findings of relevant research.

2.1 How are nurse staffing levels currently calculated?

Nurse staffing levels are currently determined through the application of the Queensland Health Business Planning Framework: Nursing Resources (BPF). The BPF is industrially mandated under the *Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012*.

The BPF was designed and developed as a result of the Ministerial Taskforce on Nursing Recruitment and Retention (1999), which identified that no means existed to effectively analyse staffing level requirements for Queensland Health and recommended a business planning model for nursing be developed as a priority. In addition, that the model include measures relating to workloads, skill mix, and patient acuity/complexity together with the training and development needs of nurses.⁹

At the public briefing, the Department advised:

*The BPF sets out the workload management methodology for calculating the nursing and midwifery hours required to provide an appropriate, professional and safe standard of health service. In practice, the BPF is underpinned by adherence to nursing and midwifery professional college standards and the application of good clinical judgement in determining the appropriate nursing and midwifery staffing levels and skill mix to meet service demand.*¹⁰

The BPF attempts to achieve a balance between service demand and the supply of nursing resources required to meet the identified demand.¹¹ Factors such as patient acuity/complexity, service quality, patient and staff safety, models of service delivery, performance targets and financial outcomes are considered when determining service demand and patient care needs.¹²

The Queensland Nurses' Union (QNU) and Queensland Health developed the BPF collaboratively, and published the original version in 2001. The QNU advised the Committee:

*The BPF is a comprehensive planning process that customises the workloads of nurses and midwives beyond the legislated ratio to suit the individual circumstances of their clinical environment. It takes into account patient activity and acuity as well as other human factors that affect nursing and midwifery workloads such as training and technology.*¹³

The BPF is completed at the ward level, driven by the nurse or midwife unit manager, in consultation with other specialties and disciplines. An internal and external environmental analysis is undertaken within the service profile, which considers things such as relevant legislation, policy and the economic environment.¹⁴

⁹ Queensland Health, Business Planning Framework, 2008, p1

¹⁰ Department of Health, correspondence, 14 January 2016, p2

¹¹ Queensland Health, Business Planning Framework, 2008, pii

¹² Queensland Health, Business Planning Framework, 2008, p2

¹³ Transcript, 16 March 2016, Brisbane, p3

¹⁴ Transcript, 16 March 2016, Brisbane, p9

The Committee was advised that the BPF is not consistently applied across Hospitals and Health Services (HHSs). One example cited was that during times of economic austerity chief financial officers may adjust the BPF to reflect economic conditions. The QNU advised:

*The poor nurse unit managers will work up a very detailed document saying, 'This is what is required to safely deliver care for this unit for the coming year,' and more often than not it is adjusted because of financial considerations. That is why we think it is so important to have the guarantee of the ratio and the application of the BPF on top of that.*¹⁵

This experience was noted by a number of nurses during the inquiry, including an Enrolled Nurse in Gladstone who explained:

*The bottom line is—and to really simplify it—nurse unit managers and nursing directors are saying, 'This is the requirement we need for staffing numbers to adequately and safely staff our wards,' and financial officers are saying, 'Sorry we do not have the money, you cannot do that.'*¹⁶

Another issue identified during the inquiry is that some people consider the BPF to be optional, even though it is industrially mandated. The QNU advised the Committee that they consider the problem is not with the tool itself but with the application of the tool.¹⁷

2.2 What will the Bill change?

There is currently no mandated maximum number (or 'cap') of patients that can be allocated to a nurse or midwife. The Committee heard that as a result, nurses currently carry highly variable, inconsistent and unpredictable workloads.¹⁸

The Bill inserts a new division into the *Hospital and Health Boards Act 2011* to provide for the required heads of power and associated provisions for mandated minimum nurse and midwife to patient ratios. The specific ratios would be prescribed in a regulation rather than in the Act.

When the Minister for Health and Minister for Ambulance Services introduced the Bill he explained:

*For nurses and midwives it provides a safer workload and that, in turn, enables them to deliver a better level of expert professional service to their patients. The Bill establishes the legislative framework to enable minimum nurse-to-patient and midwife-to-patient ratios and workload provisions to be mandated in public sector health service facilities. In particular, it provides a head of power to enable minimum nurse-to-patient and midwife-to-patient ratios and requirements relating to the nursing and midwifery skill mix to be prescribed via a regulation known as a nursing and midwifery regulation.*¹⁹

The Bill provides that minimum nurse staffing levels can be prescribed in the regulation by HHS, at stated facilities and part of facilities, and at stated times and in stated circumstances. The Explanatory Notes advise:

*This approach has been taken to ensure that the legislative scheme has sufficient flexibility to enable ratios to be gradually implemented in Services in a phased manner.*²⁰

¹⁵ Transcript, 16 March 2016, Brisbane, p7

¹⁶ Transcript, 10 March 2016, Gladstone, p6

¹⁷ Transcript, 16 March 2016, Brisbane, p8

¹⁸ See for example, Transcript, 16 March 2016, Brisbane, p7

¹⁹ Minister for Health and Minister for Ambulance Services, Transcript, 1 December 2015, p2975

²⁰ Explanatory Notes, p2

The Bill also enables the chief executive of the Department to make a nursing and midwifery workload management standard ('the standard'). The Department advised:

The management standard, developed based on the existing business planning framework, or BPF, will guide the hospital and health services when, for example, calculating the nursing and midwifery staffing requirements, developing and implementing strategies to manage staff supply and demand, and evaluating nursing and midwifery staff performance. This sophisticated planning required by the standard will allow hospital and health services to determine optimum staffing to meet service demand for each prescribed hospital ward.

The proposed nurse-patient ratios will actually underpin this planning by setting mandatory minimum staffing levels or a floor, if you like.²¹

The standard would allow for the BPF to prescribe the specific skill mix of nurses based on the acuity of patients.²²

Implementing minimum staffing levels in conjunction with the industrially mandated BPF will be distinct from other ratio models applied in Australia and around the world.²³ The QNU considers it will improve compliance with workload methodology through minimising complexity:²⁴

For example, areas such as intensive care or speciality areas such as paediatrics will have much higher ratios than one to four. They might have one on one, one to two or one to three. The BPF works all of that out. It actually provides not only staffing numbers but also skill mix and takes into consideration other factors such as technology and the like.²⁵

The Bill also enables the Minister for Health and Minister for Ambulance Services to temporarily exempt a HHS from complying with a nursing and midwifery regulation for a period of up to three months. This period can be extended by up to another three months if required.²⁶ The Department explained why this is required:

This acknowledges that extenuating circumstances may arise from time to time that temporarily prevent a Hospital and Health Service from sustaining appropriate staffing levels in a prescribed ward or facility. Such situations may include challenges in recruiting and training nursing and midwifery staff; providing appropriate levels of supervision and support; or providing accommodation or other infrastructure for additional staff. A temporary exemption may exempt a Hospital and Health Service from all or part of the regulation, or vary the application of a regulation so that it imposes a lesser requirement. The Minister may also place conditions on an exemption.²⁷

²¹ Department of Health, Transcript, public briefing, 17 February 2016, p2

²² Department of Health, Transcript, public briefing, 17 February 2016, pp4-5

²³ Transcript, 16 March 2016, Brisbane, p3

²⁴ Transcript, 16 March 2016, Brisbane, p4

²⁵ Transcript, 16 March 2016, Brisbane, p6

²⁶ Explanatory notes, p2

²⁷ Department of Health, correspondence, 14 January 2016, pp2-3

2.3 What happens in other jurisdictions?

2.3.1 United States

California was the first US jurisdiction to legislate minimum nurse-to-patient ratios in 1999 with the passage of Assembly Bill (A.B.) 394,²⁸ which came into effect in 2004²⁹. A.B. 394 required the State Department of Health Services to adopt regulations:

...that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250.³⁰

A 2002 study provided background on the use of nurse-to-patient ratios in California, including skill mix requirements:

A.B. 394 extends prior California law regarding nurse staffing in acute care hospitals. Under legislation enacted during the 1976–77 state legislative session, California hospitals must have a minimum ratio of one licensed nurse per two patients in intensive care and coronary care units. This legislation also requires that at least half of licensed nurses working in intensive care and coronary care units be RNs.³¹

A.B. 394 required the Department of Human Services to review the regulations five years after adoption, and to report to the Legislative Assembly about any proposed changes to the ratios.³² As a result, ratios were strengthened in 2008 to reduce the maximum number of patients per nurse in the following areas:

The staffing changes will impact hospital step-down units (changing from 1:4 to 1:3), telemetry units (changing from 1:5 to 1:4) and specialty care units (also changing from 1:5 to 1:4). The ratio changes mean that step-down units will need to increase their RNs by 33 percent while telemetry and specialty-care units will require a 25 percent increase.³³

The minimum nurse-to-patient ratios in California from 2015 are:

- At least one nurse to five patients in medical and surgical units
- At least one nurse to four paediatric patients
- At least one nurse to one patient in surgical operating rooms
- At least one nurse to two patients in critical care units
- At least one nurse to two active labour patients in labour and delivery suites of perinatal services
- At least one nurse to four antepartum patients who are not in active labour
- At least one nurse to four mother-baby couplets in the postpartum area of perinatal services
In the event of multiple births, the total number of mothers plus infants assigned to a single licensed nurse shall never exceed eight
- At least one nurse to six patients that are mothers only, in postpartum areas

²⁸ California Legislative Information, <site accessed 18 April 2016>

http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=199920000AB394

²⁹ Spetz, J., California's minimum nurse-to-patient ratios: the first few months (2004) *Journal of Nursing Administration* 34(12):571-8

³⁰ Assembly Bill No. 394, section 3 (*California*)

³¹ Coffman, J. M., Seago, J. A. and Spetz, J. (2002). Minimum nurse-to-patient ratios in acute care hospitals in California. *Health Affairs*, 21(5), 53-64

³² Assembly Bill No. 394, section 3 (*California*)

³³ AMN Healthcare, Healthcare News, California Tightening Nurse-to-Patient Ratios in 2008 (2007) p1

- At least one nurse to two post-anaesthesia patients
- At least one nurse to four emergency patients receiving treatment
- At least one nurse to four patients in telemetry units (a unit that provides care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval and display of cardiac electrical signals)
- At least one nurse to four patients in a specialty care unit (provides care for a specific medical condition or a specific patient population. Services provided in these units are more specialized to meet the needs of patients with the specific condition or disease process than that which is required on medical/surgical units)
- At least one nurse to six psychiatric patients³⁴

A number of other US states have introduced similar legislation.³⁵

2.3.2 Wales

The most recent jurisdiction to introduce minimum nurse staffing levels is Wales. The Safe Nurse Staffing Levels (Wales) Bill was introduced into the National Assembly for Wales in December 2014.³⁶ The *Nurse Staffing Levels (Wales) Act 2016* received royal assent and became law on 21 March 2016.

The Act seeks to ensure that nurse staffing levels are sufficient to provide safe, effective and quality nursing care to patients.³⁷ It ensures that nurses are deployed in sufficient numbers to:

(a) enable the provision of safe nursing care to patients at all times;

(b) improve working conditions for nursing and other staff; and

(c) strengthen accountability for the safety, quality and efficacy of workforce planning and management³⁸

The Act requires that Local Health Boards or NHS Trusts designate a person to calculate the number of nurses required to care for patients. The Act applies to adult acute medical inpatient wards, adult acute surgical inpatient wards and other situations as specified by regulation. The Minister must issue guidance about the calculation and maintenance of nurse staffing levels, including the extent to which nurses providing care are required to undertake supervisory or administrative functions. Also, the qualifications, competencies, skills and experience of nurses.³⁹

³⁴ Californian Department of Public Health, <site accessed 13 April 2016>

http://www.cdph.ca.gov/services/DPOPP/regs/Documents/R-37-01_Regulation_Text.pdf

³⁵ Buerhaus, P.I., Donelan, K., DesRoches, C., and Hess, R. (2009) Registered nurses' perceptions of nurse staffing ratios and new hospital payment regulations. *Nursing Economics*. 27(6), 372-376

³⁶ National Assembly for Wales, *Nurse Staffing Levels (Wales) Act 2016*, <site accessed 18 April 2016>

<http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?Iid=11778>

³⁷ National Assembly for Wales, Safe Nurse Staffing Levels (Wales) Bill Explanatory Memorandum, p3

³⁸ Safe Nurse Staffing Levels (Wales) Bill, section 1

³⁹ National Assembly for Wales, *Nurse Staffing Levels (Wales) Act 2016*, <site accessed 18 April 2016>

<http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?Iid=11778>

With regard to the method of calculation of minimum nurse staffing levels:

- (1) *When calculating a nurse staffing level, a designated person must—*
- (a) *exercise professional judgement, and*
 - (b) *take into account each of the following—*
 - (i) *the average ratio of nurses to patients appropriate to provide care to patients that meets all reasonable requirements, estimated for a specified period using evidence-based workforce planning tools;*
 - (ii) *the extent to which patients' well-being is known to be particularly sensitive to the provision of care by a nurse.*
- (2) *A designated person may calculate different nurse staffing levels—*
- (a) *in relation to different periods of time;*
 - (b) *depending on the conditions in which care is provided by a nurse.*⁴⁰

The Act does not mandate a specific minimum nurse to patient ratio.

2.3.3 Victoria

Nurse-to-patient ratios were industrially mandated in public hospitals in Victoria in 2000 through the enterprise agreement. As a result of the ratios and funding for refresher programs for nurses wishing to re-enter the workforce, an additional 2,650 full time equivalent nurses were employed between 1999 to 2001. Half of these nurses filled existing vacancies and half were additional staff employed to meet minimum ratio requirements.⁴¹

In October 2015 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* legislated minimum nurse-to-patient ratios:

*The Act will come into operation on a date to be proclaimed, and will apply to those departments and wards that are currently required to have ratios under the Enterprise Agreement. This includes certain wards within public health services, public hospitals, publicly operated denominational hospitals and multi-purpose services, and residential aged care facilities.*⁴²

The Act commenced on 23 December 2015. It does not apply to private and not-for-profit hospitals, private and not-for-profit residential aged care services and private and not-for-profit day procedure centres.⁴³

⁴⁰ Nurse Staffing Levels (Wales) Act 2016, s1

⁴¹ New South Wales Nurses' and Midwives' Association, *Safety in numbers – ratios around the world*, <site accessed 13 April 2016> <http://www.nurseuncut.com.au/safety-in-numbers-ratios-around-the-world/>

⁴² Explanatory Notes, p5

⁴³ Department of Health (Victoria), *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* <site accessed 19 April 2016> <https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act>

During the second reading debate on the Bill in the Victorian Legislative Council, Ms Gayle Tierney MPC noted:

It is fair to say that the science is settled on improved ratios and patient care. It is true that there have been ratios in Victoria contained in enterprise bargaining agreements since 2000, and they have worked. There has been a 16 per cent reduction in the risk of mortality in surgical patients with high registered nurse staffing. There have also been increased ratios in relation to the rate of falls, deep vein thrombosis and cardiac arrest, to just name a few of the improved outcomes that have come about as a result of increased nursing hours. Hospital stays have become shorter because people are less likely to suffer complications. These findings are not unique to Australia; they are observable around the world.⁴⁴

The ratios set out in the nurses' Public Sector Enterprise Agreement are replicated in the Act, and apply to the same areas described in the enterprise agreement.⁴⁵

The following ratios are legislated in Victoria -

Level 1⁴⁶ hospital, general medical or surgical ward:

- One nurse to four patients, and one nurse in charge, during morning and afternoon shifts
- One nurse to eight patients during night shifts

Level 2 hospital, general medical or surgical ward:

- One nurse to four patients, and one nurse in charge, during morning shifts
- One nurse to five patients, and one nurse in charge, during afternoon shifts
- One nurse to eight patients during night shift

Level 3 hospital, general medical or surgical ward:

- One nurse to five patients, and one nurse in charge, during morning shifts
- One nurse to six patients, and one nurse in charge, during afternoon shifts
- One nurse to ten patients during night shifts

Level 4 hospital, general medical or surgical ward:

- One nurse to six patients, and one nurse in charge, during morning shifts
- One nurse to seven patients, and one nurse in charge, during afternoon shifts
- One nurse to ten patients during night shifts

Emergency departments:

- One nurse to three beds, one nurse in charge and a triage nurse, during morning shifts
- One nurse to three beds, one nurse in charge and two triage nurses, during afternoon shifts
- One nurse to three beds, one nurse in charge and a triage nurse, during night shifts

⁴⁴ Hansard (Victoria), Legislative Council, Ms Gayle Tierney MLC, 6 October 2015, p3369

⁴⁵ Premier of Victoria, media release, 30 August 2015 <site accessed 19 April 2016>

<http://www.premier.vic.gov.au/nurse-midwife-to-patient-ratios-to-be-enshrined-in-law/>

⁴⁶ Schedule 1 of the Act (Vic) lists the 'level' of each hospital, and reflects the 2011/12 enterprise agreement

Aged high care residential wards:

- One nurse to seven patients, and one nurse in charge, during morning shifts
- One nurse to eight patients, and one nurse in charge, during afternoon shifts
- One nurse to 15 patients during night shifts⁴⁷

Victorian legislation also mandates minimum ratios for aged high care residential wards, coronary care units, high dependency units, palliative care inpatient units, operating theatres, for Rehabilitation and geriatric evaluation management, post-anaesthetic recovery rooms, special care nurseries and neonatal intensive care units.⁴⁸

2.3.4 New South Wales

No other Australian jurisdiction has legislated minimum nurse staffing levels. However, New South Wales industrially mandated nurse-to-patient ratios in public health facilities in 2010 through the NSW Public Health System Nurses' and Midwives' (State) Award 2015 which provides for specific nursing hours per patient day (NHPPD), nominated based on location categories or 'peer groups'. The NHPPD are then converted into nurse-to-patient ratios.⁴⁹ Ratios are applied to surgical medical wards, palliative care and in acute mental health units.⁵⁰

2.3.5 Western Australia

In Western Australia, nurse staffing levels are managed through applying the Nursing Hours per Patient Day (NHPPD) model. Twigg et al provided background on the implementation of this model in her 2011 study, which considered the impact of implementing the NHPPD on a number of nurse-sensitive indicators:

In March 2002 the Australian Industrial Relations Commission ordered the introduction of a new staffing method – nursing hours per patient day (NHPPD) – for implementation in Western Australia public hospitals. This method used a “bottom up” approach to classify each hospital ward into one of seven categories using characteristics such as patient complexity, intervention levels, the presence of high dependency beds, the emergency/elective patient mix and patient turnover. Once classified, NHPPD were allocated for each ward.⁵¹

The NHPPD model assist each ward to calculate the nursing hours required per patient day according to their allocated ward category and occupied beds. The Western Australian Department of Health (WA Health) advises:

The NHpPD model provides a systematic monitoring and measuring system to identify the number of nursing / midwifery hours required to provide patient care in a specific clinical area.⁵²

⁴⁷ Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Vic), s15 – s28

⁴⁸ Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Vic), s15 – s28

⁴⁹ Explanatory Notes, p5

⁵⁰ South Wales Nurses' and Midwives' Association, *Safety in numbers – ratios around the world*, <site accessed 13 April 2016> <http://www.nurseuncut.com.au/safety-in-numbers-ratios-around-the-world/>

⁵¹ Twigg, D. E., Duffield, C., Bremner, A., Rapley, P. and Finn, J. (2011) The impact of the nursing hours per patient day (NHPPD) staffing method on patient outcomes: A retrospective analysis of patient and staffing data. *International Journal of Nursing Studies*, 48(5) pp540 - 548

⁵² Department of Health (WA), Workload management (NHpPD) <site accessed 19 April 2016> http://www.nursing.health.wa.gov.au/planning/workload_man.cfm

The Australian Industrial Relations Commission ordered WA Health, via the Nurses (WA Government Health Services) Exceptional Matters Order (EMO) 2001, to meet the following duties with regard to the management of nursing and midwifery workloads:

- Prevent sustained unreasonable workload
- Allocate and roster nurses in accordance with process consistent with reasonable workload principles
- Consult, communicate and constructively interact about health service provision to patients

WA Health note the NHPPD model has been used to monitor nursing workload since 2003.⁵³

Research published by Twigg et al in 2011 found a significant decrease in the rate of a number of nurse-sensitive indicators at a hospital level following implementation of the NHPPD; average length of stay, mortality, pressure ulcers, pneumonia, central nervous system complications, deep vein thrombosis, sepsis and ulcer/gastritis/upper gastrointestinal bleed shock/cardiac arrest. In addition, the rate of the following five nurse-sensitive outcomes decreased significantly at the ward level; mortality, shock/cardiac arrest, ulcer/gastritis/upper gastrointestinal bleed, length of stay and urinary tract infections occurred. The study concluded that implementation of the NHPPD in WA improved patient safety and decreased nurse-sensitive outcomes.⁵⁴

2.4 What does the research say?

Queensland Health advised the Committee:

Extensive research undertaken over the last 20 years in over 32 countries has shown that a higher number of nurses relative to the number of patients has a positive impact on patient outcomes, including decreased lengths of stay in hospital and reduced inpatient mortality. Evidence also indicates that appropriate staffing numbers benefits the nursing workforce by reducing work-related injuries, absenteeism and turnover and increasing job satisfaction.

The Committee noted that these numerous studies have found overwhelmingly that lowering the nurse-to-patient ratio impacts positively on patient outcomes. There has been no evidence to suggest that lowering these ratios do not reflect this result. The only area of dispute is regarding what the optimal staffing levels are.

2.4.1 Nurse staffing levels and patient outcomes

Research has repeatedly established that a higher number of nurses relative to the number of patients has a positive impact on patient outcomes such as length of hospital stay⁵⁵ and inpatient mortality⁵⁶.

⁵³ Department of Health (WA), Nursing and midwifery in WA, Workforce planning, <site accessed 19 April 2016> www.nursing.health.wa.gov.au/planning/index.cfm

⁵⁴ Twigg, D. E., Duffield, C., Bremner, A., Rapley, P. and Finn, J. (2011) The impact of the nursing hours per patient day (NHPPD) staffing method on patient outcomes: A retrospective analysis of patient and staffing data. *International Journal of Nursing Studies*, 48(5) pp540 - 548

⁵⁵ See for example, Shamian J., Hagen B., Hu T. W., Fogarty T. E. (1994). The relationship between length of stay and required nursing care hours. *Journal of Nursing Administration* 24(7-8), 52–58
American Nurses Association (1999). *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting*. Washington, DC: American Nurses Publishing

⁵⁶ Manheim L. M., Feinglass J., Shortell S. M., Hughes E. F. (1992). Regional variation in Medicare hospital mortality. *Inquiry*. 29, 55–66

Research has found that nurses with increased patient workloads:

- Have reduced time for patient contact which negatively impacts care quality.⁵⁷
- Report they have insufficient time to provide patient care⁵⁸ leaving important tasks undone, such as patient education.⁵⁹
- Leave other critical tasks undone such as the administration of pain relief, hygiene, skin care⁶⁰ and communicating/comforting patients and developing/updating nursing care plans and pathways.⁶¹
- Express concern for the well-being of their patients in an environment where they feel unable to deliver quality emotional-care because of high workloads.⁶²
- Have an increased chance of experiencing burnout. A 2002 study found that with every patient added to a nurses' workload, there was a 23% increase in the chance of burnout and a 15% increase in the chance of experiencing job dissatisfaction.⁶³
- Have an increased chance of needlestick injury. Another 2002 study concluded that nurses in hospitals that have less adequate resources, leadership and support; and lower staffing and higher levels of emotional exhaustion, are three times more likely to experience needlestick injuries.⁶⁴

Research findings on the impact of nurse staffing levels on patient outcomes include:

- Nursing hours per patient day and skill mix (hours worked by RNs) can significantly reduce the rate of mortality, shock/cardiac arrest, ulcer/gastritis/upper gastrointestinal bleed, length of stay and urinary tract infections.⁶⁵

⁵⁷ Williams, A. M., S. S. Dawson and L. J. Kristjanson (2008). Translating theory into practice: Using Action Research to introduce a coordinated approach to emotional care. *Patient Education and Counseling*, 73(1), 82-90

⁵⁸ Kalisch, B. J., Tschannen, D. and Lee, K. H. (2011). Do staffing levels predict missed nursing care? *International Journal for Quality in Health Care* 23(3), 302-308

⁵⁹ Dabney, B. W. and Kalisch, B. J. (2015). Nurse Staffing Levels and Patient-Reported Missed Nursing Care. *Journal of Nursing Care Quality* 30(4), 306-312

⁶⁰ Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., & Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*, 24(4), 244-255

⁶¹ Bekker, M., Coetzee, S. K., Klopper, H. C., & Ellis, S. M. (2015). Non-nursing tasks, nursing tasks left undone and job satisfaction among professional nurses in South African hospitals. *Journal of nursing management*, 23(8), 1115-1125

⁶² Williams, A. M., & Kristjanson, L. J. (2009). Emotional care experienced by hospitalised patients: development and testing of a measurement instrument. *Journal of clinical nursing*, 18(7), 1069-1077

⁶³ Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. and Silber, J. H. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA: The Journal of the American Medical Association* (2002) 288:1987-1993

⁶⁴ Clarke, S. P., Sloane, D. M. and Aiken, L. H. Effects of Hospital Staffing and Organizational Climate on Needlestick Injuries to Nurses. *American Journal of Public Health* (2002) 92(7), pp1115-1119

⁶⁵ Twigg, D., Duffield, C., Bremner, A., Rapley, P., and Finn, J. (2011). The impact of the nursing hours per patient day (NHPPD) staffing method on patient outcomes: a retrospective analysis of patient and staffing data. *International Journal of Nursing Studies*, 48(5), 540-548

- Rates of pneumonia can be decreased by 11% with a 10% increase in the proportion of hours worked by a RN and the following nurse sensitive indicators (adverse events) can also decrease - central nervous system complications 45%, gastro intestinal bleeds 37%, urinary tract infections 34%, failure to rescue 27%, decubitus ulcers (pressure ulcers/sores) 19% and sepsis 15%.⁶⁶
- Increased total nursing hours and higher levels of Registered Nurses (RNs) reduce 'failure to rescue' events – death within 30 days in patients with complications – in surgical patients.⁶⁷
- Each additional patient added to a nurses' workload is associated with a 7% increase in the likelihood of death within 30 days of admission.⁶⁸
- Staffing levels directly affect emotional exhaustion, which is correlated with patient falls, medication errors and nosocomial (hospital acquired) infections.⁶⁹
- Adding one additional full-time equivalent registered nurse each day can reduce the risk of patient mortality and adverse patient events such as failure to rescue and health care acquired infections such as pneumonia. Research shows that length of stay is shorter by 24% in intensive care units and by 31% in surgical patients.⁷⁰
- Mortality was 26% higher in hospitals in the United Kingdom that had lower staffing levels compared to hospitals with higher nurse staffing. Nurses working in the hospitals that had lower staffing levels were approximately twice as likely to be dissatisfied with their jobs, to show high burnout levels and report low or deteriorating quality of care.⁷¹
- Nurse staffing, nurse work environments and nurse education in South Korea are significantly associated with patient mortality.⁷²

⁶⁶ Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., and Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*, 24(4), 244-255

⁶⁷ Needleman, J., Buerhaus, P., Mattke, S., Stewart, M. AND Zelevinsky, K.. Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine* (2002) 346:1715–2722

⁶⁸ Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. and Silber, J. H. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA: The Journal of the American Medical Association* (2002) 288:1987–1993

⁶⁹ Laschinger, H. K. S., and Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout engagement. *Journal of Nursing Administration*, 36(5), 259-267

⁷⁰ Kane, R. L., Shamliyan, T. A., Mueller, C., Duval, S., and Wilt, T. J. (2007). The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. *Medical care*, 45(12), 1195-1204

⁷¹ Rafferty, A. M., Clarke, S. P., Coles, J., Ball, J., James, P., McKee, M. and Aiken, L. H. (2007). Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. *International Journal of Nursing Studies*, 44(2): 175-182

⁷² Cho, E., Sloane, D. M., Kim, E. Y., Kim, S., Choi, M., Yoo, I. Y. Yoo and Aiken, L. H. (2015). Effects of nurse staffing, work environments, and education on patient mortality: an observational study. *International journal of nursing studies*, 52(2), 535-542

A number of studies have demonstrated that patient length of hospital stay decreases with increased nurse staffing levels and higher proportions of RNs.⁷³ A study in 2007 concluded that RN staffing levels are the most persistent and prominent nursing organisational characteristic for predicting patient outcomes.⁷⁴ This finding was supported by an Australian study in 2012.⁷⁵

A systematic review of evidence about nurse staffing ratios and in-hospital deaths concluded that, amongst other things, there are no studies which report serious harm associated with an increase in nurse staffing.⁷⁶

The Department acknowledged the research that correlates an increased number of nurses with positive patient outcomes in its written briefing to the Committee:

Extensive research undertaken over the last 20 years in over 32 countries has shown that a higher number of nurses relative to the number of patients has a positive impact on patient outcomes, including decreased lengths of stay in hospital and reduced inpatient mortality. Evidence also indicates that appropriate staffing numbers benefits the nursing workforce by reducing work-related injuries, absenteeism and turnover and increasing job satisfaction.⁷⁷

It should be noted that although there is a significant body of evidence indicating that professional nurse staffing is a critical component of quality patient care, the research does not recommend any optimal minimum ratios or prescribed skill mix.⁷⁸

2.4.2 Cost effectiveness

A number of studies have established that cost savings result from increased nurse staffing levels.

A 2004 report ('the Michigan report') examined:

... the hypothetical costs and the hypothetical savings that may be encountered by an acute-care hospital in Michigan as a result of reducing its patient-to- RN staffing ratio from five patients-per-RN to four patients-per-RN.⁷⁹

It found there are significant cost savings associated with a 25 per cent increase in nurse-to-patient staffing ratios, for the following key reasons:

- Reduced costs from patient complications and adverse events.
- Reduced length of stay and overall medical costs of patients.

⁷³ See for example, American Nurses Association (ANA). Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting. Washington, DC: American Nurses Publishing, 1999 and Lichtig, L. K., Knauf, R. A., Milholland, D. K. Some impacts of nursing on acute care hospital outcomes. *Journal of Nursing Administration* (1999) 29:25–33

⁷⁴ Kane R.L., Shamliyan T.A., Mueller C., Duval S. and Wilt T.J. (2007b). Nursing Staffing and Quality of Patient Care. Evidence report/ technology assessment no. 151. Vol. 2008 *Agency for Healthcare Research and Quality*, Rockville

⁷⁵ Twigg, D., Duffield, C., Bremner, A., Rapley, P. & Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: a retrospective study. *Journal of Advanced Nursing* 68(12), 2710–2718

⁷⁶ Shekelle, P. G. (2013) Nurse-Patient Ratios as a Patient Safety Strategy, *Annals of Internal Medicine*. 158:404-409

⁷⁷ Department of Health, written briefing, 14 January 2016, p1

⁷⁸ Submission 12, p3

⁷⁹ Cho, S. H., Ketefian, S., Barkauskas, V. H., and Smith, D. G. (2003). The effects of nurse staffing on adverse events, morbidity, mortality, and medical costs. *Nursing research*, 52(2), 71-79

- Reduce costs resulting from annual turnover/recruitment of RNs - the estimated cost of recruiting an RN is equivalent to an annual salary, due to expenses such as advertising, interviewing, background checks and training.⁸⁰

The study found there is a reduction of US\$22,390 for each case of hospital-acquired pneumonia that is eliminated in surgical patients resulting from lower patient-to-RN ratios and there is a reduction of US\$2,013 for each adverse drug event among medical and surgical patients that it prevented as a result of lower patient-to-nurse ratios. The report concluded:

Based solely on the cost-reduction estimates associated with reducing the incidence of hospital-acquired pneumonia, ADEs [adverse drug events], and overall reduced patient costs, the 200-bed model hospital may expect to see savings of \$9.6 million within a year of reducing the overall patient-to-nurse ratio from 5-to-1 to 4-to-1. As hospital costs grow as a result of inflation between Year 1 and Year 10, savings will also grow, reaching more than \$14 million by Year 10 ...⁸¹

Research has identified that hospital acquired pneumonia is a common complication resulting from inadequate nurse staffing levels. The Michigan report noted this complication is estimated to add between \$US22,390 and US\$28,505 per patient to hospital costs. Also, that improved nurse-to-patient ratios decrease the rate of hospital-acquired pneumonia from approximately 2.2 per cent of all surgical patients to approximately 1.3 per cent of all surgical patients.⁸²

The Lung Foundation reports that hospital acquired pneumonia costs more than \$500 million in direct costs each year in Australia, and that the mortality rate for people aged over 65 years was 27.1 per cent in 2003/04.⁸³

A number of studies in Australia have found that hospital acquired infections add 17.3 per cent to treatment costs.⁸⁴ Other Australian research found that inadequate nurse staffing was costly to Australian hospitals.⁸⁵

Research conducted by Professor Twigg and colleagues in 2013 in Western Australia identified that increased nursing hours resulted in 1,088 life years gained through the prevention of failure to rescue adverse events.⁸⁶ The QNU explained that 'failure to rescue' events result when a RN did not have the time or opportunity to provide adequate surveillance of a patient; did not identify an issue that arose early enough and the patient consequently died.⁸⁷

Professor Twigg's research calculated the cost per life year gained was \$8,907. The QNU advised that this amount is well below the reasonable cost-effective threshold in Australia of between \$30,000 and \$60,000.⁸⁸

⁸⁰ Ibid

⁸¹ Public Policy Associates, Incorporated. The model case for reducing patient-to-nurse staffing ratios in Michigan hospitals: Two scenarios. Michigan Nurses Association, June 2004

⁸² Cho, S. H., Ketefian, S., Barkauskas, V. H., and Smith, D. G. (2003). The effects of nurse staffing on adverse events, morbidity, mortality, and medical costs. *Nursing research*, 52(2), 71-79

⁸³ Lung Foundation, Respiratory infectious disease burden in Australia, Edition 1, March 2007, p9

⁸⁴ See for example, Ehsani, J., Jackson, T. and Duckett, S. J. (2006). The incidence and cost of adverse events in Victorian hospitals 2003–04. *Medical Journal of Australia*, 184(11): 551-555 and Graves, N., Harbarth, S., Beyersmann, J., Barnett, A., Halton, K. and Cooper, B. (2010). Estimating the Cost of Health Care-Associated Infections: Mind Your p's and q's. *Clinical Infectious Diseases* 50(7): 1017-1021

⁸⁵ Twigg, D. E., Geelhoed, E. A., Bremner, A. P. and Duffield, C. M. (2013). The economic benefits of increased levels of nursing care in the hospital setting. *Journal of Advanced Nursing*, 69(10): 2253-2261

⁸⁶ Twigg, D. E., Geelhoed, E. A., Bremner, A. P. and Duffield, C. M. (2013). The economic benefits of increased levels of nursing care in the hospital setting. *Journal of Advanced Nursing*, 69(10): 2253-2261

⁸⁷ Queensland Nurses' Union, Transcript, public hearing, 16 March 2016, p18

⁸⁸ Ibid

3 Examination of the Bill

This section identifies key issues raised during the Committee's examination of the Bill, including the Committee's commentary on the issues and where appropriate, recommendations to address them.

3.1 Impact of nurse staffing levels on patient outcomes

The impact of nurse staffing levels on patient outcomes is undisputed. The Committee found consistency between the anecdotal experience provided by nurses and the findings of research published in peer reviewed publications. Nurse staffing levels have a direct impact on patient outcomes. Staffing levels also impact nurses, which is considered in section 3.3 of this report.

The Committee was advised by Queensland nurses that they feel they are not able to provide an appropriate level of care to patients due to the number of patients they care for during a shift.⁸⁹ At the public hearing in Brisbane, the QNU observed:

There are currently no laws in Queensland governing how many patients can safely be allocated to a single nurse or midwife. The absence of such laws has resulted in nurses and midwives frequently experiencing unsafe workloads and expressing concern for patient safety.⁹⁰

Key issues identified resulting from inadequate nurse staffing levels that affect patient outcomes include:

- Care is not provided within the timeframe required, leading to preventable complications.⁹¹
- Hospital acquired complications occur.⁹²
- Preventable accidents and readmissions occur.⁹³
- A basic level of patient care cannot be provided, such as cleaning teeth,⁹⁴ feedings patients in a timely way⁹⁵, addressing incontinence⁹⁶ and turning patients⁹⁷ to preserve skin integrity and prevent pressure sores.
- Medication errors are made.⁹⁸
- Patient education⁹⁹ and discharge planning suffers.¹⁰⁰
- Patients feel guilty for taking up nurses' time and are less inclined to ring their bell to ask for assistance.¹⁰¹
- Patients of nurses in supervisory roles suffer due to the additional workload of these nurses.¹⁰²

⁸⁹ See for example, Transcripts, 8 - 10 March 2016 and 16 March 2016; Submissions 1, 13 and 16

⁹⁰ Ms Beth Mohle, State Secretary, Queensland Nurses' Union, Transcript, public hearing, 16 March 2016, Brisbane, p3

⁹¹ Transcript, 8 March 2016, Townsville, p7

⁹² Submission 4, p7

⁹³ See for example, Transcript, 9 March 2016, Cairns, p8 and 11; Transcript, 8 March 2016, Townsville, p5; Submission 1, p1

⁹⁴ Transcript, 9 March 2016, Cairns, p3

⁹⁵ Transcript, 9 March 2016, Cairns, p11

⁹⁶ Transcript, 8 March 2016, Townsville, p7

⁹⁷ Transcript, 8 March 2016, Townsville, p7

⁹⁸ Submission 1, p1

⁹⁹ Submission 4, p5

¹⁰⁰ Transcript, 9 March 2016, Cairns, p3 and 8, Transcript Townsville, p5

¹⁰¹ Transcript, 9 March 2016, Cairns, p5

¹⁰² Transcript, 9 March 2016, Cairns, p12

Professor Christine Duffield, Professor of Nursing and Health Services Management, University of Technology Sydney and Edith Cowan University, has published research into nurse staffing levels, nursing workload, the work environment and patient outcomes.¹⁰³

Her submission to the Committee summarised key research findings about the impact of increased nursing workload on the quality of patient care and patient outcomes. Professor Duffield noted that increased workloads limit the time nurses have for patient contact and as a result, negatively impact care quality. Nurses with a heavier patient load tend to report they have insufficient time to provide care to patients, leaving critical tasks such as the administration of pain relief, hygiene skin care and communicating and/or educating patients undone. Nurses also express concern for the well-being of their patients in an environment where they are unable to deliver quality emotional-care because of high workloads.¹⁰⁴ These findings were corroborated in evidence received directly from nurses.¹⁰⁵

The QNU told the Committee:

*...there is no evidence to suggest that ratios do not improve patient safety and the quality of nursing and midwifery care delivered. Health services with a higher percentage of registered nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and fewer adverse events such as failure to rescue, pressure injuries and infections.*¹⁰⁶

The Australian College of Mental Health Nurses (ACMHN) considers that mandated nurse-to-patient ratios "...is an important step in addressing both nurse and patient safety in health services."¹⁰⁷

While the Private Hospitals Association Queensland acknowledges research findings that conclude nurse staffing is a critical component of quality patient care, it considers that:

*...because of the unpredictability of the patient care environment, mandated ratios are ineffective in addressing the demands and constant fluctuations of patient care and nursing care needs.*¹⁰⁸

The Bill will not apply to private hospitals.

3.1.1 Nurses' experience

The experience of nurses was provided through written submissions and oral evidence at public hearings in Townsville, Cairns, Gladstone and Brisbane.

At a regional public hearing, a RN observed that current nurse staffing levels and skill mix results in preventable health issues occurring in patients. She advised:

*As a clinical nurse in a busy emergency department which sees between 230 and 250 patients a day, I regularly see the impact that insufficient staffing and skill mix has on patients in my care. I am constantly shocked at the condition of some nursing home patients who present to the emergency department with pressure area illnesses and contractures that could be avoided if proper nursing care in terms of numbers and skill mix were provided.*¹⁰⁹

¹⁰³ Duffield, C., D., Diers, L. O'Brien-Pallas, C. Aisbett, M. Roche, M. King and K. Aisbett (2011) "Nursing staffing, nursing workload, the work environment and patient outcomes." *Applied Nursing Research*, 24(4), p244-255

¹⁰⁴ Submission 4, p5

¹⁰⁵ See for example, Transcripts, 8 -10 March 2016 and 16 March 2016

¹⁰⁶ Ms Beth Mohle, Queensland Nurses' Union, Transcript, public hearing, 16 March 2016, Brisbane, p3

¹⁰⁷ Submission 10, p1

¹⁰⁸ Submission 12, p6

¹⁰⁹ Ms Katrina Giles, Registered Nurse, Transcript, public hearing, 8 March 2016, Townsville, p5

A RN and Midwife in Brisbane advised that improved ratios will enable nurses to have a better understanding of patients' conditions, facilitate better patient education, spend more time with patients and their families, and prevent readmissions.¹¹⁰

The increasing acuity of patients presenting on wards was noted by a Clinical Nurse in Cairns, and that nurses struggle to provide the wide range of care required. She noted that increased pressure results when RNs are replaced with student nurses.¹¹¹

A Regional QNU Organiser in Cairns, and former Registered Nurse and Clinical Nurse Consultant, considers that patients currently get the minimum care due to the lack of staff on wards to safely care for patients.¹¹² This view was expressed by a number of nurses.¹¹³

A RN and Midwife in Townsville advised the Committee she sometimes allocated 12 to 14 patients plus their babies on the maternity ward, when working with a casual RN or student nurse as a colleague. She considers that adequate staffing levels would prevent unsafe situations from occurring "... such as post-partum patients walking from the birth suite to the maternity ward without being escorted by a midwife and without the midwives getting handover."¹¹⁴

In response to the Committee's questions regarding the effect of patient numbers, nurses at the Committee's Cairns hearing advised:

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

Ms Carlton: Yes.

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

Ms Carlton: Absolutely.

Mrs Bishop: *I would not have to make that decision, because I would have enough time for each patient at the end of the day.*¹¹⁵

A RN and Midwife in Gladstone also expressed concern for the number of patients midwives care for at her hospital:

*It is not uncommon within our unit to have one midwife on our 15-bed ward. That is one midwife essentially responsible for 30 patients and your help is a registered nurse or even an EN. It is a 15-bed ward. I worked it the other night with an RN. They cannot assess the women. They cannot help the women with their babies. It is a lot of responsibility for that midwife. Our special care nursery can be staffed exactly the same way.*¹¹⁶

¹¹⁰ Ms Janelle Taylor, Registered Nurse, Transcript, public hearing, 16 March 2016, Brisbane, p4

¹¹¹ Ms Rachel Laas, Clinical Nurse, Transcript, public hearing, 9 March 2016, Cairns, p3

¹¹² Mrs Krissie Bishop, Regional QNU Organiser and former Registered Nurse and Clinical Nurse Consultant, Transcript, public hearing, 9 March 2016, Cairns, p4

¹¹³ See for example, Transcript, 16 March 2016, Brisbane, public hearing, p5

¹¹⁴ Ms Robyn O'Sullivan, Registered Nurse and Midwife, Transcript, public hearing, 8 March 2016, Townsville, p4

¹¹⁵ Transcript, 9 March 2016, Cairns, public hearing, pp13-14

¹¹⁶ Ms Tina Gray, Registered Nurse and Midwife, Transcript, public hearing, 10 March 2016, Gladstone, p5

The Committee sought information about the consequences resulting from the pressure on nurses' time, specifically on new mothers, babies and nurses:

Mr KELLY: *You mentioned patient education. When you are doing a shift, like the one you just described, where you have one midwife for 15 mothers and 15 or possibly more babies with an RN [Registered Nurse] or EN [Enrolled Nurse] with you, how easy is it for you to get to the patient education that you feel you need to provide?*

Ms Gray: *You do not get to the patient education.*

Mr KELLY: *What do you think the implications of that are for mothers and babies?*

Ms Gray: *The mothers are not establishing their feeding at all because you cannot get to them and stay with them to help them breastfeed and educate on that. Those mothers end up going home bottle feeding. As research shows, bottle fed babies have more illnesses than breastfed babies. That is going to impact on health costs.*

You cannot do any of your discharge education with the mothers or even just sit with a mother and teach them how to settle their baby by wrapping et cetera. You end up taking the baby off them and telling the RN or EN to nurse the baby and put it to sleep because you cannot stay with that mother.

Mr KELLY: *That must be quite stressful for midwives who have a high level of professionalism and understand what the implications are?*

Ms Gray: *Within our unit the midwives are feeling quite demoralised by this. We are very task orientated at the moment because we are just too stretched.¹¹⁷*

Some nurses observed that patients feel guilty for taking up nurses' time and choose not to ring the bell to ask for help as they can see how busy the nurses are. A Clinical Nurse in Cairns considers this has a detrimental effect on patients.¹¹⁸ A Registered Nurse in Brisbane noted:

Patients see how busy nurses are. They try to lessen our workload, often by withholding vital communications and sometimes by attempting to mobilise themselves, sometimes with disastrous and costly consequences ... Aside from the danger to patients, the stress on these young nurses is unbearable. Many leave, unable to bear the strain.¹¹⁹

This view was supported by a Registered Nurse and Midwife in Brisbane, who told the Committee:

Patients will not complain that they feel ignored or scared. They see how busy nurses are and are reluctant to stop a nurse in flight because they need to ask a question or need some reassurance.¹²⁰

3.1.2 Committee comment

The Committee notes the impact of current nurse staffing levels on patient outcomes. The Committee considers patients should be provided with a level of care, delivered in a manner that restores health, does not result in adverse events, and minimises the risk of readmission.

The Committee acknowledges that adverse patient outcomes can be caused by inadequate nurse staffing levels. The Committee recognises that nurses on the whole want to provide good quality, professional and ethical care to patients.

¹¹⁷ Transcript, 10 March 2016, Gladstone, public hearing, p7

¹¹⁸ Ms Debbie Carlton, Clinical Nurse, Transcript, 9 March 2016, Cairns, public hearing p5

¹¹⁹ Ms Moira Purcell, Registered Nurse, Transcript, 16 March 2016, Brisbane, public hearing, pp5-6

¹²⁰ Ms Janelle Taylor, Registered Nurse and Midwife, Transcript, public hearing, 16 March 2016, Brisbane, p4

Government Members acknowledged that in addition to the extensive research presented, the evidence given by practising nurses and midwives reinforced that the lack of mandated minimum safe nurse to patient ratios put them in situations where they believe they were unable to deliver the optimal care required by patients based on their professional judgement.

3.2 Other factors that affect patient outcomes

While there is general consensus that nurse and midwife staffing levels have a significant effect on patient outcomes, research shows that two other factors also have a considerable impact; skill mix and work environment.

3.2.1 Skill mix

The term 'skill mix' refers to the proportion of RNs to other staff.¹²¹ Other staff include, for example, Enrolled Nurses (EN) and Assistants in Nursing (AINs). The difference between RNs and ENs is the minimum educational requirement. A RN is required to have a three year degree from a higher education institution or equivalent from a recognised hospital-based program as a minimum.

An EN is required to have a Certificate IV or Diploma from a vocational education and training provider, or equivalent from a recognised hospital-based program. There are minimum periods RNs and ENs must have practiced in the previous five years to maintain their registration.

The Australian Institute of Health and Welfare (AIHW) explains:

Enrolled nurses include mothercraft and dental nurses where the educational course requirements are less than a 3-year degree course or equivalent. Enrolled nurses usually work with registered nurses to provide patients with basic nursing care, doing less complex procedures than registered nurses.¹²²

The Bill provides for a nursing and midwifery regulation to prescribe requirements about the skills or qualifications of the nurses or midwives included in the ratios.¹²³ It also provides that the chief executive may make a nursing and midwifery workload management standard. This would be notified by the Minister and become subordinate legislation.¹²⁴ If an HHS cannot comply with both a regulation and the standard in relation to a particular matter because of an inconsistency between them, the regulation prevails to the extent of the inconsistency.¹²⁵

The Department advised the Bill covers two components; the nurse to patient ratio, and the standard. The standard will allow for the BPF to prescribe the specific skill mix of nurses based on the acuity of patients.¹²⁶

¹²¹ Transcript, 16 March 2016, Brisbane, p12

¹²² Australian Institute of Health and Welfare, nursing workforce definitions <site accessed 13 April 2016> <http://www.aihw.gov.au/nursing-workforce-definitions/>

¹²³ Bill, clause 5

¹²⁴ Bill, clause 5

¹²⁵ Bill, Clause 5

¹²⁶ Department of Health, Transcript, public briefing, 17 February 2016, pp4-5

At the public briefing, the Department explained the management standard would be developed based on the existing BPF and would:

...guide the hospital and health services when, for example, calculating the nursing and midwifery staffing requirements, developing and implementing strategies to manage staff supply and demand, and evaluating nursing and midwifery staff performance. This sophisticated planning required by the standard will allow hospital and health services to determine optimum staffing to meet service demand for each prescribed hospital ward.¹²⁷

The Australian College of Mental Health Nurses (ACMHN) expressed support for the provisions in the Bill that enable the prescription of skills and qualifications.¹²⁸

Issues raised by inquiry participants that relate to skill mix include:

- The inclusion or otherwise of direct care positions in skill mix calculations.¹²⁹
- The absence of AINs in the minimum ratio calculations.¹³⁰
- The impact of skill mix on flexibility.¹³¹
- The ability of smaller facilities to complying with a defined skill mix.¹³²
- The level of skill of individual nurses, such as EN, varies, which would affect the skill mix.¹³³
- The Bill does not mandate a specific skill or qualification mix that would be applied to the ratios, rather this would be prescribed by regulation.¹³⁴

A Clinical Nurse at Mareeba District Hospital, which is a small rural hospital, explained why she considers that positions such as hers should not be taken into account when determining nurse-to-patient ratios, she listed key responsibilities and tasks she undertakes in her capacity as Team Leader. This includes:

1. Provide care to four patients, assist doctors with rounds and perform minor procedures on the ward.
2. Respond to clinical emergencies in all hospital areas, assist with stabilisation of patients and arrange the transfer of patients, which can remove a nurse from his or her ward for a number of hours.
3. Manage, coordinate and delegate nursing care of at least 25 patients between junior registered nursing staff, enrolled nurses and an AIN.
4. Supervise enrolled nurses and an AIN to administer nursing care. Mentor and support junior registered nurses to problem solve and learn time management skills. Support and nurture at least one nursing student from a local university or TAFE.
5. Answer most phone inquiries, as the only person who has had the complete handover of all 25 patients and there is no secretary after 3pm, overnight or on weekends.
6. Spend a number of hours on the phone trying to replace nurses who have called in sick, as there is no casual pool of nursing staff.

¹²⁷ Department of Health, Transcript, public briefing, 17 February 2016, p2

¹²⁸ Submission 10, p2

¹²⁹ See for example, Submission 13, p5; Transcript, 8 March 2016, Townsville, p8 and Transcript, 9 March 2016, Cairns, p3

¹³⁰ See for example, Submission 7, p2

¹³¹ Submission 12, p11 and 14

¹³² Submission 12, p13

¹³³ Submission 12, p14

¹³⁴ Submission 7, p4

7. Liaise with Cairns hospital medical records, as it can take up to two hours to organise new patients to be put on the computer system for data entry.
8. Organise acute hospital transfers to Cairns hospital, utilising at least one registered nurse to transfer (knowing that they are going to be off the hospital grounds or at least four hours out of their eight-hour shift or even longer if they are ramped at Cairns hospital or if the ambulance has been diverted to an accident).
9. Every blood test requires 15 minutes off the ward in an emergency to process it, refrigerate it and have it waiting for a courier to collect, as there is no on-site pathology service.
10. Source essential drugs as there is no on-call pharmacists after hours.
11. Access the laundry to replace linen and towels and replace items such as facemasks when the hospital runs out of them on Friday night in the middle of an influenza epidemic.
12. Replenish stocks of blood when all sources are depleted due to an accident, and arrange its transport to the hospital.
13. Responsible for the hospital grounds – respond to all fire alarms that occur within every section of the hospital grounds including the nurses’ quarters and dental clinic.
14. Provide access to the nurses’ quarters when swipe cards are deactivated or when staff have locked themselves out of their rooms whilst using the communal toilet.
15. Call in maintenance when the nurse call bell system will not turn off, hospital air-conditioning stops, burst water pipes occur, toilets in the nurses’ quarters are blocked or power switches in the nurses’ quarters are tripped and there is a high temperature alarm in the morgue.¹³⁵

She considers that for the health and safety of the patients it is essential that nursing team leaders, nurse unit managers or any nurses not directly involved with patient care are not given a patient load as part of the mandated nurse-patient ratios.¹³⁶

At the public hearing in Townsville, a QNU Regional Organiser explained that current nursing levels do not accurately reflect the number of staff available to provide clinical care. She advised:

What concerns a lot of people on the floor at the moment with the BPF is that a lot of sites are not implementing the BPF as they are supposed to and they put notional ratios on the wall. The notional ratio often will include the team leader, the nurse unit manager and facilitator, and it looks lovely and rosy on the wall but it is not the ratio that the staff on the floor are working to. It is the staff on the floor who have responsibility for those patients. It is incorporating the people who are actually providing the clinical care—the ratio of those staff to the nurse, not including all the other staff.¹³⁷

The Private Hospitals Association Queensland does not support the Bill, noting that the actual number of nurses and skill mix required varies between hospitals, units, shifts and patient acuity. They advised:

If the nursing and midwifery regulation prescribes the same skill mix for all medical and surgical units within the specified facilities, it may not reflect contemporary team based care models for a particular ward or unit and in consequence could result in a waste of scarce resources.¹³⁸

¹³⁵ Ms Debbie Carlton, Clinical Nurse, Transcript, public hearing, 9 March 2016, Cairns, pp3-4

¹³⁶ Transcript, 9 March 2016, Cairns, p4

¹³⁷ Ms Kaylene Turnbull, Regional Organiser Queensland Nurses’ Union, Transcript, public hearing, 8 March 2016, Townsville, p8

¹³⁸ Submission 12, p2

3.2.2 Work environment

Issues relating to the work environment experienced by nurses are not directly addressed by the Bill so are considered in this report only insofar as they relate to nurse-to-patient ratios and skill mix.

A number of inquiry participants acknowledged the positive impact that adequate nurse-to-patient ratios has on work culture.¹³⁹ The QNU advised:

Research tells us that having enough nurses and midwives to provide care of reasonable quality is fundamental to driving improvements in culture and the workplace environment and that this is central to ensuring patient safety.¹⁴⁰

A RN and Midwife in Brisbane considers the current culture is affected by the amount of work nurses are required to complete each day. She advised:

...most nurses at the moment have trouble getting out of the day that they are in. I find that everyone will commit their eight hours to doing their patient care. They will be at the bedside doing their patient care. Their documentation and everything else that they have to do is happening in their own time after hours. I think increasing the nurse-patient ratios will probably give people time to breathe. In situations where you are saying that there is a bad culture, I think the culture is coming from the fact that they are just struggling to get their work done. I have had nurses say to me, 'I can't come to work tomorrow. I can't do this again tomorrow,' and have taken sick leave, saying that to me—and I am their manager—'I can't do this again tomorrow.' I think the culture is probably coming from the overwork rather than the other way around.¹⁴¹

A QNU Regional Organiser advised that she considers nurse-to-patient ratios will positively affect culture because nurses will be less tired:

They will be able to deliver patient care. That is what they went into nursing to do. Therefore, there would be a happier workforce because they are delivering the care the patients deserve.¹⁴²

A community nurse considers that the Bill will improve the health care culture in Queensland.¹⁴³

3.2.3 Committee comment

The Committee considers that, in addition to patient outcomes, nurse staffing levels affect the work environment. Inappropriate nurse staffing levels lead to nurse burn out; stress at not being able to provide quality of care an inability to meet the basic needs of patients; overtime work required to complete paperwork and the observation of preventable complications. The Committee considers these issues have the potential to greatly affect the work environment.

Government Members acknowledge that clinical leadership, the work environment and skills mix can all have a bearing on patient outcomes. While these are important, based on evidence provided to the Committee, they do not negate the need to establish safe nurse-to-patient ratios.

¹³⁹ See for example, Transcript, 9 March 2016, Cairns, p10; Transcript, 16 March 2016, Brisbane, p3

¹⁴⁰ Transcript, 16 March 2016, Brisbane, p3

¹⁴¹ Ms Janelle Taylor, Registered Nurse and Midwife, Transcript, public hearing, 16 March 2016, Brisbane, p11

¹⁴² Mrs Krissie Bishop, Regional Organiser, Queensland Nurses' Union, Transcript, public hearing, 9 March 2016, Cairns, p10

¹⁴³ Ms Janet Baille, Submission 14, p1

Government Members noted the skill mix will be included in the new management standard, developed based on the current BPF and consider this is an appropriate approach to mandating a skill mix, as it will enable HHSs to determine optimum staffing levels to meet demand for different units within hospitals.

With regard to the inclusion of direct care positions in the mandated skill mix, Government Members acknowledge the issues associated with including these positions in a mandated skill mix and consider that it is important that the mandated skill mix correctly accounts for the lower patient load adopted by nurse positions such as Nurse and Midwife Unit Managers. Government Members believe that the issue of how nursing team or shift leaders are accounted for in the skills mix and the nurse-to-patient ratios should be considered as part of the review to be conducted after two years.

Government Members believe the arrangement proposed by the Bill would assist in ensuring different staffing levels were available based on factors such as patient acuity and likely service demand.

Government Members support the unanimous call from nurses who submitted verbal and written evidence to the inquiry calling for the introduction of a mandated minimum nurse-to-patient ratio.

3.3 Impact of staffing levels on nurses

The Committee heard evidence that described the impact of nurse staffing levels has on the physical and emotional wellbeing of nurses. Key impacts include:

- Frustration and disillusionment at not being able to provide a basic level of care, or quality of care, that patients' require and deserve.¹⁴⁴
- Increased sick leave as a result of fatigue caused by workload.¹⁴⁵
- Burnout caused by the performance of double shifts.¹⁴⁶
- Replacing nurses on leave is made more difficult by the fatigue experienced by nurses.¹⁴⁷
- Quality improvement activities are postponed or cancelled.¹⁴⁸
- Nurses take increased stress leave.¹⁴⁹
- Job satisfaction is low.¹⁵⁰
- Registration can be compromised through caring for more patients than is permitted, especially for midwives.¹⁵¹
- Nurses leave the profession, or let specific registrations lapse without renewal.¹⁵²

The QNU echoed these views, reporting:

*According to our members, the main effects of unmanageable workloads include lack of time to comprehensively complete patient care, poor motivation and staff morale, increased levels of stress, fatigue and burnout, high error rate when making clinical decisions, difficulty in fully complying with protocols and procedures, and unintended disruptions to other clinical staff and departments.*¹⁵³

¹⁴⁴ Transcript, 9 March 2016, Cairns, p11

¹⁴⁵ Transcript, 9 March 2016, Cairns, p9

¹⁴⁶ Transcript, 9 March 2016, Cairns, p9 and 11

¹⁴⁷ Transcript, 9 March 2016, Cairns, p5 and Transcript, 8 March 2016, Townsville, p7

¹⁴⁸ Transcript, 9 March 2016, Cairns, p9

¹⁴⁹ Transcript, 8 March 2016, Townsville, p7

¹⁵⁰ Transcript, 8 March 2016, Townsville, p3

¹⁵¹ Transcript, 8 March 2016, Townsville, p6

¹⁵² Transcript, 9 March 2016, Cairns, p11. Townsville, p6

¹⁵³ Transcript, 16 March 2016, Brisbane, p3

3.3.1 Nurses' experience

At a public hearing, a RN in Brisbane told the Committee that nurses are stressed to breaking point and patient care is suffering dangerously as a result.¹⁵⁴ This view is supported by the QNU, which has observed that nurses:

*...no longer feel able to deliver the quality of care they know they are capable of providing because the necessary staffing numbers and skill mix are not available. This is the source of significant ethical distress for our members.*¹⁵⁵

A RN and Midwife in Cairns considers issues that prevent nurses from providing adequate care to patients conflicts with the type of person that chooses nursing as an occupation:

*Every day nurses in our unit express concerns that they have not had enough time to provide their patients with the attention they deserve. This constant rushing means we cannot spend time with patients to answer their questions or deal with their anxieties. The inability to do our jobs as we know we should goes against the very nature of individuals who choose nursing as a career.*¹⁵⁶

A RN and Midwife in Townsville considers that excessive workloads cause Midwives to burn out, and leave maternity wards staffed by nurses and midwifery graduates who have minimal experience of general and emergency obstetric care.¹⁵⁷ She explained that newborn babies are not counted in the patient numbers, which is a concern due to the amount of care and observation they require, including:

*... blood sugar protocols, meconium observation, prolonged rupture of membrane observations, baseline observations and visual observations for intercostal recession, respiratory effort, colour and turgor... Midwives provide babies with assistance in feeding, hygiene care such as baths and nappy changes, physical observations, vaccinations, hearing and neonatal screams. Jaundiced babies require blood collection, testing and treatment by midwives with the use of phototherapy beds.*¹⁵⁸

The impact of nurse staffing levels on permanent staff was highlighted by a Clinical Nurse at the public hearing in Cairns. She explained her hospital has no casual pool of staff so there is increased pressure on permanent part-time staff to replace nurses at short notice:

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

Mrs Bishop: *And their patients.*

Mrs Carlton: *And their patients, yes.*¹⁵⁹

¹⁵⁴ Ms Moira Purcell, Registered Nurse, Transcript, public hearing, 16 March 2016, Brisbane, p5

¹⁵⁵ Transcript, 16 March 2016, Brisbane, p3

¹⁵⁶ Ms Janelle Taylor, Registered Nurse and Midwife, Transcript, public hearing, 16 March 2016, Brisbane, p4

¹⁵⁷ Ms Robyn O'Sullivan, Registered Nurse and Midwife, Transcript, public hearing, 8 March 2016, Brisbane, p4

¹⁵⁸ Ms Robyn O'Sullivan, Registered Nurse and Midwife, Transcript, public hearing, 8 March 2016, Brisbane, p5

¹⁵⁹ Ms Debbie Carlton, Clinical Nurse, Transcript, public hearing, 9 March 2016, Cairns, p5

A newly registered nurse and former EN has observed nurses in distress and tears after completing a shift where they have felt they could not provide safe nursing care to their patients:

Some feel they have been emotionally and physically damaged by the very system they work within. They will often stay behind to complete the increased amounts of paperwork now required.¹⁶⁰

Improved nurse staffing levels would improve the supervision available to student and graduate nurses, better preparing them for their role as a credentialed nurse. A RN and Midwife in Brisbane considers this would result in better practitioners.¹⁶¹ She also considers that mandated nurse-to-patient ratios would give nurses in charge more power to refuse additional patients in the absence of adequate staffing:

Having a mandated nurse-to-patient ratio would mean that nurses who are in charge after hours and on the weekends would also have something to back up the BPF to say, 'We cannot possibly accept any more patients.' It would give them the evidence to use when the bullies come out and say, 'Just take on more work. You can do it. What is one more patient? What is another patient?'¹⁶²

3.3.2 Committee comment

The Committee acknowledges the impact that staffing levels have on nurses. Nurses cannot evade the responsibility of an increasing workload, such as turning patients away or providing a reduced level of service. As a result, the level of stress experienced by nurses increases and the quality of care they are able to provide decreases. The Committee also heard evidence that these stresses result in the loss of experienced staff and an unwillingness of new staff to join the profession. Government Members further acknowledged that nurses represent the 'end of the line' when it comes to the flow on effects of financial and human resource constraints, taking on increasing workloads to accommodate an increasing patient population, increasing patient acuity and a lack of mandated minimum staffing levels.

3.4 Would minimum staffing levels improve patient outcomes and nurse experience?

The majority of evidence received, including from nurses, academics, the QNU and other organisation, reflects that mandated minimum nurse staffing levels would improve patient outcomes and nurse experience as nurses would have more time to care for patients.

However, submitters such as the Private Hospitals Association Queensland and the Australian Private Hospitals Association (APHA) oppose mandated ratios as research does not recommend a specific recommended minimum nurse staffing level and skill mix.

The three nurses who appeared at the public hearing in Cairns agreed that the mandated staffing levels in the Bill would be an improvement on the workload currently experienced by nurses.¹⁶³

¹⁶⁰ Ms Lauren Picker, Registered Nurse, Transcript, public hearing, 16 March 2016, Brisbane, p5

¹⁶¹ Ms Janelle Taylor, Registered Nurse and Midwife, Transcript, public hearing, 16 March 2016, Brisbane, p5

¹⁶² Ms Janelle Taylor, Registered and Midwife, Transcript, 16 March 2016, Brisbane, p7

¹⁶³ Transcript, 9 March 2016, Cairns, p5

A QNU Regional Organiser added that mandated ratios would result in nurses having more time to provide appropriate care to patients when patients' require it, which would reduce complications occurring.¹⁶⁴ A Clinical Nurse in Cairns acknowledged the increased time nurses' would have to treat the whole patient:

*Treating the whole patient is a key element of nursing and one that is increasingly being eroded through time constraints. The minimum nurse-to-patient ratios will provide more time to talk to patients to assess and monitor their needs, discuss their condition and to gather information relevant to discharge planning. Importantly, it will allow the nurse to become more patient focused rather than task focused.*¹⁶⁵

A Clinical Nurse from Cairns also considers that mandated ratios would benefit nurses and patients, noting nurses would experience less fatigue, there would be less sick leave and more nurses would be attracted to the profession as there would be more time for patient care.¹⁶⁶

The Australasian College for Emergency Medicine (ACEM) noted potential flow on effects of mandating ratios in some areas of a hospital and not others, specifically on patient outcomes:

*...if nurse-to-patient ratios are introduced to wards only, there may be a significant impact upon patient flow. For example, under such ratios, wards may not have the capacity to accept ED [Emergency Department] patients until the appropriate number of nurses become available. If such a situation should occur, ED patients will be required to wait for transfer to a ward. This is known as hospital access block, which can adversely impact upon all aspects of acute medical system performance. These impacts include increased patient harm and mortality, increased length of stay and also extended ambulance turnaround times.*¹⁶⁷

In the Department's response to submissions it noted that ratios would not affect the arrangements hospital currently have in place to deal with issues such as patient flow from emergency departments to medical and surgical wards:

*The ratios are not a model of care in themselves and do not operate to limit how nurses are allocated in response to patient acuity and activity on the ward. For example, on a morning shift on a prescribed ward, if there are 28 patients the ward will need to be staffed with a minimum of seven professional nurses (registered nurses or enrolled nurses). How those nurses are distributed among those 28 patients will be a decision for the person in charge of the ward, having regard to issues such as patient acuity.*¹⁶⁸

The ACMHN supports the intent of Bill while noting the importance of maintaining flexibility to account for changes in population and health needs and the changing constitution of the nursing workforce. ACMHN considers that prescribing the minimum staffing levels in a regulation will allow for more flexibility than including them in the primary legislation.¹⁶⁹

¹⁶⁴ Mrs Krissie Bishop, Regional Organiser, Queensland Nurses' Union, Transcript, public hearing, 9 March 2016, Cairns, p7

¹⁶⁵ Ms Rachel Laas, Clinical Nurse, Transcript, public hearing, 8 March 2016, Townsville, p3

¹⁶⁶ Ms Debbie Carlton, Clinical Nurse, Transcript, public hearing, 9 March 2016, Cairns, p9

¹⁶⁷ Australasian College for Emergency Medicine, Submission 5, pp1-2

¹⁶⁸ Department of Health, correspondence, 9 March 2016, p2

¹⁶⁹ Submission 10, p1

3.4.1 Committee comment

Government Members consider that mandating minimum safe nurse-to-patient staffing levels would improve both patient outcomes and the experience of nurses.

Through ensuring a safe minimum nurse staffing level is maintained, nurses would have more time to provide care for patients. A number of benefits would result from this, including better communication with patients, fewer preventable complications resulting from nurses having the time to complete required tasks and improved discharge education and planning, which would minimise preventable readmissions to hospital.

Establishing minimum safe nurse-to-patient ratios creates a new staffing standard that will assist in avoiding fatigue, stress leave and burnout. It will create a more attractive profession for new and existing nurses, improved job satisfaction and improved conditions for nurses to complete the role they have trained for. Government Members also acknowledged the evidence provided in Victoria that minimum nurse staffing levels attract former nurses to return to the profession as well as attracting new entrants.

3.5 How ratios were determined

It is proposed that the minimum staffing levels that would be introduced to prescribed units, wards or departments within prescribed public health sector facilities are:

- 1 nurse for every 4 patients during a morning shift
- 1 nurse for every 4 patients during an afternoon shift
- 1 nurse for every 7 patients during a night shift¹⁷⁰

At a public hearing, the QNU explained why it considers these minimum ratios are appropriate. The QNU cited research that shows these staffing levels minimise adverse events for patients and reduce mortality rates when compared to staffing levels such as one nurse to six or eight patients. These levels also result in increased staff satisfaction and decreased burnout levels in nurses. The QNU consider these ratios would align Queensland with the practices of Victoria, New South Wales and some international evidence.¹⁷¹

QNU acknowledged that experience in other jurisdictions, such as California and in Victoria, is that a ratio of one is to four is applied on all shifts. However, they indicated that the approach in Queensland is to apply the floor of the proposed ratios and then apply the BPF on top of that.¹⁷² They consider that the proposed ratios are a good start and will be evaluated in order to gather data around the right ratio in particular circumstances.¹⁷³

The Committee sought advice on whether the Bill would afford Nurse Unit Managers (NUMs) the flexibility to adapt nurse staff levels based on the changing needs of patients:

***Ms BATES:** So NUMs have the flexibility to put on more staff if they need to? What if they do not need more staff? What if the ward is quiet and you do not need to have one nurse for every four patients if the acuity of the patients is such that they are ambulatory and six days post-operative and you do not need to have that many staff?*

¹⁷⁰ Bill, clause 3

¹⁷¹ Transcript, 16 March 2016, Brisbane, p8

¹⁷² Ms Mohle, QNU, Public hearing transcript 16 March 2016, p8

¹⁷³ Ms Veach, QNU, Public hearing transcript 16 March 2016, p8

Dr Fleming: I do think I understand the question, and you raise the very significant point of acuity. I would say that I think it is because of the standard that has the workload management within it that makes the NUMs and the nurses 'on floor', as we say, much more confident about ensuring they do have the right number. I refer to your point about 'if the acuity is not there, what then will occur?' To be honest, ..., there will be a one to four, so if you have 24 patients you will have six nurses. That will stand. It is the higher acuity that certainly will be addressed by BPF or the workload management standard.¹⁷⁴

The Queensland Law Society (QLS) generally supports the Bill as a means to improve patient outcomes and providing safe and sustainable workloads for nurses and midwives in the public sector. It does not, however, consider that the ratios included in the Bill provide the flexibility required to always deliver an appropriate level of care to patients.¹⁷⁵ The QLS therefore recommends a wider range of prescribed ratios be considered, such as five nurses to 20 patients for morning and afternoon shifts, or four nurses to 28 patients for night shifts.¹⁷⁶

In response to this issue raised by the QLS, the Department advised that the ratios suggested by the QLS are in practice the same as those proposed by the Bill:

This is because the purpose of ratios is to prescribe the minimum nursing staff levels on a prescribed ward, having regard to the number of patients on that ward. The ratios are not a model of care in themselves and do not operate to limit how nurses are allocated in response to patient acuity and activity on the ward. For example, on a morning shift on a prescribed ward, if there are 28 patients the ward will need to be staffed with a minimum of seven professional nurses (registered nurses or enrolled nurses). How those nurses are distributed among those 28 patients will be a decision for the person in charge of the ward, having regard to issues such as patient acuity. The ratios will not affect the day to day arrangements hospitals have in place to deal with issues such as varying and fluctuating patient acuity and activity, the need for patients to be accompanied whilst undergoing diagnostic tests in other parts of the hospital; and patient flows from emergency departments to medical and surgical wards.¹⁷⁷

The QNU advised the Explanatory Notes refer to the methodology to calculate minimum numbers 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).¹⁷⁸

QNU recommended that staffing level calculations be rounded to the nearest whole number.

The Department noted it would consider including a provision in the regulation similar to that included in Victorian legislation which clarifies that a ratio may be applied in a way in order to evenly distribute the workload, having regard to the level of care required by patients on the ward. It will also consider whether to include examples to clarify the application of rounding methodology used when calculating ratios.¹⁷⁹

¹⁷⁴ Transcript, 17 February 2016, Brisbane, p5

¹⁷⁵ Submission 7, p3

¹⁷⁶ Submission 7, p4

¹⁷⁷ Department of Health, correspondence, 9 March 2016, p2

¹⁷⁸ Submission 13, p25

¹⁷⁹ Department of Health, correspondence, 9 March 2016, p2

The Private Hospitals Association Queensland does not support mandated minimum staffing levels, and considers that the same proposed minimum ratio for surgical and medical wards is inappropriate given the patient care type:

The proposed minimum ratios are the same for all surgical and medical wards and yet as noted in the example above, patient care type is critical in terms of being able to assess patient acuity accurately and the skill mix necessary to deliver appropriate care. Nurse Managers need to accurately assess the type of work on the ward and how much of it must be done by an RN or EN and how much an Assistant in Nursing (AIN) /Patient Care Assistant (PCA) may be able to do.¹⁸⁰

Most research has evaluated nurse staffing levels based on a ratio of one to four for morning, evening and night shifts, however, the Bill would introduce a ratio of one to seven for a night shift. The QNU considers the night shift ratio in the Bill is an appropriate starting point as it is based on local research and the experience of Victoria and New South Wales. The QNU emphasized the importance of the evaluation process in reviewing the minimum staffing level introduced and determining whether any change is required.¹⁸¹

3.5.1 Committee comment

Government Members support the proposed ratios as a way to address many of the issues raised by inquiry participants. Members noted research findings that the ratios would minimise adverse events for patients and reduce mortality rates when compared to other staffing levels. The ratios outlined in the Bill are based on research findings, adjusted according to Australian jurisdictional experience. In addition, the independent research program organised by the Department is considered a robust independent program that will provide definitive evidence about whether the ratios implemented are suitable or require amendment.

Given the evidence on which the ratios are based, Government Members of the Committee consider the minimum staffing levels are appropriate and support their implementation when implemented in conjunction with the BPF/standard and supported by the research and monitoring program.

Non-Government Members of the Committee also acknowledge the experience of nurses and the impact of nurse staffing levels on patient outcomes. Adequate nurse staffing levels are supported, however, Non-Government Members do not support the fixed minimum ratios as proposed by the government.

3.6 Financial considerations

Preliminary data modelling indicates that implementation of minimum nurse staffing levels would require an additional 250 nurses, at a cost of \$25.9 million in the first year and would be funded from within existing Service budget allocations.¹⁸²

¹⁸⁰ Submission 12, p7

¹⁸¹ Ms Beth Mohle, State Secretary, Queensland Nurses' Union, Transcript, public hearing, 16 March 2016, Brisbane, p8

¹⁸² Explanatory Notes, p3

The Department advised that additional modelling will refine the cost, which will change depending on the point in time it is measured:

*...in the past 12 months we have had the three or four per cent growth in activity. It requires both measures to be meaningful ... 250 nurses might equate to 270 nurses in a year's time, if that makes sense, because the activity has grown.*¹⁸³

The Committee sought advice from the Department about potential increased management costs resulting from the additional nurse workforce. The Department advised it is unlikely a new management structure would be required to manage the extra nurses, as the nurses would be spread across Queensland and absorbed into the current system.¹⁸⁴

At the public briefing, the Committee sought information about the cost of preventative health conditions arising as a result of sub-optimal staffing levels:

Mr KELLY: *... What does it cost the system, roughly, for one single pressure area to develop and be missed by a nurse? Can you put a figure on that?*

Dr Wakefield: *I can put a figure on that. Obviously there are different grades of pressure injury, but health economics research was done that suggested that the increase in the average length of stay is about three to four days for a patient who gets a pressure injury. Obviously you can compute that into the cost of a bed per day. Even leaving aside the patient distress, family distress and the pain of having a pressure injury, the additional cost on the system is three to four days of staff to bed.*

Mr KELLY: *Having an understanding of health economics, we should never rule out the costs to the family. They are not costs in a dollar sense but they are costs nonetheless.*

Dr Fleming: *Yes, emotional.*

Mr KELLY: *The research is quite clear: there are significant benefits in terms of reducing all of those instances that I have just outlined; is that correct?*

Dr Fleming: *That is correct.*¹⁸⁵

A Registered Nurse in Townsville considers the cost of implementation would be offset by "...shorter stays in hospital, less complications, increased patient safety and long-term benefits for the organisation."¹⁸⁶

The Department advised there is potential for modelling to be undertaken on the effect of minimum nurse staffing levels on, for example, rates of infection, pressure sores and mortality. The evaluation will consider this question prospectively.¹⁸⁷

Professor Di Twigg, Registered Nurse, Professor of Nursing and Dean, School of Nursing and Midwifery, Edith Cowan University, has conducted research into the economic benefits of increased levels of nursing care in the hospital setting.¹⁸⁸

¹⁸³ Department of Health, Transcript, public briefing, 17 February 2016, p7

¹⁸⁴ Department of Health, Transcript, public briefing, 17 February 2016, p9

¹⁸⁵ Department of Health, Transcript, public briefing, 17 February 2016, pp6-7

¹⁸⁶ Ms Katrina Giles, Registered Nurse, Transcript, public hearing, 8 March 2016, Townsville, p6

¹⁸⁷ Department of Health, Transcript, public briefing, 17 February 2016, p9

¹⁸⁸ Twigg, D. E., Geelhoed, E. A., Bremner, A. P. and Duffield, C. M. (2013) The economic benefits of increased levels of nursing care in the hospital setting, *Journal of Advanced Nursing*, 69(10), 2253-2261

Her research found:

...that increases in nursing hours per patient per day were cost-effective when compared with threshold interventions commonly accepted in Australia. This outcome was determined by comparing the reduction in adverse events and associated costs per life year gain before and after the increase in nursing hours.

For example, the study determined that increased nursing hours resulted in 1088 life years gained based on reductions in the number of 'failure to rescue' (death of a patient after a treatable complication has occurred) adverse events. The cost per life year gained was \$8,907, which when compared to the cost-effective threshold in Australia of \$30-60,000 per life year gained is efficient.¹⁸⁹

In her submission to the Committee Prof Twigg concluded there is a strong economic case for:

...investing in staffing methodologies that promote sufficient nursing hours and skill mix based on the efficiencies gained from reductions in the number of preventable adverse events experienced by patients. Investing in more nursing hours with a richer skill mix may involve costs upfront however, the long-term benefits for patients and health services are undeniable.¹⁹⁰

A summary of key research findings on the cost benefit of introducing minimum nurse staffing levels is provided in section 2.4.2 of this report.

3.6.1 Committee comment

The Committee noted the advice provided by the Department regarding the financial cost of establishing the proposed minimum nurse staffing levels in the first year, and that this cost would be met through existing Service budget allocations.

The Government Members acknowledge the evidence received during the inquiry that a 25 per cent increase in nurse-to-patient ratios can result in significant cost saving through reducing medical costs, retaining staff and reducing patient complications and adverse events. The Committee notes the significant additional cost that adverse events such as pneumonia add to a patient's medical care. The Committee considers that every adverse event represents an impact on a patient and their family, and that these events need to be minimised where possible. The Government Members believe that mandated minimum nurse to patient ratios would directly assist in addressing this issue.

Non-Government Members expressed concern about data modelling used to create nurse-to-patient ratios and the number of nurses needed to implement ratios created by the Bill. The Department conceded there was a need to refine the data modelling in order to apply it to a range of scenarios. Non-Government Members raised the costings associated with implementing the provisions of the Bill, as the costings drew from a variety of assumptions which could cast doubt on the presumed \$25.9 million cost.

¹⁸⁹ Submission 8, p2

¹⁹⁰ Submission 8, p2

3.7 Monitoring and review

Implementation of the Bill would be supported by independent research commissioned by the Department of Health. The Department tendered internationally for researchers that have a record in undertaking relevant research. At the public briefing, the Department provided examples of the types of questions the research endeavours to answer:

*You can actually say, 'As a consequence of this policy' - for example, in a year's time or two years time or as the research occurs from baseline - 'there has or has not been a reduction in, for example, pressure injuries and the other types of very much nurse-sensitive patient safety outcomes where we know there is a level of harm or a level of burden now.' We will be able to provide that information and it will be published at a system level. The research will identify that and it will be published in peer reviewed literature and we will be able to say with confidence whether and what the impact has been. There will always be questions about attribution and whether this change has led to that consequence.*¹⁹¹

Subsequent to the public briefing, Queensland Health announced that the University of Pennsylvania, in partnership with the Queensland University of Technology, would assess the impacts of introducing legislated minimum nurse-to-patient ratios in Queensland's public health system in July 2016. The research team will be lead by Dr Linda Aiken and Dr Matthew McHugh.¹⁹² Queensland Health noted that the University of Pennsylvania is the world leader in research on nurse-to-patient ratios and had carried out similar studies in more than 30 countries.¹⁹³

Dr Aiken is the Director of the Center for Health Outcomes and Policy Research, and the Claire M. Fagin Leadership Professor of Nursing and Professor of Sociology at the University of Pennsylvania, Philadelphia. She conducts research in the US and globally on the relationship between nursing care and patient outcomes. She has authored more than 300 scientific papers and has received a number of awards.¹⁹⁴

The QNU applauded the appointment Dr Linda Aiken and her team to undertake the evaluation:

*Professor Aiken's team will initially gather baseline data and then will evaluate the impact of the implementation of minimum ratios. This is the first time this exceptional team will conduct research in Australia and shows a real commitment to transparency and being evidence driven by all involved in this important policy initiative.*¹⁹⁵

The QNU considers the research would establish whether the ratios implemented were the most appropriate.¹⁹⁶

¹⁹¹ Department of Health, Transcript, public briefing, 17 February 2016, p9

¹⁹² Department of Health, Office of the Chief Nursing and Midwifery Officer, <site accessed <https://www.health.qld.gov.au/nmoq/optimisingnursing/nurse-to-patient-ratios.asp>

¹⁹³ <https://www.health.qld.gov.au/nmoq/optimisingnursing/nurse-to-patient-ratios.asp>

¹⁹⁴ University of Pennsylvania, School of Nursing, Linda H Aiken, PhD, FAAN, FRCN, RN <site accessed 13 April 2016> <http://www.nursing.upenn.edu/faculty/profile.asp?pid=107>

¹⁹⁵ Transcript, 16 March 2016, Brisbane, p4

¹⁹⁶ Ms Beth Mohle, State Secretary, Queensland Nurses' Union, Transcript, public hearing, 16 March 2016, Brisbane, p8

The Private Hospitals Association Queensland considers an evaluation should be enshrined in legislation and measured against a range of nursing and patient safety sensitive outcome measures, as simply monitoring compliance with mandated minimum ratios would not in itself evidence that safe patient care is being provided. Indicators include patient satisfaction and complaints, falls, pressure injuries, medication administration errors, hospital acquired infections, response to deterioration, nursing staff turnover, absenteeism and agency usage. In addition, baseline measures for these indicators should be reported as at the date of implementation, 1 July 2016, with the same indicators measured 12 months later.

The QNU also recommends the Bill include a provision requiring mandatory evaluation and reporting, including a direction for public reporting. Additionally, that the regulation require the Nursing and Midwifery Implementation Group to develop an agreed evaluation process that is carried out at least every two years to inform future phases.¹⁹⁷ The QNU recommends that section 138E(3) be amended to require the standard to include requirements about reporting nursing or midwifery workload management information to the chief executive for the purposes of open reporting to the public.¹⁹⁸

The Private Hospitals Association Queensland recommends any evaluation report be made publicly available and tabled in the Parliament.¹⁹⁹

The ACMHN questioned what data would be recorded and reported:

...for example will it be purely quantitative, or will it be used to examine qualitative aspects, such as patient outcomes and improvements to nurse workplace health and safety.²⁰⁰

3.7.1 Committee comment

The Committee strongly supports the decision to undertake an independent evaluation of the implementation of minimum nurse staffing levels, should the Bill pass. Such an evaluation would provide critical information about the effectiveness of the program, identify any adverse consequences, report financial considerations and provide guidance about any aspects that require amendment to increase the efficiency of the program.

As cited earlier, the Government Members believe that the issue of how nursing team or shift leaders are accounted for in the skills mix and the nurse-to-patient ratios should be considered as part of this review.

Due to the timing of the tendering process, detailed information about the independent research program commissioned by the Department of Health was not available. The Committee therefore cannot comment on the appropriateness of the design of the research program, or what it will examine.

The Committee is pleased with the appointment of Professor Aitken and her team, to undertake the evaluation.

¹⁹⁷ Submission 13, p5

¹⁹⁸ Submission 13, p23

¹⁹⁹ Submission 12, p2

²⁰⁰ Submission 10, p3

3.8 Other issues raised

3.8.1 Potential unintended consequences

A number of potential unintended consequences were identified that could result from the introduction of minimum nurse staffing levels. That is, that minimum staffing levels could be used as a maximum level as a result of business planning and patient flow from areas of the hospital that do not have minimum staffing levels in place could be affected, impacting surgery bookings and patient transfers.

A potential adverse use of mandated minimum staffing levels was identified during the Committee's inquiry. That is, that minimum, mandated staffing levels could be used as maximum staffing levels during business planning, rather than as a minimum level that can change depending on need. -At the public hearing, the Committee asked the QNU for more information regarding this potential issue:

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

***Ms Mohle:** Yes, we certainly do. That is I think one of the strengths of actually having ratios in conjunction with the application of the BPF. The one to four could soon become all you are going to get, even though you might demonstrate that you need one to two or one on one. That is why it is so important that you cannot separate the BPF from the ratio, because the BPF will give you the evidence that is required to actually show that you need more than the one to four. It is a belt and braces approach. As I say, other jurisdictions in the country do not have that methodology. That has been validated again and again and it has been in place for over a decade. The difficulty has been not with the tool but with its proper application.²⁰¹*

The QNU recommend that the prefix 'minimum' be used before 'nurse-to-patient ratios' in the Bill and regulation, as a way to assist with interpretation and implementation.²⁰²

As described in section 3.4 of this report, the ACEM identified that if minimum nurse staffing levels are introduced into wards only, and not emergency departments, hospital access blocks may occur when patients from emergency departments await transfer to a ward, negatively affecting patient outcomes.²⁰³

3.8.2 Committee comment

The Government Members agreed that there is the potential for the staffing levels introduced by the Bill to be used as a ceiling rather than a floor, and that this would be clearly in conflict with the intention of the Bill. Actions that could prevent this from occurring include education of relevant staff before implementation commences, monitoring actual staffing levels and providing an avenue for staff to report back to the Department when this is perceived to have occurred.

Government Members consider that good communication from Department and HHSs to hospitals is essential to ensuring the correct implementation of the legislation. A robust monitoring and evaluation program would also assist in identifying whether such adverse consequences had occurred.

²⁰¹ Transcript, 16 March 2016, Brisbane, p9

²⁰² Submission 13, p24

²⁰³ Submission 5, p2

Government Members agree that inserting the prefix 'minimum' before 'nurse-to-patient' would assist in reinforcing that the staffing levels are a minimum and flexible. Government Members recommend that the Bill and regulation be amended to include 'minimum' nurse-to-patient ratios as standard.

The Committee noted concerns raised regarding the impact of mandated minimum staffing levels in certain wards on patient flow from emergency departments. The Committee is satisfied with the response from the Department; that ratios would not affect the day to day arrangements hospitals have in place to deal with issues such as patient flows and varying patient acuity and activity.

3.8.3 Temporary exemption

A HHS may be exempted temporarily from complying with the minimum mandated nurse-to-patient ratio, and other provisions in the regulation, as a result of extenuating circumstances such as challenges recruitment and training staff.²⁰⁴ Additional detail about temporary exemptions is provided in section 2.2 of this report.

The QNU supports temporary exemptions and publication on the Department's website, while recommending that the provision go further to include reasons for the exemption and being published within 14 days of determination.²⁰⁵

3.8.4 Committee comment

The Committee notes the recommendations made by the QNU and Private Hospitals Association Queensland regarding temporary exemptions.

The Committee considers temporary exemptions are an important and realistic part of introducing minimum nurse staffing levels. The Committee acknowledges that some units and hospitals may not be in a position to comply with minimum mandated staffing levels for reasons outside their control. Temporary exemptions provide these hospitals with a grace period and a deadline by which they will be required to comply with the legislation. The Committee considers the requirements in the Bill regarding temporary exemptions, and publication of those granted, as adequate in its current form.

The Committee does not support automatic temporary exemptions as recommended by the Private Hospitals Association Queensland, as emergency situations will not always result in a hospital from being able to comply with the mandated minimum nurse-to-patient ratios. The Committee considers the Bill provides adequate safeguards for hospital that are unable to comply with the legislation in its current form.

3.9 Nurse recruitment in regional areas

A number of inquiry participants advised that regional areas in particular have difficulty recruiting nurses, and many do not have access to a casual pool of staff.

²⁰⁴ Department of Health, correspondence, 14 January 2016, pp2-3

²⁰⁵ Submission 13, p4

A Clinical Nurse in Cairns described that she often spends at least two hours on the phone trying to replace nurses who have called in sick, as there is no casual pool of staff available:

We have no casual pool of nurses, so we all just sit there and beg our permanent part-timers to come in. They will come because they have been in our shoes, because they have been on where someone has rung in sick and we have not been able to get help, or they will come because they will self-sacrifice for their work colleagues.²⁰⁶

A QNU Regional Organiser and EN advised that radiology services have been privatised in the Central Queensland HHS, which resulted in the loss of the nursing pool in the radiology service. The effect of this is that :

...nurses have to stay with patients when they go down to the radiology department within their own facility to have an MRI which may take an hour or two. That is effectively taking them off the floor and increasing the workload for their colleagues.²⁰⁷

A Nurse Manager in Gladstone considers the recruitment of nurses to regional Queensland as an endemic problem, and that changing the culture of nursing would help attract nurses back to the profession:

I can tell you now that I could name more than a dozen nurses in Gladstone alone who do not work in the health care system because of those reasons. I was talking to a nurse manager this morning who told me that people do not want to pick up extra shifts because of the workloads that are there, because of the cultures that exist. I think respecting the profession, respecting the patient and bringing that patient and quality agenda to the table will change the way that we attract nurses to regional areas.²⁰⁸

The Nurse Manager considers that introducing nurse-to-patient ratios would attract casual nurses back to the workforce.²⁰⁹

Additional consideration of work environment and culture is considered in section 3.2.2 of this report.

3.9.1 Committee comment

The Committee notes the challenges experienced in a number of regional areas in recruiting nurses, and accessing temporary staff to replace absent nurses.

The Committee agrees that adequate nurse staffing levels would enable nurses to provide an appropriate level of patient care, improving patient outcomes and nurses' experience of their profession. Government Members further noted the interstate experience that demonstrated that nurses returned to the profession in significant numbers following introduction of nurse-to-patient ratios at the same levels as those proposed in the Bill. Government Members believe that this will assist in addressing this issue.

Non-Government Members raised toxic workplace culture issues within Queensland Health as a key factor in recruitment difficulties of nurses and midwives in rural and regional areas, which was raised by Mr Lawson in his evidence to the Committee, and how this could impact on the recruitment of nurses and midwives during the implementation of the Bill.

²⁰⁶ Ms Debbie Carlton, Transcript, public hearing, 9 March 2016, Cairns, p3 and p5

²⁰⁷ Mr Grant Burton, Regional Organiser, Queensland Nurses' Union and Enrolled Nurse, Transcript, public hearing, 10 March 2016, Gladstone, p13

²⁰⁸ Mr Damien Lawson, Nurse Manager, Transcript, public hearing, 10 March 2016 Gladstone, p10

²⁰⁹ Transcript, public hearing, 10 March 2016, Gladstone, p10

4 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The Committee has examined the application of the fundamental legislative principles to the Bill. The Committee brings the following to the attention of the House.

4.1 Institution of Parliament

Section 4(2)(b) of the *Legislative Standards Act 1992* requires legislation to have sufficient regard to the institution of Parliament. Whether a Bill has sufficient regard to the institution of Parliament depends on whether, for example, the Bill sufficiently subjects the exercise of a proposed delegated legislative power (instrument) to the scrutiny of the Legislative Assembly (s4(4)(b)).

Clause 5 of the Bill inserts new section 138E which empowers the chief executive of the Department to make standards about nursing and midwifery workload management by a Hospital and Health Service. A standard made under this provision is not subordinate legislation and thus is not, itself, disallowable. Accordingly, it could be argued that this exercise of bureaucratic power does not have sufficient regard to the institution of Parliament.

To address this potential breach of fundamental legislative principle, the Bill provides that the Minister must notify the making of a standard and that the Minister’s notice is subordinate legislation (s138E(5)&(6)).

Being subordinate legislation, the Minister’s notice is subject to the requirements of section 49 of the *Statutory Instruments Act 1992* (SIA) which specifies that in order for subordinate legislation to come into effect, it must be tabled in the Legislative Assembly within 14 sitting days after it is notified under section 47. Once a notice is tabled, it can be disallowed by the Parliament under section 50 of the SIA in which case the relevant standard ceases to have effect.

It is also noted that under section 138E(8) the chief executive must publish the standard on the Department’s website.

4.1.1 Committee comment

The Committee considered that the steps taken to address the potential breach of fundamental legislative principle are adequate in the circumstances. Particularly, the requirement that the Minister notify the making of the standard, that notice’s status as subordinate legislation, the ability of the Parliament to disallow the notice, and the publication of the relevant standard on the Department’s website.

4.2 Explanatory notes

Part 4 of the *Legislative Standards Act 1992* relates to Explanatory Notes. It requires that an Explanatory Note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an Explanatory Note should contain.

Explanatory Notes were tabled with the introduction of the Bill. The Notes are fairly detailed and contain the information required by Part 4 and a reasonable level of background information and commentary to facilitate understanding of the Bill’s aims and origins.

Appendix A – List of submissions

Sub #	Submitter
001	Phil Browne
002	Professor Desley Hegney
003	Professor Linda Shields
004	Professor Christine Duffield
005	Australasian College for Emergency Medicine
006	Heart Foundation Queensland
007	Queensland Law Society
008	Professor Di Twigg
009	Australian Private Hospitals Association
010	Australian College of Mental Health Nurses
011	Midwife and Maternity Provider Organisation Australia
012	Private Hospitals Association Queensland
013	Queensland Nurses' Union
014	Janet Baillie
015	Leading Age Services Australia Ltd
016	Karen Shepherd
017	Metro North Hospital and Health Service
018	Professor John Buchanan

Appendix B – List of witnesses appearing at public briefing and public hearings

Public briefing
Brisbane – 17 February 2016
<p>Dr John Wakefield, Deputy Director-General, Clinical Excellence Division, Department of Health</p> <p>Dr Lesley Fleming OAM, A/Chief Nursing and Midwifery Officer, Clinical Excellence Division Department of Health</p> <p>Mr David Harmer, Director, Legislative Policy Unit, Strategic Policy and Legislation Branch, Strategy, Policy and Planning Division, Department of Health</p>
Public hearings
Townsville - 8 March 2016
<p>Ms Katrina Giles, Registered Nurse, Townsville Hospital</p> <p>Ms Robyn O’Sullivan, Registered Nurse and Midwife, Ayr Hospital, Townsville Hospital Maternity Services</p> <p>Ms Kaylene Turnbull, Regional Organiser, Queensland Nurses’ Union</p> <p>Ms Deb Watt, Registered Nurse, Townsville Hospital</p>
Cairns – 9 March 2016
<p>Mrs Krissie Bishop, Regional Organiser, Queensland Nurses Union</p> <p>Ms Debbie Carlton, Clinical Nurse, Mareeba District Hospital</p> <p>Ms Rachel Laas, Clinical Nurse, Queensland Health</p>
Gladstone – 10 March 2016
<p>Mr Grant Burton, Regional Organiser, Queensland Nurses Union</p> <p>Ms Tina Gray, Registered Nurse/Midwife</p> <p>Mr Damien Lawson, Nurse Manager</p>
Brisbane – 16 March 2016
<p>Ms Beth Mohle, State Secretary, Queensland Nurses’ Union</p> <p>Ms Kate Veach, Professional Research Officer, Queensland Nurses’ Union</p> <p>Ms Lauren Picker, Registered Nurse</p> <p>Ms Moira Purcell, Registered Nurse</p> <p>Ms Janelle Taylor, Registered Nurse and Midwife</p> <p>Professor Christine Duffield, Professor of Nursing and Health Services Management, University of Technology Sydney and Edith Cowan University (via teleconference)</p>

