Speech By

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MEMBER FOR MOGGILL

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HOSPITAL AND HEALTH BOARDS (SAFE NURSE-TO-PATIENT AND MIDWIFE-TO-PATIENT RATIOS) AMENDMENT BILL

Dr ROWAN (Moggill—LNP) (5.03 pm): I rise to address the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015. I also want to take this opportunity to recognise all nurses on International Nurses Day—all of those nurses who work across various healthcare environments in our hospitals, in general practices and in our residential aged-care facilities and community nurses as well.

I am strongly committed to ensuring the highest standards of safety and quality for patients in our health system. I appreciate firsthand the important contribution and value of our nursing staff in the delivery of health care. There is no doubt that having appropriately skilled and trained staff allocated in accordance with the needs of individual patients is of paramount importance to the delivery of quality outcomes for patients. What I am opposed to is legislatively prescribed nurse-to-patient and midwife-to-patient ratios that do not reflect the need for flexibility and clinical judgement in response to the patient care environment and the changing needs of patients. This bill is yet another example of this government's union driven policy agenda based on selective use of research rather than an objective analysis of available research and genuine consideration of integrated workforce strategies that enhance patient outcomes.

Mandatory minimum ratios are a blunt stick approach to staffing which do not recognise allocation of staffing based on patient acuity, the individual patient's acute condition and comorbidities, and the patient's continuum of care needs. There are very good reasons as to why outside of California in the United States and Victoria in Australia there is not widespread adoption of ratios internationally, with a more common approach being requirements for mandatory, unit specific staffing plans with accountability requirements, including public reporting. Blanket application of ratios ignores environment and contextual considerations, experience of staff, individual specialty related considerations, the physical layout of wards, available information technology in different hospitals and family needs. The bill as drafted has no reference to an integrated approach to recognising and addressing all of these factors in improving care safety and quality. As a former executive director of medical services and a deputy chief medical officer, I have had firsthand experience of seeing this in the acute care environment.

The Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 in its current form seeks to insert requirements into the Hospital and Health Boards Act 2011 to make a regulation and a standard. Unlike the transparent approach in the Victorian legislation, there is little to no detail provided in the primary legislation, with the detail on ratios identified in the draft Hospital and Health Boards Amendment Regulation 2016.

Notwithstanding my opposition to legislatively prescribed staffing levels, the Victorian model at least provides for some flexibility not evidenced in the union driven policy being considered by us today. Sections 15 to 31 of the Victorian legislation—Safe Patient Care (Nurse to Patient and Midwife to Patient

Ratios) Act 2015—recognises that there are differences between tertiary referral hospitals and other hospitals, with the identification of hospital levels and specialty units with differing staffing ratios required for these. The Victorian legislation in sections 32 to 36 also allows for application of a ratio to a ward rather than specific patient allocation so staffing is allocated according to patient need and consideration of alternative staff model trials. The Queensland approach as drafted provides for no flexibility.

Section 30B of the draft Queensland Hospital and Health Boards Amendment Regulation as written lists 28 hospitals and proposes a blanket, inflexible ratio of one to four for morning and afternoon shifts and one to seven for night duty for all medical and surgical wards without consideration to the patient care type or acuity. While evidence and my own personal and professional experience supports that patient safety is affected by staffing, including having suitably trained and skilled staff, there is no robust evidence that supports a specific staffing ratio. The *Guidance on safe nurse staffing levels in the UK*, which was developed by the Royal College of Nursing in the United Kingdom following significant clinical event related reviews, identifies—

A ratio of eight or more patients per RN is associated with patient care on a ward ... being compromised by short staffing ...

The Victorian model identifies both service location and shift variations. For example, level 3 hospitals have ratios of one to five for the morning shift, one to six for the afternoon shift and one to 10 for the night shift, compared to a tertiary referral hospital, such as the Royal Melbourne Hospital, that has one to four for morning and afternoon shifts and one to eight for night duty. There has been no suggestion or evidence that these staffing levels are adversely impacting on care outcomes. My own experience of care delivery has been that there are times when patients with acute clinical need have led to one-on-one care, with knowledge of the clinical experience of nursing staff considered in providing optimum care. There is a complete lack of clarity in the draft bill and regulation that allows for such flexing of staffing according to changing clinical need or unexpected variations in care requirements in a clinical unit.

The explanatory notes identify that the cost of implementing the proposed mandated ratios will be $29.5 million in the first year and that this will be covered from within an existing budgetary allocation. It is extraordinary that those opposite seek to propose to allocate this level of expenditure to nurse and midwife ratios and argue this is based on patient safety without providing evidence of current safety and quality performance baseline and workforce data or identifying targeted improvements with accountability measures for delivery of improved safety outcomes.

While the stated purpose of the bill is to ensure patient safety and the delivery of high-quality health services, proposed section 138F requires reporting on compliance with the prescribed ratios with no reference to requirements to demonstrate improvements in outcomes for patients against well-recognised, nursing-sensitive indicators such as pressure areas, falls, the timely delivery of medications and hospital acquired infections.

Submissions on the draft bill raised concerns regarding unintended consequences of the inflexible approach proposed to nurse-to-patient ratios. Consequences such as surgical cancellations, unit closures and transfer of patients within a hospital or to another hospital were raised. When allocating staff, the complex care needs of patients should be the primary focus of nurse managers. This bill imposes a mandated inflexible ratio to the considerations when rostering. There is no clarity in the draft Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 to help with this and no penalty provisions are identified. While proposed section 138C allows for the minister to grant by written notice a temporary exemption, this does not address the day-to-day fluctuations that occur in all clinical services and provides no details on when such an exemption is required or for what period of noncompliance. What happens when staff are off the ward supporting a patient undergoing a procedure or when there is unexpected sick leave and the ward is full?

Along with accountability for improved outcomes for nurse-sensitive indicators, the impact of this legislation including the cost impact and any unintended consequences should be publicly reported. Having sufficient nurses with the right skills in the right place should be the priority focus of all good governments while promoting responsive, safe, efficient, effective and appropriate care. Safe, quality care of patients within our health system should be supported by evidence based staffing practices with the best match of patient need and nurse competencies. This requires receptiveness to different approaches to staffing rather than using a blunt stick such as this poor public policy and associated legislation drafted by those opposite. An approach such as that being considered in the United States with the bipartisan Registered Nurse Safe Staffing Act, which requires the establishment of a committee with 55 per cent direct care nurse representation to create nursing plans for each unit, recognises that direct care nurses working closely with managers are best equipped to determine the staffing level for their patients—not legislators prescribing this—an approach that recognises educational and clinical experience, evidence based practice and the complexity of patient needs.

I oppose the prescription of mandatory ratios that do not reflect the allocation of nursing resources to patient need. This bill is another example of a narrow approach to what is a complex issue. I do not support this bill in its current form as it will not achieve the true desired outcome for both nurses and patients of our Queensland hospital system. Unfortunately, much of the Palaszczuk Labor government's approach to complex issues is far too simplistic and fundamentally flawed. However, I am pleased to note that there will be ongoing data evaluation as well as a monitoring and review process, but in my view this should have been prospective rather than retrospective. I am also very sceptical with respect to the government's proposed costings.

As the now former deputy chair of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, I acknowledge my fellow committee members and in particular the member for Mudgeeraba, who has over 35 years of clinical experience in the nursing field, for her valuable contribution in assessing this legislation. I would also like to acknowledge the work that was undertaken by the department and those who provided submissions in evaluating this legislation. In conclusion, I would also like to thank the technical scrutiny staff for their evaluation and for all those who supported the committee.