Speech By

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

Mr KELLY (Greenslopes—ALP) (5.15 pm): I absolutely support the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill. Ratios will save lives. It is that simple. Today on International Nurses Day I reflect on almost three decades of being a nurse. I pay tribute to all my nursing colleagues and to the midwives who bring us into the world and keep our mums safe. They had their day last week, and they deserve it. I would also like to acknowledge my many colleagues in the gallery and I thank them for coming this evening.

What does it mean to be a nurse? It is not about the technical skills, the clinical knowledge or the sometimes dramatic events of a work day that make for good TV. It is about taking responsibility to care for another human being no matter what their situation. Like all nurses and midwives, I have cared for a diverse array of people. I have looked after the rich and famous. I have cared for a homeless woman. I have cared for people who have tried and failed to kill themselves. I have cared for initiated Indigenous elders, children with leukaemia, people who have committed terrible crimes and so many other people. Like all nurses and midwives, my calling does not allow me to judge who I care for, just that I care—caring enough to want people to get better, not sick again; caring enough to try to stop people getting sick in the first place; and caring enough to be honest with someone and stay with them when there is no hope of recovery. Nurses and midwives do this not because they are caring for friends or family or someone they know, not because a nurse or a midwife will gain anything personally beyond a wage. Our profession is the essence of all that is good about humanity: people caring deeply about other people for no reason other than we know it is instinctively the right thing to do.

I am a third generation nurse and I am proud to be a nurse. My grandmother was a psych nurse at Sandy Gallop. My mother was a nursing student at the Mater, sadly lost to the profession at a time when nurses were not allowed to continue if they got married. My sister was also a nurse and a midwife and is now working with people with addiction problems in the Northern Territory. I have seen much change in my time as a nurse. Evidence based practice is now the norm. Nothing is more refreshing for me than to see young nurses talking about what the evidence says and discussing passionately with doctors and allied health professionals, contesting patient care based on a body of evidence but always based on deep concern for patients. I have seen massively improved outcomes in areas such as heart disease and stroke. I have seen significant improvements in the areas of cancer. I have been surrounded by nurses who have gradually and consistently improved their skills and their knowledge. I have seen vastly improved workplace health and safety practices. I think back to the eighties, when I first started, watching young men dying of HIV while we could not get the basic protective equipment that we needed. All of that has changed. Lifting equipment is now standard in hospitals, protecting our backs and, more importantly, our patients.

What has not changed is our workloads. Technology has changed the way we care for people, but we are dealing with patients who are sicker and have much more complex needs. What I am talking about tonight is a monumental change and an achievement for patient care for nurses, for midwives and for our entire community—a change that will deal with workloads. I am not rising to speak on my own behalf; I speak on behalf of the countless great nurses with whom I have worked who have inspired me, supported me, taught me and comforted me. I speak on behalf of the midwives and the student nurses. I speak on behalf of those nurses in emergency, the paediatric nurses, the medical/surgical nurses, the critical care nurses, the rehab nurses, the psych nurses and our entire profession wherever they may be working to promote and restore health. Of course, I also speak as a proud member of the QNU. I also speak on behalf of the most important nurse in my life, my wife, Susan. Like all oncology nurses, she is special. Mostly, I speak on behalf of the patients for whom nurses and midwives care because they are the people whom this legislation will benefit.

The QNU and nurses have been advocating for this for decades. This is only the fourth jurisdiction to implement this and Queenslanders should be rightly proud. This legislation is focused only on certain nurses and midwives in acute care settings in public hospitals. I have nothing but the deepest respect for all of my nursing and midwifery colleagues in every setting. I hope that this is the start of achieving real action on workloads for all nurses.

Let me describe a routine morning shift without ratios for nurses in an area that will be covered by this legislation. They will arrive at work never really knowing how many patients they might have or how sick they might be. They have just under an hour or so to assess their patients, check their emergency equipment and develop a work plan. Before that hour is up, they always start assisting with feeding, dressing, showering, toileting, cleaning teeth, checking observations and giving medications. They also have to think about managing IV fluids and drugs and catheters. Keeping patients free from pain is very high on their priority lists and some of their patients are going to need controlled drugs. Then they will have to find another nurse, take them away from what they are doing, check and administer the drugs and, of course, they will then return the favour.

After that first hour the doctors, allied health professionals and wardies start arriving to take patients away for various tests and procedures, and then the nursing team leaders start coming around to advise which patients are being discharged. As soon as you discharge that patient, the next patient is coming in and needing admission. You do not have time to muck about, and you certainly do not have time to do what you really want to do, what your patients need you to do, and that is just spend some time providing human care, so you just work that in around everything else. Do not forget about the student that you probably have with you who you are trying to educate as you go.

By midmorning it is time for checking blood sugar levels, squeezing in dressings, walking patients, educating patients and of course getting people ready for lunch. Making sure that people get adequate nutrition at lunchtime is a huge job. Then, like clockwork, everyone wants to go to the toilet again and everyone needs pain relief again. Then you have to write your notes and get ready for handover to the next shift, and of course this is all on a day when it goes to plan.

Let us talk about what commonly happens every day for every nurse: a patient deteriorates and needs a rapid response call; a patient has a fall; a patient is called to theatre with no notice; a new admission arrives with a pressure sore; a patient becomes aggressive because they have an undetected urinary tract infection that is causing delirium; someone needs a blood transfusion; an IV cannula falls out so you have to put that back in before you can give the blood transfusion; someone has a stroke; someone has chest pain; someone has no urine output; a patient needs education because they have been told they are going home and they have to be out in half an hour; a patient is told that their condition is terminal. What do you do first? What do you deal with?

What I am really trying to convey here is that nurses and midwives are really, really busy and it does not matter what shift you are on. It was not surprising that the nurses we spoke to in Brisbane, Gladstone, Townsville and Cairns shared stories with us that sounded like that typical day. They told us of people burning out and leaving the profession because they cannot do the things they have to do to fulfil their professional and ethical obligations. We know that patient education is key to keeping patients from returning to hospitals. I asked a midwife about this. She talked about what she would like to do to teach a new mum how to settle and feed a baby and how important those things are in the first few hours and days to establish patterns which research tells us have huge impacts on people for life. She said she struggled to do any discharge planning on some shifts because nurses are just stretched too far.

I spoke to some nurses about skin care and how each day they would like to fully access and document each patient's skincare needs. They would like to teach older people how to use moisturiser and cushioning to reduce the risk of skin tears. They would like to monitor fluid balance and remind

people to drink water and to change position regularly to avoid pressure sores because we know that skin tears and pressure sores have massive impacts on patients, their families and our health budget. All of those things take time, and every time a nurse or a midwife is stretched too far something is not done—something that might be small to begin with but will have a massive impact on patients. Nursing is not about glory; it is about the small things, because the small things matter. If you miss one set of obs because have you 10 patients, that patient could be in trouble. The research tells us that just one skin assessment, urinalysis, bladder scan, blood sugar level or bowel assessment not done can have massive impacts on the patient.

It is sad that we could not reach consensus as a committee. The research could not have been clearer: ratios save lives. Loads of studies, in loads of hospitals, in loads of countries, looking at loads of nurse-sensitive indicators, indicate that each additional patient added to a nurse's or midwife's workload increases the risk that a patient will suffer a nurse-sensitive adverse outcome. What does that mean in 'plainspeak'? If a nurse has to look after 10 patients your chances of falling over, becoming constipated, developing a pressure sore, becoming delirious or developing pneumonia all increase—not because the nurses are bad at their job: just because there are not enough of them. If we reduce that to four patients, then your chances of having one of those things happen decrease dramatically, and all of those are bad things. Patients can, and do, die from those conditions.

The non-government committee members will contend that more than just ratios contribute to safe patient outcomes. I agree, and so does Professor Duffield from the UTS and Edith Cowan universities. Professor Duffield talked about the importance of skills mix and leadership, but she said that the starting point is ratios. If you do not have the ratios, you cannot achieve anything else. The non-government members wanted to talk about costs. Ratios will cost money but we should not lose sight of the benefits: fewer falls, fewer skin tears, less constipation and less pneumonia. These are all immensely beneficial to the patient and to the budget bottom line. Ratios improve staff retention and quality. Nurses and midwives who stay on the job longer build a culture that develops and nurtures new nurses and improves quality patient care. Nurses and midwives who have the resources to care for patients in a manner that their professional judgement tells them is required are more satisfied, and when nurses are satisfied they stay in the job. Again referring to Professor Duffield's testimony, each time we replace a nurse it costs close to $50,000. Yes, there are costs, but there are enormous benefits. As any health economist will tell you, benefits and costs should not just be measured in terms of dollars. We are talking about people here. We have to look at quality of life and we have to take that into account.

I would like to thank the chair, the member for Nudgee, who again did an excellent job on this bill, as she does on all our bills and inquiries. I would like to thank the member for Thuringowa and the member for Buderim. I would like to thank the member for Moggill and the member for Mudgeeraba for their contribution and their reliance on their health backgrounds. It is sad to see all of them leaving the committee. I would like to thank the minister, and I would particularly like to thank the Premier. I would like to acknowledge her great leadership for carrying not just this important piece of legislation forward, but for implementing all of the other important nursing related policies. I am truly proud to be a member of this Palaszczuk government. I would like to thank the many, many nurses who gave their time. Some travelled great distances to give us their real stories of what life is like now and what life will be like if our ratios are implemented. I would like to thank Beth Mohle and all the members of the QNU who have worked so hard for this outcome.

I described a typical day for a nurse. Ms Carlton, a clinical nurse from the Mareeba Hospital, described her day at the hearing we held in Cairns. I asked her about the difficult decisions that nurses and midwives have to make about what to do first. Who has the greatest need? What is more important: pain relief, toileting, patient education, checking observations or comforting someone who has found out they have a terminal illness? They are all important. I asked her if those decisions would be made easier with ratios, and she responded that she would not need to make those decisions because she would have enough time for each patient at the end of each day.

That is what Ms Carlton wants, that is what I want, that is what every nurse and midwife wants, that is what patients want and that is what this legislation delivers. Ratios will not just save lives: they will improve lives. I commend this bill to the House.