

Queensland Parliament Hansard Green

DATE: 12/05/2016

FILE: 12052016\_001021\_LEGISLATIVE ASSEMBLY\_GREEN CHAMBER.DOCX

SUBJECT: (no subject found)

MEMBER: Mr LANGBROEK

033



**Mr LANGBROEK** (Surfers Paradise—LNP) (4.19 pm): It is my pleasure to rise to speak to the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015. As the newly minted shadow minister for health, I call on the minister to adhere to some statements that he made in his address-in-reply speech in December 2015, when he called on all of us in this place to be generous and big hearted. I look forward to that, given that this is a significant area of policy that I have had to get across. I also thank you, Madam Deputy Speaker, as the chair of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee.

As the minister said, we support quality individualised safe nursing care. Today I will refer extensively to the committee report. Page 21 of the report states—

The Committee acknowledges—  
and I think all members do—

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.

I do not think anyone would disagree with that. Page 4 of the report states—

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.

I agree with that statement, as do the members of the committee and, indeed, all members of the House, especially on International Nurses Day. We understand and acknowledge the very valuable efforts made by nurses and midwives in our hospitals. The minister has referred to this bill being about ratios and that that is an election commitment of the government. However, we on this the side of the House cannot support a bill that will mandate a prescriptive statewide ratio that will result in a one-size-fits-all approach. There are a number of reasons we cannot support the bill that I will outline over the course of my speech.

One of the most significant reasons we cannot support the bill is that we believe hospital and health services should have autonomy, just as schools in different regions have autonomy. From my former portfolio of education, I know that a one-size-fits-all approach is inappropriate when it comes to education. We do not think that the cape and Coolangatta face the same demands, whether for students or for patients. For that reason, as I indicated, we will not support this bill

We cannot support the bill because the research is not there. The committee report states that only one Australian jurisdiction has mandated specific ratios. In another part of the world, the most recent jurisdiction to bring in a ratio has not done it along the lines outlined in this bill. As a dental surgeon, I know that what we do should be based on research and data. It should not be based on an election commitment. Whilst it is worthy to honour an election commitment, it is not right to do so if there is no research to base it upon.

**Mr Power:** It is based on research.

**Mr LANGBROEK:** I take the interjection from the member for Logan, who says that it is based on research. The committee's report clearly indicates that it is not. If members opposite want to say that it fits as it was an election commitment, of course they can fashion that argument, but we reject it. Certainly I reject it. The contents of the committee report show that this is just payback for the Queensland Nurses Union, which has said this is what it wants. However, the ratio is not proved by data. In fact, only subsequent to the passing of the bill, should it pass, will the government institute a research process to analyse the effects of the ratio. We have already said that we will not support the bill and I will go into further detail about that.

Health care is rapidly changing due to advances in technology, ward design and layout, innovation and the education of our healthcare professionals. However, mandating by way of regulation and legislation ignores those changes and the complexities and realities of existing hospital staffing

strategies. The bill has four fundamental flaws that I will address. Firstly, this government has failed to articulate a clear case for the need for change to existing quality care staffing strategies. Secondly, there is a lack of evidence to support the Charlotte Street approach to nurse-patient ratios and how that will demonstrably improve patient outcomes. Thirdly, there is a lack of measures that will determine the efficacy of the bill. Lastly, I will outline the approach that should be adopted or maintained in the business planning framework, which goes to the heart of the amendment and the explanatory notes to it, which I have circulated.

I note the minister's snide remark about a bill about ratios also containing something that means the ratios will not be applied. Currently, the business planning framework is an industrial instrument and through our amendment we are seeking to make it a legislated instrument. That is a reflection of the fact that it has worked well in Queensland since 2000 or 2001, which is also stated in the committee report. We do not have a problem with saying that the business planning framework, a bit like the LCCs in schools, is where people at the frontline work together with nurse unit managers and senior executives. It is not just saying that the ratio has to be applied as currently prescribed in the bill; there are other considerations that the business planning framework should take into consideration.

I acknowledge the former shadow minister, the member for Caloundra, who has done a lot of preparation and work on this bill. Certainly he has been of great assistance to me in my preparation for today. The minister acknowledged the member for Nudgee as the chair of the health committee. Also on that committee are a doctor, the member for Moggill; two nurses, the member for Mudgeraba and the member for Greenslopes; a paramedic, the member for Thuringowa; and the member for Buderim. I acknowledge the staff of the committee. The research director, Deb Jeffery, was a member of the research staff of the Public Accounts Committee on which I served during the 51st and 52nd parliaments. I acknowledge the work of all staff, including the technical secretariat.

I came into the role of shadow minister just a couple of days ago. This committee report has enabled me to prepare for this speech, which shows me how well the committee system is bedding down in the parliament. There is a real sense that all members want to improve legislation when it comes to the House and make recommendations through amendments. The committee system gives us an overview on a bill. In the past, the explanatory notes to a bill may not have done that as adequately. I commend the changes that have come with our committee system. It is still being bedded down, but this committee report is a significant example of how we are progressing. We do not have an upper house, which has been canvassed recently during the significant debate into four-year terms. The committee system, through its ongoing progress and development, and as demonstrated through reports such as the health committee's report No. 18, is a great way for members of parliament to assess a bill and make a contribution during the debate. When I first came to this House in the 51st parliament, I would listen to some older serving members who, having looked at the title of the bill, would speak about anything to do with that title. However, having such a committee report allows members to be far more specific in their contributions.

As I have already acknowledged, the committee report notes that the committee as a whole agreed on the significant contribution that all nurses across Queensland make to the health and wellbeing of the community. I acknowledge that on International Nurses Day. I endorse that comment. I pay tribute to the hard work and dedication of all of the healthcare professionals in Queensland. The committee supports adequate nurse staffing levels and acknowledges that inadequate staffing can result in adverse outcomes. There was no clear evidence on the need to change the existing business planning framework as the approach to determine adequate staffing levels. The minister seems to align mandatory nurse-to-patient ratios to a perceived imbalance between patient needs and the number of nurses on an acute ward at any one time. This bill does not address the different levels of complexity and nursing needs among patients in a given unit. Creating a single set of nurse-to-patient staffing ratios could create a situation in which some patients receive more nursing time and others less care. That could lead to a lower quality of care for some patients, but uniformly higher costs.

034 The Private Hospitals Association Queensland, in their submission to the committee, referred to a comprehensive literature review conducted in part by the Center for Nursing Research at the University of California at Davis. It noted—

We found no evidence to justify specific nurse-to-patient ratios in acute care hospitals, especially ratios that are not adjusted for case mix and skill mix.

Similarly, Blakeman Hodge et al in their study found—

Primarily no empirical evidence supports the specific numbers assigned through mandatory ratios with better patient outcomes.

Donaldson Bolton et al concluded—

There has been little evidence that specific nurse-to-patient staffing ratios improve safety or quality. For example, a study of California hospitals before and after the imposition of mandatory ratios demonstrated an increase in costs but no improvement in quality of care.

Therefore, I can only conclude that the case for change has been driven by what I have already mentioned—that is, as well as the need to improve outcomes for patients, a payback for support at the last election campaign. As we have already heard from the member for Brisbane Central, it was the Queensland Nurses' Union that employed her during the time of the previous parliament when she was out of a job. We know the significant support that was given by the Nurses' Union. This bill today is a payback to them.

As I mentioned in the beginning of my contribution, a lack of evidence is the second reason that we will not be supporting the bill. I take members back to the Private Hospitals Association Queensland submission to the committee. They contend—

With the exception of Victoria and California, other countries and jurisdictions which have implemented or are seeking to legislate safe staffing measures have moved away from mandated minimum ratios in favour of mandatory staffing plans. Such plans are generally accompanied by a requirement for some form of disclosure or public reporting.

The PHAQ state that after an extensive international literature search, whilst there is certainly a significant body of evidence to suggest that professional nurse staffing is a critical component of quality patient care and decreased patient mortality and morbidity, the research falls short of recommending any optimal minimum ratios or prescribed skill mix—in fact, quite the contrary as the following extract from the literature highlights. It states—

Nurse staffing ratios have a relationship with reductions in hospital-related mortality in most published studies. However, lack of a published evaluation of intentional change in RN staffing from some initial value to some lower patient-RN staffing value such as 5:1 or 4:1 limits conclusions on increasing nurse staffing ratios as a patient safety strategy. The concern remains that mortality is not reduced by increased nurse staffing but by something the nurses do.

In support of advocacy to introduce mandated minimum ratios of one nurse to four patients for medical and surgical units, proponents have frequently made reference to a study by Aiken et al entitled *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Satisfaction*, which investigated the relationships between staffing levels at 168 Pennsylvania hospitals in 1999 and mortality rates of selected surgical patients. However the manner in which the results of this study have often been quoted may inadvertently mislead the reader regarding the actual study findings.

There are several weaknesses in these studies, as well as other studies, evaluating the relationship between nursing workload and patient care quality. The nurse-to-patient staffing ratios used by both Needleman's team and Aiken's team are hospital averages, not individual, nursing unit-level measures. There is no basis in these two studies for generalizing to any particular nursing unit or individual patient.

Furthermore, the measure of patient death in the select surgical patients may not be a direct measure of general, inpatient, nursing quality. It is equally likely that the surgeon or surgical environment influenced the patient's outcome. We must also be cautious in generalizing the findings of these two studies from data collected in the late 1990's to current hospital conditions.

The available evidence does not support the establishment of specific nurse-to-patient staffing ratios at this time; and the extant literature contradicts the legislative efforts endorsed by those seeking mandatory, nurse-to-patient staffing ratios.

I note that the minimum nurse-to-patient ratio in California from 2015 is at least one nurse to five patients in medical and surgical units. It makes one question the significant difference between the requirements of patients in California and here in Queensland with one to four being the ratio mentioned here.

The third issue I mention at the start of my contribution was the lack of measures that will determine the efficacy of the bill. Prior to the last election we saw the QNU putting around fliers saying 'Ratios save lives'. We are yet to see from this minister or this government what the mandated ratios will achieve. The stated intent of this bill is to improve patient safety. PHAQ recommends that the focus of reporting should be on recognised nursing and patient sensitive indicators as outlined in their submission.

I note from the committee report that it was only after the submissions that were made that the department said that research would be done. At page 35 of the committee report at 3.7 headed 'Monitoring and review', it states—

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.

That is welcomed. There is no doubt that the QNU has applauded the appointment of Dr Aiken. It says that the research team will be led by Dr Linda Aiken and Dr Matthew McHugh. Prior to this non-government members had expressed concern about the data modelling that had been used to create the 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. That is again where the non-government members raised the costings associated with implementing the provisions of the bill which, as I understand it, have been estimated at \$25.9 million. The costings have been drawn from a variety of assumptions which would cast doubt on the presumed \$25.9 million cost.

I think it is important that any evaluation report be made publicly available and tabled in the parliament. The sort of data that is going to be reported on and the sort of data that is going to be recorded are very important issues. The assessment of this monitoring and review process will be imperative. It seems that the government has the cart before the horse—having a review and doing monitoring after the bill has been passed as opposed to seeing what the evidence is before bringing in a specific ratio. There are concerns about why the government and the department have said that they are going to have a monitoring and review process only after the bill is passed.

What measures will be put in place to determine what improved outcomes will be achieved for patients? They could include patient satisfaction and complaints, falls, pressure injuries, medication administration errors, hospital acquired infections, response to deterioration, nursing staff turnover, absenteeism and agency usage. Additionally, if a hospital cannot meet the ratio I note that the minister has mentioned that exemptions will be given at times in regional Queensland or in particular cases where there may be problems with recruiting. We need to make sure that we do not see bed closures, reduced access or diminished services. Should those things be monitored as well then of course they should be reported.

The previous shadow minister for health, the member for Caloundra, went to great lengths at estimates last year, along with the member for Mudgeeraba, to ascertain the current staffing numbers and ratios in some of Queensland's health and hospital services. The CEOs of the Townsville Hospital and Health Service, the Cairns HHS and Metro North were all asked to advise the committee what the nurse-to-patient ratio is at their respective hospitals for acute patients across the seven days of the week, morning, afternoon and evening and the various levels of acute patients. Interestingly, none could give an answer, but they could detail the use of the business planning framework and detail how it provided for safe levels of patient care across their institutions. That is why we have had an amendment prepared.

035 As I said, the BPF was originally published in 2001. It has been periodically reviewed and updated in consultation with key stakeholders. That is why we believe it should not just be an industrial instrument. We are post EBA. We are awaiting a new EB. That was mentioned today in question time. There is no reason we do not believe that the BPF could not be part of a legislative instrument and not just an industrial instrument.

The BPF sets out the methodology to calculate the nursing and midwifery hours required to provide an appropriate, professional and safe standard of health service. Factors taken into account when determining these hours include the number of patients, including the total number of patients on the ward on each shift and activity such as patient discharges, admissions and transfers; the level of intensity of all patients and nature of the care to be delivered on each shift; skill mix and level of experience of staff; the need for special or intensive equipment; and the architecture and geography of the ward. The BPF approach aides in establishing staffing levels that are flexible and account for changes across each shift. It is enshrined in the nurses EB8 and provides no further changes than to continue to review its implementation across the state.

I want to refer to a couple of other specific issues in the committee report. I am concerned that on page 2 of the committee report at 'Consultation on the Bill the committee noted that representatives from 12 hospital and health services and the Queensland Nurses' Union provided the department with advice and support on the development of the bill. In a written briefing to the committee, the department reported, 'While stakeholders proposed a range of amendments to the suite of draft legislation, most were generally supportive of mandated ratios.' It mentions that the Private Hospitals Association of Queensland and the Friendly Society Private Hospital oppose the proposal to legislate for ratios but noted that mandated ratios are not proposed for the private sector in the legislation.

The concern is that, given that there was significant consultation with 12 hospital and health services and the Queensland Nurses' Union, no documents or submissions in relation to the consultation were provided to the committee. The department indicated it would take the question on notice when committee members asked for some of that information about the submissions. The question was taken on notice and the director-general's approval would be sought for the release of the documents, but the department did not provide the working documents. I think in the interests of transparency and accountability that is fairly interesting and is a condemnation of this in terms of the

information that should be coming out. If there is nothing to hide, why wouldn't that consultation information be made available to committee members?

The non-government members questioned whether the bill would meet its stated objectives given the scarcity of research into a minimum fixed ratio. I have referred to some of the data that questions the minimum fixed ratio being an issue in other jurisdictions. The bill 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 believe, as I have already said, that the business planning framework formula has not been shown to be ineffective and no evidence has been provided to establish, clinically, a need for a fixed minimum ratio. We do support change based on evidence, but we cannot support the fixed minimum as is the intention of the government to implement if the bill is passed.

I have mentioned the BPF. I do believe that the business planning framework attempts to achieve a balance between service demand and the supply of nursing resources required to meet the identified demand. The Queensland Nurses' Union and Queensland Health developed the BPF collaboratively and published the original version in 2001. 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.

It is interesting to look at other jurisdictions. I have mentioned California. In the United States they have a complex nurse-to-patient ratio. Wales is the most recent jurisdiction to introduce minimum staffing levels. I note that that legislation was introduced in 2014 into the National Assembly for Wales. It became law on 21 March 2016. It does not have a ratio as prescribed under this bill. I will quote again from page 10 of the committee report, which states—

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 ...*
    - (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.*

The simple provision in Wales, the most recent jurisdiction to bring in a minimum nurse staffing levels, is that that act does not mandate a specific minimum nurse-to-patient ratio. Yet here in Queensland there is a very specific number. That is why we have said that we have concerns with that specific number.

Victoria has had industrially mandated nurse-to-patient ratios from 2000. No other Australian jurisdiction including New South Wales has legislated minimum nurse staffing levels. I note that they have had industrially mandated nurse-to-patient ratios in New South Wales from 2010. In Western Australia, nurse staffing levels are managed through applying the nursing hours per patient day, the NHPPD, model. Importantly, even Queensland Health have acknowledged that a higher number of nurses relative to the number of patients has a positive impact on patient outcomes. We acknowledge that. We accept that. The only area of dispute is regarding what the optimal staffing levels are. That is why we have indicated our position today.

The department advised that 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. That is the autonomy principle that I have explained before. Even though there might be a class size ratio in schools, we leave that up to principals and teachers who know their own community, just as we would leave it up to nurses and nurse unit managers or maternity unit managers to work out with their senior executives whether the mix of patients and the mix of conditions affecting those patients means that a simple ratio is what would be covered in all circumstances. We just do not accept that that is actually the case.

I have made very clear our position on this bill. I note that it is not covering private hospitals. I do want to mention what the Private Hospitals Association Queensland, who do not support mandated

minimum staffing levels, had to say. They think it is inappropriate given the patient care type. They state—

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—

registered nurse—

or EN—

enrolled nurse—

and how much an Assistant in Nursing (AIN) /Patient Care Assistant (PCA) may be able to do.

We do note, and I have acknowledged, the importance of the skill mix, the experience of nurses and the impact of nurse staffing levels on patient outcomes. Again, adequate nurse staffing levels are always going to be supported.

I note that today on International Nurses Day the minister has had a go at me about what happened under our term of government. There were 1,100 more nurses under the LNP government when we left than when we began. The minister can tweet all he likes about what happened under the previous government. We did focus on front-line services. We do not support the fixed minimum ratios as proposed by the government. We do believe that a uniform, statewide ratio would burden smaller community hospitals as they often have lower severity patients—they do not try the same procedures that major teaching hospitals and tertiary hospitals do. Yet they would be required to staff at the same level as the larger teaching hospitals.

In their submission, the committee report noted that, although there is a significant body of evidence indicating that professional nurse staffing is a critical component of quality patient care, as I have mentioned a number of times today, the research does not recommend any optimal minimum ratios or prescribed skill mix.