TO THE SENATE INQUIRY INTO NURSING.

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SENATE INQUIRY INTO NURSING IN AUSTRALIA

MY name is Leone Lovell and I work for the Canberra Hospital and have been there now since 1995.

I have worked in Medical Imaging, the Renal Ward and now Mental Health since I have been at Canberra.

My prior experience has been in Medical, Surgical, Midwifery and Aged Care wards of hospitals in Victoria, New South Wales and Western Australia. I trained at the Mercy Hospital in Melbourne and have worked in private and public hospitals.

I am currently in my final year of a Law/Science Degree at the Australian National University and have completed subjects in Psychology and Health Law.

In 2000 I completed a Post Graduate Diploma in Mental Health.

In September and October of 1999 I was asked to prepare a report for the Nursing Federation in Canberra and the Canberra Hospital with a view to developing a methodology for assessing the acuity (workload) of the patients requiring hospitalisation.

To complete this task I interviewed representatives from nursing management and ward nurses from each area of the hospital. I asked what were the issues for their particular ward and what they perceived as solutions for the problems in their respective area.

The hospital had commissioned Associate Professor Debbie Piccone to design a workable nurse to patient ratio in 1996. I used this report to establish whether the specified nursing numbers accorded to this report were the actual numbers supplied. I also looked at the ward configuration that was part of the Piccone Report and compared it with the current configuration in 1999.

Both these reports can be made available to this inquiry.

In essence what I have tried to present to the Senate in this paper is an overview of the problems that confront nursing in Canberra with the background information from working in other states and areas of nursing. There are numerous reasons as to why we are losing experienced nurses and not retaining new graduates. I also have my own view of the strategies and solutions needed to rectify the problems.

Over the last few years, a number of experienced nurses have tried to speak to Nursing Management and hospital Administration to relay the problems that were occurring on the wards as a direct result of hospital policy. Management has been blinkered in the resolve to increase patient throughput and decrease nursing numbers. We have warned of the looming nursing crisis but it has fallen on deaf ears.

We are hopeful that this inquiry will pursue the issues and effect proper solutions.

I have endeavoured to explain the problems under headings and have offered the solutions that we have been proposing in an attempt to redress the nursing crisis.

INCREASED WORKLOADS AND DECREASED STAFFING.

STAFFING

Piccone v Actual

What was apparent was that the Piccone recommended nursing staff ratios were adhered to when it suited the nursing management and for my report to demonstrate that the rosters they were producing meet with the recommendations. When pushed to explain their staffing methods it was apparent that Nursing Hours per Patient Day (NHPPD) was still the formula. This formula dates back to 1956 and is a standard patient to nurse ratio which is decidedly obsolete when comparing the highly specialised care and ever changing medical treatments and technical equipment that is part of the nursing portfolio today.

NHPPD measures what? To get the number of hours required for each patient the ratio of nurses to patients is established for each shift then divided by the number of beds. The ratio of nurses to patients is based on historical data. The premise therefore is on a ratio of nurses allocated historically. The formula should commence with the number of hours required for patient care per patient and then worked backwards to a nurse to patient ratio. NHPPD is based on the wrong premise. It is not the historical nurse to patient ratio that should drive the staffing but rather the patient acuity.

Nursing Numbers Actual

There are currently shortfalls in the rosters on some wards due to lack of staff. These shortfalls are filled with “casual on call" (COC) or else the nurses prefer to work short because of the need to educate new staff to the area. Valuable time is spent showing agency staff the layout of the ward, where the medications are kept how to use the phones and where the toilet is to name a few. Workloads are increased with simple introduction to the ward. Compound this with education on the specialty area (dialysis) and the impact of short staffing on the current full time staff is obvious. Nurses need to be employed to specific areas to learn the routine and the specialty.

The rosters that I viewed as a three month snapshot showed that there were gaps. Some days there was not enough staff to fill each shift. When pressed I was informed that staff would be sent from other areas that were not as busy on the day or the current staff would do overtime and extra shifts or they would get casual/agency staff. Considering that there were gaps to some shift on a daily basis it is inevitable that some shifts would work short. Couple this with the enormity of the prospect that the nurses would be asked on a daily basis to do extra shifts and it is not hard to see why the profession is losing staff and not an attractive career option. In my own experience although I work full time I would receive a phone call at least three times a week to do a double shift or an extra shift. My husband calls it the 6am wake up call.

REDEPLOYMENT

Redeployment is currently being used as a method of staffing the hospital. The use of redeployment creates a great deal of angst.
The reasons: -

- The nurse leaving the ward considers the area of redeployment to be outside his or her level of expertise.
- The ward that the nurse has left is busy and requires that staff member to remain.
- The ward that the nurse has left becomes busy and the ward cannot get that skilled member back
- The redeployment is a daily occurrence
- The staff would prefer to take an annual leave day if the ward is quiet
- Some staff, in specialist areas, has proposed an "on call" rostering method to cater to the busy and the slow times.

Certainty of redeployment could be linked to sick leave.

Call back of part time staff for an extra shift is a type of harassment when it occurs regularly. This method of staffing is inadequate. The nursing staff work part-time for a reason and do not wish, unless specified, to be contacted outside of there agreed hours.
This may also be linked to sick leave.

PATIENT THROUGHPUT AND SEPARATION

In an attempt to contain costs the hospital administration has closed wards. This has meant that the hospital stays have shortened. Patients are pushed through the hospital system according to the case mix solution. There are so many days allocated for a specific illness etc. The turnover in each bed can be furious. The method used to count patients per day or bed occupancy does not necessarily capture the actual throughput.
This was evident in Paediatrics where there can be four children in the one bed captured as one over a twenty-four hour period. Ward 8A is a relatively stable ward. If the throughput can be approximately 24% more than the separations recorded then there is already a budget overrun. There is also the problem of assessing the NHPPD for what was captured as one patient in reality was three.

The ward closures have allowed the administration to reduce nursing numbers. Again working on the NHPPD, 1:4 morning, 1:6 evening and 1:8 ratios nurse to patient ratios, no though as to the increased workload with an increased throughput has been factored into the equation. The increased turnover has meant that admission and discharge procedures have increased as part of every shift and the fact that there are shorter stays means that no patient recovers in hospital. Therefore all patients are acute. There is not the historical mix of one patient waiting for surgery, one day 6 and 1 day 2 and 1 awaiting discharge. Since all patients are acute there is an increase in the workload that has not been addressed when working with NHPPD.

Bed closures have also re-configured the wards. Combined specialties has the obvious repercussion of increased workloads for nursing staff. Some wards have also increased the bed numbers to accommodate the ward closures in other areas. The Emergency Department (ED) now has to content with the fact that there are fewer beds in the hospital and each patient requiring admission is vying with another for the same bed. If the patient does not follow the projected pattern of recovery then the pressure falls back to the Emergency Department to find temporary accommodation in a severely understaffed section. Throughput for the Emergency Department has increased by approximately 30%– 40 % as it is without having the added problem of no outlet to the wards.

There has been no corresponding increase in the nurses on the wards or ED to cater for this increased throughput. The result is a fatigued nursing work force with the corresponding fatigue related problems. (Dawson Fatigue Scale).

ACUITY (WORKLOAD) SOCIAL

- The aging population.
- It is also apparent that the patients are "sicker" when admitted to hospital. This is due to a number of factors.
- Patients are admitted with co-morbidities. A patient with mental health problems can also require endocrinology, surgery or dialysis to name a few examples.
- Inability of people to provide care at home due to financial etc obligations.
- Lack of respite and aged care facilities.

ACUITY ADMINISTRATIVE CHANGES

- The new direction in Intensive Care (ICU) to limit the number and type of patient accepted. This pushes back onto the wards patients that were previously nursed in a 1:1 situation to a 1:4 staffing methodology.
- The amalgamation of the wards doubling the workloads in some instances
- The increased throughput, and reduced stays
- The increase numbers through ED (already by 5% in September 1999 for financial year Jul 1999-June 2000).

The outpatient duties on several wards: -

- oncology children,
- oncology ward completes the clinic treatments commenced in the day shift.
- 8A with CAPD and outpatient dressings
- Triage duties in midwifery
- Outpatient duties in midwifery.
- Mental Heath admission direct to the ward. No staff to handle problem patients in ED.

Day of Surgery Admissions:-

There has been a push to provide this “day of surgery” service where the patient is pre admitted in the clinics and presents for theatre on the day of surgery. The idea is that a bed can be found on any ward after surgery when the discharges have been completed for the day. In reality there is no bed for these patients. They must have a bed in some instance and so the patient waiting for admission from the Emergency Department must remain in this section where there are no resources to deliver ongoing patient care.

The ability to admit patients via other sources theatre, Midwifery triage, Oncology HITH, theatre DOSA, and the outpatient clinics has increased the pressure on throughput without it necessarily registering as a separation.

WARD SKILL MIX

The skill mix was of concern for most wards. This did not just relate to the registered Nurse (RN) to Enrolled Nurse (EN) ratio but to the number of new graduates accepted by this hospital. The support system for the new graduates had been cut back. The CDN's (nurse educators) now cover one shift per day and not on weekends. The new graduates are placed on evening and weekend shifts. The result is that the skill base has been eroded. There is little time to attend to a patient load let alone monitor or teach a new graduate to function independently in a specific area.

The morning weekday shift is the only shift where there is staff to provide any type of support t new graduates. The doctors (Registrars and Specialists) are on duty for their particular ward and there is a Clinical Nurse Consultant (CNC) and Nurse Manager (NM) present. On weekends and evening shifts there is only the team leader who has a patient load and an inexperienced RMO (doctor) so support is limited.

The Enrolled Nurse (EN) to Registered Nurse (RN) ratio is too high on some wards and this compounds on evening and weekend shifts when the RN duties include part of the EN workload. Therefore not only does the RN have a patient load but he or she must educate the new graduates and attend to duties that the EN cannot do.

Students without University supervision add to the workload of the RN on the wards. Education of the students or the new graduates is not the issue; it is the lack of time to fulfil the role as educator.

I see no point in canvassing the issue of returning the nursing training to the hospitals. The problem is not the inexperience of the graduates when they come to the wards it is a time issue to educate. If the nurses return to apprentice like training, where are the nurses to do this education?

Contrary to public opinion nurses now days do not have the time to do washes and run errands so what would these trainees do in a highly specialised profession for the RN who has no time. There is a need to have the knowledge before entry to the wards. Nursing has changed and there is no going back.

NURSE SYSTEM FAILURE

The information system used by the nursing management is flawed. Paperwork from PROACT that I was given had errors on the sheets themselves. The information is produced in an unreadable form that in some instances that managers' could not understand it themselves.

Some Managers and CNC's support their staff whilst others are directly antagonistic. Where the report indicated contradiction in the validation process, a direct attempt to change what was said indicated the confrontation. In this case I consider there to be a system failure. No true resolution is possible unless the problems are communicated, discussion is free and frank and there is a commitment to resolution or compromise.

Some CNC's were supportive and I note have already acted on the local issues. When validating the document some CNC's and Managers were prepared to state categorically that some of the issues raised just simply did not happen. When asked whether it occurred on the evening or weekend shifts the answer was I DO NOT KNOW.

A rotational shift for CNC's and Managers could give a different perspective to the staffing levels and the skill mix.

SHIFT CO-ORDINATORS

- The Shift Coordinators report the difficulty in providing adequate staff to the wards not just for sick leave but for shortfalls in the rosters.
- They also find it difficult to address the skill mix for areas where the rosters are inadequate.
- The "COC" and agency staff is for sick leave and special leave not for addressing the shortfalls already evident in the rosters.

SICK LEAVE and RECREATION LEAVE

Sick Leave

Sick leave has become "absenteeism". In reality it is sick leave. Nurses are overworked and constantly put under pressure to do extra shifts and overtime. This report was prepare in 1999 and nothing has changed. It is in 2001 worse than could have been imagined in 1999. The acuity tool and redeployment protocol have not been introduced with any enthusiasm from management and the nurses face a bleak future.

In 1998 I was given figures on sick leave. The nurses on the wards were complaining that sick nurses were not replaced. I graphed the figures and found that the hospital was staffing sick leave replacement at a constant 10% less than what was required. This figure could be tracked over a 12 month period.

Deliberately short staffing the wards increases the workload on the remaining staff and as a consequence the unsustainable working pace denies nurses' their much earned breaks for tea and meals. The health of the nursing workforce has subsequently failed and driven those who love the profession out.

Holiday Leave

In the ACT nurses are allocated 7 weeks annual leave per annum. In return for this, the nurses do not get loading on public holidays as in other states. The difficulty is that it is impossible to get 7 weeks leave in one year. Most nurses have been refused their annual leave on the grounds of skill mix and roster shortages.

In a profession that is so physically demanding not having the required rest periods per year can have a detrimental effect on the health of the worker. (Drew Dawson's Scale of Tiredness).

ISSUES RELATED TO THE DOWNSIZING OF OTHER SERVICES.

As each service is wound down in the hospital in the effort to cut costs the duties are transferred to the nursing staff.

- The ward clerk finishes at 1500 to 1600 and the paperwork becomes the prerogative of the nurse.
- Maintenance section does not provide twenty four-hour services so the shift coordinator must assume that duty after hours.
- The pharmacy shuts at 1800 and the shift coordinator must dispense for the night and early am.
- The reduction in wards stock and the reduction in the number of deliveries mean that nursing staff and the CNC's at night search each floor for usual ward stock.
- Social workers do not do after hours "on call" except for a SIDS case. The nursing staff picks up this duty.
- Telephone calls to the ward for the purpose of patient inquiry are constant. The nurses are distracted from direct patient care to answer the telephone. This problem was reported from all wards.

OCCUPATIONAL HEALTHAND SAFETY ISSUES

Each ward can provide issues that come under this banner. I have provided a snapshot only of Mental Health area to give an example. Mental Health has a new area for clients. Safety issues have been raised and repeatedly rejected. There is a lack of prioritising the importance of issues. Privacy is paramount over safety. The Consumer Advocate input is preferred over nursing and medical issue. The difficulty here is that the changes made to accommodate community input impacts on nursing and medical staff. They therefore suffer the consequences whilst they are powerless to control their environment. This is a dangerous systemic issue.

I have inclosed the issues that have plagued the Psychiatric Unit since I have been there which is approximately 2 year and the new building has presented further problems for the nurses.

Issues for the Psychiatric Unit February-March 2001

1. There are 53 shifts that are not covered with staff in the next roster month duration. (April 2001)
2. Sick leave is critical each shift. The staff work short or cajole a staff member to do double or come in on their day off. 6 am phone calls to staff a regular occurrence.
3. Admission direct to the ward without a medical or psychiatric clearance. This is done at the expense of already short staffing levels. Ward staff are then required to attend with the doctor to preliminary admission procedures that are usually done in ED where the appropriate facilities are located.
4. Maintenance repairs are taking months to complete. (air conditioning, broken windows, taps, broken vanity).
5. No public health hand basins. These basins were requested in February 2001 when they were admitted as items of necessity for cross infection purposes.
6. There is an increase in aggressive and violent patients. They need to be housed in the High Dependency area. Unable to do this due to lack of beds in the area.
7. Staffing in areas one to one or two to four depletes the staffing but there is no extra staff organized.
8. Bailing and sentencing clients to Psychiatric Unit (PSU) from the court system has increased. This Unit is not a secured unit and therefore cannot accommodate such clients. Previously when clients were sent to PSU for assessment they were accompanied by someone from the Remand Centre who remained whilst the client was at the Psychiatric Unit. Now they are brought and dumped with no thought for the protection of the staff members.
9. This is not a secure unit and therefore clients of this nature should not be placed here.
10. There is a constant push to go over on patient numbers when there are no beds or staff to deal with it.
11. No public phone for client use. Nursing staff taking and making phone calls for clients. Taking messages and finding clients to deliver calls and messages takes valuable time away from patient care.
12. Great deal of paperwork and phone attendance from Nursing staff that could be done as clerical

These are some of the issues arising over the last few months. The staff are stressed sick leave is a daily occurrence and staff are leaving.

HEX AND OTHER EDUCATIONAL COSTS NOT MEET BY THE HOSPITAL.

Currently Graduate nurses have a HEX debt when they commence work on the wards. When their basis income at the completion of a 3-4 year course is approximately $32,000.00 there is not much money left for necessities. I have just completed a

Mental Health Post Graduate Course which cost me $3,000.00. When there is a crisis in Nursing why do the courses cost the Nurse and not the Hospital?

There is an Education Fund and an ability to get leave for education. We, as a Union, have requested the figures on how many nurses can access these facilities. It appears that management nurses have used these funds and the leave time to complete courses to further their management aims.

Nurses on the floor cannot get time off due to lack of staffing and skill mix to attend any kind of classes so the funds go elsewhere.

A Renal nurse, in my experience, completing a renal degree in NSW could not get time off or transfers to the relevant areas because of the petty jealousies of the management nurse. She had to take her holidays to go to Sydney to do the practical part of her course. Funds and time were not available to her. The Management Nurse would not sign off on her required experiences on the ward.

My husband works for the Public Service and has had his course paid for by his Section as they viewed further qualifications to advantage the bureau. He has not had to take his holidays to attend the course, his accommodation was paid for as were his travel arrangements. The irony of all this is that the Health Department cannot see that this is kind of education is relevant to the proper care of the patients.

ADMINISTRATION AND NURSING REPRESENTATION.

Currently the position of Director of Nursing is being advertised for the Canberra Hospital. It has been advertised as a Consultant position which is indicative of the level of respect for the nursing profession.

I know that there are no nursing representatives at many Hospital management meetings so the issues that most concern nurses are not on any agenda.

When the last nursing award was negotiated people were employed with the expressed purpose of driving down the wage demands. Consequently the nurses of Canberra received a 3% pay rise over a two year period. It is apparent that this has caused the Administration some embarrassment recently when viewed with other States and mentioned in the Victorian Award Decision.

Currently there is an offer on the table that would negate the worker rights to bargain in an attempt to prevent any industrial action when the ACT election is due in November as it coincides with the expiration of the current nurses award.

Three times we have been expected to view and vote on a rehash of the same offer. The wage offer is inadequate, it is given with relinquishment of hard won conditions like full time employment and a system of assessment which makes the nurses resubmit to an appointment process which can see them lose their position.

When viewed in context of other wage expectations for other comparable professions the offer is inadequate at best.

1. To attract nurses we need to have a wage that is at least comparable to the entrance wage of schoolteachers and police (starting salary NSW teacher 1st year will be on $41,109.00.) ACT commences at $38,000.00 with a pay increase to $55,000.00 year 8 in three years with pay scale changes. This does not allow for any increases that are expected over the next three years). This is straight wages no penalties with Monday to Friday school holidays off.

2. NSW police 1st year probation constable commences on $45,558.00(that is after a 16% pay rise). The police have refused this offer and are holding out for more money.

3. NSW nurses 16.0% increase with the last two increments of 4% and 5% occurring in the final year of the award 2003 on January and July 2003. This is a 9.0% increase in the final year of the award. The offer to the nurses of Canberra is nothing in 2003 and the award will run over 2003.

4. We need short agreements, not three years, because of the nursing crisis. A short agreement will allow flexibility to meet change with speedy responses.

5. The Canberra nurses were expecting a 2.3% pay rise in the final 12 months of their current award. The pay offer is 3.7%. Therefore the offer is in fact an extra 1.4% only. This does no equate to an 11.7% pay offer.

6. By increasing the pay increments from 1.8 to 1.9 level1 and 3.4 to 3.5 level 3 only means in effect that it takes an extra year to get to the top of the pay scale.

7. If staff have not accessed the salary packaging then the pay rises have been negligible over the last award have been negligible and nurses have fallen further behind other professions in remuneration, whist their workloads have increased yet again.

NURSING CULTURE

A major difficulty is that nursing and nurses are seen as subordinate and this perception is perpetrated by the doctors and fostered by the administration. Nurses are not part of the hospital planning meetings, the nursing management is seen as the way to implement current policy on the ward nurses. Nursing management whilst ever they are employed on performance contracts will implement the policy however bad. Fear that will lose their job if they do not implement policy silences any real and meaningful discussion on where nursing fits into the overall structure of the hospital.

Nursing Management is also not willing to change. They have lost touch with the wards and therefore cannot comprehend the reason for the current distress of the ward nurses. A rotating roster so that management nurses work the 24 hour shifts would

acquaint them with the issues on each shift. A period of time spent as a clinical nurse would also familiarise then with the impact of increased patient throughput and decreased nursing staff. Proper and supportive representation of the nursing situation to the administration would unite the nursing workforce and lift morale.

Horizontal violence is a real and destructive factor in the loss of new Graduates and poor retention of experienced nurses. Fault-finding and petty jealousies supersede constructive education and support. I have personally witnessed the type of discrimination displayed by management nurses who need to pass judgement on University training by constantly picking at the new Graduates' performance. One example stands out in Mental Health where the nurse was criticised in front of her peers and the more senior nurses, doctors and clients for wearing a top that the management nurse did not feel was appropriate. There are no uniforms provided by Mental Health administration and there is no funding to buy clothes therefore there is no authority to dictate what staff wear. That nurse has since left nursing and is working in a shop for more money, less workload and no public degradation.

CONCLUSION

- Proper nursing representation at management and administration meetings.
- Public service employment for management nurses so that there is no fear of job loss in reporting problems and offering solution.
- Respect for the nursing profession as part of the hospital team.
- Remuneration in line with other similar professions like teachers and police.
- Return to the benefits of penalties for night shift and public holidays.
- Proper staffing in line with the acuity of the care needed. It took a Judge in Victoria to try to force management to abide by a system to determine workloads. It is apparent that any type of acuity tool must be a living process. As changes occur on the wards we must embrace new and different staffing methodologies.
- If there is no nursing staff to meet the acuity then beds must shut.
- Holidays must, within reason, be able to be taken when they fall due.
- Sick leave must be replaces.
- More support nurses for the new graduates so that they can call help when they need it on the wards.
- Adherence to the "Drew Dawson Scale" with regard to rostering so that fatigue is controlled by proper rostering.
- Halving of the pay increment time scale for nursing levels so that it takes 4 years to get to the top of the respective pay scale not 8 or 9 years.
- Ongoing education to be part of the working conditions for the nurses on the floor not the management nurses. Time off the ward to be factored into employment and payment for the courses undertaken must be mandatory.
- Refund of the HEX to new graduates who stay on the wards for 4 years.
- Automatic level 2 to nurses who remain with a ward for 4 years.
- Proper advertising of position in the hospital and public service rules and monitoring of the application process and appointment.
- Currently ward management nurses can stymie an application for a nurse to more elsewhere. This should not be tolerated.
- Assessment of the performance of management nurses against the degree of nurses lost from a particular area. If the retention of nurses is poor from a

particular area then thorough examination of the conditions must ensue with counselling for the management nurse being part of the process.

- Nurses without the qualifications to hold management positions should be offered redundancies or the opportunity to educate themselves in the relevant duties of the position.
- As to education. Nurses holding Masters in Bed Sores or Wound Management is self defeating. How can a community respect such inadequate lines of study. Whilst there is a need to keep current on the latest treatments it is not enough to claim as a reason to confer the award of Masters.
- Mainstream subjects should be part of a Nursing Degree and Masters. Nurses today manage nurses and systems. Surely Communication and management streams of study would better equip today's nurse more adequately that pan delivery and washes.

Finally there is no going back to training in the hospital. There are not enough experienced nurses on the wards with time to educate properly. Also we do not do washes and change beds with the historical flair that some in the community expect. We assist doctors, we help diagnosis, we deliver complicated and technical treatments, we manage patients and nurses, we educate doctors to relevant wards and protocols, we counsel and we stand by out patients by educating and caring. Nurses are in some instances the only place a patient can go for the truth. We have no other agenda except patient care yet we suffer verbal and physical abuse when patients do not get the answers that they want. We end up in Coroners' courts where the most obvious scapegoat is the powerless nurse.

Who cares about the nurses? The perception in the profession is no one. We are still there but in limited numbers as more and more of us leave through exhaustion, physical injury, better money, better working condition, no abuse and more considerate management.

Leone Lovell/Leyshon