Submission no: 15B
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SUMMARY OF QNU RECOMMENDATIONS SENATE INQUIRY INTO NURSING 2001

General Recommendations – Contextual Issues:

1. That a national analysis be undertaken of the number of people with nursing qualifications not currently in the nursing labour force that could be attracted back to nursing.
2. That in the light of this analysis the need for nursing "re-entry" and "refresher" programs and other relevant labour market programs must be determined and federal government funding be provided to meet the cost of conducting such programs until such time that the nursing skills shortage is corrected.

De-regulation/substitution agenda

3. That this inquiry investigates the magnitude and impact of the substitution of qualified nurses with unqualified personnel and the erosion of nursing models and quality of care.
4. That this inquiry investigate those factors contributing to the unacceptable level of wastage within the nursing workforce and make specific recommendations on strategies to address this issue.

Health System Context

5. That, as a matter of urgency, there be a review of currently available research and that consistent national minimum nursing staff ratios be set for each health care setting, recognising that acuity differentials will require additional qualified nurses. (Note: In 2000 such ratios were set for Victorian public hospitals.)
6. That, as a matter of urgency, consistent national parameters be set with regard to nursing skills mix in each health care setting.
7. That all health care facilities be required to make information available to the public about adherence to national parameters for nursing numbers and skill mix.
8. That all providers of health care services (public, private and not for profit) be required to report on performance and outcomes utilising a framework similar to that adopted by Council Of Australian Government for reporting on public hospital performance. (See *Report on Government Services 2001*, Figure 5.7.)
9. That as a matter of urgency, nationally comparable indicators of quality be developed for each health care setting in consultation with key stakeholders including nursing unions and regulatory authorities.

Industrial Relations context

10. That an urgent review of current wages and conditions of nurses in all states and territories be conducted. This review should pay particular attention to the nexus between the various current industrial relations legislative regimes and the outcomes for wages and conditions for nurses that facilitate the recruitment and retention of nurses.
11. Further to this review, that necessary legislative amendment be made to the *Workplace Relations Act 1996* to achieve a fairer and more appropriate wage fixing system for nurses.
12. That funding mechanisms for services in all sectors of health be constructed in a manner that enables movements in pay and conditions for nurses.

Impact of shortages on delivery of health services

13. That all future health service delivery policy proposals and any future development of a National Health Policy incorporate assessments of nursing workforce requirements.
14. That the recommendations from the Queensland Ministerial Nursing Recruitment and Retention Taskforce be examined by all states and territories for implementation. Further to this, that collaborative review such as those undertaken by the taskforce be undertaken in each state and territory every five years.
15. That the Commonwealth government coordinate national forums aimed at addressing nursing recruitment and retention issues.

National approach to workforce planning

16. That a national nursing workforce planning body be established which undertakes national workforce planning and negotiates with each state on enrolled nursing, undergraduate and post graduate nursing numbers.
17. That workforce planning models take account of the needs for specialties and rural and remote nurses prior to determining total numbers required by the system.

Clinical placement of nursing students

18. That the cost of clinical placement experience for student nurses is accurately costed and that appropriate funding is determined and allocated to support this vital part of educational preparation.
19. That health facility funding models take into account the costs of providing support for the clinical placement of student nurses.

Support for nursing students/new graduates

20. That Registered Nurses providing support to nursing students are allocated an appropriate patient load and that they are supported educationally to undertake this role.
21. That the completion of an internship year should not be a requirement for nurse registration

HECS support

22. That HECS fees for undergraduate nursing courses be waived until such time as the workforce planning analysis demonstrates the nursing shortage has eased.
23. That HECS or course fees for postgraduate study in all specialties demonstrating shortages be waived until workforce planning data demonstrates shortages have eased.
24. That undergraduate students undertaking clinical placement in rural areas be provided with additional support to compensate for the additional costs of these placements.

Enrolled nurses

25. That there be nationally recognised qualification level for Enrolled Nurses at the Diploma Level.
26. That standards of pre-enrolment courses be consistent with such courses adopting a life-span approach not be area specific eg aged care, paediatrics.
27. That specific workforce planning occur to determine future Enrolled nurse needs and that all states contribute to the education of enrolled nurses.
28. That models of care be researched to identify best practice utilisation of the Enrolled Nurse role.

29. That universities and industry recognise the curricula content and experience of Enrolled Nurses in articulation of Enrolled Nurses into registered nurse courses.

Interface with universities

30. That allocation of student nursing places to universities be based on thorough workforce planning, the nursing needs of geographical areas and the ability to resource appropriate clinical placement not just on the potential for income creation for individual universities.

Management issues relating to recruitment and retention

31. That management and funding practices in health acknowledge the needs for nurses to fulfil their need for professional satisfaction within their working lives.
32. That management and funding practices in health acknowledge the family responsibility needs of nurses.
33. That specific federal funding be allocated to support refresher and re-entry type courses, including the provision of indemnity and workers compensation cover.
34. That the QNU submission to the Queensland *Ministerial Nurse Recruitment and Retention Taskforce* be read in conjunction with this submission.

Family Friendly Initiatives

35. That an analysis of the impact of those policy initiatives of government that shifts responsibility from the collective/social to the individual (eg early discharge of patients from hospital and "aging in place" philosophy) be conducted as a matter of urgency.
36. That this inquiry commission research that would provide costings of the turnover (or wastage) of nurses. This would enable the value of the loss of a nurse to be quantified.
37. That other initiatives that would assist to retain nurses within nursing (eg portable long service scheme) be further investigated.

38. That family friendly policies continue to be promoted at state and federal government levels and that particular emphasis be placed on benefits (particularly "cost savings") of implementing best practice work and family initiatives.

39. That the Commonwealth government urgently examines the need for the provision of paid maternity leave benefit and then utilises the best mechanism to provide for a consistent paid maternity leave benefit for Australian women (eg either through the Social Security system or employer provision).

40. That urgent attention be paid to performing an examination of those management practices significantly contributing to the wastage of nurses and that appropriate corrective strategies be recommended.

41. That "best practice" models of family friendly and effective rostering be developed and actively promoted.

42. That this inquiry further investigate the specific childcare needs of nurses and make recommendations on strategies to ensure that improvements to services for nurses and their families be a priority area for government child care policy.

43. That workplace policies that encourage continuation of breastfeeding for nurses be actively promoted and that particular consideration be given to the amenities required to facilitate this outcome.

44. That research be conducted into the elder care needs of nurses and other shift workers and workers of non-standard hours.

Health and safety Issues

45. That research into broad health and safety issues be provided. Such research should:
- ♦ Identify the affect of workplace health and safety factors on the attrition of nurses.
- ♦ Develop strategies to address the identified issues.
- ♦ Review the effect of the implemented strategies.

46. That funding be provided for a project to develop an Industry Code of practice for health and safety in the health industry to be overseen by a national committee

47. That quarantined funding be allocated within government funding for health and aged care services for the purchase of equipment that will prevent or minimise injuries to nurses and other health workers (eg manual handling devices, retractable syringes, scalpel blade removers etc.)
48. That adequate funding be provided for the employment of sufficient staff to ensure work is carried out in a safe manner.

49. That a public campaign to prevent violence against nurses be supported by government.

50. That further research be conducted into significant sources of workplace stress for nurses and strategies to mitigate the impact of such stress.
51. That health managers be provided with training in change management and strategies to implement change in a manner that minimises stress to employees.

52. That a national code of practice for hours of work be developed.
53. That further research be conducted into the medium and long-term impact of shiftwork on women workers such as nurses.

54. That the use of Glutaraldehyde be eradicated in all health and aged care facilities.
55. That funding be provided to enable further expertise to be developed in the area of chemical exposures. Further to this, that specific funding be allocated for research into time weight averages for chemical exposure given the trend towards the working of longer shifts.

56. That a national standard be developed for the quality of latex gloves.

57. That particular attention be paid to the development of specific expertise in the area of resolution of air quality health and safety issues.

58. That the current legislative requirements for basic minimum amenities be reviewed and amended as necessary so that the particular minimum requirements of nurses and other shift workers are adequately addressed. Further to this, that these minimum standards be incorporated in the design of all health facilities.

59. That best practice guidelines be developed and promoted for the design of health and aged care facilities.

60. That a broad task analysis for nursing be undertaken to identify possible changes in work practices that would facilitate the return to work of injured nurses. .
61. That best practice principles for rehabilitation and return to work programs for nurses be developed and promoted.

62. That a national standard be established for the amount, content and structure of Occupational Health and Safety training within the health and aged care sectors and that sufficient funding be provided by government to ensure that such training can be provided.

Queensland Nurses' Union Submission - Senate Inquiry into Nursing

Introduction

The Queensland Nurses' Union (QNU) welcomes the opportunity to provide input into this Senate Community Affairs References Committee *Inquiry into Nursing*. Currently extreme nursing shortages are being experienced around the world. Australia must implement a coordinated and broadly based national approach to the current crisis of neglect that confronts nursing if we are to address the impact this is having on the delivery of health and aged care services in this country.

A Senate inquiry provides the perfect vehicle for such an approach. The broad nature of the terms of reference for this inquiry facilitates an examination of the major relevant issues.

It is heartening to note that this particular inquiry has a link to the recent Community Affairs References Committee *Inquiry into Public Hospital Funding.* The QNU and other branches of the Australian Nursing Federation (ANF) made detailed submissions to that particular inquiry. Recommendation 6 of the final report titled *Healing our Hospitals* highlighted the national shortage of nurses as one of several priority areas requiring priority attention.

Before addressing each of the specific terms of reference for this inquiry there are some important contextual issues we wish to highlight. In our view it is essential to examine each of the terms of reference in the context of these broader issues. We will provide some brief background information on the QNU and nursing in Queensland.

The Queensland Nurses' Union

The Queensland Nurses' Union (QNU) is the principal health union operating in Queensland and is registered in that state. In addition the QNU operates as the state branch of the federally registered Australian Nursing Federation. The QNU represents the largest number of women of any union in Queensland.

The QNU covers all categories of workers that make up the nursing workforce in Queensland, registered nurses, enrolled nurses and assistants in nursing, be they employed in the public sector or the private and not-for-profit health sectors. Our members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management.

Membership of the QNU has grown steadily since its formation in 1982 and as at June 2001 was in excess of 28,500 and still growing. Like the nursing profession as a whole, the overwhelming majority of our members are female (93%).

The QNU has a democratic structure based on workplace or geographical branches. Approximately 250 delegates are elected from the branches to attend the annual QNU conference which is the principal policy making body of the union. In addition to the annual conference the QNU has an elected council and an elected executive, which in turn have decision-making responsibilities between conferences. Council is the governing body of the union.

Predominantly, QNU members in the public sector are employed under federal awards and agreements and in the private sector are employed under state awards and agreements. In addition, since 1994 when no enterprise agreements were in place covering nursing workers, the QNU has become party to over 200 enterprise agreements.

Recent vehicles to highlight concerns of nurses

The QNU has made concerted efforts to highlight in a comprehensive way the issues that are of concern to nurses and that subsequently impact on the recruitment and retention of nurses. We have made detailed submissions to state and federal governments on nursing specific issues as well as broader issues that are impacting upon nurses. These submissions have included:

- *QNU Submission to the Senate Inquiry into the Workplace Relations Bill 1996 (1996)*
- *Issues of Concern to Queensland Nurses: A submission to the Queensland government and opposition prepared by the Queensland Nurses' Union (1997)*
- *QNU Submission to the Senate Community Affairs References Committee into Child Care Funding (1998)*
- *QNU Submission to Queensland Industrial Relations Taskforce (1998)*
- *QNU Submission into HREOC Inquiry into Pregnancy and Work (1999)*
- *QNU Submission to the Ministerial Taskforce on Recruitment and Retention: Valuing Nurses (1999)*
- *QNU Submission to Senate Inquiry into the Workplace Relations Legislation Amendment (More Jobs, Better Pay) Bill 1999 (1999)*
- *QNU Submission to the Senate Community Affairs References Committee Inquiry into Public Hospital Funding (1999)*
- *QNU Submission to Queensland Pay Equity Inquiry (2000)*
- *Various detailed QNU submissions made between 1996 and the present on reforms to aged care sector including major submissions to the review of the Resident Classification Scale and the Productivity Commission Inquiry into Nursing Home Subsidies*
- *Various submissions between 1999 to the present to the Queensland government on the implementation of the Queensland Child Care Strategic Plan 2000-2005*

We have included multiple copies of our submission to the 1999 *Ministerial Nursing Recruitment and Retention Taskforce* as this is of most direct relevance to this inquiry. (Unfortunately it is not possible to provide this document to the committee in electronic form.) Copies of other submissions noted above are available from the QNU upon request.

What is nursing?

Many attempts have and continue to be made to define the practice of nursing. In October 1998 the Queensland Nursing Council published a document titled *Scope of Nursing Practice Decision Making Framework.* This document defines nursing practice as follows: -

"Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick and disabled so that people with identified nursing needs may maintain optimal well being or achieve a peaceful death. Nursing practice is largely determined by the context in which it takes place."

The role of the nurse is broad and at times difficult to specify. This is in large part due not only to the intensely personal nature of the work performed but also because historically the so-called "soft skills" innate to predominantly female occupations such as nursing, have not been adequately identified, or ascribed appropriate value. Such skills are often difficult to articulate and indeed at times, are not formally seen as skills but rather personal attributes. (Recent pay equity inquiries in both New South Wales and Queensland have acknowledged this difficulty.)

Certainly there is an appreciation at a certain level within the community that a nurse's job is a difficult one – emotionally, physically and intellectually challenging. Nurses are generally highly regarded because of this, consistently topping public opinion polls of the "most respected" occupation. However, most members of the general community do not receive an insight into the breadth and depth of a nurse's role and the skill that nurses require to perform their role competently until such time as they (or a loved one) require nursing care. It is at such times that the value placed on caring, safe and competent nursing practice is in sharp focus. There is an obvious inconsistency between the "moral" value ascribed by the general community to nurses and the work they perform and the economic value ascribed to nurses and their work by the "market". This tension between moral and economic values is at the heart not only of the current predicament of nursing but also the wider crisis of values confronting our society.

The Queensland Nursing Council (QNC) regulates nursing practice in Queensland. The QNC is a statutory body established under the *Nursing Act 1992* and is accountable directly to parliament through the Minister for Health. It maintains registers of registered and enrolled nurses and, in consultation with the profession, consumers and others, develops, implements and monitors standards for the regulation, education, practice and conduct of nurses. As such the QNC performs a vitally important role as such standards are essential for the protection of nurses and "consumers" of health services in this state.

Nursing in Queensland

There are three categories that make up the nursing workforce in Queensland – registered nurses, enrolled nurses and assistants in nursing. Registered and enrolled nurses are licensed employees who are answerable individually to their professional registration body (the Queensland Nursing Council) as well as being subject to industrial instruments and legislation as are all other employees. Registered and enrolled nurses are employed across a wide variety of health care settings. Assistants in nursing are unlicensed employees and are employed in the non-acute care setting, predominantly in the aged care sector in this state.

Detailed statistics are available on the registered and enrolled nurse labour
force. The data is collected on an annual basis by nurse registering authorities and is provided to the Australian Institute of Health and Welfare (AIHW) for compilation of a national report. Given that other organisations (such as the Queensland Nursing Council) will be making a detailed submission on the demographic make up of the Queensland registered and enrolled nurse population we will only provide a broad overview of key issues.

A number of AIHW publications are quoted in this report. This section of our submission relies on data obtained from *Nursing Labour Force 1999 Preliminary Report, Nursing Labour Force 1998* and a paper presented to the 1999 QNU Annual Conference Professional Day by John Harding from AIHW titled *Trends in Queensland and Australian Nurses Statistics.*

The nursing labour force is unique in many ways. Features of the nursing labour force that must be taken into consideration by this inquiry include:

- **Gender –** Nursing remains a highly sex segregated occupation. In 1996 only 7.8% of nurses were male, an increase of 0.7% in the decade 1986-1996. (AIHW, 1999, p 5)

- **The high proportion of part-time employees -**The number of registered and enrolled nurses employed in a part time capacity increased from 37.8% in 1989 to 45.4% in 1998 – this compares to an increase for nurses generally in Australia for the same period from 39.2% to 44.0% (AIHW (Harding)1999 Table 4)

- **The aging of the nursing workforce** -In 1996 the average age of all employed nurses in Australia was 39.9 years (AIHW *Nursing Labour Force 1998* – average age not included in 1999 preliminary report). It should also be noted that the average age of those commencing under-graduate nursing studies is also rising.

- **The high proportion of nurses who are expected to work continuous shift work –** The majority of nurses work continuous shift work to cover the 7-day a week, 24-hour a day operation of many health services. In our view this makes the nursing labour force unique – how many other overwhelmingly female occupations or professions are expected to work continuous shift work?

- **Nursing labour force is highly mobile –** The nursing labour force remains highly mobile. Nurses are readily able to move between employment settings, be this intra-state, interstate or overseas.

- **Although nurses are employed in many different settings, almost two thirds are employed in acute care facilities in Queensland –** In 1996, 65.1% of nurses were employed in acute care hospitals and day procedure centres (compared to 61.9% employed in these settings in the rest of Australia). In the same year 15% of nurses were employed in hostels and nursing homes in Queensland (AIHW 1999).

The paper prepared by John Harding for the 1999 QNU Annual Conference (AIHW (Harding) 1999) provides an invaluable snapshot of nursing in Queensland. In particular the report compares the nature of the Queensland nursing labour force with the Australian nursing labour force and highlights some significant similarities and differences between the two. Some of the more significant differences include:

- In recent years the Queensland population has been increasing twice as fast as the Australian population

- 42% of the Queensland population lives in rural areas (29% for Australia)

- 37% of nurses work in rural areas (30% for Australia)

- Queensland health workforce (including nursing) has been increasing more rapidly because of this growth - between 1986 and 1996 there was a 24.1% increase in Queensland nursing employment and a 55.5% increase for other health professions (Australian growth in the same period - nursing 3.8% and other health professions 35.1%)

- Nurse employment per 100,000 population has been declining in both Queensland and Australia, in contrast to other health occupations

- Queensland has fewer registered and enrolled nurses per 100,000 population but more assistants in nursing

- In 1998 there were 29% more Queenslanders per 100,000 population commencing undergraduate nursing degrees than Australians per 100,000 population

According to the AIHW *Nursing Labour force 1999 Preliminary Report* (p 3), in 1999 there were 35,252 registered nurses and 7,168 enrolled nurses in Queensland The total number of registered and enrolled nurses (including multiple registrations) was 42,420 in 1999. It should be noted that this total number has decreased from 48,467 in 1993 to 41,629 in 1997, before increasing slightly again in 1998 and 1999. Enrolled nurse numbers have however steadily declined each year from the 1993 level of 10,952.

Total registrations/enrolments should not however be confused with the actual number of registered and enrolled nurses in employment. AIHW (1999, p6) labour force data for 1997 indicates that a total of 36,813 registered and enrolled nurses were employed in Queensland out of a total 41,629 (including multiple enrolments). There were 2538 registered and enrolled nurses not in the nursing labour force in that year (or around 6% of the total of 41,629). This is an under-estimation of the number with nursing qualifications, as it does not capture those who let their registration or enrolment lapse. (The total change in the numbers of enrolled and registered in this period was 6,838 – this calculation is based on figures including multiple enrolments/registrations.) While it is difficult to know the total number of registered and enrolled nurses who would be available to re-enter the nursing labour force on the data available to the QNU, we can estimate that based on the above data the number could exceed 9,000.

Insight into the extent of the wastage of nurses can also be obtained by Australian Bureau of Statistics (ABS) census data. The AIHW publication *Nursing Labour Force 1998* (p 2) contains data from the 1996 ABS census. At that time *"19.8% of Australian born persons with the highest qualification in nursing and aged between 15 and 64 years were not in the labour force, with around 16% in each age group from 25 to 54 years. For overseas-born nurses the proportion was lower – 14.3%"*. This report also highlights the significant leakage from the Australian nursing labour force through Australian nurses obtaining work overseas.

When compared to the data available for registered and enrolled nurses, little detailed data is available on assistant in nursing employment. Only total numbers of assistants in nursing employed in Queensland and Australia are available from Australian Bureau of Statistics nursing workforce data. This data was provided in the paper presented to the 1999 QNU Annual Conference by the AIHW's John Harding titled *Trends in Queensland and Australian Nurse Statistics.* (That paper suggests that the total number of nursing assistants in Queensland in 1996 totalled 5,294 or 13.8% of the total nursing workforce. The Australian figure in total for this year was 25,941 or 12.1% of the total nursing workforce.)

In Queensland the majority of assistants in nursing are employed in the aged care sector. The QNU believes the total number of unlicensed workers employed to perform nursing work far exceeds the numbers quoted above for assistants in nursing. There has been a strong substitution agenda by some employers in the aged care sector in recent years. Based on recent evidence obtained by the QNU in various Queensland Industrial Relations Commission hearings and elsewhere in recent months, we believe this push is strengthening. In our view maintaining a nursing model of care within all health settings is of critical importance, not only because this is central to maintaining standards of care, but also to ensure that meaningful career structures are available to all persons performing nursing work. The Queensland Pay Equity Inquiry (2001) report has highlighted that access to appropriate and meaningful career structures is one key determinant of equitable pay outcomes for women workers. Actions by some employers to undermine the nursing career structure by the substitution of entry level assistant in nursing positions with non-nursing classifications will have the effect of disadvantaging those workers by

reinforcing gender based pay discrimination. When these workers are removed from a nursing career structure they are denied access to a structured career path that is linked to specified educational qualifications.

We note that the terms of reference for this inquiry specifically exclude examination of assistants in nursing and their role in the health sector. We wish to place on record that the QNU values the role that assistants in nursing play in the non-acute care sector and within the framework of a nursing model of care. The issue of unregulated care providers is dealt with later in this submission. The QNU believes that unregulated care providers should be seen as a key source of future enrolled and registered nurses.

Nursing skills shortages

This committee would be well aware of the significant national and international nursing skill shortages that currently exist. After this inquiry was announced the QNU wrote to the Queensland State Office of the Department of Employment Workplace Relations and Small Business (DEWRSB) seeking clarification on a number of matters relating to the National Skills Shortage assessment process and other relevant issues. The response received from the department was helpful and informative. In summary key points about the current shortage are as follows:

- As at February 2001 the National Skills Shortage (NSS) List in Australia shows there were skills shortages identified in 16 registered nurse specialisations – operating theatre, accident/emergency, cardiothoracic, neurological, neonatal intensive care, paediatric, critical/intensive care, renal, aged care, oncology, palliative care, perioperative, indigenous health, community nursing, registered midwife and mental health nurse. Queensland identifies shortages in all of these 16 areas. The letter from DEWRSB in response to our inquiry states " *Nursing is recognised as one of the more acute areas of shortage in Australia".*

- The DEWRSB Skilled Vacancy Survey (SVS) for registered nurses for the six months until October 2000 was *"the highest number recorded in the last three years and* a*re part of an upward trend in vacancies over the last two years*".

- In the year 1999/2000 the net migration of overseas nurses to Queensland was as follows: settler arrivals –222 and net permanent and long-term arrivals –110.

- The Migration Occupations in Demand List (MODL) contains a significant number of categories of nurse. Of the 15 occupations on the Professionals list (excluding Computing and IT professionals) 80% (or 12 out of 15) are in the health field) and 40% (or 6 out of 15) are in nursing (nurse managers, registered nurses, nurse educators and researchers, registered midwives, registered mental health nurses and registered developmental disability nurses). This list is significant given that employers are exempt from local labour market testing if the occupation appears on the MODL and they are therefore able to recruit suitably qualified overseas workers to fill vacancies. Inclusion of an occupation on the MODL is therefore recognition by the government that a significant skills shortage exists in that particular occupation.

- There are presently no specific labour market programs administered by DEWRSB that are directed to alleviating identified national or state skills shortages in nursing. In the past specific nurse "re-entry" programs were funded by the Department of Training and Youth Affairs (DEETYA) but with the demise of the Commonwealth Employment Service and labour market programs generally, such programs no longer exist. (There has been some recent activity by DEETYA in providing limited funding for bridging courses for overseas-qualified registered nurses.) In our view this is a significant policy inadequacy that must be immediately addressed.

Recommendations:

That a national analysis be undertaken of the number of people with nursing qualifications not currently in the nursing labour force that could be attracted back to nursing.

That in the light of this analysis the need for nursing "re-entry" and "refresher" programs and other relevant labour market programs must be determined and federal government funding be provided to meet the cost of conducting such programs until such time that the nursing skills shortage is corrected.

Impact of the broader ideological shift

In our view the significant broader ideological shift of the last twenty years towards small government and user pays has significantly changed to the context in which nurses function – be this the educational, industrial or health system context. It is important to consider the impact this ideological shift has had in these three areas.

- **Educational:** Nurses now pay for their own education (including paying for post basic courses and "re-entry" or "re-training" courses). This shift to "user pays" in tertiary education has in effect meant that nursing students are increasingly contributing more to meeting the cost of equipping the health system with appropriately qualified nursing personnel. In the HECS environment students think very carefully about their course choices. Nursing courses have to compete with those courses that produce graduates with a higher earning capacity. (This earning capacity is important when you have a HECS debt to pay off.) There is also little incentive in this state for nurses to achieve any additional post-basic qualifications as qualifications allowances are not paid.

- **Industrial:** The de-centralisation of the labour market through the introduction of enterprise bargaining has meant that consistent rates of pay and conditions are, in the current framework, impossible to achieve even at a state level let alone a national level.

- **Health system context:** Increasingly the health sector is seen as just another market with a product to supply and one where a major priority of government is to increase efficiency – achieving the greatest "through put" at the lowest possible cost. In such an environment considerations such as quality and appropriateness of care, health outcomes, access and equity often come off second best.

The issues arising from the ideological shift in the health and industrial relations systems will be discussed in more detail below. Educational issue of concern will be then be addressed under the sections dealing with specific terms of reference for this inquiry. Firstly however, we wish to briefly touch on an ideologically driven contextual issue that is of particular concern to the QNU - the deregulation/substitution agenda within health.

De-regulation agenda

As we have stated elsewhere in this submission, there has been a push from some employers in some sectors to substitute qualified nurses with unqualified personnel. This has been particularly prevalent in the aged care sector but recently has also arisen in the private hospital sector. It is difficult to obtain current data on the extent of the de-regulation agenda. This is because detailed statistics on those unregulated workers performing nursing work (no matter what their title) are more difficult to obtain than data on the regulated nursing workforce. It is also the case that if, as we believe, this substitution behaviour has intensified in the last few years then this is yet to show up in available statistics. It will be interesting to compare ABS Census data for the years 1996 and 2001. In our view this will reveal the extent of the substitution that is occurring.

The purpose of this substitution/de-regulation agenda is, in our view, two-fold. Firstly employers save money through engaging less expensive labour in the form of unlicensed personnel. Secondly, employers remove or marginalise those workers with the educational preparation, skills and expertise to critically analyse the management of the health service being provided. All workers are accountable to their employers in the general context of the employment relationship, but regulated personnel are also accountable to their "profession" and hence the wider community for the standards of care they provide. Managerial prerogative is enhanced by the removal of such workers to the potential detriment of standards of care and accountability for such care. Employers engaged in this substitution wish to remove a "nursing model of care" and replace this with a "care model". In the process they not only devalue the role of nurses and nursing but they also strongly weaken important accountability mechanisms. Without professional mechanisms for accountability of standards of care for vulnerable recipients of health, care cannot be guaranteed especially as other mechanisms for regulation and standards are also being diminished through the removal of a role for government in regulation generally. Professional nurses will not continue to work in environments where standards of care cannot be maintained.

The QNU does not support assertions by some employers that this substitution is necessary because of the lack of availability of nursing staff. It is acknowledged that there are difficulties being experienced with recruitment of nurses in some areas but this must be looked at in a broader context. The current recruitment and retention difficulties being experienced are in our view due to the **wastage** of nursing staff – the chronic undervaluing of nurses and nursing has led to the current situation. Nurses are available to fill vacancies that currently exist – they need to be attracted to fill such vacancies and if necessary re-skilled to re-enter the nursing workforce. This is the key systemic issue that must be addressed.

Recommendations:

That this inquiry investigates the magnitude and impact of the substitution of qualified nurses with unqualified personnel and the erosion of nursing models and quality of care.

That this inquiry investigate those factors contributing to the unacceptable level of wastage within the nursing workforce and make specific recommendations on strategies to address this issue.

Health system context

In recent years there have been considerable changes in health policy and service delivery, many of which have been driven largely by economic considerations. These changes have included the introduction of the casemix model of health funding, the introduction of a contractual framework for the provision of health services (in both the public and private health sectors), the collocation of public and private health services and the privatisation of public health services. Technological advances have also contributed to a shift towards procedures being increasingly performed in stand -alone day procedure facilities. All of these significant changes have been driven largely by economic considerations – the aim being to "drive the health dollar further".

Nurses, as providers of health services, have well and truly met the call for increased efficiency that "drives the health dollar" further. The pressure to increase efficiency/productivity exists for our members in all sectors, but it is particularly relevant to examine the increase in work intensity in both the acute public and private hospital sectors.

In public acute care hospitals nurses make up around 44% of the total number of full time equivalent staff employed. Our members in this sector report that workloads continue to increase as the demand to do "more with less" increases. Public hospital "throughput" increased significantly over the last ten years in Australia – while the length of stay in hospital has decreased and the level of patient acuity has increased. Put simply, those who require hospitalisation are there for shorter periods of time and are sicker during

this time. There are also fewer nurses caring for these patients. This is consistently confirmed by research. For example, according to the AIHW report *Nursing Labour Force 1999 Preliminary Report* (p9), between 1995-96 and 1998-99 patient separations in public (acute and psychiatric) hospitals increased by 7.4% and at the same time the number of full-time equivalent (FTE) nurses decreased by 2.8%. During this time separations per FTE nurse increased by 10.5%, and an 8.5% decrease in average stays (from 4.6 to 4.2 days).

Other data on the relative efficiency and effectiveness of public hospitals in each Australian state and territory can be found in *Report on Government Services 2001* (an annual publication of the Productivity Commission). This report contains an agreed performance indicator framework for public hospitals. Although **efficiency** indicators (such as casemix adjusted relative length of stay, recurrent cost per casemix adjusted separation and labour cost per casemix adjusted separation) have been largely developed and refined over time, **effectiveness** indicators relating to quality (eg hospital service outcomes, patient satisfaction, hospital misadventure), appropriateness of care and accessibility and equity require further development. Although over time a more complete and balanced picture will be available to us via this performance indicator framework, until recent times undue emphasis has been placed on the development of efficiency or unit cost indicators at the expense of effectiveness indicators. It should also be noted that similar detailed data is not available for private hospitals.

According to the AIHW *Nursing Labour Force 1999 Preliminary Report* (p 10), during the same period in private hospitals (acute and psychiatric) there were the following changes in nursing staffing and patient statistics in Australia. There was a 16% increase in separations and an increase of 11% in FTE nursing staff. Between 1995-96 and 1998-99 separations per FTE nurse increased by 4.5%. There was also a 10.5% decrease in average stays (from 4.0 to 3.6 days) during this period. Anecdotal reports from members employed in private hospitals over the last 12 months indicate a further intensification in workloads in this sector. Members have reported to us that they feel they (and their patients) are casualties of contract negotiations between private health insurance funds and private hospitals. As a result of the pressure of negotiations with private health insurance companies over no and known gaps contracts private hospitals are doing all they can to cut costs in order to maintain profits/earning capacity. Nurses are reporting to us that their workloads are increasing as a result of the changed private health environment. We eagerly await the release of hospital activity and staffing reports for the period 1999-2000 and 2000-2001 as we feel certain that our members' complaints will be confirmed in these statistics.

The aged care sector is the next largest area for employment of nurses in Queensland after the acute care hospital sector. Unfortunately, the level of detailed statistics available for the acute care sector is not available for the aged care sector. There is the difficulty (highlighted above) of obtaining current statistics on the number of unregulated workers employed to perform nursing work in this sector. (This is because of the use of different nomenclature for the unregulated worker performing nursing work and the substitution agenda by some aged care employers in this state.) We can however provide broad statistics on the number of qualified nurses employed in this sector and the rising acuity rate.

According to nursing workforce characteristics available from the QNC's website (*Workforce Characteristics: Nurses Re-registered in Queensland 1996, 1997 and 1999*) the data on total numbers of registered and enrolled nurses employed in the nursing home and aged care sector in Queensland in 1997 and 1999 was:

1997: ENs employed in aged care in Queensland – 1,401 (22.7% of ENs)

RNs employed in aged care in Queensland – 3,419 (11.8% of RNs)

1999: ENs employed in aged care in Queensland – 1,142 (18.3% of ENs)

RNs employed in aged care in Queensland – 3,332 (11.2% of RNs)

The number of qualified nurses employed in this sector in Queensland has dropped between 1997 and 1999 yet resident dependency levels in both nursing homes and hostels continue to increase. According to the AIHW publication *Residential Aged Care in Australia 1999 – 00* (p 5):

"Between 30 June 1998 and 30 June 2000, the proportion of residents classified as high care (RCS 1 to 4) rose from 57.8% to 61.8%, while those classified as low care (RCS 5 to 8) fell from 42.2% to 38.3%".

The aged care industry itself recognises the problems associated with the increasing acuity levels in hostels in particular arising from the "aging in place" philosophy. In our view this issue requires urgent and careful attention given our concern that the nursing skill mix and staffing levels in many hostels are failing to match the acuity levels of residents.

This increasing level of dependency within aged care facilities combined with the falling numbers of registered and enrolled nurses employed in this sector in Queensland reinforces our concerns about the substitution/de-regulation agenda in the aged care sector and the likely impact this will have on resident care and safety.

One important aspect of a recent case the QNU brought before the Queensland Industrial Relations Commission was the issue of insufficient nursing staff numbers and the inappropriate skill mix of nursing staff in some aged care facilities. We therefore sought the inclusion of a nursing staffing and skill mix ratio, a move opposed by the majority of aged care employers as represented by their peak bodies appearing before the commission on their behalf. We eagerly await the decision of the QIRC on this important matter.

It is obvious from the evidence that is publicly available that workloads have intensified for nurses employed in public hospitals, private hospitals and the aged care sectors (ie the majority of the nursing workforce) in recent years. Nursing shortages are compounding the work intensification situation. As a result of this intensification nurses complain to us that they are now often unable to give the standard of care they believe should be provided. It is our fear that this is having a negative impact on the standard of patient care being delivered.

The community has expectations about the standard of care that should be provided. They also have legitimate expectations that the appropriate number and skill mix of nursing personnel will provide nursing care. In our view the current accountability mechanisms are inadequate to ensure an appropriate minimum nursing staff ratio and skill mix. Also, members of the community can experience difficulty ascertaining that the health care facility providing care actually employs an appropriate number of qualified nursing personnel. (This is particularly important given recent attempts by one private hospital chain to introduce unqualified nursing personnel into the acute care setting.)

Research conducted in the USA that was cited in a recent paper by Claire M. Fagin titled *"When care becomes a burden: Diminishing Access to Adequate Nursing"* (p 10)highlights the dangers of a de-regulation agenda in health.

"Recent studies have shown that close to 20% of hospitalised patients have a serious adverse event during their hospital stay (Silber and Rosenbaum 1997; McGlynn, Naylor, Anderson, et al. 1994). RN-to- bed ratio was the single most important factor influencing hospitals' differing success rates in saving patients who experienced serious adverse events, according to Jeffrey Silber and his associates."

The levels of adverse events in Australian health care settings are also the source of serious concern. Various strategies that aim to decrease the incidence of adverse events in this country are in the process of being implemented.

The findings of other recent US research may also be of interest to this inquiry. In June this year in Massachusetts a long awaited report of the *"Legislative Special Commission on Nursing and Nursing*

Practice" was handed down. The overarching theme of this report was contained in the covering letter to the report by its authors Senator Robert S. Creedon Jr and Brockton Representative Christine E Canavan (RN):

"Licensed nurses and the patients are inextricably linked. If the working conditions of the licensed nurse improve, direct patient care improves. If patients' concerns for quality care are met, the working conditions for the licensed nurses have been addressed. Their relationship is symbiotic."

This inquiry made 6 recommendations relating to improving the working conditions of nurses in that state, including proposing legislation to limit mandatory overtime and establish patient/staff guidelines based on patient acuity levels.

Other recent research from the USA, most notably a report from the Harvard School of Public Health titled *Nurse Staffing and Patient Outcomes in Hospitals,* highlights the important nexus between nurse staffing numbers and health outcomes for patients in some significant areas. This report recommends developments in data collection systems that would enhance further research in this important area.

Although the "crisis" in nursing in the USA appears more extreme that in Australia, the issues that were highlighted in the Massachusetts report are familiar to nurses in Australia. Recurrent themes of excessive workloads and inappropriate skills mix are common in both countries. Australia has the opportunity to learn from the US experience and take corrective action before the crisis in nursing becomes extreme.

We believe urgent action is required to address increased patient acuity levels and throughput and inadequate nursing staff numbers and inappropriate skills mix.

Recommendations:

That, as a matter of urgency, there be a review of currently available research and that consistent national minimum nursing staff ratios be set for each health care setting, recognising that acuity differentials will require additional qualified nurses. (Note: In 2000 such ratios were set for Victorian public hospitals.)

That, as a matter of urgency, consistent national parameters be set with regard to nursing skills mix in each health care setting.

That all health care facilities be required to make information available to the public about adherence to national parameters for nursing numbers and skill mix.

That all providers of health care services (public, private and not for profit) be required to report on performance and outcomes utilising a framework similar to that adopted by Council Of Australian Government for reporting on public hospital performance. (See *Report on Government Services 2001*, Figure 5.7.)

That as a matter of urgency, nationally comparable indicators of quality be developed for each health care setting in consultation with key stakeholders including nursing unions and regulatory authorities.

Industrial relations context

The QNU believes that deregulation and de-centralisation of the industrial relations system has had a significant detrimental impact on the working lives of nurses in Queensland and Australia generally. There is some hope that avenues exist to address our current concerns in the state arena (due to changes to the Queensland industrial relations legislation and the expected release later this year of a new pay equity principle in the state jurisdiction). However the magnitude of the current problems is extensive and

cannot be adequately addressed by corrective action in one jurisdiction alone. A consistent national approach must be taken to the nursing industrial relations context.

The QNU firmly believes that gender based pay discrimination is experienced by our members under enterprise bargaining and that the decentralised industrial relations system has merely served to reinforce the disadvantage of nurses. The introduction of enterprise bargaining (an adversarial wage fixing system based on industrial conflict) has had a significant detrimental effect on the wages and working lives of our members. In our view the industrial gains achieved by nurses under enterprise bargaining have been relatively poor.

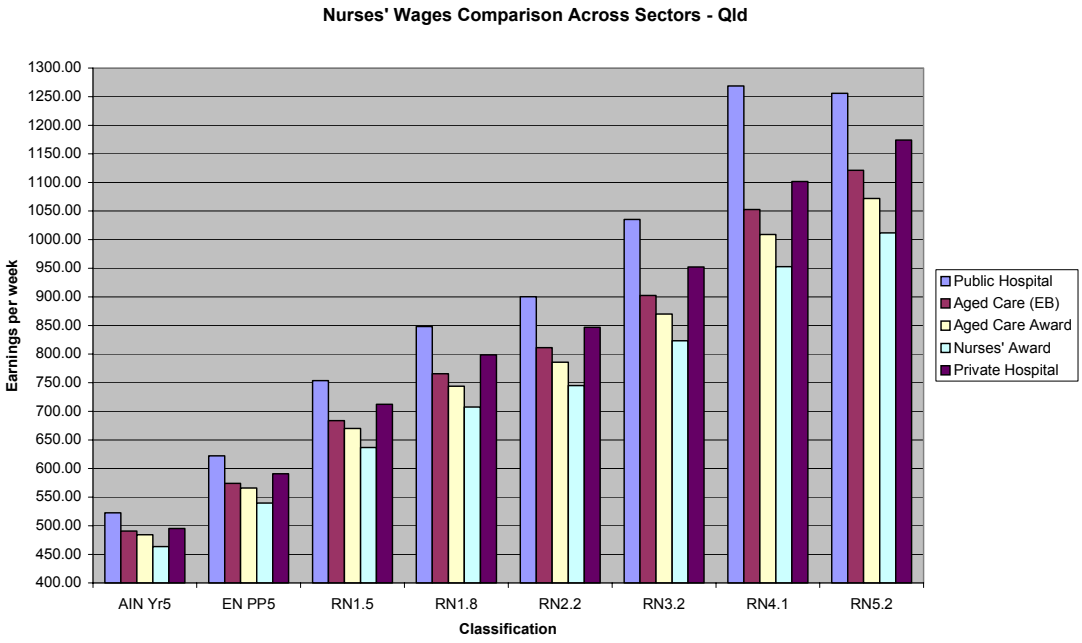
It is important to recall the industrial environment for nurses prior to the introduction of enterprise bargaining. In July 1994 all nurses in Queensland, irrespective of whether they were working in the public or private sector, in a hospital or a community setting or an aged care facility, were earning the same amount of pay for their classification. Their remuneration was determined by awards and the strong nexus between those awards, delivered pay parity. The remuneration was based on the recognition of nursing skills at that time across all sectors. We do not accept that these skills have been appropriately valued in the past.

Since July 1994 enterprise bargaining has fragmented nursing wages and to a lesser extent conditions of employment. The QNU has been party to over 200 enterprise agreements. The public sector is now on its fourth agreement while some nurses in other areas have no agreements. Currently there are 65 agreements in force in Queensland. The public sector has consistently received higher wages outcomes than the private and not for profit sectors. Many private hospitals have higher wages than aged care facilities. The disparity in wages between the sectors in a highly mobile and skill transferable occupation such as nursing results in more acute shortages of qualified nurses in those sectors that lag behind. This is clearly seen in aged care where recruitment of registered nurses is a significant difficulty. Unless the industrial relations system produces equitable outcomes across sectors recruitment and retention of qualified nurses to certain sectors will remain a significant problem.

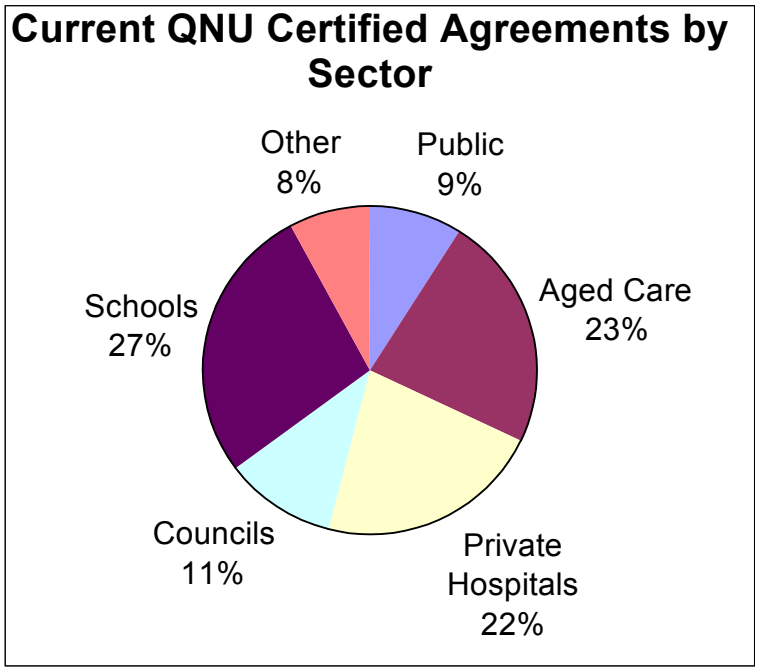
The significant anomalies and gaps between various categories of nurses in a cross section of sectors is highlighted by the table below:

Sector	AIN Yr5	EN PP5	RN1.5	RN1.8	RN2.2	RN3.2	RN4.1	RN5.2
Public Hospital	522.55	622.30	753.80	848.00	900.25	1035.35	1268.75	1255.75
Aged Care (EB)	490.80	574.10	683.80	765.80	811.40	902.60	1052.70	1121.20
Aged Care Award	484.35	566.05	670.10	743.90	785.60	870.10	1008.90	1072.00
Nurses' Award	463.60	539.80	636.80	707.50	744.80	823.40	953.00	1011.90
Private Hospital	495.28	591.02	712.17	798.78	846.96	952.20	1101.88	1173.83
$ Diff b/w max & min	58.95	82.50	117.00	140.50	155.45	211.95	315.75	243.85
% Diff b/w max & min	12.72%	15.28%	18.37%	19.86%	20.87%	25.74%	33.13%	24.10%

Note: All rates are the current rates being paid as at June 2001
1. Public Hospital rate from EB4 as at 1 April 2001
2. Aged Care (EB) rate from Blue Care EB2 as at 1 July 2000
3. Aged Care Award rate as at 1 September 2000
4. Nurses Award (taken from Hospital Nursses Award s- State) rate as at 1 September 2000
5. Private Hospital rates taken from Mayne Health EB2 as at October 2000



The movement away from a centralised wage system to that of an enterprise bargaining system has created inequities amongst the nursing labour force due to relative bargaining power. The public sector has a half a dozen agreements that cover 100% of the nursing workforce of over 23,000 nurses. The majority of major private hospitals are covered by about 14 agreements which cover over 70% of employers and an even greater percentage of the nursing workforce in the sector. Whereas in the aged care sector 15 agreements (the majority of which are with the major employers within aged care) cover only 34% of the aged care industry. In the context of a decentralised wages system the myriad of small and medium employers in the aged care sector prevents a strong collective bargaining position and thus lower wage and condition outcomes for nurses in this sector. Enterprise agreements have also been struck in other sectors but cover a very small number of nursing employees.



The negative impact of enterprise bargaining on nurses' wages and conditions is not only apparent amongst nurses in different health sectors. When the best wages outcome for nurses (ie public sector outcomes) are compared to that of other industries nurses average annualised wage increases (AAWIs) are well below average. The Department of Employment Workplace Relation and Small Business report *Trends in Enterprise Bargaining* for December 2000 provides an analysis of all agreements made in the federal industrial relations system for the December quarter. The report shows that although the AAWI for all employees under federal agreements was 3.9%, Queensland nurses under the public sector health agreement received only a 3% average annual wage increase.

The public sector performance in AAWI outcomes was less than that of the private sector, 3.8% compared to 4.1% respectively. Within the public sector although the Queensland public health sector agreement covered the largest number of employees, for average annualised wage increases it ranked 20th out of 23 possible rankings for 41 agreements certified in that quarter. For that quarter AAWIs ranged from 2.7% to 6.3%, Queensland nurses received 3%.

Table 1: Large Federal Agreements Certified in December Quarter 2000 (continued)		Duration (yrs)	Total Wage (%)	AAWI (%)	Emps	WR Act Section	Gener-ation	Notes
Public Sector Large agreements								
Infrastructure Services	State Rail Authority of NSW - Cityrail Stations Wages Functional Agreement 2000	2.4	8.0	3.3	2637	Div 3	7th	
	State Rail Authority of NSW Passenger Fleet Maintenance Depots Functional Agreement 2000	2.4	8.0	3.3	587	Div 3	7th	
	State Rail Authority of NSW Salaried City Rail Stations Functional Agreement 2000	2.4	8.0	3.3	902	Div 3	7th	
	Public Transport (Victoria) Enterprise Agreement 2000	1.0	3.0	3.0	9629	170LJ	5th	
	National Express Group Australia (Swanston Trams) Agreement 2000 - 2003	3.5	13.0	3.8	691	170LJ	5th	1,9
	National Express Group Australia (Bayside Trains) Agreement 2000 - 2003	3.0	13.0	4.3	996	170LJ	5th	1
	National Express Group Australia (V/Line) Passenger Agreement 2000 - 2003	3.0	13.0	4.3	601	170LJ	5th	1
	Connex Trains Melbourne Enterprise Agreement 2000 - 2003	3.0	13.0	4.3	790	170LJ	5th	
	Telstra Onair Business Unit Enterprise Agreement 2000	2.0	8.0	4.0	892	170LJ	4th	
	Retail Service Business Unit Enterprise Agreement 2000	2.0	8.0	4.0	8063	170LJ	4th	
	Infrastructure Services & Wholesale Enterprise Agreement 2000	2.0	8.0	4.0	19677	170LJ	4th	
	Corporate Group Business Unit Enterprise Agreement 2000	2.0	8.0	4.0	2247	170LJ	4th	
Other Services	University of Wollongong (Academic Staff) Enterprise Agreement 2000 - 2003	3.4	12.3	3.6	1084	170LJ	4th	3
	Charles Sturt University (Academic Staff) Enterprise Agreement 2000 - 2003	2.7	12.3	4.6	1760	170LJ	4th	3
	James Cook University Enterprise Bargaining Agreement 2000	3.0	12.0	4.0	2004	170LJ	4th	
	Edith Cowan University Academic Staff	2.6	14.0	5.4	828	170LJ	4th	1
	University of South Australia Academic and General Staff Enterprise Agreement 2000	3.2	12.0	3.7	2453	170LJ	4th	
	Queensland University of Technology Enterprise Bargaining Agreement Academic Staff 2000 - 03	3.8	12.3	3.2	2180	170LJ	4th	
	Murdoch University (Adademic Staff) Enterprise Agreement 2000	2.5	12.6	5.0	500	170LJ	4th	
	Australian National University Enterprise Agreement 2000 - 2003	3.5	12.5	3.6	4058	170LJ	4th	3
	Kangan Batman Institute of TAFE Teachers' Certified Agreement 2000	2.2	13.6	6.3	710	170LJ	2nd	18
	Royal Melbourne Institue of Technology TAFE Teaching Staff Enterprise Agreement 2000	2.4	13.6	5.8	852	170LJ	2nd	18
	Swinburne University of Technology TAFE Teachers' Certified Agreement 2000	2.3	13.6	5.9	741	170LJ	2nd	18
	Northern Melbourne Institute of TAFE Teaching Staff Certified Agreement 2000	2.2	13.6	6.1	743	170LJ	1st	18
	Chisholm Institute of TAFE Teaching Staff Certified Agreement 2000	2.3	13.6	5.9	1706	170LJ	1st	18
	Chisholm Institute of TAFE PACCT Staff Certified Agreement 2000	2.7	11.0	4.1	550	170LJ	2nd	
	Queensland Public Health Sector Certified Agreement (No.4) 2000	2.2	6.5	3.0	23207	Div 3	3rd	17
Public Administration and Defence	Victorian Public Service [Non executive Staff - Victoria] Agreement 2000	1.0	4.0	4.0	20006	170LJ	1st	1,2,3,4
	TAC Enterprise Agreement 2000 - 2002	2.0	6.0	3.0	520	170LJ	2nd	1,3,5
	National Library of Australia Certified Agreement 2000 - 2002	1.6	7.0	4.5	523	170LJ	2nd	19
	Attorney General's Department Agreement 2000	1.7	9.0	5.2	581	170LK	3rd	3,19
	Australian Agency for International Development Certified Agreement 2000 - 2003	3.0	10.0	3.3	600	170LJ	2nd	2,3,19
	Department of Communications, Information Technology and the Arts Agreement 2000 -2003	1.8	7.0	3.9	505	170LJ	3rd	3,5,19
	Department of Industry, Science and Resources Certified Agreement 2000 -2003	3.0	10.0	3.3	1368	170LK	3rd	19
	Securing our Future - DETYA Certified Agreement 2000	2.1	9.0	4.3	1415	170LJ	3rd	3,19
	Rockhampton City Council Enterprise Bargaining Agreement 2000	1.0	4.0	4.0	675	Div 3	3rd	17
	Maroochy Shire Council Certified Agreement 2000	2.0	8.0	4.0	1053	Div 3	3rd	1,3,16
	Gold Coast City Council Enterprise Agreement (Federal) 2000	3.0	9.2	3.1	1448	Div 3	4th	9
	Ipswich City Council Certified Enterprise Agreement 2000	2.0	6.8	3.4	1159	Div 3	5th	17
	Maribyrnong City Council Enterprise Agreement 2000	2.5	6.8	2.7	535	170LJ	4th	1
	Best Value Victoria Principles	1.1	*	*	814	170LJ	3rd	8
						Q emps	**AAWI**	
	Total Large Public Sector Agreements	**2.0**			**122290**	**121476**	**3.8**	15
	Total Large Agreements	**2.2**			**122290**	**121476**	**3.8**	15

Source: Workplace Agreements Database, DEWRSB

Notes:
1. Part or all of the wage increase is awarded on meeting defined targets
2. Individual performance assessed and remunerated
3. One-off bonus available
4. Performance pay 'pool' in place
5. Additional performance pay available
6. Parties to review the effect of CPI
7. Employees will receive a part of any profits made during the agreement
8. Conditions only agreement - No wage provisions eg. Redundancy or Superannuation agreement
9. Extra Wage increases if CPI is greater than Wage increases
10. Wage increases not quantifiable as they vary across levels, or depend on individual, company and market performance.
11. Pay increases are non cumulative
12. CPI passed on in part or in full
13. Employee Share Ownership Scheme in place
14. Pay increases vary across classification structure. Wage increases at mean/modal value.
15. Duration and AAWI are weighted by quantifiable emps. Total employee nos. include all large agr'ts (inc non-quantifiable agr'ts)
16. Employees are eligible for Safety Net, Safety Net automatically passed on or conditionally passed on
17. Known or probable Dual Jurisdiction agreement. Some of the employees are under an identical State agreement
18. New Vic Gov has varied previous TAFE Framework agreement. Wages operate to early 2000
19. Generation numbers start as the first agreement in the series is certified in the federal jurisdiciton (or in the case of APS agreements with the first agreement certified after C0993 which covered all APS agts.)

As the above tables and graphs clearly indicate, it is certainly the case that wages outcomes for nurses have been inconsistent since the advent of enterprise bargaining. Ironically, the QNU now seems to concentrate all our efforts on achieving pay parity between the public and private sectors in this environment, an outcome that had only just been achieved via the National Rates decision of the early 1990s. The QNU had only just achieved consistency of wages across sectors for nurses when enterprise bargaining was introduced and made such outcomes, by definition, a thing of the past.

The QNU believes the impact of the decentralisation of the wages system and the way that work value is determined is one of the most significant issues requiring attention by this inquiry.

In our view, enterprise bargaining is not an appropriate industrial relations framework for an industry like health. The optimal functioning of the health system, one that relies greatly on positive human interaction, is heavily dependent on cooperation between the "players" in the system **not** competition. Conflict and competition generally only serve to undermine the effective functioning of health facilities. Thus in the health sector an inherent tension exists between the nature of the work performed (and "product" produced) and the two fundamental issues central to the operation of enterprise bargaining – industrial conflict and attainment of enterprise based productivity/efficiency outcomes.

Nurses, because of the nature of their work, have particular pressures that have an impact on bargaining power. Fundamental to a nurse's work is the caring relationship with the patient/client and as such industrial action is not taken lightly. Nurses experience difficulties in taking industrial action. (For those nurses employed in small/hostile workplaces these difficulties are intensified.) The gender-based assumption inherent in enterprise bargaining is that all workers are able to easily withdraw their labour in pursuit of wage justice. This is not the case for many workers in service industries and it is clearly not the case for nurses. The bargaining power of a nurse is by definition limited by the nature of the work they perform.

The other difficulty our members' experience in an enterprise bargaining context lies with the difficulty experienced measuring productivity/efficiency in service industries. As we have stated elsewhere in this submission, nurses have been able to clearly demonstrate increased efficiency in recent years by measures such as increased throughput. However, the other aspects of increased productivity, such as measures of effectiveness and quality are more complex and meaningful indicators for these, although agreed for public hospitals at least, are only in the process of development. Measuring productivity in a service industry such as health is much more complex and time consuming than measuring productivity in other industries such as manufacturing. We believe this inherent difficulty has never been sufficiently acknowledged.

Another inherent difficulty is the way in which heath services are funded and therefore how those working in health services secure pay increases. The majority of health services are funded in large part either directly or indirectly by government. Unless government appropriations increase to adequately account for movements in wages nurses will always be disadvantaged by inability to pay arguments. Unless this is done equitably then disparity within the health sector will also be entrenched. Funding mechanisms for services in all sectors of health must enable movements in pay and conditions for nurses.
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The QNU made detailed submissions to the recent Queensland Pay Equity Inquiry on the issue of how wages are currently (and have been historically) determined and the gender based discrimination inherent in these processes. We have also commissioned research by the Australian Centre for Industrial Relations Research and Training (ACIRRT) at University of Sydney into the comparative wages and conditions outcomes for Queensland nurses over the last decade. This research confirms previous general research by ACIRRT into the impact of enterprise bargaining for women workers – nurses have performed comparatively poorly in terms of wages outcomes in the decentralised wage-fixing environment. An extract from this report, titled *Relative Pay and Conditions of Queensland Nurses throughout the 1990s: A Comparative Analysis*, in the form of a "league table" of mean hourly rates for Queensland nurses and a

number of comparator occupations over a number of years, can be found below. This table indicates the relative poor performance of nurses under enterprise bargaining. When we consider that the majority of nurses work shift work and their shift penalties have been factored into the mean hourly rate, then the picture for nurses in terms of pay outcomes is very depressing indeed. If this inquiry would like further details on the issues highlighted in these documents we will make our submission to the Queensland Pay Equity Inquiry and the final report on the research conducted on our behalf by ACIRRT available upon request.

Extract from ACIRRT report *Relative Pay and Conditions of Queensland Nurses throughout the 1990s: A Comparative Analysis* (June 2001): Mean Hourly Rates of Pay for Selected Occupations, Queensland, 1993, 1995, 1997, 1999

1993	**1995**	**1997**	**1999**
Science Professionals $21.10	School Teachers $20.30	Science Professionals $27.60	Business Professionals $22.70
School Teachers $19.50	Science Professionals $19.60	Business Professionals $23.50	School Teachers $21.90
Business Professionals $19.20	**Registered Nurses $18.80**	**Registered Nurses $21.80**	Science Professionals $21.40
Registered Nurses $17.10	Business Professionals $17.60	School Teachers $21.10	**Registered Nurses $20.70**
Enrolled Nurses $15.90	Data Processors $15.30	Data Processors $18.60	Metal Trades $17.70
Sales Representatives $15.00	Metal Trades $15.00	Metal Trades $17.70	**Enrolled Nurses $17.50**
Metal Trades $14.70	Sales Representatives $14.10	Sales Representatives $17.50	Data Processors $17.10
Data Processors $13.80	**Enrolled Nurses $13.20**	**Enrolled Nurses $15.40**	**Nursing Assistants $16.50**
Nursing Assistants $12.40	**Nursing Assistants $12.10**	**Nursing Assistants $14.70**	Sales Representatives $15.50
Sales Assistants $10.80	Sales Assistants $11.50	Sales Assistants $12.30	Sales Assistants $12.10

Source: ABS Labour Force Surveys, Unpublished Data, 1993, 1995, 1997, 1999

The issue of the current industrial relations context for nurses is of critical importance to this inquiry. Fundamental to the recruitment and retention of nurses are the issues of pay, working conditions and work value. Our current industrial relations system is failing nurses and thus the Australian community as a whole. This issue is made more complex by the fact that there are federal and state industrial jurisdictions that need to be considered and therefore differing industrial relations legislative and bargaining frameworks. (The jurisdictional issues are significant both between and within states. In Queensland alone, for example, nurses employed by Queensland Health are under the federal jurisdiction and all other members are under state jurisdiction.)

Examination should not be limited to rates of pay alone as significant differences exist with respect to conditions contained in various awards. There is a need for an urgent review of current wages and conditions of nurses in all states and territories to ensure industrial relations legislative processes and outcomes facilitate the recruitment and retention of nurses.

It should be noted that the current Queensland industrial legislation contains provisions to facilitate a return to a more centralised wage fixing system. All avenues to achieve a fair wage fixing system for nurses must in our view be examined. In particular the QNU believes that amendments need to be made

to the *Workplace Relations Act 1996* to facilitate the achievement of a fairer wage fixing system for nurses.

The industrial relations framework in which nurses operate is a complex matter and there is likely to be a divergence of opinions on how the system should be improved. However we believe there will be general agreement on one issue – the current adversarial industrial relations system has failed nurses and the health system generally and is in need of urgent review.

We strongly recommend that this inquiry pay particular and careful attention to this crucial issue.

Recommendations:

That an urgent review of current wages and conditions of nurses in all states and territories be conducted. This review should pay particular attention to the nexus between the various current industrial relations legislative regimes and the outcomes for wages and conditions for nurses that facilitate the recruitment and retention of nurses.

Further to this review, that necessary legislative amendment be made to the *Workplace Relations Act 1996* to achieve a fairer and more appropriate wage fixing system for nurses.

That funding mechanisms for services in all sectors of health be constructed in a manner that enables movements in pay and conditions for nurses.

Specific Terms of Reference for the Inquiry

a) the shortage of nurses in Australia and the impact that this is having on the delivery of health and aged care services

Problem: The current shortage of nurses is having a serious impact on the delivery of health and aged care services in this state.

In recent years the QNU has continued to highlight our concerns about the impact that the shortage of nurses is having on the delivery of health services. This committee heard evidence to this effect when we gave evidence to the recent *Inquiry into Public Hospital Funding.* We are pleased that the committee acknowledged the significance of the nursing shortages by calling this current inquiry.

There can be no doubt that shortages of nurses will have a serious impact on the quantity and quality of health and aged care services provided in this country. According to AIHW, around 55% of the health, aged and community services workforce are nurses. The important role that nurses play in the health system can not be questioned especially when it is considered that it is nurses who staff health facilities around the clock and therefore are critical to ensuring continuity and quality of care.

The evidence of increased "throughput"/activity over the last decade in all areas of the health and aged care sectors is irrefutable. Unfortunately a coordinated approach to health workforce planning has not always accompanied this growth in activity. All too often services are planned with insufficient regard to the workers required to carry out the activities planned. To add insult to injury, when it is established that there are insufficient nurses to perform the required duties, some employers seek to engage in a substitution agenda, using the nursing shortages as a convenient excuse to employ less expensive unqualified personnel. More attention must be played in the health service planning stages to the nursing workforce requirements for proposed initiatives, be these new health programs or facilities or an overall National Health Policy (should one ever exist).

In recent times the dangers of not performing appropriate workforce planning has had a significant detrimental effect on health service delivery. In the 2001 Queensland budget papers, for example, it was revealed that Queensland Health failed to reach activity targets for 1999/2000 (an estimated 710,000 episodes of care were estimated to be performed during this period buy only 670,000 were actually performed). We are also aware that on a number of occasions in various facilities across the state over the last few years theatre lists had to be postponed or cancelled because of lack of available operating theatre or intensive care nursing staff. In the mental health area delays have also been reported in the commissioning of new community based services because of the lack of qualified mental health nurses.

It must be acknowledged that significant advances have been made in the area of nursing workforce planning because of the work of the Ministerial Nursing Recruitment and Retention Taskforce in this state. Health Minister Wendy Edmond and the Beattie government generally must be congratulated for their commitment to this process. The QNU believes that Queensland is better placed than another of other states because of the significant work that has been undertaken to date in this area. We believe that the Taskforce process and recommendations are of relevance to other states and territories and we strongly urge others to consider the findings and recommendations arising from this important process.

We do however believe that addressing the issues in Queensland in isolation to the rest of Australia will not solve the current national shortage crisis. This is particularly so because of the mobility of the nursing workforce. Fixing problems in one state or territory will more than likely result in problems being created or exacerbated in another. This highlights the urgent need for a national approach to nursing workforce-planning issues. In our view, the only away in which a sustainable long term solution can be found to nursing workforce planning problems is for a nationally coordinated and consistent approach to be adopted.

Recommendations:

That all future health service delivery policy proposals and any future development of a National Health Policy incorporate assessments of nursing workforce requirements.

That the recommendations from the Queensland Ministerial Nursing Recruitment and Retention Taskforce be examined by all states and territories for implementation. Further to this, that collaborative review such as those undertaken by the taskforce
be undertaken in each state and territory every five years.

That the Commonwealth government coordinate national forums aimed at addressing nursing recruitment and retention issues.

b) opportunities to improve current arrangements for the education and training of nurses, encompassing enrolled, registered and postgraduate nurses.

Specifically make recommendations on:

(i) nurse education and training to meet future labour force needs

Problem: There is no national approach to workforce planning for nursing leading to inaction in some states or actions in others causing shortages across the system.

The current approach to nursing workforce planning is to allow each state to determine its own needs. However nursing is a very mobile profession and state borders do not limit the effect of any states action in this regard. The QNU understands that in the past some states Victoria, New South Wales and South Australia, for example, have undertaken workforce planning studies which have unfortunately resulted in the reduction in undergraduate student numbers.

This effect is now rolling out across the country and coupled with subsequent lack of uptake by school leavers into nursing courses has resulted in the current shortages being experienced.

These workforce planning studies we understand had a principle of matching nursing supply to demand at a global level. However any model based on this premise must lead to a lack of nurses in areas of specialty, or in other disadvantaged areas such as rural or remote nursing.

Queensland also undertook workforce planning studies which recommended cutting student numbers. However fuller examination of the issues resulted in decisions not to accept the consultants recommendations and Queensland has chosen to maintain a solid intake of at least 1200 new students each year.

Despite this, shortages in other states is leading to registered nurse drain to those states especially where conditions, staff ratios and wages are better than those in Queensland.

It is therefore imperative that national workforce planning is undertaken and that all states are involved then in determining a national approach to enrolled nursing, undergraduate and post-graduate nursing numbers.

Recommendations:

That a national nursing workforce planning body be established which undertakes national workforce planning and negotiates with each state on enrolled nursing, undergraduate and post graduate nursing numbers.

That workforce planning models take account of the needs for specialties and rural and remote nurses prior to determining total numbers required by the system.

Problem: The cost of clinical placement of nursing students is not appropriately resourced by either the tertiary funding arrangements or by the health facility funding models.

Clinical placement and experience for nurses is a significant factor in the appropriate educational preparation of registered and enrolled nurses. Clinical experience needs to be assisted by either appropriate facilitation or preceptorship within the facility. Either method requires funding for the student support. This vital educational experience is not adequately catered for in the current tertiary funding arrangements. Health facility budgets take no account of this support in their funding models either. Therefore this essential component of the student learning is placing a financial burden on both sectors. The result from this is friction between the parties over responsibility and it is the nurse in the workplace and the student who are put at disadvantage over the issue.

Despite the success of collaborative models the actual costing of this component of the course and allocation of appropriate funding by each sector needs to be determined.

Recommendations:

That the cost of clinical placement experience for student nurses is accurately costed and that appropriate funding is determined and allocated to support this vital part of educational preparation.

That health facility funding models take into account the costs of providing support for the clinical placement of student nurses.

Problem: Nurses providing clinical education and preceptorship to students during clinical placement are not appropriately supported or given appropriate client loads.

Due to the funding issues students are often placed in facilities where support or preceptorship is provided by a registered nurse, however this nurse is not supported to undertake this role. Anecdotal reports of such nurses being given a full patient load whilst being required to educate or support students are common. This results in higher rates of burnout for the experienced registered nurses and poorer clinical preparation of the student. There is no evidence that a commonly promoted "internship year" will either increase the quality of graduates from nursing courses or reduce the load on preceptors and experienced nurses providing clinical support.

Recommendations:

That registered nurses providing support to nursing students are allocated an appropriate patient load and that they are supported educationally to undertake this role.

That the completion of an internship year should not be a requirement for nurse registration

Problem: The cost of undertaking both undergraduate and post graduate studies required to meet nursing skill shortages is a disincentive to nurses and results in inadequate uptake of these courses by students.

The significant shortage of nurses both generally and within the specialties requires strategies which will increase the uptake into courses to meet future demand. One of the key disincentives to this is the actual cost to the nurse of these courses.

Nursing being a 24 hour per day seven day per week occupation makes undertaking university study whilst working full time a difficult proposition. This combined with the need to undertake clinical practicum as part of the course of study means that many nurses are required to drop from full time work to part time work in order to complete the courses. This results in the cost to a nurse increasing significantly. The QNU has reports from some nurses which indicate that completing a Masters in most specialties can cost nurses over $40,000 by the time course fees, lost income, books and accommodation is taken into account.

A further cost impost occurs for nurses in rural areas in terms of the significant cost to them of travel in order to undertake tertiary studies. This can amount to thousands of dollars for each placement. Also the costs for students who wish to have clinical placements in rural areas can also be prohibitive especially with the reductions occurring with regard to hospital accommodation for nurses. Many facilities have reduced nursing accommodation and many rural centres do not have suitable affordable alternative accommodation. This cost impost can only exacerbate the current shortages of rural and remote nurses.

These costs are clearly prohibitive and needs to be addressed if the areas of specialty nurse shortage are to be removed.

Recommendations:

That HECS fees for undergraduate nursing courses be waived until such time as the workforce planning analysis demonstrates the nursing shortage has eased.
That HECS or course fees for postgraduate study in all specialties demonstrating shortages be waived until workforce planning data demonstrates shortages have eased.
That undergraduate students undertaking clinical placement in rural areas be provided with additional support to compensate for the additional costs of these placements.

Problem: Enrolled nurse courses, quality and standards are not consistent between states and subsequently enrolled nurse utilisation varies between states and even within states.

Enrolled nurse entry level qualifications vary from Diploma Level in Queensland to certificate level in other states. Length of courses varies and some courses limit clinical experiences to specific areas eg aged care. This lack of consistency in education and experience has led to inconsistent utilisation of enrolled nurses in the workforce. Enrolled nurse utilisation varies from workplaces who absolutely limit the clinical component of the enrolled nurse role due to inappropriate staffing models to other workplaces where enrolled nurses are forced to work outside of their Scope of Nursing Practice.

Limited workforce planning studies have been done into the enrolled nurse workforce and even these studies have not involved the examination of appropriate models of care that may enhance the use of enrolled nurses in the health workforce.

Articulation of enrolled nurse courses into registered nurse courses is inconsistent between states and between universities within states with limited recognition given by some universities to the clinical experiences of enrolled nurses.

Recommendations:

That there be nationally recognised qualification level for enrolled nurses at the diploma level.

That standards of pre-enrolment courses be consistent with such courses adopting a life-span approach not be area specific eg aged care, paediatrics.

That specific workforce planning occur to determine future enrolled nurse needs and that all states contribute to the education of enrolled nurses.

That models of care be researched to identify best practice utilisation of the enrolled nurse role.

That universities and industry recognise the curricula content and experience of enrolled nurses in articulation of enrolled nurses into registered nurse courses.

(ii) the interface between universities and the health system

Problem: The numbers of students in TAFE, undergraduate and post graduate studies is determined by training facilities and universities with limited linkage to the needs of states or the ability of state facilities to provide appropriate clinical placement.

The current uptake of students by universities and to lesser extent by TAFE is based on economic considerations for the Universities rather than an examination of the service needs. This has led to instances to the lowering of entry requirements in some universities to fill places for financial reasons without regard to the ability to clinically place students or the need for employment in the geographical catchment of the university.

Queensland has experienced situations where the lack of uptake of course by other states has led to a transfer of places to Queensland universities without any regard to need or clinical placement.

National workforce planning and then negotiation over student placement allocation should be a major factor in determining student places available, not just the financial considerations of universities.

Recommendation:

That allocation of student nursing places to universities be based on thorough workforce planning, the nursing needs of geographical areas and the ability to resource appropriate clinical placement not just on the potential for income creation for individual universities.

(iii) strategies to retain nurses in the workforce and to attract nurses back into the profession including the aged care sector and regional areas

Problem: The wastage of nurses from the nursing workforce and inability to attract qualified nurses back into the nursing workforce is the most significant issues facing nurse workforce planners.

The Ministerial Taskforce of Nursing Recruitment and Retention in Queensland found that turnover of nurses within Queensland Health in 1998 was 21%. In some districts of Queensland Health this turnover was greater than 50%. Other states are undertaking similar studies, however it is known that turnover is a significant factor for all states. State Registration data indicates that significant numbers of qualified and Registered Nurses are not actively working as nurses at any one time. The New South Wales Department of Health has undertaken research on this issue attempting to determine those factors that would result in nurses returning to the nursing workforce.

In Queensland research was undertaken on nurses who left the employment of Queensland Health in those districts having a higher than normal turnover.

The key theme in all of this research is that factors that acknowledge the family responsibilities of nurses and management systems that acknowledge the role nursing and its values play in health care are important factors for nurses either leaving or returning to the workforce. It is clear then that to both retain and attract experienced nurses there needs to be a shift in management policy and practices away from the "cut costs at all cost" approach to one which acknowledges the family responsibility needs of nurses and acknowledges the caring quality nursing care approach nurses seek for professional fulfilment.

It is significant also that rather than facilitating return to the nursing workforce there has in fact been a shift by some states to make the return more difficult for nurses. Funding support for "refresher, re-entry" type courses has been significantly reduced in the last 5 years and nurses undertaking these courses are often required to provide their own Indemnity Insurance and Workers Compensation cover.

More details of the QNU's suggested strategies to recruit and retain nurses can be found in our detailed submission to the Queensland *Ministerial Nurse Recruitment and Retention Taskforce.* Multiple copies of this document have been provided with this submission. Rather than repeat these in this document, we strongly suggest that this submission be read in conjunction with that document.

Recommendations:

That management and funding practices in health acknowledge the needs for nurses to fulfil their need for professional satisfaction within their working lives.

That management and funding practices in health acknowledge the family responsibility needs of nurses.

That specific federal funding be allocated to support refresher and re-entry type courses, including the provision of indemnity and workers compensation cover.

That the QNU submission to the Queensland *Ministerial Nurse Recruitment and Retention Taskforce* be read in conjunction with this submission.

(iv) options to make a nursing career more family friendly

Problem: Current work arrangements do not adequately address the discontinuous nature of the majority of nurses' careers.

The working life of the vast majority of nurses is characterised by breaks in employment that allow for child bearing, child rearing and the performance of other family responsibilities (such as elder care). The non-continuous nature of the careers of the majority of nurses (and indeed the majority of other health workers) is a fundamental human resource management issue for the health industry and yet in reality little has been done to address this structural issue. There is a need for specific strategies to be implemented in these areas that recognise and address the non-continuous nature of nursing employment. (An example of this is portable long service leave, a provision the building trade has had for some years now.)

Another issue that needs to be addressed is the fundamental ideological shift that has occurred in recent decades that is evidenced by the move away from collective responsibility for health and other social services to the individual. We have mentioned one aspect of this shift earlier in our submission – the shift to user pays. But the impact goes beyond this to where responsibility lies for care (be that of children, elders or other family members) outside an institutional context. For example, when a person is discharged from hospital but is still acutely ill there is an assumption that there is a family member or significant other available to care for them at home. This person is usually assumed to be a woman. (Please see the Claire Fagin article *Burden of Care* for further discussion of the broad impact of this shift) The nurse who has such family responsibilities is doubly disadvantaged because those residual services that do exist fail to recognise shift-working arrangements. Also, difficulties are experienced by nurses in their employment relationships – employers rarely acknowledge the particular challenges faced by nurses in these situations.

Although there are complexities associated with balancing work and family in a largely 24- hour a day, 7-day a week occupation like nursing, there are many strategies available to make nursing more family friendly. Some of these do require some financial investment, which would be easily recouped through lowering nursing wastage levels. Many others require merely a more flexible approach and a change in attitude. The QNU has been lobbying for such changes for many years, with varying degrees of success. We are certainly heartened by a number of recent developments at the state government level arising from the implementation within Queensland Health of the *Ministerial Nursing Recruitment and Retention Taskforce Report* recommendations and the *Queensland Child Care Strategic Plan 2000-2005*. The Queensland Minister for Industrial Relations has also recently announced the establishment of a Work and Family Taskforce, an initiative that will be monitored closely by the QNU.

It is acknowledged that even though we view progress made to date as insufficient, it has been possible to implement more family friendly initiatives in the public sector. In the QNU's experience it has generally been much more difficult to progress the issue of family friendly initiatives in the private and not-for profit sectors. It remains the case that in all sectors many managers are too narrowly focused on the short-term cost or inconvenience and not on the longer-term gains (ie in recruitment and/or retention of nurses). In our view it is not until the wastage of nurses from the health system is quantified in dollar terms will there be a serious and concerted effort to address this issue once and for all. It gets back again to how nurses and nursing are valued. Far too many employers still see the nursing workforce as a disposable one or one that can be easily substituted for less expensive and less qualified personnel.

The actual cost to employers of wastage of experienced nursing staff is estimated to be significant. Although work is still to be done to quantify this cost in nursing, research into the cost of turnover in similar occupational groups (white collar professionals or para-professionals) ranges from $21,000 to $80,000 per "lost" employee. It would be beneficial if this inquiry were able to arrange for costings to be done on the turnover (or wastage) of nurses to enable the value of the loss of a nurse to be quantified.

The implementation of strategies aimed at addressing the balancing of work and family responsibilities of nurses would greatly enhance the recruitment and retention of nurses in the health system. The QNU believes that the following family friendly initiatives need to be pursued to address the unacceptable level of wastage of nurses from the health system.

Recommendations:

That an analysis of the impact of those policy initiatives of government that shifts responsibility from the collective/social to the individual (eg early discharge of patients from hospital and "aging in place" philosophy) be conducted as a matter of urgency.

That this inquiry commission research that would provide costings of the turnover (or wastage) of nurses. This would enable the value of the loss of a nurse to be quantified.

That other initiatives that would assist to retain nurses within nursing (eg portable long service scheme) be further investigated.

Family Friendly Policy Framework

We believe it is essential that a family friendly policy framework be in place to underpin strategies aimed at improving the recruitment and retention of nurses. The QNU has worked extremely hard to promote family friendly policies on behalf of our members. We have promoted this agenda through enterprise bargaining negotiations (in the public, private and not-for-profit sectors) and through forums such as employment equity consultative committees.

For example, under the first enterprise bargaining agreement with Queensland Health a joint consultative committee developed a raft of family friendly policies. These policies related to:

Work and Family Considerations

Special and Family Leave

Extra leave for proportionate salary
Job sharing

Six-months half pay long service leave

Child care (policy not agreed between unions and Queensland Health)

Access to telephones

These policies provided a very firm starting point for work and family initiatives within that department. The QNU actively promoted these policies, however funding was not provided at the time of finalisation (early 1997) to promote these policies within the department. It is only now in 2001 that the department is in the process of combining these policies (along with a few new policies) into one document. The plan is to have these available to employees via the Queensland Health Intranet. (Funding is still not available to provide these in multiple hard copies.) It should be noted that the above policies apply to all Queensland Health employees. Strategies specifically aimed at facilitating the balancing of work and family responsibilities of nurses are also being progressed via the implementation of Nursing Recruitment and Retention Taskforce recommendations.

Although some progress has been made in the public sector, the progression of family friendly policies in the private and not-for-profit health sectors has been mixed. It is our hope that the recently announced

Queensland Work and Family Taskforce and the establishment of a Work and Family Unit within the Queensland Industrial Relations Department will provide further impetus for the progression of family friendly policies across all Queensland workplaces.

Recommendation:

That family friendly policies continue to be promoted at state and federal government levels and that particular emphasis be placed on benefits (particularly "cost savings") of implementing best practice work and family initiatives.

Paid Parental Leave and other family friendly leave

Access to paid parental leave is a critical employment equity issue for nurses. Under the Parental Leave Award - State, all employees who have had at least 12 months continuous employment with an employer immediately preceding the date upon which she proceeds on leave, are entitled to up to 52 weeks unpaid maternity leave (provided that such leave does not extend beyond the child's first birthday). Access to paid maternity/parental leave is however somewhat limited. Paid maternity leave is available to nurses employed in the public sector and to a limited number of nurses employed in the private sector. (It is interesting to note that many private hospitals seek to split paid maternity leave into pre and post leave components, with the post leave component designed to "attract" women back to work after maternity leave.)

The current paid maternity leave "standard" entitlement for nurses in Queensland is based on the public sector entitlement of six weeks leave. The QNU and other public sector unions continue our lobbying efforts to have this increased to 12 weeks. (Prior to the 1995 state election the Goss Labor government initially promised this but when Labor lost power the Borbidge government decreased the entitlement to six weeks. To date the Beattie government has failed to match the 12-week commitment of the Goss government.) A limited number of enterprise bargaining agreements in the private hospitals and aged care sector have provisions that match the public sector six weeks paid provision. (Significantly most of the major private hospitals have paid maternity leave included in their enterprise bargaining agreements.) The union includes a provision for paid maternity leave in all our enterprise bargaining log of claims. However, the majority of private sector employers (especially those in the aged care sector) have failed to agree to our claims, arguing inability to pay. The union is continuing to pursue this issue.

The QNU believes that access to paid maternity leave must become a basic entitlement available to all women. More than 120 nations provide paid maternity leave and health benefits by law, either via the social security system or employer provision. It is a disgrace that Australia is one of three industrialised nations (with the USA and New Zealand) that does not provide for this, when countries such as Angola, Tanzania, Rwanda, India, Saudi Arabia and Hungary can do so. There is an urgent need for public debate and urgent action by government to address this embarrassing deficiency.

The current situation in Australia results in an exacerbation of the unequal treatment women suffer in employment due to their reproductive role. As significant sections of the private and not-for profit health sectors refuse to address the issue of paid maternity leave, the Commonwealth government needs to urgently examine this issue and then implement the best mechanism to provide for a consistent paid maternity leave benefit for Australian women.

QNU members report that other forms of family friendly leave are often difficult to access. This is due in large part to the management culture in health – nurses are often reluctant to approach management to secure access to basic industrial entitlements because they fear the reaction to the request. A recent example from a major public sector facility near Brisbane highlights this not uncommon occurrence. A nurse applied for paid family leave (which is debited from an employee's sick leave entitlement) for the period of time that her child was hospitalised. Her local nursing management denied the nurse this leave as did the district HRM section. In their view because the child was hospitalised management saw the

hospital as the primary care giver and not the parent. This matter took weeks to resolve, with the QNU being forced to refer this matter to Corporate Office of Queensland Health where it was eventually resolved in our member's favour. Another recent tragic example involved the death of a nurse while she was on her way home from work. Her partner, who was also employed as a nurse at the same public hospital, applied for 12 months leave without pay to enable him to care for their children and settle them following her death. He was initially denied this request and it again took our intervention and referral of the matter to Queensland Health Corporate Office before the matter was satisfactorily resolved.

Unfortunately, intervention by the QNU on behalf of members in scenarios like those quoted above is not an uncommon event. Our members are tired of having to fight for access to basic lawful entitlements and fair treatment. We believe any examination of turnover in health facilities with excessive levels of turnover/wastage would demonstrate unacceptable management practices and/or style. Urgent attention needs to be given to examination and correction of management practices contributing to the nurse wastage.

Recommendation:

That the Commonwealth government urgently examines the need for the provision of paid maternity leave benefit and then utilises the best mechanism to provide for a consistent paid maternity leave benefit for Australian women (eg either through the Social Security system or employer provision).

Access to part-time work

Although access to part time employment is common in nursing, in some facilities and circumstances nurses are actively discouraged from taking up part time work. Recently, for example, the QNU supported members in lodging a grievance against unilateral action by management in one workplace to increase their working hours. The local hospital management had determined that they had an excessive number of part-time employees and that this was adding significantly to their "on-costs". Rather than attempting to negotiate with the nurses involved or implement change over time, management released a blanket edict that after a certain date all part time employees would have to work a minimum certain number of hours. (This edict failed to recognise that the two nurses who eventually lodged a grievance over management's action had repeatedly met management's requests to work additional shifts and fill in for other employees. Their long-term loyalty to the organisation was not rewarded.) Eventually this grievance was resolved to the satisfaction of employees, but it will take some time for the nurses involved to recover from this experience and the message that was sent by management about how they are valued.

Another difficulty experienced by members quite regularly is reluctance on behalf of management in some facilities to offer part-time work to nurses in above base grade positions. This problem usually arises when a nurse is attempting to secure permanent part-time work arrangements following the birth of a child. (Typically members are denied continuing part-time employment once their child reaches two years of age, the age specified in the return to work arrangements following maternity leave.) Again it is often up to the union to support members to achieve agreement on satisfactory work arrangements. Management must be able to justify why a job cannot be performed in a part time capacity. This reluctance on behalf of management highlights an attitudinal problem that still exists within the health sector.

Recommendation:

That urgent attention be paid to performing an examination of those management practices significantly contributing to the wastage of nurses and that appropriate corrective strategies be recommended.

Family friendly rostering

It is acknowledged that fair and effective family friendly rostering is not always an easy task to master, especially given that most health services have to provide a seven day a week, 24 hour a day service. There are many forms of rostering available – request based rostering, self-rostering, forward rotating rostering and computer generated rosters to name but a few. All have their limitations and no form is guaranteed to keep all nurses satisfied. This is a perennial problem. Maximising satisfaction while covering organisational staffing and skill mix requirements is the aim of effective rostering. The Queensland Ministerial Nursing Recruitment and Retention Taskforce Implementation Group has recently provided funding for five family friendly rostering trials across the state. As a starting point the implementation group has agreed that it is necessary to develop of set of agreed principles for fair and equitable rostering that will underpin the trials. The QNU will continue to work closely with Queensland Health and other stakeholders on the implementation group to develop these principles, implement the trials and evaluate the outcomes of these trials. It is the intention to "roll out" successful rostering models elsewhere across the state once the trials are completed and appropriately evaluated. It is essential that "best practice" models of family friendly and effective rostering be developed and actively promoted.

Recommendation:

That "best practice" models of family friendly and effective rostering be developed and actively promoted.

Child Care

The availability of affordable, quality childcare services is a major determinant of workforce participation for all women. The QNU has for many years been highlighting the particular need of nurses for affordable, quality extended-hours childcare. Given that 93 per cent of nurses are women and a majority of nurses are required to work shift work, this is a particularly important employment equity issue for the health industry and one that employers have not adequately considered in the past.

It is the union's strong view that the lack of appropriate childcare services is a significant structural barrier to the recruitment and retention of nurses in this state. It is also a major barrier to nurses returning to the workforce after having children. Although childcare is not an issue for all nurses at all times during their working lives, it does impact on nursing workforce planning for discrete groups of nurses. Specific skills-mix difficulties are created by the failure to address the childcare needs of this part of the nursing workforce.

The issue is of particular relevance to experienced Level 1 or Level 2 registered nurses aged in their twenties or thirties, who are attempting to balance work and family responsibilities. A 1998 survey of nurses utilising the Lady Ramsay Child Care Centre at the Royal Women's Hospital reinforced this point. The 22 female respondents to this survey had a total of 293.5 years of nursing experience (average 13.3 years). Only one of these members was employed in a full time capacity, the remaining 21 being employed in a permanent part-time capacity (employed an average of 43 hours per fortnight). The overwhelming majority of respondents worked continuous shift work (ie are required to work all three shifts over seven days) with the remaining respondents working outside "normal" hours. All of the respondents were worked in specialty areas, with over half of them working in areas experiencing particular skills shortages at that time- intensive care, operating theatres and midwifery. These selected quotes from the respondents highlight not only the importance of a service such as the Lady Ramsay Child Care Centre (LRCCC) but also the need for flexibility in rostering and other work practices:

"I personally would have to give up work which I thoroughly enjoy because my alternative to the extended hours of the LRCCC would be a private nanny which is completely out of our budget. Before going to LRCCC, I exhausted all avenues within the community for child care that would suite my use to no avail."

"My CNC won't give me ordinary working hours due to the nature of X-Ray Department work - on-call, urgent late diagnostic and interventional procedures, shift work (earliest shift starts at 7.00am, other centres do not open until 7.00 or 7.30am!) Two of our shifts finish at 6.00 and 6.30pm - normal child care centres shut at 6.00pm - totally unsuitable for my needs. I require the government run extended hours of care that Lady Ramsay provides. If it is changed to a private company, even if it is not for profit, they may gradually cut back on the extended hours after the nominated "five year contract with the government"."

"Without Lady Ramsay I and many others may have to abandon either shift work or change work due to the absence of any other viable child care alternative."

"It is very difficult to find reliable/trustworthy care for the children when other family/relatives are unable to help. Until my husband finishes his apprenticeship I will have to work my current hours. Day care centres are difficult because I live 45 minutes from work. I have to travel through peak hour traffic to get to and from work and arrive and leave after the shift starts and finishes. If there is an emergency at the end of a shift and I arrive late to pick up the children then they charge $1 for every minute late."

"It is very difficult to get part shifts (not considered where I work) or regular shifts per week even if it seems to suit. You have to request and are constantly made to feel that you are a problem to roster and therefore feel a bit pressured. I have major problems working a late then early shift - sleeping etc. When I did try to work 10-hour breaks between shifts I felt penalised by other staff in the area for this "luxury". Many comments were made to me and anyway after a late shift I would get a 9.30am -6.00pm shift which is more tiring. I therefore resort to medications to ensure that I get sufficient sleep in these quick breaks."

"I can not obtain a permanent place and have to book in week by week with no guarantees of care being available. No other child care facility offers the same hours for shift workers. The Princess Alexandra Hospital needs a child care facility.... I am shocked that there are plans to privatise or close the Lady Ramsay Child Care Centre (LRCCC). I have been able to get a child care placement closer to home, however their hours don't suite as they cater for 9 to 5 workers on regular days. I have been on a waiting list for almost 3 years at LRCCC. There needs to be more extended day care facilities. I'm surprised any hospital would want to lose experienced nurses because of lack of suitable child care." (Parent user from another hospital.)

"It's about time people who are shift workers were considered. Not all mothers want to work permanent night duty to suit child care arrangements and some spouses don't start work at business hours, i.e. 8.30am - 9am, some start at 4am - 6am."

The above comments highlight the significance of access to appropriate affordable childcare and other family friendly initiatives to nurses. As health services expect nurses and other health workers to provide a 24-hour-a-day, 7-day-a-week service, the QNU believes they have an obligation to assist their employees to balance their work and family responsibilities.

However, in response to ongoing QNU lobbying, Queensland Health has stated repeatedly that childcare is not its core business. The QNU strongly disagrees with this. Given that women make up the bulk of the profession, the balancing of work and family responsibilities is an inherent workforce planning and management issue for nursing. For most people the availability of childcare is an integral part of balancing work and family responsibilities. For us childcare is a core "human resource management" issue. If it is not the responsibility of Queensland Health and other employers of nurses to ensure that appropriate child care services exist then where does the responsibility lie?

Currently in Queensland private sector centres do not provide services that meet the needs of continuous shift workers. Limited extended hours services are provided by Family Day Care services. It is acknowledged that many private and community sector services have amended their opening hours in recent years and this has enabled nurses who work early shifts to utilise these services. This minor

change does not address the issue of providing childcare over all shifts, an issue that has been put in the "too hard" basket for many years now. It seems that no organisation is prepared to address this issue and until very recently there has been a reluctance to provide a "whole of government" response to this complex area of need.

State and federal government departments with responsibility for childcare have (finally) in recent times turned their attention to this significant supply gap issue through the implementation of new policy initiatives. Such initiatives include trials of childcare "hubs", collocated multipurpose child care services and the funding of in home child care for shift workers. The QNU is continuing to lobby for the implementation and extension of childcare services that meet the needs of our shift-working members. (These unmet needs extend beyond pre-school aged care to vacation and emergency care.) We are continuing lobbying activity via our representation on the Queensland Child Care Forum and the implementation of child care specific recommendations contained in both the *Report of the Queensland Ministerial Taskforce on the Recruitment and Retention of Nurses* and the current Queensland Health Enterprise Bargaining Agreement (No 4).

We strongly recommend that this inquiry investigate the specific child care needs of nurses and make recommendations on strategies to ensure that improvements to services for nurses and their families be a policy priority for government.

Recommendation:

That this inquiry further investigate the specific childcare needs of nurses and make recommendations on strategies to ensure that improvements to services for nurses and their families be a priority area for government child care policy.

Breastfeeding Facilities

Although there is a national strategy to encourage breastfeeding in the general community it remains the case that in many health facilities nurses as employees continue to experience great difficulty in maintaining breastfeeding following their return to work from maternity leave. Rarely are appropriate facilities and work arrangements made available to facilitate the continuation of breastfeeding. There is an urgent need for workplace policies that encourage continuation of breastfeeding and for this to be taken into consideration in the planning of workplace amenities.

Yet again, the hypocrisy of the health sector industry failing to "practice what it preaches" with respect to its employees is evident in this area. This is a recurrent theme in this submission, be this in relation to work and family or the occupational health and safety of employees. Nurses are seen as expendable.

Recommendation:

That workplace policies that encourage continuation of breastfeeding for nurses be actively promoted and that particular consideration be given to the amenities required to facilitate this outcome.

Elder Care

Given the age profile of the nursing workforce the elder care needs of nurses needs particular attention. The "average nurse" (being around 40 years of age) often has double family responsibilities – child and elder care. We have dealt with childcare needs in some detail above. The area of elder care is however often overlooked. Those limited respite and other services that are available often fail to address the needs of shift workers. Research into the particular elder care needs of nurses and other shift workers needs to be conducted.

It is possible for shift work arrangements to be worked in such a manner that enables elder care to occur. But in reality what this means is that the nurse arranges/juggles her paid work to enable her to care for family (be this an elder or a child), in effect working two (or more) jobs.

Nurses with significant elder (or other family) care responsibilities are often under-employed and/or the work of very unsociable hours to enable the balancing of work and family responsibilities. This comes at a significant cost to the individual involved in this seemingly never-ending balancing act, a cost that is rarely appropriately acknowledged.

Recommendation:

That research be conducted into the elder care needs of nurses and other shift workers and workers of non-standard hours.

(v) strategies to improve occupational health and safety

Problem: There are a number of significant workplace health and safety issues that are affecting the recruitment and retention of nurses.

The workplace health and safety factors leading to the attrition in the nursing work force in Australia has to date not been accurately measured or recorded. The individual causes of workplace injury are generally known however the actual overall impact of each cause is not quantifiable. Because of this specific strategies or resources are not effectively being allocated to prevent or minimise the attrition of nurses because eof workplace health and safety issues.

We will highlight those issues that we believe significantly affects the health and safety of nurses and therefore impacts on the recruitment and retention of nurses. It is our belief that the health industry in general would benefit from a holistic and coordinated approach to health and safety and on that basis we believe an industry code of practice for health and safety in the health industry would be beneficial.

Recommendations:

That research into broad health and safety issues be provided. Such research should:

- Identify the affect of workplace health and safety factors on the attrition of nurses.
- Develop strategies to address the identified issues.
- Review the effect of the implemented strategies.

That funding be provided for a project to develop an Industry Code of practice for health and safety in the health industry to be overseen by a national committee.

Legislation

The relevant legislation covering occupational health and safety in this state is the *Workplace Health and Safety Act 1995*. As in other Australian states, this legislation is based on Roben's style legislation that encourages self-regulation at the workplace level. This is facilitated by obligations being placed upon the Employer, the worker and others in the workplace. Obligations are to be met by applying Risk Management Principles. Underlying these obligations are consultative arrangements at the state, industry and workplace level. Furthermore in Queensland employers with 30 or more employees are required to appoint an accredited Workplace health and safety officer. Regulations, Advisory Standards and Industry Codes of Practice underpin the Act.

The Workplace Health and Safety Division within the Department of Industrial Relations have responsibility for enforcement of this legislation.

Statistics

Significant problems exist in the keeping of health and safety statistics in the health industry. The only injury statistics available are those recorded via compensated claims through WorkCover. Based on our knowledge of the industry, we believe there is significant under reporting of injuries.

Various changes over time to the definitions of injury under WorkCover legislation have also affected the way in which injuries are reported and recorded. Furthermore the distinction that is made between record purpose only claims, medical expenses only claims and lost time claims has added to confusion and needs to be further explored.

Because of these problems reliance on statistics should be viewed with caution. It is our view that available statistics under-represent the current state of play in the health industry.

Issues requiring further consideration

Manual Tasks

Manual tasks include any activity where workers grasp, manipulate, carry, move (lift, lower, push, pull), hold or restrain a load or body part. In Queensland there are two Advisory Standards relating to this hazard:

1. Manual Tasks Advisory Standard 2000; and
2. Manual Tasks Involving the Handling of People Advisory Standard 2000

Manual Tasks can be broken into two main areas, manual tasks involving objects and those involving people. Nurses carry out both types of tasks in their daily working lives.

The manual handling of people continues to be the main cause of muscular stress injuries for nurses. Nurses are required to move people from floor to bed height, bed to chair, bed to trolley, chair to toilet, reposition them in bed, assist in mobility to name but a few of the types of manual tasks required. They are often forced to work in confined spaces that require awkward postures and the work is often repetitive. Weights of people vary from small babies weighing grams to obese people weighing over 250kg.Weights they are required to lift manually are in excess of acceptable weights in other industries.

At the 1997 QNU Annual Conference members of the QNU passed the following resolution:

This conference of QNU delegates calls on all health establishments in Queensland to implement a "No Lifting Policy" by the year 2000.

Furthermore we call on QNU to adopt the UK definition of a "no lifting policy": "That the manual lifting of patients is eliminated in all but exceptional or life threatening situations. Manual handling may only continue if it does not involve lifting most or all of a patient's weight."

We also call on QNU to develop a kit of information on implementing a "No lifting Policy" in order that members understand the concept and are empowered to raise the issue in the workplace or unit.

Based on anecdotal information we believe that approximately 90% of health care facilities in Queensland have implemented some form of a "No Lift Policy". We believe this has led to a decrease in the number and severity of back claims but not to the degree one would expect with a no lift system.

Implementing a "No Lift Policy" requires a broad approach. Issues that need to be addressed include:

- the purchase of equipment which depends on the availability of funding
- the design of buildings that allow for the utilisation of manual handling equipment eg ensuring correct width of doorways, shower and toilet areas etc
- purchasing equipment that is suitable and of appropriate quality
- ensuring there are sufficient staff to carry out the task in a safe manner
- ensuring that the equipment is easily accessible to staff
- providing sufficient training in "No Lift" systems of work

Other manual tasks required of nurses include the movement and repositioning beds and trolleys. Auditing of facilities indicates that there are very few programs within facilities ensuring regular maintenance of the wheels resulting in the need for increased force to be used by the person pushing the bed. Furthermore it must be remembered that the move to floor surfaces such as carpet means that increased force is required to move equipment around.

The level of injury to nurses resulting from manual handling tasks remains a source of concern to this union. In 1999-00, 495 registered nurses and 125 enrolled nurses were injured at work. Of these injuries 398 and 102 injuries respectively related to sprain strain injuries. (Based on unpublished QStats data.)

Manual Tasks are a major issue in the health sector and to effect any real change physical and financial resources are required. Issues requiring particular attention include the training of staff, ensuring that staffing numbers are adequate to ensure safe systems of work, the purchase of equipment, redesign of areas and design of buildings.

Recommendations:

That quarantined funding be allocated within government funding for health and aged care services for the purchase of equipment that will prevent or minimise injuries to nurses and other health workers (eg manual handling devices, retractable syringes, scalpel blade removers etc.)

That adequate funding be provided for the employment of sufficient staff to ensure work is carried out in a safe manner.

Violence against Nurses

Members report an increase in violence against them in the workplace and their tolerance of this is fast diminishing. They advise that people are increasingly presenting with an attitude of verbal abuse. In recent times there has also been an increase in the number physical assaults. This unacceptable behaviour is not always linked with alcohol or drugs abuse, however this is the major contributing factor in most instances.

There are no regulations or advisory standards relating to Violence in Queensland.

Violence includes the threat of violence as well as the actual act of violence.

Nurses have traditionally accepted that violence and aggression is a part of the job, this culture of passive acceptance is changing.

Members at the 2000 QNU Annual Conference put forth the following resolution

That this conference endorse a "Zero Tolerance to Violence by 2002" campaign and that a working party be set up to put together required resources to assist members in the formulation of appropriate policy development to occur in workplaces.

The QNU is currently preparing campaign material to assist members' action this campaign in the workplace.

Recent examples of violence towards nurses include:

- A male nurse received multiple fractures to his leg whilst attempting to restrain a violent patient. The police had escorted the patient to a mental health unit when in actual fact his symptoms related to drug abuse.

- A female experienced psychiatric nurse feared for her life when a visitor became verbally aggressive towards her and had to be escorted from the premises. Aged Care nurses advise they are regularly bitten, punched, pinched, kicked and verbally abused by residents. Furthermore they are increasingly being verbally abused and are receiving threats of violence from relatives.

- A pregnant Accident and Emergency Nurse was assisting a person with a dressing, when for no apparent reason he punched her in the stomach.

Our members report that such occurrences are becoming more regular. Members advise they no longer want their full name in direct observation of the public due to threats against their personal safety particularly in the psychiatric and emergency areas. In one instance a patient used the electoral rolls to track down nurse's addresses. Nurses are increasingly electing to have silent phone numbers to reduce the risk of violence.

Nurses are further placed at risk due to their shift times and the lack of easily accessible and safe car parking. Public transport is rarely an option due to hours of work, unexpected overtime and accessibility of reliable transport at required times. When many late and night shifts commence or finish after 10-12mn public transport is not available to nurses.

Very few facilities have effective policies and procedures in place to prevent or minimise violence against nurses or any health care staff. Security personnel are not readily available if employed at all. Officials of this union are struck by the obvious attention given to security at Corporate Office of Queensland Health compared too many health facilities. It is not uncommon for two or three security officers to be present at the front desk of Corporate Office and yet when visiting health facilities, where acts of violence occur on a regular basis, the security presence is not as visible.

Rural and remote nurses are more at risk because the supporting infrastructures such as police services are rarely available on a 24-hour basis. Quite often the nearest police officer on duty can be hundreds of kilometres away. In such instances the health facility is often the only "business" open in out of business hours and therefore becomes a target for activity. Some communities have a pattern of increased alcohol intake at certain times, which precipitates violence in the community. Those injured in such violent events usually present to the health facility for treatment and it is not uncommon for violence to continue at that venue. This often involves the use of weapons in various forms.

There is little awareness raising of these issues with nurses before they go to work in these areas. Sometimes they do not receive any training on cultural issues or procedures for dealing with violence prior to entering isolated communities so when this it occurs they are very vulnerable.

Design and location of facilities in some instance also compound personal safety issues. Examples of this include:

- An emergency unit's ambulance doors were on an automatic opener and could not be locked allowing the general public access to their acute area. In this instance equipment was left out in the open with the potential to be used as weapons against staff

- One hospital in Central Queensland had approximately 50 points of entry, with the door used as the main entrance opening on to the main highway.

- A new community health facility in a remote area was built in the middle of the tribal area used for dispute resolution.

As well as physical injuries such as fractures, sprain/strain injuries and bruising, psychological and psychiatric conditions can also result from one single incident or continuous exposure to violence.

It is difficult to identify the true extent and impact of violence in the working lives of nurses as many incidents that do not result in time off work are recorded in the patient's file and not recorded for WorkCover purposes.

It is quite clear that a campaign aimed at the general public is required to assist to decrease the incidence of violence towards nurses.

Recommendation:

That a public campaign to prevent violence against nurses be supported by government.

Psychological Injury/Stress

The current trend of injury in this area largely relates to unreasonable management action. However due to the ever-increasing pressures in relation to resources and financial constraints within the health industry we expect to see a changing pattern in the claims. We are increasingly seeing more nurses in management positions in receipt of WorkCover because of the undue stress associated with unrealistic expectations. Very few of these nurses are able to return to work as they tend to present late into their issues with symptomatology that requires long term management..

Staff from the Manual Tasks Project at the University of Queensland undertaking recent observations in the aged care sector reported that stress may present as a major issue in this sector. Particular areas of concern included shiftwork arrangements, staffing numbers and the requirement to meet standards with added responsibility and inadequate support.

Post-traumatic stress following a violent event is also a significant issue of concern to this union. Workplace bullying is also a course of concern. If not dealt with in an appropriate and timely manner post-traumatic stress and workplace bullying can both result in significant psychological damage.

The QNU has noted that there has also been an increase in nurses with psychiatric disorders being referred to the Queensland Nursing Council for Health Assessments or being in receipt of temporary disablement pensions under Q Super. Many of these people are eventually retired on the grounds of ill health. Return to work programs are difficult to devise for these nurses due to unresolved issues in the workplace, the nature of the medical advice, concerns by the employers regarding competence and the willingness of many employers to provide supervised practice or deployment to another area.

Although the data gathered on "stress claims" is problematic, it appears to us that there has been a recent increase in these types of claims. (As mentioned previously, the definition of injury excludes a lot of these matters as compensatable injuries.) Although in our view the available data "under-reports" what is occurring, data to hand indicates the following:

- Queensland Health as at January 2001 had received a total of 157 claims (all categories of workers) for the previous 12 months (based on Queensland Health WIMS data); and

- In the aged care sector claims (all categories of workers) have increased from 87 in 1997/98 to 141 as at 31/5 for 1999/00. (Based on unpublished WorkCover data.)

Recommendations:

That further research be conducted into significant sources of workplace stress for nurses and strategies to mitigate the impact of such stress.

That health managers be provided with training in change management and strategies to implement change in a manner that minimises stress to employees.

Shiftwork/Hours of Work/Fatigue

Shiftwork is a standard feature of most nurses working lives. The Health industry is a 24 hour a day, 7 day a week service, with nursing being the only significant constant in terms of staff present. Shifts are in the main assigned on an early/ morning shift, an afternoon/evening shift and a night shift rostering system. In recent times we have also seen an increase in flexible rostering practices, with short and longer shifts and late shifts working past midnight to cover busy times becoming standard features in some work units. Under current award arrangements nursing staff can be expected to work a maximum of 10 days straight and it is possible to be rostered only one day off following the ten day stint. Most full time staff would work between 6 to 8 consecutive days straight, in a combination of early, late and night shifts. A minimum 10-hour break is required under the award, however in some instances this can be and is reduced to eight hours.

Shift lengths are generally of eight hours duration, although it is possible to work shifts between four hours and ten hour's duration. Rostered shifts beyond 10 hours in length are not allowed under any state award, however a trial of a 12-hour shift roster is due to commence shortly at the Nambour Hospital ICU unit. (This has been done at the request of members in this facility and in full knowledge of the potential effects relating to fatigue.) In some theatre areas we are seeing changes in shift and rostering arrangements (particularly in relation to on-call and overtime) to cover busy periods.

Shift work research indicates the cumulative effect of fatigue and the impact on the body. In some instances it can aggravate other conditions such as diabetes, psychiatric disorders, epilepsy. The most common health problems have been gastro-intestinal complaints and sleep disorders. Furthermore we must recognise that the bodies circadian rhythms indicate that 12MN to 6 am are our regular sleeping times. Loss of this will lead to an accumulation of fatigue. Getting to bed after 12 and having a late start the next morning does not necessarily lead to being able to sleep given disturbances common because of normal family routines. An accumulation of fatigue can also lead to and exacerbate other injuries such as sprain strain injuries.

Health monitoring is a rare occurrence for continuous shiftworkers despite recommendations to do so. Another area of concern is the lack of Australian research into the medium and long term effects of shift working on women workers. The overwhelming majority of nurses are women and the vast majority of nurses work continuous shift work, yet there has been little attention has been paid to the effect that shift work has not only on the health and safety of nurses but also attrition within the profession. The lack of monitoring of the health impact and the incomplete general research on shiftwork and women are important deficits that need to be addressed.

There are currently no regulations or Advisory standards relating to hours of work. This union would also like to see a code of practice introduced for hours of work similar to that in the EEC. Given the obvious

health effects of shift work we believe the health industry should be leading by example and promoting the adoption of minimum standards relating to hours of work. However, it appears that the health and safety of employees does not receive the same attention as the health and safety of the general community.

Recommendations:

That a national code of practice for hours of work be developed.

That further research be conducted into the medium and long-term impact of shiftwork on women workers such as nurses.

Skin Penetration Injuries

Skin Penetration injuries are not uncommon in the health sector and usually result from needle stick injuries or cuts from scalpel blades. Such injuries put nurses and other health workers at risk of exposure to biological hazards such as HIV or Hepatitis. It is particularly stressful for those nurses awaiting test results following skin penetration injuries when the patient is known to be infected or in an at risk group. The QNU has assisted a number of members with WorkCover claims in this area.

Whilst facilities have protocols for dealing with such injuries these are usually resource intensive for the facility and are by nature reactive. In our view more emphasis must be placed on prevention. In the main such injuries can be prevented by the use of retractable syringes or scalpel blade removers. Once again this equipment is not utilised because of the cost of purchasing such equipment.

Recommendation:

That quarantined funding be allocated within government funding for health and aged care services for the purchase of equipment that will prevent or minimise injuries to nurses and other health workers (eg manual handling devices, retractable syringes, scalpel blade removers etc.)

Glutaraldehyde and other chemicals

Glutaraldehyde is a disinfectant used for cleaning fibre optic scopes eg endoscopes.

Side effects of Glutaraldehyde include skin and respiratory problems. However our members are reporting increased sensitivity to this substance, showing more systemic effects leading to increased sensitisation to other substances.

It is our experience in Queensland that there are very few fume cupboards available to staff for the use of Glutaraldehyde, most rely on a tub system leading to increased vapours and increased susceptibility to spills. Furthermore we have many reports of protective equipment not being available to staff and very limited training if any available on hazardous substances.

The trend towards working extended hours shifts in some areas are also a concern as the research in relation to exposure to chemicals (time-weighted averages for chemicals) are based on an 8-hour shift.

Once again there is little statistical data in this area and limited research due to the lack of experienced immunologists in Queensland with an interest in chemical sensitivity.

The ANF on a national level is calling for the eradication of Glutaraldehyde in all public and private facilities as there are other safer alternatives available.

Recommendations:

That the use of Glutaraldehyde be eradicated in all health and aged care facilities.

That funding be provided to enable further expertise to be developed in the area of chemical exposures. Further to this, that specific funding be allocated for research into time weight averages for chemical exposure given the trend towards the working of longer shifts.

Latex

Latex allergy has arisen largely due to the increased glove usage for infection control precautions. Latex is found in many health and health related products. Reactions to latex can include the following:

- Irritant Dermatitis
- Contact Dermatitis
- Immediate hypersensitivity leading to anaphylactic reactions

The manufacturing process for latex is complex and appears to have very few quality controls.

This is largely a new area of risk with legal cases still pending. Patients as well as nurses and other health workers are affected by exposure to latex.

There are no standards for latex gloves in Australia.

Recommendation:

That a national standard be developed for the quality of latex gloves.

Air Quality

Over the last two years we have had to deal with many issues relating to air quality. In facilities without air conditioning they are normally related to heat stress in the warmer months, or in air-conditioned premises it is related to inconsistencies or fluctuating temperatures.

For recent examples that highlight concerns about air quality and the use of chemicals are:

1. Staff members at a community health building were having physical reactions to an unknown chemical, causing a few to be permanently relocated. This resulted from adhesives used in the laying of new carpet and inadequate air conditioning.

2. A Central sterilising department moved into a new building two years ago with staff having intermittent physical reactions to an unknown substance. A number of whom are now permanently removed from the area. Despite multiple investigations the source of the irritant remains unknown.

3. An Intensive Care Unit had exceptionally high levels of Formaldehyde in part related to paper storage in the area and in part related to contamination of air from other areas of the hospital. Two registered nurses at level 3 of the career structure are currently unable to work.

4. Staff members at a Breast Screening Clinic continue to have physical reactions to an unknown substance at intermittent times.

Experts have investigated all of the above examples but none of them have been satisfactorily resolved. However it is clear that the air conditioning systems do not appear to be appropriate for their intended use. Once again design is a critical issue.

Appropriate investigation of such matters is hindered by the fact that there are very few experts in this area in Australia. This issue needs to be addressed via the provision of additional funding to promote expertise in this area.

Recommendation:

That particular attention be paid to the development of specific expertise in the area of resolution of air quality health and safety issues.

Amenities

In Queensland there are currently regulations and an advisory standard for Workplace Amenities. These are quite limited, defining locker areas, dining areas and seating requirements and toilets and work spaces.

Due to the hours that nurses work it is crucial that they have access to proper amenities. Although they are expected to work unsociable hours, nurses do not have easy access to meals outside "normal" working hours (on night duty for example). Quite often hospital canteens and dining rooms are not staffed at the meal break times of nurses. (Due to the nature of the work meal breaks are often not taken at regular times or emergencies often mean that meal breaks are delayed.

General research on shiftwork stresses the need for a proper diet. It is therefore crucial that nurses have access to kitchen facilities. They also need to remain hydrated (particularly in the hot summer months in Queensland) so should have easy access to cool water. Easily accessible (yet separate from public areas) staff toilets and other amenities such as showers are also a necessity, as are quiet and well equipped areas for nurses and other staff to take their breaks.

More and more we find that staff amenities are the first thing to be cut in the redevelopment or rebuilding of health facilities. A recent design for a new locked psychiatric ward for example, required staff and patients to utilise the same amenities. The basic needs of staff yet again are often overlooked.

Recommendation:

That the current legislative requirements for basic minimum amenities be reviewed and amended as necessary so that the particular minimum requirements of nurses and other shift workers are adequately addressed. Further to this, that these minimum standards be incorporated into the design of all health facilities.

Facility Design

Although Architects are guided by the building code of Australia when designing facilities, this code does not necessarily reflect health and safety requirements. Short comings aside, the regulations governing amenities and advisory standard are also of relevance.

A recent example highlights our concern about basic requirements not being catered for in facility design. The design for a new facility was supposed to incorporate overhead tracking in patient rooms for manual handling equipment. For some reason this was not incorporated into the final design and the result was bedrooms that were not large enough to incorporate the use of manual handling equipment. In this same facility toilets were secured too close to the walls which meant that toilet chairs to be utilised. There was also insufficient room allowed in the toilet for a staff member to be beside the patient if support were

needed. Furthermore, all floor surfaces had been carpeted and all patient transport is to occur in the patient's bed. Tests have indicated that the force required to move the beds would require excessive force and lead to injuries of staff. The facility is now required to purchase electric bed movers.

The design of triage (assessment) areas in the emergency departments in new or redeveloped facilities are another area of concern constantly raised by our members.. When concerns are finally investigated most triage have required redesign.

It is astounding that such problems continue to arise in new and redeveloped facilities. If they are not corrected in the planning phase the problems remain for the life of that facility. There is enough research, information and knowledge available to design a health facility that will prevent known risks and yet in our opinion many are still being built to below standard.

We believe that best practice design of health facilities need to be promoted and that guidelines for design of health facilities are required.

Recommendation:

That best practice guidelines be developed and promoted for the design of health and aged care facilities.

Resources Issues

It is our belief that workplace health and safety will not improve significantly in this industry until specific and dedicated resources are made available to do so. Improvements in health and safety require a commitment from both management and staff and the provision of adequate resources is central to this commitment.

Financial resources are required for the purchase of equipment that would prevent injuries and to put in place safe systems of work.

Recommendation:

That quarantined funding be allocated within government funding for health and aged care services for the purchase of equipment that will prevent or minimise injuries to nurses and other health workers (eg manual handling devices, retractable syringes, scalpel blade removers etc.)

Recruitment Retention Issues

The provision of safe systems of work certainly assists the recruitment and retention of nurses. For example, nurses working at a facility where a full no lift system is in place have advised us they will not work at another workplace without such a system. The right to walk out of the workplace in the same condition you walked in is now a demand of our members.

The true loss of nurses to injury each year is hard to determine however a number of factors should be taken into consideration. Any analysis should include the number of nurses employed in the public sector who are being retired on "ill health" grounds, those nurses attending WorkCover assessment Tribunal hearings, those in receipt of a Notice of Assessment for impairment as well as those in receipt of benefits under superannuation fund entitlements and government pensions. (Unfortunately it is difficult to obtain nursing specific statistics on these scenarios.)

Return to Work programs or rehabilitation of nurses is a major issue for those who have been off work for any substantial period of time and have any residual form of restriction/impairment. It is not our experience to find a facility where task analysis has been done for nursing positions. In our experience most employers are reluctant to make even basic "reasonable adjustment" changes to the workplace to

facilitate return to work. Retraining is also quite uncommon, despite the fact that nurses have readily transferable skills that should be able to be utilised away from the direct patient care area. It still appears to be a commonly held view that "once a nurse damages her back she is on the "scrap heap", unwanted by the health system. Her rehabilitation is in the "too hard" basket. It is still common for the union to have to intervene in such cases. Employers all too often seem pre-occupied justifying why the injured worker cannot return to their work area rather than how they can be accommodated in that area (with some assistance) or elsewhere in the facility. This is particularly the case in instances of back, shoulder and stress claims.

WorkCover recently commissioned research into their claims, with particular emphasis on the area of common law claims. This review identified that only 40% of workers still off work at the 16-week mark still have a job to go back to. This unfortunately applies to many nurses, despite industrial relations laws that prohibit the dismissal of an injured worker within the first 6 months of injury.

We believe there is the need for research into the area of task analysis for nurses with a view to allowing injured nurses to return to meaningful work. Furthermore there is the need for promotion of successful return to work case studies of permanently injured or impaired nurses.

Recommendations:

That a broad task analysis for nursing be undertaken to identify possible changes in work practices that would facilitate the return to work of injured nurses. .

That best practice principles for rehabilitation and return to work programs for nurses be developed and promoted.

Training

The workplace health and safety training of workers varies from facility to facility. Some receive as little as 2 hours training while others receive 16 hours training. Where such training is available it is often not possible for nurses and other health workers to be released from their work areas to attend due to staff shortages or other workload pressures. This training is often not made available at times to suite shift workers or part-time employees. Many nurses are often required to attend such training in their own time and are often not adequately compensated for doing so.

The amount, content and level of training in Occupational Health and Safety is inconsistent within nursing and in the health sector generally. We believe that there is a need for minimum competencies to be developed for occupational health and safety training.

Recommendation:

That a national standard be established for the amount, content and structure of Occupational Health and Safety training within the health and aged care sectors and that sufficient funding be provided by government to ensure that such training can be provided.

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