Submission

No 29

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation: Nurses' Association NSW

Name: Mr Brett Holmes

Position: General Secretary

NEW SOUTH WALES NURSES' ASSOCIATION
In association with the Australian Nursing Federation

ABN 63 398 164 405

In reply please quote: BH:ABU

9 November 2007

The Rev Hon Fred Nile MLC
Joint Select Committee on the Royal North Shore Hospital
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Reverend Nile,

Inquiry into the Royal North Shore Hospital

Please find attached a submission on behalf of the New South Wales Nurses' Association (NSWNA).

We appreciate the opportunity to provide our views. If you have any questions or require any clarification of the information we have provided please do not hesitate to contact me.

Yours sincerely

Brett Holmes

BRETT HOLMES
General Secretary

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Submission to

The Joint Select Committee Inquiry into *Royal North Shore Hospital*

New South Wales Nurses' Association
November 2007

Introduction

The New South Wales Nurses' Association (NSWNA) is the industrial and professional body that represents over 51,000 nurses in New South Wales. The membership of the NSWNA comprises all those who perform nursing work, including assistants in nursing (who are unregulated), enrolled nurses and registered nurses at all levels including management and education. The members of the NSWNA are also members of the Australian Nursing Federation (ANF), a federally registered industrial organisation, and form the NSW Branch of the ANF.

As such, the NSWNA has considerable interest in ensuring the existence and promotion of an efficient and effective health system in NSW. We have particular interest in contributing to the development of working environments in this system which enable nurses, and other health workers and clinicians, to deliver the best possible health care to the community while being provided with satisfying professional opportunities.

Unsurprisingly, whether these outcomes are achieved is significantly affected by the way in which health services are organised and health care is delivered. The effectiveness of the management and organisational structures underpinning these services and their facilities not only impacts substantially on the capacity of nurses, and other clinicians, to perform their jobs and to enjoy their jobs but can also determine the quality of the care that is able to be provided by clinicians.

It is therefore logical to conclude that governments and their departments would seek to ensure that organisational structures and management systems which facilitate the delivery of quality health care by clinicians are firmly in place. It is also logical to expect that when governments and their departments decide to implement organisational redesign in the pursuit of financial savings, particularly if this involves significant changes to the structures which underpin nursing operations, they should first determine the impacts such reforms may have on the quality of care delivery.

The recent restructure of health administration in NSW has been one such attempt to achieve financial savings through organisational redesign. However, the NSWNA does not believe that the impacts of this plan, on both care delivery and clinicians, were fully investigated and considered by the Department of Health and the Area Health Services prior to its implementation.

Rather than achieving its intended goal of improved resources for frontline clinicians, and thereby improving the quality of health care, the restructure has not only distracted clinicians from their primary purpose as they accommodate and incorporate required workplace changes but, in some cases, has exacerbated the factors which impede the capacity of clinicians to deliver quality care.

Clearly, responsible fiscal management of its various departments should be a key priority for any government. While, it is therefore appropriate for the NSW Government to attempt to contain escalating health expenditure, particularly in the

context of an ageing population, and increasing community expectations and demand for health services, the first priority for the health system, and all of its organisations, should be the delivery of optimum health care to the community.

However, the cost-control imperatives of the governments and bureaucracies responsible for health care delivery in NSW and those behind the restructure are creating an environment which inhibits rather than promotes the delivery of quality health care.

The current cost-containment environment of NSW's public health system and the variable models of resource allocation across the state place ever-increasing pressures on clinicians to do more with less. We frequently receive reports from our members regarding the intense frustrations they experience in their working environments which effectively paralyse the efforts they make in delivering quality care.

This issue is not new. Research commissioned by the NSWNA in 2002 to examine the factors that motivate nurses to leave the public hospital system in NSW provided clear evidence that it is exactly these frustrations that precipitate their exodus from the workforce[1]. We do believe however, that it has been intensified by the processes of the recent restructure.

The impacts of these processes have been experienced by our members across the state but most acutely, we believe, by those working in the Northern Sydney Central Coast Area Health Service (NSCCAHS). The particular approach adopted by the NSCCAHS Executive to implementing the reforms of the restructure has resulted in serious difficulties for nurses working in the Area, particularly at Royal North Shore Hospital (RNSH). Changes to management structures in the Area, coupled with the budgetary restrictions imposed by the Area Executive, have undermined nursing practice and the nursing career structure in the Area and, ultimately, the capacity of nurses to deliver quality care.

The remainder of this submission will outline exactly how the implementation of the restructure in NSCCAHS has affected nurses and their practice, specifically those working at RNSH, including the impact of changes to clinical management systems and clinical staffing and organisation structures at the hospital on nurses as well as the effectiveness of the operational management of RNSH and NSCCAHS.

Background

In 2004, the NSW Government announced its intention to restructure health administration in NSW. This decision was made both in recognition of the need to prepare the state's health system to meet the health care challenges of the future and in response to the recommendations of the Independent Pricing and Regulatory Tribunal's (IPART) 2003 review of NSW Health.

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[1] Australian Centre for Industrial Relations Research and Training (ACIRRT), 2002, *'Stop telling us to cope' NSW Nurses explain why they are leaving the profession*, University of Sydney.

The planned restructure of health administration in NSW was in particular response to the IPART review's recommendation to streamline the administration structure of the health system and to rationalise and clarify the roles and responsibilities of the Department of Health and the Area Health Services. The Department also argued that the restructure would address the review's recommendation to strengthen accountabilities in the health system and increase community and clinician involvement in health service decision-making[2].

The Department advised that the key features of the restructure would be the amalgamation of the existing 17 Area Health Services into eight larger areas and the establishment of a new system of health advisory councils, which would increase clinicians' involvement in setting future directions for the NSW Health system. Appropriate legislation would be introduced to support the establishment of these reforms.

The key benefits of the restructure, the Department argued, would be an estimated redirection of $100 million per year to frontline health services and a greater say for clinicians and the community in health planning and decision-making thereby resulting in improvements to direct patient care.

The increased funding for frontline services would be gained from changes to administrative services and the introduction of new arrangements for corporate and business services. These changes, which would result in a reduction of administrative positions, would also result in significant enhancements to direct patient care, while creating expanded employment opportunities for clinical staff. This, the Department claimed, would give doctors, nurses and allied health workers a greater say in the planning and delivery of health services[3].

The Department developed guidelines for administrators which outlined a framework for governance arrangements and management structures for the new Areas and stipulated which elements of the new arrangements would have to be developed in accordance with the framework. The Department reasoned that the framework would ensure consistency and equity between Areas while being flexible enough to accommodate differences between Areas in the scope and distribution of clinical services.

The framework also outlined minimum requirements for: the recruitment and placement of staff; strategies for the redirection of funds; communication with staff regarding the restructure and its effects; and, processes for industrial consultation. The Department advised that the reforms required to restructure the health system would be implemented in consultation with health service unions. Timeframes were then established for the Areas to develop their plans and implement the reforms of the restructure.

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[2] NSW Health, July 2004, *Planning Better Health – Background Information*, available online at: http://www.health.nsw.gov.au/pubs/2004/pdf/pbh_booklet.pdf

[3] NSW Health, 2004, *Planning Better Health – Restructure of Health Administration – Q & A*, Available online at: http://www.health.nsw.gov.au/pbh/bground/restruct.html

NSWNA's response

NSWNA's initial response to the planned restructure of NSW Health's administration was one of caution; in July 2004, we welcomed any actions that would increase the provision of resources to front-line service delivery but cautioned against reforms that would see the removal of critical support services for clinical environments.

It should be noted that we were not and are not opposed to reform or organisational redesign and development; clearly, nurses and other health professionals must adapt, evolve and progress in order to respond to health care developments and meet the future health needs of the community. However, we were, and continue to be, opposed to any reforms which result in the degradation of effective and meaningful nursing management structures and remove the critical support services required for effective operation of clinical environments. Any reform with these effects will not result in improved health outcomes for the community.

It is simply unrealistic to expect that nurses and other front-line clinicians can deliver quality care in a managerial or support vacuum.

However, detailed analysis of the NSCCAHS's plan for implementation of the restructure revealed that it proposed the removal of these critical features. NSWNA therefore engaged in an ongoing series of consultations and negotiations with NSCCAHS, as well as the Department and other new Areas, to insist upon the maintenance of vital support services and the organisational and nursing management structures that would preserve reasonable working environments for our members and enable them, and other clinicians, to deliver quality care.

Clinical management systems at RNSH

In 2005, NSCCAHS Area Executive reviewed clinical and management structures within NSCCAHS and recommended a new structure which they argued would *align clinical decision-making and budget accountability inside a framework focused on patient care and service delivery*[4]. The proposed new structure would comprise a new Divisional Management Structure[5] intended to enhance multidisciplinary team work, improve clinical input to decision–making and establish new management and clinical roles based on patients' needs and internationally recognised principles of health care management rather than preservation of 'management silos'.

Within this structure, the Area Executive proposed a more 'professional' role for nursing management. This would involve the development of substantially new roles for nurse managers with a *change in focus away from the management of budgets and staff to a focus on professional leadership, the development of nursing and nurses, quality, nursing standards of clinical practice, models of care and patient*

[4] The information in this and following sections is derived from correspondence between NSWNA and NSCCAHS Executive and records of consultations between NSWNA and our members and NSCCAHS during 2005 – 2006.

[5] The Divisional Management Structure refers to the team of Executive Managers e.g. General Manager, Clinical Director, Nurse Manager etc and their reporting lines and interactions for a particular clinical field, e.g. Surgical, Medical, Women's and Children's, across all sites in the Area.

flow. Generic managers, supported by part-time Clinical Directors, were to assume full responsibility for the operational and financial management of clinical services.

We do not doubt that the NSCCAHS Area Executive was genuine in its intent to implement a revolutionary management system that would transform the operation of clinical services within the Area and, they hoped, improve care delivery. However, the decision to consign nursing management across the Area to a professional and advisory capacity, rather than genuinely operational, was at best naïve and at worst irresponsible.

In fact, NSWNA believed this proposal to be incomprehensible.

It was perhaps driven by the current mantra, popular with those advocating health workforce redesign, of the need to dismantle professional boundaries.[6,7] This appears to be a preoccupation of bureaucratic managers despite the fact that there is little clear evidence to suggest how this strategy will lead to improved patient outcomes or increased efficiency in service delivery. As stated above, we are not suggesting that there is no place for organisational and role redesign in the health system. What we are suggesting, unequivocally, is that removing operational control from nurse managers while still expecting them to oversee clinical aspects of operations such as patient flow and the development of nursing will not achieve improved service delivery.

There is a volume of international experience which indicates that the introduction of generic managers and 'jack-of-all-trades' frontline workers at the expense of suitably qualified health professionals is an inappropriate strategy for health care delivery; it leads to increased attrition rates of nurses and other health professionals and reduced patient outcomes thereby increasing costs and reducing efficiency.[8,9,10]

This evidence is supported by local research, commissioned by NSW Health and recently released by the University of Technology Sydney (UTS), which investigated the relationship between nursing workload and skill mix and patient outcomes in order to inform future policy development on nursing workforce issues[11]. This research concluded that where nurses feel they have control over their work, are supported by leadership and colleagues, and where patient outcomes are not negatively affected, wards function well. The research makes the critical point that:

> *Understanding the nursing infrastructure is much more complicated than counting nurses or their hours, their qualifications, shifts, or job preferences. It is the interaction among these variables in the process of care delivery that influences numbers and types of nurses required and related outcomes. Understanding the work environment is critical, including the composition of and relationship between team members. The importance of nursing*

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[6] Independent Pricing and Regulatory Tribunal of NSW, August 2003, NSW Health Focusing on Patient Care, Sydney.
[7] Duckett, S.J., 2005, Health workforce redesign for the 21st century, Australian Health Review, May, Vol 29, No2.
[8] Aiken, L. et al., 2001, Cause for concern: nurses' reports of hospital care in five countries, *Leonard Davis Institute of Health Economics – Issue Brief*, Vol 6, No 8.
[9] University of Otago, 2002, Hospital survey show a third of nurses intend to quit, *Media Release*, University of Otago, New Zealand
[10] McCloskey, B. et al, 2005, Effects of New Zealand's health reengineering on nursing and patient outcomes, *Medical Care*, Vol 43, No 11.
[11] New South Wales Dept of Health, 2007, *Glueing it together: Nurses, their work environment and patient safety*, Sydney, NSW, UTS, Sydney.

leadership at the ward level to job satisfaction, satisfaction with nursing and intention to leave, which ultimately impact on patient safety, cannot be overstated[12].

The pivotal point is that *understanding the work environment is critical.* Nurses will not stay working in environments where they feel unsupported, where they are managed by people who lack clinical judgement and experience, or where they know the nurse manager has only nominal rather than full authority, i.e. budgetary and operational control.

However, this is precisely the situation that currently exists at RNSH. Within the hospital's Divisional Management Structures, there are Divisional Nurse Managers, who are responsible for certain clinical operations within their Division but who act largely in a professional and advisory capacity. This means that despite the fact that they possess the most accurate clinical information and understand the appropriate actions that should occur in response to this information the Divisional Nurse Managers do not have the authority to ensure that these actions are implemented[13].

For example, Divisional Nurse Managers (DNMs) are expected to manage vital issues such as patient throughput and bed availability but have no direct control over the funds required for extra staff and beds. Based on clinical advice obtained from the Nurse Unit Managers (NUMs), the DNMs advise the Divisional Executive regarding the possible numbers of discharges that can safely occur. However, in some instances, driven by budgetary imperatives and pressure to ensure there is sufficient capacity to meet demand,[14] non-nursing Divisional Managers do not act appropriately on the advice provided by nurse managers. Subsequent pressure may then be placed on NUMs to either discharge patients early or accept admissions that, in reality, cannot be safely accommodated by the ward at that time, as sufficient staff have not been provided.

Thus, with senior nursing management effectively 'sidelined', generic managers and doctors may demand more of nurses without providing them with sufficient staff and resources to do their jobs properly and safely. This leads to a state where nurses are attempting to deliver patient care in less than optimum, and occasionally unacceptable, situations. A particularly distressing feature of this situation for our members is when the standards of nursing care, and at times the standards of nursing education, are criticised by those without an appreciation of the factors which are genuinely responsible for the negative consequences of these situations.

The circumstance described above is just one in a litany of examples illustrating the consequences of removing operational control from senior nursing management structures (please see further examples included in the appendix of this submission). As demonstrated by these examples, the importance of effective and meaningful

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[12] New South Wales Dept of Health, 2007, *Glueing it together: Nurses, their work environment and patient safety*, Sydney, NSW, UTS, Sydney. pp. 151-152

[13] This information has been obtained from direct consultations with NSWNA members during the period 2005-2007.

[14] This refers to the mechanism understood as 'patient flow' where sufficient discharges from wards must occur to allow them to accept enough admissions from the emergency department to ensure it stays open, i.e. is not full.

nursing management structures to the operation of nursing resources and retention of nurses cannot be overstated.

As is evident from events at RNSH, the effect on nurses when these senior nursing structures are removed or disempowered is profound. Increased responsibilities are transferred to Nurse Unit Managers, compounding their frequently overwhelming workloads, who in turn, while struggling to cope with the extra demand on their wards, demand more of their staff. Overtime use increases, nurses feel overburdened, over-worked and frustrated at the level of care they are able to provide to their patients. Understandably, many leave, further exacerbating the problems within the hospital. *(Our RNSH members have reported that 3,000 hours of overtime, i.e. equivalent to 22 full-time positions, were required in just one month. The hospital currently has 100 nursing vacancies.)*

Predictably, NSWNA is fully aware of the importance of strong nursing leadership for the nursing workforce (an issue we raised repeatedly with NSCCAHS during negotiations regarding the restructure) not just from the evidence outlined above, but from other Areas where strong nursing management structures exist. In these instances, there tends to be greater job satisfaction levels among nurses and significantly lower numbers of nursing vacancies.

Recommended strategies to resolve these issues:

- The 'disconnect' between operational and professional accountability and responsibility at the divisional management level must be removed.

- The disempowerment of senior nursing management structures must be addressed as a matter of urgency with full operational control returned to the Divisional Nurse Managers in NSCCAHS, this includes the reinvestment of the authority to implement action in response to clinical advice.

- Appropriate communication structures between the Divisional Executive, which must include Divisional Nurse Managers, and Nursing Unit Managers must be implemented.

Clinical staffing and organisation structures at RNSH

The discussion above has outlined some of the impacts of the current management and organisational structures on nurse staffing at RNSH, including the effects of the increased demand on nursing services such as increased use of overtime and the large number of current vacancies. Our members report that in addition to these contributory issues, budgetary restraints and pressure to meet required benchmarks frequently result in wards operating short staffed, this often means working with at least one nursing position absent. Obviously, this increases the workload for those nurses who are present and jeopardises their capacity to deliver quality care.

These staffing crises are intensified by a lack of timely and appropriate communication between ward staff and management. The Nurse Unit Manager may advise that, in such situations as those described above, bed closures are required to ensure patient safety. However, our members report that NUMs are frequently unable to communicate this information to the Executive Managers able to act on this advice, as channels facilitating this communication do not exist. Further, although NUMs have regular contact with the Divisional Nurse Managers, who appreciate the significance of these issues for patient safety, they are unable to act on this advice for the reasons explained in the previous section of this submission.

Therefore, in some circumstances ensuring patient safety is dependent on the experience and, frankly, the strength of the Nurse Unit Manager to be able to insist on appropriate action without Executive managerial support.

Our members report similar staffing difficulties in the medical workforce, particularly among senior and experienced clinicians, resulting in further difficulties in appropriate clinical management of patients within the hospital and subsequent impacts on the capacity of both doctors and nurses to deliver quality care.

However, one of the most critical staffing issues is the lack of ancillary and administrative staff to provide support to the clinical operations of the hospital. The promised increases in funding for frontline services that the restructure would deliver as a result of changes to administrative services and the introduction of new arrangements for corporate and business services have not materialised. The reduction of administrative positions has impeded rather than enhanced the delivery of quality care. The ensuing 'expanded employment opportunities for clinical staff' have appeared only in the form of unacceptably burdensome workloads.

When ward clerks are absent it is nurses who assume the duties of the administrative operation of the ward; when pharmacy is short staffed it is nurses who assume the duties of ensuring the ward has appropriate pharmacy cover; when ward support staff are absent it is nurses who assume the duties of delivering pathology specimens, escorting patients between departments, chasing missing equipment and endeavouring to ensure that all patients have not only received a meal but have received the correct meal.

The impact of an inadequate supply of support staff within the hospital is clearly self-evident; not only does this critical shortage substantially increase the workload of nurses, it also distracts them from their primary purpose of delivering quality nursing care to their patients.

These effects have been compounded by the removal of positions from the Human Resources department within the Area, which occurred as a requirement of the implementation of the restructure. This has resulted in the elimination of a sector of staff that was not only knowledgeable, skilled and experienced in recruitment and selection processes for health care services but was also in possession of an expert understanding of the unique requirements of people management in the health sector. This included an appreciation of the particular skills and training needs of

health workers and a depth of corporate knowledge of the health system, for example, appropriate management of grievance procedures, disciplinary proceedings and other performance issues.

The loss of this expertise has resulted in significant consequences for Nurse Unit Managers who have been required to assume many of these duties for their wards. This is in addition to the clinical management of frequently understaffed wards, including rostering, managing sick leave and other absenteeism as well as overseeing administrative operation of the ward while trying to ensure the delivery of safe, quality care to all patients within their responsibility.

It is difficult to comprehend how NUMs will endure these pressures; this situation is clearly unsustainable. Yet, the NUM is perhaps the most pivotal component for clinical operations and care in any hospital. As stated earlier, "the importance of nursing leadership at the ward level to job satisfaction, satisfaction with nursing and intention to leave, which ultimately impact on patient safety, cannot be overstated"[15].

Recommended strategies to resolve these issues:

- Adequate funding must be provided and appropriately allocated by RNSH and the Area Executive to ensure that nurse staffing levels are sufficient to meet the service demands of the hospitals, this refers to both the numbers and types of nurses that are available.

- Adequate funding must be provided and appropriately allocated by RNSH and the Area Executive to ensure that there is a sufficient supply of appropriate staff to support and enable effective clinical operations within the hospital.

- Management must facilitate the effective functioning of the Reasonable Workloads Committee at RNSH. This is a component of Clause 53 of the Public Health System Nurses' and Midwives'(State) Award, the Reasonable Workloads Clause, which provides a mechanism for nurses to control their working environments by determining a reasonable and safe level of work. The committees, which must comprise appropriate personnel, i.e. those with the right skills, knowledge and authority and management support, provide a forum for consultation on reasonable workloads for nurses and a means to provide advice on workloads to management. Timely implementation of the recommendations of Workloads Committees is critical.

[15] New South Wales Dept of Health, 2007, *Glueing it together: Nurses, their work environment and patient safety*, Sydney, NSW, UTS, Sydney. p. 152

Efficiency, effectiveness and appropriateness of resource allocation and utilisation within RNSH

While NSWNA is not in a position to provide extensive comment on this issue, we can advise of the effects of inappropriate resource allocation and cost-cutting measures on nurses and nursing care. We appreciate that Area Health Services and hospitals are under pressure to meet constantly increasing demand for their services within ever tightening budgetary constraints. However, the strategy of attempting to contain costs by reducing or controlling nursing numbers, while possibly appealing to managers, is inherently flawed as there is no clear evidence to suggest that such a strategy will result in effective reduction in costs or improved delivery of care. Yet, the management at RNSH chose this option.

In February 2006, NSWNA members at RNSH took industrial action, in the form of a public rally, to protest against the restrictions being placed on nursing services by management in an attempt to negate the effects of a reported $20 million budget over-run (please see the details of the specific measures that were implemented by the management of RNSH included in the appendix of this submission). Nursing services were significantly curtailed without any coincident reduction in service levels. This resulted in an increase in nursing workloads which were unsafe for both patients and nurses. Nurses simply could not continue to provide care under these conditions.

NSWNA publicly advised the Department to fund the services at RNSH properly to match actual patient demand or reduce patient flow to a level that could be safely cared for by the number of nurses available.

NSWNA sought to resolve this issue with our members by accessing all avenues available to us: negotiating with Executive Management of the hospital, the Area and the Department; ensuring the importance of this issue was made known to the media and the community; and, ultimately engaging in industrial action.

Yet, NUMs at RNSH report that they are still experiencing difficulties in managing their allocated resources. Although NUMs are capable financial managers, our members report that because of the pressures outlined above which have necessitated an unreasonable use of overtime, many wards are frequently over budget. Therefore a more appropriate allocation of resources is required to remove these pressures by implementing genuine solutions, and minimise the use of unnecessarily costly strategies such as extensive use of overtime.

However, responsibility for and the capacity to resolve these budgetary problems ultimately rests with the Executive Management of the hospital, the Area and the Department.

Effectiveness of complaints handling and incident management at RNSH

While it is reasonable to suspect that the current difficult conditions of the clinical environment at RNSH may contribute to the occurrence of clinical incidents at the

hospital, as the layers of clinical support, supervision and management have been substantially depleted; there is no evidence to support this proposition. Although our members have requested this data from the Area and hospital management they have been unable to obtain this information.

Expansive comment on this issue by NSWNA would therefore be inappropriate, except to acknowledge that RNSH, NSCCAHS and NSW Health all possess robust mechanisms and systems to deal with these matters internally and to explain that NSWNA provides extensive advice and assistance with any of these matters whenever requests are received from our members.

However, we would like to add that we have some concerns that the advice we have been called upon to provide to our members at RNSH regarding claims of bullying and harassment at the hospital may not be an accurate reflection of the situation at the hospital.

Following the recent release of the *Review of workplace culture and allegations of bullying and harassment at Royal North Shore Hospital*, which investigated the extent of bullying and harassment at RNSH and the effectiveness of RNSH management in dealing with these issues, we examined our records to review the extent of NSWNA's involvement in cases of bullying and harassment at RNSH. This review revealed that NSWNA had assisted 23 members in such matters from 2005 to 2007. Yet, the report suggested the presence of a much wider, ingrained culture of bullying and harassment at the hospital.

We therefore suspect that our members have been reluctant to bring these issues to us perhaps because of fear of retribution from management but possibly also because of a general antipathy to union involvement in local issues from management. This suspicion is supported by the report's conclusion that complaints of bullying and harassment have not been considered seriously by RNSH management and that management needs to work supportively with staff to erode the dysfunction that is exacerbated by unnecessary levels of intimidation, not just within nursing, but across the hospital.

NSNWA welcomes the review's decision to address the issue of bullying and harassment at the hospital and supports the recommendations of the report. NSWNA also calls on the NSW Government to make inappropriate target of any employee involved in legitimate and lawful union activity an act of official misconduct.

Operational management at RNSH

This issue has been covered in the discussions above and therefore will not be reiterated here.

Strategies for improving quality of care

NSWNA acknowledges the commitment of the new Chief Executive of NSCCAHS and the Director-General of the Department of Health to review the management structures within the hospital and the Area to improve conditions for both patients and clinicians. We also acknowledge the measures that have been taken to make restorations to nursing management structures in the hospital and the Area. However, these measures are not sufficient to resolve the key issues underlying the problems we have outlined in this submission; we believe that full resolution of these problems will only be achieved following implementation of strategies outlined below.

Strategies specific to NSCCAHS

Clinical management systems at RNSH

- The 'disconnect' between operational and professional accountability and responsibility at the divisional management level must be removed.

- The disempowerment of senior nursing management structures must be addressed as a matter of urgency with full operational control returned to the Divisional Nurse Managers in NSCCAHS, this includes the reinvestment of the authority to implement action in response to clinical advice.

- Appropriate communication structures between the Divisional Executive, which must include Divisional Nurse Managers, and Nursing Unit Managers must be implemented.

Clinical staffing and organisation structures at RNSH

- Adequate funding must be provided and appropriately allocated by RNSH and the Area Executive to ensure that nurse staffing levels are sufficient to meet the service demands of the hospitals, this refers to both the numbers and types of nurses that are available.

- Adequate funding must be provided and appropriately allocated by RNSH and the Area Executive to ensure that there is a sufficient supply of appropriate staff to support and enable effective clinical operations within the hospital.

- Management must facilitate the effective functioning of the Reasonable Workloads Committee at RNSH. This is a component of Clause 53 of the Public Health System Nurses' and Midwives'(State) Award, the Reasonable Workloads Clause, which provides a mechanism for nurses to control their working environments by determining a reasonable and safe level of work. The committees, which must comprise appropriate personnel, i.e. those with the right skills, knowledge and authority and management support, provide a forum for consultation on reasonable

workloads for nurses and a means to provide advice on workloads to management. Timely implementation of the recommendations of Workloads Committees is critical.

Effectiveness of complaints handling and incident management at RNSH

- RNSH and NSCCAHS management must implement the recommendations of the *Review of workplace culture and allegations of bullying and harassment at Royal North Shore Hospital* report.

State-wide strategies

- The Director-General of the Department of Health should review the outcomes of the restructure of NSW health administration to ensure that is has been effectively implemented across the state without any negative consequences for clinicians or patients and that there is appropriate operation of clinical management systems across Areas.

- The Department of Health and the NSW Government must analyse the findings of the *Glueing it together: Nurses, their work environment and patient safety,* and ensure appropriate outcomes are implemented.

- The Department of Health and the NSW Government must ensure sufficient funding is provided to Area Health Services to enable effective operations of their facilities and ensure the delivery of quality care to patients.

- NSWNA also calls on the NSW Government to make inappropriate targeting of any employee involved in legitimate and lawful union activity an act of official misconduct.

Conclusion

This submission has outlined the issues and factors that NSWNA and our members understand to have been critical contributors to the difficulties that have been reported at RNSH.

Clearly, the nursing vacancy rate at RNSH is unacceptable. The supply of qualified nurses is not meeting demand, and the inappropriate and unresponsive management structures of RNSH, which impede nurses' ability to deliver quality care to their patients, result in a continuous flow of nurses from the system.

We know that nurses are attracted to and remain in nursing because of the intrinsic rewards gained from undertaking caring work in a professional manner, simply stated, from making a difference to the lives of their patients. While this alone is insufficient to ensure that nurses remain in the workforce - nurses expect remuneration levels and working conditions which recognise and value their

contributions to patient care and the health of the community - it is a significant factor for our members.

However, the pressures that have been detailed in this discussion have reduced the ability of nurses to obtain these rewards and diminished their capacity to deliver what they consider to be appropriate levels of care.

Nurses will not stay working in these conditions unless they can be assured of safe working environments where they are able to deliver the levels of care they believe best for their patients. Unless structures, which support the effective management of an appropriate level of care devliery, are established and maintained, the capacity of clinicians to deliver quality care will continue to be compromised.

Appendix

NSW Nurses' Association

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Budget Pressure Hits Royal North Shore Hospital

Type: Media Releases Subject: Public Hospitals

14 February 2006

Nurses feel the pinch as recruitment and resources are restricted

Special meeting tomorrow to consider industrial action

NSW Nurses Association (NSWNA) members at Sydney's Royal North Shore Hospital will hold an extraordinary branch meeting tomorrow (14 February) to consider industrial action over the restrictions being placed on nursing services because of general budget pressures at the hospital.

RNSH NSWNA branch meeting details

Date: Tuesday, 14 February 2006

Time: 1.00pm

Venue: Gore Hill Oval (adjacent to the Pacific Highway, St Leonards)

Speaker: NSWNA General Secretary, Brett Holmes

The nurses are angry that, because of a reported $20 million budget over-run at the hospital that is not of their making, nursing services are bearing the brunt of savings initiatives. Talks this afternoon between NSWNA and Health Department officials failed to resolve the issue to the satisfaction of the NSWNA.

NSWNA General Secretary, Brett Holmes, said the Health Department should increase funding to the hospital to match real patient demand or reduce the patient flow to match the nurses available.

"It is not acceptable to expect the nurses to cut back while service levels, not currently covered by the hospital's budget, continue. The Department should fund those services properly or limit them, because the nurses will not put up with the extra workload caused by restrictions to the hospital's nursing budget. Such workloads are unsafe for both the nurses and patients," Mr Holmes said.

"According to Association members, examples of the nursing budget measures being imposed are restrictions on:

the way nurses are recruited, forcing existing staff to work extra shifts and overtime and through their meal breaks;

the use of agency nurses, so that they are only employed for six or seven hours to cover an eight-hour roster;

the type of agency nurse who can be hired, so that nursing managers can only hire agency

nurses who have previously worked at Royal North Shore; and

Individual Patient Specials (IPS) - individualised nursing arrangements for patients with special needs - so that many requests for IPSs are not being approved.

"All of these restrictions are imposing extra workload on the existing nurses and, I am advised, the IPS restrictions have even led to a number of serious patient-care incidents.

"For example, I am told that one brain damaged patient on a general surgical ward, denied an IPS, later fell and was injured. Nurses are also reporting that family members are being used to help with some patients requiring an IPS, such as confused elderly patients and patients with a mental illness.

"So clearly, these limitations on nursing levels are not in anyone's, other than the bean counters, interests and the nurses intend to voice their discontent about them at tomorrow's meeting," Mr Holmes said.

The NSWNA has about 1000 members at Royal North Shore Hospital.

Media Enquiries

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NSW Nurses' Association

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Northern Sydney Central Coast AHS Nurses Will Not Cooperate With New Management Structure, Which Sidelines Nurses

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10 July 2006

NSW Nurses Association (NSWNA) members across the Northern Sydney Central Coast Area Health Service (NSCCAHS) have started voting to take industrial action in protest at the NSCCAHS's decision to reduce the role of nurses in hospital management.

The nurses are angry they are being sidelined while generic managers and doctors are being given all the power to control operational matters, including budgets, in the operating theatres and wards.

In response nurses at Manly, Wyong, Gosford, Ryde, Hornsby and Mona Vale hospitals and the Northern Sydney Home Nursing Service met late last week and voted that:

"the nurses, Nursing Unit Managers and Nurse Managers within the Area, continue to report both operationally and professionally to the Nurse Managers, who can then forward issues to the Divisional Manager. In the absence of a Nurse Manager, they will continue to report to the facility Director of Nursing."

Nurses at other hospitals and health services across the NSCCAHS will meet and vote on the same motion early this week.

NSWNA General Secretary, Brett Holmes, said the nurses have lost confidence in the senior management of the NSCCAHS and do not believe it has the ability to provide a fair, equitable structure that meets the community's need for safe service delivery.

"They believe senior management has little insight into the requirements of front line services and the roles and requirements of the nurse managers who manage those services. The point is, despite weeks of negotiations and a stop work meeting over the issue at Royal North Shore Hospital in May, senior nurses are still expected to manage vital issues such as patient throughput and bed availability, but they cannot have any direct say over the funds needed for extra staff and beds," Mr Holmes said.

"The NSCCAHS is arrogantly pushing ahead with its plan to reduce the managerial input of the largest professional group in its employ. It has even started offering redundancies to senior nurses who are no longer required because of the abolition of nurse management positions.

"All this has negative implications for nursing practice and the nursing career structure in that AHS. It will significantly undermine nursing as an attractive career option and, given that we are still emerging from a serious nurse shortage in this State, that is the last thing

we can afford to do.

"It never ceases to amaze me that, despite the lip service paid to fixing the nurse shortage, hospital administrators keep coming up with ways to undermine confidence in nursing as a profession.

"Under the proposed management restructure, nurse managers and nurse unit managers will report directly to a generic manager in each hospital division such as medicine and surgery. They currently report to a divisional nursing manager, which means they are dealing with a person who, as a nurse, has a better understanding of their issues and needs.

"The nurses will still be responsible for patient flow and bed occupancy in the hospital. However, they will now only have an advisory role on the funding required to pay for the services and nurses required to safely staff those beds. This has huge implications for workload management and safe patient care across the AHS.

"Because, short of industrial disputation over workloads and budgets, this means doctors and generic managers can demand more of the nurses without providing them with sufficient staff and resources to do their job properly and safely.

"In official research, conducted for the NSWNA in 2002 by the University of Sydney, this managerialist approach to health care was found to be the biggest reason nurses leave the profession. It is a major contributor to the serious nurse shortage we face. Yet, as we try to fix that problem, we now have this AHS reverting to this approach and undermining the role of nursing in its management structures.

"Well the nurses are not prepared to let them do it and they will not cooperate with the new arrangements. They will continue to report to senior nurses on both operational and clinical matters. This should not impact on clinical care, but it will disrupt the proposed management arrangements," Mr Holmes said.

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ABC Online

Stateline NSW

[This is the print version of story http://www.abc.net.au/stateline/nsw/content/2006/s1707661.htm]

Transcript

Nurse Leaders Out

Broadcast: 04/08/2006

Reporter: Quentin Dempster

Print Email

QUENTIN DEMPSTER: Welcome to Stateline New South Wales. I'm Quentin Dempster. Last month, nine leading nurse managers in the Northern Sydney and Central Coast Area Health Service were called in and offered redundancy or redeployment. In a restructure ordered by the area's management, their leading roles in the public hospital organisational hierarchy was deleted. These divisional nurse managers, as they were called, are being replaced by generic managers, qualified and experienced hospital managers, but without the registered nurse qualification in the job description. The nurses say they were responsible for frontline operational services, resource allocation, staffing and training. They were there to move quickly, to plug the daily operational holes in a public hospital system under intense pressure.

At Royal North Shore Hospital, all three divisional nurse managers have opted for redundancy. One of the three, Jane Etchells, says she doesn't want to work in a public health system which disempowers nurses from senior management roles at a time of maximum patient demand and chronic under-funding. After the patient horror stories through the Camden and Campbelltown hospitals affair exposed system failure, poor management practices and inadequate funding, is deleting accountable nurse leadership a good idea?

This is a difficult decision for you, isn't it?

JANE ETCHELLS, EX DIVISIONAL NURSE MANAGER: A very difficult decision, and there's been lots and lot of tears. I'm not happy with the decision, I have to say, because I have worked at Royal North Shore Hospital for a long time. I do believe in what nursing is doing at Royal North Shore Hospital, what medicine is doing at the Royal North Shore Hospital, it's a great institution, but, in the end, I have to be true to myself and value my own integrity, and I don't believe that this is the way that nursing should be going.

QUENTIN DEMPSTER: Until last month, Jane Etchells, 47, was in daily operational charge of 16 nurse unit managers, 28 clinical nurse consultants and about 800 rostered nurses, covering all surgical wards, 14 operating theatres, three intensive care units, admissions, outpatients and infection control. Her annual budget allocation? More than $20 million. While there had been talk of change during a massive restructure, pursued

by the Northern Sydney and Central Coast Area Health Service, Ms Etchells and her colleagues did not believe that the operational leadership role of divisional nurse manager would be affected.

JANE ETCHELLS, EX DIVISIONAL NURSE MANAGER: I actually found out that the position was going to be deleted two weeks ago. I was offered redundancy a week ago.

QUENTIN DEMPSTER: The three divisional nurse managers at Royal North Shore Hospital were out within 24 hours. Jane Etchells has been a nurse for 30 years, as the job changed to a profession with a university degree. Such is the demand for experienced nurses worldwide that other countries are constantly raiding Australian hospitals with inducements and incentives for qualified nurses.

RECRUITMENT ADVERTISEMENT: America is calling you. Nursing in the USA offers you career development, travel experience, green cards for the whole family.

QUENTIN DEMPSTER: Jane Etchells says she won't be going overseas and will try for a new job in public health in Victoria or, as a last resort, the private sector, but she wants the public to know why an experienced nurse manager like her won't work for New South Wales Health any more. Her now redundant position of divisional nurse manager is being replaced by a generic manager. While the salary is about to same, just over $100,000 a year, a registered nursing qualification will no longer be mandatory.

What is the fear if generic managers take over and run the hospitals?

JANE ETCHELLS, EX DIVISIONAL NURSE MANAGER: Well, I guess the fear really is that we end up with people who are looking at benchmarks and activity figures rather than patient care and an understanding of patient care.

QUENTIN DEMPSTER: Dr Stephen Christley, chief executive of the Northern Sydney and Central Coast Area Health Service, rejects Jane Etchells' concerns. We'll talk to the chief executive shortly.

The future of nurse leadership within the system was a hot button issue at a recent Nurses Association conference at Randwick.

NURSE AT CONFERENCE: Does the government have a policy on downgrading nursing management positions because we're quite alarmed - we're quite alarmed at the current trend that we're seeing, with generic management.

MAN AT CONFERENCE: I am not of the view that one size fits all.

QUENTIN DEMPSTER: Since an independent pricing and regulatory tribunal report into the health system two years ago and alarming revelations arising from the Health Care Complaints Commission inquiry into Macarthur Health, following patient horror stories, 17 area health services have been collapsed into eight. Big money was said to have been saved through this reorganisation. Stateline put these complaints, fears and concerns directly to Dr Stephen Christley, chief executive officer of the Northern Sydney and Central Coast Area Health Service.

Dr Christley, the public health system can't afford to lose highly experienced nurse managers like Jane Etchells? What do you think you're doing?

DR STEPHEN CHRISTLEY, CEO AREA HEALTH SERVICE: Well, the reason for

the restructure that's happening in Northern Sydney and Central Coast Health is based around the principle that wherever you enter the health system you should have access to the same standard of care and that care should be the best that we can possibly provide. The health system has pockets of excellence but it has not been good at translating that excellence across the system. So, our structure's based on having a common management structure in each of our hospitals and health services.

QUENTIN DEMPSTER: Dr Christley would not be drawn on Jane Etchells' personal decision to leave New South Wales Health. He denies any anti nurse motivation for the changes.

DR STEPHEN CHRISTLEY, CEO AREA HEALTH SERVICE: We are not disempowering nurses from applying for those positions.

QUENTIN DEMPSTER: So, is it all about saving more money?

DR STEPHEN CHRISTLEY, CEO AREA HEALTH SERVICE: Better patient care is driving this. The fundamental principle is that expense and care are linked. The care decisions that are made, the way care is provided, they all – they all link together with money. If we can minimise morbidity, if people have a smoother passage through hospitals, if they don't get coincident infections, if they don't get pressure areas, if they don't have complications from drugs, then we provide better care, we get better outcomes and we do it at a better cost. There is plenty of literature around the linkage of those two, and you don't focus on one and not the other.

QUENTIN DEMPSTER: Jane Etchells' other major complaint at the loss of the nurse leadership role concerns training. With productivity benchmarks, faster patient diagnosis, treatment and discharge, she says people actually staying at hospital are sicker and require very skilled care.

JANE ETCHELLS, EX DIVISIONAL NURSE MANAGER: We're all being expected to try and look after sicker patients, increase our productivity, get patients through the organisation quickly, get them out the other side so that we can admit the next patient. And I think that that is a recipe, really, for system failure. Added to that, we have now a much a number of lesser skilled workers, we have new graduates who no longer are given supernumerary time when working on the wards. They get five days when they first come out of the universities and then they will rotate from one ward to another. The first ward they work on could be coronary care, where they're looking after patients who've had heart attacks, they need to know about ECGs and managing chest pain, and the next ward they might work on might be the severe burns injury unit where they have to do complex dressings, maybe manage dressings of people's fingers to ensure they don't get contractures and that their hands will work properly afterwards, looking after the pain management of people who have major burns and they need dressings on a two daily basis. And these nurses won't get a second lot of orientation.

QUENTIN DEMPSTER: The complaints profile for your area shows that the bulk of the complaints coming from patients are about nursing, mistakes, accidents, inexperience, negligence. The removal of a nurse manager from a leadership position will only exacerbate that situation.

DR STEPHEN CHRISTLEY, CEO AREA HEALTH SERVICE: No. What you're talking about there is nursing standards and professional leadership, and we are aiming to strengthen that through this structure. Everybody has their own perspective and their own paradigm where they come from. What we're aiming to do is keep talking, developing a shared understanding. We are implementing the divisional manager roles. I

think implementing those and seeing the quality of people that are in those roles will start to take some of the fear out of it. The next thing we then have to do is make sure the nursing professional leadership is built. We have got an area director of nursing leadership arriving from England next month we are investing in this area. She's got a CBE for nursing leadership in her area of nursing specialty. I mean, we are really investing in the nursing profession Area Health Service.

QUENTIN DEMPSTER: Organisational restructures are often cynically received and resisted. Nurses told Stateline the generic manager idea had been tried and had failed in the United Kingdom and New Zealand. They predicted nurses would continue to leave the Northern Sydney and Central Coast Area Health Service, while others would not bother to apply. With the New South Wales public hospital system under maximum pressure from rising surgery waiting lists, through increasing patient demand, the government is pumping in more money to address the workforce recruitment and retention crisis. Dr Christley, obviously, is confident his restructure will cost-effectively improve the quality of patient care. With this dispute now very public, he'd better be right.