Healthy budgets are essential for safe quality care.
Labour Day Public Holiday is back in May so come celebrate at the 2016 Labour Day March & Festival.

In Brisbane the march on Monday 2 May 2016 will commence on the corner of Wharf and Turbot Streets, Spring Hill at 10am and finish with a Festival for all the family at the Brisbane Showgrounds, Bowen Hills.

Elsewhere around Queensland, marches and celebrations will take place as follows:

- Saturday 30 April: Bundaberg, Ipswich, Toowoomba and Cairns.
- Sunday 1 May: Sunshine Coast, Gold Coast and Maryborough.
- Monday 2 May: Townsville, Bowen, Mackay, Rockhampton, Gladstone and Barcaldine.

FEATURE

Election issue 4: Healthy budgets are essential for safe quality care
Taking the lead has its own rewards

There is a plethora of literature that explores the intrinsic and extrinsic motivations of nurses and midwives who aspire to become nurse/midwife leaders or executives.

There is an equal amount of literature that supports the importance of developing nurse/midwife leaders at all levels in order to transform the health care system. When I started nursing, I did not set out to become involved in strategic planning for health systems. But now I find myself being party to conversations that shape the systems, processes and work environments in which nurses and midwives work.

I find myself being the voice of our professions, and also of the patient who is often lost in strategic conversations. Health strategy is not always intuitively patient centred.

Why are nurses and midwives so good in strategic roles?

Whether in health care sector or in other industries, the skills of nurses and midwives are transferrable to the boardroom. Nurses and midwives take pride in and are rewarded for solving problems in real time.

When equipment is missing, or the wrong food is delivered, or the transport has not arrived—we do whatever is necessary to fix these problems for the benefit of our patients.

Not only that, nurses and midwives are system connectors. When we have patients or families in our care, we collect and process information about that person or family to find out what might be the cause of what brought them to us, so we can prevent it from happening again; we scan for knowledge or skill deficits to identify teaching opportunities to help people live well with their disease, improve, or die with dignity; we think about their social support; their home environment; their work and their mental wellbeing… these multitasking, systems intelligence gathering and processing skills make nurses and midwives practical, focused, problem solvers in health strategy and planning.

And the patient is at the centre of everything we do.

You may ask whether strategic planning is as fulfilling as bedside nursing—especially as not many people set out to take on such roles.

There are so many genres of nursing and midwifery work now, that not all nursing and midwifery occurs in structured organisations or in traditional caregiver roles.

The domains of our practice include research, education, and leadership as well as clinical—all of which play an important part in the business of health.

In my strategic work, I have the opportunity to influence health policy, planning and practice that benefits so many patients, nurses and midwives.

When I was ward nursing, my work impacted upon my shift colleagues and the patients allocated to my care that day. Now, even when I am not at work, my work impacts upon thousands of nurses and midwives and tens of thousands of patients.

It is rewarding in a different way, but rewarding nonetheless.

Whether you have a designated title of authority in an organisation or not, each nurse and midwife has the ability to influence his or her surroundings.

If you have an idea that you think will improve outcomes for the people receiving your care, then the leaders of your unit, your organisation or your health department will want to hear about it. Participating in your union helps you raise your voice!
The bill and regulations were introduced into the Queensland parliament in December 2015 and referred to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee for further scrutiny. Throughout March the committee held hearings interstate and in regional locations and Brisbane.

At the time of writing the committee is scheduled to deliver its final report to parliament on 29 April. Parliament will then debate the legislation. This is lawmaking in action, and the aim is to have laws passed to introduce ratios in Queensland Health facilities from 1 July 2016.

Every law needs groundwork, and the groundwork for this law was undertaken by nurses and midwives. More than 600 QNU members wrote to us about how ratios would make a difference to their daily working lives and to patient safety.

When it comes to making legislation, this testimony is absolute gold. So many of your rich and powerful stories were included in the QNU submission to the inquiry.

And a select few QNU members showed true commitment and bravery by personally fronting the hearings and giving evidence to the committee.

In Cairns, Townsville, Gladstone and Brisbane, nurses and midwives told committee members first-hand about the danger of excessive workloads and how ratios will greatly reduce the risk to nurses, midwives and our patients.

I cannot underestimate the courage it takes to front a parliamentary inquiry. Hearings are often adversarial, and have a tendency to go down unanticipated rabbit holes.

You really have to have your wits about you, and remain focused and on message.

I was so very proud of the compelling evidence provided by QNU members at these hearings. It was an enormous privilege to sit and watch these nursing and midwifery leaders in action.

I would like to thank and acknowledge them now for the exceptional leadership they showed.

The first hearings were held in Townsville on 8 March, where local QNU Organiser Kaylene Turnbull appeared, and QNU members Debbie Watt, Katrina Giles and Robyn O’Sullivan gave compelling evidence.

The very next day in Cairns the committee heard more evidence from QNU members Deb Carlton and Rachel Laas, along with Cairns Organiser Krissie Bishop.

The regional hearings ended in Gladstone the following day where more strong evidence was provided by QNU Organiser Grant Burton and QNU members Tina Gray and Damien Lawson.

At each regional hearing, QNU members attended to support their colleagues.

The Brisbane hearing took place on 16 March at Parliament House, with the upstairs gallery filled with 80 keen nurses and midwives.

At this hearing, QNU members Janelle Taylor, Moira Purcell and Lauren Picker gave detailed testimony, along with QNU Professional Research Officer Kate Veach and me.

Again and again our members at these hearings provided clear examples of the impact unsustainable workloads have on patient safety, and on nurses and midwives.

Our message couldn’t have been clearer: minimum ratios will provide a reliable and enforceable workload management tool that can help save lives.

It is this guarantee that our members have sought for so long.

This legislation is a historic commitment by the state government, and we applaud its introduction.

Yet while it is important to reflect upon our progress so far, we should never forget we still have a long way to go.

This new law is just the first step in our campaign to establish ratios in all health settings—public, private, and aged care.

Together we will continue to make real difference to patient/resident safety in Queensland.
Nurses are like cats—they seem to have 9 lives and would give them for their patients. So grateful for you all.

BJ

Midwives are the best and are not paid enough or valued enough by our health system. I credit my 7 perfect healthy babies and amazing labour experiences to the amazing support of the midwives I have encountered...

CH

**On ratios**

It is amazing that no matter where in the world we live hospital administrators are all the same. Blame the nurse. As an RN with over 23 years of experience at the bedside, I know ratios save lives. Please keep up your fight for ratios and know that nurses around the world support you. In solidarity.

MWB

It’s not just ratios...it’s also skill mix that has RNs run off their feet. Was told by a colleague the other day that she was the only RN rostered on her busy ward and she’s a CN...not good enough.

SC

Apart from the already overburdened workloads, the paperwork is ridiculous. I was told by my manager to do OHS Auditing the other day. This included questions like...is there dust behind electrical equipment, and have I implemented a cleaning plan to ensure there isn’t. I am an Enrolled Nurse, not a manager and don’t think that is my responsibility. It’s time all nurses stood up and refused to take on all of the extra workloads that we are not qualified to do. The place is way to ‘Top Heavy,’ and it is ridiculous that the workers at the coalface bear the brunt of them having way too many meetings and coming up with more ridiculous plans. I am seriously thinking of quitting the profession that I have so dearly loved because of the ridiculousness of it all. Let’s get back to basics and start looking after the patients once again!

JS

**On SA nurses refusing to treat violent drunk or drug affected patients.**

Excellent plan. This is a clear example of workers being pro-active, they are refusing to work in an unsafe and dangerous work place, which is not only their right but their obligation. They are doing the right thing.

JM

Being assaulted should not have to be part of a health worker’s job, I am not sure what the answer is...I heard that they are looking at sedation from a safe distance, whatever that means.

LR

**On aged care workforce funding and AIN/PC registration**

Pay them what they are worth, these places pay far less than the award. And stop paying the care attendants peanuts because these people are doing the physical work of caring, showering, changing incontinent people, feeding those who can’t manage themselves due to illness and disability. The carers are the ones who chat to these people, share their lives with many who no longer have family who care. They keep these people clean, dry, comfortable, nourished...all the things a person who could, would do for themselves. So, pay people what they are worth!

TB

PCAs do a wonderful job. They should be better supported, recognised & qualified. They’re not to blame for the falling standards, staff rates, pay etc, it’s management & regulatory bodies.

MOG

**Have your say**

tqn welcomes letters for publication.

- Letters should be no more than 200 words. Anonymous letters will not be published (we will consider withholding names, but do not accept unsigned letters).
- Photos may be colour or black and white.
- Send all material in the first instance to:
  The Editor,
  The Queensland Nurse,
  GPO Box 1289,
  Brisbane 4001
or by email to
dsmith@qnu.org.au

tqn also sources Your Say comments from the QNU’s social media accounts in the public domain.

The views contained in the ‘Your Say’ page do not necessarily reflect the views of the QNU.

For more information and guidance on writing and submitting a letter for inclusion in the ‘Your Say’ section refer to the QNU’s Letter to the Editor policy at
www.qnu.org.au/letters-policy

/qldnursesunion
We sometimes take it for granted that everyone knows their entitlements. However, for new entrants to the nursing and midwifery workforce it is often difficult to understand the plethora of entitlements and payslips covering our profession. In fact, many nurses and midwives are uncertain about which allowances, loadings and penalties they are entitled to given the diversity of their work and working hours.

The following questions are frequently asked of our QNU Connect call centre.

**Working in higher duties—what are your rights if going on leave?**

Many nurses and midwives often work in higher duties and are rightfully paid at a higher wage for carrying out that role. But what happens if you take leave during the period of higher duties? Which wage should you receive?

According to HR Policy B30 (for Queensland Health employees), nurses and midwives must be paid at the higher rate. In other words, you cannot be moved back to the lower wage whilst on leave. If you have been working in higher duties in Queensland Health but were paid at your lower rate whilst on leave, you should correct this with your employer or contact the QNU.

The difference could potentially be worth thousands of dollars in pay.

**What to do if an allegation is made against you**

We don't like to think about it, but the reality is sometimes nurses and midwives may find themselves in a situation where someone has made an allegation against them.

This allegation may be made by your employer, a patient or a colleague. It's vital you know what your rights are if you're put in this situation.

The most important thing to remember is that all employees facing potential disciplinary action are afforded natural justice.

**What is natural justice?**

Natural justice is a law principle that ensures there is fairness in decision making.

According to the principles of natural justice, decision-makers must be objective, free of bias, and have no personal interest in the matter being decided.

1. Individuals must also be informed of the substance of any allegations being made against them, and they must be given the opportunity to put their case forward before any decision is made.

In order to ensure you are afforded natural justice when an allegation is made against you, the QNU strongly advises nurses and midwives to follow this process:

- Ask for full details of the complaint or concerns in writing, including names, dates, times, and a description of the event or incident.
- Ask for copies of any documents and any other evidence that may be used to support the complaint or concern.
- Where there are witnesses, ask for copies of witness statements or a description of the content of witness statements.
- Write your draft response.
- Send your draft response to the QNU, along with a completed Member Request for Representation form.
- Do not provide a verbal or written response before seeking further advice from QNU. Likewise, defer any meetings with management until you have received further advice from the QNU.

**What to avoid in responding to allegations**

**Speculation:** If you don't recall an event, make this clear. Don't suggest what might have happened.

**Criticism or complaints about others:** While you may have valid reasons, this is not the place to criticise or complain. It's fine to tell the QNU, but don't include any complaints or criticisms in your response—stick to the facts.

**Making irrelevant admissions or comments:** Focus on the matter you have been asked to respond to. Stick to your recollection of events and facts related to the allegations.

**Vague comments or statements of hearsay:** This will not serve as a defense. Provide full names, dates, times and clear and concise descriptions based on observations and evidence.
The report on the review into Queensland’s industrial relations system is in, and it recommends 68 big changes.

Headlining these is the proposal to completely re-write the current but outdated Industrial Relations Act 1999 (Qld).

The QNU was an active player in this review, making a detailed written submission as well as participating in the Industrial Relations Legislative Reform Reference Group, which oversaw the review.

The review was timely—even overdue—and the recommendations will go a long way to making Queensland’s industrial relations system modern and more effective.

The Act was last reviewed 18 years ago. Since then, the industrial landscape in Queensland has changed dramatically. For one thing, the current act includes the private sector—but coverage of corporations was taken over by the Commonwealth in 2005.

As the report states, “a new act would reflect better its more limited jurisdiction of state and local government employees”.

Creating a ‘fair and balanced’ system

One of the key recommendations of the review is to “specifically promote a fair and balanced industrial relations framework”. The idea is to include fairness and balance as fundamental principles in how we understand industrial relations, making these two concepts major features of any future changes to legislation.

Reinforcing independence

The report also highlights the need to ensure stakeholders with the power to influence and change industrial relations laws are independent and apolitical. Industrial relations law, particularly in recent years, has been used as a weapon against Queensland employees and their unions.

Key elements of the system

Although the review committee had broad-ranging views on the details of the legislation, there was clear agreement on several key elements that must be a part of any modern industrial relations system. These include:

- a set of minimum standards
- collective bargaining as the most effective way of delivering fair wages and conditions
- a set of individual rights to fair treatment
- an independent commission and court.

How do we determine wages and conditions in a modern framework?

The report also stipulates that wages and conditions remain the cornerstone of any industrial relations system.

The review committee strongly recommended retaining collective bargaining as the best mechanism, with an emphasis on parties coming to agreement before turning to arbitration as a last resort.

Other recommendations

Additional recommendations made by the committee include:

- domestic and family violence leave as an employment standard
- access to a workplace bullying jurisdiction in the Queensland Industrial Relations Commission
- equal remuneration for work of equal and comparable value
- new and flexible work arrangements
- implications of digital and other disruptive technologies
- employment conditions in the ‘sharing’ economy
- new patterns of work
- safeguards around precarious employment
- changing skills requirements.

Time to sit down and write new laws

With 74 amendments made to the Act since it was first passed in 1999, it’s clearly time to sit down and look at how we can write a better, more modern set of laws that accurately reflect the needs of Queensland’s public sector and local government workers.

To read the full report visit http://bit.ly/25e841N
In an astonishing display of community solidarity, people from all walks of life made their way to Lady Cilento Children’s Hospital, where health staff were refusing to discharge baby Asha until a safe home environment was identified for her.

It was a simple action that health workers take for children in their care every day—but in this case it publicly exposed the unbelievable damage being done to asylum seekers in Australia’s offshore detention centres.

Baby Asha was admitted to LCCH after suffering burns on Nauru. When staff refused to discharge Asha until a safe home environment was found, a stand off with the Border Force Immigration Police seemed inevitable.

But over the next 10 days, people from all over the state showed up outside the hospital to prevent Asha and her family being forcibly removed from LCCH and returned to Nauru.

Unions were at the very forefront of the action, with the Queensland Council of Unions playing a strong co-ordinating role.

The actions of the protestors drew national and international media coverage, and ultimately forced Immigration Minister Peter Dutton to agree to let Asha and her family stay in community detention on the Australian mainland.

This was a major victory for all Australians who oppose asylum seeking children being housed in offshore detention centres.

Decision made on ethical grounds

Throughout the 10-day protest, nurses and midwives from across Brisbane—backed by the QNU—turned out in large numbers to support health staff at the LCCH.

QNU Secretary Beth Mohle spoke at one of the vigils, defending the rights of health workers to make clinical decisions without fear or favour.

“We must back our clinicians to make these judgements on clinical, professional and ethical grounds,” said Beth.

“They are obliged to do so because of their professional obligations as regulated health professionals.

“Clinicians do not discriminate on the basis of ethnicity, social status, gender, sexual preferences or religion. We treat all equally—that is what we do.

“It is our professional and ethical duty to do so.”

QNU policy in line with ‘Let Them Stay’ campaign

The involvement of nurses and midwives in the ‘Let Them Stay’ campaign is consistent with the QNU’s position on refugees and asylum seekers.

The QNU policy—adopted at the 2014 Annual Conference—states:

“...asylum seeking children should be housed and cared for in the community setting with family and never in closed detention.”

“...all asylum seekers and refugees should have universal access to basic health care, Medicare, the Pharmaceutical Benefits Scheme, counselling, education and opportunities to seek employment.”

The full policy can be found on the members section of the QNU website under ‘Your Work – Policy Sheets’.
Strength to strength across Logan and Ipswich

Logan – Every child. Every opportunity.
Following a successful assembly in early March, the QCA and Logan Together have taken the first steps towards meeting the needs of children in the Logan area aged 0 to 8 years.
Their 10-year plan is to co-ordinate and drive co-operation between community stakeholders, and education, health and social service providers, to ensure every child gets the support, love and care they need to thrive.
Recognising that no single organisation or government department can overcome complex social issues alone, the aim is for stakeholders to work together to establish joint priorities that will lead to genuine improvements in the quality of life for Logan youngsters.
It's true that it takes a village to raise a child, and we invite nurses and midwives to join and participate in this early childhood initiative.

Logan transport
We've also made great progress on local public transport issues.
After meeting with QCA, Logan City Council have committed to spending at least $6 million over four years to improve public transport infrastructures.
What's more, the state government has also committed to major infrastructure expenditures, to be spent on the M1 and on local transport.
This has been no easy feat—and many said it couldn't be done!

Mental health care
In the West Moreton region, we had fantastic outcomes from an Ipswich accountability assembly held in February in terms of shining a spotlight on the region's mental health service needs.
We secured commitments from local politicians, government health agencies and other organisations to start a Collective Impact Project—an initiative that will bring together organisations that co-ordinate, deliver or fund innovative mental health care across the region.
Again this will be an excellent project for Ipswich nurses and midwives to engage with in the coming months.

Re-invigorating the arts
The Re-activate Ipswich initiative continues to make headway, with collaboration continuing between arts organisations and Ipswich City Council.
The aim is to expand the Ipswich City Council 'Activate Ipswich' program, which gives businesses, artists, cultural projects and community groups a helping hand to ‘set up shop’ in vacant commercial spaces in the Ipswich CBD.
We've already identified 50 vacant premises, and we're looking for more people or groups who may be interested in taking up this unique opportunity.
For more information, email dave@qldcommunityalliance.org

Get involved and make a difference!
Nurses and midwives can register their support for the Queensland Community Alliance (we also offer training).
If you want to become involved and make a real difference in your local community, visit www.qldcommunityalliance.org

The Queensland Nurses’ Union is a foundation member of the Queensland Community Alliance.
The QNU has added a new member training course to its education program—a full day course called ‘Professional Culpability’

The course offers a comprehensive overview of the regulation of nursing and the common law aspects of negligence as it applies within the nursing context.

Split into four sessions, session one looks at the professional practice framework (PPF) developed by the NMBA, which encompasses the Codes of Ethics and Professional Conduct, the competency standards and standards for practice and the decision-making framework.

This session also offers good practical advice on how the PPF empowers nurses to challenge inadequate staffing and skill mixes, and how to resolve conflicts regarding professional practice issues.

Session two considers how the common law elements of negligence apply in the nursing context and looks at a number of case scenarios based upon real life events that led to action being taken against nurses.

Members then brainstorm what could have been done to achieve a better outcome.

In session three, members review a number of coronial and tribunal matters that were associated with poor staffing and skill mix. They then work through the steps a nurse or midwife might take when confronted with employer directives that might not comply with professional practice or standards.

In the final session, members work together using the strategies identified in the first three sessions to come up with solutions to real-life scenarios that challenge their professional judgment.

By the end of the day, participants should have both a better understanding of issues around professional culpability, and feel more confident taking action to ensure professional practice standards are met.

While this new course is booked out for the remainder of the current semester, the positive feedback we’ve received means we are keen to deliver the program again next semester, and hope to offer more dates and more courses in regional areas.

If you are interested, make sure you keep an eye out on our website for the Semester 2 QNU training program which is due out in May, or contact the QNU Education Team on 3840 1431.

TO ENROL IN THESE COURSES—

- visit the QNU website at www.qnu.org.au OR
- contact your local QNU office and ask them to send you a form OR
- ring the training unit in Brisbane on 3840 1431 or toll free 1800 177 273
Pay parity for State School RNs

If all goes to plan, State School Registered Nurses (SSRNs) will soon vote on an agreement that will give them pay parity with Queensland Health RNs.

The QNU has been working to achieve pay parity—and professional development parity—for a number of years, but our efforts were unfortunately stalled when negotiations broke down under the previous LNP government. However, the QNU has now resumed discussions with the Department of Education and Training (DET), the Office of Industrial Relations, and QH.

Significant pay increase on offer

It is agreed in principle that SSRNs will be covered by the QH EB9 for wages and professional development provisions. Their other conditions will remain the same and will be contained in a schedule to EB9.

The benefits that SSRNs will receive under the agreement include:

- 14% pay rise for NG6s, and a 27% pay increase for NG7s.
- Three days of professional development leave per year, plus an annual allowance of $1590 (paid in two instalments).
- Moving from a 36.25 hour week to a 38 hour week (full time).
- SSRNs will remain employed by the DET, but come under the coverage of EB9. The organisational structure and all reporting relationships within schools and the DET won’t change.

In-principle agreement

Following a teleconference, QNU SSRN members overwhelmingly gave in-principle support to this proposed agreement.

All going well, they will have an opportunity to vote on the agreement separately to QH nurses when it goes to ballot in the coming months.

Mater’s lack of respect for nurses and midwives all too clear in offer

Negotiations for a new enterprise agreement between Mater Public, Mater Private and the QNU began more than 12 months ago, but it wasn’t until February this year that the employer finally put a draft on the table.

Mater wants a single agreement to cover nurses and midwives from Mater public and private.

This offers the employer an excellent opportunity to show respect for its nurses and midwives by drawing the most beneficial provisions from both agreements into the new instrument, or at least preserving current employment conditions.

Unfortunately Mater seems to have a different view, and is proposing a document that on balance incorporates the lowest conditions from both instruments.

Even worse, in some cases, Mater has gone even further and is offering less than what both agreements originally provided for.

A case in point is payment for work performed on public holidays.

Mater is proposing to reduce the number of public holidays paid at 250% from three to two and pay the majority of public holidays at 150%, which is below the 200% stipulated in the Nurses Award 2010 and the current practice among the majority of other private hospitals in Queensland.

Mater has also refused to include in the agreement any minimum nurse/midwife-to-patient ratios. Even more concerning they are proposing to strip out existing workload management provisions, astoundingly claiming this is not an industrial matter.

Mater is also proposing the removal of NUMs and MUMs from the new agreement, a proposal that not only devalues the role of NUMs and MUMs but is also out of step with the rest of the public and private sectors.

Mater is expecting their nurses and midwives will accept this substandard agreement, this may be due to the threat of removing backpay if the agreement is voted down.

Come on Mater, show some respect to your nurses and midwives and make a fair offer.
This year’s QNU Annual Conference will be held on 13-15 July at the Brisbane Convention and Exhibition Centre.

An annual conference website has been developed for members to submit notices of motion, register their attendance, and access comprehensive information including travel and accommodation arrangements.

Visit www.qnu.org.au/conference2016 to view the website. Branch steering committee members should have now received their login details to access the website, which also includes all necessary deadlines.

If you have not received your login details, please contact Jenny Gett at the QNU on 3840 1430.

Who can attend?
Elected delegates from QNU Local Branches are eligible to attend. If this person is unable to attend, an elected alternate delegate from their Local Branch can attend in their place.

If a Local Branch has not elected enough delegates to fulfil their quota, alternate delegates may also attend to make up the numbers.

How do I submit notices of motion?
Much of Annual Conference is devoted to debating and voting on different notices of motion from branches.

Every year Local Branches submit notices of motion via the Annual Conference website. Notices are submitted on behalf of the Local Branch, not by individual members.

These notices are generally discussed at Local Branch meetings prior to lodgement.

Branches do not have to submit all the notices of motion at once. Multiple individual motions may be submitted.

Quality of care, workload management and ratios have been the hot topics of discussion during round one of the 2016 Meetings of Delegates (MODs).

MODS are an opportunity for the QNU leadership to touch base with branch delegates and discuss issues affecting members in both the workplace and across the profession more broadly.

The focus of the meetings around the state so far have reflected our organisational priorities, namely maintaining quality of care through workload management, implementing minimum ratios and skill mix, and firming our focus on patient/resident centred care.

Not surprisingly a good deal of the discussion during this round of MODS ties in with the progress of the ratios legislation through parliament—legislation which calls for a minimum of 1:4 (morning and afternoon) and 1:7 (night).

Penalty rates and public sector EB9 negotiations have also made it to the agenda, as did the Queensland Government’s new Nursing Policy Platform including the deployment of 400 nurse navigators.

ARAre you ready
for QNU Annual Conference?

MODS dates
4 May Bundaberg
5 May Maryborough
10 May 2016 Mackay


Note: some of the MODs dates have changed from the 2015 calendar insert you received with the December 2015 edition of tqn.
Helping Australia ‘choose wisely’

A campaign to help people make informed decisions about their health has identified 61 tests, treatments and procedures which health professionals say are often unnecessary for routine conditions.

The Choosing Wisely Australia campaign, which is facilitated by NPS MedicineWise, says many consumers are often unaware that not all tests, treatments and procedures they might want, or have been recommended, are in their best interest.

The campaign’s list includes procedures such as chest x-rays for uncomplicated acute bronchitis, ultrasounds for groin hernias, and imaging for non-specific lower back pain.

It also takes aim at the overuse of antibiotics, particularly for viral infections.

To see the full list visit www.choosingwisely.org.au/recommendations

Taking control of your health
Choosing Wisely is a web-based initiative launched last year giving the public the information they need to start conversations about treatments that provide no benefit and, in some cases, can lead to harm.

The release of the 61 item list last month was the campaign’s first major public event and attracted plenty of media coverage and discussion.

Campaign coordinators say eliminating unnecessary tests, treatments and procedures is not only good medicine, but can also help reduce medical costs for consumers.

Growing community support
The list of Choosing Wisely supporters is growing rapidly and now includes the Australian College of Nursing, the Australasian College for Emergency Medicine, the Royal Australasian College of Surgeons, the Australian Society for Infectious Diseases, and the Royal Australian College of General Practitioners.

It is also supported by publicly funded health information and advice helpline Healthdirect Australia, which collaborates with more than 160 leading health organisations to deliver health information and resources through its website.

For more information visit www.nps.org.au or www.healthdirect.gov.au

How can we help?

The QNU assists hundreds of nurses and midwives every week.

Our team—consisting of Servicing, Industrial, Occupational Health and Safety, Professional and QNU Connect staff—is here to help you when you have a workplace issue or need advice.

Jan/Feb figures

Dollars recovered on behalf of members

$320,086

Members assisted (new matters)

458

QNU Connect calls received

4203

When collaboration works

It might look like an ordinary noticeboard but this display case full of colourful QNU material is a sign of change and collaboration. The QNU board, which sits proudly in the hospital lobby is the result of the QNU and Logan hospital administrators working together to find a suitable central place for QNU material to reside. It stops posters and flyers being stuck willy-nilly on walls or ending up wedged between magazines in the tearoom. It gives the QNU great exposure and saves the hospital’s paintwork. Teamwork...nailed it!
Queensland workers will have another great reason to celebrate Labour Day this year, as the annual celebration of workers’ rights is returned to its rightful place in May. The move corrects the LNP’s petty decision a few years ago to shift the public holiday to October. The union movement never recognised the date change, and for the past three years Queensland nurses and midwives proudly marched with fellow workers on the first Sunday in May. This year, however, we will celebrate during the official Labour Day long weekend from Saturday 30 April to Monday 2 May.

A crowd of yellow and pink! As this year’s event coincides with minimum nurse/midwife-to-patient ratios being legislated in the public sector, our Ratios Saves Lives theme will be the focus again for the QNU. QNU marchers will wear the same bright yellow and pink ratios t-shirts as last year, but we will be refreshing the look by adding hats to ensure we really stand out.

Event details In Brisbane, the Labour Day march will begin as usual from the corner of Wharf and Turbot streets at 10am on Monday 2 May and end at the RNA Showgrounds. This will be followed by a family fun day, which will include rides for the kids and live entertainment. Elsewhere around Queensland, marches and celebrations will take place as follows:
- Saturday 30 April: Bundaberg, Ipswich, Toowoomba and Cairns.
- Sunday 1 May: Sunshine Coast, Gold Coast and Maryborough.
- Monday 2 May: Townsville, Bowen, Mackay, Rockhampton, Gladstone and Barcaldine.

The annual marches are an opportunity to celebrate and proudly reflect on union achievements, including the eight-hour day, minimum wages and parental leave. And with our penalty rates currently under threat from the Turnbull federal government, it’s a reminder of the work we must continue to do to protect and preserve what we’ve achieved.

Celebrating Labour Day in May

We are fabulous—so celebrate!

Nurses and midwives rarely have time to stop and reflect on the fabulous job they do every day—we’re usually just too darn busy taking care of our patients and residents!

But International Day of the Midwife on 5 May and International Nurses’ Day on 12 May are the perfect opportunity to take stock of who we are and celebrate our role as health care leaders.

Let’s face it, nurses and midwives rock. We are the heart of the health system. We keep patients safe, we save lives, we protect the vulnerable, and we give hope and comfort to people, often during some of the most frightening and stressful days of their lives.

And when we step up, we can also be drivers of change. This year’s Nurses’ Day theme is “Nurses – A Force for Change: Improving health systems’ resilience” which dovetails nicely with our current focus on ratios.

Our push for legislated ratios is a perfect example of the ability of nurses and midwives to drive change. Taking the lead for patient safety, our ratios campaign and all that it embraces—from ratios rolled out across all sectors, to transparent reporting and RNs on every shift in aged care facilities—is a plan to make a safer, more robust health system.

It’s nurses and midwives who have put ratios on the political agenda—nurses and midwives making history. And that’s certainly worth celebrating.

If you or your colleagues are holding events to celebrate International Nurses’ Day or International Day of the Midwife please email your pics to comms@qnu.org.au—we have a Facebook page we’d love to share them on!
CWP is a chronic occupational lung disease caused by long term inhalation of coal dust. Until recently, the possibility of the disease re-emerging in Australia was considered low. In fact, in 2006 the Australian government said they could “cautiously conclude that the pneumoconioses have probably stabilised and are likely to reduce in future years”.

What went wrong?

Given the legislative and compliance regime that currently exists to protect workers against the disease, it’s very concerning that this preventable disease has re-emerged. Under the current scheme, coal miners are required to undergo a medical assessment prior to commencing work and then at least once every five years.

Two factors may have impacted on the recent detection of CWP in Queensland miners: increased exposure to hazardous dust levels, and decreased monitoring of the health of coal mineworkers exposed to the dust.

In the US a similar pattern is also emerging. Since 2000 there has been an increase in the prevalence of CWP, following a steady decline over the previous 30 years.

What’s more concerning is that severe cases of the disease are being identified in miners of a younger age.

QNU supports review

The QNU supports the Monash University review and the CFMEU’s Dust to Dust Campaign that seeks:

- an independent statutory body to monitor and publicly report dust levels
- a community information and outreach program to mining communities
- radiologists qualified to internationally recognised standards to review all x-rays taken of coalmine workers and a training program in industry best practices for coal dust controls
- immediate clearance of the backlog of more than 100,000 outstanding worker medicals
- extending healthcare and screening into workers who have been retrenched or retired
- identification of other at-risk workers by randomly sampling those with 10 + years service in the mining industry.

Our submission to the Senate Health Committee conducting an inquiry into the re-emergence can be found at [http://bit.ly/blacklungreport](http://bit.ly/blacklungreport)
Looking for a good reason to get out in the fresh air and pound the pavement?

Well you can’t go past the annual Mother’s Day Classic, which will be held around the country on Sunday 8 May to raise money for research into breast cancer programs and the National Breast Cancer Foundation.

The national fundraising target this year is a whopping $4 million, but organisers say they can smash this target if every participant is able to raise just $50.

In addition to the key events in Brisbane at Southbank and the Gold Coast at Broadbeach, there will be a number of regional events held around the state at Bribie Island, Bundaberg, Cairns, Dalby, Hamilton Island, Hervey Bay, Innisfail, Joyner (North Brisbane), Kingaroy, Magnetic Island, Mitchell, Monto, Mount Isa, Sunshine Coast, Tannum Sands, Tieri, Tin Can Bay, Toowoomba, Townsville and Weipa.

So get your best pink gear on and join the fun!

For more information visit www.mothersdayclassic.com.au

Queensland Health’s Nurse Navigator program has officially rolled out, with the state’s first Nurse Navigator appointed to the North West HHS region of Doomadgee.

Registered Nurse Noel Lally was appointed to the indigenous community in March—one of eight nurse navigators to work in the North West HHS and the first of 400 who will be employed across the state. Queensland Health is currently recruiting Nurse Navigators and vacant positions are being advertised through Smart Jobs.

A two-day Nurse Navigator Induction Workshop was held on 11 and 12 April at the Lady Cilento Children’s Hospital for people interested in taking on the role.

The workshop gave would-be navigators an opportunity to network and review the initiative’s objectives and available online resources such as the Nurse Navigator toolkit.

More workshops are planned for later this year.

In simple terms, Nurse Navigators are highly experienced nurses whose role is primarily to help patients navigate the health system by identifying their health care needs and directing them to the right care at the right time.

The hope is that patients, particularly those with complex needs or chronic conditions, will be able to access necessary care quicker, which should also prevent complications and readmissions.
Carrara Health Centre moves services

On 23 March, past and present staff of the Carrara Health Centre came together for a stirring farewell as the centre closed its doors for good.

The Carrara Health Centre opened in 2008 as an interim provider of subacute care, and has served as the area’s main base for rehabilitation and aged care patients.

Over the past eight years, the centre played an important role in the recovery and rehabilitation of many of the Gold Coast’s elderly.

But Gold Coast Health has since adopted a contemporary model for rehabilitation and aged care, bringing existing services at Carrara into state-of-the-art facilities at Robina and Gold Coast University hospitals.

Centre nurse Geri, said the Carrara staff worked as a “close family”, her colleague Donna said they all made “a great combined team.”

“It will be sad to not see all our colleagues who we have worked with for eight years but I wish them all the best in their new endeavours,” Donna said.

In addition to newer infrastructure and greater patient privacy, moving to the new hospitals means there are now research facilities onsite, allowing for improvements in multidisciplinary approaches to patient care.

The benefits for patients are clear, with less need to travel in order to access resources and better co-ordination of services.

But it’s good news for nurses too.

A number of the Carrara staff have moved on to one of the newer facilities allowing them to continue giving the care they are known for—with the added bonus of more access to professional development opportunities.

Change is never easy, but the team at Carrara have whole-heartedly embraced it as an opportunity for growth and empowerment.

For many years, the ANMF and the QNU have been advocates for the regulation of Assistants in Nursing (however titled).

We believe regulation is essential for safe and quality care, through the national standardisation of qualifications and competencies for AINs (however titled), under the auspices of the NMBA.

It also ensures these workers have professional recognition they deserve.

Recently there has been a Senate inquiry into the aged care workforce (see story page 18).

The inquiry has received many submissions from stakeholders regarding the current and future workforce needs in aged care.

The Aged Care Guild, a peak body representing major private residential aged care providers, has made a submission in support of mandatory registration of Personal Care workers in aged care.

This is the first time mandatory registration for unregulated care workers has been supported by an aged care employer association.

Queensland currently supports a National Code of Conduct for Health Care Workers, which applies to all unregulated healthcare workers in aged care or in hospital and the Office of the Health Ombudsman will refer to the Code if they receive a complaint about the unregulated healthcare worker’s conduct or provision of care.

However, the enforcement of the Code is referred to as a ‘negative licensing’ system and does not impose obligations upon unregulated workers to meet minimum qualifications or competencies.

The Guild argues the registration of unregulated aged care workers should be compulsory and administered by AHPRA in the same way nurses and doctors are.

The QNU agrees with the Guild, but we go further, suggesting unregulated workers should become the ‘third level’ of nursing and be regulated by the NMBA through mandatory minimum qualifications and standards for practice.
Private sector training

QNU offers a full calendar of training courses for QNU members, including some which are designed specifically for private sector nurses and midwives.

Some of the courses for the first semester of 2016 are already fully booked but there are still a handful of places available for the following upcoming sessions in Brisbane:

**4-5 May**

**Private Sector - How to bargain and what to do**
The two-day course covers the enterprise bargaining process step by step with a focus on how we can achieve the best bargaining outcomes.

**10-11 May**

**Someone should do something about that!**
This two-day course is designed to help us move members from complaining in the tearoom to actively dealing with workplace issues.

**7 June**

**Handling grievances in the workplace**
Activists often assist members to work through individual or collective issues in the workplace.

**8 June**

**Private Sector – Ratios Save Lives**
Come along and find out what the ratios commitment means for private sector nurses in Queensland.

**16 June**

**Private Sector – Everything you wanted to know**
Are you getting the most out of your enterprise agreement? Understanding your new agreement and what you are entitled is that final step in bringing your enterprise agreement to life.

**23 June**

**Building teams to grow our voice**
Working together co-operatively is fundamental to growing our nursing and midwifery voice. Developing a team that works well together can be really hard.

To see more QNU courses, and other CPD opportunities available through the QNU check out the Education and CPD page on our website:


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**Upcoming EB agreements**

QNU members and industrial officers have a steady program of Enterprise Agreement negotiations coming up in the next few months.

Negotiations are currently under way with four private hospital groups—Fresenius, Mater North Queensland, Queensland Fertility Group, and the largest provider of private hospital services in Queensland and Australia, Ramsay Health Care.

The Ramsay Health Care negotiations include two separate agreements, one for Greenslopes and one covering the other 16 Queensland sites.

Members have already indicated they are keen to improve on existing agreements.

If you work at any of these hospitals, we urge you to let us know your concerns and suggestions.

Contact your organiser or call QNU Connect on 3099 3210 or if you are outside Brisbane, 1800 177 273.
Aged Care Senate Inquiry: The need to prioritise resident care over profits

In March, the QNU made a submission to the Senate Inquiry on the future of aged care in Australia. QNU’s submission focused on the implementation of professional nursing standards and quality of care in the aged care sector, including the recommendation that it be mandatory for aged care facilities to have a Registered Nurse on site, every shift.

Currently, there is no requirement for an aged care facility to have a Registered Nurse on the premises, and there have been cases where one Registered Nurse might be on call for as many as three facilities. Because Registered Nurses often have the capacity to handle issues that might otherwise result in hospital transfers and other costly interventions, having a nurse on site also makes good financial sense. Unfortunately, aged care facilities rarely see it this way.

A drop in direct care staffing
The QNU’s submission also noted the troubling downward trend in direct care staffing.

In the 2008-2009 financial year, aged care providers nationally spent about 66% of their Commonwealth funding on direct care staffing costs.

In the 2011-2012 financial year, this figure had dropped to 60%, and in 2014-2015, it dropped further to 55%.

It’s the QNU’s position that this pattern of continual reduction in proportional spending on direct care staffing costs should be of serious concern to the Senate Committee as well as the nursing community as a whole.

Considering a 100-bed facility operating in the top 25% of performing aged care facilities can expect to make an annual operating profit of about $1.6 million, reduced spending on direct care is even more outrageous.

We cited reports from QNU members who indicated staff regularly arrive before their shifts begin and stay back late—all unpaid—to ensure residents get the care they need.

Our position is that the need for quality care must trump profits.

There are also issues with the disconnect between increased care needs for ageing patients, federal funding and staff levels. While service providers are able to access increased funds for higher needs residents via the Aged Care Funding Instrument (ACFI) there is currently no requirement for a reciprocal increase in staffing to manage the higher level of care.

Transparent reporting
Given aged care services provide what is ostensibly an essential service, we maintain this service should be delivered within a safety and quality framework.

We also maintain that aged care reporting should be completely transparent with respect to how funding is spent and how much goes into profits.

Unfortunately, the current situation prioritises profits over resident care, and the community has little knowledge of how much care providers invest in key quality of care factors like staffing and skill mix.

We concluded that without the implementation of professional nursing standards in aged care, the quality of care for residents and working conditions for nurses were unlikely to improve, and at worse, could deteriorate.
Fiji recovery effort follows country’s worst cyclone

More than 50,000 people have been left homeless after a cyclone ripped through Fiji on 20 February.

With winds of up to 325 kph recorded during the island nation’s worst cyclone, more than 40 people were killed and entire communities flattened.

The country now faces major shortages of food, water and electricity.

The Fijian government says health care, education and agriculture are their biggest concerns in the immediate aftermath of the cyclone.

Threat to health
The outbreak of diseases is unfortunately likely following such a severe natural disaster.

The Australian Medical Assistance Team in Fiji—made up of 20 nurses, doctors and pharmacists—say they are already seeing diseases emerging as a result of the cyclone.

With large crowds of displaced people gathering together, it is easy for illnesses to spread quickly.

Health workers say they are treating people for respiratory and gastrointestinal illnesses as a result of disruptions to clean water and proper sanitation.

Donate now to support relief effort
The Australian government has donated $15 million in humanitarian assistance, which is helping provide clean water, food and shelters, as well as rebuilding vital infrastructures.

Union Aid Abroad-APHEDA is also working with the Fiji Congress of Trade Unions to help people rebuild their communities.

Donations will assist with rebuilding housing and support ongoing development activities, including re-establishing crops and small scale food production.

To make a donation—large or small—please visit https://apheda.org.au/fiji-appeal/

Short-term austerity leads to nursing shortage

Nine out of 10 UK hospitals are struggling with nurse shortages which experts say are linked with higher death rates.

Health Education England chief executive Ian Cumming told the media last week that the UK’s National Health System had more than 23,443 nursing vacancies—which is a job vacancy rate of about 10%.

He said the UK public health system—the NHS—is facing a significant nursing shortage that was likely to continue until 2020.

The figures come just a couple of months after a five year study by St George’s Hospital in London and Southampton University found that health services with the lowest mortality rates in emergency surgery had 24% more nurses than those with the highest death rates.

The nurse shortage is forcing more than two-thirds of trusts to turn to overseas and migrant workers to fill vacancies, with nurses being recruited from as far as India and the Philippines.

But even this has been hampered by tougher immigration policies.

Bursaries vs loans
To make matters worse, the UK government plans to replace its bursary scheme with loans.

Currently student nurses and midwives receive an annual bursary while they study.

While the government claims scrapping the bursary system will lift the cap on the number of students who can study nursing and midwifery, unions say introducing a loans system would turn would-be nurses and midwives away, particularly those from poorer backgrounds.

Read the full Guardian story at http://bit.ly/1XUHnua

Ratios – the solution to preventing crisis
QNU Secretary Beth Mohle said the bleak situation overseas was a reminder of why Queensland nurses and midwives were demanding safe legislated ratios.

“When the focus turns to fixing the budget bottom line, safe patient care inevitably suffers as a result,” said Beth.

“Having legislated ratios is about providing a safety net under which our nurse and midwife staffing levels cannot fall.”
We achieved some substantial outcomes during this round of negotiations. Significantly, we’ve retained all existing entitlements, while improving the current wages and conditions of Queensland Health nurses and midwives.

As you can see from the summary opposite, this in-principle agreement is very much focused on achieving better workloads for all Queensland Health nurses and midwives to keep you and those in your care safe.

Importantly, negotiations around workloads occurred within the context of establishing minimum nurse/midwife-to-patient ratios, which are due to begin rolling out in prescribed locations from 1 July 2016.

**Report back meetings**

After the in-principle agreement was endorsed by QNU Executive, nurses and midwives from QNU Local Branches were then given the opportunity to consider it. We held close to 100 meetings around Queensland so members could vote on whether the in-principle agreement was suitable to go to a ballot.

Ultimately, members voted ‘yes’. This means the in-principle agreement will now go to a ballot of all Queensland Health nurses and midwives.

**Consultation guided negotiations**

Consulting with members right across the state is fundamental to our union’s democratic structure. Nurses and midwives are the Queensland Nurses’ Union, and it’s the members who ultimately shape and influence the direction of such negotiations.

The current in-principle agreement would not look how it currently does were it not for the critical feedback QNU officials received from nurses and midwives throughout negotiations. From identifying the priorities of nurses and midwives at our annual conferences, to seeking feedback from every Local Branch when negotiations stalled in February, this process has demonstrated what we do best.

**What happens now?**

The in-principle agreement will now be voted on by all Queensland Health nurses and midwives.

A ballot will take place in the coming weeks.

With a number of overdue projects to be undertaken during the life of the agreement, we believe this agreement goes a long way to building a better work and better life for Queensland nurses and midwives.

QNU members working for Queensland Health will receive more detailed information about the ballot process.

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... WE’VE RETAINED ALL EXISTING ENTITLEMENTS, WHILE IMPROVING THE CURRENT WAGES AND CONDITIONS OF QUEENSLAND HEALTH NURSES AND MIDWIVES.
Key outcomes

- **Pay increase** of 2.5% each year over life of agreement.
- Increase the number of Enrolled Nurses Advanced Skill (ENAP) by 40% over the life of the agreement.
- Review of how on call, recall and night shifts are currently rostered in order to determine a better way forward.
- Funding to trial and implement workplace initiatives that better support NUMs and MUMs, and which address their increasing workload demands.
- **Conditions for casuals**, including introducing loading on Sundays, and removing the 32-hour weekly cap. A clause will also be introduced into the agreement stating that casual employment will not replace permanent or temporary employment.
- QH has backed away from their push to standardise annual leave and public holidays. We will review current arrangements with QH in a collaborative manner over the life of the agreement.

Getting back on track

Over the life of the agreement, the QNU will be once again working collaboratively with Queensland Health on projects that help build a better nursing and midwifery workforce.

Projects include:

- Improving the career and classification structure. We're currently working with QH to finalise new award classification descriptors (generic level statements) that better describe nursing and midwifery as they exist now. The new descriptors will be in place for EB9. Under the new agreement, we'll then be implementing a transparent classification ladder that gives nurses and midwives confidence they are classified correctly.
- Reviewing RANIP and other entitlements to rural and remote nurses, and identifying better ways to acknowledge the challenges and costs of working in rural and remote communities.
- Workforce planning:
  - Better approaches to parental leave, transition to retirement, and workforce retention.
  - Removing road blocks to advancing midwifery models of care.
  - Developing protocols to give graduates a better career path.

Workloads

- Negotiations around workloads have occurred within the context of establishing minimum nurse/midwife-to-patient ratios.
- Improvements to the Business Planning Framework (BPF) to strengthen its ability to be the underpinning tool for ensuring safe workloads and patient safety. The BPF ensures staffing levels meet varying patient demands within the minimum safety net created by ratios.
- Improving the workload concern resolution process.
Politicians have been hearing directly from nurses and midwives throughout Queensland about the urgent need for ratios.

Following the QNU’s submission to the government’s proposed ratios bill, the parliamentary committee toured regional Queensland (Townsville, Cairns and Gladstone) before another hearing at Parliament House in Brisbane.

These hearings gave politicians the opportunity to ask questions about how ratios will make a real difference to patient safety and health workers.

The hearings also gave nurses, midwives, academics and QNU officials the chance to speak about the evidence behind our ratios campaign.

QNU members spoke bravely and eloquently at each of these hearings, telling politicians how it really is at the coalface, and answering difficult questions.

Committee to deliver report soon

The committee will now review the government’s proposed legislation in light of the evidence heard in March.

“Our chance to tell it like it is

Speaking at the Brisbane public hearing, Registered Nurse Moira Purcell spoke of the impact of understaffing and unmanageable workloads.

“Understaffed and overworked, the wards are now in crisis,” Moira said.

“Proper care is impossible, proper monitoring and communication is impossible, mistakes and dangerous outcomes are inevitable.”

“Patients see how busy nurses are—they try and lessen their workload, often by withholding vital communications, sometimes by attempting to mobilise themselves, sometime with disastrous and costly consequences.”

Nurse Unit Manager Janelle Taylor spoke about the pressures on the nursing workforce in a system that is streamlined.

“The ever-increasing organisational imperatives that are introduced on a daily basis inevitably land on the nurses,” Janelle said.

“Patients are staying in hospital for shorter periods of time. Their care is streamlined, they go home quickly and often unpredictably.”

“Current nurse-to-patient ratios do not support these changes.”

“Improved ratios will mean nurses are able to spend more time with patients and families, facilitating better patient education, better understanding of their conditions and prevention of readmissions.”

Registered Nurse Lauren Picker told the committee about the emotional toll unsafe ratios have on staff.

“One of the greatest concerns that I and many of my colleagues see are nurses finishing their shifts distressed and in tears with the guilt of not being able to provide safe nursing,” said Lauren.

“They will often stay behind to complete the increased amounts of paperwork now required by what appears to be a system that has lost touch with the grassroots of health care.”
REMEMBER:

Ratios set the floor, and can be improved

Over the past month we’ve been visiting hospitals talking to nurses and midwives about ratios.

While there’s a lot of excitement out there for getting minimum ratios, there’s still some confusion as to exactly how ratios will be implemented.

Ratios will work in conjunction with the Business Planning Framework (BPF).

This means the minimum ratios of 1:4 (morning/afternoon) and 1:7 (evening) can be improved according to patient acuity and skill mix.

More staff may be required to meet patient demand, and the new legislation will allow nurses and midwives to use the BPF to establish ratios of 1:3, or even 1:1.

Visit www.ratiossavellives.com.au for more information on ratios, including how and where they will apply in the initial rollout starting 1 July 2016.
Healthy budgets are essential for safe quality care
In this edition of *tqn* we outline the last of the four vital issues on QNU’s federal election agenda.

The likely 2 July double-dissolution election makes it one of the most important elections Australians have faced (for more on double-dissolution elections, see the article on page 37).

The party that wins government will likely have control of both houses of parliament, which means power to push laws through without the usual scrutiny.

We are paying very close attention to all parties’ plans for the health sector, as well as their vision for Australia more broadly.

**Quality of care**

Over the past few editions we have examined the most important election issues for Queensland nurses and midwives.

We covered *fairness at work* in the form of penalty rates (October 2015), *innovation and sustainability* in the shape of e-health and digital hospitals (December 2015), and *universal healthcare*, specifically Medicare and accessibility (February 2016).

Now we turn to the crucial component in our daily work: *quality of care*.

**Health funding**

Health funding has been a major issue in Australia for many years now.

We all know Australia’s population is ageing, demand for health services will continue to grow, and health expenditure will continue to increase.

The solution is not to cut health services, although there is value in reviewing the allocation of health funding in acute and non-acute settings to ensure health care is delivered where and when it is needed—for example, refocusing on preventative health initiatives that keep people out of hospital.

The solution is to grow revenue, look at our collective priorities, and develop sustainable health budgets into the future.

Unfortunately, the current prognosis is not encouraging.

**Major cuts to health budgets**

The Turnbull government intends to rip $57 billion from the public health service over the next eight years.

In 2011, the federal government signed a deal with the states to fund 50% of the efficient growth in hospital activity after July 2017.

However, the Abbott government reneged on that deal, and proposed in last year’s budget to slash $57 billion from health spending.

This would mean huge cuts to health budgets, including $11.8 billion from Queensland.

More recently, at the April Council of Australian Governments meeting the federal government and the states agreed to a ‘Heads of Agreement’ for public hospitals funding.

Under this agreement the states will receive an estimated additional $2.9 billion in funding for public hospitals from 1 July to 30 June 2020.

Unfortunately this is well short of the $57 billion the states were expecting.

How the Queensland government plans to reduce health expenditure to plug such a significant funding gap is currently unknown.

**Senate committee investigates impact on northern Queensland**

A Senate Select Committee recently looked into the effects of the reduced funding in northern Queensland.

The chair of the committee, NSW Senator Deborah O’Neill, said the Turnbull government’s proposal went “against the evidence base and is constructing a perfect storm of rising health costs into the future”.

QNU Secretary Beth Mohle said the cuts would have a dramatic impact on quality of care and universal access to healthcare.

“As we approach the next federal election, the current government really needs to ask itself if cutting access to quality health care is a priority,” she said.

“We know many of our public hospital services are already stretched to the limit so it is frightening to think any of these services could be reduced by the proposed funding cuts.”

**Cuts to pathology services**

We all remember the unsuccessful attempt by the Abbott government to ram through a $7 GP co-payment.
That project was abandoned after national outcry.

However, the Turnbull government has proposed a “co-payment by stealth” of its own on pathology services.

By removing bulk billing incentives for pathology services, the Turnbull government hopes to save about $100 million per year.

Pathology companies have said they will need to raise prices to cover the loss—so people who need pathology services will pay more.

Objections to the government’s proposal in part arise from the fact pathology services are usually not ‘chosen’ by patients. Instead, people are referred to pathology services by other health professionals.

Professor Stephen Duckett from the Grattan Institute has suggested removing the ‘incentive’ aspect altogether, instead making bulk billing a mandatory requirement to providing pathology services.

**Investment is the best saving**

As the QNU’s *Ratios Save Lives* campaign has proven, investing in health saves lives and money.

For too long federal politicians have focused on how they can cut health budgets now, instead of how they can create sustainable health budgets in the future.

In this year’s federal election, we want to hear clear and specific proposals from each party on how they plan to invest in quality of care in the public health system.

**Senate hearing into Aged Care workforce**

The Australian Senate is currently conducting an inquiry into the future of Australia’s aged care sector workforce.

An ageing population means growing demand for aged care health services. Issues being investigated by the inquiry include:

- current and future workforce requirements
- challenges in attracting and retaining aged care workers
- the wages and conditions of aged care workers
- the impact of government cuts to funding.

The QNU contributed to a submission to this inquiry via the federal ANMF, which argued:

- Appropriate quality of care requires an adequate number and mix of skilled staff.
- Work performed in the aged care sector continues to be undervalued and underpaid.
- Problems in attraction and retention are not new and are well understood.
- There is a lack of will by governments and industry to address these matters seriously.

Although the committee was scheduled to report on 30 June, it is expected the committee will be suspended until after the federal election.
Regardless, the QNU expects all parties to have serious policies on how the aged care sector can be given what it needs to ensure older Australians have access to an appropriate quality of care.

Registration of AINs and PCs

The QNU is a longstanding advocate of the development of national standards for Assistants in Nursing (however titled), as well as national registration. This would go a long way to giving AINs and PCs the professional recognition they deserve.

Licensing of all workers in the aged care system would also ensure that each nurse and carer is adequately trained and supervised to provide quality care. This would keep nurses and their residents safe.

Interestingly, the Aged Care Guild—which represents nine of the largest private aged care residential providers—called for PCs to be nationally registered. Service providers have traditionally been opposed to national registration.

Leadership from our federal government on this issue would have an instant impact on the quality of care being delivered to our elderly Australians.

Funding

There are renewed calls for the federal government to restore funding to the aged care sector, following Prime Minister Malcolm Turnbull’s move to return the sector to the health portfolio. Responsibility for aged care was broadly covered under the social services portfolio under Tony Abbott’s prime ministership, a move which sparked criticism that the ageing population was not given the priority it deserved.

Now Health Minister Sussan Ley has taken charge, and the sector is already urging her to address the immediate concerns, including lack of funding and an ageing population.

According to an ABC News report, about $800 million of government funding has been ripped from the sector over the past few years.

But it’s estimated billions more need to be invested to meet demand and provide the residential and home care services required to look after Australia’s older population.

Former Chief executive of National Seniors Australia Michael O’Neill said the government now faced the challenge of reforming the aged care sector.

This includes providing adequate wages for nurses to deliver quality care to patients.

QNU Secretary Beth Mohle said reforming the aged care sector was a matter of urgency and is a major issue going into the next federal election.

“Aged care facilities are suffering from poor nurse-to-resident ratios and skill mix levels,” Beth said.

“The system will only get worse unless we act, and that includes providing the proper support to those nurses trying to deliver safe, high-quality care to residents.”
NMBA releases revised practice standards

The Nursing and Midwifery Board of Australia (NMBA) recently published its revised registration standards for continuing professional development (CPD), recency of practice (RoP) and professional indemnity insurance (PII). These revised standards are effective from 1 June 2016, in line with the start of the next annual registration period.

This means all nurses and midwives will need to meet the obligations of the revised registration standards by the May 2017 renewal period.

The revised standards do not apply to registration renewals in 2016.

The key changes are highlighted below, but you will need to read each standard in full to consider how the revisions will impact your practice.

Visit the NMBA website for more information:


Changes to CPD standards:

- Nurses and midwives who are registered but not working need to seek clarification on the requirements to complete CPD.
- Midwives with endorsement for scheduled medicines must complete an additional 10 rather than 20 hours of CPD, specifically related to prescribing and ordering of diagnostics.
- For nurses and midwives who have held registration for less than 12 months, pro rata CPD hours apply.

Changes to RoP standards:

- Nurses and midwives are provided with a definition of two main areas of practice: clinical and non-clinical practice.
- Practice hours will be recognised as meeting this standard if:
  - you hold or have held current and valid registration
  - your role involves the application of nursing and/or midwifery knowledge and skill
  - you have carried out postgraduate education leading to an award or qualification that is relevant to the practice of nursing and/or midwifery.

Changes to PII standards:

- Cover includes automatic reinstatement.
- The definition of ‘run-off’ cover has been amended for clarity.
- ‘Run-off’ cover is required for when you cease practice for matters arising from previous practice as a registered health practitioner that would otherwise be uncovered.

The QNU provides members with CPD opportunities and PII cover.

These revised standards are effective from 1 June 2016, in line with the start of the next annual registration period.

QNU members reject plans to drop RIPEN standards

Following broad consultation with members and an unprecedented number of responses, the QNU has made a submission to the NMBA in support of maintaining the current RIPEN endorsement standard.

The RIPEN Endorsement for scheduled medicines rural and isolated practice (RIPEN endorsement standard) describes the required qualification and experience a Registered Nurse must demonstrate in order to be endorsed to supply scheduled medicines under protocol.

In 2015, there were 794 RIPEN Queensland nurses registered with the Australian Health Practitioner Registration Agency (AHPRA). Queensland is Australia’s most geographically decentralised state, and its low population density outside the south-east corner and high number of very isolated communities are the main reasons why Queensland has the most RIPEN endorsed nurses in the country.

Queensland’s rural and remote communities, many of them with high Aboriginal and Torres Strait Islander populations, are already disadvantaged by geographical isolation, with less access to healthcare, higher mortality and higher morbidity.

QNU members speak out

Directors of Nursing in rural and remote areas, Clinical Nurse Consultants, Nurse Practitioners and RIPEN nurses took part in two QNU focus groups about RIPEN endorsement.

All participants, as well as those who spoke to us individually, unanimously opposed plans to withdraw the RIPEN endorsement standard.

Our members believe discontinuing the RIPEN endorsement of registered nurses would severely limit public access to medicine in rural and remote areas, and situations where there is no medical officer.

We await the outcome of the NMBA consultation paper.
But how do patients participate in their care? How can we as nurses promote patient participation? These were some of the questions NCREN researchers set out to answer in a recent research project, in which the aim was to develop strategies to enhance patient participation in care.

In the first phase of this project, our research team conducted interviews with 20 patients and 20 nurses to discover their views of patient participation. We focused on medical wards. This project was conducted at two hospitals, one public hospital in Queensland and a private hospital in Victoria. Including two states allowed us to gain a broader understanding of patient participation in different settings and with different people.

Key findings from patient interviews showed patients were motivated to take part!

Patients especially wanted an active role in ensuring their own safety, stating they were ‘on the lookout’ by monitoring their own symptoms, listening to information exchanges like bedside handover and watching medication rounds to ensure they helped keep themselves safe (Tobiano et al. 2015b). However, patients needed nurses to be welcoming and encouraging for them to be active.

Nurses also acknowledged the importance of patients as partners, identifying many activities patients could be involved in (Tobiano et al. 2015a). Yet, participation could not be based on a one-size-fits-all approach. Nurses had to consider each patient’s capabilities, characteristics and risks to determine how and what level of participation the patient can undertake. Importantly, nurses said that was their role to enable patients to participate in nursing care.

Key messages
What does this mean for your practice? Patients want to have a role in their care, and partnering with patients could enable them to be an added safety net. Nurses are key to the success of patient participation. As nurses we need to encourage and promote patient participation for it to occur.

Consequently, we have investigated patients’ and nurses’ preferences for patient participation in bedside handover. We will use these results to develop recommendations for promoting patient participation in practice.

Watch this space, as there is more come on how you can partner with your patients.

References


Good delegation favours guidelines over guesswork

The working life of a registered nurse or midwife is one that carries high levels of responsibility and accountability. The regulation of nursing and midwifery is stronger than it has ever been with nationally consistent codes and guidelines developed by the Nursing and Midwifery Board of Australia (‘the Board’).

The Board, in its role as the protector of the public in the application of nursing and midwifery practice, expects high standards of care and conduct to be engaged by every nurse and midwife. We arrive at work every day knowing that these standards will ensure the provision of safe and quality care, but as much as we would like to be able to do every episode of care for each of our patients, we know there just aren’t enough hours in the shift to do so.

This is why the Board makes provision for registered nurses to delegate or allocate certain episodes of care to other nurses and healthcare workers. Consequently, Enrolled Nurses and Assistants in Nursing (however titled) (AIN) play a vital and important role in ensuring all patients receive the care they need.

The delegation of care to another person is a serious matter and one that requires due consideration of a number of important principles, and assurances that a number of criteria have been met. Registered Nurses cannot afford to be blasé about asking ENs and AINs to undertake nursing care, nor can they make assumptions, because that’s how errors occur.

Fortunately good delegation doesn’t require guesswork, because the principles and criteria for appropriate delegation are given to us by the Board’s standards, codes and guidelines for professional practice. To help guide us in delegation and supervision, the National Competency Standards for the Registered Nurse makes a number of statements regarding delegation, one of them being that the Registered Nurse “understands (the) requirements for delegation and supervision of practice.” Similarly, the National Competency Standards for the Midwife states “Delegates, when necessary, activities matching abilities and scope of practice and provides appropriate supervision.”

As we can see, supervision must go hand in hand with delegation, the two cannot be separated, and the Board requires nurses and midwives to engage a number of principles before, during and after delegating aspects of care to other nurses, midwives and healthcare workers. The principles for appropriate delegation and supervision are set out in definitions found at the end of the Board’s National framework for the development of decision-making tools for nursing and midwifery practice (‘the DMF’). We can use these principles to answer a number of common questions asked in relation to delegation.

When does a delegation relationship exist?
The delegation relationship exists when the nurse or midwife delegates aspects of patient or resident care, which they are competent to perform and which they would normally perform themselves, to another member of the health care team.

Delegation can take two forms. It can be the transferring of authority to a competent person to perform a specific activity in a specific context; or it can be the conferring of authority to perform a specific activity in a specific context onto a competent person who does not have autonomous authority to perform the activity.

For Registered Nurses, the latter form of delegation is the one that most commonly occurs, when ENs or AINs are delegated to carry out patient or resident care activities.

It is also important to realise that once an activity has been delegated to an EN or AIN, it cannot be re-delegated by that person to someone else. If changes in the context of care occur that necessitate a re-delegation, the EN or AIN must consult with a registered nurse.

Is delegation different to allocation?
Delegation is different from allocation, which involves asking another person to care for one or more patients or residents on the assumption that the specific care required is normally within that person’s responsibility and scope of practice. However, many of the same principles and criteria that are relevant to delegation must also be considered when allocating...
the care of a patient or resident to another Registered Nurse.

For a Registered Nurse who is the clinical team leader or Nurse Grade 6, allocation often occurs when the other Registered Nurses on duty are allocated to care for specific patients. However, the principles of delegation and supervision will still apply to ensure the care required by each patient is within the scope of practice of each Registered Nurse and that the workload allocated is appropriate.

There are also two types of delegation, new delegation and established delegation. A new delegation occurs when you have not delegated the specific activity to the person before and are therefore unfamiliar with their skill and competence to perform the care competently. An established delegation exists when the person has been delegated the activity a number of times and is now able to perform the care safely and competently.

Of course, an established delegation can quickly become a new delegation if the context of care for that patient changes.

**Do I have to accept a delegation?**

Delegation is a two-way activity. The person making the delegation must have the authority to do so and the person receiving the delegation must accept it. This is because delegations are made to meet consumers’ needs and to ensure access to health care services—that is, the right person is available at the right time to provide the right care to the patient or resident.

The person receiving the delegation has a responsibility to ensure they receive any of the teaching, competence assessment and supervision required for the activity. They must be aware of the limits of the delegation and any monitoring or
CASE STUDY

What principles apply before I delegate to someone?
Essentially, the Registered Nurse who delegates a care activity to an EN or AIN must ensure that the person is able to perform the activity safely and competently. This might involve providing some teaching in the activity, but it will always involve assessing the competence of the person and providing an appropriate level of guidance and supervision.

You must also ensure that the person understands their accountability and is willing to accept the delegation. After the episode of care is completed, you must evaluate the outcome of the care provided and reflect on the practice that was engaged to determine if there are any opportunities for improvement.

What can be delegated to an Enrolled Nurse?
What can be delegated to an EN will depend upon the scope of practice of that individual EN, the specific patient and context of care, and any relevant policies of the employer. Registered Nurses must remember that EN education has been nationally consistent for less than six years, so there is a wide variety of scopes of practice for individual ENs, with many (but not all) being qualified to administer medicines and some recent graduates being qualified to administer medicines via the intravenous route.

The Registered Nurse must engage in a discussion with the EN to determine their individual scope of practice, which is established by their education, authority and competence. Another consideration is any restriction placed upon EN practice through employer policies, as some employers will not permit ENs, whether qualified or not, to administer medication intravenously.

All Registered Nurses must keep in mind that Enrolled Nurses are not permitted to practice nursing autonomously; therefore the outcomes of any episode of care delegated to an EN must be evaluated by the Registered Nurse. If the EN wishes to expand their scope of practice, the DMF provides good guidance for that process in Statement of Principle 2 on page six of the guidelines.

What can I delegate to an AIN or Personal Carer?
The Board defines AINs (and carers engaged in assisting with nursing care) as ‘non-nurses’ because they are not registered to practice as a Registered or Enrolled Nurse. The Board gives very good guidance on what can be delegated to non-nurses, who have no scope of nursing practice and no autonomous authority to engage in nursing care. As such, AINs and Personal Carers may assist with nursing care only when that activity has been delegated to them by a Registered Nurse.

Prior to delegating an episode of nursing care to an AIN or Personal Carer, the Board requires that the Registered Nurse must consider the following seven criteria:
1. Performance of the activity by a non-nurse will achieve the desired client outcomes, and the client consents, if at all possible, to the activity being performed by a non-nurse.
2. There is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a non-nurse.
3. There is professional consensus (i.e. support from the nursing profession or other experienced nurses) and evidence for the performance of this activity by a non-nurse.
4. The non-nurse is competent (i.e. has the necessary education, experience and skill) to perform the activity safely.
5. The non-nurse’s competence has been assessed by a registered nurse.
6. The non-nurse is ready (confident) to perform the activity and understands their level of accountability for the activity.
7. There is a Registered Nurse available to provide the required level of supervision and support, including education.

The Board states that if all of the above criteria are answered in the positive, the Registered Nurse may delegate the episode of care to the AIN or Personal Carer and that if any of those criteria are not met, the nursing activity must not be delegated.

The Board’s expectations around delegation and supervision, as described in this article, are found in the various Codes and Guidelines issued by the Board pursuant to the Health Practitioner Regulation National Law Act 2009 (Qld). These Codes and Guidelines form professional standards for nursing.

All nurses and midwives should be aware that failing to comply with professional standards can result in allegations of unprofessional conduct or professional misconduct. The risks of not employing the principles of delegation and supervision can be very serious and not only result in adverse outcomes for the patient or resident, but also for the individual Registered Nurse or Midwife.
Completing this reflective exercise will contribute to your Continuing Professional Development (CPD) hours.

The Nursing and Midwifery Board of Australia requires all nurses and midwives to complete a minimum of 20 hours CPD per registration year for each respective profession for which the individual holds current registration.

For example, an individual who is a Registered Nurse and a midwife must complete 40 hours of CPD.


Effective learning is not simply reading a journal article—it requires you to reflect on your readings and integrate new information where it is relevant to improve your practice. It should include:
- looking for learning points/objectives within the content on which you reflect
- considering how you might apply these in other situations to enhance your performance
- changing or modifying your practice in response to the learning undertaken.

**THE FOLLOWING IS AN EXAMPLE ONLY OF A RECORD OF CPD HOURS**
(based on the ANMF continuing education packages):

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Description</th>
<th>Learning Need OR Objective</th>
<th>Outcome</th>
<th>CPD hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>27-03-16</td>
<td>Coroner’s matter – workloads</td>
<td>Understanding the implications of the Coroner’s recommendations for the establishment of effective workload management strategies</td>
<td>To increase my knowledge about the consequences of workloads’ demands and skill mix deficits on patient safety</td>
<td>I have achieved a greater awareness of.....</td>
<td>2.5 hrs</td>
</tr>
</tbody>
</table>

1. As a Registered Nurse or Midwife, what do I need to do before I delegate nursing care to an Enrolled Nurse or delegate Midwifery care to a Registered or Enrolled Nurse?

2. As a Registered Nurse, if I delegate care to an Enrolled Nurse, AIN or Personal Carer, I must evaluate the outcome of that episode of care. How does my enterprise agreement assist me in ensuring that my employer manages this important part of my daily workload?

3. If I am the only Registered Nurse overseeing several AINs providing care for up to 100 aged care residents, how do I evaluate the outcome of every episode of care on my shift?

4. If I delegate care to an EN and there’s an adverse outcome for the patient, how would I demonstrate that I did all that was required of me prior to the delegation?

5. Our aged care facility manager has told me that several of our Personal Carers are competent at wound management. Is that good enough for me to delegate that activity to them? If not, what criteria must I consider before allowing the person to provide nursing care to a resident?

6. Why is the scope of practice of Enrolled Nurses different for each individual? What role does scope of practice play when considering delegation?

7. If one of the seven criteria for delegating to an AIN or Personal Carer is not met, I cannot delegate the activity. What does the DMF say I must do in this situation? (See DMF pages 9-10).

8. If I don’t consider the principles of delegation prior to delegating, does there need to be an adverse outcome for the patient for me to be engaging in unprofessional conduct? If not, why not?

9. Proper delegation, especially to new or inexperienced nurses and AINs, will take up a lot of my time instructing, assessing and supervising. How can QNU’s workload resources assist me in managing the additional workload?


To meet the NMBA CPD standard it is important that you can produce a record of CPD hours, if requested to do so, by the board on audit.

The time spent reading this article, reviewing the referenced material and then reflecting upon how to incorporate the information into your practice will contribute to your CPD hours.

Please keep a record of time spent doing each activity in your CPD record.
Nurses and midwives keep patients safe during their most vulnerable times.

We are happy at work when we have the time and resources to provide the high quality care our patients deserve. However, when patient care is compromised and we are unable to effect the change required to improve it we become frustrated, increasingly dissatisfied in the job and burnt out, which results in nurses and midwives disengaging from or leaving their workplace or abandoning the profession altogether.

Research shows the quality of the clinical practice environment significantly affects patient outcomes and job satisfaction in nurses and midwives, just as much as having adequate staffing numbers.

According to the world-renowned Practice Environment Scale - Nursing Work Index, one of the essential elements for a good clinical practice environment is “the responsiveness of management in resolving problems in patient care”.

To achieve this responsiveness, workplaces should have:

- a nurse/midwife unit manager (N/MUM) or immediate supervisor who is a good manager and leader
- a N/MUM who backs up their staff in decision making, even if conflict is with a doctor
- a senior nursing or midwifery administrator who is highly visible and accessible to staff
- supervisors who use mistakes as learning opportunities instead of criticisms
- supervisors who are supportive of nurses or midwives
- administration that listens and responds to employee concerns
- supervisors who praise and recognise a job well done and engage on a daily basis.

The (N/MUM) role is critical in developing a good clinical practice environment, as it is their skills in leadership and support staff which has been shown to be a significant factor in whether a workplace is perceived as good or bad.

The importance of the N/MUM role was emphasised during our recent public sector EB negotiations, and it was agreed we need to do further work throughout the life of the agreement to grapple with the workloads of N/MUM to allow them to refocus the role on clinical leadership.

Refocusing this role will involve minimising unnecessary administrative responsibilities caused by organisational restructures that have diversified the N/MUM role.

Fewer administration tasks will enable N/MUMs to lead and empower staff by maintaining and improving professional standards, staff supervision, increased teamwork, mentoring and staff recognition.

The N/MUM role is pivotal in building nurse and midwife power in the workplace.

They make a significant contribution to our ability to take control of our professional practice, as well as enabling us to advocate for our patients and other nurses and midwives.

We must all recognise and harness the power we have in the workplace through participation and leadership at every level.

Nurses and midwives must be able to act at the local level to identify issues early, and engage in productive processes to resolve or escalate those matters.

It is the N/MUM who facilitates this action by making connections within the organisation that develop into positive relationships which improve the clinical practice environment to benefit both patients and staff.

References


Rocky midwives take a stand on unsafe workloads

We are hopeful the tide may be starting to turn for midwives in the Rockhampton region with a new group established to monitor and act on excessive workloads.

Midwives endured chronic understaffing for a long time, and identified cuts to training and a lack of support for nurse graduates as serious risks to safety.

QNU members attending the local Nursing and Midwifery Consultative Forum (NaMCF) began formally raising concerns about unsafe workloads and staff shortages 10 months ago.

QNU has repeatedly raised workload issues with Central Queensland Hospital and Health Service (CQHHS), and while a number of the complaints were noted and recognised, the Service repeatedly failed to take action.

By February the situation reached a head after the CEO publicly and wrongly blamed midwives for poor outcomes in the unit.

Midwives and nurses from across the facility were justifiably outraged.

In formal correspondence to the CEO as well as the Board, the QNU outlined staff concerns regarding an unsafe practice environment and risk patient safety and listed all the failings the midwives felt remained unaddressed.

Management’s reaction to the staffing crisis they created was to suspend the Maternity Group Practice program and use those midwives to plug the gaps.

The suspension prompted angry protests from local families and the Maternity Choices consumer group who claimed women and MGP midwives were being punished for CQHHS’s poor management.

QNU Acting Secretary Sandra Eales said the union was also disappointed with the closure, and would work to ensure the program was reinstated as soon as possible.

“This is what happens when midwives have no voice and services are not properly resourced—women lose choices, and in this instance an excellent, model of care has been put on hold because the Health Service failed to maintain services effectively,” Sandra said.

“Continuity of Care models which provide better outcomes for women and higher job satisfaction for midwives are integral to providing women-centred services, and we are keen to ensure the MGP reinstated as soon as possible.”

Meanwhile in the wake of the furore, a new maternity sub-group has been formed within the Rockhampton NaMCF to focus on strengthening midwifery services.

Made up of QNU members and representatives and CQHHS management, the group will meet every two weeks to review workload reports and other matters arising, including the retention and recruitment of midwives.

There have already been some improvements.

The Service has established a Midwifery Director role and a Clinical Midwife Consultant role at the Rockhampton Hospital on a temporary basis for now but with permanent recruitment to come.

The new roles should give midwives a stronger voice, providing professional midwifery leadership which is essential to maintain a good practice environment.

“Credit must go to those Rocky midwives who took a stand for patient safety by speaking out about unsafe workloads,” Sandra said.

“There are still many changes to be made, not least of course the permanent recruitment of more midwives, but hopefully this is the start.”

“I think if Rocky teaches us anything, it demonstrates that nurses and midwives must not accept bad management and unsafe practice environments, because patients will likely suffer the consequences and nurses and midwives could be left to take the blame, while the CEO who created the unsafe conditions for both will move on up the ladder.”

We are hopeful the tide may be starting to turn for midwives in the Rockhampton region with a new group established to monitor and act on excessive workloads.
It’s an issue that has been on the QNU radar for more than a decade and we’ve supported many an inquiry, lobbied for changes in workplace practices, published information for members and decision-makers, and of course supported members standing up for their rights to work in a safe environment.

But as the problem has grown, particularly in terms of alcohol and drug-induced aggression, there is a real need for a multi-layered approach to protecting nurses and midwives from violence at work—an approach that considers everything from training, security standards and models of care to response teams, reporting and workplace design.

While attempts to engage the previous government in developing a co-ordinated response were unsuccessful, the current state government takes a more collaborative approach.

The Occupational Violence Taskforce, convened by the Health Minister earlier this year, has already met several times and hosted a state wide forum in late March.

Its focus is to influence organisational decision-making regarding occupational violence and to advocate for improvements within Queensland Health.

It will also keep the Health Minister and Director General informed about key issues, trends, and achievements related to occupational violence.

Further meetings are planned and a final report to the Minister, based on feedback and discussions, is due mid-year.

Taskforce members include the QNU and other unions, mental health clinicians, hospital and health service representatives (both metropolitan and rural), patient safety and WHS staff, Public Safety Business Agency representatives, senior nursing and medical staff, and a senior member of the Queensland Police.

In one of our earliest engagements the QNU has asked the taskforce to consider two key documents—the Victorian ANMF’s 10-Point Plan to end violence and aggression in the workplace and the Victorian Occupational Violence Against Healthcare Worker Report.

The ANMF’s plan calls for the Department of Health to develop adequate baseline standards for security and to provide funding to ensure healthcare organisations are able to comply.

A major talking point for the taskforce thus far is that zero tolerance policy imperatives are frequently watered down in the real world of clinical practice.

Because there is a culture of not reporting violent incidents within health services, the taskforce will consider how to rectify the problem.

Another area identified within the taskforce is the adequacy of current post-incident management processes, including investigation, follow-up, and support for an assaulted worker.

Environmental design is also an area for consideration. The QNU notes that single room designs create issues for security and believes that new facilities need to incorporate crime prevention designs.

The taskforce has identified some positive measures around exposure reduction, incident management, and post-assault support that could be adopted by others.

However, the QNU remains concerned that, due to the current management structure, there is no mechanism to ensure all HHSs adopt the taskforce’s recommendations.

We believe the Department of Health needs to integrate legislation, policies, and procedures and apply an anti-violence mandate across all health disciplines while facility management must demonstrate a strong commitment to changing the culture, in part by empowering staff to expect a safe workplace.

And of course, nurses and midwives can make a difference by becoming more aware of the issues and demanding high standards of behaviour in the workplace.
The founding fathers of the Australian constitution long pondered the problem of a deadlock between the two houses of parliament (the House of Representatives and the Senate) in a system where both houses are popularly elected.

The solution they arrived at was the double dissolution, a process set out in section 57 of the constitution. The first step is that a bill or bills (in the 1975 DD election there were 21 bills) must fail to pass the Senate on two occasions three months apart. This is known as the double dissolution trigger.

Next, the Prime Minister may ask the Governor-General to simultaneously dissolve both houses, however, it is entirely up to the Prime Minister whether to use the DD option.

Because it's not automatic, the decision is entirely political.

If a DD is called, all Senators and members of the House of Representatives must face an election at the same time. Usually Senators have a six-year term (except NT and ACT Senators) and only half the Senate faces election at any one time.

A DD election has to be held at least six months prior to the three-year anniversary of the date parliament first sat after the previous election.

The last step in the DD process is that if the government is returned, and the bill or bills are again rejected by the Senate, a joint sitting of both houses can be held to pass the bill/s.

DD elections have only been held six times in the 115 years since federation, and only one—under the Whitlam government—has resulted in a joint sitting of both houses.

That particular joint sitting brought in our universal health care, through the introduction of Medibank (now Medicare), parliamentary representation for the ACT and NT in federal parliament, and electoral law reforms ensuring 'one vote, one value'—all significant and worthy nation-changing reforms.

The first DD election was held in 1914 by the Joseph Cook liberal government.

That election was held 12 months into the government's new term and the trigger was an anti-trade union bill.

That bill was not significant or vital to the operation of government. It had been blatantly contrived to provide a reason for a DD election because Cook wanted control of the Senate.

The electorate overwhelmingly rejected the Cook government, and Andrew Fisher and Labor won in a landslide.

Is history set to repeat itself 112 years later?

It seems at present there is a plot unfolding worthy of Frank Underwood (from House of Cards), where a double dissolution election has been set up on the basis of re-establishing the Building and Construction Commission.

Given the recent revelations of the Panama Papers concerning corporate behaviour, is this matter truly worthy of a double dissolution election?

Or is this union demonising just a political diversion from the real issues facing Australia?
Thursday 17 March was National Close the Gap Day, and QNU staff chose to raise awareness and funds with a morning tea.

Thanks to donations of home-baked cakes, biscuits and scones, a total of $260 was raised for the Aboriginal Literacy Foundation.

National Close the Gap Day focuses on making people more aware of the campaign, and signing on to support it. You can register your support and find out how you can help spread the word by visiting http://bit.ly/1XFQ7Dy

The deadly material is now banned in Australia, after a long campaign by unions standing up for the health of workers.

However, across South East Asia—in countries including Vietnam, Cambodia, and Indonesia—hundreds of thousands of tonnes of raw asbestos are imported and knowledge of the dangers it poses to workers is not widespread.

In Indonesia alone, more than 7000 workers are currently being exposed to asbestos. These workers don’t know the risks to themselves, their families or their communities, and factory owners continue to make profits from work done in extremely unsafe conditions.

That’s why Union Aid Abroad-APHEDA has launched a campaign to completely do away with asbestos. The plan is to support local organisations in educating workers and eradicating asbestos.

Asbestos: not here, not anywhere
Progress is already being made. In Vietnam, APHEDA has supported anti-asbestos programs for a number of years, which has ultimately resulted in government support for a ban by 2020.

Work is also forging ahead in Cambodia, where efforts are being made to scale-up involvement in current campaigns.

In Indonesia the campaign targets the asbestos industry. A new partner, LION, is campaigning for all Indonesians to work without fear of injury or illness due to workplace health and safety hazards being misunderstood or unrecognised.

The focus is now also turning to support local unions and movements in Burma, Laos, and anywhere asbestos is still used.

Join the campaign
You can show your support by donating to Union Aid Abroad-APHEDA, or by making a solidarity sign and sharing on social media using #NotHereNotAnywhere.

Visit www.apheda.org.au/asbestos for more information and to find out how you can spread the word.

QNU Brisbane staff and the many goodies on offer at the National Close the Gap Day morning tea.
Fairer super for all

We are strongly advocating on behalf of our members at the Senate inquiry into the economic security of women in retirement. This inquiry is examining why women retire with significantly less super than men and what changes could be made to improve the system.

HESTA’s submission stresses that the wage gap between men and women remains the biggest factor in women retiring with less than men.

The vast majority of HESTA’s more than 800,000 members are women working in health and community services, where the gender pay gap is 27.7%, according to figures from the Workplace Gender Equality Agency.

Here are three important recommendations that underpin HESTA’s Senate inquiry submission:

Remove the $450 monthly super threshold
The successful introduction of SuperStream, which simplifies and removes the admin burden on businesses, means employers can now make contributions more easily meaning all employees should be eligible for guaranteed super contributions, including those who earn less than $450 a month.

The low income super contribution
We are continuing our campaign of pressuring the government to abolish plans to discontinue the low income superannuation contribution (LISC) in 2017.

If it’s removed, 3.6million Australians, including more than 2.1million women, will pay the same, or in some cases, a higher tax rate on their super contributions than they pay on their wages.

Value unpaid caring roles
We think Australia can learn from the many overseas examples where unpaid caring roles are recognised and remunerated.

Many European and South American countries have systems that ensure women receive a pension voucher or benefit for time taken off work to raise children or care for an elderly.

These recommendations would help ensure all Australians can afford a dignified retirement.

Want to learn more?
To read more visit hesta.com.au

With more than 25 years of experience and $33 billion in assets, more people in health and community services choose HESTA for their super.

Issued by H.E.S.T Australia Ltd ABN 66 006 818 695 AFSL No. 235249, the Trustee of Health Employees Superannuation Trust Australia (HESTA) ABN 64 971 749 321.

The super gap

Despite compulsory super being around for over 20 years, most Australian women currently don’t have anywhere near enough saved for their retirement. But there’s still a lot you can do to boost your super savings.

The facts
A study performed by the Australian Institute of Superannuation Trustees (AIST) in 2011 found that women have significantly less super than men. The study estimated a median super balance for women aged 55 to 64 years was $53,000, compared to $90,000 for men in the same age group.

While the super gender gap has gotten smaller in recent years, women still lag behind men. Super is based on earnings, so women who work part-time or in lower-paying jobs are disadvantaged. With taking time out of the workforce to raise children or care for an elderly parent, it’s easy to see women have a tougher job saving enough for retirement.

Easy ways to boost your super
1. Our Retirement Income calculator is an easy way to work out how much income you can expect to receive and how long your savings are likely to last.
2. Ask your employer to pay some of your pre-tax wage into super. Before-tax salary sacrificing can be a tax-friendly way to grow your super without impacting your budget.
3. You’ll be surprised the impact adding just 1% extra to your super has on your balance by the time you retire. After-tax contributions aren’t subject to the 15% contributions tax because you’ve already paid income tax on this money. Depending on your income, you may also be eligible for a government co-contribution to your fund.
4. Consolidate your super. It’s a quick way to boost your super, and save on extra fees and charges.

Need advice?
If you’re a QSuper member, you can access affordable personal advice from QInvest and in many cases, you can pay part of the fee from your QSuper account.

Call 1300 360 750 or visit qsuper.qld.gov.au to find more.

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- The QNU is **53,000 members strong** - we’re the most experienced union in Queensland defending and championing the rights of health care workers.
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- We **stand up for all our members**, including Registered and Enrolled Nurses, Assistants in Nursing, and Personal Carers.
- We **provide professional indemnity insurance** for all our members, so you are covered no matter where you work.
- QNU members who are Personal Carers have **Income Protection insurance** though their enterprise agreement.
- We adjust your membership fees to match your income—on average, Personal Carer membership fees are **$6 less per fortnight** than other unions.

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2016 Seminars with Australasian presenter Anne Evans-Murray

Leadership in Nursing
Brisbane – Saturday 21 May – Hotel Jen, 159 Roma St
This one day seminar is suitable for nurses and managers or anyone who wants to improve their leadership skills. Price: $260.00

Developing Confidence
Gold Coast – Saturday 28 May – 12/10 Enterprise St Mooloolaba
This one day seminar is suitable for anyone who wants to improve their life skills. Price: $190.00

Clinical Assessment Skills
Brisbane – Friday 10 & Saturday 11 June – Hotel Jen, 159 Roma St

Respiratory & Cardiac Nursing Skills
Brisbane – Fri 16 & Sat 17 September – Hotel Jen, 159 Roma St

Cardiac Arrhythmias - Basic to Complex
Brisbane – Mon 24 & Tue 25 October – Hotel Jen, 159 Roma St
These two day seminars are suitable for nurses in any clinical area; complex conditions presented by Anne Evans-Murray, author of “ECGs Simply” and “ Chest X-rays Simply”

Full: $450.00
One day: $230.00

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Information available from Health Ed Professionals Pty Ltd
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Health Ed Professionals P/Ltd & OSCA Health Education®
Course lecturers Heather James & Anne Evans-Murray

Acute Cardiac Care Course
Gold Coast: Monday 4 to Saturday 9 July, Monday 5 to Saturday 10 December 2016

Acute Complex Care Course
Gold Coast: Mon 27 June to Sat 2 July, Mon 21 to Sat 26 November
Caboolture: Monday 21 to Saturday 26 November
For Registered & Enrolled Nurses, Ambulance Officers, Students. Recognised for credit articulation at Griffith & QUT Universities as one elective subject for:
- Pre-Registration B. Nursing.
- Post Graduate Certificate courses
- Post Graduate Masters courses.

These courses are presented in intensive mode (9.00 – 5.00) over 6 days plus assessments, and are equivalent to a one semester university course in teaching and study time. The Complex Care course includes adult ALS certification.

Endorsed by Aust College of Nursing (ACN) for award of 45 CNE points.
Course costs: Undergraduate students (Residents) $775.00 Gold Coast; Caboolture $800.00. RN’s /EN’s, AO’s $1,500.00/$1,525.00, O/S students: $1,600.00

Adult Advanced Life Support Level 2 – 2 days
16-17 June, 11-12 July, 19-20 October, 14-15 December
Course costs: RN/EEN $625.00; Doctors $825.00
ACN, RACGP & ACRRM Accredited

Adult Advanced Life Support Recertification
13 July, 21 October, 16 November, 16 December 2016
Course costs: RN/EEN $350.00; Doctors $450.00

More course information available from: info@healtheducation.com.au
Heather James: 0407 135 332 – Anne Evans-Murray: (07) 5563 3054
All details & secure registration: www.healtheducation.com.au

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Gold Coast: Monday 4 to Saturday 9 July, Monday 5 to Saturday 10 December 2016

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