



Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Amendment Bill 2018

Bill Brief

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Links to key documents including the Bill, Explanatory Memorandum, Statement of Compatibility and Second Reading Speech can be found on the Library's New Bills Information Links [page for this Bill](#).

For further information on the progress of this Bill, please visit the [Victorian Legislation and Parliamentary Documents website](#).

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Executive Summary

In 2015, the Andrews Labor Government in Victoria was the first jurisdiction in Australia and the second in the world (following California in 1999), to legislate nurse-to-patient and midwife-to-patient ratios, thus enshrining in law minimum staffing levels. The ratios applied in Victoria were those set out in the existing nurses and midwives' Victorian Public Sector Enterprise Agreement, and applied to certain wards and services in hospitals covered by the Enterprise Agreement.

Following the introduction of the *Safe Patient Care Act 2015*, ratios were removed from the Enterprise Agreement and a [Taskforce](#) was convened as the mechanism to develop improvements to the ratios and to make recommendations to the Minister for Health in late 2017.

The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Amendment Bill 2018 passed the Legislative Assembly on 6 September 2018 and was introduced into the Legislative Council on 7 September 2018, but lapsed at the expiration of the 58th Parliament.

During the 2018 state election campaign, the Labor Party pledged to [strengthen nurse to patient ratios](#) if it was re-elected.

The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Amendment Bill 2018 (the Bill) was reintroduced with minor amendments to the previous version, to the Legislative Assembly on 19 December 2018, the first day of sitting of the 59th Parliament.

Essentially, the Bill aims to improve nurse and midwife to patient ratios in various clinical settings within Victorian public hospitals. It is largely the same as the original Bill, with the addition of permitting midwives to work in special care nurseries in the absence of a registered nurse.

Introduction

A nurse-to-patient ratio is the number of nurses or midwives working on a particular ward, unit or department, in relation to the number of patients they care for.¹

In 2015, the Andrews Labor Government in Victoria was the first jurisdiction in Australia, and the second in the world (following California in 1999),² to legislate minimum nurse to patient and midwife to patient ratios. The ratios applied in Victoria were those covered in the existing Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016.³ Ratios had been included in an enterprise agreement since 2000.⁴

As stated in the Premier's [media release](#), the ratios applied to publicly operated health services, hospitals and denominational hospitals, multi-purpose services and residential aged care facilities. The ratios did not apply to private and not-for-profit hospitals, residential aged care facilities and public mental health services not covered by the Agreement.

Following the introduction of the *Safe Patient Care Act 2015*, ratios were removed from the enterprise agreement and a [Taskforce](#) was established as an independent mechanism to develop improvements to the ratios and to make recommendations to the Minister for Health.

The Taskforce received over 80 submissions during its [public stakeholder submission process in 2016–2017](#) from stakeholders that included representative unions, health services, professional colleges, peak bodies and individual nurses and midwives.

The recommendations of the Taskforce to the Minister for Health culminated in the introduction of the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Amendment Bill 2018.

This Bill Brief outlines the context for the introduction of the Bill, the key points in the Minister's second reading speech and the purpose of the Bill. It provides some discussion of the evidence of the benefits of introducing nurse and midwife to patient ratios and outlines other jurisdictions' approaches to using minimum ratios for nurse to patient and midwife to patient staffing.

1. Second Reading Speech

The Minister for Mental Health, Martin Foley, introduced his second reading speech by saying that the Bill would not only improve patient care but also improve workload arrangements for nurses and midwives.

He added that 'where ratios are no longer fit for purpose and do not reflect best practice or safe staffing levels', improvements to staffing levels are timely.⁵

¹ Queensland Health (2019) '[Nurse-to-patient ratios](#)', Queensland Health website.

² While the Bill passed the Californian Parliament in 1999, ratios were not implemented until 2004. B. A. Mark et al. (2013) '[California's Minimum Nurse Staffing Legislation: Results from a Natural Experiment](#)', Pub Med NCBI website, US National Library of Medicine National Institutes of Health.

³ Health Victoria (2018) '[Improvement to ratios FAQ](#)', Health Victoria website.

⁴ Health Victoria (2018) '[Safe Patient Care Act 2015](#)', Health Victoria website.

⁵ M. Foley, Minister for Mental Health (2018) 'Second reading speech: [Safe Patient Care \(Nurse to Patient and Midwife to Patient Ratios\) Amendment Bill 2018](#)', *Debates*, Victoria, Legislative Assembly, 19 December, p. 17.

The Minister stated that the Bill specifies minimum staffing levels in clinical settings that require more complex and specialised environments. He added that there was both Australian and international evidence linking workload levels, patient outcomes and nurse-reported quality of care. He also listed the potential negative outcomes of unsustainable workloads such as burnout, absenteeism, low job satisfaction and poor retention.⁶

Minister Foley outlined the Government's commitment over the next five years to establish a \$50 million Nursing and Midwifery Development Fund, including \$10 million for rural and regional initiatives. The Fund would support the recruitment, transition to practice and professional development of nurses and midwives.

Finally, Minister Foley flagged a future amendment Bill 'to ensure we have enough staff when and where they are needed most'.⁷

2. The Bill

The Bill amends the Principal Act to:

- provide a new rounding method for determining staffing in specified circumstances;

(According to the Department of Health's [frequently asked questions](#), in most circumstances this will result in the number of nurses or midwives increasing on a ward, as the number must be rounded up to the next whole number.)

- stipulate how nurse to patient, or midwife to patient, ratios are to be determined in relation to mixed wards to which different ratios otherwise apply;
- change the nurse to patient, or midwife to patient, ratio applying to palliative care inpatient units, special care nurseries and birthing suites;
- provide for a nurse to patient ratio in relation to oncology wards, acute stroke wards, resuscitation beds in emergency departments, and haematology wards;
- enable, in specified circumstances, both nurses and midwives to staff a ward for the purpose of meeting staffing requirements for special care nurseries and postnatal wards;
- repeal various provisions by which ratios could be varied; and
- specify certain hospitals as level one hospitals and to provide that Sunshine Hospital be restricted in its use of enrolled nurses.

⁶ *ibid.*

⁷ *ibid.*, p. 18.

3. Evidence regarding ratios

In his second reading speech, the Minister for Mental Health stated:

International and local evidence... confirms a direct relationship between workload levels, patient outcomes and nurse-reported quality of care. In addition, increasing workloads have the potential to lead to burnout, absenteeism, job dissatisfaction, attrition and poor retention. In summary, higher staffing numbers lead to better patient outcomes, and an increasingly engaged workforce.⁸

An extensive amount of research has been conducted globally regarding the benefits and detriments of adopting ratios of nurses, or other healthcare providers, to patients. Advocates of implementing legislated ratios often argue that these will lead to increased levels of care, provide better working conditions for staff, and improve the low retention rates of registered nurses. Opponents, however, often cite that ratios reduce the flexibility of individual hospitals and work areas to define their own staffing and patient needs, and can also exacerbate already strained budgets.⁹ The Australian Nursing and Midwifery Federation, for example, argues that measures contained in the Bill will make the Victorian healthcare system safer and improve the quality of care provided.¹⁰ Conversely, the Victorian Healthcare Association argued in a submission to the Nurse/Midwife to Patient Ratio Improvements Taskforce that ratios do not allow for flexibility in optimising care and will have significant financial implications for the state.¹¹

This section highlights some research that has been undertaken in recent years towards the benefits or complexities of nurse or midwife to patient ratios.

One recent study undertaken in Hong Kong sought to ascertain whether a threshold exists for nurse workloads and staffing, above which the chances of survival for critically ill patients is reduced. The researchers conducted retrospective analysis on data relating to 845 patients admitted to multidisciplinary intensive care units, taking into consideration the number of patients and the number of nurses working in the units each day; the severity of patients' conditions; and hospital survival. The conclusions of the study were unambiguous:

Exposing critically ill patients to high workload/staffing ratios is associated with a substantial reduction in the odds of survival.¹²

The conclusions highlight that this statement does not only apply in circumstances where there has been a prolonged period of high workload and low staffing, and that the data indicate that 'exposure to as little as one day of high workload/staffing ratios is associated with a substantially increased risk of death in critically ill patients'.¹³ The researchers suggest that workloads, not solely patient numbers, should be taken into consideration when allocating nurse staffing in intensive care units.

⁸ M. Foley, Minister for Mental Health (2018) op. cit., p. 17.

⁹ For further discussion of the arguments for and against nursing ratios, see: S. Gordon, B. Buchanan, and B. Bretherton (2008) *Safety in numbers: nurse-to-patient ratios and the future of health care*, Ithaca: ILR Press/Cornell University Press.

¹⁰ Australian Nursing & Midwifery Federation (2018) '[Ratios Save Lives - Sign The Petition](#)', media release, ANMF, 15 September.

¹¹ Victorian Healthcare Association (2017) '[Submission to Nurse/Midwife to Patient Ratio Improvements Taskforce](#)', VHA, 16 February.

¹² A. Lee, Y. Cheung, G. Joynt et al. (2017) '[Are high nurse workload/staffing ratios associated with decreased survival in critically ill patients? A cohort study](#)', *Annals of Intensive Care*, 7(46), p. 1.

¹³ *ibid.*, p. 7.

Other studies have had similar results. For example, a comprehensive 2002 study, conducted by researchers at the University of Pennsylvania, investigated the potential link between nurse-to-patient ratios and patient mortality. The records of approximately 230,000 patients from 168 Pennsylvanian hospitals who had undergone general, orthopaedic or vascular surgery between April 1998 and November 1999 were analysed. This study found that the mortality rate for surgical patients was higher in hospitals where nurses had greater numbers of patients to care for.¹⁴ Specifically, it found that the ‘difference from 4 to 6 and from 4 to 8 patients per nurse would be accompanied by 14% and 31% increases in mortality, respectively’.¹⁵ Further:

Staffing hospitals uniformly at 8 vs 4 patients per nurse would be expected to entail 5.0 ... excess deaths per 1000 patients and 18.2 ... excess deaths per 1000 complicated patients.¹⁶

Another recent study evaluated nurse workloads in a neonatal intensive care unit in a Midwestern academic medical facility in the USA; however, this study produced somewhat different results. Data were collected from 136 nurses caring for 418 infants over the space of 11 months between March 2013 and January 2014. In the study’s conclusions, the researchers stated that implementing exclusively ratio-based initiatives with the aim of bettering health outcomes may not ‘substantially reduce missed nursing care’ in these scenarios.¹⁷ This is attributed to ‘subjective workload’, which is reportedly largely unmeasured, but ‘...presents new possibilities for tailored workload intervention’.¹⁸

Further, burnout is an important variable in evaluating healthcare delivery as it has been recognised to affect the level of care provided, overall job performance, staff turnover and psychological wellbeing.¹⁹ Alongside the results discussed above, the 2002 study also investigated the impacts of high workloads and patient numbers on nurses. The analysis of the survey results of 10,184 nurses showed that nurses with a higher number of patients were much more likely to experience burnout and job dissatisfaction than nurses with a lower number of patients. For example, the study found that:

...nurses in hospitals with 8:1 patient-to-nurse ratios would be 2.29 times as likely as nurses with 4:1 patient-to-nurse ratios to show high emotional exhaustion ... and 1.75 times as likely to be dissatisfied with their jobs...²⁰

Another study published in the *Australian Journal of Advanced Nursing*, however, challenged the notion that job dissatisfaction was a result of stress. It stated that 96 per cent of the 562 nurses surveyed as part of the study (sampled from attendance at professional conferences) ‘were moderately to highly satisfied with their work’, despite ‘acknowledged highly stressful work’.²¹

¹⁴ L. Aiken, S. Clarke, D. Sloane, J. Sochalski and J. Silber (2002) ‘[Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction](#)’, *Journal of the American Medical Association*, 288(16), p. 1987.

¹⁵ *ibid.*, p. 1991.

¹⁶ *ibid.*, p. 1992.

¹⁷ H. Tubbs-Cooley, C. Mara, A. Carle, B. Mark and R. Pickler (2019) ‘[Association of Nurse Workload With Missed Nursing Care in the Neonatal Intensive Care Unit](#)’, *Journal of the American Medical Association Pediatrics*, 173(1), p. 50.

¹⁸ *ibid.*

¹⁹ J. Pandey and M. Singh (2016) ‘[Donning the mask: effects of emotional labour strategies on burnout and job satisfaction in community healthcare](#)’, *Health Policy and Planning*, 31(5), p. 554.

²⁰ Aiken et. al. (2002) *op. cit.*, p. 1990.

²¹ V. Skinner, J. Madison and J. Harris (2012) ‘[Job satisfaction of Australian nurses and midwives: A descriptive research study](#)’, *Australian Journal of Advanced Nursing*, 29(4), pp. 25–6.

4. Other Jurisdictions

Queensland

The [Hospital and Health Board \(Safe Nurse-to-Patient Ratios\) Amendment Bill 2015 \(Qld\)](#), introduced on 1 December 2015, inserted a new division into the *Hospital and Health Boards Act 2011* (Qld) to provide for mandated minimum nurse and midwife to patient ratios in Queensland's public health system. Ratios and in-scope facilities would be prescribed in regulation by the Hospital and Health Service, allowing sufficient flexibility in the legislative scheme for a phased implementation.²²

Under the Queensland model, the Business Planning Framework (BPF)—which is the existing resource management tool—determines the optimum staff numbers and skill levels required to meet the professional nursing and midwifery workload standard ('the standard'). The mandated ratios underpin the BPF by setting the minimum number of nurses (the 'floor') required on the wards prescribed in the regulation. That is, the prescribed facilities need to comply with the standard as well as the nurse-to-patient ratios.²³ The in-scope wards and facilities in Queensland's public health sector are set out in [regulation](#).

Legislated ratios came into effect in public Hospital and Health Services on the 1 July 2016 and currently apply to adult acute medical and acute surgical wards, as well as some mental health units. The Act also allows the minister to temporarily exempt a facility for up to three months under certain extenuating circumstances, such as challenges in recruitment or provision of suitable accommodation.²⁴

New South Wales

Nurse staffing levels in NSW public health facilities are currently mandated through the industrial award. The NSW [Public Health System Nurses' and Midwives \(State\) Award](#) incorporates the nursing hours per patient day (NHPPD) as a tool to calculate nursing hours per patient day ratios based on types of wards and their location ('peer groups').

Following a rally outside parliament by nurses and midwives in September 2018 calling for mandated nurse-to-patient ratios, the Health Minister, Brad Hazzard, stated that he understood the Nurses' Association view on the need for a different formula, and more nurses would be added if needed. The Premier, Gladys Berejiklian, during question time however, would not make a commitment and expressed the Government's reservation regarding the 'blunt nature' of ratios as not providing flexibility.²⁵

²² [Explanatory notes](#), Hospital and Health Board (Safe Nurse-to-Patient Ratios) Amendment Bill 2015 (Qld), p. 2.

²³ [Nurse-to-patient ratios: Frequently asked questions \(2016\)](#) Queensland Health website, July.

²⁴ *ibid.*

²⁵ E. Han (2018) '[NSW Premier rejects nurses' demand for higher nurse-to-patient ratios](#)', *Sydney Morning Herald*, 18 September.

Western Australia

Nurse staffing levels in Western Australian public hospitals are derived from the NHPPD model. The model classifies wards into seven categories based on the level of complexity of patient care. The classification determines the number of nursing hours required per patient day.²⁶

The NHPPD has been applied since 2002, following the *Nurses (WA Government Health Services) Exceptional Matters Order (EMO) 2001*, issued by the Australian Industrial Relations Commission to WA Health, that the model be utilised to manage nurse and midwife workloads.²⁷ The WA Branch of the Australian Nursing Federation has been campaigning for legislated nurse-to-patient ratios, with rules supporting no more than four patients per nurse on a general ward on day shifts.²⁸

ACT

In September 2018, the ACT Government announced that it would develop a nurse-to-patient ratio framework with the nurses' union. An MOU was signed between the ACT Health Minister Meegan Fitzharris and the ACT Branch of the Australian Nursing and Midwifery Federation (ANMF) that a ratios framework would be developed in the next 12 months.²⁹ Since 2010, NHPPD data have been used to manage staffing levels in the ACT public health sector.³⁰

South Australia

Safe staffing levels are set out in the *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement* industrial award. Minimum staffing levels are determined according to the patient care areas.³¹ Several nursing standards determine the staffing levels for critical care departments, including emergency and intensive care units. The Nursing/Midwifery Hours per Patient Day (NMHPD) can be the nominated ratio for other units and are subject to a set of Business Rules.³²

United States

The provision in current federal regulation, the [42 Code of Federal Regulations](#) (42CFR 482.23(b)), requires Medicaid hospitals to have 'adequate numbers' of registered, licensed and vocational nurses.³³ The Safe Staffing for Nurse and Patient Safety Act ([S. 2446](#), [H.R. 5052](#)) has yet to be passed by Congress. The legislation would require participating hospitals to establish committees comprising a majority of direct care nurses to create staffing plans specific to each patient care unit.

As the existing regulation is not specific enough to be effective, states have consequently moved to implement their own regimes. State staffing laws fall into three categories: Nurse-driven staffing committees that create staffing plans specific to the hospital's patient population (a model reflected

²⁶ [Nursing Hours per Patient Day](#), WA Health website

²⁷ *ibid.*

²⁸ M. Olsen, (2019) '[No More Than Four campaign](#)', ANF (Perth) website.

²⁹ D. White, (2018) '[Government agrees to develop nurse ratios framework](#)', *Canberra Times*, 15 September.

³⁰ ACT Health (2018) *Nurses and midwives: towards a safer culture – the first step: discussion paper*, November, p. 18.

³¹ SA Health (2017) [Nursing and Midwifery Enterprise Agreement negotiations 2016](#), SA Website

³² South Australian Government (2017) *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016*, Part 3.

³³ American Nurses Association (2015) [Nurse staffing](#), ANA website.

in the current federal Act); specific nurse to patient ratios mandated in legislation or regulation (as is the case in California); and disclosure regimes whereby hospitals are required to disclose staffing levels to public and/or regulatory bodies.³⁴

The American Nurses Association supports a legislative model allowing nurses to create staffing plans for their unit. In the Association's view, this would allow for flexibility and would consider changes in patient needs, skill levels and resources, including technology.³⁵

California

California was the first US state to legislate minimum nurse-to-patient ratios. The enabling [Assembly Bill 394](#) was passed in 1999 and came into effect in 2004. The legislation specified licensed nurse numbers, as well as skill mix (number of Registered Nurses, RNs) per patient by hospital unit. Following a review of the regulation, (as stipulated in the Bill) the ratios were strengthened in 2008 with a reduction in the number of patients per nurse in step-down, telemetry and specialty care units.³⁶

Massachusetts

In 2014, Massachusetts passed a law, [Bill H.4228](#), specific to ICU requiring 1:1 or 1:2 nurse-to-patient ratios depending on stability of the patient.³⁷ In November 2018, a ballot measure that would have mandated nurse-to-patient ratios to apply to other hospital units as at 1 January 2019, was rejected by voters in the US Midterm Elections.³⁸

Wales

Wales was the first country in Europe to legislate nurse staffing levels. The *Safe Nurse Staffing Levels (Wales) Bill* was introduced in the National Assembly of Wales on the 1 December 2014 and the *Nurse Staffing Levels (Wales) Act 2016* became law on the 21 March 2016.³⁹

The Act does not mandate a specific minimum nurse-to-patient ratio; instead, provisions refer to 'sufficient nurses to allow nurses time to care for patients sensitively'.⁴⁰ The determination of nurse staffing levels is delegated to local health boards (LHBs) or the NHS Trust in Wales. In doing so, LHBs and NHS Trust in Wales must have regard to guidance issued by the Minister.⁴¹

Under the *Statutory guidance* released in November 2017, the calculated nurse staffing levels apply to adult acute medical and surgical wards. The guidance also gives instructions on the method of calculation, qualifications and skills mix required, the use of an evidence-based workplace planning tool, as well as provisions that patients must be informed of the nurse staffing levels.⁴²

³⁴ *ibid.*

³⁵ *ibid.*

³⁶ L. Beattie, (2007) 'California tightening nurse-to-patient ratios in 2008', *Healthcare News* (AMN Healthcare)

³⁷ J. Wleton, (2014) 'Massachusetts new nurse staffing law', *JONA: Journal of Nursing Administration*, v. 44(11), pp. 553-555.

³⁸ A. Kacik, (2018) 'Massachusetts voters reject mandated nurse-to-patient ratios', *Modern Healthcare*, 6 November.

³⁹ National Assembly of Wales [Nurse Staffing Levels \(Wales\) Act 2016](#).

⁴⁰ [Nurse Staffing Levels \(Wales\) Act 2016](#) s 25.

⁴¹ *ibid.*

⁴² Welsh Government (2017) [Nurse Staffing Levels \(Wales\) Act: Statutory guidance](#), 2 November.

References

Relevant Legislation

Victoria

- [Safe Patient Care Act 2015](#)

Other Jurisdictions

- [Hospital and Health Boards Act 2011](#) (Qld)
- [Nurse Staffing Levels \(Wales\) Act 2016](#) (UK)

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