AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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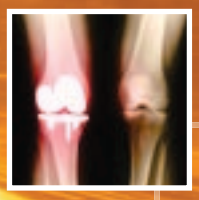
SAFE STAFFING CONSULTATION REPORT



Safety+Quality COUNCIL

AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE - MARCH 2005

AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

SAFE STAFFING CONSULTATION REPORT

March 2005

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The Australian Council for Safety and Quality in Health Care (the Council) was established in January 2000 by the Australian Government Health Minister with the support of all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The Council reports annually to Health Ministers.

This document provides a consultation report on the Safe Staffing: Discussion Paper which was prepared by TNS Social Research on behalf of the Council.

Copies of this document, the Safe Staffing: Discussion Paper and further information on the work of the Council can be found at www.safetyandquality.org or from the Office of the Safety and Quality Council on telephone: +61 2 6289 4244 or email to: safetyandquality@health.gov.au.

Disclaimer

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Foreword

The Australian Council for Safety and Quality in Health Care (the Council) was established in January 2000 by the Australian Government with the support of all Australian Health Ministers to provide national leadership and coordination of health care safety and quality activities with a particular focus on minimising the likelihood and effects of error and system failures.

As part of its *National Action Plan 2003*, the Council recognised the importance of working with stakeholders to develop and implement priority areas for action to improve the management of safe staffing in health care services. Under this priority, the Council set up a high level Safe Staffing Taskforce (the Taskforce) to look at a broad range of staffing variables and how modifications or improvements may have direct positive impacts on patient safety.

The Taskforce commissioned a major literature review to identify staffing factors associated with patient safety or quality in both health and non-health industries. Based on the findings of the review and focus group studies, the Taskforce developed the Safe Staffing: Discussion Paper, outlining the key issues and priority areas for action.

Following from the Safe Staffing: Discussion Paper, TNS Social Research was contracted by the Council to conduct the attached consultation strategy to gain stakeholder views on the scope, issues raised and priorities areas suggested in the paper to improve safe staffing. The strategy involved a mail-out to key stakeholders, a national newspaper advertising strategy, interactive workshops, telephone interviews and an analysis of written submissions from stakeholders.

The Council recognises and values the contribution of stakeholders to furthering the safe staffing agenda and is progressing the following priority action areas:

- A project to develop national principles and tools for the recognition, prevention and mitigation of fatigue in health workers.
- National action to improve clinical handover processes to ensure better transfer and continuity of patient care.
- Enhancing competency of the health workforce in patient safety through the National Patient Safety Education Framework; and
- Improving governance for patient safety by producing the Safety Management Systems checklist to support leaders and managers in ensuring their systems are safe.

SAFE STAFFING
CONSULTATION REPORT

A MARKETING RESEARCH REPORT
DEVELOPED BY TNS SOCIAL RESEARCH
FOR THE AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

March 2005

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Executive Summary

In 2004, the Australian Council for Safety and Quality in Health Care (the Council) charged TNS Social Research to conduct a consultation process with stakeholders and other consumers about the discussion paper "safe staffing".

The primary objective of this consultation was to gain opinions on the discussion paper, specifically:

- Scope of the paper and in particular the role of the Council regarding safe staffing issues;
- The issues raised in the paper; whether all staffing variables and related issues are covered adequately; and
- The priorities suggested in the paper; their feasibility, applicability to different sectors/stakeholders, suitability to the issues raised, whether any strategies have been omitted from the paper, and any barriers or facilitators to implementation.

In addition, the consultation was required to raise stakeholder and other consumer awareness of the Council's activities regarding safe staffing.

The consultation process consisted of four key activities:

- A mail out to key stakeholders and a national newspaper advertising strategy to raise awareness of the consultation process;
- Conduct of n=10 interactive workshops in capital cities and regional locations;
- Conduct of n=6 telephone interviews with key stakeholders; and
- Analysis of written submissions received from individuals and organisations.

The consultation process was highly successful in raising the awareness of the Council and the paper among stakeholders. The interest in workshops was high. Several participants travelled long distances to attend workshops and some returned early from holidays to participate such was the level of interest in the topic and the desire to be heard. In particular the involvement of a wide range of stakeholders together in workshops increased the learnings from the sessions as staff from a range of disciplines shared experiences and interested in smaller break out discussion groups.

Stakeholders were supportive of the need for change and enthusiastic about proposed action. For the wide range of stakeholders involved in the consultation, providing safer patient care was paramount and safer staffing was seen as a central issue in achieving this objective.

Feedback on the paper scope and content

The enthusiasm and commitment of workshop attendees and other contributors was reflected in the wealth of detailed comments received. The main issues raised in relation to the discussion paper are summarised below.

- The greatest criticism of the paper was the absence of efforts to address workforce supply and sustainability. Many felt that the taskforce needs to consider these macro issues and that real change can not be obtained without these being addressed. Many felt that any education regarding safe staffing and patient safety issues will be ineffectual unless sufficient resources are available to implement solutions.

- Many stakeholders believe there is insufficient evidence linking staffing variables to patient outcomes and further research needs to be conducted before real change can be implemented. Others felt instead that existing knowledge is not being used because of a lack of commitment to longer term objectives.

- The paper was criticised for focusing too heavily on medical personnel and not reflecting the whole health industry. Similarly, examples were seen to be drawn from large, metropolitan hospitals, and were not always seen as demonstrative of the regional experience. The majority expressed a strong view that risk levels rightly vary in different settings and as the definition of 'safe' relies on difference tolerances for different situations, resulting benchmarks or guidelines need to be cognisant of this.

- The redefinition of roles to reflect changing models of health care and increasing complexity in health care was seen as important in managing safe working hours. There was concern however that excessive reduction in working hours could adversely affect the time taken to train in specialties, thus affecting the number of qualified staff available to provide quality care to patients.

- Rostering was seen as an important factor in managing a safe workforce, and many supported the Council's proposal to produce guidelines. Suggestions for changes to rostering included allowing time in each roster to have breaks from observation by patients and their families, responding to individual needs of staff in designing rosters and rostering junior medical staff with one team for a longer period.

- The setting of staff to patient ratios was identified as an area where further research is required. Some stakeholders felt that setting ratios was a good way of improving staffing levels. Midwives challenged the notion of the need for a "ratio", instead suggesting that models of care need to be re-evaluated.

- Stakeholders identified that communication and documentation in the workplace needs to be improved, particularly handovers at the end of shifts, and communications between staff, encouraging a team work atmosphere. However, these issues were seen as minor in comparison to other priority areas.

- Identification and management of fatigue was seen as a major factor in safe staffing practices and thus affecting patient safety. Stakeholders recognised that fatigue is not only a factor of working hours but also of intensity of work, and pressure outside of the work day. The vocational nature of many working in the health industry means that although many are aware of fatigue as an issue, it is unlikely to take priority in the work place and education was needed to put fatigue management on the agenda.

- Organisational culture is a major factor in safe staffing, with many recognising the impact of an 'army-style', top-down culture, and a 'blaming culture', where problems are buried and mistakes not learned from. Also, a 'risk management' culture is pervading, with stakeholders feeling that staffing variables are not considered in risk management.

- A cultural change in training to a model which recognises and encourages on the job training and experience, rather than insisting on training additional to the work day, was seen as positive. Training is also required in management skills to enable cultural change and adequately address safe staffing issues.

- There was wide-spread support for regulation around safe staffing, with many stakeholders believing this was the only way to affect change. There was concern however that regulation could impose a minimum standard, and that regulations would be inflexible to individual situations. Some were also concerned that regulations would not be sufficiently flexible to work well in the wide range of health care settings.

- There was overall agreement with the increasing role of technology in the workplace. Use of technology, however, needs to be supported by the co-ordination and standardisation of systems, better sharing of systems and information, and greater training.

Priority Actions and Next Steps for Facilitating Change

Stakeholders generally responded positively to the nature of the priority actions presented in the paper and felt that the Council could play a constructive role in the following areas:

- Facilitating change at the local level, for example, in people management practices, better rostering;
- Advocacy for safe staffing, providing the catalyst for change through building a business case to support safe staffing levels, including advocacy with hospital administration, colleges and government;

- Education and communication on safe staffing issues including raising awareness of fatigue and its impacts for patient outcomes;
- Education of consumers and facilitation of consumer involvement in the development of safe staffing models;
- Supporting and funding research to better define safe models of care;
- Supporting identification of best practice models and facilitating the sharing of ideas and remedies;
- Production of guidelines and tools for use at the local level to assist in the implementation of safe staffing practices; and
- Initiating and supporting local trials or pilot programs.

Several stakeholders felt that the Council needs a course of action that has greater power - 'more teeth' - in influencing regulations, budgets and politicians. Others feared that the outcomes would be bureaucratic and document based and not enough about "doing things". There were some stakeholders who were somewhat sceptical that anything will actually change. Visible and immediate change is needed to continue to engage these stakeholders.

Stakeholders generally supported all of the seven priority areas for action as being the key issues for advancing the agenda and addressing major barriers to change. The greatest criticism of the action list was the absence of efforts to address workforce supply and sustainability. Thoughts on prioritising actions included:

- the Council should focus on what would have maximum impact in the short term, to gain momentum;
- implementing what would be greatest value for money through examining what would be easiest to influence; or
- identifying those with governance responsibilities, including working with employer organisations, practitioners in private or independent contractor arrangements, professional colleges and medical registration boards would have greatest influence on culture and behaviours at different levels.

A range of key issues emerged in discussions as to how change could be facilitated and the manner in which the Council might proceed. Key issues and suggested strategies emerging were:

- Strategies to support culture change were seen as critical. While culture change will take some time to achieve, many recognised this as the major facilitator for change, and that achieving culture change would help address a range of priorities.
- Stakeholders were seeking a balance between regulatory change and flexible local solutions.
- Stakeholders were supportive of change with clear and transparent processes and objectives that are communicated to all tiers of service provision.
- A clear time line and a balance between strategies addressing long term goals and those aiming for short term impact was seen as desirable.

- Continued consultation and involvement of clinicians in the development of strategies was seen to be an important aspect of successful implementation.

The next steps for the Council are to begin work on the priority actions including consideration of the following issues:

- Whilst stakeholders appreciate the opportunity to be heard and value the discussion, they expect some action and the Council to set about 'actually doing things'. Setting of short term goals will provide a focus for people and allow for visible achievements early on.
- Consulting with speciality groups to both engage them and to better understand them (for example, surgeons and midwives in particular who raised the importance of a specialised approach to their disciplines).
- Publicise and communicate responses to the consultation and continue to engage these health professionals. There is an expectation now created of high stakeholder involvement in formulation of safe staffing solutions;
- Engage stakeholders in work on the ground to build ownership and learn from clinicians. Several stakeholders offered their support and assistance with further work (see submissions).
- Continue to communicate and raise awareness of issues in general. The workshops are evidence of power of communication, the value in sharing ideas, challenging health professionals to think differently.

1. Background and Objectives

1.1 Background to the Project

The Australian Council for Safety and Quality in Health Care (the Council) was established in January 2000 by Australian Health Ministers to lead national efforts to improve the safety and quality of health care provision in Australia. An important focus of the Council's work is to ensure that health care professionals operate in environments in which they are appropriately supported to deliver the safest possible care. In this context, the Council has set up the Safe Staffing Taskforce (the Taskforce) to lead its work on safe staffing.

The Taskforce has developed a discussion paper outlining the key issues in safe staffing and seven proposed priority areas for action to further the safe staffing agenda. Previous to the production of the discussion paper, the Taskforce commissioned two pieces of research to inform their work:

- a major literature review to identify staffing factors that are associated with patient safety or quality in both health and non-health industries; and
- focus groups and interviews with clinicians in three states in conjunction with the NSW Health Safe Hours Taskforce.

Whilst the discussion paper is informed by this research, the paper is not intended as the definitive paper on safe staffing. The Taskforce seeks to gather more insight on the relevant issues through a wide consultation process with stakeholders in the health care industry.

1.2 Objectives of the Consultation

The overall objective of the consultation was to gain opinions from stakeholders and other consumers about the aforementioned discussion paper developed by the Council. This builds on previous research and involves the evaluation of:

- **Scope of the paper** and in particular the role of the Council regarding safe staffing issues;
- **The issues raised in the paper;** whether all staffing variables and related issues are covered adequately; and
- **The priorities suggested in the paper;** their feasibility, applicability to different sectors/stakeholders, suitability to the issues raised, whether any strategies have been omitted from the paper, and any barriers or facilitators to implementation.

2. Consultation Process

The consultation was conducted over a 6 month period and included a range of methods:

- A mail out to key stakeholders and advertisements in major newspapers to alert attention to the discussion paper and consultation process;
- Conduct of interactive workshops with stakeholders in capital cities and rural locations;
- Telephone interviews with key stakeholders and those unable to attend workshops; and
- Written submissions received from individuals and organisations.

The consultation process was highly successful in raising the awareness of the Council and the paper among stakeholders. In fact, many workshop participants indicated they had heard of the process through a range of sources, including word of mouth. This is encouraging as it shows that the process has been discussed between colleagues in a professional situation.

The interest in workshops was high. Several participants travelled long distances to attend workshops and some returned early from holidays to participate such was the level of interest in the topic and the desire to be heard. The workshops involved presentation of some background material, followed by guided discussion.

In particular the involvement of a wide range of stakeholders together in workshops increased the learnings from the sessions as staff from a range of disciplines shared experiences and interested in smaller break out discussion groups. Participants included those from a range of health care settings, public and private, aged care, mental health and community based services as well as mainstream hospitals. Stakeholders from medicine, nursing, speciality areas such as emergency, obstetrics, surgery, and neurology participated along side social workers, physiotherapists, pathologists, radiographers and a range of staff from all levels of hospital administration as well as risk managers and quality managers.

Many participants were enthused by the discussions and the workshops served to build awareness and endorsement for the Council's work through engaging stakeholders. This type of process, where through involvement, participants become supporters of the outcome, is referred to as *Action Research* - the possibility of creating change as part of the research process.

As such it requires an approach that focuses on the strengths already present and uses those to shape the future. Accordingly, the use of an appropriate methodology, such as Appreciative Inquiry (Ai)[1] was essential. The process of Ai research is based on the 4Ds depicted:

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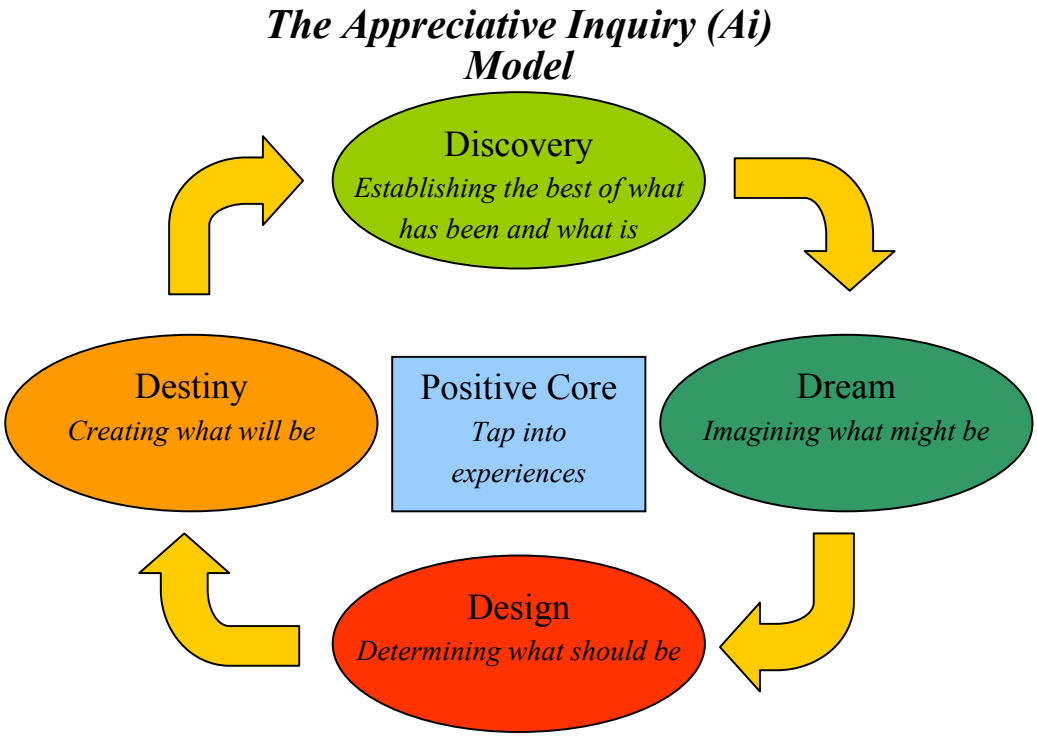
[1] *Appreciative Inquiry is largely the work of David Cooper-Rider and Suresh Srivastva. The principles outlined herein are based on their action research approach (depicted in the graph).*



The consultation process closely replicated the Ai model, using workshops and interviews with relevant stakeholders to explore:

- Perceptions of the current situation as indicated in the paper (*Discovery*);
- Perceptions of priorities for the future, and how issues might be addressed (*Dream*);
- How the issues should be addressed using the priority actions proposed in the paper as a starting point (*Design*); and
- What feedback should be provided to the Council for future work on safe staffing (*Destiny*).

All of this exploration was conducted based on stakeholders' experiences and perceptions (*Positive Core)* thus ensuring all stakeholders felt ownership of the process, and therefore the outcomes.

The comments and conclusion from the workshops, interviews and submissions are outlined in this report. The report is structured around the discussion paper, following similar headings.

3. Definitions and Scope Issues

The focus of the taskforce's efforts is outlined in the discussion paper:

> *"This discussion paper does not cover the macro issues of the health workforce including workforce numbers, training, registration, credentialing, specialisation and other such issues. It is recognised that all these factors have a role to play in the provision of safe patient care. However other processes (including some Council projects) are addressing these issues and other processes may need to be identified to address gaps."*

Whilst the taskforce's position was clearly stated as not addressing macro issues of the health workforce, many stakeholders objected to this, feeling strongly that safe staffing issues cannot be solved in isolation from workforce planning:

> *The College understands the difficulty of including all the factors associated with safe staffing but wishes to emphasize that unless the issues of health workforce and the underlying medical and consumer culture are addressed the ability to introduce and implement change will be severely hampered.*
> (p1 Royal Australian and New Zealand College of Obstetricians and Gynaecologists submission)

The domain of the taskforce's work was seen to be very broad so as to include all of health care and stakeholders were supportive of an inclusive national strategy, as articulated by the Royal Australian College of Medical Administrators:

> *...sustainable change in safe staffing at the clinician-patient interface will only be achieved through an integrated, national strategy that engages all employing health care organisations, private practitioners and other stakeholders and that utilises a combination of available levers to drive the required change in culture and practice.*
> (p3 RACMA submission)

Stakeholders felt that the work of the Taskforce should encompass all areas including aged care, private practice and community services. They were reluctant to identify any areas which should not be included in safe staffing activities noting particularly the possibilities of detrimental effects of focusing change in one area only causing flow on affects to other parts of the hospital system:

> *"in principal I agree with them ...in that we need to say that this is the safe level of staffing that can look after the number of patients we have, however it is totally inflexible....there is no way they are going to take another patient [in the ward] despite the fact that the emergency department has 40 extra patients in it, then that is a problem with regulation."*
> (workshop participant, on wards nurse patient ratios)

The discussion paper included a definition of safe staffing which particularly noted the difficulties in defining 'safe':

> *"'Safe' is not easily definable. Safety is a moving target depending on the situation, environment, levels of risk, tolerance of risk and potential outcomes. It has not yet been possible to define a minimum acceptable level of safety within the health care context – therefore managing staffing variables to achieve safety is not a precise science. This discussion needs to be considered in that context."*

Some stakeholders expressed disappointment that the taskforce did not attempt to provide a definition of 'safe' and stressed that a key outcome of the taskforces' work should be in producing benchmarks and indicators to guide health workers in managing risk. In the main however, stakeholders were appreciative of the difficulties in this area. The majority expressed a strong view that risk levels rightly vary in different settings and as the definition of 'safe' relies on difference tolerances for different situations, resulting benchmarks or guidelines need to be cognisant of this.

The definition of 'safe staffing' and of 'fatigue' in particular was an area of much debate throughout the consultation. The paper presented safe staffing as:

> *"In essence, safe staffing explores the relationship between human resource issues and (in this case) clinical outcomes. The concept of safe staffing takes into account issues such as fatigue, but also workload and staffing practices including rostering, skill and role mix, staff numbers, staff supervision and team functioning parameters."*

Stakeholders (comments on broader workforce issues withstanding), agreed with this scope and provided a wealth of comment on these and related staffing issues. In particular, participants felt that fatigue is very difficult to define and acknowledged the difficulties in measuring fatigue in individuals. Many stakeholders felt the taskforce's work should include the management of a broad range of issues related to 'fatigue management' such as stress, tiredness and burn out. Whilst recognising that these are each different concepts, participants felt that their management is relevant to the current working environment and to the objective of ensuring safety and quality in health care. Focus on a narrow concept of fatigue may be less useful.

> *"Fatigue is not necessarily working excessive hours. I've seen members of my team in very tight situations with clients and it's just full on. They may have been half an hour, an hour, or an hour and a half, but it's just been full on and they need a break…it's not just double shifts."*
> (workshop participant, mental health)

4. Reactions to the Current Situation

The enthusiasm and commitment of workshop attendees and other contributors was reflected in the wealth of detailed comments received. It should be noted however that the views of the current situation as reported here are obtained from generally more experienced and/or senior health professionals for whom safe staffing is of significant importance so as to attend a workshop, agree to an interview or prepare a submission.

In general, many were heartened by the paper and there was widespread agreement on the current situation and key issues identified. Whilst some appreciated the paper as the discussion starter rather than a lengthy/definitive paper on the topic, others felt the paper was too 'light weight', that it did not tackle the hard issues and it lacked depth. Some felt that the lack of detail indicated a lack of appreciation of the current situation and the enormity of some of the issues faced in this area.

The workshops served to delve into the detail and participants relished the opportunity to describe the current situation from their perspective. Responses to the issue raised in the paper are summarised below.

4.1 Available evidence

Many stakeholders felt that there was insufficient evidence in this area and supported the view presented in the paper that more research was required to encourage change and to develop evidenced based solutions. There was a strongly expressed alternative view however that there was a large body of knowledge in existence but changes were not being implemented due to a lack of commitment to a longer term objective. Rather, so called 'band aid' solutions relating to short term (political) objectives were implemented. Some felt that further studies would not be of great use and what was needed was greater facilitation and commitment to instituting change based on what is already known.

For many stakeholders the communication of research results and the promulgation of best practice ideas was an important issue and an area in which they felt the Council could play a vital role. Some felt that there was much to be learnt from 'simple things' and communicating both within the hospital and across institutions on local level solutions to staffing issues should be encouraged.

Some stakeholders were able to provide examples of existing evidence gathering activities which they felt were of value including the monitoring of overtime worked across all ACT Health workers in conjunction with other indicators such as absenteeism. Whilst this monitoring is traditionally undertaken elsewhere for budgetary reasons, this process was managed by the occupational health and safety team and focussed on safety outcomes rather than cost savings.

4.2 Workloads and staff practices

In general there was criticism of this section of the paper for being 'too medical' (perhaps due to the AMA focus on junior doctors) and not reflective of circumstances across the whole health care industry. Stakeholders in allied health, mental health, aged care and nursing in particular, commented on this perceived bias. Rural stakeholders also felt that all the examples offered were drawn from metropolitan/large teaching hospital situations which were less relevant to rural services which rely more on GPs.

Whilst many agreed that working hours and pressures on doctors and other health professionals are unacceptable, some stakeholders felt that the examples used in the paper were in the extreme rather than the norm:

> *The discussion on doctor fatigue and hours worked does not reflect the situation for junior medical staff at Sydney Children's Hospital. Paediatrics has a different approach to many adult institutions and the senior medical staff are often more directly involved in patient care. The junior medical staff work shorter hours and those rostered to work after hours have a low threshold to call the senior staff.*
> (p1 Sydney Children's Hospital submission)

> *"Unless I'm missing something I don't think our doctors are having that much of a problem ...rosters being in emergency are fairly flexible.....if our workers don't like something they generally come and tell us and we change it. We don't have 24 hr shifts in emergency, the longest we have is an 11 hour shift and that was at the Registrar's request so that there would be less nights...they do less nights per year. Although I acknowledge that there are areas that sound like cess pits from hell, it's not universal in medicine."*
> (workshop participant, emergency medicine)

In addition, whilst stakeholders felt that there were some common issues to be addressed for safer staffing across all areas of health care; solutions would need to be cognisant of the varying nature of workloads and intensity of work in different clinical areas.

4.2.1 Redefinition of Roles

Many felt that processes to work better/smarter with the same numbers of staff is what is really required in the health industry. Especially given the recognised long term staff shortages in nursing and in some specialties, many felt that the reality of never having enough staff for the current model needed to be addressed through work design. The Australian College of Midwives' submission challenges the assumption that more staff are needed for safer health care by outlining the evidence for caseload midwifery compared to the mainstream rostered shiftwork

where the caseload model has the potential to provide services for the same number of women with fewer staff, (p7 ACMI submission).

Stakeholders also felt that roles and responsibilities and delineations within and across disciplines needed to be reviewed. Those working in paediatrics commented on the increasing complexity in patient care and observed that additional workloads are being managed by nursing staff. Others agreed that in some cases doctors were 'doing the wrong work' in some instances, a problem thought to be amplified in rural areas where nurses could take on more of these tasks.

> *"One of the things that is not looked at (in the paper) is models of care and there are a lot of traditional models of care which actually I think make it harder to go through the safe work practices in some ways and I think that you know in rural areas there has to be a lot more innovation with regards to how you provide health care and it will impact on this interface between doctors, nurses, PMs, volunteers, community it is how you utilise that whole structure rather than setting that this particular job is delineated for this particular person or that particular designation."*
> (workshop participant, rural hospital)

Many in both metropolitan and rural areas complained about the increasing demands on clinicians to do administrative work, fill out forms etc. These stakeholders called for administrative assistants to be considered in the skill mix discussion and felt that there was a need for more ward clerks to support clinicians and allow them to get back to the main tasks for patient care.

> *"one...example is that with the District Nursing Service to accommodate increased paperwork one nurse a day now is allocated to paperwork. So it is not that it is not worthwhile but in order to then cope with face to face delivery of clinical nursing care…there has been a lot of practice change without any additional resources or money going into that"*
> (workshop participant, rural hospital)

4.2.2 Safe Hours

The AMA guidelines were well known and recognised by the majority of stakeholders although it was acknowledged that they were not always implemented. Some stakeholders felt they had been successful in influencing work practices and aiding staff in advocating for safer working conditions and that working hours for junior doctors had been reduced. Stakeholders felt however, that seniors still carried much of the pressure of long working hours and there was a need for better guidelines for sustainable rosters for senior staff.

Some felt that practices were changing particularly for more recent graduates, because of changes in expectations around work/life balance. Some stakeholders, although the minority, felt that the balance had swung too far and that the hours worked were now 'ridiculously short'. Obstetricians

acknowledged the dangers of excessive working hours but felt that shorter working hours had some negative implications unless issues of labour supply were also addressed:

> *This has meant shorter working hours, which is impacting on the level of experience that trainees attain during the training program. Also of concern is the level of supervision that trainees receive during the training program.…Based on the current training model, there is serious concern that the introduction of safe staffing regulations would lead to the time taken in a training program doubling from 6 to 12 years. To maintain supply there would need to be an increased number of registrars, resulting in fewer procedures each year per registrar and an extended time to gain necessary skills and competence. Shorter working hours often mean less supervision with only a registrar or a resident being rostered but not both together.*
> (p1 RANZCOG submission, on safe hours regulations)

The majority of stakeholders agreed with the views presented by the paper that safe staffing was much more than just the number of hours worked and work practices should include consideration of staff skill levels as well as patient acuity. Some felt however that the paper was 'light on' in this area and these complexities should be explored further.

4.2.3 Rostering

Many stakeholders described the individual response to current workloads of staff choosing to be part time or casual in order to better manage their hours. Several managers commented on the difficulties that arise as a result of ensuring all shifts are full and managing part timers in the rosters. One participant felt strongly that rather than responding to these individual changes in work practices by trying to make them fit into the existing rostering system we need to engage staff, consider what they want and need and develop creative alternatives to rostering. She felt that we need to challenge the assumption that traditional models are the only workable solution and suggested trialling some innovative alternatives.

Some stakeholders suggested a review of the rostering of junior medical staff to frequently rotate between health care teams given that effective team work is recognised as an important facet of safe staffing. Instead the roster would span over a longer time period allowing staff to become familiar with the team and their roles.

Another stakeholder commented on the added pressure on nurses who are under the constant scrutiny of patients and their families for the entire shift. It was suggested that breaks from observation could be built into rostering patterns. Nurses in mental health also called for better support given the time spent with clients relative to other mental health professionals.

Many stakeholders supported the Council's proposal to produce guidelines on rostering for safe staffing. Some noted that rostering needs to particularly consider teaching and supervisory responsibilities, adequate breaks and adequate handover and the intensity of work and/or high risk environments.

Some stakeholders suggested that national take up of rosters would be aided by addressing governance issues such as identifying safe rostering in medical staff employment contracts; linking safe rostering to accreditation processes; State licensing or financial incentives; or seeking endorsement by professional colleges and societies. Others were wary of guidelines on rostering which would not be flexible enough or adaptable to the variety of care settings.

4.2.4 Staff/Patient Ratios

Many stakeholders felt unable to define a safe model of care due to a lack of evidence in this area. Many felt that at a basic level, the provision of guidelines on safe ratios for staff numbers was needed to develop and implement such models. These stakeholders felt that benchmarks would not only give workers an informed model for designing work structures, but it would also provide a greatly needed feeling of control over their work, thus lowering stress levels.

The Royal College of Nursing supports nurse: patient ratios and presents a number of research studies highlighting the association between higher nurse patient ratios and better patient outcomes (p5 RCNA submission). They note, however, the need for up to date data on workload and staff expertise in order to set appropriate ratios and suggest this as an area for future work.

Some opponents to guidelines on ratios however, felt that there was a risk that guidelines on minimums would become actual levels in many cases. Some felt that ratios are too prescriptive (if regulated) and may have negative impacts on other parts of the hospital if implemented in one area.

Midwives felt strongly that the ratio debate was irrelevant if appropriate models of care were used:

> *The issue of ratios of staff to patients is predicated upon a system of care that is so commonplace we take it for granted – that of the use of rostered midwives to provide maternity care. Yet reliance on rostered shiftwork of midwives as a mainstream approach to providing maternity care is itself a barrier to improvements in safety and quality in maternity services. Shiftwork based care delivered in discrete wards for antenatal, labour and postnatal care, can act as a barrier to flexibility, leaves little room for individualised care and does not meet well the needs of women and their babies… it makes more sense to have staff available when they are needed, as is possible with a caseload model in which midwives work on-call.* (p4 Australian College of Midwives submission)

4.2.5 Teamwork

Teamwork was seen as central to the issue of effective work practice. It was suggested that strategies for building better teams would need to include building mutual respect across disciplines, challenging existing hierarchies and working towards a more collaborative model than the current 'top-down command'. Midwives in particular commented on doctor–midwife relationship:

> *…the lack of respect shown by some doctors for the skills, experience and clinical judgments of midwives is a cause for major concern in maternity services, and has been documented in some cases as being a factor that contributes to adverse outcomes that could have been avoided with a more collaborative approach.*
> (p3 Australian College of Midwives submission)

The emergency departments were described by several participants as a speciality area with a positive team environment. Some felt that the elimination of distance from senior to junior staff (consultants working along side junior staff regularly) helped to break down barriers. Senior staff had opportunity to relate to other staff, eg to 'talk about the footy'. Something as simple as the absence of formal attire (suits) for consultants/seniors replaced by the white gowns worn by most staff, regardless of level, can help to create an atmosphere of greater inclusion rather than one of separation and hierarchy.

Particularly with respect to implementing change and encouraging safe staffing practice, **empowerment** and **ownership** of ideas were identified as important factors for success:

> *"People are not allowed to think up new ideas and new direction…the policy people are saying that you need to do it this way but if the person who is going to enact it doesn't have 'a eureka moment' and say 'I'll do it this way', often they wont be able to do it, wont own it and wont get excited about it…we could be growing this from the ground up and really doing exciting things"*
> (workshop participant, psychology)

Stakeholders felt that the team based model needed to be applied to the design of a range of staff practices including, training, rostering and handover which is not traditionally done within a multidisciplinary framework.

4.2.6 Alternative Models of Care

Some stakeholders felt that the industry needed to take a fresh look at models of care and challenge the existing structures and processes:

"We have been using the same one since Nightingale…why does everyone have to be bathed before morning tea?" (workshop participant, nursing)

Many stakeholders were supportive of the continuity of care (rather than carer) model however in practice some stakeholders appeared to be less comfortable with the idea of leaving a patient at the end of their shift. Some nurses complained of the reduction in job satisfaction of no longer seeing a patient recover.

Stakeholders working in midwifery were less supportive of this model and instead encouraged the Council to consider alternative models such as caseload, continuity of care models. In some areas midwifes have moved away from shiftwork towards caseloads, a model which they felt could equally be applied to other roles such as community health workers or mental health workers:

There is now evidence from randomized controlled trials that changes to work practices for midwives hold the key to significant improvements in clinical outcomes. In particular, midwifery care is routinely provided across Australian hospitals by midwives working on rostered shifts, typically with 3 shifts per 24 hours....The few services that have changed their work practices so that midwives work on call to provide continuity of care from early in pregnancy, through labour and birth and in the early weeks of mothering to a caseload of women, have found significantly lower rates of medical intervention are needed to achieve safe birth, with associated lower rates of morbidity.
(p3, Australian College of Midwives submission)

The key issue for many was the need for flexibility and recognition of staff choices in their working arrangements, ie that shift work is not for everyone, on call work is not for everyone, and caseload work not for everyone. They felt that choice in job design would bring greater job satisfaction and better functioning teams as well as impacting positively on staff retention.

Provision of a 24 hour service (e.g. by hospital staff) within a Monday to Friday model for staff such as allied health professionals contributes to added stresses in hospitals:

"we are now doing pays and anything administrative is dumped on us as a nurse, vacant positions, social working, OT, dietician if they are not there and after hours when those services only work Monday to Friday. The nurses on the weekend who have already been reduced to skeleton staff because of penalty rates pick up all those other non clinical duties."
(workshop participant, rural hospital)

Some stakeholders felt that an acceptance of the realities of a 7 day a week, 24 hour service model and a review of remuneration for base rates and overtime would assist in changing cultures:

While doctor change may be difficult, a change in payment systems may provide an alternative way of altering the manner in which people think.
(p1 New England Area Health Service submission)

4.2.7 Communication and Documentation

The changes in work practice and models of care would also require changes in communication and documentation. The role of **handovers** in particular was discussed frequently in the consultation. Many felt that handover is not done well by doctors, and whilst nurses were more likely to have handovers, some methods were described as primitive and old fashioned with 'notes scribbled on bits of paper'. Some nurses worked 8-hour shifts with no official overlap meaning that handover was conducted pre or post shift for one staff member ie in their own (unpaid) time or via audio tapes of poor sound quality.

Changes in shift structures, use of casuals and agency staff and changes to multidisciplinary team based care all highlight the current shortfalls in handover procedures and **general communication between professionals**. Stakeholders were supportive of the Council's focus on communication and stressed that the changing nature of work practices and staff structures will make this even more important. The communication issues for midwives in particular are noted:

... the problem of a doctor 'knowing best and not being open to questioning' is a widespread problem in maternity services. Midwives have to get to know which doctors they can rely upon to have appropriate professional discussion with about the best options for the care of a particular woman and/or baby, and which doctors are not open to such discussion. Midwives' access to quality medical advice when it is needed is therefore often contingent upon who is on roster or on call. This is hardly an acceptable basis for providing safe care.
(p5 Australian College of Midwives submission)

Orientation was another area identified by some stakeholders as something not done well in many institutions:

We are aware of situations where medical staff are rostered to new teams or join new organisations and are required to assume a service role with no or minimal orientation. This practice is unacceptable, but change is likely to be challenging from both a cost and logistic perspective.
(p6 RACMA submission)

4.2.8 Recruitment processes

Stakeholders in several workshops and submissions noted the practice of 'slow appointments' in health care. Staff complained of non advertising of vacancies, constant rejustification for positions and months of delays in filling positions under what they felt was a deliberate strategy by the administration to save money. Whilst the detrimental affects for staff left to manage without positions being filled were described by stakeholders in several states, the strength of complaint was greatest in Tasmania were the issue was clearly a major one for staff workloads and morale.

4.3 Links between staffing variables & adverse events

Stakeholders generally felt that there was a lack of data in this area (see Available Evidence section 4.1). Some commented on the nature of data systems for staffing variables and those for adverse events which were generally separate and not compatible to allow the linking of data.

Some stakeholders noted the relationship between adverse events and staff resignations. These stakeholders encouraged efforts in this area believing that any efforts aimed towards preventing and managing adverse events will help staff moral and staff retention.

Few stakeholders could provide anecdotes of known systems or studies they were aware of which linked staffing variables with adverse events. The communication of even small efforts in this area would be beneficial such as those of this rural hospital:

> *"we went to quite some effort to look at medication errors in the hospital...we realised that looking at the individual cases the majority of medication errors were happening at 6 o'clock in the morning and that was when there was substantial pills out, and people are tired and that really doesn't make sense so they changed the main pill round to 8am and that gave a minimum number of pills out at 6 o'clock in the morning so those sort of changes make a significant difference to the number of errors."*
> (workshop participant, rural hospital)

4.4 Fatigue

Much of stakeholder discussion focused on the issue of fatigue. In particular there was much debate about what fatigue is and the difficulties with measuring an individual's level of fatigue. There was also a variety of opinions on the affect of fatigue and the ability of medical staff to function at different levels of fatigue. Some, although a minority, were not accepting of the evidence presented in the paper of the physical affects of fatigue on medical staff.

Stakeholders were in agreement about the causes of fatigue as outlined in the paper and acknowledged that fatigue is not only caused by long working hours but by the intensity of work

and the acuity of patients which have both been increasing in recent years. Stakeholders also presented a number of instances where activities and/or pressures outside of work contributed to fatigue.

In a number of workshop locations, participants felt that workplace stress and fatigue was heightened by the lack of people management skills in middle management and the lack of support provided by administrators.

Whilst all agreed that fatigue was an issue, there were varying opinions on the severity of the problem and on an individual's ability to be aware of their own fatigue and understand the implications for patient safety. Some felt that there is a huge educational task ahead (tied to culture change) as many staff were unaware of effects of fatigue eg volunteering for double shifts or moonlighting at other hospitals.

Most felt that health professionals were aware of fatigue and the surrounding safety issues but that it simply was not a priority in management of work practices at present, it is 'not on the agenda'. There was general agreement that there is currently no formal process to identify and manage fatigue and that the culture of the health profession meant that individuals would not act even if they knew they were fatigued.

The lack of management processes to deal with fatigue further adds to workplace stress, contributing to staff turnover and burn out. Some staff felt pressure to work even when they were sick as they knew that no one would be available to replace them and other co-workers would be under increased pressure. Others spoke of increases in absenteeism under staff shortages and some described staff that planned to take sick days if the roster was too arduous, further contributing to management staff problems and stress at the workplace for the remaining workers.

Some felt that changes to work practices had already been made by senior staff recognising the increasing intensity of work loads and patient acuity:

> *"We don't have 24 hour shifts in emergency, the longest we have is 11 hours…the nature of the work is full on the whole time…you physically can't do 16, 24 hour shifts because you would be working the whole time."*
> (workshop participant, emergency medicine)

Several stakeholders commented on long term fatigue caused by very long periods of intense work, resulting in 'burn out'. Stakeholders felt the work of the taskforce should address issues such as long periods where staff are unable to take holiday leave (years of working without a break in some examples) and the long periods of time on call. Medical staff on call for long periods and on a regular basis noted the affects on sleep patterns and long terms affects on their

health and well being. Those in rural areas in particular highlighted that the usual result of long periods of intense work was for staff to move to the city or to leave the profession.

A large contributor to workplace stress was the feeling of lack of control or choice about the working environment. Whilst many staff recognised that they were fatigued they felt they had no choice other than to continue on, further adding to personal stress levels and frustration with health administration.

In general, most were unwilling to withdraw services where safe staffing levels were not being met despite the possible impacts on quality of care. There were some instances, however, where this was happening:

> *"I've had a patient who travelled to Sydney who was told straight up by the anaesthetist "I've just done a 12 hour day in surgery, would you like me to take you into surgery and do another 8 hour operation on you or would you like me to wait sometime earlier in the morning?...I'm not doing surgery because it puts me at risk and by putting me at risk it puts you at risk.""*
> (workshop participant, rural hospital)

Stakeholders felt strongly that any future work on identifying and managing fatigue needed to be supported by adequate resources or it would further add to the stress and frustration of health workers who would be unable to act even though they were aware of the safety and quality issues.

4.5 Culture

The issue of culture was central to the discussion of the current situation. Stakeholders noted that health care is an old industry with many elements of culture which will take some time to change. They related to the issues touched on in the paper and elaborated on these in the workshops.

One stakeholder noted the industry is built on a top-down, 'army style' command model meaning that the culture is not one of empowerment of staff but rather of hierarchy and 'old school power plays'. Others added that this sometimes leads to bullying in the workplace. The impact of this culture on safe staffing as described by many participants was that long working hours and levels of commitment can be expected of junior staff for career advancement. Working less or speaking up about long hours may be seen as a lack of commitment by seniors.

Another facet of the culture described by stakeholders was around the caring nature of the industry. Some staff described themselves as 'our own worst enemy' because individuals were passionate about helping patients and caring for those who need help, they sacrifice their own lifestyles. Others felt that there was also an element of martyrdom here which perpetuated these behaviours.

The current culture was frequently described by stakeholders as a 'blaming culture'. Many expressed strong views about the importance of a culture of openness, where staff could speak out without bullying or fear of negative repercussions for their careers. Participants felt that most risk management approaches were reactive and looked to 'point the finger'. Some commented particularly on the nature of health care which focuses on individual accountability rather than team based responsibility and the culture of blaming oneself for not being able to cope or not wanting to admit limitations in this environment. Others felt that doctors were trained to believe that they were infallible and thus were less able to see the impacts of fatigue on their abilities.

The majority of stakeholders felt that the culture of government services today is also a barrier to change. Hospital management is seen to be budget driven making them resistant to change or suggestions outside the traditional models of care or staffing structures. Many felt that change would only happen with senior management support and that identifying the opinion leaders at the local level and working with these employees was the only way to change behaviours.

Those in the emergency speciality commented that they had a more open, team based culture than other areas and again this was attributed to leadership and action at senior level, to address issues for long working hours and other pressures in the working environment.

5. Industry comparisons

There was a divergence of views on the usefulness of comparisons with other industries as presented in the discussion paper. Some stakeholders, although finding the comparisons interesting, felt they were not always appropriate and noted what they saw as key and important differences:

> *When discussing safety in healthcare, comparisons are frequently made with the aviation industry. Many difficulties exist that can be approached using a systems approach and an understanding of human factors. However there are some significant differences; health care workers are required to respond immediately to emergencies whenever they occur whereas flight schedules fit within financial, environmental and safety constraints. Planes do not depart when a passenger arrives – passengers fit in with flight schedules not the reverse. Take offs and landings are restricted overnight, this is not the case in obstetrics or emergency situations in the health industry. The nature of healthcare places extra stresses on the workforce particularly in rural settings.*
> (p1 RANZCOG submission)

Many stakeholders, however, welcomed the industry comparisons and felt strongly that the health industry could learn greatly from the experiences of industries such as aviation, transport, petro chemical and nuclear power. These stakeholders felt that we should not be hesitant to step outside existing models of health care to really canvass true alternatives to work practice and organisation by learning from these industries.

The aviation industry in particular was raised a number of times as an industry with similar cultural barriers to that of the health industry (eg hierarchical structures and commitment to long working hours) which have been addressed through the introduction of team orientated work practices. The investigation processes of adverse events in aviation which focuses on institutional learning for prevention, was also seen as a positive model from which to learn.

6. What is required in the industry?

The discussion questions in the paper were successful in prompting and leading a constructive discussion on what is required in the health industry. The workshop discussions were lively and moderators witnessed a visible enthusiasm for action. The consultation itself provided an important opportunity for stakeholders to contribute and served to advance the thinking of stakeholders through encouraging the sharing ideas on safe staffing.

6.1 Regulation

6.1.1 Support for Regulation

Many of the representative organisations, unions and associations were supportive of regulatory reform (with suitable safeguards). Many stakeholders, in general, felt strongly that regulation was required to ensure change. Whilst guidelines were thought to be useful in raising awareness and had been used successfully in settling industrial disputes, many felt that voluntary approaches do not attract the resources required to make sustainable improvements. These stakeholders felt that change in this area would require resources and in the current environment of extreme budget pressures only through regulation or legislation would administrators be able to act, noting that presently staffing issues were the first items to be cut back under budget constraints.

Many staff, particularly those in rural areas described the negative impacts of the current situation on staff morale. Staff felt defeated by the administrative system which is very budget-driven flowing down to middle managers who are under pressure to meet budgets and further cut costs. Some felt that change will only happen if it is forced change and hence has resources to support it.

Supporters of the nurse/patient ratios in place in Victoria cited this as an instance where nurses felt empowered and could 'get some control back' into their workplace. They felt this has been an important component in retention of staff as nurses felt they had something to drawn on to support them when the management/administrative system was pressuring them to take on greater work loads.

6.1.2 Concerns

Many stakeholders were not supportive of regulation and even amongst those who felt regulation was needed, several were concerned that regulations around safe staffing include not only the level of staff but consider skill mixes/levels of experience and patient acuity. Some feared that regulations would become the minimum standards and not allow for updating of skills and provision of staffing above the regulations where appropriate.

The greatest concern of stakeholders was the risk of inflexible regulations and some felt that the transport industry comparison was a useful experience to draw from here. Many felt that hard and fast rules were not appropriate and that industry wide regulations about working hours or staffing numbers would be problematic. Regulations need to be cognisant of different levels of tolerance and the different working conditions in different care settings, rural and metropolitan locations and for specialists and generalists.

> *...defining minimum staffing levels or roles for specific clinical situations is not a viable approach. We have observed staffing strategies in the nursing profession based on defined staff-patient ratios, and consider that these strategies have been deficient because they fail to recognise the impact on patient safety of changes in local circumstances independent of staffing levels (including those related to patients, other team members and the environment within which the team is providing care).*
> (p4 RACMA submission)

6.1.3 Other strategies

Many stakeholders felt that staff needed a risk management strategy to recognise and respond to 'grey areas' ie where conditions were 'not quite right' but services are still being delivered. Many felt that regulations fall down in the critical service times which frequently occur. Parameters of such situations and appropriate responses could be informed by research (undertaken by Council) to provide evidence to support strategies.

Several stakeholders suggested ways of implementing change without regulation such as linking provision of safe staffing plans with accreditation and/or insurance to encourage change. A key issue for change without regulations is to institute strategies at the local level to address culture:

> *...reliable local strategies, designed to ensure flexible safe staffing structures and practices in the context of locally changing circumstances, are required. As noted in the discussion paper, therein lies the challenge...Major cultural change is required if reliable local approaches that contribute to achievement of the required national objectives are to become the norm, rather than the exception.*
> *(p4 RACMA submission).*

6.2 Fatigue management

Solutions to the issues presented in the paper centred on the debate of - who is responsible for managing fatigue? The range of comments received lead to the conclusion that there is a need for mechanisms and support on three levels:

- Strategies for the individual health professional;
- Organisation/employer systems and supports; and
- System wide mechanisms.

6.2.1 Individuals

Stakeholders acknowledged the need for individual accountability and responsibility in order to effectively manage fatigue, particularly given the difficulties in measuring and monitoring fatigue levels. Many felt that there was a great need for education to:

- Raise awareness of the implications of fatigue to safe patient care and build personal responsibility for actions;
- Enable individuals to develop greater self awareness to recognise their own fatigue; and
- Provide individuals with strategies for managing their own fatigue.

Some stakeholders felt that this education should include a variety of concepts and highlight the differences between fatigue, stress and tiredness, focusing on recognition of contributors including factors outside of the work environment. Training also needs to recognise that fatigue is variable and different individuals will respond differently to the same set of working conditions.

6.2.2 Employer responsibilities

Whilst many saw fatigue as an individual issue, stakeholders described the need for a balance between individual and employer responsibilities. Stakeholders saw a need for management support and resources to allow individuals to manage fatigue and to encourage behaviour and culture change. Many stakeholders felt that there was little point in educating staff about fatigue if they were not empowered to act in the workplace when they experience or witness fatigue. This in fact would further add to personal levels of stress.

Staff felt that the bottom line for them was that there is no choice other than to continue working when fatigued. These stakeholders felt that work organisation and resourcing needs to support fatigue recognition and positively reinforce behaviours, eg to say ‘thank you for being honest’ when staff admit their limitations.

Some saw the need for management and support structures for when staff were in high risk situations for example, formal structures to provide options for staff working double shifts to undertake ‘less risky’ tasks. This would require management recognition of the impacts of fatigue; a change in culture to one of openness and acknowledgement of limitations; and the provision of alternative strategies to manage the identified risks. Evidence to inform decisions would be most useful in managing the risks and many stakeholders suggested the Council could facilitate research to provide them with this information.

Stakeholders discussed a number of approaches to fatigue management addressing the two different scenarios of, firstly, those who choose to work longer hours, extra shifts or two jobs for financial reasons and those who, despite recognition of fatigue, continue to work long hours because of the dedication to the job and lack of other staff to relieve them. Whilst both groups of staff require some education about fatigue and fatigue management, more confrontational strategies may be required for the former group.

Some stakeholders felt that the culture of health care as hard working and caring meant that workers were also less willing to ask for help for themselves. Organisational support which was automatically provided in given circumstances such as counselling or debriefing services after major traumas or other incidents, was suggested as health professionals would not be likely to request services for themselves, even if they were available.

6.2.3 System Wide Mechanisms

Stakeholders highlighted a number of cases, many which were also presented in the paper, where there is a need for a system wide approach to managing fatigue. The working arrangements of those in private practice, the increase in agency staff as well as the incidence of 'moonlighting' means that staff work across many work locations and there is not one institution aware of, or able to, manage their hours. Stakeholders suggested system wide structures such as disclosure of working hours, log books etc or central governance of remuneration to create greater transparency and opportunity to highlight risks in working patterns.

6.3 Risk management

The consultation revealed that there are a variety of interpretations of, and approaches towards, risk management. Some saw risk management as data collection and a function carried out by the Risk Manager or administrative staff whilst others felt that this was a part of everyday work – "we are all risk managers". Language used by stakeholders also varied and some noted the importance of defining risk management purposefully to avoid confusion.

Many stakeholders commented that risk management is too often budget driven, and were particularly concerned when elements of risk management are linked to senior manager's performance pay. Some felt that risk management has moved towards managing the risk of legal action rather than safety and quality.

The general view of stakeholders was that staffing variables were not systematically considered in risk management, that it was the exception rather than the rule to consider such variables. One stakeholder noted that we need to identify risks before we can manage them and many staffing variables are simply not measured or managed with regard to safety and quality.

Many stakeholders felt that the health care industry was reactive rather than proactive by nature:

> *"we work in a reactive way…we are taught to respond and this impacts on our culture and the way we think…it's difficult to shake off the shackles...it impacts how we learn and how we communicate with each other."*
> (workshop participant, mental health)

Stakeholders felt that we should be encouraging a change in culture to be more proactive towards managing risk and learning from mistakes and best practice solutions to avoid incidents:

> *"We need to make sure we can get as much data as possible on the near misses so that we can see what we are actually doing that is stopping near misses from becoming sentinel events. We don't know that of the ten reported drug errors whether there were 10 reported near misses, 100 near misses or 1000…how many, with team work and nurses checking and asking, how many times we pick up mistakes…we don't know how well we are actually doing at this, or how badly."*
> (workshop participant, nursing)

Elements raised by stakeholders included the need for:

- an environment where it is acceptable to admit mistakes. ie a 'no blame culture' that analyses the root cause rather than seeking out individuals;
- more regular feedback to front line staff on the data collected;
- data on near misses to discover the scope of problems and the ways of avoiding adverse events; and
- learnings shared within the organisation and across institutions to facilitate best practice ie to be able to learn from mistakes and remedies of other staff and other hospitals. This is something that is not done in the present environment which is seen as competitive, closed and blaming:

> *"This is seen as secret business and we don't air our dirty linen, don't let other hospitals know about out near misses and let other hospitals learn from it"*
> (workshop participant, nursing)

For those who opposed the introduction of regulations on the grounds that they were too rigid, a risk management approach was the preferred solution. These stakeholders felt that armed with information about possible risks, staff would have the flexibility to continue with a certain practice and attempt to manage the risk of staff fatigue or stress. The underlying premise for such a strategy is adequate education about the risks and a culture of openness that allows staff to admit their fatigue and associated limitations. Some felt that this kind of culture change would take a long time to achieve.

6.4 Training and Education

There was widespread agreement that there is a need for training in human factors however, stakeholders were unsure how to achieve this effectively without substantial resource commitment. Whilst it would appear cost effective to incorporate training within existing systems, problems with current training structures and cultures may make this ineffective. In addition, some stakeholders called for a total revision of the training model given the nature of changes in practices under a safe staffing agenda.

6.4.1 Current training practices

Much of the workshop discussions on this topic were taken up with discussion of the failings of current systems in providing adequate access and support for training and ongoing professional development. Many staff complained of having to complete training out of hours, further contributing to fatigue, or at their own expense. Alternatively, some staff felt that they would be seen as 'slack' if they were off training or updating skills when colleagues were under pressure in their absence. Others reported that managers were reluctant to release staff for training and that positions were never backfilled.

Many commented on the fact that most health professionals train in isolation of the other health professionals with whom they work and that multidisciplinary training was needed for effective multidisciplinary teamwork. Midwives in particularly noted the lack of understanding of their expertise by doctors:

> *Midwives' expertise is often not recognised or well understood by medical staff. Becoming familiar with midwifery expertise is not part of medical training to become an obstetrician, and is not reflected in the organisation of decision-making responsibility in most maternity services… The gravity of these issues for the health and well being (or even the survival) of mothers and babies was well highlighted by the King Edward Inquiry.* (p6 Australian College of Midwives submission)

6.4.2 Developing alternative training models

Several stakeholders were interested in developing alternative models for training and managing junior staff in the learning environment given the scarce resources available:

> *"'On the job' learning, where many tasks are performed sequentially by medical staff of junior and intermediate seniority, before being reviewed by senior medical staff, may not be the most efficient way of utilising scarce resources in such an environment. New teaching and training techniques, including those made possible by new technology, need to be considered in the context of diminishing clinical contact hours and changing work participation patterns by trainee medical practitioners.*

(p5 RACMA submission)

In some workshops there was much discussion about how people learn best and the need to rethink training models in light of reducing hours and changes in staff rostering. It was suggested that learning is a complex issue requiring more thought on how, when and where, doctors learn, not simply focusing on the total quantum of time or on the traditional apprenticeship model. Despite the expressed need for change these stakeholders were also appreciative of the efforts required to change training models:

> *Any change in the current training model will require negotiation with the AMC, a significant cultural shift for the medical colleges and will take a considerable time to achieve.* (RANZCOG submission)

Participants felt that training in human factor principles should be incorporated into tertiary teaching settings to provide junior staff with these principles from the outset but also needed to be available to existing and senior staff to ensure culture change and support for these concepts in the workplace.

Stakeholders felt that a particular challenge for training would be how to incorporate the growing numbers of casual and agency staff who work across institutions. At present the education and training of casual and agency staff is largely undertaken by ad hoc full time staff without sufficient support or resources, further adding to stress for these staff.

6.4.3 Training needs

Stakeholders supported the areas for training raised in the paper. Issues concerning work practices such as team-based work and communication were raised most frequently. Training in people management, leadership and performance management was also mentioned by some stakeholders as crucial to achieving culture change.

There was also seen to be some need for training in effective rostering (although others cautioned against prescriptive guidelines in this area). Some participants felt that staff would benefit from computerised rostering systems but needed better training on how to use the full capabilities of these systems.

6.5 Improved Data and Evidence

There was a divergence of views on the need for better data and evidence to move forward in this area. Whilst many thought that there was a need for more evidenced based solutions, some felt that there was a significant amount of existing knowledge that was not being used and that outcomes from inquiries such as the King Edward Inquiry were not being implemented.

Those who were supportive of further research felt that the information gaps were around linking safe staffing with outcomes and understanding the impacts on safety and quality. Whilst some stakeholders felt that there needed to be rigorous research and significant investment in better data collection and monitoring systems, others were supportive of practical evidence from the grass roots. Some felt that there was much to be learnt from simple remedies that staff implement in their workplace and what was needed was a facility to share these ideas Others felt that reflective investigation to challenge what is currently being done rather than new research would be a useful starting point.

There was considerable debate about who would conduct and fund future research. Stakeholders felt that this was a role for the Council. There was a strongly held view that clinicians need to be involved in the research to ensure it is relevant, credible, high quality and useful. Whilst many staff wanted to undertake research, they felt that the reality of the workloads meant that there is no room for research on their schedule. Others felt that they were 'stuck in the old ways' and that staff do not take the time to stop and think about alternative ideas or challenge thinking (an opportunity which the workshops provided them). Many stakeholders were keen to be involved in trialling possible staffing models or practices.

Some stakeholders felt that staff were not engaged with the process of data collection and that delays in data of 6 months or more contributed to this. They felt that more involvement of staff in the process and more timely feedback would lead to better outcomes, encouraging staff to understand and question why and how they do things, looking for best practice models.

Stakeholders in several workshops and submissions noted the need for clarification on the number of staff shortages in many areas but particularly in nursing. Some noted that governments and senior managers in health care did not acknowledge that there was a staff shortage and thus attempts to address possible shortages could go no further. The RCNA called for national data collection systems to establish the true numbers of shortages, and monitor mobility and enrolments to plan for future workforce supply.

6.6 Emerging technologies

Overall stakeholders agreed that there is a role for technology in improving staffing practices and a need for more investment in adoption of technology and further innovations.

One stakeholder observed that technology is usually introduced to improve accounting rather than clinical outcomes. Others commented on where technology could best be used:

> *Technologies tend to be utilised in critical care areas where there are already better staff-to-patient ratios. The real need is in general areas where the numbers and skill mix are much less.*(p2 M Vidovich submission)

Many felt that current technologies were not being exploited to their full benefits. This was argued to be due a number of reasons including lack of coordination of technology already in place and insufficient training for all relevant staff. It was also suggested that ways of ensuring the competency of casual staff in recently introduced technologies is needed. Several examples were given of the current uses and applications of technology such as:

- AIMS,
- Telehealth;
- online information,
- patient information database,
- patient acuity systems,
- communication such as emailing, and
- training, simulators etc.

Participants felt there was great potential for the introduction of other technologies, such as:

- in the US, palm pilots are used for more immediate information and better communication;
- telephone advise line (as in the UK); and
- an electronic system for effective drug prescribing, dispensing and administration.

When implementing new technologies stakeholders made the following suggestions for improvements:

- coordination of systems and compatibility has to be ensured;
- greater system-wide standardisation of some technologies so information can be shared more easily;
- better training and implementation support; and
- less competitive attitudes amongst healthcare facilities (particularly hospitals), which are hindering greater sharing of technologies and innovations.

Some expressed a desire for automatic rostering systems, however, other people who had used these systems felt that they were not flexible enough to be able to account for diversity. It was suspected that this could possibly be due to a lack of training and not knowing how to use these systems to their full capacity and benefit. Some participants noted that there were reporting options available on the automatic rostering systems but they didn't know how to use them. The use of this application would be highly valuable in informing the safe staffing debate.

Some concern about the use and reliance on technology was expressed in terms of any possible technical failure which could potentially be disastrous in the health care environment. Thus, it is an essential requirement to have contingency plans for technical failure.

6.7 Other issues

6.7.1 Workforce planning and sustainability

Stakeholders were adamant that macro issues of workforce planning are crucial for successful and sustainable outcomes in safe staffing. Many saw that implementation of any safe staffing strategies would fail without appropriate workforce supply into the future. Obstetrics was offered as an example where a long term view to ensuring workforce supply is critical:

> *Nearly half of Australia's 300 private full-time obstetricians planned to stop private obstetrics. Most plan to give up their full-time private practices in the next five years. A significant reason for this decision is the need to reduce the stress on their lifestyles; other contributing factors include the cost of medical indemnity and the ever-present threat of legal action if there is not a perfect outcome…An increasing proportion of RANZCOG Fellows are choosing not to practice obstetrics, 20 years almost all new Fellows practiced obstetrics but in 2001 24% of final year O&G trainees indicated that they would not practice obstetrics. The ever-decreasing manpower is further complicating the situation as those who are still practicing obstetrics face an increasing workload.*
> (p2 RANZCOG submission)

Stakeholders felt that the long term view is not currently being examined and that policy is not in place to plan for and develop an appropriate workforce for the long term future of health care. Some called for a 'total rethink' of the way people work, train and develop in the current vocational environment. Particularly given the choices for women today, some questioned how the health profession could become a more attractive option for a long term career. Remuneration would also need to be considered given that many staff currently earn high rates of pay through additional hours and overtime and would not be prepared to accept the base rate of pay as the norm.

Stakeholders felt that the council's work would have minimal impact without consideration of these issues. They felt that what was needed was a broad look at long term career/vocational issues such as:

- training places;
- resources/funds;
- career planning and management;
- variety of staffing structures;
- role definitions/delineations and team functions;
- professional development;
- work/family balance issues particularly for females;
- job security, job design and job satisfaction; and
- expectations of those in training eg all health now a 24 hour service.

Communicating the links between addressing work practice and attracting new staff to the profession would be beneficial in gathering support for future work practice reforms and activities.

6.7.2 People Management

Stakeholders felt that the success of the recommendations that come from this process will heavily depend on the ability of managers to manage people. It was felt that the hospital system was not good at managing people, partly due to the fact that people in management positions are often promoted due to excellent clinical skills, and insufficient emphasis is placed on their people management skills.

Some staff expressed a feeling of not being valued and this leads to reduced job satisfaction and increased stress. Stakeholder felt that the first step was for managers to acknowledge the impacts on stress and fatigue of low morale, poor job satisfaction, a lack of variety in job design and low levels of ownership or empowerment. Training is needed to provide managers with the skills to structure teams and manage individuals with these issues in mind.

Stakeholders felt that introduction of training and support for people management was needed including mentoring and supervision, increased debriefing, team facilitation (managing multidisciplinary teams), feedback, performance management, and positive morale building. It was suggested that an overall approach of celebrating the positives and successes would be a step in the right direction.

6.7.3 Rural services

Participants, mainly from rural areas, felt the paper does not adequately deal with the separate issues and circumstances of heath professionals working in an isolated or rural environment, with varying structures and support facilities. The section of the paper on workloads and staffing practices was seen to be very metrocentric, focusing on different levels of in-hospital doctors while in rural and regional areas the focus would be much more on GPs.

Some rural participants approached the paper with suspicion due to a perceived lack of input from rural health practitioners to date, commenting on the lack of rural representatives on the taskforce: *"a failing right from the start".*

The complexity of issues related to rural health care was raised by a number of participants. These issues included:

- ***Consumer expectations:*** It was felt that consumer and community expectations in rural areas were much higher (see below for discussion of consumer issues). For example, in very

small facilities consumers may expect one-on-one individual care 24 hours a day, 7 days a week whilst it may be more appropriate to have a team approach to health care.

- ***Fear of closures:*** There was concern that changes due to the safe staffing agenda could lead to in a closure of facilities and that safety was sometimes used as 'an excuse' to close services and save money. Some practitioners in rural areas reported that community expectations had influenced their decisions regarding staffing practices and working hours in particular. It was believed that closures were not acceptable to the community and in small communities where there is a more personal aspect of providing services (ie where patients are generally known to health workers), the decision to close a service is almost impossible. Thus, staff find themselves continuing to work, despite the risks.

- ***Skill mix and roles:*** When there is a limited number of staff who have to cater to diverse needs and situations in any one day, skill mix was considered more crucial in rural areas. This also requires various health practitioners to engage in several roles and be generalists rather than specialists, eg rural doctors. This also applies to nurses, in that they felt they are required to wear many hats and get laden with many tasks, some which could be allayed with the appropriate administrative support.

- ***Fatigue and burn out:*** Some felt that working hours were generally longer in rural settings and that the real issue for staff was burn out over a long period of time (rather than fatigue after particular incidences of long working hours). Doctors who did not take a break for years would eventually 'burn out' and then leave the system altogether rather than seek respite and then return to duty.

- ***Staff retention:*** Rural and remote organisations have particular trouble attracting and retaining staff, due to the conditions of the work and the expense to make visits back home. There is particular need to have incentives to attract and retain rural staff. It was suggested that alternative work structures could be put in place, such as short-term contracts, so potential staff did not feel they were making unknown and overwhelming commitments that they were unsure they could fulfil. Instead staff could take a temporary position and trial rural work without fear of having to make a long term commitment to something they are unsure of.

  In cases where staff are difficult to find it was argued that a system-wide approach should be used. One participant shared an example of how doctors from surrounding areas each worked half a day for two weeks at a hospital, coordinated by the local division, until the locum arrived, thus ensuring services could be delivered and one doctor did not bare the burden of excessive hours.

- ***Transport, isolation and distance*** were raised as important issues. In some locations, for example, it can take two days to get a team of trainers to a remote location so training is not cost effective and can take its toll on those travelling long distances. In other areas, fatigue is not considered in the travel practices of staff and is becoming a barrier to participating in training held in central locations. Budget cuts mean that air fares are limited, so staff have to drive to training courses or seminars held in the city which can be some distance and involve early morning starts or driving after a full days work which further contributes to fatigue.

- ***City solutions:*** Poorly formulated legislation and guidelines can increase bureaucracy for rural staff further adding to stress and negatively impacting staff morale. Metropolitan based solutions imposed on country health professionals will meet with significant resistance. Many rural staff were wary of guidelines, fearing that they would be developed without sufficient rural health input. Some commented that benchmarks set in such guidelines were rarely applicable to rural settings.

Despite the challenges of working in rural and remote facilities, practitioners from these areas felt that they could offer some learnings to metropolitan facilities. It was argued that teams in rural health facilities still manage to provide similar services, but with less resources and people, thus it must be **human factors** such as teamwork and the management of roles and responsibilities which enable them to do this.

Many rural participants felt strongly that further consultation was required before adequate solutions could be developed for rural health settings. Some commented that to change practices in rural health would require an overt communication of an understanding of rural issues that was not demonstrated in the paper currently. Rural doctors felt that change could be achieved through seeking rural **participation in development** of guidelines and other safe staffing issues and practices to ensure their relevance and applicability.

6.7.4 Consumers

Individual consumers and representatives from consumer bodies participated in the consultation; generally consumers' level of knowledge on the topic of safe staffing was fairly limited. There were a variety of views from health professionals with regards to consumer participation, with some believing that the provision of health services should be a consumer-driven process. Some stakeholders felt more strongly that consumer participation and management of consumer expectations was critical:

> *RCNA would like to ensure that consumer participation is included as an action* [for the Taskforce]…*Consumers and health care workers need to work together from the beginning of these discussions to build collaboration.*(p8 RCNA submission)

Some stakeholders were unsure as to how consumers could be involved and felt that they would need significant education about the health care system before they would be able to contribute. Lack of information and knowledge was seen to be one of the reasons why consumer expectations can be exceedingly high and unachievable. It was felt that consumers don't understand the strains placed on the health care system and the practitioners.

Some felt that alternative models of care may not be acceptable to consumers or not meet expectations, for example, introducing the patient to several practitioners (team based cared). Some noted that implementing alternative care models will increase the need for improved communication between health professionals and the patient.

There was a feeling amongst consumers in the consultation that some health practitioners are not taught to deal with patients; and they felt that education and training should have more of a focus on this area. There was also a concern that under current short staffing circumstances, the relationship with the patient was of least importance.

Some stakeholders questioned whether the health industry was ready for an increased consumer focus. Some observed that with the aid of the internet, patients are educating themselves and consequently becoming more involved in their own care. It was argued younger doctors are more accepting of a more educated consumer base, whilst older doctors may be less communicative with patients. Consumers expressed a desire for patients to have more involvement when receiving health care. For example, it was suggested that the handover in hospitals should involve the patient rather than being conducted behind closed doors.

There was some discussion on public perceptions of health care and the role of the media in this debate. There were considered to be pros and cons of media involvement, such as the impact on staff morale when negative stories are published and the ability to implement change through raising awareness of issues. It was believed that a benefit of more informed consumers and increased media coverage is that the public would be more aware of the constraints that the health care system faces which could possibly lead them to lobby the Government for more change.

7. Priority Areas for Action

7.1 The need for action

The strength of support for change in the area of safe staffing was great. All those organisations and individuals attending workshops, participating in interviews and writing submissions were supportive of the need for change and endorsed the Council's intent to address the issues raised in the paper in some way. Many were heartened by the possibility of a third party, with some influence, taking action and commended the Council for this.

7.2 Reactions to the current proposal

7.2.1 The Role of the Council

There was wide spread support for the Council's work and appreciation of the role it plays in improving patient safety through awareness raising and agenda setting. There were a variety of views on the possible role the Council should play in furthering the safe staffing agenda.

Stakeholders generally responded positively to the nature of the priority actions presented in the paper and felt that the Council could play a constructive role in the following areas:

- **Facilitating** change at the local level, for example, in people management practices, better rostering;
- **Advocacy** for safe staffing, providing the catalyst for change through building a business case to support safe staffing levels, including advocacy with hospital administration, colleges and government;
- **Education** and **communication** on safe staffing issues including raising awareness of fatigue and its impacts for patient outcomes;
- Education of **consumers** and facilitation of consumer involvement in the development of safe staffing models;
- Supporting and funding **research** to better define safe models of care;
- Supporting identification of **best practice** models and facilitating the sharing of ideas and remedies;
- Production of **guidelines** and **tools** for use at the local level to assist in the implementation of safe staffing practices; and
- Initiating and supporting local **trials** or **pilot** programs.

Whilst there was strong support for the Council's actions there were some negative comments and scepticism about their role. Several stakeholders felt that the Council needs a course of action that has greater power - 'more teeth' - in influencing regulations, budgets and politicians.

Whilst many felt that the productions of guidelines as proposed would be helpful, they were concerned that this would have minimal impact on the ground. These stakeholders feared that the outcomes would be bureaucratic and document based and not enough about "doing things".

There were some stakeholders who were somewhat sceptical that anything will actually change, feeling that stakeholders have 'said all this before' and nothing ever changes. Quick and visible outcomes ('runs on the board') will be important in continuing to engage these stakeholders.

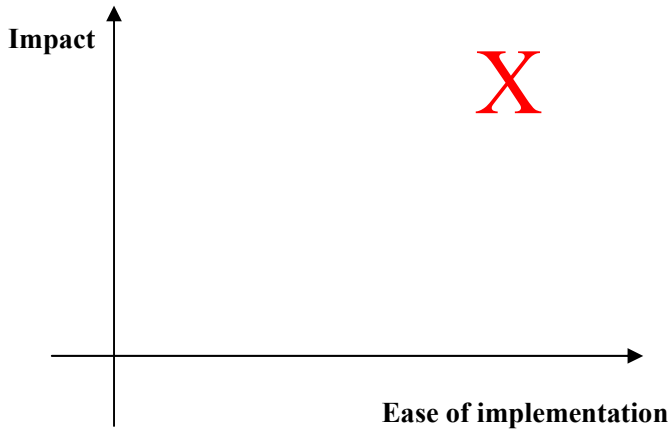
Some felt that the safe staffing task (and priority action list) was too big and therefore too difficult to achieve. Some feared that efforts would be spread too thinly and therefore little would change. Some, although a minority, suggested that the council should focus on a more narrow definition of safe staffing which targeted the human resource allocation and supply issues of working hours, rosters, skill mix and rather than the full gamut of issues presented in the paper.

7.2.2 Content and Direction of Action

Stakeholders generally supported all of the seven priority areas for action as being the key issues for advancing the agenda and addressing major barriers to change. The greatest criticism of the action list was the absence of efforts to address workforce supply and sustainability. Many felt that the taskforce needs to consider these macro issues and that real change can not be obtained without these being addressed. Many found productive discussion difficult without referencing these wider issues.

The priority of continuity of care through improved handover procedures received particular comment. Whilst universally supported as an area in need of attention and improvement (with the exception of midwives, see ACMI submission) many thought that this was a very small issue relative to others in the action list such as reducing stress. This led many in the workshops in particular to consider priorities within the action list and recommend the areas of most importance.

Many felt that whilst all issues presented were important and relevant, the council should focus on what would have maximum impact in the short term, to gain momentum. Others thought that implementing what would be greatest value for money would be best, through examining what would be easiest to influence.



Others felt that the hard issues needed to be tackled and identifying those with governance responsibilities, ie the person responsible for safe staffing at the local level and examining why they have not implemented strategies would be a good starting point. This would include working with employer organisations, practitioners in private or independent contractor arrangements, professional colleges and medical registration boards who can influence culture and behaviours at different levels:

> *".....the success of each of the other six identified priority actions will be contingent on the success of the priority action to improve governance surrounding safe staffing.*
> *We therefore consider that identifying governance responsibility, determining the existing barriers to good governance, and engaging all stakeholders in a strategy that is directed at improving governance of safe staffing, should be identified by the ACSQHC Safe Staffing Taskforce as its first priority action."*
> (p5 RACMA submission)

7.3 Achieving change

Stakeholders were eager to see improvements in safe staffing however they were also realistic about the magnitude of the barriers to change and the long term strategies required for sustainable

outcomes. A range of key issues emerged in discussions as to how change could be facilitated and the manner in which the Council might proceed. These are outlined below.

- Strategies to support **culture change** were seen as integral to the solution and particularly important for sustainable outcomes. Participants felt that changes in processes often fail because of a lack of willingness of people to really change and that these core issues of culture will need to be tackled through a range of strategies including strong leadership and role modelling.
- Although many stakeholders were concerned that solutions be **flexible** and adaptable to many care settings, many stakeholders felt that **regulation** was necessary to provide adequate funding to support new structures and to force management to change. Stakeholders were seeking a balance between regulatory change and flexible local solutions.
- Stakeholders were supportive of change with **clear and transparent processes and objectives** that are communicated to all tiers of service provision. Stakeholders recounted how numerous changes are implemented at the grass roots level with a degree of scepticism and that ownership can only be developed through an understanding of shared goals.
- A clear time line and a balance between strategies addressing **long term goals** and those aiming for **short term impact** was seen as desirable. Although many strategies will have long term goals, stakeholders felt that change would be achieved through a gathering of momentum and evidence of achievement over a shorter time frame.

- Continued consultation and **involvement of clinicians** in the development of strategies was seen to be an important aspect of successful implementation. Stakeholders believed that changes imposed on staff would meet with resistance whilst changes developed from the ground up would have greater chance of success.

8. Conclusions and Recommendations

The consultation was successful in raising awareness and support for the Council's efforts in supporting safer staffing in health care. Stakeholders were encouraged by the discussion paper and commended the Council for the work done to date and proposed for the future. A key component of the consultation process was the bringing together of staff in all disciplines and a range of care settings. The enthusiasm displayed and the constructive dialogue entered into during workshops is testament to the interest and commitment of stakeholders in furthering safer staffing and augurs well for the success of future activities.

Stakeholders were heartened by the paper and the issues raised by it, however, many felt that the issues could be expanded upon in more detail to reflect the complexity of the situation. Stakeholders generally felt that the descriptions of the current situation in health care as presented in the paper reflected their experiences, however, some felt that the examples used were in the extreme rather than the norm. Stakeholders also felt the paper needed to include a broader range of examples other than medical.

Stakeholders were supportive of the need for action and endorsed the Council's proposed actions as key areas for effort. Some however felt that the Council's role may be lacking in real power and those actions which are too document based will be less likely to be implemented.

The next steps for the Council are to begin work on the priority actions including consideration of the following issues:

- Whilst stakeholders appreciate the opportunity to be heard and value the discussion, they expect some action and the Council to set about 'actually doing things'. Setting of short term goals will provide a focus for people and allow for visible achievements early on.
- Consulting with speciality groups to both engage them and to better understand them (for example, surgeons and midwives in particular who raised the importance of a specialised approach to their disciplines).
- Publicise and communicate responses to the consultation and continue to engage these health professionals. There is an expectation now created of high stakeholder involvement in formulation of safe staffing solutions;
- Engage stakeholders in work on the ground to build ownership and learn from clinicians. Several stakeholders offered their support and assistance with further work (see submissions).
- Continue to communicate and raise awareness of issues in general. The workshops are evidence of power of communication, the value in sharing ideas, challenging health professionals to think differently.