CRIME AND CORRUPTION COMMISSION

TRANSCRIPT OF INVESTIGATIVE HEARING

CONDUCTED AT LEVEL 2, NORTH TOWER, 515 ST PAULS TERRACE, FORTITUDE VALLEY WITH RESPECT TO

File No: CO-19-1209

OPERATION IMPALA
HEARING NO: 19/0006

DAY 4 - THURSDAY 14 NOVEMBER 2019
(DURATION: 30 MINS)

LEGEND

PO Presiding Officer – ALAN MACSPORRAN QC
CA Counsel Assisting – JULIE FOTHERINGHAM
HRO Hearing Room Orderly – KELLY ANDERSON
W Witness – SANDRA EALES
LR Legal Representative – N/A

CA I call Sandra EALES.

PO Ms EALES, would you prefer to take an oath or affirmation?

W An affirmation.

PO Affirmation, thank you.

HRO Can you stand and repeat after me, please.

W Sure.

HRO I solemnly affirm and declare.

W I solemnly affirm and declare.

HRO That the evidence given by me.

W That the evidence given by me.

HRO In these proceedings.

W In these proceedings.

HRO Shall be the truth.

W Shall be the truth.

HRO The whole truth.

W The whole truth.

HRO And nothing but the truth.

W And nothing but the truth.

HRO Thank you. Take a seat.

CA Good afternoon, Ms EALES.

W Good afternoon.

CA You were provided with an attendance notice for today?

W Yes.

CA May Ms EALES be shown the attendance notice.

I tender that document.

PO Exhibit 73.

ADMITTED AND MARKED EXHIBIT 73

CA Your position is as Acting Secretary of the Queensland Nurses and Midwives Union.

W Yes.

CA And your areas of expertise are in nursing?

W And midwifery.

CA And midwifery. And you were the Assistant Secretary for the Union from early 2015 until currently?

W Yes.

CA And you were the Midwifery and Nurse Unit Manager at Queensland Health from 2010 to 2015?

W That's probably about right, yes.

CA And you have a Master's Degree in Midwifery from the University of Southern Queensland.

W Yes.

CA And you've been a member of the Union since 1980?

W Yes. I think I had one small break when I was overseas, but yes.

CA Would you like to make an opening statement? Or, the other option, is you have provided a submission, yes?

W Yes.

CA Have you got a copy of the submission there?

W I do.

CA And that is Exhibit 49. Would you like to speak to that document, or for me to ask you some questions?

W I'm happy for you to ask questions.

CA Yes, okay.

W There are a couple of additional points that I do want to make, but, I guess, I just – I'll respond to your questions first and...

CA Okay, thank you.

So the Union, could you just explain how large members – how many large a group of members there are?

W So we have 61,000 financial members.

CA So it is the largest occupational group in Queensland Health?

W In Queensland, we're the largest union, and nationally we're federated. We're the largest union nationally as well.

CA And the classification of workers include nurses, registered midwives, enrolled nurses and assistants in nursing.

W That's correct.

CA Who are employed in the public, private and not-for-profit health sectors, including aged care?

W Yes.

CA And the full range of classifications are covered with your membership; from entry-level trainees to senior management?

W Yes, from pre-registration to – we also have student members, so...

CA Yes. And in your submission, you -- the union is asking the Commission to take into account that the work is often stressful and demanding for your members. And you cite the results of a recent survey of members working with the digital medical records system. Would you like to speak about that in any more detail?

W I certainly can. I guess, one of the significant concerns that we have, we see is the introduction of systems and approaches that don't fully recognise the way nurses and midwives work and create as many, or more, problems than they try to resolve.

So certainly with – in our membership, whilst there are certainly very good aspects to having good informatics and good data around the patient record, the reality is that the way they're often designed and implemented doesn't deliver. And what we hear – and it's not just here in our space, but the international literature also identifies, that the problems create often a removal of the nurse

or midwife from the patient. So there's a disconnection. There's increased workload. And often the access is a significant issue. And some of that is partly to do with the infrastructure, so the point of care, lack of availability, or clunkiness, but also the – a big problem with workforce having access, we have increasing high rates, particularly in the private and aged care space, but also within certain areas of Queensland Health, high rates of casual and agency staff. So the – very often they come into a unit and they won't actually have the access. So there's – you know, nurses and midwives are constantly doing work-arounds to get the work done. So the shared logons is a significant work-around, but has risk for our members as well as, you know, the whole system.

CA Wouldn't you agree that every industry is now moving towards using information technology just as part of a progression with time?

W Certainly.

CA And as technology improves itself all the time, and that to integrate a technological way of working with patient data is just part of the progression of the normal pace of society?

W Yes. And certainly our professions have been part of the drive to make advances to improve the better flow of information and the better mapping of the patient journey, but the reality is is that when systems are designed over there, and away from, the -- and not seeing the way work is conducted, there's quite a big gap between how work is imagined by people who don't actually do it and how it's done by both, you know, at the bed side. And not all of nursing work is visible to those sort of data points.

I'll give you a very good example. And, I guess, this does address one of the main concerns or points that I wanted to bring up, is the – the potential when you just deliver technical or analytic solutions, and monitoring. In our profession where the foundation and the value is around care, only part of that is technical. The other part is about human connection. And sometimes the introduction of new technologies diminish the human connection part. And that's a fundamental aspect of both the value and the safety that nursing and midwifery delivers.

And there's quite a good example; just recently, there was quite a large UK study that came out that assessed nurses' worry score against the early warning tool, that is the technical device, that is used to detect deteriorating patients. And what it found was that the nurses' worry score was more predictive of that deterioration than the vital signs monitoring, which is the technical aspect of it. So I think that's just a key example of the one of the risks that we see with focus on – or, privileging, I guess, the technical above the human aspect of the work.

CA Just coming back to the terms of reference of the current public hearing that you're a part of, we're looking at ieMR database, which is the predominant holder of personal information of the public. And in the submission that the

nurses' union has provided, there's a request for more targeted training as to assist with implementation of that new database. So that would be of assistance with some targeted training for your members?

W Yes, any time there's a new system introduced, I think it's vital that there's appropriate training around that. But that is one of the aspects that I was talking before about, the -- where the work-arounds happen where you've got high agency staff and the burden of work of orientating new people to the system, is a constant work that – that after the implementation of a new system often falls on to the -- the unit manager or with the resources – nursing resources within the unit to keep up. So it's a – that's one aspect of that increased workload.

CA And then with the introduction of -- the recent introduction of ieMR, in your submission, there is the request that Queensland Health and the Hospital and Health Services mitigate the risk of unauthorised access through monitoring and disciplinary processes underpinned by relevant policy and procedure. That's at paragraph 4, on page 4, of your submission.

W Sure.

CA We've heard from two Hospital and Health Services, Mackay and the Gold Coast, and we've also heard from the Department of Health throughout these hearings, and they all appear to be focused on all of those aspects that you're asking for, the monitoring, the disciplinary processes and ensuring there's – underpinned by policy and procedure. So that does appear to be a focal point for those three agencies who have come before the public hearing.

Now, at page 4, the last two paragraphs you talk about an issue to do with the report that it's generated as a result of the P2Sentinel software for the same surname search, that there are some issues with it from being provided from eHealth to the Hospital and Health Services. That is something that Department of Health have informed the Commission they are aware of and are working on improvements to.

W I'm sorry, which part was that?

CA Page 4, the last two paragraphs.

W This is of my submission of – of the QNMU's submission you're talking about?

CA The Queensland Nurses' submission, yes.

W Yes.

CA Any other matters arising from your submission that you would like to air in the public hearing, Ms EALES?

W Yes. So, look, I think – just in terms of coming back to what I was talking about before, but in terms of the policing and monitoring, the -- some of the concerns that we have is that we don't want there to be too much focus on this one small aspect of confidentiality.

Nurses and midwives, in the way they function, navigate that space between public and private information all the time. They navigate that, you know, at the bed side with how they take in information, and who they share it with, whether it's the -- announcing the sex at birth, or the sharing of information with family members. It's a constant every day part of maintaining ethical practice for nurses and midwives.

And I guess the concern is that when you take a quite removed and just legalistic or technical approach to something that is navigated constantly, there is a risk of harm. The way that we might see that – so within our 61,000 members, whilst our members are navigating this handling of information and confidentiality, we work in an intimate space with people and their issues. And to have a removed judgment about how and when information is accessed has potential to make the workplace much less safe, a less safe learning environment, for one.

And I'll just give you a little example. So if – potentially an unauthorised access could be – in my experience, you might have a passing encounter with an individual. If I'm in a rural environment, I'm looking after a woman in labour, I may need to transfer either her, or her and her baby, out to a tertiary centre. I may have been involved in the resuscitation of one or both of them. And they're removed. I no longer am officially their carer, so potentially, you know, it could be viewed that I wouldn't have a right to be viewing their current information.

But the reality is, when you invest in that caring relationship, there is a human need and requirement professionally just to do some reflective practice, to follow up on the outcomes, to see, you know, the results of where they ended up. So there's both a clinical/professional interest, but also that human care interest.

And if you shut down the access to that or make it a trap that people can fall into, then I think you risk making the system and the people who provide the humanising aspect within it diminished.

CA Thank you for that.

Now, I'll just show you Exhibit 11.

Are you familiar with that section of the Criminal Code in Queensland?

W Look, I'm not a legal technocrat. I'm probably familiar with the general advice in there, but, yes.

CA So we are here for Operation Impala in the public hearings, we are concerned with the misuse of information by using a restricted computer, so accessing a database, using a password. And that is an offence, if it is not for work purpose, under section 408E of the Criminal Code, just to, sort of, give you a reference for what we are concerned with.

And I'll just show you Exhibit 1. It should be on the screen, yes. Have you viewed that document the Terms of Reference of Operation Impala, Misuse of Information Inquiry before now?

W Yes, I think I skimmed it.

CA So given the Terms of Reference there, so that's where we're confined to our investigation for Operation Impala. Is there anything else on point that you would like to raise here at the public hearing?

W Well, I think the, as I said, the -- one of the risks when you just focus on one aspect of the continuum, in which our members, nurses and midwives function, there is a risk that – like I said, we've got 61,000 members, they deal in this space every day that they turn up at work, and maintaining the ethical practice and understanding the barriers and how and when to access.

And, you know, in midst the constraints of the system, the work-arounds, that are imposed on them, there is a risk that the system gets a bit skewed. So we have absolutely no problem with – when there's a deliberate misuse that people and, yes, unethical conduct, that it is identified and treated appropriately. But there is risk within the -- this space, the system, that those legalistic ends and means of policing can be inappropriately used.

And I'll give you another example of this. Since we have moved to – actually, it is across all sectors it happens. When a nurse identifies a safety issue, so an unsafe workload concern, they should be able to assert their professional judgment. And part of the industrial framework for us is that they identify -- they raise a workload concern. Part of that is that they need to be able to tell the story about what the safety issue is. So part of that may be telling the story of the risk to patients. So whilst they would normally have de-identified information, sometimes just the story of the condition and telling the story about the high risk, the acuity, could potentially have identifying information in that. And what we have seen is that that excuse is often used by managers, both within aged care and in the public sector, where the nurse is discouraged from alerting – making those alerts because they will be called as breaching that private information.

So it is not a black and white issue, the discretion and the critical thinking around how to separate the public interest in revealing that private information.

CA Yes, thank you. So just to go back to the specific area of the ieMR and moving forward with that new process, clear training and clear policies would be of benefit to your members?

W Yes, and consultation at the -- prior to introduction to an area.

CA Okay, thank you very much, Ms EALES. I don't have any further questions.

PO Thank you. Ms EALES, thanks for coming. You're excused.

W Thank you.

CA That completes the witness list for today.

PO Thank you. So 10 tomorrow.

HRO All stand. This hearing is adjourned.

END OF SESSION