

# TRANSCRIPT

## FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

### Inquiry into perinatal services

Bendigo — 24 October 2017

#### Members

Mr Paul Edbrooke — Chair

Ms Cindy McLeish — Deputy Chair

Ms Roma Britnell

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#### Witness

Ms Suzanne Hartney.

**The DEPUTY CHAIR** — I welcome to these public hearings Ms Suzanne Hartney, neonatal nurse and midwife. Thank you, Suzanne, for attending here today. All evidence at this hearing taken by the committee is protected by parliamentary privilege as provided by the Constitution Act 1975, and is subject to the provisions of the Parliamentary Committees Act 2003 and other relevant legislation. Any comments you make outside the hearing will not be afforded such privilege. It is a contempt of Parliament to provide false evidence. These proceedings will be recorded, and you will be sent a proof of the transcript.

I would invite you, Suzanne, to make up to a 15-minute statement — we have half an hour allocated — and we will follow that with questions.

**Ms HARTNEY** — Thank you for the opportunity to speak today. I would just like to clarify that I am here today on my own. I am not here representing either of my employers, which are Bendigo Health or Goulburn Valley Health in Shepparton. I have 17 years experience in neonatal care, 13 of which have been at Bendigo Health. I currently work part-time in a special care nursery two days a week. I have also been an ANUM, an associate nurse unit manager, in that unit for the last two years. I also am a midwife with seven years experience, and concurrently work in the women's ward and birth suite two days a week here at Bendigo Health as well. I do casual work at Shepparton in both their maternity ward and special care — rarely the birth suite, predominantly the ward or the nursery. I have also been a member of the neonatal e-handbook subcommittee for the last three years. This role involves updating the guidelines on over 90 newborn conditions for the Victorian Maternal and Newborn Clinical Network on the Safer Care Victoria website.

Bendigo Health nursery and GV Health nursery have level 4 capabilities, with eight-cot funded units. The Bendigo unit has a growth capacity, though, to open to 15 beds in the future; there was forward planning with the building of the new hospital. The admission criteria in these units are from 32, 34 weeks, plus or minus 1500 grams. Our new hospital opened in January of this year, and since this time we have consistently seen an increase in the number of admitted babies. I believe Fiona Faulks touched on the basis, with obesity and gestational diabetes and things, which we are certainly seeing in our unit. We often admit more babies, though, than the unit is staffed for, because the acuity of care required for our babies is becoming more complex, and that is also due to maternal comorbidity. An example of this is that we now offer respiratory supports, such as continuous positive airway pressure, or CPAP, for our babies, which we have done for some time now, but we are seeing more of that, and these babies require one-to-one nursing until they are stable, which is impacting on our current ratios.

Compared to our old unit, our new nursery is fantastic: it is large and beautiful. It is generally a very lovely environment for parents and staff to be in. We are fortunate to have four parent zone rooms, where breastfeeding mothers can stay with their babies 24 hours a day. There is a pull-out bed for them and their meals are provided during that time. It is a fantastic service for families, allowing them to stay together and to promote breastfeeding. Often these rooms are allocated to families that live outside of Bendigo, as we see many women antenatally coming to our hospital now. They are also allocated to mothers and babies who require support due to a history of substance abuse during the pregnancy, so it is a quieter room for those babies that are withdrawing. There are minimal accommodation options available other than that. We used to have what we classed as the medihotel here at Bendigo Health for mothers to stay at, but unfortunately that building has been demolished with the new development and the growth of the new hospital, so we have lost that service unfortunately. There is only the capability for the four parent zone rooms. There is no future growth for eight to accommodate all babies and families that come through our unit.

I would like to talk about some of the issues facing neonatal nurses and the babies that we care for. The largest one is the inadequate numbers of qualified staff that we have in either unit that I work in, resulting in double shifts, overtime and extra shifts. The health and wellbeing of the core staff that are in the nursery is being impacted with this, with the increased stress levels of working with inexperienced staff. At present if further beds were to be open, we would be unable to fulfil that roster with the current ratios of one nurse for four babies. There is limited on-floor support for graduate midwives who rotate through our nursery. Our regular core staff are rotated to the women's ward during the two-week rotation that the students come into the nursery, therefore leaving us short-staffed on experienced staff. The two-week rotation is also limited for their learning in the postgraduate model of care midwifery course, and we find that unproductive in attracting new midwives to ongoing employment in the nursery after the course has finished. Obviously they enter a postgraduate midwife course to become midwives. That is related then around birth suite and postnatal care, where we find that neonatal care is not seen as an option for ongoing employment at the conclusion of their course.

The hospital also offers — this is Bendigo Hospital, sorry, not Shepparton — a 12-month graduate nurse program whereby nurses rotate through the special care nursery and child and adolescent unit for six-month rotations each. Often these staff members are also not well supported or educated as they often work with the ANUM on duty, and we find we have limited time to educate and support them as we have our own full workload plus other non-patient duties to attend to as the midwife in charge. Bendigo La Trobe University and Bendigo Health are considering the feasibility of running a level 2 neonatal course in the future so we can locally attract staff. Currently those courses were offered in Melbourne, and that is where I did mine many years ago. We see this as a fantastic opportunity for regional areas to grow their workforce. Unfortunately with the six-month program that we have we see that those nurses seek employment elsewhere — generally the major metropolitan hospitals such as the Royal Children's. We have seen them go there. So we have trained them up well, but then they have left to further their skills and knowledge in tertiary centres, or they have sought ongoing employment in the child and adolescent unit as their preferred rotation. Subsequently we are seeing our nurseries being staffed by an older workforce and we are unable to retain or attract the younger demographic for the future.

The recruitment and retention of neonatal nurses and midwives is not just a Bendigo Health issue. I see it dramatically at GV Health. In fact I got a phone call an hour ago to see whether I could work today because they have suddenly got a baby on CPAP. So I see in that hospital that many midwives do a shift-to-shift rotation basis, so they rock up and they do not know where they are going to work for the day. It will either be the birth suite, the ward or special care. They do not have core staff like Bendigo Health do or they have very few core staff, and they certainly do not have ANUMs there. This morning Fiona Faulks touched on clinical leadership being an integral part of future growth, and I see that more in neonatal nursing as we move forward. Certainly it is an ad hoc system on who is responsible for doing other duties if you do not have clinical leadership such as ANUMs in the unit.

We find that when you do rotate through different areas, if you are not core based somewhere too, it impacts not only on the continuity of care of our mothers and babies but also staff satisfaction and therefore skill enhancement like not having everybody being competent to look after a baby on CPAP or a baby that requires stabilisation prior to transfer to a tertiary centre. I see that the development of a neonatal nurse practitioner model would be extremely beneficial in the regional centres. I know that our clinical director of paediatrics brought this to our attention a number of years ago. Unfortunately there was no development on that, but I know that he was keen years ago for that to be done. I am not sure where that is at this point in time or whether that is even still on the table. I know that the nurses and the midwives that were probably the best candidates for that are also in their late 50s and early 60s, so it was not long term because we do not have the youth in the nursery. I am probably the second youngest in the nursery. But for future growth we need to attract younger midwives and nurses to the unit.

Under the Safe Patient Care Act there is no allowance for a supernumerary ANUM in the unit at the moment. Subsequently we are required to take a full patient load, which often includes the sickest baby in the unit, because we work with the most inexperienced staff member generally — not always but generally. Along with patient care, we must perform all the associated ANUM duties on our shift. This includes but is not limited to ward rounds and arranging admissions and transfers. That includes consulting with PIPER, replacing sick leave or roster shortfalls and liaison with birth suite staff about potential admissions and therefore staff shortages if there is the potential for multiple admissions. We also have to update statistical data entry — not that it takes long, but Reach is a program where we now update the neonatal bed status of our hospital. It is done four times a day, and even though it does not take a long time there are many clerical duties that we also have to do.

The Bendigo Health nursery does not have a ward clerk available in-house for us to do all these clerical duties, so that is on the ANUM to do as well. I do know a budget proposal is potentially being put forth to clarify that, but that is pending. So it can be very difficult as the ANUM in charge when I am looking after an admission that requires considerable time to stabilise or do procedures for and I do not have the time to support the other midwife or nurse who is on the floor as well, who may then have to pick up potentially seven babies in total while I am dealing with the new admission if we are at full capacity.

The changes to the Department of Health and Human Services neonatal capability framework has also impacted on our unit. It is now more difficult to transfer babies back to a lower level of care hospital that we have previously been able to, thereby prolonging our length of stay in Bendigo and Shepparton, and subsequently impacting on bed availability. The domino effect of this is the delayed transfer of babies back from Melbourne

and tertiary centres, which also then impacts on their bed status. It can be very difficult to find appropriate staff when we go above eight babies, with the 50 per cent rule applying in many cases. We are reviewing our escalation policy at present, and a flow chart for retaining agency staff has recently been developed to aid us in obtaining staff when we require not only just the second person but also if we need the third person because our bed numbers have increased above the ratios.

We are also seeing an increase in antenatal and perinatal admissions to the women's ward from those women who can no longer birth at their smaller home town hospitals, as was touched on this morning in the talks by Fiona and Nicola. This can be an added stress to families when their babies are admitted to special care for a prolonged period of time, above the woman's own length of stay in the maternity ward. As I said earlier, we only have four parent zone rooms, so we cannot accommodate all eight babies in our care for their mothers to stay.

The hospital has limited available accommodation. There are units around Bendigo where we may be able to get them in. They are ideally for oncology patients from out of town, but occasionally we can get them into those accommodations. But they do cost anywhere from \$80 to \$110 per night, if they live a considerable distance from Bendigo. So those women that do get transferred to us from Mildura and Swan Hill — areas like that — can get subsidised through the Victorian Patient Transport Assistance Scheme, but they have to outlay the costs first and then put in applications to get reimbursed. We see a lot of women from Echuca, but unfortunately they are 10 kilometres short of the VPTAS requirements. It is very stressful not only for their babies to be admitted to the nursery and the subsequent reasons for why they have been admitted, but they also have extra costs — they are away from their families.

We are finding that having the medihotel no longer available is impacting on our families as well. The unit is geographically much larger in space, and even though it is fantastic to have room when our previous unit was a shoebox, the babies are no longer visible from a single point; therefore they are on centralised monitors, which results in subsequent alarms when babies move or require attention due to low oxygen levels or apnoea. There is the noxious noise of the new unit, which we know is not something that we can change, but we are looking at our policies in regard to what type of monitoring certain babies need, and it is also something new to us that we now are experiencing a lot more noise. Even though it is a much bigger unit and you would think you would not hear it, the centralised monitors are there, so we have got a lot more noxious noise than we ever had. As an ANUM on duty, there may be times when I physically do not lay eyes on one of the babies that is not in my care, purely because of the size of my own workload.

Bendigo staff are not permitted to leave the unit for their meal breaks as there are only two staff rostered per shift, unless we have 9 or 10 babies and have a third staff member. That is impacting on staff as well, obviously, because we cannot leave for the safety; we would not leave one staff member in the unit whereas previously we had been. I am permitted to leave when I work at Shepparton. It is a small unit like we were in the old Bendigo Hospital, but we would encourage and promote improved ratios in all Victorian special care nurseries so that babies and families can receive the best care and also staff can be cared for as well with taking their meal breaks.

The other point is that our current staffing levels impact on the ANUM's role because we are not permitted to leave the unit without having a second staff member in there. We have the limited ability to attend to neonatal code blue events or emergencies on babies in other areas throughout the hospital, whether that be birth suite or the emergency department, in a timely manner because we cannot leave until a staff member comes to relieve us. That is in our policy — that a staff member from either the women's ward or children's ward must relieve us — but if they are busy and therefore cannot relieve us, that will impact on our ability. Our current policy is that the ANUM of special care is the coordinator of the neonatal resus, so we are finding that, and we are working through that ourselves as an organisation.

The exciting thing that Bendigo Health are also offering or doing at the moment is we are undertaking a research project on the efficacy of blood sugar monitoring on babies at risk of hypoglycaemia. It is a fantastic initiative, but it also does take a little bit of extra time. The ANUMs, or the nurse looking after the baby, are required to get informed consent from the parents to obtain a little bit of extra blood so that we can compare a bedside glucometer blood sugar monitor to that of a pathology-standard sample, whether that is sending it to pathology or performing it on our i-STAT machine in the nursery. It is a great initiative that we hope will help improve our care of our babies and may be implemented in other organisations if we find, depending on the data

analysis, the most reliable source of detecting and therefore treating hypoglycaemia in a timely manner and therefore hopefully minimising their length of stay in our unit and the management of hypoglycaemia.

In conclusion I would just like to say that in the two neonatal services where I am employed they offer amazing care for families. The nurses who care for neonates are very passionate about what they do and providing the best care that they can. However, I believe more can be done to ensure that that care is at the most optimal level that it can be and that staff satisfaction and ability to provide that care is an ongoing requirement of the Victorian government to minimise the distress of such a difficult time on families and for our most vulnerable population.

**The DEPUTY CHAIR** — Thank you. It is terrific actually to see somebody of your capability and experience before the inquiry today, and I thank you for that. Before I pursue my line of questioning, can you clarify how many cots there are at Shepparton?

**Ms HARTNEY** — Eight. It is also an eight-bed unit. Level 4 — eight bed.

**The DEPUTY CHAIR** — Eight at both, but Bendigo has got the future building.

**Ms HARTNEY** — Yes. Shepparton is undergoing a redevelopment though, and there is talk that they will go to 10 beds once the new building is built. But that has not been determined as yet is my understanding.

**The DEPUTY CHAIR** — I would like you to talk more about the neonatal nurse practitioner model, about what you understand about it, about what it looks like, where it is currently being implemented or used and the results of others.

**Ms HARTNEY** — I only know of the nurse practitioner model. I had a discussion with our clinical director of paediatrics many years ago, and he was very keen. I was not aware of a nurse practitioner model for neonates prior to a few years ago until Dr Lovett mentioned it to me during a particularly difficult shift where he thought if we had nurse practitioners they could put drips in babies. We were experiencing at that time very inexperienced doctors coming through, and we did not have 24-hour registrar coverage at that time a couple of years ago. We do now, but at that time he was keen for nurses to take on more of a role in doing certain procedures that could be done quicker than waiting for a resident who attempted to put a drip in, could not put a drip in and then waited for a registrar. So he was keen. I do not know in what framework that nurse practitioner model will be. I have never been involved in any of that before, but I just know that Dr Lovett had mentioned it a few years ago.

**The DEPUTY CHAIR** — So you do not know whether he had seen it working or not working?

**Ms HARTNEY** — No. Shepparton certainly has never broached it, or I have never heard it mentioned there. I just know that in other areas of Bendigo Health there are nurse practitioners, such as in the emergency department — one of my friends is a nurse practitioner down there. I can see the scope of how it would be feasible in a neonatal nursery, especially one of our size and our future growth.

**The DEPUTY CHAIR** — What are the main tasks that you would see the nurse practitioner undertaking? You have already mentioned a couple. What are the main things that you would —

**Ms HARTNEY** — I would see the nurse practitioner role as also being supportive of staff on the floor and assisting during the sickest admissions and those that require stabilisation and transfer to tertiary centres such as respiratory support.

**The DEPUTY CHAIR** — Is this done by doctors now?

**Ms HARTNEY** — Yes. Generally the ANUM is there and assisting with equipment and putting them on the ventilator and things. That is all nurse —

**The DEPUTY CHAIR** — So how would this be different?

**Ms HARTNEY** — I think if you have got a nurse practitioner who has the skill and the knowledge, who can then impart on those junior staff and relieve the ANUM to do the duties of an ANUM during a shift, you will have future growth. There are many comments being made by our current rotating graduate midwives that they

feel unsupported at present because of the workload of the second person or the ANUM on their shift. When you have only got two staff on and I am busy doing other things, I do not have that time to educate or support all the time on an 8-hour shift, so they are left to their own devices. I mean, they still come to you, but you do not always have the time to sit down and show them exactly, or you might do the quicker version, whereas I see a nurse practitioner as educating thoroughly, knowing policies and procedures and implementing best practice throughout the shift.

**The DEPUTY CHAIR** — Do you see points of resistance in implementing such a model?

**Ms HARTNEY** — I would hope not. I think Bendigo Health especially at this point in time with the new hospital sees the value of neonatal nurses, as do the midwives on the floor when we come to assist. I think it will be more workforce issues in that many of our experienced midwives are in the later part of their careers, and the cost involved with doing nurse practitioner training would be significant. Just having done midwifery seven years ago and the cost that that involved for me when you have got a mortgage and a family, I think cost will be one of your biggest things — unless there were scholarships or Bendigo Health funding to support a nurse to do the education, go away and do the course and then come back.

**The DEPUTY CHAIR** — I was more looking practically within the hospital.

**Ms HARTNEY** — Practically I do not see it. Currently we have a very good relationship with our paediatricians and registrars, with mutual respect across the board about what nurses are and can be good at, so I would not personally see an issue with it. I am not sure whether some medical staff might have an issue with it; I cannot answer that. But certainly from a nurse's perspective, I would not see it.

**The DEPUTY CHAIR** — Just for my benefit, to become a neonatal nurse what particular course or qualifications do you need?

**Ms HARTNEY** — I am a level 2 qualified neonatal nurse. I went to the Mercy Hospital for Women in East Melbourne when it was the old hospital, where I did a three-month course on neonates. I was supported clinically by an educator and a preceptor, and we did tutorials. It was the clinical as well as the theoretical components. There is also the tertiary level 3 course, which is the NICU course, that you can do, and we have quite a number of staff who have done NICU and quite a few staff who have done level 2 as well in our unit. I think five out of the seven ANUMs have done level 2 or level 3 certificates.

**The DEPUTY CHAIR** — And how long is the NICU course?

**Ms HARTNEY** — 12 months.

**Ms BRITNELL** — I just wanted to ask, in your opinion, if you looked at the workforce issues and the challenges on a neonate specialist nurse, or any specialty really where you have got extra responsibilities, would you put as incentives to attract people to the region support as in supernumerary, mentoring and preceptorship-type support, or financial as the highest of the incentives for encouraging people into that area of expertise?

**Ms HARTNEY** — I think that is a catch 22, because you need the financial assistance to be able to do it first, but then you need the practical in-house support to maintain it, because if you do not feel supported, I think that is going to be one of the biggest obstacles. But people need to be able to fund it to be able to start it in the first place.

**Ms BRITNELL** — I just wanted to get your understanding within the area you are working in. What sort of involvement do you have with the parents and particularly the fathers?

**Ms HARTNEY** — We are very family centred in both units that I work in. All parents are encouraged to be involved in their baby's care, whether that be nappy changing, bathing or temperature taking. They are 100 per cent encouraged to be involved in their baby's care as much as possible. Obviously we see more mothers than we do fathers within work hours — Monday to Friday, 9 to 5. At this stage we can only accommodate a mother to stay in those four-bed parent zones, because there is only one pull-out bed, but both parents are always encouraged to visit. There are no visiting hours for parents. It is open to them 24 hours a day to call or visit and see their baby, and it has always been a family-centred care approach in both nurseries that I work in.

**Ms BRITNELL** — Do you find, given the intensity of the work with you and the neonate, that it is very hard for you to be able to support the extended family, parents and the like?

**Ms HARTNEY** — At times it can be, yes, depending on my workload. Obviously if we get an admission and I need to be with that admission, I may not spend as much time assisting a mother to breastfeed her preterm baby, which obviously takes a lot more time and patience than a term baby that is well on the maternity ward. We endeavour to do as much as we can during the care time of a neonate. Care for a neonate is done around feed times, and then they are left to rest, so you get a small, half-hour opportunity each feed time to do as much as you can, and it is managing your workload around that as well. I may be working with the graduate nurse who knows nothing about breastfeeding and who may need assistance, so there are at times that juggling act of maintaining my own workload as well as supporting important factors like the inexperienced staff members' workload as well, not only for the benefit of her education but also to support mothers because obviously breastfeeding is not a short time frame. It can take considerable time, especially with a preterm baby. Even if she needs help with expressing, to set her up on a pump, with a graduate nurse who has never been a mother herself or used a breast pump, there are those things that impact on my workload as well.

**Ms EDWARDS** — You mentioned the problem that there is in transferring babies back. Can you perhaps elaborate on why that is a problem?

**Ms HARTNEY** — With the capability framework now, we antenatally see women come to us more because smaller hospitals, once a woman reaches a higher-risk category, then have to transfer her care to another hospital. Those women who reach a BMI higher than 40 might get transferred to us if they have a large for gestational age baby and their baby stays with us. There is certain criteria now in that capability framework from level 2 and level 3 hospitals where they will not take a baby back if they are under 37 weeks gestation or under 2.5 kilos. So we may have a small for gestational age baby who is otherwise well just having tube feeds every 3 hours, with some sucking feeds, but they weigh 2.1 kilos. Smaller hospitals like Swan Hill and Echuca will not take those babies back for ongoing care because they weigh under their capability framework now.

**Ms EDWARDS** — So if a baby is transferred from Bendigo Health to one of the NICU beds in Melbourne they would be very unlikely to be transferred back to Bendigo as well, because they would be kept there until they reach that particular —

**Ms HARTNEY** — No, not at all. Our capability framework is 32 or 34 weeks and 1500 grams, but we will often take back babies slightly under those gestations if they are stable enough without respiratory support to free up the bed down there.

**Ms EDWARDS** — Given that we have a shortage of neonatal nurses across the state, which is very evident, and clearly capacity around NICU beds is also problematic — and they go hand in hand — and given our wonderful new Bendigo Hospital has a beautiful new birthing suite et cetera, is there any pressure, with the demand on that service, to discharge babies earlier to free up the neonatal beds that we have?

**Ms HARTNEY** — I would say no purely from the perspective that we know that if we discharge them too early they will rebound back. If a baby needs to be readmitted after they have been discharged, the likelihood is that they will go to the children's ward, and that is not our preference if they are still a preterm baby. What we currently have is that if a baby goes home from the women's ward but then becomes jaundiced and requires phototherapy treatment, they are admitted back to the child and adolescent unit. They do not come back to us, even though they are still within that neonatal period of 28 days, because they have been home in the community, if they do not have the criteria for home phototherapy. I would not say that we would ever push out a baby to free up a bed. Many times when mums and dads come in for that rooming-in process — they have 24 to 48 hours where they come in and do all the care — we will delay them going home if we do not feel that they are safe enough or the parents feel like they are not ready to go home.

**Ms EDWARDS** — How many neonatal nurses are there at Bendigo Health and at Shepparton in Goulburn Valley Health?

**Ms HARTNEY** — Bendigo has core staff. There is something like 18 to 20 of us. I would have to look at the roster, sorry. But there is about 18 or 20.

**Ms EDWARDS** — Neonatal staff?

**Ms HARTNEY** — Yes, core staff in the nursery. Not everybody has done a level 2 or a level 3 certificate, but they have worked in the nursery for many, many years. There are many staff there that have been a lot longer than I have.

**Ms EDWARDS** — You mentioned before that you got a call to go to Shepparton because, clearly, there are not that many staff who can actually support that hospital up there.

**Ms HARTNEY** — They have — I am going off the top of my head, just from those that I have worked with — seven or eight core staff there, and then each shift someone is allocated to work in there from the whole maternity roster. They do not have the benefit that Bendigo Health has in consistency of care and the knowledge and skills, but what they do have is that they have a diverse workforce, where someone from the ward can be pulled into the nursery and do the basics quite easily. But they cannot do CPAP or stabilising.

**Ms EDWARDS** — I just had one question in relation to babies and mothers that are separated for medical reasons and what support there is to have that attachment and establishment of breastfeeding et cetera between the mum and the baby.

**Ms HARTNEY** — In one scenario, if at all possible, if the mother is stable enough after a caesarean — whether it is an emergency or an elective caesarean — and if her baby for some reason is admitted to the nursery, the mothers come back via the special care nursery on the theatre bed before they go to the women's ward so that they can see and touch their baby. They are not always able to hold their baby, but they at least see their baby, take photos and things like that. We will always update the mother if she is unable to leave her room in the women's ward if there is a concern, and we update that way. Likewise the midwives who are caring for the mother on the ward, as they are bringing down breastmilk, we will give them an update so that they can relay it back to mum. Obviously in each scenario it is different as to whether they can, but on day one they are up in the wheelchair and they come down to the nursery, and then we group their care.

Babies are only touched for a certain amount of time to allow for growth and settling and things, so everything is planned around when their care and feeds are due. We encourage mothers to come down 15 to 20 minutes before that time so that they can do nappies, temperature checks and things like that. They have kangaroo care; that is encouraged each day, if not a couple of times a day. The lactation consultants also visit throughout special care nursery, not just women's ward, and have those clinics on the ward. They also visit the nursery during a certain time — it is a different time per day — to help promote breastfeeding as well and deal with any issues that cannot be dealt with by the neonatal nurses who are looking after that baby.

It is always encouraged for parents to be involved in their baby's care. Obviously the parent zone rooms have made our lives considerably easier in that family-centred care — that wonderful initiative was instigated in the build of the new hospital — and we certainly see that mothers gain more confidence in looking after their babies and their babies do get home quicker. The mothers are much more comfortable in looking after such a small baby because they have had lots to do with them throughout their length of stay in the nursery.

**The DEPUTY CHAIR** — Thank you, Suzanne. Unfortunately we are out of time, but I would like to thank you again for coming here today. We greatly appreciate your input.

**Ms HARTNEY** — Thank you very much for having me.

**Witness withdrew.**