Draft claims in detail

The table shows the proposed minimum nursing hours per patient day to be claimed for different ward types. The equivalent ratio is also shown.

Only nurses providing direct clinical care are included in the ratios/nursing hours. This does not include positions such as NUMs, NMs, CNEs, CNCs, dedicated administrative support staff and wardspersons.

Specialty / Ward Type	Equivalent Ratios AM	PM	Night	Nursing Hours
General Adult Inpatient Wards				
Peer Group B (Major Metropolitan and Major Non-Metropolitan Hospitals)[1]	1:4	1:4	1:7	6 (includes some shifts staffed with an in charge)
Peer Group C (District Group Hospitals)[1]	1:4	1:4	1:7	
Peer Group D (Community Acute and Community non-acute Hospitals)[1]	1:4	1:4	1:7	
Peer Group F3 (Multi-Purpose Services – Acute Beds)[1]	1:4	1:4	1:7	
Peer Group F3 (Multi-Purpose Services – Aged Care Beds (DoHA funded))[2]	1:6	1:6	1:7	4.1
Inpatient Mental Health[3]				
Adult – in specialised Mental Health Facilities[4]	1:4	1:4	1:7	6 (includes some shifts staffed with an in charge)
Acute Mental Health Rehabilitation[4]	1:4	1:4	1:7	
Child and Adolescent[5]	1:2 + in charge	1:2 + in charge	1:4	10.5 + additional hours for in charge
Long Term Mental Health Rehabilitation[5]	1:6 + in charge	1:6 + in charge	1:10	3.67 + additional hours for in charge
Older Mental Health[5]	1:3 + in charge	1:3 + in charge	1:5	7.33 + additional hours for in charge
Emergency Department (adult and paediatric)[6]				
Resuscitation Beds	1:1	1:1	1:1	26
Level 4-6 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + 2 triage	1:3 + in charge + triage	8.67 + additional hours for in charge and triage
Level 3 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + triage	1:3 + in charge	
Level 2 Emergency Departments	1:3	1:3	1:3	8.67
EMUs	1:3 + in charge	1:3 + in charge	1:4 + in charge	7.83 + additional hours for in charge
MAUs	1:4 + in charge	1:4 + in charge	1:4 + in charge	6.5 + additional hours for in charge
Paediatrics[7]				
General Inpatient Wards	1:3 + in charge	1:3 + in charge	1:3 + in charge	8.67 + additional hours for in charge

Specialty / Ward Type	Equivalent Ratios AM	PM	Night	Nursing Hours
Neonatal intensive care units[8]				
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge	26 + additional hours for in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge	13 + additional hours for in charge
Special Care Nurseries[9]	1:3 + in charge	1:3 + in charge	1:3 + in charge	8.67 + additional hours for in charge

Critical Care (adult and paediatric)[10]				
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge	26 + additional hours for in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge	13 + additional hours for in charge
CCU	1:3 + in charge	1:3 + in charge	1:3 + in charge	8.67 + additional hours for in charge

Community Health and Community Mental Health services, except for Acute Assessment Teams	Limit of 4 hours of face to face client contact per 8 hour shift, averaged over a week.[11]

Community Mental Health Services (Acute Assessment Teams)	Limit of 3.5 hours of face to face client contact per 8 hour shift, averaged over a week.[11]

Notes:
Where the nursing hours/ratio in any particular unit is greater than the specified nursing hours/ratio as at the commencement date of the 2013 Award, it shall not be reduced.

In the table above, "in charge" means a nurse who does not have an allocated patient workload.

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[1] **General Adult Inpatient Wards:** This minimum staffing claim applies to all Medical, Surgical and combined Medical/Surgical wards in Peer Group B (Major Metropolitan and Major Non – Metropolitan Hospitals), Peer Group C (District Group Hospitals), Peer Group D (Community Acute and Community Non – Acute) and Peer Group F3 (Multi Purpose Service – acute beds). The staffing ratio expressed as nursing hours provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload. This claim is the same as currently legally mandated ratios/nursing hours for Peer Group A city hospitals.

[2] **General Adult Inpatient Wards:** This minimum staffing claim will apply only to the DOHA-funded beds of Peer Group F3 Multi Purpose Services.

[3] **Inpatient Mental Health:** This claim does not apply to adult acute mental health wards in general hospitals that are not 'specialised' mental health facilities, because these wards already have legally mandated nursing hours/ratios under the 2011 Award. This claim does not apply to forensic or PECC units.

[4] **Acute Adult Mental Health – Specialised Facilities and Acute Mental Health Rehabilitation:** This minimum staffing claim provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload.

[5] **Child and Adolescent, Long Term Mental Health Rehabilitation and Older Mental Health:** In addition to this minimum staffing claim, additional hours must be provided for in charge of shift across two shifts.

[6] **Emergency Department (adult and paediatric):** This minimum staffing claim applies to adult and paediatric Emergency Departments according to their NSW Health designated level. This claim applies to beds, treatment spaces, rooms and any chairs where these spaces are regularly used to deliver care. The claim includes Emergency Departments, Emergency Medical Units, and Medical Assessment Units (whether co-located with an ED or not) and other such services however named. Additional hours must also be provided for in charge of shift and triage nurses across all shifts, where specified in the table above. The minimum nursing hours/ratios will not include Clinical Initiative Nurses or any other nurse however named whose role has been introduced for a specific purpose.

[7] **Paediatrics:** This minimum staffing claim applies to all paediatric general inpatient wards including medical, surgical and combined medical surgical wards and units across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts as specified in the table above. Further additional hours must be provided for nurse escorts and work that in general adult hospitals would be described as 'ambulatory care'.

[8] **NICU:** This minimum staffing claim applies across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts as specified in the table above. Further additional hours must be provided for work that may be described as discharge nurse, neonatal family support and transport nurse (including retrieval).

[9] **Special Care Nurseries:** This minimum staffing claim applies across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts as specified in the table above. Further additional hours must be provided for work that may be described as discharge nurse, neonatal family support and transport nurse (including retrieval). The Special Care Nurseries claim does not apply to the following named special care nurseries that perform CPAP, where the HDU claim will apply instead: Blacktown, Campbelltown, Gosford, Lismore, St. George, Tweed Heads, Wollongong, Coffs Harbour, Dubbo and Wagga Wagga.

[10] **Critical Care, including Adult and Paediatrics:** This minimum staffing claim applies to Critical Care units, including Intensive Care Units, High Dependency Units and Coronary Care Units across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts. Further additional staffing (eg. access nurse) may be clinically required and if so, should be provided.

[11] **Community Health and Community Mental Health:** Work that is not included in 'face to face hours' includes travel, meal breaks and administration (eg. phone calls to other health professionals or suppliers, paperwork), otherwise known as 'indirect care'. 'Face to face hours' may also be known as 'direct care'.

Draft claims in detail (continued)

More CN/MEs needed

275 more CNEs and CMEs – working across seven days and all shifts – need to be employed.

Once the 2010 ratios system is completely implemented, there will be a definite improvement in skill mix, as the new graduates recruited in 2012 and 2013 consolidate their practice.

But achieving this will take more support than is currently promised to genuinely take some pressure off our most experienced RN/RMs. The Government can and must do more to help by funding more CNEs, and not just on day shift.

This is the practical way to thoroughly and safely assist new practitioners to consolidate their practice.

Protecting skill mix

The skill mix of the nursing workforce must be protected.

Short-sighted attempts to cut budgets by employing lesser skilled staff mean higher rates of hospital-acquired infections, adverse events and failure to rescue. Evidence-based academic research is proving this time and time again.

NSWNMA members consistently raise concerns about the inadequate support provided for beginning practitioners and the risks to patients caused when RN absences are not replaced "like for like".

Unless the Transitional Registered Nurses being employed now get proper support to stay in the system, the gradual improvements in skill mix that you have won with the new ratios system will be eroded.

So, in this claim it is recommended that NSWNMA concentrate on a claim to increase CNEs and CMEs. In the medium term this will assist retention of experienced nurses and midwives in the public system.

AINs shall be introduced only in accordance with the 2010 *Health Service Implementation Package for AINs in Acute Care*. If this plan is followed correctly then appropriate engagement of AINs will occur.

Patient 'specials'

Patients clinically assessed as requiring specialling shall have that specialling care provided in addition to the minimum mandated nursing hours for the ward/unit that that patient would ordinarily receive.

Specialling within rostered nursing hours takes time away from other patients. Patient safety must not be compromised by squeezing the budget to provide 'specials'.

Fair pay rise

The NSWNMA will seek a 2.5% pay increase per year for the life of the agreement. This will be in line with inflation forecasts by the Reserve Bank.

Members are telling us that a 2.5% pay increase without any 'trade offs' would be acceptable if it is accompanied by a legally enforceable Award containing the necessary extensions and improvements in ratios.