It's a matter of LIFE or DEATH

NSWNMA claim for 2018 Award
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2018 Claims for Improved Staffing

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Fair Pay Rise

Additional Improved Staffing

The day -to- day Operation of Staffing Ratios

Changes to Existing Award Provisions
Nurses and midwives are dedicated to providing safe care for all patients. They know what levels of staffing are necessary to provide safe and efficient healthcare in 2018. International research and local experience in New South Wales, Victoria and Queensland shows a direct correlation between staffing levels and improved patient outcomes. It confirms an increase in nursing numbers and skill mix delivers better patient outcomes and limits adverse events.

Nurses and midwives have a professional responsibility to advocate for staffing improvements on behalf of patients and, call on the Berejiklian Government to urgently put patient safety first by improving and expanding mandated nurse to patient ratios on every shift, in every NSW public hospital.

With the strongest fiscal position in the country and a robust economic outlook, the Berejiklian Government can deliver more transparent, legally enforceable ratios throughout the Public Health System. It is unacceptable that we continue to lag behind Victoria and Queensland, after both governments introduced nurse to patient ratio legislation in 2016.

Unless the Berejiklian Government commits to deliver better ratios for NSW in 2018, the state’s frontline nursing and midwifery workforce will buckle under burn-out and rising attrition rates, due largely to poor skill mix and excessive workloads. Clause 53 of the current Award explicitly states ‘The employer has a responsibility to provide reasonable workloads for nurses’, yet this staffing arrangement has been flagrantly ignored.

The Government can no longer disregard its duty of care to staff or patients and must complete the work of 2011, when phase 1 of ratios were first introduced. Official hospital data confirms the Government’s preferred ‘Nursing Hours Per Patient Day’ staffing model is flawed. It is being deliberately manipulated and undermined, prompting the need for a simpler, more transparent and accountable ratios system.

In addition to improving and expanding ratios for every shift on every day with the right skill mix:

- nurses and midwives are seeking staffing for ‘Specials’ to be separate and in addition to the mandated ratios or rostered staffing;
- ‘in charge of shift’ nurses not to be allocated a patient load and be in addition to the minimum ratios;
- where AINs and AIMs are rostered to work in an identified unit or ward, they will not be allocated a patient load and will be in addition to the ratios claim;
- new ACORN standards apply;
- an improved maternity services claim.

The NSW Nurses and Midwives’ Association 2018 Claim seeks to improve staffing levels across non-tertiary hospitals to become the same as tertiary referral city hospitals, ensuring all patients receive the same standard of nursing care, regardless of where they live.

Further details of our 2018 Ratios and Pay Claim follow:
2018 Claims for Improved Staffing

Ratios required for safe patient care will be applied on a shift by shift basis and will be based on the number of patients in each ward, unit or service. The relevant minimum ratios claim will apply to the patients who have been clinically assessed to require nursing care in that specialty, whether they are receiving nursing care in a bed, treatment space, room or chair or any other space regularly used to deliver care.

Only nurses providing direct clinical care are included in the minimum ratios. Other staff positions such as NUMs, NMs, CNEs, CNCs, dedicated administrative support staff and wardspersons are additional to the requirements of the minimum ratios.

In addition, nurses who are allocated “in charge” of shift (however named) will not be allocated a patient load and will be rostered in addition to the ratio claims below.

Nursing staff used to provide patients clinically assessed as needing specialised care will be rostered in addition to the ratio claims below.

Where Assistants in Nursing or Assistants in Midwifery are rostered to work in an identified unit or ward they will not be allocated a patient load and will be rostered in addition to the ratio claims below.

All wards, units and services will be staffed with nurses who have the relevant skills and knowledge for that speciality.

Except in specific circumstances wards or units will generally be staffed with a minimum of 85% Registered Nurses with the relevant skills and knowledge for that speciality.

Where the proportion of Registered Nurses on each shift in any ward as at the date of a new Award is higher than the new Award provision, that proportion shall not be reduced.

Where the existing ratio or skill mix provided in any particular ward or unit is better than the provisions of a 2018 Award, the existing ratio or skill mix shall not be reduced.
GENERAL ADULT INPATIENT WARDS

This minimum claim applies to all general adult inpatient wards in NSW Hospitals across the state to ensure patients receive the same level of safe nursing care, regardless of where they live or are treated.

Wards will be staffed with nurses who have the relevant skills and knowledge for that specialty.

Ratios required for safe patient care will be applied on a shift by shift basis and will be based on the number of patients being treated in each ward or unit. The ratios claim applies to patients who occupy beds in mixed function wards as well as wards used totally as medical or surgical.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Except in specific circumstances wards or units will generally be staffed with a minimum of 85% Registered Nurses with the relevant skills and knowledge for that specialty.

<table>
<thead>
<tr>
<th>SPECIALTY / WARD TYPE</th>
<th>AM</th>
<th>RATIOS</th>
<th>NIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical wards</td>
<td>1:4 + in charge</td>
<td>1:4+ in charge</td>
<td>1:7</td>
</tr>
</tbody>
</table>

CRITICAL CARE (Adult, Paediatric and Mental Health)

This minimum claim applies to Critical Care units, including Intensive Care Units, High Dependency Units and Coronary Care Units.

Wards will be staffed with nurses who have the relevant critical care skills and knowledge for critical care.

Additional nursing staff (e.g. access nurse) may be clinically required and if so, should be provided. Nurses who are part of a response team (however named) will be provided in addition to the minimum ratios. The Ratios will apply to patients who are clinically assessed as requiring critical nursing care even if they are not situated in a designated ICU or HDU (however named).

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

<table>
<thead>
<tr>
<th>SPECIALTY / WARD TYPE</th>
<th>AM</th>
<th>RATIOS</th>
<th>NIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU / PICU / MHICU (however named)</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
</tr>
<tr>
<td>HDU / Close Observations (however named)</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
</tr>
<tr>
<td>CCU</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
</tr>
</tbody>
</table>
EMERGENCY DEPARTMENT (Adult, Paediatric and Mental Health Assessment Centres*)

This minimum claim applies to adult and paediatric emergency departments according to their NSW Health designated emergency department level. This claim applies to beds, treatment spaces, rooms and any chairs or spaces 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.

The skill mix for each Emergency Department will include a minimum of 90% Registered Nurses who have the relevant skills and knowledge for this specialty and will be provided on every shift.

Where the proportion of Registered Nurses for each Emergency Department as at the date of this Award is higher than 90%, that proportion shall not be reduced.

Additional hours above the minimum ratio must also be provided to roster in charge of shift and triage nurses, on all shifts without an allocated patient load.

Minimum ratios will not include Clinical Initiative Nurses or any other nurse however named whose role has been introduced for a specific purpose. These roles are considered to be in addition to the ratios below.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

<table>
<thead>
<tr>
<th>SPECIALTY / WARD TYPE</th>
<th>AM</th>
<th>PM</th>
<th>NIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation Beds</td>
<td>1:1</td>
<td>1:1</td>
<td>1:1</td>
</tr>
<tr>
<td>Level 4-6 Emergency Departments</td>
<td>1:3 + in charge + triage</td>
<td>1:3 + in charge + 2 triage</td>
<td>1:3 + in charge + triage</td>
</tr>
<tr>
<td>Level 3 Emergency Departments</td>
<td>1:3 + in charge + triage</td>
<td>1:3 + in charge + triage</td>
<td>1:3 + in charge + triage</td>
</tr>
<tr>
<td>Level 2 Emergency Departments</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
</tr>
<tr>
<td>Level 1 Emergency Departments</td>
<td>No separate dedicated RNs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMUs</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
<td>1:4 + in charge</td>
</tr>
<tr>
<td>MAUs</td>
<td>1:4 + in charge</td>
<td>1:4 + in charge</td>
<td>1:4 + in charge</td>
</tr>
</tbody>
</table>

*Mental Health Triage and Assessment Centres (however named) will be staffed in accordance with the above ratios for Levels 4–6 Emergency Departments.
INPATIENT MENTAL HEALTH

This minimum claim applies to all inpatient mental health wards/units, ‘outlying’ inpatient mental health beds and for the care of inpatient mental health patients who are occupying non designated inpatient mental health beds.

Additional nurses will be provided when seclusions are used or when a patient requires level 1 and 2 Observations. Additional nurses will also be required in the following circumstances: diversional therapy and nurses working in ECT or group therapy nurses, nurse escorts, and nurses who are part of a response team (however named).

The skill mix for inpatient mental health will include a minimum of 85% Registered Nurses who have the relevant mental health skills and knowledge levels in mental health will be provided on every shift.

Additional Registered Nurses will be provided for peak times (e.g. admissions, discharges answering phones).

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

The minimum ratio claim for Adult Inpatient Mental Health will apply to acute and subacute units.

In the event that an adolescent is placed in an adult ward, an additional RN will be allocated to provide 1:1 care.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

<table>
<thead>
<tr>
<th>SPECIALTY / WARD TYPE</th>
<th>AM</th>
<th>PM</th>
<th>NIGHT</th>
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<tbody>
<tr>
<td>Adult Inpatient Mental Health – acute and subacute</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
<td>1:5</td>
</tr>
<tr>
<td>Child and Adolescent</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
<td>1:4</td>
</tr>
<tr>
<td>Acute Mental Health Rehabilitation</td>
<td>1:4 + in charge</td>
<td>1:4 + in charge</td>
<td>1:5</td>
</tr>
<tr>
<td>Long Term Mental Health Rehabilitation</td>
<td>1:6 + in charge</td>
<td>1:6 + in charge</td>
<td>1:10</td>
</tr>
<tr>
<td>Older Mental Health</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
<td>1:5</td>
</tr>
<tr>
<td>MHICU/PICU (however named) or patients assessed requiring this care*</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
</tr>
<tr>
<td>HDU/Close Observations (however named) or patients assessed requiring this care*</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
</tr>
</tbody>
</table>

In addition mental health nurses will be provided clinical supervision in accordance with the Australian College of Mental Health guidelines, Standards of Practice for Mental Health Nurses, as follows:

Clinical Supervision will be provided to all mental health nurses:
- 2 hours face to face paid clinical supervision leave per fortnight; and
- Paid face to face training in specialised mental health including de-escalation and responding to mental health emergencies.

* Refer to Critical Care claim for complete details.
PAEDIATRICS

This minimum claim applies to all paediatric general inpatient wards including medical, surgical and combined medical surgical wards.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Additional hours above the minimum ratio must be provided for nurse escorts and work that in general adult hospitals would be described as ‘ambulatory care’.

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<thead>
<tr>
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<th>AM</th>
<th>RATIOS</th>
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</thead>
<tbody>
<tr>
<td>Paediatrics General Inpatient Wards</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
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</tbody>
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NEONATAL INTENSIVE CARE UNITS (NICU)

The minimum ratios claim applies to ICU, HDU and Special Care Nurseries in Neonatal Intensive Care Units.

A minimum of 85% Registered Nurses who have the relevant critical care health skills and knowledge levels will be provided on every shift.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

In addition, 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 special care nurseries that perform CPAP, where the HDU claim will apply instead.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

<table>
<thead>
<tr>
<th>SPECIALTY / WARD TYPE</th>
<th>AM</th>
<th>RATIOS</th>
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<tbody>
<tr>
<td>ICU</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
<td>1:1 + in charge</td>
</tr>
<tr>
<td>HDU</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
<td>1:2 + in charge</td>
</tr>
<tr>
<td>Special Care Nurseries (without CPAP services)</td>
<td>1:3 + in charge</td>
<td>1:3 + in charge</td>
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PERIOPERATIVE SERVICES

Australian College of Operating Room Nurses Standards for Perioperative Nursing in Australia 14th edition (known as ACORN standards) as amended from time to time will apply to all Perioperative Services in NSW Hospitals.
**REHABILITATION**

This minimum claim applies to dedicated hospitals and rehabilitation wards or units.

A minimum of 85% Registered Nurses who have the relevant skills and knowledge will be provided on every shift. The skill mix for general rehabilitation wards or units will be at least two (headcount) Registered Nurses on every shift. There will be no more than one (headcount) Enrolled Nurse with the relevant skills and knowledge for this specialty and maximum of one (headcount) AIN with the relevant skills and experience in a general rehabilitation wards/units.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

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<tr>
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<th>AM</th>
<th>RATIOS</th>
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<th>NIGHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>1:4 + in charge</td>
<td>1:4 + in charge</td>
<td>1:7</td>
<td></td>
</tr>
</tbody>
</table>

**COMMUNITY HEALTH AND COMMUNITY MENTAL HEALTH SERVICES**

The nature of Community Health and Community Mental Health services does not lend itself to a ratios system.

Instead, the application of a limit of face to face client contact hours in any shift will be a starting point to put patients first.

Community Health and Community Mental Health services require a limit of 4 hours of face to face client contact per 8 hour shift, averaged over a week to be applied in order to provide safe patient care.

The nature of the work of Community Mental Health Services Acute Assessment Teams requires them to have a limit of 3.5 hours of face to face client contact per 8 hour shift, averaged over a week to provide such care.

Work that is not included in this ‘face to face hours’ claim 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’.

In addition, Community Mental Health nurses will be provided Clinical Supervision which includes:

- 2 hours face to face paid clinical supervision leave per fortnight; and
- Paid face to face training in specialised mental health including de-escalation and responding to mental health emergencies.
SHORT STAY WARDS

The following minimum claim applies:

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<tbody>
<tr>
<td>High Volume Short Stay</td>
<td>1:4</td>
<td>1:4</td>
<td>1:7</td>
</tr>
<tr>
<td>Day Only Units</td>
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3.5 hours of face to face patient care. This includes nursing staff time spent doing preparations, transfer and post-operative care prior to discharge.

DRUG AND ALCOHOL UNITS

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<th>PM</th>
<th>NIGHT</th>
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</thead>
<tbody>
<tr>
<td>Drug and Alcohol Inpatients (discrete standalone units)</td>
<td>1:4</td>
<td>1:4</td>
<td>1:7</td>
</tr>
<tr>
<td>Drug and Alcohol Outpatients</td>
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</tbody>
</table>

Each initial assessment: 90 minutes. Subsequent visits: 30 minutes (this includes case management). Dosing visits: 5 minutes.

PALLIATIVE CARE (wards and outlying beds)

This minimum claim for Palliative Care will apply to Palliative Care wards, ‘outlying’ palliative care beds, and for the care of palliative patients who are occupying non palliative care beds.

A minimum of 85% Registered Nurses who have the relevant skills and knowledge will be provided on every shift.

Where there is a patient occupying an ‘outlying’ bed a Registered Nurse with the relevant skills and knowledge will be allocated to their care.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

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<th>PM</th>
<th>NIGHT</th>
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</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>1:4 + in charge</td>
<td>1:4 + in charge</td>
<td>1:7</td>
</tr>
</tbody>
</table>
MATERNITY SERVICES

The Award will be varied to include the additional principles for Birthrate Plus® sites and for maternity services where Birthrate Plus® does not operate.

- The staffing numbers required as a result of applying the agreed Birthrate Plus® methodology will be considered a minimum and apply only to midwifery hours. The existing provisions in Clause 53 Staffing Arrangements will apply to all maternity services.

- Additional midwives will be provided when patient care cannot be sufficiently met from the midwives available.

- Maternity Services must undergo a Birthrate Plus® reassessment:
  - A minimum of every 3 years to monitor workloads and to recommend any necessary adjustments;
  - If major changes occur or are necessary to the model of care, service delivery or community practices;
  - At the request of employees, the employer or the NSWNMA, where there are major changes to the Unit Statistics e.g. caesarean, epidural, induction rate.

- Patients identified as outliers in a maternity service will require additional nursing staff to provide safe patient care, staff within the maternity service will not be used.

POSTNATAL WARD OR UNIT SKILL MIX

ACROSS ALL MATERNITY SERVICES

- Experienced midwives will be on duty at all times.

- Newborns will be counted in patient numbers when determining reasonable workloads in postnatal wards.

- Further, additional midwives will be provided for peak times involving admissions and discharges.

- In charge of shift will not be allocated a patient load.

- Where Assistants in Midwifery are rostered to work they will not be allocated a patient load and will be in addition to the midwives rostered.

- Assistants in Nursing are not permitted as part of the profile (either as permanent, casuals or agency).
STAFFING MODEL: MATERNITY SERVICES WHERE BIRTHRATE PLUS® DOES NOT OPERATE.

This minimum staffing claim applies to all Maternity Services that do not use Birthrate Plus®. Generally, these units have under 200 births per year.

Intrapartum workload:
1:1 midwifery care in labour and birth.
1:1 ratio is a minimum and would increase to reflect the additional needs of higher risk categories of women.

Antenatal Care:
1.5 hours per booking-in visit.

Antenatal Care – Inpatients:
Minimum of 3 hours per case – need to assess the workload including non-admitted Occasions of Service. The hours would increase as risk factors increase.

Postnatal Care – Inpatients:
A minimum of 6 hours per case. This would increase to reflect the additional needs of higher risk categories of women.

Travel Allowance – Community Midwifery:
As with Birthrate Plus, a travel allowance (time factor) of 17.5% is added to the time allocated for each woman. This will be increased to 20% in some facilities to reflect local distances travelled.

Leave Relief, Mandatory and Essential Education for Midwives:
Leave relief of additional 18.7% FTE is factored in when determining appropriate staffing.

Unplanned Antenatal workload in Intrapartum Services:
The Birthrate Plus score sheet is used to attach hours to the additional work.

Additional workload within Intrapartum services:
Additional hours are allocated to women with a 16 to 20 week gestation pregnancy loss and also for women with a pregnancy loss less than 15 weeks where cared for in the Birthing or antenatal/maternity unit.

Allocated midwife hours – elective caesarean section:
A minimum 4 hours per elective caesarean section.

Antenatal Care – Outpatients clinics:
Hours are determined by the type of treatment required.

Parental Education:
The Birthrate Plus score sheet is used to attach hours to the additional work.

Midwifery Models of Care:
Hours are allocated for total continuity of care i.e. all antenatal, intrapartum and postnatal care provided in the woman’s home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases.

Normal risk = 41 hours per case.

Note: No high risk births in the total continuity of care model. This is because women who have or develop risk will not be cared for within this type of model. This is due to the need for obstetric and/or medical and inpatient care.

Midwifery Models of Care:
Hours allocated for partial continuity of care i.e. all antenatal, intrapartum care with only postnatal care in the home. Care may occur in a woman’s home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases.

Hospital postnatal care can be provided by hospital midwives (see above for hours).

Normal risk = 36 hours per case.

High risk = 40 hours per case.

Postnatal care in the Home:
A minimum of 3 hours per case and would increase to reflect the additional needs of higher risk categories of women.

In addition, a travel allowance appropriate to the maternity service (see above) is added to the mean hours.
OUTPATIENTS CLINICS IN THE HOSPITAL SETTING

This minimum staffing claim applies across all Peer Groups.

ALL NEW REFERRALS
Initial assessments 90 minutes.

FOLLOW UP CLINICS

Minor consultation and clinical review clinics:
15 minutes: 4 patients per hour.

Medium consultation clinics:
30 minutes: 2 patients per hour.

Complex treatment clinics within a multidisciplinary team:
60 minutes: 1 patient per hour.
Certain Clinics may require 2 nurses for particular procedures (e.g. Vac dressings)

Hospital in home ambulatory clinic:
3.5 hours of face to face patient care.

In addition:
- Appropriate hours for case management should be included in the funded FTE to maintain a safe and holistic level of care for patients. This principle is inherent in the needs for patients in the community.
- Appropriate time for travel in the context of the local geography and traffic conditions must be factored into hours required for clinical workload.

Oncology and Dialysis:
1:1 plus in charge for complex patients.
1:3 plus in charge for non-complex patients.

Infusion/Treatment Centres:
1:1 plus in charge for complex patients.
1:3 plus in charge for non-complex patients.

EXPLANATORY NOTES

Outpatient Clinic Type

Minor Consultation: Anti-coagulant screening, orthopaedic review, phone triage, screening tests, screening results, minor wound dressing, BCG vaccination.

Medium Consultation: Excision of minor lesions, rheumatology, cardiology respiratory function, immunology, co-morbidities /drug resistant/CALD clients, non-compliant, counselling/education, wound assessment and dressing, psycho-geriatric review.

Complex Clinics: Administration of infusions of less than 1 hour, complex wound assessment and treatment/dressing, complex burns dressing, biopsies, lumbar puncture; multiple co-morbidities and complex management.

Oncology – Complexity Criteria

<table>
<thead>
<tr>
<th>Weight/ Score</th>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td>2</td>
<td>2 or more anti-neoplastic drugs</td>
</tr>
<tr>
<td>2</td>
<td>Vesicant drugs (requires continual observation of infusion site during drug administration)</td>
</tr>
<tr>
<td>2</td>
<td>Potential for hypersensitivity reaction</td>
</tr>
<tr>
<td>2</td>
<td>Multiple vital sign measurement during infusion/transfusion</td>
</tr>
<tr>
<td>2</td>
<td>ECG recording prior to or during/infusion</td>
</tr>
<tr>
<td>1</td>
<td>Pre-treatment checking of blood results</td>
</tr>
<tr>
<td>1</td>
<td>Pre-treatment assessment of toxicities from previous cycles/days of anti-neoplastic drug administration in the current course</td>
</tr>
<tr>
<td>1</td>
<td>Baseline vital signs prior to administration of anti-neoplastic drug therapy or infusion or procedure</td>
</tr>
<tr>
<td>1</td>
<td>Observation period/measuring of vital signs post completion of anti-neoplastic drug therapy or infusion or procedure</td>
</tr>
<tr>
<td>1</td>
<td>Other assessments prior to treatment, e.g. urinalysis, weight</td>
</tr>
</tbody>
</table>

Total Score (if >5, categorised as a ‘complex patient’) Criteria: For any treatment with a score of 5 or more, the treatment is complex. This would have the advantage of enabling a ‘complexity rating’ of new therapies.

Infusion / Treatment Clinics

1:1 Phototherapy and Dermal clinics. Toxicity of treatment, Portacath access, Blood Transfusions, Biological agent injections, Iron infusions etc
1:3 All other infusion types.
NSWNMA members claim a 4% increase to pay and wage-related allowances per year, commencing from the first full pay period on or after 1 July, 2018.

Year on year, significant increases in productivity have occurred on the part of frontline nurses and midwives throughout the public health system.

Evidence of this increased productivity is contained within available Bureau of Health Information data, such as rising emergency department presentations and broader hospital throughput.

Section 3 of the existing Wages Policy states:

3.1.3. Public sector employees may be awarded increases in remuneration or other conditions of employment that do not increase costs by more than 2.5 per cent per annum.

3.1.4. Increases in remuneration or other conditions of employment that increases employee related costs by more than 2.5 per cent per annum can be awarded, but only if sufficient employee related cost savings have been achieved to fully offset the increased employee related costs...

The current NSW Treasurer and Minister for Industrial Relations is also on the public record stating:

“...our policy isn’t just a blunt cap of 2.5 per cent - it allows higher wage rises if they are offset by productivity savings.”

(Daily Telegraph, 19 March 2018)

New South Wales enjoys a strong financial position, with a budget surplus of $5.6 billion and economic growth the strongest in Australia.

It is therefore imperative frontline public sector nurses and midwives are recognised for their increased productivity and are remunerated accordingly.
Additional Improved Staffing

**STAFFING FOR SPECIALS**

Additional Nurses/Midwives will be allocated to patients who have been clinically assessed as needing specialised care in addition to mandated Ratios/rostered nursing hours for all wards or units.

**CLINICAL NURSE / MIDWIFERY EDUCATORS**

An increased number of new graduates continues to be employed. To ensure new practitioners consolidate their practice, additional CNEs/CMEs need to be employed.

Achieving better skill mix will take more support than is currently provided, to meaningfully relieve pressure for the most experienced RN/RMs.

The government can and must fund more CNEs/CMEs and not just on day shifts. This is a practical way to thoroughly and safely assist new practitioners to consolidate their practice.

In addition to the minimum ratios claims, there shall be 1.4 Full Time Equivalent Clinical Nurse Educators/ Clinical Midwife Educators employed for every 30 nursing staff, and a proportion thereof where there are less than 30 such staff in a unit/service. CNEs/CMEs should be rostered across all shifts, seven days a week.
The day-to-day Operation of Staffing Ratios

APPLYING THE STAFFING RATIO TO ACTUAL PATIENT NUMBERS

The methodology used to apply the nurse:patient ratio shall be consistent with the principle of ensuring that the number of nurses available to work is commensurate with the number of patients requiring care.

Average occupancy may not reflect variations in patient numbers and therefore may not match the staff to periods of peak demand.

Consequently, the nurse:patient ratio will be calculated on actual patient numbers in a given ward/unit or service. If a ward/unit has 30 beds and only 26 beds are generally occupied, the four “unused” beds may only be used when additional staff are available to meet the ratio requirements.

While the nurse:patient ratio will apply to the number of beds that are generally occupied, any occupancy of additional beds is subject to:

1. Additional beds being available; and
2. Nurses being rostered to the level required to meet the nurse:patient ratio for the duration of the occupancy of additional beds.

Where demand requires fewer beds, staffing may be adjusted down or redeployed prior to the commencement of shifts subject to compliance with relevant Award provisions or an individual’s employment contract.

APPLYING THE STAFFING RATIO WHERE THERE ARE UNEVEN BED NUMBERS

Where the actual number of occupied beds in a unit (or the equivalent for example in EDs) is not evenly divisible by the maximum number of patients in the applicable ratio, an additional staff member will be used in proportion with the ratio.

For example, a 28 bed ward with a ratio of 1:4 would require a staffing level of 7 FTE positions. A 30 bed ward using the same ratio would require 7.5 FTE positions (i.e. with a 1:4 ratio, every additional patient would increase staffing by 0.25 FTE nurses).

The outcome will be subject to compliance with relevant Award provisions, in particular Clause 53(iii) Principles.
Changes to Existing Award Provisions

The following existing arrangements require improvement to contribute to a workplace environment conducive to safe patient care:

- Vary Clause 4(xvi) (a), Hours of Work and Free Time of Employees Other Than Directors of Nursing and Area Managers, Nurse Education to provide that days off must be consecutive, except by agreement.

- Vary Clause 8, Rosters, to require local hospital management to display rosters at least four weeks prior to the first working day of the roster and specify that rosters must be built to:
  - ensure compliance with Clause 53 Staffing Arrangements;
  - ensure training is in paid time;
  - include paid handover; and
  - include an appropriate skill mix and ensure early career nurses or novice practitioners are not the most senior nurse on shift or allocated in charge.

- Vary Clause 11 Leave for Matters arising from Family Violence to increase special leave from 5 to 20 days and include the provisions from the model clause.

- Vary Clause 34 Maternity, Adoption and Parental Leave to provide for the payment of superannuation during paid parental leave.

- Vary Clause 34 Part C Parental leave (iii) Entitlements to increase leave from one week to two weeks in line with the recommendation of the Productivity Commission’s Report into Paid Parental Leave.

- Vary subclause (ii) Principles in Clause 53 Staffing Arrangements to include the following new principle:
  - a staffing review in consultation with the NSWNMA will be conducted when a ward/unit/service is created, reconfigured or has changes proposed to the model of care. No changes will occur without agreement by the NSWNMA.

- NSWNMA and NaMO will work cooperatively over the term of the next Award to review the appropriate remuneration for NUMs/MUMs.

- Enrolled nurses who meet the criteria will be classified as Special Grade by personal grading, instead of by employer appointment.