Ratios

It's a matter of LIFE or DEATH

RATIOS, PAY & CONDITIONS AWARD CLAIM 2021

NSW NURSES & MIDWIVES' ASSOCIATION

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Ratios for NSW

Nurses and midwives remain dedicated to providing safe, quality health care for all patients in New South Wales and deserve to be valued and supported at work.

Since the global COVID-19 pandemic unfolded, nurses and midwives have been crucial in keeping our communities safe across the state, putting patients' health before their own wellbeing and their families.

Unsurprisingly, nurses and midwives have risen to the many challenges the pandemic has presented. They have adapted to rapidly changing environments and repeatedly shown their remarkable professionalism when working under pressure.

Widespread feedback from nurses and midwives is not to receive platitudes for their courage, but to achieve recognition in the form of better pay and safe workplaces.

In NSW, nurses and midwives need a transparent shift-by-shift ratios system, with an appropriate skill mix and staffing levels based on the number of patients in each ward, unit or service. They have told us understaffing in public hospitals remains widespread; vacancies are left unfilled for extended periods; work health and safety concerns are ongoing; workloads are growing yet the support or clinical guidance is not there when needed; and many suffer from workplace fatigue simply because there are not enough nurses or midwives to patients.

Highly respected, peer-reviewed international research, along with experiences in Victoria and Queensland, show a direct correlation between safe staffing levels and improved patient outcomes. The evidence indicates an increase in the number of adequately skilled nurses, shift-by-shift, delivers better health outcomes for patients and limits adverse events.

MEMBERS TOLD US:

"Increasingly we are being asked to do more and more with less and less. Staffing is being cut but our duties are increasing."

In addition to introducing staffing ratios for every shift with the right skill mix, nurses and midwives are seeking:

- staffing for 'specials' to be separate and in excess of mandated ratios or rostered staffing
- 'in charge' of shift nurses not to be allocated a patient load and to 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
- latest ACORN standards to apply across perioperative services
- latest Critical Care Standards to apply to intensive and critical care units
- improved claim for maternity services
- update Clause 53 in the Award to reflect the roll out of 6.0 NHPPD arising from the government's 2019 commitment to 5,000 additional nurses and midwives over 4 years
- confirm non-maternity patient care is excluded from Birthrate Plus® staffing
- for Peer Group D and F3 MPS facilities – a minimum of three nurses or midwives rostered for every shift, two of which must be registered nurses. Wherever an ED is open 24/7, regardless of delineation or classification, that facility requires a minimum of three staff rostered for duty, two of whom are suitably qualified to attend to an acute emergency presentation.
- ensure there is appropriate skill mix and early career nurses and midwives or novice practitioners are not the most senior nurse or midwife on shift or allocated in charge.

Nurses and midwives have a professional responsibility to advocate for staffing improvements on behalf of patients. We urge the Berejiklian Government to acknowledge its responsibility to support its clinical workforce and enter good faith negotiations to deliver fair and safe workplaces for all. This is achievable through mandated shift-by-shift nurse to patient ratios in every NSW public hospital and health service.

Fair pay increase

Nurses and midwives are well deserving of a fair pay increase for their unwavering commitment to deliver high levels of patient care during a period where the NSW health system was tested as never before, ensuring a 'gold standard' public health response.

Figures released in February 2021 show the NSW economy is recovering quickly and is in a position to invest in its health workforce, through fair pay rises and a safe staffing model.

As Australia's largest employer, the Berejiklian Government has a responsibility to ensure its workforce and their local communities are supported through difficult economic times. Appropriately remunerating all nurses and midwives in NSW is vital to ensuring sustainability of these professions into the future. Particularly when neighbouring states and territories have agreed to honour their pay increases, despite the pandemic.

Victorian nurses and midwives were paid their increase and have continued to enjoy improved allowances, conditions and safe staffing levels, due to the nurse and midwife patient ratios legislation enshrined in 2015. Meanwhile Queensland achieved ratios in 2016 and have since moved ahead of NSW on wages.

What a new ratios system would achieve

Ratios will be applied on a shift-by-shift basis, based on the number of patients in each ward, unit or service, regardless of the public hospital or health service's peer grouping.

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 that care in a funded bed, treatment space, room, chair or any other space regularly used to deliver care.

Only nurses and midwives providing direct clinical care are included in the minimum ratios. Other staff positions such as NUM/Ms, N/MMs, CN/MEs, CN/MCs, dedicated administrative support staff and wardspersons are additional to the requirements of the minimum ratios.

In addition, nurses and midwives 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 and midwifery staff for patients clinically assessed as needing "specials" will be rostered in addition to the ratio claims below.

Assistants in Nursing or Assistants in Midwifery rostered to work in an identified unit or ward 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 and midwives 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.

Upon commencement of a ratios system or new Award:

- where the proportion of registered nurses on each shift in any ward is higher than the new Award provision, that proportion shall not be reduced, and
- where the existing ratio or skill mix provided in any particular ward or unit is better, the existing ratio or skill mix shall not be reduced.

For Peer Group D and F3 MPS facilities – a minimum of three nurses or midwives rostered for every shift, two of which must be registered nurses.

Non-maternity patient care that occurs on maternity wards/units will be staffed in addition to the staffing provided for that ward/unit through the Birthrate Plus® staffing levels.

MEMBERS TOLD US:

"Our hospital has severe staff vacancies, so we're always doing overtime."

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.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
Medical/Surgical wards	1:4 + in charge	1:4+ in charge	1:7

Critical Care (Adult, Paediatric and Mental Health)

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

The Australian College of Critical Care Nurses (ACCCN) Workforce Standards for Intensive Care Nursing will apply to reflect the latest Professional Standards.

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

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). A CNC and NP as appropriate will be provided in addition to the minimum ratios.

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.

An Access Nurse should be allocated on all shifts without a 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.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
ICU / PICU / MHICU (however named)	1:1 + in charge + Access Nurse	1:1 + in charge + Access Nurse	1:1 + in charge + Access Nurse
HDU / Close Observations (however named)	1:2 + in charge	1:2 + in charge	1:2 + in charge
CCU	1:2 + in charge	1:2 + in charge	1:2 + in charge

Key components of the Standards include:

- **Requirement that there is a supernumerary clinical coordinator on every shift;**
- **Requirement that there are supernumerary ACCESS nurses (between 1:4 and 1:8 dependent on physical design of unit and level of training of workforce) on every shift;**
- **Requirement of 1 ICU liaison nurse per 10 beds;**
- **Requirement of 1 supernumerary lead nurse research for ICUs > 10 beds;**
- **Requirement that there is 1 RN within 3 metres of critically ill patients at all times;**
- **Requirements regarding post-graduate qualification-mix; and**
- **Requirement of a dedicated ward clerk from 0800h – 2000h every day.**
- **Every ICU must have a specialist critical care RN dedicated exclusively to the Nurse Manager role**
- **Requirement for an Equipment nurse, a critical care qualified RN that is an ICU equipment and technology specialist.**
- **Design and layout of the ICU must be considered when determining nurse staffing and skill mix. Where there is large number of single rooms, the nursing skill mix must be reviewed in order to ensure the safety and needs of the critically ill patient.**

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.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
Resuscitation Beds	1:1	1:1	1:1
Level 4-6 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + 2 triage	1:3 + in charge + triage
Level 3 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + triage	1:3 + in charge + triage
Level 2 Emergency Departments	1:3 + in charge	1:3 + in charge	1:3 + in charge
Level 1 Emergency Departments	No separate dedicated RNs		
EMUs	1:3 + in charge	1:3 + in charge	1:4 + in charge
MAUs	1:4 + in charge	1:4 + in charge	1:4 + in charge

*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.

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

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'.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
Paediatrics General Inpatient Wards	1:3 + in charge	1:3 + in charge	1:3 + in charge

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.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge
Special Care Nurseries (without CPAP services)	1:3 + in charge	1:3 + in charge	1:3 + in charge

Perioperative Services

The current Australian College of Perioperative Nurses (ACORN) Standards for Perioperative Nursing in Australia, as amended from time to time, will apply to all Perioperative Services in NSW Hospitals to reflect the latest Professional Standards.

Key components of the Standards include:

The minimum number of nursing staff per session/procedure should be 3.5 nurses who collectively meet the skills and qualifications needed to fulfil the following roles:

- **anaesthetic nurse – an appropriately authorised, educated and skilled anaesthetic nurse. who may be a registered nurse or an enrolled nurse under the supervision of an experienced anaesthetic registered nurse**
- **instrument nurse – a registered nurse. or an enrolled nurse performing within the limits of their competence and under the direct or indirect supervision of a registered nurse**
- **circulating nurse – another registered nurse or an enrolled nurse**
- **a 0.5 registered nurse to provide adequate assistance, support and relief. including meal breaks, to all nursing staff.**

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.

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
Rehabilitation	1:4 + in charge	1:4 + in charge	1:7

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.

Trust and transparency of nurse and midwife staffing in community services will be improved by requiring all health services to publish levels of leave replacement quarterly on their websites. The number and percentage of shifts replaced to cover nurses and midwives taking annual, sick, long service and parental leave will be published.

Short Stay Wards

The following minimum claim applies:

	RATIOS		
SPECIALTY / WARD TYPE	**AM**	**PM**	**NIGHT**
High Volume Short Stay	1:4	1:4	1:7
Day Only Units	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

SPECIALTY / WARD TYPE	RATIOS		
	AM	PM	NIGHT
Drug and Alcohol Inpatients (discrete standalone units)	1:4	1:4	1:7
Drug and Alcohol Outpatients	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.

SPECIALTY / WARD TYPE	RATIOS		
	AM	PM	NIGHT
Palliative Care	1:4 + in charge	1:4 + in charge	1:7

Maternity Services

POSTNATAL WARDS RATIO

All maternity units in NSW will implement a minimum ratio for postnatal mothers of 1 midwife to every 3 mothers and their babies. This ratio will apply over and above any Birthrate Plus® – calculated midwifery staffing hours applying to a postnatal ward.

A complete review of the current Birthrate Plus® maternity staffing system will be funded by the Ministry and conducted jointly by the Ministry and NSWNMA, to update the decade-old methodology and improve the staffing levels to account for changes in the model of care and the patient population.

ADDITIONAL PRINCIPLES FOR BIRTHRATE PLUS®

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 non-maternity patients in a maternity service will require additional nursing staff to provide safe patient care. Staff rostered within the maternity service will not be used to care for non-maternity patients.

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

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 and midwives 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 and midwives 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, the number of staff required will be "rounded up" to the nearest whole number.

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

PAY AND CONDITIONS CLAIMS

4.7% increase in pay and wage-related allowances per year plus superannuation. Next pay increase due July 2021

Free permanent parking and improved access for all nurses and midwives

Extend special allowance for Telephone Counselling to add Consulting

Update and improve definitions:

- New definition of Professional Standard
- New definition of Assistant in Midwifery

Leave arrangements

- Surrogacy Leave
- Update parental leave provisions to remove discriminatory references
- Access to paid pandemic leave for carers responsibilities

Work Health & Safety

- Annual fit testing for N95 respirator masks for all nurses and midwives
- Safety in outdoor COVID testing clinics

Miscellaneous Award improvements

- Improve hours of work clause to ensure your genuine agreement, addressing the state-wide problem of Waiver Forms removing your right to a 10 hour break between shifts
- Expand Scope of Grading Committee to include Nurse and Midwife Managers
- Ensure annual leave and overtime is clear for part-time employees
- Ensure overtime wording is clear and applies to overtime prior to shift just as it does at the completion of your shift
- Overseas recognition for incremental purposes

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