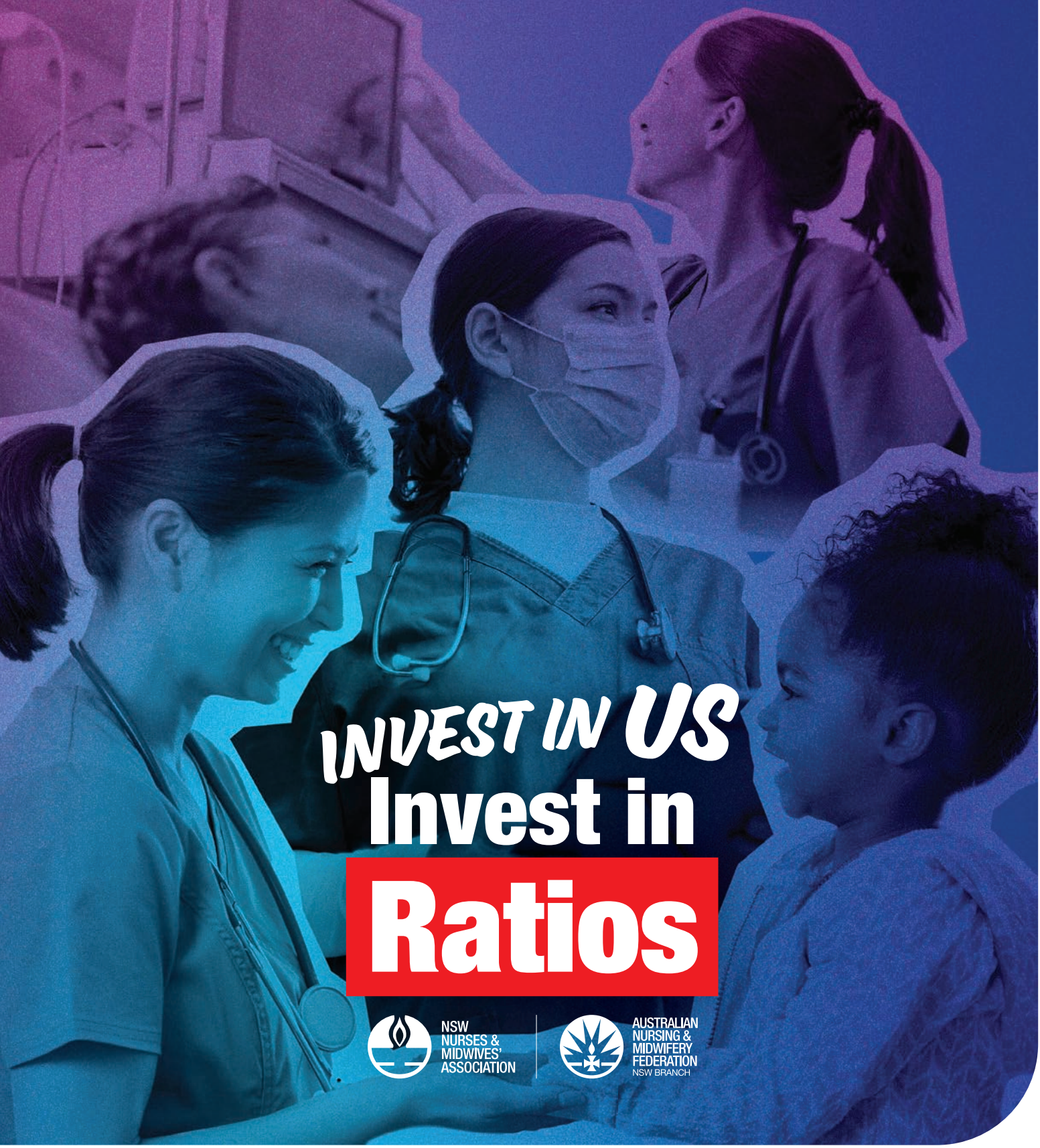

2024 PHS Log of Claims to Government

MAY 2024

Contents

Invest in Us

Invest in a sustainable Nursing and Midwifery workforce

This 2024 Log of Claims presents an opportunity for the NSW government, Ministry of Health and the NSWNMA to work together to help rebuild and invest in a sustainable workforce for the future.

Public sector nurses and midwives in New South Wales are calling for justified and necessary improvements to help rebuild our public health services. High levels of exhaustion and a decade of wage suppression, coupled with rising cost-of-living pressures, have taken a considerable toll on the nursing and midwifery workforce across our state. Now is the time to redress the impact of wage suppression by former governments and in doing so, reflect the important contribution nurses and midwives make to the state. We have a plan to achieve our shared goals.

A plan to help rebuild the nursing and midwifery workforce of NSW

Key to rebuilding the workforce is ensuring the wages and conditions of nurses and midwives in NSW are competitive nationally. A decade of wage suppression and rising inflation is working against our shared goal of rebuilding the workforce. By investing in nurses and midwives we can return NSW Health to being the national employer of choice. This can be achieved by:

Applying a one year, evidenced based **15% increase in pay**, plus superannuation, from 1 July

Making night duty more attractive by increasing **Night Duty Penalty Rates to 30%**

Ensuring 100% of the benefits from salary packaging flow to employees, doing away with the current inequity.

Nowhere feels the impact of staffing shortages greater than within maternity services. Our claim to **increase the payments for midwives working in midwifery group practice models of care to 35%** will help re-build this crucial workforce whilst providing more of the services women want across NSW.

As NSW Health brings on record numbers of New Graduates and implements Safe Staffing Levels, support for new and existing staff is crucial. Clinical Nurse/Midwifery Educators play an important role in retaining the workforce, and in enhancing workforce capabilities. A higher level of education is required for a CNE/CME to be eligible for the Continuing Education Allowance (CEA), when compared to other nurses and midwives. This is unfair. Our claim is for the **CEA to be extended to CNE/CMEs who have postgraduate certificate qualifications**, just like all other nurses and midwives.

A plan to help create work/life balance and manage fatigue

The ongoing impact of COVID-19 sees fatigue management being more important than ever as service demands continue to fluctuate. Fatigue management is key to a sustainable workforce and will help drive down staff replacement costs. Providing nurses and midwives greater work / life balance will be an increasingly important requirement for employers to retain their workforce. This can be achieved through:

Our claim for all **rostered days off to be consecutive**, unless agreed between the employee and local nursing/midwifery management.

Our claim for a **prohibition on working night duty prior to commencing a day of annual leave**, unless agreed to by both the employer and the nurse/midwife.

Our claim for **changes to published rosters requiring prior consultation** with the staff member impacted. This will ensure a conversation must occur with the impacted employee before any change is made, providing a respectful process to meet the needs of both parties

Our claim is to increase sick leave entitlements to 20 days per annum. Nurses and midwives are exposed to disease and illness at a higher rate than other public sector workers, and yet they have one of the lowest sick leave entitlements. Sick leave has become increasingly important since the COVID-19 pandemic.

Reducing inequity in patient transport services through our claim for **a meal allowance to be paid to those working in patient transport** when required to take a break away from their home base will demonstrate respect for the work they do.

Maximising industrial harmony

By rebuilding effective workplace consultation, we can ensure issues are addressed, minimising workplace conflict. Ensuring elected representatives are able to attend meetings is key. **Our claim for improvements to existing provisions and expansion of Clause 54** regarding trade union activities will ensure participation.

Invest in Ratios

Invest in the rollout of Safe Staffing Levels in every ward and hospital across NSW

Implementation of SSL

We welcome the commencement of the Safe Staffing Levels policy, and the government's commitment to deliver 2,480 Full Time Equivalent (FTE) positions within public hospitals. As this reform progresses, further FTE positions are needed to achieve full implementation across the agreed five clinical areas:

- Emergency Departments
- Intensive Care Units
- Maternity (a review of Birthrate Plus® and 1:3 in postnatal wards)
- Multi-Purpose Services
- converting Nursing Hour Per Patient Day wards and units to a shift-by-shift system

Ratios are coming to fruition in NSW with the implementation of Safe Staffing, and this represents a significant portion of the investment needed. Now that a path to implement minimum and enforceable Safe Staffing ratios has begun, including future expansion across the health system, **the government must continue to invest in this framework**.

Under the current ratios rollout, Assistants in Nursing or Midwifery cannot be introduced into a staffing profile where they do not already exist, unless consultation with the NSWNMA occurs, and the number per shift that count towards the ratio is limited. **Our claim for AiNs to be supernumerary remains**. Our position is that the government should fund this important workforce initiative within this term of government so that we are competitive nationally on workloads.

All wards, units, and departments must be staffed with nurses and midwives who have the relevant skills and knowledge for that clinical setting, and with staff supported by CNEs/CMEs to develop their skills for the clinical setting.

In line with a Memorandum of Understanding signed in 2023 between the NSWNMA and the Ministry of Health, we are seeking further funding to achieve full implementation of these historic reform measures.

This proposed Award claim is based on NSWNMA resolutions endorsed by the public sector Log of Claims Committee. It identifies ways to improve the working lives of nurses and midwives.

This comprehensive Award claim will help to retain our experienced and skilled workforce in NSW, and it will encourage the retention of our early career nurses and midwives. We need functioning and sustainable public hospitals in NSW. A well-remunerated and well-resourced nursing and midwifery workforce is critical to achieving this.

Safe Staffing ratios already won

In February 2024, NSWNMA public sector members secured agreement on the first phase of the ratios rollout.

The NSWNMA will continue to work with Safe Staffing Levels Taskforce representatives to ensure these workforce reforms are reflected in your *Public Health System Nurses' and Midwives' (state) Award.*

During phase one of the ratios rollout, our EDs will see the significant enhancement in staffing they desperately need.

As the rollout evolves, patients requiring critical care in ICUs or HDUs will be nursed by a registered nurse (except in Level 4 ICUs where enrolled nurses currently employed will continue to be counted in a 1:1 or 1:2 ratio) and additional Access nurses will ensure many ICUs receive the vital staffing support we have been seeking for many years.

Peer group A, B, and C hospitals will also have their NHPPD wards and units converted to shift-by-shift ratios, removing the problematic averaging of staff numbers that have eroded the system for so long. In addition, many wards will also benefit from improvements to the number of supernumerary in charge roles.

Where patient or bed numbers are not divisible by the relevant ratio, staff numbers will be rounded up.

Importantly, compliance with these changes will be much stronger across the health system, and the onus will be on management, and the Ministry if necessary, to promptly address any ratios shortfall in a ward or unit within 24 to 48-hours, under an agreed new escalation matrix.

Operation of minimum and enforceable staffing ratios

Evidence shows minimum staffing ratios need to vary between clinical settings and are set according to the shift (AM, PM, ND).

Nurses and midwives providing direct clinical care are counted in the minimum ratios. Other classifications, such as Nursing Unit Manager/Midwifery Unit Manager, Nurse Manager/Midwife Manager, Clinical Nurse Educator/Clinical Midwife Educator, Clinical Nurse Consultant/Clinical Midwife Consultant, dedicated administrative support staff, and wardspersons, are supernumerary to the minimum ratios required.

Nurses and midwives who are in charge of shift (however named) are not allocated a patient load and are rostered in addition where specified.

Applying staffing ratios in the clinical setting

In a ward/unit:

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 occupied, the four "unused" beds may only be used when additional staff are available to meet the ratio requirements.

In emergency departments:

The nurse:patient ratio is calculated on the number of treatment spaces generally occupied.

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.

Wherever ratios are in place and 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 ratios 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. For the five agreed Safe Staffing specialty areas, this is how rounding will apply.

Emergency Departments (Adult, Paediatric and Mental Health Assessment Centres*)

This minimum staffing 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.

Significant improvements to staffing arrangements will be introduced to emergency departments as part of the implementation of Safe Staffing Levels. The claim remains the implementation of ratios in Emergency Departments as set out in the following table.

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.

If the number of registered nurses for each emergency department (as at the date of this Award) is higher than 90%, that shall not be reduced.

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. The claim continues to be for AINs not to be counted in ratios.

Emergency Department claims already secured (via Ratios Rollout: Phase One) are outlined in the following table. **The additional claims yet to be won are highlighted (in bold):**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
Emergency Department (Level 5 & 6)*			
• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/clinical NUM – 24/7 • Triage – 34 hours per day. Eg. 1 AM, 2 PM, 1 ND (3x 8 hour shifts and 1x 10 hour shift) Skill mix: 85% RN, 15% EN (all shifts). AiNs will not be counted in ratio numbers in levels 5 & 6 EDs.	**Skill mix: 90% RN, 10% EN**	**Skill mix: 90% RN, 10% EN**	**Skill mix: 90% RN, 10% EN**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
Emergency Department (Level 4)*			
• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/clinical NUM – 24/7 if greater than 50 average daily presentations (18,000 presentations per year) • Triage – 24/7 if greater than 50 average daily presentations (18,000 presentations per year) • Triage – 34 hours per day. Eg. 1 AM, 2 PM, 1 ND (3x 8 hour shifts and 1x 10 hour shift), if greater than 110 average daily presentations (40,000 presentations per year) Skill mix: 85% RN, 15% EN/AINs (all shifts). A maximum of one AiN per shift to be counted in the ratio numbers.	**Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**Supernumerary in charge + 2 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**
Emergency Department (Level 3)			
• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/clinical NUM – 24/7 if greater than 60 average daily presentations (22,000 presentations per year). • Triage – 24/7 if greater than 60 average daily presentations (22,000 presentations per year)	**Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**Supernumerary in charge + 2 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**
Emergency Department (Level 2)			
Level 2 EDs remain part of the government›s commitment to implement Safe Staffing Levels. SSL Taskforce discussions are continuing.	**1:3 + in charge.** **Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**1:3 + in charge.** **Supernumerary in charge + 2 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**	**1:3 + in charge.** **Supernumerary in charge + 1 triage, regardless of presentation numbers.** **AINs not to be counted in ratios.**

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

Critical Care (Adult, Paediatric and Mental Health)

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

Significant improvements to staffing in critical care areas are to be introduced as part of the implementation of Safe Staffing Levels. The claim retains the commitment to the implementation of ACCCN standards, and seeks the standardisation of staffing levels across ICUs.

The claim is for the current Australian College of Critical Care Nurses (ACCCN) Workforce Standards for Critical Care Nurses to apply to all critical care areas.

Nurses who are part of a response team (however named) to be provided in addition to the minimum ratios. The ratios are to 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). Clinical Nurse Consultants and Nurse Practitioners as appropriate are to 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 (or clinical coordinator), on all shifts without an allocated patient load.

In ICU/PICU/MHICU 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 with specific duties and must be in addition to the minimum ratios claim.

Critical Care claims already secured (via Ratios Rollout: Phase One) are outlined in the following table. **The additional claims yet to be won are highlighted (in bold):**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
Intensive Care Unit (Level 5 & 6)			
• 1 RN : 1 ICU patients occupying beds (all shifts) • 1 RN : 2 HDU patients occupying beds (all shifts) provided the above ratio applies to those ICU patients required to be nursed as such (e.g. does not apply to 'ward ready' ICU patients). • Supernumerary in charge – 24/7 • Other ACCCN Standards at the discretion of the department • ACCESS role of 1:10-12 pod of beds (assumed average pod size) • Minimum unit size to require ACCESS role = 10 available/occupied beds • Rounding[1] for ACCESS role = 2 patients Skill mix: currently, some ICUs employ a limited number of ENs, these positions should be replaced by RNs through natural attrition as the incumbents resign from the unit. AINs will not count toward ratio staffing levels in ICU.	**Full implementation of ACCCN Workforce Standards**	**Full implementation of ACCCN Workforce Standards**	**Full implementation of ACCCN Workforce Standards**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
Intensive Care Unit (Level 4)			
• 1 RN* : 1 ICU patients occupying beds (all shifts) • 1 RN* : 2 HDU patients occupying beds (all shifts) provided the above ratio applies to those ICU patients required to be nursed as such (e.g. does not apply to ward ready patients in ICU). • Other ACCCN Standards at the discretion of the department • Supernumerary in charge – 16 hours per day • Additional 10 hours of supernumerary in charge, if the unit is at least 10 beds • ACCESS role not applicable Skill mix: currently, some ICUs employ a limited number of ENs, these positions should be replaced by RNs through natural attrition as the incumbents resign from the unit. AINs will not count toward ratio staffing levels in ICU.	**Full implementation of ACCCN Workforce Standards** **Supernumerary in charge in full, regardless of unit size**	**Full implementation of ACCCN Workforce Standards** **Supernumerary in charge in full, regardless of unit size**	**Full implementation of ACCCN Workforce Standards** **Supernumerary in charge in full, regardless of unit size**
High Dependency Unit (however named)			
• 1 RN* : 2 HDU patients occupying beds (all shifts) • Supernumerary in charge – 16 hours per day • Minimum unit size to require additional supernumerary in charge role = 10 available/ occupied beds Skill mix: currently, some ICUs employ a limited number of ENs, these positions should be replaced by RNs through natural attrition as the incumbents resign from the unit.	**Supernumerary in charge on all shifts**	**Supernumerary in charge on all shifts**	**Supernumerary in charge on all shifts**
Coronary Care Unit			
• 1:3 – CCU Patients occupying beds (all shifts) • Supernumerary in charge 16 hours per day • Minimum unit size to require third supernumerary in charge role = 10 available/ occupied beds	**Supernumerary in charge in full**	**Supernumerary in charge in full**	**Supernumerary in charge in full**
Close Observation Unit (however named)			
• 1:2 – COU patients occupying beds (all shifts) • Supernumerary in charge – 16 hours per day • Minimum unit size to require additional supernumerary in charge role = 10 available/ occupied beds	**Supernumerary in charge in full**	**Supernumerary in charge in full**	**Supernumerary in charge in full**

* provided that ENs who are engaged in Level 4 ICUs or HDU at the time of transition to safe staffing levels will be counted in the 1:1 or 1:2 ratio

Key components of the ACCCN standards include:

- requirement of a supernumerary clinical coordinator on every shift
- requirement of 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 of 1 RN within 3 metres of critically ill patients at all times
- requirements regarding post-graduate qualification (75% of nurses to hold qualification)
- requirement of a dedicated ward clerk from 0800hrs – 2000hrs 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.

General Adult Inpatient Wards

This minimum staffing 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.

Under the claim, wards will be staffed with nurses who have the relevant skills and knowledge for that specialty.

Staffing ratios are to be applied on a shift-by-shift basis and 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 exclusive medical/surgical wards.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on a minimum of two shifts each day, 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.

The below minimum staffing levels are soon to be implemented in those wards which currently apply the NHPPD system. This is an important step towards the full implementation of ratios.

General Adult Inpatient Wards (formerly NHPPD) claims already secured in the Ratios Rollout: Phase One are outlined in the following table. **The additional claims for yet to be won are highlighted (in bold):**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
Medical/Surgical Assessment Units (MAU & SAU)			
• 1:4 AM • 1:4 PM • 1:7 ND • Supernumerary in charge – 24/7 Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	**1:3 + supernumerary in charge** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**1:3 + supernumerary in charge** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**1:4 + supernumerary in charge** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**
NHPPD – General Inpatient (Peer Group A)			
• 1:4 AM based on occupied beds • 1:4 PM based on occupied beds • 1:7 ND based on occupied beds • Supernumerary in charge – 16 hours per day Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**
NHPPD – General Inpatient (Peer Group B)			
• 1:4 AM based on occupied beds • 1:4 PM based on occupied beds • 1:7 ND based on occupied beds • Supernumerary in charge – 8 hours per day (wards with 23 or less patients) • Supernumerary in charge – 16 hours per day (wards with 24 or more patients) Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
NHPPD – General Inpatient (Peer Group C1)			
• 1:4 AM based on occupied beds • 1:4 PM based on occupied beds • 1:7 ND based on occupied beds • Supernumerary in charge – 8 hours per day (wards with 23 or less patients) • Supernumerary in charge – 16 hours per day (wards with 24 or more patients) Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Supernumerary in charge, regardless of patient numbers** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**
NHPPD – General Inpatient (Peer Group C2)			
• 1:4 AM based on occupied beds • 1:4 PM based on occupied beds • 1:7 ND based on occupied beds • Supernumerary in charge – 8 hours per day (wards with 23 or less patients) • Supernumerary in charge – 16 hours per day (wards with 24 or more patients) Skill mix: on case-by-case basis, to be agreed between LHD and NSWNMA, will have either – 70% RN, 30% EN & AIN or 80% RN,20% EN & AIN. In C2 wards with 70% RN & 30% EN & AIN skill mix, a maximum of 2 AINs per shift.	**1:4 + supernumerary in charge** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**1:4 + supernumerary in charge** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**1:7** **Skill mix: 85% RNs.** **AINs not to be counted in ratios.**
NHPPD – MH Adult Acute			
• 1:4 AM • 1:4 PM • 1:7 ND • Supernumerary in charge – 16 hours per day Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	***See Mental Health Claim for details.***		
NHPPD – Palliative Care			
• 1:4 AM • 1:4 PM • 1:7 ND • Supernumerary in charge – 16 hours per day Skill mix: 80% RN, 20% EN & AINs. Maximum of 1 AIN per shift.	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**	**Skill mix: 85% RNs.** **AINs not to be counted in ratios.**

SSL Ratios Rollout & Skill Mix (SECURED)	Our Claims (TO BE WON)		
	AM	PM	NIGHT
NHPPD – General Rehabilitation			
• 1:5 AM • 1:5 PM • 1:7 ND based on occupied beds • In charge – 16 hours per day (Note: this ratio is aligned with current NHPPD requirements of 5) Skill mix: 70% RN, 30% EN & AINs. Maximum of 2 AINs per shift.	***See Rehabilitation Claim for details.***		

Maternity Services

The Safe Staffing Levels Taskforce continues to work towards the implementation of the agreed 1:3 ratio in post-natal, and the review of Birthrate Plus. The claim below represents the improvements that are needed across all maternity services.

Postnatal wards ratio

Birthrate Plus® to apply in maternity services in NSW with the exception of postnatal wards which require a minimum of 1 midwife to 3 women and their babies.

A complete review of the current Birthrate Plus® maternity staffing system to be funded by the Ministry of Health 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 to 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 to be considered a minimum and apply only to midwifery hours. The existing provisions in Clause 53 Staffing Arrangements to apply to all maternity services.

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

Maternity Services to 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, for example, significant increase in delivery numbers, changes to the model of care, changes to 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 to require additional nursing staff to provide safe patient care. Staff rostered within the maternity service, not be used to care for non-maternity patients.

POSTNATAL WARD OR UNIT SKILL MIX ACROSS ALL MATERNITY SERVICES

Experienced midwives to be on duty at all times.

A ratio of 1 midwife to 3 women and their babies to recognise the workload created by newborns.

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

In charge of shift not to be allocated a patient load.

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

Assistants in Nursing are not to be 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 without Birthrate Plus®. Generally, these units have under 200 births per annum.

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 – Total Continuity 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 newborn 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 – Partial Continuity 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 newborn 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.

Regional and Rural Sites
(Peer Group D and F3 MPS facilities)

The Safe Staffing Levels Taskforce is continuing to work towards the implementation of a minimum of three nurses per shift in all MPS sites, which was part of Labor's 2023 election promise. The following claim continues to press for further improvements to staffing in regional and rural settings.

Nurses and midwives working across NSW in community hospitals and Multi-Purpose Services have been dealing with a serious staffing and safety crisis for many years. A better system is needed to allow nurses and midwives to provide local communities with the clinical care they deserve.

The current staffing arrangements under Clause 53 of the Award for Peer Group D & F3 MPS sites do not provide sufficient minimum staffing levels, depriving many of these health facilities the capacity to deliver the safe patient care.

In addition, regional and rural sites do not have access to medical officers 24/7 and thereby have limited resources to respond to emergency events, leaving patients at risk where such events occur.

Staffing provisions within the Award to ensure:

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

Whenever an ED is open 24/7, regardless of delineation or classification, that facility requires **a minimum of three nurses to be rostered for duty, two of whom are suitably qualified to attend to an acute emergency presentation**.

Where regional and rural sites do not have access to medical officers 24/7 and are reliant on virtual medical officer coverage, there must be **a minimum of one additional registered nurse rostered on-call and within 15 minutes to the site**, to be present and provide physical, in-person support to respond to emergency events in addition to the two registered nurses on duty.

Inpatient Mental Health

This minimum staffing claim applies to:

- all inpatient mental health wards/units
- 'outlying' inpatient mental health beds
- inpatient mental health patients who are occupying non designated inpatient mental health beds.

Additional nurses are to be provided when seclusions are used or when a patient requires level 1 and 2 Observations. Additional nurses to 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 to 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 to be provided for peak times (e.g. admissions, discharges, answering phones).

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

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

All Mental Health Units are to have a minimum of 3 nurses at all times, regardless of the size of the unit.

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

Where Assistants in Nursing are rostered to work, they are to only be used to assist a registered nurse to perform specific duties such as manual handling and activities of daily living and are to 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 to 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 to 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.

Renal Dialysis

The following minimum staffing claim applies in hospital settings, where renal dialysis is provided:

- 1:1 on all shifts where a Medical Officer is on site, for patients who are receiving dialysis for the first time, for ICU/CCU patients that are medically unstable, have multiple comorbidities and are dialysed within an intensive care environment.
- 1:2 on all shifts for patients who require medical intervention i.e. IVABs IV treatment, blood or blood products and injections, as well as Permacath access and dressing changes or for patients diagnosed with intellectual disability or behavioural concerns.
- 1:3 on all shifts for patients requiring nursing intervention during treatment and patients who are stable during treatment.

For satellite units:

- 1:2 for complex patients requiring supervision during treatment.
- 1:3 for patients that are medically stable and compliant with plan of care and are independently mobile.

A supernumerary in charge RN is to be provided in in both hospital and satellite units. Additional support services are to be provided e.g. AiNs for all operating hours to perform ancillary duties such as restocking, cleaning, and remaking of chairs, patient observations where applicable and providing warm blankets to patients.

All renal patients are classed as reoccurring inpatients.

	RATIOS	
HOSPITAL UNITS	**AM**	**PM**
First time dialysis patients, unstable patients, patients with multiple comorbidities etc	1:1	1:1
Patients requiring medical intervention, IV medications, Permacath access or patients with intellectual disability or behavioural concerns	1:1	1:2
All other patients	1:3	1:3
SATELLITE UNITS	**AM**	**PM**
Complex patients requiring supervision	1:2	1:2
Patients who are medically stable, independently mobile and compliant with care plan	1:3	1:3

Paediatrics

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

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

Additional hours above the minimum ratio are to be provided for nurse escorts and where clinical procedures require it.

	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 staffing claim applies to ICU, HDU and Special Care Nurseries in Neonatal Intensive Care Units. The claim seeks a review of Neonatal Intensive Care Unit staffing levels in relation to ACCCN staffing standards and in consultation with the Australian College of Neonatal Nurses.

A minimum of 85% registered nurses who have the relevant critical care health skills and knowledge levels to be provided on every shift.

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

Additional hours to be provided for work that may be described as discharge nurse, neonatal family support, lactation consultant (appropriately qualified and experienced in NICU/HDU/SCN care) and transport nurse (including retrieval).

All NICU/SCN to provide full-time lactation support via a registered nurse/midwife who holds an International Board-Certified Lactation Consultant qualification and is experienced in the care of neonates requiring NICU/SCN support.

Special Care nurseries that perform CPAP will be subject to the HDU claim.

Where Assistants in Nursing are rostered to work, they are to 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 + Access Nurse	1:1 + in charge + Access Nurse	1:1 + in charge + Access Nurse
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

This claim seeks that 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 ACORN 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 claim seeks that minimum staffing claim applies to dedicated hospitals and rehabilitation wards or units.

A minimum of 85% registered nurses who have the relevant skills and knowledge are to 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) Assistant in Nursing with the relevant skills and experience in general rehabilitation wards/units.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on a minimum of two shifts each day, 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

This claim seeks that 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 achieve patient-centred care.

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

This claim seeks that the following minimum staffing 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

This claim seeks that the following minimum staffing claim applies:

	RATIOS		
SPECIALTY / WARD TYPE	**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). For nurses involved in outpatient counselling, withdrawal management or case management: A limit of 4 hours of face to face client contact per 8-hour shift, averaged over a week. Pharmacotherapy direct contacts: a minimum of 10 minutes for dosing (methadone/suboxone) and a minimum of 30 minutes for administration of depot buprenorphine medications.		

Palliative Care (wards and outlying beds)

This minimum staffing 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 a minimum of two shifts each day, 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.

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

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:

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 Educators/Clinical Midwife Educators

An increased number of Transition to Practice nurses and midwives ("new graduates") continue to be employed within the Public Health System. To ensure new practitioners consolidate their practice, additional Clinical Nurse Educators/ Clinical Midwife Educators (CNEs/CMEs) need to be employed.

Achieving a better workforce skill mix will require more support than is currently provided to meaningfully relieve pressure for the most experienced RNs/Ms.

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 CNEs/CMEs 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.

SNAPSHOT

Pay & Conditions Claim 2024

A 15% pay increase, plus superannuation, for all nurses and midwives from 1 July 2024.

NSW nurses and midwives are claiming a rate that recognises their commitment, and is competitive with other states. A decade of suppression under wage caps must be redressed.

Night Duty penalty

Our claim is a 30% penalty rate for night duty. This would bring NSW in line with other states, and properly reward nurses and midwives for working unsociable hours.

Salary Packaging improvements

Currently, the NSW government keeps 50% of the tax benefit when a public sector nurse or a midwife chooses to salary package. Our claim is to end this practice, allowing 100% of the benefit to flow directly to members.

Sick Leave entitlements

Nurses and midwives are exposed to disease and illness at a higher rate than other public sector workers. Sick leave has become increasingly important since the COVID-19 pandemic. Our claim is to increase sick leave entitlements to 20 days per annum.

Improvements to work-life balance

Our claim is for all rostered days off to be consecutive, unless agreed between the employee and local nursing/midwifery management.

Our claim is for a prohibition on working night duty prior to commencing a day of annual leave, unless agreed to by both the employer and the nurse/midwife.

Our claim is for a prohibition of published rosters being changed without prior consultation with the staff member impacted. This will ensure a conversation must occur with the impacted employee before any change is made.

Continuing Education Allowance improvements for CNEs and CMEs

A higher level of education is required for a CNE/CME to be eligible for the CEA, when compared to other nurses and midwives. This is unfair. Our claim is the CEA to be extended to CNE/CMEs who have postgraduate certificate qualifications, just like all other nurses and midwives.

Increase to car allowance and loading for Midwifery Group Practice

The current (29%) loading does not reflect the importance of MGP midwives in maternity service provision. To be competitive with other states, our claim is for a loading increase to 35%.

Trade Union activities

Our claim is for improvements to existing provisions and expansion of Clause 54 regarding trade union activities. This would include access to paid union meetings and other important measures designed to ensure you can be involved with union activities at work.

Meal Allowance for Patient Transport Service

Our claim is for a meal allowance to be paid to those working in patient transport when required to take a break away from their home base.

INVEST IN US

Invest in Ratios

NSW Nurses & Midwives' Association | Australian Nursing & Midwifery Federation NSW Branch

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