RATIOS SAVE LIVES

AUSTRALIAN NURSING & MIDWIFERY FEDERATION TASMANIAN BRANCH

ANMF
TASMANIAN BRANCH

Ratios Save Lives – Ratio Model

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Nurse:Patient ratios ensure appropriate nurse and midwife numbers which allows the provision of safe and quality care to their patients.

The evidence is irrefutable both nationally and internationally that adequate nurse and midwife numbers, coupled with appropriate skill mix and work environment, directly affect the level of safety and quality in health care services [1, 2, 3, 4, 5, 6, 7]

Ratios have been proven to be an economically sound staffing methodology. Evidence demonstrates an increase in organisational productivity, continuity of patient care and efficiency through improvement of staff satisfaction, while also reducing service variation and improving healthcare equality [1, 8, 9, 10]

The time is right to implement Nurse:Patient ratios in Tasmania, as the transition to the Tasmanian Health Service begins. The benefits for Nurse:Patient ratios are clear for the Tasmanian health system, the patients and importantly for the staff working in it.

Improving efficiency and delivering services in an economically sustainable way in the Tasmanian health system has become a key objective of the Tasmanian government. Patient ratios will contribute to improving efficiency within the Tasmanian Health Service and will be cost effective in doing so.

'Improving nurse staffing and skill mix will reduce adverse events and minimise unnecessary costs associated with inpatient complications [1, 3, 8] '

Patients will experience much safer care that is of higher quality in a Tasmanian Health Service that implements patient ratios. Increasing nurse and midwife numbers improves patient satisfaction, lowers mortality, decreases re-admissions and reduces adverse events such as postoperative complications and pressure injuries [1, 2, 3, 4, 5, 6, 7, 9, 11]

'Hospitals with a higher nurse staffing level have a 25% less rate of readmission compared to similar hospitals with lower levels of nursing staff [4]'

Improving patient safety and efficiency within the Tasmanian health system hinges upon a willing and able nursing and midwifery workforce. The nursing workforce not only has a direct impact on patient safety and the quality of care patients receive, but can impact negatively on productivity where turnover rates are high due to staff burnout and low morale [11,12,13].

'Adding one patient to a nurse or midwifes workload directly increases the rate of burnout by 23% and reduces job satisfaction by 15% [13] ,implementing ratios will increase staff satisfaction and decrease attrition rates'

The evidence is clear that nurse patient ratios are beneficial for the health system; as well as patients and staff alike and reduces health service variation while ensuring equality.

Part A – Introduction and Application

The proposed ANMF Tasmanian Branch Nurse:Patient ratio model has been constructed to ensure the best possible outcome for all ANMF (Tas Branch) members and to replace the existing staffing model, Nursing Hours per Patient Day [14].

Research was conducted on most staffing models around Australia to review the current staffing methodologies and compare them to the Tasmanian model of Nursing Hours per Patient Day (NHpPD). The research determined that nurse to patient ratios are a viable option as a staffing tool for Tasmania, if implemented as a specific model, designed to fit the Tasmanian context and ensure that no area is disadvantaged.

The proposed Tasmanian Nurse:Patient ratio model is **evidence based**. Hospitals around Tasmania have been allocated levels through the Australian Institute of Health Welfare (AIHW)– **Australian Hospital Peer Groupings**[15] . The AIHW assigned level of each Tasmanian hospital was determined and the hospital was allocated into the corresponding level in the Tasmanian Nurse:Patient Ratio Model. This level determines the appropriate ratio for each area within the hospital.

The most applicable ratios to the Tasmanian healthcare setting were then determined from the Queensland Nurses Union Initial Ratio Claim [16] and the *Victorian Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* [17] and used to develop the hybrid Tasmanian Nurse:Patient Ratio Model.

In order to correctly apply the Tasmanian Nurse:Patient Ratio Model to Tasmanian hospitals, regard must be had to the current benchmarked NHpPD categories. Any ward or unit that has **category A beds** currently in their bench marked hours [14], will need to apply a 1:3 Nurse:Patient ratio as detailed in the model. Applying this ratio to category A beds will ensure safe staffing on applicable units.

It should be noted that the applicable nurse:patient ratio's are **minimum staffing** requirements and additional staffing will be required when clinical care requirements exceed the minimum ratio. It is expected that the nurse to patient ratio will be applied in conjunction with additional nursing roles such as, but not limited to, Clinical Nurse Consultants and also

with other members of the health care team such as, but not limited to, Assistants in Nursing, Care staff along with support roles such as ward clerks and ward aides. As acuity continues to increase, additional support resources will be required.

The Tasmanian nurse to patient ratio will apply to all inpatient areas and some outpatient areas as defined in the model, however it will not apply to discrete outpatient areas e.g. Holman Clinic, Dialysis Units and Specialist Clinics.

Implementation of the Tasmanian Nurse:Patient Ratio Model will be on the understanding that **no area, hospital, ward or unit will be disadvantaged** in any way, including loss of specific nursing staff positions not otherwise mentioned in the model.

Implementation will also take into account any additional and **specialised roles** that are identified in the Tasmanian Government's 'Tasmanian *Role Delineation Framework* which do not exist currently.

Part B – Preamble

The Tasmanian Nurse:Patient Ratio Model will have immediate application to those worksites where agreed peer hospital groupings and nurse patient ratios are identified in Part C herein.

The model also acknowledges that that there will be worksites where the Nurse:Patient ratio model is not immediately applicable. In these cases the parties shall agree to develop Nurse:Patient ratios for these worksites within an agreed timeframe and/or to develop alternate workload tools on a site/sector basis in accordance with Part C.

The model also contemplates broad duties and a grievance procedure which can be applied to any worksite, whether the Nurse:Patient ratio model has been implemented or not.

Only registered nurse, registered midwife and enrolled nurse positions are covered by the ratios, however it is expected that additional nursing roles, care staff and other non nursing roles will still be required as part of the patient care teams in individual wards and units.

Associate Nurse Unit Managers A/NUMs, will be introduced as promotable Grade 5 positions in all areas in addition to direct care ratios.

Part C – Model Application Principles

Ratio Application	**Example**
(1) Except as otherwise provided— (a) a ratio applies to every ward in each hospital to which it is specified to apply; and (b) a ratio must be applied on the basis of the actual number of patients in each ward to which it applies; and (c) a ratio is a minimum requirement only and is not intended to prevent the operator of a hospital from staffing a ward with additional nurses or midwives beyond the number required by the ratio; and	For subsection (1)(b), in a ward with 30 beds where only 26 beds are usually occupied, the operator of the hospital must not use the other 4 beds unless additional staff are available to meet the ratio requirements. For subsection (1)(c), in a ward with 8 patients and a 1:4 ratio, if 3 patients require a higher level of care a 1:4 ratio will not be clinically appropriate and therefore additional nursing staff should be arranged in order to ensure safe patient care.

Application of ratios in small hospitals	Despite anything to the contrary in a ratio applying to a level 4 hospital with one ward, the operator of the hospital must staff that ward with— (a) One registered nurse on all shifts; and (b) One After Hours Coordinator or equivalent position(ANUM) who is not supernumerary, during all off-duty periods of the Director of Nursing or Director of Midwifery.
Out of hours coordination of hospitals	The operator of a hospital with only 2 wards may count one After Hours Coordinator (who is not supernumerary) towards meeting any ratio during all off-duty periods of the Director of Nursing or Director of Midwifery. The operator of a hospital with 3 wards or more must staff the hospital with a minimum of one After Hours Coordinator during all off-duty periods of the Director of Nursing or Director of Midwifery, in addition to any ratio that applies.
Rounding Method	(1) If the number of patients in a ward or the number of beds (as the case requires) is not divisible into a whole number when a ratio is applied, the number of nurses or midwives must be rounded in accordance with subsections (2), (3) and (4), as applicable.

	(2) If the actual or expected number of patients in a ward or number of beds requires less than 50 per cent of one additional nurse or midwife to be rostered in applying a ratio, the operator of the hospital is not required to roster an additional nurse or midwife in order to comply with the ratio unless safe patient care may be compromised. (3) In addition to any requirement under subsection (2), the operator of a hospital may assign a nurse or midwife to care for patients— (a) across multiple wards at night; or (b) in the case of a nurse, across multiple beds in aged high care residential wards on any shift. (4) If the actual or expected number of patients in a ward or number of beds requires 50 per cent or more of one additional nurse or midwife to be rostered in applying a ratio, the operator of the hospital must roster an additional nurse or midwife to comply with the ratio.
Demand Higher or lower than expected	(1) Beds in addition to the beds that have been staffed under a ratio may only be occupied if nurses or midwives who are not completing overtime or double shifts are available to comply with the ratio. (2) If the actual or expected number of patients on a particular day falls below the number of patients for which a ward is staffed in accordance with a ratio, the number of nurses or midwives may be adjusted down before the commencement of a shift.
Skill mix	The NUM may use no more than 25 per cent enrolled nurses, where clinically appropriate, in meeting ratios. Nursing support roles such as Assistants in Nursing and Care staff may be required to assist to provide safe patient care in addition to the minimum Nurse:Patient ratio's.
Nurse Unit Managers, Midwifery Managers, Clinical Nurse Educators/Facilitators, Clinical Nurse Consultants and Nurse Practitioners are not included in the ratios	A Nurse Unit Manager/Midwifery Unit Manager cannot be included in the ratio or allocated as the In-charge nurse. A Clinical Nurse Educator/Facilitator employed in a ward is not included in the ratio or as the 'in-charge nurse'

Nurse/Midwife Educators	Educator to Staff Ratio – all services types/wards regardless of sector and regardless of size. **1.4 FTE CNE: 30 head count of staff- maximum** (Casual/Pool unit by negotiation)
In-charge nursing positions	• Each hospital with three or more ward/units will also have a minimum of a supernumerary After Hours Co-ordinator and an Associate NUM (ANUM) per ward on each shift. • **A minimum of 5 FTE ANUM to be permanently employed per ward/unit to enable one ANUM in charge each shift each day.** • In small health facilities ie one ward, there will be one ANUM with another Registered Nurse as a minimum.
Associate Nurse Unit Managers (ANUM)	• It is expected that the ANUM will undertake the role of Nurse Unit Manager during all off duty periods of the Nurse Unit Manager (NUM) and be delegated management duties by the NUM when working in collaboration. • Example (A): After receiving sick calls from 2 staff members for the next three shifts the ANUM will review staffing and attempt to address the staffing short fall in collaboration with the after hours nurse coordinator . • Example (B): During hours when the Nurse Unit Manager is off the ward all management delegation will be allocated to the ANUM. • Example (C): During hours when the Nurse Unit Manager is on the ward or unit the ANUM will be delegated duties where applicable by the NUM such as, but not limited to, running a family meeting, conducting Professional Development Agreements or managing patient flow. • Where in exceptional circumstances such as recruitment delays or circumstances beyond the employer's control a Registered Nurse is required to act in the ANUM role, they are to paid at the applicable rate of the ANUM for duration they are acting in the role.

Defintion	**Example**
Acute Ward	Means an inpatient ward or unit where any of the following are cared for: (a) Patients who have an acute or chronic illness or an injury **(b)** Patients recovering from surgery

Bed	Includes cubicle, trolley, treatment chair, cot deliver suite or any other fixture used to accommodate a patient.
General medical or surgical ward	Means an inpatient ward or unit which either of the following are cared for: (a) Patients who have an acute or chronic illness or an injury (b) Patients recovering from surgery
Occupied	Means available to be occupied

Part D - The Tasmanian Nurse Patient Ratio Model

1. Peer Hospital Groupings

The following peer hospital groupings have been determined by the Australian Institute of Health and Welfare (AIHW), 2015.

Tasmanian hospitals have been reviewed and allocated a level by the AIHW according to a number of pre-determined factors. Public Hospitals in Tasmania are listed below along with their designated AIHW peer grouping.[15] The peer grouping was then matched with the relevant level in the Victorian Ratio Model which has been used as basis for formulating the Tasmanian Nurse : Patient Ratio Model.

Tasmanian Hospital	**Peer Hospital Grouping** (Australian Institute of Health and Welfare 2015)	**Proposed Level in Tasmanian Patient Ratio Model**
Royal Hobart Hospital	Principal Referral Hospital	Level 1
Launceston General Hospital North West Regional Hospital Burnie	Public Acute Group A Hospitals	Level 1
Mersey	Public Acute Group B Hospitals	Level 2
North East Soldiers' Memorial Hospital—Scottsdale	Public Acute Group C Hospitals	Level 3

Deloraine Hospital George Town Hospital Health West (Queenstown) King Island MPC* New Norfolk Hospital Smithton Hospital St Helens District Hospital St Marys Community Health Centre Tas	Public Acute Group D Hospitals	Level 3 (Acute) +/- Level 4: Aged Care Beds
Beaconsfield (MPS) Campbell Town (MPS) Esperance MPC Flinders Island MPC* May Shaw District Nursing Centre Midlands MPC Statewide Mental Health Services - Psychiatric hospitals	Very Small Public Hospitals	Level 4 - Rural and Regional Ratio

2. ANMF Tas. Branch Nurse to Patient Ratio Model

The below listed ratios shall apply to all inpatient areas and outpatient areas where indicated in the below model.

Application of the model shall not result in disadvantaging any area, nor any discrete nursing and support positions not specifically mentioned in the ratio model.

2.1 **General Medical and Surgical Ward** – Nurse to Patient Ratios:

Shift	Level 1 Hospital Ratios	Level 2 Hospital Ratios	Level 3 Hospital Ratios
Early	1:4: (+ In-charge)	1:4 (+ In-charge)	1:5 (+ In-charge)
Late	1:4 (+ In-charge)	1:4 (+ In-charge)	1:6 (+ In-charge)
Night	1:8 (+ In Charge)	1:8 (+ In-charge)	1:10 (+In-charge)

2.2 **Midwifery** - Midwife to Patient Ratios *(In the absence of any other model e.g. Birthrate Plus, Caseload Midwifery etc)*

Shift	All Level Hospitals Ante-natal Ratio	All Level Hospitals Delivery Suite Ratio	All Level Hospital Post Natal
Early	1:4: (+ In-charge)	1:1 Delivery Suite (+ I/C)	1:4 (+ In-charge)
Late	1:4 (+ In-charge)	1:1 Delivery Suite (+I/C)	1:4 (+ In-charge)
Night	1:4 (+ In-Charge)	1:1 Delivery Suite (+I/C)	1:4 (+ In-charge)

2.3 **Special Care Nurseries** – Nurse to Occupied Cot Ratio

Cots	9 or fewer occupied cots	10 occupied cots	11 or more occupied cots
Nurses Required	X 1 nurse for every 4 cots occupied (+ In-Charge)	X 3 nurses on every shift (+ In-Charge)	X 4 nurses on every shift + one additional nurse for every 3 extra cots beyond 11 (+ In-Charge)

2.4 **Neonatal Intensive Care** – Nurse to Occupied Cot Ratio*

Shift	Nurse to Cot Ratio
All shifts	1:1 (+ In-Charge)

2.5 **Paediatrics** – *special circumstances/services need to be considered.*

Shift	All Level Hospitals
Early	1:3: (+ In-charge)
Late	1:3 (+ In-charge)
Night	1:3 (+ In-Charge)

2.6 **Level 4 Hospitals:** Nurse to Patient Ratios *(Rural and Regional Hospital with Acute +/- Aged - high care beds/hostel) (ED staffing to be added if ED services)*

Shift	Level 4 Hospital - Nurse Ratio
Early	1:6 (+ In-charge)
Late	1:6 (+ In-charge)
Night	1:10 (+ In-charge)

2.7 **Emergency Department:**

Shift	Level 1 Hospital Ratios	Level 2 Hospital Ratios	Level 3 Hospital Ratios
Early	1:3 (+ In-charge and x 1 Triage)	1:3 (+ In-charge and x1 Triage)	1:3 (+ In-charge and x1 Triage)
Late	1:3 (+ In-charge and x 2 Triage)	1:3 (+ In-charge and x2 Triage)	1:3 (+ In-charge and x1 Triage)
Night	1:3 (+ In-charge and x 1 Triage)	1:3 (+ In-charge and x1 Triage)	1:3 (+ In-charge and x1 Triage)
In addition to the ratio's Emergency Department staffing will also meet at a minimum the College of Emergency Nursing Australasia (CENA) (2007) Standards. **CENA Standards 2007** [18]			

Required Nursing Positions Incorporated into ED's as minimum;

- Clinical Nurse Specialist (CNS) or Clinical Nurse (CN)
- Clinical Nurse Consultant (CNC)
- Clinical/Nurse Educator (CNE/NE)
- Nurse Unit Manager (NUM)/Nurse Manager (NM)
- Nurse Practitioner (NP) – minimum

and

- Mental Health Nurse (PEN) per shift (CENA Nurse staffing standards for South Australian Emergency Care Settings)

Additional Staffing Requirements for Emergency Departments

Primary Care/ Remote Area Service	**Rural Emergency Service**	**Metropolitan**	**Major Referral**
Defined as a single practitioner managing a specific client population RN available to triage 24 hrs a day Access to a medical officer for consultation	Designated assessment and treatment area with resuscitation facilities Medical Officer available on site or on call. In larger facilities staffed by a designated emergency nurse. Designated Registered nursing staff available 24 hours a day for triage Designated NUM Nurse capable of leading in resuscitation in line with Australian Resuscitation Council Guidelines, and in transfer of the acute patient to a higher level facility Access to Nurse Educator	Designated resuscitation area Designated staff allocated to the resuscitation area Designated triage RN 24 hours a day Designated NUM Designated Team Leader/Shift Coordinator Emergency Nurse Educator and Clinical Facilitator support Access to Clinical Nurse Consultant as clinical expert Appropriate numbers of nursing staff to manage the patient acuity, presentations, and workload of emergency presentations and admitted patients remaining in the ED due to access block.	Designated resuscitation area Designated staff allocated to the resuscitation area Designated triage RN 24 hours a day Designated NUM Designated Team Leader/Shift Coordinator Emergency Nurse Educator and Clinical Facilitator support Clinical Nurse Consultant as clinical expert Access to a Nurse Researcher Appropriate numbers of nursing staff to manage the patient acuity, presentations, and workload of emergency presentations and

			admitted patients remaining in the ED due to access block.

2.8 Critical Care

2.8.1 Coronary Care Unit and High Dependency Unit Ratios

- *High Dependency Ratios will apply to all Category A beds in all wards and units that have had been benchmarked accordingly under Nursing Hours per Patient Day*

Shift	Coronary Care Nurse Ratio	High Dependency Unit Nurse Ratio
Early	1:2 (+ In-charge)	1:2 (+ In-charge)
Late	1:2 (+ In-charge)	1:2 (+ In-charge)
Night	1:2 (+ In-charge)	1:2 (+ In-charge)
* Where the HDU is within an ICU or Ward/Unit the In-charge will be the ICU In-charge or Ward/Unit In-Charge		

2.8.2 **Intensive Care** – Nurse to Patient Ratio

Shift	Nurse Ratio
Early	1:1 (+ In-charge + Access)
Late	1:1 (+ In-charge + Access)
Night	1:1 (+ in charge + Access)
* In addition to the ratio's Intensive Care Unit staffing will also meet at a minimum the Australasian College of Critical Care Nurse (ACCCN, 2003) Standards. [19]	

2.8.3 Required Minimum Nursing Positions Incorporated into Critical Care Wards/Units:

- Clinical Coordinator (team leader): per shift who is guaranteed to be supernumerary for the entire shift.
- At least 1 ACCESS/Float Nurse - may be incorporated into the Clinical Coordinators role however the Clinical Coordinator should not be the only contingency nurse available for emergency admissions. That is, where a unit is required to have only 1 ACCESS nurse, a supernumerary Clinical Coordinator must also be rostered on duty.
- The ratio of ACCESS nurses required per unit/per shift will depend on the average level of skill and expertise of the total team. Therefore:

Units with < 50% qualified. ICU nurses - 1:4 Access Nurse to Patient
Units with 50-75% qualified. ICU nurses - 1:6 Access Nurse to Patient
Units with >75% qualified. ICU nurses - 1:8 Access Nurse to Patient

- Nursing Manager - In certain circumstances, (e.g. large units of 20+ beds) alternative supports will be required, and these need to be planned independently and in addition to the ratios described above.
- Clinical Nurse Educator
- Clinical Nurse Consultant
- Research Nurse

2.9 Operating Theatres

	Operating Theatre	Post Anaesthetic Recovery Rooms
Nurses Required	X1 Instrument Nurse X1 Circulating Nurse X1 Anaesthetic Nurse X 0.5 RN	X1 Nurse to each Unconscious Patient
* In addition to the ratio's staffing will also meet at a minimum the Australian College of Operating Room Nurses (ACORN, 2008) Standards [20]; The Australian and New Zealand College of Anaesthetists (ANZCA, 2006) Standards [21] Recommendations and the Gastroenterological Nurses College of Australia (GENA, 2015) position statement on minimum staffing [22] * Minimum of one A/NUM per shift per day to be rostered.		

ACORN and ANZCA Standards

(Applicable to Operating Rooms, Pre-Admission Areas, Day Surgery Units, Post-Anaesthetic Recovery Rooms)

- No more than 1:4 nurse patient ratio (Day Surgery Unit/Pre Admission Area when included within the peri-operative service)
- 1 anaesthetic nurse per operating room (all locations where anaesthesia and or sedation techniques are performed)
- Minimum 3.5 nurses = 1 anaesthetic nurse + 2 nurses (1 must be RN and 1 whom may be a suitably qualified EN) + 0.5 RN to provide assistance and relief to all nursing staff in operating room
- ACORN Management;

- senior management (ADON) with admin support, NUM per each perioperative service or site, responsible to the service manager (ADON)
- Nurse Managers are required for separate areas of clinical responsibility eg clinical consumable manager and admin support required.

Post anaesthetic recovery room - Stage 1

- Minimum of 2 nurses, 1 must be a competent recovery nurse
- 1:1 nurse patient ratio in Reception phase (initial assessment/unconscious patient/continued airway support/artificial airway support/mechanical ventilation/paediatric patient (regardless of age)
- Minimum 1:2 nurse patient ratio during Stabilisation phase
- Minimum 1:3 nurse patient ratio during Pre-Discharge phase
- 1:1 nurse patient ratio for high acuity cases e.g. ICU/HDU, high spinal block, complex thoracic, abdominal or vascular surgery (Post anaesthetic recovery room - Stage 1)
- 1:1 nurse patient ratio Paediatric Patient (regardless of age) until they meet d/c criteria (Post anaesthetic recovery room - Stage 1)
- 1:1 nurse patient ratio during initial administration of IV opiods/pain protocol and no less than 1:2 thereafter (Post anaesthetic recovery room - Stage 1)

Post anaesthetic recovery room - Stage 2 / Day surgery unit

- Minimum of 2 nurses, 1 must be a competent recovery nurse
- Minimum of 1:4 nurse patient ratio when all patients are stable/for a paediatric patient over 5yrs of age with a family member or caregiver present
- 1 nurse during elective surgery hours - Holding Bay
- 1 nurse during elective surgery hours - Stock Room
- Clinical Nurse Educator
- Nurse Sedationist – where role in place, will be considered as an additional resource

GENA STANDARDS

(Applicable to Endoscopy Units only)

- An experienced Endoscopy Nurse with therapeutic endoscopic skills is required to solely assist the Endoscopist
- If an anaesthetist is not present, a RN trained in acute resuscitative measures shall be responsible for monitoring the patient's level of consciousness cardio-respiratory status and initiating resuscitation if required
- A 3rd nurse for multiple or complex procedures
- Other nursing staff for admission
- Other nursing staff for recovery & discharge
- Other nursing staff/support staff for reprocessing of equipment

2.10 Rehabilitation and Geriatric Evaluation Management

Shift	Rehabilitation	Geriatric Evaluation Management
Early	1:4 (+ In-charge)	1:4 (+ In-charge)
Late	1:4 (+ In-charge)	1:4 (+ In-charge)
Night	1:10 (+ In-charge)	1:10 (+ In-charge)

2.11 Ambulatory Care Unit

Nurse to Chair Ratio	Positions outside ratio
1:5 (+ In-charge)	Patient Liaison Nurse responsible for clinical planning of patient bookings and a liaison for any clinical calls

Oncology Day Unit Ratio *(In the absence of any other model agreed upon by the parties)*

Nurse to Chair Ratio	Positions outside ratio
1:2 (+ In-charge)	Patient Liaison Nurse responsible for clinical planning of patient bookings and a liaison for any clinical calls

2.12 Inpatient Mental Health – Nurse to Patient Ratios

Service/Ward	AM	PM	Night
Acute mental health in general hospitals that are not specialised	1:3 (+ In-charge)	1:3 (+ In-charge)	1:5 (+ In-charge)
Adult in specialised mental health facilities	1:4 (+ In-charge)	1:4 (+ In-charge)	1:7 (+ In-charge)
Acute Mental Health Rehabilitation	1:4 (+ In-charge)	1:4 (+ In-charge)	1:7 (+ In-charge)
Child and Adolescent	1:2 (+In-charge)	1:2 (+In-charge)	1:4 (+In-charge)
Long Term Mental Health Rehabilitation	1:6 (+In-charge)	1:6 (+In-charge)	1:10 (+In-charge)
Older Adult Mental Health	1:3 (+In-charge)	1:3 (+In-charge)	1:5 (+In-charge)
HDU/PICU	1:1 (+In charge)	1:1 (+In charge)	1:1 (+In charge)

2.13 Community Health and Community Mental Health Services Caseloads

Service Type	Caseload Hours
Community Health	No more than 4 hours of face to face client contact time per 8 hour shift

Community Mental Health	No more than 4 hours of face to face client contact time per 8 hour shift
Community Mental Health Acute Assessment Teams	No more than 3.5 hours of face to face client contact time per 8 hour shift

Part E - Safe Staffing Principles

The general duties specified below are applicable to all employees who are covered by the Nurses and Midwives (Tasmanian State Service) Award**.**

1. Duty to prevent sustained unreasonable workload

The employer is to ensure that the work to be performed by an employee:

(a) is of a nature that is reasonably consistent with the performance over the ordinary time hours of a regular periodic roster of duties and tasks within the employee's classification description at the standard required for observance of the Australian Nursing and Midwifery Council (ANMC) Code of Professional Conduct. The ANMC requires that the nursing care provided or about to be provided to a patient client of the respondent employer is to be adequate, appropriate, and will not adversely affect the rights, health or safety of the patient client; and

(b) constitutes a workload at a level that is not unsustainable, manifestly unfair or unreasonable having regard to the skills, experience and classification of the employee.

*****Provided that this clause shall not operate in respect of work that is required to be performed to meet extra-ordinary circumstances of an urgent kind and is not work regularly added to the employee's weekly or daily roster.***

2. Duty to allocate and roster nurses in accordance with process consistent with reasonable workload principles.

(a) The employer shall apply the staffing model described in the Nurse:Patient model in accordance with the entirety of this Appendix.

(b) The parties agree that worksites/practice areas not covered immediately by the Nurse:Patient Ratio Model shall reflect recognised national nursing staffing standards as a minimum.

(c) The parties shall consult and agree on the development and the implementation of the model and the agreed process and ongoing management of the Nurse:Patient Ratio Model. This will include consideration of the adoption of new nurse to patient ratios as they are developed in other States.

(e) The parties agree that the development and implementation of the model shall have regard to the following key principles:

(i) clinical assessment and delivery of patient needs;

(ii) reasonable workloads to enable safety and quality of patient care;

(iii) the demands of the environment such as ward layout;

(iv) statutory obligations including workplace safety and health legislation;

(v) the requirements of nurse regulatory legislation and professional standards.

3. Duty to consult, to communicate, and constructively interact about health service provision to patients.

(a) The Employer, ANMF and HSU shall together constitute and participate in a process for consultation and communication at an Agency level and at service delivery level about overall nursing care requirements as an element in the provision of health services to patients.

(b) Nurse:Patient Ratio Steering Committee

For the purpose of complying at Agency level with the duties in clause 3, the parties shall participate in the Nurse:Patient Ratio Steering Committee. The membership of this committee shall comprise of four Agency nominees, three ANMF and one HSU representatives.

(i) The function of the committee is to oversee the implementation, refinement, development and monitoring of the Nurse:Patient Ratio Model at an Agency level.

(ii) The parties agree to trial other workload tools during the life of this agreement where it is agreed that an alternate workload tool may be more suited to a particular practice area.. The Steering Committee shall agree on the terms of reference dealing with the implementation and evaluation of any agreed trials of alternative workload tools.

(iii) The parties agree that the Steering Committee shall develop agreed business processes, systems and definitions of the model. In development of these matters, the parties agree that consistency in application across the State will occur.

(iv) For the purpose of undertaking its functions the committee shall initially meet monthly and thereafter the frequency shall be determined by the committee. A committee quorum requires equal representation of

management and union representatives and such quorum shall be no less than four (4) members.

(v) The parties agree the Steering Committee shall receive and review reports from the Nurse:Patient Ratio Workload Monitoring Committees on all relevant matters including implementation progress and evaluation of the Nurse:Patient Ratio model every six months, and as required.

(c) Nurse:Patient Ratio Workload Monitoring Committee

(i) To facilitate the implementation and monitoring of the Nurse:Patient Ratio Model a Workload Monitoring Committee (WMC) will be established at each facility and/or sector/area prior to the implementation of the model at the worksite/sector.

(ii) The WMC is to consist of equal union and employer representation with a minimum of four and a maximum of eight members. Where possible, representation on the WMC shall include Nurse Unit Managers (NUM). The parties can co-opt relevant specialised representation as agreed.

(iii) The WMC shall make recommendations within parameters agreed by the Steering Committee to the Chief Executive Officer (CEO) or delegate on the implementation, review and assessment of the application of the model, having regard to the areas where nursing services are provided.

Factors to be considered, but not limited to the following are:

- Nursing workloads generally (including outpatient clinics attached to inpatient wards)
- Admissions, discharges and patient movements generally, including transfers;
- Bed usage and management generally.
- Change to service delivery
- Monitoring of grievances.

(iv) In addition to the data reports agreed by the Nurse:Patient Ratio Steering Committee, the WMC's shall agree on additional relevant data and reporting arrangements to enable appropriate consideration of all matters.

(v) The consultative procedures in relation to the Nurse:Patient Ratio Model shall operate as far as practicable without formality with a view to reaching a consensus about matters to be considered.

(vi) Any unresolved issues arising out of the WMC shall be dealt with under the Grievance Procedure and shall commence at the beginning of Step 2 of those procedures.

(vii) The WMC shall undertake an annual review of the implementation of the model at the end of each financial year as a minimum. This report shall be forwarded to the CEO or delegate and the Nurse:Patient Ratio Steering Committee.

4. Visibility of implementation of Nurse:Patient Ratio Model

The employer shall ensure that the implementation of the Nurse:Patient Ratio Model shall be made clearly visible to nurses at all levels.

Agreed educational resources will be developed by the parties within six months of the date of registration of this Agreement.

Additionally an education program will be delivered by the Employer throughout the life of the agreement.

Part F – Grievance Procedure

Any grievance or dispute relating to nursing and midwifery workloads will be resolved by following the steps set out below. Any nurse/midwife or group of nurses/midwives or a party to the Award may raise a grievance or dispute under this procedure.

The grounds for a grievance shall include but not be limited to:

(a) Unreasonable or excessive patient care or nursing duties is required of a nurse other than occasionally and infrequently;

(b) To perform nursing duty to a professional standard, a nurse is effectively obliged to work unpaid overtime on a regularly recurring basis;

(c) A reasonable complaint about the capacity to observe professional mandatory patient care standards has not been responded to or acted upon within a reasonable time; or

(d) A particular nurse or group of nurses is being consistently placed under an unreasonable or unfair burden or lack of adequate professional guidance because of the workload or the staffing skill mix of the team

(e) The workload requirement effectively denies any reasonable access to professional development.

Work shall continue in accordance with the status quo while any grievance or dispute is being dealt with under this procedure unless interim arrangements are agreed by the parties which shall be implemented immediately. Interim measures shall ensure employee and patient safety throughout the grievance process.

Step 1 – Ward/Unit Level

If a grievance or dispute arises regarding a workload issue (including a Nurse:Patient Ratio issue) it must first be raised by the individual nurse, group of nurses at ward/unit/workplace level or by a party to this Agreement with the Nurse Unit Manager (NUM) or relevant nurse manager for resolution. The NUM (or Nurse Manager) shall consult the Director of Nursing to assist in the resolution of the workload dispute.

The parties shall agree on interim measures to ensure employee and patient safety.

This step shall be concluded within one calendar week from the time it was initially raised. If the grievance remains unresolved, Step 2 commences immediately.

Step 2 – Hospital/Worksite Level

If a grievance or dispute cannot be resolved at Step 1, the matter is to be referred in writing to the Director of Nursing who will convene a Specialist Panel without delay.

The specialist panel will include one each ANMF and HSU nominee and two management nominees (approved by the CEO/ Director of Operational Unit or delegate). The specialist panel will make recommendations, which shall be achieved by consensus. The specialist panel shall make reference to relevant data if available and applicable to the worksite in question. If a consensus is reached then the terms shall be reduced to writing with a copy to each party. If consensus cannot be reached the grievance or dispute remains unresolved.

The Specialist Panel shall make recommendations to the CEO/ Director of Operational Unit (or delegate) for the resolution of the grievance or dispute. Should the CEO/ Director of Operational Unit (or delegate) rejects the recommendations he/she shall advise the Specialist Panel of the reasons.

This step shall be concluded within two calendar weeks from the commencement of Step 2.

Step 3

If the grievance or dispute cannot be resolved at Step 2, either party may refer the matter to the Tasmanian Industrial Commission for its assistance which is to include conciliation and if necessary, arbitration.

Part G – Other Workload Tools

Application of the Model where Nurse:Patient Ratios are not applicable

Where the parties agree the Nurse:Patient Ratio is not applicable to the worksite/service area the process for determination of an appropriate workload tool will be agreed between the parties.

A working party shall be formed to develop an agreed workload tool for application in such areas. The membership of this working party shall comprise four Department nominees, three ANMF and one HSU representatives. The working party has the ability to co-opt members as agreed.

Trial of other workload tools

The parties are agreed to trial other workload tools, by mutual agreement. Furthermore, the Nurse:Patient Ratio Steering Committee shall agree on the Terms of Reference dealing with the implementation and evaluation of any agreed trials.

In the event of the parties not reaching agreement regarding trials of other workload tools the dispute may be raised through the Grievance Procedure commencing at Step 3.

Where the parties agree to trial and implement an alternate workload tool, Parts A, B, D, and E of this document continue to apply.

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