Orders

Case Details

Agreement title	Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2022
Employer	Chief Executive, Attorney-General's Department
Case number	ET-22-05689

Orders - Approval of Enterprise Agreement
Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2022

I HEREBY APPROVE this Enterprise Agreement pursuant to section 79 of the *Fair Work Act 1994*.

This Agreement shall come into force on and from 1 December 2022 and have a nominal life extending until 31 July 2025.

Commissioner Cairney

01 Dec 2022

DOC_BUILDER_ENTERPRISE_AGREEMENTS

NURSING/MIDWIFERY

(SOUTH AUSTRALIAN PUBLIC SECTOR)

ENTERPRISE AGREEMENT 2022

FAIR WORK ACT 1994 (SA)

PART 1 – APPLICATION AND OPERATION OF AGREEMENT

1.1. TITLE

This Agreement is known as the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2022 (the "Agreement").

1.2. ARRANGEMENT

1.3. DEFINITIONS

1.3.1 In this Agreement, unless the contrary intention appears:

"Agency"	means the Department for Health and Wellbeing (inclusive of SA Ambulance) or the Department of Human Services.
"ANMF"	means the Australian Nursing and Midwifery Federation (SA Branch).
"Award"	is the *Nurses (South Australian Public Sector) Award 2002* (created by the Industrial Relations Commission of South Australia, effective from the first full pay period on or after 1 April 2007).
"AIN/M"	means Assistant in Nursing/Midwifery.
"association"	means an association that is registered under the *Fair Work Act 1994* (SA) and is a party to this Agreement. For the purposes of this Agreement association means the ANMF.
"Business Rules"	means the *SA Nursing/Midwifery Enterprise Agreement Staffing Model: Business Rules 2022*.
"Chief Executive"	means the person who is the principal administrative officer within the named agency, or delegate thereof.
"DHS"	means the Department of Human Services.
"DHW"	means the Department for Health and Wellbeing (also known as SA Health).
"employer"	means the applicable employer bound by this Agreement, or delegate thereof.
"employee"	means an employee bound by this Agreement.
"EN"	means Enrolled Nurse.
"Health unit"	means SA Ambulance Service, a hospital and/or a health service incorporated pursuant to the *Health Care Act 2008* (the "Act").
"Health Unit Site"	means a site at which the activities of an incorporated hospital or SA Ambulance Service are undertaken.
"HR Manual"	means the applicable employer human resources manual (i.e. SA Health (Health Care Act) Human Resources Manual or DHS HR Manual).
"Inpatient unit"	means a unit, the purpose and function of which is to provide services to a patient or client following that person's admission to a health unit.
"LHN"	means the hospitals incorporated under the *Health Care Act 2008 (SA)* namely: Northern Adelaide Local Health Network (NALHN); Central Adelaide Local Health Network (CALHN); Southern Adelaide Local Health Network (SALHN); Women's and Children's Health Network (WCHN); Barossa Hills Fleurieu Local Health Network (BHFLHN); Eyre and Far North Local Health Network (EFNLHN); Flinders and Upper North Local Health Network (FUNLHN); Limestone Coast Local Health Network (LCLHN); Riverland Mallee Coorong Local Health Network (RMCLHN); Yorke and Northern Local Health Network (YNLHN).

"MedSTAR"	means an employee of SA Ambulance Service who is bound by this Agreement.
"NMBA"	means the Nursing and Midwifery Board of Australia.
"N/MHPPD"	means Nursing or Midwifery Hours Per Patient Day.
"Parties"	means the persons, entities and associations referred to in clause 1.4.
"Patient care area"	means ward/s, patient service unit/s, clinical unit/s or team/s (including nursing/midwifery staff) providing direct care to patients/clients.
"RN"	means Registered Nurse.
"RN (Mental Health)"	means in a mental health patient care area including a service, ward, patient service unit/s, clinical unit/s or team, RN means a Registered Nurse who is either enrolled in an approved Mental Health course or who holds qualifications in mental health practice.
"RM"	means Registered Midwife.
"SAET"	means South Australian Employment Tribunal.
This "Agreement"	means the *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement* 2022.

1.4. SCOPE & PARTIES BOUND BY THE AGREEMENT

1.4.1 This Agreement is binding upon the Chief Executive, Attorney-General's Department, the Chief Executive, Department for Health and Wellbeing, the Chief Executive, Department of Human Services (the employers); and

1.4.2 Employees who are Registered or Enrolled Nurses, Midwives and RN (Mental Health) (however titled) who are registered or enrolled (or otherwise listed) pursuant to the *Health Practitioner Regulation National Law (South Australia) Act 2010* (or successor legislation) and Assistants in Nursing/Midwifery.

1.4.3 This Agreement is binding on the Australian Nursing and Midwifery Federation (SA Branch). For the purposes of this Agreement the Enterprise is defined as the DHW; DHS; SA Ambulance Service and hospitals and health units incorporated pursuant to the *Health Care Act 2008* (SA).

1.5. DATE & TERM

1.5.1 This Agreement will come into effect from 1 October 2022 with a nominal expiry date of 31 July 2025.

1.6. RENEGOTIATION

1.6.1 The parties to this Agreement agree that negotiations in respect of a new Agreement will commence no earlier than 2 April 2025.

1.7. RELATIONSHIP TO THE AWARD

1.7.1 This Agreement is to be read and interpreted wholly in conjunction with the *Nurses (South Australian Public Sector) Award 2002* (the Award) or any successor thereto; provided that where there is inconsistency between this Agreement and the Award this Agreement takes precedence to the extent of that inconsistency.

1.7.2 This Agreement replaces and supersedes the *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2020.*

1.8. PURPOSE

1.8.1 This Agreement reaffirms the parties' commitment to the achievement of best practice and continuous improvement. The Agreement also provides for salary increases that recognise:

1.8.1.1 the contribution that nursing/midwifery employees are making to improvements in productivity and efficiency in the South Australian public health sector during the life of this Agreement;

1.8.1.2 the need to attract and retain qualified nursing and midwifery staff in the public sector; and

1.8.1.3 all changes in work value up to and including 1 October 2022.

1.9. PRINCIPAL UNDERTAKINGS

1.9.1 The parties bound by this Agreement are committed to the health reform agenda based on improving efficiency and effectiveness in the provision of health services in this State in order that the best possible health outcomes are achieved for the people of South Australia.

1.9.2 The parties bound by the Agreement agree to a continuing partnership where there is active engagement over clinical change and workforce reform initiatives designed to achieve improvements in the performance of the health system. ANMF and DHW will work in a continued partnership to reduce the average length of stay in health units wherever clinically appropriate and possible and will continue to be pro-active in engaging with reform initiatives that deliver an efficient and effective health system that maintains patient safety and care.

1.9.3 The parties in noting the relationship of these matters to efficiency and effectiveness agree to continue to work with the ANMF to implement measures that are directed towards ensuring that nurses and midwives are enabled to practice to their full scope of practice.

1.9.4 The parties bound by this Agreement are also committed to the identification and implementation of initiatives to improve standards of care, productivity and efficiency at the clinical and health unit level and recognise that nurses and midwives play an important role in the coordination and management of the patient experience.

1.9.5 In making this Agreement and in the course of its operation, the parties are expressly committed to existing terms and conditions of employment not being reduced.

1.9.6 The parties recognise that permanent part or full time employment is the preferred form of engagement for employees covered by this Agreement and that all reasonable measures will be taken to minimise the use of casual and/or temporary contracts.

1.10. AIMS & OBJECTIVES

1.10.1 The aims and objectives of this Agreement are to:

1.10.1.1 improve the structure, productivity, efficiency and effectiveness of the South Australian public health sector through the introduction of initiatives at the enterprise or health unit level;

1.10.1.2 attract nurses/midwives to, and retain nurses/midwives in, permanent full time or part time employment in the South Australian public health sector and to reduce reliance on temporary contracts and/or casual and/or agency staff to meet ongoing and planned workforce requirements;

(i) Without limiting the generality of this commitment, the employers bound by this Agreement will work to ensure that employees are offered permanent arrangements that will allow them to meet both their work and family commitments through effective promotion and implementation of flexible work arrangements.

1.10.1.3 provide for continuous workplace transformation with the objective of continuous service improvement;

1.10.1.4 improve the delivery of care and services to patients;

1.10.1.5 continue to implement initiatives that support appropriate workforce flexibility, mobility, development and performance;

1.10.1.6 facilitate flexible working hours to enable employees to balance their work and other responsibilities whilst at the same time enabling health units to meet the demands on their services;

1.10.1.7 provide for an effective system for safe inpatient unit nursing/midwifery staffing levels and skill mix within the South Australian public health system;

1.10.1.8 ensure an ongoing stable industrial relations framework at the health unit level that assists health units to improve efficiency and business performance; and

1.10.1.9 ensure ongoing cooperation between the parties to achieve improvements in work health and safety performance.

1.11. NO EXTRA CLAIMS

1.11.1 This Agreement and its salary schedules will be taken to have satisfied and discharged all claims of any description (whether as to monies or conditions).

1.11.2 The rates of pay provided for in this Agreement are inclusive of all previously awarded safety net adjustments and all future increases during the term of this Agreement, arising out of State Wage Case decisions, including safety net adjustments, living wage adjustments or general increases, howsoever described.

1.11.3 Subject to this clause, the employees, the ANMF and employer parties undertake not to pursue any further or other claims within the parameters of this Agreement, except where consistent with State Wage Case principles.

1.11.4 The provisions of this clause do not preclude an application being made to the SAET to vary the Agreement for the specified clauses below:

1.11.4.1 Clause 3.1.4 to give effect to variations to Appendix 2 staffing agreed between DHW and ANMF; and

1.11.4.2 A proposal or request for or to make a Workplace Flexibility Agreement will not be considered as a claim or extra claim, provided that in no circumstances whatsoever will there be any actual or threatened industrial action, nor threatened or actual cessation or limitation of duties or service delivery in relation thereto.

1.11.4.3 Variations will be made to this agreement in order to implement the outcomes of specific reviews that have been undertaken by the parties. The extent of those variations will be limited to the matters specified in clauses 3.4.5, 3.10.1, 3.11.1, 4.2.2, 4.7.2, 8.1.5 and 9.2.4.3. Each clause sets out the timeframe for the relevant review to be conducted and its outcomes implemented.

1.11.5 To give effect to an agreed matter, the variation will be taken to have been agreed by the parties if the applicable employer to this Agreement and ANMF agree to the variation.

1.12. NOT TO BE USED AS A PRECEDENT

1.12.1 This Agreement is not to be used as a precedent in any manner whatsoever to obtain similar arrangements or benefits elsewhere in the South Australian public sector.

PART 2 – CONSULTATION AND DISPUTE RESOLUTION

2.1 CONSULTATION

2.1.1 It is an accepted principle that effective workplace relationships can only be achieved if appropriate consultation between the industrial parties occurs on a regular basis.

2.1.2 In particular, where nursing/midwifery staff are affected, the parties are to consult in relation to any planned initiatives and strategies that are designed to achieve the objectives of the Principal Undertakings (clause 1.9).

2.1.3 The following consultation principles are applicable:

2.1.3.1 Consultation involves the sharing of information and the exchange of views between employers and the persons or bodies that must be consulted and the genuine opportunity for them to contribute to any decision-making process;

2.1.3.2 Consultation is the process by which management and employees or their representatives jointly examine and discuss issues of mutual concern. It involves managers actively seeking and then taking account of the views of employees, either directly or through their representatives, before making a decision. Meaningful consultation depends on those being consulted having adequate information and time to consider it. It is important to remember that merely providing information does not constitute consultation;

2.1.3.3 Employers must consult in good faith;

2.1.3.4 Workplace change that affects a significant number of nursing/midwifery employees should not be implemented before appropriate consultation has occurred with ANMF representatives;

2.1.3.5 ANMF representatives are to be given the opportunity to adequately consult with the people they represent in the workplace, in relation to any proposed changes that may affect employees' working conditions or the services employees provide;

2.1.3.6 The parties agree that consultation should be directed towards, but may not in all cases result in agreement over the matters under discussion/the proposed change. In such circumstances it is acknowledged that the ANMF may, where industrial matters are in dispute, seek external review of the decision by the SAET; and

2.1.3.7 It is also acknowledged by the ANMF that management may elect to proceed with implementation of measures which are not agreed following an appropriate period and form of consultation. Subject to industrial matters that are referred to the SAET the ANMF will not persist with industrial action in relation to clinical or professional matters in such situations.

2.2 GRIEVANCE & DISPUTE SETTLEMENT PROCEDURE

Any grievance, industrial dispute or matter likely to create a dispute is to be dealt with in accordance with the manner set out hereunder:

2.2.1 The parties to the Agreement are obliged to make every endeavour to facilitate the effective functioning of these procedures.

2.2.2 The parties or their representative(s) will make themselves available for consultation as required under these procedures.

2.2.3 The employee or employee representative should discuss any matter affecting an employee with the current manager of the patient care area in which the grievance, dispute or likely dispute exists.

2.2.4 If the matter is not resolved at this level, the employee or employee representative should ask for it to be referred to an appropriate manager who will arrange a conference to discuss the matter.

2.2.5 The consultation process as described in 2.2.4 will be commenced within 24 hours of the grievance, dispute or likely dispute having been indicated, or within such longer or shorter time as may be agreed by the parties.

2.2.6 If a matter cannot be resolved using the above procedures, the parties should enter into consultation at a higher level on both sides, as the parties consider appropriate. At this level of consultation officers of the

DHW or DHS, and Industrial Relations and Policy, Attorney-General's Department, as appropriate, may be involved.

2.2.7 At any stage in the procedures after consultation between the parties has taken place in accordance with the procedure, either party may request and be entitled to receive a response to its representations within a reasonable time as may be agreed upon by the parties.

2.2.8 If the grievance, dispute or likely dispute is not resolved in accordance with these procedures either party may refer the matter to the SAET for conciliation or in the event that conciliation fails to fully resolve the matter for determination, the SAET may then:

(i) Arbitrate the dispute; and
(ii) Make a determination that is binding on the parties to the dispute.
Note: If the SAET arbitrates a dispute, it may also use the powers that are available to it under the *Fair Work Act 1994* (SA).

A decision that the SAET makes when arbitrating a dispute is agreed by the parties as being appealable.

2.2.9 Without prejudice to either party, and except where a bona fide health and safety issue is involved, work should continue on a status quo basis while the matters in dispute are being dealt with in accordance with these procedures. On a status quo basis will mean the work situation in place at the time the matter was first raised in accordance with these procedures.

2.2.10 If there is undue delay on the part of any party in responding to the matter creating a grievance, dispute or likely dispute, the party complaining of the delay may take the matter to another level of the procedure if the party believes it is desirable to do so.

2.2.11 In the event of a party failing to observe these procedures the other party may take such steps as determined necessary to resolve the matter.

2.2.12 These procedures will not restrict the health unit or its representatives or its employees or representatives, which may be a duly authorised official of the ANMF, making representations to each other.

ENFORCEMENT

2.2.13 If the ANMF reasonably believes that in respect of its members there is a purported breach or non-compliance with this Agreement as approved in relation to or arising from:

(i) an express basis on which this Agreement is made; or
(ii) a parliamentary process that reduces or removes an employment benefit; or
(iii) an existing condition; or
(iv) a condition prescribed in this Agreement,

the ANMF may, without otherwise limiting its rights, seek redress to the SAET in relation thereto.

2.3 WORKPLACE FLEXIBILITY

2.3.1 The parties agree that an Agency may negotiate and reach agreement at a workplace level with employees within that workplace (including an individual employee), on more flexible employment arrangements that will better meet the operational needs of the workplace having regard to the needs of employees (including taking into account employees' family and other non-work responsibilities).

2.3.2 This clause applies to a proposal by an Agency or employee/s within a workplace to negotiate and agree flexible employment arrangements to operate within a workplace (a "Workplace Flexibility Proposal").

2.3.3 Where an Agency or employee/s intends to initiate a Workplace Flexibility Proposal, the initiator will notify the Agency or employee/s (as applicable) within the workplace likely to be affected, of the terms of the proposal and the manner in which it is intended to operate. The Agency will provide such information to the ANMF and will consult with the ANMF and affected employee/s in accordance with the consultative principles in this Agreement.

2.3.4 Consultation in respect of a Workplace Flexibility Proposal will have regard to operational efficiency and productivity work and non-work impacts on individual affected employees and whether the Proposal has policy implications across Agencies in the public sector. Where such policy implications arise, the affected employee/s, or ANMF, or the Agency may refer the Proposal to the Chief Executive DHW or DHS (as appropriate) for consultation with those employee/s and with the ANMF, and wider consultation as appropriate.

2.3.5 A Workplace Flexibility Proposal may not be put to a vote by affected employees where it proposes employment arrangements that are less favourable (considered as a whole) than arrangements applying pursuant to this Agreement (including a relevant Award) provided that this requirement will be deemed to be met where the relevant Agency and the ANMF has agreed that this requirement has been met.

2.3.6 Where a majority of affected employees agree (whether by ballot or otherwise) to a Workplace Flexibility Proposal, the employment arrangements agreed will be provided in writing and will apply as if incorporated as an appendix to this Agreement (a "Workplace Flexibility Agreement").

2.3.7 A party may apply to vary this Agreement to add any Workplace Flexibility Agreement as an appendix to remove any uncertainty in the operation of this clause in giving effect to any Workplace Flexibility Agreement. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4) and will operate only in respect of the Agency and workplace specified within the Workplace Flexibility Agreement.

PART 3 – STAFFING AND WORKLOADS

3.1 SAFE STAFFING LEVELS

3.1.1 Health unit sites are to staff to meet patient/client demand according to the relevant indicators in the remainder of this clause and appendices 1 – 5.

3.1.2 As a minimum, staffing levels must be in accordance with the provisions of this clause and read in conjunction with the provisions of Appendix 1, Appendix 2, Appendix 3, Appendix 4 and Appendix 5. These appendices set out the details of minimum staffing arrangements for each relevant patient care area. These appendices (excluding Appendix 5) will apply unless further agreement is reached to vary them using the processes established by the Business Rules (refer to Appendix 13).

3.1.3 Health unit sites other than those listed at Appendix 2 are agreed as being minimum staffed health units; that is sites for which staffing levels and mix are unchanging from day to day or by time of the day. In these sites, a minimum of 1 registered nurse/midwife and 1 other nurse/midwife must be on duty at all times. These staff are in addition to the DON/M and the N/NUM roles.

3.1.4 DHW and ANMF have developed Business Rules that support the operation and review of this clause in all relevant patient care areas. The Nursing/Midwifery Hours per Patient Day (N/MHPPD) agreed staff ratios and staff plans as provided in Appendices 2 and 3 will only be amended by agreement of the parties, provided that the business rules are consistent with the provisions of this Agreement. Business Rules review after the commencement of this agreement will only be conducted if a party bound by the agreement can establish a prima facie case for material change. Material change means that staffing levels and/or mix are no longer safe nor appropriate for the type of patient care area to the extent that significant adjustment, by the addition or removal of at least one whole shift, is necessary.

3.1.5 Where the patient care area changes in its clinical/functional/service purpose or location, the parties are required to discuss the need for a Business Rules review. Such reviews will, after 1 January 2023, only take place where either or both parties can establish a prima facie case for material change, as defined in 3.1.4, to staffing arrangements. A mere change in function or location alone will not of itself necessitate a review. Rather the change must require adjustment to staffing levels and/or mix to ensure that they are both safe and appropriate to the new purpose. Where agreement is not reached, over the need for Business Rules reviews or where the review fails to produce an agreed outcome, the parties will have access to the dispute settlement procedures to resolve any disputes.

3.1.6 In patient care areas for which a ratio has been nominated as the measure for minimum staffing, the patient care area must maintain staffing to ensure the ratios are achieved for the period for which staffing is to be determined, rostered and allocated.

3.1.7 For all metropolitan health unit sites and Mt Gambier, Pt Augusta, Pt Pirie and Whyalla Hospitals the period within which the hours must be balanced is 14 days.

3.1.7.1 From 1 November 2023, the period within which the hours must be balanced is 7 days.

3.1.8 For all other regional units sites the period within which the hours must be balanced is 28 days.

3.1.8.1 From 1 March 2023, the period within which the hours must be balanced is 14 days.

3.1.8.2 From 1 November 2023, the period within which the hours must be balanced is 7 days.

3.1.9 The parties may enter into a further agreement to move to a shorter period for the balancing of hours (to a daily or shift basis).

3.1.10 In balancing hours within the relevant period, the health unit site must ensure that, as a minimum, all of the hours available for direct patient care are rostered and worked within the period at an individual ward/unit level. In producing rosters for the relevant period the health site will include all direct patient care, project and other indirect hours.

3.1.11 The N/MUM (or equivalent) will, in consultation with their staff, allocate the direct care nursing/midwifery hours available for staffing across the relevant period in which they are to be balanced with due regard to

expected care needs of patients/clients and the workload pattern of their patient care area.

3.1.12 The N/MUM (or equivalent) will ensure that, at the commencement of every shift, the occupancy and staffing information is displayed for staff within the patient care area:

(i) Occupancy (number of beds that are occupied);
(ii) Number of nursing/midwifery staff required to meet patient/client needs; and
(iii) Agreed N/MHPPD averaged occupancy and indicative staff plan balanced over 14 days or 28 days (refer 3.1.7 and 3.1.8).

3.1.13 When, on a shift, the N/MUM (or equivalent) considers that patient care needs cannot be sufficiently met from the nurses/midwives immediately available and that additional hours should be provided in order to meet patient/client demand, the N/MUM (or equivalent) will consider solutions consistent with the business rules but which include options for action such as:

(i) deployment of nurses/midwives from/to other wards/units;
(ii) additional hours for part time staff;
(iii) engagement of casual/agency nursing/midwifery staff;
(iv) overtime;
(v) prioritisation of nursing/midwifery activities on the ward/unit;
(vi) reallocation of patients.

3.1.14 Where sufficient nursing/midwifery staff are not available, the N/MUM (or equivalent) may, with approval from the Director of Nursing and Midwifery (or delegate) limit admissions when discharges occur from the patient care area. Such approval will not unreasonably be withheld.

3.1.15 The Chief Executive, Department for Health and Wellbeing is committed to making all reasonable efforts to engage additional Regional Nurse Educators (up to 16 FTE) across regional Local Health Networks. The Chief Executive will consult with the ANMF to develop a plan and timeframe for the recruitment to these positions by 30 June 2023.

3.2 SKILLS MIX PROVISIONS

3.2.1 In health unit sites (other than regional unit sites) the skill mix for inpatient units is 70:30 registered nurses/midwives to enrolled nurses/assistant in nursing/midwifery. DHW or ANMF may seek to have the skill mix in a health unit site or part thereof adjusted should any role, service requirement or change in service volume occur in such health unit site or part thereof.

3.2.2 In regional unit sites the skill mix is maintained at the level set out in Appendix 4 (with a positive/negative tolerance factor of 5%) averaged over a 12 month period. DHW or ANMF may seek to have the skill mix in a regional unit site or part thereof adjusted should any role, service requirement or change in service volume occur at that regional unit site or part thereof.

3.2.3 Graduate nurses/midwives are to be included in the RN/M ratio but are not, unless otherwise agreed between the parties, to be rostered as the only registered nurse/midwife in a health unit site or patient care area in the first 6 months of employment.

3.2.4 DHW and the ANMF will agree on the terms for a research project to be conducted during the life of this Agreement to explore the effect of different skills mixes (of RNs, RMs, ENs and AINs) on patient outcomes, costs and staff experience in similar patient care areas.

3.3 STAFFING: DEPARTMENT OF HUMAN SERVICES

3.3.1 Staffing applicable to DHS is set out in Appendix 5. As a minimum, staffing levels must be in accordance with Appendix 5.

3.4 ROSTERING ARRANGEMENTS

3.4.1 Rostering is by a 7 day roster, other than for Monday to Friday workers, except where service delivery does not extend over 7 days of the week.

3.4.2 Notwithstanding 3.4.1 above, an employee may request a fixed day(s) off. An employee cannot be required

to nominate a fixed day off at the instigation of the employer.

3.4.3 Within six (6) weeks of approval of this agreement, a public sector agency in which the employee is engaged at the time will not contact an employee for any purpose on two (2) rostered days off per fortnight without the express consent of the employee or except where required by law. This clause is to be read in conjunction with clauses 5.1.6 – 5.1.12 of the Award.

3.4.4 Within three (3) months of approval of this agreement, where an employee is absent from duty on a rostered shift on unplanned leave, a replacement employee will, wherever practicable and in accordance with clause 3.1.13, be engaged for the entirety of the rostered shift.

3.4.5 Every employee who is not a casual employee may be required to participate in an on-call roster within reasonable limits. The on-call roster shall not be used as a means to staff services that are reasonably predictable and/or regularly provided at the time and day on which they arise. The use of on call rostering arrangements for these purposes will be reviewed within three (3) months of approval of this agreement. A party may apply to vary this Agreement to amend this clause. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

3.5 STANDARD 10 HOUR NIGHT SHIFTS

3.5.1 The night shift standard length is 10 hours subject to the following:

3.5.1.1 Night shift lengths of less than the 10 hour standard may be agreed by a majority of nursing/midwifery employees in any particular patient care area following a ballot of such employees.

3.5.1.2 If, due to staff changes or if the majority of nursing/midwifery employees subsequently wish to revert to the 10 hour standard, the roster will revert to include the 10 hour night shift within the ensuing 12 week period.

3.5.1.3 The ability of any patient care area to implement the standard 10 hour night shift will depend upon sufficient staffing numbers (with appropriate skill mix) being available at that patient care area to be able to maintain such standard shift arrangement without incurring overtime or using casual/"agency" staff (other than normal overtime or incidental use of casual/agency staff to cover absences on leave, etc.). However once introduced, the 10 hour night duty will be maintained, subject to the provisions of clause 3.5.1.1 above.

3.5.1.4 Some of the additional shift "overlap" time created by the introduction of 10 hour night shifts is to be used for professional development purposes. Over the course of any 12 month period the "overlap" time spent on professional development activity must equate to a minimum of 1 day per nurse/midwife on average.

3.5.1.5 For those nursing/midwifery employees working shifts of greater than 10 hours, nothing in this Agreement requires the reduction of such shifts, and that any changes to these shifts would require consultation at the local level with affected nursing/midwifery staff and their ANMF representatives.

3.5.1.6 Shift lengths of greater than 10 hours may continue to be introduced in accordance with clause 5.1 of the Award.

3.5.2 Ordinary hours of duty are defined as 152 within a cycle not exceeding 28 days.

3.6 CASUAL EMPLOYEES

3.6.1 A casual employee is engaged for a minimum of 3 hours.

3.6.2 Casuals will be paid a minimum period of engagement (3 hours), at the applicable rate, where a shift for which they were rostered is cancelled within 12 hours of commencement of the rostered shift.

3.6.3 Following assessment, casuals who have been engaged to work on a pattern of hours that are regular are to be converted to permanent employment status. Regular hours for casuals means employees who work some of their hours in a predictable fashion and those hours are rostered on an ongoing basis. In addition such employees may work extra hours that meet the unplanned or irregular needs of the health unit from time to time.

3.6.4 Assessment of substantive FTE for casuals under the preceding clause is based on consideration of those

hours worked in a predictable manner and those hours rostered on an ongoing basis.

3.6.5 Casual employees who are unable to accept offers of employment due to the birth of a child (as long as the break between engagements does not exceed 12 months) maintain continuity of service for the purposes of long service leave only. Such breaks between engagements are not counted for the purposes of calculating the entitlement for long service leave.

3.6.6 The provisions of this clause must be read in conjunction with clause 1.10.1.

3.6.7 The use of casual (or permanent) staff employed by a health unit is preferable to the utilisation of casual staff accessed through or employed by a labour hire agency.

3.7 PART TIME EMPLOYEES – MINIMUM SHIFT LENGTH

3.7.1 The minimum shift length for a part time employee is 3 hours.

3.8 PERFORMANCE REVIEW AND DEVELOPMENT

3.8.1 Performance review and development of employees will be developed/maintained for all nursing/midwifery staff during the life of this Agreement.

3.8.2 Employers must consult with employees and the ANMF over the model of performance review and development process to be adopted within the service and which must be directed towards fair and reasonable assessment of the employee's strengths in performance as well as identifying areas for development. An employer must provide opportunities and resources to meet the development needs of employees identified through the performance development processes.

3.8.3 Performance review and development processes must not be intertwined with disciplinary processes at any time. Where performance issues have been unable to be resolved through normal performance development processes, a disciplinary process should be commenced in place of the performance development process.

3.9 MIDWIFERY CASELOAD PRACTICE AGREEMENT

3.9.1 The Midwifery Caseload Practice Agreement is set out in Appendix 8. The provisions of this Appendix may be extended to other health unit sites not currently using the model following agreement with the respective LHN the affected employees and the ANMF. Provisions within Appendix 8 may be varied by mutual agreement of the respective LHN and the ANMF.

3.10 COMMUNITY MENTAL HEALTH STAFFING

3.10.1 Staffing levels and mix in adult community health teams in the Central Adelaide Local Health Network (CALHN) and Northern Adelaide Local Health Networks (NALHN) will be updated and made equitable with the staffing to consumer care needs methodology developed for the Southern Adelaide Local Health Network (SALHN) Community Mental Health. By 31 March 2023, a review will be completed to adapt the methodology for each team in the Local Health Networks. Those staffing details will come into effect at the time the parties reach agreement but by no later than 30 April 2023 and will be incorporated by consent into Appendix 2 by subsequent variation. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

3.11 RESUSCITATION TEAMS

3.11.1 Emergency Department staffing in areas that have dedicated resuscitation teams will be updated to reflect the utilisation of resuscitation rooms for the purposes of resuscitation activity. By the 30 June 2023, a review will be completed to inform the rostering and staffing requirements of resuscitations teams based on historical and projected resuscitation activity. This review will analyse the number of resuscitation rooms within each relevant Emergency Department and the level of utilisation of those rooms for resuscitation purposes. The staffing details will come into effect at the time the parties reach agreement but by no later than 31 July 2023 and will be incorporated by consent into Appendix 1 by subsequent variation. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

PART 4 – CAREER STRUCTURE

4.1 CAREER STRUCTURE

4.1.1 The career structure / classification descriptors are detailed in Appendix 7.

4.2 INCREMENTAL PROGRESSION

4.2.1 Nursing/midwifery employees will be entitled to progress to the next increment higher than their previous increment on their next annual anniversary date (or after completion of 1610 hours for casual/part time employees within the public sector but no earlier than 12 months) in accordance with existing incremental progression dates.

4.2.2 Within six (6) months of the date of approval of the agreement, a review will be undertaken to determine whether relevant private sector experience should be included in the 1610 hours (as referred to in 4.3.1). A party may apply to vary this Agreement to amend this clause. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

4.3 ENROLLED NURSE (CERTIFICATE) WITH NMBA NOTATION – NOT AUTHORISED IN MEDICATION ADMINISTRATION

4.3.1 The application of this classification is for ENs (Certificate) who have a NMBA registration notation and have not successfully completed the relevant medication administration education at some stage in their career and therefore, cannot administer medicines.

4.4 ENROLLED NURSE (CERTIFICATE WITHOUT NMBA NOTATION) OR ENROLLED NURSE (DIPLOMA) – TRANSLATION PROCESS USED IN 2016

4.4.1 It is noted that employees classified as EN (Certificate), who do not have a notation on their registration and have successfully completed the relevant medication administration education at some stage in their career and therefore are able to undertake medication administration, translated to the Enrolled Nurse (Diploma) salary scale from the first full pay period on or after 1 October 2016.

4.5 REGISTERED NURSE/MIDWIFE LEVEL 2 (RN/M2)

4.5.1 Registered Nurses/Midwives Level 2 with portfolio responsibilities will be supported through the provision of portfolio management time. This is calculated for specific portfolio areas and responsibilities within a patient care area and is not based on a time allocation for each Level 2 position. The allocation will be in line with the 'Guiding Principles for Portfolio Management – Nurse/Midwife (Level 2) Classification' (reference: SA Health, Version 2, July 2016) which notes the agreed methodology used to calculate the FTE requirement for portfolio management based on 1 FTE per 150 nursing/midwifery staff (FTE).

4.6 REGISTERED NURSE/MIDWIFE LEVEL 3 (RN/M3) AND LEVEL 4 (RN/M4) (INCLUDING NURSE PRACTITIONER)

4.6.1 Full-time Level 3s and Level 4s (RN/M 3/4) will, unless otherwise agreed between the employee and their manager, be entitled to one programmed day off ('PDO') per 28 day cycle, on the basis that the PDO will not be backfilled. Where a RN/M 3/4 is required by the RN/M 5/6 to work rostered shiftwork, the appropriate shift penalties as prescribed in clause 5.3 of the Award are payable.

4.6.2 In circumstances where an RN/M 3/4 is required by the RN/M 5/6 and is recorded to be on-call, the RN/M 3/4 will receive the appropriate on-call allowance in accordance with clause 9.5 of this Agreement.

4.6.3 An RN/M 3/4 who is approved to be rostered on-call and is subsequently recalled to work, will be entitled to recall payments at overtime rates as prescribed in clause 5.4.5 of the Award.

4.6.4 Where a RN/M 3/4 is required by the RN/M 5/6 to work overtime to support direct clinical care or activities, the appropriate penalties as prescribed in clause 5.4.3 of the Award are payable.

4.6.5 Registered Nurse/Midwife Unit Managers (Level 3 or 4)

(i) Who provide pivotal coordination of patient/client care delivery in a defined patient care area; and
(ii) Whose main focus is the line management, coordination and leadership of nursing/midwifery activities to achieve continuity and quality of patient/client care; and
(iii) Who are accountable for the outcomes of nursing/midwifery practice in the specific practice setting;

Are to be provided with 5 days per week during which time they will not be counted towards meeting patient/client demand for staffing related purposes. N/MUMs may allocate a component of this time to the Associate N/MUM.

4.7 REGISTERED NURSE/MIDWIFE LEVEL 5 (RN/M5) AND LEVEL 6 (RN/M6)

4.7.1 Employees classified at this level have no fixed hours of duty in accordance with clauses 4.4.1, 5.1, 5.3 and 5.4.2 of the Award. Notwithstanding this, employees classified at this level are not expected to work excessive hours. Chief Executives or delegates are required to ensure that the hours worked are reasonable in order to provide sufficient time free from all duty and that time off at the reasonable convenience of both the employee and health units is made available when excessive hours have been worked.

4.7.2 For the avoidance of doubt, no fixed hours means that employees at these levels will continue to work the equivalent of full time hours but they shall be flexibly worked to meet the needs of the health care agency and the employees concerned. Chief Executive Officers or their delegates are required to ensure that the hours worked are reasonable and provide sufficient time free of all duty (as distinct from active work). By 31 March 2023, a review will be completed with respect to this provision, to ensure that employees are not working excessive hours. A party may apply to vary this Agreement to amend this clause. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

4.7.3 The Chief Executive or delegate will consult with the ANMF in relation to any identified Level 5 RN/M or Level 6 RN/M position that the Chief Executive or delegate considers provides levels of leadership, expertise, judgement and accountability congruent with the Executive stream.

4.7.4 The Level 6 RN/M work level descriptors contained in Appendix 7 may be varied by agreement between the parties where there is a need to ensure the descriptors adequately reflect any new organisational structure. Should new organisational structure or work arrangement require employees at these levels to require work arrangements outside of normal business hours, consultation in accordance with clause 2.1 will occur.

PART 5 – PROFESSIONAL DEVELOPMENT

5.1 PROFESSIONAL DEVELOPMENT

5.1.1 Nurses and midwives will have access to the following professional development:

(i) An average of 3 days professional development leave per annum (pro rata for part-time employees, and excluding casuals). Up to 1 day of this leave will be undertaken during the shift "overlap" time made available as a result of the standard 10 hour night shift referred to in clause 3.5.1 where that shift length is worked;

(ii) Staff development, conference leave and study assistance provisions as provided by the HR Manual;

(iii) Emergency Nursing and Midwifery Education courses (ENAME) for regional nurses and midwives;

(iv) Teaching Hospital approved courses;

(v) Transition to Professional Practice.

5.1.2 Skills maintenance/training will be provided by the employer in addition to the 3 days and will include the following training:

(i) Fire safety

(ii) Manual handling

(iii) Hand hygiene

(iv) Basic Life Support (CPR)

(v) Aggression Management (where relevant and required in specific health settings)

(vi) Drug calculations

(vii) Child protection

(viii) Implementation or maintenance of clinical systems

(ix) Administration and/or record keeping

(x) Advanced Life Support (where relevant and required in specific health settings).

5.2 PROFESSIONAL DEVELOPMENT ALLOWANCE

5.2.1 Nurses and midwives will receive a Professional Development Allowance ('PD Allowance') subject to the following eligibility criteria and conditions:

a) The PD Allowance will apply on a pro rata basis for part-time employees.

b) The PD Allowance will not apply to the following employees:

- casual employees;
- classified as an AIN/M, on the basis that they are a student in a course that will lead to registration or enrolment as a nurse/midwife;
- Nurses/Midwives for the period they are undertaking the 12 month Transition to Professional Practice Program.

5.2.2 The PD allowance will increase from the current $1,200 per annum

(i) in accordance with salary increases and the operative dates of those salary increases; and

(ii) by $400 from the ffpp on or after 1 July in each of 2023, 2024 and 2025.

1 January 2023 (3%pa)	1 July 2023 ($400)	1 January 2024 (3%pa)	1 July 2024 ($400)	1 January 2025 (3%pa)	1 July 2025 ($400)
$1,236	$1,636	$1,685.10	$2,085.10	$2,147.70	$2,547.70

5.2.3 The PD Allowance will be paid into salary on a fortnightly basis including during periods of paid leave. It will not apply for any other purposes of the Agreement or the Award, such as overtime or recall, shift penalties and other allowances.

5.2.4 The PD Allowance is provided on the basis that it will be used by Nurses/Midwives to contribute to the obligations as required for Australian Health Practitioner Regulation Agency / Nursing and Midwifery Board of Australia registration under the National Registration and Accreditation Scheme, to demonstrate that they have completed the required hours of professional development.

PART 6 – SALARIES AND RELATED ARRANGEMENTS

6.1 SALARIES

6.1.1 The salary increases prescribed hereunder apply to all classifications from the dates indicated and subsume any subsequent adjustments arising from Safety Net Reviews awarded by the SAET during the life of the Agreement.

6.1.2 The salary increases recognise the need to attract and retain qualified nursing and midwifery staff in the public health system and take into account all work practice changes and improved efficiency initiatives implemented prior to the date of operation of this agreement as well as the ongoing implementation of productivity/efficiency measures during the life of this Agreement.

Note: The ANMF and the declared employer reserve their respective positions in respect of future enterprise bargaining as it relates to efficiency matters that may be proposed or may be implemented during the life of this Agreement.

6.1.3 Salary schedules and operative dates are provided in Appendix 6 and provide:

- General salary increases of 3.0% p.a. effective from the first full pay period commencing on or after:
  - 1 January 2023;
  - 1 January 2024; and
  - 1 January 2025.

6.2 ONE OFF PAYMENT

6.2.1 Subject to this clause,

a) An employee, who is employed as at 1 October 2022 (the applicable date), will be paid a one-off payment of $1,500 (gross), as soon as reasonably practicable following approval of the Enterprise Agreement by the SA Employment Tribunal; and

b) An employee, who is employed as at 1 October 2023 (the applicable date), will be paid a one-off payment of $1,500 (gross), as soon as reasonably practicable after 1 October 2023,

provided the employee meets the eligibility criteria applicable to the one-off payment.

6.2.2 Each one-off payment stands alone and will:

a) Be adjusted on a pro-rata basis for part time employees. The pro-rata calculation will be based on the employee's average hours per week worked in the12 weeks immediately preceding the last full pay period ending on or prior to the applicable date.

b) Be adjusted on a pro-rata basis for casual employees who have an entitlement to take long service leave or receive a payment in lieu as at the applicable date. The pro-rata calculation will be based on the employee's average hours per week worked in the 12 weeks immediately preceding the last full pay period ending on or prior to applicable date.

c) Not count for any other purpose whatsoever despite any other term of this Agreement, or any applicable award, unregistered agreement, contract of employment, formal or informal local workplace or agency practice, or otherwise; nor will it operate as a precedent for any future or other agreement.

d) Be paid as soon as reasonably practicable after the applicable date and in no circumstances whatsoever can an employee in respect of the applicable date be, or become, entitled to more than the amount of the one-off payment.

6.2.3 An employee who is employed in more than one contract of employment or position that comes within the Agreement will be entitled to be paid in aggregate no more than a total of the applicable one-off payment, i.e., $1,500 (gross).

6.2.4 This clause will only apply to an employee who is bound by this Agreement, employed as at the applicable date, and working in a classification and agency listed in the Agreement, in the appliable pay period ending on or immediately prior to the applicable date. This clause will cease to have any further effect in relation to an employee following payment of the applicable one-off payment pursuant to this clause.

6.2.5 The detail about methodology and eligibility applicable to this one-off payment is included in the 'Fact

Sheet: One-off Payment' as referred to in 'The Agreement Explained', which is to be read and applied in giving effect to this clause.

6.3 SALARY SACRIFICE ARRANGEMENTS

6.3.1 This sub-clause applies for the period an employee enters into a Salary Sacrifice Agreement (SSA). A SSA is the formal administrative instrument between the employer and the employee that enables salary sacrifice arrangements to be put in place.

6.3.2 An employee may elect to salary sacrifice part of the employee's salary. Salary for the purpose of calculating the amount that may be sacrificed includes, where applicable, responsibility allowance, on-call allowance, overtime payments (including recall payments), shift and weekend penalty payments and annual leave loading.

6.3.3 Where an employee enters into a SSA with an employer, the employee will indemnify the employer against any taxation liability whatsoever arising from, or in respect of, that SSA.

6.3.4 Notwithstanding any other provision or Schedule of this Agreement, where an employee has entered into a SSA the salary payable to that employee is the salary payable under the SSA.

6.3.5 Any entitlement to payment of overtime, leave loading or shift/weekend penalty allowance is based on the salary that would have been payable had the employee not entered into a SSA.

6.3.6 Where, on cessation of employment, the employer makes a payment in lieu of notice; or a payment in respect of accrued annual leave (including pro-rata annual leave) or long service leave entitlements, the payment thereof is to be based on the salary that would have been payable had the employee not entered into a SSA.

6.3.7 For the purpose of this sub-clause "taxation liability" means any liability of any description that may be pursuant to a Tax Act howsoever described.

PART 7 – OTHER CONDITIONS

7.1 RECALL TO WORK, OVERTIME AND TIME OFF IN LIEU OF OVERTIME

7.1.1 Where a part time employee works an ordinary shift and is recalled to work on that same day, payment of overtime for the recall to work applies, according to Award provisions.

7.1.2 Where an employee is recalled to work and the actual time worked is less than the minimum of 3 hours on such recall(s), the time worked is considered as interrupting the 8 consecutive hours off duty. That is, clauses 5.4.10 and 5.4.11 of the Award apply.

7.1.3 At the request of an employee and where agreed to by management, where an employee is recalled to duty the payment of recalls to work may be deferred and accumulated to be taken as time off in lieu (TOIL) with a period of annual leave. Employees may accumulate up to 2 weeks time off in lieu of payment for such recalls.

7.2 DAYS IN LIEU OF PUBLIC HOLIDAYS

7.2.1 Those mental health sites that had provision for days in lieu of payment for certain named public holidays until it was removed by ballot under the 1998 Agreement, will continue to make this provision available pursuant to the provisions of 7.2.3 or 7.2.4 for current employees only. Those employees who wished to avail themselves of this provision must have elected to do so by 31 August 2001.

7.2.2 Those mental health sites that retained the days in lieu provision referred to in 7.2.1, whether or not as a result of a ballot under the 1998 Agreement, will continue to make the provision available for current employees only.

7.2.3 Any current employee, who has elected to receive days in lieu pursuant to 7.2.1, or is currently receiving days in lieu pursuant to 7.2.2, and who is rostered for duty over 7 days of the week will not be paid penalty rates for work performed on the following public holidays (Australia Day, Easter Saturday, Easter Monday, Anzac Day and Proclamation Day), nor will the employee receive an additional day's payment if rostered off duty on these days. Instead, the employee will be granted 5 days off, to be taken in conjunction with a period or periods of annual leave.

7.2.4 Any current employee, who has elected to receive days in lieu pursuant to 7.2.1, or is currently receiving days in lieu pursuant to 7.2.2, and who is not rostered for duty over 7 days of the week but is required to work in ordinary hours on any of the public holidays named in 7.2.3, will not be paid penalty rates for the work performed on that day. Instead, the employee will be granted a day off to be taken in conjunction with a period (or periods) of annual leave for each such day worked.

7.2.5 At an employee's initiative and with the agreement of the employer, additional days off accrued under 7.2.3 or 7.2.4 may be taken at a time other than in conjunction with a period/s of annual leave.

7.2.6 For all other public holidays the provisions of the Award apply.

7.2.7 An employee may at any time elect to be paid for public holidays (pursuant to the provisions of the Award) instead of taking days in lieu. Once made, such election is permanent.

7.2.8 For the purposes of this clause, the term "current employee" means any mental health nurse employed in the public sector as at 31 August 2001. Any nurse appointed to the public sector after that date does not have access to days in lieu of public holidays worked. Current employees who transfer between mental health sites may, subject to 7.2.7, retain the days in lieu of public holidays provision.

7.2.9 Nothing in this sub-clause precludes the operation of clause 6.3.7(d) of the Award.

7.3 PART TIME EMPLOYEES WORKING VARIABLE SHIFTS – PUBLIC HOLIDAYS

7.3.1 A part time employee engaged to work variable shifts over a 5 day week (Monday to Friday), who is not required to work on a public holiday falling on Monday to Friday is to be paid for such day if the employee's established pattern of work indicates that the employee would have worked on that day had it not been a

public holiday.

7.4 PENALTY RATES FOR CHRISTMAS DAY AND NEW YEAR'S DAY

7.4.1 Where Christmas or New Year's Day falls on a Saturday or a Sunday, and is not a declared public holiday:

7.4.1.1 An employee other than a casual employee working on that day will be paid at the rate of 250% of the equivalent hourly rate for all time worked on that day.

7.4.1.2 A casual employee working on that day will be paid at the rate of 175% of the equivalent hourly casual rate for all time worked on that day.

7.5 MEAL BREAKS

7.5.1 Employees are entitled to an unpaid meal break on each day or shift of not less than 30 minutes or not more than 60 minutes duration.

7.5.1.1 Where an employee is required by an authorised person to work more than 5 hours without having had, or commenced, an unpaid meal break, the employee will be paid an additional 50% of the employee's ordinary hourly rate from the commencement of the sixth hour until such time as the employee is provided with an uninterrupted meal break or until the completion of the employee's ordinary hours of work for that day or shift. It is not the intention of the parties that these clauses or penalties will detract from providing an employee with a break after 5 hours of work.

7.5.1.2 Where an employee requests to take their meal break no later than 6 hours from the commencement of work the provisions of sub-clause a) above shall not apply. If such an employee is required by an authorised person to work more than 6 hours without having had, or commenced, an unpaid meal break the employee will be paid an additional 50% of the employee's ordinary hourly rate from the end of the sixth hour until such time as the employee is provided with an uninterrupted meal break or until the completion of the employee's ordinary hours of work for that day or shift.

7.5.2 Where an employee is interrupted during an unpaid meal break by a call to duty, such unpaid meal break is to be counted as time worked and the employee must be allowed a meal break as soon as practicable. Should it be impracticable for the employee to have a meal break during the remainder of the employee's ordinary working hours, overtime applies to the interrupted meal break.

7.5.3 Where an employee is required to remain available for duty during a meal break, the employee is to be paid at ordinary time rates (i.e. base rate and appropriate shift allowance where applicable) for the period of the break and such time is not to count as ordinary time. Such breaks are to be limited to half an hour. Where the employee is required by an authorised person to resume work during the meal break and the employee is unable to complete their interrupted meal break during the remainder of the employee's ordinary working hours, overtime applies to the interrupted meal break.

7.5.4 MedSTAR Retrieval (Operational Base) employees only:

7.5.4.1 DHW and the ANMF acknowledge that a number of anomalies have existed in the application of meal beak provisions for this cohort of employees and the following provisions seek to address that as follows:

(i) Where an employee is required to remain available for duty during a meal break, the employee is to be paid at ordinary time rates (i.e. base rate and appropriate shift allowances where applicable) for the period of the break and such time will count as ordinary time. Such breaks are to be limited to 30 minutes. Where the employee is required by an authorised person to resume work during the meal break and the employee is unable to complete their interrupted meal break during the remainder of the employee's ordinary working hours, overtime applies to the interrupted meal break.

(ii) Where an employee is required by an authorised person to work more than 5 hours without having had, or commenced, an paid meal break, the employee will be paid an additional 50% of the employee's ordinary hourly rate from the commencement of the sixth hour until such time as the employee is provided with an uninterrupted meal break or until the completion of the employee's ordinary hours of work for that day or shift.

7.6 DAYLIGHT SAVING

7.6.1 Employees will be paid at ordinary time rates (i.e. base rate and Sunday penalty rate) for the extra hour worked in the month that Daylight Saving ceases and have the option to either work an extra hour or to take one hour leave without pay in the month that Daylight Saving commences, such that it will be of no additional cost to DHW or DHS.

7.7 PERSONAL/CARERS LEAVE

Each employee is credited with 120 hours Personal/Carers leave per annum. Personal/Carers leave subsumes sick leave provisions provided by clause 6.2 of the Award, as well as special leave for urgent pressing necessity, care of sick child, bereavement leave and moving house as provided by the HR Manual.

7.7.1 Definitions

7.7.1.1 Personal/Carers leave is defined as leave approved by the employer for absences from work on account of:

(i) Personal illness;
(ii) Illness of "family member" as defined;
(iii) Bereavement as defined; and
(iv) Urgent pressing necessity as defined.

7.7.1.2 Family member is defined as a member of the employee's household, near relative of the employee, or any other person who is dependent on the employee's care or support.

7.7.1.3 Bereavement: The death of a person closely related to an employee. The employee is either emotionally distressed or attends the funeral or related arrangements or provides emotional support to another person closely related to the employee.

7.7.1.4 "Closely related" will include an employee's wife, husband, father, mother, father in law, mother in law, brother, sister, child, stepfather, stepmother, stepchild, de-facto spouse, guardian, foster parent, step parent, step brother/sister, half-brother/sister or other family member as defined in this clause.

7.7.1.5 Urgent Pressing Necessity: A matter that must be attended to by the employee that cannot be reasonably attended to by the employee outside the employee's ordinary hours of work. Examples of urgent pressing necessity include:

(i) A requirement to appear in court either as a subpoenaed witness or is defending a civil right. Court appearances in other circumstances must be covered by recreation leave or leave without pay.
(ii) Protection of the employee's family/property directly affected by flood or bushfire.

7.7.2 Entitlement

7.7.2.1 All employees who are absent from work on account of matters relating to Personal/Carers leave, as defined above, are on application, eligible for personal/carers leave without deduction of pay as provided in this clause. Personal/Carers leave is credited and recorded on the basis of 120 hours per annum on an employee's service year date of each year irrespective of an employee's roster configurations/arrangements. The entitlement is available on a pro rata basis for part time employees.

7.7.3 Limitations to Personal/Carers Leave Entitlement

7.7.3.1 During the first 6 months of service no employee is entitled to a grant of leave exceeding 60 hours.

7.7.3.2 During the first 12 months of service no employee is entitled to such a grant exceeding 120 hours.

7.7.3.3 No Personal/Carers leave is to be granted on account of:

(i) an illness caused by misconduct of the employee;
(ii) an illness that arises from circumstances within the employee's control e.g. sunburn;

(iii) normal period of absence for confinement;
(iv) attending business that could otherwise be done outside the employee's ordinary hours of duty e.g. rostered days off, flexi-time, PDOs, scheduled days off etc.; or
(v) any other circumstances which are not specifically stated in, or intended by, the definitions in this clause.

7.7.3.4 Personal/Carers Leave for part time employees is to be paid at the employee's usual salary for the number of hours normally worked.

7.7.3.5 Personal/Carers Leave accrues from year to year without limit.

7.7.3.6 Before being entitled to be paid Personal/Carers Leave the employee will within 24 hours of commencement of any period of absence, inform the employer of his/her inability to attend for duty, and as far as practicable, state the reason for the absence and the estimated duration of the absence.

7.7.3.7 Personal/Carers Leave is debited by the hour. Where a public holiday occurs on a day when an employee is absent on paid Personal/Carers leave, payment at ordinary rates is to be made for the day and the public holiday will not be deducted as a days Personal/Carers leave.

7.7.3.8 Any employee absent on account of Personal/Carers leave due to personal or family illness for more than three working days must forward a medical certificate signed by a registered medical practitioner to the employer or, if the absence is not more than 5 working days a dental certificate signed by a dental practitioner. For all urgent pressing necessity and bereavement leave, the employee is required to produce other documentation sufficient to justify the granting of paid leave.

7.7.3.9 An employee may also be required to provide a medical certificate, or other documentation, for absence on Personal/Carers leave for less than 3 days.

7.7.3.10 An employee absent due to Personal/Carers leave on the working day before and/or the working day after the employee's programmed day off/scheduled day off is not entitled to payment for such working day(s), unless the employee provides a medical certificate or statutory declaration.

7.7.3.11 Where an employee is absent due to Personal/Carers leave on a programmed day off/scheduled day off, such day stands as the programmed day off/scheduled day off, and another day will not be substituted for that programmed day off/scheduled day off. Personal/carers pay is not paid in addition to the payment for the programmed day off/scheduled day off and the day is not to be debited as Personal/Carers leave.

7.7.3.12 Where an employee has been advised of a requirement to work on a programmed day off/scheduled day off and is subsequently absent on that day due to personal/carers leave, the day is paid as a programmed day off/scheduled day off and a substitute day is not granted.

7.7.3.13 An employee if required must submit an appropriate medical certificate (or other documentation) for each week of absence.

7.7.3.14 In the case of personal illness, an employee, if so required must submit a medical certificate of fitness on resumption of work after any period of absence.

7.7.3.15 Where an employee is absent on leave without pay (other than for Workers Compensation or unpaid sick leave with a medical certificate) each hour of leave without pay which is not counted as service during a service year will reduce the Personal/Carers leave to be credited to an employee on the next service year date.

7.8 ANNUAL LEAVE

7.8.1 This clause will apply in addition to annual leave entitlements provided by Clause 6.1 of the Award.

7.8.2 An employee, other than an employee rostered over 7 days, will be granted 5 additional working days or 7 additional calendar days of leave where that employee is rostered on-call for 1 in 2 weekend on-call periods averaged over a service year (i.e. a minimum of 47 weekend on-call periods). A weekend on-call period is defined as a maximum of 24 hours that spans all or any part of a weekend day or public holiday. Such an additional week is to be treated in the same manner as annual leave for all purposes.

7.8.3 An employee who is required to be regularly rostered for duty over 6 days of the week (including Saturday and/or Sunday) will be granted annual leave at a rate of 2 1/12 working days or 2 11/12 calendar days for each completed month of service (equivalent to 5 weeks leave per service year).

7.9 DOMESTIC/FAMILY VIOLENCE LEAVE

7.9.1 Pursuant to Regulation 9(8) of the *Public Sector Regulations 2010* (SA) the Commissioner for Public Sector Employment has issued Determination 3.1 Employment Conditions – Hours of Work, Overtime and Leave, Section F – Special Leave with Pay and Leave Without Pay, which provides employees suffering from or escaping domestic/family violence access to special leave with pay. The Determination applies to employees covered by this Agreement.

7.10 ANMF REPRESENTATIVES – RECOGNITION AND LEAVE

7.10.1 DHW shall recognise all representatives of the ANMF that are authorised as such by the Secretary or their nominee.

7.10.2 The representatives may be various worksite representatives, WH&S representatives or Learning and Professional Development & Policy representatives.

7.10.3 The employer will, in recognising these representatives provide them with reasonable time, during working hours, to undertake their work as union representatives including meetings with the employer and their representatives and the capacity to visit and interview employees in the workplace provided that all reasonable steps are taken to minimise or prevent interruption to work.

7.10.4 The employer will also provide reasonable space on an ad hoc basis to the representatives to interview employees in an appropriate and confidential manner, provide reasonable access to the telephone, internet and other means of communication that can assist the representatives seek advice or guidance from ANMF staff.

7.10.5 All ANMF representatives shall be entitled to 10 days leave every 2 years as provided in the HR Manual for trade union training. In addition, those ANMF representatives or members that are elected to be delegates to the annual conference of the ANMF may utilise union education leave.

7.10.6 An employee elected to the Council or the Executive of the ANMF shall be entitled to leave without pay as necessary to allow them to attend monthly meetings as scheduled for a period of 3 hours plus reasonable travel time.

7.11 CAR PARKING

7.11.1 For those employees who have a SA Health/LHN issued permit for on-site/designated hospital car parking, a maximum fortnightly charge equivalent to $2.50 per day will apply.

7.11.2 For those employees who cannot access on-site/designated hospital car parking, the provision of free access to public transport upon presentation of valid hospital identification will apply.

7.12 SCOPE OF PRACTICE

7.12.1 The employer will facilitate work arrangements that allow each nurse and midwife to practice to the full extent of their scope of practice. This includes but shall not be limited to the autonomous and collaborative assessment, planning, implementation and evaluation of patient/client needs within the defined scope of practice of the individual nurse or midwife.

7.12.2 Nursing and midwifery practice can only be managed or reviewed by a suitably qualified and experienced nurse or midwife respectively. Elements of care delegated to nurses and midwives by other health professionals can be incorporated where appropriate into nursing and midwifery care plans however the nurse or midwife remains professionally accountable for their own practice.

7.12.3 In establishing models of care or care management, health services are required to ensure that the provisions of 7.12.1 and 7.12.2 are consistently and fully applied.

PART 8 – ONGOING CONSULTATION

8.1 WORKFORCE RENEWAL

8.1.1 DHW will actively consult with the ANMF to develop an agreed strategy that will address the current and future nursing and midwifery workforce requirements of the public health system and, in particular, the need to address intergenerational change over the next decade in a context of economic and service constraints. It is recognised that the strategy needs to be developed and applied in a cost neutral environment given budget constraints.

8.1.2 The purpose of the strategy is to develop, plan and implement measures related to specific actions aimed at improving attraction, retention, transition to retirement, and towards the learning and development of graduates, specialist clinicians and emergent leaders. It is agreed that these strategies and plans will be actively implemented during the life of this and subsequent agreements, with the parties agreeing to finalise the strategies within 12 months of the date of this Agreement.

8.1.3 The consultations will specifically address issues including:

8.1.3.1 incentives for nurses and midwives thinking of retiring from the workforce that will create opportunities for new graduates and/or nurses and midwives in the early stages of their careers;

8.1.3.2 measures that will increases the capacity for effective mentoring and skills/knowledge transfer to new and junior nursing and midwifery staff;

8.1.3.3 measures and programs that will encourage and facilitate acquisitions of specialist/advanced knowledge and skills in areas of nursing/midwifery practice requiring post graduate study;

8.1.3.4 measures and programs that will improve support for clinical leadership and management capacity within the nursing and midwifery workforce; and

8.1.3.5 systems that ensure the orderly and effective application of the Nursing and Midwifery Capability and Self Development Framework (July 2014) developed by the parties.

8.1.4 The process for consultation will include:

8.1.4.1 the establishment of a joint working group (with equal numbers of DHW and ANMF nominees); the sharing of relevant information and data including but not limited to:

(a) current nursing and midwifery workforce data;

(b) service models/changes to models;

(c) existing workforce and workforce development plans;

8.1.4.2 the development of models for incentives for early retirement that will apply in circumstances where there is agreement to actively pursue generational change within the workforce; and

8.1.4.3 the implementation strategies, including consideration of resource implications, for the consideration and approval of the parties and that address the financial constraints imposed on DHW though its budget programs.

8.1.5 Within six (6) months of the date of approval of the agreement, the current provisions in clause 8.1, including the Nursing and Midwifery Capability and Self Development Framework will be reviewed by the parties and implemented. A party may apply to vary this Agreement to amend this clause. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

8.2 INJURY AND INCOME PROTECTION POLICY

8.2.1 Additional income and injury protection will apply to employees in accordance with the Income and Injury Protection Principles set out at Appendix 9 of this Agreement where entitlements under the *Return to Work Act 2014* (SA) have ceased.

PART 9 – PENALTIES AND ALLOWANCES

9.1 CLINICAL DUTIES - REGISTERED NURSE/MIDWIFE LEVELS 5 AND 6 (RN/M5 and 6)

9.1.1 Where a RN/M 5 or 6 is required to be on-call for clinical nursing/midwifery duties, the relevant on call allowance as provided for in clause 9.5 will be paid.

9.1.2 Where a RN/M 5 or 6 is recalled to work to perform clinical nursing/midwifery duties having left the workplace (and whether or not she/he is on-call at the time of the recall), the RN/M 5 or 6 is entitled to be paid at the appropriate rate based on the RN/RM 3 rate of pay for the time spent on such recall, with a minimum of 3 hours payable.

9.1.3 In lieu of overtime payment, the RN/M 5 or 6 may elect to take the equivalent time worked as TOIL, according to clause 7.1.

9.1.4 Overtime payments or TOIL do not apply in circumstances where the RN/M 5 or 6 works in excess of 8 hours continuously or where the return to work is for purposes consistent with the duties of management, including attendance at Board meetings, security and non-nursing/midwifery emergency call outs etc.

9.2 RURAL AND REMOTE SERVICE INCENTIVE PAYMENTS

9.2.1 Employment incentive payments are payable to nursing/midwifery staff in rural and remote areas. The incentive payments are set out in Appendix 10.

9.2.2 The health unit sites affected and their Zone allocation are also set out in Appendix 11.

9.2.3 Conditions of payment:

9.2.3.1 after the fifth year in a specific Zone, no incentive payment is applicable;

9.2.3.2 no period of leave without pay will attract the incentive payment;

9.2.3.3 eligible employees employed on a part time basis will be entitled to payment on a pro rata basis in the same proportion as their part time hours bear to full time;

9.2.3.4 the incentive payment will accrue and be payable on a fortnightly basis under the same conditions as payment of Locality Allowances (and in addition to any Locality Allowances payable);

9.2.3.5 employees new to the public health sector appointed to a permanent or temporary position in a health unit site located in Zone 2, 3 or 4 are eligible for the incentive payment and will commence at Year 1 from the date of their appointment;

9.2.3.6 existing employees not located in Zone 2, 3 or 4, appointed to a permanent or temporary position in a site located in Zone 2, 3 or 4 are eligible for the incentive payment and will commence at Year 1 from the date of their appointment;

9.2.3.7 existing employees located in health unit sites within Zones 2, 3 or 4 with less than 5 years service in sites within a specific Zone are eligible for the incentive payment and will commence at their relevant Year of service within a particular Zone;

9.2.3.8 existing employees located in health unit sites within a specific Zone (regardless of whether they are in receipt of the incentive payment or otherwise) who are appointed during the life of the Agreement to a permanent or temporary position in a site within another Zone are eligible for the payment and will commence at Year 1.

9.2.4 Incidental Payments:

9.2.4.1 In addition to the Zone Payments in 9.2.2, the following incidental payments will apply to employees appointed to positions at health unit sites located in Zones 2, 3 or 4 on a permanent or temporary basis or who are seconded from sites not included in Zones 2, 3 or 4;

Incidental Payments	Payable from the first full pay period on or after 1 January 2023 $	Payable from the first full pay period on or after 1 January 2024 $	Payable from the first full pay period on or after 1 January 2025 $
Zone 2	$473	$487	$502
Zone 3	$630	$649	$668
Zone 4	$789	$813	$837

9.2.4.2 This payment shall be paid only once, at the time of taking up the appointment within any zone and applies separately to each Zone.

9.2.4.3 A review of rural and remote incentives will be undertaken by the parties and completed by no later than mid February 2023 and will take account of work already conducted by DHW, LHNs and claims raised by the ANMF during bargaining. The Measures agreed during the review period will be implemented at the time the parties reach agreement but by no later than 30 June 2023 and will be incorporated by consent into the agreement by subsequent variation. The parties agree that any such application will be dealt with in accordance with the No Extra Claims clause in this Agreement (clause 1.11.4).

9.3 NIGHT SHIFT PENALTY

9.3.1 All employees other than Registered Nurses/Midwives at level 5 and 6 are to be paid a penalty rate of 20.5% when working on rostered night shifts Monday to Friday inclusive.

9.3.2 The above night shift penalty is to apply in lieu of the rate prescribed in sub-clause 5.3.1(b) of the Award.

9.4 NURSE/MIDWIFE IN-CHARGE ALLOWANCE

9.4.1 A Nurse/Midwife In-Charge Allowance will be paid to a RN/RM1 in a particular patient care area whenever a higher-level nurse/midwife is not rostered to be on duty. Only 1 payment of the allowance will be made in respect of any one shift. Provided that a RN/RM1 who is in receipt of a Responsibility Allowance will not be entitled to also receive the Nurse/Midwife In-Charge Allowance.

9.4.2 The allowance will be paid as follows:

$15.70	per shift from the first full pay period on or after 1 January 2023;
$16.20	per shift from the first full pay period on or after 1 January 2024; and
$16.70	per shift from the first full pay period on or after 1 January 2025

9.5 ON-CALL ALLOWANCE

9.5.1 Every employee who is not a casual employee may be required to participate in an on-call roster.

9.5.2 The applicable on-call rates are set out as per the following table:

On-call Allowance	payable from the first full pay period on or after 1 January 2023	payable from the first full pay period on or after 1 January 2024	payable from the first full pay period on or after 1 January 2025
Monday - Friday	$36.50	$37.60	$38.70
Weekends/Public Holidays/Rostered Days Off	$63.70	$65.60	$67.60

9.5.3 The on-call rates apply on a per period basis, i.e. between rostered shifts, to a maximum of 24 hours. Where the period spans 2 days attracting different rates a single payment of the higher rate is to be made. Where an employee is rostered to be on-call for a period that extends over 2 rostered days off work, they will be entitled to a payment in respect of each rostered day off at the relevant rate.

9.5.4 Where nursing/midwifery staff employed in regional unit sites are rostered on-call but are not provided with 2 consecutive days per fortnight free from being rostered on-call, then such employees are to be paid double the applicable on-call rate (as provided for at clause 9.5.2 above) for each time they are rostered on-call until they are granted 2 consecutive days free from on-call.

9.5.5 Employees rostered on-call and required to perform work from home will be entitled to payment at overtime rates (or time off in lieu by agreement) for actual time worked at home, provided that the total time spent so working in any on-call period is at least 30 minutes.

9.6 RESPONSIBILITY ALLOWANCE

9.6.1 The allowances prescribed in clause 4.6 of the Award are available to registered nurses/midwives level 1 and level 2 classifications in health unit site and DHS categories 6.1 to 6.5 (where no after-hours coordinator is engaged) and to the Level 3/4 (RN/M3/4) classification in other health unit sites. The allowances are set out in the following table:

Responsibility Allowance	01/01/2023 FFPP on or after		01/01/2024 FFPP on or after		01/01/2025 FFPP on or after	
	Annual	Hourly	Annual	Hourly	Annual	Hourly
DON-M Classification 6.1 - 6.2	$4,048	$2.04	$4,169	$2.10	$4,294	$2.17
DON-M Classification 6.3	$4,048	$2.04	$4,169	$2.10	$4,294	$2.17
DON-M Classification 6.4 - 6.5	$6,750	$3.41	$6,953	$3.51	$7,162	$3.61
Grade 4-6 (as per award)	$8,093	$4.08	$8,336	$4.21	$8,586	$4.33

9.7 ADDITIONAL DUTIES ALLOWANCE

9.7.1 Payment of an allowance may be authorised where an employee continuously performs duties in addition to the employee's normal duties for a period of 5 consecutive days or more.

9.7.2 Where the employee is performing such additional duties at the request of the employer, and the additional duties do not form substantially the whole of the duties of a higher position, the employee is paid an allowance.

9.7.3 The appropriate allowance is determined according to the provisions of part 5-1-1 "Temporary Appointment to a Higher Level and Additional Duties Allowance" of the HR Manual.

9.8 HYPERBARIC ALLOWANCE

9.8.1 An employee who is required to participate in a hyperbaric chamber treatment in the Hyperbaric Medicine Unit at the Royal Adelaide Hospital will be paid an allowance per occasion. This allowance is paid in recognition of the consequential limitations on employees' social and recreational activities.

9.8.2 The allowance will be paid as follows:

$25.10	per occasion from the first full pay period on or after 1 January 2023
$25.90	per occasion from the first full pay period on or after 1 January 2024; and
$26.70	per occasion from the first full pay period on or after 1 January 2025

9.8.3 Eligibility to work in the Hyperbaric Medicine Unit, assessment of fitness for hyperbaric exposure, surface intervals, etc. will be applied as prescribed in the relevant RAH Hyperbaric Medicine Unit policies and procedures.

9.9 UNIFORM ALLOWANCE

9.9.1 A uniform allowance is paid to full time employees (pro rata part-time and excluding casuals) where required to wear a distinctive uniform or item of clothing.

9.9.2 The uniform allowance will increase in accordance with salary increases and the operative dates of those salary increases.

$8.60	from the first full pay period on or after 1 January 2023
$8.90	from the first full pay period on or after 1 January 2024; and
$9.20	from the first full pay period on or after 1 January 2025

9.9.3 This allowance is not payable where uniforms are provided free of cost to the employee.

9.9.4 This allowance is not payable during periods of leave and will not apply for any other purposes of this enterprise agreement or the award, such as overtime or recall, shift penalties and other allowances.

9.10 ALLOWANCE FOR ADDITIONAL QUALIFICATIONS

9.10.1 The amounts of the allowances for additional qualifications and conditions regarding eligibility are set out in Appendix 12. The provisions of clause 4.3.1(a) of the Award as it relates to a Bachelors Degree in Nursing will not apply in addition to the terms of this Agreement.

9.10.2 An employee will only be eligible for payment of an allowance in respect of one qualification (the highest relevant qualification held), i.e. no employee is entitled to payment in respect of more than one additional qualification.

PART 10 – WORK LIFE FLEXIBILITY

10.1 EMPLOYER PROVIDED PARENTING LEAVE/ADOPTION LEAVE

10.1.1 Employer provided parenting leave, paid adoption leave and paid leave to enable parent-child relationships through surrogacy parenting applies in accordance with this clause. For the purpose of this clause, employer provided parenting and adoption leave includes a parent taking primary caring responsibility (parent-child relationship) as a consequence of a surrogacy arrangement.

10.1.2 This clause applies to employees who commence an absence on employer provided parenting leave or adoption leave on or after the date of approval by the SAET of this Agreement:

10.1.2.1 Subject to this clause, an employee, other than a casual employee, who has completed 12 months continuous service immediately prior to the birth of the child, or immediately prior to taking custody of an adopted child (as applicable), is entitled to sixteen (16) weeks paid employer provided parenting or adoption leave (as applicable) (the "applicable maximum period"). An "adopted child" means a child under 16 years of age.

10.1.2.2 An employee who, at the time of commencing such paid employer provided parenting or adoption leave, has been employed in the SA public sector for not less than five (5) years (including any periods of approved unpaid leave) will be entitled to twenty (20) weeks paid employer provided parenting or adoption leave (as applicable) (the "applicable maximum period").

10.1.3 The following conditions apply to an employee applying for paid employer provided parenting leave or paid adoption leave:

10.1.3.1 The total of paid and unpaid employer provided parenting l/adoption/special leave is not to exceed 104 calendar weeks in relation to the employee's child. For the purposes of this clause, child includes children of a multiple birth/adoption/surrogacy.

10.1.3.2 An employee will be entitled to the applicable maximum period, paid at the employee's ordinary rate of pay (excluding allowances, penalties or other additional payments) from the date employer provided parenting/adoption/surrogacy leave commences. The paid employer provided parenting/adoption/surrogacy leave is not to be extended by public holidays, rostered days off, programmed days off, scheduled days off or any other leave falling within the period of paid leave.

10.1.4 At the time of applying for paid employer provided parenting leave or paid adoption leave, the employee may elect in writing:

10.1.4.1 To take the paid leave in 2 periods split into equal proportions during the first 12 months of the commencement of their paid leave; or

10.1.4.2 To take the paid leave at half pay in which case, notwithstanding any other clause of this Agreement, the employee will be entitled, during the period of leave, to be paid at half the ordinary rate of pay (excluding allowances, penalties or other additional payments) from the date employer provided parenting/adoption leave commences; or

A combination of 10.1.4.1 and 10.1.4.2.

10.1.5 Part time employees will have the same entitlements as full time employees, but paid on a pro-rata basis according to the average number of contracted hours during the immediately preceding 12 months (disregarding any periods of leave).

10.1.6 During periods of paid or unpaid employer provided parenting leave, sick leave with pay will not be granted for the normal period of absence for confinement. However, any illness arising from the incidence of the pregnancy may be covered by personal/carers leave to the extent available, subject to the usual provision relating to production of a medical certificate and the medical certificate indicates that the illness has arisen from the pregnancy.

10.1.7 Where both prospective parents are employed by DHW or by DHS, a period of paid employer provided parenting /adoption leave (as applicable) may be shared by both employees, provided that the total period of paid employer provided parenting and adoption leave does not exceed the applicable maximum period.

10.1.8 The entitlements available to an employee pursuant to the *Paid Parental Leave Act 2010* (Cth) (as amended from time to time) or any other federal parental leave scheme will be subject to criteria and eligibility as determined by such scheme.

10.1.9 Provisions relating to unpaid employer provided parenting /adoption/surrogacy leave that are contained in the HR Manual will continue to have application except where they may be inconsistent with the terms of this Agreement.

10.2 PAID PARTNER LEAVE

10.2.1 Subject to this clause an employee (other than a casual employee) is entitled to access up to one calendar week (i.e. five working days) (pro rata for part-time employees) of their Personal/Carers Leave entitlement on the birth or adoption of a child/ren for whom the employee has direct parental care responsibility. The leave will be taken as full working day/s within 3 months of the birth or adoption of the child/ren.

10.2.2 It is not intended that this paid partner leave entitlement will detract from any more beneficial entitlement or arrangement applicable within a health unit, DHW or DHS as at the commencement of this clause (i.e. an 'existing arrangement'). An employee can make use of that existing arrangement or the paid partner leave, but not both.

10.2.3 Except in relation to an existing arrangement; DHW or DHS specific paid partner leave policy; or a requirement of this clause, the administrative arrangements within DHW or DHS for taking this leave will generally be as applicable to Personal/Carer's Leave.

10.3 BREAST FEEDING FACILITIES

10.3.1 Where possible, breast-feeding facilities will be made available for employees.

10.4 RETURN TO WORK ON A PART TIME BASIS

10.4.1 Subject to this clause, an employee is entitled to return to work after employer provided parenting or adoption leave on a part time basis, at the employee's substantive classification level, until the child's second birthday and then has the right to revert to their substantive contracted hours. The days and hours for the part time arrangement will be as agreed between the relevant Chief Executive and the employee.

10.4.2 The following conditions apply to an employee applying to return on a part time basis:

10.4.2.1 the employee will provide such request at least 6 weeks prior to the date on which the employee's employer provided parenting or adoption leave is due to expire, and will provide to the Chief Executive (or delegate) such information as may reasonably be required, including the proportion of time sought, and the date of the relevant child's second birthday.

10.4.2.2 prior to an employee's return, the requested part time arrangements will be discussed between the employer and the employee having regard to operational requirements. The employer will not unreasonably refuse a request to work a designated proportion of time and will provide reasons for refusing any such request.

10.4.2.3 at least 6 weeks prior to the relevant child's second birthday, the employee will advise the Chief Executive (or delegate) whether the employee will revert to employment on a full time basis or seeks to continue to be employed on a part time basis.

10.4.3 An employee's return to work part time will be on a non-discriminatory basis so as to operate in the same manner as any other employee returning from a period of leave.

10.5 VOLUNTARY FLEXIBLE WORKING ARRANGEMENTS

10.5.1 The parties acknowledge the mutual benefit to the employer and employees that is gained from obtaining balance between work and other (including family) commitments for all employees covered by this Agreement.

10.5.2 The employer commits to the promotion of, and the improvement of employee awareness of these provisions, and will make every effort to enable employees to achieve flexible working arrangements consistent with this provision unless there are specific operational circumstances that prevent approval of an employee proposal/application. Where an application is not approved due to operational circumstances, reasons will be provided in writing by the relevant Chief Executive or delegate.

10.5.3 A Chief Executive or delegate will consider an employee's request to participate in a VFWA having regard both to the operational needs of the health unit or particular workplace, and the employee's circumstances.

10.5.4 This clause applies for the period an employee participates in a VFWA.

10.5.4.1 Subject to this clause, the salary or wages payable to an employee, or applicable to a position, where the employee elects to participate in a VFWA, will be adjusted to take account of the VFWA in which the employee is participating, notwithstanding any other provision in, or Schedule of, this Agreement or the Award.

10.5.4.2 Where an employee is participating in a Purchased Leave type of VFWA, the rate of pay to be used for calculating overtime payments, leave loading or shift penalties will be the rate of pay that would have been payable had the employee not been participating in the Purchased Leave arrangement.

10.5.4.3 Where an employee is participating in a Compressed Weeks type of VFWA, the nominated normal hours for any day will constitute the employee's ordinary hours for the day. Overtime will only be payable where the employee is required to work hours in excess of those ordinary hours on any day or in excess of the total of those ordinary hours in a week.

10.5.4.4 Where, on cessation of employment, the employer makes a payment in lieu of notice; or a payment in respect of accrued recreation or long service leave entitlements (instead of transferring leave credits to another employer party to this Agreement in the event the employee immediately becomes employed by that employer party), the payment thereof (or the transferred leave credits) shall have regard to any period/s in which the employee participated in a VFWA and be adjusted accordingly.

10.6 REIMBURSEMENT OF REASONABLE CHILD CARE COSTS

10.6.1 Where an employee, other than a casual employee, is given less than 24 hours prior notice that the employee is required to work outside of their ordinary hours of work, and consequently the employee utilises paid child care, the health unit will reimburse the reasonable child care costs incurred by the employee arising from performing such work, subject to this clause.

10.6.2 The prior period of 24 hours is to be calculated from the time at which the work is to begin.

10.6.3 The work, or the hour/s to be worked, is not part of a regular or systematic pattern of work or hour/s performed by the employee.

10.6.4 The reimbursement will be in respect of the reasonable costs incurred by the employee in respect of the work.

10.6.5 Reimbursement will be made for child care costs in respect of Registered Care or Approved Care after all other sources of reimbursement have been exhausted.

10.6.6 Where the child care costs are incurred for child care not in a registered or approved centre, reimbursement will be made in accordance with a child care reimbursement rate, and guidelines, published from time to time by the Commissioner for Public Sector Employment.

10.6.7 The employee will provide the agency with a Child Benefit Claim Form for either Registered Care or Approved Care, tax invoice/receipt, or other supporting documentation as may from time to time be required detailing the cost incurred, or reimbursement sought, in respect of the work.

10.6.8 For the purposes of this clause, a reference to work is a reference to the work outside the employee's ordinary hours, or regular or systematic pattern of work or hour/s, for which less than 24 hours prior notice is given.

10.7 REIMBURSEMENT OF REASONABLE TRAVEL COSTS

10.7.1 Where an employee, other than a casual employee, is required to work outside of their ordinary hours of work and the period of work starts or finishes outside of the ordinary timetabled operating hours of public transport, the employee will be entitled to reimbursement of reasonable home to work or work to home (as applicable) travel costs, subject to this clause.

10.7.1.1 The work, or the hour/s to be worked, is/are not part of a regular or systematic pattern of work or hour/s performed by the employee.

10.7.1.2 The employee ordinarily uses public transport.

10.7.1.3 Travel is by the most direct or appropriate route.

10.7.1.4 Reimbursement of reasonable taxi costs, or mileage at a rate determined from time to time by the Commissioner for Public Sector Employment.

10.7.1.5 The employee will provide the Agency with agreed documentation e.g. mileage, taxi receipts or other supporting documentation as may from time to time be required detailing the cost incurred or reimbursement sought.

PART 11 – WORK HEALTH AND SAFETY AND WELFARE

11.1 WORK HEALTH AND SAFETY RESPONSIBILITIES

11.1.1 In accordance with the *Work Health and Safety Act 2012* (SA), Agencies will ensure as far as is reasonable that all employees will be provided with a workplace environment, systems of work, plant and equipment and substances that minimise the risk of injury or illness while they are at work. DHW and DHS are committed to providing services to the community in an environment that is safe and non-threatening.

11.1.2 Agencies will provide the ANMF with a report identifying current WH&S representatives in nursing/midwifery areas. The report will be updated as necessary throughout the life of the Agreement.

11.1.3 Agencies will have a policy in relation to Respectful Behaviour in the workplace (or however defined) and will maintain such policy during the life of this Agreement.

11.1.4 Agencies will have policies and procedures supporting manual handling (or however defined) based on the DHW/DHS Guidelines in the workplace and will continue to maintain such polices during the life of this Agreement.

11.1.5 The ANMF 10 Point Plan to End Violence and Aggression is annexed to this agreement (Appendix 14) and is to be implemented.

11.2 LEAD APRONS AND RELIEF BREAKS

11.2.1 Employees required to wear a lead apron or similar protective clothing during the course of their normal duties are to be provided with appropriate, light weight aprons or protective clothing.

11.2.2 Managers of employees required to wear lead aprons are required to undertake an assessment of the risks and implement a safe system of work; this is inclusive of, but not limited to, short relief breaks during or between cases, wherever practicable.

11.2.3 Employees wearing lead aprons continuously for periods in excess of 6 hours in any one shift and without a rest break will be released from duty with pay for the remainder of the shift wherever practicable. Where an employee is not able to be released during the shift for a minimum of 2 hours, commencement by that employee of their next shift will be delayed by at least the equivalent of the number of hours continuously worked greater than 6 hours on the previous shift.

11.3 PRE-EMPLOYMENT HEALTH SCREENINGS

11.3.1 The employer's duty of care to clients is acknowledged. This duty of care includes a need to ensure, during the selection process, that prospective employees do not pose a potential threat to clients of the health unit.

11.3.2 Where the employer requires health screening/testing, the employer will meet the reasonable costs for such tests.

11.3.3 Information gathered by the employer must be relevant to a need to check and assess any such risk factors and must remain confidential to the health unit and to the individual prospective employees and not be provided to third parties. The prospective employee must be given access to information collected and an opportunity to respond.

11.3.4 The prospective employee's consent is to be obtained before seeking any such information.

PART 12 – SIGNATORIES TO THE AGREEMENT

per: E. Brooks
.....
Chief Executive, Attorney-General's Department (the declared employer for public employees per Regulation 4, *Fair Work Act (General) Regulations 2009* (SA))

Date 18/11/2022

.....
Witness

Date 18/11/22

.....
Chief Executive,
Department for Health and Wellbeing

Date 18.11.22

.....
Witness

Date 18/11/22

.....
Chief Executive, Department of Human Services

Date 18/11/22

.....
Witness

Date 18/11/22

.....
CEO/Secretary
Australian Nursing and Midwifery Federation (SA Branch)

Date 18/11/22

.....
Witness

Date 18/11/22

PART 13 – APPENDICES

APPENDIX 1 - STAFFING METHODOLOGIES IN EMERGENCY DEPARTMENTS, INTENSIVE CARE UNITS, PERI-OPERATIVE SERVICES, CARDIAC VASCULAR INVESTIGATION UNITS CATHETER LABORATORIES and ENDOSCOPY UNITS

The Standards of:

- The College of Emergency Nursing Australasia (2016)
- The Australian College of Critical Care Nurses (2016)
- The Gastroenterological Society of Australia (2006)
- The Australian College of Operating Room Nurses (2015/2016)

have informed the development of the following provisions. However, staffing levels and mix will be determined by the provisions of this Agreement and Appendix alone.

EMERGENCY DEPARTMENT STAFFING

(Applicable to Emergency Departments, *NB: service level descriptors may alter subject to outcome of SA Health Capability Service Framework (work in progress) as agreed by SA Health and ANMF)*

Tertiary: FMC, LMH, RAH, TQEH, WCH
General: Modbury, NHS
Country: Mt Gambier, Whyalla, Port Pirie, Port Augusta, Gawler, Port Lincoln, Riverland Regional (Berri), South Coast and Northern Yorke Peninsula Regional (Wallaroo)

Tertiary – Emergency Departments:

Base Staffing

- 1 nurse to every 3 patients in department (regardless of patient status e.g. admitted, emergency & short stay)

In addition to this base staffing, the department will also have:

- 1 triage nurse and 2nd triage RN or triage assistant RN/EN
- Shift Coordinator who is a senior emergency trained RN
- 24/7 Mental Health Nurse
- Dedicated Resus Team comprised of 3 RNs or 2 RNs and 1 EN
    - of a minimum 1 senior nurse with a recognised emergency nursing qualification RN
- Minimum skill mix of 2 RN at level 2, or above, to be included in overall ED staffing on a shift by shift basis
- Emergency Nurse Practitioner as per the model of care adopted for each individual emergency department
- 1 full-time equivalent (FTE) designated ED Nurse Educator

Tertiary - Extended Short Care

- 1 Level 2 RN per shift included in below:
- 1 nurse to every 4 pts + Shift Coordinator
- Senior RN experienced in patient population for that care area

General – Emergency Departments:

Base Staffing

- 1 nurse to every 3 patients in department (regardless of patient status e.g. admitted, emergency & short stay)

In addition to this base staffing, department will also have:

- 1 triage nurse and 2nd triage RN or triage assistant RN/EN
- Shift Coordinator who is a senior emergency trained RN
- Mental Health Nurse – 7 days a week, based on Mental Health Service Model
- Dedicated Resus Team comprised of 1 senior nurse with a recognised emergency nursing qualification RN, as Resus Nurse Team Leader
- Minimum skill mix of 2 RN at level 2, or above, to be included in overall ED staffing on a shift by shift basis
- Emergency Nurse Practitioner as per the model of care adopted for each individual emergency department
- 1 ED Nurse Educator , which may be included as a part of other roles

Country – Emergency Departments:
Applicable to: Mt Gambier, Whyalla, Port Pirie, Port Augusta, Gawler, Port Lincoln, Riverland (Berri), and South Coast

Base Staffing

- 1 nurse to every 3 patients which includes a minimum of 1 RN level 2 in the department (regardless of patient status e.g. admitted, emergency & short stay). This ratio includes Emergency Nurse Practitioners.

In addition to this base staffing, department will also have:

- Shift Coordinator who is a senior emergency trained RN which can be the hospital Shift Coordinator
- Mental Health Nurse - role can be available for all the hospital
- ED Nurse Educator (Level 3 or above) which may be provided at local, regional or LHN level; and
- Mt Gambier only - 1 triage nurse between 1000 hours to 2200 hours. Time span may be adjusted subject to agreement between CHSALHN and ANMF.

Country – Emergency Departments:
Applicable to: Northern Yorke Peninsula Regional (Wallaroo)

Base Staffing

- 1 nurse to every 3 patients (regardless of patient status e.g. admitted, emergency & short stay).

Country – Casualty (Emergency Departments):
All other regional unit sites - Casualty

Base Staffing

- 0.6 nursing hours per patient consultation (NHPPC)
    - In health unit sites where: For any period of 1 week or more; or
    - For any shorter period during which increased demand is reasonably predictable; and
    - Where there is forecast demand for a minimum of 3 nursing hours during the period of any nursing shift within a casualty/emergency department provided by the site; then
    - In addition to the staff indicated by the country staffing methodology specified by NMEA 2022 Appendix 2 and in addition to the demand for other shifts periods indicated by 0.6 NHPPC for casualty, the health unit site shall roster such additional nursing hours as may be necessary to provide full and separate staffing to the casualty/emergency department during that shift.
    - For example, if during a holiday period the casualty/emergency department of a country hospital experiences an increase in demand which lasts for longer than 1 week, it shall provide additional staff on shifts where the casualty/emergency department requires nurse cover for 3 hours or more.
    - For a period of less than 1 week or where demand was not able to be reasonably predicted, the increase in demand for casualty/emergency services shall be met by use of casual or agency staff, recall or overtime.

INTENSIVE AND CRITICAL CARE STAFFING

(Applicable to ICU, HDU, PICU and Critical Care Units)

Metro + Mt Gambier and Whyalla in CHSA only

- 1:1 registered nurse patient ratio for ICU patients
- 1:2 registered nurse patient ratio for HDU patients
- Clinical Coordinator/Team Leader –1 per shift must be supernumerary for all shifts (excluding CHSA). In units 15 beds or more, there may be a need for more than one clinical coordinator per shift.
- A minimum of 50% of the RN staff who provide patient care in an ICU hold a recognised postgraduate intensive care (critical care) nursing qualification
- Access Nurse / Float Nurse (excluding CHSA): Role may be incorporated into the Clinical Coordinators role, however the Clinical Coordinator should not be the only contingency nurse available for emergency admissions
    - <50% nurses ICU post grad qualification = 1 Access Nurse to 4 patients per shift
    - 50 - 75% nurses ICU post grad qualification = 1 Access Nurse to 6 patients per shift
    - >75% nurses ICU post grad qualification = 1 Access Nurse to 8 patients per shift
- 1 full-time equivalent (FTE) designated ICU Nurse Educator (excluding RGH, CHSA)
- For units15 beds or more, may have an ICU liaison nurse role, which can be part of other roles
- Where ICU/casualty nursing staffing are required to provide services in other parts of the health unit (i.e. MET, Rapid Response Team, Code-Blue, STEMI), they will be considered as an additional resource.

ENDOSCOPY UNIT STAFFING

(Applicable to Endoscopy Units)

- 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 resus if required
- A 3rd nurse for multiple or complex procedures
- Other nursing staff for admission (excluding CHSA)
- Other nursing staff for recovery & discharge (excluding CHSA)
- Other nursing staff/support staff for reprocessing of equipment (excluding CHSA)

PERIOPERATIVE STAFFING

(Applicable to Operating Rooms, Pre-Admission Areas, Day Surgery Units, Post-Anaesthetic Recovery Rooms and Cardiac Vascular Investigation Unit CVIU Catheter Labs)

- 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)
- The minimum allocation of nursing staff should be 3.5 nurses per room which includes
    - 1 anaesthetic nurse, plus
    - 2 nurses, one of whom must be an RN and one whom may be a suitably qualified EN, plus
    - 0.5 RN to provide adequate assistance, support and relief to all nursing staff in the operating room.
- Four (4) or more nurses may need to be allocated to operating room which:
    - have simultaneous procedures requiring two instrument nurses

- have a deteriorating or unstable patient
- have increased technological demands such as robotic and laser surgery

- 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 opioids/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
- Procedural rooms or laboratories where patient have a general anaesthetic are required to have a minimum of two nurses:
  - 2 nurses, one must be Anaesthetic competent and one must be Procedural competent; plus
  - 3rd nurse as a circulating/support nurse dependent on the type of procedure, patient acuity as per unit protocol
- 1 nurse during elective surgery hours - Holding Bay (excluding RGH, NHS, CHSA)
- 1 nurse during elective surgery hours - Stock Room (excluding RGH, NHS, CHSA)
- 1 full-time equivalent (FTE) Peri-operative Nurse Educator (RAH, WCH, LMH, FMC); may be part of other roles (TQEH, Modbury), and excluding (RGH, NHS, CHSA)
- Nurse Sedationist – where role in place, will be considered as an additional resource
- Medical Assistant Substitution (CHSA) - where role in place, will be considered as an additional resource

APPENDIX 2 - STAFFING METHODOLOGIES IN UNITS (NON-STANDARD BASED)

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
Central Adelaide Local Health Network (CALHN)	Royal Adelaide Hospital (RAH)	2FW1 AAUCar	Cardiology	9.17 ES
		2FW2 AAUMed 2GW1 AAUSur	Acute Assessment Unit - Medical Acute Assessment Unit - Surgical	Early & Late shifts Ratio 1:3 + TL (ES) Night shift Ratio 1:4 + TL (ES) + Mon-Fri Late shift & weekends Early & Late shifts Fast Track Nurse
		4EW1 Cards	Cardiology	9.50 ES + ECHO EN (Mon-Fri)
		4EW2 Cards	Cardiology	7.38 ES + Stress test RN (Mon-Sat)
		4F W1 CrdTh	Cardiothoracic / Cardiology	8.50 ES
		5E W1 Surg	Overnight Stay / Awaiting Discharge	Early & Late shifts Ratio 1:4 (ES) + TL Night shift Ratio 1:6 (ES) + TL
		5E W2 GenSu	General Surgery	7.38 ES
		5F W1 GenSu	General Surgery	7.38 ES
		5F W2 GS/Or	General Surgery / Orthopaedic overflow	7.38 ES
		5G W1 Ortho	Orthopaedic Surgery	7.38 ES
		5G W2 Ortho	Orthopaedic Surgery	7.38 ES
		5G W3 SIU	Spinal Injuries Unit	13.53 ES
		6E Cancer	Cancer	7.75 ES
		6F W1 Surg	Urology	7.38 ES
		6F W2 Surg	Plastics / Dermatology	7.38 ES
		6G W1 ENT	Maxillo-facial / Craniofacial / ENT / Ophthalmology / Oral Surgery	7.38 ES
		6G W2 Vasc	Vascular	7.65 ES
		6G W3 MedSp	Medical Specialties	7.38 ES
		7E BMT/Haem	Haematology	9.00 ES
		7F Renal	Renal	8.08 ES
		7G Vascular	Vascular	7.65 ES
		7G W2 Burns	Burns	11.53 ES
		8EW1 Resp	Respiratory	8.55 ES
		8EW2 NeuroS	Neurosurgery	9.00 ES
		8FW1 GenMed	General Medicine	7.38 ES
		8FW2 GenMed	General Medicine	7.38 ES
		8GW1 GenMed	General Medicine	7.38 ES
		8GW2 GenMed	General Medicine	7.38 ES
		9EW1+ W2 NeuroS	Stroke / Neurology	7.75 ES
		9FW1 GenMed	General Medicine	7.38 ES
		9FW2 GenMdG	General Medicine / Geriatrics	7.38 ES
		9GW1 GenMed	General Medicine	7.38 ES
		9GW2 GenMed	General Medicine	7.38 ES
		MH Short Stay	Mental Health Short Stay	9.74 ES
		2G PIC	Psychiatric Intensive Care Unit	11.70 ES
		2G ACUTE	Mental Health - Adult	5.36 ES
		3E - Day Centre	Cancer Day	1 nurse / 3 chairs, which reflects Ratio 1:6 + TL Apheresis Ratio 1:1
		Hospital @ home	Hospital in the home	Ratio 1:8
		Hyperbaric Unit	Hyperbaric Unit	2 RNs
CALHN - RENAL SERVICE	RAH	Dialysis Units including but not limited to: RAH - 2C & 7FG NE1A Hampstead	Satellite Dialysis Unit (state-wide service)	Ratio 1:3 with TL
	LMH	Satellite Dialysis Centre under CALHN	Satellite Dialysis Centre	Ratio 1:3 + TL
	RAH	RAH - 4GC Acute	Acute Dialysis Unit	Ratio 1:2 Apheresis Ratio 1:1
	RAH	Renal Day Centre / Medical Day Unit	Renal Day Centre / Medical Day Unit	Ratio 1:2

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
CALHN	The Queen Elizabeth Hospital (TQEH)	Cramond - MH ICU	Mental Health - Intensive Care Unit	11.20
		Cramond - MH Open	Mental Health - Open	4.74
		Ward SE	Mental Health - Older Persons	6.94 ES
		TQEH MHSSU	Mental Health Short Stay	Day shift - 4 nurses (ES) Night shift - 3 nurses (ES) For 10 beds
		Hospital @ home	Hospital in the home	Ratio 1:8
		N1A (CCU)	Cardiac Medical	11.90
		N1B	Cardiac Step Down	6.67 ES
		N2	Orthopaedics / Breast Endocrine / Plastics	6.48 ES
		NEGA	Medical Assessment Ward	8.46 ES
		NE1B	Cancer Day	Mon - Fri Ratio 1:6
		NEGB - Surgical	Surgical/Overnight Stay	Early shift Ratio 1:4 (ES) + TL Late shift Ratio: 1:4 (ES) + TL + float Night shift Ratio 1:6 (ES) + TL (2 patients allocated to TL)
		NGA	Respiratory	6.66 ES
		NGB	Palliative Care	7.20 ES
		S1	General Medicine	6.48 ES
		S2	Colorectal / Upper GI / Gastro	6.88 ES
		SGB	Geriatric Evaluation Management	6.29 ES
CALHN	Hampstead Rehabilitation Centre	SGRU	General Rehabilitation - Stroke	6.30 ES
		OARU	General Rehabilitation - Orthopaedics / Amputee	6.30 ES
		CAP	Care Awaiting Placement	4.68 ES
CALHN	Repat Health Precinct	BIRU	Rehabilitation - Brain Injury Unit	7.38 ES
		SRU	Rehabilitation - Spinal Unit	7.26 ES
CALHN	Glenside	Eastern Acute	Mental Health - Adult	5.25
	Glenside	MH Inpatient Rehab Closed	Mental Health Rehabilitation Closed	8.09 ES
	Glenside	MH Inpatient Rehab Open	Mental Health Rehabilitation Open	4.07 ES
	Community Recovery Centre/ Metro Intermediate Care Service	Queenstown ICC	Intermediate Care Centre	Early shift - 3 nurses Late shift - 3 nurses Night shift - 3 nurses
	Community Recovery Centre/ Metro Intermediate Care Service	Elpida	Community Recovery Centre (Mile End)	Early shift - 1 RN Late shift - 1 RN Night shift - 1 RN
SAMI	RAH	Radiology	Medical Imaging	Mon-Fri Early shift 20-22 nurses depending on acuity / activity, Late shift 9 nurses, Night shift 2 nurses Sat-Sun Early shift 5 nurses, Late shift 4 nurses, Night shift 2 nurses
	RAH	Nuclear Medicine	Nuclear Medicine	Mon-Fri: 2 - 3 nurses depending on acuity / activity
	TQEH	Radiology	Medical Imaging	Mon-Fri Early shift 9-11 nurses (dependent on activity / acuity) + NUM, Late shift 2 nurses Sat-Sun Early shift 2 nurses, Late Shift 1 nurse, Nuclear Medicine 1.5 nurses
	LMH	Radiology / MI	Medical Imaging	Mon-Fri Early shift 7 staff + NUM, Late shift 1 nurse Sat-Sun Early shift 1 nurse, Late shift 1 nurse Services: CT, US, Holding Bay, Procedural, Screening
	FMC	Radiology	Medical Imaging	Mon-Fri Early shift 11 nurses, Late shift 2 nurses, + NUM Sat-Sun Early shift 3 nurses, Late shift 2 nurses across all areas

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
	WCH	Medical Imaging	Medical Imaging	2 nurses per list per day Nuclear Medicine. 1 nurse per list per day call for angiography and cardiology. Fluoroscopy 2 nurses per list per day. Ultrasound / CT / MRI 2 nurses shared per list per day.
Southern Adelaide Local Health Network (SALHN)	Flinders Medical Centre (FMC)	4 South (4SMG)	Antenatal / Gynaecology	6.06 ES
		4A	General Medicine	7.38 ES
		4C	Postnatal / Obstetrics / Gynaecology	5.83 ES
		4D	General Medicine	7.25 ES
		4G NS	Neurology / Stroke	8.08 ES
		4GP	Mental Health - Anxiety & Eating Disorders	7.20 ES
		5A	Geriatric Evaluation Management	6.33 ES
		5B	Neurosurgery	7.93 ES
		5C	Orthopaedics / Plastics	6.90 ES
		5D	Elective Surgery Short Stay	Ratio 1:4 (ES) + Shift Coordinator
		5E	Gastroenterology / Medical / Surgical	6.75 ES
		5G	Haematology / Oncology	5.86 ES
		5HK - Margaret Tobin Adult	Mental Health - Adult	5.49 ES
		5J - Margaret Tobin Secure	Mental Health - Secure	13.69 ES
		6A	Respiratory / Endocrine / Dermatology / Infectious Diseases	6.29 ES
		6B	Cardiac	6.80 ES
		6C	Vascular	7.35 ES
		6D C	Cardiology	6.80 ES
		6D GM	General Medicine	7.37 ES
		6G	Medical / ICU Step Down / Renal Medicine	7.46 ES
		CCU	Coronary Care Unit	Staff (ES) 8 on Early shifts, 7 on Late shifts & 4 on Night shift + Ratio 1:1 for IABP, CPAP or code stroke
		Dialysis Unit	Dialysis Unit	Ratio 1:3 + TL
		DOSA	Day of Surgery Admissions	Ratio1:6
		FIS - Flinders Infusion Service	Infusion Centre	Ratio 1:3 for Chemotherapy chairs
		High Dependency Unit - 5F	High Dependency Unit	1:2 or 1:3 + shift coordinator
		Hospital at Home	Hospital in the Home	Ratio 1:8
SALHN	FMC	Labour & Delivery Suite Women's Antenatal Assessment	Labour & Delivery Suite	Ratio 1:1 Labour and Birth Ratio 1:2 High acute midwifery care e.g. HDU Ratio 1:3 Antenatal Assessment
		Mental Health Short Stay	Acute Adult Mental Health	Day Shift - 3 nurses (ES) + Nurse Consultant Night Shift - 3 nurses (ES) for 8 beds
		Neonatal Unit	Neonatal Unit Special Care High Dependency Convalescent and Low Dependency	Ratio 1:1 Ventilated/ airway support or 1:2 Ratio 1:3 Special Care High Dependency Ratio 1:4 Convalescent and Low Dependency *With reference to 'Standard for Maternal and Neonatal Services in South Australia 2020 Clinical Directive'*
		Paediatrics	Paediatrics	6.55 ES
		Laurel	Palliative Care	7.87 ES
		Tobruk	Rehabilitation - Stroke	6.06 ES
		Kokoda	Rehabilitation	5.87 ES
		Ward 17 (Jamie Larcombe Centre located at Glenside)	Post Traumatic Stress Disorder	5.10 ES
		Ward 18 (Open)	Psycho-geriatric	5.36 ES

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
		Ward 18 (HDU)	Psycho-geriatric Secure	11.75 ES
SALHN	Noarlunga Health Precinct	Morier Closed	Mental Health - "Closed/Secure" unit	13.27
		Morier Open	Mental Health- Open	5.00
		Myles	General Medicine	6.33 ES
		Satellite Dialysis Unit	Dialysis Unit	Ratio 1:3
		Whittaker GEM	Geriatric Evaluation Management	6.30 ES
		NH SURG SSU (Collins Ward)	Surgical Services Unit (SSU)	6.88 ES
		South ICC	Metro Intermediate Care Services	7.7 RN, 3.3 EN
		Trevor Parry Centre	Community Recovery Centre / Metro Intermediate Care Service	Early shift - 1 RN Late shift - 1 RN Night shift - 1 RN
SALHN	Repat Health Precinct	RV	Rehabilitation - focussing on lower medical acuity	5.50 ES
		RNBU	Repat Neuro Behavioural Unit	15.16 ES
		SADU	Specialised Advanced Dementia Unit	9.33 ES
Women's and Children's Health Network (WCHN)	Women's and Children's Hospital (WCH)	Adolescent Unit	Adolescent	7.25 ES
		Cassia	Medical	8.50 ES
		Kate Hill Ward	Surgical	8.50 ES
		MSSW	Medical Short Stay Ward	7.50 ES
		MDU	Medical Day Unit	1:02
		Michael Rice Ward	Haematology / Oncology	11.00 ES
		Newland	Surgical	8.00 ES
		Paediatric Surgical Ambulatory Services - Campbell	Ambulatory Paediatric Surgical	Ratio 1:6 (unless bay specials 1:4) 2 staff per Early, Late, Night shift. Shift Coordinator has full patient load (1:6) 12 beds and decrease to 10 beds if bay specials in ward. Open Monday morning to Saturday lunchtime.
		Paediatric Surgical Ambulatory Services- DOSA	Ambulatory Paediatric Surgical - Day of Surgical Admission	Early shift only - 3 nurses
		Renal Dialysis Service	Renal Dialysis	Ratio 1:2 for children over 5 years of age Ratio 1:1 for children under 5 years of age
		Rose	Medical / Surgical	9.25 ES
		Antenatal / Gynaecology	Antenatal / Gynaecology	5.15 ES
		Birthing Centre	Birthing Centre	Ratio 1:1
		Dom Mid Service	Domiciliary Midwifery Service	Early Shift 1.55
		PN	Post Natal	Woman + /- unqualified baby is 5.80 Qualified baby 5.80
		Labour & Delivery Suite / Women's HDU	Labour & Delivery / Women's High Dependency Unit	Labour & Birth Ratio 1:1 High acute midwifery care e.g. HDU Ratio 1:2
		Midwifery Group Practice	Midwifery Group Practice	As per Appendix 8
		NED	Neonatal Early Discharge	Early Shift 3.0
WCHN	WCH	NICU	Neonatal Intensive Care Unit	Ratio 1:1 Ventilated/airway support otherwise 1:2 + shift co-ordinator *With reference to 'Standard for Maternal and Neonatal Services in South Australia 2020 Clinical Directive'*
		SCBU	High Dependency- Special Care Baby Unit	8.65 ES (E shift =2.88, L shift = 2.47, ND shift = 3.08) (T/L is supernumerary) *With reference to 'Standard for Maternal and Neonatal Services in South Australia 2020 Clinical Directive'*
		WAS	Women's Assessment Unit	Early & Late shifts Ratio 1:3 + Triage + Shift Coordinator Night shift Ratio 1:3 + Triage / Shift Coordinator

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
		Women's Outpatients Department	Women's Outpatient Department	Triage (first AN visit) 2.0 Other visits (occ of service) 0.6
		Mallee	Mental Health - Paediatric	11.00 ES
		Helen Mayo House	Mental Health - Post Natal	Ratio 1:2 during the day & Ratio 1:3 Night shift (does not include the babies that accompany the mother)
Northern Adelaide Local Health Network (NALHN)	Lyell McEwin Hospital	1A Neuro Stroke	Medical Neurology / Stroke	7.40 ES
		1B	Medical	6.33 ES
		Children's Ward (1C)	Paediatrics	8.00 ES
		1D	Medical	6.33 ES
		1E - AMU	Acute Medical Assessment	7.00 ES
		1G PICU (closed)	Mental Health - Adult Closed	9.33 ES
		N1G (1G open)	Mental Health - Adult Open	6.10 ES
		1H	Mental Health - Older Persons	6.94 ES
		SSU	Mental Health Assessment Unit	Ratio 1:2
		2A	General Medicine	6.33 ES
		2B	Plastics / ENT / Breast Endocrine / Upper Gastrointestinal	6.35 ES
		2C	Orthopaedic	6.93 ES
		2D	General Medical / Neurology	6.33 ES
		2E	Colorectal / Urology	7.04 ES
		2FX	Extended Day Surgery Unit	Early & Late shifts 3 nurses Night shift 2 nurses For 11 beds
		BAUH	Birthing Assessment Unit High & Low	Ratio 1:1 Labour & Birth Ratio 1:2 High acute midwifery care e.g. HDU
		CCU	Coronary Care Unit	Early & Late shifts 4 nurses Night shift 3 nurses For 8 beds
		CSU	Cardiac Step Down	6.50 ES
		CVIS	Cardiovascular Investigation Service	Mon and Fri – 9 nurses Tues to Thurs – 10 nurses For 2 CVIS rooms (interim – for review)
		HITH	Hospital in the Home	Ratio 1:8
		Oncology Day Stay	Oncology day stay	Ratio 1:3 Chairs + OPD + Day cases
		SCN	Special Care Nursery	8.63 ES *With reference to 'Standard for Maternal and Neonatal Services in South Australia 2020 Clinical Directive'*
		WAU	Women's Assessment Unit	Early & Late shifts Ratio 1:3 + Shift Coordinator
		WHU	Women's Health Unit Antenatal / Postnatal / Births / Gynaecology	6.50 ES
NALHN	Modbury Hospital	1 East - SDU/23hr/Pre Admission	8 surgical beds	Early / Late/ Night 2 staff each shift
		2 East	General Medical Unit	6.33 ES
		3 East	Rehabilitation - General	5.81 ES
		3 West	Rehabilitation - General	5.81 ES
		SSGMU	Short Stay General Medical Unit	7.11 ES
		GEM	Geriatric Evaluation Management	6.29 ES
		Palliative Care	Palliative Care	7.29 ES
		4 East Rehab - General Rehabilitation	Rehabilitation - General	5.85 ES
		Woodleigh	Mental Health - Adult	6.33 ES
NALHN	Northgate MH	Northgate	Mental Health - Older Persons	13.00
	JNH	JNH Birdwood	Mental Health - Forensic	7.80 ES

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
	JNH	JNH Aldgate	Mental Health - Forensic	7.94 ES
	JNH	JNH Clare	Mental Health - Forensic	2.90 ES
	Kenneth OBRIEN	KOB East	Mental Health Rehabilitation	8.18 ES (interim – for review)
	Kenneth OBRIEN	KOB West	Mental Health Rehabilitation	8.18 ES (interim – for review)
	Based on Glenside Campus	Tarnanthi	Mental Health- Forensic	9.35 ES (interim – for review)
	Community Recovery Centre/ Metro Intermediate Care Service	Wondakka	Recovery & Intermediate Care	1 RN per shift
DASSA	DASSA	DASSA Withdrawal Services, Glenside Health Services	Drug & Alcohol Withdrawal	4.50
Limestone Coast Local Health Network (LCLHN)	Mt Gambier Hospital	Maternity (MGP)	Maternity Gynaecology Paediatrics, excludes Labour & Delivery	6.00 (excludes Labour & Delivery) + Labour Ratio 1:1
	Mt Gambier Hospital	Private Ward (PW)	Medical & Surgical	5.90
	Mt Gambier Hospital	Medical Ward (MW)	Medical	5.90
	Mt Gambier Hospital	Surgical Ward (SW)	Surgical	5.90
Flinders Upper North Local Health Network (FUNLHN)	Pt Augusta Hospital	Casuarina	Midwifery, Paediatrics & excludes Labour & Delivery	6.00 (excludes Labour & Delivery) + Labour Ratio 1:1
	Pt Augusta Hospital	Banksia	Medical & Surgical, (Room 8 Complex Care beds)	5.60 + Room 8 Complex Care Ratio 1:2
	WHHS	Gudya	Medical & Surgical	5.90
	WHHS	Minya Jida	Medical & Surgical	5.90
	WHHS	WCHU	Women's & Children's unit	6.00 (excludes Labour & Delivery) + Labour Ratio 1:1
Yorke & Northern Local Health Network (YNLHN)	Pt Pirie Hospital	Ward A	General Medical & Paediatrics	5.60 (inclusive of Paediatrics)
	Pt Pirie Hospital	Ward C	Maternity (excludes neonates and Labour and delivery) / surgical / private	6.00 (excludes Labour & Delivery) + Labour Ratio 1:1
Regional LHNs	Glenside CHSALHN	R&R Inpatient	Mental Health Inpatient Unit	5.85 including specials
Barossa Hills Fleurieu Local Health Network (BHFLHN)	Angaston Hospital			5.0
	Gawler Hospital			5.0
	Mt Barker Hospital			5.0
	Sth Coast Hospital			5.0
	Tanunda Hospital			5.0
Eyre and Far North Local Health Network (EFNLHN)	Pt Lincoln Hospital			5.0
Limestone Coast Local Health Network (LCLHN)	Millicent Hospital			5.0
	Naracoorte Hospital			5.0

LHN	Hospital	Patient Care Area(s)	Patient Care Area - Type/Descriptor	Minimum Nursing/Midwifery Hours Per Patient Day (NMHPPD)/Ratio and Staff Plan Note: ES - Excluding Specials
Riverland Mallee Coorong Local Health Network (RMCLHN)	Murray Bridge Hospital			5.0
	Riverland Hospital			5.0
Yorke and Northern Local Health Network (YNLHN)	Nth Yorke Peninsula Hospital		inclusive of rehabilitation beds	5.9
	Clare District Hospital			5.0
	Regional LHNs	Chemotherapy		2.0 NHPPD
	Regional LHNs	Complex Care (Stable)		6.0 NHPPD
	Regional LHNs	Labour and Delivery		Ratio 1:1
	Regional LHNs	OPD attendances		0.5 hours per attendance
	Regional LHNs	Renal		Ratio 1:3 (+TL rostered for 2 Saturday shifts in the absence of a level 3 RN for Pt Augusta Regional Dialysis Centre)
	Regional LHNs	Commonwealth Aged Care		3.2 Nursing & Patient Carer Hours Per Patient Day (NPCHPPD) average across regions
	Regional LHNs	State funded Aged Care and MPS aged care beds	Applicable to "under main roof" and "not under main roof"	3.2 NPCHPPD
	Regional LHNs	Paediatrics		5.3 NMHPPD
	Regional LHNs	Obstetrics		6.0 NMHPPD

APPENDIX 3 – REGIONAL LHNs MONITORED CARE LEVELS AND CRITERIA

Care Levels:

Complex Care (Unstable)

Complex Care (unstable) patients are patients who are either elective or emergency admissions to any CHSA facility and who are assessed as **critically ill and/or haemodynamically unstable.**

These patients will require active review and consideration of transfer to a facility with an Intensive Care Unit (ICU) or High Dependency Unit (HDU). This relocation will be achieved either through retrieval or transfer. Where these patients are being stabilised at the presenting hospital and awaiting transfer/retrieval, the patient must be managed in a monitored bed and nursed as 1:1 or 1:2 ratio based on the transfer sought (to ICU or HDU respectively).

Patients who are either elective or emergency admissions to any CHSA facility who are assessed as **haemodynamically or otherwise clinically unstable** must be transferred to a more appropriate facility with a High Dependency Unit (HDU). This relocation will be achieved either through retrieval or transfer. Where these patients are being stabilised at the presenting hospital and awaiting transfer/retrieval, the patient must be managed in a monitored bed and nursed as 1:2 ratio.

If it is not possible to achieve transfer of the client to a hospital with an ICU or HDU following request, the presenting hospital will continue to provide care with the staffing resources detailed above.

Complex Care (Stable)

Complex Care (stable) patients are patients who are admitted to any CHSA facility and are assessed with co- morbidities that require short term close monitoring without other complex care needs or associated nursing interventions, but not HDU or ICU.

These patients are managed in a monitored bed for a period of no more than 24 hour stay prior to further transfer to a general ward. Whilst monitored, patients are provided care as a 1:4 ratio. Where patient care requirements may exceed 1:4 ratio (6HPPD), clinical assessment is required by the registered nurse in charge. They will determine any changes that are appropriate to existing staffing requirements, and where necessary, engage for the required period of time additional nursing/midwifery staff.

APPENDIX 4 – SKILL MIX IN COUNTRY INPATIENT UNITS

	Ratio RN/M:EN/AIN/M
ANGASTON DISTRICT HOSPITAL	60:40
BALAKLAVA SOL MEM HOSPITAL	60:40
BORDERTOWN MEMORIAL HOSPITAL	70:30
BURRA HOSPITAL	60:40
CEDUNA HOSPITAL INC	70:30
CLARE DISTRICT HOSPITAL	70:30
CLEVE DISTRICT HOSPITAL	50:50
COOBER PEDY HOSPITAL	60:40
COWELL DISTRICT HOSPITAL	60:40
CUMMINS & DISTRICT MEMORIAL	60:40
EUDUNDA HOSPITAL	60:40
GAWLER HEALTH SERVICE	70:30
HAWKER MEMORIAL HOSPITAL	60:40
KANGAROO ISLAND GENERAL	60:40
KAPUNDA HOSPITAL	60:40
KAROONDA & DIST SOL MEMORIAL	70:30
KIMBA DISTRICT HOSP & HEALTH	60:40
KINGSTON SOL MEM HOSPITAL	60:40
LAMEROO DISTRICT HOSPITAL	60:40
LEIGH CREEK HOSPITAL	50:50
LOXTON HOSPITAL COMPLEX	70:30
MANNUM DISTRICT HOSPITAL	50:50
MENINGIE & DISTRICT MEMORIAL	60:40
MID NORTH HEALTH (BOOLEROO)	60:40
MID NORTH HEALTH (JAMESTOWN)	50:50
MID NORTH HEALTH (ORROROO)	60:40
MID NORTH HEALTH (PETERBOROUGH)	60:40
MID-WEST HEALTH SERVICE	50:50
MILLICENT & DISTRICT HOSPITAL	70:30
MT BARKER DISTRICT SOLDIERS'	70:30
MT GAMBIER & DISTRICTS	70:30
MURRAY BRIDGE SOL MEM HEALTH	60:40
NARACOORTE HEALTH SERVICE	70:30
NTHN ADELAIDE HILLS HEALTH	50:50
NTHN YORKE PEN REGIONAL	50:50
OODNADATTA HOSP & HEALTH	100:0
PENOLA WAR MEMORIAL HOSPITAL	60:40
PINNAROO SOL MEM HOSPITAL	60:40
PT AUGUSTA HOSPITAL	70:30
PT BROUGHTON DIST HOSPITAL	60:40
PT LINCOLN HEALTH SERVICE	70:30
PT PIRIE REGIONAL HEALTH	70:30
QUORN & DISTRICT MEMORIAL	60:40
RENMARK & PARINGA DISTRICT	70:30
RIVERLAND REGIONAL HOSPITAL	70:30
RIVERTON DISTRICT SOL MEMORIAL	50:50
ROXBY DOWNS HEALTH CENTRE	60:40
SNOWTOWN MEMORIAL HOSPITAL	50:50
SOUTH COAST DISTRICT HOSPITAL	70:30
SOUTHERN FLINDERS HEALTH (CRYSTAL BROOK)	60:40
SOUTHERN FLINDERS HEALTH (LAURA)	60:40
SOUTHERN YORKE PENIN HEALTH	60:40

STRATHALBYN & DIST SOLDIERS'	60:40
TAILEM BEND DISTRICT HOSPITAL	60:40
TANUNDA WAR MEMORIAL HOSPITAL	70:30
TUMBY BAY HOSPITAL	50:50
WAIKERIE HOSPITAL & HEALTH	60:40
WHYALLA HOSPITAL & HEALTH	70:30
WOOMERA HOSPITAL	60:40
YORK PENINSULA HEALTH (YORKETOWN)	60:40
YORK PENINSULA HEALTH (MAITLAND)	50:50

APPENDIX 5 – DEPARTMENT OF HUMAN SERVICES: STAFFING METHODOLOGY

Disability Services: Highgate Park	Clinical Area	Descriptor	*NPCS
	H4A	**Respiratory Unit**	**6.0 NPCS**
	H5A	**Mix Unit, including aged care beds**	**6.0 NPCS**
	H5B	**Mixed Unit, including aged care beds**	**6.0 NPCS**

*** Nursing and Personal Care Support hours per resident day (NPCS)**

DHS and the ANMF will review the staffing set out in this Appendix dependent on:

- the advent of significant evidence-based policy change and/or patient care needs; and/or
- the evidence-based implications of the transition to and implementation of the National Disability Insurance Scheme roll out and the application of the resulting individual funding model.

Variation to this Appendix may be made as agreed between the parties.

APPENDIX 6 – CLASSIFICATION AND SALARIES

Effective on and from the first full pay period after cited date

Classifications / Titles	Increment	1/1/2022 Current rate ($) per annum	1/1/2023 ($) per annum (3%pa)	1/1/2024 ($) per annum (3%pa)	1/1/2025 ($) per annum (3%pa)
Assistant in Nursing/Midwifery	1st increment	$54,080	$55,702	$57,373	$59,094
	2nd increment	$55,681	$57,351	$59,072	$60,844
Enrolled Nurse (Certificate) - not authorised in medication administration	1st increment	$58,561	$60,318	$62,128	$63,992
	2nd increment	$59,521	$61,307	$63,146	$65,040
	3rd increment	$60,800	$62,624	$64,503	$66,438
	4th increment	$62,080	$63,942	$65,860	$67,836
	5th increment	$63,360	$65,261	$67,219	$69,236
	6th increment	$64,640	$66,579	$68,576	$70,633
	7th increment	$65,920	$67,898	$69,935	$72,033
Enrolled Nurse (Diploma) or Enrolled Nurse (Certificate) - authorise in medication administration	1st increment	$60,800	$62,624	$64,503	$66,438
	2nd increment	$62,306	$64,175	$66,100	$68,083
	3rd increment	$63,728	$65,640	$67,609	$69,637
	4th increment	$64,960	$66,909	$68,916	$70,983
	5th increment	$66,557	$68,554	$70,611	$72,729
	6th increment	$68,481	$70,535	$72,651	$74,831
Advanced Skills Enrolled Nurse	1st increment	$68,481	$70,535	$72,651	$74,831
	2nd increment	$69,760	$71,853	$74,009	$76,229
Registered Nurse/Midwife (Level 1)	1st increment	$68,481	$70,535	$72,651	$74,831
	2nd increment	$70,626	$72,745	$74,927	$77,175
	3rd increment	$73,646	$75,855	$78,131	$80,475
	4th increment	$76,797	$79,101	$81,474	$83,918
	5th increment	$79,998	$82,398	$84,870	$87,416
	6th increment	$83,216	$85,712	$88,283	$90,931
	7th increment	$86,436	$89,029	$91,700	$94,451
	8th increment	$89,654	$92,344	$95,114	$97,967
	9th increment	$93,439	$96,242	$99,129	$102,103
Clinical Nurse/Midwife (Level 2)	1st increment	$79,998	$82,398	$84,870	$87,416
	2nd increment	$83,216	$85,712	$88,283	$90,931
	3rd increment	$86,436	$89,029	$91,700	$94,451
	4th increment	$89,654	$92,344	$95,114	$97,967
	5th increment	$93,439	$96,242	$99,129	$102,103
	6th increment	$94,583	$97,420	$100,343	$103,353
	7th increment	$96,762	$99,665	$102,655	$105,735
	8th increment	$98,941	$101,909	$104,966	$108,115
	9th increment	$101,120	$104,154	$107,279	$110,497
Associate Nurse/Midwife Unit Manager (Level 2)	1st increment	$94,583	$97,420	$100,343	$103,353
	2nd increment	$96,762	$99,665	$102,655	$105,735
	3rd increment	$98,941	$101,909	$104,966	$108,115
	4th increment	$101,120	$104,154	$107,279	$110,497

Nurse/Midwife Unit Manager; *Nurse/Midwife Consultant;* *Nurse/Midwife Educator;* *Nurse/Midwife Manager (Level 3)*	1st increment	$114,560	$117,997	$121,537	$125,183
	2nd increment	$117,119	$120,633	$124,252	$127,980
	3rd increment	$119,682	$123,272	$126,970	$130,779
Adv. Nurse/Midwife Unit Manager; *Adv. Nurse/Midwife Consultant;* *Adv. Nurse/Midwife Educator;* *Adv. Nurse/Midwife Manager;* *Nurse Practitioner (Level 4)*	1st increment	$120,960	$124,589	$128,327	$132,177
	2nd increment	$124,160	$127,885	$131,722	$135,674
	3rd increment	$126,080	$129,862	$133,758	$137,771
Nursing/Midwifery Director (Level 5)	5.1	$131,839	$135,794	$139,868	$144,064
	5.2	$147,199	$151,615	$156,163	$160,848
	5.3	$154,879	$159,525	$164,311	$169,240
Director of Nursing/Midwifery (Level 6)	6.1	$131,839	$135,794	$139,868	$144,064
	6.2	$139,519	$143,705	$148,016	$152,456
	6.3	$147,199	$151,615	$156,163	$160,848
	6.4	$154,879	$159,525	$164,311	$169,240
	6.5	$162,559	$167,436	$172,459	$177,633
	6.6	$176,640	$181,939	$187,397	$193,019
	6.7	$193,279	$199,077	$205,049	$211,200

APPENDIX 7 – CAREER STRUCTURE

RECLASSIFICATION AND APPOINTMENT:

Roles in the career structure will be available on a reclassification or an appointment basis, subject to meeting the minimum essential qualification for that classification.

The Advanced Skills Enrolled Nurse classification is by appointment only.

Employees can apply for a reclassification by completing an Application for Reclassification form and demonstrating that they meet the reclassification criteria (as stated in this Appendix) at the higher level. The reclassification process includes a right of appeal to a Grievance and Reclassification Appeal panel as applicable by DHW or DHS.

Any Enrolled Nurse/Registered Nurse/Midwife may be appointed to a position as a result of merit based selections subject to meeting the minimum essential criteria (i.e. Enrolled/Registered with the Registration Authority).

ASSISTANT IN NURSING/MIDWIFERY:

Assistants in Nursing/Midwifery (AIN/M) support Enrolled and Registered Nurses/Midwives in the delivery of general patient/client[1] care, and undertake basic nursing duties that would otherwise have been performed by an Enrolled or Registered Nurse/Midwife.

Employees at this level, work at all times under direct or indirect supervision[2] by a Registered Nurse/Midwife and their work may be overseen by an Enrolled Nurse within a care team. Employees at this level are accountable for their own actions.

Assistants in Nursing/Midwifery will:

- Be enrolled as a student in an undergraduate program in nursing or midwifery and have completed any training required by the employer relevant to the safe and competent performance of work at this level; or
- Be employed on the basis that the person is, or will be, undertaking a course approved by the Registration Authority for the preparation of Enrolled Nurses; or
- Hold a Certificate III or IV in one of the following health related disciplines:
    - Basic Health Care;
    - Aged Care;
    - Health Services Assistance: (Qualifications to include elective units recommended for AIN Acute care);
    - Home and Community Care;
    - Individual Support Work;
    - Or such other nationally recognised courses approved within the healthcare setting by full agreement of DHW and the ANMF.

1 Patient/client care has been used throughout this document as a generic term, which would also encompass residents, consumers and women.

2 Direct supervision is when the supervisor is actually present and personally observes, works with, guides and directs the person who is being supervised. Indirect supervision is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the consumer and the needs of the person who is being supervised (A national framework for the development of decision-making tools for nursing and practice, Nursing and Midwifery Board of Australia 2010).

Employees in these roles will undertake all or some of the following:

Direct/indirect patient/client care:

- Assist nurses/midwives in routine tasks with patients/clients associated with the activities of daily living;
- Performs a range of duties that require basic skills, knowledge, training and experience;
- Routine technical support functions at the level of setting up for nursing procedures, cleaning equipment and managing local stock levels;
- Provide person centred care.[3]

Support of health service systems:

- Contributing to the maintenance of a physically and culturally safe environment for patients/clients and staff;
- Participation in quality improvement activities through recording and reporting of data;
- Follows established guidelines, protocols, procedure, standards and systems of work as set out by the organisation.

Education:

- Such nursing care and procedures that assist them in their learning capacity to develop the competencies required to achieve the qualification in which they are enrolled.

Research:

- Contributes to evaluative research activities through recording and reporting of data.

Professional leadership:

- Has no role in providing leadership at this level.

The AIN/M work level descriptors may be varied by agreement between the parties where there is a need to ensure the descriptors adequately reflect the role and qualification.

ENROLLED NURSE:

An Enrolled Nurse (EN) is an employee who is enrolled with the Nursing and Midwifery Board of Australia. The Enrolled Nurse supports the Registered Nurse/Midwife in the provision of person-centred care consistent with regulatory and statutory requirements. Practice at this level is from novice to proficient[4] Enrolled Nurse practice. Employees at this level work under the direction and supervision of the Registered Nurse/Midwife, however at all times the Enrolled Nurse retains responsibility for his/her actions and remains accountable in providing nursing/midwifery care.

Employees in these roles will meet the following requirements:

Direct/indirect patient/client care:

- Demonstrates knowledge and skill in assessment, care and routine procedures for area of practice;
- Under the direction of a registered nurse makes decisions and takes initiative to plan and complete nursing care tasks within their scope of practice;
- Engages with patients/clients to provide person centered care.

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3 Person centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients/clients (SA Health 2014). In this document person centred care incorporates patients, clients, consumers, women, children and families.

4 The terms used by Patricia Benner to describe levels of nursing clinical competence, i.e. novice, beginner, competent, proficient and expert have been used throughout this document. For definitions on these levels of experience, skill and competence please see attached reference.

Support of health setting services:

- Contributes to quality improvement;
- Provides assistance to other members of the health care team in provision of care to individuals/groups, including overseeing the work of an AIN/M and students.

Education:

- Provides education to patients/clients, families and carers;
- Contributes to the education of others;
- Continue own professional development, seek learning opportunities and maintains own professional development portfolio of learning and experience.

Research:

- Contributes to research as appropriate;
- Recognises the importance of evidence based practice.

Professional leadership:

- Under the guidance of a registered nurse coordinates and guides activities of student enrolled nurses and assistants in nursing.

ADVANCED SKILLS ENROLLED NURSE (ASEN):

ASENs work more autonomously with a lesser requirement for supervision from a Registered Nurse. The ASEN retains responsibility for their actions whilst remaining accountable to the Registered Nurse/Midwife for all delegated functions. The ASEN is able to perform within their full scope of practice in a spectrum of roles, functions, responsibilities, activities and decision-making capacities within which the Enrolled Nurse is educated, competent and authorised to perform. Staff working at this level are proficient to expert Enrolled Nurses within their specialist field.

In addition to fulfilling all of the duties of an Enrolled Nurse, an Advanced Skills Enrolled Nurse (ASEN) is characterised by:

- High level of specialisation in an area or field of practice;
- A higher level of clinical knowledge and skills informed by further education and on the job experience;
- A greater level of delegated responsibility in the management of client care which may include
- Clinical and non-clinical roles; and
- More indirect levels of supervision.

The Advanced Skills Enrolled Nurse will either:

- Hold an Advanced Diploma of Enrolled Nursing and have three years full time equivalent experience in the relevant clinical area; OR

- Have five years full time equivalent experience in the relevant clinical area and have demonstrated advanced skills and knowledge in patient/client assessment, care management and leadership responsibilities equivalent to those set out in the advanced diploma competencies.

The Advanced Skills Enrolled Nurse is an appointment based position within specified settings as determined and required by the health unit/service.

Where an EN considers that they possess the qualifications and skills for appointment to the ASEN classification they may make a request to the relevant EDON/M to consider appointment to that level. The request should:

- Specifically address the five dot points set in the classification descriptor, as outlined above.
- Support of the line manager or other RN3s should be sought, but is not essential.

Should a request be declined a grievance request in accordance with the SA Health HR Manual may be invoked.

The normal dispute settlement procedures will also be available.

Employees in ASEN roles will meet the following requirements (in addition to requirements for lower classified roles):

Direct/indirect patient/client care:

- The ASEN is able to formulate (in collaboration with the Registered Nurse/ Midwife and patient/client) appropriate care plans within their scope of practice, discussing assessment data with the Registered Nurse/Midwife and health care team;
- The ASEN contributes to nursing/midwifery care delivery, using their advanced knowledge and skills and understanding of evidenced based practice and best practice;
- The ASEN is able to recognise alterations in psychological and physiological status, respond appropriately and promptly, and report to a Registered Nurse/Midwife and the health care team as appropriate.

Support of health setting services:

- Contributes to accreditation standards and quality improvement actions;
- Contribute to the performance review and development of others.

Education:

- Delivering education for the patient/client and their significant others;
- Be active in career development with a commitment to lifelong learning and inquiry;
- Undertake self-reflection and utilise regular practice/performance assessment to identify areas for self-development and professional growth.

Research:

- The ASEN has an increased level of knowledge and understanding of how research can be applied to nursing practice within the scope of the Enrolled Nurse;
- The ASEN demonstrates a greater depth of knowledge and skills in a speciality area with more effective integration of theory and practice.

Professional leadership:

- The ASEN is able to undertake additional leadership responsibilities using their advanced skills and knowledge e.g. Contribute to and support team leadership roles, provide mentorship and preceptorship for others, thereby acting as a resource to others in clinical practice;
- May be involved in professional committees and working parties.

REGISTERED NURSE/MIDWIFE (LEVEL 1):

Employees classified at this level provide nursing and/or midwifery services in health service settings. Staff working within this level develop from novice practitioners to a proficient level of professional practice. They consolidate knowledge and skills and develop in capability through continuous professional development and experience.
An employee at this level accepts accountability for his or her own standards of nursing/midwifery care and for activities delegated to others.

Employees in these roles will, with increasing capability meet the following requirements:

Direct/indirect patient/client care:

- Assess individual patient/client needs, plan, implement and/or coordinate appropriate service delivery from a range of accepted options including other disciplines or agencies;
- Provide direct person centred nursing/midwifery care and/or individual case management to patients/clients on a shift by shift basis in a defined clinical area with increasing autonomy over time;
- Plan and coordinate services with other disciplines or agencies in providing individual health care needs.

Support of health service systems:

- Participate in quality improvement activities that contribute to patient/client safety, risk minimisation and safe work activities within the practice setting;
- Provide ward/team leader/coordination as required on a shift by shift basis. (A team leader is a RN assigned responsibility for supporting staff and coordinating patient/client care);
- Contribute to procedures for effectively dealing with people exhibiting challenging behaviours.

Education:

- Provide health promotion and education, to patients/clients or groups and carers to improve the health outcomes of individual;
- Support nursing/midwifery practice and learning experiences for students undertaking clinical placements, orientation for new staff and preceptorship of graduates.

Research:

- Participate in evaluative research activities within the practice setting;
- Use foundation theoretical knowledge and evidenced based guidelines to achieve positive patient/client care outcomes.

Professional leadership:

- Provide, with increasing capacity over time, support and guidance to newer or less experienced staff, Enrolled Nurses, student nurses and other workers providing basic nursing care;
- Review decisions, assessments and recommendations from less experienced Registered Nurses/ Midwives and Enrolled Nurses and students.

ALL NURSE/MIDWIFE LEVEL 2 CORE ROLES/DESCRIPTORS

Employees classified at this level provide nursing and/or midwifery services in a variety of health service settings which has been consolidated by experience and/or further study. Staff working at this level develop from competent to proficient practitioners.
Work at this level is undertaken by employees with at least 3 years post registration experience. An employee at this level accepts accountability for their own practice standards, activities delegated to others and the guidance and development of less experienced staff.
Roles at this level include:

- Clinical Nurse/Midwife
- Associate Nurse/Midwife Unit Manager

Employees in these roles will meet the following requirements (in addition to requirements for lower classified roles):

Direct/indirect patient/client care:

- Provide proficient, person centred, clinical nursing/midwifery care and/or individual case management to patients/clients in a defined clinical area;
- Monitoring patient/client care plans to ensure appropriate care outcomes are achieved on a daily basis;
- Oversee the provision of nursing/midwifery care within a team/unit.

Support of health service systems:

- Assists and supports the Nurse/Midwife Unit Manager or equivalent in management, clinical, and education activities
- Plan and coordinate services including those from other disciplines;
- Act to resolve local and/or immediate nursing/midwifery care or service delivery problems;
- Support change management processes.

Education:

- Participate in clinical teaching, overseeing learning experience, and goal setting for students, new staff and staff with less experience;

- Assist the Nurse/Midwife Unit Manager and Nurse/Midwife Educators to maintain a learning culture by being a resource person, encouraging reflection and professional development, and assisting others to maintain portfolios/records of learning.

Research:

- Participate in clinical auditing, clinical trials and/or evaluative research;
- Integrate advanced theoretical knowledge, evidence from a range of sources and own experience to devise and achieve agreed patient/client care outcomes;
- Assist the Nurse/Midwife Unit Manager or equivalent to maintain and record monitoring and evaluative research activities in the ward/unit.

Professional leadership:

- Promote continuity and consistency of care in collaboration with the Nurse/Midwife Unit Manager or equivalent of the ward/unit/service;
- Provide shift by shift leadership in the provision of nursing/midwifery care within a team or unit and facilitate patient flow;
- Act as a resource person within an area based on knowledge, experience and skills.

CLINICAL NURSE/MIDWIFE

The activities required of roles at this level continue to be predominantly clinical in nature; however employees are assigned appropriate portfolios. The allocation of portfolio responsibilities should be negotiated with each employee and be consistent with the career development plan for the employee as determined by their performance review/development plan.

Clinical Nurse/Midwife working at this level develop from competent to proficient practitioners including the development and application of skills that qualify for entry into advanced practice programs.

In addition to the Registered Nurse/Midwife Level 2 core components, the Clinical Nurse/Midwife, subject to being supported to do so, will:

- Be required to participate in and/or provide clinical teaching and/or research;
- Be required to contribute to a wider or external area team working on complex or organisation wide projects such as clinical protocols, guidelines and/or process mapping;
- Be required to undertake a specific activity and/or portfolio[5] responsibility:
- Be required, within pre-determined guidelines, and in a multi multidisciplinary primary health care setting, to assess clients, select and implement different therapeutic interventions and/or support programs and evaluate client progress.

Reclassification indictors criteria - Clinical Nurse/Midwife:

3 years post registration experience and demonstrates the following:

- Coordination of service: examples may include planning care, communicating clinical changes, working with other disciplines;
- Quality and safety: examples may include audit, risk minimisation, updating clinical procedures and evidence based practice guidelines, involvement in research;

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[5] Portfolio Enabling provision 4.6.1

- Leadership: examples may include resolving clinical practice issue, team leading/shift coordination, support change management processes; and
- Clinical teaching: examples may include educating patients, staff and students, updating education resources, and encouraging reflective practice.

ASSOCIATE NURSE/MIDWIFE UNIT MANAGER (AN/MUM)

In the course of fulfilling the AN/MUM role provides specific support to the Nursing/Midwifery Nurse/Midwife Unit Manager or equivalent in the leadership of nurses/midwives in the ward/unit/service.

Within the requirements of the AN/MUM role, employees in these roles will undertake a portfolio within which they will:

- Promote continuity and consistency of care in collaboration with other AN/MUM and the Nurse/Midwife Unit Manager or equivalent;
- Assist the Nurse/Midwife Unit Manager or equivalent in the implementation of practice changes; and
- Assist the Nurse/Midwife Unit Manager or equivalent in undertaking ward/unit/service management responsibilities, eg. performance management processes, recruitment, staffing, leave management, rostering, work allocation and attendance management; financial and supplies planning and monitoring.

Reclassification indicators criteria - Associate Nurse/Midwife Unit Manager:

3 years post registration experience and demonstrates the following:

- Coordination of service: examples may include planning care, communicating clinical changes;
- Quality and safety: examples may include conducting audit, risk minimisation, updating clinical procedures and evidence based practice guidelines;
- Leadership: examples may include taking charge of a nursing/midwifery team i.e. acting N/MUM, undertaking management task such as performance appraisal, resolving clinical practice issue, changing practice; and
- Clinical teaching: examples may include educating patients, staff and students, and updating education resources.

ALL NURSE/MIDWIFE LEVEL 3 CORE ROLES/DESCRIPTORS

Staff working at this level are experts within their area and stream of practice and have a significant degree of autonomy and decision making.

Work at this level is undertaken by employees with at least 3 years post registration experience. Roles at this level include:

- Nurse/Midwife Unit Manager
- Nurse/Midwife Consultant
- Nurse/Midwife Educator
- Nurse/Midwife Manager

Up to 30% of time can be allocated to functions that are normally associated with a role or roles other than the level 3 title allocated for the position. For example a Nurse/Midwife Unit Manager may undertake, for up to 30% of their time, the work normally allocated to a Nurse/Midwife Educator, Nurse/Midwife Manager and/or Nurse/Midwife Consultant.

Employees in these roles will meet the following core requirements (in addition to relevant requirements for lower classified roles in their service stream and the specific requirements of their role, listed on the following pages):

Direct/indirect patient/client care:

- Integrate contemporary information and evidence with personal experience to support the decision making, innovative thinking and objective analysis that are expected at this level; e.g. Expert clinical knowledge underpins and informs their ability to support, lead and/or provide expert clinical care; develop and guide appropriate clinical education, and/or provide management activities that contribute to improve and optimise nursing/midwifery care.

Support of health service systems:

- Use available information systems: to inform decision making, to implement and co-ordinate processes for quality improvement, to monitor and analyse incidents and accidents, to ensure quality and safety is not compromised, to evaluate outcomes and convey information to staff;
- Contribute to the development of, implementation of, and monitoring of corporate policies and processes and lead in their area of expertise;
- Management of resources with due diligence;
- Implement and co-ordinate within span of control, processes for quality improvement and continuity within corporate risk management and nursing/midwifery professional practice frameworks;
- Identifying hazards, assessing risks and implementing, monitoring and maintaining hazard control measures;
- Maintain productive working relationships and manage conflict resolution.

Education:

- Hold a contemporary professional practice portfolio containing evidence of postgraduate qualifications, learning and practice experience that underpin a demonstrable application of knowledge and skills commensurate with the level and type of practice expected of the role;
- Ensure mechanisms are in place to support ongoing education where work and learning are integrated.

Research:

- Contribute specific expertise to monitor and evaluate research activities in order to improve nursing or midwifery practice and service delivery;
- Establishing, implementing and evaluating systems, which ensure best practice/evidence and patient/client outcomes;
- Applies evidenced based recommendations to improve practice and service function.

Professional leadership:

- Provides leadership and direction, acts as a role model, mentor, consultant and resource person.

ADDITIONAL ROLES REQUIREMENTS / DESCRIPTORS FOR EACH ROLE

NURSE/MIDWIFE UNIT MANAGER (LEVEL 3):

Employees classified at this level use their clinical knowledge and experience to provide the pivotal co-ordination of patient/client care delivery in a patient/client care area within a Health Unit/Community Service. The main focus of this role is the line management, coordination and leadership of nursing/midwifery and/or multi-disciplinary team activities to achieve continuity and quality of patient/client care and outcomes.

Employees in this role accept accountability for the outcomes of nursing/midwifery practices and/or multidisciplinary outcomes in the specific practice setting; for addressing inconsistencies between practice and policy; and for developing team performance and a positive work culture in the interest of patient/client outcomes.

Employees in this role will meet the following requirements (in addition to the above core level 3 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Provide the pivotal leadership and co-ordination of patient/client care delivery in a defined

ward/unit/service/program to achieve continuity and quality of patient/client care and outcomes and efficient patient/client flow.

Support of health service systems:

- Implement local processes to operationalise the corporate risk management framework including investigating complaints, incidents and accidents;
- Change local processes and practices in accordance with emerging service needs, care evaluation results, identified imminent systems problems, and coordination of local activities with corporate systems;
- Undertake and/or oversee, within their span of control, some or all local resource management within the corporate administrative framework. Including some or all of the following within their defined ward/unit/value stream or program: recruitment, staffing, leave management; rostering, work allocation and attendance management; financial and supplies planning and monitoring.

Education:

- Develop and maintain a learning environment, taking a coaching approach to team development, individual capability development and performance development.

Research:

- Uses metrics and research outcomes to identify the need for future evaluation or research action in order to improve practice and service delivery.

Professional leadership:

- Lead the nursing/midwifery team within the professional practice framework established by the Director of Nursing/Midwifery, and where appropriate, lead a multi-disciplinary team;
- Leads changes to models of care;
- Participate in workgroups/ programs for patient/client outcomes that extend beyond the unit/service/workplace.

Reclassification indicators criteria – Nurse/Midwife Unit Manager (Level 3)

3 years post registration experience.

Holds or is working towards a post graduate qualification relevant to their role and demonstrates the following:

- Provide the pivotal leadership and co-ordination of patient/client care delivery in a defined ward/unit/service/program to achieve continuity and quality of patient care outcomes and efficient patient flow;
- Leadership through effective decision making, identifying & managing risk and change management;
- Leading effective performance management, and building professional capability / development of the team; and
- Leading effective budget and resource management.

NURSE/MIDWIFE CONSULTANT (LEVEL 3):

Employees classified at this level provide clinical nursing/midwifery expertise for specified individual patients/clients and/or groups/populations, and/or provide clinical leadership for an area of practice, and may work in a variety of clinical settings.

Various practice models may be used to enact this role, including but not limited to:

- Primarily providing nursing/midwifery care;
- Providing clinical leadership to nurses/midwives;
- Coordination and leadership of projects and/or programs that contribute clinical expertise to improve patient/client/service outcomes;
- Nurse Practitioner Candidate: Nurses classified at this level are working towards becoming an expert and being able to provide extended practice in their specialist field, within their scope of practice. They develop their capacity for extended practice by increasing their knowledge and skills through ongoing clinical

exposure, post graduate qualifications and mentoring, with supervision by an authorised nurse practitioner and/or medical staff.

Employees in this role accept accountability for their nursing/midwifery practice, the outcomes of nursing/midwifery practices for the specific patient/client group, the professional advice given, delegations of care made and for addressing inconsistencies between practice and policy.

Employees in this role will meet the following requirements (in addition to the above core level 3 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Provide direct, expert clinical nursing/midwifery care, select and implement different therapeutic interventions, provide individual case management to a defined population of patients/clients and evaluate progress;
- Contribute expert nursing/midwifery assessment and advice to local clinical teams to achieve integrated nursing/midwifery care within a risk management framework;
- Undertake the nursing/midwifery care role with a significant degree of independent clinical decision making in the area of personal expertise;
- Be required in a multidisciplinary primary health care setting to apply nursing/midwifery expertise to assess clients, select and implement different therapeutic interventions and/or support programs and evaluate patient/client progress;
- Effective complex discharge planning / hospital avoidance through the provision of education, equipment and referral.

Support of health service systems:

- Contribute to the development and sustainability of nursing/midwifery skills for the needs of the specific population group using systems of resource and standards promulgation;
- Contribute specific expertise to nursing/midwifery practice through clinical protocol and standards development.

Education:

- Apply and share expert clinical knowledge to improve patient/client care outcomes;
- Contribute clinical expertise to learning environments, which may include individual/team capability development and/or post registration clinical teaching.

Research:

- Contribute to clinical practice research.

Professional leadership:

- Lead nursing/midwifery clinical practice within the professional practice framework established by the Director of Nursing/Midwifery and/or lead a multidisciplinary team;
- Contribute to the redesign of care and treatment practices.

Reclassification indicators criteria – Nurse/Midwife Consultant (Level 3)

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their clinical practice and demonstrates the following:

- Leading and providing expert clinical care/advice demonstrating assessment, decision making, and therapeutic intervention;
- Leading the analysis, measurement and evaluation of clinical practice;
- Leading the development of evidence based practice through measures such as clinical protocols, standards and health education resources; and

- Providing effective complex discharge planning / hospital avoidance through the provision of education, equipment and referral to support services.

NURSE/MIDWIFE EDUCATOR (LEVEL 3):

Employees classified at this level use their clinical knowledge and experience to provide a corporate support service to nursing/midwifery practice, which may include but not be limited to areas such as the provision of a range of education, training, learning experiences and materials.

Employees in this role accept accountability for the outcomes of nursing/midwifery education practices, for addressing inconsistencies between practice and policy; and for contributing to a safe and positive work culture in the interest of patient/client outcomes.

Various practice models may be used to enact this role, including but not limited to:

- Providing education and training support to a specific group of wards/units/service/ community programs and/or specific nurses/midwives;
- Providing education support in a specific education and/or training portfolio;
- Coordination and leadership of projects, programs and/or research to achieve improved educational outcomes and/or service delivery.

Employees in this role will meet the following requirements (in addition to the above core level 3 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Contribute to competency improvement and analysis, measurement and evaluation of education and professional development.

Support of health service systems:

- Plan, coordinate and provide education support for change processes, risk management practices and service improvement activities within the organisation's professional practice, education and administrative frameworks;
- Contribute to capability development requirements identified within performance development and succession planning activities;
- Coordination and leadership of projects, programs and/or research to achieve improved educational outcomes and/or service delivery.

Education:

- Contribute to the support of undergraduate and post graduate students in clinical placements;
- Contribute to the review and management of education/training programs to ensure the achievement of outcome standards and KPIs;
- Collaborate with Nurse/Midwife Unit Managers and Nurse/Midwife Consultants to co-ordinate teaching and learning processes and achieve planned outcomes;
- Provide and/or coordinate educational support within the organisation's professional practice, education and administrative frameworks;
- Contribute to the dissemination of information regarding current developments in nursing and midwifery;
- Teach and/or assess specific post-graduate/university course topics in area of own expertise;
- Undertake and/or oversee teaching sessions and assessment processes to designated student population;
- Development, delivery and evaluation of education programs and materials for all levels of nursing/midwifery staff and students and promote inter-professional learning;
- Development and writing of curriculums that articulate with the Australian Quality Training Framework.

Research:

- Undertake or oversee short term clinical and/or education research projects.

Professional leadership:

- Provide, coordinate and advise key stakeholders on education services;
- Contribute to the development of leaders;
- Responsible for ensuring that the principles of contemporary research are used in the evaluation of nursing/midwifery education programs throughout the health network for which the educator is responsible;
- Developing systems to support performance development and competency assessment.

Reclassification indicators criteria- Nurse/Midwife Educator (Level 3)

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role and demonstrates the following:

- Leading and developing programs and processes to support consistent education practices for all levels of nursing and midwifery staff and students and promote inter-professional learning;
- Leading the analysis, measurement and evaluation of education and professional development; and
- Leading the development of processes that enables capability building and work collaboratively with the N/MUM to undertake performance management and competency assessment of staff.

NURSE/MIDWIFE MANAGER (LEVEL 3):

Employees classified at this level use their clinical knowledge and experience to provide support services to both Nurse/Midwife Unit Managers and Nursing Directors in nursing/midwifery practice and services in areas including but not limited to staffing methodologies, recruitment and selection, human resource management, financial administration, patient flow, bed and resource management, accreditation and risk management processes and information systems management.

Employees in this role accept accountability for the outcomes of nursing/midwifery management practices, for addressing inconsistencies between practice and policy; and for contributing to a safe and positive work culture in the interest of patient/client outcomes. Individual employees accept accountability for their specific span of control or allocated portfolio.

Various practice models may be used to enact this role, including but not limited to:

- Providing management support to a specific span of wards/units/programs/service;
- Providing management support in a specific work portfolio/s;
- Coordinating and managing projects, programs and/or research to achieve improved patient/client outcomes and/or service delivery;
- Provides after hours oversight and management of the health service including staff allocation, operational management of patient/client flow and access, professional responsibility for nursing and midwifery staff, staffing skills mix, work health and safety responsibilities and significant events in consultation with the executive on call.

Employees in this role will meet the following requirements (in addition to the above core level 3 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Integrate corporate management activities and local service coordination to achieve continuity of patient/client services to improve and optimise nursing/midwifery care, and outcomes within their specific setting.

Support of health service systems:

- Integrate corporate and local unit/ward/program/service human and material resource management in collaboration with Nurse/Midwife Unit Manager and/or other nurse managers;
- Change local processes and practices in accordance with emerging management needs, evaluation results

and imminent systems problems;
- Lead the development and analysis, measurement and evaluation of management processes;
- Maintain a safe work environment/staffing levels/skill mix/recruitment and retention;

- Provide corporate support to nursing/midwifery practice and services within the professional practice framework established by the Director of Nursing/Midwifery.

Research:
- Coordinating and managing projects, programs and/or research to achieve improved patient/client outcomes and/or service delivery.

Professional leadership:
- Provides advice to key stakeholders on issues relating to professional practice, and workforce legislation.

Reclassification indicators criteria – Nurse/Midwife Manager (Level 3)

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role and demonstrates the following:
- Leading and developing processes to support any of the following functions: quality, accreditation, risk management practice, patient flow, bed management, equipment and information management;
- Leadership including analysis, measurement and evaluation of any of the processes above;
- Leading the development and analysis of effective recruitment and retention strategies; and
- Leading change management.

ALL NURSE/MIDWIFE LEVEL 4 CORE ROLES/DESCRIPTORS

Staff working at this level have high level expertise within their area and stream of practice and have a significant degree of autonomy.
Distinction between level 3 and level 4 roles is by comparison to like services. Level 4 roles may have greater clinical complexity and/or size of service, and/or breadth/reach/scope of practice and/or span of control[6] or sphere of influence[7], and/or number of direct supports/staff, and/or number of patients/clients.

Work at this level is undertaken by employees with at least 3 years post registration experience.
Roles at this level include:
- Advanced Nurse/Midwife Unit Manager
- Advanced Nurse/Midwife Consultant
- Advanced Nurse/Midwife Educator
- Advanced Nurse/Midwife Manager
- Nurse Practitioner

Up to 30% of time can be allocated to functions that are normally associated with a role or roles other than the level 4 title allocated for the position. For example a Nurse/Midwife Unit Manager may undertake, for up to 30% of their time, the work normally allocated to an Advanced Nurse/Midwife Educator, Nurse/Midwife Manager and/or Nurse/Midwife Consultant.

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[6] Span of control defines the number of resources (people, assets and infrastructure) for which a person is responsible. Span of control can be narrow or wide.

[7] A person with a wide span of influence must interact extensively with, and influence people in other areas/units/services. The more complex and interdependent a job is the greater the span of influence.

Employees in these roles will meet the following core requirements (in addition to relevant requirements for lower classified roles in their service stream and the specific requirements of their role, listed on the following pages):

Direct/indirect patient/client care:

- Integrate contemporary information and evidence with personal experience to support the decision making, innovative thinking and objective analysis that are expected at this level. E.g. Expert clinical knowledge underpins and informs their ability to support, lead and/or provide expert clinical care; develop and guide appropriate clinical education, and/or provide management activities that contribute to improve and optimise nursing/midwifery care.

Support of health service systems:

- Initiate, implement and co-ordinate processes, for quality improvement and continuity within corporate risk management and nursing/midwifery professional practice frameworks; e.g. investigating complaints, incidents and accidents, identifying hazards, assessing risks and implementing, monitoring and maintaining hazard control measures;
- Change local processes and practices in accordance with emerging service needs, care evaluation results, identified imminent systems problems, and coordination of local activities with corporate systems;
- Lead and coordinate the development and evaluation of clinical protocols, standards, policies and procedures;
- Develop customised Key Performance Indicators and/or outcomes measurement models that influence organisation wide reporting processes;
- Identify the need for, lead implementation of, and evaluate changes in organisational processes and practices in response to emerging service and workforce needs;
- Use available information systems to inform decision making, evaluate outcomes and convey information to staff;
- Initiate, develop and implement educational and/or clinical protocols/standards.

Education:

- Hold a contemporary professional practice portfolio containing evidence of postgraduate qualifications and learning and practice experiences that underpin a demonstrable application of knowledge and skills commensurate with the level of autonomy, decision making authority and influence of recommendations expected of the role;
- Present at conferences, undertake post graduate teaching and assessment and/or publish in refereed professional journals.

Research:

- Integrate contemporary information and research evidence with personal experience to support the decision making, innovative thinking and objective analysis that are expected at this level; e.g. Critically appraise and synthesise the outcomes of relevant research;
- Initiate, conduct, implement and/or guide a major research or systems development portfolio relevant to improved service outcomes;
- Contribute specific expertise to monitoring and evaluative research activities in order to improve nursing or midwifery practice and service delivery.

Professional leadership:

- Act as a consultant to the state or national health system in area of expertise, providing authoritative advice and recommendations;
- Act as a consultant providing high level advice to key stakeholders on national and state protocols, and issues relating to professional and clinical practice, workforce, legislation, education and/or research;
- Provides leadership and direction, acts as a role model, mentor, consultant and resource person;
- May lead and participate in state-wide services.

ADDITIONAL ROLES/DESCRIPTORS FOR EACH CLASSIFICATION

ADVANCED NURSE/MIDWIFE UNIT MANAGER (LEVEL 4):

Employees classified at this level use their clinical knowledge and experience to provide the pivotal co-ordination of patient/client care delivery in a patient/client care area within a Health Unit or Community Service. The main focus of this role is the line management, coordination and leadership of the nursing/midwifery team and/or multi-disciplinary team activities, including where relevant, such local resource management as to achieve continuity and quality of patient/client care and outcomes.

Employees in this role accept accountability for the outcomes of nursing/midwifery practices and/or multidisciplinary outcomes in the specific practice setting, for addressing inconsistencies between practice and policy; and for developing team performance within positive work cultures in the interest of patient/client outcomes.

At level 4 staff will lead, manage, oversee and advise on nursing/midwifery care and health service delivery for a defined service delivery area which is (by number of patients/clients and/or by clinical complexity and/or breadth and/or professional isolation) demonstrably beyond the usual range for that practice setting.

Level 4 RN/RM (Advanced Nurse/Midwife Unit Manager, however titled) can have line-management of Level 3 RN/RM(s), only if the Level 4 role fulfils all of the following criteria:

- The Level 4 RN/M role must be a multi-classified position; and
- The number of Level 3 RN/M reports must be less than 8; and
- The service must be within a Community service/setting/team.

Employees in this role will meet the following requirements (in addition to the above core level 4 requirements and the relevant requirements for lower classified roles in their service stream):

Support of health service systems

- Undertake and/or oversee, within their span of control, some or all local resource management within a corporate administrative framework. Including some or all of the following within their defined ward/unit/value stream or program: recruitment, staffing, leave management; rostering, work allocation and attendance management; financial and supplies planning and monitoring;
- Undertake a formal support/advisor role to Nurse/Midwife Unit Managers in relation to an area of expertise in service co-ordination.

Education:

- Develop and maintain a learning environment, taking a coaching approach to team development, individual capability development and performance development.

Professional leadership:

- Lead a nursing/midwifery and/or multi-disciplinary team;
- Initiate and lead changes to models of care;
- Participate in workgroups/programs for patient/client outcomes that extend beyond the unit/service/workplace;
- Implement important and/or influential systems used beyond own area of service co-ordination.

Reclassification indicators criteria – Advanced Nurse/Midwife Unit Manager (Level 4):

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role; and

- Manages, oversees and advises on nursing/midwifery care and health service delivery for a specified service delivery area which is (by number of patients and/or by clinical complexity or breadth) demonstrably beyond the usual range for that practice setting; OR

- Manages, oversees and advise on nursing/midwifery care and health service delivery for a specified service delivery area which is demonstrably more professionally isolated than the usual range; OR
- Leads a nursing/midwifery and/or multi-disciplinary team, which is (by direct reports and/or span of control or multiple operational links) demonstrably beyond the usual range.

ADVANCED NURSE/MIDWIFE CONSULTANT (LEVEL 4):

Employees classified at this level provide clinical nursing/midwifery expertise for specified individual patients/clients and/or groups and/or patient/client populations, may work in a variety of clinical settings.

Employees in this role accept accountability for their nursing/midwifery practice, the outcomes of nursing/midwifery practices for the specific patient/client group, the professional advice given, delegations of care made and for addressing inconsistencies between practice and policy.

At level 4 clinicians practice beyond the usual extent of nursing/midwifery scope of practice and are autonomous clinical decision makers, working independently and collaboratively in the health care system.

Various practice models may be used to enact this role, including but not limited to:

- Primarily providing direct expert nursing/midwifery care for individuals and/or groups of patients/clients;
- Providing clinical leadership to nurses/midwives within the span of appointment;
- Contribute and manage state-wide portfolios/projects/programs to contribute to the development, implementation and evaluation of relevant Departmental and Government policies.

Employees in this role will meet the following requirements (in addition to the above core level 4 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Provide expert clinical nursing/midwifery care and interventions and/or individual case management to a defined population of patients/clients;
- Be required in a multidisciplinary primary health care setting to apply nursing/midwifery expertise to assess clients, select and implement different therapeutic interventions and/or support programs and evaluate patient/client progress;
- Contribute expert nursing/midwifery assessment and advice to clinical teams to achieve integrated nursing/midwifery care within a risk management framework;
- Comprehensively assess health status including history and physical examination;
- Initiate and interpret diagnostic pathology and/or radiology;
- Initiate interventional therapies and use of health appliances or equipment;
- Clinically manage patients/clients either directly or by delegation;
- Communicate patient/client management plans to all relevant members of the health care team, including general practitioners and/or other agencies;
- Practice extensions of the nursing/midwifery role in accordance with local clinical and/or admitting privileges, agreements, practice guidelines and/or protocols;
- The role may be sessional in combination with clinical practice responsibilities.

Support of health service systems:

- Contribute to the development and sustainability of nursing/midwifery skills and practice development for the needs of the specific population group using systems of resource and standards promulgation;
- Contribute specific expertise to nursing/midwifery practice through clinical protocol and standards development.

Education:

- Apply and share expert clinical knowledge to improve patient/client care outcomes;
- Contribute clinical expertise to learning environments, which may include individual/team capability

development and/or post registration clinical teaching.

Research:

- Conduct and/or guide clinical practice research.

Professional leadership:

- Lead nursing/midwifery clinical practice within the professional practice framework established by the Director of Nursing/Midwifery and/or lead a multidisciplinary team;
- Lead the redesign of care and treatment practices.

Reclassification indicators criteria – Advanced Nurse/Midwife Consultant (Level 4):

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their clinical practice and demonstrates the following:

- Practices at a level of clinical expertise and autonomy demonstrably beyond the usual range; and/or
- Leading high level clinical practice change through the development of clinical standards, protocols, policy and/or legislation that is demonstrably beyond the usual range (e.g. whole of state level, complex & multidisciplinary).

NURSE PRACTITIONER (LEVEL 4):

A nurse practitioner is an advanced practice nurse endorsed by the Nursing and Midwifery Board of Australia to practise within their scope under the legislatively protected title 'nurse practitioner'. Nurse Practitioners are expert practitioners, practicing beyond the usual extent of a nurse, at an advanced level, with an expanded scope of practice, and with an advanced degree of autonomy and clinical decision making. They work independently and collaboratively in the health care system. Employees classified at this level provide high level clinical nursing expertise for specified individual patients/clients and/or groups/populations.

Employees in these roles accept accountability for their nursing practice, professional advice given, delegations of care made and for addressing inconsistencies between practice and policy.

Employees in this role will meet the following requirements (in addition to the above core level 4 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Provide comprehensive assessment of health status including history and physical examination; clinical management of patients/clients either directly or by delegation for a complete occasion of service to a defined patient/client population within a scope of practice;
- Ability to initiate and interpret diagnostic pathology and/or radiology; initiate interventional therapies, medications and use of health appliances or equipment; and admit and discharge from services;
- Communicate patient/client management plans to all relevant members of the health care team, including general practitioners and/or other agencies;
- Contribute expert nursing assessment and advice to local clinical teams to achieve integrated nursing care within a risk management framework;
- Practice extensions of the nursing role in accordance with local clinical and/or admitting privileges, agreements, practice guidelines and/or protocols and State and Federal legislation and regulatory requirements.

Support of health service systems:

- Identifies best practice and measures adherence to evidence based clinical practice standards, to improve local performance of clinical care i.e. audits;

- May manage (be a team leader for) a small group of staff within the specialised area of practice;
- Contribute to the development and sustainability of nursing skills for the needs of the specific population group using systems of resource and standards promulgation.

Education:

- Lead the development of education resources for health professionals and patient/client groups.

Research:

- Develops, conducts and guides clinical research to evaluate own and organisational practice to deliver informed practice change;
- Will lead by example in developing highly innovative solutions to problems based on research and inquiry.

Professional leadership:

- Influences the practice of nursing and multi-disciplinary care;
- Contribute and manage state-wide portfolios, projects, and programs to contribute to the development, implementation, and evaluation of relevant departmental and government policies;
- Contribute to redesign of care and treatment practices.

Reclassification indicators criteria – Nurse Practitioner (Level 4)

3 years post registration experience;

Holds a post graduate qualification relevant to their clinical practice.

Nursing and Midwifery Board of Australia endorsed and,

- Written confirmation of the Nurse Practitioner's endorsed scope of practice; and
- The employer is aware and supports the fact that the scope of practice has relevance to the practice setting and can be applied in the work environment.

Applicants for reclassification to Nurse Practitioner should demonstrate the following:

- Clinical practice at an expert level with high level of autonomy by leading and providing expert clinical care/advice demonstrating assessment, decision making, and therapeutic intervention;
- Leading the analysis, measurement and evaluation of clinical practice;
- Leading the development of evidence based practice through measures such as clinical protocols and standards; and
- Leading the development of education resources for health professionals and client groups.

ADVANCED NURSE/MIDWIFE EDUCATOR (LEVEL 4):

Employees classified at this level use their clinical knowledge, experience and expertise to provide a corporate support service to nursing/midwifery practice and services including but not limited to areas such as the provision and oversight of a range of education, training, learning experiences and materials.

Employees in this role accept accountability for the outcomes of nursing/midwifery education practices, for addressing inconsistencies between practice and policy; and for contributing to a safe and positive work culture in the interest of patient/client outcomes.

Various practice models may be used to enact this role, including but not limited to:

- Leading a course/program team in education and training provision;
- Leading a specific portfolio/project within education and training provision;
- Undertaking a primarily academic and research role.

At level 4 staff lead, coordinate and advise on education and training services, which are (by number of course

participants and/or by educational complexity or breadth) demonstrably beyond the usual range; AND/OR Lead the development of new or innovative courses/programs, and/or curriculum development, which meet the emergent requirements of the health sector and are beyond the scope of the usual Nurse/Midwife Educators role.

Employees in this role will meet the following requirements (in addition to the above core level 4 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/indirect patient/client care:

- Lead and analyse competency improvement requirements identified for the whole organisation/health network.

Support of health service systems:

- Plan, coordinate and provide educational support for change processes, risk management practices and service improvement activities within the organisation's professional practice, education and administrative frameworks;
- Contribute to capability development requirements identified within performance development and succession planning activities;
- Coordination and leadership of projects, programs and/or research to achieve improved educational outcomes and/or service delivery (which is demonstrably beyond the usual range);
- Contribute to the review and management of education/training programs to ensure the achievement of outcome standards and Key Performance Indicators.

Education:

- Contribute to the support of undergraduate and post graduate students in clinical placements as appropriate;
- Collaborate with Nurse/Midwife Unit Managers and Nurse/Midwife Consultants to co-ordinate teaching and learning processes and achieve planned outcomes;
- Contribute to the dissemination of information regarding current developments in nursing and midwifery;
- Teach and/or assess specific post-graduate/university course topics in area of own expertise;
- Undertake and/or oversee teaching sessions and/or assessment processes to designated nursing and midwifery populations;
- Development, delivery and evaluation of education programs and materials;
- Development and writing of complex curriculums that articulate with the Australian Quality Training Framework.

Research:

- Initiate, conduct and/or guide research within an area of education practice;
- Directly undertake and/or be accountable for a major research or evaluative project beyond the scope of the usual Nurse/Midwife Educators role;
- Responsible for ensuring that the principles of contemporary research are used in the evaluation of nursing/midwifery education programs throughout the health network for which the educator is responsible.

Professional leadership:

- Provide, coordinate and advise key stakeholders on education services;
- Contribute to the development of leaders;
- Mentor and coach Nurse/Midwife Educators in relation to an area of expertise;
- Develop systems to support performance development and competency assessment.

Reclassification Indicators criteria – Advanced Nurse/Midwife Educator (Level 4)

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role and demonstrates the following:

- Leading competent workforce development including developing systems and processes that enable Clinical Service Coordinators to demonstrate a high performing team, and developing systems to support performance development and competency assessment, and is responsible for either:
    - Leading a course/program team in education and training provision; and/or
    - Leading a specific portfolio/project within education and training provision; and/or
    - Undertaking a primarily academic and research role; OR
- Provide, oversee and advise on education services, which are (by number of students and/or by educational complexity or breadth), demonstrably beyond the usual range.

ADVANCED NURSE/MIDWIFE MANAGER (LEVEL 4):

Employees classified at this level use their clinical knowledge and experience to provide support services to both Nurse/Midwife Unit Managers and Nursing Directors in nursing/midwifery practice and services in areas including but not limited to staffing methodologies, recruitment and selection, human resource management, financial administration, bed and resource management, accreditation and risk management processes and information systems management.

Employees in this role accept accountability for the outcomes of nursing/midwifery management practices, for addressing inconsistencies between practice and policy, for contributing to a safe and positive work culture in the interest of patient/client outcomes and for developing corporate team performance. Individual employees accept accountability for their specific span of control or allocated portfolio.

At level 4 staff provide, oversee and advise on corporate management and systems services that are by complexity or breadth, demonstrably beyond the usual range; AND/OR Initiate and lead projects of significant scope and complexity such as capital works developments or major systems changes.

Various practice models may be used to enact this role, including but not limited to:

- Providing management support to a specific span of wards/units/programs/services;
- Providing management support in a specific work portfolio/s;
- Coordination, leading and/or management of complex projects, programs and/or clinical research of significant scope that contribute to the development, implementation and evaluation of strategic directions, policies, goals and objectives that support professional practice demonstratively beyond the usual range;
- Provides after hours oversight and management of the health service including staff allocation, operational management of patient/client flow and access, professional responsibility for nursing and midwifery staff, staffing skills mix, work health and safety responsibilities and significant events in consultation with the executive on call.

Employees in this role will meet the following requirements (in addition to the above core level 4 requirements and the relevant requirements for lower classified roles in their service stream):

Direct/Indirect patient/client care

- Integrate corporate and local service coordination to achieve continuity of patient/client services to improve and optimise nursing/midwifery care, and outcomes within their specific setting.

Support of health service systems

- Integrate corporate and local unit/ward/service/program human and material resource management in collaboration with Nurse/Midwife Unit Managers and/or other managers;
- Undertake the work of a portfolio beyond the usual range for the setting, within the corporate administrative framework and delegations of responsibility;
- Contribute to the development of, implementation of, and monitoring of corporate policies and processes;
- Provide corporate support to nursing/midwifery practice and services within the professional practice framework established by the Director of Nursing/Midwifery;
- Change processes and practices in accordance with emerging management needs, evaluation results and

imminent systems problems;
- Lead the development and analysis of staffing methodologies, recruitment and selection, human resource management, financial administration, bed information and resource management;
- Maintain a safe work environment/staffing levels/skill mix/recruitment and retention;
- Coordinate, lead and manage portfolios/projects/programs of significant scope to contribute to the development, implementation and evaluation of relevant practices and policies;
- Use and develop or make significant adaptation to clinical and/or management information systems.

Research
- Coordinating and managing projects, programs and/or research to achieve improved patient/client outcomes and/or service delivery;
- Directly undertake and/or oversee a major research or evaluative project beyond the scope of the usual Nurse/Midwife Manager role;
- Coordinate, lead and/or manage complex clinical research that contributes to the development, implementation and evaluation of strategic directions, policies, goals and objectives that support professional practice.

Professional leadership
- Provides advice to key stakeholders on issues relating to professional practice, and workforce legislation;
- Lead a team and/or accept accountability for a major administrative portfolio demonstrably beyond the usual range;
- Provide a support/advisor role to other Nurse/Midwife Managers;
- Act as a consultant to the state or national health system in an area of expertise.

Reclassification Indicators criteria – Advanced Nurse/Midwife Manager (Level 4)

3 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role and demonstrates the following:
- Provide, oversee and advise on corporate management and systems services that are by complexity or breadth, demonstrably beyond the usual range; OR
- Lead a team and/or accept accountability for a major administrative portfolio demonstrably beyond the usual range; OR
- Initiate and lead projects of significant scope and complexity such as capital works developments or major systems changes; OR
- Coordinate and manage portfolios/projects/programs of significant scope to contribute to the development, implementation and evaluation of relevant practices and policies.

NURSING AND/OR MIDWIFERY SERVICE DIRECTOR (LEVEL 5.1):

Employees classified at this level use their clinical knowledge and experience to provide strategic and operational leadership, governance, and direction for nursing/midwifery services for a specified small, single purpose Clinical Service in a Hospital, Stream or a Community Service. This role will usually be responsible for a service that exists within a larger division/stream, and therefore must report to a Level 5.2 or 5.3 position. The role balances and integrates strategic and operational perspectives within a specified span of appointment. Work at this level is undertaken by employees with at least 5 years post registration experience. Staff working at this level are experienced managers, practicing at an expert level within their span of control, with a high level of autonomous decision making.

Employees in this role accept accountability for the governance and practice standards of nurses/midwives, the effective implementation of corporate systems to support, evaluate and consistently improve nursing/midwifery practice and healthy work environments, and for the cost effective provision of health services within their span of appointment.

Employees in this role will meet the following requirements:

Direct/indirect patient/client care:

- Integrate and evaluate models of care;
- Build a culture which is patient/client centered and where patient/client engagement is encouraged;
- Developing and implementing strategies for effective patient flow.

Support of health service systems:

- Develops and implements a framework of clinical governance according to the highest standards of service delivery and quality improvement;
- Proactively develop and implement strategies to manage identified risk;
- Initiate and/or oversee innovations, systemic change processes, and co-ordination of responses to nursing/midwifery practice and health service needs within their span of control;
- Lead the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment;
- Within a culture of due diligence be responsible for financial budgeting and management within span of control, and contribute to financial budgeting and management for the organisation;
- Guide the use of information systems to inform decision making, and manage practice;
- Contribute to human resource systems implementation including processes and standards of nursing/midwifery staff recruitment, performance, development and retention within span of control;
- Provide corporate professional nursing/midwifery advice, leadership, and management for a single purpose service/stream with approximately 80 to 130 FTE nursing/midwifery staff; OR
- Provide professional nursing/midwifery advice and leadership to approximately 8 to 10 direct and indirect reports at Level 3 and/or 4 working within the small, single purpose service on a regular basis;
- This role may provide leadership to a small number of ancillary staff that support the nursing/midwifery service.

Education:

- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- Develop, and encourage a learning environment by mentoring and promoting team development and individual capacity building.

Research:

- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making.

Professional leadership:

- Contribute to strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- Lead, coach, coordinate and support direct reports;
- Actively participate in internal and external advisory groups, expert panels, working groups and/or committees.

Reclassification Indicators criteria - Service Director 5.1:

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Is accountable and responsible for:

- Professional or operational leadership of nursing/midwifery activities to achieve continuity and quality of service provision;

- Developing and implementing strategies for effective patient flow;
- Resource management including effective financial budgeting and management for their clinical service;
- Developing and implementing strategic directions for the service and leading change management;
- Human resource strategies that recruit, develop and retain nursing/midwifery staff in their service; and
- Proactively develop and implement strategies to manage identified risk.

NURSING AND/OR MIDWIFERY DIRECTOR (LEVEL 5.2):

Employees classified at this level use their clinical knowledge, experience and expertise to provide strategic and operational leadership, governance, and direction for nursing/midwifery services. These roles balance and integrate strategic and operational perspectives within a specified span of appointment. Work at this level is undertaken by employees with at least 5 years post registration experience.

Employees in this role accept accountability for the governance and practice standards of nurses/midwives; the development and effectiveness of systems to support, evaluate and consistently improve nursing/midwifery practice and healthy work environments, and the cost effective provision of health services within their span of appointment.

Nursing and/or Midwifery Divisional Director (Level 5.2)
Employees classified in this role provide strategic, operational and corporate management and leadership to nursing/midwifery staff.

Employees in the role of Nursing and/or Midwifery Divisional Director will typically:

Direct/indirect patient/client care:

- Professional, operational or corporate leadership of nursing/midwifery activities to achieve continuity and quality of service in the division;
- Oversee the standards of nursing and midwifery clinical practice;
- Integrate and evaluate models of care;
- Build a culture which is patient/client centered and where patient/client engagement is encouraged;
- Developing and implementing strategies for effective patient flow.

Support of health service systems:

- Provide professional nursing/midwifery advice and leadership to Level 3 and/or 4s within a division/stream containing a maximum of 100 beds (or equivalent) without a Nursing and/or Midwifery Service Director RN/M 5.1 (unless otherwise agreed by the parties) working within the nursing/midwifery division; OR
- Provide professional nursing/midwifery advice and leadership to Level 3 and/or 4s within a division/stream containing a maximum of 150 beds (or equivalent) with one Nursing and/or Midwifery Service Director RN/M 5.1 (unless otherwise agreed by the parties) working within the nursing/midwifery division;
- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division/stream. The role will usually be responsible for a service that exists within a larger division/stream, and therefore must report to a 5.3 position, the Director of Nursing/Midwifery or Executive Director of Nursing/Midwifery who has responsibility for the service;
- This role may also provide leadership and management to ancillary and other staff located within the division/stream;
- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division which may also operate within a clinical stream;
- May be required to provide management of services other than nursing/midwifery;
- Oversee human resource systems implementation including processes and standards of nursing/midwifery staff recruitment, performance, development and retention;
- Implement the corporate administrative and risk management frameworks within frame of responsibility within span of appointment;
- Contribute to and implement the corporate nursing and midwifery professional practice framework established by the DON/M;

- Develop and guide the use of information systems to inform decision making, and manage practice;
- Determine milestones and priorities;
- Lead the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment;
- Within a culture of due diligence be responsible for financial budgeting and management within span of control, and contribute to financial budgeting and management for the organisation.

Education:

- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- Lead the establishment of learning cultures across span of appointment.

Research:

- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making.

Professional leadership:

- Work collaboratively with other professionals in the leadership of a division/stream;
- Contribute and provide state-wide leadership, advice and planning nationally and state-wide on nursing and midwifery professional issues;
- Actively participate in internal and external advisory groups, expert panels, working groups and/or committees;
- Contribute to strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- Lead, coach, coordinate and support direct reports.

Reclassification Indicators criteria - Divisional Director 5.2 (criteria):

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Is accountable and responsible for:

- Professional or operational or corporate leadership of nursing/midwifery activities to achieve continuity and quality of service in the division/stream;
- Developing and implementing strategies for effective patient flow;
- Resource management including effective financial budgeting and management for their division;
- Developing and implementing strategic directions for the division and leading change management;
- Human resource strategies that recruit, develop and retain nursing/midwifery staff in their division;
- Develop, integrate and evaluate models of care;
- Implement the corporate administrative and risk management frameworks within span of appointment.

Nursing and/or Midwifery Clinical Practice Director (Level 5.2)

Employees classified in this role provide leadership to clinical staff: providing high level clinical advice, clinical service planning, evaluating practice culture, clinical research, practice development, and the role may include sessional clinical practice responsibilities.

Employees in the role of Clinical Practice Director will typically:

Direct/indirect patient/client care:

- Liaise between Clinical Networks and Health Units in regard to nursing/midwifery practices that will achieve enhanced patient/client journeys and population health targets;

- The role may be sessional in combination with clinical practice responsibilities. For example, clinical practice at advanced or extended level (Nurse/Midwife Consultant, Nurse Practitioner);
- Oversee the standards of nursing and midwifery clinical practice;
- Build a culture which is patient/client centered and where patient/client engagement is encouraged.

Support of health service systems:

- Develop an integrated, collaborative and evaluative practice culture for Level 3 and/or 4 Nurse/Midwife Clinical Consultants and Nurse Practitioners across span of appointment;
- Provide collegiate and professional leadership to and for Level 3 and/or 4 Nurse/Midwife Consultants, Nurse Practitioners, and (where appropriate) other classifications of nurses and midwives and members of a multidisciplinary team within span of appointment;
- Co-ordinate the participation of nurses/midwives in clinical guideline and protocol development between Health Units and Clinical Networks;
- Initiate systems and processes to ensure consistent clinical practice and procedures to ensure appropriate clinical outcomes, including leading and monitoring quality and service improvement activities.

Education:

- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- Develop, and encourage a learning environment by mentoring and promoting team development and individual capacity building.

Research:

- Collaboratively develop and monitor a strategic framework for clinical nursing/midwifery research and practice development in the South Australian public sector.

Professional leadership:

- Provide high level advice to Health Units, Community Services and/or Clinical Networks on extended nursing/midwifery practice issues;
- Participate in clinical services planning and review at State level;
- Professional leadership of nursing/midwifery clinical leaders to achieve effective and consistent clinical practice development;
- Provide strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- Contribute and provide state-wide leadership, advice and planning nationally and state-wide on nursing and midwifery professional issues;
- Actively participate in internal and external advisory groups, expert panels, working groups and/or committees.

Reclassification Indicators Clinical Practice Director 5.2 (criteria):

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Is accountable and responsible for:

- Professional leadership of nursing/midwifery clinical leaders to achieve effective and consistent clinical practice development;
- Developing and implementing strategic directions for clinical practice development including developing evidence based practice; and leading change management;
- Initiate systems and processes to ensure consistent clinical practice and procedures; and
- Coordinate systems and processes to ensure appropriate clinical outcomes.

Nursing and/or Midwifery Functional/Project/Program Director (Level 5.2)
Employees classified in this role have involvement in various health care assignments/projects. This may include: development, implementation and evaluation of strategic directions, policies etc. which support nursing/midwifery practice, advice on contemporary issues relating to practice, project management, strategic leadership for innovation and change. Staff at this level may also provide management of nursing/midwifery functions a for specified nursing/midwifery department/service.

Employees in the role of Functional/Project/Program Director will typically:

Direct/indirect patient/client care:

- Oversee the standards of nursing and midwifery clinical practice.

Support of health service systems:

- Lead the development, implementation and evaluation of strategic directions, policies, which support professional nursing/midwifery practice;
- May provide management of nursing/midwifery functions for a specified nursing/midwifery department/services;
- Contribute to and implement the corporate nursing/midwifery professional practice framework established by the Director of Nursing/Midwifery;
- Implement the corporate administrative and risk management frameworks within frame of responsibility;
- Utilise a project management framework including evaluation and risk mitigation;
- Oversee human resource systems implementation including processes and standards of nursing/midwifery staff recruitment, performance, development and retention;
- Lead, coach, coordinate and support direct reports;
- Lead the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment;
- May be required to manage or oversee an organisational portfolio or long term and/or significant project;
- May be required to provide management of services other than nursing/midwifery;
- Project management, implementation, evaluation and risk management of programs and projects of significant scope and complexity;
- Provide operational and professional leadership to and for Level 3 and/or 4 Nurse/Midwife Managers or Educators within span of appointment;
- Initiates and leads projects of significant scope and complexity such as major capital developments, or major system changes including (but not limited to) state-wide and national projects.

Education:

- Provide high level advice to stakeholders and health services on the management of contemporary nursing and/or midwifery issues relating to education;
- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- Develop, and encourage a learning environment by mentoring and promoting team development and individual capacity building.

Research:

- Provide high level advice to stakeholders and health services on the management of contemporary nursing and/or midwifery issues relating to research.

Professional leadership:

- Provide high level advice to stakeholders and health services on the management of contemporary nursing and/or midwifery issues relating to professional practice and workforce legislation;
- Leadership of nursing/midwifery functional services, state-wide and/or comprehensive strategies and projects to achieve effective systems and processes to support practice;

- Liaise with stakeholders, health services, Government departments and others to maximise efficiency and effectiveness implementing policy and service directions;
- Developing and implementing strategic directions specific functions, policy and advice for complex or state-wide nursing and midwifery issues and leading change management;
- Actively participate in internal and external advisory groups, expert panels, working groups and/or committees;
- Provide strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control.

Reclassification Indicators Functional/Project/Program Director 5.2 (criteria):

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Is accountable and responsible for:

- Leadership of nursing/midwifery functional services, state-wide and/or comprehensive strategies and projects to achieve effective systems and processes to support practice;
- Developing and implementing strategic directions specific functions, policy and advice for complex or state-wide nursing and midwifery issues and leading change management; and
- Project management, implementation, evaluation and risk management of programs and projects of significant scope and complexity.

ADVANCED DIVISIONAL/STREAM NURSING AND/OR MIDWIFERY DIRECTOR (LEVEL 5.3):

Employees classified at this level use their clinical knowledge and experience to provide expert level strategic and operational leadership, management, governance and direction for a specified division in a hospital or clinical stream, community service or state-wide service.

Employees at this level are accountable for standards of patient/client care, and the practice standards of nurses/midwives and/or multi-disciplinary team members. They are responsible for leading the development and ensuring the effectiveness of systems to support, evaluate and consistently improve nursing/midwifery and/or multidisciplinary team practice and healthy work environments. They are accountable for the cost effective provision of health services within their span of employment. Employees at this level have a high degree of autonomy, independent judgement and decision making.

Work at this level is undertaken by employees with at least 5 years post registration experience. This role must report to a Director of Nursing/Midwifery or Executive Director of Nursing/Midwifery.

Employees in this role will meet the following requirements:

Direct/indirect patient/client care:

- Use their clinical knowledge and experience to provide direction for nursing/midwifery including models of care;
- Build a culture which is patient/client centred and where patient/client engagement is encouraged;
- Develop and evaluate strategies for effective patient flow.

Support of health service systems:

- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division/stream which may also operate within a clinical stream and/or with oversight of multiple services;
- Provide professional nursing/midwifery advice and leadership to: Level 3 and 4 nurses/midwives, Nursing/Midwifery Service Directors - 5.1 and 5.2 (unless otherwise agreed by the parties) working within the nursing/midwifery division/stream;

- Lead, develop and guide the use of information systems to: inform decision making, manage practice and evaluate strategic policies;
- Establishment, coordination and monitoring of effective financial management within a culture of due diligence;
- Establishing quality systems which ensure that there is a focus on improvement, innovation and clinical outcomes;
- Implement the corporate administrative and risk management frameworks within frame of responsibility;
- Ensuring the existence of risk management strategies by encouraging systematic identification, assessment and management of risks which impact clinical care;
- Establishment, monitoring and review of divisional Key Performance Indicators;
- Contribute to and implement the corporate nursing/midwifery professional practice framework established by the Director of Nursing/Midwifery;
- Oversee human resource systems implementation including processes and standards of nursing/midwifery staff recruitment, performance, development and retention;
- Lead the establishment of health work environments;
- May be required to manage or oversee an organisational portfolio or long term and/or significant project.

Education:

- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- Lead the establishment of learning cultures across span of appointment.

Research:

- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making;
- Provide high level advice to stakeholders and health services on the management of contemporary nursing and/or midwifery issues relating to research;
- Critically appraise and synthesise the outcomes of relevant research.

Professional leadership:

- Lead a nursing/midwifery and/or multi-disciplinary division or stream;
- Acts as a consultant to state/national programs;
- Collaborate with health industry, community groups, professional bodies and private and public sector health providers at regional, state and national level;
- Participating in the development of strategic directions and implementation of network wide strategies;
- Provide strategic leadership for innovation, change process and coordinated responses to emerging service and workforce needs within span of control.

Reclassification Indicators criteria - Advanced Nursing/Midwifery Director 5.3

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Is accountable and responsible for:

- Professional or operational or corporate leadership of nursing/midwifery services for a division or stream and/or with oversight of multiple services;
- Lead, develop and guide the use of information systems to: inform decision making, manage practice and evaluate strategic policies;
- Establishment, coordination and monitoring of effective financial management within a culture of due diligence;
- Establishing quality systems which ensure that there is a focus on improvement, innovation and clinical

outcomes;
- Implement the corporate administrative and risk management frameworks within span of appointment;
- Ensuring the existence of risk management strategies by encouraging systematic identification, assessment and management of risks which impact clinical care;
- Establishment, monitoring and review of divisional Key Performance Indicators;
- Develop, implement and evaluate models of care.

DIRECTOR OF NURSING AND MIDWIFERY (LEVEL 6)

Employees classified at this level provide strategic and operational leadership, governance, and direction for the nursing/midwifery services within a Health Unit or Community Service. The focus of the role is on development and implementation of frameworks and systems within which nursing/midwifery employees practice, and on monitoring and evaluating clinical practice and service delivery standards. The role scope at this level may be required to extend across more services than nursing/midwifery. Staff working at this level are expert managers, practicing at an advanced level, have an extended scope of practice with a high degree of autonomous decision making.

Employees in this role accept accountability for the governance and practice standards of nurses/midwives, the development and effectiveness of systems to support, evaluate and consistently improve nursing/midwifery practice and healthy work environments and the cost effective provision of health services within their span of control.

Employees in this role will meet the following requirements:

Direct/indirect patient/client care:
- Use their clinical knowledge and experience to provide strategic and operational leadership, governance and direction for nursing/midwifery including models of care;
- Build a culture which is patient/client centred and where patient/client engagement is encouraged;
- Accountable for evaluating and consistently improving nursing/midwifery practice and healthy work environments.

Support of health service systems:
- Develop and implement a nursing/midwifery contemporary professional practice framework;
- Develop and/or implement corporate administrative and risk management frameworks;
- Develop and implement service delivery policies, goals, benchmarking frameworks and nursing/midwifery clinical practice standards;
- Develop and guide the use of information systems to inform decision making, manage practice, store corporate knowledge and convey information to staff;
- Establish standards for human resource systems implementation including processes and standards of nursing/midwifery staff recruitment, performance, development and retention;
- Contribute to and/or negotiate organisation budget and activity profiles;
- Accountable for resource management with due diligence.

Education:
- Lead the establishment of learning cultures across span of appointment;
- Ensuring staff have the capacity to meet service delivery needs, priorities and work standards.

Research:
- Lead the establishment of a culture of research enquiry;
- Integrate contemporary information and research evidence with personal knowledge and experience to support high level decision making.

Professional leadership:
- Provide professional nursing/midwifery advice, direction, and governance for a specified Health Unit or

Community Service;
- Provide corporate management of nursing/midwifery services for a specified Health Unit or Community Service;
- Lead, coach, coordinate and support direct reports and provide mentorship for less experienced nurses and midwives;
- Lead innovation, change processes, and coordinated responses to emerging service and workforce needs;
- Maybe recruited to manage or oversee an organisational/regional portfolio or long term and/or significant project;
- May be required to provide executive level management of services other than nursing/midwifery for a specified Health Unit or Community Service.

In addition to the core role requirements of employees at Level 6, a number of factors have impacts on the range of roles at this level. These include the size, breadth and complexities of the services that the role is required to lead, and the nature of the structural support for enacting the role. The Level 6 role DON/M is applied across a range of levels according to the following combinations of criteria:

Level 6.1 has a substantial number of the following characteristics but is not limited to:
- Inpatient facilities that may have variable or no occupancy levels;
- Ambulatory/outpatient services;
- Primary health services and GP support;
- Emergency service for a specific local community;
- Role manages local clinical and support services;
- Role may include substantial direct clinical care provision;
- There are no administrative or support service manager roles in place to support the Level 6 role.

Level 6.2 has a substantial number of the following characteristics but is not limited to:
- Inpatient facilities with capacity for consistent occupancy levels;
- A small range of clinical services influencing activity levels;
- Primary health services and GP support;
- Some hospital substitution services;
- Support for occasional surgical services and some visiting specialist services;
- May include Midwifery service;
- Emergency services for a specified area;
- Role is required to manage local clinical and support services;
- There is limited administrative and/or support service management for the level 6.2 role;
- Role is required to manage within more than one funding source and/or jurisdiction;
- Role may be required to oversee a second Health Service of equal or less size;
- Role may be extended to include EO responsibilities.

Level 6.3 has a substantial number of the following characteristics but is not limited to:
- Inpatient, ambulatory and outpatient services covering secondary level medical treatments and surgical services and/or mental health;
- Primary health and GP support services;
- Support for diagnostic services and/or linked community health services;
- Hospital substitution services and/or chronic disease management services;
- Emergency services, for a specified area;
- May include Midwifery/paediatric services;
- Support for some local and a limited range of visiting specialist services;
- Role provides professional leadership to nursing/midwifery services;
- Role works with more than one funding source and/or jurisdiction and/or more than one co-located service and/or non co-located Health Unit;
- Role may be required to manage additional clinical and/or support services;

- Role may be required to manage more than one organisation or service and/or
- Role may be required to provide leadership to a Level 5.1/5.2 role within an amalgamation of organisations (i.e. on another site);
- Role may be extended to include EO responsibilities.

Level 6.4 has a substantial number of the following characteristics but is not limited to:

- Secondary inpatient and outpatient services across a range of specialties;
- Support for general surgical services, secondary medical, GP and some specialist medical services that may be provided by visiting specialists;
- Primary health services and/or community programs including Hospital Substitution and/or chronic disease management;
- Emergency services for a specified coverage area and/or designated country trauma centre;
- Specialist and/or local region referral services;
- Some teaching, training and research services;

Level 6.5 has a substantial number of the following characteristics but is not limited to:

- Wide range of primary, secondary and specialist services;
- General Hospital and/or Specialist Hospital or Community Service;
- Majority of acute non-tertiary services for catchment population;
- Specialist referral centre for specific services;
- Teaching, training and research services;
- Designated elective surgical services.

Level 6.6 has a substantial number of the following characteristics but is not limited to:

- Wide range of primary, secondary and tertiary clinical services;
- Tertiary and/or Specialist Hospital;
- Majority of health services for catchment population;
- Specialist referral centre/s and clinical network supports;
- Teaching, training and research departments;
- Range of clinical support services;
- Designated regional role/influence expectations;
- Nursing/midwifery policy and executive advice functions.

Level 6.7 has a substantial number of the following characteristics but is not limited to:

- Full range of secondary and tertiary clinical services;
- Major Tertiary Hospital with Intensive Care Departments/Retrieval Services;
- Majority of tertiary services for catchment population;
- Range of specialist referral centres and clinical network supports;
- Teaching, training and research departments;
- Range of clinical support services;
- Regional role/influence;
- Nursing/midwifery policy and executive advice functions.

Reclassification Indicators criteria – Director of Nursing/Midwifery Level 6

5 years post registration experience;

Holds or is working towards a post graduate qualification relevant to their role;

Address to classification criteria at the relevant level.

APPENDIX 8 – MIDWIFERY CASELOAD PRACTICE AGREEMENT

1. Title

This Appendix is known as the Midwifery Caseload Practice Agreement.

2. Scope and Persons Bound

The provisions of this Appendix apply in respect of midwives employed in a Midwifery Caseload Practice Program.

3. Duration of the Agreement

3.1 Continued operation of this Appendix at a health unit site is subject to the provisions of clause 19, Termination.

4. Definitions

4.1 "Award" means the Nurses (South Australian Public Sector) Award 2002 or any successor thereto.

4.2 "Agreement" means the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2020 or any successor Agreement thereto.

4.3 "Employee" means a midwife employed in a Midwifery Caseload Practice Program.

4.4 "Recall" will mean a period of time the employee is required to return to work that was unplanned and not rostered.

4.5 "Caseload Midwifery" is a model of care where a client/patient has a named midwife and a backup midwife, who provides care throughout her pregnancy, labour, birth and postnatal period.

4.6 "Full care" means all midwifery care throughout the client/patient's pregnancy, labour, birth and postnatal period.

5. Employee Participation in the Midwifery Caseload Practice Program

No employee will be directed to work in a Midwifery Caseload Practice Program, which will only be staffed by midwives who have elected to join the program.

6. Relationship to the Award and Enterprise Agreement

6.1 The following Award provisions will not apply where the provisions of this Appendix are in force:

- Clause 4.4 On-Call and Recall
- Clause 5.1 Hours of Work
- Clause 5.2 Application of 38 Hour Week
- Clause 5.3 Penalty Rates
- Clause 5.4 Overtime
- Clause 6.1.3 Payment While on Leave
- Clause 6.1.5 Additional Leave Loading
- Clause 6.3 Public Holidays

6.2 The following Agreement provisions will not apply where the provisions of this Appendix are in force:

- Clause 3.5 Standard 10 Hour Night Shifts
- Clause 3.7 Part Time Employees – Minimum Shift Length
- Clause 7.1 Recall to Work, Overtime and Time Off in Lieu of Overtime
- Clause 7.3 Part Time Employees Working Variable Shifts – Public Holidays

- Clause 9.3 Night Shift Penalty
- Clause 9.4 Nurse/Midwife In-Charge Allowance
- Clause 9.5 On-Call Allowance

6.3 All other provisions of the Award and Agreement continue to apply.

7. Caseload

7.1 A full-time employee (other than a Nurse/Midwife Unit Manger (N/MUM), Midwifery Caseload Practice) is one who is available to carry a caseload of 40 booked clients/patients full care during the course of any full calendar or financial year. In interpreting the application of the Award and other conditions based on the ordinary hours of work, this caseload will equate to an employee (other than a N/MUM, Midwifery Caseload Practice) working a 38 hour week that is a full time employee under the Award.

7.2 The full time equivalent caseload for a N/MUM , Midwifery Caseload Practice will be 10 patients/clients for full care during the course of any full calendar or financial year. The span of control of a N/MUM, Midwifery Caseload Practice, will be up to 4 teams of midwives, each consisting of up to 6 full-time equivalents. Midwives may be allocated to teams in a flexible manner.

7.3 A part time employee will receive pay and conditions, as well as allocation of work on a proportional basis.

7.4 In addition to the caseload limits set by this clause 7, during absences of other employees due to planned or unplanned leave of 1 week or less, employees' (other than the N/MUM) caseloads may be increased to a maximum of 56 clients/patients. However, the caseload will not exceed 46 clients/patients on average over the year. The caseload for a N/MUM may vary up to 20 clients/patients on average due to the absence of other staff.

7.5 In regional units sites, the N/MUM'S duties may include responsibilities for other patient care areas, in which case the workload of the N/MUM and other employees (as defined) will be adjusted accordingly.

8. Patterns of Work

8.1 The employees will be free to organise their own hours of work provided that they are able to meet the assessed needs of clients/patients.

8.2 An employee will not be required to work for periods longer than 8 hours and can choose to hand over care of the employee's clients/patients, at that time. In accordance with clause 8.1, employees have the discretion to work up to, but no longer than, 12 hours to meet the needs of their clients/patients.

8.3 Each employee will have a period of at least 8 hours within a 24 hour period, continuously free of duty (other than on-call and recall).

8.4 Each employee will have an average of 2 days off duty per week free of planned work and on-call and recall.

8.5 An employee will not be permitted to work for more than 7 days in succession, other than where the employee is recalled to work.

9. Classification

9.1 An employee (other than a N/MUM) who works in the Midwifery Caseload Practice Program will be classified as a Registered Nurse/Midwife (Level 1) or a Clinical Nurse/Midwife (Level 2).

9.2 An employee who works as a N/MUM of a Midwifery Caseload Practice will be classified as a Registered Nurse/Midwife (Level 3) or (Level 4) as appropriate.

10. Salary

The salaries provided for in the Award and in the Agreement covering nurses/midwives in the South Australian public sector will be applied to midwives employed under this Agreement.

11. Loading in Lieu of Certain Conditions

11.1 Employees, other than a N/MUM, Midwifery Caseload Practice, will receive a loading of 35%, in addition to ordinary rates of pay, which incorporates the provisions referred to in clause 6 and is in recognition of the expanded practice and the flexible environment in which work is performed.

11.2 Employees who are a N/MUM, Midwifery Caseload Practice will receive a loading of 17.5%, in addition to ordinary rates of pay, which is in lieu of on-call allowance, recall payment and annual leave loading and in recognition of the expanded practice and the flexible environment in which work is performed.

11.3 These loadings will be treated as part of the ordinary rate of pay for an employee and, as such, will apply to periods of annual leave and Personal/Carers leave, as well as occasions where the employee is actively at work.

12. Annual Leave

All employees in a Midwifery Caseload Practice Program will be entitled to 6 weeks annual leave.

13. Personal/Carers Leave

13.1 Where an employee is unable to work due to illness or other relevant factors, the N/MUM, Midwifery Caseload Practice or appropriate line manager will determine if temporary re-allocation of the employee's work program to other midwives in the team is required for the period of absence. If so, the period of absence will be debited against the employee's accrued personal/carers leave.

13.2 Where the N/MUM, Midwifery Caseload Practice or appropriate line manager determines that re-allocation of the employee's work program, due to illness or other relevant factors, is not necessary and that the employee can re-order or re-schedule the employee's work program, no leave will be debited from the employee's accrued personal carers leave for the period of absence.

14. Time Records

14.1 Employees will be required to keep accurate records of all time worked including travel time, administrative work, staff development and other non-clinical activity.

14.2 It is the expectation of the parties to this Agreement that the workload will be consistent with that of a full time employee under the Award, that is, an average of 38 hours work per week and occasional recall to work.

15. Excess Hours

15.1 If an employee, at the request of the employer, works more than 332 hours in any 8 week cycle, the employee will be entitled to:

- Time off in lieu (on an hour for hour basis) of such excess hours worked, taken at the convenience of the employee and the employer within 12 months of it being accrued, and in association with a period of planned leave; or

- payment at overtime rates for the excess hours worked, that is, time and a half for the first 3 hours and double time thereafter.

15.2 The employee will have discretion as to which option is to apply in each instance.

16. Staffing Levels

Sufficient staff must be available to ensure that the average caseload for each midwife does not exceed 46 clients/patients per annum. During absences of other employees due to planned or unplanned leave, caseloads may be increased to a maximum of 56 clients/patients.

17. Transport

The use of an employee's motor vehicle and the reimbursement rates for the use of an employee's private motor vehicle will be in accordance with the HR Manual or its successor.

18. Telephone Expenses

The health unit will provide a mobile phone for each Caseload Midwife. The mobile phone is to be used in accordance with DHW Guidelines.

19. Termination of Agreement

19.2 A LHN or the ANMF on behalf of its members may terminate the operation of a Midwifery Caseload Practice Program at a specific health unit site(s). In this event, 4 weeks written notice will be given to the other party to ensure the care needs of clients/patients are met.

19.3 Notice will not be given under this clause unless prior consultation has occurred between the affected parties.

20. Variation of the terms of this Appendix

The terms of this Appendix as they apply to a specified Midwifery Caseload Practice Program at a specified health unit may be varied by agreement between the respective LHN and the ANMF.

APPENDIX 9 – INCOME AND INJURY PROTECTION PRINCIPLES

1. Whereas:
   a. the parties agree that a return to work within the meaning of the *Return to Work Act* 2014 (SA) ('RTW Act') is always the objective in the case of any work injury;
   b. the ANMF will reasonably support and cooperate in the pursuit of this objective as required by the RTW Act and these Principles;
2. Those employees who are injured on or after 1 July 2015, in circumstances where the employee:
   a. is temporarily or permanently incapacitated for work as a result of a physical or psychological injury sustained where he or she was at work or lawfully exercising their duties as a Nurse or Midwife; and
   b. the injury –
      i. resulted from conduct directed at the Nurse/Midwife that constitutes a criminal offence; or
      ii. occurred as a direct and immediate result of conduct that constitutes a criminal offence; or
      iii. occurred in other circumstances where the Nurse/Midwife is placed in a dangerous situation in the course of, or as a consequences of, acting in or engaging in their duties or position, excluding psychological injury other than that caused as a consequence of a specific incident or incidents.
   c. has an accepted claim pursuant to the RTW Act; and
   d. has had their individual entitlements exhausted pursuant to the RTW Act; and
   e. has not been assessed as having a 30% or more Whole Person Impairment (WPI); and
   f. has not made a return to work within the meaning of the RTW Act,

will be provided on the following basis:

2.1 In the case of medical expenses, ongoing cover for such expenses as are reasonably and necessarily incurred as a direct result of such accepted claim (other than those still to be covered by the Employer); or

2.2 A redemption of medical expenses referred to in 2.1.

2.3 In the case of financial support:
   a. a top-up payment to achieve 80% notional weekly earnings or 80% of the difference between actual earnings and notional weekly earning until retirement or return to work, subject to a work capacity review as per the *Workers Rehabilitation and Compensation Act* 1986 (SA) ('WRC Act 1986'); or
   b. a redemption of 2.3(a).

3. Those employees who were injured prior to 1 July 2015 in circumstances described in 2 (a) and (b) and who:
   a. have an accepted claim pursuant to the WRC Act 1986/RTW Act; and
   b. have had their individual entitlements exhausted pursuant to the RTW Act; and
   c. have not been assessed as having a 30% or more WPI; and
   d. have not made a return to work within the meaning of the RTW Act,

will be provided on the following basis:

3.1 In the case of medical expenses, ongoing cover for such expenses as are reasonably and necessarily incurred as a direct result of such accepted claim (other than those still to be covered by the Employer); or

3.2 A redemption of medical expenses referred to in 3.1.

3.3 In the case of financial support:
   a. a top-up payment to achieve 80% notional weekly earning or 80% of the difference between actual earnings and notional weekly earning until retirement or return to work, subject to a work capacity review as per the WRC Act 1986, or
   b. a redemption of 3.3 (a); or
   c. payment of an amount equivalent to the payment to which the worker would have been entitled to under section 39 of the RTW Act had their compensable injury occurred after 1 July 2015.

4. The parties agree that this matter will be a reserved matter to be resolved upon the preceding principles by 31 March 2017.

APPENDIX 10 – RURAL AND REMOTE SERVICE INCENTIVE PAYMENTS

From the first full pay period on or after 1 January 2023

YEAR	ZONE 2	ZONE 3	ZONE 4
	$PA	$PA	$PA
1	$1,105.10	$2,526.00	$4,892.50
2	$1,419.90	$2,840.80	$5,366.80
3	$1,815.60	$3,156.70	$5,680.60
4	$2,208.00	$3,549.10	$5,995.40
5	$2,526.00	$3,945.90	$6,312.30

From the first full pay period on or after 1 January 2024

YEAR	ZONE 2	ZONE 3	ZONE 4
	$PA	$PA	$PA
1	$1,138.30	$2,601.80	$5,039.30
2	$1,462.50	$2,926.00	$5,527.80
3	$1,870.10	$3,251.40	$5,851.00
4	$2,274.20	$3,655.60	$6,175.30
5	$2,601.80	$4,064.30	$6501.70

From the first full pay period on or after 1 January 2025

YEAR	ZONE 2	ZONE 3	ZONE 4
	$PA	$PA	$PA
1	$1,172.40	$2,679.90	$5,190.50
2	$1,506.40	$3,013.80	$5,693.60
3	$1,926.20	$3,348.90	$6,026.50
4	$2,342.40	$3,765.30	$6,360.60
5	$2,679.90	$4,186.20	$6,696.80

APPENDIX 11 – ZONE ALLOCATIONS – HEALTH UNIT SITES

Zone 2	*Zone 3*	*Zone 4*
Barmera Residential Care Facility (incorporating Bonney Lodge Hostel & Hawdon House Nursing Home)	Keith Community Health	Anangu Pitjantjatjara Yankunytjatjara
Bonneyview Village (Barmera)	Kingston South East/Robe Multi-Purpose Service	Andamooka Community Health Service
Mid North Health (Booleroo Health Service)	Lameroo District Health Service - Mallee Health Service	Ceduna District Health Service
Mid North Health (Booleroo Centre District Medical Centre)	Lucindale Community Health Centre	Ceduna Community Health Centre
Bordertown Memorial Hospital	Millicent and District Hospital & Health Service	Ceduna Sobering Up Centre
Burra Hospital & Health Service	Millicent Community Health	Ceduna Koonibba Aboriginal Health Service
Carnavan Hostel (Kangaroo Island)	Naracoorte Community Health	Mid West Health Wudinna
Coonalypn Downs Community Health Service		Cleve District Health & Aged Care
Maitland Hospital & Health Service	Mid North Health (Orroroo Hospital)	Cleve Medical Practice
Southern Flinders Health (Crystal Brook)	Mid North Health (Orroroo Community Home)	Cleve Community Health & Welfare Centre
Cummins & District Memorial Hospital	Mid North Health (Orroroo Health Centre)	Coober Pedy Hospital & Health Centre
Gladstone & District Community Health & Welfare Centre	Mid North Health (Orroroo Hospital House)	Coober Pedy Community Health Centre
Mid North Health (Jamestown Health Service)	Mid North Health (Peterborough Campus)	Cowell Community Health & Aged Care
Kangaroo Island Health Service	Pika Wiya Health Service (Port Augusta)	Mid West Health – Elliston Hospital
Kangaroo Island Community Health Service	Pinnaroo Soldiers' Memorial Hospital – Mallee Health Service	Hawker Memorial Hospital
Karoonda & District Soldiers' Memorial Hospital – Mallee Health Service	Port Augusta Domiciliary Care Service	Kimba District Health & Aged Care
Karoonda Home for the Aged	Port Augusta Hospital	Kimba Day Care
Loxton Hospital Complex	Quorn Health Services	Kimba Pioneer Memorial Hostel
Loxton Domiciliary Care	Whyalla Hospital & Health Service	Kimba Neighbourhood Health
Loxton Hostel	Whyalla Community Health & Domiciliary Care Services	Kingoonya Medical Centre
Loxton Nursing Home		Leigh Creek Health Services
Melaleuca Court Nursing Home		Lock Community Health & Welfare Centre
Meningie & Districts Memorial Hospital and Health Services Campus – Coorong Health Services		Marla Community Health Centre
Mid North Domiciliary Care Service (Port Pirie)		Mintabie Clarice Megaw Health Clinic
Minlaton Health Centre		Oodnadatta Hospital & Health Service
Miroma Place Hostel (Cummins)		Roxby Downs Community Health Centre
Mount Gambier and Districts Health Service		Roxby Downs Health Service

Zone 2	*Zone 3*	*Zone 4*
Mount Gambier Community Health Service		Mid West Health – Streaky Bay Hospital
Northern Yorke Peninsula		Tarcoola Hospital
Northern & Central Yorke Peninsula Community Health Service		Terrace Retirement Estate (Kimba)
Northern Yorke Peninsula Domiciliary Care Service		Woomera Hospital
Penola Multi-Purpose Service		
Pioneer Lodge Hostel (Waikerie)		
Port Broughton District Hospital & Health Services		
Port Lincoln Aboriginal Health Service		
Port Lincoln Community Health Centre		
Port Lincoln Domiciliary Care Service		
Port Lincoln Hospital & Health Services		
Port Pirie Regional Health Services		
Port Pirie Community Health Services		
Renmark Paringa District Hospital		
Renmark Hostel		
Renmark Nursing Home		
Renmark Domiciliary Care Service		
Riverland Community Health Services		
Riverland Regional Health Service (Berri campus/Barmera campus)		
Southern Flinders Health (Laura)		
Snowtown Memorial Hospital		
South East Regional Community Health Service		
Yorke Peninsula Health Service (Yorketown)		
Southern Yorke Peninsula Domiciliary Care Service		
Tatiara Community Health (Bordertown)		
Tumby Bay Hospital & Health Services		
Tumby Bay Community Health Services		
Uringa Hostel (Tumby Bay)		
Waikerie Health Services		
Waikerie Domiciliary Care Service		
Waikerie Nursing Home		

APPENDIX 12 – QUALIFICATION ALLOWANCES AND CONDITIONS OF ELIGIBILITY

1. ALLOWANCES

1.1 Registered Nurses/Midwives

Levels 1, 2, 3 and 4:

(i) An allowance equivalent to 3.5% calculated on RN/M 1maximum increment (i.e. increment 9) for the hospital certificates specified below, graduate certificates (university based or equivalent) or Diplomas issued by a University or College of Advanced Education prior to the implementation of Graduate Certificates or Graduate Diplomas in relevant nursing/midwifery practice areas;

(ii) An allowance equivalent to 4.5% calculated on RN/M 1, increment 9 for Graduate Diploma (university based or equivalent);

(iii) An allowance equivalent to 5.5% calculated on RN/M 1, increment 9 for second degree, Masters degree or PhD.

	1st pay period on or after 1 January 2023 $pa	1st pay period on or after 1 January 2024 $pa	1st pay period on or after 1 January 2025 $pa
Hospital* or Graduate Certificate	$3,368.50	$3,469.60	$3,573.70
Graduate Diploma	$4,330.90	$4,460.80	$4,594.60
Second Degree, Masters or PhD	$5,293.30	$5,452.10	$5,615.70

*The following Hospital Certificates or equivalent such as Diplomas issued by a University or College of Advanced Education prior to the implementation of Graduate Certificates or Graduate Diplomas in relevant nursing/midwifery practice areas are recognised for the purpose of entitlement to the qualification allowance:

Accident & Emergency
Anaesthetic & Recovery
Cardiovascular
Critical Care
Cardiac Care
Gerontic
Intensive Care - General
Intensive Care – Neonatal
Midwifery
Neonatology
Oncology
Operating Room
Orthopaedic
Psychiatric RN
Paediatric RN
Renal
Stomal Therapy

1.2 Enrolled Nurses (with Diploma qualifications or Advanced Skills EN salary scale)

(i) 3.5% calculated on the maximum increment (i.e. increment 6) of the Diploma salary scale for 1 or more post enrolment courses of not less than 6 months duration for only those ENs who are appointed to the Diploma or Advanced Skills EN salary scale.

	1st pay period on or after 1 January 2023 $pa	1st pay period on or after 1 January 2024 $pa	1st pay period on or after 1 January 2025 $pa
Post enrolment courses of not less than 6 months duration	$2,468.70	$2,542.80	$2,619.10

1.3 Conditions

(i) The additional qualification must be in addition to the basic qualification/s required for an employee's position and must be directly relevant** (as determined by the employer) to the employee's current practice, position or role. A qualification allowance cannot be claimed in respect of an employee's base qualification leading to registration or enrolment;

(ii) Only one allowance is payable. Where more than one additional, relevant** qualification (as determined by the employer) is held by an employee, only the higher or highest qualification allowance applicable will be paid;

(iii) The allowance is available on a pro rata basis for part time employees;

(iv) The allowance is payable on a fortnightly basis;

(v) The allowance is to be excluded when calculating penalty payments.

(vi) The allowance is payable during paid leave (excluding employer provided parenting leave/adoption leave);

(vii) An employee claiming entitlement to a qualification allowance must provide the employer with written evidence of having satisfactorily completed the requirements for the qualification for which the entitlement is claimed. The operative date will be the date upon which written evidence is provided to the employer.

** For the purpose of this clause, "directly relevant" means that the additional qualification is applicable to an employee's current area of practice. In considering whether the qualification is relevant, the nature of the qualification together with the current area of practice, the classification and the position description of the qualification holder are the main criteria.

Government of South Australia
SA Health

Australian Nursing and Midwifery Federation (SA Branch)

SA Nursing/Midwifery Enterprise Agreement Staffing Model Business Rules 2022

Introduction

The 2022 SA N/MHPPD Business Rules (The Business Rules) aim is to support the operation of the staffing models provided for in NMEA 2022 including but not limited to safe staffing levels clause 3.1 and related appendices (excluding Appendix 5).

The key use of the Business Rules is for the review and development of staffing arrangements in patient care areas affected by change including the commission or recommissioning of patient care areas over the life of the Agreement or until implementation of mandated nurse/midwife-to-patient ratio legislation.

There are three key parts to the Business Rules:

1. Processes to support the application of the staffing model.
2. Process for determination or review of N/MHPPD for new patient care areas or those that significantly change service profile (reference NMEA 2022 sub-clause 3.1.4 and 3.1.5).
3. Describes the Local Health Network N/MHPPD reporting requirements

The Business Rules support:

- The translation of NMEA 2022 provisions to practice, in relation to N/MHPPD staffing.
- Consistent and compliant application of the NMEA 2022.
- Guidance regarding system changes necessary to support consistent application of the NMEA 2022 SA N/MHPPD.

Additionally, the Business Rules provide a basis for on-going application and review of the provisions for relevant patient care areas.

1. SA N/MHPPD Staffing Model

As part of the NMEA 2022, SA Health and ANMF (SA Branch) reached agreement on the SA N/MHPPD Staffing Model as documented and described in Clause 3.1; safe staffing levels. This staffing methodology provides minimum staffing arrangements for patient care areas listed in Appendix 2 and 3 of the NMEA 2022 and other relevant patient care areas by agreement.

The minimum staffing arrangement outlined in Appendix 2 and 3 is not intended to be applied as a daily minimum, but as a minimum that is achieved by averaging daily staffing over the relevant 14 or 28 day period. The averaging of staffing hours will transition to balance over 7 days by 1 November 2023 (refer Clauses 3.1.7 and 3.1.8). If, in a particular patient care area there is a need to disaggregate the specified annual N/MHPPD to reflect seasonal demand, the N/MHPPD will be averaged over the year with the end result being the Appendix 2 N/MHPPD. Sites must identify with SA Health and ANMF (SA Branch) patient care areas that have a historical seasonal demand of Appendix 2, so that this N/MHPPD patterning can be confirmed. Any disaggregation must result in achieving the annual average N/MHPPD set out in Appendix 2 over the full year and cannot result in a lowering of the minimum staffing standards set for the year.

If a patient care area is identified as having seasonal N/MHPPD demand patterning, consideration for disaggregation of N/MHPPD will occur as part of the agreed change process (refer to Section 3 SA N/MHPPD Review Process).

For most patient care areas listed in Appendix 2 and 3, safe staffing arrangements is based on N/MHPPD approach, however in some areas nurse/midwife to patient ratios or set staffing levels are applicable.

- N/MHPPD relates to the average number of direct nursing or midwifery hours a patient receives per day on

a particular patient care area.

- A nurse/midwife to patient ratio refers to the number of patients, on average; each nurse/midwife is assigned to care for over a specific period.
- Set staffing levels refers to a set number of staff over a particular period.

A key element of the SA N/MHPPD Staffing Model is for patient care areas utilising a N/MHPPD approach to balance direct care nursing and midwifery hours over a defined period, ensuring safe staffing to meet expected patient demand.

Over the life of the NMEA 2022, staffing levels for patient care areas listed in Appendix 2 and can be reviewed following the agreed change process outlined in the Business Rules where there is an identified trigger for change (refer to clause 3.1.5 and SA N/MHPPD Review Process).

2. SA N/MHPPD Business Rules

The Business Rules support the operation of clause 3.1 of the NMEA 2022 and will be applied in a manner subject to, and consistent with the provisions of the NMEA 2022, and include:

- Projected (or base roster) staffing for an upcoming roster cycle and refer to Section 2.6: N/MHPPD Data Dictionary on how N/MHPPD can be used to calculate staffing for a patient care area.
- Daily staffing (reference NMEA 2022 clause 3.1.13).
- Benchmarking and review process to determine or alter N/MHPPD and support consistency

2.1 Transparency and Visibility Actual and Agreed Staffing (NMEA 2022 3.1.12)

The N/MUM (or equivalent) will ensure that, at the commencement of each shift the occupancy and staffing information is displayed for staff within the patient care area. This information must include:

- Occupancy (number of beds that are occupied);
- Number of nursing/midwifery staff required to meet client/patient needs;
- Agreed N/MHPPD, Average Occupancy and indicative staff plan balance over 14 days

For example, on an early shift (start time 0700 hours) for a patient care area with agreed 6.00 (ES) N/MHPPD and 24 occupied beds:

- Actual number of occupied beds at 0700 hours = 24
- Actual number of nursing/midwifery staff required = 7 (plus or minus additional for clinical specials)
- Agreed N/MHPPD (ES), Average Occupancy and indicative staff plan= 6.00 (ES) Staff Plan of Early 7, Late 6, Night 4

2.2 Converting N/MHPPD to a staff plan and creating a projected (base) roster for a 14 or 28 day cycle

The following spreadsheet/table has been developed to assist in the calculation of staffing numbers per fortnight for the patient care area, in meeting the agreed N/MHPPD, which subsequently forms a staff plan for the base (projected) roster.

To use the tool:

1. Enter the agreed N/MHPPD for the patient care area and the number of beds expected to be occupied or utilised on a regular basis for the period for which staffing is to be determined. This will provide the sum of total direct nursing/midwifery hours the patient care area should roster each period.
2. Enter the shift length in hours, for the different shifts.

3. The unit manager (Nurse/Midwife Unit Manager or Nurse/Midwife Manager or delegates) can use the tool to allocate direct care nursing resources across the different shifts over the course of the relevant period, with due regard to expected care needs of patients/clients and the workload pattern of the patient care area.
4. The goal is to match and balance the roster with the agreed N/MHPPD for the patient care area.
5. The projected (base) roster should provide for appropriate skill mix.
6. Direct care hours are included in the calculation table. The shift coordinator (who may or may not have a patient load) is counted towards the direct care hours.
7. Other indirect care hours are excluded.

14 Day Calculator

INSTRUCTIONS

Step 1	Enter the Nursing/Midwifery Hours Per Patient Day (N/MHPPD) for your ward (as per NMEA 2022 Appendix 2)
Step 2	Enter the expected occupied beds or equivalent
Step 3	Enter the correct shift lengths for early, late and night shifts
Step 4	For each of the shift on each day, enter the number of nurses/midwives rostered per shift.
Step 5	For each shift that you have a shift coordinator or in-charge with no allocated patients enter rostered

Nursing/Midwifery Hours per Patient Day (N/MHPPD)	6	Number of Expected Occupied Beds or equivalent	24	Hours Available for 14 Days	2016	

		EARLY			LATE			NIGHT		
	Shift Length	8			8			10		
		Number of Staff	Equivalent Ratio	In Charge with no allocated patients	Number of Staff	Equivalent Ratio	Team Leader with no allocated patients	Number of Staff	Equivalent Ratio	Total Hours
Week 1	Monday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Tuesday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Wednesday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Thursday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Friday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Saturday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Sunday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
Week 2	Monday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Tuesday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Wednesday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Thursday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Friday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Saturday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
	Sunday	6.0	1:4	1.0	5.0	1:4.8	1.0	4.0	1:6	144
								Hours Used For Fortnight		2016

indicates that the value can be changed

0 hours still to be allocated

Hrs used for IC Charge: 224

2.3 Daily staffing:

Applying the N/MHPPD staffing model to occupied beds

The staffing methodology used shall be consistent with the principle of ensuring the number of nurses/midwives available to work is commensurate with the number of patients requiring care, and their care needs.

Average occupancy may not reflect variations in patient numbers. The N/MUM (or equivalent) will monitor staffing regularly to ensure that the N/MHPPD or ratio is balanced over the relevant period, taking into account occupancy and/or acuity and/or skill mix.

Managing demand

Appropriate staffing will be provided to meet patient demand.

When, on a shift, the N/MUM (or delegate) considers that patient care needs cannot be sufficiently met from the nurses/midwives immediately available and the N/MUM (or delegate) considers additional nursing/midwifery hours should be provided in order to meet clinical needs, the N/MUM (or delegate) will inform the appropriate Nurse Manager/Nursing Director who, together with the N/MUM, will consider a solution in line with local escalation processes, such as following options:

- Reallocation of patients
- Prioritisation of nursing/midwifery activities within the patient care area
- Deployment of nurses/midwives from/to other patient care areas
- Additional hours for part time staff
- Overtime
- Engagement of casual/agency nursing staff

Where sufficient nursing/midwifery staff are not available, the N/MUM (or equivalent) may, with approval from the DON/M (or delegate) limit admissions when discharges occur from the patient care area. Such approval will not unreasonably be withheld.

Where demand requires fewer staff, staffing may be reduced and/or redeployed to another patient care area, subject to compliance with relevant Award provisions or an individual's employment contract.

Daily staffing 'Ready Reckoner' – example

The 'Ready Reckoner' is a tool to assist in the checking and balancing of nursing/midwifery hours. It should be noted that this provides an indication only of the average N/MHPPD per day, recognising that direct care nursing/midwifery hours to be balanced over the defined period.

Daily Staffing Calculator - to work out a "snapshot" staffing requirement for the shift by the day

INSTRUCTIONS

Step 1 ⇨ Enter the Nursing/Midwifery Hours Per Patient Day (N/MHPPD) for your ward (as per EA 2022 Appendix 2)

Step 2 ⇨ Enter the number of expected occupied beds or equivalent

Step 3 ⇨ Enter the correct shift lengths for early, late and night shifts

Step 4 ⇨ Enter the number of nurses/midwives required per shift, to match the available hours

Step 5 ⇨ Ward might allocate a shift coordinator or in-charge with no patient allocation, counted within the hours

Nursing/Midwifery Hours per Patient Day (N/MHPPD)	6		
Number of Expected Occupied Beds or equivalent	24	**Hours per day Available**	*144*

	Early	*Late*	*Night*	Total Hours
Shift Length	8	8	10	
Number of staff	7	6	4	
Nursing/Midwifery Hours per shift (per day)	56	48	40	144

indicates that the value can be changed

0 hours still to be balanced

2.4 Staffing Calculator for regional and country hospitals:

This calculation staffing tool has been developed to assist in determining the staffing requirements for regional and country patient care areas.

STAFFING CALCULATOR - for regional LHN hospitals

Instructions	
Step 1	Enter the Nursing/Midwifery Hours Per Patient Day (N/MHPPD) for your ward (as per EA 2022 Appendix 2)
Step 2	Enter the number of expected occupied beds or equivalent
Step 3	Enter the correct shift lengths for early, late and night shifts
Step 4	Enter the number of nurses/midwives required per shift, to match the available hours
Step 5	Ward might allocate a shift coordinator or in-charge with no patient allocation, counted within the hour

Average Daily Staffing Calculator - 'Ready' Reckoner

Average Acute Inpatient Beds	Number of Expected Occupied Beds or equivalent	Nursing/Midwifery Hours per Patient Day (N/MHPPD)	Hours per day Available
Acute Care	10.00	5.00	50.00
Complex Care (Stable)	1.00	6.00	6.00
Obstetics (Post Delivery)	1.00	6.00	6.00
Paediatrics	2.00	5.30	10.60
Acute Inpatient Beds	14.00		72.60

	Early	*Late*	*Night*	Total Hours per day
Shift Length	8.00	8.00	10.00	
Number of staff(inpatient beds)	4	3	2	
Nursing/Midwifery Hours per shift (per day)	32	24	20	76.00

You have allocated 3.40000000000001 more hours of extra staff

Average Aged Care Beds	Number of Expected Occupied Beds or equivalent	Nursing/Midwifery Hours per Patient Day (N/MHPPD)	Hours per day Available
Stage funded Aged Care & MPS under main roof (Commonwealth)	40.00	3.20	128.00
Average Aged Care Beds	40.00		128.00

	Early	*Late*	*Night*	Total Hours per day
Shift Length	8.00	8.00	10.00	
Number of staff (aged care beds)	6	6	3	
Nursing/Midwifery Hours per shift (per day)	48	48	30	126.00

2 hours still to be balanced

Casualty/ Outpatients	Avg Number Per Day	NHPPC	Hours per day Available
Casualty Attendances	10	0.6	6.00
Outpatient Attendances (planned)	1	0.5	0.50
Casualty/ Outpatients	11.00		6.50

Shift-by-shift requirements

Day procedure Area	Avg Number per day	staffing ration/ hrs	Hours per day Available
Renal* (Based on 8 hour shift)	3	Ratio 1:3	8.00
Chemotherapy (NHPPD)	2	2	4.00
Day procedure Area	5.00		12.00

Additional Staff required, if	no.of patients	staffing criteria	
Labour & Delivery (Active Labouring, do not count as obst until delivered)	1	1:1 (Est Labour)	
Complex Care (unstable) for retrievals (HDU/ICU)	1	1:2 or 1:1	
Extra shift required for the shift only	2.00		

Note:
- N/MHPPD excludes clinical specials
- Short shift may be included to provide the nursing hours required, or
- The shift profile could be allocated and balanced as per requirements of 3.1.7 and 3.1.8.

Reference Formula
Average Nursing/Midwifery hours per day = Agreed N/MHPPD x OBD (number of beds that are expected to be occupied/ utilised on a regular basis)
Total Nursing/Midwifery hours per day = Early hours + Late hours + Night hours

2.5 Reporting Requirements:

N/MHPPD data source

Nursing/midwifery hours are sourced from the staff rostering system, ProAct for metropolitan health unit sites and regional unit sites with exception of regional unit sites minimum staffed hospitals.

Patient activity data source

Patient/client activity (occupied beds) is sourced from the relevant patient administration system.

Future period demand roster cycle

For all metropolitan health unit sites and the regional health unit sites; Port Pirie, Port Augusta, Mount Gambier and Whyalla, the period within which the hours must be balanced is 14 days.

From 1 November 2023, the period within which the hours must be balanced is 7 days.

For all other regional LHNs and minimum-staffed health sites the period within which the hours must be balanced is 28 days.

From 1 Mach 2023, the period within which the hours must be balanced is 14 days.

From 1 November 2023, the period within which the hours must be balanced is 7 days.

N/MHPPD reporting requirements

In all Metropolitan Hospitals and Regional Hospitals inpatient care areas will provide reports to the ANMF (SA Branch) on a quarterly basis of the agreed and actual staffing levels for each relevant patient care area for the preceding quarter. These N/MHPPD reports will be an average of the hours used against the patient activity (Occupied Bed Days) for each fortnight during the quarter. Reports to include the following data:

- Local Health Network/Hospital
- Inpatient Care Area
- Reporting period
- Agreed N/MHPPD
- Average Occupied Bed Days
- Actual N/MHPPD

These reports will exclude 'standards based clinical areas' listed in Appendix 1 NMEA 2022 and outpatient/ambulatory services.

Direct care hours included in N/MHPPD report

Nurses/midwives providing direct nursing care only are included for reporting purposes. This is inclusive of the hours provided by permanent/temporary (full time and part time), casual and agency, relieving pool, overtime and call back.

Indirect care hours not included in the N/MHPPD Report

Other indirect hours, are not included.

N/MHPPD definition and calculation

- N/MHPPD is the average number of direct nursing/midwifery hours a patient receives per day
- Number of N/MHPPD x number of Occupied Bed Days = total number of direct nursing/midwifery hours per day

- Total direct nursing/midwifery hours divided by Occupied Bed Days = N/MHPPD
- Nursing/midwifery hours are calculated on the shift duration provided to the patient care area by the nurse/midwife (excluding any unpaid meal break) starting from the shift start time, regardless if the shift overflows to the next day or next roster.
- Non-productive hours relating to nurses/midwives on any type of paid leave are excluded from the N/MHPPD calculation (including, but not limited to personal/ carers' leave, annual leave, workers compensation, study leave, employer provided parenting leave, compassionate leave, family leave, parental leave, accrued day off, professional development leave, etc.)
- Patients on leave are not counted in the activity data
- Qualified babies are included

2.6 N/MHPPD Data Dictionary

Data Item	Definition
Productive nursing/midwifery hours	**The sum of direct, indirect and overtime hours
Direct hours	The sum of nursing/midwifery hours that deliver direct patient care at any time
Indirect hours	**The sum of nursing/midwifery hours that are not related to direct patient care.
Non-productive hours	**The sum of any type of paid leave for nurses/midwives. This includes but is not limited to: annual leave, personal/carers leave, professional development leave, employer provided parenting leave, partner leave, programmed day off, etc.
Direct Nursing/Midwifery Hours per Patient Day	The average number of direct nursing/midwifery hours a patient receives per Occupied Bed Day
Occupied Bed Days	Daily bed census data averaged over a specified preceding period; either 14 or 28 days as applicable.
Expected Bed Days (in determining projected/base roster)	The number of beds that are expected to be occupied or utilised on a regular basis
Average Daily Occupancy	The number of Occupied Bed Days divided by specified number of days the unit is open within a given timeframe (i.e. calendar month, year)
Clinical Nursing/Midwifery Specials	Patients that require 1:1 nursing/midwifery care following clinical assessment guidelines. Depending on patient mix, acuity and patient numbers within the ward/unit this may or may not be able to be accommodated within the N/MHPPD. Additional resources may be required consistent with professional judgement of N/MUM or equivalent (Refer NMEA 2022 clause 3.1.13).
Skill Mix **as per NMEA 2022, clause 3.2*	Ratio of Registered Nurse/Midwife (RN/M) to Enrolled Nurse/Assistant in Nursing/Midwifery In health unit sites (other than regional unit sites) the skill mix for inpatient units is 70:30 registered nurse/midwives to enrolled nurses/assistant in nursing/midwifery. Graduate nurses/midwives are to be included in the RN/M ratio but are not, unless otherwise agreed between the parties, to be rostered as the only registered nurse/midwife in a health unit site or patient care area in the first 6 months of employment.
Application of N/MHPPD **as per NMEA 2022*	Multiply the N/MHPPD for the patient care area by the number of beds that are expected to be occupied or utilised on a regular basis for the period for which staffing is to be determined and then multiply the product by the number of days in the period within which the hours must be balanced. This informs the base roster.

*** As defined in ProAct Corporate Business Rules 2018*

3. SA N/MHPPD Review Process

3.1 Overview

As per NMEA 2022, clause 3.1.5, DHW/ANMF (SA Branch) may agree during the life of the Agreement to alter the agreed staffing levels, where staffing levels and/or mix are no longer safe nor appropriate for the type of patient care area to the extent that significant adjustment, by the addition or removal of at least one whole shift, is necessary.

3.2 The process

Consultation with the ANMF (SA Branch) will be initiated by the health unit site to determine whether there should be adjustment, by agreement of the parties, to the stipulated N/MHPPD. The process will have regard to efficient practice in other similar patient care areas in SA public health services or from areas which provide care to similar groups of clients/patients. The process will include a review of N/MHPPD allocation based on characteristics such as patient complexity and acuity, intervention levels, resource consumption, existing agreed N/MHPPD for similar units and current efficient practices in SA Public Hospitals.

As per NMEA 2022 (clause 3.1.11), the process will include:

- Consultation with staff in the determination of appropriate N/MHPPD
- Consultation with N/MUM and staff in the distribution of nursing/midwifery hours over the relevant period

Typically the process will include (see flow chart pg.106), but is not limited to, the following steps (in no particular order):

Step	Review Item	Example Tool
1	Site/patient care area/ANMF (SA Branch) to initiate a review/analysis that may lead to a request to change the agreed staffing as per Appendix 2 and 3 Supportive evidence/data collated, this may include but is not limited to: Current status Comparison to similar patient care areas Existing agreed N/MHPPD for similar units and current efficient practices in SA Public Hospitals Change in complexity/ clinical mix Efficient Price Index Acuity Average length of stay (ALOS) Significant change in patient turnover Occupied Bed Days – averaged Emergency/ elective admissions Other factors, for example Births Proposed N/MHPPD requirements or ratio, skill mix and staff plan Significant change in the patient care area environment or clinical/administrative supports	Local Health Network/SA Health Business Case Profoma
2	The patient care area is benchmarked against other 'like' areas and current efficient practices including within SA hospitals This process will take into consideration a range of factors such as the level of hospital (i.e. Tertiary, General or Regional) and the type of ward, i.e. medical, surgical, mixed, pediatric, adult and/or specialty with "like" wards, nursing/midwifery weights. Indicators may include, but are not limited to, DRGs, casemix, Efficient Price Index, patient turnover, environment (i.e. geography), administrative and clinical support in order to identify the range of N/MHPPD/staffing ratios and skill mix.	Data comparison and Benchmarking. See example ward/ unit considerations (sample questions)
3	Consultation and feedback by patient care area/site/ANMF (SA Branch) (including member consultation) regarding proposed staff model.	
4	Local approval; draft proposed N/MHPPD or staffing ratio endorsed by Executive DON/M and CEO (or alternative). Recommendations made with subsequent approval by SA Health and the ANMF (SA Branch). This formalised agreement will override the NMEA 2022 Appendix 2 and 3 provisions and will not require approval by the SAET. Note where agreement cannot be reached, dispute resolution processes as outlined in NMEA 2022 may be utilised.	
5	Evaluation post implementation	

Ward/unit considerations (may include but not limited to):

Service profile

- What are the main specialties / type of beds mix for the patient care area?
- What is the maximum bed capacity of the patient care area?
- What is the average occupancy of the patient care area?
- How many hours per day is the patient care area open?
- On average, how many outliers are admitted on the patient care area per day?
- Acuity
- Procedure type/ intervention level
- Weight of case mix separation
- Average length of stay
- Births

Patient Turnover

- What is the number of average admissions per day?
- On average, how many patients per day are admitted via ED?
- On average, how many patients per day are admitted via elective, including DOSA and Outpatient?
- What is the number of average transfers in per day?
- What is the number of average transfers out per day?
- What is the number of average discharges per day?

Model of Care:

Staff profile

- Number of core staff on duty per day
- Do any staff members on duty cover additional roles / or provide consultative service outside of the unit?
- Is there other clinical nursing support provided from other designated nursing roles to the unit?
- Mix of staff

Supportive Staff: number of days/ hours of supportive staff coverage

- Administrative support (ward clerk)
- Ward ancillary
- Orderly, if applicable
- Others

Ward geography

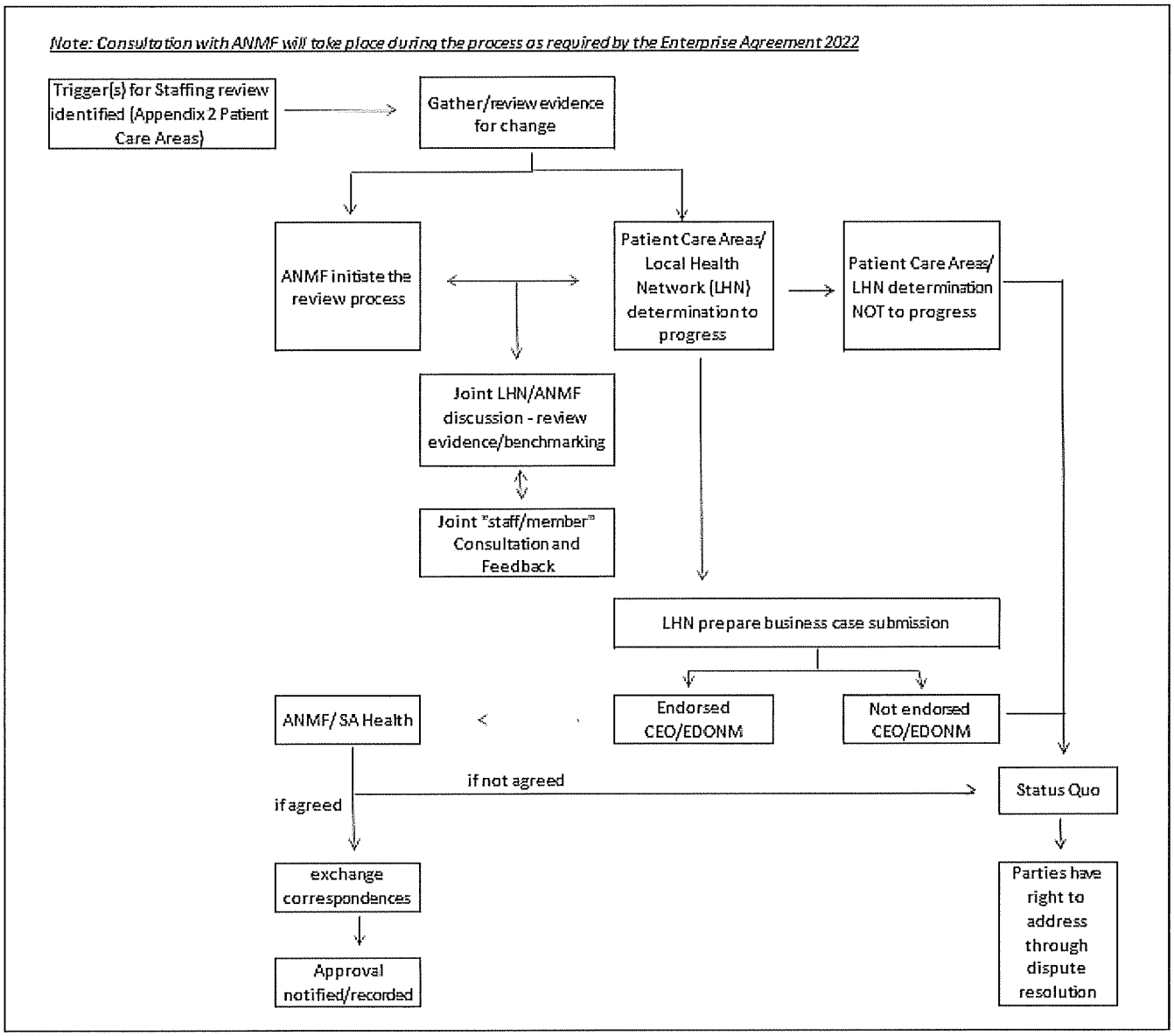
- Physical layout
- Number of nurse stations
- Number of single rooms
- Bed bay configuration

Equipment/ Technology

- Patient medication storage
- DDA cupboard
- Equipment storage
- Equipment availability
- Phone access

SA N/MHPPD Staffing Model Process for Change

(NMEA 2022 Appendix 2 and 3 Patient Care Areas)



Flow Chart

1. Trigger for review of Appendix 2 and 3 N/MHPPD or ratio (patient care areas)
2. Gather support evidence/data collation
3. Benchmarking
4. Consultation and feedback loop (local level and the ANMF (SA Branch))
5. Local approval – proposed NMHPPD or ratio endorsed by DON/M and CEO (or alternate)
6. DHW/ANMF (SA Branch) formal agreement re change (If not agreed dispute resolution)
7. Evaluation post implementation

APPENDIX 14 – ANMF 10 POINT PLAN TO END VIOLENCE AND AGGRESSION

CONTENTS

*ANMF Note: Referral to Patient Care Plan includes all associated documents e.g. Behavioural Management Plan

10 POINT PLAN TO END VIOLENCE AND AGGRESSION A GUIDE FOR HEALTH SERVICES

Australian Nursing and Midwifery Federation (SA Branch)
Working for you at work and in practice

MESSAGE FROM ADJ ASSOC PROF ELIZABETH DABARS AM

CEO/Secretary, ANMF (SA Branch)

This is what a plan to end violence looks like.

South Australia's nurses, midwives and other health workers have been left exposed to violent attacks and aggressive behaviours for far too long. With an increasing number of our members reporting serious incidents and threatening behaviours, it is clear a plan to address the issue is well overdue.

This is the Plan nurses, midwives, and all South Australians need and deserve. Because everyone has the right to feel safe and supported in our hospitals and health centres, regardless of whether they are providing or receiving care.

This Ten-Point Plan to End Violence and Aggression outlines the critical areas needed for an effective organisational response to violence and aggression—a response that is proactive and measured in place of what has historically been reactive and fragmented.

This guide can only work with the full support of the State Government and the preparedness of hospital and health service management—at every level—to drive these changes and:

- end preventable violence in health care settings
- mitigate the risks to staff, patients and visitors
- properly manage any incidents that do occur
- appropriately support any staff members involved

The Plan calls for leadership and collaboration—among governments, hospitals, health services and members of the public—if we are to genuinely make a difference and put an end to the culture of violence that is so rife in our health care settings today.

We are all aware of the problems. Here are the solutions. Everything we need to know, understand and do to end preventable violence in health care is in this Plan.

Let's work together to make our hospitals and health facilities safer for everyone.

10 POINT PLAN TO END VIOLENCE AND AGGRESSION A GUIDE FOR HEALTH SERVICES

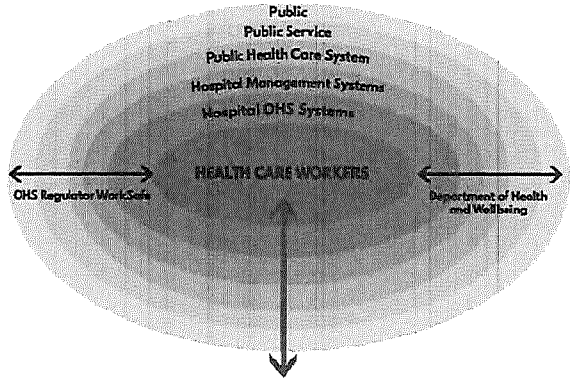
Australian Nursing and Midwifery Federation (SA Branch)
Working for you at work and in practice

INTRODUCTION

Ending aggression and violence requires changes to all levels of systems, as demonstrated in the below diagram.

This Guide is a tool to enable health care organisations to:

- review their management and occupational health and safety systems; and
- ensure that aggression and violence is appropriately recognised, represented as a risk and that action is taken to prevent incidents.



PRE-CONDITIONS

Commitment: This Guide will only be successful if implemented in an organisation and across a system that has a real and irrefutable commitment to the prevention of violence. This commitment needs to come from every level of management and be embraced across the health system. This commitment must manifest at Chief Executive Officer and Board level to acknowledge the failings of the system in its current form and pledge to address the shortcomings. Such a commitment should also include a reporting structure that provides for Directors at each Board meeting to be provided with an in-depth report of the number of assaults that have occurred within their hospital network, the details of each assault, the injuries suffered by the staff, and the corrective actions that have been put in place to reduce the risk of recurrence.

Communication, consultation and collaboration: another pre-condition to the framework is a commitment by those running the health service to undertake the 'Three Cs'—communication, consultation and collaboration—in relation to aggression and violence, but more broadly as a management imperative. Whilst the Occupational Health and Safety Act 2004 mandates health services to undertake consultation in relation to matters which affect (or may affect) the health and safety of staff, experience shows that this is rarely undertaken in the manner in which it is described. Again, this must be demonstrated from decision makers, in order to affect change at a local level. Such communication, consultation and collaboration must involve representatives of all stakeholders, including health services, unions, workers, health and safety representatives and consumers. Moreover, the presence and input at both a strategic and local level into such strategies will allow more robust systems to be developed and implemented, which will lead to wider acceptance, and increased ownership.

SCOPE

The principles and content of the ANMF (SA Branch) Ten-Point Plan is applicable to all health services and hospital facilities, including mental health, acute, emergency departments, aged care, community care and locations external to a purpose-built workplace e.g. visiting health services.

INSTRUCTIONS FOR USE

The traffic light approach supports health services in their movement from a situation with high risk factors to the lower risk solutions, stepping along the way. The Guide can also be used as an 'audit-type' tool, whereby health services are able to self-assess against the criteria in the guide, and identify their areas for improvement.

The Guide provides a starting point for health services to work towards in relation to implementation of an organisational approach to the prevention of aggression and violence. It has identified key factors that comprise each of the 10 Points, and that demonstrate or indicate compliance with the factors, and it also provides examples of high, reduced-risk solutions and low-risk solutions to each of the factors.

It is expected that facilities would be working towards the lowest risk solutions in order to ensure that their staff are provided an environment that is as safe as possible. Given the ongoing developments occurring within prevention of aggression and violence, this guide provides a starting point, however a commitment to continuous improvement, and ongoing review and revision of controls in this area is required.

TERMINOLOGY

Clinical staff – includes nurses, midwives, doctors, allied health and other clinical staff

WHSRs – work health and safety representatives

CBVA – Challenging behaviours, violence and aggression is defined by SafeWork SA as 'any behaviour with the potential to physically or psychologically harm another person or self or property. It can range from verbal abuse through to threats or acts of physical violence' (SA Health, 2015).

Employees can be exposed to aggression and violence from a range of sources including clients, consumers, patients, residents, visitors and members of the public.
Examples of CBVA include, but are not limited to:

- biting, spitting, scratching, hitting, kicking;
- pushing, shoving, tripping, grabbing;
- throwing objects, damaging property;
- verbal abuse and threats;
- using or threatening to use a weapon; and
- sexual harassment or assault.

CBVA incidents may be service-related, that is, arising when providing a service to consumers. It can be intentional, deliberate or unintentional when associated with medical conditions such as delirium, dementia and psychosis.

CBVA incidents may be external, that is, when the person exhibiting CBVA is from outside the work and care environment, but affects workers or property, and is associated with crime e.g. robbery, assault including assault to ambulance officers, or threats to harm.

Patient Care Plan – documents e.g. Behavioural Management Plan, admission documentation, risk assessments etc.

Patients – where patients are referred to, this may also be read to include clients, residents and consumers as appropriate.

NB: at all steps of the process, it is critical that frontline staff and WHSRs are involved in consultation.

1. IMPROVED SECURITY

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
1.1 Adequate provision of security with development of standards and policy for use across all health services	Security usage is decreased across the health service due to cost of personnel and services required	Agreed and funded security contracts are in place for all sites	Sufficient security is in place to provide a safe environment for all staff and visitors.
1.2 Health service responses to aggression and violence, such as Security Assist and Code Black, are consistent with state-wide guidance and apply to all situations of occupational aggression and violence.	The organisation does not have Code Black or security assist policy or procedure in place.	The organisation has Code Black Procedure in line with the national standards.	The organisation has an effective code black procedure which is reviewed and incidents are monitored regularly.
	The organisation does not have a fully functioning and effective Code Black team with an identified governance structure.	Code Black team composition is developed with clear understanding of roles, responsibilities and education for the team. Governance of the Code Black team is not identified.	Governance of the Code Black team is identified and in place (similar to Code Blue teams). The organisation has a trained, effective code black team implemented with regular reviews of team composition and training.
1.3 Security cameras	CCTV cameras are not installed or are inadequate across all sites.	CCTV cameras are installed across high-risk areas only. CCTV system is monitored inconsistently.	CCTV cameras are installed across all areas, including car parks at all health sites. CCTV system is monitored continuously and footage is able to be recorded for use as evidence. Signage to inform staff, consumers and visitors that CCTV cameras are in use are displayed in appropriate areas.
1.4 Lighting	Poor or no lighting in internal and external areas of health facilities. No systems are in place for monitoring for faults or failures.	Inadequate or insufficient lighting is installed across high risk areas. Limited systems are in place to monitor for faults or failures.	Sufficient lighting is installed across all internal and external areas of facilities. The organisation has a structured maintenance schedule and a responsive fault reporting system in place.

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10 POINT PLAN TO END VIOLENCE AND ABUSE A GUIDE FOR HEALTH SERVICES
Australian Nursing and Midwifery Federation (SA Branch)
With you at work and in practice

1. IMPROVED SECURITY

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
1.5 Access to secure areas and safe zones	The facility has no secure staff areas, safe zones, and lock-down area or procedures.	There are some established secure staff areas, safe zones, lock down areas and procedures but there are no systems in place.	A security audit of all established secure staff areas, safe zones and lock down areas and procedures has been conducted, and improvement recommendations have been implemented.
	A security risk assessment of all areas in the facility has not been conducted.	A security risk assessment of all areas in the facility has been conducted to identify high-risk areas, secure areas, safe zones and lock down areas including procedures.	A security risk assessment of all areas in the facility has been conducted to identify high-risk areas, secure areas, safe zones and lock down areas including procedures, and recommendations have been fully implemented and reviewed.
1.6 Specifically trained security personnel for Code Black and security assist are available on-site	No areas or partial areas and sites have on-site security personnel available.	Some on-site security personnel are available for some areas and sites whenever operational.	On-site security personnel are available in adequate safe numbers for all areas and sites during all operational hours.
	The training and experience of security personnel is not checked to identify whether they have health care specific training and experience.	The training and experience of security personnel is inconsistently reviewed, against a documented set of requirements.	All security personnel have had healthcare and organisation-specific training in their roles, which is checked prior to engagement against a document-ed set of criteria and is regularly reviewed and up-dated.
1.7 Personal duress alarms	A risk assessment of all areas in the health service has not been conducted to identify any need for personal duress alarms.	A risk assessment of all areas in the health service has been conducted to identify high risk areas for staff needing wall mounted and personal duress alarms, including location identification.	A risk assessment of all areas in the health service has been conducted in consultation with Workplace Health and Safety Representatives and staff to identify high-risk areas for staff needing wall-mounted and personal duress alarms including location identification, and recommendations have been implemented.

1. IMPROVED SECURITY

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
1.7 Cont.	Personal and wall-mounted duress systems are not tested.	Personal and wall-mounted duress systems are regularly tested.	Each facility has a duress alarm system procedure and testing schedule. Personal and wall mounted duress systems are regularly tested, and results are documented.
	There is no training of staff in the use of duress alarms.	There is inconsistent and unregulated training of staff in the use of duress alarms.	There is regular, consistent training of staff in the use of duress alarms, governed by procedure, including trialing the alarms.
1.8 Regular security audits of health services, including maintaining security equipment.	The facility does not have a documented security audit and risk assessment process.	The facility has a documented security audit and risk assessment process.	The facility has a documented security audit and risk assessment process with regular scheduling and implementation and review of identified risks.
	The facility has not reviewed the security audit and risk assessment tool.	The facility has reviewed the security audit and risk assessment tool.	The security audit and risk assessment tool are reviewed with a documented review schedule with results reported to the WHS committee.
1.9 Monitoring systems for community clinics.	A security risk assessment of the community clinics including monitoring systems has not been conducted.	A security risk assessment of the community clinics including monitoring systems has been conducted.	A security risk assessment of the community clinics including monitoring systems, has been conducted, and recommendations have been implemented.
1.10 Clear and visible messaging for patients, family and visitors in relation to acceptable behavioural standards in the health service.	There is no messaging to patients, family and visitors in relation to acceptable behavioural standards in the health service.	There is some messaging around behavioural expectations, but it is not proactively provided to all patients, family and visitors pre-admission, on arrival and during admission to the health service.	Clear messaging is provided to all patients, family and visitors pre-admission, on arrival and during admission to the health service, setting out appropriate behaviour, and the possible consequences of failing to comply with these expectations.

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2. IDENTIFY RISK TO STAFF AND OTHERS

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
2.1 Identified risk screening and risk assessment tools for patient/others for aggression or violence towards staff are in place.	The organisation does not have identified risk screening and assessment tools in place.	The organisation has limited clinical risk assessment tools in place for: • Cognitive Assessment; • Drug & Alcohol (acute withdrawal); • Unpredictable behaviours due to physical/mental health status; and • Others as necessary.	The organisation performs clinical risk assessments on all patients/others displaying signs of aggression using the appropriate risk assessment tool.
2.2 Patient/others identified as a high risk of aggression/violence.	No systems or preventative controls or management plans are in place for staff to use as guidelines for implementation.	Limited pathway, guidelines, procedures or management plans are in place for staff to implement.	Staff are able to plan, develop and implement individual plans to reduce the risk of aggression/violence.
2.3 Escalation process in place to help staff seeking assistance from senior management to manage aggressive or violent behaviours.	No escalation processes are in place for staff to access senior management for support or advice.	An escalation procedure has been developed but is not fully implemented or supported by senior managers.	A documented and supported escalation procedure is in place for staff. All escalation incidents are documented and reviewed, and actions taken.
			The escalation procedure is reviewed regularly and changed as required.
2.4 Monitoring and evaluating risks.	No process in place to monitor and evaluate risks relating to aggressive and violent behaviour.	Risks are monitored but not regularly evaluated.	Risks are monitored and regularly evaluated.
2.5 Searching of personal belongings when entering a health service if identified as high risk.	No procedures are in place regarding searching patient and visitors upon admission and during a patient's stay.	Limited procedures are in place regarding searching patient and visitors upon admission and during a patient's stay.	The facility has clear procedures in place around performing patient and visitor searches to ensure a consistent approach.

2. IDENTIFY RISK TO STAFF AND OTHERS

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
2.6 Health services ensure patient alert systems, including violent or aggressive behaviour, are part of admission and patient stay procedures.	No violent and aggressive patient alert system is available.	Some areas and sites have a violent and aggressive patient alert system.	All areas and sites have a violent and aggressive patient alert system with clear processes to flag and manage identified patients.
	The violent and aggressive patient alerts system is not integrated into the admission and patient stay process.	The violent and aggressive patient alerts system is somewhat integrated into the admission and patient stay process.	The violent and aggressive patient alerts system is fully integrated into the admission and patient stay process to ensure high-risk patients are identified and appropriately managed.
	The violent and aggressive patient alert system is not compatible across the network systems.	The violent and aggressive patient alert system has limited uniformity across the network.	The violent and aggressive patient alert system is uniform across the network and is compatible with all patient information systems.

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3. INCLUDE FAMILY IN DEVELOPMENT OF PATIENT CARE PLANS

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
3.1 Patient Care Plans are developed in partnership with the patient/family to identify their priorities especially if identified as high-risk for aggression or violence. Management plans are developed to identify triggers for aggression or violence with a plan to manage the behaviour.	Clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan do not identify triggers or management plan for aggressive or violent behaviour.	Some clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan have identified triggers and implemented management plans for aggressive or violent behaviour.	All clinical staff (doctors, nurses, midwives, allied health and others) involved in the development of a Patient Care Plan have identified triggers and implemented management plans for aggressive or violent behaviour.
3.2 The patient's history, presentation and risk factors, and those of their visitors and relatives, are taken into account in the development of Patient Care Plans.	The patient's history, presentation and risk factors, and those of their visitors and relatives, are not taken into account in the development of Patient Care Plans.	Only the patient's presentation is taken into account when developing Patient Care Plans and considering how the care may affect the health and safety of staff or others.	The patient's history, presentation and risk factors, and those of their visitors and relatives, are taken into account when developing Patient Care Plans and considering how the care may affect the health and safety of staff or others.
3.3 Where possible, Patient Care Plans should involve family members to ensure clear standards of behaviour are set and healthcare professionals can provide a consistent approach.	Patient Care Plans are not developed in conjunction with the patient and family/ carer.	Patient Care Plans developed in conjunction with patient and family/ carers do not seek observations, insights, information and advice on: - strategies that may increase and/or reduce the risk of aggressive or violent patient behaviour; and - proactive early intervention strategies that may reduce the risk of the violent or aggressive behaviour further escalate.	Patient Care Plans developed in conjunction with the patient and family/ carer seek observations, insights, information and advice on: - strategies that may increase and/or reduce the risk of aggressive or violent patient behaviour; and - proactive early intervention strategies that may reduce the risk that the violent or aggressive behaviour will escalate further.
	The facility has no behavioural contract policy and procedure.	A behavioural contract policy is in place, but is inconsistently applied.	A behavioural contract policy and procedure with supporting tools are consistently applied, and support is provided by management.

4. REPORT, INVESTIGATE AND ACT

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
4.1 Health services have a structured process in place to investigate incidents in a consultative and collaborative manner.	Health and safety incident investigations do not commence or are not completed in a timely manner.	Health and safety incident investigations are commenced and completed in a timely manner.	Health and safety root cause incident investigations are commenced and completed in a collaborative, timely manner, and are documented in the incident investigation procedure.
	Following a Health and safety incident, investigation is not communicated, or system learnings are not disseminated back to staff.	Following a Health and safety incident, the commencement of an investigation is communicated, or system learnings are disseminated only to injured staff or management.	Following a Health and safety incident, the commencement of an investigation is communicated, or system learnings are disseminated to all staff.
	Health and safety incidents investigations are not undertaken.	Health and safety incident investigations are undertaken, which take into account only clinical or Work Health and Safety contributing factors, and/or focus on identifying individual contributions, rather than system factors.	Health and safety incident investigations are undertaken, which take into account all relevant contributing factors, with a 'no blame' focus.
4.2 Health services demonstrate clear and relevant action over incidents.	Preventative actions are not identified nor implemented after any health and safety incidents or near misses.	Preventative actions are identified and implemented after only multiple or high-risk incidents but are not identified for less critical incidents.	Preventative actions are identified and implemented after all aggressive and violent incidents and near misses, and trends analysed to identify any patterns.
	No monitoring and review system is in place to collate and review trends, incident reports and investigations to establish if clear and relevant actions are taken and processes followed.	A formal monitoring and review system is in place to collate and review trends, incident reports and investigations to to establish if clear and relevant actions are taken and processes followed, the system is implemented on an ad hoc basis.	Formal collating, monitoring and review of incident investigations and reports are undertaken to establish trends as per the monitoring and review process.

4. REPORT, INVESTIGATE AND ACT

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
4.3 Health services meet their governance and funding requirements by ensuring boards are provided with details of violent incidents, not just statistics, so they understand the effects of violence on healthcare workers.	The facility's board and CEO do not receive health and safety incident report data.	The facility's board and CEO receive health and safety incident statistical information only.	The facility's board and CEO receive details about violent and aggressive incidents and effects on healthcare workers, as well as health and safety statistical data, and information around preventative actions taken.
4.4 Health services develop a collaborative working relationship with South Australia Police to enable prosecution of offenders.	Health services do not have a collaborative relationship with South Australia Police.	The health service has a sporadic, ad hoc relationship with South Australia Police.	The health service has a collaborative relationship with South Australia Police that assists staff to pursue their right to prosecution of offenders in a supportive manner.

5. PREVENT VIOLENCE THROUGH WORKPLACE REDESIGN

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
5.1 The physical environment is considered as contributing to the success or failure in the management of aggressive or violent behaviours. The physical environment will include, property, plant and equipment.	There is no consideration for building modifications and new designs for the safety of staff and patients in preventing and managing challenging behaviours.	There is limited planning in the building modifications or new designs to address challenging behaviours.	Building modifications and new designs address the safety of staff and patients to prevent and support the management of aggressive and violent behaviours.
			The health service has undertaken environmental and workplace design risk assessments across all areas and sites, reviewing and identifying infrastructure and process for improvements.
5.2 Reporting environmental issues which have contributed to a Code Black Emergency response call or interfered in the Code Black team management of the aggressive or violent behaviour.	No reporting systems are in place for staff reporting environmental issue/incidents.	There is limited reporting by staff of environmental issues pertaining to aggressive or violent behaviours.	Systems are in place for reporting environmental issues and staff fully utilise the reporting system.
			Issues are addressed in a timely manner.
5.3 SA Health Smoke Free Policy Directive is available to staff and implemented across all sites.	No policy or management plans are in place to address patients smoking in a smoke-free environment.	Policy is in place but there are no management plans to address patients smoking in smoke-free environment.	Management plans are in place for patients who are agitated and want to smoke in the smoke-free environment.

6. PROVIDE EDUCATION AND TRAINING TO HEALTHCARE STAFF

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
6.1 Employer-specific training and education for both health workers and security staff	Emergency procedure training including Code Black and Security Assist are not undertaken or mandated.	Emergency procedure training including Code Black and Security Assist are infrequently undertaken.	Emergency procedure training including Code Black and Security Assist are scheduled regularly, are mandatory and attended by all members of the Code Black teams, and debriefs are conducted after each to identify learnings and improvements.
	Management of aggression and violence training or related training has not been developed in consultation with staff	Management of aggression and violence training or related training has been developed in consultation with some clinical staff.	Management of aggression and violence training or related training has been developed in consultation with staff from all clinical and non-clinical areas, and is regularly reviewed for appropriateness.
6.2 All staff understand the level of educational needs, to prepare for prevention and management of aggressive and violent behaviours.	Staff have not undertaken specific training to management aggression and violence in the workplace.	Staff undertake the prescribed training such as Management of Actual and Potential Aggression (MAPA) training or any other appropriate training for areas or sites.	All staff are aware and undertake all compulsory online training in the prevention of aggressive or violent behaviours.
6.3 Standardised training for both health workers and security staff.	The health service has not benchmarked aggression and violence training programs against similar health services nor Department of Health and Wellbeing standards for consistency and quality.	The health service has started to benchmark aggression and violence training programs against similar health services and Department of Health and Wellbeing standards for consistency and quality, but has not implemented changes to address gaps	The health service has benchmarked all aggression and violence training programs against similar health services and Department of Health and Wellbeing standards for consistency and quality and has addressed identified gaps
6.4 Regular, multidisciplinary refresher training for health workers and security staff.	The facility does not offer aggression and violence refresher training to all clinical and non-clinical staff.	All clinical and non-clinical staff can access aggression and violence refresher training.	All clinical and non-clinical staff receive regular, mandatory aggression and violence refresher training. Training is collective and multi-disciplinary, involving workers from clinical and non-clinical departments.

6. PROVIDE EDUCATION AND TRAINING TO HEALTHCARE STAFF

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
6.5 Education about how to conduct incident investigations, prevent and respond to aggression and violence throughout a health worker's career.	The health services new staff induction / orientation program does not include employer-specific training about how to prevent and respond to aggression and violence.	All new staff receive employer-specific training on how to prevent and respond to aggression and violence from an individual perspective as part of the health service's induction / orientation program.	All new clinical and non-clinical staff receive employer-specific multi-disciplinary training on how the organisation will systematically prevent and respond to aggression and violence as part of the health service's induction / orientation program.
	Health workers do not receive education relevant to their knowledge, role and experience about how to prevent and respond to aggression and violence throughout their career.	Health workers have generic refresher training about how to prevent and respond to aggression and violence available on an elective basis.	Health workers receive mandatory, regular refresher training and education relevant to their knowledge, role and experience about how to prevent and respond to aggression and violence throughout their career. This includes recognition of early warning signs for agitation and pre- code responses, development of skills to reduce conflict, implementation of employer processes that consistently identify and record risks of / actual violence and safety management plans.
	Staff receive no education and training about the functions and powers of security staff and South Australia Police.	Staff receive limited generic education about the functions and powers of security staff and South Australia Police, including how and why to lodge a police report.	All clinical and non-clinical staff receive mandatory, multidisciplinary training and education about the functions and powers of security staff and South Australia Police, including their role in aggression and violence prevention and management, and how and why to lodge a police report.
6.6 Education about how to prevent and respond to aggression and violence should begin at the undergraduate level.	The health service does not monitor or review the education provided to newly qualified nurses and midwives about how to prevent and respond to aggression and violence.	The health service monitors education provided on an ad hoc basis but has no organisational policies to ensure consistent minimum education on how to respond and prevent aggression and violence is provided.	The health service monitors and reviews education provided to newly qualified nurses and midwives and has a process in place to ensure consistent minimum education is provided on how to systematically prevent and respond to aggression and violence.

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7. INTEGRATE LEGISLATION, POLICIES AND PROCEDURES

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
7.1 Health service responses to aggression and violence such as Code Black and Security Assist must be consistent with state-wide policy and apply to all situations of aggression and violence	The facility does not have a Code Black procedure.	The facility has a Code Black procedure in line with Australian Standards (AS 4083).	The facility has a Code Black procedure in line with Australian Standards (AS 4083), which is implemented, regularly trialled and used by staff.
	No clear process exists for when multiple concurrent Code Greys / Blacks are called.		A clear process and response plan exist for when multiple concurrent Code Blacks are activated, which is implemented and trialled.
	The facility does not have a Security Assist procedure.	The facility has a Security Assist procedure that is not fully implemented.	The facility has an effective Security Assist procedure that is implemented, regularly trialled and used by staff.
7.2 Workplaces integrate their violence prevention policies with other policies such as clinical assessment, de-escalation, sedation, post incident support, training and education and security policies.	Aggression and violence prevention and response system, policy and procedures are not integrated.	Aggression and violence prevention and response system, policy and procedures have been reviewed and have limited integration.	Aggression and violence prevention and response system, policy and procedures (inclusive of education and training for all staff) are implemented and regularly reviewed for consistency, and are integrated into the health service's broader systems, such as: • security policies • equipment e.g. personal duress and lead alarms • CCTV • patient searches and storage of belongings (including weapons) • storage of dangerous goods • mandatory training.
	Aggression and violence prevention and response system, policy and procedures have not been reviewed and integrated with security policies.	Aggression and violence prevention and response system, policy and procedures have been reviewed with security policies and inconsistencies have been identified.	Aggression and violence prevention and response system, policy and procedures are implemented and regularly reviewed with security policies for consistency and are integrated.

7. INTEGRATE LEGISLATION, POLICIES AND PROCEDURES

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
7.2 Cont.	Aggression and violence prevention and response system, policy and procedures have not been reviewed and integrated with clinical and non-clinical aggression and violence -related training and education policies.	Aggression and violence prevention and response system, policy and procedures have been reviewed with clinical and non-clinical aggression and violence-related training and education policies and inconsistencies have been identified.	Aggression and violence prevention and response system, policy and procedures are regularly reviewed with clinical and non- clinical staff. Aggression and violence -related training and education policies for consistency and are integrated.
	Local area processes for preventing and responding to violence have not been reviewed and are not consistent with organisational policies.	Local area processes for preventing and responding to violence have been reviewed in line with organisational policies but are not fully consistent with organisational policies.	Local area processes for preventing and responding to violence are reviewed at regular intervals and are consistent with organisational policies.
	No consultation with employees is undertaken regarding the development and review of aggression and violence -related policies and procedures.	Limited consultation is undertaken with employees regarding the development and review of aggression and violence -related policies and procedures.	Staff are regularly consulted in the development and review of all aggression and violence -related policies and procedures.
7.3 Systemic policy changes and decisions about a patient's care take into consideration any potential for the change to increase the incidence of aggression and violence	Systemic policy changes do not consider the potential to increase the prevalence of aggression and violence incidents.	Systemic policy changes consider the potential to increase the prevalence of aggression and violence incidents, but this process is not integrated within the health service's system to prevent and minimise impacts.	Systemic policy changes consider the potential to increase the prevalence of aggression and violence incidents and this process is formally integrated within the health service system to prevent and minimise the impacts.
	Decisions about a patient's care do not consider the potential to increase the prevalence of aggression and violence incidents.	Decisions about a patient's care consider the potential to increase the prevalence of aggression and violence incidents but this process is not formally integrated within the health service system, nor is there a process to prevent and minimise the impacts.	Decisions about a patient's care consider the potential to increase the prevalence of aggression and violence incidents and this process is formally integrated within the health service system, with actions implemented to prevent and minimise the impacts.

8. PROVIDE POST-INCIDENT SUPPORT

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
8.1 In the event of aggressive or violent incidents, staff members receive extensive and appropriate follow up, support and care, including information about and access to the workers' compensation system and the police reporting system process	No documented post-incident reporting procedure exists.	A post-incident reporting procedure exists but it does not incorporate all minimum standards, or it is implemented on an ad hoc basis.	The health service has a documented, implemented post-incident reporting procedure which covers: • post-incident follow-up timelines and processes for contacting involved workers; • protocols that ensure evidence is undisturbed (where applicable); • support and care options for all staff/ patients involved; • information on, and access to processes for workers' compensation system; • documented review of the patient care plan inclusive of implementing mechanisms to provide a safe workplace; • responsibility for arranging repairs without delay; and • information on, and access to processes for police reporting system without loss of pay.
		The health service's post-incident reporting procedure, processes and tools are implemented and reviewed for improvement.	The health service's post-incident reporting procedure, processes and tools are implemented and regularly reviewed for improvement and recommendations implemented.
	The health service does not provide information, support or accompany staff during the police reporting process.	The health service provides limited support to staff to pursue police reporting.	The health service provides workers with information and support and an option for accompanying staff during the police reporting and prosecution process upon request.
	Critical incident, general and operational debriefs are not conducted following incidents.	Critical incident, general and / or operational debriefs are sometimes conducted following incidents.	Clear processes, requirements and appropriately trained staff are available to conduct critical incident, general and operational debriefs following incidents.

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9. APPLY ANTI-VIOLENCE APPROACH ACROSS ALL HEALTH DISCIPLINES

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
9.1 All workers in healthcare settings have the expectation that they will not encounter violence or aggression at their workplace.	Workers do not receive messaging from management that they should not accept violence or aggression in their workplace.	All workers receive informal messaging from management that they should not accept violence or aggression in their workplace.	All workers in the health service receive consistent and supportive modelling from management that they should not accept violence or aggression in their workplace eg. formal component of training, policies, messaging, policies, follow up and put into action.
	No review of clinical training, practices, policies and procedures around behaviours of concern has occurred to ensure alignment with aggression and violence messaging, policies and procedures.	Limited review of clinical training, practices, policies and procedures around behaviours of concern has occurred to align with aggression and violence messaging, policies and procedures.	All clinical training, practices, policies and procedures around behaviours of concern are regularly reviewed to align with aggression and violence messaging, policies and procedures.
9.2 All workers' reports about aggressive or violent behaviour from a patient or their visitors should be taken into consideration when making decisions about the patient's care and management.	Aggression and violence incident reports, including Security Assist and Code Black reports, and in clinical notes, about the patient or visitor are not reflected in the patient care plan or taken into consideration when making decisions about the patient's care and management.	Aggression and violence incident reports, including Security Assist and Code Black reports, and in clinical notes, about the patient or visitor are taken into consideration when making decisions about the patient's care and management but there is no clear standardised documented process.	A clear process exists and is implemented to ensure aggression and violence incident reports, including Security Assist and Code Black incidents, in clinical notes, and any other known forms of violence or aggression in relation to the patient or visitor(s) are recorded in the medical records, and the patient care plan reflects the identified hazard.
	No weight is given to workers' reports of aggressive or violent patient behaviour by those making decisions about a patient's care plan.	Little weight is given to workers' reports of aggressive or violent patient behaviour by those making decisions about a patient's care plan.	Consideration is given to the potential aggression and violence risks as identified by all disciplines at all times, and actions are implemented to reflect concerns and prevent / minimise impacts.
9.3 In making decisions, it is important to communicate, consult and collaborate with all staff involved in the patient's management and care.	Collaborative multi-disciplinary case conferences for patients with challenging behaviour do not occur.	No clear model or process exists for regular collaborative multi-disciplinary case conferences for patients with challenging behaviour.	A clear model and process exists and is implemented for regular collaborative multi-disciplinary case conferences for patients with challenging behaviours with aggression and violence as a specific consideration. Where appropriate, this involves family members, carers and / or nominated persons.

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10. EMPOWER STAFF TO EXPECT A SAFE WORKPLACE

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
10.1 Management demonstrates commitment to changing the culture of healthcare workplaces to reflect no acceptance of aggression or violence in health services. **In workplaces where there is no acceptance of aggression or violence, staff will become empowered to report incidents, implement preventative actions, and believe in their right to a safe workplace.**	There is no challenging behaviours working party, nor challenging behaviours committee with oversight of the implementation of actions in relation to aggression and violence.	There is a challenging behaviours working party doing work in relation to prevention of violence and aggression, but there is no overarching strategy. The working party does not have reporting responsibility to a higher-level challenging behaviours oversight committee.	A high-level challenging behaviours committee is designated to have oversight of all aggression and violence work, and a further challenging behaviours working party has developed a challenging behaviours strategy and action plan to implement an organisational risk management approach to the prevention of violence and aggression.
	No executive management representatives are active members of the challenging behaviours working party.	Some executive management representatives are active members of the challenging behaviours working party	The health service CEO and executive management are active members of the challenging behaviours working party.
	Executive management does not receive any safety culture and aggression and violence -specific training.	Executive management including the CEO receive limited safety culture and aggression and violence -specific training.	All management roles (including the CEO, board and executive) receive safety culture, and aggression and violence -specific training.
	The health service does not have a prevention of challenging behaviours policy.	The health service has a prevention of challenging behaviours policy.	The health service has a collaboratively developed prevention of aggression and violence policy that is fully endorsed (signed) by the CEO and chair of the board.
	The health service incident reporting and investigation policies do not promote a no blame culture.	The health service policies refer to a no blame culture, but this is not actively supported in tools nor is it fully and actively implemented.	The health service incident reporting and investigation policies promote a no blame culture with at least 80% of staff reporting the no-blame culture is actively implemented. Further, managers are provided with education and training, and have access to incident reporting and investigation tools.
	Aggression and violence training does not exist or does not promote a non-acceptance of aggression or violence in the workplace.	Aggression and violence training does not actively promote a non-acceptance of aggression or violence in the workplace or is not based on appropriate policy.	Aggression and violence training actively promotes non-acceptance of aggression or violence in the workplace and includes workers' rights for a safe workplace and provisions if this is breached.

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10. EMPOWER STAFF TO EXPECT A SAFE WORKPLACE

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
10.1 Cont.	Use of language by senior and middle management around non-acceptance of aggression and violence does not demonstrate positive safety culture e.g. language is used which suggests that violence is an inevitable part of health care workplaces.	Use of language by senior and middle management around non-acceptance of aggression and violence sporadically and/or inconsistently demonstrates positive safety culture eg. language is sometimes / inconsistently used which suggests that violence is not acceptable, but sometimes is used suggesting violence is an inevitable part of health care workplaces.	Positive safety culture is demonstrated through consistent use of language which promotes non-acceptance of aggression and violence by all staff, including senior and middle management eg. language is always used which promotes the message that violence is never acceptable, and steps will be taken to investigate and reduce the risk into the future.
	There are no aggression and violence strategic programs or action plans in place.	There are either aggression and violence strategic programs or action plans in place, which have not been developed with stakeholders, or are not monitored by an oversight committee. The board does not receive progress reports.	Aggression and violence strategic programs and action plans have been developed in consultation with stakeholders including the ANMF (SA Branch), and are monitored by an OBVA oversight committee, with regular reports on progress presented to the board.
	No extra resourcing is provided to achieving an aggression and violence action plan and aggression and violence strategic outcomes.	Limited resourcing is allocated to achieving an aggression and violence action plan and aggression and violence strategic outcomes.	Extra resourcing is allocated to achieving an aggression and violence action plan and aggression and violence strategic outcomes.
	The health service does not invite or recognise employee challenging behaviours achievements (eg. aggression and violence safety suggestions by employees, actions taken by employees to identify aggression and violence hazards and improve safety).	Employee challenging behaviours achievements are invited and recognised in a limited capacity at an organisation-wide and local level (within the units).	Employee challenging behaviours achievements and suggestions are actively invited and recognised both at an organisation-wide and local level (within units). Improvements are made as a result with appropriate acknowledgement.
	Organisational values place prime and sole focus on patient safety and experience, without regard for staff safety.	Organisational values recognise staff safety, but it is considered secondary to patient safety.	Safety culture for both patients and staff are included and represented as of equal importance in organisational values and represented in all branding.

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10. EMPOWER STAFF TO EXPECT A SAFE WORKPLACE

CRITERIA	HIGH RISK	REDUCED-RISK SOLUTION	LOW-RISK SOLUTION
10.2 All action plans around the prevention and management of violent and aggressive incidents are developed in consultation with staff	There are no representatives from clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas on the challenging behaviours working party.	The facility demonstrates a limited commitment to an integrated approach to aggression and violence prevention by representatives of some clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas being active members of the challenging behaviours working party.	The facility has an integrated approach to aggression and violence prevention and management by actively including representatives of all clinical (doctors, nursing, midwives, allied health and others) and non-clinical areas/departments
	No WHSRs are members of the challenging behaviours working party.	WHSRs are invited, but not actively encouraged, to be members of the challenging behaviours working party and/or meetings are not scheduled to facilitate attendance.	An appropriate number of WHSRs are active members of the challenging behaviours working party and are encouraged and facilitated to attend in paid time.
	WHSRs and employees are not consulted in the formulation of the health service's challenging behaviours strategy and action plan.	Limited consultation with WHSRs and employees has occurred in regard to the development and project work of the health service's challenging behaviours strategy and action plan, with less than 65% awareness of the challenging behaviours action plan amongst staff.	WHSRs, employees and the ANMF (SA Branch) have been, and are regularly, consulted in the development and project work of the health service's challenging behaviours strategy and action plan, and there is greater than 85% awareness of the challenging behaviours action plan amongst staff.

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