

NURSING/MIDWIFERY (SOUTH AUSTRALIAN PUBLIC SECTOR) ENTERPRISE AGREEMENT 2010

File No. 05735 of 2010

**This Agreement shall come into force on and
from 9 December 2010 and have a life extending
for a period to 30 June 2013.**

THE COMMISSION HEREBY APPROVES THIS ENTERPRISE
AGREEMENT PURSUANT TO SECTION 79 OF THE FAIR
WORK ACT 1994.



DATED 20 DECEMBER 2010.

COMMISSION MEMBER

NURSING/MIDWIFERY
(SOUTH AUSTRALIAN PUBLIC SECTOR)
ENTERPRISE AGREEMENT 2010



**Government
of South Australia**

**Department of the Premier and Cabinet
Public Sector Workforce Relations
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PART 1 – APPLICATION AND OPERATION OF AGREEMENT

1.1 TITLE

This Agreement is known as the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010 (the “Agreement”).

1.2 ARRANGEMENT

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1.3 DEFINITIONS

1.3.1 In this Agreement, unless the contrary intention appears:

“ANMF”	means the Australian Nursing and Midwifery Federation (SA Branch).
“Award”	is the <i>Nurses (South Australian Public Sector) Award 2002</i> (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 <i>Fair Work Act 1994</i> and is a party to this Agreement. For the purposes of this Agreement means the ANMF.
“Chief Executive”	means the person who is the principal administrative officer within the named agency, or delegate thereof.
“DFC”	means the Department for Families and Communities.
“DH”	means the Department of Health/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 a hospital or health service incorporated pursuant to the <i>Health Care Act 2008</i> (the “Act”).
“HR Manual”	means the applicable employer human resources manual (i.e. SA Health (Health Care Act) Human Resources Manual or DFC 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.
“IRCSA”	means Industrial Relations Commission of South Australia.
“N/MHPPD”	means Nursing or Midwifery Hours Per Patient Day.
“party”	means the persons, entities and associations referred to in clause 1.4.
“Patient care area”	means ward/s, patient service unit/s or team/s (including nursing/midwifery staff) providing direct care to patients/clients.
“RN”	means Registered Nurse.
“RN (Mental Health)”	In a mental health service, ward, unit 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.
This “Agreement”	means the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010.

1.4 SCOPE & PARTIES BOUND BY THE AGREEMENT

- 1.4.1 This Agreement is binding upon the Chief Executive, Department of the Premier and Cabinet, the Chief Executive, Department of Health, the Chief Executive, Department for Families and Communities (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 Department of Health, Department for Families and Communities and hospitals and health services incorporated pursuant to the *Health Care Act 2008*.

1.5 DATE & TERM

- 1.5.1 This Agreement will operate from the date of approval by the IRCSA with a nominal expiry date of 30 June 2013.

1.6 RENEGOTIATION

- 1.6.1 The parties to this Agreement agree that negotiations in respect of a new Agreement will commence no later than January 2013.

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 *Nurses/Midwives (South Australian Public Sector) Enterprise Agreement 2007*.

1.8 PURPOSE

- 1.8.1 This Agreement reaffirms the parties' commitment, established by the Nurses' (South Australian Public Sector) Enterprise Agreements 1996, 1998, 2001, 2004 and 2007 to the achievement of best practice and continuous improvement. The Agreement also provides for salary increases that recognise:
- (i) 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;
 - (ii) the need to attract and retain qualified nursing and midwifery staff in the public sector; and
 - (iii) all changes in work value up to and including 30 June 2010.

1.9 PRINCIPAL UNDERTAKINGS

1.9.1 Ongoing Improvement

- 1.9.1.1 The parties bound by the Agreement acknowledge that the provision of health services in this State is subject to ongoing development and restructuring in order that the best possible health outcomes are achieved for the people of South Australia. To this end it is acknowledged that the *South Australian Health Care Plan 2007-2016* released on 6 June 2007 by the Minister for Health provides the platform for health service reform.

- 1.9.1.2 The parties bound by the Agreement are committed to actively engage over clinical change and workforce reform initiatives designed to achieve ongoing health service improvements.
- 1.9.1.3 The parties bound by the Agreement are also committed to the identification and implementation of initiatives to improve standards of care, productivity and efficiency at the clinical, health unit, regional and departmental level.

1.9.2 Strategic Direction

- 1.9.2.1 The parties are committed to achieving the following strategic directions, namely:

- Strengthening primary health care
- Enhancing hospital care
- Reforming mental health care
- Improving the health of Aboriginal people

1.10 AIMS & OBJECTIVES

- 1.10.1 The aims and objectives of this Agreement are to:

- (i) 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;
- (ii) attract nurses/midwives to, and retain nurses/midwives in, full time or part time employment in the South Australian public health sector and to reduce reliance on casual and/or agency staff to meet planned workforce requirements;
- (iii) provide for continuous workplace transformation with the objective of continuous service improvement;
- (iv) improve the delivery of care and services to patients;
- (v) continue to implement initiatives that support workforce flexibility, mobility, development and performance;
- (vi) facilitate flexible working hours;
- (vii) introduce new and more flexible conditions of employment;
- (viii) provide for salary increases consistent with clause 5.1 "Salaries" of this Agreement;
- (ix) provide for an effective system for safe inpatient unit nursing/midwifery staffing levels and skill mix within the South Australian public health system;
- (x) ensure an ongoing stable industrial relations framework at the health unit level that assists health units to improve efficiency and business performance; and
- (xi) ensure ongoing cooperation between the parties to achieve improvements in occupational 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 Subject to this sub-clause, the provisions of this clause do not preclude an application being made to the IRCSA to vary the Agreement for the specified clauses below:
- 3.3 - Review of Commonwealth Funded Aged Care Beds;
 - 3.4 - Skill Mix;
 - 3.5 - Community Health and Community Mental Health Workload Measurement Project;
 - 4.7.3 - RN/M Level 6 Work Level Descriptors; and
 - Appendix 7 – AIN/M Work Level Descriptors.
- 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:
- (i) 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;
 - (ii) Employers must consult in good faith;
 - (iii) Workplace change that affects a significant number of nursing/midwifery employees should not be implemented before appropriate consultation has occurred with ANMF representatives; and
 - (iv) 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.

2.2 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 supervisor in charge of the section or sections 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 DH or DFC, and Public Sector Workforce Relations 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 IRCSA for conciliation and/or determination where appropriate.
- 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.

PART 3 – STAFFING

3.1 STAFFING AND WORKLOADS – INPATIENT UNITS

3.1.1 Safe Staffing Levels

- 3.1.1.1 Health unit sites are to staff to demand in all areas according to the relevant indicator of demand for that setting.
- 3.1.1.2 In most areas of health unit sites this will mean prospectively staffing in accordance with Excelcare projected hours for each shift period (where the system has been implemented) as well as appropriate consideration of known or likely variations expected to patient number or profiles during that shift. In establishing compliance with this system for staffing, actual staffing levels will be matched to the required staffing levels in each patient care area. The relevant definitions and processes for monitoring, compliance and reporting are set out in the protocols contained at Appendix 1. Should a new information system be introduced to replace Excelcare during the life of this Agreement, the protocols will be updated and amended to reflect the language and functionality of that system but preserving the principles of consultation and agreement over change.
- 3.1.1.3 DH is considering the replacement of Excelcare by the careconnect.sa - Clinical Practice Support (CPS) or other similar system. There is no final commitment to the replacement of Excelcare or for the use of the alternate system for staffing purposes as at the time of this agreement being reached.
- 3.1.1.4 The parties will confer further over any proposals to substitute the new system for Excelcare for the purposes of staffing decision-making. If and when there is agreement between the parties to use

the new system to replace Excelcare (where it currently exists) as a staffing tool, health unit sites will staff according to the new system.

- 3.1.1.5 All relevant sites will maintain Excelcare to ensure that units of care and timings are appropriate. Protocols for the maintenance of Excelcare are attached at Appendix 1. The protocols will be used consistently and updated as necessary by further agreement of the parties to ensure that all parties have a continuing confidence in the validity of Excelcare data.
- 3.1.1.6 Following the decisions of the DH ICT Steering Committee and/or any other relevant approval processes, the parties will meet to discuss an appropriate timeframe for rollout of any new system, initially across the remaining Excelcare sites.
- 3.1.1.7 Subject to a business case being approved to extend the application of the new system it will be implemented for health unit sites not presently using Excelcare for staffing purposes.
- 3.1.1.8 If, in the first 12 months, of the approval of this Agreement by IRCSA, Excelcare can no longer operate at a particular site, that site will staff to no less than the average required daily staffing level for the 2009 calendar year. The daily required staffing will be derived from the sum of the required staffing for each of the shifts worked during any day including, where relevant, the actual staffing level for any period in substitution of the required level where the actual exceeds the required level. If Excelcare can no longer operate at a site after the initial 12 month period the site will staff to no less than the average of the patient care area's average required daily staffing level for the previous 12 months.
- 3.1.1.9 In the event that roles, service requirement or change in service volume occur in patient care areas affected by this clause, either the Chief Executive, DH (or delegate) or the ANMF may seek to have the staffing levels adjusted by further agreement.
- 3.1.1.10 The parties to this Agreement will during the first 6 months of the Agreement, explore the applicability of a nurse/midwife staffing methodology based on nurse/midwife to patient ratios. In the event that agreement is not reached during these discussions:
- If Excelcare (or CPS by agreement) is implemented and is functional, the parties will continue to manage staffing decision making in accordance with the provisions of this Agreement in respect of those systems;
 - If Excelcare (or CPS) is not implemented or functional, either party may seek to have the issues resolved through application of the dispute settlement procedure within this Agreement.
- 3.1.1.11 In circumstances where staffing levels are not able to meet demand, health unit sites will refer to the agreed shift by shift staffing requirements decision making process as set out in Section 1 of Appendix 2.
- 3.1.1.12 In wards/units/emergency departments/casualty services of health unit sites, where Excelcare or CPS has not been used to assess demand and staffing, alternative methodologies (e.g. standards, formulae etc) that have been agreed between the parties and set out in Section 2 of Appendix 2 are to be used. Staffing for operating theatres is to be consistent with the ACORN standards, for Emergency Departments with the standards of CENA, ACCCN standards for Intensive Care/High Dependency Units, and GESA standards for Endoscopy Units, that have been used to develop the terms of this section of Appendix 2. Either party may seek to have the alternative methodologies as provided at Appendix 2, Section 2 adjusted by agreement of the other party should any role, service requirement or change in service volume occur in those health unit sites listed in the appendix.
- 3.1.1.13 The ANMF and DH are to agree, within 3 months of the date of approval of this Agreement by the IRCSA, on staffing levels and arrangements for outpatient services and clinics in all hospitals and health services. At the time of agreement being reached, the parties have identified current staffing levels that will form the basis for these discussions but the adequacy or otherwise of these arrangements had yet to be tested and agreed.

3.2 COUNTRY STAFFING ARRANGEMENTS

- 3.2.1 Country health unit sites (non-minimum staffed), will use the methodology as provided in Table A to assess demand. In addition to Table A, demand is to be determined based on the provisions of sub-clause 3.2.4. Either party may seek to have the alternative methodologies as provided below adjusted should any role, service requirement or change in service volume occur in those health unit sites.

3.2.2 Table A

Clinical Area	CSM
Casualty	0.6 NHPPC
Paediatrics	5.3 NHPPD
Obstetrics	6.0 NHPPD
Acute Care*	5.0 NHPPD
Aged Care **	3.2 NHPPD
Complex Care (Stable) beds ***	6.0 NHPPD

* Inclusive of Acute medical, surgical, palliative care, mental health and rehabilitation.

** Aged Care NHPPD applies to State Funded beds and MPS aged care beds under the main roof.

*** See Appendix 3.

- 3.2.3 The above table is in addition to staffing provided for labour and delivery (1:1 staffing during labour), operating theatres, and any specialist outpatient/ambulatory services (e.g. Renal dialysis and Chemotherapy attendances) which will be staffed according to Appendix 2.

3.2.4 Staffing To Demand

- 3.2.4.1 Rosters are developed and published up to 6 weeks prior to the date for commencement.
- 3.2.4.2 A base level of staffing (RNs, RMs and ENs) is allocated on each shift based on the minimum expected number and mix of patients/clients.
- 3.2.4.3 The level of nurse/midwife staffing is allocated/rostered based on historical activity levels, elective Operating Theatre cases, and other predicted activity, using the agreed hours per patient day for the relevant category and mix set out in this Agreement along with any other relevant indicator of staffing in areas such as emergency units, outpatient areas and operating theatres.
- 3.2.4.4 Nursing/midwifery levels are reviewed at least daily to ensure the closest possible alignment to daily activity as measured by application of the provisions of this Agreement and actual staffing levels. Wherever it is not possible to provide the appropriate number of staff to meet the level established by the agreed formulae, measures will be implemented to reduce the activity including reducing the frequency or the provision of non essential interventions or where necessary through discharge and controls on admissions.
- 3.2.4.5 In the event of clinical emergencies or significant changes in the level of activity that arise during the day/shift, the Registered Nurse/Midwife in charge will determine any changes that are appropriate to staffing requirements and, where necessary, engage additional nursing/midwifery staff for that required period of time.
- 3.2.4.6 In health units where the 10 hour night duty operates, an additional 2 hours of indirect time per nurse/midwife on night duty will apply daily.
- 3.2.4.7 For minimum staffed health units at least 1 Registered Nurse/Midwife and 1 other nurse/midwife must be on duty at all times.

3.2.5 Casual/Emergency Department Staffing

- 3.2.5.1 In health unit sites where:
- (i) For any period of 1 week or more; or

- (ii) For any shorter period during which increased demand is reasonably predictable; and
- (iii) 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
- (iv) In addition to the staff indicated by the country staffing methodology specified by clause 3.2.2 and in addition to the demand for other shift periods indicated by 0.6 nursing hours per patient consultation 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.
- (v) For example, if during a holiday period the casualty/emergency department of a country hospital experiences an increase in demand for the casualty/emergency department which last 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.
- (vi) For periods 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.

3.3 REVIEW OF COMMONWEALTH FUNDED AGED CARE BEDS

- 3.3.1 DH and the ANMF will undertake a joint review of the staffing methodology applicable to Commonwealth funded aged care beds located in Country Health SA sites within 6 months of the date of approval of the Agreement by the IRCSA.
- 3.3.2 The review will be research-based and conducted by a reference group that includes experts nominated by DH and ANMF. The terms of reference and scope of the review will be determined by the reference group.
- 3.3.3 Matters agreed between the parties may become the subject of a variation to this agreement or, in the event that an agreed outcome is not achieved, either party may progress the matter in the IRCSA.

3.4 SKILL MIX

- 3.4.1 In health unit sites (other than country health unit sites) the skill mix for inpatient units is 70:30 registered nurses/midwives to enrolled nurses/assistant in nursing/midwifery. Either party 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.
- 3.4.2 In country health 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. Either party may seek to have the skill mix in a country health unit site or part thereof adjusted should any role, service requirement or change in service volume occur at that country health unit site or part thereof.
- 3.4.3 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.
- 3.4.4 DH will consult with the ANMF to review the current skill mix methodologies over the life of the Agreement with the intent of establishing clear staffing standards that reflect operational and clinical need. Each site will ensure that an appropriate mix of staff is provided to meet patient care needs at any time of the day in all patient care areas. The consideration of the mix should take into account the relative skills and experience of the nursing/midwifery group, patient activity and levels of acuity, and reflect an appropriate scope of practice.
- 3.4.5 The parties will identify appropriate terms of reference and governance arrangements.

3.5 COMMUNITY HEALTH AND COMMUNITY MENTAL HEALTH WORKLOAD MEASUREMENT PROJECT

- 3.5.1 DH commit to undertake further investigation, analysis and review of potential workload tools within Community Health and Community Mental Health settings in consultation with the ANMF. The parties acknowledge that community teams are multidisciplinary by nature and hence the consideration of workload tools should embrace wherever possible, all clinical staff. DH, in consultation with the ANMF, will:
- Develop overarching principles to be applied when determining staffing in these areas within the first 6 months of the Agreement; and
 - Explore tools for different community environments that are multi-disciplinary in nature and comply with the overarching principles.
- 3.5.2 In addition to the above clause 3.5.1, DH will commence a 6 month pilot of the “Focus of Care” tool in adult Mental Health Community settings. A joint DH/ANMF Steering Committee (Steering Committee) will be established to develop criteria to measure the suitability of the tool, and to evaluate and make recommendations regarding the suitability of implementing and extending the tool.
- 3.5.3 Should the pilot not be successful, DH will consult with the ANMF to identify an alternative tool.
- 3.5.4 In the event that DH and the ANMF cannot agree on an alternative tool and/or are unable to resolve differences via the Steering Committee, the matter shall be resolved in accordance with the Grievance and Dispute Settlement Procedure outlined in clause 2.2 of this Agreement.

3.6 ROSTERING ARRANGEMENTS

- 3.6.1 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.
- 3.6.2 Notwithstanding 3.6.1 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.

3.7 STANDARD 10 HOUR NIGHT SHIFTS

- 3.7.1 The night shift standard length is 10 hours subject to the following:
- (i) Night shift lengths of less than the 10 hour standard may be agreed by a majority of nursing/midwifery employees in any particular ward or discrete work area following a ballot of such employees.
 - (ii) 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.
 - (iii) The ability of any ward or discrete work area to implement the standard 10 hour night shift will depend upon sufficient staffing numbers (with appropriate skill mix) being available at that ward or work 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 3.7.1(i) above.
 - (iv) 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.
 - (v) 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.

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

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

3.8 CASUAL EMPLOYEES

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

3.8.2 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.

3.8.3 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.

3.8.4 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.

3.9 PART TIME EMPLOYEES – MINIMUM SHIFT LENGTH

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

3.10 PERFORMANCE REVIEW AND DEVELOPMENT

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

3.10.2 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.

3.10.3 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.

3.11 MIDWIFERY CASELOAD PRACTICE AGREEMENT

3.11.1 The Midwifery Caseload Practice Agreement is set out in Appendix 6. The provisions of this Agreement may be extended to other health unit sites not currently using the model following agreement with the health unit concerned, DH, the affected employees and the ANMF. Provisions within Appendix 6 may be varied by mutual agreement of the parties.

PART 4 – CAREER STRUCTURE

4.1 CAREER STRUCTURE AND TRANSLATION ARRANGEMENTS

4.1.1 A new Nursing/Midwifery career structure was introduced in the *Nurses/Midwives (South Australian Public Sector) Enterprise Agreement 2007*. The parties agree to amendments to the career structure as detailed in Appendix 7.

4.1.2 Appendix 5C contains provisions relating to translation arrangements to the modified career structure operative from the first full pay period on or after 1 December 2011. Upon translation, employees will perform duties consistent with those set out at Appendix 7.

4.2 INCREMENTAL PROGRESSION

- 4.2.1 From the date of approval of this Agreement by the IRCSA, 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 but no earlier than 12 months) in accordance with existing incremental progression dates.
- 4.2.2 From the date of approval of this Agreement by the IRCSA, Enrolled Nurses will no longer progress on the basis of the pay points criteria set out in the Award (i.e. Award clause 1.6.13(j) will no longer apply). Enrolled Nurses (except as per clause 4.3 below) will instead progress to the next increment consistent with clause 4.2.1 above.

4.3 ENROLLED NURSE WITH CERTIFICATE QUALIFICATIONS

- 4.3.1 Progression to increment 7 for ENs (Certificate) is subject to meeting the qualifications criteria detailed in Appendix 7.

4.4 ENROLLED NURSE WITH DIPLOMA OF NURSING QUALIFICATIONS

- 4.4.1 Employees classified in the EN with Certificate salary scale who undertake a post-enrolment Diploma translate to the Enrolled Nurse with Diploma qualification salary scale on an increment-to-increment basis.

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 unit/service 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' which notes the agreed methodology used to calculate the FTE requirement for Portfolio management was 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 Programmed days off and overtime do not apply to this classification. However, a Level 3 and 4 (RN/M 3/4) who is required, as a result of either work demands or direction, to work at least 7.6 hours over the 4 week cycle (in addition to 38 hours per week), will be entitled to one scheduled day off per 28 day work cycle.
- 4.6.2 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.
- 4.6.3 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 6.4 of this Agreement.
- 4.6.4 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.
- 4.6.5 Registered Nurse/Midwife Clinical Service Coordinators (Level 3 or 4)
- Who provide pivotal coordination of patient/client care delivery in a defined ward/unit/service/program; and
 - Whose main focus is the line management, coordination and leadership of nursing/midwifery activities to achieve continuity and quality of patient care; and
 - 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. Clinical Service Coordinators may allocate a component of this time to the Associate Clinical Services Coordinator.

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

4.8 PROFESSIONAL DEVELOPMENT

- 4.8.1 Nurses and midwives will have access to the following professional development opportunities:
- An average of 3 days professional development leave per annum. 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 3.7.1 where that shift length is worked;
 - Staff development, conference leave and study assistance provisions as provided by the HR Manual;
 - Emergency Nursing and Midwifery Education courses (ENAME) for Country Health SA nurses and midwives;
 - Teaching Hospital approved courses;
 - Transition to Professional Practice.
- 4.8.2 Skills maintenance/training will be provided by the employer in addition to the 3 days and will include the following training:
- Fire safety
 - Manual handling
 - Hand hygiene
 - CPR
 - Aggression Management (where relevant and required in specific mental health settings)
 - Drug calculations
 - Child protection
 - Implementation or maintenance of clinical systems
 - Administration and/or record keeping
 - Advanced Life Support
- 4.8.3 Health unit sites will monitor and report on Professional Development activity as provided at clause 4.8.4. The report shall be produced quarterly by the Executive Director Nursing and Midwifery (Regional Lead) and provided to the ANMF. The report may also be used by the Professional Development Forum to inform itself for the purposes of its activities as provided in clause 4.8.7.
- 4.8.4 The report will include an acquittal of all moneys spent on all professional development activities undertaken by nurses and midwives. It will also report on the number of days (expressed as hours) spent on professional development activity against the nursing/midwifery FTE on a ward/service/department basis.

- 4.8.5 Funding detailed below is provided to all sites. In sites where ProAct is utilised the report is to acquit all activity against the following criteria in terms of financial spend and hours/days per category. In sites where staff complete a time sheet, the acquittal will be in total hours and total financial spend:
- An amount equaling \$700 per employee for the average of 3 days professional development leave for activities including Clinical Unit orientation/preceptorship; specific training for introduction of new technology or clinical skills and accreditation of identified clinical skills; the maintenance of competency requirements for safe practice and the introduction of new nursing practices;
 - An amount equaling 1% of the nursing/midwifery payroll budget for the unit/service/department provided for activities including conference and study leave and course reimbursement as provided by the HR Manual;
 - An amount equaling \$200 per employee in Country Health SA for ENAME and other country specific professional development expenditure;
 - An amount that totals \$10.5 million as distributed to the regions for the following purposes: Transition to Professional Practice, and Nursing/Midwifery Capability Development programs (i.e. Teaching Hospital approved courses).
- 4.8.6 Regions will establish site/service level nursing and midwifery Training and Professional Development Forum/s that include ANMF Worksite Representative/Learning and Professional Development Representatives. ANMF representatives will be provided with relevant information and reasonable time to participate in the forum.
- 4.8.7 Each Training and Professional Development Forum will meet at least quarterly to discuss and review:
- The number of applications for professional development and study assistance (including conferences etc);
 - The number of approvals of such applications by classification and work areas;
 - Priorities for nursing/midwifery professional development needs within the health service to assist in the future determination of assistance requests;
 - Processes for the consideration of requests and allocation of resources.
- 4.8.8 DH will consult with the ANMF where any changes to professional development activities and/or funding for such activities is contemplated.
- 4.8.9 Where issues about access to, or utilisation of, professional development provisions are unable to be resolved at the forum, the matter shall be resolved in accordance with the Grievance and Dispute Settlement Procedure outlined in clause 2.2 of this Agreement.

4.9 CAPABILITY DEVELOPMENT FRAMEWORK

- 4.9.1 DH will consult with the ANMF to develop a Capability Development Framework for nursing and midwifery within 6 months of the date of approval of the Agreement by the IRCSA. The Framework will outline the capabilities required by the nursing and midwifery workforce and the gaps between actual and required capabilities to be addressed by education and training.
- 4.9.2 The Capability Development Framework will include:
- Guidelines for development at all classification levels of nursing/midwifery;
 - Learning support for nurses and midwives seeking advanced practice roles (including Enrolled Nurses), newly developed roles, primary health care and chronic disease management roles, and Nurse Practitioner roles;
 - Consideration of equity of access for nursing and midwifery staff working in country areas and/or community settings, role changes arising from changes to health service

delineation, opportunities for individuals to develop within and across career paths and workforce development requirements.

PART 5 – WAGES AND OTHER CONDITIONS

5.1 SALARIES

- 5.1.1 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 IRCSA during the life of the Agreement.
- 5.1.2 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 since 1 June 2007 as well as the ongoing implementation of productivity/efficiency measures during the life of this Agreement.
- 5.1.3 The salaries detailed in Appendix 5A provide:
- A general salary increase of 2.5% p.a. plus \$600 (in base) effective from the first full pay period commencing on or after 1 October 2010 (refer to Appendix 5A);
 - A revised career/salary structure effective from the first full pay period commencing on or after 1 December 2011 (refer to rates and translation table in Appendix 5C); and
 - A general salary increase of 2.5% p.a. effective from the first full pay period commencing on or after 1 October 2012 (refer Appendix 5A).

5.2 SALARY SACRIFICE ARRANGEMENTS

- 5.2.1 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.
- 5.2.2 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.
- 5.2.3 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.
- 5.2.4 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.
- 5.2.5 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.
- 5.2.6 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.
- 5.2.7 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.

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

- 5.3.1 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.
- 5.3.2 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.

- 5.3.3 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.

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

- 5.4.1 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 6.4 will be paid.
- 5.4.2 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.
- 5.4.3 In lieu of overtime payment, the RN/M 5 or 6 may elect to take the equivalent time worked as TOIL, according to clause 5.3.
- 5.4.4 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.

5.5 DAYS IN LIEU OF PUBLIC HOLIDAYS

- 5.5.1 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 5.5.3 or 5.5.4 for current employees only. Those employees who wished to avail themselves of this provision must have elected to do so by 31 August 2001.
- 5.5.2 Those mental health sites that retained the days in lieu provision referred to in 5.5.1, whether or not as a result of a ballot under the 1998 Agreement, will continue to make the provision available for current employees only.
- 5.5.3 Any current employee, who has elected to receive days in lieu pursuant to 5.5.1, or is currently receiving days in lieu pursuant to 5.5.2, 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.
- 5.5.4 Any current employee, who has elected to receive days in lieu pursuant to 5.5.1, or is currently receiving days in lieu pursuant to 5.5.2, 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 5.5.3, 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.
- 5.5.5 At an employee's initiative and with the agreement of the employer, additional days off accrued under 5.5.3 or 5.5.4 may be taken at a time other than in conjunction with a period/s of annual leave.
- 5.5.6 For all other public holidays the provisions of the Award apply.
- 5.5.7 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.
- 5.5.8 For the purposes of this clause, the term "current employee" means any RN (Mental Health) 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 5.5.7, retain the days in lieu of public holidays provision.
- 5.5.9 Nothing in this sub-clause precludes the operation of clause 6.3.7(d) of the Award.

5.6 PART TIME EMPLOYEES WORKING VARIABLE SHIFTS – PUBLIC HOLIDAYS

- 5.6.1 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.

5.7 MEAL BREAKS

- 5.7.1 By arrangement with the employee an unpaid meal break is allowed on each day or shift, of a duration of not less than 30 minutes or not more than 60 minutes.
- 5.7.1 No employee will be required to work more than 5 hours without an unpaid meal break during a day or shift.
- 5.7.2 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 this clause or penalty would detract from providing an employee with a break after 5 hours of work.
- 5.7.3 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.
- 5.7.4 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.

5.8 DAYLIGHT SAVING

- 5.8.1 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 DH.

5.9 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.

5.9.1 Definitions

- 5.9.1.1 **Personal/Carers leave** is defined as leave approved by the employer for absences from work on account of:
- (a) Personal illness;
 - (b) Illness of "family member" as defined;
 - (c) Bereavement as defined; and
 - (d) Urgent pressing necessity as defined.

- 5.9.1.2 **Family member** is defined as a member of the employee's household, or near relative of the employee as defined in the *Fair Work Act 1994*. The employee must have responsibility for the care of the family member concerned.
- 5.9.1.3 **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.
- 5.9.1.4 **"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.
- 5.9.1.5 **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:
- (a) 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.
 - (b) Protection of the employee's family/property directly affected by flood or bushfire.

5.9.2 Entitlement

- 5.9.2.1 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.

5.9.3 Limitations to Personal/Carers Leave Entitlement

- 5.9.3.1 During the first 6 months of service no employee is entitled to a grant of leave exceeding 60 hours.
- 5.9.3.2 During the first 12 months of service no employee is entitled to such a grant exceeding 120 hours.
- 5.9.3.3 No Personal/Carers leave is to be granted on account of:
- (a) an illness caused by misconduct of the employee;
 - (b) an illness that arises from circumstances within the employee's control e.g. sunburn;
 - (c) normal period of absence for confinement;
 - (d) 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
 - (e) any other circumstances which are not specifically stated in, or intended by, the definitions in this clause.
- 5.9.3.4 Personal/Carers Leave for part time employees is to be paid at the employee's usual salary for the number of hours normally worked.
- 5.9.3.5 Personal/Carers Leave accrues from year to year without limit.
- 5.9.3.6 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.

- 5.9.3.7 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.
- 5.9.3.8 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.
- 5.9.3.9 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.
- 5.9.3.10 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.
- 5.9.3.11 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.
- 5.9.3.12 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.
- 5.9.3.13 An employee if required must submit an appropriate medical certificate (or other documentation) for each week of absence.
- 5.9.3.14 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.
- 5.9.3.15 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.

5.10 ANNUAL LEAVE

- 5.10.1 This clause will apply in addition to annual leave entitlements provided by Clause 6.1 of the Award.
- 5.10.2 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.
- 5.10.3 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).

5.11 ANMF REPRESENTATIVES – RECOGNITION AND LEAVE

- (i) DH shall recognise all representatives of the ANMF that are authorised as such by the Secretary or their nominee.
- (ii) The representatives may be various worksite representatives, OHS&W representatives or Learning and Professional Development & Policy representatives.

- (iii) 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.
- (iv) 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.
- (v) 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.
- (vi) 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.

PART 6 – PENALTIES AND ALLOWANCES

6.1 RURAL AND REMOTE SERVICE INCENTIVE PAYMENTS

- 6.1.1 Employment incentive payments are payable to nursing/midwifery staff in rural and remote areas. The incentive payments are set out in Appendix 8.
- 6.1.2 The health unit sites affected and their Zone allocation are also set out in Appendix 9.
- 6.1.3 Conditions of payment
 - (i) after the fifth year in a specific Zone, no incentive payment is applicable;
 - (ii) no period of leave without pay will attract the incentive payment;
 - (iii) 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;
 - (iv) 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);
 - (v) 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;
 - (vi) 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;
 - (vii) 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;
 - (viii) 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.

6.1.4 Incidental Payments

- 6.1.4.1 In addition to the Zone Payments in 6.1.2, 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 October 2010	Payable from the first full pay period on or after 1 December 2011	Payable from the first full pay period on or after 1 October 2012
	\$	\$	\$
Zone 2	344	359	368
Zone 3	458	478	490
Zone 4	573	598	613

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

6.2 NIGHT SHIFT PENALTY

- 6.2.1 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.
- 6.2.2 The above night shift penalty is to apply in lieu of the rate prescribed in sub-clause 5.3.1(b) of the Award.

6.3 NURSE/MIDWIFE IN-CHARGE ALLOWANCE

- 6.3.1 A Nurse/Midwife In-Charge Allowance will be paid to a RN/RM1 in a particular ward or unit 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.
- 6.3.2 The allowance will be paid as follows:
- \$11.45 per shift from the first full pay period on or after 1 October 2010;
 - \$11.95 per shift from the first full pay period on or after 1 December 2011; and
 - \$12.25 per shift from the first full pay period on or after 1 October 2012.

6.4 ON-CALL ALLOWANCE

- 6.4.1 Every employee who is not a casual employee may be required to participate in an on-call roster.
- 6.4.2 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 October 2010	Payable from the first full pay period on or after 1 October 2011	Payable from the first full pay period on or after 1 October 2012
	\$	\$	\$
Monday - Friday	26.35	27.00	28.35
Weekends/Public Holidays/Rostered Days Off	46.05	47.20	49.55

- 6.4.3 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.

- 6.4.4 Where nursing/midwifery staff employed in country health 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 6.4.2 above) for each time they are rostered on-call until they are granted 2 consecutive days free from on-call.
- 6.4.5 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.

6.5 RESPONSIBILITY ALLOWANCE

- 6.5.1 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 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	Payable from the first full pay period on or after 1 October 2010	Payable from the first full pay period on or after 1 December 2011	Payable from the first full pay period on or after 1 October 2012
	\$pa (phr)	\$pa (phr)	\$pa (phr)
DON/M classification 6.1-6.2	2941 (1.50)	3070 (1.57)	3147 (1.61)
DON/M classification 6.3	2941 (1.50)	3070 (1.57)	3147 (1.61)
DON/M classification 6.4-6.5	4904 (2.51)	5119 (2.62)	5247 (2.68)
Grade 4-6 (as per award)	5881 (3.01)	6139 (3.14)	6292 (3.22)

6.6 ADDITIONAL DUTIES ALLOWANCE

- 6.6.1 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.
- 6.6.2 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.
- 6.6.3 The appropriate allowance is determined according to the provisions of part 5.1.1.4 "Higher Duties (Salaried Employees)" of the HR Manual.

6.7 HYPERBARIC ALLOWANCE

- 6.7.1 An employee who, during any week, is required to participate in a hyperbaric chamber treatment in the Hyperbaric Medicine Unit at the Royal Adelaide Hospital will be paid an allowance that week. This allowance is paid in recognition of the consequential limitations on employees' social and recreational activities.
- 6.7.2 The allowance will be paid as follows:
- \$18.25 per week from the first full pay period on or after 1 October 2010;
 - \$19.05 per week from the first full pay period on or after 1 December 2011; and
 - \$19.55 per week from the first full pay period on or after 1 October 2012.
- 6.7.3 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.

6.8 UNIFORM ALLOWANCE

- 6.8.1 A uniform allowance is paid to full time employees where required to wear a distinctive uniform or item of clothing as follows:

- \$4.45 per week from the first full pay period on or after 1 October 2010
- \$4.65 per week from the first full pay period on or after 1 December 2011; and
- \$4.75 per week from the first full pay period on or after 1 October 2012.

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

6.9 ALLOWANCE FOR ADDITIONAL QUALIFICATIONS

6.9.1 The amounts of the allowances for additional qualifications and conditions regarding eligibility are set out in Appendix 10. 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.

6.9.2 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 7 – WORK LIFE FLEXIBILITY

7.1 PAID MATERNITY/ADOPTION LEAVE

7.1.1 Paid maternity leave and paid adoption leave applies in accordance with this clause.

7.1.2 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 16 weeks paid maternity or adoption leave on or after 1 October 2010 (the “applicable maximum period”).

7.1.3 An employee, other than a casual employee, who, at the time of taking such paid maternity or adoption leave, has been employed in the SA public sector for not less than 5 years (including any periods of approved unpaid leave), will be entitled to 18 weeks on or after 12 months of the date of approval of this Agreement by the IRCSA (the “applicable maximum period”).

7.1.4 The following conditions apply to an employee applying for paid maternity leave or paid adoption leave:

7.1.4.1 The total of paid and unpaid maternity/adoption/parental/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.

7.1.4.2 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 maternity/adoption leave commences. The paid maternity/adoption 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.

7.1.4.3 At the time of applying for paid maternity leave or paid adoption leave, the employee may elect in writing:

- 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
- 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 maternity/adoption leave commences; or
- A combination of (a) and (b).

7.1.4.4 Where both prospective parents are employed by DH or by DFC, a period of paid maternity/adoption leave (as applicable) may be shared by both employees, provided that the total period of paid maternity and adoption leave does not exceed the applicable maximum.

- 7.1.4.5 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).
- 7.1.4.6 During periods of paid or unpaid maternity 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.
- 7.1.4.7 This clause operates notwithstanding the *Paid Parental Leave Act 2010 (Cth)* effective from 1 January 2011.
- 7.1.4.8 Provisions relating to unpaid maternity/adoption 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.

7.2 BREAST FEEDING FACILITIES

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

7.3 RETURN TO WORK ON A PART TIME BASIS

- 7.3.1 Subject to this clause, an employee is entitled to return to work after maternity or adoption leave on a part time basis, at the employee's substantive classification level, until the child's second birthday and may then revert to full time.
- 7.3.2 The following conditions apply to an employee applying to return on a part time basis:
- 7.3.3 The employee will provide such request at least 6 weeks prior to the date on which the employee's maternity 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.
- 7.3.4 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.
- 7.3.5 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.
- 7.3.6 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.

7.4 VOLUNTARY FLEXIBLE WORKING ARRANGEMENTS

- 7.4.1 The parties acknowledge the mutual benefit to the employer and employee of Voluntary Flexible Working Arrangements (VFWA) to balance work and other (including family) commitments and agree to promote and improve the awareness of VFWAs to employees during the life of this Agreement.
- 7.4.2 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.
- 7.4.3 This clause applies for the period an employee participates in a VFWA.
 - (a) 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.

- (b) 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.
- (c) Where an employee is participating in a Compressed Weeks type of VFWA (not generally applied to 7 day week workers), 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.
- (d) 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.

7.4.4 The Chief Executive, DH and Chief Executive, DFC agree to promote, monitor and evaluate the use of VFWA within health units.

7.5 REIMBURSEMENT OF REASONABLE CHILD CARE COSTS

- 7.5.1 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.
- 7.5.2 The prior period of 24 hours is to be calculated from the time at which the work is to begin.
- 7.5.3 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.
- 7.5.4 The reimbursement will be in respect of the reasonable costs incurred by the employee in respect of the work.
- 7.5.5 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.
- 7.5.6 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 Employment.
- 7.5.7 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.
- 7.5.8 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.

7.6 REIMBURSEMENT OF REASONABLE TRAVEL COSTS

- 7.6.1 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.
 - (a) 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.
 - (b) The employee ordinarily uses public transport.

- (c) Travel is by the most direct or appropriate route.
- (d) Reimbursement of reasonable taxi costs, or mileage at a rate determined from time to time by the Commissioner for Public Employment.

7.6.2 The employee will provide the agency with such tax invoice/receipt or other supporting documentation as may from time to time be required detailing the cost incurred or reimbursement sought.

PART 8 – OCCUPATIONAL HEALTH, SAFETY AND WELFARE (OHS&W)

8.1 OHS&W RESPONSIBILITIES

- 8.1.1 In accordance with the *Occupational Health Safety & Welfare Act (1986)*, health units 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. DH and DFC are committed to providing services to the community in an environment that is safe and non-threatening.
- 8.1.2 DH will provide the ANMF with a report identifying current OHS&W representatives in nursing/midwifery areas. The report will be updated as necessary throughout the life of the Agreement.
- 8.1.3 The SA Health Respectful Behaviour policy (or its successor) will continue to be implemented/maintained by DH during the life of this Agreement.
- 8.1.4 Manual handling policies and procedures based on the Department of Health Manual Handling Guidelines will continue to be implemented/maintained during the life of the Agreement by health units that do not have equivalent policies and procedures in place.

8.2 LEAD APRONS AND RELIEF BREAKS

- 8.2.1 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.
- 8.2.2 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.
- 8.2.3 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.

8.3 PRE-EMPLOYMENT HEALTH SCREENINGS

- 8.3.1 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.
- 8.3.2 Where the employer requires health screening/testing, the employer will meet the reasonable costs for such tests.
- 8.3.3 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.
- 8.3.4 The prospective employee's consent is to be obtained before seeking any such information.

PART 9 – SIGNATORIES TO THE AGREEMENT

..... Date.....
Chief Executive, Department of the Premier and Cabinet
as the declared employer for public employees

..... Date

Witness

..... Date.....
Chief Executive, Department of Health

..... Date.....

Witness

..... Date.....
Chief Executive, Department for Families and Communities

..... Date.....

Witness

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

..... Date.....

Witness

PART 10 – APPENDICES

APPENDIX 1 – EXCELCARE PROTOCOLS

BACKGROUND

As detailed in clause 3.1, there is a requirement to use ExcelCare for staffing resource calculation (i.e. staff to patient care demand based on shift projections) to ensure safe staffing levels. It is also agreed that compliance to the agreement means that there is alignment between actual staffing levels with the required time for patient care in the corresponding period. It is also agreed that the Excelcare system must be maintained accurately and transparently.

This document is divided into 4 sections:

Section 1: Guiding Principles: In response to changing environments and the ongoing requirements of the *Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010*, effective leadership and management of the ExcelCare System is required. ExcelCare should be managed under guiding principles adapted for DH and implemented through regions.

Section 2: Local Hospital Governance: This section details the hospital governance practices and definitions for Units of Care (UoC), audit, staffing and reporting. These practices are required to improve and maintain the integrity of the ExcelCare system.

Section 3: Timing Definitions: These include definitions of direct and indirect time, and historical examples of activities that contribute to direct and indirect time.

Section 4: Timing Methodology: This section details the process for timing care to develop UoC. The aim of the definitions is to ensure consistent application of the process and to ensure statistical validity and reliable timings.

Section 1: Guiding Principles

The following guiding principles ensure effective leadership and management of the ExcelCare system.

- Governance:
 - The ExcelCare System is managed at local hospitals; however there is an imperative to have state-wide definitions to ensure consistent practice in relation to how issues are managed in order to ensure consistent reporting of information.
 - This includes developing protocols and processes at a range of levels for system development, system modification, and leadership through ExcelCare subject matter consultants. Wherever levels are created for leadership and decision making in relation to these systems, processes for effective consultation and agreement must be developed and agreed with the ANMF.
- Accountability:
 - The (Executive) Director of Nursing/Midwifery (DON/M) will be accountable for approving changes to UoCs following the necessary processes for consultation and agreement.
- Consultation:
 - Consultation provisions within the Agreement and within this document have been developed to ensure effective processes exist for consultation and agreement on all relevant matters.

In order to establish an agreed point for the ongoing use and maintenance of the ExcelCare system it is agreed that all sites will provide details of all changes made to the system in relation to standards, UoC and/or timings (or any other content or system that may impact on staffing decision making/resource calculation) during 2010. The ANMF will consider the changes that have been made and will indicate its agreement or objection to the changes being maintained in the system. In the event that agreement is not reached over any matter the system will revert to that content which applied in relation to the disputed materials prior to the change being effected. Should a site wish to pursue the changes it shall use the local hospital governance processes outlined in this document. It is agreed that all such changes will be advised to the ANMF CEO/Secretary within 8 weeks of the approval of this Agreement and that the response of the union will be provided to the site (Executive) DON/M within a further period of not more than 6 weeks.

Section 2: Local Hospital Governance

Leadership to ensure consistency across the state is the responsibility of DH. The (Executive) DON/M are responsible for ensuring consistency at the local hospital sites. Governance of the ExcelCare database, administration, timings and maintenance is the responsibility of each respective hospital. The below reflect contemporary practice and should be implemented at Hospitals where ExcelCare operates.

2.1 Units of Care (UoC)

UoC (inclusive of content and timings) are to be developed and revised based on evidence-based practice in consultation with the ANMF and clinical staff at each site and in accordance with local procedures and practice review processes.

2.1.1 Establishing and Reviewing UoC

Each hospital will convene a Nursing and Midwifery ExcelCare Governance Committee. Membership is representative of a cross section of hospital nurses and midwives, managers and the ANMF nominated representatives. The committee will meet on a monthly basis.

UoC (inclusive of the site UoC Library and associated standards) are maintained and reviewed through Committee processes and by relevant Hospital clinicians.

UoCs are underpinned by evidence based clinical practice and linked to procedures including nursing and midwifery and multidisciplinary clinical procedures, guidelines, pathways and standards.

UoC establishment, alteration or deletion is determined by Hospital specific changes in practice, clinical services/patient profile and technology.

Hospitals must ensure that nurses and midwives at all levels can participate in the development and review process. This should provide for:

- Notification to all (relevant) nurses and midwives when a particular UoC is to be created, deleted or placed under review;
- The ability of nurses and midwives to identify issues or comment on the changes that should be considered in altering the UoC; and
- The ability of nurses and midwives to comment on draft changes to the UoC as the review group considers them.

2.1.2 Review and Endorsement

The review and endorsement process incorporates configuration checks to ensure coding accuracy and minimisation of content and timing duplication. The formal agreement of the ANMF CEO/Secretary or delegate will be sought to all changes before they are authorised for implementation by the (Executive) DON/M.

2.2 Care Planning Auditing

Information from ExcelCare is used in relation to care planning, staffing, patient costings, quality evaluation and benchmarking. Formal auditing of ExcelCare and documentation in conjunction with the Medical Record using an audit tool is a quality monitoring and improvement activity that should be undertaken regularly in each ward.

Each nurse and midwife providing care is responsible for reviewing the accuracy of ExcelCare care plans and documentation of care for their allocated patients on a shift by shift basis.

2.2.1 Audit and Review Objectives

- Provides a process to monitor the accuracy and validity of clinical documentation in ExcelCare and the paper based Medical Record.
- Supports the accurate recording of care requirements, to provide accurate and timely calculation of resource information to support staffing decision making.
- Measures consistency of documentation compliance with documentation standards.

2.2.2 Review Processes

Review processes are used for assessing care plans and projections for patients that are presently receiving care within the period of time under review and is referred to within the staffing decision making tree at Appendix 2, Section 1.

These processes should be undertaken by the Clinical Services Coordinator and/or nurse/midwife in charge of the patient care area in collaboration with the relevant nurse/midwife providing care and

would explore any projected care requirements that appear to be outside the expected range at the time of projections being undertaken.

Such review activity must be undertaken in collaboration with the nursing/midwifery staff responsible for the care. The care plans for patients should not be altered without the agreement of the nursing/midwifery staff accountable for the care and treatment of the patient at the time of any proposed change. Patient care plans and records or projections can not to be altered in any case retrospectively.

2.2.3 Audit Process

Audit processes are directed towards the review of patient care plans for a past period in order to identify practice and planning matters that may require revision to the use of the system, the content of units of care etc. Such changes will operate prospectively, that is from the time that they are made.

Data reviewed after the period of time can be used to identify errors in the application of the system to the plan of care in order to determine where there is a need for practice change, education or the need for a review of content/timings that will assist with meeting the objective of maintaining the system in good order and ensuring that the systems timings functions reflect the real care requirements of patients as accurately as possible.

Sites undertake care plan auditing in accordance with an agreed Health Service/Health Site Audit Plan (incorporating an agreed tool and determination of audit frequency). Such tools and plans will be developed and implemented at the local level following consultation with the relevant site committees.

2.3 Staffing To ExcelCare

In applying the ExcelCare Staffing methodology the following are the key concepts:

2.3.1 Staffing to Projections and Demand

Projected Time Definition:

The predicted number of nursing hours, for the next projection interval, inclusive of ExcelCare direct time, as indicated by UoCs on the patients nursing care plan at the time of projection and the indirect time.

Projected time is used for shift by shift staffing decision making purposes. The Nursing and Midwifery Shift by Shift Staffing Requirements Decision Making Tree (Appendix 2, Section 1) defines the sequential decision making steps to be undertaken in priority order for the provision of staffing to meet patient care requirements. The Nursing and Midwifery Shift by Shift Staffing Requirements Decision-Making Tree is also available on the DH Intranet and on the ANMF website www.anmfsa.org.au.

Projected time differs to the N/MHPPD report. Reporting on N/MHPPD provides retrospective data including Required N/MHPPD and Actual N/MHPPD.

Required Nursing or Midwifery Hours Definition:

Total number of nursing/midwifery hours inclusive of ExcelCare direct time, as indicated by UoCs on patients nursing or midwifery care plan, and the pro-rated indirect time required by all patients in a patient care area during the 24 hour period.

When considering the application of this definition for compliance purposes under this agreement where the minimum staffing levels in a patient care area exceed the hours derived from care requirements for any shift period, the actual hours for that period will be substituted for the required.

For example:

Ward XX required 64 hours care for an early shift, 56 hours on a late shift and 30 hours on the night shift. The required hours nursing or midwifery time equals the sum of those hours, or 150 hours. However if Ward XX has a minimum safe number of staff required on night duty of 4, (or 40 hours) the actual number of 40 hours will be substituted for the 30 required in demonstrating compliance with the required nursing/midwifery hours. The real value of the required hours in this case would be 160 hours.

The site governance groups will identify any existing minimum staffing arrangements that apply within the hospital and will consider any proposals for change to these arrangements consistent with the consultation and agreement processes for review of other aspects of the system. This process for current arrangements must be completed within a period of 8 weeks from the date of approval of the agreement provided that any change to pre-existing practice must be notified and agreed between the hospital and the ANMF should that be proposed within that period of time.

Actual Nursing/Midwifery Hours Per Patient Day Definition:

Actual N/MHPPD includes all paid productive time, worked and paid type codes, inclusive of overtime worked in a patient care area during the 24 hour period.

Reporting on staffing to demand

Each hospital is required to provide to the CEO/Secretary of the ANMF a report on not less than a monthly (4 weekly cycle) basis the required and actual staffing levels for each patient care area for the preceding month. These reports will also provide variance reports, and, where the variances are negative, reasons for the variation and action taken by the hospital to secure the appropriate number of staff and/or to reduce activity to reflect the available number of staff.

The ANMF will, where the variances are of a level and/or a duration that impact adversely on nursing/midwifery workloads, raise concerns in writing with the (Executive) DON/M seeking specific reform or action. The (Executive) DON/M will respond in writing within 7 days of such a complaint being received.

In the event that agreement cannot be reached between the ANMF and the relevant (Executive) DON/M, the dispute settlement procedure set out in this agreement shall apply.

2.4 Nurse and Midwife Education: Use of the ExcelCare System

Sites should ensure (through orientation and induction processes) that all new employed staff receive appropriate training on use of the system.

Staff should be identified in each clinical area to act as resource persons, mentors in relation to effective use of the system.

Section 3: Timing Definitions within ExcelCare

It is important to ensure there is consistency in reporting from ExcelCare and to avoid overlapping activities between ProAct¹ and ExcelCare. Below are relevant definitions.

3.1 Excelcare Direct and Indirect Time Definitions

The Excelcare system separates nursing/midwifery time into direct and indirect components as follows:

3.1.1 *Direct Time*

Direct time is the time allocated to perform care/activity by nurses/midwives that can be clearly attributed to a specific patient. The time (in minutes) is attached to the Observations and Interventions (OI) within the UoC.

Embedded Time is the time allocated which is assigned to all patients. Activities that are a component of specific nursing/midwifery care but do not require an individual description. The time is 'embedded' into an existing UoC that is assigned to all patients' care plans.

3.1.2 *Indirect Time*

Indirect time is the time allocated to perform activities by nurses/midwives that affect all patients in a unit/area as defined in ExcelCare as a Station. This time cannot be directly attributed to an individual patient and is pro-rated to all current patients at the Station.

Indirect time is subdivided into fixed and variable.

- Variable Indirect Time is the time allocated that will change according to patient numbers and/or activity.
- Fixed Indirect Time is the time allocated that is not affected by changes in patient numbers and/or activity.
- Unit/Ward (Station) Fixed Indirect Time is the fixed time allocated for activities that occur whether there are patients present or not on the unit/ward.

It is essential that there is no overlap between activities classified in both Excelcare as indirect and ProAct as indirect. All activities coded in ProAct as Indirect Productive as detailed in the document 'ProAct Business Rules (2003)' must not be defined in Excelcare as an indirect time. ProAct worked and paid codes and the activities captured in worked and paid codes are the only activities to be captured in Excelcare.

¹ ProAct is the Nursing and Midwifery Rostering System that provides the source data for the calculation of nursing and midwifery actual direct care hours.

ProAct		Interface ↔	Excelcare
Productive			Total Time
Direct	Worked & Paid Codes (WP)		Direct
	Overtime & Paid Codes (OP)		Indirect
Indirect	Roster codes not related to direct patient care <i>e.g. clinical management, supernumerary</i>		

3.2 Indirect Activities

The following table indicates activities that have been identified as being common practice. It is acknowledged that organisations may identify other nursing/midwifery indirect activities and not all of the listed relevant activities will be relevant at each site. These are to be allocated to the fixed or variable categories according to the definitions in point 1.1.2. Depending on the organisations core business, some of the following activities may be interchangeable between the subcategories of indirect time.

NOTE: Activities CANNOT be used in MORE than one category.

Excelcare Timing Component		Activities
Direct Time	Embedded Time	<ul style="list-style-type: none"> All available UoCs • Meal trays • Tea/coffee rounds
Indirect Time	Variable Indirect	<ul style="list-style-type: none"> • Telephone Calls • Call Bells • Linen Bag Maintenance • Bed Cleaning • Documentation <ul style="list-style-type: none"> ○ Excelcare ○ Case notes - reading ONLY
	Fixed Indirect	<ul style="list-style-type: none"> • Handover • DDA Checks • Emergency Trolley Checks • Equipment Checks • Inservice (if not entered on ProAct) • Linen Bag Maintenance • Telephone Calls • Ward Rounds, e.g. <ul style="list-style-type: none"> ○ Drs, Physio ○ Ward co-ordination (when coded as WP in ProAct)
	Ward/Unit (Station) Fixed Indirect	<ul style="list-style-type: none"> • Handover • Checking DDA's/emergency trolley • Door bells • Telephone calls • Linen bag maintenance

3.3 Guidelines for Identification of Indirect Time

In order to identify what nursing/midwifery activities are considered indirect the following categories can be considered. These categories are presented as a guideline only to determine and group indirect nursing and midwifery activities.

Excelcare Indirect Category	Excelcare Indirect Associated Timed Activity
Documentation	<ul style="list-style-type: none">Medical Records: Includes reading and writing in medical records and electronic systemsOther: Ordering stores, patient allocations, reading ward communication and other hospital specific documentation.
Communication	<ul style="list-style-type: none">Incoming phone calls, call bells (answering, not interventions)Liaison with other health professionalsHand-overWard meetings/roundsPatient portable phones (calls)
House Keeping	<ul style="list-style-type: none">Empty linen bagsRe-stockingCleaning <p>NOTE: An organisation may decide that there are no housekeeping activities undertaken by Nurses/Midwives</p>
Legal & Professional Management	<ul style="list-style-type: none">Checking DDA'sChecking Emergency and other trolleysOrientation (Only to include orientation not captured in ProAct)
Shift Coordinator/Team Leader/Ward Coordinator	<ul style="list-style-type: none">Liaison CommunicationsDirector of Nursing/Midwifery ReportWard/Unit management (Only to include Ward/Unit Management not captured in ProAct)Bed management
Embedded Times	<ul style="list-style-type: none">Organisational decision of what is embedded and where it is attached.

Section 4: Timings Methodology

4.1 Timing Frequency

Direct and indirect timings are to be reviewed when there have been changes in nursing/midwifery practice/procedures, the ward/units core business, geography of work areas, variation in procedures/activities between areas and/or variation in required or actual N/MHPPD not explained by variations in the elements listed above or a need is identified through analysis of clinical documentation audits and in accordance with changes to the Agreement. Indirect timings are to be updated annually and where there are significant changes to any of the elements described above.

4.2 Statistical Validation of Timings

All timings are recorded as 'the average time (in minutes) that the average nurse /midwife spends performing the activity under average circumstances for the average patient.' The specific nursing and midwifery activity is timed across all patients groups (if appropriate), all shifts (if appropriate) over 7 days.

The 10% trimmed mean obtained from 20 observations or timings is taken as the average. To obtain the 10% trimmed mean, the 20 observations or timings are taken and then sorted from lowest to highest value. The two lowest and two highest readings are then discarded, and the usual arithmetic mean calculated from the remaining 16 observations.

NOTE: If more than 20 timings are collected discard the top 10% and the lowest 10% of the values. For example, 58 timings are collected therefore the top 6 and lowest 6 are discarded leaving 46 timings. To obtain the trimmed mean the sum of the 46 timings is then divided by 46.

Example

The following 20 timings (in minutes) were observed for the insertion of an indwelling catheter in a male patient:

17	19	19	18	14	14	19	24	19	19	18	16	24	17	18	14	15	23	22	21
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Sorted into size order these become:

14	14	14	15	16	17	17	18	18	18	19	19	19	19	19	21	22	23	24	24
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Drop the two lowest and highest observations:

14	15	16	17	17	18	18	19	19	19	19	19	21	22	23
----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

The 10% trimmed mean is now simply the sum of the above 16 observations divided by 16, i.e. 10% trimmed mean = $294/16 = 18.38$ minutes.

4.3 Timing Process

The timing values, for use in ExcelCare, are recorded by nurses/midwives using work-sampling techniques. The relevant definition is for stop/start times. That is, timing commences at the point when the nurses begins preparation for the activity and stops when the nurse and midwife completes the activity, including cleaning up and disposal of equipment where this is defined in the OI. Interruptions are excluded from the time.

A total of 20 timings are collected randomly and should be representative of all areas and patients where the activity occurs and a range of nursing expertise.

If the timings sample reveals that some patient groups have significant deviations from the mean, consideration should be given to reviewing if the UoC is appropriate to the needs of the patient group.

Possible bias that may occur during the timing process, that may influence the quality of timings, could include:

- reliability of collection
- definition and specificity of activity to be timed
- skill of nurse performing procedure
- differences in procedures/activities between areas
- geography of work areas
- patient variables

If there is bias operating related to geography and skill then the total sample should included 20 timings of each skill or type of geographical setting.

The direct timing should be collected within a few weeks to reduce any possible bias's that may occur. If it is not possible to collect the timings within this period of time, then the UoC should:

- Professionally assessed time added until there is significant timings collected; or
- The UoC should be time adjusted.

As agreed to by the Department of Human Services (now DH) and the then ANF (now ANMF) on 22 November 2002:

'All health sites must use the agreed Department of Health timings process (package) or apply the agreed statistical methodology which requires the actual repeated timing of the OIs to be delivered and the determination of a mean time for inclusion in the UoC. Staff consultation should take place in the same manner as set out for the review of UoC above.'

'Where new UoCs are being developed or implemented without timings that have been validated through this process, the relevant nursing and midwifery staff should be consulted about the interim timing to be used and this process should reflect the same consultative process as set out for the review of UoC².'

References

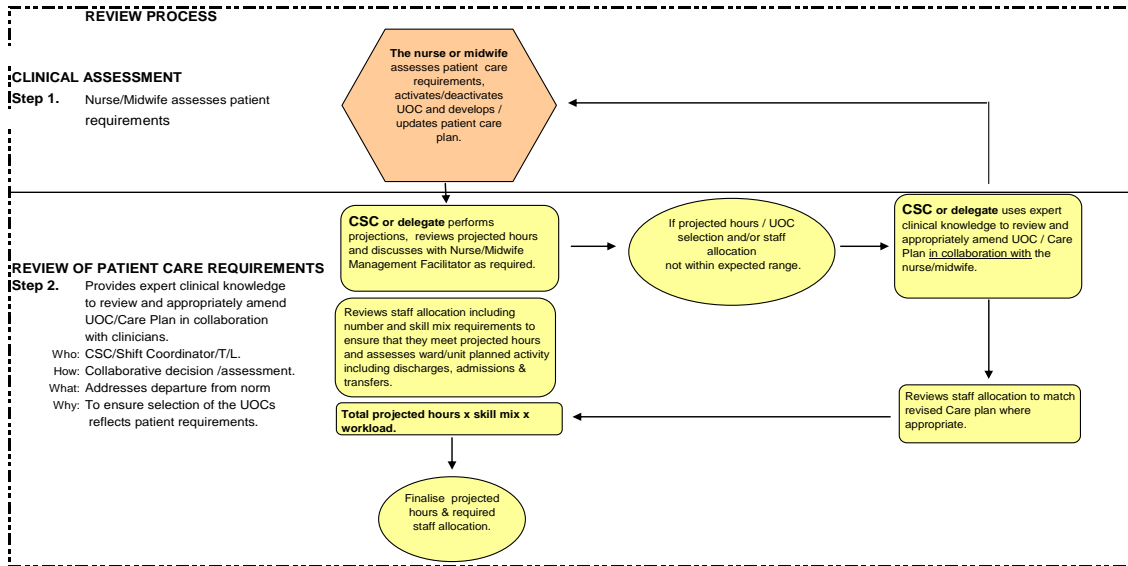
1. Department of Human Services, Directors of Nursing, Australian Nursing Federation, 'Operational Issues Associated With Excelcare' (v2 300902), 2003
2. South Australian Health Commission, Nursing Automated Systems Project, 'Direct /Indirect Timings' Document
3. South Australian Health Commission Nursing Automated Systems Project, 'Statistical Validation of Timings for Excelcare' Document.

² As Agreed by Department of Human Services, Directors of Nursing, Australian Nursing Federation, 'Operational Issues Associated With Excelcare' (v2 300902), 2002

APPENDIX 2 - STAFFING AND WORKLOADS – INPATIENT UNITS – STAFFING METHODOLOGY

- Section 1:** Nursing and Midwifery Shift by Shift Staffing Requirements Decision Making Tree
- Section 2:** Staffing Methodologies in Emergency Departments, Intensive Care Units, Peri-Operative Services and Endoscopy Units
- Section 3:** Staffing Methodologies in Units other than Excelcare (Non-Standard Based)

Section 1: Nursing and Midwifery Shift by Shift Staffing Requirements Decision Making Tree



This decision making tree defines the sequential decision making steps to be undertaken in priority order for the provision of staffing to meet patient care requirements.

It is noted that terms used in this decision making tree may vary from site to site.

It is noted that this decision making tree will be applied within the existing health unit site's bed management procedures/policies provided that the necessary reduction in activity is achieved.

LEGEND

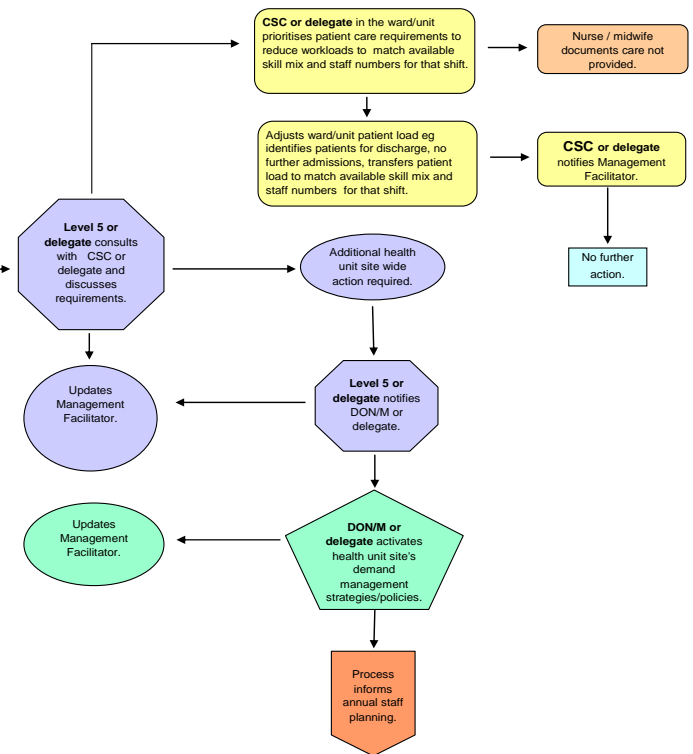
CSC or delegate
 Clinical Services Consultant or delegate
 Shift Coordinator / Team Leader or such named

UOC
 Unit of Care

Management Facilitator
 Nurse/Midwife Management Facilitator, Staffing Coordinator, Nurse/Midwife Manager, health unit site Coordinator or such named is responsible for the overall coordination of the health unit site's staffing resources

Level 5 or delegate
 Nursing/Midwifery Director or so named or delegate such as Nurse/Midwife Manager and/or as defined by after-hours policy

DON/M
 Director of Nursing/Midwifery or so named or delegate as defined by on-call policy



SECTION 2: STAFFING METHODOLOGIES IN EMERGENCY DEPARTMENTS, INTENSIVE CARE UNITS, PERI-OPERATIVE SERVICES AND ENDOSCOPY UNITS

The standards of:

- The College of Emergency Nursing Australasia (2007)
- The Australian College of Critical Care Nurses (2003)
- The Gastroenterological Society of Australia (2006)
- The Australian College of Operating Room Nurses (2010)

have been agreed for application within relevant services under this Agreement.

The summaries set out below do not reflect the full language and context of the standards but are intended as a ready reference. If there is doubt over the intention or meaning of the summarised information, please refer to the full standards for advice and interpretation.

The following aspects of the identified standards will be applied in Emergency Departments, Intensive Care Units, Peri-Operative Services and Endoscopy Units.

CENA STANDARDS 2007

(Applicable to Emergency Departments)

Tertiary: FMC, LMH, RAH, TQEH, WCH, (NB TQEH to be treated as a General Hospital once service changes)

General: RGH, NHS, Modbury

Country: Mt Gambier, Whyalla, Port Pirie, Port Augusta, Gawler, Port Lincoln & Berri

- 1 nurse to every 3 pts in dept (regardless of pt status e.g. admitted, emergency & short stay)
- 1 triage nurse and 2nd triage RN or triage assistant RN/EN (excluding RGH, CHSA)
- For Tertiary EDs only - dedicated Resus Team comprised of 3 RNs or 2 RNs and 1 EN minimum 1 senior emerg trained RN
- For General EDs (excluding RGH) – dedicated Resus Team comprised of 1 senior emerg trained RN as Resus Nurse Team Leader
- Shift Coordinator who is a senior emerg trained RN (for CHSA sites: can be the hospital Shift Coordinator who may not be emergency trained)
- Mental Health Nurse (excluding RGH. For CHSA sites: role can be available for all the hospital)
- Minimum skill mix of 1 RN at level 2 and level 3 to be included in the above
- Emergency Nurse Practitioner as per requirement of individual department
- ED Nurse Educator (Level 3 or above) which may be included as a part of other roles

Extended short care

(NHS EECU staffed as part of ED)

- 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

ACCCN STANDARDS 2003

(Applicable to ICU, HDU, CCU, PICU, NICU)

Metro + Mt Gambier and Whyalla in CHSA only

- 1:1 nurse pt ratio for ICU pts
- 1:2 nurse pt ratio for HDU pts
- Clinical Coordinator/Team Leader - 1 per shift must be supernumerary for all shift (excluding CHSA)
- 50% post graduate qualified critical care nurses
- 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 = 1:4 Access Nurse to Pts
 - 50 - 75% nurses ICU post grad qualification = 1:6 Access Nurse to Pts
 - >75% nurses ICU post grad qualification = 1:8 Access Nurse to Pts
- 1 designated Clinical Nurse Educator (excluding RGH, CHSA)

- Where ICU/casualty nursing staffing are required to provide services in other parts of the health unit (i.e. MET, code-blue, STEMI), they will be considered as an additional resource.

GESA STANDARDS 2006

(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 pt'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)

ACORN STANDARDS 2010

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

- No more than 1:4 nurse patient ratio (Day Surgery Unit/Pre Admission Area when included within the peri-operative service)
- 1 anaesthetic nurse per operating room (all locations where anaesthesia and or sedation techniques are performed)
- Minimum 3.5 nurses = 1 anaesthetic nurse + 2 nurses (1 must be RN and 1 whom may be a suitably qualified EN) + 0.5 RN to provide assistance and relief to all nursing staff in operating room
- 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 pt/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 pt 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 pt ratio when all pts are stable/for a paed pt over 5yrs of age with a family member or caregiver present
- 1 nurse during elective surgery hours - Holding Bay (excluding RGH, NHS, CHSA)
- 1 nurse during elective surgery hours - Stock Room (excluding RGH, NHS, CHSA)
- Clinical Nurse Educator (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

SECTION 3: STAFFING METHODOLOGIES IN UNITS OTHER THAN EXCELCARE (NON-STANDARD BASED)

AHS	Wards/Unit	Staffing Methodology	Comments
Noarlunga Health Service	Satellite Dialysis Unit	Ratio 1 to 4 chairs + Team Leader	
Flinders Medical Centre	Labour & Delivery Suite	Labour & Birth - Ratio 1:1 (24 MHPPD) High acute midwifery care e.g. HDU - Ratio 1:2 (12 MHPPD)	
	Neonatal Unit + (High Dependency Unit)	NICU Ratio 1:1 Specials require 1:1 and include: Infants HFOV < 28 weeks for first 24 hours or until stable, infants requiring cooling therapy for HIE, Infants receiving Nitric Oxide therapy, infants in intensive care requiring surgery. Special Care high Dependency 1:3 Convalescent Care and low Dependency 1:4	
	Surgical Short Stay Ward (5D)	Ratio 1:4	
	Hospital at Home	Ratio 1:8	
	CCU	1:4 plus shift coordinator (for sleep apnoea 1:2, if in coronary care but highly unstable 1:1, IABP 1:1 if nursed outside ICU)	
	4GS (Elective Short Stay)	1:4 with min 2 staff	
	5D (Emergency Short Stay)	1:4 plus shift coordinator	
	DOSA (Day of Surgery Admissions)	Ratio 1:6	
	HODU	1:3 for Chemotherapy chairs	
	Radiology	3 nurses in Level 3 (physical location), 3 nurses in Level 2, 1 nurse in Southern Imaging	
	Satellite Dialysis	1:3 + T/L	
Lyell McEwin Health Service	Oncology (day stay)	1 Nurse per 2 Outpatient Clinics + 1 Nurse : 3 Chemo Chairs	Unit staffing includes Outpatients and Day Chemo.
	Satellite Dialysis Centre	Ratio 1 to 3 chairs + TL	(optimum staffing, currently employing to this number) RAH Responsibility
	1A	6.64 NHPPD	Interim level only – alternative staffing system to be introduced
	1B	6.26 NHPPD	Interim level only – alternative staffing system to be introduced
	2A	6.41 NHPPD	Interim level only – alternative staffing system to be introduced
	2B	5.88 NHPPD	Interim level only – alternative staffing system to be introduced
	2C	7.04 NHPPD	Interim level only – alternative staffing system to be introduced
	CSU	6.5 NHPPD	Interim level only – alternative staffing system to be introduced
	SCN	9.56 NHPPD	Interim level only – alternative staffing system to be introduced
	WD1C	12.92 NHPPD	Interim level only – alternative staffing system to be introduced
	WHU	4.51 NHPPD	Interim level only – alternative staffing system to be introduced
The Queen Elizabeth Hospital	CCU	NHPPD 10.40 (Specials Bi-Pap & Intra Aortic Balloon Pump Ratio 1:1) and covers code blue/MET calls	Standard nursing pattern is for 5 staff am, 5 pm and 3 staff nights plus continuous nursing for IABP and Bipap
	MDA	1 to 3 chairs + T/L	Maint Dialysis Unit
	Medical Assessment Unit	Currently staffing to Excelcare	Final staffing model subject to review and agreement between the parties
	WSC	1 to 4 chairs plus TL	Wayville Satellite Centre
Modbury Hospital	CCU	NHPPD 10.5 Clinical specials and Ventilated/airway support patients 1:1	
	General Wards	Ratio 1:4	
	Palliative Care	NHPPD 6.5 (Ideal as per Palliative Care Australia Guide for Service Provision)	
	OPD	Approximately 0.3 hours per patient booked	
	Paeds Ward	Ratio 1:4	

<u>Hampstead Rehabilitation Centre</u>			NHPPD of 6 currently used in combination with Excelcare. Further discussion to take place between the parties.
	Brain Injury Unit	6.00 NHPPD	
	Satellite Renal Dialysis Unit	Ratio 1:4 + T/L	

<u>Royal Adelaide Hospital</u>	TPS	3-4 staff dependent on Lists. If only 3 Procedures on list, 3 staff will be provided. If more than 4-5 Procedures, 4 staff will be provided.	Staffed Mon, Tues, Wed, Fri (varies dependent on procedures booked in.)
	Radiology	Mon-Fri Day Shift 10-12 dependant on activity/acuity, Late Shift 6 staff, Night shift 1 staff, W/End 4 staff early/late	
	DSON - Day Surgery Overnight	Staffed 2 on Early, 3 on Late, 2 on Night	Must be a minimum of 2 staff to have the ward open. 3 staff on when patients come back from theatre (high acuity)
	CVIU	2 RNs for Electrophysiology Suite: 3 RNs for Interventional Imaging Suites x 2, 0800 - 1800: Day Procedure/Recovery - 1T/L + 5RN/EN mix 0730 - 2100 +1RN Non Interventional Investigations + CSC	
	Oncology Day Centre	1 nurse: 3 chemo chairs	May vary depending on complexity of treatments. Also 2 RN's on a late shift 2x a week and 2 RN's on a Saturday for out of hours treatments.
	Haematology Day centre	1 nurse: 2 chemo chairs	May vary depending on complexity of treatments, many treatments require 1:1 care but often balanced out by less acute patients
	Nuc Med	1 RN/EN per day	
	HBUS	2 Staff, 1 RN and 1 RN/EN	
	Dialysis Unit	Ratio 1:3 with T/L	

MENTAL HEALTH SERVICES

<u>Lyell McEwin Health Services</u>	1G (open)	5.2 NHPPD	Includes first nursing specials on days
	1G (HDU)	9.33 NHPPD	Includes first nursing specials on days
	1H	5.8 NHPPD	Staffing under review due to expectation of increasing acuity

<u>Royal Adelaide Hospital</u>	C3 (Psychiatric Ward)	5.11 NHPPD	Excelcare under review
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<u>The Queen Elizabeth Hospital</u>	Crammond (Open Acute)	4.74 NHPPD	
	Crammond (PICU)	11.2 NHPPD	

<u>Glenside Campus</u>	Jacaranda	4.02 NHPPD	
	Rosewood	4.90 NHPPD	
	Village Hostel	3.08 NHPPD	
	R&R Inpatient	4.54 NHPPD	Currently staffing, under consultation with ANMF
	JNH Aldgate	7.94 NHPPD	
	JNH Birdwood	7.80 NHPPD	
	JNH Clare	2.90 NHPPD	
	JNH Grove Closed	7.00 NHPPD	
	The Glen	3.9 NHPPD	Current staffing, under consultation with ANMF
	Birches South A	9.09 NHPPD	
	Birches South B	3.85 NHPPD	Current staffing, under consultation with ANMF
	Birches North	3.03 NHPPD	Current staffing, under consultation with ANMF
	Cedars NW	5.25 NHPPD	
	Cedars PICU	10.52 NHPPD	

<u>Oakden Campus</u>	Clements	4.30 NHPPD	
	Makk	3.25 NHPPD	
	McLeay	3.20 NHPPD	

Modbury Hospital	Woodleigh	5.00 NHPPD	
Metro Intermediate care services	South, east, west	RN3 unit manager, 7.7 RN, 3.3 EN	Interim levels only - final staffing subject to review and agreement between the parties
Community Recovery Centres	Elpida	1 RN per shift	
	Wondakka	1 RN per shift	
	Trevor Parry	1 Clinician per shift, 1 RN overnight	
Noarlunga Health Service	Psych Ward	5 NHPPD open 13 NHPPD closed	Currently under consultation with ANMF Currently under consultation with ANMF
Flinders Medical Centre	MTC 5J	11.89 NHPPD	
	MTC 5H/K	4.77 NHPPD	
	Ward 4G (Psych)	5.82 NHPPD	

CYWHS

Womens and Childrens Hospital	Dom mid service	1.55 MHPPD (Early Shift)	MHPPD = (midwifery hours per patient day)
	Breast Feeding Unit	1.90 MHPPD (Early Shift)	
	Post-natal	Woman +/- unqualified baby 5.40 MHPPD Early Shift 2.11 MHPPD Late Shift 1.56 MHPPD Night Duty Shift 1.73 MHPPD	Pro-rated across each shift
	Post-natal	Qualified baby 5.40 MHPPD Early Shift 2.11 MHPPD Late Shift 1.56 MHPPD Night Duty Shift 1.73 MHPPD	
	Antenatal/Gynae Ward	5.15 MHPPD Early Shift 2.09 MHPPD Late Shift 1.74 MHPPD Night Duty Shift 1.32 MHPPD	
	Labour & Delivery Suite & Women's HDU	Labour & Birth - Ratio 1:1 (24 MHPPD) High acute midwifery care e.g. HDU - Ratio 1:2 (12 MHPPD)	
	Midwifery Group Practice	As per Appendix 6	
	Birthing Centre	Ratio 1:1 (24 MHPPD)	
	NICU	Ratio 1:1 Ventilated/airway support Ratio 1:2 + shift co-ordinator each shift	
	SCBU (High Dependency)	Total = 8.43 MHPPD AM shift = 2.88 MHPPD PM Shift = 2.47 MHPPD ND Shift = 3.08 MHPPD	T/L is supernumerary
	Neonatal Early Discharge (NED)	AM Shift only = 3.0 MHPPD	
	Women's Outpatients Department	Triage (first AN visit) = 2.0 MHPPD Other visits (occ of service) = 0.6 MHPPD	
	Women's Assessment Service (WAS)	Staff as an Emergency Dept - 1:3 pts + AM & PM shift - Triage + Shift Coordinator ND Shift - triage/shift coordinator	
	Medical Day Unit	1:02	
	Renal Dialysis Service	1:2 for children over 5 years of age 1:1 for children under 5 years of age	Provides a 24 hours per day, seven days per week on call service
	Medical Imaging		
	Fluoroscopy	2 nurses per list per day	OH&S recommendations - 2 staff per list Requirement to wear lead for long periods
	Nuclear Medicine	1 nurse per list per day	all areas open 0830-1700 M-F
	Ultrasound/CT/MRI	2 nurses shared per list per day	on call for angiography and cardiology

Paediatric Surgical Ambulatory Services			
		Ratio 1:6 (unless bay specials 1:4) 2 staff per shift E, L, ND. Shift Coordinator has full patient load (1:6) Funded for 12 beds, decreases to 10 beds if bay specials in ward.	Use Excelcare for care plans, but do not use it to project staffing. Open Monday morning to Saturday lunchtime.
	Campbell		
	DOSA	3 staff early shift only Can admit up to 20 patients in am and 20 patients pm	Open 0700 -1530
	Helen Mayo House	Staff 1:2 during the day and 1:3 Night duty (does not include the babies that accompany the mother)	All 12 hr shifts

CHSA

Country Health			
	OPD attendances	0.5 NHPPD	
	Chemotherapy	2.0 NHPPD	
	Renal	Ratio 1:3	
	Labour and Delivery	Ratio 1:1	
	Banksia	4.86 NHPPD	Interim level only – alternative staffing system to be introduced
	Casuarina	5.83 NHPPD	Interim level only – alternative staffing system to be introduced

DFC

Disability SA			
	Aged Care	4.0 NHPRD (nursing hours per resident day)	
	H4B		
	H5A		
	H5B		
	Specialised Care	6.0 NHPRD	
	H3B		
	H4A		Staffing currently subject to review
	Lifestyle	4.0 NHPRD	
	H3A		

APPENDIX 3 – COUNTRY HEALTH SA (CHSA) 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 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
MILLCENT & 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
ODDNADATTA 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 5A – CLASSIFICATION AND SALARIES

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

Classification	Increment	1/10/2010	1/12/2011 Refer to Appendix 5B for translation	1/10/2012
<i>Student in Enrolled Nursing*</i>				
<i>Assistant in Nursing/Midwifery</i>	1st increment	40456	42250	43306
	2nd increment	41407	43500	44588
<i>Enrolled Nurse (Certificate)</i>	1st increment	43479	45750	46894
	2nd increment	44430	46500	47663
	3rd increment	45381	47500	48688
	4th increment	46332	48500	49713
	5th increment	47286	49500	50738
	6th increment	48237	50500	51763
	7th increment	49188	51500	52788
<i>Enrolled Nurse (Diploma)</i>	1st increment	45381	47500	48688
	2nd increment	46332	48500	49713
	3rd increment	47286	49500	50738
	4th increment	48237	50500	51763
	5th increment	49188	51500	52788
	6th increment	50084	52500	53813
	7th increment	50980	53500	54838
<i>Advanced Skills Enrolled Nurse</i>	1st increment		52500	53813
<i>(Operative from first full pay period on or after 1 December 2011)</i>	2nd increment		53500	54838
	3rd increment		54500	55863
<i>Registered Nurse/Midwife (Level 1)</i>	1st increment	50980	53500	54838
	2nd increment	52659	55000	56375
	3rd increment	54898	57250	58681
	4th increment	57137	59500	60988
	5th increment	59377	61750	63294
	6th increment	61615	64000	65600
	7th increment	63855	66250	67906
	8th increment	66093	68500	70213
	9th increment	67772	70750	72519
	10th increment		73000	74825
<i>Nurse/Midwife Specialist**</i>				
<i>Clinical Nurse/Midwife (Level 2)</i>	1st increment	59377	61750	63294
	2nd increment	61615	64000	65600
	3rd increment	63855	66250	67906
	4th increment	66093	68500	70213
	5th increment	67772	70750	72519
	6th increment	70012	73000	74825
	7th increment	71131	74500	76363
	8th increment	72251	76000	77900
	9th increment	73370	77500	79438
	10th increment		79000	80975

<i>Associate Clinical Service Coordinator (Level 2)</i>	1st increment	70012	73000	74825
	2nd increment	71131	74500	76363
	3rd increment	72251	76000	77900
	4th increment	73370	77500	79438
	5th increment		79000	80975
<i>Nurse/Midwife Clinical Service Coordinator/Clinical Practice Consultant/Education Facilitator/Management Facilitator (Level 3)</i>	1st increment	84006	89500	91738
	2nd increment	86805	91500	93788
	3rd increment		93500	95838
<i>Nurse/Midwife Clinical Service Coordinator/Clinical Practice Consultant/Education Facilitator/Management Facilitator/ Nurse Practitioner (Level 4)</i>	1st increment	89604	94500	96863
	2nd increment	91843	97000	99425
	3rd increment		98500	100963
<i>Nursing/Midwifery Director (Level 5)</i>	5.1	98560	103000	105575
	5.2	110315	115000	117875
<i>(Operative from first full pay period on or after 1 December 2011)</i>	5.3		121000	124025
<i>Director of Nursing/Midwifery (Level 6)</i>	6.1	98560	103000	105575
	6.2	104158	109000	111725
	6.3	110315	115000	117875
	6.4	115354	121000	124025
	6.5	120391	127000	130175
	6.6	131027	138000	141450
	6.7	143901	151000	154775

* Translate to Assistant in Nursing/Midwifery from first pay period on or after approval of Agreement by IRCSA as per Appendix 5B

** Translate to Clinical Nurse/Midwife (Level 2) from first pay period on or after approval of Agreement by IRCSA as per Appendix 5B

APPENDIX 5B – TRANSLATION ARRANGEMENTS

The following translation arrangements will apply from the date of Approval of this Agreement by the IRCSA:

STUDENTS IN ENROLLED NURSING

This classification will be abolished and employees classified as either Student in Enrolled Nursing Under 21 or Student in Enrolled Nursing 21+ will translate to Assistant in Nursing/Midwifery first increment.

ASSISTANTS IN NURSING/MIDWIFERY

All new appointments to this classification will commence at the first increment of this classification and progress to the second increment as prescribed in clause 4.2.

NURSE/MIDWIFE SPECIALIST

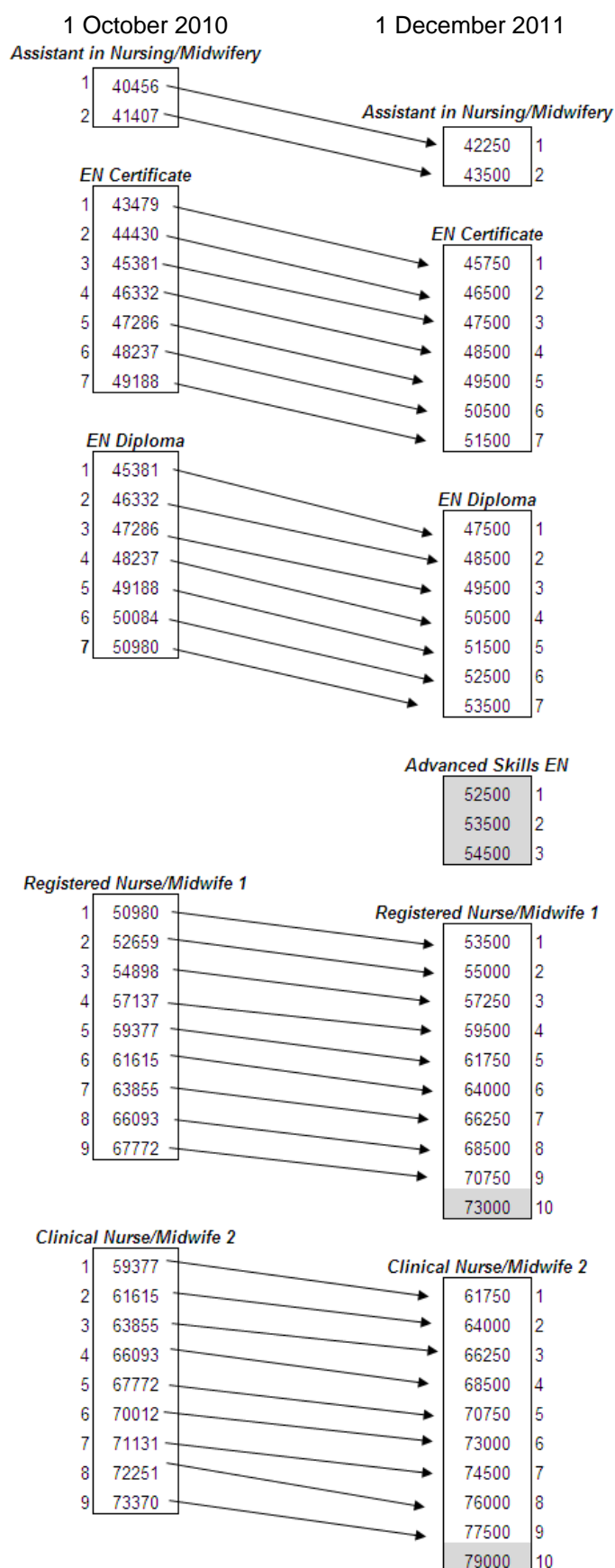
On the date of approval of the Agreement by the IRCSA, Nurse/Midwife Specialists will translate to the Clinical Nurse/Midwife (Level 2) classification as per the table below.

<i>Nurse/Midwife Specialist</i>	<i>1/10/2009</i>		<i>Clinical Nurse/Midwife 2</i>	<i>1/10/2010</i>
1st increment	58981	→	1st increment	59377
2nd increment	61165	→	2nd increment	61615
3rd increment	63896	→	3rd increment	63855
4th increment	65534	→	4th increment	66093
5th increment	67173	→	5th increment	67772
		→	6th increment	70012
			7th increment	71131
			8th increment	72251
			9th increment	73370

Incremental progression arrangements will apply in accordance with clause 4.2 of this Agreement.

APPENDIX 5C - NURSING AND MIDWIFERY MODIFIED CAREER STRUCTURE

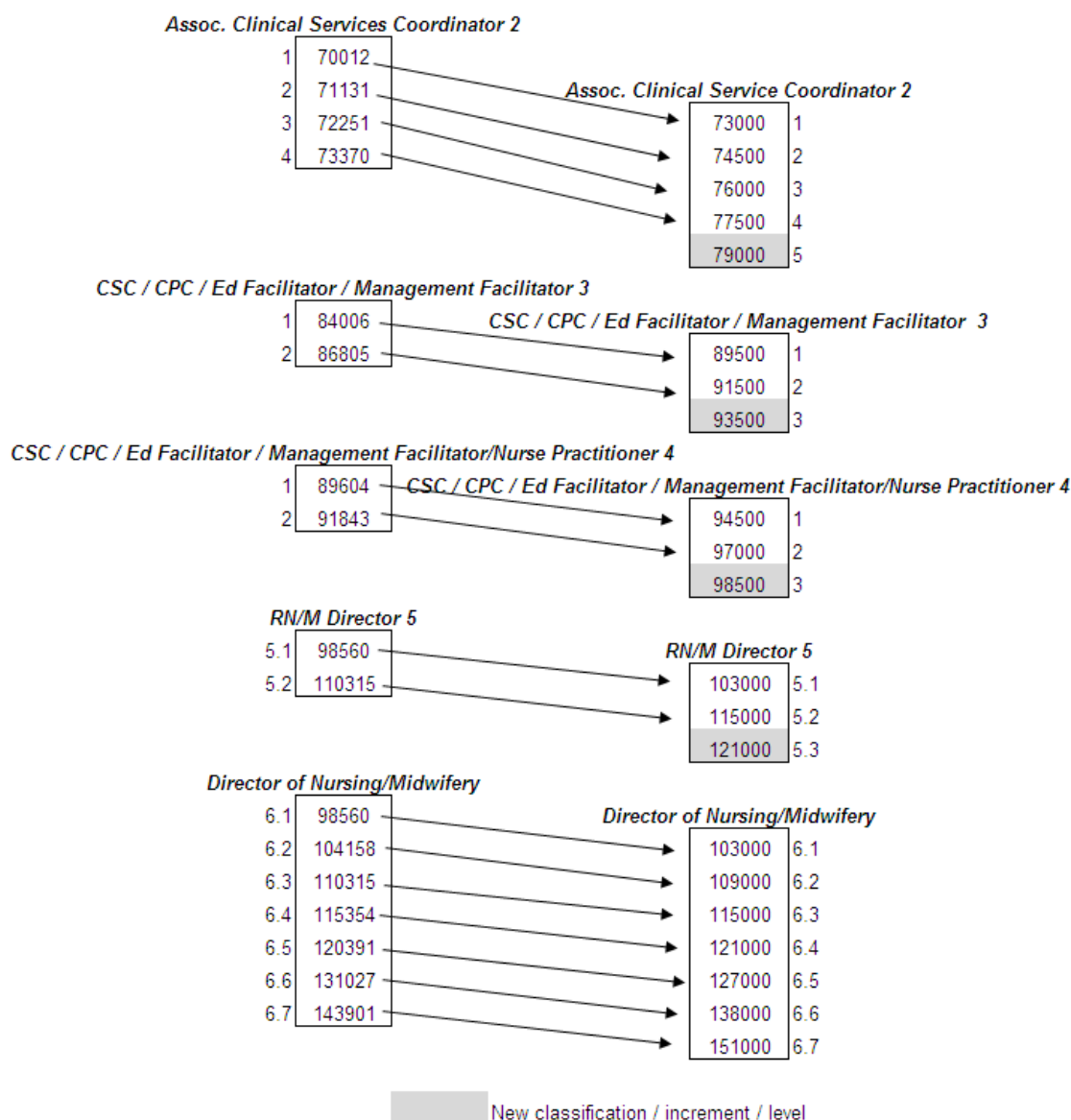
Salaries from first full pay period on or after 1 October 2010 translate to salaries effective from the first full pay period on or after 1 December 2011.



Salaries from first full pay period on or after 1 October 2010 translate to salaries effective from the first full pay period on or after 1 December 2011

1 October 2010

1 December 2011



Modified Career Structure Arrangements Operative from the first full pay period on or after 1 December 2011

As at the first full pay period on or after 1 December 2011, employees will translate from the current applicable increment to the equivalent increment in the modified structure as shown above. For example, a Registered Nurse/Midwife Level 1, increment 3 will, as at 1 December 2011 translate to Registered Nurse/Midwife Level 1, increment 3 in the modified career structure.

Incremental progression arrangements will continue to apply in accordance with clause 4.2 of this Agreement.

APPENDIX 6 – MIDWIFERY CASELOAD PRACTICE AGREEMENT

1. Title

This Agreement is known as the Midwifery Caseload Practice Agreement.

2. Scope and Persons Bound

This Agreement is between DH and the ANMF in respect of midwives employed by hospitals or health services incorporated pursuant to the Health Care Act 2008 in a Midwifery Caseload Practice Program, which is the subject of a formal agreement between the DH and the ANMF.

3. Duration of the Agreement

3.1 This Agreement will operate until 30 June 2013.

3.2 Continued operation of the Agreement is subject to the provisions of clause 19, Termination of Agreement.

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 2010 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 whilst this Agreement remains 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 whilst this Agreement remains in force:

- Clause 3.7 Standard 10 Hour Night Shifts
- Clause 3.9 Part Time Employees – Minimum Shift Length
- Clause 5.3 Recall to Work, Overtime and Time Off in Lieu of Overtime
- Clause 5.6 Part Time Employees Working Variable Shifts – Public Holidays
- Clause 6.2 Night Shift Penalty

- Clause 6.3 Nurse/Midwife In-Charge Allowance
- Clause 6.4 On-Call Allowance

6.3 All other provisions of the Award and Enterprise Agreement continue to apply as if this Agreement did not exist.

7. Caseload

- 7.1 A full-time employee (other than a Unit Head, 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 Unit Head, 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 Unit Head, 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 Unit Head, Midwifery Caseload Practice, will be 4 teams of midwives, made up of up to 6 full time equivalents.
- 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 Unit Head) 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 Unit Head may vary up to 20 clients/patients on average due to the absence of other staff.

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 Unit Head) 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 Unit Head 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 Enterprise 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 Unit Head, 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 Unit Head, 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 Unit Head, Midwifery Caseload Practice 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 Unit Head, Midwifery Caseload Practice 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 DH Guidelines.

19. Termination of Agreement

- 19.1 DH or the ANMF on behalf of its members may withdraw from this Agreement and it will cease to operate. In this event, 4 weeks written notice will be given to the other party to ensure the care needs of clients/patients are met.
- 19.2 A health unit 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 Agreement

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

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, operative from 1 December 2011.

Reclassification or appointment to the Advanced Nursing/Midwifery Director (RN/M 5.3) classification is available from 1 December 2011.

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 DH or DFC.

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 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 supervision by a Registered Nurse/Midwife and their work may be overseen by an Enrolled Nurse within a care team.

Assistants in Nursing/Midwifery will be either:

- 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;
- 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.

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

- Assistance to nurses/midwives in routine tasks with patients/clients associated with the activities of daily living;
- Routine technical support functions at the level of setting up for nursing procedures, cleaning equipment and managing local stock levels;
- Verbal and written communication related to routine work activities;
- Contributing to the maintenance of a physically and culturally safe environment for patients and staff;
- Participation in quality improvement activities;
- 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.

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 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 patient-centred care. 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.

ENROLLED NURSE WITH CERTIFICATE QUALIFICATION - INCREMENT 7

Refer to clause 1.6.13 of the Nurses (South Australian Public Sector) Award 2002 and clause 4.3 of this Agreement.

Progression - There is no automatic progression from increment 6 to increment 7.

An Enrolled Nurse (Certificate) may progress from increment 6 to increment 7 on successful completion of 80 nominal hours of structured education in module/modules relevant to the EN practice setting. Structured education

may be delivered through classroom or distance modules and includes assessment, which ensures the competencies/objectives of the module have been met. Examples of such modules include: Orthopaedics, Advanced Skills Nursing for Activities for Daily Living, Continence Management, Introduction to Mental Health, Care of the Aged in Acute Setting, Rehabilitation etc.

On application for progression to increment 7, evidence of successful completion includes copies of certificates etc or confirmation from the course coordinator/institution etc that the employee was enrolled/attended/assessed and successfully completed the course requirements.

The 80 nominal hours may consist of a number of separate courses of less than 80 hours (with a minimum of 16 hours duration) but relating to a common area of practice (and in total at least 80 hours) and with demonstration of assessment and completion components for each course.

Mandatory training courses are not eligible for inclusion as part of the 80 nominal hours.

ADVANCED SKILLS ENROLLED NURSE:

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 client assessment, care management and leadership responsibilities.

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

REGISTERED NURSE/MIDWIFE (LEVEL 1):

Employees classified at this level provide nursing and/or midwifery services in health service settings. Roles within this level 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:

- Provide direct nursing/midwifery care and/or individual case management to patients/clients on a shift by shift basis in a defined clinical area;
- Assess individual patient/client needs, plan and implement or coordinate appropriate service delivery from a range of accepted options;
- Provide health education, counselling and/or therapeutic/rehabilitation programs to improve the health outcomes of individual patients/clients or groups;
- Plan and coordinate services with other disciplines or agencies in providing individual's health care needs;
- Participate in quality assurance and/or evaluative research activities within the practice setting;
- Contribute to patient/client safety, risk minimisation and safe work activities within the practice setting;
- Use foundation theoretical knowledge and evidence based guidelines and apply these to a range of activities to achieve agreed patient/client care outcomes;
- Practice as a Registered Nurse within a nursing model established to support patient/client centred care or, as a Registered Midwife work in partnership with women respecting and supporting their right to self determination in the life processes of pregnancy, birthing and parenthood;
- Contribute to procedures for effectively dealing with people exhibiting challenging behaviours;
- Review decisions, assessments and recommendations from less experienced Registered Nurses/ Midwives and Enrolled Nurses and students;
- Provide support and guidance to newer or less experienced staff, Enrolled Nurses student nurses and other workers providing basic nursing care;
- Support nursing/midwifery practice and learning experiences for students undertaking clinical placements, orientation for new staff and preceptorship of graduates;
- Continue own professional development, seek learning opportunities and develop and maintain own professional development portfolio of learning and experience.

CLINICAL NURSE/MIDWIFE (LEVEL 2):

Employees classified at this level provide advanced nursing and/or midwifery services in health service settings. The activities required of roles at this level are predominantly clinical in nature. 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.

Employees in these roles will:

- Provide proficient clinical nursing/midwifery care and/or individual case management to patients/clients in a defined clinical area;
- Assess patients/clients needs, plan, implement and coordinate appropriate service delivery options and communicate changes in condition and care;
- Oversee the provision of nursing/midwifery care within a team or unit;
- Provide health education, counselling and/or therapeutic/rehabilitation programs to improve the health outcomes of individual patients/clients or groups;
- Plan and coordinate services including those of other disciplines or agencies as required to meet individual and/or group health care needs;
- Monitor client care plans and participate in clinical auditing and/or evaluative research to ensure appropriate patient care outcomes are achieved on a daily basis;
- Demonstrate and promote a risk minimisation approach to practice and support implementation and maintenance of systems to protect patients and staff;
- Integrate advanced theoretical knowledge, evidence from a range of sources and own experience to devise and achieve agreed patient care outcomes;
- Work within and promote a nursing model of client centred care or midwifery model of partnership and support for women's right to self determination in life processes;
- Act to resolve local and/or immediate nursing/midwifery care or service delivery problems;
- Support change management processes;
- Contribute to communication processes that effectively deal with challenging behaviours and the resolution of conflicts;
- Work within a team to attain consistency of nursing/midwifery practice standards and local service outcomes;
- Participate in clinical teaching, overseeing learning experience, and goal setting for students, new staff and staff with less experience;
- Act as a resource person within an area based on knowledge, experience and skills;
- Manage own professional development activities and portfolio, support the development of others and contribute to learning in the work area.

In addition to the foregoing the employee may:

- 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 responsibilities;
- 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 Indicators (criteria):

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 audit, risk minimisation, updating clinical procedures and evidence based practice guidelines;
- Leadership: examples may include resolving clinical practice issue, team leading, changing practice; and
- Clinical teaching: examples may include educating patients, staff and students, and updating education resources.

ASSOCIATE CLINICAL SERVICE COORDINATOR (LEVEL 2):

In the course of fulfilling the role of Clinical Nurse/Midwife, the Associate Clinical Service Coordinator role provides specific support to the Nursing/Midwifery Clinical Service Coordinator role in the leadership of nurses/midwives in the ward/unit/service. Work at this level is undertaken by employees with at least 3 years post registration experience.

Within the requirements of the Clinical Nurse/Midwife role, employees in these roles will undertake an Associate Coordinator portfolio within which they will:

- Promote continuity and consistency of care in collaboration with other Associate Clinical Service Coordinators and the Clinical Service Coordinator of the ward/unit/service;
- Assist the Nursing/Midwifery Clinical Service Coordinator in ongoing communication and implementation of practice changes;
- Assist the Nursing/Midwifery Clinical Service Coordinator to maintain and record monitoring and evaluative research activities in the ward/unit;
- Assist the Nursing/Midwifery Clinical Service Coordinator and Nursing/Midwifery Educators to maintain a learning culture by encouraging reflection and professional development and assisting others to maintain portfolios/records of learning; and
- May be required to assist the Nursing/Midwifery Clinical Service Coordinator in undertaking performance management processes and/or rostering and/or oversight of supplies and/or equipment.

Reclassification Indicators (criteria):

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 CSC, 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.

NURSE/MIDWIFE CLINICAL SERVICE COORDINATOR (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 defined ward/unit/service/program 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. Work at this level is undertaken by employees with at least 3 years post registration experience.

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.

Various practice models may be adopted by health services to enact this role, including but not limited to:

- Primarily leading a patient/client care area, nursing/midwifery and/or multi-disciplinary clinical practice/service team;
- Undertaking a combination of patient/client care area/team leadership and resource management;

All employees in these roles will:

- Coordinate and oversee nursing/midwifery care and health service delivery for a specified ward/unit/service/program;
- 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;
- 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;
- Maintain productive working relationships and manage conflict resolution;
- Develop and maintain a learning environment, taking a coaching approach to team development, individual capability development and performance management;
- Implement and co-ordinate within span of control, processes for quality improvement and continuity within corporate risk management and nursing/midwifery professional practice frameworks;
- Use available information systems to inform decision making, evaluate outcomes and convey information to staff;
- 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;
- 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.

In addition to the foregoing, employees in practice models combining patient care area team leadership and resource management will:

- Undertake and/or oversee 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.

Reclassification Indicators (criteria):

3 years post registration experience:

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

- Leading a team to improve quality and addressing service risks;
- Leadership through effective decision making, and change management;
- Leading effective performance management, and building professional capability / development of the team; and
- Leading effective budget and financial management.

NURSE/MIDWIFE CLINICAL PRACTICE CONSULTANT (LEVEL 3):

Employees classified at this level provide clinical nursing/midwifery expertise for specified individual patients/clients and/or groups and/or patient/client populations, and may work in a variety of clinical settings. Work at this level is undertaken by employees with at least 3 years post registration experience.

Employees in this role accept accountability for the outcomes of nursing/midwifery practices for the specific client group and for addressing inconsistencies between practice and policy.

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

- Primarily providing direct expert nursing/midwifery care for an individual or group of patients/clients;
- Providing clinical leadership to nurses/midwives;
- Coordination and leadership of projects and/or programs that contribute clinical expertise to improve patient/client/service outcomes.

All employees in this role will:

- Integrate contemporary information and evidence with personal experience to support the decision making, innovative thinking and objective analysis that are expected at this level;
- Apply and share expert clinical knowledge to improve patient/client care outcomes;
- Lead nursing/midwifery clinical practice within the professional practice framework established by the Director of Nursing/Midwifery, and contribute specific expertise to clinical protocols and standards development and promulgation;
- Contribute specific expertise to nursing/midwifery practice through clinical protocol and standards development;
- Maintain productive working relationships and manage conflict resolution;
- Contribute clinical expertise to learning environments, which may include individual/team capability development and/or post registration clinical teaching;
- 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.

In addition to the common role requirements above, employees in practice models primarily providing expert care will:

- Provide expert clinical nursing/midwifery care and interventions and/or individual case management to a defined population of patients/clients;
- 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.

In addition to the common role requirements above, employees in clinical leadership practice models will:

- Lead nursing/midwifery clinical practice within the professional practice framework established by the Director of Nursing/Midwifery, and/or lead a multidisciplinary team;
- Contribute expert nursing/midwifery assessment and advice to local clinical teams to achieve integrated nursing/midwifery care within a risk management framework;
- 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 monitoring and evaluative research activities in order to improve nursing or midwifery practice and service delivery.

Reclassification Indicators (criteria)

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 and standards;
- Leading the development of education resources for health professionals and client groups.

NURSE/MIDWIFE EDUCATION FACILITATOR (LEVEL 3):

Employees classified at this level use their clinical knowledge and experience to provide corporate support services to nursing/midwifery practice in areas such as provision of learning experiences, educational materials and expertise to support clinicians undertaking local teaching. Work at this level is undertaken by employees with at least 3 years post registration experience.

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; and
- Coordination and leadership of projects, programs and/or research to achieve improved educational outcomes and/or service delivery.

Employees in these roles will:

- Provide and/or coordinate educational support within the organisation's professional practice, education and administrative frameworks;
- 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;
- Contribute to the review and management of education/training programs to ensure the achievement of outcome standards and key performance indicators;
- Undertake and/or oversee teaching sessions and assessment processes;
- Contribute to capability development requirements identified within performance development and succession planning activities;
- Contribute to competency improvement requirements identified within performance management activities;
- Provide education support for change processes, risk management practices and service improvement activities;
- Contribute to the support of undergraduate and post graduate students in clinical placements as appropriate;
- Collaborate with Clinical Service Coordinators to co-ordinate teaching and learning processes and achieve planned outcomes;
- Maintain productive working relationships and manage conflict resolution;
- Contribute to the promulgation of information regarding current developments in nursing and midwifery;
- 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.

In addition to the foregoing, employees with portfolio responsibilities will:

- Teach and/or assess specific post-graduate/university course topics in area of own expertise;
- Undertake or oversee short term clinical and/or education research projects.

Reclassification Indicators (criteria)

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 consistent education practices for all levels of nursing and midwifery staff and students;
- Leading the analysis, measurement and evaluation of education and professional development; and
- Leading the development of processes that enables the Clinical Service Coordinator to undertake performance management and competency assessment of their staff.

NURSE/MIDWIFE MANAGEMENT FACILITATOR (LEVEL 3):

Employees classified at this level use their clinical knowledge and experience to provide corporate support services to nursing/midwifery practice and services in areas such as staffing methodologies, recruitment and selection, human resource management, financial administration, bed and resource management, accreditation and risk management processes and information systems management. Work at this level is undertaken by employees with at least 3 years post registration experience.

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.

All employees in these roles will:

- Provide corporate support to nursing/midwifery practice and services within the professional practice framework established by the Director of Nursing/Midwifery;
- Integrate corporate and local unit/ward/program/service human and material resource management in collaboration with Clinical Services Coordinators and/or other managers;
- Integrate corporate and local service coordination to achieve continuity of patient/clients services;
- 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;
- Maintain productive working relationships and manage conflict resolution;
- Implement and co-ordinate processes for quality improvement and service continuity within corporate risk management and nursing/midwifery professional practice frameworks;
- Use available information systems to inform decision making, evaluate outcomes and convey information to staff;
- Contribute to the development of, implement, and monitor corporate policies and processes;
- Change processes and practices in accordance with emerging management needs, evaluation results and imminent systems problems;
- 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.

In addition to the foregoing, employees with portfolio responsibilities will:

- Undertake the work of the portfolio within the corporate administrative framework and delegations of responsibility;
- Where required by the organisation, provide “after hours” oversight and management of the activities of the health service including staff allocation, implementation of disaster response and recalling staff as required.

Reclassification Indicators (criteria):

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 and risk management practice, 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.

ADVANCED NURSE/MIDWIFE CLINICAL SERVICE COORDINATOR (LEVEL 4):

Employees classified at this level provide the pivotal co-ordination of patient/client care delivery in a defined ward/unit/service/program 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 activities, including where relevant, such local resource management as to achieve continuity and quality of patient/client care and outcomes. Work at this level is undertaken by employees with at least 3 years post registration experience.

Employees in this role accept accountability for the outcomes of nursing/midwifery practices 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.

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

- Primarily leading a patient/client care area nursing/midwifery and/or multidisciplinary practice/service team;
- Undertaking a combination of patient/client care ward/unit/service nursing/midwifery team leadership and resource management.

Employees in this role will:

- Manage, oversee and advise on nursing/midwifery care and health service delivery for a specified service delivery area which is (by number of patients/clients and/or by clinical complexity or breadth) demonstrably beyond the usual range for that practice setting; OR
- Manage, oversee 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
- Lead 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;
- Initiate, implement and co-ordinate processes within span of control, for quality improvement and continuity within corporate risk management and nursing/midwifery professional practice frameworks;
- 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;
- Maintain productive working relationships and manage conflict resolution;
- Develop and maintain a learning environment, taking a coaching approach to team development, individual capability development and performance management;
- Use available information systems to inform decision making, evaluate outcomes and convey information to staff;
- 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;
- 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.

Employees in this role may be required to:

- Undertake a formal support/advisor role to Clinical Service Coordinators in relation to an area of expertise in service co-ordination;
- Implement important and/or influential systems used beyond own area of service co-ordination;
- Initiate, conduct, implement and/or guide a major research or systems development portfolio relevant to improved service outcomes and beyond the scope of the Clinical Service Co-ordination role;
- Undertake and/or oversee, within their span of control, some or all local resource management within the corporate administrative framework;
- Act as a consultant to the state or national health system in area of expertise;
- Present at conferences, undertake post graduate teaching and assessment and/or publish in refereed professional journals.

Reclassification Indicators (criteria):

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 CLINICAL PRACTICE CONSULTANT OR NURSE PRACTITIONER (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.

Level 4 clinicians may 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. Work at this level is undertaken by employees with at least 3 years post registration experience.

Employees in this role accept accountability for their nursing/midwifery practice, professional advice given, delegations of care made and for addressing inconsistencies between practice and policy.

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:

- Integrate contemporary information and evidence with personal experience to support the decision making, innovative thinking and objective analysis that are expected at this level;
- Apply and share expert clinical knowledge to improve patient/client care;
- Maintain productive working relationships and manage conflict resolution;
- Contribute clinical expertise to learning environments, which may include individual/team capability development and/or post registration clinical teaching;
- 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.

In addition to the foregoing, the employee in this role exhibits a substantial proportion of the following characteristics according to the model in which they practice.

In a patient/client management role and in accordance with the context, patient need, and any required authorisation, may be required to:

- Comprehensively assess health status including history and physical examination;
- Initiate and interpret diagnostic pathology and/or radiology;
- Initiate interventional therapies, medications 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;
- Admit and discharge from inpatient and/or clinic settings;
- Practice extensions of the nursing/midwifery role in accordance with local clinical and/or admitting privileges, agreements, practice guidelines and/or protocols and State and Federal legislation and regulatory requirements;
- The role may be sessional in combination with clinical practice responsibilities.

In a clinical leadership role and in accordance with the context and patient/client need, may be required to:

- Lead nursing/midwifery clinical practice within the professional practice framework established by the Director of Nursing/Midwifery;
- Contribute expert nursing/midwifery assessment and advice to local clinical teams to achieve integrated nursing/midwifery care within a risk management framework;
- 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 to redesign of care and treatment practices;
- Contribute to clinical supervision and/or practice development;
- Conduct and/or guide clinical research;
- Act as a consultant to the state or national health system in area of expertise;
- Present at conferences and undertake post graduate teaching and assessment and/or publish in refereed professional journals.

Reclassification Indicators (criteria):

3 years post registration experience;

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

- Demonstrates clinical practice at an expert level by undertaking the majority of the following characteristics (where they are relevant to the practice setting and role):
 - Comprehensively assess health status including history and physical examination;
 - Initiate and interpret diagnostic pathology and/or radiology where that is enabled and authorised;
 - Initiate interventional therapies, medications and use of health appliances or equipment within any limits created by application of the law or policies and procedures;
 - Clinically manage clients either directly or by delegation;

- Communicate patient management plans to all relevant members of the health care team, including general practitioners;
- Admit and discharge from inpatient and/or clinic settings where that is enabled through locally applicable policies and procedures;
- Practice extensions of the nursing/midwifery role in accordance with local clinical and/or admitting privileges, agreements, practice guidelines and/or protocols and State and Federal legislation and regulatory requirements.
- 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 EDUCATION FACILITATOR (LEVEL 4):

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 and oversight of a range of education, training, learning experiences and materials. Work at this level is undertaken by employees with at least 3 years post registration experience.

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.

Employees in this role will:

- 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;
- Lead a nursing/midwifery and/or multi-disciplinary team of educators and/or trainers in the initiation, coordination, implementation and evaluation of a formal education program for a designated student group;
- Initiate, develop and implement educational and/or clinical protocols/standards, harm minimisation strategies and quality benchmarks;
- 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;
- Contribute to the review and management of education/training programs to ensure the achievement of outcome standards and key performance indicators;
- Undertake and/or oversee teaching sessions and/or assessment processes to designated student populations;
- Contribute to capability development requirements identified within performance development and succession planning activities;
- Contribute to competency improvement requirements identified within performance management activities;
- Provide education support for change processes, risk management practices and service improvement activities;
- Contribute to the support of undergraduate and post graduate students in clinical placements as appropriate;
- Collaborate with Clinical Service Coordinators and Clinical Practice Consultants to co-ordinate teaching and learning processes and achieve planned outcomes;
- Maintain productive working relationships and manage conflict resolution;
- Mentor and coach Education Facilitators in relation to an area of expertise;
- Initiate, conduct and/or guide research within an area of education practice;
- 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.

Employees in this role may be required to:

- Undertake a formal academic role as a major component of role;
- Undertake a formal research coordinator role as a major component of role;
- Act as a consultant to the state or national health system in area of expertise;

- Directly undertake and/or be accountable for a major research or evaluative project beyond the scope of the usual Education Facilitator role;
- Lead 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 Education Facilitator role;
- Lead development of new or innovative education delivery, instructional design programs and/or knowledge access mechanisms to address the emergent requirements of the health and education sectors;
- Present at conferences and/or publish in refereed professional journals.

Reclassification Indicators (criteria):

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 MANAGEMENT FACILITATOR (LEVEL 4):

Employees classified at this level use their clinical knowledge and experience to provide a corporate support service to nursing/midwifery practice and services in areas such as staffing methodologies, recruitment and selection, human resource management, financial administration, bed and resource management, accreditation and risk management processes and information systems management. Work at this level is undertaken by employees with at least 3 years post registration experience.

Employees in this role accept accountability for the outcomes of nursing/midwifery management practices, for addressing inconsistencies between practice and policy, and for developing corporate team performance within a 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 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.

Employees in this role will:

- 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;
- Integrate corporate and local unit/ward/service/program human and material resource management in collaboration with Clinical Services Coordinators and/or other managers;
- Integrate corporate and local service coordination to achieve continuity of patient/clients services;
- 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;
- Maintain productive working relationships and manage conflict resolution;
- Use and develop or make significant adaptation to clinical and/or management information systems;
- Develop customised Key Performance Indicators and/or outcomes measurement models that influence organisation wide reporting processes;
- Directly undertake and/or oversee a major research or evaluative project beyond the scope of the usual Management Facilitator role;
- Identify the need for, lead implementation of, and evaluate changes in organisational processes and practices in response to emerging service and workforce needs;
- 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.

Employees in this role may be required to:

- Undertake the work of a portfolio beyond the usual range for the setting, within the corporate administrative framework and delegations of responsibility;
- Where required by the organisation, provide “after hours” oversight and management of the activities of the health service including staff allocation, implementation of disaster response and recalling staff beyond the usual range of responsibility;
- Provide a support/advisor role to other Management Facilitators;
- Act as a consultant to the state or national health system in an area of expertise;
- Act as a consultant providing high level advice to key stakeholders on issues relating to professional and clinical practice, workforce, legislation, education and/or research;
- Present at conferences and/or publish in refereed professional journals.

Reclassification Indicators (criteria):

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.

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 the cost effective provision of health services within their span of appointment.

Employees in this role will typically:

- Provide corporate professional nursing/midwifery advice, leadership, and management for a single purpose service/stream with approximately 80 to 130 FTE nursing/midwifery staff;
- 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;
- 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;
- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making;
- Contributes to divisional nursing/midwifery professional practice framework established by the Director of Nursing/Midwifery and led by the Nursing and/or Midwifery Divisional Director;
- Implement the corporate administrative and risk management frameworks within span of responsibility;
- Contribute to financial budgeting and management within a culture of due diligence;
- 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;
- Lead, coach, coordinate and support direct reports;
- Lead the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment;
- Contribute to strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role.

Reclassification Indicators Service Director 5.1 (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 leadership of nursing/midwifery activities to achieve continuity and quality of service provision;
 - Resource management including effective financial budgeting and management for their clinical service;
 - Developing and implementing strategic directions for the service and leading change management; and
 - Human resource strategies that recruit, develop and retain nursing/midwifery staff in their service.

NURSING AND/OR MIDWIFERY DIRECTOR (LEVEL 5.2):

Employees classified at this level use their clinical knowledge and experience 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.

All employees in this role will:

- Provide corporate professional nursing/midwifery advice, leadership, and management for a specified division/stream; OR
- Provide corporate professional nursing/midwifery advice and leadership to a specified group of nurses/midwives; OR
- Provide corporate professional nursing/midwifery advice, leadership, and management of functions, programs and projects;
- Initiate and/or oversee innovations, systemic change processes, and co-ordination of responses to nursing/midwifery practice and health service needs within span of control;
- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making;
- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role.

Nursing and/or Midwifery Divisional Director (Level 5.2)

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

- 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 or the Director of Nursing/Midwifery or Executive Director of Nursing/Midwifery who has responsibility for the service.
- 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; AND
- This role may provide leadership to a small number of ancillary staff located within the division/stream to support corporate nursing and/or midwifery functions;
- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division which may also operate within a clinical stream;
- 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;
- Undertake financial budgeting and management within a culture of due diligence;
- Develop and guide the use of information systems to inform decision making, and manage practice;
- 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;

- Provide strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- 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.

Reclassification Indicators 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;
- Resource management including effective financial budgeting and management for their division;
- Developing and implementing strategic directions for the division and leading change management; and
- Human resource strategies that recruit, develop and retain nursing/midwifery staff in their division.

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

Employees in the role of Clinical Practice Director will typically:

- Provide collegiate and professional leadership to and for Level 3 and/or 4 Clinical Practice Consultants, Nurse Practitioners and (where appropriate) General Practice Nurses within span of appointment;
- Develop an integrated, collaborative and evaluative practice culture for Level 3 and/or 4 Clinical Practice Consultants and Nurse Practitioners across span of appointment;
- Collaboratively develop and monitor a strategic framework for clinical nursing/midwifery research and practice development in the South Australian public sector;
- Provide high level advice to Health Units, Community Services and/or Clinical Networks on extended nursing/midwifery practice issues;
- Co-ordinate the participation of nurses/midwives in clinical guideline and protocol development between Health Units and Clinical Networks;
- Liaise between Clinical Networks and Health Units in regard to nursing and midwifery practices that will achieve enhanced patient/client journeys and population health targets;
- Participate in clinical services planning and review at State level;
- The role may be sessional in combination with clinical practice responsibilities.

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;
- Coordinate systems and processes to ensure appropriate clinical outcomes.

Nursing and/or Midwifery Functional/Project/Program Director (Level 5.2)

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

- Provide management of nursing/midwifery functions for a specified nursing/midwifery department/services; AND/OR
- Contribute to the development, implementation and evaluation of strategic directions, policies, goals and objectives which support professional nursing/midwifery practice;
- Provide operational and professional leadership to and for Level 3 and/or 4 Management Facilitators or Education Facilitators within span of appointment;
- Provide high level advice to stakeholders and health services on the management of contemporary nursing and/or midwifery issues relating to professional practice, workforce, legislation, education and/or research;
- Actively participate in internal and external advisory groups, expert panels, working groups and/or committees;
- 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;
- Undertake financial budgeting and management within a culture of due diligence;
- Develop and guide the use of information systems to inform decision making, and manage practice;
- Utilise a project management framework including evaluation and risk mitigation;

- Liaise with stakeholders, health services, Government departments and others to maximise efficiency and effectiveness implementing policy and service directions;
- 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;
- Provide strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- 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.

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 strategic and operational leadership, governance and direction for nursing/midwifery and/or management of multi-disciplinary services for a specified division in a Hospital or clinical stream, or Community Service or state-wide service. This role must report to a Director of Nursing/Midwifery or Executive Director of Nursing/Midwifery who has responsibility for the service. Work at this level is undertaken by employees with at least 5 years post registration experience.

Employees at this level are accountable for the governance and practice standards of nurses/midwives and/or multi-disciplinary team. 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; and accountable for the cost effective provision of health services within their span of employment.

Employees in this role will:

- Lead a nursing/midwifery and/or multi-disciplinary division or stream.

Employees in the role of Advanced Divisional/Stream Nursing/Midwifery Director will typically:

- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division/stream with oversight of multiple services;
- Provide professional nursing/midwifery advice and leadership to the following staff: Level 3 and 4, Nursing and/or Midwifery Service Director - RN/M 5.1 and RN/M 5.2 (unless otherwise agreed by the parties) working within the nursing/midwifery division/stream;
- Provide corporate management of nursing/midwifery services for a specified nursing/midwifery division/stream which may also operate within a clinical stream;
- 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;
- Undertake financial budgeting and management within a culture of due diligence;
- Develop and guide the use of information systems to inform decision making, and manage practice;
- 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;
- Provide strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within span of control;
- 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.

Reclassification Indicators Advanced Director 5.3 (criteria):

5 years post registration experience;

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

Leading a nursing/midwifery and/or multi-disciplinary division or stream.

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.

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 undertake a substantial number of the following:

- Provide corporate 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;
- Develop and implement a corporate nursing/midwifery professional practice framework;
- Develop and/or implement corporate administrative and risk management frameworks;
- Undertake financial budgeting and management within a culture of due diligence;
- Initiate and/or oversee innovations, systemic change processes, and co-ordination of responses to nursing/midwifery practice and health service needs;
- 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;
- Lead, coach, coordinate and support direct reports;
- Lead the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment;
- Contribute to and/or negotiate organisation budget and activity profiles;
- Lead innovation, change processes, and coordinated responses to emerging service and workforce needs;
- Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making;
- Hold a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role;
- May be required 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;
- Role may be extended to include EO responsibilities.

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.

APPENDIX 8 – RURAL AND REMOTE SERVICE INCENTIVE PAYMENTS

From the first full pay period on or after 1 October 2010

YEAR	ZONE 2	ZONE 3	ZONE 4
	<i>\$pa</i>	<i>\$pa</i>	<i>\$pa</i>
1	803	1835	3555
2	1032	2064	3899
3	1319	2293	4127
4	1605	2580	4357
5	1835	2867	4587

From the first full pay period on or after 1 December 2011

YEAR	ZONE 2	ZONE 3	ZONE 4
	<i>\$pa</i>	<i>\$pa</i>	<i>\$pa</i>
1	838	1916	3711
2	1077	2155	4070
3	1377	2394	4308
4	1675	2693	4548
5	1916	2993	4788

From the first full pay period on or after 1 October 2012

YEAR	ZONE 2	ZONE 3	ZONE 4
	<i>\$pa</i>	<i>\$pa</i>	<i>\$pa</i>
1	859	1964	3804
2	1104	2209	4172
3	1411	2454	4416
4	1717	2760	4662
5	1964	3068	4908

APPENDIX 9 – 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 (Booleeroo Health Service)	Lameroo District Health Service - Mallee Health Service	Ceduna District Health Service
Mid North Health (Booleeroo 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	Naracoorte Community Health	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 10 – 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 1, 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.

	1 st pay period on or after 1 October 2010 \$pa	1 st pay period on or after 1 December 2011 \$pa	1 st pay period on or after 1/10/12 \$pa
Hospital* or Graduate Certificate	2372	2476	2538
Graduate Diploma	3050	3184	3263
Second Degree, Masters or PhD	3727	3891	3989

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

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

- (i) 3.5% calculated on the maximum step (i.e. increment 7) 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.

	1 st pay period on or after 1 October 2010 \$pa	1 st pay period on or after 1 December 2011 \$pa	1 st pay period on or after 1 October 2012 \$pa
Post enrolment courses of not less than 6 months duration	1784	1873	1919

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 payable during paid leave;
- (vi) 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.

** 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.