

**Submission
No 30**

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

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Legislative Assembly
Inquiry into the Management of Health Care Delivery in
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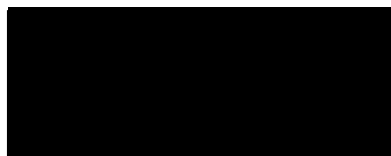
The New South Wales Nurses and Midwives Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes Assistant in nursing (who are unregulated), Enrolled Nurses, Registered Nurses and Midwives at all levels including management and education.

The NSWNMA has approximately 62,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and age care services.

We welcome the opportunity to make a submission to the Legislative Assembly Inquiry into the Management of Health Care Delivery in NSW.

This submission is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.




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Introduction

The NSW Nurses and Midwives' Association (NSWNMA) welcomes the 'Inquiry into the Management of Health Care Delivery in NSW' and has provided this submission for your review as a related matter to the inquiry.

The Association acknowledges the work being conducted by many agencies to minimise the use of seclusion nationally and we agree with the direction of this work as it follows current international trends and best practice principles for patient centred care, trauma informed care and crisis prevention strategies.

Patient safety and staff safety has always been a priority of the NSWNMA and our members, along with evidence based clinical practice that provides best care for the individual. Seclusion and restraint events hold many risks and appropriate measures to help reduce the number of seclusion and restraint episodes will also reduce the exposure of clients and staff to the associated risks.

Seclusion is ultimately about safety. It is usually only a small number of high risk clients that are involved in most seclusion episodes. Seclusion and restraint is predominantly used to manage risk of harm to others.

"the most common reason recorded was harm to others"

(Seclusion and restraint use in adult inpatient mental health care: An Australian perspective, C Oster, A Gerace, D Thompson, E Muir-Cochrane, 2014).

This research indicated that 84% of episodes had harm to others as the reason for seclusion and with 20% of patients accounting for 70% of the hours for seclusion.

Restriction of an individual's liberty due to the imminent risk of harm must be weighed against their safety and/or the safety of others by the multidisciplinary team and managed with the intention of least restrictive care. It should only be utilised with due consideration to the benefits and the risks involved.

For this reason, the NSWNMA holds the view that the use of seclusion and restraint can be reduced in NSW, but only with the right support and resources in place. The Association holds the view that seclusion must remain an option and necessary last resort to ensure optimum safety in NSW mental health facilities.

We believe that where there is an increased level of seclusion and restraint use in NSW mental health units, it cannot be seen in isolation from the underlying problems within mental health service in NSW.

General Comments

Funding

Systemic issues within the mental health services have been created by inadequate funding of the public mental health services over many years (since the implementation of deinstitutionalisation), and even though mental health funding was supposed to be 'protected' and spent on mental health, 'leakage' to other areas of health have occurred (Auditor-General's report Performance Audit, Mental Health workforce, NSW Health 2010), forcing Local Health Districts (LHDs) to create budget saving, rather than to allow the implementation of evidenced based best practice to ensure optimum safety of clients and staff. The impact of this tight fiscal strategy is now having an impact on clinical outcomes in mental health services.

A lack of leadership by government, along with restrictive budget constraints has led to mental health services being poorly resourced. Given the new employment profile of a non-specialised and inexperienced mental health workforce, along with the difficulty of retaining senior mental health qualified nurses, the level of safety for clients and staff is now approaching a critical level.

Rather than addressing the issues, the government appears to have stepped back, absolving itself from its overall responsibilities, allowing the LHDs to make decisions that are driven more by strict budget constraints. This has forced LHDs to resort to stop gap low cost measures in order to remain in budget at the cost of evidenced based best practice that ensures better safety of clients.

We have seen that with the push for community based services, funding has been diverted from public health services such as mental health, to the point that the public health service is so neglected and lacks capacity to provide the care as required. These neglected services can only 'fail' in delivery of care. Then we have

services that could be seen as 'profitable' in the private sector being handed over to community based providers.

Community based providers do not have the skilled staff or resource capacity to ensure provision of care as required, and are failing (we have already seen the failure with Port Macquarie in NSW). The government or the LHD is then expected to rescue the service and continue provision of these services without appropriate resources or funding available. An example is the Neami Dubbo Mental Health Rehabilitation & Recovery Centre facility which opened in 2012-13 and co-located on the grounds of the Dubbo Base Hospital. Neami National, a non-government mental health organisation that provides support services to people with mental illness, had management of the \$7.2 million, 10-bed facility. The NSWNMA branch at Dubbo Base Hospital raised concerns about safety and blurred lines of responsibility in regard to the facility operation in 2014. The facility has recently been handed back to the Far West LHD and put out to tender to be managed by another community based provider.

The victims in this failure of privatisation are always the most vulnerable, that is the clients of the service.

- 1) Improved funding and transparency is desperately needed for mental health services along with the immediate reversal the current government strategy for the privatisation of mental health services.

Mental health nursing specialty

This tight fiscal strategy has had a detrimental effect on staffing levels and skill mix in mental health units and community mental health services. A lack of acknowledgment of the competency, education and experience of specialist mental health nurses has resulted in experienced mental health nurses feeling they have been undervalued and their calls for interventions that would help create improvements in service delivery ignored. This has led to them either moving to other areas of health, often to other positions outside of mental health that are eager to utilise their skill sets, or leaving the profession altogether.

To manage the loss of experienced mental health nurses LHDs have resorted to a 'genericisation' of senior nursing management positions in mental health services. This has meant that in some services, the specialty of mental health nurses at the clinical level, is now often being managed by those with no or a very limited mental health nursing background.

We have also seen by a number of LHDs across NSW, the removal of specialty criteria for mental health experience and qualifications as a requirement for mental health nursing positions in mental health services when advertising for staff, resulting in the loss of mental health nursing and management positions to other disciplines, particularly in community.

A number of members have expressed concern in regard to the acute decline in the qualified and highly experienced specialist mental health nursing workforce due to experienced nurses moving to other sectors of nursing and an aging workforce retiring from the profession. This attrition will leave less experienced junior nurses without adequate mentorship and role modelling available to them from these senior specialist mental health nurses'. The qualifications, experience and competencies of senior mental health nurses is a valuable resource we cannot afford to lose. The mentorship they provide must be available to nurses new to the specialty of mental health.

- 2) To ensure that the specialty of mental health nursing is acknowledged and that senior mental health nursing experts are valued and retained, there needs to be a State-wide requirement that the recruitment of suitably qualified mental health nurses is a priority. The creation of more Clinical Nurse Specialist level two (CNS II) positions may encourage the recruitment and retention of senior mental health nurses.

PICU Units

On 2 December 2014, the Association wrote to Mr Peter Carter, Acting Director Mental Health Drug and Alcohol Officer, asking that the Ministry review the 'Mental

Health Bed Types for Inpatient Units 2006/2007' (PD2007_019) (made obsolete 14 December 2014).

The Association expressed concern that there were only 62 PICU beds across the State. It was estimated that there were a further 270 HDU/Observation beds across NSW Mental Health services acting in the role of de facto MHICU/PICU beds.

Mr Carters reply (received on 17th June 2015) stated that many LHDs use informal terms to describe local options for mental health inpatient care. These informal terms include 'Mental Health High Dependency Units' (HDUs) and 'Mental Health Observation Units' (Obs). These local *"terms refer to models of care as part of the local MH Acute Inpatient Unit"*.

Mr Carter also stated that PICU beds catered for the *"most disturbed mental health patients who are unable to be cared for safely within Local Health Districts (LHD) acute care options"*, *"MICUs are tertiary level units funded at the highest level of funding of any mental health service in NSW to allow a level of staff to safely stabilise a person's condition."* ...*"HDU and Obs beds are not tertiary-level services nor are they funded by the Ministry of Health at the same rate as MHICU Services"*.

What must be acknowledged is that HDUs and Obs units often perform the same function as PICUs when having to manage highly disturbed clients, usually for extended periods of time. PICU/MHICU beds are in extremely short supply across the State and are always in very high demand, waiting times can often be up to weeks at a time (if a bed does become available). These HDUs and Obs units are underfunded and under resourced to cope with highly aggressive clients, requiring a higher use of seclusion to manage high risk clients.

With the centralisation of the majority of MHICU beds in the Sydney metro region, the geographical location of rural mental health HDUs and Obs units in NSW leaves them exposed when required to manage high risk patients. Due to the distance and associated risks with transferring clients to approved PICUs, rural HDUs and Obs units can often be required to manage this type of client for extended periods.

This has an impact on risk and the rates of seclusion at these rural sites, as seclusion is often the only safe option available when managing the *“most disturbed mental health patients who are unable to be cared for safely within Local Health Districts (LHD) acute care options”*.

- 3) There needs to be an immediate increase of funding for more PICU/MHICU beds and units across the State, to reduce the exposure of clients and staff to the risks associated with managing very high risk clients within under resourced and inappropriately designed mental health units, especially units isolated by distance from any supporting PICU.

Community mental health

In some community teams, non-nursing mental health professionals, such as allied health staff, are managing clients on complex medication regimes without any real understanding of the medications side effects, complications or management protocols in regard to these complex medications (for example clozapine). Our members are gravely concerned that this is not best practice and could lead to a relapse of a patient’s condition, possibly leading to seclusion on readmission, or worse, to a fatal outcome due to poor medication management, which could have been avoided.

Long term mental health clients receiving sustained release medication via injection attend depot clinics in community mental health services. These clinics are managing to see a very high number of clients each day. Often there is only one nurse managing the clinic, working alone in such an environment places them at risk. Nursing staff are required to provide depot medications not only for their own clients, but are also required to administer depot medication for all allied health staff clients. The clinic nurse is required to do a mental state assessment at the time of medication administration, but due to the high numbers of client bookings per day and the limited time each client is booked in for, this is an unrealistic work load expectation and can only eventually lead to poor outcomes.

Our members working in community have also expressed deep concerns that staff are not being back filled when they go on leave. Clients care is compromised as clients cannot be managed appropriately with understaffing at community mental health services, leading to a higher probability of relapses occurring.

- 4) Nurses have the competencies for medication administration and need to case manage clients on complex medication regimes. Mental health depot clinic must be staffed at appropriate levels to manage workloads safely (with a minimum of 2 nursing staff rostered to the clinic). All staff should be back filled in all services to ensure staffing ratios are kept optimum for client care and safety.

Key Performance Indicators

Emergency Department (EDs) have enormous pressure to push all patients through to meet time constraint created by Key Performance Indicators (KPIs). This has caused a need to fast track mental health clients through EDs to meet KPIs. Meeting KPIs appears to drive the care we are providing, rather than best practice principles for patient centred care, trauma informed care and crisis prevention strategies.

Increased documentation requirements to meet KPIs, particularly in community mental health, results in a decreased allocation of time that is needed for mental health nurses to provide care and attention to clients. The allocation of adequate time per patient would go a long way to helping prevent community based clients relapsing and requiring admission.

Due to this need to meet KPIs, LHDs are forced to meet budget driven funding models rather than care models that promote best practice and positive client outcomes.

- 5) Emergency Department KPIs for mental health need to be appropriate to and separate from the KPIs for medical/surgical clients. Consideration must also be given to the workloads and documentation requirements for community services to meet KPIs, as we believe there are many community staff working with caseloads far in excess of being reasonable and safe.

Observations in mental health facilities

The Association acknowledges there have been situations where failures in the patient observation process has unfortunately resulted in tragic consequences for patients. The Association strongly advocates that all staff comply with State and local policy at all times to ensure best possible client outcomes.

Our members have on a number of times communicated their concern that with the poor physical layout and design of some units and with the high number of patients requiring observation (with frequency of 10 or 15 minutes), it is unrealistic to manage and in some cases unachievable. A delay caused by caring for one patient can result in a number of observations not occurring in the specified time frames.

The NSWNMA wrote to the then Minister for Mental Health, Hon, Jai Rowell, MP on 13 August 2014, to express our concern that 'close observation' forms used in a number of Local Health Districts (LHDs), had pre-determined times listed at regular 10 or 15 minute intervals for the nurse to sign against rather than the actual time the observation took place. This is in contradiction to the recommendations by the then Deputy State Coroner, Magistrate M. MacPherson, during the Coronial inquest for Nicholas Choon Choon Ang, 2nd September 2011 (file ref: 1360/2005).

The Association recommended in our letter to the Minister at that time (2014), a state-wide policy be developed, similar to '*Between the Flags*', to help with the introduction of any new policy, forms and education for nurses around the recording of observations of mental health patients in the public system. That any policy and form development needs to be specific in the required steps and responsibilities

regarding the type of observation, distance required for attending in person, what has been observed to ensure accurate observations.

This would then help to ensure a comprehensive understanding is provided of the policy and nursing responsibilities, with regard to the 'observation' requirements.

State Coroners Court of New South Wales, Magistrate Derek Lee, Deputy State Coroner, in the inquest into the death of Ahlia Raftley, 9/6/2017 (file 2015/84416) made a number of recommendations to Hunter New England LHD (HNELHD) including:

Recommendation 4

I recommend that HNELHD provide increased and regular education and training to nursing staff within mental health units regarding completion of patient observation charts to ensure that observations are accurately recorded at the times that they are performed, and to avoid the practice of "block recording" where observations are recorded collectively and subsequent to the time of the actual observation.

Recommendation 5

I recommend that HNELHD amend the Mental Health Levels of Observation – Psychiatric Intensive Care Unit (PICU) policy issued on 31 July 2015 to ensure that clear instructions are given to nursing staff regarding the performing of observations day and night, and how observations should be performed in order to ensure the safety of patients.

The Deputy State Coroner in the same inquest recommended to the NSW Minister for Health:

Recommendation 2

I recommend that the NSW Minister for Health give consideration to increasing patient-to-nurse ratios within the Psychiatric Intensive Care Unit of the Mater Mental Health Centre, Waratah to ensure that patient safety is not compromised.

There is a need to have sufficient numbers of nursing staff on all units on all shifts, to be able to ensure the safety of patients is not compromised.

Mental health units have minimum staffing overnight and are forced to rely on staff to come from other areas before a minimum number (5 -6 staff) is available to undertake a restraint procedure safely. Attempting to restrain without adequate numbers creates increased risks of injury. This can impact on the staff feeling quite vulnerable when managing a high risk client without adequate numbers. Nursing Hours Per Patient Day (NHPPD) or Nurse Patient Ratios are only a minimum and patient acuity must always be considered and appropriately managed. There is a need to have sufficient numbers of nursing staff on all units on all shifts, to be able to implement a restraint procedure safely when required.

Staff try not to wake clients due to the detrimental effects of poor sleep hygiene on the client's mental state, but there can be a reluctance to disturb clients at night when nursing numbers are lowest, due to the fear of aggression and violence that could result. The Association would like to suggest that we need to look at ways of supplementing observation of clients overnight, which will not disturb sleep, including the use of modern technology. There needs to be further investigation of these technologies, such as under blankets that measure breathing and movement or electronic wristbands that monitor pulse or oxygen levels.

The Deputy State Coroner again in the same inquest recommended to HNELHD:

Recommendation 7

In the event that the application by the Black Dog Institute for an innovation grant to trial back-to-base pulse oximetry units across a number of Local Health Districts is unsuccessful, I recommend that the HNELHD give consideration to independently conducting its own trial to assess the acceptability and feasibility of using pulse oximetry units to continuously monitor inpatients in mental health intensive care units within the district.

The Association supports the recommendations by the Deputy State Coroner as above and goes further to ask the Minister for Health to develop an education program similar to the 'Between the Flags' and initiate a State wide roll out of education across all LHDs. The Ministry also needs to look into adopting technology as another method of monitoring inpatient mental health client's vital signs overnight.

- 6) The numbers of nursing staff on duty need to be appropriate for the number of patients and their acuity to ensure patient safety is not compromised. During negotiations for nurse patient ratios/Nursing Hours Per Patient Day (NHPPD), the Association was forced to compromise on the ratios/NHPPD in large mental health facilities as compared to stand alone mental health units in general hospitals. The outcome of 5.5 NHPPD in large mental health facilities verses 6 NHPPD in general hospitals is patently wrong and should be fixed.

A mental health education program on mental health observations developed, similar to the 'Between the Flags', with a State wide roll out across all LHDs.

Adopting technology as another method of monitoring inpatient mental health client's vital signs overnight.

Workforce development

Qualified and experienced RNs and ENs in acute mental health areas are required to make informed clinical decisions based on their education and expert experience. This is paramount for delivery of optimal health care to clients and critical to maximising the safety of both clients and staff.

On behalf of our members, the Association wrote to the then Minister for Mental Health, the Hon Pru Goward, MP, on 14 December 2016, outlining our members concerns that nurses are able to be employed in acute mental health units with only a very basic mental health knowledge and education (at a novice level).

Lack of mental health education, skills and experience for nursing staff in this specialty area can compromise patient care and safety, resulting in poorer outcomes

for clients and the service, including higher use of seclusion. We expressed the need for a consistent education and learning program across the LHDs for nurses new to the specialty of mental health nursing, similar in format to the '*Transition to Mental Health Nursing*' program for new graduates. Such a program for all nurses new to mental health is urgently required.

Our members have also expressed concern that across some services, very junior nurses are being promoted to senior levels including mental health Unit Managers and Clinical Nurse Specialist (CNS) grades. We are aware of situations where first year registered nurses are being rostered in charge as team leaders in acute mental health forensic units.

This has created the situation where very junior nurses inexperienced in the specialty of mental health nursing are expected to manage teams that care for highly complex and high risk clients, with minimal support or leadership available to them.

This places unreasonable responsibilities and stress on these nurses new to mental health and is a key factor in academic research on why young nurses leave the profession prematurely.

We have heard of an initiative in Victoria to employ Nurse Practitioners (NPs) in mental health units to act as role models for other staff new to mental health.

Another initiative we have heard of is a program where senior mental health nurses, when due to retire, rather than losing their valued experience on retirement, are offered part time employment as mentors for nursing staff working in mental health units.

- 7) As a workforce development strategy, we believe initiatives need to be developed and incentives need to be in place to retain our valuable experienced mental health nursing workforce to mentor nurses new to mental health, to help grow our own specialist mental health nursing workforce. Mental health nursing requires a sound theoretical base upon which experiential mentoring can establish the necessary interpersonal and competency skills needed for safe practice.

Skill mix

Inappropriate skill mix in mental health units is a major concern. Skill mix is more than a variation in the qualification of nursing staff rostered on duty. Skill mix encompasses the level of experience on each roster, staff can be novice to highly experienced. Skill mix can impact on the care and safety of clients and staff.

There have been issues with mental health units frequently relying on pool staff from the general wards to make up numbers. Pool staff with minimal level mental health experience can create more risk due to their lack of understanding with managing complex mental health clients and safe care provision can be compromised.

"Both the numbers and the skill mix of nursing staff can greatly influence seclusion and restraint use. Sufficient staff must be present to make timely observations and implement alternatives very early in a situation that could become a behavioural emergency. Short staffing can contribute to greater use of restraint and seclusion -- not just because of the numbers, but because the way we tend to behave when we are short staffed can intensify a conflict. When we are short-staffed, we feel stressed and pressured and become more directive (eg, issue commands and orders, use confrontational limit setting), which can lead to greater use of restraints or seclusion to more quickly resolve a crisis."

(Alternatives to Restraint and Seclusion in Mental Health Settings: Questions and Answers From Psychiatric Nurse Experts, Laura Stokowski, 2007.

<http://www.medscape.com/viewarticle/555686>)

LHDs have tried to address their tight budget constraints by the employment of low cost non-regulated workers to staff mental health units, including the ongoing attempt by one LHD to employ Assistants in Nursing (AINs) in its Mental Health Intensive Care Unit (MHICU), [appendix 1].

We strongly oppose this staffing budget measure, as we are of the opinion that this situation creates a severe risk to patients and staff and would result in higher use of seclusion.

In a recent study conducted at the Northern Sydney LHD '*Direct care activities for assistants in nursing in inpatient mental health settings in Australia: A modified*

Delphi study, Cowan, Brunero, Lamont, Joyce, Collegian (2015) 22, 53-60, looks at the direct care activities that were seen as acceptable to be performed by AINs. What was not found acceptable was the activity of “Conducting MSE Notify of change of Mental State” (page 57).

The mental status examination (MSE) or mental state assessment is one of the core components of mental health nursing. It is an ongoing assessment of mental health clients functioning and risk. This finding from the study, reinforces the argument against employing AINs or other unregulated worker in acute mental health settings. It must be noted that AINs are valuable members of the nursing team and they have a distinct role in the provision of health care. It must also be acknowledged that their qualifications and knowledge in performing their role in specialised acute areas such as acute mental health is quite restricted in comparison to the RN or EN with relevant mental health qualification and experience. Unqualified workers are only able to perform a custodial role in the acute mental health setting; this is in contradiction to a patient centred care approach.

We are of the view that in acute mental health services where clients are held under the ‘Mental Health Act’, it would follow that patient acuity would require the constant application of a high level of mental health nursing skills. These therapeutic skills are beyond the ‘scope of practice’ of an unregulated worker.

There would be decreased direct time the mental health nurse would have with the client, and it is when doing everyday activities with the client that the mental state assessments through conversations can occur.

“The time that nurses spend with each patient in any inpatient mental health setting would conceivably include such activities as mental state assessment and assessment of risk, attempting to understand the patient’s perspective of their current situation, as well as implementing strategies to meet the care needs of those patients.”

(Care zoning in a psychiatric intensive care unit: strengthening ongoing clinical risk assessment, Antony Mullen, Vincent Drinkwater and Terry J Lewin, Journal of clinical Nursing (23, 731–743, doi: 10.1111/jocn.12493) 2013, page 732)

“Barker (1998), Chambers (1998), Peplau (1952) and Travelbee (1966) testify to the fact that the therapeutic relationship is ‘the rock’ on which psychiatric nursing is built. Therefore, a full and unequivocal understanding of what forms these relationships is paramount to performing the role of a psychiatric nurse.”

(Psychiatric nurse's perceptions of the constituents of the therapeutic relationship: a grounded theory study, Scanlon A, Journal of Psychiatric and Mental Health Nursing, 2006, 13, 319–329 Page 320).

The NSWNMA position has always been that AINs and other unregulated workers should not be employed at the expense of registered or enrolled nurse positions and must be employed to provide nursing care only where clinically appropriate.

Including non-regulated workers in the skill mix creates issues for registered nurses in regard to delegation of nursing care as per the ‘Decision Making Framework’, (Nursing and Midwifery Board, Codes and Guidelines, National Framework for Decision Making). Any nursing care in any mental health unit requires an ability to perform a mental state assessment to be able to assess any change in risk, which can vary from moment to moment with complex clients. Delegating care tasks to an unregulated worker in an acute unit places them at risk due to their lack of knowledge and competency in performing a mental state assessment.

Recovery orientated model of care promoted by the National Standards for Mental Health Services 2010, requires knowledge of illness and individualised care. When unregulated workers are included in the skill mix, a team nursing approach is required. This is a less desirable model especially in mental health units. When clients are suffering from an acute illness, a high level of skill and intensity of nursing is required to manage their recovery safely and efficiently.

Clearly, the introduction of unregulated workers into acute mental health units needs to be based on the best outcome for clients. The available research indicates dilutions of skill mix will have adverse effects on the care to consumers. In our opinion the introduction of unregulated workers into acute mental health units will result in a higher use of seclusion in these mental health units.

- 8) Replacing mental health nursing staff should only be done with equally qualified and experienced nursing staff. The employment of unregulated workers, including AINs into the skill mix, should not occur in any acute mental health units.

WHS responsibilities

The NSW Health 'Aggression, Seclusion & Restraint in Mental Health Facilities in NSW' PD2012_035 (2012) states:

"Health workers, particularly those who work in mental health units and emergency departments, carry a greater risk of work-related aggression than workers in many other occupations" (page 2).

"Because mental illness and mental disorder can sometimes lead to diminished control, impulsivity and lack of ability to self regulate behaviour,"

"Involuntary confinement and a feeling of lack of control can be distressing for anyone, particularly mental health consumers, and can preface an aggressive incident (Finfgeld-Connett, 2009)" (page 3)

The Lamp article in *Volume 72 No 11 December 2015 – January 2016 Page 12 – 13* outlined the level of aggression and violence occurring in the Yaralla PICU at Cumberland Hospital in the previous year (2014). Forty-Five assaults causing injury to nurses occurred over 34 months and referred to the Cumberland Hospital PICU as "One of Australia's most dangerous workplaces". The Nursing Unit Manager (NUM) of the unit sustained a severe brain injury during one altercation; other nurses also have had severe injuries.

Violence and aggression in acute mental health and PICUs is a well-known and a well-documented occurrence. Clients are often highly agitated, volatile and unpredictable. It would be negligent to place any nursing staff into this type of environment without the competency and education required to manage these clients and without the option of having seclusion available for the containment of highly volatile and aggressive clients. Doing so would be placing nurses in a situation that has a high probability of risk and high likelihood of serious harm occurring.

“When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not put themselves, their colleagues or mental health consumers at unnecessary risk.”

(The NSW Health ‘Aggression, Seclusion & Restraint in Mental Health Facilities in NSW’ PD2012_035, 2012, page 2)

The NSW Work Health and Safety Act 2011 No 10, Section 18, Subdivision 2, 18, What is “reasonably practicable” in ensuring health and safety,

- (a) the likelihood of the hazard or the risk concerned occurring, and
- (b) the degree of harm that might result from the hazard or the risk, and
- (d) the availability and suitability of ways to eliminate or minimise the risk,

The National Mental Health Standards 2010 Standard 2 Safety , states:

- 2.6 *The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.*
- 2.8 *The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care.*
- 2.9 *The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks.*

- 9) The risk to staff in acute mental health facilities is well known, clearly understood and documented in NSW Health policy. There is a foreseeable and predictable risk with a high likelihood of harm. Seclusion must remain an option in mental health facilities as a last measure to help mitigate the risk of violence to staff and patients.

Models of care

The recovery orientated model of care promoted by the National Standards for Mental Health Services 2010, requires knowledge of mental illness and individualised nursing care planning and nursing care provision.

Any skill mix that includes AINs requires a 'team nursing' approach. A team nursing model of care is a way of utilising less expensive skill mix strategies to reduce costs. Team nursing originated in the 1950's and 1960's. This is more of a custodial approach to care, with quality of patient care far from optimum. A better model of care option would be the 'primary nursing' model or a model of care similar to the 'Tidal Model'.

Primary nursing is individualised complete care with the goal of meeting all of the individualised client needs during their admission. These care models are more aligned to the recovery approach to mental health nursing care. The 'Tidal Model' helps to re-empower clients who have been disempowered by their mental illness and the intervention of mental health services.

"Any focused recovery approach, when applied to care-giving, uses the nurse /patient relationship, described so long ago by Peplau. In the context of this relationship, people in care should have a chance to tell their story and have it respectfully listened to, understood and valued"

'A Recovery Approach to Mental Health Care (Using the Tidal Model)', Turning the Tide Handbook, The Centre of Excellence in Interdisciplinary Mental Health University of Birmingham & Birmingham and Solihull Mental Health NHS Trust, 2008, page 10.

- 10) An appropriate model of care consistent with the recovery approach that complies with the National Mental Health Standards, should be adopted uniformly across all NSW mental health facilities to reduce confusion and promote consistency and knowledge on clinician responsibilities with care provision.

Specialling (1:1 nursing)

The Association has been contacted by a number of our members concerned that across NSW, LHD's specialling policies require the first special on the unit, to be taken out of the allocated rostered nursing numbers, leaving the unit short of the required full complement of rostered nursing staff as per NHPPD.

Another cost saving strategy by LHDs is to provide an unregulated worker such as an Assistant in Nursing (AINs) as the special. It is the view of the NSWNMA that this practice goes against evidenced based clinical practice and places the least qualified staff members responsible for managing the highest risk clients.

In a recent state-wide survey conducted by the NSWNMA across all sectors of nursing, it was revealed that the demand for specials in mental health was 42.16% of overall specials provided. The survey also highlighted that in 48% of respondents said additional staff was not provided, increasing the workload of those staff.

Experienced RNs were only provided in 16.33% of cases.

'Specials' require extra staff, Monday 29th May 2017,
(<http://www.nswnma.asn.au/specials-require-extra-staff/>)

- 11) All specials (1:1 nursing) must be in addition to the normal rostered staffing numbers for that shift and subsequent shifts until the special requirement is no longer required.

Leadership

There is a dire need for sound and clear clinical and management leadership at all levels, to help ensure adequate workforce development and the availability of evidence based prevention tools to successfully reduce seclusion use in NSW.

Leadership towards organisational change must provide guidance to staff on alternative and evidenced based clinical practice. Leadership by management is not demonstrated through the basic control measure of policies and checkbox list enforcement alone.

Adoption of a consistent model of care by the NSW Ministry of Health, consistent observation levels and processes, along with specialising protocols across NSW is long overdue, particularly as NSW Health has no policy on specialising of clients in MH inpatient Units.

- 12) Clear leadership with robust governance processes is required at all levels of management, this includes nursing leadership, with consistent State-wide processes and models of care will help drive the required culture change at all levels.

Conclusion

Numerous research projects and studies into seclusion and restraint have been conducted. The evidence is clear that seclusion use can be reduced with the right investment in the appropriate resources.

The NSWNMA is of the opinion that the complete elimination of seclusion as a management option would expose our members to a highly foreseeable risk. If this occurs how will NSW Health maintain the safety of staff working in this environment?

When patients present with psychosis or under the influence of illicit drugs such as 'ice' and require containment, it becomes an issue about safety, there needs to always be an option to address this type of situation when patients and nurses are at risk.

The specialty of mental health nursing appears to be at the mercy of cost constraints that are creating a situation where low cost, least qualified, unregulated staffing options are being utilised. We strongly advocate that all NSW LHDs adopt nurse to patient ratios as a minimum staffing level in their mental health services as the appropriate nursing numbers to be able to manage clients and their level of acuity safely.

LHDs need to employ mental health qualified nurses in mental health units to further comply with the National Mental Health Standards.

National Mental Health Commission's 'A case for change: position paper on seclusion, restraint and restrictive practices in mental health services', May 2015. Outlines six core strategies.

Three of the six core strategies we believe that need immediate attention are:

- 1) leadership to change,
- 2) workforce development and
- 3) the availability of seclusion and restraint reduction tools.

The twelve priority areas that the Association would like to see improved immediately to support the reduction of seclusion and restraint across NSW are:

- Appropriate staffing levels for patient numbers to ensure client and staff safety delivered through the extension of legally enforceable and minimum nurse to

patient ratios. The Association's claim for mental health staffing in inpatient and community is attached (appendix 2) with the exception of acute adult inpatient units, all claims since 2011 have been ignored at an unknown cost to patient safety.

- Appropriate skill mix for the acuity of clients on the unit to ensure client and staff safety.
- A formal state wide face to face education program on mental health observations developed for staff new to mental health units, similar to the 'Between the Flags', with a state wide roll out across all LHDs in addition to the online training modules for staff to complete.
- A consistent education and learning program across the LHDs for nurses new to the specialty of mental health nursing, similar in format to the '*Transition to Mental Health Nursing*' program for new graduates,
- Leadership by management to promote culture change with emphasis on recovery and trauma informed care.
- Mentoring and role modelling by competent and qualified senior mental health nursing staff of evidenced based care in the mental health services.
- Appropriate evidenced based clinical interventions and treatment options available on all mental health units to help support staff in reducing the use of seclusion and restraint.
- Employment incentives such as increased CNS II positions, to recruit and retain competent, qualified and experienced mental health nursing staff in mental health units to act as appropriate role models to new and inexperienced staff.
- A clearly articulated model of care, consistent across NSW, to provide a consistent framework for staff in mental health units, outlining care to be provided.
- Appropriately qualified nursing staff to perform all 'specials' as an extra to rostered staff, with no requirement for the first special to come out of rostered nursing numbers.
- Adopting technology as another method of monitoring inpatient mental health client's vital signs overnight and throughout the patient stay in acute care.

- immediate increased funding for more PICU/MHICU beds and units across the state, to reduce the exposure of clients and staff to the risks associated with managing very high risk clients within under resourced and inappropriately designed mental health units

This will be the starting point to helping our members feel supported and confident that they have adequate resources available to manage reducing seclusion and restraint in mental health units. The Association strongly believes that seclusion can be reduced, but should always remain an option as a management tool in mental health units.

'Despite the potential legal, ethical and clinical challenges associated with seclusion, it is likely that it will remain a part of psychiatric in-patient care for the foreseeable future. It is increasingly recognised as a necessary intervention to maintain individual patient safety and ensure the safe and therapeutic management of a psychiatric in-patient ward.'

Use of seclusion for managing behaviour disturbance in patients, Giles Newton-Howes, Advances in psychiatric treatment (2013), vol. 19, 422–428.

<http://apt.rcpsych.org/content/aptrpsych/19/6/422.full.pdf>

We want to avoid any situation where managers feel pressured to improve seclusion data without the appropriate resources in place, putting staff in a position where they feel more vulnerable and at high risk of harm to meet KPIs.

This will require a multifaceted approach and require the right leadership on all levels for this to be addressed. There is a perception of a disconnect between senior managers meeting KPIs and the front line clinicians which does not encourage a culture of change and engagement but rather pressure for management of risk using seclusion.

We strongly recommend a state wide rollout of face to face education for staff on the psychological impacts of seclusion and alternative options. Alongside a state-wide policy on seclusion and restraint, including a consistent state-wide observations framework for mental health.

This would align with and supplement the Deputy State Coroner's recommendation for HNELHD to provide regular education for nursing staff regarding completion of observation charts and accurate recording as recommended.

We need to ensure appropriate support for training is available to develop the nurses at the clinical level with the necessary competencies to work safely and be able to change the culture from budget driven to an effective recovery orientated and trauma informed care. This approach will be far more effective in reducing seclusion and restraint episodes and improve the safety and outcomes for clients.

Ms Kevin Ann Huckshorn, in her paper 'Reducing Seclusion and Restraint Use in Inpatient Settings: A phenomenological Study of State Psychiatric Hospital Leader and Staff Experiences' stated:

"Over time, most hospital staff learned new skills to avoid R/S use and demonstrated new beliefs, as evidenced by the data that show that R/S are now rarely used and only for dangerous behaviors (Figure 1 and Figure 2). Key challenges, such as a lack of resources, communication issues, staff uncertainty in practicing new ways of working, and an initial negative reaction to change, are common barriers to implementing organizational changes."
(page 44)

"The introduction of a new approach that engendered new thinking about R/S occurred initially through specific and credible external training; this training was seen as a key change agent." (page 45)

(Journal of Psychosocial Nursing and Mental Health Services · October 2014).

Mental health nurses will need support to strengthen the culture and to ensure they have the resources to drive the changes required to help reduce seclusion and restraint and ensure the safety of mental health clients through evidence-based best practice.

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Appendices

Appendix 1: NSW Nurses and Midwives' Association,
Assistants in Nursing (AINs) working in PICU: The evidence to oppose.

Appendix 2: NSW Nurses and Midwives' Association,
Ratios: A claim to put patient safety first.

Appendix 1:

Assistants in Nursing (AINs) working in PICU:

The evidences to oppose.

Introduction

The NSW Nurses and Midwives' Association (NSWNMA) firmly holds the opinion that Assistants in Nursing (AIN) are valuable members of the health care team, and this is supported by research. The NSWNMA strongly supports assistants in nursing with their role in assisting regulated nurses in the provision of nursing care where clinically appropriate.

The NSWNMA recognises the increasing trend for LHD mental health services employing unregulated health workers (such as AINs), in an attempt to reduce their costs.

The argument put forward by a number of NSW Local Health Districts (LHD) for employment of AINs in acute mental health is that it would free up the Registered Nurse (RN) from the mundane tasks and allow them to focus more on RN nursing duties.

The counter argument against employing AINs in acute mental health units is that it will lead to a negative impact on patient outcomes and the safety of both clients and staff, along with a corresponding rise in health care costs due to higher workers compensation costs and longer and more frequent client admissions.

The Director of Nursing, Mental Health Drug and Alcohol Services in a letter to the Hornsby Ku-ring gai Hospital Branch dated 18th May 2016, acknowledges "that the MHICU is an area of expert clinical skill and high acuity services".

Qualified and experienced RNs and Enrolled Nurses (ENs) in acute mental health areas are required to make informed clinical decisions based on their education and expert experience. This is paramount for delivery of optimal health care to clients and critical to maximising the safety of both clients and staff.

The NSWNMA position has always been that AINs should not be employed at the expense of registered or enrolled nurse positions and must be employed to provide nursing care where clinically appropriate.

The specialty of mental health nursing appears to be at the mercy of cost constraints that could see the highly qualified and experienced mental health nurse lose out to the cheaper, less qualified unregulated AIN. We must strongly advocate that all NSW mental health facilities employ RNs and ENs with the appropriate mental health experienced and/or mental health qualifications, in units such as PICUs/MHICUs and strictly adhere to the National Mental Health Standards.

General Comments

Role of AINs in a PICU

The definition Assistant in Nursing (Public Health) (AIN) as per the NSW Health 'Assistants in Nursing Working in the Acute Care Environment Health Service Implementation Package' 2009 (page 32), is:

- *“A worker who assists nurses to provide fundamental patient/consumer nursing care who is not licensed to practice as a registered or enrolled nurse/midwife.”*

The minimum educational requirement for an AIN working in NSW Health in any acute care environment is a Certificate III level qualification or is currently enrolled in a nursing degree programme as a student and has completed a minimum of 1 year study.

Their care activities are limited to basic nursing care only (these activities are outlined in the 'Assistants in Nursing working in the acute care environment, Health Service Implementation Package', NSW Health, 2009).

It must be noted that AINs are valuable members of the nursing team and have a distinct role in the provision of health care. It must also be acknowledged that their qualifications and knowledge in performing their role in specialised acute areas such

as acute mental health is quite restricted in comparison to the RN or EN with relevant mental health qualification and /or experience.

Communication is paramount to developing and maintaining the therapeutic relationship and model of care in mental health nursing. The AIN does not have sufficient grounding or understanding of the complexities of mental illness and the importance of communication in developing a rapport to build a therapeutic relationship with clients, limiting accessibility and ability to assess the level of risk with the client.

This lack of understanding will impact on the AINs ability to interact at a level that will allow them to sufficiently gauge the mental state of clients.

AINs are often required to work in areas with patients who need acute care without having the required knowledge, skills or competencies to manage the needs of acute care patients. Introducing AINs in such a critical and specialised area where communication, mental state observation and risk assessment, the core abilities required of nurses in acute mental health, are adding extra responsibilities onto the RN. This practice can only provide more opportunities for problems to arise, such as increased aggression and higher rates of seclusion.

The AIN has not had any of the essential formal education to provide a sound basis to further develop the required clinical knowledge, expertise, skills and competencies required for working in this highly specialised environment.

One of the major flaws in the proposal to introduce AINs to PICUs is that it only looks at the activities or role that an AIN can do in an acute care, low risk environment only. It is not examining the AIN in the context of a high acuity and high risk setting. There is no evidence of any risk assessment having been completed to evaluate the outcomes that would result from introducing AINs into the acute mental health setting.

The evidence provided by a risk assessment would highlight that this proposal would place the AIN at immense foreseeable risk with a high probability of harm.

To introduce an AIN into this type of environment without them having the appropriate education or level of clinical expertise and competencies would place them at risk and be in breach of the Work Health and Safety Act.

AINs at Increased risk of exposure

In a recent study conducted at the Northern Sydney LHD 'Direct care activities for assistants in nursing in inpatient mental health settings in Australia: A modified Delphi study', Cowan, Brunero, Lamont, Joyce, Collegian (2015) 22, 53-60, looks at the direct care activities that were seen as acceptable to be performed by AINs.

The paper provided consensus outcomes from a panel of nursing experts, on a number of possible activities that may be acceptable for the AIN in inpatient mental health settings. The panel of nursing experts held either senior management positions or clinical positions to the level of clinical Nurse Consultant.

The studies primary focus is in addressing some of the basic 'direct care activities' that may be applicable to AINs working in mental health. These basic direct care activities or 'tasks' that the AIN may be able to perform are more applicable to the medical/surgical wards or aged care sector rather than mental health specific.

The activities of care outlined in the study, were taken from the 'Assistants in Nursing working in the acute care environment' Health Service Implementation Package, *NSW Health (2009)*. But the study failed to address (*page 6*) the issue of:

"What is the ratio/average number of unstable patients that require constant application of technical skills beyond the scope of practice of an AIN?"

The average number of unstable patients in a mental health ICU is 100%, which is why they are held under the Mental Health Act.

We are of the view that in acute mental health services where clients are held under the Mental Health Act, the patients would have to be seen as requiring constant application of mental health nursing therapeutic skills and competencies. These therapeutic skills are beyond the 'scope of practice' of an AIN.

What was not found acceptable by this panel of nursing experts in this study was the activity of "Conducting MSE Notify of change of Mental State" (page 57). This finding from the study, when you have a clear understanding of the mental health assessment process, reinforces the argument against employing AINs in acute mental health settings.

The mental status examination (MSE) or mental state assessment is one of the core components of mental health nursing. It is an ongoing assessment of mental health clients functioning and risk.

The MSE is an appraisal of the mental health client's appearance, behaviour, mental cognition and overall bearing of a client. It is a "snapshot" of a person's mental state and helps in the assessment of risk at a given point in time.

The mental state examination takes into consideration the:

- Appearance
- Behaviour
- Mood and affect
- Speech
- Cognition
- Thoughts (content and process)
- Perception (Dissociative symptoms, delusions, Hallucinations)
- Insight and Judgement

The above, all contributes to the risk assessment and the management plan of the mental health client and is an ongoing activity performed during any interaction or engagement with the clients.

Mental health nurses are frequently faced with the need to manage client's very complex mental health symptoms. Clinicians working in highly volatile and intensive environments such as PICUs need to have the knowledge and skills to identify mental health symptoms, and have the competency to manage the symptoms quickly.

By not having the skill base or competency to perform a MSE, the AIN is at a disadvantage of not being able to monitor the client's ongoing mental state to assess if there is any deterioration or change in risk level, thus exposing them to an increased probability of risk and possibly a high degree of harm if there is any deterioration. No amount of orientation or 'on the job' education that may be provided, would mitigate the risks involved. The only safe option available would be to eliminate the risk by not employing the AIN in this type of work environment.

RN supervision of AINs

The RN usually has completed an undergraduate degree and often done further study such as a graduate diploma or Master in Mental Health at a University to specialise in mental health nursing.

"The effective care and treatment of mental disorders requires nursing staff to apply a combination of pharmacological, psychological and psychosocial interventions in a clinical meaningful and integrated way (WHO, 2001)."

(Mapping nursing activity in acute inpatient mental healthcare settings, Bee PE; Richards DA; Loftus SJ; Baker JA; Bailey L; Lovell K; Woods P; Cox D, Journal of Mental Health, April 2006; 15(2): 217 – 226, (Page 218)

Highly educated and experienced nursing clinicians are required to provide optimum care with managing clients who have often been detained under the mental health act due to their very high level of un-wellness and are often a danger to themselves and/or others. It must follow that clients who need this high level of observation and expert clinical management require the most skilled and highly qualified staff to care for them in the most therapeutically effective way during their admission to ensure best possible outcomes

"It may be as the informants in this study believed, that other units are unable to care for 'PICU patients' especially because of large spaces, limited structured environment and a lack of skilled staff."

(The core characteristics and nursing care activities in psychiatric intensive care units in Sweden, Salzmänn-Krikson M; Lützn K; Ivarsson A; Eriksson H, International Journal of Mental Health Nursing (2008) 17, 98–107, page 104)

A positive therapeutic relationship is necessary for a successful outcome for clients. The employment of staff with the clinical knowledge, experience and competencies to provide this intervention must be factored into the cost of staffing the unit. To achieve therapeutic interventions we must ensure that RNs who have mental health experience and the competencies to provide clinical interventions that develop and maintain a therapeutic relationship with their clients is the most cost effective way of managing clients in a PICU.

“This professional aspect of care relates to how psychiatric nurses change their approach within relationships and what makes these relationships professional and therapeutic. Therapeutic relationships differ from any other kind of relationships because psychiatric nurses are bound by a code of conduct and also a duty of care.”

“Individualized care in relation to how psychiatric nurses perceive the therapeutic relationship also describes a process of care provision in relation to continuous care by a team of nurses. Continuity of care is significant in relation to building therapeutic relationship.”

(Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study, Scanlon A, Journal of Psychiatric and Mental Health Nursing, 2006, 13, 319–329 Page 322)

Part of what shapes the therapeutic relationship is the code of conduct and a duty of care the nursing clinician works within. Professional accountability of the nursing clinician allows more autonomy in developing an individualised care plan and provides greater opportunities to develop rapport and build a therapeutic relationship with the client. These opportunities occur while the nurse assists the client during everyday living activities such as making their bed or assisting them with their showering. These ‘moments’ during the sharing of everyday activities provide an opportunity for the nurse to engage the client and build trust and develop a rapport, while allowing the nurse to explore and informally assess the mental state of the client. This allows an ongoing assessment and evaluation of the client in different settings and provide for better health outcomes than would be possible in a team nursing framework.

“The time that nurses spend with each patient in any inpatient mental health setting would conceivably include such activities as mental state assessment and assessment of risk, attempting to understand the patient’s perspective of their current situation, as well as implementing strategies to meet the care needs of those patients.”

(Care zoning in a psychiatric intensive care unit: strengthening ongoing clinical risk assessment, Antony Mullen, Vincent Drinkwater and Terry J Lewin, Journal of clinical Nursing (23, 731–743, doi: 10.1111/jocn.12493) 2013, page 732)

“Barker (1998), Chambers (1998), Peplau (1952) and Travelbee (1966) testify to the fact that the therapeutic relationship is ‘the rock’ on which psychiatric nursing is built. Therefore, a full and unequivocal understanding of what forms these relationships is paramount to performing the role of a psychiatric nurse.”

(Psychiatric nurses perceptions of the constituents of the therapeutic relationship: a grounded theory study, Scanlon A, Journal of Psychiatric and Mental Health Nursing, 2006, 13, 319–329 Page 320)

The qualifications, experience and competencies of the mental health nurses must be recognised. Mental health nursing is a specialty area and though a team (custodial) nursing care model appears less costly it will prove to be less effective resulting in poorer client outcomes and eventually cost more in the long term.

“However AINs’ knowledge/ skills base is significantly less than that of an RN. Indeed, Deshong and Henderson (2010) recognise that AINs often work with patients who need acute care, without the required knowledge or skills to adequately cope. Clarke (2004, p67) also supports this view, adding that ‘educated and experienced nurses’ often make informed clinical decisions which lead directly to positive patient outcomes”.

(Getting the mix right: Assistants in Nursing and skill mix, Shearer T, ANMJ Nov 13 vol 21 no 5 Page 26)

The *Mental Health Drug and Alcohol Services, Northern Sydney LHD, 'Assistant in Nursing Workforce Guidelines' 2014*, policy states that the AIN will be "responsible for their own actions and will remain accountable to the registered nurse for all allocated duties." But the registered nurse is still ultimately accountable for the actions and care provided to the client delegated to the AIN by the RN and responsible for the AINs safety, this means that the RN is not only accountable for the AINs actions but also any increased and foreseeable risk that provision of delegated care may place the AIN in.

The Australian Health Practitioners Regulatory Agency 'Decision Making Framework' would exclude RN s from delegating any activities to an AIN due to the fact that the AIN is lacking the education background and competency to be able to perform tasks in a safe manner as:

"the complexity of care required by the client indicates that a nurse should perform the activity, because specific knowledge or skill is needed"

Nursing practice decision flowchart narrative, Nursing-and-Midwifery-Board---Codes-and-Guidelines---National-framework-for-decision-making---September-2007 (page 8).

The AIN would require constant supervision from the RN as they are unable to perform a mental state exam (which provides an ongoing assessment of the client's mental state and risk level).

By having to constantly supervise the AIN, this would interfere with the ability for the RN to supervise and monitor the mental health of their own clients adequately.

High risk and probable Harm

The NSW Health 'Aggression, Seclusion & Restraint in Mental Health Facilities in NSW' PD2012_035 (2012) states:

"Health workers, particularly those who work in mental health units and emergency departments, carry a greater risk of work-related aggression than workers in many other occupations" (page 2).

*“Because mental illness and mental disorder can sometimes lead to diminished control, impulsivity and lack of ability to self-regulate behaviour,”
“Involuntary confinement and a feeling of lack of control can be distressing for anyone, particularly mental health consumers, and can preface an aggressive incident (Finfgeld-Connett, 2009)” (page 3)*

The Lamp article in *Volume 72 No 11 December 2015 – January 2016 Page 12 – 13* outlined the level of aggression and violence occurring in the Yaralla PICU at Cumberland Hospital last year. Forty-Five assaults causing injury to nurses in 34 months and on pages 14, referred to the Cumberland Hospital PICU as “One of Australia’s most dangerous workplaces”. The NUM sustained a brain injury during one altercation; other nurses have had similar injuries.

Violence and aggression in acute mental health and PICUs is a well-known and documented expected occurrence. The intensive structure and specialised clinical environment of a PICU with a high staff to Patient ratio 2:1 places clients at very close to ‘constant observation’. This is due to the fact that the clients are very unwell and a danger to themselves and or others. It must follow that clients who need this high level of observation require the most skilled and highly qualified staff.

Clients are often highly agitated, volatile and unpredictable. It would be negligent to place a minimally qualified worker such as an AIN into this type of work environment. Doing so would be placing the AIN in a situation that has a high probability of risk of harm and a high likely hood of serious harm. The mental health client would also be deprived of the opportunity of receiving the highest quality of care they need from highly qualified and competent nursing staff.

*“When making decisions about strategies to manage disturbed behaviour, it is important that health workers do not put themselves, their colleagues or mental health consumers at unnecessary risk.”
(The NSW Health ‘Aggression, Seclusion & Restraint in Mental Health Facilities in NSW’ PD2012_035, 2012, page 2)*

The NSW Work Health and Safety Act 2011 No 10, Section 18, Subdivision 2, 18,
What is "reasonably practicable" in ensuring health and safety,

- (a) *the likelihood of the hazard or the risk concerned occurring, and*
- (b) *the degree of harm that might result from the hazard or the risk, and*
- (d) *the availability and suitability of ways to eliminate or minimise the risk,*

The risk to staff in acute mental health facilities is well known, clearly understood and documented in NSW Health policy. Therefore there is a foreseeable and predictable risk with a high likely hood of harm that has a high possibility of permanent damage or even death.

The NSW Work Health and Safety Regulation 201, Chapter 3, General risk and workplace management, Part 3.1 Managing risks to health and safety.

34 *Duty to identify hazards*

A duty holder, in managing risks to health and safety, must identify reasonably foreseeable hazards that could give rise to risks to health and safety.

35 *Managing risks to health and safety*

A duty holder, in managing risks to health and safety, must:

- (a) *eliminate risks to health and safety so far as is reasonably practicable, and*

The NSWNMA is of the opinion that the only safe option available is to eliminate any exposure to the risk altogether by not employing AINs to work in this high risk environment.

To introduce an AIN into this type of environment knowing that they do not have the appropriate qualification or formal training that would ensure an appropriate level of clinical expertise and skill level to work in such a work environment would be in breach of the Work Health and Safety Act.

The National Mental Health Standards 2010 Standard 2 Safety, states:

- 2.6 *The MHS meets their legal occupational health and safety obligations to provide a safe workplace and environment.*
- 2.8 *The MHS can demonstrate investment in adequate staffing and resources for the safe delivery of care.*
- 2.9 *The MHS conducts a risk assessment of staff working conditions and has documented procedures to manage and mitigate identified risks.*

Employing AINs in acute mental health can be argued that it goes against the National Standards for Mental Health Services, Standard 2: Safety.

A more 'custodial' approach to inpatient care with less qualified staff will lead to a rise in aggression and will undoubtedly lead to more use of seclusion. A rise in aggression will result in an increased exposure to risk of injury for both clients and staff.

The recovery orientated model of care promoted by the National Standards for Mental Health Services 2010, requires knowledge of illness and individualised care. When AINs are included in the skill mix, a team nursing approach is required. The team nursing approach is a less desirable model especially in a PICU, due to the client presentation and profile, with clients suffering from an acute illness as a high level of skill and intensity of nursing required to manage their recovery safely and efficiently.

To comply with the National Mental Health Standards and as required by the Work Health and Safety legislation, the employer must either control the risk, which is not possible in this situation as the risk is too complex to have standard measures, therefore the risk must be eliminated, which can only be done by **not** employing AINs to work in this environment.

Due Diligence of Officers

There is a foreseeable risk involved of violence occurring in acute mental health units and having AINs as part of the skill mix in this intensive nursing environment would be exposing all in the acute care environment to an undue increased risk of harm.

The NSW Work Health and Safety Act 2011 No 10,

Division 4 Duty of officers, workers and other persons,

27 Duty of officers

- (1) If a person conducting a business or undertaking has a duty or obligation under this Act, an officer of the person conducting the business or undertaking must exercise due diligence to ensure that the person conducting the business or undertaking complies with that duty or obligation.*

Division 5 Offences and penalties

31 Reckless conduct—Category 1

(1) A person commits a Category 1 offence if:

- (a) the person has a health and safety duty, and*
- (b) the person, without reasonable excuse, engages in conduct that exposes an individual to whom that duty is owed to a risk of death or serious injury or illness, and*
- (c) the person is reckless as to the risk to an individual of death or serious injury or illness.*

Maximum penalty:

- (a) in the case of an offence committed by an individual (other than as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking)—\$300,000 or 5 years imprisonment or both, or*
 - (b) in the case of an offence committed by an individual as a person conducting a business or undertaking or as an officer of a person conducting a business or undertaking—\$600,000 or 5 years imprisonment or both, or*
 - (c) in the case of an offence committed by a body corporate—\$3,000,000.*
- (2) The prosecution bears the burden of proving that the conduct was engaged in without reasonable excuse.*

In order for Officers to practice their '*Due Diligence*', the only foreseeable control to introduce is the elimination of AINs from such high risk environments. Placing AINs at such a foreseeable risk should not be taken as an acceptable risk.

Skill mix

A common argument to employing AINs is that they will allow the RN to focus on more relevant nursing activities. The Northern Sydney LHD has expressed the intention to employ a staffing mix of 70% RN 20%EN and 10% AIN across all units of the LHD.

"Nurses have expressed concerns that changes to staffing are often made without evaluation of how the decisions will affect patient safety and that they may have adverse outcomes for patients, nurses and organizations (CNA, 2005, p. 1)."

Valuing Health-Care Team Members, Working with Unregulated Health Workers, A Discussion Paper. Pan- Canadian Planning Committee on Unregulated Health Workers 2008. (Page 10)

One common complaint is that the demand on the RNs time to oversee the AIN often becomes excessive, detracting from their ability to perform their own nursing activities adequately.

While trying to manage their own patient allocation they must also oversee and manage the duties not able to be performed by the AINs under their direct supervision for which the RNs are legally accountable.

Having a skill mix that includes AINs in an area such as a PICU significantly increases the RNs work load.

"a number of large international studies, mostly within medical–surgical units, indicate that as RN–patient ratios decreased, the level of work satisfaction decreased and burnout increased. Safety was also compromised as the RN–patient ratio decreased, that is, there was an increase in death from hospital complications and an increased mortality."

(Addressing the mental health nurse shortage: Undergraduate nursing students working as assistants in nursing in inpatient mental health settings, Browne, Graeme; Cashin, Andrew; Graham, Iain; Shaw, Warren, International Journal of Nursing Practice 2013; 19: 539–545, page 540).

Clearly, the introduction of AINs into mental health needs to be based on the available research that indicates changes in skill mix, where AINs are introduced, can have adverse effects on the care to consumers.

Therefore we would have to question the rationale for Northern Sydney adopting this approach to staffing of acute mental health units, when research and evidence does not support this proposition. In mental health this would mean higher risks of increased aggressive incidents and violence and higher risk of injury to clients and staff.

Consultation

The NSW Work Health and Safety Act 2011 No 10,
Part 5 Consultation, representation and participation

Division 1 Consultation, co-operation and co-ordination between duty holders

47 Duty to consult workers

(1) The person conducting a business or undertaking must, so far as is reasonably practicable, consult, in accordance with this Division and the regulations, with workers who carry out work for the business or undertaking who are, or are likely to be, directly affected by a matter relating to work health or safety.

49 When consultation is required

(d) when proposing changes that may affect the health or safety of workers

Consultation must take place before any changes are initiated in any work place, so any risks identified and appropriate ways of adequately managing or (if too complex to manage appropriately and safely as in this situation) elimination of the risks.

Conclusion

The NSWNMA firmly holds the opinion that Assistants in Nursing (AIN) are valuable members of the health care team, and this is supported by research. The NSWNMA strongly supports assistants in nursing with their role in assisting regulated nurses in the provision of nursing care where clinically appropriate.

Placing the AIN in the acute mental health environment would be placing the AIN in a situation that has a high probability or risk of harm as they would be expected to work in an environment that far exceeds their level of competency and scope of practice.

With the evidence provided it must be seen that the AIN is not capable of performing a role in the PICU for all practicable purposes.

- The push for AINs in acute mental health units including PICU is driven by cost saving and is very short sighted.
- There is no assessment of the risk that would result from this proposal as required under legislation.
- The PICU and indeed acute mental health nursing units have a high level of violence and aggression occurring with staff injuries resulting.
- AINs do not have the necessary skills to manage these acute complex and unpredictable clients, usually held under the 'Mental Health Act' (in itself an indication of their un-wellness).
- AINs are limited by their limited training and activities they are able to perform in this clinical environment.
- The skill mix would have an adverse impact on the RN's ability to perform their own work, and provide the expert interventions required, leading to a more unstable environment.
- This proposal does not meet the National Mental Health Standards for safety.
- Placing the AIN in the acute mental health environment would be in breach of the Work Health and Safety Act and regulations.

- There is foreseeable risk involved with the employment of AINs in acute mental health units and employing them in any acute unit with this knowledge could be argued as negligent.
- RNs could be seen to be negligent when delegating duties to AINs in such an environment.
- Short term cost saving is lost in the long term due to:
 - Increased aggression and possible client/staff injuries.
 - Poor patient outcomes, including higher rates of seclusion and longer more frequent admissions.
 - Increased workers compensation premiums and liability of risk.

The evidence provided in this document, highlights that the proposal to employ AINs in acute mental health facilities would place the AIN at immense foreseeable risk with a high probability of harm.

To introduce an AIN into this type of environment would place them at risk and be in breach of the Work Health and Safety Act.

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Ratios: A claim to put patient safety first

*Every patient, in every community, deserves the same level
of safe care*

2017

It's time to extend mandated ratios in NSW

Research indicates patient outcomes improve when nursing hours increase. With the strongest fiscal position in the country and a robust economic outlook, the NSW Government can afford to deliver more funding for improved ratios throughout the state.

Nurses and midwives have a professional responsibility to their patients to advocate for such improvements and call on the Berejiklian Government to put patient safety first by improving and extending legally enforceable mandated nursing hours / equivalent ratios within the *Public Health System Nurses' and Midwives' (State) Award*. New South Wales is now lagging behind other states, including Victoria and Queensland, which introduced nurse to patient ratio legislation in 2016.

It is incumbent on the Berejiklian Government to deliver these changes and make patient safety the priority in our health sector.

In addition to improving and extending nursing hours / equivalent ratios, nurses and midwives are seeking: guaranteed staffing for outpatient settings; specials provided whenever clinically needed; the payment of superannuation while on paid parental leave; pay for clinical advice when not rostered on; increased sick leave of 5 days; the payment of higher grade duties for all shifts, and 4 weeks minimum notice for display of rosters.

Our claim seeks to improve the staffing levels funded in non-tertiary hospitals to the same levels as tertiary referral city hospitals, ensuring patients receive the same level of safe nursing care, regardless of where they live or are treated.

Further details of our claim to put patients first are outlined in the following tables.

2017 Claims for Improved Staffing

They indicate the proposed minimum Nursing Hours Per Patient Day required for safe patient care for different ward types, averaged over one week. The equivalent ratios are also shown. Only nurses providing direct clinical care are included in the nursing hours / equivalent ratios. This does not include positions such as NUMs, NMs, CNEs, CNCs, dedicated administrative support staff and wardspersons.

Where the nursing hours / equivalent ratio provided in any particular unit is greater than the specified nursing hours / equivalent ratio, as at the commencement date of the 2017 Award, those nursing hours shall not be reduced. In the tables that follow, “in charge” means a nurse who does not have an allocated patient workload.

General Adult Inpatient Wards

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Peer Group B (Major Metropolitan and Major Non-Metropolitan Hospitals)	1:4	1:4	1:7	6 (includes some shifts staffed with an in charge)
Peer Group C (District Group Hospitals)	1:4	1:4	1:7	
Peer Group D (Community Acute and Community non-acute Hospitals)	1:4	1:4	1:7	
Peer Group F3 (Multi-Purpose Services – Acute Beds)	1:4	1:4	1:7	

This minimum staffing claim applies to all medical, surgical and combined medical/surgical wards in Peer Group B (Major Metropolitan and Major Non-Metropolitan Hospitals), Peer Group C (District Group Hospitals), Peer Group D (Community Acute and Community Non-Acute Hospitals) and Peer Group F3 (Multi-Purpose Services – Acute Beds). The staffing ratio expressed as nursing hours provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload. This claim is the same as currently legally mandated ratios/nursing hours for Peer Group A city hospitals.

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Peer Group F3 (Multi-Purpose Services – Aged Care Beds (Department of Social Services))	1:6	1:6	1:7	4.1

This minimum staffing claim will apply only to the Department of Social Services-funded beds of Peer Group F3 Multi Purpose Services.

Emergency Department (adult and paediatric)

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Resuscitation Beds	1:1	1:1	1:1	26
Level 4-6 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + 2 triage	1:3 + in charge + triage	8.67 + additional hours for in charge and triage
Level 3 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + triage	1:3 + in charge	
Level 2 Emergency Departments	1:3	1:3	1:3	8.67
EMUs	1:3 + in charge	1:3 + in charge	1:4 + in charge	7.83 + additional hours for in charge
MAUs	1:4 + in charge	1:4 + in charge	1:4 + in charge	6.5 + additional hours for in charge

This minimum staffing claim applies to adult and paediatric emergency departments according to their NSW Health designated level. This claim applies to beds, treatment spaces, rooms and any chairs where these spaces are regularly used to deliver care.

The claim includes emergency departments, emergency medical units, and medical assessment units (whether co-located with an ED or not) and other such services however named.

Additional hours must also be provided for in charge of shift and triage nurses across all shifts, where specified in the table above.

The minimum nursing hours / ratios will not include Clinical Initiative Nurses or any other nurse however named whose role has been introduced for a specific purpose. These roles are considered to be in addition to the minimum nursing hours / ratios.

Inpatient Mental Health

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Adult – in specialised Mental Health Facilities*	1:4	1:4	1:7	6 (includes some shifts staffed with an in charge)
Acute Mental Health Rehabilitation*	1:4	1:4	1:7	

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Child and Adolescent#	1:2 + in charge	1:2 + in charge	1:4	10.5 + additional hours for in charge
Long Term Mental Health Rehabilitation#	1:6 + in charge	1:6 + in charge	1:10	3.67 + additional hours for in charge
Older Mental Health#	1:3 + in charge	1:3 + in charge	1:5	7.33 + additional hours for in charge

This claim does not apply to adult acute mental health wards in general hospitals that are not 'specialised' mental health facilities. These wards currently operate with legally mandated 6 nursing hours/ratios equivalent. This claim does not apply to forensic or PECC units.

* This minimum staffing claim provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload.

In addition to this minimum staffing claim, additional hours must be provided for in charge of shift across two shifts.

Paediatrics

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
General Inpatient Wards	1:3 + in charge	1:3 + in charge	1:3 + in charge	8.67 + additional hours for in charge

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

Additional hours must also be provided for in charge of shift across all shifts as specified in the table above. Further additional hours must be provided for nurse escorts and work that in general adult hospitals would be described as 'ambulatory care'.

Neonatal Intensive Care Units

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge	26 + additional hours for in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge	13 + additional hours for in charge
Special Care Nurseries	1:3 + in charge	1:3 + in charge	1:3 + in charge	8.67 + additional hours for in charge

This minimum staffing claim applies across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts as specified in the table above. Further additional hours must be provided for work that may be described as discharge nurse, neonatal family support and transport nurse (including retrieval).

The Special Care Nurseries claim does not apply to the following named special care nurseries that perform CPAP, where the HDU claim will apply instead: Blacktown, Campbelltown, Gosford, Lismore, St. George, Tweed Heads, Wollongong, Coffs Harbour, Dubbo and Wagga Wagga.

Critical Care (Adult and Paediatric)

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge	26 + additional hours for in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge	13 + additional hours for in charge
CCU	1:2 + in charge	1:2 + in charge	1:2 + in charge	13 + additional hours for in charge

This minimum staffing claim applies to Critical Care units, including Intensive Care Units, High Dependency Units and Coronary Care Units across all Peer Groups. Additional hours must also be provided for in charge of shift across all shifts. Further additional staffing (eg. access nurse) may be clinically required and if so, should be provided.

Community Health and Community Mental Health services

The nature of Community Health and Community Mental Health services does not lend itself to the application of the nursing hours / equivalent ratios methodology. Instead, the application of a limit of face to face client contact hours in any shift will be a starting point to put patients first.

Community Health and Community Mental Health services require a limit of 4 hours of face to face client contact per 8 hour shift, averaged over a week to be applied in order to provide safe patient care.

The nature of the work of Community Mental Health Services Acute Assessment Teams requires them to have a limit of 3.5 hours of face to face client contact per 8 hour shift, averaged over a week to provide such care.

Work that is not included in this 'face to face hours' claim includes travel, meal breaks and administration (eg. phone calls to other health professionals or suppliers, paperwork), otherwise known as 'indirect care'. 'Face to face hours' may also be known as 'direct care'.

Short Stay Wards

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
High Volume Short Stay	1:4	1:4	1:7	6 (Includes some shifts staffed with an in charge)
Day Only Units	3.5 nursing hours per patient. This includes nursing staff time spent doing preparation, transfer and post-operative care prior to discharge			

This minimum staffing claim applies across all Peer Groups. The staffing ratio expressed as nursing hours for High Volume Short Stay provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload.

Drug and Alcohol Units

Specialty / Ward Type	Equivalent Ratios			Nursing Hours
	AM	PM	Night	
Drug and Alcohol Inpatients (discrete standalone units)	1:4	1:4	1:7	6 (Includes some shifts staffed with an in charge)
Drug and Alcohol Outpatients	These time-based figures can be converted to a 'nursing hours' model: Each initial assessment: 90 minutes Subsequent visits: 30 minutes (this includes case management) Dosing visits: 5 minutes			

This minimum staffing claim applies to the following Inpatient Units: Corella Lodge (Fairfield); Gormand Unit St. Vincent's Hospital; Herbert St. RNS; Lake View Newcastle; Wyong Hospital; Nepean Centre for Addiction; O'Connor House Wagga Wagga; Riverlands Lismore; Ward 64 Concord and Watershed Wollongong. The staffing ratio expressed as nursing hours for Drug and Alcohol Inpatients provides the option of rostering some shifts with a nurse in charge who does not also have an allocated patient workload.

Staffing Model: Maternity Services where Birthrate Plus does not operate

Intrapartum workload: A minimum of 1:1 midwifery care in labour and birth. This would increase to reflect the additional needs of higher risk categories of women.

Antenatal Care: 1.5 hours per booking-in visit.

Antenatal Care – Inpatients: Minimum of 3 hours per case – need to assess the workload including non-admitted Occasions of Service. The hours would increase as risk factors increase.

Postnatal Care – Inpatients: A minimum of 6 hours per case. This would increase to reflect the additional needs of higher risk categories of women.

Travel Allowance – Community Midwifery: A travel allowance (time factor) of 17.5% is added to the time allocated for each woman. This will be increased to 20% in some facilities to reflect local distances travelled.

Leave Relief, Mandatory and Essential Education for Midwives: Leave relief of additional 18.7% FTE is factored in when determining appropriate staffing.

Unplanned Antenatal workload in Intrapartum Services: The Birthrate Plus score sheet is used to attach hours to the additional work.

Additional workload within Intrapartum services: Additional hours are allocated to women with a 16 to 20 week gestation pregnancy loss and also for women with a pregnancy loss less than 15 weeks where cared for in the Birthing or antenatal/maternity unit.

Allocated midwife hours – elective caesarean section: A minimum 4 hours per elective caesarean section.

Antenatal Care – Outpatients clinics: Hours are determined by the type of treatment required.

Parental Education: The Birthrate Plus score sheet is used to attach hours to the additional work.

Unplanned Antenatal workload in Intrapartum Services: The Birthrate Plus score sheet is used to attach hours to the additional work.

Midwifery Models of Care: Hours are allocated for **Total continuity of care** i.e. all antenatal, intrapartum and postnatal care provided in the woman's home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases. Normal risk = 41 hours per case. **Note:** No high risk births in the total continuity of care model. This is because women who have or develop risk will not be cared for within this type of model.

This is due to the need for obstetric and/or medical and inpatient care.

Midwifery Models of Care: Hours allocated for **Partial continuity of care** i.e. all antenatal, intrapartum care with only postnatal care home. Care may occur in woman's home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases. Hospital postnatal care can be provided by hospital midwives (see above for hours). Normal risk = 36 hours per case. High risk = 40 hours per case.

Postnatal care in the Home: A minimum of 3 hours per case and would increase to reflect the additional needs of higher risk categories of women. In addition, a travel allowance appropriate to the maternity service (see above) is added to the mean hours.

This minimum staffing claim applies to all Maternity Services that do not use Birthrate Plus.

Staffing Model: Outpatients Clinics in the hospital setting

This minimum staffing claim applies across all peer groups. This is a new 2017 claim recommended by the NSWNMA clinical reference group.

All new referrals

Initial assessments 90 minutes or 1.5 nursing hours per patient.

Follow up clinics

Minor consultation and clinical review clinics: 15 minutes: 4 patients per hour or 0.25 nursing hours per patient.

Medium consultation clinics:

30 minutes: 2 patients per hour or 0.5 nursing hours per patient.

Complex treatment clinics within a multidisciplinary team:

60 minutes: 1 patient per hour or 1 nursing hours per patient. Certain Clinics may require 2 nurses for particular procedures (e.g. Vac dressings).

Hospital in home ambulatory clinic:

3.5 nursing hours per patient. In addition:

- Appropriate hours for case management should be included in the funded FTE to maintain a safe and holistic level of care for patients. This principle is inherent in the needs for patients in the community.
- Appropriate time for travel in the context of the local geography and traffic conditions must be factored into hours required for clinical workload.

Oncology and Dialysis:

1:1 plus in charge for complex patients.
1:3 plus in charge for non-complex patients.

Infusion/Treatment Centres:

1:1 plus in charge for complex patients.
1:3 plus in charge for non-complex patients.

Explanatory Notes

Outpatient Clinic Type	
Minor Consultation	Anti-coagulant screening, orthopaedic review, phone triage, screening tests, screening results, minor wound dressing, BCG vaccination.
Medium Consultation	Excision of minor lesions, rheumatology, cardiology respiratory function, immunology, co-morbidities /drug resistant/CALD clients, non-compliant, counselling /education, wound assessment and dressing, psycho-geriatric review.
Complex Clinics	Administration of infusions of less than 1 hour, complex wound assessment and treatment/dressing, complex burns dressing, biopsies, lumbar puncture; multiple co-morbidities and complex management.

Oncology - Complexity Criteria	Weight/Score
2 or more anti-neoplastic drugs	2
Vesicant drugs (requires continual observation of infusion site during drug administration)	2
Potential for hypersensitivity reaction	2
Multiple vital sign measurement during infusion/transfusion	2
ECG recording prior to or during/infusion	2
Pre-treatment checking of blood results	1
Pre-treatment assessment of toxicities from previous cycles/days of anti-neoplastic drug administration in the current course	1
Baseline vital signs prior to administration of anti-neoplastic drug therapy or infusion or procedure	1
Observation period / measuring of vital signs post completion of anti-neoplastic drug therapy or infusion or procedure	1
Other assessments prior to treatment, e.g. urinalysis, weight	1
Total Score (if ≥ 5 , categorised as a 'complex patient')	
Criteria: For any treatment with a score of 5 or more, the treatment is complex. This would have the advantage of enabling a 'complexity rating' of new therapies.	

Infusion / Treatment Clinics	
1:1	Phototherapy and Dermal clinics Toxicity of treatment, Portacath access, Blood Transfusions, Biological agent injections, Iron infusions etc
1:3	All other infusions types.

Clinical Nurse / Midwifery Educators

Record numbers of new graduates continue to be employed. To ensure that new practitioners consolidate their practice, an additional 275 Clinical Nurse / Midwifery Educators working across seven days and all shifts need to be employed.

Ancillary mechanisms for putting patients first

To put patients first, some existing ancillary arrangements need to be improved to make them more responsive to patient need.

Existing arrangements that need improvement include:

- Patients clinically assessed as needing specialised care in addition to the rostered nursing hours for all wards or units. It is clinically inappropriate for specialised care to be within rostered nursing hours because it takes time away from other patients. Patient safety must not be compromised by squeezing the budget and taking care hours away from other patients in a ward where specialising is required.
- The mechanism for determining average patient numbers needs revision as it is evident to all nursing practitioners that 'the midnight census' does not accurately reflect the needs of patients.
- The *2010 Health Service Implementation Package for AINs in Acute Care* needs to be more rigorously applied across NSW Health facilities to ensure an appropriate level of care.

Other claims – changes to existing Award provisions

Vary subclause (ii) of Clause 8 Rosters, to require local hospital management to display the roster at least four weeks prior to the commencing date of the first working period of the roster.

Vary subclause (i) of Clause 24 Higher Grade Duty to remove the requirement to act in higher grade duty for minimum continuous period of a least five working days before Higher Grade Duty applies.

Vary Clause 25 Overtime to provide for the payment of overtime when a clinician provides clinical advice when they are not rostered to work.

Vary Clause 34 Maternity, Adoption and Parental Leave to provide for the payment of superannuation during paid parental leave.

Vary Clause 37 Sick leave to increase sick leave entitlement from 10 day to 15 days.

No right to bargain

Our wages claim in the context of the *Industrial Relations (Public Sector Conditions of Employment) Regulation 2011*

Since the NSW Coalition Government's introduction of the *Industrial Relations Amendment (Public Sector Conditions of Employment) Act 2011* and the *Industrial Relations (Public Sector Conditions of Employment) Regulation 2011*, there has simply been no legal capacity for public sector workers in this State to achieve a pay increase higher than that mandated by the Government without direct trade-off of hard won conditions.

Through the Government's manipulation of industrial laws, the most that is supposed to be given to NSW nurses and midwives is 2.5% per annum, unless trade-offs are made. This is regardless of their increasing skill levels, their levels of real productivity or any of the other factors that normally affect wage fixation. The new legal regime is neither fair nor does it constitute a genuine bargaining process.

In this context and consistent with the *NSW Public Sector Wages Policy 2011*, the Association claims a 2.5% salary increase to all Award classifications and allowances starting from the first pay period to commence on or after 1 July 2017.