SA Nursing/Midwifery Enterprise Agreement
Staffing Model Appendix 2

Business Rules
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1. Introduction

This document provides an overview of the South Australian Nursing and Midwifery Staffing Model and Nursing/Midwifery Hours per Patient Day (N/MHPPD) Business Rules which have been developed as part of the Nursing/Midwifery (SA Public Sector) Enterprise Agreement 2013 (NMEA 2013). Specifically, the methodology is outlined in NMEA 2013 clause 3.1, safe staffing levels and sub-clause 3.1.2 stipulates that the SA Department for Health and Ageing (DHA) and Australian Nursing and Midwifery Federation (ANMF SA Branch) will develop business rules to support the operation of the staffing model.

There are two key parts to the Business Rules:

a) Processes to support the application of the model.

b) Process for determination or review of N/MHPPD for new patient care areas or those that significantly change service profile (reference NMEA 2013 sub-clause 3.1.9).

The Business Rules support:

> The translation of NMEA 2013 provisions to practice, in relation to N/MHPPD staffing.
> Consistent and compliant application of the NMEA 2013.
> Guidance regarding system changes necessary to implement SA N/MHPPD.

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

The SA N/MHPPD Business Rules applies to patient care areas listed in Appendix 2 that utilise a N/MHPPD approach to staffing.

The SA N/MHPPD Model will be progressively implemented in relevant patient care areas across SA Health with full effect in March 2014 (or as soon as practicable thereafter).

2. Background

For the past twenty-five years between 12 and 14 of the largest public hospitals in South Australia (SA) have used ExcelCare, an electronic clinical nursing and midwifery care planning system which incorporates a staffing resource tool. ExcelCare will soon be superseded by the implementation of the new clinical multidisciplinary information system, Enterprise Patient Administration System (EPAS); the vehicle for delivering a state-wide electronic health record (EHR) within South Australia. EPAS incorporates patient/client care planning functionality but does not include a staffing resource calculation therefore an alternative staffing model and methodology needed to be developed.

ExcelCare is no longer a requirement for staffing in the NMEA 2013 however, the care-plan functionality will continue to be utilised until EPAS has been rolled out at individual sites.

In addition to ExcelCare areas, it was agreed to apply the new staffing methodology to relevant country health unit sites that previously used the Country Staffing Methodology (reference NMEA 2010), wards/units utilising Clinical Practice Support (CPS) system and other relevant patient care areas using a ratio or set staffing model as listed in Appendix 2.
3. SA N/MHPPD Staffing Model

As part of the NMEA 2013, SA Health and ANMF (SA Branch) reached agreement on the SA N/MHPPD Staffing Model as documented and described in Clause 3.1; safe staffing levels. This new methodology provides minimum staffing arrangements for patient care areas listed in Appendix 2 of the NMEA 2013 and other relevant patient care areas by agreement.

The minimum staffing arrangement outlined in Appendix 2 is not intended to be applied as a daily minimum, but as a minimum that is achieved by averaging daily staffing over the relevant 14 or 28 day period (refer 4.2). If, in a particular patient care area there is a need to disaggregate the specified annual N/MHPPD to reflect seasonal demand, the N/MHPPD will be averaged over the year with the end result being the Appendix 2 N/MHPPD. Sites must identify with SA Health and ANMF (SA Branch) patient care areas that have a historical seasonal demand prior to implementation of Appendix 2, so that this N/MHPPD patterning can be confirmed. Any disaggregation must result in achieving the annual average N/MHPPD set out in Appendix 2 over the full year and cannot result in a lowering of the minimum staffing standards set for the year.

Post implementation of Appendix 2 if a patient care area is subsequently identified as having seasonal N/MHPPD demand patterning, consideration for disaggregation of N/MHPPD will occur as part of the agreed change process (refer to Section 5. SA N/MHPPD Review Process).

Overall, Appendix 2 is based on staffing arrangements that were in place prior to the commencement of the new Agreement. For most patient care areas this is a N/MHPPD approach, however in some areas nurse/midwife to patient ratios or set staffing levels apply.

> N/MHPPD relates to the average number of direct nursing or midwifery hours a patient receives per day on a particular ward/unit.

> A nurse/midwife to patient ratio refers to the number of patients, on average; each nurse/midwife is assigned to care for over a specific period.

> Set staffing levels refers to a set number of staff over a particular period.

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

In developing the SA N/MHPPD (Appendix 2) for patient care areas that staffed to ExcelCare, statewide data was analysed to ensure a robust data set to underpin the new model. For patient care areas that use or apply a staffing methodology other than ExcelCare, consensus was reached in consultation with Directors of Nursing/Midwifery (DON/M), SA Health and the ANMF (SA Branch) with an agreed review period.

The intent of clauses (3.1.2 and 3.1.3) is that Appendix 2 will commence operation during March 2014. Until then, and subject to the provisions of the ensuing paragraph, the status quo (base roster) as at 6 November 2013 will be preserved.

Inpatient care areas listed in Appendix 2 of the NMEA 2013 will migrate during March 2014, or as soon thereafter as practicable, from the status quo nursing hours to the staffing levels listed in Appendix 2 provided that no significant gain or loss occurs. Tolerance levels from status quo to the appendix number have been agreed as:
No increase to hours > 0.10 N/MHPPD
No decrease to hours > 0.15 N/MHPPD

N/MHPPD for patient care areas asterisked (** in Appendix 2 of the NMEA will be reviewed following endorsement of these Business Rules and will be completed by 6 March 2014, or sometime thereafter as practicable. The agreed priority areas for review include asterisked patient care areas within:

- Mental Health
- CHSALHN
- SALHN
- CALHN
- NALHN

Over the life of the NMEA 2013, staffing levels for patient care areas listed in Appendix 2 can be reviewed following the agreed change process outlined in the Business Rules where there is an identified trigger for change (refer to Section 5. SA N/MHPPD Review Process).

The implementation of the SA N/MHPPD model will be undertaken by SA Health/ANMF (SA Branch) in a way that allows for the ongoing development and refinement of the model to achieve consistent nursing/midwifery hours and nurse/midwife to patient ratios across SA Health and an agreed SA Health/ANMF (SA Branch) SA N/MHPPD Review Process supports this paradigm.

The parties have agreed to review the Business Rules six months post implementation of Appendix 2 staffing levels. Any revised Business Rules must still operate consistent with the terms of the principal agreement.

4. SA N/MHPPD Business Rules

The Business Rules have been developed to support the operation of clause 3.1 of the NMEA 2013 and will be applied in a manner subject to, and consistent with the provisions of the NMEA 2013, and include:

- Projected (or base roster) staffing for an upcoming roster cycle (reference NMEA 2013 clause 3.1.5.1) and how N/MHPPD can be used to calculate staffing for a patient care area.
- Daily staffing (reference NMEA 2013 clause 3.1.12).
- Benchmarking and review process to determine or alter N/MHPPD and support consistency (reference NMEA 2013 clause 3.1.9).

4.1. Country Health Services Casualty/Emergency Department (as in NMEA 2010)

Country health unit sites will use the staffing methodologies as set in NMEA 2013, Appendix 2 (non-standard based units).
In health unit sites where:

- For any period of 1 week or more; or
- For any shorter period during which increased demand is reasonably predictable; and
- Where there is forecast demand for a minimum of 3 nursing hours during the period of any nursing shift within a casualty/emergency department provided by the site; then
- In addition to the staff indicated by the country staffing methodology specified by NMEA 2013 Appendix 2 and in addition to the demand for other shifts periods indicated by 0.6 NHPPC for casualty, the health unit site shall roster such additional nursing hours as may be necessary to provide full and separate staffing to the casualty/emergency department during that shift.
- For example, if during a holiday period the casualty/emergency department of a country hospital experiences an increase in demand which lasts for longer than 1 week, it shall provide additional staff on shifts where the casualty/emergency department requires nurse cover for 3 hours or more.
- For a period of less than 1 week or where demand was not able to be reasonably predicted, the increase in demand for casualty/emergency services shall be met by use of casual or agency staff, recall or overtime.

4.2. Converting N/MHPPD to a staff plan and creating a projected (base) roster for a 14 or 28 day cycle

The following spreadsheet/table has been developed to assist in the calculation of staffing numbers per fortnight for the patient care area, in meeting the agreed N/MHPPD, which subsequently forms a staff plan for the base (projected) roster.

To use the tool:

1. Enter the agreed N/MHPPD for the patient care area and the number of beds expected to be occupied or utilised on a regular basis for the period for which staffing is to be determined. This will provide the sum of total direct nursing/midwifery hours the patient care area should roster each period.
2. Enter the shift length in hours, for the different shifts.
3. The unit manager (Clinical Service Coordinator (CSC)/Nurse Management Facilitator (NMF) or delegates) can use the tool to allocate direct care nursing resources across the different shifts over the course of the relevant period, with due regard to expected care needs of patients/clients and the workload pattern of the patient care area.
4. The goal is to match and balance the roster with the agreed N/MHPPD for the patient care area.
5. The projected (base) roster should provide for appropriate skill mix.
6. Direct care hours are included in the calculation table. The shift coordinator (who may or may not have a patient load) is counted towards the direct care hours.
7. Other indirect care hours are excluded.
4.3. Daily staffing

**Applying the N/MHPPD staffing model to occupied beds**

The staffing methodology used shall be consistent with the principle of ensuring the number of nurses/midwives available to work is commensurate with the number of patients requiring care, and their care needs.

Average occupancy may not reflect variations in patient numbers. The CSC (or equivalent) will monitor staffing regularly to ensure that the N/MHPPD or ratio is balanced over the relevant period, taking into account occupancy and/or acuity and/or skill mix.

**Managing demand**

Appropriate staffing will be provided to meet patient demand.

When, on a shift, the CSC (or delegate) considers that patient care needs cannot be sufficiently met from the nurses/midwives immediately available and the CSC (or delegate) considers additional nursing/midwifery hours should be provided in order to meet clinical
needs, the CSC (or delegate) will inform the appropriate Nurse Manager/Nursing Director who, together with the CSC, will consider a solution in line with local escalation processes, such as following options:

- Reallocation of patients
- Prioritization of nursing/midwifery activities within the patient care area
- Deployment of nurses/midwives from/to other patient care areas
- Additional hours for part time staff
- Overtime
- Engagement of casual/agency nursing staff

Where sufficient nursing/midwifery staff are not available, the CSC (or equivalent) may, with approval from the DON/M (or delegate) limit admissions when discharges occur from the patient care area. Such approval will not unreasonably be withheld.

Where demand requires fewer staff, staffing may be reduced and/or redeployed to another patient care area, subject to compliance with relevant Award provisions or an individual’s employment contract.

**Daily staffing ‘Ready Reckoner – example**

The ‘Ready Reckoner’ is a tool to assist in the checking and balancing of nursing/midwifery hours. It should be noted that this provides an indication only of the average N/MHPPD per day, recognising that direct care nursing/midwifery hours to be balanced over the defined period.

<table>
<thead>
<tr>
<th>INSTRUCTIONS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Enter the Nursing/Midwifery Hours Per Patient Day (N/MHPPD) for your ward (as per EA 2013 Section 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td>Enter the number of expected occupied beds or equivalent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 3</td>
<td>Enter the correct shift lengths for early, late and night shifts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 4</td>
<td>Enter the number of nurses/midwives required per shift, to match the available hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 5</td>
<td>Ward might allocate a shift coordinator or in-charge with no patient allocation, counted within the hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Nursing/Midwifery Hours per Patient Day (N/MHPPD) | 6 | | |
| Number of Expected Occupied Beds or equivalent | 24 | Hours per day Available | 144 |

<table>
<thead>
<tr>
<th>Early</th>
<th>Late</th>
<th>Night</th>
<th>Total Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift Length</td>
<td>8</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Number of staff</td>
<td>7</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Nursing/Midwifery Hours per shift (per day)</td>
<td>56</td>
<td>48</td>
<td>40</td>
</tr>
</tbody>
</table>

*indicates that the value can be changed* 0 hours still to be balanced
4.4. Reporting Requirements

**N/MHPPD data source**

Nursing/midwifery hours are sourced from the staff rostering system, ProAct for metropolitan health unit sites and Country Health SA (CHSA) health unit sites; Port Pirie, Port Augusta, Mount Gambier and Whyalla.

**Patient activity data source**

Patient/client activity (occupied beds) is sourced from the relevant patient administration system.

**Future period demand roster cycle**

For all metropolitan health unit sites and the following CHSA health unit sites; Port Pirie, Port Augusta, Mount Gambier and Whyalla, the period within which the hours must be balanced is 14 days.

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

**N/MHPPD reporting requirements**

In all Metropolitan Hospitals and the 4 CHSA (Mount Gambier, Port Augusta, Port Pirie and Whyalla), inpatient care areas will provide reports to the ANMF (SA Branch) on a quarterly basis of the agreed and actual staffing levels for each relevant patient care area for the preceding quarter. These N/MHPPD reports will be an average of the hours used against the patient activity (Occupied Bed Days) for each fortnight during the quarter. Reports to include the following data:

- Local Health Network/Hospital
- Inpatient Care Area
- Reporting period
- Agreed N/MHPPD
- Average Occupied Bed Days
- Actual N/MHPPD

These reports will exclude 'standards based clinical areas' listed in Appendix 1 NMEA 2013 and outpatient/ambulatory services. Reporting will commence from 1 July 2014 and the first quarterly report will be provided in October 2014. In the event of material variation (clear trend) of staffing below or above the agreed N/MHPPD, then SA Health or ANMF (SA Branch) will initiate a process to resolve the matter.

Country Health SA Local Health Network sites listed in Appendix 2 of the NMEA 2013 (excluding ExcelCare sites and minimum staffed wards) will submit a copy of their base relevant roster(s) to ANMF (SA Branch) on or before 6 March 2014, or as soon as practicable thereafter. Where there is a material change to staffing from that set out in the base roster, ANMF (SA Branch) will be advised by the Executive Director of Nursing and Midwifery.
Direct care hours included in N/MHPPD report

Nurses/midwives providing direct nursing care only are included for reporting purposes. This is inclusive of the hours provided by permanent/temporary (full time and part time), casual and agency, relieving pool, overtime and call back.

Indirect care hours not included in the N/MHPPD Report

Other indirect hours, are not included.

N/MHPPD definition and calculation

> N/MHPPD is the average number of direct nursing/midwifery hours a patient receives per day
> Number of N/MHPPD x number of Occupied Bed Days = total number of direct nursing/midwifery hours per day
> Total direct nursing/midwifery hours divided by Occupied Bed Days = N/MHPPD
> Nursing/midwifery hours are calculated on the shift duration provided to the patient care area by the nurse/midwife (excluding any unpaid meal break) starting from the shift start time, regardless if the shift overflows to the next day or next roster.
> Non-productive hours relating to nurses/midwives on any type of paid leave are excluded from the N/MHPPD calculation (including, but not limited to: personal/carers’ leave, annual leave, workers compensation, study leave, maternity leave, compassionate leave, family leave, parental leave, accrued day off, professional development leave, etc.)
> Patients on leave are not counted in the activity data
> Qualified babies are included

4.5. N/MHPPD Data Dictionary

<table>
<thead>
<tr>
<th>Data Item</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productive nursing/midwifery hours</td>
<td><strong>The sum of direct, indirect and overtime hours</strong></td>
</tr>
<tr>
<td>Direct hours</td>
<td>The sum of nursing/midwifery hours that deliver direct patient care at any time</td>
</tr>
<tr>
<td>Indirect hours</td>
<td><strong>The sum of nursing/midwifery hours that are not related to direct patient care.</strong></td>
</tr>
<tr>
<td>Non-productive hours</td>
<td><strong>The sum of any type of paid leave for nurses/midwives. This includes but is not limited to: annual leave, personal/carers’ leave, professional development leave, maternity leave, parental leave, programmed day off, etc.</strong></td>
</tr>
<tr>
<td>Direct Nursing/Midwifery Hours per Patient Day</td>
<td>The average number of direct nursing/midwifery hours a patient receives per Occupied Bed Day</td>
</tr>
<tr>
<td>Occupied Bed Days</td>
<td>Daily bed census data averaged over a specified preceding</td>
</tr>
<tr>
<td>Expected Bed Days (in determining projected/base roster)</td>
<td>The number of beds that are expected to be occupied or utilised on a regular basis</td>
</tr>
<tr>
<td><strong>Average Daily Occupancy</strong></td>
<td>The number of Occupied Bed Days divided by specified number of days the unit is open within a given timeframe (i.e. calendar month, year)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Clinical Nursing/Midwifery Specials</strong></td>
<td>Patients that require 1:1 nursing/midwifery care following clinical assessment guidelines. Depending on patient mix, acuity and patient numbers within the ward/unit this may or may not be able to be accommodated within the N/MHPPD. Additional resources may be required consistent with professional judgement of CSC or equivalent (Refer Section 4.2.2).</td>
</tr>
<tr>
<td><strong>Skill Mix</strong> <em>(as per EA 2013, clause 3.3)</em></td>
<td>Ratio of Registered Nurse/Midwife (RN/M) to Enrolled Nurse/Assistant in Nursing/Midwifery</td>
</tr>
<tr>
<td></td>
<td>In health unit sites (other than country health unit sites) the skill mix for inpatient units is 70:30 registered nurse/midwives to enrolled nurses/assistant in nursing/midwifery.</td>
</tr>
<tr>
<td></td>
<td>Graduate nurses/midwives are to be included in the RN/M ratio but are not, unless otherwise agreed between the parties, to be rostered as the only registered nurse/midwife in a health unit site or patient care area in the first 6 months of employment.</td>
</tr>
<tr>
<td><strong>Application of N/MHPPD</strong> <em>(as per EA 2013)</em></td>
<td>Multiply the N/MHPPD for the patient care area by the number of beds that are expected to be occupied or utilised on a regular basis for the period for which staffing is to be determined and then multiply the product by the number of days in the period within which the hours must be balanced. This informs the base roster.</td>
</tr>
</tbody>
</table>

**5. SA N/MHPPD Review Process**

**Overview**

As per NMEA 2013, clause 3.1.9, DHA/ANMF (SA Branch) may agree during the life of the Agreement to alter the agreed staffing levels, where

- There is a significant change to the patient population of the patient care area:
  - For example: a patient care area significantly changes specialty focus (medical to surgical focus)

- There are significant changes in practice, equipment or to models of care that may impact on the requirement for nursing/midwifery staff:
  - For example: significant changes to models of care, nursing/midwifery workload elements/tasks or changes underpinned by SA Health Care plan and health reform agenda

- There are significant changes to the distribution of work across times of the day and/or days of the week:
  - For example: changes to the type or distribution of work
> There are any significant changes to the environment in which work is performed:
  - For example the physical location of a patient care area changes

The patient care area/Local Health Network will identify the need and grounds for review to the DON/M through submission of a business case. Alternatively the ANMF (SA Branch) may initiate the review process by letter to the DON/M setting out the grounds for change upon which ANMF (SA Branch) believes that such a review is necessary. The grounds must relate to the criteria set out in the Business Rules.

**The process**

Consultation with the ANMF (SA Branch) will be initiated by the health unit site to determine whether there should be adjustment, by agreement of the parties, to the stipulated N/MHPPD. The process will have regard to efficient practice in other similar patient care areas in SA public health services or from areas which provide care to similar groups of clients/patients. The process will include a review of N/MHPPD allocation based on characteristics such as patient complexity and acuity, intervention levels, resource consumption, existing agreed N/MHPPD for similar units and current efficient practices in SA Public Hospitals.

As per NMEA 2013 (clause 3.1.9.2), the process will include:

> Consultation with staff in the determination of appropriate N/MHPPD
> Consultation with CSC/staff in the distribution of nursing/midwifery hours over the relevant period

Typically the process will include (see flow chart pg.16), but is not limited to, the following steps (in no particular order):

<table>
<thead>
<tr>
<th>Step</th>
<th>Review Item</th>
<th>Example Tool</th>
</tr>
</thead>
</table>
| 1    | Site/patient care area/ANMF (SA Branch) to initiate a review/analysis that may lead to a request to change the agreed staffing as per Appendix 2. Supportive evidence/data collated, this may include but is not limited to:  
  > Current status  
  > Comparison to similar patient care areas  
  > Existing agreed N/MHPPD for similar units and current efficient practices in SA Public Hospitals  
  > Change in complexity/ clinical mix  
  > Efficient Price Index  
  > Acuity  
  > Average length of stay (ALOS)  
  > Significant change in patient turnover  
  > Occupied Bed Days – averaged  
  > Emergency/ elective admissions  
  > Other factors, for example Births  
  > Proposed N/MHPPD requirements or ratio, skill mix and staff plan | Local Health Network/SA Health Business Case Profoma |
Ward/unit considerations (may include but not limited to)

### Service profile
- What are the main specialties / type of beds mix for the ward/unit?
- What is the maximum bed capacity of the ward/unit?
- What is the average occupancy of the ward/unit?
- How many hours per day is the ward/unit open?
- On average, how many outliers are admitted on the ward/unit per day?
- Acuity
- Procedure type/ intervention level
- Weight of case mix separation
- Average length of stay
- Births

<table>
<thead>
<tr>
<th></th>
<th>Significant change in the patient care area environment or clinical/administrative supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The patient care area is benchmarked against other ‘like’ areas and current efficient practices including within SA hospitals (NMEA 2013 clause 3.1.9.1 and 3.1.9.2.) This process will take into consideration a range of factors such as the level of hospital (i.e. Tertiary, General or Country) and the type of ward, i.e. medical, surgical, mixed, paediatric, adult and/or specialty with “like” wards, nursing/midwifery weights. Indicators may include, but are not limited to, DRGs, casemix, Efficient Price Index, patient turnover, environment (i.e. geography), administrative and clinical support in order to identify the range of N/MHPPD/staffing ratios and skill mix.</td>
</tr>
<tr>
<td>3</td>
<td>Consultation and feedback by patient care area/site/ANMF (SA Branch) (including member consultation) regarding proposed staff model.</td>
</tr>
<tr>
<td>4</td>
<td>Local approval; draft proposed N/MHPPD or staffing ratio endorsed by Executive DON/M and CEO (or alternative). Recommendations made with subsequent approval by SA Health and the ANMF (SA Branch). This formalised agreement will override the NMEA 2013 Appendix 2 provisions and will not require approval by the IRCSA. Note where agreement cannot be reached, dispute resolution processes as outlined in NMEA 2013 may be utilised.</td>
</tr>
<tr>
<td>5</td>
<td>Evaluation post implementation</td>
</tr>
</tbody>
</table>
Patient Turnover

- What is the number of average admissions per day?
- On average, how many patients per day are admitted via ED?
- On average, how many patients per day are admitted via elective, including DOSA and Outpatient?
- What is the number of average transfers in per day?
- What is the number of average transfers out per day?
- What is the number of average discharges per day?

Model of Care

Staff profile

- Number of core staff on duty per day
- Do any staff members on duty cover additional roles/ or provide consultative service outside of the unit?
- Is there other clinical nursing support provided from other designated nursing roles to the unit?
- Mix of staff

Supportive Staff: number of days/ hours of supportive staff coverage

- Administrative support (ward clerk)
- Ward ancillary
- Orderly, if applicable
- Others

Ward geography

- Physical layout
- Number of nurse stations
- Number of single rooms
- Bed bay configuration

Equipment/ Technology

- Patient medication storage
- DDA cupboard
- Equipment storage
- Equipment availability
- Phone access
SA N/MHPPD Staffing Model Process for Change (NMEA 2013 Appendix 2 Wards/Units)

Flow Chart
1. Trigger for review of Appendix 2 N/MHPPD or ratio (patient care areas)
2. Gather support evidence/data collation
3. Benchmarking
4. Consultation and feedback loop (local level and the ANMF (SA Branch))
5. Local approval – proposed NMHPPD or ratio endorsed by DON/M and CEO (or alternate)
6. SA Health/ANMF (SA Branch) formal agreement re change (If not agreed dispute resolution)
7. Evaluation post implementation