Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015
Implementation guide
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Implementation guide
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Minister’s foreword

Nurse-to-patient and midwife-to-patient ratios mean better care and better outcomes for patients.

The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 is landmark legislation for Australia, and is arguably the most comprehensive nursing and midwifery staffing legislation in the world.


Under the Act, minimum numbers of nurses and midwives per patients are preserved.

This means that Victorian patients can be assured that nurses and midwives will be able to continue doing what they do best, which is deliver outstanding patient care. Furthermore, this legislation will protect the integrity of our highly respected nursing profession into the future.

I would like to thank Victoria’s hardworking nurses and midwives, and the Australian Nursing and Midwifery Federation, who have all worked so hard to see this legislation introduced and passed.

This guide has been prepared to assist hospital operators, nurses and midwives with the implementation of the Act which puts patients first and will assist in building a stronger health system for all Victorians.

Hon Jill Hennessy MP
Minister for Health
## Definitions and abbreviations

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>the Act</td>
<td>Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015</td>
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<tr>
<td>the Agreement</td>
<td>Nurses and Midwives (Victorian Public Sector) (Single Interest Employers)</td>
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<td></td>
<td>Enterprise Agreement 2012–2016</td>
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<td>CWMA</td>
<td>Current Workload Management Arrangement, as defined by clause 4(f)</td>
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<td></td>
<td>of the Agreement</td>
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<td>the department</td>
<td>Department of Health and Human Services</td>
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<td>Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios)</td>
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<td>Regulations 2015</td>
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<td>Secretary</td>
<td>Secretary of the Department of Health and Human Services</td>
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Purpose

This guide will assist operators of hospitals, and nurses and midwives to implement the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015. It outlines the scope and intent of the new legislation, and can be used to prepare for commencement of the Act and beyond.

While the Act will have minimal impact on hospitals, operators of hospitals should have processes in place to ensure the correct compliance and application of ratios once they become law.

Operators of hospitals must also understand their responsibilities and obligations, and be able to effectively communicate key parts of the legislation to affected employees.

It is equally important that nurses and midwives understand the legislation and have the necessary knowledge of how ratios and variations to ratios are applied in their workplace.

This guide is a resource for all parties affected by the Safe Patient Care Act.
Background

The Victorian Government has committed to enshrine the nurse-to-patient and midwife-to-patient ratios contained in the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016 (‘the Agreement’) into legislation.

Public health services use these ratios to determine nurse and midwife staffing levels in Victoria, and they form the basis for the current workload management arrangements as outlined in the Agreement.

These arrangements have been in place since 2000, and they are traditionally set out in Schedule C of the Agreement.

Legislating ratios takes them off the bargaining table in future industrial negotiations.

The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 ensures that ratios for the number of nurses and midwives per patient in Victorian public hospitals will be retained into the future.
Scope of the Act

The Act replicates the arrangements and scope of the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016. Hospitals and wards covered by the Agreement are the only services that are impacted by this legislation. Wards or services within public hospitals that are not already obliged to meet ratios are not impacted by this legislation. These services are predominantly same-day hospital services where patients do not stay overnight – such as day surgery, day procedural, chemotherapy and renal dialysis areas within public hospitals.

Victorian public mental health services and private and not-for-profit hospitals, day procedure centres and private residential aged care facilities are covered by different enterprise agreements. Therefore, they will not be covered by this Act.
About the Act

The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 will be the first piece of legislation to guarantee nurse and midwife staffing in a state or territory’s public health services. Legislating ratios will protect them during future industrial negotiations.

The Act closely replicates the arrangements and scope in the current enterprise agreement, and includes provisions that allow health services the flexibility to negotiate variations to meet the changing nature of health and the evolving needs of the Victorian patients.

The Act comprises four main components:

1. It codifies nurse-to-patient and midwife-to-patient ratios for certain ward types as set out in the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016. Specifically, the intent is to replicate ratios as set out in Schedule C of the Agreement.

2. It codifies arrangements for certain public facilities and unions to agree to variations of nurse-to-patient and midwife-to-patient ratios. These arrangements are replicated from clause 42 in the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016.

3. It outlines processes for managing disputes, compliance and reporting of matters relating to the Act.

4. It sets out the process for transitioning to the Act where non-compliance may exist, and the saving of arrangements that may exist relating to ratios and variations to ratios under the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016.

About the Regulations

Regulations give effect to particular sections of the Act and specify more detailed processes.

The Regulations that exist for this Act relate to the operation of:

• operating theatres (s. 25[2]), specifying prescribed criteria whereby the operator of a hospital may reduce or increase the number of nurses with whom an operating theatre is staffed
• variations from ratios (Division 4 of Part 2), specifying prescribed considerations, principles, requirements and procedures relating to a proposal to vary a ratio.
• local dispute resolution (s. 41[2]), specifying prescribed criteria for how a local dispute must be resolved.


Recommended action

Operators of hospitals should put in place processes to ensure all nurses, midwives and managers are familiar with the Act and Regulations.

This should include making copies of the Act and Regulations accessible.
Applying the ratios

Nurse-to-patient and midwife-to-patient ratios must be applied to every ward specified in the Act. Furthermore, ratios need to be applied on the basis of the actual number of patients in each ward. Where the number of patients drops below the number for which a ward is staffed, the number of nurses or midwives may be adjusted before the start of a shift. Extra beds above those that would normally be staffed can only be occupied by a patient if the required numbers of nurses or midwives are available to meet the ratio provisions within the Act. Importantly, ratios are a minimum requirement and the Act is not intended to prevent the operator of a hospital from staffing a ward with additional staff beyond the number required by the ratio if there is reason to do so.

Recommended action
Operators of hospitals should ensure documentation is readily available to demonstrate:

- compliance with baseline nursing and midwife ratio levels
- process for recruiting to baseline nursing and midwife ratio levels
- process for reporting of nurse and midwife ad hoc replacement.

Flexible application of ratios and rounding method
The Act contains provisions for the flexible application of ratios.

A ratio may be applied in a flexible way in order to evenly distribute workload, having regard for the level of care required by patients in the ward.

The ratios within the Act provide the minimum numbers of nurses or midwives for a ward based on the number of actual patients within that ward. The Act does not require each nurse or midwife within that ward to be allocated to care for the same number of patients.

For example, in a ward with eight patients and a one-to-four ratio, if three patients require a higher level of care, and five patients require a lower level of care, then one nurse may be assigned to care for the three patients requiring the higher level of care, and the other nurse to the other five patients.

This may legitimately result in some nurses and midwives either being assigned fewer or more patients than prescribed in the relevant ratio.
Rounding method

The Act contains provisions for a method of rounding when the number of patients in a ward or the number of beds (as the case requires) is not divisible into a whole number when a ratio is applied.

Where the actual number of patients in a ward requires less than or equal to 50 per cent of one additional nurse or midwife, the operator of the hospital is not required to roster an additional nurse or midwife.

Where the actual number of patients in a ward requires greater than 50 per cent of one additional nurse or midwife, an additional nurse or midwife must be rostered.

Higher or lower demand than expected

Where the demand for beds is high, the operator of a hospital may only open additional beds if the additional nurses or midwives required under the ratio provisions are available and engaged to ensure ongoing compliance with the ratio requirements.

Take for example the case in which a ward of 28 physical beds usually has only 24 of those beds occupied by patients. As the ward normally only plans to have nurses to cover the 24 occupied beds, the hospital operator can only open the four beds that are normally unused if additional nurses are assigned to the ward to meet the ratio requirements for 28 occupied beds for the period that the additional four beds are open and occupied.

If the actual or expected number of patients on a particular day falls below the number of patients for which a ward is staffed in accordance with a ratio, the number of nurses or midwives may be adjusted down before the start of a shift.

Take for example a ward that has the physical capacity for 32 patients and normally has 32 actual patients. If before the start of a shift there are only 28 patients with no additional patients expected, the hospital may legitimately choose to make those beds unavailable for admission for that next shift.

The hospital may apply the appropriate ratio based on 28 patients in that ward for the next shift, and may adjust down the number of nurses or midwives in accordance with the ratio requirements before the start of that shift.
Applying the ratios in residential aged care

When reviewing ratios in residential care facilities, refer to the definition of aged high-care residential wards and high-care beds within the Act.

The definition includes only residential aged care services that are operated by hospitals within the meaning of the Act, and that have been approved as a provider by the Commonwealth within the meaning of the *Aged Care Act 1997*.

The Act is not intended to apply to any residential aged care services operated by private or not-for-profit organisations that are not captured within the definition of hospital in the Act.

The nurse-to-patient ratios in the Act are intended to apply only to high-care allocated places within the meaning of the *Aged Care Act 1997* as at 30 June 2014, while specifically excluding any high-care allocated places that are used for people receiving aged-persons mental health residential care as funded by the Department of Health and Human Services.

Additionally, the nurse-to-patient ratios are not intended to apply to any low-care allocated place within the meaning of the *Aged Care Act 1997* as at 30 June 2014.

Nurse-to-patient ratios for residential aged care facilities apply to an allocated place within the meaning of the *Aged Care Act 1997* and remain fixed, rather than applying to the actual level of care required by the resident, which can vary over time.

Take for example a residential aged care service operated by a hospital (as defined by the Act) that has 60 beds. Those beds include 30 high-care allocated places, 20 high-care allocated places where funding is provided by the Department of Health and Human Services for aged persons mental health residential care, and 10 low-care allocated places. The nurse-to-patient ratios in the Act apply only to the 30 high-care allocated places, irrespective of the care requirements of the residents using the beds at any given time.

**Recommended action**

Operators of aged residential care facilities should ensure documentation is readily available regarding allocated high-care places as of 30 June 2014.
Variations to ratios

As was the case with the enterprise agreement, an operator of a hospital, a nurse or a midwife can propose a variation to a ratio.

Importantly, operators of hospitals must take into account multiple factors when considering a variation with the primary consideration being the impact on the quality of patient care.

Additionally, the Regulations provide that any proposal to vary a ratio must consider, so far as relevant:

- the profile of patients in the ward as to age, expected length of stay, complexity of treatment and case mix
- the capacity of the nurses or midwives with which the ward is staffed to complete their duties within the existing rostered number of nursing or midwifery hours
- clinical risks to the quality of patient care, including risks of falls, medication errors, sepsis, thrombosis, pressure ulcers, pneumonia and urinary tract infections
- the occupational health and safety of the nurses or midwives with which the ward is staffed, including the physical environment of the ward
- the engagement of the nurses and midwives with which the ward is staffed

A template to assist the operator of a hospital, or a nurse or midwife to develop a proposal to vary a ratio to document these considerations can be found in Appendix 1.

When a proposal to vary a ratio has been implemented after having complied with the requirements set out in the Act and the accompanying Regulation, the operator of the hospital is taken to comply with the relevant ratio or requirement under the Act.

The Act and Regulations outline the following options that can be considered as part varying from ratio.

Redistribution of nursing or midwifery hours

An operator of a hospital, or a nurse or a midwife may propose that the hours generated by nurse-to-patient or midwife-to-patient ratios on a particular ward be redistributed or increased within the ward over a specified period.

Section 33 of the Act and Regulation 7 provide more details about redistributing nursing or midwifery hours.

Below-ratio distribution

An operator of a hospital, or a nurse or a midwife may propose that the hours generated by nurse-to-patient or midwife-to-patient ratios on a particular ward not be fully used for a specified period.

Section 34 of the Act and Regulation 8 provide more details about below-ratio distribution.

Alternative staffing model

The Act sets out provisions whereby the operator of a hospital may propose that an established alternative staffing model based on nursing hours per patient day is trialled instead of applying a ratio.

Section 35 of the Act and Regulation 9 provide more details about alternative staffing models.
Local agreement to vary

The operator of the hospital and a relevant union may enter into an agreement to vary either a ratio, or the application of a rounding method.

Operators of hospitals and a relevant union can use this part of the legislation to address local issues or requirements via negotiation and agreement between the affected parties.

Section 36 of the Act and Regulation 10 provide more details about local agreements to vary.

**Recommended action**

Operators of hospitals should ensure documentation is readily available to demonstrate:

- any formally agreed variation to ratio
- a local process is in place to support any proposal to apply a variation from ratio.

Any party considering entering into an agreement should seek advice from their own nominated representative.
Compliance, reporting and enforcement

Local dispute resolution

Any nurse or midwife who works at a hospital covered by a ratio, or a relevant union, may at any time notify the operator of the hospital of an alleged breach of a ratio or a ratio variation. A local dispute must then be resolved in accordance with the prescribed resolution process as outlined in Regulation 11.

All parties involved in the dispute must act in good faith and make a genuine effort to resolve the matter before the matter can be referred to the Magistrates’ Court.

Figure 1 shows the procedures contained in Regulation 11.

Figure 1: Local dispute process

- Aggrieved employee or relevant union notifies the operator of the hospital in writing of alleged breach via their immediate supervisor.
- Without prejudice to the outcome of the local dispute, the operator of the hospital must, as soon as practicable after the notification suspend the course of conduct alleged to constitute a breach of the ratio or ratio variation for the duration of the resolution procedures set out in the local dispute resolution Regulation.
- Operator of hospital must arrange a meeting within 48 hours after the notification, or as otherwise agreed, between aggrieved employee, or their representative, and immediate supervisor, or their representative, to discuss local dispute.

Dispute resolved?

- Has the aggrieved employee, or their representative, made a request for a meeting within 48 hours, or as otherwise agreed, after the end of the previous meeting?
- Has the operator of the hospital arranged a meeting on their own initiative within 48 hours after the end of the previous meeting?

Dispute resolved?

- The operator of the hospital must arrange a meeting within 48 hours, or as otherwise agreed between the aggrieved employee or their representative and a representative of the operator other than the immediate supervisor.

Dispute resolved?

- Either party can refer the matter to the Magistrates’ Court.
Referral to Magistrates’ Court

With the introduction of the Act, the jurisdiction for which disputes relating to nurse-to-patient and midwife-to-patient ratios has changed.

The enterprise agreement operates under federal law, whereby the Fair Work Commission and the Federal Court had jurisdiction for matters relating to ratios.

Now, under state law, the Act provides for an alternative compliance regime under the jurisdiction of the Magistrates’ Court, with the Magistrates’ Court decision being reviewable on a question of law to the Supreme Court.

Referral of matters to the Industrial Division of the Magistrates’ Court can occur after a local dispute process provided for in the Act and Regulations has been followed and there is no reasonable possibility of the matter being resolved. Where any party fails to comply with the dispute resolution procedures set out in the Regulations, the dispute may be taken to be not able to be resolved and therefore may be referred to the Magistrates’ Court. Any person making a referral to the Magistrates’ Court must notify the Secretary of the Department of Health and Human Services within seven days.

Figure 2: Overview of dispute resolution process

- Nurse, midwife or relevant union notify hospital of alleged breach
- Local dispute resolution process followed in good faith
- Matter unable to be resolved
- Application to the Industrial Division of the Magistrates’ Court
- Person making application must also notify the Department of Health and Human Services Secretary within seven days of application

Magistrates’ Court process

Following an application to the Industrial Division of the Magistrates’ Court, the proceeding shall be listed for a directions hearing and the court will notify the parties of that date.

At the directions hearing the presiding Magistrate will endeavour to ascertain the matters in dispute between the parties and explore the possibility of settlement. If the proceeding cannot be resolved at the directions hearing it will be either:

- referred for mediation to be conducted by a Judicial Registrar of the court at a date to be arranged, or
- listed for hearing before a Magistrate sitting in the Industrial Division.

The current rules of the industrial division of the Magistrates’ Court are shown in Figure 3.
Figure 3: Magistrates’ Court processes relating to the Act

Application to Magistrates’ Court

Directions hearing with Magistrate

Dispute resolved

Directions hearing with Magistrate

Dispute not resolved

Mediation with Judicial Registrar

Dispute not resolved

Hearing before Magistrate

Dispute resolved following declaration by the Magistrate

Finding that the operator of the hospital did comply with:
- a ratio
- ratio variation, or
- good faith consultation with respect to proposing and making and ratio variation.

Finding that the operator of the hospital did not comply with:
- a ratio
- ratio variation, or
- good faith consultation with respect to proposing and making and ratio variation.

Principal Registrar to notify the Secretary of the making of the declaration.

Hospital to report the finding, any civil penalty issued and the action taken relating to the matter.
Power of Magistrates’ Court

If a local dispute cannot resolve a matter, an application can be made to the Magistrates’ Court:

1. to make a declaration on whether or not an operator of a hospital complied with:
   - a ratio
   - a ratio variation
   - a requirement to undertake consultation in good faith with respect to the making of a ratio variation.

2. to grant an injunction restraining the operator of the hospital from contravening or continuing to contravene:
   - a ratio
   - a ratio variation
   - a requirement to undertake consultation in good faith with respect to the making of a ratio variation.

Injunctive relief

Following an application to the Magistrates’ Court, an interim injunction may be granted restraining the operator of a hospital from engaging in or continuing the current course of conduct. If an interim injunction is granted, the Magistrates’ Court must then determine the application as a matter of urgency.

If the Magistrates’ Court grants an injunction, it must notify the Secretary of the Department of Health and Human Services within seven days.

If an injunction is granted, the operator of the hospital must report this in their next annual report.
Civil penalty

If the Magistrates’ Court declares that the operator of the hospital did not comply with a ratio or ratio variation, a civil penalty not exceeding 60 penalty units may be applied. This penalty can only be applied if the actions of the hospital were deemed to be wilful and serious.

When the Magistrates’ Court makes a declaration, it must notify the Secretary of the Department of Health and Human Services within seven days.

If a civil penalty is issued, the operator of the hospital involved in that matter must report in their next annual report the finding of the Magistrates’ Court, the amount of the penalty issued and the action taken during that year relating to the matter.

Figure 4: Process to apply to the Magistrates’ Court

Costs of Magistrates’ Court

When making an application to the Magistrates’ Court, any costs incurred for filing an application or for mediation are to be paid for by the party making the application.

If a matter is resolved in favour of the party making the application, costs may be incurred by the other party in the dispute. This would be a matter for the Magistrates’ Court to decide.
Powers of the Secretary

The Secretary of the Department of Health and Human Services may give a written Safe Patient Care Direction to the operator of a hospital for the purpose of giving effect to the objective of the Act in relation to:

- a requirement that the operator comply with a ratio or a variation to ratio, including a requirement arising out of a declaration made or injunction granted by the Magistrates’ Court
- any other matter or thing necessary or appropriate to be directed in order to give effect to the objective of the Act.

In providing a Safe Patient Care Direction, the Secretary must also provide a copy to any member of the public on request, and to any relevant union within a reasonable timeframe after giving the direction.

The Act requires the operator of a hospital to which a Safe Patient Care Direction is issued to comply with that direction.

Procedure for giving Safe Patient Care Compliance Direction

The Secretary must provide the operator of a hospital with a copy of the proposed Safe Patient Care Direction and provide 48 hours notice before issuing the direction.

The operator of the hospital is able to provide written feedback before the direction is given. Any feedback from the operator must be taken into account by the Secretary when determining whether the direction is to be given and the content of the direction. The operator of a hospital must comply with the direction and report in their annual report.

Figure 5: Procedure for giving Safe Patient Care Compliance Direction

1. The Secretary provides the operator of the hospital a copy of the proposed Safe Patient Care Compliance Direction 48 hours before officially given.
2. Operator of hospital reviews proposed direction and provides written feedback before the proposed direction is issued.
3. Secretary reviews feedback.
4. Secretary takes feedback into account and determines whether to give the direction, and the nature of the direction if it is to be given.
5. If direction given, operator complies with direction.
6. Operator reports direction in annual report.
Reporting responsibilities

Operators of hospitals are obliged to report the following outcomes in their annual report of operations for a financial year:

- any finding by the Magistrates’ Court that the operator of a hospital:
  - did not comply with a ratio
  - did not comply with a variation to a ratio, or
  - did not consult in good faith with nurses, midwives and relevant unions in respect of a proposed variation to ratio
- any action taken as a result of the Magistrates’ Court finding
- any injunction that may have been granted by the Magistrates’ Court
- whether a civil penalty was imposed by the Magistrates’ Court, and if so the amount of that penalty
- any Safe Patient Care Compliance Direction.

Legislative compliance

Matters of legislative compliance related to the Act need only be reported in an annual report where an adverse finding has been made by the Magistrates’ Court.

Recommended action

Operators of hospitals should have relevant policies and procedures in place to ensure:

- all employees are aware of their obligations to act in good faith during a ratio dispute
- hospital operators should ensure a process is in place to meet the reporting requirements under the Act.

Operators of hospitals should incorporate the compliance and reporting requirements of the Act into their legislative compliance monitoring program.
Savings and transitional arrangements

Pre-existing higher staffing arrangements

The Act sets out provisions for preserving agreed and pre-existing higher-than-ratio staffing arrangements. For this to occur the following must exist:

- A formal written agreement by someone with the appropriate authority, outlining staffing arrangements on a ward. In general terms, an agreement would be expected to come from the Department of Health and Human Services, the Victorian Hospitals Industrial Association or the operator of a hospital.
- Approved funding by a person or body that has responsibility for providing that funding, except in the case of an agreement at a hospital level to provide equivalent full-time nurses or midwives with no additional recurrent funding. In general terms, the person or body that has responsibility to provide funding is usually the Department of Health and Human Services.

The section relating to saving pre-existing higher-than-ratio staffing is not intended to apply to any above-ratio or higher staffing arrangements that are in place but have not been the subject of formal correspondence specifying the nature of the arrangements. Formal correspondence is intended to mean letters on the letterhead between the parties to the Agreement or a hospital, or not intended to include rosters, minutes of meetings or emails.

Hospitals may propose to vary these pre-existing high staffing arrangements using the provisions in the Act, specifically Division 4 of Part 2.

Pre-existing lower staffing arrangements

The Act sets out provisions for managing pre-existing lower-than-ratio staffing arrangements. The section outlines that any below-ratio CWMA that is in effect immediately before the Act commences is recognised by the Act and able to continue for a period of 12 months.

There may be instances where a hospital has not traditionally met the ratio requirements of an enterprise agreement for a number of reasons, including a lack of available nurses or midwives within the local labour market to employ.

The intent of this section is to allow any hospital that has traditionally had staff levels below the ratio requirements in the Act to have 12 months to determine whether they are able to meet the requirements.

If a health service cannot meet the requirements, it can use the provisions in Division 4 of Part 2 of the Act to ensure that variations from the ratios are legitimately captured and documented to ensure ongoing compliance with the Act.
Pre-existing variations to ratios

The Act sets out savings provisions for any pre-existing variations from ratios that have been the subject of a clause 42 proposal under the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016 and that were in effect immediately before the commencement of the Act.

Saved variations from ratios that have been subject to clause 42 of the Agreement may include:

- redistribution of nursing hours
- below-ratio distribution
- alternative staffing model.

Furthermore, a saved variation would include any arrangement (other than those above) made under the Agreement that allows a hospital to staff a ward with a lower number of nurses or midwives than is required by a ratio, and is in effect before the commencement of the Act. These other arrangements are taken to be an existing local agreement under the Act.

It is intended that any variation previously proposed and implemented under the Agreement does not need to be refreshed due to the commencement of the Act, and are taken to be a ratio variation under the relevant provision in Division 4 of Part 2 of the Act.
Figure 6: Process for reviewing pre-existing higher/lower staffing arrangements and pre-existing variations to ratios

<table>
<thead>
<tr>
<th>Review current staffing levels against required ratio</th>
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<tr>
<td><strong>Staffing levels meet required ratio</strong></td>
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<tr>
<td>➔ No further action required</td>
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<tr>
<td><strong>Staffing levels below required ratio</strong></td>
</tr>
<tr>
<td>➔ No formal documented below ratio arrangements</td>
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<tr>
<td>➔ Formal documented below ratio arrangements</td>
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<tr>
<td><strong>Staffing levels higher than required ratio</strong></td>
</tr>
<tr>
<td>➔ Higher staffing that is not subject of a formal written agreement</td>
</tr>
<tr>
<td>➔ Higher staffing is subject of a formal written agreement as per clause 47 of the Act</td>
</tr>
<tr>
<td><strong>Pre-existing variation to ratio implemented</strong></td>
</tr>
<tr>
<td>➔ Saved variations from ratios that have been subject to Clause 42 of the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016 may include a:</td>
</tr>
<tr>
<td>➔ redistribution of nursing hours</td>
</tr>
<tr>
<td>➔ Below ratios distribution</td>
</tr>
<tr>
<td>➔ Alternative staffing model</td>
</tr>
<tr>
<td>➔ No further action required</td>
</tr>
<tr>
<td><strong>Action:</strong> Within 12 months of commencement of Act operators of hospitals:</td>
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<tr>
<td>➔ implement actions to meet ratio, or</td>
</tr>
<tr>
<td>➔ use provisions in Division 4 of Part 2 of Act to ensure that any variations from the ratios are legitimately captured and documented.</td>
</tr>
<tr>
<td>➔ No further action required</td>
</tr>
<tr>
<td>➔ No further action required</td>
</tr>
<tr>
<td>➔ Staffing levels must be saved as part of Act</td>
</tr>
<tr>
<td>➔ No further action required</td>
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</tbody>
</table>
Recommended actions

Operators of hospitals should ensure documentation is readily available for:

- any variation to ratio made in accordance with clause 42 of the *Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016* prior to commencement of the Act
- any formerly funded higher-than-ratio arrangements
- any local agreement previously made covering an arrangement (other than a clause 42 proposal under the Agreement) that allows a hospital to staff a ward with a lower number of nurses or midwives than is required by a ratio.

Operators of hospitals should liaise with their representative for further advice on managing existing below ratio arrangements.
Summary of recommended actions

Introduction of the Act and Regulations
1. Operators of hospitals should put in place processes to ensure all nurses, midwives and managers are familiar with the Act and Regulations. This should include making copies of the Act and Regulations accessible.

Application of ratios
2. Operators of hospitals should ensure documentation is readily available to demonstrate:
   • compliance with baseline nursing and midwife ratio levels
   • process for recruiting to baseline nursing and midwife ratio levels
   • process for reporting of nurse and midwife ad hoc replacement.

3. Operators of aged residential care facilities should ensure documentation is readily available regarding allocated high-care places as of 30 June 2014.

Variations to ratios
4. Operators of hospitals should ensure documentation is readily available to demonstrate:
   • any formally agreed variation to ratio
   • a local process is in place to support any proposal to apply a variation from ratio.

5. Any party considering entering into an agreement should seek advice from their own nominated representative.

Compliance, reporting and enforcement
6. Operators of hospitals should have relevant policies and procedures in place to ensure:
   • all employees are aware of their obligations to act in good faith during a ratio dispute
   • hospital operators should ensure a process is in place to meet the reporting requirements under the Act

7. Operators of hospitals should incorporate the compliance and reporting requirements of the Act into their legislative compliance monitoring program.

Savings and transitional arrangements
8. Operators of hospitals should ensure documentation is readily available for:
   • any variation to ratio made in accordance with clause 42 of the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016 prior to commencement of the Act
   • any formerly funded higher than ratio arrangements
   • any local agreement previously made covering an arrangement (other than a clause 42 proposal under the Agreement) that allows a hospital to staff a ward with a lower number of nurses or midwives than is required by a ratio.

9. Operators of hospitals should liaise with their representative for further advice on managing existing below-ratio arrangements.
Appendix 1: Considerations for a variation to ratio

The following template has been developed to assist hospitals, nurses or midwives when proposing a variation to ratio under Part 2, Division 4 of the Act. This template may be utilised to form part of the any proposal being developed.

**Quality of care (mandatory to complete)**

Outline quality of care factors for patients on the ward:

Key questions may include:

- What are the key measures of ‘quality of patient care’ for nurses/midwives on the ward?
- How is the ward currently performing against these measures?

What is your data source?

How will the proposed variation from ratio impact upon/respond to quality of patient care on the ward?
Patient demand
If relevant to the proposal outline how many patients (on average) you have in the ward:

Key questions may include (where appropriate):
- What are the approximate patient numbers?
- Does this vary due to demand at different time?
- Does it vary on different days of the week?
- What are the primary causes of any variation?

What is your data source?

How will the proposed variation from ratio impact on / respond to patient demand on the ward?

Patient profile
If relevant to the proposal outline the patient profile in the ward:

Key questions may include (where appropriate):
- What is the predominant age/age profile of patients?
- What is the average length of stay?
- What is the patient throughput? (i.e. emergency admissions, elective admissions, transfers to/from critical case areas)

What is your data source?

How will the proposed variation from ratio impact upon/respond to the patient profile on the ward?
Patient complexity
If relevant to the proposal outline the clinical nursing/midwifery assessment and needs of the patients in the ward:

Key questions may include (where appropriate):
- What is the predominant patient mix?
- What is the average patient complexity/acuity?
- What are the primary nursing requirements for patients, in general?

What is your data source?

How will the proposed variation from ratio impact upon/respond to patient complexity on the ward?

Clinical risk
If relevant to the proposal outline clinical risk factors for patients on the ward, including any nurse sensitive adverse outcomes:

Key questions may include (where appropriate):
- How is clinical risk measured on the ward?
- How is the ward currently performing against these measures?
- What is the average occurrence of the following nurse sensitive adverse outcomes on the ward:
  - falls (with or without injury)
  - urinary tract infections
  - pneumonia
  - pressure ulcers
  - thrombosis
  - sepsis
  - medication errors (with or without patient consequences)?
- Are the nurse sensitive adverse outcomes currently at/above/below the acceptable level?
- Have there been any significant clinical risk issues/adverse patient outcomes on the ward?
What is your data source?

What will the proposed variation from ratio impact upon/respond to clinical risk on the ward?

Nursing and midwifery workload

If relevant to the proposal outline any current issues with nurses/midwives completing duties within rostered hours:

Key questions may include (where appropriate):

• On average, how much additional time (paid/unpaid overtime) do nurses/midwives on the ward work?
• Are nurses/midwives more likely to work additional hours on a particular shift?
• Are nurses/midwives more likely to work additional hours on a particular day of the week?
• What are the primary reasons for nurses/midwives working additional hours?
• On average, are nurses/midwives on the ward able to take scheduled meal/rest breaks?
• Has the ward received patient complaints/feedback regarding delays to care?

What was your data source?

How will the proposed variation from ratio impact upon/respond to nursing workload on the ward?
Nursing/midwifery environment
If relevant to the proposal outline any demand of the physical environment that influences how nurses/midwives in the ward take up their role:

Key questions may include (where appropriate):
Are there particular challenges on the ward due to:
- ward design?
- patient layout?
- specialised equipment?
- patient placement due to acuity/care requirements?

What is your data source?

How will the proposed variation from ratio impact upon/respond to any demands of the physical environment?

Nurse/midwife safety
If relevant to the proposal outline any occupational health and safety concerns for nurses/midwives on the ward:

Key questions may include (where appropriate):
- What are the primary safety concerns for nursing/midwifery staff on the ward?
- What types of ‘near misses’ have been reported through the risk management system?
- What types of injuries/illnesses have resulted in worker’s compensation claims?
- Have there been any provisional improvement notices (PINs) on the ward?
- What is the average sick leave utilisation on the ward?
- Are nurses/midwives more likely to take sick leave on a particular shift?
- Are nurses/midwives more likely to take sick leave on a particular day of the week?
What was your data source?

How will the proposed variation from ratio impact upon/respond to any OH&S concerns for nurses/midwives on the ward?

Nurse and midwife engagement

If relevant to the proposal outline the current level of engagement of nurses/midwives on the ward:

Key questions may include (where appropriate):

- How would you describe the nursing/midwifery culture of the ward?
- Are nurses/midwives on the ward positively engaged?
- How is the NUM generally regarded by the nursing/midwifery staff? How long has the NUM been in place?
- How is the ward performing against KPIs?
- Is the ward performing above/below expectations in any particular area(s)?
- Have there been any complaints of bullying or harassment involving nurses/midwives on the ward?
- Have there been any complaints of unfair treatment involving nurses/midwives on the ward?
- Are any of the nurses/midwives on the ward currently involved in performance management/disciplinary processes?
- Have any of the nurses/midwives on the ward been rewarded/recognised for particular achievements?

What is your data source?

How will the proposed variation from ratio impact upon/respond to nurse/midwife engagement on the ward?
Nurse and midwife profile
If relevant to the proposal outline the current profile of nurses/midwives on the ward:

Key questions may include (where appropriate):
- What is the age profile of nurses/midwives on the ward?
- What is the experience profile of nurses/midwives on the ward?
- What is the proportion of full-time, part-time, casual nurses/midwives on the ward?
- What other roles are part of the ward team?
- What is the skill-mix of the ward (e.g. proportion of RN vs EN vs unregulated healthcare worker)?
- What proportion of nurses/midwives are employed on a fixed-term basis?
- Are any of the nurses/midwives on the ward currently accessing parental leave entitlements (i.e. about to commence leave, about to return from leave, accessing part-time employment)?
- Do any of the nurses/midwives on the ward have a need for roster flexibility due to work/family commitments?

What was your data source?

How will the proposed variation from ratio impact upon/respond to the nurse/midwife profile on the ward?