Business Planning Framework:

a tool for nursing and midwifery workload management

5th Edition 2016

Paediatric Setting Addendum 2018

Queensland Government

Published by the State of Queensland
(Queensland Health), January 2018

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QH789 9/16

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Introduction

The Business Planning Framework: a tool for nursing and midwifery workload management 5th Edition (BPF 5th Edition) is the industrially mandated tool to support business planning for the purpose of managing nursing and midwifery resources and workloads in public sector health facilities. The principles of the BPF 5th Edition apply to all remote, rural, regional and metropolitan nursing and midwifery services in Queensland Health. This addendum is designed to recognise the unique challenges for nurses working in paediatric settings and must be used in conjunction with the BPF 5th Edition.

The Paediatric Setting Addendum was developed to meet the commitment between Queensland Health (QH) and the Queensland Nurses and Midwives' Union (QNMU) under the provisions of the Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9) 2016. The agreement identified the need to further contextualise the BPF 5th Edition for a range of settings, including paediatric, to support compliance with the Nursing and Midwifery Workload Management Standard.

The Paediatric Setting Addendum was created by a statewide paediatric nursing Specialty User Group in partnership with QNMU and the Department of Health.

This addendum will assist nursing staff within paediatric settings to:

- determine and manage the unique circumstances within their service that require special consideration when applying the principles of the BPF 5th Edition
- articulate productive (direct and indirect) nursing activity within their service
- understand the current and emerging demand considerations for nursing hours within their setting
- develop planning tables identifying productive and non-productive hours relevant to paediatric settings
- identify and describe client and service complexity and activity indicators to improve consistency in the application of the BPF 5th Edition in paediatric settings

Module 1: Development of a service profile

This section relates to BPF 5th Edition module 1: pages 13-26

Business planning in the context of paediatric settings

There are a number of common nursing workload management and workforce planning issues within paediatric settings. These are recognised nationwide as critical areas of concern. The most frequently discussed issues involve:

- articulating paediatric nursing work
- managing patients with variable chronological and developmental age
- validating indirect paediatric nursing hours
- managing variable occupancy rates
- access to paediatric nursing specialists
- opportunities for paediatric specific education
- accessing suitable paediatric data collections and reporting systems

There are a broad range of service activity types at level 1 to level 6 Clinical Services Capability Framework (CSCF) in paediatric settings. The CSCF determines the level of service to be provided based on the service description criteria with all Children's Services being delivered in a safe and appropriate physical environment. Examples of physical environmental requirements include:

- isolation area for infectious paediatric patients
- provision of play facilities
- identified physical safety and security measures
- access to educational support for patients during extended admission periods
- provision of a dedicated treatment room
- maintaining the bed area as a safe space
- provision of facilities for – breast feeding and breast milk storage, parents and siblings to stay near the child and amenities for parents onsite[1]

The application of Nursing Hours Per Patient Day (NHPPD) in the paediatric setting needs to take into consideration patient developmental and chronological age and acuity measures. Patient age ranges include infant (less than 12 months), children (1 to 14 years) and adolescents (14 to 18 years). The calculation of productive hours needs to incorporate staffing requirements for direct and indirect activities that may not regularly occur in other health settings (refer to Table 2: Key productive and non-productive nursing hours). These requirements further emphasise the importance of professional judgement in the calculation of the productive nursing hours.

[1] *Department of Health CSCF v 3.2 Children's services*

Other key considerations in a paediatric setting include:

Benchmarking

Benchmarking of service activity and relative performance measures within paediatric health facilities is complex, this relates to:

- the paediatric ward/unit may be the only area in the Hospital and Health Service (HHS) where paediatric inpatient care is provided (stand-alone service)
- the impact of the distance to secondary and tertiary referral centres (higher CSCF)
- the variations in cohorts of patients, physical layout, the service models/models of care across the state and nationally

Funding models

The current funding models may not reflect the broad range of service activity undertaken and the growing complexity/acuity. For example:

- areas such as child health, community, and some regional, rural and remote facilities are block funded
- calculations based on number of episodes, with limited consideration of patient acuity, lead to poorly articulated nursing demands
- impact of changes in acuity and complexity of care such as delivering higher complexity healthcare, for example high flow oxygen therapy, diabetes education, and maintenance chemotherapy in regional, rural and remote health settings
- capacity and capability of the specialist paediatric nursing workforce to respond to changes including low frequency high risk clinical skill/capability, for example paediatric trauma
- minimum safe staffing levels must consider the requirement for paediatric speciality training consistent with the CSCF
- application of DRG categories, where paediatric specific DRGs do not exist, means additional costs for providing paediatric care may not be accounted for

Recruitment, retention and succession planning

Paediatric nursing care is highly specialised and often provided in HHSs as a stand-alone ward/unit. A number of recruitment, retention and succession planning challenges result from this, which include:

- the requirements to gain a specialist paediatric qualification, such as travel, temporary relocation, access to training placements and mentors, can adversely impact the individual and/or the HHS
- the unique nature of the post-graduate study in paediatrics where the student is required to be working in a clinical paediatric setting to undertake the course needs consideration with regard to requirements for study time and / or flexibility in their work hours
- limited capacity to release staff to develop paediatric skills, knowledge and qualifications
- career pathways into paediatric specialty education may be limited
- unique patient cohorts lead to increased considerations for succession planning into specialist roles such as Cystic Fibrosis, Diabetes, Connected Care
- a lower than state average age of paediatric nurses, which may have impacts including demand for maternity leave and millennial workforce mobility trends
- limited opportunities for undergraduate nursing students to have clinical placements in the paediatrics setting, which may impact on the attraction of the future workforce
- the HHS transition to practice strategy entails a commitment to invest in skill development of new graduates in this specialised area. The support hours required to complete post- graduate year may be as many as 152 hours (or greater) depending on the CSCF level and cohort of patients.
- consideration of the availability of support models, such as Telehealth Emergency Management Support Unit (TEMSU) and remote or mobile (multi-site) Clinical Facilitators

- workforce maldistribution (for example, limited paediatric nurses in remote areas) results in role substitution and expanding role functions within paediatric nursing
- in regional, rural and remote areas, there is limited access to a paediatric trained casual workforce for the management of emergent leave and short term planned leave
- challenges in providing Professional Development Leave (PDL)/mandatory training and role specific training when they are not available locally and require travel

Patient transition to adult care

There are a number of patients with care that will progress after the age of 18, such as cystic fibrosis, diabetes and mental health. This often requires complex planning for transition and ensuring continuity of the patients care journey. Paediatric nurses require:

- additional skill development for supporting transition of patients into adult services
- capacity development for planning the transition of long term paediatric patients into adult services
- support and education for the family to facilitate the transition

Business planning considerations

This section relates to BPF 5th Edition Module 1.4: page 15

The BPF 5th Edition outlines the general factors a service should consider when analysing the internal and external environment as part of developing their service profile. However, there are a variety of business planning factors which influence the paediatric setting and result in service demand fluctuations. These internal and external factors need to be considered when analysing service demand. Wards and services should annually assess the impact of each factor on their environment and make the necessary adjustments to the allocation of nursing hours.

Table 1 provides examples of several business planning considerations relevant to the paediatric setting, based on recognised internal and external influences. Consideration of the impact and level of influence these have on nursing workloads to support the productive hours is required.

Table 1: Business planning consideration for the paediatric setting

<table>
<tr><th>Influences
(internal and external)</th><th>Service impact</th><th>Examples of workload management considerations</th></tr>
<tr><td>Locality of service
(Internal)
(Metropolitan, regional, rural and remote)</td><td rowspan="4">The locality, type and catchment area of a service will influence the balance of service demand and supply.
Examples:
Paediatric health services need to consider the workload impacts of delivering a broad range of health services in adult based hospitals. Additional paediatric resourcing needs to be considered (for example, education, staff support, succession planning).
Limited resources in stand-alone wards/units after hours requiring nursing staff to perform non-nursing duties such as, transporting patients, meal preparation, administrative work and bed cleaning.
Diversity of age groups requiring non-standard bed setup and undertaking procedures away from the bed area as it is a ‘safe space’.
All services need to consider the impact of skill mix on optimal service delivery.</td><td>Direct nursing hours :
Calculation of clinical hours for direct care, allocation of clinical hours (rosters), selection of service activity/ acuity measures, use of minimum safe staffing requirements.</td></tr>
<tr><td>Type of Service
(Internal)
(e.g. paediatric ward, short stay unit, outpatient facility)</td><td>Indirect nursing hours:
Calculation of clinical hours for indirect care, travel, program/service based education, succession planning, quality activities and research.</td></tr>
<tr><td>Catchment area
(Internal)
(Local Hospital and Health Services versus Statewide Services)</td><td>Workforce planning:
Development of strategic local/ Statewide workforce plans to inform FTE requirements, skill mix profiles and macro workforce planning formulas.</td></tr>
<tr><td>Nursing and midwifery structure
(Internal)
(Roles, functions, accountabilities and relationships between all categories of nursing staff)</td><td rowspan="3">The model of care selected for a service will influence the nursing support structure required. Nursing roles and how they relate with other clinical roles will impact on the balance of service demand and supply.
Different models of care may be required depending on acuity and skill mix of staff.
Examples:
Consideration of time spent waiting for legal consent and carer support for procedures.
Behavioural, developmental and social considerations.
The accessibility and level of support available to and from other services may vary. Nursing services should account for the productive hours required to manage the demand from these interactions.
Limited paediatric skills of casual workforce to support emergent leave cover and increased patient acuity and activity.</td><td>Direct nursing hours:
Calculation of clinical hours for direct care provided in and outside the service, position classifications for the clinical hours required, allocation of clinical hours (rosters), selection of optimal service activity/acuity measures, safe staffing levels.</td></tr>
<tr><td>Support structure
(Internal)
(Providing support to other services and/or receiving support from other services)</td><td>Indirect nursing hours:
Calculation of clinical hours for non-direct care networking/collaboration (internal and external) travel, staff training, professional development, quality activities and research.</td></tr>
<tr><td>Model of care
(Internal)
(Multi-functional teams)</td><td>Workforce planning:
Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service.
Devising operational and organisational structures to support staff in applying the chosen model of care.
Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.</td></tr>
</table>

Table continued overleaf ››

Table 1: Business planning consideration for the paediatric setting (continued)

Influences (internal and external)	Service impact	Examples of workload management considerations
Policy/legal factors **(External)**	Changes in health policy and legislation will influence service delivery and staff requirements. Common change drivers include governments (commonwealth/state), licensing organisations, professional and industrial groups. *Examples:* *Legislation – Workplace Health and Safety Act, Child Protection Act 1999, Mental Health Act 2015* *The National Framework for Protecting Australia's Children 2009-2020* *Queensland Health – Strategic plan* *Clinical Services Capability Framework* *Professional standards such as Australian College of Children and Young People's Nurses* *Ryan's Rule*	***Direct nursing hours:*** Calculation of clinical hours for direct care (based on available funding), position classifications for the clinical hours required, registration commitments for clinical hours, allocation of clinical hours (rosters), selection of optimal service activity/acuity measures, and use of minimum staffing requirements.
Economic factors **(External)**	Funding policies, the national economy and the interface between public and private health care providers will influence the delivery of paediatric services and the number of staff required. *Examples:* *Service improvement initiatives can provide non-recurrent funding increases for services which achieve the targeted results. These incentives could impact the skill and number of nurses required for service delivery.* *Peaks and troughs in activity may make it difficult to roster within financial constraints.* *Outlier adult patients in the paediatric unit and the challenges of maintaining nursing skillset for adult patients when working in paediatric setting.*	***Indirect nursing hours:*** Calculation of hours for indirect and non-productive activities such as policy development, business planning, service interfaces, travel, staff training, professional development, quality activities and research.
Social/population factors **(External)**	Population and social economic demographics and community expectations will impact on the types of paediatric health services offered, how the services are offered, staffing numbers and skill mix required for service delivery. *Examples:* *Delivering health services to a community with a high proportion of Indigenous and/or non-English speaking people will impact the number and type of clinical hours required to operate the service.* *If point of care is away from home there can be factors which impact the ability of carers being able to travel to support the child (transport and accommodation affordability).* *Unpredictability of parent involvement and engagement in child's care.*	***Workforce planning:*** Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service. Devising operational and organisational structures to support staff in applying the chosen model of care. Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.

Nursing core demand considerations

To improve the consistency and transparency in the application of the BPF 5th Edition, specific demands on direct and indirect nursing hours in the paediatric setting have been categorised to assist in articulating nursing work. The categories are based on the most common and frequent demands placed on nurses within the paediatric setting. The following section will explore the relationships between core demand considerations and the context of practice in paediatric settings.

Client/service complexity

When reviewing client and/or service complexity there are a number of unique considerations for the paediatric setting, these include:

- complexity of caring for patients across the age continuum 0-18 years
- recognition that the patients have specific needs related to their developmental and chronological age which impacts on their care across the 24 hour period
- the unique family dynamic, which includes family centred care, where all activities need to reflect a family centred approach
- provision of emotional support and education to family members and carers, particularly discussions about diagnosis, care planning and health education. Engagement may involve discussions with the child, parent/guardian, siblings and the wider family support network, tailored for the individual needs.
- the effect of the absence of family or carer on the patient's feelings of safety and security which impacts on the time the nurse is required to engage with the child
- the timing of healthcare activities. These may need to vary according to the presence of the parent/carer which often leads to the need for additional nursing resources for scheduling and rescheduled interventions.
- the professional and safety standards for paediatrics that require two nurses to check, prepare and administer medications at the bedside
- managing the deteriorating paediatric patient which requires frequent and close observation, assessment and intervention
- being aware that procedures often require additional staff, with specific skills/training to provide safe care, for example clinical holding and distraction techniques
- being aware that the bed area is a safe zone. Procedures and treatments are undertaken in a dedicated area away from the bed space e.g. treatment room for intravenous insertion, requiring additional nursing time for preparation and transport.
- the need to facilitate patient movement between departments and external services. The nurse may need to escort the patient for care, for example radiotherapy or Royal Flying Doctor Service transfers
- considerable legislative requirements, in particular obtaining consent and meeting requirements of the Child Protection Act 1999[2], managing the impact of child custody arrangements[3], age of consent laws[4] and upholding the Rights of the Child[5]
- the paediatric patient may require additional emotional support and or time for care due to anxiety, abuse or neglect

[2] *https://www.legislation.qld.gov.au/view/html/inforce/current/act-1999-010*
[3] *https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf*
[4] *http://www.legalaid.qld.gov.au/Find-legal-information/Personal-rights-and-safety/Health-and-medical/Medical-consent#toc-consenting-to-medical-treatment-as-a-child-or-young-person*
[5] *https://www.humanrights.gov.au/convention-rights-child*

- caring for paediatric patients who are experiencing mental health issues. This creates additional challenges including; demand on numbers and skill mix of nurses for the provision of safe care and managing risk. For example specialling of patients who are at risk of self-harm and consideration of co-location of patients.

Model of care/service delivery

Paediatric nurses recognise the role of parents/caregivers in the care of the paediatric patient, therefore paediatric models of care need to incorporate this into practice. Examples include partnership care, family centred care, shared care and negotiated care. How this care is provided will vary between services and health facilities and needs to be defined by the paediatric nursing specialists of the service.[6,7]

Models of care will vary depending on:

- staffing availability and skill mix
- patient acuity
- patient chronological and developmental age
- proximity to higher CSCF facilities, for example Paediatric Intensive Care Unit or tertiary facility
- ward layout and proximity to associate/support services
- access to paediatric and adolescent mental health services
- mixed models of care within the one unit for example inpatient combined with short stay patients, and/or adult patients

[6] *Dennis, C., Baxter, P., Ploeg, J., and Blatz, S. (2017).) Models of partnership within family-centred care in the acute paediatric setting: a discussion paper. Journal of Advanced Nursing 73(2), 361–374*

[7] *Young. J., McCann, D., Watson, K., Pitcher, A., Bundy, R., and Greathead D. (2006). Negotiation of care for a hospitalised child: nursing perspectives. Neonatal, Paediatric and Child Health Nursing, 9(3), p 7 – 14.*

Technology and materials management

The introduction of digital systems and eHealth technology requires significant input from nurses. Often systems require modification to meet the needs of paediatric patients and their families, resulting in staff needing to assist other streams to customise the systems, for example, ieMR in the paediatric setting.

The time spent on accessing and recording of information on multiple systems also needs to be considered.

Additional considerations include;

- introduction of digitalized hospitals requires additional training, for example, ieMR downtime processes
- access to technology at the point of care (workstation on wheels)
- stable connectivity to the internet
- asset management of paediatric specific equipment including obtaining quotes, maintenance coordination, education for implementation and Health Technology Equipment Replacement (HTER) management
- imprest and drug management processes

Nursing staff should build indirect hours into the service profile to account for training and ongoing systems management.

Community interface

Community and consumer engagement is pivotal to the delivery of holistic paediatric care. Paediatric settings have a variety of service delivery models which provide care to families in their communities, including school based care, primary health care as well as inpatient units. The ward, unit or department may directly and/or indirectly interact with the following groups:

- Community Advisory Networks (CANs)
- Parent Advisory Networks (PANs)
- Non-Government Organisations (NGOs)
- Aboriginal Community Controlled Health Services (ACCHS)
- primary health care providers
- National Disability Insurance Scheme (NDIS) and associated private sector service providers
- community health service providers
- Hospital in the Home (HITH) and extended midwifery services
- community respite residential care providers
- specialised Statewide services such as Children's Advice and Transport Co-ordination Hub (CATCH) and Connected Care
- government agencies, such as Department of Community Services (DoCS) and Education Queensland

The time staff commit to these activities needs to be considered when calculating the productive nursing hours for the service. Both quantitative and qualitative information regarding community interface activities needs to be considered.

Quality and safety

Quality and safety activities within paediatric settings are primarily governed by legislation and organisational policy. The productive nursing hours of the health service are influenced by quality and safety processes. This distribution of direct and indirect hours needs to be contextualised for the health service based on variables such as type of service delivered, staff competency required, and location of unit or program.

Some key quality and safety components which may impact productive nursing hours include:

- patient/family safety, for example the level of supervision required for patients
- staff safety, for example management of aggressive behaviour in adolescent patients

- mandatory and requisite training requirements, such as paediatric advanced life support
- policy, procedure and clinical guideline development and review, particularly in wards or units where the paediatric unit is part of an adult facility
- clinical portfolio extension beyond ward or unit, providing specialist paediatric nursing advice throughout the facility
- incident and near miss reporting in the paediatric setting involves identification and management of challenging family behaviours
- ergonomics and design requirements to ensure a safe environment such as securing any area where a patient/child could enter and be exposed to risk of harm (e.g. stores room)
- paediatric specific audits
- management of Ryan's Rule requests
- implementation of Root Cause Analysis, Human Error and Patient Safety outcomes

As this is not an exhaustive list, a review of your local activities, quality planning and incident reporting process is recommended.

Education and service capacity development

The CSCF identifies training recommendations/ requirements for paediatric nurses. As part of the service profile, consideration should be given to the CSCF modules that are relevant for the particular paediatric service for establishing education and requisite training requirements including any associated travel time.

Consideration needs to be given to supporting staff to:

- undertake the Transition to Paediatric Practice Program
- travel to tertiary and other relevant education facilities that provide specialist paediatric training
- participate in regional and remote placements such as the Regional Development Program and the Nursing and Midwifery Exchange Program
- develop a unit specific education plan
- engage in succession planning
- develop as a paediatric nurse, progressing from novice to expert
- utilise professional development leave

It is important to note that for a nurse to participate in specialist paediatric post graduate education there is a requirement for them to be employed and working in the paediatric setting.

Leadership and management

The paediatric service may sit within a specialist paediatric facility or predominately adult health service. As such, consideration needs to be given to the individual leadership and management requirements and support systems. This may impact the level of demand placed on productive nursing hours. The demand considerations include:

- skill and knowledge requirements to lead and manage in the unique paediatric context
- service accountabilities and responsibilities beyond the paediatric unit
- management of staff, noting that in some services the workforce has higher than average maternity leave
- organisational and HHS engagement, including influencing clinical practice and providing paediatric expertise in committees
- supporting and sustaining the specialist paediatric nurse staffing profile which includes classification, scope of practice and training/ skills development
- interactions with nursing and multidisciplinary team members for management of complex care
- managing consumer expectations in line with agreed service provision

- facilitating a peer support network for Nurse Unit Managers, Clinical Nurse Consultants and Nurse Educators who work in isolated paediatric units

Research and evidence based practice

Undertaking research and evidence based practice activities will influence the number of indirect nursing hours required for service delivery. Research and evidence based practice is essential to improve the standards of care that will produce better health outcomes for clients and their families.

Consideration should be given to the impact on nursing hours when implementing research outcomes into clinical practice.

Health policy, clinical guidelines, strategic plan and health legislation

There are a number of legislative and policy requirements that influence the paediatric setting. These should be considered when developing service profile, resource allocation and evaluation of performance. Key examples listed below:

- Strategic plans:
  - » Children's Health Queensland Strategic Plan 2016-2020[8]
  - » Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023[9]
- No Jab No Pay Legislation[10] - Promotes immunisation for babies, children and adolescents to increase uptake within the community

- Carmody Inquiry and Report[11]- The recommendations have impacted on staffing requirements to ensure that agencies, professionals and organisations work with vulnerable children and families and each other in a sustainable and collaborative way
- Child Protection Act[12]- Legislates that all children have a right to be protected from harm
- Adoption Act 2009[13]- Promotes the wellbeing and best interests of adopted individuals throughout their life
- Guardianship Legal Consent – Guide to Informed Decision-making in Health Care 2017[14]– provides a guide to implementing the principles of informed decision making into clinical practice. Part 3 relates specifically to children and young people.
- Professional standards - Australian College of Children and Young People's Nurses (ACCYPN) standards[15]– Professional organisation which sets competencies and standards expected of nurses caring for children and young people
- Australian Human Rights Commission, Rights of the Child[16]- Recognises that children have the same human rights as adults in addition to needing special protection because of their vulnerability
- Ryan's Rule[17]- The escalation process to raise a concern when a patient's health is worsening or not improving as expected
- Working with Children Check/Blue Card Check[18]– A key prevention and monitoring system of people working with children and young people in Queensland
- Barrett Adolescent Centre Commission of Inquiry Report[19]- The inquiry made recommendations about engagement and consultation with patients and staff when major service changes are considered
- Memoranda's in place may also impact on the type and level of service required from Queensland Health to an agency, for example Education Queensland

[8] *http://qheps.health.qld.gov.au/childrenshealth/docs/bus-services/budgetreports/chq-strat-plan.pdf*
[9] *http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/$File/DOH_ImplementationPlan_v3.pdf*
[10] *https://www.qld.gov.au/health/conditions/immunisation/childcare*
[11] *http://www.childprotectioninquiry.qld.gov.au/*
[12] *https://www.legislation.qld.gov.au/view/pdf/2005-04-29/act-1999-010*
[13] *https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-029#pt.1-div.2*
[14] *https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf*
[15] *https://www.accypn.org.au/wp-content/uploads/091016-POSITION-STATEMENT-Minimum-Standards.pdf*
[16] *https://www.humanrights.gov.au/convention-rights-child*
[17] *https://www.health.qld.gov.au/psu/ryans-rule-patient,-family-and-carer-escalation-process*
[18] *https://www.bluecard.qld.gov.au/*
[19] *https://www.health.qld.gov.au/research-reports/reports/review-investigation/barrett-adolescent-centre*

Module 2: Resource allocation

This section relates to BPF 5th Edition Module 2: pages 27-47

Establishing total nursing resource requirements

STEP 1	Calculate total annual productive nursing and/or midwifery hours required to deliver service.	Go to BPF 5th Edition page 31
STEP 2	Determine skill mix/category of the nursing/ midwifery hours.	Go to BPF 5th Edition page 35
STEP 3	Convert productive nursing/midwifery hours into full-time equivalents.	Go to BPF 5th Edition page 38
STEP 4	Calculate non-productive nursing and/or midwifery hours in accordance with nursing and midwifery award entitlements.	Go to BPF 5th Edition page 39
STEP 5	Convert non-productive nursing and/or midwifery hours into full-time equivalents.	Go to BPF 5th Edition page 43
STEP 6	Add productive and non-productive full-time equivalents together and convert into financial resources in partnership with business team.	Go to BPF 5th Edition page 44
STEP 7	Allocate nursing and/or midwifery hours to meet service requirements.	Go to BPF 5th Edition page 47

Productive nursing hours include both direct and indirect clinical hours. Calculating the number of productive hours required for a paediatric setting is the first step in managing nursing workloads and establishing the total operating nursing budget, specifically identifying the FTE required.

Creating a list of standard direct and indirect nursing activities in your unit or practice area will assist in articulating and monitoring the use of productive hours. As outlined in the BPF 5th Edition, this consultation process should be undertaken with unit staff.

Information gathered about productive hours can be used to inform a number of service requirements such as staffing numbers, skill mix, models of care and education/training programs. It is important to document all nursing activities relevant to your service, especially those considered unique to your unit or practice area. Defining productive hours increases the understanding of the nursing work being performed and provides an excellent foundation when developing a service profile.

Table 2 provides examples of key productive and non-productive nursing activities for a paediatric setting and should be used in conjunction with the BPF 5th Edition (pages 27- 47).

Total productive hours =

direct hours

+

indirect hours

Table 2: Examples of key productive and non-productive nursing hours

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Service delivery				
Operational and strategic planning		x		Business and strategic planning
Scheduling clinics		x		Template development and adjustments
Models of service delivery		x		Case management /group sessions Family centred care Mixed models within the one unit (e.g. Inpatient and short stay)
Patient Flow activities	x	x		Room allocation, managing overruns, directing clients Movement of patients within the organisation and between HHSs'
Room management	x			Age appropriate room setups
Inventory and stock control		x		Sterile stock management and ordering Equipment maintenance and ordering
Chart coordination and management		x		Preparing charts, managing client information, test results and follow up appointments
Client assessments	x			Physical assessments
Referral management		x		Triaging and prioritising diagnostics testing
Clinic triage	x			Triaging clients
Client and family education	x	x		Delivering health education Planning health education programmes/sessions
Clinic delivery	x			Phone clinics, dressing clinics, outreach clinics
Procedures	x			Includes set ups, procedures and clean ups Moving of patient to a procedure room and observation during procedure
Telehealth services	x			Patient follow-ups
Care planning and evaluation	x			Client related arrangements such as patient travel, translators, complex diagnostics, and discharge planning
Clinical documentation	x			Medical records, client related charts
Clinical handover/handoff	x			Patient transfers
Client escorts	x			Intra and inter-hospital
Clinical area preparation	x			Preparing for procedural clinics
Clinical team leading		x		Staff coordination
Follow ups		x		Post discharge, reviewing 'not ready for care' clients
Service data collection and analysis		x		Client activity

Table continued overleaf ››

Table 2: Examples of key productive and non-productive nursing hours (continued)

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Clinical Audits	x	x		Clinical audit related to patient, patient care and patient records
Toy Cleaning		x		Cleaning toys between patients
Telephone Calls	x			Screening, visitor screening
Boarders/carers/parents	x			Managing boarder patients
Meal census	x			Collecting meal census sheets
Medication administration	x			Double check medication administration process at the bedside Introduction of ieMR adds additional work
Closed unit visitor management	x	x		Process to admit adults into closed unit for safety
Age appropriate play and diversional activities	x			
School activities		x		Transporting patients to and from school School visits to reintegrate child with peers
Staff management				
Rostering		x		Daily, weekly and monthly rostering of staff
Leave management		x		Annual, sick, fatigue and study/research leave
Skill mix management and allocation		x		Team leader duties
Human resource management		x		Pay enquires, staff movement forms
Performance Appraisal and Development Activities and succession planning		x		Regular performance review/appraisal, performance development, succession planning activities
Recruitment and retention		x		Advertising, interviewing, developing retention strategies
Data collecting and analysis		x		Labour expenditure, leave management, monthly reports
Staff travel		x		Organising travel for visiting medical staff, undertaking travel
Incident reporting	x	x		Completing and investigating incident reports, root cause analysis (RCA) and recommendation implementation
Financial Managements		x		Developing and monitoring financial activity, budgets

Table continued overleaf ››

Table 2: Examples of key productive and non-productive nursing hours (continued)

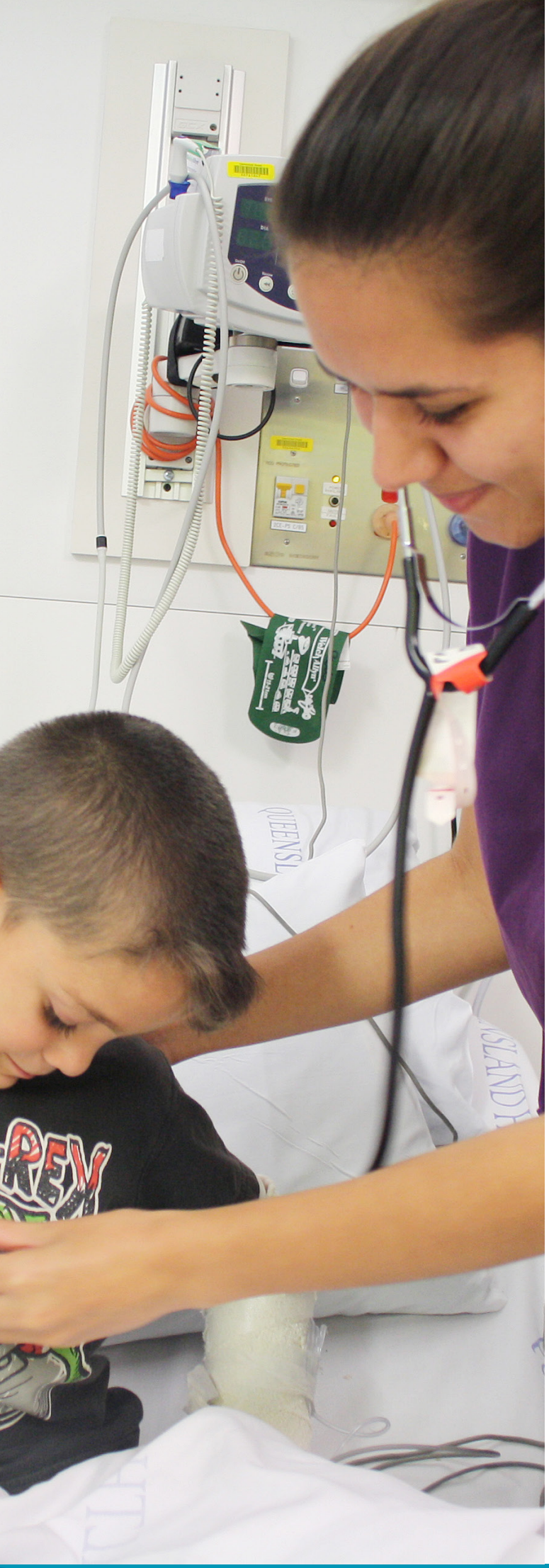
Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Staff development				
Clinical supervision		x		Professional support/learning, reflective practice
Clinical facilitation		x		Undergraduate, postgraduates and new starters
Mandatory/ speciality training			x	Basic life support, child safety, ergonomics
Staff education (in clinical area)		x		Internal and external - Paediatric Transition Program
In-service training		x		Ward-based education/training sessions
Professional development/portfolios		x		Clinical portfolios
Performance appraisal and development		x		Regular performance review/appraisal, performance development
Succession planning		x		Workplace shadowing, professional development
Staff meetings		x		Unit/workplace based
Evidence-based practice		x		Research activates/service based projects
Clinical Performance Assessment Tool (CPAT)		x		Assessor and Assessee preparation, planning, assessment and feedback
Unit / Service specific orientation		x		Onboarding new staff members – nurses, medical officers and other disciplines as required
Policy development and enforcement				
Committee participation		x		Internal and external committees
Quality audits/safety checks		x		Designated by legislation, policy or quality programs
Health service planning		x		Service capacity building and workforce planning
Clinical governance practices		x		Policy review and development
Change management of new clinical and non-clinical policies and procedures		x		Time taken to introduce and imbed a change to clinical or non-clinical practice within a service
Patient complaint/ feedback and management		x		Patient complaints, service delivery issues, Ministerial responses

Table continued overleaf ››

Table 2: Examples of key productive and non-productive nursing hours (continued)

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Information management				
Balanced scorecard		x		Evaluation tools
Data analysis		x		Service improvements
Business planning and management		x		Service profile development
Electronic medical records	x	x		Client related information and storage record Staff training in system use
Other				
Travel		x		Travel associated with service delivery e.g. outreach clinics
Equipment and infrastructure maintenance		x		Car servicing, building repairs
Consumer engagement activities		x		Participation
Fund raising activities		x		Participation

Please note: Education and training programs provided within the clinical service/program/facility are considered indirect hours. Clinical hours associated with mandatory training and professional development leave for education purposes are allocated within non-productive hours.



Service activity

The professional judgement of nursing staff informs the minimum skill mix required to build a staffing roster to meet the demand created by the model/s of care.

Financial activity does not always easily or directly translate into nursing activity. In the paediatric setting a key role of the nurse is to ensure family centred care. This requires focus not only on the child but the family (which can present in a variety of forms) and the particular challenges when supporting families with a child undergoing paediatric health care.
The paediatric setting requires nurses to provide care based on the developmental age of the child and considerations of the particular vulnerabilities of children. The additional time taken as hours or fractions of hours reflecting the contact with multiple individuals or agencies engaged in the patients care must be considered.

For example in the paediatric setting nurses are providing:

- **Care for non-admitted patients:**
  Paediatric nurses may be required to perform services on non-admitted patients. For example, a paediatric outpatient may be moved to an inpatient area for a procedure to be undertaken by a skilled paediatric nurse.
- **Safety of the child:**
  - » guardianship or custody arrangements impacts on the nurses time to coordinate and manage planned supervised and unexpected visits
  - » care is provided in a space away from the bedside ‘safe space’, which involves time for the nurse to explain, transfer, support/ undertake care and transfer back to the child’s room.
  - » scheduling of care can be impacted by the availability of family/support persons

- » care may be impacted when the child does not have a parent or legal guardian present to consent
- » clinical deterioration or behavioural challenges are unpredictable and alter the nursing activity, for example 1:1 care and paediatric expertise will be required to care for the deteriorating child or safely provide interventions for behavioural disturbances
- » paediatric units are usually considered as "closed units" and as such more time is required undertaking visitor management

- **Medication management:**
  - » requires double checking of medication as well as double checking the patient details and medication at the bedside
  - » complex calculations of doses based on weight
  - » additional administration safeguards, for example use of IV burettes, IV pumps and medication pump software
- **Care of the vulnerable child:**
  - » paediatric patients who have experienced multiple hospital exposures, abuse and neglect require additional nursing resources with the aim to establish feelings of safety and security
  - » nurses may need to be present and provide documentation for police evidence in cases of sexual or physical abuse
  - » considerable nursing activity may be required for managing family dynamics, expectations, education and navigation of the health services on discharge.
- **Meet the holistic needs of the child:**
  - » supporting the child when isolated in hospital due to medical need or family unable to be present, for example when family is unable to travel, during periods of respite or in cases of abandonment
  - » school or educator support to limit impact of illness on education, will require scheduling and impacts on nursing hours
  - » engagement with the family requires nurses to spend time supporting and educating siblings at various developmental ages
- **Specialised paediatric outpatient services:** Outpatient clinics are often provided on an outreach basis. Nurse led clinics are often provided by staff undertaking other clinical responsibilities. Examples of specialist nurse led clinics include:
  - » Clinical Nurse Consultant, Nurse Practitioner or Nurse Navigator clinics
  - » chronic disease clinics
  - » specialty clinics
  - » immunisations
  - » child health clinics
  - » school based clinics
  - » mental health clinics

In the absence of a nursing data set for the paediatric setting, clinical discretion and professional judgment is exercised. Some examples of activity measures that are commonly used have been identified and listed in Appendix 1 under the following headings:

- Emergency activity
- Short Stay Activity
- Inpatient Activity – Paediatric Area
- Inpatient Activity – Non - Paediatric Area
- Outpatient Activity
- Patient Transport
- Tele-health Activity
- CATCH / Connected care

Module 3: Evaluation of performance

This section relates to BPF 5th Edition Module 3: page 48-54

Data collection for paediatric settings

Data collection supports the measurement of financial outcomes and service performance and partially, workload demand. The available information systems may not always capture the data required for conducting a comprehensive environmental analysis of nursing in the paediatric setting.

Table 3 outlines key identified information systems available in the paediatric setting, they may not provide the required information so local data bases or spread sheets may be developed.

Table 3: Paediatric settings information systems and data collections

Information system/collection	Purpose	Informs
Hospital Based Corporate Information System (HBCIS)	Queensland Health's enterprise patient administration system, capturing and managing both admitted and non-admitted patient, clinical, administrative and financial data.	- Activity - Workforce - Services - Performance - Client demographics - Referral/waitlist - Appointment scheduling - Financial reporting
Queensland Hospital Admitted Patient Data Collection (QHAPDC)	The QHAPDC is the morbidity collection for all patients who have been admitted and separated from a hospital in Queensland. The information collected is used to manage, plan. Research and fund facilities at a local state and national level.	- Activity - Client complexity - Client trends - Performance - Client outcomes - Funding
Enterprise Discharge Summary (EDS)	The EDS application uses information from a number of existing Queensland Health specialist systems to create a legible, consistent, electronic discharge summary. It allows the summary to be delivered electronically to general practices in a secure, timely and standardised format.	- Client trends - Client complexity - Client outcomes - Performance
Primary Related Incident Management and Evaluation System (PRIME)	Management of clinical incidents and health care complaints. In the process of being phased out with QH moving to RiskMan	- Performance - Service safety - Client outcomes
RiskMan	An integrated incident reporting system	- Clinical and non- clinical incident reporting - Case management - Consumer/staff feedback - Risk management
Decision Support System (DSS Panorama)	Provides summary data reports displaying aggregate expenditure, budgets, variances and balances for cost centres and account codes for services. Reports are available for agency use, overtime, leave/ absenteeism, position occupancy and work centres.	- Workforce - Expenditure - Performance - Nurse Sensitive Indicators - Hospital at a glance
Integrated Electronic Medical Record – ieMR	An electronic system that manages patient health care and treatment record	- Client Care - Client Outcomes
Patient Access Coordination Hub (PACH)	Under development	- Dashboard

Table continued overleaf ››

Table 3: Paediatric settings information systems and data collections (continued)

Information system/collection	Purpose	Informs
Patient Flow Manager (PFM)	System which displays admitted patient status and electronic journey board	- Inpatient admission journey - Estimated date of discharge - Dietary requirements - Allergy - Allied health referrals - Inter hospital transfers
Enterprise Scheduling Management –ESM	A scheduling system for outpatients that enables clinicians to have a single view of patient appointments in a patient's ieMR.	- Outpatient appointments
Integrated Workforce Management (IWFM)	Work force management solution, application of award and scheduling compliance rules, timely, accurate and cost effective pay outcomes	- Rostering
WorkMAPP	Workforce management and planning tool	- Resource planning - People planning - Resource projections - Reports
Other information systems (for example: TrendCare)	Information system may be used to store local data sets	

As per the BPF 5th Edition, when a balanced scorecard is available, it assists in identifying service objectives, selecting appropriate performance measurements and monitoring the progress of those objectives. The balanced scorecard highlights both successful and unsuccessful performance trends and allows service comparisons to be made internally and externally. If a balanced scorecard is not available it will be necessary to determine local performance indicators.

There are a number of nurse-sensitive indicators suitable for evaluating the quality of paediatric nursing services such as:

- client/family satisfaction
- evidenced-based paediatric clinical practice guidelines
- health screening processes/outcomes
- clinical incident reviews
- readmission rates
- pressure injuries
- falls (need to consider falls as a part of normal child development)
- hand hygiene
- medication administration

Examples of workforce specific quality indicators in the paediatric setting include:

- vacancy rate
- staff turnover
- overtime used
- casual/agency hours usage
- workload issues
- absenteeism
- mandatory education completion rate
- requisite and/or unit specific education completion rate
- paediatric transition program completion rate
- post graduate paediatric program completion rate
- availability of access to professional development (cognisant of data limitations)

Key performance indicators should be chosen based on the individual service, with consideration of the consumer, staff, and the greater organisation.

Measurement of performance should include quality indicators including results from accreditation cycles and periodic reviews, further examples can be seen on page 50 of the BPF 5th Edition.

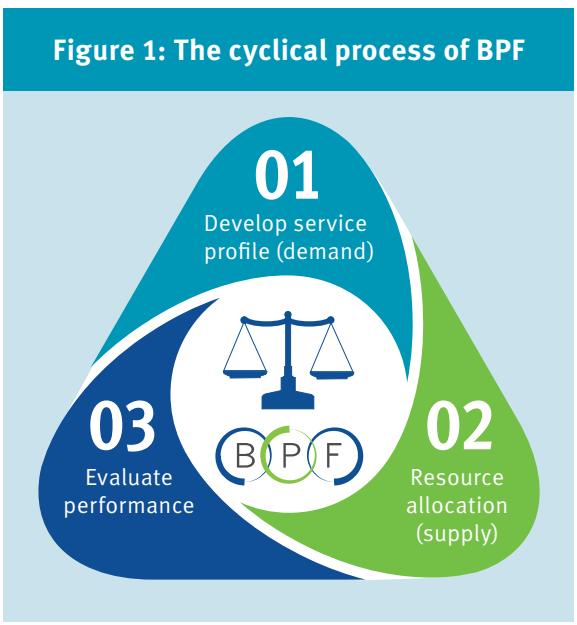
Forecasting and benchmarking

In the paediatric setting, as there are no standardised data sets, benchmarking can prove challenging. In the absence of reliable benchmarking, the evaluation of performance can be used to inform forecasting in paediatric settings.

Some Health Services contribute to data sets such as Children's Healthcare Australia (CHA) and/or the Health Roundtable. The value of the data varies as each health service is unique and has individual variables making meaningful comparisons between the services challenging.

A key component of the BPF cycle is evaluation of performance, which assists in assessing results against the planning as well as forms key information when commencing the next annual cycle. This is depicted in Figure 1.

Figure 1: The cyclical process of BPF



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Appendix 1: Example Activity Measures Identified for Paediatric Settings

- Emergency activity
  - » triage category (admitted and non-admitted)
  - » age groups (admitted and non-admitted)
  - » time of presentation
  - » time off stretcher
  - » walk-ins versus Ambulance presentations
  - » Queensland Emergency Access Target (QEAT)
  - » did not waits
  - » left after treatment commenced
  - » Transfer In and Transfer Out
  - » planned return visits
  - » unplanned return visits
  - » mental health presentations (e.g. requiring one on one care)
- Short Stay activity
  - » fractional bed days
  - » NHPPD
  - » age groups
  - » Queensland Emergency Access Target (QEAT)
  - » average length of stay
  - » admitted patients and transferred patient
- Inpatient activity – paediatric area
  - » Occupied Bed Days, Fractional Bed Days, Accrued Bed Days
  - » age groups
  - » Average Length of Stay
  - » separations
  - » Transfer In and Transfer Out
  - » Diagnostic Related Group (DRGs) and International Classification of Diseases (ICDs) for complexity indicators
  - » Nursing Hours per Patient Day (NHPPD)
  - » Weighted Activity Units
  - » boarder mothers (number)
  - » Hospital in the Home (HITH) patients - number
  - » outliers (adult patient in and paediatric patients out)
- Inpatient activity – non-paediatric area
  - » Number of requests
  - » Type of requests – procedures, PIV insertion, resuscitation, transport, x-ray
- Outpatient activity
  - » number of appointments
  - » clinic groups
  - » new to review appointments
  - » appointment number by healthcare group
  - » waiting times
  - » failure to attend
  - » cancellation by patient and by family
  - » procedures
  - » visiting clinic support and coordination
- Patient transport
  - » internal transfers e.g. x-ray – number, hours
  - » off campus transfers e.g. RFDS – number, hours
- Telehealth activity
  - » time spent in provider clinic
  - » time spent in receiver clinic
- CATCH / Connected Care
  - » time spent discussing patient management plans
  - » time spent planning transfers
  - » time spent arranging back transfers

Acknowledgements

Queensland Health acknowledges the authors, reviewers and editors of the Business Planning Framework EB9 Addenda Project from which this document is derived.

This addendum was authored by Queensland Health, Office of the Chief Nursing and Midwifery Officer (OCNMO), and Queensland Nurses and Midwives Union (QNMU) by:

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Queensland Health would also like to thank its nurses and midwives for contributing to this project and delivering excellent standards of evidence-based patient care to the people of Queensland.

Special acknowledgement is given to members of:

The Paediatric Setting Speciality Users Group –

- Desley Horn, Specialty Practice Lead: Paediatric Setting Addendum, LCCH, CHQS
- Helen Alvers, Nurse Unit Manager, Mackay Base, MHHS
- Michelle Hutch, NUM, Caboolture Hospital Paediatrics, MNHHS
- Jane Walker Smith, A/ Nurse Manager, LCCH, CHQS
- Tarryn Mullavey, Nursing Director – Service Planning, NWHHS
- Kirsty Franklin NUM, WMHHS
- Lynda Briggs, NUM Children's Ward & SSU, Children's OPD, The Prince Charles Hospital, MNHHS
- Melissa Zornig, CN, Logan Hospital, MSHHS
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- Lynette Zeller, Speciality Practice Lead: Maternity Services Addendum
- Desley Horn, Speciality Practice Lead: Paediatric Setting Addendum

The BPF Subject Matter Expert Reference Group - Glenn Hokin, Jane Davies, Jane Walker-Smith, Jeff Dippel, Jeffrey Souter, Juliet Graham, Lesley Reid, Lynne Cameron, Michelle Eley, Neil Pratt, Paolo La Penna, Rachelle Cooke, Rohan Harbert.

The EB9 Executive Directors of Nursing and Midwifery Services

- Chris Small, EDNM, South West HHS
- Veronica Casey, EDNM, Metro South HHS
- Judy Morton, EDNM, Townsville HHS
- Alanna Geary, EDNM, Metro North HHS

The statewide Executive Directors of Nursing and Midwifery Services.

Special acknowledgement is given to the following contributors:

- Shelley Nowlan, Chief Nursing and Midwifery Officer, OCNMO
- Diana Schmalkuche, Director of Nursing, Workforce Sustainability, OCNMO
- Rachel Borger, Director, Industrial Relations, Employment Arrangements Unit, DOH
- Renee Muggleton, Project Support Officer, Employment Relations, DOH
- Susan Krimmer, Acting Assistant Director of Nursing, OCNMO for her contribution in co-leading and commencing the project.