

Business Planning Framework:

a tool for nursing and midwifery workload management

5th Edition 2016

Rural Setting Addendum 2018

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Contents

Introduction	2
Module 1: Development of a service profile	3
Business planning in the context of rural settings	3
Business planning considerations.....	6
Nursing and midwifery core demand considerations	9
Module 2: Resource allocation	14
Module 3: Evaluation of performance	24
Data collection for rural settings.....	24
Forecasting and benchmarking	27
Balancing supply and demand in nursing/midwifery services	28
References	30
Appendix 1: Example activity measures identified for Rural Settings.....	32



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 rural, rural, regional and metropolitan nursing and midwifery services in Queensland Health. This addendum is designed to recognise the unique challenges for nurses and midwives working in rural settings and must be used in conjunction with the BPF 5th Edition.

The Rural 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 rural, to support compliance with the Nursing and Midwifery Workload Management Standard.

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

This addendum will assist nursing and midwifery staff within rural 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 and midwifery activity within their service
- understand the current and emerging demand considerations for nursing and midwifery hours within their setting
- develop planning tables identifying productive and non-productive hours relevant to rural settings
- identify and describe client and service complexity and activity indicators to improve consistency in the application of the BPF 5th Edition in rural 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 rural settings

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

- articulating rural nursing and midwifery work
- validating indirect rural nursing and midwifery hours
- applying standard business planning definitions to rural settings and;
- accessing suitable rural data collections and reporting systems

These issues have also been validated through the statewide Business Planning Framework Generic Review 2017.

The unique challenges of rural communities compound the challenges of describing rural nursing and midwifery work. Population numbers often vary with transient groups, temporary employment models (such as fly-in fly-out), major tourist events, caravanning groups and mining industry and create short to medium term service demand. These fluctuations have implications on nursing and midwifery staff that are difficult to resource in a timely manner.

The increasing rates of socioeconomic disadvantage in rural areas and resulting effects on health, as well as the increased prevalence of mental health and chronic disease, all impact on the complexity and demand on services¹.

The geographical isolation of rural services results in unique differences to practice. Nursing and midwifery practice in rural settings often requires a generalist approach as there is wide variability in service delivery, dependent upon the needs of the community.

It is often the case in rural Queensland that there is limited on-site access to allied health, primary health, and specialist services, other than through visiting services, whereby such services are available for a few days a month, or on an ad hoc basis. The lack of preventative and primary health care impacts on the health outcomes of rural residents as well as the workload of the nurses and midwives providing services.

There are a broad range of service activity types at level 1-4 Clinical Services Capability Framework (CSCF) in rural settings².

The CSCF determines the level of service to be provided based on the minimum capability criteria, resulting in high frequency

¹ <http://ruralhealth.org.au/publications>

² <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf>

of patient transfers and retrievals. Typically, the Director of Nursing / Facility Manager (DON/FM) undertakes this activity and as such, the true resourcing implications are not demonstrated. Accurate recording of escort activity in calculating nursing and midwifery resources is required.

The application of Nursing Hours Per Patient Day (NHPPD) or Nursing Hours Per Occasion of Service (NHPOS) or Nursing Hours Per Unit of Activity (NHPUA) does not provide an adequate representation of the full scope of activity and/or acuity demands upon nursing and midwifery within the rural health setting. The calculation of productive hours needs to incorporate staffing requirements across all service types recognising the need for nurses and midwives in rural settings to undertake roles that would be otherwise staffed in regional and metropolitan facilities. This further emphasises the need to draw on/rely on the professional judgement of the uniquely placed nurses and midwives undertaking the work in the calculation of the nursing and midwifery hours required. The following are key considerations in a rural setting:

- Benchmarking
 - » Benchmarking of service activity and relative performance measures within rural health facilities is complex and affected by limited or absent clinical information systems or mismatched performance reporting frameworks
 - » Benchmarking can also be challenging within rural health facilities due to the varied models of care for similar demographic and service characteristics and geographically located communities (i.e. Multipurpose Health Service (MPHS) vs. acute hospital model)
- Infrastructure
 - » Ageing building infrastructure and building design impacts upon workflow efficiency, occupational health and safety and security of staff
- » Insufficient technology infrastructure (mobile network coverage, unreliable internet coverage, no Wi-Fi in health facilities)
- » Limited or absent clinical information systems impacting recording of activity and subsequent data reliability. This includes quantitative methods to individually measure nursing and midwifery workloads
- » Workload metrics that are in place are focused on general staff workload (incorporating all health providers), patient activity and procedures undertaken and therefore do not accurately capture all the productive contributions of nursing and midwifery staff
- Inflexible funding models
 - » block funding may not reflect the broad range of service activity types undertaken and growing complexity/acuity
 - » introduction of services traditionally performed within ABF facilities
 - » Calculations based on number of episodes, with limited consideration of patient acuity, leading to poorly articulated nursing and midwifery demands
- Impact of changes in acuity and complexity of care
 - » Changing acuity of health services (delivering higher complexity healthcare such as renal dialysis and chemotherapy in rural health settings)
 - » Significant rural midwifery workforce resourcing implications exist in association with implementation of National Maternity Services Plan 2010³ and the changing consumer expectations for evidence based continuity of care midwifery models in rural communities
 - » Capacity and capability of the nursing and midwifery workforce to respond to these changes and maintenance of

³ <http://www.health.gov.au/internet/main/publishing.nsf/content/maternityservicesplan>

generalist rural nursing and midwifery skills including low frequency high risk clinical skill/capability (i.e. perioperative/ maternity/ trauma)

- Recruitment, retention and succession planning
 - » The vast distances between communities and services, small local populations with diverse health needs, and comparatively small health workforce in any location adds complexities that need to be factored into managing the workforce⁴
 - » Limited opportunities for undergraduate nursing and midwifery students to have clinical placements in the rural setting have implications on the attraction of the future workforce
 - » Graduates are fundamental in succession planning; however adequate education infrastructure must accompany growing graduate numbers, particularly in facilities with low numbers of total workforce full-time equivalent (FTE)
 - » Support models such as Telehealth Emergency Management Support Unit (TEMSU) and rural or mobile (multi-site) Clinical Facilitators require resourcing consideration
 - » Workforce maldistribution results in role substitution and expanding role functions within nursing and midwifery
 - » There is limited access to a casual workforce for the management of emergent leave and short term planned leave.
 - » This can be due to Professional Development Leave (PDL)/mandatory training and role specific training requirements that are not held locally and travel is required.

- Role of the Rural DON/FM

- » The Rural DON/FM role has a substantially broad health service management function (both operational and strategic) inclusive of inter-professional leadership, management and workforce planning.
- » The DON/FM in rural hospitals, community hospitals, Multi-Purpose Health Services (MPHS) and Primary Health Centres (PHC) additionally provide the middle management support creating indirect activity demands. In other facilities, this middle management support would normally be provided by Nurse Unit Manager (NUM)/Midwife Unit Manager (MUM) positions.
- » The DON/FM provides direct clinical care and participates in on call arrangements; consideration to fatigue should be made.
- » The DON/FM provides direct and indirect hours; which requires consideration when calculating workload demands. For example, the DON/FM is also responsible for operational and strategic planning, building, equipment and asset maintenance, fleet car management, management of food safety, hotel services management, emergency management planning, radiation safety audits, community engagement, consultative forums, accommodation management.



⁴ https://www.health.qld.gov.au/_data/assets/pdf_file/0039/672978/rural-remote-workforce-strategy.pdf

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 rural 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 and midwifery hours.

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



Table 1: Business planning consideration for rural settings

Influences (internal and external)	Service impact	Examples of workload management considerations
<p>Locality of service (Internal) (Metropolitan, regional, rural and remote)</p>	<p>The locality, type and catchment area of a service will influence the balance of service demand and supply.</p> <p><i>Examples:</i> <i>Rural health services need to consider the workload impacts of delivering a broad range of health services in geographically isolated and dispersed communities.</i></p>	<p>Direct nursing and midwifery 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</p>
<p>Type of service (Internal) (e.g. emergency, primary health clinic, operating theatre)</p>	<p><i>This means that a large component of travel associated time needs to be factored into resourcing the service demand activity</i></p> <p><i>Role substitution and role expansion has resulted in a proportion of workload is comprised of non-nursing duties, such as ambulance, pharmacy, pathology, x-ray, meal preparation/hotel services and mortuary services as examples. This needs to be considered within the context of practice impacts workload management.</i></p>	<p>Indirect nursing and midwifery hours: Calculation of clinical hours for indirect care, travel, program/service based education, succession planning, quality activities and research</p>
<p>Catchment area (Internal) (Local Hospital and Health Services versus Statewide Services)</p>	<p><i>All services need to consider the impact of skill mix on optimal service delivery.</i></p>	<p>Workforce planning: Development of strategic local/ statewide workforce plans to inform FTE requirements, skill mix profiles and macro workforce planning formulas.</p>
<p>Nursing and midwifery structure (Internal) (Roles, functions, accountabilities and relationships between all categories of nursing and midwifery staff)</p>	<p>The model of care selected for a service will influence the nursing/midwifery and support structures required. Nursing and midwifery roles and how they relate with other clinical roles will impact on the balance of service demand and supply.</p> <p><i>Examples:</i> <i>In rural health care, nursing and midwifery roles can be categorised by the skills required to meet client demand (i.e. orthopaedic, maternity, mental health, endocrine, renal). To accommodate the wide range of skills required, a level of flexibility in role description is necessary which can impact on the number of nursing and midwifery staff employed and their workloads.</i></p>	<p>Direct nursing and midwifery 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.</p>
<p>Support structure (Internal) (Providing support to other services and/or receiving support from other services)</p>	<p><i>Within rural communities, access/support from other services may be limited. Nurses/ midwives within these environments may be required to practice autonomously at an advanced level. The classification of positions within these communities will reflect this requirement.</i></p>	<p>Indirect nursing and midwifery hours: Calculation of clinical hours for non-direct care networking/collaboration (internal and external) travel, staff training, professional development, quality activities and research.</p>
<p>Model of care (Internal) (Multi-functional teams)</p>	<p><i>The accessibility and level of support available to and from other services may vary. Nursing and midwifery services should account for the productive hours required to manage the demand from these interactions</i></p>	<p>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.</p>

Table continued overleaf >>

Table 1: Business planning consideration for rural settings (continued)

Influences (internal and external)	Service impact	Examples of workload management considerations
<p>Policy/legal factors (External)</p>	<p>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.</p> <p><i>Examples:</i> Legislation – Work Health and Safety Act 2011 Commonwealth - health reform Queensland Health – strategic plan</p>	<p>Direct nursing and midwifery 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.</p>
<p>Economic factors (External)</p>	<p>Funding policies, the national economy and the interface between public and private health care providers will influence the delivery of rural health services and the number of staff required.</p> <p><i>Examples:</i> 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/midwives required for service delivery.</p>	<p>Indirect nursing and midwifery 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.</p>
<p>Social/population factors (External)</p>	<p>Population demographics and community expectations will impact on the types of remote health services offered, how the services are offered, staffing numbers and skill mix required for service delivery.</p> <p><i>Examples:</i> Delivering health services to a community with a high proportion of non-English speaking people will impact the number and type of clinical hours required to operate the service.</p>	<p>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.</p>

Nursing and midwifery core demand considerations

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

Client/service complexity

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

- Higher rates of ill health, increased risk factors, morbidity for defined diseases⁵
- Impact of environmental issues, such as physically dangerous occupations and factors related to driving (for example: long distances, greater speed, isolation, animals on roads)⁶
- Higher rates of harmful or hazardous use of cigarette and alcohol consumption, compared to metropolitan areas⁷
- Differences in access to services resulting in higher death rates, for example from coronary heart disease and motor vehicle accidents⁸
- Higher population rates of Aboriginal or Torres Strait Islander in rural areas with associated poorer health outcomes. An added complexity in providing continuity of care is the transient nature of the Indigenous population.

Australian Indigenous Health InfoNet⁹ provides comprehensive data on these outcomes, including:

- » Babies born to Aboriginal and Torres Strait Islander women are almost twice as likely to die in their first year as those born to non-Indigenous women
- » Around one-in-eight (13%) Aboriginal and Torres Strait Islander people reported having some form of cardio-vascular disease
- » Diabetes affects 13% of Aboriginal and Torres Strait Islander adults
- » Aboriginal and Torres Strait Islander people were five times more likely than non-Indigenous people to be admitted into hospital for COPD, three times more likely to be admitted for influenza and pneumonia and nearly twice as likely to be admitted for asthma
- » 34% of Aboriginal and Torres Strait Islander children aged 4-14 years reported having tooth or gum problems
- Allied health, primary health and specialist services may only be available from visiting services, provided largely on an ad hoc basis. This limited access to preventative and primary health care impacts greatly on the health outcomes of rural residents and the nursing and midwifery workload demand.
- The dispersed population in rural areas requires investigation and consideration in the resourcing and provision of services¹⁰

⁵ <http://www.healthinonet.ecu.edu.au/health-facts/summary>

⁶ <http://www.aihw.gov.au/rural-health-impact-of-rurality/>

⁷ <http://www.aihw.gov.au/rural-health-impact-of-rurality/>

⁸ <http://www.aihw.gov.au/rural-health-impact-of-rurality/>

⁹ <http://www.healthinonet.ecu.edu.au/health-facts/summary>

¹⁰ <http://statistics.qgso.qld.gov.au/qld-regional-profiles>

- The fluctuation of the population with seasonal visitors such as ‘grey nomads’ who are typically retirees with added health complexities as well as the fly-In fly-Out workforce which can change the population by thousands impacting on nursing and midwifery demand
- The Index of Relative Socio-Economic Disadvantage ranks geographical areas in terms of their relative socio-economic disadvantage. This information is key in rural settings and is important to review when assessing complexity of service delivery ¹¹.

Model of care/service delivery

The rural setting does not have the opportunities for economies of scale which are available in larger facilities; therefore models of care and/or nursing and midwifery roles may require flexibility to meet demand. Some examples of this are:

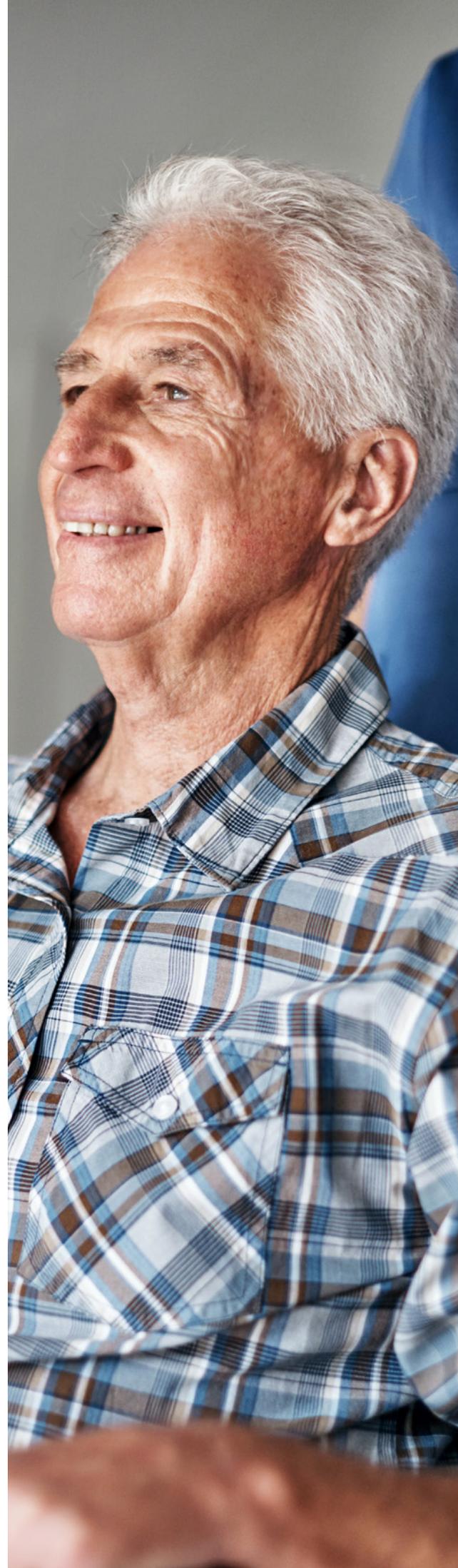
- facility management is often undertaken by the DON role
- nurses and midwives may assume additional non-clinical roles when working in isolation, such as maintenance coordination, ambulance service provision, pharmacy and pathology collection
- isolated practice and associated safety considerations
- nurses practicing in an advanced scope of Rural and Isolated Practice Registered Nurse (RIPRN) endorsement

These are all impacted by the geographic isolation, problematic transport, poor infrastructure (including internet/phone services), as well as harsh extremes of climate and high turnover of workforce.

Services must reflect and have the capability to meet the minimum criteria as determined by the CSCF ¹².

¹¹ <http://statistics.qgso.qld.gov.au/qld-regional-profiles>

¹² <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/modules>



Technology and materials management

The introduction of systems and eHealth technology requires significant input from nurses and midwives. Often there is no or limited on-site IT support in rural facilities, resulting in the staff needing to assist other streams in using the systems (for example, medical officers and locums who rotate through the service).

The time spent on accessing and recording of information on a number of systems needs to be considered, particularly the impact of the unstable internet connectivity. Nursing and midwifery staff should build indirect time to account for training and ongoing systems management.

Community interface

There are a variety of service delivery models within the rural setting that provide care to consumers across primary care and inpatient units. In most cases, the individual models inter-relate and generate demand on productive hours within the connecting services. The unit or department may directly and/or indirectly interact with the following service areas:

- community engagement through Community Advisory Networks (CAN) and local service coordination with Non-Government Organisations (NGOs)
- Aboriginal Community Controlled Health Services (ACCHS)
- primary health care providers
- private sector service providers
- community health service providers
- acute inpatient and extend inpatient services
- community residential care providers
- specialised statewide services such as mental health and paediatrics services

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

Quality and safety

Quality and safety activities within rural health services are primarily governed by organisational policy and legislation. The productive nursing and midwifery hours of the health service are influenced by quality and safety processes. The distribution of direct and indirect hours need 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 and midwifery hours include:

- client safety
- staff safety
- mandatory/requisite training requirements
- policy development and review
- portfolios
- incident and near miss reporting and management.

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

Education and service capacity development

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

Leadership and management

In a rural setting, leadership and management organisational structures are often flatter than larger organisations. This may impact the level of demand placed on productive nursing and midwifery hours. Leadership and management roles are closely linked with local service delivery model.

The demand considerations include:

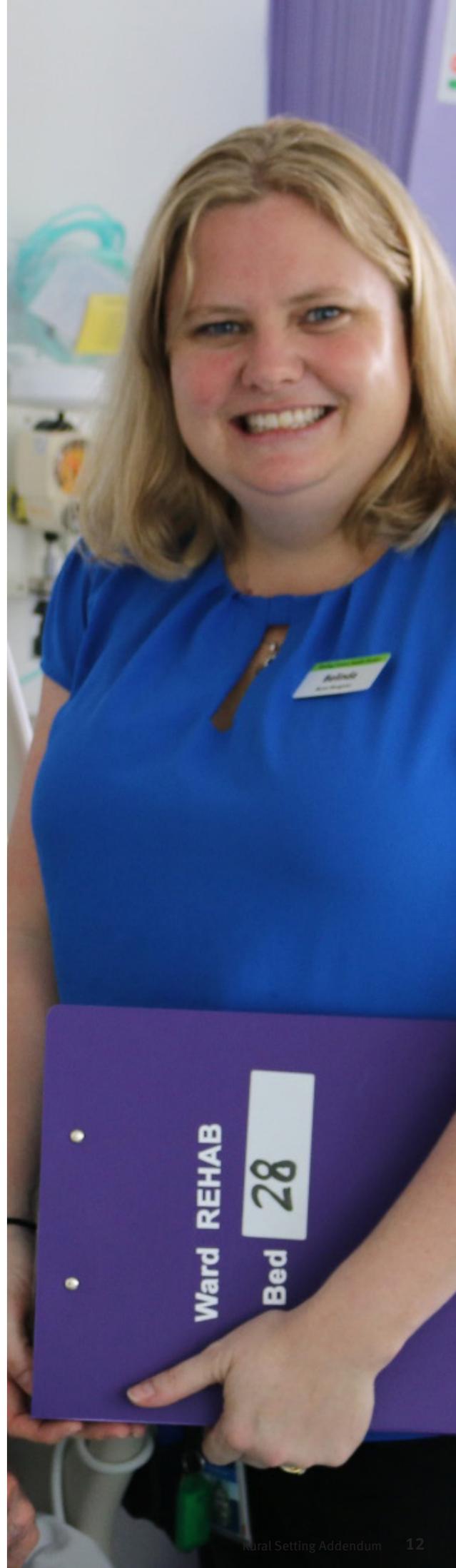
- skill requirements of leaders and managers
- service accountabilities and responsibilities
- human resource management (for example recruitment, succession planning, business planning)
- organisational involvement (including committees, networking)
- organisational culture
- staffing profile (including classification, scope of practice, training and skills)
- interactions with multidisciplinary team members

The multiple responsibilities that the rural DON undertakes requires additional consideration when developing direct, indirect and non-productive hours. These include:

- on call allocations
- direct clinical care expectations
- facility management activities

Research and evidence based practice

Undertaking research and evidence based practice activities will influence the number of indirect nursing and midwifery 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.



Health policy, clinical guidelines, strategic plan and health legislation

There are a number of legislative and policy requirements that influence the rural setting. These should all be considered when developing service profile, resource allocation and evaluation of performance.

- Health policy - Advancing rural and remote health service delivery through workforce: A strategy for Queensland 2017-2020¹³
- Primary Clinical Care Manual (PCCM) - guides practice including assessment and management of a range of clinical conditions and presentations. Also provides a Drug Therapy Protocol (DTP) for specified clinical situations and endorsement/authorisations¹⁴
- Chronic Conditions Manual - collection of guides produced from contemporary evidenced literature and developed using best practice frameworks¹⁵
- Strategic plans:
 - » National Maternity Services Plan 2010. Five year vision that “all Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live”¹⁶
 - » Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023¹⁷
- Health legislation:
 - » Nursing and Midwifery Board of Australia (NMBA) Endorsement for scheduled medicines for registered nurses (rural and isolated practice). This standard sets out the qualifications and other requirements that must be met in order for a registered nurse or applicant for registration as a nurse to be granted an endorsement under section 94 of the National Law as qualified to obtain, supply, and administer scheduled medicines.¹⁸
 - » Health Act 1937, Health (Drugs and Poisons) Regulation 1996. Detail about registered nurses in regard to isolated practice and supply of controlled drugs on discharge from hospital.¹⁹



¹³ https://www.health.qld.gov.au/__data/assets/pdf_file/0039/672978/rural-rural-workforce-strategy.pdf

¹⁴ <https://publications.qld.gov.au/dataset/27722ad1-4a1e-4a28-a3d7-bafea915bc00/resource/06f04fcb-6eb6-45eb-9770-c4a79a715b62/download/primary-clinical-care-manual-edition-9.pdf>

¹⁵ <https://publications.qld.gov.au/dataset/ef6d9f9e-e8aa-445e-a345-02a016e7251b/resource/bbe5439c-be87-45b6-b704-3b557fbee1e0/download/chronicconditionsmanual1stedition.pdf>

¹⁶ [https://www.health.gov.au/internet/main/publishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/\\$File/maternityplan.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/8AF951CE492C799FCA257BF0001C1A4E/$File/maternityplan.pdf)

¹⁷ [http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/\\$File/DOH_ImplementationPlan_v3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/$File/DOH_ImplementationPlan_v3.pdf)

¹⁸ <http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines.aspx>

¹⁹ <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealDrAPoR96.pdf>

Module 2: Resource allocation

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

Establishing total nursing and midwifery resource requirements

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

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

Creating a list of standard direct and indirect nursing and midwifery 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 and midwifery activities relevant

to your service, especially those considered unique to your unit or practice area. Defining productive hours increases the understanding of the nursing and midwifery work being performed and provides an excellent foundation when developing a service profile.

Table 2 provides examples of key productive and non-productive nursing and midwifery activities for a rural 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 and midwifery hours

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Service delivery				
Admitted services				
Models of service delivery				Acute adult/paediatric inpatient wards, Perioperative (operating theatre, endoscopy, DOSA) , maternity services (i.e. team midwifery, midwifery group practice,), residential aged care
Direct clinical care activities	x			Patient assessment, planning, implementation and evaluation activities
Clinical documentation	x			Completion of all relevant medical record forms, referral forms, progress notes, clinical pathways (e.g.: patient held maternity care record), CIMHA electronic medical record
Clinical handover	x			Shift to shift, inter-facility, intra-facility, accepting clinician case manager
Multidisciplinary case conference	x	x		Team based care planning.
Patient and family education/ care planning meetings	x			Health/disease management education, treatment and goal planning collaboration
Patient escorts, transfers and retrievals		x		Transfer documentation, transport arrangements, patient preparation, intra-hospital/service liaison
Surgical procedures	x			Includes set up, procedures and environmental cleaning
Telehealth specialist consultations (admitted)		x		Telehealth equipment set-up, patient preparation/consultation assistance
Shift coordination		x		Team leading, after hours bed/ service capacity management
Patient acuity/bed system data entry		x		Clinical systems: Trendcare, Patient Flow Manager
Clinical incident reporting		x		Incident reporting systems data entry
Non-admitted services				
Models of service delivery				Emergency department, outpatient/ambulatory clinics, Primary Health Centres, extended community (home-based), outreach clinics, AODS, school-based,
Emergency triage and care delivery	x			Triage assessment/EDIS data entry, client assessment, clinical/electronic record documentation cannulation & phlebotomy, minor procedures, community liaison
MET/trauma team	x	x		Medical/trauma emergency response team (internal/ external)
Medical imaging (X-ray, ultrasound)	x			X-ray services (licensed operator), image management
Referral management		x		Triaging and prioritising, appointment management
Scheduling clinics	x			Template development and adjustments
Clinic delivery	x			Preparing charts, managing client information, test results and follow up appointments
Client assessments	x			Physical/social/health literacy assessments
Direct clinical care activities	x			Patient assessment, planning, implementation and evaluation activities

Table continued overleaf >>

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Clinical documentation	x			Completion of all relevant medical record forms, referral forms, progress notes, clinical pathways (e.g.: pt. held maternity care record), CIMHA electronic medical record
Procedures/treatments	x			E.g.: renal dialysis, clinical measurements, pathology collection Includes set ups, procedures and clean ups
Telephone consultation/ advice	x			Assessment, counselling, education
Multidisciplinary case conference	x	x		Team based care planning.
Client and family education	x			Delivering health education
Tele-health specialist consultations (non-admitted)		x		Telehealth equipment set-up, patient preparation/ consultation assistance
Clinical service support activities				
Medical record coordination and management		x		
Patient Travel Subsidy Scheme (PTSS) administration		x		PTSS claims assistance, approvals (notifications/ certifications), recordkeeping/accounting
Pharmacy		x		Stock ordering, control, dispensary, disposal, records management
Pathology (collection, preparation, transport)	x			Phlebotomy and other pathology specimen collection, processing
Vaccine management		x		Stock ordering, cold chain management
Inventory and stock control		x		Sterile stock management and ordering
Central sterilising services	x			Decontamination, reprocessing re-useable items
Infection Control		x		Screening, clinical surveillance, nosocomial outbreak management
Staff management (all streams)				
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/shift coordinator duties
Human resource management		x		Payroll system information management, staff movement forms, performance improvement
Recruitment and retention		x		Advertising, interviewing, developing retention strategies
Workforce data collection and analysis		x		Labour expenditure, leave management, monthly reports
Staff travel		x		Organising travel for visiting medical staff, undertaking travel

Table continued overleaf >>

Table 2: Examples of key productive and non-productive nursing and midwifery 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
Continuing Professional Development (personal)			x	Personal professional development supported via access to professional development leave
Staff education (in clinical area)		x		Internal and external
In-service training		x		Ward-based education/training sessions
Professional development/portfolios		x		Clinical portfolios
Performance appraisal and development (PAD)		x		Participation in PAD process and Performance Improvement Plan
Succession planning		x		Workplace shadowing, professional development
Staff meetings		x		Unit/ workplace based
Evidence-based practice		x		Research activates/service based projects
Corporate and clinical governance				
Committee participation		x		Internal and external committees
Accreditation Framework		x		Quality management systems (multiple accreditation programs: egISO:9000, National Safety and Quality Health Standards, Australian Aged Care Quality Agency)
Quality audits/safety check		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
Ministerial responses		x		Patient complaints, service delivery issues
Information management				
Balanced scorecard		x		Evaluation tools
Service data collection and analysis		x		Service improvements
Business planning and management		x		Service profile development
Electronic medical records	x			Client related information and storage record

Table continued overleaf >>

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Facility management				
Service coordination		x		Coordination of clinical services within facility and integration with local area NGOs
Operational and strategic planning		x		Business and strategic planning
Building, equipment and asset maintenance		x		Minor and capital works planning,
Fleet car management		x		Car bookings, servicing, record keeping
Hotel services management		x		Management of waste, food safety requirements, environmental cleaning, grounds
Emergency management planning		x		Continuity of service planning/disaster response planning (local government/non-government services)
Community engagement		x		CAN membership/community forums
Consultative forums		x		Industrial/clinical networks/regional networks
Accommodation management		x		Accommodation access, bookings,
Other				
Travel		x		Travel associated with service delivery e.g. outreach clinics
Mortuary		x		Admission, viewing, discharge procedures.
Meal preparation		x		

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 is allocated within non-productive hours.



Service activity

The professional judgement of nursing/ midwifery 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 and midwifery activity. In the rural setting, the roles of nurses and midwives span emergency, outpatient, pharmacy, inpatient and dialysis services, so the time taken as hours or fractions of hours reflecting these multiple activities must be considered.

For example in the rural setting nurses and midwives are providing:

- **Pharmacy services:** One Occasion of Service (OOS) in pharmacy can mean that the patient has had one script dispensed, or it can mean the patient has had 12 scripts dispensed. In this example, there are vastly different nursing and midwifery times required to deliver each activity. Further consideration should be given when the service is provided as part of the continuity of care in the primary health setting as opposed to services or facilities that directly roster nurses to pharmacy activities.
- **Pathology services:** In a metropolitan facility, nurses and midwives involvement in pathology may be limited to collection of blood from the patient. However, in a rural facility, the nurses and midwives involvement may include collection, centrifuging and storage of the blood. Additional responsibilities include packaging and transporting the blood to the airport or another facility for processing. These activities are equal in their financial weighting, but require vastly different amounts of nursing and midwifery time. Additional training is required for rural nurses and midwives undertaking packaging and transport of pathology specimens.

- **Medical imaging (X-ray):** Nurses and midwives undertake X-ray tasks, OOS can vary in complexity, for example, one OOS can mean over 10 separate exposures resulting in much more nursing and midwifery time dedicated to the activity. The indirect hours associated with maintenance, file management, legislated reporting and associated compliance reports for medical imaging should be considered. The associated time to become a licensed X-Ray Operator must also be considered for services where nurses and midwives deliver this activity.
- **Ambulance services:** Hospital based ambulance services are provided by nurses in rural settings. When developing the nursing hours required, the need for backfill and on call implications must be considered. It is important to note that the rural setting can require travel across extensive distances which impacts on the nursing hours required for backfill and to manage fatigue. Additional training is also required to deliver this service.
- **Outpatient services:** Outpatient clinics are often provided on an outreach basis. The clinic providers include nursing and midwifery staff, medical staff, allied health or other NGOs (e.g. Primary Health Network contractors) attending from out of the local area. This requires additional time to prepare the clinics. Nurse and midwife-led clinics are often provided by staff undertaking other clinical responsibilities. Examples of specialist nurse and midwife-led clinics include:
 - » Nurse Navigator clinics
 - » chronic disease clinics
 - » wound clinics
 - » school based clinics
 - » immunisations
 - » maternal health clinics
 - » specialty clinics
 - » domiciliary services
 - » mental health clinics
 - » sexual health clinics



- **Telehealth services:** Nurses and midwives are required to deliver and facilitate services via telehealth. The impact of this is that the nurse or midwife may be required to transport the patient to the hospital for their appointment. Alternatively they may provide tele-health in the patient’s home setting, which requires additional time to locate the patient, transport additional equipment and conduct the session.
- **Mortuary services:** Rural hospitals often provide the only morgue facility in their geographical area. Persons who are deceased within the community are transported to the hospital morgue. Care of the deceased person can be the responsibility of the nurses and midwives. Nursing and midwifery activity includes thermometer checks, maintenance of morgue, facilitating viewings of the deceased and assisting patient handling when the undertaker transports the deceased. This nursing and midwifery activity is not reflected in financial activity.
- **Non clinical activity:** Nurses and midwives often perform a large amount of non-clinical activities which need to be acknowledged when considering hours for service delivery. Some examples of additional non-clinical requirements are:
 - » generator maintenance/checking
 - » QFleet management
 - » patient travel
 - » procurement
 - » scheduled and non-scheduled asset maintenance
 - » clinical forms management
 - » stores management
 - » accommodation management
 - » emergency planning management
 - » management of waste
 - » management of food safety requirements
 - » management of environmental cleaning requirements
 - » project management (such as refurbishments as BEMS not on site)
 - » consumer engagement committees (e.g. CANS)

In the absence of a nursing and midwifery data set for rural settings, 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
- inpatient activity
- aged care activity
- outpatient activity
- hospital based ambulance activity
- primary health clinic activity
- mortuary activity
- telehealth activity
- CSSD activity
- non-clinical activity

The following is a table that provides an example of associating direct nursing and midwifery activity with hours in a service that combines multiple service delivery (for example outpatient and emergency). This table does not include inpatient activity. The times allocated are examples only and should be tailored to each specific site through collaboration with nursing and midwifery staff working in the service area.

Table 3: Example of multiple service delivery nursing and midwifery direct care activity (excluding inpatient)

Nursing and midwifery activity	Times associated with activity unit	MAC Form Data - OOS	Nursing and midwifery hours to provide service requirements
Service activities			
Pharmacy			
OOS (MAC)	0.5 = 30 mins		
Dosette boxes	0.75 = 45 mins		
Items supplied/dispensed	0.17 = 10mins		
Radiology			
OOS (MAC)	1.25 = 75 mins		
Number of X-rays	1 = 60 mins		
Pathology			
Number of tests	0.17 = 10 mins		
Number of ISTAT	0.34 = 20mins		
Mortuary cares			
Direct community referral & admit	4 hrs		
Facility referral & admit (deaths data)	4 hrs		
Patient travel			
Patient travel PTSS	1 hr		
Ambulatory care			
Accident & Emergency			
A&E Total			
A&E Cat 1	10		
A&E Cat 2	8		
A&E Cat 3	4		
A&E Cat 4	2		
A&E Cat 5	0.55		
Did not wait	0.55		
A&E other	0.55		
Emergency transfers (A&E or OPD)	6.0		
Outpatient			
Total OOS	0.5		
Telehealth total OOS	2.0		
Telehealth provider OOS	1.5		
Telehealth recipient OOS	2.0		
Total nursing and midwifery hours for OOS activity			

*note: QH data sets, including MAC data, are detailed in Table 4.

Module 3: Evaluation of performance

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

Data collection for rural 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 and midwifery in the rural setting.

Table 4 outlines key identified information systems available in rural health service, they may not provide the required information so local data bases or spread sheets may be developed.

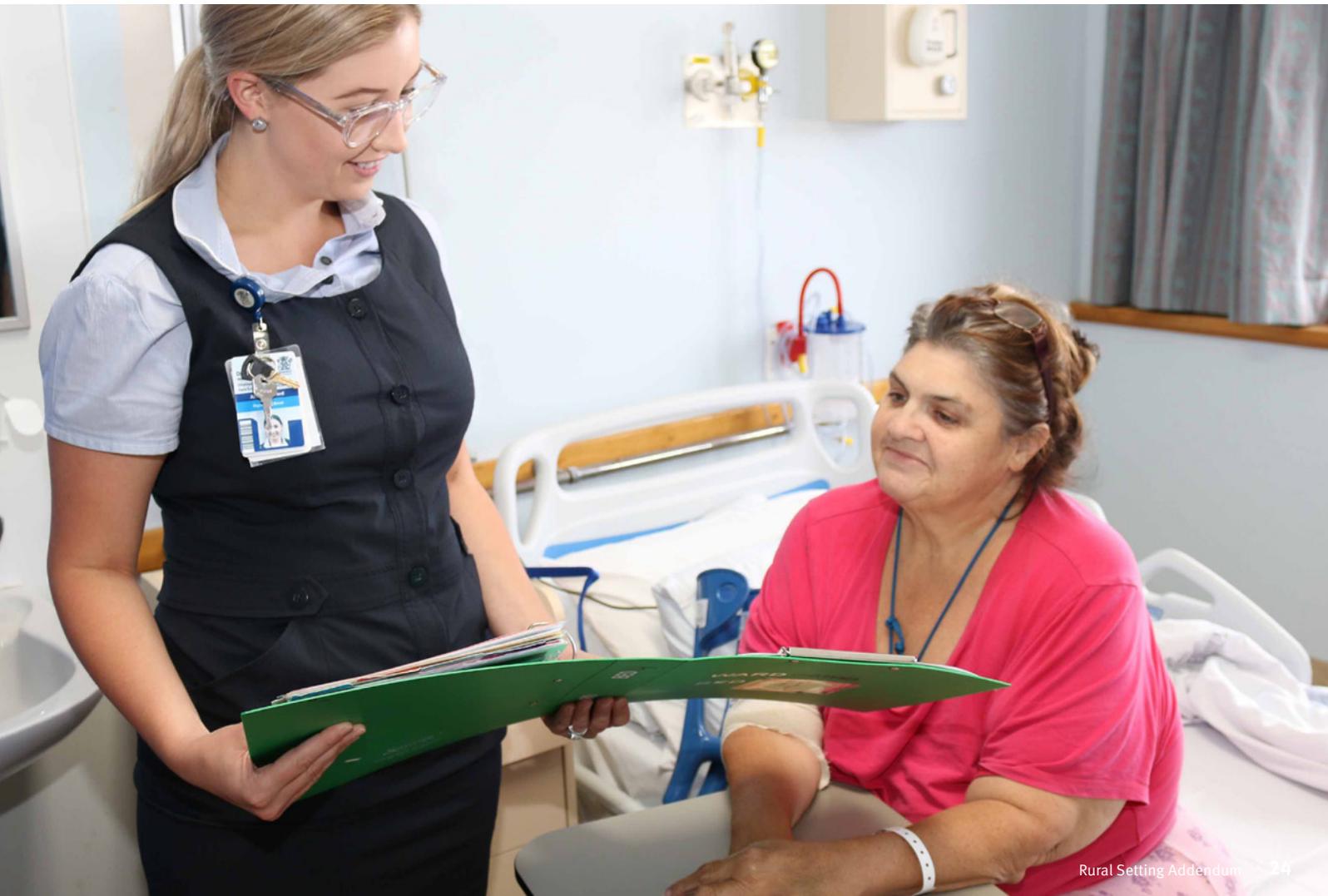


Table 4: Rural Health Services Information Systems and Data Collections

Information system/collection	Purpose	Informs
<p>Monthly Activity Collection (MAC)</p> <p>Note: MAC reporting to become obsolete in 2018/19</p>	<p>Collects aggregate (or summary level) data on ‘admitted’ and ‘non-admitted’ patient activity from public acute hospital facilities, public residential psychiatric hospitals and public nursing homes/hostels/independent living units and multipurpose health services each month. Data is routinely reported on QH’s internet and internet sites.</p>	<p>Activity</p> <p>Provider type</p> <p>Client type</p> <p>Service type</p> <p>Performance</p> <p>Financial reporting</p>
<p>Outpatient Services Information Management System (OSIM)</p>	<p>Customer service focused system that assists clinicians to manage waiting times, administration processes, clinical statics and patient appointments.</p>	<p>Session type</p> <p>Care type</p> <p>Delivery setting</p> <p>Clinic type</p> <p>Service type</p> <p>Service delivery</p> <p>Activity</p> <p>Referral/waitlist</p> <p>Financial reporting</p>
<p>Hospital Based Corporate Information System (HBCIS)</p>	<p>QH’s enterprise patient administration system, capturing and managing both admitted and non admitted patient, clinical, administrative and financial data.</p>	<p>Activity</p> <p>Workforce</p> <p>Services</p> <p>Performance</p> <p>Client demographics</p> <p>Referral/waitlist</p> <p>Financial reporting</p>
<p>Queensland Hospital Admitted Patient Data Collection (QHAPDC)</p>	<p>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.</p>	<p>Activity</p> <p>Client complexity</p> <p>Client trends</p> <p>Performance</p> <p>Client outcomes</p> <p>Funding</p>
<p>Enterprise Discharge Summary (EDS)</p>	<p>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.</p>	<p>Client trends</p> <p>Client complexity</p> <p>Client outcomes</p> <p>Performance</p>
<p>Primary Related Incident Management and Evaluation System (PRIME)</p>	<p>Management of clinical incidents and health care complaints.</p>	<p>Performance</p> <p>Service safety</p> <p>Client outcomes</p>
<p>RiskMan</p>	<p>RiskMan will provide the HHS with an integrated, web based system for the collection and management of the incidents, feedback, risks and case management.</p>	<p>Incident reporting</p>
<p>Decision Support System (DSS Panorama Necto)</p>	<p>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.</p>	<p>Workforce</p> <p>Expenditure</p> <p>Performance</p>
<p>Emergency Department Information System (EDIS)</p>	<p>Electric system for recording emergency department activity including presentation, triage category, length of stay, ICD and clinical notes etc.</p>	<p>Activity</p> <p>Acuity</p> <p>Client outcomes</p>

Table continued overleaf >>

Table 4: Rural Health Services Information Systems and Data Collections (continued)

Information system/collection	Purpose	Informs
Rural Emergency Department Information System (rural EDIS)	Tailored program to meet rural/remote emergency department needs.	Activity Acuity Client outcomes
Operating Room Management Information System (ORMIS)	The primary business purpose of ORMIS is to provide an enterprise software solution that facilitates and assists in effectively managing and maintaining operational efficiency of QH's operating theatre departments.	Activity
The Viewer	The Viewer is a read-only, web-based application that sources key patient information from a number of existing QH enterprise clinical and administrative systems.	Client activity Client outcomes
Queensland Health Enterprise Reporting Service (QHERS)	QHERS is an online application through which QH employees can access a number of custom made statistical reports.	Activity
Consumer Integrated Mental Health Application (CIMHA)	Integrated electronic mental health medical record.	Mental health activity

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 rural nursing and midwifery services such as:

- client satisfaction
- evidenced-based clinical practice guidelines
- health screening processes/outcomes; and
- client education practices.

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

- vacancy rate
- staff turnover
- overtime used
- casual/agency hours usage
- workload assessments
- absenteeism
- requisite competency rate

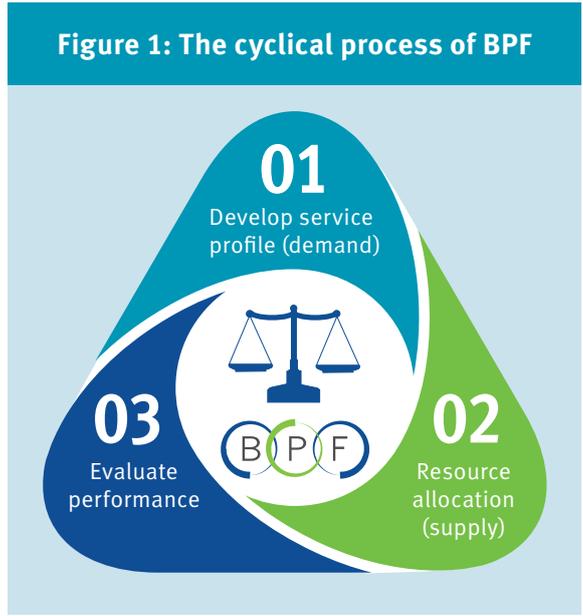
Key performance indicators should be chosen based on the individual service, with consideration to the consumer, staff, and the greater organisation.

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 rural 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 rural settings.

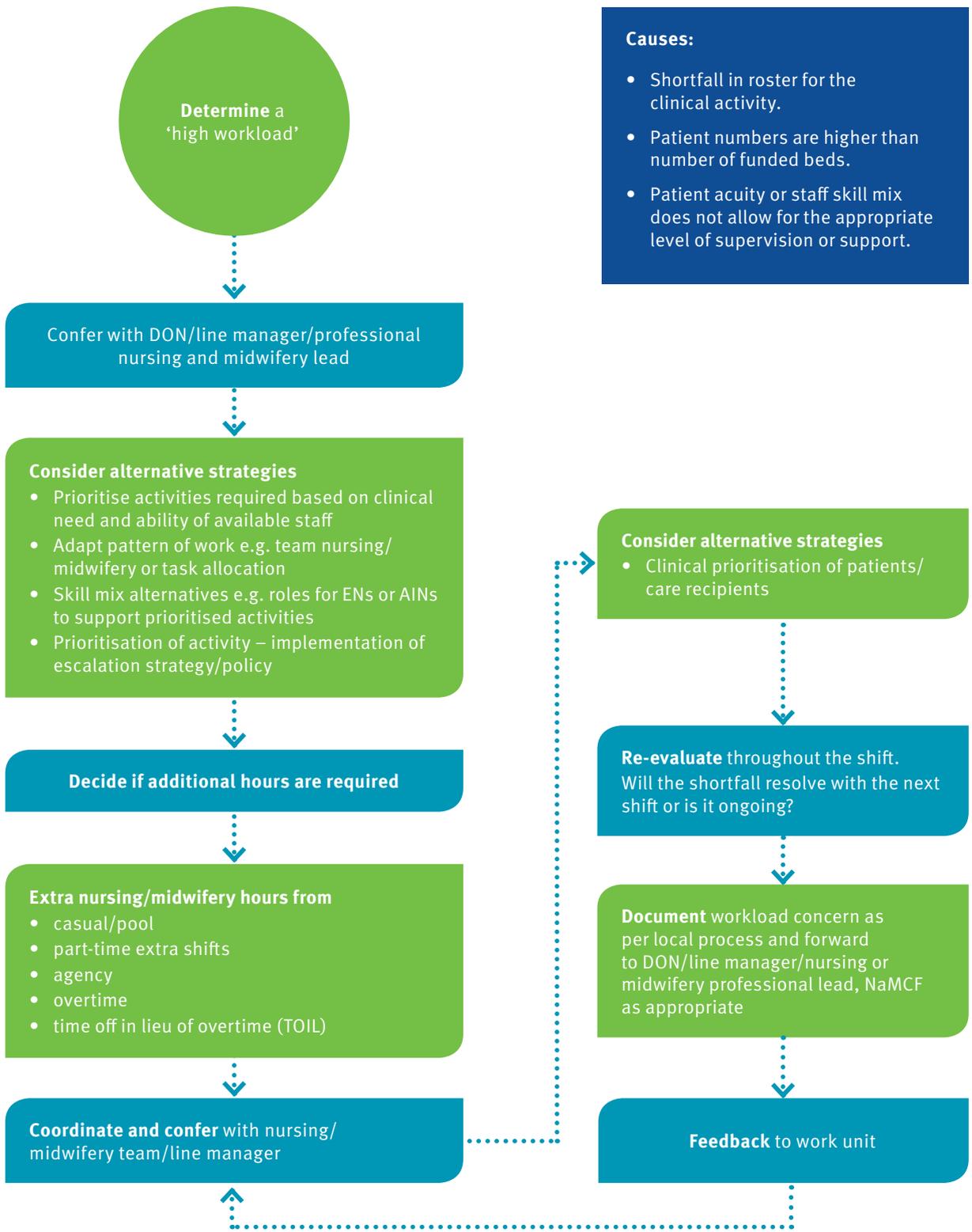
A key component of the BPF cycle is evaluating performance, this will assist in assessing results against the planning as well as form key information when commencing the next annual cycle, this is depicted in Figure 1.



Balancing supply and demand in nursing and midwifery services

This section relates to BPF 5th Edition Balancing Supply and Demand: page 55 and *The Nurses and Midwives (Queensland Health) Award - State 2015, Clause 39*





References

Queensland Health Reference Sources

Access Improvement Service

<http://qheps.health.qld.gov.au/caru/>

Better Health for the Bush 2014

https://www.health.qld.gov.au/__data/assets/pdf_file/0027/436815/better-health-bush.pdf

Clinical Services Capability Framework version 3.2

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf>

Clinical Services Capability Framework Service Modules version 3.2

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/modules>

Overtime Human Resources Policy

https://www.health.qld.gov.au/__data/assets/pdf_file/0026/396017/qh-pol-185.pdf

Prevention and Control of Healthcare Associated Infection (HAI) Implementation Standard

<http://qheps.health.qld.gov.au/psu/safetyandquality/standards/standard-three.htm>

Queensland Health Governance of Outpatient Services

https://www.health.qld.gov.au/__data/assets/pdf_file/0027/396117/qh-pol-300.pdf

Queensland Hospital and Health Services Performance Framework 2016

<https://publications.qld.gov.au/dataset/e1c2648f-eb8e-4e7f-a0d7-42604cd9212f/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc/download/pmffinal11.8.16.pdf>

Queensland Health Outpatient Services Implementation Standard

https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf

Criteria Led Discharge Service Delivery Model

<https://www.health.qld.gov.au/improvement/improving-services/sdm-cld>

Patient Safety Health Service Directive

https://www.health.qld.gov.au/__data/assets/pdf_file/0020/150734/qh-hsd-032.pdf

Queensland Health Performance Framework 2016

<https://publications.qld.gov.au/dataset/e1c2648f-eb8e-4e7f-a0d7-42604cd9212f/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc/download/pmffinal11.8.16.pdf>

Queensland Health Procurement Procedures

<http://qheps.health.qld.gov.au/hsq/procurement/procedures/list.htm>

Statement of Government Health Priorities

http://qheps.health.qld.gov.au/ppb/docs/hsram/hlthpriorities_2016_17.pdf

State Reference Sources

Anti-Discrimination Act 1991

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/A/AntiDiscrimA91.pdf>

Child Protection Act 1999

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf>

Child Protection (Offender Reporting) act 2004

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtORA04.pdf>

Child Protection Regulation 2011

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectR11.pdf>

Chronic Conditions Manual 2015

<https://publications.qld.gov.au/dataset/ef6d9f9e-e8aa-445e-a345-02a016e7251b/resource/bbe5439c-be87-45b6-b704-3b557fbee1e0/download/chronicconditionsmanual1stedition.pdf>

Coroners Act 2003

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/CoronersA03.pdf>

Environmental Protection Act 1994

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/E/EnvProtA94.pdf>

Environmental Protection Regulation 2008

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/E/EnvProtR08.pdf>

Guardianship and Administration Act 2000

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf>

Health (Drugs and Poisons) Regulation 1996

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealDrAPoR96.pdf>

Health and Hospitals Network Act 2011

<http://www.legislation.qld.gov.au/LEGISLTN/ACTS/2011/11AC032.pdf>

Health Practitioners Regulation National Law Act 2009

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthPracRNA09.pdf>

Health Ombudsman Act 2013

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthOmbA13.pdf>

Industrial Relations Act 2016
<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/I/IndustRelA16.pdf>

Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9) 2016
http://www.qirc.qld.gov.au/qirc/resources/pdf/certified_agreements/cert_agreements/2016/ca32_2016.pdf

Power of Attorney Act 1998
<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PowersofAttA98.pdf>

Primary Clinical Care Manual 2016
<https://publications.qld.gov.au/dataset/primary-clinical-care-manual-9th-edition>

Public Sector Ethics Act 1994
<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PublicSecEthA94.pdf>

Queensland Health Nurse and Midwives Award – State 2015
http://www.qirc.qld.gov.au/qirc/resources/pdf/awards/n/nurses_and_midwives_130417.pdf

Queensland Government Statistician’s Office – Regional Profiles
<http://statistics.qgso.qld.gov.au/qld-regional-profiles>

Right to Information Act 2009
<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/R/RightInfoA09.pdf>

Work Health and safety Act 2011
<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/W/WorkHSA11.pdf>

National Reference Sources

Aboriginal and Torres Strait Islander Health Performance Framework
http://www.health.gov.au/internet/main/publishing.nsf/Content/oatsih_health-performanceframework

Australian Bureau of Statistics
<http://www.abs.gov.au/ausstats>

Australian Government Department of Health and Ageing Website
<https://agedcare.health.gov.au/>

Australian Indigenous Health Info Net
<http://www.healthinfonet.ecu.edu.au/health-facts/summary>

Australian Institute of Family Studies
<http://www.aifs.gov.au/>

Australian Institute of Health and Welfare
<http://www.aihw.gov.au/>

Australian Institute of Health and Welfare – Rural & Remote Health
<https://www.aihw.gov.au/reports/rural-health/rural-remote-health/contents/rural-health>

Australian Safety and Quality Framework for Health Care 2010
<https://www.safetyandquality.gov.au/wp-content/uploads/2012/04/Australian-SandQ-Framework1.pdf>

A Framework for Remote and Isolated Professional Practice 2014
<https://crana.org.au/uploads/pdfs/revised-framework-remote-practice-aug2014-29af33e3.pdf>

Framework for Remote Practice
https://crana.org.au/files/pdfs/Framework_for_Remote_Practice.pdf

The Health of People Living in Remote Australia
<http://ruralhealth.org.au/sites/default/files/publications/nrha-remote-health-fs-election2016.pdf>

Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023
[http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/\\$File/DOH_Implementation_Plan_v3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/$File/DOH_Implementation_Plan_v3.pdf)

National Primary Health Care Strategic Framework
<http://www.health.gov.au/internet/main/publishing.nsf/Content/nphc-strategic-framework>

National Health Reform Performance and Accountability Framework
https://ahha.asn.au/system/files/docs/publications/performance_and_accountability_framework_ahha_response.pdf

National Maternity Services Plan 2010
<http://www.health.gov.au/internet/main/publishing.nsf/content/maternityservicesplan>

National Rural Health Alliance inc.
<http://ruralhealth.org.au/publications>

Nursing and Midwifery Board of Australia (Australian Health practitioner Regulation Agency - APHRA)
<http://www.nursingmidwiferyboard.gov.au/>

Professional Standards of Remote Practice: Nursing and Midwifery 2016
https://crana.org.au/uploads/pdfs/Professional-Standards_Remote-Practice_NursingMidwifery_Jun2016.pdf

Registration standard: Endorsement for scheduled medicines for registered nurses (rural and isolated practice) 2011
<http://www.nursingmidwiferyboard.gov.au/Registration-Standards/Endorsement-for-scheduled-medicines.aspx>

Workplace Relations Act 1996
<https://www.legislation.gov.au/Details/C2006C00104>

Appendix 1: Example Activity Measures Identified for Rural Settings

- Emergency activity
 - » triage category (admitted and non-admitted)
 - » did not wait
 - » left after treatment commenced
 - » transfer presentation
 - » planned return visits
 - » unplanned return visits
 - » mental health presentations (e.g. requiring one on one care)
- Inpatient activity
 - » Occupied Bed Days, Fractional Bed Days, Accrued Bed Days
 - » Average Length Of Stay
 - » One Day Stays
 - » separations/discharges
 - » maintenance/transitional care
 - » palliative care
 - » Diagnostic Related Group (DRGs) and International Classification of Diseases (ICDs) for complexity indicators
 - » occupancy percentage of ward/hospital
 - » Nursing Hours per Patient Day (NHPPD)
 - » Weighted Activity Units (WAU)
 - » patient transfers
- Aged care activity
 - » Occupied Bed Days
 - » complexity indicators (e.g. Aged Care Funding Instrument score, care package requirements)
- Outpatient activity
 - » pharmacy activity (including scripts dispensed, webster packs, number of OOS)
 - » X-ray activity
 - » Pathology activity
 - » renal dialysis numbers broken down to self-care or assisted
 - » WAU
 - » tier 2 clinic activity
 - » visiting clinic support and coordination
- Hospital Based Ambulance Activity
 - » number of call outs
 - » number of out of hours call outs
 - » number of patients treated
 - » number of kilometres travelled on call out
 - » complexity of patients called out
- Primary Health Clinic activity
 - » school based clinic OOS or activity
 - » community health screening activity
 - » number of out of hours OOS
 - » number of community health promotion days/attendees
- Mortuary activity
 - » number of inpatient transfers
 - » number of deceased community members cared for
- Telehealth activity
 - » time spent in provider clinic
 - » time spent in receiver clinic
- Central Sterilising Department activity
- Non-clinical activity
 - » time spent undertaking maintenance
 - » time spent undertaking procurement
 - » time spent undertaking accommodation management
 - » time spent undertaking food safety requirements
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