Business Planning Framework:

a tool for nursing and midwifery workload management

6th Edition 2021

Prisoner Health Services Addendum

Queensland Government

Published by the State of Queensland
(Queensland Health), November 2024

For more information contact:

Office of Chief Nurse Officer,
Clinical Excellence Division, Department of Health,
GPO Box 48, Brisbane QLD 4001,
email: ChiefNurse-Office@health.qld.gov.au

An electronic version of this document is available at http://qheps.health.qld.gov.au/nmoq/workforce-sustainability/bpf/addendums.htm

Disclaimer:

This Prisoner Health Services BPF Addendum is the "Offender Health BPF addendum" referred to in *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* and it applies to all nurses and midwives defined in EB10 and the *Nurses and Midwives (Queensland Health) Award — State 2015* (updated 1 September 2018) as being a Correctional Health Service employee.

Definitions

EB10 – Correctional Health Services employee means a nurse or midwife employed in a correctional facility.

Award – Correctional Health Services employee means a nurse or midwife employed in a correctional facility in any classification.

Contents

Introduction

The Business Planning Framework: a tool for nursing and midwifery workload management 6th Edition (BPF 6th Edition) and any subsequent edition/s is the industrially mandated tool to support business planning for managing nursing and midwifery resources and workloads in public sector health facilities. The principles of the BPF 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 and midwives working in prisoner health services and must be used in conjunction with the BPF 6th Edition.

The Prisoner Health Services Addendum was developed to meet the commitment between Queensland Health 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* and the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018*. The agreements identified the need to further contextualise the BPF 5th Edition for a range of settings, including prisoner health services, to support compliance with the BPF.

The Prisoner Health Services Addendum was created by a statewide prison health services nursing Specialty User Group in partnership with the QNMU and the Department of Health.

This addendum will assist nursing and midwifery staff within prisoner health services to:

- determine and manage the unique circumstances within their service that require special consideration when applying the principles of the BPF 6th 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 prisoner health services
- identify and describe client and service complexity and activity indicators to improve consistency in the application of the BPF 6th Edition in prisoner health services.
- Under the Government Election Commitment GEC1558 Trial, there were specific roles identified as being beneficial to support the delivery of care in Prisoner Health Services. These include Access Nurse (or however titled noting this is not an indicative title) and Shift Team Coordinator (or however titled) and as determined by the Prisoner Health Centre requirements.
- This edition has been updated by the Office of the Chief Nurse Officer in partnership with a Reference Group of key stakeholders with subject matter expertise including participants of the GEC1558 Trial and the QNMU.

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 prisoner health services

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

- articulating prisoner health nursing and midwifery work
- validating direct and indirect productive prisoner health nursing and midwifery hours
- applying standard business planning definitions to a prison environment (for example consideration of safety and security factors that impede the provision of health services
- accessing and developing suitable prisoner health data collections and reporting systems
- timely access to resources (i.e. medical imaging and/or medical procedure wait times) impacting on prisoner health services care delivery and outcomes
- addressing and aligning process and service consistency across prisoner health nursing and midwifery services statewide
- providing prisoner health services within the relevant prisoner health services funding methodology
- funding prisoner health services to ensure service demand is balanced with supply as described in the associated BPF.

Acuity and complexity of care

The acuity and complexity related to the provision of prisoner health services may be associated with the socioeconomic and psychological status of patients, the impact of imprisonment on health including communicable diseases, addictions, disability, indigenity, behavioural impacts such as assault and other issues such as mental health. Furthermore, prisoner health services often provide care to a disproportionate population of persons with a disability and Aboriginal and Torres Strait Islander peoples who have a higher representation to particular chronic disease morbidity and mortality issues and as such may require a higher incidence of prisoner health services that is culturally safe, relevant and appropriate.

Infrastructure

Ageing infrastructure and/or prison facility design and/or layout originally built for historical capacity requirements that which may not be currently suitable to the continually increasing capacity requirements and/or natural disasters. The large metal presence of gates, fencing, razor wire/steel panelled walkways may pose a significant risk to prisoner health staff and as such staff may be instructed to avoid such areas which may impact on workflow and prisoner health services delivery, and the occupational health, safety and security of staff. For example, lack of clinical space impacts on the delivery of clinical and confidential prisoner health services; additionally, the availability of handwashing facilities may not be appropriate which may also have an infection control impact. Furthermore, due to the security requirements the infrastructure design and materials contributes to an environment with limited natural light and a cooler climate respectively which can impact on the health and wellbeing of prisoner health services staff.

Large distances between the allocated health areas in relation to the patient accommodation and areas for dispensing and/or administrating medications is significant. For example, one medication round can be a distance of 2.5kms. This has additional impact where nurses and midwives work across facilities that are complex and contains more than one patient facility on site. The time between doors being opened and allowing staff into areas causes further delay. The large population and over capacity of patients within facility building/s may also create barriers to the delivery of prisoner health services as it relates to both patients and staff safety. The nursing and midwifery staff must provide services for the number of patients seeking prisoner health services and their associated occasions of service, regardless of the original built capacity of the prison.

Safety and security considerations

Prisoner health services provided essential equipment such as medication trolleys, dressing and emergency equipment may be difficult to manoeuvre which may result in staff carrying such to required areas. This and the potentially large distances required to be travelled for emergency response may therefore impact on the physical safety of staff and the time taken to deliver the appropriate productive nursing and midwifery care.

The context of the over capacity of prisons requires the careful consideration of occupational violence risk factors; including both verbal and physical assault. These risks may be exacerbated by medication diversion and irrespective of causation require management from Queensland Corrective Services (QCS) officers.

Furthermore, in this context the health and well being of nurses and midwives must be considered and enacted through the provision of psychological support including peer, forensic liaison officer, Employment Assistance Services and other supportive care measures. Nursing and midwifery safety must also be considered in the context of the QCS emergency response and type of control agent method used to manage patients demonstrating inappropriate behaviour.

In the prisoner health setting, nursing and midwifery staff are required to comply with extensive security and access requirements which impacts on the time taken to deliver care. For example, access may be restricted in areas where multi-level patient accommodation, lack of ramps and uncovered pathway area/s exist; the need to be escorted by QCS officers when walking through areas that patients have access to; delays in ingress and egress from work areas; and inability to access patients in a timely manner.

Funding models

It has been recently identified that due to a lack of complete, reliable and comparable activity and cost data for offender health services across the state, there is significant variation in service availability and offering[1].

This variation in funding provision and service availability adds complexity when attempting to benchmark across other offender health services.

The statewide 'per patient' block funding arrangement between QCS and Queensland Health creates its own difficulties for the application of the BPF whenever Hospital and Health Service (HHS) Service Profiles indicate a greater service need than that which is funded. This has been acknowledged in the Offender Health Services Review (2019).

Offender Health Services Review (2019)

In 2019, an independent review of offender health services in Queensland was conducted at the request of the Department of Health.

The review Report contains a range of recommendations across the following five broad themes:

1. **Relationships and Governance**
2. **Workforce**
3. **Access**
4. **Service Standards and Models**
5. **The Correctional Environment and Interfaces with QCS[2].**

Considerations from the Offender Health Services Review Report will be incorporated throughout this document as relevant.

[1] *https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project*
[2] *https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project*

The importance of prisoner health

The prison population is one of the most stigmatised and socially disadvantaged groups in Australia. Generally, patients have lower levels of education, are socially isolated, financially dependent and experience high levels of poor physical health, psychiatric illness and engage in risky behaviours such as tobacco use, violence, increased alcohol consumption and illicit drug use when compared with the general population.

Improving the health of patients is a hallmark of a just society. It is also an important public health measure given that the patient population moves between prisons and the wider community.

Queensland has international obligations under the United Nations Mandela Rules to ensure that patients enjoy the same standards of health care as is available in the wider community. These rules also requires that prisoners have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

Systemic challenges

Through significant consultation, the following systemic challenges were identified in the Review:

- An increase in total prisoner numbers of 19.4 per cent on an average annual head count basis between 2015 and 2018 (including prisoners in both public and private prisons)
- Overcrowding of the prisoner population, with most prisoner health centres operating above built capacity
- The consequences of overcrowding, including the need for QCS to change their processes in order to maintain safety and security
- The continued use of a historic funding model that may no longer reflect the costs of service delivery at prisoner health centres
- Complex health needs of prisoners
- The nature of different prisoner health centres (e.g. reception centres versus placement centres) drives variation in workload and cost[2]
- The lack of suitable health specific infrastructure within which to deliver health care services
- Conflict between the corporate objectives of QCS and the delivery of health services.

These unaddressed systemic challenges have resulted in a range of issues such as:

- A workforce that at times feels unsupported and frustrated by their inability to deliver the level and standard of services that they strive to provide
- A prison population whose health care needs have not been consistently met
- Inefficiencies in care delivery due to the capacity to focus only on the day to day delivery of basic (primary) care and little capacity to address issues strategically
- Fragmentation in the delivery of services
- Inadequate funding to meet the identified service delivery in Service Profiles
- Significant variability in the nature and availability of services for prisoners[3].

[3] *http://www.ccc.qld.gov.au/corruption/taskforce-flaxton/exhibits/exhibit-106-taskforce-flaxton.pdf*

Business planning considerations

THIS SECTION RELATES TO BPF 6TH EDITION MODULE 1: PAGES 15-28

The BPF 6th 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 prisoner health services and result in service demand fluctuations. These internal and external factors need to be considered when analysing service demand within a prisoner health services environment. Prisoner health centres and services must annually assess the impact of each factor on their environment and make the necessary adjustments to the planning and allocation of nursing and midwifery hours.

Table 1 provides examples of several business planning considerations relevant to prisoner health services, 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: TABLE 1 BUSINESS PLANNING CONSIDERATIONS FOR PRISONER HEALTH SERVICES

INFLUENCES (INTERNAL AND EXTERNAL)	SERVICE IMPACT	EXAMPLES OF WORKLOAD MANAGEMENT CONSIDERATIONS
Locality of service **(Internal)** (Metropolitan, regional, rural and remote)	The locality, type and catchment area of a service will influence the balance of service demand and supply. *Examples:* *Prisoner health services need to consider the workload impacts of delivering care in each correctional facility.* *This means that a large component of workload may be non-nursing duties that have an indirect impact on the BPF development, such as Request for information from stakeholders and external services e.g. health discharge and status reports, filing and chart transfer/archiving, or Corrective services requests, parole board information and reports, Ombudsmen requests regarding services provided. This needs to be considered within the context of practice and the impacts upon workload management.* *Consideration must also be given to the physical layout of the facility, with appropriate time and fatigue considerations applied where nursing staff are required to deliver services across multiple locations with different levels of security required.* *All services need to consider the impact of skill mix on optimal service delivery.*	***Direct productive nursing hours:*** Calculation of direct clinical hours spent in activities directly related to nursing or midwifery care e.g. clinically focussed supervision and mentorship, allocation of clinical hours (rosters), selection of service activity/acuity measures, use of minimum safe staffing requirements.
Type of service **(Internal)** (e.g. reception only, reception, remand sentenced, male only, female only, male and female, detention unit, protection status, low security, low open section, medium security, high security, maximum security, workcamp, disability, inpatient service (if provided)		***Indirect productive nursing hours:*** Calculation of indirect clinical hours for hours spent in activities that support clinical process e.g. portfolios, travel, program/service-based education, succession planning, quality activities and research. Additional inclusions may include regulatory requirements, safety and security processes, requirements inherent to the environment, reporting and health discharge/ legal requirements (parole board, Queensland Detention Operations, Detention and Offshore Operations Command, legal representations, ministerial and Ombudsmen requests).
Catchment area **(Internal)** (Local HHS versus Statewide services, transfers between facility and HHS boundaries, Secure Unit accessibility and specialist services requirements, transfers for court and legal requirements)		***Workforce planning:*** Development of strategic local/ statewide workforce plans to inform FTE requirements, skill mix profiles and macro workforce planning formulas.

Table continued overleaf ››

TABLE 1: TABLE 1 BUSINESS PLANNING CONSIDERATIONS FOR PRISON HEALTH SERVICES (CONTINUED)

INFLUENCES (INTERNAL AND EXTERNAL)	SERVICE IMPACT	EXAMPLES OF WORKLOAD MANAGEMENT CONSIDERATIONS
Nursing and midwifery structure **(Internal)** (Roles, functions, accountabilities and relationships between all categories of nursing staff)	The model of care selected for a service will influence the nursing and support structures required. Nursing roles and how they relate with other clinical roles will impact on the balance of service demand and supply. *Examples:* *In prison facilities, nursing and midwifery roles can be categorised by the skills required to meet client demand (i.e. medication administration, acute response model required within correctional facilities, chronic disease management, blood borne virus management, 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.* *May include additional support roles such as Access Nurse (or however titled noting not an indicative title) and Team Leader/Shift Coordinator (or however titled) dependant on the specific Prisoner Health facility requirements.* *Within prisoner health settings, access/support from other services may be limited. Nurses within these environments may be required to practice autonomously at an advanced level. The classification of positions within this setting will reflect this requirement.* *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.*	***Direct productive nursing hours:*** Calculation of direct clinical hours spent in activities directly related to nursing or midwifery care e.g. clinically-focussed supervision and mentorship 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.
Support structure **(Internal)** (Providing support to other services and/or receiving support from other services)		***Indirect productive nursing hours:*** Calculation of indirect clinical hours for hours spent in activities that support clinical process e.g. networking/collaboration (internal and external) travel, staff training, professional development, professional meetings (e.g. Nursing Consultative Forum), quality activities and research.
Model of care **(Internal)** (Multi-functional teams, model of service delivery)		***Workforce planning:*** Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service. *The Access nurses (or however named noting not an indicative title) may provide "on-the-floor" assistance, coordination, contingency on the shift, or staff sick mid-shift), Education/orientation (of junior staff, relatives, and others), Supervision and Support.* *A Team Leader and/or Shift Coordinator is a registered nurse who may:* ● *Be designated this function on a shift or roster, within a Prisoner Health care facility by the line manager and is recognised by the nursing workforce within that facility during that shift or roster as fulfilling this function.* *Be responsible for providing oversight, leadership, communication, and coordination of nursing workforce activities within the Prisoner Health care facility for the shift to ensure delivery of safe prisoner care.* *Be responsible for the effective clinical and operational readiness of the prisoner Health* Resonsible for a specific client population and able to function in more complex situations while providing support and direction to registered nurses/registered midwives, enrolled nurses, unregulated healthcare workers and other healthcare workers. 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.

TABLE 1: TABLE 1 BUSINESS PLANNING CONSIDERATIONS FOR PRISONER HEALTH SERVICES (CONTINUED)

INFLUENCES (INTERNAL AND EXTERNAL)	SERVICE IMPACT	EXAMPLES OF WORKLOAD MANAGEMENT CONSIDERATIONS
Policy/legal factors **(External)** (Funding models, memoranda of understanding, HHS who are prescribed employers, Office for Prisoner Health & Wellbeing.)	Changes in health policy and legislation will influence service delivery and staff requirements. Common change drivers include governments (commonwealth/state), licensing organisations, regulators, professional and industrial groups. *Examples:* *Legislation – Workplace health and safety, Commonwealth - Health reform, Queensland Health – Strategic plan, Human Rights Act 2019 (Qld) Health Ombudsman Act 2013 (Qld), Mental Health Act 2016 (Qld), Corrective Services Act 2006 (Qld), Coroners Act 2003 (Qld), Hospital and Health Boards Act 2011 (Qld), Health (Drugs and Poisons) Regulation 1996 (Qld), Memorandum of Understanding between Queensland Corrective Services and Queensland Health Hospital and Health Services), Youth Justice Act 1992 (Qld)* *Offender Health Services Review – Queensland Health* *Australian Commission on Safety and Quality in Health Care (developing Primary Health Care Standards)* *Nursing and Midwifery Board of Australia Codes and Guidelines* *Clinical Services Capability Framework (CSCF)*	***Direct productive nursing hours:*** Calculation of direct clinical hours spent in activities directly related to nursing or midwifery care e.g. clinically-focussed supervision and mentorship (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 models)	Funding policies, the national economy and accessibility of public health care providers will influence the delivery of primary and secondary health 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.*	***Indirect productive nursing hours:*** Calculation of indirect clinical hours for hours spent in activities that support clinical process and non-productive activities e.g. such as policy development, business planning, service interfaces, travel, staff training, professional development, quality activities and research.
Social/population factors **(External)**	Population demographics and consumer expectations will impact on the types of prisoner health services offered, how the services are offered, staffing numbers and the skill mix required for service delivery. *Examples:* *Delivering health services to a community with a high proportion of non-English speaking people, poor, numeracy, literacy and health literacy skills will impact the number and type of clinical hours required to operate the service.*	***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. Differentiating Model of care versus service delivery model and improvements leading away from reactive nursing to planned intervention and care management. Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.

Nursing and midwifery core demand considerations

To improve the consistency and transparency in the application of the BPF 6th Edition, specific demands on direct and indirect productive nursing and midwifery hours in the prisoner health services 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 prisoner health services. The following section will explore the relationships between core demand considerations and the context of practice in prisoner health services. The following are considered key considerations for prisoner health settings when developing a service profile.

Client service/complexity

Nursing and midwifery staff at prison facilities are often the primary contact to provide, explain and assess the patients' health and health literacy needs and refer to other healthcare professionals as appropriate. This often requires multiple contact opportunities and added resources to complete i.e. cultural liaison input, appropriate literature, therapeutic relationship establishment.

At present QCS prohibits the supply of safe sex products, needle exchange, and needle disposal units. The availability of such resources has a significant impact in an environment that has increased blood borne virus and sexually transmitted infection statistics. This has a social and financial impact on communities.

These differing additional factors have individual and relevant variances to care delivery and process and require recognition when considering nursing input into providing the required services.

Model of care/service delivery

The Offender Health Services Review Report (2019)[4] recommends a "continued use of a nurse-led primary care model with increased emphasis on preventative care. This would be expected to benefit Queensland Health more broadly through the avoidance of costly hospital care during (imprisonment) and following release." Service delivery should also consider midwifery-led models of care, given that some women birth without obstetric assistance in prison.

Technology and materials management

Currently many of the Queensland Health prisoner health services rely on manual processes associated with hard copy paper based medical files. Furthermore, the lack of eHealth technology impacts on efficient access to, delivery, and/or storage of confidential patient documentation, especially during cases of patient relocation within sites and/or between services. Hard copy paper based medical files and/or manual processes can impact on the time spent by staff efficiently accessing and documenting patient information. This and the potential transfer of current processes to a digital platform such as iEMR requires input from nurses and midwives, which will impact

[4] *https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project*

on the time spent delivering prisoner health services and the training associated with same. The impost on nurses and midwives may be minimised by ensuring Business Continuity Plans are robust; and iEMR and systems interface effectively and efficiently with hard copy paper based and/or other Queensland Health Information Communication Technology systems.

Prisoner health services material management within prisoner health services impacts on the indirect care time provided by nurses and midwives as it relates to organising facility maintenance service providers that require access. This involves potentially troubleshooting logistic and ergonomic transport of equipment that may be focused on prisoner health service safety and security rather than health status or management which may be in part due to the structural design of a facility.

The eventual introduction of electronic medical record management into prisoner health services in each HHS and the training required to implement it will need to be factored in to Service Profile development as appropriate.

Community/Hospital interface

The operating systems and processes, and the limited availability and access to health centres impacts on the ability to provide patient prisoner health services especially with increasing patient populations. Transportation and prisoner health services escort of patients potentially impacts the delivery of planned prisoner health services at correctional facilities, acute facilities, outpatient centres and furthermore.

Escorting of patients by prisoner health services staff, within and/or external to facilities impacts on the time required to deliver care to other correctional facility patients by remaining prisoner health services staff. Additionally, there are impacts when transferring to external services such as Emergency Departments, as the prison may not have acute or complex care capacity.

Quality and Safety

Prisoner health services delivery should be aligned to relevant Health Practitioner Standards, Codes and Guidelines, the National Safety and Quality Health Services Standards (NSQHSSs) and respective Hospital and Health Service (HHS) policy/procedures and/or guidelines.

Education and service capacity development

Education and training recommendations requires consideration of the relevant correctional services facility capacity maintenance and/or development related to the patient demographic; for example, the requirement for occupational violence prevention and training.

Succession planning

Experienced nursing and midwifery staff within prisoner health nursing and midwifery have a responsibility to orientate, induct, and teach as well as role model the integration of professional nursing and midwifery standards into practice. This is important for ensuring therapeutic boundaries are maintained and appropriate prisoner health services are delivered to patient/s. Time required to effectively provide the above must be factored into Service Profile development and the BPF.

Leadership and management

Prisoner health services within correctional services is considered primary health care. The leadership and management is often flatter in nature than larger organisations. As such, nursing and midwifery line managers, incorporates both operational and strategic functions (i.e. direct and indirect) that impacts on their time. Some demand considerations include, but are not limited to:

- Key stakeholder engagement within an isolated practice environment including, but not limited to, inter-agency (i.e. QCS and Queensland Health Management Teams), organisational involvement (i.e. committees and networking) and establishing and maintaining communication channels, and organisational culture and reporting
- development and maintenance of service agreements
- Human Resource management functions and
- Service Profile development

Research and evidence-based practice

Undertaking research and integrating 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 patients. Local, State and National QCS research requirements require consideration as the associated activities will impact on nurses and midwives time related to workload resourcing.

Health policy, clinical guidelines, strategic plans and health legislation

There may be a number of legislative and policy documents impacting prisoner health services Business Planning Frameworks may include, but not limited to:

- Statewide Offender Health Services strategic plans that articulate clear and measurable service priorities and goals require development
- Policies and procedures related to standardised patient health care delivery that may be aligned to the Australian Charter of Healthcare Rights specific to prisoners.
- Interagency Memoranda of Understanding (MoU)
- HHS Service Agreements

Module 2: Resource allocation

THIS SECTION RELATES TO BPF 6TH EDITION MODULE 2: PAGES 30-41

Establishing total nursing and midwifery resource requirements

The following steps outline the process to calculate the productive and non-productive nursing and midwifery hours required, and to convert those hours into FTE:

Step 1 Calculate total annual productive nursing and/or midwifery hours required to deliver service

Step 2 Determine skill mix/category of the nursing/ midwifery hours

Step 3 Convert productive nursing/ midwifery hours into full-time equivalents

Step 4 Calculate non-productive nursing and/or midwifery hours in accordance with nursing and midwifery award entitlements

Step 5 Convert non-productive nursing and/or midwifery hours into full-time equivalents

Step 6 Add productive and non- productive full-time equivalents together and convert into financial resources in partnership with business team

Step 7 Allocate nursing and/or midwifery hours to meet service requirements

Productive nursing and midwifery hours include both direct and indirect clinical hours. Calculating the number of productive hours required for a prisoner health service 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 6th 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.

Total productive hours =

direct hours
+
indirect hours

Table 2 provides key productive and non-productive nursing and midwifery activities for a prisoner health service, and should be used in conjunction with the BPF 6th Edition (pages 32-33).

TABLE 2: KEY PRODUCTIVE AND NON-PRODUCTIVE NURSING HOURS

ACTIVITY	PRODUCTIVE		NON-PRODUCTIVE	EXAMPLES
	DIRECT	INDIRECT		
SERVICE DELIVERY				
Types of service delivery	x	x		Nursing assessment and triage (e.g. Reception), transfer to other facilities, discharge (to community, Commonwealth custody, death in custody), Emergency Care (including on-site responses to codes), specialist clinics, Nurse Practitioner clinics, nurse-led pathology services, Opioid Substitution Treatment (OST), Public Health Screening (including immunisation, outbreak management, blood-borne virus management, sexual health clinics), chronic disease management, aged care assessment, palliative care
Direct clinical care activities	x			Patient assessment, planning, implementation and evaluation activities, physical / social / health literacy assessments, supporting activities of daily living, medication management and administration, Nurse Practitioner clinical care
Emergency triage and care delivery (including first aid response for staff)	x			Patient / staff assessment and treatment, clinical record documentation, cannulation & phlebotomy, minor procedures
Clinical documentation	x			Completion of all relevant medical record forms, referral forms, progress notes, clinical pathways, CIMHA electronic medical record, public health register updates
Clinical handover	x			Shift to shift, inter-facility, inter-agency, accepting clinician case manager, MRQ – prescription / dependency history
Referral management	x	x		Triaging and prioritising, appointment management
Case coordination	x	x		Coordination of client care across a number of interagency services including QCS and Prison Mental Health
Scheduling clinics	x			Template development and adjustments, coordination of visiting clinics (e.g. Allied Health Services, Medical Officer clinics, Nurse Practitioner clinics)
Clinic delivery	x			Preparing charts, managing client information, test results and follow up appointments, site safety
Procedures/Treatments	x			E.g. Pathology Collection, wound care, Includes set ups, procedures and clean ups
Multidisciplinary case conference	x	x		Team based care planning, case coordination
Patient education/ care planning meetings	x			Health / disease management education, treatment and goal planning collaboration, includes patient / QCS staff / community groups
Patient escorts, transfers and retrievals	x	x		Transfer documentation, transport arrangements, patient preparation, inter-hospital/service liaison, patient care / supervision, court / legal transfers, maternity / birthing transfers, QAS collaboration

Table continued overleaf ››

TABLE 2: KEY PRODUCTIVE AND NON-PRODUCTIVE NURSING HOURS (CONTINUED)

ACTIVITY	PRODUCTIVE		NON-PRODUCTIVE	EXAMPLES
	DIRECT	INDIRECT		
Telehealth specialist consultations	x	x		Telehealth equipment set-up, patient preparation/ consultation assistance
Advocacy	x	x		Actions taken to focus on the development of a client's capacity to plead their own case or act on their behalf. Consenting to care, care planning, medical assessment for parole board, advanced care directives, end of life planning, Prison Mental Health Services
Access Nurse	x			The Access nurses (or however named noting not an indicative title) may provide "on-the-floor" assistance, coordination, contingency on the shift, or staff sick mid-shift), Education/orientation (of junior staff, relatives, and others), Supervision and Support.
Shift Coordination This position may span over all activity types within this table	x			Staff coordination, reallocation, allocation, and rostering activities Handover and safety huddles Ensuring compliance with hospital Prisoner Health and HHS policies and procedures Ensuring a safe environment is maintained for staff and prisoners Providing support to nursing staff and medical staff as required Undertakes role of principal/ primary responder and attends all code blues or significant events to offer support to nurses, with coordination of care with QCS and Queensland Ambulance Service (QAS) Assists with telehealth appointments, or delegates responsibility to nurses working in the respective area – all require nursing support Liaise with QCS supervisors and other corrections staff to facilitate the prompt movement of prisoners to the medical health centre or external medical centres/ emergency departments if indicated Assists other staff with clinical expertise and facilitate opportunistic learning Provides support with education in new procedures / new roles for staff. Responds as necessary if escalation is required: Queensland Ambulance Service | Emergency Dept | Virtual Emergency Department (when instructed – during times of high workload demand)

Table continued overleaf ››

TABLE 2: KEY PRODUCTIVE AND NON-PRODUCTIVE NURSING HOURS (CONTINUED)

ACTIVITY	PRODUCTIVE		NON-PRODUCTIVE	EXAMPLES
	DIRECT	INDIRECT		
CLINICAL SERVICE SUPPORT ACTIVITIES				
Medical record coordination and management		x		
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, delivering of stock across facility, invoicing
Infection Control	x	x		Screening, clinical surveillance, outbreak management, monitoring of disease outbreaks and at risk populations
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/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
Staff debrief and support		x		Post incident, post code, linking with Employee Assistance Program
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: KEY PRODUCTIVE AND NON-PRODUCTIVE NURSING HOURS (CONTINUED)

ACTIVITY	PRODUCTIVE		NON-PRODUCTIVE	EXAMPLES
	DIRECT	INDIRECT		
STAFF DEVELOPMENT				
Clinically-focussed supervision and mentoring		x		Professional support/learning, reflective practice
Clinical facilitation		x		Undergraduate, postgraduates and new starters
Orientation/ Mandatory / speciality training			x	Basic life support, Occupational violence prevention, ergonomics, QCS service and site specific, health service and site specific
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, quality activities
Performance appraisal and development		x		Participation in PAD process
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 Frameworks (as relevant)		x		Quality management systems (accreditation programs: ACHS / NSQHS Standards)
Quality audits/safety check		x		Designated by legislation, policy or quality programs
Service improvement initiatives		x		Policy development, quality activities, HHS mandatory reporting
Health service planning		x		Service capacity building and workforce planning
Clinical governance practices		x		Policy review and development, Federal Government Inspectors
Participation in research initiatives		x		National Blood Borne Virus Survey, Healthy Persons Report
Ministerial responses		x		Patient complaints, patient outcomes, service delivery issues

Table continued overleaf ››

TABLE 2: KEY PRODUCTIVE AND NON-PRODUCTIVE NURSING HOURS (CONTINUED)

ACTIVITY	PRODUCTIVE		NON-PRODUCTIVE	EXAMPLES
	DIRECT	INDIRECT		
INFORMATION MANAGEMENT				
Balanced scorecard		x		Evaluation tools
Service data collection and analysis		x		Service improvements
Business planning and management		x		Service profile development, business case development
Electronic medical records	x			Patient related information and storage record
FACILITY/SERVICE MANAGEMENT				
Service Coordination		x		Coordination of clinical services within facility and integration with QCS and other service providers (e.g. prison mental health services)
Operational and strategic planning		x		Business and strategic planning
Building, Equipment and Asset maintenance		x		Minor and capital works planning, BEMS, BTS
Fleet car management		x		Car bookings, servicing, record keeping
Emergency Management planning		x		Continuity of service planning / disaster response planning (local and external services)
Consumer engagement		x		Development of Consumer Advisory Networks
Consultative Forums		x		Industrial/Clinical networks/Regional networks
Service networking / collaboration / stakeholder engagement		x		Developing connections and relationships with other agencies/service providers
OTHER				
Travel		x		Travel associated with service delivery

Direct/indirect service delivery will vary based on the function of the individual's role and may vary from site to site.

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 and midwifery staff is a valid criterion for deeming a definitive staffing level of nurses and midwives as being safe, including 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 prisoner health setting, the role of nurses spans multiple services including medication administration, chronic disease management, acute care, blood borne virus management, orthopaedic, maternity, mental health, endocrine, and renal, so the time taken as hours, or fractions of hours, reflecting these multiple activities must be considered.

In the absence of a nursing and midwifery data set for prisoner health 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:

- Assessment
- Medical/Nurse Practitioner Review
- Medication Management
- Clinical Care
- Legislation
- Continuum of Care
- Documentation
- Consumer interaction
- Miscellaneous duties

Module 3: Evaluation of performance

THIS SECTION RELATES TO BPF 6TH EDITION MODULE 3: PAGE 42-49

Data collection for prisoner health services

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 prisoner health services.

Recommendation G1.6 of the Offender Health Services Review Report (2019)[5] recommends that, in accordance with eHealth Queensland requirements, an activity data collection for offender health services should be developed and implemented to enable performance to be monitored across the system. This should also integrate with the planned state-wide offender health electronic medical report system to support reporting.

Table 3 outlines key identified information systems available in prisoner health services, however they may not provide all the required information, so local data bases or spread sheets may be developed.

[5] *https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project*

TABLE 3: PRISONER HEALTH SERVICES INFORMATION SYSTEMS AND DATA COLLECTIONS

INFORMATION SYSTEM/COLLECTION	PURPOSE	INFORMS
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. Prisoner Health Services are the recipient of EDS reports.	Client trends Client complexity Client outcomes Performance
The Viewer	A web-based application available on desktop computers and mobile devices, The Viewer collates data from multiple Queensland Health systems, ensuring healthcare professionals can access patients' information quickly, without having to log in to different systems.	Client trends Client complexity Client outcomes
Consumer Integrated Mental Health Application (CIMHA)	Supports mental health's strategic, reporting and functional requirements through a single state-wide data base.	Client information reporting
Pyxis® MedStation ES	Advanced system that automates the distribution, management and control of medications. The system includes a network of secure storage units located in patient care areas such as emergency departments	Medication management
RiskMan	Replacing PRIME with a staged release over 2017-2018 throughout each HHS	Performance Service safety Client outcomes Staff outcomes Consumer feedback system
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
WorkBrain / myHR	myHR is a new application that provides real-time access to establishment and employee information located within SAP HR, providing users with enhanced capability to manage their workforce.	Workforce information

As per the BPF 6th 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.

Key performance indicators should be chosen based on the individual service, with consideration to the consumer, staff, and the greater organisation. The following key performance indicator suggestions have been identified in the Offender Health Services Review Report (2019):

- KPIs relevant to all health facilities and staff; for example, compliance with notifiable incident and notifiable disease reporting, accreditation, credentialing, incident reporting etc
- Initial assessment: percentage of comprehensive assessments, triaging and referrals completed within 24 hours of reception
- Chronic disease management: percentage of patients with chronic disease for whom a chronic disease plan is implemented
- Communicable disease: percentage of patients offered communicable disease screening upon reception (e.g. HIV, viral Hepatitis, other sexually transmitted infections (STIs)
- Communicable disease: percentage of patients vaccinated for communicable diseases including all vaccinations covered in the childhood immunisation schedule, and seasonal influenza
- Communicable disease: rates of transmission within prisoner health centres of STIs and blood borne viruses (BBV)
- Access: Waiting times for nursing assessment and review
- Patient satisfaction with offender health services
- NB: KPIs may need to be targeted to cohorts of prisoners with certain lengths of sentence[6].

Measurement of performance should include quality indicators such as results from accreditation cycles and periodic reviews. Further examples can be seen on page 43 of the BPF 6th Edition.

[6] *https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project*

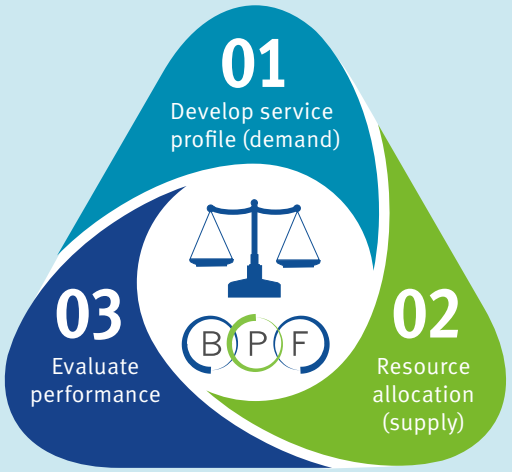
Forecasting and benchmarking

Benchmarking of service activity and relative performance measures within prisoner health services is complex and affected by inconsistent, limited or absent clinical information systems or mismatched performance reporting frameworks. Additionally, benchmarking can be challenging due to the varied execution of the primary health care model, differing types of patients confined at the facility, and the purpose of the facility in the patient progression.

The Offender Health Services Review Report (2019)[7] acknowledged that there is "a lack of complete, reliable and comparable activity and cost data for offender health across the state". Whilst the introduction of recommended activity data collection systems and an integrated Electronic Medical Record in the future will support forecasting and benchmarking, in their absence, forecasting based off QCS projections and manual data collection to support benchmarking respectively is reasonable.

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.

FIGURE 1: THE CYCLICAL PROCESS OF BPF



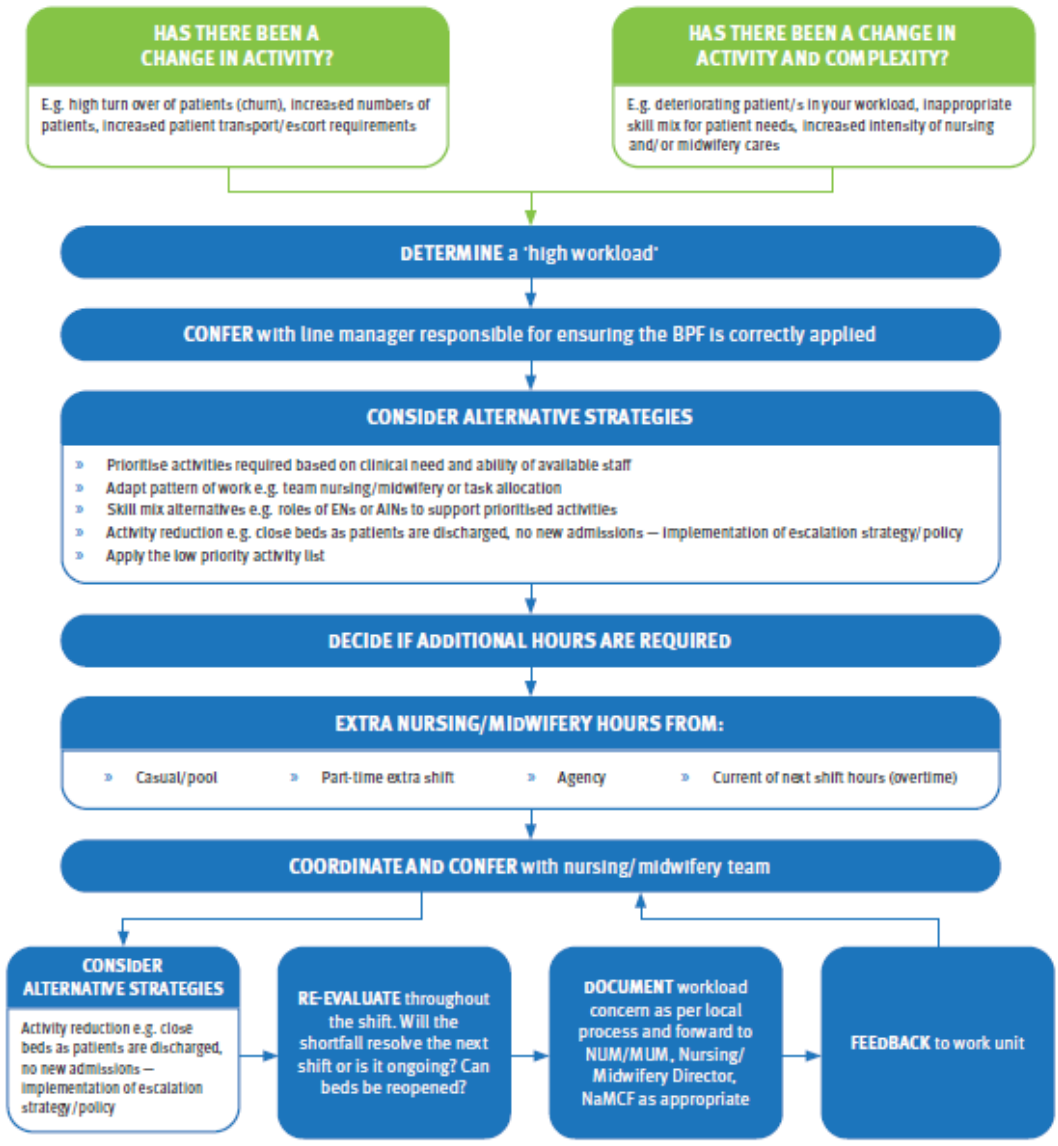
Balancing supply and demand in nursing/ midwifery services

THIS SECTION RELATES TO BPF 6TH EDITION
BALANCING SUPPLY AND DEMAND: PAGE 47

Emergent imbalances in a service may occur on any shift and can be caused by:

- Unexpected leave of staff members who are unable to be replaced
- Unplanned increases in service activity/ acuity/complexity

In this event, nurses and midwives should have workload management strategies in place to ensure consumer and staff safety which include but are not limited to the "low priority activity list" and escalation process (refer back to list of strategies pg. 53). The flow diagram below provides guidance for managing emergent imbalances in supply and demand as they arise on a shift:



References

Queensland Health Reference Sources

Office of the Chief Nursing and Midwifery Officer
https://www.health.qld.gov.au/ocnmo

Healthcare Improvement Unit
http://qheps.health.qld.gov.au/caru/

Operating Guidelines – Memorandum of Understanding between Queensland Health and Queensland Corrective Services (Confidential Information Disclosure)
https://www.health.qld.gov.au/__data/assets/pdf_file/0032/444767/info_share_opp_guide.pdf

Clinical Services Capability Framework
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf

Clinical Services Capability Framework Service
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/modules

Human Resources Policy – Overtime
https://www.health.qld.gov.au/__data/assets/pdf_file/0026/396017/qh-pol-185.pdf

Queensland Health Specialist Outpatient Services Implementation Standard
https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf

Best Practice Rostering Guidelines Queensland Health Nurses and Midwives
https://qheps.health.qld.gov.au/hr/policies-agreements-directives/enterprise-bargaining/nurses-midwives/rostering

Health Service Directive – Patient Safety
https://www.health.qld.gov.au/__data/assets/pdf_file/0020/150734/qh-hsd-032.pdf

Index of procurement procedures
http://qheps.health.qld.gov.au/hsq/procurement/procedures/list.htm

Multicultural Health
https://www.health.qld.gov.au/multicultural

Occupational Violence Prevention in Queensland Health's Hospital and Health Services Task force Report 31 May 2016
https://www.health.qld.gov.au/__data/assets/pdf_file/0024/443265/occupational-violence-may2016.pdf

Guidance Note - Occupational violence prevention and management
https://qheps.health.qld.gov.au/__data/assets/pdf_file/0020/640622/ov-prevemgmnt-gn.pdf

Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 Investment Strategy 2015-2018
https://www.health.qld.gov.au/__data/assets/pdf_file/0020/161831/making-tracks-inv-strat.pdf

Closing the Gap in Queensland (Aboriginal and Torres Strait Islander Health Branch)
https://www.health.qld.gov.au/public-health/groups/atsihealth/closing-the-gap

Health Consumers Queensland Consumer and Community Engagement Framework
https://www.hcq.org.au/wp-content/uploads/2017/03/HCQ-CCE-Framework-2017.pdf

The Business Planning Framework: a tool for nursing and midwifery workload management 6th Edition (BPF 6th Edition)
https://www.health.qld.gov.au/__data/assets/pdf_file/0022/1103773/bpf-2021.pdf

State Reference Sources

Anti-Discrimination Act 1991
https://www.legislation.qld.gov.au/view/pdf/2017-06-05/act-1991-085

Child Protection Act 1999
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004
https://www.legislation.qld.gov.au/view/pdf/inforce/2017-07-01/act-2004-052

Child Protection (Offender Reporting and Offender Prohibition Order) Regulation 2015
https://www.legislation.qld.gov.au/view/html/inforce/current/sl-2015-0172

Chronic Conditions Manual: Prevention and Management of Chronic Conditions in Australia – 1st edition 2015
https://publications.qld.gov.au/dataset/chronic-conditions-manual

Coroners Act 2003
https://www.legislation.qld.gov.au/view/pdf/inforce/2019-07-01/act-2003-013

Human Rights Act 2019
https://www.legislation.qld.gov.au/view/pdf/asmade/act-2019-005

Health (Drugs and Poisons) Regulation 1996
https://www.legislation.qld.gov.au/view/html/inforce/current/sl-1996-0414

Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB11) 2022

https://qheps.health.qld.gov.au/hr/policies-agreements-directives/enterprise-bargaining/nurses-midwives

Queensland Health Nurse and Midwives Award – State 2015
https://www.qirc.qld.gov.au/sites/default/files/nurses_and_midwives_swc18.pdf?v=1542538772

Australian Primary Health Care Nurses Association (APNA) Correctional health nursing
https://www.apna.asn.au/profession/what-is-primary-health-care-nursing/correctional-health-nursing

National Reference Sources

Summary of Aboriginal and Torres Strait Islander health status
https://healthinfonet.ecu.edu.au/learn/health-facts/overview-aboriginal-torres-strait-islander-health-status/

Australian Commission on Safety and Quality in Health Care
https://www.safetyandquality.gov.au/standards/nsqhs-standards

Australian Charter of Healthcare Rights
https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

Prisoner Specific References

Queensland Department of Health (Queensland Health) 2018, Offender Health Services Review Final Report, Queensland Health, Brisbane.
https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project

The health of Australia's prisoners 2018
https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents

Australian Institute of Health and Welfare The health of Australia's prisoners 2015
https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/contents/table-of-contents

Standard Minimum Rules for the Treatment of Prisoners
http://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

Corrective Services Regulation 2017
https://www.legislation.qld.gov.au/view/html/inforce/current/sl-2017-0176

Corrective Services Act 2006
https://www.legislation.qld.gov.au/view/pdf/2017-05-30/act-2006-029

Overcrowding at Brisbane Women's Correctional Centre
https://www.ombudsman.qld.gov.au/publications/ombudsman-investigative-reports/overcrowding-at-brisbane-womens-correctional-centre-report

Queensland Government Prisons and Detention Centres
https://www.qld.gov.au/law/sentencing-prisons-and-probation/prisons-and-detention-centres

Queensland Corrective Services
https://corrections.qld.gov.au/about-queensland-corrective-services/

Released Prisoners Returning To Prison
https://www.sentencingcouncil.vic.gov.au/statistics/sentencing-statistics/released-prisoners-returning-to-prison

Queensland Corrective Services Publications –
https://corrections.qld.gov.au/documents/publications/

Queensland Parole Boards Annual Report 2017-18
https://corrections.qld.gov.au/documents/publications/
Queensland Corrective Services Drug and Alcohol Policy
https://corrections.qld.gov.au/documents/publications/

The United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules)
https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

Persons in Corrective Services
http://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0

Prisoners in Queensland
https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia/latest-release

Medication use by Australia's prisoners 2015: how is it different from the general community?
https://www.aihw.gov.au/reports-data/population-groups/prisoners/overview

Appendix 1: Example Activity Measures Identified for Prisoner Health Services

The following are examples of activity measures for Prison Health Services. Activities for each prison will vary, dependent upon the role that QCS determines for that prison.

Assessment

- Reception triage
- Reception health – comprehensive
- Reception health – referral to other health services
- Transfers in from other correctional centres
- Transfers back from court
- Transfers back from hospital
- Transfers out to other correctional facilities
- Post Code Yellow
- Attending Code Blue
- Post Code Blue
- Alcohol and Drug Withdrawals

Medical/ Nurse Practitioner Review

- As per triage process and prisoner health service guidelines
- Chronic Disease management and referrals
- Acute Care management and referrals
- Routine best practice recommendations for stages of life

Medication management

- Review of medication needs on transfer
- Alcohol and drug withdrawal regimes
- Administration of regular medications: including Scheduled medications
- Administration of PRN and Nurse Initiated medications
- Medication reviews
- Monitoring compliance
- Diversion risk assessment

Clinical Care

- Wound care and management
- Observations
- Blood Glucose management
- Vaccinations
- Antenatal/Postnatal care
- Termination of Pregnancy (TOP) care
- Palliative care
- Disability care
- Aged care
- Mental Health care
- Referral to specialised services – Prison Mental Health, Sexual Health, Midwifery
- Communicable disease screening, vaccination and treatment, including access to universal testing and treatment for Hepatitis C in Queensland correctional centres in conjunction with broader population health approaches in the community, to ensure that prisoner health centres do not become a reservoir for Hepatitis C
- Discharge planning, including sending discharge summaries to patients' My Health Record to enable continuity of care in the community
- Coordinating access to allied health services including podiatry, dietetics and physiotherapy
- Diagnostic services appropriate to the primary care setting
- Multidisciplinary alcohol and other drugs (AOD) addiction services
- Multidisciplinary chronic pain management services
- Chronic disease screening and ongoing management
- Sexual and reproductive health care and education

Legislation

- Safety Orders

Continuum of Care

- Discharge documentation
- Transfer documentation
- Transfer of treatment/medication: scripts vs supply

Documentation

- Medical File documentation
- Release of Information (ROI)
- Pathology review
- Radiology review
- Source collateral health information
- Other prisons
- Community health services
- Hospitals
- Pharmacies

Consumer interaction

- Management of Health Service Requests
- Response to Blue Letters
- Response to Office of the Health Ombudsman (OHO) and Ministerial requests

Miscellaneous duties

- Mandatory training
- Continuous professional development
- Supervision and mentoring of Registered Nurses
- Health education for patients
- Harm minimisation education for patients
- Review/triage of waiting lists
- Arranging patient attendance and escort by QCS officers
- Arranging escort of staff by QCS officers
- Awaiting ingress and egress through secure doorways
- Additional time required to administer medicines during lockdowns
- Relief time to engage in prisoner health service redesign
- Other QCS information request/s

Acknowledgements

Queensland Health acknowledges the authors, reviewers and editors of the Business Planning Framework EB9 and EB10 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:

- Denise Sticklen, Speciality Practice Lead: Correctional Services Addendum
- Tarryn Seumanu, Assistant Director of Nursing (OCNMO) (co-lead)
- Amanda Clark, Assistant Director of Nursing (OCNMO) (co-lead)
- Jamie Shepherd, Professional Officer Team Leader, QNMU (co-lead)

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 Correctional Services Speciality Users Group –

- Denise Sticklen, Speciality Practice Lead: Correctional Services Addendum, NUM Townsville Men's and Women's Correctional Centre Townsville HHS
- Vickye Coffey, DONM/Facility Manager, Mareeba Hospital, Cairns and Hinterland HHS
- Vanessa Brooks, ND / Program Manager,Mental Health & Specialised Services, West Moreton HHS
- Juliet Graham, Nursing Director of Workforce, West Moreton HHS
- Robin Stocks, Nurse Manager Informatics, Wide Bay HHS
- Keith Portman, CN, Palen Creek Correctional Centre, Metro South HHS
- Raquel How, Nurse Practitioner, Wacol Prison, West Moreton HHS
- Suzanne Golby, Nurse Educator, Wacol Prison, West Moreton HHS
- Gayle Hocking, NUM, Wide Bay Correctional Services, Wide Bay HHS
- Lorraine Reid, NUM, Wolston Correctional Centre
- Evelyn Dwyer, NUM, Brisbane Correctional Centre
- Cara-Lee Bradley, ADON, Prisoner Health Services
- Bradley Elms, Program Manager, Wide Bay Mental Health Alcohol and Other Drugs Service, WBHHS
- Kim Hyam, NUM, Borallon Training Correctional Centre
- Suzanne Suthers, NUM, Brisbane Youth Detention Centre
- Marie Finlay, Director of Operations/Nursing Director, Prisoner Health Services (Mental Health and Specialised Services West Morton Health Service)
- Darren Holzberger, DON, Capricornia Correctional Services
- Marlena Kussrow, A/NUM, Beaudesert Correctional Services

The BPF Strategic Addenda Project Team –

- Andrew Stevens, Principal Industrial Advisor, DOH
- Greg Moore, EB9 Project Manager, DOH
- Kylie Badke, Industrial Officer, QNMU
- Tarryn Seumanu, Speciality Practice Lead: Remote Setting Addendum
- Jillian Richardson, Speciality Practice Lead: Rural Setting Addendum
- Denise Sticklen, Speciality Practice Lead: Correctional Services Addendum
- Debbie McCarthy, Speciality Practice Lead: Emergency Departments Addendum
- Lynette Zeller, Speciality Practice Lead: Maternity Services Addendum
- Desley Horn, Speciality Practice Lead: Paediatric Addendum

The BPF Subject Matter Expert Reference Group - Glenn Hokin, Jane Davies, Jeff Dippel, Jeffrey Souter, Juliet Graham, Lynne Cameron, Michelle Eley, Neil Pratt, Paolo La Penna, Rachelle Cooke, Rohan Harbert, Cindy Patterson, Dean Cartwright, Clair Nunn, Fiona Jonsen, Gillian Tassell, Helen Gold, Janette Mollee, Jo-anne Doyle, Kylie Cookson, Melissa Cavill, Ninette Johnstone, Robin Stocks, Troy Lane.

The EB9 and EB10 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
- Michelle Garner, EDNM, North West HHS
- Robyn Henderson, EDNM, West Moreton HHS
- Julie Rampton, EDNM, Mackay 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
- Karyn Ehren, Director of Nursing, Workforce Sustainability
- Rachel Borger, Director, Industrial Relations, Employment Arrangements Unit
- Renee Muggleton, Project Support Officer, Employment Relations
- Diana Schmalkuche, Director of Nursing, Workforce Sustainability, OCNMO for her contribution in co-leading and commencing the project.
- Sandra Eckstein, Assistant Director of Nursing, OCNMO for her contribution in co-leading and commencing the project.
- Susan Krimmer, Acting Assistant Director of Nursing, OCNMO for her contribution in co-leading and commencing the project.
- Sharyn Hopkins, Professional Officer, QNMU for her contribution in co-leading and commencing the project.
- Denise Breadsell, Professional Officer, QNMU for her contribution in draft review.
- Sarah Beaman, Acting Professional Officer, QNMU for her contribution in draft review.
- Leanne Jiggins, Professional Officer, QNMU for her contribution in draft review.
- Kate Veach, Director Organising & Professional Services, QNMU for her contribution in draft review.