Business Planning Framework:

a tool for nursing and midwifery workload management

6th Edition 2021

Emergency Department Addendum 2024

Queensland Government

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

For more information contact:

Office of the Chief Nurse Officer,
Clinical Excellence Division, Department of Health,
GPO Box 48, Brisbane QLD 4001,
email: ChiefNurse-Office@health.qld.gov.au,
phone 07 3328 9237.

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

Disclaimer:

Contents

Introduction

The Business Planning Framework: a tool for nursing and midwifery workload management 6th Edition (BPF 6th 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 6th Edition apply to all remote, rural, regional and metropolitan nursing and midwifery services in Queensland Health. This addendum is designed to recognise the unique challenges for nurses working in emergency departments and must be used in conjunction with the BPF 6th Edition.

The Emergency Department 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 6th Edition for a range of settings, including emergency departments to support compliance with the Nursing and Midwifery Workload Management Standard.

The emergency department addendum was created by a statewide emergency department nursing Specialty User Group in partnership with QNMU and the Department of Health.

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.

This addendum will assist nursing staff within emergency departments 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 hours within their setting
- develop planning tables identifying productive and non-productive hours relevant to emergency departments
- identify and describe client and service complexity and activity indicators to improve consistency in the application of the BPF 6th Edition in emergency departments
- develop overall staffing profile outside the recognised identified clinical zones or identified treatment spaces, per the GEC1558 - Ratios Exploration Emergency Department Policy Analysis Report

Module 1: Development of a service profile

This section relates to BPF 6th Edition module 1: pages 10-28

Business planning in the context of emergency departments

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

- articulating nursing work in the emergency department,
- validating indirect emergency nursing hours and;
- applying standard business planning definitions to emergency department settings

Emergency departments are the front door of the health facility and, for many people, form their primary contact with the health care system, providing an important interface between the community and the health facility.[1,2]
Emergency services are responsible for the reception, triage, initial assessment, stabilisation, management of patients of all age groups from neonatal to geriatric presenting with acute and urgent aspects of illness and injury, and referral to ongoing care.[3,4,5]

Emergency departments are not stand-alone facilities. To provide safe and effective service delivery, emergency departments rely on a suite of support services from both within and external to the service.[6]

Factors that should be considered when contextualising the BPF 6th Edition to emergency departments include consideration of:

- the amount of activity/number of presentations the department delivers
- the Clinical Services Capability Framework (CSCF) Emergency Services level
- distance to higher CSCF Emergency Services (i.e. tertiary centres, retrieval services) if relevant
- proximity of public transport (e.g. if accessibility of emergency department is more convenient than access to a General Practitioner clinic)
- the population and demographic of patients
  - » consideration of remote, rural, regional, or metropolitan facility
  - » socioeconomic status of population

[1] *www.acem.org.au/Standards-Publications/Policies-Guidelines.aspx*
[2] *https://www.health.qld.gov.au/__data/assets/pdf_file/0027/444276/cscf-emergency.pdf*
[3] *www.acem.org.au/Standards-Publications/Policies-Guidelines.aspx*
[4] *http://www.health.gov.au/internet/main/publishing.nsf Content/387970CE723E2BD8CA257BF0001DC49F/$File/Triage%20Workbook.pdf*
[5] *https://www.health.qld.gov.au/__data/assets/pdf_file/0027/444276/cscf-emergency.pdf*
[6] *https://www.health.qld.gov.au/__data/assets/pdf_file/0027/444276/cscf-emergency.pdf*

  - » Aboriginal and Torres Strait Islanders population
  - » Changes to population in line with tourist events/seasons
- Emergency care performance indicators such as:
  - » ambulance transfer times
  - » patient off stretcher times (POST)
  - » total length of stay (LOS)
  - » ambulance lost minutes
  - » unexpected departures from the ED
  - » waiting times at the ED
  - » National Emergency Access Target (NEAT)
- emergency departments are the first point of contact for emergency management situations (e.g. influenza epidemics, acts of terrorism)
- 'ambulance bypass' or "diversion" or "load sharing" should not be utilised by facilities unless in cases of internal or external disaster,[7] therefore it is difficult for emergency departments to redirect activity if balance of demand for services outweighs supply of workforce
- direct impact of inpatient occupancy on emergency department patient flow
- increasing exposure to occupational violence[8]
- infrastructure and emergency department design
  - » aging building infrastructure and building design impacts upon workflow efficiency, occupational health and safety and security of staff.
  - » consideration of department size –ensuring staffing numbers to support square meterage of department
  - » consideration of department layout – isolation rooms, proximity to designated off-site smoking areas, location of allied health services (i.e. radiology department)

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 within the emergency department. The calculation of productive hours needs to incorporate staffing requirements for direct and indirect activities that may not regularly occur in other health settings (refer to Table 1: Key productive and non productive nursing hours).

These requirements further emphasise the importance of professional judgement in the calculation of the productive nursing hours.

[7] *https://www.health.qld.gov.au/__data/assets/pdf_file/0030/365448/qh-gdl-956.pdf*
[8] *https://www.health.qld.gov.au/__data/assets/pdf_file/0024/443265/occupational-violence-may2016.pdf*

Business planning considerations

This section relates to BPF 6th Edition page 13 - 27

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 the emergency department and result in service demand fluctuations. These internal and external factors need to be considered when analysing service demand. Wards and services should annually assess the impact of each factor on their environment and make the necessary adjustments to the allocation of nursing hours.

Table 1 provides examples of several business planning considerations relevant to the emergency department, 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 emergency departments

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:* *The higher CSCF level sites are the referral sites for lower CSCF level emergency departments, it must consider this activity as part of service demand e.g. inter-hospital transfers, burns, spinal, neuro surgery, paediatrics, ICU.* *Any emergency department of CSCF level 4 and above become referral site for feeder hospitals. This leads to workload impact of transfers, inter-hospital transfers, and direct admissions.* *All services need to consider the impact of skill mix on optimal service delivery.*	***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.
Type of Service **(Internal)** (e.g. Emergency care, resus, Nurse Practitioner lead model, fast track, short stay unit, mental health acute care team, diagnostics)		***Indirect nursing and midwifery hours:*** Calculation of clinical hours for indirect care, travel, program/service based education, succession planning, quality activities and research.
Catchment area **(Internal)** (Local Hospital and Health Services versus Statewide Services)		***Workforce planning:*** Development of strategic local/ Statewide workforce plans to inform Full Time Equivalent (FTE) requirements, skill mix profiles and macro workforce planning formulas.
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 and midwifery roles, and how they relate with other clinical roles, will impact on the balance of service demand and supply. Models of care known to improve the patient flow and safety in the Emergency Department are required. GEC1558 Policy Analysis findings, including identified support roles such as waiting room nurses, access nurses, clinical leads, and dedicated ambulance triage nurses. *Examples:* *In emergency, nursing roles can be categorised by the skills required to meet patient demand (i.e. orthopaedic, correctional, mental health, endocrine, renal, paediatrics, geriatric). To accommodate the wide range of skills required, a level of flexibility in the scope of the role is necessary which can impact on the number of nursing staff employed and their workloads.* *Different models of care may be required depending on acuity and skill mix of staff. Nurses within these environments may be required to practice autonomously at an advanced level.* *The accessibility and level of support available to and from other services may vary. Nursing services should account for the productive hours required to manage the demand from these interactions.*	***Direct nursing hours:*** Calculation of clinical hours for direct care provided in and outside the service, position classifications for the clinical hours required, allocation of clinical hours (rosters), selection of optimal service activity/acuity measures, safe staffing levels.
Support structure **(Internal)** (Providing support to other services and/or receiving support from other services)		***Indirect nursing hours:*** Calculation of clinical hours for non-direct care networking/collaboration (internal and external) travel, staff training, professional development, quality activities and research.
Model of care **(Internal)** (Multi-functional teams)		***Workforce planning:*** Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service, including direct support roles. 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, including the uptake and implementation of support roles. Consider the implementation and uptake of identified support roles - explain the actual roles in detail Patient and staff safety - promote e.g. OV such as waiting room nurses, access nurses, and dedicated Queensland Ambulance Service (QAS) .

Table 1: Business planning consideration for emergency departments

Influences (internal and external)	Service impact	Examples of workload management considerations
Policy/legal factors **(External)**	Changes in health policy and legislation will influence service delivery and staff requirements. Common change drivers include governments (commonwealth/state), licensing organisations, professional and industrial groups. *Examples:* *Legislation – Work Health and Safety Act 2011* *Commonwealth - health reform* *Queensland Health – strategic plan* *Occupational violence – task force recommendations* *Mental Health Act and Public Health Act resulting in changes in service delivery requirements.*	***Direct nursing hours:*** Calculation of clinical hours for direct care (based on available funding), position classifications for the clinical hours required, registration commitments for clinical hours, allocation of clinical hours (rosters), selection of optimal service activity/acuity measures, and use of minimum staffing requirements.
Economic factors **(External)**	Funding policies, the national economy and the interface between public and private health care providers will influence the delivery of outpatients and ambulatory 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. This builds community expectation for service delivery not aligned to recurrent funding model.*	***Indirect nursing hours:*** Calculation of hours for indirect and non-productive activities such as policy development, business planning, service interfaces, travel, staff training, professional development, quality activities and research.
Social/population factors **(External)**	Population demographics and community expectations will impact on the types of emergency health services offered, how the services are offered, staffing numbers and skill mix required for service delivery. *Examples:* *Delivering health services to a community with a disproportionate number of homeless people, lower socio-economic demographic, and those with substance abuse will impact the number and type of clinical hours required to operate the service.* *Increasing number of emergency presentations to public hospitals related to substance use and/or abuse results in increased risk of occupational violence which necessitates appropriate resourcing to meet training requirements.* *The risk of occupational violence in an emergency department is disproportionate to an acute health centre.*	***Workforce planning:*** Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service. Devising operational and organisational structures to support staff in applying the chosen model of care. Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.

Nursing core demand considerations

To improve the consistency and transparency in the application of the BPF 6th Edition, specific demands on direct and indirect nursing hours in the emergency department have been categorised to assist in articulating nursing work. The categories are based on the most common and frequent demands placed on nurses within the emergency department. The following section will explore the relationships between core demand considerations and the context of practice in emergency departments.

Client/service complexity

When reviewing client and/or service complexity there are many unique considerations for the emergency setting, these include:

- complexity of caring for patients from neonatal to geriatric age groups
- the unique family dynamic in times of high stress and uncertainty[9]
- caring for patients who are experiencing mental health issues. This creates additional challenges including; demand on numbers and skill mix of nurses for the provision of safe care and managing risk. For example specialling of patients who are at risk of self-harm and consideration of co-location of patients
- increasing presentations by older people, from both the community and residential aged care facilities, which have special needs and considerations for care and discharge[10]
- managing multiple patient traumas, resuscitation bays, acute and sub-acute presentations and collaborating with other service providers such as mental health services, Queensland Ambulance Services and Queensland Police Service in the one setting at the same time
- vulnerability to occupational violence due to consumers being in stressful, unpredictable and potentially volatile situations. Causal factors of aggression and violence include medical conditions such as dementia, delirium, mental illness or head trauma. Other factors include substance abuse or anti-social behaviours[11]
- being aware that procedures often require additional staff, with specific skills and training to provide safe care, for example, cardioversion, suturing and plastering
- being aware that some procedures and treatments are undertaken in a dedicated area away from the bed space or outside of the department e.g. procedure room for plastering requiring additional nursing time for patient preparation and transport
- managing patients with broad diversity of conditions/diagnoses, multiple comorbidities with varied chronicity and complexity, all within the one department
- provision of emotional support and education to family members and carers, particularly discussions about diagnosis, care planning, and health education. This includes support to families whose loved one has died within the emergency department
- the need to facilitate patient movement between departments and external services. The nurse or midwife may need to escort the patient for care e.g. to inpatient wards or offsite for Royal Flying Doctor Service transfers
- being aware of the availability of 24 hour primary care providers in the community, and limited availability of bulk-bill services which can increase the number of presentations to emergency departments
- community perceptions of emergency access targets e.g. impression that you will be seen in four hours or less regardless of acuity of presentation

[9] *https://www.health.qld.gov.au/__data/assets/pdf_file/0024/443265/occupational-violence-may2016.pdf y*
[10] *https://link.springer.com/article/10.1186/s40886-016-0049-y*
[11] *https://www.health.qld.gov.au/__data/assets/pdf_file/0024/443265/occupational-violence-may2016.pdf*

- predictable unpredictability of presentations to the emergency department e.g. influenza season variances, major events (such as concerts, sporting events) bringing an influx of population
- provision of culturally safe care for people, including time spent to ensure valid consent, for example, engagement of interpreter services to ensure patient and family are appropriately informed for decision making
- managing the waiting room, which is recognised as a high-risk environment, by increasing clinical nursing support and advanced clinical surveillance to optimise patient and staff safety and supervision
- managing escalation, de-escalation, surge management, and ramp flow

Model of care/service delivery

There are varied models of care for service delivery in the emergency department. Additional to traditional emergency service delivery, models of care include:

- Short Stay Unit (SSU)
- Fast Track
- Medical Access/Assessment Planning Unit (MAPU) or Cinical Decision Units (CDUs)
- Nurse Practitioner-Led Clinics
- Geriatric Emergency Department Intervention (GEDI)
- Medical Emergency Team (MET) response coordination
- Senior Early Assessment Team (SEAT)

Models of care will vary depending on:

- staffing availability and skill mix
- patient acuity
- patient age (i.e. some facilities have separate paediatric emergency and adult emergency departments)
- patient demographics
- proximity to higher CSCF facilities, for example tertiary Intensive Care Units or facility
- ward layout and proximity to associate/ support services
- access to mental health services
- access to community health service providers

There are a broad range of service activity types at level 1 to level 6 CSCF in emergency settings (including Children's Emergency Services). The CSCF determines the level of service to be provided based on the service description criteria.

Technology and materials management

The introduction of digital systems and eHealth technology requires significant input from nurses. Often systems require modification to meet the needs of emergency departments, resulting in staff needing to assist other streams to customise the systems, for example, integrated electronic Medical Record (ieMR) in emergency settings.

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

Additional considerations include;

- introduction of digitalized hospitals requires additional training, for example, ieMR downtime processes
- access to technology at the point of care (workstation on wheels, iPads) and management of information communication technology related assets
- stable connectivity to the internet (Wi-Fi drop out issues)
- asset management of emergency specific equipment including obtaining quotes, maintenance coordination, education for implementation and Health Technology Equipment Replacement (HTER) management
- ensuring that equipment (such as cardiac monitors) are interchangeable, not only within the unit, but within the facility/HHS
- ensuring that assets range from neonatal, paediatric, adult and bariatric sizing
- imprest and drug management processes – electronic systems such as Pyxis

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

Community interface

Community and consumer engagement is pivotal to the delivery of emergency care. Emergency departments have connections with a variety of service providers which impact service delivery including patient presentation and discharge or transfer from the emergency department.

The emergency department may directly and/or indirectly interact with the following groups:

- Queensland Ambulance Service (QAS)
- Queensland Police Service (QPS)
- Aboriginal Community Controlled Health Service
- community respite residential care providers
- community health service providers, including nurse led clinics
- Department of Community Services
- National Disability Insurance Scheme and associated private sector service providers
- Non-Government Organisations, e.g. homeless support services, alcohol and drug addiction support services, youth and adult mental health support services
- primary health care providers including local General Practitioner practices
- Hospital in The Home (HiTH) services
- Community Advisory Networks
- specialised statewide services such as Retrieval Services Queensland (RSQ), transplant services
- private sector service providers

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

Quality and safety

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

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

- patient/family safety, for example the level of supervision required for mental health patients at risk of self-harm
- staff safety, for example management of aggressive behaviour in patients (which includes dementia and delirium, mental health related diagnosis, and drug or alcohol-fuelled aggression)
- mandatory and requisite training requirements, for example paediatric and adult advanced life support (further detailed in Education and service capacity development)
- policy, procedure and clinical guideline development and review, at facility and HHS level
- clinical portfolio extension beyond department, providing specialist emergency nursing advice throughout the hospital and health service
- incident and near miss reporting in the emergency setting. This involves identification and management of challenging patient and family behaviours
- ergonomics and design requirements to ensure a safe environment e.g. safe environments for mental health patients, safe environment for triage nurse

- emergency specific audits e.g. triage auditing
- implementation of Root Cause Analysis (RCA), Human Error and Patient Safety outcomes

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

Education and service capacity development

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

Consideration needs to be given to supporting staff to:

- undertake the Transition to Emergency Practice Program
- attend additional training and upskill for roles such as:
  - » triage nurse
  - » resuscitation/medical emergency support team member
  - » emergency flow coordinator
  - » Clinical Initiatives Nurse (CIN)
  - » Geriatric Emergency Department Intervention team member
  - » trauma review nurse
- achieve training requirements across the lifespan and roles in the emergency setting, such as:
  - » paediatric advanced life support and adult advanced life support
  - » ventilation skills competency for neonatal, paediatric and adult patients
  - » geriatric emergency care
  - » Emergency Triage Education Kit (ETEK)
  - » Trauma Nursing Core Course (TNCC)
  - » Maternity Emergency Course
- travel to tertiary and other relevant education facilities that provide specialist emergency training
- develop a unit specific education plan
- engage in succession planning
- develop as an emergency nurse, progressing from novice to expert
- utilise professional development leave
- strike the balance between “growing our own” (i.e. new to the emergency setting) and recruiting experienced staff to support team growth and service requirements

In the emergency setting, there may be limited access to a casual workforce that has the skill set or required training to support management of emergent leave and short term planned leave in the department. This needs to be considered when developing the service profile.

Leadership and management

The emergency service activity has direct effects on the inpatient and outpatient activity of the hospital. As such, consideration needs to be given to the individual leadership and management requirements, and support systems to ensure streamlined patient flow. This may impact the level of demand placed on productive nursing hours. The demand considerations include:

- skill and knowledge requirements to lead and manage in the unique emergency context, including management of higher grade nursing positions (i.e. NG7 Nurse Unit Manager (NUM) managing a team including NG8 Nurse Practitioner roles)
- service accountabilities and responsibilities beyond the emergency department (e.g. Medical Emergency Team, Disaster Management Planning, Occupational Violence committees)

- management of staff, noting that emergency departments are exposed to acute and traumatic stressors more frequently than other areas[12] and therefore need to consider time for staff support/debriefing
- organisational and HHS engagement, including influencing clinical practice and providing emergency expertise in committees
- supporting and sustaining the specialist emergency nurse staffing profile which includes classification, scope of practice and training/ skills development
- interactions with nursing and multidisciplinary team members for management of complex care
- managing consumer expectations in line with agreed service provision
- facilitating a peer support network for NUM, Clinical Nurse Consultants (CNCs) and Nurse Educators across the state

Research and evidence based practice

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

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

[12] *https://www.ncbi.nlm.nih.gov/pubmed/17365896*

Health policy, clinical guidelines, strategic plan and health legislation

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

- Occupational Violence Prevention in Queensland Health's Hospital and Health Services[13]
- Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 [14]
- Hospital and Health Service strategic plans[15]
- Mental Health Act 2016[16]
- National Safety and Quality Health Service (NSQHS) Standards[17]
- Memorandum of Understanding – Queensland Health and Queensland Police Service Mental Health Collaboration 2016[18]
- Use of Retrieval Services Queensland – Health Service Directive[19]
- Queensland State Disaster Management Plan 2016[20]
- Chronic Conditions Manual[21]
- Service improvements and delivery models – Care in the emergency department[22]
- Department of Health Guideline: Emergency Department Access[23]

[13] *https://www.health.qld.gov.au/__data/assets/pdf_file/0024/443265/occupational-violence-may2016.pdf*
[14] *http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4ECCA257E8B00007AC5/$File/DOH_ImplementationPlan_v3.pdf*
[15] *https://www.health.qld.gov.au/system-governance/strategic-direction/plans/hhs-plan*
[16] *https://www.legislation.qld.gov.au/browse/inforce*
[17] *https://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/*
[18] *https://www.health.qld.gov.au/__data/assets/pdf_file/0034/573991/mou_qh_qps_mhcollab.pdf*
[19] *https://www.health.qld.gov.au/__data/assets/pdf_file/0020/151193/qh-hsd-005.pdf*
[20] *http://www.disaster.qld.gov.au/Disaster-Resources/Documents/Queensland-State-Disaster-Management-Plan-2016.pdf*
[21] *https://publications.qld.gov.au/dataset/ef6d9f9e-e8aa-445e-a345-02a016e7251b/resource/bbe5439c-be87-45b6-b704-3b557fbee1e0/download/chronicconditionsmanual1stedition.pdf*
[22] *https://www.health.qld.gov.au/improvement/improving-services/service-models*
[23] *https://www.health.qld.gov.au/__data/assets/pdf_file/0030/365448/qh-gdl-956.pdf*

Module 2: Resource allocation

This section relates to BPF 6th Edition Module 2: pages 30-41

Establishing total nursing resource requirements

SUPPLY AND DEMAND

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

Creating a list of standard direct and indirect nursing activities in your unit or practice area will assist in articulating and monitoring the use of productive hours. As outlined in the BPF 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 activities relevant to your service, especially those considered unique to your unit or practice area.

Defining productive hours increases the understanding of the nursing work being performed and provides an excellent foundation when developing a service profile.

Table 2 provides examples of key productive and non-productive nursing activities for an emergency department and should be used in conjunction with the BPF 6th Edition (pages 27- 47).

Total productive hours =

direct hours

+

indirect hours

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Service management				
Operational and strategic planning		x		Business and strategic planning
Models of service delivery	x	x		Case management/integration
Patient area management (infrastructure and equipment)		x		Resus, triage, short stay, procedural, ambulatory, waiting room
Inventory and stock control		x		Consumable management and ordering
Service data collection and analysis		x		Data integrity, activity review, validation, analysis
Service delivery				
Patient assessments	x			Physical assessments, mental health assessments
Referral management	x	x		Triaging and prioritising diagnostics testing, outpatient referrals, integrated care pathways
Triage	x			Triaging patients, information gathering, collateral, data collecting, decision making to direct patient flow, consumer engagement, streaming, resource allocation, level of expertise, liaise with QAS/QPS etc., nurse initiated care, time to meaningful cares
Patient and family education	x			Delivering health education
Clinic delivery	x	x		Follow-up phone clinics, dressing clinics, outreach clinics, re-presentation management, consideration for remote and rural areas
Consumer liaison/patient follow-ups	x	x		Public phone calls, answering calls, directing phone calls, patient enquiries
Clinical procedures	x	x		Includes set ups, procedures and clean ups, patient monitoring, patient education, patient and family support, patient preparation, procedure sedation, documentation
Telehealth services	x	x		Patient to tertiary, TEMSU, resus management, nursing homes, RSQ, consultancy to lower CSCF level services, virtual services
Care planning and patient journey coordination	x	x		Client related arrangements such as patient travel, translators and complex diagnostics, time pressured, QEAT
Clinical documentation	x			Medical records; client related charts; multiple information systems with no interoperability; correlation, collation and dissemination of information, screening tools, national standards
Clinical handover	x			Patient transfers – inter-hospital and intra-hospital (for example: public to private, radiology, wards), child safety, QAS QPS, inter-service (residential aged care facility), inpatient service, shift to shift, break to break
Patient escorts	x			Intra and inter-hospital, push/pull, procedural and diagnostic transfers, wait time related to transfers (areas ready for accepting), waiting for retrieval services (e.g. QAS)

Ambulance Triage	X		X	Triaging patients arriving by ambulance, information gathering, collateral, data collecting, decision making to direct patient flow, consumer engagement, streaming, resource allocation, level of expertise, liaise with QAS/QPS etc., nurse-initiated care, time to meaningful cares
Waiting Room	X			Provides clinical supervision and surveillance, observation, escalation and de-escalation of care, triage support during surge, patient education, and family support. This role is not a treatment nurse, rather an identified support role essential for maintaining patient safety and flow. Delete "flow" and consider replacing with surveillance
Access nurse	X			Provides escorts for in-hospital and inter-hospital transfers, surge response to clinical areas as required e.g., resus and acute cubicles, and supporting the expedition of inpatient transfers to wards. In the context of the Emergency Department, this is a multipurpose role available for flexing capability to support care provision to areas with high demand. This role works closely with Team Leaders / Shift Coordinators in response to surge demand and redeployment of resources.

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Transfer management (pre and post emergency department care)	x	x		Management of ramped patients, collating information to do transfer, conflict resolution, QAS liaison and shared care
Clinical team leading		x		Staff coordination, patient management, patient flow, safety, data management, complexity
Clinical care facilitation and education	x			Opportunistic bedside teaching
Staff management				
Rostering		x		Daily, weekly and monthly rostering of staff
Leave management		x		Annual, sick, fatigue and study/research leave, PDL, QSuper/WorkCover management, psychological support – bereavement leave etc.
Skill mix management and allocation		x		Team leader duties, resource allocation, 24/7 management, succession planning implementation and support
Human resource management		x		Pay enquires, staff movement forms, performance improvement, managing up
Recruitment and retention		x		Advertising, interviewing, developing retention strategies
HR and finance delegate responsibilities		x		Labour expenditure, leave management, monthly reports
Staff travel		x		Organising staff travel, undertaking travel
Staff development				
Clinical supervision		x		Professional support/learning, reflective practice, preceptor models
Clinical facilitation		x		Undergraduate, postgraduates and new starters, facilitation between skill set in ED (for example, resus to triage to subacute to short stay), staff progression novice to expert
Speciality or requisite training			x	Child safety, advanced life support, paediatric advanced life support, Suicide Risk and Management in Emergency Department settings, ETEK, occupational violence, Aggressive Behavioural Management, domestic violence, cannulation, venepuncture, TNCC, Trauma Nurse Paediatric Course

Mandatory training			x	Localised to each HHS, e.g. ergonomics, basic life support
Staff education (in clinical area)		x		Internal (including in-service training, ward-based education/training sessions) and external
Professional development/ portfolios		x		Clinical portfolios
Performance appraisal and development (PAD)		x		Participation in PAD process and Performance Improvement Process, career progression pathways
Succession planning		x		Workplace shadowing, professional development, secondment management
Staff meetings		x		Unit/ workplace based
Evidence-based practice		x		Research activities/service based projects

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Policy development and enforcement				
Committee participation		x		Internal and external committees
Quality audits/safety checks		x		Designated by legislation, policy or quality programs
Health service planning		x		Service capacity building and workforce planning
Clinical governance practices		x		Policy review and development, clinical guidelines and work unit guidelines
Patient feedback management		x		Patient complaints, service delivery issues, patient feedback, ministerial
Information management				
Balanced scorecard/ operational reporting		x		Evaluation tools
Data analysis		x		Service improvements, KPI management
Business planning and management		x		Service profile development
Electronic medical records	x			Client related information and storage record, multiple systems
Other				
Travel		x		Travel associated with service delivery e.g. outreach clinics
Equipment and infrastructure maintenance		x		Building repairs, clinical equipment repairs, HTER management, general asset management
Procurement and plant maintenance		x		HHS dependent, asset acquisition
Disaster Management		x		Preparedness and staff training (hospital exercise) for events such as mass casualty; epidemic; natural disasters ; special event management e.g. commonwealth games, sport events, schoolies, concerts

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 staff informs the minimum skill mix required to build a staffing roster to meet the demand created by the models of care.

Financial activity does not always easily or directly translate into nursing activity. In the emergency setting, there are varied types of service activity which require nursing hours, but this activity may not be accurately reflected in emergency financial activity.

- Unexpected departures from the Emergency Department (includes Did Not Wait and Left After Treatment Commenced)
  - » When a patient presents to the emergency department, they are seen by the triaging nurse and assessed. They may also be reviewed in the waiting room by a nurse, such as a CIN and Waiting Room Nurse. If this patient chooses not to wait for treatment, this presentation is captured as Did Not Wait (DNW) activity and does not attract any activity based funding, even though a nurse spent time with, and has triaged and assessed that patient.
- **Transfer activity**
  - » Some lower-level CSCF emergency services are required to provide higher level services until transfer of patients can occur (e.g. invasive ventilation for an extended period until RFDS transfer can be arranged). This has impacts on staffing requirements.
  - » If there is no bed availability for a patient to transfer (either intra-hospital or inter-hospital), this increases the demand on nursing hours in the emergency department, whilst also limiting availability of rooms to treat waiting emergency patients which impacts on patient flow.

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

Module 3: Evaluation of performance

This section relates to BPF 6th Edition Module 3: page 42-49

Data collection for emergency departments

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

Figure 2 outlines key identified information systems available in the emergency department. These may not provide all of the information required, so local data collection and analysis processes may be developed.

Table 3: Emergency department information systems and data collections

Information system/collection	Purpose	Informs
Emergency Department Information System (EDIS)	EDIS was designed based on clinical input and follows the progression of a patient through the ED. The system is able to monitor patient progress and provide alerts, and record treatment details. Data collection is a key component of this program.	Activity Acuity Client outcomes
FirstNet	Registration and clerical functions, triage and tracking electronic orders and result viewing, including laboratory, radiology, consult, and diet orders and results, electronic medications management, emergency specific nursing and medical documentation, discharge summaries, decision support, including alerts and notifications, operational and regulatory reporting	Activity Acuity Client outcomes
Hospital Based Corporate Information System (HBCIS)	Queensland Health's enterprise patient administration system, capturing and managing both admitted and non-admitted patient, clinical, administrative and financial data.	Activity Workforce Services Performance Client demographics Referral/waitlist Financial reporting
Queensland Hospital Admitted Patient Data Collection (QHAPDC)	The QHAPDC is the morbidity collection for all patients who have been admitted and separated from a hospital in Queensland. The information collected is used to manage, plan. Research and fund facilities at a local state and national level.	Activity Client complexity Client trends Performance Client outcomes Funding
Enterprise Discharge Summary (EDS)	The EDS application uses information from a number of existing Queensland Health specialist systems to create a legible, consistent, electronic discharge summary. It allows the summary to be delivered electronically to general practices in a secure, timely and standardised format.	Client trends Client complexity Client outcomes Performance
Monthly Activity Collection (MAC) **Note:** MAC reporting to become obsolete in 2018/19	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 Queensland Health's internet and internet sites.	Activity Provider type Client type Service type Performance Financial reporting
Consumer Integrated Mental Health Application (CIMHA)	Supports mental health's strategic, reporting and functional requirements through a single statewide data base.	Client information reporting
Queensland Health Enterprise Reporting Service (QHERS)	Online application through which Queensland Health employees can access a number of custom made statistical reports. QHERS provides users the ability to view, print and save reports designed to increase the capability and effectiveness of management reporting.	Reporting

Table 3: Emergency department information systems and data collections

Information system/collection	Purpose	Informs
Management Information System - Emergency Department Flow Monitor	This application is an end to end management system of emergency care including, not only details of current patients in the emergency department (ED) and patients expected to arrive in the coming hours but, more importantly, the current actions required to improve patient flow, patient treatment times and specific KPIs every 5 minutes. This application also provides in-depth, interactive reporting recent shifts and the last 10 days in the Emergency Department.	Patient flow Shift planning Short-term activity projection
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
Patient Flow Manager / Journey Boards	The Electronic Patient Journey Board (EPJB) displays patient information for clinical staff and allows patient information to be entered and updated throughout the care delivery process, from admission to discharge. EPJB are highly visible and promote a multidisciplinary approach to patient care and discharge planning. Often coloured flags are utilised in the form of a 'traffic light system' to indicate whether a referral or patient requirement is complete or incomplete.	Patient occupancy dashboard Patient flow planning

Figure 3: Remote setting health services information systems and data collections

Information system/collection	Purpose	Informs
TrendCare	TrendCare is a workforce planning and workload management system that provides dynamic data for clinicians, department managers and hospital executives. It supports care planning to ensure best practice, patient nurse dependency measurement and equitable workload allocation; human resource and fiscal management, roster development and patient dietary information.	Training record Performance development plans
McKesson Capacity Planner	An on line tool used to forecast patient demand and align staffing resources	Workload allocation Capacity management

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.

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

- patient satisfaction
- use of evidenced-based clinical practice guidelines and tools
- patient education practices
- median wait time to treatment
- percentage of patients who did not wait for treatment
- number of unplanned re-presentations
- number of in-department falls
- hand hygiene compliance
- medication administration

Examples of workforce specific quality indicators in the emergency department include:

- vacancy rate
- staff turnover
- overtime used
- casual/agency hours usage
- workload issues
- absenteeism
- mandatory education completion rate
- requisite and/or unit specific education completion rate

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

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

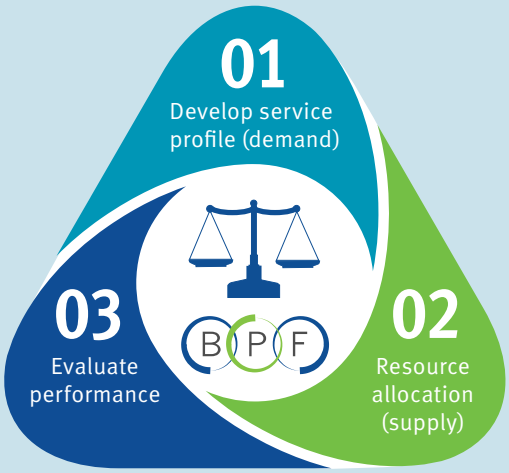
Forecasting and benchmarking

Benchmarking like emergency departments within Queensland can prove to be challenging due to the varied factors that impact demand on an emergency service such as geographical location, community services, socioeconomic status of the population and more, as discussed in Module One. Emergency departments within Queensland Health have the ability to benchmark against the Emergency Length of Stay Key Performance Indicator in the System Performance Reporting[24] platform, and the Hospital Performance Reporting[25] website.

Whilst there is a standardised framework for classification of emergency presentations, being the Australasian Triage Scale (ATS),[26] there may still be inconsistency in application of this scale[27]. This may have further impacts on the ability to accurately benchmark with other emergency departments.

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



[24] *http://qheps.health.qld.gov.au/spr/home.htm*
[25] *http://www.performance.health.qld.gov.au/hospitalperformance/HHS.aspx?id=87*
[26] *http://www.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-triage+Review+Fact+Sheet+Documents*
[27] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4458479/*

References

Queensland Health Reference Sources

Clinical Services Capability Framework version
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

Australian Guidelines for the Prevention and Control of Infection in Healthcare
https://www.safetyandquality.gov.au/sites/default/files/2021-05/australian_guidelines_for_the_prevention_and_control_of_infection_in_health_care_-_current_version_-_v11.6_11_may_2021.pdf

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

Patient Safety

https://qheps.health.qld.gov.au/clinical-excellence/patient-safety

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

Queensland Multicultural Health Policy and Action Plan 2024-2029
https://www.health.qld.gov.au/public-health/groups/multicultural/policies-plans-strategies/plans/multicultural-health-action-plan

Statement of Government Health Priorities
https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1346237/DOH_strategic_plan_2024_update.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 OmbudsmanAct 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

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
https://www.indigenoushpf.gov.au/

Australian Bureau of Statistics
https://www.abs.gov.au/

Australian College of Emergency Nursing
https://www.acen.com.au/

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

Australian Indigenous Health Info Net
https://healthinfonet.ecu.edu.au/

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

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

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

College of Emergency Nurses Australasia
http://www.cena.org.au/

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

National Primary Health Care Strategic Framework
http://www.health.gov.au/internet/main/publishing.nsf/Content/6084A04118674329CA257BF0001A349E/$File/NPHCframe.pdf

National Health Reform Performance and Accountability Framework
http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/0C3097B45A9657E9CA2579C10008DD00/$File/0508%20FINAL%20PAF.pdf

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

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

Appendix 1: Example activity measures identified for emergency departments

- triage category (admitted and non-admitted)
- number of did not wait presentations
- number of left after treatment commenced presentations
- number of transfer presentations, including mode of transfer (e.g. QAS vehicle, fixed wing aircraft located offsite, helicopter transfer on-site)
- number of inpatient admissions from emergency department (including escort requirement)
- number of planned return visits (including triage category)
- number of unplanned return visits (including triage category)
- number of mental health presentations (e.g. requiring one on one care)
- number of geriatric presentations
- number of paediatric presentations
- time and day of presentations
- length of time in emergency department (Emergency Length of Stay [ELOS], Queensland Emergency Access Target [QEAT])
- Patient Off Stretcher Time
- number of Medical Emergency Team (MET) responses provided by the emergency department, including number of nurses in attendance and location within the facility of the MET responses
- Short Stay Unit admissions (including length of stay)
- number of interventional treatments/ procedures (e.g. casting fractured limbs, suturing)
- influenza 'season' presentations
- number of patients requiring escorts outside of department (e.g. to radiology department)
- number of bariatric patients who require multiple-person assist, and additional equipment resourcing
- number of occasions/length of time for inpatient admissions remaining in emergency department due to unavailable inpatient beds
- number of presentations transferred to theatre from emergency department
- number of i-Stat (point of care blood testing) occasions of service
- walk-ins versus ambulance presentations

Acknowledgements

2024 Update
This updated addendum was authored by Queensland Health, Office of the Chief Nurse Officer (OCNO), and Queensland Nurses and Midwives Union (QNMU) by:

- Angelina Zande-Wilkins, Director of Nursing, OCNO
- Prue Cable, A/Assistant Director of Nursing, OCNO
- Linda Perry, ADON Emergency & Clinical Support Services, Logan Hospital, Metro South HHS
- Shaun Robertson, Nursing Director, Emergency & Clinical Services, GCUH, Gold Coast HHS
- Michelle Eley, Nurse Manager, Nursing Workforce & BPF, GCUH, Gold Coast HHS
- Carol Jeffers, A/DON, Workforce Planning, Metro North HHS
- Emily Bell, A/NUM, Emergency Department, QEII Jubilee Hospital, Metro South HHS
- Kelly Dwyer, Professional Officer, QNMU
- Daniel Seage, Industrial Officer ,QNMU
- Emily Hanna, Industrial Officer, QNMU

2021 Addendum Development
Queensland Health acknowledges the authors, reviewers and editors of the Business Planning Framework EB9 Addenda Project from which this document is derived.

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

- Debbie McCarthy, Speciality Practice Lead: Emergency Departments Addendum
- Sandra Eckstein, Assistant Director of Nursing, OCNMO (co-lead)
- Tarryn Mullavey, Acting Assistant Director of Nursing, OCNMO (co-lead)
- Sharyn Hopkins, Professional Officer, 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 Emergency Department Speciality Users Group –

- Debbie McCarthy, Speciality Practice Lead: Emergency Departments Addendum
- Tarryn Mullavey, Nursing Director – Service Planning, North West HHS
- Lesley Laffey, DON Cloncurry, North West HHS
- Allan Rowe, NUM ED, The Prince Charles Hospital, Metro North HHS
- Amanda Smith, NUM Children's ED, The Prince Charles Hospital, Metro North HHS
- Amanda Scanlon, Nursing Director and Facility Manager, Mackay HHS
- Graeme Poole, NUM, Atherton Hospital, CHHHS
- Desley Horn, Nurse Manager, LCCH, CHQ
- Melissa Heather, NUM, Ipswich Hospital, West Moreton HHS
- Juliet Graham, Nursing Director of Workforce, West Moreton HHS
- Robin Stocks, NM Informatics, Wide Bay HHS
- Muireann Wynne, CNC, Logan Hospital, Metro South HHS
- Julie A Oliver, A/Nursing Director, ED, MHHS

Acknowledgements

The BPF Strategic Addenda Project Team -

- Andrew Stevens, Principal Industrial Advisor, DOH
- Greg Moore, EB9 Project Manager, DOH
- Kylie Badke, Industrial Officer, QNMU
- Tarryn Mullavey, 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
- Colleen Glenn, Speciality Practice Lead: Maternity Services Addendum
- Desley Horn, Speciality Practice Lead: Paediatric Addendum

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

The EB9 Executive Directors of Nursing And Midwifery Services -

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

The statewide Executive Directors of Nursing and Midwifery Services.

Special acknowledgement is given to the following contributors:

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