Queensland Nurses & Midwives' Union

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In association with the Australian Nursing and Midwifery Federation QNMU Branch
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OUR REF: SUB22/0193

2 November 2022

Senator Barbara Pocock
Chair
Select Committee on Work and Care
PO Box 6100
Parliament House
Canberra ACT 2600

Email: workandcare.sen@aph.gov.au

Dear Senator Pocock,

Re: Senate Select Committee on Work and Care – Additional Information Requested

Thank you for the opportunity to appear at the Committee hearing in Brisbane on Monday 31 October 2022, along with QNMU Industrial Officer Kevin Crank and QNMU Research and Policy Officer Dr Belinda Barnett.

As stated on Monday, this inquiry is of fundamental importance to our members given the longstanding and entrenched undervaluing of the work they perform. Significant systemic structural barriers contribute to this undervaluing, including the construct of our industrial relations framework. The existing approaches to Gender Pay Equity and Work Value cases for example, have in large part failed to adequately address the issue of undervaluing of care work and we welcome the current government's commitment to addressing this critical issue. The current methods of valuing the work of our members are not fit for purpose.

At the heart of the undervaluing is the nature of the work our members perform and the lack of bargaining power inherent in caring work. Because of the power imbalances inherent in the employment relationship, it is difficult for workers to take industrial action. But it is much harder for our members to do so given this could require them to walk away from a person who is ill and/or vulnerable and to also leave their colleagues who are often already providing care in the over-stretched and under-resourced health and aged care system. (Noting of course that this requires our members to be creative about the type of action undertaken, given the predominant focus of their work is caring for people not making profits.)

The relational load is central to the work and identity of our members, it is why they do what they do. The work of our members is predominantly "other focused" and this results in our members often being taken for granted as it is assumed they will always put the needs of others first. This ongoing tension of balancing the safety and other needs of both workers and those they care for that is inherent in caring work is well understood by health and aged care employers.

Reconciling often competing interests of safety and quality and maintaining "budget integrity" in the care economy is also central to the appropriate valuing of care work. This results in significant ethical or moral

distress for our members when nurses and midwives are unable to perform the quality of work they know is required. Their clinical judgement is far too often ignored and not respected. The same is true for other workers in the care economy, the vast majority of whom are women.

The industrial and professional interests of our members are inextricably linked. The number one industrial and professional priority of our members continues to be ensuring appropriate workloads that keep both those in the care and nurses and midwives safe. But unfortunately, this focus on safety is effectively required to be "traded off" by our members for other advances related to pay and conditions. Workers in male dominated industries will not bargain around safety, but for too long our members have been expected to do so.

As promised at the hearing, please find attached the following materials that may be of assistance to the inquiry:

- Opening statement
- The Queensland Health *Best Practice Rostering Guidelines*
- A summary of recent research of QNMU members around current workforce priorities

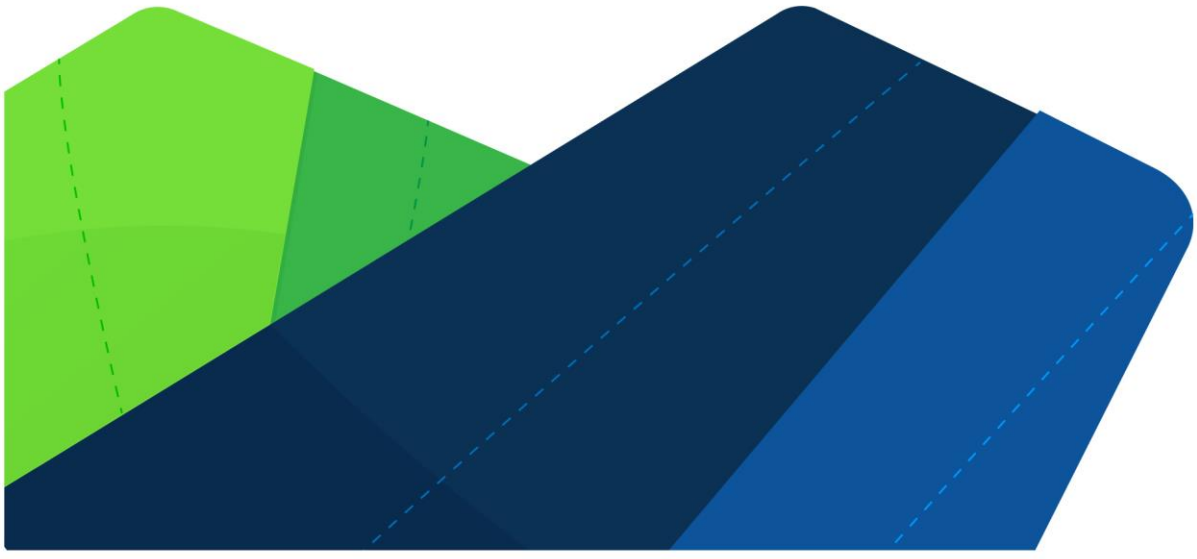
- A short summary of work we are advancing with Queensland Health to develop a multi-dimensional nursing and midwifery scorecard incorporating QNMU's Positive Practice Environment Standards
- QNMU's Positive Practice Environment Standards for Nursing and Midwifery

Yours sincerely,

Beth Mohle
Secretary

Best Practice Rostering Guidelines

Queensland Health Nurses and Midwives



Queensland Government

Best Practice Rostering Guidelines

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Nurses and Midwives Implementation Group

Office of the Chief Nursing and Midwifery Office

Queensland Nurses and Midwives Union

Employment Relations Team

Module One: Rostering Principles

Overarching Principle: Delivering safe quality frontline services

Effective rostering is a pivotal function in delivering quality frontline services, as it is the mechanism which ensures that nursing and midwifery resources are appropriately allocated in order to provide:

1. Safe and high quality patient care;
2. Support and resourcing for staff to provide safe and high quality care; and
3. Delivery of safe, affordable, sustainable and continually improving health services.

These rostering principles have been designed to assist in the development of rosters and form the basis for decision making. The principles are numbered for identification purposes only and do not indicate an order or priority:

Principle 1: The organisation has appropriate governance and negotiation processes in place for developing rosters that promote accountability, consultation, collaboration and transparent decision-making in the creation, approval, posting, monitoring and reporting of rosters.

Principle 2: Rostering aims to achieve a balance between service demand and supply of resources and support where necessary, appropriate adjustments to minimised and correct emergent imbalances to ensure safe, high quality nursing/midwifery services.

Principle 3: Nurses and midwives are rostered to provide a suitable skill mix to meet identified service demand and maintain patient safety.

Principle 4: Rosters must make appropriate provision for adequate staff supervision, training and clinical handover.

Principle 5: Rostering conforms to relevant regulatory frameworks, including industrial awards and agreements, workplace health and safety legislation, antidiscrimination legislation and policies/procedures.

Principle 6: Rostering is designed to mitigate fatigue and take into account the health and safety needs of nurses and midwives in order to provide a safe workplace and optimal patient care.

Principle 7: Rostering practices are based on co-operation between management and staff in order to promote fairness, equity and work-life balance, whilst still providing appropriate flexibility to facilitate organisational staffing needs.

Module Two: Legal implications of rostering

Legal implications of rostering

Rosters are legal documents that recognise the allocation of nurses and midwives to a particular ward or unit on a specific day for a particular shift or time period. Rosters can be used in a court of law or coroner's hearings to accord accountability and responsibility for patient care.

- Rosters must satisfy all legal provisions including:
- National and state laws, Acts, Regulations, Standards
- Awards
- Certified agreements
- Quality codes, frameworks and guidelines in place. For example: national standards pertaining to specialised areas of practice; or, direct or indirect supervision of enrolled nurses on a shift.
- Workplace health and safety provisions (Module Three)

Important points to consider and action in the development of a roster to limit a significant causal component of a court hearing include:

- Maintain all award, certified agreement and HR Policy provisions when developing a roster
- Deal with employees fairly and transparently when allocating shifts
- If rostering a 24 hour service, monitor the roster for equity and fairness of allocation of shifts including night duty
- Document all interactions involved in the development of the roster and maintain documentation on all shift changes
- Maintain and store completed published rosters (including changes) in accordance with the Queensland Health Clinical Records Management Policy, Procedure and Implementation Standards which outlines the mandatory auditable requirements for the management, appraisal and disposal of administrative, clinical and functional records
- Disposal of administrative and functional records
- Ensure all requests are in writing and signed by the appropriate delegates

- Maintain all documentation in a logical filing system which can be accessed by the accountable delegate
- Develop and utilise a checklist which documents all the important provisions to be maintained.
- Maintain a signed copy of the completed checklist with a master copy of the roster
- Post only rosters signed by the accountable delegate and ensure any changes are signed by the nurse/midwife unit manager or delegate prior to publishing on roster.

Roster Responsibilities

The strategic responsibility and accountability for rostering is assigned to the executive director of nursing and midwifery who delegates the responsibility to a nursing/ midwifery director, nurse/ midwife manager, or the nurse/ midwife unit manager. The task of developing the roster may be further delegated to a '*roster coordinator*'. The roster coordinator manages the portfolio of roster development in partnership with the nurse/midwife unit manager. The nurse/midwife unit manager or delegate approves the published roster.

Rostering Change Management and consultation

Any change to rostering practices involves consultation and negotiation with the relevant nursing and midwifery team members and endorsement within the organisational governance processes and structures. Employee participation in the change process is essential in order to facilitate effective change and foster an organisational culture committed to reform and quality improvement in health service delivery. Where there are significant changes it is essential to comply with the requirements to consult in accordance with the Award and the Agreement.

A working knowledge and application of change management is a critical element when implementing effective rostering practices.

Under the *Work Health and Safety Act 2011* there is also a duty to consult workers who carry out work and are likely to be directly affected by a matter relating to work health or safety (eg. roster design).

Industrial Entitlements and Obligations

Line managers are reminded that an authorised union industrial officer has a right to inspect employee records, including rosters, as part of a time and wages inspection under Section

345 of the *Industrial Relations Act 2016* and clause 38 of the Award. An authorised union industrial officer who exercises this right must comply with sections 345 and 348 of the *Industrial Relations Act 2016*.

All directors of nursing, nursing/midwifery directors, nurse/managers, nurse/midwife unit managers and other clinical employees who coordinate the development of rosters are required to have a high level of knowledge and application in the following areas:

- The *Business Planning Framework – a tool for nursing workload management*
- Effective communication strategies
- Clear understanding of all role descriptions and responsibilities
- Code of Conduct for the Queensland Public Service
- Knowledge of Industrial Awards and Agreements
    - *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* (the Agreement)
    - *Nurses and Midwives (Queensland Health) Award – State 2015* (the Award)
    - *Information Privacy Act 2009*
    - *Work Health and Safety Act 2011*
    - *Anti-Discrimination Act 1991*
    - *Industrial Relations Act 2016*
- Relevant Queensland Health Human Resource (HR) policies
    - HR Policy C4 *Work Life Balance*
    - HR Policy G3 *Reasonable Adjustment*
    - HR Policy G1 *Diversity*
    - HR Policy B5 *Nursing Workload Management*
    - HR Policy C7 *Special Leave*
    - HR Policy E13 *Workplace Harassment*
    - HR Policy C51 *Annual/Recreation Leave*
    - HR Policy C15 *Allowances*
- Fatigue management strategies

Privacy Considerations

Queensland Health has a longstanding commitment to ensuring the privacy and confidentiality of personal information. Queensland Health recognises the importance of managing personal information in a way that respects the privacy of employees. Information privacy is essentially about acknowledging that individuals should have control over, or at least be fully informed about, the way personal information about them is handled.

In respect of rosters and roster development, it is important that all directors of nursing and midwifery ensure that all employees, including roster coordinators and nurse unit

managers/midwifery unit managers, comply with relevant legislation including the *Information Privacy Act 2009 (Qld)* and the *Industrial Relations Act 2016.*

Ward/unit rosters must be posted in accordance with the Award provisions and must be able to be accessed by the employees on the roster. Each displayed roster should show the following information:

- Employee's Name
- Grade/Classification
- Work Location
- Rostered Hours

Ward/unit rosters can be copied, including photocopied or photographed, and taken home by the ward/unit employees, for the limited use of identifying their rostered hours, work locations, responsibilities, authority and duties. Employees are not to disclose the contents of the roster to anyone else or use the information contained in the roster for any other purpose, to ensure the safety of employees at work. Rosters can be disclosed to authorised officers consistent with the provisions of the *Industrial Relations Act*. Employees must keep copies of rosters secure in order to prevent unauthorised access by others. Employees are reminded that they are required to comply with the standards and ethical principles of the Code of Conduct.

Rosters are not to be placed on the Queensland Health internet/intranet unless steps have been taken to ensure security of the record/s. Rosters must not be placed on non-Queensland Health internet sites unless authorised by Queensland Health.

It is acceptable to distribute rosters by email to the employees on the roster, only if those employees agree.

Personal information including; contact phone numbers, email or postal addresses, can be shown on displayed rosters only at the express request of the employee.

Employee's contact details and personal information will be accessible only to appropriate employees (e.g. a line manager) and will be used for legitimate work purposes only (e.g. managing rostering gaps or follow up of an urgent work related matter).

Module Three: Work Health and Safety and Shift Design

Work Health and Safety Overview

Nursing and midwifery rosters must minimise and/or control the health risks associated with work in accordance with the *Work Health and Safety Act 2011* and *Work Health and Safety Regulation 2011.*

As an employer, Queensland Health has a duty to provide employees with a safe and healthy work environment. Under the *Work Health and Safety Act 2011*, the employer must assess risks and implement and review control measures to prevent and/or minimise risk exposure. The *Work Health and Safety Regulation 2011* describes how to control and prevent hazards in the workplace.

The service should have an open and transparent fatigue management strategy in place. Fatigue related matters will be managed in co-operation with the employee and employer, to ensure the safety of both patients and the nurse/midwife.

What is fatigue and its effects?

Fatigue is defined as, "a decreased capacity to perform mental or physical work, or the subjective state in which one can no longer perform a task"[1].

Fatigue inhibits the ability of an individual to function normally. Fatigue can be associated with impaired or reduced vigilance, reaction time and decision-making[2]. Fatigue primarily arises as a result of inadequate restorative sleep, but is also influenced by time of day and how long an individual has been awake[3].

Shift-related fatigue can also have negative effects on health, including increased risk of heart disease, high blood pressure, stomach ulcers, gastrointestinal disorders, depression, increased vascular stress and decreased fertility[4].

Common signs of fatigue can include:

- desire to sleep

[1] Queensland Health (2014), Fatigue Risk Management Policy
[2] Geiger-Brown et al., (2012). Sleep, sleepiness, fatigue, and performance of 12-hour-shift nurses
[3] Queensland Health (2014), Fatigue Risk Management Policy
[4] Ferri, P., et al. (2016). The impact of shift work on the psychological and physical health of nurses in a general hospital: a comparison between rotating night shifts and day shifts. *Risk Management and Healthcare Policy*, 9, 203-211; Lo, S., et al. (2010). Working the night shift causes increased vascular stress and delayed recovery in young women. *Chronobiology International*, 27(7), 1454-1468.; Gamble, K, Resuerh, D. Johnson, C. (2013). Shift work and circadian dysregulation of reproduction. *Frontiers in Endocrinology,* 4(92), 109.

- involuntary napping
- micro-sleeps
- reduced vigilance
- delayed reaction times
- decreased alertness
- poor judgement
- decreased motor skills
- irritability
- poor hand-eye co-ordination
- reduced visual perception
- degradation in physical and mental performance.

There are a number of hazards (both work and non-work related) that may contribute to fatigue. Some workers are at a higher risk of fatigue because of their work typically involves some or all of the factors contributing to fatigue. Major causes of fatigue include:[5] [6] [7]

Work-related fatigue	Non-work-related fatigue
• Shift length/extended hours of work • Shift work/roster patterns (including shift rotation) • Night work • On call and recall requirements • Workloads	• Family and social responsibilities/obligations • Community activities • Emotional stressors • Long distance travel prior to work/long commuting times[8]

[5] Workplace Health and Safety Queensland, (2011). Managing fatigue A guide for the workplace *The State of Queensland (Department of Justice and Attorney-General)*

[6] Australian Nursing Federation (2010). Fatigue Prevention. http://www.anf.org.au/pdf/policies/P_Fatigue_prevention.pdf

[7] Nursing 2018 Critical Care, Volume 13 Number 1. "Fatigue and critical care nurses: Considerations for safety, health, and practice" by Barbara B. Hobbs, Lori Wightman. P:8.
Berger AM, Hobbs, BB. Impact of shift work on the health and safety of nurses and patients. Clin J Oncol Nurs. 2006; 10(4): 465-471

[8] Commuting time is a non-work related fatigue factor, and nurse and midwifery unit managers need to be aware of the effect of this on the roster, and provide a supportive approach to employees' travel within the confines of the roster requirements, to meet service delivery needs.

• Unplanned overtime • Inadequate time between shifts for sleep • Work design • Second jobs • Irregular and unpredictable working hours • Stress • Time of day when work is performed and sleep obtained • Emotional and cognitive demands • Exposure to some hazards, such as heat, lead wearing, manual handling, prolonged standing	• Age • Current health and fitness level • Physical activity • Disruption to circadian rhythms • Sleep disorders • Prior sleep loss • Poor quality of sleep • Other employment

Fatigue Risk Management

Having fatigue risk management ensures workplace fatigue is managed in a proactive manner while minimising its effects and related risks on the workplace, employees, patients and others. This is achieved by having a best practice risk management framework as a core business function[9].

Taking into account sound risk management when developing rosters and shift design can help:

- maintain the health and wellbeing of employees
- minimise risk of patient harm caused by fatigue
- maintain a safe and healthy work environment
- educate and improve awareness of the effects of fatigue on employees
- appropriately manage any emergent imbalance in supply and demand.

[9] Queensland Health (2014), Fatigue Risk Management Policy

To properly manage risk exposures, employers and employees – both in general and as part of shift design – should:

- identify workplace hazards
- determine who might be harmed and how
- decide on control measures
- put controls in place
- review the controls regularly[10].

HR Policy I1 *Fatigue Risk Management* and the *Queensland Health Fatigue Risk Management System* provides further detail and integrates management practices and procedures to manage fatigue. It also assists with meeting Work Health and Safety obligations by outlining the steps that identify, assess, control and review risks on a regular basis and through objective thresholds specifically for local environments.

> *By developing a flexible work system that can respond to instances of fatigue when they arise on a day to day basis, it will help to effectively manage fatigue risk when it does occur.*

Where a number of factors combine this can create high to extreme risk situations (of fatigue). Generally, individuals should not be rostered beyond these thresholds. If reaching high levels of fatigue, a worker should make their employer aware, so that the employer, where possible, can replace the worker with another clinician.

Where a worker is not replaced, and/or there are proposed exceptions where risk cannot be minimised due to extraordinary circumstances, these situations must be escalated to the appropriate delegate for approval.

Some areas may require more effort and planning to resolve risks. Resolution of health and safety issues should be enabled through inclusive consultation and communication between interested parties.

If additional assistance is required, refer to the OHS committees, and/or contact Safety and Wellbeing: OHS@health.qld.gov.au

[10] https://www.safeworkaustralia.gov.au/risk

Workplace training

The employer should develop and maintain a training process around implementing fatigue risk management systems[11]. This ensures that information and training provided to workers is suitable on all fronts, including:

- the nature of the work
- the nature of the risks associated with the work
- the control measure implemented
- the information is readily understandable by any person.

Shift Design

When designing rosters of managing working time arrangements, there are a number of factors to consider: shift length, number of consecutive shifts before short breaks (1-2 days), time off between shifts, amount of night work and frequency of breaks longer than 2 days. Each of these factors is known to influence fatigue-related risk in the context of accumulation of fatigue or recovery from fatigue.

Effective rostering of employees requires collaboration (and consultation) between employees and management and the union. Employees may request the support of a union delegate in discussions related to rostering and industrial interpretation and implementation. This is part of the collaborative partnership and should be viewed by roster coordinators as supporting good roster management practices.

(see also: Change Management; local business rules)

Thresholds will also need to adhere to Awards, Certified Agreement requirements, Queensland Health policy etc. Please see clauses 18, 19 and 29 of EB10.

[11] Fatigue Risk Management Systems Resource Pack p23

Business Planning Framework and service profile is in place for the unit

Ensure adequate staff rostered in accordance with the BPF to provide safe levels of staffing and to allow for adequate rest periods. Successful allocation of clinical hours is achieved when a balance has been reached between service demand and the supply of appropriate numbers and skill mix of nursing/midwifery staff.
The nursing/midwifery skill mix required for any particular service may differ by time of day, day of the week and other relevant service delivery factors.
Plan for back-fill of employees who are on leave (e.g. annual or sick leave).
Having sufficient FTE in the service profile facilitates safe workload management and minimises the need for overtime and on-call/recall arrangements.
Make appropriate adjustments where necessary to minimise and correct emergent imbalances (e.g. unexpected leave; unplanned increases in service activity/acuity/complexity).
Confer and co-ordinate with NUM/MUM/nursing and midwifery team where necessary to consider alternative strategies and implement strategies to manage emergent imbalances.

Shift Length

Remember to consider the risk levels associated with the planned or rostered hours (not on call) and relevant fatigue risk mitigation actions/controls. (E.g. 10-12 hours length of shift, risk level is moderate; initiate moderate fatigue risk mitigation actions). * Note that other rostering factors may impact on risk levels.

Fatigue related risk increases with increasing shift length, due to time awake and time on task[12].

Maximum shift length set up to 10 hours (Award standard). However, shift lengths can range from 4 to 10 hours under the Award, and extend to 12 hours under a formal agreement (between QH and the QNMU and employees).

Limit overtime to a maximum of 2-4 hours – maximum of a 12 hour shift in 24 hours.

Limit the maximum working hours in one week inclusive of overtime worked to 48 hours per week.

The evidence suggests that when a person works more than 48 hours within a week, the increased competition between sleep and other activities results in sleep of a limited quality and length. The individual begins to accumulate a sleep debt, which causes fatigue levels to rise, and affects health and safety.

The Award provides that an employee may work a maximum span of four 12 hour shifts in certain combinations; or a maximum of 5 shifts in a row where it is a combination of 8 and 12 hour shifts. This threshold was introduced as the evidence suggested that fatigue-related accidents can increase when working four or more consecutive 12-hour shifts.

Where 12 hour shift arrangements are in place:

- Keep a copy of the local 12 hour shift agreement and be aware of its contents.
- Ensure individual employee/s have a written agreement in place.
- Identify all meal breaks (and rest pauses if possible) on the daily roster sheet.
- Be aware employees cannot work more than 12 hours, including any overtime.
- There is no ability to shorten the 10 hour break when working under a 12 hour shift agreement.

[12] Fatigue Risk Management Systems Resource Pack, page 31.

Part time employment: Part time Nurses and Midwives are engaged in accordance with Clause 8.2 of the Award. These employees have specific contracted hours of service, and may also be 'on call' on days that they are rostered to work. Roster co-ordinators need to be aware that any recall worked by a part-time employee, as a result of being on call, should not cause the part-time employee to exceed their contracted weekly hours, and that exceeding the employee's rostered ordinary hours of work will trigger an entitlement to overtime payment.

Break between shifts

The amount of sleep obtained between shifts is heavily dependent on the length and timing of breaks from work. The only effective way to reverse the effects of fatigue and to prevent fatigue is sleep. Professor Drew Dawson, an internationally acclaimed sleep scientist, notes that population studies recommend seven to nine hours of sleep. He says there is measurable impairment that is inconsistent with safe work. Professor Dawson believes we should say 'this is how much sleep you need in order to work safely', and 'if you have had less than this amount of sleep, tell someone'. Being awake for 17 hours to 19 hours straight has been proven by research to be the equivalent of a blood alcohol concentration reading of 0.05%. This increases to 0.10% after 20-25hrs of wakefulness[13] [14]. The effects of this documented to include a 20% chance of making a serious error and taking 14% longer to complete simple tasks[15].

*Remember to consider the risk levels associated with time off between shifts and initiate the relevant fatigue risk mitigation actions/controls. (Eg. >12 hours break risk level is low; 10-12 hours risk level is moderate; 8-10 hours break risk level is high.) *Note that other rostering fatigues may impact on risk levels.*

[14] Safe Work Australia, Fatigue, https://www.safeworkaustralia.gov.au/fatigue.
[15] Australian Medical Association Limited (2006) Best Practice Rostering: Training and Resource Kit Practical Tools for Rostering Doctors.
[16] Workplace Health and Safety Queensland, (2011). Managing fatigue A guide for the workplace *The State of Queensland (Department of Justice and Attorney-General).*
[15] Australian Medical Association Limited (2006) Best Practice Rostering: Training and Resource Kit Practical Tools for Rostering Doctors

Ensure there is **a minimum of 10 hours break** between consecutive shifts (unless a written agreement is in place).

The break between shifts should provide:

- minimum period off duty allows for an uninterrupted eight-hour sleep cycle;
- a break from continuous professional responsibilities, and
- time to perform the individual activities of daily living.

NB: There are special conditions relating to rest breaks after overtime, on call and recall outlined in the Agreement.

Frequent late/early shift changeovers should be avoided in any rostering pattern due to fatigue risk factors.[16]

There are a number of different roster models that allow nurses and midwives to have a 10 hour break. Examples include:

- A unit roster pattern that includes a 10 hour night shift, with 6 hour late or early shifts that accommodate the 10 hour break.
- A unit roster pattern that includes a 10 hour night shift, with 8 hour late or early shifts that accommodate a longer change over period. This allows time for handover, in-service, education and time to attend meetings.
- A unit roster pattern utilising 8 hour night shifts, with 8 hour early and late shifts that accommodate a 10 hour break. That is, staggered start and finish times to meet known fluctuations in demand.

Avoid accumulation of sleep debt over extended periods, and ensure there is adequate opportunity for recovery.

Where 8 hour break agreements are in place:

- Best practice is to limit the number of 8 hour breaks across a roster for each employee to minimise accumulation of sleep debt over extended periods, and to ensure there is adequate opportunity for recovery.

[16] Queensland Health (2011) Working Arrangement Project – Nursing Roster Survey

- The 8 hour agreement is in place to determine the break between the termination of ordinary work on one day and the commencement of ordinary work on the next day.
- Ensure individual employee/s have a written agreement in place.
- Be aware of, and comply with the requirements of IRM2.5-18 "Breaks between shifts", in particular:
    - The circumstances in which an employee can still be provided with a 10 hour break, and
    - That where an employee who is on call and recalled to work, the 8 hour agreement will no longer apply for this period.
- An 8 hour break agreement is signed and retained by both the nurse/midwife and the line manager and roster coordinator. This agreement is between the employer and employee and can be rescinded at any time by the employee.
- Fatigue risks that can impact on accumulation of sleep debt and increase fatigue risks include: [17] [18] [19]
    - The impact of late finishing times on the time away from work
    - The distance from workplace to the car park
    - Commuting times to and from work
    - Time required to unwind after work
    - Insufficient versus sufficient sleep opportunity between shifts

Shift work schedule/biologic rhythms

Remember to consider the risk levels associated with the shift work schedule and initiate relevant fatigue risk mitigation actions/controls.

* Note that other rostering factors may impact on risk levels

[17] Workplace Health and Safety Queensland, (2011). Managing fatigue A guide for the workplace The State of Queensland (Department of Justice and Attorney-General).
[18] Australian Medical Association Limited (2006) Best Practice Rostering: Training and Resource Kit Practical Tools for Rostering Doctors.
[19] Queensland Health (2011) Working Arrangement Project – Nursing Roster Survey.

No employee should be rostered to perform ordinary duty for more than 10 consecutive days or shifts unless mutually agreed otherwise[20]. **Safe Work Australia recommends limiting consecutive work days to a maximum of 5 – 7 days** [21].

Each employee will be allowed two whole consecutive rostered days off in each week which are not to include accrued days off[22]. *(See Award/agreement provisions as there may be limited circumstances where RDOs can be rostered differently).*

Limiting the number of quick returns and ensuring at least a 10 hour break between shifts may help to reduce fatigue for the shift working population.

Early starts [23]

Limit the number of successive early starts (to 4 maximum if possible).

Early start times (before 6am) give workers less time to get adequate sleep. The evidence suggests that it is very difficult to go to sleep during the early evening (6-9pm). This is because the internal body clocks are set for alertness[24].

Rosters should try to provide rest and recovery periods and avoid/minimise circadian disruption and accumulation of sleep deficits.

Allocating shift and night workers consecutive days off to allow for at least two full nights' sleep including some weekends[25]. Building regular free weekends into the shift schedule supports work/life balance.

Prefer forward and consistent rotational shift patterns (i.e. clockwise rotation (morning/afternoon/night) to the counter-clockwise (afternoon/morning/night) rotation). The

[20] Nurses and Midwives (Queensland Health) Award – State 2015
[21] Safe Work Australia, Guide for Managing the Risk of Fatigue at Work, November 2013
https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwieq-X30urZAhWJzLwKHZSeBM8QFggnMAA&url=https%3A%2F%2Fwww.safeworkaustralia.gov.au%2Fsystem%2Ffiles%2Fdocuments%2F1702%2Fmanaging-the-risk-of-fatigue.docx&usg=AOvVaw1qUJcdBwnOP8ouRT9qS6EW – page 18/26
[22] Nurses and Midwives (Queensland Health) Award – State 2015
[23] Safe Work Australia, Guide for Managing the Risk of Fatigue at Work, November 2013
https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwieq-X30urZAhWJzLwKHZSeBM8QFggnMAA&url=https%3A%2F%2Fwww.safeworkaustralia.gov.au%2Fsystem%2Ffiles%2Fdocuments%2F1702%2Fmanaging-the-risk-of-fatigue.docx&usg=AOvVaw1qUJcdBwnOP8ouRT9qS6EW – page 18/26
[24] Workplace Health and Safety Queensland, (2011). Managing fatigue A guide for the workplace The State of Queensland (Department
of Justice and Attorney-General)
[25] Safe Work Australia, Guide for Managing the Risk of Fatigue at Work, November 2013
https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwieq-X30urZAhWJzLwKHZSeBM8QFggnMAA&url=https%3A%2F%2Fwww.safeworkaustralia.gov.au%2Fsystem%2Ffiles%2Fdocuments%2F1702%2Fmanaging-the-risk-of-fatigue.docx&usg=AOvVaw1qUJcdBwnOP8ouRT9qS6EW – page 20/26

forward rotational shift pattern has been found to be better for employees, as it is easier to go to bed later and get up later, rather than retiring earlier and arising earlier.

A **fast** forward rotational shift pattern is described as working a small number of consecutive shifts together, before moving to the next shift. The next shift's commencement time is later than the previous shift. For example:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Day	Day	Late	Late	Night	Night	Off	Off	Off	Day	Late	Late	Night	Off

A **slow** forward rotational shift pattern is described as working a large number of consecutive shifts together, before moving to the next shift. The next shift's commencement time is later than the previous shift. For example:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Day	Day	Day	Late	Late	Off	Off	Late	Late	Night	Night	Night	Off	Off

Try to keep the shift system as regular as possible and avoid rapid shift changes.

A variety of different shift patterns affect the "body clock" and make it more difficult for the body to readjust to a normal sleeping pattern[26].

Allow flexible working time arrangements (to provide consideration of employee's needs/preferences).

Consider periods of non-work following a sequence of shifts, for example night duty.

Consider roster implication of employees who hold multiple positions within Queensland Health, i.e. Concurrent and aggregate employment.

Ensuring adequate breaks during a shift e.g. for hydration

Minimise overtime wherever possible.

[26] Australian Medical Association Limited (2006) Best Practice Rostering: Training and Resource Kit Practical Tools for Rostering Doctors.

Encourage healthy eating at work and regular fluid intake/ Providing access to healthy food and fluids at work.

Consider if there are other factors that may increase fatigue during the shift, including emotional and cognitive demands, prolonged standing, heat, lead wearing and manual handling.

On call and recall

On-call rosters present a unique set of challenges and therefore the controls and assessments associated with rostered on-call work needs to focus on the frequency of on-call periods as well other work-related factors unique to that workplace[27].

The roster coordinator must take a diligent approach to managing fatigue for employees who are placed on call outside ordinary or rostered working hours.

Employees who work overtime, are placed 'on call', or are recalled to duty are entitled to the provisions of Clause 19 of the Agreement, to the exclusion of clauses 18.1 – 18.5 of the Award.

Nurses and midwives at **Grade 10 and above** may be required to work additional hours in accordance with Clause 18.3 of the Agreement. These employees do not work static hours set by a roster.

NB: There are special conditions relating to rest breaks after overtime, on call and recall outlined in the Agreement.

On call vs rostered shifts – this will depend on the situation. Workload is one factor that will assist in determining whether rostered shifts are preferable to on call shifts[28].

Employees placed 'on call' may be required to work frequent overtime, and there is the potential for them to incur high levels of fatigue. The frequency of on-call periods therefore needs to be managed to provide adequate recovery sleep opportunities.

[27] FRSM Resource Pack
[28] FRSM Resource Pack, pg27

Publish any on call arrangements with each roster.
Wherever possible, on call should not be allocated between a late and an early shift.
Wherever possible, avoid assigning on call allocations on an employee's day off.
Develop clear guidelines/local processes for the ward or service for use of on-call and recall. Ensure there is an agreed process in respect of employees who have worked a period of recall. E.g. what controls have been put in place for situations where the nurse/midwife has had a busy night but is scheduled to work the following morning? Ensure there is adequate downtime between the last recall event and resuming subsequent rostered duties.
Where possible, nurses and midwives should receive a minimum of eight days free from all forms of on-call in every four week period.
Consider the individual's competencies and skills prior to allocating on call.
Include the requirement to perform 'on call' in role descriptions where it is a regular expectation of the position.
On call is a common practice used to address varying demand and staffing shortfalls in hospitals. Intensive care units (ICUs), emergency departments (EDs), operating theatres and procedural areas might be more likely to experience fluctuations in demand than other nursing units, thus requiring nurses to work on call. In areas where fluctuations in demand and acuity occur, on call should be subject to risk assessment (using Defences in Depth strategy), and not used as a workload management tool.
Fatigue risk matrix: The Fatigue Risk Management System Resource Pack provides information about assessment and the types of controls that can be implemented for management of fatigue, and the fatigue related risks associated with on call and recall.

For example:

Risk Guide for Consecutive On Call Shifts		
Low risk	Moderate risk	High risk
1-2 consecutive days	3-4 consecutive days	Greater than 4 consecutive days
	Initiate moderate fatigue risk mitigation actions	Initiate high risk fatigue risk mitigation actions Report and document with unit director and/or EDMS and/or appropriate delegates Individual and team based controls Mandatory assessments Consultation/advice to eliminate and minimise risks

The likelihood of being required to attend at the workplace outside of ordinary hours should be considered when on call rosters are allocated.

On call and recall should be considered in the context of the on call setting (for example, staffing and service requirements may be different in rural and remote settings) and the likelihood of being recalled to attend the workplace.

- The risk matrix should be considered in the context of the on call setting, and the likelihood of being required to attend at the workplace. Note that the controls associated with on-call work will depend on frequency, staffing and service requirements.

Retain all employees' phone numbers in secure electronic and paper based files, for access by the manager, after hours Nurse Manager, or others who may require them.

Ensure employees are aware, if organisational change processes propose to introduce on call on a regular basis.

Night Duty

It is an expectation that all nurses and midwives working for Queensland Health will be rostered to work across all shifts patterns as required. This includes a requirement to work nights.

There is ample evidence demonstrating an association between shift work and sleep problems[29]. Nurses and midwives who work recurring night shifts present with chronic fatigue and sleep alterations more frequently than day shift nurses and midwives[30]. Chronic partial restriction of sleep (small reductions in sleep duration that accumulate over multiple nights) can also produce sleepiness and cognitive performance deficits equivalent to or greater than the impairment associated with acute sleep deprivation. This is particularly true when sleep debt is allowed to accumulate over extended periods with limited opportunity for recovery[31]. Providing adequate rest/recovery periods has also consistently been highlighted as central in promoting shift workers' safety, well-being and health[32].

*Remember to consider the risk levels associated with the night duty and initiate relevant fatigue risk mitigation actions/controls. * Note that other rostering factors may impact on risk levels*

Limit night duty to 4 consecutive night shifts at a time in a fortnight with 2 nights off following last night shift. Where possible, restrict the number of successive night shifts rostered. Remember that numerous consecutive night shifts are likely to require a longer interval of 'off duty' time between blocks of shifts to recover

[29] See for example Sallinen M.. Kecklund G. (2010) 'Shift work. sleep, and sleepiness-differences between shift schedules and systems', Scandinavian Journal of Work and Environmental Health, 36, pp. 121-33.
[30] Caruso C. (2014) 'Negative Impacts of Shiftwork and Long Work Hours', Rehabilitation Nursing, 39, pp. 16–25.
Ferri, P., Guadi, M. Marcheselli, L., Balduzzi, S., Magnani, D. & Di Lorenzo, R. (2016) 'The impact of shift work on the psychological and physical health of nurses in a general hospital: a comparison between rotating night shifts and day shifts', Risk Management and Healthcare Policy, 9, pp. 203-211.
Hakola T., Paukkonen M., & Pohjonen T. (2010) 'Less quick returns-greater well-being', IndustrialHealth, 48, pp. 390–394.
Vitale, S., Varrone-Ganesh, J. & Vu, M. (2015). Nurses working the night shift: impact on home, family and social life. Journal of Nursing Education and Practice, 5(10) 70-78.
[31] Belenky et al., 2003: Dinges et al., 1997, Van Dongen et al 2003.
[32] Ha kala et al., 2010; Caruso, 2014.

Rosters should include a break of at least 48 hours from the completion of night duty, to the commencement of the next shift[33].

Where possible, limit nights shifts to 8 hours[34].

Avoid accumulation of sleep debt over extended periods, and ensure there is adequate opportunity for recovery.

Be aware of the potential for lowered alertness on night shift, for example from 3am - 5am, and consider that tasks required during the early hours of the morning may require additional supervision, and the scheduling of regular breaks.

Night shift will not be rostered immediately before commencing annual leave or long service leave (unless otherwise requested by an employee), as an employee cannot be rostered to work and be on leave at the same time (leave commences at midnight where leave is approved between two dates rather than for rostered shifts).

Night shift should be rostered in an equitable manner. The frequency of rotation to night shift is influenced by each unit's clinical requirements and is guided by the unit's local business rules. Local business rules may determine the pattern in which night duty is worked. For example: night shifts separated each week, or worked as a block.

Example:

This table is an example of how proportional night duty requirements for employees on a ward could be shared equitably over a 4 week period:

FTE	12 hour shifts	8 hour shifts
1.0	6 nights	6 nights one month 5 nights the next
0.9	6 nights one month 5 nights the next	6 nights one month 5 nights the next

[33] Australian Medical Association Limited (2006) Best Practice Rostering: Training and Resource Kit Practical Tools for Rostering Doctors.

[34] Safe Work Australia, Guide for Managing the Risk of Fatigue at Work, November 2013 https://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwieq-X30urZAhWJzLwKHZSeBM8QFggnMAA&url=https%3A%2F%2Fwww.safeworkaustralia.gov.au%2Fsystem%2Ffiles%2Fdocuments%2F1702%2Fmanaging-the-risk-of-fatigue.docx&usg=AOvVaw1qUJcdBwnOP8ouRT9qS6EW – page 18/26.

0.8	5 nights	5 nights
0.7	5 nights one month 4 nights the next	5 nights one month 4 nights the next
0.6	4 nights	4 nights
0.5	4 nights one month 3 nights the next	4 nights one month 3 nights the next
0.4	3 nights one month 2 nights the next	3 nights
0.3	2 nights	3 nights one month 2 nights next
0.2	2 nights one month 1 night the next	2 nights

It is important to get into a good sleeping habit, regardless of whether you are sleeping during the day or at night. Keeping to a regular sleep schedule – going to bed at the same time and waking up at the same time – is recommended as a way to promote good sleep but can for obvious reasons be difficult for a shift worker.

There is increasing evidence of the benefits of a short restorative sleep during night shift breaks. Employers need to consider the evidence base promoting the benefits of power napping on a night shift break and put appropriate policies and resources (for example, adequate supervision and rest room facilities) in place to support power napping.

Avoid rostering workers on permanent night shifts.

Be mindful of individual written arrangements, including those for medical reasons etc.

Note: Managers may receive requests from employees to work different shift arrangements and need to consider all requests. Limiting the number of nights in a roster is negotiated in consultation with the individual employee. If employees request night duty to be restricted outside the local convention, roster coordinators should give due consideration to the nature and reasons for the request and the provisions of HR policy G3 re reasonable adjustment.

See: Request to work permanent night duty; Requests to not work night duty.

Allow short naps of no longer than 15-20 minutes in allocated breaks for employees who are working night duty or overtime. This requires rostering sufficient employees or establishing relief arrangements within the service or facility.
Provide a room/sleep pods for workers to sleep while on break or before commuting home[35] [36].

Requests to work permanent night duty

If organisational considerations allow, Queensland Health may support an employee who requests to work only night duty for a period of time, to suit their work and life commitments.

In considering if such a request can be accommodated, it is recommended management:

- considers the request in the context of all ward/unit employees shift preferences, and fairness of rostering
- considers service delivery requirements and the agreed BPF service profile
- reaches an agreement with the employee for them to also be rostered for an agreed period during business hours (non-night duty) to reinforce retention of skills and knowledge that are not utilised frequently on night duty
- provides the employee with a written copy of any agreement to such a rostering arrangement
- supports professional development activities for the employee, as negotiated with the nurse/midwife unit manager to meet the employee's requirements
- finalises or continues the arrangement in consultation with the employee at an agreed review date
- only agrees to extend the arrangement by negotiation and with consideration of the above dot points.

If a request for permanent night duty is made due to medical reasons, management should:

- Consider Queensland Health HR Policy G3: *Reasonable Adjustment* and the *Anti-Discrimination Act 1991*.

[35] *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* Clause 31.4.
[36] Royal College of Nursing, A Shift in the Right Direction, October 2012.

- Ensure the arrangement has an agreed review date and an agreed end date
- Provide the employee with a copy of the agreement for the temporary rostering arrangement
- Include consideration of relevant medical opinions and clearance in any agreement to enter such a temporary arrangement
- Consider involving the local workplace health and safety team.

Requests to not work night duty

In considering if such a request can be accommodated, it is recommended management should:

- Consider the request in the context of ward/unit service delivery requirements as detailed in the BPF service profile
- Consider the request on an employee equity basis.
- Consider the request in the context of the work and life commitments of the employee
- If agreed, provide the employee with a written copy of the agreement for the rostering arrangement. Finalisation or continuation of such an arrangement should occur following consultation with the employee at the proposed review date.
- If the request is not agreed to, document the resolution of the request, including any information provided to the employee.
- Any extension of the arrangement should be dependent on the considerations outlined above.

If a request for no night duty is made due to medical reasons, management should:

- Consider Queensland Health HR Policy G3: *Reasonable Adjustment* and the *Anti-Discrimination Act 1991*.
- Ensure any agreement to a period of no night duty has an agreed review date and an agreed end date,
- Provide the employee with a copy of the agreement for the temporary rostering arrangement.
- Include consideration of relevant medical opinions and clearance in any agreement to enter such a temporary arrangement
- consider involving the local workplace health and safety team.

Module Four: Award Provisions including Leave

Industrial Framework and Leave

Rostering processes are dependent on industrial awards, certified agreements and HR policy provisions and. *Nurses and Midwives (Queensland Health) – State 2015 Award* (the Award) and *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* (the Agreement) and any replacement award or agreement prescribe the terms and conditions of employment for Queensland Health nurses and midwives, as well as the Business Planning Framework.

While policies do not replace the primary source of entitlement (the Award and the Agreement) they, along with local unit conventions and practices also impact on the rostering process of units, departments, facilities and services and must be clearly documented.

For the achievement of effective practice in rostering, it is essential that all nurses and midwives, roster coordinators and all levels of management have a sound knowledge level regarding the industrial framework for nurses and midwives.

Managing Leave Entitlements

Planning, monitoring and evaluation of ‘planned’ and ‘unplanned’ leave is essential, to ensure effective service provision. The following options provide support for achieving successful roster management.

Queensland Health encourages all employees to access their leave on a regular basis. It has been shown that lengthy periods of continuous employment:

- may be detrimental to employee well-being and productivity; and
- increase the financial and internal control measure liabilities of Queensland Health.

For the achievement of effective practices in rostering, it is essential that all levels of management, roster coordinators and payroll have a sound knowledge level regarding the leave entitlements.

Appropriate staffing levels should be identified within the operating environment of the service, considering both productive and non-productive (including all leave as well as mandatory and requisite training requirements) nursing and midwifery hours. Compliance with the Business Planning Framework will ensure backfill of employees while on leave, including annual leave, sick leave, mandatory and requisite training and professional leave.

Processes for Managing Leave

- Each clinical area / business unit will have identified a maximum number of leave places (in FTE) allowable at any one time.
- Leave is to be consistent with BPF allocation of non-productive hours.
- Budget allocated for leave cover should be monitored and scheduled effectively to ensure that leave cover is equitably distributed across the year. Factors to consider include: school holidays, Christmas, large sporting or community events, peak work periods - for example winter months.
- Employees applying for leave have sufficient credit to meet their requests.
- Industrial entitlements are checked when requests for leave are submitted. There may be local business rules around how much minimum/maximum notice is required for submission of for certain types of leave requests.
- A leave request form must be completed when requesting leave. This form will be signed by the NUM / MUM following approval of leave.
- Employees are to be advised of the outcome of their application within five working days, per HR Policy C51 – *Annual/Recreation Leave*.
- If leave is refused explanation will be clearly documented on the leave request form and clearly communicated with employee directly or via email.
- The original form will be filed in the NUM's / MUM's office and a copy sent to payroll for processing.

Process for Managing Unplanned Leave

- If an employee requires urgent leave approval they should consult the NUM/ MUM.
- Employees unable to work shifts due to unplanned leave (for example: sick leave) must contact the clinical area or call centre as soon as possible, consistent with local business rules.
- During business hours, the delegate can organise filling of the leave.
- Possible options may include:
    - Deployment of employees from within the relevant business unit / Hospital and Health Service.
    - Deployment from relief pool or nursing resource unit if available.

- Approach part-time employees and casual employees.
- Engage a request from a Hospital and Health Service pool or agency.
- Ability to perform overtime of those currently on shift.

Information Locator: Award and Agreement

Roster management needs to take account of the requirements of the following industrial instruments:

Legislation: *Industrial Relations Act 2016*

Award: *Nurses and Midwives (Queensland Health) Award - State 2015* (the Award)

Certified Agreement: *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* (the Agreement)

Business Planning Framework: a tool for nursing and midwifery workload management

Information Locator: Leave

Roster management needs to take account of the requirements of the following industrial instruments:

Legislation: *Industrial Relations Act 2016*

Award: *Nurses and Midwives (Queensland Health) Award - State 2015* (the Award)

Certified Agreement: *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* (the Agreement);

Types of leave	Location
Annual leave Annual leave at half pay	• Annual leave entitlements vary according to the place of work • Clause 19 of the Award • Queensland Health HR Policy *C51 - Annual/Recreation Leave*
Personal leave (Sick leave; Carer's leave; Bereavement leave; Cultural leave)	• Personal leave is provided for in the *Industrial Relations Act 2016*, Division 6 of the QES • Clause 20 of the Award. • Queensland Health HR Policy C64 – *Sick Leave* • Queensland HR Policy C9 - *Carers Leave* • Queensland Health HR Policy C11- *Bereavement Leave* • Queensland Health HR Policy C7 – *Special Leave*

Parental leave	• *Industrial Relations Act 2016*, Division 8 of the QES. See Sections 55 to 62 of the Act • Clause 21 of the Award • Minister for Industrial Relations Directive 17/18 - *Paid Parental Leave* • Queensland Health HR Policy C26 – *Parental Leave*
Long service leave	• Industrial Relations Act 2016, Division 9 of the QES. • Clause 22 of the Award. • Queensland Health HR Policy C38 - *Long Service Leave*
Family leave	• Queensland Health HR Policy C26 – *Parental Leave*
Special Leave	• HR Policy C7 – *Special Leave* includes: - Donor leave - State Sporting team leave - Emergency attendance leave - Emergency management course attendance leave - State of emergency disaster attendance leave - Seminar and conference leave - Elections and local authority leave - Floods, cyclones, bushfires and storms - Interview attendance - Reserve forces training - Pre-retirement planning seminars • HR Policy C6 - *Court attendance and Jury Service*
Industrial Relations Education Leave	• Clause 37 of the Award • Queensland Health HR Policy *C39 – Industrial Relations Education Leave*

Professional Development Leave	• Clause 8 of the Agreement • Clause 25 of the Award: • Clause 25.1 Seminar and conference leave • Clause 25.2 Professional development leave, Nurse Grade 3 and above • Clause 25.3 Professional development leave – RANIP employees • Queensland Health HR Policy G15 – *Professional Development Package for Nurses and Midwives Grade 3 (Enrolled Nurses) and above* • Health Services Act 1991 – Directive of the Governor in Council, No. 1/98 *Performance Appraisal and Development* • Queensland Health HR Policy G8 – *Learning and Development* • Queensland Health HR Policy C50 – *Seminar and Conference Leave – Within and Outside Australia*
SARAS – Study and Research Assistance Scheme	• Queensland HR policy G10 – *Study and Research Assistance Scheme*
Extra leave for proportionate salary/ Purchased Leave	• Clause 19 of the Award • Queensland Health HR Policy C21 – *Purchased Leave*
Banked time arrangements	• Clause 35 of the Agreement
Compulsory Christmas/New Year closure	• Clause 19.7 of the Award
Public Holidays	• *Industrial Relations Act 2016* • Clause 23 of the Award

Jury Service	• Jury Service leave is provided for in the *Industrial Relations Act 2016*, Division 12 of the QES. See Section 119 • HR Policy C6 – *Court Attendance and Jury Service*
RANIP	• HR Policy C2 – *Remote area nursing incentive package* • See Award clauses: - 13.2 Annual isolation bonus - 13.15 Professional Development Allowance - 19.8 Airfares - 25.3 Professional Development Leave - 26 Transfer and appointment expenses
Domestic Violence Leave	• HR Policy C73 – *Support for employees affected by domestic and family violence* • Directive 4/15 – *Support for employees affected by domestic and family violence*
Concessional Leave Day	• HR Policy C32 - *Compulsory Christmas/New Year Closure*
Purchased Leave	• HR Policy C21 – *Purchased Leave*
Mandatory Training	• Clause 30.4 of the Agreement

Module Five: Equity, Fairness and Balance

Roster Equity and Fairness

Equity and fairness in the treatment of employees are important considerations in the development of a roster.

Roster coordinators should consider the following:

- that all employees have equal opportunity for roster requests
- the individual needs and or circumstances of employees
- health and safety issues for individuals and the group
- sharing of all routine shift – morning/day shifts, night duty, late shifts and weekend shifts equitably among employees
- compliance with agreed processes for managing individual requests that cannot be met (for example apply any local criteria for requesting approval, discuss with the nurse/midwife unit manager for resolution, follow local conventions on timeframes for notifying employees)
- maintaining statistics on rosters – e.g. night duty worked, and log the number of requests made and met per roster period
- completing roster surveys and roster audits on a regular basis
- succession planning/higher duties and Performance Appraisal and Development (PAD) in collaboration with the NUM/MUM
- compliance with the relevant policies governing recruitment, particularly the circumstances requiring merit based processes, to support succession planning of nurses and midwives at all levels.
- goals of the PAD process for each employee in regard to allocation of opportunities for professional development, for promotional positions and for higher duties
- where an employee is acting in a higher role, ensure their substantive position is backfilled.

Creating Work Life Balance

Flexible Working arrangements

Queensland Health **HR Policy C5** *Flexible Working Arrangements* includes information on:

- flexible working arrangement options and the guidelines.
- job share arrangements and processes.
- home based telecommuting.
- breastfeeding and work.

Aggregate and Concurrent Employment

Employees may be engaged in more than one role within Queensland Health, providing the total hours of engagement do not exceed the equivalent of one full-time equivalent (FTE) role.

Queensland Health **HR Policy C47** *Aggregate and Concurrent Employment* includes information on:

- multiple engagements (see further details below), and
- combining part-time and casual employment.

Multiple appointments (working in more than one unit /ward)

Multiple appointments within Queensland Health can be:

- concurrent (different positions which make up one FTE but which are either not the same level or stream or both)
- aggregate (one position which is split up among different units/ districts / services to make up one FTE)

Employees of Queensland Health are not eligible to be employed in a position/s equating to more than one full-time equivalent. The employee cannot be further engaged in the Queensland public service, public sector or other government jurisdiction in a full-time, part-time or casual capacity that results in engagement in more that one full-time equivalent position.

Managing these appointments for roster purposes is a joint responsibility of the employee and the nurse/midwife unit manager. Responsibilities include:

- employees ensuring their nurse/midwife unit manager is aware of multiple contracts both within and across other Hospital and Health Services,
- nurse/midwife unit managers communicating with each other within Queensland Health to ensure that all roster provisions are met in all rosters

involved in making up the total work hours for the employee, including the accrued days off (ADO) and 10 hour breaks if applicable,

- employees communicating with roster coordinators in both work units to ensure that they are maintaining safe work practices in managing their fatigue,
- ADOs being negotiated between both nurse / midwifery unit managers so the ADOs are taken on a pro-rata basis for all positions held by the employee within Queensland Health.

More detailed information on responsibilities of managers and supervisors can be found in the Queensland Health *Guideline for the Management of Aggregated and Concurrent Employment*.

Employment other than Queensland Health – Second Jobs, Volunteer Work, Family Businesses & Family duties (Paid or Unpaid)

Employment within Queensland Health does not remove an employee's right to be employed in another organisation or family business in a paid or voluntary capacity.

An individual employee is responsible to provide safe quality competent care in line with nursing and midwifery registration requirements, so individuals need to consider the impact holding a second position may have on their fatigue levels.

Managing such activities for roster purposes is a joint responsibility of the employee and the nurse/midwife unit manager. Responsibilities include:

- employees ensuring their nurse/midwife unit manager is aware of other employment or volunteer work;
- employees communicating with other private facilities and agencies about their Queensland Health work arrangements to ensure that they are maintaining safe work practices in managing their fatigue; and
- employees should be mindful of their fitness for duty and talk to their manager or supervisor to let them know when they are fatigued, and managers should be alert to signs of fatigue in employees.

Other considerations

Generational Considerations

A social generation is a group of people who share formative or binding experiences, and common social characteristics and attitudes as well as demographic statistics in common[37]. A generation is all the people in a group or country who are of a similar age, especially when they are considered as having the same experiences or attitudes[38]. Queensland Health may now have up to five generations represented within the workforce.

Considering the ageing workforce and skill shortages in the Australian labour market, Queensland Health recognises the value of having a multidisciplinary and multigenerational workforce.

Queensland Health HR Policy G2 - *Diversity and Inclusion* identifies responsibilities of managers and supervisors in promoting diversity and tolerance in the workplace.

A workforce with varied backgrounds, education, training, and work and life experiences, enriches workplace diversity and creates an organisation that is more capable of providing responsive health care services to a diverse Queensland community.

An example of a multigenerational team includes younger university graduates who are starting their careers being teamed with mature-aged nurses or midwives who have 30 years of in-depth patient care experience. Positive mentoring processes with consideration of generational factors are important to support beginning nurses and midwives as they transition from theory to practice.

Cultural Considerations

More than 270 languages are spoken in Queensland with 8% of Queenslanders speaking a language other than English. Many different cultural attitudes and values are represented within the workforce. Queensland Health recognises and values the cultural diversity and contribution of all employees. Cultural Leave as outlined in section 9 of Queensland Health HR Policy C7 - *Special Leave* ensures that employees can observe days of cultural, ceremonial and/or religious significance.

Some examples of cultural considerations include:

- an employee who is required by their cultural, religious and/or ethnic background to participate in significant cultural, ceremonial and/or religious obligations, is provided reasonable opportunity to do so by Queensland Health;

[37] Farlex Inc., (2011). The Free Dictionary, Huntingdon Valley, PA 19006 USA.
[38] https://www.collinsdictionary.com/dictionary/english/generation

- consideration of a roster change for employees who have cultural considerations that impact upon their ability to participate in rosters at particular times;
- possible changes to shift times to reflect the needs of different cultural, religious and/or ethnic background to participate in cultural, ceremonial and/or religious obligations during a shift.

Line managers and roster coordinators should understand and incorporate the *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* and other *Aboriginal and Torres Strait Islander protocols* which support culturally appropriate roster development and alignment with Section 9.2 of HR Policy C7 - *Special Leave*.

Workplace Harmony

Queensland Health recognises that workplace bullying is a serious workplace issue which is not acceptable and must be eliminated. Queensland Health is committed to providing a safe, secure and supportive workplace.

Every employee has the right to work in an environment free from any form of workplace harassment—appropriate workplace behaviour is the responsibility of every employee. Behaviour which would constitute harassment in the workplace is unacceptable and will not be tolerated in any form, under any circumstances, by any employee within Queensland Health.

Queensland Health HR Policies which apply to the prevention of workplace bullying include:

- HR Policy E1 - *Workplace conduct and ethics*
- HR Policy E2 - *Anti-discrimination and vilification*
- HR Policy E12 - *Grievance Resolution*
- HR Policy E13 - *Workplace Harassment*
- HR Policy G2 - *Diversity and inclusions*

The Code of Conduct for the Queensland Public Service outlines Queensland Health's policy on bullying and provides guidelines to employees and managers on how to manage workplace harassment.

Module Six: Rostering New Graduates

Best Practice Rostering for Newly Graduated Nurses and Midwives – EN, RN and RM

Orientation Days

- All newly graduated nurses and midwives should be enrolled in a formal orientation program that will assist in their transition to the health care work force.

Transition to practice education programs

- Opportunities should be provided to undertake a transition to practice or competency based program within the Hospital and Health Service. This program should provide a blended learning model that will enable the graduate nurse and midwife to reach the clinical competency for that specialty. Rostering needs to support the newly graduated nurses and midwives to participate in all components of the programme.

Preceptor Support

- Newly graduated nurses and midwives should be rostered with a preceptor or equivalent position during the initial rostered fortnight within the clinical unit, as a minimum.
- A preceptor or equivalent position should provide guidance, coaching and education over the course of a newly graduated nurse or midwife's employment within the clinical unit.
- Ongoing clinical and educational support should be planned and determined in line with the Business Planning Framework (BPF) and the model of nursing or midwifery care that is currently practised within that unit.
- Support should be provided to that will assist the newly graduated nurse or midwife to attain key clinical assessments and consolidate their learning.

Study Days

- All education/study days for newly graduated nurses and midwives should be planned in advance and included in the published roster.

Night Duty

- Night duty that is rostered within the first month of the graduate nurse or midwives' commencement must be fully supported by a preceptor or equivalent position within the clinical unit.
- Wherever possible night shift should be avoided within the first month of employment.

Annual Leave

- Graduate nurses and midwives should be encouraged to access and negotiate recreation leave to minimise fatigue and support a sustainable work life balance.

Module Seven: Rostering Models and Techniques

Business Planning Framework

In Queensland Health, the *Business Planning Framework – a tool for nursing workload management* (BPF) is the mandated tool for managing nursing and midwifery workloads.

The methodology of the BPF allows nurses and midwives to determine appropriate staffing levels to meet service requirements and furthermore assists them to develop processes to evaluate the efficiency/effectiveness of their services. This framework does not rely on pre-determined nurse patient ratios to manage nursing and midwifery workload. Instead the BPF promotes balancing the supply of employees with service demand which is primarily achieved during roster development. Employee rosters are a vital process in reaching a successful balance of supply and demand.

To roster an appropriate number of categories/grade of nursing and midwifery personnel based on the service profile developed through utilisation of the BPF, a number of steps are essential, including the need to:

1. Calculate the total productive (direct and indirect) nursing and midwifery hours using nursing hours per patient day/nursing hours per occasions of service/nursing hours per activity unit
2. Determine the core skill mix and category of nursing/midwifery hours required
3. Convert the productive nursing hours into FTE using the established formulas within the BPF
4. Calculate non-productive nursing/midwifery hours to inform the total FTE requirements for the service/ward/unit. Using the established formulas within the BPF
5. Establish the roster on the appropriate hours and skill mix required to meet service demand
    a. Considering acuity requirements is essential in the provision of quality safe care
    b. Considering activity trends on a daily, weekly, monthly basis informs the design of the roster

Ongoing assessment, monitoring and evaluation of the core roster structure are required regularly as changes in service delivery context climate, capability and capacity evolve.

Shift Times and Service Activity

Organising nursing and midwifery work around rigid tasks and employee needs does not always equate to meeting patient care needs. Rostering of nursing and midwifery hours to match peak care demand times allows for improvement in the quality of patient care based

on trends over time, promotes better planning of employee requests and supports improvements in employees' quality of working life.

Shift start and finish times can be modified locally to:

- Ensure suitable number of employees maintain patient safety and care at all times during the 28 day roster cycle; and
- Meet the work life balance needs of employees such as carer responsibilities. For example: childcare availability for working parents.

In order to manage all the different shift start times, length and activity fluctuation it may be necessary to develop a 24 hour staffing template. The following are **examples only** of the total number of employees required at different hours of the day.

Example 1: A Metropolitan Emergency Department

	6am	8am	11am	1pm	3pm	5pm	7pm	11pm	1am
CNC	1	2	1	1	2	1	1	1	1
CN	1	2	2	2	4	2	2	1	1
RN	10	15	20	25	25	25	20	15	10
EN	2	4	6	6	6	6	6	4	2
AIN	1	2	2	2	2	1	1	1	1
Totals	15	25	31	36	39	35	30	22	15

Example 2: A Small Rural Multipurpose Health Service (MPHS)

	6am	8am	11am	1pm	3pm	5pm	7pm	11pm	1am
CNC	1	1	1	1	1	1	1	1	1
CN	1	2	2	2	2	2	1	1	1

RN	0	1	1	1	1	0	0	0	0
EN	1	3	3	3	3	4	4	1	1
AIN	5	5	1	1	1	5	5	0	0
Totals	8	12	8	8	8	12	11	3	3

Example 3: A Medical/Surgical Ward

	6am	8am	11am	1pm	3pm	5pm	7pm	11pm	1am
CNC	1	1	1	1	1	1	1	1	1
CN	1	2	2	2	2	2	1	1	1
RN	0	1	1	1	1	0	0	0	0
EN	1	3	3	3	3	4	4	1	1
AIN	5	5	1	1	1	5	5	0	0
Totals	8	12	8	8	8	12	11	3	3

Rostering Models

There are many different rostering models currently being used in nursing and midwifery and other industries where employees are required to work a 24 hour a day 7 day a week roster. There is no one roster model that is better than another. All roster models have strengths and weaknesses, and some may be a hybrid of the models below.

The following table outlines four primary roster models utilised in Queensland Health.

	Costs / time to develop	Employees Input	Employer Input
Request-based rostering	Very high	High	Some
Self-rostering	Very high	Complete	Little
Demand-based (Dynamic) rostering	High	Little	Very high
Cyclic Rostering – Fixed or Rotational	Very low	Little	Very high

New roster models and methods are evolving with new technology, for example, the Integrated Workforce Management System (IWFM). IWFM is a key strategic initiative for Queensland Health which will provide a single, consistent and organisation-wide workforce management solution and real time and reliable workforce information.

Strengths and weaknesses of Rostering Models

Request-based rostering – most popular method

Requests for particular work hours are gathered from employees, usually on a blank roster form. At a set time, the manager responsible for the roster will allocate any vacant shifts that have not been requested by employees. Local convention guidelines need to be in place covering minimum nursing and midwifery hours and skill mix, number of requests for fixed shifts etc.

Request based rostering

	Patient	Employee	Organisation	Costs / Time
Strengths	Ensures the correct nursing / midwifery skill mix is available to provide a safe, cost, effective, high standard of care if minimum nursing / midwifery groups are set for each shift	Allows for employee input into the rostering process. Employees have a high level of control over the roster. May accommodate employee's preferences.	Documented evidence of requests to enable fair and equitable roster development. Control of rostering stays with organisation	High
Weaknesses	Possible difficulties with providing care continuity	May create a large degree of uncertainty as roster changes from month to month. 'First in' principle may disadvantage some employees	May create a culture of employees requesting particular shifts or even full rosters, which can disadvantage others. Refusing requests to meet service needs may be necessary. Can be a complex an onerous task for nurse / midwifery unit managers and roster co-ordinators who are required to constantly negotiate	High

			changes to meet requested shift. In many instances rosters are built around requests which creates an imbalance between demand and supply.	

Self-rostering – also a common method

The process of self-rostering involves the preparation of a roster, which identifies pre-planned leave and all vacant shifts. Employees may choose their roster in a spirit of mutual co-operation and negotiation. The manager will advise employees when this must be completed, and on completion will check to ensure that shift coverage meets the requirements for safe staffing and industrial entitlements.

Demand based (dynamic) rostering

	Patient	Employee	Organisation	Costs / Time
Strengths	Ensures the correct nursing / midwifery skill mix is available to provide a safe, cost effective, high standard of care.	Can allow for employees preferences / requests into the rostering process.	The nurse / midwifery unit managers and roster co-ordinator have complete control over the roster.	High
Weaknesses	Possible deficiencies if acuity	Level of flexibility required from employees.	Nurse / Midwifery unit managers and roster co-ordinators must have high	High

	increases from the pre-determined requirement	Employees have limited say into the roster through requests.	knowledge of employee's preference and award provisions. Can be a laborious and time-consuming process.	

Cyclic Rostering – Fixed or Rotational

Cyclic rosters have a set pattern, constantly repeated over a predefined period.

Cyclic Rostering – Fixed or Rotational

	Patient	Employee	Organisation	Costs / Time
Strengths	Roster is built based on patient needs. Nursing / midwifery skill mix is rostered to provide a safe, cost effective, high standard of care.	Work Life balance can be planned around work. Employees are aware of their roster in advance. Equal access to penalty shifts and days off. Promotes teamwork and helps establish stable work groups.	Prepared in advance. Published in advance. Offers both management and employees a degree of simplicity and a high degree of predictability. Promotes teamwork and helps to establish stable work group. Can provide a workable roster with best shift combinations. Decrease time required by nurse / midwifery unit managers and roster co-ordinators to build the roster.	Minimal

Weaknesses		Employee must organise their own shift swaps. Employees have no involvement during the planning of the roster. Employees have no ownership of the roster. Employees requests are assessed against patient need. Employee's perception is that rosters are no flexible. New employees to the team must fit in to the existing roster pattern.	Perceived that there are a large number of shift changes after the roster is published.	Minimal

Module Eight: Local Business Rules

Developing local business rules

Roster Business Rules need to be developed to provide a clear and visible approach to promote fairness and equity in the management of the roster. Below are some key considerations for developing local rostering Business Rules:

1. **Type of rostering model utilised in the unit (see Module Seven - Rostering Models)**
2. **Resource allocation (in accordance with the *Business Planning Framework*)**
   - Total productive and non-productive nursing and midwifery hours;
   - Agreed Skill Mix for each shift on each day;
   - The number of work hours and start and finish times; and
   - The ideal number of morning, afternoon and night duty work hours to be worked by employees as a minimum.
3. **Training and development commitments**
   - Transition support and preceptorship practices;
   - Processes for rostering of organisational employee development, core unit / specialty training requirements and performance appraisal and development plan; and
   - Total number of hours required for training and development each roster cycle (in accordance with the *Business Planning Framework*).
4. **Management of planned and unplanned leave**
   - Processes for negotiating and scheduling annual/planned leave entitlements;
   - Processes for reporting in sick or inability to work a rostered shift; and
   - Total number of FTE who can be on leave in each roster cycle.
5. **Agreed processes for:**
   - The frequency of rotation to night shift;
   - The maximum number of requests per roster cycle;
   - Access to weekends off;
   - How on call is managed, such as transport arrangements (taxi vouchers etc);

- Shift swapping / changes to a roster;
- Allocation of accrued days off; and
- Allocation of days off following completion of night shift.

6. Utilisation of additional nursing or midwifery hours

- Processes for managing employees requiring replacement during and after hours; and
- Processes for approval of overtime and Time Off In Lieu of overtime (TOIL).

7. Time frames for communication of requests in respect of:

- Leave;
- Education requests; and
- Individual shift requests.

8. Reporting mechanisms

- Internal escalation process for rostering issues.

9. Responsibilities

- Identify the role in the unit which has responsibility for drafting, approving, publishing, amending, maintaining and evaluating rosters;
- Employees are not to disclose the contents of the roster to anyone outside of the workplace to ensure the safety and privacy of employees at work, unless authorised to do so;
- Employees must keep copies of rosters secure to prevent unauthorised access by others; and
- Employees are reminded that they are required to comply with the standards and ethical principles of the Code of Conduct.

10. Documentation

- Documented process for storage of data, electronic and paper based; and
- Ward/unit rosters can be copied, including photocopied or photographed, and taken home by the ward/unit employees, for the limited use of identifying their rostered hours, work locations, responsibilities, authority and duties.

11. Evaluation

- Roster Audits – How often a roster audit is completed; and
- Establish Key Performance Indicators (KPIs) – Agreed KPI between Roster co-ordinator – Line Manager and employees.

Local Conventions and Guidelines

To ensure best practice, fairness and equity in roster management and to minimise fatigue, local conventions or guidelines must be developed and published in units to take account of local context. These guidelines are developed in collaboration and consultation with unit employees, and if requested, the union.

The guidelines serve as a communication mechanism for unit employees regarding local rostering protocols and promote equity in the rostering approach.

Rosters must be award/ agreement compliant and with best practice as outlined in this guide. Examples of the possible content of local convention guidelines include:

- The rostering method used;
- Criteria for:
  - shift swapping / changes to a roster
  - allocation of accrued days off
  - allocation of night duty
  - the allocation of days off following completion of night shift:
- The number of work hours and start and finish times;
- The agreed number of morning, afternoon and night duty work hours to be worked by all employees as a minimum;
- Access to weekends off;
- The maximum number of requests per roster cycle;
- Sick leave process – consistent with the *Nurses and Midwives (Queensland Health) Award – State 2015*; and

The frequency of rotation to night shift.

Module Nine: Roster Checklist

Check List				
Hospital and Health Service / Unit:				
Roster Pay Period:		Roster Date:	From:	To:
Does this roster reflect the Master Roster Profile?			Yes	No
If No, provide reasons:				
Actual hours FTE this Roster:		Budgeted FTE:		
Will the roster be displayed at least 14 days prior to the commencement of the four week work cycle? ☐				
Clinical Nurse or Clinical Midwife rostered for each shift?			Yes	No
Are the relevant skill mix groups represented on all shifts?			Yes	No
If No, provide reasons:				

Higher Duties forms completed?	Yes	No	N/A
Employee Movements forms completed?	Yes	No	N/A
Recreation leave allocated as per Master Roster Profile?	Yes	No	N/A
Employees on long term leave rostered? (Long Service/Maternity)	Yes	No	N/A
All other leave rostered? (Education, Portfolio, Special Leave)	Yes	No	N/A
Any other backfill required? (Mandatory training etc.)	Yes	No	N/A
Agreed ADOs allocated?	Yes	No	N/A
Employees rostered as per contracted hours?	Yes	No	N/A
Concurrent and Aggregate employee's hours correct?	Yes	No	N/A

Check List			
Shift Length			
Shift start and finish times covered with minimum employee numbers required?	Yes	No	N/A
Have consecutive work days been limited to a maximum of 5 - 7 days? *If no, go to fatigue section.*	Yes	No*	N/A
12hr Shift agreement signed?	Yes	No	N/A
Have scheduled no more than 3x12hr shifts in a row, followed by two shifts off for rest and recovery? *If no, go to fatigue section.*	Yes	No	N/A
Identified meal breaks on the roster?	Yes	No	N/A
Break between shifts			
10-hour+ break between all shifts? *If no, go to fatigue section.*	Yes	No	N/A
If there is 8hr break (between shifts) agreement forms, are they checked and up to date?	Yes	No	N/A
Are 8hr breaks allocated? *If yes, go to fatigue section.*	Yes	No	N/A
Night duty			
Are there individual written agreements? (eg. permanent nights/requests not to work nights) *be mindful of review dates	Yes	No	N/A
Has night shift been shared equitably over the roster?	Yes	No	N/A
On call arrangements			
Has on call been shared equitably over the roster?	Yes	No	N/A
On call arrangements have been published.	Yes	No	N/A
Have you avoided rostering on call allocations between a late and an early shift, or on an employee's day off, and ensured a minimum of eight days free from all forms of on-call in every four week period?	Yes	No	N/A
Deficits?			
Short term contracts offered to fill deficits?	Yes	No	N/A

Check List			
Part-time employees approached to fill deficits (Max 72hrs)?	Yes	No	N/A

WH&S and Fatigue Risk Management			
The below issues have been escalated to the appropriate delegate: *<insert who issues have been raised with, any controls>*			
Shift length comment:			
Shift work schedule/biologic rhythms comment:			
Nighty duty:			
On call and recall:			
Other (eg. fatigue risk matrix completed etc):			
Complete Work Brain Reports			
Time Code Report (Fatigue)	Yes	No	N/A
Detailed Overtime Report	Yes	No	N/A
Employee Rostered vs Contracted Hours Reports	Yes	No	N/A
Complete DSS Reports			
Employee Summary	Yes	No	N/A
Overtime Report by employee	Yes	No	N/A
Rostered Fatigue	Yes	No	N/A
Employee 8 hr Report	Yes	No	N/A
Deficits shifts forwarded to Casual Pool Team / Nursing resource Unit	Yes	No	N/A
Has the roster been checked to ensure compliance with the award/ agreement?	Yes	No	N/A
Any rostering issues brought to the attention of your line manager	Yes	No	N/A

Signatures:

.....	.....	.....
Roster Co-Ordinator	Nurse / Midwifery Manager	Nursing Director / Director of Nursing

<insert> Hospital & Health Service
<insert unit>
Twelve Hour Shift Agreement 20<insert>

1.1 Arrangement of Agreement

PART 1 - PRELIMINARY MATTERS

1.1.1 Title

This Agreement shall be known as the <insert> Hospital & Health Service <insert unit> Twelve Hour Shift Agreement 20<insert>.

1.2 Objectives

The objective of this Agreement is to formalise the local arrangements to implement clause 15.3 Twelve hour shift arrangements of the *Nurses and Midwives (Queensland Health) Award – State 2015*.

1.3 Operation

This Agreement shall operate from <insert date> to <insert date>.

1.4 Definitions

Award means *Nurses and Midwives (Queensland Health) Award – State 2015*

EB10 means *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018*

Employer means a Hospital and Health Service in their capacity as the employer of employees covered by the Award.

Employee means and includes an employee within a classification defined in Schedule 1 of the Award

HHS means Hospital and Health Service

Night shift means a shift commencing at or after 6.00pm or before 7.30am the following day, the major portion of which is worked between 6.00pm and 7.30am.

QNMU means Queensland Nurses and Midwives' Union

1.5 Coverage

This Agreement applies to all employees, including casual and temporary employees working in the <insert unit>.

1.6 Parties bound

The parties to this Agreement are the insert name of HHS and the QNMU.

1.7 Relationship with other industrial instruments

This Agreement shall be read and interpreted wholly in conjunction with the Award and EB10 and any subsequent and relevant certified agreement or award in force or created during its period of operation.

1.8 Consultative process

(a) The parties recognise that for this Agreement to be successful the measures contained within this Agreement must be implemented through an open consultative process.

(b) The parties to this Agreement commit to involving employees of the <insert unit> in appropriate consultation necessary to implement these working arrangements.

(c) Employees will be encouraged to participate in the consultative processes by allowing adequate time to understand, analyse and respond to any information or proposal in relation to the ongoing implementation of this Agreement.

1.9 Grievance resolution

(a) The parties will use their best endeavours to cooperate in order to avoid grievances arising between the parties or between an employer and individual employees. The emphasis will be on negotiating a settlement of any issue at the earliest possible stage in the process.

(b) Two or more current grievances made by the same employee about related matters, or a grievance from more than one employee about related matters may be dealt with as one grievance.

(c) In the event of any disagreement between the parties as to the interpretation, application or implementation of this Agreement clause 7 of the Award will apply.

(d) Where a bona fide safety issue is involved, the HHS shall ensure that:

(i) the status quo prior to the existence of the grievance or dispute is to continue while the procedure is being followed; and/or

(ii) the employee shall not work in an unsafe environment. Where appropriate, the employee shall accept reassignment to alternative suitable work/work environment in the meantime; and

(iii) the employer/management in conjunction with the Occupational Health and Safety Committee, will promptly ensure that the problem/s is/are resolved having regard to occupational health and safety standards.

Provided that maintenance of the status quo shall not apply in an unsafe environment.

PART 2: PARTICIPATION AND REVERSION

2.1 Participation in the 12 hour shift arrangements set out in this Agreement will be on a voluntary basis.

2.2 Employees who do not participate in the 12 hour shift arrangements will continue to work within the current arrangements outlined the Award and EB10.

2.3 Employees who participate in the 12 hour shift arrangements may subsequently elect to revert to the Award and EB10 arrangements by giving four weeks' notice of their intention to do so without detriment. In exceptional circumstances, including

emergent extended sick leave, the employer may waive the requirement for four weeks' notice.

2.4 To participate in 12 hour shift arrangements staff must sign and date the 12 hours shift arrangement form to indicate their agreement to participate. Should staff wish to no longer take part in the arrangements that same form will also record their signature and the date at which participation ceases. The form must be retained as a time and wage record.

PART 3: TERMS AND CONDITIONS

3.1 Shift Times

For the purposes of this Agreement, the 12 hour shifts will operate in accordance with a shift roster covering a 24 hour per day operation over a seven day week.

3.2 Ordinary hours

The ordinary hours of work shall be an average of 38 hours per week, but no greater than 80 hours in any one fortnight, to be worked according to a roster agreed between the parties.

3.3 Payment of Ordinary Hours

(a) Each fortnight full-time employees participating in 12 hour shift arrangements will receive:

(i) payment for 76 ordinary hours regardless of the number of ordinary hours such an employee is rostered to work during that fortnight; and

(ii) payment for any penalties owed and overtime worked during the preceding fortnight;

(iii) less any period of unpaid leave.

(b) Where an employee either enters or withdraws from these 12 hour shift arrangements during a four week roster cycle, they may receive an adjusted pay that is less than that specified in clause 3.3(a) above.

3.4 Night shift

(a) The penalty rate for a night shift is 20 per cent. This penalty rate will be paid fortnightly on the basis of the actual number of applicable hours worked.

(b) Provided that such night shift allowance shall not apply to shift work performed on Saturday and Sunday where the extra payments prescribed by clause 3.5 apply.

3.5 Weekend work

(a) All time worked up to and including 12 hours in any rostered shift of ordinary hours between midnight Friday and midnight Saturday shall be paid at the rate of time and one-half.

(b) All time worked up to and including 12 hours in any rostered shift of ordinary hours between midnight Saturday and midnight Sunday shall be paid at the rate of time and three quarters.

3.6 Overtime

(a) Authorised overtime worked in excess of the employee's rostered ordinary hours of work, as provided for in this Agreement, shall be remunerated in accordance with the Award and EB10.

(b) For occupational health and safety reasons an employee should not perform overtime immediately before or following a 12 hour shift of ordinary hours. Overtime may be worked if it occurs immediately before or after an ordinary hours shift, so long as the total of ordinary hours and overtime worked is less than 12 hours.

3.7 Meal breaks

(a) An employee who works a shift of 12 ordinary hours is entitled to one paid and one unpaid meal break, each of 30 minutes duration.

(b) The first meal break is to occur between the fourth and sixth hour and the second meal break is to occur during the ninth and tenth hours from the commencement of duty.

3.8 Rest pauses

(a) An employee who works a shift of 12 hour ordinary hours is entitled to a rest pause of 10 minutes duration in the employer's time in the first and second half of an ordinary 12 hour shift.

(b) The rest pause shall be taken at a time to suit the convenience of the employer and so as not to interfere with the continuity of work where continuity, in the opinion of the employer, is necessary.

(c) The employer may combine both rest pauses into one 20 minute rest pause, with the 20 minute rest pause and meal breaks arranged in such a way that the ordinary working day is broken up into four approximately equal working periods.

3.9 Rostered days off

a) Each employee shall be allowed in each fortnight:

(i) two blocks of three consecutive days off; or

(ii) two consecutive days off and four consecutive days off; or

(iii) where mutually agreed in writing, three blocks of two consecutive days off.

b) Employees may only be allowed to have a single rostered day off, at their own written request and where this is in accordance with this Agreement.

3.10 Rosters

(a) Rosters setting out the employees' days of duty and starting and finishing times on such days shall be displayed in a place conveniently accessible to employees at least 14 days before the commencement of each four week work cycle.

(b) An employee may only work a maximum of three of the same type of 12 hour shifts in a row. This means an employee may only work a maximum of three day shifts or three night shifts in a row.

(c) An employee may work a maximum span of four consecutive twelve hour shifts where those shifts are a combination of:

(i) two day and two night shifts; or

(ii) one day and three night shifts; or

(iii) three day and one night shift.

(d) Where an employee works a combination of eight and 12 hour shifts a maximum of five consecutive shifts may be worked. This will include a minimum of two eight hour shifts.

(e) Rosters will be designed to ensure workplace fatigue is managed so as to minimise its effects and related risks on the workplace, employees, patients and others through the application of a best practice risk management framework as a core business function.

Breaks between rostered shifts

(a) An employee is to be allowed a rest break of not less than 10 hours between the termination of a shift of ordinary hours and the commencement of another shift of ordinary hours.

(b) The ability to agree to shorten breaks between shifts to eight hours under clause 15.6(b) of the Award does not exist under this Agreement.

3.11 Annual leave

(a) Clause 19 of the Award shall apply for all employees except as provided below:

(i) Where work is performed in two 12 hour shifts per day over a period of seven days per week and employees engaged in such work perform their duties in varying shifts allocated in rotation by the officer of the facility duly authorised in that regard, every employee so engaged in such shift work who has completed a full year of employment shall be allowed additional annual leave at the rate of 38 hours per year in respect of the period during which such shifts have been worked.

(ii) Annual leave will be debited equivalent to the ordinary hours per shift the employee would have worked had they not been on paid leave. Such leave will therefore be paid and debited on the basis of hours actually taken.

(iii) The maximum entitlement to annual leave will be six weeks per annum.

3.12 Sick Leave for Employees Working Twelve Hour Shifts

Sick leave will be debited equivalent to the ordinary hours the employee would have worked had they not been on paid sick leave. Such leave will therefore be debited and/or paid on the basis of hours actually taken.

3.13 Other Leave

All other leave will be debited equivalent to the ordinary hours the employee would have worked had they not been on paid or unpaid leave.

3.14 Part-time employees

(a) Part-time employee means employee engaged in accordance with clause 8.2 of the Award, except that a part-time employee is entitled to a minimum payment of four hours per engagement on any one day, and may be rostered up to 12 ordinary hours on any one day.

(b) A part-time employee is engaged to work regular hours fewer than 38 hours per week, however, part-time employees are to have their contracted hours of work specified in writing and such hours are to equate to the actual hours the part-time employee works.

(c) Overtime provisions of this agreement and the award apply where an employee works authorised overtime in excess of their rostered ordinary hours.

(d) Subject to the provisions below all other entitlements within this Agreement shall apply pro-rata to a part-time employee.

(e) Employees participating in 12 hour shift arrangements will receive payment as follows each fortnight:

(I) payment for the rostered hours they have been engaged to work that fortnight; and

(II) payment for any ordinary hours they worked in addition to those they were rostered to work during that fortnight in the four week roster cycle; and

(III) payment for any penalties owed and overtime worked during the preceding fortnight;

(IV) less any period of unpaid leave.

PART 4: MONITORING AND EVALUATION

4.1 Trial Arrangements

(a) The parties will comply with the enterprise flexibility and facilitative and consultative provisions of the Award at clauses 6 and 11.

(b) The 12 hour shift arrangements for <insert unit> shall be trialled for <four months/six months/12 months>.

(c) Either party may withdraw from the trial at any time during the trial period by written notice of no less than 21 days to the other party, providing all reasonable attempts has been made to resolve any problems that may arise during the trial period and the grievance resolution procedure at clause 1.9 of this Agreement have been exhausted.

(d) One month before the trial's conclusion the parties will evaluate the outcome of the trial and negotiate future working arrangements.

(e) Prior to the commencement of a 12 hour shift arrangement trial, the parties are to establish a method for evaluation of the workability and effectiveness of the proposed shift arrangements. Such evaluation is to include, but is not to be limited to, consideration of the factors outlined in clause 4.2 of this agreement.

4.2 Ongoing Monitoring and Evaluation

(a) On going monitoring and evaluation on the effectiveness of 12 hour shift arrangements shall include, but not be limited to, consideration of the following factors:

(i) Patient outcomes;
(ii) Health and safety;
(iii) Adverse incidents;
(iv) Staff satisfaction;
(v) Financial implications;
(vi) Sick leave;
(vii) Childcare implications;
(viii) Effects on family and social life;
(ix) Effects on work performance;

(x) Effects/impacts upon other units in same speciality area;
(xi) Professional development;
(xii) Communication;
(xiii) Effects on management – recruitment and retention; and
(xiv) Impact on other work units of <insert HHS>.

(b) The above methodology may be varied by agreement of the parties (and documented above).

PART 5: OTHER

5.1 Participation in Training and Development Activities

(a) Where an employee working in accordance with this Agreement participates in training development activities, management will take a reasonable approach in determining whether an employee either commences duty before, or returns to duty after the activity ceases.

(b) Factors, which should be considered, are the location and duration of the activity, reasonable travelling time, and the balance of shift remaining.

PART 6: SIGNATURES

6.1 Signatories for the agreement

Signed for and on behalf
Print Name and Position Date

<insert HHS appropriate nursing delegate>

Witnessed

Print
Name Date

Signed for and on behalf

Print
Name

Date
Queensland Nurses and Midwives' Union

Witnessed

Print

Name

Membership Survey and MoDs focus groups

Summary report

October 2022

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Introduction

The QNMU was invited to attend a summit convened by Queensland Health on 27 September 2022 in Brisbane to discuss the current health workforce crisis. In preparation for the summit, the QNMU gathered information from mini focus groups conducted as part of the round of QNMU Meetings of Delegates (MoDs). A broader membership survey was also distributed to all members to identify members' key areas of action or focus for the QNMU.

In preparation for attending the public hearing for the *Senate Select Committee on Work and Care Inquiry* (the Inquiry), the QNMU has collated our members' responses when we asked them:

- What is your primary job role?
- What is your primary place of work?
- What are the biggest barriers to you staying in nursing and/or midwifery?

We have also included a summary of the themes arising from the MoDs where members were asked:

- What is the biggest barrier to staying in nursing and midwifery?
- What would make nursing and midwifery more attractive as a career?

There was broad consistency of issues raised by members in both the survey and MoDs focus groups.

Findings from survey

A total 6443 members responded to the survey, noting that 6,440 members completed the whole survey in full.[1]

Primary job role

The majority of respondents reported that their primary role is a Registered Nurse (70.75%). The second most represented group is Enrolled Nurses (12.41%), followed by Midwives (6.49%).

Primary job role	Count	%
Registered Nurse	4,556	70.75%
Enrolled Nurse	799	12.41%
Midwife	418	6.49%
Nurse Practitioner	48	0.75%

[1] The following summary provides an overview of results as at 23/09/22 12:57 PM.

AIN/Carer	352	5.47%
More than one role	267	4.15%
Grand Total	**6,440**	**100.0%**

Primary workplace

The majority of respondents (64.53%) work in the public sector. The second most common workplace is in the private sector (17.67%), followed by aged care (11.97%).

Primary workplace	Count	%
Public sector	4,156	64.53%
Private sector	1,138	17.67%
Aged care	771	11.97%
Other	143	2.22%
More than one sector	232	3.60%
Grand Total	**6,440**	**100.0%**

Biggest barriers to retention

Question: *What are the biggest barriers to you staying in nursing and/or midwifery?*

Respondents were asked to preference their top 5 issues. Dangerous workloads were the most commonly referenced option as a top issue for members (78.42%). Following that, moral distress or fatigue (76.13%) was highly chosen.

The following table orders the biggest barriers by highest count to lowest count. The rows in bold are the barriers the QNMU included in our opening statement to the *Senate Select Committee on Work and Care Inquiry* public hearing.

Biggest barriers	Count	%
Dangerous workloads	5,050	78.42%
Moral distress or fatigue	4,903	76.13%
Income is insufficient	4,061	63.06%
Physical demands	3,958	61.46%
Physical/psychological safety	3,602	55.93%
Difficult to balance work and family/carer responsibilities	**3,276**	**50.87%**

Risk adverse culture (i.e., prohibiting your authority to make clinical judgements, excessive documentation)	2,996	46.52%
Inflexible rostering	**2,579**	**40.05%**
Casualisation or difficulty obtaining permanent employment	1,270	19.72%
Insufficient hours being offered	505	7.84%
Grand Total	**6,440**	**100.0%**

The QNMU also analysed the responses of the over 800 participants who worked predominantly in the aged care sector. These members ranked these two issues even higher than the survey respondents overall, with 82% nominating 'Difficulties balancing paid work with family/carer responsibilities' as a retention barrier, and 64% nominating 'Inflexible rostering' a barrier.

Findings from MoDs

In September and October 2022, mini-focus groups were held as part of MoDs across 10 sites in Queensland. The key themes identified aligned with the member survey responses from the whole of QNMU membership survey.

In response to Question 1: *What is the biggest barrier to staying in nursing and midwifery*, concerns raised included:

- Inflexible/poor rostering that is not family friendly.
- Inability to properly plan and balance work and family responsibilities, given excessive work demands.
- Lack of employer provided or free universal childcare that meets the needs of shift workers.
- Lack of safety for nurses and midwives and patients/residents – need to focus on safety and respect.
- Normalizing of the unacceptable – e.g., constant badgering to work additional shifts, unacceptable levels of violence towards nurses and midwives.
- Inability to make decisions – necessary authority not delegated.
- The burden of knowing you are going into a shift where there will be staff gaps that cannot be filled. This is occurring repeatedly (this is now the norm and complaints are going unanswered).
- Not being able to say no – their commitment to patients and supporting colleagues is being exploited).
- Being unable to access leave and other entitlements.
- Feel unsupported by the system – just a number.

- Too much pressure on experienced nurses/midwives – the stress is breaking them. The demand is on individuals to cope, not the system to find solutions.
- Not able to secure permanent positions despite current excessive demand/workloads.
- Poor culture/lack of respect and valuing.
- Poor pay in aged care.
- Demographic pressures – e.g., ageing of the workforce

In response to Question 2: *What would make nursing and midwifery more attractive as a career?*

- Listen to us and respect us – feeling valued and heard and clinical judgement respected.
- Better rostering – family friendly, 9-day fortnights etc – enhanced/supportive rostering.
- Better pay (in some areas, but others strongly said they would prefer better workloads right now).
- Consistency of pay and conditions across all sectors – not having to constantly fight for this.
- Employer provided/universal child-care that meets shift worker needs.

From the feedback we are receiving from our members, many are experiencing difficulties with balancing their home/carers responsibilities with a workplace that is not always supportive or flexible for their workforce.

Acknowledgements:
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Queensland Nurses &
Midwives' Union

Introduction

A POSITIVE practice environment, within the work setting, has been described as "settings that support excellence and decent work, that strive to ensure the health, safety and personal wellbeing of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations". [1]

Nurses and midwives are integral in the provision of safe, efficient and high-quality health and aged care for all consumers.

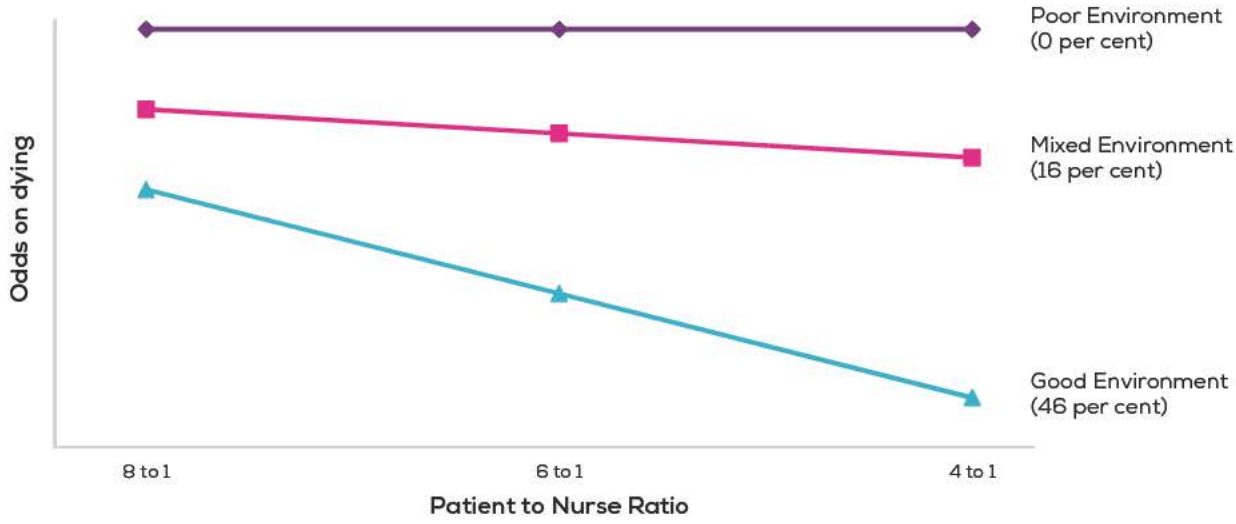
International and national research outcomes have consistently identified that a positive practice environment in the workplace promotes safety and quality. There is a dependent relationship between a nurse and midwifes' work environment and consumer outcomes such as improved patient safety, workforce retention, decrease missed nursing care, fatigue management and improved collaborative clinical relationships. [2,3,4,5,6,7]

A positive practice environment is created through establishing and maintaining foundations of safe quality care: good leadership, a safe learning environment,

FIGURE 1

Effect of improved nurse staffing on mortality depends upon quality of work environment

Aiken et al. Medical Care, 2011.



The difference in the odds on dying in hospitals with 8:1 and 4:1 patient/nurse ratios is:

- 0 per cent in hospitals with poor environments
- 16 per cent in hospitals with mixed environments
- 46 per cent in hospitals with good environments.

i Qualities of a good practice environment include:
- enough nurses/midwives to provide care of a reasonable quality;
- participation by nurses/midwives in hospital governance and decision-making;
- responsiveness of management in resolving problems in patient care;
- investment in a highly qualified nurse/midwife workforce; and
- organisational commitment to quality and safety.

As measured by the Practice Environment Scale, Nursing Work Index.

Introduction

adequate staffing and resources, optimising participation in healthcare governance and decision- making processes, supporting collegial relationships and organisational commitment to quality and safety. [8,9,10]

A positive practice environment[i] coupled with improved nurse and midwife staffing and skill mix will dramatically improve patient mortality. This effect on nursing is described in Figure 1. [11,12,13]

In Queensland, to support nurses and midwives' workloads, minimum nurse-to-patient ratios were legislated for prescribed medical and surgical units in 2016. [14,15]

Since the State Government legislated nurse-to patient-ratios, independent Queensland research[16] has shown, within these prescribed medical and surgical units, there has been improved health outcomes, lower costs, better patient experience and improved staff satisfaction, with:

145 deaths avoided

255 readmissions avoided
(estimated cost saving of $1.2-2.4M)

29,200 hospital days avoided
(estimated cost saving of $50-81M). [19]

Nurses working on prescribed medical and surgical units have seen an average workload reduction of:

1-2
patients during the day

1-3
patients on night shift [20]

The independent Queensland research also demonstrated that a reduction of one patient per nurse was associated with:

9% less
chance of dying in hospital

7% less
chance of readmission within 7 days

3% reduction in length of stay

7% reduction in nurse burnout [21]

A positive practice environment being established and maintained is central to optimising consumer, nursing and midwifery safety.[17,18] Without a positive practice environment even the right levels of staffing and skill mix levels will have little to no effect on patient safety and quality of health outcomes as demonstrated in Figure 1.[19,20] ■

Purpose

THE PURPOSE of this document is to outline a set of foundational positive practice environment standards for nurses, midwives and unregulated care workers in Queensland. It must be read and utilised in conjunction with nursing and midwifery professional codes and standards for practice and the National Code of Conduct for Health Care Workers (Queensland) [21].

The Positive Practice Environment Standards (the Standards) provide a foundation for nurses, midwives and unregulated care workers to thrive, in the delivery of health and aged care nursing and midwifery services.

The nursing and midwifery professional and industrial identity is underpinned by our core values: caring, advocacy, holism, professionalism, fairness, collectivism, equality and opportunity.

The Standards can be used by many. All nurses, midwives, and unregulated care workers who work in the nursing and midwifery professions, organisations who employ them will be able to utilise the Standards to ensure the delivery of safe quality care. Consumers will be able to utilise the Standards to assist them in recognising the characteristics of an environment which delivers safe, high-quality healthcare.

There is extensive nursing and midwifery research [22,23,24,25,26,27,28,29] that clearly establishes what the elements of a positive practice environment are:

- safe staffing levels
- physical and psychological safety
- autonomous and collaborative practice
- shared governance and decision-making
- organisational commitment to safety and quality;
- research and innovation, and
- transformational leadership.

The Standards reflect these elements and must form the basis of all environments where nurses and midwives work. ■

STANDARD 1

S1

Nurses and midwives must have safe workloads

CRITERIA 1.1 Minimum safe staffing and skill mix

Minimum safe staffing and skill mix is essential for safe workloads in nursing and midwifery practice.

- Nurses, midwives and unregulated care workers work in an environment that has minimum safe staffing and skill mix in place.
- Nurses, midwives and unregulated care workers have a process in place within the organisation to escalate workload issues.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Maintain their ability to work by: ▪ nurses and midwives maintaining current professional registration ▪ nurses and midwives are responsible for developing, maintaining and improving their own professional scope of practice ▪ nurses and midwives developing skills and competencies within their scope of practice ▪ nurses and midwives recognising that their professional judgement is a valid criterion for deeming definitive safe staffing levels and skill mix, and ▪ applying the workload reporting escalation process to raise workload issues and identify trends.	Coordinate the service availability and appropriate distribution of the nursing and midwifery workforce by: ▪ establishing and maintaining appropriate safe staff numbers and skill mix for the practice environment through best practice rostering, recruitment and retention strategies ▪ recognising and advocating, that professional judgement of frontline nurses and midwives is the most valid criterion for deeming definitive safe staffing levels and skill mix ▪ providing and encouraging the uptake of opportunities for nurses and midwives to undertake professional development ▪ understanding organisational budgetary influences and processes to optimise service ▪ undertaking a comprehensive service analysis and budget preparation ▪ exerting influence over service budget requirements with operational and professional line managers ▪ reporting regularly on budget allocation and safety and quality outcomes, and ▪ acting to address and rectify workload issues, reports and service trends.	Commitment to maintaining at least minimum safe staffing, skill mix and workload escalation processes by: ▪ optimising the availability and appropriate distribution of the nursing and midwifery workforce throughout the organisation ▪ employing nursing and midwifery executive positions to provide the highest level of professional advice ▪ nursing and midwifery executive acting as equal collaborative partners in the planning and delivery of health and aged care services ▪ nursing and midwifery executive have executive budgetary accountabilities ▪ developing and implementing organisational wide budget allocation that is sustainable, sufficient, equitable, timely and transparent ▪ recognising safety of patients relies upon professional judgement of frontline nurses and midwives which is the most valid criterion for deeming safe staffing levels ▪ acting to address and rectify escalation of workload issues, reports and organisational trends, and ▪ directing organisational and professional change management agendas.

STANDARD 2

S2 Nurses and midwives must practice in a physically, psychologically and culturally safe environment

CRITERIA 2.1 Safe, High Quality Health and Aged Care

Wellbeing for all is increased when there is safe, high quality health and aged care.

- Nurses, midwives and unregulated care workers' wellbeing is increased when a system of safe, high quality health or aged care is established that focuses on evidence-based consumer centred care.
- Nurses and midwives provide an evidence-based primary focus on the delivery of safe, high quality care, that is consumer centred.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Actively engage in nursing and midwifery work within an evidence-based just culture by: ▪ nurses and midwives maintaining control over their own professional practice at all levels ▪ providing patients/residents, families and carers are the central focus of service delivery by acting as a consumer advocate ▪ nurses and midwives applying critical thinking and decision making in practice ▪ nurses and midwives explaining critical thinking and decision making to others in a psychologically safe environment ▪ engaging in lifelong learning at all levels including; undergraduate programs, transition to practice/ graduate, reflective practice and professional supervision, mentoring, peer group supervision and networking ▪ participating in technological changes including for example, digital design, that includes maintenance and de-commissioning, and ▪ participating in workplace health and safety, and accreditation compliance requirements within the service.	Advocate for and embed a just culture for the nursing and midwifery workforce by: ▪ providing opportunities for nurses and midwives to enhance their clinical competence and participation in organisational governance ▪ nurturing an ethos of collegial generosity to support practice development ▪ supporting, encouraging and advocating for lifelong learning at all levels ▪ providing rosters which accommodate adequate numbers and skill mix, training and access to transition and early career programs ▪ embedding processes in place to systematically identify and manage workplace hazards ▪ leading the inclusion of frontline nurses and midwives in the design of healthcare and aged care digital technologies ▪ role- modelling application of the principles of transformational leadership in practice ▪ creating and encouraging an environment of "speaking up" ▪ representation on organisational meetings that impact on the service, including technological changes such as digitisation, and ▪ promoting service workplace health and safety, and accreditation compliance.	Build and maintain a just culture within the nursing and midwifery workforce and broader organisation by: ▪ demonstrating organisational commitment to a well-defined and responsive escalation pathway that underpins safety and quality of care in relation to all operational and professional decisions ▪ providing adequate safe nursing and midwifery workforce and skill mix ▪ leading appropriate and timebound consultation, training and safe systems of work must be implemented, monitored and transparently reported ▪ demonstrating organisational commitment to lifelong learning for all nurses and midwives through policy and training ▪ committing to quality and safety through appropriate funding, policy and training ▪ providing a safe practice work environment ▪ supporting recovery following physical and or psychological injury and or illness ▪ establishing and implementing a robust governance framework for all technological change including digitisation that allows nurses and midwives to partner in leading technological advances from design to maintenance and de-commissioning, and ▪ leading organisational workplace health and safety, and accreditation compliance.

Nurses and midwives must practice in a physically, psychologically and culturally safe environment

S2

CRITERIA 2.2 A Just Culture [ii,30]

Wellbeing for all is increased when a just culture is embedded into the work environment.

- Nurses, midwives and unregulated care workers' wellbeing is magnified when there is a just culture of inclusion, cohesion, transparency, predictability, resilience, excellence and leadership that fosters trust, learning and accountability.
- Nurses, midwives and unregulated care workers must work in an environment that ensures their physical psychological and cultural safety[iii], at all times.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Actively engage in nursing and midwifery work within an evidence-based just culture by: ▪ nurses and midwives establishing collegial professional and interprofessional relationships that are responsive and agile ▪ offering and accepting genuine appreciation of self and others work ▪ rejecting blame approaches ▪ valuing constructive positive professional relationships to foster collegial generosity ▪ undertaking meaningful, and satisfying work ▪ demonstrating integrity, authenticity and accountability for actions, and ▪ exemplifying ethical conduct by role modelling.	Advocate for and embed a just culture for the nursing and midwifery workforce by: ▪ applying a high level of multiple communication points and negotiation skills ▪ modulating a physically, psychologically and culturally safe service ▪ moderating and facilitating resolution of conflicts, and ▪ providing opportunities for genuine appreciation of others work.	Build and maintain a just culture within the nursing and midwifery workforce and broader organisation by: ▪ promoting an organisational just culture both internally and externally ▪ championing organisations in establishing and maintaining physically, psychologically and culturally safe by executive example ▪ maintaining contemporary policy and procedures in relation to physical, psychological and cultural safety, and ▪ remaining ultimately accountable and subject to transparent compliance reporting and consequences.

ii A just culture: is restorative, providing an environment of trust, healing, compassion and accountability. These positive effects in the work environment produce a way of thinking for nurses and midwives that allows the development and expression of diversity, insight, creativity and critical thinking.

iii Cultural safety: principles are imbedded in the Nursing and Midwifery Board of Australia's Code of conduct for nurses and Code of conduct for midwives (the Codes) and provide guidance on how nurses and midwives work in partnership with First Nation Peoples. The codes describe how people are treated regardless of difference, to care for their unique needs. Cultural safety requires nurses and midwives to undertake an ongoing process of self-reflection and cultural awareness.

STANDARD 3

S3 Nurses and midwives must work in an environment that promotes autonomous and collaborative practice

CRITERIA 3.1 Autonomous Practice

The autonomous practice of registered nurses and midwives must be recognised and respected by all.

- Registered nurses and midwives must work autonomously within their scope of practice.
- Unregulated care workers must work under the delegation of a named and accessible registered nurse or midwife, and under the supervision of a nurse or midwife.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Nurses, midwives and unregulated care workers work collaboratively to deliver safe quality health and aged care by: ▪ supporting and empowering registered nurses and midwives to work autonomously ▪ focusing on consumer care, including maintaining partnerships, consumer engagement, and consumer involvement in health and aged care programs, and ▪ maintaining a safe positive work environment. **Supervision** ▪ ensuring enrolled nurses and unregulated care workers always have a named and accessible registered nurse or midwife within the organisation to provide adequate delegation and supervision.	Strengthen nursing and midwifery practice within their area of health and aged care by: ▪ promoting decentralised control over consumer care decisions to frontline clinicians from nurse and midwife managers ▪ providing clear work roles, responsibilities, accountabilities and reporting lines ▪ negotiating adequate resources including staffing and skill mix, managerial support, through strong operational and professional leadership ▪ recognising and supporting each individual registered nurse and midwifes' professional autonomy ▪ enabling nurses and midwives to work to their full scope of practice ▪ publicly recognising nurses and midwives' professional integrity, authenticity and accountability for their practice, and ▪ publicly recognising unregulated care workers' work; under the supervision and delegation of a registered nurse or midwife.	Nursing and midwifery executive acts as champion role models for the nursing and midwifery professions across organisations by: ▪ recognising nursing and midwifery executives uniquely provide peak professional governance and accountability for the professions on behalf of the organisation and the professions ▪ enabling and encouraging autonomous registered nurse and midwife practice, and ▪ promoting collaborative professional practice for all nurses and midwives at all levels.

Nurses and midwives must work in an environment that promotes autonomous and collaborative practice

S3

CRITERIA 3.2 Collaborative Practice

The nursing and midwifery professions require collaborative practice to deliver safe quality care for all.

- Nurses and midwives work collaboratively to deliver safe quality health and aged care for all.
- Nurses and midwives determine their professions scope of practice through their professional networks.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Nurses, midwives and unregulated care workers work collaboratively to deliver safe quality health and aged care by: ▪ effectively communicate and collaborate with the multidisciplinary team, including clinical handover ▪ fostering collegial and collaborative professional relationships, through good communication and shared activities such as peer review, evidence-based practice activities and education, and ▪ liaising consistently with relevant professionals, unregulated care workers and agencies to facilitate access to services and continuity of care for consumers.	Strengthen nursing and midwifery practice within their area of health and aged care by: ▪ coordinating and collaborating with multidisciplinary team/s to deliver services ▪ providing opportunities for professional and inter-professional collaboration and professional development, and ▪ providing expert advice, reporting and evaluation to collaboratively inform others, including the executive and consumers, of the service delivery and outcomes.	Nursing and midwifery executive acts as champion role models for the nursing and midwifery professions across organisations by: ▪ providing consistent communication with all key stakeholders at each stage in the assessment, planning, implementation and evaluation of new sustainable models of care ▪ recognising nursing and midwifery executives are collaborative executive partners ▪ actively engaging with all executives to provide operational leadership, governance and support through transparency and interpretation of health and aged care delivery of services and reporting ▪ advising other health service executive on innovative value-based models of nursing and midwifery practice that provide quality clinical consumer focused outcomes ▪ effectively monitoring and reporting on nursing and midwifery professional issues to other health service executive, including innovative nursing and midwifery service delivery models of care, and ▪ championing the recognition and celebration of nursing and midwifery success at all levels, throughout the organisation.

STANDARD 4

S4 Nurses and midwives must be actively included in organisational governance and decision-making

CRITERIA 4.1 Organisational governance and decision-making

Nurses and midwives within the practice environment are accountable for their own practice; and registered nurses and midwives have the authority for decision making for their professions within an organisation.

- Nurses and midwives must work in an environment that empowers all levels of nursing and midwifery to work in shared governance models.
- Nurses and midwives must work in an environment that allows professional visibility and authority.
- Nurses and midwives must apply the Nursing and Midwifery Board of Australia's Decision Making Framework in practice.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Actively participate in organisational governance and decision making by: ▪ demonstrating collaboration with others at all levels of nursing and midwifery. **A nurse or midwife** ▪ participating in the decision making regarding clinical practice including technologies and processes affecting the delivery of healthcare ▪ participating in hospital, health and aged care governance and decision making processes, and ▪ participating in organisational accreditation and compliance processes, including but not limited to maintenance of mandatory training.	Effectively and efficiently advocate for, and promote adequate nursing and midwifery resources to meet the demand for nursing and midwifery services by: ▪ managing responsiveness in resolving problems related to consumer care ▪ representing nurses and midwives in the practice area and actively engaging at internal and external meetings to advocate for services ▪ possessing an equal voice in discipline and interdisciplinary forums, with the professional and operational power to define professional practice at all levels ▪ actively engage with workload management processes to ensure sufficient supply of resources for the demand on nursing and midwifery services ▪ actively engaging with organisational accreditation and compliance processes ▪ collaboratively assess, plan, implement and evaluate quality and safety management systems, and ▪ developing a collaborative shared vision for the service embedded through values, behaviour and communication.	Adequately invest and actively engage and consult with the nursing and midwifery workforce by: ▪ employing a nursing and midwifery executive position to provide peak professional nursing and midwifery governance and decision making ▪ acting as an equal and collaborative partner in the planning and delivery of health services ▪ investing in a highly qualified nursing and midwifery workforce, grounded in the premise that an organisation's employees are their most important, valuable resource and asset ▪ implementing recruitment and retention strategies, remedial processes and policies ▪ consulting with internal and external key stakeholders about significant change and provide change management support for employees ▪ empowering organisational structures to provide the professional scaffolding to enable all levels of the nursing and midwifery professions to provide high standards of safe quality care to consumers ▪ including nurses and midwives on committees, executive level discussions and boards ▪ providing high level organisational nursing and midwifery positions with professional, operational and financial delegations to lead complex development, implementation and evaluation of policies, regulation and funding drivers to lead health and aged care change management ▪ providing efficient and effective multiple points of communication and feedback to allow the flow of information throughout the organisation and to external stakeholders including the community ▪ providing an organisational climate which is reflective of effective and efficient management and leadership practices, peer support, shared values and worker participation in decision making at all levels ▪ engaging with the nursing and midwifery workforce at all levels to ensure successful accreditation and compliance processes for the organisation, and ▪ championing nursing and midwifery workforce planning and innovative models of care within and outside the organisation.

STANDARD 5

Nurses and midwives must lead and/or participate in research and innovation

S5

CRITERIA 5.1 Research and Innovation

Nursing and midwifery research and innovation within the practice environment is broad and wide ranging, using a variety of methodologies.

- Nurses and midwives must conduct evidence-based practice research.
- Nurses and midwives must lead and contribute to health and aged care service research and innovation.
- Nurses and midwives must participate in innovative quality improvement and accreditation processes.
- Nurses and midwives must develop health policies, practices, systems, products and technologies.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Access and involvement with nursing and midwifery research and innovation at all levels by: **Nursing research** ▪ providing the foundation for high-quality, evidence-based nursing care ▪ undertaking nursing research that strengthens nursing education ▪ undertaking evidence based practice to contribute to the safety, quality and cost effectiveness of nursing practice in all settings, and ▪ focusing primarily on consumer outcomes, in particular addressing the social determinants of health. **Midwifery research** ▪ understanding the mechanisms that support women in pregnancy, during childbirth and early parenting within a wellness framework ▪ undertaking midwifery research that strengthens midwifery education ▪ using a primary health care approach to investigate the public health strategies which contribute to maternal and infant health and wellbeing in all geographical areas ▪ providing safe, quality and cost effective midwifery care in all geographical areas, and ▪ promoting the broader issues of midwifery models of care, services development and management, workforce, policy formulation and education. **Innovation** ▪ nurturing professional curiosity by nurses and midwives ▪ undertaking quality improvement projects and accreditation processes, and ▪ contributing evidence toward innovations to improve the quality of nursing and midwifery practice.	Facilitate a nursing and midwifery research and innovation culture by: ▪ promoting a research and innovation culture in the practice area including data collection, analysis and dissemination of findings, and ▪ facilitating the ability of nurses and midwives to continually embed best practice into their scope of practice.	Champion capacity and capability investment of human, built and financial resourcing in nursing and midwifery research and innovation by: ▪ providing adequate resourcing and funding for professional, political and industrial interventions so that nurses and midwives are adequately represented as researchers ▪ providing appropriate resources to undertake and publish health and aged care research, including a proportionate access to research funding ▪ growing capability and capacity by strengthening support, career progression and education for nurses and midwives ▪ enabling nurses and midwives to undertake structured research in practice, with clear links to tertiary institutions ▪ creating physical, psychological and culturally safe environments by building trust and capacity within the team which supports research and learning at all levels ▪ creating physical, psychological and cultural safety for better critical decision making as well as promoting resilience and wellbeing of individuals ▪ implementing innovative policy frameworks focused on recruitment and retention of the nursing and midwifery workforce, and ▪ sponsoring recognition programs at all levels of nursing and midwifery.

STANDARD 6

S6 Nursing and midwifery leadership must be recognised at all levels

CRITERIA 6.1 Transformational leadership[iv]

Within the practice environment, transformational leadership underpins the nursing and midwifery professions.[31]

- Nurses and midwives must practice transformational leadership at all levels.
- Nurses and midwives must motivate and inspire others to act as role models for their professions.
- Nurses and midwives must lead innovative contemporary models of nursing and midwifery care.

Cues	Cues	Cues
Frontline Workers	**Nurse and Midwife Managers**	**Executive and the Organisation**
Assert their professional judgement and support others to provide safe quality nursing and midwifery care to all consumers by: ▪ asserting their professional judgment without recrimination from other professionals ▪ challenging other professionals critical thinking and decision making when required in a psychologically safe environment, and ▪ engaging and educating colleagues on the critical role of asserting their professional judgement has on the nursing and midwifery provision of safe and quality health and aged care.	Act as a role model for transformational leadership by: ▪ exemplifying courageous leadership by upholding and articulating professional values, codes and standards for practice ▪ encouraging work life balance through complying with relevant legislation and regulations ▪ raising awareness of positive impact of healthy and supportive environments ▪ role-modelling positive practice behaviour ▪ undertaking, transparent decision making to provide visibility across the organisation, open communication, a just culture of best practice, recognition and reward program, and succession planning ▪ acting as a motivator, and ▪ exemplifying collaborative decision making and connective leadership and partnerships to implement transformational change management and models of care.	Foster transformational leadership at all levels of nursing and midwifery by: ▪ developing a high quality, performance and consumer orientated nursing and midwifery professional workforce ▪ promoting a just culture in the service of putting the consumer first ▪ providing professionally endorsed and evidence-based policies and procedures, which can be easily understood and adopted by staff ▪ focusing health and aged care administrators and regulators on transparency, compliance and public reporting ▪ recognising all nurses and midwives are accountable for their practice ▪ providing an appropriate degree of accountability for high level operational managers and leaders ▪ enhancing the recruitment, education, training and support of nurses and midwives in the provision of health and aged care, in particular those in nursing and midwifery leadership positions ▪ integrating the essential shared values of the just culture into the nursing and midwifery profession across the organisation ▪ developing and sharing methodologies and processes to improve measuring and understanding the performance of individual nursing and midwifery professionals, teams, services and organisations for the benefit of the consumer and other key stakeholders of the system ▪ sponsoring and presenting awards and public recognition of individuals, services, health or aged care facilities that demonstrate the effectiveness of positive practice environment, for examples; through improved consumer satisfaction, public opinion, improved recruitment and retention of staff ▪ influencing, modifying and embedding value-based economic mechanisms that affect and impact the health of consumers, staff and health services organisations, and ▪ fostering and supporting sustainable professional practice models which are nurse and/or midwife-led and are designed, implemented and advanced over time.

iv Transformational leadership: creates positive practice environments that enhance safety and quality of consumer care. Transformational leaders support nurses and midwives; self-efficacy, sense of competence, while driving cultural and practice change and modelling behaviours such as mentoring and creating a learning environment.

Glossary

Consumers [32]

Consumers are people who use, or who potentially use health services, including family and carers. Consumers may participate as individuals or as part of groups, organisations, or communities as part of health services.

Criteria

Criteria have been used to focus on key areas of a positive practice environment for the individual, the nurse or midwife manager and the organisation.

Cues

Cues have been used to provide key generic examples of components of nursing and midwifery positive practice environments. They are neither comprehensive nor exhaustive. Cues will assist the nurse and midwife to adequately translate the Positive Practice Environment Standards using their professional judgement in assessing nursing and or midwifery practice; self-reflection; and in curriculum development. Further it will enable other key stakeholders to identify a positive practice environment when planning services or engaging with nurses and midwives.

Cultural Safety [33,34,35]

Cultural safety principles are imbedded in the Nursing and Midwifery Board of Australia's Code of conduct for nurses and Code of conduct for midwives (the Codes) and provide guidance on how nurses and midwives work in partnership with First Nation Peoples. The codes describe how people are treated regardless of difference, to care for their unique needs. Cultural safety requires nurses and midwives to undertake an ongoing process of self-reflection and cultural awareness.

Frontline Workers

Frontline workers are nurses, midwives and unregulated care workers (however titled) who work predominately in clinical areas and undertake nursing and midwifery work.

Just Culture [36,37]

A just culture, is restorative, providing an environment of trust, healing, compassion and accountability. These positive effects in the work environment produce a way of thinking for nurses and midwives that allows the development and expression of diversity, insight, creativity and critical thinking.

Patient

The term patient is used to denote all recipients of nursing and midwifery care. For examples; residents, clients, consumer and the woman.

Professional Practice

Professional practice refers to the practice of nurses and midwives who are authorized by the Nursing and Midwifery Board of Australia through regulation and registration with the Australian Health Practitioner Regulation Agency; having undertaken and completed the required education and maintain professional competency within their own nursing and or midwifery scope of practice.

Nursing and Midwifery Work

Nursing and midwifery work both refer to the work of all individuals who undertake nursing and or midwifery, whether regulated or unregulated.

Transformational Leadership [38]

Transformational leadership creates positive practice environments that enhance safety and quality of consumer care. Transformational leaders support nurses and midwives; self-efficacy, sense of competence, while driving cultural and practice change and modelling behaviours such as mentoring and creating a learning environment.

Unregulated Care Workers

Unregulated Care Workers (however titled) provide nursing and midwifery care under the supervision and delegation of a registered nurse or midwife. ■

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Qld Government Election Commitment

Nursing and midwifery scorecard

A Government Election Commitment in 2020 committed to the development of a nursing and midwifery scorecard that reflects the QNMU's Positive Practice Environment Standards for Nursing and Midwifery.

A key component of this commitment is to report on the provision of safe workplaces for nurses and midwives. Queensland Health in collaboration with QNMU is developing an outward facing nursing and midwifery scorecard that incorporates the QNMU Positive Practice Environment Standards, which are:

- *Standard 1 – Nurses and midwives must have safe workloads*
- *Standard 2 – Nurses and midwives practice in a physically, psychologically and culturally safe environment*
- *Standard 3 – Nurses and midwives work in an environment that promotes autonomous and collaborative practice*
- *Standard 4 – Nurses and midwives be actively included in organisational governance and decision making*
- *Standard 5 – Nurses and midwives lead and/or participate in research and innovation*
- *Standard 6 – Nursing and midwifery leadership must be recognized at all levels*

The Positive Practice Environment scorecard's first bi-annual survey of the nursing and midwifery workforce will provide qualitative data on their work environment. This scorecard is expected to be completed and publicly reported in 2024.

The QNMU Positive Practice Environment Standards for Nursing and Midwifery document is attached.