Attachment F

Summary of The Minimum Care Hours Model applied in public sector RACFs in Queensland.

In 1999, Queensland Health, in collaboration with the QNU, utilised the suggested Residential Classification Scale (RCS) care hours and developed a tool called the Decision Support Tool (DST). The principles guidelines for DST are attached Appendix 1.

In March 2008, the Commonwealth replaced RCS with Aged Care Funding lnstrument (ACFI). This new funding instrument did not have an associated tool that allocates care hours.

In November 2008, QH together with the QNU identified similarities between the two funding instruments and were able to adjust the DST accordingly.

Here, we present a step by step guide to assist with the preparation of the RCS/ACFI Conversion DST. The steps in this process are to be used with the RCS/ACFI Conversion DST Report Tool template.

The circumstances in the public sector are unique in that the enterprise bargaining agreement establishes clinical judgement as a valid criterion for determining safe workloads.

STEP 1

The toll is particularized for the RACF - including the details of the RACF and the date on which the report is prepared.

STEP 2

The "Resident Details" worksheet of the RCS/ACFI Conversion DST Report Tool template is prepared by completing the Assessment Date and Resident Name fields.

STEP 3

The information contained in the RCS-ACFI Categories worksheet of the RCS/ACFI Conversion DST Report Tool template, is used to identify the "mapped" category for each resident. Once the "mapped" category for a resident has been determined, the template has a number of preset formulas that will automatically calculate the statistics as data is entered.

* NB: The RCS categories are mapped to ACFI scores and this comparison is based on clinical professional judgement.

STEP 4

The Staff Details worksheet of the RCS/ACFI Conversion DST Report Tool template is prepared by entering the number of rostered hours for each direct care position every shift on every day. The positions to be used in these calculations are:

- Clinical Nurse
- Registered Nurse
- Enrolled Nurse (EN) / EN Advanced Practice
- Assistant In Nursing
- Diversional Therapist / Recreation Officer
- Diversional Therapy Assistants / Social Nurses
- Allied Health (including Physiotherapy Aide)
- Operational Services Officer - Wardsperson

The position hours used in the calculations are direct care hours – this relates to the RCS measure. The template has a number of preset formulas that will automatically calculate the statistics as data is entered.

STEP 5

The "Summary Report" worksheet of the RCS/ACFI Conversion DST Report Tool Template is reviewed.

STEP 6

The information in the "Summary Report" is reviewed.

Please note that Queensland Health and the union agreed the variance between the Indicated Minimum Care Hours and the Actual Care Hours should be no more than 0.25 - 0.35 in the negative (i.e. no more than 35% below the lndicated Minimum Care Hours). lf the variance is to fall below this range, appropriate bed management strategies will be developed in a consultative manner by the parties.

STEP 7

A copy of the Summary Report is provided to the joint health department /union consultative forum.

Appendix 1

Principles - Minimum Nursing Care Hours Model

A joint committee of the QNU and Queensland Health representatives agreed upon a set of principles.

I. The agreed methodology for determining care staff to resident staffing ratio has statewide applicability but local level sensitivity. The parties agree that a single model be implemented across all Queensland State Govemment Nursing Homes to project care hours and guide resource allocations. While the model would provide a consistent rnethodology across all State Govemment Nursing Homes, individual facilities will need to adjust resource allocations and rosters according to local requirements.

2. The income source for the model would be based on the Residential Classification Scale (RCS) as per the Commonwealth Schedule plus Queensland Health supplementation as stipulated by the Queensland Government.

3. The hours of care per resident (and average hours of care across a unit or facility) would be linked to resident acuity.

4. In the absence of any alternative dependency model, the previous methodology of the RCI would continue to be utilised for projecting care hours linked to dependency.

5. Rostered hours and skill mixes would be developed within available resources as guided by the care hours model ,these principles and the current Enterprise Bargaining Agreement.

6. Facility level decisions on adjustments to the rostered hours and skill mix would rest with the Director of Nursing based on:

- Clinical judgernent of current resident care needs

- Meeting of the criteria of the Commonwealth Standards across a whole unit or
- facility
- Environmental conditions (such as ward layouts)
- Sound industrial principles.

The Director of Nursing will consult with the consultative forum or a workloads management committee as appropriate, on matters of concern raised by staff.

7. The staff arrangements will ensure:

- Access to Award Entitlements;
- Workload management is achieved and that there are adequate breaks from duty.
- Workloads and Resident Care are not adversely affected because of non replacement of 'minimum care hours' due to leave requirements;
- The achievement of award breaks, rest pauses and off duty times are facilitated in rostering and included within the development of the final hours model for the facility;
- Annual and Sick/long Service Travel Study leave replacement is facilitated to achieve delivery of at least the minimum care hours required to care for residents.

8. The staffing arrangement will ensure that no nurse will be left without immediate* access to another staff member when caring for residents.

9. Staff members must be trained and competent in the 'No Lift' policy of Queensland Health and the facility. That staff members must be able to undertake assistance with resident care, fire and emergency procedures.

**'immediate' means within verbal hearing distance (buzzer internal to the unit not the complex or by calling out). That is they must be available within the vicinity of each other. Nurses must be able to be assisted even 'they cannot call for help, that includes any absence is noted by another staff member. Definition of a unit is not the issue, but rather the availability of immediate assistance of another staff member to a nurse.*

10. Recognition that there are currently two award standards operating in State Government Nursing Homes.

I l. The principles of Duty of Care and accessibility to RN are to be encompassed in the model. The QNU recognises that actual numbers are facility sensitive and dependent on factors such as links, support systems and facility layouts. An individual nurse must be able to discharge their Duty of Cure - utilising as guidance QNC * Decision Making Framework, October 1998 - when delegating nursing work.

12. Appropriate training, education, resources and equipment will be provided to care staff in order to ensure that the agreed tool can be implemented in a timely manner.

13. The variance between the Indicated Minimum Care Hours and the Actual Care Hours should be no more than .25-.35 in the negative (ie no more than 35% below the Indicated Minimurn Care Hours). If the variance is to fall below this range appropriate bed management strategies will be developed in a consultative manner by the parties.

14. The Local Consultative Forum is to receive proceeding months care hours. This format is to be agreed between the union & Queensland Health and is to provide information on:

- Resident Classification of each Unit
- Minimum Care Hours Indicated, Actual hours delivered the variance.
- The Roster - showing staffing number's skill mix (including leave arrangements)