Appendix 1

ANMF (Vic Branch) Submission - Response Template *Review of the Health Services (Health Service Establishments) Regulations 2013* ['Regulations'] – August 2023

QUESTIONS FOR PUBLIC COMMENT

HEALTH SERVICE DEFINITIONS AND SCOPE

QUESTION 1: Are the definitions for medical health service, surgical health service, speciality health service, anaesthesia, renal dialysis, and emergency medicine clear, current, workable, and effective?

The definitions are workable, however require some amendments to ensure the Regulations keep pace with evolving modes of health service delivery, use contemporary nomenclature and provide adequate regulation of antenatal and maternity and newborn services.

To achieve this, ANMF (Vic Branch) recommends the following amendments:

Section 7 (c) - Specialty Health Services

RECOMMENDATION 1:

ANMF (Vic Branch) recommends r.7(c) (xiv) be amended from 'obstetrics' to 'maternity and newborn services'.

RECOMMENDATION 2:

ANMF (Vic Branch) recommends r.7 (c) (vii) be amended from 'emergency medicine' to 'emergency medicine and emergency nursing'.

RECOMMENDATION 3:

ANMF (Vic Branch) recommends r.7 (c) be amended to include:

1. Coronary care
2. Perioperative Services (incorporating operating theatres, PACU and preadmission)
3. Antenatal and maternity and newborn services
4. Special Care Nurseries
5. Neonatal intensive care
6. Palliative Care
7. High Dependency
8. Domiciliary and Hospital in the Home services
9. Rehabilitation and geriatric evaluation and management
10. Early Parenting Centres
11. Maternal and Child Health

Section 5 - Definitions Surgical Health Service
RECOMMENDATION 4:

ANMF (Vic Branch) recommends r.5 (c) (iii) be amended to state:

'surgical health service means a health service (other than emergency stabilisation treatment) that—…

(c) uses or requires one or more of the following—…

(iii) Preoperative, intraoperative and post-operative observation and care of the patient by nursing staff'.

Other Definitions

RECOMMENDATION 5:

ANMF (Vic Branch) recommends r.5 be amended to include the following definitions:

'Nurse Practitioner candidate

A Nurse Practitioner candidate will mean a Registered Nurse engaged to undertake a course of study and undertake clinical experience leading to endorsement as a Nurse Practitioner'.

'**Nurse Practitioner**

Nurse Practitioner means a Registered Nurse who has satisfactorily completed a course of study and undertaken clinical experience that, in the opinion of the Nursing and Midwifery Board of Australia, qualifies the nurse to use the title Nurse Practitioner'.

'**Endorsed Midwife**

Endorsed Midwife means a registered midwife who has satisfactorily completed a course of study and undertaken clinical experience that in the opinion of the Nursing and Midwifery Board of Australia, qualifies the midwife to use the title endorsed midwife'.

QUESTION: 2 (a) Are additional definitions of prescribed speciality health services needed in the Regulations to address ambiguity?

Yes, as outlined above, additional definitions of prescribed speciality health services are needed.

RECOMMENDATION 6:

ANMF (Vic Branch) recommends that the following clinical areas be added to the definition of speciality health services:

1. Coronary care
2. Perioperative Services (incorporating operating theatres, PACU and preadmission)
3. Antenatal and maternity and newborn services
4. Special Care Nurseries
5. Neonatal intensive care
6. Palliative Care
7. High Dependency
8. Domiciliary and Hospital in the Home services

9. Rehabilitation and geriatric evaluation and management
10. Early Parenting Centres (however titled)
11. Maternal and Child Health

QUESTION 2 (b): If so, can you provide details about what issues you experienced or expect due to ambiguity about the meaning of a prescribed speciality health service?

RECOMMENDATION 7:

ANMF (Vic Branch) recommends that the Regulations be amended to:

1. Keep pace with evolving modes of health service delivery. For example, provision of nursing care in the home through Hospital in the Home.
2. Keep pace with the role of Nurse Practitioner Candidates, Nurse Practitioners and Endorsed Midwives.
3. Use contemporary nomenclature. For example, Perioperative Services (incorporating operating theatres, PACU and preadmission). Anaesthesia services does not adequately describe the service provided under perioperative services.
4. Ensure adequate regulation of antenatal and maternity and newborn services. With the exception of s 26B, the existing Regulations do not provide any requirements for staffing levels and skill mix within antenatal and maternity and newborn services.
    a. In some instances, this has led to inadequate staffing levels and skill mix, and more relevantly, rostering of insufficient numbers of registered midwives to meet the midwifery care needs of women in labour and receiving antenatal and post-natal care. This has created clinical risk and led to unreasonable and unsafe workloads for our members.
    b. The Objectives of the Regulations are outlined in Regulation 1 which state that "the Objectives of the Regulations are:

        to provide for the safety and quality of care of patients receiving health services in or from health service establishments by

        prescribing—

        1. requirements for staffing; and
        2. procedures for the handling of complaints; and
        3. records to be kept; and
        4. other requirements to ensure the welfare of patients….[1]".

To ensure these Objectives are met, the Regulations must include 'antenatal and maternity and newborn services' under the definition of a prescribed speciality health service.

[1] *Health Services (Health Service Establishments) Regulations 2013* (Vic) r 3 (1).

QUESTION 2 (c) : If additional definitions are needed to reduce ambiguity, which speciality health services should be defined and what authoritative source should the definition draw on?

So far as is practicable, it is important that terminology and nomenclature within the Regulations aligns with the legal, industrial, professional and ethical frameworks applying the practice of the registered health practitioners who are governed by the Regulations.

Applied to the membership of ANMF (Vic Branch), authoritative sources would include:

- *The Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024*[2].
- *The Safe Patient Care (Nurse to Patient and Midwife to Patient) Ratios Act 2015 (Vic)*[3] .
- Professional Codes, Standards and Guidelines set out by the Nursing and Midwifery Board of Australia.
- Professional Practice Standards set out by nurses and midwives within speciality areas of practice. For example, in regard to Perioperative Services, the standards and guidelines set out by the Australian College of Perioperative Nurses (ACORN) are an authority to inform matters including but not limited to, nomenclature, staffing levels and skill mix.
- Similarly, in regard to critical care and intensive care, the Australasian College of Critical Care Nursing Workforce Standards[4] and the College of Intensive care Medicine Guidelines[5];set the accepted standards of the profession and therefore serve as an authoritative source to underpin the Regulations.

QUESTION 2 (d): Do you consider clarification is required in relation to the terms 'alcohol or drug detoxification (detoxification – acute phase)' or 'mental health services'? If so, please provide details of the ambiguity or clarification needed.

MENTAL HEALTH SERVICES AND AOD SERVICES

RECOMMENDATION 8:

ANMF (Vic Branch) recommends that the definition of mental health services is consistent with the *Mental Health and Wellbeing Act 2022* (Vic)[6] and *Mental Health and Wellbeing Regulations 2023* (Vic) [7]

For clarity, s 3 (1) of the *Mental Health and Wellbeing Act 2022* provides that:

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[2] *The Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024.*
[3] *The Safe Patient Care (Nurse to Patient and Midwife to Patient) Ratios A*ct 2015 (Vic)
[4] Australian College of Critical Care Nursing 2016. Workforce Standards for Intensive Care Nursing. Melbourne, ACCCN Ltd ISBN 9 780646 960739 www.acccn.com.au/aboutus/position-statements-standards
[5] College of Intensive Care Medicine 2016 Minimum Standards for Intensive care Units. CICM https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf
[6] *Mental Health and Wellbeing Act 2022* (Vic) s3 (1).
[7] *Mental Health and Wellbeing Regulations 2023* (Vic).

Mental Health and Wellbeing Service means—

(a) a service performed for the primary purpose of—

(i) improving or supporting a person's mental health and wellbeing; or

(ii) assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or

(iii) providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress; or

(b) a service, or a service belonging to a class of service, that is prescribed to be a mental health and wellbeing service—

but does not include—

(c) a non-legal mental health advocacy service; or

(d) a service, or a service belonging to a class of service, that is prescribed not to be a mental health and wellbeing service.

RECOMMENDATION 9:

ANMF (Vic Branch) recommends the definition of Alcohol or Drug Detoxification (Detoxification – Acute Phase) contained within r.7(c) (i) be amended to remove the words 'Acute Phase'.

QUESTION 3: Do you support amending the Regulations to define cosmetic surgery as a type of health service? If yes, why? If not, why not?

ANMF (Vic Branch) supports the definition of cosmetic surgery but propose that this is expanded to include cosmetic procedures, or an additional definition added.

Cosmetic procedures could be defined as, a variety of surgical techniques and procedures, including facelift, thread lift, eyelid surgery, body contouring, dermabrasion, laser skin resurfacing, implants, liposuction, and cosmetic injections, such as injections of botulinum toxin Type A or soft tissue dermal fillers.

ANMF (Vic Branch) notes the recently updated Nursing *and Midwifery Board of Australia (NMBA) Nurses and Cosmetic Procedures Position Statement* [8] and its predominant focus on individual practitioners. Whilst we acknowledge that a focus on the individual is one element of reducing risk, we believe that quality and safety is best achieved through a focus on robust and comprehensive sound regulatory framework, safe systems of work and good governance.

Decisions on scope of practice, and better consumer outcome, will be strengthened when all cosmetic surgery and procedures are captured within the appropriate regulatory framework, and there is greater governance and oversight of these emerging practices.

[8] *Nursing and Midwifery Board of Australia (NMBA) Nurses and Cosmetic Procedures Position Statement* June 2023 https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/position-statements/nurses-and-cosmetic-procedures.aspx#:~:text=The%20NMBA%20considers%20that%20the,relating%20to%20pharmacodynamics%20and%20pharmacokinetics.
Last accessed 18 September 2023.

The Regulations have an important role to play in achieving this.

RECOMMENDATION 10:

ANMF (Vic Branch) recommends that the Regulations be amended to define cosmetic surgery as a type of health service, to achieve greater governance and oversight of cosmetic surgery.

QUESTION 4: Do you have any other comments about the scope of prescribed speciality health services in the Regulations and any current or anticipated future impacts on quality, safety and access to health services?

It is important the Regulations keep pace with emerging modes of heath service delivery and ensure adequate regulation of medical and surgical health services which are provided in the primary care setting.

RECOMMENDATION 11:

ANMF (Vic Branch) recommends the Regulations be amended to:

I. Regulate provision of medical health services and surgical procedures provided within the primary care setting. For example, mobile IV therapy ("fluid and vitamin therapy"), iron infusions, removal of lesions. These services and procedures do not fit within the definition of surgical health services and medical health service, which creates a Regulation void. With an increased focus on providing care in the community to relieve pressure on acute care health services, it is important that Primary Care health settings be regulated.

II. Regulate the provision of cosmetic dentistry as opposed to functional dentistry. These are very long cases that require anaesthesia, specialised equipment, undertaken by a registered dental practitioner. To ensure regulatory oversight of this health service, the Regulations should be amended.

REGISTRATION AND ACCREDITATION

QUESTION 5: Do you have any comments about the registration of private hospitals and day procedure centres (noting that amendments to registration criteria or other provisions in the Act are outside the scope of this review of the Regulations)?

The amendments that are proposed in the Review of the Health Servies (Health Service Establishments) Regulations 2013 Discussion Paper ["Discussion Paper"] are not onerous, and they generally apply nationally to public health services and have been recently introduced part within aged care service. ANMF is supportive of the proposed.

Prescribing health services under the Regulations ensures medical and surgical health services are performed in registered facilities that set minimum safety and quality standards and are regulated by the department. This is critical to reducing clinical risk and promoting high quality care.

<u>QUESTION 6:</u> Do you have any comments about the role accreditation to the NSQHS Standards plays in ensuring the safety and quality of health services provided by private hospitals and day procedure centres?

ANMF (Vic Branch) supports the role of the NSQHS Standards. They have been purposefully developed and implemented nationally to meet the robust criteria expected within all health services in Australia. The NSQHS Standards should be incorporated into the Regulations, with a provision that where they are updated or amended from time to time, that the approved private hospital and day procedure centre has to apply the current standards of the day.

At the same time, our members have expressed concern that the process of accreditation is too heavily focussed on providing written evidence that the NSQHS Standards have been 'theoretically' met, rather than assessing their 'actual' implementation in the healthcare setting. The existing process has been described as a tick box exercise with too little involvement from nurses and midwives at the point of care.

In a survey distributed to over 15,000 ANMF (Vic Branch) members within private hospitals and day procedure centres ['ANMF Survey'] recipients observed that:

"Accreditation standards are important however...... most hospitals spend a lot of time getting ready for accreditation and putting policies in place/ educating staff in the lead up. Only to drop the ball once the accreditation has been passed[9]".

'Try speaking to coal face workers rather than taking information and making decisions based of looking at graphs and data[10]'.

RECOMMENDATION 12:

ANMF (Vic Branch) recommends that the Regulations be amended to ensure accreditation focuses more greatly on implementation of the NSQHS Standards, and that this be informed by seeking the input of nurses and midwives who are directly involved in the provision of nursing and midwifery care.

<u>QUESTION 7:</u> In relation to the accreditation process, are there opportunities to better communicate the respective roles of the Commission, accreditation assessment bodies and the department?

Potentially. There is always opportunity for improvement in communication. However, it is usual practice that each private hospitals or day procedure centres employ a Quality person that takes carriage of all matters within the service that require an accreditation assessment or some type of compliance monitoring. The ACSQHC also regularly communicates updates to any accreditation processes with health services directly.

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[9] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished. (September 2023).
[10] Ibid.

QUESTION 8: Do you support amending the Regulations to require health service establishments to display their accreditation certificate in a prominent place? If not, why not?

Yes. Most day private hospitals and procedure centres display their accreditation certificate in a public place within their business anyway. ANMF (Vic Branch) cannot see how this would be any impost on a business into the future.

QUESTION 9: Do you see any role for additional accreditation schemes to supplement quality and safety requirements under the Act, Regulations and NSQHS Standards?

No.

QUESTION 10: Do you have any comments on the penalties and sanctions related to registration and accreditation (noting amendments to the Act are beyond scope of this review but feedback on this issue may inform decisions on any future reforms)?

ANMF does not have any further comment on the proposed penalty and sanctions at this time.

CLINICAL GOVERNANCE

QUESTION 11: Do you support private hospitals and day procedure centres being required to comply with the Safer Care Victoria Victorian Clinical Governance Framework? If yes, why? If not, why not?

Yes, ANMF supports amending the Regulations to require private hospitals and day procedure centres to comply with the Safer Care Victoria Victorian Clinical Governance Framework.

The Safer Care Victoria Victorian Clinical Governance Framework[11] [Framework'] arose out of significant system failures at Djerriwarrh Heath Services. The Framework provides a broad set of principles to promote quality and safety and to reduce clinical risk.

Requiring private hospitals and day procedure centres to comply with this broad set of principles would maintain fidelity to the Objectives of the Regulations as set out in Section 1 of the Regulations. This would mean that irrespective of the health care settings, all Victorians have access to high quality care referenced against one yardstick or framework for clinical governance. From the perspective of health care outcomes, public health, and equitable access to health care, ANMF (Vic Branch) can see no plausible rationale to exclude private hospitals and day procedure centres from the Safer Care Victoria Victorian Clinical Governance Framework.

[11] *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017 https://www.safercare.vic.gov.au/publications/clinical-governance-framework last accessed 16 September 2023.*

RECOMMENDATION 13:

ANMF (Vic Branch) recommends that private hospitals and day procedure centres be required to comply with the Safer Care Victoria Victorian Clinical Governance Framework.

QUESTION 12: Are there elements of the Victorian Clinical Governance Framework that might require clarification or adjustment in order to apply effectively to private hospitals and day procedure centres?

Nomenclature within the Victorian Clinical Governance Framework would need amending to reflect the addition of private hospitals and day procedure centres.

QUESTION 13: What impacts on private hospitals or day procedure centres do you anticipate this requirement would have?

The most significant impact would be to support private hospitals or day procedure centres to ensure they have systems to reduce risk, improve outcomes and to provide high quality care to the Victorian Public.

The impact on quality of care is expressed simply by recipients to the ANMF Survey including:

(this will achieve) "…safer work environment for staff, less need for agency and casual staff, improved patient outcomes[12]".

"Why don't they already have to comply? Why should they be held to a different standard than the public sector[13]"

"Private hospitals need to be held accountable to the same standards that public hospitals have to follow[14]".

"One governing framework in place would allow adequate provisions for better, safer patient health care outcomes[15]".

QUESTION 14: Do you support private hospitals and day procedure centres being required to comply with SCV's Credentialing and scope of clinical practice for senior medical practitioners policy? If yes, why? If not, why not?

N/A

QUESTION 15: What impacts on private hospitals or day procedure centres do you anticipate this requirement would have?

N/A

[12] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished (September 2023).
[13] Ibid.
[14] Ibid.
[15] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished (September 2023).

QUESTION 16: Do you support mandating the Guideline for providers of liposuction; best practice guideline for clinicians, and those involved in the provision of liposuction through the Regulations instead of through a direction from the Secretary? If yes, why? If not, why not?

Yes, in addition to this ANMF support all liposuction including that which is <200mls to be captured by this regulation and required to comply with the Guideline.

QUESTION 17: Do you support a requirement in the Regulations that the clinical governance protocols of a health service must set out the roles and responsibilities of key clinical leadership positions? If not, why not? If so, which positions do you consider should be addressed in the protocols?

Whilst role clarity is essential to achieving quality and safety, accountability and the functioning of a cohesive team, ANMF (Vic Branch) submits that regulatory mechanisms to establishing clear roles and responsibilities would ensure that Position Descriptions are not the sole mechanism to outline roles and responsibilities of key clinical leadership positions. These should align with the principles outlined in the *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance Framework June 2017*[16].

RECOMMENDATION 14:

ANMF (Vic Branch) recommends that clinical governance protocols of a health service stipulate that the roles and responsibilities of key clinical leadership positions be clearly articulated in applicable position descriptions and align with the proposed regulations, and principles outlined in the *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance Framework June 2017.*

QUESTION 18: Do you consider that the current use of clinical staff not directly employed, to work in private hospitals or day procedure centres, may pose a risk to patient safety?

ANMF (Vic Branch) is opposed to precarious employment and support employment practices which promote a stable, and reliable supply of nurses and midwives.

At the same time, there are circumstances where employees may choose to accept casual employment. For example, this may be a means to support a predominantly female dominated workforce to manage parenting responsibilities.

To ensure quality and safety it is critical that all nurses and midwives are supported with opportunities to undertake high quality sector consistent professional development and learning opportunities and are appropriately orientated to the health care setting and the nursing and or midwifery team. To promote a positive learning culture and to ensure that professional development is prioritised consistently across the state, the Regulations could be amended to stipulate that private hospitals and day procedure centre provide dedicated time and opportunities for nurses and midwives to undertake professional development. This could also be further achieved through developing common learning modules across the state to promote consistency. ANMF would welcome consultation on specific amendments to the achieve this.

[16] *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017* (Department of Health and Human Services, June 2017)

In the interim, we do not accept the underpinning assertion 'that use of clinical staff not directly employed' necessarily presents a risk to patient safety. Instead, we submit that a lack of systems to support staff to be oriented to the workplace and to have equitable access to professional development, irrespective of their mode of employment, should be the focus of reducing risk.

QUESTION 19: Do you support amending the Regulations to require that the clinical governance protocols of a health service establishment must set out how staff and VMO fatigue (including cumulative fatigue arising from work undertaken at multiple facilities) is monitored and managed? If yes, why? If not, why not?

Yes, ANMF (Vic Branch) is supportive of this proposal, any interventions to manage fatigue will reduce risk and promote quality and safety.

Specifically, we highlight that as part of the existing sentinel event/ adverse action processes in Victoria, fatigue and related incidents could be monitored under the existing category of resource or organisational management (under subcategory 11).

RECOMMENDATION 15:

ANMF (Vic Branch recommends that the Regulations require that the clinical governance protocols of a health service establishment must set out how staff and VMO fatigue (including cumulative fatigue arising from work undertaken at multiple facilities) is monitored and managed.

QUESTION 20: Do you have any comments on the benefits and implications of setting (in clinical governance protocols or centrally in government requirements) a maximum surgical list length?

Whilst the length of surgical lists and session times are acceptable, they can become significantly extended due to over booking of surgical lists across the public sector and private sectors, resulting in significant intensification of work and excessive hours of work for perioperative and PACU staff. Whilst there are stringent theatre booking systems in place, the number of cases on a list is mandated by the consultants and employers appear to do little to control this. Add the "emergency" case as often no dedicated staffed emergency theatre and the overtime and potential multiple recalls becomes significant.

In addition to these impacts, there is concern with the existing system around the impacts of fatigue on the safety of staff and patients. There is significant evidence around the links between staff and patient safety[17] in particular around patient outcomes being negatively impacted by work environment factors, such as shifts greater than 12 hours in length (page 8) resulting in a higher rate of nursing errors (twice as likely compared to shorter shifts) and even nine hours in a single shift associated with 2.7 times greater chance of patients acquiring infection. The lack of regulation of list lengths, and the common overruns of these lists mean that staff are regularly working over their rostered shift times, resulting in occupational health and safety risk to staff, due to the impacts of fatigue, but also presenting increased risk of adverse patient safety outcomes. The Occupational Health and Safety Act

[17] *Evidence Review Linking worker health and safety outcomes with patient outcomes*. Institute for Safety Compensation and Recovery Research November 2017 Evidence Review 190

2004 (Vic) and related Acts provide clear obligations on employers to provide working environments and systems of work that are safe and without risk to health (so far as practicable) for staff, but also for others, which includes patients. Therefore, the continuous failure to regulate and monitor list length overruns is resulting in potential breaches of their obligations, on top of failing to provide appropriate environments and controls for staff and patient safety.

Furthermore, it is uncommon for such list overruns (and the associated fatigue) to be reported as incidents in order to appropriately monitor the impacts and effects of this on staff and patients. As outlined in the recommendations from the Francis Report (in particular, recommendation 12), these incidents are of concern around patient safety, and therefore reporting of these incidents must be insisted upon. Without appropriate reporting, it is impossible to monitor the real consequences of these list overruns, and the inappropriate hours that are worked as a result (and the consequential fatigue). Whilst there are clear list lengths determined in advance, health service failure to monitor the number of cases insisted upon by consultants in effect is planning for this to occur. As noted above, patients returning to wards with less staff to provide the care is also resulting in increased risk of adverse outcomes for patients[18] and staff due to increased workload, decreased support and assistance and burnout.

Of course, it is understood that there are scenarios where emergency cases present, requiring immediate attention. Currently these are undertaken in the context of the impacts of a delay in surgery to patient outcomes, however the same concern and consideration is not taken for the impact on staff of undertaking the surgery. A risk assessment should be undertaken to balance the clinical risk to the patient of delaying the surgery, whilst also considering the risks to staff (and consequently patients) of undertaking the procedure. Where clinically necessary, the surgery should occur, however evidence-based fatigue management strategies relating to staff fatigue levels must be implemented to ensure that risk of adverse patient or staff safety outcomes are minimised.

RECOMMENDATION 16:

ANMF (Vic Branch) recommends that the Regulations require private hospitals and day procedure centres to identify and implement evidence-based fatigue management strategies in consultation with ANMF (Vic Branch) to ensure that risk of adverse patient or staff safety outcomes are minimised.

QUESTION 21: Do you support amending the Regulations to include mandatory requirements for the ongoing education of nursing and midwifery staff working at private hospitals and day procedure centres.

It is critical that private hospitals and day procedure centres, have systems in place which:

a. promote a positive learning culture;

b. provide dedicated learning time;

[18] *Evidence Review Linking worker health and safety outcomes with patient outcomes*. Institute for Safety Compensation and Recovery Research November 2017 Evidence Review 190. Page 9

c. prioritise learning;

d. support early graduated nurses and midwives to transition to practice; and,

e. support the ongoing continuous professional development of nurses and midwives.

ANMF (Vic Branch) is supportive of amending the Regulations to require private hospitals and day procedure centres to have systems in place to support these outcomes.

We require further discussion regarding what is intended by amending the Regulations to 'mandate requirements for the ongoing education of nursing and midwifery staff working at private hospitals and day procedure centres' but are supportive inserting a requirement in the Regulations for private hospitals and day procedures centres to have systems in place which ensure nurses and midwives have dedicated time set aside for timely access to ongoing professional development which meets their self-identified learning needs. This could also be achieved through inserting a requirement in the Regulations for private hospitals and day procedures to comply with the *Best Practice Clinical Learning Environment (BPCLE) Framework*[19] when delivering learning for nurses and midwives.

Also, noting that Private Hospitals play a pivotal role in employing newly gradated nurses and midwives, and supporting them to transition to practice, it is appropriate to amend the Regulations to require private hospitals and day procedure centres to provide transition to practice programs which align which the Nursing *and Midwifery Transition to Practice Program Guidelines 2018*[20].

Access to ongoing education is deemed important to our members as reflected in their responses to the ANMF Survey including:

"Education is so so important and should be protected. education means staff stay up to date on new principles, are highly skilled and experienced, and can confidently perform their duties. Education support junior staff in becoming valued senior staff. without this, healthcare will crumble[21]".

"Setting a benchmark of education standards is important to Nursing[22]".

"If it isn't mandated it will not happen[23]".

"private hospitals need to be held accountable for making many discharge nurses and education roles redundant. I know this has already been reported. Our wards are suffering without clinical educators. We had a staff member leave after their first day crying and not

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[19] Department of Health and Human Services, 2016. https://www.health.vic.gov.au/education-and-training/best-practice-clinical-learning-environment-bpcle-framework last accessed 16 September 2023.
[20] *Nursing and Midwifery Transition to Practice Program Guidelines 2018* (Department of Health and Human Services) https://www.health.vic.gov.au/nursing-and-midwifery/nursing-and-midwifery-graduates last accessed 15 September 2023.
[21] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished. (September 2023).
[22] Ibid.
[23] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished. (September 2023).

return. Our graduates are overwhelmed. We need to fight for our staff or we will all have no choice but to leave. thank you for conducting this survey, I've learnt a lot![24]".

RECOMMENDATION 17:

ANMF (Vic Branch) recommends that the Regulations be amended to require private hospitals and day procedure centres:

I. to provide transition to practice programs which align which the Nursing and Midwifery Transition to Practice Program Guidelines 2018.

II. to design and deliver learning for nurses and midwives in accordance with the Best Practice Clinical Learning Environment (BPCLE) Framework.

III. to provide dedicated learning time.

<u>QUESTION 22</u>: How does the requirement for a committee with responsibility for quality and safety currently work in practice across diverse private hospitals and day procedure centres?

Recipients to the ANMF Survey provided mixed responses including:

> "Yes, our hospital currently has very good quality assurance programs and a committee in place[25]"; and,
>
> "I think that each location operates independently and there is no uniform practices[26]"
>
> "Quality and Safety committee implementations can only improve patient safety[27]".

Noting the diversity of experiences, there is merit in exploring amendments to the Regulations which promote greater consistency in the processes and systems to achieve quality and safety in private hospitals and day procedure centres.

<u>QUESTION 23:</u> Could mandatory requirements in the Regulations for the committee responsible for quality and safety improve patient safety – for example, a minimum meeting frequency of once every three months or a requirement for a Chair with no financial interest in the health service?

Yes, and quality and safety could be promoted through requiring the membership of these committees to include the nurses and midwives involved in providing direct patient care.

[24] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished. (September 2023).
[25] Ibid.
[26] Ibid.
[27] Ibid.

QUESTION 24: Do you support amending the provisions for quality and safety protocols in the Regulations to include a requirement that these protocols include processes for assessing the reliability, availability and timeliness of adjunct diagnostic services, whether provided by the health service establishment or an external supplier. If yes, why? If not, why not?

Yes, ANMF (Vic Branch) is supportive of this proposal. Timely access to high quality diagnostic serves is a critical element of providing safe patient care.

STAFFING REQUIREMENTS

QUESTION 25: Do you support amending the Regulations so that the appointment now titled 'Director of Nursing' can be 'however titled' if the position has the qualifications, experience, and authority of the nurse who is in charge of clinical services in the facility. If so, why? If not, why not?

It is important that the word 'nursing' be retained in the title, and that the role of the Director of Nursing not be conflated with the role of the 'Nurse in Charge.' The two roles are not interchangeable, and nomenclature should reflect the accepted standards of the profession and the relevant industrial and legal framework including that set out in the *Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024* [28]*['Agreement', and the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (Vic) ['SPC Act'].*

Under s3 of the SPC Act, "**a nurse in charge** means a registered nurse or equivalent who is undertaking, whether temporarily or permanently the role of –

(a) a nurse unit manager or equivalent; or

(b) An associate nurse unit manager or equivalent[29]".

A nurse in charge relates to the management of a ward or unit, while a Director of Nursing relates to the senior nurse for the site, and responsible for the nursing service.

The Regulations should be amended to require the appointment of a Director of Midwifery where the private hospital offers maternity and newborn services, and the Director of Nursing does not hold registration with the Nursing and Midwifery Board of Australia ["NMBA"] as a midwife. The Director of Midwifery must hold registration with the NMBA as a midwife, and therefore be educationally prepared to be a oversee the provision of maternity care.

Consistent with the arrangements applying to the DON, the Regulations should also insert a requirement for there to be an Acting Director of Midwifery ['DOM"] in circumstances where the DOM is absent, incapacitated or the position is vacant. The qualification requirements of this role, should be the same as that applying to the DOM.

[28] *Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024.*
[29] *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (Vic).

RECOMMENDATION 18:

ANMF (Vic Branch) recommends that:

I. The title of Director of Nursing be retained within the Regulations.

II. Where the private hospital offers maternity and newborn services, the Regulations be amended to require the appointment of:

a) a Director of Midwifery, who is a midwife, where the Director of Nursing does not hold registration with the Nursing and Midwifery Board of Australia as a midwife.

b) A Midwife Unit Manager per ward /unit providing maternity and newborn services; and

c) An Acting Director of Midwifery.

QUESTION 26: In relation to the qualifications and experience requirements of the Acting DON, which of the below options do you support and why:

Option 1 – maintain the status quo – no qualifications or experience requirements in Regulations, and no limit on the length of time that an Acting DON can be appointed for.

Option 2 – require the Acting DON to meet the same qualifications and experience requirements of the DON, which are that they are a registered nurse, and have 12 months practical experience in nursing management, and have at least five years clinical experience as a registered nurse).

Option 3 – enable the position of Acting DON to be used to upskill staff.

ANMF supports amending the Regulations according to Option 2. This option does not prevent private hospitals and day procedure centres from utilising this to achieve Option 3. That is, to upskill staff and support succession planning.

QUESTION 27: If the Acting DON is not required to have the same level of experience and qualifications as the DON, would you support a requirement that an Acting DON appointment is for a maximum of 12 months. If so, why? If not, why not?

N/A

QUESTION 28: To ensure adequate nursing supervision by a suitably qualified person, which of the following options do you support, and why / why not?

Option 1 – status quo – no change to requirements in the Regulations.

Option 2 – require a DON or nominated nurse in charge with the same qualifications and experience as the DON to be:

- on-site at all times in private hospitals

- on-site for a minimum number of hours each week in day procedure centres. What might be an appropriate number of hours?

Option 3 – for private hospitals and day procedure centres, require a nurse with at least three years relevant clinical experience to be on-site to supervise the provision of medical health services?

ANMF (Vic Branch) favours Option 2, achieved through inserting a requirement for private hospitals and day procedure centres to appoint a Deputy Director of Nursing.

Under c4 of the Agreement a "Deputy DON means an Employee who is a Registered Nurse appointed as the Deputy Director of Nursing and who deputises for the DON and assists in nursing administration[30]".

Noting the DON/M (and any acting DON/M) may be required to be offsite to perform nonclinical aspects of the role, the Deputy DON/M role would ensure nurses/midwives have access to timely clinical nursing leadership. In turn, this would reduce clinical risk, promote quality and safety and support the retention and recruitment of staff. Similarly, there must be after hours coordinator, who is a registered nurse, to be responsible for the site in the off-duty periods of the DON.

RECOMMENDATION 19:

ANMF recommends the Regulations be amended to:

I. insert a requirement for private hospitals and day procedure centres to appoint a Deputy Director of Nursing to deputise for the DON.

II. insert a requirement for private hospitals and day procedure centres to appoint a Deputy Director of Midwifery to deputise for the DOM.

III. insert a requirement for private hospitals and day procedure centres to appoint an after hours coordinator, who is a registered nurse, to be responsible for the site in the off-duty periods of the DON

QUESTION 29: For day procedure centres, would you support there being a maximum number of facilities that a DON can be nominated for? If so, why and what might be an appropriate number?

If not, why not?

ANMF (Vic Branch) does not support the proposal envisaged in the Discussion Paper. Instead, we recommend that the DON be responsible for a maximum of one day procedure facility. In support of this submit that:

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[30] *Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024.*

The Regulations should be consistent with the yardstick set by the Nurses *and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020 to 2024.* Clause 90.3 states that *… each employer must employ a full time DON on each campus, excluding community health centres".*

The position of Director of Nursing ['DON'] provides clinical nursing leadership which in turn, is critical to achieving quality and safety, and the retention and recruitment of staff.

Timely access to clinical nursing leadership is critical to achieving quality and safety as recognised in the *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017*[31], which relevantly identifies that great health outcomes are achieved through ensuring:

"Strong, transparent supportive and accessible leadership (which) fosters a culture of learning, accountability and openness with a strong clinical engagement[32]"

ANMF is therefore opposed to allowing the DON to be responsible for more than one campus of a health facility. This would result in unmanageable and unsafe workloads and obstruct their capacity to provide timely nursing leadership. This would result in reduced clinical oversight, with nurses feeling unsupported. In turn, this would militate against retention and recruitment and create clinical risk.

RECOMMENDATION 20:

ANMF (Vic Branch) recommends the Regulations stipulate the DON is responsible for a maximum of one day procedure centre.

QUESTION 30: Would you support a requirement in the Regulations about the hours a DON must devote to non-clinical activities. If so, why, and which of the below options do you support and why:

Option 1 – maintain the status quo – no minimum non-clinical hours requirements in Regulations.

Option 2 – amend the Regulations to mandate the minimum hours that the DON must devote to non-clinical activities – for example, one non-clinical day per week.

Option 3 – amend the Regulations to require clinical governance policies to address how the DON will undertake their non-clinical duties.

ANMF (Vic Branch) is broadly supportive of Option 3, and therefore arrangements for the DON to have adequate time to perform all elements of their role including non-clinical and clinical functions.

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[31] *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017* (Department of Health and Human Services, June 2017) Pages 4 and 5.
[32] Ibid.

QUESTION 31: Do you support including a requirement in the Regulations for private hospitals with 200 or more overnight beds or that have an intensive care unit, emergency department, or acute rehabilitation ward to have an on-site Medical Director (however named)? If yes, why? If not, why not?

Yes ANMF (Vic Branch) supports this proposal consistent with the *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017.*

QUESTION 32: Do you support including a requirement in the Regulations that an on-site Medical Director (however named) responsible for a private hospital with 200 or more overnight beds cannot be responsible for any other facilities? If yes, why? If not, why not?

Yes ANMF (Vic Branch) supports this proposal consistent with the *Safer Care Victoria Delivering high quality healthcare. Victorian clinical governance framework June 2017.*

Additionally, where maternity services are provided an onsite Maternity Services Director to be named.

QUESTION 33: Do you support requiring a private hospital to have an on-site Chief Executive Officer if it has 200 or more overnight beds? If yes, why? If not, why not?

N/A

QUESTION 34: Do you support any requirements for additional required senior appointments such as hospitals that provide maternity services being required to appoint a Director of Midwifery or a Midwife in Charge, or a requirement to appoint a Chief Executive Office or Medical Director (however named)? If yes, why? If not, why not?

Yes, ANMF (Vic Branch) recommends amending Regulation 26B to require a senior midwifery position to provide clinical oversight (Director of Midwifery, with professional requirements equivalent to those applying to the DON as set out in Regulation 14 (2).

In circumstances where the service operates in the off-duty period of the DON, a Registered Nurse should be appointed to fulfil the role of the DON in the off-duty periods of the DON (typically an After Hours Coordinator).

Consistent with the arrangements applying to the DON, the Regulations should also insert a requirement for there to be an Acting Director of Midwifery [‘DOM”] in circumstances where the DOM is absent, incapacitated or the position is vacant. The qualification requirements of this role, should be the same as that applying to the DOM.

RECOMMENDATION 21:

ANMF (Vic Branch) recommends that:

I. r. 26B be amended to require a senior midwifery position to provide clinical oversight (Director of Midwifery, with professional requirements equivalent to those applying to the DON as set out in Regulation 14 (2).

II. where the service operates in the off-duty period of the DON, a Registered Nurse be appointed to fulfil the role of the DON in the off-duty periods of the DON (typically an After Hours Coordinator).

SUFFICIENT NURSING STAFF FOR PRIVATE HOSPITALS:

QUESTION 35: In relation to the minimum nurse-to-patient ratios, which of the below options do you support and why:

Option 1 – maintain the status quo – no changes to the current minimum nurse-to-patient ratios required by the Regulations.

Option 2 – increase the general minimum nurse-to-patient ratios required by the Regulations for private hospitals and introduce minimum nurse-to-patient ratios for high dependency units, intensive care units and emergency departments.

Option 3 – amend the Regulations to require the that the clinical governance policies and procedures of a facility must set out staffing arrangements, including nurse-to-patient ratios, for high dependency units, intensive care units and emergency departments, with minimum nurse-to-patient ratios for the other wards specified in the Regulations.

Option 4 – amend the Regulations to require that the clinical governance policies and procedures of a facility must set out all staffing arrangements, including minimum nurse-to-patient ratios. Current nurse-to-patient ratios in the Regulations would be removed.

ANMF (Vic Branch) supports Option 2 – 'increase the general minimum nurse-to-patient ratios required by the Regulations for private hospitals and introduce minimum nurse-to-patient ratios for high dependency units, intensive care units and emergency departments'.

Background

Nurse to patient and midwife to patient ratios were first introduced in Victoria in 1999 as part of the Blair Decision[33] . At the time, there was as a severe shortage of nurses and midwives. Crucially, approximately 20,000 nurses and midwives were registered in Victoria but were not willing to work in the public sector. Hospitals were struggling to cope with more than 1300 equivalent full time nursing vacancies.

The introduction of minimum nurse and midwife to patient ratios were central to turning this dire situation around. Their introduction provided a means for nurses and midwives to regulate workload, reduced intensification of work and meant that nurses and midwives were able to provide safe patient care. With manageable workloads, nurses and midwives felt safe to return to the public sector. Combined with additional improvements in their terms and conditions of employment, the severe staffing shortages resolved. By 2006 an additional 7000 nurses and midwives were recruited to the public sector [34]

Applied to private hospitals and day procedure centres, the introduction of nurse to patient and midwife to patient ratios, should be seen as an essential mechanism to address the staffing shortages cited in the *Review of the Health Servies (Health Services Establishment) Regulations 2013 Discussion Paper August 2023* ['Discussion Paper"], and to meet the Objectives of the Regulations outlined in Section 1 of the Regulations, to

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[33] *Victorian Hospitals Industrial Association and Australian Nursing Federation Nurses (Victorian Health Services) Award 1992* https://www.fwc.gov.au/documents/decisionssigned/html/s9958.htm

[34] On the Record, ANMF (Vic Branch) first Published July 2020 edition of the Handover https://otr.anmfvic.asn.au/articles/industrial-action-commissioner-wayne-blair-and-private-arbitration-in-perth last accessed 16 September 2023.

“provide for the safety and quality of care of patients receiving health services in or from health service establishments by

prescribing—

1. requirements for staffing[35]”.

The increased workforce numbers undoubtedly also supported Victoria’s workforce during the pandemic.[36] This would also be the case for the private sector, augmenting nursing and midwifery workforce numbers and therefore patient safety [37, 38].

ANMF (Vic Branch) has been working with the private sector in a bid to improve staffing levels and ensure, at a minimum, that staffing, and skill mix is evidence based and reflects best practice approach.

Despite this work, evidence suggests workload pressures are increasing in private hospitals, rather than improving staffing levels and workplace governance.

There are around 85 private hospitals, including private day procedure units in Victoria. Between 2011 and 2016 there was a 17 per cent increase in the number of patient days in private hospitals and day procedure units. In addition, private hospital earnings increased by around 20 per cent.

This increased demand has escalated the pressure being placed on nurses and midwives working in the sector who have also stepped up to support their public health colleagues and public health patients during the COVID 19 pandemic. Further the increased demand without adequate staffing risks patients' safety.

It is critical that the Victorian public have access to high quality care irrespective of whether they choose to receive this in the public or private hospital system.

ANMF (Vic Branch) therefore recommends that Option 2 be adopted with the following amendments:

General medical and surgical wards(ALL INPATIENT SETTINGS NOT OTHERWISE SPECIFICALLY NAMED)

RECOMMENDATION 22:

ANMF (Vic Branch) recommends:

I. Amending the current ratio in r.27 (2) from one nurse to ten patients (1:10), to one nurse to 1:5 patients (1:5) during the morning and afternoon shifts for private hospitals.

II. Amending the current ratio in r.27 (2) of one nurse to fifteen patients (1:15), to one nurse to ten patients (1:10) during the night shift for private hospitals.

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[35] *Health Servies (Health Services Establishment) Regulations* 2013 (Vic).

[36] Nursing and Midwifery Board Australia 2023 Statistics https://www.nursingmidwiferyboard.gov.au/about/statistics.aspx

[37] Aitken et al 2002 Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction *JAMA*. 2002;288(16):1987-1993. doi:10.1001/jama.288.16.1987 https://jamanetwork.com/journals/jama/fullarticle/195438

[38] Twigg, D. E., Duffield, C. M., Thompson, P., & Rapley, P. 2010. The impact of nurses on patient morbidity and mortality - the need for a policy change in response to the nursing shortage. *Australian Health Review*, 34(3), 312 -316. https://www.publish.csiro.au/ah/AH08668

High Dependency Units

RECOMMENDATION 23:

ANMF (Vic Branch) recommends in High Dependency Units (HDU), inserting a requirement for:

I. A ratio of one nurse for every two patients; and,
II. One nurse in charge.

ANMF (Vic Branch) supports the definition of a HDU proposed in the Discussion Paper.

'A HDU is a specially staffed and equipped area of a hospital that provides a level of care intermediate between intensive care and the general ward care.'

ANMF (Vic Branch) would also welcome discussion on the other questions within the Discussion Paper including requiring that a HDU be on the same site as an Intensive Care Unit (ICU) and considering inserting a definition of a Close Observation Unit to differentiate it from a HDU.

Intensive Care Units

RECOMMENDATION 24:

ANMF (Vic Branch) recommends in Intensive Care Units inserting a requirement for:

I. A ratio of one nurse for every patient as per the Australasian College of Critical Care Nursing Workforce Standards[39] and the College of Intensive care Medicine Guidelines[40]; and,
II. One nurse in charge.

Emergency Departments

RECOMMENDATION 25:

ANMF (Vic Branch) recommends In Emergency Departments, inserting a requirement for

I. a minimum ratio of one nurse for every three treatment spaces (1:3); and,
II. one triage nurse; and,
III. one nurse in charge.

[39] Australian College of Critical Care Nursing 2016. Workforce Standards for Intensive Care Nursing. Melbourne, ACCCN Ltd ISBN 9 780646 960739 www.acccn.com.au/aboutus/position-statements-standards

[40] College of Intensive Care Medicine 2016 Minimum Standards for Intensive care Units. CICM https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf

Emergency Department Resuscitation Bays

RECOMMENDATION 26:

ANMF (Vic Branch) recommends in Emergency Department resuscitation bays, inserting a minimum ratio one nurse for each patient (1:1) for occupied Emergency Department resuscitation bays.

Perioperative Services (incorporating operating theatres, PACU and preadmission) Operating Theatres

RECOMMENDATION 27:

ANMF (Vic Branch) recommends in operating theatres inserting a requirement for there to be minimum of

I. one instrument nurse;
II. one circulating nurse;
III. one anaesthetic nurse.
IV. The operator of a hospital may reduce or increase the number of nurses with whom an operating theatre is staffed in accordance with the prescribed criteria.
V. In this section, operating theatre means an operating theatre that is being utilised to perform a surgical procedure.

RECOMMENDATION 28:

ANMF (Vic Branch) recommends in Post-anaesthetic recovery rooms, inserting a requirement for there to be one nurse for each unconscious patient on all shifts.

Sufficient midwifery staff:

QUESTION 36: In relation to the minimum number of midwives to be working in antenatal, delivery suites, and post-natal wards when patients are admitted, which of the below options do you support and why:

Option 1 – maintain the status quo – no changes to the Regulations and the Regulations would not mandate minimum midwife-to-patient ratios.

Option 2 – amend the Regulations to insert a minimum requirement of 2 midwives for every 3 patients in birthing suites.

Option 3 – amend the Regulations to require hospitals that provide maternity services to ensure there is at least 1 midwife on the ward whenever there is a maternity patient admitted or when a birth is in progress with the staffing arrangements further detailed through clinical governance policies.

ANMF (Vic Branch) supports Option 2.

RECOMMENDATION 29:

ANMF (Vic Branch) recommends that Regulation 27 be amended to insert requirements for:

I. a minimum of 2 midwives for every 3 birthing suites; and,

II. no less than 75% of staff in antenatal and post-natal units be registered midwives, and a minimum of two midwives be rostered to all shifts in addition to the birth suite staffing.

III. A Midwifery Unit manager be appointed, and an Associate Midwifery Unit manager to be rostered in their absence.

IV. A nurse working in an antenatal/postnatal ward must have completed a total of 48 hours supernumerary placement in the antenatal postnatal ward.

V. Where maternity services are provided, for clinical governance and professional reporting, a midwife is to be appointed at a classification of that higher than Midwifery Unit Manager, for example, Director of Midwifery, Program Director of Maternity Services.

VI. This recommendation is to ensure that safe midwifery care is provided to women utilising the private health sector, and to minimise the risk of adverse events resulting from insufficient clinical oversight.

VII. There needs to be included a definition of “Midwife”, and where “Nursing” is mentioned, the phrase “Nursing and Midwifery should be use, similarly, where “Nurse” is referenced, “Nurse or Midwife” should be used.

Special care nurseries

RECOMMENDATION 30:

ANMF (Vic Branch) recommends that Regulation 27 be amended to insert requirements for:

I. The operator of a hospital should staff a ward that is a special care nursery as follows—

   a. in the case of 7 or fewer occupied cots, on all shifts—
   b. one nurse or midwife; and

II. for every 4 additional occupied cots beyond 4, one person, being either a nurse or a midwife;

III. for every 4 additional occupied cots beyond 4, one person, being either a nurse or a midwife; and

IV. a nurse in charge or a midwife in charge; and

V. on the night shift one nurse or midwife; and for every 4 additional occupied cots beyond 4, one person, being either a nurse or a midwife; and a nurse in charge or a midwife in charge.

VI. The operator of a hospital should staff a special care nursery with 6 occupied cots, on all shifts, with 2 persons, each being either a nurse or a midwife.

VII. A nurse or midwife with whom the operator of a hospital staffs a special care nursery must have completed the equivalent of at least 64 hours' employment per fortnight as a nurse or a midwife during a 12-month period; or a total of 64 hours' supernumerary placement in a special care nursery.

SUFFICIENT CRITICAL CARE REGISTERED NURSES:

QUESTION 37: Do you support requiring that the number and deployment of CCRNs, linked to the type and acuity of patients receiving health services, must be included in clinical governance policies and procedures of private hospitals?

Yes. This should align with the accepted standards of the profession as set out by the Australian College of Critical Care Nursing (ACCCN) and the College of Intensive Care Medicine (CICM) who recommend a minimum of 60% qualified (post graduate trained) CCRN staff in ICU/CCU and an optimal ratio of 75% qualified (post graduate trained) CCRN staff.[41]

SUFFICIENT NURSING STAFF FOR DAY PROCEDURE CENTRES:

QUESTION 38: Do you think the current nurse-patient ratios for DPCs in the Regulations are fit for purpose? If not, why not?

RECOMMENDATION 31:

ANMF (Vic Branch) recommends that the nurse-patient ratios for day procedure centres align with those outlined in Recommendation 27, Perioperative Services.

SUFFICIENT OVERNIGHT CLINICAL STAFF:

QUESTION 39: Do you support amendments to the Regulations requiring that all overnight hospitals must have a medical practitioner or nurse practitioner on-site 24 hours a day, separately from persons engaged to work in a private hospital's Emergency Department or Intensive Care Unit? If so, why? If not, why not? If not, would you suggest including an alternative requirement in the Regulations to address any risk to patients?

Yes, ANMF (Vic Branch) supports these prosed amendments. Nurses and midwives within private hospitals and day procedure centres care for a cohort of patients who have increasingly complex health care needs and are high acuity. Patients in this cohort are at risk of a deterioration in their health condition. This is particularly apparent in the emergency department and intensive care setting, where patients present due to their unstable and changing health condition. It is therefore vital that private hospitals and day procedure centres be equipped to meet the health care needs of these patients.

Consideration should also be given to the role of these medical practitioners in ensuring support for obstetricians in care of women accessing maternity services.

This will reduce clinical risk, reduce morbidity and mortality and promote quality and safety for this patient cohort.

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[41] Australian College of Critical Care Nursing 2016. Workforce Standards for Intensive Care Nursing. Melbourne, ACCCN Ltd ISBN 9 780646 960739 www.acccn.com.au/aboutus/position-statements-standards

RECOMMENDATION 32:

ANMF (Vic Branch) recommends that the Regulations require that all overnight hospitals must have a medical practitioner or nurse practitioner on-site 24 hours a day, separately from persons engaged to work in a private hospital's Emergency Department or Intensive Care Unit.

PRE-TREATMENT CLINICAL ASSESSMENT AND DISCHARGE OF PATIENTS

QUESTION 40: Should the Regulations be amended to require that patients receiving mobile health services (such as from a mobile anaesthetist) must undergo a pre-treatment clinical risk assessment (noting that in practice this generally already occurs with patients who receive mobile anaesthetic services)? If so, why? If not, why not?

Yes, it is critical that the Regulations be amended to regulate mobile health services. Preclinical assessment should be provided by mobile anaesthetist. Similarly, the staffing levels and skill mix of mobile anaesthetic services should be regulated to require employment of registered nurses in the delivery of the mobile health services. Clear policies and guidelines need to be developed to ensure mobile anaesthetic service remain on site until patient is at Stage 2 level recovery.

RECOMMENDATION 33:

ANMF (Vic Branch) recommends that Regulations be amended to require that patients receiving mobile health services (such as from a mobile anaesthetist) must undergo a pre-treatment clinical risk assessment.

QUESTION 41: Should the Regulations be amended to require a pre-admission clinical risk assessment to be reviewed/assessed/finalised by a clinical staff member? If so, why? If not, why not?

Yes, ANMF supports amending the Regulations to require a pre-admission clinical risk assessment to be reviewed/assessed/finalised by the registered health practitioner who is educationally prepared to provide the service to the patient.

QUESTION 42: Should the Regulations be amended to require that the proprietor of a registered private facility must ensure the anaesthetist reviews the pre-admission clinical risk assessment before a patient commences treatment for planned procedures that involve anaesthesia, noting that the department understands that in practice this generally already occurs? If so, why? If not, why not?

Yes, ANMF supports this proposal.

<u>QUESTION 43</u>: Should the Regulations be amended to require that the full pre-admission clinical risk assessment be recorded in writing and retained rather than just the result of the assessment, noting that the department understands that in practice this generally already occurs? If so, why? If not, why not?

ANMF supports the proposal but notes the requirement is embedded within the NSQHS 6 Communicating for Safety.

<u>QUESTION 44</u>: What impacts has the current requirement (introduced in 2018) to include all medications currently prescribed in a patient's discharge summary had on private hospitals, day procedure centres, and patients?

N/A

QUESTION 45: Should the Regulations be amended to replace the requirement to include all medications currently prescribed to a patient with the below requirements? If so, why and if not, why not?

For private hospitals – a full list of prescribed medications, irrespective of whether the medication is in relation to the heath service received at the health service establishment, must be on the patient's discharge summary if they stay one or more nights in the facility.

For private hospitals – any changes or additions to prescribed medications must be on the patient's discharge summary for patients who are discharged within one day.

For day procedure centres – any changes or additions to prescribed medications must be on the patient's discharge summary.

ANMF (Vic Branch) supports Option a) believing this will best promote quality and safety and reduce clinical risk.

REGISTERS AND RECORDS

<u>QUESTION 46</u>: Should the Regulations be amended to require that the operation theatre register be used to record all surgical health services or speciality health services carried out in operating theatres and procedure rooms? If so, why? If not, why not?

ANMF understands this already exists and has no comment at this point.

<u>QUESTION 47:</u> Given advancements and changes in record keeping systems, is the specific requirement to keep an operation theatre register still fit for purpose?

ANMF (Vic Branch) supports mechanisms to 'keep an operation theatre register'. We acknowledge that technological advancements may impact how this is achieved. The Regulations should reflect that this may be achieved electronically or hard copy as relevant to the health service.

MANDATORY REPORTING TO THE DEPARTMENT AND SAFER CARE VICTORIA

QUESTION 48: Should the Regulations be amended to require private hospitals and day procedure centres to report to the department transfers out of patients? If so, why? If not, why not? What would you consider an appropriate threshold for such a reporting requirement (i.e. which transfers should be reportable)?

Yes, ANMF (Vic Branch) supports this proposal. It will provide critical data regarding clinical risk and help inform the review and optimise systems of care.

Appropriate thresholds might include a deterioration in patients' health conditions, or an adverse event.

In determining am 'appropriate threshold' and related amendments to the Regulations, consideration should be given to the Recommendations of State Coroner Judge John Cain in the Inquest into the Death of Antoinette O'Brien[42].

This tragic case highlighted the critical importance of establishing clear and consistent tools and mechanisms to:

I. provide clear and effective communication between health care professionals involved in the care of a patient, and comprehensive handover at the time of transferring a patient from one health care facility to another.

II. ensure that any deterioration in a patient's condition is managed safely and appropriately, including transferring a patient out of a private hospital to a health care facility so that a patient can receive the appropriate level of assessment intervention, monitoring and care.

The Regulations must be amended to ensure this occurs, and incorporates the formal Recommendations below:

I. "all health facilities, public and private are required to undertake root cause analysis reports of sentinel events and serious adverse patient safety events; and

II. private hospitals be required to have an independent member on a root cause analysis panel consistent with the requirements imposed on public hospitals…

III. that SCV develop and promote a state-wide tool or tools to assist in the proper handover of patients between health professionals and in transfers between health services. An example of such a tool is the ISBAR which captures relevant information in a meaningful and effective way[43]"

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[42] Inquest into the Death of Antoinette O'Brien. Coroners Cort of Victoria. 7 March 2023. Court Reference: COR 2017 004055
https://www.coronerscourt.vic.gov.au/sites/default/files/COR%202017%204055%20-%20O%27BRIEN%2C%20Antoinette%20%28Annie%29%20%20-%20Form%2037%20Finding%20into%20death%20following%20inquest.pdf

[43] Inquest into the Death of Antoinette O'Brien. Coroners Cort of Victoria. 7 March 2023. Court Reference: COR 2017 004055 P 56

In amending the regulations, it is important to incentivise private hospitals and day procedure centres to report situations of adverse events or a deterioration in the patient's health condition. It is equally important to protect against the unintended consequence of a private hospitals and day procedure not reporting events which may expose a system failure or potential medical negligence.

As simply put by a recipient to the ANMF Survey:

"there shouldn't be a barrier to reporting. However, when pride, ego or the potential to be scrutinised or publicly criticised in a wider setting is threatened reports may not be put in[44]".

RECOMMENDATION 34:

ANMF (Vic Branch) recommends that the Regulations be amended to require private hospitals and day procedure centres:

I. to 'report to the department transfers out of patients'.

II. to implement the Recommendations of Judge Cain including but not limited to requiring private hospitals to undertake root cause analysis reports of sentinel events and serious adverse patient safety events, and to have an independent member on a root cause analysis panel consistent with the requirements imposed on public hospitals.

III. to ensure robust systems and tools (including us e of the ISBAR tool) to assist in the proper handover of patients between health professionals and in transfers between health services.

QUESTION 49: If day procedure centres were required to report to the department any transfer out of patients due to significant deterioration, how often or quickly should the reports be made to the department, and what key information should be provided?

Same or next day reporting, noting smaller private hospitals and day procedure centres may require additional time due to limited resourcing.

QUESTION 50: Do you have any comments regarding the proposal to mandate sentinel event reporting via an approved pathway (currently the Sentinel event portal)?

It is important that nurses and midwives within private hospitals and day procedure centres are supported in reporting and managing sentinel events and have timely access to relevant staff within the responsible government department.

ANMF (Vic Branch) supports this proposal believing it will provide critical data regarding clinical risk and provide a means to better support our members.

[44] Survey of ANMF (Vic Branch) Members, Review of the Health Servies (Health Service Establishments) Regulations 2013. Unpublished. (September 2023).

QUESTION 51: Noting that amendments to the Act are beyond scope of this review, but acknowledging that the protections in the Act are relevant to any mandate for SAPSE reviews, do you find the current legislation (the Act) has sufficient protections in place to ensure rigorous and transparent review processes of adverse incidents? If not, why not?

Yes, ANMF (Vic Branch) would support amendments which required SAPSE reviews to be undertaken consistently across the state and in accordance with the processes provided for by Safer Care Victoria.

QUESTION 52: Do you have any comments regarding the proposal for health service establishments to have protocols that align with Safer Care Victoria's Adverse Patient Safety Event Policy?

RECOMMENDATION 35:

ANMF (Vic Branch) recommends that the Regulations be amended to require private hospitals and day procedure centre to have protocols that align with Safer Care Victoria's Adverse Patient Safety Event Policy.

QUESTION 53: Do you foresee any barriers for health services to comply with a requirement to have an independent person on their SAPSE review panel should they choose to conduct a protected review?

No.

QUESTION 54: Do you foresee any barriers for health services to conduct a review using an approved methodology (for example, root cause analysis, London Protocol or in-depth case review) for all sentinel events and SAPSEs?

No, provided comprehensive and individualised education and training is provided to support private hospitals and day procedure centres to apply this methodology, including that already set out by Safer Care Victoria.

QUESTION 55: If data-reporting systems were free and/or integrated, do you see any barriers for private health services to report all adverse events through VHIMS? Do you see a value in receiving tailored performance reports from VAHI?

No, provided comprehensive and individualised education and training is provided to support private hospitals and day procedure centres to apply this methodology. This would improve oversight and improve the quality of data used to inform the need to identify and implement system changes to reduce clinical risk and improve patient care.

QUESTION 56: Do you support the Regulations being amended so that information relating to adverse events recorded and reviewed under r.48 is available to the Secretary upon request?

Yes, ANMF (Vic Branch) supports this proposal.

QUESTION 57: Do you have any comments regarding the proposal to maintain the existing regulation (r.32A) regarding open disclosure?

ANMF (Vic Branch) support implementation of consistent processes across the state. We therefore recommend that r32A be amended to incorporate requirements for private hospitals and day procedure centres to adopt the *Victorian Duty of Candour Guidelines*[45] and the *Victorian Duty of Candour Framework*[46].

QUESTION 58: Do you support the Regulations being amended to require that a day procedure centre providing mobile services (such as mobile anaesthesia) is required to report annual data to the department?

Yes ANMF (Vic Branch) supports this proposal. This emerging mode of service delivery is currently not well regulated, The Regulations should be amended to achieve the Objectives of the Regulations outlined in Regulation 1 including:

"to provide for the safety and quality of care of patients receiving health services in or from health service establishments by

prescribing—

1. requirements for staffing; and
2. procedures for the handling of complaints; and
3. records to be kept; and
4. other requirements to ensure the welfare of patients…[47]".

ANMF (Vic Branch) is concerned that the provision of general anaesthetic and sedation to Paediatric patients in medical imaging settings presents unacceptable clinical risk and creates a practice environment where our members may be practicing outside the standards of the profession, and therefore at risk of sanctions under the *Health Practitioner Regulation National Law (Victoria) Act 2009*[48].

RECOMMENDATION 36:

ANMF (Vic Branch) recommends the Regulations be amended to require that a day procedure centre providing mobile services (such as mobile anaesthesia) report annual data to the department?

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[45] *Victorian Duty of Candour Guidelines*, State of Victoria, Safer Care Victoria October 2022. https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour last accessed 15 September 2023.

[46] *Victorian Duty of Candour Framework. An Implementation Guide Safer Care Victoria October 2022.* https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour.

[47] Health Services (Health Service Establishments) Regulations 2013 (Vic).

[48] Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic).

QUESTION 59: Do you think the listed data points are appropriate? Are there other metrics that would support risk-based monitoring of the services provided?

Before commenting, ANMF (Vic Branch) would welcome the opportunity to better understand this question.

QUESTION 60: Do you have any comments regarding the burden of reporting this data?

Support should be provided to Private Hospitals and Day Procedure Centres by provision of statewide consistent, comprehensive and accessible education and training on meeting data reporting requirements.

QUESTION 61: Do you have any comments regarding the current process of reporting data to VICNISS?

No, not at this point.

THE PATIENT EXPERIENCE: RIGHTS, INFORMED CARE AND COMPLAINTS

QUESTION 62: Do you have any feedback or suggestions for improvements or additions to any of the regulations related to patient rights, informed care and complaints? If yes, please reference the regulation number in your response.

Not at this point, except to observe patient complaints are reported through existing accreditation agencies.

QUESTION 63: Would you support a requirement in the Regulations for de-identified data about complaints to be reported, or made available, to the Secretary, to inform risk-based monitoring of service safety? If so, why? If not, why not?

Yes, this would help achieve quality and safety through adopting a non-punitive, systems-based approach to human error. In turn this would help reduce clinical risk and promote high quality care.

QUESTION 64: What would be the benefits and/or implications of health service establishments adopting the Partnering in healthcare framework alongside the existing patient engagement policy? Would that constitute a significant shift from current arrangements?

No comment at this point.

OFFENCES, PENALTIES AND SANCTIONS

QUESTION 65: Do you have any feedback on the existing penalty offences and penalty amounts in the Regulations (as summarised in Appendix A – Penalties and offences in the Regulations)? If yes, please reference the regulation number in your response.

ANMF (Vic Branch) would welcome further consultation on this question.

In the interim, we recommend that Appendix A be amended to include penalties for any newly acted Regulations, including but not limit to, those relating to questions within section 4 of the Discussion Paper, titled staffing requirements.

The regulations should also ensure mechanisms for rapid resolution of alleged non-compliance with regulated staffing arrangements.

RECOMMENDATION 37:

ANMF (Vic Branch) recommends that the existing penalties and offences outlined in Appendix A of the Regulations be amended to incorporate any newly enacted Regulations arising from the Review of the Regulations.

QUESTION 66: Do you have any suggestions for additional offences and penalties that could be prescribed in the Regulations?

No comment at this point.

QUESTION 67: Do you support the introduction of infringements to allow the department to deal with less serious breaches in a way that is swift, direct and proportionate to the offence? If yes, why? If not, why not?

No comment at this point.

OTHER ISSUES

QUESTION 68: Do you have any preliminary comment on the fees set out in the Regulations?

No comment at this point.

QUESTION 69: Should the Regulations be amended so that health service establishments must ensure treatment agents are available for clinical emergencies that require pharmacological intervention – for example, treatments specific to anaesthesia. If so, why? If not, why not?

No comment at this point.

QUESTION 70: Are there any other issues related to the Regulations that have not specifically been raised in this discussion paper that you would like to raise with the department?

RECOMMENDATION 38:

ANMF (Vic Branch) recommends the Regulations be reviewed every five years to ensure they keep pace with evolving modes of health service delivery, changes to the accepted standards of the profession, and use contemporary nomenclature.

QUESTION 71: Do you agree that the requirements in the Regulations to prevent scalding of patients (r.41) can be removed from the Regulations without impacting on the delivery of safe health services?

No, we recommend the Regulations still set the accepted standards irrespective of other protections.

QUESTION 72: Are there any other specific areas of the Regulations that you would like to raise with the review team as a requirement that may be duplicative, unclear or contain an error?

As already described.