Mona Vale Hospital Allied Health HSU Industrial Action

HSU Members in the following professions pledge to implement and maintain the following work bans indefinitely until North Sydney Local Health District implements in the recommendation in Option 1 of the Mona Vale Hospital (MVH) Allied Health staffing report, with the exclusion of Physiotherapy.

- Occupational Therapy.
- Speech Pathology.
- Social Work.
- Dietetics and Nutrition.
- Podiatry.

How to understand this action and their implementation

Annexure A and B of this document contains the understood and agreed workplace controls between the HSU (acting as nominated representative for MVH Allied Health staff) and the PCBU. These actions continue to operate as agreed until September 1, 2024, unless expressly stated otherwise in this document.

The industrial action items listed below in the form of work bans will continue indefinitely for HSU members until such time as they are varied or removed through majority of members.

If there is any inconsistency between the agreed controls and HSU action, this document will apply for HSU members.

HSU members will remove these bans and rectify any retrospective impact, if possible, upon the following:

- Funding and agreement provided in full for option 1 of the report titled *Review of MVH Allied Health Service* as updated on June 2024 and provided to the HSU on June 19, 2024.

<u>Hospital wide Allied Health work bans:</u>

- Allied Health staff attendance at Patient Journey Boards (PJB) will not exceed 15 minutes.
- No audits will be completed.
- No HSU members will attend, participate in or represent in committees or projects at a hospital, service of district level, unless an exception is made at the Department level
- HSU members will not participate in the Goal Setting Program.

<u>Occupational Therapy:</u>

- New Patients will not be seen after 3:45pm, urgent referrals may be seen based on clinical capacity and judgement.

- OT staff will not see more than 2 NDIS patients for every 1 FTE. Additional NDIS referrals will be waitlisted within team for allocation as capacity allows.
- OT staff will only provide handovers where Department FTE falls by 2 or more FTE.
- Key information and staffing levels reported daily at PJB. If staffing levels are critical i.e. 3 FTE or less (IP total is 6 FTE) this will be communicated via email from OT HOD/AH Manager to respective NUMs, as early as possible.
- OT staff will not participate in the PMES.
- Home visits will cease except in cases of critical need to ensure safe discharge. All others will be handed to appropriate community providers.
- OT will commence a waitlist for allocations based on staffing restrictions, work will be performed strictly in accordance with this waitlist.

<u>Nutrition and Dietetics:</u>

- Remove current capping of patients per clinician and implement below:
    - University students excepted by exception and on election of Departmental staff.
    - HSU members will not participate, assist with or complete the Nutrition Care audit.
    - HSU members will not participate, assist with or complete the IP document audit.
    - HSU members will not participate, assist with or complete CHSP documentation audit.
    - HSU members will not participate, assist with or attend NSLHD meetings.
    - TIL will be utilised only for priority 1 referrals after 3:30pm and applied to the clinician for increments of 10 minutes as opposed to current accrual for 30 minutes.
    - Inpatients:
        - Priority 1 referrals referred after 3:30pm will not be seen that day unless it is safe to do so according to staffing and clinician workload.
        - On reduction of 1 staffing FTE for Department (i.e. 2 Dietitians excluding HoD), the following work practices will be implemented:
            - Priority 1 and 2 referrals to be triaged alongside existing reviews and seen as clinical capacity allows.
            - Priority 3 and 4 referrals will not be seen until staffing returns to 100% and seen as capacity allows.
            - No attendance at case conference and family meetings, written handover provided and PJB attendance as capacity allows.
        - On reduction of 2 FTE for Department (i.e. 1 Dietitian and HoD) the following practices will be implemented:
            - Clinician will see urgent reviews and priority 1 referrals as capacity allows.

- Priority 2 referrals triaged but may not be seen until staffing improves and clinical capacity allows.
- Priority 3 and 4 referrals to be held over until staffing returns to 100%.
- No attendance at case conference and PJB, written handover if capacity allows.

- Outpatients:
  - On 1 July 2024, Dietetics lost 4 hours of administration assistance.
  - Clinician will reduce clinical workload by total of 4 hours through the implementation of a reduction / go-slow on outpatients to allow 4 hours of administrative work to be performed.
  - Priority 4 patients will not be seen.

Social Work:

- New Patients will not be seen after 3:45pm, urgent referrals may be seen based on clinical capacity and judgement.
- SW will not take on blanket referrals except for stroke patients and others deemed high psychosocial concerns as per category 1.
- The following caseload caps will be implemented:
  - Rehab (based on 40 patients):
    - 1 SW FTE: 10 patients which may be reduced based on level of complexity, maximum complexities per 1 FTE:
      - 2x RACF placements per week.
      - 2x NDIS applications per week.
      - 1 X NCAT application per week.
  - PCU (based on 10 patients):
    - Caseload caps for 1 FTE (where there is no leave):
      - 8 active PCU patients depending on the level of complexity / need.
      - PCU SW to support to GEM will be Monday-Wednesday where capacity allows.
  - GEM (based on 6 patients):
      - PCU SW to provide support Monday-Wednesday, where capacity and staffing allows.
      - Family meetings will not occur and handover provided unless critical and urgent need.
      - Case conference attendance not to occur unless workload demands allows.

Speech Pathology:

- New Patients will not be seen after 3:45pm, urgent referrals may be seen based on clinical capacity and judgement.
- PCU/GEM:
    - HSU Speech Pathology members will only attend the wards 3 days a week. As it currently stands, this will be Monday, Tuesday, and Friday. Urgent referrals may be accommodated on other days if staffing allows. PJB will only be attended on above listed days, if capacity allows.
    - PCU case conference will be provided with a written handover, unless staffing capacity allows face to face attendance
- ARU:
    - PJB will be limited to 2 days a week maximum attendance.
    - PJB attendance will not occur if there are no active speech pathology patients on the ward.
- General Outpatient services will be reduced from 0.8 FTE to 0.42 FTE.
    - HSU members who are not CHSP funded will not partake in home visits except in exceptional circumstances.
- No service will be provided at BCHC.
- student placements by exception only.
- Rehab maintenance patients will only be seen once a week.
- Outpatient intensive voice therapy Parkinson's Disease programmes will be reduced.
- Further to this, during periods of reduced staffing, the departmental priority document will be referred to in order to guide patient management and meeting attendance.

Annexure A:

DRAFT: MVH Allied Health Workload Control Measures from 13/06/24 to end of July 2024 [Note: at this time, these have been extended to 1 September, 2024]

Current implemented control measures across AH:

- Departments work off priority documents when staffing is low to ensure that workloads are manageable and to prevent staff working beyond rostered hours.
- Attendance at case conferences is dependent on staffing levels and when necessary, a handover is provided in lieu of attendance.
- Patient Journey Boards (PJB) are limited where possible to 15 minutes (20 minutes for PCU/ GEM). If in the event PJB is extended, AH staff are not expected to stay at the meeting
- Involvement in Quality Projects and audits are at the discretion of the individual teams and staff members dependent on their capacity to manage their clinical caseload.
- Approval to increase part time staff hours or utilise casuals in times of critical levels of staffing – must be approved by the AH Manager.

- Membership at committees to remain at one AH delegate – more than one can attend if there is capacity / preference. AH delegates may send apologies if no capacity to attend.
- Protected lunch breaks where possible.
- HODs Huddle implemented (2nd Wednesday of the month) to alternate with HODs/AHM (last Wednesday of the month) to limit email traffic – staff bring items to the meeting for group discussion. On trial.

To Commence:

- HODs to complete a weekly template to show staffing levels in terms of green-amber-red and template to be uploaded into Teams site. AH HODs to cease attendance at Bed Meeting once this is achieved.

- New patients will not be seen after 3.45pm (urgent referrals may be considered based on clinical judgement).
- CPD attendance closely monitored by HOD – re-think who can attend what in the future.

<u>Individual Department Control Measures:</u>

Nutrition & Dietetics:

- Phone calls will not be answered between 12.30—1.15pm
- High priority enteral feeds and allergy patients will not be seen after 3.30pm Monday to Thursday and after 3pm on a Friday.
- Capping of patients per clinician: Level 1/2 capped to 7 active patients (6 if one is an enteral feed) - a new admission would be seen based on priority however a patient of lower priority would be “discharged” from the list to cap at 7.
- Capping of HOD caseload at 2 active patients
- Nutrition care audit on hold – next one due October
- IP Doc audit on hold – next one due October
- NSLHD meetings – HODs to put in apologies during extended period of leave June to October
- No university student placements

Occupational Therapy:

- Consider capping of patients pre clinician however staff are already working like this and utilising priority document.

- Review assessment process for personal alarms in the community eg OP group rather than HV
- Consider putting “out of office” during times when workload is high stating possibility of delayed response.
- Take student “placements by exception” only.

Neuropsychology:

- Time management by prioritising clinical work over administrative tasks.
- Reducing outpatient caseload when IP work increases.
- If possible/necessary, pausing outpatient scheduling while one of staff member is on annual leave
- Adapting battery and report length to be shorter if possible and necessary
- Declining inappropriate timelines for referrals (e.g., if the patient has been referred for neuropsych but EDD is in 2 days)
- Delay outpatient report turnaround time if possible to adjust for urgent inpatient referrals

Physiotherapy:

- On low staffing, Patients are seen once a day (instead of twice i.e. below Stroke guidelines). Patients seen by PTA and in a group setting.
- Consideration to capping - if new patients are admitted and the number exceeds this limit, the NP would not be seen until another had been discharged.
- Consideration to staff caseload to cover IP/OPs – somewhat dependent on whether CHSP funding is continued beyond 30/6/24.
- Deployment of outpatient staff to IPs when IP staffing is low – short term measure only.

Podiatry:

- OPs prioritised to patients with wounds only
- Triage of IPs – will prioritise to OPs if required

Social Work:

- Re-visit non-blanket referrals for IP rehab wards and PCU (GEM to remain blanket referral).
- Will consider a capping system.
- SW HOD attendance at length of stay meeting – AI to talk with JW re value of attending and ongoing attendance. Could an email be provided or escalation pathway be implemented.

Speech Pathology:

- Reduction in outpatient intensive voice therapy Parkinson’s Disease programmes

- Reduction in general OP activity to free up more time for IPs (CHSP targets will still be worked towards).
- Limited offering of home visits for CHSP patients, where appropriate. (current)
- Reduced intensity of inpatient rehab when insufficient staffing : patient ratios. Depending on caseload/staffing, active high priority rehab patients may only be seen x1 daily if capacity allows. Lower priority active patients may be seen less frequently, but will aim for 3x per week.
- SP will not attend PJB if there are no active patients on the ward (e.g. ARU).
- Nil BCHC service provision (current)
- Student placements by exception only (current)
- SP HOD to co-share NAH meeting attendance with level 1/2 SP

Annexure B

The control measures as outlined below are suggested to be modified, as below:

New patients will not be seen after 3.45pm (urgent referrals may be considered based on clinical judgement).

Response:

MVH Executive and the NSLHD Executive Director of Allied Health, do not support the blanket rule that no new admission will be seen after 3.45pm.

Proposal:

New patients arriving to the ward after 3.45pm will be triaged to see if they can wait until the morning for assessment with no clinical risk – if a patient needs to be seen and the clinician is required to stay beyond the end of their shift due to clinical concerns, the clinician will be given Time in Lieu or be paid over-time. It is noted that this is likely to be an exceptional circumstance.

N&D: Capping of patients per clinician - Level 1/2 capped to 7 active patients (6 if one is an enteral feed) - a new admission would be seen based on priority however a patient of lower priority would be "discharged" from the list to cap at 7. Capping of HOD caseload at 2 active patients.

OT, PT, SW to consider capping.

Response:

Although MVH Executive and the NSLHD Executive Director of Allied Health strongly supports a manageable caseload for all staff, they do not support a rigid capping of patients per clinician.

Proposal:

MVH Executive supports the continued use of Departmental Clinical Priority documents to manage caseload. The number of patients seen on any given

day is dependent on the case mix and requirements of the given caseload on that day.

As per Speech Pathology control measures, clinicians can reduce intensity/ length of time of intervention: see lower priority patients less frequently, for example.

As always, please don't hesitate to raise any concerns on the above with Jane or myself.

Regards,
James Stormon