Working Together Pilot Project Report & Implementation Guide

December 2020

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Executive Summary

This report presents an evaluation of the Working Together project (the Project). The objective of the project was to co-design, trial, and evaluate improved nursing and midwifery workload allocation and management practices at pilot sites while working within the prescribed nurse/midwife to patient ratios outlined in the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015 (the Act), and keeping with requirements of the current enterprise agreement.

The design and pilot implementation of the project was funded by the Department of Health and Human Services (the Department) in response to reports of challenges associated with workload allocation and management being faced by nurses and midwives working within Victorian public health services, the Department of Health and Human Services (the Department) agreed to fund the design and pilot of the Working Together project. This project aimed to explore and address these workforce challenges and contribute to the Department's strategic priorities, providing person-centred care and sustainable services, and improving workforce availability, capability, collaboration, leadership, wellbeing and engagement.

The project was jointly implemented in one Victorian regional public health service (Northeast Health Wangaratta) and one Victorian metropolitan public health service (Western Health). Western Health was the lead organisation. The two pilot sites worked in partnership and with a university evaluator (Deakin University).

The project was evaluated to determine to what extent the objectives and outcomes of the pilot were achieved and to inform decisions about the value of expanding the project to other health services. The evaluation included three components at each of the project sites (Western Health and Northeast Health Wangaratta):

1. Data audit of key measures;
2. Pre- and post-implementation surveys; and
3. Pre- and post-implementation interviews.

The implementation and evaluation of the Working Together project was affected by several adverse events including bushfires in regional Victoria (January 2020) and the COVID-19 pandemic (since March 2020). Nevertheless, a comparison of the pre and post-implementation data indicated:

- An improvement in the quality of patient care, as perceived by nurses and midwives;
- An increase in the proportion of nurses/midwives who indicated that they will continue to work as a nurse/midwife;
- An increase in the proportion of nurses/midwives who believed their hospital is a good place to work;
- An increase in nurses' and midwives' job satisfaction;
- A reduction in nurses' and midwives' role ambiguity, and
- A reduction in the number of missed elements of patient care, and adverse events at the project sites.

The preliminary findings align with the rationale for the Working Together project.

Nurses and midwives who participated in the evaluation overwhelmingly identified the importance of and need for appropriate workload allocation which considers patient acuity and skill mix, and ensures sufficient numbers of nurses/midwives to manage the workload and provide high-quality patient care while simultaneously promoting staff satisfaction.

The bushfires and the COVID-19 challenges in Victoria during the Project reduced the time available for nurses/midwives to implement their chosen initiatives and for the program's effects to fully emerge. It is recommended that the implementation of the project at other health services in the future allows sufficient time for initiatives to be implemented and that pre and post-implementation evaluation data collected so that any changes resulting from the project can be captured.

Introduction

Context

Health services such as Western Health (WH) and Northeast Health Wangaratta (NHW) have and continue to experience significant nursing and midwifery workforce issues such as difficulties with recruitment and retention of skilled nurses and midwives in speciality areas such as emergency care, critical care, maternity services, special care nursery, and aged care. As a result, health services can resort to using high levels of casual agency staff to help bridge the gap. Combined with continuing decrease of inpatient length of stay, and increase in patient complexity and acuity at Western Health and Northeast Health Wangaratta have resulted in an increased requirement for patient specialling; this has significant financial impact. Staff sick leave is traditionally higher than that of other health professions, and the usage of the casual workforce is a constant attribute within nursing and midwifery team. All of these factors contribute to nursing and midwifery teams at Western Health and Northeast Health Wangaratta being at risk of experiencing unsustainable and unachievable workloads; erosion of teams; poor transfer of knowledge from experienced to less-experienced clinicians; and decreased job satisfaction, personal and mental well-being. These factors all have a potentially detrimental impact on the prevalence of missed elements of patient care (which affect the patient experience); nurse/midwife satisfaction and engagement; the ratio of part-time and full-time staff; nurse/midwife retention and sick leave rates; and the use of additional unplanned and unbudgeted resources.

The Working Together project has involved the co-design, trialling and evaluation of improved nursing and midwifery workload allocation and management practices at Western Health and Northeast Health Wangaratta, while working within the prescribed nurse/midwife to patient ratios outlined in the Act, and in keeping with requirements of the enterprise agreement.

The Working Together project aimed to improve the working lives of nurses/midwives and decrease any fundamental elements of care that are missed in the current paradigm of their work by:

- Undertaking sector-wide consultation with Directors of Nursing and Midwifery;
- Developing an evaluation plan;
- Developing a comprehensive communication strategy;
- Establishing a project steering committee;
- Developing and implementing an action-learning leadership program for Unit Managers;
- Developing a comprehensive co-design based change management strategy; and
- Developing resources and toolkits.

Expected outcomes of the project included improved workforce capability, well-being, and availability, and patient care at Western Health and Northeast Health Wangaratta. The model proposed that better workload management, a more productive work environment, and work satisfaction that comes from providing a high standard of clinical care would help improve retention and keep highly-skilled and dedicated nurses and midwives in the workforce.

This report aims to present an evaluation of the Working Together Project to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved, and inform decisions about expanding the project to other health services.

Program background

Nursing & Midwifery professionals are the largest health workforce in Victoria and play a key role in delivering high-quality healthcare and improving outcomes for the Victorian community. However, the workforce continues to experience challenges from increased patient acuity and complexity, changing patient needs and expectations, and resultant workload allocation and management practices. Impacts are seen in terms of service delivery, teamwork, preceptoring, and workforce participation and availability.

A shortage of nurses is being experienced in Australia and other high-income countries, and there is evidence of decreasing job satisfaction and retention of nurses (Tran et al. 2010). Job dissatisfaction among hospital nurses in the USA has been found to be four times greater than that of an average worker, and one in five nurses report that they intend to leave their current job within one year (Aiken et al. 2001). Nurses and midwives leave the profession for various personal and professional reasons including burnout and stress (Duffield & O'Brien-Pallas 2002); feelings of overwork (Australian Health Workforce Advisory Committee 2004); and difficulties providing their desired quality of care. If nurses and midwives feel valued, in control and; supported by their employer, and are provided with career opportunities they are more likely to remain in the workforce (Deravin et al. 2016) and less likely to develop compassion fatigue, anxiety, depression, stress and burnout (Hegney et al. 2013).

Various models for the delivery of nursing and midwifery care such as patient allocation, primary nursing and team nursing have been implemented over the past few decades (Fairbrother, Chiarella & Braithwaite 2015; Fernandez et al. 2012). Nevertheless, there is mixed evidence about their effectiveness on patient and staff outcomes. A systematic review on the effect of various models of care found that the team nursing model (group of nurses caring for a large group of patients for one shift) resulted in significantly decreased incidence of medication errors and adverse intravenous outcomes, as well as lower pain scores among patients. However, there were no significant differences in nursing outcomes relating to role clarity, job satisfaction and nurse absenteeism rates among any of the models of care investigated (Fernandez et al. 2012). However, another systematic review concluded that it was not possible to determine whether team nursing or total patient care models were more effective in terms of staff wellbeing (e.g. job satisfaction, stress levels and staff turnover) in acute care settings due to the limited amount of research conducted in this area (King, Long & Lisy 2015). The latter review was also unable to ascertain if the type of model of care affected absenteeism or burnout as these factors were not investigated in any of the identified studies, and recommended that further research was needed (King, Long & Lisy 2015).

The *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (the Act) legislates minimum levels of nursing and midwifery staffing for patient care in certain areas of Victorian public health services. A hospital operator is obliged under law to meet the requirements of a nurse to patient ratio or midwife to patient ratio or ratio variation. The ratios can, however, be implemented in a flexible way, and while considering the care requirements of individual patients. Therefore, in some

circumstances, one nurse or midwife may be responsible for caring for fewer very unwell, complex patients, while another nurse or midwife may care for more patients who require less complex care.

In response to reports of challenges associated with workload allocation and management being faced by nurses and midwives working within Victorian public health services, the Department of Health and Human Services (the Department) identified a need to explore and address these workforce challenges. As a result, the Working Together project was established and funded by the Department. The project also contributes to the Department's strategic priorities of providing person-centred care and sustainable services, and improving workforce availability, capability, collaboration, leadership, wellbeing and engagement.

The aim of the Working Together project was to co-design, trial and evaluate improved nursing and midwifery workload allocation and management practices at pilot sites, while working within the prescribed nurse/midwife to patient ratios outlined in the Act, and in keeping with requirements of the current enterprise agreement. In order to determine if there were any differences or similarities (in project outcomes) between metropolitan and regional health services, the project was jointly implemented in one Victorian regional public health service (Northeast Health Wangaratta) and one Victorian metropolitan public health service (Western Health). Western Health was the lead organisation. The two pilot sites worked in partnership and with a university evaluator (Deakin University).

The objectives of the project were to:

- improve the effectiveness of nursing and midwifery workload allocation and management at Western Health and Northeast Health Wangaratta;
- increase hours worked, and reduce nursing and midwifery workforce sick leave, turnover, and use of agency, overtime and supplementary staffing, at Western Health and Northeast Health Wangaratta; and
- develop and disseminate resources to improve nursing and midwifery clinical workload allocation and management to other Victorian public health services.

Both Western Health and Northeast Wangaratta have experienced and continue to experience significant and similar nursing and midwifery workforce challenges such as the recruitment and retention of skilled nurses and midwives in specialty areas such as the Emergency Department, Critical Care, maternity services, special care nursery, and aged care.

For Northeast Health Wangaratta this resulted in the active recruitment of international registered nurses to meet their current patient activity. Western Health used high levels of agency staff to help bridge the gap. Historically, Northeast Health Wangaratta had not engaged agency nurses but had to utilise these services to meet maternity service needs; this resulted in significant financial impact. The increase in complexity and acuity at both Western Health and Northeast Health Wangaratta resulted in an increased requirement for patient specialling, which also has a significant financial impact. Sick leave and the usage of casual staff has increased year on year, requiring further analysis, as current projections were unsustainable.

The models of care and allocation of work practices within nursing and midwifery teams at both Western Health and Northeast Health Wangaratta are informed by the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* and the Enterprise Agreement. Whilst they meet the requirements of both the Act and the Agreement, they have evolved over time and there were concerns from staff and their leaders about the ways the nursing and midwifery teams worked:

- Unsustainable and unachievable workloads: the methodologies widely used to allocate nursing/midwifery work did not allow for reliable, predictable and achievable workloads. They were widely based on geography, patient numbers, and bed numbers, and did not take into consideration patient complexity, acuity, skill mix of staff, or expected activity. This resulted in the inconsistent quality of care delivery to patients and contributed to missed elements of care.
- Erosion of team: the models of care previously in place resulted in nurses/midwives working as a sole practitioner confined to their allocated room/zone. These models did not support the even distribution of workload. They also did not support staff to be able to easily access support/assistance, have confidence that their patients would be cared for whilst they were on a break, or allow for realignment of resources/effort as demands change.
- Poor transfer of knowledge from experienced to less-experienced clinicians: the manner in which nurses/midwives are often allocated work often results in them working in isolation, this has had a detrimental impact on the ability of more experienced nurses/midwives to teach and support their more inexperienced colleagues and transfer knowledge/wisdom.
- Decreased well-being and mental health: with continual demand on the capacity of the frontline nursing/midwifery workforce, nurses and midwives face persistent occupational stress through churn/demand, complexity, and fast-paced work. If not addressed, this can result in poorer mental health and well-being.

Investigation of these matters by Western Health, with their nurses and midwives, identified that they were having a detrimental impact on:

- The prevalence of missed elements of care - impacting on patient experience
- Nurse/midwife satisfaction and engagement
- Nurse/midwife mix of part-time/full-time – with reports that nurse/midwives reduce their contracted hours as a result of these issues.
- Nurse/midwife retention rates
- Nurse/midwife sick leave rates
- The utilisation of additional unplanned and unbudgeted staffing resources

The previous models of patient allocation/patient care appear to have predominantly stemmed from:

1. An overly-simplistic and incorrect interpretation of the ratio requirements under the Act. The ratios are not the issue, as they allow for inherent flexibility; however, the over-simplistic allocation of 1:4 by the 'in-charge' respective of the patient care requirements, their complexity, or the skill/experience of the nurse/midwife is a significant factor of the concerns mentioned above.
2. A lack of critical thinking relating to patient complexity, acuity, and skill mix. This likely occurred when nursing/midwifery managers (or their delegate) believed that they had to allocate 1:4, and so they were not in the habit of assessing competing needs when it came to the allocation of

work or development of models of care. They were also not supported to make different allocations.

3. A perceived lack of permission (from their manager and leaders) or ability for Unit Managers to implement alternative models of care to address these issues.

Scope of the project

The Working Together pilot project was funded by the Department of Health and Human Services, Victoria, primarily to address challenges associated with the nursing and midwifery clinical workload allocation within Victoria public health services. The pilot project was implemented in two health services, Western Health (lead service) based in western metropolitan Melbourne and Northeast Health Wangaratta, based in Wangaratta in regional Victoria.

The project was intended to occur in multiple teams across two health services simultaneously in order to understand any differences in implementation between two services, what outcomes/learning might be transferrable to other health services, and also compare and contrast the implementation and outcomes of the project in a metropolitan health service and a regional health service.

A Registered Nurse was employed as a full-time project manager at each site, commencing in February 2019. Co-design was used as the project methodology in order to ensure the voice and preferences of the nurse and midwife were valued and heard during the development and trialling of strategies. The project teams were assisted by an external consultant (Linda Betts & Associates) to learn about co-design but they determined their own initiatives and strategies. .

Each health service managed the nomination and selection process of the pilot wards independently of each other with the commonality being that Unit Managers opted in to become a pilot ward following an expression of interest process.

Table 1 Pilot wards at each Health Service compared to non-pilot wards

	Western Health	Northeast Health Wangaratta	Total wards
Pilot Wards*	14	7	21
Non-pilot wards	86	12	98

*The term 'wards' is used in this report to describe wards, departments, units and includes areas where patients received day treatments or stayed overnight

Unit Managers from twenty-two (22) teams across the two sites, expressed interest in trialling strategies as part of the Working Together project and all participated in the pilot project until the conclusion apart from one team. The Unit Manager from this team opted out of the project after participating in the first workshop with the reasons for withdrawal including being new to the Unit Manager role and managing many changes in her unit at the same time. This Unit Manager and her team did not request to opt back into the pilot.

Table 2 Pilot wards categorized by patient type

Pilot ward patient group	Western Health	Northeast Health Wangaratta
Adult Medical	6	1
Adult Surgical	-	1
Subacute	-	1
Rehabilitation	1	-
Transitional Care	-	1
Critical Care (CCU/ICU/ED)	3	2
Women's Health (maternity)	2	1
Ambulatory	2	-
Perioperative Services	-	-
Paediatric & Neonatal Services	-	-
Mental Health Services	-	-
Home & Community Services	-	-
Total wards	14	7

At both sites, the pilot wards included an intensive care unit, medical ward, and women's health services (including Birthing). Staff from perioperative, paediatrics, neonatal, community and mental health service teams did not volunteer to participate in the trailing of strategies.

Getting started

As this project is attempting to address cultural norms, beliefs, allocation methods and workload management practices that has evolved over decades, Western Health and Northeast Health Wangaratta believed that a comprehensive strategy and program that aimed to address these issues was required. Both services were cognizant that this program of work was a significant project, as it was attempting to change long-held beliefs and culture and would take extensive planning and consultation, careful implementation along with an evaluation to be successful. To meet this requirement, working in partnership, the proposed approach included:

- Sector-wide consultation: Western Health and Northeast Health Wangaratta engaged with the sector more widely through the established Executive Directors of Nursing & Midwifery (EDONM) and Directors of Nursing & Midwifery (DONM) groups at key points in the project, including planning, commencement, and preliminary evaluation to seek input, views, learning from previous work and opinions to inform the approach, and ensuring that the methodology and plan was replicable and meets the needs of the sector more broadly.
- Independent evaluation: Western Health had an established and productive relationship with Deakin University with an active Professorial Chair of Nursing role in place and as such Deakin's commitment to assist with the development of the evaluation and research approach for this project. This included a literature review, ethics application, retrospective and prospective data analysis of key metrics and organisational records, semi-structured interviews, surveys and focus groups with nurses/midwives, managers and stakeholders to enable the measurement of the impact on the project on nurses/midwives and key metrics.

- Development of a comprehensive communication strategy that addressed the risk, issues, and needs of all internal and external stakeholders.
- Robust project governance: a project steering committee was established and included key representatives from Western Health, Northeast Health Wangaratta, and the Department. Key external stakeholders including the Australian Nursing & Midwifery Federation (ANMF) were invited to join the committee but respectfully declined the invitation. This Committee was chaired by the Western Health EDONM.
- A detailed project plan and associated reporting methodology were developed.
- Development and implementation of an action-learning component for Unit Managers which enabled them to be involved in the co-design, development, trialling, implementation, and evaluation of an alternative model of workload management. Additionally, this component of the program intended to develop their critical thinking capacity and covered aspects including change management, project delivery, and strategic thinking. The program aimed to not only implement any new workload management solution but also enhance the capability and capacity of this important group in leading and managing the nursing and midwifery workforce.
- Development of resources and toolkits to allow for informed replication and extension of this work into other health services across Victoria.

The aim of this strategy and program was to make a positive impact on the working lives of nurses/midwives and in doing so decrease any fundamental elements of patient care that may have been missed in the current paradigm of their work.

Assessing Need

Focus groups for nursing and midwifery staff were held in July 2019 to ascertain nursing and midwifery staff views and experiences of working at their respective health services (Western Health and Northeast Health Wangaratta). The themes from the focus groups were shared with the attendees at the co-design workshop.

The responses from the focus groups elicited rich qualitative data about the current pressures and challenges impacting front line teams. During the co-design workshop the Unit Managers were specifically asked for their feedback on the focus group themes and while they were not 'surprised' by the commentary received, they appreciated having contemporary and independently gathered data to further inform their thinking. The combined focus group data validated their ward-based views and experiences.

Focus groups were held across three Western Health hospitals in July of 2019 and attended by 66 nursing and midwifery staff including registered nurses (RN), registered midwives (RM), enrolled nurses (EN), Associate Nurse Unit Managers (ANUM), Associate Midwifery Unit Managers (AMUM), Midwifery Unit Managers (MUM), and Nurse Unit Managers (NUM) in both permanent and casual roles. Nearly 50% of attendees were from the wards that would go on to pilot strategies with the remaining attendees from wards & units that were not part of the pilot. Staff volunteered to attend the focus group sessions which were held during the day (it was not possible/feasible to hold focus during the evening for staff who were working night shifts or the weekend), Monday to Friday across

three hospitals (Sunshine Hospital, Footscray Hospital & Williamstown Hospital). The focus groups at Western Health were facilitated by members of the health service's in-house Organizational Development team and the 'Working Together' project officer also attended in order to provide context for the study. The focus groups were audio-recorded and transcribed. The transcript with de-identified responses was used to identify the main themes.

Two focus groups were held at Northeast Health Wangaratta at different two sites (Illoura Aged Care and the main hospital campus). These focus groups were facilitated by an external organisation with the Project Officer from Northeast Health Wangaratta hosting the session and the Western Health Project Officer supporting.

It was originally intended that the same external facilitator would be used for the focus groups at both sites with the Northeast Health Wangaratta participants attending virtually via an online platform. However, due to an unstable and unreliable internet connection between the two health services this was not possible and it was also decided by the project team that it would be more beneficial for NHW staff to attend a focus group in person.

Table 3 – focus group attendance numbers, method, and number of focus group sessions

Health Service	Number of sessions (July 2019)	Number of participants
WH	5	62
NHW	2	49
Totals	**7**	**111**

During all focus groups, nurses and midwives freely and willingly shared their views and experiences of working.

Sixteen (16) questions were asked in the focus group (Appendix 17) and commenced with the nurses/midwives being asked to describe the things that don't work for them that contribute to a work day being challenging, followed by what makes a day challenging for their colleagues.

The summary of key issues contributing to a 'bad work day' included:

- Poor communication (within multi-disciplinary team)
- Not enough staff; especially not experienced staff
- Higher acuity than expected/anticipated
- High number of admissions
- Feeling burnt out
- Multiple patient/bed moves during the shift
- Lack of equipment

Staff were asked to describe their nursing or midwifery workload in one word with many terms used to describe their workload including: fluctuating; tsunami; frustrating; exhausting; overwhelming; relentless.

Despite the strong adjectives used to describe the workload, staff were able to state why they returned to work for their next and subsequent shifts including:

- Love of nursing; Love of taking care of people
- Supportive team; friends work here; like the people
- Doing your best; a sense of community
- Being paid; holiday and sick leave

Staff were also asked to describe occasions of care that they had not been able to provide, but had wanted to; and then this was retrospectively compared to patient-reported missed elements of care in the literature (Kalisch, Xie & Dabney, 2013). There was significant alignment between the focus group responses and the elements reported in the study by Kalisch, Xie & Dabney (2013) including mouth care, bathing, discussion about tests and procedures, and talking with patients.

Table 4 – Reported missed elements of care vs literature

	Kalisch et al (2013)		Western Health Focus Groups (2019)
1	Mouth care	1	Teeth
2	Ambulation	2	Documentation
3	Moving patients out of bed	3	Talking to patients
4	Discussion about tests/procedures	4	Prevention strategies
5	Bathing	5	Wash or shower
		6	Linen changes

The focus groups ended with questions ascertaining the components of a good day followed by any considerations or suggestions for making changes. A good day consisted of:

- Having breaks
- Beds and equipment being available
- Adequate staffing
- Good skill mix
- Minimal handover (referring to time and detail)
- Clear communication
- Additional people to be available for non-nursing tasks such as tuning TV, transferring patient phone calls, and unpacking stores

The group's recommendations to the project group included:

- That those on 'ground to be part of the solution';
- Involve the staff;
- Projects about nurses should be led by nurses.

The data from the focus groups confirmed that the project hypothesis was indeed correct. Although the models of care and allocations of work practices were informed by the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* and the Enterprise Agreement there were issues identified by the focus group participants about the ways teams worked together and how these issues were impacting on nurses and midwives such as:

- The workload was unsustainable and unachievable
- The concept of ‘team’ and ‘teamwork’ was being loosely interpreted and not visible
- Skill mix was not optimal
- Nurse and midwife wellbeing and health were at risk

Design and methodology – co-design principles

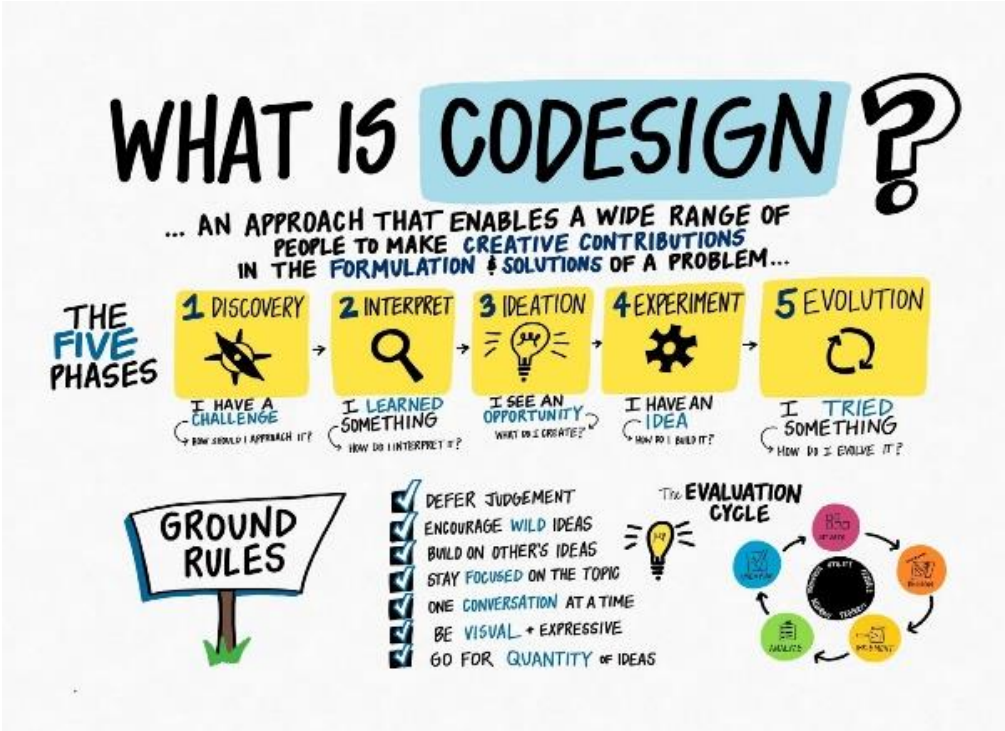
The project aimed to identify nurse and midwifery selected strategies that would improve nursing and midwifery workload allocation and management practices within a twelve-month timeline. By intentionally using co-design methodology, we hypothesized that by using this methodology the workforce would feel more supported to choose and develop initiatives that had a higher chance of success, longer-lasting impact and change, and increase the likelihood of the strategies meeting the needs of nurses and midwives.

Co-design methodology is a well-known methodology in healthcare as an approach that enables a group of people, usually the service user's stakeholders, to actively participate in designing a solution to their problem. During the Working Together pilot, we intentionally used the term *co-design principles* as opposed to co-design, as the voice and preferences of the nurse and midwife were more heavily considered, as opposed to the voices of all other stakeholders and service users such as patients, clients, managers and other health professionals. Additionally, we intentionally did not consult these other stakeholders for their ideas to improve the ways that nurses and midwives could work together. Instead, we encouraged and focused on listening to nurses and midwives and assisting them in identifying and trialling solutions for their respective teams.

Working Together project participants (Unit Managers, Associate Unit Managers, RN and RM) were introduced to co-design methodology at two facilitated co-design workshop in July and August of 2019 – one each at WH and one at NHW. Unit Managers from the pilot wards were invited to attend the workshop along with 2-3 others from their teams including Associate Unit Managers, Registered Nurses & Registered Midwives. Content of the workshop included project background, context, sharing of focus group themes, group activities, introduction to co-design, use of Plan-Do-Study-Act (PDSA) cycle, and creative design models. The attendees were intentionally not directed towards the identification of particular solutions, models, or frameworks.

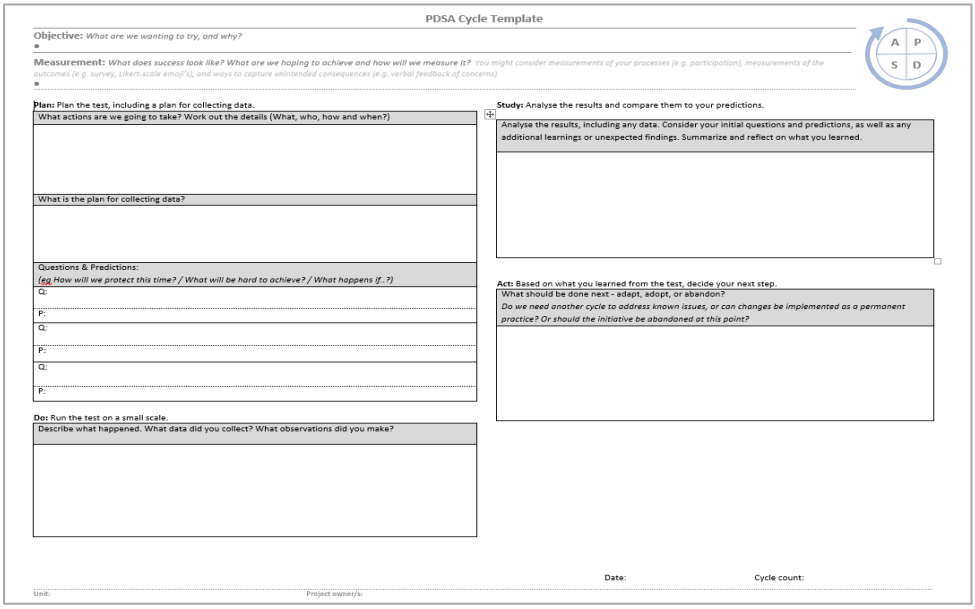
While most attendees were familiar with the concept of working with patients when redesigning parts of a health care service, they were not as familiar with co-design as a methodology or philosophy. The diagram from DME for Peace (https://www.dmeforpeace.org/breaking-barriers-human-centered-peacebuilding/retrieved July 2019) was one of the models used to visually explain the methodology in the workshop pre-reading recourses. The five phases from the DME for Peace (2016) infographic were applied informally during the workshop and reinforced over the proceeding months.

Diagram 5 – Co-design diagram (DME for Peace)



During the co-design workshop participants were re-introduced to the use of a PDSA template (Betts, 2019) to document their initial idea, move through the PDSA cycle in a structured way, and test and challenge their idea or proposed change before determining what modifications if any need to be made. Although many of the participants had used the PDSA cycle templates before, this had been in the context of quality improvement initiatives, and using the PDSA cycle template for small practice changes within their teams was novel.

Diagram 6 – PDSA cycle template



Following the co-design workshop, the Unit Managers were supported by the project officers to discuss their ideas (solutions) with their larger teams and then encouraged them to start trailing strategies.

Most participants left the co-design workshop with multiple ideas (strategies) that they planned to experiment with after further consultation/discussion with their wider, respective teams. However, a few participants needed additional assistance over the following month to firm up and choose strategies to implement. The chosen strategies included strategies that individual teams had tried before but without visible or demonstrable effects on their team; some participants were keen to attempt these again.

This stage of the project was led by the Unit Managers with minimal intervention by the two project officers to ensure that any strategies trialled were identified and enacted by the respective units. There was deliberate effort to not try to impose strategies the project officers believed would answer the pilot hypothesis. However, to ensure Unit Managers felt supported and that the project met with success, the project officers had brief, regular, pre-arranged check-in sessions with Unit Managers. During these catch-ups, the project officers were able to discuss the Unit Managers' ideas, talk about the proposed strategies, view any resources, notices, or guides that were being developed, and provide general support and encouragement. The Unit Managers participated in the project as part of their substantive role, which is standard practice in the public healthcare system. The check-in sessions between Unit Managers and project officers continued over five months and were supported by the circulation of relevant readings, resources, and emails and texts of encouragement.

It is challenging to quantify and describe the amount of support or the role that the project officers gave during this period as it varied between sites and also between departments/wards on the sites. However, during one of the post-project focus groups, a Unit Manager described their project officer as being the "queen of text support" which perhaps highlights the value that was placed on one aspect of support, the words of encouragement delivered via text messaging. The project officers believed that their role was to ensure that Unit Managers felt empowered to lead their teams and; make their own decisions, and encouraged them to initiate change at a unit level. Unit Managers were given permission, scope, and space to improve the workday for their nursing or midwifery staff using unique strategies. This 'permission for Unit Managers to 'lead their teams' was reinforced by the respective Chief Nurse.

Unit Managers at Northeast Heath Wangaratta were supported with an additional three short follow-ups sessions (October 2019, December 2019 & February 2020) which were facilitated by an external facilitator, the Clinical Services Director (Chief Nurse), or Project Officer. During these follow-up workshops, the pilot ward teams came together to explore and share the projects in each area. Each team presented the projects currently underway, their triumphs, barriers, what was working, and what didn't. They explored common threads from project outcomes, how to interpret failures, and ignite teams, to investigate the option to adapt other teams' work for further local adaption. Teams also explored planning for sustainability after the completion of the project and the concept of how an embedded project should be measured by ongoing review and adaption, rather than via a successful trial of three months. The Studer Group (2004) principles were reinforced during the

Northeast Health Wangaratta workshops by the Chief Nurse as these were an integral part of the local culture and were the foundation that would underpin any newly developed strategies.

The Unit Managers at Western Health attended a group follow-up workshop with their Executive Director of Nursing and Midwifery (Chief Nurse) in September 2019 where they presented their ideas and strategies to the group and received peer and leader feedback. The additional scheduled follow-up session in February 2020, with the external facilitator was cancelled due to a conflict with local priorities (COVID-19 planning).

Executive Sponsorship

As the Working Together project was addressing issues with the way nurses and midwives were working, and some long-held beliefs on interpretation of the Act and enterprise agreement, close and committed Executive sponsorship and leadership were important to achieving outcomes.

Executive sponsorship and support are pivotal to the success of any project and conversely the lack of support is often a common reason that a project may fail. The executive sponsor for the Working Together project was a member of the hospital Executive which meant the project was able to be championed at Executive level and then throughout the organisation. Despite the size of the pilot project at Western Health (14 wards out of 86), the pilot was mentioned in the monthly CEO report, monthly nursing and midwifery newsletter, monthly directorate meeting and at the local ward meetings. This messaging was important to ensure that staff were aware that nurse and midwifery wellbeing was important to the Executive and was reinforced by the Sponsors' accessibility and visibility during the project.

The Executive Sponsors ensured that the project officer was provided with the necessary counsel, training and tools to complete the project along with associated funding. At Western Health the project officer attended training on Microsoft Project, Co-design & Behaviour Change Models. Additionally, at Western Health requests for two extensions to the project were supported by the Executive sponsor and able to be funded locally. These responses signified commitment and support to the pilot and the project officers.

Another key role, the Sponsors played was to ensure the project officers and pilot wards remained faithful to the project methodology of co-design. While the methodology was pre-chosen, the strategies to achieve the outcome were not and the project officers were kept focused on the methodological approach, especially when they momentarily considered guiding the pilot wards towards a particular set of strategies that had appeared to work elsewhere. The sponsors believed that sustained improvements to nurses and midwives work day, would only be achieved if the changes that were adopted were actually used beyond the pilot period. Co-design methodology increased the chance of success through staff exploring and trialling solutions they believed would benefit them.

Governance

The project and the project officers were supported by a project steering committee that was chaired by the Western Health Executive Director of Nursing and Midwifery and met monthly from March 2019 to February 2020. Due to the geographical distances between the two healthcare sites (approximately 250 km) the meetings were held online via the Zoom platform. Other members of the steering committee participated in the meeting via Zoom from their workplace locations (the Department, Melbourne city; Deakin University, Burwood; Western Health, Footscray) and it was found to be a convenient and reliable platform.

The members of the steering committee were responsible for monitoring the project milestones and; key performance indicators, and resolving project risks and any issues escalated. Additionally, they contributed to program development and consultation, provided specialised information on best practices, and supported the facilitation of change at a local level.

Consultation

The relevant union that represented all the staff that participated in the pilot (the Australian Nursing and Midwifery Federation) was invited to be a member of the project steering committee. After attending the initial steering group meeting, the offer of being an ongoing member was respectfully declined.

As the relevant union was not represented at the steering committee, to ensure that genuine consultation was undertaken throughout the pilot both participating health services ensured that the project was a standing item at their regular consultative meetings with the Australian Nursing and Midwifery Federation. Progress of the project, updates, any relevant risks or issues and outcomes were shared through these meetings; with the opportunity to provide feedback, raise concerns or seek further information.

Communication Plan

Implementation of the project was guided by a formal communication strategy, developed for the project by an Australasian based independent consultancy firm. The communication strategy covered the key milestones of the consultation and co-design process along with communication tactics and suggested channels.

The three key goals of the communication plan were:

1. To position the Working Together pilot as a valuable and beneficial process that empowers nurses and midwives to make available staffing levels work for them and their patients.
2. To drive nursing and midwifery staff participation in and engagement with the consultation and co-design process for Working Together.
3. To support the Working Together Project with clear, timely, and targeted communication that lays the groundwork for staff acceptance of, and participation in, the trial.

The approach focused on the development of a core story that could be communicated across all target audiences; segmenting audiences so that communication could be tailored to their specific

needs; encouraging the flow of messages both outwards, radiating from the Working Together Project team, and across Western Health and Northeast Health Wangaratta.

The three communication objectives were:

1. To communicate the opportunity and rationale for the change to build stakeholder awareness and understanding.
2. To generate critical stakeholder cooperation and participation to ensure successful delivery of a co-designed Working Together pilot and engage them in the process, address questions and concerns, and minimise issues.
3. To support the project with clear, timely, and targeted communication to inform stakeholders of the co-design process and trial.

To support the communication plan visibly, a project logo was developed and was intentionally branded without a tagline to not pre-empt the co-design solutions and strategies. The logo (pictured right) has an icon of a 'W' that is the interconnection with circles above to represent three people interacting with one another. The bright colours were chosen for their sense of joy and brightness.

The logo was used on resources and documents used by the Unit Managers, the steering committee, on any presentation resources, and in the email signatures of the project officers. It is anticipated that the Working Together logo (and a tagline) will be used by the future rendition of the Model of Nursing & Midwifery Care at Western Health.

The communication plan was operationalised and updates of the Working Together initiatives were shared with the respective managers of the Unit Manager, their professional leads, and the wider nursing and midwifery workforce through pre-existing communication channels.

Putting it all together

The project methodology of co-design meant that units were encouraged to try and experiment with ideas or strategies that the team and Unit Manager believed would assist them in having a better workday and be able to provide improved care. Most unit managers (and their teams) left the first co-design workshop with multiple ideas they could try to improve the workday including a revamping of things they had tried previously.

Unit Managers were directed to trial and evaluate strategies at a unit level, after consulting with their wider team, and how they did this varied between teams. Some faithfully used the PDSA templates supplied at the workshop and documented each step, reassessed and evaluated, while others used large sheets of 'butchers' papers' to brainstorm ideas or discussed them at ward meetings before trialling. A few teams at each site revamped and revised strategies that they had tried before but this time, they introduced the strategies as a change that was putting nurse or midwife wellbeing at the centre. The staff members who had tried to change practices before appreciated the support and encouragement from the Unit Managers to pursue their proposed changes.

Assembling a puzzle without a picture on the box.

During this part of the project, the project team described the final strategies as being like pieces of a jigsaw puzzle. To achieve results from Working Together, just like no one piece will reveal the picture, no single initiative will achieve the intended outcomes.

Continuing with the analogy, the border pieces (easy to find and are needed to place other pieces), were important foundational initiatives – without addressing these issues the intended outcomes would be elusive.

Middles pieces (satisfying once discovered, and helping to create the overall picture) were initiatives that added value only once foundational elements were addressed.

Teams on the pilot wards/departments identified the core foundational elements that need to be working well for a team to be high-functioning included:

- Handover
- Staff allocation (and reallocation during the shift as required)
- Team nursing
- Intra-shift wellbeing checks
- Ensuring breaks occurred
- Leaving on time and together
- Proactive nursing
- Optimizing use of double staffing time

Other elements that were identified by teams as ideas, and therefore important to address but would be unlikely to reap rewards if there were unresolved issues in foundational elements included:

- Staff ideas box
- Knowing who we are working with (staff photo boards & skill level ID badges)
- Standardized 'in charge' handover / duty sheets
- Consistent use of patient bedside communication/white boards
- Lean ward (clean and tidy ward)
- Staff wellness initiatives (celebrations, acknowledgments, toiletries)
- Department/team charter

Missing pieces

Staff at workshops and focus groups identified some pieces were missing from their strategies and they would be keen to explore solutions to the related problems in the future. They raised problems that if resolved, would also be able to improve the work day of a nurse or midwife. These problems or challenges included:

- New and innovative patient discharge solutions
- Managing perceived tension between early patient discharge time (access) and the plan for the day developed between the patient & their nurse
- Nursing & Midwifery lounge area (rest area) with break/sleep chairs
- Acuity tool to assist with patient allocation

Example:
An example of a suite of strategies that fitted this analogy was the unit that started with ensuring their staff bathrooms had toiletries for the staff to use while on duty, along with words of affirmation displayed on the mirrors and posters. This was starting with a centre piece of the jigsaw rather than a foundational element. Whilst the toiletries meant that the staff were indeed able to freshen up during the shift and perhaps feel buoyed when reading the affirmation, it alone was unlikely to make tangible positive impact whilst foundational elements (edge pieces) were not addressed.

However, the Unit Managers knew that these alone didn't meet the goal of enabling staff to feel supported and listened to, so they moved on to their next strategy. Their next strategy was the introduction of timely, informal debriefing by their staff members. This debriefing was in addition to the formal EAP service funded by the health service and provided a forum for staff to feel supported in a timelier, responsive manner. Staff expressed interest in becoming support leads, received training, and then were available during the shift for staff to debrief with a peer. The support leads were able to refer staff to more formal EAP as required and if requested.

Both health services highly valued the facilitated co-design workshop, as the facilitator played a pivotal role in the development of the initial co-designed strategies by linking the current reality (focus group themes, industry data, community context) with future directions (predictions and trends). Partnering with an external provider for their expertise was a key learning during the project. Utilising the co-design methodology principles enabled the teams to identify what problems or issues reported by their staff mattered the most to them and how they would attempt to solve them.

At project initiation, we assumed that teams would all seek to improve their allocation process and shift management process in a direct manner. However, most teams at Western Health approached this less directly and aimed to create an improved allocation process. Only one team used allocation practices as a focus for their ward project. Using the co-design methods all other teams chose different challenges to focus team attention on transformational change. Interestingly, Northeast Health Wangaratta nurses had been using Team Nursing as the model of care in ward environments before commencement of the Working Together project and each participating team wished to continue using the team nursing model.

Co-designed initiatives

Whilst a core element of the Working Together project was co-design and empowering Unit Managers to lead and teams to identify, design, implement and evaluate their own strategies, there were many similarities between issues and initiatives developed across the pilot wards/departments.

These are provided to give readers an insight into work that was undertaken to achieve the outcomes described in the evaluation section below; however a core part of the success of the project was the utilisation of co-design and the development of the Unit Manager group through the project.

Although not led to any specific areas of focus, the teams on the pilot wards/departments identified the same foundational elements of Working Together that need to be working well for a team to be high-functioning. Whilst each initiative or improvement varied in different wards/departments, each successful element addressed these foundational elements mentioned earlier, included:

- Handover
- Staff allocation (and reallocation during the shift as required)
- Team nursing
- Intra-shift wellbeing checks
- Ensuring breaks occurred
- Leaving on time and together
- Proactive nursing
- Optimizing use of double staffing time

The foundational elements and their components are described primarily to assist other healthcare services with future trials of the strategies and methodology and should not be used as a recipe for success. The elements will seem familiar to most healthcare services and are certainly not original or novel but the key point of difference perhaps, is that the Unit Managers chose to trial these strategies with their teams and adapted them to meet local needs. Most would also highlight that the strategies weren't rolled out with posters and promotional tool kits but rather led by the local champion (the Unit Manager).

1. *Handover*

   Handover was considered to be an important strategy to nurses and midwives because if done correctly, it allows staff to leave their shift on time as well as continuing to meet professional standards and expectations. The pilot's wards were familiar with the components of handover, structure and the legal responsibilities of handover but were frustrated with how long handover took and the flow on effect this had on patient care and their own personal lives. Double staffing time was available between the morning and late shifts in the 8 hour shift wards but not available on any other shifts so maximising the 30 minutes available was important. An example of how one ward improved their handover processes and as a result allowed staff to leave on time, is outlined in the example box below.

Example:

One medical ward (medical ward 3) focused on improving staff handover primarily to enable their staff to leave work on time and in doing so would ensure that relevant patient information was also consistently handed over. They believed that their staff were often late in leaving due to handover going longer than planned or needed and by improving the structural process, they would see if their hypothesis was correct.

The NUM worked in partnership with an ANUM for this strategy and developed draft standards for the ward handover which were typed on A4 size guides and placed on the wall of the handover room. Prior to the sharing of the idea with the staff, the duo shared their plan with the other ANUM's and gathered feedback and support.*

The A4 size guides were typed on a computer and printed in black and white (low cost, low tech due to the PDSA cycle being in progress). The notes included information about the start times, target duration, content to be covered in the group handover and content to be covered in bedside handover. It also specifically mentioned that two nurses (team) were to receive handover of both their patient allocations and not just their own single load. The patients were expected to be included in the bedside handover if awake. Like many hospitals in Victoria, this unit was very familiar with ISBAR/ISOBAR handover framework and the use of an EMR to document handover but the formalized structure and focus on efficient use of nurse time was novel. The draft guide also recommended that one nurse update the EMR during the bedside handover and the other complete the safety checks and update the patient white board (communication board) with the help of the patient. This was an intentional strategy to ensure 'team nursing' happened for all aspects of patient care and not just with tasks that required two or more nurses. The NUM was able to confirm that the guide did help her team and enabled "early home times and proper transfer of accountability between professionals" (Medical Ward NUM). A staff member felt that this strategy and concern for her home time (going home on time) meant that the "leaders on my ward are making an effort to keep the ward a positive workplace" (Medical Ward Nurse).

This medical ward became a key ward for the treatment of COVID-19 positive patients during the pandemic and needed to adjust their strategies to meet COVID safe work practices. These included moving the handover to the patient day lounge (larger space); putting a door on the day lounge (soundproofing); allocating seating and standing spaces for the staff in the day lounge; reducing the bedside handover from 4 nurses/1 patient to 2 nurses/1 patient. The focus on going home on time and working in a team remained and the medical ward NUM was pleased to report that positive work place score (Unit Manager Pulse Survey) improved from 70% (January 2020) to 80-90% (August 2020).

** The ANUM was promoted to Unit Manager of a newly formed COVID-19 Ward during the COVID-19 pandemic and introduced the structured handover tool to their new ward and team. This Unit Manager trialled some extra components including staff leaving the shift together, a mailbox for posting suggestions to the Unit Manager and leaving the shift with an intentional acknowledgment from the ANUM. Often this acknowledgment was in the form of a round of applause from the Unit Manager and ANUM, for all of the nursing staff as they exited via the staff hallway. This acknowledgment was well appreciated after a shift wearing COVID- safe PPE*

2. *Staff and Patient Allocation*

   Within the state of Victoria, the allocation of patients is guided by the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* and this piece of legislation was adhered to during the pilot. What was explored by some pilot wards was strategies on how to allocate patients to staff based on patient acuity as opposed to geographical nursing (allocation based on bed or room numbers). Many wards had pre-determined patient allocations and this was visible on staff white boards or even on paper and electronic

handover sheets in the form of room numbers (e.g. Team A Rooms 1-4, 5-8; Team B Rooms 9-12, 13-16 etc.). Pre allocating staff to patient rooms made no concession for patient acuity or skill mix considerations and this was a source of frustration by staff in the focus groups. Pilot wards that trialled different allocation methods, focused primarily on adhering to the ratios within the concept of team and trialled team size, swapping between teams of 2 and 3. This was operationalized with the allocation of team of 2 or 3 nurses for example caring for 8 or 12 patients (1:4 ratio). The geographical structure of some wards posed challenging with staff requesting that they care for patients geographically located together to maintain line of sight and within earshot. No unit chose to develop a patient acuity tool to guide their allocation practices and staff identified in focus groups at the end of the pilot that the development of an acuity tool would further assist in helping their work day.

3. *Team Nursing*

Most units believed that they were already working in small teams before the pilot and the evidence of the team members' names were evident on allocation sheets and staff white boards. During the pilot, teams' trialled working in teams of 3 instead of 2 or teams of 2 instead of 3 to see if the team composition made a difference to the work day. However, most teams continued to work with the same number of people at the end of the pilot as they had at the beginning as the numbers in the team didn't seem to make a significant difference. What was altered in the team concept, was the behaviours of the team members receiving handover, in that all members of the sub-team received handover from the preceding sub-team as opposed to primary nurse only handover.

Teams also ensured that each team member knew who they were working with (name and skills) by introductions during the handover. Introductions were not required if all members of the team knew each other (e.g. no Bank, Pool or Agency Staff). Two wards also trialled the use of stickers attached to name badges which identified their higher level of skill such as a post-graduate specialty qualification. The primary purpose of the sticker was to ensure newly graduated staff or staff new to the specialty would be able to easily identify another staff member with local and specialty knowledge.

4. *Nurse/Midwife in charge responsibilities (breaks, intra-shift wellbeing checks, leaving on time*)

Many of the smaller strategies are clustered under this category of 'nurse in charge responsibilities' which as the name suggests, ensured that the 'in charge' responsibilities were overt to promote nurse and midwife wellbeing during the shift. These responsibilities including ensuring that all staff received their break and rest entitlements during the shift, ability to leave on time and wellbeing checks during the shift. The formalization of these responsibilities was occurring organically for some units while other unit's developed a tool to ensure that all the process happened. One unit developed a tool with a traffic light coding system (red, amber, green) that was used to check how staff felt their shift was going from their perspective. If they indicated that their shift was green, this meant that they could give help to others who were red or simply continue what they were doing, if all of their other colleagues were also 'green' at that point in time. The traffic light system indicated what help was needed and also the staff members' capacity to help colleagues.

5. *Proactive nursing*

Hourly rounding was an important protocol at Northeast Health Wangaratta and was incorporated into the pilot strategies as a principle for achieving clinical outcomes and improving patient satisfaction. Hourly rounding is a best practice that encourages nurses to be proactive instead of reactive to workload. Proactive nursing care was important to both health care services and also formed part of the strategies at Western Health. Four of the WH pilot wards used technology to assist them measure the effects of proactive nursing as opposed to recording evidence of hourly rounding. These units had a 'nurse presence' function in the nurse call system and used this to see how often nurses were in patients' room and how long call bells were left before being attended to. Interestingly, this data was only accessed when Unit Managers were required to respond to patient feedback or when the Unit Manager was reviewing the workload of staff. The information from the nurse presence button was able to contribute to nurse workload commentary as it identified the complexity of patient care measure by the amount of time spent with each patient.

6. *Optimizing the use of double staffing time*

Double staffing time occurs between all shifts but ranged in duration from 30 minutes (morning to night, afternoon to night) to 150 minutes (morning to afternoon). Double staffing time was used for handover, education and in the afternoon for meal breaks and staff identified many ways that the use of this time could be improved. Teams developed guides and recommendations (usually typed flyers) that identified when handover started and finished; when professional development started and finished and when meal breaks could be taken. The guides were used as a guide and remained flexible e.g. staff were still able to have a break if they missed the recommended time. The guides enabled them to be flexible, adapt and accommodate other activities such as ward meetings and staff celebrations (usually afternoon shift). No teams chose to work on altering the shift start and finish times.

7. *Ward meetings*

Ward meetings occurred frequently, sporadically, or randomly in the project teams before the pilot and most wards delayed or postponed the ward meeting due to acuity. During the pilot some units trialled more regular (weekly) ward meetings and kept them as succinct as required but ensured they occurred. Staff and Unit Managers found the regular ward meetings beneficial and staff raised new ideas and suggestions for improvements during the meetings. When ward meetings were no longer permitted due to COVID safe practices, some wards commenced online ward meetings using the computers-on-wheels. Some wards reported that their ward meeting attendance rate increased for other reasons too, as whilst not expected, staff were now choosing to attend the meeting on their day off using their personal phone or computer. Meetings held online meant that more staff attended and participated in the ward meetings. A few wards found that an online meeting system didn't work for their service due to not having enough computers for staff and reverted back to a previous behaviour of less frequent ward meetings.

8. *Leaving on time and leaving together*

The inability to leave on time was a frustration for staff in focus groups and prolonged handover was a common reason for the delay. Pilot ward teams worked on improving their

handover practices (mentioned above) but some wards also focused on leaving on time and leaving together. One unit had rapid success in ensuring that all of the morning staff went home on time by encouraging the staff to assemble for a 5 minute huddle, 30 minutes from the end of the shift. They discussed what needed to be done in the last 30 minutes of the shift, who needed help and who could give help. This Unit Manager reported that within a few days, all staff members on the morning shift were able to go home on time, leave together and help other team members. Within a few months, the huddle was moved back to the 60 minute mark and staff continued to help each other and go home on time.

9. *Staff ideas and suggestions to Unit Manager*

Listening and responding to staff was a strategy that was widely implemented and was (usually) low cost, low tech and typically an ideas box, list or emailing pf ideas to Unit Manager. Many of the wards developed idea walls or idea boxes for staff to identify problems and suggest solutions. Although wards had always welcomed problem identification and suggestions from staff, what was novel this time, was the feedback system to staff. Unit Managers acknowledged receipt of the notes and explored with staff what was going to be actioned (or not), when this would happen, who else needed to be involved and if it was safe or legal. One Unit Manager started this process by asking the ANUM group for ideas and was pleasantly surprised when a list of 41 items was presented. The Unit Manager worked through the list and was able to action many of the ideas immediately. Mostly, the response involved purchasing items (low cost) to enhance the day for the bed side nurse e.g. small equipment and supply repository in each four bedded room; increased number of patient thermometers and a reminder flag for medical team to complete the Acute Resuscitation Plan for Adults (ARP) documentation. This ANUM and the rest of them team now regularly raise requests and share ideas with the Unit Manager.

10. *Staff wellness initiatives*

Teams identified in the focus groups at both health services that coming together was a key component of feeling safe and at home on a ward. They acknowledged that they had friends at work and liked and trusted the people they worked with. Many pilot wards enhanced this aspect of their ward culture even further during the pilot and created formal structures to ensure staff were all included in celebrations such as a monthly birthday party, birthday calendars and schedules for afternoon teas. Birth of staff babies, marriages and graduations were also celebrated within teams. Complementary toiletries and affirmation signs were displayed in rest areas along with an abundance of shared food. The ability to 'come together' ceased abruptly during the COVID-19 pandemic and this was discussed frequently by pilot wards. Sharing of food no longer occurred, gatherings ceased and density quotients were enacted for all tea rooms and rest areas. Some pilot wards modified the structures and moved to an online celebration model with one for example having a weekly staff evening session hosted by the Unit Manager. Staff were able to eat and drink in comfort and without PPE on, from the comfort of their own home.

Unit Manager Development

A fundamental part of Working Together was the empowerment and development of the participating Unit Managers.

Empowerment

Empowering Unit Managers ensured that they had the confidence required to thrive during the pilot and set them and their teams up for success. Evidence of this strategy was able to be seen more clearly at the conclusion of the pilot than at commencement and we are sharing some suggestions from the Unit Managers on how others might approach this strategic approach.

1. Listen to your staff. What do they perceive are the problems or issues? What are the solutions?
2. Trust the views and perspectives you hear from your staff as their perspective is uniquely their own.
3. Trust and appreciate the Unit Managers. Unit Managers manage multiple priorities during their work day and these priorities will vary according to the day and demands. Be directed by Unit Managers as to when they want to meet to discuss the project strategies, how often and at what location. Some Unit Managers may also want email, phone and text support to complement or supplement face to face visits.
4. Share resources or information that you have, discover or identify with Unit Managers to support the team strategies.
5. Be authentic and have a good attitude. Our project was about improving the work day for nurses and midwives and it was important that the project officers believed with the Unit Managers, that the day could be improved. Having a sense of hope and optimism was important.
6. Establish and maintain a meaningful professional relationship (between staff and unit managers and unit managers and their managers) which will encourage open dialogue. Unit Managers and their staff will be more likely to share sensitive information about their work day, what they have done or haven't done if they feel safe and their views and experiences will be protected.

Unit Manager Development

The participating Unit Managers were provided with development opportunities during the pilot period including theory on co-design, design thinking, change management, engagement, understanding of hyper aroused environments and introduction to tools (PDSA & creative thinking exercises). They were encouraged to think empathetically to examine the perspectives of all staff in their team (new to experienced), use available to data to inform decisions; seek out new data (small group or ward survey); foster a sense of hope or optimism that things can be better; and experiment, practice and collaborate at work with others. Unit Managers were supported to apply this into practice by the project officers through guidance, mentoring and encouragement. The Unit Managers were encouraged to connect with other pilot wards and share ideas and suggestions. Although many had pre-existing connections with each other they started connecting with Unit Managers from outside their directorate, division or campus for the purpose of collaborating. They freely borrowed ideas from each other and adapted them to their local practice and culture.

Spending time together at the workshops or check-in sessions during the project was highly valued by the participants and is believed to be a key factor in the project's success through the establishment of a theoretical foundation and the development of support networks. Additionally, having dedicated time away from the busyness and focus of the clinical space provided participants with a place to pause, think and be curious about what could be improved in their own work space and with their own teams. The facilitation skills and knowledge of the external consultant optimized the development sessions and participants highly recommend these sessions.

The tangible and intangible benefits of participating in the project are still being fully realised at the time of this report and most have centred around the recognition that the project Unit Managers had grown in confidence in leading their own teams and making decisions. Other benefits have included the Unit Managers being selected to act up in higher roles for secondment positions; receiving organisation wide staff and team awards; representing the organisation at State event and; participating in an Australian-wide leadership development program on behalf of the organisation.

Interruptions & Disruptions

During the project, there were many interruptions and disruptions affecting Unit Managers at their local levels, state level, and globally. While some of these disruptions could be predicted and risk strategies developed at project commencement, many were not anticipated. We didn't anticipate the challenging bushfire season for Victoria in 2019/2020 or the global pandemic caused by COVID-19. Additionally, the disruptions affected each health service differently and is described because it will be useful for other health services embarking on a similar project.

1. Amendments to the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act (2015)

The team from Northeast Health Wangaratta believed that the project journey was adversely impacted by staffing shortages that were present following the implementation of the amendments to the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Northeast Health Wangaratta had difficulties securing extra staff to meet the new requirements due to a smaller pool of locally available registered and enrolled nurses, as most available nurses were already working for the service. By contrast, Western Health was not adversely impacted by the changes to the Act and had been able to hire staff before the commencement of the new requirements of the legislation. As a metropolitan health service, Western Health has access to a wider pool of available nurses and was able to plan and recruit staff in advance of changes to the Act.

2. Bushfire impact

The bushfire season that occurred during the project was a particularly unusual and was regarded as a particularly intense fire season for the State of Victoria. The impact of the bushfires affected both services differently with many complex issues; therefore this report only provides a brief description of the impact of the fires on staff and their community.

Northeast Health Wangaratta was directly affected by the bushfires with staff being part of the fire and emergency responses, caring for their families and also continuing to staff the hospital.

This meant that the project teams re-prioritized during this time and balanced the needs of the community with their personal and professional life.

Like many metro health services, Western Health experienced air quality at hazardous levels and staff being concerned for families, friends, and properties affected by bushfires but did not notice a decrease in resources or an increase in personal leave.

The issues experienced by Northeast Health Wangaratta during the project may occur in other health services but responses to challenges are unique to the specific health service, their geographical location, and infrastructure. For example, Western Health can respond to staffing deficits by accessing a large and established pool or bank and if unable to meet the request, utilise the services of a staffing agency within the area. By contrast, if Northeast Health Wangaratta has a staffing deficit they are unable to access the same number (or any) of casual or agency staff due to the size of the nursing pool in the community and the distance from the nearest neighbouring health service.

3. Project timeline

During the project, the teams identified that the project timelines might impact the project outcomes and this concern was raised with the project sponsors. The project was funded for a 12-month duration which included all components of the project timeline from initiation to closure. This meant that Unit Managers had to trial, implemented, and evaluate trials between August 2019 (project workshop) and December/January 2020 to allow the evaluation data and associated report to be completed by February 2020. The Department of Health and Human Services team were pragmatic in their understanding of this challenge and comfortable in extending the evaluation component of the project to allow for a longer sustained practice change. The Western Health project officer was able to be supported for an additional extra 4 months but Northeast Health was unable to support an extension of the project timeline or Project Officers time. As such, the projects at Northeast Health Wangaratta were finalised and evaluated in accordance with the original project timeline (February 2020) and their evaluation data is reflective of the shorter time period.

4. COVID-19

COVID-19 was first identified in late 2019 but the novel virus didn't truly impact teams at Western Health until early February 2020, when significant planning and preparation occurred. Western Health anticipated that they would need an extension to the project as Unit Managers were re-directed to plan for a pandemic, wards were realigned to accommodate COVID-19 positive patients, suspected or negative co-horting, Unit Managers reassigned to new units and the staff were upskilled to prepare for an influx of unwell patients and staff. Western Health was able to support and fund an additional extension of the project officer and The Department of Health and Human Services supported an extension of the project given the demands of COVID-19 on the health system.

5. Adapting strategies

Due to its location and proximity to many high risk COVID environments, Western Health was significantly impacted by the COVID-19 pandemic outbreaks in Melbourne. The health service had the highest number of COVID-19 positive and suspected cases in Victoria, had supported extensive external testing initiatives, numerous testing sites and directly supported 51.3% of the residential aged care outbreaks in Victoria at the time. Despite this Western Health continued the Working Together pilot during Wave 1 (March-June 2020) and Wave 2 (July-November 2020) of the COVID-19 pandemic. Whilst the pilot was not at the forefront of priorities at this time, most Unit Managers were keen and able to adjust and alter strategies to meet the new COVID-safe requirements. Strategies that were unable to be altered were revisited by Unit Managers and their reasons for introducing the change explored to find a new solution or they simply just paused the strategy.

Examples:

One example of an adaption was on the acute medical ward (medical ward 3) that introduced a myriad of strategies including the formalisation of the way the shift should start to ensure handover was robust and team nursing occurred. This included a team huddle, allocation of patients to pairs of staff, patient handover involving the patient, updating patient communication board, and electronic handover tool. During Wave 1 (and Wave 2) this ward became a designated inpatient unit for COVID positive patients, and the Unit Manager had to readjust the trialled strategies to remain 'COVID safe'. As indicated above, the team huddle was moved from the handover room to the patient day lounge (change); patients were allocated to pairs of staff (no change); team handover still involved patients but only one staff member received handover (change), and updated electronic documentation. The Unit Manager also procured a door for the patient day lounge to make it soundproof for the nursing team. As having a ward meeting was now more difficult as staff were all sitting or standing 1.5 metres apart and wearing N95 masks and a face shield, the team instead shared updates and notices in the smaller team handover.

By contrast, another unit (medical ward 6) said that they had changed their ward handover from being delivered in the handover room to being delivered via Zoom with staff using their mobile computer on wheels to listen and receive handover. This ward did not have a day lounge or large enough room to accommodate the staff in a COVID safe way. They utilized a hallway at the back of their ward (no patients, visitors, or other staff) for the staff to line up and listen to handover via their computers on wheels.

Another NUM (Medical Ward 4) also improved team handover and allocation for their Working Together project and reflected that COVID meant that she could make even "more changes to the handover process" and that the change was "accelerated due to COVID". She reported feeling very "comfortable and confident in making changes" and "staff were aware that it was a work in progress and they could change back" and would keep trailing ideas on the job.

Many of the strategies during the project involved 'coming together' to celebrate successes. This included the team celebrating completion of postgraduate courses, maternity leave, new staff, birthdays, fun day with shared food, usually held in the handover room. COVID-19 restrictions meant that staff were unable to celebrate together or share food in this way which led to some wards

adapting by celebrating virtually over emails or Zoom. As mentioned earlier, one unit revisited this strategy and introduced a weekly Zoom ‘catch up’ session with the Unit Manager and staff were encouraged to bring their own snacks and drinks to capture the previously shared ambiance of celebrating and being together with food.

Evaluation

The formal evaluation of the Working Together Pilot Project was led by a team from Deakin University, using a mixed-methods design and sought to determine to what extent the objects and outcomes of the pilot were or were not achieved and to inform decisions about expanding the pilot to other health services.

This project was also evaluated during the pilot by Unit Managers evaluating their own strategies using the PDSA tool and surveys (Mentimeter; Survey Monkey). Western Health also conducted focus groups at the end of the project term and also Pulse Surveys. Further information about these initiatives can be found in Appendix 14 and 17.

Evaluation framework

Evaluation purpose

The evaluation aimed to determine to what extent the objectives and outcomes of the Working Together project were (or were not) achieved; and inform decisions about expanding the project to other health services.

Key evaluation questions

The findings of the evaluation will:

1. Determine to what extent objectives and outcomes of the pilot were (or were not) achieved; and
2. Inform decisions about expanding the pilot to other health services and in other acute and sub-acute wards.

Scope

The evaluation was conducted from March 2019 to September 2020. Nurses and midwives employed at Western Health and Northeast Health Wangaratta were invited to complete a survey and/or interview both prior to and after the implementation of the Working Together project. Workplace data (e.g. staff turnover, absenteeism rates) both pre- and post-implementation of the project were also collected.

- Data audit conducted: Western Health March 2019 – May 2020; Northeast Health Wangaratta March 2019 – January 2020
- Pre-implementation surveys conducted: Western Health June – August 2019; Northeast Health Wangaratta May – July 2019
- Post-implementation surveys conducted: Western Health March – June 2020; Northeast Health Wangaratta February – April 2020
- Pre-implementation interviews conducted: Western Health & Northeast Health Wangaratta June – July 2019

- Post-implementation interviews conducted: Western Health September 2020 (no post-implementation interviews conducted at Northeast Health Wangaratta)

Evaluation Governance

Ethics approval for the evaluation of the Working Together Project was obtained from the Western Health Low Risk Ethics Panel (HREC/19/WH/51355, 27 March 2019), the Northeast Health Wangaratta Human Research Ethics Committee (Project Id 51986, 1 May 2019) and the Deakin University Human Research Ethics Committee (2019-120, 4 April 2019). Copies of the approval letter from each ethics committee are included in Appendix 1: Ethics Approvals & Documents.

Cost

Deakin University was awarded funding of $100,000 to undertake the evaluation.

Evaluation design

The evaluation of the Working Together project was undertaken as a mixed-methods project which included three components:

1. Audit of key metrics and organisational records (quantitative data);
2. Pre- and post-implementation surveys of nurses, midwives, ANUMS/AMUMS and NUMS/MUMS (quantitative data); and
3. Pre- and post-implementation semi-structured interviews with nurses, midwives, ANUMS/AMUMS, and NUMS/MUMS (qualitative data).

A mixed-method approach enabled data to be collected and analysed both pre- and post-implementation of the Working Together project. The use of different methods expands the breadth, depth, and range of the research, resulting in more comprehensive results. Quantitative data collection methods such as surveys enable data to be collected from a large number of respondents and provide data on associations between the factors under investigation. However, such data are not sufficient to capture the richness of nurses' and midwives' individual experiences of and attitudes towards the implementation of the Working Together project. Qualitative findings from the interviews support the quantitative findings and provide a more in-depth understanding of nurses' and midwives attitudes, perceptions, and satisfaction with current workload allocation and management practices and the Working Together project.

Evaluation method

Component 1 (Retrospective data audit)

A retrospective audit of Western Health and Northeast Health Wangaratta staff / organisational records was conducted. Data were collected twelve months prior to the project as well as data six months (Northeast Health Wangaratta) and twelve months (Western Health) post-implementation.

Data included (per month / annually as available):

- overtime costs;
- supplementary staffing costs (includes agency);
- clinical nursing and midwifery sick leave;
- clinical nursing and midwifery staff turnover;
- incident reports and adverse event rates;
- patient, family and carer satisfaction (from patient surveys);
- patient complaint rates;
- patient allocations; and
- Selected data from nurses' and midwives' responses to the Western Health People Matter Survey.

Component 2 (Pre-and post-implementation surveys)

All nurses, midwives, NUMS, ANUMS, MUMS, AMUMS employed by Western Health were invited to complete:

- A pre-implementation survey which was available in Qualtrics (an online survey platform). The survey consisted of two main sections. The first section included questions about participants' demographic characteristics (such as age, position, years of clinical experience, ward, and site). The second section collected information about nurses and midwives' perceptions of, and satisfaction with, current workload allocation and management practices.

- A post-implementation survey (conducted at 6 months post-implementation) was also available in Qualtrics. The survey included questions about nurses and midwives' perceptions of, and satisfaction with, current workload allocation and management practices; level of acceptance of the project, perceived impact (benefits, difficulties and changes to workflow and practice), including impact on patient care; and instances of on-the-job preceptoring and mentoring.

Surveys included validated instruments on staff satisfaction, perceptions of workload allocation and management, and other aspects of nursing/midwifery practice targeted by the project.

Table 6: Survey data sources

Variable	Tool	Time	Description
Work satisfaction	The NDNQI-Adapted Index of Work Satisfaction (Taunton et al. 2004)	T1 & T2	Measures nurses' & midwives' work satisfaction at the patient care unit level.
Perceived stress	Perceived Stress Scale (Cohen, Kamarck & Mermelstein 1983)	T1 & T2	Measures the degree to which situations are appraised as stressful.
Role clarity and tension	Job-related Tension Index (Lyons 1971)	T1 & T2	Measures the relationships between role clarity and reported satisfactions, tensions, and propensities to leave the organisation
Role conflict and ambiguity	Role Conflict and Ambiguity Scale (Rizzo, House & Lirtzman 1970)	T1 & T2	Measures role conflict and ambiguity.
Socio-demographic characteristics	Study specific questions	T1 & T2	Age, country of birth, position, years of clinical experience, ward (Working Together pilot vs non-Working Together ward), site
Patient safety and quality of care	Study specific questions	T1 & T2	Questions adapted from the RN4CAST survey (Sermeus et al. 2011)
Missed elements of patient care	Study specific questions	T1 & T2	Questions adapted from The Missed Nursing Care Survey (MISSCARE Survey) (Kalisch & Williams 2009)
Intention to continue in role	Study specific questions	T1 & T2	Intention to continue working as a nurse/midwife and at Western Health/Northeast Health Wangaratta
Workload allocation and management	Study specific questions	T1 & T2	Perceptions of workload allocation and management
Assessment of the Working Together pilot	Study specific questions	T2	Level of acceptance of the project, perceived impact (benefits, difficulties and changes to workflow and practice), including impact on patient care

Timepoints:
T1: pre-implementation
T2: 6 months post-implementation

Component 3 (Pre-and post-implementation interviews)

All nurses, midwives, ANUMS/AMUMS, NUMS/MUMS and Directors of Nursing were invited to participate in individual semi-structured interviews. The interviews were audio-recorded and transcribed for analysis.

Pre- and post-interviews were conducted by a member of the research team using an interview guide.

- The pre-implementation interview elicited richer, contextual understandings into nurses' and midwives' perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring. In interviews with NUMS, ANUMS, MUMS, AMUMS, and Directors of Nursing, further discussion was facilitated on factors informing and influencing decision-making on patient allocation/perceived flexibility to innovate to meet changing patient needs and staff skills.

- The post-implementation interviews also elicited participants' perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring. In addition, information was elicited on their attitudes, perceptions, acceptance, use, and perceived impacts of the project. In interviews with NUMS, ANUMS, MUMS, AMUMS, and Directors of Nursing, further discussion was facilitated on factors informing and influencing decision-making on patient allocation/perceived flexibility to innovate to meet changing patient needs and staff skills.

Results of the quantitative and qualitative analyses were triangulated to evaluate and consolidate findings.

Participants or data sources

All nurses and midwives employed at each health service (Western Health and Northeast Health Wangaratta) including those from both the Working Together pilot wards and the non-Working Together pilot wards were sent an email from the research team both pre- and post-implementation of the project inviting them to complete a survey and/or participate in an interview.

Data collection

The pre- and post-implementation surveys and interview guides (Western Health and Northeast Health Wangaratta) are attached as Appendices (Appendix 2: Surveys; Appendix 3: Interview Guides).

Data analysis

Components 1 and 2 (quantitative data)

Organisational data

- Descriptive statistics were used to report the organisational data in the twelve months pre-implementation and the six months post-implementation, including overtime costs; supplementary staffing costs (includes agency); clinical nursing and midwifery sick leave; clinical nursing and midwifery staff turnover; the number of incident reports and adverse events; patient, family and carer satisfaction (from patient surveys); patient complaint rates and patient allocations.

Survey data

- Scores on standardized instruments were compared pre- and post-implementation, including:
    - Work Satisfaction Index: total scores and scores on Autonomy, Professional Status and Pay subscales
    - Perceived Stress Scale total scores

    - Tension, Satisfaction, Propensity to Leave, Role Clarity, and Need-for-Clarity indices derived from the Job-related Tension Scale.
    - Role Conflict and Ambiguity subscale scores
- Pre- and post-implementation data were compared between Working Together wards and other wards within each health service, and in the combined dataset.
- Post-implementation data were compared between Working Together wards and other wards within each health service, and in the combined dataset.
- Post-implementation data were compared with pre-implementation data for Working Together wards/non-Working Together wards within each health service, and in the combined dataset.
- As data were not matched, independent samples t-tests (normally distributed data) and Mann-Whitney U tests (non-normally distributed data) were used to compare pre and post data from the standardised instruments.
- Chi-square tests were used to test for significant change in the proportion of respondents indicating that they intend to continue working at Western Health/Northeast Health Wangaratta, and that they intend to continue working as a nurse/midwife.
- Responses to questions evaluating the Working Together project were summarised using descriptive statistics.
- Quantitative data analysis was conducted using IBM SPSS Statistics version 26.

Component 3 (qualitative data)

- The interview transcripts were de-identified, coded and analysed using thematic analysis techniques commonly practised in qualitative research (Braun & Clarke 2006). As identified by Braun and Clarke (2006) this consists of six phases. Phases 1 and 2: Transcripts are repeatedly read and reread, and coded. Phases 3–5: Codes are grouped into meaningful categories that describe how participants talked about the topics, including contradictions and exceptions. Themes are created, named and defined in order to explain and interpret the content. Examples of the identified themes are selected in the final phase (phase 6) and related back to the research objective. The analysis was conducted by members of the research team and interpretations were discussed within the research team until consensus was reached.
- NVivo was used for qualitative analysis.
- NVivo was also be used to facilitate thematic analysis of the free text comments provided in the surveys.
- Results of quantitative and qualitative analyses were triangulated to evaluate and consolidate findings.

Ethical assessment

Participation in the survey and interview components of the evaluation was voluntary and participants could withdraw at any time, and not participating did not adversely affect their employment or relationship with Western Health or Northeast Health Wangaratta.

The only risks to participants were inconvenience and the time taken to participate.

The research did not impose any harm, discomfort, and/or inconvenience listed in the National Statement on Ethical Conduct in Human Research for participants, the research team, Deakin

University, and Western Health. In particular, there was no physical, psychological, social, legal, and economic harm associated with the current research.

It is possible that some survey and/or interview questions may have made some participants feel uncomfortable. If they did, or if they felt they would like to discuss them, it was suggested in the Participant Information Sheet (Appendix 1: Ethics Approvals & Documents) that they may benefit from contacting their GP, employee assistance program, or one of the organisations listed.

Participants who completed a pre and/or post-implementation survey, and/or interview were eligible to go into the draw for a $100 gift voucher (four gift vouchers were distributed in total at each health service: 1. Pre-implementation survey; 2. Post-implementation survey; 3. Pre-implementation interview; and 4. Post-implementation interview). The purpose of this small incentive (gift voucher) was to increase the participation rate. As the pre and post-implementation surveys are anonymous, instructions were included at the end of each survey advising respondents who would like to go in the draw for the gift voucher to send an email to the researchers (email address provided). This was to ensure that respondent's names and contact details were not submitted with their completed survey. Completion of the pre- and post-implementation survey(s) was taken as implied consent. Interview participants provided written or verbal (recorded) consent prior to or at the beginning of their interview.

Ethics approval for the evaluation of the Working Together Project was obtained from the Western Health Low-Risk Ethics Panel (HREC/19/WH/51355, 27 March 2019) and the Deakin University Human Research Ethics Committee (2019-120, 4 April 2019).

Privacy assessment

Component 1 (Data audit)

There were no foreseeable issues relating to staff privacy. This was a retrospective audit involving access to existing hospital records. Consent was not sought for this component of the project as the data accessed was used for a purpose related to that of its original collection and was collected by researchers/quality monitors who would normally have access to that data. To seek consent would be inconvenient for staff and potentially raise concerns/anxiety.

Components 2 & 3 (pre- and post-implementation surveys and interviews)

The surveys were anonymous and the data was not be associated with any identifying information. We removed identifiers before transcribing the interview recordings and subsequent data analysis. The research team kept a password-protected list of interview identifier codes on a secure drive which was accessible only to the research team, and in a separate location to study data. The researchers took every effort to maintain the confidentiality of the participants or any other personal information of participants.

Timeline

The evaluation timeline is shown in the table below:

Activity	Dates
Prepare ethics application	January-February 2019
Ethics approval	March 2019
Nurse and midwifery managers provide contact details of all nurses & midwives at Western Health	March-April 2019
Data collection: retrospective data audit (Pre & post-pilot)	March 2019 - May 2020
Data collection: surveys (Pre)	March-April 2019
Data collection: interviews (Pre)	March-April 2019
Implementation of Working Together pilot at Western Health/Northeast Health Wangaratta	May 2019
Data collection: surveys (Post)	February -May 2020
Data collection: interviews (Post)	August - September 2020
Quantitative and qualitative data analysis	October 2019 – September 2020
Preparation of a report to the Department	October 2020
Preparation of manuscripts and presentations	October 2020 – February 2021

Key findings

Data are presented under the following headings: staff wellbeing, patient safety and quality of care, Intention to continue in and satisfaction with role and health service, workload allocation and management, and assessment of the Working Together project. Where appropriate, free-text comments from the surveys and interview quotes have been included in the relevant sections to elaborate on quantitative data.

To what extent were the objectives and outcomes of the pilot achieved?

Surveys:

A total of 345 surveys were completed. Over two-thirds of the survey respondents were RNs; most respondents were born in Australia; on average they were aged in their early to mid-forties; and approximately a quarter of survey respondents at Western Health worked in one of the Working Together project wards whereas approximately three-quarters did at Northeast Health Wangaratta (this is due to the greater number of wards which implemented Working Together project initiatives at Northeast Health Wangaratta) (Appendix 4: Survey data tables).

Table 7: Survey response rate

Health Service	Pre-implementation survey		Post-implementation survey	
	Completed surveys	Response rate*	Completed surveys	Response rate*
WH	131	4.4%	118	3.9%
NHW	60	6.0%	36	3.6%
Total	191	4.8%	154	3.9%

* Approximately 3,000 nurses and midwives are employed at Western Health, and 1,000 are employed at Northeast Health Wangaratta.

Interviews:

Pre-implementation interviews were conducted with 13 nurses/midwives: 5 from Western Health and 8 from Northeast Health Wangaratta. On average interview, participants were aged 47.8 years, had practised as a nurse/midwife for 25.7 years, and had been employed at their health service for 11.6 years. Most were born in Australia (n=8, 61.5%), and were RNs (n=8, 61.5%). The interviews ranged from 13 to 57 minutes with an average duration of 25.4 minutes.

Post-implementation interviews were conducted with 3 nurses/midwives, all of whom were employed at Western Health. On average the participants were aged 40.3 years, had practised as a nurse/midwife for 18.7 years, and had been employed at Western Health for 14.3 years. The interviews ranged from 15 to 21 minutes with an average duration of 21.5 minutes. The bushfires in regional Victoria in December 2019/January 2020 had a negative effect on the recruitment of post-implementation interview participants at Northeast Health Wangaratta and the COVID-19 pandemic from March 2020 had a negative effect on the recruitment of post-implementation interview participants at Northeast Health Wangaratta and Western Health.

Staff Wellbeing

Staff wellbeing was assessed in the pre- and post-implementation surveys using the following psychometric instruments: Perceived Stress Scale, Tension Index, Satisfaction Index, Role Conflict Scale, and Role Ambiguity Scale.

No significant differences were found in the mean perceived stress, tension, satisfaction, and role conflict scores before or after the implementation of the Working Together project at both health services (Appendix 4: Survey data tables).

No significant difference was found in mean role ambiguity score pre- and post-implementation at Western Health however, there was a significant difference in the mean score pre- and post-implementation overall, in the non-Working Together wards at Western Health and at Northeast Health Wangaratta, with the post-implementation mean scores significantly lower than the pre-implementation mean scores indicating less role ambiguity among nurses/midwives working at these sites after the Working Together project had been implemented (Appendix 4: Survey data tables).

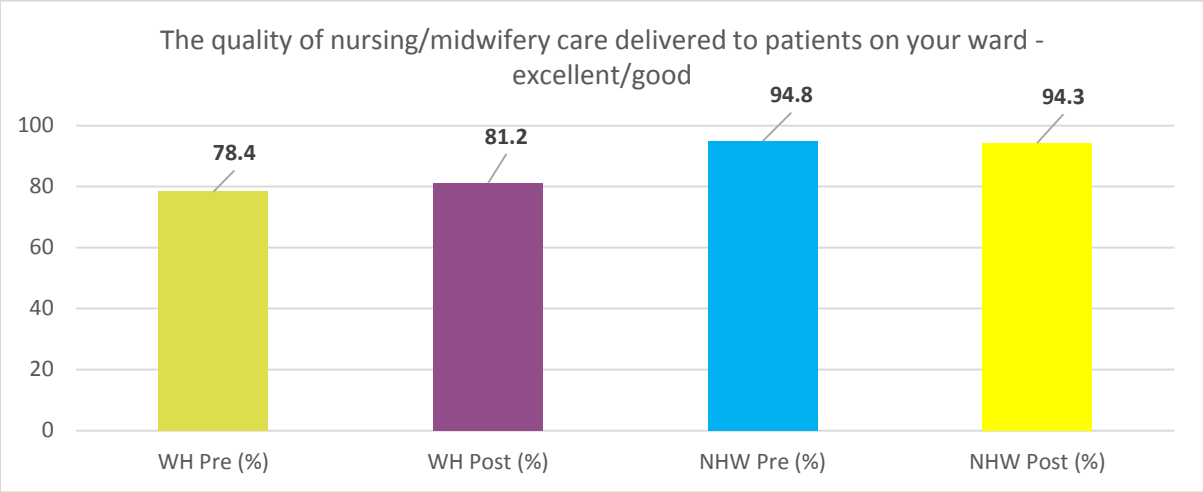
Absenteeism

The data audit indicated a slight decrease in the personal leave (average hours per month) taken by nurses and midwives at Western Health after the implementation of the Working Together project (5.63% vs 5.50%) whilst there was an increase in sick leave (average days per month) at Northeast Health Wangaratta (1096.25 vs 1150.81) (Appendix 5: Data audit tables).

Patient safety and quality of care

Patient care

There was a slight increase in nurses' and midwives' perceptions of the quality of care provided to patients and patient safety on their ward after the implementation of the Working Together project (Figures 1 & 2; Appendix 4: Survey data tables).



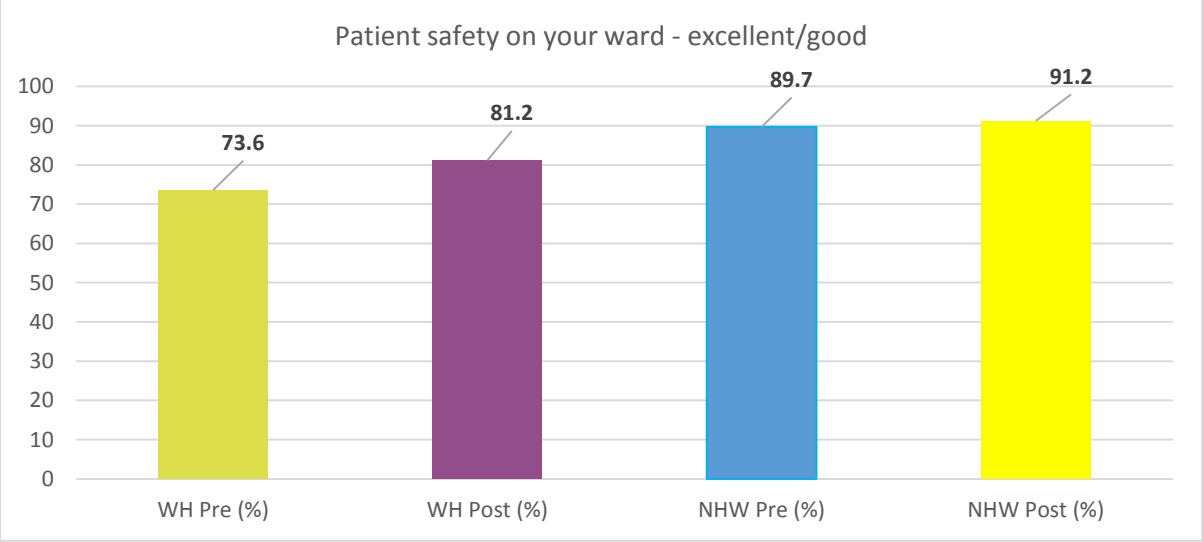


Figure 8: Patient safety (pre- and post-implementation surveys)

Missed elements of patient care

Fewer missed elements of patient care were reported at both health services after the Working Together project was implemented (Figures 3 & 4; Appendix 4: Survey data tables).

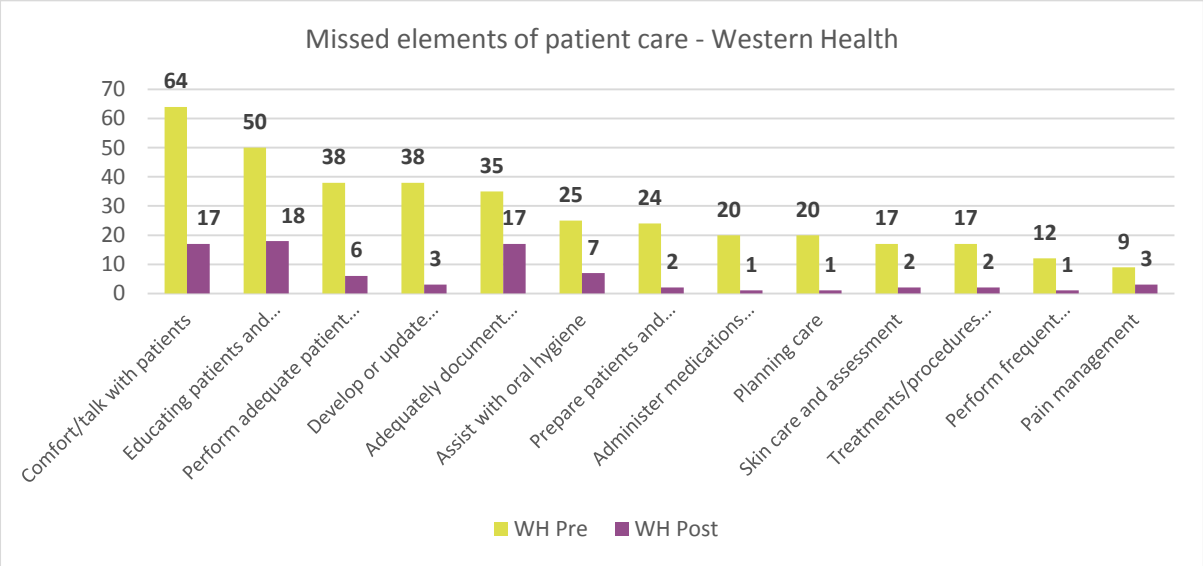


Figure 9: Missed elements of patient care – Western Health (pre- and post-implementation surveys)

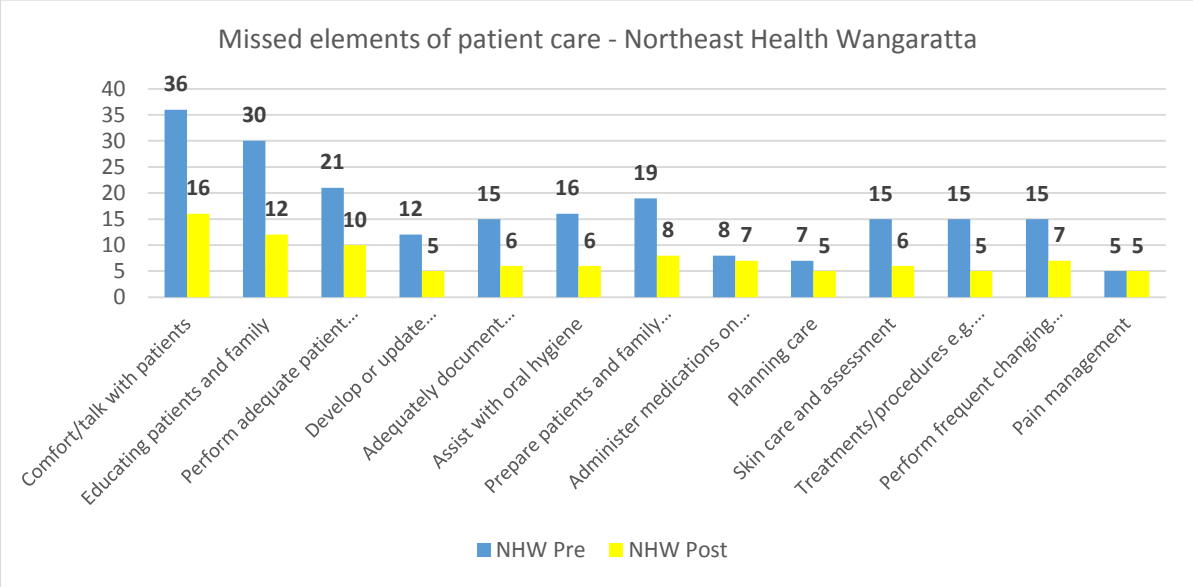


Figure 10: Missed elements of patient care – Northeast Health Wangaratta (pre- and post-implementation surveys)

Many survey respondents commented that time limitations often meant that they were unable to provide certain aspects of patient care.

- Patients care and outcomes are very often neglected because we are only crunching numbers. We have no time to deal with sick patients and their family. (Western Health Pre-implementation survey respondent)
- We do not have the time to attend to all tasks let alone properly. (Northeast Health Wangaratta Pre-implementation survey respondent)

- Work is every task orientated, not patient focused most of the time. I feel sorry for my patients when I don't get to wash them, talk to them, brush their teeth. Simple things. (Northeast Health Wangaratta Pre-implementation survey respondent)
- Nurses and midwives at both health services who participated in a pre-implementation interview also reported that although they felt they were providing good patient care, there were often elements of patient care that were missed due to their (heavy) workload.
- They commented that this was unfortunate as they felt that these 'basic' elements of care were important for patient outcomes including length of stay and patient satisfaction.
- Sometimes I just feel like at the end of the shift like you – I mean I know I've done the best I can and the patient's well cared for, but just sometimes you just have that feeling that you know I could've done more, but because I was so busy or caught up with say one patient in particular that might've been really unwell that I feel like … I may have sort of neglected other patients, I haven't been able to spend as much time with them. (Northeast Health Wangaratta Pre-implementation Interview Participant #8)
- A lot of basic care needs aren't being met because you're, like when you're prioritising say somebody's got you know the hypotension or they've become febrile, so you're concentrating on managing those symptoms and forgetting about all, well not forgetting but you just don't have time to do those basic care needs, like you know pressure area care or even brushing dentures. (Northeast Health Wangaratta Pre-implementation Interview Participant #1)
- There's lots of things [that get missed] … just a lot of those basic hygiene needs, even taking patients to the toilet on a regular basis, so they're not soiling incontinence aids and – or just getting patients out of bed for all their meals. (Northeast Health Wangaratta Pre-implementation Interview Participant #1)
- You're trying to rush, I mean I know on the midwifery unit you're trying to get these women out as quickly as possible, so you're just sort of give a bit of verbal diarrhoea to give them all the education and stuff, and then when they fail it's sort of not – it's really not their fault, it's our fault because we haven't been able to give them the appropriate education. (Northeast Health Wangaratta Pre-implementation Interview Participant #2)
- Nurses are being taken away from basic nursing care, because they've got so much more paperwork to do. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- Yeah, so the basics that the nurses are taught, you know like our oral hygiene and just basic ADLs for a patient, they can get missed because you don't have the time to do all your showers before 10am, before the doctors do their rounds and you know you've got to get your ECGs done for those that are on telemetry before the doctors rounds. It's a real push of time. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- Well I mean our clientele are usually older patients, and I mean they don't shower every day at home, but you know it's easy for them to be missed for 2 or 3 days …because the nurses didn't actually get time to go back and do that shower, a patient could be sitting you know 2 or 3 days without a shower. That's very common. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- Look there's always shifts in a week where you do the important stuff, and when I say the important stuff it's like the airway, breathing, circulation, and the niceties such as you know

two cups of tea instead of one or you know turn every hour instead of every 2 hours. There are shifts when the niceties don't get done, and that's merely because of the volume of patients that we have going through yeah. And not just the volume but the complexity. (Northeast Health Wangaratta Pre-implementation Interview Participant #6)

Adverse Events

The survey data indicated a decreasing trend in the number of adverse incidents occurring 'a few times a month or more' at both health services after the implementation of the Working Together project (Figures 5 & 6; Appendix 4: Survey data tables). These included medication errors (patients receiving the wrong medication, time or dose), pressure ulcers after admission, patients' falls with injury, and patient complaints.

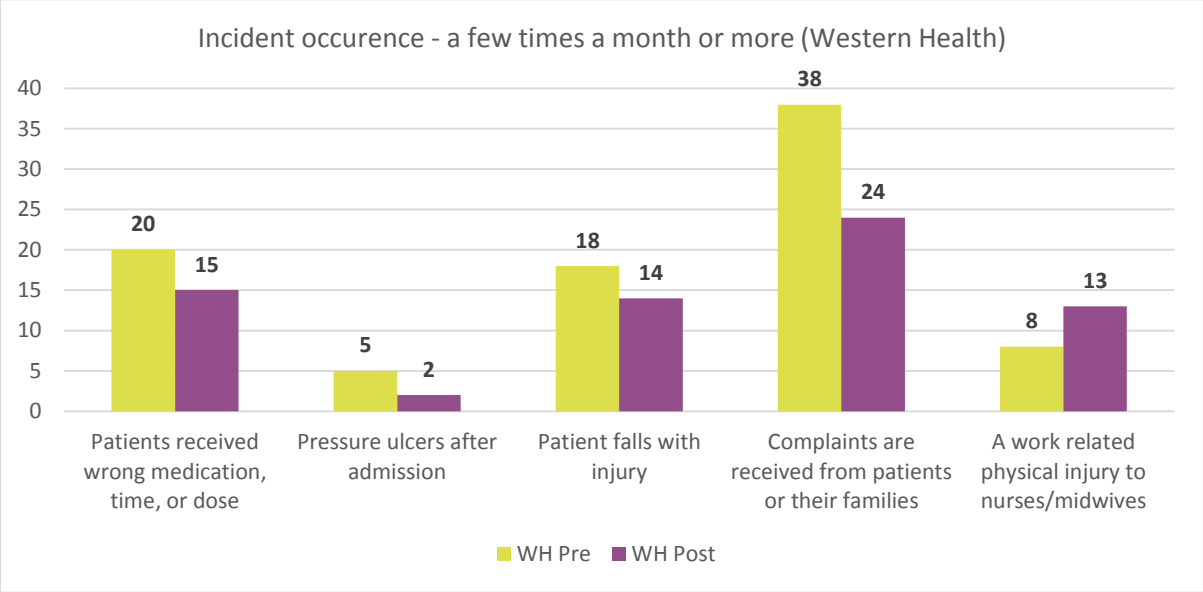


Figure 11: Number of incidents – Western Health (pre- and post-implementation surveys)

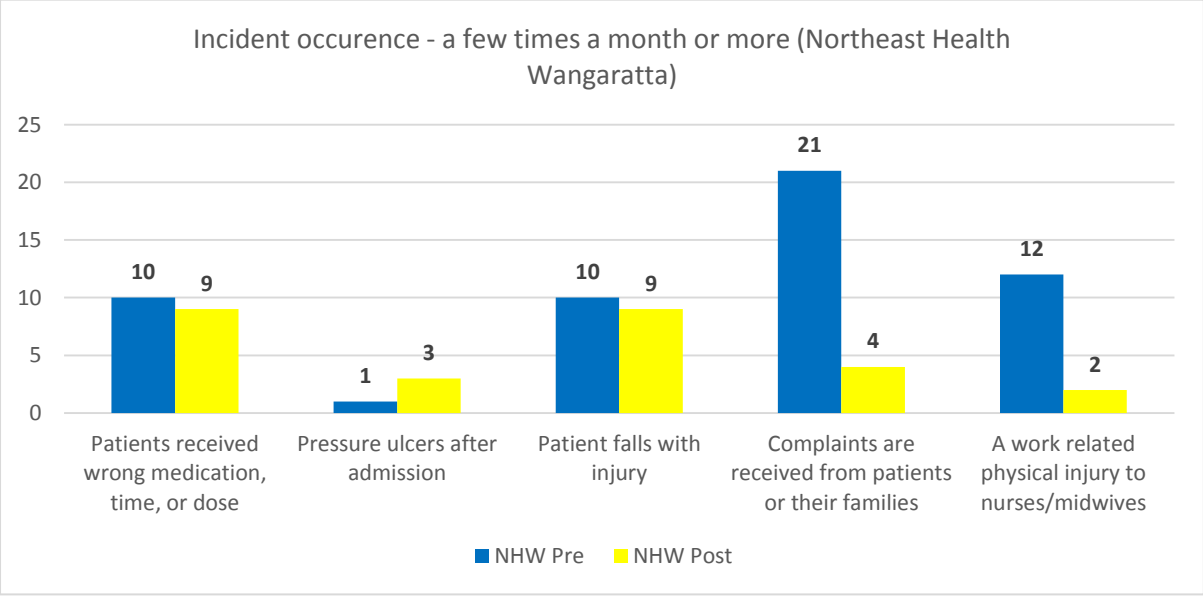


Figure 12: Number of incidents – Northeast Health Wangaratta (pre- and post-implementation surveys)

The data audit also indicated a slight decrease, after the implementation of the Working Together project, in the average number per month of:

- sentinel events at both health services (Figure 7; Appendix 5: Data audit tables),
- inpatient falls per 100 bed days (Western Health: 0.69 vs 0.63; Northeast Health Wangaratta: 4.29 vs 4.98),
- adverse events at Western Health (1.82 vs 1.75), and
- high-risk medication errors at Western Health (65.17 vs 53.25) (Appendix 5: Data audit tables).

Although there was an increase in the average number per month of patient complaints at Western Health (83.3 vs 89.6), there was also an increase in the number of patient compliments (20.3 vs 23.5) (Appendix 5: Data audit tables).

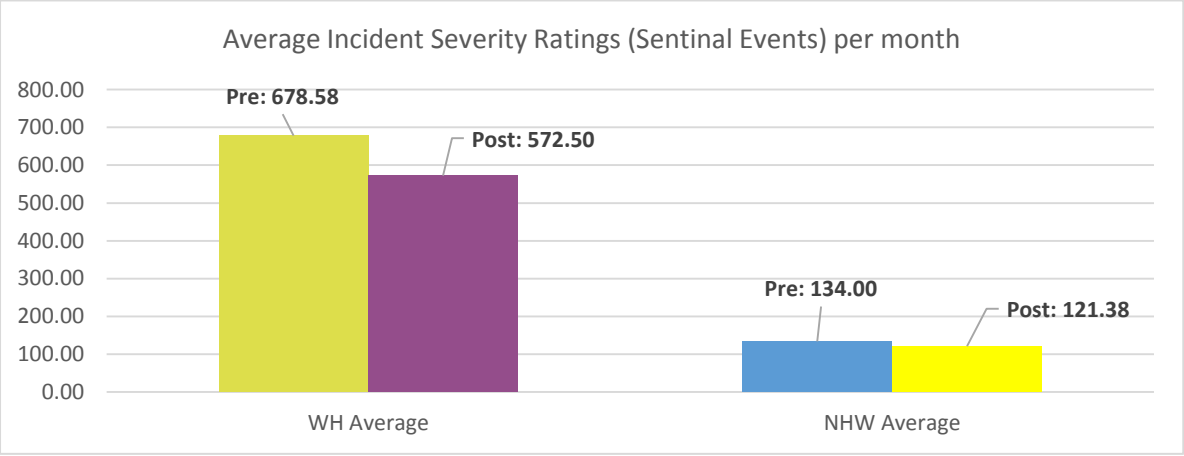


Figure 13: Average number of incidents per month (sentinel events) (data audit)

Pressure injuries

The data audit indicated the average number of pressure injuries did not change (Western Health) or increased (Northeast Health Wangaratta) after the implementation of the Working Together project (Figure 8; Appendix 5: Data audit tables).

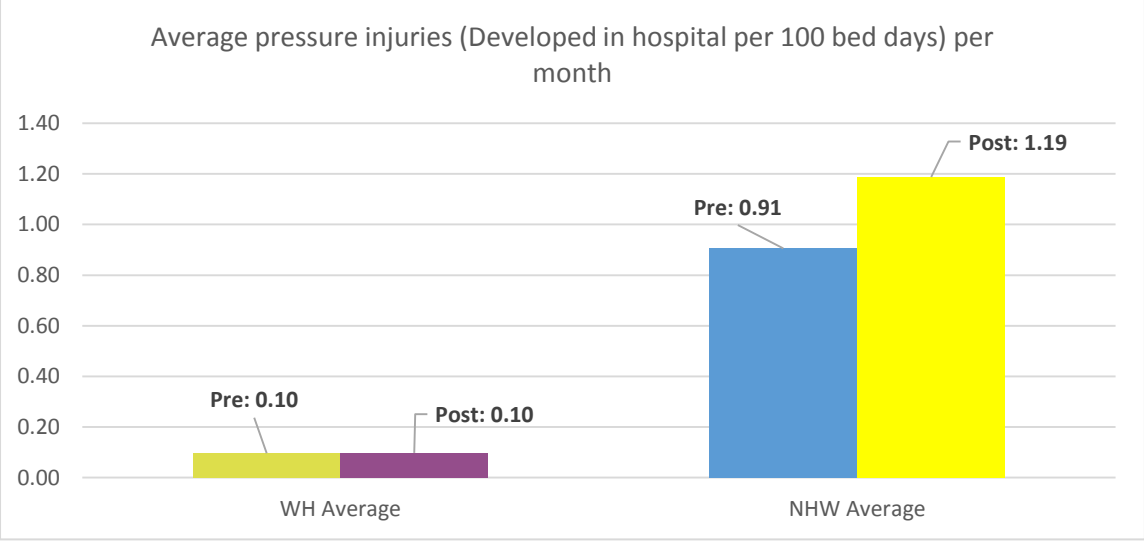


Figure 14: Average number of pressure injuries per month (data audit)

Intention to continue in and satisfaction with role and health service

Nurses and midwives were asked in both the pre- and post-implementation surveys about their intention to stay at their health service. There was an increase in the proportion of nurses/midwives at Western Health who indicated that they intended to stay at Western Health for more than one year but a slight decrease in the proportion at Northeast Health Wangaratta (Figure 9; Appendix 4: Survey data tables).

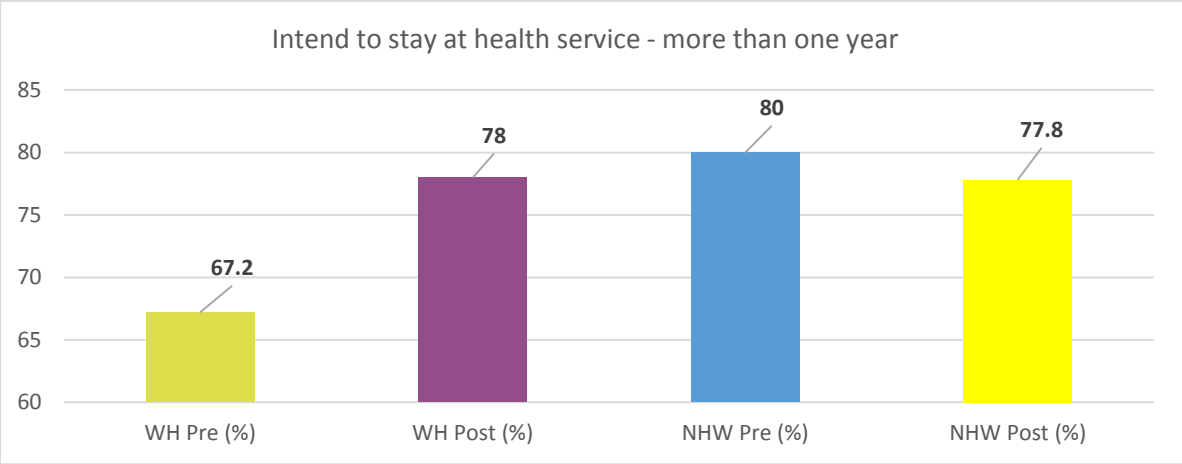


Figure 15: The proportion of nurses/midwives who intend to stay at their health service (pre- and post-implementation surveys)

There was an increase at both health services in the proportion of nurses/midwives who reported in the surveys that they intended to continue working as a nurse/midwife for more than one year (Figure 10; Appendix 4: Survey data tables).

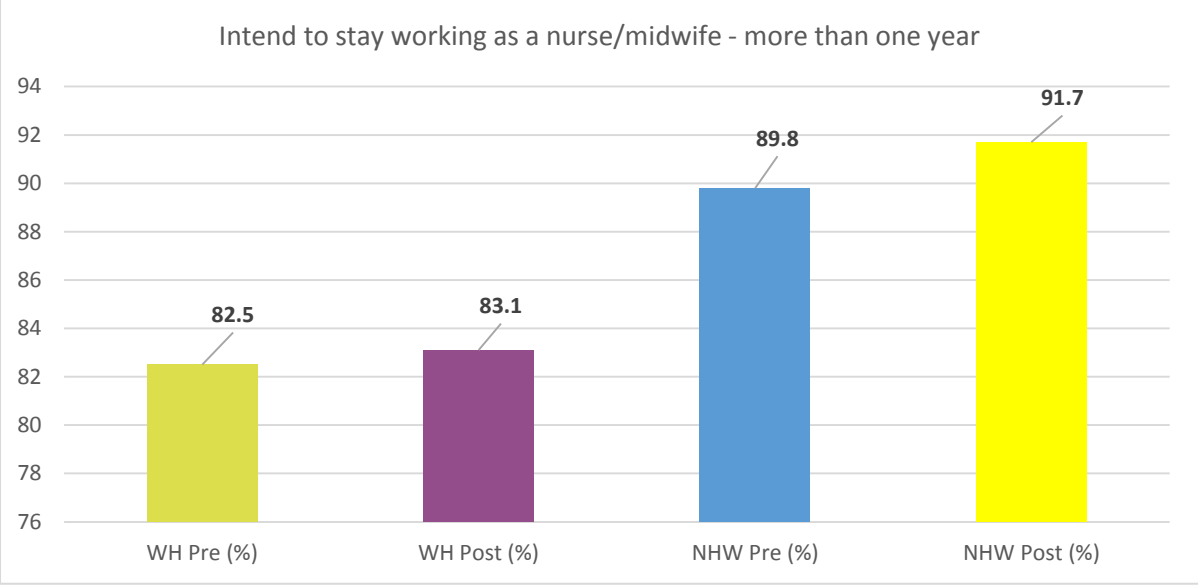


Figure 16: The proportion of nurses/midwives who intend to stay working as a nurse/midwife for more than one year (pre- and post-implementation surveys)

There was a slight increase in the proportion of nurses/midwives at both health services who reported satisfaction with their jobs after the implementation of the Working Together project (Figure 11; Appendix 4: Survey data tables).

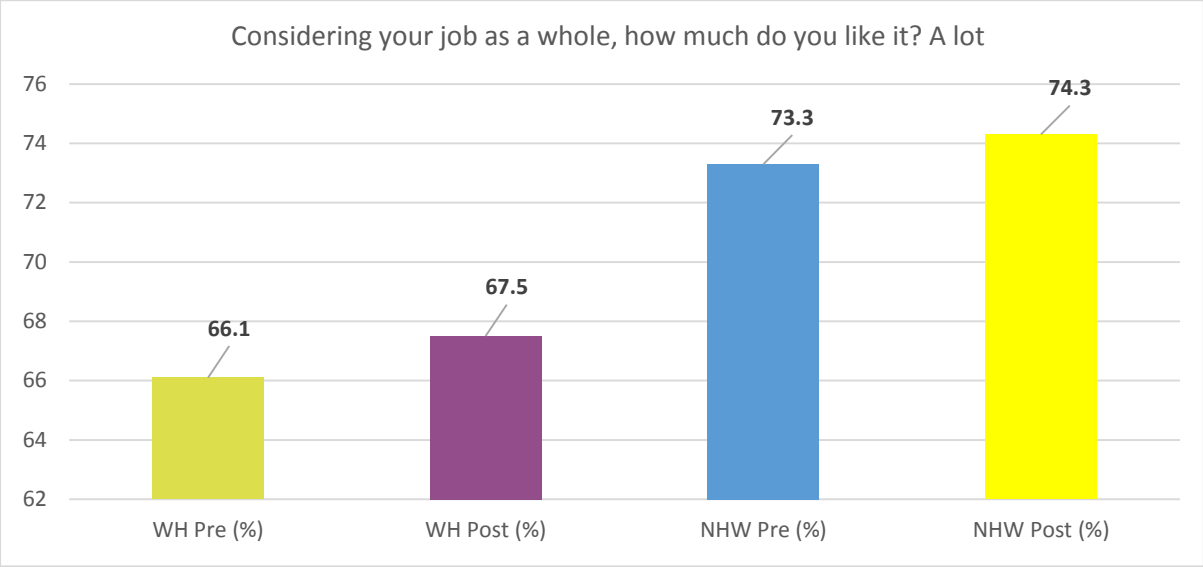


Figure 17: The proportion of nurses/midwives who reported that they liked their job 'a lot' (pre- and post-implementation surveys)

There was a considerable increase in the proportion of nurses/midwives at both health services who reported that they considered their hospital to be a very good or good place to work after the implementation of the Working Together project (Figure 12; Appendix 4: Survey data tables).

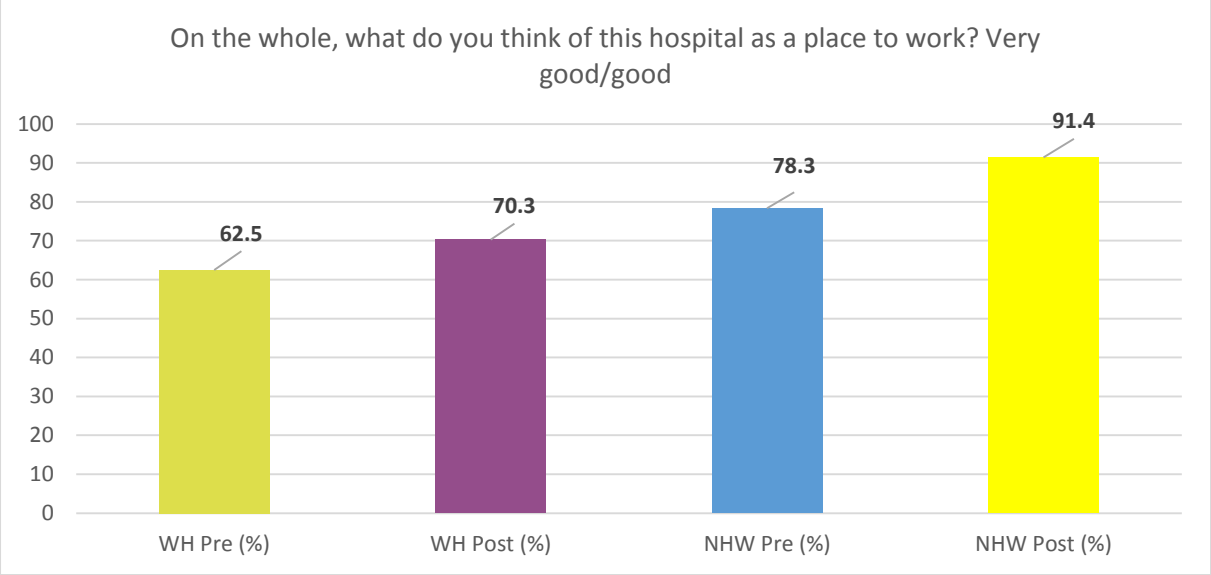


Figure 18: The proportion of nurses/midwives who considered their hospital to be a very good or good place to work (pre- and post-implementation surveys)

A number of factors were identified by the pre-implementation interview participants as affecting staff satisfaction including high workload, patient acuity, and occupational violence. Participants also acknowledged initiatives implemented by management at their health service which contributed to improved staff satisfaction.

- Some weeks [I feel] overworked because of not so much the number of the clients but the nature of the clients we're dealing with. One week it can be what's all the fuss you know this job's easy, the next week I'm calling security, or I have to call the police to have someone removed. Sometimes I think it can feel as though you're just holding on kind of thing. (Western Health Pre-implementation Interview Participant #2)

Staff turnover

The data audit indicated a slight decrease in staff turnover (average monthly number (FTE) of leavers divided by the monthly actual FTE x 100, %) after the implementation of the Working Together project at Western Health (0.7% vs 0.6%) (No or limited staff turnover data was available from Northeast Health Wangaratta) (Appendix 5: Data audit tables).

Workload allocation and management

Patient acuity

Many survey (pre- and post-implementation) respondents and pre-implementation interview participants reported that workload allocations did not take into account patient acuity and often resulted in adverse outcomes for patients:

- Workload allocation in midwifery does not take into account patient acuity. …Workload is also as per EBA, however, this does not take into account the complexity of the women and neonates that we are caring for at Western Health. (Western Health Pre-implementation survey respondent)
- Nurse patient ratio is 1:5 and with heavy and acutely ill patients in our ward, we will not be able to provide the right care, we are supposed to deliver. Which is sad and disappointing. It is in turn increasing [the number of] falls, pressure injuries and patient complaints. (Western Health Pre-implementation survey respondent)
- Patients are so much sicker and ratios have not kept up with that. (Northeast Health Wangaratta Pre-implementation survey respondent)
- Acuity of patients creating impossible workloads. (Western Health Post-implementation survey respondent)

The nurses and midwives who participated in the pre-implementation interviews also reported that they were caring for 'sicker' patients and more patients with comorbidities and as a result, patients' care needs had become more complex. They felt this had increased their workload and there were insufficient staff to effectively and appropriately manage patient needs; and also had a negative impact on their work satisfaction with many reporting feeling burnt out:

- I think sometimes our workload is too heavy, it can get quite busy and hectic on the medical ward, and it's probably to do with like the acuity of patients, I think yeah they seem to be you know a lot more unwell and yeah the workload can be pretty heavy in that respect at times. Sometimes it's okay, but yeah a lot of the time you feel, especially when I was full time yeah, you'd tend to feel a bit burnt out. The patients are so unwell and yeah it's just so busy. (Northeast Health Wangaratta Pre-implementation Interview Participant #8)
- I think the current workloads are really quite heavy, a lot of our patients are now coming in with a lot of comorbidities … it's not just a sort of standard one thing that we're hoping to

treat for them, there's multiple conditions that we're trying to manage. (Northeast Health Wangaratta Pre-implementation Interview Participant #1)

- When you've got your real sickies you haven't actually got that extra staff to help with that. Because I know on one shift not that long ago you know there was 4 sick patients in a room you know that had a nasogastric, IV, a drain, IDC, they were needing all sorts of other procedures being done 2 to 4 hourly, there was like 2 of those in a room and then you have a semi confused patient and there's only one person in that room, you know. Because the other staff had to go and work, look after the other 4 patients that we had. And it's all very well having them all in the one room, but you still needed an extra pair of hands, not all the time, but you know there's not that ability to be able to flex people I think. (Northeast Health Wangaratta Pre-implementation Interview Participant #2)
- So whilst we have ratios which are a godsend … it's where you need to increase the staffing for [patient] complexity … that's where you run into issues. (Northeast Health Wangaratta Pre-implementation Interview Participant #5)
- When I first started in the emergency department we had 3 people working on a day shift, 3 people would be pushed to the max, but you'd get the job done. We now have 6 sometimes 7 working and we're struggling because the local population has changed, it's got a lot older and as you get older you get sicker, we're keeping people at home longer that sort of thing. So our allocation by nature of the demographic of the area has had to change. (Northeast Health Wangaratta Pre-implementation Interview Participant #6)

Workload allocation

Difficulties providing appropriate and high-quality patient care due to patient ratios on night duty compared to during daytime shifts were reported by several survey respondents and pre-implementation interview participants:

- Western Health forgets children are sick at night as well and parents are even more worried and anxious due to being tired with a sick child and yet we don't have time to assure them as the ratio is 1:6 as opposed to the Day ratio of 1:4 plus an ANUM and a CSRN both of whom don't have a patient load on Days. (Western Health Pre-implementation survey respondent)
- Patient allocations need to be reduced for night staff and the in-charge shouldn't have a workload. (Western Health Post-implementation survey respondent)
- Pre-implementation interview participants also commented that workload allocations need to consider patient acuity, staff skill mix, and workload.
- Workload allocation needs to be skill mixed, so the most sickest patients needs to go to your more senior staff. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- I think sometimes it's unfair, and they don't really take into account workload, and I think the same people tend to get the more difficult patients and so I think allocation is based on like looking after your friends sometimes. (Western Health Pre-implementation Interview Participant #4)
- Thinking about sort of giving people a break, so for example if one nurse has been in a certain area that you know is quite difficult, like it's about rotating those nurses around. (Western Health Pre-implementation Interview Participant #4)

- I think the one to four ratio is brilliant but it's no good if you haven't got the right person allocated or you make that room too heavy. What I don't understand is they might say this room's really heavy, but they're not glued to the floor. They're not nailed in, you can move them, you can move them to other parts. (Western Health Pre-implementation Interview Participant #3)

Patient ratios

Pre-implementation interview participants identified nurse/midwife patient ratios as both a 'blessing and a curse'. Nurses/midwives reported that it was often difficult to provide high quality patient care within the current nurse/midwife: patient ratios particularly when caring for patients with complex needs or high acuity patients:

- Well if you don't have enough nurses then you can't provide the best practice and the best care, and patient centred care, which is what we're all about. So the patient centred care has to drop off because you can't make yourself available for the 6 or 8 patients that you have. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- So whilst we have ratios which are a godsend, … it's where you need to increase the staffing for complexity and or patient care, that's where you run into issues slash problems. (Northeast Health Wangaratta Pre-implementation Interview Participant #5)

Some nurses and midwives who participated in a pre-implementation interview expressed a preference for 'team nursing' as it provided additional support especially for less experienced or bank/pool staff:

- When you're a team you feel as though you can bounce questions off each other better. And so if you've sort of suddenly got a question you sort of think … you know I'll go and ask so and so. (Northeast Health Wangaratta Pre-implementation Interview Participant #2)
- I think if [team nursing] is done correctly, so there are I think – if the tasks are divvied up and the care's divvied up sort of equally so that sort of one nurse isn't doing, caring for 8 patients rather than the 4 and the other one's just sitting down. Yeah so I think if it's done correctly I think it's worthwhile. (Western Health Pre-implementation Interview Participant #4)
- I think team nursing would be fantastic because in that case even if you had someone from bank pool who doesn't know anything she's teamed up with someone and someone is overseeing her, and it would give her faith at the end of the day. (Western Health Pre-implementation Interview Participant #1)

Others felt that having nurses/midwives responsible for a certain number of patients ensured accountability and reduced the number of elements of patient care that were missed:

- Sometimes in the team nursing I think maybe you thought the other nurse might've done something but they haven't and they thought you have, and it might be missed. (Northeast Health Wangaratta Pre-implementation Interview Participant #8)
- I have a preference that one nurse is responsible for each, for a particular patient, so that – you know because we all have to be accountable for our actions, and if we're accountable for at least one patient, or however many patients, there's no grey areas as to who's going to do what and you know who's not doing certain tasks for those patients. … I think if you're responsible for your patients, there's no ambiguity with who's doing the progress notes,

who's writing the care plans. (Northeast Health Wangaratta Pre-implementation Interview Participant #1)

- In my experience, and I did both team and individual nurse care, and in my experience I found being responsible for 4 patients I knew exactly what was going on, whereas I found if I was in charge and had some Div2s working under me for example, I'd still have to be checking and making sure. So I actually liked having my own patients rather than team nursing, because you knew exactly what was going on and I didn't think things weren't getting missed or worried that things were going to get missed. (Northeast Health Wangaratta Pre-implementation Interview Participant #4)
- I think the allocations the one to four in the day and I think one to five in the afternoon is great but I think it's also a curse as well because you sort of feel as if you're stuck in that. (Western Health Pre-implementation Interview Participant #3)

Staff skill mix

Staff skill mix was identified by survey respondents as sometimes having a negative impact on patient care:

- Skill mix is poor at the hospital. Sometimes only one or two Grade 2 permanent staff so it puts a lot of pressure on them to do their work and also adhere to policy such as drug checking. (Western Health Pre-implementation survey respondent)
- At times there may not be adequate staff with right skill mix available due to inadequate number of workforce availability. (Northeast Health Wangaratta Pre-implementation survey respondent)

Pre-implementation interview participants also identified the importance of ensuring a suitable staff skill mix when allocating patients/workload in order to provide appropriate patient care, and the amount of support that less experienced staff often required:

- I think you know the in-charge's try and allocate probably the most sickest patients or the ones with the most complex needs to the relevant staff that have those higher skills and you know more experience. (Northeast Health Wangaratta Pre-implementation Interview Participant #1)
- Our skill mix is not terrific. So on an afternoon shift which is a heavier patient load, you have 5 and 6 patients each, you could be the only senior nurse. And all the rest are new grads or new staff that have been out maybe a year, 2 years … there's not enough experienced nurses. (Northeast Health Wangaratta Pre-implementation Interview Participant #3)
- Especially night duty they have a lot of sick leave and it's covered by bank or casual staff, some of them don't have the care factor and they don't have the experience to look after kids. (Western Health Pre-implementation Interview Participant #1)
- I think also even within that ward you need to look at things like your nursing experience, maybe have an experienced nurse with the ICU patient for the first 24 to 48 hours and as they improve, or within your ward move your sicker patients nearer to the nurses' station with the right nurse with maybe the bay next door is not as heavy so that nurse can then assist with the complex patients next door. (Western Health Pre-implementation Interview Participant #3)

Overtime

The data audit indicated that the average total monthly overtime cost increased at both health services after the implementation of the Working Together project in May 2019 (Figure 13; Appendix 5: Data audit tables).

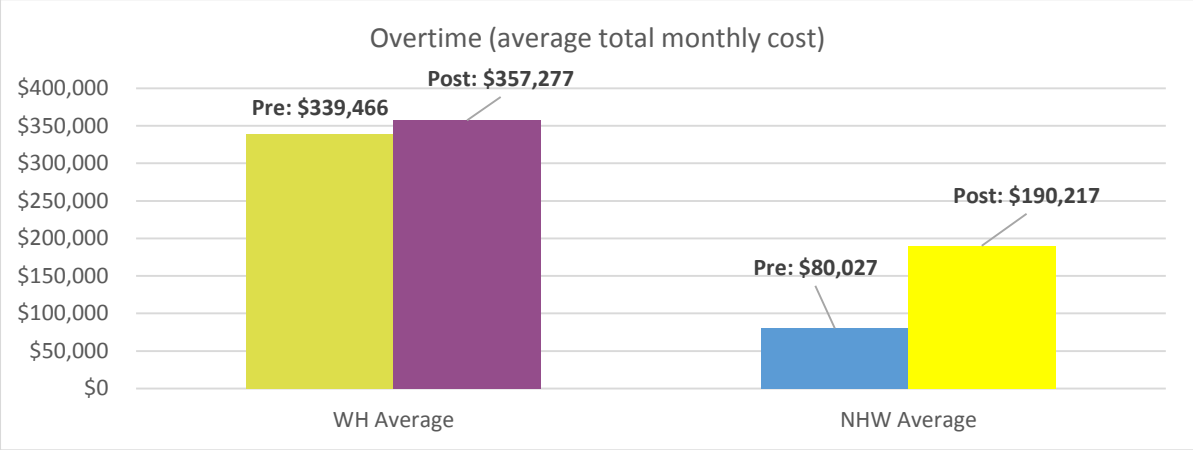


Figure 19: Average overtime cost per month (data audit)

Assessment of the Working Together project

Most post-implementation survey respondents (n=29, 82.9%) at Northeast Health Wangaratta and almost half at Western Health (n=53, 44.9%) had heard of the Working Together project. This reflects the proportion of wards/areas in which the Working Together project was implemented in each health service.

Of the survey respondents who had heard of the Working Together project, approximately a quarter to a third at Western Health, and a quarter to just over half at Northeast Health Wangaratta, thought that it was very successful or successful in improving workload allocation for nurses/midwives, reducing staff turnover and absenteeism, improving the quality of patient care, maximising the use of each nurse's/midwife's skills and experience, and reducing the use of agency staff in their area (Figure 14; Appendix 4: Survey data tables).

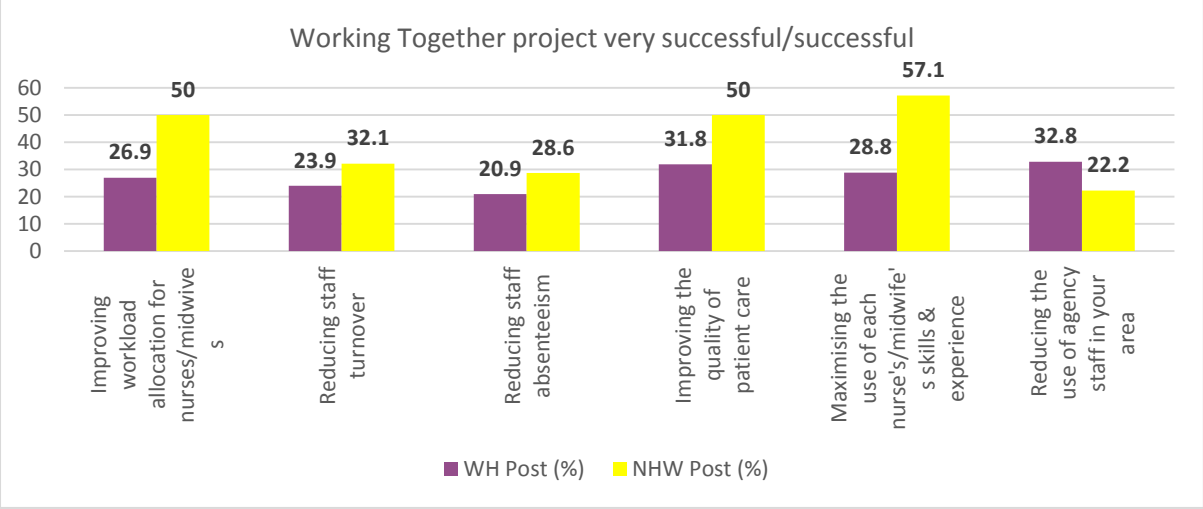


Figure 20: The proportion of nurses/midwives who thought the Working Together project was successful/ very successful (post-implementation survey)

The post-implementation interview participants (Western Health) felt that the Working Together project was 'broadly successful', 'a good initiative', 'worthwhile', and had 'achieved its aims'. For example, one participant reported that her ward now uses patient acuity instead of nurse: patient ratios to allocate workload; and another discussed the improvements made to the handover process and communication in her ward as a result of the project.

The participants particularly enjoyed the Working Together sessions that had been conducted at Western Health at the beginning of the project; They believed that these sessions provided concise, relevant information and enabled nurses/midwives to share their (often common) concerns, and appreciated the opportunity to discuss what needs to be improved and possible solutions – 'it felt like someone was listening'.

However, participants also identified that the COVID-19 pandemic had impacted or 'overruled' the implementation of Working Together initiatives in their area. They reported that they either had to delay or cancel planned initiatives due to pandemic-related changes in workplace procedures, patient care and allocation, and the redeployment of many nurses/midwives to other areas. As a result, participants believed that 'it was too early to tell' if the Working Together project had affected factors such as the quality of patient care, staff satisfaction, and workload allocation.

A few post-implementation survey respondents felt that the Working Together project initiatives had not had a substantial impact on workload allocation.

- I was very eager to be involved in this project, however within Maternity Services I observed no change in patient and/or staff quality or safety improvements. One poster was placed on the tea room doors suggesting staff think about things they were grateful for during that shift and walking to our cars as a group at the end of shift.. (Western Health Post-implementation survey respondent)
- I feel that the project has not done a lot to address the pressure that experienced nurses are under having to care for their own patient load as well as mentoring and assisting less experienced nurses/new graduates. (Western Health Post-implementation survey respondent)
- It was not a great time for the ward to participate in "anything new". There was a lack of ward ANUMs at the time due to Annual Leave, secondment and emergency leave. There were no real "leaders" to affectively LEAD this opportunity. I have NOT seen any improvement or changes on the ward since this project was implemented. There has been talk generated however so hopefully we can continue with the chat and basics plans that have been talked about. (Northeast Health Wangaratta Post-implementation survey respondent)

One participant also commented that they did not believe that the Working Together project or initiatives would be able to address the 'main problem' of having sufficient nurses/midwives to cope with the workload. The participant identified that as a result of the heavy workload nurses on her ward often were unable to provide 'basic' patient care such as cleaning a patient's dentures or washing their hair. She suggested that Western Health should consider employing Personal Care

Attendants such as those at the Olivia Newton-John Cancer Wellness and Research Centre who undertook tasks such as feeding patients, making beds and washing patients.

Nevertheless, participants commented that the Working Together project had 'opened their eyes to what was possible' and they hoped they would have the opportunity to 'embed' their planned initiatives post-pandemic.

Strengths and Limitations

A strength of the evaluation was the participation of a diverse sample of nursing and midwifery staff at each health service. Validated instruments were used to assess perceived stress, role clarity and tension, and role conflict and ambiguity.

The survey is limited by the use of two sets of cross-sectional data, which cannot reveal causal relationships. It is not possible to attribute any changes observed during the implementation period to this trial of Working Together. The comparison of survey responders with non-responders was not possible because the survey was anonymous.

Although the survey response rate was relatively low, it is similar to that of other studies which have used unsolicited surveys with nurses and midwives. Due to infection control protocols at Western Health during the COVID-19 pandemic, nurses and midwives could only be invited to participate in the post-implementation surveys and interviews via email and the survey had to be completed online. It was not possible to accurately determine the number of nurses and midwives who received the link to the survey; thus, our conservative estimation of the response rate was based on the total number of nursing and midwifery staff employed at Western Health.

The study was conducted at one large metropolitan health service and one regional health service in Victoria; therefore, the results may not be generalisable to other health services or settings. However, lessons from the project can still be learnt and adapted to other health services as the foundational workforce issues are similar across most health services.

The implementation and evaluation of the Working Together project were impacted by a number of unforeseen and adverse events including bushfires in regional Victoria in December 2019 – January 2020, , and other events such as the opening of the new Joan Kirner Women's and Children's at Western Health in May 2019. These events had a particularly negative impact on the post-implementation survey and interview participation rates.

Due to delays with the commencement of the Working Together project, it was only possible to collect data 10 months (up until May 2020) at Western Health and 7 months (up to January 2020) at Northeast Health Wangaratta after the project was implemented. It is possible that this timeframe has not allowed sufficient time to pass for changes to occur and the program's effects to emerge (especially given the disruption of the COVID-19 pandemic to the health services from March 2020). It is recommended that the future implementation of the project at other health services collect post-implementation data over a longer period of time so that any changes resulting from the project can

be captured; this is important given the goal of evaluation is to identify and understand the program's results including those that are unintentional.

The study was conducted at one large metropolitan health service and one regional health service in Victoria; therefore, the results may not be generalisable to other health services or settings.
The implementation and evaluation of the Working Together project were impacted by several unforeseen and adverse events including bushfires in regional Victoria in December 2019 – January 2020, the opening of the new Joan Kirner Women's and Children's at Western Health in May 2019 and the COVID-19 pandemic from March 2020. These events had a particularly negative impact on the post-implementation survey and interview participation rates.

Key conclusions

The objective of the Working Together project was to co-design, trial and evaluate improved nursing and midwifery workload allocation and management practices at pilot sites, while working within the prescribed nurse/midwife to patient ratios outlined in the Act, and in keeping with requirements of the current enterprise agreement. The project was evaluated in order to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved; and inform decisions about expanding the project to other health services. The evaluation included three components at each of the project sites (Western Health and Northeast Health Wangaratta):

1. Data audit of key measures;
2. Pre- and post-implementation surveys; and
3. Pre- and post-implementation interviews.

The implementation and evaluation of the Working Together was affected by several adverse events including bushfires in regional Victoria (December 2019 - January 2020) and the COVID-19 pandemic (March 2020 -). Nevertheless, the findings provide preliminary evidence that the Working Together project may have contributed to an improvement in the quality of patient care; an increase in the proportion of nurses/midwives who will continue to work as a nurse/midwife and the proportion who believe their hospital is a good place to work; an increase nurses' and midwives' job satisfaction; and a reduction in nurses' and midwives' role ambiguity, the number of missed elements of patient care, and adverse events at the project sites.

The reduced timeframe of the project and the adverse events during the project have meant that nurses/midwives had limited or insufficient time to implement their chosen initiatives and for the program's effects to fully emerge. It is recommended that the future implementation of the project at other health services allows sufficient time for initiatives to be implemented and the post-implementation evaluation data to be collected so that any changes resulting from the project can be captured.

Of note, consistent with the rationale for the Working Together project, the nurses and midwives who participated in the evaluation overwhelmingly identified the importance of and need for appropriate workload allocation that considers patient acuity and skill mix and ensures sufficient numbers of nurses/midwives to manage the workload and provide high quality patient care while simultaneously promoting staff satisfaction.

Recommendations & Next Steps

The objective of the Working Together pilot project was to co-design, trial, and evaluate improved nursing and midwifery workload allocation and management practices at pilot sites while working within the prescribed nurse/midwife to patient ratios outlined in the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* (the Act), and also keeping within requirements of the current enterprise agreement. The project was evaluated to determine to what extent the objectives and outcomes of the pilot were achieved and to inform decisions about the value of expanding the project to other health services.

Comparing the pre and post-implementation data, moderate changes were noted, which demonstrated that the project rationale was able to be validated, despite the challenges encountered during project implementation. These challenges included several adverse events, specifically the bushfires in regional Victoria (January 2020) and the COVID-19 pandemic (since February 2020).

The moderate changes included:

- An improvement in the quality of patient care, as perceived by nurses and midwives;
- An increase in the proportion of nurses/midwives who indicated that they will continue to work as a nurse/midwife
- An increase in the proportion of nurses/midwives who believed their hospital is a good place to work;
- An increase in nurses' and midwives' job satisfaction;
- A reduction in nurses' and midwives' role ambiguity, and
- A reduction in the number of missed elements of patient care, and adverse events at the project sites.

What this has also demonstrated is that nurses and midwives who participated in the pilot believed that elements within their work situation could be improved; nurses and midwives should be supported and encouraged to identify their own solutions and; changes in behaviour require the development of more complex initiatives than just a roll out 'poster'.

We recommend the following next steps for use in the pilot hospitals and other organisations:

1. Reinforce the importance of nurse/midwife-led solutions as co-design methodology was valued and appreciated by the participating units
    - Implement ongoing governance policies that encourage and support specific and innovative nurse/midwife led models.
    - Provide support for Unit Managers to be empowered to test, trial and evaluate their and their staffs ideas and innovations.
2. Ensure active validation of views and experiences from focus groups or other data sources
    - Staff appreciated the opportunity to share their views and experiences in local forums such as focus groups, unit meetings and feedback boxes as long as it was preceding action e.g. they had confidence that action was going to follow
3. Acknowledged the importance of leadership including the senior leadership team

4. Collaborate and partner for expertise with others as health service may not have access to all types of experts required
5. Review survey measures to ensure they are appropriate for initiatives implemented as part of the Working Together project, include possible confounders (other simultaneous interventions / events) and ensure sample sizes are sufficient to allow multivariate analysis
6. Longer data collection period post-implementation to ensure capture of any changes
    - Collaborate and develop a longitudinal study involving more health services across Victoria

The evaluation overwhelmingly identified the importance of and need for appropriate workload allocation which considers patient acuity and skill mix, and ensures sufficient numbers of nurses/midwives to manage the workload and provide high-quality patient care while simultaneously promoting staff satisfaction.

The bushfires and the COVID-19 challenges in Victoria during the Project reduced the time available for nurses/midwives to implement their chosen initiatives and for the program's effects to fully emerge. It is recommended that the implementation of the project at other health services in the future allows sufficient time for initiatives to be implemented and the post-implementation evaluation data collected so that any changes resulting from the project can be captured.

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Appendix 1 Ethics approvals & documents

Western Health

Office for Research
3rd Floor, Western Centre for Health Research and Education Sunshine Hospital
Furlong Rd. St Albans VIC 3021
Tel. +61 3 8395 8074
Fax. +61 3 8395 8259
ABN 61 166 735 672

WESTERN HEALTH LOW RISK HUMAN RESEARCH ETHICS PANEL APPROVAL TO CONDUCT RESEARCH
AND
SITE SPECIFIC ASSESSMENT (SSA) AUTHORISATION

28 March 2019

Professor Bodil Rasmussen
Chair in Nursing, Western Health Partnership School of Nursing and Midwifery, Faculty of Health
Western Health
Sunshine Hospital 17 Furlong Rd
St Albans VIC 3021

Dear Prof Rasmussen,

LREP Project Number: HREC/19/WH/51355

Project Title: Evaluation of the Working Together Pilot Project

LREP Approval Date: 27March 2019 SSA Approval Date: 27 March 2019

Principal Investigator/s: Prof Bodil Rasmussen

Associate Investigator/s: Dr Sara Holton, Dr Karen Wynter

I am pleased to advise that the above project has been given ethics approval by the Western Health Low Risk Ethics Panel (LREP). The LREP confirms that your proposal meets the requirements of the National Statement on Ethical Conduct in Human Research (2007).

This project has also been issued with site specific approval to be conducted at Western Health.

Ethics & Governance approval for this project applies at the following sites:

Footscray Hospital
Sunshine Hospital
Williamstown Hospital
Sunbury Day Hospital
Drug & Alcohol Services
Hazeldean Transition Care

Conditions of Ethics Approval and Governance Authorisation:

You are required to submit to the LREP:

The actual start date of the project at Western Health.

An Annual Progress Report (that covers all sites listed on approval) for the duration of the project. This report is due on the anniversary of LREP approval date. Continuation of ethics approval is contingent on submission of an annual report, due within one month of the approval anniversary. Failure to comply with this requirement may result in suspension of the project by the LREP.

A comprehensive Final Report upon completion of the project.

- Submit to the LREP for approval any proposed amendments to the project including any proposed changes to the Protocol and Participant Information and Consent Form/s.
- Notify the LREP of any adverse events that have a material impact on the conduct of the research.
- Notify the LREP of your inability to continue as Principal Investigator.
- Notify the LREP of the failure to commence the study within 12 months of the LREP approval date or if a decision is taken to end the study at any of the sites prior to the expected date of completion.
- Notify the LREP of any matters which may impact the conduct of the project.

Approved/Noted Documents:

Document	Version	Date
Human Research Ethics Application (HREA) Form; HREC/51355/WH-2019-169724	2	28 March 2019
Victorian Specific Module (VSM)		19 February 2019
Western Health LREP Site Specific Form		20 February 2019
Statement of Approval – Nursing and Midwifery		22 February 2019
Protocol	2	25 March 2019
Participant Information and Consent Form – Surveys	1	07 February 2019
Participant Information and Consent Form – Interviews	1	07 February 2019
Summary of Results Request Form	1	07 February 2019
Participant Email Invitation – Survey	1	07 February 2019
Letter of Invitation Cover Letter – Interviews	1	07 February 2019
Demographic Survey – Interview Participants	1	07 February 2019
Pre-Intervention Interview Guide	1	07 February 2019
Post-Intervention Interview Guide	1	07 February 2019
Pre-Implementation Survey (Qualtrics Survey Software)		21 February 2019
Post-Implementation Survey (Qualtrics Survey Software)		21 February 2019
Data Collection Tool	1	21 February 2019
Research Collaboration Agreement between Western Health, Northeast Health Wangaratta and Deakin University		18 February 2019
Curriculum Vitae & WH Researcher Code of Conduct (2012) Bodil Rasmussen Sara Holton Karen Wynter		 23 February 2018 22 November 2018 23 February 2018
ICH Good Clinical Practice Bodil Rasmussen		 25 February 2019

The Office for Research may conduct an audit of the project at any time.

The Office for Research Western Health wishes you and your colleagues every success in your research.

Yours sincerely,

Ms Noelle Gubatanga

Research Ethics & Governance Administration Officer
On behalf of the Western Health Low Risk Ethics Panel Western Health Office for Research
Email: ethics@wh.org.au

Appendix 1.2: Northeast Health Wangaratta Human Research Ethics Committee Letter of Approval

Northeast Health Wangaratta Human Research Ethics Committee ETHICS APPROVAL
Professor Bodil Rasmussen Building Y
221 Burwood Hwy Burwood
Victoria 3125
Australia

1 May 2019

Dear Professor Bodil Rasmussen,

Project Title	Evaluation of the Working Together Pilot
Project ID	51986
Review Reference	HREC/51986/NEHW-2019-172102(v3)
Local Reference Number	

I am pleased to advise that the above project has received ethical approval from Northeast Health Wangaratta Human Research Ethics Committee (HREC).

The HREC confirms that your proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* (2007). This HREC is organised and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007), and all subsequent updates, and in accordance with the *Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95)*, the Health Privacy Principles described in the *Health Records Act 2001* (Vic) and Section 95A of the *Privacy Act 1988* (and subsequent Guidelines).

Approved Documents

The following documents have been reviewed and approved:

Document Type	File Name	Date	Version
Invitation to participant	Invitation letter to participants (component 3interviews Cover letter Interviews	01/03/2019	1
Victorian specific module (VSM)	Victorian Specific Module NHW	21/03/2019	1
Other project-related documentation	Summary of results form	21/03/2019	1
Other project-related documentation	NHW Pre -Intervention Interview Guide	21/03/2019	1

Participant information and consent form	Participant information and consent form (survey)	25/03/2019	1
Participant information and consent form	Participant Information and Consent Form (component 3 interviews)	25/03/2019	1
Other project-related documentation	Wet ink signatures from HREA	01/04/2019	1
Invitation to participant	Invitation email to participants at NHW (component 2 surveys)	02/04/2019	1
Other project-related documentation	Bodils wet ink signature for HREA	02/04/2019	1
Protocol	NHW Protocol Document Version two SH	18/04/2019	2
Other project-related documentation	NHW Post Implementation Interview Guide	18/04/2019	2
Other project-related documentation	NHW data collection tool Version 2	18/04/2019	2
Questionnaire	NHW pre implementation survey (component 2) Version two SH	18/04/2019	2
Questionnaire	NHW Post implementation survey (component 2) Version 2 SH	18/04/2019	2
Other project-related documentation	Dr Roger Barker- reply version two to HREC	18/04/2019	1
Other project-related documentation	Statements of support for the WTP data collection	18/04/2019	1

Research Governance Authorisation

Research governance/site specific assessment (SSA) authorisation must be obtained by each participating site before the research project can commence at that site.

You are required to provide a copy of this HREC approval letter to the principal investigator of each site covered by this ethics approval. A copy must be included in each site's research governance/SSA application.

Conditions of Ethics Approval

1. You are required to submit to the HREC:
   - An Annual Progress Report (that covers all sites listed on approval) for the duration of the project. This report is due on 1st May 2020 / the anniversary of HREC approval. Continuation of ethics approval is contingent on submission of an annual report, due within one month of the scheduled date. Failure to comply with this requirement may result in suspension of the project by the HREC.
   - A comprehensive Final Report upon completion of the project.
2. Submit to the reviewing HREC for approval any proposed amendments to the project including any proposed changes to the Protocol, Participant Information and Consent Form/s

and the Investigator Brochure.

3. Notify the reviewing HREC of any adverse events that have a material impact on the conduct of the research in accordance with *Safety Monitoring and Reporting in Clinical Trials Involving Therapeutic Goods* (NHMRC, 2016).
4. Notify the reviewing HREC of your inability to continue as Principal Investigator.
5. Notify the reviewing HREC of the failure to commence the research project within 12 months of the HREC approval date or if a decision is taken to end the research project at any of the sites prior to the expected date of completion.
6. Notify the reviewing HREC of any matters which may impact the conduct of the research project.
   - If your project involves radiation, you are legally obliged to conduct your research in accordance with the Australian Radiation Protection and Nuclear Safety Agency *Code of Practice 'Exposure of Humans to Ionizing Radiation for Research Purposes'* Radiation Protection series Publication No.8 (May 2005) (ARPANSA Code).
7. The HREC, authorising institution and/or their delegate(s) may conduct an audit of the research project at any time.

Yours sincerely,

Ms Simone Sammon
HREC Secretariat
Northeast Health Wangaratta

Appendix 1.3: Deakin University Human Research Ethics Committee Letter of Approval Error! Bookmark not defined.

Human Research Ethics

Deakin Research Integrity Burwood
Campus Victoria Postal: 221 Burwood
Highway Burwood Victoria 3125
Australia Telephone 03 9251 7123
research-ethics@deakin.edu.au

MEMORANDUM

To: Prof Bodil Rasmussen

School of Nursing & Midwifery

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 04 April, 2019

Subject: 2019-120
Evaluation of the Working Together Pilot Project

Please quote this project number in all future communications

Approval granted by Western Health Low Risk Ethics Panel HREC for this project will be noted at the DUHREC meeting to be held on 13/05/2019.

It will be noted that approval has been granted for Prof Bodil Rasmussen, School of Nursing & Midwifery, to undertake this project as stipulated in Western Health Low Risk Ethics Panel HREC approval documentation.

The approval noted by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the memo. It is your responsibility to contact the HREC should the project be discontinued before the expected date of completion. You are reminded that:

The Deakin logo should be on any participant documents, including the Plain Language Statement, or where that is not possible, ensure Deakin University's involvement in the project is clearly written in the documentation

The Deakin Human Research Ethics Office needs to be notified immediately if any complaints are received An annual/progress report must be submitted to the approving HREC and at the conclusion of the project, a final report must be submitted to the Deakin HREC.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit research-ethics@deakin.edu.au Telephone: 03 9251 7123

defined.

Western Health

Western Health Low Risk Human Research Ethics Panel

PARTICIPANT INFORMATION AND CONSENT FORM

Version *2* Dated *17 June 2019*
Site *Western Health*

Full Project Title: Evaluation of the Working Together Pilot Project

Principal Researcher: Professor Bodil Rasmussen

Associate Researcher(s): Dr Sara Holton and Dr Karen Wynter

This Participant Information and Consent Form is **5** pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Participant Information Sheet contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information Sheet carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to evaluate the Working Together Pilot Project.

Western Health (WH) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. WH is currently using high levels of agency staff to help bridge the gap.

Later this year WH will implement the Working Together Pilot project. The aim of the Working Together Pilot is to improve the effectiveness of nursing and midwifery workload allocation and management at WH.

You are invited to participate in this research project because you are a nurse or midwife employed at Western Health.

The aim of this project is to evaluate the Working Together Pilot so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at WH both before and after the pilot is implemented.

This research will be conducted by a group of researchers from Western Health and Deakin University.

All nurses and midwives who are employed at WH will be invited to participate in the project.

3. Procedures

Participation in this project will include your involvement in the following two components:

1. Pre-implementation:

   You will be invited to participate in a pre-implementation survey. The pre-implementation survey will be available via Qualtrics, an online survey tool, for 3 weeks. If you prefer you also have the option of completing a hard copy of the survey. The survey will take approximately 15-20 min to complete and will consist of two sections. The first section will include questions about your demographic characteristics (such as your age, years of clinical experience, ward, site, and health service). The second section will ask about your perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at WH.

2. Post-implementation:

   You will also be asked to complete two post-implementation surveys (one at 6 months post-implementation and the other one at 12 months post-implementation). The post-implementation surveys will also be available via Qualtrics, an online survey tool, for 3 weeks. They will take approximately 15-20 min to complete. The surveys will include questions about nurses and midwives'

perceptions of, and satisfaction with, current workload allocation and management practices; level of acceptance of the Working Together pilot program, perceived impact (benefits, difficulties and changes to workflow and practice), including impact on patient care; and instances of on-the-job preceptoring and mentoring.

4. Possible Benefits

The information you provide will help us to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved; and inform decisions about expanding the pilot to other health services.

5. Possible Risks

We believe there are minimal risks with your participation. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

It is possible that questions about the workplace may make some people feel uncomfortable or arouse unpleasant memories. If they do, or you would like to discuss them, you might benefit from contacting your GP or employee assistance program. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

6. Alternatives to Participation

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You can stop responding to the online surveys any time. Your incomplete responses will be excluded from the analysis. The surveys will be anonymous and you will not be asked to identify yourself. As participants are de-identified once all data has been collated and analysed, it will not be possible to remove your individual data.

7. Privacy, Confidentiality and Disclosure of Information

By completing the online survey(s) you are telling us that you consent to take part in the study. All information collected in this project will be de-identified. Your information will be used only for the purpose of this research project and it will be disclosed only with your permission, except as required by law. All electronic data will be deleted from computers after five years. It is anticipated that the results of this research project will be published and/or presented in a variety of forums to improve workforce capability, wellbeing and availability and patient care at Western Health and other health services. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information.

9. Results of Project

We would like to let you know what we have learnt through this project. We will email all nurses and midwives at Western Health a summary of the results once they are available (expected to be in the first half of 2020), and publish the findings on the Western Health intranet.

10. Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher. The researcher responsible for this project is:

Professor Bodil Rasmussen
Chair of Nursing
Western Health – Deakin Partnership
School of Nursing and Midwifery
Faculty of Health
Deakin University
Email: Bodil.Rasmussen@wh.org.au (Western Health)
Phone: (03) 8395 8155 (Western Health)

11. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Position:	Manager, Western Health Office for Research
Telephone:	(03) 8395 8073
Email:	ethics@wh.org.au

(You will need to tell the Manager the name of one of the researchers given in section 10 above.)

12. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Western Health or Deakin University.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Complete the survey(s) only after you have had a chance to ask your questions and have received satisfactory answers.

13. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Western Health Low Risk Human Research Ethics Panel and the Deakin University Human Research Ethics Committees.

14. Reimbursement for your costs

You will not be paid for your participation in this project. However, all nurses and midwives who complete a survey (pre and/or post-implementation) will be eligible to go into the draw for a $100 gift voucher

Appendix 1.5: Western Health Participant Information and Consent Form (interview)

This Participant Information and Consent Form is 7 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to evaluate the Working Together Pilot Project.

Western Health (WH) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. WH is currently using high levels of agency staff to help bridge the gap.
Later this year WH will implement the Working Together Pilot project. The aim of the Working Together Pilot is to improve the effectiveness of nursing and midwifery workload allocation and management at WH.

You are invited to participate in this research project because you are a nurse or midwife employed at Western Health.

The aim of this project is to evaluate the Working Together Pilot so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at WH both before and after the pilot is implemented.
This research will be conducted by a group of researchers from Western Health and Deakin University.
All nurses and midwives who are employed at WH will be invited to participate in the project.

3. Procedures

Participation in this project will include your involvement in the following two components:

1. Pre-implementation:

   You will be invited to participate in an interview prior to the introduction of the Working Together pilot about your perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at WH. If you are a NUM, ANUM, MUM, AMUM or Director of Nursing, you will also be asked about the factors which inform and influence decision-making about patient allocation, your perceptions about the flexibility you have in your role to meet changing patient needs and staff skills.

2. Post-implementation:

   You will be invited to participate in an interview after the Working Together pilot has been implemented about your perceptions of, and satisfaction with, current workload allocation and management practices; your thoughts and experiences of the pilot program; and your perceptions of its impact (benefits, difficulties and changes to workflow and practice) including impact on patient care.

Interviews at each stage of the project will be conducted either via telephone or face-to-face in a meeting room at your hospital, will take no longer than 30 minutes, and be conducted at a time that is convenient for you (such as 'double-staffing' time). The interviews will be facilitated by a member of the research team.

4. Possible Benefits

The information you provide will help us to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved; and inform decisions about expanding the pilot to other health services.

5. Possible Risks

We believe there are minimal risks with your participation. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

It is possible that questions about the workplace may make some people feel uncomfortable or arouse unpleasant memories. If they do, or you would like to discuss them, you might benefit from contacting your GP or employee assistance program. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

6. Alternatives to Participation

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You can stop responding to the online surveys any time. Your incomplete responses will be excluded from the analysis. Collected data from the interviews will be de-identified before being analysed. The surveys will be anonymous and you will not be asked to identify yourself. As participants are de-identified once all data has been collated and analysed, it will not be possible to remove your individual data.

7. Privacy, Confidentiality and Disclosure of Information

By signing the consent form (attached) you consent to participating in the pre- and post-implementation interviews. All information collected in this project will be de-identified. Your information will be used only for the purpose of this research project and it will be disclosed only with your permission, except as required by law. All electronic data will be deleted from computers after five years. It is anticipated that the results of this research project will be published and/or presented in a variety of forums to improve workforce capability, wellbeing and availability and patient care at Western Health and other health services. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information.

9. Results of Project

We would like to let you know what we have learnt through this project. We will email all nurses and midwives at Western Health a summary of the results once they are available (expected to be in the first half of 2020), and publish the findings on the Western Health intranet.

10. Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher. The researcher responsible for this project is:

Professor Bodil Rasmussen
Chair of Nursing
Western Health – Deakin Partnership
School of Nursing and Midwifery
Faculty of Health
Deakin University
Email: Bodil.Rasmussen@wh.org.au (Western Health)
Phone: (03) 8395 8155 (Western Health)

11. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Position:	Manager, Western Health Office for Research
Telephone:	(03) 8395 8073
Email:	ethics@wh.org.au

(You will need to tell the Manager the name of one of the researchers given in section 10 above.)

12. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Western Health or Deakin University.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will allow that person or the research supervisor to inform you if there are any special requirements linked to withdrawing. . If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the research team.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

13. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Western Health Low Risk Human Research Ethics Panel and the Deakin University Human Research Ethics Committees.

14. Reimbursement for your costs

You will not be paid for your participation in this project. However, all nurses and midwives who complete an interview (pre and/or post-implementation) will be eligible to go into the draw for a $100 gift voucher.

15. Consent Form

Site: Western Health **Project title: Evaluation of the Working Together Pilot Project**

I have read, and I understand the Participant Information.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) ……

Signature…… Date

Name of Witness to Participant's Signature (printed) ……

Signature…… Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature…… Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.

Note: All parties signing the Consent Form must date their own signature.

REVOCATION OF CONSENT FORM

Revocation of Consent Form

Full Project Title: Evaluation of the Working Together Pilot Project

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Western Health or Deakin University.

Participant's Name (printed) ……

Signature…… Date

Appendix 1.6: Northeast Health Wangaratta Participant Information Sheet (survey)

Northeast Health Wangaratta Low Risk Human Research Ethics Panel

Participant Information and Consent Form
Version 2
Dated 18 June 2019

Evaluation of the Working Together Pilot Project
Component 2: Survey

Principal Researcher: Professor Bodil Rasmussen

Associate Researcher(s): Dr Sara Holton and Dr Karen Wynter

This Participant Information and Consent Form is 5 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Participant Information Sheet contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information Sheet carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to evaluate the Working Together Pilot Project.

Northeast health Wangaratta (NHW) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. NHW is currently using high levels of pool, casual and agency staff to help bridge the gap.

Later this year NHW will implement the Working Together Pilot project. The aim of the Working Together Pilot is to improve the effectiveness of nursing and midwifery workload allocation and management at NHW.

You are invited to participate in this research project because you are a nurse or midwife employed at NHW.

The aim of this project is to evaluate the Working Together Pilot so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at NHW both before and after the pilot is implemented.

This research will be conducted by a group of researchers from Western Health, Deakin University, and NHW

All nurses and midwives who are employed at NHW will be invited to participate in the project.

3. Procedures

Participation in this project will include your involvement in the following two components:

Pre-implementation:

You will be invited to participate in a pre-implementation survey. The pre-implementation survey will be available via Qualtrics, an online survey tool, for 3 weeks. If you prefer you also have the option of completing a hard copy of the survey. The survey will take approximately 15-20 min to complete and will consist of two sections. The first section will include questions about your demographic characteristics (such as your age, years of clinical experience, ward, site, and health service). The second section will ask about your perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at NHW.

Post-implementation:

You will also be asked to complete two post-implementation surveys (one at 6 months post-implementation and the other one at 12 months post-implementation). The post-implementation surveys will also be available via Qualtrics, an online survey tool, for 3 weeks. They will take approximately 15-20 min to complete. The surveys will include questions about nurses and midwives' perceptions of, and satisfaction with, current workload allocation and management practices; level of acceptance of the Working Together pilot program, perceived impact (benefits, difficulties and changes to workflow and practice), including impact on patient care; and instances of on-the-job preceptoring and mentoring.

4. Possible Benefits

The information you provide will help us to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved; and inform decisions about expanding the pilot to other health services.

5. Possible Risks

We believe there are minimal risks with your participation. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

It is possible that questions about the workplace may make some people feel uncomfortable or arouse unpleasant memories. If they do, or you would like to discuss them, you might benefit from contacting your GP or employee assistance program. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

6. Alternatives to Participation

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You can stop responding to the online surveys any time. Your incomplete responses will be excluded from the analysis. The surveys will be anonymous and you will not be asked to identify yourself. As participants are de-identified once all data has been collated and analysed, it will not be possible to remove your individual data.

7. Privacy, Confidentiality and Disclosure of Information

By completing the online survey(s) you are telling us that you consent to take part in the study. All information collected in this project will be de-identified. Your information will be used only for the purpose of this research project and it will be disclosed only with your permission, except as required by law. All electronic data will be deleted from computers after five years. It is anticipated that the results of this research project will be published and/or presented in a variety of forums to improve workforce capability, wellbeing and availability and patient care at Western Health and other health services. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information.

9. Results of Project

We would like to let you know what we have learnt through this project. We will email all nurses and midwives at Western Health a summary of the results once they are available (expected to be in the first half of 2020), and publish the findings on the Western Health intranet.

10. Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher. The researcher responsible for this project is:

Professor Bodil Rasmussen
Chair of Nursing
Western Health – Deakin Partnership
School of Nursing and Midwifery
Faculty of Health
Deakin University
Phone: (03) 8395 8155 (Western Health)
Email: Bodil.Rasmussen@wh.org.au

11. Other Issues

If you have any other complaints about any aspects of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact
Research Development and Governance Officer NHW

Dr. Anita Star
Phone 03 5722 5139
Email Anita.Star@nhw.org.au
(Available Monday and Tuesday)

Ethics Committee Secretary NHW

Simone Sammon
Phone 03 5722 5149
Email Simone.Sammon@nhw.org.au
(Available Tuesdays only)

Urgent concerns raised to the:
Acting Director of Education and Research NHW

Jacqui Verdon
Phone 03 5722 5411
Email Jacqui.verdon@nhw.org.au

12. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Western Health or Deakin University.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Complete the survey(s) only after you have had a chance to ask your questions and have received satisfactory answers.

13. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Northeast Health Wangaratta Low Risk Human Research Ethics Committee and the Deakin University Human Research Ethics Committees.

14. Reimbursement for your costs

You will not be paid for your participation in this project. However, all nurses and midwives who complete a survey (pre and/or post-implementation) will be eligible to go into the draw for a $100 gift voucher.

Appendix 1.7: Northeast Health Wangaratta Participant Information and Consent Form (interview)

Northeast Health Wangaratta Low Risk Human Research Ethics Panel

Participant Information and Consent Form

Version: 2	Dated: 18 June 2019
Site:	Northeast Health Wangaratta
Full Project Title:	Evaluation of the Working Together Pilot Project
Component 3:	Interview
Principal Researcher:	Professor Bodil Rasmussen

Associate Researcher(s): Dr Sara Holton and Dr Karen Wynter

This Participant Information and Consent Form is 7 pages long.
Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Participant Information contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.
You will be given a copy of the Participant Information and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to evaluate the Working Together Pilot Project

Northeast Health Wangaratta (NHW) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. NHW is currently using high levels of agency staff to help bridge the gap

Later this year NHW will implement the Working Together Pilot (WTP) project. The aim of the WTP is to improve the effectiveness of nursing and midwifery workload allocation and management at NHW.

You are invited to participate in this research project because you are a nurse or midwife employed at NHW.

The aim of this project is to evaluate the Working Together Pilot so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at NHW both before and after the pilot is implemented.

This research will be conducted by a group of researchers from NHW, WH, and Deakin University.

All nurses and midwives who are employed at NHW will be invited to participate in the project.

3. Procedures

Participation in this project will include your involvement in the following two components:

Pre-implementation:

You will be invited to participate in an interview prior to the introduction of the Working Together pilot about your perceptions of, and satisfaction with, current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at NHW

If you are a NUM, MUM, ANUM, AMUM, or Director of Clinical Services, you will also be asked about the factors which inform and influence decision making about patient allocation, your perceptions about the flexibility you have in your role to meet changing patient needs and staff skills.

Post-implementation:

You will be invited to participate in an interview after the Working Together pilot has been implemented about your perceptions of perceptions of, and satisfaction with, current workload allocation and management practices; your thoughts and experiences of the pilot program; and your perceptions of its impact (benefits, difficulties and changes to workflow and practice) including impact on patient care.

Interviews at each stage of the project will be conducted either via telephone or face-to-face in a meeting room at your hospital, will take no longer than 30 minutes, and be conducted at a time that is convenient for you (such as 'double-staffing' time).

The interviews will be facilitated by a member of the research team from Deakin University. (Not by Working Together Pilot Project staff from NHW)

4. Possible Benefits

The information you provide will help us to determine to what extent the objectives and outcomes of the pilot were (or were not) achieved; and inform decisions about expanding the pilot to other health services.

5. Possible Risks

We believe there are minimal risks with your participation. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

It is possible that questions about the workplace may make some people feel uncomfortable or arouse unpleasant memories. If they do, or you would like to discuss them, you might benefit from contacting your GP or employee assistance program. You will not be asked to disclose anything that you do not wish to, and nothing that identifies an individual participant will ever be released.

6. Alternatives to Participation

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You can stop responding to the online surveys any time. Your incomplete responses will be excluded from the analysis. Collected data from the interviews will be de-identified before being analysed. The surveys will be anonymous and you will not be asked to identify yourself. As participants are de-identified once all data has been collated and analysed, it will not be possible to remove your individual data.

7. Privacy, Confidentiality and Disclosure of Information

By signing the consent form (attached) you consent to participating in the pre- and post-implementation interviews. All information collected in this project will be de-identified. Your information will be used only for the purpose of this research project and it will be disclosed only with your permission, except as required by law. All electronic data will be deleted from computers after five years. It is anticipated that the results of this research project will be published and/or presented in a variety of forums to improve workforce capability, wellbeing and availability and patient care at NHW, WH and other health services. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

8. New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information. This new information may mean that you can no longer participate in this research. If this occurs, the person(s) supervising the research will stop your participation. In all cases, you will be offered all available care to suit your needs and medical condition.

9. Results of Project

We would like to let you know what we have learnt through this project. We will email all nurses and midwives at Northeast Health Wangaratta, a summary of the results once they are available (expected to be in the first half of 2020).

10. Further Information or Any Problems

If you require further information or if you have any problems concerning this project (for example, any side effects), you can contact

The principal researcher:

Professor Bodil Rasmussen
Chair of Nursing
Western health-Deakin Partnership
Phone 03 8395 8073 (Western Health)
Email Bodil.Rasmussen@wh.org.au

11. Other Issues

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Research Development and Governance Officer NHW

Dr. Anita Star
Phone 03 5722 5139
Email Anita.Star@nhw.org.au
(Available Monday and Tuesday)

Ethics Committee Secretary NHW

Simone Sammon
Phone 03 5722 5149
Email Simone.Sammon@nhw.org.au
(Available Tuesdays only)

Urgent concerns raised to the:

Acting Director of Education and Research NHW

Jacqui Verdon
Phone 03 5722 5411
Email Jacqui.verdon@nhw.org.au

12. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with Northeast health Wangaratta

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.
If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will allow that person or the research supervisor to inform you if there are any health risks or special requirements linked to withdrawing.

13. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethical aspects of this research project have been approved by the Western Health Low Risk Human Research Ethics Panel as well as the Northeast Health Low Risk Human Research Ethics Committee

14. Reimbursement for your costs

You will not be paid for your participation in this project. However, all nurses and midwives who complete a survey (pre and/or post-implementation) will be eligible to go into the draw for a $100 gift voucher.

15. Consent Form

Site:	Northeast Health Wangaratta
Project title:	Evaluation of the Working Together Pilot Project

I have read, and I understand the Participant Information.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed) ……

Signature…… Date

Name of Witness to Participant's Signature (printed)

……

Signature…… Date

Declaration by Researcher*:
I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature…… Date

* A senior member of the research team must provide the explanation and provision of information concerning the research project.
Note: All parties signing the Consent Form must date their own signature.

REVOCATION OF CONSENT FORM

Full Project Title: Evaluation of the Working together Pilot Project

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with Northeast Health Wangaratta, Western Health or Deakin University.

Participant's Name (printed) ……

Signature…… Date

Appendix 2: Surveys Error! Bookmark not defined.

Appendix 2.1: Western Health Pre-implementation survey Error! Bookmark not defined.

Evaluation of the Working Together Project

Pre-implementation survey

Thank you for your interest in the research study "Evaluation of the Working Together Project". The study has been approved by the Western Health Low Risk Ethics Committee and the Deakin University Human Research Ethics Committee.

The aim of this study is to evaluate the Working Together project so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at Western Health both before and after the pilot is implemented.

The study participant information sheet tells you more about the study and can be accessed via this link: Working together participant information sheet

Please read through the participant information sheet.

We will not ask you to write your name on this survey but will ask you to create a unique code number known only to you. To add another layer of privacy, we will assign you a study id. The personal code you generate will not be stored in the database with your answers, we will just use it to link your responses to this survey and the second (post-implementation) one if you choose to participate in both.

There are no right or wrong answers to the questions in this survey. We are simply interested in your experiences, thoughts and opinions. If you are unsure about how to answer a question, please mark the response which corresponds most closely to how you feel.

The survey will take approximately 15-20 minutes to complete.

Your completion of the survey indicates your consent to participate in the study.

Thank you for your participation. If you have any questions about the study please contact Dr Sara Holton or Dr Karen Wynter at email:
WHDeakinPartnership@wh.org.au .

Please create your own unique code (no spaces, no commas, no full stops) as described below:

The first letter of your name (lower case)
Your month of birth (use two numbers)
The first two letters of your mother's surname (maiden name) (lower case)

For example, the codes for the following people would be:
Susan Jones is born in February and her mother's surname (maiden) is Brown.
s02br
Lei Zhang is born in June and his mother's surname (maiden) is Zhang.
l06zh

The format of this code is required so that you can remember it when you do the post-implementation survey. Your unique code will not be linked to your Western Health employee number.

Section 1. Some questions about you

What was your age at your last birthday?

In which country were you born?

What is your current position?

- RN
- EN
- Midwife
- Nurse & Midwife
- Nurse Practitioner

Other ([please specify

How many years have you practised as a nurse/midwife?

How many years have you been employed at Western Health?

How long do you intend to stay working as a nurse/midwife at Western Health?

- Up to one year
- More than one year
- I don't know

How long do you intend to stay working as a nurse/midwife?

- Up to one year
- More than one year
- I don't know

Which division/ward do you work in at Western Health (please choose the ward where you spend most of your time)?

Division

Ward/Area

If you responded 'other' to the above question, please specify below which area you mainly work in at Western Health.

Section 2. Work Satisfaction

This section asks some questions about how satisfied you are with your work at Western Health.

Nurses/midwives with whom I work (at Western Health) would say that:

Autonomy (Amount of job-related independence, initiative, and freedom, either permitted or required in daily work activities)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Nurses/midwives are supervised more closely than is necessary	○	○	○	○	○	○
2. They have sufficient input into the program of care for each of their patients	○	○	○	○	○	○
3. They have too much responsibility and not enough authority	○	○	○	○	○	○
4.Nurses/midwives have a good deal of control over their own work	○	○	○	○	○	○
5. They are frustrated sometimes because their activities seem programmed for them	○	○	○	○	○	○
6. They are required sometimes to do things on the job that are against their better professional judgement	○	○	○	○	○	○
7. Nurses/midwives need more autonomy in their daily practice	○	○	○	○	○	○
8. They are free to adjust their daily practice to fit patient needs	○	○	○	○	○	○

Nurses/midwives with whom I work (at Western Health) would say that:

Professional Status (*Overall importance or significance felt about your job both in your view and in the view of others)*

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.They are satisfied with the status of nursing/midwifery in the hospital	○	○	○	○	○	○
2. Staff in other departments appreciate nursing/midwifery	○	○	○	○	○	○
3. They are proud to talk to other people about what they do on the job	○	○	○	○	○	○
4.What they do on the job is really important	○	○	○	○	○	○
5. What they do on the job does not add up to anything really significant	○	○	○	○	○	○
6. More recognition of nurses/midwives is needed from hospital management	○	○	○	○	○	○
7. Patients (family members) acknowledge nursing's /midwifery's contribution to their care	○	○	○	○	○	○
8. They recommend this hospital to others as a good place for nurses/midwives to work	○	○	○	○	○	○
9. Their work contributes to a sense of personal achievement	○	○	○	○	○	○

Nurses/midwives with whom I work (at Western Health) would say that:

Pay (*Dollar remuneration and fringe benefits received for work done*)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Their present salary is satisfactory	○	○	○	○	○	○
2. A lot of nurses/midwives at this hospital are dissatisfied with their pay	○	○	○	○	○	○
3. The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital.	○	○	○	○	○	○
4.The latest salary increases for nurses/midwives at this hospital are not satisfactory	○	○	○	○	○	○
5. They are being paid fairly compared to what they hear about nurses/midwives at other hospitals	○	○	○	○	○	○
6. An upgrading pay schedules for nurses/midwives is needed at this hospital	○	○	○	○	○	○

Section 3. Your thoughts and feelings

The next questions ask about your feelings and thoughts during the last month. For each question, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is don't try to count up the number of times you felt a particular way but rather indicate the option that seems like a reasonable estimate.

In the last month, how often have you ...

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1. Been upset because of something that happened unexpectedly?	○	○	○	○	○
2. Felt that you were unable to control the important things in your life?	○	○	○	○	○
3. Felt nervous and 'stressed'?	○	○	○	○	○
4. Dealt successfully with irritating life hassles?	○	○	○	○	○
5. Felt you were effectively coping with important changes that were occurring in your life?	○	○	○	○	○
6. Felt confident about your ability to handle your personal problems?	○	○	○	○	○
7. Felt that things were going your way?	○	○	○	○	○
8. Found that you could not cope with all the things you had to do?	○	○	○	○	○
9. Been able to control irritations in your life?	○	○	○	○	○

	Never (1)	Almost never	Sometimes (3)	Fairly often	Very Often (5)

		(2)		(4)	
10. Felt that you were on top of things?	○	○	○	○	○
11. Been angered because of things that happened that were outside of your control?	○	○	○	○	○
12. Found yourself thinking about things that you have to accomplish?	○	○	○	○	○
13. Been able to control the way you spend your time?	○	○	○	○	○
14. Felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

Section 4. Your work

This section asks some questions about your work at Western Health.

How often do you feel bothered by:

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1.Been unclear on just what the scope and responsibilities of your job are	○	○	○	○	○
2. Not knowing what opportunities for advancement or promotion exist for you	○	○	○	○	○
3. Not knowing what your immediate superior thinks of you, how she evaluates your performance	○	○	○	○	○
4. The fact that you can't get information needed to carry out your job	○	○	○	○	○
5. Not knowing just what the people you work with expect of you	○	○	○	○	○
6. Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday	○	○	○	○	○
7. Thinking that the amount of work you have to do may interfere with how well it gets done	○	○	○	○	○
8. Feeling that you have to do things on the job that are against your better judgement	○	○	○	○	○
9. Thinking that you'll not be able to satisfy the conflicting demands of various people over you	○	○	○	○	○

Considering your job as a whole, how much do you like it?

- ○ A lot
- ○ A little
- ○ Not at all

On the whole, what do you think of this hospital as a place to work?

- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Very poor

If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?

- ○ I would prefer to stay
- ○ I would prefer to leave
- ○ I don't know

How long would you like to stay working at this hospital?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

If you had to quit work for a while (for example, because of pregnancy, carer responsibilities etc), would you return to this hospital?

- ○ Yes
- ○ No
- ○ I don't know

How important is it to you to know, in detail, ...

	Very important	Important	Fairly important	Slightly important	Not important
1. What you have to do on a job?	○	○	○	○	○
2. How you are supposed to do a job?	○	○	○	○	○
3. What the limits of your authority on a job are?	○	○	○	○	○
4. How well you are doing?	○	○	○	○	○

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. Have enough time to complete my work	○	○	○	○	○
2. Feel certain about how much authority I have	○	○	○	○	○
3. Perform tasks that are too easy or boring	○	○	○	○	○
4.Have clear, planned goals and objectives for my job	○	○	○	○	○
5. Have to do things that should be done differently	○	○	○	○	○
6. Feel there is a lack of policies and guidelines to help me	○	○	○	○	○
7. Am able to act the same regardless of the group I am with	○	○	○	○	○
8. Am corrected or rewarded when I really don't expect it	○	○	○	○	○
9. Work under incompatible policies and guidelines	○	○	○	○	○
10. Know that I have divided my time properly	○	○	○	○	○
11. Receive an assignment without enough people to complete it	○	○	○	○	○
12. Know what my responsibilities are	○	○	○	○	○

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
13. Have to break a rule or policy in order to carry out an assignment	○	○	○	○	○
14. Have to “feel my way” in performing my duties	○	○	○	○	○
15. Receive assignments that are within my training and capability	○	○	○	○	○
16. Feel certain how I will be evaluated for a raise or promotion	○	○	○	○	○
17. Have just the right amount of work to do	○	○	○	○	○
18. Work with two or more groups who operate quiet differently	○	○	○	○	○
19. Know exactly what is expected of me	○	○	○	○	○
20. Receive incompatible requests from two or more people	○	○	○	○	○
21. Am uncertain as to how my job is linked	○	○	○	○	○
22. Do things that are likely to be accepted by one person and not accepted by others	○	○	○	○	○
23. Am told how well I am doing in my job	○	○	○	○	○
24. Receive an assignment without adequate resources and materials to execute it	○	○	○	○	○
25. Explanation is clear of what has to be done	○	○	○	○	○
26. Work on unnecessary things	○	○	○	○	○
27. Have to work under vague directives or orders	○	○	○	○	○
28. Perform work that suits my values	○	○	○	○	○
29. Do not know if my work will be acceptable to my boss	○	○	○	○	○

Section 6. Patient care

The next questions ask about your experiences of providing patient care at Western Health.

In general, how would you describe ...

	Excellent	Good	Fair	Poor
The quality of nursing/midwifery care delivered to patients on your ward?	○	○	○	○
Patient safety on your ward?	○	○	○	○

On your most recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them? Please mark all that apply:

- ☐ Comfort/talk with patients
- ☐ Educating patients and family
- ☐ Develop or update nursing/midwifery care plans
- ☐ Perform adequate patient surveillance
- ☐ Adequately document nursing/midwifery care (on appropriate forms/EMR)
- ☐ Assist with oral hygiene
- ☐ Perform frequent changing of patient position (PAC)
- ☐ Planning care
- ☐ Administer medications on time
- ☐ Skin care and assessment
- ☐ Prepare patients and family for discharge
- ☐ Treatments/procedures e.g. dressings
- ☐ Pain management
- ☐ Other (please specify) _____

How often do each of the following incidents occur?

	A few times a month or more often	Once a month or less often	Never
Patients received wrong medication time, or does	○	○	○
Pressure ulcers after admission	○	○	○
Patient falls with injury	○	○	○

	A few times a month or	Once a month or less	Never

	more often	often	
Complaints are received from patients or their families	○	○	○
A work related physical injury to nurses/midwives	○	○	○

Section 5. Anything else?

Have we missed anything? If you have anything else you would like to tell us about the effectiveness of nursing and midwifery workload allocation and management at Western Health, please write in the box below.

All nurses and midwives who complete the survey are eligible to go into the draw for a **$100 gift voucher**.

If you would like to participate in the draw **please email your name and email address** to: WHDeakinPartnership@wh.org.au

Please note that your name and email address cannot be linked to your responses to the survey questions, they are anonymous.

Thank you for completing this questionnaire.

Your responses will contribute to improving the effectiveness of nursing and midwifery workload allocation and management at Western Health. Deakin University CRICOS Provider Code 00113B.

Evaluation of the Working Together Pilot Project

Post-implementation survey

Thank you once again for your interest in the research study " Evaluation of the Working Together Pilot Project", and completing the first survey before the Project was implemented. This is the second (post-implementation) and final survey we will ask you to complete.

The study has been approved by the Western Health Low Risk Ethics Committee and the Deakin University Human Research Ethics Committee.

The aim of this project is to evaluate the Working Together Pilot project so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at Western Health both before and after the pilot is implemented.

The study participant information sheet tells you more about the study and can be accessed via this link: Working Together Participant Information Sheet survey

Please read through the participant information sheet.

Once again we will not ask you to write your name on this survey but will ask you to enter the unique code number which is known only to you. This personal code you generated has not be stored in the database with your answers, we will just use it to link your responses to the pre-implementation survey and this second (post-implementation) one.

There are no right or wrong answers to the questions in this survey. We are simply interested in your experiences, thoughts and opinions. If you are unsure about how to answer a question, please mark

the response which corresponds most closely to how you feel.

The survey will take approximately 15-20 minutes to complete.

Your completion of the survey indicates your consent to participate in the study.

Thank you for your participation. If you have any questions about the study please contact Dr Sara Holton or Dr Karen Wynter at email: WHDeakinPartnership@wh.org.au.

Please enter the unique code that you created for the first pre-implementation survey. This code (no spaces, no commas, no full stops) consisted of :

The first letter of your name (lower case)
Your month of birth (use two numbers)
The first two letters of your mother's surname (maiden name) (lower case)

For example, the codes for the following people would be:
Susan Jones is born in February and her mother's surname (maiden) is Brown.
s02br
Lei Zhang is born in June and his mother's surname (maiden) is Zhang.
l06zh

Section 1. Some questions about you

What was your age at your last birthday?

In which country were you born?

What is your current position?

- ○ RN
- ○ EN
- ○ Midwife
- ○ Nurse & Midwife
- ○ Nurse Practitioner
- ○ Other ([please specify

How many years have you practised as a nurse/midwife?

How many years have you been employed at Western Health?

Which site do you work at?

- ○ Sunshine Hospital
- ○ Footscray Hospital
- ○ Williamstown Hospital
- ○ Sunbury Hospital
- ○ Hazeldean

Where do you work? (specific clinical area)

- ○ Ward
- ○ Theatre
- ○ Emergency department
- ○ Maternity
- ○ Other (please specify)

Section 2. Your thoughts about the Working Together Pilot Project

This section asks about your thoughts about the Working Together Pilot Project which was recently implemented at Western Health. The aim of the Working Together Pilot was to co-design, trial and evaluate improved nursing and midwifery workload allocation and management practices at Western Health.

Have you heard of the Working Together Pilot project?

- ○ Yes
- ○ No
- ○ I don't know

If yes, do you think that the Working Together Pilot project was successful in ...

	Very successful	Successful	Neither successful or unsuccessful	Unsuccessful	Very unsuccessful
Improving workload allocation for nurses/midwives	○	○	○	○	○
Reducing staff turnover	○	○	○	○	○
Reducing staff absenteeism	○	○	○	○	○
Improving the quality of patient care	○	○	○	○	○
Maximising the use of each nurse's/midwife's skills and experience	○	○	○	○	○
Reducing the use of agency staff in your area	○	○	○	○	○

Section 3. Work Satisfaction

This section asks some questions about how satisfied you are with your work at Western Health.

How long do you intend to stay working as a nurse/midwife at Western Health?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

How long do you intend to stay working as a nurse/midwife?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

Nurses/midwives with whom I work (at Western Health) would say that:

Autonomy (*Amount of job-related independence, initiative, and freedom, either permitted or required in daily work activities*)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Nurses/midwives are supervised more closely than is necessary	○	○	○	○	○	○
2. They have sufficient input into the program of care for each of their patients	○	○	○	○	○	○
3. They have too much responsibility and not enough authority	○	○	○	○	○	○
4.Nurses/midwives have a good deal of control over their own work	○	○	○	○	○	○

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
5. They are frustrated sometimes because their activities seem programmed for them	○	○	○	○	○	○
6. They are required sometimes to do things on the job that are against their better professional judgement	○	○	○	○	○	○
7. Nurses/midwives need more autonomy in their daily practice	○	○	○	○	○	○
8. They are free to adjust their daily practice to fit patient needs	○	○	○	○	○	○

Nurses/midwives with whom I work (at Western Health) would say that:

Professional Status (*Overall importance or significance felt about your job both in your view and in the view of others)*

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.They are satisfied with the status of nursing/midwifery in the hospital	○	○	○	○	○	○
2. Staff in other departments appreciate nursing/midwifery	○	○	○	○	○	○
3. They are proud to talk to other people about what they do on the job	○	○	○	○	○	○
4.What they do on the job is really important	○	○	○	○	○	○
5. What they do on the job does not add up to anything really significant	○	○	○	○	○	○
6. More recognition of nurses/midwives is needed from hospital management	○	○	○	○	○	○
7. Patients (family members) acknowledge nursing's /midwifery's contribution to their care	○	○	○	○	○	○
8. They recommend this hospital to others as a good place for nurses/midwives to work	○	○	○	○	○	○
9. Their work contributes to a sense of personal achievement	○	○	○	○	○	○

Nurses/midwives with whom I work (at Western Health) would say that:

Pay (Dollar remuneration and fringe benefits received for work done)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Their present salary is satisfactory	○	○	○	○	○	○
2. A lot of nurses/midwives at this hospital are dissatisfied with their pay	○	○	○	○	○	○
3. The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital.	○	○	○	○	○	○
4.The latest salary increases for nurses/midwives at this hospital are not satisfactory	○	○	○	○	○	○
5. They are being paid fairly compared to what they hear about nurses/midwives at other hospitals	○	○	○	○	○	○
6. An upgrading pay schedules for nurses/midwives is needed at this hospital	○	○	○	○	○	○

Section 4. Your thoughts and feelings

The next questions ask about your feelings and thoughts during the last month. For each question, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is don't try to count up the number of times you felt a particular way but rather indicate the option that seems like a reasonable estimate.

In the last month, how often have you ...

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1. Been upset because of something that happened unexpectedly?	○	○	○	○	○
2. Felt that you were unable to control the important things in your life?	○	○	○	○	○
3. Felt nervous and 'stressed'?	○	○	○	○	○
4. Dealt successfully with irritating life hassles?	○	○	○	○	○
5. Felt you were effectively coping with important changes that were occurring in your life?	○	○	○	○	○
6. Felt confident about your ability to handle your personal problems?	○	○	○	○	○
7. Felt that things were going your way?	○	○	○	○	○
8. Found that you could not cope with all the things you had to do?	○	○	○	○	○
9. Been able to control irritations in your life?	○	○	○	○	○
10. Felt that you were on top of things?	○	○	○	○	○
11. Been angered because of things that happened that were outside of your control?	○	○	○	○	○
12. Found yourself thinking about things that you have to accomplish?	○	○	○	○	○
13. Been able to control the way you spend your time?	○	○	○	○	○
14. Felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

Section 5. Your work

This section asks some questions about your work at Western Health.

How often do you feel bothered by:

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1.Been unclear on just what the scope and responsibilities of your job are	○	○	○	○	○
2. Not knowing what opportunities for advancement or promotion exist for you	○	○	○	○	○
3. Not knowing what your immediate superior thinks of you, how she evaluates your performance	○	○	○	○	○
4. The fact that you can't get information needed to carry out your job	○	○	○	○	○
5. Not knowing just what the people you work with expect of you	○	○	○	○	○
6. Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday	○	○	○	○	○
7. Thinking that the amount of work you have to do may interfere with how well it gets done	○	○	○	○	○
8. Feeling that you have to do things on the job that are against your better judgement	○	○	○	○	○
9. Thinking that you'll not be able to satisfy the conflicting demands of various people over you	○	○	○	○	○

Considering your job as a whole, how much do you like it?

- ○ A lot

- A little
- Not at all

On the whole, what do you think of this hospital as a place to work?

- Very good
- Good
- Fair
- Poor
- Very poor

If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?

- I would prefer to stay
- I would prefer to leave
- I don't know

How long would you like to stay working at this hospital?

- Up to one year
- More than one year
- I don't know

If you had to quit work for a while (for example, because of pregnancy, carer responsibilities etc), would you return to this hospital?

- Yes
- No
- I don't know

How important is it to you to know, in detail, ...

	Very important	Important	Fairly important	Slightly important	Not important
1. What you have to do on a job?	○	○	○	○	○
2. How you are supposed to do a job?	○	○	○	○	○
3. What the limits of your authority on a job are?	○	○	○	○	○
4. How well you are doing?	○	○	○	○	○

I…….

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. Have enough time to complete my work	○	○	○	○	○
2. Feel certain about how much authority I have	○	○	○	○	○
3. Perform tasks that are too easy or boring	○	○	○	○	○
4.Have clear, planned goals and objectives for my job	○	○	○	○	○
5. Have to do things that should be done differently	○	○	○	○	○
6. Feel there is a lack of policies and guidelines to help me	○	○	○	○	○
7. Am able to act the same regardless of the group I am with	○	○	○	○	○
8. Am corrected or rewarded when I really don't expect it	○	○	○	○	○
9. Work under incompatible policies and guidelines	○	○	○	○	○
10. Know that I have divided my time properly	○	○	○	○	○
11. Receive an assignment without enough people to complete it	○	○	○	○	○
12. Know what my responsibilities are	○	○	○	○	○

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
13. Have to break a rule or policy in order to carry out an assignment	○	○	○	○	○
14. Have to “feel my way” in performing my duties	○	○	○	○	○
15. Receive assignments that are within my training and capability	○	○	○	○	○
16. Feel certain how I will be evaluated for a raise or promotion	○	○	○	○	○
17. Have just the right amount of work to do	○	○	○	○	○
18. Work with two or more groups who operate quiet differently	○	○	○	○	○
19. Know exactly what is expected of me	○	○	○	○	○
20. Receive incompatible requests from two or more people	○	○	○	○	○
21. Am uncertain as to how my job is linked	○	○	○	○	○
22. Do things that are likely to be accepted by one person and not accepted by others	○	○	○	○	○
23. Am told how well I am doing in my job	○	○	○	○	○
24. Receive an assignment without adequate resources and materials to execute it	○	○	○	○	○
25. Explanation is clear of what has to be done	○	○	○	○	○
26. Work on unnecessary things	○	○	○	○	○
27. Have to work under vague directives or orders	○	○	○	○	○
28. Perform work that suits my values	○	○	○	○	○
29. Do not know if my work will be acceptable to my boss	○	○	○	○	○

Section 6. Patient care

The next questions ask about your experiences of providing patient care at Western Health.

In general, how would you describe ...

	Excellent	Good	Fair	Poor
The quality of nursing/midwifery care delivered to patients on your ward?	○	○	○	○
Patient safety on your ward?	○	○	○	○

On your most recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them? Please mark all that apply:

- ☐ Comfort/talk with patients
- ☐ Educating patients and family
- ☐ Develop or update nursing/midwifery care plans
- ☐ Perform adequate patient surveillance
- ☐ Adequately document nursing/midwifery care (on appropriate forms/EMR)
- ☐ Assist with oral hygiene
- ☐ Perform frequent changing of patient position (PAC)
- ☐ Planning care
- ☐ Administer medications on time
- ☐ Skin care and assessment
- ☐ Prepare patients and family for discharge
- ☐ Treatments/procedures e.g. dressings
- ☐ Pain management
- ☐ Other (please specify) _____

How often do each of the following incidents occur?

	A few times a month or more often	Once a month or less often	Never
Patients received wrong medication time, or does	○	○	○
Pressure ulcers after admission	○	○	○
Patient falls with injury	○	○	○

	A few times a month or more often	Once a month or less often	Never
Complaints are received from patients or their families	○	○	○
A work related physical injury to nurses/midwives	○	○	○

Section 7. Anything else?

Have we missed anything? If you have anything else you would like to tell us about the Working Together Pilot project, please write in the box below.

All nurses and midwives who complete the survey are eligible to go into the draw for a $100 gift voucher.

If you would like to participate in the draw please email your name and email address to: WHDeakinPartnership@wh.org.au

Please note that your name and email address cannot be linked to your responses to the survey questions, they are anonymous.

Thank you for completing this questionnaire.

Your responses will contribute to improving the effectiveness of nursing and midwifery workload allocation and management at WH.

Deakin University CRICOS Provider Code 00113B.

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Appendix 2.3: Northeast Health Wangaratta Pre-implementation survey

Evaluation of the Working Together Project

Pre-implementation survey

Thank you for your interest in the research study "Evaluation of the Working Together Project". The study has been approved by the Northeast Health Wangaratta Human Research Ethics Committee and the Deakin University Human Research Ethics Committee.

The aim of this study is to evaluate the Working Together project so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at Northeast Health Wangaratta both before and after the pilot is implemented.

The study participant information sheet tells you more about the study and can be accessed via this link: NHW Working Together Evaluation Participant Information and Consent Form survey

Please read through the participant information sheet.

We will not ask you to write your name on this survey but will ask you to create a unique code number known only to you. To add another layer of privacy, we will assign you a study id. The personal code you generate will not be stored in the database with your answers, we will just use it to link your responses to this survey and the second (post-implementation) one if you choose to participate in both.

There are no right or wrong answers to the questions in this survey. We are simply interested in your experiences, thoughts and opinions. If you are unsure about how to answer a question, please mark the response which corresponds most closely to how you feel.

The survey will take approximately 15-20 minutes to complete.

Your completion of the survey indicates your consent to participate in the study.

Thank you for your participation. If you have any questions about the study please contact Dr Sara Holton or Dr Karen Wynter at email:
WHDeakinPartnership@wh.org.au .

Please create your own unique code (no spaces, no commas, no full stops) as described below:
The first letter of your name (lower case)
Your month of birth (use two numbers)
The first two letters of your mother's surname (maiden name) (lower case)

For example, the codes for the following people would be:

Susan Jones is born in February and her mother's surname (maiden) is Brown.
s02br

Lei Zhang is born in June and his mother's surname (maiden) is Zhang.
l06zh

The format of this code is required so that you can remember it when you do the post-implementation survey. Your unique code will not be linked to your Western Health employee number.

Section 1. Some questions about you

What was your age at your last birthday?

In which country were you born?

What is your current position?

- RN
- EN
- Midwife
- Nurse & Midwife
- Nurse Practitioner
- Other ([please specify

How many years have you practised as a nurse/midwife?

How many years have you been employed at Northeast Health Wangaratta?

How long do you intend to stay working as a nurse/midwife at Northeast Health Wangaratta?

- Up to one year
- More than one year
- I don't know

How long do you intend to stay working as a nurse/midwife?

- Up to one year
- More than one year
- I don't know

Which site do you work at?

- ○ Northeast Health Wangaratta
- ○ Illoura Aged Care

Where do you work? (Specific Clinical Area)

- ○ Ward
- ○ Theatre
- ○ Emergency department
- ○ Maternity
- ○ Other (please specify) _____

Section 2. Work Satisfaction

This section asks some questions about how satisfied you are with your work at Northeast Health Wangaratta.

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Autonomy (*Amount of job-related independence, initiative, and freedom, either permitted or required in daily work activities*)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Nurses/midwives are supervised more closely than is necessary	○	○	○	○	○	○
2. They have sufficient input into the program of care for each of their patients	○	○	○	○	○	○
3. They have too much responsibility and not enough authority	○	○	○	○	○	○
	Strongly	Agree	Agree	Disagree	Disagree	Strongly

	agree (1)	(2)	more than disagree (3)	more than agree (4)	(5)	disagree (6)
4.Nurses/midwives have a good deal of control over their own work	○	○	○	○	○	○
5. They are frustrated sometimes because their activities seem programmed for them	○	○	○	○	○	○
6. They are required sometimes to do things on the job that are against their better professional judgement	○	○	○	○	○	○
7. Nurses/midwives need more autonomy in their daily practice	○	○	○	○	○	○
8. They are free to adjust their daily practice to fit patient needs	○	○	○	○	○	○

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Professional Status (*Overall importance or significance felt about your job both in your view and in the view of others)*

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.They are satisfied with the status of nursing/midwifery in the hospital	○	○	○	○	○	○
2. Staff in other departments appreciate nursing/midwifery	○	○	○	○	○	○
3. They are proud to talk to other people about what they do on the job	○	○	○	○	○	○
4.What they do on the job is really important	○	○	○	○	○	○
5. What they do on the job does not add up to anything really significant	○	○	○	○	○	○
6. More recognition of nurses/midwives is needed from hospital management	○	○	○	○	○	○
7. Patients (family members) acknowledge nursing's /midwifery's contribution to their care	○	○	○	○	○	○
8. They recommend this hospital to others as a good place for nurses/midwives to work	○	○	○	○	○	○
9. Their work contributes to a sense of personal achievement	○	○	○	○	○	○

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Pay (*Dollar remuneration and fringe benefits received for work done*)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Their present salary is satisfactory	○	○	○	○	○	○
2. A lot of nurses/midwives at this hospital are dissatisfied with their pay	○	○	○	○	○	○
3. The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital.	○	○	○	○	○	○
4.The latest salary increases for nurses/midwives at this hospital are not satisfactory	○	○	○	○	○	○
5. They are being paid fairly compared to what they hear about nurses/midwives at other hospitals	○	○	○	○	○	○
6. An upgrading pay schedules for nurses/midwives is needed at this hospital	○	○	○	○	○	○

Section 3. Your thoughts and feelings

The next questions ask about your feelings and thoughts during the last month. For each question, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is don't try to count up the number of times you felt a particular way but rather indicate the option that seems like a reasonable estimate.

In the last month, how often have you ...

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1. Been upset because of something that happened unexpectedly?	○	○	○	○	○
2. Felt that you were unable to control the important things in your life?	○	○	○	○	○
3. Felt nervous and 'stressed'?	○	○	○	○	○
4. Dealt successfully with irritating life hassles?	○	○	○	○	○
5. Felt you were effectively coping with important changes that were occurring in your life?	○	○	○	○	○
6. Felt confident about your ability to handle your personal problems?	○	○	○	○	○
7. Felt that things were going your way?	○	○	○	○	○
8. Found that you could not cope with all the things you had to do?	○	○	○	○	○
9. Been able to control irritations in your life?	○	○	○	○	○

	Never (1)	Almost	Sometimes	Fairly	Very Often

		never (2)	(3)	often (4)	(5)
10. Felt that you were on top of things?	○	○	○	○	○
11. Been angered because of things that happened that were outside of your control?	○	○	○	○	○
12. Found yourself thinking about things that you have to accomplish?	○	○	○	○	○
13. Been able to control the way you spend your time?	○	○	○	○	○
14. Felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

Section 4. Your work

This section asks some questions about your work at Northeast Health Wangaratta.

How often do you feel bothered by:

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1.Been unclear on just what the scope and responsibilities of your job are	○	○	○	○	○
2. Not knowing what opportunities for advancement or promotion exist for you	○	○	○	○	○
3. Not knowing what your immediate superior thinks of you, how she evaluates your performance	○	○	○	○	○
4. The fact that you can't get information needed to carry out your job	○	○	○	○	○
5. Not knowing just what the people you work with expect of you	○	○	○	○	○
6. Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday	○	○	○	○	○
7. Thinking that the amount of work you have to do may interfere with how well it gets done	○	○	○	○	○
8. Feeling that you have to do things on the job that are against your better judgement	○	○	○	○	○
9. Thinking that you'll not be able to satisfy the conflicting demands of various people over you	○	○	○	○	○

Considering your job as a whole, how much do you like it?

- A lot
- A little
- Not at all

On the whole, what do you think of this hospital as a place to work?

- Very good
- Good
- Fair
- Poor
- Very poor

If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?

- I would prefer to stay
- I would prefer to leave
- I don't know

How long would you like to stay working at this hospital?

- Up to one year
- More than one year
- I don't know

If you had to quit work for a while (for example, because of pregnancy, carer responsibilities etc), would you return to this hospital?

- Yes
- No
- I don't know

How important is it to you to know, in detail, ...

	Very important	Important	Fairly important	Slightly important	Not important
1. What you have to do on a job?	○	○	○	○	○
2. How you are supposed to do a job?	○	○	○	○	○
3. What the limits of your authority on a job are?	○	○	○	○	○
4. How well you are doing?	○	○	○	○	○

I ...

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. Have enough time to complete my work	○	○	○	○	○
2. Feel certain about how much authority I have	○	○	○	○	○
3. Perform tasks that are too easy or boring	○	○	○	○	○
4.Have clear, planned goals and objectives for my job	○	○	○	○	○
5. Have to do things that should be done differently	○	○	○	○	○
6. Feel there is a lack of policies and guidelines to help me	○	○	○	○	○
7. Am able to act the same regardless of the group I am with	○	○	○	○	○
8. Am corrected or rewarded when I really don't expect it	○	○	○	○	○
9. Work under incompatible policies and guidelines	○	○	○	○	○
10. Know that I have divided my time properly	○	○	○	○	○
11. Receive an assignment without enough people to complete it	○	○	○	○	○
12. Know what my responsibilities are	○	○	○	○	○

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
13. Have to break a rule or policy in order to carry out an assignment	○	○	○	○	○
14. Have to “feel my way” in performing my duties	○	○	○	○	○
15. Receive assignments that are within my training and capability	○	○	○	○	○
16. Feel certain how I will be evaluated for a raise or promotion	○	○	○	○	○
17. Have just the right amount of work to do	○	○	○	○	○
18. Work with two or more groups who operate quiet differently	○	○	○	○	○
19. Know exactly what is expected of me	○	○	○	○	○
20. Receive incompatible requests from two or more people	○	○	○	○	○
21. Am uncertain as to how my job is linked	○	○	○	○	○
22. Do things that are likely to be accepted by one person and not accepted by others	○	○	○	○	○
23. Am told how well I am doing in my job	○	○	○	○	○
24. Receive an assignment without adequate resources and materials to execute it	○	○	○	○	○
25. Explanation is clear of what has to be done	○	○	○	○	○
26. Work on unnecessary things	○	○	○	○	○
27. Have to work under vague directives or orders	○	○	○	○	○
28. Perform work that suits my values	○	○	○	○	○
29. Do not know if my work will be acceptable to my boss	○	○	○	○	○

Section 6. Patient care

The next questions ask about your experiences of providing patient care at Western Health.

In general, how would you describe ...

	Excellent	Good	Fair	Poor
The quality of nursing/midwifery care delivered to patients on your ward?	○	○	○	○
Patient safety on your ward?	○	○	○	○

On your most recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them? Please mark all that apply:

- ☐ Comfort/talk with patients
- ☐ Educating patients and family
- ☐ Develop or update nursing/midwifery care plans
- ☐ Perform adequate patient surveillance
- ☐ Adequately document nursing/midwifery care (on appropriate forms/EMR)
- ☐ Assist with oral hygiene
- ☐ Perform frequent changing of patient position (PAC)
- ☐ Planning care
- ☐ Administer medications on time
- ☐ Skin care and assessment
- ☐ Prepare patients and family for discharge
- ☐ Treatments/procedures e.g. dressings
- ☐ Pain management
- ☐ Other (please specify) _____

How often do each of the following incidents occur?

	A few times a month or more often	Once a month or less often	Never
Patients received wrong medication time, or does	○	○	○
Pressure ulcers after admission	○	○	○
Patient falls with injury	○	○	○

Complaints are received from patients or their families	○	○	○
A work related physical injury to nurses/midwives	○	○	○

Section 5. Anything else?

Have we missed anything? If you have anything else you would like to tell us about the effectiveness of nursing and midwifery workload allocation and management at Northeast Health Wangaratta, please write in the box below.

All nurses and midwives who complete the survey are eligible to go into the draw for a **$100 gift voucher**.

If you would like to participate in the draw **please email your name and email address** to: WHDeakinPartnership@wh.org.au

Please note that your name and email address cannot be linked to your responses to the survey questions, they are anonymous.

Thank you for completing this questionnaire.

Your responses will contribute to improving the effectiveness of nursing and midwifery workload allocation and management at Northeast Health Wangaratta. Deakin University CRICOS Provider Code 00113B.

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Appendix 2.4: Northeast Health Wangaratta Post-implementation survey

Evaluation of the Working Together Project

Post-implementation survey

Thank you for your interest in the research study "Evaluation of the Working Together Project", and completing the first survey before the project was implemented. This is the second (post-implementation) and final survey we will ask you to completed

The study has been approved by the Northeast Health Wangaratta Human Research Ethics Committee and the Deakin University Human Research Ethics Committee.

The aim of this study is to evaluate the Working Together project so we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at Northeast Health Wangaratta both before and after the project was implemented.

The study participant information sheet tells you more about the study and can be accessed via this link: NHW Working Together Evaluation Participant Information and Consent Form survey

Please read through the participant information sheet.

We will not ask you to write your name on this survey but will ask you to create a unique code number known only to you. To add another layer of privacy, we will assign you a study id. The personal code you generate will not be stored in the database with your answers, we will just use it to link your responses to this survey and the second (post-implementation) one if you choose to participate in both.

There are no right or wrong answers to the questions in this survey. We are simply interested in your experiences, thoughts and opinions. If you are unsure about how to answer a question, please mark the response which corresponds most closely to how you feel.

The survey will take approximately 15-20 minutes to complete.

Your completion of the survey indicates your consent to participate in the study.

Thank you for your participation. If you have any questions about the study please contact Dr Sara Holton or Dr Karen Wynter at email:
WHDeakinPartnership@wh.org.au .

Please create your own unique code (no spaces, no commas, no full stops) as described below:
The first letter of your name (lower case)
Your month of birth (use two numbers)
The first two letters of your mother's surname (maiden name) (lower case)

For example, the codes for the following people would be:

Susan Jones is born in February and her mother's surname (maiden) is Brown.
s02br

Lei Zhang is born in June and his mother's surname (maiden) is Zhang.
l06zh

The format of this code is required so that you can remember it when you do the post-implementation survey. Your unique code will not be linked to your Western Health employee number.

Section 1. Some questions about you

What was your age at your last birthday?

In which country were you born?

- Australia
- Other

What is your current position?

- RN
- EN
- Midwife
- Nurse & Midwife
- Nurse Practitioner
- Other ([please specify

How many years have you practised as a nurse/midwife?

How many years have you been employed at Northeast Health Wangaratta?

Which site do you work at?

- Northeast Health Wangaratta
- Illoura Aged Care

Where do you work? (Specific Clinical Area)

- ○ ADU
- ○ Aged Care
- ○ Community Nursing
- ○ Critical care unit (CCU)
- ○ Dialysis
- ○ Emergency department
- ○ General medical
- ○ General surgical
- ○ Maternity services
- ○ Oncology
- ○ Outpatients
- ○ Subacute ward
- ○ Theatre
- ○ Other (please specify)

Section 2. Your thoughts about the Working Together Pilot Project

This section asks about your thoughts about the Working Together Project which was recently implemented at NHW. The aim of the Working Together Project was to co-design, trial and evaluate improved nursing and midwifery workload allocation and management practices at NHW.

Have you heard of the Working Together Pilot project?

- ○ Yes
- ○ No
- ○ I don't know

If yes, do you think that the Working Together Pilot project was successful in ...

	Very successful	Successful	Neither successful or unsuccessful	Unsuccessful	Very unsuccessful
Improving workload allocation for nurses/midwives	○	○	○	○	○
Reducing staff turnover	○	○	○	○	○
Reducing staff absenteeism	○	○	○	○	○
Improving the quality of patient care	○	○	○	○	○
Maximising the use of each nurse's/midwife's skills and experience	○	○	○	○	○
Reducing the use of agency staff in your area	○	○	○	○	○

Section 3. Work Satisfaction

This section asks some questions about how satisfied you are with your work at Northeast Health Wangaratta.

How long do you intend to stay working as a nurse/midwife at Northeast Health Wangaratta?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

How long do you intend to stay working as a nurse/midwife?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Autonomy (Amount of job-related independence, initiative, and freedom, either permitted or required in daily work activities)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Nurses/midwives are supervised more closely than is necessary	○	○	○	○	○	○
2. They have sufficient input into the program of care for each of their patients	○	○	○	○	○	○
3. They have too much responsibility and not enough authority	○	○	○	○	○	○
4.Nurses/midwives have a good deal of control over their own work	○	○	○	○	○	○
5. They are frustrated sometimes because their activities seem programmed for them	○	○	○	○	○	○
6. They are required sometimes to do things on the job that are against their better professional judgement	○	○	○	○	○	○
7. Nurses/midwives need more autonomy in their daily practice	○	○	○	○	○	○
8. They are free to adjust their daily practice to fit patient needs	○	○	○	○	○	○

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Professional Status (Overall importance or significance felt about your job both in your view and in the view of others)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.They are satisfied with the status of nursing/midwifery in the hospital	○	○	○	○	○	○
2. Staff in other departments appreciate nursing/midwifery	○	○	○	○	○	○
3. They are proud to talk to other people about what they do on the job	○	○	○	○	○	○
4.What they do on the job is really important	○	○	○	○	○	○
5. What they do on the job does not add up to anything really significant	○	○	○	○	○	○
6. More recognition of nurses/midwives is needed from hospital management	○	○	○	○	○	○
7. Patients (family members) acknowledge nursing's /midwifery's contribution to their care	○	○	○	○	○	○
8. They recommend this hospital to others as a good place for nurses/midwives to work	○	○	○	○	○	○
9. Their work contributes to a sense of personal achievement	○	○	○	○	○	○

Nurses/midwives with whom I work (at Northeast Health Wangaratta) would say that:

Pay (Dollar remuneration and fringe benefits received for work done)

	Strongly agree (1)	Agree (2)	Agree more than disagree (3)	Disagree more than agree (4)	Disagree (5)	Strongly disagree (6)
1.Their present salary is satisfactory	○	○	○	○	○	○
2. A lot of nurses/midwives at this hospital are dissatisfied with their pay	○	○	○	○	○	○
3. The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital.	○	○	○	○	○	○
4.The latest salary increases for nurses/midwives at this hospital are not satisfactory	○	○	○	○	○	○
5. They are being paid fairly compared to what they hear about nurses/midwives at other hospitals	○	○	○	○	○	○
6. An upgrading pay schedules for nurses/midwives is needed at this hospital	○	○	○	○	○	○

Section 4. Your thoughts and feelings

The next questions ask about your feelings and thoughts during the last month. For each question, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is don't try to count up the number of times you felt a particular way but rather indicate the option that seems like a reasonable estimate.

In the last month, how often have you ...

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1. Been upset because of something that happened unexpectedly?	○	○	○	○	○
2. Felt that you were unable to control the important things in your life?	○	○	○	○	○
3. Felt nervous and 'stressed'?	○	○	○	○	○
4. Dealt successfully with irritating life hassles?	○	○	○	○	○
5. Felt you were effectively coping with important changes that were occurring in your life?	○	○	○	○	○
6. Felt confident about your ability to handle your personal problems?	○	○	○	○	○
7. Felt that things were going your way?	○	○	○	○	○
8. Found that you could not cope with all the things you had to do?	○	○	○	○	○
9. Been able to control irritations in your life?	○	○	○	○	○
10. Felt that you were on top of things?	○	○	○	○	○

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
11. Been angered because of things that happened that were outside of your control?	○	○	○	○	○
12. Found yourself thinking about things that you have to accomplish?	○	○	○	○	○
13. Been able to control the way you spend your time?	○	○	○	○	○
14. Felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

Section 5. Your work

This section asks some questions about your work at Northeast Health Wangaratta

How often do you feel bothered by:

	Never (1)	Almost never (2)	Sometimes (3)	Fairly often (4)	Very Often (5)
1.Been unclear on just what the scope and responsibilities of your job are	○	○	○	○	○
2. Not knowing what opportunities for advancement or promotion exist for you	○	○	○	○	○
3. Not knowing what your immediate superior thinks of you, how she evaluates your performance	○	○	○	○	○
4. The fact that you can't get information needed to carry out your job	○	○	○	○	○
5. Not knowing just what the people you work with expect of you	○	○	○	○	○
6. Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday	○	○	○	○	○
7. Thinking that the amount of work you have to do may interfere with how well it gets done	○	○	○	○	○
8. Feeling that you have to do things on the job that are against your better judgement	○	○	○	○	○
9. Thinking that you'll not be able to satisfy the conflicting demands of various people over you	○	○	○	○	○

Considering your job as a whole, how much do you like it?

- ○ A lot
- ○ A little

- ○ Not at all

On the whole, what do you think of this hospital as a place to work?

- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor
- ○ Very poor

If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?

- ○ I would prefer to stay
- ○ I would prefer to leave
- ○ I don't know

How long would you like to stay working at this hospital?

- ○ Up to one year
- ○ More than one year
- ○ I don't know

If you had to quit work for a while (for example, because of pregnancy, carer responsibilities etc), would you return to this hospital?

- ○ Yes
- ○ No
- ○ I don't know

How important is it to you to know, in detail, ...

	Very important	Important	Fairly important	Slightly important	Not important
1. What you have to do on a job?	○	○	○	○	○
2. How you are supposed to do a job?	○	○	○	○	○
3. What the limits of your authority on a job are?	○	○	○	○	○
4. How well you are doing?	○	○	○	○	○

I …

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
1. Have enough time to complete my work	○	○	○	○	○
2. Feel certain about how much authority I have	○	○	○	○	○
3. Perform tasks that are too easy or boring	○	○	○	○	○
4.Have clear, planned goals and objectives for my job	○	○	○	○	○
5. Have to do things that should be done differently	○	○	○	○	○
6. Feel there is a lack of policies and guidelines to help me	○	○	○	○	○
7. Am able to act the same regardless of the group I am with	○	○	○	○	○
8. Am corrected or rewarded when I really don't expect it	○	○	○	○	○
9. Work under incompatible policies and guidelines	○	○	○	○	○
10. Know that I have divided my time properly	○	○	○	○	○
11. Receive an assignment without enough people to complete it	○	○	○	○	○
12. Know what my responsibilities are	○	○	○	○	○
13. Have to break a rule or policy in order to carry out an assignment	○	○	○	○	○
14. Have to "feel my way" in performing my duties	○	○	○	○	○
15. Receive assignments that are within my training and capability	○	○	○	○	○
16. Feel certain how I will be evaluated for a raise or promotion	○	○	○	○	○
17. Have just the right amount of work to do	○	○	○	○	○
18. Work with two or more groups who operate quiet differently	○	○	○	○	○
19. Know exactly what is expected of me	○	○	○	○	○

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
20. Receive incompatible requests from two or more people	○	○	○	○	○
21. Am uncertain as to how my job is linked	○	○	○	○	○
22. Do things that are likely to be accepted by one person and not accepted by others	○	○	○	○	○
23. Am told how well I am doing in my job	○	○	○	○	○
24. Receive an assignment without adequate resources and materials to execute it	○	○	○	○	○
25. Explanation is clear of what has to be done	○	○	○	○	○
26. Work on unnecessary things	○	○	○	○	○
27. Have to work under vague directives or orders	○	○	○	○	○
28. Perform work that suits my values	○	○	○	○	○
29. Do not know if my work will be acceptable to my boss	○	○	○	○	○

Section 6. Patient care

The next questions ask about your experiences of providing patient care at Northeast Health Wangaratta.

In general, how would you describe ...

	Excellent	Good	Fair	Poor
The quality of nursing/midwifery care delivered to patients on your ward?	○	○	○	○
Patient safety on your ward?	○	○	○	○

On your most recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them? Please mark all that apply:

- ☐ Comfort/talk with patients
- ☐ Educating patients and family
- ☐ Develop or update nursing/midwifery care plans
- ☐ Perform adequate patient surveillance
- ☐ Adequately document nursing/midwifery care (on appropriate forms/EMR)
- ☐ Assist with oral hygiene
- ☐ Perform frequent changing of patient position (PAC)
- ☐ Planning care
- ☐ Administer medications on time
- ☐ Skin care and assessment
- ☐ Prepare patients and family for discharge
- ☐ Treatments/procedures e.g. dressings
- ☐ Pain management
- ☐ Other (please specify _____)

How often do each of the following incidents occur?

	A few times a month or more often	Once a month or less often	Never
Patients received wrong medication time, or does	○	○	○
Pressure ulcers after admission	○	○	○
Patient falls with injury	○	○	○
Complaints are received from patients or their families	○	○	○
A work related physical injury to nurses/midwives	○	○	○

Section 7. Anything else?

Have we missed anything? If you have anything else you would like to tell us about the Working Together Pilot project, please write in the box below.

All nurses and midwives who complete the survey are eligible to go into the draw for a **$100 gift voucher**.

If you would like to participate in the draw **please email your name and email address** to: WHDeakinPartnership@wh.org.au

Please note that your name and email address cannot be linked to your responses to the survey questions, they are anonymous.

Thank you for completing this questionnaire.

Your responses will contribute to improving the effectiveness of nursing and midwifery workload allocation and management at NHW.

Deakin University CRICOS Provider Code 00113B.

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Appendix 3: Interview guides

Appendix 3.1: Western Health Pre-implementation interview guide

Evaluation of the Working Together Pilot Project

Pre-intervention Interview Guide

[*Thank participant for volunteering; introduce self.] [Go through informed consent process.]*
[Discuss demographic survey; process for obtaining summary of results]
(Reminder that can withdraw at any time, and can choose not to contribute to particular topics.] [Any questions before we start?]

"Western Health (WH) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. WH is currently using high levels of agency staff to help bridge the gap.

So we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at WH."

- What do you think of current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at WH?

- Are you satisfied with current workforce allocation and management practices?
  Why?/Why not?

- How do you think current workforce allocation and management practices affect quality of patient care?

- Do you think that current workload allocation and management practices maximise the use of each nurse's/midwife's skills and experience, and accommodate varying levels of staff and experience?
  Why?/Why not?

- Do you think one nurse/midwife should be responsible for the care of a certain number of patients?
  Why?/Why not?

- Do you think that a team of nurses/midwives should provide care for a group of patients?
  Why?/Why not?

Do you feel overworked?

- Why?/Why not?
- Do you think that there are any barriers to effective workload allocation at WH?
- Examples?

- What do you think should be done to improve current workload allocation and management practices at WH?

- Do you think that there are any aspects of patient care that are missed or left at the end of a shift? If yes,
- What types of patient care? Examples?
- Why do you think these get missed? [*eg Tension or communication breakdowns within the nursing team, Lack of back up support from team members, Other departments did not provide the care needed, Inadequate hand-off from previous shift or sending unit, Unbalanced patient assignments, Unexpected rise in patient volume and/or acuity on the unit, Urgent patient situations (eg, a patient's condition worsening), Inadequate number of staff*
- Do you think any of these are critical to patient outcomes?

<u>Additional questions for ANUMS/AMUMs, NUMS/MUMs and DoNs</u>

What factors do you think inform and influence decision-making about patient allocation at WH?

- Do you think there is flexibility with workforce allocation at WH to meet changing patient needs and staff skills?
    - Why?/Why not?

- Do you think that patient-centred care is practised at WH?
    - Why/why not?
    - How is this evident?
      [prompts:
        - *patients involved in decision-making;*
        - *patients treated with dignity, respect and sensitivity to his/her cultural values and autonomy;*
        - *co-ordination of clinical care;*
        - *patients provided with information about their clinical status, progress and prognosis, processes of care, and information to facilitate autonomy, self- care and health promotion;*
        - *patients receive appropriate assistance with pain management, activities and daily living needs, hospital surroundings and environment;*
        - *patients receive appropriate emotional support and alleviation of fear and anxiety about their physical status, treatment and prognosis, impact of the illness on themselves and family;*

- patient's family and close friends are involved in decision making and supported as caregivers;
- patients provided with details about how to care for themselves after discharge (eg medications, physical limitations, dietary needs, ongoing treatment and services, how to access care when it is needed).

Appendix 3.2: Western Health Post-implementation interview guide

Evaluation of the Working Together Pilot Project Post-intervention
Interview Guide
[Thank participant for volunteering; remind about first pre-intervention interview.] [Go through informed consent process.]
[Discuss demographic survey; process for obtaining summary of results]
[Reminder that can withdraw at any time, and can choose not to contribute to particular topics.] [Any questions before we start?]

"Western Health (WH) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, special care nursery and aged care. WH is currently using high levels of agency staff to help bridge the gap.

Since we last spoke, WH has implemented the Working Together Pilot project. The aim of the Working Together Pilot is to improve the effectiveness of nursing and midwifery workload allocation and management at WH.

So we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at WH since the Working Together Pilot has been implemented at WH."

- What did you think of the Working Together pilot?
  - Do you think it was successful?

- What impact do you think the Working Together pilot had on workload allocation, staff turnover, absenteeism, patient care etc?

- Do you think workload allocation and management practices, and instances of on-the-job preceptoring and mentoring have changed since the Working Together Pilot was implemented at WH?
  - In what ways?
  - Better or worse than before?

- Has the Working Together pilot changed your level of satisfaction with workforce allocation and management practices?
  - In what ways?

- Do you think the Working Together pilot has affected the quality of patient care?
  - In what ways?

- *[prompts: patient-family experience, key elements of patient care, patient-centred care etc]*

- Do you think that the Working Together pilot has maximised the use of each nurse's/midwife's skills and experience, and accommodated varying levels of staff and experience?
  - In what ways?

- Do you think that there are any barriers to effective workload allocation at WH?
  - Examples?

- Do you think that there are any aspects of patient care that are missed or left at the end of a shift? If yes,
  - What types of patient care? Examples?
  - Why do you think these get missed? [*eg Tension or communication breakdowns within the nursing team, Lack of back up support from team members, Other departments did not provide the care needed, Inadequate hand-off from previous shift or sending unit, Unbalanced patient assignments, Unexpected rise in patient volume and/or acuity on the unit, Urgent patient situations (eg, a patient's condition worsening), Inadequate number of staff*
  - Do you think any of these are critical to patient outcomes?

<u>Additional questions for ANUMS/AMUMs, NUMS/MUMs and DoNs</u>

- Do you think that the factors which inform and influence decision-making about patient allocation at WH changed as a result of the Working Together pilot?
  - In what ways?

- Do you think the Working Together pilot enhanced or reduced flexibility with workforce allocation at WH to meet changing patient needs and staff skills?
  - In what ways?

- Has the Working Together pilot changed your perceptions of whether or not nurses/midwives feel overworked; stressed; levels of job satisfaction; intentions to leave WH etc?
  - In what ways?

- Do you think the Working Together pilot has increased the hours nurses/midwives work? Reduced nursing and midwifery workforce sick leave, turnover, use of agency, overtime and supplementary staffing?
  - In what ways?

- Do you think there have been any changes to patient-centred care at WH since the Working Together pilot was implemented?
  - How is this evident?
  - *[prompts:*
  - *patients involved in decision-making;*

- *patients treated with dignity, respect and sensitivity to his/her cultural values and autonomy;*
- *co-ordination of clinical care;*
- *patients provided with information about their clinical status, progress and prognosis, processes of care, and information to facilitate autonomy, self- care and health promotion;*
- *patients receive appropriate assistance with pain management, activities and daily living needs, hospital surroundings and environment;*
- *patients receive appropriate emotional support and alleviation of fear and anxiety about their physical status, treatment and prognosis, impact of the illness on themselves and family;*
- *patient's family and close friends are involved in decision making and supported as caregivers;*
- *patients provided with details about how to care for themselves after discharge (eg medications, physical limitations, dietary needs, ongoing treatment and services, how to access care when it is needed).*

Appendix 3.3: Northeast Health Wangaratta Pre-implementation interview guide

Evaluation of the Working Together Pilot Project
Pre-intervention Interview Guide
[*Thank participant for volunteering; introduce self.] [Go through informed consent process.]*
[Discuss demographic survey; process for obtaining summary of results]
(Reminder that can withdraw at any time, and can choose not to contribute to particular topics.] [Any questions before we start?]

"Northeast Health Wangaratta (NHW) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, and aged care. NHW is currently using high levels of agency staff to help bridge the gap.

So we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at NHW."

- What do you think of current workload allocation and management practices, and instances of on-the-job preceptoring and mentoring at NHW?

- Are you satisfied with current workforce allocation and management practices?
    - Why?/Why not?

- How do you think current workforce allocation and management practices affect quality of patient care?

- Do you think that current workload allocation and management practices maximise the use of each nurse's/midwife's skills and experience, and accommodate varying levels of staff and experience?
    - Why?/Why not?

- Do you think one nurse/midwife should be responsible for the care of a certain number of patients?
    - Why?/Why not?

- Do you think that a team of nurses/midwives should provide care for a group of patients?
    - Why?/Why not?

- Do you feel overworked?
    - Why?/Why not?
    - Do you think that there are any barriers to effective workload allocation at NHW?
    - Examples?

- What do you think should be done to improve current workload allocation and management practices at NHW?

- Do you think that there are any aspects of patient care that are missed or left at the end of a shift? If yes,
    - What types of patient care? Examples?
    - Why do you think these get missed? [*eg Tension or communication breakdowns within the nursing team, Lack of back up support from team members, Other departments did not provide the care needed, Inadequate hand-off from previous shift or sending unit, Unbalanced patient assignments, Unexpected rise in patient volume and/or acuity on the unit, Urgent patient situations (eg, a patient's condition worsening), Inadequate number of staff*
    - Do you think any of these are critical to patient outcomes?

<u>Additional questions for ANUMS/AMUMs, NUMS/MUMs and DoNs</u>

- What factors do you think inform and influence decision-making about patient allocation at NHW?

- Do you think there is flexibility with workforce allocation at NHW to meet changing patient needs and staff skills?
    - Why?/Why not?

- Do you think that patient-centred care is practised at NHW?
    - Why/why not?
    - How is this evident?
    - *[prompts:*
        - *patients involved in decision-making;*
        - *patients treated with dignity, respect and sensitivity to his/her cultural values and autonomy;*
        - *co-ordination of clinical care;*
        - *patients provided with information about their clinical status, progress and prognosis, processes of care, and information to facilitate autonomy, self- care and health promotion;*
        - *patients receive appropriate assistance with pain management, activities and daily living needs, hospital surroundings and environment;*
        - *patients receive appropriate emotional support and alleviation of fear and anxiety about their physical status, treatment and prognosis, impact of the illness on themselves and family;*
        - *patient's family and close friends are involved in decision making and supported as caregivers;*
        - *patients provided with details about how to care for themselves after discharge (eg medications, physical limitations, dietary needs, ongoing treatment and services, how to access care when it is needed).*

Appendix 3.4: Northeast Health Wangaratta Post-implementation interview guide

Evaluation of the Working Together Project

Post-intervention Interview Guide

[Thank participant for volunteering; remind about first pre-intervention interview.]
[Go through informed consent process.]
[Discuss demographic survey; process for obtaining summary of results]
[Reminder that can withdraw at any time, and can choose not to contribute to particular topics.]
[Any questions before we start?]

"Northeast Health Wangaratta (NHW) has experienced in the past and continues to experience significant nursing and midwifery workforce issues such as the recruitment and retention of skilled nurses and midwives in speciality areas such as ED, Critical Care, maternity services, and aged care. NHW is currently using high levels of agency staff to help bridge the gap.

Since we last spoke, NHW has implemented the Working Together project. The aim of the Working Together Project is to improve the effectiveness of nursing and midwifery workload allocation and management at NHW.

So we are interested in hearing from you about your experiences and perspectives of nursing and midwifery workforce allocation and management practices at NHW since the Working Together Project has been implemented at NHW."

- Are you aware of the Working Together project?
    - What aspects are you aware of?
    - Were you involved in any way?

- What did you think of the Working Together pilot?
    - Do you think it was successful?

- What impact do you think the Working Together project has had on workload allocation, staff turnover, absenteeism, patient care etc?

- Do you think workload allocation and management practices, and instances of on-the-job preceptoring and mentoring have changed since the Working Together Project was implemented at NHW?
    - In what ways?
    - Better or worse than before?

- Has the Working Together project changed your level of satisfaction with workforce allocation and management practices?

- In what ways?

- Do you think the Working Together project has affected the quality of patient care?
  - In what ways?
  - *[prompts: patient-family experience, key elements of patient care, patient-centred care etc]*

- Do you think that the Working Together project has maximised the use of each nurse's/midwife's skills and experience, and accommodated varying levels of staff and experience?
  - In what ways?

- Do you think that there are any barriers to effective workload allocation at NHW?
  - Examples?

- Do you think that there are any aspects of patient care that are missed or left at the end of a shift? If yes,
  - What types of patient care? Examples?
  - Why do you think these get missed? [*eg Tension or communication breakdowns within the nursing team, Lack of back up support from team members, Other departments did not provide the care needed, Inadequate hand-off from previous shift or sending unit, Unbalanced patient assignments, Unexpected rise in patient volume and/or acuity on the unit, Urgent patient situations (eg, a patient's condition worsening), Inadequate number of staff*
  - Do you think any of these are critical to patient outcomes?

<u>Additional questions for ANUMS/AMUMs, NUMS/MUMs and DoNs</u>

- Do you think that the factors which inform and influence decision-making about patient allocation at NHW changed as a result of the Working Together project?
  - In what ways?

- Do you think the Working Together project enhanced or reduced flexibility with workforce allocation at NHW to meet changing patient needs and staff skills?
  - In what ways?

- Has the Working Together project changed your perceptions of whether or not nurses/midwives feel overworked; stressed; levels of job satisfaction; intentions to leave NHW etc?
  - In what ways?

- Do you think the Working Together project has increased the hours nurses/midwives work? Reduced nursing and midwifery workforce sick leave, turnover, use of agency, overtime and supplementary staffing?
  - In what ways?

- Do you think there have been any changes to patient-centred care at NHW since the Working Together project was implemented?
    - How is this evident?
    - *[prompts:*
        - *patients involved in decision-making;*
        - *patients treated with dignity, respect and sensitivity to his/her cultural values and autonomy;*
        - *co-ordination of clinical care;*
        - *patients provided with information about their clinical status, progress and prognosis, processes of care, and information to facilitate autonomy, self-care and health promotion;*
        - *patients receive appropriate assistance with pain management, activities and daily living needs, hospital surroundings and environment;*
        - *patients receive appropriate emotional support and alleviation of fear and anxiety about their physical status, treatment and prognosis, impact of the illness on themselves and family;*
        - *patient's family and close friends are involved in decision making and supported as caregivers;*
        - *patients provided with details about how to care for themselves after discharge (eg medications, physical limitations, dietary needs, ongoing treatment and services, how to access care when it is needed).*

Appendix 4: Survey data tables

Appendix 4.1: Western Health Pre- and Post-implementation Survey Results Error! Bookmark not defined.

Demographics

Table 4.1.1 Respondent characteristics

Variable	Pre Number (%)	Post Number (%)
Age (Pre n=127; Post n=115) range, mean	21-69, 42.5	22-69, 40.2
Country of birth (Pre n=127; Post n=116)		
Australia	85 (66.9%)	82 (70.7%)
Overseas	42 (33.1%)	34 (29.3%)
Current position (Pre n=129; Post n=118)		
RN	86 (66.7%)	89 (75.4%)
EN	12 (9.3%)	5 (4.2%)
Midwife	11 (8.5%)	8 (6.8%)
Nurse & Midwife	9 (7.0%)	11 (9.3%)
Nurse Practitioner	2 (1.6%)	1 (0.8%)
Other	9 (7.0%)	4 (3.4%)
Years practised as a nurse/midwife (Pre n=126; Post n=118) range, mean	0-46, 17.2	1-48, 22.8
Years employed at WH (Pre n=126; Post n=118) range, mean	0-38, 8.3	0-36, 16.5
Division (Pre n=129; Post n=118)		
Clinical Support & Specialist Clinics	3 (2.3%)	5 (4.2%)
Community Integration & Partnerships	0 (0.0%)	1 (0.8%)
Community Integration, Allied Health & Service Planning	1 (0.8%)	1 (0.8%)
Drug Health Services	3 (2.3%)	1 (0.8%)
EDON	3 (2.3%)	0 (0.0%)
Emergency, Medicine & Cancer Services	38 (29.5%)	31 (26.3%)
Mental Health		1 (0.8%)
Perioperative & Critical Care Services	24 (18.6%)	35 (29.7%)
Subacute & Aged Care Services	18 (14.0%)	12 (10.2%)
Women's & Children's	23 (17.8%)	24 (20.3%)
Other	16 (12.4%)	7 (5.9%)
Working Together pilot ward (Pre n=127; Post n=116)		
No	96 (75.6%)	85 (73.3%)
Yes	31 (24.4%)	31 (26.7%)

Working Together Project (post-implementation survey only)

Heard of the Working Together Project (n=118): Yes (n=53, 44.9%), No (n=54, 45.8%), I don't know (n=11, 9.3%)

Table 4.1.2 Working Together Project

If yes, do you think that the Working Together Pilot was successful in...	Very successful/ Successful (n, %)	Neither/Unsuccessful/ very unsuccessful (n, %)
Improving workload allocation for nurses/midwives (n=67)	18 (26.9%)	49 (73.1%)
Reducing staff turnover (n=67)	16 (23.9%)	51 (76.1%)
Reducing staff absenteeism (n=67)	14 (20.9%)	53 (79.1%)
Improving the quality of patient care (n=66)	21 (31.8%)	45 (68.2%)
Maximising the use of each nurse's/midwife's skills and experience (n=66)	19 (28.8%)	47 (71.2%)
Reducing the use of agency staff in your area (n=67)	22 (32.8%)	45 (67.2%)

Intentions

Table 4.1.3 Intentions

Variable	Up to one year	More than one year	Don't know
Intend to stay at WH			
Pre (n=128)	4 (3.1%)	86 (67.2%)	38 (29.7%)
Post (n=118)	4 (3.4%)	92 (78.0%)	22 (18.6%)
Intend to stay working as a nurse/midwife			
Pre (n=126)	3 (2.4%)	104 (82.5%)	19 (15.1%)
Post (n=118)	3 (2.5%)	98 (83.1%)	17 (14.4%)

Work satisfaction

Table 4.1.4 NDNQI Work Satisfaction Scale

Item	Agree (n, %)	Disagree (n, %)
Autonomy		
Nurses/midwives are supervised more closely than is necessary		
Pre (n=129)	32 (24.8%)	97 (75.2%)
Post (n=118)	41 (34.7%)	77 (65.3%)
They have sufficient input into the program of care for each of their patients		
Pre (n=129)	95 (73.6%)	34 (26.4%)
Post (n=118)	80 (67.8%)	38 (32.2%)
They have too much responsibility and not enough authority		
Pre (n=129)	78 (60.5%)	51 (39.5%)
Post (n=118)	75 (63.6%)	43 (36.4%)
Nurses/midwives have a good deal of control over their own work		
Pre (n=128)	83 (64.8%)	45 (35.2%)
Post (n=118)	82 (69.5%)	36 (30.5%)
They are frustrated sometimes because their activities seem programmed for them		
Pre (n=127)	81 (63.8%)	46 (36.2%)
Post (n=117)	81 (69.2%)	36 (30.8%)
They are required sometimes to do things on the job that are against their better professional judgement		
Pre (n=129)	61 (47.3%)	68 (52.7%)
Post (n=117)	71 (60.7%)	46 (39.3%)
Nurses/midwives need more autonomy in their daily practice		
Pre (n=129)	99 (76.7%)	30 (23.3%)
Post (n=117)	94 (80.3%)	23 (19.7%)
They are free to adjust their daily practice to fit patient needs		
Pre (n=129)	83 (64.3%)	46 (35.7%)
Post (n=118)	72 (61.0%)	46 (39.0%)
Professional status		
They are satisfied with the status of nursing/midwifery in the hospital		
Pre (n=129)	86 (66.7%)	43 (33.3%)
Post (n=118)	84 (71.2%)	34 (28.8%)
Staff in other departments appreciate nursing/midwifery		
Pre (n=129)	93 (72.1%)	36 (27.9%)
Post (n=118)	79 (66.9%)	39 (33.1%)
They are proud to talk to other people about what they do on the job		
Pre (n=128)	112 (87.5%)	16 (12.5%)
Post (n=117)	102 (87.2%)	15 (12.8%)
What they do on the job is really important		
Pre (n=129)	126 (97.7%)	3 (2.3%)
Post (n=118)	114 (96.6%)	4 (3.4%)
What they do on the job does not add up to anything really significant		
Pre (n=129)	15 (11.6%)	114 (88.4%)

Item	Agree (n, %)	Disagree (n, %)
Post (n=118)	21 (17.8%)	97 (82.2%)
More recognition of nurses/midwives is needed from hospital management		
Pre (n=129)	118 (91.5%)	11 (8.5%)
Post (n=118)	104 (88.1%)	14 (11.9%)
Patients (family members) acknowledge nursing's/midwifery's contribution to their care		
Pre (n=128)	109 (85.2%)	19 (14.8%)
Post (n=118)	95 (80.5%)	23 (19.5%)
They recommend this hospital to others as a good place for nurses/midwives to work		
Pre (n=128)	110 (85.9%)	18 (14.1%)
Post (n=118)	97 (82.2%)	21 (17.8%)
Their work contributes to a sense of personal achievement		
Pre (n=128)	110 (85.9%)	18 (14.1%)
Post (n=118)	102 (86.4%)	16 (13.6%)
Pay		
Their present salary is satisfactory		
Pre (n=127)	60 (47.2%)	67 (52.8%)
Post (n=117)	40 (34.2%)	77 (65.8%)
A lot of nurses/midwives at this hospital are dissatisfied with their pay		
Pre (n=128)	79 (61.7%)	49 (38.3%)
Post (n=117)	81 (69.2%)	36 (30.8%)
The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital		
Pre (n=128)	44 (34.4%)	84 (65.6%)
Post (n=117)	26 (22.2%)	91 (77.8%)
The latest salary increases for nurses/midwives at this hospital are not satisfactory		
Pre (n=128)	64 (50.0%)	64 (50.0%)
Post (n=117)	88 (75.2%)	29 (24.8%)
They are being paid fairly compared to what they hear about nurses/midwives at other hospitals		
Pre (n=128)	73 (57.0%)	55 (43.0%)
Post (n=117)	66 (56.4%)	51 (43.6%)
An upgrading of pay schedules for nurses/midwives is needed at this hospital		
Pre (n=128)	97 (75.8%)	31 (24.2%)
Post (n=116)	106 (91.4%)	10 (8.6%)

Perceived Stress Scale (Cohen et al 1983)

Table 4.1.5 Perceived stress scale (PSS-10)

Scale	Min	Max	Mean	SD
PSS-10 (10 items)				
Pre (n=125)	1.0	35.0	17.1	7.2
Post (n=111)	0.0	38.0	16.9	6.8

PSS-10:

- Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress.
- Scores ranging from 0-13 would be considered low stress.
- Scores ranging from 14-26 would be considered moderate stress.
- Scores ranging from 27-40 would be considered high perceived stress

Role Clarity, Satisfaction and Tension (Lyons et al 1971)

Table 4.1.6 Tension Index (9 items)

Scale	Min	Max	Mean	SD
Tension Index (9 items)				
Pre (n=122)	10.0	45.0	25.2	7.4
Post (n=113)	9.0	45.0	25.2	7.5

Tension Index:
Responses to each item are coded from 1 to 5 and summed. The possible range is from 9 to 45.

Table 4.1.7 Tension Index

Tension Index (How often do you feel bothered by …)

Item	Never (n, %)	Often (n, %)
Being unclear on just what the scope and responsibilities of your job are		
Pre (n=125)	106 (84.8%)	19 (15.2%)
Post (n=118)	105 (89.0%)	13 (11.0%)
Not knowing what opportunities for advancement or promotion exist for you		
Pre (n=126)	99 (78.6%)	27 (21.4%)
Post (n=117)	79 (67.5%)	38 (32.5%)
Not knowing what your immediate superior thinks of you, how she evaluates your performance		
Pre (n=126)	82 (65.1%)	44 (34.9%)
Post (n=118)	77 (65.3%)	41 (34.7%)
The fact that you can't get information needed to carry out your job		
Pre (n=126)	104 (82.5%)	22 (17.5%)
Post (n=118)	97 (82.2%)	21 (17.8%)
Not knowing just what the people you work with expect of you		
Pre (n=126)	100 (79.4%)	26 (20.6%)
Post (n=116)	93 (80.2%)	23 (19.8%)
Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday		
Pre (n=126)	82 (65.1%)	44 (34.9%)
Post (n=118)	83 (70.3%)	35 (29.7%)
Thinking that the amount of work you have to do may interfere with how well it gets done		
Pre (n=126)	73 (57.9%)	53 (42.1%)
Post (n=116)	73 (62.9%)	43 (37.1%)
Feeling that you have to do things on the job that are against your better judgement		
Pre (n=126)	110 (87.3%)	16 (12.7%)
Post (n=118)	93 (78.8%)	25 (21.2%)
Thinking that you'll not be able to satisfy the conflicting demands of various people over you		
Pre (n=127)	91 (71.7%)	36 (28.3%)
Post (n=118)	82 (69.5%)	36 (30.5%)

Satisfaction Index:

Responses to the two items are summed. The possible range is 2 to 7. Lower scores indicate more satisfaction.

Table 4.1.8 Satisfaction Index

Scale	Min	Max	Mean	SD
Satisfaction Index (2 items)				
Pre (n=127)	2.0	8.0	3.6	1.4
Post (n=117)	2.0	8.0	3.4	1.4

Item	A lot (n,%)	A little (n,%)	Not at all (n,%)
Considering your job as a whole, how much do you like it?			
Pre (n=127)	84 (66.1%)	37 (29.1%)	6 (4.7%)
Post (n=117)	79 (67.5%)	33 (28.2%)	5 (4.3%)

Item	Very good/good (n,%)	Fair/poor (n,%)
On the whole, what do you think of this hospital as a place to work?		
Pre (n=128)	80 (62.5%)	48 (37.5%)
Post (n=118)	83 (70.3%)	35 (29.7%)

Propensity to leave Index:

Responses to three items.

Table 4.1.9 Propensity to leave Index

Item	Prefer to stay (n,%)	Prefer to leave (n,%)	Don't know (n,%)
If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?			
Pre (n=127)	79 (62.2%)	21 (16.5%)	27 (21.3%)
Post (n=118)	85 (72.0%)	17 (14.4%)	16 (13.6%)

Item	Up to 1 yr (n,%)	More than 1 yr (n,%)	Don't know (n,%)
How long would you like to stay working at this hospital?			
Pre (n=128)	5 (3.9%)	89 (69.5%)	34 (26.6%)
Post (n=117)	3 (2.6%)	84 (71.8%)	30 (25.6%)

Item	Yes (n,%)	No (n,%)	Don't know (n,%)
If you had to quit work for a while would you return to this hospital?			
Pre (n=127)	78 (61.4%)	5 (3.9%)	44 (34.6%)
Post (n=118)	84 (71.2%)	10 (8.5%)	24 (20.3%)

Need for clarity index:
Responses to four items. How important is it to you to know, in detail …

Table 4.1.10 Need for Clarity Index

Item	Important (n,%)	Not important (n,%)
What you have to do on a job?		
Pre (n=128)	124 (96.9%)	4 (3.1%)
Post (n=117)	111 (94.9%)	6 (5.1%)
How you are supposed to do a job?		
Pre (n=128)	121 (94.5%)	7 (5.5%)
Post (n=117)	110 (94.0%)	7 (6.0%)
What the limits of your authority on a job are?		
Pre (n=127)	117 (92.1%)	10 (7.9%)
Post (n=117)	102 (87.2%)	15 (12.8%)
How well you are doing?		
Pre (n=128)	119 (93.0%)	9 (7.0%)
Post (n=116)	108 (93.1%0	8 (6.9%)

Role conflict and ambiguity scale (Rizzo et al)
Higher scores on the scale show high role ambiguity/conflict.

Table 4.1.11 Role Conflict & Ambiguity Scale

Scale	Min	Max	Mean	SD
Role conflict (15 items)				
Pre (n=123)	34.0	61.0	46.1	5.9
Post (n=115)	36.0	68.0	46.2	5.6
Role ambiguity (14 items)				
Pre (n=123)	25.0	54.0	41.1	5
Post (n=114)	22.0	50.0	40.0	5.0

Role conflict scale range (possible scores): 15-75
Role ambiguity scale range (possible scores): 14-70

Patient care
In general how would you describe …

Table 4.1.12 Patient Care

Item	Excellent/good (n,%)	Fair/poor (n,%)
The quality of nursing/midwifery care delivered to patients on your ward?		
Pre (n=125)	98 (78.4%)	27 (21.6%)

Post (n=117)	95 (81.2%)	22 (18.8%)
Patient safety on your ward?		
Pre (n=125)	92 (73.6%)	33 (26.4%)
Post (n=117)	95 (81.2%)	22 (18.8%)

On your recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them?

Table 4.1.13 Missed elements of care

Item	Pre n (%)	Post n (%)
Comfort/talk with patients	64 (48.9%)	17 (17.3%)
Educating patients and family	50 (38.2%)	18 (18.4%)
Perform adequate patient surveillance	38 (29.0%)	6 (6.1%)
Develop or update nursing/midwifery care plans	38 (29.0%)	3 (3.1%)
Adequately document nursing/midwifery care (on appropriate forms/EMR)	35 (26.7%)	17 (17.3%)
Assist with oral hygiene	25 (19.1%)	7 (7.1%)
Prepare patients and family for discharge	24 (18.3%)	2 (2.0%)
Administer medications on time	20 (15.3%)	1 (1.0%)
Planning care	20 (15.3%)	1 (1.0%)
Skin care and assessment	17 (13.0%)	2 (2.0%)
Treatments/procedures e.g. dressings	17 (13.0%)	2 (2.0%)
Perform frequent changing of patient position (PAC)	12 (9.2%)	1 (1.0%)
Pain management	9 (6.9%)	3 (3.1%)

How often do each of the following incidents occur?

Table 4.1.14 Incidents

Item	A few times a month or more (n, %)	Once a month or less (n, %)	Never (n, %)
Patients received wrong medication, time, or dose			
Pre (n=121)	20 (16.5%)	66 (54.5%)	35 (28.9%)
Post (n=111)	15 (13.5%)	62 (55.9%)	34 (30.6%)
Pressure ulcers after admission			
Pre (n=119)	5 (4.2%)	54 (45.4%)	60 (50.4%)
Post (n=110)	2 (1.8%)	45 (40.9%)	63 (57.3%)
Patient falls with injury			
Pre (n=118)	18 (15.3%)	49 (41.5%)	51 (43.2%)
Post (n=111)	14 (12.6%)	45 (40.5%)	52 (46.8%)
Complaints are received from patients or their families			
Pre (n=120)	38 (31.7%)	61 (50.8%)	21 (17.5%)
Post (n=111)	24 (21.6%)	61 (55.0%)	26 (23.4%)
A work related physical injury to nurses/midwives			
Pre (n=120)	8 (6.7%)	79 (65.8%)	33 (27.5%)
Post (n=113)	13 (11.5%)	66 (58.4%)	34 (30.1%)

Table 4.1.15 Free-text comments

Theme	Pre-implementation survey	Post-implementation survey
Patient acuity	• For in charge- Please consider acuity when allocating patients • Hoping workload at night would depend on how the acuity of the patient is but not just the number. • The number and complexity of patients referred to our department is growing continuously but staffing lags behind. I hate the feeling that my staff may be struggling to meet demands. Many of my staff often say their work is not valued by others. • Workload allocation in midwifery does not take into account patient acuity. Whilst it is important for midwives to have shift-to-shift autonomy over how they plan their day, there are limited resources +++ for care planning, discharge planning, coordinating care between disciplines, etc. Workload is also as per EBA, however this does not take into account the complexity of the women and neonates that we are caring for at WH, nor does this take into account the demand for services, which naturally leads to a much higher turnover and therefore work effort required of midwifes to ensure flow though maternity services. These are key reasons why we have midwives leave to work within other hospital networks.	• As a pool RN, some wards have such high acuity or workload that a float is needed to assist with the workload. However, this fact gets ignored when brought up with the in-charge. When things are left incomplete & handed over to the next staff member to add to their to-do list, they are unhappy however it is out of our control when time restraints are one of the main issues. • Not getting the appropriate breaks. Acuity of patients creating impossible workloads. Leaving work late with multiple people to handover to. No debriefs or team meetings. Poor team work as everyone busy with own workloads & no extra staff member available to float. Disjointed & complex referral systems (all paperwork should be either paper based or on one computer program). Equipment not readily available.
Patient ratios / allocation	• ANUM's having a workload on night duty when the same routine of care or even more is required in terms of number of admissions over a longer shift … the new ward layout means time needs to be considered, as an ANUM with an equal number of patients allocated it is hard to make sure or even eyeball all the children, this is a great risk when untrained paediatric staff are looking after the patient, High Flow oxygen and oxygen and babies nurse ratio needs to be assessed 1:6 is way too	• Managers and NI should consider why they give more pt load to casual staff than regular staff (for example casual night staff has to look after 8 difficult patients each while regular staff only look after 4 or 5 easy patients each) Is this working together? • more cohesion needed between obstetricians and midwives. Need more natural therapies talked about during birthing. Postnatal definitely

Theme	Pre-implementation survey	Post-implementation survey
	much. … WH forgets children are sick at night as well and parents are even more worried and anxious due to being tired with a sick child and yet we don't have time to assure them as the ratio is 1:6 as opposed to the Day ratio of 1:4 plus an ANUM and a CSRN both of whom don't have a patient load on Days. Night Duty ratio 1:6 plus CSRN and ANUM has a ratio of 1:6 • Effectiveness of allocating nursing workload is different on different wards. As a person that has worked as pool and in several wards, it can be a very different culture in a ward depending mostly on management and the culture allowed to thrive in those environments. Personally, although I feel like I will never have control of certain things in my life - I don't feel overwhelmed by it as I feel that's the way life is: unpredictable in the most impeccable times. • I feel that some wards have patient allocations more than other wards which results in patients receiving less time/care from their nurses. eg nurses allocated 6 patients for a PM shift and 5 patients for an AM shift. • I feel that the workload for the NIC on night duty is unreasonable as they have to take a patients load as well as be in charge of the entire ward. This places undue stress on the NIC and increases the difficulty of their position. • Midwifery allocation is a significant issue in the new JK building, particularly the Maternity Assessment Centre. Women may present with undifferentiated medical conditions on top of complicated pregnancies and there are not enough midwives or medical staff to provide them safe and timely care. Furthermore, having a midwife in charge plus caring for 6 women is unsafe and	needs only 1:3 ratio, 1:4 is now too heavy • On our ward allocation of patients could be better. In maternity you often received all or most of your patients back, even 24 hours after a shift (as they keep a record). On my current ward this is very little continuity of care, and for the children and their parents I think it is important. It is also beneficial as you have more background on your patient from looking after them previously. • Particularly on the children's ward it would be nice where possible to be allocated the same patients at least between a late shift and an early shift • Patient allocations need to be reduced for night staff and the in charge shouldn't have a workload

Theme	Pre-implementation survey	Post-implementation survey
	consequently women receive inadequate care. Other concerns I have are around the allocation of workload to new graduate midwives. Grad midwives are frequently given very complex women and babies to care, particularly on the postnatal wards. They may not be able to access education or clinical support as priorities are frequently directed to Birthing. • Midwifery has to be looked at separately than nursing as we function differently. The wards also have to be looked at differently than clinics / MAC or Birthing which are very specific areas. • Nurse PT ratio is 1:5 and with heavy and acutely ill pts in our ward, we will not be able to provide the right care, we are supposed to deliver. Which is sad & disappointing. It is in turn increasingly the falls, pressure injuries & pt complaints, which will cost huge amount of money to the hospital than getting extra staff. • Our ward is a very busy ward, sometimes i feel that we are pushed to the limit. It would be of help to be able to get extra staff when we are having an extra busy period • Subacute wards that have non-subacute patients but still have 5:1 patient load can be very heavy physically to nurses, especially if there is a lack of supply or equipment in the ward and staff have to go to another ward and borrow them. • The current ratios in the subacute ward is not able to meet the demands of the acuity and manual handling of patients, This issue was brought up by the Rehabilitation physicians after major incidences and unfortunately they are currently on stress leave because they are being performance	

Theme	Pre-implementation survey	Post-implementation survey
	managed when they have informed the clinical services director that the nursing staff cannot cope with this amount of acuity. Older patients who are frail and delirious are expected to take part in intensive rehab programs. Patients are moved very quickly because of bed access demands but are sometimes being sent back to the acute ward in less than 24 hours. This results in staff not being able to provide proper rehab nursing care. Other hospitals have a policy on the number of bariatric and hoists transfers that they can take but unfortunately we have no policy. WE currently have a very ineffective assessment team who assess and authorize the transfer of some very unsuitable patients. Other wards like ward 2 A are given extra EFT and specials for workload to cope • unfair allocations - in charge night duty has a full patient load as well as responsibilities of being in charge. Night ratios are 1:6 - babies are not included in our numbers, even though midwives will do majority of cares. Day/evening is the same workload as night shift. No one sleeps at night on a maternity ward - except the partners! It doesn't matter how heavy your load is you still get up to your ratio. Majority of the time day/evening shift are always over ratio. Patient care is frequently neglected. Women aren't being taught essential tools of being a parent- just the basics. More education needed ie: what to expect when going home, settling etc...these could be conducted during the day on maternity wards to better equip families for when they go home • wards such as rehab and gem are the heaviest wards to work on as nurses. I do not understand why the	

Theme	Pre-implementation survey	Post-implementation survey
	ratio is 5 to 1 nurse. it is very heavy and hard to work and i usually do not go to those wards due to this • Workload in ALL maternity areas, far exceeds the staff numbers allocated to provide the service!	
Patient care and safety	• CSRN role(a new role in Children's ward- a support staff(Retrieval Nurse)- OHS issue- with regards to retrieving pts from ED(Sunshine Hospital) to ward- Travel takes nearly 10 mins walk each way, what if we have 8 admissions in a shift? I think that is OHS issue. • management seem oblivious to poor care • My role is caring for patients at risk or currently deteriorating. It is common for ward staff to not have enough time or resources to properly monitor patients if they require escalation of care or closer supervision. This increases the risk of further patient deterioration as the nurse's workload does not allow for additional time to be allocated to a single patient, regardless of how unwell. • The recent opening of the Joan Kirner Centre has been associated with increased nursing staff in ED- this has been good-so the high pressured shifts with potential for missed nursing care have not been experienced by me in the very recent past. I would have answered several questions very differently had I been asked say over the last year... • The recent Sunshine ED staff increases have made nursing in resuscitation a lot safer and reduced problem of missed nursing care and failure to rescue. However, I have noticed that streamlined team work may not occur in cubicles-for example when doing a medication Check I observed a nurse with a large work load and patients with unmet	

Theme	Pre-implementation survey	Post-implementation survey
	hygiene/continence needs-which I was able to assist with. My point is that this nurses adjacent workers did not pickup on the opportunities to provide nursing care. • Unable to perform holistic nursing by providing enough information to patient and family because of the burden of pushing for beds. Patients care & outcomes are very often neglected because we are only crunching numbers. We have no time to deal with sick patients and their family. Sometime we have no time to spend with patients and give them education regarding their health. It seems like we are pressured by Management to discharge patient when we know that they are not completely ready. We have no time to complete all the nursing tasks, because we have very limited experienced nurses and there is no time to coach them. We are always under pressure.	
Staff morale/satisfaction, stress and safety	• Lack of equipment on the ward poses a problem, the distance from ED in terms of transport of the patient from ED to JKWC is too much for the CSRN, considering the other admin responsibility, the clicks that have formed with new management, the lack of appreciation, and the constant feeling of being put down by the managers to the point I got told to withdraw my job application. At WH, it's now who you know not what you know. The lack of appreciation for senior experience. WH campaigns to support mental health but they are the cause of it. People don't want to pick up shifts because of the bullying and lack of appreciation. • inadequate staffing and increased risk of patient dissatisfaction and aggression towards staff due to cancellation of planned care eg. IOL's	• there is a failure of staff being thanked at the end of the shift for the work performed • This may not be applicable to the Working Together Pilot project, but the wellbeing hub is fantastic. • To re-look at rostering and how this can better be improved, adequate days off between shifts, less late earlier, required days off post nights, not singular days on. Providing safety for staff from patients and families who are aggressive. Adequate meal breaks, payed for overtime and being acknowledged for doing overtime.

Theme	Pre-implementation survey	Post-implementation survey
	• IT USED TO BE A GREAT PLACE TO WORK, BUT DUE TO THEIR BEING TOO MANY "CHIEFS & NOT ENOUGH INDIANS" SO TO SPEAK & PEOPLE LIE TO GET WHAT THEY WANT, IT IS AN AWFUL PLACE TO WORK!!! • Its been stressful recently with the move to JKWC and the shortage of staff. Caseload midwives have been allocated shifts to the wards while still maintaining a full time caseload which we are obliged to help out but it feels like its happening more and more with no cover for us in caseload. • Lack of supportive staff. Staff refusing team work & helping others regardless of workload. Staff refusing to educate new staff, bank or agency & make them feel discriminated or useless - particularly graduates who are new to their career. Lack of support in terms of mental health & debrief. • not enough staff with personal leave and staff working a lot of overtime to cover so cases don't get cancelled, staff shortages • Q15 comment: I have my moments when I don’t want to be here. Section 5 comment: Lots of pressure on nurses. Management should have a pt load to see how hard it is. Out of touch with what goes on. When agency or bank on more pressure put on regular staff. Pt's families can be quite demanding, rude not enough support towards staff. Never told by management you are doing a good job, only when bad. Wards dirty and lots of wastage. Some staff do the best with Pt care, quite few burnt out and don't do ADL's [activities of daily living]. So subsequently left to the ones who go beyond their care. • Support for staff from verbally abusive and potentially abusive clients	

Theme	Pre-implementation survey	Post-implementation survey
	• There have been too many changes, too quickly with limited support from management. We are constantly understaffed, and many staff are quite inexperienced. This directly impacts on patient care and staff morale • wards are extremely under staffed. Nurses get abused (offhand remarks, rudeness, sarcasm, verbal aggression) daily from family members who get frustrated as they don't receive efficient care for their loved ones simply because there are not enough staff to carry out tasks. Most of my colleagues are stressed out, over worked, and overwhelmed by their high workload every day. • we are micro managed for the profession by allied health and not allowed to conduct the duties that we are highly trained for and qualified for. Lacks nursing management in this department and we have lost our medical management focus and it has been replaced by social work focus. There needs to be a balance.	
EMR	• each staff has a different understanding about documentations on the new system EMR • EMR is actually taking time away from patients. Too focused on getting screens completed. Take me longer to get tasks for patients completed because of EMR. Feel that clinical assessment skills will be lost by nursing staff as they become reliant on EMR to tell them what to do especially for junior staff. • Since EMR was introduced, Nursing care has changed dramatically and not for the better. Nurses are so stressed because they have less time to spend on patient care as the WoWs take all our time and a lot of the patients are intimidated by the presence of them if taken into their room.	

Theme	Pre-implementation survey	Post-implementation survey
Staff skill mix	• lack of skilled staff overnight that poses a risk as some of the staff (pool, bank and agency still don't know how to assess children, due to inadequate training and lack of care factor • In Midwifery, skill mix on the ward and allocating patient load to meet midwives skill level should be taken into account. On night duty, the ratio of 1:6 women, which really is 1:12 patients when the woman has had a caesarean and the baby requires observations, breastfeed assistance plus formula top ups and the woman is in a shared room with no partner to help, or this week I cared for 5 women, 2 of which had twins. 5 women and 7 babies- that includes post op care and frequent feeding assistance and maintaining adequate surveillance and task completion for the other women and newborns. On one night shift, there was no nurse on level 7 over night, where one gynae patient had a PICC line. Skill mix and ratio, especially on nights would go a long way to improving patient care and reduce stress on midwives. • In relation to the last question in sec 6, it is unclear if you are referring to my patients or generally? There should be a sec for student/grad supervision needs and ability/time to provide. Also for expectations re nurses to participate in committee/groups with no provision of floater etc to cover workloads- participation often linked to promotions • sKILL MIX IS AN ONGOING ISSUE, THERE IS TOO MUCH PRESSURE ON RN'S WHEN THERE ARE NO OTHER NURSES AVAILABLE TO HELP CHECK DD MEDICATIONS. IT PUTS ME BEHIND IN MY WORK CHECKING ALL OF THE MEDICATIONS WITH EN'S AND GRADS AND MAKES ME FEEL	

Theme	Pre-implementation survey	Post-implementation survey
	THAT MY WORKLOAD IS UNMANAGEABLE • Skill mix is poor at the hospital. Sometimes only one or two Grade 2 permanent staff so it puts a lot of pressure on them to do their work and also adhere to policy such as drug checking. With the number of meetings NIC going to they are not available to adequately supervise the ward. There is often not enough equipment or consumables to do your job effectively and on time • skill mix. Often it is very junior mix which burns out the senior nurses. Senior nurses also have other responsibilities given to them on top of patient work load, and yet they are expected to still deliver great patient care for their patients whilst still looking over the junior nurses patient load to ensure that the junior nurse is not sinking. • Sometimes Bank and Pool nurses are allocated the more challenging patients and have a more complex workload (? due to geographical patient allocation), they also may suffer from less teamwork and support from their colleagues on a shift and also suffer from not being able to debrief during/after a challenging shift • When patients get allocated to the nursing staff who is on during the shift, it should always be considered how well the staff is trained or how often the staff has worked on the particular ward. Generally wards have gotten better over the years but there is still wards who allocate a heavy or difficult workload to agency or bank nurses which is neither good for the nurse who isn't familiar with the ward nor the patient. • Generally if there is a very heavy workload of patients it should be split between 2 nurses, so that everyone can mange their workload.	

Theme	Pre-implementation survey	Post-implementation survey
	A lot of paper work/EMR work is in my eyes not necessary. From my point of view bank staff allocation seems to be worse since the introduction of the new allocation system. I don't feel valued getting a text message (amongst 10 other people). Whoever answers the text message first, gets the shift. It is sad that in a profession where we care for people we don't feel cared for by management. From the point of view of the ANUMs the new roster system creates double work as it doesn't talk to the old system (roster on) which is still in use adding to their already busy work day.	
Workload		• Not getting the appropriate breaks. Acuity of patients creating impossible workloads. Leaving work late with multiple people to handover to. No debriefs or team meetings. Poor team work as everyone busy with own workloads & no extra staff member available to float. Disjointed & complex referral systems (all paperwork should be either paper based or on one computer program). Equipment not readily available. • Too much work load, staff call in sick, we are given staff inadequately trained. Regular staff have to carry them on the shift. Nurses not even having time to do hygiene as so much work to do. Very sick pts not really acute pts. Palliative only have four pts, as well as Acute. We have five in the morning and six in the evening. However, we get acute and palliative pts. No concessions give. We have a large amount of falls risk pts. As well as behaviour pts. Management don't care. Lot of burnt out.

Theme	Pre-implementation survey	Post-implementation survey
		Staff constantly rushing cutting corners in pt care as they have unrealistic workloads.
Work systems		• Not getting the appropriate breaks. Acuity of patients creating impossible workloads. Leaving work late with multiple people to handover to. No debriefs or team meetings. Poor team work as everyone busy with own workloads & no extra staff member available to float. Disjointed & complex referral systems (all paperwork should be either paper based or on one computer program). Equipment not readily available. • The issue of profession discretion and selecting between competing requirements needs to be worked on. • the hospital sometimes lack the skill to make patients and their families comfortable during their outpatient appointments. Often they are made to sit for long waiting times to see a specialist. Waiting times can be alleviated if there was a database that gave them mobile phone contact when next in line or rough waiting times so that families can be active and move while waiting. RCH do this with ease, and families benefit from this - this is recent feedback received.
Rostering		• To re-look at rostering and how this can better be improved, adequate days off between shifts, less late earlier, required days off post nights, not singular days on. Providing safety for staff from patients and families who are aggressive. Adequate meal breaks, payed for overtime

Theme	Pre-implementation survey	Post-implementation survey
		and being acknowledged for doing overtime.
Working Together project initiatives		• I was very eager to be involved in this project, however within Maternity Services I observed no change in patient and/or staff quality or safety improvements. One poster was placed on the tea room doors suggesting staff think about things they were grateful for during that shift and walking to our cars as a group at the end of shift. There are quite a lot of midwives eager to improve every aspect of our work and to support each other, this could have been an ideal opportunity to seize that passion and build a strong, compassionate frontline leadership group. • I feel that the project has not done a lot to address the pressure that experienced nurses are under having to care for their own patient load as well as mentoring and assisting less experienced nurses/new graduates. • Name of division change R/v staff allocations and look at redoing admission procedures to cover the change
Other	• Haven't addressed "outpatient" care scenarios	• Difficult to answer some questions due to COVID and redeployment to a different area • I am a new employee with this organisation and have been here for 5 weeks so it was difficult to answer your questions based on this. I hav really enjoyed working in different roles throughout the team and feel it is a great model so that we all know how each role works.

Theme	Pre-implementation survey	Post-implementation survey
		• Many of these tasks are irrelevant to midwives • policy and procedure is not well written nor well linked or easy for search.

Appendix 4.2: Northeast Health Wangaratta Pre- and Post-implementation Survey ResultsError! Bookmark not defined.

Demographics

Table 4.2.1 Respondent characteristics

Variable	Pre Number (%)	Post Number (%)
Age (Pre n=60; Post n=34) range, mean	23-62, 43.2	23-69, 46.2
Country of birth (Pre n=60; Post n=35)		
Australia	56 (93.3)	32 (91.4%)
Overseas	4 (6.7)	3 (8.3%)
Current position (Pre n=60; Post n=36)		
RN	38 (63.3)	21 (58.3%)
EN	16 (26.7)	9 (25.0%)
Nurse & Midwife	5 (8.3)	4 (11.1%)
Other	1 (1.7)	2 (5.6%)
Years practised as a nurse/midwife (Pre n=60; Post n=32) range, mean	2-41, 16.6	2-50, 19.8
Years employed at NHW (Pre n=60; Post n=28) range, mean	1-35, 11.7	1-35, 14.5
Site work at (Pre n=58; Post n=36)		
NHW	49 (84.5%)	33 (91.7%)
Illoura Aged Care	9 (15.5%)	3 (8.3%)
Clinical area (Pre n=59; Post n=36)		
Ward	26 (44.1)	13 (36.1%)
Theatre	3 (5.1)	2 (5.6%)
Emergency department	6 (10.2)	4 (11.1%)
Maternity	2 (3.4)	4 (11.1%)
Other	22 (37.3)	13 (36.1%)
Working Together pilot ward (Pre n=60; Post n=36)		
No	13 (21.7)	9 (25.0%)
Yes	21 (35.0)	25 (75.0%)
Unable to determine	26 (43.3)	

Working Together Project (Post-implementation survey only)

Heard of the Working Together Project (n=36): Yes (29, 82.9%), No (6, 17.1%)

Table 4.2.2 Working Together Project

If yes, do you think that the Working Together Pilot was successful in…	Very successful/ Successful (n, %)	Neither/Unsuccessful/ very unsuccessful (n, %)
Improving workload allocation for nurses/midwives (n=28)	14 (50.0%)	14 (50.0%)
Reducing staff turnover (n=28)	9 (32.1%)	19 (67.9%)
Reducing staff absenteeism (n=28)	8 (28.6%)	20 (71.4%)
Improving the quality of patient care (n=)	14 (50.0%)	14 (50.0%)

Maximising the use of each nurse's/midwife's skills and experience (n=28)	16 (57.1%)	12 (42.9%)
Reducing the use of agency staff in your area (n=27)	6 (22.2%)	21 (77.8%)

Intentions

Table 4.2.3 Intentions

Variable	Up to one year	More than one year	Don't know
Intend to stay at NHW			
Pre (n=60)	4 (6.7%)	48 (80.0%)	8 (13.3%)
Post (n=36)	1 (2.8%)	28 (77.8%)	7 (19.4%)
Intend to stay working as a nurse/midwife			
Pre (n=59)	1 (1.7%)	53 (89.8%)	5 (8.5%)
Post (n=36)	0 (0.0%)	33 (91.7%)	3 (8.3%)

Work satisfaction

Table 4.2.4 NDNQI Work Satisfaction Scale

Item	Agree (n, %)	Disagree (n, %)
Autonomy		
Nurses/midwives are supervised more closely than is necessary		
Pre (n=59)	12 (20.3%)	47 (79.7%)
Post (n=35)	11 (31.4%)	24 (68.6%)
They have sufficient input into the program of care for each of their patients		
Pre (n=59)	46 (78.0%)	13 (22.0%)
Post (n=35)	34 (94.4%)	1 (2.9%)
They have too much responsibility and not enough authority		
Pre (n=59)	34 (57.6%)	25 (42.4%)
Post (n=31)	12 (38.7%)	19 (61.3%)
Nurses/midwives have a good deal of control over their own work		
Pre (n=59)	42 (71.2%)	17 (28.8%)
Post (n=35)	26 (72.2%)	9 (25.0%)
They are frustrated sometimes because their activities seem programmed for them		
Pre (n=59)	38 (64.4%)	21 (35.6%)
Post (n=35)	14 (40.0%)	21 (60.0%)
They are required sometimes to do things on the job that are against their better professional judgement		
Pre (n=59)	35 (59.3%)	24 (40.7%)
Post (n=35)	17 (48.6%)	18 (51.4%)
Nurses/midwives need more autonomy in their daily practice		
Pre (n=58)	42 (72.4%)	16 (27.6%)
Post (n=35)	23 (65.7%)	12 (33.3%)
They are free to adjust their daily practice to fit patient needs		
Pre (n=59)	36 (61.0%)	23 (39.0%)
Post (n=35)	28 (80.0%)	7 (20.0%)
Professional status		
They are satisfied with the status of nursing/midwifery in the hospital		

Item	Agree (n, %)	Disagree (n, %)
Pre (n=58)	38 (65.5%)	20 (34.5%)
Post (n=36)	29 (80.6%)	7 (19.4%)
Staff in other departments appreciate nursing/midwifery		
Pre (n=59)	41 (69.5%)	18 (30.5%)
Post (n=36)	30 (83.3%)	6 (16.7%)
They are proud to talk to other people about what they do on the job		
Pre (n=58)	49 (84.5%)	9 (15.5%)
Post (n=36)	33 (91.7%)	3 (8.3%)
What they do on the job is really important		
Pre (n=58)	58 (100%)	0 (0.0%)
Post (n=35)	34 (97.1%)	1 (2.9%)
What they do on the job does not add up to anything really significant		
Pre (n=57)	6 (10.5%)	51 (89.5%)
Post (n=36)	4 (11.1%)	32 (88.9%)
More recognition of nurses/midwives is needed from hospital management		
Pre (n=58)	44 (75.9%)	14 (24.1%)
Post (n=36)	30 (83.3%)	6 (16.7%)
Patients (family members) acknowledge nursing's/midwifery's contribution to their care		
Pre (n=58)	55 (94.8%)	3 (5.2%)
Post (n=36)	34 (94.4%)	2 (5.6%)
They recommend this hospital to others as a good place for nurses/midwives to work		
Pre (n=59)	55 (93.2%)	4 (6.8%)
Post (n=36)	35 (97.2%)	1 (2.8%)
Their work contributes to a sense of personal achievement		
Pre (n=59)	50 (84.7%)	9 (15.3%)
Post (n=36)	34 (94.4%)	2 (5.6%)
Pay		
Their present salary is satisfactory		
Pre (n=59)	34 (57.6%)	25 (42.4%)
Post (n=36)	21 (58.3%)	15 (41.7%)
A lot of nurses/midwives at this hospital are dissatisfied with their pay		
Pre (n=58)	25 (43.1%)	33 (56.9%)
Post (n=34)	18 (52.9%)	16 (47.1%)
The pay they get is reasonable, considering what is expected of nurses/midwives at this hospital		
Pre (n=59)	21 (35.6%)	38 (64.4%)
Post (n=36)	17 (47.2%)	19 (52.8%)
The latest salary increases for nurses/midwives at this hospital are not satisfactory		
Pre (n=59)	31 (52.5%)	28 (47.5%)
Post (n=36)	19 (52.8%)	17 (47.2%)
They are being paid fairly compared to what they hear about nurses/midwives at other hospitals		
Pre (n=59)	34 (57.6%)	25 (42.4%)
Post (n=35)	17 (48.6%)	18 (51.4%)
An upgrading of pay schedules for nurses/midwives is needed at this hospital		
Pre (n=59)	41 (69.5%)	18 (30.5%)
Post (n=36)	28 (77.8%)	8 (22.2%)

Perceived Stress Scale (Cohen et al 1983)

Table 4.2.5 Perceived Stress Scale (PSS-10)

Scale	Min	Max	Mean	SD
PSS-10 (10 items)				
Pre (n=58)	5.0	38.0	18.0	6.3
Post (n=35)	5.0	26.0	15.9	5.5

PSS-10:

- Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress.
- Scores ranging from 0-13 would be considered low stress.
- Scores ranging from 14-26 would be considered moderate stress.
- Scores ranging from 27-40 would be considered high perceived stress

Role Clarity, Satisfaction and Tension (Lyons et al 1971)

Table 4.2.6 Tension Index

Scale	Min	Max	Mean	SD
Tension Index (9 items)				
Pre (n=58)	14.0	42.0	25.0	5.9
Post (n=34)	14.0	34.0	24.0	5.3

Tension Index:
Responses to each item are coded from 1 to 5 and summed. The possible range is from 9 to 45.

Tension Index (How often do you feel bothered by …)

Item	Never (n, %)	Often (n, %)
Being unclear on just what the scope and responsibilities of your job are		
Pre (n=60)	54 (90.0%)	6 (10.0%)
Post (n=35)	29 (82.9%)	6 (17.1%)
Not knowing what opportunities for advancement or promotion exist for you		
Pre (n=60)	45 (75.0%)	15 (25.0%)
Post (n=35)	29 (82.9%)	6 (17.1%)
Not knowing what your immediate superior thinks of you, how she evaluates your performance		
Pre (n=60)	46 (76.7%)	14 (23.3%)
Post (n=35)	29 (82.9%)	6 (17.1%)
The fact that you can't get information needed to carry out your job		
Pre (n=60)	51 (85.0%)	9 (15.0%)
Post (n=35)	30 (85.7%)	5 (14.3%)
Not knowing just what the people you work with expect of you		
Pre (n=59)	53 (89.8%)	6 (10.2%)
Post (n=35)	32 (91.4%)	3 (8.6%)
Feeling that you have too heavy a work load, one that you can't possibly finish during an ordinary workday		

Item	Never (n, %)	Often (n, %)
Pre (n=60)	43 (71.7%)	17 (28.3%)
Post (n=35)	24 (68.6%)	11 (31.4%)
Thinking that the amount of work you have to do may interfere with how well it gets done		
Pre (n=60)	35 (58.3%)	25 (41.7%)
Post (n=35)	25 (71.4%)	10 (28.6%)
Feeling that you have to do things on the job that are against your better judgement		
Pre (n=59)	54 (91.5%)	5 (8.5%)
Post (n=34)	33 (97.1%)	1 (2.9%)
Thinking that you'll not be able to satisfy the conflicting demands of various people over you		
Pre (n=60)	44 (73.3%)	16 (26.7%)
Post (n=35)	28 (80.0%)	7 (20.0%)

Satisfaction Index:

Responses to the two items are summed. The possible range is 2 to 7. Lower scores indicate more satisfaction.

Table 4.2.7 Satisfaction Index

Scale	Min	Max	Mean	SD
Satisfaction Index (2 items)				
Pre (n=58)	2.0	7.0	3.2	1.3
Post (n=)	2.0	6.0	2.8	1.0

Item	A lot (n,%)	A little (n,%)	Not at all (n,%)
Considering your job as a whole, how much do you like it?			
Pre (n=60)	44 (73.3%)	13 (21.7%)	3 (5.0%)
Post (n=35)	26 (74.3%)	8 (22.9%)	1 (2.9%)

Item	Very good/good (n,%)	Fair/poor (n,%)
On the whole, what do you think of this hospital as a place to work?		
Pre (n=60)	47 (78.3%)	13 (21.7%)
Post (n=35)	32 (91.4%)	3 (8.6%)

Propensity to leave Index:

Responses to three items.

Table 4.2.8 Propensity to leave index

Item	Prefer to stay (n,%)	Prefer to leave (n,%)	Don't know (n,%)
If you were completely free to choose, would you prefer to continue working in this hospital or would you prefer not to?			
Pre (n=59)	44 (74.6%)	6 (10.2%)	9 (15.3%)
Post (n=)			

Item	Up to 1 yr (n,%)	More than 1 yr (n,%)	Don't know (n,%)

How long would you like to stay working at this hospital?			
Pre (n=60)	3 (5.0%)	47 (78.3%)	10 (16.7%)
Post (n=)			

Item	Yes (n,%)	No (n,%)	Don't know (n,%)
If you had to quit work for a while would you return to this hospital?			
Pre (n=60)	49 (81.7%)	2 (3.3%)	9 (15.0%)
Post (n=)			

Need for clarity index:

Responses to four items. How important is it to you to know, in detail …

Table 4.2.9 Need for clarity index

Item	Important (n,%)	Not important (n,%)
What you have to do on a job?		
Pre (n=60)	56 (93.3%)	4 (6.7%)
Post (n=35)	34 (97.1%)	1 (2.9%)
How you are supposed to do a job?		
Pre (n=60)	56 (93.3%)	4 (6.7%)
Post (n=35)	34 (97.1%0	1 (2.9%)
What the limits of your authority on a job are?		
Pre (n=)	56 (93.3%)	4 (6.7%)
Post (n=35)	33 (94.3%)	2 (5.7%)
How well you are doing?		
Pre (n=60)	53 (88.3%)	7 (11.7%)
Post (n=35)	32 (91.4%)	3 (8.6%)

Role conflict and ambiguity scale (Rizzo et al)

Higher scores on the scale show high role ambiguity/conflict.

Table 4.2.10 Role conflict and ambiguity scale

Scale	Min	Max	Mean	SD
Role conflict (15 items)				
Pre (n=59)	35.0	62.0	46.3	5.0
Post (n=34)	30.0	60.0	45.3	5.6
Role ambiguity (14 items)				
Pre (n=59)	29.0	51.0	41.2	4.6
Post (n=33)	28.0	45.0	38.8	3.8

Role conflict scale range (possible scores): 15-75

Role ambiguity scale range (possible scores): 14-70

Patient care

In general how would you describe …

Table 4.2.11 Patient care

Item	Excellent/good (n,%)	Fair/poor (n,%)
The quality of nursing/midwifery care delivered to patients on your ward?		
Pre (n=58)	55 (94.8%)	3 (5.2%)
Post (n=35)	33 (94.3%)	2 (95.7%)
Patient safety on your ward?		
Pre (n=58)	52 (89.7%)	6 (10.3%)
Post (n=34)	31 (91.2%)	3 (8.8%)

On your recent shift, which of the following activities were necessary but left undone because you lacked the time to complete them?

Table 4.2.12 Missed elements of patient care

Item	Pre	Post
Comfort/talk with patients	36	16
Educating patients and family	30	12
Perform adequate patient surveillance	21	10
Prepare patients and family for discharge	19	8
Assist with oral hygiene	16	6
Adequately document nursing/midwifery care (on appropriate forms/EMR)	15	6
Perform frequent changing of patient position (PAC)	15	7
Skin care and assessment	15	6
Treatments/procedures e.g. dressings	15	5
Develop or update nursing/midwifery care plans	12	5
Administer medications on time	8	7
Planning care	7	5
Pain management	5	5

Table 4.2.13 Incidents

How often do each of the following incidents occur?

Item	A few times a month or more (n, %)	Once a month or less (n, %)	Never (n, %)
Patients received wrong medication, time, or dose			
Pre (n=58)	10 (17.2%)	35 (60.3%)	13 (22.4%)
Post (n=35)	9 (25.7%)	21 (60.0%)	5 (14.3%)
Pressure ulcers after admission			
Pre (n=59)	1 (1.7%)	40 (67.8%)	18 (30.5%)

Post (n=34)	3 (8.8%)	21 (61.8%)	10 (29.4%)
Patient falls with injury			
Pre (n=59)	10 (16.9%)	39 (66.1%)	10 (16.9%)
Post (n=34)	9 (26.5%)	19 (55.9%)	6 (17.6%)
Complaints are received from patients or their families			
Pre (n=59)	21 (35.6%)	31 (52.5%)	7 (11.9%)
Post (n=34)	4 (11.8%)	26 (76.5%)	4 (11.8%)

A work related physical injury to nurses/midwives			
Pre (n=59)	12 (20.3%)	42 (71.2%)	5 (8.5%)
Post (n=34)	2 (5.9%)	25 (73.5%)	7 (20.6%)

Table 4.2.14 Free-text comments

Theme	Pre-implementation survey	Post-implementation survey
Patient acuity	• management (coordinators) are so focused on patient numbers not acuity. When we request additional staff due to high pt acuity, the requests are not taken seriously. … At the end of the day, patient safety is compromised due to inadequate ratios and majority of the time due to pt acuity. Our safety is also at risk and there is nothing we can really do about it as management do not listen. It would be great to do ward specific education and smart time. • Our patients are so complex and multiple services are requested before discharge home. • Continuing higher acuity of patients to safe nursing ratios is an issue. Having patients in the wrong ward due to lack of medical or CCU beds. 100% believe in right patient right bed. • General wards often have a mixture of palliative, stroke, and acutely unwell patients some would be in HDU units at larger metropolitan hospitals with higher nurse ratios where NHW keep the same ratio not taking into account what the acuity of the patient is. This leading to sub optimal care for patients and sometimes unsafe work conditions for staff. Also skill mix of staff is quite often unsafe. • patients are sooo much sicker and ratios have not kept up with that. Often patients on a ward should be in a high dependency unit but no room in our high dependency unit so are pushed out for someone even more sick. Why can't they go to another hospital if we don’t have room and that is what they need. Constant movement of patients around the hospital to create beds means that a surgical patient may be moved to three different wards or back and=d	• We try to spread non ambulant and heavier patients throughout ward but sometimes this is not possible. We seem to have an increase in delirium patients requiring one on one care.

	forth between 2 wards multiple times during their stay. This is so dangerous, creating more and more handovers where people actually know less about the patient each time, not to mention the enormous nursing resources this takes up as they have to be packed up, physically moved, handover given and then another patient rushed into that bed before they are ready just because they have been in ED for so long. Patients are frequently coming to the wards before they are properly assessed or managed in ED just because of the time factor! so they go the empty bed, regardless of which ward it is in, then they still can't get assessed properly for a number of hours especially if they are an outlier because we can't access Dr. Just feels like the most unstable patients are often moved out of areas that are well resourced such as CCU and ED, into poor resourced areas because of numbers or time target! really unsafe!!!!!!!!!	
<u>Patient ratios</u>	• Breaks on night shift are practically non-existent. we do not have adequate staffing to ratios. • Continuing higher acuity of patients to safe nursing ratios is an issue. Having patients in the wrong ward due to lack of medical or CCU beds. 100% believe in right patient right bed. • General wards often have a mixture of palliative, stroke, and acutely unwell patients some would be in HDU units at larger metropolitan hospitals with higher nurse ratios where NHW keep the same ratio not taking into account what the acuity of the patient is. This leading to sub optimal care for patients and sometimes unsafe work conditions for staff. • patients are sooo much sicker and ratios have not kept up with that.	

	Often patients on a ward should be in a high dependency unit but no room in our high dependency unit so are pushed out for someone even more sick. Why can't they go to another hospital if we don't have room and that is what they need. Constant movement of patients around the hospital to create beds means that a surgical patient may be moved to three different wards or back and=d forth between 2 wards multiple times during their stay. This is so dangerous, creating more and more handovers where people actually know less about the patient each time, not to mention the enormous nursing resources this takes up as they have to be packed up , physically moved, handover given and then another patient rushed into that bed before they are ready just because they have been in ED for so long. Patients are frequently coming to the wards before they are properly assessed or managed in ED just because of the time factor! so they go the the empty bed, regardless of which ward it is in, then they still cant get assessed properly for a number of hours especially if they are an outlier because we can't access Dr. Just feels like the most unstable patients are often moved out of areas that are well resourced such as CCU and ED, into poor resourced areas because of numbers or time target! really unsafe!!!!!!!!!	
<u>Patient care and safety</u>	• We do not have enough time to complete general tasks let alone code with a MET or CODE- then we are actually screwed. We do far too many bed moves for the same patients and it's just for fair. … We do not have the time to attend to all tasks let alone properly. … At the end of the day, patient safety is compromised due to inadequate ratios and majority of the time due to pt acuity.	

	• We have so much pressure by management to move patient on to get bed for theatre. We have pressure to do multiple tasks for multiple patients. Our patients are so complex and multiple services are requested before discharge home. Us nurses get pressure to discharge patient but we can't until other service eg. dr with scripts, physio and OT review. … Work is every task orientated, not patient focus most of the time. I feel sorry for my patients when I don't get to wash them, talk to them, brush their teeth. Simple things. I get to annoyed about moving patients throughout the hospital, just to return back to our ward, when they return straight back to where they started. • Constant students back to back throughout the year effects our workload greatly, to the point it is impacting our patient care and job satisfaction. • General wards often have a mixture of palliative, stroke, and acutely unwell patients some would be in HDU units at larger metropolitan hospitals with higher nurse ratios where NHW keep the same ratio not taking into account what the acuity of the patient is. This leading to sub optimal care for patients and sometimes unsafe work conditions for staff. • I believe that due to the pressures of an influx of medical patient on the weekends, there is extreme pressure in the mornings to discharge patients early. Patients aren't given adequate time to shower and dress. Some young people may have a broken arm or leg and they are not truly assessed o how well they will cope on discharge with showering etc. Staff often fell they do not have enough time to treat the sick and medical unstable as they are told there priority is for discharge and new admission. There is also too	

	many forms to fill out. I also believe i don't often get time to chat to my patients, this can have a big effect between a good stay and a bad stay. Because most angry, agitated people can be pleased, by having someone to vent to. • Patients often are under dual bed cards such as surgical/medical/orth. The teams do not communicate to each other and have ward rounds at different times, leaving the care of the patient unclear and undecided. Making for an increased workload on nurses and in charges having to chase the information, and when conflicting care is documented, often there is no follow up from treating teams as no one is willing to make a decision. • Pressure constantly on for "rounding" usually from management who have not worked ward work for quite some time. Patients' expectations have increased over the years but family responsibility, involvement and contact ability has decreased which puts immense pressure on the discharge planning phase of patients. • there are times that patients can receive injury from incorrect positioning for a procedure and this is something that happens less than once a month	
<u>Staff morale/satisfaction, stress and safety</u>	• We are a young ward of staff and I feel like because of that we are taken for granted as if we can work miracles. … I feel like when it a person is under a performance review they still get way with murder and it's just not fair. We are not appreciated for our hard work and that's why we are sick of this place. Breaks on night shift are practically non-existent. we do not have adequate staffing to rations. I feel like our work is not appreciated. We are encouraged not to have friendships with I feel like we are "just a number" to management..	

	and nothing else which feels pretty shit. … Our safety is also at risk and there is nothing we can really do about it as management do not listen. • Coming from a young-based ward, I feel like we are not getting supported enough from management and this creates stress on the senior and ANUM nurses which creates stress on us starting up nurses. …. I feel like I don't get any appreciation at work. • Constant students back to back throughout the year effects our workload greatly, to the point it is impacting our patient care and job satisfaction. • Feel very unsupported at higher levels of management (not our direct supervisor) in relation to issues related specially to our unit. • I believe we are very well supported at Illoura from RN, and Management, a recent bulling experience i was involved in at the start of the year was handled, confidentially, with respect and compassion to myself and my family, leaving us feeling very blessed and appreciated. • Our ward (maternity) has current policies and guidelines. However, many doctors request procedures to be done they way they prefer, ignoring protocols. This makes it difficult to do our job effectively and consistently. Also staff shortages ae chronic. Staff retention is low and morale is often low. It has been witnessed that senior staff (on the floor) are often harassing and bullying many staff, often in a passive manner. Many staff have reported that they felt unsupported by some senior staff and that is why they have left. • physical and verbal violence towards staff has gotten worse.	
<u>Staff development</u>	• I don't feel like I can grow, there is not opportunity to go for promotion. I have done extra University study	

	outside work and I don't get to use it and no appreciation. • There is not a lot of time allocated to educating the large number of nursing students and graduate nurses that are in the hospital. • Insufficient and inappropriate support models for education and support. Clinical support staff designed as a role to support new staff now dragged into world of students/undergraduates. No time to support staff so further pressure on ward clinical staff. Clinical support staff being asked to cover too much with too little resources and being renumerated at too low a classification - grade 3 clinical support should not be expected to be completing under graduate or post graduate assessments. that should be at an Educator level.	
<u>Staff skill mix</u>	• At times there may not be adequate staff with right skill mix available due to inadequate number of workforce availability • Constant students back to back throughout the year effects our workload greatly, to the point it is impacting our patient care and job satisfaction. • General wards often have a mixture of palliative, stroke, and acutely unwell patients some would be in HDU units at larger metropolitan hospitals with higher nurse ratios where NHW keep the same ratio not taking into account what the acuity of the patient is. This leading to sub optimal care for patients and sometimes unsafe work conditions for staff. Also skill mix of staff is quite often unsafe.	
<u>Recommendations/ other</u>	• It would be great to do ward specific education and smart time.	• thank you NHW for your support of staff, Illoura should be very proud of their supportive management.
<u>Working Together project</u>		• It was not a great time for the ward to participate in "anything new". There was a

		lack of ward ANUMs at the time due to Annual Leave, secondment and emergency leave. There were no real "leaders" to affectively LEAD this opportunity. I have NOT seen any improvement or changes on the ward since this project was implemented. There has been talk generated however so hopefully we can continue with the chat and basics plans that have been talked about. • Would have liked Comm Nws. to have been more involved in project.

Appendix 4.3: Western Health & Northeast Health Wangaratta Pre- and Post-implementation Survey Results (comparison) Error! Bookmark not defined. Error! Bookmark not defined.

Perceived stress scale

PSS-10 (10 items)

Health service		N	Mean	SD	Sig
Overall (both health services)					p=0.320
	Pre	187	17.4	6.9	
	Post	149	16.7	6.5	
WH					p=0.827
	Pre	128	17.1	7.2	
	Post	114	16.9	6.8	
WH WT wards					p=0.635
	Pre	31	15.9	6.7	
	Post	30	16.7	5.7	
WH non WT wards					p=0.475
	Pre	95	17.5	7.4	
	Post	82	16.8	6.8	
NHW					p=0.093
	Pre	59	18.0	6.3	
	Post	35	15.9	5.5	

No significant differences found in mean perceived stress scale score pre- and post-implementation in both health services.

Tension Index

Health service		N	Mean	SD	Sig
Overall (both health services)					p=0.798
	Pre	180	25.1	7.0	
	Post	147	24.9	7.1	
WH					p=0.989
	Pre	122	25.2	7.4	
	Post	113	25.2	7.5	
WH WT wards					p=0.766
	Pre	29	26.1	7.5	
	Post	29	25.6	6.5	
WH non WT wards					p=0.979
	Pre	91	24.8	7.5	
	Post	82	24.8	7.7	
NHW					p=0.429
	Pre	58	25.0	5.9	
	Post	34	24.0	5.3	

No significant differences found in mean tension index score pre- and post-implementation in both health services.

Satisfaction Index

Health service		N	Mean	SD	Sig
Overall (both health services)					p=0.219
	Pre	187	3.4	1.4	
	Post	152	3.3	1.4	
WH					p=0.323
	Pre	127	3.6	1.4	
	Post	117	3.4	1.4	
WH WT wards					p=0.078
	Pre	30	4.0	1.5	
	Post	31	3.3	1.2	
WH non WT wards					p=0.510
	Pre	93	3.5	1.4	
	Post	84	3.4	1.4	
NHW					p=0.168
	Pre	60	3.2	1.3	
	Post	35	2.8	1.0	

No significant differences found in mean satisfaction index score pre- and post-implementation in both health services.

Role conflict scale

Health service		N	Mean	SD	Sig
Overall (both health services)					p=0.804
	Pre	182	46.2	5.6	
	Post	149	46.0	5.6	
WH					p=0.864
	Pre	123	46.1	5.9	
	Post	115	46.2	5.6	
WH WT wards					p=0.700
	Pre	31	46.6	6.0	
	Post	30	46.1	4.9	
WH non WT wards					p=0.614
	Pre	90	45.8	5.9	
	Post	83	46.3	5.9	
NHW					p=0.364
	Pre	59	46.3	5.0	
	Post	34	45.3	5.6	

No significant differences found in mean role conflict score pre- and post-implementation in both health services.

Role ambiguity scale

Health service		N	Mean	SD	Sig
Overall (both health services)					**p=0.008**
	Pre	182	41.1	4.9	
	Post	147	39.7	4.7	
WH					p=0.078
	Pre	123	41.1	5.0	
	Post	114	40.0	5.0	
WH WT wards					p=0.704
	Pre	31	41.3	5.3	
	Post	29	41.8	4.8	
WH non WT wards					**p=0.010**
	Pre	90	41.2	4.9	
	Post	83	39.2	4.9	
NHW					**p=0.013**
	Pre	59	41.2	4.6	
	Post	33	38.8	3.8	

No significant difference was found in mean role ambiguity score pre- and post-implementation WH; however, there was a significant difference in the mean score pre- and post-implementation overall, in the non WT wards at WH and at NHW with the post mean scores significantly lower than the pre mean scores indicating less role ambiguity.

Missed elements of patient care

Item	WH Pre	WH Post	NHW Pre	NHW Post
Comfort/talk with patients	64	17	36	16
Educating patients and family	50	18	30	12
Perform adequate patient surveillance	38	6	21	10
Develop or update nursing/midwifery care plans	38	3	12	5
Adequately document nursing/midwifery care (on appropriate forms/EMR)	35	17	15	6
Assist with oral hygiene	25	7	16	6
Prepare patients and family for discharge	24	2	19	8
Administer medications on time	20	1	8	7
Planning care	20	1	7	5
Skin care and assessment	17	2	15	6
Treatments/procedures e.g. dressings	17	2	15	5
Perform frequent changing of patient position (PAC)	12	1	15	7
Pain management	9	3	5	5

Patient care (excellent/good)

Item	WH Pre (%)	WH Post (%)	NHW Pre (%)	NHW Post (%)
The quality of nursing/midwifery care delivered to patients on your ward?	78.4	81.2	94.8	94.3
Patient safety on your ward?	73.6	81.2	89.7	91.2

How often do each of the following incidents occur? A few times a month or more

Item	WH Pre (%)	WH Post (%)	NHW Pre (%)	NHW Post (%)
Patients received wrong medication, time, or dose	20	15	10	9
Pressure ulcers after admission	5	2	1	3
Patient falls with injury	18	14	10	9
Complaints are received from patients or their families	38	24	21	4
A work related physical injury to nurses/midwives	8	13	12	2

Intentions – more than one year

Variable	WH Pre (%)	WH Post (%)	NHW Pre (%)	NHW Post (%)
Intend to stay at health service	67.2	78.0	80.0	77.8
Intend to stay working as a nurse/midwife	82.5	83.1	89.8	91.7

Like job – a lot

Item	WH Pre (%)	WH Post (%)	NHW Pre (%)	NHW Post (%)
Considering your job as a whole, how much do you like it?	66.1	67.5	73.3	74.3

Think hospital a 'very good/good' place to work

Item	WH Pre (%)	WH Post (%)	NHW Pre (%)	NHW Post (%)
On the whole, what do you think of this hospital as a place to work?	62.5	70.3	78.3	91.4

Do you think that the Working Together Pilot was very successful/successful in...	WH Post (%)	NHW Post (%)
Improving workload allocation for nurses/midwives	26.9	50.0
Reducing staff turnover	23.9	32.1
Reducing staff absenteeism	20.9	28.6
Improving the quality of patient care	31.8	50.0
Maximising the use of each nurse's/midwife's skills & experience	28.8	57.1
Reducing the use of agency staff in your area	32.8	22.2

Appendix 5: Data audit tables

Appendix 5.1: Western Health Data audit

Appendix 5.1.1 – WH People matter survey – Nursing and Midwifery

Western Health People matter survey – Nursing and Midwifery

Table 1: Western Health Nursing and Midwifery People Matter Survey data 2018 and 2019

2018		2019	
Considering everything, how satisfied are you with your current job	59%	70%	Overall job satisfaction % Satisfied
I am proud to tell others I work for my organisation	73%	72%	Engagement - % Proud to tell others work for WH
I would recommend my organisation as a good place to work	72%	71%	Would recommend WH as good place to work
This health service does a good job of training new and existing staff	72%	70%	WH does a good job training staff
There are adequate opportunities for me to develop skills and experience in my organisation		77%	Have adequate opportunities for me to develop skills and experience in my current job
I get a sense of accomplishment from my work	87%	77%	Get a sense of accomplishment from work
I understand how my job contributes to my organisation's purpose		93%	Percent who have a clear understanding of how own job contributes to their workgroup's role
I enjoy the work in my current job	87%	79%	Enjoy work in current job
My job allows me to utilise my skills, knowledge and abilities	90%	88%	My job allows me to utilise my skills, knowledge & abilities
I would recommend a friend or relative to be treated as a patient here	74%	73%	Would recommend a friend/relative to be a patient at WH
Patient care errors are handled appropriately in my work area	84%	81%	Patient care errors are handled appropriately in my work area
No correlating question		53%	People in my workgroup generally coped well with the change
How would you rate your current level of work-related stress	21%	20%	% who experience high to severe work-related stress
The workload I have is appropriate for the job that I do	46%	54%	Unable to take breaks due to workload

Appendix 5.1.2 - Western Health Nursing and Midwifery staffing data

Table 1: Western Health Nursing and Midwifery staffing data – Pre-Implementation

Staff/Organisational data *(total WH Clinical Nursing & midwifery)*	May-18 Month 1	Jun-18 Month 2	Jul-18 Month 3	Aug-18 Month 4	Sep-18 Month 5	Oct-18 Month 6	Nov-18 Month 7	Dec-18 Month 8	Jan-19 Month 9	Feb-19 Month 10	Mar-19 Month 11	Apr-19 Month 12	**Average**
Overtime costs (Total monthly cost, $)	$251,009	$309,377	$465,925	$351,409	$363,195	$358,564	$331,103	$514,696	$305,277	$238,139	$255,813	$329,087	**$339,466**
Supplementary staffing costs (ie agency, bank, pool) (Total monthly cost, $)	No data												
Personal Leave hours taken (%)	5.8%	6.0%	6.2%	6.8%	6.1%	5.9%	5.4%	5.5%	4.5%	5.1%	5.3%	5.0%	**5.6%**
Staff turnover (monthly number (FTE) of leavers divided by the monthly actual FTE x 100) %	0.60%	0.40%	1.10%	0.90%	0.70%	0.50%	0.40%	1.20%	0.70%	0.70%	0.70%	0.50%	**0.70%**
Specials													
Behavioural shifts per month	208	269	219	237	205	130	188	151	123	66	65	71	**161.0**
Psychiatric shifts per month	181	189	111	76	81	129	93	112	86	87	105	177	**118.9**

Clinical acuity shifts per month	211	165	293	440	477	452	430	540	499	448	454	314	**393.6**

Table 2: Western Health Nursing and Midwifery staffing data – Post implementation

Staff/Organisational data *(total WH Clinical Nursing & midwifery)*	May-19 Month 1	Jun-19 Month 2	Jul-19 Month 3	Aug-19 Month 4	Sep-19 Month 5	Oct-19 Month 6	Nov-19 Month 7	Dec-19 Month 8	Jan-20 Month 9	Feb-20 Month 10	Mar-20 Month 11	Apr-20 Month 12	**Average**
Overtime costs (Total monthly cost, $)	$435,140	$427,904	$655,445	$342,943	$386,313	$345,410	$260,593	$288,073	$259,483	$255,243	$273,497		**$357,277**
Supplementary staffing costs (ie agency, bank, pool) (Total monthly cost, $)	$1.5M	$1.5M	$1.5M	$1.5M	$1.4M	$1.5M	$1.8 M	$1.7M	$1.9M	$1.6M	$1.6M	$1.3 M	**$1.7M**
Personal Leave hours taken (%)	5.4%	5.7%	5.7%	5.7%	6.2%	5.6%	5.8%	6.3%	4.9%	5.2%	5.8%	3.7%	**5.50%**
Staff turnover (monthly number (FTE) of leavers divided by the monthly actual FTE x 100) (%)	0.60%	0.40%	0.80%	0.60%	0.60%	0.80%	0.50%	0.70%	0.80%	0.70%	0.40%	0.30%	**0.60%**
Specials													
Behavioural shifts per month	142	240	151	140	216	246	305	238	216	247	145	116	**200.2**
Psychiatric shifts per month	61	107	122	122	122	196	126	121	165	238	115	121	**134.7**
Clinical acuity shifts per month	314	253	297	297	212	135	259	322	351	373	292	211	**276.3**

Appendix.5.1.3 – Western Health Nursing and Midwifery staffing data

Table 1: Western Health nursing and midwifery data - Pre implementation

Nursing/midwifery data	*May-18*	*Jun-18*	*Jul-18*	*Aug-18*	*Sep-18*	*Oct-18*	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	**Average**
Source - MaP reports	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
Number of incidents/adverse events (total per month)	2	1	2	2	1	1	3	2	1		2	3	**1.82**
Total inpatient Falls	191	208	177	196	182	206	173	186	159	158	208	188	**186.00**
1. Severe-Death/Severe						2							
2. Moderate	2	1	2	2	1	1	3	2	1		2	3	**1.8**
3. Mild	131	131	117	133	114	121	105	101	95	90	124	119	**115.1**
4. No Harm/Near Miss	58	76	58	61	67	82	65	83	63	68	82	66	**69.1**
Falls per 100 bed days	0.71	0.79	0.65	0.72	0.68	0.75	0.65	0.69	0.59	0.64	0.75	0.71	**0.69**
High Risk Medication Errors	69	58	57	54	59	47	97	103	59	73	48	58	**65.2**
Medication errors 1+2	0	0	0	1	1	1	1	0	1	4	0	1	**0.83**
Total Incident Severity Ratings (Sentinal Events)	698	688	630	648	619	632	801	828	590	684	661	664	**678.6**
1. Severe-Death/Severe	1	1				2				2		1	**1.4**
2. Moderate	19	5	11	12	7	13	9	15	10	10	13	8	**11**
3. Mild	384	352	340	371	330	327	362	387	294	297	327	342	**342.8**
4. No Harm/Near Miss	294	330	279	266	282	290	430	426	286	375	321	313	**324.3**
Infection Prevention													
HAI (Hospital associated Staph Aureus Bacteraemia)(rate/10,000)	0.5	0	0.5	0	0	0.5	1.1	1.1	0	0	0.5	0.6	**0.40**
WH acquired C Difficile Infections (rate)	0.7	2	1.5	1.1	1.6	1.3	0.8	2.4	1.4	1.7	2.3	0.7	**1.46**
Percentage of times hand hygiene practices are correctly performed	*91%*	*91%*	*91%*	*90%*	87%	91%	90%	90%	89%	89%	90%	91%	**90.0%**

Nursing/midwifery data *Source - MaP reports*	*May-18* Month 1	*Jun-18* Month 2	*Jul-18* Month 3	*Aug-18* Month 4	*Sep-18* Month 5	*Oct-18* Month 6	Nov-18 Month 7	Dec-18 Month 8	Jan-19 Month 9	Feb-19 Month 10	Mar-19 Month 11	Apr-19 Month 12	**Average**
Healthcare - associated staphylococcus aureus bacteraemia (number of BSI)	1	0	1	0	**0**	**1**	2	2	0	0	1	1	**0.75**
Iv ste cares (IV line related BSI)	1	0	0	1	0	1	1	0	0	0	0	1	**0.4**
WH acquired VRE BSI (number of cases)	0	1	0	0	0	0	0	0	4	0	0	0	**0.4**
Hand Hygiene Compliance (WH overall%)	91%	91%	91%	90%	87%	91%	90%	90%	89%	89%	90%	91%	**90.00%**
Hand Hygiene HCW Moments (Nurse)	93%	92%	90%	91%	84%	93%	90%	90%	90%	91%	88%	91%	**90.25%**
In-hospital Mortality of patients													
Death in low mortality DRG's	0.03%		0.02%		0.05%	0.01%	0.05%	0.02%	0.04%	0.05%	0.02%	0.02%	**0.03%**
Admitted for AMI	1.54%	2.86%	2.47%	3.45%	1.11%	5.38%	5%	1.59%	1.47%	1.25%	2.63%	1.54%	**2.52%**
Admitted for Stroke	6.25%	12.50%	10%	6.52%	16.67%	4.88%	7.69%	5.71%	12.12%	10%	3.13%	13.04%	**9.04%**
Admitted for fractured NoF	3.33%	2.94%		6.90%	10%	10%	15%	4.55%	7.41%	6.67%		3.70%	**7.05%**
Admitted for pneumonia	1.37%	8.22%		3.09%	5.19%	6.41%	4.23%	2.44%	6.67%		3.80%	5.17%	**4.67%**
Pressure injuries - Developed in hospital per 100 bed days	0.08	0.12	0.11	0.11	0.07	0.09	0.12	0.09	0.07	0.12	0.09	0.09	**0.10**
Nutrition													
Diagnosed episodes of malnutrition	144	104	106	109	101	121	103	122	141	111	123	117	**116.8**
Prevalence of diagnosed malnutrition (%)	6.81%	5.23%	5.16%	5.27%	5.13%	5.51%	5.16%	6.22%	6.91%	6.11%	6.06%	5.89%	**5.79%**
Sub-acute													
Average Length of stay excluding HITH	1.46	1.51	1.56	1.48	1.53	1.52	1.48	1.52	1.55	1.53	1.52	1.51	**1.51**
Separations Sub Acute	337	306	298	298	287	353	289	258	324	278	274	287	**299.1**

Nursing/midwifery data *Source - MaP reports*	*May-18* Month 1	*Jun-18* Month 2	*Jul-18* Month 3	*Aug-18* Month 4	*Sep-18* Month 5	*Oct-18* Month 6	Nov-18 Month 7	Dec-18 Month 8	Jan-19 Month 9	Feb-19 Month 10	Mar-19 Month 11	Apr-19 Month 12	**Average**
Average Length of stay excluding HITH Sub Acute	19.18	17.49	21.61	18.65	21.13	20.05	17.69	20.68	19.3	20.28	21.84	19.74	**19.8**
Separations													
Length of Stay - Total Separations	11,824	11,052	11,275	11,932	10,906	11,976	11,281	10,964	10,875	10,406	11,717	11,098	**11276**
Discharges													
Discharge Summary Completion rate (EMR Records All campuses) (% completed)	96%	95%	95%	95%	95%	95%	95%	95%	94%	95%	95%	94%	**94.92%**
Discharge summaries completed within 48 hrs of discharge	75%	75%	75%	74%	72%	73%	74%	73%	75%	76%	75%	71%	**74.00%**
Complaints and compliments													
Patient complaints (total per month) (MAP data)	88	74	88	104	89	74	84	59	94	88	83	75	**83.3**
Patient compliments (total per month) (MAP data)	17	14	13	28	18	21	23	18	21	24	17	30	**20.3**

Table 2: Western Health nursing and midwifery data – post-implementation

Nursing/midwifery data *Source - MaP reports*	May-19 Month 1	Jun-19 Month 2	Jul-19 Month 3	Aug-19 Month 4	Sep-19 Month 5	Oct-19 Month 6	Nov-19 Month 7	Dec-19 Month 8	Jan-20 Month 9	Feb-20 Month 10	Mar-20 Month 11	Apr-20 Month 12	Average
Number of incidents/adverse events (total per month)	3	1	1	2									**1.75**
Total inpatient Falls	193	153	172	203	150	160	170	181	157	160	165	142	**167.2**
1. Severe-Death/Severe				1									**1**
2. Moderate	3	1	1	2			2		1	1	2	1	**1.6**
3. Mild	122	105	119	118	96	102	112	95	89	94	98	109	**104.9**
4. No Harm/Near Miss	68	47	52	82	54	58	56	86	67	65	65	32	**61.0**
Falls per 100 bed days	0.693	0.559	0.606	0.728	0.553	0.58	0.643	0.679	0.591	0.62	0.645	0.665	**0.63**
High Risk Medication Errors	61	47	62	69	75	60	50	52	46	52	34	31	**53.25**
Medication errors 1+2	1	1	1	2	4	4	4	0	3	2	2	0	**2.00**
Total Incident Severity Ratings (Sentinal Events)	628	589	608	678	576	581	550	597	565	628	443	427	**572.50**
1. Severe-Death/Severe				2		1				1		1	**1.25**
2. Moderate	6	6	7	8	2	10	5	4	6	7	4		**5.9**
3. Mild	347	308	336	352	298	323	303	310	274	304	238	214	**300.6**
4. No Harm/Near Miss	275	275	265	316	282	247	242	283	285	316	201	212	**266.6**
Infection Prevention													
HAI (Hospital associated Staph Aureus Bacteraemia)(rate/10,000)	1.1	1.1	0.5	1.1	0.6	1.6	0	0.56	1.64	2.29	0	0	**0.87**
WH acquired C Difficile Infections (rate)	1.8	3.7	1	2.2	1.1	2.4	2	1.6	1.9	2.3	2.3	0.5	**1.90**
WH acquired VRE BSI (number of cases)	3	0	0	0	2	0	0	0	0	0	0	0	**0.4**
Percentage of times hand hygiene practices are correctly performed	91%	90%	90%	91%	90%	90%	89%	89%	88%	89%	93%	94%	**90.3%**

Nursing/midwifery data *Source - MaP reports*	May-19 Month 1	Jun-19 Month 2	Jul-19 Month 3	Aug-19 Month 4	Sep-19 Month 5	Oct-19 Month 6	Nov-19 Month 7	Dec-19 Month 8	Jan-20 Month 9	Feb-20 Month 10	Mar-20 Month 11	Apr-20 Month 12	Average
Healthcare - associated staphylococcus aureus bacteraemia (number of BSI)	2	2	1	2	1	3	0	1	3	4	0	0	**1.6**
Iv ste cares (IV line related BSI)	2	0	0	3	1	0	0	0	1	0	0	0	**0.6**
Hand Hygiene Compliance (WH overall%)	91.00%	90.00%	90.00%	90.00%	90%	90%	89%	89%	88%	89%	93%	94%	**90.25%**
Hand Hygiene HCW Moments (Nurse)	92%	93%	91%	90%	92%	92%	88%	90%	89%	91%	94%	95%	**91.42%**
In-hospital Mortality of patients													
Death in low mortality DRG's	0.04%	0.06%	0.02%	0.01%	0.04%	0.02%		0.01%	0.08%	0.02%	0.06%	0.03%	**0.04%**
Admitted for AMI			3.13%	3.45%	1.27%	1.49%	3.33%	1.37%	1.41%	1.30%	1.54%	3.13%	**2.14%**
Admitted for Stroke		7.14%	5.26%	17.24%	4.76%	3.45%	6.25%	17.86%	10.53%	3.13%	3.32%	5.00%	**7.63%**
Admitted for fractured NoF		4.35%			3.45%	9.68%	5.26%		9.09%	9.09%	3.85%	11.11%	**6.99%**
Admitted for pneumonia	7.69%	1.30%	2.44%	2.56%	5.32%	2.11%	3.90%	9.68%	1.49%	2.04%	4.41%	2.13%	**3.76%**
Pressure injuries - Developed in hospital per 100 bed days	0.101	0.084	0.106	0.086	0.092	0.127	0.076	0.101	0.075	0.101	0.121	0.098	**0.10**
Nutrition													
Diagnosed episodes of malnutrition	120	110	129	130	139	141	123	150	136	131	129	81	**126.6**
Prevalence of diagnosed malnutrition (%)	5.62%	5.49%	5.82%	5.91%	6.43%	6.52%	6.32%	7.30%	6.78%	6.68%	6.28%	5.23%	**6.20%**
Sub-acute													
Average Length of stay excluding HITH	1.51	1.53	1.57	1.47	1.54	1.48	1.45	1.48	1.52	1.48	1.51	1.48	**1.50**
Separations Sub Acute	341	292	324	355	333	346	308	316	317	290	383	231	**319.7**
Average Length of stay excluding HITH Sub Acute	19.89	17.96	18.86	18.06	18.24	17.95	16.26	18.6	19.14	18.54	16.41	16.61	**18.04**

Discharges													
Discharge Summary Completion rate (EMR Records All campuses) (% completed)	94%	94%	95%	95%	95%	96%	96%	96%	95%	95%	96%	95%	**95.2%**
Discharge summaries completed within 48 hrs of discharge	72%	73%	78%	76%	73%	76%	76%	74%	71%	75%	78%	78%	**75.0%**
Length of Stay													
Length of Stay - Total Separations	12084	11216	11942	11955	11108	12120	11464	11446	11439	11090	11161	9056	**11340**
Complaints and compliments													
Patient complaints (total per month) (MAP data)	90	80	110	105	88	137	65	77	81	86	90	66	**89.6**
Patient compliments (total per month) (MAP data)	31	34	29	21	17	32	21	22	18	23	18	16	**23.50**

Appendix 5.2: Northeast Health Wangaratta Data audit

Appendix 5.2.1 – NHW People matter survey – Nursing and Midwifery

Table 1: NHW Nursing and Midwifery People Matter Survey data 2018 and 2019

People Matter Survey Questions	2018	2019
Overall job satisfaction % Satisfied	76%	82%
Engagement - % Proud to tell others work for NHW	76%	81.7%
Would recommend NHW as good place to work	73%	82%
NHW does a good job training staff	67%	74%
Have adequate opportunities for me to develop skills and experience in my current job	71%	77%
Get a sense of accomplishment from work	87%	84%
% who have a clear understanding of how own job contributes to their workgroup's role	92%	93%
Enjoy work in current job	90%	88%
My job allows me to utilise my skills, knowledge & abilities	91%	91%
Would recommend a friend/relative to be a patient at NHW	83%	87%
Patient care errors are handled appropriately	82%	82%
% who experience high to severe work-related stress	24%	15%

Appendix 5.2.2 - NHW Nursing and Midwifery staffing data

Table 1: NHW Nursing and Midwifery staffing data – Pre-Implementation

Staff/Organisational data *(total WH Clinical Nursing & midwifery)*	May-18 Month 1	Jun-18 Month 2	Jul-18 Month 3	Aug-18 Month 4	Sep-18 Month 5	Oct-18 Month 6	Nov-18 Month 7	Dec-18 Month 8	Jan-19 Month 9	Feb-19 Month 10	Mar-19 Month 11	Apr-19 Month 12	**Average**
Overtime costs (Total monthly cost, $)	$114,979	$89,289	$150,015	$65,021	$63,073	$70,673	$50,026	$86,867	$57,356	$53,049	$54,647	$105,328	**$80,027**
Supplementary staffing costs (i.e. agency) (Total monthly cost, $)	$14,852	$5,657	$9,484	$5,526	$14,727	$33,125	$31,527	$24,271	$22,842	$42,975	$43,445	$49,115	**$17,396**
Sick leave (total number of days)	1605.87	1134.98	1126.03	1369.67	1141.14	1368.40	972.84	945.36	798.65	776.99	865.64	1049.41	**1096.25**
Staff turnover (monthly number (FTE) of leavers divided by the monthly actual FTE x 100)	No data												

Table 2: NHW Nursing and Midwifery staffing data – Post implementation

Staff/Organisational data *(total WH Clinical Nursing & midwifery)*	May-19 Month 1	Jun-19 Month 2	Jul-19 Month 3	Aug-19 Month 4	Sep-19 Month 5	Oct-19 Month 6	Nov-19 Month 7	Dec-19 Month 8	Jan-20 Month 9	Feb-20 Month 10	Mar-20 Month 11	Apr-20 Month 12	**Average**
Overtime costs (Total monthly cost, $)	$50,122	$65,224		$221,535	$239,589	$285,563	$211,854	$257,634					**$190,217**
Supplementary staffing costs (i.e. agency) (Total monthly cost, $)	$79,631	$45,976											**$62,804**
Sick leave (total number of days)	1251.72	1090.22	1307.32	1092.66	1110.21	1187.73	1016.86	1149.79					**1150.81**
Staff turnover (monthly number (FTE) of leavers divided by the monthly actual FTE x 100)			108.33	26.32	40.91	35	4.94	21.74					**39.54**

Appendix 5.2.3 – NWH Nursing and Midwifery data

Table 1: NWH Nursing and Midwifery data - Pre implementation

Nursing/midwifery data *Source - MaP reports*	*May-18* Month 1	*Jun-18* Month 2	*Jul-18* Month 3	*Aug-18* Month 4	*Sep-18* Month 5	*Oct-18* Month 6	Nov-18 Month 7	Dec-18 Month 8	Jan-19 Month 9	Feb-19 Month 10	Mar-19 Month 11	Apr-19 Month 12	**Average**
Medication errors (rating 1)	0	0	0	0	0	0	0	0	0	0	0	0	**0.00**
Medication errors (rating 2)	1	0	0	0	0	0	0	0	1	0	0	1	**0.13**
Medication errors (rating 3)	4	6	14	10	6	4	8	10	10	6	16	7	**7.75**
Medication errors (rating 4)	32	48	40	19	63	18	8	13	30	27	45	41	**30.13**
Falls per 100 bed days (org wide per 1000 bed days)	2.8	6.4	5.2	5	4.3	3.8	3	3.8	5	4.8	2.9	4.2	**4.3**
Total inpatient falls													
1. Severe-Death/Severe	0	0	0	0	0	0	0	0	0	0	0	0	**0**
2. Moderate	1	2	0	0	1	0	0	3	1	1	1	1	**0.9**
3. Mild	3	15	12	13	8	12	5	5	14	12	8	13	**9.1**
4. No Harm/Near Miss	14	23	22	20	16	12	13	16	17	16	9	13	**17.0**
Total Incident Severity Ratings (Sentinal Events)													
1. Severe-Death/Severe	0	0	0	0	0	0	0	0					**0.0**
2. Moderate	2	1	3	2	1	3	1	4					**2.1**
3. Mild	62	54	52	76	59	53	48	58					**57.8**
4. No Harm/Near Miss	78	80	77	110	63	67	56	62					**74.1**
Ulcers/ pressure injuries - Developed in hospital per 100 bed days	**0.9**	**1.4**	**2**	**0.75**	**1.3**	**0.3**	**0.3**	**0.3**	**0.75**	**0.66**	**1.7**	**0.6**	**0.9**

Table 2: NWH Nursing and Midwifery data - Post implementation

Nursing/midwifery data *Source - MaP reports*	May-19 Month 1	Jun-19 Month 2	Jul-19 Month 3	Aug-19 Month 4	Sep-19 Month 5	Oct-19 Month 6	Nov-19 Month 7	Dec-19 Month 8	Jan-20 Month 9	Feb-20 Month 10	Mar-20 Month 11	Apr-20 Month 12	**Average**
Medication errors (rating 1)	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
Medication errors (rating 2)	0	0	0	1	0	0	0	0	0	0	0	1	**0.1**
Medication errors (rating 3)	13	4	6	10	6	3	2	4	13	4	6	10	**6.0**
Medication errors (rating 4)	33	28	26	62	31	27	24	30	33	28	26	62	**32.6**
Falls per 100 bed days (org wide per 1000 bed days)	4.3	6.8	6.1	4.7	5.2	5.3	3.7	3.7	4.3	6.8	6.1	4.7	**5.0**
Total inpatient falls													
1. Severe-Death/Severe	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
2. Moderate	1	0	3	0	0	2	0	2	1	0	3	0	**1.0**
3. Mild	9	15	12	8	17	10	3	6	9	15	12	8	**10.0**
4. No Harm/Near Miss	18	26	25	23	17	24	19	13	18	26	25	23	**20.6**
Total Incident Severity Ratings (Sentinal Events)													
1. Severe-Death/Severe	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
2. Moderate	2	3	0	0	2	1	2	6	3	1	2	3	**2.0**
3. Mild	42	52	73	62	42	36	25	47	55	50	69	78	**47.4**
4. No Harm/Near Miss	59	98	81	45	172	47	32	42	71	72	92	96	**72.0**
Ulcers/ pressure injuries - Developed in hospital per 100 bed days	1	0.9	1.2	1.2	0.6	1.2	1.8	1.6	1	0.9	1.2	1.2	**1.2**

Appendix 6: Interview themes & quotes Error! Bookmark not defined.

Appendix 6.1: Pre-implementation interview themes and quotes

Working Together Project
Pre-implementation Interviews
Themes

Seven themes about workforce allocation were from the pre-implementation participant interviews:

Theme 1: Patient acuity – "patients are getting sicker"
Nurses and midwives (especially at NHW) reported that they were caring for 'sicker' patients and more patients with comorbidities and as a result, patients' care needs had become more complex. This had an impact on their workload (increased it; not enough staff to manage patient needs) and affected their work satisfaction (feelings of being burnt out).

I think sometimes our workload is too heavy, it can get quite busy and hectic on the medical ward, and it's probably to do with like the acuity of patients, I think yeah they seem to be you know a lot more unwell and yeah the workload can be pretty heavy in that respect at times. Sometimes it's okay, but yeah a lot of the time you feel, especially when I was full time yeah, you'd tend to feel a bit burnt out. The patients are so unwell and yeah it's just so busy. (NHW Pre-implementation Interview Participant #8)

I think the current workloads are really quite heavy, a lot of our patients are now coming in with a lot of comorbidities … it's not just a sort of standard one thing that we're hoping to treat for them, there's multiple conditions that we're trying to manage. (NHW Pre-implementation Interview Participant #1)

By the time they come into hospital you know they're barely able to do anything for themselves anymore. So it does take a lot of our time, which you know you're sort of getting stretched across 4 or 5 patients of a morning shift and you know 5 or 6 of an afternoon shift, and it's really, it can be really quite difficult to sort of prioritise your tasks. (NHW Pre-implementation Interview Participant #1)

I've been on a medical ward now for 10 years … but since I first started there our workloads have increased immensely, … our patients are getting sicker, our paperwork is becoming a lot more complex and more time consuming as well. And that's another thing that impacts on our patient care. (NHW Pre-implementation Interview Participant #1)

When you've got your real sickies you haven't actually got that extra staff to help with that. Because I know on one shift not that long ago you know there was 4 sick patients in a room you know that had a nasogastric, IV, a drain, IDC, they were needing all sorts of other procedures being done 2 to 4 hourly, there was like 2 of those in a room and then you have a semi confused patient and there's only one person in that room, you know. Because the other staff had to go and work, look after the other 4 patients that we had. And it's all very well having them all in the one room, but you still needed an extra pair of hands, not all the time, but you know there's not that ability to be able to flex people I think. (NHW Pre-implementation Interview Participant #2)

So whilst we have ratios which are a godsend, … it's where you need to increase the staffing for [patient] complexity … that's where you run into issues. (NHW Pre-implementation Interview Participant #5)

I've worked everywhere and to be honest regional hospitals probably cope with much sicker people than a lot of Melbourne hospitals because they're very area specific in Melbourne and if they're sick you just shoot them off somewhere else. (NHW Pre-implementation Interview Participant #5)

As patients become sicker and their care needs become much more complex, that is drug administration, wound care, all of the things which are becoming much more complex because we're keeping patients alive longer, it's both ends of the scale, so that's your elderly and your infirm, and also the younger which are much more complex that may not have actually survived past a year. (NHW Pre-implementation Interview Participant #5)

When I first started in the emergency department we had 3 people working on a day shift, 3 people would be pushed to the max, but you'd get the job done. We now have 6 sometimes 7 working and we're struggling because the local population has changed, it's got a lot older and as you get older you get sicker, we're keeping people at home longer that sort of thing. So our allocation by nature of the demographic of the area has had to change. (NHW Pre-implementation Interview Participant #6)

Look there's always shifts in a week where you do the important stuff, and when I say the important stuff it's like the airway, breathing, circulation, and the niceties such as you know two cups of tea instead of one or you know turn every hour instead of every 2 hours. There are shifts when the niceties don't get done, and that's merely because of the volume of patients that we have going through yeah. And not just the volume but the complexity. (NHW Pre-implementation Interview Participant #6)

Theme 2: Patient care – missed elements of patient care

Nurses and midwives at both health services reported that although they felt they were providing good patient care, there were often elements of patient care that were missed due to their (heavy) workload. They commented that this was unfortunate as they felt that these 'basic' elements were important for patient outcomes including length of stay and patient satisfaction.

Sometimes I just feel like at the end of the shift like you – I mean I know I've done the best I can and the patient's well cared for, but just sometimes you just have that feeling that you know I could've done more, but because I was so busy or caught up with say one patient in particular that might've been really unwell that I feel like … I may have sort of neglected other patients, I haven't been able to spend as much time with them. (NHW Pre-implementation Interview Participant #8)

Basic care like hygiene and mouth care and pressure area care and all those sort of things, sometimes at the end of the shift you think you would've liked to have done a little bit more of that stuff too. (NHW Pre-implementation Interview Participant #8)

When you're doing those sorts of basic things that's when you're sort of checking over your patient as well, like it's alright to walk into the room and see them from the bed, but I think when you're spending that bit of time with them doing that, and you're speaking with them or you know getting to know them as well, plus you're doing those basic you know needs that I think sometimes can get missed. (NHW Pre-implementation Interview Participant #8)

A lot of basic care needs aren't being met because you're, like when you're prioritising say somebody's got you know the hypotension or they've become febrile, so you're concentrating on managing those symptoms and forgetting about all, well not forgetting but you just don't have time to do those basic care needs, like you know pressure area care or even brushing dentures. (NHW Pre-implementation Interview Participant #1)

I do think that if we had even somebody on a shorter shift to help with a lot of the hygiene, where you know you need those 2 staff to assist with hygiene, whether it's a bed bath or you know helping a stroke patient get up into a shower. Yeah you sort of do need that extra set of hands to help. (NHW Pre-implementation Interview Participant #1)

There's lots of things, and I guess it all depends on the day as well. But yeah just a lot of those basic hygiene needs, even taking patients to the toilet on a regular basis, so they're not soiling incontinence aids and – or just getting patients out of bed for all their meals. (NHW Pre-implementation Interview Participant #1)

it's a combination of things, I think we're, it's such a fast paced environment now as well, you've got doctors coming around doing rounds, you want to try to catch up with them to find out what the plan is, you're chasing the doctors for drug orders that have been written incorrectly, or you've got a patient that's unwell, and yeah there's – you've got, while you're with one of your patients you've got your other 3 patients that could be needing something as well. So I think you're cutting a lot of your tasks short instead of doing them I guess properly, and completely, you're just doing half jobs. (NHW Pre-implementation Interview Participant #1)

You're trying to rush, I mean I know on the midwifery unit you're trying to get these women out as quickly as possible, so you're just sort of give a bit of verbal diarrhoea to give them all the education and stuff, and then when they fail it's sort of not – it's really not their fault, it's our fault because we haven't been able to give them the appropriate education. (NHW Pre-implementation Interview Participant #2)

Junior staff don't know about mouth care, people are not having their teeth cleaned after meals or you know before they go to bed. And actually clearing away all the excess stuff, making the bed area tidy so that at night shift it's clear for patients when they can't see because the lights are out. (NHW Pre-implementation Interview Participant #2)

Nurses are being taken away from basic nursing care, because they've got so much more paperwork to do. (NHW Pre-implementation Interview Participant #3)

Yeah, so the basics that the nurses are taught, you know like our oral hygiene and just basic ADLs for a patient, they can get missed because you don't have the time to do all your showers before 10am, before the doctors do their rounds and you know you've got to get your ECGs done for those that are on telemetry before the doctors rounds. It's a real push of time. (NHW Pre-implementation Interview Participant #3)

Well I mean our clientele are usually older patients, and I mean they don't shower every day at home, but you know it's easy for them to be missed for 2 or 3 days because you know you're looking at your care plan and oh yeah it was done yesterday, but in actual fact it was done the day before, because the nurses didn't actually get time to go back and do that shower, a patient could be sitting you know 2 or 3 days without a shower. That's very common. (NHW Pre-implementation Interview Participant #3)

Look there's always shifts in a week where you do the important stuff, and when I say the important stuff it's like the airway, breathing, circulation, and the niceties such as you know two cups of tea instead of one or you know turn every hour instead of every 2 hours. There are shifts when the niceties don't get done, and that's merely because of the volume of patients that we have going through yeah. And not just the volume but the complexity. (NHW Pre-implementation Interview Participant #6)

Theme 3: patient ratios – 'a blessing and a curse'

Participants identified nurse/midwife patient ratios as both a 'blessing and a curse'. Nurses/midwives reported that it was often difficult to provide high quality patient care within the current nurse/midwife: patient ratios particularly when caring for patients with complex needs or high acuity patients.

Well if you don't have enough nurses then you can't provide the best practice and the best care, and patient centred care, which is what we're all about. So the patient centred care has to drop off because you can't make yourself available for the 6 or 8 patients that you have. (NHW Pre-implementation Interview Participant #3)

So whilst we have ratios which are a godsend, … it's where you need to increase the staffing for complexity and or patient care, that's where you run into issues slash problems. (NHW Pre-implementation Interview Participant #5)

Some nurses and midwives expressed a preference for 'team nursing' as it provided additional support especially for less experienced or bank/pool staff. Whilst others felt that having nurses/midwives responsible for a certain number of patients ensured accountability and reduced the number of elements of patient care that were missed.

Sometimes in the team nursing I think maybe you thought the other nurse might've done something but they haven't and they thought you have, and it might be missed. (NHW Pre-implementation Interview Participant #8)

I have a preference that one nurse is responsible for each, for a particular patient, so that – you know because we all have to be accountable for our actions, and if we're accountable for at least one patient, or however many patients, there's no grey areas as to who's going to do what and you know who's not doing certain tasks for those patients. … I think if you're responsible for your patients, there's no ambiguity with who's doing the progress notes, who's writing the care plans. (NHW Pre-implementation Interview Participant #1)

When you're a team you feel as though you can bounce questions off each other better. And so if you've sort of suddenly got a question you sort of think … you know I'll go and ask so and so. (NHW Pre-implementation Interview Participant #2)

In my experience, and I did both team and individual nurse care, and in my experience I found being responsible for 4 patients I knew exactly what was going on, whereas I found if I was in charge and had some Div2s working under me for example, I'd still have to be checking and making sure. So I actually liked having my own patients rather than team nursing, because you knew exactly what was going on and I didn't think things weren't getting missed or worried that things were going to get missed. (NHW Pre-implementation Interview Participant #4)

I think if [team nursing] is done correctly, so there are I think – if the tasks are divvied up and the care's divvied up sort of equally so that sort of one nurse isn't doing, caring for 8 patients rather than the 4 and the other one's just sitting down. Yeah so I think if it's done correctly I think it's worthwhile. (WH Pre-implementation Interview Participant #4)

I think team nursing would be fantastic because in that case even if you had someone from bank pool who doesn't know anything she's teamed up with someone and someone is overseeing her, and it would give her faith at the end of the day. (WH Pre-implementation Interview Participant #1)

I think the allocations the one to four in the day and I think one to five in the afternoon is great but I think it's also a curse as well because you sort of feel as if you're stuck in that. (WH Pre-implementation Interview Participant #3)

Theme 4: Patient safety

Participants felt that patient safety was often adversely affected by high workloads and patient acuity.

On night shift it is just ridiculously unsafe, just unsafe because with that layout if kids are throwing up at bed 21 and 22 I cannot not go down and see what nurse is doing because I've got my own lot up the front. … So I really think that the workload is too much at the moment, it's unsafe, kids don't get sick during the day they get sick at night. (WH Pre-implementation Interview Participant #1)

Theme 5: Staff satisfaction

A number of factors were identified by the interview participants as affecting staff satisfaction including high workload, patient acuity, occupational violence. Participants also acknowledged initiatives implemented by management at their health service which contributed to improved staff satisfaction.

I've worked in ED for a very long time, I don't think that I would have the same enthusiasm and passion if I worked full time in that environment. It is very draining, it's an unstable environment and I don't mean that from a management perspective at all, I just mean from the clientele that goes through. (NHW Pre-implementation Interview Participant #6)

This man was shackled, and he couldn't, you couldn't provide any care unless there was four security guards there, and you sort of come into work and you're thinking oh am I going to be hurt today? (WH Pre-implementation Interview Participant #4)

I think they do like executive walk arounds and little things, and [manager's name] doing like a forum now every month to listen to staff, I think that that's good, and having conversations. (WH Pre-implementation Interview Participant #5)

There are countless nights in my career that I've gone home and not slept because you're thinking about something. And it plays on your mind and, I think if all midwives are honest, every single one of them has suffered a traumatic, something traumatic. (WH Pre-implementation Interview Participant #5)

We need to be more appreciated, the culture needs to change because it is affecting patient care. (WH Pre-implementation Interview Participant #1)

Some weeks [I feel] overworked because of not so much the number of the clients but the nature of the clients we're dealing with. One week it can be what's all the fuss you know this job's easy, the next week I'm calling security, or I have to call the police to have someone removed. Sometimes I think it can feel as though you're just holding on kind of thing. (WH Pre-implementation Interview Participant #2)

Theme 6: Staff skill mix

Participants identified the importance of taking into account/ensuring an appropriate staff skill mix when allocating patients/workload in order to provide appropriate patient care, and the support that less experienced staff often required.

Yeah I think when the allocations are done now people who are doing allocation does sort of try to take into consideration the skill mix, so like the more unwell patients would go to the more senior nurses. (NHW Pre-implementation Interview Participant #8)

I think you know the in-charge's try and allocate probably the most sickest patients or the ones with the most complex needs to the relevant staff that have those higher skills and you know more experience. (NHW Pre-implementation Interview Participant #1)

I think there's some people that have gone into the, like the ANUM role, or the in-charge role, that they have, none of them have had sort of – because there's so many junior staff they've had to move the sort of less junior up into more senior roles without giving them any real education or support into that role. (NHW Pre-implementation Interview Participant #2)

Our skill mix is not terrific. So on an afternoon shift which is a heavier patient load, you have 5 and 6 patients each, you could be the only senior nurse. And all the rest are new grads or new staff that have been out maybe a year, 2 years … there's not enough experienced nurses. (NHW Pre-implementation Interview Participant #3)

Skill mix is our biggest thing because we seem to just get to a certain point where everyone's trained up in all the different specialties and then we have a mass exodus and we sort of get back to training people up again and making sure – because we have about 7 or 8 different specialties in theatre, so you have to make sure that someone is allocated overnight or on weekends that knows orthopaedics and knows urology and have someone that actually knows each area well enough, so that can be a little bit tricky too if you're looking to fill some spots and there's someone that puts their hand up but they don't know any orthopaedics or urology, well you know you have to sort of knock them back. (NHW Pre-implementation Interview Participant #4)

I don't think in the actual workload, sorry, the nursing workloads they're looking at skill mix either. So we might have like, I've been on a shift recently in which there was myself and a person in charge, like the person in charge, and the rest were all grads and bank, and so I was the only one that could check, double check drugs with everybody else. (WH Pre-implementation Interview Participant #4)

Especially night duty they have a lot of sick leave and it's covered by bank or casual staff, some of them don't have the care factor and they don't have the experience to look after kids. (WH Pre-implementation Interview Participant #1)

I think also even within that ward you need to look at things like your nursing experience, maybe have an experienced nurse with the ICU patient for the first 24 to 48 hours and as they improve, or within your ward move your sicker patients nearer to the nurses' station with the right nurse with maybe the bay next door is not as heavy so that nurse can then assist with the complex patients next door. (WH Pre-implementation Interview Participant #3)

If you have got a bank staff or a pool staff that's never worked on that ward you stick them in a bay with really sick patients you just set them up to fail. … the allocation needs to be right, the seniority of nurses needs to be looked at to make sure you get the appropriate for that workload. (WH Pre-implementation Interview Participant #3)

Theme 7: Workload allocation

Participants discussed workload allocation in terms of staff shortages, patient acuity, and appropriate skill mix.

I mean we'd always like more staff, there's always – I think the other thing that, well when you've got your real sickies you haven't actually got that extra staff to help with that. Because I know on one shift not that long ago you know there was 4 sick patients in a room you know that had a nasogastric, IV, a drain, IDC, they were needing all sorts of other procedures being done 2 to 4 hourly, there was like 2 of those in a room and then you have a semi confused patient and there's only one person in that room, you know. Because the other staff had to go and work, look after the other 4 patients that we had. And it's all very well having them all in the one room, but you still needed an extra pair of hands, not all the time, but you know there's not that ability to be able to flex people I think. (NHW Pre-implementation Interview Participant #2)

Workload allocation needs to be skill mixed, so the most sickest patients needs to go to your more senior staff. (NHW Pre-implementation Interview Participant #3)

As far as allocations go, the in-charge nurse actually allocates the theatres and dependent on skill mix, yeah so we have a lot of graduate nurses and new staff coming through who don't know all the different specialties, so that has to be taken into consideration. (NHW Pre-implementation Interview Participant #4)

some people from the old school of thinking have not quite got their head around how do we allocate, and make workload effective, not only from a patient number but an environmental perspective, so instead of splitting allocations from one end of the ward to the other because it suits the purpose, have to think about oh how do we do this, how do we do it in teams, how do we do it so that it works better. (NHW Pre-implementation Interview Participant #5)

Unfortunately in the emergency department we don't have a whole lot of say over who comes through the door and how we manage them, but certainly there is every effort made to maintain a reasonable workload. (NHW Pre-implementation Interview Participant #7)

There was a recognition within the hospital and the department that the night shifts were no longer the quiet shift, and that was recognised and that has had a really positive impact on patient care and also I believe staff satisfaction and things. (NHW Pre-implementation Interview Participant #7)

I think sometimes it's unfair, and they don't really take into account workload, and I think the same people tend to get the more difficult patients and so I think allocation is based on like looking after your friends sometimes. (WH Pre-implementation Interview Participant #4)

Thinking about sort of giving people a break, so for example if one nurse has been in a certain area that you know is quite difficult, like it's about rotating those nurses around. (WH Pre-implementation Interview Participant #4)

I find the biggest issue, and this is what I often do when I have a complex, long term patient come up in ICU, it's about allocating the patients to the right areas so you can sometimes because you can often get wards where you have patients with lots of social issues, behavioural issues and it may be dementia

patients which you can't control, it might be an IV drug user or an alcoholic that is obviously unwell but awake enough to cause trouble, they might be in a room with the dementia lady, the alcoholic, the IV drug user and the ICU patient and I think what needs to be done better first of all is I think the coordinators need to do a better job of allocating patients. … I think also even within that ward you need to look at things like your nursing experience. (WH Pre-implementation Interview Participant #3)

I think the one to four ratio is brilliant but it's no good if you haven't got the right person allocated or you make that room too heavy. What I don't understand is they might say this room's really heavy, but they're not glued to the floor. They're not nailed in, you can move them, you can move them to other parts. (WH Pre-implementation Interview Participant #3)

If the bank nurse is really new then again it comes down to your allocation. You need to maybe make it a bit easier for them. … So the allocation needs to be right, the seniority of nurses needs to be looked at to make sure you get the appropriate for that workload. *(WH Pre-implementation Interview Participant #3)*

Appendix 7 - Acknowledgments and thanks

- Adj/Prof Shane Crowe, Executive Director, Nursing & Midwifery, Western Health
- Rebecca Weir, Executive Director of Clinical Services, Nursing, Midwifery & Allied Health, Northeast Health Wangaratta
- Jason O'Keefe, Chief Operating Officer (Acting) Northeast Health Wangaratta
- Carolyn Fisher, Nurse Consultant, Working Together Project, Northeast Health Wangaratta
- Melody Trueman, Assistant Director of Nursing & Midwifery (Working Together), Western Health
- Debra Hill, Director, Employee Relations, Business Partnerships & Injury Management Western Health
- Anne Wright, Manager, Organisational Development, Western Health
- Eugenia Lambis, Organisational Development, Western Health
- Fiona Shanks, Director People & Culture, Northeast Wangaratta
- Linda Betts of Linda Betts & Associates – Co-design & Follow Up Workshops for Western Health & Northeast Health Wangaratta
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- Kerryn Eccleston, Manager, Nursing, Midwifery and Paramedicine Workforce Unit, the Department
- Rebecca J Radford, Senior Policy Advisor, Nursing, Midwifery, and Paramedicine Workforce, Department of Health & Human Services
- Duncan Baluch, Manager, Nursing, Midwifery, and Paramedicine Workforce Unit, Department of Health & Human Services.
- Prof Bodil Rasmussen, Chair of Nursing, Western health/Deakin University Partnership
- Dr. Sara Holton, Senior Research Fellow, Western Health/Deakin University Partnership
- Dr. Karyn Wynter, Senior Research Fellow, Western Health/Deakin University Partnership
- Ms. Ashleigh Neagle, Research Assistant, Deakin University - Evaluation data collection
- Ms. Fiona McGregor, Research Assistant, Deakin University – Evaluation data collection
- Jennifer (Jenny) Tull, Nurse Unit Manager, Illoura Aged Care, Northeast Health Wangaratta
- Sally Arthur, Nurse Unit Manager, Surgical Ward, Northeast Health Wangaratta
- Helen Scales, Associate Midwifery Unit Manager, Northeast Health Wangaratta
- Rian John, Associate Nurse Unit Manager, Surgical Ward, Northeast Health Wangaratta
- Anne Hiskins, Associate Nurse Unit Manager, Medical Ward, Northeast Health Wangaratta
- Nicole Davies, Director of Nursing & Midwifery, Western Health
- Joy Turner, Director of Nursing & Midwifery, Western Health
- Lisa Smith, Operations Manager, Maternity Services, Women's & Children's, Western Health
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Thanks also to the nurses and midwives who participated in the evaluation component by completing surveys, interviews or participating in focus groups. We thank you for sharing your personal views and experiences.

Appendix 8 - Steering Committee

The project steering committee met monthly from March 2019 to February 2020 and due to the geographical distances between the two healthcare sites (Sunshine Hospital, Melbourne, and Northeast Health Wangaratta Hospital, Wangaratta) the meetings were held via zoom. Other members of the steering committee occasionally participated in the meeting via Zoom from their workplace location (the Department, Melbourne city; Deakin University, Burwood; Western Health, Footscray).

The members of the steering committee were responsible for monitoring the project milestones, key performance indicators, and resolving project risks and any issues escalated. Additionally, they contributed to program development and consultation, provided specialised information on best practices and supported the facilitation of change at a local level.

Committee members:

- Adj/Prof Shane Crowe, Executive Director of Nursing & Midwifery, Western Health (Chair)
- Rebecca Weir, Director of Clinical Services, Northeast Health Wangaratta
- Carolyn Fisher, Nurse Consultant, Working Together Project, Project Lead Northeast Health Wangaratta
- Melody Trueman, Assistant Director of Nursing & Midwifery (Working Together), Western Health (Minutes and administration support)
- Debra Hill, Manager, Employee Relations, Western Health
- Kerryn Eccleston, Manager, Nursing, Midwifery and Paramedicine Workforce Unit, DHHS (March – November 2019)
- Rebecca J Radford, Senior Policy Advisor, Nursing, Midwifery, and Paramedicine Workforce, DHHS
- Duncan Baluch, Manager, Nursing, Midwifery and Paramedicine Workforce Unit, DHHS (December 2019– February 2020)
- Prof Bodil Rasmussen, Chair of Nursing, Western health/Deakin University Partnership
- Dr. Sara Holton, Research Fellow, Western Health/Deakin University Partnership
- Fiona Shanks, Director People & Culture, Northeast Wangaratta
- Nicole Davies, Director of Nursing & Midwifery, Western Health
- Joy Turner, Director of Nursing & Midwifery, Western Health
- Lisa Smith, Operations Manager, Maternity Services, Women's & Children's, Western Health
- Jennifer (Jenny) Tull, Nurse Unit Manager, Illoura Aged Care, Northeast Health Wangaratta
- Sally Arthur, Nurse Unit Manager, Surgical Ward, Northeast Health Wangaratta
- Helen Scales, Associate Midwifery Unit Manager, Northeast Health Wangaratta
- Rian John, Associate Nurse Unit Manager, Surgical Ward, Northeast Health Wangaratta
- Anne Hiskins, Associate Nurse Unit Manager, Medical Ward, Northeast Health Wangaratta

Appendix 9 - Project Governance and Project Team

The project team consisted of the project leads from Western Health & Northeast Health Wangaratta and the lead nursing executive from each healthcare service.

Name	Position
Adj/Prof Shane Crowe	Executive Director of Nursing & Midwifery Western Health, Melbourne, Victoria - Project Sponsor for Western Health
Rebecca Weir	Director of Clinical Services, Nursing & Midwifery Northeast Health Wangaratta, Wangaratta, Victoria - Project Sponsor for Northeast Health Wangaratta
Melody Trueman	Assistant Director of Nursing & Midwifery (Working Together) Western Health, Melbourne Victoria. - Project Lead, Western Health
Carolyn Fisher	Nurse Consultant – Working Together Project Northeast Health - Project Lead, Northeast Health Wangaratta

Project Governance – Supporting structures

Roles	Governance Responsibilities	Project Responsibilities
Steering Committee	• Monitor project milestones • Monitor agreed KPI's • Resolve project risks and issues escalated	• Contribution to program development and consultation • Provide specialised information e.g. clinical services and 'best practice' • Determine implementation • Resolve any disputes or grievances • Facilitate change on a local level
Project Sponsor WH & NHW	• Overall project sponsor (Western Health) • Executive oversight (WH & NHW) • Sign off deliverables/milestones (WH & NHW) • Act as reinforcing sponsor for change implementation Accountable for the Implementation	• Chair steering committee (WH) • Provide project leadership (WH & NHW) • Provide project oversight (WH & NHW) • Provide strategic and operational advice • Assign project roles and responsibilities • Provide access to data

Project Team (WH & NHW)	• Plan and execute the project • Responsible for the implementation • Monitor budget • Report project outcome	• Coordinate and liaise with other parties to facilitate project success (WH) • Manage communications to stakeholders + feedback • Organise working parties (as required) • Determine appropriate stakeholders involvement • Manage stakeholders • Ensure quality objectives are achieved
Reference Group Committee NHW	• Escalate arising issues from workforce • Plan for execution strategies for the project • Monitor KPIs	• Contribute to project development and consultation • Engage with stakeholders and front line staff • Provide information from WH and NHW • Actively contribute to co-design methodology and facilitation.
Chair of Nursing & Research Team (Deakin)	• Lead and oversee project evaluation	• Advise on ethic / privacy and other requirements according to their expertise • Provide coaching and guidance with project methodology
Nursing & Midwifery Advisory Committee Western Health	• Monitor agreed KPI's	• Contribution to program development and consultation
Strategy and Planning, DHHS	• Monitor project milestones & agreed KPI's • Authorise resources and allow modifications	• Provide funding for the pilot project • Sign off deliverables/milestones
Nursing & Midwifery Service Northeast Health Wangaratta	• Monitor agreed KPI's	• Contribution to program development and consultation • Provide specialised information e.g. clinical services and 'best practice' • Facilitate change on a local level

Appendix 10 - Risk & Issue Register

Issues and risks that arose during the project duration were raised at the monthly steering committee along with any actions to resolve that issue to date. The steering committee provided input and guidance and resolved all issues collaboratively. Risks were allocated a risk rating (likelihood combined with consequence) and monitored for the duration of the project. Risks were rated as low, moderate, high, or extreme.

All issues and risks that arose or were documented during the project were resolved and are shared in the project report only to assist other health services in the future.

Examples of issues (Western Health & Northeast Health Wangaratta combined) that were raised during the project term

- Participating in the pilot would add to the Unit Manager workload
- Initial reluctance to participate in the pilot by some unit managers
- Development of a communication plan
- Adding financial incentive to encourage survey participation
- Using zoom for focus groups
- Poor internet connectivity between health care services
- Unit Managers not having sufficient office/administration time
- Impact of State (Victoria) bushfires on staffing, leave & rostering
- Development of project strategies

Examples of items from the Risk Register

- Disengagement with the project due to change fatigue (Low)
- Failure to communicate the project plan (Moderate)
- Resistance to change and for trialling of the new strategies (High)
- Failure to comply with The Safe Patient Care Act (High)

Appendix 11 - Communication Plan

A formal communication strategy was developed for the Working Together Project by Western Health & Northeast Health Wangaratta by SenateSHJ, an Australasian based independent consultancy firm.

The communication strategy covered the key milestones of the consultation and co-design process along with communication tactics and suggested channels.

The three key goals of the communication plan were:

1. To position the Working Together pilot as a valuable and beneficial process that empowers nurses and midwives to make ratios work for them and their patients.
2. To drive nursing and midwifery staff participation in and engagement with the consultation and co-design process for Working Together.
3. To support the Working Together Project with clear, timely, and targeted communication that lays the groundwork for staff acceptance of, and participation in, the trial.

The approach focused on:

- Developing a core story that could be communicated across all target audiences
- Segmenting audiences so that communication could be tailored to their specific needs
- Encouraging the flow of messages both outwards, radiating from the Working Together Project team, and across Western Health and Northeast Health Wangaratta.

The strategy aimed to:

- Position the Working Together pilot as a valuable and beneficial process that empowers nurses and midwives to get involved in identifying and implementing strategies that make ratios work for them and their patients
- Drive nursing and midwifery staff participation in, and engagement with, the consultation and co-design process for Working Together.

Communication objectives:

- To communicate the opportunity and rationale for the change to build stakeholder awareness and understanding
- To generate critical stakeholder cooperation and participation to ensure successful delivery of a co-designed Working Together pilot and engage them in the process, address questions and concerns, and minimise issues
- To support the project with clear, timely, and targeted communication to inform stakeholders of the co-design process and trial

A project logo was developed by White Creative (for SenateSHJ) and was intentionally branded without a tagline to not pre-empt the co-design solutions and/or strategies.

The logo has an icon of a 'W' that is the interconnection with circles above to represent three people interacting with one another. The bright colours were chosen for their sense of joy and brightness.

Appendix 12 – The approach

Focus groups were held across three campuses of Western Health in July of 2019 and attended by 66 nursing and midwifery staff including RN, RM, EN, ANUM, AMUM, MUM, and NUM in both permanent and casual roles. Nearly 50% of attendees were from the wards that would go on to pilot strategies with the remaining attendees from wards & units that were not part of the pilot. Staff volunteered to attend the focus group sessions which were held during daylight hours, Monday to Friday across three campuses (Sunshine Hospital, Footscray Hospital & Williamstown Hostile). The focus group at Western Health were facilitated by members of the Western Health in-house Organizational Development team with the 'Working Together' project officer present to provide context for the study. The focus groups were audio-recorded and de-identified responses documented to assist with theming.

Two focus groups were held at Northeast Health Wangaratta at different two campuses (Illoura Aged Care and main hospital campus). These focus groups were facilitated by Rachael Davison of Value Edge Consulting with the Nurse Consultant from Northeast Health Wangaratta hosting the session and the Western Health project lead supporting.

The project team had planned to have the same facilitator for both focus groups with the Northeast Health Wangaratta participants attending virtually via the zoom platform. This did not eventuate due to an inability to guarantee stable and reliable internet service between the two health services and the belief that it would be more beneficial for staff to attend a focus group in person from their perspective and also the facilitators.

Table – focus group attendance numbers, method, and number of sessions

Time	Attendees	Delivery method	Sessions
July 2019	WH = 62 NHW = 49	In-person	WH = 5 NHW = 2
August 2020*	WH = 22 NHW = n/a	Via zoom	WH = 3

The focus groups at Western Health in August 2020 were facilitated via zoom due to the restrictions caused by the COVID-19 pandemic in Victoria. The workplace restrictions have meant that all meeting rooms were closed for staff gatherings/meetings, no mixing of staff from different units and campuses, and density quotient on all spaces. As a result, the number of attendees at the focus groups was greatly reduced as staff were no longer gathering together at double time for professional development activities such as focus groups. Most staff attended the focus group on a rostered day and used a personal computer, laptop, or phone with a camera and microphone

Focus group purpose July 2019

The primary purpose of the July 2019 focus group was to ascertain nursing and midwifery staff views and experiences of working at either Western Health or Northeast Health Wangaratta to better inform the attendees at the co-design workshops.

The responses from the focus groups gathered rich qualitative data about the current pressures and challenges impacting front line teams.

The focus group activity at Northeast Health Wangaratta identified that the nurses and midwives had a strong sense of camaraderie and teamwork. Participants articulated a willingness to go above and beyond to support their team and provide the best care for their patients. Remarkably the focus group participants identified poor teamwork and alignment as a negative impactor on their work.

During all focus groups, Nurses and Midwives appeared to be willing to share their views and experiences of working as they were quick to respond to the questions.
The summary of key issues contributing to a 'bad work day' included:

- Poor communication (within MDT)
- Not enough staff; not enough experienced staff
- Higher acuity than expected/anticipated
- High number of admissions
- Feeling burnt out
- Multiple patient/bed moves during the shift
- Lack of equipment

Staff were asked to describe their workload in one word with the following terms used to describe the workload; fluctuating; tsunami; frustrating; exhausting; overwhelming; relentless. Despite the strong adjectives used to describe the workload, staff were able to state why they came back for their next and subsequent shifts including;

- Love of nursing; Love of taking care of people
- Supportive team; friends work here; like the people
- Doing your best; a sense of community
- Being paid; holiday and sick leave

Staff were asked to describe occasions of care that they hadn't been able to provide but had wanted to and then this was retrospectively compared to patient-reported missed elements of care in the literature (Kalisch & Dabney, 2013). There was a significant correlation between the focus group responses and the elements reported by Kalisch, Xie & Dabney (2013) including mouth care, bathing, and discussion about tests, procedures, and talking with patients.

Kalisch et al (2013)		Western Health Focus Groups (2019)
Mouth care	1	Teeth
Ambulation	2	Documentation
Moving patients out of bed	3	Talking to patients
Discussion about tests/procedures	4	Prevention strategies
Bathing	5	Wash or shower
	6	Linen changes

The focus groups ended with questions ascertaining the components of a good day followed by any considerations for making changes.

A good day consisted of;

- Having breaks
- Beds and equipment being available
- Adequate staffing
- Good skill mix
- Minimal handover (referring to time and detail)
- Clear communication.
- Additional people to be available for non-nursing tasks such as tuning TV, transferring patient phone calls, and unpacking stores

The group's closing advice to the project group included statements

- That those on 'ground to be part of the solution';
- Involve the staff;
- Projects about nurses should be led by nurses.

Focus group purpose August 2020

The focus of the August 2020 focus groups was to ascertain the views and experiences of staff working at Western Health one year after the first focus groups to identify if the workplace had changed for staff, why it had changed and what else could Western Health do to assist staff. As anticipated, the COVID safe work restrictions featured frequently in the conversation and some staff struggled to recall what their work-life was like between August 2019 and March 2020.

Focus groups were not conducted at Northeast Health Wangaratta as the project for this health service finished in February 2020 as planned.

The summary of key issues contributing to a 'bad work day' included:

- Poor communication with doctors of border (patients under specialised care who would normally be allocated a bed on the specialty 'home ward') patient (new)
- Skill mix of staff (previously was not enough staff/not enough experienced staff)
- Higher acuity than expected/anticipated (unchanged)
- Lower acuity than expected (new)
- None of our own patients (new)
- Multiple patient/bed moves during the shift (unchanged)
- Visitor restrictions (new)

Staff were asked to describe their workload in one word and used different adjectives to a year ago with the following terms used to describe the workload; highly variable; challenging; compromised; crazy; busy. Staff were able to state why they came back for their next and subsequent shifts including;

- Camaraderie; team effort; teamwork; motivated to help each other; all in it together
- Great time at work;
- Feels like family; Come back to work for colleagues
- Let buddies down if you don't show up
- Enjoy patient care;

One participant declined to answer the question because she stated that 'she didn't feel like coming into work today" and didn't want to share her thoughts publically. She attended this focus group towards the end of her shift.

Staff were asked to describe occasions of care that they hadn't been able to provide over the last year and many recalled episodes of palliative care that they had wanted to improve on. An increase in the number of bariatric patients having inpatient stays was noted and working with different teams of doctors. Staff explained that they were working with different teams of doctors now as the patients were now primarily assisted to wards/units based on their COVID-19 infection status as opposed to treating teams.

Focus group attendees were asked if they could recall any strategies or ideas that had been implemented with their teams over the past year. The focus group facilitator did not mention the Working Together project at this point to not prompt the memories of the attendees but the attendees were aware they were attending a focus group as part of the Working Together project. Working Together strategies that were developed by unit managers as part of the project are noted in brackets.

Attendees mentioned the following ideas:

- The acuity grading system (Working Together)
- Leaving work on time (Working Together)
- The addition of an end of shift huddle occurred then stopped (Working Together but then removed due to COVID gathering restrictions)
- Huddle still occurring (Working Together)
- Traffic light system (Working Together)
- Handover process, hourly rounding, and use of nurse presence button data (Working Together)
- Changes to handover (Working Together and then adapted due to COVID restrictions)
- Changes to in charge handover (Working Together)
- Large group handover and ward meetings via Zoom & using patient lounge and hallway (Working Together adapted for COVID safe strategies)
- Using patient booking system to ensure staff breaks are allocated (Working Together)
- Leadership team using zoom for meetings
- Using walkie talkies in isolation patient rooms and for ANUM communication
- Encouragement to enrol in other courses to increase happiness at work
- Staff welfare and social support (Working Together)

The focus groups ended with questions ascertaining the components of a good day followed by any considerations for making changes.

A good day consisted of;

- Patient plans from all units (doctors)
- No patients waiting for care; Giving most of the care today; All tasks are done
- No patients going to ICU
- Teamwork.
- Tomorrow, I come back to work
- Having a laugh; fun at work;

- Having an end of shift huddle all together really works
- Finish work on time;

The group's closing advice to the project group included some feedback on the Working Together was:

- Working Together was fantastic; Time to think about what WE wanted to do; not being told. Staff felt more valued as a result; 'Working Together' was specific to our area, see benefits better. Good platform to explore ideas; Identify issues to pilot solutions; Staff benefit from it all.
- We are developing staff who want to progress or make a difference.
- Staff with fresh ideas (are used)
- Teamwork – vital for a successful day and team
- COVID has helped bring us together as a team

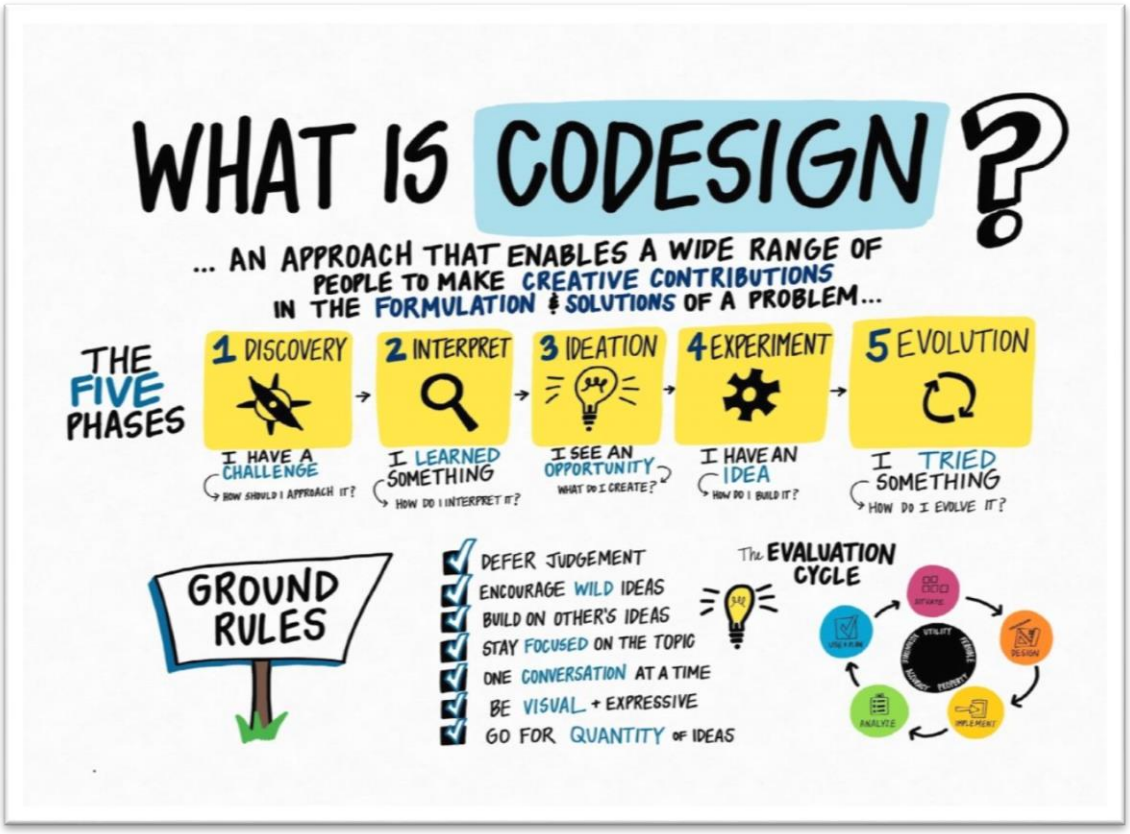
Ideas for future initiatives were also included:

- Find ways of (in person, group) debriefing in a COVID safe way
- Unit Manager support/catch up group
- Place to eat alone without interruption; break areas for rest
- More PSA and Ward Clerk support
- Identify ways to meet the demands of the public in cancer services
- Non-nursing duties still occupy nursing time
- How to share food together in a COVID safe way (acknowledge doctors last day; maternity leave farewell; graduates finishing etc.); sharing food is part of our culture.

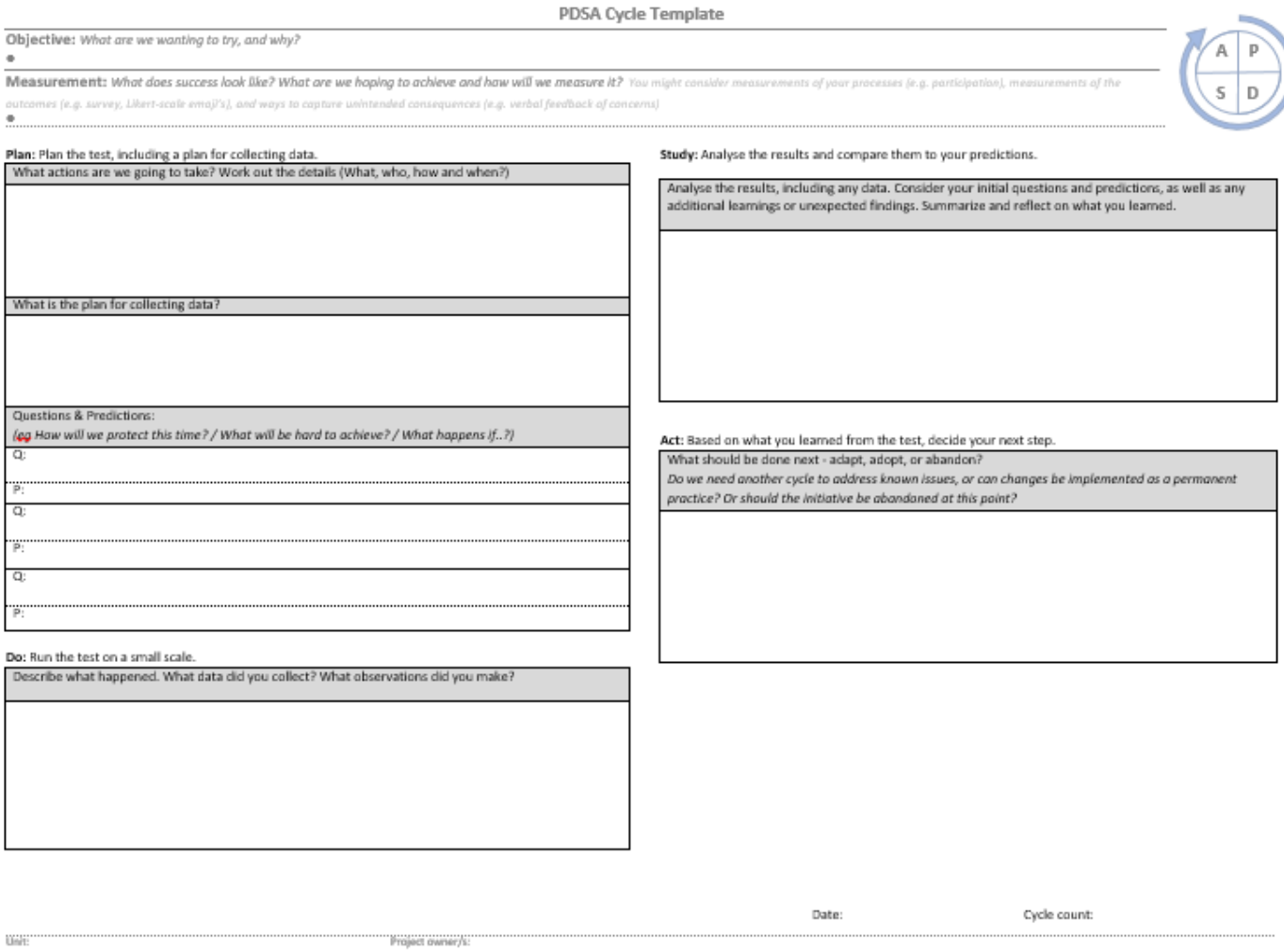
Appendix 13 - Methodology

Co-design methodology is a well-known methodology in healthcare as an approach that enables a group of people (users and/or stakeholders) to actively participate in designing a solution to their problem. The Working Together project activity sought to use co-design principles in the project methodology to increase the likelihood of the strategies meeting the needs of nurses and midwives. The term *co-design principles* is intentionally used as opposed to co-design as the voice and preferences of the nurse and midwife were more heavily weighted towards as opposed to the voices of all other users such as patients, clients, managers and other health professionals.

Working Together project participants were introduced to the co-design methodology at the first workshop and the diagram below from DME for Peacehttps://www.dmeforpeace.org/breaking-barriers-human-centered-peacebuilding/ was useful in explaining the methodology. The five phases from the DMEforPeace, 2016 infographic were applied informally during the workshop and reinforced over the proceeding months.



During the co-design workshop participants were also introduced to the use of a PDSA template (Linda Betts & Associate's, 2019) to document their initial idea and then move through the PDSA cycle in a structured way to test and challenge their idea/change before determining what modifications if any need to be made. Although many of the participants had used the PDSA cycle templates before in the context of quality improvement initiatives, using the PDSA cycle template for small practice changes was novel



PDSA Cycle Template

Objective: *What are we wanting to try, and why?*

Measurement: *What does success look like? What are we hoping to achieve and how will we measure it? You might consider measurements of your processes (e.g. participation), measurements of the outcomes (e.g. survey, Likert-scale emoji's), and ways to capture unintended consequences (e.g. verbal feedback of concerns)*

Plan: Plan the test, including a plan for collecting data.

What actions are we going to take? Work out the details (What, who, how and when?)

What is the plan for collecting data?

Questions & Predictions:
(eg How will we protect this time? / What will be hard to achieve? / What happens if...?)

Q:
P:
Q:
P:
Q:
P:

Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

Study: Analyse the results and compare them to your predictions.

Analyse the results, including any data. Consider your initial questions and predictions, as well as any additional learnings or unexpected findings. Summarize and reflect on what you learned.

Act: Based on what you learned from the test, decide your next step.

What should be done next - adapt, adopt, or abandon?
Do we need another cycle to address known issues, or can changes be implemented as a permanent practice? Or should the initiative be abandoned at this point?

Date: Cycle count:

Unit: Project owner(s):

Most participants left the co-design workshop with multiple ideas (strategies) that they planned to experiment with after further consultation/discussion with their wider, respective teams. A few participants needed additional assistance over the following month to firm up and choose strategies to implement, including strategies that they had tried before but were unable to see or demonstrate effects on their team.

The Institute for Healthcare Improvement (2020) has a PDSA Essentials toolkit that is free for registered users that other healthcare services may find useful. (Retrieved October 2020, from http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx)

Appendix 14 – Pulse Survey

The use of Pulse Surveys (employee engagement) were introduced into the Working Together Project at Western Health in early 2020 and repeated at the end of the project. The pulse survey was developed by Anne Wright and Melody Trueman and drew on evidence from the Gartner model of 'employee engagement survey. Pulse surveys are well-validated tools that measure employee engagement in a timely 'real-time' manner (as opposed to annual) to allow for adjustment of strategies and to ascertain current perspective and perception.

Unit Managers were asked to complete the pulse survey on behalf of their team and the data points were themes from the August 2019 focus groups along with an opportunity for free text commentary. The % rating was calculated from reviewing the focus group themes and assigning a value based on the number and weight of responses. The findings from the pulse surveys are included elsewhere and the questions are listed below for use by other health services.

Working Together 'Pulse Check'

1. What percentage of your staff would agree with the specific theme from the original focus group data? Please rate your responses in the second column

Focus group theme	% staff agreement (pre)	% staff agreement (pulse check)
Excellent communication		
Great staffing; ratios; allocation		
Excellent support; Enough experienced staff;		
Appropriate acuity		
Feelings of energy and joy (versus. burnt out; tired)		
Stable patient journey (frequent bed and patient moves)		
Predictable workload (versus. Tsunami, frustrating, exhausting, relentless, overwhelming)		
Love nursing/midwifery; love taking care of patients;		
Like the people; like the team; have friends at work		
Able to provide patient care as desired (e.g. teeth, talking, prevention, linen changes, hygiene)		
People available for non-nursing tasks		

2. What is different now? What have you done so far or implemented that could have caused this change? Or what has caused the possible change for your team (if any)?

3. Do you have any quotes or stories from staff that support the change in % score?

4. Do you agree that your ward is a more positive place to work in? On a scale of 1-10 with 10 meaning that you strongly agree *that your ward is a positive place to work*, what number would you assign?

5. Do you have any other feedback to share? E.g. have you noticed a higher engagement shown through increased willingness, more camaraderie, breaks being taken, time shared with others, etc.

Appendix 15 - Strategies

Strategies - Western Health

Area	Strategies
Medical Ward 1	• ANUM rounding & traffic light checklist system for workload and support • Safe & tidy ward checklist for day staff (free up night shift time) • Start of shift introductions • Double staffing time being used for CPD & handover • Handover improvements (reduction of time; ISBAR)
Maternity Services	• Debriefing by staff in addition to formal EAP • Regular meetings with MUM's to gain feedback. • Leave on time together • Identification of staff skill level for baby checks (who can I ask for help) • Toiletries for staff in bathrooms
Medical Ward 2	• Improve teamwork (avoid "not my patient' scenario) • Sub-team duty list. Team of 2 to support, ensure breaks are taken, answer each other queries) • Day shift meal break allocation before handover • Leaving on time together. Check-in with others. Thank your colleagues. • Reformatting handover to include patient. • Celebrating successes with shared food
CCU 1 & 2	• Rotations between sites ceased; ANUM's now leading stable teams. Know who you are working with. • New handover tool for ANUM (A3) and staff (IPM) • Reduction in group and bedside handover times • Double staffing time being used for lunch, CPD, handover. • In-service ideas box • Supportive and cohesive team – staff ID badge labels to identify who has a post-graduate qualification (can give support and knowledge) and who is new or rotating (can ask for frequent support) • Staff photo and role board (top section gives support and knowledge; the bottom section should expect to receive support and informed knowledge). Used the skills of a CNS who has secondary employment as a wedding photographer. • Existing staff receive emails from NUM when new staff join the team (includes a profile on their experiences, skills, and knowledge) • Aware of the impact of leadership on others; NUM working with ANUMs now • Daily NUM update (risks, alerts) • Assisting and shadowing ANUM • Equipment near patient beds (staff request)

Ambulatory 1	• Staff leaving on time and together. No need for unscheduled overtime in the day unit. • Introduced end of shift huddle (with traffic light system) to provide an opportunity for staff to help each other and leave on time. • The electronic patient booking system was revised with a new rule for blocking out spaces to allow nurses to have meal breaks.
Medical 3	• Handover improvements; Format for large group handover; Buddy system at the bedside; Receive handover for two patient loads together; Patient whiteboard and electronic medical record updated simultaneously; • Nurse presence light system to record patient wait times and time in the room. • Staff photo board to highlight the team
ICU	• Rounding tool for a senior nurse; involve families; • Sleep and rest strategies • Behaviour code of conduct guide (above/below the line behaviour) • Handover changed due to COVID. Group handover focused on alerts for the unit and staff.
Ambulatory 2	• Introduction of fortnightly meetings; listening to staff; • Modification of tearoom (staff request) • Communication board updated; language changed on signs e.g. word complaint replaced with a solution • Leaving work on time
Medical Ward 4	• ANUM rounding with staff • Teams of three changed back to teams of 2 nurses • ANUM falls reduction project • Going home on time
Medical Ward 5	• Flexible team allocations (depending on patient acuity as opposed to geography); teams of reduced to 2. • Handover revised • Celebrating team togetherness through social events; changed to weekly zoom catch-ups during covid-19
Medical Ward 6	• Flexible team allocations (depending on patient acuity as opposed to geography) includes sharing the patients between nurses. • Staff able to request equipment and other resources for their orle
Rehabilitation Ward	• ANUM leading break allocation; • Team building lunches; Regular staff meetings; • Flexible rostering for personal appointments • Leaving on time • Escalating staffing concerns • NUM has the authority to do what is required; thank and support staff • NUM active presencing

Strategies – Northeast Health Wangaratta

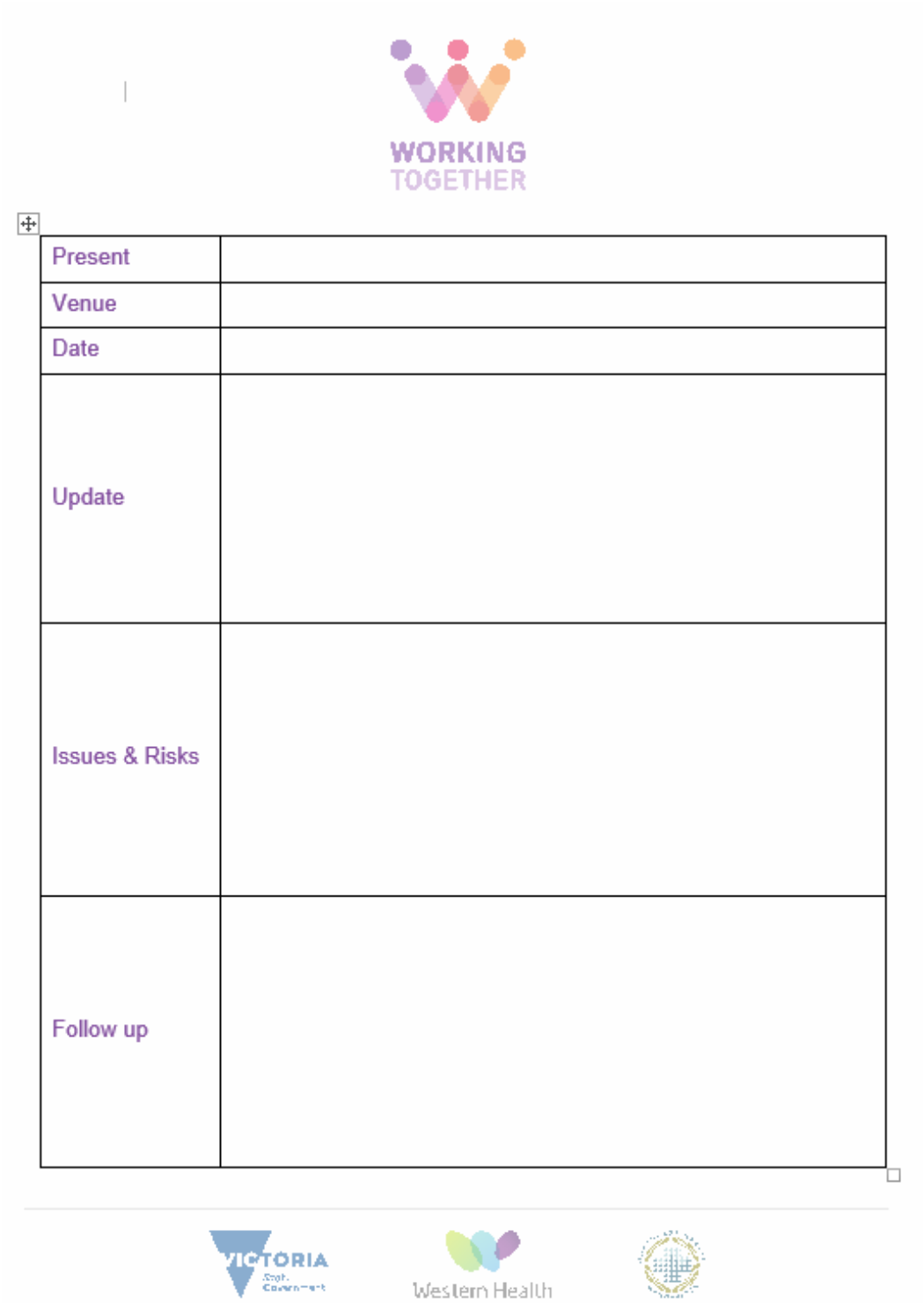
Area	Strategies
Medical Ward	• Lead nurse role within each bedside nursing team • Team nursing traffic light (workload acuity) report • REST Initiative – prompting staff wellbeing through meal breaks (REST = Rest, Energise, Support, Teamwork)
Subacute Ward	• Lead nurse role within each bedside nursing team • Team nursing traffic light (workload acuity) report

Aged Care & Transitional Care Unit	• Improvement's to team & nursing allocation
	  ○ Supporting team nursing processes
	  ○ Handover changes
	  ○ Promotion of meal breaks

Surgical Ward	• Alignment of patient care priorities framework
Emergency Department	• Improved on boarding & orientation processes
Maternity Services	• Development of post-delivery handover tool
CCU (ICU)	• Standardisation of patient care & handover ('FAST HUGS IN BED Please' mnemonic framework)

Appendix 16 – Unit Manager Templates

Template 1 – A4 size note page for recording updates from check in sessions with Unit Managers



Template 2 –A3 size PDSA Cycle Template

PDSA Cycle Template

Objective: *What are we wanting to try, and why?*

Measurement: *What does success look like? What are we hoping to achieve and how will we measure it?* *You might consider measurements of your processes (e.g. participation), measurements of the outcomes (e.g. survey, Likert-scale emoji's), and ways to capture unintended consequences (e.g. verbal feedback of concerns)*

Plan: Plan the test, including a plan for collecting data.

What actions are we going to take? Work out the details (What, who, how and when?)
What is the plan for collecting data?
Questions & Predictions: *(eg How will we protect this time? / What will be hard to achieve? / What happens if..?)*
Q:
P:
Q:
P:
Q:
P:

Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

Study: Analyse the results and compare them to your predictions.

Analyse the results, including any data. Consider your initial questions and predictions, as well as any additional learnings or unexpected findings. Summarize and reflect on what you learned.

Act: Based on what you learned from the test, decide your next step.

What should be done next - adapt, adopt, or abandon? *Do we need another cycle to address known issues, or can changes be implemented as a permanent practice? Or should the initiative be abandoned at this point?*

Date: Cycle count:

Unit: Project owner/s:

Template 3 –A3 size sheet for unit managers to document initial ideas and encourage feedback from their wider team

We are a lead ward for the 'Working Together' initiatives.

This initiative aims to codesign, trial and evaluate strategies that improve the working lives of our nurses and midwives by drawing on the expertise of our own people to codesign the new workplace program, Working Together. We are putting nurse and midwife wellbeing front and centre with this initiative and it is an exciting opportunity and your input is crucial for change.

Here is what we want to achieve

Here is what we are doing to achieve the goals

What else could we do to improve your work day?

Write your own ideas & solutions here

Appendix 17 – Focus group guide & questions

Guidelines for the focus group and associated question guide were developed by Anne Wright and used at Northeast Health Wangaratta and Western Health at the commencement of the project. An adjusted version (comparing work practices at present to pre-COVID safe work practices) was used at the conclusion of the project at Western Health.
The focus groups were usually scheduled to occur during double staffing time to maximise attendance with light catering provided (August 2019).
At the end of the project, the Western Health focus groups were held online using zoom to meet COVID safe work practices. The majority of staff attending these focus groups were on rostered days off and used a personal laptop, PC, or phone with audio and camera to participate. Other staff participated using work devices (laptops and personal computers) in private offices.

Focus Group Questions

1. In thinking about a workday, think about the things that don't work that contribute to the day being challenging. Then can you tell us what contributes, what are the issues that make it bad or more challenging?
2. When you are thinking about your colleagues and those you manage to supervise, what makes a day challenging for them?
3. When thinking about nursing and midwifery workloads, how would you describe them?
4. So, do you think that patient load and allocation works well currently?
5. Knowing that all strive to give the best care they can, have you any examples or stories of care that nurses weren't able to give or provide and what was it that got in the way?
6. Knowing the challenges, how do you think your team stacks up in terms of the underlying motivations? What keeps them coming back, what drives their persistence?
7. Thinking about your team, what percentage would you say were highly motivated compared to just doing their job?
8. What do you think would keep them motivated in that space?
9. What do you think would help those just doing their job to fire up a bit more and what will keep the motivated ones staying motivated?
10. Do you think nursing and midwifery teams are willing to be challenged?
11. What makes a good day for you and your colleagues?
12. What needs to change to make it better, or to ensure a good day happens of the time?
13. What do you think or know of that has been tried before?
14. What could be attempted to improve something in this area different, for yourselves or your colleagues this time?
15. What would be the key criteria or important to consider if trying something new?
16. Are there any other thoughts or comments you would like to make or share?

Appendix 18 – Abbreviations

WH	Western Health
NHW	Northeast Health Wangaratta
The Department	Department of Health & Human Services
NUM	Nurse Unit Manager
MUM	Midwifery Unit Manager
UM	Unit Manager
AMUM	Associate Midwifery Unit Manager
ANUM	Associate Nurse Unit Manager
WT	Working Together Pilot Project
PSA	Patient Services Assistant/Attendant
RN	Registered Nurse (various levels from beginners to experts)
EN	Enrolled Nurse
The Act	Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015
Bank	Nurses and Midwives employed to work for the healthcare service 'bank' team. May work across multiple units.
Casual	Nurses and Midwives working casually for the healthcare service. May work across multiple Units.
COVID-19	A coronavirus (COVID-19) that was first identified in China in December 2019. This virus outbreak was declared a pandemic in March 2020 by the World Health Organisation. This resulted in several measures to control and contain the outbreak, including social/physical distancing, closure of nonessential services, and schools. Health services also implemented measures aimed at protecting employees while providing best care for patients including the use of personal protective equipment (PPE) at work and COVID-safe workplace strategies.