Nursing and Midwifery Services

Best Practice Rostering and Staff Deployment Principles

**Endorsed by the Australian Nursing Federation NT Branch
and Department of Health Consultative Committee**

2012

Contents

Introduction

The purpose of Nursing and Midwifery Rosters is to ensure that a continuity of nursing services is provided by the Department of Health.

Best practice staff rostering and deployment involves a complex range of human resource legislation, union agreements, policies and procedures and personal requests that are ongoing and applied to all nursing day or shift workers. The rosters are prepared in the individual work units and coordinated to ensure patient care is provided and staff working conditions are maintained.

The purpose of this document is to establish and identify:

- Territory-wide, key best practice rostering and deployment principles;
- preparation of a roster appropriate to the work unit;
- daily and shift monitoring roles;
- staff deployment criteria; and
- the evaluation outcomes.

Accountabilities are required at many levels throughout the hospital or health service and are identified for each procedure. This is clarified in the policy document.

Rosters are legal documents that identify the staff allocated to a particular work place for a specific shift. Rosters can be used in courts of law or coronial hearings to identify accountability for patient care.

All rostered shifts are subject to change if the ward staffing criteria (skill mix and staff profile) have not been met. Ongoing consultation and discussion with staff about rosters and deployment standards are a requirement for every Clinical Manager, Team Leader or delegate.

The education of the Clinical Manager about rostering and deployment should be undertaken formally, at the induction of staff to new roles and ongoing, through mentorship of new managers with experienced Clinical Managers who have proven abilities in developing and achieving quality rosters.

Rosters should not be developed in isolation but in connection and liaison with the whole Hospital or Health Service to be staffed.

This document acknowledges the contribution of the Alice Springs Hospital, Nursing Services *"Rostering Principles and Guidelines",* (2007) and Royal Darwin Hospital, Emergency Department, *"12 Hour Roster Proposal"*, (2009) and previous guidelines prepared by the Principal Nurse Advisor September 2009.

Network Policy

Best Practice Rostering and Staff Deployment

Target Audience

All Nurses and Midwives employed within the Northern Territory Department of Health.

POLICY STATEMENT

Rostering and Deployment of Nurses and Midwives will comply with the *"Acute Care Nursing and Midwifery Services Best Practice Rostering and Staff Deployment Principles"* in conjunction with the *"Enterprise Bargaining Agreement 2011-14"*

Policy Purpose

This policy directs the application of the *Acute Care Nursing and Midwifery Services Best Practice Rostering and Staff Deployment Principles* as the guiding document for the rostering and deployment of nursing and midwifery staff in the acute care and Mental Health settings of the Department of Health, to ensure that safe quality patient care is provided while maintaining a healthy and safe work life balance for nurses and midwives.

Definitions

Responsibilities

The General Manager through the Nursing Director is responsible and accountable for the deployment of Nurses and Midwives. The Clinical Nurse Manager is responsible and accountable for the preparation and implementation of the roster and deployment of nurses and midwives

Nursing Director is used as a generic term for the most senior nurse in the facility.
A Rostering Education Program will be approved by the Chief Nursing & Midwifery Officer and provided by Clinical Learning Branch.

Policy content and Implementation
- Rostering practices must adhere to the Best Practice Rostering and Staff Deployment principles.

- All individuals responsible for rosters must attend the Department of Health education program on preparation and implementation rostering as a mandatory requirement every 2 years.
- Rosters must be prepared to ensure continuous, safe, quality care to patients.
- A Roster appeals process will be available

Key Aligned Documents

Northern Territory Public Sector Nurses' and Midwives 2011–2014 Enterprise Agreement.

Key Legislation, Acts and Standards

Health Practitioner Regulation National Law 2009
Workplace Health and Safety Act (NT) 2007
Public Sector Employment and Management Act (NT) 1993
Poisons and Dangerous Drugs Act (NT) 1983

Evaluation / Accountability for Monitoring and Review

Rosters will be audited and signed off by the Nursing Director before posting.
Rosters will be audited independently annually and reported through the Principal Nurse Advisor to the Australian Nursing Federation.
Nursing Directors will be responsible for ensuring that Managers and relevant staff attend the approved education program
Records will be maintained by Nursing Directors of Managers and relevant staff attendance at Rostering Education programs.
The Education program will be evaluated annually by clinical learning.

1. **Best Practice Rostering and Deployment Principles**

1. Patients have a right to expect and receive safe, effective nursing and midwifery care.

2. The provision of safe and effective nursing and midwifery care takes precedence over an individual's roster preference although negotiation is always to be attempted. Staff are redeployed to wards or units where skills and/or number of staff can be best utilised.

3. In the Acute Care setting Nursing Hours Per Patient Day (NHPPD) workload model from Western Australia is the accepted Department of Health management tool to establish the numbers of nurses or midwives rostered (staffing profile) to each ward and department, for each shift.

4. The Unit Rostering System should meet service delivery requirements and where possible individual requirements.

5. There should be equitable distribution of special shift requests, unpopular shifts and shifts attracting penalty rates.

6. Staff are deployed across twenty-four (24) hours per day on a twenty eight (28) day roster in sufficient numbers to meet the average known/predicted workload of a particular clinical unit.

7. Rostering systems endeavour to support work life balance and address "safe working hours" limits (agreed maximum hours to be determined between the Department and ANF) that impact on patient outcomes and staff health and satisfaction.

8. The Clinical Manager uses clinical judgement in all instances to ensure patient safety and effective care are balanced with the appropriate number and skills of nursing/midwifery staff required to meet the ongoing and changing clinical need of the unit.

2. **Preparation for Rostering**

The preparation of a roster should commence at least three (3) weeks prior to its implementation. The roster should be prepared by the Clinical Manager/Delegate with oversight and final authorisation by the Nursing Director. The Roster must be posted one week (7days) before commencement.

2.1 Roster Shifts

Full Time Staff

Full time staff are employed for one, 80 hour fortnight and one, 72 hour fortnight = 152 hour month.

Any changes or additions to the current shift times must be in consultation with the Nursing OneStaff coordinator and OneStaff changed to reflect the actual shift times as the roster is a legal document of work attendance.

Programmed/Paid Day Off (PDO)
A PDO x 1 per roster month - this is taken on day shift in conjunction with days off. A PDO **can not** be **assigned** to be taken on **Sundays** or **Public Holidays**. If the complete roster is on night duty, then 70 hours plus a PDO will be worked in one fortnight instead of 80 hours. PDO accrue after 19 days have been worked and every 19 days there after.

Part time, casual or agency staff are not coded for PDOs.

Staff working a rotating roster, including shift work cannot accumulate PDO's.
Remote Area Nurses may accumulate up to 5 PDO's.

Rostered Days/Nights Off = X
Days off = 2 per week → no more than seven (7) consecutive days should be worked between RDO.
Nights off = 3 per week → no more than five (5) consecutive nights should be worked between RNO.

Any staff requesting to work longer stretches between days off should discuss it with and have it approved by the Clinical Manager.

Part Time Staff

Part time hours are as per contract or agreement with the Co Director/Nursing Director or equivalent. The negotiated hours should be spread evenly across both fortnights of the roster.

To determine the number of hours a part time person should be rostered:
• Part time component, multiplied by 152; e.g. 0.526x152=79.9 or 80 hours for the month.

Overtime for Part Time staff: Is in accordance with Employment Instruction Number 14 and the NTPS Nurses and Midwives 2011 – 2014 Enterprise Agreement. Clause 44 of the Agreement allows overtime to be paid in certain situations before the minimum 64 hours is reached; i.e. overtime associated with Restriction duty.

Part time staff must have 2 Rostered Days Off (RDO) assigned per week on their roster. All other days must be left blank if they are not rostered to work.

Breaks Between Shifts

Rostered shifts need to allow a nine and a half hour (9.5) break, as per the Public Sector Nurses Enterprise Bargaining Agreement.

If overtime has been worked which **does not** allow a nine hour break to be received between the end of the rostered shift and the commencement of the next rostered shift then a rest of 9.5 hours **must** be given before commencing the next shift otherwise additional penalty payments are incurred. This is a minimum requirement.

2.2   Roster Principles

1.   All rosters are four week cycles.

2.   There are four (4) rostered days off per fortnight/pay period and six (6) rostered nights off per fortnight/pay period. PDO x 1 per roster for full time staff.

3.   Part time staff must have 2 RDO's each week identified on their roster

4.   Check that the desired staff profile (numbers of RNs and Ends) and skill mix is correct.

OneStaff has been set up to identify the number of hours / skill / shift / week required on the roster. Mypaysheet can record hours worked.

5.   Check how many shifts were worked at the end of the previous roster to ensure they meet the nights/days off criteria. You can access this information quickly and easily by looking at the calendar screen in OneStaff or the column on the Edit Skeleton Screen (see "Rostering Made Easy" documentation).

6.   ARL, study days, orientation should already be on the plan sheets when they are printed. Enter onto the Plan Sheets any additional leave which has been granted or approved since the sheets were printed.

7.   **REQUESTS** - Staff may make in writing desired **REQUESTS (4 only)** onto the plan sheet this should be in **RED.**

   1. Every effort should be made to grant these requests, and if not granted an explanation will be provided to the employee who should be informed ASAP.
   2. Part time staff are entitled to pro-rata requests.
   3. A request made that is in addition to the four allowed requests should be in pencil - there **is no guarantee that these requests will be able to be granted and they should not be expected**.
   4. Requests are limited by agreement to x **4 per month**.
   5. Requests for regular study leave to attend lectures etc., not approved under Bylaw 41, will be counted as desired request.

Night duty should be assigned first and rotated fairly amongst all staff. There should be where possible, two (2) senior staff rostered per shift.

8.   On any shift where there is not a Clinical Manager or a CNS rostered the senior person should be assigned a Shift Responsibility Allowance (SRA) code for that shift.

9.   Fair distribution of penalty shifts should occur. The SRA should be premised on knowledge and skills.

10.   Morning shift prior to days off and a late shift after days off should be given as a norm. Clinical Managers/Delegates should discuss with staff if this is not possible.

11.   Single days off or split/nights should be negotiated with staff by mutual agreement.

12.   Programmed day off (PDO) **MUST** be in conjunction with RDO & **NOT** on Public Holidays or Sundays.

13.   Shift Workers must have a minimum of one weekend off per month. Week end shifts should be evenly distributed, where possible each full time staff member should receive 4 out of 8 weekend shifts in a four week period. This should be pro rata for part time staff.

14.   CNE/Clinical Managers are rostered using the CNE workshift code for all shifts unless they are required to form part of the patient care team and in that case they are given the normal morning workshift code.

15.   The Clinical Manager, CNE, Ward Clerks and Health Workers who normally only work M-F have Public Holidays off as an additional day.

16.   Day shifts → no more than seven (7) consecutive days will be rostered.

17.   Night shifts → no more than five (5) consecutive nights will be roster

18.   Roster MUST be posted and available for all staff on the ward ONE WEEK prior to commencement (as *per agreement with ANF*). This is a minimum and where possible rosters should be posted with a longer lead in time.

19.   Ensure a preceptor is rostered with new graduate/student as per Graduate Nurse/ Midwife Program Policy.

20.   Graduate Nurses must not be rostered on night duty in the first roster of a new rotation.

21.   Include Aboriginal Health Workers on the roster but they are NOT counted in the Nursing Hours per Patient Day staffing (as applicable).

22.   Hospital rosters are based upon NHPPD calculations and any discrepancy in excess of 10% in a month should be reported to the Nursing Director with justification.

2.3   Roster Changes

After the roster has been posted or commenced, roster changes may be negotiated with the Clinical Manager. Roster changes with peers and authorised by the Clinical Manager/Delegate must ensure a safe skill mix and staff profile (numbers).

Changes to the roster are to be in writing on the appropriate form signed by the Clinical Manager, all areas filled in, including ward.

Changes should be negotiated at least 24 hours prior to commencement of the shift to be worked, unless an emergency situation arises.

Change in Rostered Hours of Duty

Nurses will be given a regular starting and ceasing time for each rostered day which should not be changed unless seven 'days' notice is given. When for reasons of sickness, the absence of an employee or organisational need/acuity the agency did not have seven days' notice available to complete the notice period; then notice

should be provided as soon as practicable. Notification can be in person, by telephone, email or text message. The notification must be acknowledged before it can be confirmed.

Employees should be aware that they have a responsibility to provide adequate notice to managers of absences to minimise the impact

2.4   Leave: Annual Recreation (ARL)

Annual Recreation Leave (ARL) is available to employees to be taken upon accrual of entitlements. The planning for the ARL 12 month calendar takes into account operational requirements and employee preferences. Every effort will be made to accommodate employee preferences however when planning for staffing levels to match operational requirements it may not be possible to meet every employee's nominated preference.

- Employees (except casuals) are granted 6 weeks ARL with a part time employee accruing ARL on a pro rata basis in accordance with their contracted hours.
- **Seven day a week shift workers** are entitled to an additional weeks paid recreation leave provided that the shift worker is rostered to perform duty on not less than 10 Sundays during a year.
- For less than 10 Sundays, accrual is at the rate of half a day for each Sunday rostered.
- Employees transferring into another Ward or Unit after the ARL roster has been approved will have to seek consideration from the relevant work unit manager for the same dates to be transferred. The employee and manager will work collectively to seek suitable dates.

Planning for ARL is the responsibility of the Clinical Manager or Delegate and is to be prepared in advance for a full calendar year. Employees are to be given the opportunity to indicate when they wish to take ARL through the process determined by individual work sites. ARL is team unit based and is booked with, and approved by the Clinical Manager or Delegate. Annual Leave requests should be approved at least 8 weeks prior to the annual leave commencement date. In Remote Health

annual leave must be booked 3 months in advance to allow the manager or delegate to backfill.

Each unit has an agreed ARL component. The ARL component cannot be exceeded unless negotiated by the Clinical Manager with the Co-Director or equivalent.

Alternatively, if the ARL component is not met, staff in excess of need can be redeployed to other units to meet identified staffing profile deficits.

All units should have a yearly unit leave planner displayed for staff.

If ARL is booked and a ward change is imminent, staff need to re-negotiate the leave with the Clinical Manager or relevant delegate of the new area. If this cannot be done, the original ARL may need to be cancelled and a new date chosen or negotiated with the previous ward for them to allow you to use part of the ARL component or delay the transfer to the new ward until after the ARL.

Bank/Pool staff ARL is approved by the Line Manager.

When determining leave for high demand periods consideration needs to be given to equity and fairness for all staff in the relevant service. Team units can determine a process for allocation of leave during these periods.

Where ARL is unable to be granted discussion between the manager and employee to identify and negotiate alternative options is to occur.

Where ARL may be delayed due to personal or workplace issues employees and their manager or delegate will work collectively to seek suitable alternative dates.

ARL which has been approved may only be altered by the Manager or Delegate.

Cancellation or changes to the ARL roster can only be done in writing by the manager directly to individual employees.

If an employee is aggrieved by a decision not to grant ARL then they may refer the matter to their Nursing Director or equivalent level who will consider the issues for a final decision.

Where an employee has recreation leave credits in excess of two years or three in the case of a compulsory transferee, the CE may on giving a minimum of two months notice and provided the direction is reasonable, direct the employee to take the recreation leave within a three month period, or a period agreed to between the manager and employee. This will reduce the leave credits to at least 2 or 3 years as the case may be.

2.5   Study Leave

The appropriate Study Leave forms on the ward are completed with the CNM support and approval. Signed forms are sent to the delegated officer.

3. Definitions

3.1   Unit Based/Self/Request Rostering

Unit Based, Self or Request rostering is used in most wards/areas across the Northern Territory. Units will have "local" business rules on how local rostering will be implemented and monitored. All "local" business rules need to be documented and comply with the Northern Territory, Public Sector Employment Management Act and Human Resources policies and procedures and reflect work patterns and organisational needs.

Unit Based, rostering supports the concept of professional development by encouraging staff to take responsibility for members of a work team and to ensure

nurses care for other nurses. Nurse/midwife numbers and experience must be evenly distributed over each day and each shift.

Rostering can only work when staff member's effectively communicate and consult with each other. It is a method of demonstrating professional accountability that can strengthen team cohesiveness.

3.2   12 Hour Rosters

Modified shift lengths will be applied to the work place to generate increased efficiencies in ward/unit operations and management, and meet the employment needs of staff. Already, a range of shift lengths are used in Territory hospitals; from 4 to 12 hour shifts.

12 hour shifts require specific Agreements, due to the impact on staff and the management of wards/units. Appendix A fully describes what is required for the implementation of 12 Hour Rosters with the authority of the Chief Executive and the Commissioner for Public Employment. Consultation with the Australian Nursing Federation (ANF) and change management is also required.

Whilst not a device to reduce the entitlements of staff, 12 hour shifts that commence before 12 midday (12:00) do not attract penalties even when the shift finishes after 18:00 hours, i.e. 19:30 hours.

4.   Roster Checklist

When the roster is completed at ward/unit level, then *CHECK*: the following:

- All staff are included on the roster and have a roster assigned for the period/ hours that they are employed during the roster period.

- Night duty on the previous roster to ensure you have not rostered that person on an early on the first day of the new roster.

- Number of shifts worked on the previous roster to ensure that they are not working more than seven days.

- No more than the recommended 7 consecutive shifts have been rostered.

- No single days off.

- A senior staff member/ Team Leader is rostered for each shift and if necessary has been assigned a Shift Responsibility Allowance (SRA) code.

- Staff profile (number) for each shift is achieved.

- Skill mix is appropriate and desired cover is met.

- A preceptor is working with the new graduates or student midwife as per guidelines

- That a morning shift prior to and a late shift after days off, have been rostered where possible.

- All full time staff have a programmed day off (PDO) which is attached to rostered days off, and they are not on Sunday or a Public Holiday.

- Part time staff are rostered the correct number of hours and additional hours identified if above contract hours. RDO's identified for Part Time Staff

- ARL and Study Days have all been entered correctly.

Rosters must be displayed in the ward 7 days prior to commencing work on that roster. Once the roster has been displayed on the ward area ALL changes to that roster must be negotiated with the individual staff member and approved / authorised by the Clinical Manager

12 HOUR ROSTER GUIDELINES

DEPARTMENT OF HEALTH AND FAMILIES

Clause 47.2 – Variation to Working Arrangements for Groups of Employees of the *Northern Territory Public Sector Nurses and Midwives' 2011-2014 Enterprise Agreement* (the Agreement) provides for the provision of flexible workplace arrangements between the agency and employees.

47.2. Flexible Working Arrangements

47.2.1   A group of Employees and the Agency may agree to depart from the standard approach specified in or developed in accordance with this Agreement, including amongst other matters:

   a) hours of work including rostered days off or restricted duties;
   b) commuted salaries or allowances;
   c) meal breaks; and
   d) Leave.

47.2.2 Such agreement will:

   a) result in more efficient operations;
   b) be genuinely agreed to by the majority of Employees involved;
   c) result in Employees being better off overall than the Employees would have been if no variation had been made;
   d) be recorded in writing and approved by the CEO;
   e) if required by the parties, include a mechanism to terminate and/or review the agreement; and
   f) require approval of the Commissioner and implementation via a Determination or other appropriate instrument.

47.2.3   Employees may choose to be represented by their nominated representative in relation to the development and implementation of flexible working arrangements under this clause.

47.2.4 The Union will be consulted on proposed arrangements prior to the approval of the Commissioner.

The introduction of 12 hour shifts into specific work units in the agency provides:

- Efficiency gains in terms of planning rosters that revolve around 24 hour shifts;
- Nursing staff report more satisfaction with working 12 hour shifts;
- Ensure quality and safety of patient care;
- Work within the nursing budget;
- Employees make decisions of choice to work in areas that have 12 hour shifts;
- The majority of nurses in a work unit would need to support the introduction of 12 hour shifts; nurses may elect not to participate in 12 hour shifts;
- The Australian Nursing Federation (ANF) will be consulted with regard to the introduction of proposed 12 hours shift in workplaces;
- 12 hour rosters will not reduce nurses' entitlements;
- The Roster Guidelines below provide the conditions under which the 12 hour rosters will work.

Rostering Arrangements

WORKING 12 HOUR SHIFTS TO BE VOLUNTARY

It will not be compulsory for a nurse to work the 12 hour shift roster.

ROSTER GUIDELINES

Roster guidelines regarding 12 hour shifts as set out below should be observed unless the employee requests otherwise and the employer agrees subject to OH&S and operational requirements.

- No more than three consecutive night shifts
- No more than three consecutive day shifts
- No more than four consecutive shifts (as long as the four shifts are two days then two nights then a minimum of three days off)
- There should be a reasonable distribution of days off between blocks of shifts e.g. minimum 3 days unless otherwise negotiated.
- Shifts should not be compacted to produce an excessively long break
- The roster pattern will be planned over a period of four weeks.
- Full time nurses will work 152 hours/month.
- Part time workers will have the opportunity to increase or decrease their contracted hours to best fit their 12 hour roster.

5.1   12 HOUR SHIFT ROSTER PROVISIONS

The following provisions will apply to employees working the 12 hour shift roster:

Hours of Work

Rosters

The shifts will be averaged over 28 days to ensure the nurse has worked 152 hours.

Nurses may arrange a mutually agreed shift change based upon the replacement having the necessary skills and knowledge and will not create a fatigued situation.

Shift Times:

Unless otherwise agree to will be

0700 - 1930 hours
1900 - 0730 hours

Minimum Break between Shifts

Where practicable, the minimum rostered break between shifts shall be at least 11.5 hours. Shorter breaks should not be rostered because this does not allow sufficient time for rest and recuperation.

Meal Breaks

Nurses working 12 hour shifts shall be allowed two 30 minute meal breaks during each shift.

One of the 30 minute meal breaks shall be counted as time worked (paid meal break). (Rostered span of 12 hours 30 minutes).

The first meal break shall be taken within 5 hours of commencing duty if it is an unpaid meal break.

Accrued Days Off (ADO) or Programmed Days Off (PDO) can apply to the 12 hour shift roster providing that the roster is based on (152 hours per month).

Overtime

Overtime will not be worked to extend the span of the 12 hour 30 minutes shift (i.e. nurses are not to work overtime immediately preceding or following an ordinary 12 hours shift).

Overtime worked on days off duty shall be paid as per the Agreement.

Shift Penalties

Shift penalties, for time worked, will be paid in accordance with the Agreement. These are:

(a)	M – F 1900 – 0730	22.5%
(b)	Saturday	50%
(c)	Sunday	100%
(d)	Public Holiday	150%

Contracted Hours

Part time nurses will have their agreed hours (see clause 44.3) maintained; however part time nurses may elect to vary their agreed hours to suit the working of 12 hour rosters.

Leave Provisions

Any form of leave taken will be debited at 12 hours

EDUCATION

Education of nurses is to continue to be available to nurses working the 12 hour roster.

TRIAL

12 hour rosters will be reviewed 6 monthly

The reviews will consider:

- Data from staff questionnaires;
- Roster costing;
- Occupational Health and Safety performance data;
- Personal leave, incident and staff replacement statistics on a monthly basis;
- Bed utilisation and occupancy rates; and
- Any other relevant information that will assist in evaluation.

DISPUTE AND WITHDRAWAL PROVISIONS (13.5(a)

i. Dispute

The Dispute Settling Procedures – Clause 13 of the Agreement will be utilised if a dispute arises from the application of the 12 hour roster.

ii. Withdrawal Provisions

(a) If at any time, the majority of nursing staff in a work unit or hospital management believe the roster to be unworkable, and every effort has been made to resolve the issues with the co-operation of all the parties, staff may withdraw from the trial by a majority vote of the nursing staff in the unit. Hospital management may also determine that if the roster is inefficient or detrimental to patient care or operational requirements then withdrawal from the agreement may also occur.

(b) Any nurse who finds the 12 hour roster to be unworkable may revert to their previous roster after having given notice of one four week roster cycle.

(c) If the number of staff working 12 hour roster falls below the minimum FTE requirement for the work unit then the continuation of the trial must be reviewed by staff and management.

END

6. REFERENCES

Alice Springs Hospital (2007) *Nursing Services Rostering Principles and Guidelines,* local publication.

Queensland Health (2003) *Best practice framework for rostering nursing personnel*, Brisbane.

Royal Darwin Hospital (2009) *12 Hour Roster Proposal*, (2009) Emergency Department, local publication.

Appendix 1

Roster Checklist/Audit

Ward / Cost Centre/s: **NHPPD FTE:**   **Roster Profile:**

Roster commencing: **Actual FTE for roster period**

COVERAGE

	WEEK 1							WEEK 2							WEEK 3							WEEK 4						
	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W
Deficits																												
Surplus																												

SKILL MIX (provide comment on any concerns)

ACTION TAKEN TO REDUCE DEFICITS / IMPROVE SKILL MIX

ROSTERED INDIRECT/NON PRODUCTIVE HOURS (excluding CNM/CNE)

	WEEK 1	WEEK 2	WEEK 3	WEEK 4	COMMENT
Annual Leave					Budgeted FTE for ARL
Office days					
Study days					
Other					

Acute Care Nursing and Midwifery Services Best Practice Rostering Principles have been applied in the development of this roster   Y   N

Roster developed by (name and designation):   Roster approved by (name and designation):