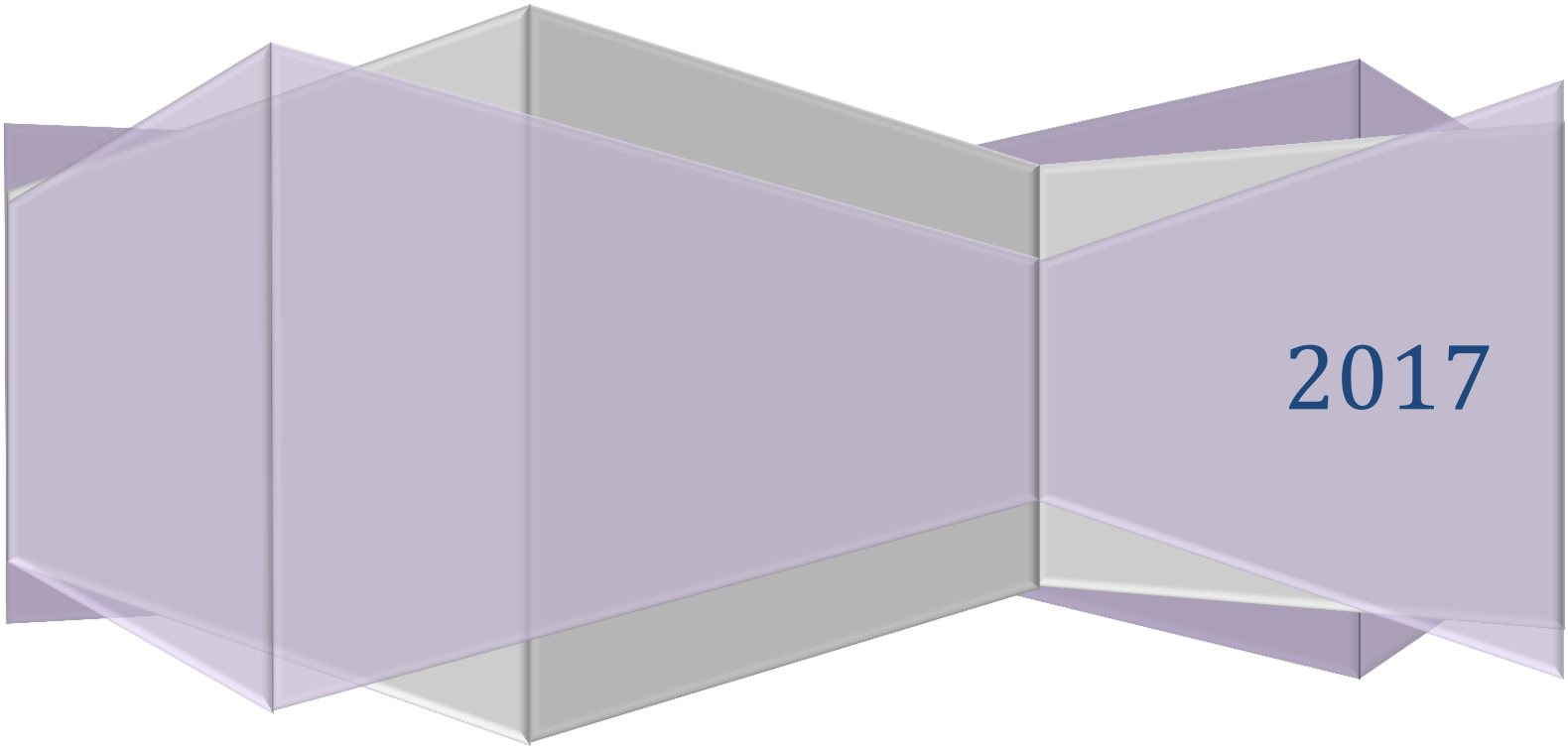
Critical Care Networks-National Nurse Leads

Best Practice Principles to Apply When Considering Moving Critical Care Nursing Staff to a Different Clinical Care Area.



2017

Introduction

Critical Care provides specialist expertise and facilities to manage and monitor patients with potentially life threatening conditions, whose needs cannot be met in the ward environment. To care for such patients effectively and safely requires specialised skills and expertise of medical and nursing staff experienced in the management of these problems.

At times there may be a requirement to move nursing staff from one area to another to minimise risk to patient care standards. In principle this should only be required to meet short term (<12 hrs), unplanned need and should balance the relative risks of ensuring patient safety across the organisation. The process outlined in Appendix 1 should be followed if this is required to ensure there is enough resource in Critical Care to maintain patient safety for this highly vulnerable patient population.

Very sick patients need to be admitted to critical care units promptly and these units should have the requisite resources immediately on hand, including competent and appropriately trained nursing staff. Critical Care activity and the associated nursing workload are dynamic and can vary significantly throughout a shift. Emergency admissions and patient deterioration are not predictable, and therefore the number of nurses on shift should safely allow for flexibility to respond to changes in patients' clinical conditions and unit activity and demands.

Minimum Standards for Safe Staffing

The nurse staffing standards published in the Guidelines for the Provision of Intensive Care (2015) [1] cite the Core Standards for Intensive Care Units[2] and in the Adult Critical Care Clinical Reference Group Service Specification[3] provide nurse staffing standards to produce a positive impact on both quality of care and safety for critically ill patients.

- **Level 3 patients** (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum **1:1** to deliver direct care
- **Level 2 patients** (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum **1:2** to deliver direct care
- **PLUS** a Clinical Co-ordinator (this person is not rostered to deliver direct patient care to a specific patient) 24/7 [4]

- **Units with greater than 10 beds** will require additional (this person is not rostered to deliver direct patient care to a specific patient) registered nursing staff over and above the clinical coordinator to enable the delivery of safe care. *The number of additional staff per shift will be incremental depending on the size and layout of the unit (e.g. multiple single rooms). Consideration needs also be given during events such as infection outbreak.*

As well as measuring individual patient dependency, other aspects of nursing care should be taken into account in determining nursing requirements: [4]

- Skill mix of nurses
- Geography of the unit
- Needs of patients/relatives
- Barrier nursing / side wards

Risks to Consider

There are significant risks associated with moving specialised staff to non-specialised areas.

- Critical Care nursing staff may have little or no experience working as qualified nurses on general wards and /or management experience.
- Direct correlation has been established between nursing staffing levels in critical care and the incidence of adverse events.[5]
- Reduction in staffing numbers will impact on the opportunity for junior nurses to work with seniors caring for more complex patients allowing them to complete and sign off competencies [1]. This is essential to develop a competent workforce.

Each occasion that staff members are moved should be clearly risk assessed and monitored, and if recurrent, should be investigated to see if remedial or supportive action is required.

The RCN provided advice for Staff being moved from their normal working environment.[6]

"Employers can usually ask specialist nurses to work on wards, however if the specialist nurse has any doubt about their competence they must decline and give reasons why. For example, they may state that they have not worked on a ward for over 10 years if ever, so are not up to date, or that they would be working outside their professional code. If the nurse does not feel competent to work in this area they should discuss their concerns with the manager, document them and have the option to call the RCN for advice.

If the specialist nurse agrees to move, they should start to collate evidence of how the move will impact on their own area of work in an attempt to prove that this way of managing staffing problems will only have a knock on effect in other areas." (www.rcn.org.uk)

Best Practice Recommendations

Acknowledging the above statement, CC3N recommend that the following principles should apply when considering the movement of nursing staff from critical care to a different clinical area:

Organisation (Person responsible for decision to move staff)
• Risk assessment completed and process followed. • Member of staff must be able to return to critical care at <1 hours' notice • Orientation to new area / supervision. • Ensure staff member is not asked to take charge of another area unless a documented risk assessment deems this the lesser risk to the patients. • Ensure staff member is not asked, or expected, to provide care outside their area of competence, in particular drug administration may be an area of concern in an unfamiliar care area.[7] • Training (Critical Care nurses may not use the same patient records system / electronic systems used in the different area).
Area (Shift Leader Critical Care)
• Risk assessment completed and process followed. • Redeployment of Bank / agency staff first. • Monitor occurrence and staff redeployed. • Ideally staff with recent ward experience in the same organisation should be considered before those who may not have worked in the area requiring support. • Provide support for staff members – clinical supervision.
Individual
• Work within area of competence.[7] • Access training when available.

In conclusion allowing Critical Care to manage their staffing flexibly helps managers provide a better resourced service and benefits nurses allowing them to work in their chosen speciality. The use of variable shift patterns / self-rostering and flexible use of annual leave provide options for workload flexibility. Moving staff to a different area reduces the ability to provide a flexible workforce in order to provide safe staffing levels in critical care.[7]

References:

1: ***Guidelines for the Provision of Intensive Care Services***, 2015, the Faculty of Intensive Care Medicine / the Intensive Care Society

2: ***Core Standards for Intensive Care Units***. Faculty of Intensive Care Medicine and Intensive Care Society. FICM 2013.

3: Service Specification for Adult Critical Care Services. NHS England, 2014.

4: Standards for Nurse Staffing in Critical Care 2009 BACCN.

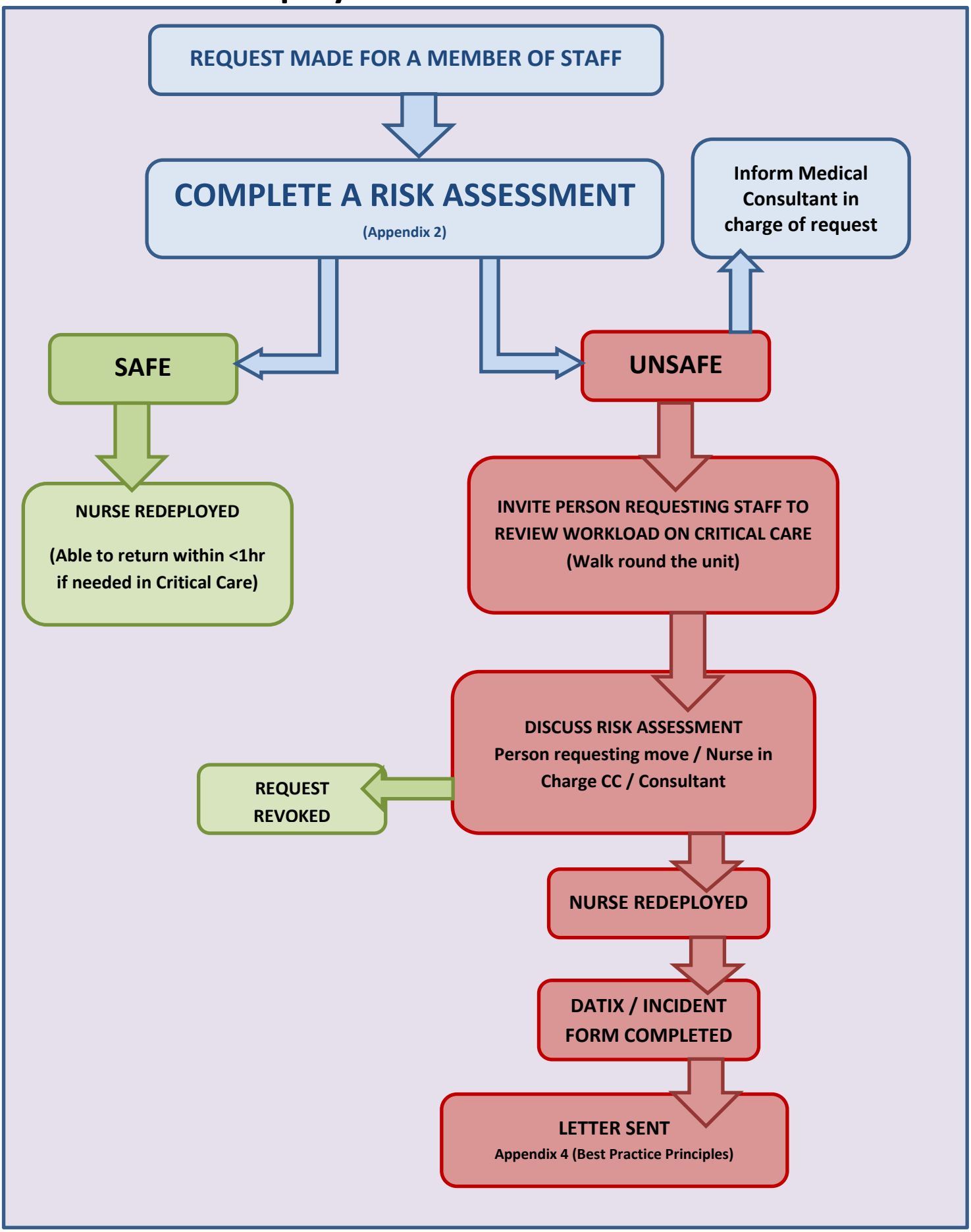
5: ***Safety, effectiveness and costs of different models of organising care for critically ill patients: Literature review***. Coomes M, Lattimer V. (2007).International Journal of Nursing Studies; 44:115-129

6: ***https://www.rcn.org.uk/get-help/rcn-advice/moving-staff Accessed 24th Oct 2016***

7: The **code*: professional standards of practice and behaviour for nurses and midwives.*** London: NURSING AND MIDWIFERY COUNCIL (NMC), 2015.

8: Guidance ***for nurse staffing in critical care***. 2003 RCN

Redeployment of Critical Care Staff



Appendix 2

Critical Care Staffing Status / Risk Assessment

To be completed by co-ordinator for all movement of staff to any ward area.

Date & Time of request:	**Ward area that is short staffed:**
Name of person requesting staff move from CC	
Person completing form (Senior Nurse on duty) **Name & Designation:**	

Number of Staff on duty in Critical Care		
Qualified		
Un- Qualified		
Level of Care for patients on the Unit (number of patients)		
Level	**Number of Patients**	**Number of nurses required**
Level 3 (1:1)		
Level 2 (1:2)		
Level 1		
Level 0		
Co-ordinator		
Units with greater than 10 beds +1 member of staff		
TOTAL		

Total Number of Nurses on duty	
Total required for dependency	
+/- enough resource **(as per National Safe Staffing Standards for Critical Care)**	

Other Factors to be considered: Barrier nursed patients; confused /agitated patients; Patients on renal replacement; complex patient /family.
Other Action(s) already taken / to be taken:
Name of Senior Nurse Informed: **Time:**

Below required standards	EQUAL	Above required standards
Contact Duty Matron and directorate manager to seek support from other areas	There is **insufficient** capacity to support other areas of the organisation	Critical Care staff can offer support to other areas of the organisation nurse **must be able to return** at short notice(<1hour) as required by shift leader

Appendix 3

Process to follow when risk assessment is not adhered to:

1. The coordinator / nurse in charge of critical care will invite the person requesting redeployment of staff to attend the unit and review the situation with them.

2. If the disagreement cannot be resolved and the coordinator / nurse in charge considers redeployment unsafe they should contact the senior manager responsible for critical care or on-call manager. The purpose of the call is to review the situation with them and communicate that if staffing levels are reduced through redeployment that it will compromise the safety of the critically ill patients within the department.

3. If the senior manager cannot resolve the situation and the coordinator / nurse in charge still feels that safety on the unit would be compromised then the coordinator / nurse in charge must contact the consultant on-call for critical care if not already involved and inform them of the situation. The coordinator / nurse in charge, senior manager, Consultant should explore all possible avenues to resolve the situation and maintain patient safety.

4. If the situation cannot be resolved then the executive on call should be contacted and briefed about the situation and steps taken so far.

5. If the situation cannot be resolved with senior management, Consultant and executive involvement then coordinator / nurse in charge must complete DATIX incident report and detail in writing the situation. The letter (Appendix 1) may be used (or an adapted version) and copies set to:

    - The person requesting the redeployment
    - The senior manager involved
    - The lead nurse for Critical Care
    - The Directorate Manager
    - The Director of Nursing

Appendix 4

Trust Logo

Date: _ _ / _ _ / _ _ _ _

Time: _ _:_ _

Dear Sir / Madam

I was the senior nurse in charge of the department of Critical Care at *name of hospital* on the Early/Late / Night shift on __ / __ / ___.

Despite following the steps in the process detailed in the attached document, staff were redeployed to another clinical area and in my clinical judgement this compromised the safety of patients in the department. I could not therefore guarantee the safety of patients under these circumstances.

I write to inform you of my grave concern and request this incident be investigated according to Trust clinical governance process.

Yours sincerely

Copies to:

- The person requesting the redeployment: _____
- The senior manager involved: _____
- The lead Nurse for Critical Care: _____
- The Directorate manager: _____
- The Director of Nursing: _____

Adapted: from Doncaster and Bassetlaw Hospitals Teaching Hospitals