

INDEPENDENT ASSESSMENT COMMITTEE REPORT SUMMARY

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Employer: Sault Area Hospital, Emergency Department

Board: Chair, Joan Cardiff; ONA Nominee, Cindy Gabrielli; Employer Nominee, Diane Bagrie.

Decision Date: June 15, 2012

Professional Practice Specialist: Jo Anne Shannon

The Independent Assessment Committee (IAC) did conclude that the RNs working in the Emergency Department (ED) have been required to perform more work than is consistent with proper patient care.

“The IAC concluded that additional staffing resources are required.” The IAC specifically recommended the addition of 11.25 RN hours per day, in the form of an additional RN scheduled to work 1200 – 2400 hours. Further, the IAC recommended the addition of a Unit Aide position 24/7 to assume non-nursing duties and “enable the nurses to focus on patient care needs” Another key statement is “Appropriate staffing is essential to the delivery of safe and effective patient care, and it helps to ensure efficient throughput processes in the ED.”

A key statement by the IAC is that the National Emergency Nurses Association (NENA) standards are the minimally accepted competence level of the RN practicing in an ED setting. “The IAC believes that all RNs practicing in the ED must meet these standards in order to ensure safe and effective care for their patients.”

The IAC stated that autonomous RPN scope of practice in the ER should not be expanded beyond the current assignment to the Fast Track area, and revision of the patient assignment should not include RPNs being independently responsible for patient care in either the Sub-acute and “See and Treat” areas. The IAC expressly stated that “There are no circumstances in which RPNs should hold an independent patient assignment within the Acute Zone”.

The IAC focused considerable attention on the need for the assignment of a full-time educator to the ED, instead of the current shared educator between ED and ICU. This need is exacerbated by the IAC’s concern that the ED is currently without a permanent Nurse Manager. The IAC recommended that at the very least, the Educator should be seconded on a full-time basis to the ER until at least six months following the appointment of a permanent Nurse Manager, and then ensure that the Educator is available to the ER on a clearly defined basis (minimum 2.5 days/week). “The Educator role is not, and should not be seen, as an “office” position.” The Educator role should be actively involved in clinical practice issues in the ED, including the integration of new RNs into the ED.

Another important recommendation is to resurrect the ONA Mentorship Program that was implemented in 2002, but discontinued approximately 5 years ago across the Hospital, with the change in focus at the senior management level on cost containment and budget reduction. This recommendation, along with the focus of a full-time educator was in response to ONA’s concerns related to the influx of novice and new grad RNs into the ED over the next few months and years.

In addition, the IAC addressed the downloading of the tasks of phlebotomy and performing ECGs to the RN staff by stating that “the use of nurses to perform lab work is not an effective use of nursing or fiscal resources which may significantly slow patient flow within the ED.”

Another key statement by the IAC is that the addition of RN and Unit Aide hours “will not, in isolation, address the level of discontent that the RNs are experiencing.” The IAC believes that other factors related to a lack of trust, empowerment and control are impacting the RNs ability to balance patient care needs and workload requirements. Given these other factors, the IAC stressed that their recommendations need to be considered in entirety.

The IAC identified in total 35 recommendations, focusing in the areas of leadership and empowerment, practice, staffing and workload, and corporate responsibilities:

4.2.1 Leadership and Empowerment

First-line leadership roles are sentinel to the health and functioning of a nursing unit/department. The SAH ED is currently without a Manager, and has only part-time Educator support. At least until a permanent Nurse Manager is recruited, and optimally after that, the ED requires the support and leadership of a full-time Educator.

1. *Appoint the Educator to the ED on a full-time basis. If this is not corporately possible, appoint the Educator to the ED on a full-time basis until the permanent ED Nurse Manager has been recruited and in place for six months, and thereafter ensure the Educator is available to the ED on a clearly defined basis (minimum 2.5 days per week).*
2. *Focus the Educator’s role on practice and education issues, including implementation of medical directives, and integration of newly hired RNs into the ED, with active involvement in clinical practice issues within the ED.*

The philosophical approach regarding funding for emergency services in Ontario is moving towards a ‘pay for performance’ model, which requires consistent improvement in ED wait times and patient length of stay for funding to be maintained. The RNs must now manage the competing priorities of patient care and funding requirements, and without opportunities to discuss the impact of this dissonance and discuss/develop strategies to effectively address it, are feeling disempowered. Resurrection of the Unit Council, enabling RNs to assume leadership and accountability for practice issues and decisions, and implementation of formal communication mechanisms are required.

3. *Resurrect the ED Nursing Unit Council, to provide a venue for discussion of and resolution of issues relating to operational functioning of the ED and clinical practice issues relating to the provision of patient care.*
Terms of Reference to include:
 - a. *Purpose: to make collaborative decisions regarding practices and procedures that enhance the quality of patient care and practice environment*
 - b. *Chair: co-chaired by ED Educator and an ED RN selected by nomination*

- c. *Membership: defined membership, including 4 RNs and 1 RPN selected by nomination, one allied health team member, ED PCC, ED Educator and ED Nurse Manager, with a defined membership term of two years*
- d. *Meetings: held biweekly until firmly established, then monthly*
- e. *Agenda: developed jointly by the co-chairs and published in advance of the meeting*
- f. *Minutes: adopt the format used by SAH HAC*
- g. *Distribution of Minutes: by email and in Communication Book*

Facilitate RN involvement by ensuring that RNs are relieved from patient care assignment during Unit Council meetings, and are remunerated as per discussion at HAC.

- 4. *Implement a Communication Book which is*
 - a. *located in a central location within the ED that enables easy access by all working RNs and RPNs,*
 - b. *maintained by the ED Nurse Manager, and*
 - c. *the responsibility of the RNs and RPNs to read.*
- 5. *Maintain regular Staff Meetings, held monthly and chaired by ED Nurse Manager.*
 - a. *Purpose: ensure communication of corporate and program issues, initiatives and outcomes, including quality assurance indicator outcomes.*
 - b. *Minutes: posted online and in Communication Book*

The opportunity to participate in a leadership position, such as Charge Nurse and Triage Nurse, provide RNs with both a sense of ownership of the ED and a more comprehensive understanding of the complex inter-relationships required for smooth and effective departmental functioning. In order to balance available nursing resources with required patient care needs, the Charge Nurse needs to have authority to revise the patient assignment as required.

- 6. *Implement revised role responsibilities for the Charge Nurse, specifying the expectation that the Charge Nurse will have authority to revise the patient assignment to ensure nurses are located in the areas within the Department with the greatest patient volumes/care needs.*
- 7. *Confirm in policy that RPN independent patient assignments will remain within the Fast Track Zone. RPNs may assist with the care provision in the Subacute and Acute Zones in collaboration with RNs, but should not assume an independent patient assignment.*
- 8. *Continue the practice of rotating the AR and Triage RN roles among ED RNs who have 2-3 years ED experience and/or demonstrate leadership qualities.*
- 9. *Continue the practice of 'shadow assigning' the Triage RN role.*

A formal mentorship relationship is of tremendous benefit and support to RNs. The

previously developed Mentorship Program needs to be synthesized to increase its effectiveness for mentors, mentees and Nursing Management, and then revitalized across the Hospital.

10. *Revise the existing Mentorship Program Workbooks to synthesize the key elements for mentors and mentees, and formally re-implement the Program in the ED (and elsewhere).*

In order to effectively support workload concerns, and to provide RNs with confidence that those relating to 'ongoing issues' will be addressed, the clinical Administrator-on-Call requires an understanding of the issues impacting the functioning of all programs, to enable consistent decision-making by everyone assuming the clinical Administrator-on-Call role.

11. *Develop a comprehensive education/guideline binder, to facilitate consistent decision-making among all Administrators-on-Call.*
12. *Re-communicate the process for notification of the Clinical Administrator-on-Call, the Service Administrator-on-Call, and the Senior Administrator-on-Call to all SAH nursing staff.*

4.2.2 Practice

CTAS triage assessment provides an indication of the acuity of the patient presenting to the ED, and provides a guideline regarding the required timeframe for nursing and physician assessment. Documentation of the initial CTAS triage assessments must remain unchanged.

13. *Cease the practice of altering the initial documented CTAS category, as determined at the time of initial patient presentation to the ED, during the patient's visit in the ED.*

Consistent implementation of the 'fax and go' policy will require changes in practice on the part of both ED and inpatient unit RNs, but is required to support timely movement of admitted patients from the ED to the designated inpatient bed.

14. *Communicate expectation that patient transfer from the ED to inpatient units uses the 'fax and go' policy, and take appropriate action to address issues as required.*

The number of medical directives in use in the ED will expand significantly within the next several months, as the 13 new medical directives currently in process are approved and implemented. Effective implementation will require clarity regarding where and by whom medical directives are to be implemented, a defined education and competence evaluation process, and evaluation of their effectiveness.

15. *Develop a policy regarding implementation of medical directives which will optimize patient flow within the ED and will enable implementation of the directives at a time and location that is in the best interest of the patient.*

16. *Nurse Educator, Nurse Manager and Medical Director jointly develop a defined process for evaluation of competence of all RNs to implement medical directives, which includes a formal delegation of authority for competence evaluation from the Medical Director to the Nurse Educator.*
17. *Evaluate the implementation of the new medical directives, following six months of use, by means of :*
 - a. *a random audit of 500 ED patients who did / did not have medical directives, and*
 - b. *RN staff survey**to determine appropriateness of implementation and requirements for revisions of content, and addition/discontinuation of specific directives.*

Clarity regarding the requirements for constant care attendant support is required, to ensure a balance between patient safety and nursing workload.

18. *Re-evaluate the constant care policy to identify guidelines for determination of when constant care is and is not required on a 1:1 basis for patients for whom safety of self or others is a concern.*

Provision of effective patient education and discharge teaching is a challenge within a busy ED. Clarification of the scope/content of required education/discharge instructions, together with support for RNs to gain required knowledge base and use of relevant standardized teaching tools, will greatly enhance the consistent provision of patient education by all RNs.

19. *The ED Educator, ED Nurse Manager and Unit Council research standardized teaching tools, including those available through the Meditech system, from other EDs within the Northeast LHIN, from the Provincial Clinical Educators Group, and on the public domain on the internet, and select those with specific relevance for implementation in the SAH ED.*
20. *Continue to work with Meditech to implement an automatic referral to community agencies.*
21. *Survey the ED nursing staff regarding their perception of the scope, adequacy and content of patient education in 12 months.*

The Fast Track Zone is very effectively caring for almost 45% of the SAH ED patients. However, review of patient volumes and pace of flow of patients through Fast Track is required by 1800 each evening, to ensure that all patients have received treatment when Fast Track closes at 2200.

22. *SAH implement a formal policy whereby the Charge RN/Charge MD implement a resource allocation plan each evening by 1800, including the reassignment of nursing and/or physician resources to Fast Track from the Acute or Subacute Zones, and/or the integration of CTAS 4 and 5 patients into the Subacute Zone as required to ensure closure of the Fast Track Zone by 2200.*

4.2.3 Staffing and Workload

Appropriate staffing is essential to the delivery of safe and effective patient care, and helps to ensure efficient throughput processes in the ED. Baseline nursing staffing needs to reflect the Zone configuration within the ED, the volume and acuity of patients presenting to and remaining within each Zone for treatment, and the nursing skill mix providing patient care. The current baseline staffing provides a total of 21 RN shifts (236.25 hours), 2 RPN shifts (22.5 hours) and 1 RN(EC) shift (7.5 hours) over a 24-hour period.

The RPN and RN (EC) staffing in the Fast Track Zone is appropriate, and should be maintained.

23. Maintain the current nursing staff mix and nursing staffing pattern in the Fast Track Zone.

The RN staffing within the Acute, Subacute and Triage Zones requires rebalancing to ensure that the nursing resources relate to the volume and care needs of patients within each Zone, and requires the addition of one 11.25 hour RN shift per 24-hour period.

24. Alter the baseline RN staffing complement within the ED as follows:

- i. Reassign one (1) RN from the Acute Zone to the “See and Treat” area of the Subacute Zone on the day (0700 – 1900) and night (1900 – 0700) shifts to provide two (2) RNs in ‘See and Treat’ on a 24/7 basis.*
- ii. Revise the current 1000 – 2200 shift to 1100 – 2300, and assign this RN to the Acute Zone, to provide five (5) RNs in the Acute Zone during the ‘surge’ period.*
- iii. Assign one (1) RN in the ‘See and Treat’ area as a ‘shadow assignment for the Triage RN between 2400 – 1200.*
- iv. Add one (1) RN midshift. 1200 – 2400, and assign this RN as a float to “See and Treat”, with the following as criteria for reassignment to the Triage Zone:*
 - a. more than two (2) patients awaiting initial CTAS assessment, and/or*
 - b. Triage RN unable to complete CTAS reassessments of patients in the Triage Waiting Room within the time frames specified by the CTAS Standards, and*
 - c. lunch and supper break coverage for the Triage RN.*

The key element which tips the balance of patient census, patient flow and nursing staffing resources is the number of admitted patients waiting in the ED for inpatient bed placement. Admitted patients place a very significant pressure on ED resources. A clearly defined approach, which articulates consistently applied criteria and decision-making authority, is required to ensure appropriate nursing resources to care for admitted patients.

25. *Develop and implement a decision-tree which determines when additional staff, above the RN baseline, is required to effectively care for patients presenting to the ED and admitted patients waiting in the ED for an inpatient bed and clarifies decision-making authority.*

In an active ED such as SAH, nursing resources need to be focused away from non-nursing tasks such as stocking and ordering supplies, drawing blood and calling in additional staff.

26. *Implement a Unit Aide position within the ED on a 24/7 basis.*
27. *Conduct a cost-benefit analysis to determine the most efficient and effective way to provide phlebotomy and ECGs within the ED.*
28. *Educate the ED Unit Assistants to develop the shift-by-shift Call Sheet, seeking clarification as required from the Charge Nurse.*
29. *Assign responsibility for calling in additional RN staff, in the order identified on the Call Sheet, to the Unit Assistants.*

The RNs currently work a range of 11.25 hour schedules, including a 'traditional' (days only) schedule worked by the PCCs, a day-evening schedule worked by 4 RNs, a 'weekend worker' schedule worked by 4 RNs, and an 'innovative' (4-on / 5-off) schedule worked by 27 RNs. Rebalancing the schedule to provide a more even balance of baseline shift coverage among the full-time RNs, together with ongoing evaluation of scheduling options, will be of long-term benefit.

30. *Include both qualitative (anonymous RN survey) and quantitative (sick time and overtime) analysis when evaluating the current '4-on / 5-off innovative schedule'.*
31. *Revise the current master rotation, within the requirements of the Letter of Understanding, to ensure more consistent coverage of the baseline staffing requirements by the full-time staff.*
32. *Explore flexible/innovative approaches to RN scheduling, including but not limited to exploration of an 1860 hour rotation, inclusion of more than 27 RNs in the 'innovative schedule' currently being piloted, to support RN work/life balance.*

4.2.4 Corporate Initiatives

Several issues are outside of scope of the ED, but impact on the functioning of the ED. Addressing the placement of 'orphan' patients, clarifying and managing the IV pump policy, and implementing the approved changes in the Triage Assessment area will be of benefit.

33. *The Hospital determine the most appropriate location of 'orphan' patients, and provide appropriate staffing resources to support the required care needs*

in the unit/department selected.

34. *Manage the IV Pump Policy by:*
 - a. *clarifying when IV pumps are and are not required for safe patient care,*
 - b. *allocating a specific number of IV pumps to each unit/department, and*
 - c. *assigning responsibility for management of the allocated IV pumps to the unit/department.*

35. *Move forward expeditiously with the approved renovations of the Triage Assessment area. In the meantime, install a “panic/code” button in the Triage Assessment area which can be clearly heard within the core ED.*

The IAC encouraged the Hospital and the Association to work together to address these 35 recommendations within the ED. “The IAC believes that implementation will have a positive impact on the quality of RNs’ worklife, workload and satisfaction, and the quality of patient care.”