Position Statement

Australian College of Critical Care Nurses

ACCCN Position Statement (2006) on the Use of Healthcare Workers other than Division 1* Registered Nurses in Intensive Care

ACCCN acknowledges the important contribution of Enrolled Nurses (Division 2 RN)* (EN) in many roles and settings, and is supportive of all nurses who wish to enhance their skills and knowledge to enable them to work in specialist areas. ACCCN believes the best way to achieve the appropriate skill level for specialist areas is through a formal post-graduate program in that specialty.

This position statement is based on current evidence regarding the effect of healthcare workers other than Division 1* Registered Nurses on patient outcomes in the intensive care environment. It is also supported by the ACCCN "Position Statement on Intensive Care Nurse Staffing"[1], the Joint Faculty of Intensive Care Medicine (JFICM) "Minimum Standards for Intensive Care Units"[2], and the Australian Council of Healthcare Standards "Guidelines for Intensive Care Units"[3].

- All intensive care patients must have a Division 1 Registered Nurse allocated exclusively for their care
- High dependency or stepdown patients (within intensive care) who require a nurse to patient ratio of 1:2, should have a Division 1* Registered Nurse allocated exclusively to their care
- Enrolled Nurses (Division 2 RNs**) may be allocated duties to assist the Division 1* Registered Nurse, however any activities which involve direct contact with the patient, must always be performed in the immediate presence of the Division 1* Registered Nurse
- Unlicensed Personnel should only be used to assist the Division 1 Registered Nurse perform direct patient care for specific duties such as manual handling. Otherwise their duties should be confined to non-nursing duties, housekeeping, etc.

Discussion

Many factors that result in decreased recruitment and retention are causing the current world-wide nursing shortage. One idea that has been promulgated as a potential solution to the shortage of nurses in intensive care is the use of personnel other than Division 1 Registered Nurses. This idea suggests the issue is one of 'workload', ie. a group of tasks that can easily be delegated to any healthcare worker. This concept fails to recognise the expertise and knowledge of the Division 1 RN (especially those with a postgraduate qualification) that has been demonstrated to decrease the risk of adverse patient outcomes[4,5].

The use of Division 2 RNs/ENs** and unlicensed healthcare workers in the intensive care setting has been examined in North America and the United Kingdom, with a number of studies identifying a relationship between low Division 1 RN staffing levels, higher patient mortality rates and increased adverse events [6-12]. Other studies provide evidence that the number of Division 1* RN hours per patient per day influences the quality of patient care[13-15].

The British Association of Critical Care Nurses (BACCN) performed a critical appraisal of the literature to inform their position statement on nurse-patient ratios within intensive care[16]; included in this review was an examination of the use of staff other than (Division 1*) Registered Nurses. The BACCN position statement states that it is the right of intensive care patients to be cared for by a (Division 1*) Registered Nurse, and that the acuity of the intensive care patient should be the determining factor when matching their needs with the knowledge and skills of the Registered Nurse delivering their care [16].

The Canadian Association of Critical Care Nurses (CACCN) [17] position statement on the use of non-regulated health personnel in intensive care areas identifies how critical-thinking is both invaluable

and essential in the provision of care to critically ill patients. They also assert the process involved in the delivery of nursing care to this specific population of patients, represents a complex integration of knowledge, judgement, organisation and evaluation. While CACCN do not unequivocally rule out the use of these personnel in this setting, they believe the quality of patient care would be compromised with their use, and they do not endorse the use of non-regulated personnel in direct patient care roles in intensive care areas[15].

In Australia, while there has not been a formal examination of the use of Division 2 RNs/ENs** within the intensive care setting, two publications that inform this debate come from the Australian Incident Monitoring Survey. The first paper examined 3,600 reports which identified 89 incidents related to nursing staff shortages; 373 incidents related to nursing staff shortages being a contributing factor in the incident, and 81% of the adverse events reported resulted from inappropriate numbers of nursing staff or inappropriate skill mix[18].

The second paper from this group examined 735 reports which identified 1,472 incidents relating to nursing staff inexperience. Of the 1,472 incidents 20% led to adverse outcomes for the patient. The authors believe that nursing care without appropriate expertise poses a potential increased risk of harm to the patient. They concluded that the rate of errors made by experienced intensive care nurses was likely to increase during periods of staffing shortages, when inexperienced nurses required supervision and assistance[15]. Another Australian study also suggests that unlicensed assistive personnel undertaking basic patient care can limit the RNs capacity to assess the total patient condition in context, and as such could impede response to clinical deterioration[24].

The introduction of less skilled nurses or unlicensed personnel into the intensive care environment would greatly increase the supervisory workload of the current workforce. Given that several Australian and American studies have identified workload as a major reason for nurses leaving the profession, this strategy has the potential to further exacerbate attrition, rather than provide a solution[19-21]. In addition, the notion of up-skilling Division 2 RNs**/ENs and Unlicensed Personnel to fix a nursing shortage crisis ignores the underlying problems faced by the nursing profession[20]. Interestingly, these strategies are more likely to be considered by administrators than nurses[23].

In summary, systematic reviews in Australia and large studies overseas have concluded that an all RN skill mix is associated with improved patient outcomes (including satisfaction), quality of life after discharge, treatment compliance, decreased costs , and both reduced length of stay and adverse events.

The introduction of healthcare workers other than Division 1* RNs to provide direct patient care in Australian intensive care units is considered inappropriate, problematic and hazardous; and therefore will not be supported by the ACCCN until there is evidence that clearly demonstrates it would be safe and beneficial to do so.

** Division 1 Registered Nurses is the term used in Victoria for nurses who are referred to as Registered Nurses in all other states of Australia. RNs in all states must undertake a 3 year undergraduate degree.*

*** Division 2 Registered Nurse is the term used in Victoria for nurses who are referred to as Enrolled Nurses in other states of Australia. The educational preparation varies between states, but is primarily conducted in the vocational sector; it ranges from a 12-month certificate to an 18-month diploma. One of the most contentious differences between jurisdictions and educational preparation is the inclusion of medication administration.*

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