Report

Enrolled Nurse – Critical Care Units Project

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Enrolled Nurse – Critical Care Units Project

1. Introduction

The Enrolled Nurse – Critical Care Units project commenced in May 2006. The project aimed to investigate whether there was a role for Endorsed Enrolled Nurses (EENs) in the Intensive Care Unit and to pilot the role in Intensive Care Units (ICU) across NSW.

1.1. Background

For the past 10 years, Intensive Care has been in the “top five” specialty vacancy areas and in the past 5 years there have been an average of 100 full time equivalent positions being recruited each month as reported in Nursing DOHRS. In order to ensure quality care to patients and the provision of a safe working environment, there was a need to evaluate the way in which care is delivered\(^1,2\).

1.2. Enrolled Nurse Education

Enrolled Nurses (EN) have cared for patients in acute care settings for many years. In 2004, the education of ENs was expanded to incorporate a range of skills including medication administration. In 2008, the enrolled nurse qualification was included in the Health Training Package which aimed to standardise the education of enrolled nurses nationally. Enrolled Nurses complete either a Certificate IV (e.g. NSW and Victoria) or a Diploma to meet requirements for enrolment with the registering authorities. In addition there are opportunities for enrolled nurses to undertake further studies in specialty areas, where relevant, and obtain an Advanced Diploma. NSW is currently in transition to a new model for delivery of the Enrolled Nursing course.

In 2004, NSW Enrolled Nurses who completed a medication administration course accredited by the Nurses Registration Board became Endorsed Enrolled Nurses. The medication administration module was included in all pre-enrolment courses from 2005 onwards.

1.3. Enrolled Nurses in ICU

Traditionally the nursing workforce in intensive care units (ICU) across NSW has consisted of Registered Nurses (RNs). While a number of units have indicated they are able to maintain staffing levels, the potential for this to continue is uncertain. The workforce is ageing and there are insufficient graduates from nursing programs to meet the future demands for intensive care services. It is important that nurses gather relevant information and test options in order to develop a well informed position on which to base future workforce skill mix. Having the opportunity to test these options in a controlled situation rather than in more difficult situations such as significant staff shortages is preferable. Effective teamwork is a vital component of high quality care delivery, and requires the co-operation of a range of clinicians to realise in practice.
Project Outline

1.4. Project Objectives

- Develop, implement and evaluate new models of care, that incorporate EENs into the nurse staffing skill mix of ICUs, over a six month period in pilot sites across NSW.

- Evaluate the impact of the new models of care in relation to impact on patient safety, changes in staff satisfaction, experience of staff in working with the new models of care and challenges in delivering patient care within a partnership model.

- Address issues and make recommendations related to sustainability and generalisability of the new models of care delivery.

1.5. Pre Planning Phase

1.5.1. Project Officer

A Project Officer (PO) was appointed in May 2006 to co-ordinate the project and engage with relevant stakeholders in planning, implementing and evaluating pilot programs in ICU across NSW. The PO undertook a literature search relating to staffing models in ICU, staffing levels and patient outcomes, skill mix in ICU and workload in ICU. The PO also contacted ICUs within NSW and across Australia to establish the current distribution of ENs in ICU.

1.5.2. Potential pilot sites

Seven ICUs originally expressed an interest in being pilot sites and being involved in planning the requirements for the pilot programs. The potential pilot sites were:

- Four Principal Referral Hospitals
- One Major Metropolitan Hospital
- Two Major Non-metropolitan Hospitals

After discussing their potential to be a pilot site, one Principal Referral Hospital decided not to become involved in the project. Therefore six sites were involved in the planning process.

1.5.3. Reference Group

A Reference Group was established in July 2006, comprising key stakeholders to be informed of progress of the work and help plan the evaluation strategy.

Representation on the Reference Group included:-

- Chief Nursing and Midwifery Officer (Chair)
- Project Officer – Nursing & Midwifery Office
- Policy Analyst & Nursing Careers Officer – Nursing & Midwifery Office
- ICU Nurse Managers & Nursing Unit Managers (metropolitan)
- ICU Nurse Managers & Nursing Unit Managers (rural)
- ICU Directors
- ICU Nursing Educators
- NSW Clinical Nurse Consultants for Rural Emergency/Critical Care Services
- Area Directors of Nursing & Midwifery
- Australian College of Critical Care Nurses
- Nursing Chair Intensive Care Taskforce
- NSW Enrolled Nurse Professional Association
• Intensive Care Coordination & Monitoring Unit
• State-wide Services Planning
• NSW Nurses’ Association
• TAFE NSW
• The College of Nursing
• Clinical Services Redesign
• Consumer
• Academic

The Reference Group met every 3 months between July 2006 and April 2008. Feedback from members of the Group was shared with the Working Party and incorporated into the planning for pilot programs.

1.5.4. Working Party

A Working Party (WP) was established in August 2006, chaired by the Project Officer, comprising representatives from the potential pilot sites, to plan, implement and evaluate pilot programs in up to six ICUs across NSW. The working Party met face to face monthly between August 2006 and September 2008. The Project Officer made site visits to each of the potential pilot sites as required to support WP members in engaging with staff members about the project.
2. Planning Phase

Engaging staff in potential pilot sites

A number of opportunities were offered to staff in the potential sites to engage with the project and planning the pilot program for their site.

2.1. Claims, Concerns, Issues

Claims, Concerns and Issues arise from Fourth Generation Evaluation described by Guba & Lincoln in 1989\textsuperscript{3}. Fourth Generation Evaluation is an approach to evaluation that places stakeholders’ concerns, claims and issues at the centre of the evaluation process.

Use of this method enabled Intensive Care Unit nurses to identify the elements of importance to them in evaluating models of patient care delivery that incorporated Enrolled Nurses. Staff in each potential pilot site were offered the opportunity to attend face to face sessions and other modes to identify positive aspects relating to models of care delivery incorporating ENs and RNs, concerns about the introduction of these models of care and issues that needed to be addressed during the planning phase. The information from each site was collated into a common document to reflect the claims, concerns and issues across all sites (see Appendix 1). The Working Party incorporated the identified issues into the pilot program planning and development of a risk management plan.

2.2. Care mapping

Staff in the potential pilot sites developed and validated multidisciplinary team and nursing care maps by undertaking a care mapping process. The process provided opportunity for the multidisciplinary team in each potential pilot site to identify the contribution of individual disciplines to patient care in the intensive care unit.

Nurses in each potential pilot site then used the process to identify the nursing care provided to patients in the intensive care unit. Information from all potential sites was collated to form one multidisciplinary care map and one nursing care map relating to ICU patients. This process highlighted the level of complexity and challenges to introducing EENs. The completed care maps were then validated by potential pilot sites. Elements from the nursing care maps were then used by the Working Party to examine the level of responsibility of RNs and EENs in relation to patient care.

2.3. Ward meetings

Working Party representatives engaged with staff at ward meetings in considering how pilot programs would work in each site and to offer staff opportunities to contribute to the planning process. Suggestions and feedback from staff was shared at Working Party meetings and incorporated in planning processes as appropriate.

2.4. Dissemination of information

2.4.1. Information Sheets

The Working Party developed Information sheets at regular intervals to update progress on planning processes. These were distributed to each potential pilot site, to the wider ICU community via the Reference Group representatives and were available on the Nursing and Midwifery Office (NaMO) and Intensive Care Coordination and Monitoring Unit (ICCMU) websites.
2.4.2. Websites

The Nursing & Midwifery Office web site contained a page relating to the project. The Intensive Care Coordination & Monitoring Unit web site made available notes of Working Party meetings and Information Sheets.

2.4.3. Presentations

- **NSW Enrolled Nurse Professional Association Annual Conference, 2006.** The project officer presented the project and potential planning process.
- **Critical Care in the Vineyards Conference, April 2008.** One of the Nurse Educators from a pilot site presented the project including a local perspective.
- **ACCCN Hot Topics Evening, September 2008.** Three presentations relating to the project and local pilot programs were made by the Project Officer, a Nursing Unit Manager, and a CNS.

Other means of disseminating information about the project included feedback by members of the Working Party and Reference group to the areas/groups that they represented. Contact details for the Project Officer and Working Party members were available on the Information Sheets and websites. An article by the Chief Nursing & Midwifery Officer and Project Officer updating progress on the project was published in Critical Times Newsletter (ACCCN publication) in late 2007.

3.5 Withdrawal of Potential Pilot Sites

During the planning process and discussions relating to models of care to be tested in the pilot programs, the ICU staff at one of the Principal Referral Hospitals identified that a pilot program would not be feasible for their unit due to geographical layout. This hospital withdrew from any further involvement in the project.

3.6 Proposal

A proposal detailing the pilot programs and resources required was submitted to the Area Directors of Nursing and Midwifery in four Area Health Services, covering five organisations:

3.6.1 Resources

It was anticipated that two ENs would be seconded into the pilot programs at each site. Funding for these positions and release time for education would be met by the Area Health Services. The Nursing & Midwifery Office agreed to provide funding for a data collection facilitator in each site. Printing costs e.g. for resource folders and posters highlighting aspects of care undertaken by ENs for each site was met by the Nursing and Midwifery Office.

Three Area Health Services ratified the proposals, and four organisations prepared to commence pilot programs early in 2008.

Another Area Health Service was unable to ratify the proposal; so a Major Metropolitan ICU was unable to proceed with a pilot program.
4. Pilot Programs

4.1 Models of Care Delivery

In determining criteria relating to EN within the pilot programs, the Working Party in consultation with ICU staff determined that the ENs should have medication endorsement in order to be eligible for a pilot program. There was extensive discussion throughout the planning process with the Working Party, Reference Group and potential pilot sites, about possible models of care delivery incorporating partnerships between RNs and EENs. The following three models were agreed upon as being feasible to test:

1. 1 RN & 1 EEN sharing the care of two stable ICU patients
2. 1 RN & 1 EEN sharing the care of a complex ICU patient
3. 1 EEN assisting a number of RNs to deliver care to patients (1 RN/ICU patient)

Three of the pilot sites (2 Principal Referral Hospitals and a Major Non-metropolitan Hospital), elected to test model 1 in which 1 RN & 1 EEN share the care of two stable ICU patients. In the event that there weren’t suitable patients to allocate to this model, these units would revert to model 3 with the EEN assisting a number of RNs to deliver care to patients.

The Major Non-metropolitan Hospital elected to test models 2 and 3, recognising that the staffing profile in their unit was already short of RNs and they consistently had a number of RN positions which were being actively recruited with little success.

Appendix 2 outlines the models of care delivery for each site in detail.

4.2 Recruitment of Enrolled Nurses

Position description

The Working Party developed and agreed on a position description for the pilot program (see Appendix 3) based on generic positions descriptions for ENs available in the Area Health Services. There was no intention to expand the role of the EEN, rather to enable EENs to fulfil their Scope of Practice within a new context i.e. ICU.

Essential Criteria

The Working Party and NaMO agreed a set of essential criteria.

Essential Criteria

- Current Authority to Practice in NSW as an Endorsed Enrolled Nurse
- Minimum of 3 years current experience in an acute care setting
- Demonstrated knowledge of basic assessment skills
- Demonstrated effective communication and interpersonal skills
- Demonstrated commitment to working effectively within a team to provide quality nursing care
- Demonstrated commitment to maintaining and developing professional growth

Expression of Interest

An Expression of Interest was circulated within the pilot sites to recruit EENs to the program. The intention was to second EENs from another clinical area in the pilot site hospital. In the case of one Major Non Metropolitan Hospital, 2-3 enrolled nurses currently working in the high dependency unit (HDU) would undertake the pilot program as a rotation between HDU and ICU.
Selection Process

Selection was made by means of interview within each pilot site. In order to achieve consistency across sites, a common set of interview questions were developed and agreed by the Working Party.

4.3 Support for the Pilot Programs

The members of the WP in conjunction with nurses in the pilot sites identified that a support structure was needed for the pilot program. The structure included a team leader, who was not allocated a set patient load, and a clinical nurse educator or access nurse role to support RNs and EENs working in a new model of care delivery. This support structure was outlined in the proposal that was ratified by the Area Health Services.

The pilot programs were structured to maximise the amount of support available. It was agreed that EENs would work morning shifts only, Monday to Friday for approximately four months of the six month program. This would provide the opportunity to evaluate whether the proposed partnership model of care worked in reality while ensuring that experienced nurses were present to support the RN and EEN. In some units, it was anticipated that this may involve the use of other staff e.g. Nursing Educators, Clinical Nurse Consultants, Nursing Unit Managers, Research Nurses. It was also anticipated that this group would liaise closely with the ICU nursing team leader in regards to availabilities and changes, on a shift-to-shift basis.

The Working Party also agreed that there would be flexibility to review the shifts worked as the pilot programs progressed with potential to expand the shifts worked beyond the morning shift.

Orientation and Education for EENs

The pilot sites had orientation programs for new members of staff. The members of the WP coordinated adaptation of the orientation programs within individual units for use with EENs in the pilot programs.

The emphasis of orientation and education was on applying skills and knowledge that EENs currently have to patient care delivery in a new setting e.g. meeting the hygiene needs or pressure area care for an ICU patient. Each pilot site determined the length of an orientation program and preceptor requirements, based on local context and resources available.

Throughout the pilot programs in each site, EENs had access to routine in-service and education sessions, as well as separate education sessions and packages targeted to their specific needs. Pilot sites adapted existing competency packages to enable EENs in the pilot programs to undertake appropriate competency assessment at a local level.

Preparation and Education for RNs/ICU Staff

A number of resources were made available to staff in the pilot sites in preparation for the pilot programs:

- **Resource Folder**
  The WP prepared a resource folder incorporating information about delegation and supervision, skills taught during the EN course, RN responsibilities when working with an EEN, National Competencies for the Enrolled Nurse, examples of an RN & EEN working in partnership to deliver patient care and aspects of patient care that can be undertaken by EENs. Two resource folders were made available in each pilot staff for staff access.

- **Posters**
  Aspects of patient care that can be undertaken by EENs were developed into A3 posters and a set was made available to each pilot site for display in staff areas.
• Staff in each pilot site were offered the opportunity to attend local information/education sessions relating to the role of EENs, the pilot programs and the models of care delivery being tested.

4.4 Risk management plan

The WP developed a risk management plan for the project to highlight potential risks of the pilot programs, including resource requirements i.e. funding and staffing (for the program and on a shift-by-shift basis), recruiting suitable EENs and RNs to participate in the pilot, changes in patients’ clinical condition and attitude of and impact on RNs in the unit. The plan was adapted for use locally by team leaders in determining allocation of suitable patients to the RN/EEN.

4.5 Data collection

Survey
A survey was offered to nurses in the six potential pilot sites originally involved in planning pilot programs in 2007, prior to starting the pilot programs and was again offered to nurses in the three sites that undertook pilot programs towards the end of the 6-month program. The survey had been developed by the Centre for Applied Nursing Research for use by Bankstown-Lidcombe Hospital in their Models of Care Project. The survey explored individual’s perceptions of the workplace including relationships with colleagues, communication, teamwork, the environment in which they practised and their job. The surveys were anonymous and a descriptive analysis was undertaken in NaMO independently of the units.

Interviews
The data collection facilitator in each site conducted interviews with a number of key nursing and medical staff e.g. Nursing Unit Managers, Intensive Care Consultants to elicit their experiences of employing EENs in the ICU during the pilot programs.

Exit interviews were completed with two EENs in different sites who chose to withdraw early from the pilot programs.

Focus Groups
Staff in each pilot site were invited to attend focus groups during their pilot programs to identify the positive aspects of the programs and the challenges faced. The focus groups were facilitated by the Project Officer and/or the data collection facilitator in each site. Claims, Concerns, Issues activities were repeated during the course of some of the focus groups.

Daily Journal Forms
Team Leaders in each site were asked to complete a Daily Journal Form for their shift detailing types of patients allocated to the RN/EEN working in partnership, the perceived activity in the unit and any critical incidents occurring during the shift, whether related to the patients allocated to the RN & EEN or generally within the unit. Information from the Daily Journal Forms was entered into an Excel spreadsheet for the Project Officer.

Feedback Forms
Registered Nurses and EENS were provided with blank feedback forms on which to identify their experience of the pilot program. The Feedback Forms were anonymous and completed forms were placed in a locked box for collection by the data collection facilitator in each site.

Unit/Staffing Data
Each pilot site was asked to provide quantitative data already available in the unit in relation to staffing e.g. number of FTE RNs employed, vacancy rate, RN sick leave and the unit, e.g. length of stay.
5. Evaluation findings

The evaluation findings of the pilot programs consist mostly of qualitative data that reflects the experiences of the staff in the three units that undertook 6-month pilot programs. The evaluation strategy included use of quantitative data such as sick leave and staff turnover rates. However, as there were only two EENs employed in each of the pilot program, as part of a much larger workforce comprising RNs, such quantitative data has relatively little meaning.

5.1 Pilot program information

The Intensive Care Unit at a Major Non Metropolitan Hospital was involved in all of the planning for pilot programs and commenced a pilot program with two EENs working in their High Dependency Unit, which is co-located with the Intensive Care Unit. However, the secondment occurred for only a brief period before the unit faced a number of general staffing and operational issues. As a result of these issues, the ICU staff determined that they were unable to undertake the 6-month pilot program and subsequently were withdrawn.

The remaining three sites undertook 6-month pilot program (two Principal Referral Hospitals and one Major Non Metropolitan Hospital). All units identified that they would employ a maximum of 2 enrolled nurses in the pilot program due to level of nursing support available and unfamiliarity of RNs with the EEN's role, in many cases.

Two EENs were seconded to each of three pilot sites:

- **A Principal Referral Hospital: January - June 2008** – two EENs from an acute orthopaedic ward in the hospital applied were seconded into the pilot program. Both EENs were in the first year of the Bachelor of Nursing degree.
- **A Principal Referral Hospital: February-July 2008** – two EENs from acute ward areas in the hospital applied and were seconded into the pilot program. Both EENs had had many years of nursing experience at EN level.
- **A Major Non Metropolitan Hospital: 5 June - December 2008** – two EENs applied and were seconded into the pilot program. One EEN had been working in an acute ward area in the hospital and the other EEN was employed in the High Dependency/Coronary Care Unit, so was already known to ICU staff.

Withdrawals

Two EENs withdrew from the pilot programs at Principal Referral Hospitals after 3 months; one highlighting that personal expectation about working in ICU was not being fulfilled within the pilot program and the other highlighting that ICU was not an environment in which she enjoyed working. Both EENs gave feedback about their experiences during the time spent in the program. Both of these units decided not to attempt to recruit further EENS as they had completed half of the pilot program period. This resulted in only one EEN completing the pilot programs at two of the Principal Referral Hospitals. Both EENS recruited to the pilot at a Major Non Metropolitan Hospital completed the program.

As stated above, two EENs had already commenced conversion to RN when pilot programs commenced (one of these withdrew from the program). Two of the other EENS involved in the pilot programs have expressed a desire to undertake the Bachelor of Nursing degree as a result of working in ICU during the pilot and one EEN expressed an intention to seek a position in the high dependency unit following the pilot program.

Survey

Staff in all potential pilot sites completed the survey. It was planned to compare information gained from surveys completed at the end of the pilot programs in participating units. However, the response rate to the second survey was too low to be representative of the nurses in the unit;
therefore comparisons could not be made to gauge any impact of the presence of EENs in the units.

**Daily journal forms**

Team leaders recorded details of patients allocated, in terms of whether the patients were considered to be high dependency or intensive care patients, whether ventilated or not, level of care required e.g. presence of central and arterial lines, receiving inotropic infusions, need for intubation or extubation on that shift and whether patients needed to be escorted elsewhere e.g. to theatre or scanning departments.

The daily journal forms were not completed consistently and became less well completed as the pilot programs progressed. Some team leaders allocated mainly high dependency patients to the RN and EEN working together while some team leaders did allocate mechanically ventilated patients to the RN and EEN. Allocation of these patients proved to be extremely challenging in situations where patients were in single rooms or were not located in adjoining beds as it was difficult for the RN and EEN to work in partnership effectively.

At a Major Non Metropolitan Hospital, the EENs were allocated to either:

- Work with an RN caring for a more complex/high acuity patient or
- Assist two RNs caring for two patients or
- Assist all RNs in the unit caring for ventilated patients.

In all of these three allocations, feedback from RNs and EENs was positive as the EENs were providing support and extra help to the RNs.

**Feedback from staff**

A number of themes emerged from the feedback given by staff during the pilot program.

*Feedback relating to the model of care delivery involving an RN and EEN caring for two patients:*

Both RNs and EENs identified allocation of patients as a challenge:

- Allocation
  - Challenges removing moving patients and reallocating e.g. if patients were discharged or patient acuity changed
  - RN/EEN were allocated high dependency patients rather than ventilated patients
  - Working with different RNs – the challenge of explaining the EEN scope of practice each time they worked with a different RN led to some frustration for EENs.
  - Having appropriate patients to allocate to the RN/EEN partnership is the key
  - When the RN/EEN partnership was allocated HDU patients or patients ready for discharge to the ward – the tendency was to divide the patients and care for one each, therefore the partnership in care delivery lapsed.

Other themes that emerged from feedback given by the EENS related to personal feelings and attitudes:

- Personal feelings
  - Not achieving any personal goals
  - Feeling a burden
  - Feeling useless at times – limitations on practice (local policy restrictions)
  - Missed working independently and autonomously

- Attitudes
  - Improved as pilot progressed, became more relaxed - no negative comments
- Staff open to pilot and teamwork in general – suboptimal working relationship with RN on occasions
- Positive attitude
- As the pilot program progressed and staff became used to the EENs, the partnership started to lapse and there was some 1:1 patient allocation when the two nurses were allocated high dependency patients

The skill of the RNs impacted on the way in which an RN and EEN worked together. In situations where the RN had a lot of experience in ICU and was confident in their own abilities, the partnership worked better.

Feedback from Team Leaders also highlighted variable attitudes towards the pilot program with some RNs displaying very positive attitudes towards working with EENs and other RNs expressing feelings that care of patients was not as high when an EEN and RN cared for two patients.

Other themes that emerged form the feedback given by RNs related to relief of RNs for meal breaks and workload:

- **Break relief**
  - Nurses working with patients cover each other’s meal breaks so there were significant challenges with doing this when an RN and EEN were caring for two patients – the EEN could not cover the RN’s break because they could not be left alone with ICU patients so this meant that (for example) two RNs would have to cover four patients during the RN/EEN meal break.

- **Workload**
  - Perception that workload for RN increased because of being responsible for more than one patient
  - Limitations to EEN’s practice because of local policy restrictions

RNs identified that knowing the EEN’s scope of practice was an issue, however they became more used to the program as it progressed.

**Feedback from Team Leaders**

Feedback from Team Leaders was similar to that of other RNs: The feedback highlighted the challenges with patient allocation and the need to relocate nurses when patients were discharged or patient acuity increased. They identified that covering meal breaks for RNs working with EENs presented significant challenges particularly when the RNs caring for other patients in the same area were less experienced or new graduates. Feedback from Team Leaders also highlighted the perception of increased workload with the RN having responsibility for two patients rather than one, even though he/she was working with another nurse. Team leaders identified that there was lack of communication between the RN and EEN at times.

**Feedback relating to the model of care delivery involving an RN and EEN caring for 1 more complex/higher acuity patient or EEN assists RNs with patient care (1 RN/patient)**

Both RNs and EENs identified this model of care delivery to be of benefit to patients and staff. Registered nurses perceived that fundamental patient care such as hygiene needs and pressure area care was performed to a higher standard with the help of the EENs, particularly when the unit was busy:

- Benefits to other ICU staff
  - Taking pressure off RNs and, in particular, the team leader (T/L) – EENs helped with the patient care that previously T/L was asked to do
  - Most RNs were positive
  - Doctors responded well
  - Everyone worked well with the EENs
Other themes identified by EENs related to education

Education

- Learning about ventilators etc
  - From RNs
  - From doctors when they are teaching other doctors
  - The clinical nurse educators developed a good orientation package

Registered nurses, in their feedback, also identified education as being valuable. The RNs highlighted their ability in many cases of working with the EENs to educate and help the EENs to learn about the care of patients in ICU and to develop new skills within their scope of practice. The majority of RNs at a Major Non Metropolitan Hospital identified the help and support offered by the EENs in caring for patients as invaluable and that during the pilot program fundamental patient care improved, particularly when the unit experienced high activity. These anecdotal reports by nurses of an improvement in patient care could not be validated with quantitative data, due to the small number of EENs employed in each unit.

Summary

Model of care delivery
Registered and endorsed enrolled nurses worked effectively together in using a model of care delivery where an EEN assisted an RN or RNs to care for patients in ICU while maintaining a ratio of one RN for each mechanically ventilated patient. This model worked particularly well in a Major Non Metropolitan Hospital, which had already identified shortages in RN staffing of ICU.

When a model of care delivery involving an RN and EEN working in partnership to care for two patients in ICU was used, nurses experienced significant challenges. As the pilot programs progressed and RNs became accustomed to the presence of the EEN in each unit, attitudes towards employing an EEN in the unit generally improved, however the challenges remained. Allocation of patients was particularly challenging when one patient needs more attention than the other or when patients were in single rooms or were not located in adjacent beds. This led to situations of the RN spending more time with the higher acuity patient and the EEN caring for other patient. The result of such situations was that other staff e.g. NUM/CNE needed to work with the EEN and this increased pressure on the unit as a whole.

Registered nurse attitudes
Resistance to employing EENs in ICU was high, particularly in allocating two patients to an RN and EEN. Registered nurses generally had high expectations of EENs and were largely unfamiliar with the role and scope of practice of EENs. Endorsed enrolled nurses reported feeling some frustration at the need to repeatedly inform RNs of their role within the pilot program and scope of practice. This situation eased as the pilot programs progressed. There were individual incidents of negative attitudes displayed towards EENs by RNs, in particular complimentary comments made to or overheard by EENs. Again, these attitudes generally improved as the pilot programs continued.

Perceptions of patient safety
Some RNs appeared to expect EENs to function at the same level as RNs and identified concerns for patient safety as EENs could not care for patients in ICU unaided even with education. As with reports if improvements in patient care, impact on patient safety could not be validated with meaningful quantitative data due to the small number of EENs involved in the pilot program.

There were few reports of critical incidents in any unit during the pilot programs. A medication error involving an RN and EEN soon after one of the pilot programs commenced was managed according to local protocol.

The ICUs at two Principal Referral Hospitals vary in the level of nursing support available. The number of staff members who are not allocated a patient load, such as Team Leader, Clinical Nurse Consultant, Clinical Nurse Educator or Nurse Educator, Nursing Unit Manager and Nurse Manager is generally higher in the ICU at Principal Referral Hospitals. Despite this higher level of
support staff, the model of care delivery involving an RN and EEN caring for two patients presented significant challenges. This was particularly evident at a Principal Referral Hospital, where patients are nursed in single rooms. This increased the difficulty experienced by RNs and EENs in working in partnership to deliver patient care.

6. Recommendations

- Enrolled nurses currently work in high dependency and coronary care units in public hospitals across NSW and fulfil an important role in care delivery to high dependency patients. Enrolled Nurses should continue to fulfil this role.

- A direct patient care role for EENs in intensive care using a model in which an RN and an EEN care for two patients demonstrated difficulties. The challenges presented relate to workplace culture with its emphasis on a nurse to patient ratio of 1:1 for mechanically ventilated patients; geographical layout of units, particularly with a high level of single patient rooms and meal break relief for RNs.

- There is a valuable role for EENs to undertake direct patient care for intensive care patients when a model of care delivery is used that incorporates the EEN supporting and assisting RNs to care for patients in ICU.

- Engaging all staff within intensive care units in relation to changes in staffing mix, introduction of roles or changes to models of care delivery is vital to the successful implementation of sustainable changes. Staff at all levels should be involved in reviewing existing models of patient care delivery and developing new models.
7. References


Acknowledgements

The nurses and members of ICCMU who gave their time and commitment, and made a valuable contribution to the Working Party in engaging staff within their units; planning, implementing and evaluating the pilot programs.

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The members of the Reference Group for their contribution to the planning process during the project.
Appendix 1: Summary Claims, Concerns, Issues potential pilot sites

CLAIMS

- **Staffing/workload**
  - Improve nursing numbers – more stable workforce.
  - An extra pair of hands.
  - More available staff – greater pool of staff for ICU.
  - Extra to numbers – fabulous resource. Could be ACCESS nurse no. 2 and help RNs.
  - Could decrease workload of RN.
  - Decrease the overtime expected of RNs.
  - May relieve the RN shortage.

- **Care delivery**
  - Holistic care.
  - Can help with fundamental care e.g. mouth care etc, which may get missed when overworked.
  - Work with ICU patient under guidance of RN.
  - Can enhance patient care – greater scope of care.
  - Reduces feeling like an RN lackey.
  - Learn specified tasks e.g. ABGs.
  - Building skills – tapping into EN skills.
  - Look after HDU pts nearing ward placement.
  - Could care for non-ventilated patients, especially when gridlocked.
  - Helps with allocation of patient loads especially if inexperienced RNs.

- **Teamwork**
  - Change that may lead to better team skills.
  - Encourage relationships between RNs and ENs as well as other staff and improve attitudes.
  - May enhance the nursing/general culture/workforce within the unit.
  - Share knowledge.
  - Improved team nursing

- **Career path**
  - Learning environment.
  - Succession planning – encourage ENs to convert to RN.
  - Better for ENs.
  - Good for EN’s morale.
  - Increased role satisfaction for ENs.
  - Able to encourage RNs by providing more opportunities for ENs.
  - Broaden EN knowledge base.

- **Other tasks**
  - Answer phones.
  - Can check emergency equipment/trolleys etc.
  - Transfer patients to wards.

- **Cost effective**
  - If save money – use for greater good.

- If EN training is updated it might make RN training get overhauled.
• May force us to review the role of RN.
• Role of RN may change, supervising analyzing - may develop more leadership.
• May help RNs to increase their education and supervision skills.

- Cream of crop of ENs, may be better than some RNs and they will probably be really motivated, really want to be in ICU.
- Bring new ideas.
- May be able to spend more time with families.
- Already have two EENs on permanent staff.

CONCERNS

- Care Delivery
  • How ENs and RNs work together – what level of care?
  • Has to be black and white what ENs are allowed to do eg grey area of inotropes.
  • Care may get fragmented
  • ENs working outside scope of practice – being pressured by management & RNs, and also ENs taking on extra things outside scope of practice.
  • Models of care to be introduced.
  • Challenge to maintain patient-centred approach with changing MoC.

- Skills/knowledge
  • Level of knowledge.
  • Level of competency of ENs.
  • Assessment skills eg changes in trends – skill level.
  • Maintaining EN skills.

- Expectations
  • RN expectations of ENs are greater than they should be.
  • Expectation of RN for EN to just do fundamental care.
  • (RNs) don’t know what to expect – difficult to visualize.
  • Staff not knowing what ENs can do.
  • Accountability
    • Will ENs be accountable for own practice?
    • RN responsible and accountable for EN if major incident with EN - responsibility falls on RN.
    • Legal responsibilities.

- Teamwork/culture
  • Resistance of staff to ENs – gaining RN acceptance.
  • May upset the general culture/workforce within the unit.
  • RN and EN attitudes eg abuse of each other’s roles.
  • Change of management – involves a big change to the way things are done.
  • RNs level of responsibility for EN’s practice – unawareness of RNs and ENs.
  • May just be task allocation.

- Workforce
  • Diluting the skill mix.
  • May adversely affect RN retention – mass resignation of RNs.
  • May take RNs from the bedside – may force RNs into management role – purely coordinating.
  • Difficulty in rostering.
  • ?bigger priority to attain 50% trained RNs in ICU dept as per ACCCN position statement.
- **Pilot program**
  - Some management staff bending the rules:
    - Moving away from defined MoC ie numbers vs skill mix.
    - Moving HDU ENs out of pilot program to cover HDU.
  - EN sick – replace with any EN.
  - That ENs counted in numbers by management external to ICU.
  - EN may be directed to work by team leaders to help where needed.
  - Danger – that after pilot program – creep occurs, becomes open season to bring in more ENs.
  - Will be used ‘abused’ as a replacement RN (by management).
  - Concern that ‘rules’ will be broken.
  - ENs not part of the pilot program will be brought to work in ICU.

- **Patient acuity**
  - If give EN stable HDU patient, patient may become unstable or ventilated.
  - Unsuitable patients i.e. recent high acuity – all ventilated or complicated.
  - Relief of breaks – complicated patients.
  - Not always going to have right type of patient in unit.

- **Resources**
  - Not cost effective.
  - Clinical Nurse Educator without a patient load.
  - Train them in ICU then leave to do RN training etc.
  - Not enough resources.
  - Finances.
  - Education resources – where from? Support resources.

- **Workload/pressure**
  - Increase workload for RNs as concerned whether ENs are working within role – need extra supervision.
  - RNs may be overwhelmed with extra workload of education/supervision.
  - Increased complexity of education and supervision (added to New Graduates, students, new staff etc).
  - Added stress for team leader especially if team leader taking patient, supervising junior staff, agency staff, and now EN.
  - EN feels so overwhelmed – alienated from group, feel unwelcome increased stress.
  - Reduced morale from ENs – increases pressure on them and make feel unsupported and stressed.
  - Increased Educator workload – education resources, burden on existing education.
  - More pressure on a system that is already at state of collapse.

- Increased patient incidents.

- Job satisfaction for ENs: not much opportunity in nursing care. Limited and decreased autonomy.

- May need pay recognition.

- Will it make some RNs lazier?

- Appropriate supervision.

- Patients/families might not have confidence in the workforce.

- Enforced change of working conditions on RNs.
ISSUES

- Care Delivery
  - What are the guidelines for practice?
  - What will the model of care look like?
  - How can we define the specifics of a model of care?
  - What is the RN’s level of responsibility for EN’s practice in ICU/what is the legal responsibility of RNs in relation to ENs?
  - How are RNs and ENs made aware of that?

- Pilot program
  - How do we structure the pilot program to ensure that ENs aren’t brought in on an ad hoc basis eg when an EN on the program is off duty?
  - When will it happen?
  - How long pilot program?
  - What will happen to ENs employed in the pilot program?
  - What are the costs to run the pilot? How much funding needed?
  - What is criteria for EN to work in ICU?
  - What is Model of Care?
  - Who will be responsible for recruiting?
  - Will units be forced to continue after the pilot program but have the resources withdrawn?
  - How many ENs per unit?

- Training
  - Will ENs get more (extra) training in ICU?
  - What education is required to ensure ENs have necessary skills to work in ICU?
  - How are ENs going to be trained?
  - What resources are needed to provide education/support?
  - How is an education program developed and implemented?
  - How can we educate and involve staff in the change management process?

- What do Intensivists feel about it?

- What are the RN’s expectations of the ENs?

- What does supervision mean?

- What do RNs need (education/training) to supervise/work with ENs effectively?

- Will they be counted as extra staff or in numbers/will they be in staff establishment?

- How can we enable staff to respect each other and each other’s roles?

- Will they work night shifts?

- Will they just be task orientated?
Appendix 2: Models of Care delivery

INTENSIVE CARE UNIT

Enrolled Nurse - Critical Care Units

Pilot Program

Proposed models of care delivery
PRINCIPAL REFERRAL HOSPITAL A

Primary model
1. 1 RN/1 Endorsed EN (EEN) = 2 patients
   Patients must be side by side/adjacent e.g. 1+2, 2+3, 3+4, 4+5

Secondary models
1. 1 EEN – acting in a clinical support role providing and assisting with fundamental cares, MRO swabs, procedures, ventilator circuit changes, dressings, tapes, room set-ups etc under the supervision of the bedside RN and the team leader

2. 1RN/1EEN = 1 complex high acuity patient /critical patient requiring more than 1:1 nurse/patient ratio

Rostering
- Months 1-4 the EEN shall work morning shifts Monday to Friday to ensure adequate support and supernumerary team leader/NUM support.
- Months 5 – 6 yet to be defined, there may be the potential to extend to evening shifts, depending on progress in the pilot program.

Models of Care in Practice
- The most important characteristic associated with the implementation of a model of care in the pilot program is its dynamic nature. This element is widely recognised in critical care areas. Hence it is a factor that must always be noted in the staff allocation to intensive care patients.
- Any of the models of care highlighted above can be implemented following adequate staff awareness and education. The adherence to guidelines will allow allocation of EENs to appropriately educated RNs to engage in team based nursing care delivery to 1 or 2 intensive care patients. These intensive care patients must be allocated according to the selection guidelines.
- The selection guidelines are explicit in order to minimise subjective decision-making by the potential variety of staff that can make decisions regarding staff allocation.
- New admissions to ICU will not be received or cared for by an EEN until the patient is fully assessed by medical staff and RNs and deemed appropriate, by in charge nursing staff, to be cared for within the pilot program.
- The NUM or Nurse Manager of Intensive Care will always have the discretion to swap between agreed models of care, in consultation with the intensive care in charge nurse.

Escape Clause
- If ICU status is not appropriate for the primary model currently in use, consider swapping to a secondary model, and if still not appropriate, seek further advice from Nurse Manager regarding pilot strategy.
- A registered nurse & an enrolled nurse care for a complicated/high acuity patient (model of care 3).
- If the model of care is changing frequently (more than once in an 8-hour shift) the ICU nurse in charge will need to seek further advice from ICU Nurse Manager regarding pilot strategy.
- Grouping of patients for convenient staff allocation to facilitate a model of care should not be achieved by moving critically ill patients.

- If there are 4 or more paediatric patients (up to 18 years of age) in the ICU, re-allocation of staff to model of care 2 should follow. Referral to the Nurse Manager for further advice is appropriate.

- If the ICU Nurse Manager determines that the pilot program should be ceased, prior to the appointed end date, because of patient safety concerns, this will be done in consultation with the Nursing & Midwifery Office and arrangements made for appropriate cessation of the program.

These are statements that reflect our individual units needs regarding patient and staff safety, and the delivery of high quality nursing care.

Options

- 2 Access RNs and 1EEN clinical support in ICU (i.e. model of care 2)
- 1 RN and 2 EENs in HDU (i.e. the EEN working in the pilot program would deploy to HDU)
- If the ICU is quiet the EN may be redeployed to any unit within the hospital as per the current plan. Ideally in the pilot program attempts will be made to utilise the EN elsewhere in the ICU.
- Deployment of ENs and RNs working in the pilot program will be monitored. If deployment occurs on a regular basis, this will be discussed with the project officer and strategies to reduce the impact on the pilot program will be developed.

Patient Selection Guidelines

The list of duties outlined below delineates a collective of potential tasks that may be attended under either direct or indirect supervision from a registered nurse. Thus, it is explicit that care delivery to two patients is via a team-based approach, where upon the RN is ultimately responsible for the care of the two patients.

The list of duties is dynamic and in no way limits what an EN may be recognised as capable of attending within their scope of practice.

At all times, the models of care to be employed in the pilot program involve an RN and EEN working in partnership to deliver patient care

The EEN is able to:

- Care for a patient with a tracheostomy tube (TT) in situ in partnership with an RN (however not a new TT i.e. surgical or percutaneous tracheostomy for the first 24 hours.).

- Perform tracheostomy care including succioning, cuff pressure measurement, dressings, inner cannula change, and change securement device with the assistance of an RN. All cares performed according to unit policy.

- Care for non ventilated patients

- Care for a patient receiving non-invasive ventilation in partnership with an RN following the successful completion of relevant self directed learning package (SDLP).

- Assist with fundamental cares of patients in the Intensive Care Unit, including basic hygiene & washes, mouth, eye and pressure area care.

- Perform and record patient observations including temperature, pulse, respiratory rate, blood pressure (non-invasive or invasive).
• Perform CPR, and assist with patient resuscitation under the supervision and direction of an RN.

• Assist with connection/zeroing of monitors.

• Receive blood for blood gas analysis – attend analysis (prior in-service regarding use of blood gas machine to be attended – competency attended).

• Administer approved medications with the exception of inotropes, vasopressors and schedule 8 medications.

• Administer medication via all usual routes (O, IM, IV, SL, SC) with the exception of epidural, intrathecal and intracranial routes.

• Check narcotic infusion with RNs.

• Check blood and blood products once the relevant SDLP has been completed.

• Change rates of ward strength GTN/dopamine under supervision of an RN.

• Assemble the equipment for preparation of infusions, e.g. noradrenaline, dopamine etc under the supervision of Registered Nurse prepare/check infusions.

• Assemble IV therapy equipment.

• Care for a patient with an arterial line and CVC in partnership with an RN (per Area Health Service policy).

• Undertake report writing within the EN scope of practice.

• Undertake manual handling including patient transfer, lifting & moving under the direct or indirect supervision of an RN and within the policy and procedural guidance of the ICU.

Patients cared for by an RN and EEN must:
• Be haemodynamically stable.

• Have no more than single organ failure (e.g. lungs).

• Meet certain conditions = FiO2 < 40%, PEEP <10cmH2O, stable (not acutely desaturating when immediately off therapy).

What EENs in ICU can’t do:
• Paediatrics

• Care of:
  - ICP/EVD
  - CTS (post operative Cardiothoracic surgery)
  - Pulmonary Artery Catheters
  - PiCCO
  - Pacing
  - CRRT (Continuous Renal Replacement Therapy)

• Medical Emergency Team

• IAP-intra-abdominal pressures (but can assist in performing task)

• Arrhythmia (unstable/acute)
New admissions until patient is fully assessed and deemed appropriate, by the in charge nurse, that the patient can be cared for within the pilot program model of care.

Unit Rules
- Patient care will be delivered in partnership with an RN – team nursing between RN & EEN.
- Employed Monday - Friday, ‘M’ shifts until review after month 4 of the pilot program.
- Availabilities – an Access nurse without patient care responsibilities must be available to provide support for the RN & EEN working together. This may involve the use of non clinical staff: nursing educators, clinical nurse consultants (Level 2 or 3), nursing unit managers, equipment nurse, and research nurses (that are able to work clinically or supervise) – this group must inform the ICU I/C nurse of availabilities and changes.
- Staff meal relief will continue to be attended by RNs.
- EENs will not carry the DD/S8 keys, only the in charge nurse or an RN delegate.
- EENs will team nurse only with named or allocated mentors on all occasions.

Education Plan
- Compulsory/mandatory education attended prior to commencement in ICU, inclusive of basic life support, infection control, fire, moving safely, staff health.
- Unit orientation of between 2 and 4 weeks encompassing a specifically planned program for EENs.
- SDLP on:
  - medication management
  - CVC management
  - care of the sedated patient with an artificial airway
  - respiratory management (including anatomy & physiology, non-invasive ventilation, tracheostomy management) with competency assessment
  - checking blood & blood products.
- Completion of a modified “RIPPLES” for EENs in ICU.

Orientation and Mentorship
- The EEN will have 2 orientation days with the Nursing Education Unit, followed by 3 buddy/supernumerary days working with an RN with 1 ICU patient.
- The EEN will be mentored each shift by one of four nominated RNs for 2-4 week period to contextualise their skills, become familiar with routines, policies and procedures and complete an education plan. Further competencies to complete will be provided beyond this period.
- Beyond four weeks, the EEN will be supervised on a continuous basis for the duration of the pilot program, but the EEN will be accountable for their own practice.
- The mentor RNs must be familiar with the orientation and competency/skills package for the EEN and have a sound understanding of the EEN’s scope of practice.
- Mentors must work within the pilot study guidelines and can refer to the resource folder (developed for the pilot program) for further information.
Mentors must have completed the hospital based mentor program.

Mentors and unit staff
- All mentors and unit staff will require in-service to clearly identify appropriate and inappropriate roles and responsibilities when working with EENs in the ICU.

Commencement Plan
- Following a successful interview mid October, pilot ENs would be given the medication package, cardiac physiology and respiratory physiology packages to complete prior to commencing employment.

- Upon starting work in the pilot program, a 2 to 4-week theory/practice in ICU orientation program inclusive of supernumerary time with mentors should follow.

- Following the completion of this program a performance appraisal and entry interview prior to working clinically would occur with an ICU nursing management representative and an ICU education unit representative (appraisal and interview proforma provided by the pilot program team).

- Each mentor should complete an evaluation form (an appropriate evaluation form provided by the pilot program team).
PRINCIPAL REFERRAL HOSPITAL B

Primary Model
1. 1 Registered nurse (RN)/1 Endorsed Enrolled Nurse (EEN) caring for 2 patients. Patients must be side by side/adjacent e.g. 3+4, 4+5

Secondary Models
2. 1 EEN acting in a clinical support role providing and assisting with fundamental care, MRO swabs, procedures, ventilation circuit changes, dressings, tapes, room set-ups etc under the supervision of the bedside RN and the team leader.
3. 1 RN and 1 EEN caring for 1 complex high acuity patient/critical patient requiring 2:1 nursing ratio.

Rostering
- Months 1 to 4, the EEN shall work morning shifts Monday to Friday to ensure adequate support and supernumerary team leader/NUM support.
- Months 5-6 yet to be defined.

Models of Care in Practice
- The most important characteristic associated with the implementation of a model of care in the pilot program is its dynamic nature. This element is widely recognised in intensive care areas. Hence it is a factor that must always be noted in the staff allocation to intensive care patients.
- Any of the models of care highlighted above can be implemented following adequate staff awareness and education. The adherence to guidelines will allow allocation of EENs to appropriately educated RNs to engage in team based nursing care delivery to 1 or 2 intensive care patients. These intensive care patients must be allocated according to the selection guidelines.
- The selection guidelines are explicit in order to minimise subjective decision-making by the potential variety of staff that can make decisions regarding staff allocation. This will also ensure consistency amongst participating pilot sites.
- No new admissions to Intensive care will be immediately or received or cared for by an EEN until the patient is fully assessed by medical staff and deemed appropriate to be cared for by an RN and EEN working in partnership, by in charge nursing staff.
- The NUM or Nurse Manager of Intensive Care will always have the discretion to adjust a model of care if clinical conditions dictate, in consultation with the intensive care team leader.

Escape Clause
- If ICU status is not appropriate for the primary model currently in use consider swapping to a secondary model and if still not appropriate, seek further advice from Nurse Manager regarding pilot strategy.
- If the model of care is frequently changing e.g. more than once in an 8-hour shift, advice should be sought from the Nurse Manager regarding the pilot strategy.
- Grouping of patients for convenient staff allocation to facilitate a model of care should not be achieved by moving critically ill patients.
These are statements that reflect our unit’s needs regarding patient and staff safety, and the delivery of high quality nursing care.

**Patient Selection Guidelines**

**Unit Rules**
- Care delivery is a partnership between an RN and EEN. The EEN is under the supervision of the RN.
- The EEN is not to be allocated a sole patient load.
- Employed Monday - Friday, morning shifts until review at month 4.
- Support – An access nurse or team leader without patient care responsibilities must be available to provide support to the EEN and RN.
- This may involve the use of other staff: nursing educators, clinical nurse consultants, nursing unit managers, research nurses (that are able to work clinically or supervise in the clinical area) – this group must inform the ICU team leader nurse of availabilities and changes.
- Staff meal relief will continue to be attended by RNs.
- EEN staff will not carry the DD/S8 keys, only the in-charge nurse or an RN delegate.
- EENs will team nurse only with named or allocated mentors on all occasions.
- EENs will not participate in the Cardiac Arrest Team.

**Orientation and Preceptorship**
- The EEN will have one orientation day with the Clinical Nurse Educator and then three buddy/supernumerary days working with an RN with one ICU patient.
- The EEN will be preceptored each shift by one of 4 nominated RNs for a four week period to contextualise their skills, become familiar with routines, policies and procedures and complete an education plan. Further competencies to complete will be provided beyond this period.
- Beyond 4 weeks the EEN will work in partnership with an RN to deliver care for the duration of the pilot program. The EEN at all times remains accountable for their own practice.
- The preceptor RNs must be familiar with the orientation and competency/skills package for the EEN and have a sound understanding of the scope of practice of the endorsed enrolled nurse.
- Preceptors must work within the pilot program guidelines and can refer to the resource folder for further information.
- Preceptors must have completed the hospital based Preceptor Program

**Education Plan**
- Compulsory/mandatory education to be attended prior to commencement in ICU, inclusive of basic life support, infection control, fire, manual handling and occupational health.
- Unit orientation and preceptorship of 4 weeks encompassing a specifically planned program for EENs.
- Competencies on medication management, CVC management, care of the sedated patient with an artificial airway, respiratory management including anatomy & physiology, non invasive ventilation, tracheostomy management with competency assessment.

- Completion of a modified skills package.

**Preceptors & Unit Staff**

- All preceptors and unit staff will require in-service to clearly identify appropriate and inappropriate roles and responsibilities when working with EENs in ICU.

**Commencement Plan**

- Following successful interview mid October, pilot EENs would be given the medication package, and relevant education packages to complete prior to commencing employment.

- Upon starting, a 4-week theory/practice in ICU orientation program inclusive of some supernumerary time with preceptors will follow.

- An initial appraisal within 4 weeks of commencement and a performance appraisal at completion of the program will occur with the ICU nursing unit manager or clinical nurse educator. (appraisal proformas will be provided by the pilot program team).

- Each mentor/preceptor should complete an evaluation form (an appropriate evaluation form will be provided by the pilot program team).

**EENs are able to assist in the care of:**

*(General guide)*

- Stable ventilated patients (hence not multi-organ failure).

- Stable tracheostomised patients (i.e. not a new tracheostomy e.g. surgical or percutaneous tracheostomy for the first 24 hours).

- Non ventilated patients

- Infusion administration via peripheral IV route using infusion pumps

- Arterial lines (dependent on haemodynamic stability versus instability)

- Stable cardiac rhythm

- Non Invasive Ventilation/mask

- FiO2 < 40%, PEEP < 10cmH2O, stable (not acutely desaturating when immediately off therapy)

- CVC care – as per St Vincent’s policy.

- Cardiovascular support.

- NG feeding

**EENs in ICU are unable to directly care for:**

*(within scope of practice)*

- ICP/EVD
- Immediate post operative cardiothoracic surgery patients
- IABP
- Pulmonary Artery Catheters
- PICCO
- Pacing
- IAP-intra-abdominal pressures (but can assist in performing task)
- ECMO
- CRRT (Continuous Renal Replacement Therapy)
- Arrhythmia (unstable/acute)
- New admissions until patient is fully assessed and deemed appropriate to be cared for by an RN and EEN working in partnership by nursing team leader.
- IPPV
- Ventilator parameters and settings.
- Care and repositioning of ETT
- TPN administration

For additional Information – refer to the pilot program resource folder.

Statement of Suitable Duties
- The list of duties outlined below delineates a collective of potential tasks that may be attended under either direct or indirect supervision from a registered nurse. Thus, it is explicit that care delivery to two patients is via a team-based approach, where upon the RN is ultimately responsible for the care of the two patients.
- The list of duties is dynamic and in no way limits what an EEN may be recognised as capable of attending within their scope of practice.
- Perform BLS, and assist with patient resuscitation under the supervision and direction of an RN.
- Assist with fundamental cares of patients in the Intensive Care Unit, including basic hygiene & washes, mouth, eye and pressure area care.
- Patient observations including temperature, pulse, respiratory rate, non invasive BP or invasive BP.
- Receive blood for blood gas analysis – attend analysis (prior in-service regarding use of blood gas machine to be attended – competency attended).
- Perform tracheostomy care including suctioning, cuff pressure measurement, dressings, inner cannula change, and change securing device with the assistance of an RN. All cares performed according to unit policy.

- Administer approved medications with the exception of inotropes, vasopressors and schedule 8 medications.

- Medication administration via all usual routes (O, IMI, IVI via peripheral line, SL, SC) with the exception of epidural, intrathecal and intracranial routes.

- Check narcotic infusion with RNs.

- Assemble the equipment for preparation of infusions, e.g. nor adrenaline, dopamine etc under the supervision of a registered nurse prepare/check infusions.

- Assemble IV therapy equipment.

- Care of a patient with an arterial line and CVC following successful completion of relevant competency.

- Care of the NIV patient following the successful completion of relevant competency.

- Report writing within the EN scope of practice.

- Manual handling including patient transfer, lifting & moving under the direct or indirect supervision of an RN and within the policy and procedural guidance of the ICU.

**Definitions**

All staff involved must be apprised of the following definitions in order to function appropriately within any of the team based models of care:

- Accountability, Delegation, Supervision, Direct Supervision, Indirect Supervision and Responsibility.

Please refer to the resource folder.
MAJOR NON METROPOLITAN HOSPITAL

The pilot program at a Major Non Metropolitan Hospital will be conducted in a slightly different way to the other pilot sites. The Hospital has a small number of ICU beds and would be unable to accommodate more than one EN in the pilot program. There is also some uncertainty of having sufficient patients who would be suitable to be cared for within the pilot program. Therefore, the pilot program will involve a rotation of 2 or 3 ENs currently working in the high dependency unit, through the intensive care unit, throughout a roster period.

This proposal will enable some of the ENs who are already working in HDU to experience patient care delivery in the ICU and will provide opportunity for those ENs to support each other in the pilot program.

The ENs are already part of the multidisciplinary team (ICU and HDU are staffed by the same RNs and medical staff/allied health staff) and the RNs are already aware of those aspects of care that can be undertaken by ENs.

**Model of Care 1**

The model that has been suggested for use in the ICU of this Major Non Metropolitan Hospital will consist of the following nurse to patient ratio: 1RN + 1EN: 2 ICU patients (1 RN and 1 EN sharing the care of two stable patients)

Patients must be located next to each other and both patients must have been stable for at least a 24hr period prior to allocating according to this model of care.

**Model of Care 2**

The default model of care that has been suggested for use in this ICU consists of: 1 EN assisting a number of RNs to deliver patient care (1:1 RN to patient ratio will be maintained) or EN works in HDU as normal.

This model will be utilised when there are no suitable ICU patients for the allocation of Model 1.

The ENs who would participate in the pilot program do not currently have medication endorsement but will be undertaking the course prior to the pilot.

**Unit Rules**

- Care delivery is a partnership between an RN and EN. The EN is under the supervision of the RN.
- The EN is not to be allocated a sole patient load.
- Employed Monday - Friday, morning shifts until review at month 4.
- Support – An access nurse or supernumerary team leader, without patient care responsibilities, must be available to provide support to the EN and RN.
- This may involve the use of other staff: nursing educators, clinical nurse consultants, nursing unit managers, research nurses (that are able to work clinically or supervise in the clinical area) – this group must inform the ICU team leader nurse of availabilities and changes.
- Staff meal relief will continue to be attended by RNs.
• EN staff will not carry the DD/S8 keys, only the in-charge nurse or an RN delegate.

Orientation & education plan
The Major Non Metropolitan Hospital HDU currently has an orientation program for Enrolled Nurses who commence work there. This program will be adapted for use in the pilot program.

An education program will build on the skills and knowledge that the ENs already have and application of these in the ICU setting e.g. meeting the hygiene needs of an ICU patient. It is anticipated that the majority of RNs working in the ICU will be involved in working with the ENs in the pilot program.
Appendix 3: Position Description for pilot programs

POSITION DETAILS

Position Title: ENDORSED ENROLLED NURSE
Reports To: Director of Nursing through the Nursing Unit Manager
Division: (Please insert relevant division)
Award: Public Health System Nurses’ and Midwives’ (State) Award – Endorsed Enrolled Nurse
Hours per week: 38 hours per week
Contract type: Temporary Full-Time for 6 months secondment
Date: September 2007

MAIN PURPOSE OF POSITION

In a multidisciplinary team environment and in partnership with the registered nurse, the endorsed enrolled nurse (EEN) provides safe, patient-centred effective nursing care for patients with acute medical and surgical disorders in accordance with the relevant legislation, organisational policies and procedures and professional standards of practice.

The EEN will be given the opportunity to acquire relevant educational and clinical experience to care for patients in the Intensive Care Unit in partnership with RNs.

KEY ROLE AND RESPONSIBILITIES

Works in partnership with the registered nurse to provide a safe standard of nursing care to patients.

Implements delegated nursing activities that assist in meeting patient needs.

Recognises and reports changes in individual/group behaviour.

As a member of the health care team, the EEN assists in the planning, delivery and evaluation of nursing care to the level of their competence and responsibility, in collaboration with the registered nurse.

Clarifies instructions to achieve safe outcomes and maintains interdependent relationships with the registered nurse and healthcare team.

The EEN uses and promotes effective oral and written communication in order to work with patients, clients, visitors and a range of professionals such as nursing staff, allied health, medical staff and support services. In addition the EEN uses effective written and verbal skills to communicate, negotiate and to organise their workload in conjunction with the registered nurse.

Ensures all their nursing documentation is legible, dated, signed and meets all legal and ethical requirements.

Maintains confidentiality and privacy of patients at all times in accordance with the Code of
Conduct – NSW Health (Policy Directive PD 2005 _626)

Demonstrates respect for the values, customs and spiritual beliefs of individuals and groups. Acts in such a way that the rights of individuals and groups are protected in all circumstances and outcomes of actions are safe and effective.

Practices within the parameters of the endorsed enrolled nurse scope of practice, demonstrating knowledge of role limits and maintains professional knowledge and skills.

Practices within the policy directives and guidelines issued by NSW Health and complies with AHS and facility policies and protocols.

Accepts responsibility for own actions and omissions in the provision of patient care.

Demonstrates commitment to infection control within the intensive care unit, occupational health, safety and rehabilitation principles and maintains nursing standards and patient services in conjunction with the registered nurse to a level which ensures patient safety and quality of care.

Displays initiative and willingness to learn in the performance of all assigned duties.

Regularly evaluates own work performance with the registered nurse and/or Nursing Unit Manager.

Attends all mandatory training and takes advantage of opportunities for learning by updating knowledge and skills through education courses, seminars and in-service.

Participates in quality improvement activities related to the unit.

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**KEY RELATIONSHIPS**

The EEN will be required to establish and maintain effective working relationships and communication with the following people and groups:

- Nurses and other members of the health care team
- Clinical Nurse Educators
- Nurse Educators
- Nursing Unit Managers/ Nurse Managers
- Other hospital staff
- Patients and their significant others

**CHALLENGES/PROBLEM SOLVING**

- Dealing with acutely ill people and their concerned friends and relatives
- Working under the supervision and direction of, and in partnership with, a registered nurse
- Learning how to use skills and knowledge in a new environment
- Learning how to use a range of new technology
JOB DEMANDS

EENs must be able to meet the physical and psychological demands as listed on the attached checklist.

DECISION MAKING

Decisions are made based on the level of training and always in consultation with a registered nurse.

Essential criteria

- Current Authority to Practice in NSW as an Endorsed Enrolled Nurse
- Minimum of 3 years current experience in an acute care setting
- Demonstrated knowledge of basic assessment skills
- Demonstrated effective communication and interpersonal skills
- Demonstrated commitment to working effectively within a team to provide quality nursing care
- Demonstrated commitment to maintaining and developing professional growth

VERIFICATION

This section verifies that the position holder and supervisor/manager have read the above position description and are satisfied that it accurately describes the position.

POSITION HOLDER

Signature................................................................. Date.....................................

SUPERVISOR/MANAGER

Signature................................................................. Date.....................................
**JOB DEMANDS CHECKLIST** The purpose of this form is to describe the physical and psychological risk factors associated with the job. Applicants must review this form to ensure they can comply with these requirements.

<table>
<thead>
<tr>
<th>Physical Demands of Job Tasks</th>
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<th>F</th>
<th>C</th>
<th>R</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td>Kneeling/Squatting</td>
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<td></td>
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<td>X</td>
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<tr>
<td>Leg/Foot Movement</td>
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<td>Hand/Arm Movement</td>
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<tr>
<td>Bending/Twisting</td>
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<td>Standing</td>
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<td>Driving</td>
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<td>Sitting</td>
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<td>Reaching</td>
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<tr>
<td>Walking/Running</td>
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<tr>
<td>Climbing</td>
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<td>X</td>
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<tr>
<td>Working at heights</td>
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<tr>
<td>Lifting/Carrying</td>
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<tr>
<td>Restraining</td>
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<tr>
<td>Pushing/Pulling</td>
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<td>X</td>
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<tr>
<td>Grasping</td>
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<td>X</td>
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<tr>
<td>Manual Dexterity</td>
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<td>X</td>
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</tbody>
</table>

**Sensory Demands of Job Tasks**

| Sight                       |   |   |   |   | X  |
| Hearing                    |   |   |   |   | X  |
| Smell                      |   |   |   |   | X  |
| Touch                      |   |   |   |   | X  |

**Psychological Demands**

| Managing high turnover of work |   |   |   |   | X  |
| Dealing with bodies after death eg. transporting to mortuary |   |   |   |   | X  |

**Psychosocial Demands**

| Tasks involve interacting with distressed people |   |   |   |   | X  |
| Tasks involve interacting with people with mental illness/disability |   |   |   |   | X  |

**Exposure to Chemical Hazards**

| Gases | Tasks involve working with gases |   |   |   |   | X  |
| Liquids | Tasks involve working with liquids which may cause skin irritations if contact is made with skin – e.g. dermatitis |   |   |   |   | X  |
| Hazardous Substances | Tasks involve handling hazardous substances including storage and or transporting |   |   |   |   | X  |

**Working Environment**

| Sunlight | Exposure to sunlight |   |   |   |   | X  |

**Accident Risk**

| Surfaces | Tasks involve working on slippery or uneven surfaces |   |   |   |   | X  |
| Housekeeping | Tasks involve working with obstacles within the area – bad housekeeping |   |   |   |   | X  |
| Manual Handling | Tasks involve manual handling |   |   |   |   | X  |

**Biological Hazards**

| Biological Products | Tasks involve working with blood/blood products/body fluids |   |   |   |   | X  |