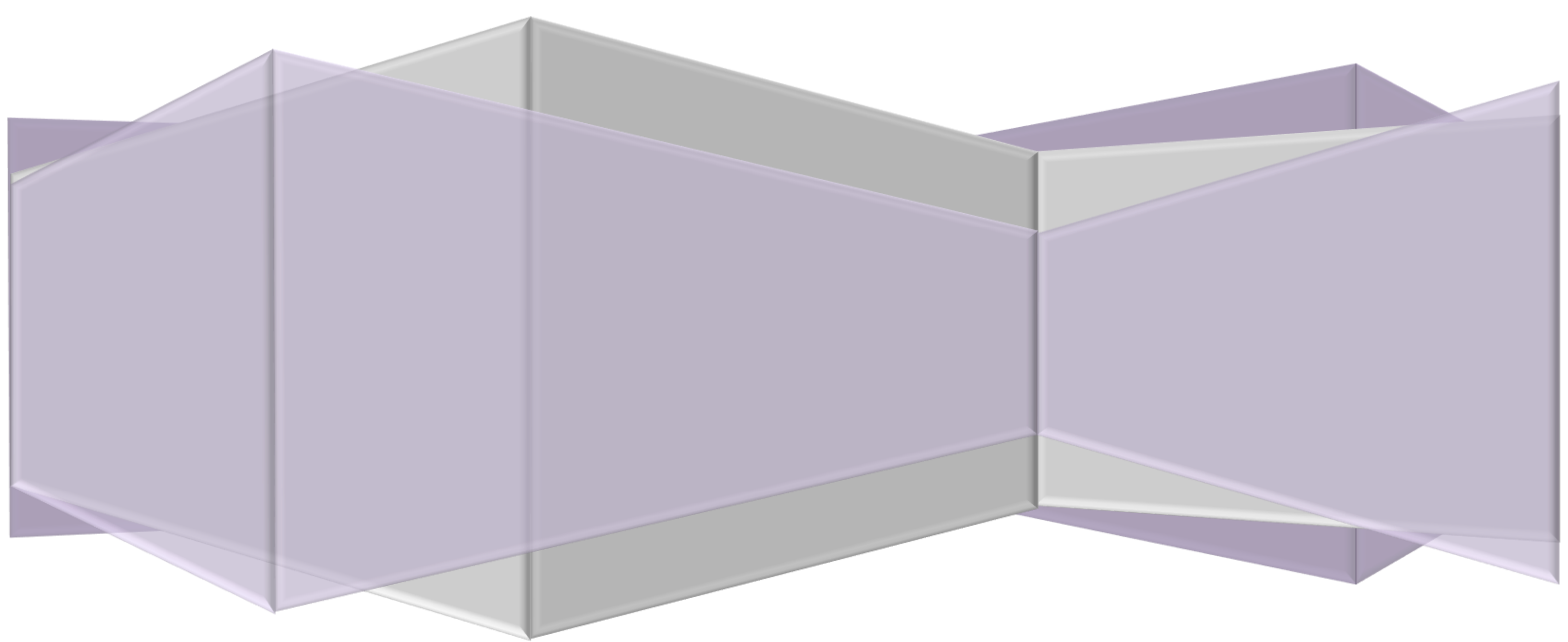
Critical Care Networks-National Nurse Leads

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



Version 3 –August 2024

Introduction and Development

Critical care is a multi-professional, multidisciplinary service which must deliver an integrated care pathway focused on patient need whilst addressing quality, governance and supporting optimal outcomes for patients.[1] It provides specialist expertise and facilities to manage and monitor patients with potentially life-threatening conditions, whose needs cannot be met in the ward environment. To care for such patients effectively and safely requires specialised skills and expertise of medical and nursing staff experienced in the management of these problems.

To minimise risk to patient care standards, Trusts are required to optimise resource and staff allocation to support different clinical areas where there are staff shortages. This may entail Critical Care Nurses (CCN) working in unfamiliar settings with unfamiliar patient population such as wards and ED. In organisations with more than one critical care unit such as specialty burns, neuro, cardiac and paediatric, CCN may be required to work in another unit.

In principle, moving critical care nursing staff to a different clinical area should be a short-term re-deployment for a period of 12 hrs or less to cover unplanned shortage of staff or high demand and should balance the relative risks of ensuring patient safety across the organisation. It is recommended that the process outlined in Appendix 1 should be followed if this is required to ensure there is enough resource in Critical Care to maintain patient safety for this highly vulnerable patient population.

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

A small working group initially developed these best practice principles in response to feedback received from Critical Care units as concerns had been raised regarding the frequent movement of critical care staff to ward areas which they reported as potentially unsafe. Key considerations for safe short-term re-deployment of staff and associated risks are identified further in the document. This document provides an objective tool that would support a standardised approach to risk assessment and decision making should a request be made to move critical care staff to other areas of the hospital /organisation. This document has been shared with CC3N group members for feedback and subsequent endorsement.

This Guidance has been updated in 2024 by Karen Wilson – Chair of CC3N & Lead Nurse for Cheshire and Mersey Critical Care Network, Michaela Jones Lead Nurse and Associate Director NW London Critical Care Network and Sarah Entwistle, Innovation and Nursing Lead, East of England Critical Care Network

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Minimum Standards for Safe Staffing

These best practice principles provide a framework to ensure that staffing ratios in Adult Critical Care do not compromise the safety and quality of care provided. This document is intended to assist in the decision to move staff from critical care, the audience includes.

- Senior Nursing Management with Site responsibility
- Adult Critical Care Unit Managers
- Critical Care Unit Shift Co-ordinators

The nurse staffing standards published in the Guidelines for the Provision of Intensive Care version 2;1 (2022)[1] cite the Core Standards for Intensive Care Units[2] and the Adult Critical Care Clinical Reference Group Service Specification[1] provides standards for nurse staffing ratios to ensure a positive impact on both quality of care and safety for critically ill patients.

- **Level 3 patients** (level guided by ICS levels of care[3]) require a registered nurse/patient ratio of a minimum **1:1** to deliver direct care

- **Level 2 patients** (level guided by ICS levels of care[4]) require a registered nurse/ patient ratio of a minimum **1:2** to deliver direct care

- **PLUS,** a Clinical Co-ordinator (this person is not rostered to deliver direct patient care to a specific patient) 24/7 [4]

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

As well as measuring individual patient dependency, other aspects of nursing care should be taken into account in determining nursing requirements:[5]

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

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[1] Faculty for Intensive care medicine (2022) *Guidelines for the Provision of Intensive Care Services (version 2.1)*,-Available at: Guidelines for the Provision of Intensive Care Services | The Faculty of Intensive Care Medicine (ficm.ac.uk)

[2] Faculty for Intensive Care Medicine (2013) Core standards for intensive care units. Available at: Intensive Care Society | Core Standards for ICUs (ics.ac.uk)

[3] The Intensive Care Society (2021) *Levels of Adult Critical Care* (version 2) Available at: Intensive Care Society | Levels of care (ics.ac.uk)

[4] BACCN. (2009) *Standards for Nurse staffing in Critical Care* BACCN_stafffing_doc_08_revision-12-09_00.indd

To note:
NICE SG1 - Safe staffing for nursing in adult inpatient wards in acute hospitals[5] and the **Safer Nursing Care Tool**[6] (SNCT) are not designed for Critical Care areas (Both L3 Intensive Care & L2 High Dependency)

Risks to Consider

There are significant risks associated with moving specialised staff to different clinical areas.

- Different electronic patient records / system outside of critical care.
- Critical Care nursing staff may have little or no experience working as qualified nurses on general wards and /or management experience.
- Critical Care nursing staff re-deployed to another critical care unit may have little or no experience working in the specialty for example ED.
- Direct correlation has been established between nurse staffing levels in critical care and the incidence of adverse events.[7]
- A reduction in critical care nurses on shift will impact on the opportunity for junior CCN to work with senior CCNs caring for more complex patients with less exposure and supervision in practice to complete and sign off National Critical Care Nursing Competencies (CC3N 2015)[8] This is essential to develop a safe and competent workforce.

Each occasion that staff members are moved must be clearly risk assessed and monitored in line with local Trust Policy, and if recurrent, should be investigated to see if remedial or supportive action is required.

The RCN provide advice for Staff being moved from their normal working environment.[9]

Employers can usually ask specialist nurses to work on wards, however if the specialist nurse has any doubt about their competence they must decline and give reasons why. For example, they may state that they have not worked on a ward for over 10 years if ever, so are not up to date, or that they would be working outside their professional code. If the nurse does not feel competent to work in this area they should discuss their concerns with the manager, document them and have the option to call the RCN for advice.
If the specialist nurse agrees to move, they should start to collate evidence of how the move will impact on their own area of work in an attempt to prove that this way of managing staffing problems will only have a knock-on effect in other areas.

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[5] National Institute for Health Care Excellence (NICE) (2014) *Safe staffing for adult inpatient wards in acute hospitals – SG1*. Overview | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE
[6] National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for urgent and emergency care.
[7] Coomes, M. & Lattimer, V. (2007) Safety, effectiveness and costs of different models of organising care for critically ill patients: *International Journal of Nursing Studies*; 44 (1)115-129

[8] CC3N (2015) National Critical Care Nursing Competency Framework. Available at Step Competency Framework (cc3n.org.uk)

[9] RCN (2024) *Redeployment and unsustainable pressures*. Available at Redeployment and unsustainable pressures | Royal College of Nursing (rcn.org.uk). Accessed 21/08/2024

Staff Mental Health and Wellbeing

There is documented evidence from critical care networks (nationally in 2023)[10] that being asked to work on other wards is a significant contributor to stress experienced by adult critical care nurses and the impact of this on stress and staff retention should be recognised when staff deployment is planned locally. There is strong evidence that creating the core conditions to ensure workplaces are safe and supportive improves staff experience and patient care. The Intensive Care Society have created a workforce wellbeing best practice framework to guide senior hospital management and the critical care teams on ways to provide the best possible employee experience within critical care.[11] This framework should also be used in relation to staff moves.

In order to support staff that have been moved to other wards, Professional Nurse Advocates (PNA) should be given protected time to enable them to provide nurses with the much-needed support that they may need following re-deployment to another area. Further information and recommendations on the PNA role and the role within critical care can be found at

https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate/

https://www.cc3n.org.uk/professional-nurse-advocate.html

(add link to new PNA role profile once published)

Peer support is another defined wellbeing role within critical care. Peer support offers a systematic, strategic approach to intervening to sustain staff who are coping well and to provide initial support those who are struggling.

The Intensive Care Society provide training for the peer support role and have produced a peer support strategy this can be found at:

Intensive Care Society | Peer Support (ics.ac.uk)

Best Practice Recommendations

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

Organisation (Person responsible for decision to move staff)
• Risk assessment completed and internal process followed. • Member of staff must be able to return to critical care at <1 hours' notice • Orientation to new area / supervision. • Ensure staff member is not asked to take charge of another area unless a documented risk assessment deems this the lesser risk to the patients. • Ensure staff member is not asked, or expected, to provide care outside their area of competence; in particular drug administration may be an area of concern in an unfamiliar care area[12].

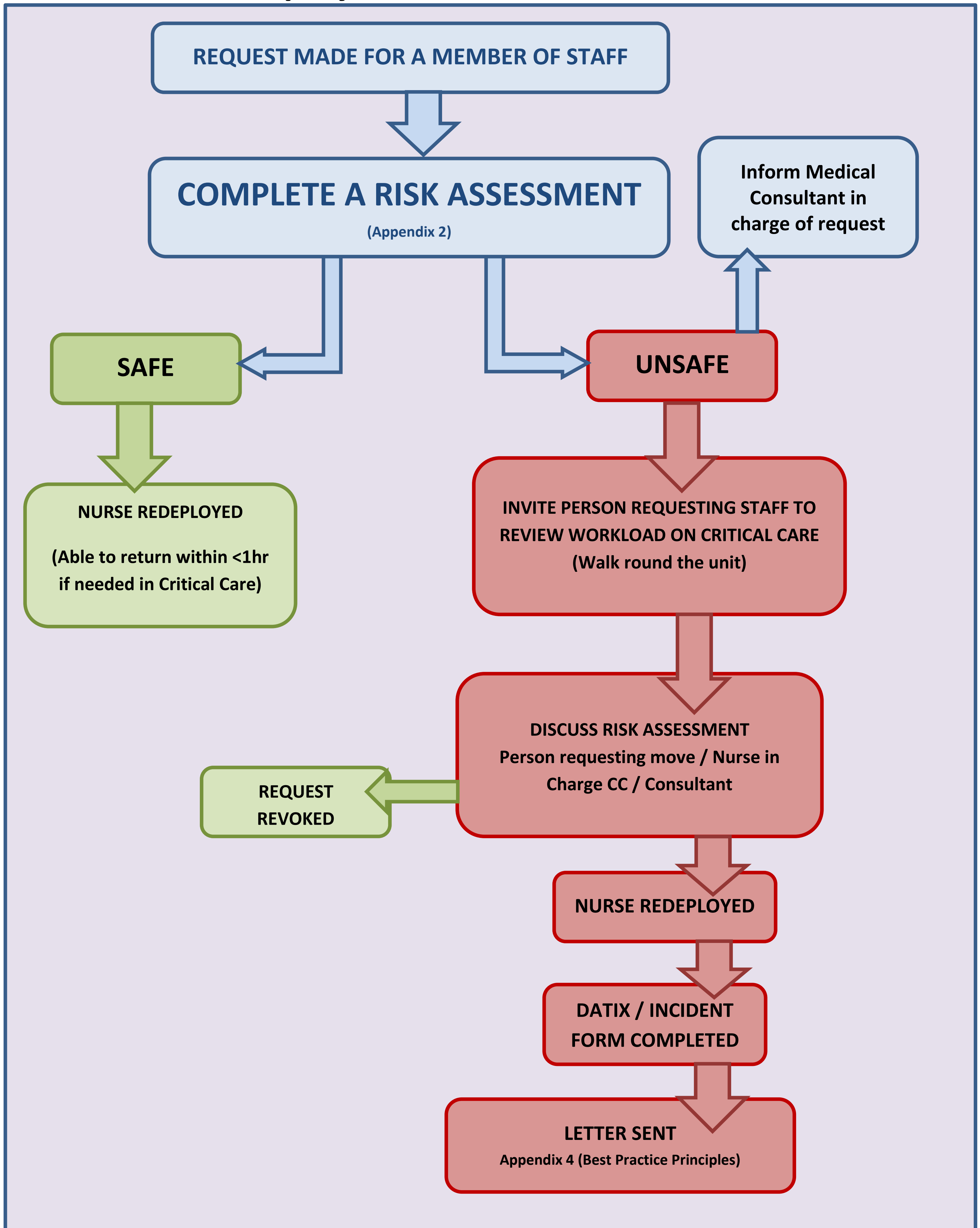
[10] Critical Care Nurse Leads (CC3N) (2023) *National Critical Care Retention Survey report*.
[11] Intensive Care Society (2021) *Workforce Wellbeing best practice framework*. Available at: https://ics.ac.uk/resource/wellbeing-framework.html
[12] Nursing and Midwifery Council (NMC), (2015). *The* code*: professional standards of practice and behaviour for nurses and midwives* The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

• Training (Critical Care nurses may not use the same patient records system / electronic systems used in the different area). • Staff may not be aware of general ward processes to support patient flow. • Ensure Staff Member has a post shift check in by a member of staff who is responsible for staff wellbeing for example PNA or peer supporter
Area (Shift Leader Critical Care)
• Risk assessment completed and process followed. • Redeployment of Bank / agency staff first. • Monitor occurrence and staff redeployed. • Ideally staff with recent ward experience in the same organisation should be considered before those who may not have worked in the area requiring support. • Provide support for staff members – Restorative clinical supervision, in-shift and post shift wellbeing checks with a PNA and / or peer supporter.
Individual
• Work within area of competence.[13] • Access training when available. • Ask for wellbeing support when needed and attend Restorative Clinical Supervision / post shift wellbeing checks with PNA and / or peer supporter.

Allowing Critical Care to manage their staffing flexibly helps managers provide a better resourced service and benefits nurses enabling them to work in their chosen speciality. The use of variable shift patterns / self-rostering and flexible use of annual leave provides options for workload flexibility. Moving staff to a different area reduces the ability to provide a flexible workforce in order to provide safe staffing levels in critical care.[13] However, there is an acknowledgment in times of crisis this is necessary to provide safe care for all patients, this document ensures that safe staffing levels in critical care units are not compromised.

[13] RCN (2003) *Guidance for Nurse staffing in critical care*.

Redeployment of Critical Care Staff



Appendix 2

Critical Care Networks-National Nurse Leads

Critical Care Staffing Status / Risk Assessment

To be completed by co-ordinator for all movement of staff to any ward area. This is a template that can be used if not one already in place at own Trust. This document can be used to support the critical care team assessment of safety to facilitate discussions re the request.

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

Number of Staff on duty in Critical Care			
Registered			
Non-registered			
Level of Care for patients on the Unit (number of patients)			
Level	**Number of Patients**	**Calculate**	**Number of nurses required**
Level 3 (1:1)		=	
Level 2 (1:2)		Divide by 2	
Delayed Discharges:			
Level 1			
Level 0			
		Co-ordinator	
		Units with greater than 10 beds +1 member of staff	
		TOTAL	

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

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

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

Process to follow when completing risk assessment:

1. Compete number of nurses on duty
2. Detail number of patients and their level of care [4]
3. Calculate number of nurses required as per recommended ratio:
   Level 3 (1 nurse: 1 patient), Level 2 (1 nurse: 2 patients) [4]
4. Calculate staffing levels and capability to help

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

5. Inform person requesting staff if able to support

Process to follow when risk assessment is not adhered to:

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

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

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

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

5. If the situation cannot be resolved with senior management, Consultant and executive involvement then coordinator / nurse in charge must complete DATIX incident report and detail in writing the situation.

The letter (Appendix 4) **may** be used (or an adapted version) as agreed by local unit policy and copies sent to:

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

Trust Logo

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

Time: _ _: _ _

Dear Sir / Madam

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

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

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

Yours sincerely

Copies to:

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

Adapted: from Doncaster and Bassetlaw Hospitals Teaching Hospitals

2024 Critical Care Networks National Nurse leads (CC3N)
Review Date: August 2026

Whilst this document is applicable in England, other UK countries are welcome to adopt it as required.

Comments regarding this document can be made via:

https://www.cc3n.org.uk/contact-us.html

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