

HHR Demonstration Project  
April 2009

RN/RPN Utilization  
Toolkit Project





Generously funded by the Nursing  
Secretariat, Ontario Ministry of  
Health and Long-Term Care



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## Acknowledgements

The Project Steering Committee would like to thank the Nursing Secretariat of the Ontario Ministry of Health and Long-Term Care for their generous funding of this project. Our gratitude is extended to the nurses who completed the clinical reviews and those who completed a questionnaire or participated in the focus group interviews. In addition, our sincere appreciation is extended to the health care organizations that supported the reviews, focus group interviews, and questionnaire completion. We would also like to convey our humble gratitude for contributions by Alex Kiss, Patricia Lyon, Ross Riggs, and Salin Kim. Finally, we would like to acknowledge the work of the College of Nurses of Ontario and Linda Lee O'Brien-Pallas.

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## 1. Introduction

Nurse staffing is critical to patient safety, health and well being, as nurses deliver more individual health care than any other healthcare provider (CHSRF, 2006). Appropriate staffing is not dependent merely upon the number of nurses providing care on a clinical ward, but involves having nurses with the right skills, experience, education, working within the right type of staffing model and the right mix of other healthcare providers (CHSRF, 2006).

Across Canada, provincial governments are facing record deficits and health care funding reductions. Nursing resources are frequently scrutinized for potential cost savings in times of budget constraints. As a result, pressure is placed on nursing administration and managers to consider various staff mix changes, including alternations in RN/RPN ratios as well as the addition of unregulated workers.

Nursing leaders require evidence-based tools and processes in order to formulate and justify staff mix decisions that meet patient care needs and are fiscally responsible. The College of Nurses of Ontario's (2008) three-factor framework on the Utilization of RNs and RPNs emphasizes the integration of patient, environment, and nurse factors in determining the appropriate category of nurse caregiver.

This toolkit is designed to assist decision makers with the complex task of matching patient care needs, nursing human resources, and the environment. It is comprised of two key tools, the Patient Care Needs Assessment (PCNA) and Unit Environmental Profile (UEP). These tools are intended to be used in conjunction with the specific consensus-based review process as described in this document. Application of the tools and process will assist nursing leaders who are contemplating staff mix changes as well as those who are re-evaluating their current staff mix, for example when there are changes in the patient population or environmental context.

The consensus-based review process includes the staff nurses caring for the patients in the clinical unit as well as key unit nursing leaders. Involvement of both front-line staff and nurse leaders in determining patient care needs facilitates a comprehensive and shared understanding of the range of needs, how they relate to RN/RPN utilization and enhances the acceptance of potential changes in skill mix.

Utilization of this toolkit requires a clear understanding of the factors that impact skill mix decisions and how they inter-relate. For example, knowledge of current scope of practice for both RNs and RPNs; awareness of what is currently happening in the health care environment; labour relations considerations; workforce demographics; attrition; and regulatory changes can all impact the appropriateness of skill mix changes. Ultimately, it is essential that leaders have knowledge and ability to measure and monitor trends in patient, nurse, team, and system outcomes in order to evaluate and defend their decisions.

## 2. Development of the Toolkit

In 2007, the Ontario Ministry of Health and Long-Term Care identified the need for long range health human resource (HHR) planning. In response, the Nursing Secretariat funded 17 Demonstration Projects. The “RN/RPN Utilization Tool-Kit Project” was one of the projects selected for funding. The partnership of hospitals for this project included the lead, Sunnybrook Health Sciences Centre (SHSC), and University Health Network, St. Michael’s Hospital, Hamilton Health Sciences, North York General Hospital, Scarborough General Hospital and Kingston General Hospital. The mix of academic and community hospitals in southern Ontario offered a broad scope for the project focusing on medical-surgical units.

The purpose of the demonstration project was to produce a toolkit based on the PCNA and UEP to support nursing staff mix decision-making for medical-surgical inpatient units in both large and small hospitals. To achieve this, the project involved the systematic assessment of the reliability and validity of the PCNA, the validity of the UEP, and the procedure for conducting a unit review. The project also included a description of the processes through which nursing leaders would utilize the data from the unit reviews in making nursing staff mix decisions.

A descriptive exploratory design using a combination of quantitative and qualitative approaches, and a convenience sample of 36 medical/surgical units across seven acute care hospitals was used. Reviews of patient care needs were conducted on each participating unit on two separate occasions, using a consensus-based approach. Information about unit characteristics was collected by survey following the patient reviews on each unit. Debriefing meetings were held with unit leaders to review patient and unit data and explore ways in which these data could be used to support nursing staff mix decision-making. Focus groups with review participants were conducted following the reviews to assess participants’ responses and perceptions of the review process.

The research supported the validity and reliability of the Patient Care Needs Assessment tool and the consensus based process for conducting patient care reviews. While the analysis of the data evaluating the Unit Environmental Profile tool provided limited evidence of the tool’s face validity and feasibility, it did indicate that the respondents were reasonably satisfied that the UEP tool was capturing some of the elements of interest to determine environmental complexity. The results also showed that managers had some understanding about how to use the PCNA data but were less clear about how to integrate UEP information into nursing staff mix decisions.

### **3. Description of Tools and Process**

The RN/RPN Utilization toolkit has four components. It is designed to assist decision makers with the complex task of matching patient care needs, nursing human resources, and the environment in acute care medical/surgical units.

#### **3.1. Patient Care Needs Assessment Tool**

The Patient Care Needs Assessment (PCNA) tool (see Appendix A) is used to provide a composite picture of the nursing care needs of patients on an inpatient unit. The tool assesses each patient's needs for nursing care based on the stability, complexity, and predictability of the patient's condition and their level of risk for negative outcomes. The PCNA is structured so that responses to questions about specific elements of the patient's situation and plan of care build to an assessment of their levels on each of these four dimensions.

Evaluation of the PCNA has shown that it is effective in discriminating among patients with respect to these four dimensions. The College of Nurses of Ontario's three-factor framework (2008) suggests that RPNs are prepared to care autonomously for less complex, more stable and predictable patients who have less risk for negative outcomes, while the greater depth and breadth of the knowledge base of RNs is required to manage the care of more complex, less predictable, higher risk patients.

The PCNA is completed by a panel of nurse reviewers for each patient on the unit using a consensus-based review process. The panel consists of the patient's assigned nurse, the manager and/or team leader, and the advanced practice nurse, clinical nurse specialist, or clinical educator associated with the unit. A nurse facilitator who is not part of the unit clinical team leads the review panel. The review panel may also wish to assign a designated scribe to document responses to the PCNA questions.

#### **3.2. Patient Care Needs Assessment Review Process**

The characteristics of the review process are based on the belief that through respectful engagement between front line nurses and nursing leaders on the unit the needs of patients can be articulated and agreed upon using the tool. The need for guided facilitation through each question is paramount in order to achieve collaboration and to reach consensus on the responses and ratings.

In the review the tool is applied systematically to each of the patients on the unit. This involves the facilitator reading each item aloud and inviting input and discussion from the review team members regarding an appropriate response to the item. Through discussion, the group comes to consensus on the scoring for each item on the tool. The consensus response to each item is documented on the PCNA tool by the facilitator, or by an assigned scribe.

A typical review for a unit of 30 medical-surgical inpatients requires six to seven and a half hours.

The clinical review team is comprised of 2 – 3 “external” participants and 2 – 3 “internal” participants. External participants include nurse leaders external to the clinical unit. Internal participants include the nurse caring for the patient that is being reviewed and nurse leaders such as the manager, clinical educator, and/or charge nurse.

It is strongly recommended that the external review team members remain consistent within an organization. Expertise in conducting and facilitating the reviews develops with experience. The knowledge gained about the subtle differences in patient populations and the impact this may have on staffing decisions is invaluable.

Advance preparation of staff and leaders is advised prior to the clinical review. Preparation includes communication about the roles of RNs and RPNs, the purpose of the clinical review, the tools, and the process. Advance communication and discussion with the unit staff is intended to clarify the project goals and objectives, provide an opportunity to address myths and misbeliefs about staff mix, and to review current information regarding RN/RPN scope of practice. Presentations at nursing councils, nursing newsletters, unit staff meetings, one-on-one discussions with staff, and e-mail notices may be utilized to prepare the front line staff for the reviews. Repeated communication may be necessary.

Providing information to the leaders as well as the front line staff is a key strategy for success. Preparatory information should include:

- Overview of the RPN diploma program curriculum
- College of Nurses of Ontario 3-factor framework for utilization of RNs and RPNs (College of Nurses of Ontario, 2008)
- Written articles, discussion at nursing council, meetings with the nursing leaders, meetings with staff nurses, and distribution of the tools

Clinical review leaders are advised to prepare for the role of facilitator through coaching, role modeling and sharing tips to maximize their ability to conduct the reviews according to the principles for achieving respectful engagement. External review team members should have a clear understanding of consensus-based decision-making.

Practical aspects of the preparation for each review include advanced booking for an additional nurse. The role of this nurse is to provide coverage for each of the nurses on the unit as they take turns participating in reviewing their assigned patients. A room should be booked for the review, catering arranged if required, and photocopies of the tools should be obtained (PCNA tool for each patient and each reviewer, list of definitions, and a copy of the UEP tool for the clinical manager).

It is important to have one person responsible for coordinating the review process on the day of the review. This can be the facilitator or another individual who is not part of the unit clinical team. The steps for conducting the review are as follows:

- I. Ensure that all review panelists are available.
- II. Establish the order in which the nurses on the unit will participate in the review. Identify the process that will be used for each nurse to hand over their assignment and how each nurse will be informed of their turn to participate.
- III. Arrange for the review panel members to have access to the patient's health record including the chart, medication profiles, kardexes, flowsheets, and shift report notes during the review.
- IV. Identify which member of the internal review team will review the chart when needed, and which member will review the kardex.
- V. Decide in advance the plan for seating, order of staff nurse participation, and breaks. It is helpful for the facilitator to sit across from the staff nurse as this enables direct eye contact and engagement of the staff nurse.
- VI. Review the Guidelines for Leaders (see Appendix B) prior to inviting the staff nurse to join the review team.
- VII. Using the introductory script as a guideline (see Appendix C), provide an overview of the project for each new nurse as she/he joins the review and explain the role of each member at the table including the scribe, if present
- VIII. Provide a copy of the PCNA tool and definitions to everyone. Review the definitions for stability, complexity, and predictability (see Appendix D) with the team members as needed to facilitate scoring.
- IX. Conduct each patient review by posing the questions in order to the internal review team members as a group (patient's nurse, unit nurse leaders). Provide time for response by the nurse and the internal review team members then check with everyone else at the table to see if they agree or if there is anything else to add. Do not skip questions or make assumptions. If there is disagreement among panel members regarding the appropriate response to an item, seek clarity or elicit additional detail by asking questions, summarizing or reading back the responses from other questions.
- X. Document each response on the PCNA tool.
- XI. As the review team completes the review on each patient group the patients into three categories based on the client continuum [Less complex, predictable, low risk for negative outcome(s) >>>> highly complex, unpredictable, high risk for negative outcome(s)]. (College of Nurses Practice Guideline for Utilization of RNs and RPNs, May 2008).

### 3.3. Unit Environment Profile Tool

The Unit Environment Profile (UEP) tool (see Appendix E) was designed to inform decision-makers of the complexities and dynamics of their clinical practice setting. Complementing the results of the Patient Care Needs Assessment (PCNA) reviews, the UEP tool is based on the understanding of the necessity to appreciate the context in which nurses practise and by so doing better inform the decisions regarding staff-mix. Supported by evidence from the literature (O'Brien-Pallas, Irvine, Peereboom, & Murray, 1997; College of Nurses of Ontario, 2008) the tool includes 41 items addressing personnel characteristics and unit characteristics.

### 3.4. Staff-Mix Decision Making

Nurse staffing, specifically the number of RNs in the staffing mix, as well as the experience level and knowledge/skills of nurses impact the effectiveness of surveillance, interpretation of cues and action required to rescue the patient from negative consequences (Clarke & Aiken, 2003). The optimal nurse staffing model ensures that there is enough RN staffing to provide effective surveillance. In addition the nurses caring for the patients should have the education level, knowledge and skills working with a specific patient population to interpret cues, and take appropriate immediate actions. Access to personnel who can assist in the appropriate intervention is also important to ensuring patient safety.

When making decisions regarding staffing and skill mix it is important to consider multiple factors. They include:

- Patient/family Care Needs
- Complexity of the Environment
- Nursing complement currently in place and any predicted changes
  - Years of experience
  - Knowledge and expertise
  - Ratio of novice to experienced staff
- Current context within your organization

Summarize the data from the Patient Care Needs Assessment and bring the information together with data from the Unit Environment Profile which includes information about the make up of Nurses on the unit.

Assemble the leaders that support the unit to review the information. It is helpful to include leaders who are involved in the practice and operations of the unit, including those who participated in the review and those who did not. After reviewing all the data determine if the leaders feel comfortable that the data reflects the patient population and the unit.

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If the leaders are comfortable with the data, the group may identify a number of possible changes to the staff mix and model of care that could be made. It is helpful to map out different models based on the PCNA data, environmental complexity data, and the nurse data to inform the discussion. Compare and contrast both risks and benefits to each model from a number of perspectives.

Elements to consider include:

- Workload
- Scheduling implications (including replacement plans)
- Continuity of care
- Costs associated with change
  - potential labor relations costs
  - professional development (educational materials for skill development, RN/RPN team building, and inter-professional collaboration)

Assess the leadership required to support the new model and establish the resources.

## **4. Critical Success Factors and Lessons Learned**

Once the team identifies the final model to implement it is important to identify the key outcome measures that will be used to monitor the impact of changes and evaluate the model. Evaluation measures should be robust and include nurse, patient and system outcomes.

Possible metrics could include:

- Pressure ulcer incidence rates
- Falls-related injury rates
- Patient satisfaction scores
- Hospital-acquired infection rates
- Nurse and team satisfaction
- Staff turnover rates
- Patient length of stay

Dedicating time to review what nurses do and know about the patients and families through the consensus based review process builds capacity through shared understanding of the nursing knowledge and skill, critical thinking and care planning that is involved in caring for the patients and families on that unit. Although staff nurses may be apprehensive about speaking in front of their manager and other nursing leaders before going through the review the benefit of engaging front line staff is emphasized as a critical success factor for adoption and successful implementation of change.

One aspect of nursing work that is not captured through the toolkit is the amount of time and physical demands associated with meeting the needs of patients. Traditional workload measurement processes are designed to assess the volume of work that patients' needs generate, and to estimate the time required to meet those needs. In

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applying the results of the toolkit to staff mix decision-making, it is important that this aspect of nursing work be integrated into the decision.

Additional uses of the tools and processes may also be identified in the future.

Therefore the PCNA might be adapted for, or integrated with procedures for guiding the daily assignment of nurses to patients. Since the CNO framework also emphasizes the knowledge, skill, and experience level of the individual nurse as well as the registration category, these factors would also need to be considered in matching individual nurses with patients. Similarly, the toolkit could be used to assist in determining appropriate staffing ratios; that is, the number and mix of patients assigned to each nurse, and the total nursing staff complement required on a unit.

Further use of the toolkit includes determining the supports that are required for optimal nursing practice and patient outcomes. For example, the toolkit could be applied as part of a comprehensive learning needs assessment for nursing staff. Because it facilitates the collection of data about the needs of the population of patients on a unit as well as the environmental supports available to the nursing staff, results could be used to inform development of educational programs that would match the requisite knowledge and skills to meet the needs of unique patient populations. Understanding the needs of patients, characteristics of nurses along with the supports and demands of the environment could also help to identify other enhancements such as the number and focus of nursing leadership roles or the addition of unregulated personnel.

The project team developed and tested components of the toolkit based on the College of Nurses of Ontario three-factor framework for utilization of RNs and RPNs. Results support the utility of the tools and procedures in informing nursing staff mix decision-making. Future research is required to evaluate the quality of decisions resulting from application of the toolkit, and to illuminate the processes through which nursing leaders can best translate the information generated through the tools into staff mix decisions.

## 5. References

Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Nurses Association*, 288 (16), 1987-1993.

Canadian Health Services Research Foundation [CHSRF] (2006). *Staffing for safety: A synthesis of the evidence on nurse staffing and patient safety*. Ottawa, ON: Author.

College of Nurses of Ontario (2008). *Practice Guideline: Utilization of RNs and RPNs*. Toronto, ON: Author.

O'Brien-Pallas, L., Irvine, D., Peereboom, E., & Murray, M. (1997). Measuring nursing workload: Understanding the variability. *Nursing Economics*, 15(4), 171-182.

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## 6. Appendix A - Patient Care Needs Assessment Tool

Date: YY/MM/DD	Patient # <input type="text"/> <input type="text"/>	Reviewer Initials: <input type="text"/> <input type="text"/>
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1. What issue(s) are important to this patient's care that currently need(s) to be addressed?			
2. Vital Signs:	Yes	No	Comments:
a. Have the patient's vital signs been within the following criteria <sup>1</sup> over the last 24 hour period? <ul style="list-style-type: none"> <li>- Respiratory Rate is between 8 and 30 breaths per minute.</li> <li>- O<sub>2</sub> Saturations are greater than 90% on less than 50% O<sub>2</sub> or 6L/min.</li> <li>- Systolic Blood Pressure is between 90 and 200 mmHg with no more than 40 mmHg decrease.</li> <li>- Heart Rate is between 40 and 130 beats per minute.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Are the patient's vital signs within the expected range for this patient's condition?	<input type="checkbox"/>	<input type="checkbox"/>	
c. How often does the patient need to have his/her vital signs checked?	Q2H <input type="checkbox"/> Q4H <input type="checkbox"/> Q6H <input type="checkbox"/> Q8H <input type="checkbox"/> OTHER: <input type="text"/>		
3. Level of consciousness:	Yes	No	Comments:
a. Is the patient's current level of consciousness within expected range for her/his condition?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Is the patient currently experiencing fluctuations in level of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the patient require increased monitoring for development of complications? (For example, you are worried about the health of this patient and are keeping a close eye on him/her)	<input type="checkbox"/>	<input type="checkbox"/>	

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5. Has the patient been experiencing acute confusion/agitation requiring ongoing assessment and treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
6. Does the patient's condition require increased assessment and adjustment in the plan of care? (For example, due to pain, fluctuating lab results, persistent fever, loss & grief, fluctuating mood, blood glucose is not well controlled)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
7. Does the patient require interventions/treatments that will have an immediate systemic effect, which may create an urgent or emergent situation? (For example, new IV treatment, Heparin infusion therapy, chemo therapy, high alert drug treatment, first-time blood transfusion)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
8. In the last 48 hours, has the patient had an unexpected health event or crisis? (For example, severe or acute episode requiring immediate intervention such as a sudden drop in blood pressure, O2 saturation level, blood glucose, fall)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
9. Do the patient and/or family have complex support needs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
10. Are the patient and/or family facing complex decisions that require coordination/collaboration with multiple team members?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:
11. Overall, how stable is this patient?	Very Stable 1      2      3      4      5      6		Very Unstable
12. Overall, how complex is this patient?	Less Complex 1      2      3      4      5      6		Highly Complex
13. Overall, how predictable is this patient?	Highly Predictable 1      2      3      4      5      6		Less Predictable
14. Overall, how at risk is this patient for negative outcomes?	Less Risk 1      2      3      4      5      6		High Risk

<sup>1</sup>Critical Care Secretariat, Ontario Ministry of Health and Long-Term Care [MOHLTC]. (2007). *Ontario's critical care strategy: Implementation of critical care response teams (CCRTs) in Ontario hospitals – Year one*. Retrieved April 7, 2008 from [http://www.health.gov.on.ca/english/providers/program/critical\\_care/docs/ccs\\_ccrt\\_rp\\_01\\_20070101.pdf](http://www.health.gov.on.ca/english/providers/program/critical_care/docs/ccs_ccrt_rp_01_20070101.pdf)

\*\*\*The PCNA tool is intended to be used in conjunction with the specific consensus-based review process as described in the RN/RPN Utilization Toolkit.

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## 7. Appendix B - Guidelines for Nursing Leaders

Based on the pilots we have compiled the following suggestions to guide you in working with the unit staff. Prior to the data collection please review the following guidelines and discuss relevant aspects with the nursing leaders from each unit in order to facilitate a comfortable environment for the staff nurses and minimize any feelings of discomfort.

- Arrange seating to minimize segregation of the staff nurse – helpful if the leaders sit on either side
- Pose questions to the unit staff as a group
- The staff nurse may find it helpful to have the chart
- Put away distractions such as blackberries and minimize the use of pagers
- Do not engage in side conversations or note writing in front of unit staff
- Provide a copy of the definitions and the PCNA tool for unit staff to refer to
- Throughout the review reinforce the consensus approach. Allow time for discussion and encourage input from all participants
- Include all staff working that day – agency and relief staff may require more input from the nursing leaders
- Where possible include the team leader/charge nurse who will know about patient/family history/issues

## **8. Appendix C – Introductory Script for Unit Review Process**

Welcome staff nurse and thank them for their participation. Introduce everyone at the table.

Briefly go over the background and purpose of the study. Reinforce that the purpose of the data collection on the review day is to test the tool.

Outline the process of reviewing each patient using the PCNA tool

- ❑ Go over the consensus approach
- ❑ Define the role of all the members of the unit team at the table
- ❑ Explain that the unit review will be repeated in a week or so

Reinforce the importance of patient confidentiality and that the external researchers should not know the name of the patient.

Confirm that the staff nurse understands the study and ask if she/he has any questions.

Before starting with the first patient tell the nurse that one researcher will record the answers. Offer to read out each question for the first patient.

Check if the nurse has any questions after finishing the first patient. Before carrying on give them the option to either follow the tool themselves or continue reading out each element.

After completing the review thank the nurse. Advise each staff member to approach any one of the leaders at the table if they have any questions, concerns or suggestions about the tool or the process and to alert the unit leader if there are any rumors or concerns they feel should be addressed.

## 9. Appendix D - Definitions of Stability, Complexity, & Predictability

<p>Stability refers to how quickly and how much or how little the patient's condition/care needs are changing.</p>	<p>Stability is high when patient changes are minimal and occur over a longer period of time. Stability decreases when changes are substantial and/or are occurring rapidly.</p>
<p>Complexity is concerned with the amount and diversity of factors that are affecting the patient's condition.</p>	<p>Complexity of care increases when patients' care needs are fluctuating or are not well-established, when multiple health problems are present, or when interventions may affect multiple systems or conditions.</p>
<p>Predictability refers to how well we can anticipate what is going to happen with the patient.</p>	<p>Predictability is high when patient care needs and responses are expected, and plans for care can be developed in advance. Predictability decreases when patient care needs are unknown, and a plan of care cannot be determined in advance.</p>

Definitions drawn from:

College of Nurses of Ontario. (2008). *Practice Guideline for the Utilization of RNs and RPNs*. Toronto, ON: Author.

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## 10. Appendix E - Unit Environment Profile Tool

VARIABLE	DESCRIPTION	DATA
Nursing Staff	How many RNs (total FTE's) work on this unit?	
	How many RPNs (total FTE's) work on this unit?	
	Number of Full-Time/Part-Time/Casual Nursing Staff (total number of individuals, not FTE's)	
Budgeted Skill Mix	Number of Unregulated Patient Care Providers (total FTE's)	
Experience of Staff Nurses	Number of Staff Nurses registered with College of Nurses Ontario for less than 3 years	
	Number of RNs with less than 1 year experience working on the unit	
	Number of RPNs with less than 1 year experience working on the unit	
	Number of unit Staff Nurses 55 and over	
Educational Preparation of Nurses	Number of Certificate RPNs	
	Number of Diploma RNs/RPNs	
	Number of Degree RNs	
	Number of Masters Prepared RNs	
	Number of Nurses with Specialty Certificates (e.g. CNA certification, gerontology certificate, critical care certificate, etc)	
Characteristics of Unit	Average Length of stay	

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Description of Support on Unit	Manager	Yes	No	
	Other unit-based nursing leader support (e.g. Educator, APN)	Yes	No	
	Other nursing leader support on consultative basis	Yes	No	
	Access to Rapid Response Team	Yes	No	
	Access to other allied health support (Specify roles)			
	In-charge/Team leader without assignment (day shift)	Yes	No	
	Number of medical teams on the unit			
	Any clinical Associates, or Physician assistant role?	Yes	No	
	Do you have nursing students on the unit? If so, what times of the year and what year of nursing?			
	Other nursing roles on the unit			
Occupancy	Average occupancy year to date			
	Number of budgeted beds			
Nurse-patient ratio	Average # of patients per nurse on each shift 7 days a week			
Policies, Procedures, and Guidelines	Access to policies and procedures relevant to practice area	Yes	No	
	Care pathways/protocols/plans of care specific to patient population(s) on unit (includes medical directives if appropriate)	Yes	No	
	Standardized assessment tools specific to patient population(s) on unit	None		
		Some Policies/Protocols Exist Policies/Protocols available for most situations/populations		
Unanticipated events	Number of infectious disease outbreaks in past 3 months			

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	Number of Code Blue calls in past 3 months	
	Number of calls to Rapid Response Team in last 3 months	
	Total number of transfers to ICU in the last 12 months	
Sick Time	Average sick rate (sick hours as percentage of productive hours)	
Overtime	Average OT hours as percentage of productive hours	
Agency Use	Average Agency hours as percentage of productive hours	
Staff Turnover	Percentage of unit staff nurse turnover over the past year (internal and external)	
Admissions	Average number of admissions and transfers in (per day, evening, night)	
Composition of Patients	How many different CMGs are cared for on this unit?	1 to 5
		5 to 10
		Greater than 10
		Please Explain:
Other Unit Factors	Are there other events that are not specifically related to the complexity of an individual patient, that would impact unit environmental complexity?	

Drawn upon work of Linda O'Brien-Pallas (University of Toronto) on environmental complexity.

\*\*\*The UEP tool is intended to be used in conjunction with the specific consensus-based review process as described in the RN/RPN Utilization Toolkit.