NURSE ON CALL ROSTER: Meeting Predicted Demand?

Tom Andrews CNS & Stephen James CNM, Wellington Hospital Intensive Care Unit.

Background
Historically, during the winter there is a higher rate of elective surgical cancellation, staff sickness and demand for intensive care beds. Previously nurses were phoned daily on an ad hoc basis to cover shortfalls. To improve our system and provide surety of cover we set about putting in place a mechanism that would help to alleviate these problems. In June 2007, Wellington ICU introduced a voluntary On-Call roster to enable us to meet our requirements.

Aims & Objectives
- Greater utilisation of nursing budget with staff only working when needed
- Improve access for elective surgery
- Reduction of workload for Charge Nurses recruiting staff for overtime shifts
- Reduced intrusion into staff home life by constant calling for extra work
- Nurse retention improved through good staffing levels
- Reduction of the impact from expected sick rates
- Ensure staff have equal access to extra duties

Methods
A voluntary roster that offers up to a maximum of 2x12hr day and 2x12hr night shifts was developed. Once the regular nursing roster is completed the on call roster is calculated to meet shortfall. These shifts are to cover the predicted elective workload, staff sickness and increased acute demand. Where good roster numbers were available and elective demand was down, fewer on call shifts were required.

Evaluations
To evaluate this initiative the utilisation and costs were reviewed. Of all the nurses who volunteered for on call 12% were not required to work. Having staff at work when they were needed meant paying for 70% of the 12hr duty.

Anecdotally feedback was sought from the Charge Nurses. They reported positively on the initiative. They described benefits including guaranteed staff availability, reduced work sourcing nurses, and less interruption to staff on their days off.

Since its inception the on call roster has grown in popularity to the point where it is often oversubscribed. Faced with the highest patient hours on record nurses have been available to meet the demand. This was despite an average nurse vacancy of 7%. The on call roster has cost the equivalent of 3.0 FTE to fund and has been cost neutral because of the existing vacancy. There has been a drop in sick leave rates, however it is uncertain as to whether this is attributable to the introduction of the on call roster.

Conclusions
The response to the initiative has been universally positive. The ability to cope with record admissions and increased patient hours were markers of its success. Day to day flexibility and the ability to address unpredicted staffing issues are strengths. This is now an integral part of the planning and management of our patient throughput.