NURSING+ MIDWIFERY

An Evaluation of the RUSON Pilot at Western Health

May 2022

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Western Health

Executive Summary

The Registered Undergraduate Student of Nursing (RUSON) role has existed in Victoria for some time in various forms. The role can provide complementary benefits for employers, patients and the RUSONs alike and is evolving all the time, becoming even more topical since the advent of the COVID-19 pandemic and the subsequent challenges for the nursing workforce; however, the importance of this role as a 'third tier' resource was already cemented in light of nursing workforce shortages, increasing age and co-morbidities in our contemporary patient population and their concomitant higher acuity.

A RUSON is registered as a student with AHPRA and has completed at least 12 months of their Bachelor of Nursing degree (or 24 months if a double degree), assisting the nursing team under the delegation and supervision of a Registered Nurse, providing care that is 'additional' to the ratios mandated by the Safe Patient Care (Nurse to Patient and Midwife to Patient ratios). A benefit of this role is that it is an additional proactive, socialised and known part of a team rather than a more reactive resource relatively unfamiliar with the team.

This Pilot occurred across 6 wards at Western Health, all of which accommodated patients with complex clinical needs and co-morbidities, including behavioural issues and advanced age. Forty-nine RUSONs were initially deployed across these wards for the duration of the Pilot (November 2020-November 2021) under the guidance of some ground rules including having no more than 10 RUSONs per ward and working a minimum of 8 hours per fortnight across a 12-hour period Monday-Friday. In addition, local Nurse Unit Managers determined the most effective start and finish times for their needs and how many RUSONs they could employ up to a maximum of 80 hours per week. Each ward agreed that, for the duration of the Pilot, they would not request or use other behavioural or acuity specials, excluding security and psychiatric 'specials' if a RUSON was available on a shift.

Data was collected through the analysis of retrospective indicators, surveys and small focus groups to enable a holistic overview of stakeholder perspectives. The three main themes identified through the qualitative data analysis were the 'value' to the patient experience, the value to the 'team' and the RUSON role governance. The role was described as a 'gatekeeping' one through the ability to provide consistent patient contact – answering call bells and spending time talking to patients, essentially releasing the time for Registered Nurses to manage acuity, access and demand. The advantages of this 'gatekeeping' function were not necessarily shown in all retrospective auditing of key indicators due to the presence of so many other confounding variables, including the effects of the pandemic on hospitalisations, workforce stresses and frequently changing policies. However, even small or no improvements in key indicators may be seen positively in the face of increasing acuity. Rolling the RUSON role out more widely may allow for amplification of the advantages already seen and for planned mitigation around the areas for improvement reported.

Role governance was seen as integral to maximise effectiveness and the Pilot has proffered ways of tightening key processes; examples from feedback include the need to work with multiple University partners to ensure RUSON supply and availability, having a single and consistent point of RUSON recruitment and having common expectations of the role from the perspective of operational management including generic tools for Nurse Unit Managers to confidently manage their local workforce as integral components of their teams. In addition to this, a governance framework that aligns the role professionally, through the Nurse Unit Managers, to a role within the Nursing and Midwifery Directorate, could add a more seamless level of guidance and support to evolve this role into one that maximally benefits all stakeholders. An opportunity here is to more closely relate the RUSON workforce with Western Health/University Nursing Fellowship programs which transition to graduate employment of Western Health-enculturated nurses who know our systems, processes and values.

The RUSON Pilot has shown benefits for the RUSONs themselves and their teams; opinions have suggested that this translated to the patient experience. 'Releasing time to care' and 'gatekeeping' are both patient-focused sequalae of the role – many variables were measured as part of the Pilot and some supported the role very well whereas others provided more neutral support. The macro and micro-environments played a very large part in determining role efficacy but the perception of role support from stakeholders at this time of significant workforce fatigue and stress may contribute to invaluable burnout reduction

in the future in our nursing workforce in general; continuous evaluation of the RUSON role in non-pandemic times may provide further quantitative measures.

Key findings

- The RUSON role enabled others to better manage acuity and access demands
- The RUSON role released more time to spend with patients and was viewed as an essential role by peers
- The RUSON role contributed to risk prevention and could be described as the ‘gatekeeper’ of the patient experience through their engagement and presence
- Tighter and more consistent governance over the role is required, particularly in terms of structured induction processes and scope of practice guidance

Key recommendations

- Expand the RUSON workforce across all wards at Western Health in 2022
- Improve governance structures, ensuring the Nurse Unit Managers have consistent and standard tools to maximise the benefits of the RUSON role
- Provide Nursing and Midwifery Directorate support for this key role by facilitating the success of our RUSONs ‘through’ appropriate support of our Nurse Unit Managers
- Maximise the RUSON ‘pipeline’ to funnel into Fellowship Programs and graduate employment at Western Health, maximising their gained knowledge of systems and processes. Provide mentoring for them to encourage them to successfully transition through these time points. A successful pipeline may successfully shape the type and length of graduate support needed.

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Introduction

The Registered Undergraduate Student of Nursing (RUSON) role has existed in some jurisdictions in Australia for some time and the RUSON nomenclature is part of a non-standardised suite of terms used to describe an 'assistant' workforce that supports a healthcare system facing nursing workforce shortages in the setting of greater patient acuity, increasing age and greater co-morbidities. Guidance as to how to employ and deploy these roles successfully, in conjunction with legislative/industrial frameworks, exist to support the RUSON role (Department of Health and Human Services, 2020; Australian Nursing and Midwifery Federation, 2020).

A RUSON is employed at a University undertaking undergraduate or graduate nursing studies and is registered with AHPRA as a student nurse. At commencement of paid employment as a RUSON they must have successfully completed at least twelve months of the Bachelor of Nursing degree (or equivalent), or a minimum of 24 months if completing dual Bachelor of Nursing/Midwifery degree. The RUSON works solely as an assistant to the nursing team, providing care delegated by a Registered Nurse that aligns with the scope of practice outlined in the Western Health RUSON Activities List, whilst remaining under direct or indirect supervision. The current Nurses and Midwives (Victorian Public Sector) Enterprise Agreement (2020-2024) has a clear indicative role for the RUSON in Part 85.

The RUSON role is sometimes referred to as a 'third tier' role, along with the RUSOM (Registered Undergraduate Student of Midwifery) and Health Assistants (Health Care Workers, Personal Care Attendants, etc.). During 2019/2020, Western Health utilised approximately 63,000 hours of additional nursing support beyond the ratios mandated in the Safe Patient Care (Nurse to Patient and Midwife to Patient ratios), equating to about $3.7 million. Additional resources are normally deployed to respond to patients with higher clinical needs, require constant observation or have individual behavioural characteristics placing them at risk of harm either to themselves or others. These resources are 'reactive' and come at a premium cost but are not part of the 'team' that would normally care for patients in that specialty area. The RUSON role is a proactive way of providing these resources in a more cost-effective, consistent and continuous and planned way, delivered by staff who are part of the team with a known skillset and scope of practice.

Existing literature illuminates different aspects of the RUSON (or otherwise known) role and some of this knowledge was taken into account in the design of the Pilot and during the analysis and reflection on the data. Hasson et al (2013) recognised that balancing the role of a student and a health care assistant was not easy – it is worth noting that this balance was difficult even 8 years ago prior to a more expansive scope of practice. Of particular note in their study was that students could question the value of their clinical placements when working as a paid team member – the approach in our Pilot was to achieve a more symbiotic relationship between paid employment and clinical placements. The 'tension' between paid employment and clinical placements has been a recurring theme in the literature – Algoso and Peters (2012) note that the 'Assistant in Nursing' role plays a more active role in patient care than the more 'passive' student role on placement where achieving competencies are the goal. The active participation may also enable the building or a professional identity and enculturation rather than being on the periphery as a student.

Willetts et al (2021) reported on some of the perspectives of Nurse Leaders in terms of the RUSON workforce – selected key points included the RUSONs being seen as team members as opposed to 'transient' workers, improving ward morale and work environment, and were missed when not working. The RUSON workforce model was also evaluated by Kenny et al (2021) from a rural health perspective – they reported that patients were probably the biggest winners due to the above ratio workforce; however, the RUSONs did report some challenges with balancing their learning needs with employer needs.

The aims of this Pilot were to:

- Understand the value of the RUSON role in terms of future strategic workforce planning, employee health and wellbeing and improved patient access to quality, safe services
- Explore RUSON role satisfaction and intention to return to Western Health following University graduation
- Explore whether RUSONs will be more advanced in their skills, confidence and ability to manage their time as a future graduate nurse

- Ascertain whether the RUSON role could lead to greater satisfaction of the Western Health nursing workforce
- Measure whether the RUSON role resulted in improvements to patient/client outcomes and experience whilst providing a cost effective and sustainable workforce model for Western Health

Pilot and Evaluation Setting

Western Health is a large, and growing, multi-campus public health service servicing a large, multi-cultural catchment area in excess of 900,000 people. Over 10,000 staff provide Best Care for the community in a range of contexts including adults, paediatrics and newborn, providing acute and subacute hospital care and community-based services.

The settings for the Pilot are a subset of Western Health, namely 6 ward areas (2B and 3B at Footscray and GC, Rehabilitation, 2A and 3E at Sunshine). The commonality between these wards was a complex patient population with a combination of clinical needs, chronic co-morbidities, advanced age and behavioural issues requiring more constant observation. A total of 49 RUSONs were initially deployed as part of the Pilot although there was some attrition over time due to resignations and pregnancies. 45 of the total were female and 4 male.

The RUSON pilot ran from November 2020 until November 2021 and a set of ground rules was put in place for the duration, including:

- Each ward area would be allocated a maximum of 10 RUSONs able to work a minimum of 8 hours/fortnight across a 12-hour period Monday-Friday
- The most effective 'local' start and finish time would be determined by the respective Nurse Unit Manager (NUM) and actual shift lengths may be a mixture of 4, 6, 8 hours up to a maximum of 12 hours per day
- The NUMs would determine how many RUSONs they could employ up to a maximum of 60 hours per week – the RUSON is part of the overall ward FTE and reports directly to the NUM
- In the event of personal or annual leave, other work obligations or clinical placements, the RUSON vacancy may be filled using an increase in the hours of another RUSON, or through the usage of a casual in-house Health Care Worker (HCW)
- Each ward area would agree, for the duration of the Pilot, not to request or use other behavioural or acuity specials, excluding security and psychiatric 'specials' if a RUSON is available on a shift. In preference, the RUSON will provide the necessary team support to enable appropriate care of patients with behavioural/acuity needs.
- There was a specific core activity list (see Appendix 1) that identified what the RUSONs were allowed and not allowed to perform, and this was distributed across the wards. This document includes the elements that were expanded later in the Pilot to cater for the 'surge' RUSON group.

Pilot Governance

The Executive Director of Nursing and Midwifery sponsored this Pilot, having oversight of both the pilot and the evaluation. Operational pilot project implementation was delegated to the ADoNM (Inspiring Innovation) and project evaluation was delegated to the DoNM (Inspiring Innovation). A Working Group with membership representation from Western Health management, employees and the Australian Nursing and Midwifery Federation (Victorian Branch) met regularly, and reviewed all aspects of the pilot and provided feedback and recommendations. Any implementation issues were escalated to the Executive Director of Nursing and Midwifery and the Working Group at the regular meetings.

Pilot Design

A combination of retrospective data obtained through various organisational systems and through surveys (quantitative), along with small focus group discussion (qualitative) was used to collect data for this evaluation. Data was managed ethically and

with due privacy diligence; in addition participation was voluntary from all stakeholders involved. Consent was implied through participation either during surveys or focus group attendance.

The qualitative component of the evaluation was designed to elicit a 360 degree perspective of the RUSON role in the Pilot wards; the following stakeholder groups were consulted to share their views:

- The Registered Undergraduate Student of Nursing group located in pilot ward areas
- The Nurses within the teams they intersected with
- Nurse Unit Managers
- Operations Managers
- Clinical Educators
- Divisional Directors
- Directors of Nursing

In addition, the following quantitative data was obtained through a retrospective audit of organisational data both before and during the duration of the Pilot:

- Selected Incident reports/adverse events
- Patient compliments and complaints
- Falls rate
- Pressure injury rate
- Staff satisfaction (this was measured through focus group discussion)
- Recognition and management of delirium
- Cost of overtime and supplementary staffing

Results – Quantitative Surveys

RUSON

A total of 32 RUSONs were invited to participate in the survey at completion of the Pilot. Of the 32 potential respondents, 28 (87.5%) were female and 4 (12.5%) were male. A total of 8 RUSONs fully completed the survey (response rate of 25%).

Table 2: Experiences of the RUSON role at completion of Pilot

	Strongly agree n (%)	Somewhat agree n (%)	Somewhat disagree n (%)	Strongly disagree n (%)	Not applicable n (%)
The employment on-boarding process was smooth and efficient	4 (50.0)	2 (25.0)	1 (12.5)	1 (12.5)	0 (0.0)
I found the transition from my study to the workplace seamless	4 (50.0)	2 (25.0)	1 (12.5)	1 (12.5)	0 (0.0)
I feel I am a valued member of the team	6 (75.0)	1 (12.5)	0 (0.0)	1 (12.5)	0 (0.0)
I feel supported in my role	5 (62.5)	1 (12.5)	1(12.5)	1 (12.5)	0 (0.0)
I receive adequate supervision	4 (50.0)	2 (25.0)	0 (0.0)	2 (25.0)	0 (0.0)
I feel out of depth in my role	0 (0.0)	2 (25.0)	0 (0.0)	6 (75.0)	0 (0.0)
I have been asked to conduct tasks that are outside of my job description	1 (12.5)	1(12.5)	2 (25.0)	3 (37.5)	1 (12.5)
I feel I have more skills to offer than I am currently allowed to use	6 (75.0)	2 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)
I have been asked to do tasks that I have not been trained to do	0 (0.0)	1 (12.5)	2 (25.0)	4 (50.0)	1 (12.5)
I find the work enjoyable	6 (75.0)	1 (12.5)	0 (0.0)	1 (12.5)	0 (0.0)
I find the work stimulating	4 (50.0)	3(37.5)	0 (0.0)	1 (12.5)	0 (0.0)
If I was offered ongoing employment, I would continue in the role	5 (62.5)	0 (0.0)	1 (12.5)	1 (12.5)	1 (12.5)
I feel the RUSON experience will be invaluable to my studies	5 (62.5)	2 (25.0)	0 (0.0)	1 (12.5)	0 (0.0)

	Always n (%)	Almost always n (%)	Sometimes n (%)	Rarely (%)	Never (%)
Activities of daily living (assist shower/wash)	6 (75.0)	2 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)
Activities of daily living (assist grooming – hair/teeth)	4 (50.0)	2 (25.0)	2 (25.0)	0 (0.0)	0 (0.0)
Assist patients to mobilise	7 (87.5)	0 (0.0)	1 (12.5)	0 (0.0)	0 (0.0)
Assisting with toileting	7 (87.5)	1 (12.5)	0 (0.0)	0 (0.0)	0 (0.0)
Performing catheter care/emptying	3 (37.5)	1 (12.5)	3 (37.5)	0 (0.0)	1 (12.5)
Assisting patients with meals	5 (62.5)	3 (37.5)	0 (0.0)	0 (0.0)	0 (0.0)
Attending to bed/linen changes	7 (87.5)	1(12.5)	0 (0.0)	0 (0.0)	0 (0.0)
Spend time talking to patients	8 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Answering call bells	8 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

Tidying/clearing clutter from work areas and rooms	6 (75.0)	2 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)
Performing vital signs	2 (25.0)	2(25.0)	1 (12.5)	0 (0.0)	3 (37.5)
Providing health education	0 (0.0)	0 (0.0)	2 (25.0)	2 (25.0)	4 (50.0)
Performing medication administration	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	8 (100.0)
Performing administrative tasks	0 (0.0)	0 (0.0)	1 (12.5)	3 (37.5)	4 (50.0)

Nurses working with RUSON Pilot Group

A total of 82 nurses completed the survey in the period April-June 2021 (approximately 5-7 months following Pilot commencement). Characteristics of the sample are reported in the table below.

Participant role

ANSWER CHOICES	RESPONSES	
RN - Registered Nurse	90.24%	74
EN - Enrolled Nurse	6.10%	5
RN/RM - Registered Nurse and Registered Midwife	0.00%	0
RM - Registered Midwife	0.00%	0
NP - Nurse Practitioner	0.00%	0
Doctor (not further defined)	0.00%	0
Allied Health (not further defined)	3.66%	3
Administration or clerical	0.00%	0
Student Health Professional (on placement)	0.00%	0
TOTAL		82

Have you worked with a RUSON before on one of the Pilot wards?

ANSWER CHOICES	RESPONSES	
Yes	97.47%	77
No	2.53%	2
TOTAL		79

How would you rate the preparation of the RUSONs for the role?

ANSWER CHOICES	RESPONSES	
Well prepared	58.97%	46
Somewhat prepared	20.51%	16
Prepared	17.95%	14
Under-prepared	2.56%	2
Not prepared	0.00%	0
TOTAL		78

Are the RUSONs working within their scope of practice?

ANSWER CHOICES	RESPONSES	
Yes	100.00%	78
No	0.00%	0
TOTAL		78

Are the RUSONs adding value or contributing to the provision of patient care?

ANSWER CHOICES	RESPONSES	
A great deal	71.79%	56
A lot	24.36%	19
A moderate amount	3.85%	3
A little	0.00%	0
None at all	0.00%	0
TOTAL		78

How would you rate the completion of the activities performed by the RUSONs?

ANSWER CHOICES	RESPONSES	
Very high quality	42.25%	30
High quality	52.11%	37
Neither high nor low quality	5.63%	4
Low quality	0.00%	0
Very low quality	0.00%	0
TOTAL		71

Do you think the patients and/or their families are happy with the care delivered by the RUSONs?

ANSWER CHOICES	RESPONSES	
Very satisfied	62.32%	43
Satisfied	33.33%	23
Neither satisfied nor dissatisfied	4.35%	3
Dissatisfied	0.00%	0
Very dissatisfied	0.00%	0
TOTAL		69

Results – Qualitative Surveys

Guided focus groups were conducted at the completion of the Pilot in December 2021. A total of 5 Focus Groups were held, all of a duration of 30-45 minutes. The groups comprised Nurse Unit Managers (NUMs) (2 sessions), Clinical Educators, Directors of Nursing and Midwifery and Operations Managers/Divisional Directors. At one of the NUM sessions, they were asked to bring the views of their staff to to avoid taking key resources out of circulation. A specific Focus Group was not held with the Pilot RUSONs themselves to keep them in working circulation – instead they contributed to data through completion of surveys. One 'interview' was informally conducted with a pilot RUSON who was happy for data to be added to the evaluation where appropriate. In addition, there were other 'virtual' debriefs of RUSONs but these were not appropriate for data collection. A total of 17 individuals contributed to the small focus group data in total where data was written but not recorded due to the low numbers of participants at each session and the potential for identification.

Data from the focus groups was analysed to check for tangible themes; each focus group was facilitated using 'a 'guide' which comprised 4 broad questions which were (i) Do you think the RUSON role has added value in terms of health, wellbeing and engagement of your teams? (ii) Do you think there has been value to the patient experience? (iii) Are the current scope of practice and patient care practices useful and (iv) Do you think there are any learnings from the Pilot?

The three most apparent themes from guided discussion with the RUSONs, their teams, Nurse Unit Managers, Clinical Educators, Operations Managers, Divisional Directors and Directors of Nursing were the 'value' to the patient experience, the value to the 'team' and RUSON role governance.

Theme 1: The 'value' to the patient experience

The RUSON role was described as 'releasing' time to spend with patients – this could be RUSON-time or time invested by other team members who felt 'released'. The RUSONs were very visible to patients and able to do things that could be seen as 'extra' such as making cups of tea and assisting with meals. The role allowed others to manage acuity and other pressures such as demand and access; in fact, they were see as 'patient experience gatekeepers' through prompt answering of call bells for example. This 'funnelling' through being first-responders was described as a risk prevention approach.

"*We should build a more structured gatekeeping approach with specific RUSON accountabilities such as toilet rounding and mealtime supervision*" (anonymous via Focus Group).

"*Patients really value the RUSONs as they are always available and visible whereas nurses are often busy with other tasks*" (anonymous via Focus Group).

Feedback suggested that patient experience could be optimised even further by more creative and agile start/finish times such as at 0600 hrs. In addition, being part of a 24/24 roster with a specific roster line and specific delegated accountabilities such as toilet rounding and mealtime patient supervision would be advantageous.

Theme 2: The 'value' to the team

Staff on the Pilot wards reported that the RUSON role was missed greatly when it was not there for any reason; it was felt that they had been enculturated and socialised into their teams in a 'business as usual' sense although part of a Pilot. They were seen as an extra pair of hands therefore releasing any perceived pressure on a shift. Some staff reported that they would metaphorically 'fight' over the RUSON on the shift due to their knowledge of the efficacy of the role. Other words used included 'indispensable' and 'essential' components of the team.

"*The RUSONs would be greatly missed if they were not there – it feels like they are already part of the culture and contribute to risk prevention*" (anonymous via Focus Group).

Opportunities to enhance team socialisation was described as existing, such as making the RUSON role an established role budgeted and governed by each individual ward. The role was seen as beneficial for the team, the patient experience and the RUSON's preparation for their nursing career.

"*Perhaps the scope of practice could be a little different depending on student year level although this would require clear communication"* (anonymous via Focus Group).

Theme 3: RUSON role governance

Governance was inclusive of the contexts of recruitment, induction, scope of practice and retention/replacement. Although the staff on the Pilot wards had clarity over who their Pilot RUSONs were, the emergence of a surge RUSON workforce during the Pilot caused some confusion in terms of governance across the different groups. Feedback suggested that a single recruitment process, scope of practice, induction process and contractual arrangement would be beneficial, along with a clear point of contact for advice.

"*There is a great opportunity to build a more structured approach to governance including a formalised mentoring opportunity for RUSONs*" (anonymous, Focus Group).

The presence of RUSON-specific clinical education support was also seen as beneficial both from the RUSONs themselves and the ward teams – this role also enabled some key tools to become available to support the role. Due to the relative 'embryonic' nature of the RUSON workforce, the leadership teams on the wards needed to understand the role a little better which was difficult during a period of constant change and demands.

Stakeholder groups commented that the scope of practice seemed reasonable for a new, but evolving role and that caution should be given to expanding it too much in the future to avoid widening any 'grey' areas which may increase risk. A RUSON is not a Nurse 'yet' so their scope should clearly indicate this; however, once registered with AHPRA thought should be given to widening the scope as a bridge between the RUSON role and the commencement of a formal graduate program (as this may be 5 months in some cases). Other feedback suggested some increase in scope would be beneficial, including taking of blood glucose levels and vital signs. In essence, having a single source of truth in preference to a different scope/duty list depending on whether the RUSON was part of a Pilot or the surge workforce.

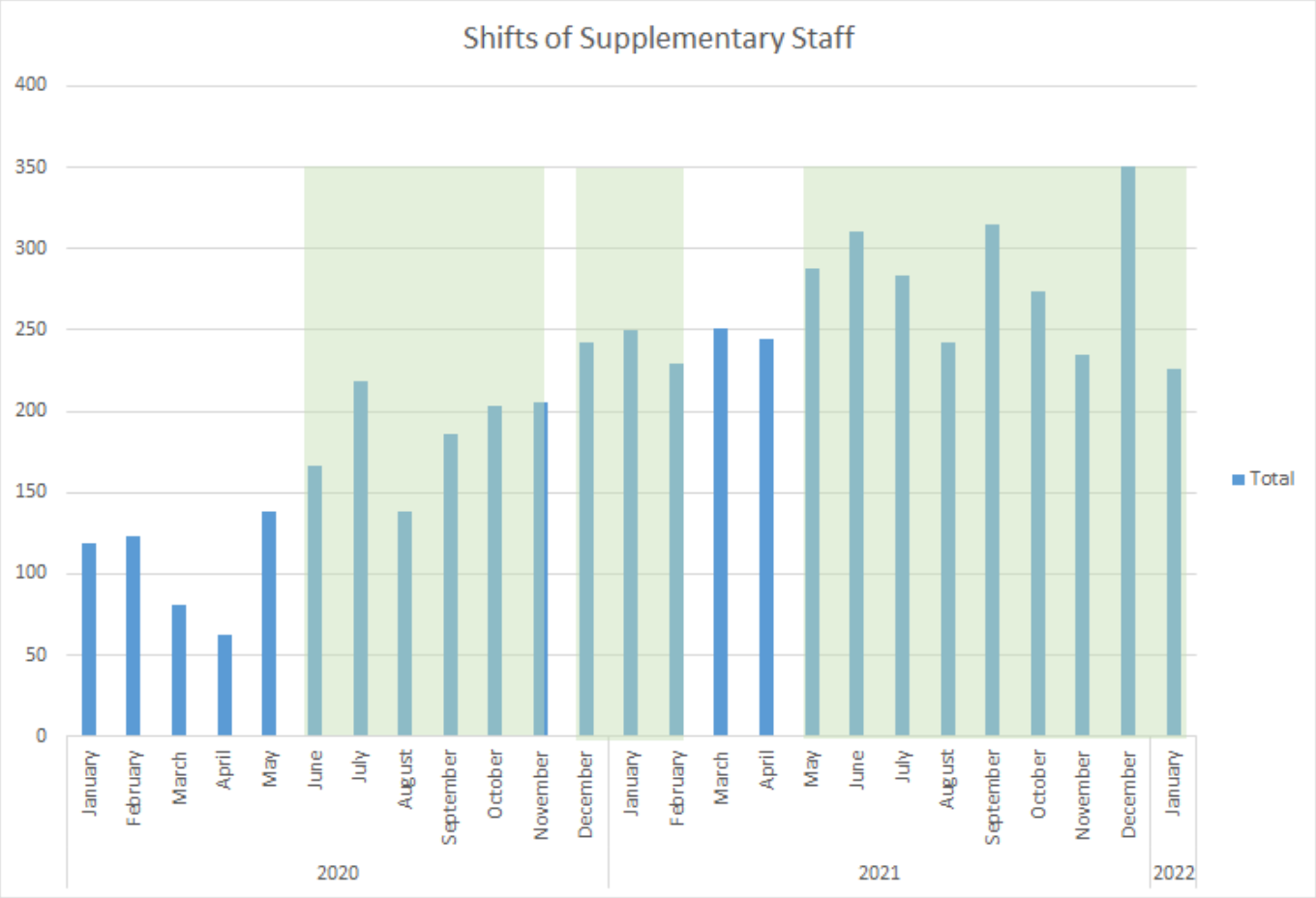
"*Improve communication with University partners to avoid RUSONs being taken off shifts in the event of last-minute placements being prioritised*" (anonymous via Focus Group).

There was a suggestion that RUSONs could rotate to two different areas in 12 months to maximise their exposure and preparation for becoming a Nurse – however with their limited hours it may take them longer to be socialised into the team. Feedback also suggested that the role should be rolled out to all wards to maximise organisational benefit but with greater clarity over contractual arrangements and other expectations such as WeLearn competencies, leave management and performance management and development. Oversight of a pathway from RUSON to Graduate Nurse at Western Health where transition is supported was seen as beneficial.

"*The RUSON role would be a win/win for everyone if they successfully transitioned to graduates here at Western Health*" (anonymous via Focus Group).

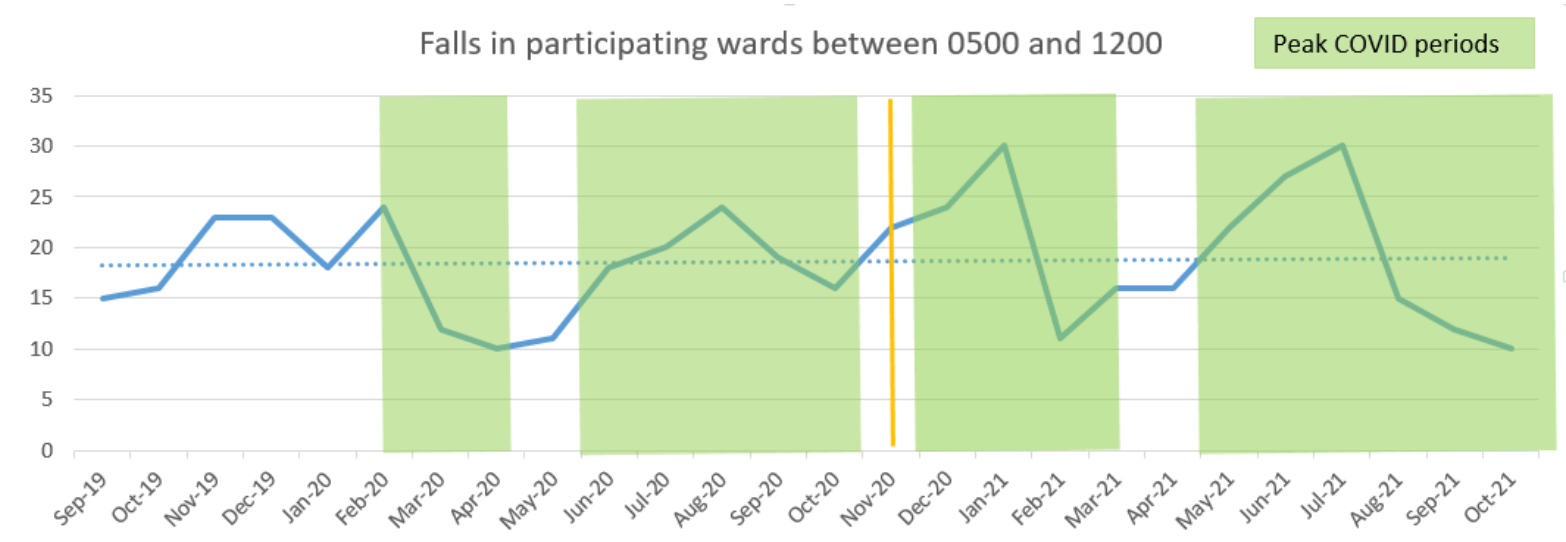
Retrospective Indicators

Use of supplementary staff during RUSON Pilot (Pilot Wards):

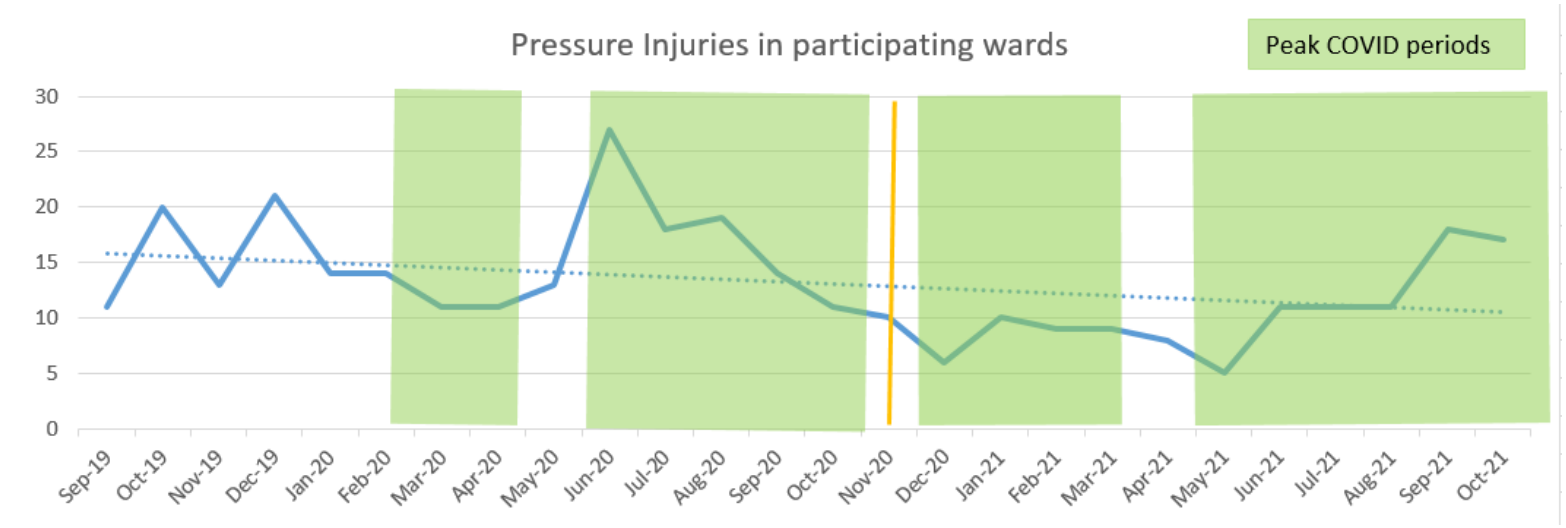


When viewing the use of supplementary staff it must take into consideration the impacts of COVID 19 (shaded). March 2020 saw the implementation of the first lockdowns which had a twofold impact on our ward environments, 1. Less patients were being admitted and 2. Covid infected patients were rare. This resulted in an excess of beds and nursing staff which is reflected in the low use during March and April. May 2020 saw the start of the second wave where patients were presenting either with COVID infections or multisystems deterioration through delay in presentation or both. This continued almost unabated until the end of the trial.

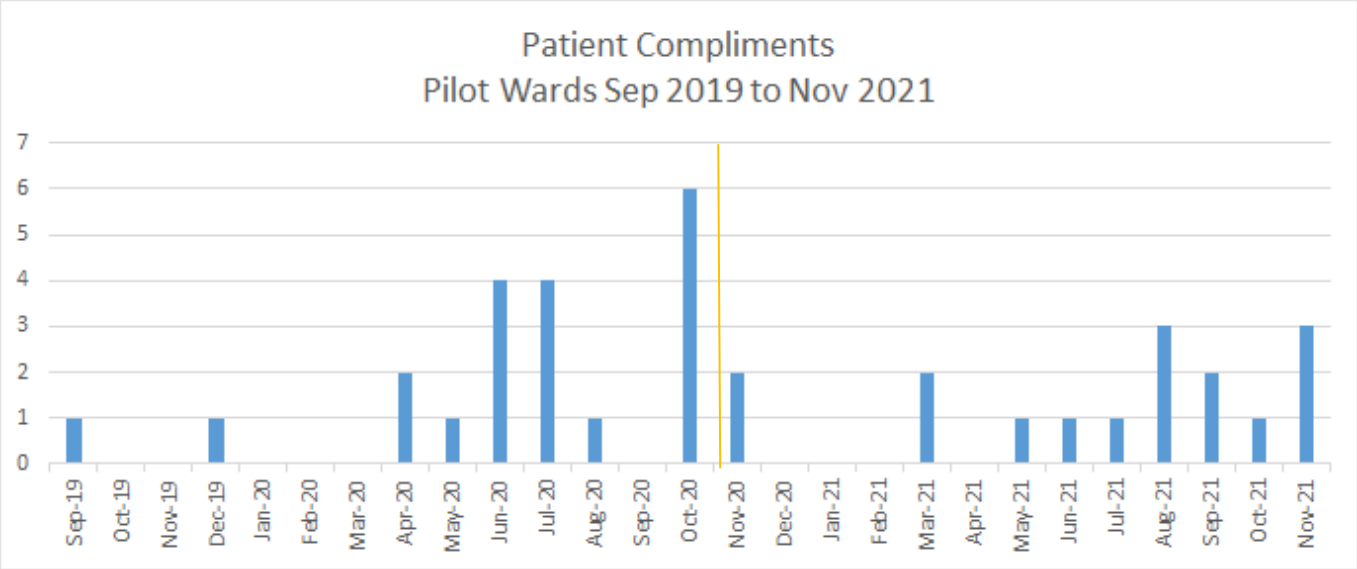
Falls on Pilot Wards during Pilot:



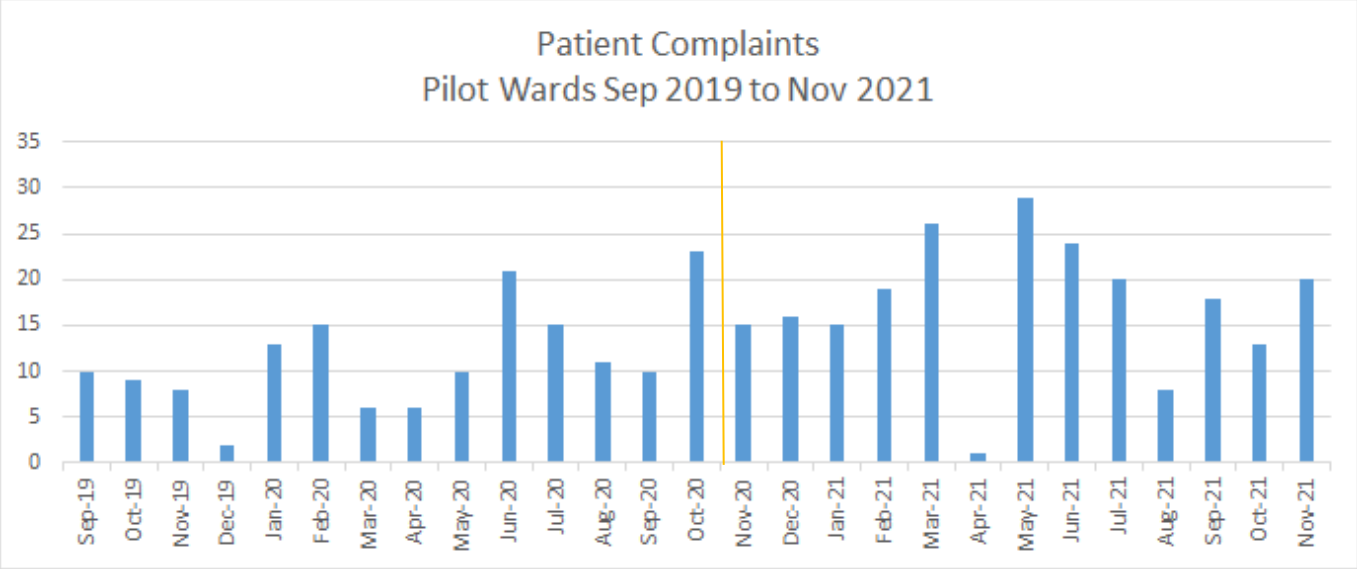
Pressure Injuries on Pilot Wards during Pilot:



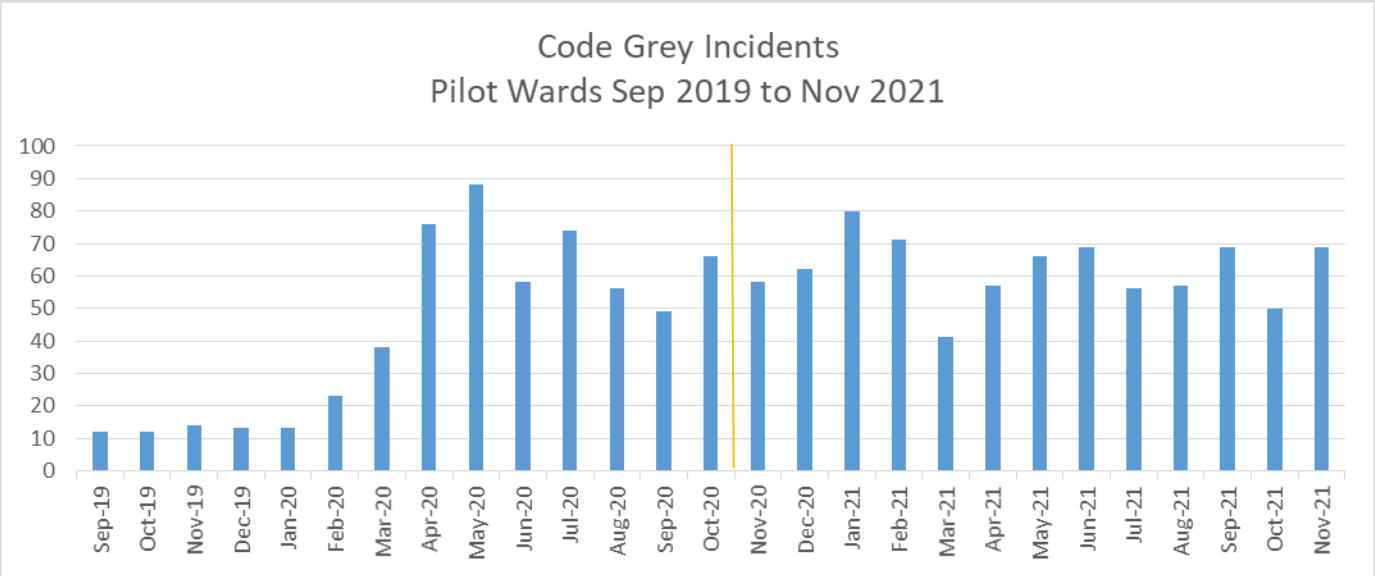
Compliments on Pilot Wards during Pilot



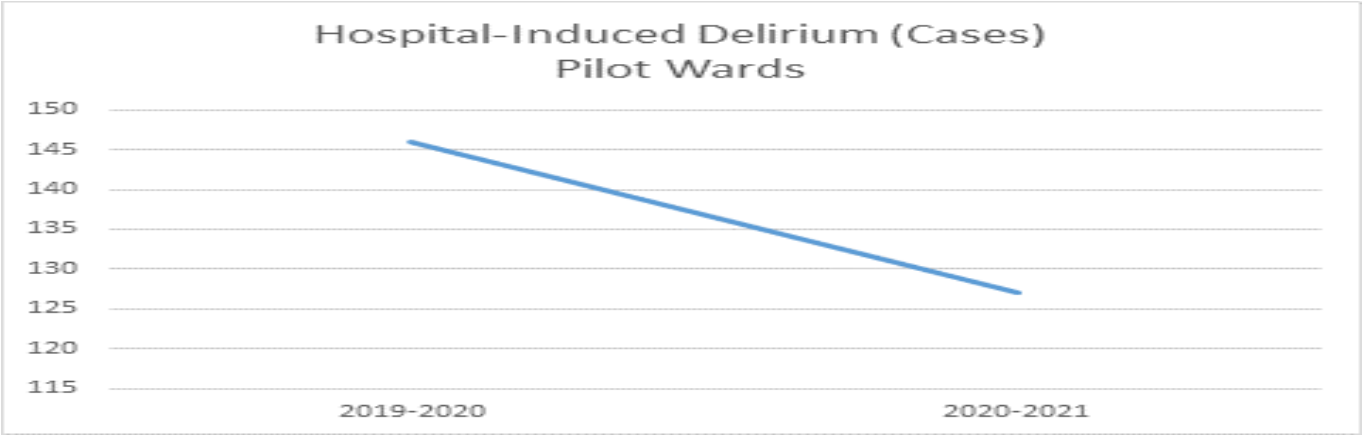
Complaints on Pilot Wards during Pilot



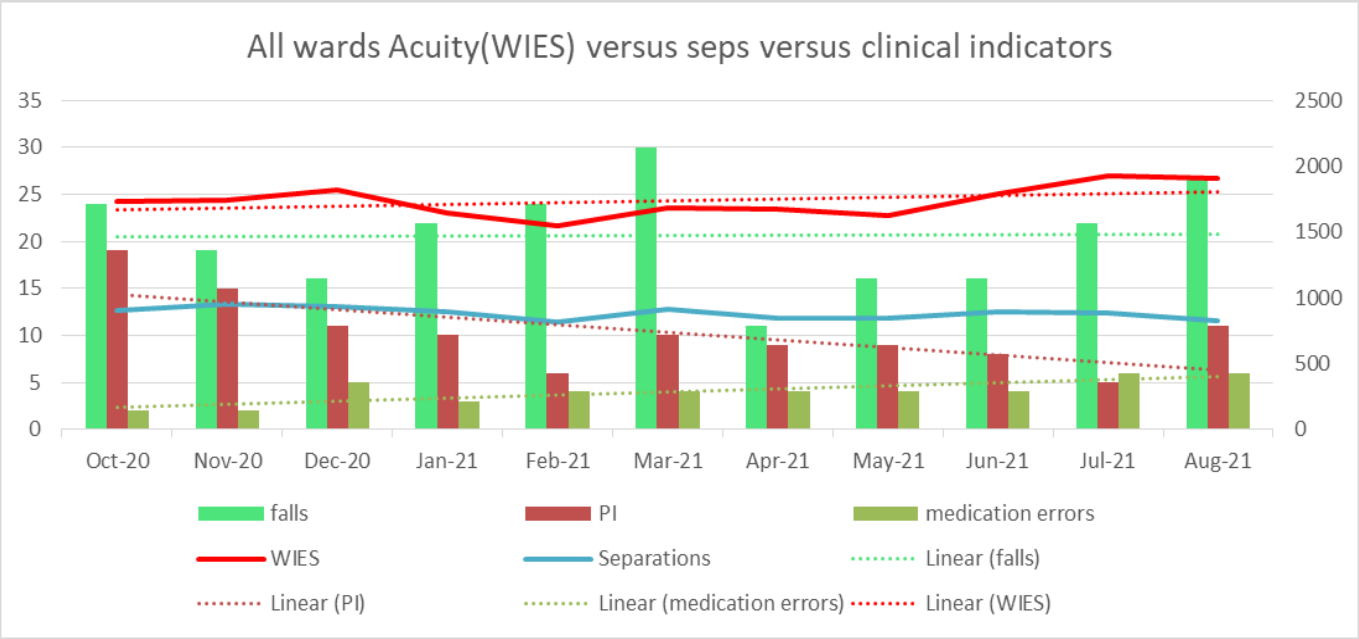
Code Grey incidents on Pilot Wards during Pilot



Hospital-induced delirium on Pilot Wards during Pilot

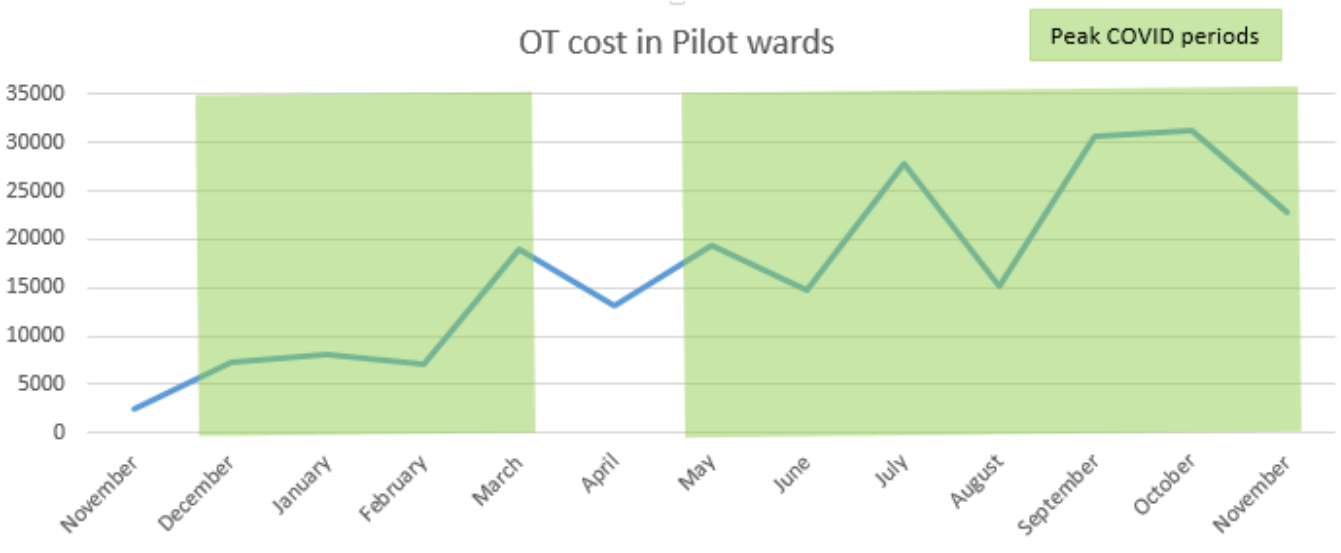


WEIS across Western Health during Pilot



Of note in this graph is the increasing WIES used as an indicator of patient acuity and complexity and the rate of nurse sensitive indicators. Despite a significant increase in patient complexity and all of the challenges provided by the management and cohorting of patients presented by COVID the nurse sensitive indicators remained relatively stable throughout the trial.

Overtime costs on Pilot Wards during Pilot



Limitations of Pilot

The data supports the efficacy of the RUSON role from different perspectives but there are confounding variables affecting how the data should be viewed.

- The COVID-19 pandemic, and its unprecedented effects on workforce governance and staff wellness, may have affected how the RUSON role was perceived and may have amplified both the positive and negative aspects reported
- The ability to measure data at planned time points through surveys, interviews and focus groups was adversely affected by the availability of staff to be released. In fact, 'interviewing' as a source of data collection was deemed to be inappropriate in terms of resource usage
- The advent of the 'surge' workforce meant that RUSONs were distributed widely across the Organisation, in a variety of different ward/clinical and non-clinical areas with differing tasks, governance and scope of practice
- Data sources such as Riskman rely on incident detection and entry, both of which may have been adversely affected by pandemic-related work stresses.

Discussion

The evaluation data suggests that the introduction of the RUSON role has been advantageous for the RUSONs themselves, their team members and Managers alike and, in itself, this evaluation has provided an opportunity to co-design how the role evolves into the future. The RUSONs have felt supported and valued and found the environment mostly enjoyable and stimulating. In addition, the work was thought to be mostly valuable to them in terms of supporting their studies to become Registered Nurses. They gave valuable feedback about improvements required with the on boarding processes which was a theme that crossed over other groups. The RUSONs spent most of their time talking to patients and answering call bells and less time doing vital signs, primary/secondary health education and administrative tasks. Talking to patients and answering call bells were also seen as important by Nurse Unit Managers, Operations Managers and Divisional Directors – this congruence of paradigm is key as it forms the single most important commonality of expectations and is evidence of the 'gatekeeping' function that the RUSON role performs. The advantages of this 'gatekeeping' function were not necessarily shown in all retrospective auditing of key indicators due to the presence of so many other confounding variables, including the relatively short timeframe of the Pilot and the effects of the pandemic on hospitalisations, workforce stresses and frequently changing policies and direction. However, reduction in hospital-acquired delirium on the Pilot wards may be indicative of the benefits of spending time talking to patients and re-orientating them to their environments. Some RUSONs felt that they had more skills to offer than the scope of practice that was offered.

The Pilot traversed a 'time' complicated by other variables – at the beginning of the Pilot, it may have taken the RUSONs some time to feel embedded and socialised due to the fact there were relatively few consistent shifts. Some improvements were shown in the number of patient falls, a small reduction in complaints and an increase in compliments were seen but perhaps offset by no real changes in the incidence of pressure injuries or code greys. An increase in overtime costs was also seen towards the end of the Pilot when hospitalisation rates were significantly increasing, along with staff furlough numbers. A gradual increase in the use of additional resources, although at face value appearing to be 'at odds' with the RUSON role, may be due to a WEIS that trended upwards at Western Health and the generally increased morbidity and acuity of patients who may not have received prompt primary or secondary prevention strategies during the previous second pandemic wave in Victoria when access to services was difficult during the enforced lockdowns. Even small or no improvements in key indicators may be seen positively in the face of increasing acuity.

Rolling the RUSON role out more widely may allow for amplification of the advantages already seen and for planned mitigation around the areas for improvement reported. Governance of the role is important to maximise effectiveness and the Pilot has proffered ways of tightening key processes – examples from feedback include the need to work with multiple University partners to ensure RUSON supply and availability, having a single and consistent point of RUSON recruitment (usually bulk as at the beginning of the year but local in the event of a resignation), having common expectations of the role from the perspective of operational management including generic tools for Nurse Unit Managers to confidently manage their local workforce as integral components of their teams. In addition to this, a governance framework that aligns the role professionally, through the Nurse Unit Managers, to a role within the Nursing and Midwifery Directorate, could add a more seamless level of guidance and support to evolve this role into one that maximally benefits all stakeholders. An opportunity here is to more closely relate the RUSON workforce with Western Health/University Nursing Fellowship programs which transition to graduate employment of Western Health-enculturated nurses who know our systems, processes and values. In turn, this may reduce the amount of graduate support required (time and/or intensity).

Conclusion

The RUSON Pilot has shown benefits for the RUSONs themselves and their teams and opinions have proffered that this has translated to the patient experience. ‘Releasing time to care’ and ‘gatekeeping’ are both patient-focused sequalae of the role – many variables were measured as part of the Pilot and some supported the role well whereas some provided more neutral support. The macro and micro-environments have played a very large part in determining true efficacy either from quality or fiscal perspectives but the perception of role support from stakeholders at this time of significant workforce fatigue and stress may contribute to an invaluable reduction in future burnout potential in our nursing workforce in general; continuous evaluation of the RUSON role in non-pandemic times may provide more accurate quantitative measures.

Thank you to all of those key stakeholders involved in the Pilot project – our RUSONs, ward staff, Nurse Unit Managers, Clinical Educators, Operations Managers, Divisional Directors, Directors of Nursing and Midwifery and the Australian Nursing and Midwifery Federation. Thank you to Doug Mill for support with data collation and to Melody Trueman for the initial Pilot design and implementation.

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Appendix 1

RUSON (Registered Undergraduate Student of Nursing)

Expanded Core activities & excluded activities list

Pandemic Surge Workforce - October 2021

Introduction

The Registered Undergraduate Student of Nursing (RUSON) works as part of the health care team, assisting Registered and Enrolled Nurses to provide delegated aspects of patient care. Elements of direct and indirect patient care will be delegated in accordance with the professional judgment of the supervising registered nurse and in accordance with the level of achieved educational preparation and assessed competence of the individual RUSON.

RUSON's are enrolled at a University to undertake undergraduate nursing study, registered with Australian Health Professionals Registration Agency (AHPRA) as a student nurse, and who at commencement of their employment have successfully completed at least twelve months of the Bachelor of Nursing Undergraduate Degree (Clause 106.1 Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2020-2024)

RUSONs undertake activities that have been delegated and supervised by a registered nurse in accordance with the Nursing Midwifery Board Australia (NMBA) Registered Nurse standards for practice (2016) https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD16%2f19524&dbid=AP&chksum=R5Pkrn8yVpb9bJvtpTRe8w%3d%3 and the NMBA Decision Making Framework for Nursing and Midwifery. https://www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD19%2f29157&dbid=AP&chksum=9LilUkdFvM5AJeKIaJZd1A%3d%3d

Registered nurses can only delegate aspects of care to a RUSON, which are consistent with the educational preparation, skill level and assessed competencies of the RUSON. RUSONs are not to be given sole allocation of patients, as articulated in the Delegation and Supervision Guidelines for Victorian nurses and midwives (DHS, 2014). http://www.health.vic.gov.au/__data/assets/pdf_file/0011/887654/Delegation-Guide-Nurses-Midwives.pdf

RUSONs can work shifts of 4 hours or more (morning and evening) and 10 hours (nights), Monday to Sunday.

The following Core Activity List has been developed to assist staff to understand the activities a RUSON may undertake under the delegation and supervision of the registered nurse. In exercising clinical judgment, the registered nurse will also take into account the patient's acuity and risk of clinical deterioration.

Pandemic Surge Expanded Core Activity

The following activities can be delegated in accordance with the professional judgement of the supervising Registered Nurse, in accordance with the level of achieved educational preparation and assessed competence through university studies of the individual RUSO

Area of care	Activity	Excluded activities
Hygiene	• Assist with oral hygiene – brushing teeth, dentures, mouth wash/toilet • Assist with simple eye care – eye toilet • Assist with brushing and washing hair • Assist with showering, washing and bed baths • Assist with dressing and undressing • Shaving (with electric razor) Grooming – non-medicated skin care and make up • Removal of make-up and nail polish for procedures • Hand-hygiene • Pre-operative site preparation (with surgical clippers only)	• Shaving patients with non-electric razors or blades, or patients with facial / neck surgery or injuries • Washing hair for patients with spinal, head and neck surgery or injuries • Cutting/trimming nails • Pre-operative shaves with razors/blades
Toileting	• Change incontinence pads or aids • Empty, record and provide urinary bottle • Empty, record and provide urinal pans • Empty, record and provide commode chair • Empty and record urinary catheter bag drainage • Change of IDC anchoring device • Document and report elimination amounts to Registered Nurse • Apply, empty and record condom drainage • Assisting patient with emptying of long term ostomy bags	• Changing ostomy bags • Hourly urinary catheter measures • Emptying of new ostomy bags (stoma < 6 months old) • Recent urological surgery
Manual handling & mobility	• Assist with patient transfers, sitting patients out of bed/on toilet/commode • Assist patients to change position in bed • Assist with provision of pressure area care (including assist with log roll) • Mobilising patients (assisted up to independent) • Assist in the use of manual handling hoists/aids • Assist allied health professionals e.g. with mobility, re-apply braces • Transport for discharge or day leave (as approved by medical staff), or to transit lounge	• Head control for log rolling • Transport of patients awaiting transfer to other facilities
Nutrition	• Assist patients with menu selection • Assist with safe meal set up, cut up food, adjusting table and opening packages • In consultation with the RN, assist with feeding patients • Provide water/refilling water jugs or making drinks for patient	• Feeding patients with difficulties, or receiving parenteral or enteral nutrition • Refilling of water jugs or making drinks for patients on fluid restrictions, with dysphagia, modified diet/fluids or nil orally
Environment	• Ensure falls prevention strategies are in place – call bell, phone, bedside table in reach, bed lowered, trip hazards removed • Maintain safe and tidy ward environment • Placing flowers in vases, water changes for flowers/vases • Making beds	• Sole responsibility for checking of emergency equipment including Resuscitation trolley, bedside suction, oxygen and air
Communication	• Answering call bells including staff assist • Reporting and/or escalating all care and concerns to supervising registered nurse/s • Clerical answering and transferring calls/intercom • Referring all aspects of care out of scope to RN • Direct visitors to ward or RN for assistance • Respond to, escalate, and report emergencies as	• Provide clinical advice or confidential information and advice to patients or families • Taking verbal clinical orders from unregulated health care workers, administrative, medical or allied health staff

	per hospital policy • Attend handover and local team meetings or education sessions • Orientate patient and family/carers to ward environment • Seek regular feedback from supervising RN/s and reflect on practice	• Accepting delegated duties from an enrolled nurse (EN) • Taking verbal results via telephone • Advice, counselling, confirming new diagnosis and communicating confidential information
Documentation	• Complete fluid balance chart: Oral input and urine output and report to RN • Complete food chart – dietary and fluid intake • Complete bowel chart – output and report to RN • Complete weight and height and report to RN • Assist in the documentation of valuables • Assist in filling out bedside communication boards • Complete incident reporting as per local hospital policy	• Patients on fluid restriction • Completing progress notes in EMR • Documenting on general observation charts and in EMR • Completing patient care plan details on communication boards or handover sheets
Maintenance	• Restock supplies and equipment • Cleaning and putting away equipment between use i.e. – infusion pumps, bed frames • Equipment maintenance	• Sole responsibility for restocking emergency supplies in resuscitation trolley • Restocking medication supplies
Other duties	• Constant observation of low risk behaviours, provided managing clinical aggression education has been completed • Diversional therapy/activities i.e. – reading to patients • Assist in the care of the deceased patient • Packing and unpacking patient belongings • Attend professional development sessions • Attend and report staff meetings • Initiate emergency response alarms as per organisational policy • Relieving staff for meal breaks • Running simple errands within hospital grounds • Re-application of anti-embolic stockings	• Measurement and initial fitting of anti-embolic stockings • Patient escorts, unless outlined in core duties list • Collection and labelling of specimens • Care of complex patients • Medication administration (all routes, including drops and topical creams) • Intravenous therapy management • Oxygen therapy • Suctioning • Wound management • Tracheostomy management • Emptying of wound and ICC drainage bags • Prescribed hair treatments • Allocated as the primary nurse /carer for patients including constant special or watch
COVID 19 Close contact tracing, specimen collection (oropharyngeal and nasal swabs) and non-invasive temperature testing	• Collecting specimens for COVID-19 testing including obtaining oropharyngeal and deep nasal swabs • Completing non-invasive temperature checks and documenting findings and contact details • Undertaking tracing of persons who are deemed to be close contacts of suspected or confirmed cases of COVID 19	• Serology testing is excluded
COVID 19 Vaccination	Students who have successfully completed more than 12 months of study of a Bachelor program leading to initial registration with AHPRA as a registered nurse, may undertake the following authorised vaccination activities once their training (including the prescribed modules) and supervision arrangements are met. These activities may include: • reconstitute COVID-19 VACCINE in accordance with the manufacturer's instructions and transfer to a single-use syringe • label the syringe for administration (where the product is not labelled when delivered) • administer COVID-19 VACCINE to persons approved as eligible to receive the vaccine • Practice must be line with the Public Health	

	Emergency Orders found at https://www.coronavirus.vic.gov.au/victorian-covid-19-vaccination-guidelines	
Personal Protective Equipment (PPE) Spotter	Undertaking PPE Spotter activities consistent with the PPE Spotter Position Description published by the Healthcare Infection Prevention & Wellbeing Taskforce, including: • Spotting and supervision of appropriate use of PPE, including observing, guiding, correcting technique during donning and doffing • Formal and informal monitoring and auditing of appropriate use of PPE within clinical settings (e.g. when providing care to patients) and non-clinical settings (e.g. breakrooms, cafes). Working with and supporting the Quality and Safety/Infection Prevention and Control/COVID-19 Response Team (or other relevant area(s) with: • Undertaking risks assessments through audits and spot checks on adherence to infection prevention measures (such as physical distancing) including proposing and implementing remedial actions, where required, as part of a continuous improvement process to support behavioural change • Training and promotional activities to create the conditions for workplace culture and behaviour change (e.g. information sessions, emails, posters) • Ongoing education and knowledge improvement of staff aligned with current public health advice. • Responding to occupational health and safety issues for staff experiencing skin and/or pressure injuries associated with prolonged use of PPE.	
Clinical Practice Extension - Contribution to patient assessment	Where the RUSON has completed the services' competency assessment and completed the necessary education relevant to the duty, as part of their bachelor program, the RUSON may perform the following duties as delegated in appropriate contexts only by supervising registered nurse: • Vital signs • Blood glucose levels • Urinalysis • Simple wound dressings.	