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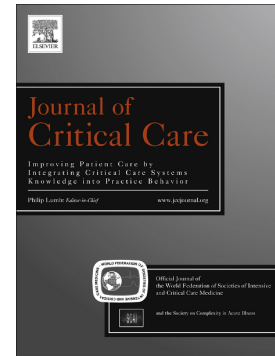
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Measuring the nursing workload in intensive care with the Nursing Activities Score (NAS): A prospective study in 16 hospitals in Belgium

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Abstract

Purpose:

The evaluation of nursing workload is a common practice in intensive care units (ICUs). It allows the calculation of an optimal nurse/patient ratio (N/P) which is a major challenge to ensuring the quality of care while controlling the costs of health care. The objectives of this study were, therefore, to evaluate the N/P ratio and to study nursing activities in intensive care in French-speaking Belgium.

Methods:

The Nursing Activities Score (NAS) was prospectively recorded by shift for two periods of one month each in 16 French-speaking Belgian hospitals for a total of 316 ICU beds in 24 ICUs.

Results:

We included 3,377 patients in the study, of which 64% were medical (versus surgical). The results for 24-hour NAS (68.6%) were significantly different from the NAS per shift (Morning: 61.3%, Afternoon: 58.4%, Night: 55.0%). Outliers were significantly more prevalent among men and patients who died and outliers had longer stays in the ICU. Finally, mobilization-positioning and clinical-administrative tasks took, on average, more time for nurses in the ICU.

Conclusions:

There is a significant difference in N/P ratio between the Belgian regulation (1/3) and the one calculated by the NAS (1/1.5). A systematic objective assessment of shift workload should be done to avoid N/P ratio differences in intensive care.

Keywords: Nursing Activities Score, workload, intensive care unit, shift

Introduction

In Europe, intensive care units represent 4.5% of hospital beds but consume 15% to 20% of total hospital expenditure. Nursing staff account for 60% of the direct costs of the Intensive Care Unit (ICU) budget [1]. Thus, an objective strategy to evaluate nursing activities is essential to optimize the use of resources and to avoid overstaffing, especially with current budget constraints [2-4].

In fact, insufficient nurse staffing is detrimental to the outcomes of intensive care patients [5-6]. Studies have demonstrated an association between inadequate nurse-to-patient ratio (N/P) and high mortality [6-11]; an increase in complications and adverse events [6,10,12-14]; an increase in nosocomial infections [12,15-18]; poor satisfaction of relatives and families of the patient [12,19-20]; an increase in pressure ulcers [12,21-22]; missing care [23]; poor pain management [24]; increased length of stay due to surgical complications [25]; and more musculoskeletal injuries and burnout injuries in nurses [26]. In addition, these factors increase hospital costs.

However, the optimal N/P ratio in intensive care has not been fully established and depends mainly on expert opinion [27-28] even though a 1/2 ratio was determined to be a threshold limit according to a recent observational study [11]. This ratio, however, varies from one country to another because it is dependent upon the organization of ICUs and the triage practices for admission [29]. In addition, in recent decades, ICUs have been constantly evolving by admitting older patients with multiple comorbidities [30-31]. This leads to more complex care and procedures with closer monitoring, leading to an increase in the nursing workload [32]. In Belgium, a 1998 federal law set arbitrarily, and without foundation, a minimum N/P ratio of 1/3 [33]. It is, therefore, important to evaluate the needs of the patient to allow for an adequate assessment of the optimal N/P ratio.

In recent decades, several tools for measuring the workload in critical care nursing have been published. Scales (e.g. TISS, TISS-28, NEMS) mainly evaluate the severity of disease and the complexity of therapeutic procedures [34-36] which are poorly correlated with the workloads of nurses [37]. There are also other scales (e.g. PRN, TOSS, OMEGA, NIC, SoPRA, VACTE, NRC11) that are only national instruments, with subjective weighting of items, and are seldom published [38-45]. The Nursing Activities Score (NAS) covers 81% of nursing activities and is independent of disease severity. In addition, the remaining 19% of activities (personal activities of nurses) are accounted for in the score. This retrospective scale specific to intensive care can be

encoded by shift or by day (24h). This tool has been validated in no less than 99 ICUs from 15 countries and is included in a large number of international publications [46]. It allows for an approach to the nursing workload that measures the nursing time consumed per patient. Comprised of 23 items, it includes both direct and indirect care. Each item representing a nursing activity is subject to a binary choice (for 18 items) or multiple choice (for 5 items). The score (per patient) is expressed as a percentage and varies from 0% to 177%. This represents the proportion of nursing time needed to provide care to the patient (100% = 1 nurse). The weighting of the items was done according to the "worksampling" method which is a reliable method resulting from industrial engineering, making it possible to measure action times without the inconvenience of timing.

The objectives of this study were, therefore, to evaluate the real N/P ratio and that obtained by the NAS, to compare the NAS score per 24h and per shift, and to analyze the variability of nursing activities according to shift in intensive care units in French-speaking Belgium.

Patients, materials, and methods

Setting and patients

This was a prospective observational study that was conducted in 16 university and general hospitals in French-speaking Belgium for a total of 316 mixed ICU beds (surgical, medical, pediatric) [Appendix 1]. All patients admitted during two 1-month periods: January 15 to February 15, 2018 (P1) and May 1 to May 31, 2018 (P2) were evaluated. These periods were chosen to compare data between winter and spring and outside school holidays in Belgium.

Instrument

The NAS scale used in this study has been translated, and adapted to Belgium, for use by shift. This version of the scale was published in a previous study by Bruyneel et al. and validated by Professor Miranda (author of the NAS scale) [47]. The score was encoded via a computer tool (Epimed Monitor[®]) at the end of each shift by nurses at the bedside. In our sample, nurses worked either in two shifts, 12h during the day or 12h at night, or in three shifts, mainly 8h in the morning, 8h in the afternoon, or 11h at night. The score was encoded as soon as the patient was admitted to the unit until they were discharged.

Training of the nursing staff

The nurses were trained (theory and practical exercises) by the research team for one hour between March 2017 and November 2017 on the use of the validated scale [47]. Trainers used the same training materials for training at each site and a reference person from the study was available by phone 24/7. The tool and tutorial were distributed to all nurses and explanatory videos were available. In addition, a dozen nurses per hospital underwent further training to facilitate the implementation of the NAS and check the correct recording of data on a daily basis.

Included NAS data

The NAS score per 24h was obtained by taking the maximum of each item recorded by shift [46]. Given the limited NAS data collected in Pediatric Intensive Care Units (PICUs), and to allow comparisons, we have grouped the NAS data from the morning and afternoon shifts into a single NAS day for these pediatric patients. Indeed, 82% of PICU NAS data were encoded in two shifts.

118 NAS records were excluded because the scores were not completely encoded.

Statistical analyses

For comparisons of asymmetric variables, the Mann-Whitney and Kruskal-Wallis tests were used. For symmetric variables, we used the ANOVA test and the chi-squared test for proportion comparisons. Statistical analyses were performed with Software for Statistics and Data Science (14.0, Texas) and XLSTAT (Addinsoft 2019, Long Island in NY, USA). A p value <0.05 was considered statistically significant.

Each NAS item is associated with a weighting defined in the original study (e.g., medication: 5.6%). In Table 2, average times per activity according to frequency and weighting are shown. This calculation also makes it possible to summarize the multi-choice items.

To calculate outliers (high NAS), two methods were used because no consensus has been found in the literature. First, the median was used as a reference. Second, the formula (75th percentile + 1.5 * inter-quartile range) described by Pirson et al was also calculated to determine large outliers [50]. The analysis of the variables influencing the workload of ICU care staff was conducted step-by-step to determine which variables had independent effects. Variables were selected from the recorded data and a previously published study [48,51].

Ethical considerations

A unique, anonymous number was randomly assigned for each patient and hospital institution included in the study. We obtained permission from all nursing directorates for the

implementation and extraction of data. In addition, the company, Epimed Monitor, signed confidentiality agreements with all the hospital departments. Finally, all of the hospital ethics committees were consulted and we obtained the authorization of the local committees for the hospitals that requested it (P17/82_20/12; B325201734614). Due to the observational nature of the study and the anonymization of the data, the written consent of patients or relatives was not required.

Results

Sociodemographic characteristics

This study included 3,377 patients, including 144 (4%) pediatric cases. The occupancy rate was 77.8% in winter and 70.8% in spring. The median (P25-P75) length-of-stay (LOS) was 2 days (1-5) during both periods of the study. On average, a nurse cared for 2.5, 2.8, and 3.0 intensive care beds in the morning, afternoon, and night shifts, respectively. All ICUs in this study were medical-surgical ICUs with half of the beds dedicated to cardiac surgery and 42% to neurosurgery (Table 1).

Nursing Activities Score

By patient and shift

A total of 31,815 recordings by shift were encoded and 13,937 NASs per 24 hours were calculated. All NAS medians by shift, except that of the NAS day, varied significantly from the NAS per 24 hours (68.6%) (Figure 1). The median NAS was significantly different for the three shifts (61.3%, 58.4%, 55.0%). For NASs in two shifts, the median varied significantly between day (68.3%) and night (56.7%). A slight difference of 0.9% in NAS per 24h was observed between the two periods. Regarding the PICU data, day and night NAS scores were significantly different with scores of 60.4% and 58.4%, respectively. The scores were lower for the day, and more importantly, for the night compared to adults.

By NAS item

For multiple-choice items, the "normal" items were chosen in the majority of cases (+/- 70%). However, for the *Mobilization and positioning* items, 70% of the items were encoded "more than normal". The choice "much more than normal" was rarely recorded (<5%). The intensity selection for *Monitoring and titration* did not vary between day and night. On the other hand, the

Mobilization and positioning and *Administrative and managerial* task items were valued more during the day than at night. *Specific interventions* inside and outside the ICU, items 22-23, were encoded in 10% to 22% of cases during the day and only 1% to 7% at night. The patients included in the study were intubated or tracheotomized in 31% to 38% of cases, under vasoactive drugs in 18% to 25% of cases, on hemofiltration in 4% to 8%, and 2% had an external ventricular bypass catheter. No cardiac massage was performed during either registration period (Appendix 2).

The items *Mobilization and positioning* and *Administrative and managerial tasks* are those that take the most time in the daily care of a patient. In three-shift situations, the *Mobilization and positioning* item took longer, on average, and represented about 10% of a nurse's working time compared to the average NAS (68%). A significant decrease in this task was observed at night during three work shifts but not in two-shift situations. *Administrative and managerial tasks* took longer in two-shift situations and was more important during the day (15%) than at night (8%). *Monitoring and titration* tasks were as intense during the day than at night in two-shift workplaces but varied significantly over three shifts. Seven items (1-3-4-6-7-8-17) accounted for 75% to 89% of the time consumed for a patient, depending on the shift. The intensity of items between shifts was significantly different when working in three shifts. When working in two shifts, this was observed for only eight items (Table 2).

Related variables of high NAS

Results from the outlier calculations were variable. For example, 44% of outliers were observed on the basis of the median compared to only 2.1% for the formula from Pirson et al. However, for both methods, the proportion of high NAS was significantly higher in men and in deceased patients. Lastly, outliers had longer hospital stays than the general population (Table 3).

Discussion

In this study, the demographics, with an average age of 61 years and a death rate of 8.6%, are similar to previous studies on critical care workload [11,37,49-52].

The implementation of the NAS by shift allowed us to accurately calculate nursing time per patient expressed as a percentage. In our study, the organization of work was either three shifts (8-8-11h) or two shifts (12h). In total, we collected nearly 32,000 records with a majority of

NASs (88%) encoded in three shifts. To our knowledge, only one study also evaluated the NAS score in three shifts. In comparison to this study, also done in Belgium [49], we note that our results (morning: 61.3%, afternoon: 58.4, and night: 55.0%) were about 15% higher.

The PICU NAS results (morning: 60.4% and night: 58.4%) are substantially similar to other studies in pediatric intensive care units [53,55].

Relative to the NAS per 24 hours, significant differences are observed when compared to the NAS per shift except for the NAS daytime. In view of the results, it is therefore better to encode the NAS by shift to determine a precise N/P ratio. With an average score of 68.6%, we have a result very similar to Greece (64.6%) [50], Brazil (66.4%) [51], and Italy (65.9%) [54] but lower, by report, than Norway (96.2%) [56]. The differences can be explained by the organization (e.g. triage of ICU patients, presence of intermediate unit) of health care in different countries [50]. Currently, in Belgium, a 1998 regulation imposes a minimum of two nurses for every six beds, but our results suggest that an optimal N/P ratio would be rather 1/1.5.

For both methods of calculating outliers, gender, ICU death, and length of stay in ICU show a significant relationship when analyzing the variables influencing the high NAS. For the latter two variables, these patients were probably more unstable and required more surveillance. The objective of the study was not to perform benchmarking between hospitals, however, there is a high variability in the number of outliers between them. These results are completely identical to two previous studies on the analysis of factors associated with NASs [37,51].

We choose the NAS as it is more cited in the literature, a review of 2015 had found 36 articles referring to the score [4]. In addition, the tool is used worldwide [45,49,50,56] and is not very time consuming [47]. Finally, the authors of a recent literature review report that the NAS is the best instrument for defining ICU nursing endowment. Indeed, NAS is the most extensively examined workload tool, with generally reliable results. It is also a system that focuses on the whole of the critical care nurse's workload [5].

Administrative tasks represent a large part of the nursing activity. These tasks are proportionally more important when the shifts are in 12 hours because the day nurses make the majority of admissions and discharges of patients. Administrative staff could reduce the weight of this item to nurses and free up time for direct care. The second most important item is "mobilization and positioning". Indeed, 2% to 6% of our patients require three or more nurses to mobilize them, which is explained by the instability and the equipment of the patients.

Seven of the 23 items alone account for 75% to 89% of the nursing time consumed per patient. The encoding of only these items could reduce the encoding time and provide a relatively representative score of the time consumed per patient. However, this could lead to significant approximations as has been described for NEMS [36]. In particular, these items allow for comparison of NAS scores by pathology.

This study has some limitations. First, we did not record a disease severity score in our sample. However, these scores (e.g. SOFA and APACHE II) are weakly or moderately correlated with NAS [37]. In addition, the results of the SAPS 2 and SAPS 3 studies did not always reflect nursing needs [57]. Nevertheless, some NAS items allowed us to describe our sample from a medical point of view (e.g. vasoactive drug, intubation). This study was conducted on only two distinct periods of one month. However, current literature does not prevent us from generalizing our results over the year. Third, the encoding was not verified by the authors at the bedside of the patient in all hospitals. However, all nurses at the participating centers received one hour of training for coding and reference nurses in each center were trained more thoroughly. Finally, for pediatric outcomes, we have very few NASs encoded compared to adult NAS. Further study of pediatric cases may be needed to evaluate the optimal Pediatric N/P ratio.

This study demonstrates that it is feasible to implement the NAS scale in a large number of ICUs. In addition, these results demonstrate a significant gap between legislation and the real N/P ratio and the importance of evaluating the workload in ICU. Further studies on the analysis of the impact of this N/P ratio gap on the quality of patient care in the ICU would be interesting. This article could add a new approach to scientifically define N/P ratio legislation through health policies. Finally, given the variability of outliers by hospital, the use of the NAS would allow the financing of the nursing staff per hospital according to their case-mix of intensive care.

Conclusions

This study demonstrates that it is feasible to implement the NAS scale in a large number of ICUs.

The NAS per 24h is significantly higher than that per shift. There is a difference between the ratio calculated by the scale (1/1.5) and the legislation in Belgium (1/3). An objective measure of the daily workload with validated tools and by shift seems recommended in order to avoid these differences.

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Tables

Table 1: Sociodemographic description of the sample (n=3,377, 16 hospitals, and 24 ICU's)

	Period 1 (n = 1,795)	Period 2 (n= 1,582)	All periods (n=3,377)
Sex (% ♂/♀)	60/40	60/40	60/40
Age (years), mean $\pm$ SD	62.0 $\pm$ 19.6	60.4 $\pm$ 21.2	61.3 $\pm$ 20.4
Pediatric cases (>15 years), n (%)	62 (4)	84 (5)	146 (4)
Length of stay (days), median (IQR) ^a	2 (1-6)	2 (1-5)	2 (1-5)
Occupancy rate, mean $\pm$ SD	77.8 $\pm$ 16.4	70.8 $\pm$ 19.0	73.8 $\pm$ 18.2
Orign, %			
Emergency surgery	11.1	11.3	11.2
Scheduled surgery	24.5	25.5	24.4
Medical	64.5	63.4	64.4
Destination (%)			
Deceased	9.1	8.2	8.6
Ward	82.7	83.4	83.1
Other hospital	4.1	2.7	3.6
Home	3.5	3.2	3.3
Other	0.6	2.5	1.4
Description of hospitals			
Number of hospitals, n	16	16	16
Number of ICUs, n	24	24	24
Number of beds, n	316	316	316
Number of beds, medical-surgical, n (%)	316 (100)	316 (100)	316 (100)
Number of PICU beds, n (%)	24 (7.6)	24 (7.6)	24 (7.6)
Number of beds, neuro surgery, n (%)	135 (42.7)	135 (42.7)	135 (42.7)
Number of beds, cardiac surgery, n (%)	157 (49.7)	157 (49.7)	157 (49.7)
Ratio ICU bed/nurse, mean $\pm$ SD			
Morning	2.5 $\pm$ 0.8	2.7 $\pm$ 0.6	2.5 $\pm$ 0.68
Afternoon	2.7 $\pm$ 0.9	2.9 $\pm$ 0.8	2.8 $\pm$ 0.9
Night	3.1 $\pm$ 1.0	2.9 $\pm$ 0.8	3.0 $\pm$ 0.9

Legend: ^a1 month; SD=standard deviation; ICU=Intensive Care Unit

Table 2: Average time per activity obtained according to item frequency and weighting of the original NAS scale (expressed as a percentage)

Example: Monitoring and titration (4.5% in 1a, 12.1% in 1b, and 19.6% in 1c according to the original NAS scale) takes 6.3% of the nurse's time at night in 3 shifts compared to average NAS per patient (55%)

Activity	3 Shift				2 shift		
	Morning (n = 9,856)	Afternoon (n=9,126)	Night (n=9,352)	pvalue	Day (n=1,945)	Night (n=1,536)	pvalue
1. Monitoring and titration	7.0 ± 3.9	7.1 ± 4.0	6.3 ± 4.2	0.026	7.4 ± 4.4	6.9 ± 4.2	<0.001
2. Laboratory, biochemical investigations	3.4 ± 1.8	3.3 ± 1.8	3.6 ± 1.6	0.085	3.7 ± 1.5	3.7 ± 1.5	<0.001
3. Medication, vasoactive drugs excluded	5.3 ± 1.3	5.2 ± 1.4	4.7 ± 2.0	<0.001	5.4 ± 1.0	5.3 ± 1.3	<0.001
4. Hygiene procedures	7.4 ± 5.7	6.7 ± 5.4	5.8 ± 5.6	0.003	8.6 ± 6.2	7.3 ± 5.8	<0.001
5. Care of drains, all (except gastric tube)	1.4 ± 0.8	1.3 ± 0.8	1.2 ± 0.8	0.837	1.1 ± 0.9	1.1 ± 0.9	<0.001
6. Mobilization and positioning, including procedures	10.5 ± 3.5	10.4 ± 3.5	8.8 ± 4.8	0.429	11.0 ± 3.5	10.7 ± 3.4	<0.001
7. Support and care of relatives and patient	5.3 ± 6.7	5.9 ± 7.6	3.7 ± 5.5	<0.001	6.3 ± 7.9	5.1 ± 6.7	<0.001
8. Administrative and managerial tasks	10.0 ± 8.9	8.7 ± 8.3	6.3 ± 6.9	<0.001	15.1 ± 9.6	8.3 ± 8.1	<0.001
9. Respiratory support	1.1 ± 0.6	1.1 ± 0.6	1.0 ± 0.6	0.009	1.1 ± 0.6	1.1 ± 0.6	<0.001
10. Care of artificial airways	0.7 ± 0.9	0.7 ± 0.9	0.6 ± 0.9	0.204	0.6 ± 0.8	0.6 ± 0.9	0.03
11. Treatment for improving lung function	2.8 ± 2.1	2.7 ± 2.1	2.4 ± 2.2	0.881	2.0 ± 2.2	2.0 ± 2.2	0.008
12. Vasoactive medication	0.3 ± 0.5	0.3 ± 0.5	0.3 ± 0.5	0.179	0.2 ± 0.5	0.2 ± 0.5	0.001
13. Intravenous replacement of large fluid losses	0.1 ± 0.5	0.1 ± 0.6	0.1 ± 0.5	0.27	0.2 ± 0.6	0.2 ± 0.6	<0.001
14. Left atrium monitoring: pulmonary artery catheter	0.2 ± 0.5	0.2 ± 0.5	0.1 ± 0.5	0.401	0.1 ± 0.3	0.1 ± 0.3	<0.001
15. Cardiopulmonary resuscitation after arrest	-	-	-	-	-	-	-
16. Hemofiltration techniques, dialysis techniques	0.6 ± 2.0	0.6 ± 2.0	0.4 ± 1.8	0.153	0.3 ± 1.6	0.4 ± 1.6	<0.001
17. Quantitative urine output measurement	6.1 ± 2.4	6.0 ± 2.4	5.4 ± 2.9	<0.001	6.5 ± 1.9	6.6 ± 1.6	<0.001
18. Measurement of intracranial pressure	0.0 ± 0.2	0.0 ± 0.2	0.0 ± 0.2	0.191	0.0 ± 0.2	0.0 ± 0.2	<0.001
19. Treatment of complicated metabolic acidosis/alkalosis	0.1 ± 0.4	0.1 ± 0.4	0.1 ± 0.3	0.622	0.1 ± 0.3	0.1 ± 0.3	<0.001
20. Intravenous hyperalimentation	0.2 ± 0.6	0.2 ± 0.6	0.1 ± 0.6	0.272	0.1 ± 0.6	0.1 ± 0.6	<0.001
21. Enteral feeding through gastric tube	0.4 ± 0.6	0.4 ± 0.6	0.4 ± 0.6	0.141	0.4 ± 0.6	0.4 ± 0.6	<0.001
22. Specific intervention(s) in the intensive care unit	0.4 ± 1.0	0.3 ± 0.9	0.2 ± 0.6	<0.001	0.6 ± 1.2	0.2 ± 0.7	<0.001
23. Specific interventions outside the intensive care unit	0.2 ± 0.6	0.1 ± 0.5	0.0 ± 0.2	<0.001	0.2 ± 0.6	0.0 ± 0.2	<0.001

Legend:

Summary of Nursing Activities Score, available scale in publication of Miranda Crit Care Med 2003; 31:374 –382 [46]

Mean ± standard deviation; p value: ANOVA Test

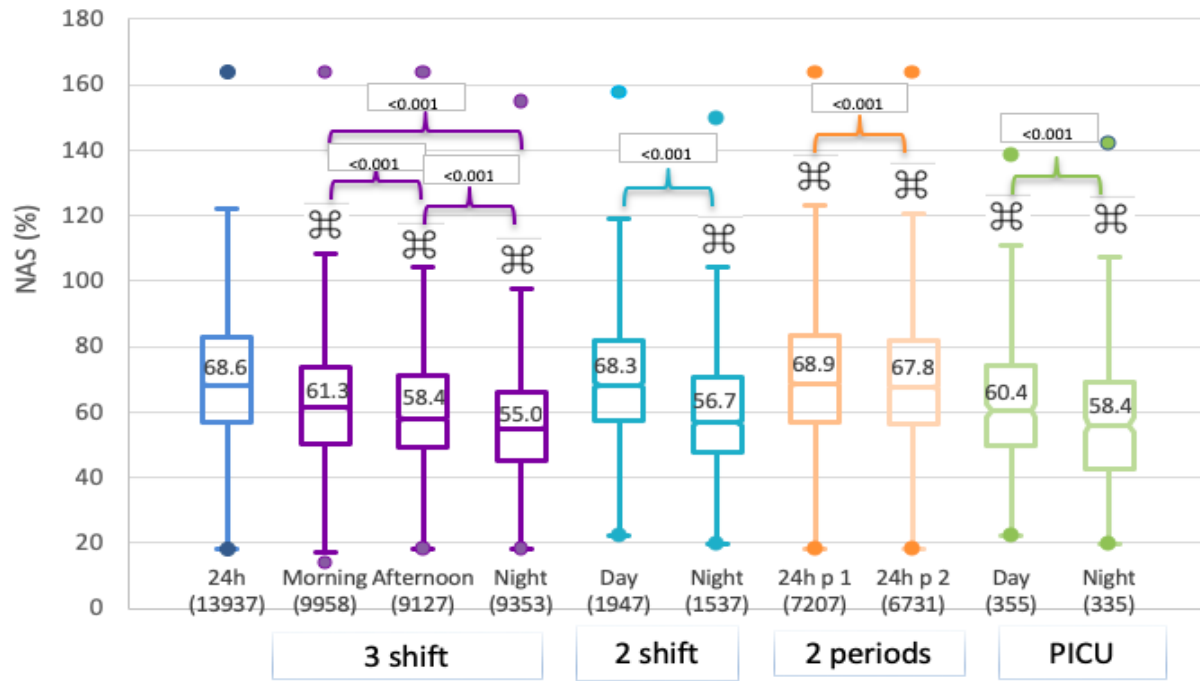
Table 3: Analysis of variables related to high NAS compared with low values according to two formulas: the median and the medico-economic formula

		<i>Outliers Median</i>	<i>p value</i>	<i>Outliers P75+1.5 IQR</i>	<i>p value</i>
Proportion of outliers by hospital, %	Med [P25-P75]	44.0 [35.4-55.0]	<0.001 ^a	2.1 [1.1-2.6]	<0.001 ^a
Outliers NAS by Sex, %	F	47.8	0.005 ^a	2.0	0.027 ^a
	M	50.2		2.6	
Outliers NAS by period, %	1	50.4	0.007 ^a	2.3	0.733 ^a
	2	48.1		2.4	
Outliers NAS by shift, %	2	54.0	<0.001 ^a	2.4	0.876 ^a
	3	48.5		2.3	
Outliers NAS by ICU discharge, %	Alive	46.2	<0.001 ^a	1.5	<0.001 ^a
	Dead	72.7		9.4	
Length of stay outliers and inliers	Outliers NAS, %	42.3	<0.001 ^b	2.1	0.005 ^b
	Outliers Med [P25-P75], Day	7 [3-17]		8 [3-15]	
	Inliers Med[P25-P75], Day	5 [2-11]		6 [2-14]	
Age	Outliers NAS, %	49.3	0.389 ^b	2.4	<0.001 ^b
	Med outliers [P25-P75], Years	65 [55-75]		62 [52-72]	
	Med inliers [P25-P75], Years	66 [54- 75]		66 [54-75]	

Legend: a: chi squared, b: Mann Whitney, Med=median, p25=percentile 25th, P75=percentile 75th, IQR : interquartile range ,F=Female, M=Male

Figures

Figure 1: Box plots representing the median NAS divided by shift and 24h



Legend:

P1 = period 1, P2 = period 2; PICU = NAS afternoon and morning are combined into one day;
 ☿: comparison NAS 24h with p value < 0.001 (Test Kruskal Wallis for multiple comparison and Mann Whitney for simple comparison)

Appendices

Annex 1: Hospitals participating in the study

Hospital	ICU Beds
CHU Marie Curie, Hôpital Civil - Charleroi	32
CHU Ambroise Pare - Mons	14
Clinique de l'Europe, site Saint Michel - Bruxelles	8
CHwapi - Tournai	36
CHC Clinique Notre-Dame - Waremme	6
CHR de la Citadelle - Liège	48
CHR East Belgium - Verviers	18
CHU Brugmann site Victor Horta et Paul Brien - Bruxelles	35
Clinique Saint-Jean - Bruxelles	15
CHC Clinique de l'Espérance - Montegnée	10
CHC Clinique Notre-Dame - Hermalle	6
CHC Clinique Saint-Joseph - Liège	22
HIS Hopitaux Iris SUD, site Bracops - Bruxelles	12
Hôpital de Jolimont, La Louvière	22
Hôpital Universitaire des Enfants Reine Fabiola - Bruxelles	18
CHU Tivoli - La Louvière	14
Total	316

Annex 2: Description items of NAS by shift

Items	3 shift, frequency (%)			pvalue	2 shift, frequency (%)		pvalue
	Morning (n=9856)	Afternoon (n=9126)	Night (n=9352)		Day (n=1945)	Night (n=1536)	
1. Monitoring and titration	9805 (99)	9070 (98)	8426 (90)		1935 (99)	1520 (99)	
1a. Hourly vital signs, regular registration and calculation of fluid balance	6689 (68)	6125 (67)	5884 (63)	0.001	1268 (65)	1087 (71)	0.001
1b. Present at bedside and continuous observation or active for 2 hrs or more in any shift	2911 (30)	2757 (30)	2375 (25)		575 (30)	374 (24)	
1c. Present at bedside and active for 4 hrs or more in any shift for reasons of safety	205 (2)	188 (2)	167 (2)		92 (5)	59 (4)	
2. Laboratory, biochemical and microbiological investigations	7706 (78)	7106 (78)	7818 (84)	<0.001	1651 (85)	1326 (86)	0.229
3. Medication, vasoactive drugs excluded	9267 (94)	8474 (93)	7873 (84)	<0.001	1875 (96)	1454 (95)	0.013
4. Hygiene procedures	9727 (99)	8748 (96)	7634 (81)		1885 (97)	1455 (95)	
4a. Performing hygiene procedures such as dressing of	7108 (72)	6734 (74)	5804 (62)	<0.001	1174 (60)	1038 (68)	<0.001
4b. The performance of hygiene procedures took 2 hrs in any shift	2347 (24)	1842 (20)	1701 (28)		670 (34)	401 (26)	
4c. The performance of hygiene procedures took 4 hrs in any shift	272 (3)	172 (2)	129 (1)		41 (2)	16 (1)	
5. Care of drains, all (except gastric tube) 1.8	7399 (75)	6785 (74)	6333 (68)	<0.001	1181 (61)	949 (62)	0.522
6. Mobilization and positioning, including procedures	9725 (99)	8971 (98)	8008 (86)		1908 (98)	1502 (98)	
6a. Performing procedure(s) up to three times per 24 hrs	2695 (27)	2506 (27)	2541 (27)	<0.001	398 (20)	343 (22)	<0.001
6b. Performing procedure(s) more frequently than 3 times per 24 hrs, or with two nurses, any frequency	6679 (68)	6208 (68)	5312 (57)		1391 (72)	1122 (73)	
6c. Performing procedure with three or more nurses, any frequency	351 (4)	257 (3)	155 (2)		119 (6)	37 (2)	
7. Support and care of relatives and patient	9103 (92)	8563 (94)	6560 (70)		1879 (97)	1370 (89)	
7a. Support and care of either relatives or patient requiring full dedication for about 1 hr in any shift	8523 (86)	7853 (86)	6258 (67)	<0.001	1711 (88)	1284 (84)	<0.001
7b. Support and care of either relatives or patient requiring full dedication for 3 hrs or more in any shift	580 (6)	710 (8)	302 (3)		168 (9)	86 (6)	
8. Administrative and managerial tasks	9743 (99)	9011 (99)	8311 (89)		1919 (99)	1492 (97)	
8a. Performing in routine	6733 (68)	6821 (75)	7063 (76)	<0.001	811 (42)	1149 (75)	<0.001
8b. Performing administrative and managerial tasks requiring full dedication for about 2 hrs in any shift	2916 (30)	2113 (23)	1209 (13)		1081 (56)	337 (22)	
8c. Performing administrative and managerial tasks requiring full dedication for about 4 hrs or more of the time in any shift	94 (2)	67 (1)	39 (0)		27 (1)	6 (0)	
Ventilatory support							
9. Respiratory support	7476 (76)	7011 (77)	6566 (70)	<0.001	1465 (75)	1219 (79)	0.005
10. Care of artificial airways: endotracheal tube or tracheostomy cannula	3733 (38)	3483 (38)	3189 (34)	<0.001	602 (31)	536 (35)	0.014
11. Treatment for improving lung function	6160 (63)	5605 (61)	4999 (53)	<0.001	867 (45)	715 (47)	0.246
Cardiovascular support							
12. Vasoactive medication, disregard type and dose	2442 (25)	2281 (25)	2138 (23)	0.001	356 (18)	306 (20)	0.277
13. Intravenous replacement of large fluid losses.	470 (5)	532 (6)	442 (5)	0.001	122 (6)	102 (7)	0.66
14. Left atrium monitoring: pulmonary artery catheter with or without cardiac output measurement	902 (9)	839 (9)	740 (8)	0.002	68 (3)	56 (4)	0.813
15. Cardiopulmonary resuscitation after arrest, in the past period of 24 hrs	0	0	0	-	0	0	-
Renal support							
16. Hemofiltration techniques, dialysis techniques	745 (8)	664 (7)	523 (6)	0.001	86 (4)	73 (5)	0.642
17. Quantitative urine output measurement (e.g., by indwelling urinary catheter)	8577 (87)	7843 (86)	7200 (77)	<0.001	1796 (92)	1454 (98)	0.006
Neurologic support							
18. Measurement of intracranial pressure	189 (2)	190 (2)	174 (2)	0.529	38 (2)	32 (2)	0.787
Metabolic support							
19. Treatment of complicated metabolic acidosis/alkalosis	851 (9)	879 (10)	659 (7)	<0.001	87 (4)	67 (4)	0.874
20. Intravenous hyperalimentation	545 (6)	517 (6)	439 (5)	0.006	83 (4)	62 (4)	0.735
21. Enteral feeding through gastric tube or other gastrointestinal route (e.g., jejunostomy)	3348 (34)	2975 (33)	2678 (29)	<0.001	586 (30)	530 (35)	0.006
Specific interventions							
22. Specific intervention(s) in the intensive care unit	1576 (16)	1127 (12)	504 (5)	<0.001	432 (22)	114 (7)	<0.001
23. Specific interventions outside the intensive care unit: surgery or diagnostic procedures	1037 (11)	691 (8)	112 (1)	<0.001	198 (10)	25 (2)	<0.001

Summary of Nursing Activities Score, available scale in publication of Miranda Crit Care Med 2003; 31:374 –382

[46]; Legend: p value: chi square per shift and per item

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Take-home message:

- In this study, there is a significant difference between the adjusted ratio in Belgium (1/3) and that calculated by the NAS (1/1.5)
- The NAS score per 24h is significantly higher than by ~~two~~ and ~~three~~ shifts
- In Activities that take on average more time are the administrative tasks and mobilizations of the patient