



Royal College
of Nursing

Safe staffing for older people's wards

RCN summary guidance and recommendations



Acknowledgements

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Introduction

Hospital care for older people is currently an area of intense public concern across the UK. Older people and their families' experience of care should be one of safety, dignity and comfort, delivered by staff that have the right skills and qualities to care. Unfortunately, there have been numerous reports published over the last few years that are critical of NHS hospital care for older people in all four countries of the UK:

- Patients Association (2011) *We have been listening, have you been learning?* Patients Association: Harrow.
- Alzheimer's Society (2009) *Counting the cost*, Alzheimer's Society: London.
- Royal College of Psychiatrists (2011) *Report of the National Audit of Dementia Care in General Hospitals*, Royal College of Psychiatrists: London.
- Care Quality Commission (2011) *Dignity and nutrition inspection programme. National overview*, Care Quality Commission: Newcastle upon Tyne.
- Parliamentary and Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. London: The Stationery Office.
- Older People's Commissioner for Wales (2011) *Dignified Care?* Older People's Commissioner for Wales: Cardiff.
- Mental Welfare Commission for Scotland (2010) *Dementia: decisions for dignity*, Mental Welfare Commission for Scotland: Edinburgh.

These reports raise issues about older people's human rights, dignified care and hospital experience, that are highly relevant to, but not exclusive to nursing practice. The Royal College of Nursing (RCN) acknowledges the mounting public concern about whether care for older people is currently fit for purpose, and strongly condemns failures in care, at any level. Concerns must be addressed and a clear way forward identified.

Economic pressures

Changes to NHS services in 2012, such as those triggered in England by the 'Nicholson Challenge' to save 20 billion pounds by 2014 to 2015, are creating immense pressure for hospital services to reduce admissions and length of stay. This means that as beds are closed and admission avoidance strategies implemented, hospitals today can only provide care for older people who are the frailest, most acutely ill and have the most complex needs. To deliver safe nursing care to this group of patients demands both skill **and** time. For example, to provide double-handed care for people who are acutely ill and immobile; to spend thirty minutes or more helping and monitoring a person who has swallowing difficulties to take food and drink safely; to establish communication with someone who has both sensory and cognitive impairments.

In addition, there is a high incidence of delirium (which can develop very quickly) resulting in high risks for patients, challenging behaviour and unpredictable need for additional nursing support. Despite this, our evidence (RCN, 2012) shows that the vast majority of hospitals still have inadequate basic nursing establishments on older people's wards and unsatisfactory arrangements to provide additional skilled support when needed at short notice.

Staff ratios

The RCN has previously published guidance (RCN, 2010a) on staffing which presented the positive association between registered nurse (RN) staffing levels and patient outcomes: more registered nurses means better care, increased patient safety, improved patient experience. Yet older people, who often have the most complex and intense needs of all, often do not fully benefit. Our current work (RCN, 2011; RCN, 2012) has confirmed that older people’s wards have a more dilute skill mix than other types of wards:

- 9.1 to 10.3 patients per RN on older people’s wards
- 6.7 patients per RN on adult general/medical/ surgical wards
- 4.2 patients per RN on children’s wards.

(RCN, 2011; RCN, 2012)

This means that on a typical daytime shift, only half the nursing staff on duty on an older people’s ward are registered nurses. With this

skill mix, there is a risk that care giving may be inappropriately delegated, with very few RNs feeling they have the time to supervise health care assistants (HCAs) properly. On older people’s wards that have fewer RNs than others, more episodes of missed or compromised care are reported. Furthermore, the total staffing levels (RNs plus HCAs) are too low; on a typical day on a 28-bed ward there will only be six staff on duty (three RNs and three HCAs). Together with the low skill mix, this means that often there is simply not enough time and skill to satisfactorily deliver activities such as comforting and talking with patients, yet we know that this is of fundamental importance and high value for older patients and a source of distress for nurses if it cannot be carried out.

Table one shows how frequently different aspects of care are compromised due to lack of time and, that overall, the risk of compromised care is correlated with staffing levels.

Table 1: Correlation between lack of time and care left undone

Activity	Nurses reporting that activity was left undone, or was done inadequately on their last shift due to lack of time
Comforting/talking to patients	78%
Promoting mobility and self care	59%
Oral hygiene	48%
Falls prevention	45%
Sufficient change of patient’s position	41%
Information giving to patients and families	38%
Helping patients with food and/or drink	34%
Helping patients use the toilet or manage incontinence	33%
Prepare patients and families for discharge	30%
Skin care	30%
Pain management	19%
Care for dying patients	17%

Skill mix

It is unacceptable that there should be a more dilute skill mix on an older people's ward than on a general medical, surgical or other adult ward. This is an historic disadvantage dating back to the 'geriatric' wards of the past, which were staffed predominantly by nursing auxiliaries and stigmatised by institutional regimes and depersonalising care such as 'toilet rounds'. Support workers (such as health care assistants and assistant practitioners) do receive training, are caring and competent but sometimes the standard of their training can vary considerably (Griffiths & Robinson, 2010) and they should not be directly substituted for registered nurses. Staffing for older people's wards must be modernised and all traces of age discrimination eliminated.

Today's older people's wards need enough staff, highly skilled nursing teams and flexible staffing arrangements. They cannot weather further cuts. We have evidence from the RCN's *Frontline First* campaign that 48,000 NHS posts have gone, or are earmarked to go, in England alone. With these short-sighted cuts, the NHS faces a very real danger of losing many members of a highly skilled workforce.

Safe staffing for older people's wards (RCN, in print) draws on further evidence from our survey of nurses who work on older people's wards, nurse focus groups, a panel of expert nurses from across the UK, stakeholder consultation and literature review, to set out guidance and recommendations for provision of good quality, compassionate and safe nursing care for older people in hospital. It identifies what the factors and challenges are in caring for older people in hospital today and sets out what is needed to meet the expectations of patients, nurses and the public, both now and in the future. It is obvious that simply increasing overall staffing levels without addressing related factors such as leadership, skills and skill mix, staff attitudes, environment of care and workforce organisation will not, in itself, bring improvements in standards of care and patient experience. Therefore, these related areas and the underpinning premise that older people have a right to good nursing in hospital have been directly addressed throughout these recommendations and accompanying full report (in print).

RCN key recommendations

1. Ultimately, safe day-to-day staffing levels for older people's wards should be determined locally, following principles that are set out in the RCN *Guidance on Safe Staffing Levels in the UK* (RCN, 2010) but with specific considerations relating to the nature of care for older people with complex needs. We have heard evidence from many nurses that existing workforce planning tools may not adequately reflect the quality or quantity of care needed by older people. Regardless of the specific tools that may be used, planning or reviewing the staffing levels for older people's wards should:
 - use a systematic approach and use it consistently
 - involve staff in both the principles and outcomes of a review
 - triangulate: for example, patient dependency-based workload tools should be complemented with professional judgement and benchmark data from matched comparators
 - have adequate uplift: having identified the nursing staff needed, the establishment itself must be calculated to allow for service delivery times and staff away from the service. The RCN recommends that a 25 per cent uplift is applied
 - evaluate: the only way that we can judge whether the staffing level for a service is optimal is by looking at indicators of its sufficiency
 - be regularly reviewed. The Healthcare Commission (England and Wales) recommended that staffing should be reviewed at least every two to three years.
2. Ward sisters/senior charge nurses on older people's wards should be empowered to make decisions on safe staffing for their area. Use of acuity/dependency tools alone is not sufficient to determine staffing requirements for older people's wards. Ward sisters/senior charge nurses must be helped to use their professional judgement to ensure safe and realistic day-to-day workload planning. Professional judgement should take account of the following factors that are specific (although not completely exclusive) to older people's care:

- the environment of care including its geography and its appropriateness for caring for older people, particularly for people with dementia and people at risk of falls
 - additional need for one-to-one care or other additional support for patients suffering from delirium, acute confusion, wandering, falls or other high risks
 - time required to support relatives and lay carers and to involve them appropriately in care
 - time and skills required to manage complex discharges
 - time needed to communicate with older patients who may have sensory or cognitive impairments
 - the skills and competence of the staff available in caring for older people
 - time needed to provide essential care in a compassionate and person-centred way
 - time needed to supervise and support health care assistants, assistant practitioners and other support worker roles, to ensure that care is person-centred rather than task-driven, and that support workers maintain and develop appropriate skills in the care of older people.
3. The RCN does not recommend a universal minimum staffing level. However, the RCN does have recommendations on skill mix (RCN, 2006) and our evidence relating to older people’s wards (RCN, 2012) also indicates that there is a threshold of staffing numbers below which care becomes compromised. Our recommendations for older people’s wards are given below, but the ward sister/senior charge nurse must be the final arbiter of whether the staffing for that day is appropriate for the specific needs and case mix of patients on the ward (see point 3(iii)).

(i) Skill mix

The current skill mix on older people’s wards is typically 50:50 registered nurse: health care assistant. On a typical 28-bed ward, which has six staff on day duty, this equates to one registered nurse for nine patients. For basic safe and satisfactory care, and to benchmark with the skill mix on general adult medical/surgical wards, it should be at least one registered nurse for seven patients (numbers have been rounded to the nearest whole number). For ideal care, the skill mix on older people’s wards should also aim to meet the RCN recommendations of a ratio of registered nurse to health care assistant of 65:35 or above (RCN, 2006). This equates to a registered nurse to patient ratio of 1:5. The skill mix on older people’s wards should therefore be at least 1:5 to 1:7 RN: patient, never exceeding 1:7. Some areas may need a richer skill mix than this depending on patient need.

(ii) Overall staffing numbers

Many older people’s wards are currently functioning on six staff for 28 beds, which is not enough for safe care, let alone good quality care. For basic safe care the overall staffing levels should not drop below one member of staff to 3.3 to 3.8 patients (depending on acuity). This means that on a typical 28 bed ward, at least eight staff would be required on duty rather than the current six, with no less than four of these being registered nurses. This excludes the ward sister/senior charge nurse, who should be supervisory (see 3(iv)). It also excludes any additional requirements to provide one-to-one care or other support for high-risk patients.

	Skill mix	RN: patient ratio	Staff: patient ratio	Number of RNs	Total staff on duty
Current	50:50	1:9	1: 4.6	3	6
Basic safe care	50:50	1:7	1: 3.3 – 3.8	≥4	≥8
Ideal, good quality care	65:35	1:5 - 1:7	1: 3.3 – 3.8	4 - 6	≥8

(iii) Additional nursing support

Ward sisters/senior charge nurses must have rapid access to additional nursing resource during periods of high patient acuity, dependency and risk. This includes provision for one-to-one care when needed. This resource must be budgeted within the service and be immediately available for the supervision and support of patients at high risk of harm, such as patients with disturbed behaviour, who wander, or who are at very high risk of falls. These staff must be appropriately skilled to care for older people. Expert opinion suggests preferred options could be access to a local nursing bank or flexible 'pool' of nurses that is surplus to the ward establishment, from which staff can be allocated on a daily basis. It is not acceptable that wards must wait for additional assistance, that agency nurses are used in these roles, or that funding for 'specials' has to go into 'overspend'.

(iv) Senior clinical support

Ward sisters, charge nurses and their teams should also have access to senior clinical support and leadership from nurses who are expert in the care of older people (such as consultant nurses) and there should be adequate arrangements for psychiatric liaison and specialist dementia advice. Data on the exact number of posts, such as consultant nurses, is not available but we do know that distribution is inequitable across the UK. Hospitals, trusts and health boards must ensure that there is at least one senior clinical role and adequate numbers of support roles and arrangements for their organisation. These posts should deliver both clinical and service development skills, providing direct care as well as championing older people's care across the organisation and nurturing innovation and improvement at ward level.

4. Strong leadership for older people's wards is essential, both at ward sister/charge nurse level and from executive nurse directors.

(i) Ward sisters/senior charge nurses must have sufficient time to lead and support their teams. Simply meeting recommended staffing levels or deploying additional staff will not provide safe care unless the leadership and organisation of the workforce is right. There must be a nurse in charge of every shift. The RCN (2009) recommended that all ward sisters

and team leaders become supervisory for the purpose of maintaining and improving the quality and consistency of health care experienced by patients and service users. This recommendation applies as much to older people's care as any other. On older people's wards, the ward leader has a key role in developing a positive culture towards older people's care. Recruiting and retaining staff that have the right skills and attitudes to care for older people, championing older people's rights and with zero tolerance to age discrimination.

(ii) Executive nurse directors/directors of nursing must provide strong leadership and support to ward sister/senior charge nurses and their teams. This means that they must:

- champion the needs of older people at board level
- recognise the key role of the ward sister in achieving high standards in the care and culture on their ward
- empower their ward sisters/senior charge nurses to deploy these recommendations
- support development of metrics that identify the nursing contribution and champion this at board level
- ensure that systems are in place to assure the quality of care for older people across the organisation
- identify budgets for safe staffing and flexible additional resources
- regularly review staffing establishments with their ward leaders.

5. Wards must have sufficient professional staffing and support at patient meal times to ensure that all patients who need assistance with food and drink receive it. Older patients may have extra need for assistance due to nutritional factors, swallowing difficulties, cognitive and sensory impairments. This increases the time needed to provide compensatory care for patients as well as to promote independence. Older patients also need help to prepare for mealtimes, wash their hands or to open containers. This is not just a nursing role and may involve other members of the health care team such as doctors and therapists. For patients with less complex needs, use of new roles such as nutritional assistants and arrangements for supplementary support by non-clinical staff,

families or volunteers should be explored. If family or volunteer support is used, this should not replace NHS nursing staff, but should be deployed to supplement activities for patient comfort, social and psychological support, preparation and non-complex support with eating and drinking.

6. Appropriate training in the knowledge and skills to care for older people must be available to all nurses at both pre- and post-registration levels, and to health care assistants and assistant practitioners, appropriate to role. This includes knowledge and skills on:
 - delivering dignified, person-centred care for older people and understanding the patient experience
 - human rights, mental capacity issues and safeguarding vulnerable older people
 - understanding the ageing process and how this impacts on health and wellbeing
 - recognition and management of cognitive impairment, dementia, delirium and depression
 - identifying frailty and co-morbidity and the impact on health need
 - communication when meeting the needs of people with cognitive and sensory impairment
 - identifying and meeting psycho-social needs in later life
 - meeting carers' needs
 - continence promotion and management of incontinence
 - nutritional needs in later life and support with eating and drinking.

In our current survey (RCN, 2012) less than half of registered nurses thought that health care assistants had the training and support they needed to care for older people. Our focus groups have also identified a shortfall in appropriate specialist courses in the care of older people for registered nurses. For all staff, continuing professional development is vulnerable to economic pressures and the RCN has concerns regarding the impact on quality of care. The RCN (2011) has identified that 35 per cent of NHS nurses report that the amount of continuing professional development time has decreased in the last year. This raises serious concerns for the quantity and quality of future professional development for nurses caring for older people.

For health care support worker roles (HCSW), the current UK Government proposes the development of a code of conduct and minimum standards for education and training in 2012 (already in place in Scotland), followed by a system of voluntary registration to be introduced in 2013. The RCN continues to call for a mandatory system of regulation in order to adequately protect the public. Together with staffing levels, the regulation of HCSWs remains a high profile campaigning issue.

7. Ward sisters/senior charge nurses must have a determining influence in selecting staff for their teams, but must also have adequate administrative and human resources support for this process. Recruitment and selection of nursing staff should aim to identify staff that have the right knowledge and skills to care for older people and include a focus on values and attitudes. Subsequent support, development and appraisal of staff should be led by the ward sister and focus on performance in this area. Our survey has identified that 90 per cent of nurses enjoy working with older people, but only 14 per cent feel that the specialty has a positive image. Appropriate leadership needs to be in place to develop the workforce, attract high-quality staff and nurture pride in working with older people. Ward sisters/senior charge nurses have a key role to play in this.
8. Metrics need to be developed that recognise the full nursing contribution, including compassionate care, communication and its impact on patient experience and outcomes. Our evidence strongly indicates that there is inconsistency in current metrics, which neither effectively capture this nor inform workforce planning for older people's wards properly. Caring for older people is not just a series of tasks, but is complex and time consuming, both in terms of the physical needs and the psychological/social needs of patients. This does not get accurately reflected in current planning. The RCN has published its *Principles of nursing practice* (RCN, 2010b) which sets out a framework describing the breadth and value of nursing care, including care and compassion, which patients, colleagues, families and carers can expect from nursing. This applies to the care for older people and needs to be accurately reflected in outcome measures and workforce planning.

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Notes



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