

Persistent challenges to providing quality care

An RCN report on the views and experiences of frontline nursing staff in care homes in England



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Acknowledgements

The RCN would like to thank every member who responded to the care home survey. The issues this survey touched on are clearly important to RCN members, and are of increasing relevance – as shown by the increase of survey respondents in 2011 compared to 2010 (from 339 to 584). Views of members are a crucial part of understanding the challenges that care homes face today, and importantly, of how these can be overcome. The RCN is keen that the voice of members is heard in this debate so that consistent, quality care can be accessed by every care home resident, wherever they live in England.

Introduction

The inconsistent quality of care in care homes has been an area that, over the years, the Royal College of Nursing (RCN) has repeatedly identified and called for urgent action on. In 2004 and 2010, the RCN carried out surveys of its members who work in care homes and published the reports *Impact of low fees for care homes in the UK* (Royal College of Nursing, 2004) and *Care homes under pressure* (Royal College of Nursing, 2010). What was striking about both reports' findings was their similarity, despite having been conducted six years apart. Findings included: rising dependency and care needs of residents, inappropriate admissions and lack of equipment, inadequate staffing levels and inappropriate skill mix to meet nursing and care needs.

These findings pointed to worrying trends relating to the quality of care in care homes. These are likely to be compounded by the social, political and economic contexts in which care homes operate, and to result in further, unprecedented demands on care home services, including:

- The population is ageing and people are living longer with long-term conditions and disabilities, resulting in increasing care home needs.
- There is the much cited goal of shifting care from provision in the acute to the community sector – the argument being that the community can best accommodate patients' needs. The question remains – does it have the capacity to do so?
- As the NHS struggles to meet increased demand on its services with less money (the £20 billion efficiency or 'Nicholson' challenge), reducing lengths of stay and bed capacity will lead to more people being cared for outside of the NHS, including in care homes.
- There have been policies to encourage hospital discharge such as fines for local authorities who cannot find places for patients. Although this may change (Luke Clements Training, 2011), this means more (and sicker) people returning back to care homes after hospitalisation.
- Efforts to manage claims that early discharge, which can be to care homes, is leading to high re-admission rates (Roberts, 2010) include a 30 day re-admission penalty for the NHS. In light of its relatively recent application, its full impact is unknown. Whilst the balance of where people

in need of care actually receive it (at home, in a care home, or in the NHS) is changing, the RCN believes that it is likely that such policies will be impacting on care home admissions, with residents entering with more complex needs than before.

- The Health and Social Care Bill is unprecedented in the scale of the reforms it proposes to the NHS, and will no doubt have significant implications for social care too.

In view of the scale and pace of changing demand and of the previous surveys' findings, the RCN felt it had a critical role to monitor and report on the key frontline insights that its members can provide. The RCN therefore decided to run the care home survey again in 2011.

Heightened media and public interest into the quality of care homes in England has resulted from notable, appalling examples of care such as Winterbourne View and the alarming, failure of the business model underpinning Southern Cross Healthcare – managed by venture capitalists and then the largest care home provider in the UK. This interest brings an opportunity for RCN members' views to be more widely heard and, we hope, finally acted on. Both Winterbourne View and Southern Cross sharply focused minds on the vulnerability of care home residents, who trust and depend on care services and staff for their continued health and wellbeing, and on the fragility and unsuitability of some care home providers.

The work of care home staff is clearly critical to the lives of many vulnerable people, and the challenges to staff providing high-quality care have been long overlooked. RCN members form part of a workforce that is increasingly demoralised and devalued. The RCN will continue to highlight these challenges until fair and sustainable resources are provided and reforms are implemented that accommodate the care needs of residents in England's care homes.

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Executive summary

RCN Surveys

In 2004 and 2010, the RCN carried out surveys of its members who work in care homes. Both survey findings (RCN, 2004 and RCN, 2010) identified the same, worrying challenges to providing quality care in care homes. Given the projected growth in demand of care homes, owing to issues such as an ageing population and the Government's stated goals and policies (i.e. the shift from the acute to the community), the RCN felt that it must monitor and again report on members' key, frontline insights into care homes in England.

The RCN carried out the survey again in 2011. There were 584 RCN member responses in 2011, compared to 339 in 2010.

Key findings

It is important to first note that many respondents were positive about aspects of the care they could provide and the support they received from their organisation. However, even these responses were tempered by the feeling that good care is delivered despite an array of significant challenges.

From all responses, ten key challenges to delivering high-quality care were identified. Many of them are interdependent and, in particular, stem from the lack of funds that the care home sector has had to manage with for many years.

What was particularly striking was that it seems that no progress on addressing the concerns and the challenges that members flagged in 2010 has been made. Indeed, one year on and the picture looks even worse for care homes, their residents and their staff.

The ten key challenges identified are:

1. Funding and admissions

There are three key areas where the lack of funding is affecting the types of residents that care homes accept:

- **people are being admitted with more severe and complex care needs, but with inadequate funding allocated to meet their needs as both social care and Continuing Health Care (CHC) eligibility criteria are being tightened.**

As found in last year's survey, respondents stated that the lack of social care funding in local authorities and tightening eligibility criteria for both health and social care needs

were resulting in residents being placed in homes with much greater dependency needs. While it is right that people are supported to stay at home for as long as possible, the feeling was that local authorities can only afford to fund care needs requiring care home placements when they become critical, or certainly more acute than previously, a problem accentuated by the reductions in CHC budgets. This means some people have to stay at home when their needs would be more appropriately cared for, and their quality of life and independence improved, in a care home

- **'inappropriate' residents are accepted – i.e. residents with needs that a care home may be inadequately equipped to meet are accepted as the home needs to fill vacant places.** There was a significant increase from last year's responses: last year 34% agreed with this statement, this year 48% of respondents agreed (up 14%)
- **care homes have an increasing preference for self-funding residents** in light of the low fees local authorities pay and cuts to CHC, and since higher fees could be charged for private residents. Some care homes manage the low fees from local authorities by only taking residents who can privately top-up payment. This situation clearly has implications for equal access to care.

2. Staffing levels

The shortage of care assistants and registered nurses was reported to be among the top issues that most frustrate respondents about their jobs. However, while many members feel that staffing levels are a key issue and concern for them, the lack of guidance on staffing levels in care homes, makes it hard to quantify the extent of the problem. It was nonetheless clear from members' responses that staffing levels are an issue that puts considerable pressure on staff and therefore:

- impacts on the quality of care that they can deliver. Many members felt that the care they were delivering fell short of their own expectations
- compounds the pressure homes have with meeting the needs of residents with higher dependency and more complex needs.

3. Appropriate skill mix

Again, the lack of guidance around appropriate ratios for registered nurses and health care assistants makes it difficult to quantify how significant the issue of skill mix is. However, 15% of respondents stated that there is not always a registered nurse who knows the home and residents in charge, and nearly one in ten respondents (8%) said that a health care assistant or an auxiliary nurse takes charge of the care home frequently.

With the increased ‘medicalisation’ of homes, the lack of a clinical oversight in some homes puts residents’ safety at risk, as well as considerable pressure on those staff who are not clinically qualified and who are left in charge.

4. Recruitment and retention

The problem of recruitment and retention in the care home sector has been widely discussed, and again was raised by RCN members in the previous care home surveys.

In 2004, only 4% of respondents had worked in their current workplace for less than one year and 20% had worked in their workplace for more than ten years. In 2011, 26% respondents had worked in their current workplace for less than one year and 14% had worked in their organisation for ten years or more.

A key concern about high turnover and the difficulty in recruiting staff relates to skill mix. Often new starters lack appropriate skills and subsequently have to learn on the job. Worryingly, one respondent said that errors were being overlooked by management so that staff do not leave.

Agency staff are often used to meet problems in recruitment and retention that care homes face. Whilst recognised for their invaluable staffing input, particularly in filling in for colleagues who are off sick, some respondents did state that the use of agency and bank staff can have an impact on safety, care quality and continuity of care, and are often strangers to the residents in their own homes. On the other hand, some care homes, exactly for these reasons, do not use agency staff, placing greater pressures on the workforce.

Many respondents pointed to carers’ low pay, often being the minimum wage, £6.08 for workers aged 21 and over and £4.98 for workers aged between 18-20 (Directgov, 2011), or barely above it, as a main cause of the difficulty in

recruitment and retention of carers in homes. A number of respondents stated that care staff often left or did not want to work at the home as they could get better pay working at the local supermarket or airport.

5. Low levels of moral and extreme pressure at work

Inadequate funding, staffing levels and low pay are clearly taking their toll on the care workforce, as many respondents talked about the low levels of morale among staff in their organisation.

This finding is critical, not only because morale is directly linked to the quality of the output that a workforce delivers (Department of Health, 2009), but also because it is a result of the challenges that all three RCN surveys on care homes have highlighted. If the challenges that care homes face remain overlooked year on year, it is likely that the morale of its workforce will continue to deteriorate. This has worrying implications for the quality of care staff can deliver, and would result in the further reduction of the workforce as more staff leave, further compounding existing problems.

6. Lack of training

Again, as in the 2004 and 2010 surveys, many issues were raised by respondents about training. These included:

- a lack of funding to provide training, particularly to provide anything above and beyond statutory training and more advanced or specialist training (i.e. catheterisation, ECG, IV therapy or dementia care)
- a lack of training for care assistants courses which are considered essential in the provision of even basic care (i.e. manual handling)
- if staff attend training, it often leaves the home understaffed. Some staff attend training on their days off
- the high turnover of staff often results in care staff having to support their new employees, and provide training on the job
- a feeling that some organisations’ only concern around training is to fulfil Care Quality Commission (CQC) requirements, not to develop their workforce and to provide better care
- a fear that training will be ‘the first thing to go’ in care homes as management responds to reduced fees from local authorities.

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7. Lack of equipment

Also a notable finding of last year's survey, respondents mentioned their concern about the lack of equipment in the care home they work in. The equipment needed ranged from care specific items such as hoists and shower chairs, clinical items such as sphygmomanometers and SATS machines, general first aid equipment and more everyday items such as bed linen and kitchenware.

When asked if they have access to adequate equipment and medical supplies needed to care for the residents, 26% of respondents disagreed with this statement, up by 6% from last year.

8. Inspections and bureaucracy

Bureaucracy was again cited as a chief concern by RCN members in this year's survey. Many respondents implied that CQC inspections created much of the bureaucracy, which caused management to focus on its' completion.

However, it is important to note that respondents were in support of CQC inspections, with 89% agreeing that inspections of care homes are required to ensure that quality and safety is maintained.

A key finding of the RCN member survey on social care (Royal College of Nursing, 2011a), discharge planning was also said to create a large amount of bureaucracy, which is duplicative, time-consuming and ultimately takes care staff away from delivering frontline care. In the 2011 care home survey, nearly four in ten respondents (39%) said that they spend a large amount of time handling discharge planning and the referral process when residents are transferred from hospitals.

9. The ethic of the care home and concerns about the general management

There were a number of respondents who raised concerns over the business ethic of the care homes they work for, feeling that the organisation and/or general management were driven by profit-making rather than providing high-quality care.

Poor general management was a top concern from open responses regarding what most frustrates respondents about their jobs. Some respondents felt that the organisation's management failed to engage with and utilise the experience of frontline care staff. Respondents also felt unsupported by management and the organisation.

Worryingly, a few members said management staff had neither supported them nor taken them seriously when they had tried to report a concern regarding the care of residents.

10. Difficulties working with professionals from other sectors

Some respondents mentioned the difficulties they face when trying to work with professionals from other sectors because of the shortages of such staff in the community. For instance, some 27% respondents did not feel that there is adequate out of hours support for residents who need medical attention.

Some respondents also felt that a cultural divide between the different professional teams existed and that, compared with nursing staff in the NHS, care home nursing staff were not as highly respected or valued.

RCN Recommendations

The findings of the 2011 RCN care home survey paint a worrying picture of the many daily challenges that care home staff strive to overcome to deliver quality care in care homes. Many of these challenges are not new, with RCN members identifying some of the same concerns in the 2004 and 2010 RCN care homes surveys. However, the scale of these challenges is new. Following years of neglect, these issues have significantly worsened. In particular, the challenges facing care homes and their staff have resulted in the continued depletion of workforce morale to further compound issues relating to staffing shortages and patient safety and care quality. With wholesale reform of both care systems planned, there is a clear opportunity for the Government to address these issues that for too long have been overlooked. The RCN asks that the recommendations below are addressed as a matter of urgency.

- 1. Re-evaluate how funding is allocated to cover the needs of residents in care homes.** Under the current system, the complex care needs and levels of dependency of residents is not appropriately met by local authority funding. This is exacerbated by the continued tightening of eligibility criteria for long-term care as local authorities and NHS providers struggle to make savings. Hence, care homes increasingly prefer to accept self-funders into their homes as local authority care homes fees are too low. Low fees also result in some care homes, desperate to fill vacant places, taking on residents whose needs they cannot appropriately accommodate. If this funding issue continues to be ignored, it is likely that serious breaches to residents' safety will occur.
- 2. Low care homes fees and the shortage of funding means that staffing levels in many care homes are inadequate, risking the safety of residents.** The RCN has called for mandatory staffing levels to be developed in acute and community settings, which must be taken into account by commissioners, regulators and inspectors. The RCN believes that staffing levels in care homes require the same approach (Royal College of Nursing, 2011b). **The RCN calls for national guidance on staffing levels and ratios for care homes. This will need to be determined and applied locally according to the dependency and needs of residents in a home's care and to the demands of the home's day (early and late) and night time shifts.**
- 3. The RCN urges the DH to review the impact of NHS policies on the services provided in the community, including the cited goal of the shift of the provision of services from the acute to the community.** The 2011 care homes survey shows that not only is there insufficient capacity in care homes to deal with the increasing medicalisation of its residents, but also that there are inadequate NHS services in the community to support care homes in their work. Whilst the shift from the acute to the community is a laudable ambition, the Government will have to double-run acute and community services for a certain period of time to ensure that the community has the appropriate capacity to deal with an increase in service users. **The RCN would like to see the Government acknowledge that its ambition needs to be matched with much greater investment if it is to become a reality.**
- 4. Problems with recruitment and retention and low terms and conditions – in addition to the many other significant challenges care home staff are managing – are resulting in low levels of morale in the workforce.** Efforts to address this must be taken forward at a national level, as the seriousness and scale of the issue means local efforts alone will make little headway. **The Government must consider care home workforce planning and address what needs to be in place to ensure that this workforce is also appropriately supported, trained, qualified and valued.** If not addressed, the RCN fears more and more staff will leave the sector, with significant implications for resident safety and care quality.
- 5. The Government must review the bureaucratic and discharge planning systems in place in both the health and social care systems.** RCN members repeatedly tell us how much of their time is spent on completing forms relating to discharge, rather than frontline care (Royal College of Nursing, 2011a). This is not a sector specific issue to care homes but consumes the time and energy of frontline staff across the care systems. As the CQC further refines its approach as result of the DH capability review (Department of Health, 2012), the RCN hopes that the balance of regulation and delivering frontline care is considered. **Growing demand and the need to deliver sustainable and more seamless and integrated care within**

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and between the care sectors, means the Government cannot afford to overlook this issue.

- 6. The RCN has consistently stated that the regulation of health care assistants must be made mandatory and accompanied by a programme of standardised training.** In all care settings, health care assistants are carrying out more and more care duties, including those considered to be nursing roles. This survey has shown that for staffing shortages where registered nurses are unavailable, health care assistants will fill in. Since they are unregulated and lack standardised training, this raises significant issues for patient safety and public protection. Like nurses, health care assistants are in close contact with vulnerable and older residents. It is vital that each member of the nursing team is clear about their level of accountability and that the registered staff are confident when delegating tasks to their colleagues. **Regulation, a code of conduct and standardised training would help give health care assistants a much clearer role definition to help ensure that they are only asked to perform tasks suitable for their competencies, thereby maximising safety and quality of care.**
- 7. Appropriate policies need to be in place in care homes for dealing with staff who raise concerns over the quality of care being provided.** Staff must be aware of the employer's policy for raising concerns and feel able to approach their managers, no matter how serious their concern. Failing this, they should be aware of CQC and its hotline, and raise their concerns to them.
- 8.** The failure of the business model of Southern Cross signals that there are insufficient mechanisms in place to appropriately scrutinise and regulate the financial sustainability of care providers. Care providers deliver vital services for many frail and vulnerable people, people who cannot be easily moved from one home to another as it causes increased stress-related behaviour, morbidity and even mortality. Whilst it is clear that the sustainability of care home providers (and indeed other care providers) is extremely important, therefore, the nature of the mechanisms needed is not. This is compounded by the findings of this survey, showing that many care home staff feel that care home general management and owners often put profit not care first. **The RCN**

believes that the DH must review this area to develop a clearer understanding of the risks of financial failure in the care home sector and to identify any gaps in the regulation specifically for social care finances. It may be that further regulation is needed, or this could be a role that Monitor undertakes in the future.

- 9. The RCN calls for an urgent solution to social care funding, including how to increase funding, with a social care white paper no later than this spring as promised by the Government.** This will be an important step in addressing the long-term and severe underfunding of the care home sector.

Background on care homes

There are 18,255 registered care homes in England, with a total of 459,448 registered places (Care Quality Commission, 2010a). Three quarters of the care provided by care homes is defined as nursing care, although many of the same tasks are carried out in the provision of both nursing and residential care (Bupa and Centre for Policy on Ageing, 2011). Two types of care home exist; care homes and care homes with nursing. Their distinctions are defined as (Care Quality Commission, 2010b):

- a care home provides personal care (help with washing, bathing and medications) and board and lodging. Some care homes are registered to meet a specific care need, such as dementia or terminal illness. In these homes, a district nurse or an NHS specialist nurse would be invited to address the nursing needs. Care homes are therefore not required to employ a registered nurse in their home
- a care home with nursing will have a qualified registered nurse on duty 24 hours per day to administer nursing care.

This report applies the generic term care home to refer to both.

Over the past 30 years there has been a notable shift in the types of providers of care homes, resulting from changes in Government policies and changes in the market place. Thirty years ago local authorities directly owned and ran most care homes; today care homes are predominantly provided by the independent sector and, under current Government plans, local authorities will no longer provide any such services (Department of Health, 2010).

While care home services in England are largely provided by the independent sector, funding for social care services is split between local authorities and the service user (or their family). Eligibility for funding for care services is determined by local authorities through a two-fold assessment process:

1. an individual needs assessment (House of Commons Health Committee, 2010) is undertaken to determine the suitability of a care option. Standard thresholds for needs assessment are categorised as low, moderate, substantial or critical, and based on these thresholds funding for care services is determined

2. a means test assessment is undertaken to determine an individual's capital value (including all assets) and how much they can contribute to their care costs. Currently, the means-tested threshold, above which people are liable for their full care costs, is £23,250 – the average income of a single pensioner is £13,998 (Ross, 2011).

Today, self-funders in care homes constitute around 30-33% of care home residents, leaving local authorities funding the majority of care places (Bupa and Centre for Policy on Ageing, 2011). However, in light of the ageing population and people living longer with long-term conditions and disabilities, funding from local authorities for care has been under severe pressure. Increasingly, local authorities have been left with little choice other than to meet rising demand by tightening eligibility criteria: leaving more people to self-fund, go without care or wait until they meet the eligibility threshold. This trend has been compounded by the broader economic context, which has resulted in significant cuts (of 28% over a four year period) to local authorities' budgets (Local Government Association, 2010).

The result of tightening social care criteria and the general shortage of public funds (both from local authorities and the NHS) for care homes are said to be contributing factors to what is being termed the 'medicalisation' of care homes – or the reported finding that people are entering care homes with much more severe and complex care needs (Bowater and Rainey, 2012). The care home provider Bupa has gone as far as to compare the current provision of care home care as derived from the Victorian poor law model, with provision increasingly being "last resort only used for a relatively brief period, near the end of life, by those with the highest dependency and the greatest need" (Bupa and Centre for Policy on Ageing, 2011). However, it is not yet known how much other possible contributory factors could be responsible for care homes increasingly having to care for residents with severe and complex care needs – such as the shift from acute to community care and early discharge policies. What seems most likely is that both the economic and political contexts and contributory policy drivers and directions seem to be putting more strain on the capacity of care homes. This latest RCN survey will go some way to see how, and if, care homes are coping with this trend.

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Finally, whilst there has been a political consensus for some time around the urgent need for reform of social care funding to better accommodate rising needs, the scale of the problem, a host of other significant issues such as the fairness of the current and future system, and competing political ideologies, means a political consensus on how to reform the system is long overdue (Royal College of Nursing, 2011a). It is hoped, however, that the current Government's independent commission on funding for long-term care will lead to a political consensus early in 2012, when the promised white paper on social care reform is published, so that funds can urgently be injected into the system.

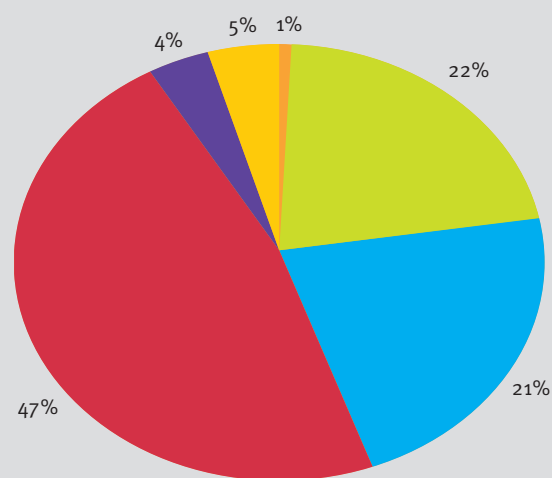
Survey method and profile of respondents

All RCN members who work in care homes in England (8,222) were emailed a link to the online survey. One reminder was sent. There were 584 RCN member responses to the survey this year, compared to 339 last year. This level of interest is significant given how busy RCN members are in their professional lives. The survey consisted of 34 open and closed questions, and ran from 19 July 2011 to 19 August 2011. Like last year, respondents included a wide range of nursing staff working in an equally wide range of different types of care homes. Most respondents were sisters or staff nurses (47%), with the next two largest groups of respondents being managers (22%), and matrons and senior nurses (21%).

The breakdown of providers respondents work for has changed notably since the RCN's first care home survey in 2004, though statistics are not directly comparable in light of the self-selecting nature of the surveys. Still, the differences are notable and indicate how quickly changes have taken place in the care home marketplace. In 2004, the number of respondents working for large chains was 24%, for small companies 25%, with most working for individually owned homes 46%.

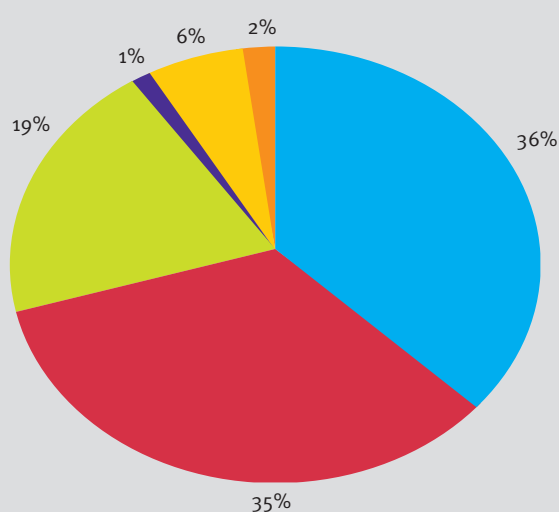
Overall, however, a wide range of providers own the homes that respondents in 2011 work for as shown in the chart below.

Breakdown of the types of roles member respondents have



- Home owner/Senior director
- Manager
- Matron/Senior nurse
- Sister/Staff nurse
- Health care assistant
- Other

Breakdown of the types of care homes member respondents work in



- Part of a large chain
- Part of a small company
- Individually owned
- Local council
- Voluntary sector
- Other

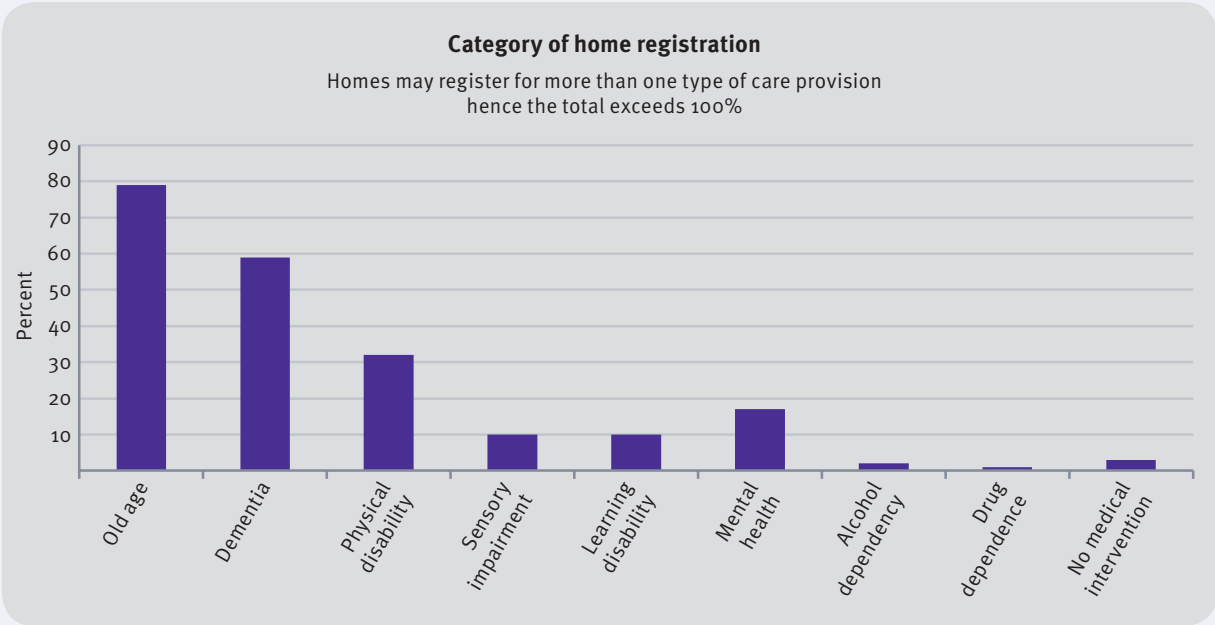
Mirroring trends in the care home market place, very few of the care homes that respondents work in are owned by local councils (1%), with most respondents working for large chains (36%) or small companies (35%), and nearly a fifth (19%) working for individually owned homes.

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Most respondents work in care homes registered as nursing homes (79%). Very few respondents work in homes with no medical intervention (3%), with most respondents working in homes registered with CQC as old age (78%) and dementia (59%).

The care home market that respondents work in is clearly also diverse in relation to the size of care

homes. The bed capacity of the care homes ranged from four beds to 171 beds, the average number of beds was 51 (a few noted plans to imminently increase bed capacity). The number of residents ranged from four residents to 158 residents, the average was 45.



Main report

It is important to first note that many respondents were positive about aspects of the care they could provide and the support they received from their organisation. Some respondents fully endorsed their organisation and the care it delivered (there was some correlation between such responses and the respondent having a more senior role in the home). When asked to rate the quality of care their organisation delivered, 79% of members felt that it was good, although one in ten respondents (11%) did not agree and 10% neither agreed nor disagreed.

However, other survey responses painted a more complex picture of the care being delivered in care homes, and revealed that even the most positive examples were tempered by the feeling that good care is delivered despite an array of significant challenges. From the survey's responses, it has been possible to identify key challenges to delivering high quality care. Many of them are interdependent and, in particular, stem from the lack of funds that the care home sector has had to manage with for many years. What is particularly striking is that it seems no progress on addressing the concerns and the challenges that members flagged in 2010 has been made. Indeed, one year on and the picture looks worse for care homes, residents and their staff.

For instance, perhaps reflecting the context of the economic crisis, concern regarding closure of the home due to financial pressures has risen since last year. Last year only 17% of respondents (66% were not concerned and 17% neither agreed nor disagreed) were concerned about this, whilst this year some 28% of respondents said that they were concerned (52% were not concerned and 20% neither agreed nor disagreed).

We have had lots of staff leave just recently, there are pressures from councils and CQC to provide a "Harrods-quality service for Woolworths prices", staff feel under immense pressure to provide quality care. I fear that care homes may not exist if cuts are made continuously.

Manager, working for an individually owned care home

Other key challenges to providing quality of care seem also to have intensified, again often compounded by or because of the shortage of

funding the sector is facing. These are discussed below under the following headings:

1. Funding and admissions
2. Staffing levels
3. Appropriate skill mix
4. Recruitment and retention
5. Low levels of moral and extreme pressure at work
6. Lack of training
7. Lack of equipment
8. Inspections and bureaucracy
9. The ethic of the care home and concerns about the general management
10. Difficulties working with professionals from other sectors.

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Challenges to delivering high-quality care

1. Funding and admissions:

There are three key areas where the lack of funding is affecting the types of residents that care homes accept:

- people are being admitted with more severe and complex care needs, but with inadequate funding allocated to meet their needs as eligibility criteria for health and social care are tightened
- ‘inappropriate’ residents are accepted – i.e. residents with needs that a care home may be inadequately equipped to meet are accepted as the home needs to fill vacant places
- care homes’ increasing preference for self-funding residents in light of the low fees local authorities pay.

Increasing dependency and complex needs of residents

As found in last year’s survey, respondents stated that the lack of social care funding in local authorities and tightening eligibility criteria for both health and social care needs was resulting in residents being placed in homes with much greater dependency needs. Whilst it is right that people are supported to stay at home for as long as possible, the feeling was that local authorities can only afford to fund care needs requiring care home placements when they become critical, or certainly more acute than previously, a problem accentuated by the reductions in CHC budgets also.

This means some people have to stay at home when their needs would be more appropriately cared for, and their quality of life and independence improved, at a care home.

Local authorities are not funding or placing clients in care. They are being kept at home until the dependency is very high putting extra strain on the staff and the home.

Manager, part of a small company

Due to local authority cutbacks homes are not receiving realistic fees for residents. Our local council has now frozen residency fees for the past three years and this has had an impact on staff training as we have obviously had to make some cut backs ourselves.

Manager, part of a small company

Nearly two in ten respondents (19%) did not feel that the complex needs of residents are adequately

addressed in the home, 70% of respondents felt that they were adequately addressed and 11% neither agreed nor disagreed. These figures compared similarly with last year’s (18% did not feel needs were adequately addressed, 73% felt they were and 10% neither agreed nor disagreed).

My only concern is that we are now taking in residents who need palliative and terminal care. This means a lot more input from RNs over a short period and the turnover and workload is much increased without any increase in staffing.

Sister/staff nurse, working for part of a large national chain

‘Inappropriate’ residents are accepted

There was a significant increase from last year’s responses regarding concerns that financial pressures sometimes mean that the care home accepts residents who are not suitable to the category of registration. Last year 34% agreed with this statement, this year 48% of respondents agreed (up 14%). However, 41% did not agree with this statement and 11% neither agreed nor disagreed.

This financial ‘necessity’ is likely to account for a particularly worrying concern of respondent members: 22% of respondents felt that they are placed in a position of having to do things that are against their nursing judgement (65% did not agree with the statement and 14% neither agreed nor disagreed). This was up significantly from last year when only 16% of respondents agreed with this statement (74% of respondents disagreed and 10% neither agreed nor disagreed).

Care homes’ increasing preference for self-funding residents

Some respondents stated that the lack of funding meant that their workplace increasingly did not take on residents funded by local authorities, since higher fees could be charged for private residents. Some care homes manage the low fees from local authorities by only taking residents who can privately top-up payment. This situation clearly has implications for equal access to care.

Short funding by social services is always a problem. Every patient receives the same quality of care, but there is a huge deficit for the proprietors. We would always choose the private patient at the moment.

Matron/senior nurse, working for an individually owned home

We cannot afford to take in residents that are local authority funded without a top up.

**Manager,
part of a small company**

Some members also mentioned how cuts in funding come from the NHS for nursing and Continuing Health Care are making self-funders more attractive admission options to care homes.

Funding is the biggest issue - those being admitted to nursing homes are mostly having quite complex needs and needing lots of support. Continued Health Care Funding is often difficult to get and the amount given has dropped by nearly £100 a week. In some cases it would not be in the care home's interest to apply for it as it would be a drop in funding as the person privately funds at a higher rate and they are not allowed to top up in CHC funding, e.g. for a premium room. I do not feel the Social Services funding levels is anywhere near the level needed to maintain a quality service and attain all the outcomes set by CQC.

**Sister/staff nurse,
part of a small company**

2. Staffing levels

When asked whether there are enough full-time registered nurses employed to meet residents' needs, nearly four in ten disagreed (38%), which was up significantly from last year (29% disagreed). Although 51% of respondents (12% neither agreed nor disagreed) felt that there were sufficient numbers, this is clearly a worrying number, particularly since many of the concerns raised by members in response to open questions were around staffing shortages.

Staffing levels are the biggest issue facing us every day.

**Sister/staff nurse, working
for part of large national chain**

The shortage of care assistants and registered nurses was reported to be among the top issues that most frustrate respondents about their jobs. However, whilst many members feel that staffing levels is a key issue and concern for them, the lack of guidance on staffing levels in care homes, makes it hard to quantify the extent of the problem.

For instance, some respondents noted that night shifts and post-lunchtime shifts were often understaffed. From respondent information, the following reflects the average number of staff in the day and night:

- day time: 2 registered nurses and 8 care assistants
- night time: 1 registered nurse and 3 care assistants.

However, the lack of guidance – which it is understood would have to be locally applied as residents' needs would vary – means that this statistic only proves that night shifts are less well staffed.

Nonetheless, while it may be hard to quantify the issue, it is clear from members' responses that staffing levels are an issue that puts considerable pressure on staff and, therefore:

- impacts on the quality of care that they can deliver
- compounds the pressure homes have with meetings the needs of residents with higher dependency and more complex needs.

This is discussed below.

Staffing levels and quality of care

Whilst minimum staffing levels remain as they are our care will never meet the standards it should, no matter how hard we try.

**Sister/staff nurse,
working for part of large national chain**

One respondent said the home felt like a 'conveyor belt' in light of staffing shortages, and many other respondents also felt that they were unable to offer personalised, patient-centred care that provided for patients' social and emotional needs. In some instances, this had implications for residents' independence and choice and control over what they would like to do every day, and in some cases it seems that basic needs are not being met. For instance, one member said that some residents would like to have a daily bath or shower, but they can only be offered twice a week. Another respondent said that because of the staffing levels night staff are often expected to get residents up early in order to help the day shift.

When I work a 12 hour night shift I start at 8pm, there are 20 residents on my unit, I have one carer and I am the nurse. The home is supposed to be patient-centred. I would love to be able to spend more time with the residents, listening to them and talking to them. By the time I finish giving out the medication, most of them are asleep!

Sister/staff nurse, working for a small company

We only have time to carry out basic care needs. No time to spend with residents who may be distressed, or simply need some interaction with another human being. We have an activities co-ordinator for 15 hours per week, but this should not be purely left to her.

**Matron/senior nurse,
working for part of a large national chain**

Persistent challenges to providing quality care

We are failing to meet the standards of care of service users because of inadequate staffing levels. We hardly find time to sit and chat with clients. We are always rushing to finish the shift duties. We know that it's a business, but management forget that we are dealing with humans who call and respect the care home as their own home, but we are always rushing them and they lack the 'quality' type of care.

Sister/staff nurse, working for part of a large national chain

Residents waiting too long to be taken to the toilet; dressings not getting changed as often as they should; coming in early and staying late just to do what is needed to keep the place running; no time to talk to resident; rushing all the time; mounting paperwork – to name a few [concerns]!

Sister/staff nurse, working for part of a large national chain

Service users who are catheterised [are] left in a chair for several hours at a time without even standing up to relieve pressure. [The] bare essentials are done only.

Sister/staff nurse, working for a small company

Staffing shortages and residents with higher dependency and complex needs

Reiterating findings from the previous RCN surveys, staffing shortages compounded the issues that members reported about receiving residents into the home who have higher and more complex dependency needs.

Although the staff/resident ratio is appropriate to the number of residents, it does not reflect the high dependency of residents and so staff work under increased pressure to give a high standard of care. This is difficult at times and is not understood by senior management.

Matron/senior nurse, working for a small company

This means that people are more dependent and have more complex needs. This is not reflected in the fees paid by local councils and health commissioners and therefore providers are not always able to recruit staff due to low wages, poor career opportunities and high workloads.

Manager, working for an individually owned home

Due to time and financial constraints staffing sometimes is inadequate. They look at numbers of residents and not their dependency and cut staff accordingly.

Sister/staff nurse, working for a small company

Only that even though we have the 'legal' number of carers per shift, we always need more as the dependency of the residents is so much greater than it used to be.

Matron/senior nurse

We are not short staffed according to CQC, etc., but levels of dependency have significantly risen in last 2 to 3 years. Staffing levels should be reviewed.

Matron/senior nurse, working for part of a large national chain

Low staffing levels and the increasing dependency of the residents, mean that we can only manage to give basic care and are forced to prioritise who we attend to first.

Manager, working for an individually owned home

A few respondents also noted that the needs of people with 'residential' places are not taken into account when management determine nursing staffing numbers, yet these individuals sometimes need more care than nursing patients.

Many residents in our home are assessed as residential, which means fewer staff to resident ratio. I feel that a number of our residential clients should be nursing, as the nurses on duty have to become involved with their care between district nurse visits.

Sister/staff nurse, home currently in administration

3. Appropriate skill mix

In addition to inappropriate levels of staffing, respondents raised concerns over the skill mix of the home. Again, the lack of guidance around appropriate ratios for registered nurses and health care assistants makes the issue difficult to quantify.

An area that sheds some light on how much of an issue skill mix is for care homes is the person in charge of the home. This role is a pivotal and an integral role to the care home and the quality of clinical care it can provide, and who undertakes it can neatly demonstrate problems with skill mix and staffing shortages.

For instance, whilst 78% of members stated there is always a registered nurse who knows the home and residents in charge, some 15% disagreed, and 7% neither agreed nor disagreed. In addition, nearly one in ten respondents (8%) said that a health care assistant or an auxiliary nurse takes charge

of the care home frequently (3% occasionally, 5% rarely) although 84% said never. With the increased 'medicalisation' of homes, the lack of a clinical oversight in some homes is a worrying finding, putting residents' safety at risk, and considerable pressure on those staff who are not clinically qualified and who are left in charge.

4. Recruitment and retention

The problem of recruitment and retention in the care home sector has been widely discussed, and again was raised by members in the previous care home surveys. Members' survey responses reveal both the causes and its implications, such as staffing shortages and the impact this has on the quality of care residents receive.

There was a broad spectrum of years spent in post by member respondents, with 14% working at their organisation for 10 years or more, 7% between 7-9 years, 19% between 4-6 years, 34% between 1-3 years and 26% for less than 1 year. In 2004, only 4% of respondents had worked in their current workplace for less than 1 year and 20% had worked in their workplace for more than 20 years.

Respondents reported that the managers of the organisation were more transient than RCN nursing staff with 17% being in post for less than 6 months, 16% between 6 months and 1 year, 18% between 1-2 years, 17% between 3-5 years and 27% for 5 and above years. High staff turnover in care homes is clearly not limited to the frontline workforce.

A key concern about high turnover and the difficulty in recruiting staff related to skill mix, as often new starters lack appropriate skills and subsequently have to learn on the job.

Due to the constant staff turnover further staff are employed that have no experience and most importantly no ongoing training in basics such as adequate manual handling, dementia awareness, infection control and, as the nurse in charge, my role within the home is so pressurised that I am unable to have time allocated in which to support them.

Sister/staff nurse, working for an individually-owned home

Worryingly, one respondent said that errors were being overlooked by management so that staff do not leave.

Management at times fail to condemn wrong practices by carer assistants fearing that they might leave which would result in more staff shortages.

Sister/staff nurse, working for an individually-owned home

Agency staff are often used to meet the problems in recruitment and retention that care homes face. When asked whether a large proportion of agency staff take on the role of the registered nurse in the home, 12% agreed, 14% neither agreed nor disagreed, and 74% disagreed. Whilst also recognised for their invaluable staffing input, particularly in filling in for colleagues who are off sick, some respondents did state that the use of agency and bank staff can have an impact on safety, care quality, continuity of care and are often strangers to the residents, in their own homes. Their lack of training and 'buy-in' into the home and their role in it were frequently cited as being partly responsible for these issues.

We are lucky to have a core team of very experienced registered nurses (with 30 years' experience, I am lone of the novices!). However, on the few occasions that agency nurses have been used, we have had quality issues. This includes a recent serious medication error.

Matron/senior nurse, part of a small company

Our home employs minimal contracted staff and large numbers of bank staff. The bank staff all work there on a fairly regular basis. This is only done to save money as they can juggle contracted staff hours around and then only pay for absolute minimum of bank staff. Residents are then not being cared for by the same staff all the time which gives less than perfect care due to staff not being totally aware of any recent issues/concerns.

Sister/staff nurse, working for an individually owned home

On the other hand, for these reasons some care homes do not use agency staff, placing greater pressures on the workforce.

My only concern is working short staffed at night. The home manager has made every effort to fill vacancies but many applicants are just not suitable. We do not use agency staff at all. So if we are unable to cover with regular day or night staff we work short. A night shift under these circumstances [is] exhausting.

Matron/senior nurse, working for part of a large national chain

Many respondents pointed to carers' low pay, often being the minimum wage, currently £6.08 for workers aged 21 and over and £4.98 for workers aged between 18-20 (Directgov, 2011), or barely above it, as a main cause of the difficulty in recruitment and retention of care staff in homes. A number stated that care staff often left or did not

Persistent challenges to providing quality care

want to work at the home as they could get better pay working at the local supermarket or airport. One respondent said that nurses in care homes were the lowest paid in the region.

Care staff feel that the hourly rate of pay they receive does not reflect the responsibility they take especially when they find that they could be paid better in a supermarket.

Manager, working for part of a small company

We have some wonderful carers working within the home for only a few pence above the minimum wage.

Matron/senior nurse, working for part of a small company

The best thing I can say is that where I work most of the staff are kind and compassionate people and do their best in sometimes challenging situations, but they just aren't rewarded enough.

Sister/staff nurse, working for part of a small company

For many respondents, the solution to improving quality in care homes started with increasing the wages of care staff so that appropriate numbers of and appropriately skilled staff could be recruited and retained.

It is a false economy to pay low wages for staff as then you attract only poor staff. The level of care goes down, which brings problems for the home and more expense. If care homes value their staff and want to employ good quality staff they need to increase the pay, but they would then have less problems.

Matron/senior nurse, working for part of a large national chain

Until carers are paid a decent wage we will be in this awful situation where it is so hard to retain good staff.

Sister/staff nurse, working for part of small company

5. Low levels of morale and extreme pressure at work:

Inadequate funding, staffing levels and low pay is clearly taking its toll on the care staff workforce, as many respondents talked about the low levels of morale among staff in their organisation.

Too few staff, low staff morale, long shifts. Feel like a general dogs body, not a nurse a lot of the time. I work myself to the point of exhaustion and often come home in tears but at least I have job security.

Matron/senior nurse, working for part of small company

This finding is critical, not only because morale is directly linked to the quality of the output that a workforce delivers (Department of Health, 2009), but also because it is a result of the challenges that all three RCN surveys on care homes have highlighted. If the challenges that care homes face remain overlooked year on year, it is likely that the morale of its workforce will continue to deteriorate. This has worrying implications for the quality of care staff can deliver, and would result in the further reduction of the workforce as more staff leave, further compounding existing problems. Indeed, a few respondents were so disillusioned by their work and workplace and said they were seeking employment elsewhere.

Very glum and, as a newly qualified nurse in my first post, I am left disappointed and quite disillusioned by the nursing/care profession/sector!

Sister/staff nurse, working for part of small company

Some members said the demands of relatives and the organisation's approach to management added to the pressures of their job. The lack of recognition for doing a good job was also rated by respondents as a top issue that most frustrates them about their job.

Staff often feel undervalued and unimportant, however the occasional "thank you" does wonders to morale.

Sister/staff nurse, working for part of a large national chain

There was some feeling that low morale was the product of the negative media image of care homes and wider societal views, which result from care scandals such as Winterbourne View, and which they feel unfairly represents the sector as a whole. Negative media reports were also rated by respondents as a top issue that most frustrates them about their job.

6. Lack of training

The majority of staff agreed that there was an ongoing training and supervision programme for staff, although nearly one in ten (8%) disagreed with this statement. Again, as in the 2004 and 2010 surveys, many issues were raised by respondents about training. These included:

- a lack of funding to provide training, particularly to provide anything above and beyond statutory training and more advanced or specialist training (i.e. catheterisation, ECG, IV therapy or dementia care)

- a lack of training for care assistants courses which are considered essential in the provision of even basic care (i.e. manual handling)
- if staff attend training, it often leaves the home understaffed. Some staff attend training on their days off
- the high turnover of staff often results in care staff having to support their new employees, and provide training on the job
- a feeling that some organisations only concern around training is to fulfil CQC requirements, not to develop their workforce and to provide better care
- a fear that training will be ‘the first thing to go’ in care homes as management responds to reduced fees from local authorities.

There were some respondents, for the most part more senior staff, who felt that their care home did offer adequate training and support for their staff’s development needs. These respondents felt that training did benefit both the staff and residents.

Our investment in training and supporting of staff pays dividends in regard to the high standard of care that our residents receive who have complex neurological health care issues and challenging behaviour.

**Director of clinical care,
working for part of small company**

7. Lack of equipment

Also a notable finding of last year’s survey, a number of respondents mentioned their concern about the lack of equipment in the care home they work in. The equipment in need ranged from care specific items such as hoists and shower chairs, clinical items such as sphygmomanometers and SATS machines, general first aid equipment and more everyday items such as bed linen and kitchenware.

Underfunding from social and CHC services, i.e. £5.25 for incontinence equipment per resident, the same for 8 years.

Manager, part of a small company

When asked if they have access to adequate equipment and medical supplies needed to care for the residents, 63% of respondents said that they have access to adequate equipment and medical supplies needed to care for residents, and 26% of respondents disagreed with this statement (11% neither agreed nor disagreed). The proportion of respondents who disagreed with the statement was up by 6% from last year (respondents who agreed were down by 8%).

8. Bureaucracy and inspections

Bureaucracy was rated by respondents as another top issue which most frustrates them about their job, and again was identified as a chief concern in the RCN’s two previous surveys. Many respondents implied that CQC inspections created much of the bureaucracy, which caused management to focus on its completion.

The home is generally well staffed and run but pressure from CQC means they want evidence of everything that goes on, i.e. if the residents are involved in activities. This causes the management to ask staff to write down everything which takes us away from caring for the residents anyway. It’s a paper exercise which does not prove the quality of the care.

**Sister/staff nurse,
working for part of small company**

There is too much time spent qualifying actions and evidencing in writing. The mantra of ‘if it is not written, it has not happened’ is extremely unhelpful.

**Matron/senior nurse,
working for part of a large national chain**

Paperwork takes the largest part of registered nurse’s workload and they are not aware what is going on on the floor.

**Sister/staff nurse,
working for part of a large national chain**

However, it is important to note that respondents support CQC inspections. The majority of respondents (89%) agreed that inspections of care homes are required to ensure that quality and safety is maintained (6% neither agreed nor disagreed and 5% disagreed). One finding of the report may point to progress being made by care homes to fulfil CQC standards. In 2010, 63% of respondents said that the clinical lead in the care home was a registered nurse. In 2011, this figure was up 13%. The RCN raised this issue with CQC in 2009 following our concern that this requirement was not being met. In some cases, it was not possible to have a registered manager who was also a registered nurse (the figure for the registered manager being a registered nurse has remained quite stable at 85%). Clinical expertise at a senior level is required within the home to ensure residents’ health care needs are appropriately assessed and met.

A key finding of the RCN 2010 member survey on social care (Royal College of Nursing, 2011a), discharge planning also was said to create a large amount of bureaucracy. The chief concern was that it was duplicative, time-consuming and ultimately took care staff away from delivering frontline care.

Persistent challenges to providing quality care

Nearly four in ten respondents (39%) said that they spend a large amount of time handling discharge planning and the referral process when residents are transferred from hospitals, 32% disagreed and 29% neither agreed nor disagreed. Some comments referred to differences in how discharge documentation was completed and how much time was spent completing forms received by hospitals about patients.

9. The ethic of the care home and concerns about general management

There were a number of respondents who raised concerns over the business ethic of the care homes they work for. These respondents felt the organisation and/or general management were driven by profit, rather than providing high-quality care. One respondent suggested that a limit is put on the amount of profit a home can make, with the rest being reinvested into the care of the residents.

I work in a privately owned nursing home. There always appears to be a conflict between providing quality care of all categories, e.g. nursing, catering, domestic duties, etc., against financial interest. That is, it is run on a shoestring. This causes stress for staff who are striving to meet all holistic needs of the residents.

Sister/staff nurse, working for an individually-owned home

I think care for profit is the problem, along with changes for the worse in funding, i.e. the manager still needs to make his profit and corners are being cut even more as he is getting less in fees. I can already see the knock on effect for the residents and staff. It just isn't fair that an elderly person who has lost so much, i.e. health, independence, spouse, their home, has to spend their final months or years being given 'value' food and squash, and at the mercy of homes using, at times, inappropriate methods and broken equipment.

Sister/staff nurse, working for part of small company

Poor general management was a top concern from open responses about what most frustrates respondents about their jobs. Some respondents felt that the organisation's management failed to engage with and utilise the experience of frontline care staff. This impacted on how valued staff felt in the organisation and was a cause of frustration amongst them. One respondent said that the home's 'absentee owners' demanded far too much from staff and "fail[ed] to see the link between a successful home and excellent care".

This is a new care home being set up and is meeting with all the usual teething problems, but this is also being hampered by the lack of knowledge by management for the clientele as they have no knowledge or previous experience in working with dementia, not supported, trained appropriately nor valued.

Sister/staff nurse, working for part of a large national chain

All the staff in my home are good at their jobs, are caring and conscientious, but the owners treat them all with contempt, have no insight into the working of the home and seem to see the place as a business run for profit.

Matron/senior nurse, working for part of a large national chain

Too many people with no nursing background have the last word.

Sister/staff nurse, working for part of a large national chain

Respondents also felt unsupported by management and the organisation.

Care staff feel unsupported and not valued, the only time when they see management is when they are investigated for a complaint or they want people to work overtime because of staff shortages due to sickness in most cases.

RCN member

Worryingly, a few members said management staff had neither supported them nor taken them seriously when they had tried to report a concern regarding the care of residents.

10. Working with other sectors

Some respondents mentioned the difficulties they face when trying to work with professionals from other sectors because of the shortages of such staff in the community and also because of a professional, cultural divide.

Whilst 59% of respondents felt that there is adequate out of hours support for residents who need medical attention, some 27% did not agree and 14% neither agreed nor disagreed.

The difficulties we are facing at the moment [are] access to community and specialist nursing services, e.g. tissue viability nurse. The waiting list for physiotherapist and wheelchair services are also too long.

Sister/staff nurse, working for part of small company

Other respondents also mentioned access to GPs, and the treatment and equipment they can

prescribe, and dentists was also a problem. One respondent described the GP as being 'reluctant' to give access to venepuncture.

Kit and equipment can be problematic. The companies have one supplier, and the hospitals another. Access to simple items, MSU bottles, blood vacutainers, path forms, is always via the GPs – we cannot get them direct from the NHS, which is a pain!

Manager, part of a large national chain

Some respondents also felt that a cultural divide between the different professional teams existed and that, compared with nursing staff in the NHS, care home nursing staff were not as highly respected or valued.

Persistent challenges to providing quality care

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