Safe staffing for older people’s wards

RCN full report and recommendations
Acknowledgements

Contributors

Report prepared by:
Nicky Hayes, Older People's Adviser, RCN
Jane Ball, Deputy Director, National Nursing Research Unit, Florence Nightingale School of Nursing and Midwifery, King’s College London
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As our population ages and people live longer with chronic disease, older people have become an even more significant part of our society. Their health and care needs are often complex and require high levels of knowledge, skill and compassion.

It is important that older people have access to the highest levels of dignified care, which upholds their rights as outlined by the National Pensioners Convention dignity code. It is a privilege to care for our older citizens and is an area where nursing actions can make a real difference to people’s lives. It is also an area of nursing which can give a great deal of job satisfaction.

The Royal College of Nursing is very proud of the many nurses who provide extremely high quality care. We have found many examples of excellent practice but share the concerns of our colleagues, and the public, that high standards are not universal. The care and treatment of older people is not always valued as it should be and is often under resourced, delivered in poor environments, with inadequately trained staff.

In this report we have highlighted the imbalance of resources that underpin many of the concerns about older people's care today. Our research has uncovered the extent to which nurses on older people's wards are working to maximum effort yet, still cannot always deliver both the quality and quantity of care they believe is necessary.

This report gives evidence-based recommendations on the range of staffing levels required to enable safe care. It also identifies that, in addition to safe staffing, there is a requirement for strong leadership, high levels of training and a positive-practice environment. This will lead to older people receiving the quality of care they need, a respect for their human rights and being treated with dignity.

We call on commissioners and providers to act on these recommendations to provide good quality care provision to older people, so that they have a positive, therapeutic experience and that public confidence can be ensured.

Janet Davies, RCN Director of Nursing & Service Delivery
1. Summary

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.
- Older People’s Commissioner for Wales (2011) *Dignified care?* Older People’s Commissioner for Wales: Cardiff.

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 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, do not always 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 1 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: Aspects of care compromised due to lack of time

<table>
<thead>
<tr>
<th>Activity</th>
<th>Nurses reporting that activity was left undone, or was done inadequately on their last shift due to lack of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comforting/talking to patients</td>
<td>78%</td>
</tr>
<tr>
<td>Promoting mobility and self care</td>
<td>59%</td>
</tr>
<tr>
<td>Oral hygiene</td>
<td>48%</td>
</tr>
<tr>
<td>Falls prevention</td>
<td>45%</td>
</tr>
<tr>
<td>Sufficient change of patient's position</td>
<td>41%</td>
</tr>
<tr>
<td>Information giving to patients and families</td>
<td>38%</td>
</tr>
<tr>
<td>Helping patients with food and/or drink</td>
<td>34%</td>
</tr>
<tr>
<td>Helping patients use the toilet or manage incontinence</td>
<td>33%</td>
</tr>
<tr>
<td>Prepare patients and families for discharge</td>
<td>30%</td>
</tr>
<tr>
<td>Skin care</td>
<td>30%</td>
</tr>
<tr>
<td>Pain management</td>
<td>19%</td>
</tr>
<tr>
<td>Care for dying patients</td>
<td>17%</td>
</tr>
</tbody>
</table>
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 and 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 nearly 56,000 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.

This document 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 a literature review. It sets 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 report.

Definitions of standards of care

The term “basically safe care” refers to a staffing threshold below which care giving activities become compromised or not done due to lack of time, as identified by nurses responding to our survey. Ideal, good quality care means more than this: it still means that care giving activities are not compromised due to lack of time, but also that care is delivered as identified in our recommendations, ie with compassion within the context of care giving, resulting in a positive patient experience.
2. 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% 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.

(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.

Table 2: Recommendation on skill mix and staffing levels (based on 28 bed ward)

<table>
<thead>
<tr>
<th>Skill mix</th>
<th>RN: patient ratio</th>
<th>Staff: patient ratio</th>
<th>Number of RNs</th>
<th>Total staff on duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>50:50</td>
<td>1:9</td>
<td>1: 4.6</td>
<td>3</td>
</tr>
<tr>
<td>Basically safe care</td>
<td>50:50</td>
<td>1:7</td>
<td>1: 3.3 – 3.8</td>
<td>≥4</td>
</tr>
<tr>
<td>Ideal, good quality care</td>
<td>65:35</td>
<td>1:5 – 1:7</td>
<td>1: 3.3 – 3.8</td>
<td>4 - 6</td>
</tr>
</tbody>
</table>

(RCN, 2010a)
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 less than half of registered nurses thought that health care...
assistants had the training and support they needed to care for older people. The focus groups 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) identified that 35% of NHS nurses report that the amount of continuing professional development time had 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% of nurses enjoy working with older people, but only 14% 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 captures this nor informs 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.
3. Method/approach

This publication was organised around phases of consultation and evidence gathering, using both quantitative and qualitative methods.

Initial consultation was carried out with leaders from key stakeholder organisations and charities that address older people’s issues. There were two round table events which looked at verifying concerns about staffing and older people’s care in hospital, consulting over project outputs and identifying common issues for future action.

The evidence base was analysed through a review of recent media, reports and research literature on issues relating to older people’s care, staffing, nurses’ attitudes and dignity issues. This identified issues and gaps in our understanding of provision of safe nursing care for older people in hospital that could be further explored through surveys, focus groups and field work.

A survey of RCN members who work with older people in NHS hospital settings was carried out in August to September 2011. A follow-up survey in October was aimed specifically at nurses working on older people’s wards (rather than general or other specialist wards that included older people). King’s College London provided consultancy and support for development and analysis of the surveys.

Evidence and advice from nurses who are expert in the care of older people was obtained through several sources: focus groups, interviews and discussions with frontline nurses held during visits to RCN Scotland, RCN Northern Ireland and NHS hospitals in England and Wales; a workshop with expert nurses from across the UK at the RCN in October 2011; and consultation with the British Geriatrics Society Nurse Special Interest Group, which includes senior gerontological nurses from the four UK countries.

The four RCN UK country directors, their advisers and the England regional directors were approached for advice on country and region specific issues on older people’s hospital care, and were formally consulted on the project survey results and recommendations.
4. Background and evidence base

Concerns about older people’s care in hospital

In 2011, the Health Service Ombudsman for England, Ann Abraham, published a report on care for older people in NHS hospitals in England, remarking “... a picture of NHS provision that is failing to respond to the needs of older people with care and compassion and to provide even the most basic standards of care.” (PHSO, 2011, p5). Her report triggered widespread concern about older people’s care and has been a catalyst for much subsequent reflection and calls for action.

Age UK, the NHS Confederation and the Local Government Association launched their commission on improving dignity in care in 2011 and published a draft report in March 2012 (Age UK, NHS Confederation and LGA, 2012). They identify ongoing age discrimination towards older people as a fundamental cause of undignified care and call for positive attitudes at all levels from individual to society. They call for:

“Fundamental changes to the culture, leadership, management, staff development, clinical practice and service delivery of care homes and NHS hospitals to secure the dignified care that is the right of all older people, with the belief that if we get it right for older people, we get it right for everyone.”

The Care Quality Commission (CQC) (2011), in its dignity and nutrition inspections of one hundred hospitals in England, identified areas where standards were not being fully met:

“Both staff and patients told us that there were not always enough staff with the right training on duty to spend enough time giving care.”

CQC further pointed out that the levels of under resourcing make poor care more likely, and those who run our hospitals must play their part in ensuring that budgets are used wisely to support frontline care staff.

Concerns about care for older people had been gaining momentum several years prior to the publication of the Ombudsman’s report, and were not confined to NHS care in England.

Waiting for change, Age UK (2010a) acknowledged the importance of establishing the right staffing levels necessary to maintain privacy in hospital, calling on health care providers to ensure hospital staffing ratios take into account adequate staff to deliver personal and intimate care in a way which ensures fundamental privacy.

The Mental Welfare Commission for Scotland, in its 2010 report Where do I go from here?, identified many positive aspects of the care and treatment of older people in mental health admission wards. However, it raised specific concerns relating to patient safety, human rights and assistance with food and drink. In June 2011 the Cabinet Secretary for Health and Wellbeing announced a new programme of inspections to provide assurance that the care of older people in acute hospitals is of a high standard. NHS boards will be measured against a range of standards, best practice statements and other relevant national documents that are relevant to the care of older people in acute hospitals, including the Clinical Standards Board for Scotland Clinical Standards for older people in acute care (2002).

In 2011 the Older People’s Commissioner for Wales published Dignified care? This report identified variation in staffing levels and raised concerns that ward managers were sometimes unaware of the necessary staffing complements to run wards appropriately. The report stated:

“Amongst many older people and their relatives, there was a perception that staff levels were too low, adversely affecting staff responsiveness and the time available for meaningful interaction with older people.” (p.17)

The Alzheimer’s Society’s Counting the cost (2009) report identifies that staff not having enough time on wards and not having enough staff as key factors in providing insufficient one-to-one person-centred care that people with dementia need:

“Hospitals need to look at staff capacity for delivering high quality dementia care. They will also need to prioritise workforce development budgets for dementia. These need to be a priority in the current financial context to help increase the capacity and throughput of the service by supporting people with dementia out of hospital as quickly as possible.” (p.45)

There are widespread concerns about staffing levels and associated issues, with clear calls for action to address the problems. The recent report of the National Audit of Dementia further calls on the Royal College of Nursing to:

“... provide guidance to trusts/health boards on how staffing levels should be determined, including consideration of measures of acuity and dependency sensitive to the care of people with dementia.” (RCPsych, 2011 p.143).
Economic pressures and appropriate staffing

As stated above, changes to NHS services in 2012, such as those triggered in England by the ‘Nicholson Challenge’ to save 20 billion pounds by 2014/15, 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. For older people’s wards, there is little evidence that the NHS has robustly planned to meet this changing demand. Staffing is an important component of the complex mix of factors that underpin good quality care and crucially will support achievement of efficiency measures and targets. This has been recognised by a number of recent reports and investigations into NHS care for older people.

The challenge of staffing appropriately for the delivery of dignified, safe care for older people in hospital is clearly not just about staff numbers, task delivery or speeding patients through a system under pressure. Key themes and messages from these reports are an expectation that care will be delivered compassionately, by appropriately skilled staff on wards that have adequate numbers of staff to give the individual attention people feel they need. To achieve this, it is essential that we shake off any residual poor image that clings to older people’s care (and the nurses that provide it) and demonstrate a caring, professional and equitable approach across all services and client groups.

‘Cinderella’? The image of older people’s care

The commission into improving dignity in care (Age UK, NHS Confederation and LGA, 2012) identified ongoing concerns about ageism and attitudes towards older people as a causative factor in undignified care. Older people’s services, and their nurses, have certainly not enjoyed a rosy image over the years, and the specialty has been seen as unattractive and difficult to recruit to. Perception of the status of nursing older people has remained low, despite the fact that there is a growing recognition amongst student and qualified nurses of the skilled nature of the job (Nolan et. al, 2002). Current concerns may well reflect a legacy dating right back to the days of workhouses and subsequently the old style NHS geriatric wards, which were considered to be unpopular with nurses and of low status and poor resource (Reed and Clarke, 1999). Chronic underfunding, poor environment, understaffing and poor educational preparation have dogged older people’s services over the years, highlighting the negative perception and low value that has been assigned to older people’s care in the past.

Jane Brooks (2009) eloquently illustrates some of the key themes defining care on older people’s wards in the period between 1955 and 1980:

- laborious nature of the work
- the requirement to work unpaid overtime
- lack of resources
- lack of interest in the patients and staff from other areas of the hospital
- daily routines for patients and staff are defined around mealtimes
- confinement of staff and patients on the wards.

These type of conditions resulted in staff with a low self-esteem and failure to see patients as people, reinforcing the stereotype of a second-class service, kept out of sight and out of mind. The wards were staffed predominantly by nursing auxiliaries who received little or no training and who, like today, constituted an unregulated section of the workforce. Many staff were highly committed and dedicated to providing the best care they could, but working within massive constraints and limited access to professional development. With pre-registration general nurse training still academically at certificate level at that time, it is likely also that the state registered nurses who were in charge of the wards had little, or no theoretical groundwork in application of research relevant to the ageing process and the psycho-social issues in health and wellbeing.

With a historically low skill-mix, ‘basic care’ has tended to be delegated to unqualified staff who are sometimes task orientated and prioritise speed; and if students are allocated to work with these staff, disillusionment and conflict of ideals can set in: “it’s like a conveyor belt, rather than people’s needs being individually met,” (student nurse) (Alabaster, 2006), “that’s how we do it... we treat
them all the same,” (nursing assistant) (Cowdell, 2010). However, nurses have been found to enter nurse training with positive attitudes towards older people and to retain these for the first year (Ryan et. al, 2007). It’s important to recognise that the reality of working on wards which require highly skilled and intensive work, yet lack the structures to properly prepare and support staff, may be a far more significant determining factor in whether nurses wish to work there than negative or ageist attitudes towards the client group.

The reality of nursing older people

Older people account for approximately 70% of hospital bed days and half of recent growth in emergency admissions (CHAI, 2006). The needs of many older patients in hospital today present a unique care challenge due to frailty, complexity and co-morbidities, including significant conditions such as dementia. There is no justification for describing older people’s care today as ‘just basic’. In general terms, older people with dementia use up to a quarter of hospital beds (Alzheimers Society, 2009). They are likely to have additional mental and physical care needs, and are five times more likely to develop delirium than someone who does not have dementia (RCPsych, 2005). The prevalence of delirium on medical wards is 20 to 30% and there is a significant associated burden in terms of length of stay, increased incidence of dementia and higher rates of falls and pressure sores (NICE, 2010). This demands highly skilled care.

Nurses must also balance the management of acutely ill patients with those with dementia who wander, and the difficulty of providing stimulation for those who are medically ready for discharge but are awaiting placement (McLafferty and Morrison, 2004). Older people’s wards, by nature, tend to concentrate patients with these types of needs. This creates both intense workloads and unpredictability due to incidence of delirium and associated risk. This can change on a day-to-day basis. Peaks and troughs in demand are therefore a further complicating factor when attempting to understand staffing requirements. Unfortunately, nursing literature is peppered with ongoing concerns about the struggle to meet demand, resulting in frustration for staff and poor quality care for patients:

“My workplace lurches from one staff crisis to another – trained and untrained .... On day duty I did the work of two people practicably daily,” And: “… it’s all a mad rush which does not make for good caring.” (Schofield et. al, 2005)

Demand often peaks at mealtimes, when a greater proportion of patients on older people’s wards (as compared with general wards) may need help with taking food and drink. Mealtimes and staffing levels have been linked in a number of sources, for example, Age UK’s Hungry to be Heard report (Age UK, 2010b). This states that malnourished patients stay in hospital for longer and have a higher mortality rate than well-fed patients. Having sufficient staff at mealtimes is implicit to meeting Age UK’s ‘Seven steps to ending malnutrition in hospital.’

Commenting on increasing service demands in Time to care? Responding to concerns about poor nursing care, Sawbridge and Hewison (2011) note:

“Despite this, a rudimentary examination of staffing levels would not indicate a significant rise commensurate with these changing demands. It is fundamental to ensure that staffing levels on each shift are sufficient to meet the ever changing needs of patients.” (p.27)

Delivering dignified care for older people in hospital

It is clear from the reports and commissions into older people’s care in hospital, that dignified, compassionate care is top of the agenda. In reality, this care must be delivered in the context of the pressures described above (an inequitable distribution of staffing but increasing intensity of patient need, including cognitive impairment, sensory impairment and delirium). It’s a challenge that strikes at the heart of nursing. Delivery of dignified, compassionate care needs time and resources if it is to be more than a smile, or a few kind words. The RCN dignity in care project survey (Baillie et. al, 2009) identified three key areas that promote dignified care.

1. Environment and resources, including adequate bed space and privacy.
2. Organisational issues, including leadership, management ethos and adequate staffing.
3. Care activities and how they are conducted, ie staff behaviour which is planned, thoughtful and delivered in a sensitive way.
The survey illustrated how nurses try to provide dignified care through thoughtful planning and sensitive communication, preserving privacy and promoting choice, but there must be adequate support to do this. This includes appropriate staffing levels, good leadership and an environment that supports dignified care. Poor staffing levels and high workload in acute care affect the time available to care for patients and maintain their dignity. Many of the nurses surveyed also worked in physical environments that were not ideal for dignified care, for example, overcrowding with nowhere to have private discussions.

The PANICOA study (Tadd et. al, 2011) identified the following key elements of dignified care:
- respectful communication
- respecting privacy
- promoting autonomy
- addressing basic human needs such as nutrition, elimination and personal hygiene needs in a respectful and sensitive manner
- promoting inclusivity and participation by providing adequate information
- promoting a sense of identity
- focusing on the individual and recognising human rights.

It also revealed the challenge of delivering dignified care. Well-motivated staff were often compromised due to a number of factors, including:

“... untenable staffing levels and a strictly demarcated and hierarchical division of labour. These factors can result in a failure to provide continuity of care and care which protects and promotes the individual's dignity.”

(Tadd et. al, 2011, p9)

Bridges et. al (2010) have also rigorously explored dignified care, identifying three key underpinning themes.

1. Connect with me

Continuity of existing relationships with family members and reciprocal relationships with staff members is important. These provide a sense of security and enhance the individual’s sense of significance, belonging and continuity.

2. See who I am

Appreciating and sustaining each person’s identity using a relationship-centred approach. The practitioner should understand the meaning of health and illness to the individual and respond meaningfully.

3. Involve me

Equity between individuals, this means respecting the person's right to self-determination and establishing an equitable relationship through which information is openly shared and meaningful participation can take place.

These studies provide useful frameworks for understanding the breadth of dignified care, and the extent to which it requires positive values, skill and enough time. Compassionate, dignified care is skilled care. Until we are able to effectively capture the time needed, and costs of delivering the compassionate component of care, we will not be able to get staffing levels right.

Determining staffing levels

Despite the concerns about staffing that have been raised by the reports referenced so far, we have very little hard data on the actual numbers of nurses typically on duty – either on exemplary wards or on wards where care has been deemed unacceptable. The few small-scale research studies that have been carried out into staffing factors and care on older people’s wards are not specific to the UK and do not provide enough evidence to be generalised beyond their local context (Morin and Leblanc, 2005; Hooks and Roberts, 2007; Siegler et. al, 2002; Henderson et. al, 2011; Laine et. al, 2005).

Previous RCN commissioned research on staffing identified considerable variation between overall staffing in the UK countries and within specialties – with older people’s care wards having the lowest nurse to patient ratios, and most dilute skills mix. The RCN employment survey (2011) identified that older people’s wards have significantly fewer registered nurses per patient than other types of wards:
- 10.3 patients per RN on older people's wards
- 9.1 patients per RN on general wards
- 4.6 patients per RN on children’s wards.

We do not have data that is specific to older people’s wards within each UK country but Table 3 shows the overall staffing levels and skill mix across the four countries.
The role of ward leaders and the need to support them appropriately. All health organisations in Wales submit their plans to the National Leadership and Innovation Agency for Healthcare (NLIAH) workforce development unit.

Northern Ireland

Recently, staffing levels in hospitals in Northern Ireland have had a richer skill mix than other UK countries; although overall staffing levels are lower (see Table 3). It is recognised that adequate uplift must be applied; having identified the nursing staff needed, the establishment itself must be calculated to allow for service delivery times (i.e. shift patterns) and staff time away from the service (i.e. an ‘uplift’). The RCN recommends a minimum uplift of 25% is applied. Since May 2011, workforce planning in Northern Ireland has been undergoing a review commissioned by the Public Health Agency, facilitated by the Northern Ireland Practice and Education Council for nursing and midwifery. Within this, a specific work programme is exploring normative staffing levels. This is focusing on general medical and surgical wards and anticipates that recommendations will be agreed for those care areas. It is not predicted that any dilution to the skill mix will be recommended. There are no current plans to specifically address older people’s wards.

England

In England there is no central process or agreed workforce tool in use. For example, the NHS Institute for Innovation and Improvement (2012) promotes the use of the Safer nursing care tool, whilst Skills for Health (2012) offers Keith Hurst’s Nursing workforce planning tool. The Centre for Workforce Intelligence was established in 2010, with the aim of informing workforce planning. They published a report on workforce and implementation challenges for the older people’s pathway (CFWI, 2011), in which they reviewed

<table>
<thead>
<tr>
<th>Country</th>
<th>Scotland</th>
<th>England</th>
<th>Wales</th>
<th>Northern Ireland</th>
<th>All nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean patients per nurse</td>
<td>8.8</td>
<td>8.5</td>
<td>10.5</td>
<td>7.2</td>
<td>8.8</td>
</tr>
<tr>
<td>RNs as percentage of all staff</td>
<td>60</td>
<td>59</td>
<td>56</td>
<td>66</td>
<td>60</td>
</tr>
<tr>
<td>N= number of nurses</td>
<td>180</td>
<td>543</td>
<td>150</td>
<td>125</td>
<td>998</td>
</tr>
</tbody>
</table>

Table 3: Patient to nurse ratios (all shifts) and skill mix on NHS ward by country

(RCN, 2010a)
eight models of care, assessing the economic, quality of care and workforce considerations, but this did not directly address staffing levels on older people’s wards.

**Leadership: the role of the ward sister/charge nurse**

It can be seen from this brief survey of the four country’s approaches to workforce management that the role of the ward sister/charge nurse is considered key to determining appropriate ward staffing. Reports that have been critical of hospital care for older people, such as the recent *Commission on dignity in care* (Age UK, NHS Confederation, Local Government Association, 2012), recognise the role as essential to the overall delivery of safe, good quality care. The Older People's Commissioner for Wales (2011) first recommendation is that, on older people's wards, the ward manager must be empowered with the skills and authority to create a culture of dignity and respect, including the authority to select staff, knowledge of the staffing numbers on their ward and the support of specialist consultant nurses. Unfortunately, in practice, ward sisters and charge nurses may lack the practical support necessary and the real authority to make and lead changes. The RCN calls for them to be empowered, supported and resourced adequately to do this. It identifies that the ward sister/charge nurse role is fundamental to the organisation and delivery of hospital nursing and to the standards of care on each hospital ward. Staff management, recruitment and supervision are key aspects of the role of the ward sister/charge nurse, alongside roles in clinical practice, education and teaching (RCN, 2009).

**Workforce planning tools**

The RCN believes that workforce tools have a place within a robust approach to workforce review but they are not sufficient on their own, as they are not supported by evidence of their reliability or consistency. The RCN identifies the following essential elements as key to planning or reviewing nurse staffing (regardless of the specific tools used).

- **Systematic** – use a systematic approach and apply it consistently.
- **Staff involvement** – involve staff in both the process and outcomes of a review.
- **Triangulate** – for example, patient dependency-based workload tools should be complemented with professional judgment and benchmark data from matched comparators.
- **Adequate uplift** – having identified the nursing staff needed, the establishment itself must be calculated to allow for service delivery times (i.e. shift patterns) and staff time away from the service (i.e. an 'uplift*'). The RCN recommends an uplift of 25% is applied.
- **Evaluation** – the only way we can judge whether the staffing level for a service is optimal is by looking at indicators of its sufficiency. This relies on good quality HR data and patient outcomes/quality data being collected. This data should be used to review and inform services (at the unit and board level).
- **Regular review** – the Healthcare Commission recommended that staffing should be reviewed every two to three years.

Our exploration of safe staffing for older people’s wards takes, as a starting point, the premise that strong leadership is essential at all levels. In addition, the empowerment of the ward sister/charge nurse to make decisions about staffing on their wards is likewise an essential factor in achieving good, safe care.
Box 1: Recommendation 1

**Recommendation 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’s *Guidance on safe staffing levels in the UK* (RCN, 2010a), 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:

1. **Use a systematic approach and use it consistently.**
2. **Involve staff in both the principles and outcomes of a review.**
3. **Triangulate** – for example, patient dependency-based workload tools should be complemented with professional judgement and benchmark data from matched comparators.
4. **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% uplift is applied.
5. **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.
6. **Regularly review.** The Healthcare Commission (England and Wales) recommends that staffing should be reviewed at least every two to three years.

Box 2: Recommendation 2

**Recommendation 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 enabled 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.

1. **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.
2. **Additional need for one-to-one care**, or other additional support for patients arising from delirium, acute confusion, wandering, falls or other high risks.
3. **Time required to support relatives and lay carers and to involve them appropriately in care.**
4. **Time and skills required to manage complex discharges.**
5. **Time needed to communicate with older patients who may have sensory or cognitive impairments.**
6. **The skills and competence of the staff available in caring for older people.**
7. **Time needed to provide essential care in a compassionate and person-centred way.**
8. **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.
Box 3: Recommendation 4

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

1. 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) recommends 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, in recruiting and retaining staff that have the right skills and attitudes to care for older people, to champion older people's rights and have zero tolerance to age discrimination.

2. Executive nurse directors/directors of nursing must provide strong leadership and support to ward sisters/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.

Box 4: Recommendation 7

Recommendation 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, identifying individuals who have the right qualities to care for older people. 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% of nurses enjoy working with older people, but only 14% 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 as professional, modern nursing. Ward sisters/senior charge nurses have a key role to play in this.
Skill mix: The value of registered nurses

The RCN has long argued the value of gerontological nursing, both in hospitals, care homes and other care settings, including the role of the older people’s specialist nurse (RCN, 2001). What a difference a nurse makes (RCN, 2004) clearly sets out the contribution of the nurse who has knowledge and skills about caring for older people. Due to the complexity of older people’s needs, nurses must draw on a wide range of knowledge about the ageing process and its impact on all aspects of health, treatment and care needs. For example:

“Consider the nurse who is trying to calm a patient who has dementia and who is noisy and disruptive. During that process, the nurse engages in a complex collection of cognitive, behavioural and practical steps...the deconstructed steps, taken out of context by an unskilled practitioner, would not necessarily result in an effective outcome.” (RCN, 2004)

The skills of the registered nurse are essential, both in planning and delivering care, and in supervising health care assistants and assistant practitioners. Whilst the skills and roles of health care assistants vary, there is no regulation of their roles or mandatory training, and their priorities tend to be task and speed orientated (Alabaster, 2006). Unskilled care may have significant impact on patient experience, for example: being washed on the bed rather than being helped to follow the person’s usual routine as far as possible; having personal care ‘done’ rather than participating; being fed rather than being supported to eat and drink more independently. The end result may appear to be the same, that is, patients who look clean and have received food and drink, but the journey they underwent to get there may be very different, depending on the qualifications and skills of their carer.

In many cases, although support workers (such as health care assistants and assistant practitioners) do receive training and are caring and competent, the standard of their training can vary considerably (Griffiths and Robinson, 2010). Therefore they can not be directly substituted for registered nurses.

In its inspection report, the Care Quality Commission (CQC, 2011) pointed out that “those who are responsible for the training and development of staff, particularly in nursing, need to look long and hard at why ‘care’ often seems to be broken down into tasks to be completed, rather than the person who needs to be looked after.” The situation reported by respondents to our survey (see section 5, below) further illustrates some of the reasons for this.

Registered nurses are essential for good quality care in all specialties and settings. In the report Safe nurse staffing levels in the UK (2010a), the RCN presented evidence that, as the number of patients per registered nurse increases, episodes of compromised care increase accordingly (see Table 4). The guidance also identified that short staffing increases staff stress, with ongoing impact on the cost and quality of care provision. In general, nursing has been demonstrated to have an impact on patient outcomes including mortality, pressure sore rates, wound infections, medication errors, weight loss, length of stay and improved patient experience.

Table 4: Episodes of compromised care and understaffing
Staffing issues are complex and it is important to acknowledge that there will be no simple solution to determining the optimal staffing levels required to meet current demand on older people’s wards within each UK country. The Royal College of Nursing’s position statement on staffing, published in 2010, acknowledges that:

“There is no universal truth about the number of nurses needed, and no shortcuts to identifying the optimal level. Neither the RCN nor any other national body can claim to know what staffing levels should be. Because services, and the staff required to provide them, must be shaped on the basis of patient need – an obvious truism that is nonetheless easily overlooked in our quest to get guaranteed patient safety, and use resources wisely.” (RCN, 2010a).

The RCN recognises that a unilateral call for more RNs or staff in general is not the solution. Simply providing more staff in total does not necessarily guarantee better care. It’s essential that we look at efficient, informed, local use of resources, together with an understanding of the nature of complex care. The driver should be patient need not service-related factors. If we start with a good understanding of the nature of frailty and complexity in acute and rehabilitation care, and then identify the factors necessary to support wards to meet the need, then we should be able to get the staffing right.
5. Findings

**Stakeholder views**

Two round table events were held with chief executives, presidents and older people’s leads from key charities, professional bodies and organisations. They were asked about their concerns and issues relating to care for older people in hospital, and also specifically asked what they would like to see the RCN do in response. This process identified a number of areas of contemporary concern about older people’s care in hospital and about how we may wish to address them.

- Provision of safe, dignified care for older people is seen as not just a nursing issue: engagement of all professional groups in issues relating to dignified care for older people is important – this includes the role of doctors working with nurses to monitor and improve quality.
- Engagement of patient/older people’s groups is important.
- There is a need to evidence how staffing levels and establishments are determined, including, if necessary, challenging directors of nursing/service providers about this.
- Provision of lower or dilute staffing levels is a form of discrimination against older people that should be challenged.
- Minimum staffing levels may be hard to apply as there can be special cases and each ward is different, however, we could address numbers of staff needed to deliver on quality of care.
- Metrics for care and compassion are hard to establish but measures, such as patient stories, could be explored.
- There is a need to recognise the prestige of caring for older people and to reward staff, recognise good practice and to provide incentives.

These views and issues provided a valuable context for the ongoing exploration and evidence gathering project phase.

**RCN safe staffing for older people survey 2011**

The survey was undertaken between August and September 2011. The Royal College of Nursing has a UK-wide membership of approximately 410,000 members, including registered nurses, health care assistants and student nurses. An email invitation to complete the survey was sent to 125,062 RCN members, drawn from the membership database and excluding those whose membership details indicate that they are unlikely to work with older people in an NHS hospital. 1,687 of those responded by completing the questionnaire. Of these, 240 were identified as working in the NHS, on a hospital ward, providing care for older people. The analysis presented here is based on the responses of these 240 nurses.

The questionnaire covered:

- where recipients worked (NHS, hospital, type of ward)
- number of beds and patients on the ward
- characteristics of patients, including respondents opinion of whether frail
- staffing numbers and skill mix (typically scheduled, ideally needed and in reality on the last shift worked)
- staff views (work environment, service quality, workload and older people’s nursing generally)
- activities omitted or compromised due to lack of time.

Respondents were given the option of submitting comments in addition to responses to questionnaire items.

**Respondents**

Two-thirds (65%) of those responding to the survey were staff nurses, with just over a fifth (22%) of responses coming from ward sisters/charge nurses, one in ten from ‘others’ and 3% from health care assistants. Hence the majority of nurses taking part were on pay band 5 (63%), with 32% above this and 5% on bands 3/2.

**Context of care**

The data reported here focuses solely on respondents working on NHS older people’s wards. These wards had typically 28 to 30 beds, although a number were considerably larger (up to 47 beds) and the survey also covered some smaller units.

**Staff views**

Our results confirm that the vast majority of nurses working on these wards (about nine out of 10) enjoy working with older people, and are confident that they have the knowledge and skill they need to deliver high standards of care. Despite this, however, only half consider the quality of care where they work to be excellent, and less than half (43%) would be happy for their relative to be cared for on their ward.
Their negative responses provide some insight into why this might be: 63% say care is compromised several times a week due to short staffing. Also, much of the care on older people’s wards is delegated by RNs, with the majority of essential care provided by health care assistants (HCAs), according to 59% of respondents. Less than half of respondents consider that HCAs currently have the training and support they need to care for older people, and very few, just 16% of respondents, consider that RNs have sufficient time to give the supervision required to HCAs to ensure high standards.

Care left undone or compromised due to lack of time
Nurses were given a list of twelve essential care activities, and asked: “On your most recent shift, which of the following activities were necessary for older patients, but inadequately done/undone because you lacked the time to complete them?”

“Unlike other wards where younger patients get themselves washed and showered independently, it can take ten minutes just to coax an older patient out of bed and up to twenty minutes to help a patient with dementia to take all their pills. No acknowledgment is made of the increased needs of older people so sometimes I write ‘unable’ and they don’t get their medication because there frankly isn’t the time to keep going back to help them with it. They don’t get walked to the loo, just a commode beside the bed because it could take two nurses ten minutes to walk them.”
Survey respondent

“The dependency of the patients means we need more ‘bodies’ on the ward to provide a high level of nursing care. Nutritional needs are not being met because there are more people that need feeding than there are staff. Additionally, we have acutely ill people who need regular observation. This is before looking at medication rounds, ward rounds, social referrals, communicating with families, completing all audits and meeting government and CQC targets, two-hourly commode checks. As a sister, I still have to complete supervision and mentoring. These take me away from clinical work. We also have those who need one-to-one due to dementia and/or acute confusion who may be wandering or at high risk of falls.”
Survey respondent

The proportion of respondents (n=240) indicating that each activity was either undone or done inadequately is shown in Table 5. Most frequently neglected aspects of care were: comforting/talking to patients (78%), rehabilitation activity (59%) and oral hygiene (48%).

Table 5: Activities that were left undone, or done inadequately due to lack of time

<table>
<thead>
<tr>
<th>Activity</th>
<th>Proportion of nurses reporting that activity is compromised</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. Comfort/talk with patients</td>
<td>78%</td>
</tr>
<tr>
<td>h. Rehabilitation (eg, promote mobility and self-care)</td>
<td>59%</td>
</tr>
<tr>
<td>c. Oral hygiene</td>
<td>48%</td>
</tr>
<tr>
<td>a. Patient falls prevention</td>
<td>45%</td>
</tr>
<tr>
<td>l. Sufficient changing of patient position</td>
<td>41%</td>
</tr>
<tr>
<td>f. Information giving to patients and family</td>
<td>38%</td>
</tr>
<tr>
<td>g. Helping patients with food and/or drink</td>
<td>34%</td>
</tr>
<tr>
<td>j. Helping patients use the toilet or manage incontinence</td>
<td>33%</td>
</tr>
<tr>
<td>b. Skin care</td>
<td>30%</td>
</tr>
<tr>
<td>i. Prepare patients and families for discharge</td>
<td>30%</td>
</tr>
<tr>
<td>d. Pain management</td>
<td>19%</td>
</tr>
<tr>
<td>k. Care for dying patients</td>
<td>17%</td>
</tr>
</tbody>
</table>
With staffing levels averaging six staff for 28 patients, nurses must prioritise care activities based on decisions relating to urgency, risk and time available. The survey found that communication and comforting patients was the care activity that was most often compromised due to lack of time, with 78% of nurses identifying this during their last shift. The recent CARE campaign survey (Waters, 2011) also acknowledged that poor communication is a problem and attributed this primarily to staffing levels and workload: 41% attributed it to insufficient staff and 25% attributed poor communication to being too busy and having to prioritise activity. Some research literature also points to the low priority that can be attached to communication, which slips down the priority list when workload is heavy. Staff may feel guilty about spending time talking to patients in case it is perceived as ‘wasting time’ (Henderson et al., 2010). Yet time spent on communication and comforting, as a cornerstone of compassionate care, is both highly valued and expected by patients and the public.

**Staffing levels and skill mix**

A key objective of this survey was to explore and verify staffing levels on older people’s wards by collating some facts and figures about skill mix and the actual numbers of staff actually on duty, rather than the total funded staff establishment. We asked the nurse on the ground specifically about the adequacy of staffing on their ward, whether the ‘typical’ numbers scheduled are sufficient and, if not, what staffing would be needed to cover a shift.

**Skill mix**

“The number of RNs to look after the complexity of older people’s needs is never understood and instead delegated to care assistants.”

Survey respondent

The survey found that currently, a total of six staff – three HCAs and three RNs – are typically on duty on an early shift, to provide cover for a 28 bed ward. Therefore the skill mix remains typically 50:50; more dilute than the RCN benchmark for hospital wards which is 65% RNs to 35% HCAs. This compares with data from the RCN employment survey of the skill mix on general adult wards of 1 RN: 6.7 patients (RCN, 2011). This is a discrepancy of two RNs between older people’s wards and general adult wards (surgical/medical).

**Overall staffing levels**

On the question of whether the existing levels were adequate, 80% reported overall staffing levels were not generally sufficient to meet patient needs.

“The staffing levels given do not take into account patient dependency, merely patient numbers. The majority of our patients are totally dependent for assistance with their activities of daily living. No account is taken in staffing when we have patients who exhibit challenging behaviour.”

Survey respondent

“Sometimes there are just not enough staff to complete daily tasks without rushing, such as IV antibiotics, helping patients with meals and washes, everything is a rush. Patients can feel undervalued.”

Survey respondent

On average, nurses report that a total of 8.1 nursing staff are actually needed to provide cover on a typical 28 bed ward to meet needs safely, which equate to a ratio of 3.3 patients per staff.

The results for an early shift are seen in Table 6 (overleaf). The staffing figures have been divided by the number of beds to give an estimate of the typical patient to nurse staff ratio, and number of patients per registered nurse.
Table 6: Daytime staffing on NHS older people’s wards (typical beds = 28)

<table>
<thead>
<tr>
<th></th>
<th>Typical number of staff rostered to be on duty</th>
<th>Staff on duty on last shift</th>
<th>Staffing needed to meet patient needs safely and provide a satisfactory level of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total nursing staff</td>
<td>6.3</td>
<td>5.9</td>
<td>8.1</td>
</tr>
<tr>
<td>RNs</td>
<td>3.1</td>
<td>3.0</td>
<td>3.9</td>
</tr>
<tr>
<td>HCAs</td>
<td>3.2</td>
<td>3.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Skill mix (%RNs)</td>
<td>49%</td>
<td>50%</td>
<td>48%</td>
</tr>
<tr>
<td>Patient : all staff ratio</td>
<td>4.1</td>
<td>4.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Patient : RN ratio</td>
<td>9.0</td>
<td>9.1</td>
<td>7.0</td>
</tr>
<tr>
<td>N=</td>
<td>N=230</td>
<td>N=96</td>
<td>N=193</td>
</tr>
</tbody>
</table>

Determining safe staffing levels

In order to identify the threshold below which overall care might become unsafe due to compromised activities, we grouped the total number of activities compromised into three bands: high, medium and low level of care compromised. All responses that indicated only three or less of the activities from Table 5 (above) were compromised, were grouped as the ‘low’ band, those where four to five were compromised were grouped as ‘medium’ band, and if six or more activities were compromised, these were grouped ‘high’ band. The numbers of patient per nurse were correspondingly grouped, giving an average of patients per nurse for each band. It can be seen from Table 7 that the staffing levels in areas where nurses reported low levels of compromised care, were much better at 8.4 patients per RN than those who reported high level of compromised care, where the number of patients per RN rose to 10.2. However, because staffing on most wards is well below the level considered necessary by nurses working there, the vast majority of all nurses (89%) reported care was compromised in some way on their last shift. We have very few examples of ‘good’ care environments to look at to determine the staffing associated with uncompromised care.

Table 7: Average nurse to patient ratios by volume of compromised care on last shift (early)

<table>
<thead>
<tr>
<th>Compromised care (number of activities)</th>
<th>Patients per RN (mean)</th>
<th>Patients per nurse (mean)</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (0-3)</td>
<td>8.4</td>
<td>3.8</td>
<td>33</td>
</tr>
<tr>
<td>Medium (4-5)</td>
<td>8.1</td>
<td>4.2</td>
<td>24</td>
</tr>
<tr>
<td>High (6-12)</td>
<td>10.2</td>
<td>4.7</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>9.1</td>
<td>4.2</td>
<td>96</td>
</tr>
</tbody>
</table>
Table 2: Recommendation on skill mix and staffing levels (based on 28 bed ward)

<table>
<thead>
<tr>
<th>Skill mix</th>
<th>RN: patient ratio</th>
<th>Staff: patient ratio</th>
<th>Number of RNs</th>
<th>Total staff on duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>50:50</td>
<td>1:9</td>
<td>1: 4.6</td>
<td>3</td>
</tr>
<tr>
<td>Basically safe</td>
<td>50:50</td>
<td>1:7</td>
<td>1: 3.3 – 3.8</td>
<td>≥4</td>
</tr>
<tr>
<td>care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ideal, good</td>
<td>65:35</td>
<td>1:5 - 1:7</td>
<td>1: 3.3 – 3.8</td>
<td>4 – 6</td>
</tr>
<tr>
<td>quality care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Box 5: Recommendation 3

Recommendation 3

The RCN does not recommend a universal minimum staffing level. However, the RCN does have recommendations on skill mix (RCN, 2006), and evidence relating to older people's wards also indicates that there is a threshold of staffing numbers below which care becomes compromised. The RCN's 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).

1. Skill mix

The current skill mix on older people's wards today 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 basically 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. 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.

2. 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 basically 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 recommendation 4). It also excludes any additional requirements to provide one-to-one care or other support for high-risk patients.
6. Focus groups and expert nurses

During field work at six hospitals in England and Wales in 2011, focus groups were held with frontline nurses from older people’s/complex care wards, orthopaedic and rehabilitation wards, where the majority of care is for older people with complex needs. These nurses were invited to join the focus groups via their managers (matron or head of nursing), who also contributed to discussions in most cases. Whilst this aspect of selection could potentially have introduced bias into the groups, it was used as a pragmatic approach to reaching frontline staff that needed to be released from duty for the meeting. All grades of nursing staff were represented. Participants were specifically asked to describe the reality of caring for older people today; any staffing-related issues in their areas and issues in delivering dignified care for older people. Open discussion was also encouraged regarding any other issues they were concerned about in caring for older people in hospital. They described the challenges involved in caring for a majority of highly dependent patients with complex needs and meeting unpredictable demands and what they felt was needed to meet this challenge successfully.

Key issues revolved around having both the time to care and the skills and support for quality of care: having enough staff who understand how to deliver dignified care, skilfully; who can access appropriate training in care of older people; and who have strong leadership and specialist support in care of older people.

Working with older people today brings nurses a mixed experience: personal enjoyment and satisfaction in working with this client group, tempered by the challenge of meeting complex needs within a system under pressure. Nurses also express considerable frustration in the lack of public recognition of the quality of care that is provided under quite difficult circumstances. Despite this, and in line with our survey findings, the majority of nurses confirmed that overall they enjoy working with older people and have a positive regard for the patients they care for.

Box 6: Nurses’ views on working with older people

“I enjoy working with older people and their families. It’s frequently challenging and demanding, but I feel I can make a real difference.” A consultant nurse

“We want to get across to people how rewarding it can be.” A matron

“It’s not an easier option to care for older people ... calling it ‘elderly care’ doesn’t capture the complexity or the responsibility we have.” A matron

“It’s so diverse and patients’ life experiences are so interesting. One of my patients was a nuclear scientist but you wouldn’t know to look at him.” A staff nurse
Staffing levels and time to care

In line with the survey findings, many participants emphasised the importance of having enough time, both for providing personal care and for communication with patients and families. In particular, many nurses described the time needed to address the special circumstances that often arise for frail older people due to sensory and/or cognitive impairments. They confirmed the high value they place on establishing effective communication both with patients and their families and visitors. The reality is that both time and skill are needed to establish effective communication with frail patients, and to meet the needs of families and informal carers for information and support. Short staffing, lack of time and pressure of competing priorities, all conspire to reduce opportunities to do this.

The time needed to communicate effectively and compassionately, and to provide psychological support is real, but difficult to quantify. It’s not always a separate activity, but is integral to all aspects of care for older people and is what makes patients feel that they’ve been treated as an individual and with dignity. Our focus groups and expert nurses were clear that it is not captured effectively by existing workforce tools or reflected in workforce planning. This supports the RCN position that workforce requirements should not be calculated on the basis of tools alone, but should triangulate in order to take in all factors. For appropriate staffing on older people’s wards, an understanding of the real time that is needed for communication and compassionate care, such as that identified by our expert nurses and focus groups, will help to get staffing levels right.

Box 7: Time to care

“You end up going home feeling that you’ve not done everything you need to do.” A staff nurse

“Giving people information is vital. I’d love to take time to speak to every relative.” A ward sister

“Workforce tools don’t capture work such as DST* completion, or the extra time needed to spend with older relatives, counselling patients or extra time to take medication or complete care or manage delirium/wandering.” A consultant nurse

*DST – Decision Support Tool, part of a set of documents that can be up to sixty pages long, completed primarily by nurses as part of an assessment of patient eligibility for NHS funded continuing health care.
Delivering dignified care

Across the board, the nurses we talked to were clear that caring for older people who have complex needs is highly skilled work. It is not “just the same as caring for anyone else”, nor is it just synonymous with delivering generic dignified care. Dignity is central to the care of older people, but additional characteristic factors relate to ageing.

- Frailty, particularly amongst the oldest people.
- Complex needs of many of the oldest people.
- A person-centred, comprehensive approach. A focus on the tasks of care is inappropriate for this client group. Older people with complex needs require skilled care by experienced, trained nurses who can take an individual approach and address physical, psychological and social needs.
- Multidisciplinary working in all aspects of care, particularly in rehabilitation and discharge planning.
- The need for nurses to move on from traditional nursing models which do not fully describe frailty or complex needs, to more comprehensive gerontological assessment.

Nurses themselves recognise and value the qualities of kindness and compassion in delivering compassionate care for older people, despite the increasing acuity and technical nature of health care. The epithet “too posh to wash” was dismissed by our respondents, who highlighted the need for all nurses to know how to communicate and deal with people, and to demonstrate skill in fundamental personal care. They were clear that whilst caring with kindness and compassion can be demonstrated by a reassuring word or a touch as you are passing, it is also a skill that overcomes communication barriers such as sensory and cognitive impairment, and recognises emotional need. It is an important integral part of all care giving. This requires additional time if it is to be more than just a gesture.

The expert nurse group in the workshop also identified other elements of dignified care that require a high level of skill and time to deliver, such as:

- applying person-centred care with more evidence base and frameworks than ‘in the old days’
- individualising care, using the Alzheimer’s Society This is me leaflet, story books and personal items to orientate and personalise the person’s bed space
- carrying out risk assessments, not just of the environment but also of the person, taking into account mental capacity, ability to give informed consent, the impact of decisions on the person with cognitive impairment and minimisation of fear or distress to them or family/others
- ensuring confidentiality when dealing with person-centred care plans – using an informed and accountable approach to personal information, so that it is shared appropriately.

The expert panel discussed the frameworks identified by Tadd and Bridges (see chapter 4) in the context of delivering dignified care. They agreed that the frameworks captured the key themes relating to dignified care. They also identified the limitations of these frameworks in reflecting the impact of the ageing process on all aspects of health, illness and hospital care, and the additional time needed for this compared with caring for younger adults. To understand the reality of delivering dignified care for older people in hospital, our experts felt that it is essential to also consider the ageing process and its impact on health, illness and recovery in old age.

Training in caring for older people

Many areas are delivering excellent in-house training, including dignity training and dementia training (associated with implementation of the National Dementia Strategy). However, focus group participants felt that there was a lack of other appropriate post-registration specialist training courses specific to the care of older people. The adequacy of the pre-registration curricula was also frequently questioned. In our current survey, less than half of registered nurses thought that health care assistants had the training and support they needed to care for older people. Although registered nurses have a professional responsibility to keep themselves up to date, it’s essential that they have access...
to appropriate training and development. It’s also essential that service providers fulfil their responsibilities in this area by making training available to staff, both registered nurses and health care assistants.

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, across the board, 35% of NHS nurses report that the amount of continuing professional development time has decreased in the last year. This raises serious issues for the quantity and quality of future professional development for nurses caring for older people.

For health care support worker roles, 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.

Box 8 shows the essential knowledge and skills identified for caring for older people in hospital. The RCN calls for appropriate training in these knowledge and skills to be available to all nurses at both pre- and post-registration levels, and to health care assistants and assistant practitioners (appropriate to role).

Box 8: Recommendation 7

**Recommendation 7**

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 relating to ageing and health. This includes:

- 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 skills, for example, 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.
Leadership and specialist support

The focus groups and advisory groups were clear that if good standards of care are to be maintained, and excellence aimed for, ward teams must have sufficient specialist clinical support from experienced, skilled nurses such as clinical nurse specialists for older people or consultant nurses, as well as empowered ward sisters/charge nurses. These roles provide additional leadership and support for practice and service development, and management of the most complex cases.

During the course of the fieldwork and focus groups, many examples of good practice in the care of older people were identified. In these cases, appropriate staffing levels had been achieved and strong leadership was in place, both at ward level and executive level, with additional clinical leadership and support available from clinical nurse specialists and/or consultant nurses for older people.

The examples in Box 9 illustrate how a combination of appropriate staffing, strong nurse leadership and support from clinical nurse specialists, enables excellent care to flourish.

Box 9: The benefits of safe staffing, strong leadership and specialist support

**Aneurin Bevan Health Board**

In the Aneurin Bevan Health Board, Wales, Executive Director of Nursing Denise Llewelyn and her team champion and support care for older people across the organisation. They have produced a dignity in care video – called “look closer, see me”. The video is based on the poem *The crabbit old woman*. Featuring images of older women and narrated by members of both clinical and non-clinical staff, this powerful video is used on induction to reinforce positive values and respect for older people and the contribution that all staff have to make towards dignity and respect. Deputy Director Jayne Elias has facilitated work to map the health board’s dignity plan to the quality framework *Fundamentals of care*, and are looking at the impact of care on outcomes, which are included in a delivery framework from the Welsh Assembly Government’s continence and dementia plans. At ward level, with support from Denise and Jayne, ward leaders Senior Sister Julie Ross and Sister Vicky Williams have transformed a ward that was formerly considered to be failing due to poor staffing and poor environment. The ward was moved into a new area and implementation of the *1000 lives programme* triggered initiatives such as: the introduction of dementia activity boxes; improved signage, eg yellow doors to toilets; use of patients’ own cups brought in by relatives, and intentional rounding. Benefits demonstrated include: reduced falls, reduction in the use of call bells, and reduction in complaints. They feel that this has made a huge difference to staff morale and patient outcomes/safety. Sister Vicki explains that, “Nurses must know their roles and responsibilities. We work more effectively now, and have improved care through team building and better working, not just through staffing levels.”

**University Hospital Birmingham**

Margaret Harries is the Lead Nurse, Older Adults. As part of the hospital’s *Delirious about dementia* programme, she supported nurses on the acute wards to work alongside their activities co-ordinator and volunteers to help to optimise the opportunity for patients to eat and drink. They hold ‘let’s lunch’ and afternoon teas, with tables set up in the day room, or by patients’ beds if they are not well enough. They use china cups and tea pots and create a comfortable, homely atmosphere. The role of the professional nurse is essential: to record food and fluid charts, optimise mobility and ensure patient safety.

This initiative flourishes within an organisation that has excellent leadership. Wards are adequately staffed, with the ward sister making staffing decisions and managing staff flexibly, and an innovative and well supported volunteer programme.

As well as a good skill mix and the right numbers of staff, good leadership and organisation at all levels ensure that patients can receive good care. Sister Martha Bardini ensures that her ward has a focus on nutrition. Patients have an option for cooked breakfast, all patients use food diaries and volunteers help to prepare patients for meals. Red trays and jugs are used for patients who have high-level needs. She is enthusiastic about the volunteer programme, “we have a good relationship with our volunteer organiser. Patients can get dressed if they are well enough and go through to the dayroom for lunch.”
Managing unpredictable demand

“With the type of patients we have, sometimes we can have three or four patients on the ward who need a member of staff to special them [one-to-one care]. Yet staff can still be taken off us. We can ask management for staff but will rarely get it as escalation wards have now been opened up. This jeopardises patient care and staff safety.”
(survey respondent)

“The increased dependency of older patients ending up in hospital at crisis is increasing. Dementia with challenging behaviour is increasing and becoming difficult to manage in the acute environment. This is not taken into account with current staffing levels. Older patients’ care is challenging and unpredictable, making it difficult to review.”
(survey respondent)

The focus groups confirmed that workload on older people’s wards, like all wards, hits peaks and troughs during the day, but with additional demand compared with general adult wards. This is particularly the case around mealtimes when many patients need lengthy assistance, and at other times when patients are delirious, wandering or at high risk of falls.

Mealtimes and assisting older patients with food and drink

Mealtimes, access to food and drink, and adequate support are issues of paramount concern to patients, the public and nurses (see section 4). From our survey, 34% of nurses reported that helping patients with food and/or drink was compromised on their last shift. Our focus groups supported our survey findings; whilst nurses make every attempt to prioritise these activities, even so, there can be times when there is so much pressure that even this essential area of care becomes compromised. Our expert nurses were clear that there is no substitute for professional, skilled nursing assistance when patients have health conditions or disability that affects their swallowing or ability to take food or drink. They also recognised that for the social aspects of mealtimes, and for routine help such as preparing for meals or opening packets, informal carers can have a valuable role, providing that support and supervision is available from ward staff. Examples of good practice abound: University Hospital Birmingham’s Let’s lunch; the use of nutritional assistants at mealtimes, used at York Hospital; identification of needs of people with dementia through use of discreet bed signs at Huddersfield Royal Infirmary; almost universal implementation of red tray systems and protected mealtimes. Whilst there’s no one solution to addressing peak demand at mealtimes, our experts agreed that there must be a local strategy and that sufficient NHS staff must be available when patients need assistance.

Box 10: Recommendation 3(iv)

Recommendation 3(iv)
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. There should also be 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 such as this, 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.
Box 11: Recommendation 5

Recommendation 5
Wards must have sufficient professional staffing and support at patient mealtimes 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. Sometimes 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.

Managing delirium, wandering and high risk
Periods of high demand are exacerbated by high levels of dementia and delirium amongst frail patients which result in unpredictable levels of need and risk: agitation, wandering and challenging behaviour, all require intensive and skilled nursing support in order to provide good care, which respects the individual and treats them compassionately. However, there is no consistency between hospitals in resourcing for times of high acuity and dependency on older people’s wards. Even when basic staffing numbers are sufficient for a ‘normal’ day’s demand, the situations when ‘specials’ are needed, ie one-to-one support for patients who are very highly dependent, acutely confused, have challenging behaviour or are a very high risk of falls or other harm, arise on an unpredictable basis and pose additional staffing requirements. Nurses may find that on arrival on a shift, a patient has developed delirium which requires one-to-one care for that shift, yet there is no efficient way for the service to provide it.

Flexibility, one-to-one care and ‘specialling’
Flexibility of workforce is important and the expert view is that ward sisters/charge nurses should not have to just stick to the “rules” of early and late shifts, but should be able to deploy their nurses flexibly as well as to call in extra resource at short notice. The nurse in charge needs to be empowered both to use their professional judgement about safety on a day-to-day basis and to call in resources when needed.

“We need to think differently about how we manage the off-duty and work smarter about shifts and the work load.” A matron

Expert opinion generally agreed that when one-to-one care is needed, ideally this would be a nurse from within the ward team, or who is skilled in supporting patients with these types of needs, who would be assigned to provide care for them. If a nurse from the ward team is assigned, then additional support for the team as a whole is needed to backfill that nurse’s time. Typically, a bank nurse is requested to supplement the staff numbers, but the supply process is highly variable and usually does not result in timely help. Help must also be skilled, and the experts were unanimous that ‘any agency nurse’ will not do. Rarely is there any funding allocated for additional bank nurse cover, with most nurses believing that the costs go into ‘overspend’. The inefficiency of the system means that risk on the ward is raised and the amount of time that is available for routine care of all patients is reduced. This may not be a daily occurrence but happens frequently enough to categorise the situation as part of the nature of caring for older people in hospital today.

Working smarter, being well organised and applying frameworks, such as the Productive ward (NHS Institute for Innovation and Improvement, 2010) in England, and its equivalent in other UK countries, can ensure that staff are deployed as sensibly as possible and reduce waste. However, our experts were clear that additional resources are still needed on a flexible basis for older people’s wards. An example of how this can work in practice is described in Box 12.
Box 12: Managing unpredictable demand

King’s College Hospital NHS Foundation Trust

Three older people’s wards at King’s College Hospital have a typically acute and complex case load, with unpredictable demand for additional one-to-one support for patients. Following a recent staffing level review, the division within which these wards are managed have increased the basic nursing establishment and added additional flexible posts to work across the wards according to demand. These registered nurses are therefore available immediately to support individual wards that have high acuity or risk.

Box 13: Recommendation 3(iii)

Recommendation 3(iii)

Ward sisters/senior charge nurses must have rapid access to additional nursing resources 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 at very high risk of falls). These staff must be appropriately skilled to care for older people. Expert opinion suggests the preferred option 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’.

Metrics, measures and frameworks

Outcomes measurement within the NHS is rapidly developing, but the link between staffing levels for older people’s wards and quality measures has yet to be fully established. Patterson et. al (2011) raised concerns about staffing and potential impact on patient care through staff interviews and questionnaires, and Griffiths et. al (2008) explored, but finally rejected, staffing levels as a potential indicator for use as a nursing metric. Many nurses who contributed to this project have argued for development of metrics that capture the compassionate side of care and how this translates into the time they need, and staffing levels that enable them to deliver it. One of the challenges in this is the inevitable subjectivity of measuring patient experience, for which existing quantitative measures such as those used for falls, infection control and catheter-associated urinary tract infections are inappropriate.

We specifically explored these issues in the workshop with invited expert nurses, held at the RCN. Workshop participants identified that, whilst many wards are now using initiatives such as dignity rounds, data does not capture or share the impact of compassionate care appropriately. ‘Nurse sensitive indicators’ and nursing dashboards are still in their relative infancy, and are incomplete without these measures. The risk is that, until appropriate measures are developed, pressure on time and pace will continue to force care as tasks. Patient choice is not always then reflected. For example, during an inspection one participant described being, “in trouble because a patient had not shaved… but the patient didn’t want it. There was nothing on the inspector’s tick list that showed whether the patient had had a choice or not.”

The workshop participants argued that we should be aiming for consistent standards and continuous improvement, not just waiting for the Care Quality Commission to inspect. Methods such as real-time patient feedback are promising, although need further development in practice. The way that feedback is given is crucial if it is to: be meaningful for nurses; ensure that good practice is maintained, and enable nurses to identify opportunities for improvement. Feedback is not very effective if it is delivered remotely, such as from trust-wide surveys or with a time-lag that prevents practitioners from associating feedback with original events. Nurses are already leading on observations of care and patient stories, using these to provide feedback to their teams.
Challenges

- How to measure the time taken to facilitate, counsel and support patients, and to evidence that this has an impact on patient outcomes.

- Measuring compassion, kindness and associated desired values, “without taking a Daily Mail approach such as measuring how often nurses smile” (consultant nurse).

- Identifying how the qualities and values of compassionate care can be described within a professional approach to care, rather than a lottery of who is allocated a nice nurse to look after them.

- Ward managers need the time to support and manage staff and ensure that feedback is given and acted on.

- How to increase nurses’ sense of ownership of patient experience measures and empowerment in profiling these within their hospitals and services.

- Articulating the skill requirements of staffing older people's wards and shaking off historic trends of ‘palming off poor staff’ there.

The Principles of Nursing Practice

We invited a group of expert nurses to contribute to a workshop in October 2011. At this we explored the relevance of the RCN’s Principles of Nursing Practice framework (RCN, 2011b) to the care of older people and discussed the potential for development of metrics capturing compassionate care.

The RCN Principles do not provide a direct tool for this, but they do describe broad outcomes of nursing that can be mapped to specific client groups such as older people. Through analysis of apparently simple examples of good care, it was possible to reveal the underlying complexity of care for older people and the extent to which it illustrates the full range of RCN Principles of Nursing Practice. It was suggested that this may inform future work to develop appropriate measures and outcomes for older patients.

We have incorporated a number of examples, including some contributed from nurses across the UK from the RCN’s older people’s portal. One example that is drawn from excellent multidisciplinary working is shown in Box 14 (overleaf). Further examples can be found at: www.rcn.org.uk/development/practice/older_people/best_practice_gallery
Box 14: The principles of nursing practice applied to older people’s care

**University Hospital of North Staffordshire**

Fiona Howell is the Senior Clinical Nurse for Older People. She is part of a team which set up the University Hospital of North Staffordshire Frail Elderly Assessment Unit (FEAU). This provides rapid multidisciplinary assessments, prevents unnecessary admissions and ensures timely and appropriate transfers of care to either a specialist acute elderly care environment or an alternative community setting when required. The unit has improved patient experience and quality of care, improved continuity of care, reduced length of stay and reduced potential reported harm.

Fiona has summarised how the care for older people on the unit illustrates the framework of the Principles of Nursing Practice as follows:

**Principle A**

Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

*Dignity champions, open visiting, dementia butterfly scheme, use of This is me document, Excellence in Practice Accreditation Scheme (EPAS)*

**Principle B**

Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

*Complaints management, adverse incidents review, training and education, Meaningful Activity Participation Assessment (MAPA)*

**Principle C**

Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

*Adverse incident reporting, MAPA, EPAS, Safety Express, CQUINs*

**Principle D**

Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

*Dementia training, dignity champions, vulnerable adult champions, implementing daily ward rounds, intentional rounding, customer care training*

**Principle E**

Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

*CQUINS, safety Express, ward meetings, clinical governance structure, clinical supervision*

**Principle F**

Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care.

*Education sessions, training matrix*
Box 14: continued

**Principle G**
Nurses and nursing staff work closely with their own team and with other professionals, making sure patients’ care and treatment is co-ordinated, is of a high standard and has the best possible outcome.

**Multidisciplinary meetings across all older people’s wards, EPAS**

**Principle H**
Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

**Specialist practice for older people, customer care reviews, outside agency support, Newcastle 50+.**

**Metrics to board level**
Participants were asked how they thought trust boards could increase their awareness of older patients’ issues. Suggestions included:

- walk abouts/go-see visits
- foundation trust governors involvement in programmes of visits to wards
- chief nurses working on the wards
- ‘back to the floor’ programmes for senior staff.

Where directors may not themselves be clinicians, to avoid the pitfalls of being a lay person looking at quality of care, clinical prompts and checklists could be used – clinicians could script questions for directors to use when visiting the wards, to help them look for the right things. This could be linked to the *Principles of nursing practice* with prompts and a summary form.

Box 15: Recommendation 8

**Recommendation 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 either effectively captures this or informs 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.
7. Conclusions

Our survey, workshop and focus group findings confirm that appropriate staffing levels are vital as part of a matrix of factors that underpin good patient care and positive outcomes.

Delivery of compassionate, dignified care for older people requires both time and skill. In many hospitals today, older people’s wards do not have enough staff or registered nurses. Older people’s wards continue to be disadvantaged in terms of staffing compared with other wards, resulting in a current situation that cannot consistently deliver the amount or quality of care that nurses wish to give, or that older people and the public expect to receive.

For many of the nurses we consulted during this project, a key area for development is a way of capturing the contribution of compassionate care, developing appropriate metrics that are visible and meaningful from ward to board and interpreting this into workforce planning.

Through a literature review, the survey, focus groups, workshop and stakeholder events, we have examined the current issues in detail and produced a number of recommendations for appropriate staffing and the essential factors that support it: enough staff, appropriate skill mix, strong leadership, training and education about ageing and the ageing process, an appropriate environment of care and development of outcome measures that accurately reflect the time needed to deliver compassionate care.

The RCN calls on commissioners, service providers, education providers and the government to support these recommendations and ensure that they take responsibility for implementation in NHS hospitals and for monitoring the impact on older people’s care.
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9. List of contributors

Report prepared by:
Nicky Hayes, Older People’s Adviser, RCN
Jane Ball, Deputy Director, National Nursing Research Unit, Florence Nightingale School of Nursing and Midwifery, King’s College London

Expert nurse contributors:
Chris Beech, Consultant Nurse, Services for Older People, NHS Forth Valley
Dr Jo Booth, Reader, Glasgow Caledonian University
Dr Robert Boyd, Consultant Nurse for Dementia, NHS Tayside
Neil Bryson, Head of Operations for Older People’s Mental Health Services, Bradford District Care Trust
Lucy Connolly, Assistant Chief Nurse, York Hospital Foundation Trust
Sheila Dunbarr, Independent Nurse, Liverpool
Jayne Elias, Assistant Director of Nursing, Aneurin Bevan Health Board
Sheba Freeman, Health Care Assistant, RCN member, London
Dr Jenny Gordon, Programme Manager, Evidence for Practice, RCN Institute
Margaret Harries, Lead Nurse Older Adults, University Hospitals Birmingham NHS Foundation Trust
Hazel Heath, Independent Nurse Consultant and Chair, RCN Older People’s Forum
Fiona Howells, Senior Nurse for Older Adults, University Hospital of North Staffordshire NHS Trust
Heidi Jensen, Head of Nursing, Guy’s and St Thomas’ NHS Foundation Trust
Soline Jerram, Consultant Nurse for Older People and Intermediate Care, Berkshire Healthcare Foundation Trust and Chair, Nurses Special Interest Group, British Geriatrics Society
Siobhan Jordan, Director of Nursing, Ipswich Hospital NHS Trust
Denise Llewellyn, Director of Nursing, Aneurin Bevan Health Board
Trudi Marshall, Practice Development Nurse, NHS North Lanarkshire

Alison Moon, Chief Nurse, University Hospitals Bristol NHS Foundation Trust
Jeanette Power-Jepson, Matron, South Tees Hospitals NHS Foundation Trust
Julie Sadler, Lead Nurse Vulnerable Adults, Ipswich Hospital NHS Trust
Barbara Schofield, Consultant Nurse, Calderdale and Huddersfield NHS Foundation Trust
Gill Smith, Matron, Sheffield Teaching Hospitals NHS Foundation Trust
Rosemary Strange, Independent Nurse Consultant, Belfast
Dr Caroline Nicholson, Florence Nightingale School of Nursing & Midwifery King’s College London
Frazer Underwood, Consultant Nurse, Royal Cornwall Hospitals Trust
Alice Webster, Deputy Director of Nursing, East Sussex Healthcare NHS Trust
Dr Jonathan Webster, Deputy Director Quality & Corporate Assurance, NHS Outer North West London

Focus groups and site visits hosted by
Chris Beech, Consultant Nurse, Services for Older People, NHS Forth Valley
Denise Llewellyn, Aneurin Bevan Health Board
Alice Webster, East Sussex Healthcare NHS Trust
Margaret Harries, University Hospitals Birmingham NHS Foundation Trust
Barbara Schofield, Calderdale and Huddersfield NHS Foundation Trust
Siobhan Jordan, Ipswich Hospital NHS Trust
Rita Devlin, RCN Northern Ireland
Gill Smith, Sheffield Teaching Hospitals NHS Foundation Trust
Lucy Connolly, York Hospital Foundation Trust
Stakeholder group

Professor Mike Crawford, Royal College of Psychiatrists
Clare Gorman, NHS Confederation
Katherine Murphy, Patients Association
Louise Lakey, Alzheimer’s Society
Clare Moonam, Parkinson’s UK
Gordon Conochie, Princess Royal Trust for Carers
Margit Physant, Age UK
Ruthe Isden, Age UK
Sir Richard Thompson, Royal College of Physicians
Dr David Oliver, National Clinical Director for Older People, Department of Health
Dr Finbarr Martin, President, British Geriatrics Society
Soline Jerram, Chair, Nurses Specialist Interest Group, British Geriatrics Society
Pauline Myers, Chair, Townswomens Guilds
Dr Paul Lelliott, Royal College of Psychiatrists
Ian Norris, Council Member, Royal College of Nursing
Ann Farenden, Nursing and Midwifery Council

Additional advice from:
Rita Devlin, Senior Professional Development Officer, RCN Northern Ireland
Kathryn Fodey, Nursing Officer, Department of Health Northern Ireland
Ellen Hudson, Associate Director, RCN Scotland
Jude Leitch, policy lead on older people and mental health nursing, RCN Scotland
Fiona MacKenzie, Programme Manager, Nursing and Midwifery Workload and Workforce Planning Programme, Scotland
Carolyn Mason, Head of Professional Development, RCN Northern Ireland
Norman Provan, Associate Director, RCN Scotland
Martin Semple, Associate Director, RCN Wales
Dr Winn Tadd, Reader, School of Social Sciences, Cardiff University
Expert nurse contributors:

Chris Beech, Consultant Nurse, Services for Older People, NHS Forth Valley
Dr Jo Booth, Reader, Glasgow Caledonian University
Dr Robert Boyd, Consultant Nurse for Dementia, NHS Tayside
Neil Bryson, Head of Operations for Older People’s Mental Health Services, Bradford District Care Trust
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Frazer Underwood, Consultant Nurse, Royal Cornwall Hospitals Trust
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