Acute care

Achieving safe staffing for older people in hospital

Nicky Hayes and Jane Ball present the results of a survey that reveals the complexities and pressures of caring for this group of inpatients on wards today

Abstract

Hospitals provide care for older people who are the frailest, most acutely ill and have the most complex needs, yet older people’s wards in many hospitals are poorly staffed.

The Royal College of Nursing (2012) has published summary guidance and recommendations on safe staffing for older people’s wards. The guidance and recommendations were developed as part of a project that explored staffing and factors underpinning good quality nursing care for older people in hospital. The full report of the project will be published later this year.

This article presents further data from the project exploring the relationship between staffing levels and care delivery, as well as staff views on the adequacy of staffing and approaches to workforce planning at ward level. It also explores the practical implications for nurses working on older people’s wards.

Keywords

Acute hospitals, care delivery, compassionate care, staffing levels

Adequate staffing is vital for compassionate, dignified care, yet historically older people’s wards have been poorly staffed compared with other adult wards (Royal College of Nursing (RCN) 2011). The RCN (2012) summary guidance on safe staffing for older people’s wards (Box 1) was developed in response to ongoing evidence that these wards are poorly staffed in terms of numbers of staff and the number of registered nurses (RNs) deployed. It established that six nurses, of whom half are RNs and half are healthcare assistants (HCAs), staff a day shift on a typical 28-bed NHS hospital ward. This is less than the RCN (2009) recommended skill mix of 65:35 RN to HCA. RN levels are important. Previous research has identified that increased numbers of patients for each RN is related to increased episodes of compromised and poor quality care (RCN 2010, Aitken et al 2012).

Public concern

A number of reports have highlighted widespread public concern about the quality of older people’s care in hospital (Parliamentary and Health Service Ombudsman 2011, NHS Confederation et al 2012). These concerns have arisen in a climate of increasing economic pressures on NHS services, such as the challenge to save £20 billion in England over three years. The dependency of older inpatients is known to be increasing, with a prevalence of delirium in patients on medical wards of between 20 and 30 per cent (National Institute for Health and Clinical Excellence 2010) and up to one quarter of beds occupied by people with dementia (Alzheimer’s Society 2009). It is essential that organisations ensure that wards have enough staff, with the right skill mix and with the right qualities, knowledge and skills to care for older people.

While adequate staffing is essential for good care, it is important to acknowledge that compassionate, dignified care can only be delivered in a system that also has optimum environmental, organisational and professional features, including (Baillie et al 2009):

- Adequate bed space and privacy.
- Effective leadership and management ethos.
- Staff behaviours that are planned, thoughtful and delivered in a sensitive way.

The ward sister role is crucial in managing resources effectively (RCN 2009), with older people’s wards...
no exception. The RCN (2012) guidance calls for ward sisters and charge nurses to be able to exercise professional judgement and control of staffing levels on a day-to-day basis, managing fluctuations in demand, and accessing additional staff at short notice if needed. This does not mean that substantial variation between wards is acceptable. Laine *et al* (2005) suggest that inefficient and inappropriate allocation of staff has been an important factor in variation between ward staffing. To avoid this, it is essential that flexibility is underpinned by robust planning and is linked to outcome measures that are sensitive to older patients’ experience of care. An important aspect of the RCN project was therefore to identify what approaches to workforce planning are used on older people’s wards and whether they have been reviewed in line with the increasing dependence of older inpatients.

**Method**

Two surveys of RCN members working on older people’s wards in NHS hospitals in the UK were carried out in August to September 2011 and October 2011. King’s College London undertook the survey design and analysis. An email invitation to complete the survey was sent to 125,062 RCN members drawn from the membership database and excluding those whose details indicated that they were unlikely to work with older people in NHS hospitals. A series of focus groups with front line nurses working on wards in six hospitals in England and Wales and workshops and discussions with invited expert gerontological nurses across the UK were also carried out.

**Results**

There were 1,687 responses and 240 respondents were identified as working directly on NHS hospital wards for older people. Two thirds of these were staff nurses and one fifth were ward sisters. Responses from the 240 nurses who worked directly on NHS older people’s wards are the focus of this article.

Respondents were asked about the number of patients on the ward at the time of the survey. By dividing this number by the total number of beds, it was possible to obtain a snapshot of bed occupancy. This confirmed that NHS wards are running at maximum capacity, with an average occupancy of 97 per cent. Four out of five wards identified 100 per cent bed occupancy. Alongside this high bed occupancy, respondents identified a high level of frailty of older patients on their wards, with typically 57 per cent of patients being identified not just as old but also frail. Many respondents described workloads as demanding because of pressure on beds, and rapid turnover of admissions and discharges: ‘In order to achieve the fast turnover of patients required we are sometimes pushed to the limit to move patients’ (survey respondent).

Older people’s ward sizes varied around an average of about 28 beds and focus groups confirmed that the environments vary enormously between hospitals, from old-style Nightingale wards through to a handful of new, single-room hospitals and modern private finance initiative extensions to ageing estate. These environments often present

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**Box 1** Summary of Royal College of Nursing (RCN) guidance and recommendations on safe staffing for older people’s wards

1. Local determination of safe day-to-day staffing levels for older people’s wards, following principles that are set out in the RCN (2010) Guidance on Safe Staffing Levels in the UK, but with specific considerations relating to the nature of care for older people with complex needs.

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.

3. Recommended skill mix and staffing levels (based on a 28-bed ward).

<table>
<thead>
<tr>
<th>Skill mix</th>
<th>Registered nurse (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>1:4.6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Basic safe care</td>
<td>50:50</td>
<td>1:7</td>
<td>1:3.3-3.8</td>
<td>≥4</td>
</tr>
</tbody>
</table>

Ward sisters/senior charge nurses must also have rapid access to additional nursing resources during periods of high patient acuity, dependency and risk. They should also have access to senior clinical support and leadership from nurses who are expert in the care of older people.

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

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.

6. Appropriate training in the knowledge and skills to care for older people must be available to all nurses at pre- and post-registration levels, and to healthcare assistants and assistant practitioners, appropriate to role. This includes knowledge and skills relating to ageing and health.

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 those who have the right knowledge and skills to care for older people and include a focus on values and attitudes.

8. Metrics need to be developed that recognise the full nursing contribution including compassionate care, communication and its impact on patient experience and outcomes.

(RCN 2012)
unique challenges for nurses to supervise and support patients who are frail, confused or unsteady on their feet. Two examples are described in Box 2. Unpredictability and risk are important factors on older people’s wards today because of the high incidence of delirium and dementia.

Sixty six per cent (n=158) of respondents said there were generally not enough RNs to meet patient needs. Many of their comments illustrate the reality of striving to meet the complex needs of patients when staffing levels are not adequate: ‘The skill mix doesn’t allow for enough time to be given to the basic care needs of the patients. With one RN often in charge of 12 patients, her time is spent doing drug rounds and intravenous infusions therefore there is no time left for proper patient assessment.’ ‘Levels determined by amount of patients not patients’ clinical needs, staff often taken off for other wards.’ ‘Having worked for many years on a children’s ward (where the parents are usually present and carry out a lot of the basic care needs of their child), I find the staffing levels in elderly medicine unsafe. The patients often need assistance with all aspects of their care, are often confused and need close supervision to prevent them falling. Frequently there is insufficient staff to supervise these patients safely.’

Respondents were also asked to identify whether, on their last shift worked, care was compromised in any of 12 essential care activities:
- Comforting/talking with patients.
- Promoting mobility.
- Oral hygiene.
- Falls prevention.
- Changing a patient’s position.
- Information giving to patients and families.
- Helping patients with food and/or drink.
- Continence care.
- Skin care.
- Preparing patients and families for discharge.
- Pain management.
- Care for dying patients.

Across all the items nine out of ten nurses (89 per cent) reported that at least one aspect of care had been neglected due to lack of time. On average, nurses flagged between four and five out of 12 activities that had been neglected on their last shift. Nurses who reported that these activities were compromised were working in environments that had significantly worse patient to RN ratios.

**Workforce tools** Respondents were asked to identify how staffing levels were determined where they work. Forty three per cent (n=103) reported that staffing levels had not been set using a particular system or tool but were ‘historical’. Of the 57 per cent (n=137) who identified that a system had been used, 31 per cent (n= 42) referred to a dependency scoring system and 26 per cent (n=36) to some other method.

Comments from one respondent illustrate the inadequacy of attempting to use workforce tools alone to determine staffing levels: ‘It depends on patient demand. This cannot easily be equated to patient numbers. Sometimes less patients need more looking after and this depends on variables such as acute illness, which can suddenly change, the amount patients ask you to do for them (some people expect you to do more for them than others, likewise with relatives, who can be very time consuming) and level of confusion. Some of these issues are ignored (relatives’ demands/time spent on the phone) when considering staff ratios... when it is argued that a nursing day is complex and variable, this is often dismissed because of messy reality and complexity does not easily lend itself to reduction to a few variables.’

In response to a question asking them when staffing levels were last reviewed, two thirds (n=160) did not know. One said: ‘Staffing levels need to be reviewed and increased. These levels are based on when the ward was a male diabetes ward
with a lot of independent, self-caring, young clients. We are now complex care, acute care of the elderly with most patients fully dependent, high risk of falls and confused.’

Focus group and workshop participants also confirmed the need to identify further measures of the compassionate and less easily quantifiable components of care and patient outcomes, that can sit alongside ‘nurse sensitive indicators’ on nursing dashboards and properly inform workforce planning.

**Discussion**

The project captured front line nurses’ reports of actual staffing levels and associated issues, but inevitably the methodology used has limitations. The survey and focus group methods may have introduced bias because the sample of RCN members and the focus group participant selection was not randomised. However, the use of multiple approaches including expert opinion sought to reduce this as far as possible. The results confirm the rapid throughput, intensity and complexity that is typical among the older population being treated in acute hospitals. They also support the case for improved staffing on many older people’s wards.

Nursing older people is highly skilled work, requiring specific knowledge and experience to meet the needs of patients who may have sensory, cognitive and communication impairments as well as acute illness and high levels of physical dependency. It is essential that overall staffing levels are improved and that the wards have sufficient RNs on duty. While HCAs have a valuable supporting role, their priorities tend to be task orientation and speed (Alabaster 2006) and there are many activities that they cannot carry out.

The results demonstrate that on wards where there is poorer RN staffing, care activities are more likely to become compromised. This supports previous research on staffing, illustrating that simply providing ‘enough pairs of hands’ on the ward might get more tasks done, but it does not necessarily improve patient care and experience. We know from reports such as those of the Parliamentary and Health Service Ombudsman (2011) and the Commission on Dignity in Care for Older People (NHS Confederation et al. 2012) that compromised care is unacceptable and that for older patients and their families, the less quantifiable activities such as talking, comforting and receiving information are a priority throughout their hospital stay. The RCN project evidence therefore supports factoring in sufficient time for professional communication and information giving for older patients and families, as well as the many other activities that nurses must carry out.

*While workforce planning tools may have a place in determining staffing levels, they do not provide a complete picture*

A ward sister survey respondent summed up the demands placed on her and her staff, and how she managed her priorities on the previous evening: ‘Last night on our acute ward, I had a patient in pain – they were my first priority, needing controlled drugs. I also had a poorly patient, and absconding patients. Three sets of relatives arrived, all needing counselling that the patient was dying, and they all needed to be the centre of attention. Every day we have this kind of conflict, plus bed pressure, the need to prepare and clean beds, and time-consuming admissions and discharges. The pressure is on the nurse to co-ordinate all this and deal with the bed manager’.

The project results support earlier RCN (2010) guidance that while workforce planning tools may have a place in determining staffing levels they do not provide a complete picture and should only be used as part of a triangulation method. In the case of older people’s care this means application of professional judgement and consideration of specific factors including the environment, and the complex and often unpredictable needs of the frail older inpatient population today. As the examples in Box 2 illustrate, there is no single staffing solution when faced with common factors such as
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environmental issues, because of the many other determining factors. Ultimately, the ward sister/charge nurse is best placed to make decisions on a day-to-day basis according to real-time requirements.

The survey results confirm that most nurses are not aware when staffing levels for their ward were last reviewed and illustrate the frustration that some are experiencing with ongoing low staffing levels that have not taken into account the reality of care today. It is important to observe that although the RCN guidance sets out threshold figures for safe staffing, these are not absolute and many areas may need more staff. Benchmarks may play a part in ensuring safe staffing levels, particularly in the context of current economic pressures.

Conclusions and implications for nursing practice

The findings illustrate the challenges of providing care on older people’s wards today, and the enormous demands that are placed on today’s nurses. Adequate staffing, with the right number of RNs, is essential to meet the challenge. Staffing issues are complex, requiring local solutions, but the RCN (2012) guidance and recommendations can be used by nurses at all levels to review the situation in the area they work and consider all the factors necessary to support good care.

Application of the guidance may support nurses to challenge inadequate resources and to work with colleagues to identify solutions. Further work is needed to develop appropriate metrics and measures that capture the full extent of complex care for older people, including the time needed to deliver care with compassion.

Although care can be compromised on wards where staffing is insufficient, many nurses and teams in hospitals demonstrate excellent, innovative practice, but possibly lack sufficient platforms to publicise and share their work. Nurses and the public may now view and share examples of good practice through a number of routes including the RCN website (see panel).

Find out more

The RCN has set up two websites that feature good practice examples, information and resources on caring for older people and people with dementia.

- www.rcn.org.uk/development/practice/older_people
- www.rcn.org.uk/development/practice/dementia

References


Royal College of Nursing (2012) Safe Staffing for Older People’s Wards. RCN Summary Guidance and Recommendations. RCN, London.

Conflict of interest

None declared