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Clinical Nursing Governance in a Department of Elderly Medicine: an exploration of key issues and proposals for future development

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May, 2000

Summary

This report provides the main findings of a review of aspects of nursing workload and retention in the Department of Elderly Medicine, Portsmouth HealthCare NHS Trust. It was instigated in response to nursing shortages which ultimately resulted in bed closures. The work involved a review of methods of nursing workload measurement, and questionnaires and interviews with 29 staff.

A key finding generated from the review of nursing workload measurement methods, is that there is no method that is of sufficient validity and reliability to accurately identify the numbers and grades of nurses required to staff the wards.

The interview data generated close agreement in the perceptions of staff, nurses, managers, doctors and administrators, regarding the key reasons responsible for nursing staff shortages. These were categorised within the Clinical Governance framework as clinical risk management, education and continuing professional development, and clinical leadership issues.

Recommendations are made which are intended to assist the department address some of the issues which collectively lead to a shortage of clinical nursing time. In addition, a programme of systematic development in gerontological nursing practice is proposed.

Acknowledgements

I wish to thank the nurses, managers, directors, administrators, secretaries and the Trust librarian for their co-operation, assistance and willingness to share their perspectives, without which the review and this report would not have been possible.

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Section One: Introduction

1.1   Introduction

This report is the result of a review into aspects of Clinical Nursing Governance in the Department of Elderly Medicine, Portsmouth HealthCare NHS Trust. It was instigated by the Departmental General Manager in November 1999, as a consequence of nurse shortages. The work commenced on 1 December 1999, and concluded on 30 April 2000. The Trust's Nursing Director was responsible for the review, using part of her Trust hours, and part of her academic University time. In addition, many individuals contributed a great deal in terms of expertise, experience and information, much of which forms the foundation of this report.

1.2   Background

The pressure on hospital beds for older people,* already an important national issue, heightened for the Trust during 1999. A shortage of qualified nurses, high agency nurse usage, high sickness levels, insufficient numbers of registered nurses to appropriately cover shifts and high staff turnover, led to bed closures and became the focus of considerable concern in all areas in the Department of Elderly Medicine (DEM)*. There was much anecdotal evidence regarding nurse shortages, and regular reports of inappropriate levels of staffing. However, there was insufficient knowledge to determine how many nurses of which grades there should be, to safely staff the wards.

During mid 1999, a small focused working group aimed at supporting the Department's managers was set up. This was to provide advice and support to the process of seeking solutions to increasing staffing difficulties. It was recognised that solutions were required in the short, medium and long term. Many steps were already being taken to recruit new nurses, but these initiatives were off set by high numbers of nurses leaving. In addition to special recruitment measures, and as part of a strategic plan, the Trust agreed to support the recruitment of nurses from the Philippines. The first cohort is due to arrive in Portsmouth in June 2000. In addition to the need to recruit new registered nurses and health care support workers, there was widespread agreement about the importance of two further issues:

- The retention of experienced staff.
- The importance of accurately determining how many nurses of what grade were required to safely staff wards in the Department.

These two issues led to the review reported here, which forms part of the medium to long term development plan within the Department. Although nursing shortages affected all care areas within the Department and all grades, the focus of this review is on the in-patient areas. This includes continuing care, palliative care, rehabilitation, stroke care and the acute care wards.

* "older people" refers to those aged 65 years and over
* "DEM" is the Department of Elderly Medicine

1.3   Purpose

There were three main aims for the review, which were important in clinical governance terms. These were to:

* Explore staff perceptions relating to nursing staff retention and workload.
* Identify and report on literature relating to these perceptions.
* Investigate methods of nursing workload measurement appropriate to the care of older people, that would identify both the numbers and grades of nurses required to provide safe and high quality patient care.

1.4   Structure of the report

The report is presented in four sections:

Section one, provides a general introduction to the review and an overview of the background issues.

Section two, consists of a review of nursing workload measurement methods.

Section three, presents findings from staff interviews and questionnaires. Trust reports and information from literature sources are also provided.

Section four, sets out proposals for a programme of development.

Each section of this report is presented as a stand alone paper. The overall document reflects the total work undertaken for the review, which is also summarised in a Executive Briefing paper, available separately. Comments and further discussion on the process of review and the contents of this report are welcome.

1.5   Interim Report

The review commenced on 1 December 1999, when it was widely acknowledged that morale among nursing staff was at a low ebb. High winter workloads added to the pressures under which staff in all professions and in both the local hospitals were

working, and there were real signs that morale among nursing staff was exceptionally low.

During the Christmas and Millennium period, in spite of continuing difficulties, the period passed relatively smoothly, primarily due to the good will of staff. However, by early January, instead of improving, the situation was considered to be deteriorating, and increased resignations of experienced staff added to the difficulties. This had a further impact on the Department's ability to adequately staff wards and beds were closed as a safety measure.

At this stage, six weeks into the review, data had been collected from 29 staff, including 17 G /acting G grade nurses. In qualitative terms, the interview evidence was of a consistent nature, and from a sufficiently high number, to determine that it provided an adequate representation of views from this group. In response therefore to the situation in the department, the decision was made to release an interim report of key findings with broad recommendations generated from the interview data.

The interim findings and proposed recommendations were shared with staff in meetings and as a consultation paper. These were generally received positively and in response, many recommendations are currently being implemented. The interview evidence upon which the recommendations were made, is provided in this final report. This is supported by examples taken from nursing literature and research.

Since early February, many changes have taken place in the Department. It would therefore be unhelpful to simply repeat the interim report in an expanded format. In consequence, the focus of this document is on the clinical nursing governance implications of the review. While it is hoped that the document will be used as a resource, it should be regarded as a beginning and not an end in itself. Many issues are included in this report and some of these may require further, more in depth investigation in the future.

1.6 Review Methods

The methods used for data collection and analysis were as rigorous and as close to scientific ideals as possible, given the short review period and the complexity of the issues under investigation. However, there is a widely acknowledged tension between quick problem-focused service evaluations and the scientific rigour required in a multicentre funded RCT. The methods used to collect and analyse data are intended to provide the most trustworthy evidence possible, within the resources available at the time. Given that much of the information collected is perceptual, some of this will have changed, especially in the light of several initiatives currently taking place within the Department.

1.6.1   Data collection

Information was collected from a range of sources.

- Questionnaires, developed and validated by Nolan *et al* (1999), from G and acting G and F grade nurses (N=17).

- Semi structured interviews with G and acting G grade nurses, F grade nurses, consultants, managers, secretaries and administrators (Overall total N=29).

- Written sources such as Departmental Reviews, Contract Reviews and other internal reports.

- Systematic but time restricted literature search, and methodological review of approaches to nursing workload measurement. This is presented in section two.

- A wide ranging review of literature, relevant to issues raised during interviews, is included in section three.

- Questionnaire analysis was based on simple numeric compilation and the results integrated into the findings.

- Content analysis of all qualitative interview material using NU*DIST software, which generates themes from the interview data.

- Assessment of Trust documents for information relevant to the aims of the review.

- Critical appraisal of appropriate literature.

The interview responses were recorded in shorthand and transcribed within six hours and the records destroyed according to normal practice. There was no identification code on any of the transcripts. Ethical approval was not sought because the work is considered an internal audit using research based methods.

1.7   Completeness of the Investigation

This was a short life review conducted over four months. The approaches to data collection, analysis and the production of this report have been subject to peer review. It is acknowledged that it may have been difficult for some being interviewed by a senior member of Trust staff. Although it was anticipated, everyone involved responded enthusiastically and there were no signs of reluctance to share opinions and experiences. It is therefore possible to conclude that the information obtained during the interviews was a true reflection of staff perceptions at that time.

Many sources of information, such as formal Trust reports were reviewed but these were never intended to be used to track changes in health care provision over time. There are also differences in the structure, content and availability of many of these.

This is a phenomenon common to all National Health Service Trusts, which have been subject to many policy driven organisational changes over a number of years, requiring different information to be collected and reported in a variety of formats. Some limited information is nevertheless provided, with the acknowledgement that some of it is incomplete. However, it is used if it helps to describe the context of nursing within the Department or in the Trust.

The original plan for the review included interviews with a sample of all other grades of nursing staff. As a result of the circulation of the interim report, this was not possible within the allotted time available.

1.8   Summary

This introduction provides the background and rationale for a two stage research based review of aspects of nursing workload in a Department of Elderly Medicine. It describes that section two is a methodological review of nursing workload measurements methods, which aim at identifying nursing resource requirements. Section three presents interview and questionnaire data, provided in a thematic clinical governance structure and section four, proposals for future development.

Note
There is much to say that is complimentary about the staff working within the Department and in particular about their commitment to working with older people. However, in common with all situations that are subject to scrutiny, scope for future reflection and development are inevitably revealed. Given that this report is presenting the information provided by staff, together with many of their solutions, it is clear that much reflection and development is already underway.

Section two: A methodological review of approaches to nursing workload in the care of hospitalised older people

2.1 Introduction

This section provides a review of the literature relating to methods that purport to measure nursing workload in the care of hospitalised older people, as a means of estimating requirements for nurse staffing. It is based on a review of all primary literature sources published between 1980 and 1999, and relates to continuing care, palliative care, acute care, rehabilitation and stroke care. The term older people, is used to refer to people aged 65 years and over.

2.2 Background

The provision of healthcare for an increasing number of older people is a challenge for most NHS organisations. There has been a notable increase in the numbers of older people admitted as emergencies to NHS hospitals, particularly in those aged 65 years and over. In longer stay areas the situation is equally one of full wards and with patients with multiple, complex and often long standing conditions. Although some of the practices differ, fundamental gerontological nursing skills are essential to all DEM wards. It is essential therefore, to understand what are the appropriate nurse staffing levels to provide the best possible patient care.

Several recent reports and policy documents point to the importance of understanding how many nurses of what grades are necessary to provide safe and optimal care for patients in hospitals (DoH,1999). The Health Advisory Service (2000), raised concerns over the quality of care for older people in acute hospitals, where staff were reported as "*over-stretched and under pressure*". The Review of Eastbourne Hospitals Trust, which resulted from a number of serious clinical incidents, recommended that there should be agreement on the ways to decide the right nursing skill mix for in-patient areas (Greenwood, 1999).

All westernised countries currently report a shortage of nurses, and most are now recruiting nurses from other less industrialised countries (Spurgeon, 2000; Buchan and Edwards, 2000). There is a well reported shortage of nurses in England, particularly in the South East region which results in a high use of agency staff. The use of temporary staff is associated with lower levels of care and poorer patient outcomes (Davidhizar *et al*, 1998), and it is related to additional supervision requirements from permanent staff, adding to existing high workloads (Prescott, 1986).

Despite the clear need to identify accurately the requirement for nurses to staff wards, there remains no recommended method or "gold standard" method currently available (Bridel,1993). Furthermore, there is no guide to provide nurses and their managers with an overview of methods which are the most valid and reliable. The absence of

such guidance has led to the methodological review of the literature reported in the following pages.

2.3 Aim of the review

The aim of this review is to answer one question, which is; *"Is there a method of nursing workload measurement available which will tell us how many nurses of what grade are required to provide safe and optimal care for older hospitalised people?"*

2.4 Method overview

This review is not considered systematic in the usual sense, because of the short period of time available to undertake it to designated standards (Chalmers and Altman, 1996). However, it does adopt systematic methods to literature searching and to the critical appraisal of the literature retrieved.

The review process covered the years 1980 to 1999 but it identified only four articles in the review target area, of hospitalised older people. Each of these report on small scale local developmental projects. These were of extremely low scientific credibility, especially in terms of their attention to the basic requirements of validity and reliability. **In consequence, it was concluded that, given the information currently available, there was no published method of nursing workload measurement with which to accurately identify nurse staffing requirements in hospitals for older people.**

In the absence of sufficient evidence, a further search was undertaken of all the literature relating to nursing workload measurement systems that were used in any adult care environments. In total 264 publications were found, but none of these provided sufficient evidence that they would be transferable to the care of older people in hospitals in this country.

These findings suggest that research and development should be undertaken in the area and, in consequence, it is the subject of an application for grant to fund research. In the absence of an appropriate measurement instrument, this section provides an overview of methodological strengths and weaknesses associated with nursing workload measurement methods.

2.5 Search method in summary

A search of three electronic bibliographic databases CINHAL, BIDS (Social Science) and Medline for the years 1980-1999 was undertaken. In addition, a hand search of all relevant peer reviewed nursing journals for the year 1999 was made, and the Cochrane database, the Nursing database and the Royal College of Nursing database were also accessed. A comprehensive set of search terms was identified from previous work in this sphere (Thomas, 1995). The inclusion criteria for the second stage of the review

was, *any publication reporting any design of workload measurement that was used to determine nurse resource requirements in the care of hospitalised adults.* Key terms used were, nursing older people, workload, nursing establishment, nursing shortages, nursing resources, nursing dependency and skill mix. Publications retrieved were all written in the English language.

2.6   General issues

Nursing workload assessment methods are used to record information either about what nurses do (the work), and/or to determine a category of patient need (the load), at given points in time. Some but not all methods are used to identify nursing resource requirements. The purpose for which a method was designed for is essential to its subsequent validity and many workload measurement methods were not designed to be used to predict requirements for nurse staffing. Predicting requirements for nurse staffing is difficult because it is not always possible to anticipate all the events which alter the need for nursing input. While it may be possible to predict simple, repetitive events that occur in uncomplicated healthcare situations, health care for older people in hospital is frequently complex and therefore less predictable. This means that designing workload measurement methods is particularly difficult for this speciality.

Of the 264 papers reviewed for this report, the quality, method, design and rigour of the published methods were of such variability that most could not be compared. A very small number used randomised control methods, but these were from countries other than the United Kingdom. In most cases, insufficient detail about how the method was derived is provided, against which to judge the method. When it was available, the structure and content were dissimilar to other publications and focused on a wide range of diverse variables. In addition, in the vast majority of cases, the evidence was limited to descriptions of small-scale service provision projects, or they were developed for specific patient groups.

In order to measure nursing workload accurately, instruments are required which are valid and reliable. The question of validity (whether instruments measure what they are designed for) is of great importance for their reliability. Reports of validity measures are rarely included in the literature but when they are, they do not extend to include face, content, criterion and construct validity. Face validity is a measure of whether an instrument produces reasonable data, from the viewpoint of its users. Content validity is a measure of whether the items within the instrument adequately reflect the conceptual definition of its scope. Criterion related validity is a measurement of the relationship between measurements made, using an instrument and an external variable, often termed a "gold standard", with which it is expected to correlate. Construct validity is a measure of how well an instrument supports or conforms with theories or constructs. Exploring the construct validity of nursing workload measurement is difficult because there are no proven theories and constructs about its distribution for researchers to test them against.

The reliability of the method depends on the stability/consistency with which it measures what it is intended to measure. Therefore repeated measurements by the method on the same sample, should yield the same results.

The use of nursing workload measurement methods as a means of identifying requirements for nurse staffing is a complex process. First the measurement method has to meet validity requirements mentioned earlier. However, even if it was rigorously developed to scientific standards, it then must be able to identify accurately nursing workload. Therefore, attention has to be made to the development of an instrument **and** its application.

Workload measurement methods were first developed in America and Canada, and these countries maintain strong methodological leads. However, given that health care provision and costing methods in England are different from these countries, it is unlikely that they transfer effectively to the NHS, although some Trusts are still using imported American methods.

Nursing care is provided within the context of a multidisciplinary team, which has a significant impact on the care provided. There is, for example, evidence that shows agency nurses and other nurses new to a ward, including student nurses, require supervision and information, which can be time consuming to provide. In particular, there is anecdotal evidence that suggests that doctors who are new to wards because of rotations are also very time consuming for permanent nursing staff. The physical ward environment also clearly creates additional work for nurses. Shortages of equipment, laundry and basic physical facilities such as hand washing basins, require more nursing activity to achieve the same levels of patient care. It is possible therefore, for the same patient and nurse groups, working in different locations and with different teams to have higher workloads. These variables, while clearly important do not appear in the literature.

Workload measurement methods exhibit other major deficiencies. First, their use is restricted to nursing, effectively establishing nursing as a discipline that can be managed outside of the context of the rest of the health care system. Second, by simply calculating the number of "bodies" necessary to care for a number of patients, suggests that organisational factors, management style, interruptions and ward lay out are unimportant, when this is plainly not the case.

Nurses are the sole professionals providing 24 hour continuous patient care. For this reason, when other members of the health care team are off duty, nurses tend to pick up a range of tasks, and literally fill the gaps left by most other groups of staff. This is frequently necessary, in terms of patients welfare and the smooth running of a ward. When the Ward Clerk is off duty in the evenings and at weekends, answering the telephone and undertaking other administrative tasks falls to the nurse. These extra activities are not included in most workload measurement instruments, but when they are, they are usually counted in an "other" activity group. The lack of information about what is included in the "other" category has important implications for the effective management of skill mix. If activities that should or could belong to another group are grouped together, nurses are likely to continue undertaking tasks that do not use their expertise appropriately, and add to existing workloads.

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Inaccuracies in workload measurement are possible when the same method is used to identify requirements for nurse staffing, in different specialist care environments. For example, the provision of nursing care in palliative care environments is very different to that required in rehabilitation wards. The focus of each is on different elements of care but each are of equal importance. Much time is needed in palliative care to listen and to support relatives, while in the rehabilitative setting, much time is spent in teaching and encouraging independent activities. Simple workload measurement systems may not be able to detect the different but equally relevant clinical practices (Needham, 1997). Overall, most workload measurement methods tend to focus on the more physical task related aspects of care so that, for example, listening in palliative care and encouragement in rehabilitation may fall into "other" category. In so doing, these methods fail to capture the interpersonal nature of much nursing practice and have attracted considerable criticism as a result.

Jenkins-Clark (1995), urge caution about the over ambitious claims made for many nursing workload measurement systems. She compared the estimates of several methods with actual hours worked, and demonstrated wide variations between them. The reliability of workload measurement methods ultimately depends on the ward nursing staff and it is suggested that appropriate initial and on-going training is crucial to this end.

2.7   Types of Nursing Workload Measurement

There are two main types of nursing workload measurement methods that are primarily used to identify nurse-staffing requirements. These are, *patient classification systems* which focus on aspects of the patient and involve some form of estimated need for nursing and, *nurse activity* which is based on counts of nurse generated actions. More recent methods attempt to combine the two approaches.

2.7.1   Patient classification and dependency methods

Patient classification methods were designed initially to measure costs associated with Diagnostic Related Grouping (DRGs) in America (Prescott *et al*, 1991). The use of DRG's is problematic, as it is clear that not all patients in the same groups experience the same symptom severity (Kovner *et al*, 1993). Patients classified in the same group can consume different amounts of services at different times because for example, of the existence of other conditions. This applies particularly to older people who may have multiple and chronic health problems. In addition, the use of this method is based on the assumption that medical diagnosis is the most important factor in determining requirements for nursing care. Campbell *et al* (1997), in their statistical analysis, concluded that DRG's and other approaches to case mix groupings, were not a reliable predictor of nursing workload.

Many patient classification systems were intended originally as financial management instruments and not to determine requirements for nursing care, but many are used for this purpose (Lacovna, 1999). Several nursing "resource" measurement methods which are currently used in this country, were directly derived from American nurse

costing tools. In consequence, not only are many of these designed for purposes other than those for which they are used, but also their country of origin has a totally different health care system. This means, in the absence of appropriate validation in this country and systematic reliability testing, it is unlikely that many methods currently used in this country perform the function for which they were purchased.

All classification systems have in common criterion lists, which are used to generate a patient related score (Diznor, Buist and Dassen,1998; Fagerstom and Rainio,1999). They commonly assign patients to a low-high care category or provide a score which equates to a "need for nursing score". These scores are then converted into workload indices which are used to predict staffing requirements (Fagerstrom, Bergbom-Engberg,1998; Fagerstrom *et al*, 2000). O'Brian-Pallas (1992), examined the estimated hours of nursing care predicated by four workload systems based on patient classification. Using the systems (PRN 80, PRN 75, NISS and GRASP) on the same patient group, differences in the hours of care required varied by up to four hours per day for each patient assessed. A similar finding was reported in this country by Hurst (1993).

Just as patient classification systems were mainly developed in other countries during the 1970s. In the United Kingdom, nursing dependency methods emerged at around the same time (Turner-Stokes, Tonge and Nyein, 1998). Despite a large number of articles reporting on dependency measures, there is a notable lack of conceptual rigour and methodological investment in most of these (Carr-Hill and Jenkins-Clark,1995). They also lack clarity regarding the purpose of the instrument and tend to be based on very small scale, short-term projects in discrete geographical locations or in specific clinical specialities.

Dependency measures involve subjective estimates of patients' reliance on, and "need" for nursing care (Miller,1985), but the assessment of need tends to be highly subjective (Turner-Stokes, Tonge and Nyein,1998). Furthermore, while a patient may be dependent, dependency can result from nursing actions or as a result of organisational imperatives. For example, in terms of dependency on nurses for feeding, it often takes longer for a person to feed himself than for a nurse to feed him. In wards around the country providing continuing care for older people, it is common for many to require help, or to receive total support with food. In these situations, it may be quicker, and therefore considered more efficient for a nurse to feed patients. This is not patient dependency but may derive from, rather than being causal to nursing practice.

2.7.2   Nursing activity methods

The organisation of nursing work into tasks and activities, which are relatively straightforward to measure, came into vogue in the 1980's as a result of the "contract" culture. There are many examples of methods that record the time that nurses take to perform certain tasks and which subsequently produce averages of these. However, just as there is no such thing as an average patient or nurse, there are few average situations in gerontological care environments.

It is relatively straightforward to observe and count some tasks that nurses perform as part of their normal daily work. This could equally apply to the tasks that doctors and therapists undertake, but workload measurement has generally been avoided by these groups. However, while simple physical tasks can be easily measured, the "caring" and interpersonal aspects of nursing have not adequately been included in the past. Furthermore, activity counts are based on the assumption that nursing activity is linear, meaning that events occur in a logical sequence. This is plainly not the case, as many human physiological functions are likely to occur at similar times. For example, meal times take place at fixed intervals, which means that within a short period of time afterwards and around the same time, many patients will need some assistance with toilet related issues. Therefore, workload measurement methods need to be sensitive to peaks in activity which include many or most of the same at the same time.

A weakness in all the workload measurement systems reviewed to date is that they record, and frequently do so poorly, what is currently being done against pre-set criteria. In this sense they may act as a barrier preventing the development of clinical practice. This is because of two tendencies, the first is that people may prioritise what they will be measured against, and secondly when there is a substantial pressure on time, people are likely to replicate expected behaviours rather than innovate.

Nursing workload measurement is not workload study, similar to that commonly undertaken in factory environments. The variables involved are human, organisational and scientific. Simple measures based on just one of these will not capture the complex, multidimensional nature of nursing. Furthermore, nursing is not about "doing to" but should be founded on relationships with patients, carers and others. For this reason, workload measurement systems designed solely by nurses, are likely to focus on professionally defined characteristics. These might not be the most important to patients and their families but which in turn may impede the development of real patient centred care.

2.8   Summary

The determination of nursing resource requirements is a challenge for all health care organisations. Nurse staffing decisions are currently made on a range of methods available, including those based on historical formulae that is long since forgotten. There is a significant lack of attention to the basic issues of validity and reliability in most of the publications reviewed. In consequence, there is no method currently available that would help to identify the numbers and grades of nurses required in the Department to provide safe and optimal levels of care. This indicates a need of primary research in this sphere.

Section Three: Clinical Nursing Governance: an exploration of key issues

3.1 Introduction

This section describes the process and the findings of a review of issues initially relating to nursing retention and workload conducted in the Department of Elderly Medicine (DEM), Portsmouth Health Care NHS Trust between December 1999 and April, 2000. As a result of developments within the Department many issues highlighted by staff during interviews and through questionnaires, are in the process of resolution. However, there remain some clinical nursing governance matters, that would benefit from further discussion, innovation and implementation. These are presented in this section.

In the White Paper, A First Class Service - Quality in the NHS (DOH, 1998) Clinical Governance is described as:-

"A framework through which NHS organisations are accountable for continuously improving the quality of their services, and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

3.2 Structure of the section

The themes generated from the transcripts of staff interviews and questionnaires, fitted well into three broad clinical governance groups, Clinical Risk Management, Education and Training, and Leadership (DoH, 1998). These groups are also closely related to the Government's Strategy for Nursing (DoH, 1999), which emphasises the importance of these three areas to the future of the health service. Each theme is introduced with a general and short summary description of the theme. Quotations from the transcripts, which particularly capture the overall sentiment of the data, also appear in the opening passages. In some, quotations also appear later, particularly if the theme is broad.

Following the introductory paragraphs, evidence from a range of literature sources is summarised. Evidence in the form of Trust and Departmental reports most commonly appears at the end of each theme. Trust and Departmental evidence is identified by an asterisk in the right hand border.

3.3   Methods

Several methods of data collection were used to obtain information regarding the perceptions of people with close knowledge of the Department. These were:

- Questionnaires completed by ward sisters/ acting ward sisters (n=17).
- Semi-structured interviews with ward managers/acting ward managers, medical consultants, managers and administrators (Total n =29).

3.3.1   Questionnaires

The purpose in using a questionnaire was primarily to obtain baseline information against which to compare staff perceptions at some future date. The questionnaire selected was developed, validated and published by Nolan, Lundt and Brown, (1999) in Sheffield, where is was used with a sample of 465 nurses (Appendices 1,2,3). The questionnaires comprised two main sections:

- Thirty-four items addressing the work environment scored on a five point Likert scale (strongly agree-strongly disagree).
- Sixteen items about perceived changes in the workplace over the last 12 months including two global measures of job satisfaction.

The questionnaires were analysed but because of the low numbers involved the results have low statistical power. No firm conclusions can therefore be drawn from these but they can be used as a baseline against which to compare staff perceptions in the future, if required.

3.3.2   Interviews

Interviews were held with Ward Sisters/G grade nurses, those in acting G grade positions and F grade nurses with broad responsibilities such as night cover for the whole Queen Alexandra Hospital. Elderly Medicine site. In addition, interviews were conducted with consultants, administrators and managers to provide an overall sample of 29. The interviews all took place in or close to the individual's base or at a location of their choice. Each lasted between 40 minutes and 100 minutes. Responses from the interviewees were recorded in short hand and transcribed into NU*DIST software. Content analysis was undertaken using this software programme which generates key themes from interview data. The interview and questionnaire data are integrated in this report with evidence from published literature in related fields.

3.4   Departmental and Trust information

A wide range of Trust reports and Departmental documents were accessed for the review. These extended back to 1988 and a selection is provided when it helps to describe the context of nursing in the Department.

3.5　Limitations

It is acknowledged that it may be difficult for staff to be explicit when interviewed by a Nursing Director, albeit in a research capacity. This however, did not appear to inhibit the interview discussions which were detailed and clear about what the key issues were perceived to be. As in all qualitative research, it is important to acknowledge that these perceptions can change and given that there are many differences in DEM at the time of writing this report, these perceptions are likely to have altered.

The nature of this research undertaken was qualitative and involved primarily one individual collecting and analysing data. As in usual research practice, checks of the interpretation of the interview material were made. While validity and reliability are not an issue in qualitative enquiry, its authenticity in reproducing accurately the views of those interviewed is of great important. Therefore, feedback sessions were undertaken with individuals, and with groups during the presentations of the interim report. There was agreement that the findings and recommendations represented those held at the time of the interviews. This feedback was obtained from all groups interviewed, including managers, wards sisters, consultants and administrators.

Only those topics during those interviewed are included in this report. However, there are clearly a number of important clinical nursing issues that are not included. The omitted issues tend to be those where there is little or no associated difficulty. This is an expected phenomena in qualitative research studies, as people tend to report the negative and not what is going well (Webb and Stimson, 1976). It may appear therefore, that there is much yet to be achieved in the Department. While this is to a certain extent true, this would be common to all Trusts that have not had the opportunity to focus time and energy into long term development programmes. **It must be said that there are many examples of effective practices and innovations in the Department.** For example, the wards have excellent access to pressure relieving equipment. This provision is of an exceptionally high standard when compared to other hospitals on a national basis. In addition, there was and remains, a remarkable commitment to working with older people, which was prevalent in all the occupational groups interviewed. The fact that staff were so ready to reflect on practices and processes, and consider the potential for new ways of working, signals that much can be achieved in the future.

3.6　Clinical Nursing Governance

Clinical Governance is part of the Government's strategy for ensuring the quality of care becomes the driving force for the development of health services in England (DoH, 1998). As the largest occupational group in the NHS, nurses are central to the success of this strategy, and more important, to improvements in patient care. The themes generated from the interview data, are all highly significant dimensions of clinical nursing governance. These are, *Clinical Risk Management, Education and Continuing Professional Development, and Leadership*. The themes, belonging to these are shown in table one.

Table one: Clinical Governance area and interview themes.

Clinical Governance area	Interview themes
Theme one: **Clinical risk management -**	**Workload factors** Increased activity Decreased nurse availability Agency nurses **Clinical nursing practice** Outcomes of nursing Evidence based practice Hospital acquired infections Dementia Nutrition Patient and family involvement Record keeping Nursing handover Discharge planning Administrations of medicines
Theme two: **Education and Continuing Professional** **Development -**	Newly qualified nurses Continuing professional development Clinical supervision
Theme three: **Leadership -**	Ward sisters Clinical Nurse Managers Health care support workers

3.6.1 Clinical Risk Management

Clinical risk management refers, for the purposes of this report, to any clinical practice that has the potential for implied or direct and commonly negative effects on patients, their relatives or staff. This theme is in two parts and relates to aspects of workload and clinical nursing practice. It is clear that there are close interactions between many of these topics. The issues are often closely related, with one acting as a precursor to, and exacerbating the next. For example, consistently high activity is likely to have an impact on the ability of staff to perform at their maximum potential. This can lead to low morale, which in turn affects retention and sickness levels. A shortage of nurses may result in the high use of agency nurses, with implications for continuity of care and enhanced clinical risk, and so the cycle continues. A similar

view of the relationship between a number of variables was produced by Ovrevriet (1992), in his "low morale cycle".

3.6.1.1 A runaway train: Increased Activity

During the interviews the strongest theme was of a year increase in workload. There was a sense of unrelenting work to be done with little time to reflect on practice or on occasions to do more than to provide basic care. These words or similar were used frequently:

"We just seem to be reacting all the time, and it feels just like there is no let-up. You want to do your best for patients but it sometimes feels like you are on a run-a-way train - without a driver".

Between 1985 and 1995, the annual flow of NHS patients through acute hospitals in Great Britain increased by 28 per cent, whereas hospital bed capacity fell by 33 per cent (OHE, 1997). Between 1984 and 1997, emergency hospital admission rose by 50 per cent (Kendrick, Frame and Povey, 1997). A fall in the average length of in patient stay has in part, off set the increase in patient numbers. In 1989/90, the average length of stay was 30 days for people aged 85 years and over, to 16 in 1998/99, and from 21 in 1989/90 to 12 in 1998/99 for people aged 75-84 years (DOH, 2000). The average length of stay for people aged 75-84 in the acute wards in DEM in December 1999 was 9.4 days.   *   *

The Government's Emergency Action Team report suggests that average bed occupancy rates of more than 85% are associated with increasing emergency readmissions. The average bed occupancy in the acute wards in DEM in December   * 1989 was 82%, in December 1999 it was 98%.

The most dramatic rise in national emergency admissions occurs in people over the age of 65 years (Blatchford and Capewell,1997). In an Oxfordshire study, the readmission rate was found to have doubled between 1968-1985, with 75 per cent increases in emergency readmissions. The majority of these occurred in people with underlying chronic conditions, and many had a history of multiple previous hospital admissions (Long *et al*, 1999).

There are reported to be variations in hospital readmission rates, although the reasons for these are not entirely clear. However, it is known that readmission rates are associated with increasing age (Tierney and Worth, 1995). The presence of chronic disease is reported to contribute to emergency readmissions, which have a much higher prevalence in older age (Bowman *et al*, 1999; Hobbs, 1995). In addition, rapid hospital turnover has been cited as an important contributing cause (Harrison *et al*, 1995; Hanrally and Robinson, 1999; Harrison *et al*, 1995). Emergency admissions and readmissions are particularly important during winter months. A heightened vulnerability to smaller sustained variations in demand, such as fluctuations in demand arising from MRSA and influenza epidemics can seem to "tip" the balance and precipitate a hospital bed crisis (Coast *et al*, 1995). The winter peaks, creating

what is known as winter pressures, principally reflect exacerbation's of cardiovascular and respiratory illness (Currie, 1998; Kendrick, Frame and Povey, 1997) and people with congestive heart failure are particularly at high risk for repeated readmissions (Hansen, bull and Gross, 1998). Increased winter demands, are considered to occur usually any time between mid November and mid February, but are most pronounced during early January (Coast *et al*, 1997).

In a study of hospital emergency admissions, Coast and her colleagues, demonstrated that between 10 and 15 per cent of emergency admissions could potentially be managed in alternative services. The people that this most applies to are likely to be over 75, to be admitted via their General Practitioner and be admitted outside of normal working hours. The study also found that 62 percent of hospital stays were for the provision of lower intensity care (Coast *et al*, 1997).

These findings do not indicate that emergency admissions are higher during out of hours periods and weekends. Although there are variations in mean daily admissions, these have been found **not** to be higher during out of hours periods (Whynes *et al*, 1999). In a study of 2131 records, it was discovered that admissions at weekends were significantly lower than those occurring during the working week. Admissions were highest on Monday with a second smaller peak on Friday. During the twenty four hour period, admissions peaked at midday and thereafter declined with a mini peak between 18-20 hours (Whynes *et al*, 1999).

Several reports are available which refer to perceptions that the demand for medical ∗ beds, in Portsmouth, particularly those for older people, have for some time exceeded ∗ supply. In 1991, the estimated need for acute medical beds, mainly for use by older ∗ people, was 30 below Wessex RHA figures (Departmental correspondence, 1991). In ∗ 1996, it was reported that as many patients were going through medical beds in the ∗ five winter months as the seven summer months (internal Departmental Report, ∗ 1996). The Consultant workload within DEM has been reported to be exceptionally ∗ high over a number of years with correspondence and internal reports referring to this ∗ as far back as 1989. In 1999, a report was produced summarising the increasing and ∗ high workloads of consultants. It suggests that, in addition to structural and ∗ organisational variables, demographic and epidemiological issues have contributed to ∗ a year on year increase in demand for in patient medical care for older people, which ∗ have not been matched by the provision of additional beds. ∗

When medical workloads are high this is reflected invariably, in high nursing workloads. In common with the rest of the NHS, there is no empirical research which demonstrates the relationship between medical and nursing workload or that provides data of a longitudinal nature. However, there are some sources of professional wisdom which help to describe elements of nursing workload. One of these, is that requirements for nursing input in all care environments tends to occur in peaks. These relate primarily to periods of transition including admission, sudden deterioration, discharge and death. Given the short length of stay of most patients, they tend to be more ill for their relatively brief period as an inpatient. This causes a concertina effect making peak activity, periods associated with discharge and admission, occur closer together. The considerable nursing workload associated with this type of activity does not appear on any recorded statistics.

Records of patient activity in the Department were reviewed, where available, back to 1989. Structural changes have occurred in DEM over the past 12 years, resulting in ward name and function changes. This means that tracking ward based activity over a number of years is extremely time consuming and difficult. Alterations such as the creation of mixed sex wards in 1994, and the change back to single sex wards in 1997, in addition to ward upgrading have reduced the number of available beds. In consequence, the number of overall admissions have reduced over the years. However, this is off set by the marked decline in the length of stay in all wards. The combination of fewer beds, an ageing population with greater requirements for health care, and shorter hospital stays have resulted, with little doubt, in a compression of, and increase in, sustained activity over the past ten years.

The activity of nurses resulting from changes in health care practice and policy are poorly researched and not well understood. Increasing levels of technology, which are now regarded as normal, were rare ten years ago. Complex pharmacological interventions, medical investigations and treatments result in the use of more nursing time and time of a more highly skilled nature. The absence of literature in this sphere is an important omission for the nursing profession, with a consequence that it is not possible to demonstrate scientifically either what nurses have done in the past or what they do now.

More than 65% of the work performed by a registered nurse is reported to be in some way influenced by others including physicians, administrators, and professionals from other disciplines (Moloney and Maggs, 1999). Furthermore, the number of activities performed by registered nurses is significantly higher than other groups (Murphy *et al*, 1997).

Although there is no empirical evidence describing changes in nursing workload and practice, there is some subjective information available in Trust reports, that point to changes in some aspects of nursing practice over a number of years. An example of this is found in a report based on a review of 76 long stay patients in one ward between January - June, 1987. This showed that 20% of patients required two nurses to assist them to move from a bed to a chair. A simple survey of 44 patients in one week in January 2000, determined that the help of two nurses was required for all patients in two wards.

A patient audit has been maintained in one continuing care ward for the past nine years. In 1992, the average Barthel for patients was 4.1, in 1996 it was 2.1 and it 1999 it was 0.89. In 1992, 77% of patients had urinary incontinence and 65% faecal incontinence, now these percentages are each 100%. While there are no studies which evaluate the additional nursing input required by these changes, they are important indicators of increased requirements for nursing care.

The picture of sustained high activity and many structural changes undoubtedly affects the sense of well being of staff who were clear about the unrelenting nature of their work. Added to this, the seasonal winter increase in workload also tends to occur during periods of high staff sickness and annual leave due to school holidays. This means that on top of chronically high workloads, peaks occur which are exacerbated by periods of greater staff shortage.

The so called *"winter pressures"* have been the focus of much organisational and clinical activity. Much of this has concentrated primarily on a lack of hospital beds. This shortage however, is frequently a euphemism for a lack of nurses to provide care for patients who might require these beds. There is little doubt that just as the lack of nurses significantly affects the availability of beds for patient care, there are also important workload for nurses in the Department as a result of seasonal peaks in activity.

It can be accepted that nursing workload has increased over the years. However, if this is accepted there must also be some agreement that the requirements for nursing care have also changed. To simply provide more nurses without clarity about what they should be doing to meet the present day health needs of older people, is not acceptable. This is akin to treating a symptom (high workload) and not the root cause. One major part of the cause is undoubtedly higher patient throughput. If Coast *et al* (1997), are correct that 15% of older people could be cared for elsewhere (and other work indicates that this is so), part of the solution lies in preventing admissions in the first place.

Nursing workload is exacerbated by unplanned activities and there is a sense that this may contribute to low morale and in turn, poor retention. However, the interviewees felt that under current circumstances it was not possible to plan, either because of the unpredictable nature of nursing, or because of the lack of time for reflection and development of practice. These perspectives appear to have led to two consequences, the first is that there are some aspects of care that predates current knowledge of clinical effectiveness and the health potential of older people. The second is that, sustained high activity may lead to what Salvage calls " factory farm or conveyor belt" approaches to care, which focus on throughput before quality and the patient experience (Salvage, 2000).

One of the most dramatic features of this theme, relates to how sustained high workloads affected the individuals sense of personal control. The feeling that one has some control over ones working life is closely related to job satisfaction. It is clear that high activity, can lead to clinical risk situations, as shown later in this section.

3.6.1.2 Making do: Shortages of nurses

A shortage of nurses was considered to impact significantly on quality of care and on the ability to improve and sustain high standards of care. Difficulty in recruitment and retention, and absences due to sickness were stated as major reasons for the delivered shortage of staff.

"The thing is, at one time people - well we all really - would struggle in when we felt rough. It's not the same now - people just don't have the energy"

The recruitment and retention of nurses is an issue of national and international concern, with most countries reporting shortages in qualified nurses (Buchan and Edwards, 2000; Health Committee, 1999; Secombe and Small, 1997). In England, 80

per cent of Trusts are reported to be experiencing "medium to high" problems in recruiting professional staff (Audit Commission, 1991;1997). Since 1993, the number of newly qualified nurses joining the UKCC register has fallen from 32,143 in 1993 to 26,465 in 1997/8. This is partially as a result of a reduction in the number of training places for nurses in the early 1990's, as a result of Project 2000 (Buchan and O'May, 1998).

The South East region is one of the most seriously affected by registered nurse shortages. Part of the reason stems from the number of people in the region with higher education qualifications (23.5% compared to 20.5% nationally). Higher educational attainment is considered to give younger people wider options, and nursing is not currently regarded as an attractive career choice (Reed and Clark, 1999). The region is also characterised by relatively low unemployment, 2.6% compared to 4.4% for the United Kingdom. However, one of the most important features, particularly as far as recruitment is concerned are the high accommodation costs (GOSE, 1999).

The registered nurse vacancies were highest in the Trust. On June 6 1999, DEM had 17.06 (74%) D grade nurse vacancies out of 23.06 for the whole Trust. Out of 48.38 E grade vacancies, 10.63 (22%) were in the Department.

Nursing shortages in DEM are not a new phenomenon, as records show, in 1989 there were three recorded incidents in one winter month when no qualified nurse was available to cover shifts either from permanent, bank or agency staff. In 1991, an audit demonstrated a high level of absenteeism due to sickness. Staff sickness was also reported to be high in 1992, with an DEM £47,000 overspend, mainly due to the use of agency nurses.

Absences due to sickness leave a heavy burden for the remaining ward staff, and Departmental Review and Trust information sources indicate that sickness levels were higher in DEM than the rest of the Trust. To illustrate, in 1999/00 sickness rates in the Department in one quarter in 1999 were 6.9 compared to 5.5 for the rest of the Trust. There is also evidence that sickness rates were increasing in the Department over a number of years, as shown in table two.

| Table two - Annual sickness rates in Department ||||
1996/97	1997/98	1998/99	1999/2000
5.5	5.7	5.7	5.9

High sickness levels on a sustained basis, place a significant burden on nurses remaining in the wards and is an obvious cause for concern. However, there is evidence from Trust information that show seasonal variations in absences due to sickness. Figure one shows the aggregated sickness rates for Trust staff for the years 1995-1999 inclusive. January has the highest rates which, as shown earlier is the peak period for "winter pressure admissions".

Figure one: Aggregated staff sickness rates between 1995-1999 by month.

Percentage of Sickness Rates 1995-2000
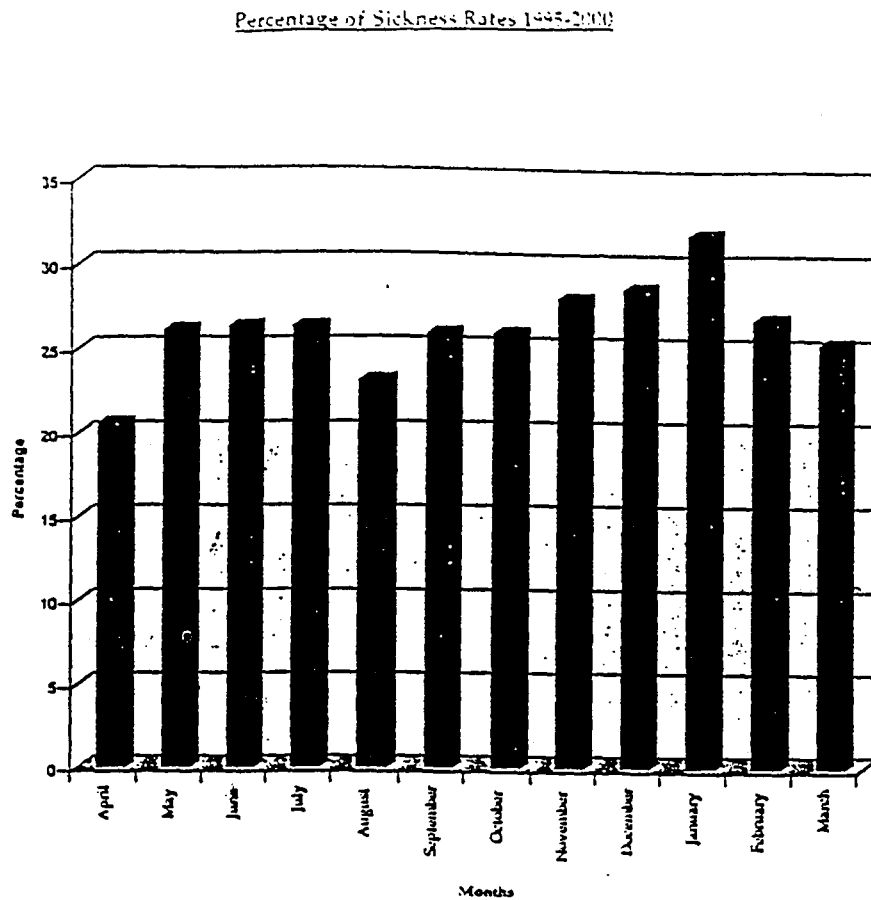
Every year infectious diseases have resulted in bed closures and staff sickness. In addition each year *"patients are turned away from the department"* for a range of reasons, including shortages of nurses and full wards. This practice dates as far back as the 1980's and in some years, has averaged 2 people "turned away" each day.

While the number of nurses in training has been decreasing, healthcare markets requiring more nurses have been expanding. For example, there has been an increase in the number of nurses required to provide healthcare in the private sector (DoH. 1997). The development of NHS Direct resulted in the employment of more than 800 nurses mainly at G grade and above. Nurse shortages are likely to remain over the new few years, as nursing will lose, through retirement, many of its experienced practitioners. One in five on the UK professional register is now aged 50 or over (Buchan, 1999). In DEM in January 2000, the situation is different with a relatively

young workforce of which 56 per cent is aged 39 years or younger, as shown in table three.

Table three: Age and grade of registered nurses				
Age of Registered Nurses	Grades			
	D	E	F	G
40 and over	46	37	8	9
39 and under	40	66	9	14

The issue of an ageing workforce is important as fewer nurses tend to work beyond the age of 55 years in the NHS than in other sectors (Buchan and Edwards, 2000). Older nurse attrition appears to be linked to problems of balancing work and domestic commitments and to job satisfaction. In a survey of older qualified nurses, it was found that while 68% were working in the profession, 16% worked in other employment and 15% were economically inactive (Buchan and Edwards, 2000). If these statistics apply to the Portsmouth population, it does suggest that there may still be a pool of nurses who might consider returning to the profession under the right circumstances.

The high profile government campaign designed to attract new recruits into nursing, acknowledges that it may be particularly difficult in areas providing care for older people. Attracting young people into nursing is thought to be difficult in part due to the poor image that nursing possesses. However, this poor image is particularly associated with nursing and older people (Helmsely-Brown and Foskett, 1999). This is significant since older people have the greatest need for nursing services, but comparatively few nurses may be willing to provide such care (Gilchrist, 1999; Girvin, 1998).

In a study by Randawa and Durand (1999), nurses who had decided not to return to work after childbirth, perceived nursing to have greater responsibility, more emphasis on paperwork and the feeling that the traditional hands on role was disappearing when compared to their previous working experiences. Morale was thought to be low because of short staffing, high levels of stress, low pay and a feeling of being undervalued by managers. Nearly all those who returned to practice in the NHS went back when their family circumstances allowed them to do so.

Krausz and Fredbader (1996), suggest that non-returners cannot at present, afford to rejoin the NHS if they have young children, because of the high costs of child care and because internal rotation systems are not employee friendly. Half of those in their study that returned to practice, did so on the bank and the majority of non-returners said that bank nursing would be the only option for them if they were to return. This is predominantly because it allows people to work flexible shifts to fit in with school hours and holidays.

Organising shifts is straightforward when service issues are paramount, but when meeting the needs of people who work them becomes the central priority, there is no doubt that it becomes highly complicated. Staff scheduling methods are

organisational functions that do not involve just the production of a list of nurses names against dates and times, but involves the management of people's social lives. It also has significant implications for the delivery of nursing care and the effective management of excessive workloads. Instead of being regarded as merely a paper exercise, with short term implications, it should be perceived as a function essential to the effective running of a service and to the delivery of optimal patient care.

Methods which roster nurses to specific duties could be used to predict periods of high nursing utilisation during periods of daily or seasonal activity. At the present time, although some wards have introduced other methods, staff rotas are planned to meet the basic aim of staffing a ward. The provision of nurses to staff the wards, reflects historical patterns of care delivery, so that the highest numbers of staff are scheduled for duty in the morning shift. In the past, as an integral part of task focused nursing, most nursing work had to be completed by 12 midday for lunch, or in time for 2 pm visiting. The morning period tended to be a time of great activity, while the afternoon period devoted more to the patients rest and generally catching up for nursing staff. It is important that nurses and their managers have the opportunity to reflect on this and determine if it is patients or organisationally determined needs that dictate patterns of workload.

Even when wards have moved on to the notion of 24 hour care, outdated methods of organising staff working rotas can hold back the delivery of responsive nursing care. Clearly more work needs to be undertaken to address what patients needs are, and for nurse allocation to be determined accordingly.

The problems surrounding nursing turnover have been well documented (Cavanagh, 1990). In particular there are concerns about the impact of turnover on staff morale, on patterns of communication and working practices. Turnover is also expensive in terms of recruitment costs, staff training and on going supervision. There is evidence that high nurse turnover can also have a detrimental psychological impact on patient care (Phillips, 1987).

Exit forms in the Department show that the vast majority of nurses leave for reasons of promotion or for family reasons. However, the type of questions can direct the answers obtained, so that the full picture may not be obtained through this method. Turnover per se does not necessarily signal low staff satisfaction or low morale, it can equally indicate that people have reached a natural end to a period of work. The patterns of reasons for nurse resignations varies from nurse to nurse and this suggests that there is no single reason which might be responsive to simple remedial action.

3.6.1.3 Playing musical nurses: Agency nurses and other temporary staff

> The issue of agency and other temporary nursing staff was considered to influence the standards of nursing care and morale. There was a great deal of movement of staff between wards and the use of agency nurses was high. This impacted on the sense of team working and created tensions between ward staff who were moved to wards where perhaps they felt their best skills did not lie. The decisions to move nurses was made centrally and added to the sense of low levels of autonomy within the unit.
>
> *" It started years ago when we were short but never stopped - we always seem to have agency nurses or if we have enough someone is moved to another ward -its just like playing musical nurses - but it's no fun".*

Several events and changes within the Department seem to have led to somewhat centralised management processes. This means that many of the functions which were previously part of the ward sisters role, were drawn into the central management function. For example, it was recalled that when there were nursing shortages in 1992/3, staff started to be moved around the Department in an attempt to fill gaps. Although the intention was to maintain a safe service, the consequence of what became sustained practice, was a strong sense of loss of choice and control. Nurses felt insecure that they might be moved, and often this occurred. Sometimes this involved moving from the area that they had chosen to work for which some felt inappropriately trained to work. This was often explained as *"working like an agency nurse - but not being paid like one"*. The most common reason given for staff redeployment to other wards was absence due to sickness.

Deployment practices which involve moving people around without the full agreement of staff, will not give the impression of valuing them - a central hallmark of quality improvement (Katz and Green, 1992). The term "floating" has been ascribed to this practice. Floating staff to other units results in a lack of consistent staff, which in turn leads to poor continuity of nursing care. It is reported that this is related to increases in such events as medication errors (Davidhizar *et al*, 1998), and is therefore an important clinical governance issue.

Nurses are particularly frustrated when they feel a lack of input into decisions about their work and their schedules. When individuals are able to control their work, their level of satisfaction invariably increases. The practice of "floating" is considered to cause stress among staff (Beard, 1994; Foxall, 1990). Staff satisfaction influences retention but it is also likely to influence the quality of work undertaken. In consequence, staff satisfaction is a crucial clinical governance issue with implications for workload.

Agency nurses were regarded as having variable clinical skills and that some required very close supervision. In addition, it was felt that they seldom worked to the required grade. This meant that if there was one registered DEM nurse and one agency, in many situations, this was akin to their being just one registered nurse to undertake the range of work required in a busy ward environment.

A study of patients' views of nurses in continuing care demonstrated that agency nurses were viewed negatively (Ford, 1997). Bloom *et al* (1997), assessed the effects of four nurse-staffing patterns on the financial efficiency of patient care delivery using multivariate analysis. These were, the use of agency registered nurses, part time registered nurses, rich skill mix and, experienced registered nurses. They found that the most expensive method in terms of both personnel and hospital operating costs, involved the use of agency nurses. The use of part time staff and experienced nurses were related to the lowest costs. The authors suggest that staffing decisions have a significant impact on both personnel and operating costs of a hospital. Although American costing systems are different, the costs of employing agency nurses are known to be high and not just in financial terms.

Between 1996/7 and 1998/9 the national expenditure on agency nurses rose by 47%   *
from £216 million. The use of agency nurse costs in DEM rose from £144,248 in   *
1997/8 to £281,526 in 1998/99. During 1999, there were times when on some wards   *
20 per cent of all nurses were temporary, bank agency or were from another ward.   *

This carries important clinical governance implications in terms of the financial management and the provision of effective and appropriate patient care. The use of temporary staff is associated frequently with poor continuity of care and poor outcomes of care (Petersen *et al*, 1996). In addition, research has shown that agency nurses are less independent and more subject to direct supervision by permanent staff. They also rely on permanent staff for information about patients which creates additional demands (Prescott, 1986), with implications for overall workload.

The lack of continuity associated with agency staff is likely to affect the sense of coherence that patients consider they receive. This sense of coherence is reported to be important in terms of patient satisfaction and its lack is an important cause of complaints regarding care (Larrson and Larrson, 1999). For many patients in hospital wards, it is increasingly a different nurse who provides care. The delivery of this care may occur on the basis of little other information about patients other than that relating to the day's clinical picture (Taylor, 1995). Persons experiencing such care over long periods of time, often come to feel objectified and even dehumanised. Obviously care that is individualised to the needs of patients requires knowledge of that person, which may be difficult to attain for temporary staff.

3.6.2   Clinical nursing practice

The second large grouping within the clinical risk assessment dimension, relates to clinical nursing practice. The interview data generated five themes which focus on aspects of direct and indirect patient care.

3.6.2.1 Climb every mountain: Outcomes of nursing care

> Given the perceptions of constantly high workloads, the issue of audit and evaluation of nursing practice received a low priority at all levels. Hundreds of letters and cards were received by each ward every year but systematic, objective and clinical evaluations were rare.
>
> *"We should measure the outcomes of clinical care, but to get started -thats a big mountain to climb - we would need some help with the what, how and when"* .

Thomas and Brennan (2000), reviewed a random sample of medical records of 15,000 hospitalised patients discharged from American hospitals during 1992. People aged 70 years and over were found to have a higher incidence of preventable events relating to medical and nursing procedures, such as adverse drug incidents and preventable falls. This age group also experienced more permanent disability and death as a result of these events. The authors concluded that age was not an independent predictor of preventable adverse events but that the complexity of care was implicated.

There is mounting and strong evidence pointing to the relationship between aspects of clinical nursing practice and the outcomes of care. In an early study Miller (1985), proposed that patient length of stay was related to specific nursing practices and the type of nursing provided. She compared wards that were providing task focused care and individualised care. After adjusting for case mix, in the wards providing task focused care, she found a strong association with the number of pressure sores and nearly three times as many patients had in dwelling catheters. Petersen *et al* (1998), emphasise the importance of continuity of care in preventing adverse events. Prescott (1993), published a review summarising 13 research papers, which examined the relationship between clinical outcomes and skill mix. She demonstrated that with a higher ratio of registered nurses, clinical outcomes were consistently better. Beckman *et al* (1998), aimed to identify incidents associated with nursing staff shortages. Of 647 incidents reported anonymously, 405 were related to staffing shortages.

Relating outcomes solely to nursing practice may be difficult, as outcomes may be affected by factors other than to nursing. However studies report a relationship between nurse shortages and adverse events such as patient readmission rates (Hunt and Hogan, 1998). McCloskey (1998), measured six adverse patient outcomes; medication errors, patient falls, urinary and respiratory tract infections, skin breakdown, patient complaints, and mortality against the total hours of nursing care available, and the proportion of these hours delivered by registered nurses. She found an inverse relationship between registered nurse hours of care and rates of medication errors, skin breakdown and patient complaints. When the proportion of registered nurses rose to 87.5%, it related to a lower incidence of negative outcomes, however, when the registered proportion increased beyond this level; the trend towards reduced adverse events ceased (McCloskey, 1998). Other American work recommends 70% registered nurse proportion to unqualified staff in medical units primarily providing care for older people (Sovie, 1995).

Blegen, Goode and Reed (1998), found that the proportion of hours of care delivered by registered nurses was inversely related to the unit rates of three adverse patient outcomes over one year. These were, medication errors per 10,000 doses from self reported incidents, decubiti rates from chart reviews, and complaints initiated by patients and their families. Katz and Schroeder (1994), used 25 aspects of care in a study designed to determine what nursing quality professionals perceived to be the key functions at ward level. Nurses were asked to rate each aspect on a scale, those related as most important were, medication, safety and infection control.

The average length of stay has been examined in relationship to nursing hours per patient and total hours matched to patient intensity and weightings (Brewer and Frazier, 1998; Shaimain *et al*, 1994). These have demonstrated that lower lengths of stay are directly related to higher nurse staffing.

Some aspects of clinical nursing practice were perceived to be particularly sensitive to high activity and low staff availability periods. While these were consistently raised during the interviews, other aspects of care were notable by their absence, such as tissue viability and continence promotion. The elements of care discussed most commonly by staff were perceived to be most sensitive to staff shortages, high workloads and the use of temporary staff. These were, hospital acquired infections, care of people with dementia, nutrition, record keeping and information exchange methods.

3.6.2.2 Not enough to go round: Evidence based practice

There is a view in the Department that some aspects of nursing practice would benefit from a more research evidence based approach. Shortage of time, training in evidence based practice and limited access to computerised information sources are given as the main barriers to implementing evidence based practice in a more systematic manner. There is currently no computer or journal resource within the Department. Access to the library on both Queen Alexandra and St Mary's sites in during normal working hours. Although access can be obtained outside of these hours release from the wards is often difficult and requires leaving the building which adds to time away from the ward.

"We know there is loads of research evidence - the Practice Facilitators help with this but there are just not enough to go round".

It is essential that nurses gain evidence based practice skills. It is suggested that this is not always the case in nursing environments for older people. Nolan and Keady (1996), suggest that some poorly evaluated gerontological practices continue. Nolan, Morgan and Curran (1998), suggest that a complex array of barriers exist to research utilisation but the foremost of these is the organisation within which nurses work. Furthermore, a perceived lack of authority to introduce change in patient care is still regarded as one of the most significant barriers to the implementation of research based practice (Hunt, 1996).

The existence of evidence based practice, knowledge and skills is the foundation for the development of a culture of service evaluation and research in a healthcare organisation. Without this foundation, it is difficult to develop practitioners with sufficient confidence and knowledge to be able to set up objective service evaluations and research projects.

3.6.2.3 Prevention - everyone's business: Hospital acquired infections

One of the key issues that was considered to cause additional workloads was hospital acquired infections (HAI). Although staff felt that practices were very good in this respect, it was accepted that maintaining this was not always possible to the desired high standards especially when there were staffing difficulties.

"Infections cause a lot of worry, we try really hard but it's not the same (with agency nurses) when you don't know your team and how efficient they are at prevention and you just can't be every where all the time to watch what goes on".

The National Audit Office, suggested recently that the NHS in England could save an estimated £150 million and many hundreds of lives by tightening infection control mechanisms in hospitals. At least 100,000 cases of hospital acquired infections occur each year in England with an estimated 5,000 deaths, which cost the NHS in the region of £1bn annually. Improved education of staff, better surveillance of patients and involvement of clinical managers in the control of infection are proposed would reduce the burden of HAI by an estimated 15% each year (NAO, 2000). The burden in terms of hospital bed availability is considered to result in the regular loss of 27 beds each day per 400 bed hospital (Plowman, 2000).

To be considered a hospital acquired infection (nosomial), the infection should occur 72 hours after admission to hospital (Caddow, 1989). In the first national prevalence survey of nosomial infection, the overall prevalence was 9.2%. Nosomial urinary tract infections were the most commonly occurring infection and accounted for 30.3% of the total (Meers *at al*, 1981). The second national study conducted in 1993/4, revealed a similar overall prevalence of 9.0%, with a stated prevalence of urinary tract infection prevalence of 26.8% (Emmerson *et al*, 1996). Crow *et al* (1986), estimated that around 10% of all hospital patients have in dwelling catheters and suggested that the costs of infections to hospitals was exceptionally high.

In a study of 1000 patients with a hospital stay of over 30 hours, 215 met a pre-set definition of having HAI. In these patients 7.8% had one or more infections. Following discharge, 19% of patients without a previously defined infection, reported symptoms that met the criteria for HAI. During their stay in hospital 13% of patients with an infection died compared to 2% who did not have an infection. The mean length of stay was 8 days for uninfected patients and ranged from 10 to 45 days for those with infections (Tearse and Barrett, 1997).

The relationship between nurse under staffing and hospital-acquired infections has been investigated, and as a result it was concluded that a shortage of nurses

contributes significantly to the presence of Methcillin resistant staphyloccus aureus (Fridkin, 1996). In a further study, the incidence of new cases of MRSA correlated with peaks of nursing staff workload and times of reduced nurse-patient ratios within a unit monitored over a 19 month period (Vicca, 1999). Nurses express concern about infection control issues. Gould and Ream (1994), identified problems with nurse's ability to perform infection control precautions during routine activities, citing lack of resources as a key influencing factor.

The Public Health Laboratory Service recommends that Trusts review infection control procedures and ensures that guidelines are properly implemented. It also suggests that problems may occur during periods of high workload where basic infection control measures may be reduced by cutting corners (PHLS, 2000; RCN, 1999). The National Audit Office warned that there had been a rise in risk factors for hospital acquired infections. It identified patient throughput together with increased staff mobility as among the trends that undermine effective infection control.

Sources of infection are known to be hands, footwear and pens (Gould, 1991). In addition, curtains, slings, hoists and chairs have been found to be a source of contamination and beds that are situated close to others increase the likelihood of cross infection. Research demonstrates that staphylococci can survive as long as seven weeks in fabric containing polyester, and enterococci has been shown to survive even longer (Boden, 1999; Jones, 1992; Haigh, 1993; Rogers, 1993).

Efforts to control MRSA are supported by National Guidelines (BSAC, 1998; May, 2000), which determine that the single most important way to prevent the spread of MRSA is by effectively decontaminating hands after patient contact. Bandolier (2000), outlines how simple handwashing procedures reduced hospital infections by 50 per cent.

Some hospitals have made an important impact on HAI's. An audit carried out in Guys and Thomas's Hospitals NHS Trust, estimated that the annual cost of HAI was £3.9m, based on an extra length of stay of three days per infected patient. The hospital has since reported that with more effective control measures there has been a 30% reduction in MRSA.

During the period of the review in DEM, there were several beds closed because of infections on the wards, included in these were MRSA and infections causing diarrhoea and vomiting. It was common for nursing staff to also be affected by the latter and for this to result in short term absences through sickness. Although complete longitudinal information is not available, there are indications that closed beds and associated staff absence are long standing issues within the Department. For example, reports relating to October -December 1991, show that 108 bed days were lost as a result of infectious diseases. Unfortunately, this information is not provided for the rest of the year. However it is reported that 456 acute admissions were "turned away" from the acute wards during 1991/92. How many of these refused admissions were directly as a consequence of infections is not known, but snap shot information is available from fixed periods for many years.

In October 1994, 198 beds were lost because of diarrhoea and vomiting. In November *
this rose to 308, which was 10% of the acute beds available at that time. In the third *
quarter 1995, 158 beds were closed because of diarrhoea vomiting. However, there *
remains some uncertainty about policies, guidelines and protocols in this sphere. There *
were bed closures due to HAI during 1998 and 1999 but many of these have not been *
recorded in official statistics. There is a view that the true incidence of HAI is *
uncertain. In part because there are often delays in the formal confirmation of an *
infectious disease outbreak on the wards. It is considered that formal declaration of an *
outbreak can take several days and pathology results may also be slow. Increased *
patient turnover and lack of appropriate intervention because of delays may be creating *
additional clinical management difficulties. Part of the problem stems from a lack of *
very clear protocols regarding nursing actions which means that responses to infectious *
diseases are variable. This is an issue for further work and development. *

As a result in delays in the declaration of infectious disease events, information
relating to lost bed days is inaccurate. There were many examples of this during the
period of the review. It is currently not possible for the Trust to count the financial cost *
of HAI, which it is urged to do in a recent Health Service Circular (HSC, 2000). *

The issue of staff training is of paramount importance to the prevention and control of
infections in hospitals. However, in DEM's extensive yearly in house training
programme during 1999, there was one session offered on infection control issues. Of
the four staff who requested to attend on the day, two attended. An hour-long session
is provided as part of the Department's induction programme and there will certainly
be informal training that takes place in the wards. However, given the importance of
the issue to patients and to the organisation of care, it is crucial that practice is
reviewed and appropriate on-going training implemented for all staff.

Hospital acquired infections inevitably result in a requirement for additional nursing
input. Therefore in addition to undesirable patient outcomes, they cause additional
nursing workload. Increased workload in turn may cause nurses to cut corners and so
the cycle continues. Furthermore, there is much anecdotal evidence that points to the
relationship of some forms of HAI to sick leave in nurses. This sickness, particularly
of the gastro-intestinal variety tends to lead to short term, unplanned sickness in wards
that may already have higher workloads because of HAI.

3.6.2.4 An increasing dilemma: Dementia

There was a view, that there had been a steady increase in the numbers of patients with cognitive impairment on all the wards. These patients were sometimes confused and distressed which made the provision of nursing care difficult in busy ward environments. In longer stay wards a high proportion of people have co-existing physical and cognitive disorders which complicates clinical practice. In acute wards there is often pronounced difficulty in the management of severely ill, yet disorientated older people.

"We get more confused people with dementia than ever. It is really hard to meet their cognitive needs in an acute ward environment".

"Most of our patients (in continuing care wards) have physical and mental health conditions. Overall, there is not much difference between us and EMH wards - except we are as expert at physical care as they are with mental health".

The nursing work associated with the provision of care for people with physical conditions and co-existing cognitive impairments is known to be high. In hospitals providing continuing care for older people 70.6% were found also to have significant cognitive impairment (Hickey, Clinch and Grourke, 1997). Given the increasing prevalence of dementia with advancing years, rising to 30% at 80 years (van Breleler and Larskemp, 1995), providing appropriate care for people with dementia is an important issue.

An investigation into best practice in the care of acutely ill hospitalised people with coincidental dementia found that care was sub-optimal, with a clear focus on physical aspects of a patients care (Tolson, Smith and Knight, 1999). These authors found in their sample of 213 patients aged 65 years and over, that 66% were suffering from persistent cognitive deficit. However, no record of formal nursing (or medical) assessment of the problem could be located in the patients' notes. Furthermore, the care plans of only 15% of patients with impaired cognition were sensitive to special individual needs, and that acknowledgement of a problem tended only to occur when behaviours which were difficult to manage, such as wandering or aggression occurred (Tolson, Smith and Knight, 1999).

In people with cognitive impairment, transitional periods, admission, discharge and transfer are known to be particularly difficult and confusing (Johnson and Abbott, 1999). Approaches aimed at minimising confusion and agitation are usually highly structured and organised. The literature advocates the provision of a home like environment, including personal belongings, appropriate home like decor and familiar life style patterns such as meal times (Hamel, *et al*, 1993; Matthews *et al*, 1996; Meddaugh, 1990). These helpful facilities are at variance with hospital life in many DEM care environments, and there is evidence that patients have to fit into ward routines rather than the other way around (Reed, 1992; Waters and Easton, 1999).

Kitwood's (1995), work on changing the culture surrounding traditional dementia care, involved the identification of poor care areas. He described poor care areas as those where the patients have given up and where there is a pervasive sense of apathy and boredom. He suggested that the staff in these areas are likely to be cynical and relate to each other and patients in superficial ways. Other literature suggests that hospitals suffering catastrophic incidents have a poorer staff to patient ratio (Beck *et al*, 1990), and demoralised staff that have poor training (Freyne and Wrigley, 1996).

In DEM's longer stay wards, people with cognitive impairment in addition to multiple physical illnesses make up the largest proportion of patients. This situation has changed over the years and carries important implications for nursing workload and clinical practice. In January 1994, an audit carried out on Jersey Ward showed that out of 17 patients in continuing care beds, the average Mental Test Score was 3.5 with 65% with a score of below 2. In April 2000, the MTS could only be used with five patients because of their level of cognitive ability and the average for these was 2.05. The MTS is a validated instrument, which measures cognitive ability, and serves to demonstrate that there has been an important change in the case mix in this ward.

There is no doubt that the co-existence of physical and cognitive disorders creates greater demands on, and for, nursing resources in all care environments. Such patients are often immobile and require highly skilled nursing care to support most human functions. However, when a patient is admitted to an acute ward suffering from cognitive illness in addition to their acute physical condition, which requires highly technical medical treatments and complex nursing, there is often extreme difficulty in providing optimal care. It is increasingly common for patients admitted to acute wards to be confused and sometimes aggressive, and they may want to wander around or from the ward. Providing nursing care for these patients and often for their neighbours is challenging and discussions should occur within the Department and with providers of healthcare for older people with mental health problems, regarding options for care for patients in this situation.

3.6.2.5 Not just meals on wheels: Food and nutrition

One of the most time consuming aspects of nursing care is considered to be concerned with patient feeding and nutrition. Sometimes it was considered that the process of feeding patients may be subject to the effects of nurse shortages and high workloads.

"It is difficult not to get mechanistic where feeding is involved. People think it's a task but it's important for clinical outcomes and emotional health - it's not just meals on wheels".

Nurses commonly help patients with feeding when the patient has a cognitive impairment associated with dementia or following a cerebral incident. However, a task focused approach to feeding has been identified in wards providing care for people with dementia and it is reported that it is also commonly seen in busy wards as a time saving measure (McGillvray and Marland, 1999). The "feeding task" is often found to be delegated to the most junior and least well qualified members of the ward team with important clinical implications (Burnham, 1996; Watson and Dery, 1997).

The staff to whom patient feeding is delegated, are considered to have insufficient up to date information and education regarding the complexity of some conditions, or the most effective approaches to feeding based on an individual's abilities. Events surrounding meals are normally an important part of a person's social life but Perry (1998), suggested that food is often given without any interaction between the staff member and patient and with insufficient clinical nursing supervision (Maryon Davis and Bristow, 1999). It is therefore of little surprise that 30-40% of hospital food is wasted annually at an estimated cost of £144m, including the cost of food, labour and overheads (HCA, 2000). In consequence of these factors, the average patient nutritional intake in hospitalised older people is much lower than it should be (Allison, 1999). A further consequence is that a dependency upon others for feeding, has been found to be the determinant risk factor for aspiration pneumonia, an important adverse event, particularly found in long stay environments (Langmore *et al*, 1998).

In addition to the risks associated with feeding processes, there are other adverse outcomes associated with poor nutrition. These include; an increased likelihood of complications, delayed recovery, longer hospital stays and increased mortality (Green, 1999). This has implications for effective bed management, hospital costs and nursing workload. The importance of adequate nutrition was reinforced recently by the Government Chief Nurse, who proposed that *"nutrition is a fundamental part of nursing, which is every bit as important as the monitoring of vital signs"* (Mullally, 2000). It is also reported that nurses do not give nutrition the same amount of attention as the administration of medicines (Lennard-Jones, 1995). Although there are important scientific differences between the terms of malnutrition and under nutrition, there is agreement regarding the importance of patient assessment and detection of low nutritional intake or its potential.

Poor nutrition is common in at least 10-30% of community dwelling older people with chronic disease (Ward and Rollings, 1999). This group is likely to be admitted to hospital more frequently than those without chronic conditions, and subsequently it is important for nurses to have a high degree of awareness regarding this. Despite its high incidence and importance, McWhirter and Pennington (1994), suggest that only 5% of undernourished patients receive extra nutritional support. The key to this appears to be the use of valid assessment tools and regular monitoring of weight and/or body fat. Arrowsmith (1999), critically appraised six commonly used nutritional assessment tools and found that none met basic validity and reliability criteria or demonstrated a beneficial effect on clinical practice. Prouse and Lyne (1999), point to a lack of clarity in the terms used in screening tools, which can lead to differences in interpretation and variability in subsequent nutritional interventions.

A strongly held perspective from the interviews was that senior members of nursing staff did not usually undertake helping to feed people in DEM because of time constraints. As a consequence of insufficient qualified nurses on the wards, patient feeding was often delegated to less senior staff with little supervision. The issue of assisting patients with their food is mainly a concern in the longer stay wards, although the issue of adequate nutritional status is important to all in patient areas. On one long-stay ward in 1987, 8 out of 20 patients could feed themselves. In January 2000, all 18 patients required total feeding or significant assistance with food. This

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change is important in terms of nursing workload and it is possible that some of the findings reported in the literature may be found in some ward situations.

There are examples of nutritional audits being conducted within the Department but there is little evidence that the recommendations of these are sufficiently followed through and appropriately monitored. While training is provided throughout the Trust, and through a high profile Trust Feeding People Group, the practical skills of all grades of staff requires review and development. A small amount of time is available to support evidence based nursing practice in nutrition but this is part of the Link Nurse role, which is due for review in DEM this year. The role of Link nurses is referred to again later in this report.

3.6.2.6 A stitch in time: Patient information

> Patient and relative information were regarded as an integral part of the nurses role but in times of nurse shortage, this became difficult to always achieve regularly or in appropriate depth.
>
> *"Of course we want to spend more time with patients and their families but there are just so many pressing things that have to be done... and then people get unhappy... it's as if we just can't get to the stitch in time".*

Appropriate information sharing with patients and their relatives has long been recognised as beneficial for both physiological and psychological outcomes (Colera and Tanks, 1998; Clearly, *et al*, 1992). Patients who are well informed are more likely to adjust to hospitalisation, cope with stressful procedures, experience less pain and recover more quickly from invasive procedures (Sutherland, 1980; Latter *et al*, 1992; Curtis and Lacey, 1996). Hjelm-Karlsson (1989), tested the effect of structured information giving before intravenous pylorography. An intervention group was given structured verbal and written material before the procedure, and psychological reactions to the event compared with a control group given standard verbal information. They found that the experimental group were calmer, felt more safe, more relaxed and more in control of their situation.

Frith (1991), studied literature relating to information giving in radiography, and found that attention to the psychological needs of patients and their relatives is critical to their well being. A plethora of research shows, in stroke care for example, that if patients' psychological needs are not addressed, this will adversely affect patient's physical rehabilitative outcomes (Bennett, 1996; Glass and Maddox, 1992; Schubert *et al*, 1992). It is well known that many people, during a course of radiography, feel physically unwell or depressed. Frith (1991), summarised the main information needs of people undergoing radiotherapy which included a description of the radiotherapy room and equipment, information about possible side effects and corrections of misconceptions. Providing this information had a positive effect on anxiety levels of people undergoing radiotherapy.

Despite the known importance of information giving to patients and their relatives, this may be given low priority during periods of high activity in some wards. Patients

and their relatives are frequently in a high state of anxiety. This anxiety clearly increases if worries and concerns are not expressed and addressed and may sometimes later emerge as a complaint. The information to patients and their relatives could be improved in DEM if standards for the frequency of information sharing were determined. Although there may be a view that this already occurs, it is not always observed. Furthermore, there is relatively little known about what specific information would be helpful.

High quality patient care occurs in an environment that correlates with that which has a high degree of nurse, physician and patient satisfaction variables (Grindel *et al*, 1996). Patient satisfaction with nursing encompasses four dimensions; the art of care; physical environment; technical quality of care and efficacy. The art of care is regarded as the most important aspect of nursing care in respect to patients perceptions of quality and satisfaction. This focuses on the nature of caring shown to the patient.

Attributes and behaviours perceived positively by patients include, friendliness, patience and sincerity. Behaviours perceived negatively include abruptness, disrespect and behaviours that elicit shame, guilt or emotional or physical pain (Greenech, Long and Miller, 1992). It would be logical to assume that if staff do not feel emotionally strong and well supported, as it may be difficult for them to always demonstrate the positive emotional aspects of nursing, which are valued so highly by patients.

Although there are criticisms of satisfaction measurement methods (Carr-Hill, 1992), studies that document patient satisfaction with nursing suggest that it is the most important predictor of patient's overall satisfaction with their hospital care (Lemke, 1997; Graveley and Littlefield, 1992). Furthermore, it is reported that patients cannot easily dissociate nursing care from general hospital care (Abranowitz, 1987; Young, 1996). Because emotional interpersonal skills are often subtle, patients cannot always put their finger on what it was that made a hospital stay a good or bad experience (Vuori, 1987).

As a subjective assessment of the quality of health care, satisfaction represents a complex mixture of perceived need, expectations of care, and the experience of care (Wilkin *et al*, 1992). Perceptions of need for care and expectations of care are considered frequently to be well formed before hospitalisation. Furthermore, it is suggested that patients and their relatives that have the most unrealistic expectations about care, are those who are most unhappy with, and complain most about the care they receive (Williams, 1994).

In gerontological care environments, it is acknowledged that, in addition to the high prevalence of multiple health problems in patients, there is often the additional dynamic of concerned relatives. This scenario is not evidenced in younger adult in-patient environments. Many relatives and other carers now spend much of their time engaged in a caring activity and want to extend their caring responsibilities to the ward situation.

Hospitalisation brings with it much anxiety and natural concern, and it is essential that relatives and carers should have access to regular professional information, support and advice. However, while this is natural, nurses and doctors in elderly care environments must, in addition to providing hospital care, frequently spend a considerable amount of time with the patients and relatives, a relatively new phenomena. This situation is unknown in other healthcare speciality, except perhaps paediatrics, where great changes in terms of family participation have been made over recent years.

3.6.2.7 Paper over people: Nursing records

> Nursing records were sited as a major cause of high workload. There was a pervasive view that the records were over long and duplicatory. In addition, they were difficult to use to retrieve relevant clinical information for consultants and other doctors.
>
> *"The records take ages to complete so sometimes they are not done all that well but what do you choose - paper over people?"*.

Nursing documentation has undergone many changes over recent years, primarily it seems, as a consequence of policy rather than changes in clinical practice or patient requirements (Martin, Hinds and Felix, 1999). One aspect of nursing documentation is the care plan, which was first implemented in the USA in the 1930's, as a means of teaching students about processes of nursing care. In this country this led to considerable financial and human effort being directed into what became the Nursing Process, a highly bureaucratic approach to record keeping. In most parts of the country, care plans have evolved from the Nursing Process with rather less attention to possible patient benefits, and more being paid to record keeping for defensive purposes.

Moloney and Maggs (1999), investigated the relationship between nursing care plans and patient outcomes in one NHS Trust. They found evidence that a variety of methods were in use across the hospital and that the emphasis in the documentation was on the process of care planning and the keeping of records up to date, rather than patient outcomes and progress. Gwozdz and Del Tongo Armansco (1992), suggest that care plans are generally completed in a mechanistic manner and almost as a separate entity from the actual care that takes place. Instead of being used to evaluate care, audits of records frequently aim to ensure that date, initials and required spaces are completed.

Mason (1999), found that in 4 out of 5 clinical areas studied, the Activities of Daily Living section of care plans, had no positive influence on nursing practice. She concluded that care plans were not providing an effective organising frame for the planning, provision or evaluation of clinical nursing practice. Nurses have been reported to be ambivalent about record keeping and this is thought to related to tensions between the realities of nursing practice, and the nature of nursing records (Allen, 1998). That is, the documentation papers do not reflect current clinical practice.

Patient records are an important instrument for the safety, continuity and quality of patient care yet, Ehrenberg *et al* (1996), found an insufficient link between the recorded patient care and the actual condition of the patient. In addition, unless the record system is user friendly there is an increased potential for error and variability between practitioners (Cockbill-Black *et al*, 1999; Griffiths and Hutchings, 1999).

An estimated 15-20% of nurses' time is reported to be spent documenting aspects of patient information (Miller and Pasterino, 1990), and it is given as a significant reason for working overtime (Moody and Snyder, 1995). Given that such a huge proportion of time is estimated to be spent in records-related activities, it is essential that they are of maximum benefit. However, 66% of nurses in one study, perceived that the documentation they used for patients were less than useful (Meurier, Vincent and Parmer, 1998).

Although there are differences in the type of information that should be recorded on patients in different care environments, such as palliative or stroke care, a priority should be to demonstrate evidence of care provided. However, it is of little value to patients if the wrong things, those least important to patient care, are reported well. A growing body of opinion suggests a need to redesign nursing documentation to provide better information in a more straightforward, more readily retrievable format (UKCC, 1993,1998; Audit Commission, 1993; HSC, 1997).

The nursing records in the Department are a source of some criticism based on their format. During admission up to 10 nursing assessments are completed relating to   * different aspects of patient care but many are overlapping and time consuming to   * complete. Most of these have not been validated (Lyne, Papanikoan and Lycett, 1999) and have not been subject to measures of reliability. In consequence, there is variation in the manner of completion of the records, which can expose the nurse to risk.

It is essential to determine the primary purpose of nursing records. If they are a means of protection for nurses, then it is likely that they will remain overlong and duplicatory. If the purpose is to provide a source of information to inform clinicians about a patient's progress and responses to treatment, the design of the record is likely to be different. Using the current system, it is clearly difficult for nurses to always access relevant clinical details about patients, for example during ward rounds.

Ward sisters estimate that it takes around 45 minutes to complete the current record system, in part because information is kept in different parts of the document. In addition to being time consuming, it is also difficult to use to follow through a patients progress and there is a tendency to miss important factors or to over record, so that several similar issues are recorded in different locations.

In addition to the time it takes to complete the records on a shift by shift basis, there is also a cost associated with the use of paper. There is a considerable waste of paper as a result of the way in which the documentation was originally designed. This would be relatively straightforward to address.

3.6.2.8 Doing the right thing - right: Nursing Handover

Nursing handover was raised as a key issue in terms of being time consuming but essential. The key issue observed to be not whether it should be done but how. Many examples of trials in this area were currently being undertaken to compare the different types for user friendliness and efficiency.

"How you pass on patient information is less important than the what. Passing on the wrong information - in the right way, helps no-one".

Nursing handover is a means of transferring patient information, which usually takes place between staff at the end and beginning of a shift. Much of the information given during handover is considered to be anecdotal and descriptive. Webster (1999), in his qualitative study carried out in one ward in the Department in 1998, found that most information passed on during ward handover was routine, subjective and not related to aspects of patient care. He suggests that the information relayed told nurses very little about the individual patient and their nursing needs or the effectiveness of nursing care. Several different methods of nursing handover are being trailed in some wards, and evaluations of these would beneficial to other parts of the Trust.

3.6.2.9 Planning to go home: Discharge planning

Discharge, admission and patient transfer clearly result in greater requirements for nursing input. However, because there is no common nursing record in the district, new records need to be created on admission to any other care area within the district. Therefore, new notes were required on admission to DEM, to Community Hospitals and from district nursing, although patient held records are in use in community nursing.

"Patients say -I've already been asked that three times and it does affect their confidence in us. When they go home we really do not know how we have done-met their needs and how they are doing. It would be good to have regular proper feedback - not just a few surveys now and then - otherwise - we are kept in the dark, and how can we learn to do things better?"

Communications with patients and their relatives is a fundamental issue but communication between groups of staff concerning patient care is essential to effective care (Pheby and Thorne, 1994). Discharge planning is a process whereby patient needs are identified and evaluated and assistance is given in preparing the patients to move from one level of care to another, hospital to home or another facility (Jackson, 1994; Naylor *et al*, 1994).

There is persistent evidence that discharge processes require more co-ordination and linkage across and between providers of care (Anderson and Helms, 1998; Driscoll,

2000). Armitage and Kavanagh (1998), demonstrated that deficiencies in hospital discharge procedures persist and can be costly in terms of patient outcomes and hospital costs. The National Audit Office, in their study of hip replacements identified discharge policies and practices as weak (NAO, 2000). For patients, carers and health professionals, preparation for return to home is a key aspect of care quality about which concerns are expressed (Bull, 1992; Marks, 1994).

3.6.2.10 Administration of medication

Traditional nursing care involves the total responsibility of patients over 24 hour periods. Administration of medications is one of the functions most commonly undertaken by nurses (but not in all wards). The process of removing all drugs on admission and giving them out is not particularly empowering. There were differences of opinion regarding the right time and way to administer drugs.

"Some wards use different systems. We have annual competency assessments but not when pressure is highest so what we do in quiet times might be quite different. Not all errors are reported - some are not worth it".

There has been a dramatic increase in the number and range of pharmacological products used in the treatment and care of older people (Bull *et al*, 1995; Markowitz *et al*, 1997). This increase has resulted in more complicated prescribing patterns of increasingly complex substances (Cheek and Gibson, 1996). Research has demonstrated that workload factors can influence negatively nurse medication error rates (Conklin, MacFarland and Kinnie-Steeves, 1990). Roseman and Booker (1995), identified deficiencies in staffing as an important cause of adverse medication events. Leape *et al* (1995), in their five year study, found that errors increased with the number of days worked per month by temporary staff. Errors decreased when the amount of overtime hours worked by permanent staff increased. Blegen *et al* (1998), found that the proportion of hours of care delivered by registered nurses was inversely related to unit rates of medication errors.

Nursing medication administration systems differ widely throughout England. Poster (1988), conducted a study to evaluate medication systems and associated errors. Two systems were compared, a single nurse administration system where one nurse was allocated to do a drug round and, a primary nurse system where one nurse administered medications, only to the patients for whom she was directly responsible. A total of 260 errors were reported over a 12 month period (out of 258,549 doses), representing an error rate of 0.1%. The safest system was the primary nurse system and it is suggested that interruptions during whole ward rounds, may contribute to the higher rate of errors.

A number of definitions exist as to what constitutes a medication error. The American Society of Hospital Pharmacists (1992), have identified nine categories of errors which are:

- Omission errors.
- Unauthorised drug errors.
- Wrong dose errors.
- Wrong route errors
- Prescription form errors.
- Frequency rate errors.
- Dose preparation errors.
- Wrong dose preparation errors.
- Incorrect administration technique.

Reason (1990), states that errors are initially caused by a unique combination of several necessary, but singly insufficient factors. He has described several of the error evoking conditions as, unfamiliarity with a task, shortage of time, poor performance, inexperience or poor feedback on performance from the system.

O'Shea (1999), suggests that medication errors are not solely a nursing issue, but are a complex multidisciplinary problem. In practice it is more common for nurses to report medication errors than other professional groups, even though a number of reported incidents involve medical prescribing practices. It is acknowledged that reported incidents may not always provide reliable information. For example, staff may be reluctant to report incidents for fear of censure, the stigma associated with making a mistake, or because of legal reasons (Arnolt and O'Connor, 1996). Even when effective incident monitoring systems are in place, reporting is considered to still remain poor (Cullen et al, 1995). Vincent (1998), in a review which focused on reasons for non reporting of incidents, concluded that current systems do not provide a reliable index of the rate of adverse events. He recommends measures to increase reliability which include clear definitions of incidents, more simple methods of reporting, designated staff to collect incident data, staff feedback and education.

The administration of medicines was considered an important element of workload in that it was a time consuming activity for nurses. It was also one in which high workloads were associated with the frequency of errors. There is support for this view in the literature. There is a well developed administration of medicines competency programme in DEM. Further development is required in terms of how and by whom the assessments are carried out, to ensure that these occur to a consistently high standard. It would also be beneficial if regular updating could be provided for staff with responsibilities in this area, as part of the clinical governance development programme. Furthermore, nurse administered medication is itself a topic of some debate. Deeks and Bryatt (2000) found that the vast majority of patients who self administered their medications would like to do so again. They also found that patients who administered their own medication in hospital were more likely to report their overall care as excellent.

3.7   Education and Continuing Professional Development

The issue of training is clearly integral to the continuing development of nurses, nursing practice and patient care. Its importance is applicable to all stages in nurses' professional careers but there are critical time periods, in particular those which involve role transitions which require special input. The stages that were referred to as requiring special training and support are during the first six months at least for newly qualified nurses, all new staff to the Department, all staff who had been promoted to a new grade, especially one with greater responsibilities, such as G grades.

3.7.1   Growing into roles: Newly qualified nurses

One major concern raised during the interviews related to workload and retention, was the level of practical skill and confidence present in newly qualified nurses. Although there were exceptions, most new nurses were considered to require extensive supervision, direction and development. The situation was seen as a cause of higher workload for existing staff, so that although it was easier to fill rotas when new staff arrived on a ward, many newly registered nurses initially added to existing work. There was much sympathy for those new nurses who found their new responsibilities brought uncertainty and discomfort.

"You just feel that they have so much to take in that education hasn't prepared them for. They just need time - our time and theirs, to help them grow into their new roles - it's not an over night thing".

The present nurse education system delivers courses at higher academic level than the previous apprentice-based training programme (McCleod Clark, 1996), but students spend less time working in practice environments (Hillier and Stuttle, 1998; Luker *et al*, 1996; UKCC, 1999). It is considered that, on the whole, present day student nurses qualify with less experience and therefore less expertise in clinical situations (Bick, 2000). The first six months post registration are particularly stressful for new staff nurses (Andres and Wallis, 1999), a time described as a period of stress, uncertainty and fear (Melia, 1987).

Bjork (1999), highlights the issue of practice skills development in newly qualified nurses and found in his study, that many felt unprepared in terms of drug administration, insertion and care of naso-gastric tubes, female catherterisation, assisting at cardiac arrest and care of dying people and their relatives. These aspects of care are integral to all areas in DEM and it is obviously important that new nurses feel confident and competent in providing such care to patients. The literature is clear that newly qualified nurses have special needs for a planned programme of development and supervision.

3.7.2 Continuing professional education: professional training for professional development

There was a strong consensus that there were numerous training opportunities provided by the Trust, available through educational institutions and via the Department's own training programme. Many courses were available but frequently these were focused on a single clinical issue, and were classroom and skills based. In addition, while the Department developed and ran their own programme, the same sessions were provided for the whole range of staff, in terms of grade and experience, and were therefore considered inappropriate by some.

While there were many opportunities for people to learn about aspects of disease and nursing care, there was no training that would provide an annual short update in a range of topics. For example, nursing practice evidence is changing rapidly yet access to such evidence is time consuming and courses on the process of evidence based practice - searching methods and critical appraisal skills, are not generally available.

"Clinical governance means that we all must be more professionally accountable, this means we need professional training to help us achieve this".

Training, if it requires time away from the ward, presents difficulties for the staff leaving the ward, and for those left behind (Nolan, Owens and Nolan,1995). Many of the sessions arranged by the Department were cancelled due to low numbers attending. There is obviously a need for a review of the training programme, particularly in the light of clinical governance requirements.

Barriball, While and Norman (1992), assert that there is a lack of evidence relating to the continuing education needs of nurses in clinical practice. They also suggest that there is a lack of data regarding the impact of continuing education on clinical practice. For example, there is evidence that the way cardio-pulmonary resuscitation is taught is different to what is required in practice (Meerabeau and Page, 1999). It is considered that the theory, taught in a classroom environment, relates to a standard drill but that the patient's condition and timing of events are unpredictable. The "team" is hurriedly put together as the emergency occurs and these may not have met or worked together before (Davies and Gould, 2000)). These and other authors suggest that CPR training should occur as close to wards as possible, it should use ward instruments and as far as possible, be based around teams that work together in real life situations.

Increasing clinical demands suggest that work based learning, recently advocated in several policy documents, might be more effective than classroom based courses. Learner led, work based education is a means of ensuring that conceptual frameworks can be related with greater clarity to real life situations. The bringing together of practice and theory in this way, offers the greatest opportunity for patients to benefit and for nurses to extend and reinforce existing knowledge.

3.7.3 The scaffolding of good clinical practice: Clinical supervision

> While Clinical Supervision was considered a desirable aim for all staff in the Department, it was accepted that this had been developed in a variable manner.
>
> *"Clinical supervision is really important to good practice - it supports it - a bit like scaffolding when buildings are going up - or for new ones. Building nursing without it is just plain dangerous but it needs a proper structure and implementation plan - it's patchy here".*

Clinical supervision is considered to be beneficial to most aspects of nursing practice (Bassett, 1999). For example, there are reports of the efficacy of clinical supervision in terms of increased nurse satisfaction (Begat *et al*, 1997; Bishop, 1998; Bond and Holland, 1998; Brocklehurst, 1997; Butterworth, 1997; Hallberg and Norberg, 1993; Johns, 1993,1994). A similar finding is reported in relationship to preceptors and preceptees (Myrick and Barrett, 1998). However, there is evidence that staff involved in these support roles may not have sufficient training (Craddock, 1993) or support themselves to undertake these roles adequately (Barrett and Myrick, 1998; Foy and Waltho, 1989; Parry, 1999). Concern has also been expressed about the lack of support, particularly to newly qualified nurses and its relationship to attrition (Hanneman, 1996).

Mentorship, Preceptorship and Clinical Supervision are closely related in their aims to provide a means for nurses (and others) to develop their professional practice for the benefit of patients. These titles are used to describe the expert clinical support advocated for nurses at different stages in their professional careers. Mentorship is usually related to pre-registration students on their practice placements. Preceptorship tends to relate to the support provided to newly qualified nurses, usually in their first year, and Clinical Supervision to the on-going professional development of nurses throughout theircareers. These titles are used interchangeably in published papers and in clinical practice. They frequently have unclear aims and are not afforded the organisational priority they deserve. The important factor relating to the supervision of nurses in a supportive, developmental way, is that there are a number of benefits accruing from approaches which encourage nurses to reflect on their practice.

In the DEM, supervision has not yet been implemented in a systematic manner. Much of the responsibility for its implementation is shouldered by the Clinical Practice Facilitators who have many other objectives and priorities. To obtain full benefits, supervision of all grades of nurses should not be regarded as a separate entity or an additional task, but part of quality enhancement and clinical governance processes.

3.8 Theme Three The "glue" of staff satisfaction and effective care: Clinical leadership

> The issue of low morale was another strong theme perceived to be associated with several issues, including high workloads, lack of management time to give support and supervision, and lack of time for ward sisters to provide this in the ward environment. Constant work with diminishing interpersonal rewards were a feature of the interviews with a strong undercurrent that there seemed to be no end in sight. The term "burnout" was used commonly and there was a view that for many going to work was not always looked forward to. These words or similar were used by many nurses:
>
> *"Everyone, nurses, domestics, doctors, patients and families need to know who is in charge - in front, at the head of the team leading the ward or Department. This is difficult if you are stuck in an office".*

There are a number of recent policy documents that emphasise the importance of leadership to the modernisation of the NHS (DOH, 1998; DOH, 1999). In terms of nursing, there is an important leadership component in all qualified nurse roles, but the responsibility that goes with this increases with the seniority of the nurse. Effective leadership in clinical practice is considered as essential to the job satisfaction of the whole team and to effective nursing care.

3.8.1 Job Satisfaction

> Job satisfaction was considered to be low among all staff. This related to the continued pressures of too much to do, some of which was considered to detract from the work that people considered they had come into nursing to do.
>
> *"It's not the patients, I love this part of my work, but it is the constant high pressure - we feel tired, but it's the patients and your staff that keep you going".*

Kennedy and Grey (1997), suggest that it is not high workload in terms of the numbers of patients cared for that causes stress in nursing. Instead they suggest that it is caused by a combination of high workload with a lack of staff, inappropriate skill mix, abusive patients and poor communication with other professionals.

The sense of satisfaction of nursing staff is known to be related to feelings of personal control and autonomy (Buchan, 1999). There is support from the work on *"Magnet"* hospitals in America which have higher nurse satisfaction than comparative controls (McClure *et al*, 1983; Mitchell and Shortell, 1997; Aitken *et al*, 1994; Tovey and Adams, 1999). Tongs, Rothstein and Canter (1991), suggest that aspects of a nurses work that are important to job satisfaction include; continuity in nurse-patient relationships, autonomy to initiate independent nursing actions, individual accountability for clinical outcomes and regular performance feedback from managers. Restrictions in clinical decision making autonomy are considered to result in overly controlled and restricted nursing practice (Prescott, Dennis and Jacox, 1987).

Autonomy is described as the perceived independence or control over ones work activities (Abbott *et al*, 1994; Mcloskey, 1990).

One in four NHS staff say they experience significant levels of psychological stress compared with the wider national workforce. Levels of stress are reported to vary across Trusts. Those with interdisciplinary co-operation and good communication have the lowest levels, as well as those that place a strong emphasis on giving staff more control over their working lives (Williams, 1998).

Cavanagh and Coffin (1992), in their study of 221 female nurses, demonstrated that five variables had statistically significant effects on job satisfaction. These were participation, routine, promotion, kinship and opportunities. The largest coefficient involved participation, suggesting that the more people were involved with decision making processes, the more likely they are to feel satisfied in their job, a finding in keeping with other studies.

There are reported to be 360,000 working days lost annually in the NHS because of stress related illness among the nursing workforce (DoH, 1999). Increased absenteeism is considered to be related to "burnout" (Caton *et al*, 1988; Newman, 1974). Burnout is defined as a syndrome of emotional exhaustion, depersonalisation and a sense of reduced personal accomplishment that occurs among individuals who do people work of some kind (Cheng *et al*, 2000).

Burnout occurs when a person reaches a state of physical, emotional and mental exhaustion due to stress, most often the day to day type (Constable and Russell, 1986; Pines and Aronson, 1988). Research findings have linked several work environmental factors to nurses and burnout. High burnout levels have been associated with, lack of autonomy (Barrell, 1996; Sullivan, 1989), a lack of clarity about work objectives and responsibilities (Savickli and Cooley, 1987), inadequate support (Penn *et al*, 1988), and high workloads with few emotional rewards (McNeese-Smith, 1999; Gassman, 1994; Melchior *et al*, 1996). Although there are some differences in the research which demonstrates stress and burnout related variables, a strong theme runs through this work. This relates primarily to the affective domain rather than the actual physical work undertaken.

Frith and Britten (1989), investigated to what extent burnout variables were significant predictors of sickness and job turnover. A cohort of qualified nursing staff working in long stay settings was followed over a two-year period. Emotional exhaustion was found to predict the frequency of absences of more than 7 days, while feelings of depersonalisation were found to correlate with job turnover. Kirk *et al* (1993), in a study of nurses over 18 months, found that over time they experienced increasing amounts of job stress and emotional exhaustion. This had indications for the continued support of nurses and reviews of their responsibilities and pressures.

3.8.2 "Jills" of all trades: Ward Sisters

A strong interview theme concerned the role of the ward sister. There had been many changes in recent years that gradually centralised the responsibilities and sphere of control of the ward sisters. Examples included, ward budgets and staff interviews. The intention behind this was to remove as much administrative work as possible to permit more time for clinically based practice. Although the intention was good, many ward sisters felt a loss of autonomy and control, and this in turn had a negative effect on morale.

The shortage of registered nurses also had an effect on the ward sisters capacity for clinical leadership. It was common for them to be included on ward rotas, along with other grades of nurses. This meant that the leadership functions of evaluation, teaching, planning and clinical supervision were impossible for them to undertake in a systematic manner. Clearly this made an important impact on morale, in the words of one ward sister;

"No matter how hard you try, you never get everything you should done. You never feel in control. You start something and get interrupted, you begin again and so on - that's part of the problem there are no limits - no boundaries - you feel just like a Jill-of-all-trades".

The quality of nursing care is considered to be more closely related to the ward sister post than any other single variable. Kitson (1986), recommends that the role of the ward sister is crucial to the creation of a supportive culture of care especially concerning the unique needs of older people. Successful nursing teams are known to have good clinical leaders who acts as change agent facilitating nursing development (Shaw and Bosanquet, 1993).

Koivula, Paunonen and Laippala (1998), found that exhaustion was the most important factor preventing quality improvement in nursing. The more exhausted the nurses were, the more impeded the nurses professional development, work commitment and motivation.

Clinical Governance points to the importance of clinical leadership in nursing, as the key to effective nursing practice and management. Antrobus and Kitson (1999), suggest that clinical leadership is at the heart of the future of nursing. There is sufficient known about the characteristics of effective clinical leaders from a range of different development projects in this area. The Trust's Clinical Nursing Development Programme was one of the first in the country to focus on facilitating nurses to develop key leadership skills. The clinical leadership issue is now of paramount importance to both the Government Strategy for Nursing and to Clinical Governance. During the next year, the Department of Health will expect that all ward sisters have appropriate training in all the aspects of clinical leadership, including budget management and clinical supervision (Milburn, 2000).

The past two decades have seen many changes in the ward sister role. The Audit Commission (1991) found that there was insufficient devolution of management responsibility to charge nurses and recommended that budget management, staff recruitment, skill mix and shift control should be devolved to ward level. The King's Fund (1990), advised that the ward sister role should be redirected away from controlling management style and towards a more enabling facilitating approach. In the Department, staff selection processes and budgetary control were central management functions.

There were two part time Clinical Practice Development Facilitators in the Department, working to support the development of evidence based practice and clinical supervision. Their workloads were extremely high for the numbers of staff, but their input to wards was much appreciated. A number of different initiatives were instigated by the CPDF's, and their expertise was sought by other parts of the Trust. Also in the Department were Link/Resource nurses who focused on one area of clinical practice, such as nutrition, continence or tissue viability. These roles were due for review in 1999.

The Lecturer-practitioner role is one which is considered to bridge an acknowledged theory-practice gap in nursing (Davis, 1989; Dearman, 1993; Hollingworth, 1997; Lathleen, 1995; McNally, 1994; Mason and Jinks, 1994; Vaughan, 1990). The roles were first developed to assist newly qualified nurses needs for practical and interpersonal skills development (Mason and Jinks, 1994; French, 1992). There is some evidence that well structured lecturer practitioner posts can provide expert practitioners, who can also focus clearly on teaching and facilitating student learning in the clinical environment (Elcock, 1998; Fairbrother and Ford, 1998).

There has been some success associated with specialist nurse roles (Fenton, 1992). Naylor and McSharry (1995), demonstrated that patients who have access to specialist nurses are more knowledgeable, more proficient in self care and more satisfied with the care they receive when compared with normal service provision. The Value for Money Unit (1994), found in their study of medical wards that up to 15% of all medical staff work could be undertaken by others in particular by qualified nurses, who in turn spent at least 15% of their time on transferable activities.

Expert nurses can effectively reduce the intensity of junior doctors' workload in many areas of care. Over 75 nights, one night duty Sister in charge of eight general and vascular surgical wards in Edinburgh Royal Infirmary, succeeded in reducing the workload of three on-call pre-registration house officers by 46%. This was achieved by instigating a protocol whereby all calls from ward nurses went in the first instance, to the night sister (personal correspondence). Other work demonstrates clearly that nurses can safely and cost effectively replace doctors in some of the work that they do (Read *et al,* 1999).

3.8.3 Fire fighting: Clinical Nurse Managers

> There was a considerable amount of sympathy for the managers of DEM, who had high administrative and managerial responsibilities. In 1997 there were two Clinical Nurse Managers in DEM but his was reduced to one in 1998. It was acknowledged that the span of control was too wide for one clinical manager to meet the individual support and clinical supervision required by ward sisters, particularly in times of high workloads. In addition, because of nurse shortages a considerable proportion of time was spent by all managers in the Department, trying to fill shifts in increasingly difficult circumstances. The following were words used by nurses and their managers.
>
> *"The agenda is so big and getting bigger all the time - and the number of agendas are growing as well. You (they) spend so much time fire fighting that there is not much time left to provide clinical support on the wards".*

Historically, nurses wishing to advance their careers had to select either management or education (Beaman, 1986). Clinical grading resulted in a much flatter career structure with fewer proportional opportunities for senior nursing roles (Ororigoroechea, 1996). Analysis of the role is difficult because they are heavily influenced by the health care systems of which they are part, meaning that comparison is impossible (Carroll and Adams, 1994). As a consequence, there are wide ranging opinions and anecdotal evidence about what the roles should focus on, leading to different expectations, especially regarding clinical involvement.

The importance of having managers who can integrate their knowledge of clinical nursing with effective decision making, in order to support effective care is reported (Chandler, 1991; Fulton and Wilden, 1998). The development of staff as a main resource in the provision of high quality care, suggests that the ability to develop knowledge and skills in others is a key component of the nurse manager role (Chase, 1994). Given that clinical nurse managers spend most of their time working with people (Duffield, 1993; Everson-Bates and Fosbinder, 1994), it is not surprising that interpersonal skills are regarded also as integral to the role. As a consequence, there are wide ranging opinions and anecdotal evidence about what the role should focus on, leading to different expectations regarding clinical involvement.

3.8.4 Backbone of the service: Health Care Support Workers

> As highly valued members of the healthcare team - many referred to healthcare support workers as *"the backbone of the service".*

One solution to the shortage of nurses has been the increased recruitment of health care support workers (Ball, Hurst and Frankilin, 1989). Prescott (1993), suggested that cost reduction measures should not simply target numbers and grade of nursing staff without a clear understanding of what the various grades of nurses do, and their impact on patient outcomes. However, in the United Kingdom, many changes were made in the ratio of registered nurses to support staff, in most Trusts during the 1980's

and 1990's. Such changes termed "skill mix", were not directly related to the skill or the experience of the nurse but were primarily associated with their grades. These changes were instigated with insufficient attention to evaluation, so the impact in clinical terms is unknown (Buchan, Seccombe and Ball, 1996).

It is considered that the potential pool of health care support workers is much larger than that of registered nurses. However, as a group they are also considered to have a greater tendency to more frequently change jobs (Vance and Davidizar, 1997). According to some, the costs of replacing support workers are likely to be much higher than expected because of the need for lengthy supervision. This is thought to lead to lower all round productivity in the work environment (Grant *et al*, 1988).

Support workers have much to offer in terms of their permanence on the wards, their practical experiences and their knowledge of local communities, but many are reported to perceive little difference between their own roles and those of qualified nurses (Workman, 1996). In times of registered nurse shortage, health care support workers may for a number of reasons, extend their roles. This may in some cases, lead to an inappropriate allocation of work, with implications for patient care (Ahmed and Kitson, 1993).

There are indications that vocationally prepared support workers can provide high quality care (Warr, Gobbi and Johnson, 1998). In America, all health care support staff are required to possess certificates to practice (Chang, 1995). Obtaining a clear picture of the impact on patient care, resulting from the use of support staff has proven difficult. There are methodological problems with existing investigations which lack a common framework for analysis. In addition, the data collection time frame tends to be less than a year, resulting in short term findings susceptible to the vagaries of organisational change.

3.9   Summary

In this section, the findings from 27 interviews and 17 questionnaires are presented, together with information from Trust reports. It is supported by research evidence and other publications from mainly nursing literature sources.

The interview and questionnaires generated main themes, which fitted well with three clinical governance groups, clinical risk management, education and leadership. The results highlighted what was probably long standing high workloads which were characterised by additional peaks of higher activity. This in turn was coupled with patients whose illnesses tended to be more severe at times of increased nurse shortages. The overall impact of this on all staff was a sense of feeling overwhelmed, with little means of controlling their working lives. There were indications that high activity carried implications for clinical nursing practice. So that not only did high activity create situations of greater clinical risk, clinical risk situations such as hospital acquired infections, in turn, created a higher workload. Other aspects of direct patient care were similarly implicated and supported by research evidence, such as administration of medications, discharge planning and care of people with dementia.

Although there is a case for more nurses, especially during peak activity and staff absences periods, this will not alone, address the issues raised in this review. The review shows that many factors have contributed to the overall situation and therefore in solving one part of the problem with for example, more nurses, an important symptom but not the major disease is tackled. To solve the underlying problem requires a greater understanding of what, when and how nursing care should be provided. In order for this to occur, staff involvement in a systematic planning process is required.

Education, professional development and leadership generated less information, than that related to workload and clinical practice. It is likely that this was the case because education in particular was not the greatest priority when compared to the provision of patient care, yet care is impoverished by its lack. Leadership and the opportunity to lead, were the third key clinical governance dimension. However, both education and leadership are essential to the management of clinical risk, including workload and clinical factors.

Just as workload factors carry implications for effective patient care, these issues alone will also not resolve the difficulties facing the Department. Given the commitment and motivation of staff, the issues raised in the review are likely to be responsive to change. Providing it takes place within an overall development programme, which is owned by all those involved in it. A template for further development in the Department is provided in the following section.

Section Four: Progress in 10% steps: Recommendations for Clinical Nursing Governance

4.1   Introduction

In this final section of the report, the main findings of the interviews and questionnaires form the basis for recommendations to the issues raised. The three key Clinical Governance issues, clinical risk management, education and continuing professional development, and leadership, provide the cornerstone for these recommendations. The recommendations should help the Department address many of the issues raised by staff during their interviews. These suggestions alone, cannot produce the sustained change required in the Department, neither are they written in tablets of stone, but are intended to help start processes of change. To maximise the potential for permanent change, effective clinical leadership is necessary, together with professional education and development of DEM's nurses.

The recommendations are divided into two main parts. The first (4.2 and 4.3), relate specifically to workload issues and proposes ways of managing high activity periods. It also suggests avenues for the Department to explore, which have been shown in other areas to improve the variables implicated in the recruitment and retention of staff. The second part (4.4), recommends a gerontological development programme, which will provide education and professional development and clinical leadership opportunities for nurses. These recommendations build on the developments already taking place in the Department and on its new clinical management structure.

It was clear from the findings of the review that there were nurse shortages, due in part to poor retention and high sickness levels. However, a shortage of nurses was not the sole issue, but it was one of a number of issues, that together led to the difficulties facing the Department. The consequence of this, is that steps taken to resolve a single issue, will still leave a number of others, to compromise clinical care in the future. For this reason, this report will not just recommend more nurses. As this is just part of the problem, it can only be one part of an overall solution. What is required is a number of well planned, systematic interventions which involve staff at all levels. Since many of the difficulties have been long standing, there are no short cuts or quick fixes.

It is important to recall that all of the issues and solutions included in the review have been raised repeatedly by staff. They will now have much of the responsibility for helping to manage the future developments in the Department. Since the change agenda is fairly extensive, it is suggested that many of these are amenable to 10% changes. To staff that have already experienced many changes, another may seem daunting, but just 10% will feel within the reach of most, and should result in a greater sense of success and control.

4.2 Clinical Risk Management

4.2.1 High activity

There is evidence from several sources to support the view that the Department has been working under pressure for a number of years, and that activity in the Department has been high, as demonstrated by:

- High bed occupancy, 98% in December 1999. The Government's Emergency Action Team suggest that occupancy over 85% is associated with emergency readmissions.
- Length of stay for the acute wards is short, 9.3 days in December 1999, compared to a national average of 12 days (DoH,1999).
- Admissions are highest between mid November to mid February, with a peak in early January.
- Patient severity indicators for long term care have increased.

4.2.2 Nurse shortages

There are sufficient indications to conclude that there were nursing shortages in the Department:

- Sickness levels in the Department have been increasing and in 1999, were higher than the rest of the Trust.
- Staff sickness is highest in January (a peak patient activity period).
- The costs of agency nurse use doubled between 1998-1999.
- In 1999, DEM had the highest D grade registered nurse vacancy levels, 17.06 out of 23.06 total Trust vacancies.

4.3 Recommendations

The recommendations aim to help the Department manage activity, staff shortages and clinical practices which together lead to higher workloads. Senge (1990), suggests that full understanding of a system can only be reached by contemplating the whole, but that people tend to focus on snap-shots or isolated parts of it, and in doing so rarely solve the deepest and often the most important problems. There is a need to find time to examine more closely the relationships between a number of events and processes, which have contributed to the difficulties in the Department. It is also important to take a more global perspective of the overall local health system of which the Department forms just one part.

4.3.1 Prevention of admissions

The most obvious way of controlling workload, is to prevent admissions to the Department. Coast *et al* (1997), suggest that 15% of people admitted to hospital could be cared for in another location. According to the Portsmouth and South East Hampshire Health Improvement Programme, there were 10,720 emergency

admissions to people aged over 75 years in 1998. If 10% of avoidable admissions were prevented, this would represent a nominal saving of 1072 beds. Although a number of developments in intermediate care and rehabilitation are currently in the early stages, there are nursing specific interventions that have been shown to be helpful in reducing hospital admissions and reducing lengths of stay.

4.3.1.1 Nurse Consultants and Specialist Nursing roles

There is considerable potential for preventing admissions as a result of the development of new nursing roles (Milburn, 2000). It has been demonstrated that Consultant Nurses and nurses in advanced specialist roles, can help to prevent avoidable hospital admissions and emergency readmissions. Nursing roles associated with chronic conditions, such as respiratory disease and long standing heart disease have been shown to be beneficial (Manley, 2000; Read, 1999). In addition, consultant nurses and nurses working together across service boundaries can help to smooth the transitions, for example from, home to hospital, and in doing so prevent readmissions. The creation of these roles in Portsmouth should be considered, for potential applications to the Regional Health Authority in September.

4.3.1.2 Nursing beds

Nursing beds are a form of intermediate care, as a half way house between home and acute services. Many examples of hospital at home schemes are already common place in other health districts. Some similar examples exist in Portsmouth, for example the CAP's scheme, but these would need to be extended to cover larger populations and wider geographical locations. There have been many evaluations of nursing beds which have shown considerable benefits for patients. There is less certainty regarding cost savings because nursing beds tend to be part of a much larger hospital settings, and cost effectiveness remains largely uninvestigated.

4.3.1.3 Nurses as Care Managers

The system of nursing care management, used successfully for some time in community nursing should be investigated, and if possible implemented, particularly in the longer stay wards. Although this would involve some changes, given the Government's aim to bring social and health care closer together, this would be a useful local initiative, subject to sufficient prospective evaluation.

4.3.2 Improving the flow of patient information

Nursing is currently provided by different services in Portsmouth. This means that an older person can be in the care of the District or Practice nurse for a number of years, before they are admitted to hospital. Although patient held records are used by HealthCare Trust staff, they do not always accompany a person to hospital, so that a valuable information source is lost. This has implications for timely treatment and lengths of stay. New records are created on admission to every service and every profession in Portsmouth, which can lead to fragmented care. When care is broken up into distinct segments, characterised for example, by different record systems, there is potential for communication breakdowns and delays in the provision of timely and

appropriate patient care. In the absence of patient held and whole system multidisciplinary records, it is logical that nurses in all Trusts and primary care should use the same record system, to assist continuity of care, reduce duplication and improve information flows.

4.3.3 Learning from patients

There is currently little cross-speciality working, with a result that each nursing speciality focuses on their own area, with sometimes little understanding of the care provided in other areas. All qualified nurses should follow patients through the health care system, at least once a year. The purpose of this is to enable nurses to gain experience and in particular the patient's perspective of their journey though the healthcare system. In terms of DEM, nurses following a patient home or to another institution, with their agreement, would provide a unique opportunity to find out directly from patients, what worked well in their care and what could be improved. It would also create a greater understanding of "life after hospital care" currently lacking from many nurses experiences.

4.3.4 Care protocols

Care protocols should be developed in a limited range of topics, in order to improve patient care. Heidenreich, Ruggerio and Massie (1999), describe the use of a care protocol for people with pneumonia. This resulted in antibiotics being given within two hours of admission compared to twelve prior to the use of the protocol. Reported benefits include, shorter hospital stays, reduced mortality and improved nurse and patient satisfaction levels. To be fully effective, protocols should be developed between Trusts and primary care in high volume and/ or severity conditions, where a patient is likely to require the care of more than one service during their illness journey.

4.3.5 Additional clinical specialists

In addition to the use of protocols in selected topics, consideration should be given to the use of other staff groups which can improve patients healthcare in effective ways, especially during peak activity periods. Additional chest physiotherapists during the peak winter activity periods which feature high numbers of people with respiratory disease, would logically increase the likelihood of more rapid patient recovery.

4.3.6 Care pathways

Care pathways, also known as critical and clinical pathways, have been subject to some criticism on the basis that they do not easily fit the needs of older people who may have multiple health problems. However, there are many publications which report benefits from using them which include, shorter hospital stays (Cockram, Gibb and Kalva, 1997). Marrie (2000), in a controlled trial of a care pathway for the treatment of community acquired pneumonia, described the use of a pathway with 1,743 patients. Pathway use was associated with a 1.7% reduction in bed use per patient (4.4 vs 6.1 days).

4.3.7 Care pathways as a patient information source

Lindstrom, Laird and Soscia (1995), developed what they refer to as a patient friendly pathway. This was used to provide information to patients and their relatives to help them manage their hospital stay (an example is shown in appendices 5 and 6). It was also considered to be useful in helping patients and their families to develop more realistic expectations of hospital care. Although this approach is most commonly used on admission to hospital, if used by primary care staff prior to admission, it may be a useful preparatory tool.

4.4 Nursing shortages

The evidence indicates that activity and nurse shortages tend to peak over the same period. This is the classical winter pressure picture. It is superimposed in the Department on probably years of chronically high workloads, which accounts for the sense of exhaustion apparent in most professional groups. Interventions are suggested at a number of levels. These are aimed at reducing the use of agency and other temporary nurses, improved management of ward bed facilities, improved staff satisfaction and the development of clinical nursing practice.

4.4.1 A "root cause" analysis

The Department should conduct a "root cause analysis" of activity and staff resources and plan for peak activity around the findings. This should apply to seasonal variations and daily variations in activity. This approach was taken by Luther and Walsh (1999), in a hospital that had been experiencing high agency nurse costs and poor patient satisfaction indicators. They conducted a retrospective analysis, going back several years, of patient activity and nurse shortages. This revealed that when patient activity was highest, this was invariably matched by staff absences, and that other seasonal crisis were precipitated by predictable events such as school holidays. The approach enabled them to plan events such as training for low activity periods.

4.4.2 Nursing input to bed management

In the Department, people felt that, while bed management occurred, the implications for nursing of consistently high numbers of severely ill people were not always adequately considered. The provision of such care has implications for nurses, for clinical nursing practice and ultimately retention. Luther and Walsh (1999), also developed a basic workload tool which is used to capture the intensity of patient care requirements on wards. The red, amber and green Zone system is used to monitor the capacity of ward staff to cope with varying amounts of workload. A designated red Zone indicates high workload pressure and subsequently increased levels of clinical risk. Amber is a manageable workload and green is comfortable.

The Zone process involves a senior nurse discussing patient variables with a senior ward nurse at a fixed time each day. If patient intensity is such that the ward is in a red Zone, this is related to the bed manager and ward consultant, and no further admissions are admitted to that ward, and if necessary additional staff provided. The

purpose of this is to add a clinical nursing dimension to bed management and the authors report a reduction in agency nurse costs, and improved patient and staff satisfaction. In terms of DEM, the Zone or a similar system, carried out each day would provide a more systematic and more objective evaluation of ward workload.

4.4.3 Increasing nurse numbers

Once the peak activity periods are known, consideration should be given to increasing nurse availability for these times. If Buchan and Edwards (1999), are correct that 15% of qualified nurses would return to work if the hours were amenable to child care responsibilities, this may mean that there remains a pool of nurses living in the Portsmouth area that might consider returning. Special recruitment programmes, aimed specifically at this group have been successful in other Trusts and should be considered. Flexibility nurse programmes are now used quite widely, in addition to annualised hours, and these and other flexible shift systems should be considered. Details of these are available through the NHS recruitment programme and in the nursing literature.

4.4.4 Two plus one nurses

Although there is currently no method which will validity and reliably help the department determine the correct number and grade of nurses required to safely staff the wards, there are some elements from which to start. Trusts in the areas surrounding Portsmouth all tend to advocate two qualified nurses to a ward. Although this is a reasonable starting point, this only allows for one or two very ill patients and for regular qualified nurse duties to be undertaken. General co-ordination, fielding of unexpected events, student and junior nurse supervision, consultant rounds and the management of admissions, discharges and deterioration in patients conditions are simply added on to the work expected of the two registered nurses.

4.4.5 Adequate skill mix

While on occasions, during the evening and at night, two registered nurses together with appropriate support may be acceptable, the lack of overall day to day ward management, produces some of the sense of uncontrollability felt by nursing staff in the review. This is particularly true, if the registered nurses are newly qualified D grade nurses. Consideration should be given to the correct mix of experience when planning registered nurse cover on a ward, so that at least one senior qualified grade is present at all times. In addition, it is important that there is adequate cover during peak activity periods, with two plus one registered nurses available. This mean that one nurse is always available to undertake the roles which ensure the overall smooth running and continuity of patient care. Innovative methods of flexible working for experienced staff are likely to be particularly helpful, especially in terms of shorter shifts to cover high activity periods.

4.4.6 Nurse to patient ratios

The Belgian Government fixed hospital nurse staffing levels in 1987, based on an analysis of 24 hour care. This suggested that one nurse should be available close to the bedside of patients 24 hours a day. For an average ward of 24 patients, there must be 6 registered nurses, three nursing support workers (similar to enrolled nurses) and three unqualified support workers. The government require a 50% registered nurse allocation with a 75 percent qualified nurse allocation on all shifts (personal correspondence).

4.4.7 Non nursing duties

Non nursing activities, should be reviewed, including out of hours and at weekends. A 10 percent reduction in avoidable administrative work for an average registered nurse equates to a saving of 3.75 hours per week. If 20 wards saved 10% of non clinical time a week, over one year this would save 780 hours, or 0.5% a full time equivalent nurse for the Department. A 20% reduction in avoidable administrative or other non clinical work, would result in a saving of 1950 hours each year or 10 full time nurses.

4.4.8 Reduction of agency nurse use

A reduction in the use of agency nurses is a priority in terms of the quality of patient care, continuity and cost. Initiatives aimed at reducing agency nurse use should include improved planning for known high shortage periods. A year on year decrease in the use of agency nurses is recommended. Although the precise amount should be agreed with ward sisters, it is suggested that an initial target of 10% would be achievable. If this was achieved, it would result in around £28,152 savings in the first year for the Department, a sum which should be reinvested back into clinical care.

4.5 Developing Clinical Nursing Practice

The development of clinical nursing practice is integral to a programme of systematic improvements in the issues raised by staff, as causing them some concern. To take place in a meaningful and sustained manner requires education and continuing professional development for all grades, within a clear clinical leadership structure. The following recommendations are made in the light of research in the sphere of practice development. It is presented in four phases which can occur simultaneously:

4.5.1 Phase one

The development of Clinical Governance working groups consisting of volunteers from all grades with an interest in the specific topic:

- Clinical supervision
- Clinical practice development
- Education and continuing professional training
- Recruitment and retention
- Activity and workload

These should be small groups with a limited membership period and with objectives for each period. The purpose of these groups is to examine the issues raised by this review and other sources and act as an expert panel providing advice to the management team on issues affecting and affected by, clinical nursing practice.

4.5.2 Cross Trust and speciality nursing networks

There is much expertise in the Department that could be used to the benefit of other Trusts and to primary care. However there is no clinical gerontological network for nurses to share good practice and innovations in care. A district gerontological nursing network should be considered for development in the future.

4.5.3 Phase two

A gerontological clinical nursing development programme, for senior (initially F and G grade) nurses in the Department. It is recommended that a nine month (approximately) programme is commissioned from the RCN Institute to facilitate the further development of clinical nursing practice in the Department.

4.5.4 Phase three

The accreditation of wards that are working to the best standards of patient care. This is a new concept but one that is gaining favour. It would be undertaken with the RCN Institute and in line with benchmarking initiatives (Cooper *et al*, 2000).

4.5.5 Phase four

A Gerontological Specialist Nurse Programme (MSc) developed in the School of Post Graduate Medicine with other academic and clinical partners. This programme would be available to nurses in the Department but is also designed to attract nurses from other parts of the country. Qualified, experienced nurses would spend time in the accredited wards in training posts. Supervision would be provided within the Department by H and I grades.

The purpose of these initiatives is to provide a Specialist Gerontological Programme for experienced nurses which will enhance their confidence and competence, improve patient care and improve recruitment, retention and staff job satisfaction. It is not

intended to create an elitist programme by excluding all but senior nurses. On the contrary, this is just the start of the process. In addition, the training and development needs of other grades of staff should be identified through the Phase one working groups, especially in relation to role transitions.

Some staff may feel daunted by the prospect of more change. They may still be experiencing low energy levels and feel that they do not have the extra capacity for further developmental work. While this is understandable, much of the sense of feeling overwhelmed seemed to be related to a lack of autonomy and control. The recommended initiative is a way that nurses can assemble greater autonomy and control of their working lives and improve the care they provide for patients.

4.6   Summary

This section sets out a number of steps that can be taken in the Department, which if implemented in a planned and systematic way, could minimise the risks associated with high nursing workloads and poor retention. The importance of staff invlovement is emphasised together with taking a wider view of some of the issues raised during the course of the review. Although nurse shortages created difficulties in the Department, in shifting the focus away from an emphasis on only providing more nurses, the true complex relationship between many factors has been highlighted. Some of these factors are caused by higher workloads, and in the case of some clinical practice issues, themselves cause higher workloads. Some further work is required involving staff at all levels and must be supported fully by the organisation and its management.

In this summary, ways of improving some aspects of patient care are highlighted. It is accepted that there may be others which are of greater priority for future development. For this reason the working groups are proposed which will help the Department build on what is currently good and working well, whilst creating new ways of providing expert nursing care within a Clinical Governance framework.

The Assessment of Work Environment Schedule

Below are a number of statements about the environment in which you work. Please indicate how much you agree with each statement by placing a circle around the number that best reflects your opinion:-

Thinking about the place in which I work I feel that:-

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The workload is shared fairly	5	4	3	2	1
Criticism is given in a just way	5	4	3	2	1
The environment of care for patients is good	5	4	3	2	1
Study leave is allocated in a fair manner	5	4	3	2	1
I have the opportunity to give total patient care	5	4	3	2	1
I am encouraged to develop my full potential as a nurse	5	4	3	2	1
There is a good spirit of co-operation with my co-workers	5	4	3	2	1
I am an active participant when important decisions about patients are made	5	4	3	2	1
The amount of work I am given to do is realistic	5	4	3	2	1
The overall quality of nursing care provided is high	5	4	3	2	1
I am part of a team	5	4	3	2	1
I am able to get easy access to my manager	5	4	3	2	1
My overall working conditions are good	5	4	3	2	1
There are sufficient opportunities for me to participate in continuing education	5	4	3	2	1
I am allowed to use my full range of skills	5	4	3	2	1

Thinking about the place in which I work I feel that:

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I am given respect by my superiors	5	4	3	2	1
My work is interesting	5	4	3	2	1
My personal development is given high priority by my manager	5	4	3	2	1
I am regularly given the opportunity to assume a leadership role	5	4	3	2	1
I am congratulated when I do things well	5	4	3	2	1
I have the opportunity to assume a leadership role	5	4	3	2	1
I am actively encouraged to develop my skills	5	4	3	2	1
I would be supported if I applied to study leave	5	4	3	2	1
I am consulted when changes in working conditions are planned	5	4	3	2	1
There is sufficient time to provide the type of care I would like to	5	4	3	2	1
My opinions are listened to by my superiors	5	4	3	2	1
I can try new ideas without fear of criticism	5	4	3	2	1
Staff are given the opportunity to develop new ways of doing things	5	4	3	2	1
It is possible to influence the decisions of senior nurse managers	5	4	3	2	1
There are adequate resources for the workload	5	4	3	2	1
There are adequate resources to provide good care	5	4	3	2	1
I have the opportunity to make decision on my own	5	4	3	2	1

Perception of Workplace Change Schedule

Below are a number of statements about your workplace. For each item please indicate how things have changed in the last 12 months by placing a circle around the response that best reflects your opinion.

During the last 12 months:-

	Increased significantly	Increased slightly	Neither increased or decreased	Decreased slightly	Increased significantly
The sense of personal achievement I get from work has	5	4	3	2	1
The levels of stress if feel have	5	4	3	2	1
The morale of my nursing colleagues has	5	4	3	2	1
My workload has	5	4	3	2	1
The quality of care I am able to give has	5	4	3	2	1
My confidence in the future of the NHS has	5	4	3	2	1
My job satisfaction has	5	4	3	2	1
My feelings of job security have	5	4	3	2	1
The amount of administrative work I have to do has	5	4	3	2	1
My satisfaction with my overall working conditions has	5	4	3	2	1
My satisfaction with pay has	5	4	3	2	1
The amount of time I have for direct patient care has	5	4	3	2	1
My responsibilities have	5	4	3	2	1

Broad Questions to explore	Clinical Governance areas
1. a) What on the whole is nursing care like on your ward? b) In the rest of the Department? c) How do you know? d) Are there exceptions to this? e) What are these and what are they caused by?	Monitoring Clinical practice Audit Clinical Performance of colleagues
2. a) What do patients, their carers and families think of the care you provide? b) How do you know?	Audit of consumer feedback
3. What issues influence the care you provide? (If not covered in 1.d)	Clinical risk assessment
4. a) If you think your care could be improved, in what ways? b) Are you able to share your best practice with others, and they with you? Please give examples.	Evidence based practice Dissemination of best practice
5. How do you decide how many nurses you need?	Clinical risk assessment Evidence based practice
6. a) What do you NOT do when you are short of nurses? b) How do you decide?	Clinical risk assessment Evidence based practice
7. a) Did your training prepare you for your current role? b) Does continuing professional development help you / your team in their roles?	Leadership Education Continuing professional development
8. a) What are the reasons for nurse shortages? b) What happens if you have nurse shortages? c) What should the Trust do? d) What should the Department do? e) What can you do?	Monitoring Clinical practice Clinical risk management
9. Any other issues?	

Figure 1. continued

Patient Care	Patient Outcomes	INTERVENTIONS				
		Emergency Dept.	Admission Day	Day 2	Day 3	Day 4
2. Knowledge deficit related to disease process and self-management.	2. The patient/ significant other will communicate understanding of disease process, treatments, and follow-up care. Date _____ If not achieved, write a corrective note.	__ Implement Emergency Department Teaching Guideline	__ Patient/family assessment __ Implement Learning Checklist for Compromised Respiratory Status	__ Patient/family assessment __ Continue Learning Checklist for Compromised Respiratory Status __ Evaluate for MDI conversion & teaching. B-agonist, inhaled steroids. __ Evaluate for DME,HH,SNF __ Discuss discharge date with physician	__ Patient/family assessment __ Continue Learning Checklist for Compromised Respiratory Status __ Evaluate for MDI conversion & teaching. B-agonist, inhaled steroids. __ Evaluate for DME,HH,SNF __ Discuss discharge date with physician	__ Finalize arrangements __ Complete Learning Checklist for Compromised Respiratory Status in preparation for discharge tomorrow
		CRASP: 8am - 4pm ____	CRASP: 8am - 4pm ____	CRASP: 8am - 4pm ____	CRASP: 8am - 4pm ____	CRASP: 8am - 4pm ____

Emergency Dept.			Admission Day			Day 2			Day 3			Day 4		
INIT	PRINT NAME	TITLE	INIT	PRINT NAME	TITLE	INIT	PRINT NAME	TITLE	INIT	PRINT NAME	TITLE	INIT	PRINT NAME	TITLE

All assigned Registered Nurses are responsible to update / review, and sign the patient care path each shift.

©1994 This Care Path is to be used as a guideline only and does not necessarily imply a standard of care.

Figure 1. SOC form for adult chronic obstructive pulmonary disease/asthma with options for patient individualization.

PATIENT LEARNING CHECKLIST   Page 1 of 3

DIAGNOSIS: COMPROMISED RESPIRATORY STATUS

Addressograph

INTERVENTION CODES	PATIENT / SIGNIFICANT OTHER CODES
A. Questions answered	A. Needs instruction
B. Reinforcement Provided	B. Needs reinforcement
C. Information provided; list written materials	C. Demonstrates verbal understanding
D. Task demonstrated	D. Returns demonstration
E. Multidisciplinary Referrals; specify	E. See flow record
F. Refer to class	F. Alteration in mental status prevents meaningful interaction
G. N/A	G. Teaching complete

TEACH / DEMONSTRATE	INTERVENTION				PATIENT/SIGNIFICANT OTHER RESPONSE				COMMENTS
	CODE	DATE	TIME	INITIAL	CODE	DATE	TIME	INITIAL	
A. Review Information About Your Plan of Care sheet for Compromised Respiratory Status.									
B. Signs and symptoms of Compromised Respiratory Status:									
• tiredness									
• reduced peak flow									
• chest tightness									
• cough									
• color									
• wheezing									
• shortness of breath									
• dyspnea									
• increased respiratory rate									
• dizziness or light-headed feeling									
C. Signs and symptoms of Infection:									
• elevated temperature									
• changes in character, color, and amount of sputum									
• increased respiratory rate									
• shortness of breath									
• wheeze or stridor									
• increased cough									
• malaise									
D. Dietary Regimen									
• force fluids (unless contraindicated)									

Figure 2. continues

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Figure 2. continued

APPENDIX FIVE B

TEACH / DEMONSTRATE	INTERVENTION				PATIENT/SIGNIFICANT OTHER RESPONSE				COMMENTS
	CODE	DATE	TIME	INITIAL	CODE	DATE	TIME	INITIAL	
· mechanical soft diet									
· avoid caffeine if on Theophylline									
· Nutritional Services referral									
E. Activity Progression Regimen									
· use beta agonist prior to exercise									
· pace activities during the day to avoid fatigue									
· arrange activities after respiratory treatment									
F. Avoid people with respiratory infections, poorly ventilated places, and crowds.									
G. Do not smoke or allow smoking in the house.									
H. Respiratory Regimen									
· peak flow measurement									
· MDI/spacer use									
· oxygen administration									
· breathing techniques									
· Respiratory Care Services referral									
I. Medications									
· Review medication instruction sheet in the Asthma Teaching Packet									
· Purpose · Rescue beta agonist · Preventive inhaled steroids									
· Use · take bronchodilators before inhaled steroids · replace caps on inhalers after use · spacer use · rinse mouth after using inhaled steroids									
· Consult physician before using over-the-counter drugs.									
J. Asthma Education									
· Review Asthma Resource Packet · definition of asthma · asthma care plan · peak flow meter use and maintenance · MDI/spacer · resource list · asthma IQ · adult immunizations · triggers									

Figure 2. continues

Figure 2. continued

TEACH / DEMONSTRATE	INTERVENTION				PATIENT/SIGNIFICANT OTHER RESPONSE				COMMENTS
	CODE	DATE	TIME	INITIAL	CODE	DATE	TIME	INITIAL	
· Refer to Asthma Class · patient/significant other call 372-1903 to schedule									
K. Call the Advice Nurse for the following:									
· questions about the asthma care plan									
· if the patient remains in the yellow zone with no improvements after designated interventions									
· signs and symptoms of infection									
· signs and symptoms of compromised respiratory status									

INITIAL	SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE

Figure 2. Patient Learning Checklist with directives and information for patient education.

APPENDIX SIX A

Chart 1
Sacred Heart-St. Mary's Hospitals, Inc.
PLAN OF CARE: CONGESTIVE HEART FAILURE
ESTIMATED LENGTH OF STAY: 4 Days
Supplies Given: Adm. Kit _PN 2-1-94_ Urinal _PN 2-1-94_ Bedpan _PN 2-1-94_ Air Mattress _PN 2-1-94_

FOCUS Date:	Day of Admission	Day 2	Day 3	Day 4
ACTIVITY	Activity intolerance related to dyspnea • Restrict activity 30 min before and 60 min after meals *Expected outcome* • Activity as tolerated _PN 2-1_	• Restrict activity 30 min before and 60 min after meals • Chair 30 min t.i.d. for meals • Ambulate 60 ft in hall w/assist • Bathroom privileges *Expected outcome* • Able to tolerate activity without distress _PN 2-2_	• Ambulate 100 ft t.i.d. *Expected outcome* • Able to perform ADLs and ambulation without the use of O₂ _____	• Prepare pt for discharge home *Expected outcome* • Able to tolerate activity without distress _____
NUTRITION Needs assist _no_ Consult needed? _no_	(NAS diet or) _____ _PN 2-1_	NAS diet or _____	NAS diet or _____	NAS diet or _____
TREATMENTS Skin _PN 2-1_ protocol _____ Fall protocol _PN 2-1_	Alteration in fluid balance related to compromised cardiac output • Vital signs q4h • I&O • Daily weight • Telemetry if ordered • Heparin lock • O₂ at _3 L/min_ • Assess lung and heart sounds q shift and p.r.n. • Assess pedal edema and pulses q shift	• Vital signs q4h • I&O • Daily weight • Telemetry if ordered • Heparin lock • O₂ at _3 L/min_ • Assess lung and heart sounds q shift and p.r.n. • Assess pedal edema and pulses q shift *Expected outcomes* • Pt's foot edema is decreased or pt has lost weight (min 1 lb) _PN 2-2_ • Pt has improved breath sounds _PN 2-2_	• Vital signs q shift • I&O • Daily weight • Discontinue telemetry if previously ordered _____ • Heparin lock • O₂ p.r.n. (If still needed, consult cardiopulmonary services for need for home O₂.) • Assess lung and heart sounds q shift • Assess pedal edema and pulses q shift	• Vital signs q shift • I&O • Daily weight • Discontinue heparin lock _____ • Discontinue O₂ _____ • Assess lung and heart sounds q shift • Assess pedal edema and pulses q shift *Expected outcomes* • Feet/ankle edema resolved _____ • Unlabored respirations _____
TEACHING	• Review Plan of Care with pt • Explain medications to pt. • Give copy of Plan of Care to pt • Give info sheet on congestive heart failure to pt • Home health referral needed _yes PN 2-1-94_ • Home O₂ needed _possibly PN 2-1-94_	*Expected outcome* • Pt can verbalize understanding of present medications _PN 2-2_	• Discharge medication sheets given _____ • Home health referral arranged if needed _____ • Home O₂ arranged if needed _____	*Expected outcomes* • Pt can verbalize understanding of present medications _____ • Discharge medication sheet reviewed and pt can verbalize understanding _____ • Discharge instructions reviewed and pt can verbalize understanding _____ • Pt can verbalize understanding for need of follow-up visit and when to call doctor _____

OTHER FOCAL AREAS
• Durable power of attorney _yes PN 2-1_
• Living will _yes PN 2-1_
• Code status _full PN 2-1_

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Chart 2
Sacred Heart–St. Mary's Hospitals, Inc.
PLAN OF CARE: CONGESTIVE HEART FAILURE   PATIENT COPY
ESTIMATED LENGTH OF STAY: 4 Days

FOCUS Date:	Day of Admission	Day 2	Day 3	Day 4
ACTIVITY	You can move around as you are able. Avoid becoming overtired or short of breath. You should remain in bed 30 minutes before your meals and 60 minutes after your meals.	You should increase your activity slowly. Start by sitting up in the chair for meals and walking short distances with the help of the nurses twice a day.	You should be starting to feel better and should be able to do mild activities without your oxygen. If you can't tolerate this, your doctor may suggest using oxygen at home. A home care nurse would then come by to check on you for a few weeks.	You should be able to walk in the halls and take your own bath without trouble breathing. You'll go home today if your doctor feels you're ready.
NUTRITION	You'll be on a no-added-salt diet. The dietitian will come to talk to you about this if you don't understand. A salt substitute is available if you need it. (Salt causes your body to hold in extra fluids, making your swelling worse and causing your heart to work even harder.)	Low-salt diet	Low-salt diet	Low-salt diet. Ask your doctor or nurse if you should continue this diet at home.
TREATMENTS	The nurse will measure the amount of fluid you take in and put out. The nurse will listen to your heart and lungs to see if they are getting better. You may have to use oxygen for the first day or two to help you breathe easier. You'll be weighed daily. You'll have an intravenous needle placed in your hand or arm. This will be used to give you medication. You may have a telemetry heart monitor on. Nurses in the intensive care unit will monitor your heart's rhythm.	Treatments will remain the same.	Some treatments will remain the same. You'll use oxygen only when you feel you need it. The heart monitor will be discontinued if previously ordered.	Some treatments will remain the same. Your oxygen may be discontinued. Your needle will be removed if you're going home.
TEACHING	You'll need to understand what is going on with your body. Please ask questions if you don't understand something. You'll be given a sheet to explain what congestive heart failure is. Ask about your medications if you're unfamiliar with them.		You'll be given information sheets that explain the medication you'll take at home. You should know about the right foods to eat and what types of food you should avoid. Your doctor may order a follow-up by a home health nurse.	You'll need to follow up with your doctor. Make sure you know when your appointment is. Know what problems may require medical attention.

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