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One Year On: Aspects of Clinical Nursing Governance in the Department of Elderly Medicine

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Executive Summary

This summary reports the findings of a review into aspects of clinical nursing governance in the Department of Elderly Medicine, Portsmouth HealthCare NHS Trust. The same methods were used as those in an initial review conducted between January and May 2000. This first review was instigated as a result of high staff turnover and recruitment difficulties which had implications for bed availability and care quality.

As a consequence of the first review, many changes have been implemented. There was clear evidence of increased responsiveness to staff requests for different ways of working, and several statistical indicators demonstrated improvements. A new clinical career structure had enabled clinical supervision to be developed and in general morale throughout the division was much higher than it had been previously.

The NHS modernisation agenda requires that more improvements are made in the future. espcially those based around patient care needs. The report recommends some ways in which the division can rise to meet these challenges in the future

1. Introduction

1.1 During the early months of 2000, a review was conducted into aspects of Clinical Nursing Governance in the Department of Elderly Medicine, Portsmouth HealthCare NHS Trust. It was instigated primarily as a result of short term bed closures which occurrred as a result of high turnover and nursing recruitment difficullties. The subsequent report made a number of recommendations and provided several learning points for the division. One year later the review was repeated in order to assess progress and describe improvements. This report provides a summary of the findings of the second review, together with recommendations for future action.

1.2 The aims of this report are to:

- Describe current aspects of clinical nursing governance, and compare these to the previous year.
- Identify key nursing and operational issues, in particular those with relevance to nursing workload and with implications for patient care quality, and suggest learning points and recommendations relating to these.

1.3 In the course of the review, information was obtained from a range of literature sources, including government policy documents and Trust reports, in addition to research based sources. Evidence was also collected from nurses, doctors and managers, which in numerical and descriptive aspects, were very similar to the previous year's sample.

In addition, time was spent observing ward practices, reviewing records, and listening to the views of various grades of nursing and other staff. However, ward sisters were the main contributors to the previous review and, therefore, this group are the main informants to this report.

1.4 The report is presented in three main parts, which, after this brief introduction, consist of:

- Key Findings, from all the sources listed above.
- Policy influences on patient care and nursing.
- Recommendations for future development.

2. Influences on Clinical Nursing Practice

2.1 The interview and questionnaire evidence demonstrated some outstanding issues which nurses considered affected the quality of patient care. The key theme relating to this is nursing workload.

2.2 Nursing workload

The determination of nursing resource allocation and skill mix remains a challenge. Ward Sisters are experiencing an increased level of clinical and managerial autonomy, decision making complexity and accountability in relation to their overall management and patient care (Douglas and Mayewski, 1996; Fulton and Wilden, 1998).

In a recent large scale study of stress among Ward Sisters, it was reported that they perceived their roles had become increasingly complex and most found it difficult to provide the multiplicity of functions expected of them. Most spoke of constant crisis management and of feeling a loss of control of clinical and professional issues (Allen, 2001).

There remains no means of obtaining reliable data on direct patient care activities and patterns of staff allocation, necessary for making precise staffing decisions. However, research shows that there is a wide variation in practice which results in different amounts of time spent by Registered Nurses in direct care activities. For example, the direct patient care activities (those which involve personal contact with a patient) have been reported as follows:

Ward Sisters	-	6-9%
Registered nurses	-	31-44%
HCSW	-	43-61%
(Source: Flynn, *et al,* 1999)		

In theory, the level of nursing care depends upon the actual number of staff available, the effectiveness of the delivery system and the care requirements of the patient. In reality, in periods of high activity, a return to routine practice is observable. This has been most clearly demonstrated in continuing care environments. Research indicates that when staff are working under time pressures, an acute care delivery model features strongly (Goldman, 1998). However, retreating to traditional nursing practice is a feature in all care situations under time pressure. It permits the nursing focus to be on tasks to be completed, rather than the needs of a whole person associated with high quality nursing practice, and this focus on tasks has been shown to be associated with a higher incidence of adverse events and other negative patient outcomes (Thomas and Brennan, 2000).

In common with most Trusts, managing workloads and staff absences that in turn increase workloads, requires more focused work and planning especially around "root cause analysis".

Predicting holiday periods and known months / weeks of high sickness is a relatively straightforward process, and even predicting the days, times which carry the highest risk of adverse events occurring are possible using Trust data sources. Using this data to plot and project the need for additional staff will help manage the sense of overload, and engagement of Ward Sisters in this process should help the sense of control and role conflict (Barber and Iwai, 1996).

Role conflict has been defined as the simultaneous occurrence of two or more pressures, so that compliance with one makes it difficult to comply with another. It is considered a better predictor of staff burnout than any other variable, e.g. high workload. The practical value of this finding is that it permits managers to minimise role conflict, by defining with staff what their key practices are in any given situation. This alone will help to set parameters of care and liberate nurses to focus on the most important patient focused aspects of care.

Research shows that overall, qualified nurses spend between 25-45% of their time on non-nursing duties. Ball, *et al,* 1989; Waters and Luker, 1996, have argued for the freeing up of non-nursing activities to increase the provision of professional patient care.

Registered Nurses are the most versatile of direct nursing care providers and, in consequence, are often expected to absorb the duties of others along with their own responsibilities. This is particularly true on evening, weekend, holiday and night shifts, when other services are curtailed or do not function. Taken together, the lack of support services and doing the work of others, forces nurses to spend a substantial amount of time in non-patient care activities. Historically, nurses have performed whatever activity that was necessary, such as ordering supplies, making appointments and arranging transfers. Much of this, if needed at all, could be performed by others.

A review of the workload literature revealed that a large proportion of non-patient activity could be reduced if the following were in place:

- new assistive personnel
- new types of work
- use of labour saving technology
- restructuring of the roles of Registered Nurses (Prescott, *et al,* 2000)

There is mounting support for the notion of reframing the nursing shortage problem from that of a nursing shortage, to a shortage of nursing time. This permits a focus on what nurses do with their time rather than that of establishment or allocation. The approach demands more flexible staffing systems which reflect patient demands, unlike current methods which are often unbalanced, so that the busiest times have less or the same staff as quieter periods.

To achieve this requires an objective appraisal of current use of staff against high demand periods, with an aim of providing sufficient nurses to achieve an adequate number and skill mix of nurses to meet patient demands. Ad hoc or traditional establishment based approaches are not sufficiently sensitive to patient requirements and, therefore, threaten the quality of patient care.

3. Key Findings

3.1 It was clear, throughout the review process, that there had been substantial changes within the division. Many of these were in direct response to the requests of ward sisters to develop aspects of their role.

On the whole, morale was found to have improved, and most nurses felt in greater control of their working lives. In addition to qualitative and observational material, Trust statistical sources supported the view that changes had taken place within the division, and that these had direct and indirect implications for improvements in the quality of patient care.

3.2 Specific developments and achievements during previous 12 months:

3.2.1 The initial year 2000 report demonstrated mainly short term bed closures which were occurring on a regular basis, particularly around the high demand *"winter pressure"* months. This coincided with the period when staff sickness was also higher and was further compounded by annual leave due to school and bank holidays. The change in bed closures between 1999/2000 and 2000/2001 is fairly dramatic. However, the 2000/2001 result is against the trend of previous years, as shown in table 1.

Table 1

Bed Closures

1999 October-December	57	beds closed
2000 January-April	34	beds closed
2000 October-December	0	beds closed
2001 January-April	0	beds closed

There has been a concerted effort to control bed closures within the division and these have clearly met with success.

The use of temporary staff has been associated with poor patient outcomes and it was important for the division to reduce the use of these over the past year, which it has achieved as demonstrated in table 2.

Table 2 Temporary staff

Agency nurse costs	1999/2000	£471,000
	2000/2001	£447,000
Bank nurse costs	1999/2000	£ 63,668
	2000/2001	£54,082

The retention of good staff was also a key priority for the division during the past year and wastage rates have reduced by more than 50%, with most nurses leaving for career development purposes (table 3).

Table 3

Qualified nurse wastage	Year	%
	1999/2000	22%
	2000/2001	10%

Pressure on beds continues to remain high with occupancy remaining at around 98% for acute wards and 100% for continuing care wards. However, the difficulty in discharging patients to independent nursing and residential nursing homes increased, because of reduced capacity.

A new senior management team commenced work in the division between January and March 2000. In addition, a newly created clinical leadership structure consisting of two "H" and one "I" grade nurses was established in August to provide clinical leadership, supervision and advice to facilitate the improvement of patient care.

Interviews with senior ward nurses and others, undertaken the previous year, indicated that more could be done to increase the autonomy and authority of ward managers. During the past year, significant developments have taken place within the division which addressed most of the issues raised, including:

- The creation of working groups on key topics - clinical governance, education.
- Protected ward leadership time - at least one day a week.
- F grades in all departments.
- The title has been changed from Ward Managers to Wards Sisters.
- Uniforms have changed for qualified - unqualified staff.
- Development of closer working relationship with Southampton University, School of Nursing through specific group membership, liaison and teaching.
- Monthly meetings between Clinical and General Managers.
- Increased authority to recruit staff and 24 hour responsibility for patient care.
- Ward budgets for ward sisters
- Housekeeper roles increased.
- Additional overseas nurses (appointed over existing establishment).
- Regular clinical supervision.
- Changes in bleep holder system.
- Increased access to equipment for patient care.
- Specialist Gerontological Nursing Development Programme for F and G nurses.
- The development of a curriculum for an MSC Gerontological Nursing is near to completion

3.3 A Nurse Consultant (Stroke Care and Rehabilitation) proposal has been approved by the Regional Health Authority and the Department of Health. Interviews will be held in October 2001

3.4 Ward sister perceptions

Interviews were held with all but three ward sisters and for practical reasons, because of an on-going review, the night sisters were not interviewed. The main themes produced during the interviews are provided below. Narratives are used to help expand and clarify the issues raised.

3.4.1 Management, supervision and support

- The new general management team were found to be open, accessible and facilitative. " *They operate an open door policy and always greet you with a smile, and take action to support you*".

- The senior clinical leadership team (H and I grades) were also considered to be constructive and supportive.
- This was particularly noticeable in the accounts of the long-stay ward sisters, "*We have much more clinical support and advice than ever before, clinical supervision happens regularly which makes all the difference*". However, some ward sisters reported that insufficient time was available (from the senior nursing team), for regular clinical supervision and involvement in ward based clinical practice.

3.4.2 Education and training

- Over the past year, many nurses have participated in the ALERT course, this has been well evaluated and will help nurses identify signs that a patient's condition is deteriorating and to take appropriate action.

- The development and implementation of the Gerontological Nursing Development Programme, although designed in response to the expressed needs of nursing staff, did not meet all of the needs of all of the nurses.
  However, it was on the whole evaluated positively and provided a forum which brought F and G grade nurses together, giving them time with expert facilitation, to actively plan to meet patient care needs more directly.
  In the words of one acute ward sister, *"The programme enabled me to look at things, well patients differently, to ask them what THEY wanted - for the first time"*.

3.4.3

- Questionnaire results

During individual meetings, ward sisters repeated completion of the questionnaires first used in 2000, relating to their perceptions of several aspects of their work.

The issues raised in the questionnaires are summarised overleaf:

3.4.4.1

	2000		2001	
	No	Yes	No	Yes
Nurses feel supported by management	X			X
Access to manager good	X			X
Able to use range of skills	X			X
Criticism given fairly	X			X
Staff consultation good	X			X
Views listened to	X			X
Quality of care high		X		X
Morale high	X			X
Stress levels high		X		X
Not enough time for patient care		X		X
Too much administration		X		X

3.4.4 Other issues for further consideration and development

<u>Exchanging experience and skills</u>
Discussions have commenced to permit qualified Elderly Medicine nurses to exchange with others, especially with Elderly Mental Health. However, closer working on a number of levels is desirable and will be referred to again later.

A good example of cross-Trust working is the Winter Outliers Scheme, in which an Elderly Medicine Ward Sister provided clinical advice regarding older people's care on general medical wards.

3.4.4.2 <u>Nursing Shortages</u>
Nursing within the division has been over-establishment for several months resulting in cost pressures. The addition of overseas nurses helped to staff wards but the cost, in time taken to train and supervise these new nurses has also been high. The division requires a period of consolidation in order to obtain the full benefit of the additional nurses. There remains the issue of a shortage of nursing time precipitated by sickness and annual leave, this aspect is returned to in part 4.

A recommendation of the 2000 report, was that more focused planning of high absence periods should take place. Although there is much improved management of absences, periods of shortage still occur. While agency nurse costs have reduced, it still remains too high, primarily due to night nursing at weekends and to sickness cover. Greater use should be made of previous years personnel data to predict periods of high use and more systematic planning should go into preparing for these periods.

3.4.4.3 <u>Bed management</u>
Senior nurses now have an input into bed management.

3.4.4.4 <u>Skill mix</u>
There remain a disproportionate number of junior qualified staff on the wards. There are plans in the division to develop nurses into higher grades but this can only occur when nurses have achieved appropriate levels of competency.

3.4.4.5 Non-nursing duties

Non-nursing duties continue to distract nurses away from their primary function - direct patient care. Although all wards have Ward Clerks and Housekeepers, some further work is required to ensure that appropriate work is undertaken by grades other than nurses.

3.4.4.6 Practice variation

Nursing practice between wards continues to vary, without clear rationales. While this may be in the best interests of patients and their families, some practice continues which seems to have more of a historical than a research basis.

3.4.4.7 Night nursing

As ward sisters now carry 24 hour responsibility for patient care the role of the night sisters requires review and change in the light of nursing policy and practice developments.

4. Future Challenges

There have been several policy developments in the past twelve months that will shape and inform the future of nursing in the Department of Elderly Medicine.

4.1 "*Essence of Care*": Benchmarks

"*Essence of Care*" offers a toolkit for nurses and organisations to use as part of their quality improvement programme. Developed by patients, consumer groups and professionals, it provides best practice guidance in 8 fundamental aspects of care of importance to all professionals, but especially nurses providing direct care.

Areas covered include: principles of care; personal and oral hygiene; nutrition; continence and bladder care; pressure ulcers; safety of clients with mental health needs; record keeping; and, privacy and dignity. It is intended to be used as an integral part of Clinical Governance at local level enabling nursing teams to compare and benchmark their practice against others.

4.2 Ten Key Skills

The "Ten Key Skills for Nursing" are aspects of advanced practice undertaken by qualified nurses in different parts of the country. The Government want to see these skills introduced to all Trusts by all nurses competent to undertake them and in consequence, has included these skills as part of the Assessment Performance Monitoring Framework (2001) for all Trusts.

These skills are:
1. Order diagnostic investigations such as pathology laboratory tests and x-rays.
2. Make and receive referrals, such as direct to a therapist or a pain consultant.
3. Admit and discharge patients for specific conditions and with agreed protocols.
4. Manage a patient caseload, such as for diabetes or rheumatology.
5. Run their own clinics - for example, ophthalmology and dermatology.
6. Prescribe medicines and treatments.

7. Carry out a wide range of resuscitation procedures such as defibrillation and intubation.
8. Perform minor surgery and out patient procedures.
9. Use computerised decision support and triage patients to the most appropriate health practitioner.
10. Take a lead in the way local health services are organised and run.

Source: Assessment Performance Framework 2001

Specialist Practitioner Roles

The roles outlined in the "Key Skills" are forms of advanced nursing practice which have been developed to meet some challenging and complex health care demands, especially in the sphere of chronic conditions.

Nurse practitioners currently fill these roles in many areas, but it is possible that many, appropriately trained nurses could also undertake these as part of their normal clinical practice.

Nurse practitioner roles in the past have been differentiated from other nursing roles because they possess:

- A specific nurse practitioner qualification (approximately 18 months)
- Prescribing rights
- Skills in assessment and history taking
- Referral rights to other professionals and discharge / admission capabilities
- A high level of judgement and decision making
- Diagnostic capabilities (From Walsh, 1999)

Although the Government are clear that many nurses should be able to take on these roles, the key to nurse practitioner status does not lie in an ability to undertake specific aspects of the role. It lies in appropriate degree level qualification and wide ranging responsibilities for a clinical caseload. Many examples of Nurse Practitioner/ Clinical Nurse Specialist role currently exist, the following are a few examples:

- Discharge liaison
- Diabetes
- Palliative Care
- Admission Clerking
- Night Nurse Practitioners
- Dementia
- COPD
- Congestive heart failure
- Nursing Homes

Nurse practitioners are proving to be a valuable resource to patients and health care by taking on defined caseloads where there is clear local need. For example, they have significantly reduced the workload of GPs in residential and nursing home care in some areas. They have also impacted significantly by reducing prescribing costs and the inappropriate use of continence products. Through specific clinical interventions, they have improved patient care and staff knowledge.

4.3 National Service Framework for Older People

National Service Frameworks (NSFs), are drawn up by the Department of Health with the support of users of the service, clinicians, managers and staff. The National Service Framework for Older People, sets standards for the care of older people across health and social services. It contains eight standards:

- Rooting out age discrimination.
- Person-centred care.
- Intermediate care.
- General hospital care.
- Stroke.
- Falls.
- Mental health in older people.
- Promoting an active, healthy life.

Progress towards achieving standards will be monitored by the Regional Office through the Performance Assessment Framework in Health and Social Services.

4.4 East Hampshire Primary Care Trust

The Division of Elderly Medicine together with Elderly Mental Health, will be managed by the East Hampshire Primary Care Trust from April 2002. This creates an unprecedented opportunity for nursing care to be developed and standardised across the divisions in ways that benefit patient care.

4.5 "Modern Matrons"

Each Trust in England is required to have senior nursing roles termed "Modern Matrons" in post by April 2002 (HSC 2001/010). These post holders will each oversee a group of wards and are intended to become the "recognisable face of authority at ward level".

There are three main strands to the matron role which will be graded at no lower than an "H" grade:

- Securing and assuming the highest standards of clinical care by providing leadership to the professional and direct care staff with the group of wards for which they are accountable

- Providing a visible, accessible and authoritative presence in ward settings to whom patients and their families can turn for assistance, advice and support

- Modern Matrons will have the authority to directly deal with the above issues and will be responsible for between 4-6 ward areas. They will work closely with and through Ward Sisters, who will also be required to deliver ward care according to the following supportive policies:

Supporting policies

There are a number of policy initiatives which are part of the modernisation agenda, designed to resolve some of the most high profile quality of care issues. These include:

The NHS Clean Hospitals Programme - which includes a requirement that senior nurses should have the authority to influence standards when contracts or in-house specifications are set; to make sure that standards are properly monitored and improvements made, if required. If service standards are not met, "Matrons" will have the authority to instruct that payment for services are withheld.

Quality of Hospital Food and Patient Information - Guidance has been issued regarding the 24 hour availability of food. Closer working is required between nurses and Catering Managers, but Matrons will again have the authority to withhold payment from providers if standards are not met.

- The Introduction of Ward Housekeepers by April 2004 will provide support services to meet patient and ward organisational needs.
- Patient Forums and Patient Advocacy and Liaison Service (PALS) - Ward Sisters are required to play an important role in ensuring that patient concerns are addressed on the spot. Modern Matrons are also seen as integral to first and second line problem solving.
- Ward Environment Budgets - Ward Managers already have been issued with these budgets. The Matron's role will be to ensure the most appropriate use is made of these funds and support Ward Sisters in their decision making process.
- Prevention and Control of Hospital Acquired Infection - The Modern Matron is considered at the heart of this initiative.
- Clinical Leadership Development - The government has extended the availability of the LEO (Leading Empowered Organisations) and the Royal College of Nursing Clinical Leadership Programme to all qualified grades of nursing and other clinical staff. Modern Matrons are regarded as having co-ordination roles in training programmes in Trusts.

Implementation

Portsmouth HealthCare NHS Trust has a model of Modern Matrons in the Department of Elderly Medicine. These two posts were introduced in August 2000 as part of the initial review recommendations. The Trust is required to develop these posts in other in-patient areas by April 2002.

4.6 Summary

This report is produced in the light of unprecedented change for nursing. Shortage of nursing time in the wards leave nurses feeling overworked and pressured by being unable to fulfil all the demands on their time. The nursing care of older patients is physically and emotionally taxing. It is also highly skilled and staff (and their patients) deserve supervision and training so that they can continue to develop and improve their practice, while feeling that their work is recognised and valued.

The role of the Ward Sister is crucial to the provision of good nursing care. In general, throughout the division, they are skilled, well motivated and resourceful, trying to produce the best nursing practice, often in very difficult circumstances and in environments that are far from optimal.

The key to addressing many of the outstanding issues in the division, lies in reviewing what all grades of staff do and identifying new ways of working, new grades of staff and in reframing what may be seen as a shortage of staff to a deficit of staff time.

5. Main Recommendations

Nursing care in the Trust and within the Department of Elderly Medicine, is taking place against a background of unprecedented change. The modernisation agenda presents the challenge of developing services that are sensitive and responsive to patient care needs. This requires a new approach to the planning and delivery of clinical nursing practice and care.

Many positive changes have taken place in the division during the past year and these are highly commendable. In order to maintain the initiative and support the development of further improvements, the following comments and recommendations are made:

- Work should be undertaken to more specifically plan for periods of known shortage, such as annual holidays, and detailed actions designed to reduce staff absences and the use of temporary staff during these periods.
- Staff should be aware of their work priorities during peak activity periods. Clear protocols should be developed to ensure that decisions about patient care priorities are determined ahead and not during staff shortages or peak activity periods.
- More work should be undertaken with ward sisters to "reframe" the shortage of nurses into a shortage of nursing time in order to facilitate the development of roles not essential to be undertaken by qualified nurses to be delegated to other grades of staff.
- An audit of sources of high patient need should be undertaken. For example, many patients are admitted from other hospitals and locations with existing conditions requiring high levels of nursing care e.g. pressure sores. Admission monitoring should take place as part of routine quality monitoring processes.

- Closer working arrangements should be developed with the primary care sector to

implement initiatives used in other Trusts to reduce admissions and improve discharge processes.

- The development of a shared bank with Elderly Mental Health should be investigated.

Modernising nursing services

Several roles should be reviewed and developed in the light of recent government policy initiatives. Modern Matron roles should be developed from current "H" grade posts; A proposal should be produced to develop nursing practice in order to achieve the "*Ten Key Skills*"; Night Nurse Practitioner roles should be developed in order to provide advanced practice skills on a 24 hour basis; and better control of agency time;

- The "outliers" scheme (those older people who are cared for in wards other than in Elderly Medicine), should be extended to provide expert nursing advice to Accident and Emergency Department, in line with the NSF. Roles in support of nursing and medicine should be investigated and implemented where possible, for example the Medical Technician role and the Ward Housekeeper roles, especially those in traditional out-of- hours periods.
- Regular audits of the wards clinical nursing practice against agreed standards should be introduced, using for example, the government's "*Essence of Care*" benchmark standards.
- An annual review of aspects of clinical nursing governance along the Commissioning for Health Improvement framework (Appendix 1) should be conducted in tandem with the Division of Elderly Mental Health, to monitor and assess progress and identify areas for improvement.
- Exchanges should take place in line with the "Rotation" initiative, particularly within the Division of Elderly Mental Health and Elderly Medicine, to support staff development and the sharing of expertise.
- Consideration should be given as to how the 'H' and 'I' roles can be managed in the event of a Nurse Consultant appointment. These roles are considered as pivotal to the continued development of patient care in the division.
- Finally, a strategy for nursing older people should be produced and updated regularly to take account of workforce, training and clinical governance issues, ideally with Elderly Mental Health.
- Service transformation requires transformational leadership. A challenging development programme for all H/I grade nurses in EMH and Elderly Medicine should be developed to equip senior nurses with the skills necessary to implement change.
- Some of these recommendations require additional funding. The division is still struggling with an historical overspend, which may indicate under funding. Support from the PCT Commissioners through the SAFF process will be necessary.

Conclusion

This report summarises the outcome of a review into aspect of clinical nursing

guidance in the Department of Elderly Medicine, Portsmouth HealthCare NHS Trust. It recognises the commitment of managers and staff to improvements in care provision and provide recommendations for future development.

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