WORKFORCE PLANNING CONSIDERATIONS FOR ACUTE MEDICAL UNITS

A GUIDANCE PAPER AND TOOLKIT

August 2011

The Society for Acute Medicine
Authored by elected Nurse Representatives of the SAM Council
Liz Lees and Liz Myers, Nurse Consultants in Acute Medicine

Table of Contents

Introduction

This guidance paper and toolkit builds upon The Society for Acute Medicine recommendations for nurse staffing on Acute Medical Units[1] by expanding the concept of nurse staffing levels to encompass a multi-professional team approach, with relevant tasks delegated to both registered and non registered practitioners. The terms 'registered practitioner' and 'non registered practitioners'[2] will be used throughout this paper to reflect the terminology used in national policy documents that represents what was traditionally known as qualified nurses and healthcare assistants.[3]. It is intended to guide the registered and non registered skill mix and has been developed to be used both as a guidance paper and an interactive toolkit. It will demonstrate the scope of core tasks for registered and non registered practitioners in acute medicine where there is potential role overlap or clear possibility for delegation.

It is hoped it will provide transparency and clarity for Acute Medical Units to consider their workforce needs and which NHS Bands of staff (NHSKSF, DH, 2004) best fit these needs, rather than numbers of staff per bed per shift[4] [5] Actual staff numbers per shift will depend upon the size and configuration of the unit and the nature of the services offered as part of acute medical care[6].

Background

Nursing policy guidance documents in the UK focus on recommendations for nurse staffing in NHS Hospital general wards but there is reluctance to recommend ideal numbers of nurses per shift, with the focus concentrating on methods to review ward nurse staffing levels[7]. Specialist areas are not included within the remit of this national guidance and thus there is no current national guidance for acute medical units. Attempts have been made to predict staffing requirements using an acuity-dependency tool[8] (Hurst, 2002). However this tool can be cumbersome to use in the demanding, high-turnover environment of an AMU and does not adequately capture the assessment workload associated with these units.

Rationale

This aim of this paper is to enable those with a responsibility for establishing or reviewing the staffing on an AMU to consider five key areas:

1. To enable an understanding of the nature of the workload in AMU.
2. To estimate the registered and non registered practitioner skill mix
3. To understand the contributions of the members of the multi-disciplinary team within AMU.
4. To identify workforce requirements to meet the safety and quality agenda.
5. To identify areas for shared skills and competency development.

Context

Acute Medical Units (AMUs) have been established in many NHS Hospitals and the specialty has evolved rapidly over the past decade[9]. New medical teams with Consultants in Acute Medicine have been established leading to a redesign of the way medical care is delivered[10] alongside the modernising medical careers agenda[11]. Conversely there has been little investment in AMU nursing teams. Registered and non registered staff groups are gradually evolving to accommodate the needs of acute medical patients, with little investment by comparison and there is a lack of national guidance to support changes in practice. Consequently, any investment in practitioners has been disparately decided at local levels by individual hospitals keen to ensure care outcome measures are met. Moreover, effort is concentrated on the current state rather than looking to the future vision of acute medical units and their changing remit.

The Society for Acute Medicine posted recommendations for AMU nurse staffing on their website in 2004. This document recommended a minimum baseline standard but emphasised the need to take other factors into account. These factors include high patient acuity, high throughput and direct admissions to acute medical units. These factors are discussed in detail in the acute medicine taskforce report (RCPL, 2007). However fixed staffing ratios are no longer recommended as these often are interpreted as the maximum staffing and do not take into account differences in skills, complexity, size of the individual units and the unit environment (RCN, 2006).

Structure

An acute medical unit is usually divided into distinct clinical areas to stream the patients referred from GP or through the Emergency department. Typically they will comprise of

Assessment Area

An area where patients who are referred are seen by the multi-disciplinary team and initial investigations are conducted prior to a decision being made to observe, admit or discharge home.

Ambulatory Area

This is an area where clinical care, including assessment, diagnosis and treatment can be provided on a same day basis. In addition, where treatment/short period of observation may be commenced prior to discharge home; for example, an admission for the treatment would not be required – but the treatment may not be available in the local community .

Short stay area (24 – 48 hours)

This area is recommended for patients who may be discharged within 48 hours. Although patients may not be of high acuity they may be high in dependency. Rapid turnover and the need for robust discharge planning over a short timescale leads to a demanding role for nurses. This can be part of the AMU or maybe accommodated separately according to the geographical layout of the hospital.

High Dependency Unit (within AMU)

It is recommended that the AMU has the facility to care for level 2 patients in a dedicated area with dedicated staffing.

General principles within the AMU structure:

1. Level two areas within acute medical units must be staffed in accordance with critical care staffing recommendations – a ration of one nurse per two beds (1:2).

2. Coordination and capacity management is a core function within acute medical units – depending upon the size of the unit it is suggested this function is owned by a Band 6 registered practitioner for the entirety of a shift. Nonetheless, Bed management support to ensure adequate patient flow may be required to achieve a hospital wide perspective on capacity.

3. Monitored areas must be staffed by registered practitioners with the appropriate skills

4. Clerical and porter duties should not be carried out by registered staff. Employment of clerical and dedicated porter staff at key times of the day is recommended.

5. A dedicated senior nurse should be appointed e.g. nurse consultant or lead nurse to work in close cooperation with the lead consultant in acute medicine.

Scope

Definition of acute medicine unit

This is a specialised area of an acute hospital where patients suffering from acute medical illness can be assessed and initially admitted[12]. Further detail regarding the differences between general wards and acute medical units has been added to this definition for the purpose of clarity regarding the role of the registered and non registered practitioners.

Differences between acute medical wards to other general areas

Acute medical units are distinctly different to that of general wards in NHS Hospital. They have been configured with operational policies to provide an optimal environment for high quality of medical and nursing assessment and care twenty four hours a day, over seven days a week prior to admission, discharge or transfer to the appropriate environment. There is a close working interface with Accident and Emergency Departments and Critical Care Units. Registered and non registered staff are therefore expected to manage high volumes of:

- Unplanned (non elective) admissions on a daily basis
- High volumes of patient discharges on a daily basis
- High volume of transfers to other in patient wards on a daily basis
- Initial nursing assessments and risk assessments
- First line treatments and interventions
- Clinically sick patients requiring stabilisation before transfer
- Frequency and timing of Consultant Ward rounds

As a consequence the workload is not static and a registered practitioner in charge of an area of five beds may actually assess and transfer up fifteen patients per twelve hour shift (depending on the volume of patients seen in the AMU).

Patients being transferred from acute medical units to other in patient areas will have a plan of care in place, where initial assessments and admission documentation for safe transfer has been completed as a minimum.

Definition of the role of Registered Practitioners (Nurses) within an Acute Medical Unit

Registered practitioners working within an acute medical unit manage an unpredictable and challenging workload caused by the diversity/dependency of patients and the complexity of care delivered. It is suggested that nurses function throughout at least five different modes of working in any given shift and the modes may be carried out as a continuum of care which proactively progresses the patient journey; the mode may interface with other practitioners delivering care at a specific point in time, or be part of care delivered in parallel to a whole group of patients. The modes of working are suggested below:

First mode: Emergency care & stabilisation

Second mode: Assessments and related actions

Third mode: Admission & general patient care post admission

Fourth mode: Ward rounds, reviews, progress chasing, referrals and follow up

Fifth mode: Coordination, discharging and transfers

The usefulness of these descriptions is applicable to the organisation of staff to deliver functions which fall within these modes of working. With the exception of the first mode, which is a core function and cannot be included as planned workload it is suggested that separating the modes will allow staff to focus on a specific function to expedite care and align responsibility.

Staff trying to deliver care in all modes will likely find it impossible to execute all functions satisfactorily and the quality of care delivered may deteriorate as a consequence. The notion of staff being in charge of a group of patients or allocated bay or area is fundamental; the critical difference is that it is recognised that the modes can be separated, shared and focussed upon, especially at key times of the day – provided that there is excellent communication and handover between staff. Other members of the nursing team e.g. chest pain, respiratory or diabetic specialists may provide in-reach to the AMU but are not part of the nursing establishment.

Skills & Skill mixing

The acute medical unit team will be made up of registered and non registered practitioners. The registered component will be predominantly registered nurses at different levels from 5 to 9, based on an experience & skill trajectory, usually aligned with NHS pay banding indicating pay scales. The levels of registered practitioner are defined within 2011 guidance from the Department of Health (Appendix, 1).

Non registered practitioners are generally health care assistants and assistant practitioners on bands 1 to 4 of the NHS Knowledge Skills Framework pay bandings. HCA's undertake training and initial preparation – usually but not exclusively coordinated by hospital education departments. The most recognised type of training is non vocational qualifications. An assistant practitioner has usually undertaken a two year foundation degree via college or university[13]. Tasks/role/activities maybe delegated provided that training and supervision mechanisms are in place.[14] Both HCA's and Assistant practitioners undertake a diverse range of roles and fulfil numerous functions within an acute medicine unit; either as a member of the substantive team or as a visiting 'in reach' member of staff.

- Health care assistants (supporting registered nurses, chaperone, observation, general care)
- Assistant practitioners (Physician assistants, functional assessments and liaison)
- Support workers (porters and domestic staff)
- Technicians (ECG recording, pharmacy support)

Suggested Skills Matrix

The potential contributions of the registered and non registered acute medicine team have been represented on a skills matrix. A feature of workforce planning is that there is a skills based work system supported by competencies. A feature of modernising nursing careers is that there is transferability of skills to allow for progression across the clinical bandings. Transforming the work within an acute medical unit will require that both aspects are considered as tasks frequently undertaken are often not exclusive to one role or clinical banding. Moreover, in the future there may also need to be consideration regarding pathways of care across the primary/ acute care interface with the need to develop new roles requiring skills in all areas aligned to acute medicine.

Identify your team members:

NHS BANDING	Job Title	Fundamentals of Role

Skills matrix

The matrix specifies skills and activities generally associated with an acute medical unit. In order to identify the likely skill mix of staff it is suggested:

1. Identify skills carried out exclusively by band 5 & 6 registered staff
2. Identify skills from the same band 5 & 6 list, skills that could be carried out by band 3 or 4 assistant practitioners or HCA's with appropriate training and competency achievement.
3. Identify skills that are carried out exclusively by HCA's.

Example:

No	Skills *types = direct clinical (d) or indirect (I)	Type*	Reg. (6)	Reg. (5)	Non reg (3/4)	HCA (2)	Admin	Support staff
1	Transfers and Escorts	D	x	x	x	x		x
2	Discharge planning	I	x	x	x	x	x	X
3	Ward rounds	I	x	x				

Skill 1 (transfers and escorts) is carried out by all bands of staff. It is possible to achieve greater clarity over this aspect with an operational policy that is aligned to patients' conditions and MEWs score. It may mean an increase in support workers with appropriate skills to enable transfers and escorts.

Skill 2 (discharge planning) is a shared role through appropriate delegation of key aspects. Not represented here is the Doctors role in discharge planning (decision maker). Additionally, intermediate care and transport staff are not represented. However, this task has been selected to demonstrate how difficult is can be to attempt to separate some activities.

Skill (3) (ward rounds) are the domain of registered practitioner responsibilities. They cannot be delegated and will take considerable time out of each day at key times in the morning and evening. Staffing should take account of this.

Skills template (adjust to fit by adding or removing skills)

No	Skills *types = direct clinical (d) or indirect (I)	type	Reg. (6)	Reg. (5)	Non reg (3/4)	HCA (2)	Admin	Support
1	Nutritional							
2	Hygiene							
3	Elimination (inc care of catheter)							
4	Vital signs (inc action on MEWs)							
5	Chaperone duties							
6	Cannulae insertion							
7	Venepuncture							
8	IV drugs and fluid management							
9	ANTT (aseptic technique)							
10	Medication administration							
11	Admission assessments							
12	Admission process							
13	Prep for invasive procedures							
14	Recording ECG and handover							
15	Verification of expected deaths							
16	Sampling ABG							
17	Commencement of CPAP							
18	Administration of Oxygen							
19	Insertion of urinary catheter							
20	Blood transfusion							
21	Cardiac Monitoring							
22	Clinical handovers							
23	SLT assessments							

24	All near patient testing							
25	Progress chasing							
26	Referrals to MDT and In reach							
27	Care Planning & evaluation							
28	Coordination of AMU							
29	Transfer of patients & Escorts							
30	Bed changes & bed moves							
31	Discharge planning							
32	Bed management (EDD)							
33	Ward rounds							
34	Notes, filing and clinics							
35	Meet and greet.							
36	Complaints management							
37	Appraisals & recruitment							
38	Sickness management							
39	Procurement and stock							
40	Supervision and preceptorship							
41	Training and education							
42	Quality standards							
43	Liaising with relatives/carers							

Creating a time line

The next aspect of work that will help to determine the acute medicine skill mix required on your unit is to use a time line to determine the times of core functions of the unit.

The fundamental aspects of care that are predictable are:

- Times of Consultant ward rounds
- Times of handovers (medicine and nursing and therapies)
- Times of medication rounds
- Times of food/meals
- Times of visiting
- Times of greatest volume of referrals (approximate)
- Times of most transfers out (approximate)

Time	Activity	Staff on duty
07.00		
08.00		
09.00		
10.00		
11.00		
12.00		
13.00		
14.00		
15.00		
16.00		
17.00		
18.00		
19.00		

Coordinator role

This role is critical to the smooth running and flow of patient activity into and out of the acute medical unit. The name 'coordinator' is given to numerous roles within hospitals, hence there is a need to be explicit regarding what you would like to the coordinator to do.

This will assist you in deciding whether it needs to be a registered practitioner, a dedicated role or a shared trans-disciplinary role. For example, a time of peak admissions, discharges and transfers the coordinator maybe supernumerary.

The following table identifies what are regarded as core elements of a coordinator role. If all aspects are to be undertaken by one person they would need to be free from a clinical case load for the shift:

Activity	yes	no
Putting out bleeps		
Deciding where to place patients (referrals)		
Deciding where to place patients (transfers)		
Liaising with bed management		
Liaising with the Emergency Department		
Ensuring the safe transfer of patients into the AMU		
Achieving single sex standard		
Taking GP referrals (pager)		
Handing over patients to other areas		
Ensuring the safe transfer of patients from AMU		

Recommendations for staffing

It is suggested that units utilise some of the tools within this paper to analyse their staffing requirements taking into account skills evolution across the healthcare workforce. This will allow local variances in operational functioning of the AMU to be accommodated. It is essential that managers seeking to review establishments must be aware of the nature and complexity of the nursing role within the AMU as outlined in this paper. Consideration must also be given to future workforce needs particularly in relation to transference of roles form other professions.

Given that the RCN recommends a baseline staffing ratio for a general acute ward to be 65% (registered) to 35% (unregistered); the baseline for registered staff staffing ratios within an acute medical unit (or ward) need to be proportionately greater - to encompass all the skills/facets attributed to AMU's. This may be as high as 75% registered staff required to deliver safe effective care.

In parallel it must not be overlooked that 'Liberating the Talents' and integrally the vision for the future; is that the NHS workforce will align skills to NHS pay Bandings to accommodate a career pathway which forms a trajectory.

NB: If the skills analysis reveals that the majority of skills identified are undertaken by registered staff, the likely outcome will result in a ratio of at least 75% (registered) to 25% (unregistered).

Equally, if the skill to be performed is yet to be acquired (visionary – forward plans) that may indicate transference of that skill from another professional body, such as Physiotherapy or Medicine. In this case it must be clear at what NHS band and what type of practitioner is to assume the role after relevant training. For example, it may be a task being performed at Band 4, supervised by a registered practitioner.

In delivering high quality care in these challenging times the NMC review[15] stated:

The NMC is often asked about safe staffing levels, and these questions are being asked even more often at this time of restructuring and recruitment freezes.

Ultimately, responsibility for identifying safe staffing levels must rest with managers of healthcare services and the nurses and midwives working in them. The closer to the frontline that decisions about quality are taken, the better they are likely to be.

Glossary

Registered Practitioner: will have completed a recognised programme of training which is professionally recognised and university supported with a registered qualification. They will be registered to practice and be regulated by a national professional body.

Note: the term registered practitioner does not exclude Doctors. However there is a tendency to refer to Doctors outside of the registered practitioner group.

Non Registered Practitioner: will have completed relevant non vocational training, which may be university supported but will not have a registered qualification or be regulated by a national professional body. The role is primarily to support registered practitioners.

Reference List

[1] Society of Acute Medicine (2004) recommendations for nurse staffing on AMU; unpublished paper from Council members in 2004

[2] Department of Health (2011) CNO webpage: modernising nursing careers/framework/tools. www.dh.gov.uk

[3] Department of Health: Modernising nursing careers: setting the direction (2006), Department of Health, London.

[4] RCN policy position (2010) evidence-based nurse staffing levels, Royal College of nursing, London.

[5] Patterson, J., (2011) The effects of nurse to patient ratios. *Nursing Times*, 107 (2), pp22-25.

[6] Rafferty AM, Clarke S, Coles J, Ball J, James P, McKee M, Aiken L (2007). Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records. *International Journal of Nursing Studies*, February, 44(2): pp175-182

[7] Royal College of Nursing (2006) Policy Guidance 15/2006: Setting Appropriate Ward Nurse Staffing levels in NHS Acute Trusts, RCN, London, September 2006.

[8] Hurst K. (2002) Selecting and applying methods for estimating the size and mix of nursing teams. www.who.int/hrh/documents/hurst_mainreport.pdf

[9] Langlands, A., Dowdle, R., Elliot., A. et al (2008) RCPE consensus statement on acute medicine, Edinburgh.

[10] Mc Neill, Brahmbhatt, DH, Prevost AT, et al (2009) What is effect of a Consultant presence in an Acute medical unit? Journal of Clinical Medicine 9: 214 – 8.

[11] Department of Health (2004): Modernising medical careers: the next steps, London

[12] Acute Medical Care: the right person in the right setting, first time: report of the acute medicine task force (2007), Royal College of Physicians of London.

[13] Supervision, accountability and delegation of activities to support workers: a guide for registered practitioners and support workers (2006) intercollegiate paper developed by CSP, RCSLT, BDA and the RCN.

[14] Health care assistants and assistant practitioner: delegation and accountability: essential guide (2008) Nursing standard. RCN publishing company. London.

[15] NMC review (2011) Issue 1., Spring 2011 http://www.nmc-review.org/issues/issue-one/delivering-high-quality-care/

Appendix 1 – Broad definitions of registered practitioner roles – within AMU

• Level 5 – Junior Registered Practitioner (a band 5 nurse, from newly registered and awarded up to five years of increments on the NHS pay scale). They will take charge of a group of designated patients under the supervision or guidance of a Band 6 nurse.

• Level 6 – Experienced practitioner (a band 6 nurse, recruited from progression at band 5 with experience in acute medicine, again awarded up to five years of increments on the NHS pay scale). They support the leadership of a team of band 5 nurses and the shift management or coordination roles within the unit. They may also take an active role in teaching and supporting the Band 7 nurse in managing the AMU.

• Level 7 – Senior practitioner and Advanced nurse practitioner (a band 7 nurse: two routes clinical and non clinical with progression from band 6 nurse in acute medicine).

Clinical route: at this level can be trained advanced nurse practitioners or nurses meeting the characteristics within the broad statement: An advanced nurse practitioner - is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, characteristics of which are shaped by the context and/or country which s/he is credentialed to practice.[1]. They will also be registered as an advanced nurse practitioner on the NMC register.

Non clinical route: (A band 7 nurse with significant relevant management experience progressing from Band 6). They operationally lead the AMU in recruitment, appraisal, sickness management and the daily functioning of the AMU.

• Level 8 – Consultant practitioner: (A band 8 Nurse - two routes: clinical and non clinical progressing from Band 7 in acute medicine).

Consultant Nurse - clinical: A master's degree is mandated for entry level. Providing clinical expertise, contributes to service development, lead research/audit and ensure, practice development and education. They have a breadth of skills to ensure the maintenance of clinical excellence. Nurse consultants must undertake research and expand the evidence base for acute medicine.

A Lead nurse/matron – non clinical with experience gained at each level from level 5 accumulating expertise in both operational/strategic management skills – having progressed from level 7. A Masters degree is not mandated for this group – but study at masters level in appropriate topic is recommended.

[1] Royal College of Nursing (2010) Advanced Nurse Practitioners, National Guidance, RCN, London

• Level 9 – Senior leader. (a band 8 b,c,d or 9 nurse in senior strategic/leadership position). Progressed from band 7 gaining experience in management and leadership roles with a relevant portfolio of expertise. They may have completed a leadership programme at national level and are likely to be Masters Level educated. They usually work at Board level and maybe a Head Nurse for medicine – depending on the size of the Trust.