

Safe Staffing in a

Hospice Setting

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Background

Despite the NHS having safe staffing reporting requirements in place since 2014^{1,2}, this has not been applied to hospices. There are also no specific staffing standards for hospice In-Patient Units.

Aims

- To understand the reality of the In-Patient Unit (IPU) staffing levels.
- To begin to understand the impact of staffing levels on care delivery.
- To understand the impact on demand and capacity of the service.
- To support the community team when considering the need for admission to the IPU.
- To provide assurance to ourselves and Trustees.
- To support the wider health and care system.

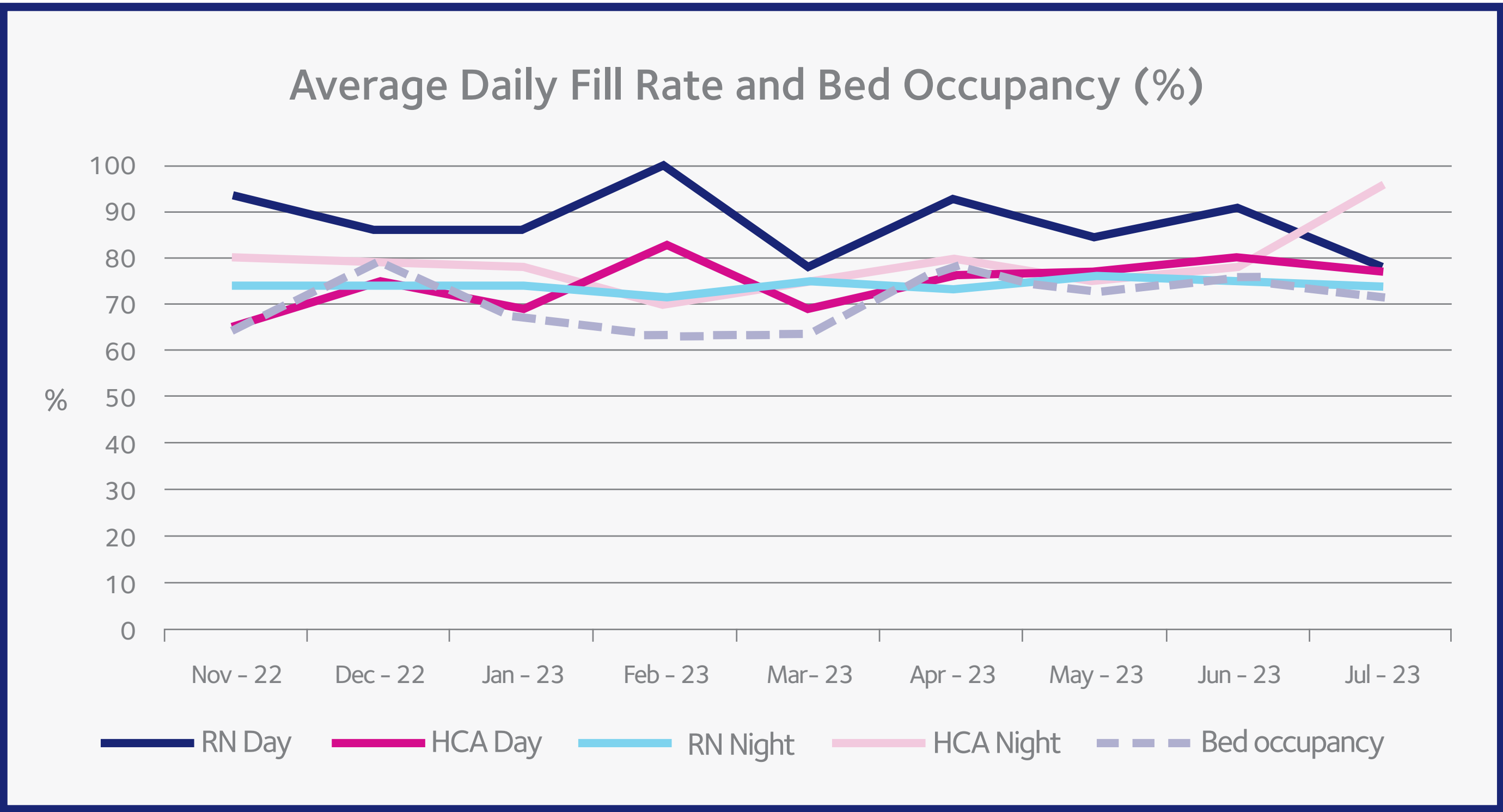
Methods

Retrospective audit performed over nine months (November 2022 to July 2023) collecting actual registered nursing (RN) and health care assistant (HCA) staffing numbers against planned staffing levels.

Reviewed against numbers of patients and the standard calculation for Care Hours Per Patient Day (CHPPD) was applied.

Results

- Data based on 16 beds occupancy:
- High levels of CHPPD (15.9 hrs a day average) = amount of direct care given to patients and families by nursing team on the IPU per day.
 - At no point since the work began was the CHPPD below 14hrs a day – suggesting safe staffing levels.



- When fill rates (% of hrs covered against what is needed) were below 70% there was also a decrease in admissions to the IPU – suggesting that safety was considered as part of the admissions process (patients were still admitted within 48hrs).
- Staff vacancy factor: 13% (7.79 whole time equivalent WTE).
- Fill rates at night are more consistent possibly due to a more stable workforce with set working patterns
- Average bed occupancy was 68.8%.
- The fill rate fully aligned to this (average of 76.5%).

Conclusions

- Overall, the IPU is safely staffed when reviewed with this tool.
- Further work is needed to align with dependency tools.
- Need to link this work with Patient Safety Incident Response Framework (PSIRF) implementation and patient safety /experience data.
- Annual reporting would be beneficial for the organisation.

1. NHS England (2013) How to ensure the right people, with the right skills, are in the right place at the right time A guide to nursing, midwifery and care staffing capacity and capability. <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>
2. Robert Francis QC (2013) The Mid Staffordshire NHS Foundation Trust Public Inquiry <https://webarchive.nationalarchives.gov.uk/ukgwa/20150407084231/http://www.midstaffpublicinquiry.com/report>
3. Royal College of Nursing (2023) Impact of Staffing Levels on Safe and Effective Patient Care: Literature Review
4. NHS England. Safer nursing care tool (no date) <https://www.england.nhs.uk/nursingmidwifery/safer-staffing-nursing-and-midwifery/safer-nursing-care-tool/>

How can we ensure safe staffing in hospices?

In line with the Francis Report² which called for greater openness and transparency in health care, we currently use the following mechanisms to assess safe staffing:

- Reported incidents.
- Feedback from patients, families, carers and staff working on IPU.

Since June 2014 all hospitals are required to publish:

- Number of nurses and support workers per shift.
- Percentage of shifts meeting safe staffing guidelines (excluding medics and allied health professionals).

Since there are no guidelines for hospices we have also applied the above in principle.

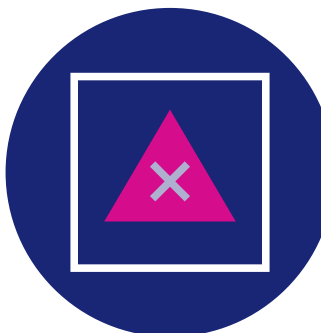
Along with this, professional judgement plays a key role:

“No workforce planning tool can incorporate all relevant factors in settings; therefore, cross-checking is recommended by combining workforce tool outputs with professional judgement and benchmarking of quantitative and qualitative indicators against peers, to increase confidence in and assurance of estimated staffing requirements.” National Quality Board, 2018

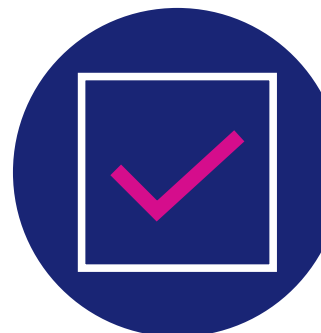
Safe Staffing – benefits and limitations



Retrospective understanding of staffing levels.



Can be used when incidents/complaints happen to determine staffing levels on any given day in the wider sense than just a single shift.



Has potential to be used prospectively to plan capacity available.



Only applicable to in-patient settings.



Needs to be considered with other tools, e.g. acuity and dependency (of which there are no specific ones for hospices).



Propose annual report on safe staffing.



- Need to align demand and capacity across all services –IPU, hospice at home, virtual ward.
- For the IPU to increase capacity to take more patients, consideration to staffing levels, skill mix and clinical criteria would need to be reviewed.



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