1. Introduction

This report was commissioned by the Director of Nursing and Modernisation and is the second scheduled establishment review undertaken during 2014, to ensure all stakeholders including patients, staff and the Trust Board understand the risks and assurances associated with current nurse staffing levels and the actions required to ensure care is provided safely.

Recommendations that were made in the May 2014 acuity review were fully supported by the Trust and recruitment has taken place to increase the staff in the ward areas identified. Across all in-patient wards a new band 6 practice facilitator was agreed to work with the increase in newly qualified staff appointed and an increase in staff to support the ward managers to have supervisory status.

It is recognised that safe staffing nursing workforce reviews need to occur biannually to ensure up to date staffing that is dynamic and reflective of the current wards status and patient acuity.

2. Executive Summary

In summary, this nurse establishment review included all The Walton Centre inpatient wards and the summary recommendation of the review is included at page 14. The review followed the same format as the previous report to enable comparison of acuity data over time. This report concurs with the original investment in staff and does not recommend any further investment or reduction in staffing following this second acuity review.

This review used the same evidence based Safer Nursing Care Tool (SNCT- Shelford Group), as recommended by NICE (2014), the Professional Judgement Model (Telford), the safe staffing alliance principles where appropriate and compared these to the funded and actual establishments of the Trust. Nurse sensitive indicators were also incorporated for
triangulation, and it should be noted that there was no evidence of concern from these indicators when undertaking the review.

The acuity SNCT review took place during November 2014. The project included two weeks’ of data collection, data analysis, national benchmark review and report writing. This report focuses on the nursing staff alone and it should be remembered that the efficiency of a nursing team will be influenced by the way in which they are led, the way in which they work with other healthcare professionals including AHP, pharmacists and medical staff. The support to the ward/unit by other non-clinical staff including clerical, portering and housekeeping staff is essential.

3. Background

The national focus on safe staffing on wards has been increasing since the publication of three important national reviews, Francis, Keogh and Berwick. All three reports shared a common purpose to review patient safety either specifically at certain organisations or more generally in the NHS.

The National Quality Board published in 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)’ this report detailed 10 Expectations in relation to nurse staffing and have been agreed principles in this report namely;

**Expectation 1.** *Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing and care staffing capacity and capability.* At the Walton Centre, the Board have received previous reviews of nurse staffing and received the first biannual review in May 2014. This report is the second biannual review.

**Expectation 2.** *Processes are in place to enable staffing establishments to be met on a shift by shift basis.* The Walton Centre has robust escalation procedures in place undertaken throughout the day to ensure staffing meets patient need on a shift by shift basis. The board of directors receive an exception report monthly reviewing actual staffing against planned on a shift by shift basis, and identifying any issues. MIAA are finalising a
review of daily staffing arrangements in the Trust and the level of assurance will be shared in due course.

**Expectation 3.** *Evidence-based tools are used to inform nursing and care staffing capacity and capability reviews.* This report details the triangulation of evidence-based tools, including SNCT, Telford and nurse-sensitive indicators.

**Expectation 4.** *Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.* Nurses utilise the NMC raising concerns approach within the organisation to complement existing Trust processes. The Trust has also joined the Nursing Times ‘speak out safely’ campaign to build on these foundations further and ensure staff feel supported and encouraged to raise any concerns.

**Expectation 5.** *A multi-professional approach is taken when setting nursing and care staffing establishments.* At the Walton Centre, representatives of finance, HR and management have been part of the project group in relation to the safe staffing review.

**Expectation 6.** *Nurses and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.* Ward Managers have been allocated supervisory status to support ward staff, each ward now has a full time practice facilitator who works alongside new starters modelling the way and supporting their induction, furthermore the organisation has an uplift built in nurse staffing to ensure time for training and staff development.

**Expectation 7.** *Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing establishment review.* In May 2014 the Walton Centre Trust Board agreed to the presentation of a biannual safe staffing review and a monthly staffing exception report, is now included in the Quality Report which builds on previous foundations. Detail of the staffing on a daily basis across the Trust can also be found on the Trust website with links from NHS Choices and Unify.

**Expectation 8.** *NHS providers clearly display information about the nurses and care staff present on each ward, clinical setting, department or service on each shift.* The Trust had
an initial system in place since April 2014. The staffing displays are now purpose built following feedback from staff and patients and staffing display boards are in all areas.

**Expectation 9.** Providers of NHS services take an active role in securing staff in line with their workforce requirements. The Trust has systems in place in relation to this and is continuing to strengthen its recruitment processes in particular. The Trust is increasing the hospitals presence at recruitment fairs and has a recruitment campaign on the website with the development of trust videos. At a time of national nurse recruitment difficulties the Trust percentage vacancy rate for nursing is within green rating on the workforce scorecard.

**Expectation 10.** Commissioners actively seek assurance that the right people, with the right skills are in the right place at the right time within the providers with whom they contract. A copy of the acuity report will be shared with specialist commissioners to ensure transparency.

4. **Terms of Reference**

The review has been undertaken to determine the safe nurse staffing levels required and support the Trust in:-

- Benchmarking WCFT wards against ‘best practice’ wards and services in other Trusts
- Recommending safe, quality ward and staffing establishments, based on current workloads and anticipated workloads for future planning on all wards within the Trust.
- Enabling the correct skill mix and staffing levels to ensure patient acuity and the Trusts service requirements are taken into account on a regular basis within the manpower plan of the Trust.
- Oversee the collection and reporting of data from the wards to help provide accurate reporting of present staffing and skill mix structure and processes.
- Ensure that when collected, the data in the reports is used to review and update staffing levels and skill mix on the relevant wards and support them in being able to provide safe, quality patient care
- Ensure on-going sustainability of the correct staffing and skill mix on the wards and to ensure patient acuity is taken into account in:-
- Patient assessment
- Personalised care planning and risk assessments
- Implementing and reviewing personalised care plans
- The safety and quality of patient care services.

- Consider patient safety and clinical governance issues that are relevant to staffing levels, skill mix and patient acuity.

This review included by ward; professional judgement model, SCNT model, benchmarking, safe staffing alliance principles where relevant, funded and actual establishments, agreed clinical indicators and ward activity (admissions, discharges, transfers and deaths). Recommendations are being made based on the overall picture for each ward.

5. Supported by internal project group and staff:

Director of Nursing and Modernisation
Deputy Director of Nursing
Lead Nurses
Unit Matrons
Ward Managers
Finance representative
Human Resources representative
Divisional Manager - Medicine

6. Methodology

The acuity/dependency tool chosen remains the same as the May 2014 review and is the Safer Nursing Care Tool (SNCT). The SNCT is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. It is suggested as an appropriate tool by NICE (2014) following review of tools and is seen as:

- Appropriate for use in any acute hospital within the UK, however the tool is not neuroscience specific.
• Used in conjunction with 9 Nurse Sensitive Indicators (NSI) (patient falls, infection rates, pressure ulcer incidence, patient safety incidents, non patient safety incidents, sickness, staff turnover, medication errors and complaints) which can all be linked to staffing.

• Able to support benchmarking activity in organisations when used across Trusts. This will assist in facilitating consistent nurse-to-patient ratios in line with agreed standards across similar care settings in England.

• It can be accessed on
  http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

6.1 Caution with the SNCT data

The SNCT should be used to assess patient dependency and acuity at least twice a year (results being presented at January and July board meetings, noting that there is no board in December). The model is very clear that decisions should not be taken on one set of data alone and that ideally trusts should have three sets of data before making significant changes to the workforce. The Trust has taken the approach to triangulate the SNCT information as previously described with Telfords, safe staffing alliance and nurse sensitive indicators to improve the reliability of the data – however where the information is conflicting the review has noted this and advised monitoring trend to inform the next 6 monthly review of those areas before any further staffing changes are recommended.

6.2 Evidence to support safe staffing ratios

There is a body of evidence (Rafferty et al, Griffiths et al 2013, Kane et al 2007, Needleman et al 2011, Ball et al 2012) to support the assertion that on general wards (including elderly care) during the daytime, a ratio of more than 8 patients per registered nurse (RN) significantly increases the risk of harm and constitutes a potential breach in patient safety. This ratio should not be viewed as an acceptable minimum but as an alert to potential patient safety concerns. This is referred to as the Safe Staffing Alliance Principle in the report.

For nurses to provide safe and compassionate care and treat patients with dignity and respect consistently; staffing levels should not breach the recommended 1:8 (trained nurse to patient ratio) for those areas applicable. Each clinical area should have its staffing
determined by experienced and knowledgeable senior nurses and within the WCFT expertise of the ward manager, matron and lead nurse for the area and Deputy Director of Nursing was utilised and approved by the Director of Nursing and Modernisation.

7. Report

The review for each ward brings together the SCNT information, Telfords (professional judgement), safe staffing alliance principles where appropriate and the clinical nurse indicators for November, followed by the recommendation.

7.1 Neurosurgical Wards

Cairns Review

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 150 general surgical wards. The acuity of neurosurgery patients was noted to be higher in May 2014, and although it was seen to be similar to general surgery wards in November 2014 (see table below) a decrease in staff numbers is not recommended until further acuity reviews have demonstrated this is a consistent change or not. The professional judgement model recognised in May 2014 an increase in need of HCA at night, this has been monitored over the past 6 months and its has been determined additional staffing for HCA on nights is not required based on current patient acuity.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Cairns (May 14)</th>
<th>Cairns (Nov 14)</th>
<th>150 General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>49%</td>
<td>70%</td>
<td>62%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>23%</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>27%</td>
<td>24%</td>
<td>22%</td>
</tr>
<tr>
<td>Level 2</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Level 3</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant/low harm with sickness being above the trust average.

Recommendation:
Following review the investment required is nil.
Review HCA requirements on nights at next acuity review

**Caton Review**

Following the analysis of the data from the staffing tool, SNCT notes that the ward has a similar number of trained staff and a higher number of support staff when compared with 150 general surgical wards. It should be noted that the acuity for Caton Ward patients has increased from the May 2014 two weeks measured, where acuity was lower than expected, and is now more in line with acuity expectations and higher than in the general surgical wards.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Caton (May 2014)</th>
<th>Caton (Nov 2014)</th>
<th>150 General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>87%</td>
<td>58%</td>
<td>62%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>10%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>3%</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Level 2</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Level 3</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant/low harm with the exception of two falls with minor harm. Sickness is below the trust average.

**Recommendation:**
Following review the investment required is nil

**Dott Review**

Following the analysis of the data from the staffing tool, SNCT recommends an increase in current RN staffing when compared with 150 general surgical wards. The acuity modelling demonstrates a higher level of acuity of patients which was also reflective of the period in May and may be seen as a consistent level of acuity. This is supported when using the Telford model of professional judgement. The professional judgement model recognised in
May 2014 an increase in need of HCA at night, this has been monitored over the past 6 months and its been determined additional staffing for HCA on nights is not required based on current patient acuity.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Dott (May 2014)</th>
<th>Dott (Nov 2014)</th>
<th>150 General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>61%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>9%</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>16%</td>
<td>38%</td>
<td>22%</td>
</tr>
<tr>
<td>Level 2</td>
<td>13%</td>
<td>0%</td>
<td>1%</td>
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<tr>
<td>Level 3</td>
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<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators show low harm with sickness above the trust average.

**Recommendation:**
Following budgetary realignment the investment required is nil

**Sherrington Review**

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 150 general surgical wards, however the acuity of neurosurgery patients was noted to be higher in May 2014 and a decrease is not recommended until further acuity review data can be captured and reviewed. This is supported when using the Telford model of professional judgement.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Sherrington (May 14)</th>
<th>Sherrington (Nov 12)</th>
<th>150 General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>44%</td>
<td>82%</td>
<td>62%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>28%</td>
<td>9%</td>
<td>15%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>28%</td>
<td>9%</td>
<td>22%</td>
</tr>
<tr>
<td>Level 2</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
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<tr>
<td>Level 3</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators identify low harm. Sickness is at the trust average.
Recommendation
Following budgetary realignment the investment required is nil.

7.2 Neurology Wards

Chavasse Review

Following the analysis of the data from the staffing tool, SNCT notes that staffing is higher when compared with 98 Neurology wards. Although the benchmark group used is based on neurology wards, these are spread across general hospital services and do not have the geography associated with Chavasse Ward. However both acuity reviews undertaken has demonstrated patients on Chavasse Ward were a lower dependency than expected and therefore caution in interpreting this data is needed. It is recommended that no change is made on this data and it will require further reviews to determine any change required (ref section 6.1). Chavasse Ward also has a telemetry facility on the ward which needs a higher proportion of support staff than on other neurology wards. The professional judgement model recommends the current level of RNs.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Chavasse (May 14)</th>
<th>Chavasse (Nov 14)</th>
<th>98 Neurology Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>75%</td>
<td>89%</td>
<td>31%</td>
</tr>
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<td>Level 1a</td>
<td>7%</td>
<td>6%</td>
<td>26%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>18%</td>
<td>5%</td>
<td>42%</td>
</tr>
<tr>
<td>Level 2</td>
<td>0%</td>
<td>0%</td>
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</tr>
<tr>
<td>Level 3</td>
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<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant harm with sickness at the trust average.

Recommendation
Following review the investment required is nil

Lipton Review
Following the analysis of the data from the staffing tool, SNCT notes that staffing is higher than compared with general rehabilitation wards. Although the benchmark group used is based on 26 neuro rehabilitation wards, these are across general hospital services and do not have the acuity or the specialised care requirements of patients that are seen on Lipton Ward as a specialist Trust. The table below identifies a significant increase in patient’s acuity on Lipton Ward over the two reviews when compared to other Neuro rehabilitation areas. This is supported when using the Telford model of professional judgement.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Lipton (May 14)</th>
<th>Lipton (Nov 14)</th>
<th>26 Neuro Rehab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>8%</td>
<td>69%</td>
<td>42%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>87%</td>
<td>31%</td>
<td>40%</td>
</tr>
<tr>
<td>Level 2</td>
<td>5%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Level 3</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
</tr>
</tbody>
</table>

The review identified current funded establishment meets safer staffing alliance principles. The nine nurse sensitive indicators indicate insignificant harm and there is currently no sickness on the ward.

**Recommendation**

Following review the investment required is nil.

**CRU Review**

Following the analysis of the data from the staffing tool, SNCT notes the ward has a higher number of staff when compared with 26 neuro rehabilitation wards, however the acuity of neurosurgery patients was noted to be significantly higher and a decrease is not recommended, furthermore these are spread across general hospital services and do not have the acuity of the patients on CRU as a specialist hospital. The table below identifies a significant increase in patient’s acuity on CRU when compared to other Neuro rehabilitation areas. This is supported when using the Telford model of professional judgement.

The last review agreed an increase in trained staff following the recognition of the increased acuity of the patients in the complex rehabilitation unit and it was noted that a further increase in HCA was likely to be required following a move to the new build. The new
facility has seen an increased need of HCA staff to provide cover for the 20 single room facility and wider foot print of the ward. The professional judgement model has also recognised an increase in need of HCA and this has been consolidated by the rehab networks professional opinion following review of the wards layout. This requirement and funding has been agreed as part of the development of the new facility. When the unit expands to 30 beds a further increase in staffing is required and the recruitment of these have been agreed as part of the wider preparation plans for CRU.

<table>
<thead>
<tr>
<th>Acuity</th>
<th>CRU (May 14)</th>
<th>CRU (Nov 14)</th>
<th>26 Neuro Rehab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Level 1a</td>
<td>0%</td>
<td>0%</td>
<td>42%</td>
</tr>
<tr>
<td>Level 1b</td>
<td>100%</td>
<td>100%</td>
<td>40%</td>
</tr>
<tr>
<td>Level 2</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Level 3</td>
<td>0%</td>
<td>0%</td>
<td>6%</td>
</tr>
</tbody>
</table>

The unit in the past did not have the level of patient acuity it now experiences which was demonstrated in the review to be a high dependency – it is therefore appropriate to benchmark this with acute wards safe staffing alliance principles. The nine nurse sensitive indicators indicate low harm and there is currently no sickness on the ward.

**Recommendation**

Following review the investment required is additional HCA however not trained staff in all shifts which has been agreed with the network appendix 2 details the new staffing numbers for the 20 bedded CRU in the new build.

8 Further Reviews

8.1 Clinical Coordinator/ANP Review

It was identified, following discussion in the Trust, that the Advanced Nurse Practitioner (ANP) and Clinical Coordinator (CC) roles were not functioning as anticipated when the roles were developed and a review was requested to identify what was successful and what required adjustment.
The job descriptions currently held by the post holders within these roles were circulated and comments on how the roles are working were requested from MDT stakeholders. A series of focus groups were also held which provided an opportunity for the roles to be discussed and a review of how well they were functioning to be undertaken. Good representation from all clinical professions, specialties and grades provided a comprehensive discussion around the roles, and further sessions were held with senior medical staff so that recommendations could be made.

It was agreed from all the focus groups that the role of the Clinical Coordinator whilst adding some value was not fulfilling the requirements of the Trust as it is designed currently and needed to be changed. The Advanced Nurse Practitioner Role was generally working however not consistent in all areas, and speciality specific requirements changed the roles which caused some confusion. There was also a lack of clarity from some in relation to the ANP teams associate specialist nurse roles too.

Recommendations made:

**For Clinical Coordinator Role**

- Explore development of a standalone Night sister role.
- Development of a new role, or adaption of current roles and responsibilities within existing staff to support inpatient care at ward level
- This would require further training

**For ANP Roles**

- ANP posts should be developed and job planned to provide support at ward level as part of a structured team that are integrated with the medical teams approach

Following on from these recommendations has seen a wider middle grade review undertaken and a further business case will be developed to support the changes required to cover middle grade capacity gaps.
9 Overall Recommendations

The Director of Nursing and Modernisation and Deputy Director of Nursing acknowledge the findings and recommend that the Trust Board continues to staff the wards to the current levels, with the exception of CRU, where increased staffing has already been identified as required and funding agreed. They note that no concerns have been raised from the results of the nurse sensitive indicators or from patient feedback on the patient’s experience at the Trust with the current establishments. Nurse shift patterns and nurse to patient ratios are identified in appendix 2.

The review has identified on some wards the need to continue to monitor HCA usage at night over the coming months as recent or previous usage has been higher, this will inform the next review and determine whether this is a trend that requires additional staffing for HCA on nights or not in relation to demands on specialling.

The wider middle grade review which will be undertaken may have effects on the ward staffing requirements and may support higher patient acuity on surgical wards in the future. It is suggested the changes are taken into account in future reviews.

Following the release of NICE guidance on nurse staffing for acute trusts last year and the recommendation of ‘red flags’ to support acuity reviews and safe staffing the Professional Nursing Forum have agreed the approach within the Trust and these will be included to add further depth and triangulation to future biannual staffing reviews.

The Director of Nursing and the Director of Finance with the executive team have been working together to ensure the investments in posts following the May acuity review have appropriate financial support and this information will be detailed in the financial reports.

10 References


Francis, R (2013) the Mid Staffordshire NHS Foundation Trust Public Inquiry, London


Keogh, B., (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England

National Quality Board 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.


Royal College of Nursing, making the business case for ward sisters / team leaders to be supervisory to practice, (2010), RCN, London


Appendix 1.

**SNCT Classification System** (for scoring patient’s care level)

**Level 0**: requires hospitalisation and needs met by providing normal ward care. Care requirements may include:
- Elective medical or surgical admission – e.g. routine micro disc
- May have underlying medical condition requiring on-going treatment
- Patients awaiting discharge
- Post-operative/post-procedure care – observations recorded half-hourly initially then four-hourly.
- Two to four hourly observations
- Early Warning Score is within normal threshold.
- Fluid management
- Oxygen therapy less than 35%
- PCA
- Confused patients not at risk, (pleasantly confused)
- Patients requiring assistance with some daily living activities requiring one person to mobilise, or one experiencing occasional incontinence

**Level 1a**: Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate. Care requirements may include:
- Increased observation and therapeutic interventions
- Early Warning Score – trigger point reached and requiring escalation
- ECG monitoring
- Post-operative care following complex surgery
- Emergency admissions requiring immediate therapeutic intervention
- Instability requiring continual observation/invasive monitoring
- Oxygen therapy greater than 35% +/-; chest physiotherapy two to six hourly
- Arterial blood gas analysis – intermittent
- Twenty-four hours after tracheostomy or extra ventricular drains, lumber drains
- Severe infection or sepsis
- Pain Control – titration regime
Level 1b: Patients are stable but are dependent on nurses to meet most or all daily living activities. Care requirements may include:

- Complex wound management requiring more than one nurse or takes more than one hour to complete.
- VAC therapy where ward-based nurses undertake the treatment
- Patients with spinal instability/spinal cord injury
- Mobility or repositioning difficulties requiring two carers or more
- Complex intravenous drug regimens – including those requiring prolonged preparatory/administration/post-administration care. e.g. ketamine
- Patient and/or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome.
- Patients on end-of-life care pathway
- Confused patients who are at risk or requiring constant supervision
- Requires assistance with most or all daily living activities
- Potential for self-harm and requires constant observation
- Facilitating a complex discharge where this is the ward nurse’s responsibility

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit. Care requirements may include:

- Deteriorating/compromised single organ system
- Post-operative optimisation (pre-op invasive monitoring)/extended post-op care
- Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure
- First 24 hours following tracheostomy
- Requires several therapeutic interventions including:
  - Greater than 50% oxygen continuously
  - Continuous cardiac monitoring and invasive pressure monitoring
  - Drug infusions requiring more intensive monitoring; e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium, pain management – intra-thecal analgesia
- CNS depressed airway and protective reflexes
- Invasive neurological monitoring

Level 3: Patients needing advanced respiratory support and/or therapeutic support of multiple organs. Care requirements may include:

- Monitoring and therapy for compromised/collapse involving two or more organ/systems
- Respiratory or CNS depression/compromise requires mechanical/invasive ventilation
## Appendix 2.

### Professional Judgement - Ward Staffing Establishments

<table>
<thead>
<tr>
<th></th>
<th>Early</th>
<th>Late</th>
<th>Night</th>
<th>Trained Nurse to patient ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Sat - Sun</td>
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