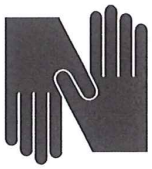
SKILL-MIX AND STAFFING IN CHILDREN'S WARDS AND DEPARTMENTS



Royal College of Nursing

Guidance for clinical professionals and managers who are responsible for children's services in acute settings

SKILL-MIX AND STAFFING IN CHILDREN'S WARDS AND DEPARTMENTS

Contents

The RCN Paediatric Nurse Manager's Forum exists to support all nurses working with children in a supervisory or managerial capacity and is particularly aimed at those at G grade or above with continuing responsibility for care.

This document has been written by the RCN Paediatric Nurse Manager's Forum in response to numerous enquiries from both members and non-nursing managers of children's services who have frequently approached the Royal College of Nursing for help and advice in the staffing and organisation of the nursing workforce.

It is designed as a checklist to be used when considering staffing paediatric areas to support the delivery of a high quality service to children. It is based on the experiences of members from the Paediatric Nurse Manager's Forum and perceived best practice within the profession and the available literature. It is aimed at all clinical professionals and managers with responsibility for children's services in any acute setting.

It is a dynamic document, which we hope to update, amend and expand. However, it is not intended to be in any way prescriptive – rather to stimulate thought, discussion and inform local assessment of need. It offers a guide to the principles to be borne in mind when addressing nurse-staffing issues.

Members of the Forum Steering Committee can be contacted through the RCN (address on back page). Comments and contributions are welcomed on this document and other children's nursing and services issues.

Background

The Department of Health in England and Wales' (DoH) document, *The Welfare of Children and Young People in Hospital*, states: "Flexibility is required in defining childhood. It is generally accepted that children have distinctive health needs until school leaving age (up to age 19) and that adolescents deserve particular attention. In some instances – e.g. chronic sickness or disability – the transition to adult requires close co-operation between children's' departments and other specialities" [1].

And the DoH's document, *Child Health in the Community*, says: "The purpose of health services for children is to enable as many children as possible to reach adulthood with their potential uncompromised by illness, environmental hazard or unhealthy life style" [2].

The care for sick children in an acute setting has developed in recent years prompting reviews of the nursing and staffing structures. As so little up to date literature is available, the RCN is frequently asked to advise on typical staffing levels and skill mix.

The most commonly raised enquiries include questions on:

- unification and reconfiguration of children's services
- the development of ambulatory paediatrics
- increased day care and other short stay admissions
- higher in-patient acuity
- changes in medical staffing
- developing services, for instance adolescents and children's mental health
- expanding nursing roles
- more inter-agency and cross service work to meet the growing needs of children with continuing complex care
- changing role for families in partnership with health service providers in the acute and community setting
- financial pressures.

Principles

Any changes to nursing skill-mix or staffing must take account of recommendations and guidance from the available literature. It is recommended that as part of any workforce review, the following references and quoted documents are read and noted.

- The failure to implement guidance on good practice is a serious impediment to the improvement in the quality of hospital services for children and young people [3].
- "The importance of the special needs of children must be recognised not only by policy makers in government but also by managers and professionals on the ground" [4] [5] [13].
- Children should receive specialist-nursing services managed and supervised by and professionally accountable to a senior children's trained nurse [1] [6] [13].
- A minimum of two registered children's nurses on duty 24 hours in all children' s wards and departments [1] [6].
- There is a registered children's nurse available 24 hours a day to advise on the nursing of children in other departments, for instance intensive care units, A & E and outpatient departments [1] [6].
- The planning of children's services encompasses the views of consumers, children, family and carers [7] [13].
- Children's psychological and physiological needs differ from those of adults and need to be considered in decisions concerning staffing [6] [13].
- Involving parents in care involves special skills in teaching and supporting [6] [13].
- The UN Convention on the Rights of the Child [8].
- The UKCC Code of Professional Practice [9].
- The commissioning of services takes heed of the special needs of children and their families' [10].
- The Children's Acts. [11]
- A high quality service has been proven to need highly qualified and competent professional nurses working within a stimulating research based environment with an emphasis on life long learning opportunities.[12]
- The recommendation for an acute paediatric unit is that the minimum ratio of qualified to unqualified staff is 70:30.

Factors to be considered in nursing workforce reviews

You will need to gather information, within the categories described here.

The political environment

This influences the development of child health services at national, regional and local level. Consider the following:

- How are child health services commissioned?
- Within the locality know your 'champions' and supporters of child health services, for example, community health councils, health authorities.
- Where is child health placed within the trust strategy and priorities?
- How are child health services commissioned?
- What are the local implications of the formation of primary care groups – and their equivalents in Wales, Scotland and Northern Ireland – local health improvement programmes and any service agreements on the commissioning for children's services?

Human resources

This supports the dynamic workforce planning

strategy and is reactive to changes in professional roles, expectations, responsibilities and service developments. Look at:

- Your knowledge and the flexibility of the staff budget.
- Local staff turnover and trends.
- Developments which may influence future staffing structures.
- Roles and responsibilities, including multi-skilling options.
- Undertaking a workforce analysis to determine appropriate qualified to unqualified staffing ratios.
- Impact of the preceptorship period for newly qualified staff.
- Impact of clinical supervision.
- Vacancy factors.
- Local recruitment factors.
- Impact of mandatory training requirements for all staff.
- Impact of sickness levels and maternity leave on staffing requirements.

Working patterns

This should support the efficient use of resources, creating the flexibility to improve recruitment and retention of nursing staff. Issues to examine include:

- Flexible rostering, such as annualised hours, to meet the peaks and troughs in activity.
- Staffing to meet the 24 hour care needs with an acceptable skill mix.
- Family-friendly policies to meet the needs of staff. The unit should consider employment of part-time, job share and variable shift patterns.

Activity and service levels

This identifies the dimensions of the service to be sustained. Consider:

- Finished consultant episodes.
- Case-mix.
- Nursing dependency levels.
- Contract income.
- Your health authority's strategic service priorities.
- Trust strategic priorities.
- Directorate development plans.
- Demographic and epidemiological trends.
- Possible re-configuration of services.
- Activity levels.
- Length of stay.

Learning Environment

This should support education and training for students and trained staff. Look at:

- Student allocation – rostered or supernumerary placements'
- Numbers of students allocated with differing learning outcomes to be met.
- Preceptorship for newly qualified staff.
- Delivery of mandatory training.
- Post Registration Education and Practice (PREP) requirements.
- Education and training development to meet role expectation and to support development of new roles related to service development.
- Continuing education and life long learning
- Induction and orientation programme.
- Provision of clinical supervision and support for trained staff.

Clinical Grading and Pay Structure

- Staff should be graded in accordance with the national clinical grading criteria.

Safety issues

The aim is to create a safe and secure environment for children, families and staff. Look at:

- The Clothier Report recommendations in relation to recruitment policies, for example, police checks and occupational health checks [6].
- Critical incident reporting.
- Risk management and complaints policy.
- Use of bank and agency staff.
- Health and safety environment audits.

And finally, you should ensure that any decisions made from the review undertaken are supported within the principles of this document.

Nursing workforce planning

Unfortunately there is no single formula available for assessing staffing of a typical children's ward, although some methods have been documented many of which have been tried, with varying success, in children's wards. Moreover, there is no such thing as a 'typical children's ward' and so many factors vary that a local system will need to be developed. The following four techniques have been found to be the most successful and here we look at their advantages and disadvantages:

Professional judgement method

This estimates the staffing numbers and skill-mix required in relation to the number of beds available and the anticipated activity. Calculations are based on the senior clinical and managerial staffs' previous experience and knowledge.

The advantages are that it:

- is based on knowledge of existing working patterns, the skills and expertise of staff and anticipated case-mix
- takes into account the dependency of children
- appreciates anticipated changes in local practices
- is well accepted within the paediatric team
- is quick, simple, and inexpensive to use
- is easy to update
- means developments and changes can be easily incorporated.

The disadvantages are that it is:

- not supported by current research studies
- not scientifically credible
- difficult to demonstrate methodology
- not supported by child and family dependency or activity analysis
- subjective.

Nurses per occupied bed

Here staff-to-patient ratios are derived from actual staffing levels, using historical or live nursing data judged to be satisfactory. For instance, in paediatrics, historical regional figures may suggest that a children's unit requires a higher ratio of nurses than a comparable adult unit, whilst high dependency areas require even more nursing staff.

The advantages are:

- the methodology is accepted as credible by some
- it is reassuring to both less experienced nurse managers and staff at ward level, who know that their ward is staffed according to regional 'norms'.

The disadvantages are:

- no consideration is given to local service provision or individual ward structures and facilities
- it is not supported by child and dependency studies
- there is no demonstrable methodology
- patient dependency is not reflected in the formula.

Dependency and activity analysis

This is a measurement tool which balances the available nursing hours with the required ones. It is weighted according to the amount of nursing time – direct and indirect – required to care for children with varying degrees of need, for instance, theatre days or 'on take' periods.

The advantages are:

- nurses feel part of the process
- it uses clearly demonstrable methodologies
- nurses have ownership of the results
- it is robust, flexible and adaptable.

The disadvantages are that it:

- requires considerable time and effort from the nursing team
- is difficult to reflect time for psychological care
- can fail to reflect daily, weekly and seasonal fluctuations in workload
- can mask important differences in individual patients
- is not able to respond quickly enough to changes in the condition of patients
- needs constant revalidation for credibility
- is usually a retrospective view.

Timed nursing interventions

This is a method which measures the frequency of nursing interventions. Each patient's direct care nursing needs for the day are recorded on a locally developed intervention checklist. Next each intervention is matched with a locally agreed time. An allowance is made for indirect care and rest time.

The advantages are:

- it is less time-consuming than activity and dependency analysis.
- timed interventions can easily be updated
- it can be transferred to other care settings.

The disadvantages are:

- the check list can be arduous to complete
- it reduces the holistic nature of nursing care to individual tasks.

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July 1999

Published by the Royal College of Nursing,
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