

**ST BRENDAN'S HOSPITAL
Dublin**

Report of the Review of Nursing Staff Levels

February 1997

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**ST BRENDAN'S HOSPITAL
Dublin**

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**Report of the Review
of Nursing Staff Levels**

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CONTENTS

		Page
1	INTRODUCTION	1
1.1	Background to the Review	1
1.2	Beds and Services Managed by St Brendan's Hospital	1-3
1.3	Synopsis of the Report	3
2	APPROACH TO THE REVIEW AND METHODOLOGY	4
2.1	Programme Phases of the Review	4
2.2	Determination of Approach to the Review	4
2.3	Objectives of the Review	5-6
2.4	Preparation and Completion of the Survey	6
3	ASSESSMENT OF WORKLOAD	7
3.1	Historical Determination of Establishment	7
3.2	General Description of the Nursing Workforce Study	8
3.3	Approach	8
3.4	The Study	11
3.5	Limitations of the Study Design	11
3.6	Design	11-13
3.7	Acuity	13
3.8	Learner Nurses	13-14
3.9	Recommendations for Staffing, Grade Mix and Distribution by Unit	14
3.10	Safe Numbers	16
3.11	Annual Leave , Sickness and Other Absence	16

CONTENTS - continued

	Page
4 WORKFORCE PLAN BY SPECIALTY	17
4.1 Introduction	17
4.2 Comments and Recommendations for Acute Care Wards	18-19
4.3 Comments and Recommendations for the Special Care Wards	21
4.4 Comments and Recommendations for the Long Stay Mobile Psychiatric Care Wards	23
4.5 Comments and Recommendations for the Elderly Mentally Infirm Wards	25
4.6 Comments and Recommendations for Rehabilitation and Hostel Care	27-28
4.7 Comments and Recommendations for Day Care	29
5 IMPROVING THE DELIVERY OF NURSING CARE	31
5.1 Making Nursing Care more Patient Focussed	31
5.2 Approach to the Organisation of Nursing Care	31-32
5.3 Continuity of Care	32-33
5.4 The Shift Pattern	33-34
5.5 Care Planning	34-35
5.6 Confinement	35
5.7 Environmental Factors	36
5.8 Opportunities for Patient Activity	37-38
5.9 Assessment of the Quality of Patient Care	38

CONTENTS - continued

	Page
6 DEVELOPING CLINICAL SKILLS	39
6.1 Training and Education	39
6.2 In-Service Training	39
6.3 Post Registration Education	40
6.4 Training and Education Survey	41
A) Qualifications	41
B) Psychiatric Nursing Careers	41
C) Experience of In- Service Training	42
D) Experience of Post Registration Education	42
E) Identified Training and Education Needs	43
6.5 Commentary regarding Training and Education	44-46
6.6 Multidisciplinary Teamwork and Learning in the Clinical Setting	46
7 MANAGEMENT OF NURSING SERVICES	47
7.1 Senior Nursing Management and the Central Nursing Office	47
7.2 Nursing Officers and Unit Management	48-49
7.3 Flexibility of the Nursing Establishment	49
8 RECOMMENDATIONS	50-52
References	53
List of Appendices at commencement of tabulated section.	

LIST OF FIGURES, TABLES AND GRAPHS

	Page
 FIGURES	
Figure 1	Major factors influencing Nurse Staffing Requirements 5
 TABLES	
Table 1	Bed complement of Wards, Hostels and Homes by Specialty 9-10
Table 2	The Mental Health Care-Timings per Occupied Bed used in St Brendan's Hospital Workforce Plan 13
Table 3	Workforce Plan - Acute Psychiatric Care Wards 18
Table 4	Workforce Plan - Special Care Wards (ICU) 20
Table 5	Workforce Plan - Long Stay Mobile Psychiatric Care Wards 22
Table 6	Workforce Plan - Elderly Mentally Infirm Wards 24
Table 7	Workforce Plan - Rehabilitation and Hostel Care 26
 GRAPHS	
Graphs 1 - 5	Staff per Bed in each Ward/Hostel/Home during the week of the Survey 15

REVIEW OF NURSE STAFFING LEVELS AT ST BRENDAN'S HOSPITAL

1 INTRODUCTION

1.1 Background to the Review

On 12 February 1996, under the auspices of the Labour Relations Commission (cc 94 - 487), an agreement was reached to review the nurse staffing levels at St Brendan's Hospital. The parties to the agreement were the Eastern Health Board (EHB) and representatives of the Psychiatric Nurses Association (PNA) and the Service Industrial Professional Technical Union (SIPTU).

Subsequently we were invited to undertake the Review, the Terms of Reference being

“ To investigate and make recommendations regarding nursing levels required at St Brendan's Hospital.”

On 22 July 1996 we met representatives of the Board and St Brendan's Hospital and, on 31 July 1996, full time officers and local representatives of the staff organisations. Following these meetings we put forward our proposed approach to the Review and, with the agreement of all parties, commenced work on 12 August 1996.

We would like to record our thanks for the high level of co-operation we received from all parties to the agreement and especially the staff of St Brendan's Hospital who assisted in all aspects of the Review. The approach we adopted was entirely of our own design and was based upon the needs we identified during the initial fact-finding phase. At no time was the independence of our review challenged or compromised.

1.2 Beds and Services Managed by St Brendan's Hospital

Until 1986 St Brendan's Hospital was a large psychiatric hospital of 987 in-patient beds. The Eastern Health Board¹ records that, as a result of Service Development towards a Community-Based Adult Psychiatric Service, the number of beds, on site, reduced to 385 by 1990. The hospital now manages 401 beds or placements (250 on the main campus, 40 on other hospital sites and 101 in community settings). Nursing staff are also provided, from the establishment, for Mount Pleasant, a 10 bedded hostel managed by another Sector. In addition the hospital manages a Day Centre for the Homeless and Occupational and Industrial Therapy Services.

¹ Refer to page 53

The 250 beds available on the hospital campus are currently constituted as follows:-

Admission Units x 2	67
Assessment Unit	8
Special Care Units x 4	54
Rehabilitation Unit x 1	20
Long Stay x 4 (including Homeless Service)	71
Elderly Mentally Infirm x 1	30
Day Service for the Homeless x 1	--
Total	<u>250 beds</u>

The Hospital manages further in-patient services for the Elderly Mentally Infirm as follows:-

Unit 5, Cherry Orchard Hospital	25
Unit 10, James Connolly Memorial Hospital	15
Total	<u>40 beds</u>

In addition the hospital manages the following High Support Hostels in community settings:-

1 - 5 Grangegorman Villas	10
264/266 North Circular Road	18
1 - 5 Orchard View	18
Adare House	11
Weir Home	30
San Remo	14
Total	<u>101 places</u>

Staff from Orchard View provide oversight of 26-29 Stanhope Terrace, a further 8 place hostel supervised by house parents.

The Industrial / Occupational Therapy Department which is managed and staffed by nurses at St Brendan's Hospital has an average daily attendance of about 90.

The hospital currently provides acute in-patient services for the Finglas and Cabra Sectors of Area 6, a population of about 80000.

In 1995 there were a total of 1142 admissions and 1161 discharges. These were comprised of 992 voluntary and 150 involuntary admissions. Although there were approximately 200 more admissions on each of the years 1993 and 1994 the proportions of voluntary and involuntary admissions remained similar to 1995.

Published plans¹ for the alternative provision of acute in-patient services will effect a reduction to 200 beds on site at St Brendan's Hospital.

The budget allocation for St Brendan's Hospital for 1996/97 is £ 10.694m (pay £8.472m and non-pay £2.222m.)

1.3 Synopsis of the Report

Section 2 of the Report describes the overall approach to the Review and the process of information gathering and data collection. It then sets out the main factors determining nurse staffing requirements at St Brendan's Hospital and how these influenced the Review Objectives.

Section 3 considers how the nursing establishment has previously been agreed and managed and then describes the approach to the assessment of the nursing workload. It includes an account of the Units and bed usage current at the time of the Review. This Section also considers the role of Student Nurses and a range of organisational issues which affect the nursing workload and nursing availability.

Section 4 provides a Workforce Plan relating to each specialty and summarises the nurse staffing recommendations arising from the Review.

Section 5 focuses upon the delivery of nursing care. It reviews current practice at the hospital and describes ways and means by which nursing care could be enhanced.

Section 6 considers the importance of training and education in ensuring the effectiveness of nurses. It addresses the need to improve clinical skills in order to meet the challenges of a changing and increasingly specialist service.

Section 7 reviews the current arrangements for the management of nursing services and makes proposals for improved assessment of nursing effectiveness. Opportunities are explored for devolving responsibility to Unit level for decisions on matters directly influencing patient care.

Finally Section 8 provides a range of recommendations linked contextually to the Report.

¹ Refer to page 53

2 APPROACH TO THE REVIEW AND METHODOLOGY

2.1 Programme Phases of the Review

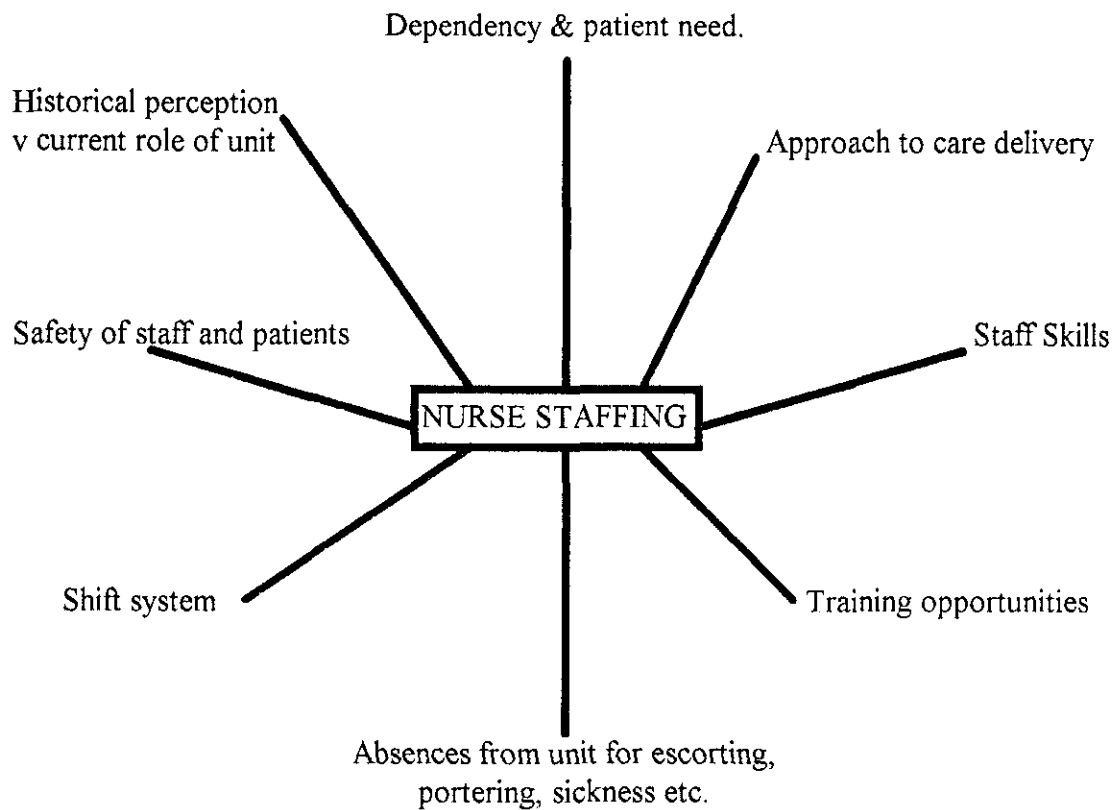
The process of obtaining background information and data collection was completed over three periods. These were

- 12 - 16 August 1996 - Meetings with management and staff representatives
- Visits to Units to obtain a profile of role and activity
- 14 - 18 October 1996 - Meetings with management and staff representatives
- Piloting of research instruments and data collection forms on 7 Units representative of the range of services managed by the hospital.
- 4 - 5 November 1996 - Meetings with managers and staff representatives
Meetings with Nursing Officers (or deputies) to explain the full study.
- 6 - 13 November - Completion of full study
- Final meetings with management and staff representatives

2.2 Determination of Approach to the Review

The desire of all parties to complete the Review as speedily as possible inevitably determined the approach. However, we recognised that the exercise could only be successful if the process was thorough and that our conclusions were based upon sound evidence. It was determined to use the initial information gathering phase not only to obtain profiles of each Unit but also to assess the main factors which determine nurse staffing requirements at St Brendan's Hospital and its' associated services. The range of influencing factors identified is illustrated in Figure 1.

Figure 1 Major factors influencing Nurse Staffing Requirements



2.3 Objectives of the Review

At the commencement of the Review it was recommended to all parties that, following the initial exploratory phase, a more detailed set of objectives would be determined. The identified influencing factors illustrated in Figure 1 were used as the basis for setting these objectives. The purpose of this step was to ensure clarity regarding the approach being adopted and to provide the opportunity to discuss any matters which were unclear or required expansion or amendment following debate. The objectives were made available prior to the second period of the Review and were adopted unamended. These were as follows:-

- i. To agree and apply a simple method of assessing dependency and patient need. This method may vary between specialities and could serve as an ongoing tool for assessing variations over time.
- ii. To assess the main factors supporting or preventing individualised patient care.

- iii. To assess skill requirements which will enhance nursing effectiveness.
- iv. To assess training opportunities and uptake for an agreed sample of nurses.
- v. To measure levels of staff absence from Units (for escorting, portering, sickness, 39 hour agreement, off-ward training activity), and the impact upon patient care.
- vi. To assess, for each Unit, safe (not optimum) levels of staffing to be maintained by day and by night.
- vii. To analyse levels of sickness/absence.

2.4 Preparation and Completion of the Survey

During the second period of the Review, whilst the research instruments and data collection forms were being devised and tested, the emerging approach was shared with management and staff representatives, as well as the participating staff on the seven pilot units. Criteria were tested and formulated.

From the information received and the feedback from staff, a range of alternative criteria were developed and adapted to identify patient need within the following areas:-

- i Acute Psychiatry,
- ii Special Care,
- iii Long Stay Mobile Patients,
- iv Elderly Mentally Infirm,
- v Rehabilitation and High Support Hostel Care,
- vi Day Care Services for the Homeless.

From Wednesday 6 November to Tuesday 13 November 1996 the full survey was completed, using the tried and tested survey instruments. Therefore the period of the study spanned a weekend and included parts of two working weeks.

3 ASSESSMENT OF WORKLOAD

3.1 Historical Determination of Establishment

The Nursing Establishment at St Brendan's Hospital has been largely determined on an historical basis, the basic complement having been agreed some years ago. No major review of this kind has previously taken place and therefore perceptions of nurse staffing requirements have remained largely static. Both the number of posts and grades has been determined and agreed with the Programme Manager and appointments to these posts are organised by the Personnel Department of the Eastern Health Board with hospital representation on the appointment panels.

The annual budget to meet the agreed establishment is provided within the overall hospital budget but the Chief Nursing Officer, who has responsibility for management of the nursing service, does not receive financial information on a regular basis during the year in order that he may manage the budget as well as the establishment. Therefore determination and management of the establishment remains centralised within the Board and this reduces the opportunity for flexible management within an agreed and monitored budget. The Chief Nursing Officer is therefore able to allocate agreed posts as he perceives demand but he is hampered in adopting solutions which might aid a more flexible approach.

One of the effects of working to an historical establishment is that staffing requirements within the hospital may also be perceived on an historical basis. In other words, when the overall establishment is distributed around the hospitals' units, decisions are based upon historical perceptions of workload which may remain unchanged and unchallenged for very long periods. The lack of a systematic approach to workload measurement system adds to the likelihood of stasis and this proves frustrating to Nursing Officers when they are acutely aware of the changing demands of the patient population. Workload may change over time, examples being:-

- Patients being prepared for rehabilitation to community care requiring higher levels of intervention and support.
- Increasing frailty of elderly residents or patients in hospital or community settings
- Trends in admissions such as higher throughput of patients with acute needs
- Dangerous or collusive behaviour.

3.2 General Description of the Nursing Workforce Study

Nurse Staffing is a complex issue and no single aspect can be considered in isolation. Hirsh (1986,²) says “..... that nursing workforce planning is concerned with three main issues:-

- i Decisions about the ideal size and mix of nursing teams;
- ii Nursing education, recruitment and career development issues;
and
- iii Questions about the effective deployment of nurses to provide quality patient-focused care.”

This definition captures the essence of nursing workforce planning which is, perhaps, one of the most important and demanding management tasks to be undertaken in order to develop a way forward within today’s Health Service in Ireland.

3.3 Approach

In order to assess the nursing workforce needed in St Brendan’s Hospital, Hostels and Homes it was decided to survey all twenty three wards and units.

² Refer to page

Table No 1 Bed Complement of Wards, Hostels and Homes by Specialty

1 Acute Psychiatric Care

- 3A. Male Admission Ward, 30 beds. Approximately 8* Acute Beds; remainder occupied by Long Stay Mobile Patients.
- 3B. Female Admission Ward, 37 beds. Approximately 18* Acute Beds; remainder occupied by Long Stay Mobile Patients.
- Assessment Unit. 8 beds for initial assessment before transfer within the hospital. Approximately 4* beds used for assessment; remainder occupied by Long Stay Mobile Patients.

* Approximate Acute usage at the time of the Review

2 Special Care

- 8A Male Patients, 13 beds + 3 rooms
- 8B Male Patients, 13 beds + 3 rooms.
- Unit O Female Patients, 15 beds + 2 rooms
- Unit R Female Patients, 13 beds + 4 rooms.
- NB Additional rooms designated for use as seclusion areas; not designed or suitable for regular occupancy.

3 Long Stay - Mobile Patients

- 1A Male Patients, 14 beds.
- 2A Male Patients, 17 beds.
- 23A Female Patients, 24 beds.

In-patient Unit for Homeless Male Patients, 16 beds 2 of which are designated as Acute Beds.

Table No 1 - continued

4 Elderly Mentally Infirm

10B	Approximately 21 Male and 9 Female Patients, 30 beds.
Unit 10	James Connolly Memorial Hospital, Male Patients, 15 beds.
Ward 5	Cherry Orchard Hospital, Female Patients, 25 beds.

5 Rehabilitation and High Support Hostels

Ward 23	10 Male and 10 Female Patients, 20 beds.
---------	--

High Support Hostels:

Weir Home	30 Male Residents
San Remo	14 Male and Female Residents
Adare House	11 Males and Female Residents
264/266 North Circular Road	18 Male and Female Residents (elderly)
Grangegorman Villas	10 Male and Female Residents including 2 in lower support
Orchard View	18 Male and Female Residents

6 Day Care

Day Centre for the Homeless with approximately 45 Male Daily Attendees.

Occupational/Industrial Therapy approximately 86-90 Daily Attendees.
30% from Home, 56% from Hostels, 14% from the Hospital Wards.

3.4 The Study

Patient dependency was chosen as the method of workload-measurement together with nursing care timings taken from studies carried out in Mental Health Care Settings in Northern Ireland and the United Kingdom.

Patient dependency is a 'bottom up' approach to calculating the number of staff needed to nurse a group of patients according to their illness or frailty. It is sometimes referred to as a 'patient demand' system. In the past, hospital and nursing managers made a guesstimate of the staff needed according to the number of beds in each ward, with some consideration given to the type or speciality of the ward. This was known as the 'top-down' approach.

3.5 Limitations of the Study Design

The timescale of the Review would not allow for patient dependency patterns to be properly established. These patterns are usually agreed after at least six months daily recording of each patient's dependency levels. Local care-timings are established after a full-scale nursing activity analysis which involves a 7 day study for 24 hours per day, by non-participant observers. The following study design was therefore agreed upon.

3.6 Design

The dependency classification was based upon the 'Criteria for Care' model (Ball and Goldstone, 1986)³ but each ward was asked, in a preliminary survey, to identify and prioritise the key clinical indicators relevant to their particular patient group. After the dependency descriptions were written a pilot study was conducted on seven wards to allow for minor refinements of the survey instrument. Then, during the study, the nurses classified patients into each of the dependency levels according to their dependence on nursing care and support. A separate dependency criteria was produced for each of the six clinical areas of care (see Table 1, pages 9-10). This approach was particularly necessary in the Day Centre for the Homeless where there is no known existing dependency model.

Each Ward, Hostel and Home was surveyed twice during the seven day long study. At the same time a record was made of the staff available to each Ward, Hostel and Home. Also an assessment of staff required was made by professional judgement. Included in those assessments were any factors which made extra demands on the staff thereby reducing the normal levels of nursing staff available. These were :-

- Patients who required to be 'specialised'; that is prescribed, individual, constant observation and care by one nurse. For their protection, or the protection of others, patients may require constant observation within the ward or whilst in seclusion.

³ Refer to page 53

- Patients who required nurse escorts. Escorting may be necessary in order to accompany a patient for transfer to another hospital or for out-patient treatment. Sometimes more than one escorting nurse may be required and absences may be from one hour to a whole day or night.
- Staff borrowed by or lent to wards.
- Staff who had time off for the 39 hour week. (See Section 5.4)
- Staff away because of training/education.
- Staff sent off wards to pick up supplies etc.

The effect of these absences, or alternative duties, is to reduce the availability of rostered staff. Where only two staff are rostered to a Unit this creates a dilemma as it would be unsafe to leave the remaining patients in the care of one nurse. Equally in a Special Care or Admission Unit although more staff may be rostered, unsafe staffing levels may occur due to the unscheduled absence.

It is acknowledged that, while the above study design is perfectly adequate for the purposes of this survey, a word of caution must be voiced if it were to be used for generalisation to other hospitals or services. Recognised validation and reliability studies would be required.

Fawcett (1985)⁴ calls the dependency method the 'bottom-up' approach to workforce planning because the recommended number and grade mix of nurses required is based upon patient and nursing information gathered at the bedside. Dependency ratings alone are of little use for deciding staffing levels without pairing each dependency level to nursing care timings. It is then a simple matter to work out the total nursing hours required by each Unit and compare them with the total nursing hours available.

A real issue for this study was that there were no local care-timings available within Mental Health Nursing, therefore historical care-timings were used (See Table 2). These had been collected in extensive studies carried out in recent years, in Psychiatric Hospitals in the United Kingdom and Northern Ireland (Hurst and Howard 1988)⁵, (Hurst and Quinn 1992)⁶, (Owens and Hurst 1991)⁷. Their appropriateness to this study was evaluated in two ways.

1. By comparing the acuity levels on each Unit at St Brendans and the acuity levels recorded in similar wards of the published studies.

⁴ Refer to page 53

⁵

⁶

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2. By correlating the number of ward staff quoted in the published studies with the estimated staff requirement made by nursing staffs' professional judgement, in each Unit of St Brendan's. The correlation proved to be between 0.7 and 0.8, which was deemed acceptable.

3.7 Acuity

Means the average workload per occupied bed used as a performance or a nursing demand indicator.

Table No. 2 The Mental Health Care-Timings per occupied bed used in St Brendan's Hospital Workforce Plan.

Speciality	Staff per occupied bed
Acute Psychiatric Care	0.72
Special Care (ICU)	0.99
Long Stay Mobile	0.46
Elderly Mentally Infirm	0.65
Rehabilitation	0.64
Hostel Care	0.44

Please note 19.2% weighting allowance should be added to each Care-Timing to achieve the number of wholtime equivalent

3.8 Learner Nurses

The planned changes in nursing education will have a dramatic effect on nursing work-force planning. A nurse learner will change from a care-giver to a care-observer and will be supernumerary to the members of the nursing team. Research shows that 60% of traditional learner-nurses' clinical time is spent in giving direct patient care (Ball et al 1989)⁸. It is difficult to estimate exactly how traditional learner-nurses should be evaluated. Storey and Bell (1985)⁹ for example, recognise:

- i That learners, at different stages of training contribute different amounts of patient care;
- ii The uneven flow of learners sometimes makes predicting their contribution difficult;
and
- iii The mix of learners adds a further difficulty to calculating their contribution to staffing.

⁸ Refer to page 53

⁹

During the survey there appeared to be an erratic distribution of learners, as well as a mix of general student nurses and psychiatric student nurses. In view of the impending change in status of the student nurses within the clinical setting, their inclusion in the workforce plan during this study was to consider the psychiatric student nurses as additional unqualified staff members, to complete the numbers in the provision of safe staffing during short periods of the day eg meal breaks. No doubt in the future the traditional psychiatric student nurses will be properly evaluated according to their seniority within the training schedule and the contribution they make to patient care, then recommendations will be made on their replacements in the nursing team.

3.9 Recommendations for Staffing, Grade Mix and Distribution by Unit.

Staffing levels clearly depend on the Workload per Unit. This, however, is not the only factor. Grade Mix, Shift Systems and Safe Numbers must also be considered.

It is to be expected that the Special Care Units will have the highest relative staffing levels, followed by, in order, the Acute Psychiatric Units, the Elderly Mentally Infirm, Rehabilitation and then the Long Stay Units for Mobile Patients. It would be expected that the residents of hostels and homes would be more independent but in at least two of the hostels, the residents were elderly and more frail.

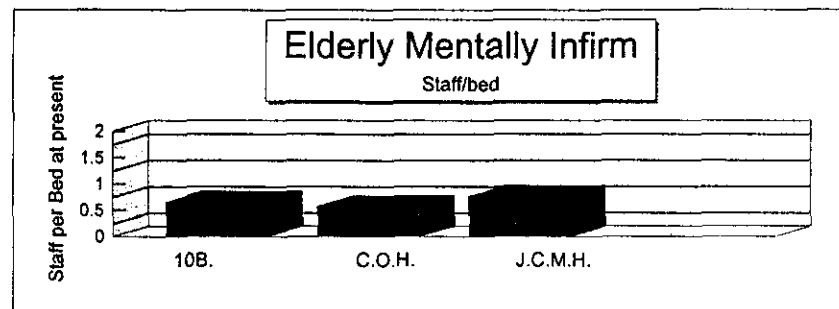
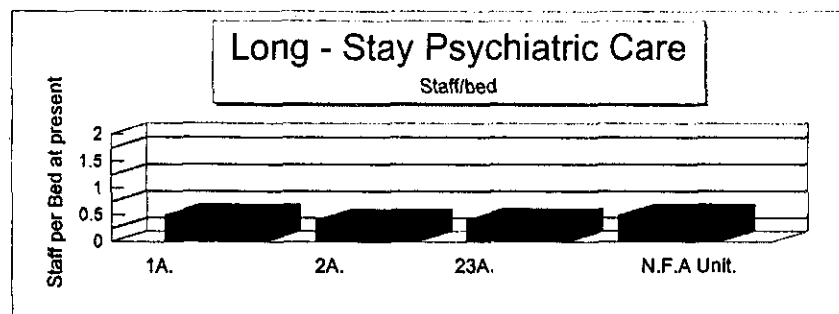
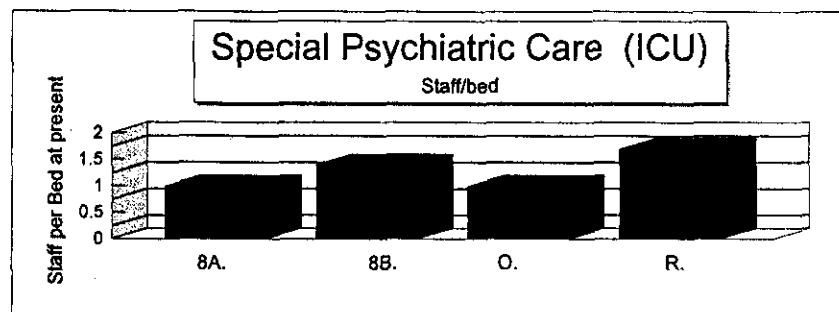
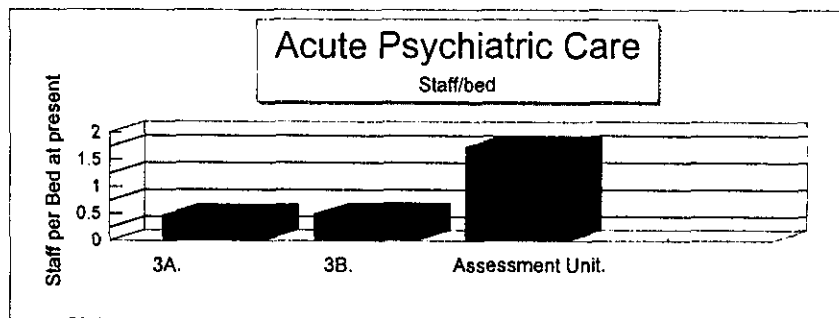
Included in the staff required by workload are the following factors identified during the survey :-

- Character of patient case mix;
- Staff hours spent specialising patients;
- All recorded time spent on escort duties;
- Hours off taken by staff for 39 hour week;
- Time spent by staff on trips off the wards;
- Number of patients who remain on the Unit during the day.

A record is available in **Appendix 8** of the times involved in the key other factors which affected nurse staffing during the week of the survey.

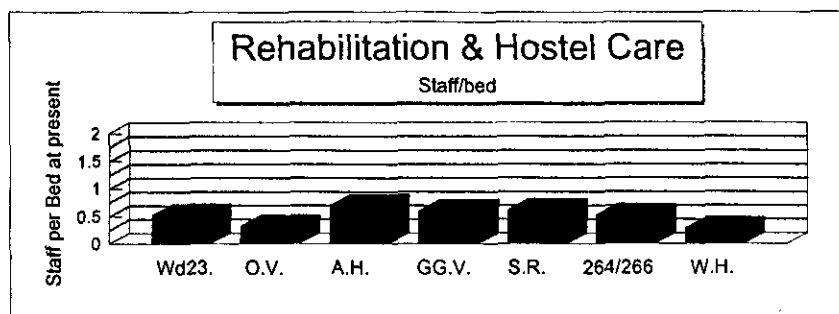
Graphs 1-5 following show the present staff situation, based on the number of staff per bed in each ward/hostel/home during the week of survey.

Graphs 1 — 5 Number of nurses per bed in each ward/hostel/home during the week of the Survey



Key to the above Graph

10B = Ward 10B. St. Brendans Hospital
C.O.H. = Ward 5. Cherry Orchard Hospital
J.C.M.H. = James Connolly Memorial Hospital



Key to the above Graph

Wd 23 = Ward 23 St. Brendans Hospital
O.V. = Orchard View Hostel
A.H. = Adare House
GG.V. = Grangegorman Villas
S.R. = San Remo
264/266 = 264/264 North Circular Road
W.H. = Weir Home

3.10 Safe Numbers

The need to have sufficient staff on hand to deal with problems and prevent, and control potentially violent situations, is a key issue which must be addressed in conjunction with workload measurement.

3.11 Annual Leave, Sickness and Other Absence

The Central Nursing Office at St Brendan's Hospital provides central management and recording of annual leave, sickness and other absence. When a nurse submits certification of their sick leave they are removed from the Unit Roster and replaced by the Central Nursing Office. Similarly a central change sheet is posted weekly which notifies movement of staff from day to night duty, or vice versa, movement from one Unit to another and replacements for staff who are to commence scheduled annual leave. In controlling the allocation of annual leave a limit of 40 nurses per week is allowed from the overall establishment. Therefore absence due to annual leave is managed within clearly defined limits and staff (except those on Week end time) are replaced on the roster.

As would be expected the level of absence due to sickness and other causes varies throughout the year. An analysis of actual absence for these reasons on each Monday from 2 October 1995 to 23 September 1996 (52 weeks) shows an average of 19.61 nurses or "hands on" nursing aides absent per week. This represents 5.82% of the overall nursing workforce. The lowest number of recorded absences was 9 nurses on 6 November 1995 and the highest was 27 on both 12 and 19 August 1996. The corresponding absences during the two weeks covered by the full study were 15 nurses on 4 November 1996 and 20 nurses on 11 November 1996.

Therefore the numbers of staff recommended by workload in Tables 3-7, (Section 4) **do not** include staff needed for

- Annual Leave cover and
- Sickness and Absence.

The statistics for Annual Leave and Sickness and Absence calculate at 19.2% of the Total Staff per Annum.

4 WORKFORCE PLAN BY SPECIALTY

4.1 Introduction

This Section includes Tables 3-7 which summarise for each Unit, and in areas of specialism the

- Number of Patients and Bed Occupancy at the time of the Study;
- Actual Number of Staff assigned to the Unit;
- Number of Staff required by Workload;
- Number of Staff recommended for Safe Cover;
- Acuity;
- The recommended Staff and Grade Mix.

Each Table is followed by comments and recommendations by specialty.

NB For other factors which affected nurse staffing during the seven days of the Study see Appendix 8.

Table No: 3

Acute Psychiatric Care Wards

Ward / Unit	No of patients + Bed Occupancy	No of staff assigned to ward (actual)	No of staff required by workload	Recommended staff for safe cover	Acuity	Recommended staff grade-mix
3A	30 8 Acute 22 Long Stay 100%	14.5 plus 1 ECT Nurse 1 Student Nurse	16.1 plus 1 ECT Nurse	16.5 Staff plus 1 ECT Nurse	4.2	14.5 Qualified 2 Unqualified 1 ECT Nurse
3B	37 18 Acute 19 Long Stay 100%	18.5 plus 2 Student Nurses	21.7 Staff	21.7 Staff	4.7	17.7 Qualified 4 Unqualified
Ass Unit 24 Hour Open Ward	8 4 Acute 4 Long Stay	14 plus 2 Nursing Officers Night Duty 3 Student Nurses	5.22 Staff (small ward)	15 Staff	4.9	14 Qualified 1 Unqualified

NB Recommended unqualified staff may be interpreted as 'traditional' psychiatric student nurses or 'hands on' nursing aides.

4.2 Comments and Recommendations for Acute Care Wards*

In the Acute Care wards it is necessary to provide staff for 100% bed occupancy. This particularly applies in the Assessment Unit which is open for admissions throughout 24 hours.

Of the 75 Acute Care beds, at the time of the survey, only 40% were occupied by Acute patients and 60% by those requiring Long Stay Care. This patient care mix is not ideal because of the unpredictability of new admissions. This creates a considerable dilemma for nurses seeking to cope with such competing needs.

A Safe Level of three staff is the recommended number for Acute Care. It is however, unsafe if lengthy periods of the day are covered by this basic level of staffing.

*** For details of Hourly Staffing Levels over Seven Days see Appendix 1.**

The number of staff on duty to provide safe levels would be enhanced if:

- Some week-end time staff worked between 9 am and 6 pm.
- More use was made of the three lunch and a tea-break periods.
- If at least one post on each ward was staffed by two part time qualified nurses with duty rosters flexible enough to meet the peaks and troughs of the workload.

It is possible for a senior Psychiatric Student Nurse to complete safe staff numbers, but for short periods only eg meal breaks. General Student Nurses are regarded as supernumerary.

- 3A** The occasions when staffing dips below safe levels are meal breaks, especially at the week-ends. Part time staff with flexibility in their rosters could cover these unsafe periods. A third nurse is required to provide safe levels at night, an alternative being to base the Nursing Officer for Night Duty on this ward rather than the Assessment Unit
- 3B** This ward has a very large in-patient population and the geographical layout creates difficulties with supervision and observation of patients. The staffing level that the workload is demanding will be sufficient to provide adequate cover.

Assessment Unit

The workload on this ward generates the need for very few nurses. This is because the ward is too small to be efficiently staffed in a cost effective manner. Ideally, a small ward like this should be twinned with another of similar size. The staff cover could then be more efficiently deployed across both areas, based upon demand. Two part-time staff with flexible duty rosters would alleviate the shortfall at meal break times and week-ends.

Table No: 4

Special Care Wards (I.C.U)

Ward / Unit	No of patients + Bed Occupancy	No of staff assigned to ward (actual)	No of staff required by workload	Recommended staff for safe cover	Acuity	Recommended staff grade-mix
8A	13 there were 16 patients 123% At 100% Occup.	16	123% Requires 18.6 Staff 100% Requires 15.9	17	19.8	15 Qualified 2 Unqualified
8B	13 100%	14	13.6	17	15.6	15 Qualified 2 Unqualified
O	15 there were 16 patients 106% At 100% Occup.	16	106% Requires 17.2 staff 100% Requires 16.2	17	20.9	15 Qualified 2 Unqualified
R	13 there were 10 patients , 76.9%	17	100% Requires 17.5 staff 76.9% Requires 14.7	17.5	25.4	16 Qualified 1.5 Unqualified

NB Recommended unqualified staff may be interpreted as 'traditional' psychiatric student nurses or 'hands on' nursing aides.

4.3 Comments and Recommendations for the Special Care Wards*

The staff in Special Care Wards look after the most disturbed and volatile patients in the hospital. Therefore these critical-care wards require to be staffed for 100% bed occupancy at all times.

In these wards the rooms for seclusion or rest are for the use of existing bed patients and should not be used to accommodate extra patients over and above the bed complement. However, because of pressure on beds, these rooms were being misused at the time of the Study and this created bed occupancy of over 100%.

During the week of the survey it was noted that some of the wards were asked to lend staff to less acute areas. This management practice undermines the safety of patients and staff as well as adversely affecting the quality of nursing care.

A ward clerical officer shared between the four wards is recommended.

A safe level of 3 nurses is recommended in this speciality. However as was highlighted before, only short periods during the day should be covered by such a low staffing level.

8A Unfortunately three patients in this ward were being inappropriately housed in seclusion rooms during the survey period as there were no other beds available. This is clearly inappropriate practice.

If the practice of lending staff to other wards stopped and the extra post recommended was divided between 2 part-time nurses, with flexibility in their rosters, safe staffing levels would be achieved on this ward.

8B Two more nurses are required for night duty. One extra post on day duty, with the same degree of flexibility as recommended on 8A, would address meal breaks and other unsafe periods.

O This ward was busy and had a high throughput of patients during the week of the survey. As on 8A one patient was being nursed permanently in the seclusion room as there was no bed available on the ward.

R This wards bed complement has been reduced to ten patients for a few weeks. At present the ward is extremely busy with some very high-risk patients.

*** For details of Hourly Staffing Levels over Seven days see Appendix 2.**

Table No: 5

Long Stay Mobile Psychiatric Care Wards

Ward / Unit	No of patients + Bed Occupancy	No of staff assigned to ward (actual)	No of staff required by workload	Recommended staff for safe cover	Acuity	Recommended staff grade-mix
1A	12 92%	6	5.8 (small ward)	9	6.2	7 Qualified 2 Unqualified
2A	17 100%	7	8	10	6.1	6.5 Qualified 3.5 Unqualified
23A	24 100%	10 plus An Art Therapist	11.1	11 plus An Art Therapist	5.36	6.5 Qualified 4.5 Unqualified
N.F.A Inpatient unit	16 2 Acute Beds 14 Long Stay 100%	8	8	10	12.1	8 Qualified 2 Unqualified

NB Recommended unqualified staff may be interpreted as 'traditional' psychiatric student nurses or 'hands on' aides.

4.4 Comments and Recommendations for the Long Stay Mobile Psychiatric Care Wards*

The staffing levels required in order to meet the workloads on these wards are not sufficient to provide safe levels of staff during the day or at night.

The periods of greatest need are:-

- 12 midday to 6 pm daily on all wards;
- Saturdays and Sundays on all wards;
- 1A and 2A require two staff per night.

Part-time staff with flexibility within their duty rosters could cover these shortfalls. As is the case on 2A 1A and the N.F.A. Unit could then introduce some structured therapy for the patients who remain on the ward all day.

*** For details of Hourly Staffing Levels over Seven Days see Appendix 3.**

Table No: 6

Elderly Mentally Infirm Wards

Ward / Unit	No of patients + Bed Occupancy	No of staff assigned to ward (actual)	No of staff required by workload	Recommended staff for safe cover	Acuity	Recommended staff grade-mix
10B	29 96.7%	19 plus 1 Student Nurse	18.9	19	42.4	11 Qualified 8 Unqualified
C.O.H ward 5	24 96.0%	14	15.6	16	40.4	10 Qualified 6 Unqualified
J.C.M.H unit 10	13 86.6%	10	8.5	11	25.1	7 Qualified 4 Unqualified

NB Recommended unqualified staff may be interpreted as 'traditional' psychiatric student nurses or 'hands on' aides.

4.5 Comments and Recommendations for the Elderly Mentally Infirm Wards*

The care of these older patients is physically very demanding for nurses and the principles of safety at work would not recommend the long-shift patterns worked at present by staff on these wards.

It is recommended that the long term use of Buxton Chairs is researched by the nurses and physiotherapists and that a Policy on Restraint is reintroduced by the Senior Nurse Manager.

Because of the size of 10B and Ward 5 in Cherry Orchard Hospital, a safe level of three staff is suggested. Unit 10 in James Connolly Hospital requires two staff for safe cover.

10B The use of the three lunch and tea break periods would help prevent the dips in safe staffing levels.

Diversional therapy for patients should be possible with the recommended staff numbers. Currently no such activity is provided. A more stable work force as well as an even distribution of grades across both nursing teams would enhance the quality of the patient care and help staff morale.

Ward 5 - Cherry Orchard Hospital

On a large ward such as this, two qualified nurses and an aide are required during the night. The extra day duty post is needed mainly to cover meal break periods but it is hoped that a more structured diversional therapy programme could also be implemented.

Unit 10 - James Connolly Memorial Hospital

Meal break periods are the main causes of staff shortfall below two.

Two people, part time sharing one post with flexi-shifts is recommended and, as on other wards, therapy needs could then be met.

*** For details of Hourly Staffing Levels over Seven Days see Appendix 4.**

Table No: 7

Rehabilitation and Hostel Care

Unit / Hostel	No of Residents + Bed Occupancy	No of staff assigned to ward (actual)	No of staff required by workload	Recommended staff for safe cover	Acuity	Recommended staff grade-mix
Ward 23	17 85%	9 plus 1 Student Nurse	10.9	10	1.2	9.6 Qualified 1.3 Unqualified
Orchard View	18 100%	6 plus 2 Student Nurses	7.9	8 plus 2 Student Nurses	1.1	6 Qualified 2 Unqualified
Grangegorman Villas	8 plus 2 Residents in lower support 100%	6 plus 1 Student nurse 1 Security officer	3.52	7 plus Security Officer	1.2	6 Qualified 1 Unqualified
Adare House	10 90.9%	7 plus 1 Student Nurse	6	8 plus Student Nurse	1.8	6 Qualified 2 Unqualified
264/266 North Circular Rd	17 94.4%	9 plus 1 Student Nurse	8.42	9.5 plus 1 Student nurse	2.1	7.5 Qualified 2 Unqualified
San Remo	13 92.9%	8	6.1	9	1.4	6 Qualified 3 Unqualified
Weir Home	21 70%	6 plus 2 extra attendants on night duty	7.5	6.5 plus 2 night attendants	1.4	5.5 Qualified 2 Unqualified
N.F.A day centre	Ave 45 attenders over 7 days	5	7	7	Not Known at survey	7 Qualified
IT/OT	Ave 86-90 attenders over 5 days	4 plus 1 Student Nurse	-	-	-	No recommendation

NB Recommended unqualified staff may be interpreted as 'traditional' psychiatric student nurses or 'hands on' aides.

4.6 Comments and Recommendations for Rehabilitation and Hostel Care*

It is understood that the Consultant and Senior Managers are already engaged in a reassessment of the Rehabilitation Services with special emphasis on Hostel Care and the changing needs of residents.

The aim of the workforce review is to have sufficient staff to meet the workload demand as well as maintain a safe level of two staff on duty in each care area. Cognisance has been taken of the fact that in some Hostels there are very few residents who remain 'at home' during the day, while in others with older residents many choose to remain in-doors. Other factors taken into account are:-

- The amount of escort time needed by the residents for rehabilitative as well as clinical purposes.
- The number of patients who leave their 'home base' every day for therapy as well as those who remain.
- The hours staff require off for the 39 hour week.

It is emphasised that the extra staff recommended within this plan are to provide safe cover and most escort needs. It is, therefore, vital that they should have flexibility within their duty rosters. This flexibility will facilitate the matching of staffing levels to patient/residents needs.

Ward 23 The length of time patients spend at therapy depends on the progress and stage of their rehabilitation programme. During the survey week 14 patients left the ward for varying lengths of time.

Some of the nursing staff are very experienced and well qualified in rehabilitative and counselling skills but feel these skills are not always recognised or used sufficiently within the multidisciplinary team.

Orchard View Home

The staff on night duty should be increased to two per night. Approximately 10 residents leave the hostel each week day to attend work or therapy. The extra staff are especially needed to cover the week-end as well as meeting some short fall during the week.

*** For details of Hourly Staffing Levels over Seven Days see Appendices 5 and 6**

Grangegorman Villas

There were many days during the survey week when, for long periods of time, only one person was on duty. The recommended extra staff should be deployed to alleviate this problem.

Adare House

Two staff members are required on night duty each night. Occupational Therapy is provided in a unit attached to the house. The extra staff hours are needed particularly at the week-ends.

264/266 North Circular Road

This three storey building is not suitable or convenient for the elderly clients who are there at present. Five of them are over 80 years of age.

An immediate priority is staff training in fire-drill and evacuation procedure as well as the mandatory provision of a fire escape.

It is suggested that an additional staff member on week-end time, works from 9am - 6pm and the extra staff hours recommended provide cover at the week ends.

San Remo Home

The suitability of this building also needs to be assessed with an emphasis on safety and security for both residents and staff. The extra post recommended within the plan should be divided between two staff required to cover the shortfall at meal breaks and some afternoon activities.

Weir Home

The extra hours recommended will be sufficient to cover the staff meal break times and most of the escort needs of this home.

4.7 Comments and Recommendations for Day Care*

N.F.A. Day Centre

Given the level of disturbance and violence which occurred in this unit during the survey week, a safe level of three staff should be maintained.

The ability to diffuse and manage challenging and unpredictable behaviour, including skills in control and restraint, are essential requirements for all on duty in this centre.

There are no known care-timings for Psychiatric Day Centres. The staff levels recommended are, therefore, calculated on the need to maintain three nurses per day on duty.

One post, possibly divided between two part time people, will meet the need when there is a rise in the work load.

Occupational and Industrial Therapy Workshop

This is a well organised and managed unit, providing an essential service for patients and others. There are 123 possible attendees coming from different home environments:-

21% from their own homes

10.6% from wards at St Brendan's Hospital

26.8% are classed as 'drop ins'

41.6% from Hostel Care

The average daily attendance, Monday to Friday, is 85-90 persons.

In view of the fact that there is no established means of assessing workload in this type of facility, no recommendation can be made.

*** For details of hourly staffing levels over seven days see Appendix 7.**

5 IMPROVING THE DELIVERY OF NURSING CARE

5.1 Making Nursing Care more Patient Focused

The Review identified a spread of quality of nursing care ranging from that which was highly patient focused, and planned, to the clearly custodial. Sometimes, but not always, the reason for the provision of custodial care, in terms of lack of intervention and fulfilment of a care plan, was due to the minimal number of available staff.

Both nurse managers and other disciplines have important roles to play in supporting Nursing Officers in their key role of developing patient focused care. The support of a collaborative multidisciplinary team is essential, as is the safeguarding of adequate staffing and continuity of care.

5.2 Approach to the Organisation of Nursing Care

To achieve patient focused nursing care the Nursing Officer must decide how responsibilities should be allocated. Four alternative approaches may be described in the following ways:-

- | | |
|--------------------|--|
| Task Allocation | - Each nurse does a particular set of tasks for all patients on the ward. |
| Patient Allocation | - Each nurse looks after the needs of an allocated group of patients for the duration of the shift. |
| Team Nursing | - A team of nurses is responsible for care planned and delivered to individual patients throughout their stay. |
| Primary Nursing | - Each patient keeps the same nurse throughout their stay, who evaluates their care and has 24 hr. responsibility for ensuring the delivery of that care either by themselves or by one of a small number of associate nurses. |

The Review demonstrated a number of factors which hindered or supported the delivery of individualised patient focused care. These included:-

- The number of available nurses
- Consistency of the number of available nurses to meet workload

- Continuity ie the degree to which nurses were familiar with the patients for whom they were caring and their individual needs.
- Changes in approach between shifts caused by eg lack of a ward nursing manager having insight and control of all shifts, night and day, and lack of sufficient overlap between shifts.
- The competence of nurses in assessment and up to date and meaningful care planning.
- The effectiveness or availability of a multidisciplinary team and the opportunity for the nurse responsible for an individual patient's care to contribute effectively within the team as part of the development of the overall treatment plan.

NB Whilst there are various approaches to the organisation of nursing care at St Brendan's Hospital, the title 'Key Nurse' is commonly used. Therefore this nomenclature will be used within the Report when referring to a nurse designated as having responsibility for an individual patient's nursing care.

5.3 Continuity of Care

Continuity of care is essential if patients are to be able to identify that they are being treated as individuals. The current structure, and organisation of nurse staffing at St Brendan's Hospital does not support effective continuity. All Staff Nurses and Nursing Aides (those who work with patients alongside the Registered Nurse are commonly referred to as 'Hands On Nursing Aides' at St Brendan's Hospital) are rostered following periods of annual leave and sickness.

Rotation of staff to night duty (an important managerial approach which helps nurses to avoid spending over-prolonged periods on night duty) is relatively random and upon completion of a period of night duty a nurse is liable to return to another Unit. Therefore a Staff Nurse may work on one Unit on a day shift, move to another Unit on night duty and return to yet a different Unit on days. Nursing Officers and Deputy Nursing Officers, although allocated to a specific unit are also liable (although less frequently) to move to night duty.

If nursing care at St Brendan's Hospital is to be more patient focused, it is evident that there must be a change from the current system of constant rostering. Movement of staff between Units should be on a planned basis and not linked to arrangements for covering sickness and annual leave. Movement between night and day duty should, as far as possible, be within the rostered Unit.

In view of the lack of continuity of staffing a patient is liable to have a regular change of Key Nurse (if a nurse is allocated). Firstly, in determining the approach to a professional relationship with the patient, the nurse will be uncertain as to how long that relationship might last. It may be no more than a week, or it may be months.

Secondly, this uncertainty does not support the joint ownership of a Care Plan between patient and nurse. If a Care Plan is to be live and meaningful, it should be reviewed by the nurse and the patient, when the Key Nurse appointment is made. From the patient's perspective it is difficult for him or her to be responsive to, and supportive of, the Care Plan if the Key Nurse is regularly changed. The continuity of such a relationship is vital in long-stay care, as progress in response to care and treatment may only be measurable over a lengthy period. Such change may best be achieved when both nurse and patient can be given time and space to demonstrate progress.

A third effect of lack of continuity is the lack of recognition of the Key Nurse's role in contributing to the work of the multidisciplinary team. The Key Nurse should be able to prepare reports for the team, and to be in attendance when a Case Review takes place. Unfortunately it is a rare occurrence for Key Nurses to be present at the Case Review and more commonly progress is reported by the Nursing Officer or Deputy Nursing Officer.

5.4 The Shift Pattern

The standard shift pattern at St Brendan's Hospital is comprised of a long day, worked on a day on/day off basis. Similarly the night shift is worked on a night on/night off roster. This shift is similar to that worked in other Irish psychiatric hospitals and is of long standing.

The only amendment to this shift arose with the reduction of the working week to 39 hours with effect from 1 July 1990. At that time an agreement was reached not to change the shift pattern but for day staff to accumulate the hours owing and to periodically work a shift reduced by 4 hours. This shortened day normally finishes at 4 pm. Night staff similarly accumulate hours owing and periodically have an additional night off.

The only staff who do not work this shift pattern are the Assistant Chief Nursing Officers when they are not providing site cover, some Nursing Officers who work from 8am to 5pm, 5 days per week (including a Sunday on alternate weeks and Nurse Therapists and Occupational/Industrial Therapy Nurses who are all involved with the provision of activities for patients either within the Units or in Departments. (Staff working these hours are locally referred to as ' Week-end Timers'.) Part time staff are only employed to provide specific functions eg management of the ECT Suite, and not to complement full time staff.

An important feature of this shift pattern is that it provides no time for the sharing of information between shifts, either between day/night or between one day and another. This has an inevitable impact upon continuity of care although, due to the lack of overlap, the shift pattern is economical in comparison with those which involve a large overlap between shifts.

A second feature of the shift is the effect of the long day upon the delivery of care. During our Review we became aware of the physical demand placed upon staff in having to work a long day. Psychiatric nursing can be extremely demanding and this is particularly apparent in the care of the Elderly Mentally Infirm and areas of Special Care.

Thirdly the agreement regarding the 39 hour week causes disruption to patient care. Staff leaving early from the day shift are frequently not replaced and this reduces levels of staffing, sometimes below an appropriate level to adequately fulfil the workload. Consequently patient care suffers.

5.5 Care Planning

Reference has been made to the importance of effective Care Planning and the involvement of patients in this process. For Care Plans to be live, and meaningful, the organisation of nursing care must be by Patient Allocation, Team Nursing or Primary Nursing. Where two or less nurses are allocated to a Unit, this approach to nursing care is logically impractical, and a Task Based approach is inevitable.

Whilst there are alternative ways in which nursing care may be organised, nurse staffing and its organisation within a psychiatric service should be adequate to ensure that the following principles of Care Planning are achieved:-

- The nurse will be qualified and fully trained to assess and plan care.
- The patient will know which Key Nurse is responsible for his/her care.
- The patient will be aware which other members of staff are in the nursing team.
- The patient will have the opportunity to discuss treatment, care and concerns with his/her Key Nurse.
- The patient, whenever practical, will participate in preparation of the Care Plan and on-going discussion and change.
- The patient's relatives will know which Key Nurse is responsible for his/her care.

- The role of the Key Nurse will be supported and acknowledged by the Nursing Officer and members of the multidisciplinary team.
- The patient will be informed if the Key Nurse has to be changed and the Care Plan should be shared, and discussed with the newly appointed nurse.

5.6 Confinement

The following Units at St Brendan's Hospital are regularly locked throughout the day and night.

1A, 2A, 8A, 8B, O, R, 10B, Homeless In-Patient Unit and 23A

In addition Unit 5 at Cherry Orchard Hospital and Ward 10 at James Connolly Memorial Hospital are routinely locked.

The Special Care Wards (8A, 8B, O and R) are required to provide a controlled environment. They provide care for mentally disordered patients who may be an actual or potential danger, and therefore the Units are required to be locked for the protection of the public. However within the Units, side rooms which are designated for use for purposes of seclusion are being misused for occupancy simply as a result of overflow within the hospital. The rooms are not designed, or intended for regular occupancy, and include two rooms with padded walls. The misuse of accommodation places considerable pressure upon staff as well as being an abuse of the patients required to use them. The practice self-evidently reduces the options of the care team if these rooms are required for their intended purpose. In addition the staff rostered for these Units are provided for the available bed occupancy and not to cover the additional beds.

The external locking of Units (other than Special Care), and the locking of internal doors in all Units, requires review to establish whether or not, in each case, it is essential or due to custom and practice.

A further form of confinement is the widespread use of Buxton - style chairs in elderly care areas. The continual use of such chairs causes loss of mobility and contraction of limbs. No physiotherapy support is available to advise nurses regarding maintenance of movement and mobility or to provide treatment for patients.

5.7 Environmental Factors

The Eastern Health Board¹ has recorded it's awareness that "The design and layout of Units (at St Brendan's Hospital) is totally unsatisfactory for modern practices in the provision of a therapeutic milieu and there is a further problem in them being detached from the catchment areas with a resultant break of the link in the overall care process." The Review demonstrated the impact that the unsuitability of the buildings, and their layout, has upon the delivery of care.

In spite of the continuing rationalisation of the use of the hospital stock through the closure of dilapidated and peripheral wards the remaining occupied Units are largely badly maintained, suffer from inappropriate layout and fail to provide the degree of privacy and dignity that patients have every right to expect.

The paucity of the environment impacts upon both staff and patients. It encourages the maintenance of institutional and custodial approaches to care e.g. lack of privacy in bedroom and sanitary areas, the concentration of groups of unoccupied patients in day areas, (sometimes to safeguard observation), and restriction of movement and access as a result of the large number of locked Units and internal doors.

The environmental impact upon patients and nurses is further exacerbated by the failure to adequately maintain the hospital buildings and high support hostels. One of the major frustrations for Nursing Officers is the considerable investment of their time and effort in seeking to obtain responses to constantly repeated requests for basic maintenance. Small improvements, such as a well maintained shower, can make a considerable impact upon privacy and the life and well being of the patient as well as considerably reducing staff frustration. We can only observe that the service contrasts markedly with that at other Eastern Health Board hospitals we visited both in timeliness and efficiency.

¹ Refer to page 53

5.8 Opportunities for Patient Activity

Organised activity for patients is available in three settings namely

- a) An Occupational / Industrial Therapy area managed and staffed by nursing staff. This comprises departments for contract work, carpentry, printing and arts and craft
- b) Nurse Therapy Groups which are staffed by appointed Nurse Therapists. These are organised on or adjacent to Units. One service is available to the 4 Special Care Wards and other services are available on Units 2A and 23A.
- c) The Courtyard. Occupational Therapy services managed and staffed by Occupational Therapists and provided on a sessional basis.

From Units at St Brendan's Hospital (other than Ward 23, The Rehabilitation Unit), an average of 20 (out of 230) patients attend regular occupational or diversional activities away from their residence. Approximately 14 out of 20 patients on Ward 23 attend occupational activities for varying periods ranging from 3 hours per day to 2 hours per week.

There are no regular occupational or diversional activities provided on or off ward for patients at Unit 10, James Connolly Memorial Hospital or Unit 5, Cherry Orchard Hospital. An average of 29 (out of 101) residents of hostels and homes attend regular occupational activities or outside work. A summary of the number of patients and residents leaving their Units for occupational activity is contained in **Appendix 9**.

The number of patients who may potentially have the opportunity to attend Nurse Therapy Groups was 20. However, on the Special Care Unit, the area normally available for Nurse Therapy has been used as a living area for patients for the last 12 months whilst ward refurbishment takes place. This service is potentially available to the 54 patients resident in the Special Care area and has been sadly missed during its closure. This has led to added pressures upon nursing staff in this area as patients have largely remained confined on their Units throughout the week.

When the Nurse Therapy service for the Special Care Units is reopened regular organised daily activity will, at present levels, therefore be available for approximately 100 patients living in St Brendan's Hospital. For the remaining 150 patients there is no provision other than that organised by Unit nursing staff.

The lack of planned activity , designed to meet individual needs, leads to an aimless existence for those able to benefit. Additionally, the lack of diversional activity may lead to the exacerbation of antisocial behaviour or deterioration in the patient's psychological or physical condition, all of which is both harmful for the individual as well as adding to the nursing workload. It is particularly apparent that there are no appropriate and regular activities organised for Elderly Mentally Infirm patients on Units managed by St Brendan's Hospital.

5.9 Assessment of the Quality of Patient Care

The issues addressed in this Section of the Report are all measurable through the adoption of a systematic approach to standard setting and audit. No such multidisciplinary or unidisciplinary quality assurance methods are being used to assess the quality of patient care. The results of Clinical and /or Nursing Audit in relation to an agreed set of standards could have provided invaluable information as a background to the Review. Additionally no formal mechanisms are in place for regularly obtaining, and using, the views of patients and relatives.

6 DEVELOPING CLINICAL SKILLS.

6.1 Training and Education

Good quality nursing care requires not only that staffing is adequate but also that nurses are equipped with the right skills and education to adapt to modern care requirements and developing psychiatric practice. This section of the report focuses upon the ways and means by which clinical skills are being developed, or could be developed, at St Brendan's Hospital and therefore the potential for the improvement of nursing practice.

It is part of the professional responsibility of each nurse to ensure that they keep up to date with changes and developments in nursing practice, professional thinking and current research. In addition they require a wider awareness of developments within psychiatry and the implications for their role.

Over recent years developments in education and training at St Brendan's Hospital have provided opportunities for staff in terms of both In-Service Training and Post Registration Education.

6.2 In-Service Training

An Assistant Chief Nursing Officer has delegated responsibility for providing In-Service Training Courses using teaching accommodation within the Nurse Education Centre. A programme is currently planned on the basis of allocated weeks during February and November. During the designated weeks the number of staff rostered for annual leave is reduced by one half, and this reduces the impact upon staffing availability in clinical areas is. The one week programmes are organised for Nursing Officers, Deputy Nursing Officers and Staff Nurses. No organised training, on a similar scale, is provided for supporting care staff.

The ACNO responsible for In-Service Training has completed a survey to evaluate how the programme might be improved and the main subjects requested by staff for inclusion in future programmes.

The main subject matter included in the current programmes includes:-

- i Health Service Developments;
- ii Current Managerial and Administrative Issues;
- iii Management Skills;
- iv Lifting Techniques;
- v Prevention and Management of Violence including Control and Restraint Techniques;
- vi Changes and Developments in Psychiatric Practice.

6.3 Post Registration Education

The Nurse Education Centre on the site of St Brendan's Hospital, serves as the centre of psychiatric pre and post registration education for the Eastern Health Board. As part of their training students of both psychiatric and general nursing undertake placements in clinical areas at St Brendan's Hospital. The Units currently used are the Assessment Unit, 3A, 3B, 23, 23A, Orchard View, Adare House and Grangeegorman Villas. Therefore students are obtaining experience in Admission, Assessment and Rehabilitation Services provided by St Brendan's Hospital but not in Special Care, Continuing Care or Care of the Elderly Mentally Infirm.

Learning objectives are agreed but do not always act as a systematic basis for learning within the clinical area. There was no evidence of clinical staff seeking, or obtaining, basic teaching skills or qualifications.

The Nurse Education Centre provides Post Registration Courses at either certificate or diploma level in the following subjects:-

- i Challenging Behaviour
- ii Diploma in Child and Adolescent Psychiatric Nursing
- iii Diploma in First Line Management
- iv Rehabilitation
- v Forensic Psychiatry
- vi Mentoring
- vii Post Registration Mental Handicap or Psychiatric Nursing for those already holding one qualification.

Although many of these courses are available on site there is currently little uptake by nurses from St Brendan's Hospital. For example there are no nurses from the hospital on the current courses for Child and Adolescent Psychiatry, Forensic Psychiatry and Mentoring and only 2 nurses on the Challenging Behaviour Course.

6.4 Training and Education Survey

A Training and Education Survey was completed as part of the Review, and 41 Registered Nurses were interviewed (6 Nursing Officers, 6 Deputy Nursing Officers, and 29 Staff Nurses). This represents 13% of all Registered Nurses employed by St Brendan's Hospital. The Survey revealed the following:-

A Qualifications

- Number of Registered Psychiatric Nurses - 41 (all)
- Number of Registered General Nurses - 7
- Post Registration Qualifications at Certificate, Diploma or Degree level covered the following subject areas:-
 - Behavioural Psychotherapy - 4 Nurses
 - Health Services Management - 4 Nurses
 - Counselling - 3 Nurses
 - Nursing or other Degrees - 3 Nurses
 - Family Therapy - 2 Nurses
 - Eating Disorders - 2 Nurses
 - Bereavement Support - 2 Nurses

Examples of other individual qualifications covered the subject areas of Health Promotion, Challenging Behaviour, Reality Therapy, Alternative Medicine, Information Technology and a Nursing Diploma.

B Psychiatric Nursing Careers

- 75% of those interviewed had been trained at St Brendan's Hospital and had generally spent all of their careers at the hospital.
- 22% completed basic training within the previous 10 years.
- 37% completed basic training between 10 and 20 years ago.
- 29% completed basic training between 20 and 30 years ago.
- 12% completed basic training between 30 and 40 years ago.

C Experience of In-Service Training

- 38 interviewees (93%) recalled having been offered the opportunity of In-Service Training within the last 3 years. The small number who reported negatively included those appointed recently or on a temporary contract.
- 33 interviewees (80%) recalled having taken up the opportunities offered for In-Service Training on at least one occasion.
- Reasons for not taking up opportunities for In-Service Training included:-
 - Inability to attend as on prolonged night duty;
 - Family commitments and job sharing;
 - Found previous course boring;
 - Believed could keep up-to-date through work.

D Experience of Post Registration Education

- 7 (17%) interviewees recalled having been offered opportunities for Post Registration Education over approximately the last three years. Additionally many more were aware of advertised courses and the opportunity to apply for places.
- A further 11 (27%) interviewees recalled having requested opportunities for Post Registration Education over approximately the last three years.
- Of these nurses who had been offered, or had requested Post Registration Education opportunities, 7 (39% of those offered/requested) took up the opportunity and undertook courses at certificate, diploma or degree level.
- Reasons for not taking up or seeking opportunities for Post Registration Education included:-
 - "Lack of interest in academia"
 - "Have to pay myself as little opportunity for obtaining reimbursement"
 - "Have to do in my own time and/or difficult to get time off"
 - "Family Commitments"
 - "No places available on course applied for"

E Identified Training and Education needs

Opportunity was provided for interviewees to identify subject areas which they believed would enhance their ability or advance their knowledge of psychiatric nursing. Of the subjects suggested three were identified most commonly. These were:-

- i Skills in Patient Care Programming, Report Writing and Rehabilitation Programming.
- ii Counselling and Support skills.
- iii Prevention and Management of Challenging Behaviour including Control and Restraint Techniques.

Other subjects identified fell into the broad areas of:-

- i Updating in regard to Psychiatric Practice e.g. Medication, Law, Patient Occupation and Therapy and Working with Groups.
- ii Specific therapeutic interventions e.g. Relaxation, Anger Management, Reminiscence, Sonus, Aromatherapy, and Working with Adolescents.
- iii Supporting improved physical nursing care.
- iv Teaching skills to support teaching of both students and rostered staff within the clinical area.
- v Learning together within Multidisciplinary Teams.

6.5 Commentary regarding Training and Education

The review identified a high level of activity and opportunity, in the provision of both In-Service Training and Post Registration Education. The planning of In-Service Training is providing Registered Nurses with the opportunity to undertake one or more periods of training over three years. Available Post Registration Programmes are publicised, and there is evidence that, if nurses are interested in their professional development they have access to this information and, in some cases, have availed themselves of the opportunities provided.

However there is not a systematic approach to-

- a) Identification of qualifications and skills;
- b) Use and matching of the broad range of available skills to identified activity with patients;
- c) Individual planning of training and education needs with each member of the nursing workforce.

The Survey demonstrated the wide range of skills which nurses have at their fingertips but which they largely find they are unable to use. A number of reasons were given as to why this is the case. Most commonly suggested were:-

- i Shortage of staff to enable nurses to have the time to use skills;
- ii Lack of recognition, support and encouragement, (sometimes from other disciplines who are unclear regarding the nurses role and believe nurses should provide “care” and not “therapy”);
- iii Lack of opportunity to work with groups or identify a personal caseload;
- iv Lack of suitable facilities e.g. quiet areas or interview rooms and equipment.

There is no central, accessible, personnel record which provides data regarding the education and training background of each member of staff and therefore a ready means of identification of relevant skills. However, a recent survey has been completed (to which we have had preliminary access) which has reviewed available skills through a confidential staff skills questionnaire. This survey broadly confirms our findings in demonstrating the largely untapped resources of staff skills available.

There is therefore a need to establish, on an individual basis:-

- a) A continually updated record of qualifications and skills,
- b) A plan for future training and education,
and
- c) A matching of skills to workload on a planned basis.

In addition to training and education needs being identified on an individual basis, and skills being used upon completion of programmes, there is a need to plan training and education programmes to meet the needs of the patients across the service as a whole. At present the organisation and development of In-Service Training is largely divorced from the work of the School of Nursing. A joint Education Committee is not currently functioning and therefore there is a lack of integrated planning. Two examples serve to illustrate the point.

Over recent years a number of nurses were encouraged to attend a course leading to a Diploma in Counselling Skills, the course being provided at the Nurse Education Centre. Those selected reported that they attended in their time off, if the classes did not coincide with their duties, or received time off if it did. Fees, paid by the student in advance, were reimbursed only in some cases. Additionally they reported that, on completion of the course they lacked support to use and apply the learned skills.

The second example refers to courses relating to the Prevention or Management of Challenging Behaviour. Those provided include a short course in Break Away Skills, a more advanced course in Control and Restraint Techniques and the one year part time Challenging Behaviour Programme. Whilst prevention, avoidance and break away techniques may be used we found no evidence that the techniques of Control and Restraint (including working within a three person team to diffuse an episode of violence or potentially violent behaviour), were being used.

The hospital has invested considerably in training a large number of nurses in these techniques. However, in practice, nurses working within a Unit where these techniques might be used, may find themselves alone as the only person having attended the course. Therefore they have no confidence in, or sometimes awareness of, whether or not other nursing colleagues have these skills, and the skills are unused and rapidly become out of date. Clearly, if it is the intention that such learning is to be used in the appropriate situation, it is essential that all nurses in the clinical area concerned are trained and confident in those techniques and that their skills are regularly updated.

In addition to the emphasis upon classroom based training and education, the teaching focus should be more strongly based within each Unit. This may be achieved by:-

- i Recognition that Nursing Officers and Deputy Nursing Officers need to obtain basic teaching qualifications and to play a lead role in developing clinically based teaching programmes.
 - ii Tutorial staff must work closely with staff in the Units in support of student nurses and in developing some clinical areas (e.g. which are not currently used for placement.
 - iii The identification and fostering of clinical skills which will support the future development of Specialist Services, (wherever the location of future provision).
 - iv The appointment of an experienced teacher who will have full-time responsibility for co-ordinating the development of In-Service Training and Post Registration Education for the services provided by St Brendan's Hospital and for fostering the development of clinical skills for emerging specialist services.
- Special Care)

Where skills are identified as being key to the future development of services, nurses should be supported financially, and with appropriate time off, to undertake available programmes. Additionally nurses should be encouraged to develop their own skills through further study and the policy for negotiating financial support and/or time off should be clear to all and be seen to be consistently applied.

6.6 Multidisciplinary Teamwork and Learning in the Clinical Setting

If nurses are to be most effective they must be accepted as full participants within a multidisciplinary team. Equally each Registered Nurse must demonstrate that they have the essential skills to make a substantive contribution within the team. Guidelines, which may assist in the development of multidisciplinary teamworking, are provided in **Appendix 10**.

7 MANAGEMENT OF NURSING SERVICES

7.1 Senior Nursing Management and the Central Nursing Office

The Chief Nursing Officer of St Brendan's Hospital carries responsibility for the management of all Nursing Services as well as Domestic and Household Staff. He is supported by seven Assistant Chief Nursing Officers and three full time nursing staff who have specific responsibility for Staff Rostering. The Central Nursing Office acts as the administrative and personnel focus for all staff managed by the CNO.

The Nursing Establishment is agreed with the Programme Manager of the Eastern Health Board and therefore the CNO controls the agreed establishment but not, in a real sense the Nursing Budget. Key decisions in regard to control of the Nursing Establishment are made by Central Nursing Office staff. These include:-

- All staff allocation to Units;
- Allocation to Day and Night Duty;
- Allocation of Annual Leave;
- Replacement of staff absent due to illness or for other reasons;
- Provision of cover, if available, for staff undertaking escort duties, 'specialling' of patients, and other duties involving extended absence from a Unit.

This centralised approach to the management of nursing resources creates a 'dependency' culture. The Central Nursing Office is automatically seen as responsible for problem-solving in regard to any matters regarding staff allocation and distribution. Therefore Nursing Officers and Deputy Nursing Officers, responsible for the management of nursing within each Unit, do not have the power to take many decisions which could assist the smooth running of their service and the care of their patients.

The ACNO's have various specific responsibilities and work either 'Weekend Time' or the Long Day when they are, on rotation, providing Duty Cover for the Hospital. Both the CNO and ACNO's work during alternate weekends. In view of the large amount of centralised administrative activity it is often difficult for ACNO's to focus upon the clinical development of services or upon the assessment of the effectiveness of the delivery of those services over time.

Regular visits are made to all Units but there are no **systematic** methods in place for assessing the quality of services. Paragraph 5.9 emphasised the importance of regular audit of services, based upon an agreed set of standards and ACNO's could be more effective in their role if they had specific accountability for elements of the service linked to a systematic approach to quality assurance.

7.2 Nursing Officers and Unit Management

Some Nursing Officers work weekdays and alternate weekends (referred to as 'Weekend Time'. Others work the Long Day on a Day on/Day off basis as do the staff working on their Unit. Those working Weekend Time have oversight of their Unit on both shifts. They are therefore in a position to assure continuity of practice and the implementation of Unit plans and policies across both shifts. However the majority of Nursing Officers work Day on/Day off and therefore, unless they specifically plan to vary their shift, only meet with those staff working their shift and do not meet with the Deputy or other staff on the opposite shift.

The Night Shift is largely managed as a separate entity to the Day Shift. Although there is rotation of staff between days and nights, the management of the night service is the responsibility of a designated ACNO and Nursing Officers rotating from days. Nursing Officers do not have the opportunity to take responsibility for the allocation of their own rostered staff on to Night Duty or to assure the continuity of care by reviewing services over 24 hours.

In view of the centralised approach to management and allocation, Nursing Officers are not able to assume the measure of delegated responsibility indicated by their salary and grading. More importantly, without a greater degree of delegated responsibility they are unable to assure the continuity of care desirable for their patients or residents. To achieve this continuity Nursing Officers would require:-

- i Assured continuity of staffing with consultation regarding any changes;
- ii Allocated staff numbers which include allowances for Annual Leave, Sickness, Training and Night Duty;
- iii Autonomy to roster staff over days and nights and to schedule Annual Leave ;
- iv Information Systems which will assist in Rostering and Care Planning;
- v Preferably knowledge of the agreed, allocated, Unit Budget for Staff, Furnishing and Provisions and regular, up to date, information regarding its usage;
- vi Training in Staff and Budget Management;
- vii Increased flexibility in employment and deployment of staff between grades and shifts: the key principle being to match staffing to workload and patient need.

To achieve this measure of delegation will require careful planning and Nursing Officers and Deputy Nursing Officers will need to undertake training to prepare them for these responsibilities, which should be part of their role. The benefits will be improved continuity of care and the opportunity to take decisions effecting patients lives at Unit level. This will then free staff of the Central Nursing Office to provide more effective managerial and clinical support to Units and to assure the quality of services in a systematic way.

7.3 Flexibility of the Nursing Establishment

The Nursing Workforce Plan (Section 4) makes staffing recommendations which provide the opportunity to introduce more flexibility. The greater proportion of nursing staff work a long day or night and are employed on a full time basis. The appointment of part time staff, working flexible hours, would assist at times when the nursing workload is at its highest. If the Nursing Officer had the opportunity to plan the roster of such staff this would assist in meeting predictable peaks and troughs.

Additionally, within both the budget and establishment, provision needs to be made for a flexible approach to the unpredictable duties highlighted in Paragraph 3.6. The availability of a small nursing bank or similarly flexible part of the workforce would considerably assist the response to these situations and support the maintenance of adequate staffing within the Units.

8 RECOMMENDATIONS

Management of Nursing Services	Page Reference
1 To implement the recommended staffing levels for workload and safe cover over 24 hours.	17-29
2 To introduce a valid and reliable Workload Measurement System which embraces the major factors influencing staffing levels.	7-16
3 To provide financial information which will enable the Chief Nursing Officer to manage the nursing service within an agreed budget.	7,47
4 To introduce more flexibility in the nursing service through the introduction of staff able to work at times of greatest demand.	17-29, 33-34, 49
5 To reduce the use of the long day shift in those areas of the Hospital where physical and psychological demands upon staff are at their highest.	33-34
6 To improve the time available for handover between shifts.	34
7 To review the 39 hour week agreement to avoid the current unpredictable and disruptive shortfalls of staffing on day shifts.	34
8 To focus the organisation of nursing services upon continuity of care and, to enable this, devolve responsibility to Nursing Officers on a planned basis.	32-33 48-49
9 To give Assistant Chief Nursing Officers defined responsibility and accountability for an area of service.	47
10 To develop the ACNO's role to improving the effectiveness of nursing services and a systematic approach to quality assurance.	38,47
11 To develop a Strategy for Nursing at St Brendan's Hospital, with clear aims and objectives, which will include a reflection of the recommendations within this Report.	

	Page Reference
Improving the Delivery of Nursing Care	
12 Nursing Officers to develop the most appropriate and effective method(s) in organising and managing nurses to ensure that they are empowered to deliver patient-focused care.	31-35
13 To individually plan and design patient's/resident's care needs to achieve optimum outcomes.	31-35
14 To develop a structured and ongoing approach to Care Planning on all Units.	31-35
15 To ensure that patients/residents are full participants in Individualised Care Planning.	31-35
16 To cease the practice of using seclusion/side rooms when other beds are full.	22,35
17 To review the use of Buxton-style chairs with a view to the provision of improved forms of care.	26,35
18 To review the use of unsuitable hostels/homes for elderly and infirm residents.	29
19 To review the requirement for the routine locking of internal doors and (with the exception of the Special Care Units) to review the routine locking of external doors.	35
20 To urgently improve the adequacy of the maintenance of the patient environment with a view to a regular and timed approach to repairs.	36
21 To complete a review of Health and Safety issues resulting from the poor environment eg use of stairs by the elderly and infirm and difficulties of lifting and handling.	36
22 To develop opportunities for organised occupation or activity for all patients/residents.	37-38

	Page Reference
Development of Clinical Skills	
23 To promote organised learning of all staff, not only in the classroom, but also within each Unit and through visits to other services.	46
24 To provide the opportunity for all Nursing Officers and Deputy Nursing Officers to obtain basic teaching qualifications.	46
25 To continue to develop the In Service Training programme and training priorities to include subject matter relevant to the promotion of patient focused care.	39,43
26 To establish and maintain an up to date record of the nursing qualifications, skills and training of each nurse.	44-45
27 To provide facilities and opportunities for nurses to use and develop acquired skills and training.	44-45
28 To provide training in basic care skills for 'hands on' nursing aides.	39
29 To identify and foster clinical nursing skills required for the future development of psychiatric services.	46
30 To appoint a teacher with full time responsibility for the development of In Service Training and promotion of Post Registration Education.	46
31 To publish, and consistently apply, a policy in relation to conditions of service and funding of In Service Training and Post Registration Education.	46
General Recommendations	
32 To implement a multidisciplinary approach to Quality Assurance including the establishment of measurable standards and ongoing audit and feedback.	38,47
33 To seek the active cooperation of all disciplines to ensure effective multidisciplinary and collaborative planned care.	31-33 46

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- 1) Eastern Health Board (November 1995) 'Psychiatric Services. Development Programme into the next Millennium.'
- 2) Hirsh W (1986) 'Planning with a purpose,' Senior Nurse, 4, 3, pp 18-20
- 3) Ball J., Goldstone L.A. (1986) 'Criteria for Care' - The Manual of the North-West Nurse Staffing Levels System, Newcastle-Upon-Tyne Polytechnic Products Limited.
- 4) Fawcett R (1985) 'Manpower Planning : Art or Science?' Nursing Mirror 160, 1, pp 20-22
- 5) Hurst K and Howard D (1988) 'Measure for Measure' Nursing Times 84, 22, pp 30-32
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- 8) Ball J, Hurst K, Booth M and Franklin R (1989) '....But who will make the Beds' A Research Based Strategy for Ward Nursing Skills and Resources for the 1990's. Leeds : University of Leeds, Nuffield Institute.
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LIST OF APPENDICES

HOURLY STAFFING LEVEL OVER SEVEN DAYS:

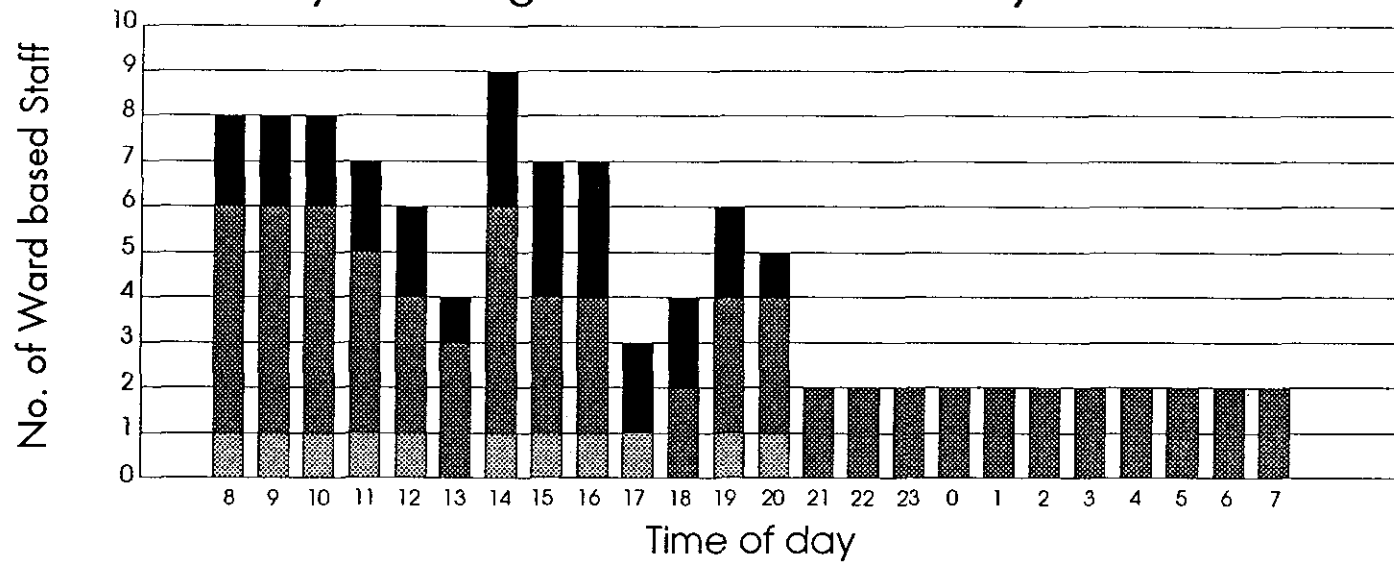
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| Appendix 1 | Acute Care Wards |
| Appendix 2 | Special Care Wards |
| Appendix 3 | Long Stay Mobile Psychiatric Care Wards |
| Appendix 4 | Elderly Mentally Infirm Wards |
| Appendix 5 | Rehabilitation Unit |
| Appendix 6 | Rehabilitation Hostels and Homes |
| Appendix 7 | Day Care |

OTHER APPENDICES

- | | |
|--------------------|---|
| Appendix 8 | Other factors which affected nurse staffing during the week of the Survey |
| Appendix 9 | Number of Patients/Residents who leave their Units to attend Occupational Therapy or Work |
| Appendix 10 | Guidelines for Multidisciplinary Clinical Team Working. |

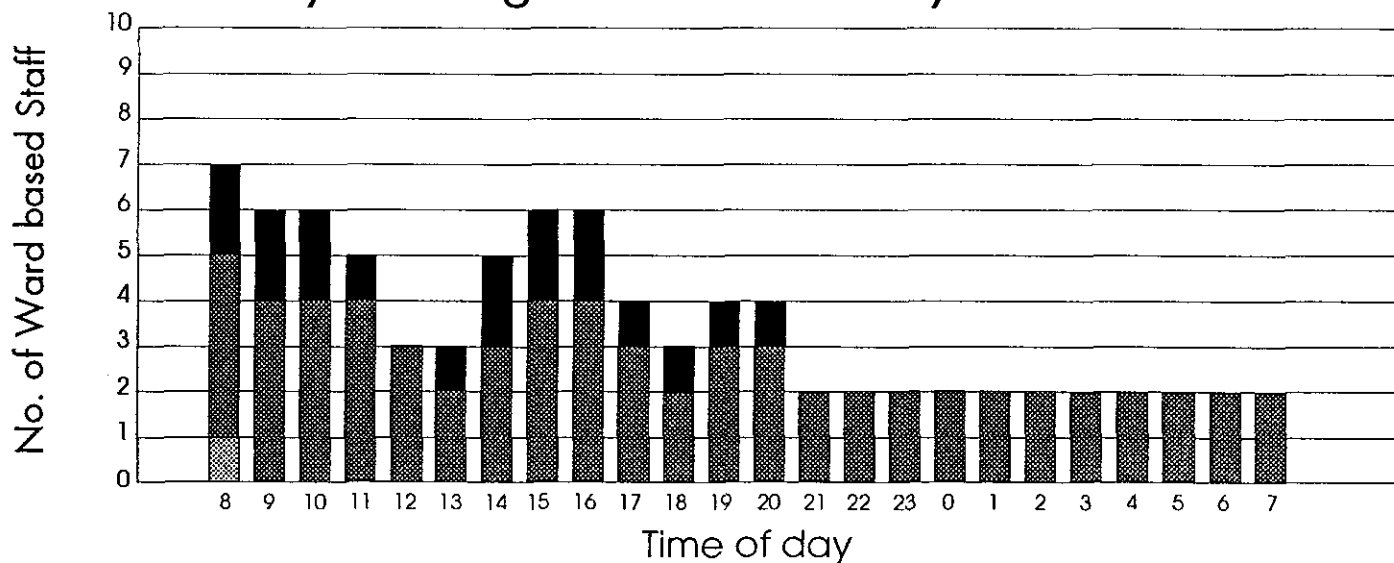
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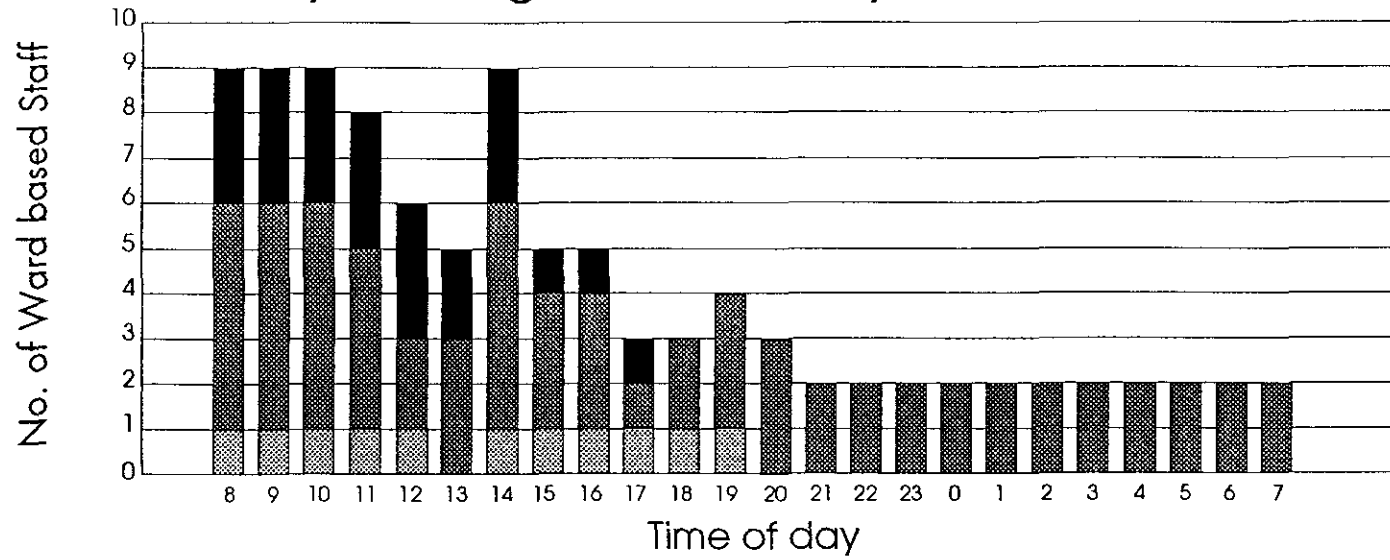
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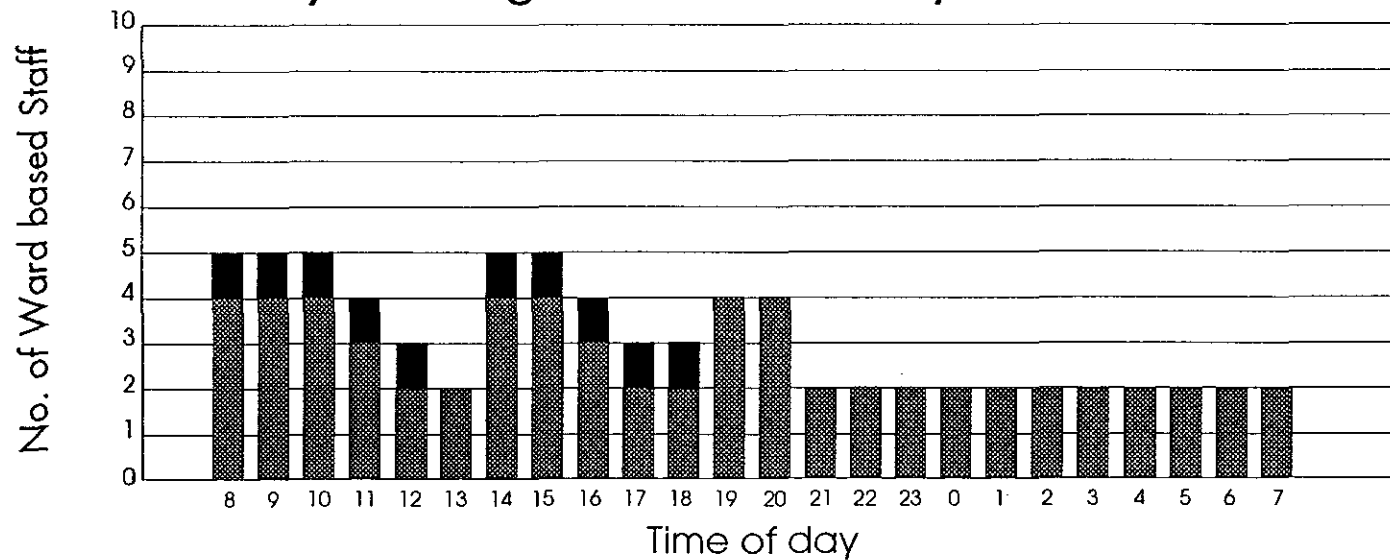
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- Staff Nurses
- Std Nurses
- Aide/Hands-on

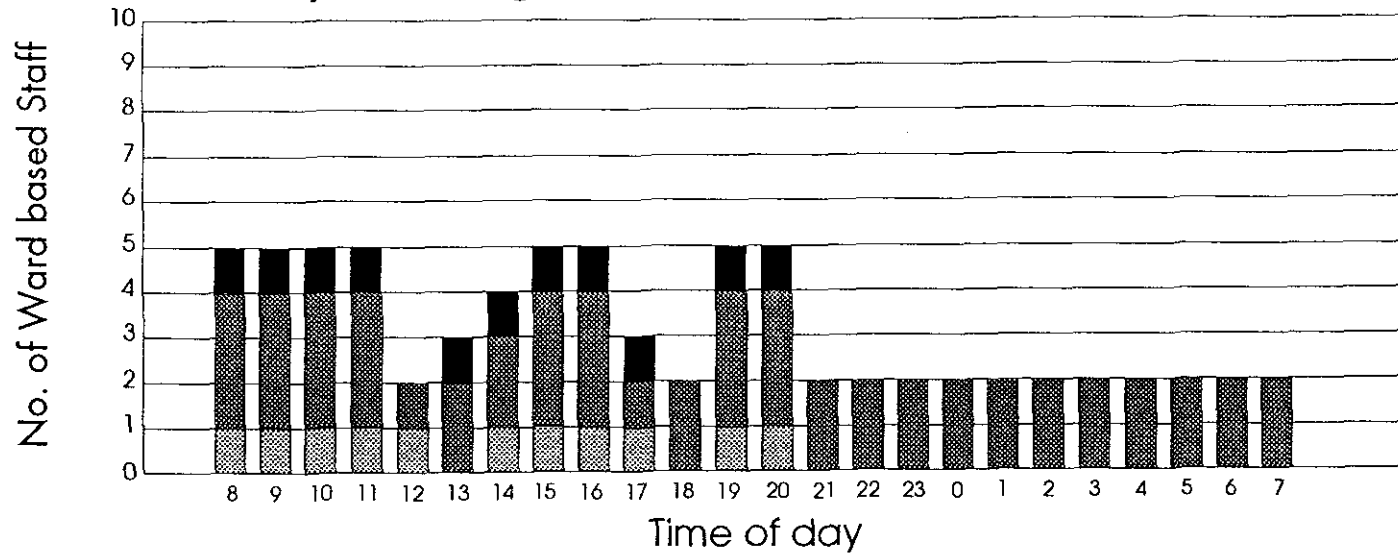
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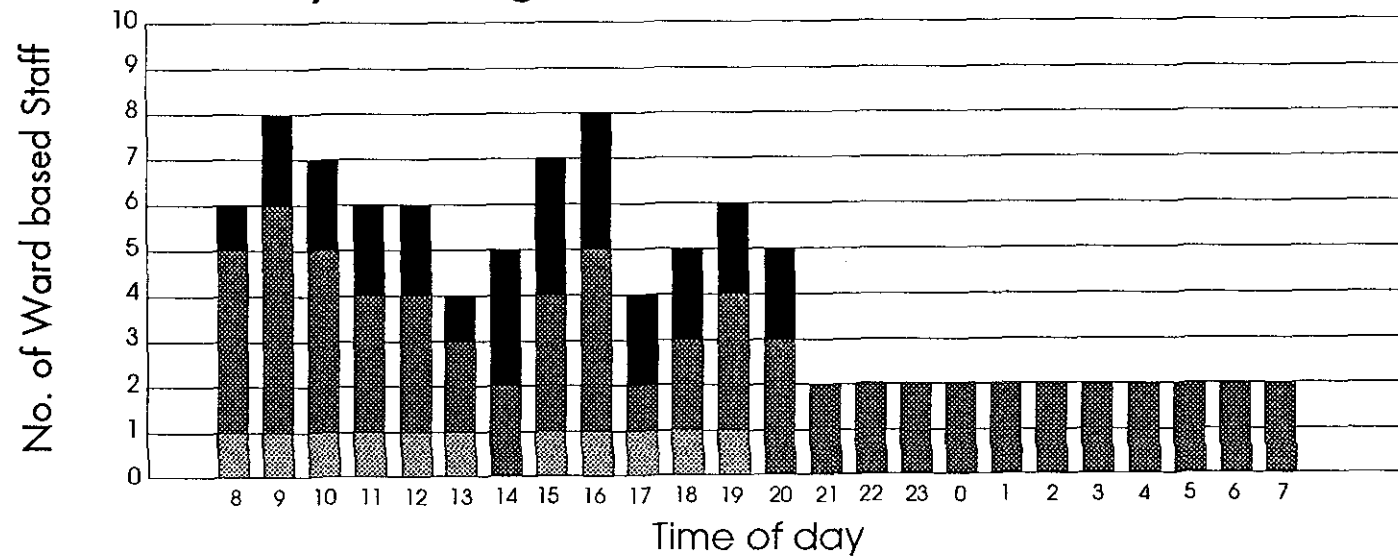
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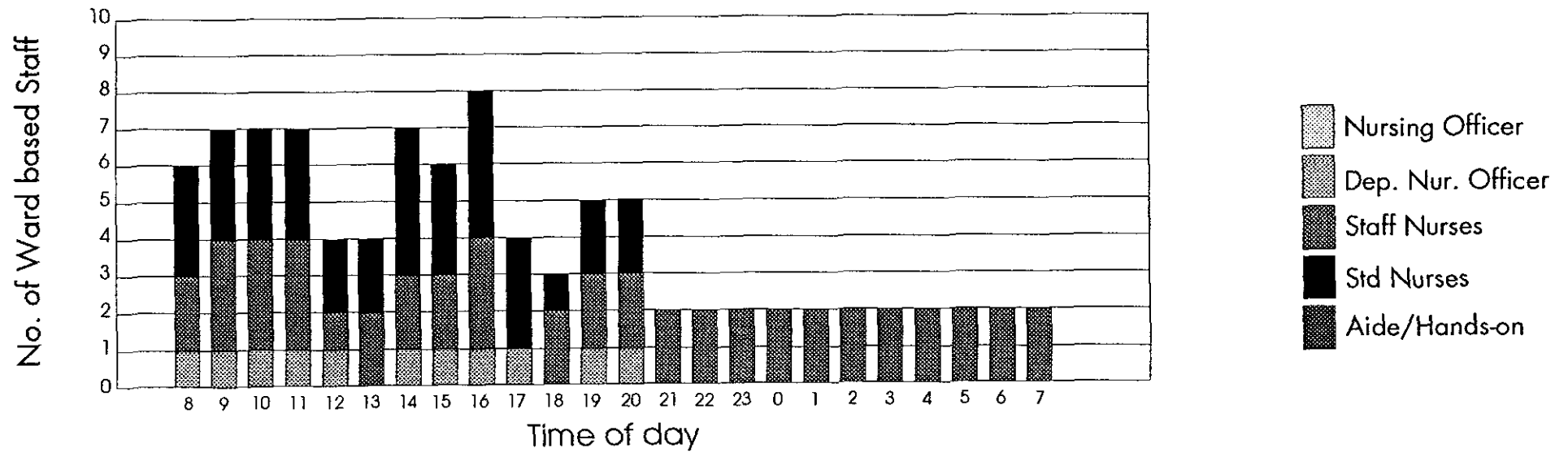
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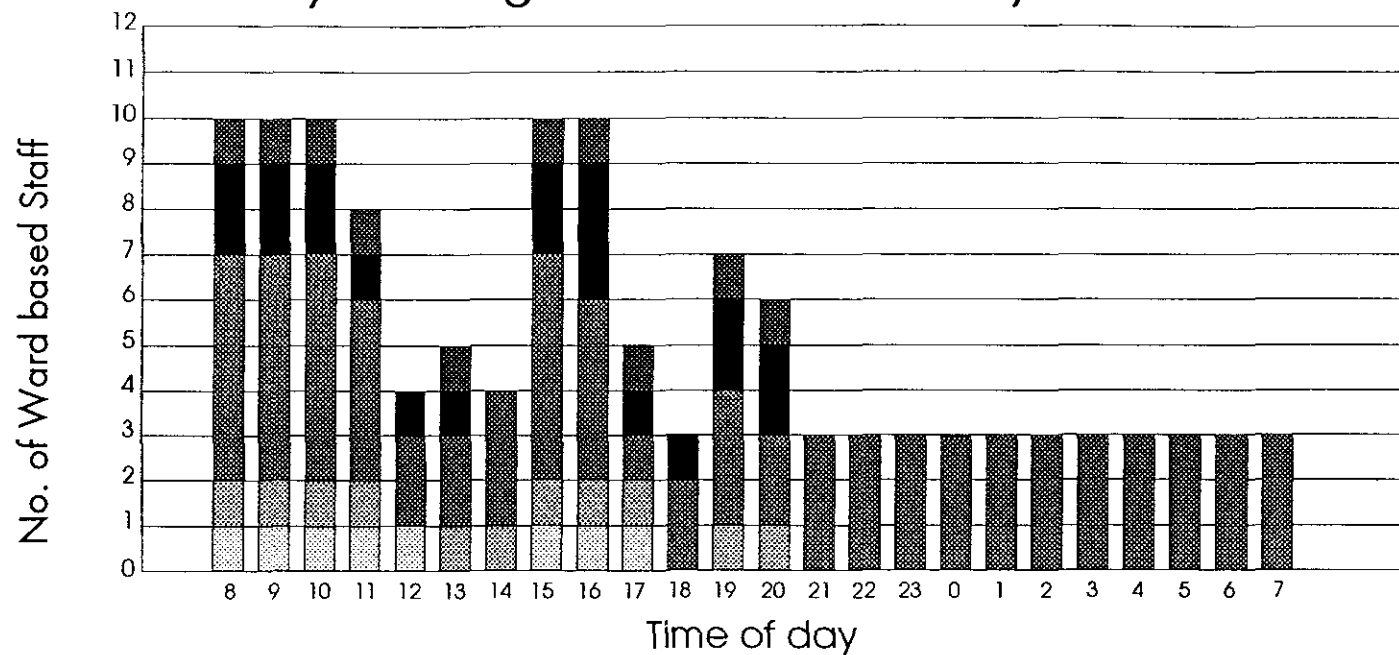
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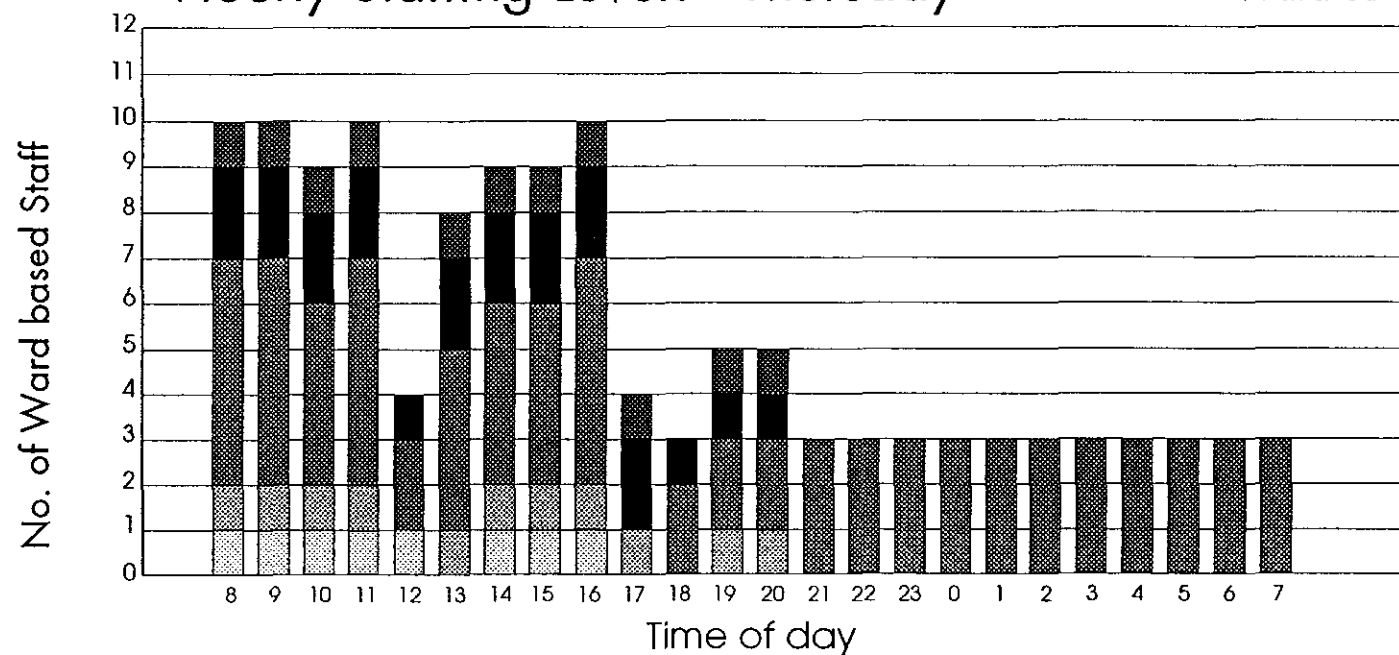
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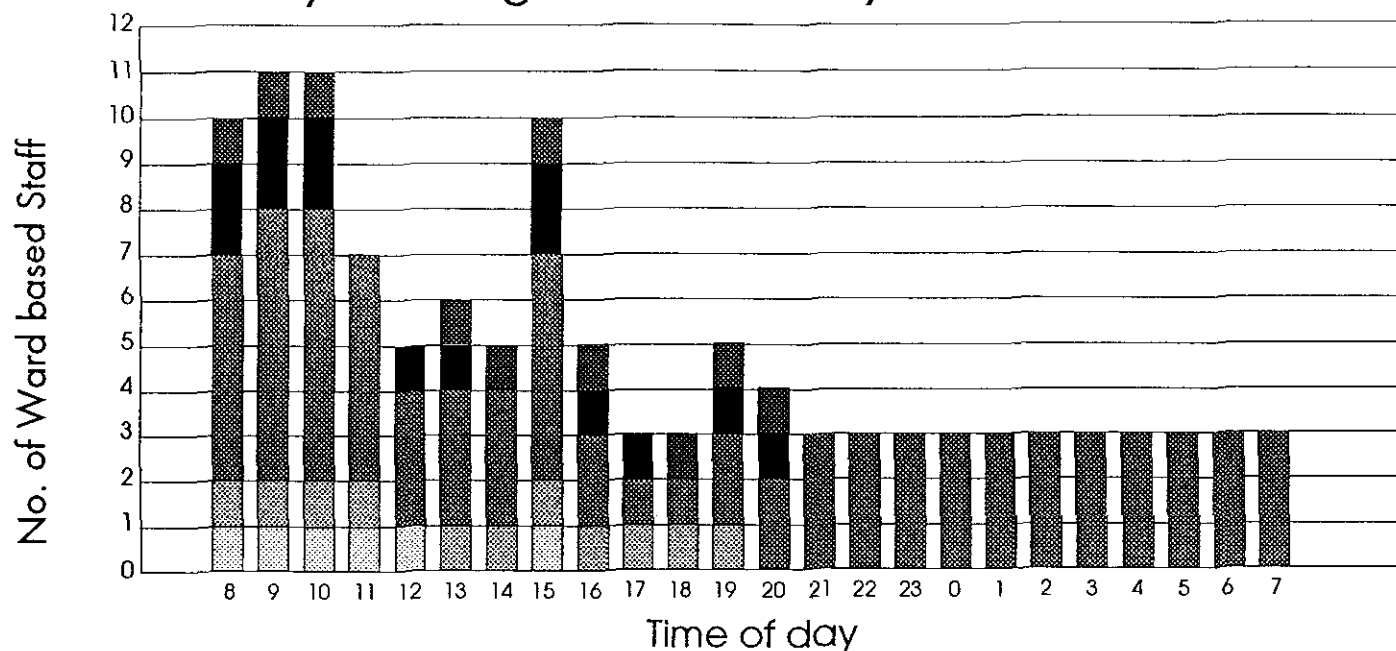
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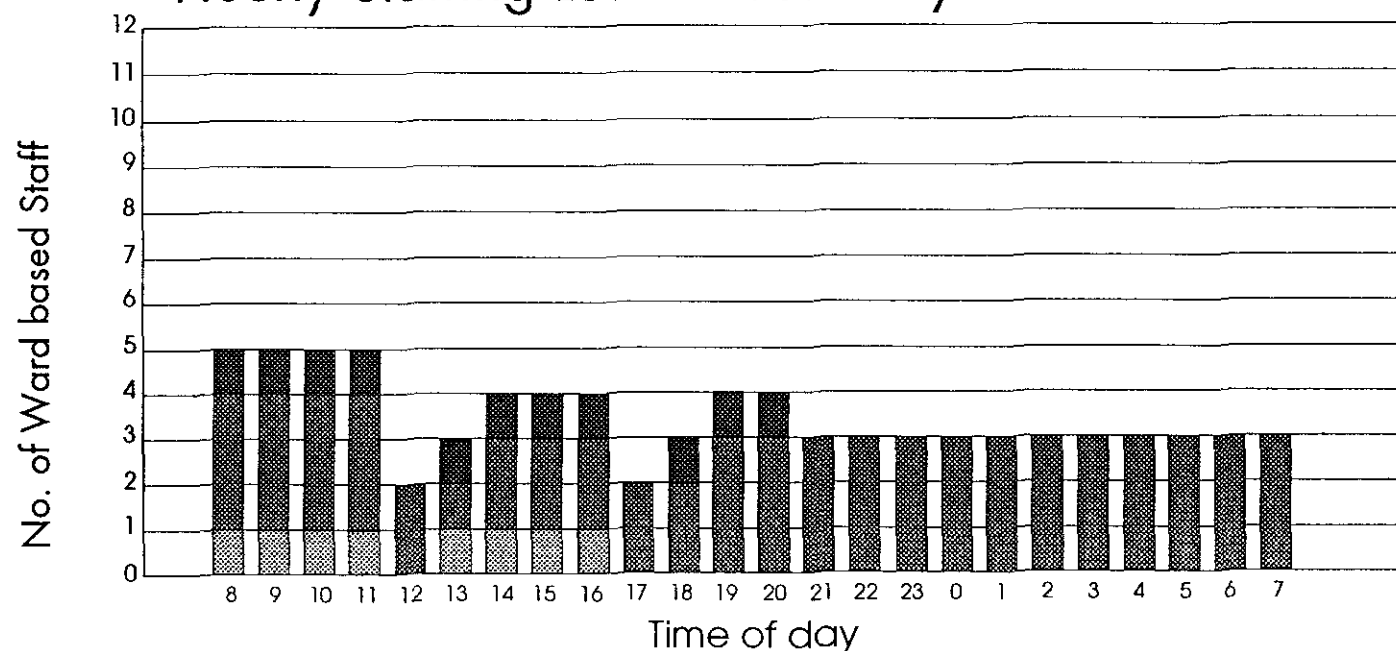
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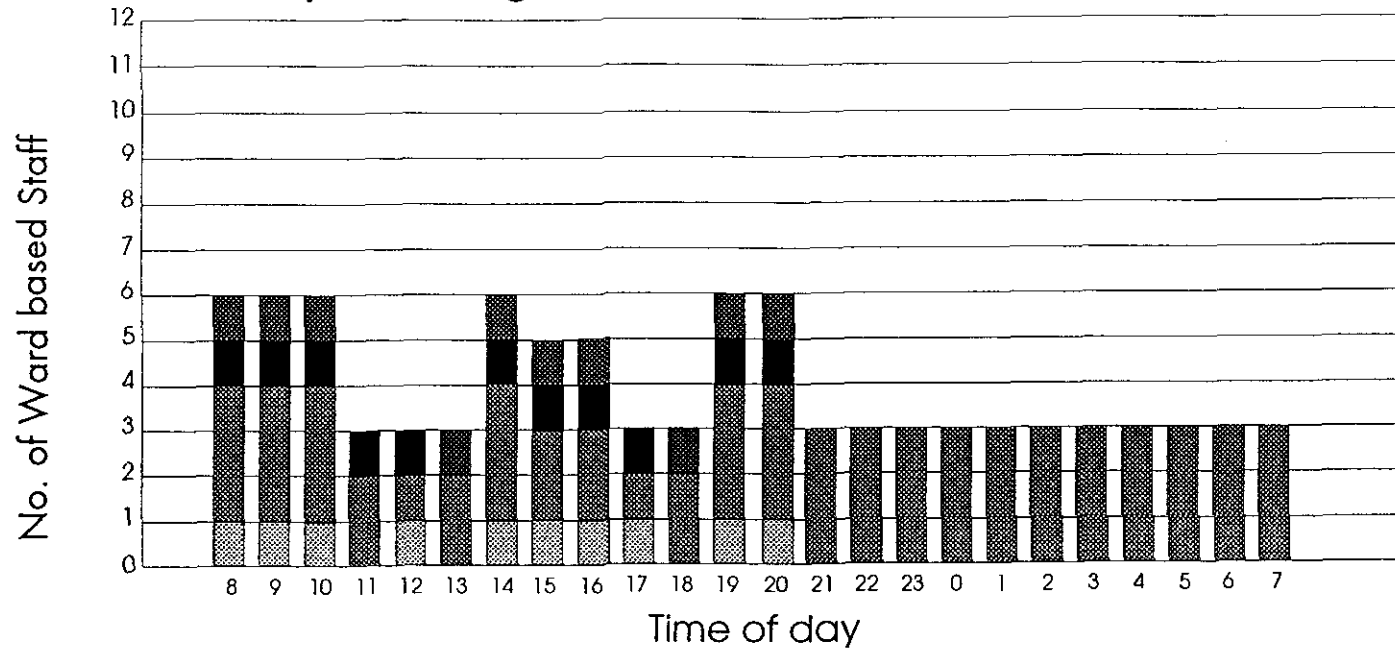
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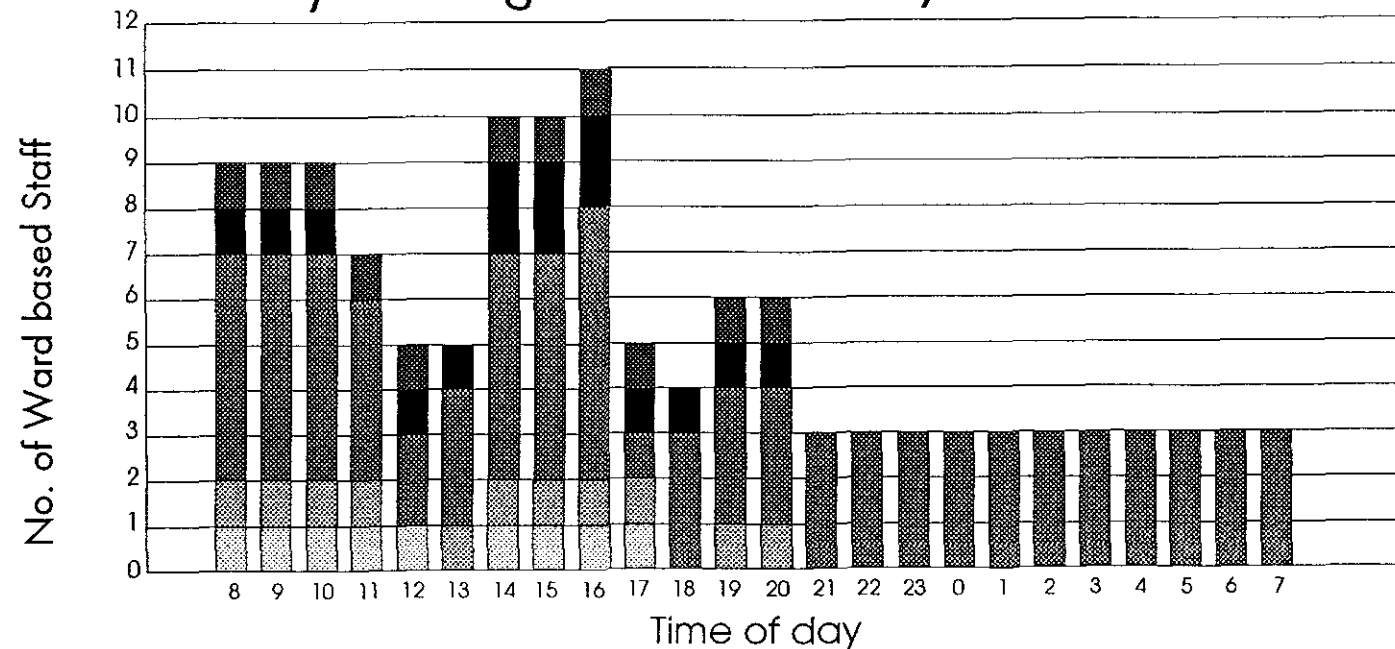
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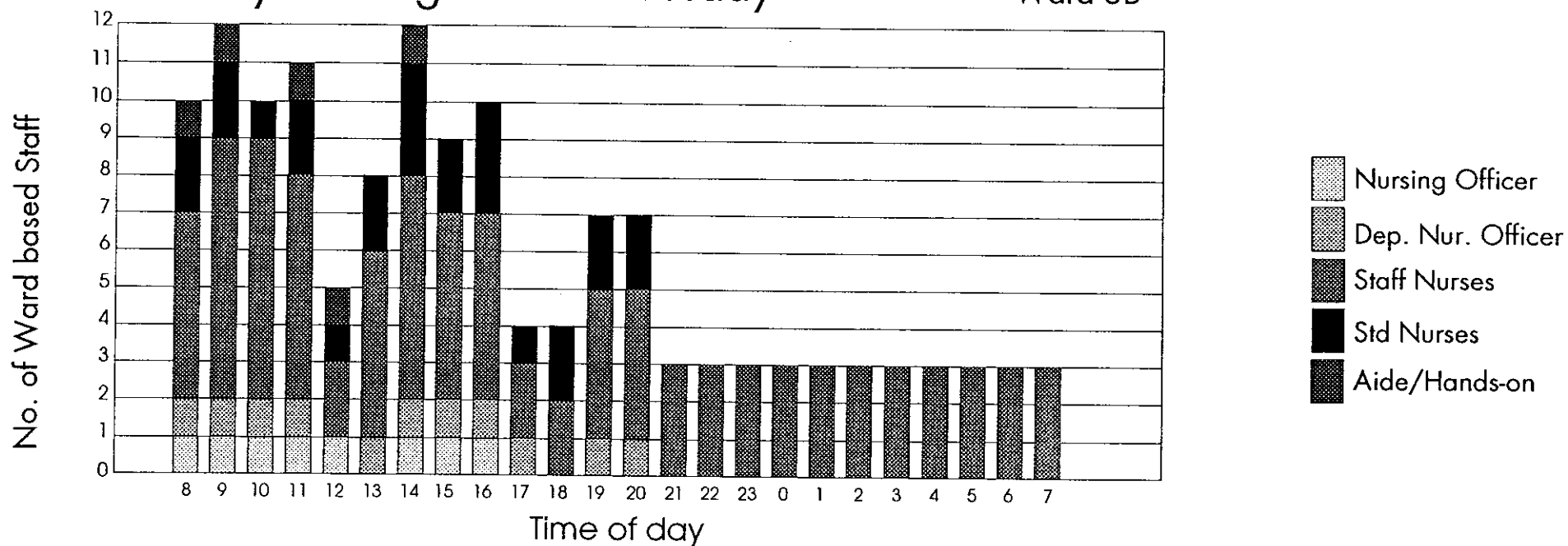
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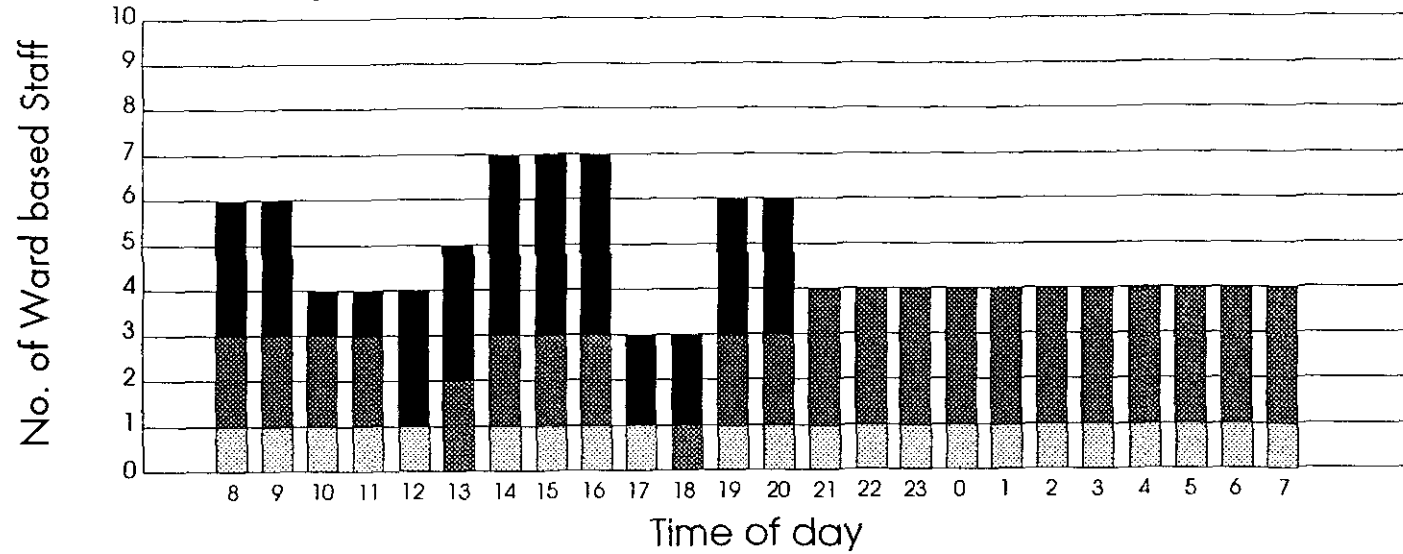
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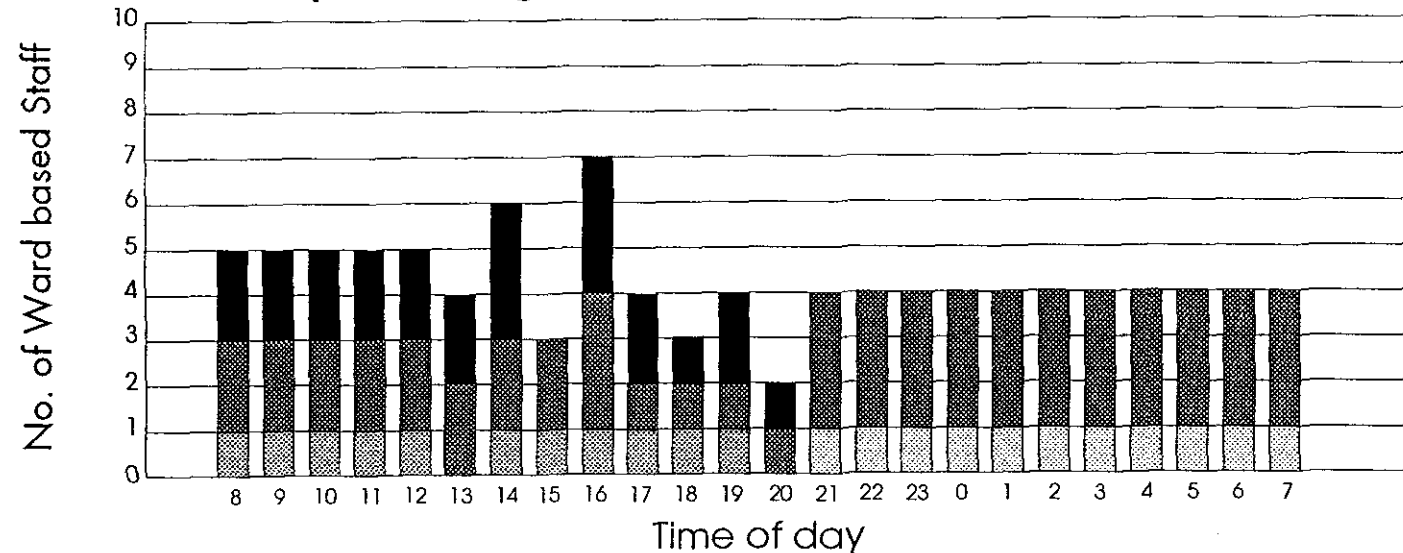
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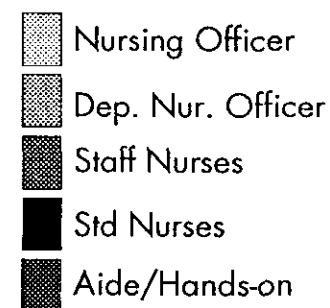
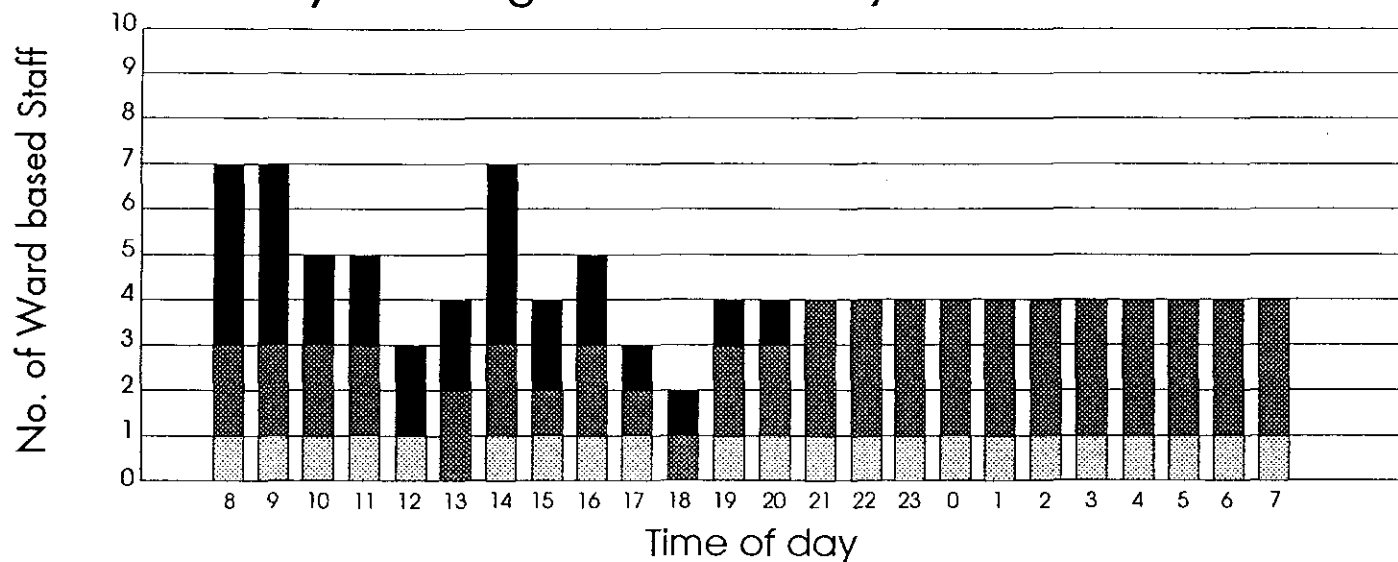
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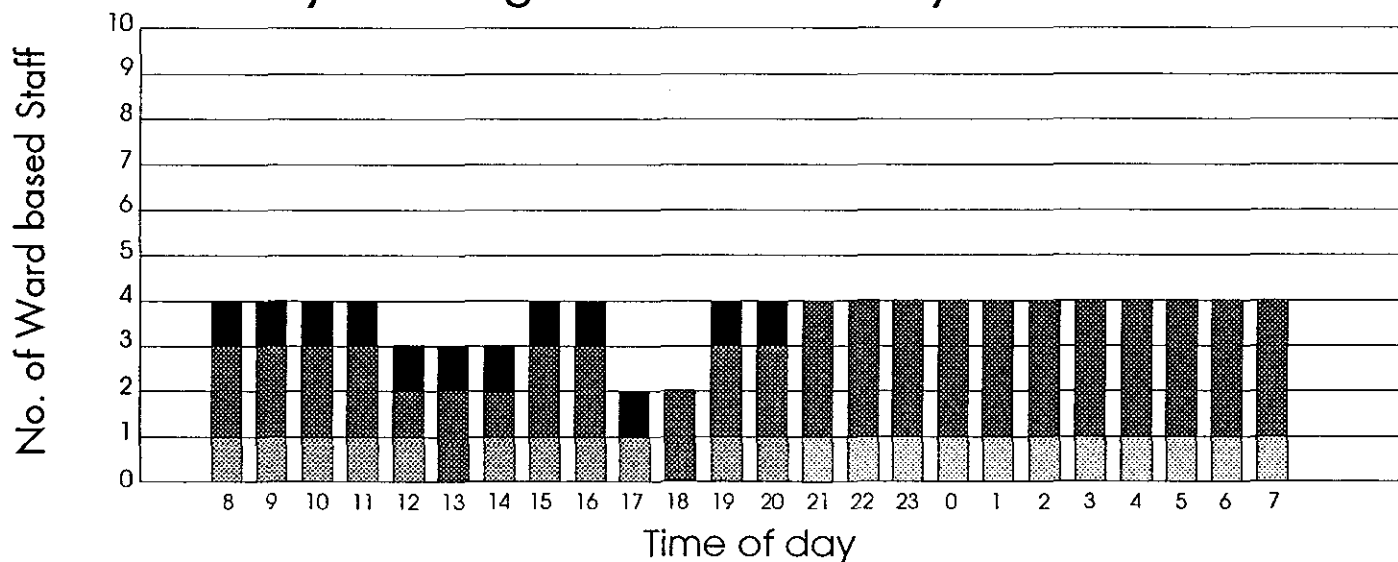
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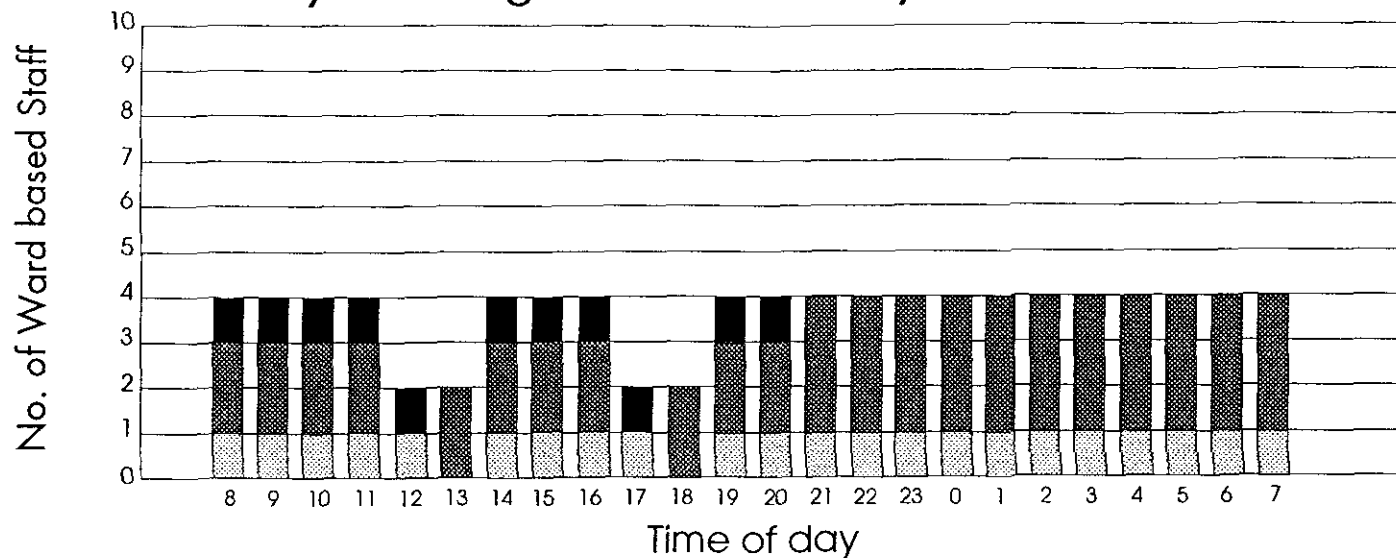
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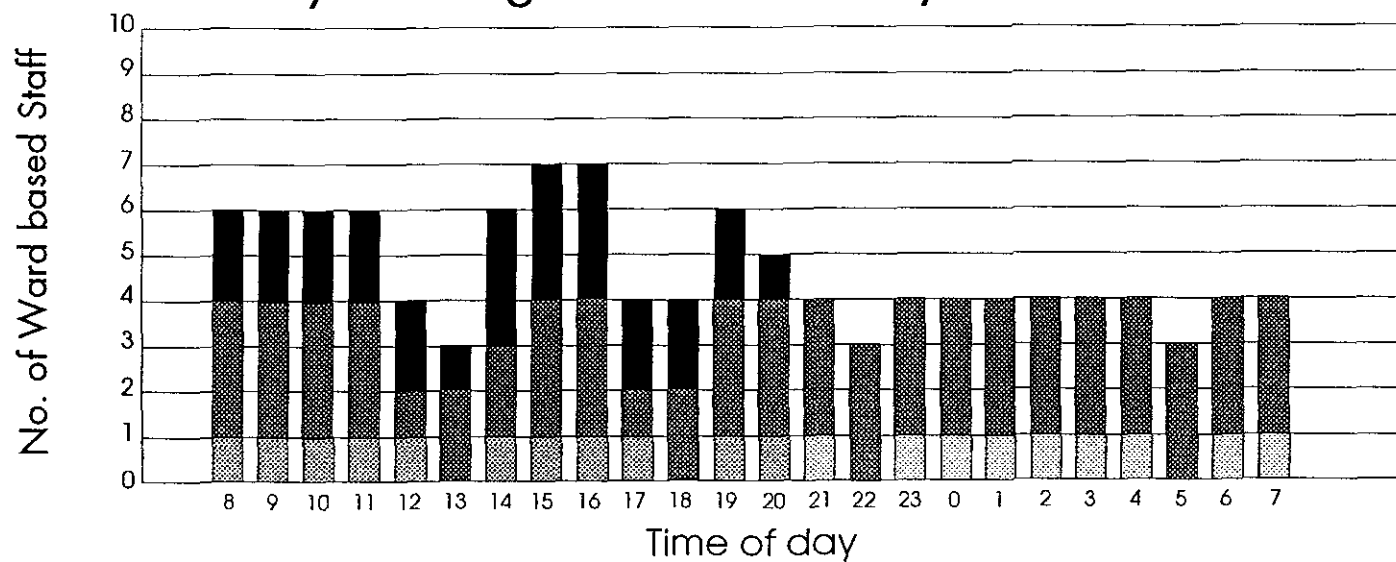
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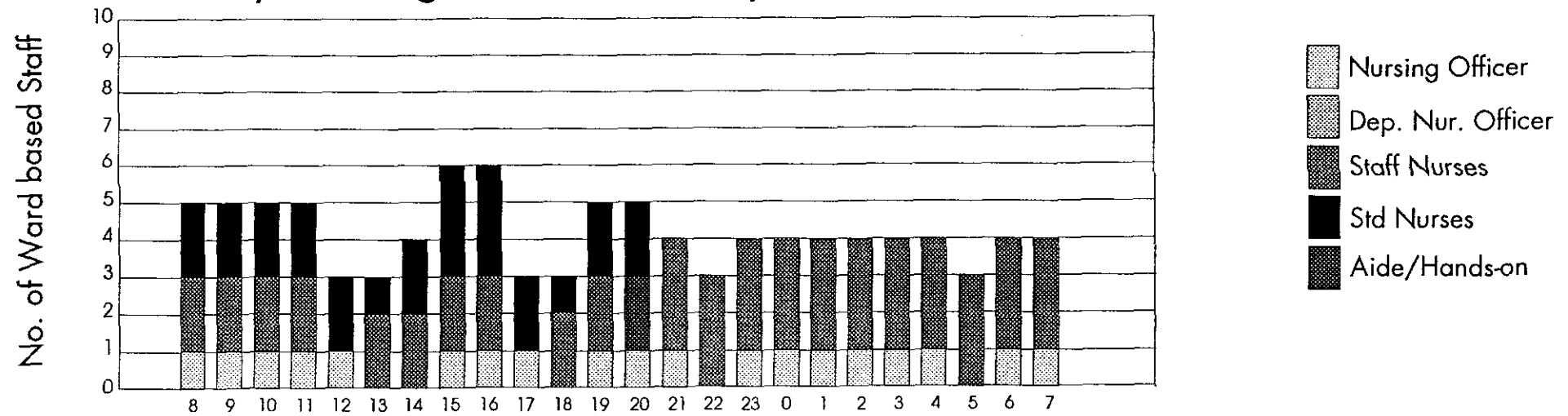
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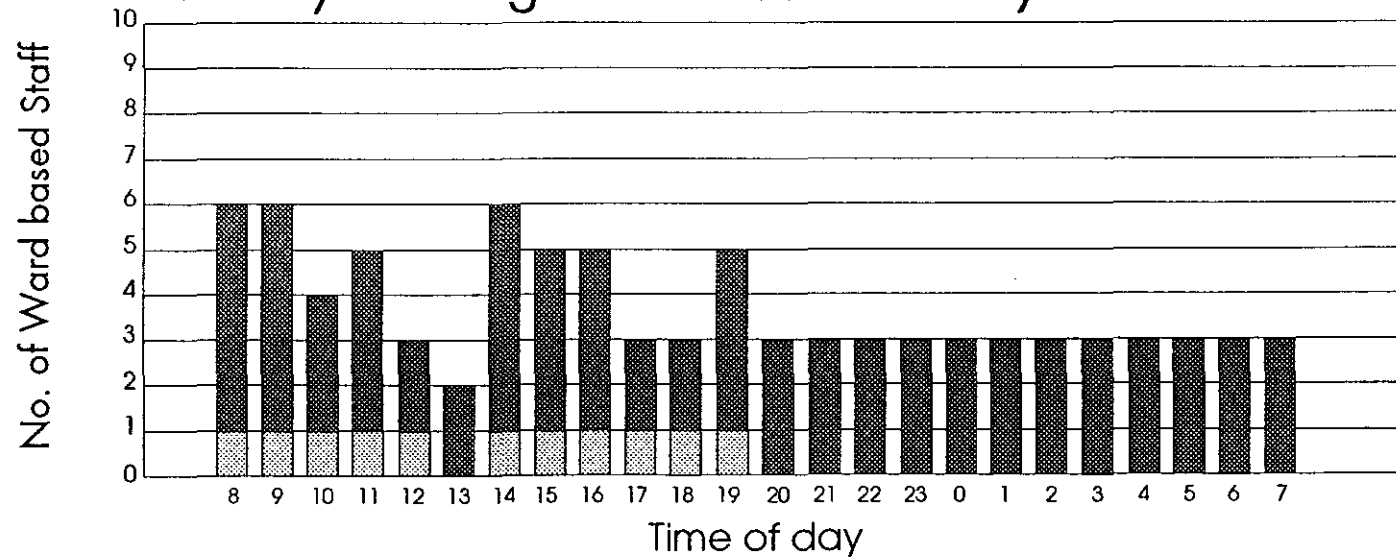
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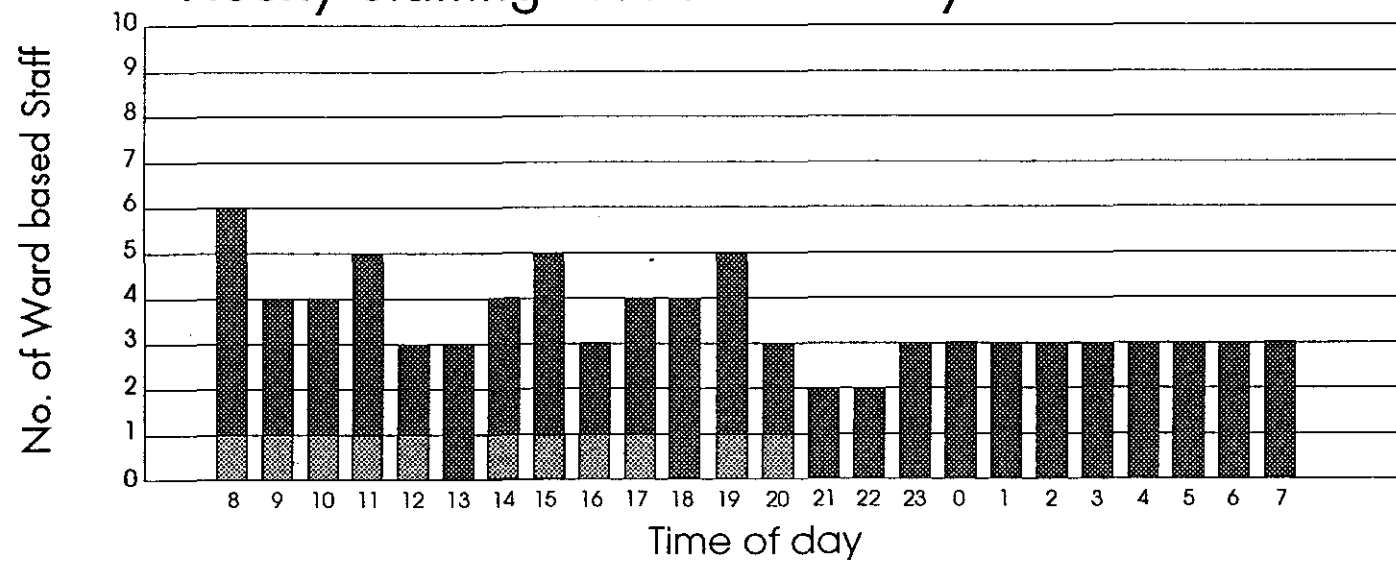
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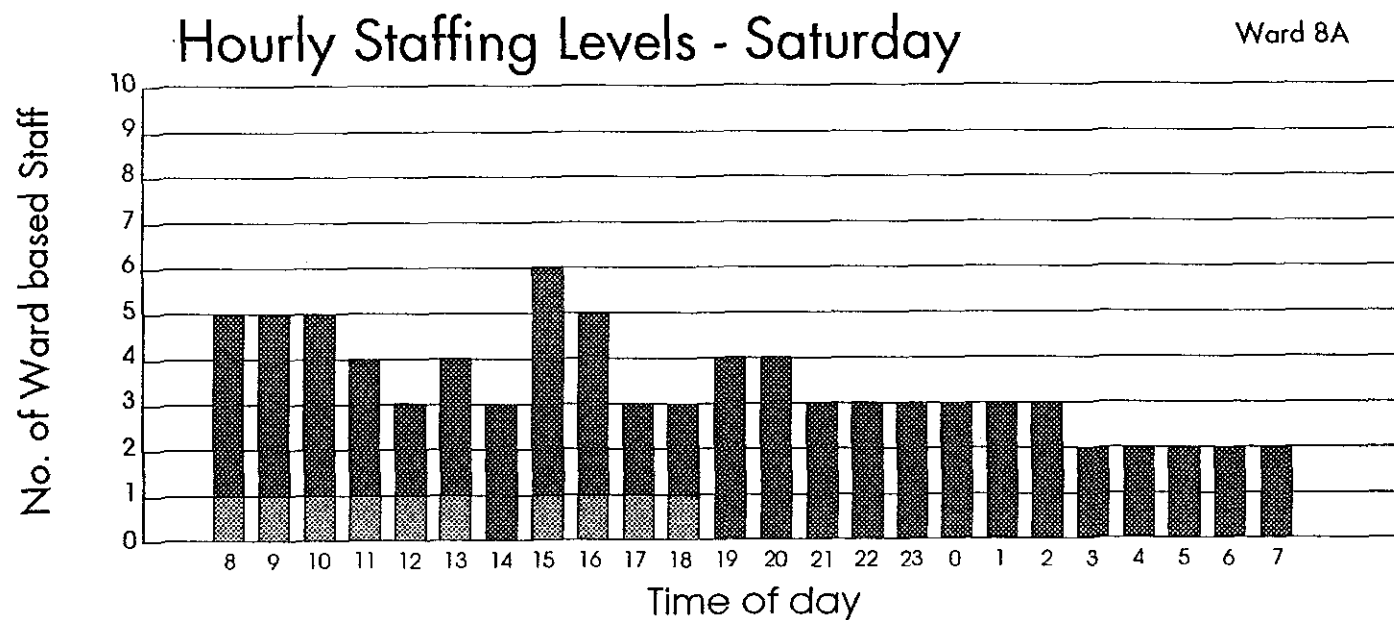
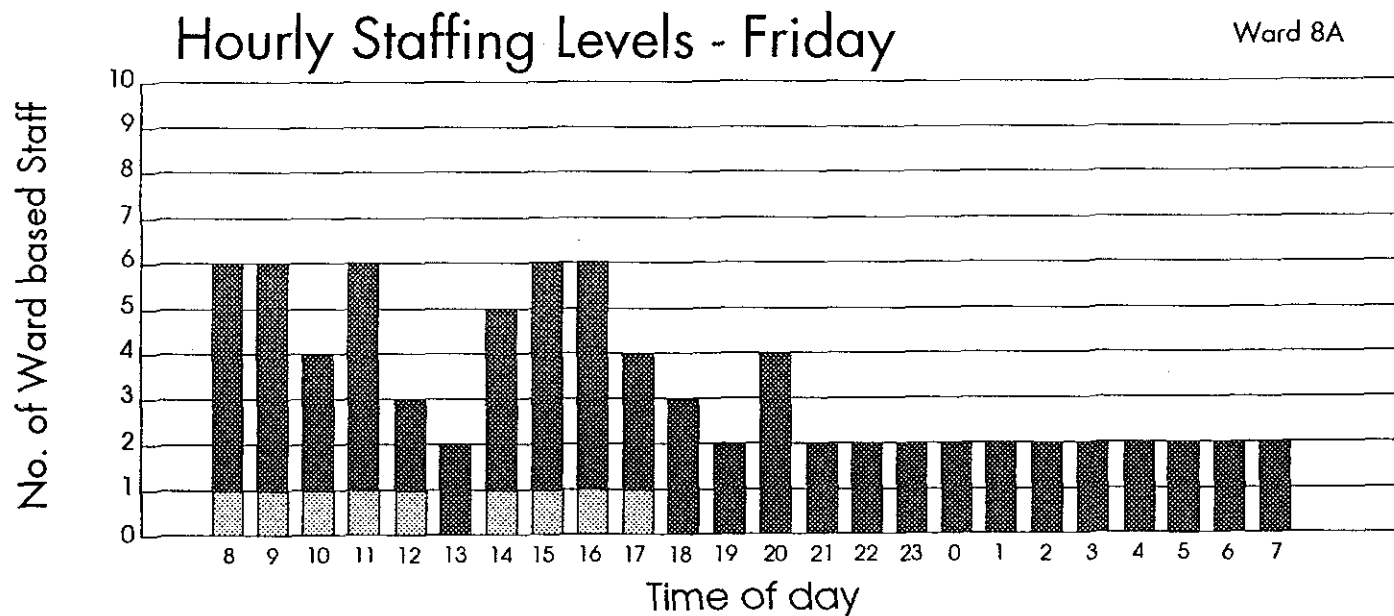
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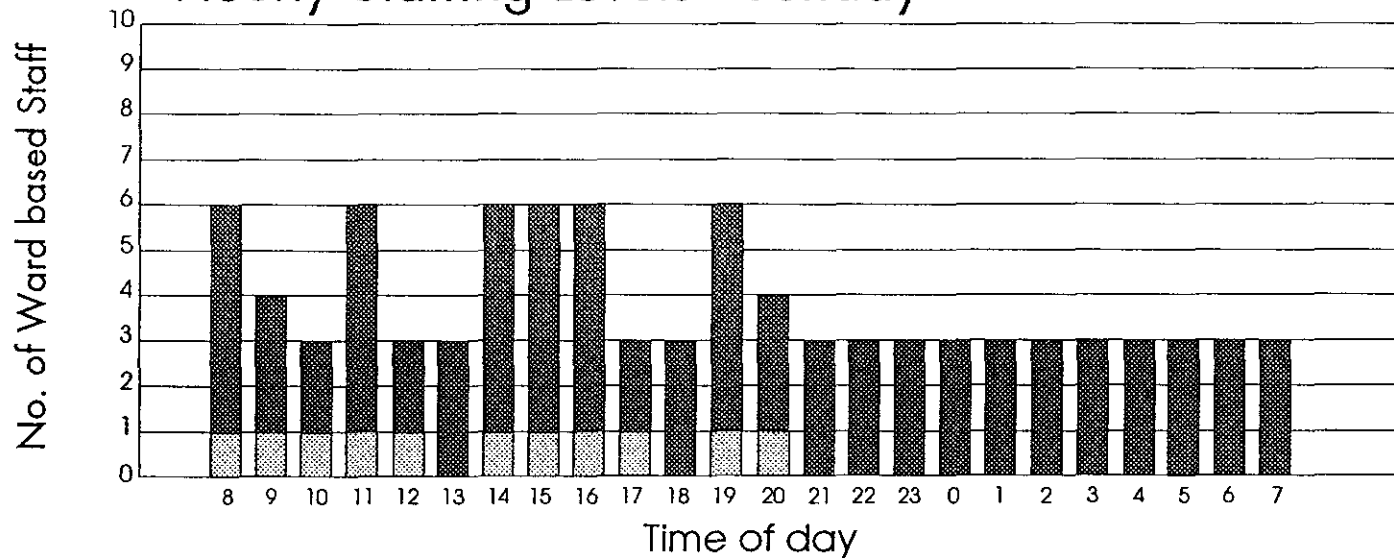
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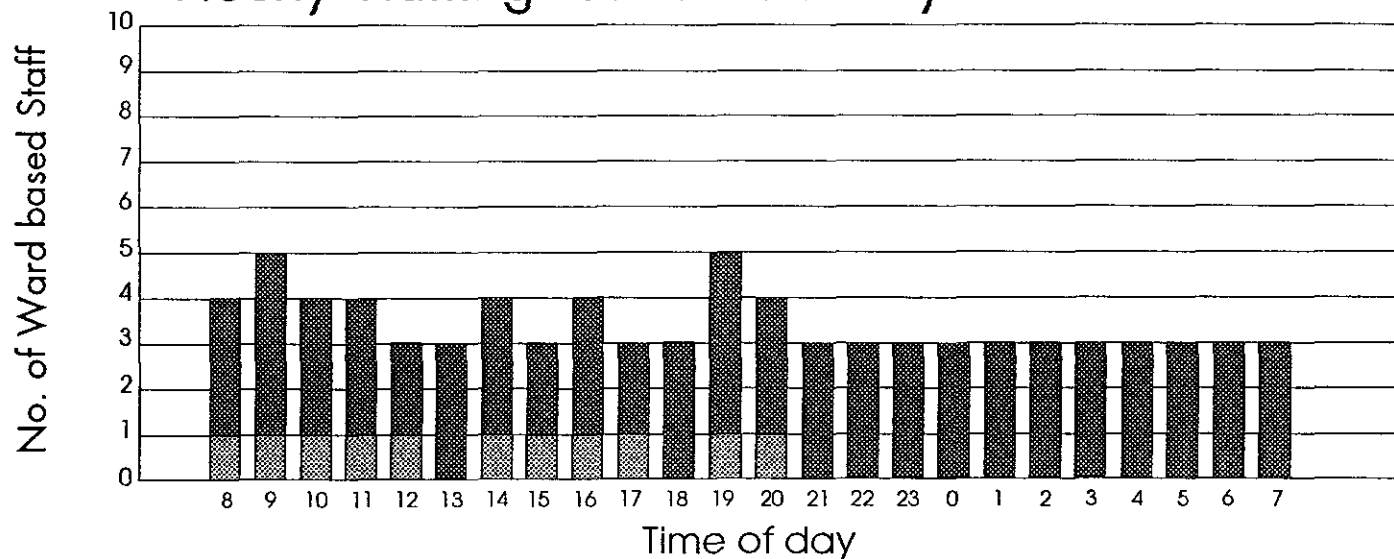
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



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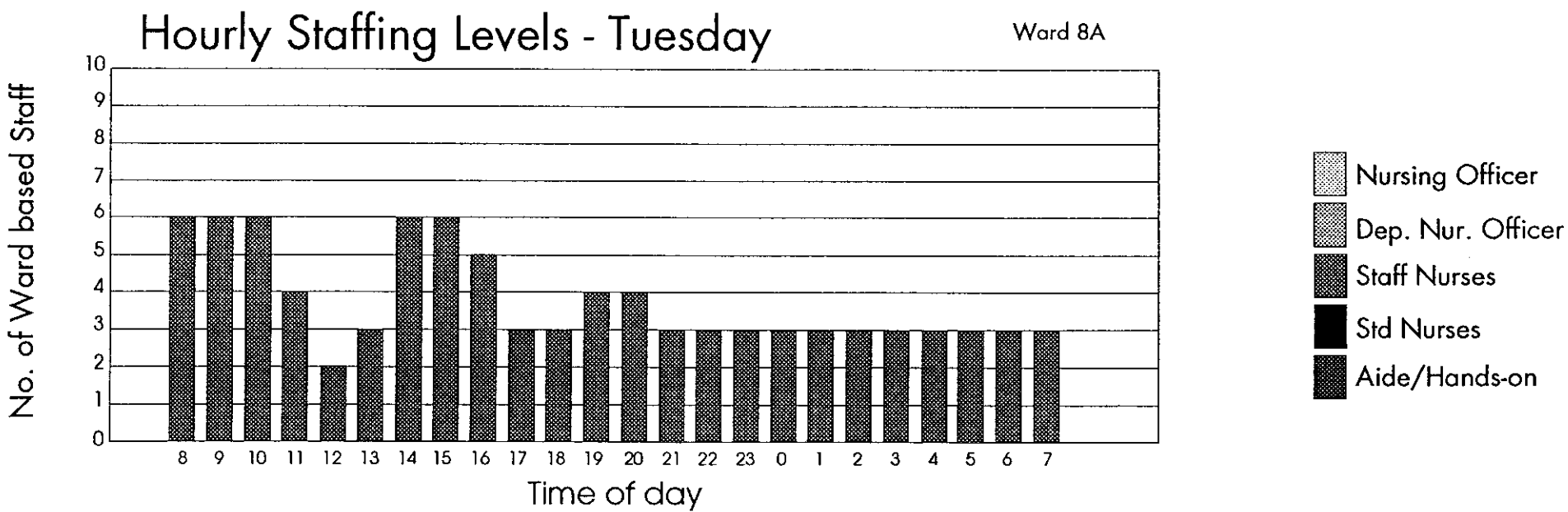


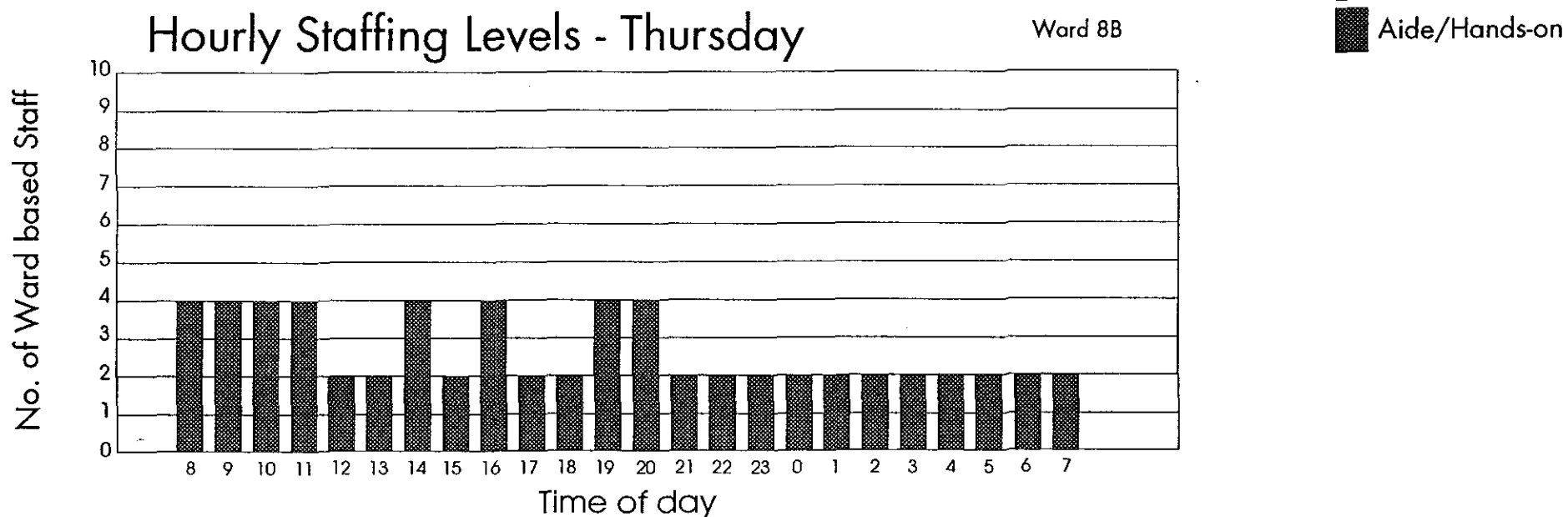
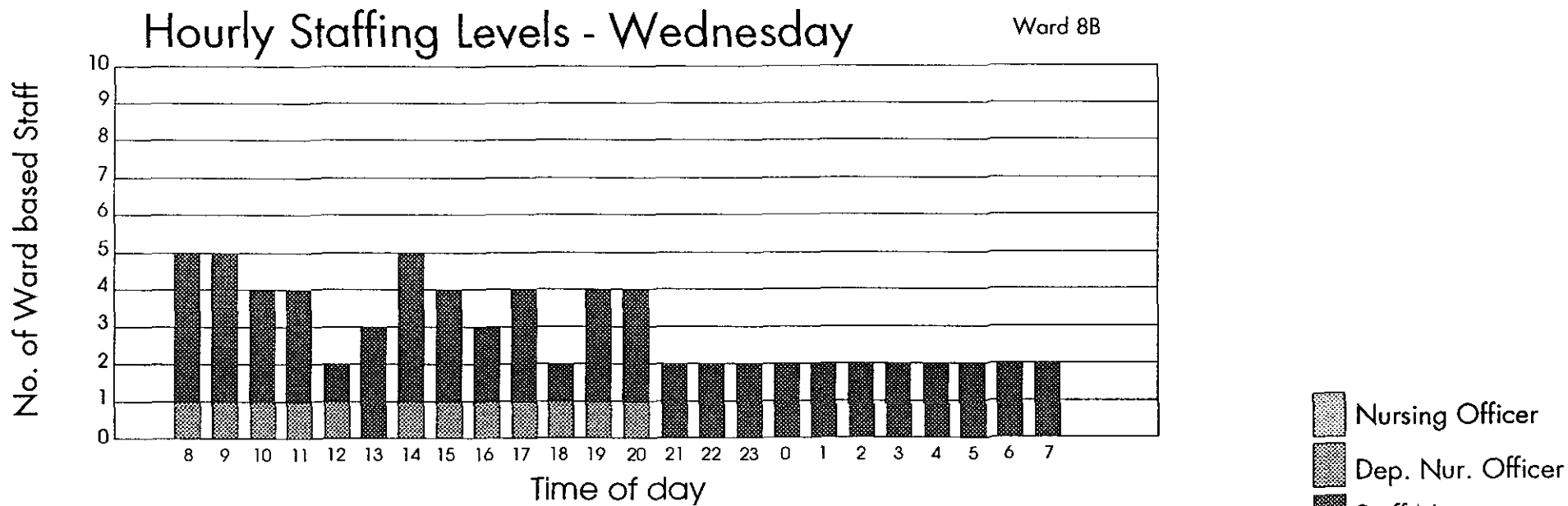
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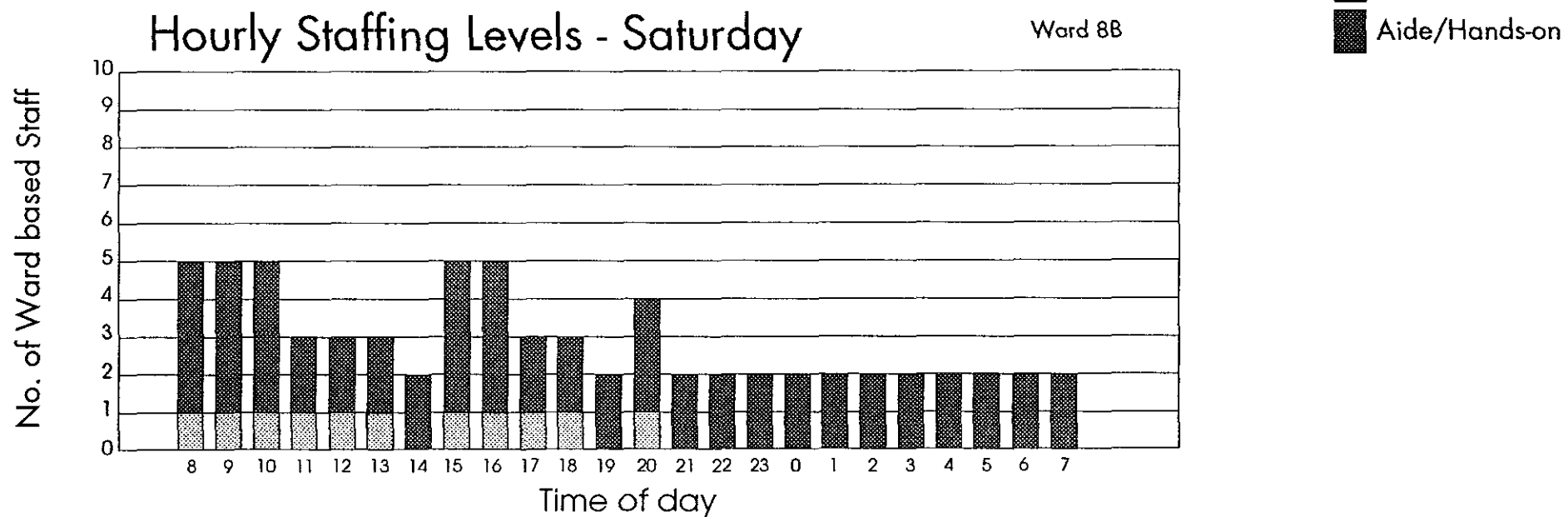
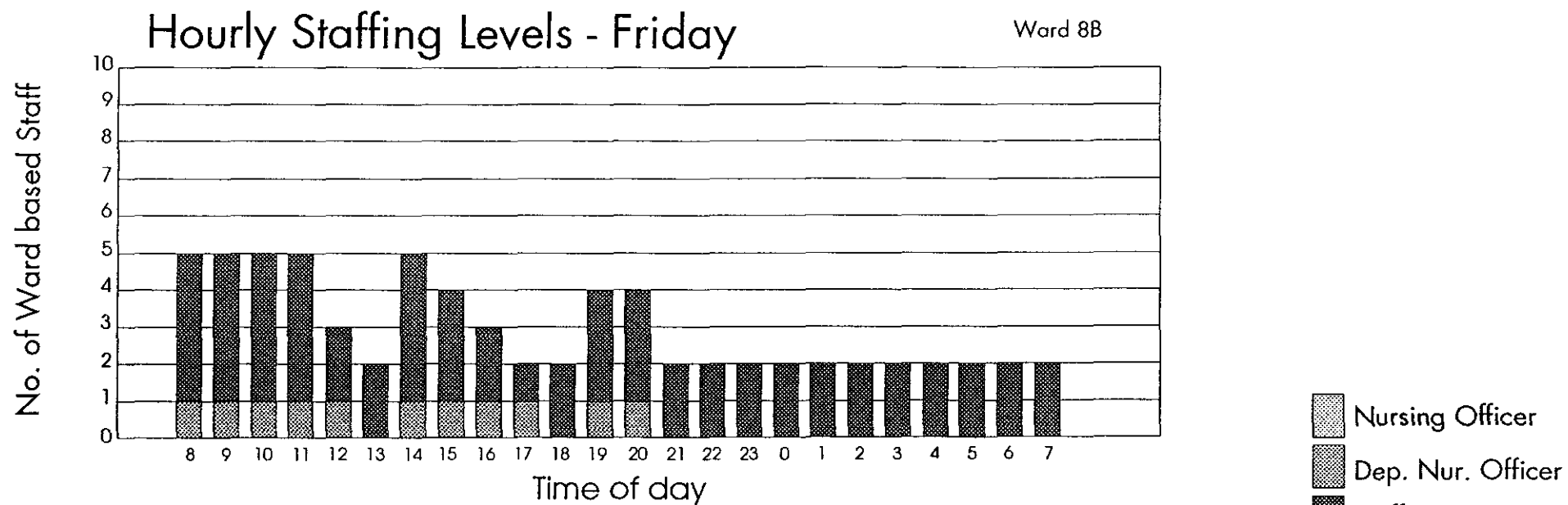
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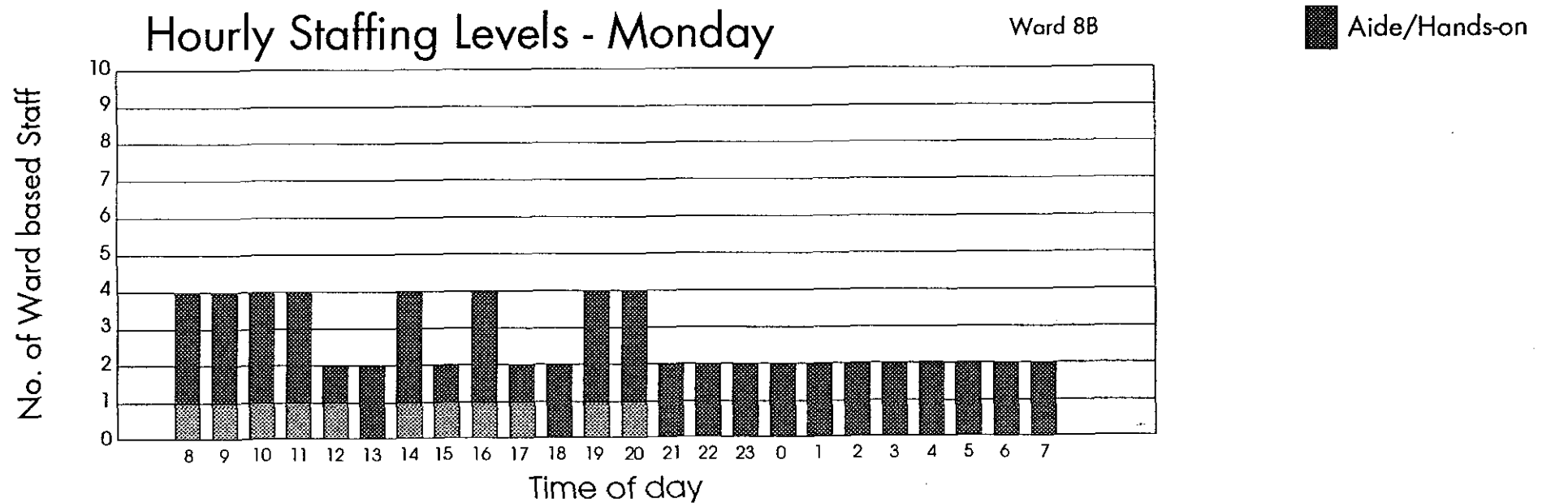
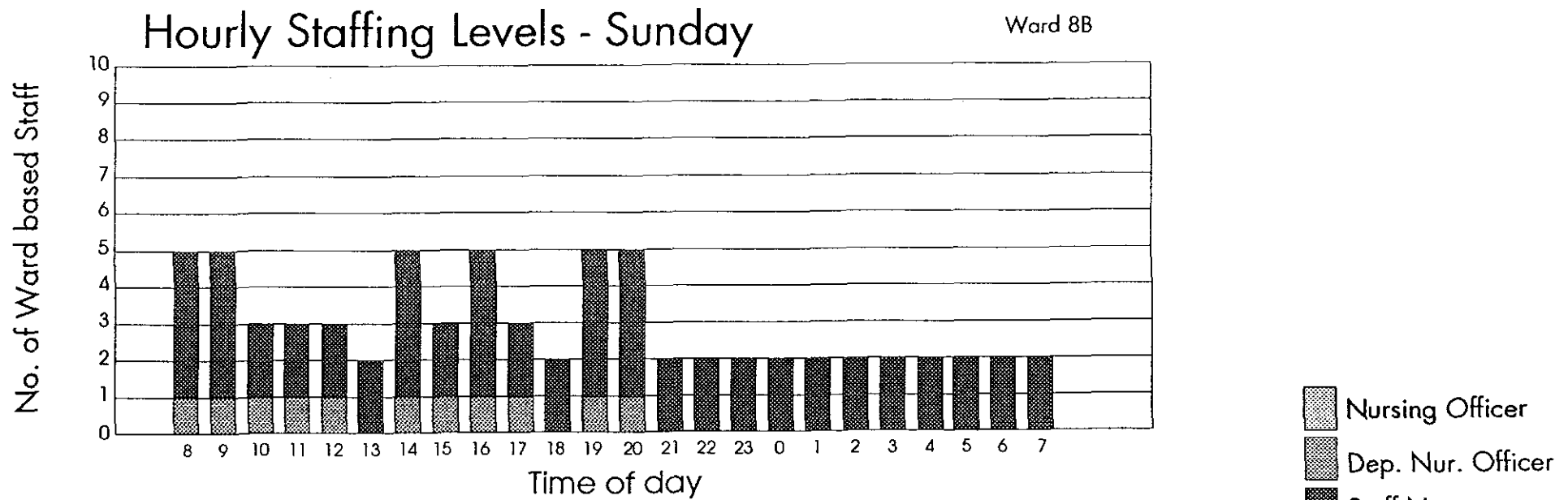


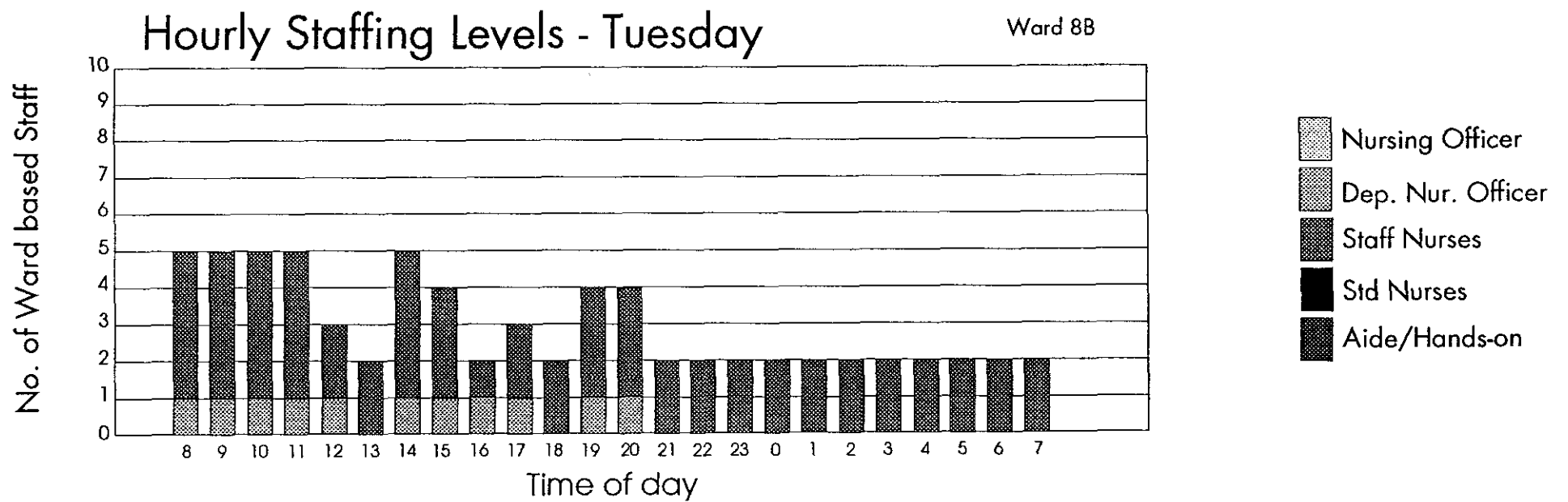
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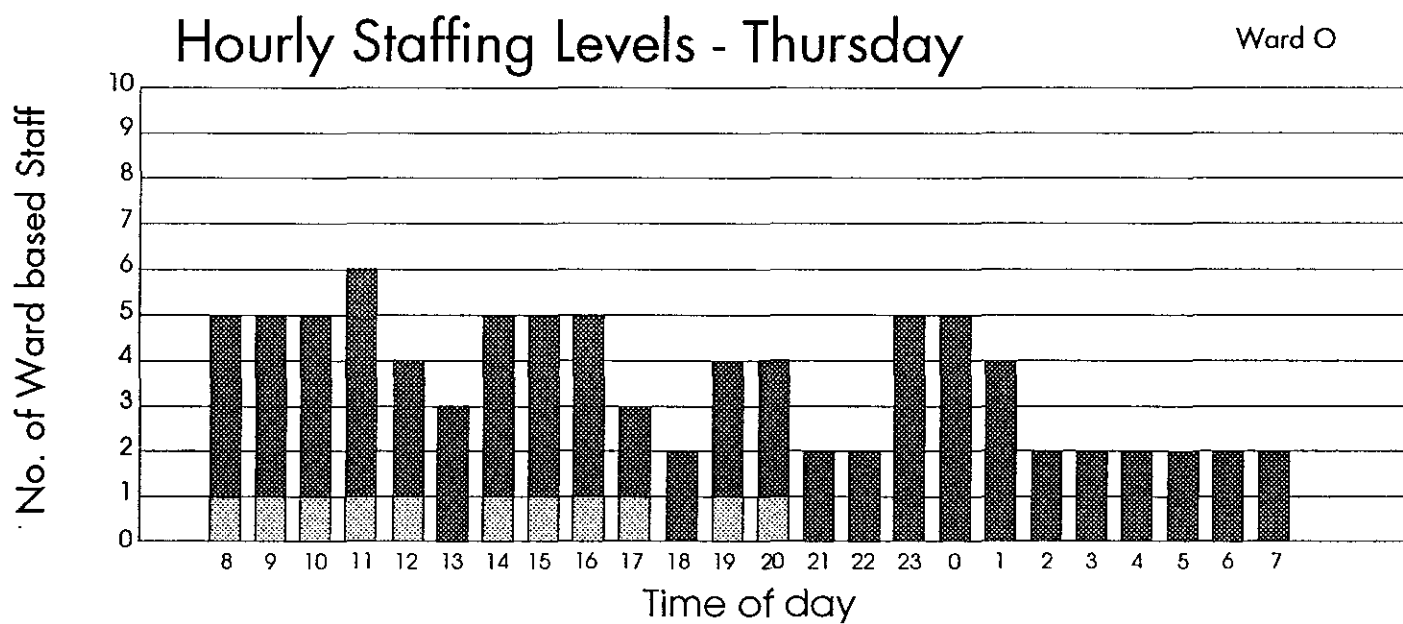
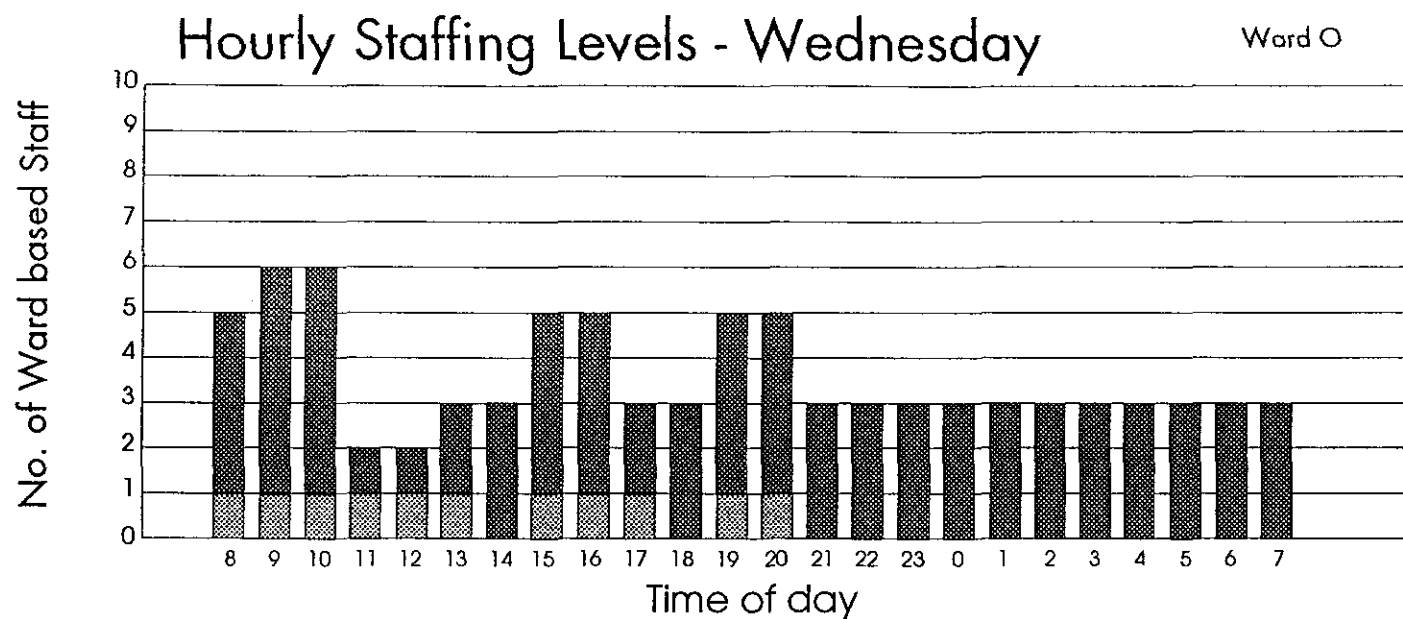









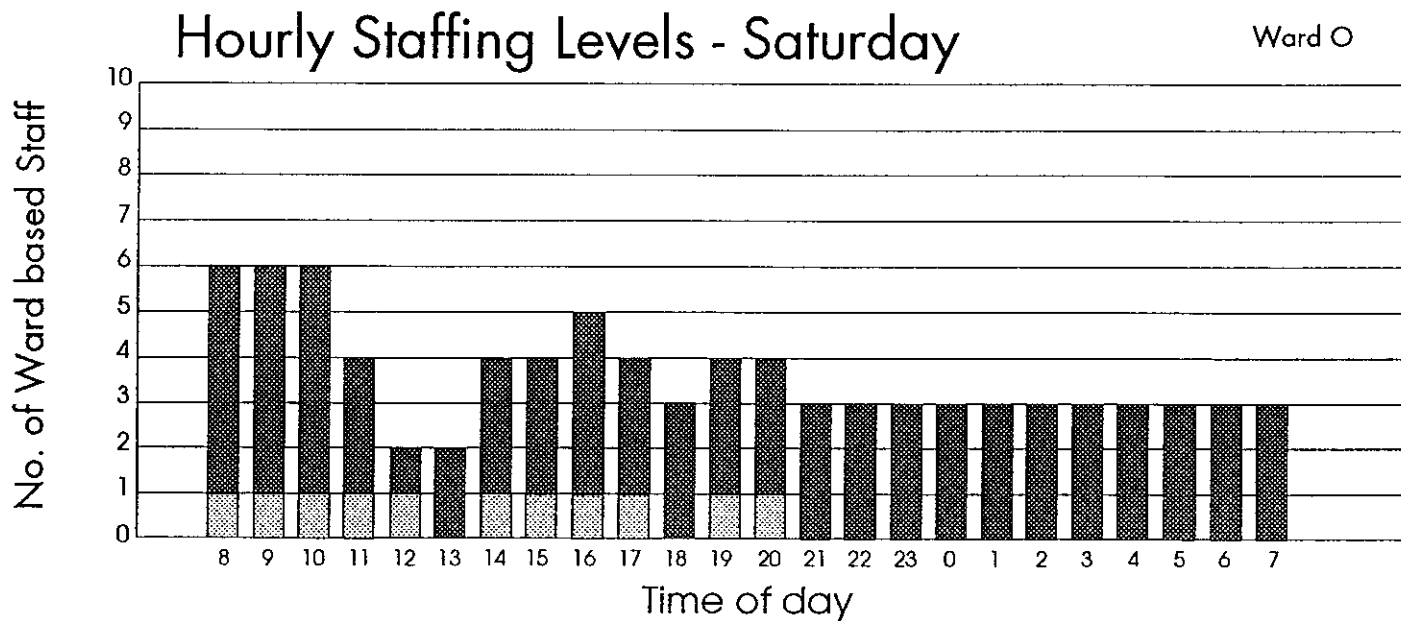
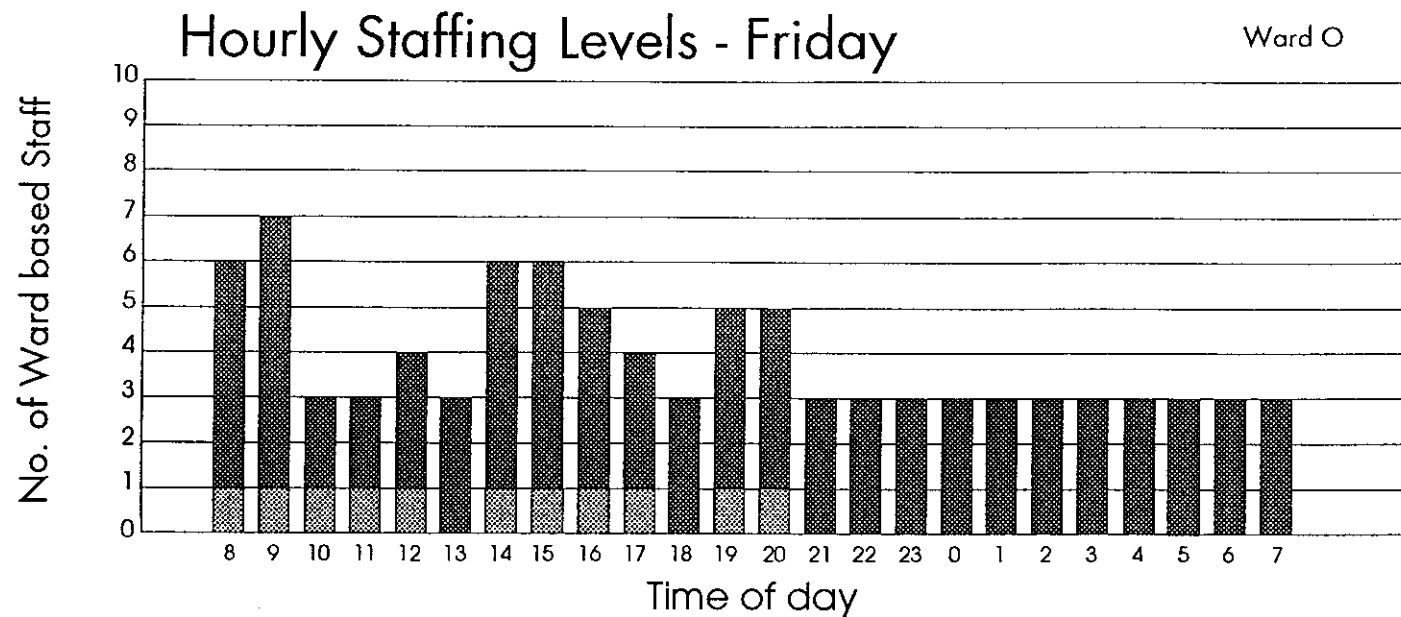


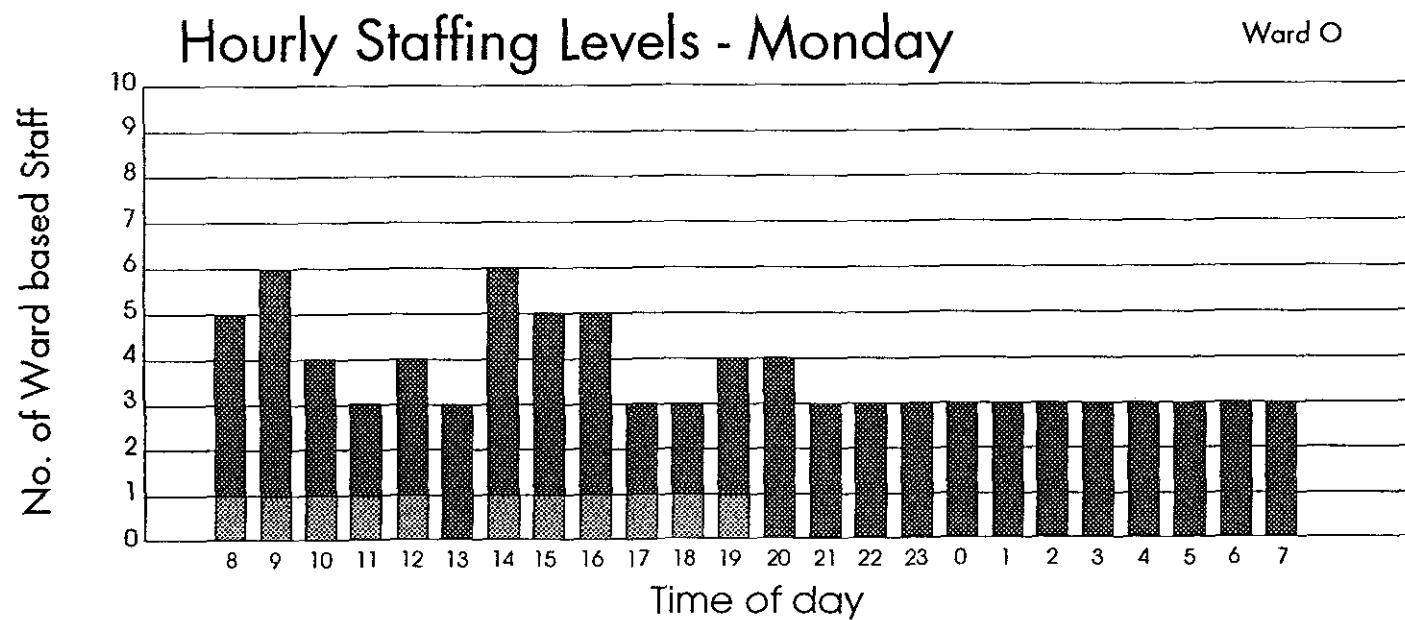
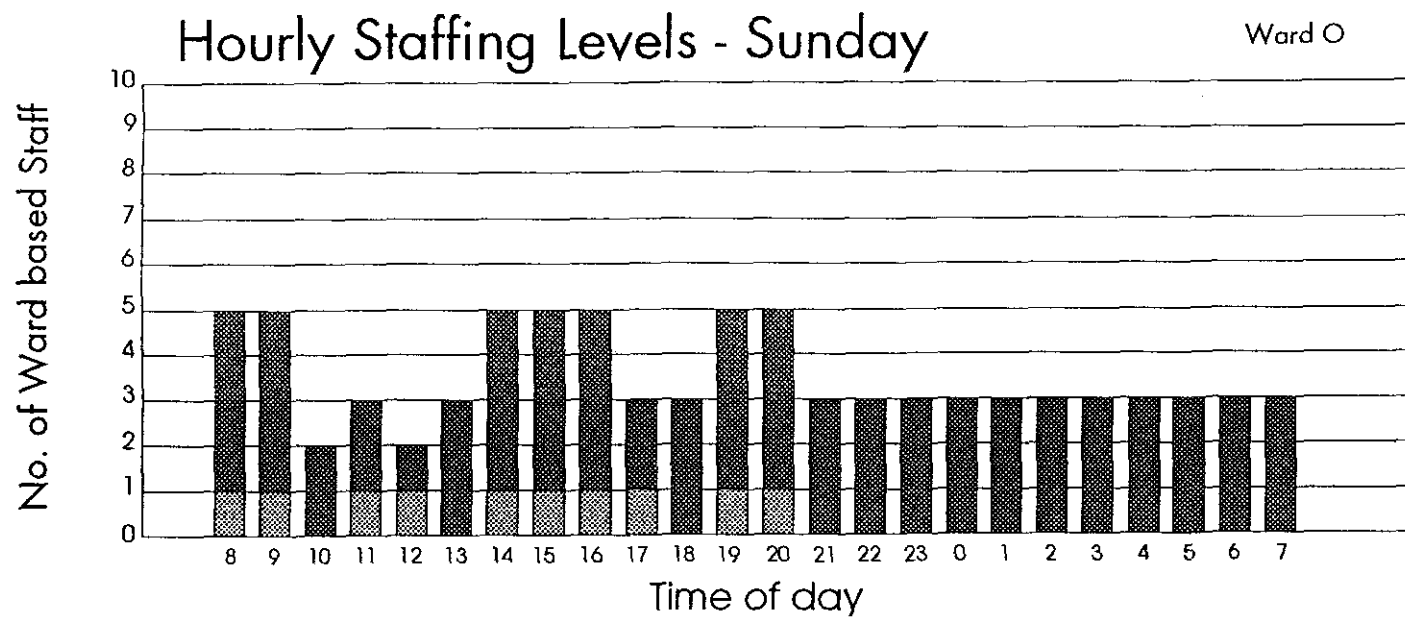


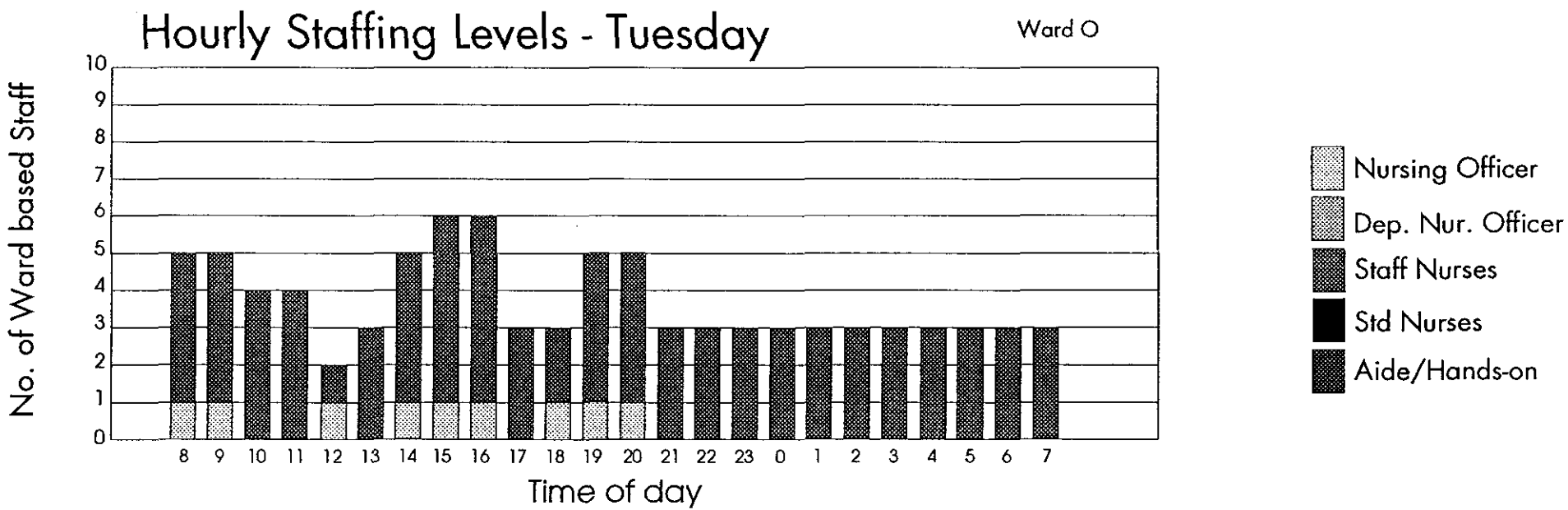




-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on

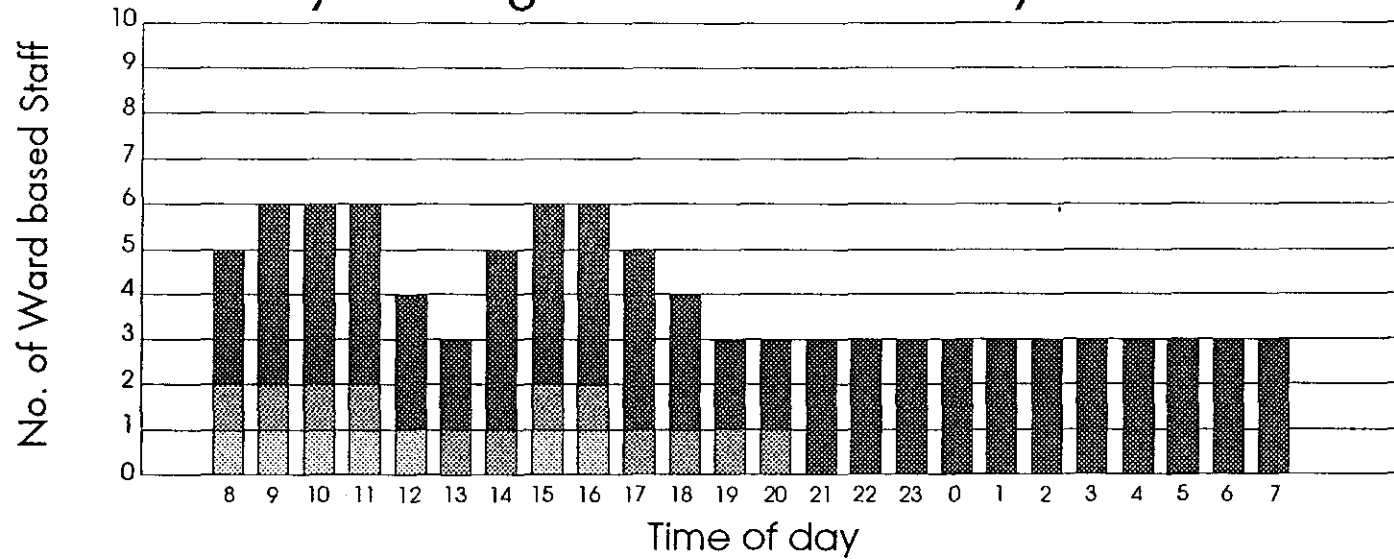






Hourly Staffing Levels - Wednesday

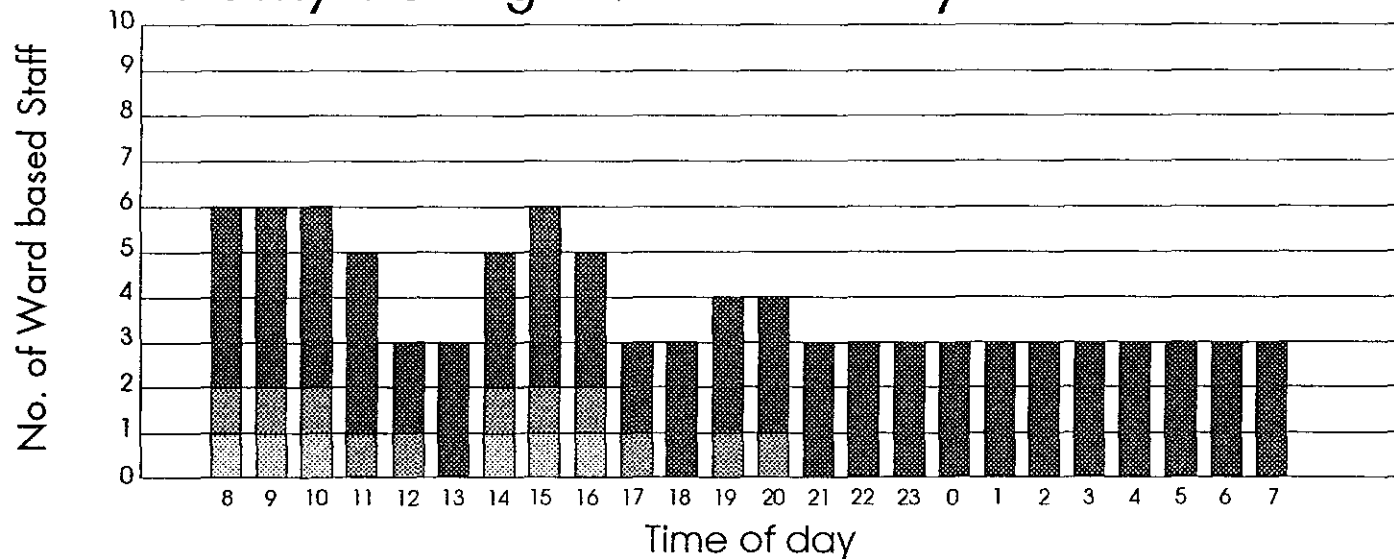
Ward R

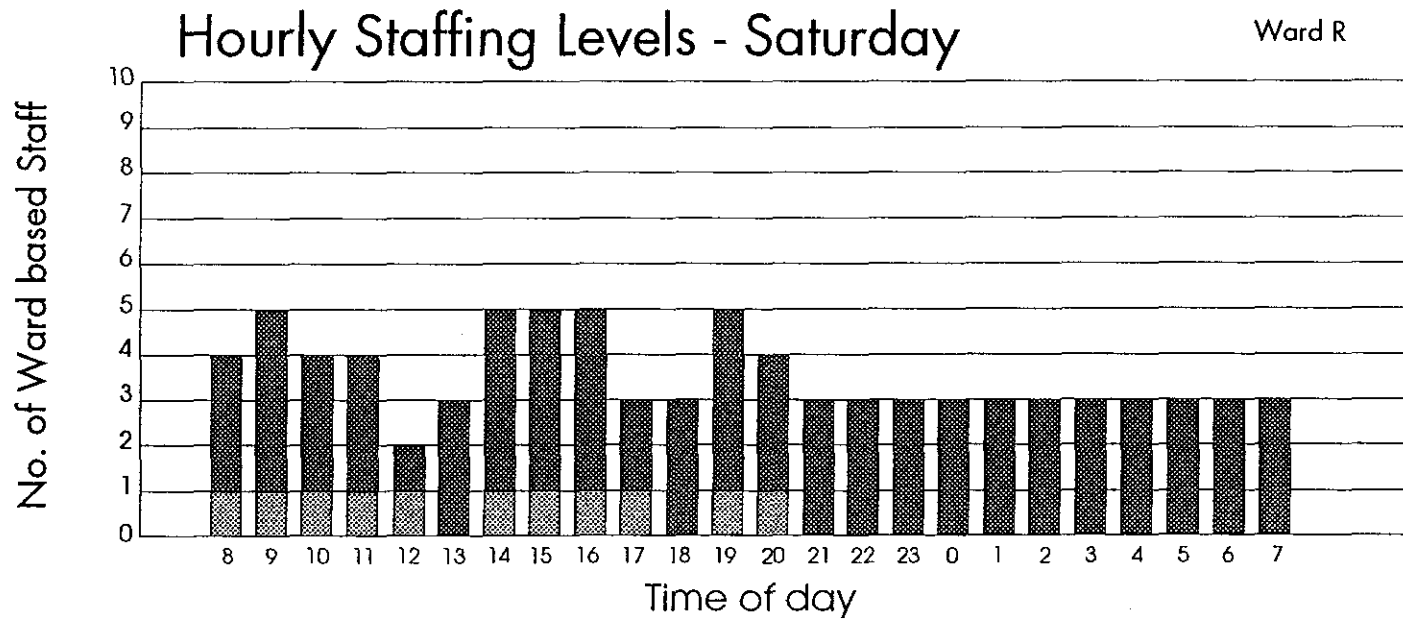
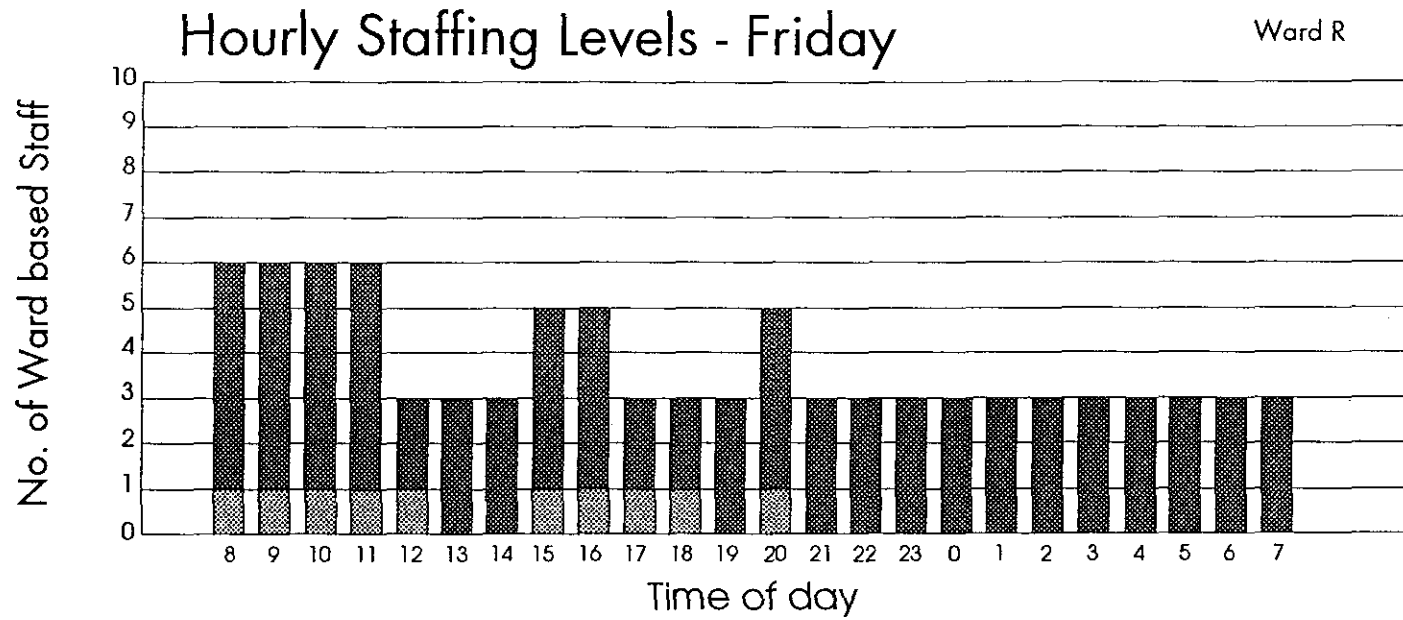



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

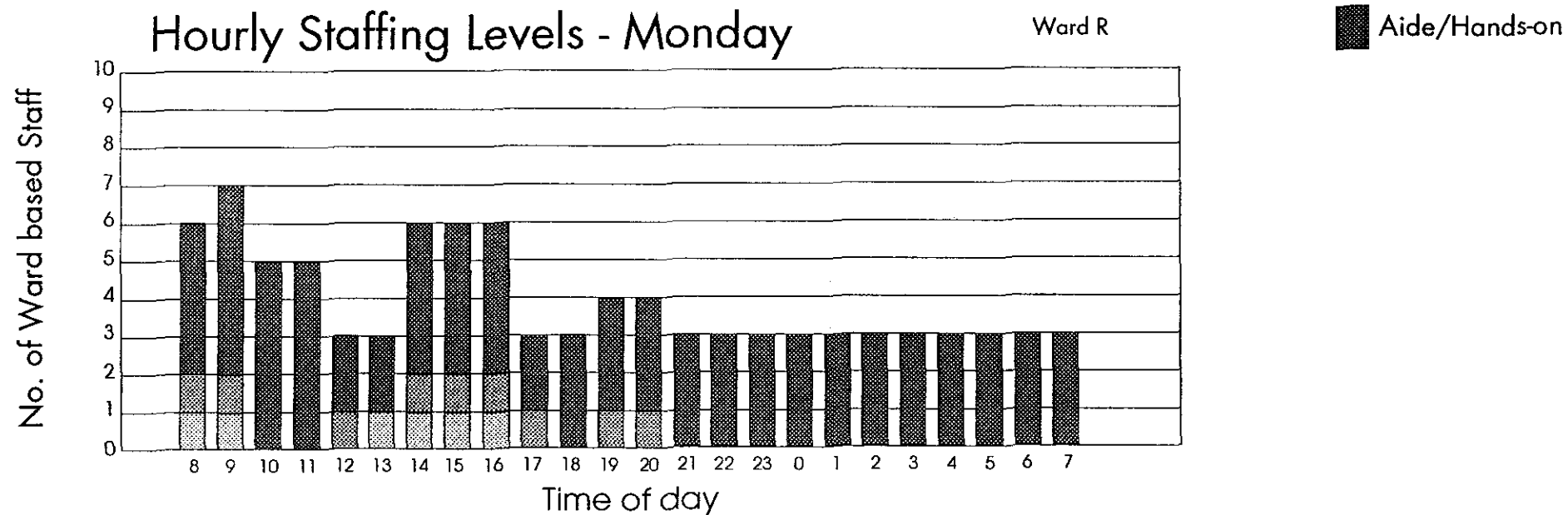
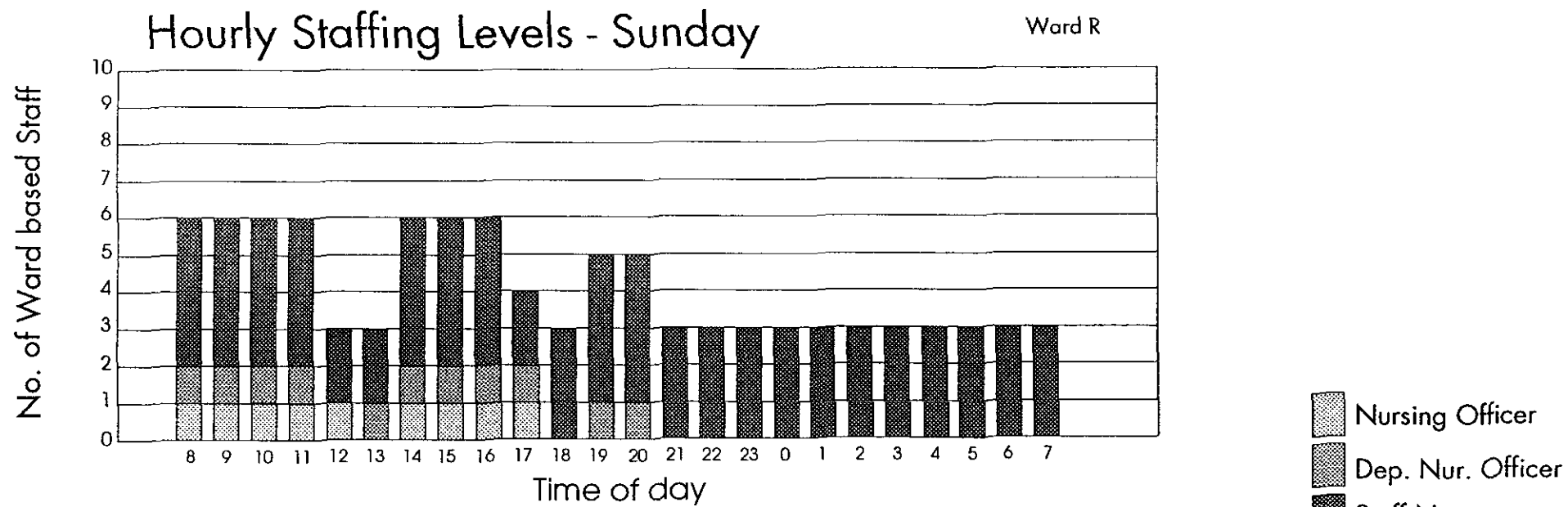
Hourly Staffing Levels - Thursday

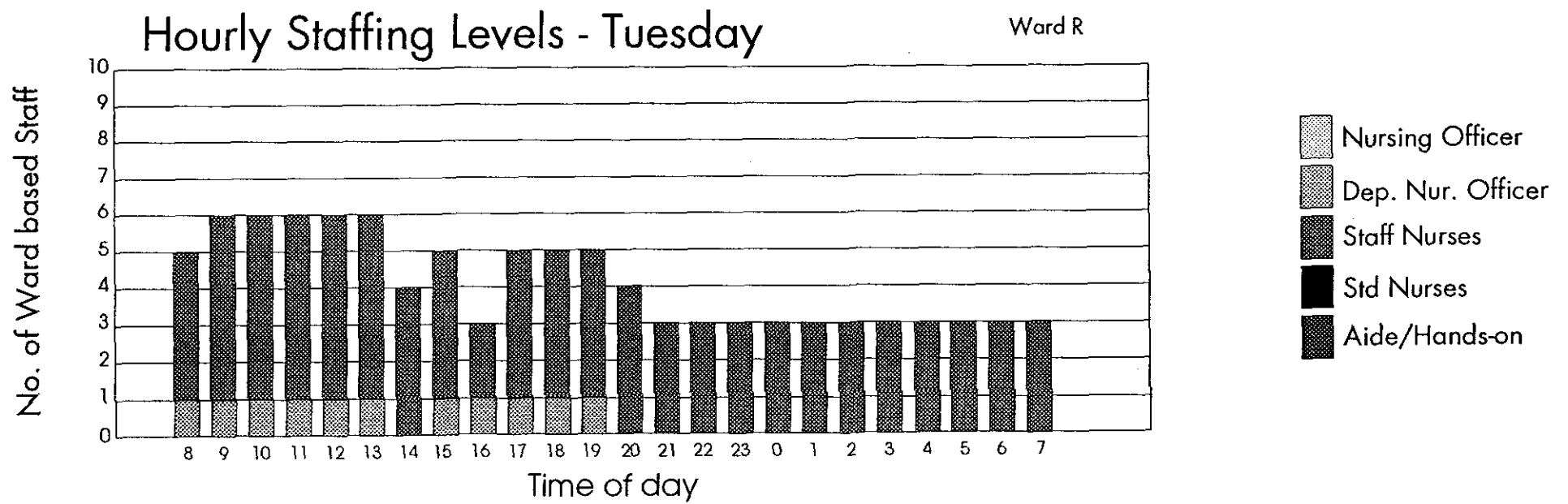
Ward R

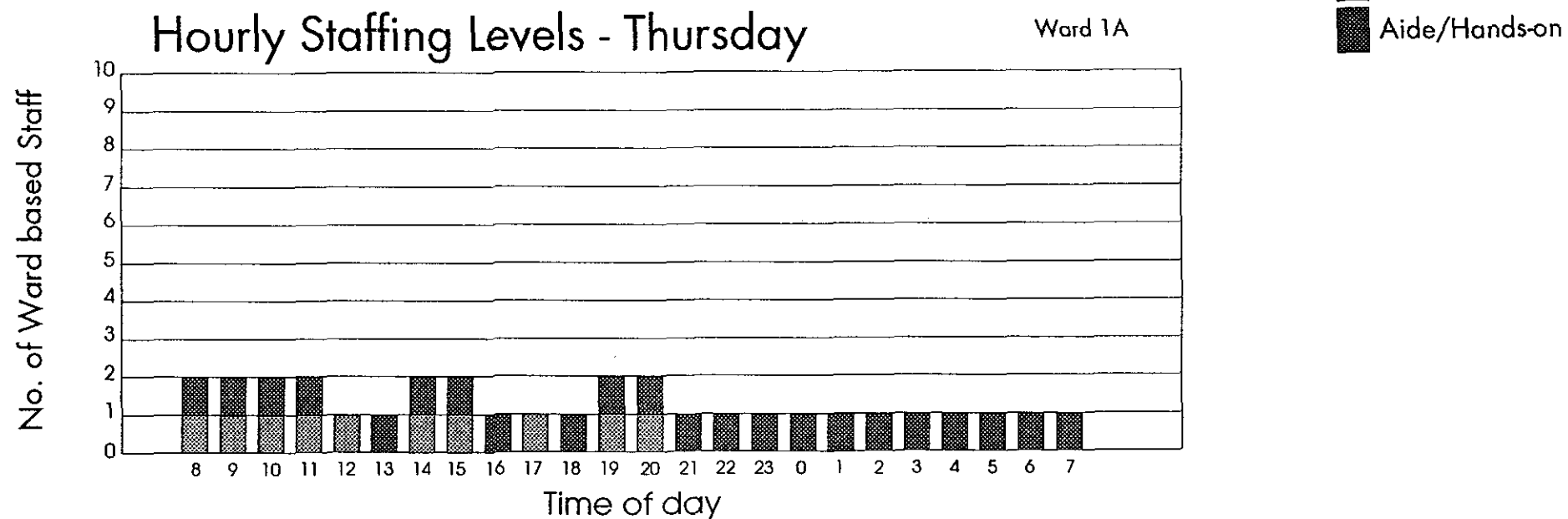
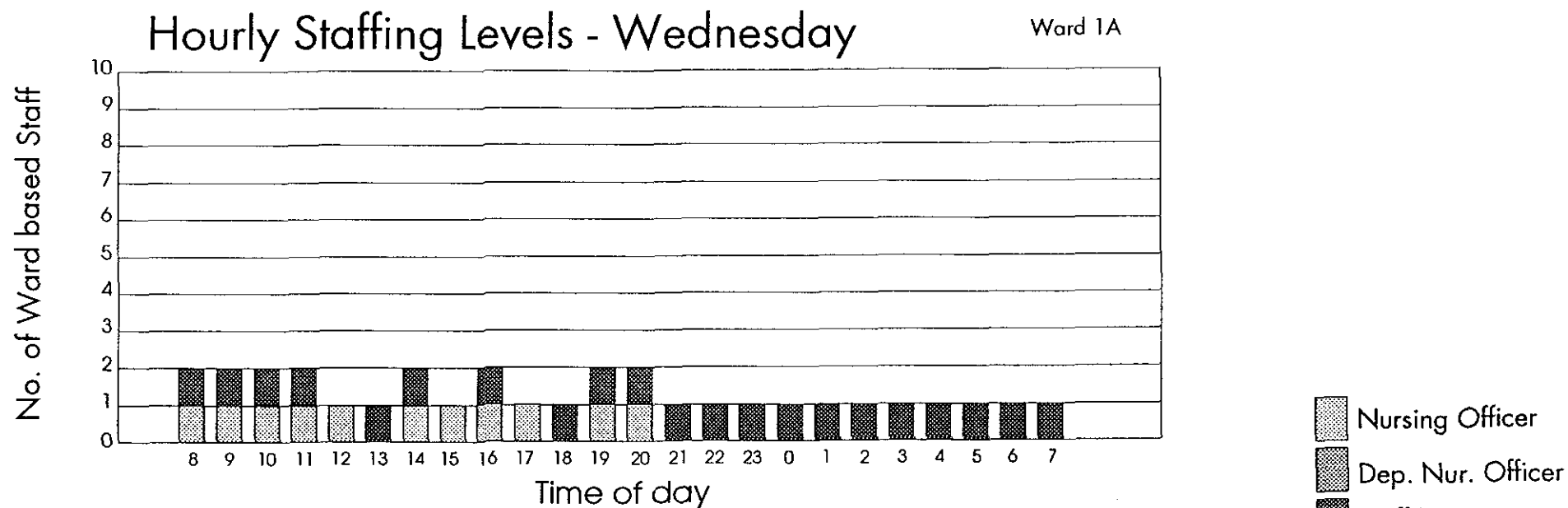




-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on

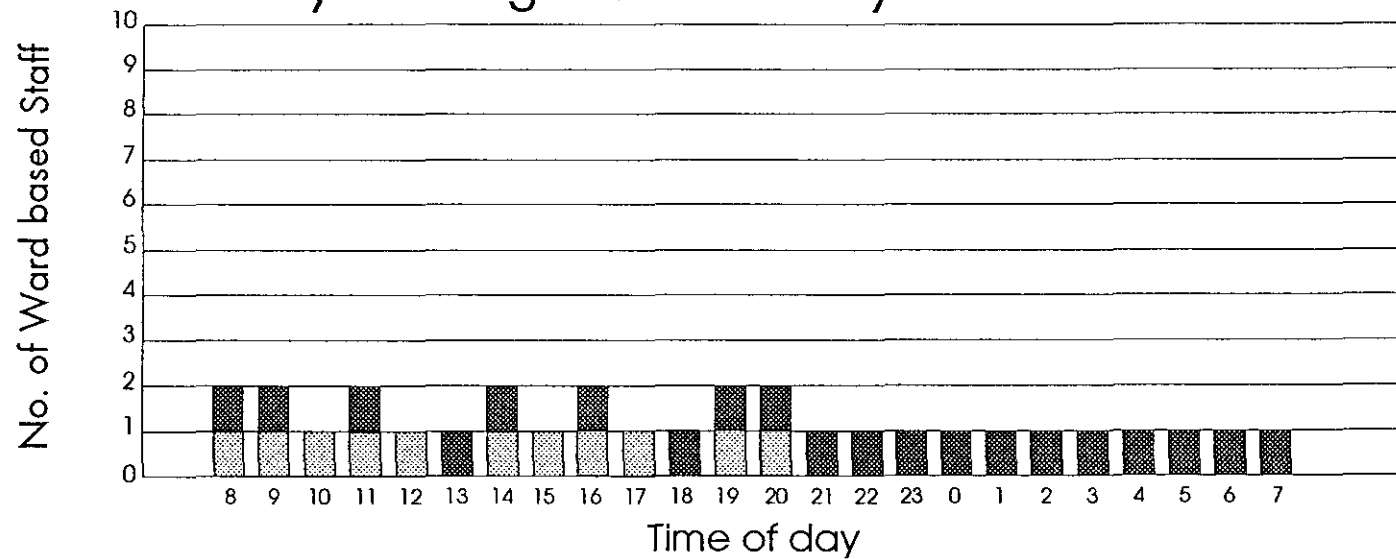






Hourly Staffing Levels - Friday

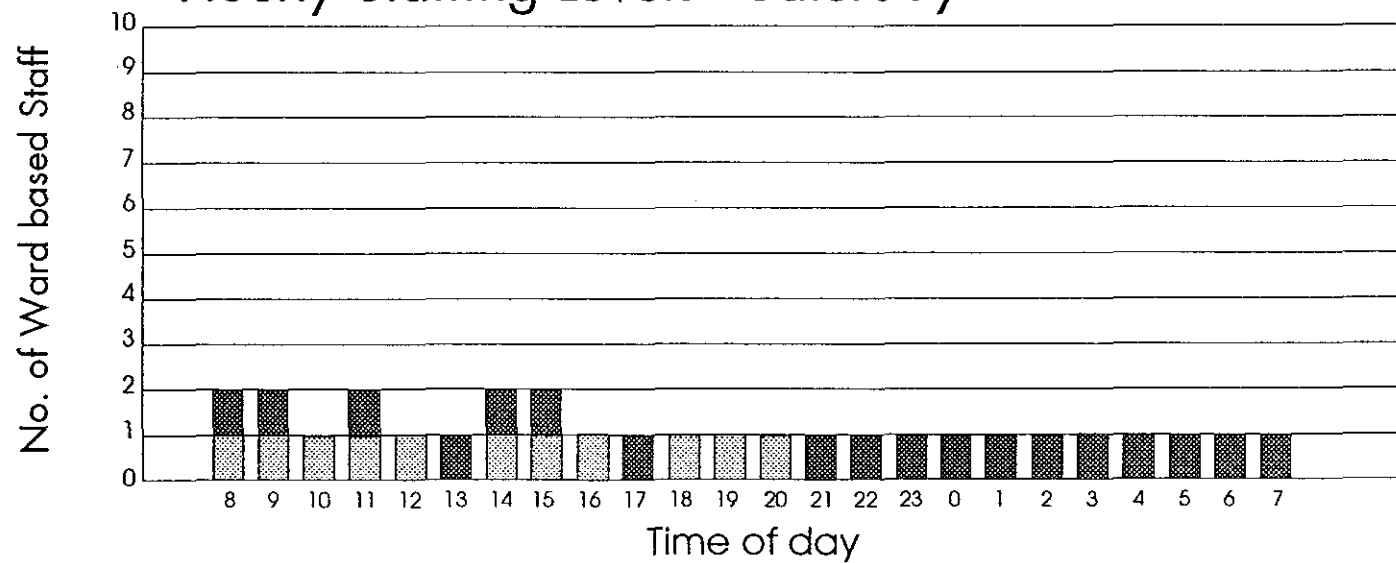
Ward 1A



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

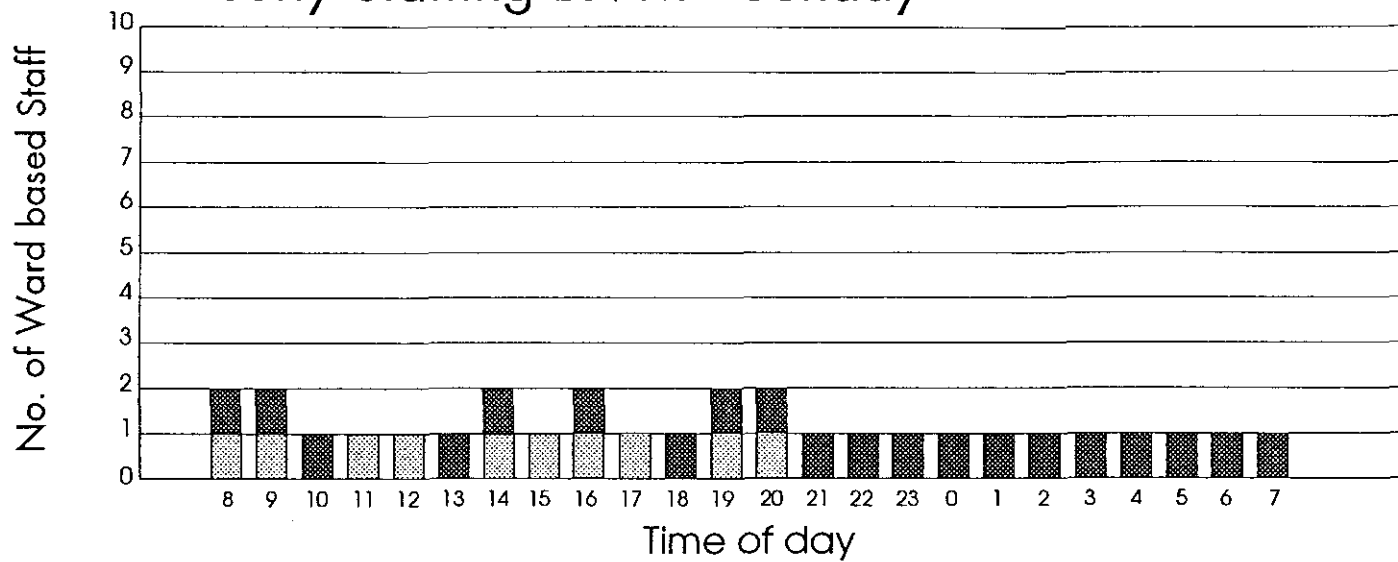
Hourly Staffing Levels - Saturday

Ward 1A



Hourly Staffing Levels - Sunday

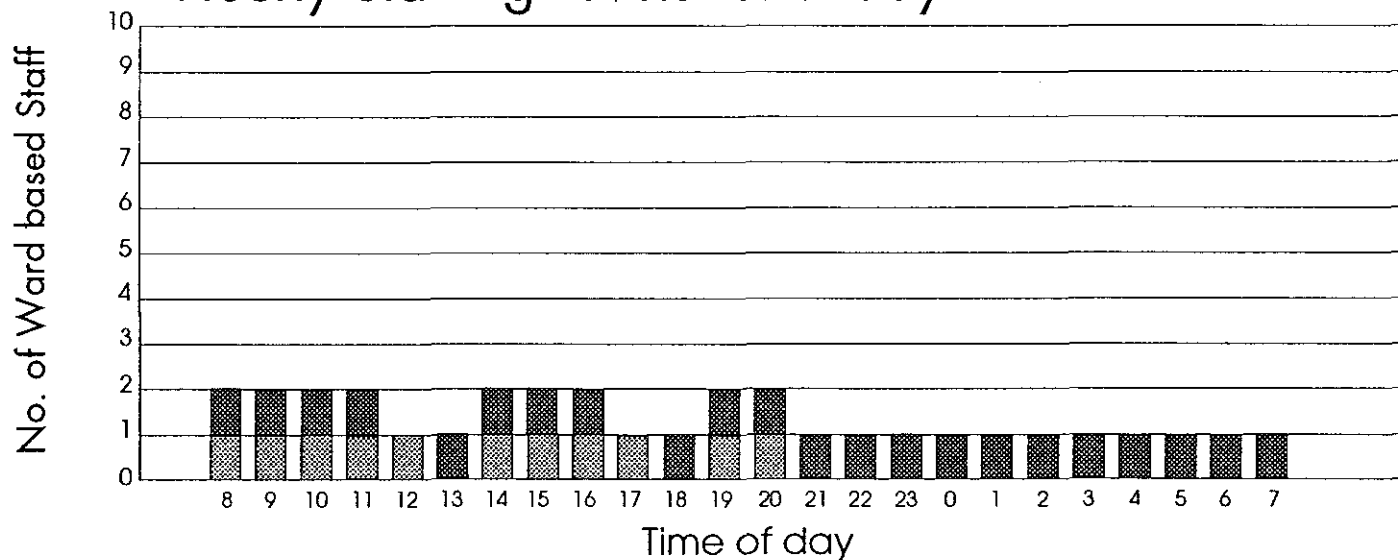
Ward 1A

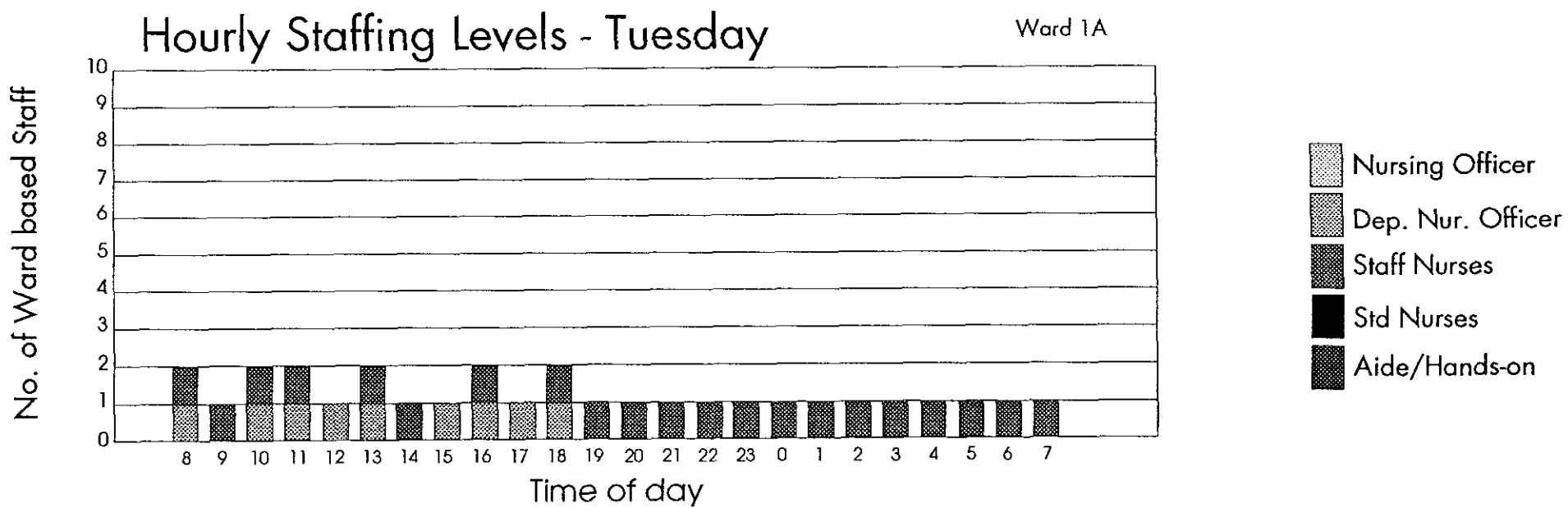


- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Monday

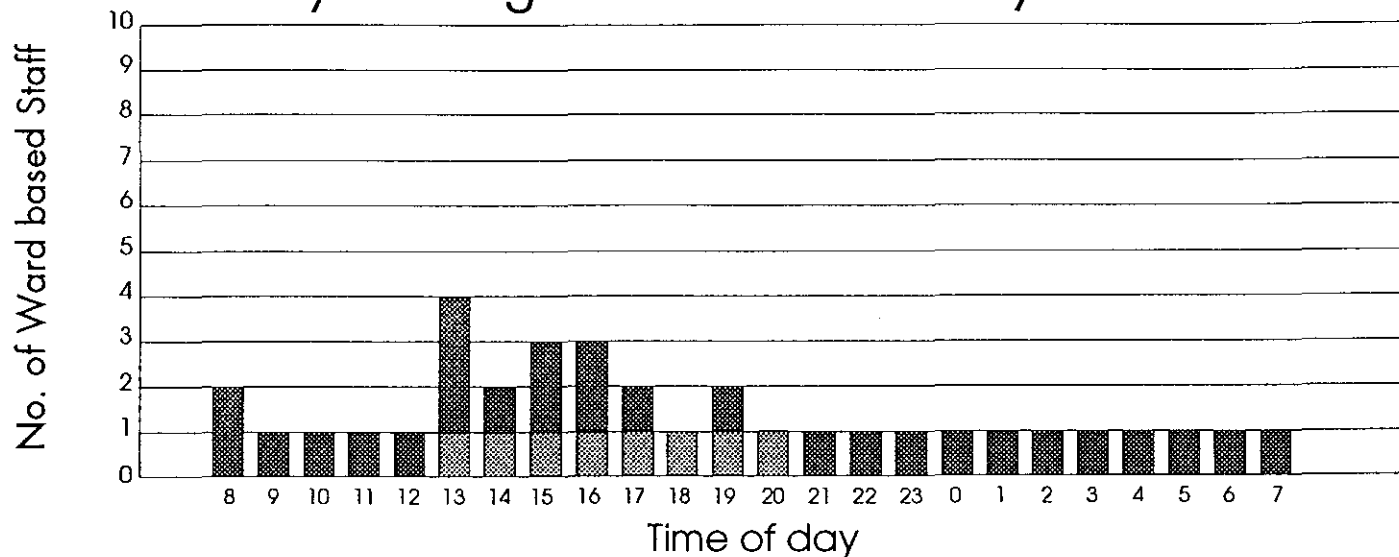
Ward 1A





Hourly Staffing Levels - Wednesday

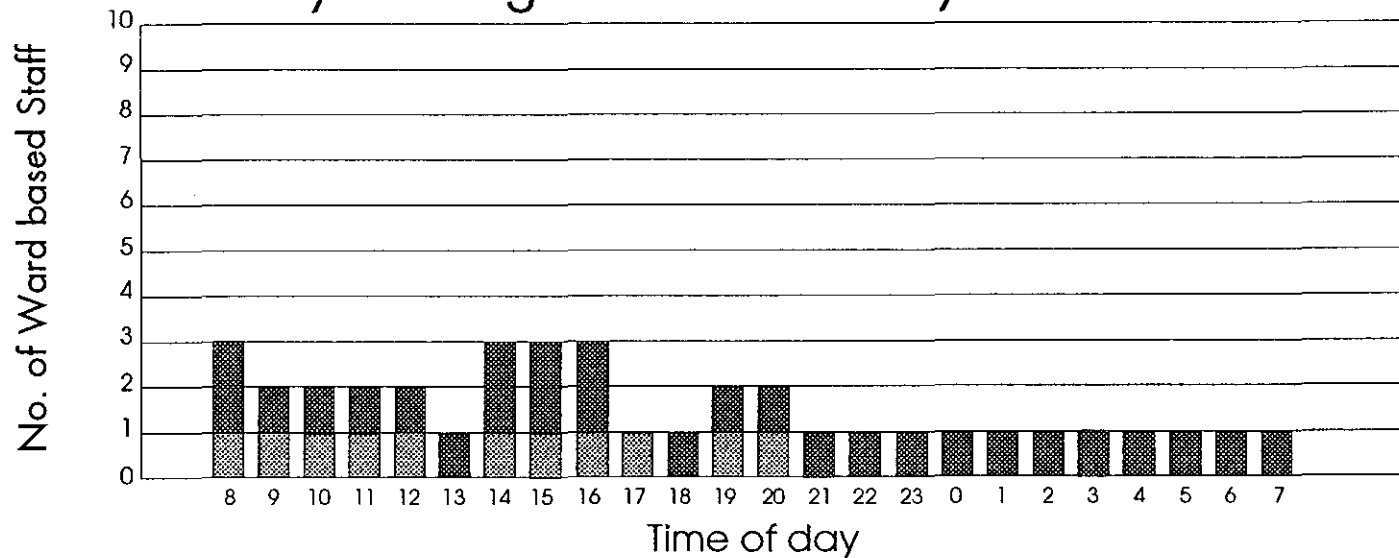
Ward 2A



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

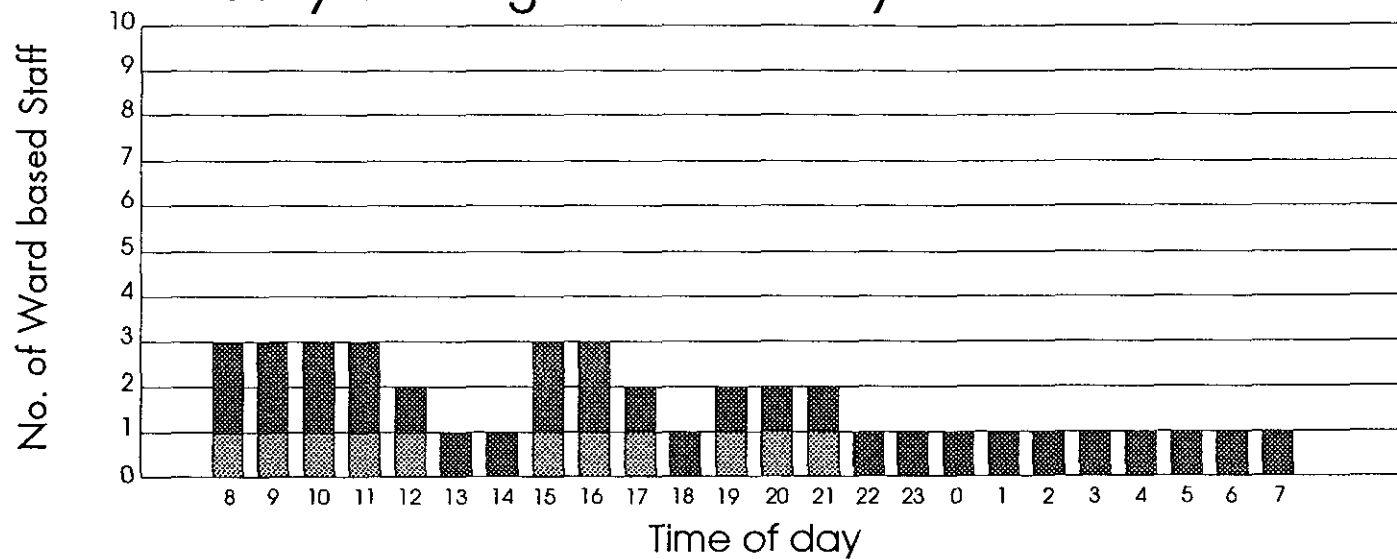
Hourly Staffing Levels - Thursday

Ward 2A



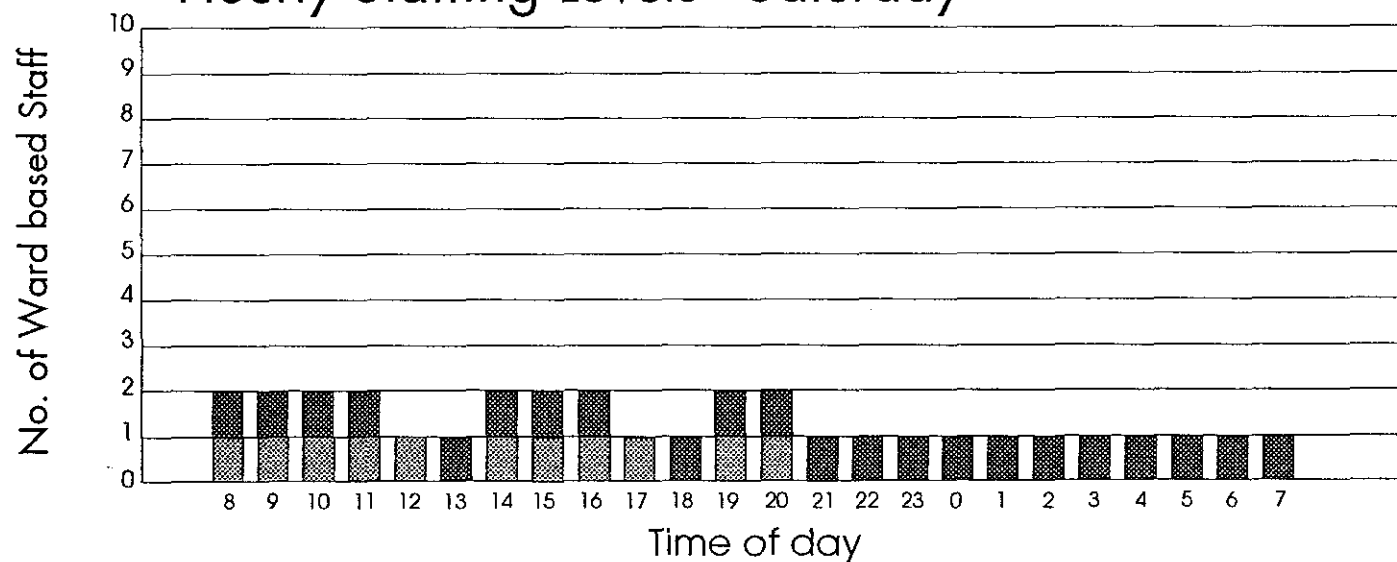
Hourly Staffing Levels - Friday





Ward 2A



Hourly Staffing Levels - Saturday

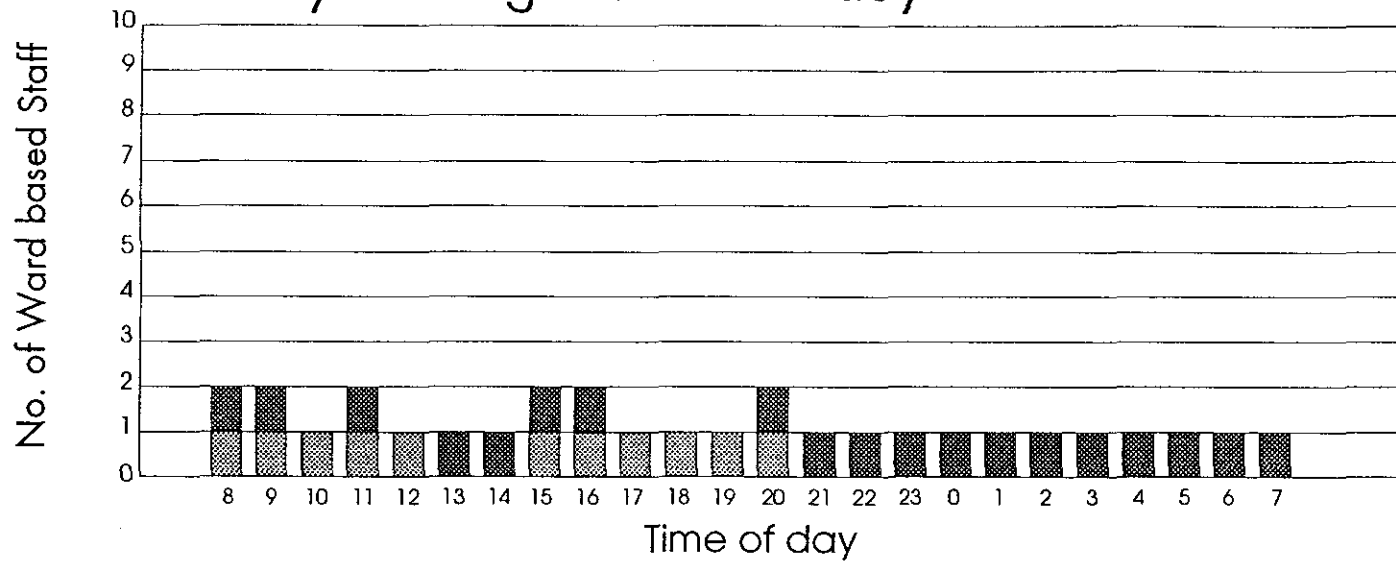
Ward 2A



-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on

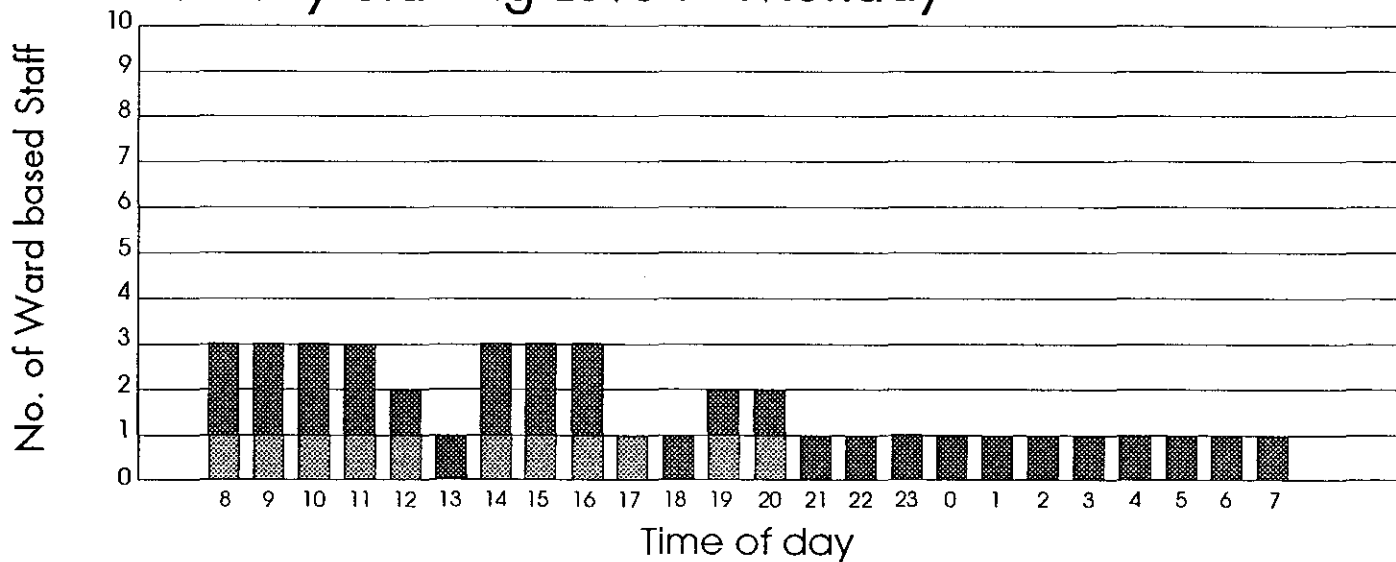
Hourly Staffing Levels - Sunday




Ward 2A

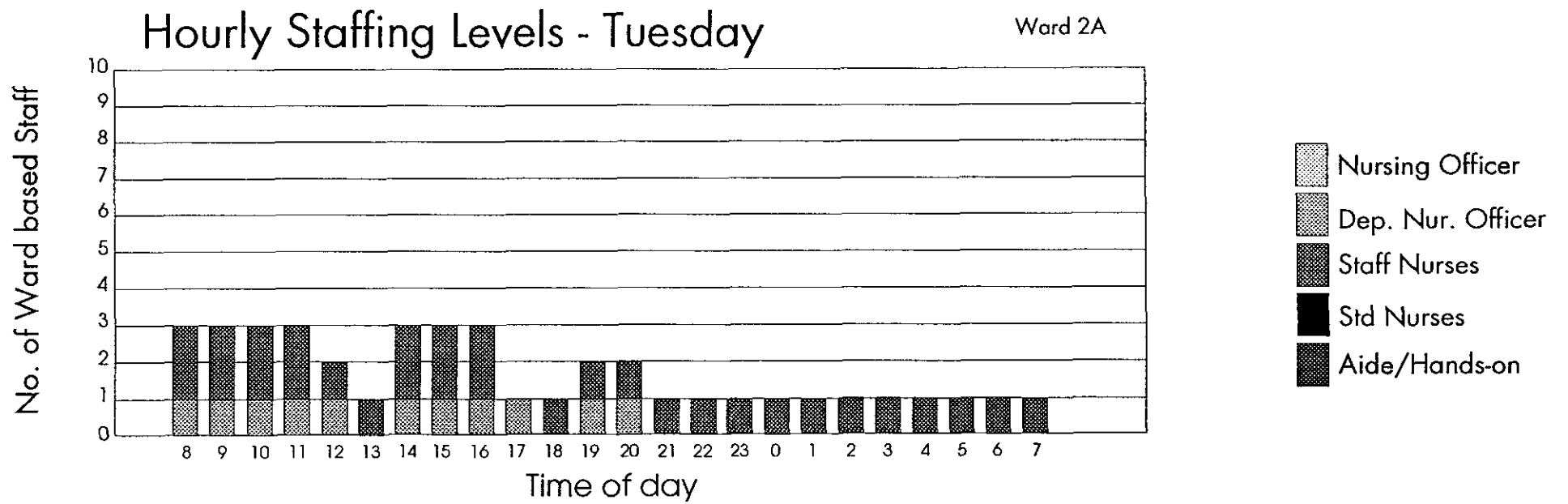


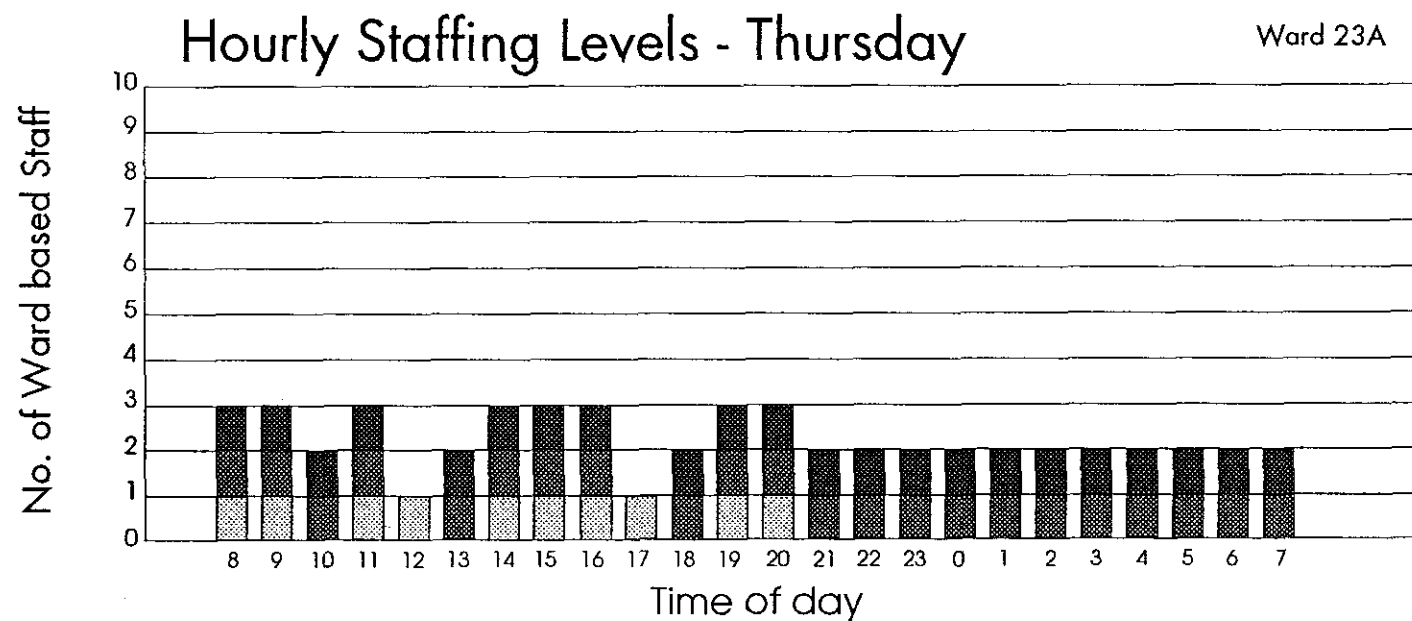
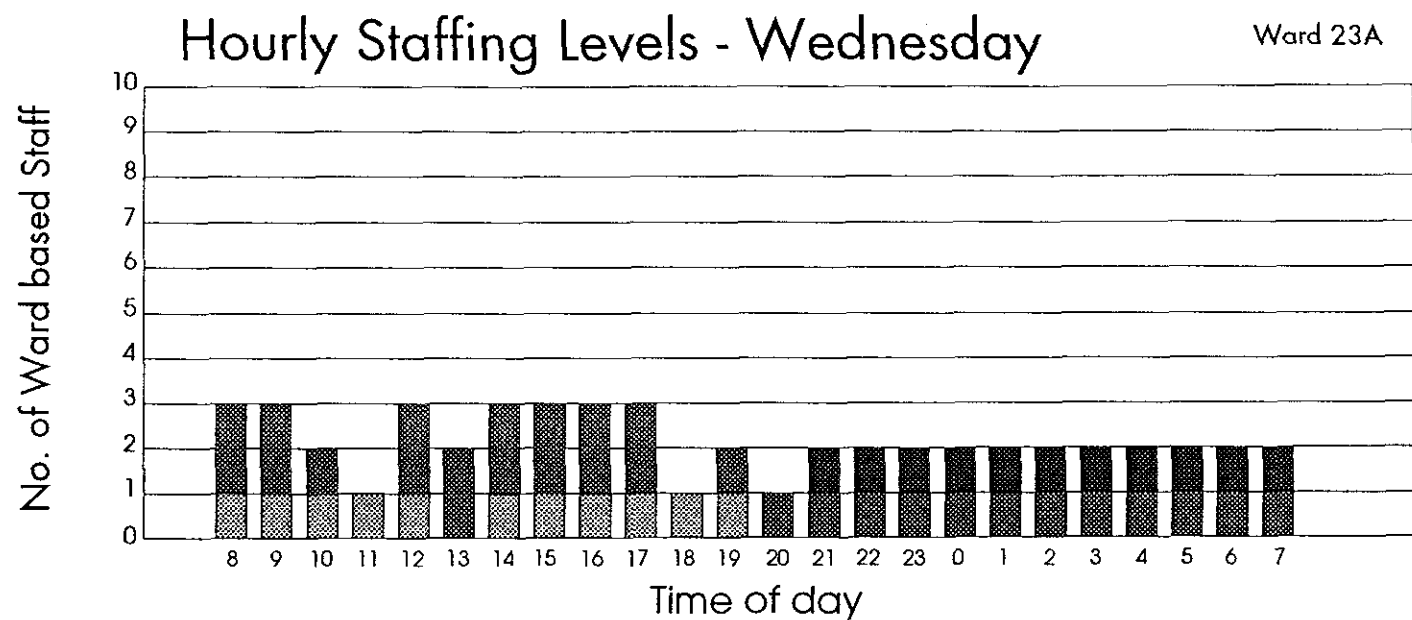
Hourly Staffing Levels - Monday






Ward 2A



-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on

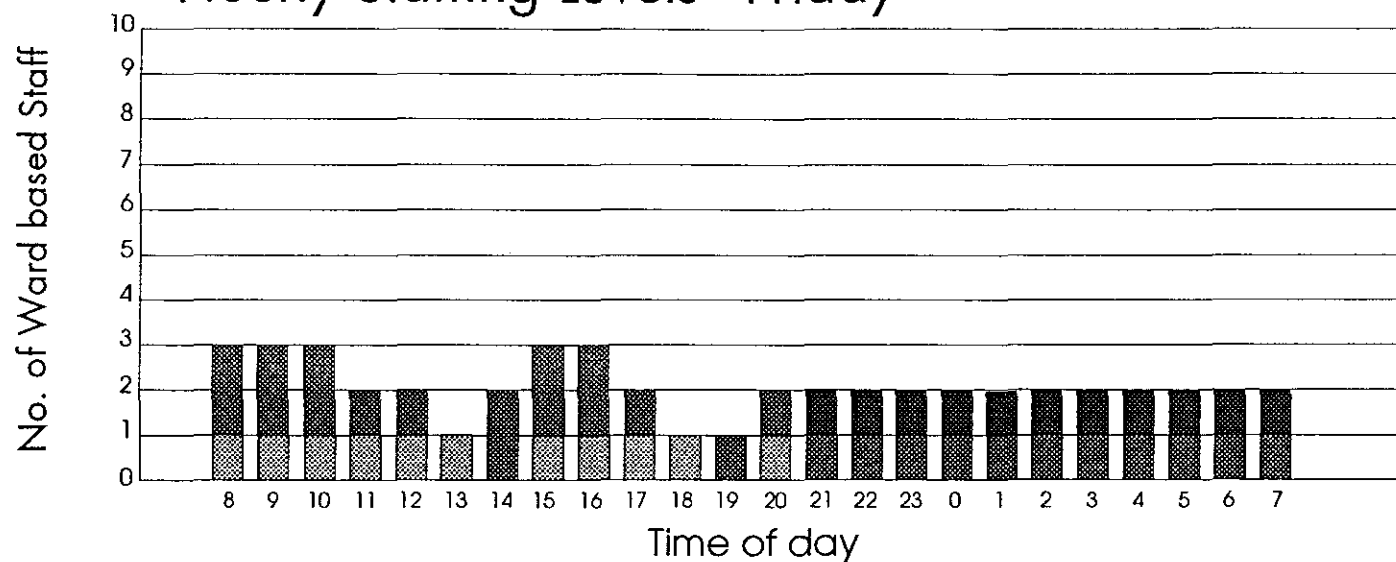




-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on

Hourly Staffing Levels - Friday

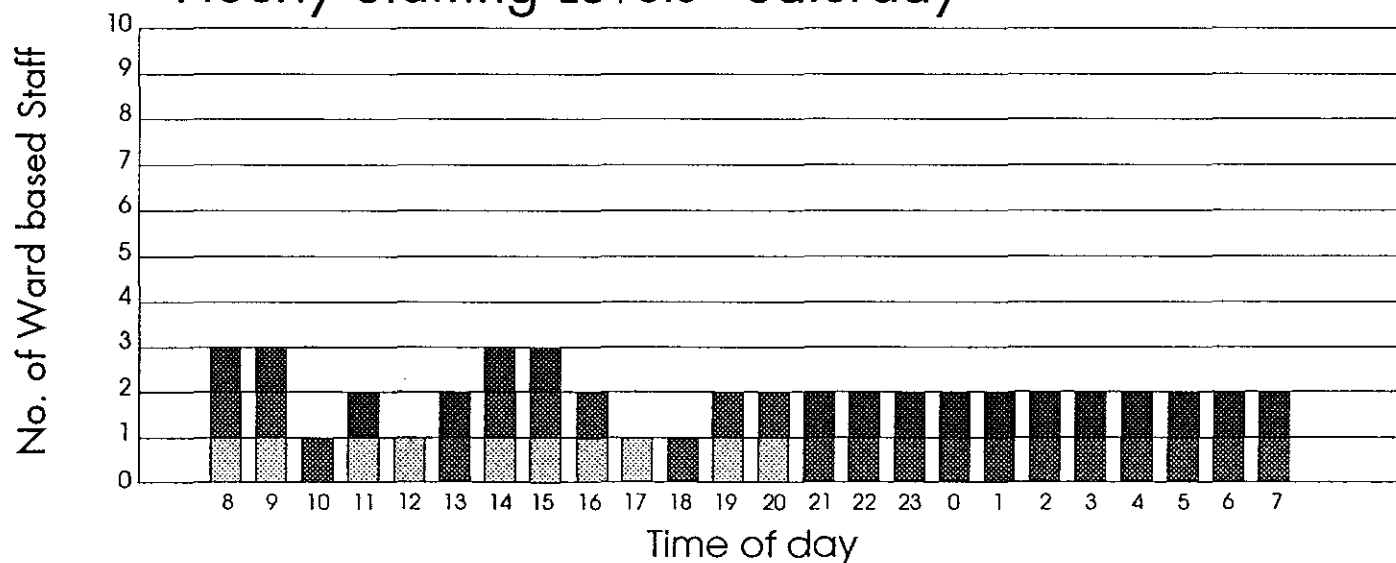
Ward 23A



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

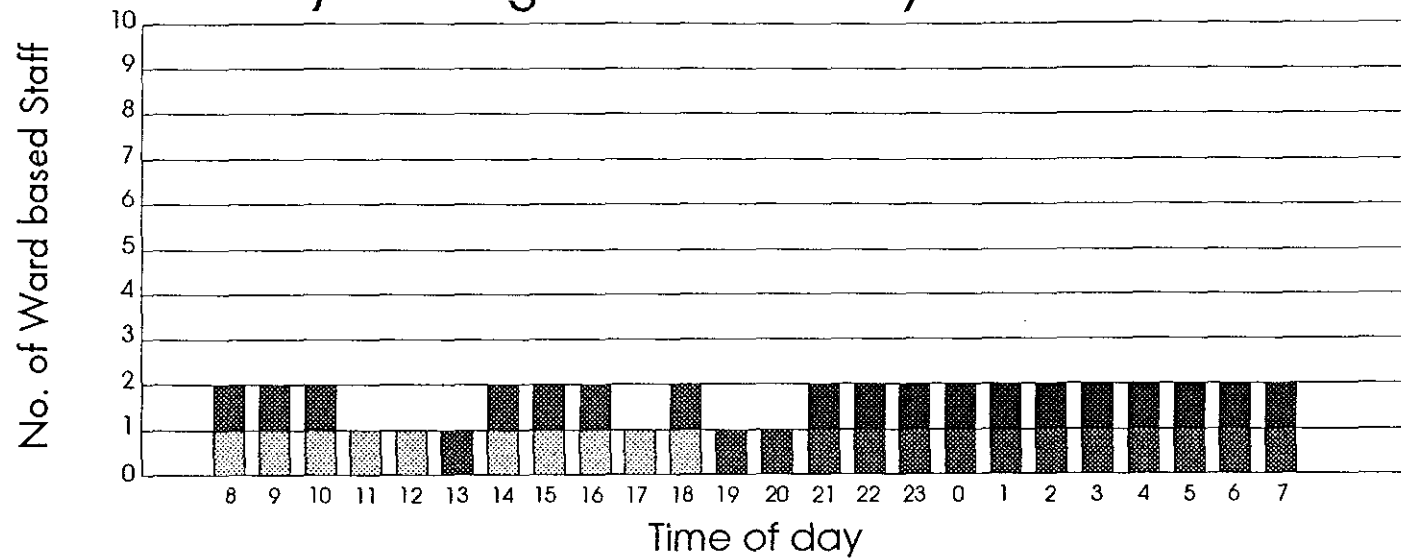
Hourly Staffing Levels - Saturday

Ward 23A



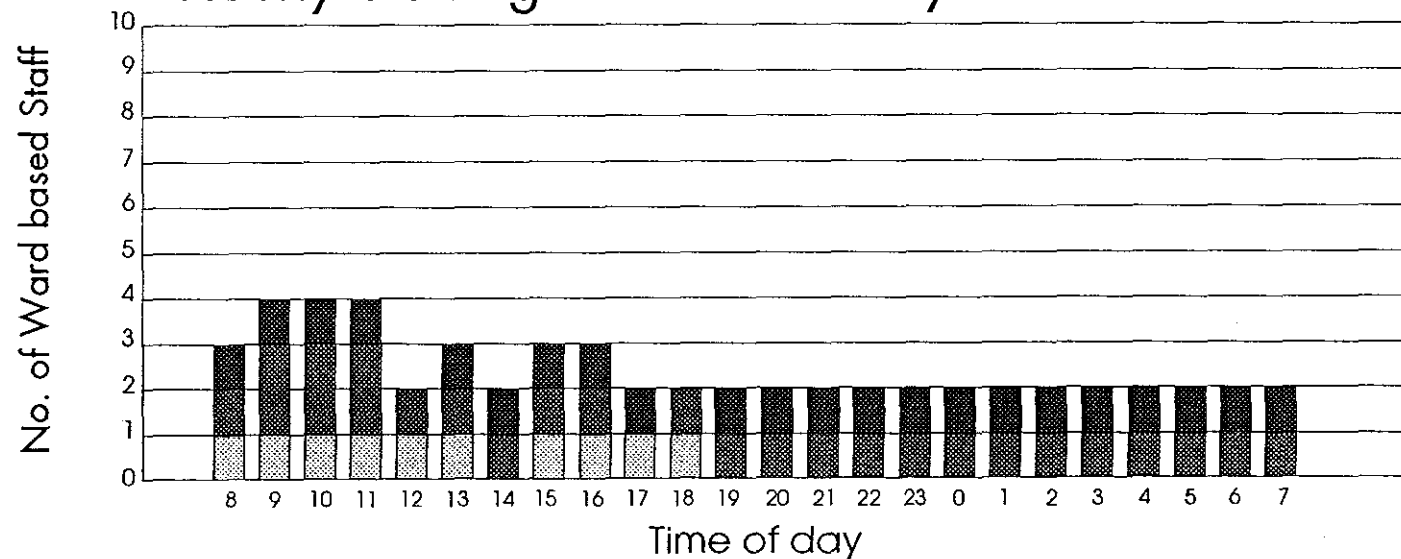
Hourly Staffing Levels - Sunday

Ward 23A

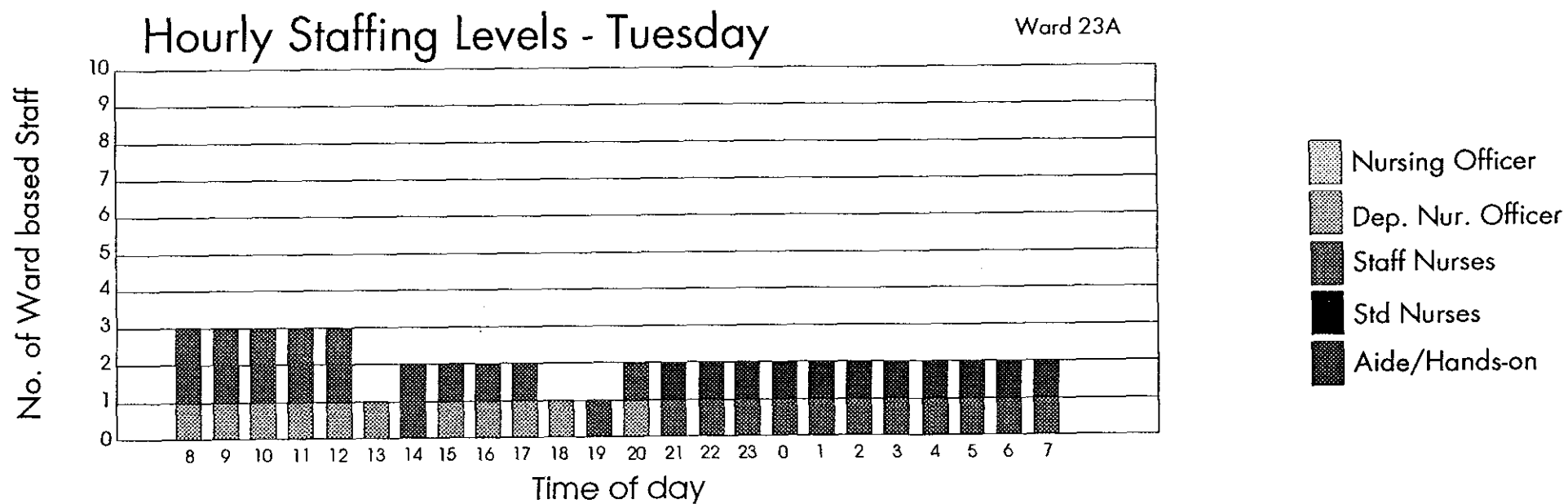


Hourly Staffing Levels - Monday

Ward 23A

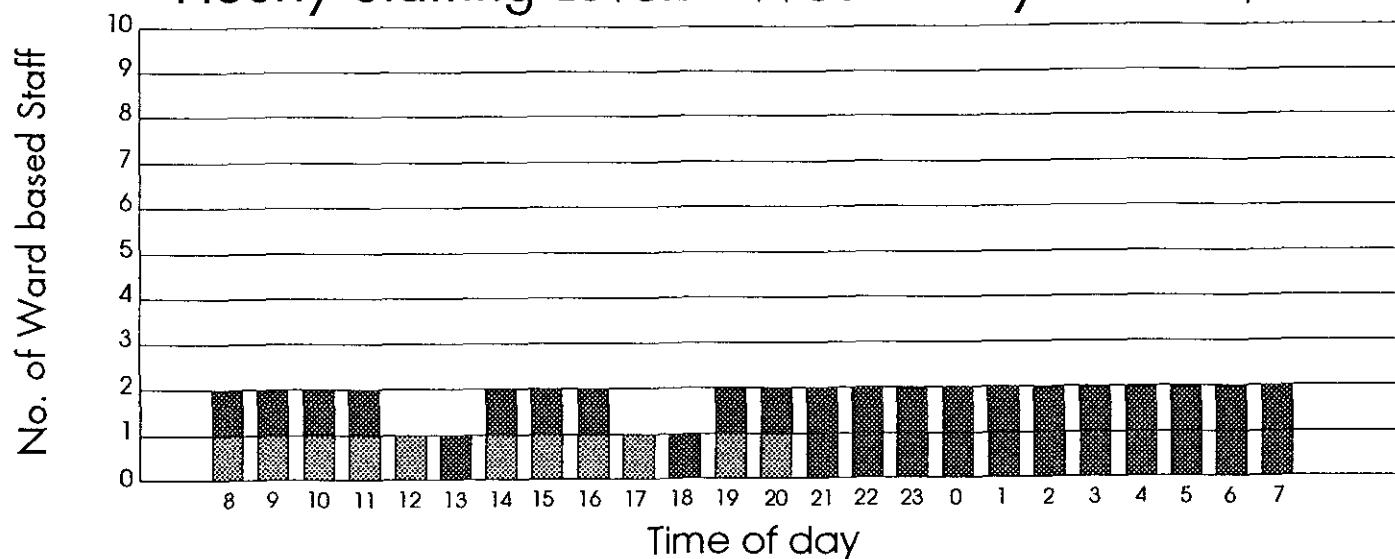


-  Nursing Officer
-  Dep. Nur. Officer
-  Staff Nurses
-  Std Nurses
-  Aide/Hands-on



Hourly Staffing Levels - Wednesday

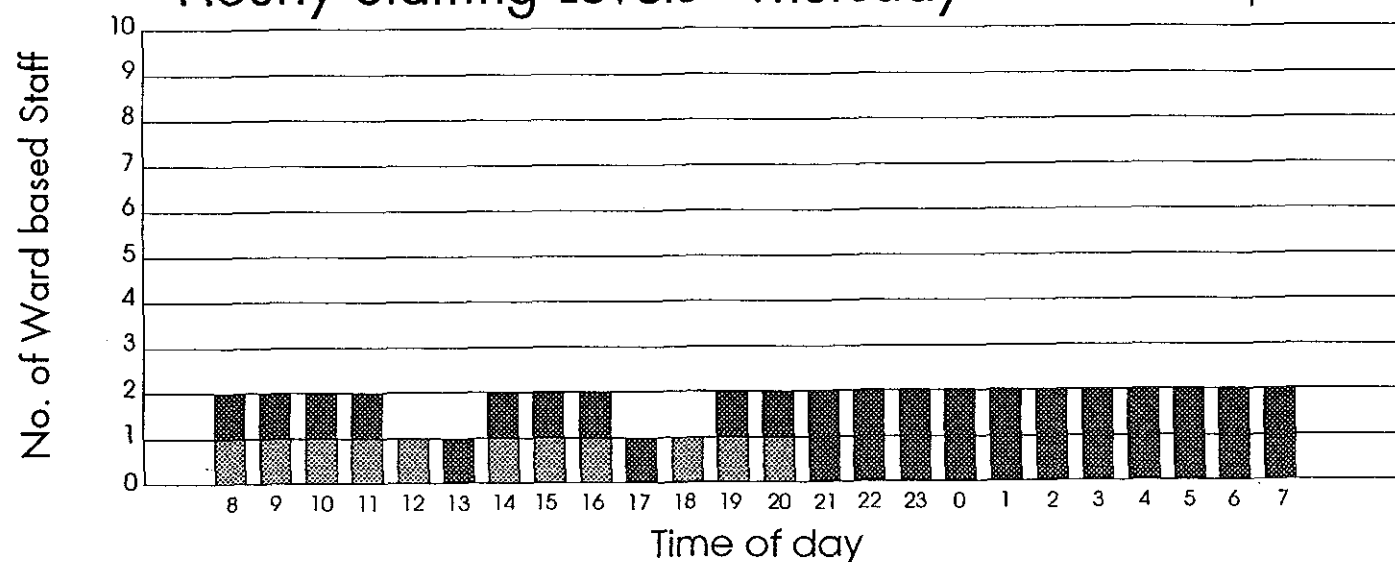
N.F.A. Inpatient Unit



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

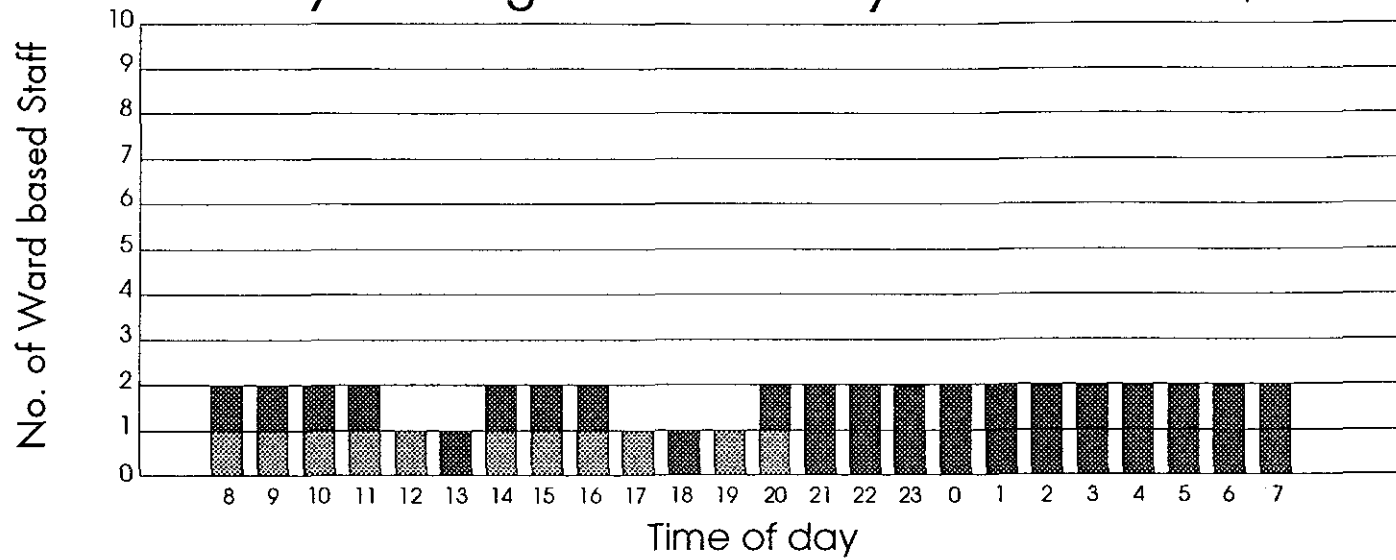
Hourly Staffing Levels - Thursday

N.F.A. Inpatient Unit



Hourly Staffing Levels - Friday

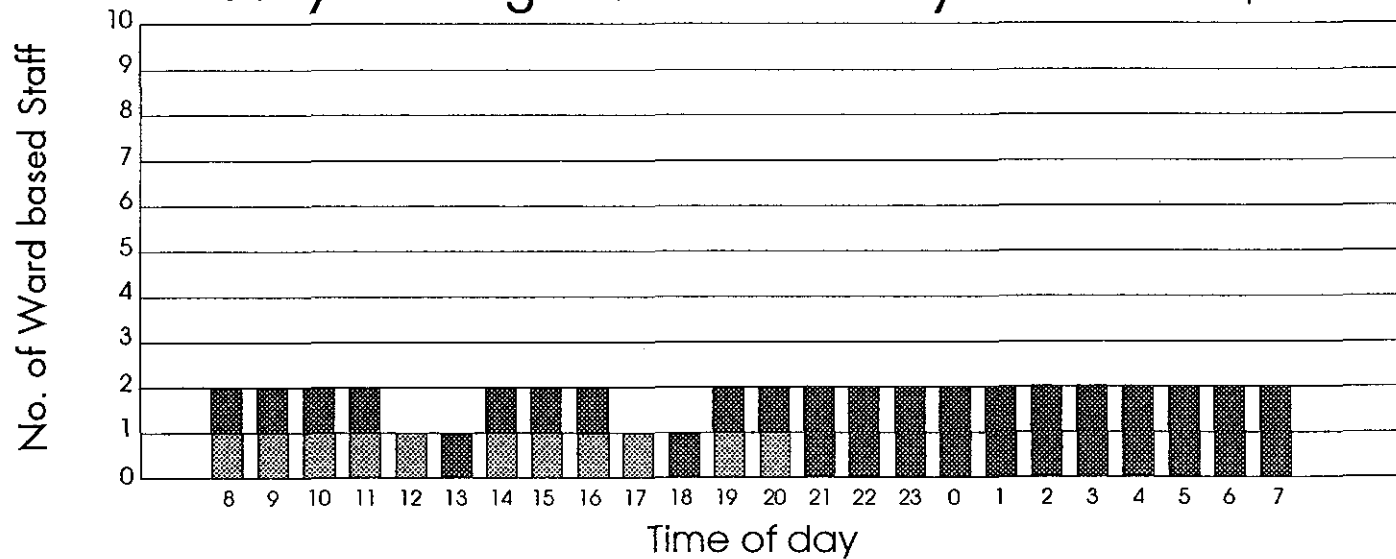
N.F.A. Inpatient Unit



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

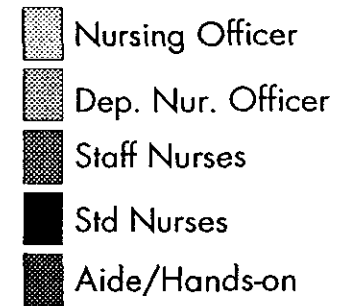
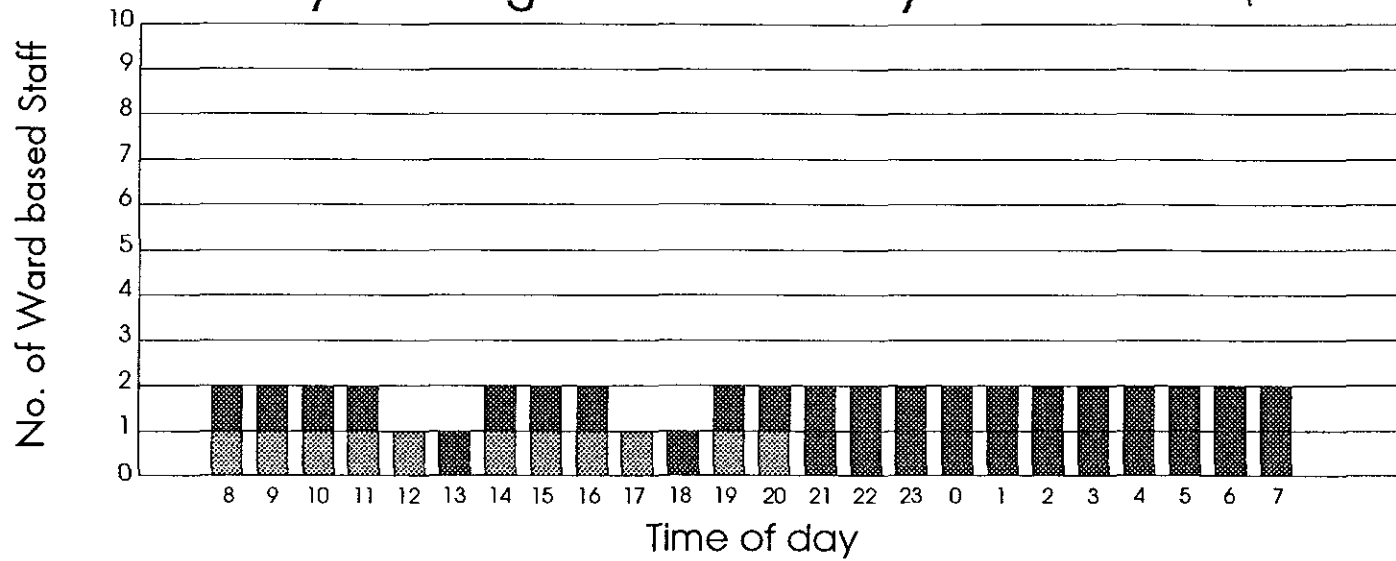
Hourly Staffing Levels - Saturday

N.F.A. Inpatient Unit



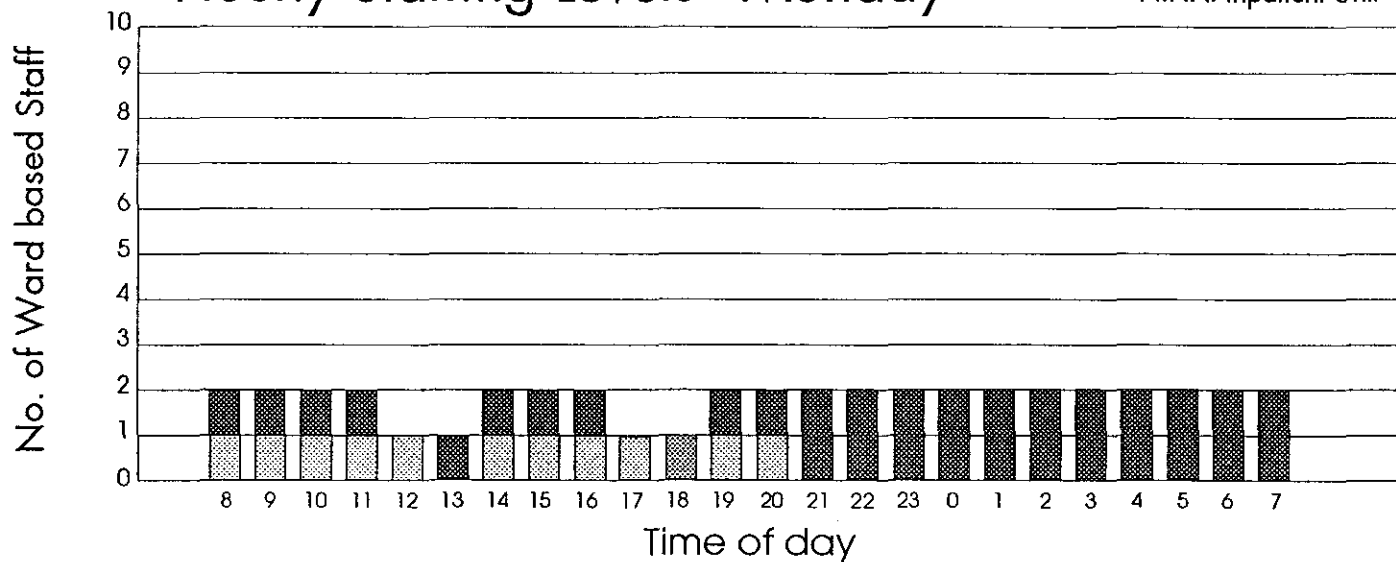
Hourly Staffing Levels - Sunday

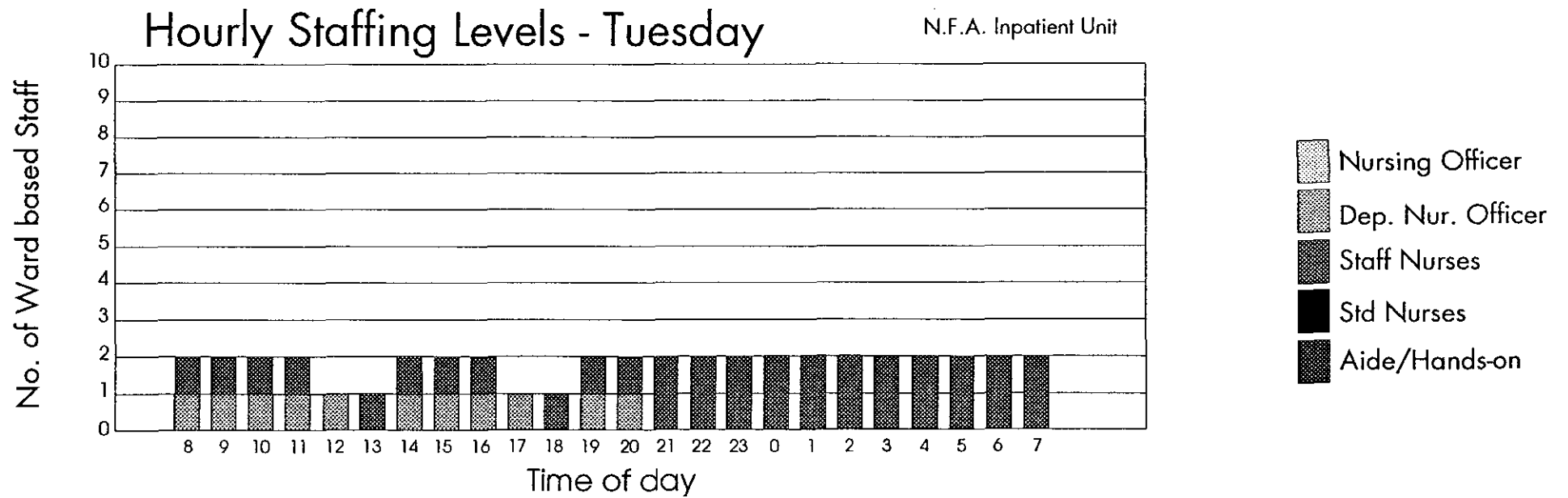
N.F.A. Inpatient Unit



Hourly Staffing Levels - Monday

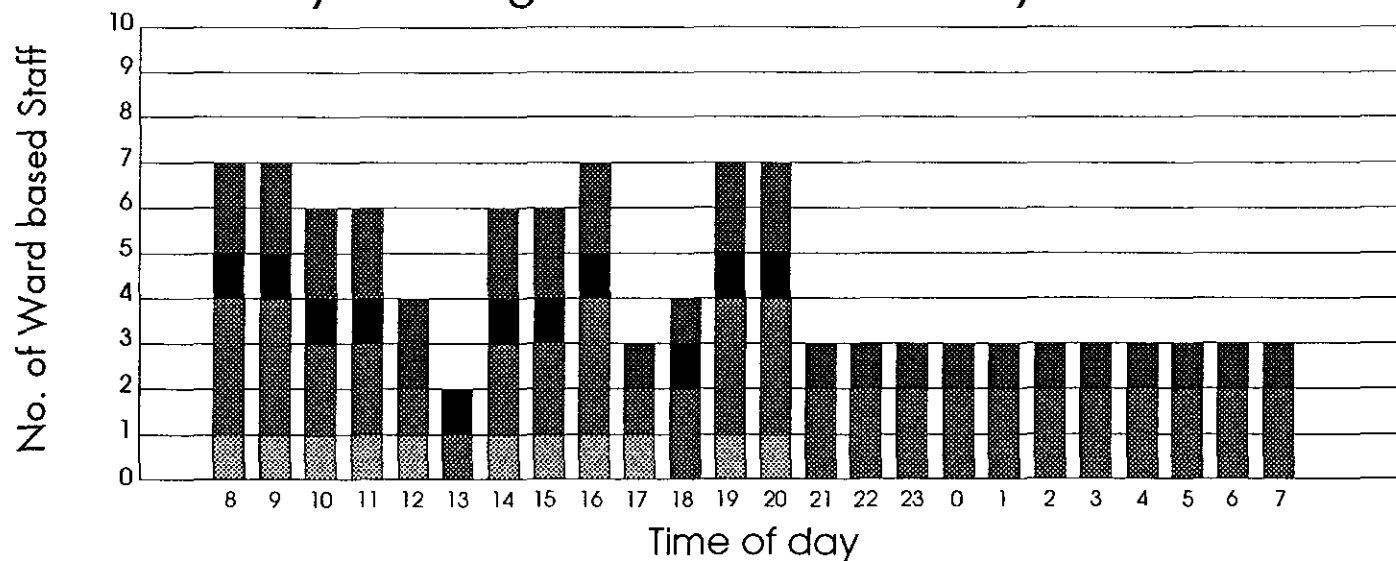
N.F.A. Inpatient Unit





Hourly Staffing Levels - Wednesday

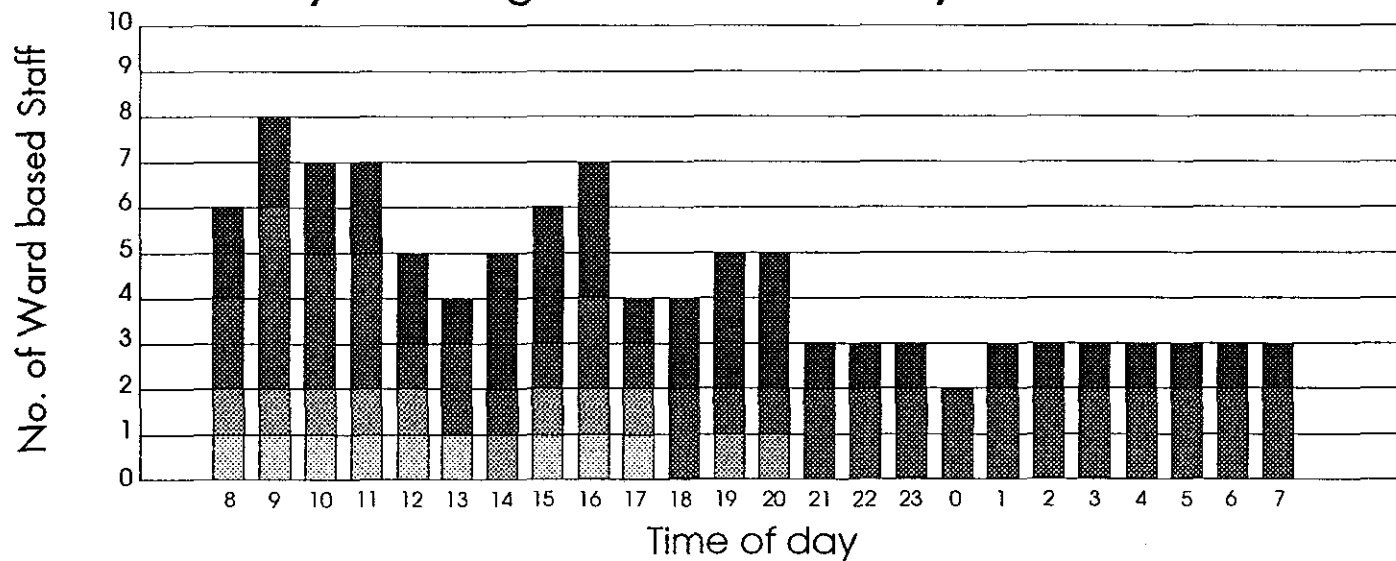
Ward 10B



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

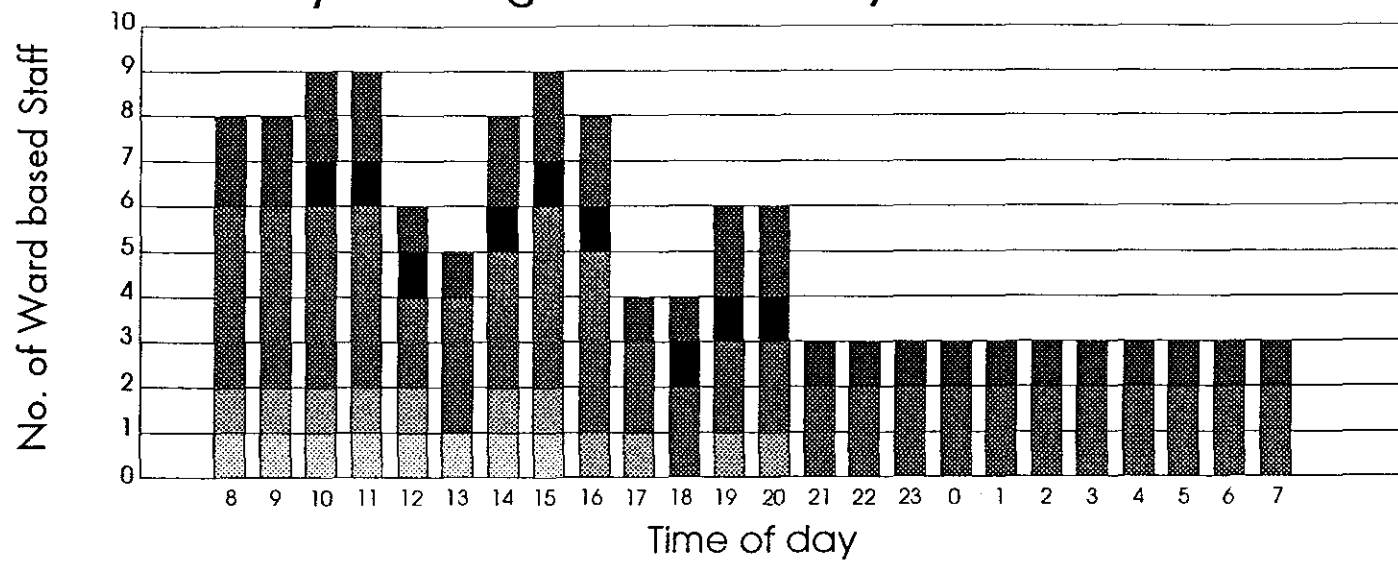
Hourly Staffing Levels - Thursday

Ward 10B



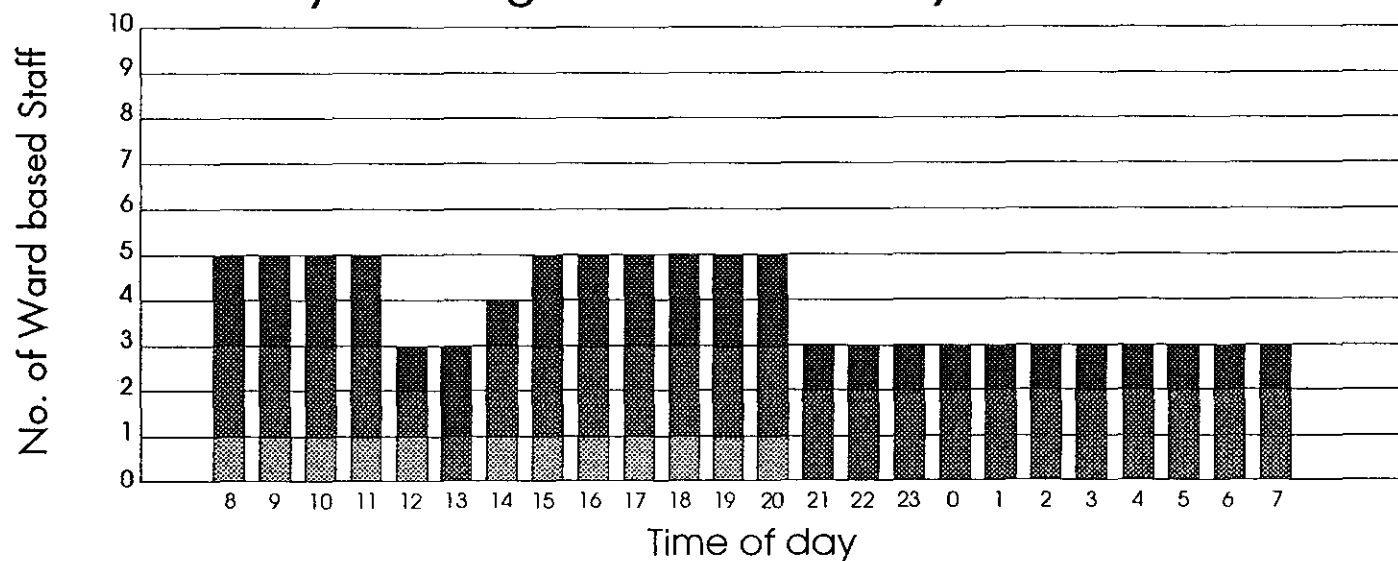
Hourly Staffing Levels - Friday

Ward 10B

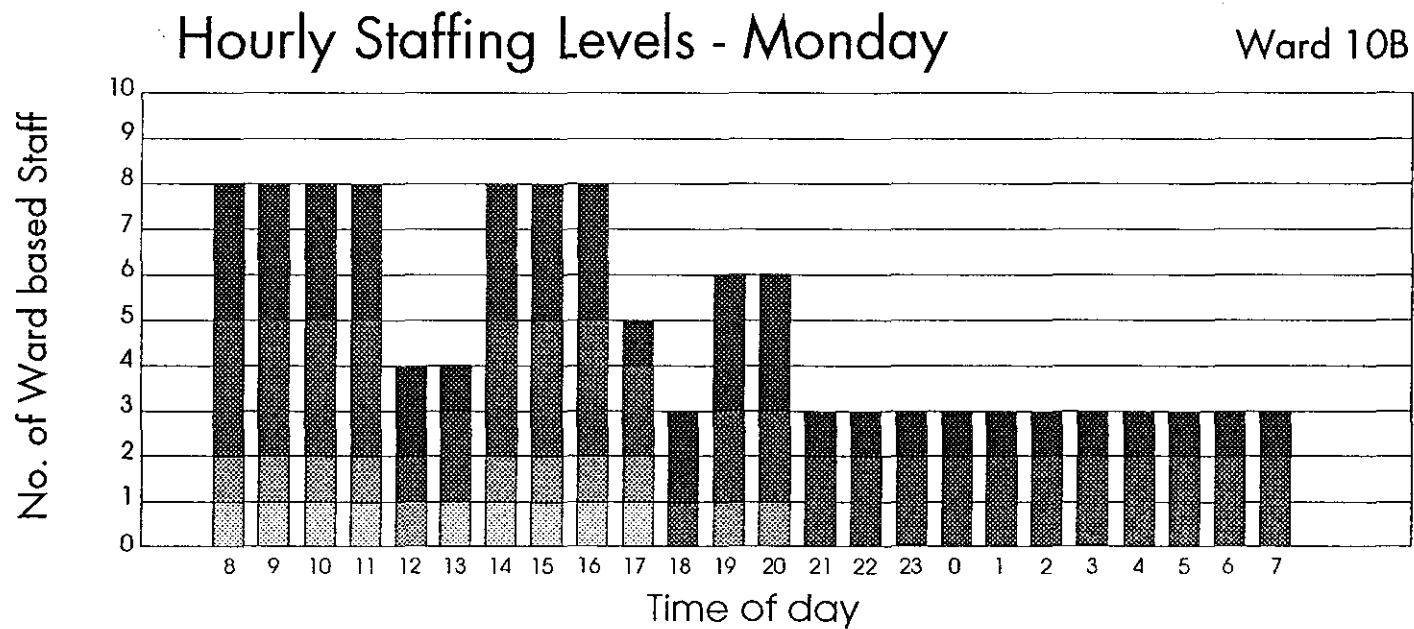
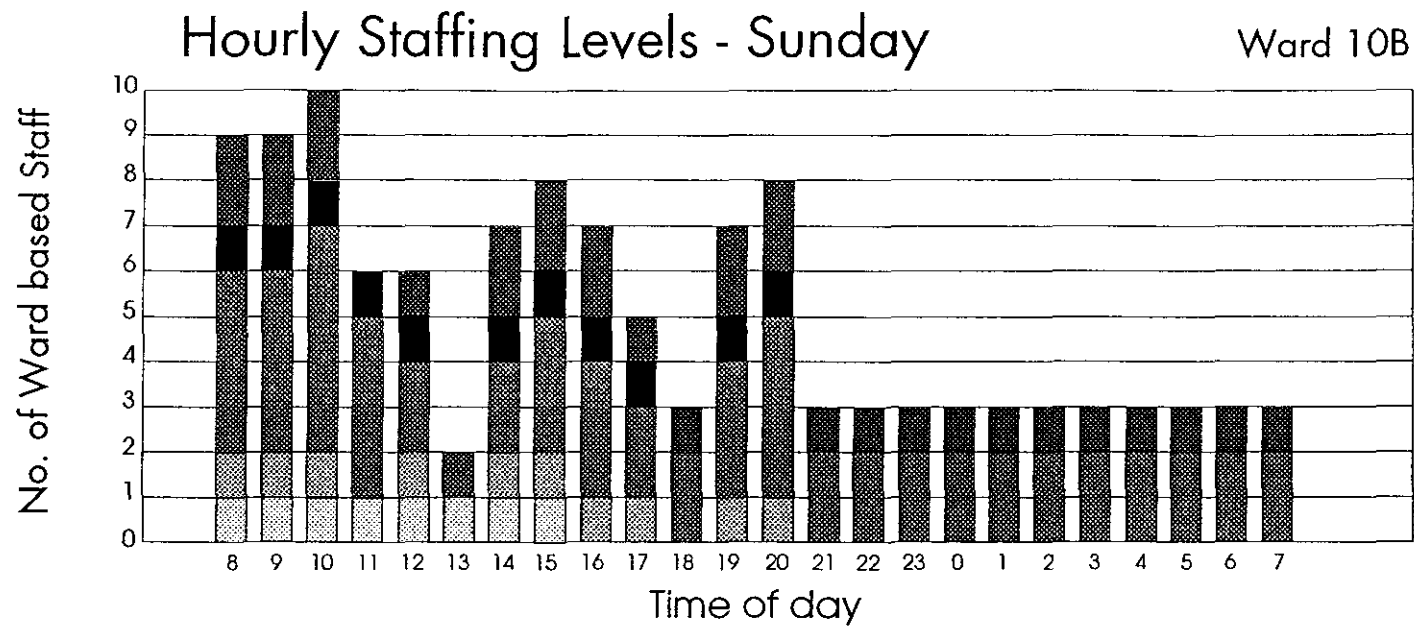


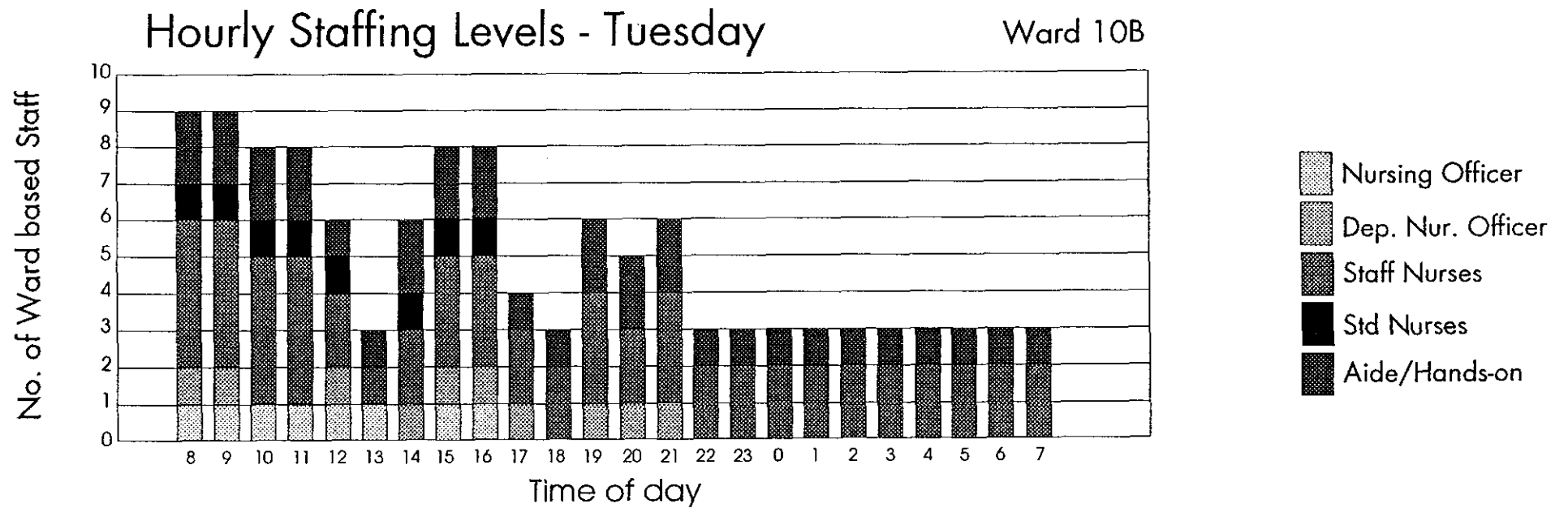
Hourly Staffing Levels - Saturday

Ward 10B



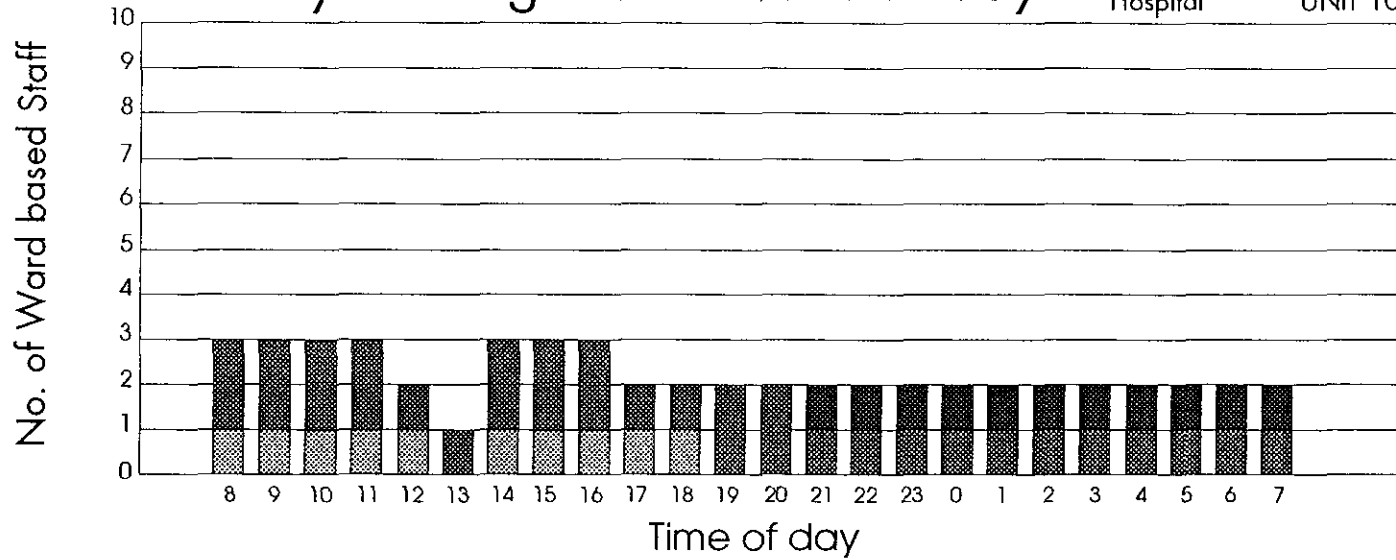
- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on





Hourly Staffing Levels - Wednesday

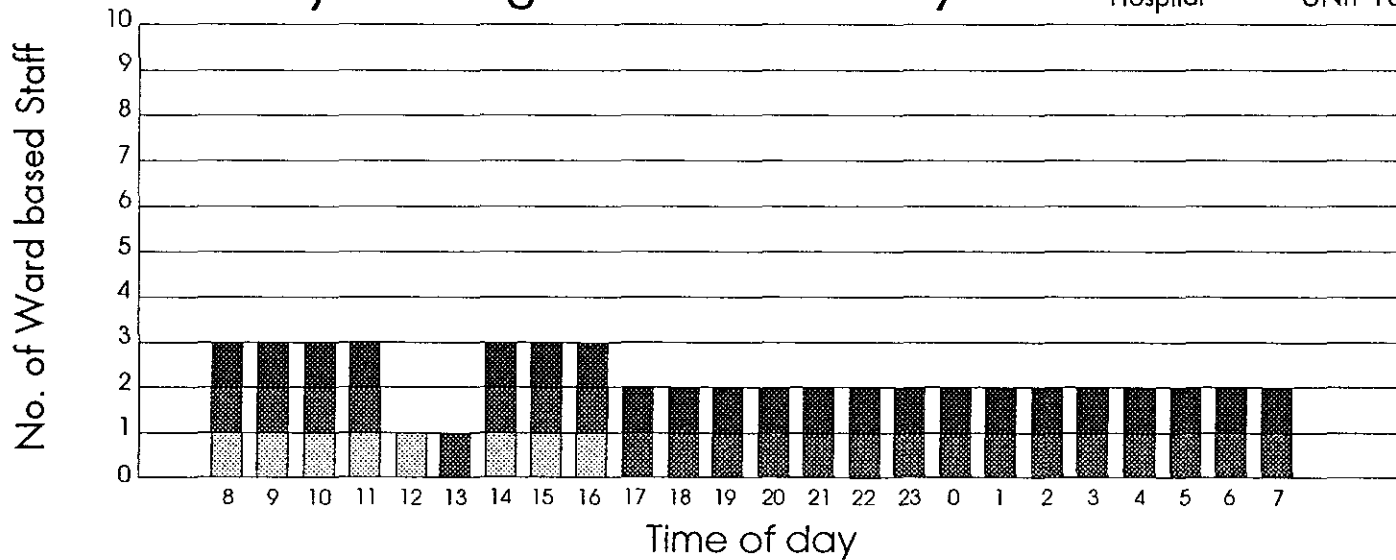
James Connolly Memorial
Hospital UNIT 10

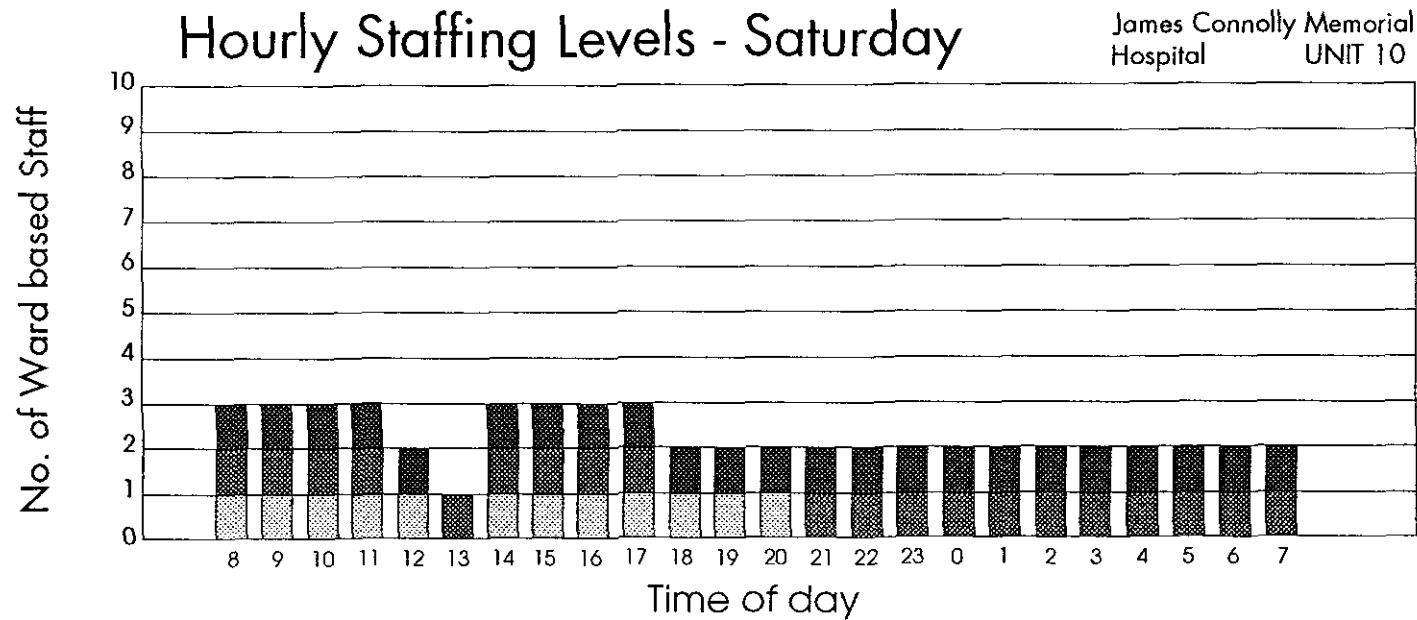
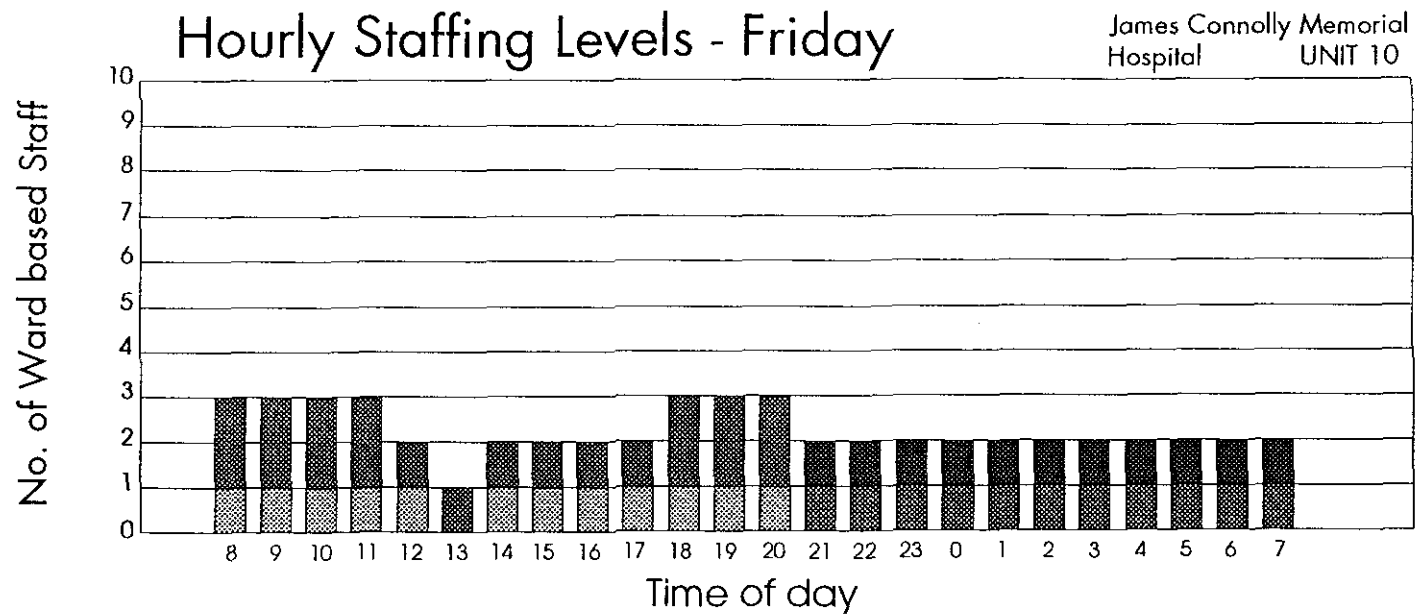


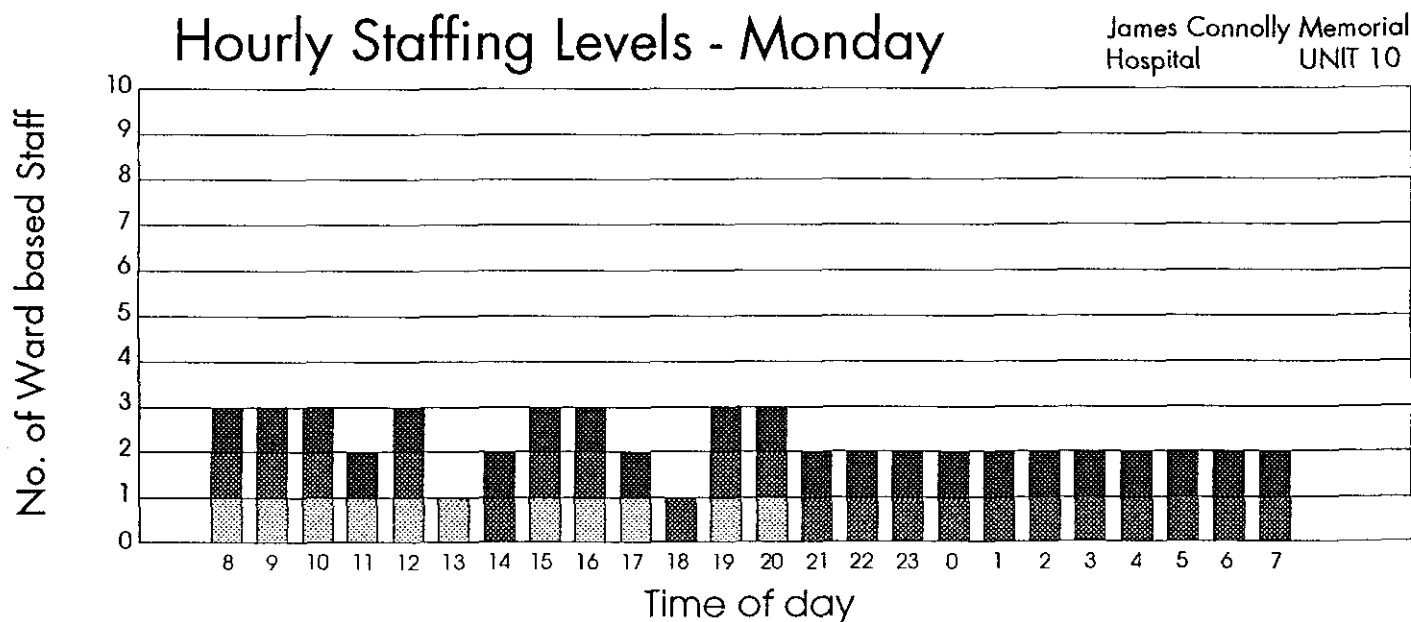
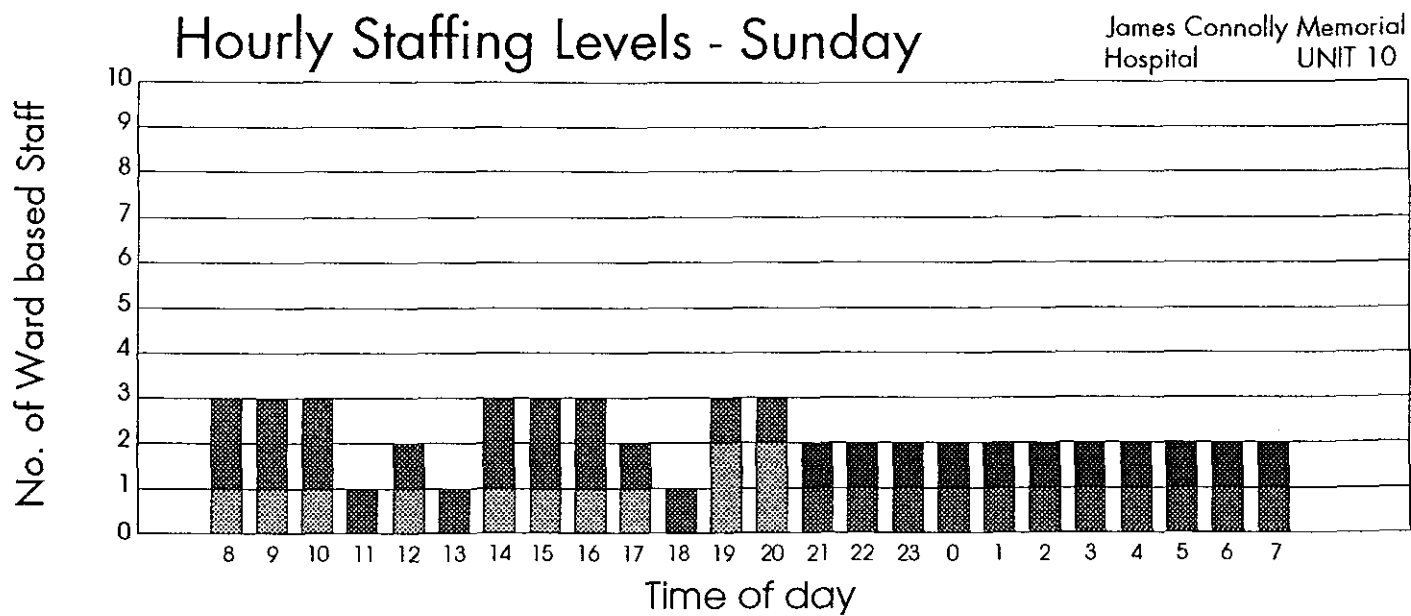
- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Thursday

James Connolly Memorial
Hospital UNIT 10

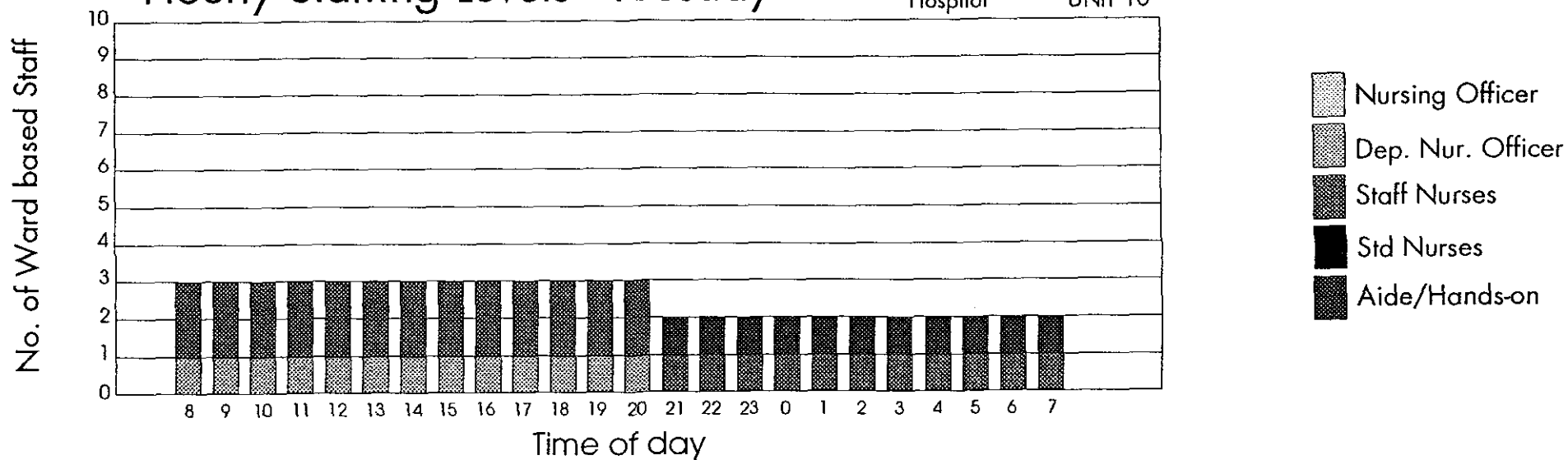


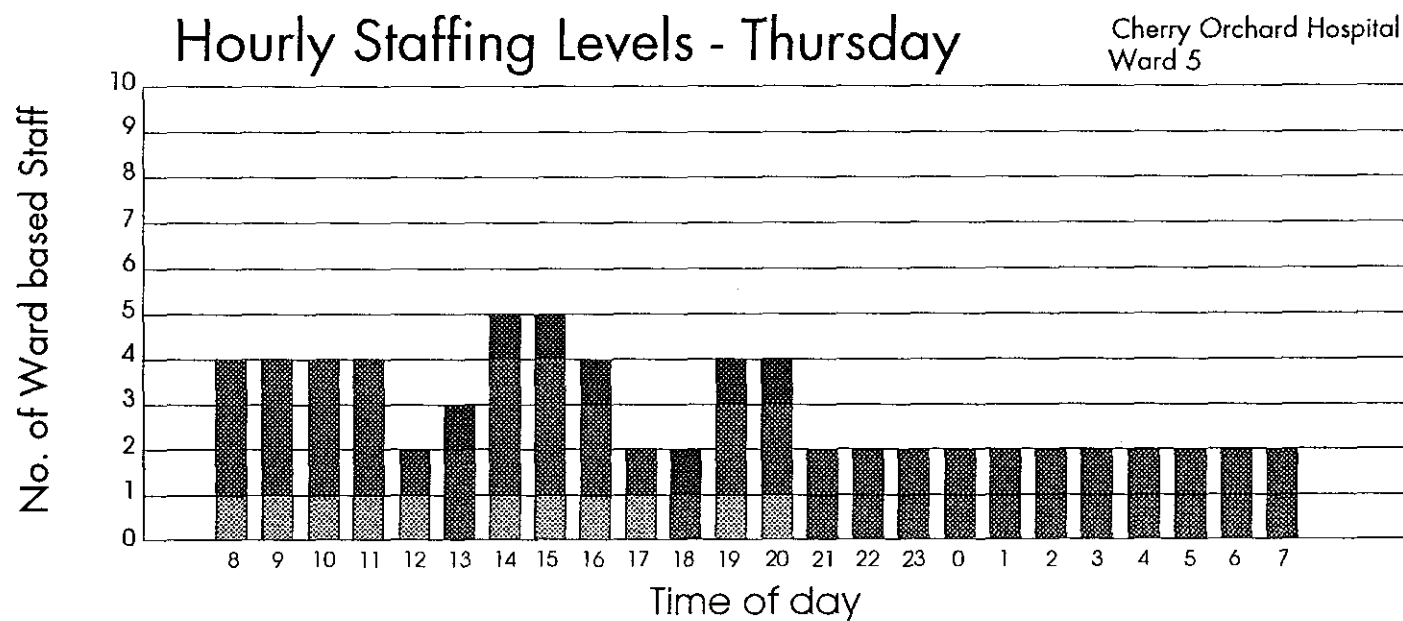
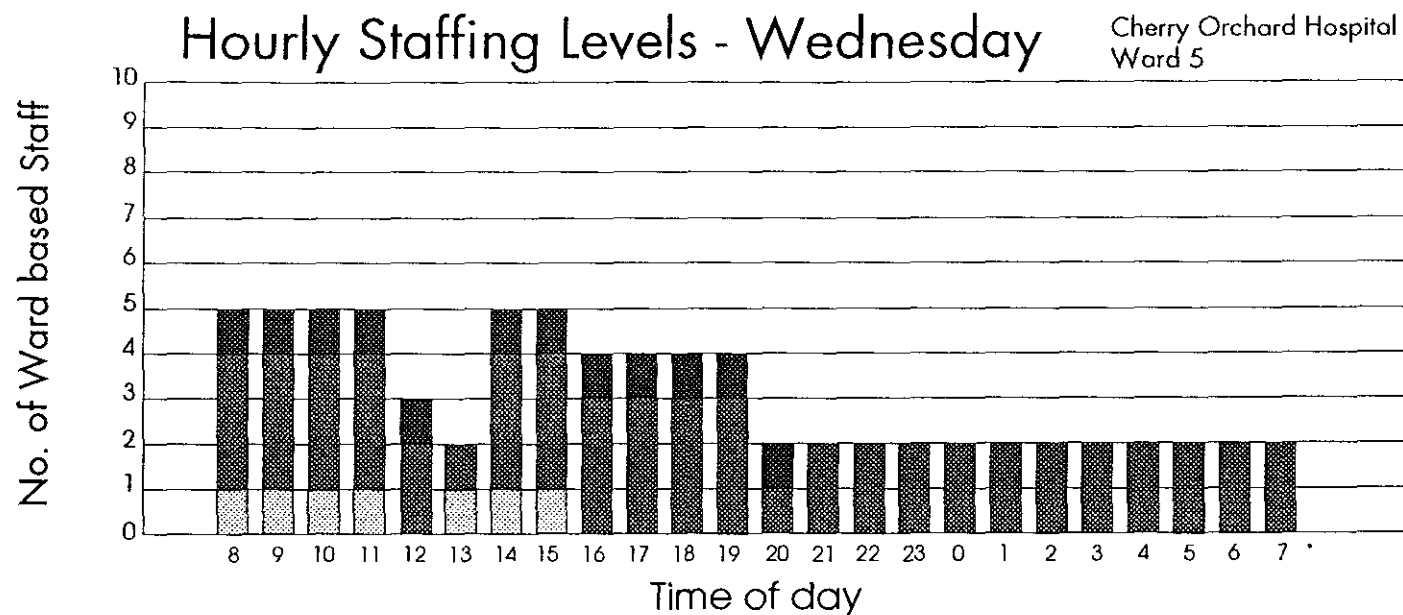


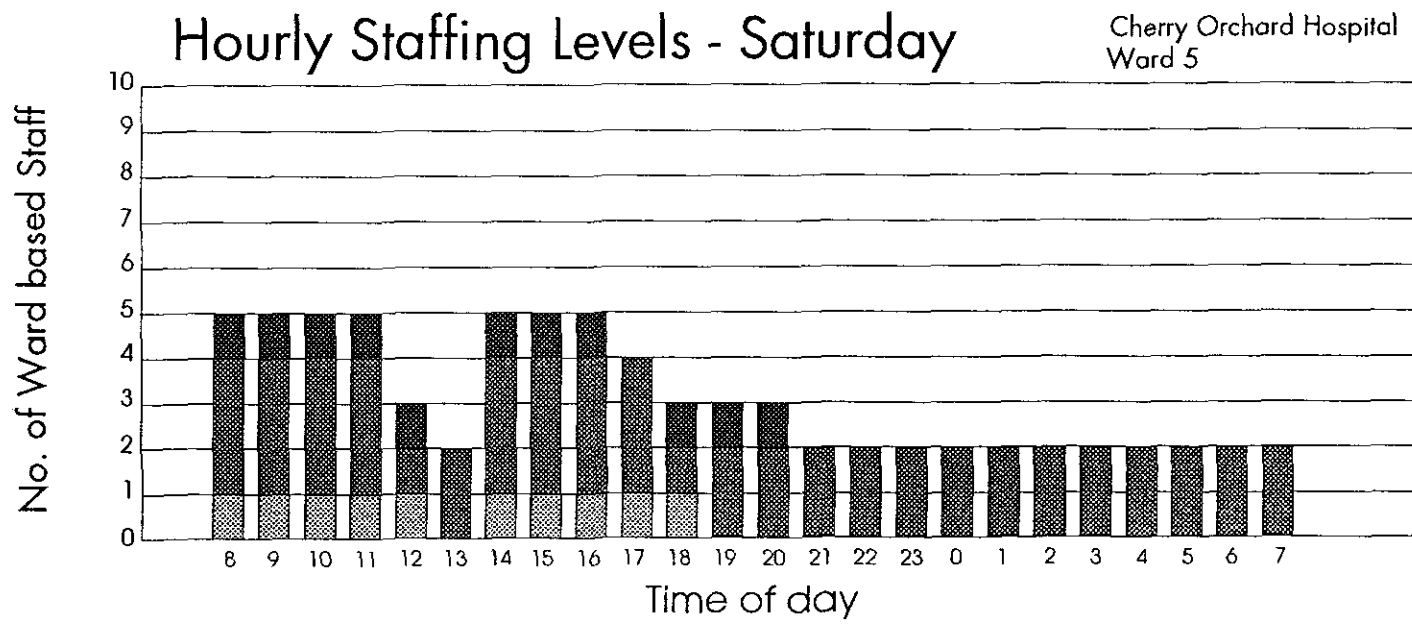
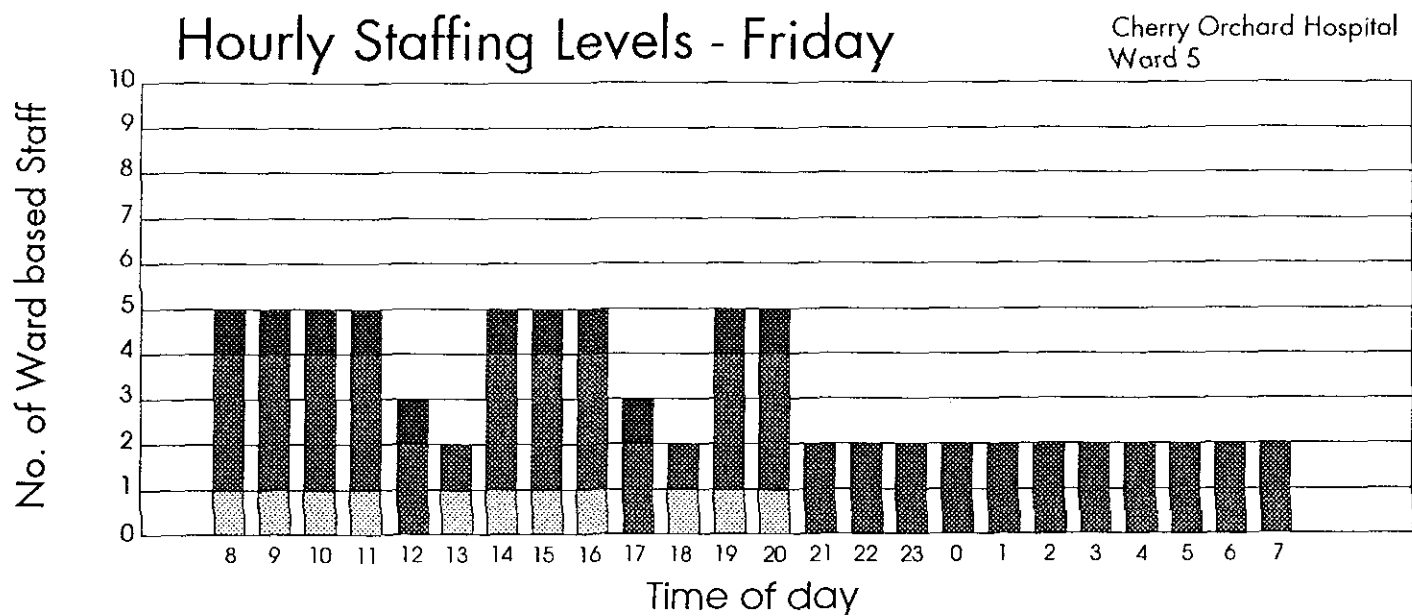


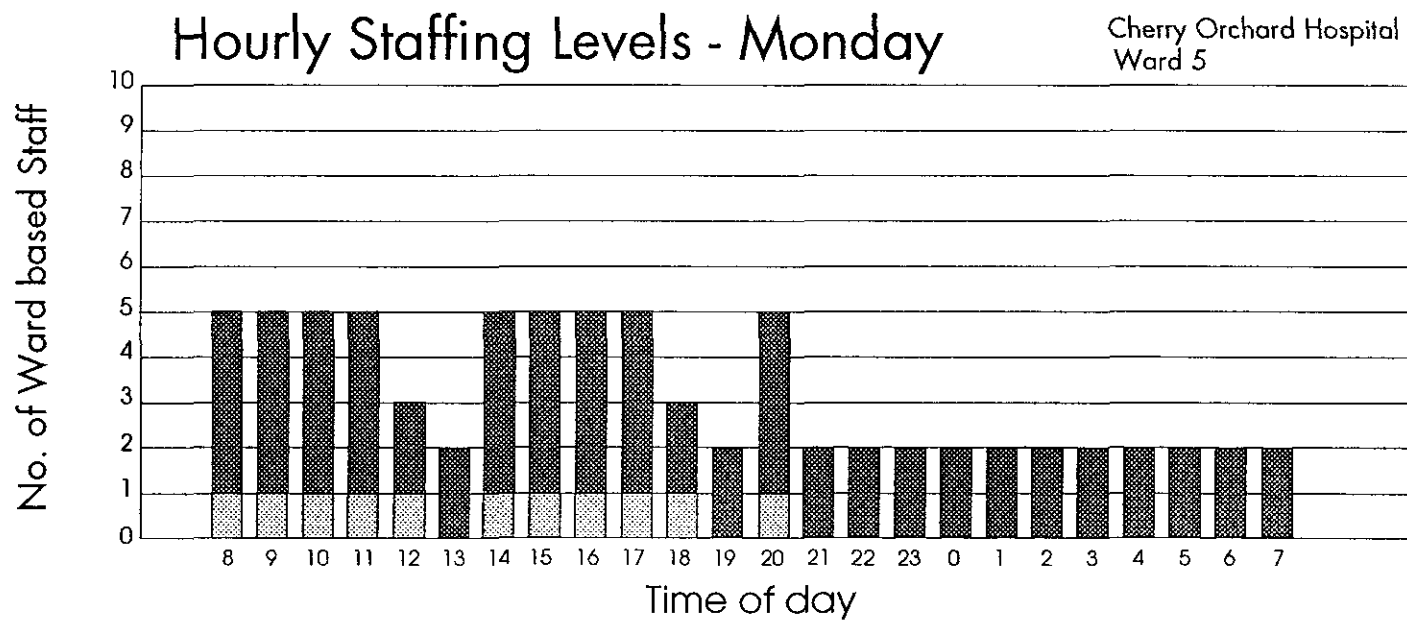
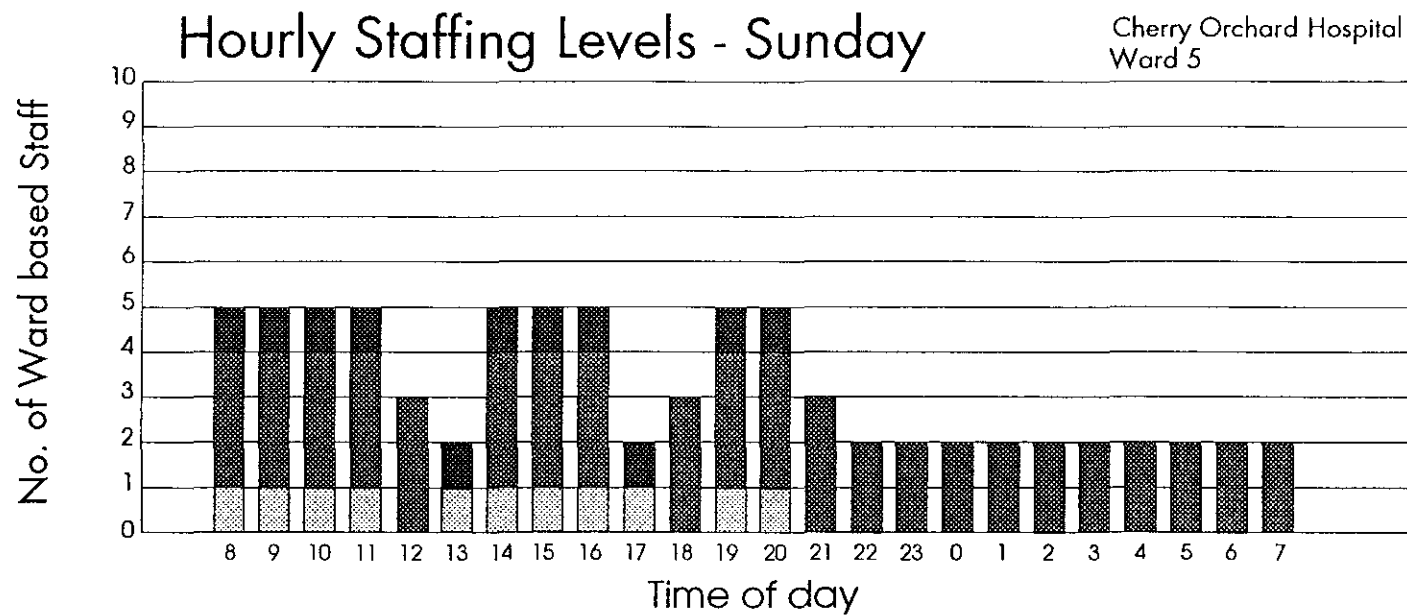
Hourly Staffing Levels - Tuesday

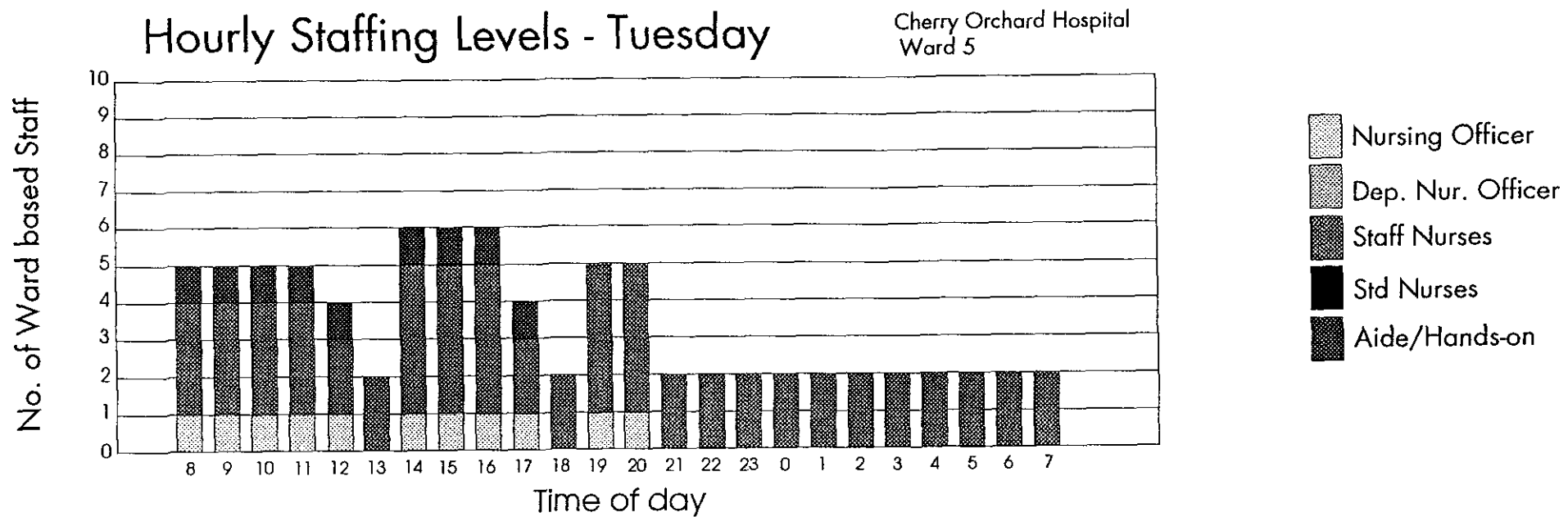
James Connolly Memorial
Hospital UNIT 10

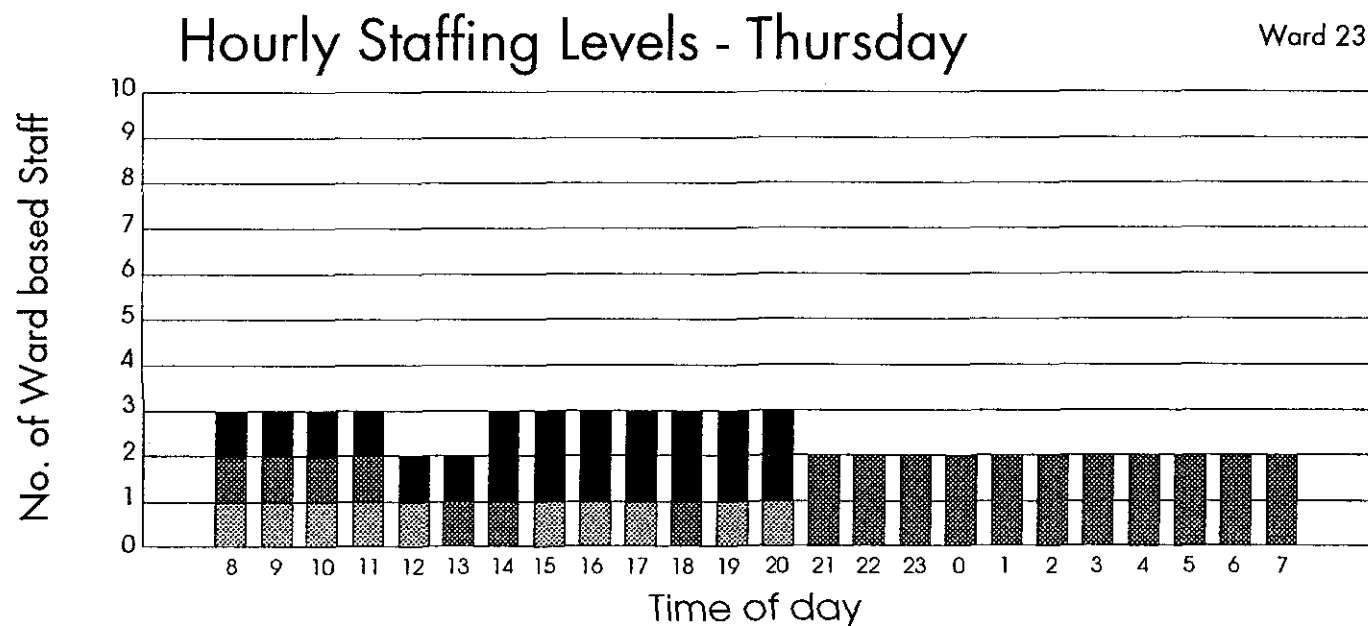
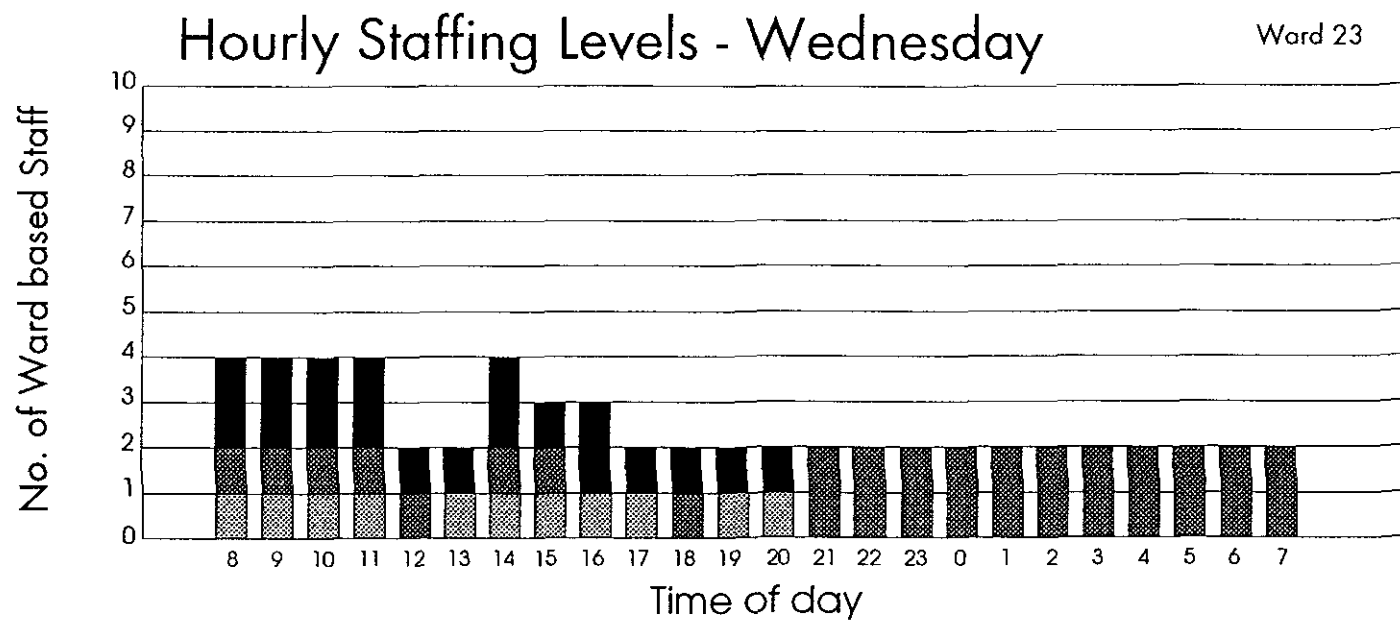






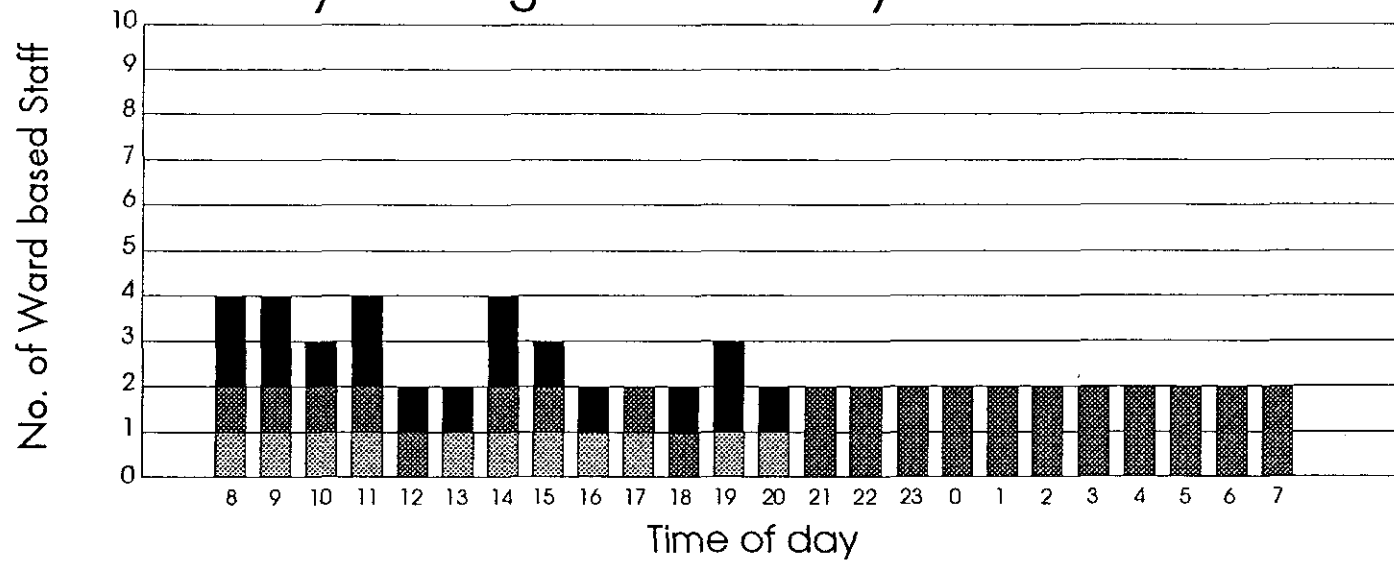






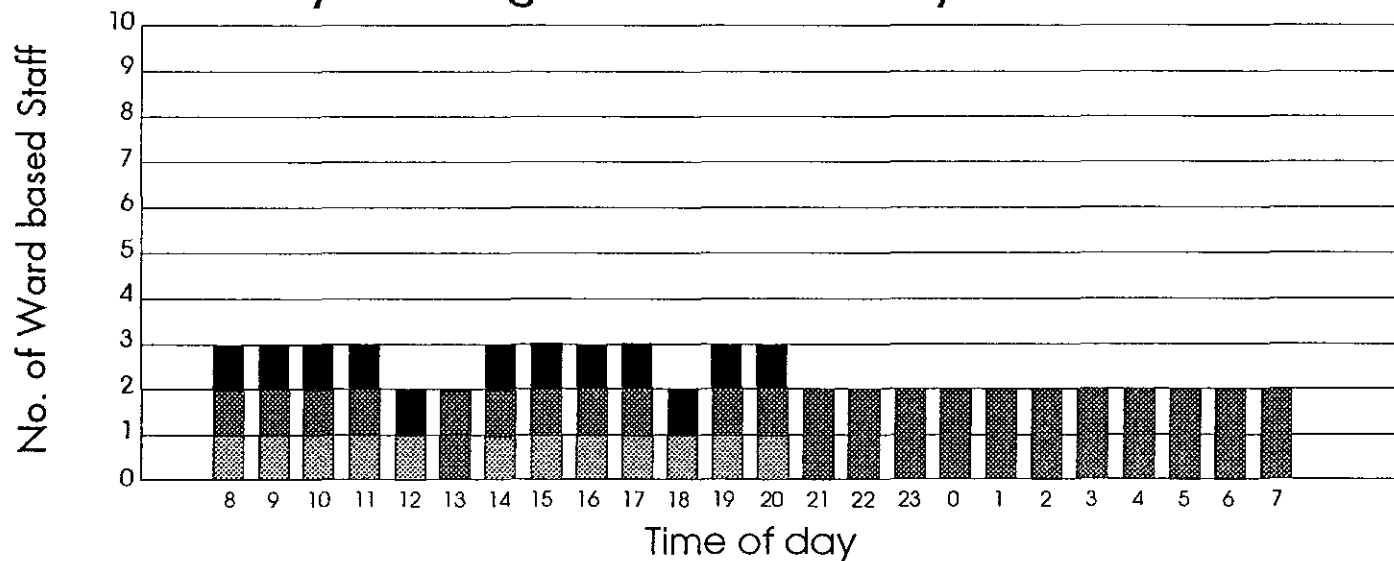
Hourly Staffing Levels - Friday

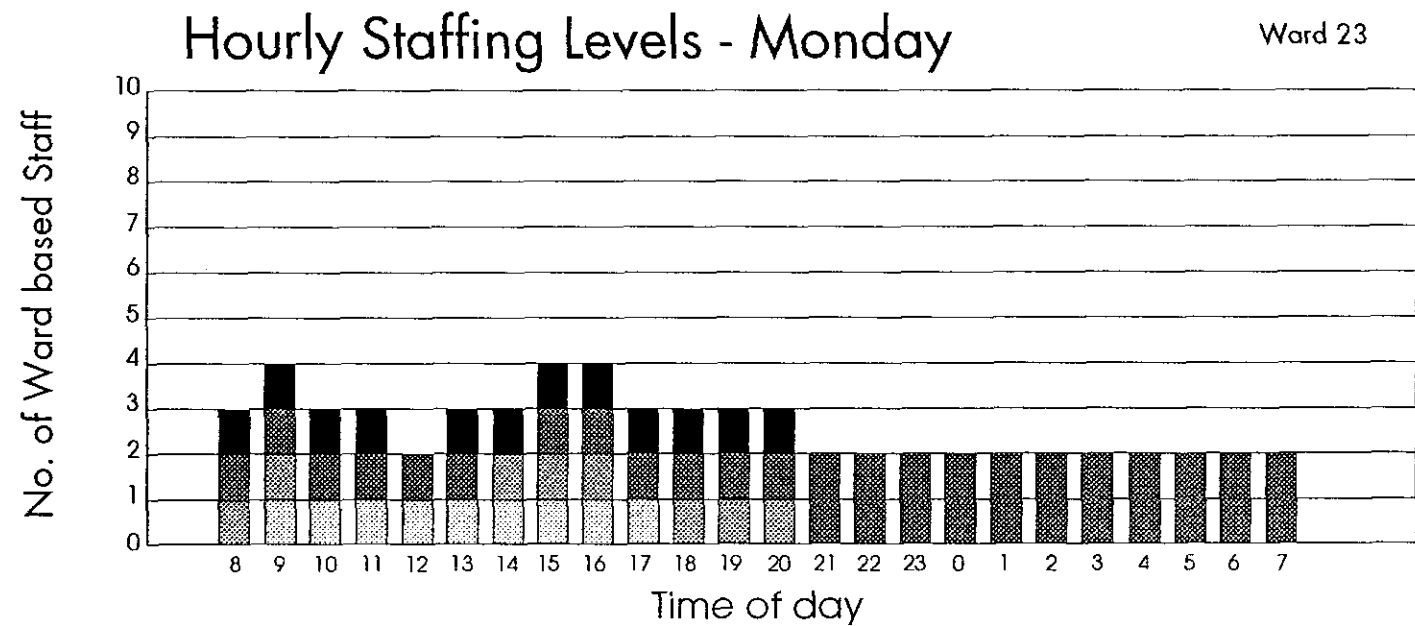
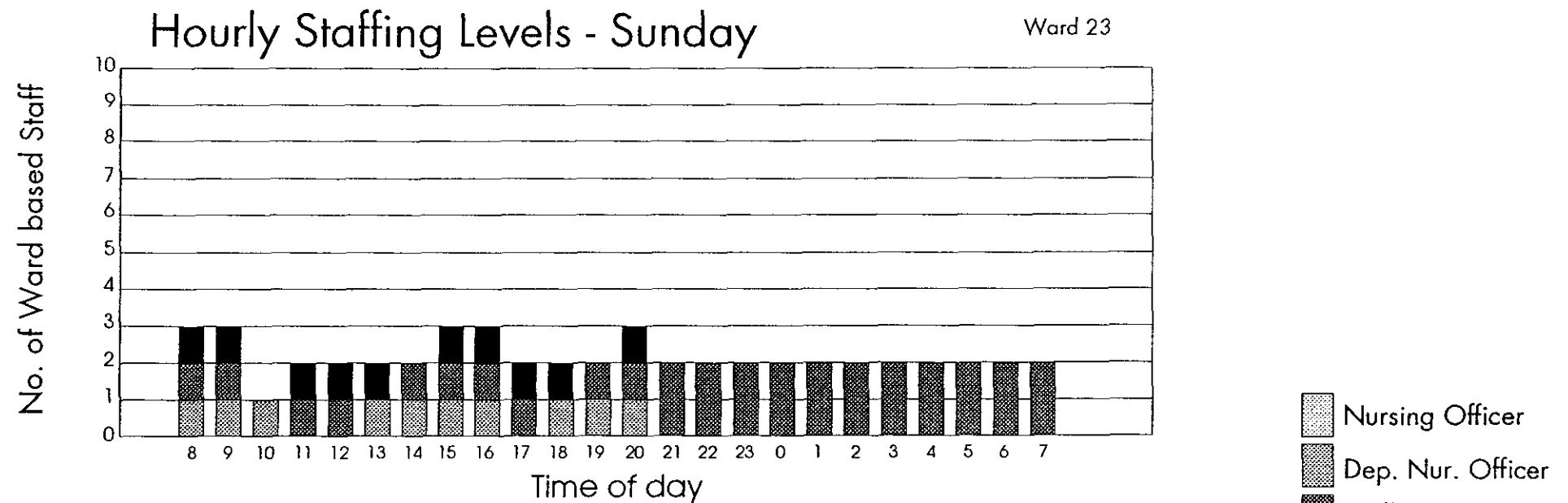
Ward 23

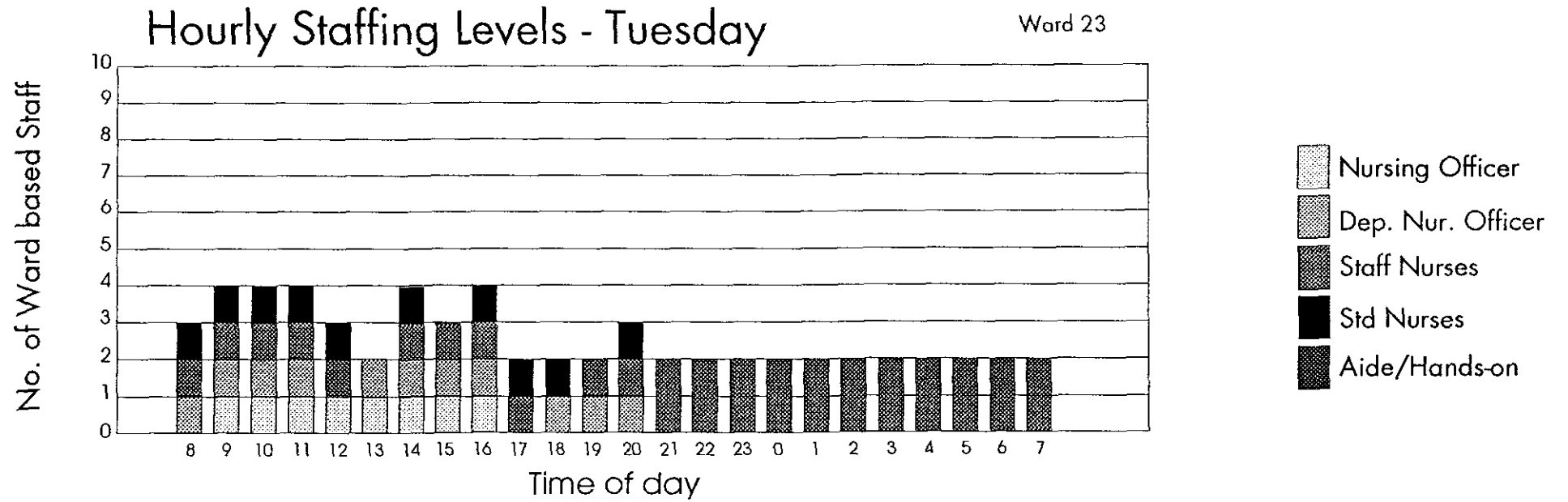


Hourly Staffing Levels - Saturday

Ward 23

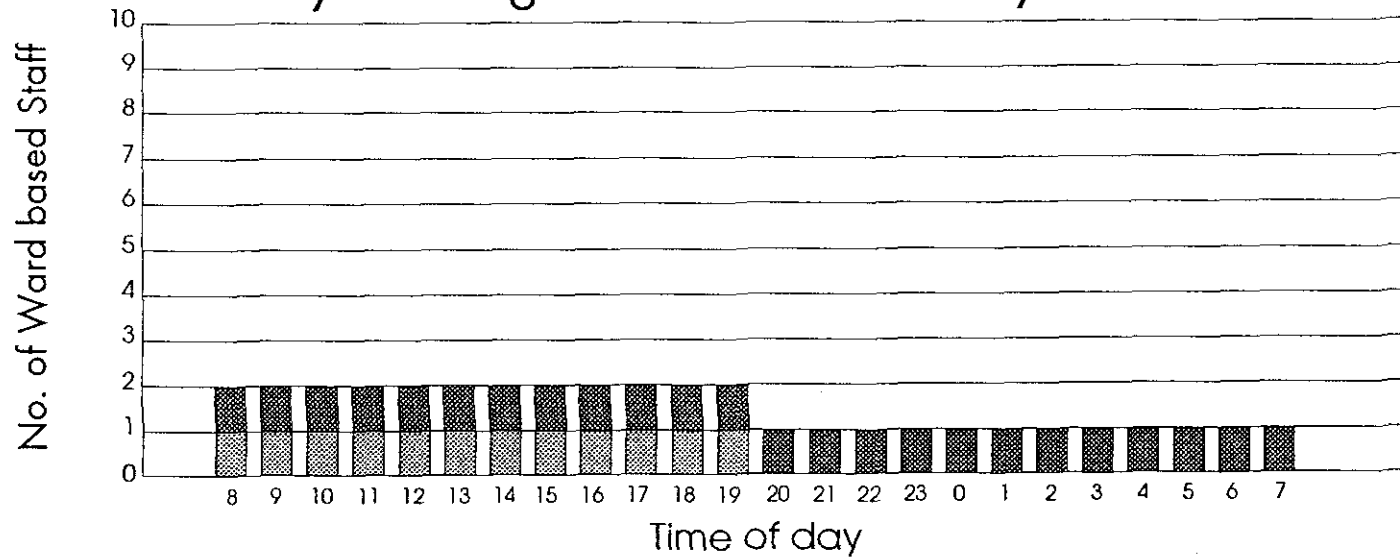






Hourly Staffing Levels - Wednesday

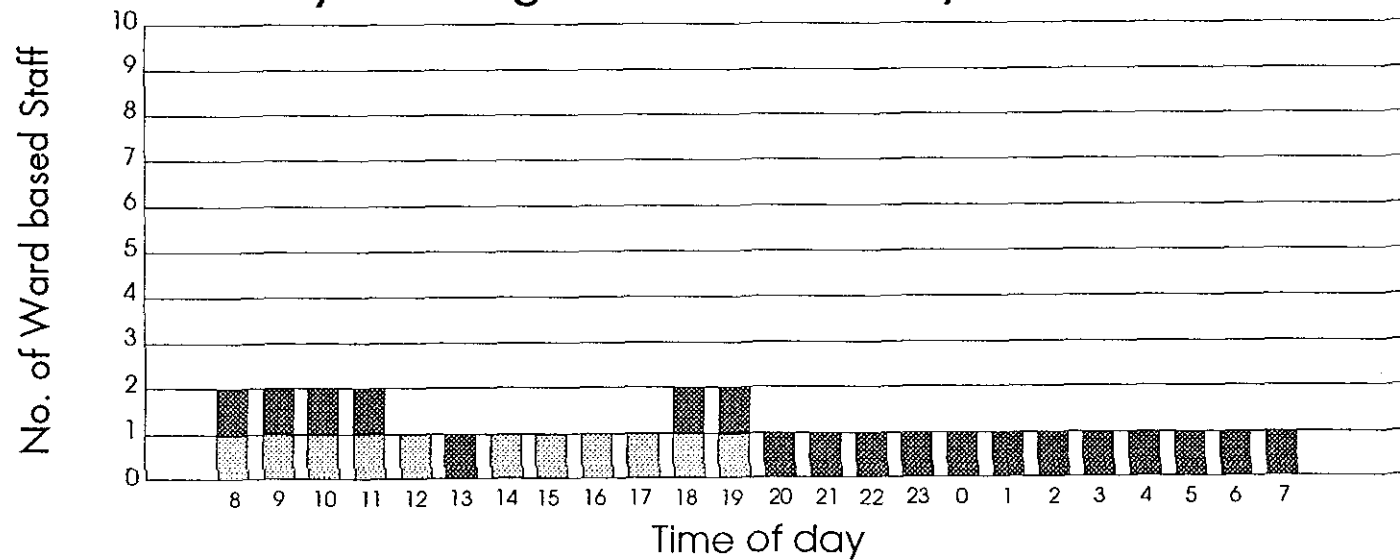
Weir Home

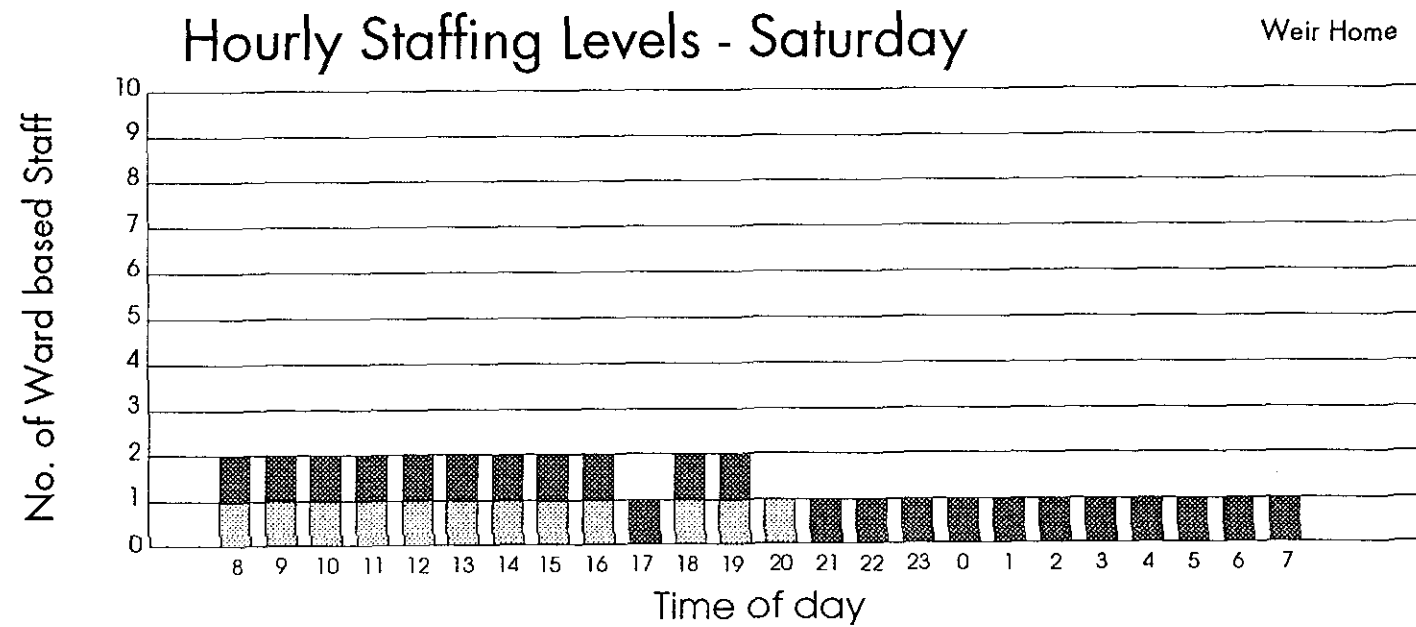
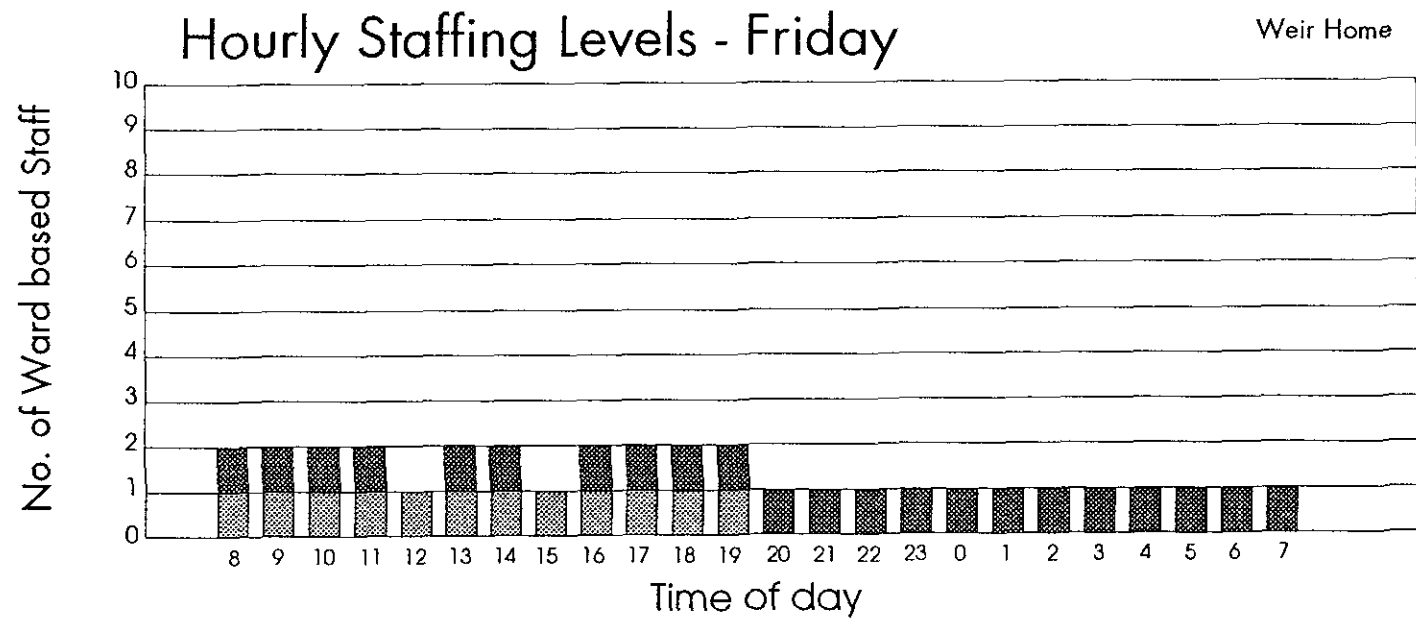


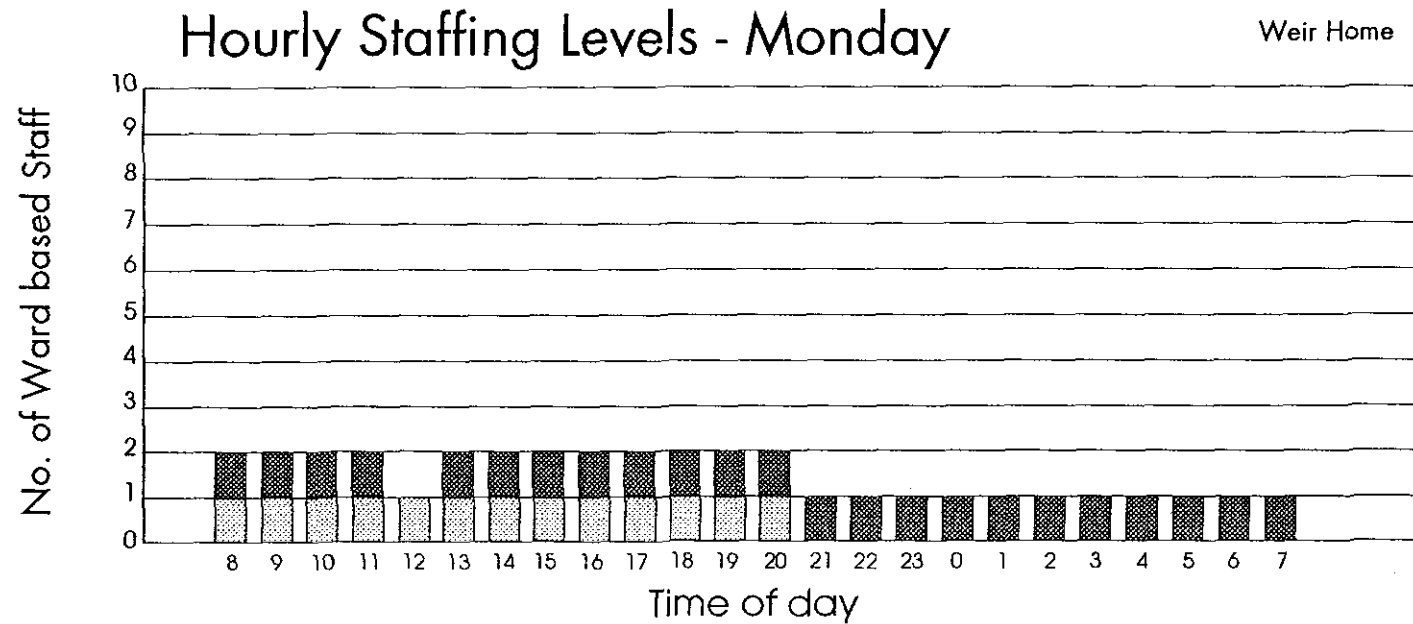
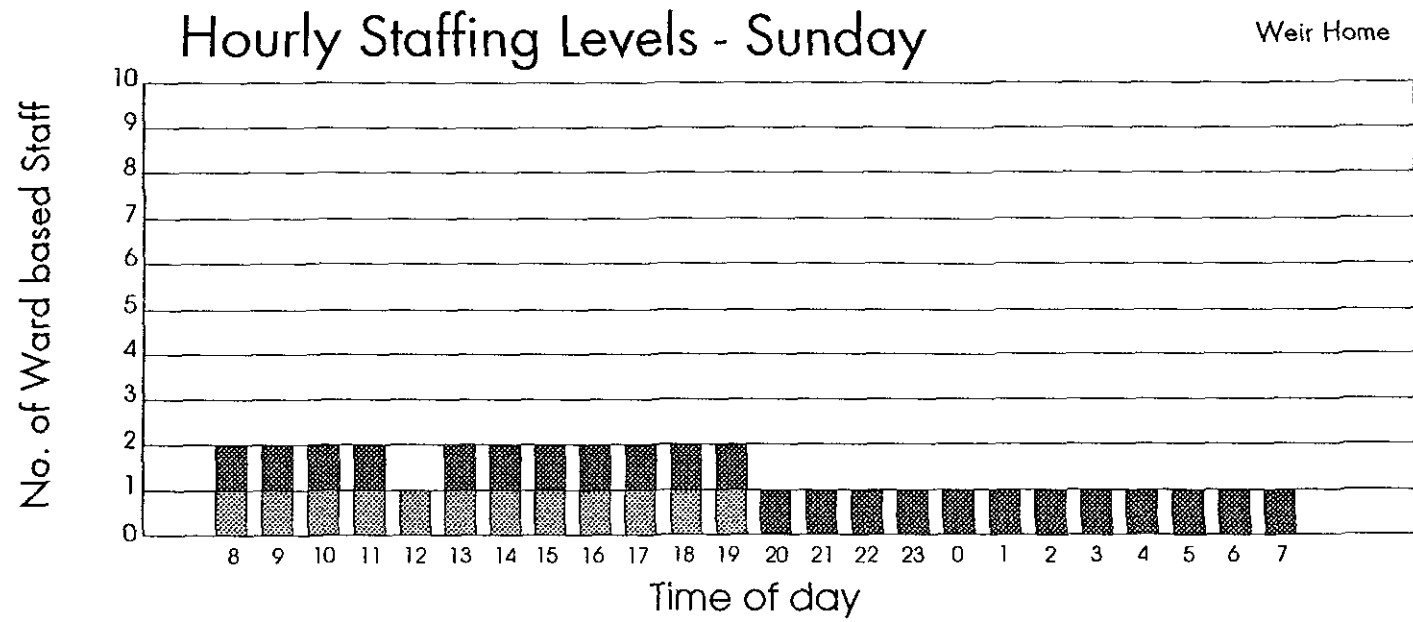
- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

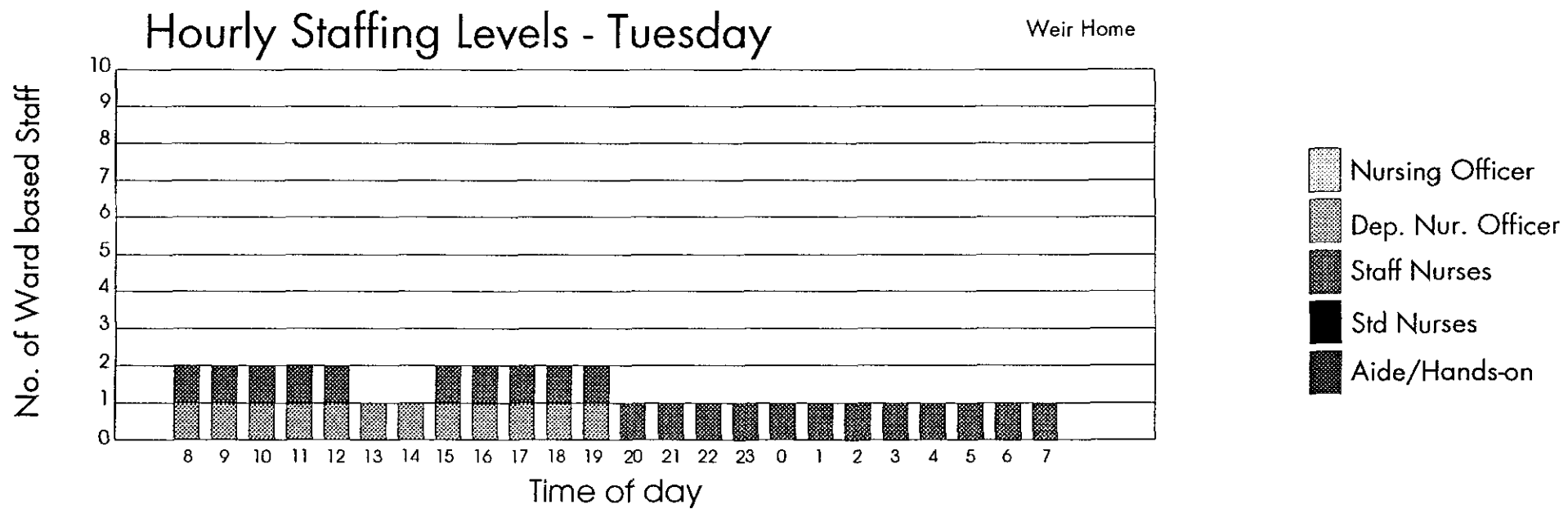
Hourly Staffing Levels - Thursday

Weir Home

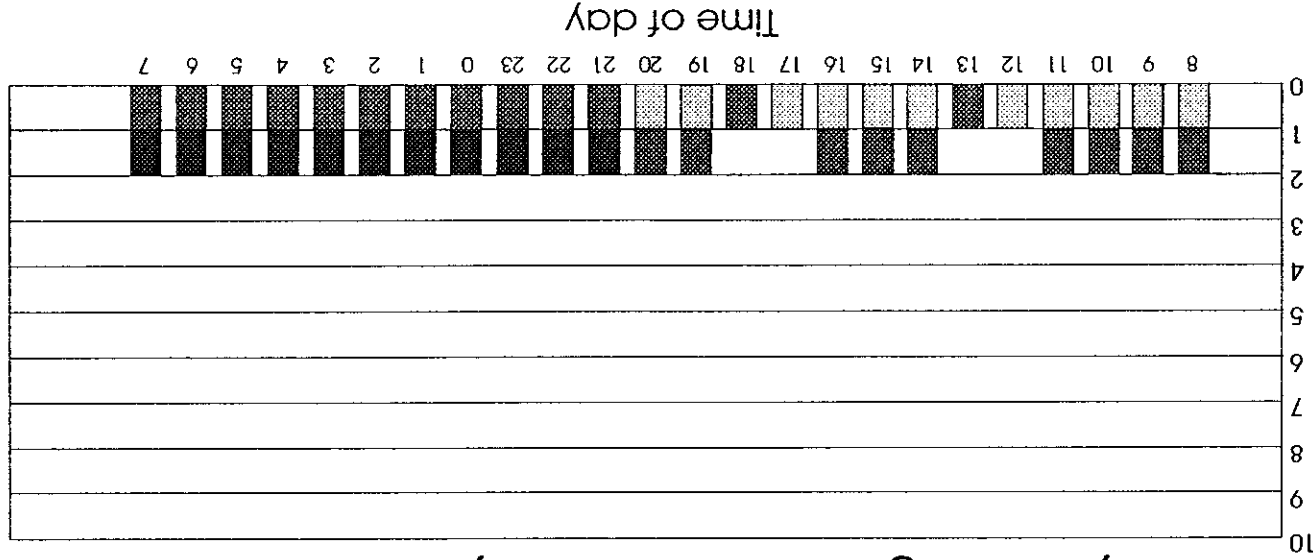








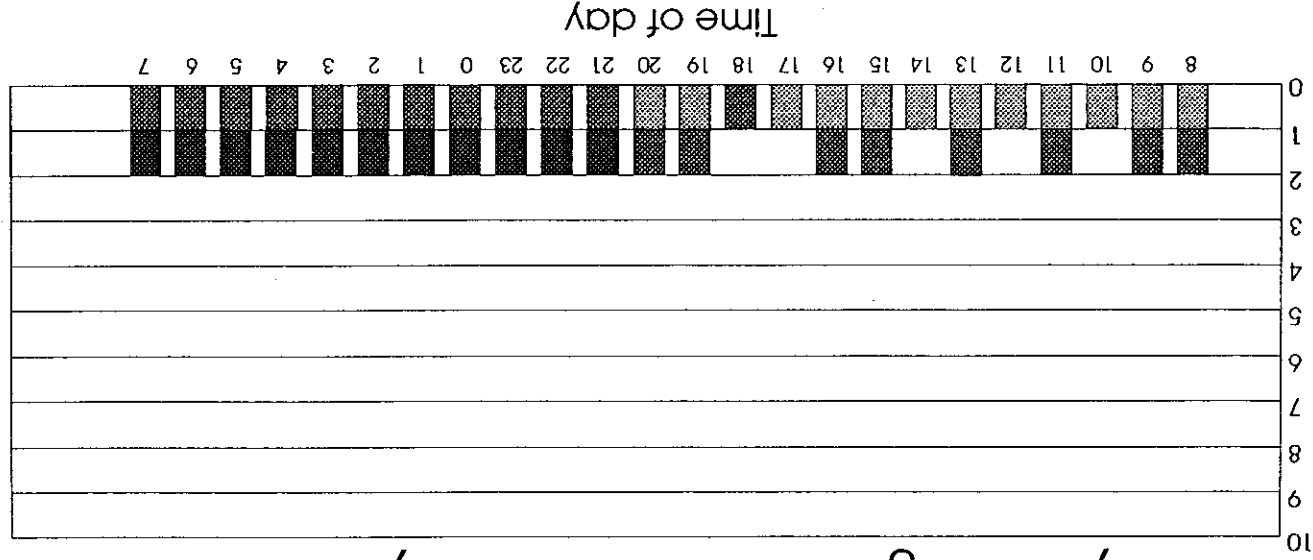
No. of Ward based Staff



Hourly Staffing Levels - Thursday

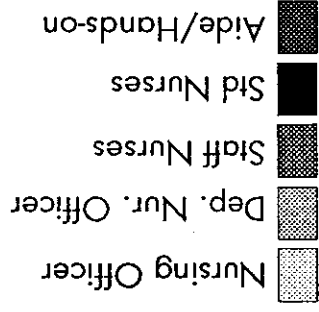
San Remo

No. of Ward based Staff



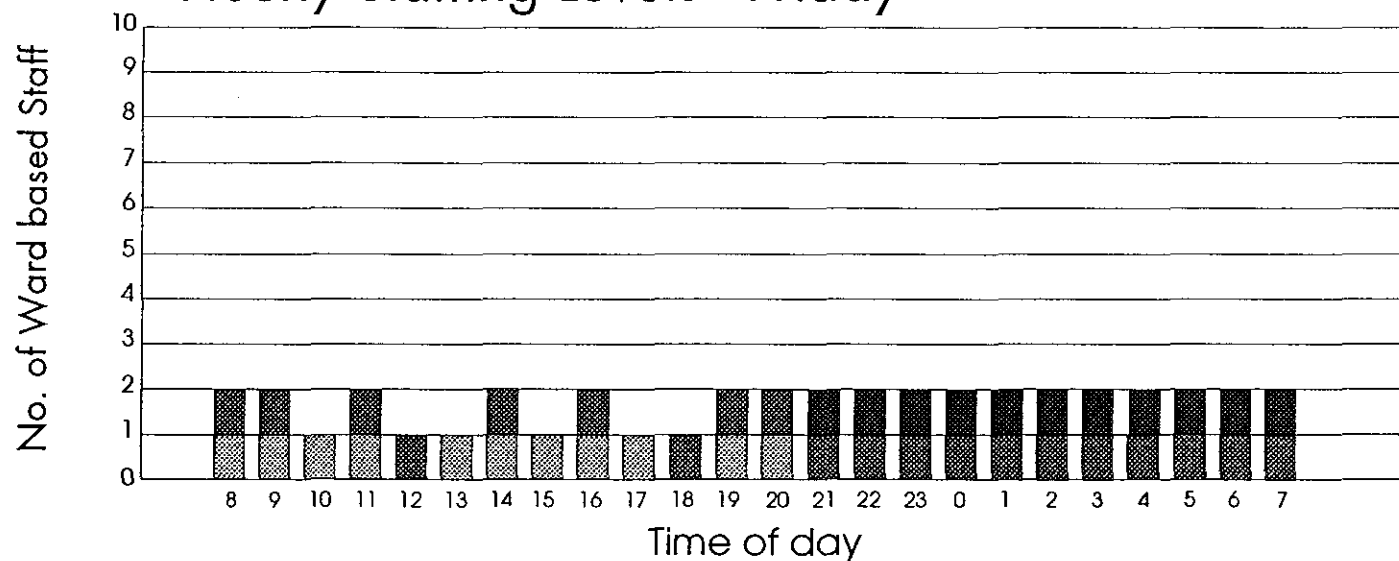
Hourly Staffing Levels - Wednesday

San Remo



Hourly Staffing Levels - Friday

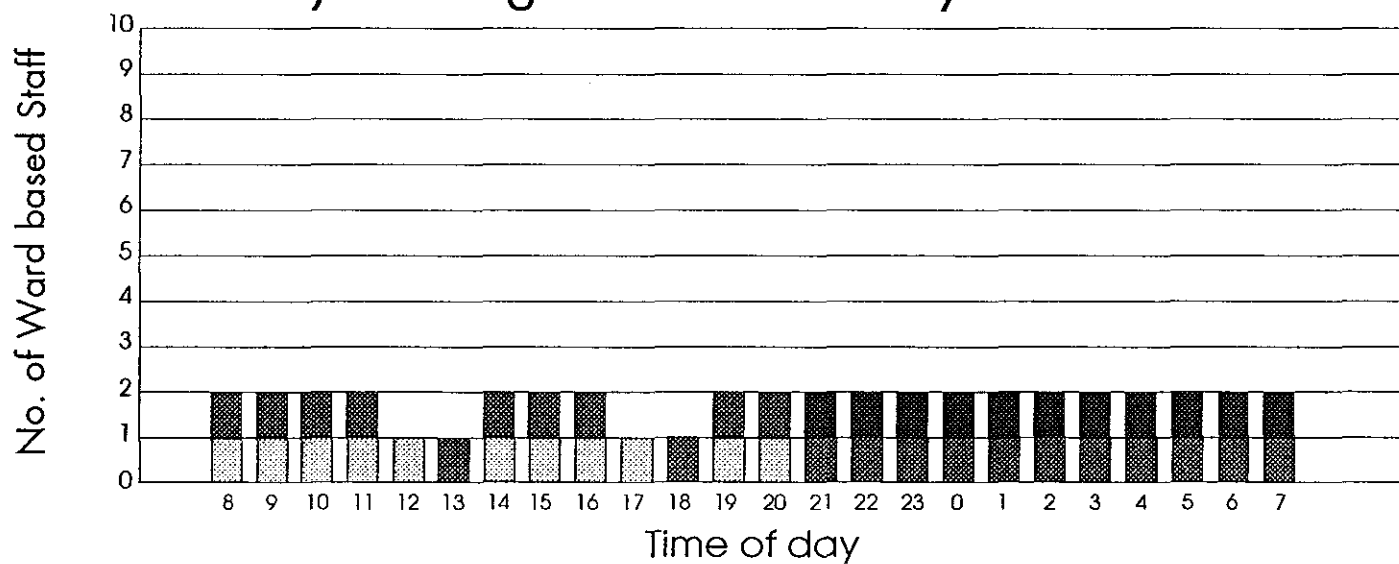
San Remo



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Saturday

San Remo



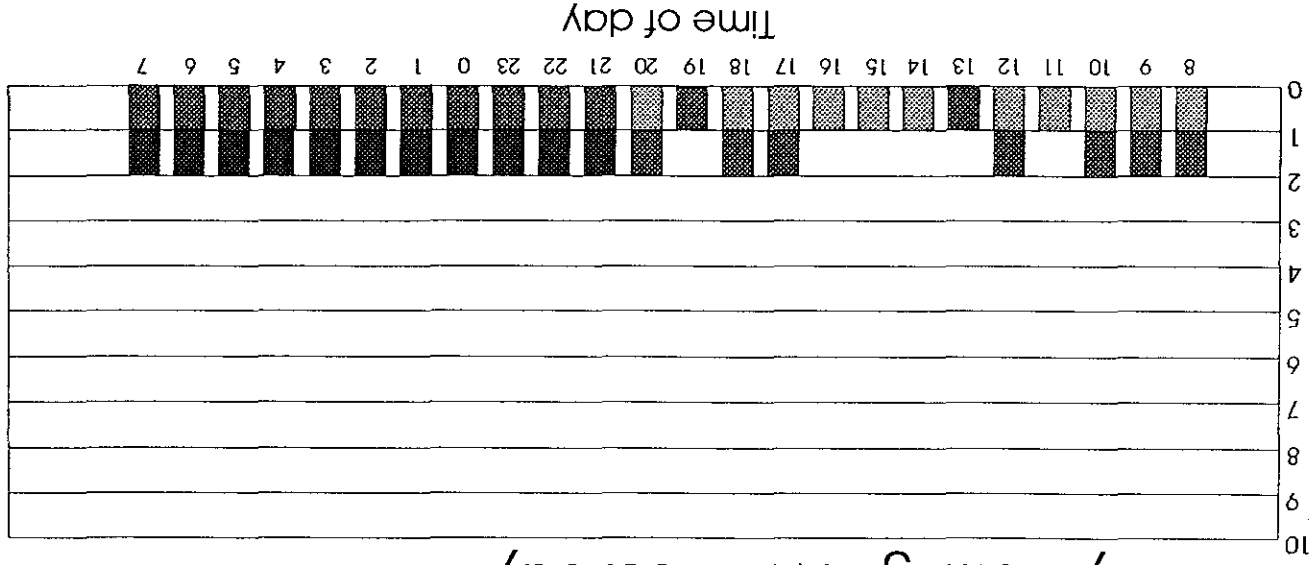
No. of Ward based Staff



Hourly Staffing Levels - Monday

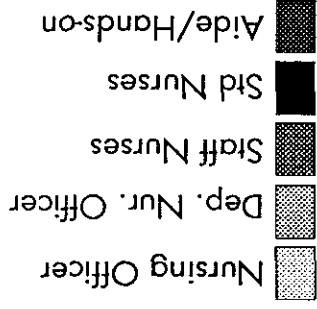
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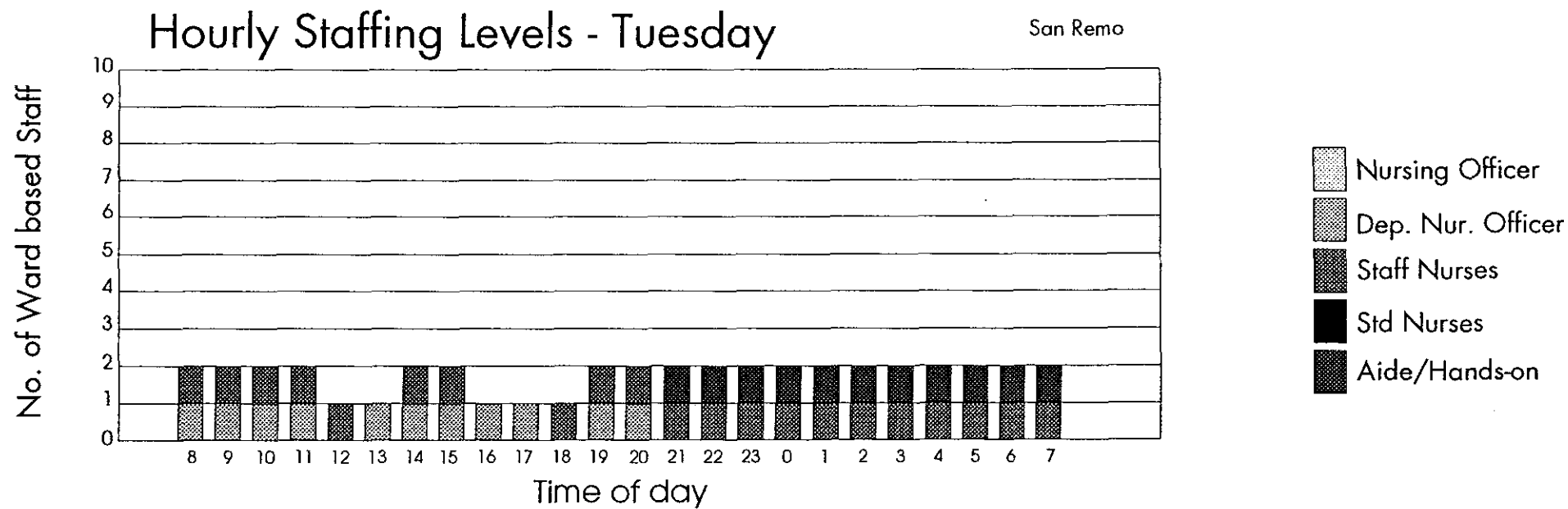
No. of Ward based Staff



Hourly Staffing Levels - Sunday

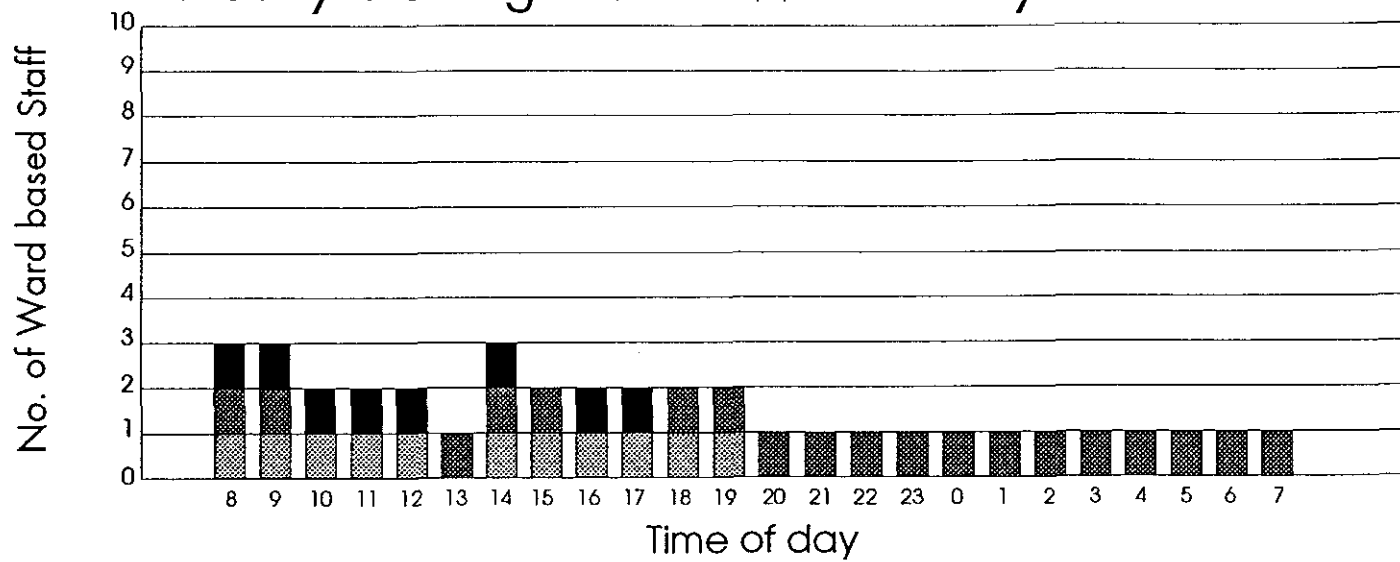
San Remo





Hourly Staffing Levels - Wednesday

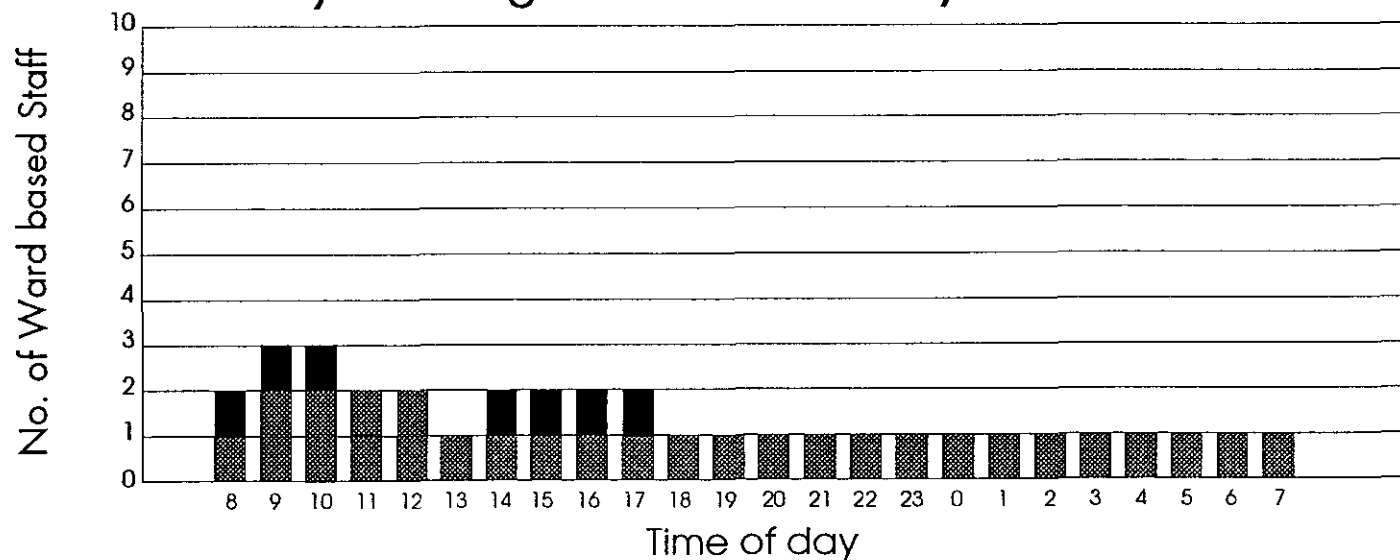
Adare House

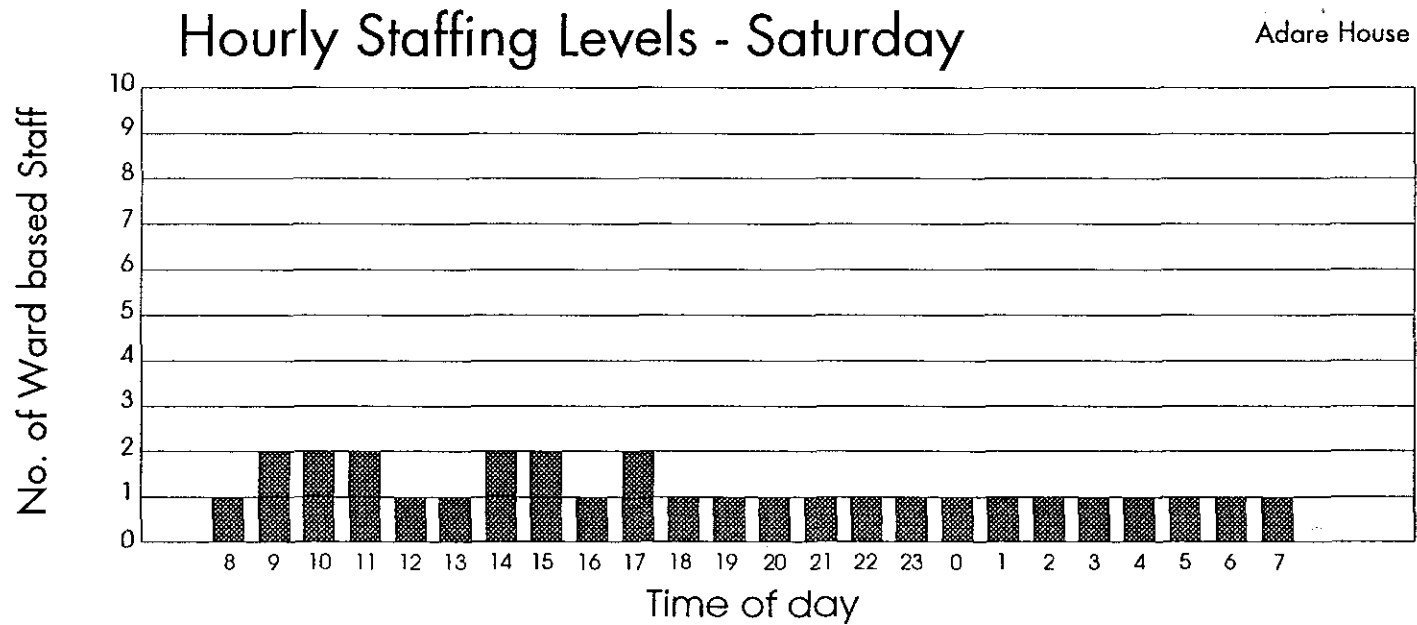
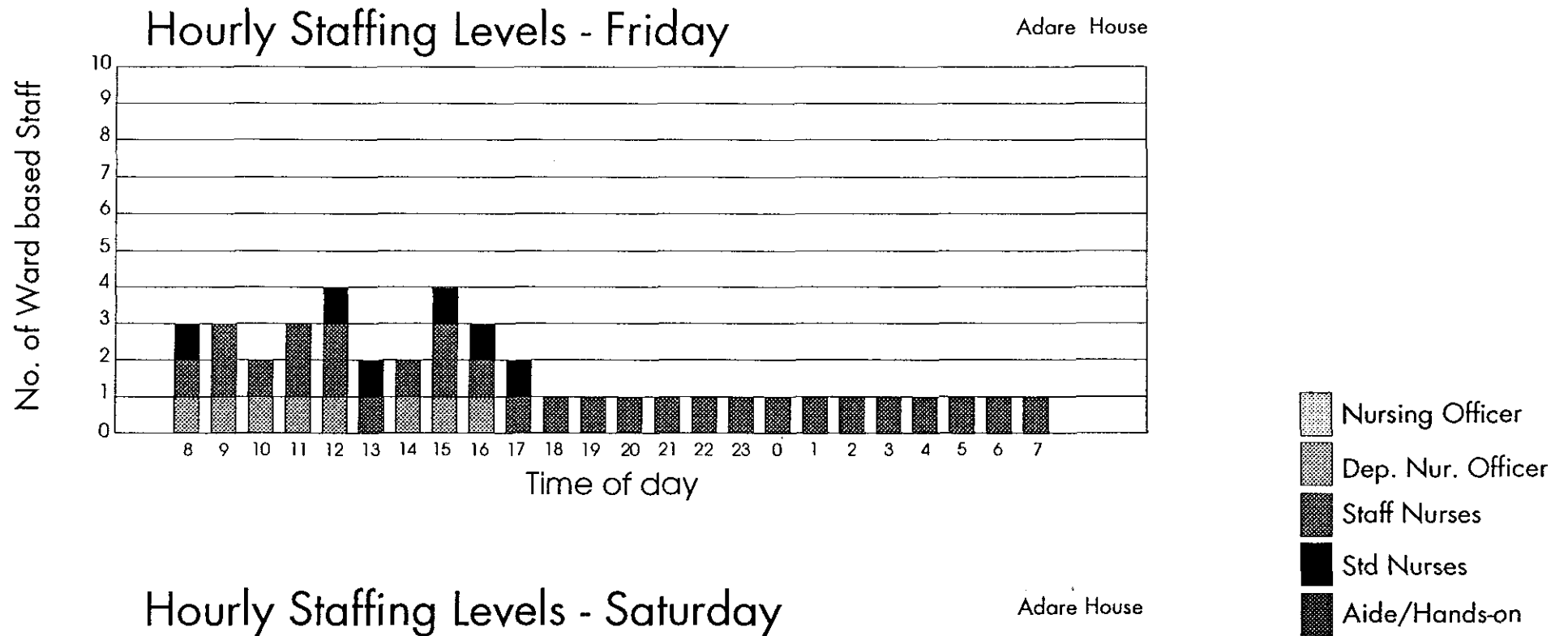


- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Thursday

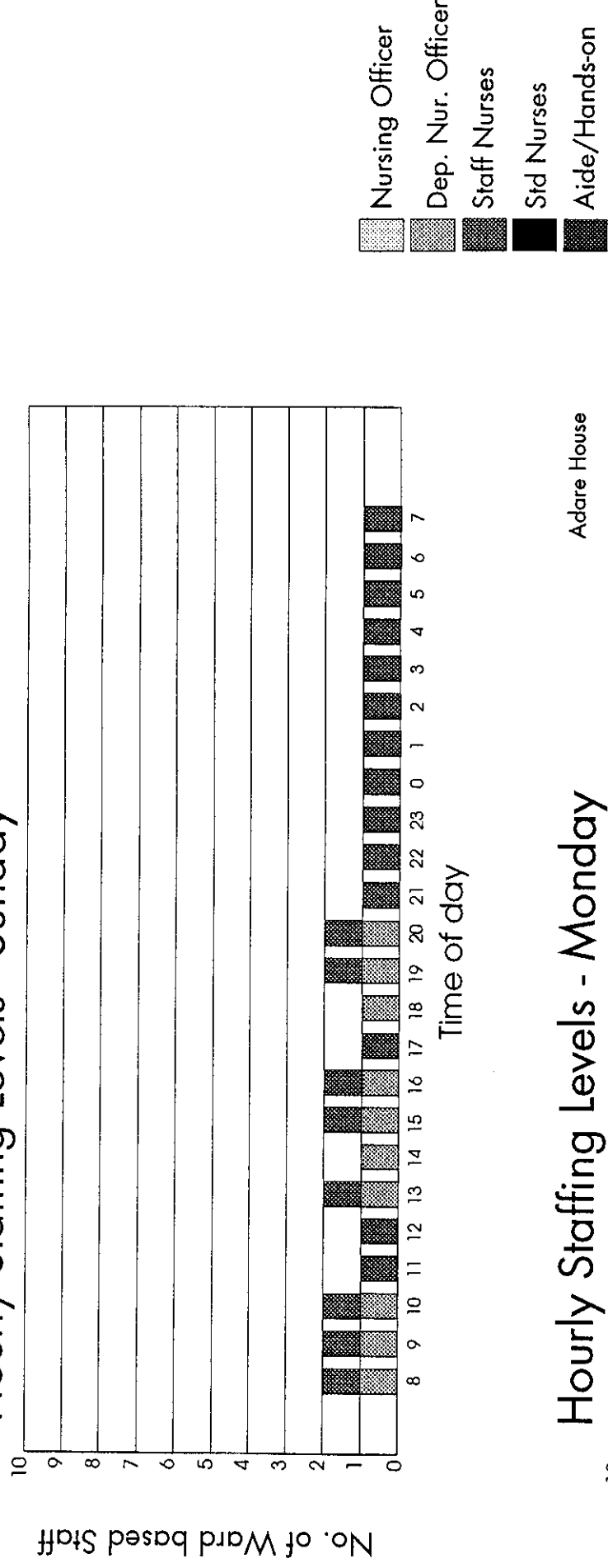
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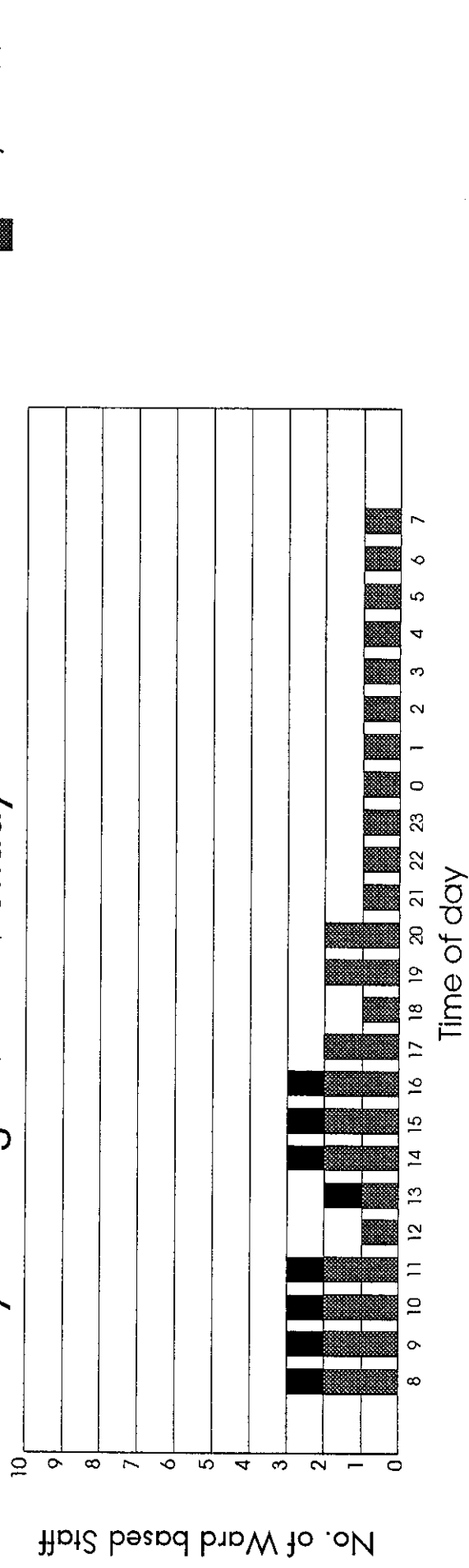
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Adare House



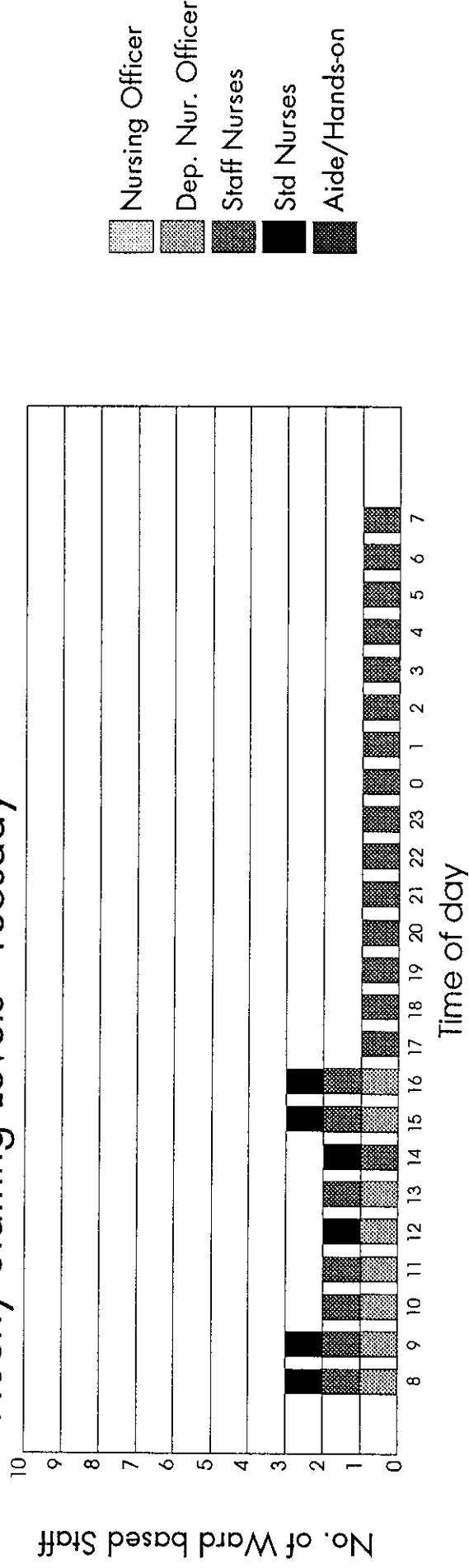
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Adare House

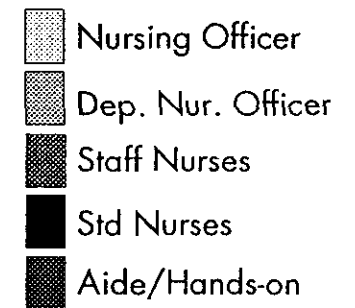
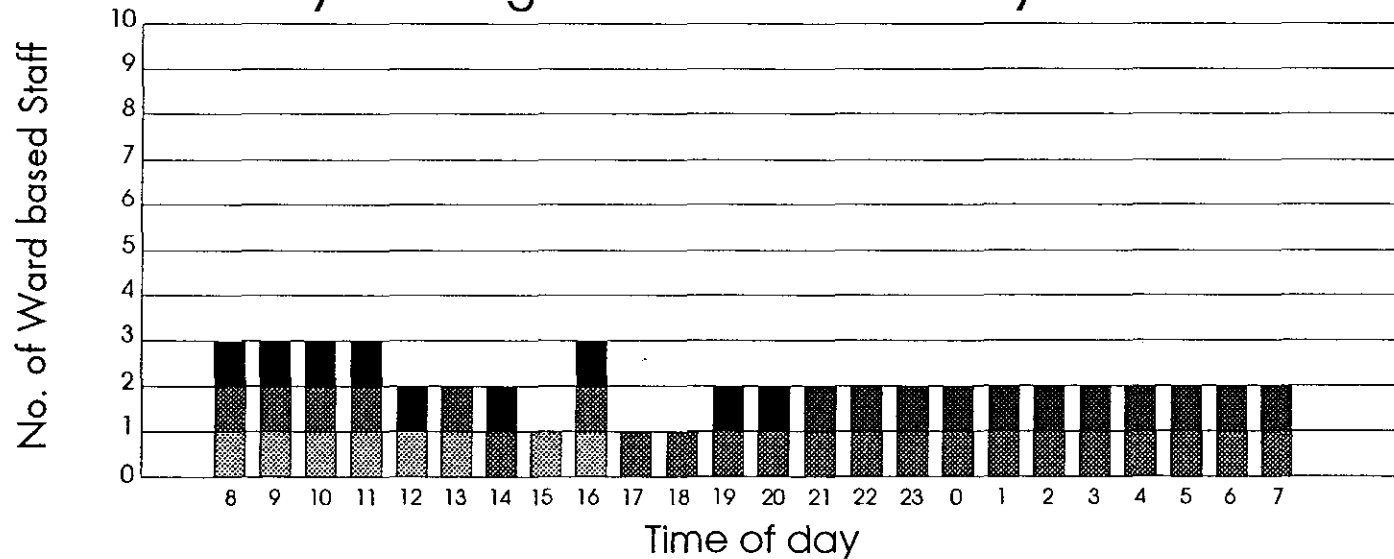


Hourly Staffing Levels - Tuesday

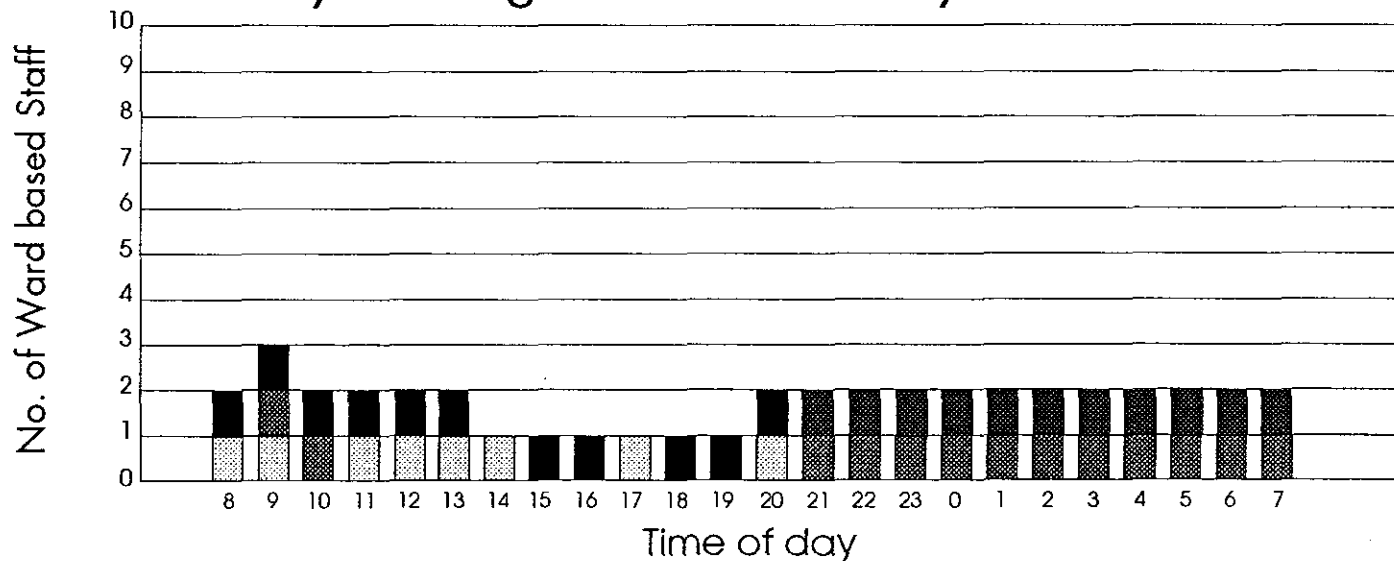
Adare House



Hourly Staffing Levels - Wednesday 264/266 Nth. Circular Rd.

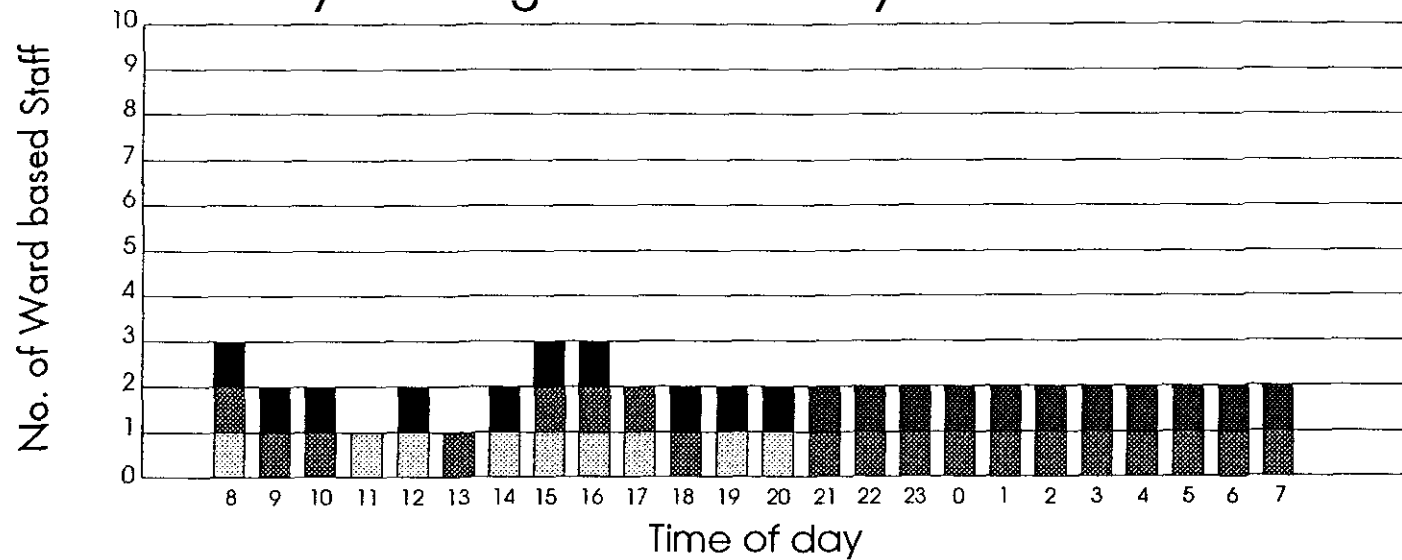


Hourly Staffing Levels - Thursday 264/266 Nth. Circular Rd.



Hourly Staffing Levels - Friday

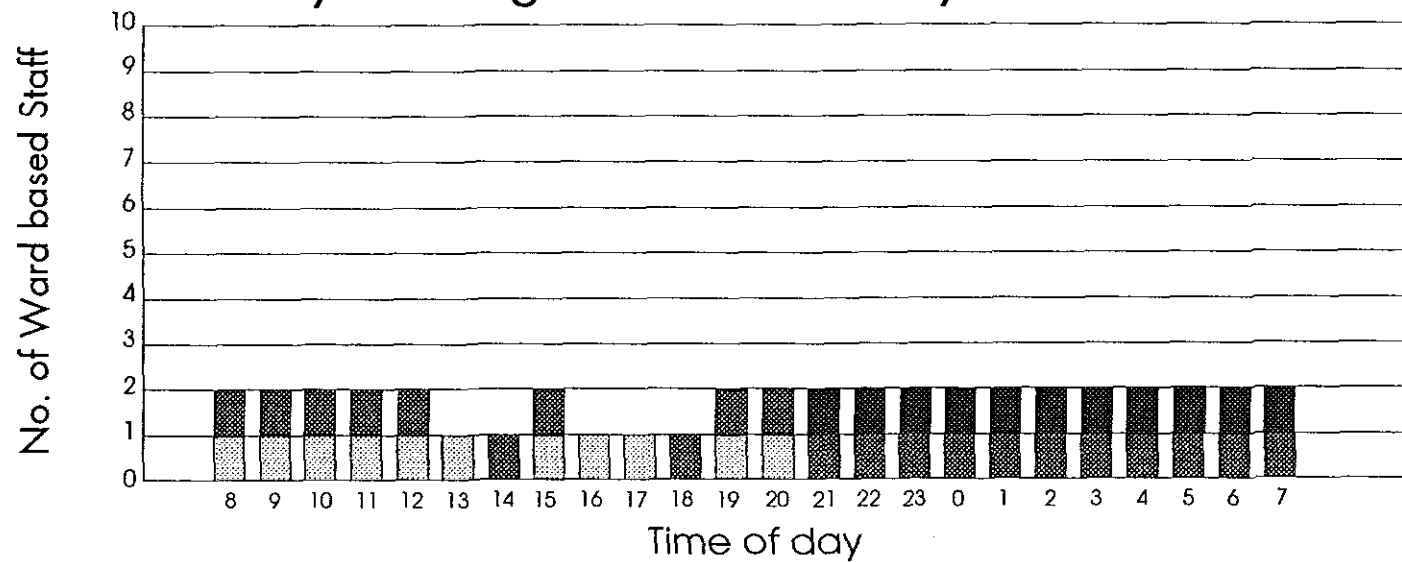
264/266 Nth. Circular Rd.



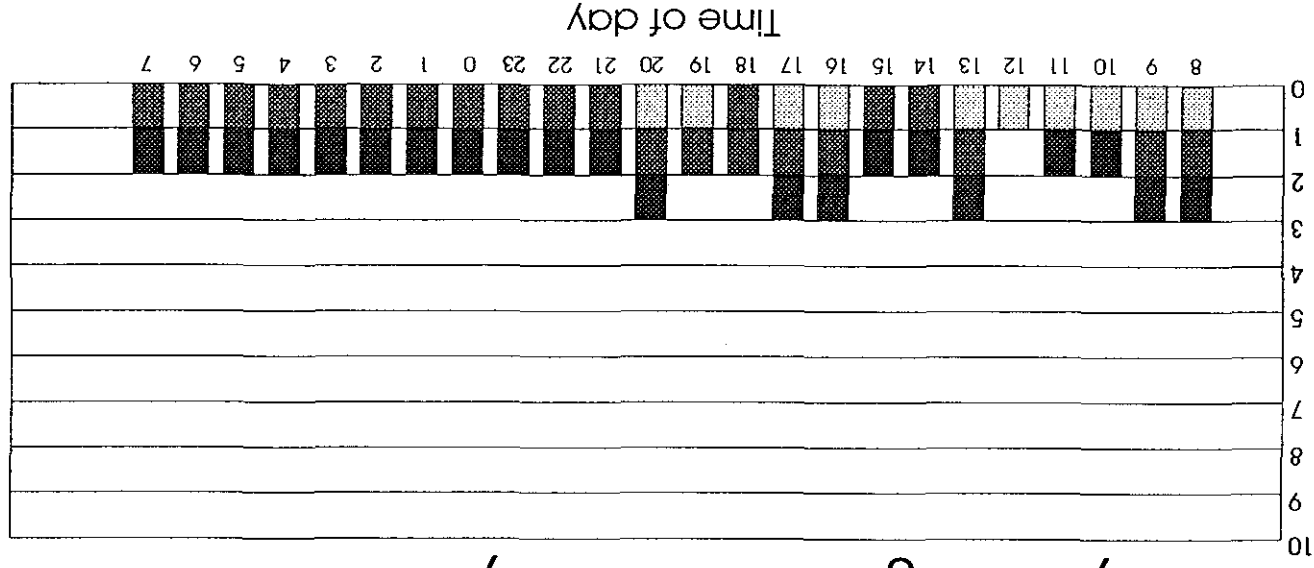
- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Saturday

264/266 Nth. Circular Rd.



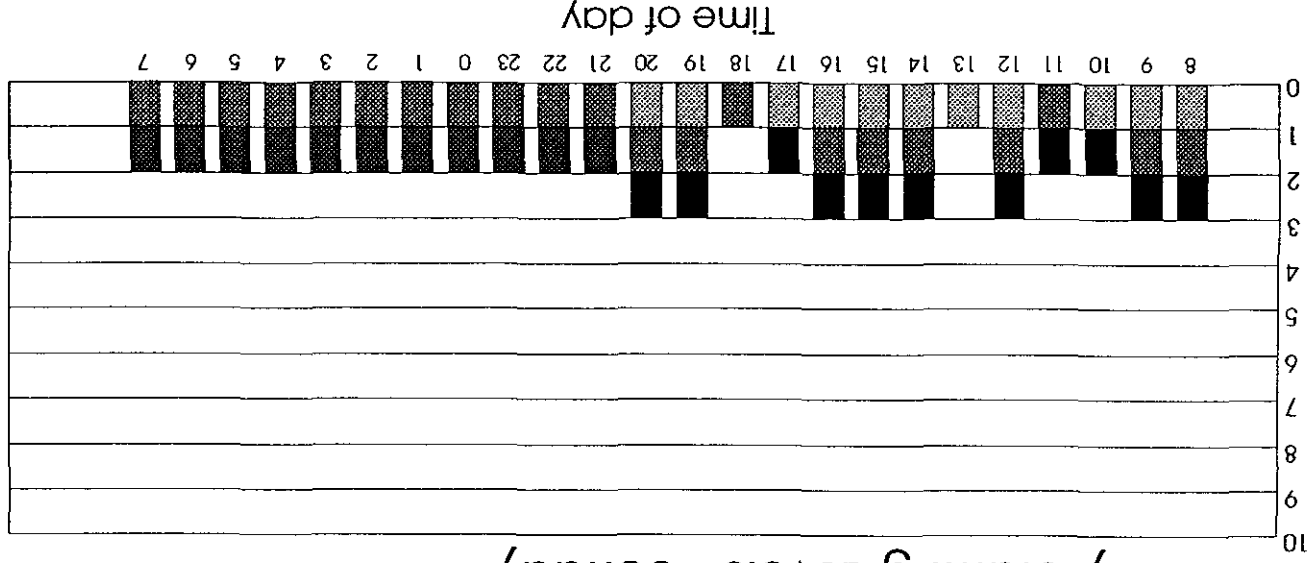
No. of Ward based Staff



Hourly Staffing Levels - Monday

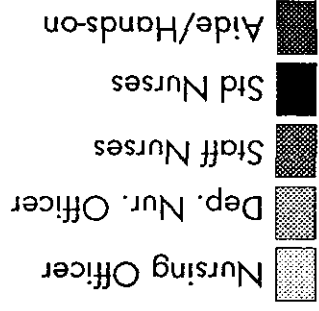
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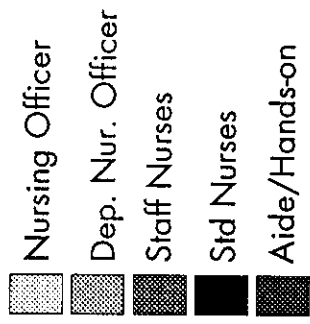
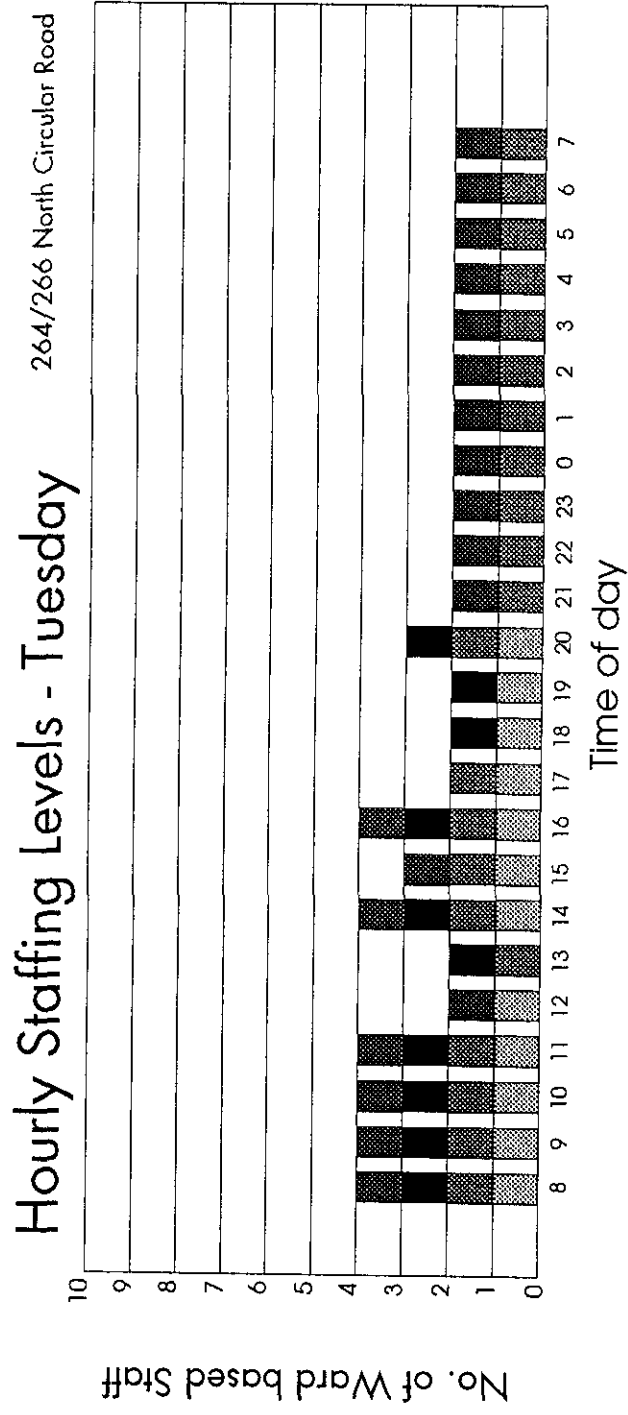
No. of Ward based Staff

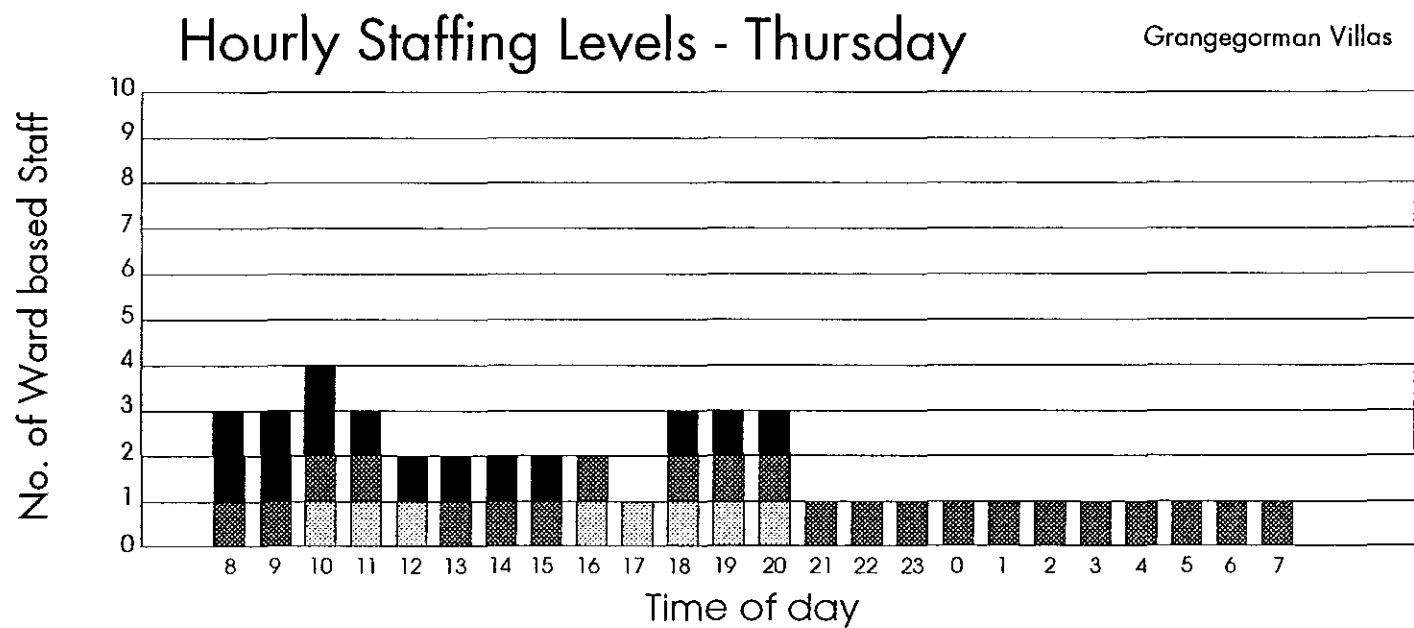
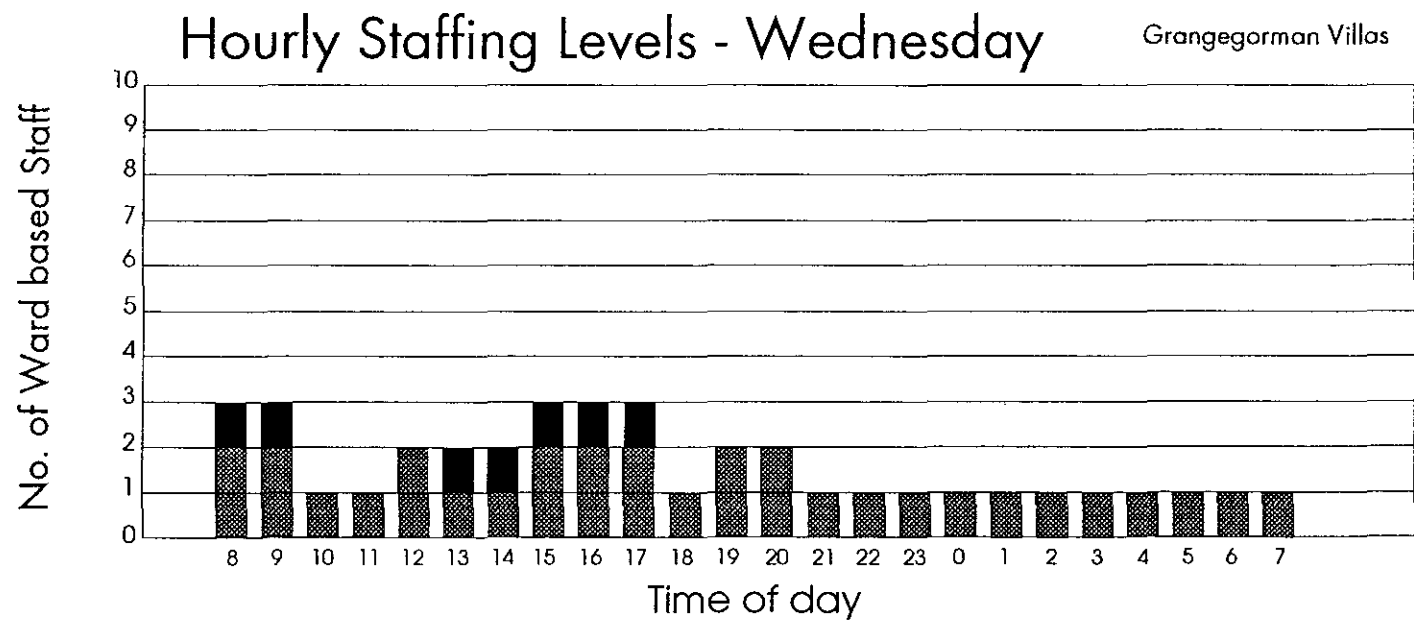


Hourly Staffing Levels - Sunday

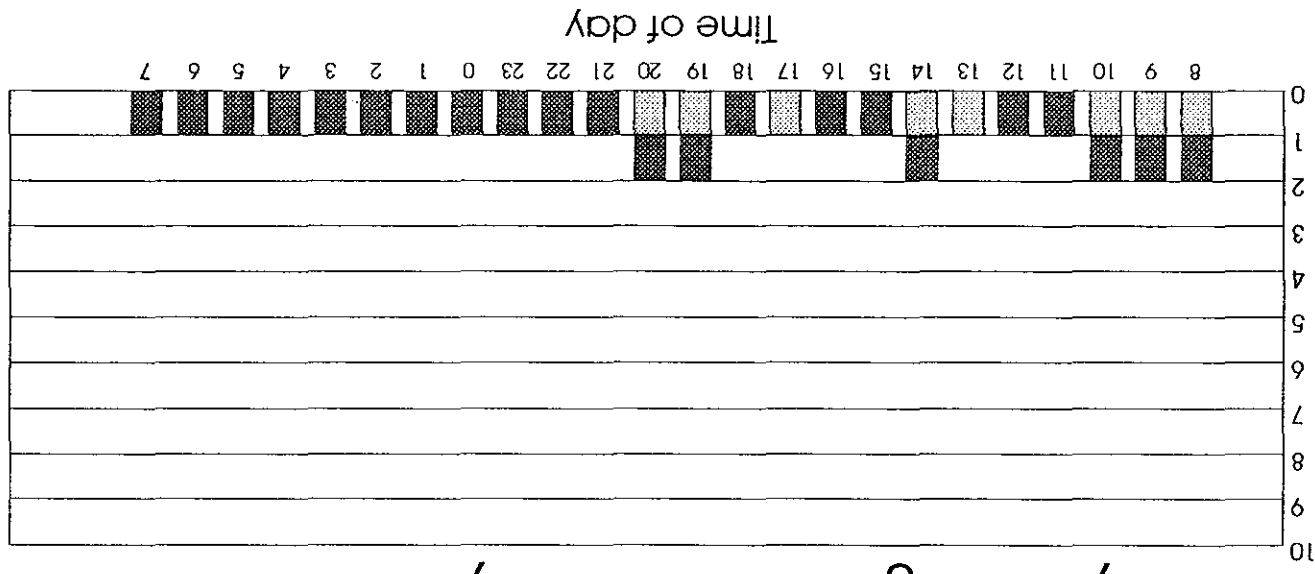
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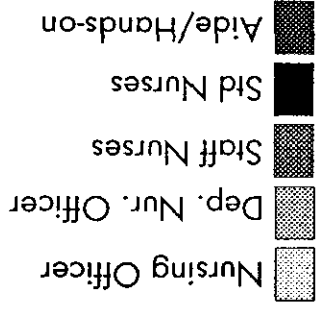
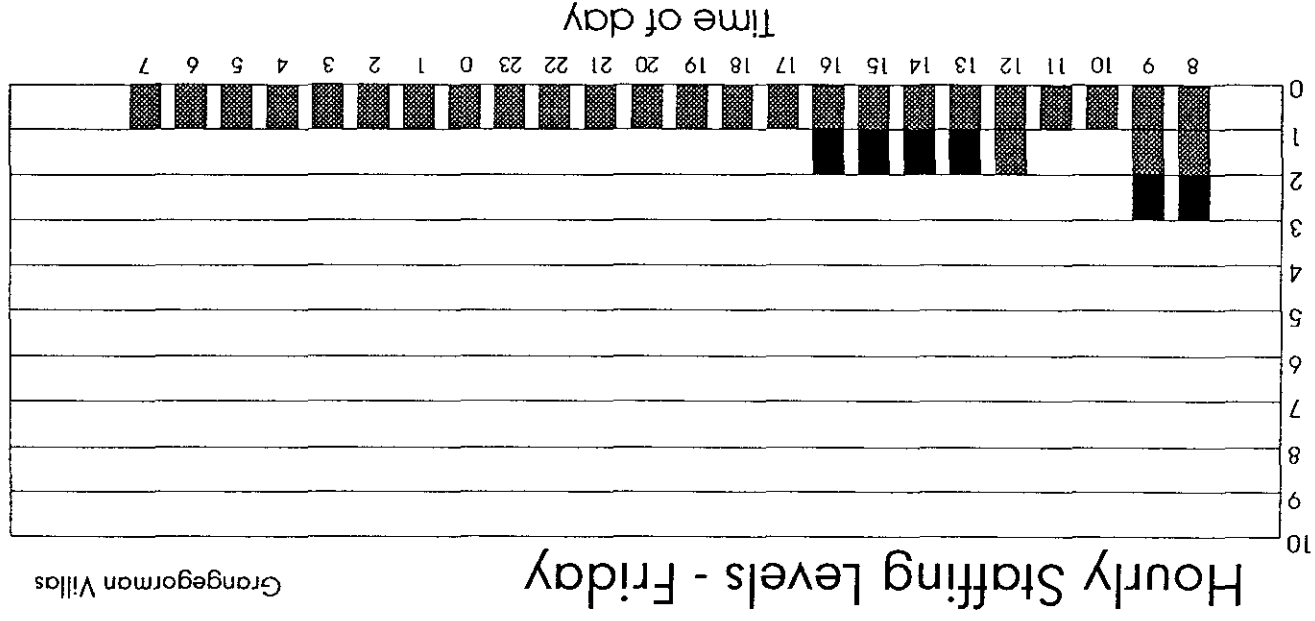




No. of Ward based Staff

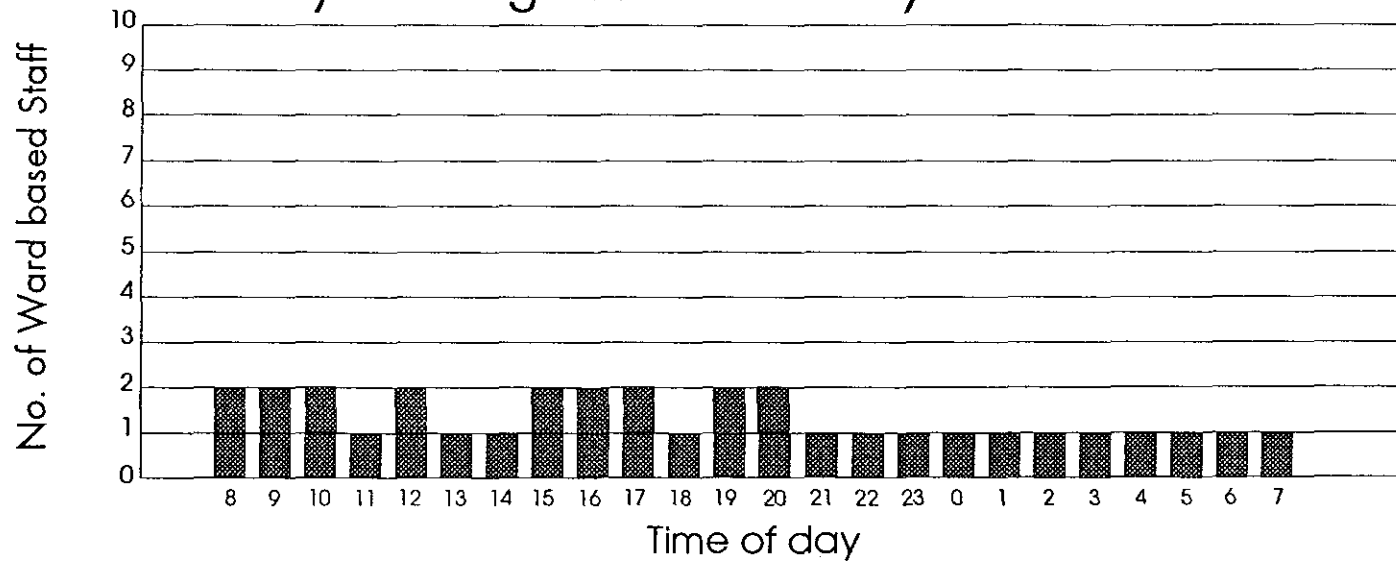


No. of Ward based Staff



Hourly Staffing Levels - Sunday

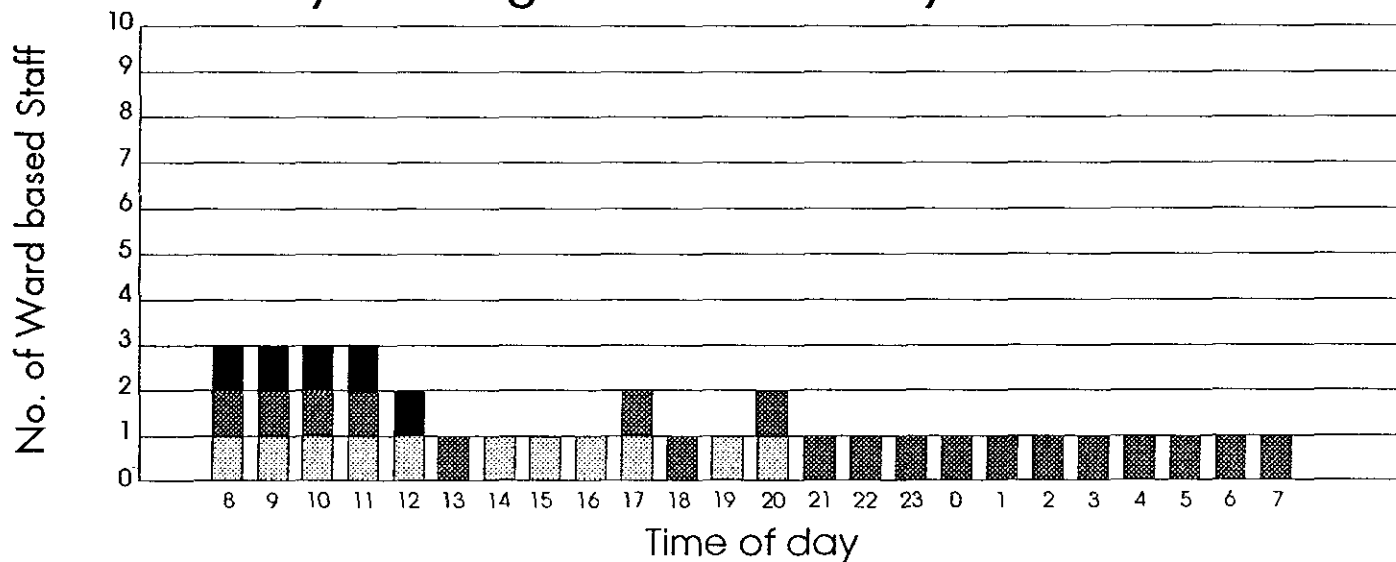
Grangegorman Villas

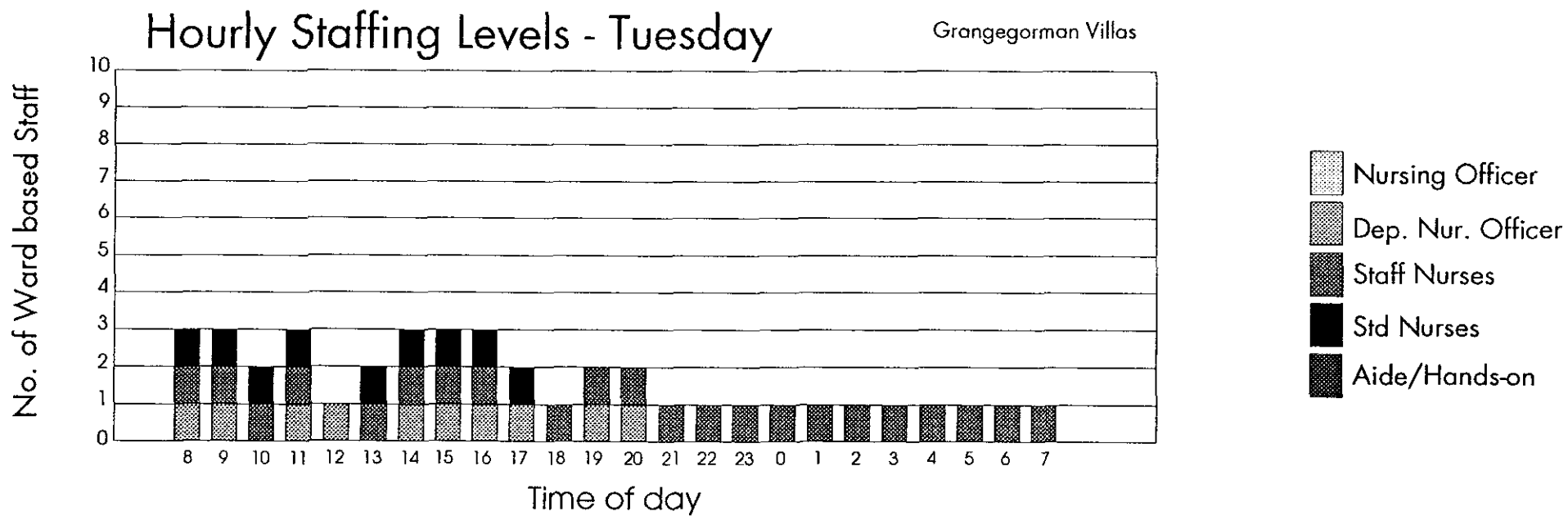


- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Monday

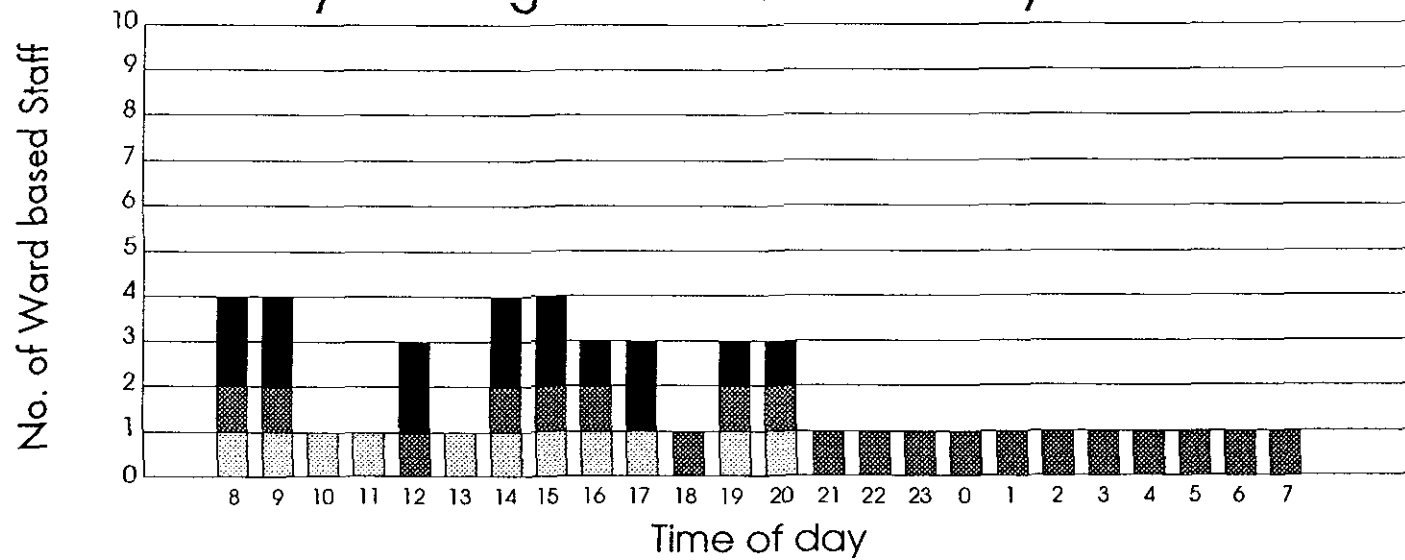
Grangegorman Villas





Hourly Staffing Levels - Wednesday

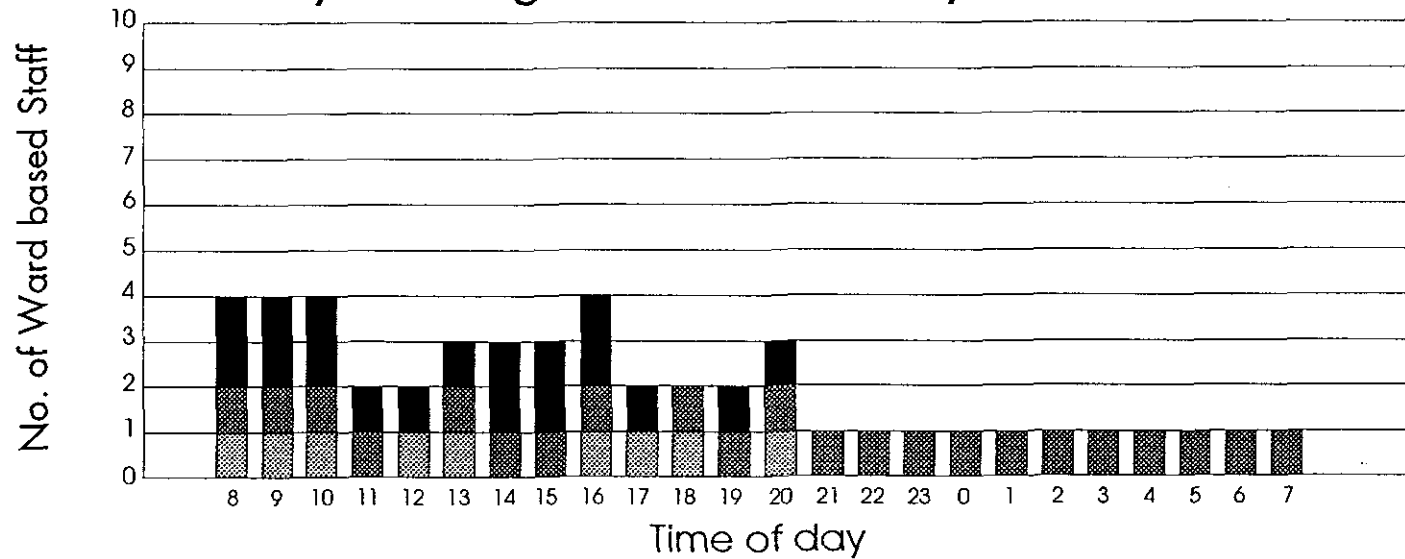
Orchard View



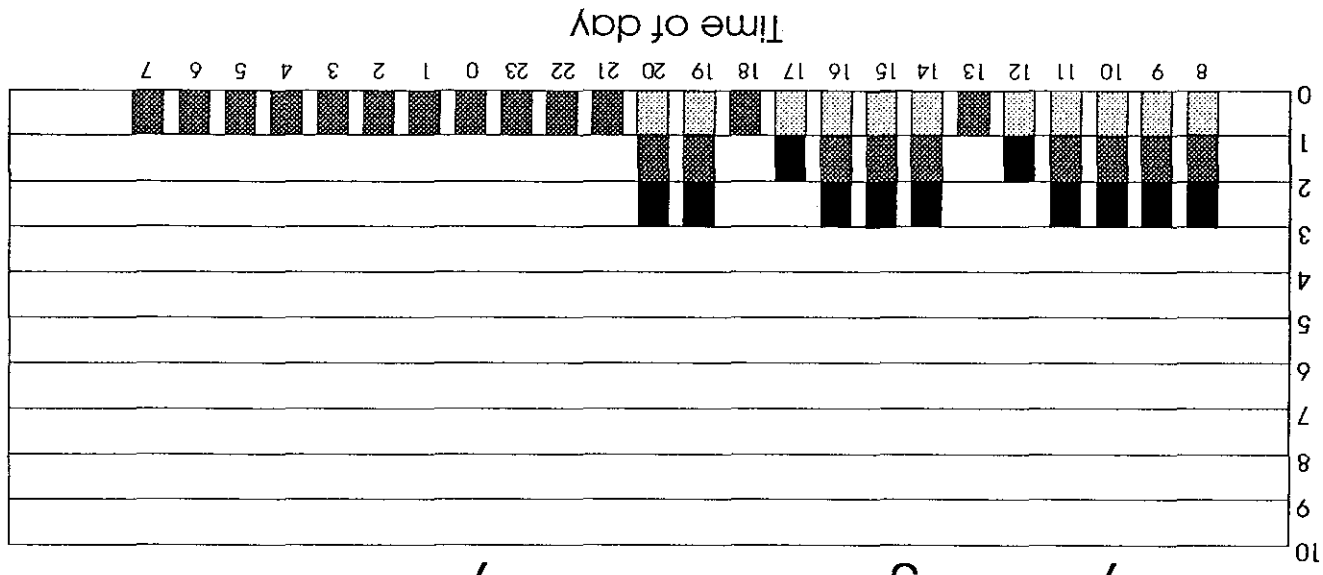
- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

Hourly Staffing Levels - Thursday

Orchard View



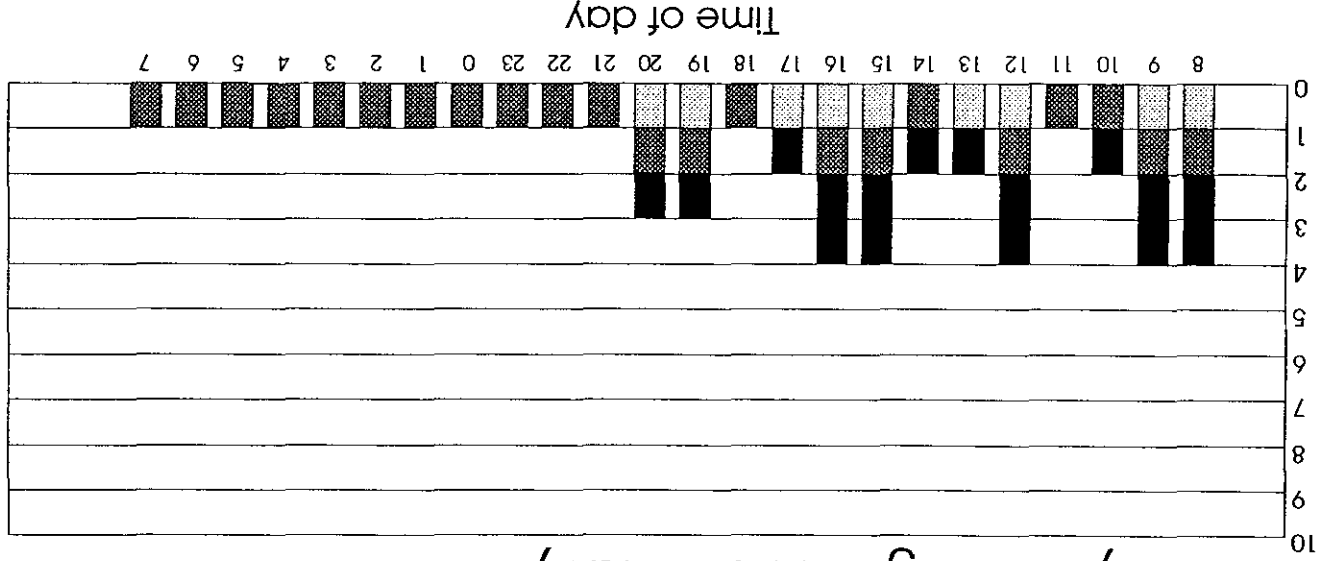
No. of Ward based Staff



Hourly Staffing Levels - Saturday

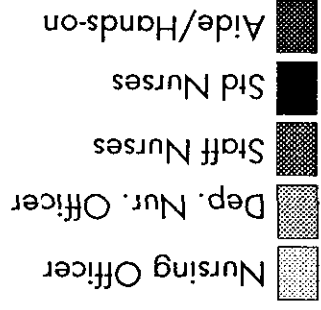
Orchard View

No. of Ward based Staff

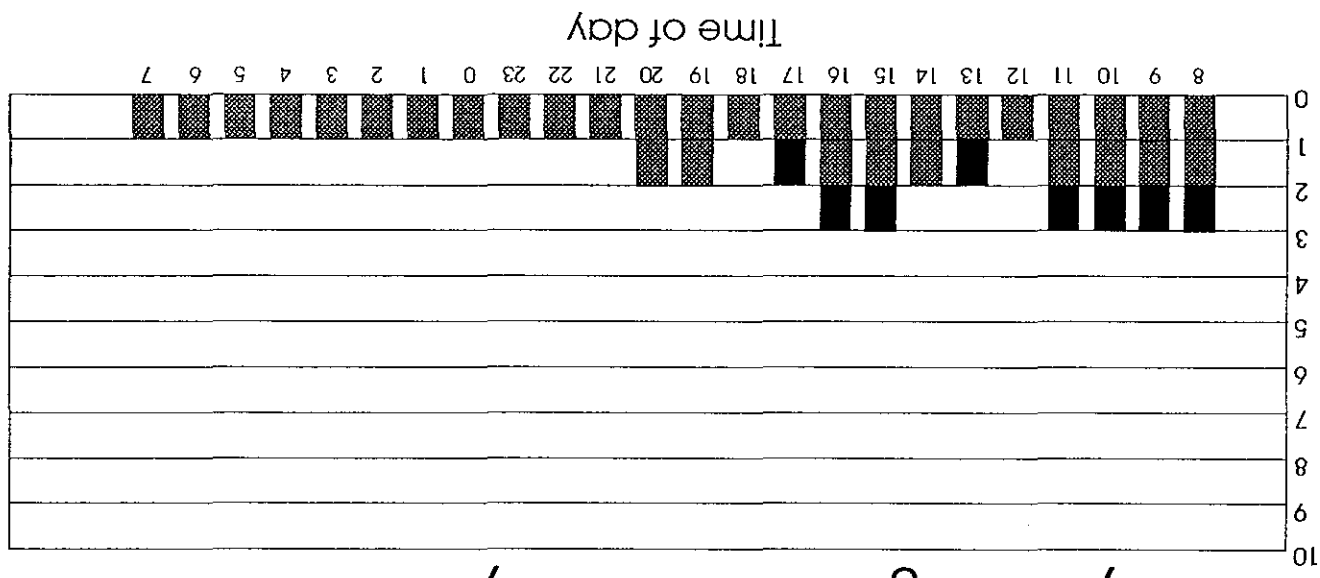


Hourly Staffing Levels - Friday

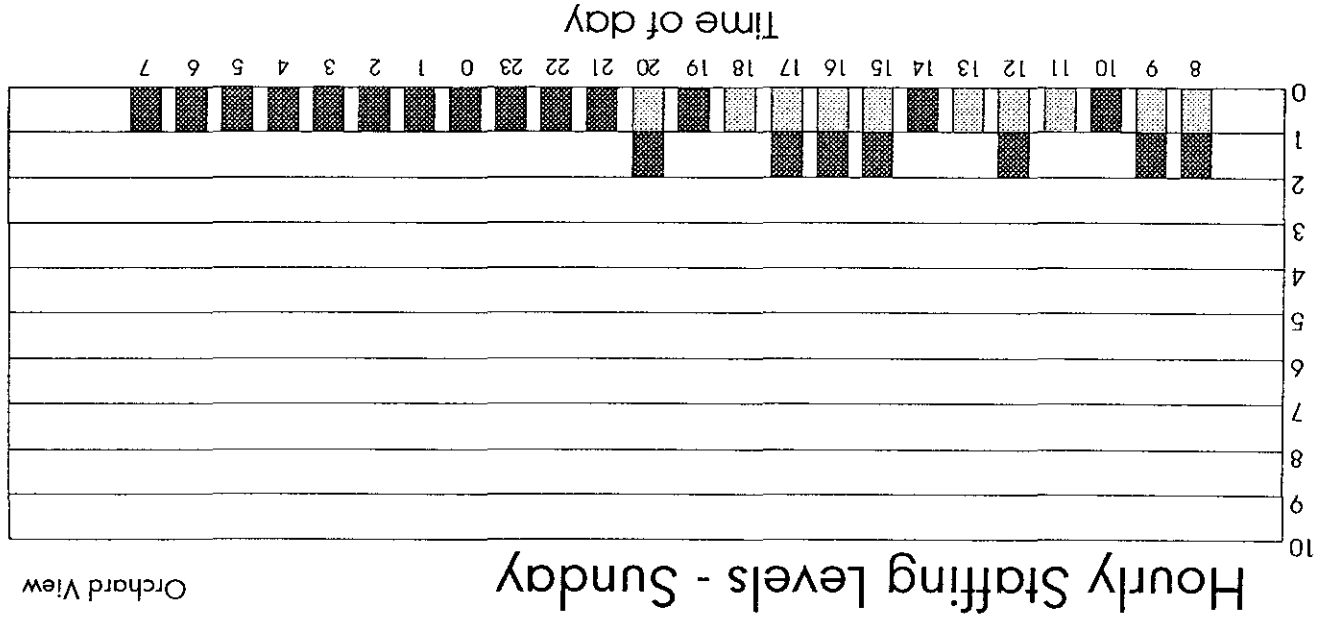
Orchard View



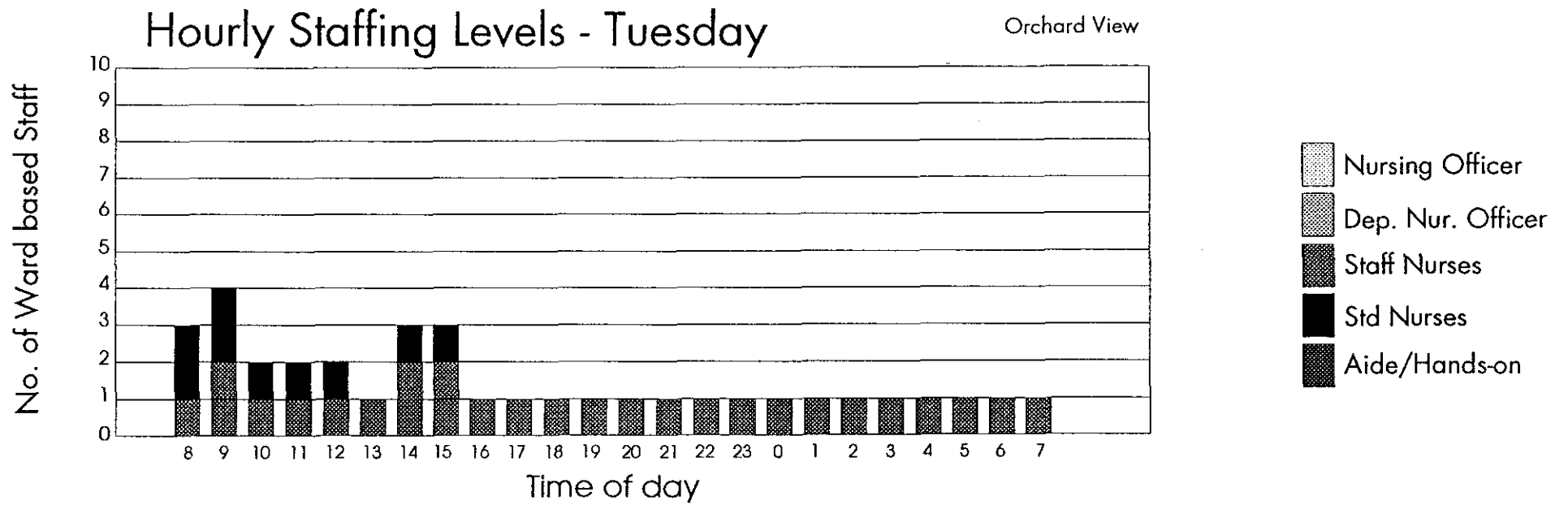
No. of Ward based Staff



No. of Ward based Staff

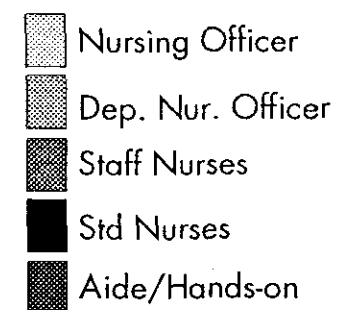
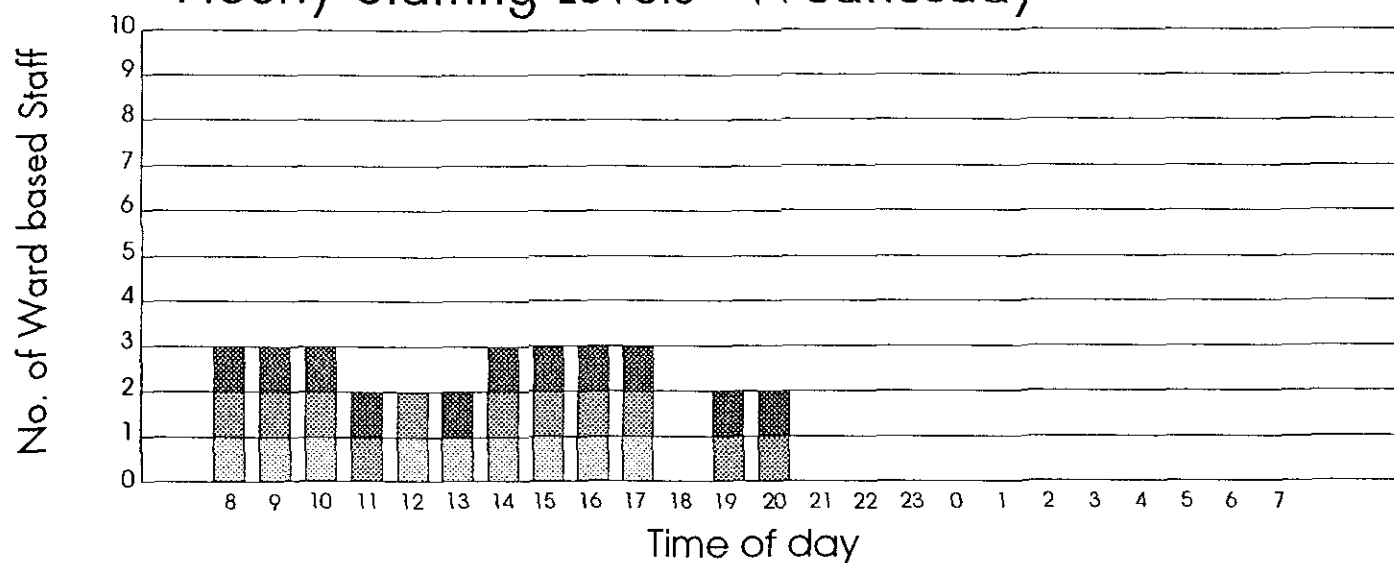


- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on



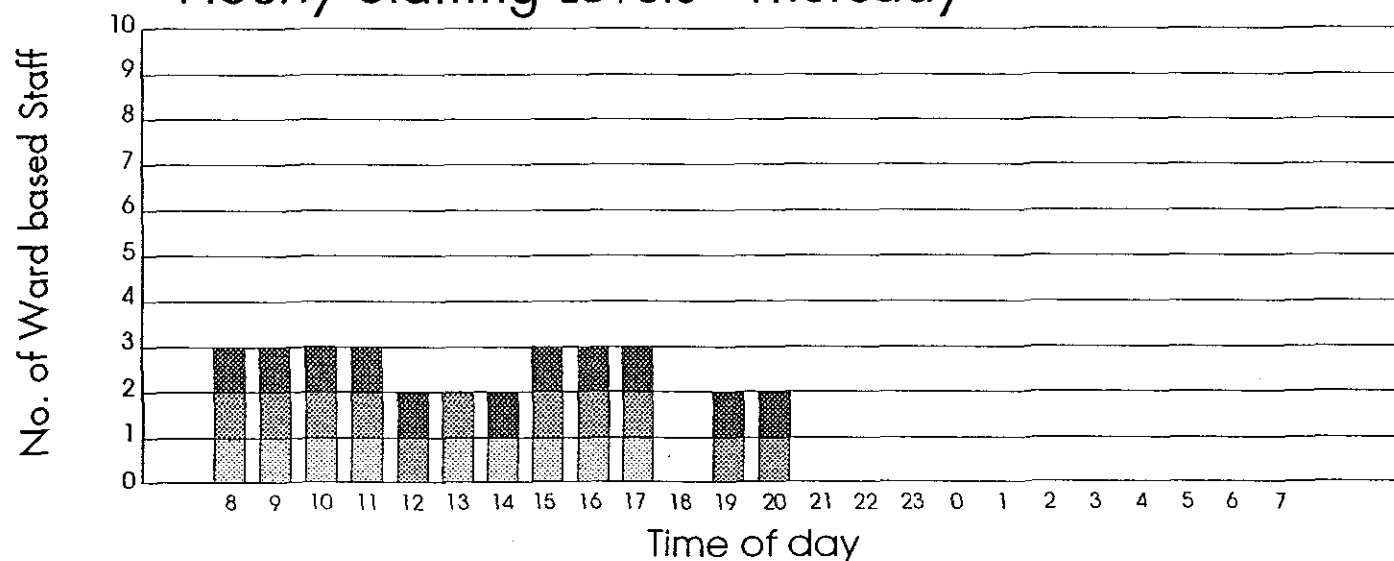
Hourly Staffing Levels - Wednesday

N.F.A. Day Centre



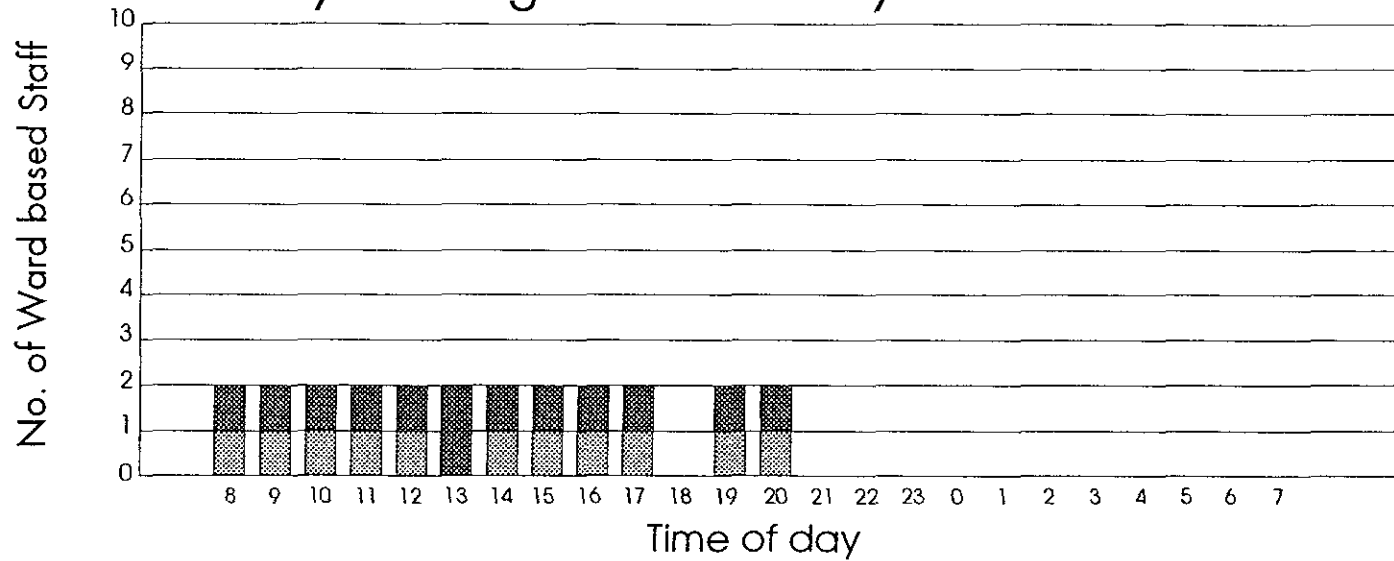
Hourly Staffing Levels - Thursday

N.F.A. Day Centre



Hourly Staffing Levels - Friday

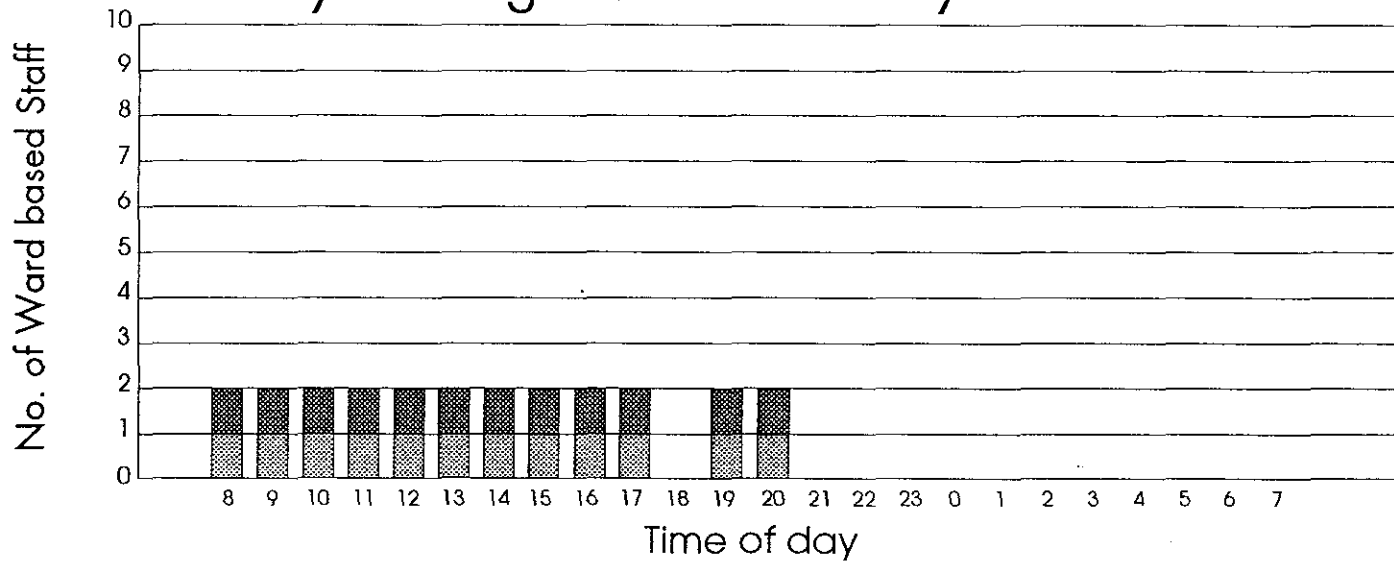
N.F.A. Day Centre



- Nursing Officer
- Dep. Nur. Officer
- Staff Nurses
- Std Nurses
- Aide/Hands-on

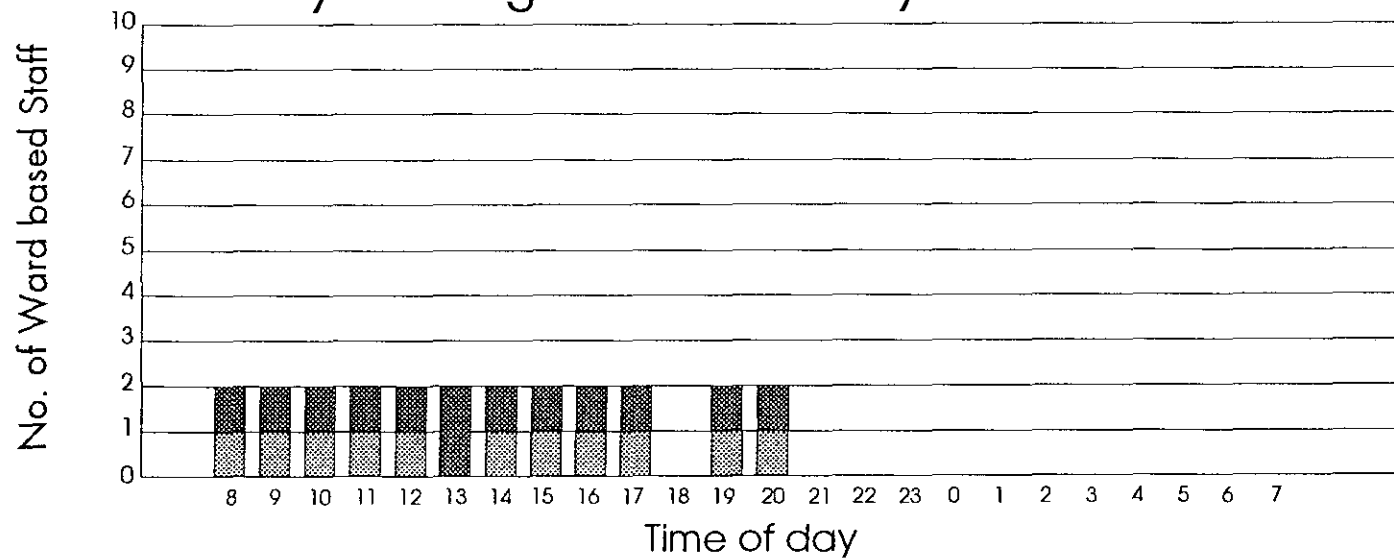
Hourly Staffing Levels - Saturday

N.F.A. Day Centre



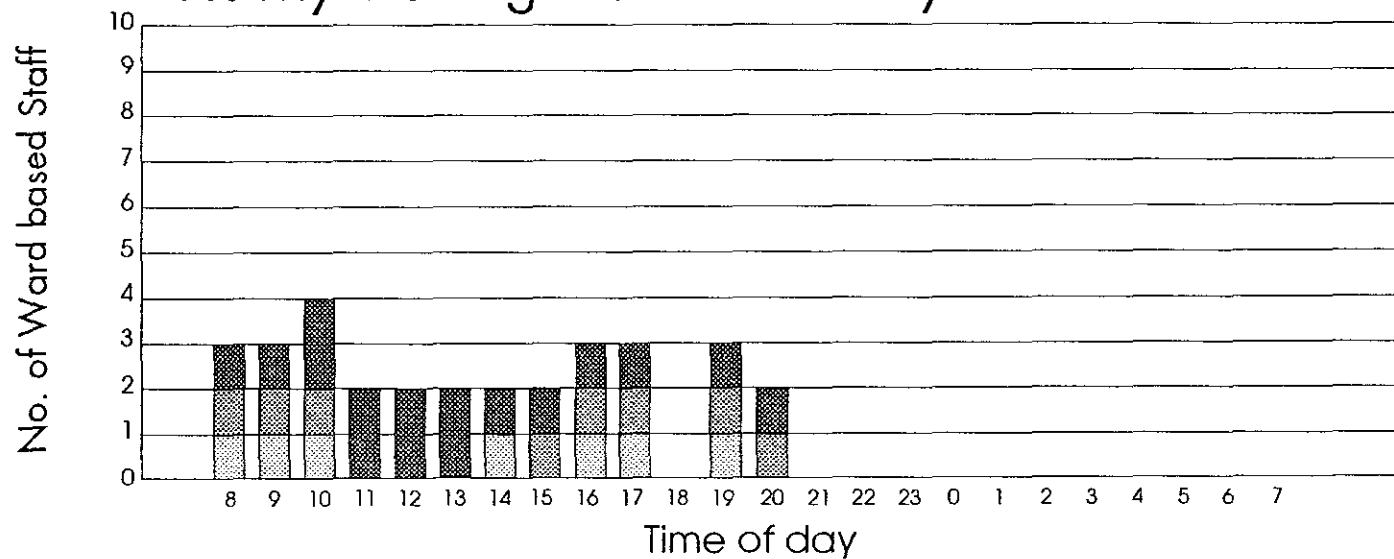
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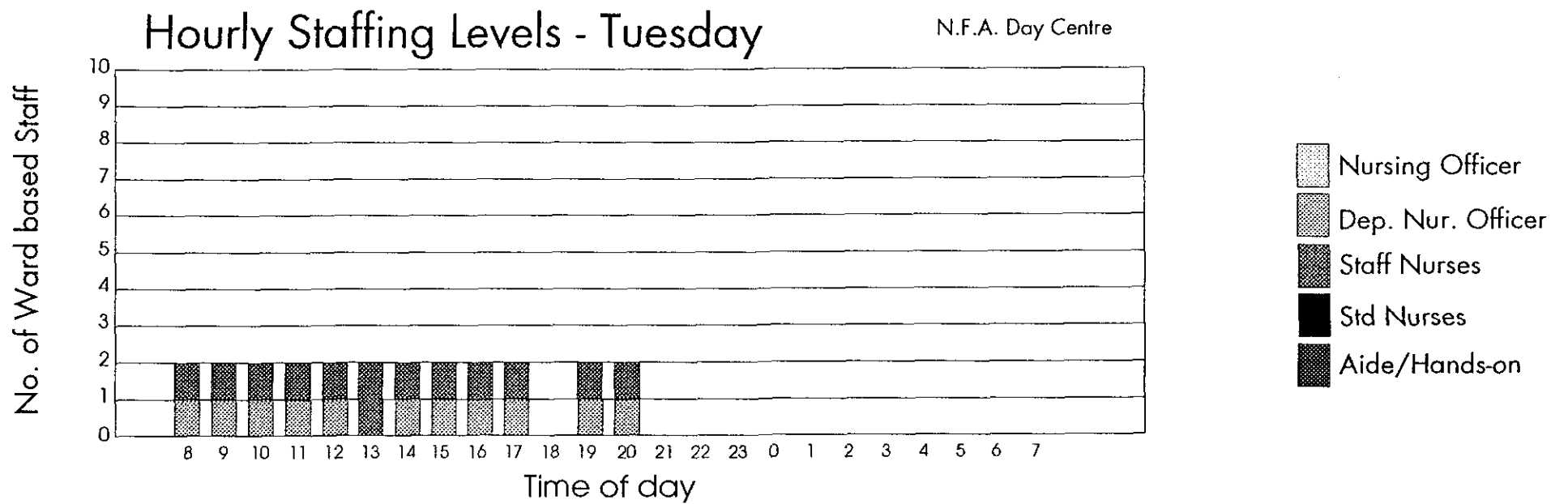
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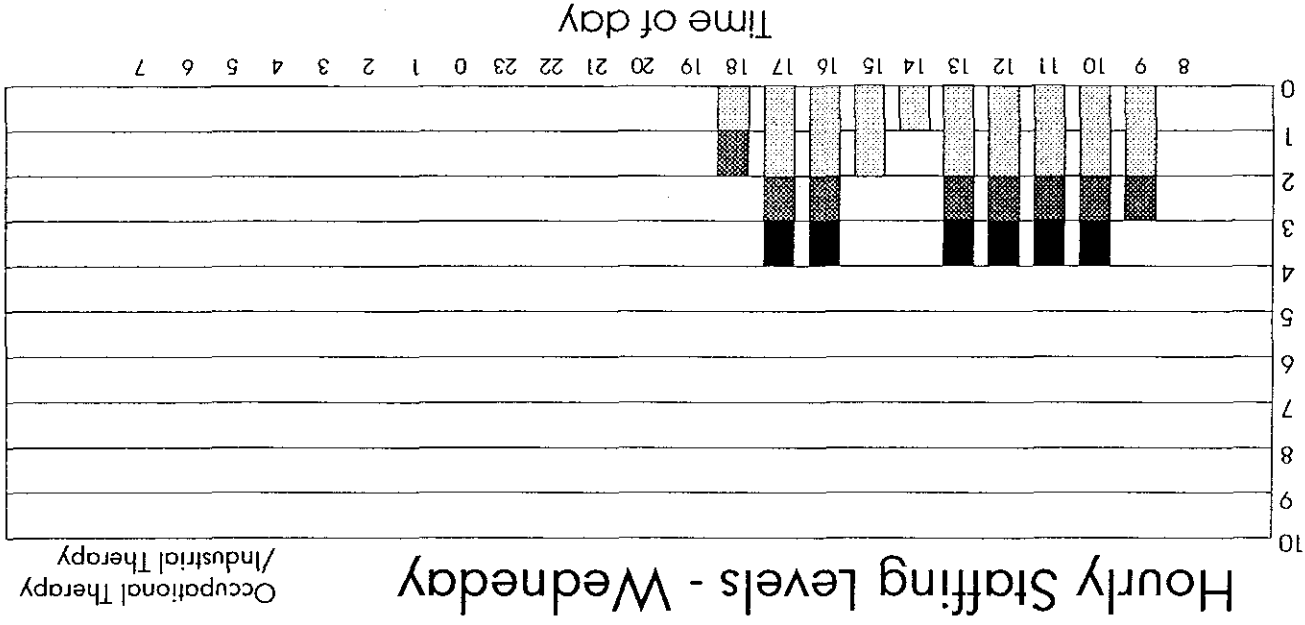
Hourly Staffing Levels - Monday

N.F.A. Day Centre

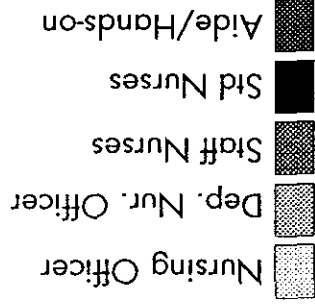
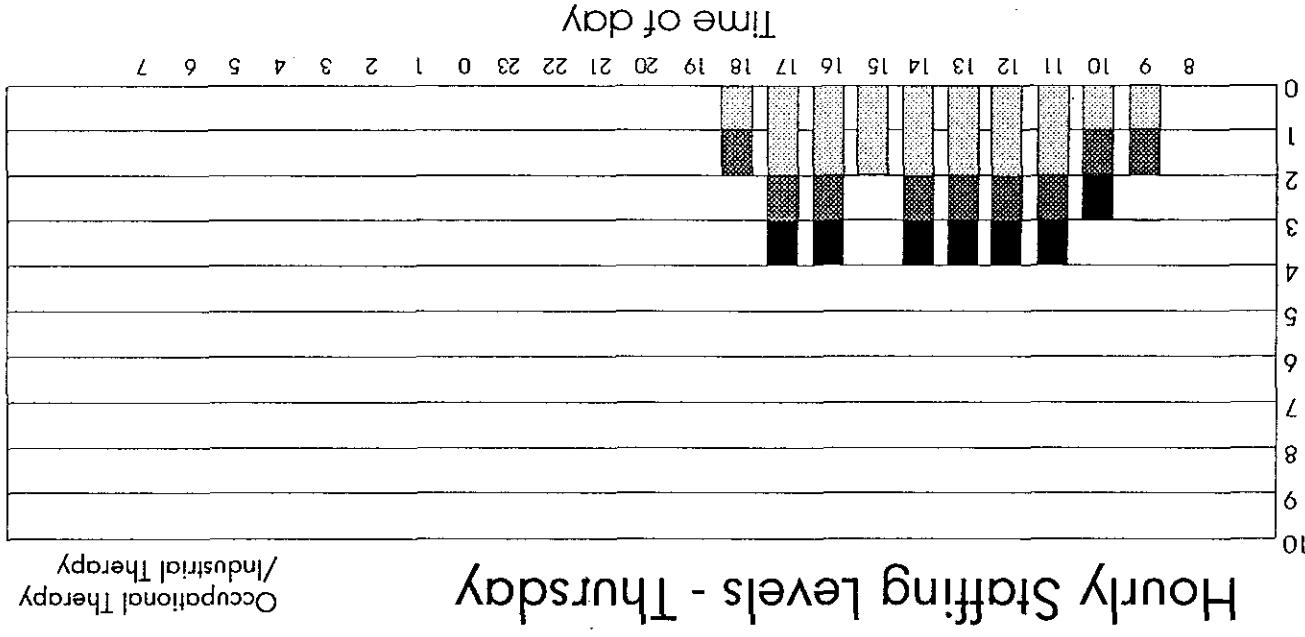


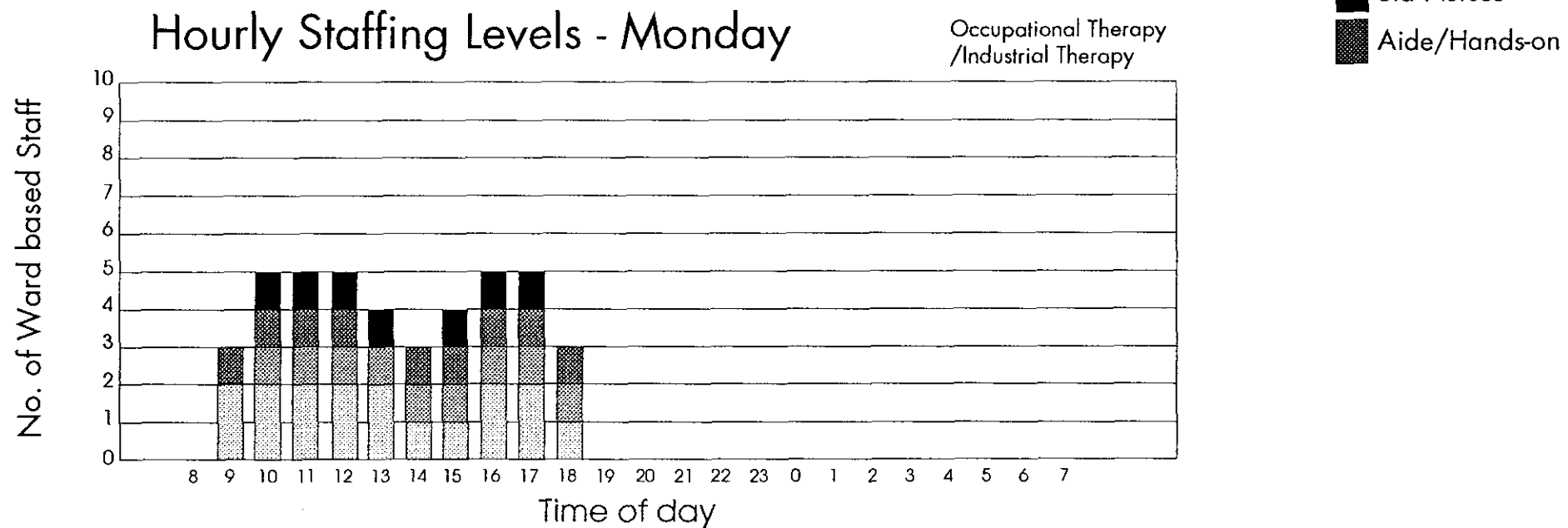
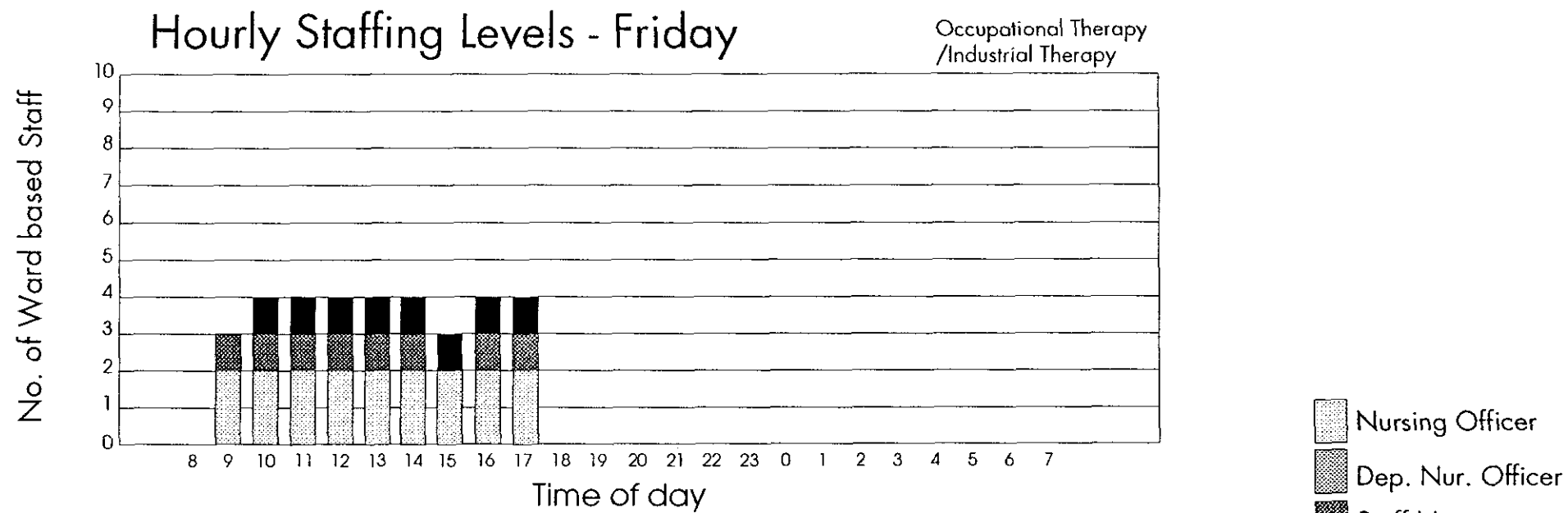


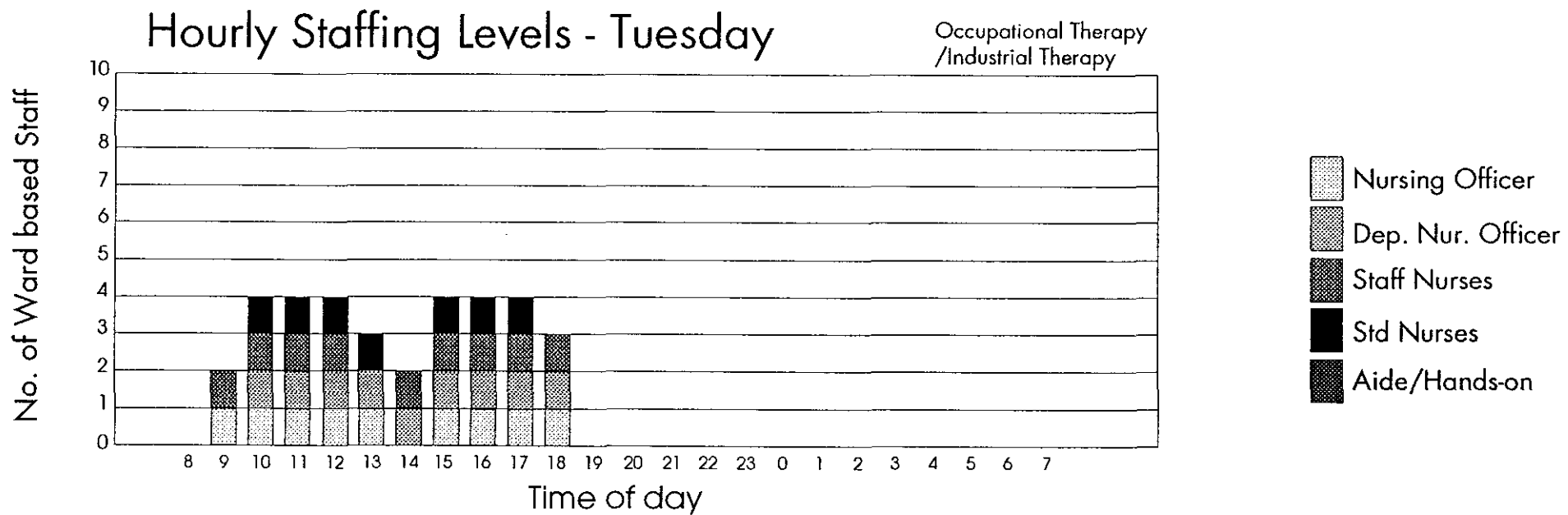
No. of Ward based Staff



No. of Ward based Staff







Appendix No 8 Other Factors which affected Nurse Staffing during the week of the Survey.

Speciality	Escorts	39 Hr Week	Specialling	Trips
Acute Care	26.25 Hrs	24 Hrs	Nil	2.75Hrs
Special Care	54.5 Hrs	50 Hrs	227.5 Hrs + 79 Hrs of seclusion obs	10.5 Hrs
Long Stay	13.5 Hrs	9 Hrs	Nil	3 Hrs
E.M.I	14 Hrs	14 Hrs	Nil	1 Hr
Rehabilitation	40.75 Hrs	41 Hrs	Nil	27.75 Hrs
IT / OT	Nil	Nil	Nil	7.5 Hrs
NFA Day Centre	6 Hrs (To Court)	Nil	Nil	Nil
Totals =	155 Hrs	138 Hrs	227.5 Hrs	52.5 Hrs

Lending of staff:-

10 B	50 mins
23 A	4 hours
Unit R	4 hours plus 1.5 hours in school
Unit 8 B	6 hours
Unit 3 A	4 hours

**Appendix No 9 Number of Patients/Residents who leave Units to attend
Occupational Therapy or Work**

Acute Wards

3A	2 patients x 5 days
3B	3 patients - 2 x 5 days - 1 x 2-3 days
Asses Unit	1 patient x 5 days
Total = 6 patients	

Special Care

8A	1 patient x 5 days
8B	Nil
O	1 patient x 2-3 hours per day
R	1 patient x 2-3 hours per day
Total = 3 patients	

Long Stay

1A	2 patients x 5 days
2A	Nil
23A	4 patients - 3 x 5 days - 1 x 2 days
N.F.A Unit	1 patient x 5 days
Total = 7 patients	

Appendix 9 - continued

Rehabilitation

Ward 23	14 patients - 1 x 5 days - 13 from 3 hours per day - 2 hours per week
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Total = 14 patients

Hostels

Orchard View	10 residents x 5 days
G G Villas	4 residents x 5 days
San Remo	2 residents x 5 days
264 / 266	2 residents x 5 days (10 - 12 patients x 2 hours per week)
Adare House	5 residents x 4 days (5 residents attend therapy within the house)
Weir House	5 residents to O.T. x 5 days 1 resident to paid employment x 5 days
Total = 29 residents	

Appendix 10

GUIDELINES FOR MULTIDISCIPLINARY CLINICAL TEAM WORKING

Summary

Multidisciplinary team working is at the heart of the delivery of health care services in modern psychiatric practice. Its key characteristics include:-

- * The identification of the core team within agreed policy and practice;
- * Agreed working methods;
- * Understanding and facilitation of each others' roles;
- * The Consultant Psychiatrist as leader;
- * Formal recording of its activities and decisions.

The work of the team includes treatment planning for individual patients, and other clinical matters. It also includes business items eg. relating to the service it offers and policy development. All aspects of activity (process and content) should be open to review and clinical audit.

This paper explores these aspects of multidisciplinary working in greater detail and makes a number of recommendations.

The Core Team

Within psychiatric hospitals, the clinical team should ideally include:-

- * The Consultant Psychiatrist (the leader of the team),
- * Other doctors,
- * Nursing Officer and other members of nursing staff, including Key Nurses, as appropriate,
- * Social Worker,
- * Psychologist,
- * Occupational/Industrial Therapy representatives.

Appendix 10 - continued

There may be additions. Some clinical teams include other therapists eg Drama Therapist/Art Therapist etc

Agreed Working Methods: process and content

All teams need to work together in an agreed way. They need to meet at least every two weeks together and to an agreed agenda. A programme of dates for case conference and clinical team meetings needs to be planned in advance so that the key members are able to be forewarned eg key nurses are able to attend.

All team members have an equal contribution to make.

Patients should be invited to their case conferences and should be involved in their treatment planning. They should sign their treatment plans and should have the opportunity to keep a copy if thought clinically appropriate. A new treatment programme should be prepared annually and regularly reviewed throughout the year.

As well as clinical issues, the clinical team will need to address business and policy issues. These include how the team is going to implement hospital policy for the group of patients it looks after.

Skills required within the Clinical Team

Each team member has a responsibility to participate in a way which facilitates the most effective working of the team. The skills and attributes necessary for this include:-

- * An understanding of each others roles;
- * Empathetic and non-judgmental approach;
- * An appreciation of others viewpoints even though maybe diametrically opposed to ones own;
- * Patience, tolerance and an ability to work under pressure at times;
- * Good communications;
- * A knowledge of group functioning and dynamics;
- * Effective leadership and a shared understanding and vision.

Appendix 10 - continued

Sometimes these skills have been acquired through training and experience. Others are naturally able to function in this way. However most people benefit from exposure to further training in these areas. Programmes of team building exercises and other courses can be invaluable and should be included in any organisational development approach where multidisciplinary team working is at the heart.

Medical Leadership

'Leadership is discovering the route ahead and encouraging and - personality permitting - inspiring others to follow. Hence leadership is most needed in changing times, when the way ahead is not clear'.

'Managers have subordinates. Leaders have followers: people who recognise and find attractive the leaders sense and purpose. Leaders are those who can get the people with whom they work, whether subordinate or not, to be convinced co-operators. Leaders make others feel what they are doing matters and hence makes them feel good about their work'.

Rosemary Stuart
Leading in the NHS 1989

The Consultant Psychiatrist has an important role as the leader of the clinical team. The direct responsibility to see that all the disciplines caring for the patients are co-ordinated and used effectively to pursue the major objective of the best treatment for patients cannot be abrogated. This implies acceptance of leadership of the multidisciplinary team, dealing with clinical problems and accepting the responsibilities of that leadership. It is now widely appreciated that leadership is not determined only by the authority of the position. Again leadership qualities often evolve following specific training.

Activities and Decision Making

The activities of the team, and their decisions should be formally recorded in an agreed manner, and the record distributed to all members of the team within a week, for further discussion at the next meeting if necessary. This is to ensure that the team members have an agreed understanding of the proceedings and way forward, as well as an opportunity for further discussion if required to enhance understanding.

Appendix 10 - continued

Audit

All the activities and decision making of the clinical team should be open to clinical audit. 'Closing the cycle' ie feeding back audit results to the clinical team is the most important aspect of this process. It should lead to an identification of areas where practices can be improved, and to identify areas where there are inadequate resources.

Conclusion

Members of clinical teams are the most important people within the organisation: they deliver healthcare services to patients. There are recognised ways of practising, monitoring and improving multidisciplinary clinical team working and this paper has outlined some of them.

FURTHER READING

Furnell J, Flett S and Clark D F (1987) Multidisciplinary clinical teams: some issues in establishment and function. *Hospital and Health Services Review*, January 15 - 18.

Reed John (1995) Leadership in the mental health service: what role for doctors? *Psychiatric Bulletin*, 19, 16 -72.

Soni S D, Steers L, Warne T and Swag W (1989) Multidisciplinary teams and line management. *Psychiatric Bulletin* 13, 657 - 661.

Sims A and Sims D (1993) Top teams. *Health Service Journal* 24 June 1993 pp 28-30.

Stewart R (1989) *Leading in the NHS: a practical guide*. London: Macmillan.