NHS England

Safer Staffing: A Guide to Care Contact Time

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Contact Details for further information	Jane Cummings Chief Nursing Officer NHS England Quarry House Leeds england.contacttime@nhs.net

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Safer Staffing: A Guide to Care Contact Time

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

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Foreword

In November 2013, we published: *How to ensure the right people, with the right skills, are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability (NQB Guidance)*[1].

In this guide, endorsed by the National Quality Board (NQB), I set out the expectations of commissioners and providers to optimise nursing, midwifery and care staffing capacity and capability so that they can deliver high quality care and the best possible outcomes for their patients.

The NQB guidance was designed to assist providers in fulfilling the commitments made in *Hard Truths – the Journey to Putting Patients First*[2], with regard to publishing nurse, midwife and care staffing levels and undertaking in-depth reviews of staffing establishments every six months using evidence based tools. I confirmed that we expected all organisations to be meeting these expectations currently, or taking active steps to ensure they do so in the very near future.

In March 2014, Professor Sir Mike Richards and I wrote to you all providing more details in relation to publishing staffing data from April 2014 onwards[3].

I am delighted that one year on from the publication of the NQB guidance, so much progress has been made.

All NHS organisations are now publishing ward level staffing information on NHS Choices; the National Institute for Health and Care Excellence (NICE) has published a guideline to support safe staffing for nursing in adult in-patient wards in acute hospitals[4] and endorsed the first nurse staffing tool. NICE has also launched a national consultation on safe staffing guidance in maternity settings, and further

[1] Available from: http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
[2] Available from: https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
[3] Available from: http://www.england.nhs.uk/wp-content/uploads/2014/03/staffing-letter.pdf
[4] Available from: http://www.nice.org.uk/guidance/sg1

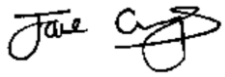
guides and endorsements will follow in accident and emergency departments, and mental health inpatient settings. In the meantime work is on-going through *Compassion in Practice - Action Area Five: ensuring we have the right staff, with the right skills in the right place*[5] to develop workforce tools and guidance for mental health, learning disability and community care settings.

Earlier this year, as part of the drive to deliver safe and effective care, it was decided to develop a guide for providers identifying 'care contact time'. The guide published today sits alongside the NQB guidance; NICE guidelines and NICE endorsed safe staffing toolkits, to give providers a suite of toolkits to support them in making decisions to secure safe staffing for their patients and service users. We would strongly recommend for those Trusts that have not already undertaken this exercise a baseline assessment should be undertaken by summer 2015.

The NQB guidance also indicated a clear expectation that commissioners in their engagement with providers should be assuring themselves that they have sufficient nursing, midwifery and care staffing capacity and capability to meet the outcomes and quality standards they require and use appropriate commissioning and contractual levers to bring about improvements.

Despite the progress made to date, we must not be complacent. Strong leadership at all levels is paramount in driving through effective and long lasting change. It requires open and honest discussions at board level, and successful staff engagement to tackle complex issues and make difficult staffing decisions. However, these must be made, if we are to ensure safe staffing.

There are a number of tools referred to within the guide. Links to these are included at the end of the document. Whilst we are not mandating a particular approach, it is important to ensure local consistency in the use of the tools is maintained to provide meaningful comparisons over time.



Jane Cummings, Chief Nursing Officer for England

[5] Available from: http://www.england.nhs.uk/nursingvision/actions/area-5/

1 Introduction

Since the publication of the Francis Report, in response to the Mid Staffordshire NHS Foundation Trust Public Inquiry[6] there have been a number of publications relating to staffing levels, including *Hard Truths – the Journey to Putting Patients First,* which included a commitment to publish nurse staffing levels for all NHS organisations.

NHS organisations are now publishing ward level nurse staffing information on NHS Choices; the National Institute for Health and Care Excellence (NICE) has published a guideline to support safe staffing for nursing in adult in-patient wards in acute hospitals and endorsed the first nurse staffing tool. Further NICE guidelines and endorsements will follow for other specialties.

This guide builds on the work already undertaken and sits alongside the NQB guidance, NICE guidelines and NICE endorsed staffing models, to give providers a suite of toolkits to support them in making decisions to ensure safe staffing care for their patients and service users.

2 Background and context

Staffing levels impact upon the ability of nursing and midwifery staff to provide high quality care. As described in the foreword, the focus on delivering safe staffing has been in response to reports that suggest nurses and midwives are not visible enough and are often too busy with administrative tasks to deliver direct care to patients. NICE guidelines recommend monitoring and action to ensure patients are receiving *'the nursing care and contact time they need'* with the emphasis on *'safe patient care, not the number of available staff'*. There has been much debate regarding the need to go beyond the numbers to determine 'safe' staffing levels.

It is important to not only consider the types of activity being undertaken, but where these add value. The Productive Ward[7] focused on improving ward processes and

[6] Available from: http://www.midstaffspublicinquiry.com/
[7] Available from: http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

environments to help nurses, midwives and therapists spend more time on patient care thereby improving safety, experience and efficiency. The case studies illustrate how this could be done.

The focus of the *productive ward releasing time to care programme* was the identification and elimination of activities that did not add value to patients. For example, staff spending time searching for equipment that could have been readily available in a better planned environment. Where there are higher than expected levels of non-patient activities, these should be explored to identify what proportion are 'do not add value' activities, and what proportion are legitimate and important non-contact activities, such as student supervision and staff training.

It should be recognised that other staff groups can positively influence the delivery of contact time. This, for example, will include allied health professionals, housekeepers and ward clerks. Consideration should be given to this when assessing tasks undertaken, such as the value of stores being unpacked by registered staff.

Within the guide a number of tools are referenced. The choice of tool is for local determination. What is important is that the same tool is used each time so that improvements can be consistently monitored. This is because each tool has variations in terms of methodology; for example, how activities are categorised. Links to these tools are provided in section 9.

3 Care contact time

In undertaking their duties, it is acknowledged that a range of elements make up the role of the nurse or midwife. All of these are important in ensuring that the patient receives the best possible quality of care.

It is important to note that whilst a significant element of nursing and midwifery staff time should be spent providing direct care, such as patient hygiene, this needs to be balanced with indirect patient care. For example, attendance at multi-disciplinary ward rounds or liaising with families to plan discharge, as well as other activities, such as supporting and mentoring students and newly qualified nurses or midwives.

All of these are essential in providing high quality care, good patient outcomes and a high quality clinical learning environment. An example of how nursing activities can be defined and grouped can be found in Appendix A.

It is acknowledged that safe staffing is much more than just looking at the number of staff on wards. The measurement and understanding of care contact time can be used to drive local improvement, support the determinant of a robust nursing and midwifery establishment and the effective deployment of staff. The appropriate balance of nursing and midwifery activities will vary according to the specialty of a ward or unit, the dependency and acuity of its patients, as well as other factors.

Improvements can be made to contact time by using the tools available and this is shown in case study 6.3 - In one of the wards in this case study, direct contact time increased from 53% to 78% through the introduction of ward led modifications in practice. At the same time, length of stay reduced, the number of patients discharged early in the day increased and discharge planning improved.

4 Safer staffing: beyond numbers

Since the publication of the NQB guidance, a review of case studies has been undertaken to look at the association between the numbers of staff; both registered and non-registered, available on a shift and the impact that this has on the level of direct and indirect care experienced by patients. These have included:

- A review of information held by the UK nursing database. This is the database that generates the 'multipliers' (Nursing resource in full time equivalent (FTE)) for the Safer Nursing Care Tool (SNCT)[8];
- Examination of the 'Care Contact' pilot across 14 provider organisations
- A review of information gathered from trusts already measuring care contact time.

These are set out in the case studies in section six.

[8] Available from: http://shelfordgroup.org/library/documents/Shelford_Safer_Nursing_23May14a.pdf

5 The Care Contact Time Guide: How Organisations can use this Guide

This Care Contact Time Guide supports providers and commissioners in getting nursing, midwifery and care staffing right. The information above is useful to consider, but this guide is essentially about implementing good practice. No guidance can or should replace the ability and professional judgement of nursing and midwifery leaders, managers and healthcare professionals in making difficult staffing decisions on a daily basis and with a longer term perspective.

The NQB guidance published last year requires organisations to publish an analysis of actual staff each month versus the planned staff. Additionally, every six months trust boards are required to undertake an in-depth review of nurse staffing requirements, using evidence based tools and NICE guidance and to set out the planned staffing levels in a paper to the trust board. This Care Contact Time Guide sets out the following additional recommendations:

- The trust board should consider undertaking a contact time assessment to provide a baseline indication of the construction of care provided.

- It is recognised that appropriate care contact time will vary according to the patient dependency and specialty. For example, Intensive Therapy Units would be expected to have a higher level of contact time than general wards, as their patients have a higher level of acuity and dependency.

  Therefore on a ward by ward basis, the data collated should be considered alongside other indicators, which could include:

  - Planned/required vs actual staff numbers

  - Quality metrics aligned to the type of care being provided including:
    - Friends and Family Test (FFT),
    - Staff FFT,
    - NICE red flags (Appendix B) and
    - Locally agreed quality metrics

- Temperature checks of contact time should be undertaken using a consistent methodology to assess any changes in contact time and consider any impact this may have on patient care.

  They should be undertaken in the following circumstances where

  - quality indicators are falling
  - if the care model is changed (for example the introduction of seven day working)
  - if there is a change in skill mix, or
  - introduction of new technology, including major IT programmes,

  and within specialties on a six monthly basis as outlined in the NQB guidance and NICE guideline.

- The inclusion of an understanding of the delivery and impact of care contact time within a ward leadership training and development strategy should be described within the Board report, with progress being monitored and reported to the Board. Health Education England's (HEE) national education and training package on safe staffing, when available, will provide trusts with materials for local use by nurses and midwives.

6 Case reviews and their key outcomes

It is essential that indirect contact time is factored into nurse staffing establishments and that its value is considered alongside direct contact. More often these elements are essential to determining the patients' plan of care to ensure individualised care is given and also to improve their pathway through the system. Our experience at Salford Royal has been to enable indirect contact time to be undertaken as close to the patients' bedside as possible using information technology and a reorganisation of the model of care delivery.
Elaine Inglesby Burke, Salford Royal NHS Foundation Trust

6.1 Case study one: Care Contact Time Pilot

14 trusts volunteered to participate in a care contact time pilot. This consisted of 13 acute and one mental health trust.

Information was derived directly from ward nursing staff using a prescribed data collection instrument, based on the Productive Ward Releasing Time to Care Guidance. Each member of rostered staff was asked to complete a template describing the type of activity they were undertaking during a shift. The pro-forma categorised the activities into groups including direct and indirect contact time, and other activities. This ensured that all staff on the shift were included and negated the need for audit staff to observe and record.

Staff from participating organisations and wards took part in a webinar which explained data collection methodology/instruments and use. The tool required completion by individual staff members and required analytical support.

Data was collected over two 24 hour periods during August, one being at a weekend and one a week day. All organisations used elderly/or medical wards. Recording of time spent was allocated according to agreed definitions of direct, indirect and non-patient activities. Across most trusts there was a difference between direct care contact times over the weekend, compared to the weekday. This could be explained by a decrease in requirements for other indirect activities such as ward rounds and multi-disciplinary meetings. It may also be supporting key activities such as appraisal, training or undertaking audits which are critical components in the delivery of safe care.

Participating wards submitted a ‘ward profile descriptor, including information on ward specialty, ward layout/design, planned and actual staffing ratios, support staff (e.g. ward clerk, discharge staff and others), and technology support for nursing. All these descriptors varied considerably between organisations, as did the recorded contact time.

Direct care contact time in a midweek 24 hour period varied between wards from 38% to 61% for registered nurses and from 64% to 86% for non-registered staff. Indirect care contact time also varied between wards from 23% to 42% for registered nurses and from 9% to 26% for non-registered staff. This suggested that contact hours do not necessarily equate directly to staff numbers and there are potentially many factors that influenced this variation. These include data collection variations, dependency, acuity and turnover of patients, and the organisation and leadership of care on the ward. This strongly supports further interrogation of contact hours within organisations.

The box below gives examples of how Nurse Leaders should use these variations

to ask the right questions.

Using Care Contact Time as another tool to achieve safe nursing and midwifery staffing

Locally collected care contact time can be analysed to show:

- Changes over time in the proportion of nursing time spent on direct care, indirect care, associated work or unproductive time
- The relationship between patient dependency/acuity and how much nursing time is spent on direct care, indirect care, associated work or unproductive time
- The relationship between overall nursing staff available per bed and how much nursing time is spent on direct care, indirect care, associated work or unproductive time
- Breakdowns in the proportion of nursing time spent on direct care, indirect care, associated work or unproductive time by each grade of nursing staff

These are some theoretical examples of how Chief Nurses might use this kind of analysis alongside other data sources:

The Chief Nurse in Somewhere NHS Foundation Trust pilots seven-day ward clerk support to release nursing time for direct care at weekends. This exercise shows most pilot wards have managed to increase the proportion of nursing time spent on direct care and reduce the time spent on indirect care during the pilot.

The Chief Nurse in Someplace NHS Foundation Trust appreciates that wards whose patients have high dependency/acuity will tend to spend a higher proportion of nursing time providing direct care, but one ward's figures suggest they are spending a very high proportion of time on direct care compared to similar wards. The ward has also seen more complaints, and nurse documentation audits show gaps in assessment and care planning. Exploration confirms that in this case the move to more nursing time spent on direct care has not been for good reasons; staff felt under too much workload pressure to spend time with relatives, or to attend to important aspects of indirect care. The Chief Nurse acts by providing advice to help the relatively inexperienced ward manager to more effectively support her staff to balance their time across all of the important nursing elements.

The Chief Nurse in Anytown NHS Foundation Trust looks at the relative proportion of time spent on direct patient care by Band 5 staff nurses. It appears that the amount of time Band 5 staff nurses are able to spend on direct patient care is mainly influenced by the skill mix of staff immediately junior to them on each ward. This finding helps inform local plans for developing advanced support workers.

75% of staff involved fed back that the method was easy to use, but it does require analytical support and it is noted that this is not the only tool available to measure care contact time.

The intent of the pilot was to use the data to help inform ward managers and senior staff as to how staff spending their time in order to inform improvements and potential changes to deployment of staff.

Gill Harris, Chief Nurse, NHS England (North) – gill.harris5@nhs.net

6.2 Case study two - Open and Honest, Central Manchester University Hospitals NHS Foundation Trust (Adaptation of the productive ward tool)

There have been examples of improvements demonstrated within the *clocks data (* local modification of productive ward). We cannot attribute a direct causal effect from collecting data using activity clocks to improved patient outcomes; however we have seen the impact of identifying a problem in the data, initiating improvement work and then reviewing the impact on activity after the changes have been introduced. For example:

- One adult medical ward – completed improvement work related to ward rounds and discharge processes – registered nurse indirect care time reduced by 7% and direct care time increased to 73% within six months
- One children's ward – completed improvements related to their meals service – the time spent on meals by registered nurses increased by 10% and their overall direct care time increased by 9% after the change
- Elderly care ward – team identified from the activity clocks that a large proportion of time appeared to be spent on documentation which due to the layout of the ward and the need to use computers, often meant staff could not be with patients. They identified that patients were often anxious when staff were not visible and at increased risk of falls. The ward has placed workstations in each bay, which has enabled staff to be visible and respond proactively to patients' needs. Whilst the time undertaking documentation has not reduced significantly, other indicators of care have improved
- Adult Orthopaedic Unit – the activity clock data identified that a large proportion of registered nursing time was used to admit patients on the day of surgery. The team wanted to understand if it was possible to make any improvements to the admission process, improving patient experience and if possible reducing the time of the process. Training was undertaken with nursing assistants to undertake patient clinical observations and pre-operative bloods. Registered nurses are now able to spend time delivering in-patient care and patient feedback has shown an increase in scores in relation to communication with patients
- Adult Surgical ward – the team identified that a large proportion of time for staff was being dedicated to blood sampling especially during the early shift. The team undertook an exercise to review all blood requests over a period of time, with the medical team and identified that a number of requests were unnecessary or duplicates. A criterion for blood requests was developed with the medical team and implemented. This has resulted in a 50% reduction in the number of blood requests and blood samples taken. Staff report that they spend less time taking blood samples and it is anticipated that, when activity clock data is collected again, that this will be evident in the data.

- Adult High Dependency Unit – the team identified that patient's satisfaction with nutrition was poor, and activity clocks showed the process was time consuming. The team have made a number of changes which have improved patient and staff experience of the process:
  - Introduced menu and individual patient ordering process for breakfast times
  - Agreed fixed meal times with meals provider for critical care areas
  - Clearly identified roles and responsibilities of staff within the process
  - Focus at meal times on ensuring patients are prepared for meals and assisted where necessary.

Gill Heaton, Chief Nurse and Deputy Chief Executive, Central Manchester Hospitals - gill.heaton@cmft.nhs.uk

6.3 Case study three - Project WOW (Ways of Working) at Guys and St Thomas' NHS Foundation Trust (Productive Ward)

In May of this year three wards at Guys and St Thomas' NHS Foundation Trust embarked on implementing a range of activities to improve their contact facing time, which was on average 45%. The three ward sisters were given the authority to plan what they wanted to do and they were supported through the Fit for Future campaign to do this. Their ward bedside TVs were activated as computer terminals, individual bays were given their own lockable notes trolleys, each bay had its own phone and the nurse in charge was given a mobile phone. In four months the contact facing time has risen to 75% (see table below for details) and their Family and Friends Test score has risen. They no longer spend wasted time walking round the ward looking for the nurse in charge or a set of notes. Their satisfaction is higher and the patients, who always got good care, rate it even higher. The nurses are in control and the Trust is very proud of what they have achieved, proving it's the smallest things that create the biggest difference.

Project WOW was developed to redesign the nursing model on three wards (two medical and one older peoples ward). The aim of the project was to increase the amount of time nurses spent on direct patient care. There were four elements to the project:

- Bay based nursing decreasing time nurses have to spend moving around the ward and releasing time for direct patient care
- Discharge nurse discussing discharge plans with patients and their relatives, completing the Health Needs Assessment and Decision Support Tool
- Nurse in Charge seven days a week implemented to ensure there is consistent leadership across the whole seven day week
- Mobile phones for the nurse in charge to improve communication with the Acute Admission Wards, Project WOW wards and Site Nurse Practitioners, enabling quicker decision making.

Outcomes

- Direct care time percent has increased on all three wards, as the table below shows:

	Ward One	Ward Two	Ward Three
April 2014	40%	57%	53%
July 2014	63%	76%	78%

Project WOW Percentage direct care time on three wards

- Length of stay has fallen on the three wards

- The number of patients discharged before 11am and 2pm has increased
- The 1:8 staff/patient ratio at night helps getting lights turned off earlier and staff going home on time.
- Discharge planning has improved and health needs assessments are being completed faster.

A survey in July 2014 showed the following improvements in staff satisfaction:

- More staff reporting that they felt they were able to spend enough time with their patients
- They were able to do their job to a standard they were pleased with
- They were able to engage in meaningful conversation with patients and relatives
- Staff satisfaction with the quality of care they were able to give had increased on all three wards taking part in the pilot.

Eileen Sills, Chief Nurse, Director of Patient Experience, Guys & St Thomas' NHS Foundation Trust – Eileen.sills@gstt.nhs.uk

7 Next steps - what we will be doing next

7.1 Health Education England

7.1.1 Education and training package on safe staffing

Through *Compassion in Practice Action Area Five: ensuring we have the right staff, with the right skills in the right place*, NHS England and Health Education England are establishing a working group to design and develop a bespoke education and training package on safe staffing for nurses and midwives. Currently nurses and midwives do not receive specific education or training on safe staffing with most practitioners learning this 'on the job'. The development of the education and training package will ensure there is a consistent approach for nurses and midwives to develop an understanding of the key principles; methods; tools and guidance available to support decisions in relation to ensuring safe and effective staffing, across all practice settings.

It is planned that there will be three levels of education and training aimed at:

- Frontline staff
- Matrons / Heads of Nursing and Midwifery
- Directors of Nursing

It is proposed that the content will include education and training in relation to:

- Establishment setting and monitoring
- Recruitment and retention
- Contribution to workforce planning and education commissioning
- Workforce development
- Staff deployment
- Supervision of staff

7.1.2 Action Area Five - timeline for reports and tools in development

Report	Timeline
Mental Health Inpatient Staffing Framework	Due November 2014
National Nursing Research Unit report on 12 hour shifts	Due December 2014
Safer Nursing Care Tool for Paediatric In-Patient settings	Work complete awaiting details of launch date
Safer Nursing Care Tool for Accident and Emergency Units -	In progress
Development of an i-Pad APP for the Safer Nursing Care tool for adult in-patient settings	Proof of concept testing complete implementation details to be finalised.

Research is being commissioned by HEE on:

- impact of supervisory status for lead sister / charge nurse or equivalent
- links between staff numbers and outcomes (patient and staff)
- More in-depth research on the impact of 12 hour shifts on staff (RNs and HCSWs) and patients

7.2 NICE

7.2.1 NICE Endorsement Programme

This is a new programme to formally endorse guidance support resources produced by external organisations.

The aims of the endorsement programme are to ensure that:

- Users are confident that using an endorsed resource will support implementation of the relevant NICE guidance recommendations or use of the quality standards identified
- External producers who are developing support resources have the opportunity to work with NICE to ensure their resources are aligned to NICE recommendations.

7.2.2 NICE safe staffing guidelines in development

The following table provides a timeline for the NICE safe staffing guidelines in development.

NICE Guideline	Timeline
Safe Midwife Staffing in Maternity Settings	February 2015
Accident and emergency departments	May 2015

8 Summary

This Care Contact Time Guide complements other tools available for trust boards and nurse directors in assessing safe nurse staffing requirements. It is important to recognise that whilst significant amounts of nursing and midwifery staff time should be spent providing direct care, there needs to be a balance. This should include an appropriate level of time dedicated to indirect care, non-direct activities such as staff training and appraisals.

Within the guide a number of tools are referenced. There is no recommendation as to the tool organisations should use. This is for local determination. What is important is that the same tool is used each time so that improvements can be assured. This is because each tool has variations in terms of methodology for example how activities are categorised. Consistency will only be achieved by using the same tool. Links to these tools are shown at the end of the document.

It is the overarching responsibility of the Board to ensure that the services they provide have safe staffing levels that meet the need of their patients. The Nurse Director has an explicit role in advising and supporting the Board in relation to this.

We know that nurse staffing numbers do not necessarily equate to the level of direct care given to patients and measuring these can highlight where improvements could be made.

Ultimately, ward leadership makes the difference in terms of how available staff are deployed at ward level, and this must be the focus going forward. The value in determining how contact time is being utilised is to ensure staff are deployed most effectively to enable safe, good quality care to be provided to all our patients.

9 Tools to support implementation

Examples of some tools currently available include:

- Safer Nursing Care Tool™ (SNCT) Available from: http://shelfordgroup.org/library/documents/Shelford_Safer_Nursing_23May14a.pdf
- Productive Care Ward - Productive learning models are available from: www.theproductives.com

10 Useful links:

- Department of Health (2014) *Hard Truths – The Journey to Putting Patients First Volume One and Volume Two.* Available from: https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response
- National Quality Board (2013) *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability*. Available from: http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
- NICE safe staffing guideline for nursing in adult inpatient wards in acute hospitals available online: http://www.nice.org.uk/guidance/sg1

- NICE Safe Staffing Guidelines in development – further information available from: https://www.nice.org.uk/guidance/service-delivery--organisation-and-staffing/staffing
- Open and Honest Care: driving improvements - http://www.england.nhs.uk/ourwork/pe/ohc/

Appendix A – Example of how nursing activities can be defined

Definitions will change slightly according to the tool used locally, and the table below outlines some of the activities these tools typically include.

Care contact time	**Direct care contact time** (also known as direct patient care)	In most tools, direct patient care would include: • all hands-on care (for example assistance with eating and drinking, patient hygiene, administering medication, taking clinical observations) • providing one-to-one observation or support to patients (for example, taking them to or from theatres) • all direct communication with patients
	Indirect care contact time (also known as indirect patient care)	In most tools, indirect patient care would include: • patient documentation • professional discussions to plan the patient's care • discharge planning • communication with patient's relatives and friends • ordering investigations • shift handovers
Other nursing activities	**Other patient-focused activity**	In most tools, this would include nursing activities directed at patients in general (rather than specific patients), for example: • Completing nursing audits • Checking clinical equipment
	Staff-focused activity	In most tools, this would include activities to support and develop staff, for example: • Student support • Giving and receiving training sessions • Personal development reviews • Schwarz rounds
	Ward/unit-focused activity	In most tools, this would include activities such as • Ensuring environmental safety and cleanliness • Ordering or unpacking stock Some of these may be appropriate nursing activities, but some may divert time from direct care contact.
Unproductive time	**Personal staff time**	In most tools, this would include staff meals breaks, etc.
	Wasted time	This could include time wasted through waiting for equipment, for colleagues, or for other reasons

Appendix B – NICE Nursing Red Flags

Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than two registered nurses present on a ward during any shift.

Note: other red flag events may be agreed locally.