A project to modernise the role of the ward manager

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Fractured neck of femur accounted for more than 1.7 million bed days in 2003 (Department of Health, 2003). This article discusses how the role of the ward manager on an older persons’ trauma ward was modernised to provide a specialist service for outlying patients while maintaining ward management responsibility. This project is well established and has been successfully applied to coronary care.

Patients admitted with fractured neck of femur are usually aged over 65 and very frail and vulnerable, often as a result of chronic conditions. It is therefore not uncommon for these patients to require complex medical and nursing interventions and intensive rehabilitative expertise. To meet the needs of this patient group and achieve good clinical outcomes, the multidisciplinary team must be highly skilled and effectively coordinated by someone with strong leadership. This is vital when considering that in 2003 89,000 patients with a mean age of 77 were admitted with fractured neck of femur and accounted for more than 1.7 million bed days (DoH, 2003).

Model of care

In 1997 a 28-bed older persons’ trauma ward was established for patients predominantly with fractured neck of femur. The aim was to centralise care and establish a dedicated multidisciplinary team with the competencies needed. These included:

- Medical management;
- Nursing care;
- Rehabilitation;
- Social and psychological issues;
- Discharge planning.

The challenge of caring for this group increases with the age of the patient. At this trust 84 is the average age of the 500 patients admitted each year with fractured neck of femur. The team focused on developing an integrated care pathway that would make explicit the standards to be achieved and the interventions by each discipline, ensure consistency and continuity, and facilitate clinical audit. To support this the medical management of the ward was reduced from six consultants to one care of older people and one orthopaedic consultant.

A multidisciplinary team meeting takes place each week to review each patient’s progress through the pathway, and identify and act on any variations. Due to capacity, about 10 per cent of patients are admitted to general surgical wards as outliers each year.

Prior to the role redesign

There were concerns that patients not directly admitted to the older persons’ trauma ward appeared to be disadvantaged. This perception was supported by feedback from patients who had been outliers, staff delivering care to these patients without the relevant level of expertise and staff admitting patients to the trauma ward from other areas.

Centralising services and expertise has facilitated significant improvements for patients. The next stage in the journey was to improve the service to outlying patients. Modernisation and The NHS Plan centre on working in new ways to use available resources effectively, creating roles that are patient focused and steering change with strong clinical leadership.

The journey

As the clinical leader the senior nurse manager provides the vision and drive to accept responsibility for outliers and to explore and implement innovative approaches to reducing the variation in services to patients. The Modernisation Agency model for improvement – plan, do, see, act (PDSA) – was used by the senior nurse manager.

The first stage involved the team being supported to reflect on patient outcomes. Clinical audits using integrated care pathways highlighted the following:

- Patient group was admitted to a range of wards;
- Nursing model and care pathway varied depending on patient location;
- Waiting list issues for emergency surgery;
- Preoperative and postoperative management;
- Bed management and utilisation;
- Length of stay varied depending on admitting ward;
- Delays in rehabilitation and discharge planning;
- Availability of clinical expertise.

Modernisation – changing roles

Reflecting on the issues above, a novel approach to patient care and the ward manager role was developed. The aim was to improve outlier access to the high-quality care available at the trust. This was to be achieved through expanding the ward manager role to provide a specialist service while maintaining
WARD MANAGEMENT RESPONSIBILITY. The model used was based on the outreach model developed within critical care.

In critical care much has been written about gains to patient care, staff development, service quality and clinical outcomes as a result of developing and implementing outreach services (Dawson et al, 2000). The ward manager would act as an expert resource for staff outside the immediate area and manage a caseload.

The proposal for a shared care approach combining a nurse-led outreach service with medical and allied health professional (AHP) care was presented to the elderly trauma team. The outreach service would facilitate provision of expertise and assistance to staff and patients on outlying wards.

Perceived benefits and outcomes included:
- A hospital-wide tracking system;
- Patients’ advocacy to ensure care needs were met;
- Triaging patients to aid prioritisation;
- A better informed multidisciplinary team;
- Efficient bed management;
- Improved customer care;
- Reduced length of stay.

The ward manager was key to the provision of the outreach service. The ward manager had the level of clinical and theoretical expertise required, together with an interest in influencing the care outlying patients received. The plan for the outreach service was that the ward manager would visit all outlying patients daily, assessing each patient’s care needs. This would enable the ward manager to provide

<table>
<thead>
<tr>
<th>TABLE 1. IMPROVEMENTS RESULTING FROM THE PROJECT</th>
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<tbody>
<tr>
<td><strong>PRACTICE ISSUES</strong></td>
</tr>
<tr>
<td>Nursing and therapy care pathway not used outside the elderly trauma ward</td>
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<tr>
<td>Ward manager from the elderly trauma ward attends the morning trauma meeting but information is not passed on to other wards</td>
</tr>
<tr>
<td>Bed management</td>
</tr>
<tr>
<td>Information and communication</td>
</tr>
<tr>
<td>Medical pro forma not used outside the elderly trauma ward</td>
</tr>
<tr>
<td>Knowledge and skills of nurses on outlying wards</td>
</tr>
</tbody>
</table>
direction and specialist advice to nursing staff, coordinate the medical and AHP input and prioritise patient transfer to the ward. The service would also involve providing information to patients and relatives about the treatment plan and ensure discharge planning commenced at the earliest opportunity. The ward manager would provide regular education and training sessions for non-orthopaedic staff.

The measurable outcomes for the pilot were:
- Improvements in nursing care based on best practice standards;
- Coordinated medical and AHP input preoperatively and postoperatively;
- Prioritisation of patient transfers to the elderly trauma ward;
- Better communication with patients and relatives;
- Effective bed management and utilisation;
- Increased customer satisfaction;
- Education and support to staff on outlying wards.

The older persons’ trauma team agreed to the remit of the pilot and the outcome measures. The major area of concern was the fear of losing the ward manager to a nurse specialist role. A main issue was the loss of the ward manager’s clinical expertise to the team as well as ward management and organisation. This reflects ongoing concerns that nurse specialist roles deplete clinical expertise at ward level (Castledine, 2000; Ford et al, 2001). However, the senior nurse manager leading the project captured the imagination of the team by detailing the vision of a modern ward manager with a dual role. The benefits would be an expert in the ward environment improving quality at ward level and sharing expertise across the wider patient community, as well as retention of senior clinicians at ward level, role expansion and modernisation.

The outreach service was successfully introduced in September 2002 and met the project outcome targets. The service to outliers with fractured neck of femur has improved significantly (Table 1, p31).

The modern ward manager project for older persons’ trauma is now well established and has been successfully applied to coronary care. The role is being considered for other patient groups and used as a model for future nurse specialist roles.

### Discussion

The project demonstrates how a well-established role such as the ward manager can be modernised in a needs-driven, patient-focused approach grounded in ward-based care in an acute setting. The model is in line with the fundamental principles of The NHS Plan and displays the government’s intention that modernisation should promote innovation and creativity. In addition, it shows how nurses can use clinical governance to place the patient at the centre of quality improvement.

The important position of nursing is reflected by its place in modernisation and the government’s assertion that ‘never before have nurses had the opportunity to be at the centre of activity and be in a position to drive and shape events within their organisation’ (DoH, 1997). Nurses should seize this opportunity to use their knowledge and expertise of patients’ needs and expectations to drive service improvement. The modern ward manager specialist is a prime example of this and, most importantly, keeps senior clinicians at the frontline of care delivery, raises the profile of ward-based nursing and makes explicit the value of nursing.

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**TABLE 2. PRE-ROLE REDESIGN**

<table>
<thead>
<tr>
<th>APRIL-JUNE 2001</th>
<th>Ward admitted to</th>
<th>Average time to transfer to elderly trauma ward (ETW) (days)</th>
<th>Time to discharge (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All wards except ETW</td>
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<td>33.8</td>
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</tr>
<tr>
<td>ETW</td>
<td>-</td>
<td>25.1</td>
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**TABLE 3. POST-ROLE REDESIGN**

<table>
<thead>
<tr>
<th>APRIL-JUNE 2004</th>
<th>Ward admitted to</th>
<th>Average time to transfer to elderly trauma ward (ETW) (days)</th>
<th>Time to discharge</th>
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</thead>
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<tr>
<td>All wards except ETW</td>
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<td></td>
</tr>
<tr>
<td>ETW</td>
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<td>21.5</td>
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