How skill mix affects quality of care

In this article...

- How the media has reported recent failings in care
- The link between staff-to-patient ratios and outcomes
- Key issues to tackle to ensure the nurses’ role is recognised and to improve care

**5 key points**

1. Healthcare assistants increasingly provide fundamental care
2. The nurses/HCA boundary is blurring
3. The media has reported care failures as failures in nursing
4. There is a correlation between low nurse-to-patient ratios and high rates of mortality, morbidity and adverse events
5. Hospitals with the right culture, workforce, and leadership improve patient satisfaction and save money by reducing adverse events

Nursing in the UK is receiving unprecedented criticism following a number of high-profile reports into deaths and adverse events. We reject the view of many critics that modern-day nursing is broken or has lost its way.

The title “nurse” should mean a qualified, registered practitioner, regulated by standards and revalidation through a professional regulatory body. Caring and competence are not mutually exclusive. Indeed, Florence Nightingale was one of the most intelligent, educated and articulate women of her day and a role model for delivering compassionate care. Sadly, the view of many in healthcare, the media and the general public is that an educated nursing workforce means one that lacks compassion.

The title “nurse” is used for unqualified and unregulated support workers, who deliver a high proportion of care. This is not a criticism of these practitioners, who are in the main highly committed, but it is rare that criticisms levelled at nursing care differentiate between those who deliver it.

The challenge

Healthcare has become increasingly complex, with fundamental nursing care increasingly provided by unregistered healthcare assistants. This has blurred the boundary between nurses and HCAs even though the skill, knowledge and experience required to care for people with complex comorbidities is increasing.

The media has reported recent events as failures in nursing. The Mid Staffordshire NHS Foundation Trust Inquiry (2010) reported that the most basic elements of care were neglected for many patients. For example, calls for help to use the bathroom were ignored and patients were left lying in soiled sheets and sitting on commodes for hours. Staff failed to make basic observations and pain relief was provided late or, in some cases, not at all.

The Patients Association (2010) drew attention to care experienced in hospitals and the Parliamentary and Health Service Ombudsman’s (2011) report highlighted poor care received by older people.

In these cases, care was provided by a majority of unregistered staff with insufficient nurses to supervise them.

This does not reflect the whole story. The Care Quality Commission (2011) published a national overview of their dignity and nutrition inspection programme, which found that around half the hospitals gave cause for concern. CQC chair Dame Jo Williams linked this to staffing issues: “Many people told us about the wonderful nurses in their hospital, and then said how hard pressed they were to deliver care. Having plenty of staff does not guarantee good care (we saw unacceptable care in well-staffed wards, and excellent care on understaffed ones) but not having enough is a sure path to poor care. The best nurses and doctors can find themselves delivering care that falls below essential standards because they are overstretched…. There are levels of under-resourcing that make poor care more likely, and those who run our hospitals must play their part in ensuring that budgets are used wisely to support frontline care staff” (CQC, 2011).

Large studies in several countries have shown unequivocally a correlation between low nurse-to-patient ratios and high mortality, morbidity and adverse event rates (Needleman et al, 2011; Duffield et al, 2009; Rafferty et al, 2007; Aiken et al,
Fundamental care is an intricate web to achieve a high-quality patient experience and outcome. Nurses are trained in this and can deliver it as part of a holistic package in a different way from support staff.

When washing or feeding frail and vulnerable people, nurses observe and talk to them, taking the opportunity to assess them holistically. To ensure patients remain hydrated, nurses need to assess their oral intake and skin, assess for any difficulties in drinking and devise alternative strategies if oral intake is insufficient.

Nurses are not “too posh to wash”. They are loaded with other tasks delegated by managers, doctors and others and, as an unintended consequence, reduced the perceived value of fundamental nursing care to a set of tasks that anyone could deliver.

Furthermore, nurse-to-HCA ratio has been reduced to a level where nurses cannot do all that is expected of them, delivering the care patients have the right to expect, while supervising other staff.

The Royal College of Nursing and others are calling for a mandatory skill mix of 6:1:5 nurses:HCA in the UK; however, the total number of staff is also critical.

US requirements are more precise. California, for example, requires one nurse for every five patients and higher levels in specialist units. Mandatory minimum levels have been set in other countries but the evidence suggests that raw numbers alone do not improve outcomes (Donaldson and Shapiro, 2010; Burns Bolton et al, 2007).

Aiken et al (2003) linked nurses’ educational level to patient outcomes, while Aiken et al (2008) reported that the practice environment was a major factor in achieving this:

» Set nurse staffing budgets at the levels found in hospitals with the lowest mortality and morbidity rates. This is a necessary but not enough by itself to improve care. It needs to be matched by:

» Strong, empowered leadership at the point of care. Ward leaders need authority to provide individualised patient care and to be able to account for how they have achieved these. These two actions can only be productive if they are implemented from within;

» A supportive organisational culture that understands that the complexity of healthcare delivery cannot be reduced to a series of task-focused process targets.

The intelligent analyst would understand the economics of such an added-value proposition. Length of stay in hospital would be reduced and there would be fewer complications, while earlier observations and intervention when condition changed would reduce costs associated with failure to rescue patients in the long run. Evidence-based nurse-to-patient ratios will, we believe, save money, improve the quality of care, reduce the high-profile failures of fundamental care delivery and produce a healthcare system we are all proud of.

We need a fundamental change in public attitude to be clear about role expectations and the skills of someone with the title “nurse” and the added value they bring. Nursing is not “broken”. We have the right to entrust our own care and well-being, and that of our loved ones at vulnerable times in their lives, to the care, knowledge and skill that only registered nurses can deliver. This can be achieved by ensuring there are sufficient registered nurses on each shift, with effective ward leadership and organisational culture, to allow them to do what they do best.

References
Patients Association (2010) Listen to Patients, Speak up for Change. tinyurl.com/listen-patients.