How to optimise the registered nurse contribution in care homes

Staff shortages are leading some managers to review traditional patterns of working. But, as Hazel Heath explains, any changes must not compromise the care essential to meet the choices and complex needs of older individuals.

Abstract
This article aims to offer ideas that may be useful to care homes when considering priorities for registered nurse (RN) work. Drawing on the findings of research into the work of RNs and care assistants in UK care homes (Heath 2006), it discusses the distinct contribution of RNs, the delegation of nursing interventions and the need for a 24-hour RN presence. International debates on the distinct contribution of RNs in residential settings for older people are also acknowledged.

Keywords
Care assistants, care homes, complex care, registered nurses, residents

CARE HOMES offer a vital service for the estimated 400,000 older people around the UK who live in them (Care Quality Commission (CQC) 2010). Care needs continue to increase as residents become older, experience multiple comorbidities and disabilities, and often end their lives in care homes (British Geriatrics Society (BGS) 2011).

At the same time, because government funding for care homes is not ring-fenced, representative organisations have warned of a need for action to prevent services collapsing and vulnerable people being left without care (English Community Care Association 2011, Registered Nursing Home Association 2011).

A major issue for many care homes is the shortage of registered nurses (RNs) and, in successive surveys, nurses report that the mismatch between care need and RN availability has a negative effect on quality of care provided (RCN 2004a, 2010). The average ratio in care homes with nursing has been reported as one RN caring for 17 residents in a day shift, but some are caring for more than 35 residents (RCN 2010).

Care homes are responding to nursing shortages in many ways. Some managers are looking to identify nursing tasks that could be delegated to care assistants (CAs); some are negotiating with regulatory organisations on levels of RN supervision for specific aspects of care; and others are proposing alternative models of staffing that do not require a 24-hour RN presence.

Nursing interventions
To target RN resources effectively, researchers, policymakers and service providers have sought to identify elements of nursing work that could be undertaken by less qualified and less expensive staff. A review of international nursing literature highlights research that observed the tasks, activities or interventions performed by RNs compared with CAs (Heath and All Ireland Gerontological Nurses Association (AIGNA) 2010). These studies conclude that, in many situations, RNs and CAs perform similar tasks and question whether RN input is needed in the form and quantity in which it exists.

In the UK, O’Kell (2002) identified a range of tasks that, with training, CAs are capable of undertaking, including minor dressings using an aseptic technique, catheter care, cutting toenails of people with diabetes, percutaneous endoscopic gastrostomy (PEG) and nasogastric feeding, administration of medicines, including insulin injections and care planning.

Care home residents are prescribed an average of 7.2 medicines each (Alldred et al 2009) and administering these is time consuming. Spending...
hours giving out medicines is not widely considered to be the best use of RN time and there are strong arguments for RNs leaving medicines with CAs to give to residents. However, ‘administering medication’ is not the only activity that a good RN is undertaking while he or she is at the medicine trolley. Box 1 presents a case study of RN expertise. In addition to medication administration, this example shows how the RN observed residents, supervised staff and prevented a potentially critical situation.

There are clear guidelines on delegation of nursing activities (RCN 2011) and specifically on the administration of medicines (Nursing and Midwifery Council 2010). In day-to-day care home life, most hands-on caring is undertaken by CAs with little or no direct supervision from RNs. Older residents and families have said that they value this support (Heath 2006) and, given the realities of funding pressures and RN shortages, CAs will continue to be the major care providers.

When considering who can deliver which elements of care, we need to look beyond the task or observable activity to focus on the knowledge, skills, experience and expertise that the person undertaking the intervention will bring to this. It is this expertise, and how it is used, that will influence outcomes for residents.

**Distinct contribution**

Nursing has been defined as: ‘The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.’

Nursing has a particular purpose, mode of intervention, domain, focus, value base and commitment to partnership (RCN 2003). RNs in care homes for older people bring to their work two fundamental elements of expertise (Heath and AIGNA 2010):

- Caring, empathy, understanding patients as individuals, communication, building therapeutic relationships and working with families – person-centred care.
- Clinical nursing knowledge, skills, experiences and clinical judgement through which RNs support health, identify ill health and ill being and manage medical aspects of care including medicines and therapies.

**Box 1 Administering medication: an example of registered nurse expertise**

**The setting:** A large lounge in a care home unit for 30 people with dementia and mental health needs with windows on all sides and corridors leading to bedrooms. Residents were having breakfast assisted by care assistants (CAs), who were also taking meals to residents still in their bedrooms.

**Registered nurse (RN) actions:** The RN was standing with the medicine trolley dispensing medicines from bubble packs prefilled by the pharmacist. Having been off duty for a few days, she was taking time to note any changes that had occurred in her absence. She was:

- Noticing changes in the drugs prescribed.
- Identifying errors in prescriptions.
- Identifying drugs that had not been given appropriately.
- Checking medication doses with the British National Formulary.
- Assessing a resident’s need for a drug, for example, checking pulse before giving digoxin.
- Identifying other needs for medicines, for example, laxatives, pain relief.

**The RN also:**

- Asked CAs to change the radio channel to one the residents might like.
- Asked CAs to ensure that the three residents still in their bedrooms were given breakfast.

**That is, she managed the environment and monitored the residents overall.**

- Intervened to stop Mr S being given non-diabetic orange juice.
- Noticed N was having trouble chewing her toast and asked CA to take her to put in her teeth.
- Greeted individual residents with a smile, chatted with them, responded to them, noted actions to be taken later, for example, speaking to their relative.
- Asked CA to put rollers in Mrs B’s hair as her family was visiting later.
- Noticed how residents were looking: T’s trousers were wet and RN asked CA to attend to this; ‘W, you look tired, would you like a rest after breakfast?’; ‘M, are you cold? [CA] will you bring M’s cardigan, please’.
- Noted that drugs for a person with Parkinson’s disease needed to be given at 10am.
- Noticed F was not walking as well as usual, wrote a note to see him later and refer to physiotherapist.

**That is, she acknowledged residents, knew them as individuals, knew what their day might bring, cared for their comfort and wellbeing, assessed and supported their health and functioning.**

- Noticed how the CAs were working and corrected a moving/handling technique.
- Determined CA’s priorities: ‘do this and then do that’.

**That is, supervised and taught staff.**

- Locked the trolley, walked over to the dining table and spoke to a resident who had stood up with a knife in his hand and was walking towards another resident. ‘Where’s your frame C, let me find it. Come to the chair, C and I’ll get your toast.’ Took the knife from C’s hand, helped him to sit in an armchair and brought his toast and a walking frame.

**That is, anticipated and prevented what could be a critical situation.**
Consider the expertise used by the RN in Box 1 and how this was synthesised through her work.

As the RCN (2004b) describes, nursing is a complex process founded on the ability to integrate and synthesise appropriate knowledge from multiple sources such as:

- **Empirical knowledge.** In this situation an understanding of medicines, dosages (when and how they should be given) contraindications, side effects, ageing, multiple pathology, mental health in later life and the experience of living with a dementia.

- **Tacit knowledge.** This underpins actions that are taken almost automatically, without necessarily rationalising what the nurse is doing or why – in this case instinctively knowing how residents might be feeling; anticipating and preventing a critical situation.

- **Skills.** For example, the assessment of health, social and psychological needs, ‘being with’, supporting individual residents.

- **Experience.** The understanding that derives from recognising a similar pattern of events from a previous encounter. In this situation, for example, an innate recognition of usual patterns in the homes (sights, sounds, movement patterns), patterns of chewing toast without dentures and recognising abnormal gait requiring physiotherapy assessment.

The RN was skilled at recognising situations, understanding the potential consequences and selecting appropriate actions. Crucially, through this expertise, she was able to ‘nip things in the bud’ and prevent problems escalating.

In addition, the author’s (Heath 2006) research identified dimensions that RNs bring to their work.

![Figure 1: Simplified model of registered nurse (RN) work identified in research](image-url)

**Aim of RN work**
To make life as good as possible for residents by improving quality of life, maintaining normal life, promoting individual health, wellbeing, functioning and fulfillment.

**Challenges of RN work**
- Total responsibility and accountability; complexity of the RN role; pressure of the job; obtaining care for residents; limited medical and multiprofessional input; limited specialist input; inadequate medical documentation; supervising a largely untrained workforce; staffing difficulties and shortages; complexity and diversity of resident need and care; working in a closed community.

**Expertise that RNs bring to their work**
- Professional nursing knowledge, skills and experiences including clinical knowledge and skills; code of professional conduct; legal and ethical issues; health and safety; leadership and management; teaching and supervising staff; multiprofessional working.
- Personal knowledge, skills and experiences; personal beliefs and motivations; knowledge of older individuals in the context of biography and family over time.
- Plus dimensions not highlighted in the literature or RN job descriptions.

**Dimensions of RN work**

- Mental health care; prevention and relief of distress
- Drugs, dressings and ‘anything medical’
- Acute/critical care; accidents, emergencies
- Risk assessment, balancing and management
- Therapeutics
- Preventative care; anticipatory care
- Health promotion
- Problem identification; problem solving
- Palliative care
- Maintenance care
- ‘Hands-on’, one-to-one care
- Death and dying
- Advocating for; obtaining external services
- Rehabilitation care; re-enablement
- Maintenance care
- ‘Hands-on’, one-to-one care
- Advocating for; obtaining external services
- Rehabilitation care; re-enablement

(Heath 2006)
that are not highlighted in the literature or their job descriptions, such as dealing with emergencies, risk assessment and risk management, rehabilitation/re-enablement, therapeutics and health promotion (Figure 1). If these aspects are not recognised, other than by RNs themselves, this raises questions as to whether such elements would exist in care if RNs did not bring them.

Outcomes from RN work

Observation of caring work in care homes reveals an array of complex interactions and interrelationships – multifaceted, multidimensional and multilevel. Outcomes from the work can be identified in a broad range of ways and in different time frames. In the example in Box 1, preventing a potentially critical incident when a resident picked up a knife had an immediate impact. Other outcomes, such as those consequent to the residents receiving correct medication, being greeted warmly and individually acknowledged, or being in an environment that is calm and pleasant, are less obvious in the everyday realities of care home life, but are cumulative and affect residents in the longer term.

Being unable to chew food, people with diabetes drinking non-diabetic orange juice, sitting in wet trousers or not receiving a physiotherapy assessment for a walking problem will ultimately affect these individuals' health, functioning, wellbeing and quality of life. This is particularly important for care home residents with complex needs and frailty who, without active intervention and compensatory care, will deteriorate.

The author's research (Heath 2006, 2010) found that the strongest influence on outcomes of care for older people in residential settings was the knowledge, experience, skills and caring attributes of those delivering care. The study concluded that, while CAs helped residents to function and feel valued, and they could form close family-type relationships with residents, the health knowledge and clinical expertise of RNs was critical in determining residents' health outcomes, particularly in the long term. RNs also influenced the environment, atmosphere and quality of care in the home (Heath 2006, 2010).

Determining when RN intervention is needed

In determining when an RN is required, the following three concepts are increasingly being recognised as useful: complexity, stability/predictability and vulnerability/risk. Complexity can relate to:

■ Health needs, illnesses, disabilities and mental health needs, particularly distress, withdrawal or behaviour which challenges.

■ Treatment, therapy, care and support regimens, for example, mechanical/technical assistance, such as PEG, subcutaneous fluids, syringe driver and wound dressing.

■ Any interventions that often need reassessing, for example, intractable pain, medication regimens and mental health strategies.

■ The complexity of relationships with older people, family and supporters.

■ The likelihood of the need for referral to a specialist/under the care of a specialist.

Stability/predictability relate to a person's physical and mental health status; how likely this is to remain in a steady state if treatment and care regimens continue and also the extent to which the person's response to internal and/or external triggers can be anticipated with some certainty through established and reviewed care plans. Instability occurs particularly with conditions that can fluctuate, for example, Parkinson's disease or diabetes; unpredictability occurs particularly with mental health needs (RCN 2004c).

Vulnerability/risk can arise due to:

■ Physical frailty.

■ Multiple conditions.

■ Poor nutritional state.

■ Mental health need, such as cognitive impairment or low motivation.

■ Lowered ability to anticipate risk and take avoiding action in sensory impairment.

It can include the inability to make one's own needs known, to think/reason or make decisions, to take cues from the environment, to control or negotiate the environment safely, to meet one's own needs or to accept help. It can be related to an individual's degree of positivity/negativity, self-image, self-esteem or motivation. The higher the complexity, instability/unpredictability and vulnerability/risk, the more intensive is the need for RN intervention. These ideas offer potential for development and a tool based on the concepts of stability, complexity, predictability and risk of negative outcomes is being developed in Canada (Blosterah et al 2010).

Once the need for RN intervention has been identified, the type of intervention, for example, direct care, supervisory, monitoring or managing, can be identified (RCN 2004c).

RN presence

The need for a 24-hour RN presence in care homes, and removing the legal requirement for this presence, has long been debated. Alternative models of service have been developed (Eyers and Bryan 2006). Research (Heath 2006, 2010, Heath and AIGNA 2010) suggests that a 24-hour RN
Residential settings

Clinical expertise in palliative and end of life care; recognising transitions; managing pain and other symptoms, promoting comfort; day-by-day support for residents and families.

In the context of the complexity of healthcare needs among care home residents, the round-the-clock presence was deemed essential by residents, families and staff. This presence could make life or death differences in acute or emergency situations.

Valuing care home nursing

While recent reviews of international literature suggest that nursing practice in long-term care settings is still widely perceived as routine care, delivered to residents with non-complex needs (McGilton et al 2011), the situation is the opposite in many UK care homes.

Nursing homes are nurse-led units. Care home RNs often carry overall responsibility and accountability for everything that occurs in the home and how the home interacts with the outside world. Unlike their colleagues working in hospital wards, care home RNs can be responsible for:

- The home’s buildings and grounds and everything that goes on at the premises.
- Registration and regulatory requirements, including unannounced inspection visits.
- Clinical expertise in palliative and end of life care; recognising transitions; managing pain and other symptoms, promoting comfort; day-by-day support for residents and families.
- Preventing health problems and gradual deterioration, for example, maintaining mobility, nutrition, continence, bowel functioning through continuous monitoring and assessment of residents’ health and wellbeing, along with proactive care regimens.
- Maintaining an optimum physical and psychological environment for older people’s functioning and wellbeing, recognising how individuals are negotiating environments, which is particularly important for people with a dementia.
- Promoting mental health and wellbeing through managing care staff and regimens; recognising and dealing with distress through being present, knowing individual residents and using supportive skills.
- Managing complex medication regimens; determining when medication should and should not be administered by assessing the resident’s health status; recognising adverse effects.

Figure 2 Priorities that registered nurses (RNs) in care homes have to balance

| Views, needs and priorities of residents, relatives, staff, management and everyone involved in the home. | Different needs of different residents and relatives. |
| Needs of the home as a whole. | Needs of individual residents. |
| Residents’ need for dignity, adulthood and independence. | Needs that arise from ill health and disability. |
| Maintaining a homely domestic environment. | Complex clinical need requiring clinical facilities and equipment. |
| Freedom of choice, movement, activities. | Safety regulations. |
| What residents want. | What RNs believe is in residents’ ‘best interests’. |
| Maintaining an open culture. Work flexibility and responsiveness. | Maintaining appropriate relationships, respect and discipline. |
| Showing warmth and caring to residents. | Giving the ‘wrong messages’. |
| Potential for all residents to benefit from nursing, physiotherapy, specialist professional input or specific equipment. | Potential for one resident to benefit from intensive, sustained professional input or equipment. |

Balance

Presence in care homes for older people is essential for:

- Managing acute illness and emergencies; referring to appropriate professionals; preventing crisis situations; preventing unnecessary hospitalisation through being ‘on the spot’ and making professional judgements.
- Preventing health problems and gradual deterioration, for example, maintaining mobility, nutrition, continence, bowel functioning through continuous monitoring and assessment of residents’ health and wellbeing, along with proactive care regimens.
- Maintaining an optimum physical and psychological environment for older people’s functioning and wellbeing, recognising how individuals are negotiating environments, which is particularly important for people with a dementia.
- Promoting mental health and wellbeing through managing care staff and regimens; recognising and dealing with distress through being present, knowing individual residents and using supportive skills.
- Managing complex medication regimens; determining when medication should and should not be administered by assessing the resident’s health status; recognising adverse effects.
Residential settings

- Actions in case of fire, including evacuation of residents and staff.
- All equipment, assessment and suitability, ordering, adaptation or maintenance.
- Promoting the home and business opportunities. In care homes, RNs are the lead, usually sole, clinician on site and are accountable for the safety, care, health and wellbeing of residents in a unit or the home overall. Levels of responsibility are particularly high in the context of the limited multiprofessional team support available (BGS 2011).

As lead clinicians, RNs take responsibility for bringing in other professionals and obtaining optimum services and treatment for residents. Care home RNs also commonly monitor the progress of residents when they are outside the home, for example, in hospital and how families are coping. In addition, because the care home is also home for the residents, RNs have to balance a range of priorities in their work (Figure 2, page 27). These are not straightforward to achieve.

Conclusion

Demand for care home places is difficult to predict accurately, but it is expected to double in the next 20 years (RCN 2010). As the numbers of older people continue to increase, particularly the oldest old, the healthcare needs of the resident population will remain highly complex (BGS 2011).

The need to understand how to use all staff skills and resources to the optimum is urgent. There is scope for reconsidering the RN role, and particularly the ‘anything and everything’ aspects, such as responsibility for buildings, equipment maintenance and administration (Perry et al 2003, Heath 2006). However, to optimise the RN contribution, we need to look beyond the tasks to focus on the needs of individual older people, the expertise that RNs, CAs and other staff bring, and how teams can work together most effectively.

The complexity of care in care homes should never be underestimated. An ageing population requires high levels of expertise and commitment from care home staff and their work is crucial to enhance the health, wellbeing, functioning and quality of life for the people who live in such homes.

References


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Conflict of interest

None declared.

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