The Royal College of Emergency Medicine

Royal College of Nursing

Nursing Workforce Standards for Type 1 Emergency Departments

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Contents

Foreword

Patients depend on acute care delivered in our Emergency Departments (EDs). We are the frontline of the NHS. An appropriate ED workforce is the most important factor for providing safe, effective, high quality emergency care in a timely, cost-effective and sustainable manner. This requires a balanced team of nurses, doctors, allied health professionals and support staff, with appropriate knowledge and skills.

Over time a number of organisations have endeavoured to make recommendations regarding the nursing workforce in EDs [1,2]. However, specific standards have never previously been established.

Professor Dame Donna Kinnair
Chief Executive and General Secretary of the Royal College of Nursing

Therefore, in the collective interests of patient safety and quality of care, the Royal College of Nursing (RCN) Emergency Care Association (ECA) and the Royal College of Emergency Medicine (RCEM) have collaborated to define, for the first time, the nursing workforce standards for Type 1 EDs.

This collaboration represents something greater than just a workforce standard – it represents a recognition that the ED team is truly multidisciplinary.

Dr Katherine Henderson
President of the Royal College of Emergency Medicine

Scope

This document details the nursing workforce standards for Type 1 EDs. It is designed to be used by those responsible for planning, commissioning and implementing nursing workforce models, whilst supporting the delivery of the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3].

The nursing workforce refers to Registered Nurses, Nursing Associates and non-registered care workers, such as Healthcare Assistants and Clinical Support Workers, unless otherwise specified. (See Glossary for description of Nursing Roles).

These standards are not intended for use in areas such as clinical decision units or observation wards that may fall under the governance of EDs, which should be staffed according to ward models.

Emergency Nurse Practitioners (ENPs), Advanced Nurse Practitioners (ANP), Advanced Clinical Practitioners (ACPs) and others working as clinical decision makers such as liaison mental health practitioners are also excluded from these standards.

Glossary of Nursing Roles in the Emergency Department

Adapted from the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3]. Where level of competency is stated it is this framework which is referred to.

Where pay scale bandings are stated, they refer to the NHS Agenda for Change pay bandings.

Clinical Support Worker / Healthcare Assistant: A non-registered care worker working under the supervision of a Registered Nurse, who is accountable for the care delivered. They are invaluable members of the team in supporting direct care to patients, particularly in relation to the essential provision of hydration, hygiene and elimination needs. Clinical support workers, with additional training, may also undertake clinical observation of vital signs, or undertake investigations such as urinalysis or ECG recording. Furthermore they may complete prescribed treatments for patients such as application of casts, and wound dressings according to local protocols. They do not administer medications. Typically they are Band 2 or 3.

Associate Practitioner / Nursing Associate (England only): Work within defined local policies and are accountable for their practice. They have a required level of knowledge and skill beyond that of the traditional support worker, and are able to undertake clinical work in domains that were previously the remit of registered professionals, such as advanced wound closure. Their remit is comprehensive and extended, working under unsupervised guidance from Registered Nurses. They contribute to the core work of nursing, freeing up Registered Nurses to focus on more complex clinical care. Typically they are Band 4.

Foundation Staff Nurse: A Registered Nurse who is either newly qualified, or new to emergency nursing; has not yet acquired the competencies of an Emergency Nurse. These nurses require supervision in practice, ranging from direct supervision in their initial weeks, to indirect supervision as they near the accomplishment of an Emergency Nurse. They should be working to complete the Level 1 competencies. Typically they are Band 5.

Emergency Nurse: A Registered Nurse who has completed preceptorship, and has achieved the Level 1 competencies. They are able to work with individual patients, or groups of patients, without direct supervision in the emergency care setting. This includes initial assessment and the provision of treatment (but not diagnosis) for patients. In EDs, this is likely to include working with patients in the resuscitation room, those with major illness or injury and those with minor presentations. They should be working to complete the Level 2 competencies. Typically they are Band 5 or 6.

Emergency Charge Nurse: An Emergency Nurse who has completed level 2 competencies, is a clinical expert and proactively develops themselves and others. They lead and supervise the clinical work of others and can manage the emergency care setting as a whole; managing patient flow and delegating care accordingly. In EDs they should work in close partnership with the Emergency Medicine Consultant and clinical decision makers to ensure safety of patients and best use of resources. They should focus on leadership, educational and/or research competencies. Typically they are Band 6 or 7.

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Practice Educator: This is an Emergency Nurse who has completed Level 2 competencies and facilitates educational opportunities in the ED. They provide supervision in practice, deliver training sessions and assessment of competencies. They often teach on nationally recognised courses (for example, Advanced Life Support). They should be working towards education-specific competencies and/or qualifications. Typically they are Band 6 or 7, depending on the leadership responsibilities of the role.

Practice Development Lead: This is an Emergency Nurse who has completed Level 2 competencies and leads the education strategy for the ED. They provide supervision in practice and deliver some training sessions, whilst establishing the training requirements to ensure the necessary workforce skill mix. They will link the education strategy for the ED with the overall strategy for education in the organisation. They will work closely with the Lead Nurse Manager and/or Matron / Senior Lead Nurse, the Clinical Director, and other education providers, including Higher Education Institutes (HEIs). Typically they are Band 7 or 8a.

Lead Nurse Manager: This is an Emergency Nurse who has completed Level 2 competencies and is responsible for the day-to-day operational management of the ED, including workforce management and implementation of local policy and clinical guidelines. Typically they are Band 7 or 8a.

Matron (England and Wales) / Senior Lead Nurse (Scotland and Northern Ireland): This is an Emergency Nurse who has completed Level 2 competencies and is responsible for quality assurance and quality improvement in the ED; including responding to patient feedback and ensuring clinical incidents are investigated, and any recommendations actioned. Typically they are Band 8a.

Emergency Nurse Consultant: A clinical expert in emergency nursing with responsibility for emergency care leadership; including strategic development of policy and practice, research, education and advanced clinical practice. Typically they are Band 8b or 8c.

1. Definitions of emergency medicine by the International Federation For Emergency Medicine.

Nursing Workforce Standards for Type 1 Emergency Departments

	Standard	Additional rationale / consideration
1	The ED nursing workforce will be reviewed on at least an annual basis.	ED nursing workforce reviews will take into account significant seasonal variation in nursing workload.
2	The ED nursing workforce will be determined by triangulating: • professional judgement - **Telford Model** [4] (see Appendix) • nursing workload, calculated using the **RCN ECA Baseline Emergency Staffing Tool (BEST)** [5] (see Appendix) or other appropriate ED nursing workload tool • benchmarked with appropriately selected and comparable peers [2].	Professional judgement will take into account nursing roles, local workstreams / models of care and local ED / hospital geography. The ED nursing workload will inform the shift patterns and skill mix for the nursing workforce.
3	Each ED will have a **Lead Nurse Manager** (Band 7 / 8a).	See Glossary for role summary.
4	Each ED will have a **Matron / Senior Lead Nurse** (Band 8a).	See Glossary for role summary. In Trusts with more than one ED, the **Matron / Senior Lead Nurse** may work across more than one site, supported by a **Lead Nurse Manager** on each site.
5	Each ED will have at least one **Emergency Nurse Consultant** (Band 8b / 8c).	See Glossary for role summary. In Trusts with more than one ED, the **Emergency Nurse Consultant** may work across more than one site. EDs may require more than one **Emergency Nurse Consultant** to lead on specific sub-specialty clinical domains.
6	Each ED will have a WTE dedicated **Practice Development Lead** (Band 7 / 8a).	See Glossary for role summary. The **Practice Development Lead** will lead the education strategy, which will be aligned to the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3].

	Standard	Additional rationale / consideration
7	In EDs with > 75 individuals in the nursing workforce, **Practice Educators** (Band 6 / 7) will be required to support the **Practice Development Lead**.	See Glossary for role summary. **Practice Educators** may be required full time, but may also fulfil a dual role as **Emergency Charge Nurses**.
8	When calculating the nursing workforce WTE a **minimum uplift of 27%** will be applied to cover planned leave, unplanned leave, mandatory training and specialty specific training, without compromising patient safety.	Emergency nursing is unique in its provision of care to the full spectrum of adult and paediatric patients with acute illness and injury. Additionally, complex safeguarding issues may be identified for all age groups that require action. Therefore, the training requirements are above and beyond that which are needed in many other clinical areas. An uplift of greater than 27% may be required if the skill mix of the nursing workforce has a high proportion of **Foundation Staff Nurses** or part-time staff.
9	The nursing workforce will comprise a minimum of 80% Registered Nurses.	The skill mix of the nursing workforce should comprise: 30% **Emergency Charge Nurses** 40% **Emergency Nurses** 10% **Foundation Staff Nurses** 20% **Nursing Associates or Clinical Support Workers.** See Glossary for role summaries. This skill mix ensures sufficient **Emergency Charge Nurses / Emergency Nurses** to deliver safe clinical care whilst providing appropriate supervision of **Foundation Staff Nurses**, Student Nurses, **Nursing Associates** and **Clinical Support Workers**.
10	A minimum of 50% of Registered Nurses will be in possession of an academic post registration award in emergency nursing.	Nurse education programmes will be mapped to the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3].

	Standard	Additional rationale / consideration
11	All **Nursing Associates** and **Clinical Support Workers** will have training for their role to include competency assessment and a personal development plan according to local policy.	Even when experienced in clinical support work in other environments, Nursing Associates and Clinical Support Workers will require specific education and competencies to work in the ED.
12	Individuals appointed to the nursing workforce will be allocated a supernumerary period.	Where individuals have no previous ED experience this should be for a minimum of 4 weeks to include structured induction and close supervision to gain basic specialty competence. Where individuals are changing ED, or roles within an ED, this should be for a minimum of 2 weeks to include structured induction.
13	The shift patterns for the nursing workforce will be determined by the predicted variation in clinical demand according to time of day and day of week.	Staggering of shift start times may be required to correspond with peaks in clinical demand. Where this is the case, EDs must be mindful of the impact this may have on staff briefing at the start of shifts and make suitable arrangements for communication and patient handover.
14	Rostering patterns for the nursing workforce will take into account best practice on safe shift working, minimising the use of long shifts where appropriate and in consultation with staff.	Longer shifts are preferred by some individuals, such as those with caring responsibilities or those who travel long distances to work. However, fatigue at the end of a long shift can result in clinical error [6, 7]. Cumulative fatigue can result in health problems for staff and even 'burnout'. Where staff work long shifts, employers should offer appropriate support with respect to their health and well-being, and their ability to provide safe and effective patient care at the end of their shifts. Opportunities should be offered to move to shorter shift times where this is preferred. Shift patterns should be sustainable and facilitate the wellbeing, recruitment and retention of nursing staff.

	Standard	Additional rationale / consideration
15	No greater than 20% of individuals on any given shift will be from bank or agency outwith the substantive ED nursing workforce. When using Registered Nurses from bank or agency, the ED must be assured that they are competent to work in the role or clinical area to which they are allocated. All staff from bank / agency will be provided with ED orientation.	The use of temporary, bank, overtime and agency staff is associated with increased clinical risks due to factors such as variable clinical ability, limited relevant experience and unfamiliarity with the specialty and / or the local geography of the ED. Additionally, the use of temporary, bank, overtime and agency staff is associated with financial risk for the ED / Trust.
16	There will be a nominated **Emergency Charge Nurse / Emergency Nurse** lead for each of the cross cutting themes and clinical domains in the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3].	These areas include: • Patient assessment • Pain assessment and management • Medicines management • Moving and handling • Infection prevention and control • Safeguarding children and adults • Documentation and record keeping • Preventing and controlling violence and aggression • Caring for acutely ill adults • Caring for adults requiring resuscitation • Caring for adults with minor injury and illness • Caring for children and young people • Caring for people with mental health needs • Caring for older people • Emergency planning and disaster management Leads will be allocated non-clinical time to facilitate quality improvement and development in these areas. In some EDs leads may have more than one area of responsibility.

	Standard	Additional rationale / consideration
17	There will be a nominated lead for nursing research.	Research active EDs have better clinical outcomes [8]. Nursing research is essential to build the evidence base for emergency nursing practice.
18	There will be a clinical co-ordinator (**Emergency Charge Nurse** Band 6 / 7) on duty 24/7 in addition to the nursing workforce required to deliver direct patient care.	The clinical co-ordinator will provide leadership, supervision and oversight of the entire ED, working in conjunction with the medical shift leader to ensure patient safety and quality of care.
19	An **Emergency Charge Nurse** or an **Emergency Nurse with level 2 competencies** will be the nominated shift lead for the resuscitation area.	The nominated shift lead for the resuscitation area will deliver direct patient care and oversee the care of other patients in the resuscitation area; supervising more junior staff. If there are no patients in the resuscitation area, this nurse should be available to work flexibly in other areas of the ED as required, or take the opportunity to deliver ad hoc training or undertake quality improvement tasks.
20	There will be a minimum of 1 Registered Nurse to each patient in the resuscitation area.	This ratio will be at least 2 Registered Nurses to 1 patient during the resuscitative phase of illness or injury, such as cardiac arrest and the initial assessment of major trauma. Where patients do not require resuscitation, but are nursed in that area due to a crowded ED, or have been stabilised and are awaiting further investigations or transfer to a ward, 1 Registered Nurse may be able to care for 2 patients.

	Standard	Additional rationale / consideration
21	There will be a minimum of 1 **Emergency Charge Nurse** / **Emergency Nurse** to undertake initial assessment / triage 24/7.	Additional **Emergency Nurses** will be required at times of high demand (as predicted by the **RCN ECA BEST** [5]), or when multiple areas are in use, to ensure that initial assessment / triage is completed for all patients within 15 minutes. This nurse will require assistance from **Nursing Associates** or **Clinical Support Workers** to facilitate timely investigations and interventions where these are undertaken. Where the nurse completing the initial assessment undertakes a 'streaming' function to direct patients to services beyond the ED, they will be an **Emergency Charge Nurse** and have undertaken specific training for this role.
22	There will be a minimum of 1 Registered Nurse to 3 cubicles where **moderate and high dependency** patients are nursed.	In regularly crowded EDs the use of '*1 Registered Nurse to 3 cubicles*' should be replaced with '*1 Registered Nurse to 3 patients*' to reflect that there may be more **moderate and high dependency** patients being nursed in a clinical area than there are cubicles. This is an absolute minimum and should not substitute more detailed planning based on output from the **RCN ECA BEST** [5]), which may indicate that additional nursing staff are required at certain times. The use of corridors and non-clinical areas to nurse patients is unacceptable. However, when this is unavoidable, a risk assessment must be completed to ensure that the area used has the necessary equipment and resources to minimise patient safety risks. Escalation procedures must ensure that staffing is matched to the nursing workload.

	Standard	Additional rationale / consideration
23	Where EDs receive children there will be at least two Registered Children's Emergency Nurses on shift.	This is in line with **Facing the Future: Standards for children in emergency care settings** [9]. These standards should be used in conjunction with this document when planning the workforce for paediatric EDs.
24	The nursing workforce on shift will be sufficient to accommodate staff breaks without compromising patient safety and quality of care.	When determining the nursing workforce on shift, there is merit in identifying one or more individuals to 'float' in order to provide cover for staff breaks. This approach also allows increased staffing in specific clinical areas on a flexible basis as a result of surges in clinical demand and to provide 1 to 1 nursing care for patients at high risk of harm to themselves or others.
25	Audio-visually separate areas of the ED will have a minimum of 2 members of staff present at all times, unless a reliable and effective method for summoning immediate support is in use.	This is to mitigate the clinical and personal safety risks to patients and staff.
26	Where other registered healthcare professionals, such as paramedics, are used to complement the nursing workforce, they must be able to demonstrate the relevant competencies from the **RCN ECA National Curriculum and Competency Framework for Emergency Nursing** [3] for the role / clinical area to which they are allocated.	
27	The nursing workforce will be complemented by other staff such as receptionists, ward clerks, porters and housekeepers.	These roles enable the most effective use of the nursing workforce.

Converting the nursing workforce model into a Whole Time Equivalent (WTE) number

Once the nursing workforce model and the shift pattern have been established using the above standards, the total WTE number for the entire nursing workforce should be calculated as follows:

Calculation:	
a)	Establish daily nursing hours required by totalling the duration in hours of each individual shift (minus unpaid breaks)
b)	Daily nursing hours required (a) x 7 = Weekly nursing hours required
c)	Weekly nursing hours required (b) / 37.5 = WTE nursing workforce required before uplift
d)	WTE nursing workforce required before uplift (c) x 1.27 = WTE nursing workforce required including uplift
e)	WTE nursing workforce required including uplift (d) + WTE for specific roles* if not included above = Total WTE number for the entire nursing workforce

* Such as Lead Nurse Manager, Matron / Senior Lead Nurse, Emergency Nurse Consultant, Practice Development Lead, Practice Educator, other.

Determining the financial cost of the total WTE nursing workforce

This should be done with finance team colleagues. They often require a sample rolling roster for the total WTE nursing workforce to allow them to determine the financial cost based on their assumptions in terms of pay scale, costs and the impact of evening, night and weekend working and public holidays.

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Appendix - Approaches that may be used to determine the nursing workforce

The Baseline Emergency Staffing Tool (BEST) [5]

The BEST was developed by the Royal College of Nursing (RCN) Emergency Care Association (ECA). It is designed to estimate ED nurse staffing requirements based on a combination of the number of patients attending the ED and a measure of their nursing dependency - not their acuity.

The BEST methodology is described in detail elsewhere. https://www.rcn.org.uk/get-involved/forums/emergency-care-association/best-tool. However, in general terms, each patient attending the ED during a defined data collection period is assigned a nursing dependency score using the Jones Dependency Tool (JDT). This is the only validated tool for measuring patients' nursing dependency in the ED. The assigned nursing dependency scores allow each patient to be categorised as low, moderate, high or total nursing dependency. For the data collection period BEST facilitates quantification of any disparity between the nursing workload and staffing levels by:

- Analysing the volume and pattern of nursing workload in the ED according to dependency category.
- Tracking this against the number of staff rostered per hour.
- Calculating the WTE nursing workforce and skill mix required using nurse to patient ratios for each of the nursing dependency categories.

Calculated staffing per hour is based on the nursing workload for the entire data collection period at the 80th centile. The 80th centile is recommended because staffing to maximum demand would mean surplus nursing capacity for the majority of the time, yet staffing to the 50th centile would result in insufficient nursing capacity to provide essential nursing care for half of the time.

The Telford Model [4]

The professional judgement method such as that advocated by, and subsequently modified from, Telford is one of the oldest methods described for nursing workforce planning. The methodology originally advocated by Telford surveys experienced ED nursing staff. This approach recognises that these are the experts who are best placed to make a professional judgement on the appropriate nursing workforce levels based on their knowledge of the number of patient attendances, case mix, acuity and nursing dependency of patients combined with the local geography of the ED. A survey should ask respondents to detail the numbers of nursing staff by Band and role / clinical area that should be rostered for duty during each shift.

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Review

Usually within three years or sooner if important information becomes available.

Key words for search

Nurse, nursing, staff, staffing, workforce, Emergency Department, ED

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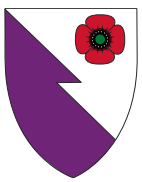

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