Conclusion Implementation of the RUN PC tool utilising the patients’ IPOS scores demonstrates that patients are waiting on the hospice waiting list for a shorter period of time. The RUN-PC allows us to identify the patients with the greatest urgency and we can respond accordingly to their need.

Aims To provide quality assurance on staffing levels within the hospice inpatient unit. To obtain intelligence on bed occupancy, demand, and capacity, and our ability to support the wider health and care system in relation to specialist palliative and end-of-life care.

Method A retrospective audit was performed over 6 months (Nov. 2022 to Mar. 2023) collecting actual nursing and health care assistant staffing numbers against planned staffing levels. This was reviewed against numbers of patients and the standard calculation for Care Hours Per Patient Day (CHPPD) was applied.

Results We were safely staffed within our budgeted staffing establishment for registered and unregistered workforce, and expectations on hours filled. Nights were better staffed than days due to more set patterns of working for that group of staff. There was an average of 16 CHPPD received by patients and their families. Lower staffing levels aligned with lower bed occupancy, suggesting we flexed our staffing to meet clinical need and demand on services. There was no impact on our ability to achieve other deliverables, including time from referral to admission.

Staffing levels demonstrate that we could have potentially taken more admissions on occasions, had the demand for inpatient beds been present showing we can support the systems in which we operate.

Discussion We recognise that safe staffing is only a tool, and for it to be fully effective (Royal College of Nursing. Impact of staffing levels on safe and effective patient care: literature review [Internet] (2023)), it needs to be reviewed alongside additional information such as adapted dependency tools (NHs England. Safer nursing care tool [Internet] (no date)) and capacity and demand information. We have committed to continuing to review this information, including an annual report, and will adapt other national tools for our use as they become available.

Background Twice daily admissions meetings at 9am and 3pm are held between the inpatient, community nursing and medical teams at our hospice. To date, the decision to admit is based on bed availability alongside staffing numbers. However, the complexity of the current inpatients is not always objectively considered, and on occasion challenges relationships between the teams. A literature search was carried out to explore current use of acuity/dependency scores and identified an Australasian hospice nursing acuity tool. This was subsequently adapted for our unit.

Aims To create a tool which gives an objective view of the complexity of the patients in a hospice inpatient unit. To use this tool in admissions meetings to aid communication and decision making around capacity to admit. To evaluate the use of this tool after a pilot. To review our inpatient admission guidelines accordingly.

Method Each morning before 9am and each afternoon before 3pm, the complexity score will be calculated by the nurse in charge of the inpatient unit using the acuity tool. This score will then be shared in the admissions meeting, alongside bed and staffing status. It is anticipated that this score will be most useful in the decision of whether or not to admit emergency same day inpatient requests, which understandably cause heightened concern amongst staff. The complexity score will be an objective measure of whether the admission can be achieved safely.

After three months of using this in the admissions meeting, a survey will be sent to staff members involved in the admissions process to understand whether this has been helpful in understanding the ward complexities and aiding decision making in admissions meetings.

Results Interim informal feedback from staff is positive.

Background Despite the NHS having safe staffing reporting requirements in place since 2014 (NHS England. 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 quantity and capability [Internet] 2013; Francis. The Mid Staffordshire NHS Foundation Trust Public Inquiry [Internet] 2013), this has not been applied to hospices. There are also no specific staffing standards for hospice inpatient units.

Aims To explore current use of acuity/dependency scores and identified the complexity of the current inpatients is not always objectively considered, and on occasion challenges relationships between the teams. A literature search was carried out to review 

Discussion We recognise that safe staffing is only a tool, and for it to be fully effective (Royal College of Nursing. Impact of staffing levels on safe and effective patient care: literature review [Internet] 2023), it needs to be reviewed alongside additional information such as adapted dependency tools (NHs England. Safer nursing care tool [Internet] (no date)) and capacity and demand information. We have committed to continuing to review this information, including an annual report, and will adapt other national tools for our use as they become available.

Background Twice daily admissions meetings at 9am and 3pm are held between the inpatient, community nursing and medical teams at our hospice. To date, the decision to admit is based on bed availability alongside staffing numbers. However, the complexity of the current inpatients is not always objectively considered, and on occasion challenges relationships between the teams. A literature search was carried out to explore current use of acuity/dependency scores and identified an Australasian hospice nursing acuity tool. This was subsequently adapted for our unit.

Aims To create a tool which gives an objective view of the complexity of the patients in a hospice inpatient unit. To use this tool in admissions meetings to aid communication and decision making around capacity to admit. To evaluate the use of this tool after a pilot. To review our inpatient admission guidelines accordingly.

Method Each morning before 9am and each afternoon before 3pm, the complexity score will be calculated by the nurse in charge of the inpatient unit using the acuity tool. This score will then be shared in the admissions meeting, alongside bed and staffing status. It is anticipated that this score will be most useful in the decision of whether or not to admit emergency same day inpatient requests, which understandably cause heightened concern amongst staff. The complexity score will be an objective measure of whether the admission can be achieved safely.

After three months of using this in the admissions meeting, a survey will be sent to staff members involved in the admissions process to understand whether this has been helpful in understanding the ward complexities and aiding decision making in admissions meetings.

Results Interim informal feedback from staff is positive.

Background Despite the NHS having safe staffing reporting requirements in place since 2014 (NHS England. 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 quantity and capability [Internet] 2013; Francis. The Mid Staffordshire NHS Foundation Trust Public Inquiry [Internet] 2013), this has not been applied to hospices. There are also no specific staffing standards for hospice inpatient units.

Aims To provide quality assurance on staffing levels within the hospice inpatient unit. To obtain intelligence on bed occupancy, demand, and capacity, and our ability to support the wider health and care system in relation to specialist palliative and end-of-life care.

Method A retrospective audit was performed over 6 months (Nov. 2022 to Mar. 2023) collecting actual nursing and health care assistant staffing numbers against planned staffing levels. This was reviewed against numbers of patients and the standard calculation for Care Hours Per Patient Day (CHPPD) was applied.

Results We were safely staffed within our budgeted staffing establishment for registered and unregistered workforce, and expectations on hours filled. Nights were better staffed than days due to more set patterns of working for that group of staff. There was an average of 16 CHPPD received by patients and their families. Lower staffing levels aligned with lower bed occupancy, suggesting we flexed our staffing to meet clinical need and demand on services. There was no impact on our ability to achieve other deliverables, including time from referral to admission.

Staffing levels demonstrate that we could have potentially taken more admissions on occasions, had the demand for inpatient beds been present showing we can support the systems in which we operate.

Discussion We recognise that safe staffing is only a tool, and for it to be fully effective (Royal College of Nursing. Impact of staffing levels on safe and effective patient care: literature review [Internet] 2023), it needs to be reviewed alongside additional information such as adapted dependency tools (NHs England. Safer nursing care tool [Internet] (no date)) and capacity and demand information. We have committed to continuing to review this information, including an annual report, and will adapt other national tools for our use as they become available.