Royal College of Nursing

Nursing assessment and older people

A Royal College of Nursing toolkit

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First revision

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Contents

1 Introduction

Older people have increasingly been the focus of health and social care policy (DH, 1999, 2001, 2003; DSSSP, 2002, 2004; WAG 2003 a & b; Scottish Executive, 2001 a & b, 2002). Health and social care policy impacts significantly on older people, and in particular on their continuing care needs. Changes in the boundaries of health provision and pressures for cost containment have profoundly affected older people as well as service providers.

Many older people have found themselves means-tested for services that have historically been provided free of charge. Arrangements for NHS-funded nursing care for older people (DH, 2003) limits the money available in England by the use of a formula that interprets low, medium and high need. In Wales and Scotland a contribution to the cost of care is paid.

The RCN supports the principles of a multi-agency approach to assessment, like, for example, the single assessment process (SAP) (DH, 2002b) and the national service framework (DH, 2001). However, any multi-agency approach needs to reflect, in both its structure and process, good, contemporary nursing practice. The introduction of the registered nursing care contribution (RNCC) in England (DH, 2001) requires nurses to calculate registered nursing time within a prescribed framework.

This RCN assessment tool was initially developed to assist nurses in the identification and articulation of their contribution to the health and social wellbeing of older people. This new edition aims to continue with that aim, in the light of contemporary health and social care policy developments.

The tool is the first of its kind to focus on determining the level and type of registered nursing input needed by an individual older person. It has been developed by expert gerontological nurses to identify the specific areas where nursing is needed and to provide evidence to justify the required nursing intervention.

This booklet:

- explains why nursing assessment is important
- describes the role of the expert nurse in the care of older people
- outlines how the debate about continuing care affects the nursing care of older people
- draws on the work of a 1997 RCN report, *What a difference a nurse makes* (RCN, 2004a) on the benefits of expert nursing to the clinical outcomes in the continuing care of older people
- explains each of the tool's five stages, including the rationale that underpins them.

Primarily intended for use by registered nurses who are undertaking an assessment of an older person currently in a care home, it may also be used by nurses working in the community and in hospitals to assess an older person's need for nursing care.

Included in this publication are some simple tables that provide you with a key to some of the questions asked. In addition, examples and case studies are provided to show how the tool might be used in your everyday work.

2

About this assessment tool

This RCN assessment tool enables:

- comprehensive assessment of an older person's health status
- identification of the need for input by a registered nurse, through the application of a stability/predictability matrix
- an estimate of the level of nursing intervention needed
- an estimate of the number of registered nurse hours required, through the use of a scoring formula
- identification of evidence to support decision-making and practice.

Designed to be used as part of the overall assessment of a resident in a care home, it can be used to contribute to the SAP process and the funded nursing determinations. Continuing its primary intention, it can also be used to develop nursing care plans that are person-centred and that facilitate best nursing practice. The tool will assist nurses to both articulate and quantify the nursing contributions to care, within the context of contemporary good practice. It is not meant to be used in isolation, but rather as the nursing component to the multi-disciplinary assessment of need in older people.

The tool links with the framework for outcome definition developed by expert gerontological nurses and outlined in *What a difference a nurse makes*. The framework was formulated from the work of Seedhouse (1986) and Kitwood (1997), evidence of good practice and a review of the literature on the care of older people. It promotes the concept of holistic care and the aim that older people live as independent a life as possible (RCN, 1996).

As a result, this assessment tool offers a nursing framework for decision-making by nurses that encompasses a comprehensive range of essential care components. For example, the tool could be used to identify a nursing intervention that could stabilise or monitor a health problem, so enabling an older person to follow their chosen lifestyle as closely as possible.

Primarily for use in care homes, this tool assumes that nursing care will be delivered within a nursing framework. However, it seeks to make effective use of all available skills and resources. There is no intended suggestion of exclusivity in the nursing input within any of the categories. Sometimes a nursing intervention will result in the disappearance of the need for nursing care. The 'no nursing' option can be selected in any category, or the decision made that, rather than delivering the care directly, a registered nurse is needed to manage a specific aspect of care or to supervise others.

Finally, while the tool aims to guide nurses to the need for specific specialist assessment, it is only part of an assessment process that must take as its starting point the biography of the older person. Within this tool, ethnicity and culture are seen as integral components of every category.

3 Nursing and older people

Individuals who need continuing care have inter-related health and social care needs. Nurses have long argued that distinctions between the two are unworkable (RCN, 1993 a & b, 1995, 2004a).

The SAP is intended to ensure that older people receive appropriate, effective and timely responses to their health and social care needs and that professional resources are used effectively (DH, 2002b).

The challenge for nurses in articulating their distinct contribution to the overall care of older people has been that much of their work is invisible - it is not directly observed. These 'hidden' aspects (McKenna, 1995) can encompass highly intricate assessment, detection, monitoring and evaluation techniques, as well as subtle communication skills, which can help a patient to balance their health needs with their chosen lifestyle.

Nurses use clinical judgement to enable older 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 (RCN, 2003).

Further, nurses work in partnership with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team. Where appropriate they will lead the team, prescribing, delegating and supervising the work of others. At other times they will participate under the leadership of others, but always remaining personally and professionally accountable for their own decisions and actions (RCN, 2003).

In the drive for cost containment in services, it is often suggested that 'nursing care as a product is highly simplified by non-nurse buyers not possessing a clear idea of what professional nurses can/should do and how it differs from less skilled, cheaper labour… these health care managers may accept unfounded assumptions and myths about nursing costs, care-giver mix and nursing productivity' (Patterson, 1995). But 'if we cannot name it, we cannot control it, finance it, research it, teach it, or put it into public policy' (Clark J and Lang N, 1992 in *Defining nursing*, RCN, 2003).

As key providers of health and social care, nurses have come under increasing scrutiny from policy makers and service providers (Bagust and Slack, 1991; Buchan and Ball, 1991; Bagust, Slack and Oakley, 1992; Carr-Hill, Dixon and Gibbs et al, 1992; Buchan, Seccombe and Ball, 1997; Savage, 1998; Needleman et al, 2002). This extensive work demonstrates that nursing is a cost-effective service, particularly when registered nurses are present in sufficient numbers within the skill mix. The same studies also show that nursing interventions can result in significant positive patient outcomes.

4 The role of assessment

Systematic and sensitive assessment has been a key requirement of government policy in primary health and community care. A multi-agency and multi-disciplinary partnership enhances patient care, prevents the waste of valuable resources, and could have a positive impact on the whole of the health and social care system for older people.

Joint NHS and social services assessment is viewed as a necessity to enable successful hospital discharge and should not only be offered before entering a care home. A successful multi-agency assessment will prevent delayed hospital discharge.

In the face of the converging reliance on care management and the targeting of public funding, assessment has increasingly become an important policy tool (Challis et al, 1996). Much of the research and debate has focused on the role of assessment in relation to placement (Peet, Castle, Potter et al, 1994).

It is the view of the RCN that nurses in all settings will continue to work collaboratively with colleagues in the development and delivery of integrated, 'joined up' assessments. However, it is also the view of the RCN that nurses will continue to need a nursing assessment tool to guide their day-to-day nursing practice, in keeping with their professional accountability and responsibility to older people.

In its policy development work, the RCN has focused on the need for nursing care, rather than the location of care delivery (RCN, 1993 a & c, 1995, 2004a). Evident throughout has been absence of a tool that articulates the specific need the older person may have for an intervention from a registered nurse.

Assessment strategies in nursing have been influenced by the problem-solving framework of the nursing process and nursing models. Assessment of need is integral to the care process and has received much attention in relation to the establishment of eligibility criteria for long-term care. Few people would dispute the assertion that good quality and effective care for older people is influenced by the use of comprehensive, client specific assessment (Rubenstein, Calkins and Greenfield et al, 1988). The quality of assessment will be greatly enhanced by the participation of the client and carers to the assessment process ensuring that the client's wishes are foremost and, wherever possible, the client's own words are used to reflect their needs.

Assessment is a multi-disciplinary activity, and a range of instruments has been developed. These include the index of independence in activities of daily living (Katz and Stroud, 1963), the Barthel index, (Mahoney and Barthel, 1965) the Crighton Royal behaviour rating scale (Wilkin and Jolley, 1979), the Clifton assessment procedures for the elderly (Pattie and Gilleard, 1979), the general health questionnaire (Goldberg, 1972) and the geriatric mental health state schedule (Copeland, Kelleher and Keller et al, 1976).

A number of assessment tools have attempted to measure outcomes in care in terms of quality of life, but this has remained elusive to define and difficult to measure (Bowling, 1991 and 1995; Fletcher, Dickinson and Philip, 1992).

Some tools have been developed specifically to assess need, dependency and quality, for example:

- *Monitor: an index of the quality of nursing care for acute medical and surgical wards* (Goldstone, Ball and Collier et al, 1984)
- *Senior monitor: an index of quality nursing care for senior citizens of hospital wards* (Goldstone, Maselino and Okai et al, 1986)
- *Nursing home monitor II: an audit of the quality of nursing care in registered nursing homes* (Morton, Goldstone and Turner et al, 1992)
- *Criteria of care* (Ball and Goldstone, 1984)
- *REPDS* (Fleming and Bowles, 1984)
- *Quality of patient care scale (QUALPACS)* (Wandelt and Ager, 1974).

While such dependency tools can help to identify need for care, they do not assist in articulating the specific need for nursing. The RCN believes this is one of the reasons why it has been impossible to separate the social care needs of older people from their health care needs. In *Selecting and applying methods for estimating the size and mix of nursing teams*, Hurst et al (2002) examine the contribution of 43 articles, books and

reports that address the special issues of nursing older people for nursing workforce planners.

Nolan and Caldock (1996) believed that any framework for assessment should be:

- flexible and able to be adapted to a variety of circumstances
- appropriate to the audience it is intended for
- capable of balancing and incorporating the views of a number of carers, users and agencies
- able to provide a mechanism for bringing different views together, while recognising the diversity and variation within individual circumstances.

5 The role of the nurse

Older people's continuing care needs are met in a variety of settings, including their own home, supported housing, residential care, a nursing home or hospital. At some stage many older people are likely to require registered nursing care.

Older people in hospital or who live in care homes are likely to be vulnerable. Indeed the RCN would argue that if older people are vulnerable enough to require placement in a care home, then it is likely that some level of nursing intervention will be needed. The role of the nurse as an enabler of health in older people is crucial in continuing care settings (RCN, 2004a).

In a care home, registered nurses have multiple roles that reflect the diverse nature of nursing. Different functions that contribute to the optimum health and overall wellbeing of older people include:

- supportive - including psychosocial and emotional support, assisting with easing transition, enhancing lifestyles and relationships, enabling life review, facilitating self-expression and ensuring cultural sensitivity
- restorative - aimed at maximising independence and functional ability, preventing further deterioration and/or disability, and enhancing quality of life. This is undertaken through a focus on rehabilitation that maximises the older person's potential for independence, including assessment skills and undertaking essential care elements, for example, washing and dressing
- educative - the registered nurse teaches self-care activities - for example, self-medication - health promotion, continence promotion and health screening. With other staff, the registered nurse engages in a variety of teaching activities that are aimed at maximising confidence in competence and continuously improving the quality of care and service delivery
- life-enhancing - activities that are aimed at enhancing the daily living experience of older

people, including relieving pain and ensuring adequate nutrition

- **managerial** - the registered nurse undertakes a range of administrative and supervisory responsibilities that call for the exercise of managerial skills. Such responsibilities include the supervision of care delivered by other staff and the overall management of the home environment.

(RCN, 1996)

The knowledge, skills and experience of nurses

Registered nurses have:

- **Broad empirical knowledge**
  This derives from the fundamental sciences from which nursing is synthesised - such as philosophy, physiology, sociology - from nursing knowledge and research, or from an allied profession, such as medicine, pharmacology or ergonomics.
- **Tacit knowledge**
  This enables nurses to act on hunches or intuition and engage in holistic problem solving. This can be particularly significant in unpacking the complexities of change in the health of older people.
- **Broad experience**
  This enables nurses to recognise similarities in patterns of events from previous encounters with older people. Registered nurses recognise the subtle changes in an older person's health status, understand the potential consequences and then act appropriately.
- **A broad range of skills**
  In everyday practice, registered nurses use a variety of skills including:
  - Observation - for example, recognising significant changes and formulating opinions
  - Psychological – for instance, interpersonal communication with residents, their families and colleagues
  - Supporting, encouraging, facilitatory and counselling skills
  - Reflecting, challenging and giving constructive feedback.

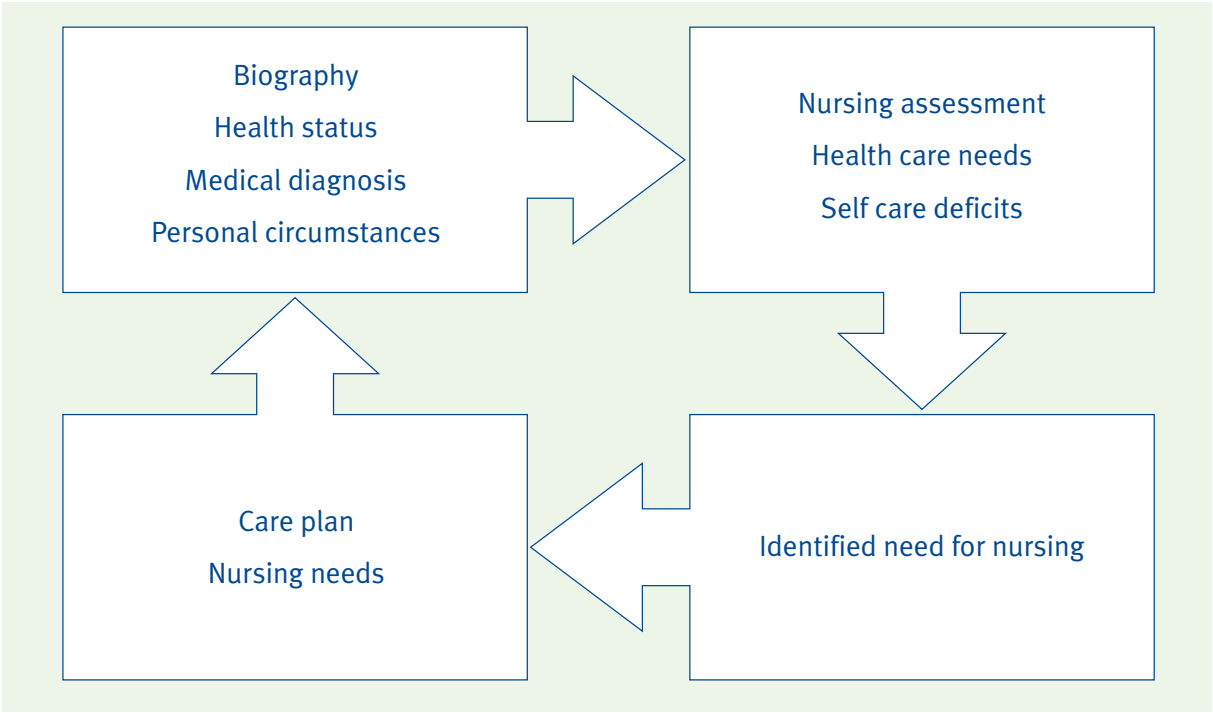
6 Nursing and assessment

In general, outcome measurement has focused on a health gain or health maintenance score, or an overall wellbeing result (French, 1997). However, because quality of life is difficult to define and even more difficult to measure - particularly with physically and mentally vulnerable people - outcomes from nursing in continuing care are not easily articulated (RCN, 2004a). The focus of the RCN's assessment tool is therefore on increasing quality of life, rather than perceiving health gain simply as increased longevity.

Assessment is considered to be the first step in the process of individualised nursing care. It provides information that is critical to the development of a plan of action that enhances personal health status. It also decreases the potential for, or the severity of, chronic conditions and helps the individual to gain control over their health through self-care.

Assessment of older people requires a comprehensive collection of information about the physical, biological, psychosocial, psychological and functional aspects of the older person. It will enquire into physiological functioning, growth and development, family relationships, social networks, religious and occupational pursuits. (DH, 2002b). It is vital that the health assessment includes a thorough appraisal of what are commonly referred to as 'activities of daily living'. The RCN believes that this must be linked to the overall health assessment. Nurses should relate the person's ability to undertake daily living activities to an assessment of health status, which is linked to medical diagnosis (Figure 1). The key throughout is the individual's biography and personal circumstances.

Figure 1: A framework for assessing the needs of older people



The more expert the nurse, the more speedy and accurate are their judgements and predictions (Benner and Wrubel, 1989). Studies that distinguish between the ability of expert nurses and novice nurses in relation to assessment and decision-making have helped identify the nature of expert assessment in relation to practice outcomes. (Benner, 1984; Benner, Tanner and Chesla, 1992).

For the purpose of this work, nursing is defined as 'a service for older people who have their nursing needs identified by a nurse, receive that care either directly or under the supervision and management of a nurse' (RCN/ Age Concern, 1997). Nurses must be registered by the Nursing and Midwifery Council (NMC).

Both the RCN and Age Concern believe that, in the interests of equity and economy, long-term nursing should be funded for all older people who need nursing care.

Clearly many older people have care needs, but not all need their care to be given or supervised by a registered nurse. Care is provided by a mixed workforce. The cost of that care can best be determined by establishing skill mix weightings. Therefore the RCN's assessment tool provides a code to skill mix – the level of nursing intervention required and the number of hours. It has been designed to assist both commissioners and providers in costing more accurately nursing care for older people. In order to achieve this there is a need to articulate the processes involved in 'expert' nursing with older people, and a need to identify the criteria for the measurement of effective practice.

7

The five stages of the RCN assessment tool

The completion of all the stages of the RCN's assessment tool ensures that the decision-making process is explicit and transparent, illustrating the contribution of expert nurses to the care of older people. Together, the stages result in a holistic assessment of the nursing needs of an older person.

The importance of the older person's contribution to the assessment cannot be over-emphasised. It is vital that the client and their carer are involved in its completion. If the person being assessed is unable to contribute - for example because of lack of mental capacity - the views and experiences of their carers should be taken into account.

The assessment tool is intended to inform everyone involved in the care of an older person - including informal carers and the client themselves - of the process leading to a care plan. To that end, it should be written in simple, easy to understand language. Wherever possible it should include the words and phrases used by the client and their carer.

Stage 1

Background

This stage assesses the older person's health status through essential care components and categories of ability or need. It can be used alone to formulate a care plan.

There are three essential care components:

- maximising life potential
- prevention and relief of distress
- maintenance of health status.

These are based on Seedhouse's (1986) concept of health as 'potential', and derived from the domains of the RCN framework for outcome definition in the care of older people, outlined in *What a difference a nurse makes*. They generate up to 25 categories of ability or need that can be used to assess an individual's complex health status.

How it works

Within each category of need, five descriptor statements distinguish varying levels of an older person's ability or disability, and their need for care. The headings are:

Essential care component 1 – maximising life potential

Categories: Personal fulfilment
Spiritual fulfilment
Social relations
Sexuality
Cognition

Essential care component 2 – prevention and relief of stress

Categories: Communication
Pain control
The senses
Memory
Orientation
Loss, change and adaptation
Behaviour
Relatives and carers

Essential care component 3 – promotion and maintenance of health

Categories: Personal hygiene
Dressing
Motivation
Sleeping
Mobility
Elimination of urine and faeces
Risk
Eating and drinking
Breathing
Emotion

Within each category, the nurse should assess the older person, selecting the most appropriate descriptor, using the letters A, B, C, D or E, for the individual's abilities or disabilities and their needs for care. This letter should be placed under the appropriate stability/predictability column – as assessed in stage 2.

Not all statements within the selected descriptor may be relevant to the individual, but the nurse should select the statement that most closely represents their abilities and needs – in other words, the best fit.

At the end of the assessment form, there is space for three additional categories. These can be used for specific interventions that the assessor believes cannot be captured within other categories. For example, a resident may require frequent assessment and treatment by a registered nurse because of a wound, or may require frequent assessment and administration of medication to control pain during an acute or terminal illness.

These additional categories will also include problems not referred to in the main text of the assessment - such as falls, managing medication, or specific issues relating to financial management. Wherever possible, needs such as wound care, self-medication or stoma care should be assessed within the 23 pre-set categories. However, where this is not possible, then the 'extra' blank categories should be labelled and used accordingly.

Stage 2

Background

This stage assesses the stability and predictability of a person's health status by applying a matrix, which acts as the trigger for potential registered nursing input. This would be in the form of both preventive and reactive nursing interventions. This second stage is perhaps the most complex, as it analyses how an individual's care needs might be met – in other words, what skills, knowledge and expertise are required.

The stability and predictability matrix has been specifically devised to acknowledge and encompass the complex factors that influence health status in older age. For example:

- the physical processes of ageing can cause instability in various body systems at any one time
- multiple pathologies are usually present. Older people entering the health care system commonly have upwards of four medical diagnoses
- diseases present differently in older age, making recognition and diagnosis more complex
- older people tend to be prescribed more drugs, and to more commonly experience adverse drug reactions (ADRs) which may present differently in younger people
- older people's personal adaptation to life changes - and the changes associated with moving into communal living – create the need for management of transition
- older people's individual responses to day-to-day situations are based on their personality and life experiences.

While some factors might be stable at any one point in time, not all of them will be. The instability of various factors at different times complicates the situation. Individuals also react psychologically and physiologically to changes in health status in ways that can be predictable or unpredictable.

Added to this, once any of these influences on an older person's health begin to become unstable, a domino effect can be set off. This may exacerbate an already precarious homeostasis that results in a rapid deterioration in health.

You may find the following definitions useful:

- stable – health or disease processes are in a steady state and likely to remain so, providing correct treatment and care regimes continue
- unstable – a fluctuating disease process resulting in an alternating health state and requiring frequent or regular intervention or treatment
- predictable – a person's response to internal and/or external triggers can be anticipated with some certainty, through established interventions and regularly reviewed care plans
- unpredictable – a person's response to internal or external triggers cannot be anticipated with any certainty. Continuous assessment, care planning, intervention and review are required.

How it works

Place the descriptor code letter - A, B, C, D or E – that you assessed in stage 1 under the appropriate stability and predictability column.

Some examples

The following examples demonstrate how stability and predictability can be assessed within specific categories. The examples deal with four different women in a nursing home. Each is trying to retain her independence, despite a series of strokes and multiple disabilities.

It might be assumed that each woman has the same nursing needs. However, by making decisions about the stability of each individual's health, and the predictability of her responses, the need for nursing intervention becomes clear in each case.

Example 1 – stable and predictable

Category – social relations

This resident actively seeks and enjoys social contact. She openly acknowledges her physical difficulties and jokes with other residents about them. In this category, she would be assessed as stable and predictable.

Category – eating and drinking

Despite some speech difficulties, this resident is able to make and express choices in food and drink. She generally enjoys food, and although she takes longer to eat than other residents at the table, she engages their patience until she finishes her meal. In this category, she would be assessed as stable and predictable.

Example 2 – stable but unpredictable

Category – social relations

This resident actively seeks and enjoys social contact but sometimes becomes very upset by this. There is no apparent pattern to her emotional upset and so far it has not been possible to predict when this might happen. In this category, she would be assessed as stable but unpredictable.

Category – eating and drinking

Despite speech difficulties, this resident is able to make and express choices in food and drink. She enjoys her food but will occasionally choke, usually when she becomes embarrassed and tries to eat as quickly as other residents at her table. She then intermittently becomes distressed. In this category, she would be assessed as stable but unpredictable.

Example 3 – unstable but predictable

Category – social relations

This resident has enjoyed playing bridge for years but has recently experienced transient ischaemic attacks during which she loses touch with reality. She acknowledges her deterioration but is determined to continue playing bridge. Despite dysphasia, she jokes that there are worse places to die than at the bridge table. In this category, she would be assessed as unstable but predictable.

Category – eating and drinking

This resident is able to make and express choices, but sometimes does not have the clarity of thought to do so. Her swallowing reflex is not reliable and she often chokes. Although obviously frustrated at these changes, she usually tries to eat and sometimes glances at the feed aids as if to say, 'Oh well, this is what it's come to'. In this category she would be assessed as unstable but predictable.

Example 4 – unstable and unpredictable

Category – social relations

Although this resident has always enjoyed social contact, her transient mental 'absences' and unstable physical disabilities are making this progressively difficult. She has begun to become frustrated and angry at these changes, and is often aggressive with other people. It can be difficult to calm her. In this category, she would be assessed as unstable and unpredictable.

Category: eating and drinking

This resident is sometimes able to make and express choices in food and drink, but often does not have the presence of mind or the interest to do so. Her swallowing reflex causes frequent choking which frustrates her greatly. Often she refuses food and drink, despite sensitive encouragement and support. In this category, she would be assessed as unstable and unpredictable.

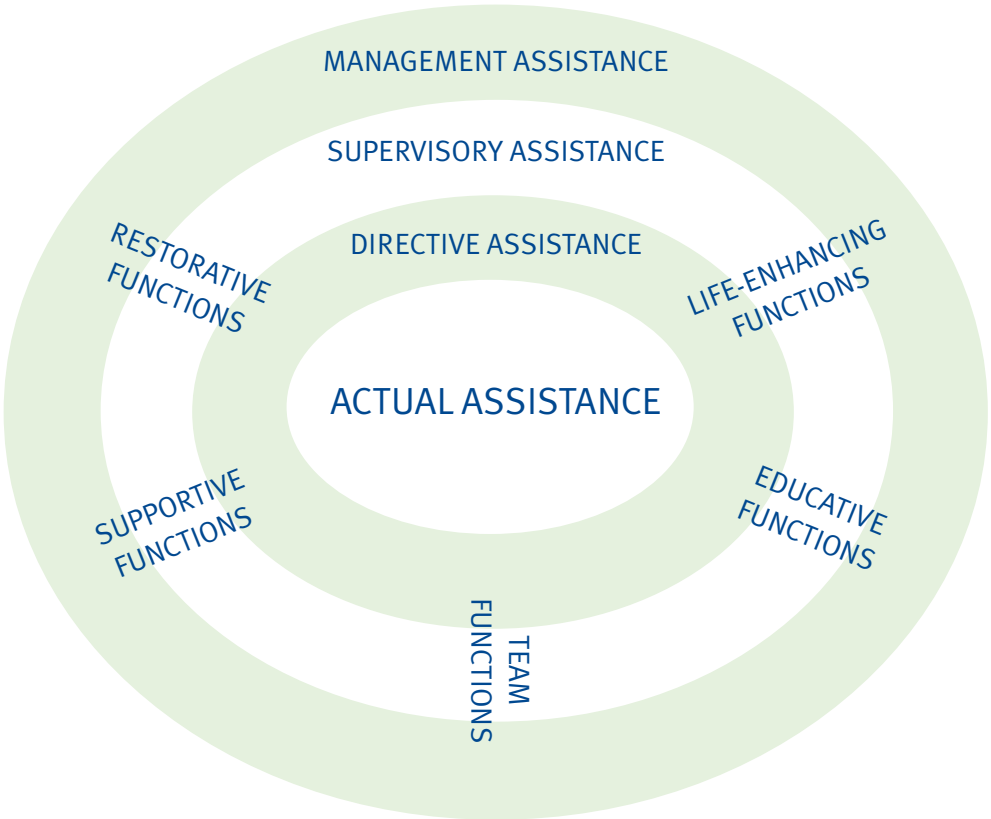
Stage 3

Background

This stage assess the level and frequency of input by a registered nurse, determining what form the nursing input will take, including a 'no nursing' option. It defines the level of nurse intervention, differentiating between management, supervising and actual or directive care giving roles. It does this by measuring the need for four types of assistance that reflect the degree of engagement between the nurse and the older person. These are:

- actual - the registered nurse directly engages with the resident and/or significant others, undertaking clinical/technical or therapeutic activities on the resident's behalf
- directive - the registered nurse uses teaching, guiding, advisory and supportive interventions as part of the rehabilitation/maximising potential/re-enablement of the resident and/or significant others
- supervisory - the registered nurse monitors or guides care without frequent direct engagement with the patient and/or significant others
- management - the registered nurse either manages a specific, stand alone care intervention on an intermittent basis, or the service, which delivers nursing on a continuous basis.

Figure 2: Model illustrating nursing assistance



How it works

Each type of assistance carries a score:

- 0 = no nursing
- 1 = management
- 2 = supervision
- 3 = actual
- 4 = directive

Determine the level of nursing intervention needed to meet nursing care need for each category. Once this has been identified, place the score number in the box directly beneath the appropriate heading and alongside the category.

When the level of assistance within each category has been identified the scores can be aggregated to assist in workforce planning – see the box on page 14.

Stage 4

Background

This stage identifies the number of registered nurse hours required, through the use of the registered nursing indicator.

A review of the literature and expert opinion informed the process of developing this tool's scoring system. Existing assessment tools were analysed in order to establish the principles on which the level of nursing intervention was determined. The review demonstrates that *Criteria of care* (Ball and Goldstone, 1984) are established on similar principles to the RCN's assessment tool.

In the *Criteria of care* formula, different aspects of care are awarded different weightings – in other words, number of hours. Research concluded that the maximum contact between a patient and a registered nurse was 8.8 hours during a 24-hour period. This was calculated through continuous observation of nursing over 24 hours and through an analysis of different types of nursing activity - direct care versus indirect care.

The researchers highlighted four levels of 'patient dependency'. They also identified maximum contact between nurses and patients for each level of dependency.

Dependency level I	= 1 hour
Dependency level II	= 1.2 hours
Dependency level III	= 2.5 hours
Dependency level IV	= 4.1 hours

Using this formula, a scoring system was developed for the RCN's assessment tool. To allow for the addition of a 'no nursing' score, five score ranges were developed. Scores were calculated by dividing the total possible assessment score achievable (100) by the maximum number of hours of contact with a registered nurse (8.8 hours). For example, if in each of the 25 care components, an older person is assessed as needing the highest level of nursing care - which carries a score of 4 for each care component. Thus 25 x 4 = 100.

Working with this formula the score ranges were set at intervals of 11 and calculated according to the weightings - maximum contact time in hours - from *Criteria of care*.

The registered nursing indicator

Assessment score	Registered nursing input
0	= 0 hour
1-11	= 1 hour
12-23	= 1.2 hours
24-48	= 2.5 hours
49-100	= 4.1 hours

As the RCN's assessment tool focuses on ability rather than dependency, the scoring system positively rejects dependency in favour of working towards independence. To this end, it is weighted to reflect the nursing role in maximising potential. Extensive piloting demonstrates results that clearly validate the tool's scoring system.

How it works

After completing stages 1 to 3, you can begin to calculate the scoring by:

- adding the nursing intervention score for all the descriptors in each of the three essential care components using the summary assessment sheet
- adding the three sub totals to achieve one overall total
- checking the total alongside the registered nursing indicators
- checking that the registered nursing indicator score equates to a number of hours
- inserting the number of hours of registered nurse intervention that is required each 24 hours.

Workforce planning

You can use the RCN's assessment tool to help you with workforce planning and time management. The formula will enable you to work out the number of hours spent on management, supervision, actual and directive nursing.

To calculate how the total nursing input is divided up, first convert the total registered nursing input from hours to minutes - multiply by 60. Then add up the nursing input for each level of intervention - management, supervision, actual and directive.

To work out the number of minutes spent on management each 24 hours, divide the score for management by the total assessment score and then multiply input, in minutes. Using the same calculation – the workforce planning formula – this exercise can then be repeated for supervision, actual and directive nursing.

Workforce planning formula

$$\frac{\text{total score for each nursing intervention}}{\text{total assessment score}} \times \text{total registered nursing input (in minutes)} = \text{number of minutes spent on each nursing intervention (per 24 hours)}$$

The following example shows how you can calculate the number of minutes spent on 'actual' nursing when the scores for actual nursing add up to 9 and the total assessment score is 37. Using the registered nursing indicator, we know that the total registered nursing input is 2.5 hours.

- First calculate the registered nursing input in minutes:
  2.5 hours x 60 = 150 minutes
- Using the actual nursing score - 9 - apply the workforce planning formula:
  $\frac{9}{37} \times 150 = 36.5$ minutes
- So in every 24 hours, the resident needs $36\frac{1}{2}$ minutes of actual nursing care.

8 Conclusion

Stage 5

Background

This final stage provides the evidence for decision-making and practice – encouraging nurses to collect evidence to support the decisions they have made. This could include research in support of the decision, knowledge gained from working with the resident or the preferences of an individual resident.

How it works

Review your decision-making through the process of the assessment. It is important to remember that the resulting assessment may differ from your current perception of the number of hours of nursing available. In other words the assessment may indicate that you need more or less nursing hours that are currently available. Identify the evidence that supports your decisions and your intended practice.

When identifying evidence it is useful to consider levels of 'best evidence'. Is there robust research or knowledge gained from working with the resident? Have they expressed preferences that support your decisions?

This assessment tool can be used to:

- contribute to the generation of a care plan
- identify the need for registered nursing involvement
- define the precise nature of that involvement
- state the hours of registered nursing required for each of the residents
- state the hours needed on different elements of nursing intervention for each resident
- act as a trigger for further specific assessment – for example, pressure damage risk.

Additionally, each resident's assessment can be used as a workforce-planning tool. Individual assessment scores can be aggregated to achieve organisational scores that relate both to skill mix and staffing.

9

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Appendix: Assessment sheets

- Supporting information
- Essential care components
  1. Maximising life potential
  2. Prevention and relief of distress
  3. Promotion and maintenance of health status
  4. Spare care components
- Summary assessment

The following assessment sheets are intended to be photocopied. The sheets can also be downloaded and printed from the website at www.rcn.org.uk

When photocopying the sheets, please retain the RCN copyright logo.

Supporting information

Resident's name

Client's expectations

When completing the assessment, this tool is intended to reflect a person-centred approach throughout. Please add a statement that reflects the views, wishes, strengths, preferably using the client's own words.

Supporting information

Resident's name

Clinical background

Details of medical conditions and diagnosis.

Disease prevention history

History of blood pressure monitoring _____

Vaccination history _____

Drinking and smoking history _____

Exercise pattern _____

Health screening:

Breast _____ Prostate _____

Cervical _____ Cholesterol _____

Other _____

Immediate environment and resources at home

Location _____

Heating _____

Access _____

Amenities _____

Problems managing the home _____

Problems with access to local facilities and services _____

Financial management

Does the client have a problem with budgeting?

How much help does the client receive in managing money?

Essential care component

1 Maximising life potential

Resident's name

Category: Personal fulfilment	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	No nursing 0	Management 1	Supervision 2	Actual 3	Directive 4	Rationale/evidence
A. Independent in self-fulfilment.										
B. Needs encouragement to express needs and wants towards self-fulfilment.										
C. Needs assistance to achieve needs and wants.										
D. Needs assistance towards achieving fulfilment, or towards reconciliation of non-fulfilment.										
E. Non-fulfilment causing physical or mental distress requiring considerable intervention.										

Category: Spiritual fulfilment										Rationale/evidence
A. Independent in fulfilling spiritual needs.										
B. Needs some assistance with meeting spiritual needs.										
C. Needs someone to be present while spiritual needs are met, and/or assistance to fulfil religious rituals.										
D. Wants to fulfil spiritual needs and/or religious rituals, but unable to do so for physical or mental reasons.										
E. Disturbed about circumstances, seeks regular and constant spiritual comfort. Needs total assistance with meeting spiritual needs and/or religious rituals.										

Category: Social relations										Rationale/evidence
A. Relates well with others, mixes well, initiates and accepts social contact and/or prefers own company, or is indifferent to the company of others.										
B. Prefers own company, or indifferent to the company of others. Needs help to initiate communication.										
C. Relates well to a few people only, reserved. Appears to enjoy company but seems to lack confidence.										
D. Avoids or resists social contact and/or appears reluctant to communicate. Limited effective contact.										
E. Is withdrawn, or exhibits over-involvement. Exhibits disruptive or dysfunctional behaviour.										

Essential care component

1 Maximising life potential

Resident's name

Category: Sexuality	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Independent in fulfilling individual need to express sexuality through personal presentation, relationships or activities.										
B. Able to express sexuality independently. Requires some assistance with facilitating privacy, relationship opportunities or personal presentation.										
C. Needs assistance to express sexuality for e.g. personal presentation. Enjoyment of desired relationships requires management of the environment.										
D. Needs staff assistance in establishing appropriate environment to fulfil sexual needs and expression of sexuality. May need specialist assessment, such as from a psychosexual therapist.										
E. Exhibits significant challenging behaviour in respect of sexuality. May need therapeutic intervention and/or close supervision or support.										

Category: Cognition										Rationale/evidence
A. Able to manage own affairs and make appropriate decisions with past, present and future in perspective. Can talk and/or present information in a clear logical manner and in context.										
B. Reasons and thinks adequately but has occasional difficulties with memory and/or making decisions.										
C. Able to think but has difficulty with memory and decision-making. Ability to reason inhibited, but is able to make decisions if offered limited options, guidance and reassurance.										
D. Unable to reason and think adequately without continuous support. Able to make decisions if offered limited options, guidance and reassurance.										
E. Unable to think or reason for self, or to make a decision. Needs constant compensatory actions.										

Essential care component

Resident's name

2 Prevention and relief of distress

Category: Communication	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	No nursing 0	Management 1	Supervision 2	Actual 3	Directive 4	Rationale/evidence
A. Communicates in their usual way. Is able to use their first language and/or express their views, needs and desires in a manner understood by most people,										
B. Is able to communicate verbally but non-verbal or emotional communication skills are not always congruent with verbal communication.										
C. Has developed a method of communication using verbal and non-verbal methods which require close attention by others. Able to communicate (their views and desires) in a lucid way, which usually needs some confirmation by the person listening.										
D. Experiences some difficulty in expression and/or comprehension which needs assistance, through understanding and interpretation and/or the use of aids/adaptations. Able to understand information given.										
E. Has limited or no communication. The communication may be conducted using aids, non-verbal signs and signals or monosyllables. The interpretation of needs and views is complex.										

Category: Pain control										Rationale/evidence
A. Pain free. Self caring in the management of pain.										
B. Experiences pain which they are able to manage and can ask when treatment is required.										
C. Experiences regular or protracted pain which cannot be managed unsupported, although needs can be expressed. Needs assistance, supervision or support in controlling the pain.										
D. Able to express verbally protracted pain, but unable to specify the type of pain or its effects. Requires a range of interventions to control pain.										
E. Unable to describe needs in respect of pain. The level of pain experienced can only be seen through behaviour, facial or bodily expression and emotional state. Requires complex interventions.										

Essential care component

2 Prevention and relief of distress

Resident's name

Category: The senses	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Independent in sensory function or able to compensate using other senses. Able to manage aids independently.										
B. Utilises all senses through the use of aids/adaptations. Assistance required in routine care of equipment.										
C. Senses significantly deficient. Needs assistance in using aids and adaptations.										
D. No benefit gained from any aids or adaptations, needs direction to undertake any personal or public activity.										
E. Unable to use one (or more) senses, or compensate for loss through adaptation or aids. Needs continuous support due to loss of ability to understand instruction, interpretation or description.										

Category: Memory										Rationale/evidence
A. Unimpaired memory, recall ability within usual pattern.										
B. Occasionally forgetful but easily reminded.										
C. Difficulty in recalling recent events, but can compensate through confabulation and needs supportive reorientation to clarify thinking. Does not appear distressed.										
D. Difficulty in recalling very recent events and spatial information. Some distress evident but reassurance is accepted. Intervention requires ergonomic, social and interpersonal memory cues. The risk to personal safety has to be assessed.										
E. Unable to recall events and spatial information. Repetitive speech present and high levels of prolonged distress evident. Needs continuous supervision in respect of ergonomic and social cues, and direct intervention to carry out a small level of personal care. Needs continuous risk assessment and management in respect of personal safety.										

Essential care component

Resident's name

2 Prevention and relief of distress

Category: Orientation	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Orientated to time, place and person and responds appropriately.										
B. Evidence of occasional disorientation and/or distress. Needs supportive information to clarify thinking.										
C. Needs regular orientation and psychological support to maintain functioning and/or prevent distress.										
D. Disorientated to time, place and person, with occasional distress. Needs continuous reassurance, as no appropriate cues are taken from the environment.										
E. Disorientated to time, place and person. Requiring constant reorientation and reassurance due to distress. Needs regular risk assessment and intervention.										

Category: Loss, change and adaptation										Rationale/evidence
A. Able to identify, express and adapt to circumstances.										
B. Is adjusting emotionally to circumstances and/or is positive about self image. Able to initiate interactions with others. Expresses emotions freely.										
C. Has not yet adjusted emotionally to circumstances and/or has a negative self image. Identifies in self that moods and emotions fluctuate, and is aware of the stimuli that cause this. Is able to express desire for emotional support.										
D. Has not yet adjusted emotionally to circumstances, resulting in a negative self image. Identifies in self that moods and emotions fluctuate, but is unaware of the stimuli that cause this. Is able to express desire for emotional support.										
E. Has not yet adjusted emotionally to state of dependency, resulting in a negative self image. Does not identify in self that moods and emotions fluctuate or the resulting behavioural effects. Is unaware of the stimuli that cause this and does not accept support freely.										

Essential care component

2 Prevention and relief of distress

Resident's name

Category: Behaviour	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Behaviour is appropriate within the context of individual culture and ethnicity, the current location and social interaction with others.										
B. Behaviour is appropriate within the context of individual culture and ethnicity, the current location and social interaction with others and guidance or support.										
C. Behaviour is appropriate within the context of individual culture and ethnicity, the current location and social interaction with others. Needs regular supervision to anticipate behaviour and responses.										
D. Has difficulty defining and displaying appropriate behaviour within the context of individual culture, the current location and social interaction with others. Behavioural response will vary according to the social stimuli needing skilled guidance, advice and support.										
E. Has difficulty in defining and displaying appropriate behaviour within the context of individual culture, the current location and social interaction with others. Actions and responses will vary even to the same stimuli. Needs regular intervention, support and management in order to protect self and others from the negative effect of challenging behaviour.										

Category: Relatives and carers										Rationale/evidence
A. Relatives and/or significant others are supportive and involved and appreciate the care needs. They actively participate.										
B. Relatives and/or significant others are supportive and appreciate care needs. They are not actively involved.										
C. Relatives and/or significant others need regular support and guidance in relation to accepting placement and identified care needs.										
D. Differences of views/needs/wants between relatives and/or significant others requires a high degree of management and sensitive support.										
E. Totally opposing views/needs/wants between relatives and/or significant others leading to conflict which needs management but may be unresolved.										

Essential care component

3 Promotion and maintenance of health status

Resident's name

Category: Personal hygiene	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Independent in attending to own hygiene needs										
B. Able to attend to own hygiene needs once necessary equipment has been arranged. Skin integrity is intact and is not at risk from damage.										
C. Needs some help to attend to own hygiene needs including the arrangement of necessary equipment. Skin integrity is intact but is at some risk from damage. Needs assistance with a bath/shower to maintain skin integrity and/or self esteem.										
D. Needs help with meeting hygiene needs including the arrangement of necessary equipment. Skin integrity is intact but is at high risk from damage. Has a bath/shower which needs to be fully supervised.										
E. Fully dependent on others to meet hygiene needs. Skin integrity is intact but is at very high risk. Needs complete assistance with bathing to help maintain skin integrity and self esteem.										

Category: Dressing										Rationale/evidence
A. Can dress appropriately with no assistance or supervision.										
B. Is able to identify and make choices about clothing preferences appropriate to environment and temperature. Has a disability that affects ability to dress independently. Once clothes have been placed within reach, can manage to dress, but may need help with fastenings or buttons. Uses aides to put on shoes and socks/stockings.										
C. Is able to identify and make choices about clothing preferences appropriate to environment and temperature. Has a disability that affects ability to dress independently. Needs clothes laying in the right order and requires help or supervision with dressing (including help with buttons/fastenings). Is unable to put socks/stockings and shoes on without assistance.										
D. Is unable to make choices about clothing preferences appropriate to environment and temperature. Has a disability that affects motivation and therefore is often unwilling/unable to assist in any way. Needs clothes laying in right order and requires prompting with dressing. Is unable to put socks/stockings and shoes on without assistance.										
E. Fully dependent on others to dress.										

Essential care component

3 Promotion and maintenance of health status

Resident's name

Category: Motivation	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1	2 Management	3 Supervision	4 Actual / Directive	Rationale/evidence
A. Is motivated to achieve daily living activities independently.										
B. Has a disability that affects performance of daily living activities. Is motivated to adopt to their environment by using aides and adjustments.										
C. Has a disability that affects performance of daily living activities. Is motivated to adapt to their environment by using aides and adjustments, but occasionally needs encouragement, prompting and reassurance.										
D. Motivation fluctuates due to changing health status and/or acceptance of disability. Needs regular and frequent prompting, encouragement and reassurance.										
E. Motivation appears to be absent due to significant disease processes.										

Category: Sleeping										Rationale/evidence
A. Maintains usual sleep pattern without assistance.										
B. Has an established sleep pattern that rarely alters according to external or internal stimuli. Has a routine that once adhered to results in achieving normal sleep. Needs support with adjusting environment to assist with achieving normal sleep.										
C. Has an established sleep pattern that rarely alters according to external or internal stimuli. Has a routine that, once adhered to, results in achieving normal sleep, but the quality of sleep is affected by emotional and physical wellbeing.										
D. Has an erratic sleep pattern that is affected by emotional and physical wellbeing. Does not have an established routine, but various interventions applied to achieve comfort result in achieving sleep. Needs help in the night and reassurance that someone is there to assist.										
E. Has an erratic sleep pattern that is affected by emotional and physical wellbeing. Does not have an established routine, but various interventions applied to achieve comfort result in achieving short periods of sleep. Restless throughout the night for a variety of reasons that are difficult to predict. Disorientated and requires help in the night and constant reassurance that someone is there to assist.										

Essential care component

Resident's name

3 Promotion and maintenance of health status

Category: Mobility	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	No nursing 0	Management 1	Supervision 2	Actual 3	Directive 4	Rationale/evidence
A. Independent with or without assistance or aids (including wheelchair). Able to manage steps/stairs independently.										
B. Able to get out of chair and bed without assistance. Walks with an aid or assistance, but needs reminding to use it. Is aware of obstacles to safe mobility and dangers to personal safety.										
C. Able to get out of chair and bed without assistance but ability to mobilise fluctuates. Walks with a frame, but needs supervision. Is aware of obstacles to safe mobility and dangers to personal safety.										
D. Unable to get out of chair and bed without assistance and/or ability to mobilise fluctuates. Walks with assistance and/or aide. Is unaware of obstacles to safe mobility and dangers to personal safety.										
E. Unable to get out of chair and bed without full assistance. Cannot stand or walk without physical support. Is unaware of obstacles to safe mobility and dangers to personal safety. Spends most of the time in a chair or bed and is at risk of developing complications due to immobility.										

Category: Elimination of urine and faeces										Rationale/evidence
A. Attends to elimination needs independently and/or is continent.										
B. Is aware of need to eliminate urine and/or faeces. Some dribbling incontinence but is able to change own pads which are used for security. Needs assistance from one person to get to the toilet but is able to attend to own needs once there.										
C. Is aware of need to eliminate urine and/or faeces. Inability to manage own toileting, including selecting an appropriate environment. A regular and planned continence programme minimises periods of incontinence to less than once weekly.										
D. Is aware of need to eliminate urine and/or faeces. Needs assistance from one person to get to the toilet, but does not respond to stimuli resulting in periods of incontinence. Does not respond to continence programme without supervision.										
E. Is unaware of need to eliminate urine and/or faeces due to loss of sensation and muscle tone and/or mental state, resulting in an inability to manage own continence. Has periods of incontinence. Level of disorientation requires constant supervision of continence programme.										

Essential care component

Resident's name

3 Promotion and maintenance of health status

Category: Risk	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Is able to assess themselves and the situation and make an informed decision about the degree of risk to self and others. Feels safe in a social group, surroundings or environment.										
B. Is able to assess themselves and the situation and make an informed decision about the degree of risk to self and others. Does not feel safe or is unsafe in a social group, surroundings or environment and needs regular support.										
C. Is aware of surroundings and dangers to personal safety, but is unable to make safe decisions and/or take appropriate action to maintain safety for self and others.										
D. Is aware of surroundings and dangers to personal safety but unpredictable health status leads to heightened potential for making unsafe decisions and/or an inability to take appropriate action to maintain safety for self and others. Needs supervision to perform certain activities and/or tasks.										
E. Is unaware of surroundings and dangers to personal safety leading to an inability to make safe decisions. Is unable to assess themselves and the situation and make an informed decision about whether they are at risk or at risk to others. Does not feel safe in a social group, surroundings or environment.										

Essential care component

Resident's name

3 Promotion and maintenance of health status

Category: Eating and drinking	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Is able to identify and make choices about food and fluid preferences and the need to eat and drink according to hunger and thirst. Is able to manage own eating and drinking independently.										
B. With support is able to identify and make choices about food and fluid preferences and the need to eat and drink according to degree of hunger and thirst. Is able to manage own eating and drinking once food and aides have been arranged and positioned. At some risk of under nutrition.										
C. With assistance, is able to identify and make choices about food and fluid preferences and the need to eat and drink according to degree of hunger and thirst. Uses aides to assist with eating and drinking and needs supervision in their use. At risk of under nutrition.										
D. Is unable to identify and make choices about food and fluid preferences and the need to eat and drink according to degree of hunger and thirst. Uses aides to assist with eating and drinking and needs continuous supervision in their use. Has an established feeding programme which needs managing. At high risk of under nutrition.										
E. Is unable to identify and make choices about food and fluid preferences and the need to eat and drink according to degree of hunger and thirst. Needs complete assistance with eating and drinking. In order to maintain nutritional status has an artificial feeding programme which needs continuous supervision.										

Essential care component

3 Promotion and maintenance of health status

Resident's name

Category: Breathing	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	Rationale/evidence
A. Is able to attend to daily needs independently.										
B. Experiences breathlessness. Is able to make adjustments to assist with breathing and is independent in the use of therapeutic treatments, but requires support with their preparation.										
C. Experiences breathlessness. Differing trigger factors affect degree of breathlessness experienced, but is aware of limitations and how to manage these. Sometimes requires oxygen therapy. Needs assistance to make adjustments to environment to assist with breathing.										
D. Experiences breathlessness. Differing trigger factors affect degree of breathlessness experienced, but is unaware of limitations and how to manage these. Needs assistance with the use of therapeutic treatments and in adjusting environment to assist with breathing.										
E. Experiences breathlessness. Differing trigger factors affect degree of breathlessness experienced, but is unaware of limitations and how to manage these. Sometimes needs regular supervised oxygen therapy and is unable to ask for this. Needs full assistance in making adjustments to own environment to assist with breathing.										

Category: Emotion										Rationale/evidence
A. Able to express emotions freely and appropriately.										
B. Making adjustments emotionally to life status. Motivated and able to initiate interaction with others. Express emotions freely and appropriately.										
C. Has not yet adjusted emotionally to life circumstances. Identifies in self that moods and emotions fluctuate, but is aware of the stimuli that cause this. Is able to express desire for emotional support.										
D. Has not yet adjusted emotionally to life status. Identifies in self that moods and emotions fluctuate, but is unaware of the stimuli that cause this. Is able to express desire for emotional support.										
E. Has not yet adjusted emotionally to life status. Does not identify in self that moods and emotions fluctuate or the resulting behaviour. Is unaware of the stimuli that cause this and does not accept support freely.										

Essential care component

Resident's name

4 Spare care components

Please use the blank sections below for additional needs required by your clients

Category:	Stable and predictable	Stable and unpredictable	Unstable and predictable	Unstable and unpredictable	No nursing 0	Management 1	Supervision 2	Actual 3	Directive 4	Rationale/evidence
A. Independent in managing additional specific need. No staff involvement required.										
B. Needs assistance to manage specified need in relation to advice/guidance.										
C. Needs assistance to manage additional specified need independently but will participate.										
D. Is unable to manage additional specified need independently but will participate.										
E. Is fully dependent on others to manage additional specified need.										

Category:										Rationale/evidence
A. Independent in managing additional specific need. No staff involvement required.										
B. Needs assistance to manage specified need in relation to advice/guidance.										
C. Needs assistance to manage additional specified need independently but will participate.										
D. Is unable to manage additional specified need independently but will participate.										
E. Is fully dependent on others to manage additional specified need.										

Summary Assessment

Use this chart to summarise your assessment scores

Essential care component:	0 No nursing	1 Management	2 Supervision	3 Actual	4 Directive	
1 Maximising life potential						
Personal fulfilment						
Spiritual fulfilment						
Social relations						Sub total
Sexuality						
Cognition						
2 Prevention and relief of distress						
Communication						
Pain control						
The senses						
Memory						
Orientation						
Loss, change and adaptation						Sub total
Behaviour						
Relatives and carers						
3 Promotion and maintenance of health status						
Personal hygiene						
Dressing						
Motivation						
Sleeping						
Mobility						
Elimination of urine and faeces						
Risk						
Eating and drinking						Sub total
Breathing						
Emotion						
(Optional) Additional category						Sub total
(Optional) Additional category						
Workforce planning sub totals						

Resident's name

Nurse assessor _____

Date _____

Review date _____

Signature _____

Total assessment score

Registered nursing input per 24 hours ____ hours

x 60 ____ minutes

Workforce planning guide

Type of nursing	Total score	Registered nursing input (minutes per 24 hours)
Management		
Supervision		
Actual		
Directive		

Workforce planning guide formula

To calculate the nursing input for each area of care:

$$\frac{\text{Workforce planning sub total}}{\text{Total assessment score}} \times \text{Total RN input (in minutes)} = \text{number of minutes spent on each nursing intervention (per 24 hours)}$$

The registered nursing indicator

Assessment score		Registered nursing input
0	=	0 hours
1-11	=	1 hour
12-23	=	1.2 hours
24-48	=	2.5 hours
49-100	=	4.1 hours

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