

Ward closures

Shortages of staff and resources leave nurses in charge of wards in a vulnerable position.

Continuing our series on nursing policies, ANTHONY CARR describes the procedures laid down by Newcastle Health Authority for times when the level of service becomes unacceptable.

NURSES IN charge of wards can feel vulnerable when trying to maintain safe standards of patient care if, at the same time, they have insufficient resources. To cover this anxiety a working party of doctors and nurses, chaired by the chief nursing officer, met "to consider situations where a reduction in nursing or other staff within a ward or department produces a level of service to patients which becomes unacceptable to the nurse in charge and/or the medical consultant or his deputy; and to make recommendations on possible courses of action to be followed". They proposed a policy, which was subsequently approved by the district's hospital medical committee and the health authority. The policy, successfully used on several occasions, was circulated to wards and departments.

The policy was planned in three phases, according to the situation: the non-admission of patients; short-term closure; longer term closure of wards.

The ward sister and nursing officer were to bear an important responsibility in assessing the situation, especially during times of crisis, and bringing this information to the attention of senior nurse colleagues and the appropriate medical consultants.

Phase 1: Immediate action - non-admission of patients.

If an occasion arises when the staffing of a ward or department is insufficient to maintain acceptable levels of patient care, the appropriate medical consultant, the director of nursing services (or the most senior nurse on duty in the nursing division) and the unit administrator (or the most senior administrator within the unit) should be empowered to stop further admissions for that day.

The chairman of the medical staff committee and the district administrator should be told immediately. Other hospitals in the health authority with some interest in the decision must be informed. All official communications must be through the unit administrator. Any extension of the non-admission of patients for more than one day should

be considered only with the agreement of the chairman of the medical staff committee.

Phase 2: Short-term closure of ward (up to four weeks).

Should a situation arise where patients would be at a considerable risk from leaving a ward open, either because of insufficient staffing, breakdown of equipment or failure of essential services, then consideration must be given to closing the ward. The appropriate medical consultant(s), chairman of medical staff committee, the director of nursing services and the unit administrator must be empowered to institute closure proceedings.

Immediate discussion by this group, headed by the chairman of the medical staff committee, is essential as this service may have to be reprovided elsewhere in the hospital or the district. The unit administrator must inform other interested hospitals and the district administrator and the decision must be confirmed by the district management team.

Phase 3: Longer term closure of ward (over four weeks).

After closure of a ward for four weeks, the officers involved in the closure should meet with the district management team to consider the matter further.

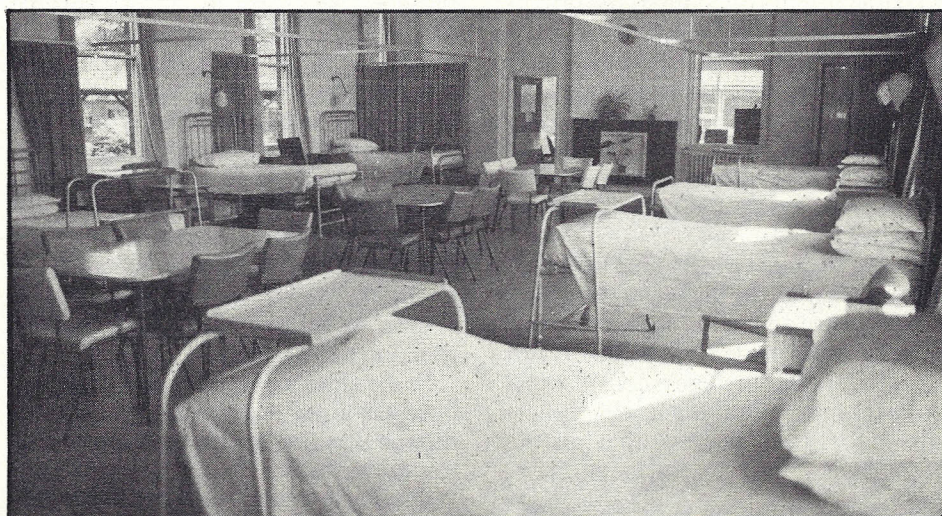
The working party noted the great importance of discussion at an early stage with all those intimately involved in the care of patients at the ward level. Action

to correct the situation should be taken at the lowest level consistent with the responsibility of each member. In the working party's view, it was the ward sister and the nursing officer, in discussion with senior colleagues and the consultant, who should decide when the level of care had reached unacceptable levels. Although the ward sister and nursing officer would be the right people to draw the attention of the medical consultant to the shortage of staff, only the DNS would know what total resources were available.

It is important for the various parties involved in any procedure to agree jointly on the action to be taken. Therefore, the doctor, nurse or administrator unable to agree to any proposed action, should make their views known through their own system of communication; and later confirm in writing so that the district medical officer, chief nursing officer or district administrator is able to examine the situation further and without delay.

Finally, the working party understood that proposals had been discussed in some regions about a numerical system of staffing so that, if the agreed levels were not maintained, patients were not admitted. It was felt that such a system was difficult to assess and that a false sense of security could be produced by staffing levels being above the minimum agreed, but there is still evidence of inadequate standards of care ☐

Next week: Drug control.



Sign of the times? An empty ward.

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