Royal College of Nursing

NURSING WORKFORCE ACADEMY

NURSING WORKFORCE STANDARDS

Supporting a safe and effective nursing workforce

RCN INSTITUTE OF NURSING EXCELLENCE

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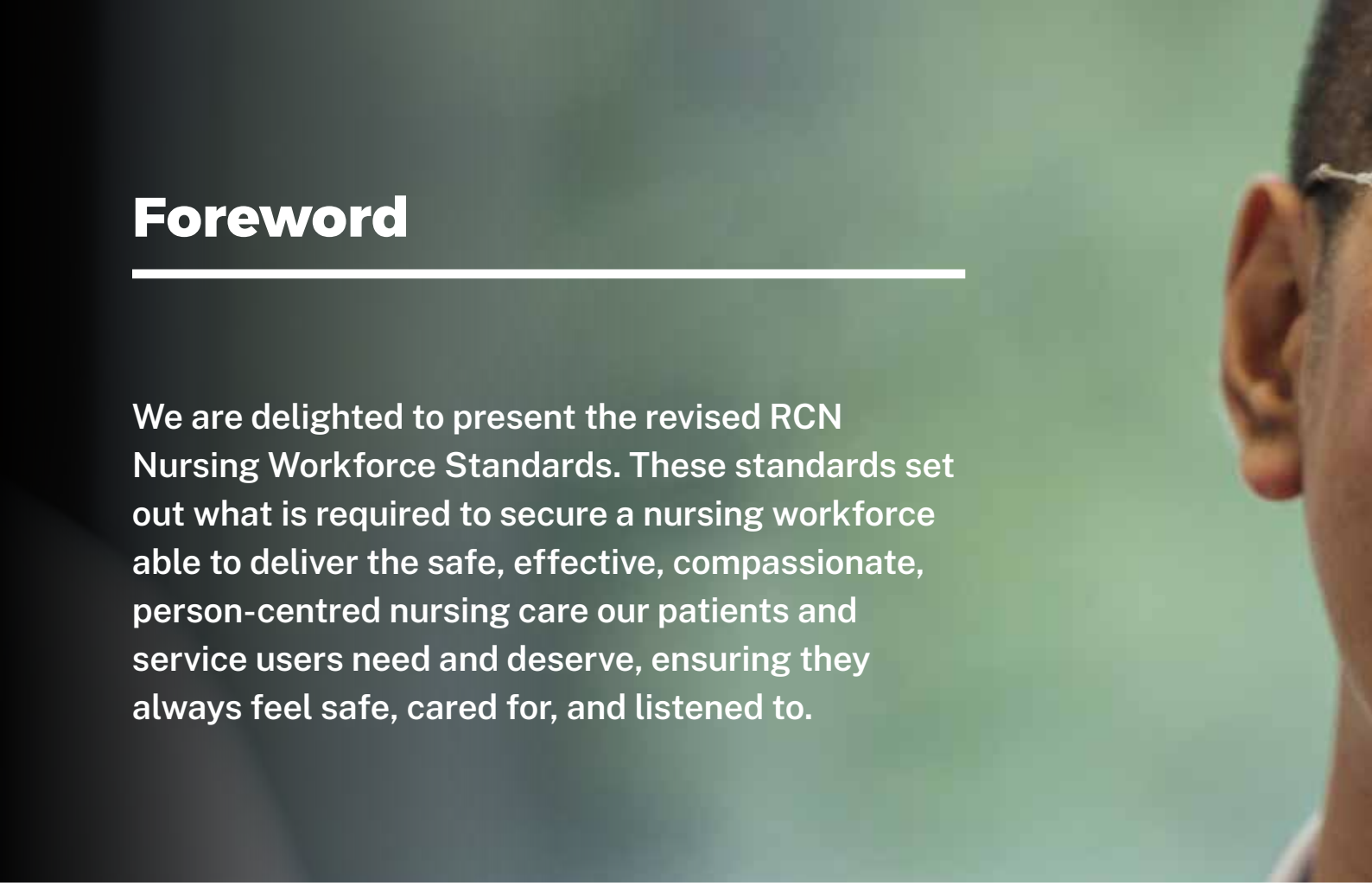


Foreword

We are delighted to present the revised RCN Nursing Workforce Standards. These standards set out what is required to secure a nursing workforce able to deliver the safe, effective, compassionate, person-centred nursing care our patients and service users need and deserve, ensuring they always feel safe, cared for, and listened to.

The RCN's *Nursing Workforce Standards* were originally introduced in 2021 and were backlit by the effects of the COVID-19 pandemic. They were the first national blueprint for addressing nursing shortages, setting out the standards we expect of a nursing workforce in all health and care settings across the UK.

Since then, and in the face of government inaction across the UK, the nursing workforce crisis has deepened. It is therefore vital that we equip our profession with this revised set of standards, ensuring they remain relevant, incorporate feedback from our members, and reflect new evidence and policies.

They must be ready to empower the nursing profession to tackle the challenges it is facing today.

While the environment we work in has changed, the need for quality care remains. The COVID-19 pandemic's significant impact on health and care services is still being felt today. The nursing profession continues to face many challenges, and a strong focus on recruitment and retention is essential. Health and social care services are in urgent need of investment and reform. So, the Nursing Workforce Standards have now been revised to update, clarify, and strengthen our position to meet the scale and urgency of the current challenge.

Nursing is the largest safety critical profession in health care. Getting the right numbers of nursing staff with the right skills in place is, quite literally, a matter of life and death.

Working with our members and listening to their professional nursing expertise, we've made evidence-based changes.

Our standard on the setting of workforce establishments now states that nurse staffing must always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Setting the right establishment must inform budget setting, not be driven by financial constraints. We have updated our standard on the calculation of the uplift (or headroom) in a

nursing establishment to stipulate that this must be a minimum of 27% to maintain safe and effective staffing during planned and unplanned leave. This should help to ensure that patients and service users always have access to continuous high-quality nursing care.

We have strengthened our standards on access to continuing professional development, and the right to work in healthy and safe environments.

The standards are for all nursing staff and alongside them, we offer practical tools to support you in your workplace. So, no matter where you work or your nursing role, these standards are for you. They set out our expectations of employers in providing a safe and effective nursing workforce which in turn will have a positive impact of the care patients and service users receive.

The changes we have made are important and necessary. They include new information about tackling racism and discrimination in the workplace and preparing for future health and climate emergencies. There is new guidance on the right to ask for reasonable adjustments during pregnancy, and for those with a disability.

As the Voice of Nursing, it is our responsibility to stand up for the profession across the UK. We believe that strong, visible nursing leadership is needed at board level, and that all nursing staff can make a real difference to influence the shape of service provision and the quality of nursing care. Investment in the nursing workforce provides evidenced benefits in the health and wealth of the nation.

Nicola Ranger
RCN General Secretary and Chief Executive

Rachel Hollis
FRCN Chair of RCN Professional Nursing Committee

Introduction

These standards apply across all settings in which nursing care is provided, and across the whole of the United Kingdom. The standards are designed to support a safe and effective nursing workforce alongside each nation's legislation.

They are to be used by:

- those responsible for funding, planning, contracting, commissioning, designing and providing services which require a nursing workforce in any setting
- nurse leaders involved in workforce planning and setting nurse staffing establishments
- all members of executive/corporate boards who are accountable and responsible for ensuring the safety and effectiveness of nursing services
- employers responsible for improving the health, wellbeing and safety of the nursing workforce
- local, regional and national organisations seeking to effect positive change for the nursing workforce
- regulators of health and care services
- professional regulators, for example, the Nursing and Midwifery Council (NMC)
- universities delivering courses for pre- and post-registration nursing students
- the nursing workforce to understand their rights and the support needed to deliver safe and effective care.

The standards are aligned to and may be used alongside the *RCN Employment Standards for Independent Health and Social Care Sectors.*

Key references to support the standards have been included for the first time. They can be found on pages 34-38.

Robust workforce planning is fundamental to the standards, although they do not define specific models or tools of nursing workforce planning. Nursing establishments should be set to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Where there is established practice or setting specific guidance, this should be followed, and the nursing workforce standards are to be used alongside such guidance.

When setting establishments a 27% minimum uplift or headroom must be implemented to support safe and effective staffing during planned and unplanned absences.

The recommendation of 100% supervisory or supernumerary status for registered nurse leads such as ward, department or nursing home managers will promote strong, visible nursing leadership to support and supervise the delivery of high-quality nursing care for patients and service users.

The standards support continued professional development for the nursing workforce. They promote the emotional, psychological, mental, and physical health and wellbeing of all nursing staff. The nursing workforce should work in environments that are safe, just and inclusive, this must be a priority for all employers.

The nursing workforce as defined in this resource is intended to include registered nurses, and nursing support workers (including registered nursing associates). It does not include supernumerary students, volunteer staff or others such as housekeeping and clerical staff. Midwifery is not included as they have their own guidance.

The 14 workforce standards are grouped into 3 key themes:

Responsibility and accountability

These 4 standards outline where the responsibility and accountability lie within an organisation for setting, reviewing and taking decisions and action regarding the nursing workforce.

Clinical leadership and safety

These 6 standards outline the need for registered nurses with lead clinical professional responsibility for teams, their role in nursing workforce planning and the professional development of that workforce.

Health, safety and wellbeing

These 4 standards outline the health, safety, dignity, respect and inclusive values of the nursing workforce to enable them to provide the highest quality of care.

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.

The nursing workforce should be recognised and valued through fair pay, terms and conditions.

Key Definitions

Executive level registered nurse
A registered nurse who has executive responsibility on the corporate board and is ordinarily responsible for assuring the board in nursing workforce issues. Executive level registered nurses have a pivotal and transformational role in an organisation. They navigate a complex set of stakeholders and partners in the service of organisational values and must use their influence at board level to guide nursing priorities for their organisation.

Designated senior registered nurse lead
A nurse leader in smaller organisations where there is no executive nurse who has authority to make decisions about setting nursing establishment. They will report directly to the responsible board or senior management team.

Registered nurse lead
Each clinical team or service that provides nursing care must have a registered nurse lead. This function may be fulfilled by registered nurses holding different titles, but the requirement of the role is set out in the descriptor for Standard 5.

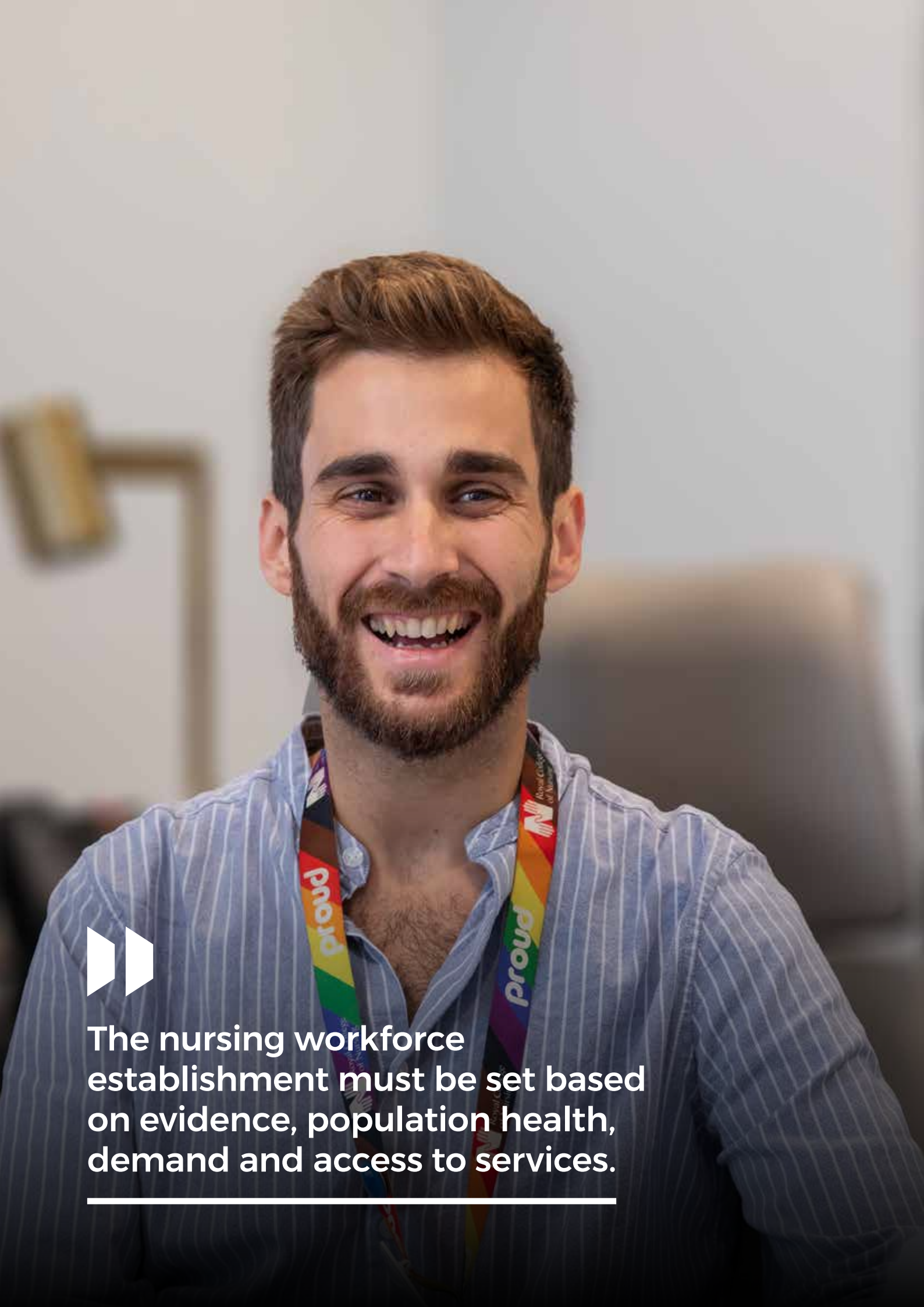
Staffing for safe and effective care
Having the right number of registered nurses and nursing support workers with the right knowledge, skills and experience in the right place at the right time is critical to the delivery of safe and effective care for all those who use health and care services.

Nursing support workers
Support the registered nurse in the provision of nursing care. This term encompasses a wide range of roles and titles which may include registered nursing associates, assistant practitioners, health care assistants, health care support workers and nursing assistants.

Corporate board
The body with the ultimate governance responsibility for any organisation providing health and care services.

Patients/service users
In these standards, this refers to those who use or are affected by the services of professionals within the nursing workforce. This umbrella term also covers clients, residents, children, and other common terms.

Pre-registration nursing students
Any individual enrolled onto an NMC-approved education programme whether full-time or part-time. This also includes student nursing associates and student nurse apprentices.



The nursing workforce establishment must be set based on evidence, population health, demand and access to services.

Responsibility and Accountability

Standard 1

All organisations providing, contracting, or commissioning nursing services must have an executive level registered nurse on the board who is responsible for setting the nursing workforce establishment and the standards of nursing care. All members of the board are accountable for the provision of a nursing workforce that will ensure the safety and effectiveness of service provision.

a. The executive level registered nurse gives assurance to the board. They must be accessible to the nursing workforce and provide strong, visible nursing leadership. The duty placed on registered nurses by the Nursing and Midwifery Council (NMC) Code to raise concerns to protect the public must be upheld.[1]

b. In smaller organisations such as general practices, care homes, and some third sector organisations, there may not be an executive level registered nurse. This exception must be recognised within the documented organisational structure. The organisation must evidence the use of nursing expertise within their commissioning body/partner organisation. A designated senior registered nurse lead with the authority to make decisions must be identified. They are responsible for reporting to the board, senior management team or a named individual accountable for safe nurse staffing.

c. The executive level nurse (or designated senior registered nurse lead) is responsible for providing professional, strategic, and operational advice and assurance to boards and commissioners on nurse staffing.[2] This is to ensure that those accountable fully understand nursing workforce demands, and this must be recorded and visible in board papers and minutes. The board are accountable for the decisions they make and the actions they do, or do not take in response to information, advice and recommendations. Any such decisions and actions must also be recorded.

d. Safe and effective nurse staffing should be a standing item at every board meeting. The record of this discussion and any decisions made will allow for scrutiny of staffing decisions by patients and service users, the public, staff, commissioners, board of governors, regulators and staff representatives.

e. Each organisation should have a board-approved risk management and escalation process in place to enable real-time nurse staffing risk escalation and mitigation, with a clear and transparent procedure to address severe and recurrent risks.

Responsibility and Accountability

Standard 2

The nursing workforce establishment must be set based on evidence, population health, demand and access to services. This should be reviewed, recorded and reported regularly and at least annually by the board.

a. Workforce planning and setting the nursing establishment and skill mix, using appropriate data and methodologies,[3] should be led by the professional nursing knowledge and experience of the executive registered nurse, who should sign off that establishment on behalf of the board.

b. Setting the nursing workforce establishment at safe and effective levels should explicitly inform the organisation's financial planning and budget setting, rather than being driven by financial constraints.

c. A continuous quality improvement approach to setting nurse staffing establishments should be taken to ensure the nurse staffing for each unit/service is sufficient to meet predicted levels of need. A triangulated approach is required and will include (but is not limited to):

   - evidence-based workforce planning tools
   - patient/service users' dependency, acuity and complexity
   - professional judgement[4]
   - clinical quality indicators
   - benchmark data from matched comparators
   - minimum 27% uplift or headroom (see Standard 8).

d. Establishments should be set in such a way as to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio).[5] Where a registered nurse-to-patient ratio has been set (through legislation or evidence-based guidance supported by professional consensus), employers must ensure that establishments are sufficient to always exceed the minimal level.

e. When planning and setting the nursing establishment the right skill mix must be deployed to meet the needs of patients/services users and services. Nursing is a safety-critical profession and evidence has shown that having more registered nurses with degree level education offers patients and service users better outcomes, including reduced mortality rates.[6]

f. A sustainable nursing educator workforce must be in place to support and develop nursing staff and students to deliver evidence-based, high-quality, and compassionate nursing care.

Responsibility and Accountability

g. A framework should be in place that enables regular review of the nursing establishment, and whether safe staffing levels are achieved or not. This framework should include the metrics to be considered (quality of care, patient outcomes and workload) as well as the trigger points for when a review should take place, for example, when serious concerns have been raised about quality of care, never events, increased incident reporting, sickness levels or a change in service provision.

h. Once any review is completed, the findings and any recommendations must be presented to the board accountable for decision making on resourcing service provision and workforce. An action plan should be created to address any issues identified and decisions taken.

i. Workforce data should be reviewed at least monthly, alongside care quality data,[7] by the executive nurse (or designated senior registered nurse lead) and red flags must be investigated and reported with transparency. Workforce red flags include (but are not limited to):

   - high vacancy rate
   - when substantive staff are less than 80% (see Standard 9)
   - inability to meet the agreed skill mix
   - increased temporary staffing
   - increased staff redeployment
   - increased overtime/unpaid breaks
   - high sickness and turnover rates
   - increased staff disciplinaries
   - negative staff and patient feedback.

j. Where registered nurses such as advanced nurse practitioners work in inter-disciplinary or medical rosters, they must not also be counted as part of the nursing establishment.

k. Essential support staff such as clerical, housekeeping and catering staff, should not be considered as part of the nursing workforce when determining the nursing establishment to meet clinical need.

l. All pre-registration nursing students must be 100% supernumerary whilst on placement. Protected supernumerary time must be given as stipulated within their education programmes. All students must be supported to raise concerns when supernumerary time is not protected whilst on placements.

Responsibility and Accountability

Standard 3

Up-to-date business continuity plans must always be in place to enable staffing for safe and effective care during critical incidents or events.

a. Business continuity plans need to be developed with nursing leadership, taking into consideration:
    - the ability to manage and react to critical incidents, pandemics and climate emergencies
    - situations in which the nursing workforce is compromised, understaffed or redeployed
    - that contingency plans should align to the organisational risk management and escalation processes.
b. Partnership working and staff-side engagement with recognised trade unions on the principles, development and outcomes of business continuity planning and review is vital to accurately reflect nursing, foster collaboration and build organisational cohesion.[8]
c. The business continuity plan should be reviewed and tested at least annually.
d. Serious concerns and/or incidents affecting safety and/or quality of care must also trigger a review of the business continuity plan.
e. The nursing workforce must be supported and encouraged to raise concerns and report incidents or near misses that negatively impact on patients or service users, services and the nursing workforce.[9]
    - Staff must be supported to raise concerns in ways that feel safe and in which they have confidence, without fear of detriment. This may include using their trade union staff representatives, trusted impartial individuals within organisations, and Freedom to Speak Up Guardians/champions.[10]
    - Local processes must be in place and used to raise concerns. These processes must be developed in partnership with staff and representatives to encourage more reporting and to make the process easy, fast and reliable.
    - All concerns raised must be documented, appropriately investigated and responded to. Boards and senior managers must have oversight of the different concerns raised across their organisations.
    - Effectively using duty of candour will further develop trust in nursing by patients, servicer users, families and carers.
    - Appropriate follow up, action, and response by accountable managers creates psychologically safe environments, just and learning cultures.[11]

Standard 4

The nursing workforce should be recognised and valued through fair pay, terms and conditions.

a. Employers should have a transparent pay policy which sets out pay structures, pay progression and the criteria for how pay is increased annually to reflect changes in the cost of living. Pay should reflect the experience, expertise and level of nursing practice at which individuals are working.

b. All nursing staff require a written contract of employment issued before the first day of their new employment. On commencement of employment, pay scales must be built upon the Real Living Wage.[12]

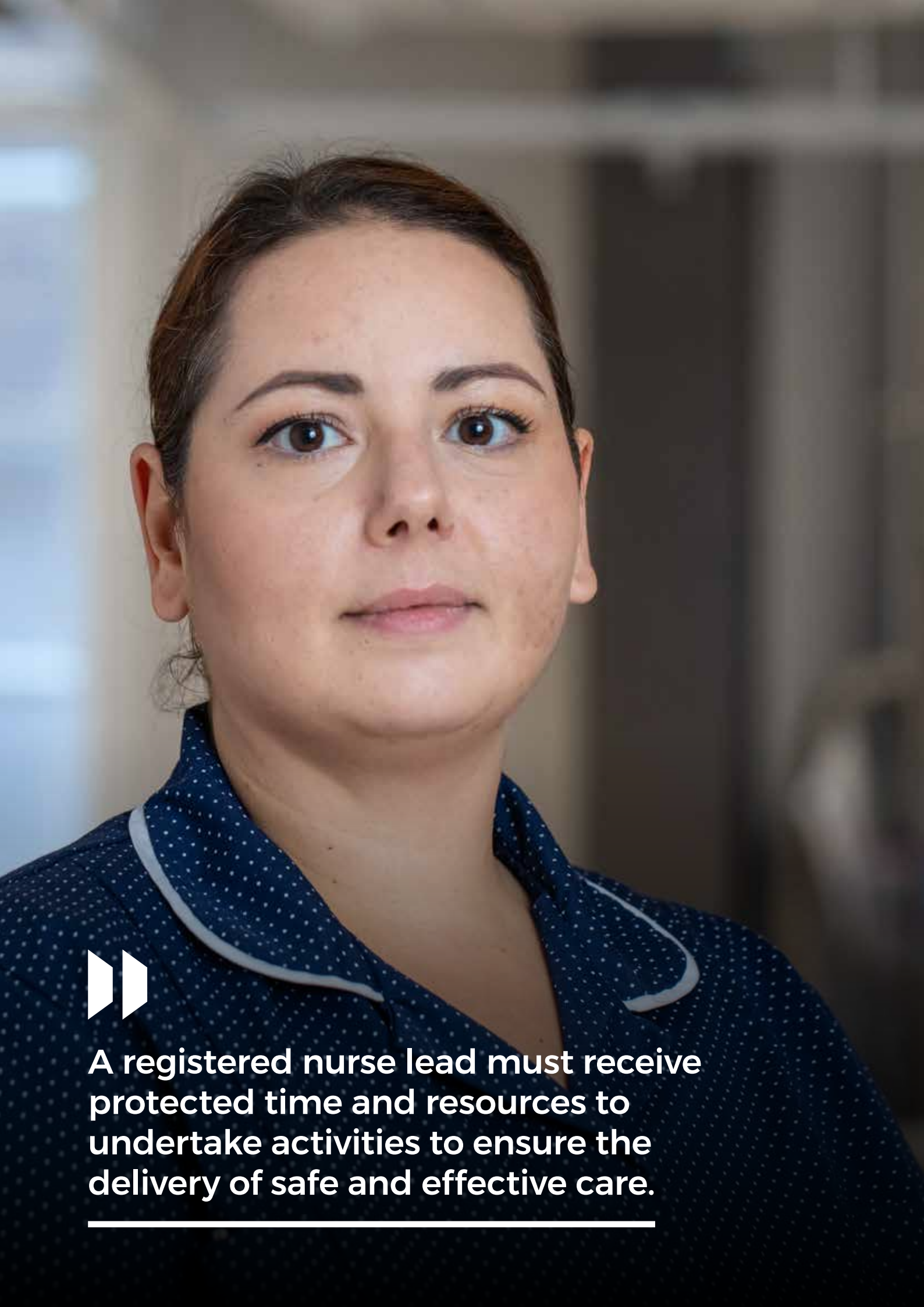
c. All members of the nursing workforce:

- must be compensated for any additional costs of working including unsocial or additional hours worked
- should have access to good quality, sustainable pension provision beyond the statutory minimum
- should have contractual sick pay, parental leave and annual leave beyond the statutory minimums
- should have a fair and transparent process to request a grading/banding review or job evaluation review if they believe that their role has changed beyond their current job description.[13]

d. Fair and equitable pay, terms and working conditions are achieved by engaging directly with the nursing workforce, through the RCN and any other recognised trade unions/ professional organisations.

e. The right to membership of a trade union and/or professional body should be presented to and/or discussed with all new employees at their induction.[14]

f. Employers have vicarious liability for their nursing staff and therefore employers are required to have employer indemnity insurance to insure employees' work.



A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.

Clinical Leadership and Safety

Standard 5

Each clinical team or service that provides nursing care must have a registered nurse lead.

a. The registered nurse lead provides visible nursing leadership, knowledge, skills and expertise and is responsible for the maintenance of the standards of nursing care within the team or service.[15, 16]

b. The registered nurse lead will have the responsibility to identify the nursing workforce required to provide safe, effective, high quality and compassionate care.[17]

c. They will respond to real time and recurrent risks to nurse staffing levels and take actions to mitigate risks to patients/service users and to nursing staff.

d. If risk mitigation such as reducing caseloads or bed closures cannot be achieved, the registered nurse lead will escalate the risk in line with the organisational policy. Risk escalation and response must be documented.

e. The escalation and reporting line should lead to the executive level nurse (or the designated senior registered nurse lead) and hence the accountable board (See Standard 1).

f. Where the registered nurse lead does not have another (senior) registered nurse as a direct line manager they must have a clear professional line to alternative nursing leadership.[18]

Clinical Leadership and Safety

Standard 6

A registered nurse lead must receive protected time and resources to undertake activities to ensure the delivery of safe and effective care.[19]

a. Their role in the leadership team as the senior voice of nursing in the workplace must be reflected and incorporated into role descriptions and job plans.

b. The registered nurse lead will be 100% supervisory/supernumerary and not counted in the numbers as part of the nursing workforce allocation.[20] Exceptions to this should be considered as a red flag and a clear rationale must be documented, agreed by the board, highlighted and made accessible to commissioners, regulators, staff representatives and/or recognised trade unions.

c. The registered nurse lead provides strong visible leadership across the 4 pillars of nursing: clinical, research, education and leadership.[21, 22] Time and resource are required for (but not limited to):

   - leading and managing the team
   - improving and monitoring the safety and quality of care delivered
   - improving and monitoring patient and service-user experience
   - improving and monitoring workforce experience and wellbeing
   - workforce planning, monitoring, recruitment and retention
   - budget management
   - clinical and regulatory audits
   - initiating quality improvement programmes
   - research and innovation
   - clinical supervision, staff development and succession planning
   - monitoring health and safety data from adverse incidents and near misses involving staff and people who use services
   - listening, supporting and engaging with families, carers and relatives of patients/service users, as appropriate.

d. Organisations must invest in the leadership and management skills and capabilities of all their nursing leaders through personal and professional development.

Standard 7

All members of the nursing workforce must have access to high quality, contractually funded continuing professional development (CPD) with protected (paid) time to undertake it.

a. Workforce planning and setting of the nursing establishment should include a learning needs analysis to inform the commissioning and provision of education and training.

b. All education and training must align to the needs of those using services, the practice setting, and the professional development needs of the nursing workforce.[23]

c. The delivery of high quality, evidence-based care requires nursing staff to undertake CPD beyond mandatory and/or statutory training and to be supported to engage in lifelong learning.[24]

d. Provision should be made for (but not be limited to) the following:
   - support with revalidation (for NMC registrants)[25]
   - supervision (clinical/restorative) and reflective practice
   - assessment, supervision, and teaching
   - coaching and mentorship
   - access to formal education and research opportunities
   - personal and professional development plans and reviews, including annual appraisal
   - careers support and succession planning
   - leadership training for all the nursing workforces.

e. The nursing workforce has a right to complete all their statutory, mandatory and CPD training within working time/hours or given time back in lieu.

f. Resources, including protected time for regular professional reflection, should be in place to support ongoing learning and evidence-based practice development.[26] The nursing workforce must have access to nursing educators and professional development teams to support evidence-based nursing, lifelong learning and CPD.

g. Organisations should monitor, report on and record the number of training sessions cancelled due to staffing shortages and how much CPD is undertaken outside working hours, to make meaningful improvements.

Clinical Leadership and Safety

Standard 8

When calculating the nursing workforce establishment whole time equivalent, a minimum uplift (or headroom) of 27% will be applied that allows for the management of planned and unplanned absence.

a. An agreed tool for calculating uplift/headroom should be used which must consider each of the following (as a minimum):[27]
    - annual leave – reflective of length of service
    - study leave/continuing professional development (CPD) – this must meet or exceed the statutory requirements for NMC registrants
    - sickness absence – which should reflect the actual sickness level in an organisation rather than the target level
    - parental leave – for staff with children under 18 years old
    - other leave, which includes (but is not limited to): carer's leave, jury service, and compassionate leave
    - maternity, paternity or adoption leave – the level of uplift should reflect the fact that nursing remains an almost 90% female profession.[28]
b. Professional judgement considerations for nursing workforce establishment and uplift/headroom should include (but not be limited to):[29]
    - environmental issues, for example, single rooms, layout
    - geographical issues, for example, travel requirements for community-based staff
    - shift patterns/length of the working day/flexible working
    - patient/service user acuity, complexity and dependency
    - high enhanced observation/1:1 requirement
    - patient/service user high turnover
    - professional regulatory requirements
    - staffing skill mix, levels of registered nurse required (enhanced/advanced/consultant)
    - time required to support/mentor students
    - time required to support staff, for example, phased return, clinical/restorative supervision, capability support, time to access nurse advocates/clinical psychologists, team building/meetings.

Standard 9

If the substantive nursing workforce falls below 80% for a department/ team, this should be an exception, a red flag. It must be escalated, recorded and reported to the board/senior management and shared with staff representatives/trade unions.[30]

a. All vacancies in the nursing workforce should be recruited to as soon as they arise.

b. If redeploying nursing staff, their knowledge, skills and competence must be considered to protect both patients/service users and the nursing workforce.[31]

   - Redeployed staff must always have an induction, orientation and handover.
   - Redeployed staff should never be expected to take charge of the area to which they are redeployed.
   - Redeployed staff should be supported to raise concerns when asked to work outside their limits of competence.
   - All staff redeployment must be done fairly, with support, and consideration of psychological safety and staff wellbeing.
   - The frequency and extent of staff redeployment must be monitored, recorded and reported by all organisations for transparency, accountability and review (See Standard 2i).

c. Bank and agency nursing work provides services and nursing staff with flexibility on both an individual and an organisational level. When using nursing staff from bank or agency, the service must be assured that they are competent and confident to work in the role or setting to which they are allocated. Staff skill mix should be matched to the acuity and dependency of patients/service users, within approved guidelines.

d. The bank or agency workforce must follow approved employment practices and clearance. The host organisation and employer must co-operate and communicate on the management of the health and safety risks to the temporary worker.

e. All staff from bank or agency will be provided with orientation and local induction which must include access to incident reporting systems and how to escalate concerns. A welcoming and supportive work environment offers psychological safety and can ensure the quality and safety of the care provided.[32]

Clinical Leadership and Safety

Standard 10

All members of the nursing workforce must be appropriately prepared and work within their scope of practice and (for registrants) in accordance with the NMC Code.[33]

a. The nursing team is diverse and includes registered nurses, nursing support workers and nursing students. All members of the nursing team must work within the limits of their competence and have access to the right education, training, development and supervision in keeping with their level of practice and the setting in which they work.[34]

b. A registered nurse must never be substituted with a nursing support worker (which includes registered nursing associates) or any other health care professionals.[35]

c. The work of the registered nurse increases in its complexity beyond the point of registration. Employers should recognise the level of nursing practice required within the workforce to meet nursing care needs in the services they provide[36] (See Standard 7).

d. The registered nurse lead will ensure that:

- all newly appointed members of the nursing workforce are allocated a period of supernumerary time and structured induction
- newly registered nurses have a period of structured preceptorship[37]
- individuals with no or limited previous experience in an area have tailored preceptorship periods, which includes structured inductions and close supervision, until specialty competence and confidence are achieved
- for more senior/experienced staff taking on additional or different roles, including promotions, management and leadership, a preceptorship period is still needed until competence and confidence are achieved
- all nursing students must have support and supervision whilst on placement (see Standard 2l)
- practice learning supervisors and assessors must have access to professional development specific to these roles and time and resource to liaise with the approved education institution
- there is an up-to-date NMC placement audit to support students in placement.[38]

e. Fostering leadership capability is integral to all members of the nursing workforce throughout their careers, to embed just and psychologically safe cultures and strengthen the nursing voice.

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.

Health, Safety and Wellbeing

Standard 11

Working patterns for the nursing workforce must be based on best practice and safe working. Working patterns must be agreed in consultation with staff, and their trade union representatives.

a. Where longer working hours may be preferred, the risk must be recognised and steps taken to mitigate fatigue-related incidents and errors and potential burnout. Best practice advice on mitigating fatigue risks from organisations such as the Health and Safety Executive should be followed, including adequate rest breaks, limits to the number of back-to-back long days and nights, avoidance of shifts longer than 8 hours, and time to recuperate after a stretch on night shifts or on-call shifts.[39]

b. Employers should support opportunities for nursing staff to work flexibly, with the criteria for doing so set out in a policy that is applied fairly to everyone. All posts should be included for consideration of flexible working, including for example, more senior roles. Self or team rostering and internal rotations can also be considered.[40]

c. Flexibility with annual leave should be considered to support the diverse needs of the nursing workforce. Annual leave must never be used to manage sickness absence.

d. The nursing workforce should have timely access to work schedules/rotas. A minimum of 8 weeks in advance will support staff to plan and have improved life-work balance.

e. All work schedules/rotas must ensure that that the right skill mix is in place to meet the needs of patients/services users and services (See Standard 2).

f. Any member of the nursing workforce with a disability is entitled to reasonable adjustment to support them at work.[41]

g. The nursing workforce must always be supported to take breaks during their working hours. Staffing levels and rotas/schedules should allow for staff to have uninterrupted breaks. Any breaks missed must be a red flag and be visible on schedules/rotas.[42]

Standard 12

The nursing workforce should be treated with dignity and respect and work in environments where equity, diversity, and inclusion are embedded in the workplace culture.[43]

a. Employers should be able to demonstrate sustained investment and improvement in ensuring that their workplaces are fully inclusive in culture and are anti-discriminatory and anti-racist.

b. Employment policies, practices, processes and cultures, as well as leadership styles, must intentionally support and nurture psychological safety to create inclusive workplaces for all. This includes freedom from all forms of bias, discrimination, bullying, incivility, sexism, and inequity.[44]

c. The nursing workforce must be treated with dignity by their employers, managers, colleagues, patients/service users, and the public.

d. Employers should support and facilitate access to training that supports inclusive workplaces, such as the RCN Cultural Ambassador Programme. Training should include engaging with a variety of groups to understand the full range of different people's needs, cultures and risk factors.[45]

e. Employers should promote and encourage the development of support networks or groups which offer a sense of belonging, safe spaces, and additional support for their staff with protected characteristics.[46]

f. All organisations must monitor, record and publish data on their workforce's protected characteristics.

g. Employers must abide with the 2010 World Health Organization (WHO) *Global Code of Practice on the International Recruitment of Health Personnel* when recruiting staff from outside the United Kingdom (UK).[47]

h. The nursing workforce recruited from outside the UK must be recognised for their prior skills, knowledge and expertise and supported in their career development and career progression.

i. Equitable access to continued professional development (CPD) should be in place to reduce underrepresentation of minoritised groups in nursing leadership roles and increase opportunities for career progression.

Health, Safety and Wellbeing

Standard 13

The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

a. Employers must meet their legal duties and put measures in place to reduce risks to health and safety, including (but not limited to):[48]
   - violence and aggression
   - back and musculoskeletal disorders
   - work-related stress
   - occupational infections
   - exposure to chemical and biological hazards
   - hazardous work environments, for example, overcrowding and "corridor care", wet floors, presence of mould and reinforced autoclaved aerated concrete (RAAC).

b. The employer must identify additional risks to new and expectant mothers and put measures in place to reduce those risks.

c. The nursing workforce have a professional responsibility to create healthy environments that improve health and wellbeing, and their employers must support them in this. Health, safety and wellbeing is more than just the absence of work-related disease or injury, rather, an emphasis on achieving good physical and mental health.[49]

d. The Health and Safety Regulations require the provision of safe and well-maintained buildings with adequate welfare facilities, for example, break/rest rooms, changing facilities and personal lockers. Where indicated by a risk assessment there must be access to suitable and sufficient, well-maintained resources (eg PPE, moving and handling equipment).

e. The risks to members of the nursing workforce working in people's homes or community settings should be assessed and managed by their employer. The nursing workforce must be given adequate information and training to undertake a dynamic risk assessment when carrying out home visits and know what steps to take if they feel in danger.

f. Nursing staff who are lone workers must have suitable means of raising the alarm and access to appropriate safety equipment, such as (but not limited to) lone worker devices, mobile phones, high-vis jackets, torches, GPS safety devices, SOS/panic alarms, and prompt access to support and advice.[50]

g. To prevent fatigue, safe driving rules must be adhered to when nursing staff drive as part of their work, for example, taking at least a 15-minute break after every 2 hours of driving. Therefore, enough time must be allocated between patient/service user visits for the nursing workforce working in communities. Access to safe parking is needed for staff safety and wellbeing.[51]

Standard 14

Employers must actively protect, promote and support the wellbeing of the nursing workforce.

a. Utilising the working environment as a place for promoting health and wellbeing is vital to enable a healthy and safe workforce. Meeting core wellbeing needs is non-negotiable. Nursing staff must always have access to drinking water alongside comfortable and relaxing spaces, away from working areas to take their breaks, eat, and drink.[52]

b. The nursing workforce, regardless of where and when they work must have access to healthy eating options. As a minimum, staff should have access to a fridge, microwave, kettle and/or access to food, canteens, shops and/or restaurants. Where staff work in 24-hour and 7-day services, all staff, especially those working nights, weekends or in the community must have 24/7 access to facilities.[53]

c. The psychological health and wellness of nursing staff must be a priority for all employers. Acknowledging the nature of nursing work, employers should proactively support the emotional wellbeing of the workforce. Good practice anticipates and expects the need for support with emotional and psychological wellbeing. Support should be planned for and a normalised component of practice.[54, 55]

d. Employers should provide opportunities for participation in health and wellbeing initiatives and facilitate access to proactive sessions that promote physical and mental good health. Team building and social interactions can be beneficial for staff wellbeing.

e. The nursing workforce must have access to occupational health services or employee assistance programmes. All recommended occupational health screening, vaccines and immunisations and physical/psychological support must be made easily accessible by employers.

f. The nursing workforce must be given manageable workloads to be able to deliver care safely and effectively (using Standards 2 and 3) and to protect staff wellbeing and reduce risk of moral injury, associated work-related stress and burnout. Nurses who are well, deliver safer and more compassionate care.[56]

The nursing workforce is entitled to work in healthy and safe environments to protect their physical and psychological health and safety.

Glossary

Absences
Agreed and non-agreed non-attendance at a workplace. Absenteeism is habitual absence from work.

Corridor care
Corridor care is a term which has gained widespread usage to describe the provision of care in non-designated areas (including corridors). This is usually due to overwhelming demand or lack of available resources. Other terms include, temporary escalation areas, ‘fit to sit’, 'one upping', or 'boarding'.

Direct care
Care provided personally by a member of staff. May involve any aspect of health care including treatments, counselling and education regarding people who use services.

Duty of candour
Is a legal and ethical obligation for health and social care providers to be open and transparent with patients, service users and their next of kin when things go wrong with their care or treatment.

Indirect care
Nursing interventions that are performed to benefit people who use services but do not involve direct contact with these individuals and communities.

Independent employer
Any independent contractor, employer organisations that may or may not be commissioned by the public sector. This will include private employer health care providers, most social care providers; GP practices; out of hours/call centres; social enterprises and community interest companies; charities, private surgical, mental health and learning disability hospitals; independent treatment centres; public/private schools; private industry.

Missed care
Required care for people who use or need services that is omitted in part or fully, or care that is delayed.

Nurse retention
A strategy which focuses on preventing nurse turnover and keeping nurses in an organisation’s employment.

Nursing establishment
The total number of staff needed to provide sufficient resource to deploy a planned roster, which will enable registered nurses and nursing support workers to provide care to people who need or use services and that meets all reasonable requirements in the relevant situation. This includes adding an allowance when calculating staffing numbers for planned and unplanned staff absence.

Never events
Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all health care providers.

Nurse staffing
Rota and whole time equivalent (WTE) for a nursing team. The nurse staffing level refers to both the required establishment and the actual staffing level per shift/allocated workday. The maintenance of the nurse staffing level should be funded from the organisation's revenue allocation.

Nursing workforce
The total number of nursing staff (registered nurses and nursing support workers) working within an organisation, sector or country.

Patient/service user acuity
This refers to how ill the patient is, their increased risk of clinical deterioration and how complex their care needs are. This term is sometimes used interchangeably with the terms 'patient complexity' and 'nursing intensity'. An acuity-based staffing system regulates the number of nurses in a nursing service according to the individual's needs and not according to numbers of people who use or need services.

Patient/service user dependency
The level to which the patient is dependent on nursing care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care, hygiene and mobilisation.

Patient/service user safety
Patient safety is the prevention of errors and adverse effects to patients and service users associated with health care. It is closely correlated to safe staffing levels.

Public sector
Refers to employers that are publicly funded – either as an arm's length body of the Department of Health and Social Care, or via another government department or directorate such as education, home office, and criminal justice. Examples include local authorities, statutory agencies such as inspectorates and regulators.

Protected time
'Protected learning time' is time spent by students on pre-registration programmes in a health, care or other setting during which students are learning and are supported to learn.

Real Living Wage
The Real Living Wage is a voluntary hourly wage rate in the UK, calculated based on the actual cost of living. It is higher than the government-mandated National Minimum Wage and National Living Wage.

Red flag
Warning signs or indicators that something might be wrong or problematic. Recognising these red flags can help in making informed decisions and to protect from potential harm.

Registered nurse-patient/service user ratios
Number of people who need or use services assigned to an individual registered nurse; based upon the acuity and/or dependency of the patient/service user for nursing care.

Seasonal variation in nursing workload
Variations and fluctuations in demands for care by people who need or use services, such as differing attendance rates.

Shift patterns
The organising of shifts to ensure patients have continued access to nursing care whatever the day or time of day. The shifts could be rotational between day, night and weekend working, or fixed or a continuous working pattern.

Skill mix
Percentage of different health care personnel involved in provision of care, for example, between registered nurses and nursing support workers, or between different health care professions.

Social care
Health, care and practical support services provided to individuals to support with activities of living (which may include nursing care) in their own homes, residential homes, nursing homes and communities. Most of the UK residential care (with or without nursing) and domiciliary care is provided by independent employers, which include charities and private care management companies, however most social care services are delivered by independent sector home care and residential care providers.

Staff rotas/schedules/rosters
A list of staff and associated information such as working times, responsibilities and locations for a given time period.

Substantive position
An employee's permanent position of employment.

Supernumerary (nursing students)
Is when students in practice or work placed learning are supported to learn without being counted as part of the rostered staffing establishment.

Supernumerary/supervisory (registered nurse lead)
The registered nurse lead is not counted in the regular staffing numbers. They oversee and manage others. They are responsible for guiding, directing, and evaluating the performance of employees or team members in delivering safe and effective nursing care.

Team
A group of staff brought together to achieve a common goal. Often associated with an inter-disciplinary approach to care for people who use services.

Understaffing
A situation where there are insufficient numbers of staff to operate effectively, with an impact on patient/service user and staff safety.

Uplift/headroom
Adding an allowance when calculating staff numbers for planned and unplanned staff absence.

Vacancies
Paid posts which are newly created, unoccupied, or about to become vacant and the employer is actively searching for suitable staff. Temporary staff may be able to fulfil posts during the recruitment of permanent staff.

Whole time equivalent
Also known as full time equivalent (FTE), is a standardised measure that represents the workload of an employee. It is commonly used in workforce planning and budgeting to standardise the working hours of part time employees into the equivalent of full time employees.

Workforce planning
The process of analysing the current workforce and determining future needs, including identifying any gaps between current and future provision. This should be based on the demand for the services the workforce will provide.

Employers must actively protect, promote and support the wellbeing of the nursing workforce.

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