



**Safe, sustainable and productive staffing**

**An improvement resource for  
adult inpatient wards in acute  
hospitals: Appendices**

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

The NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health & Social Care

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# Appendix 1: Principles of professional judgement in adult inpatient wards in acute hospitals

Staffing decisions based solely on professional judgement – the expert opinion of clinical staff – are considered subjective and may not be transparent. However professional judgement and scrutiny should be used to interpret the results from evidence-based tools, taking into account the local context and patient care needs. This element of a triangulated approach is key to bringing the outcomes from evidence-based tools and comparisons with peers together in a meaningful way.

Professional judgement and knowledge should also inform the skill mix of staff at all levels and real-time decisions about staffing that are taken to reflect changes in casemix, acuity/dependency and activity.

The skill mix between registered and non-registered care staff reflects the likely workload, skills and competencies required to care for patients locally.

Consideration should be given to the following principles of professional judgement – the contextual factors in reaching a decision (eg competence, experience, staff known to the patient, familiarity with the team, activities and environment, etc):

- it is suitable for use in all specialties
- it is based on the subjective and objective judgement of the lead nurse for their particular area
- registered professionals are accountable and responsible for their decisions and actions, including legal and ethical considerations
- it takes account of actual workload over a specific time period
- it is inclusive of all activity, eg planned and unplanned workload, ward attenders and ad-hoc activity
- it informs decisions on required staff numbers

- numbers and skill mix judgements are validated when agreement is reached between the lead nurse and manager.

## Appendix 2: Nursing red flags (NICE)

The National Institute for Health and Care Excellence (NICE) guideline *Safe staffing for nursing in adult inpatient wards in acute hospitals* (2014)<sup>1</sup> recommends red flags relating to adult inpatient wards. **Recommendations for the registered nurses on wards who are in charge of shifts are:**

- Monitor the occurrence of the nursing red flag events (as detailed below) throughout each 24-hour period. Monitoring of other events may be agreed locally.
- If a nursing red flag event occurs, it should prompt an immediate escalation response from the registered nurse in charge. An appropriate response may be to allocate additional nursing staff to the ward or areas in the ward.
- Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events to inform future planning of ward nursing staff establishments or other appropriate action.

### Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - pain: asking patients to describe their level of pain level using the local pain assessment tool
  - personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration
  - placement: making sure that the items a patient needs are within easy reach
  - positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.

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<sup>1</sup> [www.nice.org.uk/guidance/SG1](http://www.nice.org.uk/guidance/SG1)

- A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (that is, the loss of more than 25% of the required registered nurse time).
- Fewer than two registered nurses present on a ward during any shift.
- Note: other red flag events may be agreed locally.

The NICE guideline (2014) also recommends the following safe nursing indicators:

- adequacy of meeting patients' nursing care needs
- pressure ulcers
- medication administration errors
- missed breaks
- planned, required and available nurses for each shift
- falls
- nursing overtime
- high levels and/or ongoing reliance on temporary nursing
- compliance with any mandatory training.

NICE recommends monitoring to ascertain whether the ward nursing staff establishment adequately meets patients' nursing needs using the safe nursing indicators. These are indicators for which there is evidence that they are sensitive to the number of available nursing staff and skill mix. It is advised that data on these safe nursing indicators is continuously collected (using data already routinely collected locally where available) and the results of regular analysis considered.

The results of the safe nursing indicators should be compared with previous results from the same ward at least every six months. The comparisons should also take into account the specific ward and patient characteristics (such as patient risk factors and ward specialty). Reported nursing red flag events should also be reviewed when undertaking this monitoring and prompt an earlier examination of the adequacy of the ward nursing staff establishment.

## Appendix 3: CHPPD

### CHPPD 'ready reckoner'

For staff more accustomed to patient-to-staff ratios, a rough 'ready reckoner' conversion may help you check for obvious anomalies and understand what the new unit of measurement means so that implausible or incorrect data can easily be recognised.

- One of these works down from higher to lower intensity wards/units. A unit such as an ITU which provides all its patients with one-to-one care from registered nurses would have an actual RN-CHPPD of at least 24 (for every 24 hours of patient care hours, 24 hours of a registered nurse is required). In reality this would be slightly higher to allow for handovers, breaks and other important nursing activities not conducted at the bedside. Halve this (two patients to one nurse) to give an actual RN-CHPPD of at least 12, halve again (four patients to one nurse) to give an RN-CHPPD of 6, halve again (eight patients to one nurse) to give an RN-CHPPD of 3.
- Another rough checking method is to think of a 24-bedded ward (this makes the maths easy given the 'patient day' in CHPPD is 24 hours). A total CHPPD of six is equivalent to six members of nursing and support staff being constantly available on a 24-bed ward day and night (although in reality this would not be evenly spread over the 24-hour cycle).

### Calculation and collection of CHPPD

Care hours per patient day (CHPPD) is the unit of measurement recommended in the [Carter report](#) (2016) to record and report deployment of staff working on inpatient wards. It is made up of registered nurses and support worker hours. All acute trusts have been required to report their actual monthly CHPPD based on the midnight census per ward to NHS Improvement since May 2016.



## Appendix 4: Generic statement on care of people with learning disabilities

All healthcare providers must strategically plan for an interdisciplinary workforce who is able to meet the often complex needs of people with learning disabilities. It is a legal requirement that reasonable adjustments are made to ensure that people with learning disabilities have equal opportunities for their health needs to be met (Equality Act 2010).<sup>2</sup> People with learning disabilities are more likely to have undiagnosed or wrongly diagnosed health needs and die prematurely from preventable causes (Healthcare for All 2008; CIPOLD 2013).<sup>3</sup>

Meeting these requirements in terms of safe and sustainable staffing includes:

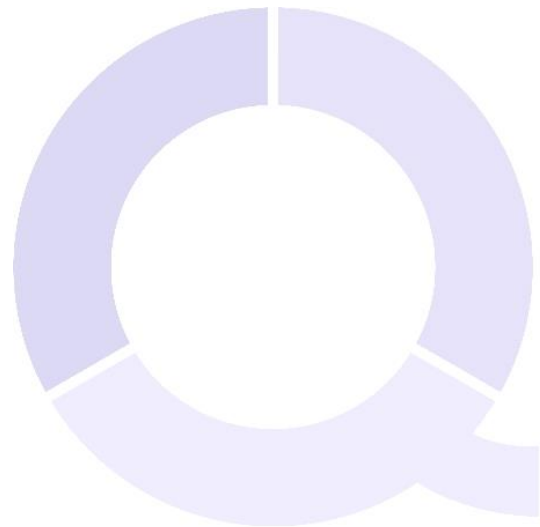
- ensuring that within the staffing establishment there are sufficient numbers of specialist staff available
- providing regular training to the wider workforce to ensure that they are able to identify people who may present with learning disabilities, autism or other complex communication needs
- embracing flexibility in the way care is delivered, allowing enough time and support to enable quality outcomes
- ensuring all staff are aware of their duties under the Mental Capacity Act (2005)<sup>4</sup> and the need to work in partnership with the individual, their families, carers and other multi-agency professionals
- having workforce plans with the capacity to ensure that everyone's right to receive appropriate healthcare is realised.
- appropriate liaison with community multidisciplinary teams if reasonable adjustments are not sufficient to ensure equality of healthcare.

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<sup>2</sup> [www.gov.uk/guidance/equality-act-2010-guidance](http://www.gov.uk/guidance/equality-act-2010-guidance)

<sup>3</sup> [www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf](http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf)

<sup>4</sup> [www.legislation.gov.uk/ukpga/2005/9/contents](http://www.legislation.gov.uk/ukpga/2005/9/contents)



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