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Is it time to set minimum nurse staffing levels in English hospitals?

Increasing economic pressures on healthcare systems raise concerns about how workforce cuts and reconfigurations may affect quality [1]. Currently there are no centrally set minimum staffing levels for National Health Service organisations; providers are responsible for determining staffing requirements locally. In this Policy+ we look at the impact mandated minimum Registered Nurse (RN) staffing levels have had in other countries and consider current guidelines and recommendations.

Why are mandated staffing levels an issue in 2012?

In the UK, the Royal College of Nursing (RCN) has played a key role in lobbying for safe nurse staffing levels [2] and at Congress in 2011 they voted in favour of legally enforceable nurse staffing levels. It is argued that assessment of adequate staffing levels requires robust data on current staffing, as well as data on patient outcomes and quality [3]. The issue was recently debated in the House of Lords (as an amendment to the health and social care bill) where it was proposed that a maximum number of patients per registered nurse should be mandated [4]. In 2004, the RCN commissioned Prof James Buchan to critically review the use of nurse to patient ratios [5]. A key concern is that a 'minimum' ratio of nurses to patients can become a 'maximum' and that nationally set levels fail to take account of local variation. But arguably ratios are simple and easy to use, and where they lead to improved staffing levels, they can create a more stable workforce that is less dependent on temporary staffing cover.

Experience outside the UK: The impact of standardised and mandatory nurse to patient ratios

In California, United States of America, ratios were set in 1999 (eg. 1:5 on medical and surgical wards). To date fifteen states in the US have legislation aimed at addressing safe nurse staffing but California is the only state to have specific ratios applying to each speciality in all hospitals. Evidence of reported impact in California includes:

- No evidence that ratios have increased costs [6].
- Hospital nurses typically care for one patient less than nurses in other states, the lower caseload is significantly related to lower patient mortality [7].

In Victoria, Australia minimum nurse to patient ratios were legally mandated in the public sector in 2001 (1:4, plus one in charge on medical/surgical wards). In 2004 the way in which the registered nurse to patient ratio was expressed was changed to 5:20, to give more flexibility on registered nurse deployment across the ward [8]. The Australian Nursing Federation (ANF) reports that ratios have led to:

- Better recruitment and retention of nurses and greater workforce stability.
- Adequate numbers of nurses rostered six weeks in advance.
- Directors of Nursing having fully funded budgets to provide safe staffing levels, and a reduced reliance on agency staff.
- Better patient care; beds are not kept open unless there are sufficient staffing levels.
- More manageable nursing workloads.
- Increased job satisfaction for nurses, more workplace stability, and reduced stress [9].

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Recommendations and guidance on staffing levels in the UK

Professional bodies and associations in the UK have put forward recommendations for nurse staffing levels in different specialities. For example, it is recommended that every patient in a critical care unit has access to a RN with a post registration qualification in the specialty, and that there is a ratio of 1:1 for ventilated patients [10]. Whilst on children's wards, a daytime RN to patient ratio of 1:3 is recommended for children under 2 years of age, and 1:4 for other ages [11]. On mental health wards, the Royal College of Psychiatry [12] suggests that a daytime ratio of 1:5 RN's per patient is likely to be needed for acute wards. But they go on to caution about the use of minimums, and recommend that "the determination of appropriate staffing will involve dialogue between managers, nurses and other clinicians" [12].

This is a common thread; staffing recommendations provided in the UK are accompanied by a proviso that staffing needs to take into account specific local factors and be based on an assessment of clinical need and other factors that influence staffing requirement (such as range of services, unit/ward layout, team mix).

Conclusions and implications

- International evidence suggests that mandated registered nurse to patient ratio can improve nurse staffing and lead to better recruitment, generate a more stable workforce, and more manageable workloads for staff. The impact on patient outcomes is less clear but there is evidence that the resultant lower caseloads are related to lower levels of patient mortality.
- Ratios and recommendations are specialty specific. Existing recommendations are focussed on clearly defined and delineated settings, where patient need is relatively predictable and consistent. Data about current staffing related to safe and effective care delivery is needed to determine the appropriate 'minimum' or recommendation for a wider range of settings, such as acute care for older people.
- There is a need to clarify how existing ratios are expressed and to explore other measures of staffing, such as nursing hours per patient, or per bed.

Key points for policy

- Defining minimum nurse staffing levels could help to stabilise the nursing workforce, ensure safe levels of staffing, and deliver care to an agreed standard. However, careful consideration needs to be paid to variations in patient needs and local clinical contexts, as well as the potential impact on patients.
- Setting a mandated minimum has major consequences not just in terms of investment required to set up and establish (and periodically recalibrate), but also in terms of mechanisms needed to monitor compliance and deal with non-compliance.
- Ratios currently in use focus on numbers of registered nurses to patients. There is also a need to look at overall staffing levels, and the skill mix of the nursing team.
- Ratios do not obviate the need for robust mechanisms for workforce planning locally, to ensure that the right staff with the right skills are in place to meet patient needs.

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