Safe staffing for nursing in A&E departments

NICE safe staffing guideline

Draft for consultation, 16 January to 12 February 2015

Contents

Introduction

The Department of Health and NHS England have asked NICE to develop evidence-based guidelines on safe staffing, with a particular focus on nursing staff, for England. This request followed the publication of the following reviews and reports:

- Francis report on Mid Staffordshire (2013)
- Keogh review into the quality of care and treatment provided in 14 hospital trusts in England (2013)
- Cavendish review, an independent enquiry into healthcare assistants and support workers in the NHS and social care setting (Cavendish 2013)
- Berwick report on improving the safety of patients in England (2013).

The need for guidelines on safe staffing, including nursing staff, was also highlighted in the recent policy documents and responses:

- How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board 2013)
- Hard truths. The journey to putting patients first (Department of Health 2013)
- High quality care for all, now and for future generations: transforming urgent and emergency care services in England. (NHS England 2013).

Focus of the guideline

This guideline makes recommendations on safe nursing staff requirements for Accident and Emergency (A&E) settings, based on the best available evidence. The guideline focuses on nursing staff requirements in type 1 A&E departments. In this guideline, nursing staff refers to registered nurses and non-registered nursing staff such as healthcare assistants or assistant practitioners, unless otherwise specified.

The guideline recommendations are split into different sections:

- Recommendations in section 1.1 are aimed at hospital boards, senior management and commissioners. They focus on the responsibilities that

organisations have and actions that organisations should take to support safe nursing staff requirements in A&E departments.

- Recommendations in section 1.2 are aimed at senior registered nurses responsible for determining A&E nursing staff requirements or those involved in setting the A&E nursing staff establishment. They focus on the process for setting the A&E nursing staff establishment and the factors that should be taken into account when undertaking this process.
- Recommendations in section 1.3 are aimed at senior registered nurses who are in charge of shifts in the A&E department and are about ensuring that the A&E department can respond on a shift by shift basis to situations that may lead to an increased demand for nursing staff and to variation in the numbers of nursing staff needed and the numbers available.
- Recommendations in section 1.4 are aimed at senior management and registered nursing managers and are about monitoring whether safe A&E nursing staff requirements are being met. This includes recommendations to review nursing staff establishments and adjust if required.

(For further information, see the scope for the guideline.)

This guideline is for NHS provider organisations and others who provide or commission services for NHS patients. It is aimed at healthcare boards, chief nurses, hospital managers, A&E managers, registered nurses, non-registered nursing staff, other healthcare professionals and commissioners. It will also be relevant to those responsible for services affecting attendance into, transfer out of, and discharge from A&E, and of interest to regulators and the public.

Those responsible and accountable for staffing for nursing in A&E departments should take this guideline fully into account. However, this guideline does not override the need for, and importance of using professional judgement to make decisions appropriate to the circumstances.

This guideline does not cover nursing workforce planning or recruitment at network, regional or national levels, although its content may inform these areas. It does not cover other types of urgent care settings or the effectiveness of different service delivery models.

This guideline does not address staffing requirements in relation to other staff groups such as advanced nurse practitioners, emergency nurse practitioners, allied health professionals, nurse consultants or medical consultants, although we acknowledge that a multidisciplinary approach and the availability of other staff and healthcare professionals are an important part of safe staffing for A&E nursing. The guideline takes into account the impact of the availability of other staff groups on nursing staff requirements.

Related documents

The National Quality Board for England considers that nursing staff capacity and capability are the main determinants of the quality of care experienced by patients, and has issued guidance about what is expected of commissioners and providers in this area (National Quality Board 2013). NHS England and the Care Quality Commission also recently published joint guidance to NHS trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels. The Department of Health (2014) has published its consultation response to introducing fundamental standards to promote care that is safe, high quality, and puts patients first. A comprehensive review of the NHS urgent and emergency care system in England is being undertaken, led by Professor Sir Bruce Keogh, and NHS England and the National Quality Board have recently released a Guide to Assessing Care Contact Hours. This guideline should be read alongside these documents.

Toolkits to support the guideline

The guideline will also be of interest to people involved in developing evidence-based toolkits for assessing and determining safe nursing staff requirements. NICE offers a separate process to assess whether submitted evidence-based toolkits for informing staffing requirements comply with the guideline recommendations. Details of any toolkits that can help with implementing this guideline are listed alongside other resources.

Staffing ratios

Minimum registered nurse-to-patient ratios in A&E departments are recommended in this guideline based on the evidence available and the Safe Staffing Advisory

Committee's knowledge and experience. The Committee's discussions about staffing ratios are contained in the 'Evidence to recommendations tables' document that is published alongside the guideline.

Patient-centred care

Assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for A&E. Assessment of patients' nursing needs should take into account individual preferences and the need for holistic care and patient contact time.

Patients, and their family members and carers if appropriate, should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. Healthcare professionals and others responsible for assessing safe nursing staff requirements for A&E should also refer to NICE's guidance on the components of good patient experience in adult NHS services.

It is also important to note that patients have rights and responsibilities as set out in the NHS Constitution for England: all NICE guidance is written to reflect these. The Department of Health and NHS England's Compassion in Practice strategy also sets out a shared purpose for nurses, midwives and care staff to deliver high-quality, compassionate care, and to achieve excellent health and wellbeing outcomes.

Evidence to recommendations

When drafting these recommendations, the Safe Staffing Advisory Committee considered evidence from the systematic review and an economic analysis report, as detailed in section 2. In some areas there was limited or no published evidence. In these cases, the Committee considered whether it was possible to formulate a recommendation on the basis of their experience and expertise. The evidence to recommendations tables presented in appendix 1 detail the Committee's considerations when drafting the recommendations.

The Committee also identified a series of gaps in the evidence – please see section 3 for further details.

When drafting the recommendations the Committee considered:

- whether there is a legal duty to apply the recommendation (for example, to be in line with health and safety legislation)
- the strength and quality of the evidence base (for example, the risk of bias in the studies looked at, or the similarity of the patient populations covered)
- the relative benefits and harms of taking (or not taking) the action
- any equality considerations.

Strength of recommendations

Recommendations using directive language such as 'ensure' and 'provide' indicate that the Committee was confident that a course of action would lead to improvements in safe nursing care.

If the quality of the evidence or the balance between benefits and harms means that more time should be taken to decide on the best course of action, the Committee has used 'consider'.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with health and safety regulations).

1 Recommendations

The recommendations in this guideline cover nursing care provided in type 1 A&E departments.

Recommendations in section 1.1 focus on the responsibilities that organisations have and actions that organisations should take to support safe nursing staff requirements in A&E departments.

The recommendations in section 1.2 outline the process and factors to be considered when setting the A&E nursing staff establishment. Recommendations in section 1.3 are about ensuring that the A&E department can respond on a shift by shift basis to situations that may lead to an increased demand for nursing staff and to variation in the numbers of nursing staff needed and the numbers available.

Section 1.4 is about monitoring whether safe A&E nursing staff requirements are being met. This includes recommendations to review nursing staff establishments and adjust if required.

1.1 Organisational strategy

These recommendations are for hospital boards, senior management and commissioners.

Focus on patient care

1.1.1 Ensure that patients attending A&E departments receive the nursing care they need at all times of the day and night, on weekdays and at weekends.

Accountability for A&E nursing staff establishments

1.1.2 Develop procedures to ensure that there are enough registered nurses and non-registered nursing staff (referred to as the A&E nursing staff establishment) to provide safe care at all times to patients attending A&E departments. The board should ensure that the budget for the A&E department covers the required nursing staff establishment.

1.1.3 Ensure that all A&E departments have the capacity to:

- Deliver the nursing care that all patients need from the time of attendance at the department, through initial and on-going assessment, and care delivery to discharge.
- Provide triage, minor, major, resuscitation and paediatric A&E services, and where appropriate major trauma A&E services.
- Provide staff to cover all the nursing roles needed for each shift, including coordination and oversight of each shift.
- Provide specialist input for children by having a registered children's nurse on each shift or, where the level of service provided does not warrant this, at least 1 A&E nurse on each shift with education, training and competency in children's nursing.
- Provide specialist input for older people, people with learning disabilities, sensory impairment, mental health needs (including dementia) or complex psychosocial needs, and to address language barriers.
- Allow for the following:
  - Uplift (for example, annual leave, maternity leave, paternity leave, study leave and sickness absence).
  - Time for all A&E nursing staff to provide and receive specialty specific continuing professional development and statutory and mandatory training.
  - Time for all A&E registered nurses to provide training and mentorship for student nurses.
  - Time for all A&E registered nurses to provide training and supervision for non-registered nursing staff.
- Predict and respond to variation over time as indicated by records of A&E nursing staff requirements (for example, changes in demand for A&E services).

1.1.4 Develop procedures to ensure that the A&E nursing staff establishment is developed by registered nurses with:

- responsibility for determining nursing staff requirements at A&E departmental level and

- experience and training in setting staffing establishments.

1.1.5 Procedures should ensure that the chief nurse (or delegated accountable staff) approves the A&E nursing staff establishment.

1.1.6 Ensure that senior nursing managers (for example, A&E matrons) are accountable for the A&E nursing staff roster that is developed from the A&E nursing staff establishment.

Organisational level actions to enable A&E responsiveness

1.1.7 Develop escalation plans to address risk to patient care posed by:

- variation in demand for A&E services
- variation in nursing needs
- departmental crowding.

1.1.8 Develop escalation plans in collaboration with A&E registered nurses with responsibility for determining nursing staff requirements at A&E departmental level.

1.1.9 Determine the level of risk at which escalation plans should take effect locally, taking into account the size of the A&E department and the availability of neighbouring services.

1.1.10 Ensure that escalation plans contain actions to address variation in demand for A&E services and nursing needs in the A&E department. These may include:

- addressing patient flow issues throughout the organisation
- moving patients out of the A&E department to an appropriate alternative location
- sourcing extra staff (for example, using an on-call system).

1.1.11 Ensure that escalation plans also contain actions to:

- make the A&E department safe if departmental crowding cannot be resolved

- respond to deficits in A&E nursing staff without compromising patient care in other parts of the hospital.

1.1.12 Ensure that the chief nurse (or delegated accountable staff) approves actions within escalation plans related to A&E nursing staff.

1.1.13 Develop action plans to address crowding in A&E departments in collaboration with other organisations to facilitate a whole system response. These might include:

- mental health trusts
- ambulance trusts
- primary and community services
- social care services.

1.1.14 Facilitate and promote multidisciplinary working in the A&E department.

Monitor adequacy of A&E nursing staff establishments

1.1.15 Review the A&E nursing staff establishment at board level at least every 6 months, ensuring that the review includes analysis of:

- nursing red flag events (see box 3)
- safe nursing indicators
- data on variation in demand for A&E services.

1.1.16 Review the A&E nursing staff establishment at board level more frequently than every 6 months if:

- staff absenteeism is increasing
- departmental crowding occurs frequently
- A&E nursing staff deficits occur frequently
- escalation plans are implemented frequently
- local services are reconfigured and this may impact on demand for A&E services.

1.1.17 Change the A&E nursing staff establishment if the review indicates this is needed.

1.1.18 Discuss the A&E nursing staff establishment with commissioners at least every 12 months (this may be part of contract reviews).

Monitor and respond to changes

1.1.19 Ensure that there are procedures in place for monitoring and responding to unexpected changes in A&E nursing staff requirements throughout a shift.

1.1.20 Ensure that there are procedures in place for:

- informing members of staff, patients, family members and carers what nursing red flag events (see box 3) are (for example, by publicising them in the A&E waiting room)
- enabling members of staff, patients, family members and carers to report nursing red flag events (see box 3) to the A&E registered nurse in charge of the shift
- monitoring and responding to nursing red flag events (see box 3).

1.1.21 Ensure that responses to nursing red flag events and unexpected changes in A&E nursing staff requirements do not cause nursing red flag events in other parts of the hospital.

Promote staff training and education

1.1.22 Ensure that all A&E nursing staff receive training to deliver the care they are required to provide, including:

- specialty specific continuing professional development
- statutory and mandatory training
- training in providing care for children, older people, people with learning disabilities, sensory impairment, mental health needs (including dementia) or complex psychosocial needs, and in addressing language barriers.

1.1.23 Ensure that all A&E nursing staff have time allocated for:

- training and mentoring student nurses on placement in the A&E department or non-registered nursing staff
- supervising and assessing the competencies of non-registered nursing staff
- taking part in clinical governance activities (for example, audit).

1.1.24 Ensure that A&E registered nurses have time allocated for activities related to setting the A&E nursing staff establishment, and assessing the nursing staff needed for each shift, including collecting and analysing data.

1.1.25 Involve A&E nursing staff in developing and maintaining nursing staff policies and governance, including escalation planning.

1.2 Setting the A&E department nursing staff establishment

These recommendations are for senior registered nurses responsible for determining A&E nursing staff requirements or those involved in setting the A&E nursing staff establishment.

1.2.1 Determine the nursing staff establishment for the A&E department at least every 6 months.

1.2.2 Use the following systematic assessment to calculate the A&E nursing staff establishment. Evidence-based toolkits endorsed by NICE could be used to support this assessment:

- Use historical data on demand for A&E services over at least the past 2 years to predict likely nursing hours for the next 6 months.
- Determine the average A&E nursing workload according to day of week and time of day over 7 days. Consider the following as a prompt:
  - patient, environmental and staffing factors (box 1)
  - nursing care tasks and activities (box 2).
- Estimate the nursing time needed to perform the nursing care tasks and activities (box 2).
- Calculate the total nursing hours that are needed over 7 days.

- Identify the nursing care activities for which A&E registered nurses are responsible and the activities that can be safely delegated to trained and competent non-registered nursing staff. Base this on the local configuration of services and range of staff available (such as registered nurses with specialist skills [for example, mental health]).
- Increase the weekly average number of nursing hours to account for the following:
  - uplift (annual leave, maternity leave, paternity leave, study leave and sickness absence); determine the rate of uplift locally
  - variation in predicted demand and the need for flexibility in deploying nursing staff across the A&E department (the daily average number of nursing hours should meet no less than the average daily demand [based on a similar day or the same day in previous years] plus at least 1 standard deviation)
- Divide the calculations by 37.5 to determine the number of whole time equivalents needed for the A&E nursing staff establishment.

1.2.3 Check that the calculations in recommendation 1.2.2 provide enough A&E nursing staff to meet the following minimum ratios and adjust if necessary:

- 1 registered nurse to 1 cubicle in triage
- 1 registered nurse to 4 cubicles in minors and majors
- 1 registered nurse to 2 cubicles in the resuscitation area.

1.2.4 Check that the calculations in recommendation 1.2.2 provide enough A&E nursing staff to meet nurse-to-patient ratios for the following situations when needed:

- major trauma (2 registered nurses to 1 patient)
- cardiac arrest (2 registered nurses to 1 patient)
- priority ambulance calls (1 registered nurse to 1 patient)
- family liaison (1 registered nurse to 1 patient's family/carers).

1.2.5 Ensure that 1 band 7 (or equivalent) registered nurse is included on every shift at all times to lead, supervise and oversee the shift.

1.2.6 Use professional judgement when undertaking the systematic assessment and checking the calculations for the A&E nursing staff establishment.

1.2.7 Base the A&E nursing staff roster on the A&E nursing staff establishment calculations, taking into account any specific times of the day or week when the A&E department is likely to be busy. Consider staggering shift start times of individual nursing staff to correspond with peaks in demand.

Box 1 Factors to consider when determining A&E nursing staff requirements

Patient factors

- Number of patients attending A&E.
- Patient case mix:
  - Patient demographics (for example, patients whose first language is not English, older people, people with learning disabilities, sensory impairment, mental health needs [including dementia] or complex psychosocial needs)
  - Patient acuity
  - Patient dependency (for example, as measured by the Jones Dependency Tool or other similar tool).
- Patient hours spent in the A&E department.
- Patient support needed (for example, the support they need to return home when discharged from the A&E department).
- Needs of patients, family members or carers who may be receiving life changing news.

Environmental factors

- Functions of the A&E department (for example, whether there is an integrated 'observation' ward or clinical decision unit).
- Proximity of related units within the hospital (for example, clinical decision units, 'observation' wards or imaging departments) and where patients might go when they leave the A&E department (for example, medical admissions ward).

- Layout of the A&E department (for example, number of side rooms and bays for specific services such as minors, majors or resuscitation).
- Local geography and availability of neighbouring services.
- Proximity of related units outside the hospital (for example, specialist major trauma centres).
- Seasonal variance, bank holidays and local events (for example, local festivals).

Staffing factors

- Nursing activities and responsibilities, other than direct patient care, including:
  - Accompanying patients being transferred within the hospital or to another hospital or unit.
  - Communicating with family members and carers.
  - Liaison with other specialists, departments or services (for example, social care or mental health services) outside the A&E department.
  - Training and mentorship of student nurses.
  - Training and supervision for non-registered nursing staff.
  - Undertaking audit.
- Availability of other members of the A&E multidisciplinary team (for example, other clinicians, support staff and administrative staff).
- Proportion of A&E nursing staff with specialist skills (for example, in mental health or children's nursing).
- Proportion of temporary A&E nursing staff.

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Box 2 Ongoing A&E nursing care tasks and activities that affect nursing staff requirements (this is not an exhaustive list)

Overarching tasks and activities of the nurse in charge of the shift

Coordinate and allocate available resources during a shift	Deploy appropriate actions if major incident declared
Assess all patients arriving by ambulance	Ensure patient flow and mitigate against crowding issues
Overview of the department as a whole	Liaise with wards and on-call managers
Request and negotiate beds for admission	Ensure staff wellbeing
Troubleshoot and problem solve	Make decision to call on-call consultant
De-escalate potentially volatile situations	

Routine tasks and activities required of A&E nursing staff as the patient progresses through the A&E department

Attendance and initial assessment	Ongoing assessment and care delivery	Discharge
Reception of patients	Assessment of patients with undifferentiated presentations	Handover to wards
Assessment of patients with undifferentiated presentations	Assessment of pain and administration of pain relief	Discharge planning, arrangement of transport and safe discharge follow-up
Prioritisation	Requesting investigations	Providing instructions and written information to patients and/or family members or carers
Assessment of pain and administration of pain relief	Administration of medication	
	Personal care (for example, toileting, nutrition,	

Risk assessment Requesting investigations Initial wound assessment and care Onward referral Obtaining patient information (for example, previous case notes) Safeguarding	hydration and positioning) Observations Skin and pressure area care Meeting immediate nursing needs Carry out investigations Procedures (for example, catheterisation) Treatments (for example, complex wound care) Assist and prepare equipment for procedures Patient escorts Collecting information from patient or family members/carers Obtaining patient information (for example, previous case notes) Involving patients and family members or carers in decisions about their care Providing additional support for children, older people, people with learning disabilities, sensory impairment, mental health needs (including dementia) and complex	Liaison with outside agencies Safeguarding Support for family members or carers Care after death

	psychosocial needs, and addressing language barriers Safeguarding Collecting data (for example, feedback from patients, information for revalidation purposes, audit, information for setting the staffing establishment) Supervision of non-registered nursing staff	

Additional nursing care time needs to be factored in for patients with additional nursing care needs, for example 20 – 30 minutes per activity or more than 30 minutes if additional needs are significant.

Additional nursing care needs may include the following:

- Complex conditions such as multiple morbidities or health needs
- Assistance with eating and drinking
- Difficulties with communication including sensory impairment or language difficulties
- Medication requiring complex preparation or administration
- Assistance needed with mobilisation
- Assistance needed with toileting needs

1.3 Assessing differences in the number and skill mix of A&E nursing staff needed and number of A&E nursing staff available

These recommendations are for senior registered nurses who are in charge of shifts in the A&E department.

1.3.1 At the beginning of every shift assess differences between the A&E nursing staff needed for that shift and the following shift, and the number of staff available. This assessment could be facilitated by using an evidence-based toolkit endorsed by NICE. Take into account the patient, staffing and environmental factors outlined in box 1.

1.3.2 Use professional judgement when assessing the differences between A&E nursing staff requirements and the number of staff available.

1.3.3 Assess differences between the A&E nursing staff needed and the number of staff available during a shift when:

- there is unexpected variation in demand for A&E services or nursing needs
- there is unplanned staff absence
- patients are spending longer than needed in the A&E department (often because of departmental crowding)
- patients need extra support, specialist input or continuous nursing
- a nursing red flag event has occurred (see recommendation 1.3.5).

1.3.4 Follow escalation plans if the number of A&E nursing staff available is different from the number of staff needed. Action could include:

- moving patients out of the A&E department to an appropriate alternative location
- delegating activities to suitably trained and competent staff
- sourcing extra staff (for example, by allocating extra on-call or temporary staff).

1.3.5 Throughout each shift, monitor reported nursing red flag events shown in box 3. Monitor other events as agreed locally.

1.3.6 If a nursing red flag event is reported this should prompt an immediate escalation response by the registered nurse in charge of the shift. An appropriate response may to allocate additional nursing staff to the department.

1.3.7 Keep records of:

- differences between the number of A&E nursing staff needed and the number of staff available for each shift
- nursing red flag events reported and actions taken.

Use these records to inform planning of the future A&E nursing staff establishment.

Box 3 Nursing red flag events

- Missed care, for example:
  - untreated pain
  - delay in meeting patients' toileting needs
  - delay in meeting patients' hydration or nutrition needs.
- Falls.
- Patients leaving the A&E department against advice.
- Missing patients.
- A shortfall of more than 25% of registered nurse time available compared with the actual requirement for the shift.
- Violence and aggression towards staff (for example, from patients, family members or carers).
- A crowded[1] A&E department.

[1] Define locally how a crowded A&E department can be identified. The following measures may provide a useful starting point:

- ability of ambulances to offload patients
- patients who leave without being seen or treated
- time until triage
- A&E occupancy rates
- patients' total length of stay in the A&E department

1.4 Monitor and evaluate A&E nursing staff establishments

These recommendations are for senior management and registered nursing managers to support safe staffing for A&E nursing.

1.4.1 Monitor whether the A&E nursing staff establishment adequately meets patients' nursing needs using the safe nursing indicators in box 4. Consider continuous data collection of these safe nursing indicators (using data already routinely collected locally where available) and regularly analyse the results. See section 8 for more information on safe nursing indicators.

1.4.2 Compare the results of the safe nursing indicators with previous results at least every 6 months.

1.4.3 Analyse reported nursing red flag events (see box 3) when undertaking this monitoring and prompt an earlier examination of the adequacy of the A&E nursing staff establishment if this is indicated.

Box 4 A&E safe nursing indicators

Patient experience measures

Data for these indicators can be collected using the Accident and Emergency Department (A&E) survey and A&E clinical quality indicators:

- Service experience of patients using A&E services.
- Duration of time waiting to first speak to or be examined by a nurse.
- Adequacy of care and treatment in terms of reassurance, privacy, respect and dignity.

Clinical quality indicators

Data for these indicators can be collected using the A&E clinical quality indicators:

- Patient left without being seen – number of attendances where the patient left without being seen by a clinician.

- time until a doctor first sees the patient
- time from decision to admit to ward admission
- number of patients in the A&E department who are waiting for an inpatient bed.

- Total time spent in the A&E department – time spent from arrival at A&E to admission, transfer or discharge.
- Time to initial assessment – time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs) for all patients arriving by emergency ambulance.

Staff reported measures

Data can be collected for some of the following indicators using the NHS staff survey:

- Missed breaks – record the proportion of expected breaks that were unable to be taken by A&E nursing staff.
- A&E nursing overtime work – record the proportion of A&E nursing staff working extra hours (both paid and unpaid).
- A&E appraisals – record whether an appraisal has taken place in the past 12 months.
- Staff morale – record the proportion of A&E nursing staff job satisfaction.

A&E nursing staff establishment measures

Data can be collected for some of the following indicators from the NHS England and Care Quality Commission joint guidance to trusts on the delivery of the 'Hard Truths' commitments on publishing staffing data regarding nursing, midwifery and care staff levels and more detailed data collection advice since provided by NHS England.

- High levels and/or ongoing reliance on temporary nursing staff – record the proportion of hours provided by bank and agency nursing staff in the A&E department (the agreed acceptable levels should be established locally).
- High levels of staff turnover – record the rates of nursing staff turnover in the A&E department (the agreed acceptable levels should be established locally).
- Compliance with any mandatory training in accordance with local policy (this is an indicator of the adequacy of the size of the A&E nursing staff establishment).

Note: other A&E nursing staff indicators may be agreed locally.

2 Evidence

The Committee considered the following commissioned reports.

- **Evidence review**: Drennan J, Recio Saucedo A, Pope C et al. (2014) Safe Staffing for Nursing in Accident and Emergency Departments. University of Southampton.
- **Economic analysis**: Optimity Matrix (2014).

The review and economic analysis are available on the NICE website.

The evidence review considered the following review questions:

- What patient outcomes are associated with safe staffing of the nursing team?
- Is there evidence that demonstrates a relationship between nursing staff numbers and increased risk of harm?
- Which outcomes should be used as indicators of safe staffing?
- What patient factors affect nursing staff requirements as patients progress through an A&E department? These include:
  - Patient case mix and volume, determined by, for example, local demographics and seasonal variation, or trends in attendance rates (such as bank holidays, local or national events, and the out-of-hours period)
  - Patient acuity such as how ill the patient is, their increased risk of clinical deterioration and how complex and time consuming the care they need is
  - Patient dependency
  - Patient risk factors, including psychosocial complexity and safeguarding
  - Patient support (that is, family, relatives, carers)
  - Patient triage score
  - Patient turnover
- What environmental factors affect nursing staff requirements as patients progress through A&E? These include:
  - Availability and physical proximity of other separate units (such as for triage) or clinical specialties, such as the ‘seven key specialties’ (that is, critical care, acute medicine, imaging, laboratory services, paediatrics, orthopaedics and general surgery), and other services such as social care

  - Department size and physical layout
  - Department type (for example, whether it is a major trauma centre)
  - What staffing factors affect nursing staff requirements as patients progress through an A&E department? These include:
  - Availability of, and care and services provided by other multidisciplinary team members such as emergency medicine consultants, anaesthetists, psychiatrists, pharmacists, social workers, paramedics and advanced nurse practitioners and emergency nurse practitioners who are not part of the core A&E nursing establishment
  - Division of activities and balance of tasks between registered nurses, healthcare assistants, specialist nurses and other healthcare staff who are part of the A&E team
  - Models of nursing care (for example, triage, rapid assessment and treatment)
  - Nursing experience, skill mix and specialisms
  - Nursing staff transfer duties within the hospital and to external specialist units
  - Nursing team management and administration approaches (for example, shift patterns) and non-clinical arrangements
  - Proportion of temporary nursing staff (for example, bank and agency)
  - Staff and student supervision and teaching
- What approaches for identifying nursing staff requirements and/or skill mix, including toolkits, are effective and how frequently should they be used?
- What evidence is available on the reliability and/or validity of any identified toolkits?
- What organisational factors influence nursing staff requirements at a departmental level? These include:
  - Availability of other units or assessment models such as short-term medical assessment or clinical decision units, ambulatory care facilities or a general practitioner working within the hospital
  - Crowding (for example, local factors influencing bed occupancy levels and attendance rates such as changes in usual climate temperatures which results in over-full A&E or wards)
  - Organisational management structures and approaches
  - Organisational culture

  - Organisational policies and procedures, including staff training
  - Physical availability of inpatient wards or specialist units to transfer patients out of A&E to other parts of the hospital.

The economic analysis used the best available evidence and data from the UK to examine the trade-offs between outcomes and cost and investigated the effects of varying attendance volumes, staff numbers and skill mixes.

3 Gaps in the evidence

The Safe Staffing Advisory Committee identified a number of gaps in the available evidence and expert comment related to the topics being considered. These are summarised below.

- There is limited evidence directly identifying the relationship between safe staffing of the A&E nursing team and patient safety outcomes.
- There is no evidence about environmental factors that might modify the relationship between A&E nursing staff requirements and patient safety outcomes.
- There is limited evidence about organisational, staffing and patient factors that might modify the relationship between A&E nurse staffing requirements and patient safety outcomes.
- There is a lack of evidence for decision support approaches, frameworks, methods or toolkits.
- There is a lack of economic evidence around safe nurse staffing in A&E departments.
- There is lack of UK-based published primary studies about mandatory nurse-to-patient ratios in A&E departments.
- There is limited data on patient dependency in A&E departments because this is not often measured or recorded electronically.

4 Research recommendations

Research recommendations are in development and will be included in the final guideline.

5 Related NICE guidelines

Details are correct at the time of consultation on the guideline (January 2015). Further information is available on the NICE website.

Many other pieces of NICE guidance are relevant to this guideline on safe staffing for nursing in A&E departments, including clinical guidelines on specific acute conditions (see the NICE website for further details).

Published

- Head Injury (2014) NICE guideline CG176.
- Patient experience in adult NHS services (2012) NICE guideline CG138.
- Self-harm (2004) NICE guideline CG16.

Under development

NICE is developing the following guidance (details available from the NICE website):

- Acute medical emergencies in adults and young people, service guidance. NICE service guidance. Publication expected November 2016.
- Major trauma services. NICE service guidance. Publication expected February 2016.
- Major trauma. NICE clinical guideline. Publication expected February 2016.
- Complex fractures. NICE clinical guideline. Publication expected February 2016.
- Spinal injury assessment. NICE clinical guideline. Publication expected February 2016.
- Fractures. NICE clinical guideline. Publication expected February 2016.
- Violence and aggression (update). NICE clinical guideline. Publication expected April 2015.

6 Glossary

Advanced nurse practitioners

Registered nurses with advanced clinical skills who independently manage an entire episode of patient care in an emergency setting. In A&E their scope of practice is

wide and they will manage patients typically presenting to the ‘majors’ end of the department.

Band 7 nurse

Band 7 refers to the Agenda for Change payment band for registered nurses who meet particular criteria related to their specialised knowledge, skills and experience. Nurses at this level are considered to be senior and experienced nurses.

Cubicle

When patients are being actively assessed or treated in an A&E department they will be allocated a cubicle. Typically in ‘majors’ the patient will stay in the allocated cubicle for the duration of their stay in A&E. In the ‘minors’ area they may move in and out of several cubicles during their patient journey.

Demand for A&E services

This term is used to cover A&E attendance volumes, profile (patient demography and need) and pattern (the time of day and day of the week when patients attend A&E).

Departmental crowding

When emergency department function is impeded because the number of patients waiting to be seen, undergoing assessment and treatment, or waiting for departure exceeds the physical bed and/or staffing capacity of the emergency department.

Emergency nurse practitioners

Registered nurses with advanced clinical skills who independently manage an entire episode of patient care in an emergency setting. Their scope of practice varies depending on departmental requirements. They will manage patients typically presenting to the ‘minors’ end of the A&E department.

Family liaison

Family liaison refers to the role of nursing staff in supporting family and carers who may be receiving life changing news in relation to the health of a loved one. The role includes providing intense emotional and practical support to bereaved family and

carers, which may take several hours. Dedicated time is needed with family and carers in order to deliver news in a sensitive manner that respects the emotions of those involved.

Majors

When patients receive initial assessment in the A&E department they are assigned a triage category that allocates them to different areas of the department according to their needs. The ‘majors’ department will see patients presenting with urgent health needs that need immediate attention upon arrival.

Major trauma

Trauma can be defined as physical injury caused by events such as road traffic accidents, falls, explosions, shootings or stabbings. The term ‘major trauma’ is therefore used to describe multiple injuries involving different tissues and organ systems that are, or have the potential to be, life threatening. Trauma patients require specialist care from a multidisciplinary group of professionals.

Minors

When patients receive initial assessment in the A&E department they are assigned a triage category that allocates them to different areas of the department according to their needs. The ‘minors’ department will see patients presenting with less urgent health needs.

Missed care

When a patient does not receive an aspect of care that has been assessed by healthcare professionals as being required. Care may have been delayed, performed to a suboptimal level, omitted or inappropriately delegated.

NICE endorsement programme

A new programme which formally endorses guidance support resources produced by external organisations. The programme will assess resources such as toolkits which aim to estimate nursing staff requirements. NICE awards an endorsement statement to toolkits that meet the endorsement criteria.

Non-registered nursing staff

Non-registered nursing staff work in hospital or community settings under the guidance and supervision of a registered healthcare professional. Their titles may include healthcare assistant, healthcare support worker, nursing auxiliary, nursing assistants and assistant practitioners. Their responsibilities vary, depending on the healthcare setting and their level of training and competence.

Nursing red flag events

Negative events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to senior nurse in charge of the shift and response may include allocating additional staff to the ward/unit or other appropriate response.

Nursing skill mix

The composition of the nursing team in terms of qualification and experience. This is typically expressed as a percentage of registered nurses to non-registered nursing staff. Nursing skill mix should also include individual clinical competencies and different areas of expertise and grades of registered nurses and non-registered nursing staff.

Nursing staff

This refers to registered nurses and non-registered nursing staff, unless otherwise specified.

Nursing staff establishment

The number of nursing staff funded to work in the A&E department. This includes all nursing staff in post, as well as unfilled vacancies or vacancies being covered by temporary staff. Nursing staff establishments are usually expressed in numbers of whole-time equivalents.

Nursing staff requirement

The nursing staff required in the A&E department. This should take into account all nursing care needs of patients, environmental factors and staffing factors including

nursing activities other than direct patient care. This can be expressed as number of nursing hours.

Nursing staff roster

The daily staffing schedule for registered nurses and non-registered nursing staff to work in the A&E department.

Patient acuity

Refers to seriousness of a patient's condition, the risk of clinical deterioration and their specific care needs. This term is sometimes used interchangeably with the terms 'patient complexity' and 'nursing intensity'.

Patient 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 and hygiene, and mobilisation.

Registered nurse

A registered nurse holds active registration with the Nursing and Midwifery Council with a licence to practise. Nursing is a regulated profession for registered nurses, but they may delegate and supervise the delivery of nursing activities to non-registered nursing staff.

Safe nursing care

When reliable systems, processes and practices are in place to meet required care needs and protect people from missed care and avoidable harm.

Safe nursing indicators

Positive or negative signs that can be monitored and used to inform future nursing staff requirements or prevent negative events related to nursing staff levels happening in the future.

Service delivery models

Models of how services should be organised and configured (for example location, content, timing and configuration of a service), what resources (for example staff and equipment) are needed and the processes that need to be followed to ensure the efficient provision of clinical and cost-effective healthcare interventions.

Standard deviation

A mathematical term used to measure the spread of a set of numbers around an average, and therefore how much variation there is from the average.

The following examples illustrate how to calculate the average number of attendances plus 1 standard deviation as part of the process outlined in recommendation 1.2.2. If multiple years' worth of A&E attendance data is available:

- calculate the average daily attendance on a specific day (for example, 13 January)
- work out the standard deviation of that average (using a scientific calculator or spreadsheet application that contains statistical functions)
- add the 1 standard deviation calculation to the average daily attendance.

Alternatively, with limited historical data on A&E attendances:

- calculate the average daily attendance on a similar day (for example, a Tuesday in winter, or bank holiday Mondays)
- work out the standard deviation of that average (using a scientific calculator or spreadsheet application that contains statistical functions)
- add the 1 standard deviation calculation to the average daily attendance.

Toolkit

A practical resource to facilitate the process of calculating the nursing staff requirements for departments or organisations. It may be electronic or paper-based.

Type 1 A&E departments

Consultant-led 24-hour services with full resuscitation facilities and designated accommodation for the reception of A&E patients.

7 Contributors and declarations of interest

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Declarations of interests

The following members of the Safe Staffing Advisory Committee made declarations of interest. All other members of the Committee stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Georgina Dwight	Remuneration from consultancy undertaken in 2011 for Acertus Ltd – Search and Selection	Personal pecuniary interest	Declare and participate
Hugh McIntyre	Chair of Quality Standards Advisory Committee	Personal pecuniary interest	Declare and participate
Elaine Inglesby	Member of the Safe Staffing Alliance	Personal non-pecuniary interest	Declare and participate
Julia Scott	NICE Social Care Fellow (until May 2014), honorary Fellow of Brunel University Chief Executive of the College of Occupational Therapists	Non-personal pecuniary interest Personal non-pecuniary interest	Declare and participate Declare and participate
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Elizabeth West	Researcher with an interest in nurse staffing levels with published research in this area. Frequently review articles on nurse staffing for publication in academic journals.	Non-personal pecuniary interest	Declare and participate
Rebecca	Annual honorarium as a member of the Editorial	Personal	Declare and

Hoskins	board of International Emergency Nurse Journal (Elsevier)	pecuniary interest	participate

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8 Safe nursing indicators

Patient experience measures

A&E safe nursing indicator: patient experience measures

Data collection

Local collection could use the following Accident and Emergency Department (A&E) survey questions developed by the Care Quality Commission which contains a number of questions where the patient's experience of care could be affected by the number of available nursing staff:

Doctors and nurses

Q.10 Did you have enough time to discuss your health or medical problem with the doctor or nurse?[2]

Your care and treatment

Q.17 While you were in the A&E department, how much information about your condition or treatment was given to you?

Q.19 If you needed attention, were you able to get a member of medical or nursing staff to help you?[2]

Pain

Q.30 Do you think the hospital staff did everything they could to help control your pain?[2]

Local collection of patient experience could use these questions to provide a more frequent view of performance than is possible through annual surveys alone, but please note NHS Surveys asks that local patient surveys avoid overlap with national patient surveys: www.nhssurveys.org/localsurveys

Outcome measures

Patient satisfaction with A&E care and treatment.

[2] These questions may also reflect care from medical staff.

Data analysis and interpretation

The annual national survey results for your hospital can be compared with previous results from the same hospital and with data from other hospitals (but be aware that comparison between hospitals is subject to variation in expectations of care between different populations). Data from more frequent local data collection, where available, can be compared with previous results and with data from other wards in your hospital.

Clinical quality safe nursing indicator: patients leaving without being seen

Measure

Patients leaving without being seen: record any attendance at A&E where a patient left without being seen in accordance with the A&E clinical quality indicators.

Definition

A patient is defined as leaving without being seen when any attendance results in the patient leaving without receiving treatment as described in indicator 4 of the A&E clinical quality indicators.

Data collection

Proportion of attendances at an A&E department in which an attendance is recorded as left before being seen.

Numerator: the number in the denominator with an attendance code of left before being seen.

Denominator: number of A&E department attendances.

Data source: Local data collection. These data are currently collected by the Health and Social Care Information Centre in A&E clinical quality indicators generated by Hospital Episode Statistics (HES).

Outcome measure

Rate of A&E attendance without being seen.

Data analysis and interpretation

The rate of A&E attendances where patients leave without being seen may be sensitive to the number of available nursing staff in an A&E department. Treatment for patients who attend A&E departments needs a multidisciplinary approach, and leaving without being seen rates may also be affected by:

- patient choice, availability and accessibility
- availability and accessibility of appropriate facilities

- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe nursing indicator: total time spent in A&E department

Measure

Total time spent in the A&E department: time spent from arrival at A&E to admission, transfer or discharge. Data can be collected via A&E clinical quality indicators.

Definition

Total time spent in the A&E department is defined as the time between arrival and registration on the hospital information systems to the time that the patient leaves the department to return home or to be admitted to the ward bed (including the A&E department observation beds) in line with indicator 3 of the A&E clinical quality indicators.

Data collection

Median time spent from arrival at A&E to admission, transfer or discharge.

Data source: Local data collection. These data are currently collected by the Health and Social Care Information Centre in A&E clinical quality indicators generated by Hospital Episode Statistics (HES).

Data analysis and interpretation

The median time spent in A&E should be compared with previous results from the A&E department.

Although the median time spent in A&E may be sensitive to the number of available nursing staff and support they offer, care in the A&E department is provided by a multidisciplinary team. Time spent in A&E may also be affected by:

- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Safe nursing indicator: time to initial assessment

Measure

Time to initial assessment: time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs) for all patients arriving by emergency ambulance. Data can be collected via A&E clinical quality indicators.

Definition

Time from arrival by emergency ambulance to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs) as described in indicator 6 of the A&E clinical quality indicators.

Data collection

Proportion of patient hours spent in A&E from arrival by emergency ambulance to start of full initial assessment.

Numerator: the number of total patient hours spent in A&E from arrival to start of full initial assessment.

Denominator: number of A&E department attendance arrivals by emergency ambulance.

Data source: Local data collection. These data are currently collected by the Health and Social Care Information Centre in A&E clinical quality indicators generated by Hospital Episode Statistics (HES).

Outcome measures

Patient safety.

Data analysis and interpretation

Time to initial assessment should be compared with previous results from the A&E department.

Although the time to initial assessment in A&E may be sensitive to the number of available nursing staff and support they offer, care in the A&E department is provided by a multidisciplinary team. Time spent in A&E may also be affected by:

- patient choice
- availability of appropriate facilities
- availability of all healthcare professionals and support staff
- knowledge and skills of all healthcare professionals and support staff.

Staff reported measures

Safe nursing indicator: missed breaks

Measure

Missed breaks: record the proportion of expected breaks that were not taken by A&E nursing staff.

Definition

A missed break occurs when nursing staff are unable to take a scheduled break due to lack of time.

Data collection

Proportion of expected breaks for nursing staff working in A&E that were not taken.

Numerator: the number in the denominator that were not taken.

Denominator: the number of expected breaks for nursing staff in A&E.

Data source: Local data collection.

Outcome measures

Proportion of missed breaks because of lack of time among nursing staff in A&E.

Safe nursing indicator: A&E nursing overtime

Measure

A&E nursing overtime work: record the proportion of A&E nursing staff working extra hours (both paid and unpaid). Data can be collected via NHS staff survey.

Definition

Nursing overtime includes any extra hours (both paid and unpaid) that nursing staff are required to work beyond their contracted hours at either end of their shift.

Data collection

a) Proportion of nursing staff in A&E departments working overtime.

Numerator: the number in the denominator working overtime.

Denominator: the number of nursing staff in A&E departments.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

b) Proportion of nursing hours worked in A&E departments that are overtime.

Numerator: the number in the denominator that are overtime.

Denominator: the number of nursing hours worked in A&E departments.

Data source: Local data collection. Data are also collected nationally on the number of staff working extra hours (paid and unpaid) in the NHS National Staff Survey by the Picker Institute.

Outcome measures

Staff experience.

Safe nursing indicator: A&E appraisals

Measure

A&E appraisals: record whether an appraisal has taken place in the past 12 months. Data can be collected via NHS staff survey.

Definition

A&E appraisal includes whether an appraisal, annual review, development review, or knowledge and skills framework (KSF) development review took place within the past 12 months.

Data collection

Proportion of nursing staff in A&E departments who had an appraisal within the past 12 months.

Numerator: the number in the denominator who had an appraisal within the past 12 months.

Denominator: the number of nursing staff in A&E departments.

Data source: Local data collection. Data are also collected nationally on the number of staff receiving appraisals NHS National Staff Survey by the Picker Institute.

Outcome measures

Staff experience.

Safe nursing indicator: A&E staff morale

Measure

Staff morale: record the proportion of A&E nursing staff reporting job satisfaction.
Data can be collected via NHS staff survey.

Definition

Nursing staff morale includes the proportion of nurses who claim to have job satisfaction.

Data collection

Proportion of nursing staff in A&E departments who report job satisfaction.

Numerator: the number in the denominator who report job satisfaction.

Denominator: the number of nursing staff in A&E departments.

Data source: Local data collection. Data are also collected nationally on staff morale in the NHS National Staff Survey by the Picker Institute.

Outcome measures

a) A&E nursing job satisfaction.

b) Rates of A&E nursing staff turnover.

c) Rates of sickness.

A&E nursing staff establishment measures

Safe nursing indicator: high levels and/or ongoing reliance on temporary nursing staff

Measure

High levels and/or ongoing reliance on temporary nursing staff: Record the proportion of hours provided by bank and agency nursing staff in the A&E department (the agreed acceptable levels should be established locally).

Definition

Registered nurses who are working in A&E departments who are not contracted with the A&E department.

Data collection

a) Proportion of registered nurses who are working in A&E departments who are not contracted with the A&E department.

Numerator: the number in the denominator who are employed on bank contracts.

Denominator: the number of registered nurse shifts per calendar month to work in the A&E department.

Data source: Local data collection.

b) Proportion of nurses who are working in A&E departments who are on agency contracts.

Numerator: the number in the denominator who are employed on agency contracts.

Denominator: the number of registered nurse shifts per calendar month to work in the A&E department.

Data source: Local data collection.

Outcome measures

Expenditure (£) on bank and agency staff per ward.

Safe nursing indicator: high levels of staff turnover

Measure

High levels of staff turnover: record the rates of nursing staff turnover in the A&E department (the agreed acceptable levels should be established locally).

Definition

Registered nurses working in A&E departments who leave the A&E department to work on another ward or in another organisation.

Data collection

Proportion of registered nurses who leave the A&E department.

Numerator: the number in the denominator who leave the A&E department.

Denominator: the number of registered nurses in the A&E department.

Data source: Local data collection.

Outcome measures

Nursing turnover rate.

Safe nursing indicator: compliance with any mandatory training

Measure

Compliance with any mandatory training in accordance with local policy (this is an indicator of the adequacy of the size of the A&E nursing staff establishment).

Definition

Nurses working in A&E departments who are compliant with the mandatory training that has been agreed in line with local policy.

Data collection

Proportion of registered nurses working in the A&E department who are compliant with all mandatory training.

Numerator: the number in the denominator who are compliant with all mandatory training.

Denominator: the number of registered nurses in the A&E department.

Data source: Local data collection.

Outcome measures

Percentage compliance with all mandatory training.

9 About this guideline

How this guideline was developed

The Department of Health asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on safe staffing for nursing in A&E departments (see the scope).

The recommendations are based on the best available evidence. They were developed by the Safe Staffing Advisory Committee – for membership see section 7.

The guideline was developed in line with the methods and processes contained in the manual for developing all NICE guidelines.

Other versions of this guideline

The recommendations from this guideline will be incorporated into a NICE Pathway.

We will produce information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice will be available.

See the NICE website for details of the NICE endorsement programme for toolkits.

Your responsibility

This guideline represents the views of NICE and was arrived at after careful consideration of the evidence available and the Committee's considerations. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guideline is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guideline, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of

opportunity and foster good relations. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

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