How do staffing issues impact on patient safety?

The recent Health Committee report† on patient safety (July 2009) stated that inadequate staffing levels play a major role in undermining patient safety.

This article explores patient safety issues in relation to staffing levels, based on current reports to the RLS from healthcare professionals. It also includes commentary from other organisations involved in monitoring the quality of healthcare in the NHS.

Staffing issues: facts and figures

The following is an analysis of incidents reported to the RLS which relate to issues such as ‘lack of suitably trained/skilled staff’. The incidents included in the analysis were reported as occurring between April 2008 and March 2009, and were reported to the RLS by the end of June 2009.

Of all the incidents reported to the RLS during this period, 3.4 per cent (33,335) were reported as relating to staffing issues. The majority of these incidents (79 per cent) caused no harm, with 14 per cent causing low harm and six per cent moderate harm. There were 20 incidents reported as causing severe harm to the patient, and six incidents coded as causing the death of a patient (see table 1).

Incidents reported primarily occurred in acute care settings (90 per cent), with a small proportion reported in mental health settings (four per cent) and community services (five per cent) (see figure 1 on page 12).


Table 1: Staffing incidents as a proportion of all incidents types by speciality

<table>
<thead>
<tr>
<th>Clinical speciality</th>
<th>Lack of suitably trained/skilled staff</th>
<th>All incidents</th>
<th>Percentage of staffing incidents of all incidents (by speciality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics and gynaecology</td>
<td>6,485</td>
<td>98,891</td>
<td>6.6</td>
</tr>
<tr>
<td>Accident and Emergency (A&amp;E)</td>
<td>1,878</td>
<td>34,391</td>
<td>5.5</td>
</tr>
<tr>
<td>Dentistry – general and community</td>
<td>52</td>
<td>1,068</td>
<td>4.9</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>386</td>
<td>7,979</td>
<td>4.8</td>
</tr>
<tr>
<td>Surgical specialties</td>
<td>6,203</td>
<td>151,354</td>
<td>4.1</td>
</tr>
<tr>
<td>Medical specialties</td>
<td>12,036</td>
<td>326,317</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
<td>2,279</td>
<td>64,183</td>
<td>3.6</td>
</tr>
<tr>
<td>Other specialties</td>
<td>594</td>
<td>19,614</td>
<td>3.0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>144</td>
<td>6,032</td>
<td>2.4</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td>617</td>
<td>32,063</td>
<td>1.9</td>
</tr>
<tr>
<td>Unknown</td>
<td>209</td>
<td>12,180</td>
<td>1.7</td>
</tr>
<tr>
<td>Primary care/community</td>
<td>842</td>
<td>51,825</td>
<td>1.6</td>
</tr>
<tr>
<td>Mental health</td>
<td>1,368</td>
<td>129,316</td>
<td>1.1</td>
</tr>
<tr>
<td>PTS (Patient Transport Service)</td>
<td>23</td>
<td>2,744</td>
<td>0.8</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>204</td>
<td>32,522</td>
<td>0.6</td>
</tr>
<tr>
<td>Missing/not provided</td>
<td>15</td>
<td>3,456</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33,335</strong></td>
<td><strong>973,935</strong></td>
<td><strong>3.4</strong></td>
</tr>
</tbody>
</table>
Figure 1:
Staffing incidents as a proportion of all incident types by specialty

Source: Incidents reported to the RLS that occurred between April 2008 to March 2009
The lack of suitably trained/skilled staff is a patient safety issue in all clinical settings that report to the RLS. However, the lack of suitably trained/skilled staff is more frequently reported in obstetrics and gynaecology. Other areas, such as mental health and learning disabilities, report a much lower rate of incidence.

Overall, the reporting category ‘lack of suitably trained/skilled staff’ appears to have been used in cases where no specific incident occurred, but where staff have had concerns about staffing levels. It is important to remember that staffing issues can also be a contributory factor in patient safety incidents reported in other categories.

Examples of staffing-related incidents

**Acute/general care:** Due to (A ward) staying open, a staff nurse from (B ward) had to work on (A ward) leaving two qualified nurses and two auxiliary nurses on (B ward). Seven patients requiring close observations, two post-op patients requiring close observations, five needing regular observations, one out-lying orthopaedic patient in a lot of pain, 13 patients on IV medication. Patients noticed staff were busy and were commenting on lack of staff. Ward very busy, insufficiently staffed, nurse practitioners aware that staff couldn’t take a break, little help offered, no support. Last 3 nights have been very busy. Ward left unattended for 10 mins on 02/05/08 as had to push lady on bed to CDS.

**Maternity:** Tried to close one empty room. 3 TCI and no movement as wards full. 8 inductions of labour, (*** unable to take. Both said maybe but wanted consultant to consultant referral. (*** told to transfer to (*** as closed to new transfers. Two inductions delayed and referred to day assessment. High priority inductions – 2 later but others unable to continue with induction as only 6 midwives instead of 8 on late shift.

**Mental health:** Only five staff on duty. A high degree of clinical need. At current time high level of risk on unit unable to fully maintain safety of unit, unable to attended to updating care plans due to need to prioritise patient care.

The majority of incidents reported related to nurse/midwifery staffing (as above) but there are also reports that relate to other staff groups. For example:

**Surgical:** 4 patients awaiting surgical review – one on 8 hours awaiting plan in resus, 2 on 6 hours awaiting registrar review, and one patient on 3 hrs 45 now being seen by house officer. Have been attempting to contact surgical team for over an hour – apparently in theatre. Consultant contacted, but off site. Surgical patients waiting for long time without review.

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Case study: impact of staffing on the care of seriously ill patients

The need to improve the care of seriously ill patients was identified shortly after the inception of the RLS, and is now a key objective of the patient safety campaigns in both England and Wales.

A review of 61 incidents in which patients died revealed three emerging themes:

- routine observations not taken (14 cases);
- observations taken but deterioration in the patient’s condition not recognised (30 cases);
- delay in medical attention reaching the patient (17 cases).

Further research by the NPSA in November 2007 found that staffing and workload issues were important underlying causes of incidents where the deterioration of the patient was not recognised or acted upon.

Staffing factors meant healthcare professionals did not have enough time to carry out observations, follow up patients showing signs of deterioration, or generally spend time with patients. Staff reported that this made it more difficult for them to carry out visual observation or to be certain of the significance of observations in the context of the patient’s previous history.

The significance and value of carrying out observations was sometimes not well understood, but even where it was recognised, tasks that were important to patient comfort (including mealtimes, morning washes etc) competed for staff time. Staffing availability could be very different out of hours, especially at night and at weekends, and might be affected by levels of agency or bank staff and the mix of junior and senior staff.

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1 See www.patientsafetyfirst.nhs.uk and www.wales.nhs.uk/sites3/home.cfm?orgid=781
Staffing levels and safety: external views

The Health Committee report was clear that it is unacceptable for patient safety to be compromised by inadequate staffing levels. The report, Patient Safety: Sixth report of session 2008–09, states:

‘…inadequate staffing levels have been major factors in undermining patient safety in a number of notorious cases… NHS organisations must ensure services have sufficient staff with the right clinical and other skills…’

The findings of a recent review of Mid-Staffordshire NHS Trust† (undertaken by the Healthcare Commission) reinforce this view. The report highlights that the relationship between staffing levels and patient care was a contributory factor to the trust’s failings. For example, some of the key findings were:

- ‘There were not enough doctors on duty out of hours, and the most senior surgical doctor after 9pm could be quite inexperienced’
- ‘There were too few doctors and nurses, alongside poor training and supervision’
- ‘Other incidents that were reported by staff consistently highlighted problems relating to the levels of staff’
- ‘The medical wards on floor two were seriously understaffed and there were grave concerns about the standards of nursing care’.

The NPSA, the NHS Appointments Commission and the NHS Confederation have published a fact sheet to help board members identify gaps in their safety culture, and work to improve it by answering seven key questions. The fact sheet specifically highlights staffing levels as an important consideration, suggesting that boards should always be kept informed of serious and ongoing issues, and that they need to recognise the links between staffing, quality outcomes and patient safety‡.

Conclusion

The NPSA is reliant on NHS staff to report patient safety incidents to the RLS. Whilst the statistics show higher levels of staffing-related incidents in some areas, e.g. obstetrics, in a voluntary reporting system it is not possible to be certain whether there are particular problems in this speciality or whether the staff in the speciality are more aware of the risks.

However, it is clear from figures that, from the perspective of staff, patient safety and staffing issues are often interlinked. These concerns are supported by a number of other organisations involved in monitoring the quality of healthcare in the NHS.

All staff in the NHS are encouraged to report patient safety incidents to the RLS, including those incidents related to staffing, whether or not they result in actual harm. The NPSA will continue to monitor the RLS and other related information in order to ensure continuing improvement in patient safety.

# National Patient Safety Agency, NHS Appointments Commission, NHS Confederation. Questions are the answer? Seven questions every board member should ask about patient safety. 2009. Available at: www.npsa.nhs.uk/hrils/reporting/seven-questions-every-board-member-should-ask-about-patient-safety/