

# Brief guide: staffing levels on mental health wards

## Context

CQC inspection teams should always assess nurse staffing levels on mental health wards. An inspection team might have to assess whether:

- The total number of nurses on each shift is sufficient to provide safe care.
- There are enough qualified nurses on each shift.
- There are effective procedures for bringing in additional staff whenever needed.
- All nurses know the service users and are familiar with the ward procedures.
- The nurses on duty have the right skills to make the ward safe (for example, resuscitation, or physical interventions).

## Evidence required

### Step 1: Identify signs that there might be a problem with staffing levels.

1. Apparent high use of agency and bank staff.
2. Apparent high rates of sickness absence.
3. Staff report that they are stressed, over-worked or cannot spend enough time with people who use services.
4. People who use services report that staff are “too busy” to spend one-to-one time with them.
5. Cancelled one-to-one sessions, ward activities therapy sessions or escorted leave (including under section 17) or failure to observe ward protected time.
6. The ward does not bring in additional staff when the patient group includes a higher than usual number of patients who require high levels of observation and/or intensive nursing care.

### Step 2: Find out what we already know.

We routinely ask for information about nurse staffing levels on wards, about sickness absence and about use of agency and bank staff.

### Step 3: Compile the facts. Determine:

1. The total nursing establishment of the ward, expressed as full-time equivalents, and how this is broken down by band. How many of these posts are currently unfilled and how many are filled by people who are currently on sick-leave or seconded away?
2. The staff turnover (using length of service as a proxy)?
3. The rate of sickness absence (calculated by dividing the sum total sickness absence days by the sum total days available per month for each member of staff).
4. The usual nursing shift pattern for the ward – a.m./p.m./night?
5. How temporary staff are inducted to the ward. Are ‘regular’ temporary staff used to provide a degree of consistency?
6. The minimum training requirements for the ward - how compliant are they?

From examining the rosters of shifts actually worked during the previous three months:

7. What proportion of all shifts were worked by agency staff and worked by bank staff?
8. How many individual agency and bank staff worked shifts (this is some measure of whether the agency and bank staff are likely to be familiar with the ward)?
9. How many shifts did not have a full complement of staff?
10. Was it clear that the staff on duty had a safe skill mix? (for example, resuscitation or physical intervention training)?

#### **Step 4: Check the provider's policies and procedures for evidence that:**

1. The provider has undertaken a review of staffing needs for the ward<sup>1</sup> (check when the director of nursing last submitted a report to the board on ward staffing).
2. The ward has a procedure for increasing the number of nurses at times when the ward has a higher than usual number of service users who require high levels of observation or intensive nursing care.
3. If 10% or more posts are vacant, the trust has an active recruitment plan for ward nurses.

## **Reporting**

All information about staffing levels should be reported in the **'safe staffing'** section under the **'safe'** key question. If we find that a ward/core service has failed to properly assess the staffing needs for wards or frequently fails to ensure that staffing levels are safe or frequently fails to ensure that staff are employed who are familiar with the ward and with the patients, this might be evidence that is also considered under the **'good governance'** section of the **'well-led'** key question.

If we mention staffing levels, or any of the signs that staffing levels might be insufficient (see step 1 above), we must state clearly the facts that support this (see step 3 above).

## **Policy position**

There is no national guidance that providers have to follow. In 2009, the Royal College of Nursing reported that the average number of nursing staff per shift on mental health wards was 4.3. Half of these nurses were unqualified<sup>2</sup> and the average ratio of nursing staff to service users on all shifts was 4:1.

Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. The number of staff required per shift will vary according to the number of beds, the nature of the patient group and the number of patients on any day who require intensive observation or nursing care. It will also depend on the availability of other members of the multidisciplinary team, such as occupational therapists.

## **Link to regulations**

The relevant regulation to assess staffing levels is regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<sup>1</sup> There is no evidence-based and widely recognised tool for assessing staffing levels on mental health wards.

<sup>2</sup> This term refers to 'nursing auxiliaries', 'healthcare assistants' and 'Band 3' nursing staff

## Appendix 1: Examples of how to report staffing levels

Staff or patient comments on staffing levels should not be reported in isolation nor should statements be made, such as staffing levels were 'inadequate' 'unsafe' 'stretched' or 'too low', without giving the evidence to back this.

Staffing levels should be reported as follows:

“Two service users reported to the inspectors that visited Violet ward that shifts often included nurses they had never met before. When we checked the rosters, we found that 40% of shifts over the past three months had been worked by agency and bank nurses, and that these shifts had been worked by 23 different nurses.”

“A Band 5 nurse on Colgan ward told us that he considered the staffing levels were sometimes too low to guarantee safe care. We found that on the last three occasions that the seclusion room had been used, that two nurses had been assigned to observe the service user in the seclusion room and that additional nursing staff had not been brought in to cover this. This left just two staff members (one Band 5 and one Band 3) to cover the rest of the 20-bedded ward area.”

“When we checked the case-notes of ten detained patients, we found six occasions over the past four weeks when section 17 leave had been cancelled at short notice. Six patients that we talked to reported that they had not had a one-to-one session with their named nurse in the previous two weeks. The staff rosters showed that, over the past four weeks, the ward, which had a 4:5:5 shift pattern, had not had its full complement of nursing staff on 48 of the 90 shifts because of staff sickness absence.”