

Professional Judgement Framework:

A guide to applying professional judgement in nurse staffing reviews

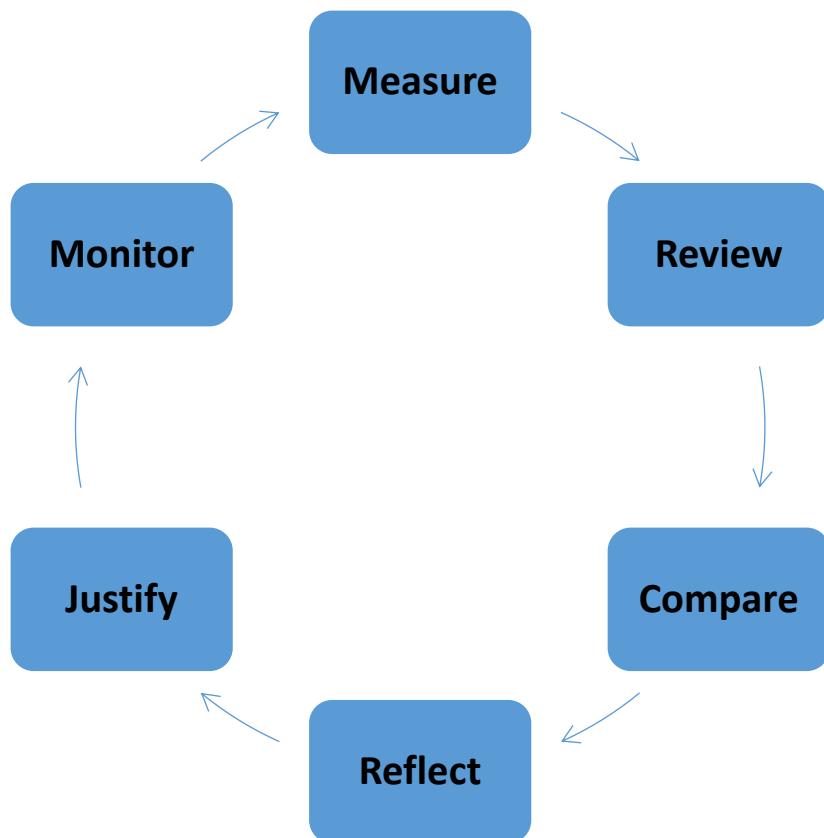


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How to use this framework

- This framework is designed to guide your application of ‘professional judgement’ when considering the results of staffing reviews and the establishment recommendations using the acuity dependency measure of the Safer Nursing Care Tool.
- The guide is based on evidence relating to the use of the Safer Nursing Care Tool on acute general hospital wards and has been developed with those settings in mind, although the principles may apply in other settings.
- It is intended to provide a number of ‘prompts’ that might help sense check the results of staffing reviews and help to provide confidence in the results, or else flag circumstances where judgement might be used to recommend a variation from the calculated figures.
- It is aimed both at those with less experience looking for guidance, and those with more experience looking for help on how to articulate intuitive judgements using available evidence.
- Similar issues are likely to arise when considering the results of *any* tool.
- The framework is based on the results of research funded by the National Institute for Health Research in England, and has been developed working alongside a number of professional experts.
- We acknowledge the current vacancy constraints and that staffing decisions will need to factor in the availability of staff. The use of ongoing risk assessment to maintain patient safety within and across wards and departments is therefore critical.



The staffing review cycle

Staffing review is a continuous process and not a one-off event. The steps can be described as a part of a continuous cycle (Figure 1).

- **Measure** the acuity/dependency of patients over the recommended period using the most relevant up-to-date licensed Safer Nursing Care Tool
- **Review** the data you have collected, and use this professional judgement framework and associated tools to consider the results and to help flag particular issues that may affect the staffing requirement of this ward
- **Compare** the calculated establishment to current staffing levels and the establishment to other similar wards and consider possible reasons for any differences. Consider buddying up with colleagues from another ward (or Trust) to review
- **Reflect** on the recommended establishment by referring to evidence and consider implications for daily deployment
- **Justify** your decision of what the establishment should be
- **Monitor** any changes on the ward that affect staffing requirements and indicators that staffing may not be sufficient^A, such as patient and staff outcomes^O (although expect some random variation)
- **Measure again** - every 6 months or sooner if monitoring indicates a reason for change

Figure 1 The staffing review cycle

Initial sense-checks: things that might make you look particularly closely at the suggested staffing levels...

Can what's being suggested be right: does it seem to be in the right "ball-park"?

- Measurements can help guide staffing decisions but cannot possibly take into account all the complex factors that determine staffing requirements. Also, just like all measurement, acuity and dependency measures can be imprecise or inaccurate because of variation in the sample, how measurements are taken and because not all patients in the same category need precisely the same amount of care. If the number seems wrong, it may well be!

Is a new recommended staffing level different from the current staffing establishment or the establishment of similar wards?

- Obviously, if the measurement never resulted in a changed recommendation there would be no point in reviewing establishments. However, the current establishment level is a good starting point for considering any recommended changes. Is there a major difference? Is the current establishment based on acuity and dependency? Have there been service changes since last review? Are there problems with the existing staffing levels or the quality of care? What do staff on the ward say? Is there a high or increasing number of safety incidents / red flags?

Is the ward operating with a lot of vacancies, high staff turnover, sickness absence and/or using a high level of temporary staff?

- There appears to be a vicious cycle whereby wards that use a lot of temporary staff, for example due to vacancies, may not always have the capacity to meet patient need because of the relative inefficiency of using temporary staff.¹ These wards may benefit from targeted support in the short to medium term in order to help stabilise. It may be that the high use of temporary staff /staff turnover is an indicator that the existing establishments were not properly reflecting requirements.

Have there been changes in the ward since the last establishment review?

- Changes such as the mix of patients or the physical layout of a ward can change the staffing requirements². This is not always reflected in the measurements and so especial care needs to be taken when reviewing staffing after any such changes, even if adjustments were made to accomodate them. The NHSI's "Developing workforce safeguards" report^B recommends reviewing establishments when changes happen rather than waiting for a scheduled review.

Is the current staff being rostered properly?

- 'Efficient' rostering of staff can be difficult and 'ideal' rosters are not always achievable. However, sometimes wards run into problem because more staff are routinely rostered on days of lower demand leaving insufficient staff for other days. Help with rostering is available in NHS England's Nursing and midwifery e-rostering guidance^C.

Accuracy of the measurements

Who assessed patients' acuity/dependency levels – have they received training and do they have experience?

- There is evidence that the SNCT acuity and dependency measurement can be done reliably and can be valid, such that two experts will agree on how to categorise a patient³. However, reliability and validity are properties of the measurements that are taken, not the measure itself⁴. Staff assessing the SNCT should be properly trained and their competence assessed⁵. Ideally this needs to be retested from time to time. If not, it is possible that there is both imprecision (random error) and systematic mistakes (bias) in the measurement. Staff need training and support while becoming experienced in assessing acuity/dependency levels.

How many days of SNCT acuity/dependency ratings were you able to collect? Was it enough?

- To get a reliable estimate of typical patient need and so estimate the establishment you need to observe 'enough' patients. This means measuring all the patients on the ward every day over a period of time. Guidance for the SNCT suggests a minimum number of days, but for some wards there is more variability from day to day, making it harder to get an accurate baseline. We've developed a tool to give you an idea of how precise your establishment might be (see **benchmarks** in accompanying document). Sometimes you might benefit from collecting a few days more data, other times you may simply have to be more cautious about using the recommended establishment.⁵

Is the 22% uplift (for annual leave, study leave etc.) appropriate for this ward?

- The SNCT multipliers have an inbuilt 22% uplift but some wards might require a higher uplift if (for example) they have higher rates of absence than is typical.⁶ For example the age profile of staff affects annual leave entitlements and parental leave rates, while some wards have higher study leave requirements for specialty-mandated training.

Particularities of nursing work on this ward

Does this ward have high patient turnover/throughput?

- Although the SNCT includes an allowance for patient turnover (admissions / discharges), the level of activity can vary a lot between wards⁷. Special multipliers have been developed for acute admissions units but other wards with unusually high turnover might also need more staff. In general, turnover is reflected by the unit's length of stay - units with shorter stay may need more staff for a given level of acuity / dependency.

Does the layout of this ward add to workload e.g. because of distance or difficulty observing patients?

- There is some evidence that suggests that some ward layouts may impact on how care is delivered⁸. For example, some ward layouts with a high proportion of single rooms can make it harder to monitor patients and also make it harder for staff to find colleagues. This is being studied for the next version of the SNCT.

Does the the number of beds on the ward increase the (relative) staffing requirement?

- Small wards can be difficult to staff because there needs to be a minimum number of staff present at all times to ensure safety. This means that the daily staffing requirement may be higher than implied by the calculated establishment.

Does the amount of work on this ward vary between times of day and day of week?

- Predictable variation by time of day and day of week might be addressed by careful rostering. Do the rosters match known variation? However, if demand is unpredictable it may be that more staff are needed to cope with fluctuations in demand. Are staff working flexibly between teams within and, where needed, across wards so that patient needs are met?

What is 'usual' care for this ward?

- Depending on who is rating patients, keep in mind that some aspects of care that are 'normal' ward care for this unit might still reflect higher acuity and dependency for the patients. For example, on cancer wards it is usual to deliver a high number of infusions, but this is not 'normal' ward care.

Is there a lot of 'specialalling'/enhanced care /1:1 care?

- Although this might be accounted for when it is covered by 'extra' staff outside the establishment, consider whether the establishment is sufficient to cover work associated with these patients, including covering for breaks taken by the staff providing specialalling. The current version of the SNCT provides a new level of care for continuous care on a one to one basis - sometimes referred to as 'specialaling'.

Any other factors that might make this ward unusual in some way?

- The SNCT multipliers reflect average need across a wide group of patients and a wide range of settings. The recommended staffing levels provide a guide but this guide will not reflect every possible situation. While every ward is 'different' and this average works well for many wards there might be specific factors that mean that the measured demand doesn't work well in a particular setting. We have tried to highlight a few factors above.

Local staffing context and daily demand

Are there particular skills required? Does the establishment allow for this?

- The fewer staff that are available to undertake a specific role, the more challenging it will be to make sure staff with the appropriate skills are rostered. Have such factors been considered in the establishment? If at least one member of such staff is required on each shift, it is likely that at least 40% of staff in the establishment will need to be trained to ensure reliable coverage⁹.

Does the skill mix meet the needs of the patient mix on this ward?

- Skill mix should also be considered as part of establishment review. If some staff are unable to provide a full range of care (e.g. more junior RNs), overall staffing requirements for more experienced staff may be increased because the staff group as a whole are less flexible and there is more planning involved in allocating work.

What is the level of skill and experience for the team as a whole?

- If a lot of staff in the establishment are new and / or junior, is there a plan to ensure that staff requiring support get the support they require?

What shift patterns are used?

- It's important to balance the needs of patients and staff, whatever shift patterns you use. Where a mix of shift patterns is used in a single ward, overall staffing requirements may be increased because of the need for multiple handovers¹⁰.

Further reading

Safer Nursing Care Tool multipliers are currently being updated. The most up-to-date version at the time of printing is: The Shelford group. (2014). Safer Nursing Care Tool Implementation Resource Pack.

Further guidance

A) Monitoring nursing red flag events can help with identifying staffing problems both during the shift and in the longer term. NICE
<https://www.nice.org.uk/guidance/sg1/chapter/1-recommendations> Box 2: Nursing red flags

B) Review establishments when changes happen rather than waiting for a scheduled review. NHSI Developing workforce safeguards.
<https://www.england.nhs.uk/ourwork/safe-staffing/developing-workforce-safeguards/>

C) Guidance is available on good rostering practice. Nursing and midwifery e-rostering: a good practice guide. https://www.england.nhs.uk/wp-content/uploads/2020/08/20190903_UPDATED_Nursing_Midwifery_E-Rostering_Guidance_September_2019.pdf

D) The Safer Nursing Care Tool measurements should be carried out by trained observers. Developing workforce safeguards. Appendix 6: SNCT assessment to meet criteria <https://www.england.nhs.uk/wp-content/uploads/2021/04/developing-workforce-safeguards-appendices.pdf>

Research evidence

[0] One potential cause of poor patient and staff outcomes is low nurse staffing levels. Shin, S., Park, J. H., & Bae, S. H. (2018). Nurse staffing and nurse outcomes: A systematic review and meta-analysis. *Nursing outlook*, 66(3), 273-282. Blume, K.S., Dietermann, K., Kirchner-Heklau, U., Winter, V., Fleischer, S., Kreidl, L.M., Meyer, G. and Schreyögg, J., 2021. Staffing levels and nursing-sensitive patient outcomes: Umbrella review and qualitative study. *Health Services Research*, 56(5), pp.885-907.

[1] For example, days with high use of temporary staff (both registered nurses and assistants) are associated with a higher risk of patients dying. Dall'Ora, C., Maruotti, A., & Griffiths, P. (2020). Temporary Staffing and Patient Death in Acute Care Hospitals: A Retrospective Longitudinal Study. *J Nurs Scholarsh*, 52(2), 210-216. <https://doi.org/10.1111/jnu.12537>

[2] Factors such as the mix of patients or the physical layout of a ward can affect the staffing requirements although not all evidence is of good quality Griffiths, P., Ball, J., Drennan, J., James, L., Jones, J., Recio-Saucedo, A., & Simon, M. (2014). The association between patient safety outcomes and nurse / healthcare assistant skill mix and staffing levels & factors that may influence staffing requirements.

[3] Inter-rater reliability was calculated as Cronbach's alpha =0.99 for 30 students. The SNCT acuity and dependency multipliers were validated against an alternative measure and they are updated over time to reflect changes. a) Hurst, K., Smith, A., Casey, A., Fenton, K., Scholefield, H., & Smith, S. (2008). Calculating staffing requirements. *Nursing Management* (Harrow, London, England: 1994), 15(4), 26-34. b) Smith, S., Casey, A., Hurst, K., Fenton, K., & Scholefield, H. (2009). Developing, testing and applying instruments for measuring rising dependency-acuity's impact on ward staffing and quality. *International Journal of Health Care Quality Assurance*, 22(1), 30-39. <https://doi.org/doi:10.1108/09526860910927934>

[4] There is no evidence that the SNCT provides “optimal” staffing levels – it seems that staffing at higher levels is associated with a further reduction in patient mortality. a) Griffiths, P., Maruotti, A., Recio Saucedo, A., Redfern, O. C., Ball, J. E., Briggs, J., Dall'Ora, C., Schmidt, P. E., & Smith, G. B. (2018a). Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. *BMJ Qual Saf*. <https://doi.org/10.1136/bmjqqs-2018-008043>
b) Griffiths, P., Saville, C., Ball, J. E., Culliford, D., Pattison, N., & Monks, T. (2020). Performance of the Safer Nursing Care Tool to measure nurse staffing requirements in acute hospitals: a multi-centre observational study *BMJ open*, 10(e035828). <https://doi.org/10.1136/bmjopen-2019-035828>. **Similarly, for the RAFAELA tool, staffing at higher levels than recommended is associated with further reductions in patient mortality and patient safety incidents.** a) Fagerström L, Kinnunen M, Saarela J. Nursing workload, patient safety incidents and mortality: an observational study from Finland. *BMJ Open* 2018;8:e016367. <https://doi.org/10.1136/bmjopen-2017-016367> . b) Junntila JK, Koivu A, Fagerström L, Haatainen K, Nykänen P. Hospital mortality and optimality of nursing workload: a study on the predictive validity of the RAFAELA Nursing Intensity and Staffing system. *Int J Nurs Stud* 2016;60:46–53. <https://doi.org/10.1016/j.ijnurstu.2016.03.008>

[5] In a computer simulation study, when baseline staffing was set to meet the average demand on a ward, 32% of patient shifts (across 4 hospitals) were understaffed by more than 15% after redeployment and hiring from a limited pool of temporary staff. The amount of understaffing differed between wards. Setting baselines higher than the average reduced understaffing rates. Saville, C., Monks, T., Griffiths, P., & Ball, J. E. (2020). Costs and consequences of using average demand to plan baseline nurse staffing levels: A computer simulation study *BMJ Qual Saf*. <https://doi.org/10.1136/bmjqqs-2019-010569>

[6] In the official statistics for 2016-2019, absence rates for registered nurses are around 4.5% while for staff supporting doctors/nurses/midwives they are between 5.7-5.8% <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

[7] There was a 29-fold difference (0.01–0.29 admissions and discharges per care hour) between the lowest and highest turnover wards when analysing 81 wards at four hospital Trusts. Pg 45 “Other factors potentially affecting workload” Griffiths, P., Saville, C., Ball, J. E., Chable, R., Dimech, A., Jones, J., Jeffrey, Y., Pattison, N., Recio Saucedo, A., Sinden, N., & Monks, T. (2020). The Safer Nursing Care Tool as a guide to nurse staffing requirements on hospital wards: observational and modelling study. *Health Services and Delivery Research* 8(16), 1-161. <https://doi.org/10.3310/hsdr08160> **High patient turnover per nurse has been shown to be associated with negative patient outcomes, for example with an increased hazard of death.** Griffiths P, Maruotti A, Recio Saucedo A, Redfern OC, Ball JE, Briggs J, et al. Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. *BMJ Qual Saf* 2019;28:609–17. <https://doi.org/10.1136/bmjqqs-2018-008043>

[8] Wards with a higher proportion of single rooms (when controlling for other variables) were associated with lower odds of reporting staffing adequacy according to three measures, although confidence intervals were wide and relationships were not statistically significant. Griffiths, P., Saville, C., Ball, J. E., Culliford, D., Pattison, N., & Monks, T. (2020). Performance of the Safer Nursing Care Tool to measure nurse staffing requirements in acute hospitals: a multi-centre observational study *BMJ open*, 10(e035828). <https://doi.org/10.1136/bmjopen-2019-035828>

[9] According to a computer simulation analysis, if at least one member of specialist staff is required on each shift, it is likely that at least 40% of staff will need to be trained to ensure reliable coverage. Pg 65-66, "Specific skills: intravenous-trained registered nurses", Griffiths, P., Saville, C., Ball, J. E., Chable, R., Dimech, A., Jones, J., Jeffrey, Y., Pattison, N., Recio Saucedo, A., Sinden, N., & Monks, T. (2020). The Safer Nursing Care Tool as a guide to nurse staffing requirements on hospital wards: observational and modelling study. *Health Services and Delivery Research* 8(16), 1-161. <https://doi.org/10.3310/hsdr08160>

[10] Nurses were more likely to report there were not enough staff when a mix of short and long shifts were used. Saville, C., Dall'ora, C., & Griffiths, P. (2020). The association between 12-hour shifts and nurses-in-charge's perceptions of missed care and staffing adequacy: a retrospective cross-sectional observational study. *International Journal of Nursing Studies*, 112, [103721]. <https://doi.org/10.1016/j.ijnurstu.2020.103721>

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