VIEWS & REVIEWS

NO HOLDS BARRED

Margaret McCartney: Taking patient safety seriously means minimum staffing levels

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What is essential care? Being clean, washed, dressed. Being helped to eat, drink, use the toilet. Receiving appropriate drugs on time. Being able to rest. Being treated humanely and with kindness. Being monitored properly. Being noticed when in pain or distressed, if blood pressure falls, if agitated, or if the bathroom door has been locked for so long that something may be seriously wrong.

Basic healthcare is far beyond “basic”; it is everything. Without it, patients are not safe.

The evidence that having more staff is associated with longer survival has been accumulating and should be difficult to ignore.¹⁻³ Strikingly, a nurse looking after one extra patient is associated with a 7% increase in the likelihood of patient death within 30 days of admission (the overall death rate in this study was 1.3%). In English stroke units, having 1.5 rather than three nurses for each 10 beds is associated with one extra death within a month, in every 25 patients admitted.⁴

It comes as no surprise to anyone who has been rushing around like a proverbial blue arsed fly that understaffing is associated with mistakes and near misses.⁵⁻⁶ But poor staffing doesn't just risk poor care for patients; it also risks chronic stress and burnout among staff.⁷

And our politicians seem not to have understood. The former health secretary, Andrew Lansley, said in 2011 that understaffing “is no excuse. We're talking about the incorrect administration of insulin, putting someone in a boiling hot bath, or failing to identify a patient using their name.”

“That isn't because you're understaffed, that is because you are doing it wrong and because there is no process by which that is properly checked.”⁸ Yet the best people can make the worst mistakes, when the environment allows.⁹

This is also about quality. To promote good deaths, for example, we need the stalwarts of its delivery—our district nurses—to help us. In 2013 England had 5739 district nurses, half as many as in 2002 (10 446).⁴⁻⁵ With their numbers so depleted, how can we deliver good, hands-on care?

The truth is that we are not taking patient safety seriously enough to implement safe staffing levels. The current health secretary, Jeremy Hunt, said in 2013 that he would reject calls

for minimum staffing levels,¹⁰ even though a report by the healthcare safety guru Donald Berwick stated, “Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context.”¹¹

The National Institute for Health and Care Excellence has ruled on safe staffing in acute, emergency, and maternity care but has been told by NHS England to abandon further analysis.¹² Bravo to them for publishing it anyway. If staffing were a drug, doctors would be ordered to prescribe more of it. The lack of evidence on implementing safe staffing levels is a scandal.

Competing interests: I have read and understood the BMJ policy on declaration of interests and declare the following interests: I'm an NHS GP partner, with income partly dependent on Quality and Outcomes Framework points. I'm a part time undergraduate tutor at the University of Glasgow. I've written two books and earn from broadcast and written freelance journalism. I'm an unpaid patron of Healthwatch. I make a monthly donation to Keep Our NHS Public. I'm a member of Medact. I'm occasionally paid for time, travel, and accommodation to give talks or have locum fees paid to allow me to give talks but never for any drug or public relations company. I was elected to the national council of the Royal College of General Practitioners in 2013 and am chair of its standing group on overdiagnosis. I have invested a small amount of money in a social enterprise, Who Made Your Pants?

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