UNISON
the public service union

a UNISON survey into staff/patient ratios on our wards

Contents

Foreword

Over the last 12 months we have seen increasing media coverage of poor levels of patient care and on some occasions neglect. At the same time nurses have been expressing their concern regarding staffing levels. In May 2011 at UNISON's national nursing seminar a speaker from the New South Wales Nursing Union in Australia described the impact of their successful campaign to introduce legally enforceable nurse to patient ratios. Our debate at the seminar highlighted our members' concerns about the environment and culture in which they work and the impact on them as individuals and their levels of morale and motivation.

The Mid Staffordshire inquiry, Winterbourne View and the Patients Association have told compelling stories of the impact of poor care. In all of these cases poor nursing care was highlighted. To help inform our own position on nurse to patient ratios we wanted our own snap shot of what nursing is like in the UK over a 24 hour period.

We chose 6 March 2012 for our 24 hour survey - a normal day with no unusual seasonal weather to contend with, no major incidents or high levels of flu. What we found was that our members' experiences on that day were far from perfect. Members told us that they were unable to care for patients in the way they felt they should have and many felt unable to give safe, dignified compassionate care. This was in spite of the majority of members working more than their contractual hours on that day, something they tell us is normal.

We work in multidisciplinary teams, however when things go wrong our members told us that it is only nurses and healthcare assistants who are held to account. Staff feel that they cannot raise concerns without repercussions for them and their colleagues and in many cases, when someone raises issues they do not feel they are listened to. This culture seems not to have changed despite the Mid Staffordshire inquiry.

I find the results of this survey deeply worrying for patients, staff and the service. In our recommendations we seek to address some of the ways in which we will act on our members' concerns.

Gail Adams
Head of Nursing UNISON

Introduction

“ If the ward is short some staff do double shifts or sometimes have to work part of the shift with unsafe numbers. ”

UNISON is the largest public sector union in health with 450,000 members employed across the service. We are the voice for nurses. This survey is the first of its kind, taking evidence from a single 24 hour period from members across the country and in several different branches of the health service. A number of issues have arisen from this research.

UNISON has a long history of negotiating and campaigning on behalf of staff across the spectrum of health specialisms. As the voice of the whole healthcare family we are instrumental in influencing policy at a regional, national and international level.

UNISON is the union of choice for many nurses across the UK and has over half a million members working in healthcare – over 60% of whom are in the nursing family. For many years we have been the leading force in negotiation on the issues of key importance to nurses in improving the terms and conditions of their working lives. We do this by listening to their views, aspirations, concerns and working with them to develop key objectives.

We have a long history of researching and gathering evidence on a range of issues facing nurses, including pay, roles and responsibilities.

From both statistical and anecdotal evidence we know that nurses feel very strongly about minimum staffing ratios, which they believe to be fundamental to patient safety and quality of care. UNISON wants to ensure that nurses are given the opportunity to perform their caring role to the best of their ability and that their contribution to care provision is recognised.

UNISON engages nurses through many avenues, and in our project group of nurses we have overseen and contributed to the development of this work.

Summary of main points and recommendations

> **“ We were three qualified nurses short. Bank and agency staff were unable to cover the shortfall. So the senior nurse for the unit cancelled her plans and helped out despite having not worked on a ward for 20 years. ”**

Almost 90% of respondents are in favour of legislation to set minimum nurse to patient ratios.

One of the key findings of the survey is that staff overwhelmingly feel that understaffing affects their ability to do their job. Almost three quarters (73.2%) said they did not have enough time to spend with patients to deliver dignified, safe, compassionate care.

The survey reveals that there is no “one size fits all” when setting staff patient ratios. Patient lives are at risk so getting the mix right is crucial. Consideration must be based on multiple categories reflecting departments, fields, specialities and wards.

The self-policing of staffing levels is largely ineffectual, especially in a climate of budget cuts. There were numerous reports that minimum ratios were not being followed, were changed to fit budgets, or were counting students as staff. Even where they were in place, levels varied widely and were decided without staff agreement.

When staff made use of their organisation’s understaffing policy they did not feel listened to and no action was taken to avoid similar problems in the future. Legislation would ensure employers maintained a safe environment for both staff and patients.

Almost two thirds of respondents reported they had worked some overtime on March 6, with only one in 13 receiving any payment for it. Many reported that they were often unable to take breaks or meals due to understaffing and unreasonably high workloads.

Where bank and/or agency staff were used, the biggest staff concern was the unavoidable fact that they don’t have the same workplace knowledge as permanent staff (such as where supplies are kept, who is who, etc), and so cannot always perform to the same speed or standard. There were related concerns about the regular use of expensive bank and agency staff as damaging to the skill mix.

Respondents felt strongly that they will be held accountable if anything goes wrong on their shift, regardless of contributing factors such as understaffing. Making a difficult situation worse, they also feel unable to report unsafe practices for threat of being bullied or held responsible for the concerns they raised.

Recommendations

UNISON will work with other organisations, including patient bodies, to identify a UK model of nurse to patient ratios for different specialities. We will aim to use international evidence as a benchmark.

- UNISON will campaign for national legislation to enshrine minimum nurse to patient ratios in all healthcare settings. We will be discussing this with MPs to encourage them to support our position and to make sure that they are helping their local NHS staff achieve staffing levels that enable them to deliver safe, compassionate and dignified care.
- UNISON will encourage, support and enable members to raise concerns locally when they do not believe that staffing levels are adequate to deliver safe, compassionate and dignified care.
- UNISON branches and regions will use the findings in the survey to have discussions with employers at local, regional and national level about how staff can be helped to raise their concerns.
- UNISON will follow up this survey with independent academic research to look more deeply into this issue.
- UNISON will review all its advice and guidance following the Mid Staffordshire Inquiry to ensure that it is updated and fit for purpose.

Survey background

> **“ Crisis has become the norm. ”**

Nurses and other healthcare workers were asked to record details about their shift during the 24 hour period of 6 March 2012. UNISON provided a worksheet with a list of the information they would need to record, and then asked them to enter this data into an online survey.

The survey contained 45 questions, mostly multiple choice, that asked respondents about three main topics:

- Their workplace – the region, field in which they worked, whether the organisation already had minimum staffing levels, etc.
- Their shift on 6 March 2012 – when was it, how long did it last, how many patients were present, how many staff members were present, etc.
- Their opinions on staffing levels – whether they supported minimum staffing levels for nurses and/or health care assistants, the impact on patient care, etc.

All responses to the survey were entered into the web survey. UNISON also provided PDF and hard copy versions of the survey for respondents who were unable to access the web survey.

UNISON received 1,644 responses to the survey, and were able to use 1,556 (the others couldn’t be used due to factors such as duplicate/triplicate responses, response dates and “required” questions that were left unanswered). A copy of the survey questionnaire is available in Appendix one.

The survey was advertised widely to UNISON members on the UNISON website, UNISON’s healthcare social media such as Facebook and Twitter, inclusion in UNISON’s weekly health circulars to all health branches, information in UNISON’s nursing newsletter, and two personalised emails to all members working as nurses, healthcare assistants, midwives and health visitors. Information was also posted on many UNISON branch web pages across the country.

The survey was open to non-members as well, and was advertised on the Nursing Times website and through the Nursing Standard.

The survey questions were designed to provide UNISON with a richer picture of the situation our nurse members are facing. We hear regularly from members who are frustrated with the ratio of nurses to patients in their workplace and who feel that as a result they are not able to deliver care to the best of their abilities. UNISON champions quality patient care as well as the fair treatment of staff. Set staffing levels have proven positive effects in both these areas.

Several major healthcare incidents have been in the news recently, the most recent of which is the Mid Staffordshire Inquiry. Patient care was investigated and found to be significantly lacking. The trust had implemented a cost saving plan that resulted in abominably low levels of care, during which brutal staff cuts were made and the skill mix was reorganised without sufficient information or planning. This background was another contributing factor to UNISON’s decision to undertake this research.

Before beginning this research, UNISON investigated the impact of set nurse to patient ratios in existing academic and

professional studies. We found that certain states in Australia and the United States had used legislation to address the issue of safe levels of staffing. This legislation was implemented in both countries after long periods of hard campaigning by unions, nurses, charities and patient groups.

In both countries the campaigns focused primarily on the issue of improving patient care by making workloads manageable and providing adequate numbers of nurses. Public support was enlisted by appealing first and foremost to the interests of patients. After legislation was implemented, the quality of healthcare was improved along with job satisfaction and staff welfare.

In the UK, research has been undertaken linking nurse to patient ratios and patient mortality. A study by Professor Rafferty in 2007[1] reported "26% higher mortality for patients in hospitals that had the highest patient to nurse ratio." Meaning poorer nurse staffing levels. The study also found that "Nurses in these hospitals were also more likely to report low or deteriorating quality of care on their ward or in their hospital."

In the financial situation there is a current and real danger of healthcare providers reducing staffing as a means to achieve their proposed financial targets. Evidence of this is starting to emerge. In London hospital trusts have been advised that they can safely slash spending on nursing by up to 50%.[2]

1 Rafferty AM, Clarke SP, Coles J, Ball J James P, McKee, and Aitken LH, 2007 Outcomes of variation in hospital nurse staffing in English Hospitals, International Journal of Nursing Studies, 44 (2) pp. 175 - 182

2 Nursing Times, 3 April 2012, vol 108 no14/15, page 2 - 3

Studies establish solid links between understaffing, stress[3], job satisfaction and patient care. Workplaces that report understaffing are likely to have high levels of stress and low levels of job satisfaction. In turn, workplaces with high stress and low job satisfaction are likely to have more patient safety incidents and higher rates of patient mortality.

What also is clear from the majority of research in this field is that there is not a "one size fits all" ratio that would be appropriate for every area of healthcare. It is important therefore to take into account the various specialities and to also allow for flexibility in terms of nurse deployment and changing circumstances. California developed nurse/patient ratios for different parts of the service[4]. Similar systems were developed in both Victoria[5] and New South Wales in Australia.[6]

The University of Pennsylvania published the impact of the introduction of nurse to patient ratios in America by surveying more than 22,000 registered nurses in California, Pennsylvania and New Jersey. The results proved that minimum ratios saved patients

3 Department of Health, 2009, The Boorman Report, NHS Health and well being review, final report

4 California Nurses Association & National Nurses Organisation Committee, 2008, The ratio solution, Oakland, California

5 Gerdtz MF & Nelson S, 2007. Journal of Nursing Management 15 (1) pages 64 – 71 , A Model of minimum nurse to patient ratios in Victoria, Australia

6 New South Wales Nurses Association, 2011, The Lamp 68 (1), The Offer on ratios

lives:[7] "Improved nurse staffing, however it is achieved, is associated with better outcomes for nurses and patients."

The survey questions were written with assistance, suggestions and revision from UNISON's Nursing and Midwifery Committee, a panel of 20 UNISON activists from across the country with backgrounds that range from service provision to academia. All committee members work in the healthcare industry in fields of nursing and/or midwifery.

NHS Staff Survey 2011

The concerns and feelings voiced by respondents in this survey echoed concerns in the recent NHS Staff Survey. The NHS Staff Survey is an annual survey of the 366 NHS organisations in England. All full and part time staff directly employed by an NHS organisation on 1 September 2011 could participate and the survey received a response rate of 54%.

The NHS Staff Survey[8] uncovered a trend in falling satisfaction with working for the NHS, compared to previous years. Among the highlights relevant to this survey, the NHS Staff Survey found that:

- Only 32% were satisfied that their trust values their work.
- 53% of staff regularly worked unpaid hours
- 46% felt they do not have enough time to carry out all their work.
- 42% felt they cannot meet all the conflicting demands on their time at work.
- 65% of staff attended work when they felt too ill to attend.
- Only 30% said there was enough staff in their organisation for them to do their job properly.

Respondents to our survey were slightly more likely to feel there was not enough staff in their organisation to enable them to do their job properly, at 19.6%, compared with the NHS Staff Survey's 30%. Both figures however are worryingly low.

7 Linda H. Aiken, Douglas M. Sloane, Jeannie P. Cimiotti, Sean P. Clarke, Linda Flynn, Jean Ann Seago, Joanne Spetz, and Herbert L. Smith, 2010, University of Pennsylvania, Implications of the California Nurse Staffing Mandate for Other States

8 Department of Health, 2011, NHS Staff Survey

Composition of respondents

> **“ We were short staffed as has been happening on a frequent basis of late. ”**

The 1,556 usable responses came from staff distributed fairly evenly across the UK. The largest percentages of respondents came from Scotland and the North West, at 17% and 15.5% of total responses.

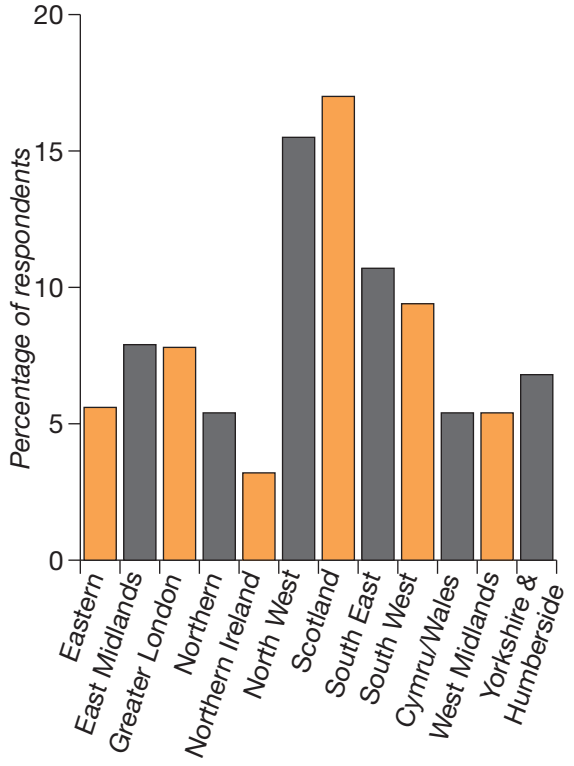
The lowest percentages of responses were from Northern Ireland at 3.2% and the Northern region, Cymru/Wales and West Midlands, all at 5.4%. Every region responded to the survey.

general hospitals (37.4%). The second largest group worked in mental health, which was 21.3% of the total. The smallest percentage of respondents worked in learning disabilities (3%).

Of the 150 (9.8% of) respondents who selected “Other” workplace, 38 wrote in that they work in a care or nursing home. This amounts to 2.5% of the total responses and was the largest group not represented by our pre-selected categories.

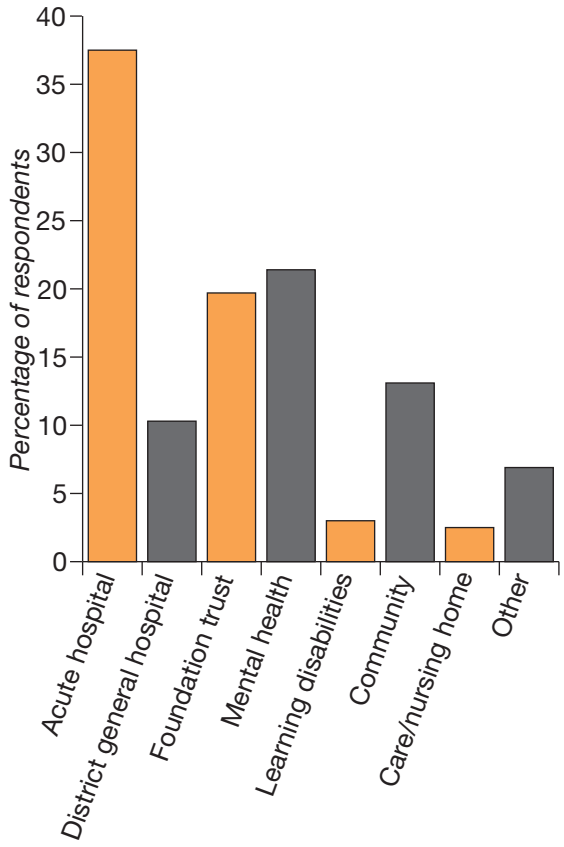
Respondents’ regions

Over a third of respondents worked in acute



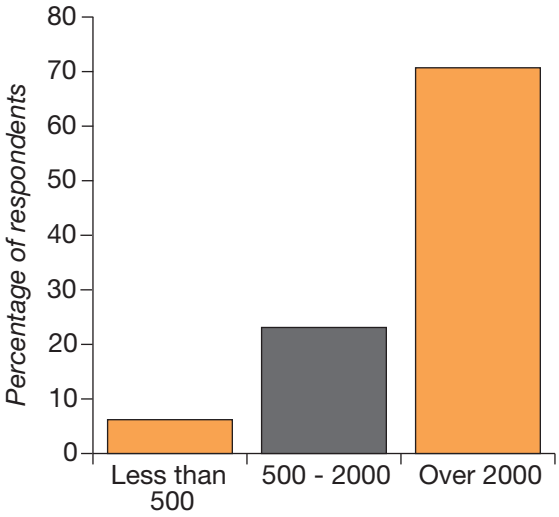
Respondents’ workplace

Over two-thirds (70.7%) of respondents



worked for very large organisations with over 2,000 employees. Only 6.2% of respondents worked in organisations with fewer than 500 staff.

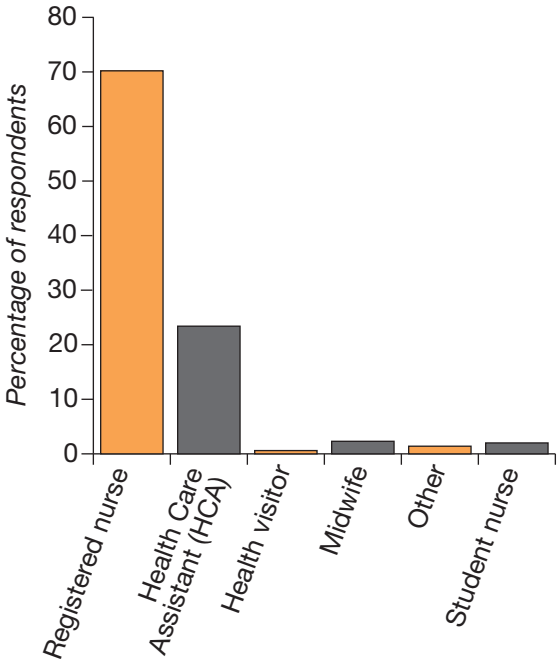
Size of respondents' workplaces: total employees



The survey was designed with the expectation that registered nurses would be the primary respondents, but with the flexibility to include healthcare workers and other roles as well. The issues surrounding nurse to patient ratios and safe staffing levels affect all workers in health services. Although the most direct impact will be felt by NMC registered nurses who may or may not be able to provide an appropriate level of care, the knock-on effects hit every member of their team. Understaffing will place strain on healthcare assistants who may be asked to perform work above their pay band, on specialists on the ward or place of care, and on every member of staff if patients become upset by long waits for care.

Indeed, registered nurses made up the bulk of respondents at 70.2%. Most of the remaining responses (23.4%) were from healthcare assistants, assistant practitioners, support workers and those in similar roles. The remaining respondents were made up of midwives (2.3%), health visitors (0.6%) and those who described themselves in an 'Other' category (3.4%.) Of these 'Other' respondents, 2% self-identified as student nurses.

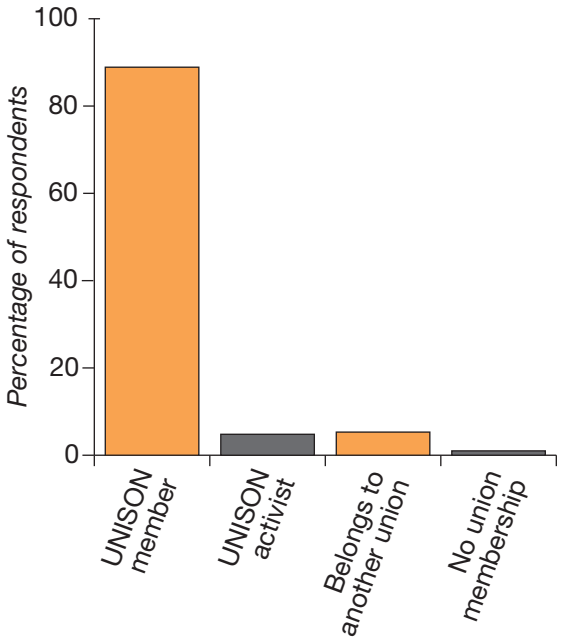
Respondents' job roles



It will probably come as no surprise that the vast majority of respondents were UNISON members. Although the survey was advertised on external sites such as The Nursing Standard and The Nursing Times, most of the promotion utilised existing UNISON channels of communication to our members.

93.7% of respondents were UNISON members, most of whom were lay members. Of this number 4.8% were UNISON activists, representatives or stewards. 5.3% of respondents belonged to another union and only 1% did not belong to any union.

Respondents' union membership



Impact of staffing levels

> **“ Due to staff shortages patient care was compromised and therefore two patients had falls. ”**

Respondents overwhelmingly felt that the staffing levels in their workplace impacted directly on the quality of care they were able to provide. Across all respondent groups, the majority felt that the nurse to patient ratio in their workplace on 6 March 2012 was inadequate and that it resulted in the delivery of a lower standard of care.

> **“ My workload meant that I was unable to deliver the standard care that I would like. And I considered it unsafe. ”**

> **“ I feel the main concern is the safety aspect. I often feel relieved to get to the end of a busy shift and am thankful that no errors were made. ”**

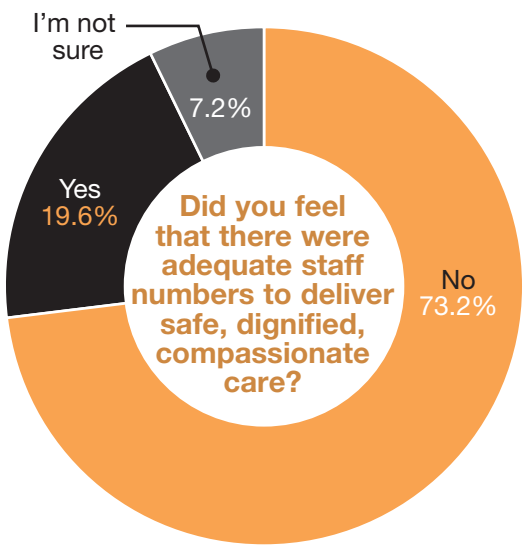
Reports poured in from respondents who regularly faced understaffed shifts. Many reported that vacancies weren’t filled and absences weren’t covered when permanent staff were off sick, on annual leave or maternity leave. Others told of their team members being sent to cover absences on other wards, only serving to leave them short of staff. Some reported that funding was the problem and the employer couldn’t afford more staff.

> **“ We were told shifts were not being covered as the ward budget could not cover the pay for bank staff and the pay for anyone off sick. ”**

> **“ I had to cover another ward’s breaks due to sickness, leaving my ward short-staffed. ”**

Particularly with recent events such as the experience of Mid Staffordshire and the exposure of low levels of patient care, much attention is being given to care measured in safety, compassion and dignity. UNISON has championed dignified and compassionate care for a long time and feels strongly that this needs to be as high a priority as safety.

Respondents were asked “Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?” 73.2% of respondents said no, while only 19.6% said yes. 7.2% responded that they weren’t sure.

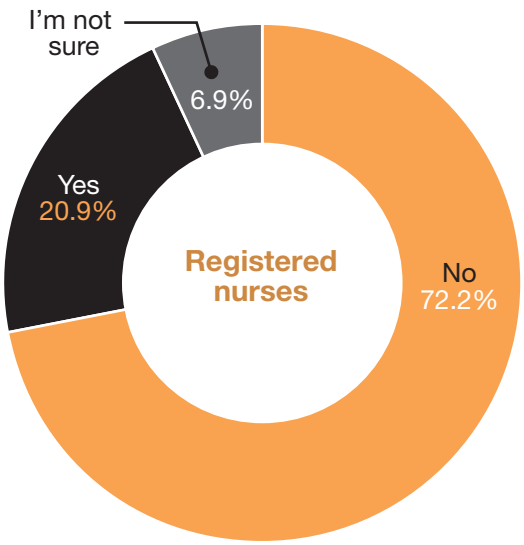


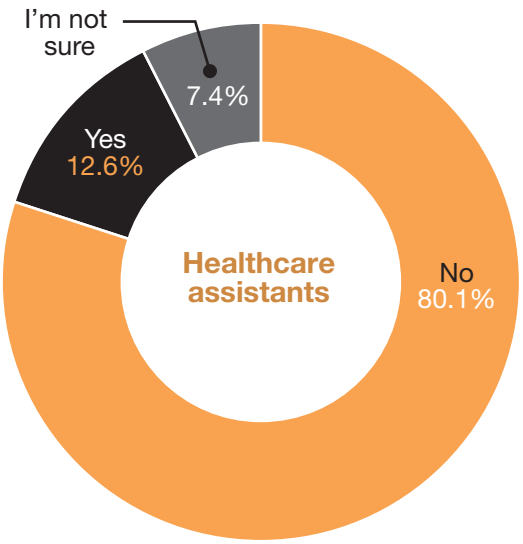
**“ The Care Quality Commission (CQC) requirement is three trained nurses, five healthcare support workers [in my area].
While CQC was visiting regularly we had agency staff, now we have dropped to pre CQC levels.
We are a major event waiting to happen. ”**

We have chosen to compare here how registered nurses, healthcare assistants and those working different shifts responded to this question. Registered nurses and healthcare assistants were chosen to be broken out due to the respondents' background knowledge of their work. In other words, we thought it possible that on some topics a nurse may have a different point of view than a healthcare assistant, merely due to the depth of their levels of subject knowledge.

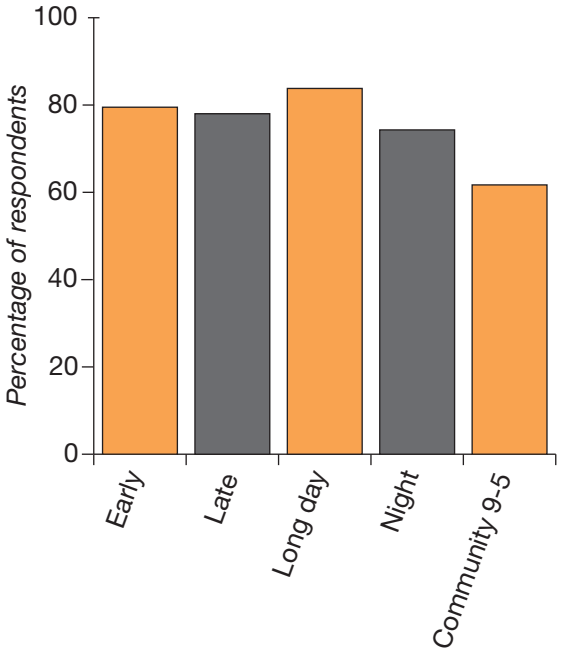
Shifts were chosen to be broken out as well due to the varying levels of activity at different times of the day.

How registered nurses, healthcare assistants and respondents by shift answered the question about providing safe, dignified and compassionate care:





By shift worked on 6 March 2012, the percentages of respondents who felt they did not have enough staff on the shift to deliver safe, dignified, compassionate care.



“ I don’t want to compromise my registration number and put my residents at risk. ”

As is evident from these responses, the majority of respondents across every group felt that not only was their shift understaffed, but this prevented them from delivering safe, dignified, compassionate care.

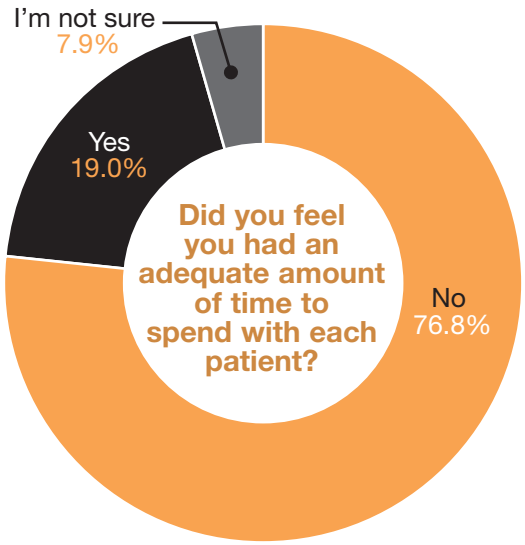
Common rhetoric is to blame nurses and healthcare assistants for poor quality patient care. UNISON members in nursing tell us time and again about stereotypes, scapegoating and other poor practice stories that end with nurses receiving 100% of the blame in any given situation.

“ Data is always skewed. Whatever number of staff on the ward (usually under) nurses will go without breaks and work unpaid overtime to make sure patients are safe. If these shifts go without incident then the management will deem them as fine. If they don’t then it will be the nurses’ fault. ”

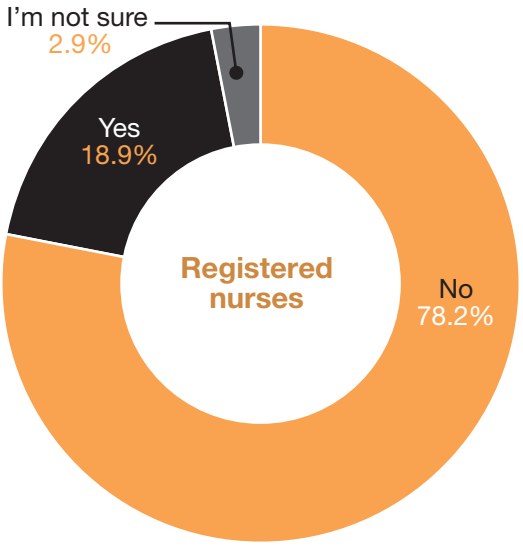
The overwhelming response that low levels of staffing actively degrades patient care cuts right through the myth that the problem here is with the nursing staff. Nurses and healthcare staff are raising issues about their ability to deliver high levels of care while short staffed, and these concerns are falling on deaf ears.

“ Recently the ward has been stretched to full capacity. Two weeks ago, although we tried to the best of our ability, four patients were in wet beds. We went to each patient to clean them up, but with limited staff some of the patients were left an unacceptable amount of time in a wet bed. This is unacceptable and upsetting seeing standards of care drop because of staffing levels, or should I say lack of staffing levels. ”

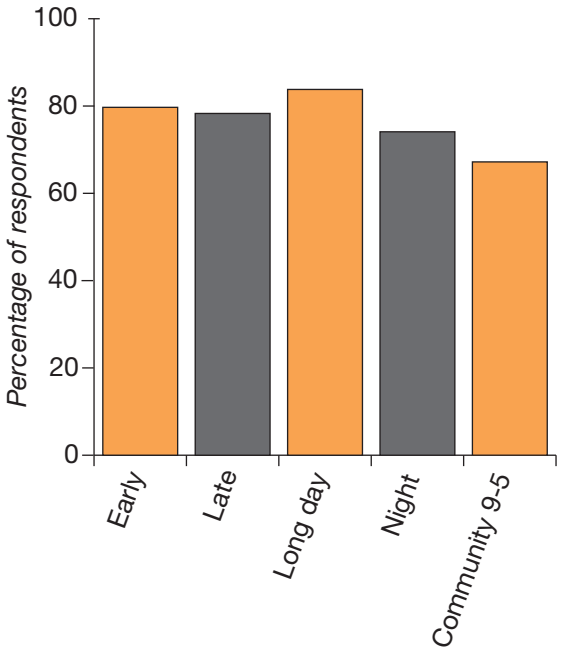
When asked “Did you feel you had an adequate amount of time to spend with each patient?”, the vast majority of total respondents said no (76.8%).

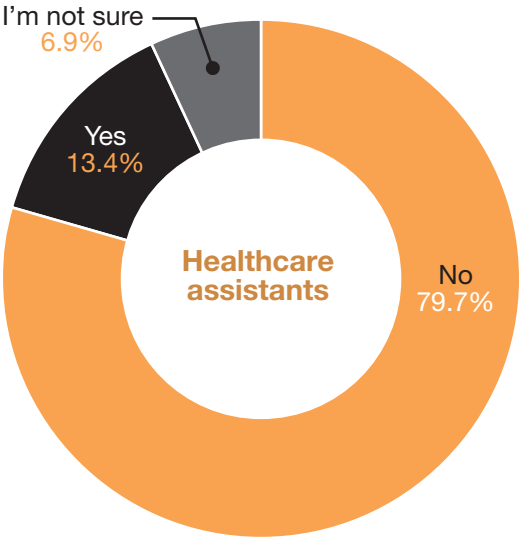


Broken down by role and shift, the percentages of respondents who felt they did not have enough time with each patient remain quite high:



By shift on 6 March 2012





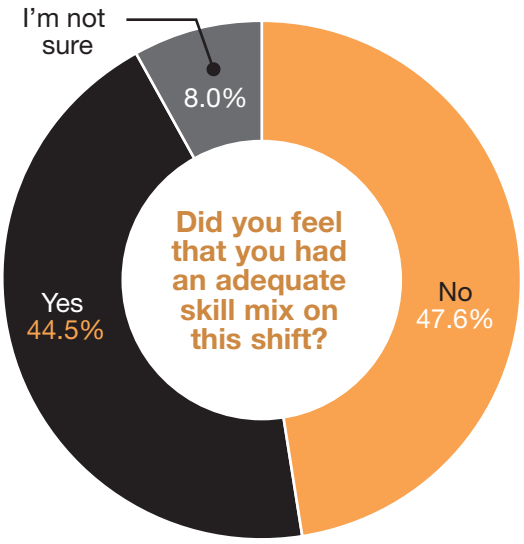
In summary, on a randomly chosen day, over three-quarters of respondents felt that:

- They did not have an adequate amount of time to spend with each patient due to understaffing or unreasonable workloads.
- This understaffing had a detrimental and directly correlated effect on the level of patient care they were able to provide.

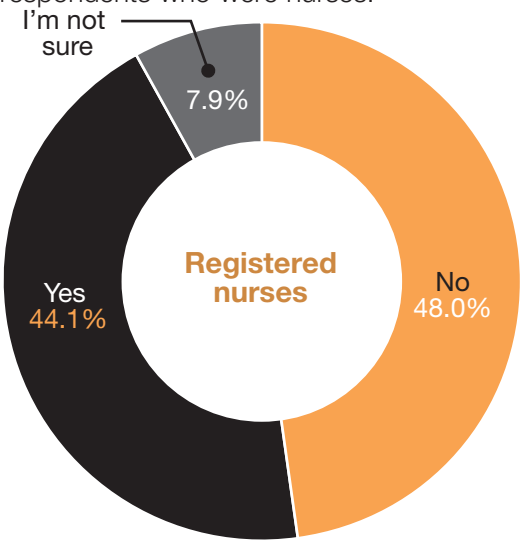
> **“ It is so unfair to the patients who have to wait for long periods to have a wash or get changed or even get attention because we are too busy dealing with so many things at the same time. ”**

The provision of safe staffing levels in nursing is an issue that UNISON strongly supports. Academics from around the world as well here in the UK have provided evidence that a minimum nurse to patient ratio saves lives and results in better patient care. We believe it’s time for the UK to develop legislation which ensures our patients receive minimum nurse to patient ratios.

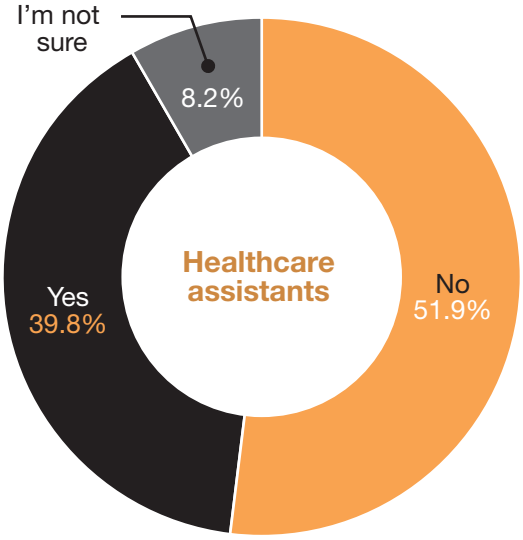
Respondents were also asked about the skill mix on their shift and whether they thought it was adequate, regardless of whether they believed more total staff should have been present. Answers were evenly split. Of the total number of respondents, 47.6% felt there was not an adequate skill mix during their shift, while slightly fewer (44.5%) felt there was. 8% weren’t sure.



The results were roughly the same from the respondents who were nurses:



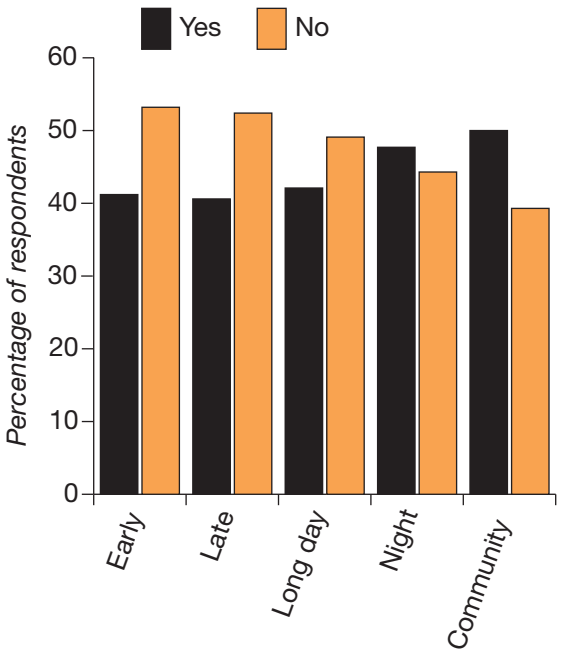
Results were slightly more divided from healthcare assistants:



> **“ Skill mix and capability needs to be planned, not ad hoc as it is currently. ”**

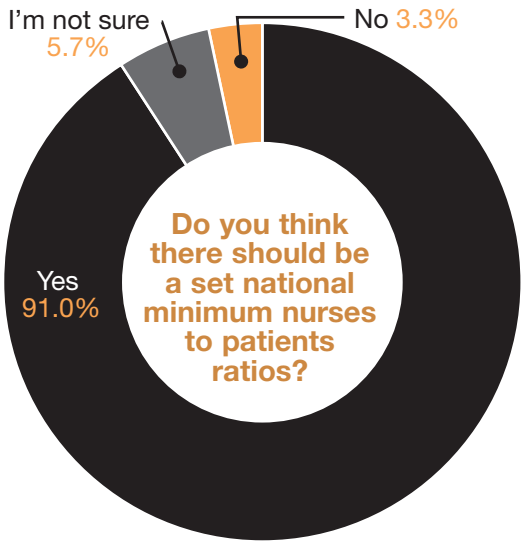
Some shifts were more likely to feel they had an adequate skill mix than others – although no shift had an overwhelming majority of respondents feel their skill mix had been adequate. Early and late shifts, which are usually the busiest shifts, were the most likely to feel that skill mix was inadequate, as represented in the graph below.

By shift on 6 March 2012, respondents who felt the skill mix was adequate



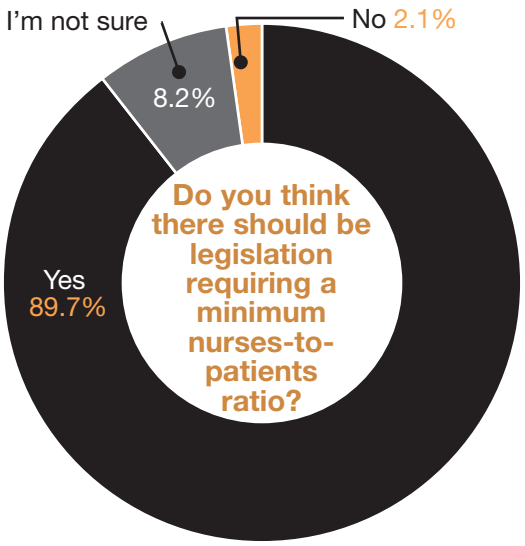
The survey results have already established that many NHS workplaces are understaffed and in need of additional healthcare workers. The responses to this question confirm what should be common sense – nurse to patient ratios ensure that staff have sufficient time to care. The needs of the relevant speciality and expected patient care must be properly considered. This process should of course include a full staff consultation; there is no one better to advise on the needs of a ward or shift than the people who regularly work there.

The vast majority of survey respondents supported set minimum nurse to patient ratios for their area of care. 91% of all respondents answered yes when asked “Do you think there should be a set national minimum nurses to patients ratios?” 3.3% responded no, while 5.7% were not sure.

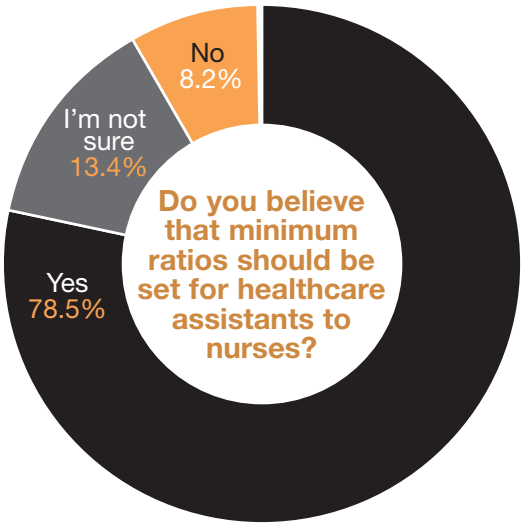


> **“ I feel that minimum ratios would alleviate the stress on all staff members. Constant staff shortages are not good for morale or safety. ”**

When asked whether they were in favour of legislation requiring a set minimum ratio, the responses in support were also very high. 89.7% wanted legislation requiring minimum ratios, 2.1% did not, and 8.2% were undecided.



More than three quarters of respondents were in favour of set minimum ratios for healthcare assistants to nurses. 78.5% supported these ratios, 8.2% were opposed, and 13.4% were uncertain.



"Staff to patient ratios need to be addressed in law, made clear to all and widely implemented. This should ensure that care quality is delivered to a high standard and that penalties are widely detailed and debated. The public's knowledge should be improved about what can be done to ensure their loved ones receive compassion, kindness and gentle care."

"It is about time that healthcare assistants and assistant practitioners were registered, as more and more is getting put on them and they are a vital link to the patients. But this is always overlooked."

Respondents were given several places to feed back on thoughts, opinions or issues they felt they hadn't been able to properly convey through the multiple choice survey answers. One outcome of these text boxes was explanations why a handful of respondents did not support minimum staffing ratios and their reasons for this. Their rationales fell into one of three categories.

Category one: I don't support set minimum nurse-to-patient ratios because I think it will give employers justification to always have on hand only the bare minimum of staff.

> **"If minimums were set that is what you would get without assessing the actual demand and intensity of nursing required."**

Some employers may see the implementation of a minimum nurse to patient ratio as a rule they can easily fulfil by keeping to it at all times – irrespective of patient dependency.

However UNISON has already witnessed that enforced minimum safe staffing levels cause employers to act and add staff to the rotas. On 30 November 2011 UNISON took national industrial action over pensions. As part of our plans to ensure emergency cover, discussions took place at a local level to agree which services would be provided and what cover would be needed in the different wards, units and departments in addition to what care needed to be maintained in patients' homes.

As a result, a number of employers sought to ensure higher levels of cover on 30 November than they would on any other normal day when activity is clearly higher. While we acknowledge that this didn't happen everywhere, it's clear from respondents that nurses already feel they are working below safe levels on a daily basis.

Category two: I don't support set minimum nurse-to-patient ratios because I don't think it will make a difference; employers will just ignore it and it will be a waste of time.

> **"We usually always work on bare minimum, and when we had minimum ratios these were just reduced as management saw fit."**

Unfortunately this concern is not without cause. As this report will detail later, over 30% of respondents worked for an organisation that already had rules in place governing minimum nurse to patient ratios or policies to address understaffing. Problems with self-policing of these policies and ratios were reported to us, which are explained later in this report and underscore the point that legislation is necessary to achieve uniformly safe staffing levels.

Category three: I don't support set minimum nurse-to-patient ratios because healthcare fields vary so much that a minimum ratio appropriate for one area will not be appropriate for a different area.

> **"I would be uncomfortable suggesting that we have 'minimum staffing levels' set, as I would be concerned that this is what management would see as being the recognised level of staff no matter the circumstances within a designated area."**

Concerns were raised about how to determine appropriate minimum ratios for each area of care, given that fields vary so drastically. For example, staffing requirements in a maternity ward are going to be quite different from the requirements for a secure mental health ward, and both of these will differ from what is an appropriate caseload for an elderly care community worker. And even within each of these areas, requirements are going to change from day to day in entirely unpredictable ways as new patients arrive, the health of existing patients changes, and the projected number of discharges varies.

Policy makers who oppose set minimum ratios find comfort in these differences, and the argument has been put forth that because one ratio is not applicable to every field, then it isn't possible or reasonable to put into place *any* minimum ratios that don't already exist.

UNISON doesn't believe that just because something is difficult it should be abandoned. We are not suggesting a single nurse to patient ratio for every field. This would be a disservice to staff working in critical and high intensity environments, and potentially inefficient in areas that work at different paces due to the needs of their patients or service users.

Different specialities will require different ratios. UNISON wants the best for both staff and patients. After all, at one time or another all of our members are patients too. For this reason staffing ratios should have flexibility built into them to take in local variations and changing circumstances. We believe it is possible to look across the UK and develop systems which enable us to set minimum nurse to patient ratios for different specialists based on international evidence.[9]

This survey also uncovered high levels of dissatisfaction, stress and frustration among the respondents, which were not questions included in the survey. Instead, these issues were so important to so many respondents that hundreds of people took the extra time to write in the details of their personal circumstances and the ways in which they have been affected.

> **"It's an endless cycle: nurses work to the bone on a shift where they were short staffed; they don't take breaks, drink water or go to the toilet; they're working under the normal pressures of trying to deliver good care, manage acutely ill patients and meeting the demands of bed management pressures; then they become physically exhausted and are sick themselves for the next shift."**

9 Linda H. Aiken, Douglas M. Sloane, Jeannie P. Cimiotti, Sean P. Clarke, Linda Flynn, Jean Ann Seago, Joanne Spetz, and Herbert L. Smith, 2010, University of Pennsylvania, Implications of the California Nurse Staffing Mandate for Other States

“ The unsafe levels of risk have damaged my health and I have had sickness as a result. ”

The links between stress, job satisfaction and productivity are measurable. Academic and professional studies, including Boorman[3], confirm the impact of sickness absence is not just on the individual but is also a quantifiable, financial cost to the service. The following points are fundamental:

- Understaffing, unreasonably high workloads and frequent unpaid overtime lead to stress.
- Workers who are stressed and generally unhappy in their jobs perform their roles to a much lower standard than happy workers.
- In effect, happy staff deliver improvements in standards of care and the quality of patient outcomes.

UNISON, as the trade union that looks after people who spend their lives caring for others, has been campaigning to reduce workplace stress for many years. No one should be made to work in an environment that leaves them feeling undervalued, stressed or miserable. Although some employers will refuse to improve their workplace on the grounds of improving employee welfare, they need to wake up to the fact that the knock-on effect to patients is both considerable and measurable.

3 Department of Health, 2009, The Boorman Report, NHS Health and well being review, final report

Organisations with minimum staffing levels and understaffing protocols already in place

> **“ Some time ago we were asked by management what our minimum ratios should be. However it seems to have been a pointless exercise as it has not been documented anywhere and is never adhered to. ”**

Several of the survey questions asked about organisations with set minimum nurse to patient ratios or short staffing policies already in place. After sorting the responses into categories for organisations that did have ratios or policies in place and those which did not, it was surprising how little difference there was between respondents' answers.

What evidence we received instead was a vast amount of information on how these minimums and policies are individually self-policed to such a degree that they might as well not even exist.

Some organisations with set minimum nurse to patient ratios simply ignore them:

> **“ We have set safe staffing levels already. But we rarely run at that level. On the early shift on 6 March we should have had four trained nurses and four healthcare support workers. But instead we only had two healthcare support workers. ”**

Other organisations use their budget to set the ratios:

> **“ I am a ward manager and have had nurse to patient ratios enforced on my unit in terms of cost per bed per day rather than the level of dependence of the patients. ”**

Still others re-categorise patients to fit the ratios:

> **“ Senior staff change the dependency of patients to suit the number of staff on duty, so as to show that we can 'cope' even when we can't. ”**

While some others count students toward the ratio, despite students' supernumerary status:

> **“ My ward regularly counts students in the numbers. ”**

Organisations with policies to address understaffing most frequently use one (or all) of the following options to address the shortage:

- Bring in bank or agency staff.
- Call staff at home and ask them to come in on their day off.
- Borrow staff from other wards or workplaces.

Respondents reported problems with bank and agency staff, mostly due to inexperience or unfamiliarity with the specific working environment and patients. This is detailed later in this report.

Problems were also reported with the other methods – calling staff at home and borrowing staff from other workplaces.

“ Staff are over worked. We get called at home when we’re off and pressured to do extra-shifts due to a shortage of staff. ”

“ When we do have the required ratio nurses the duty manager will often take a nurse off our ward to cover another ward that is short staffed. So basically the whole of the hospital is running on short staff. ”

“ The ideal staffing ratios for my ward are probably adequate and we could deliver a good standard of care if we were at full numbers. But this is just a dream. We have sickness and there is simply no cover; today I was three qualified nurses short on a day shift and neither the bank, nor agency could cover it. Our staff shortage policy involves reporting shortages via a reporting policy, but in fairness to senior nurses, if they can’t cover, they can’t cover. We are always robbing Peter to pay Paul. So we pull staff from next week to cover, or we have staff from other wards. Or we cancel mandatory training. This worries me. ”

These are temporary solutions that are being treated as though they are sustainable for the long term, when of course they cannot be. Moving a nurse from a fully staffed ward to a short staffed ward merely changes the location of the problem. This is like taking a pile of dirty laundry and moving it into another room – the result is that you still don’t have any clean clothes. And as this process proceeds, stress levels rise, job satisfaction drops and morale goes with it.

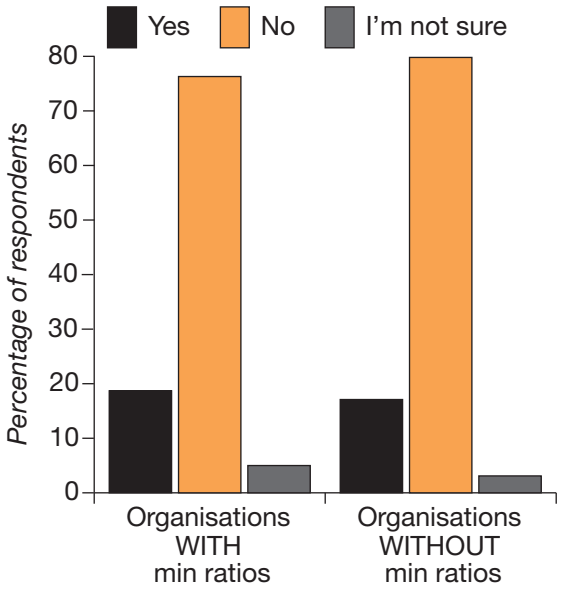
The remainder of this section discusses the differences between answers to key questions from respondents who worked in organisations with short staffing protocols and/or minimum ratios versus respondents from those without. It is important to keep in mind that many of these organisations with ratios or policies in place are not representative of the success of legally enforced minimum nurse to patient ratios. Instead, these organisations truthfully represent what happens when employers facing massive budget cuts are allowed to self-police their own staffing levels.

Organisations with minimum staffing levels and/or protocols to address understaffing did not report high levels of satisfaction with the amount of time they had with each patient, or with the ability to deliver safe, dignified, compassionate care. These organisations did on the whole fare better than their counterparts however.

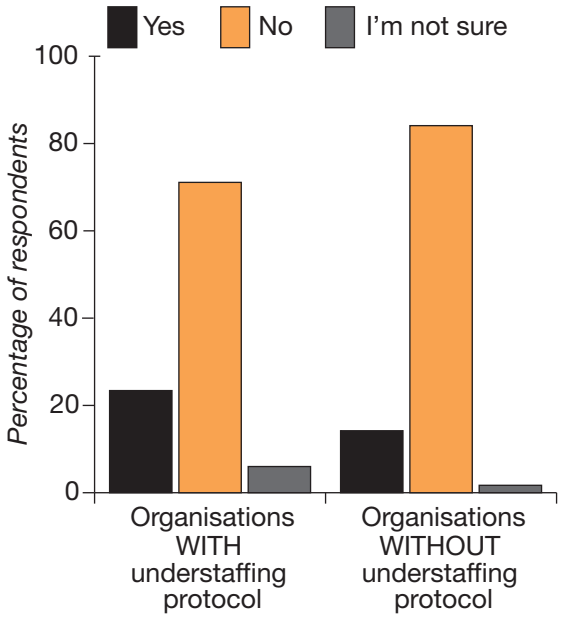
Adequate time

When all respondents were asked if they felt they had adequate time with each patient, the vast majority (76.8%) of all respondents said no. When broken down into respondents from organisations with minimum staffing levels already in place or protocols to address understaffing issues, there was some variance, the most in organisations with understaffing protocols. See the following two graphs:

Adequate time: respondents from organisations with/without minimum nurse to patient ratios currently in place:



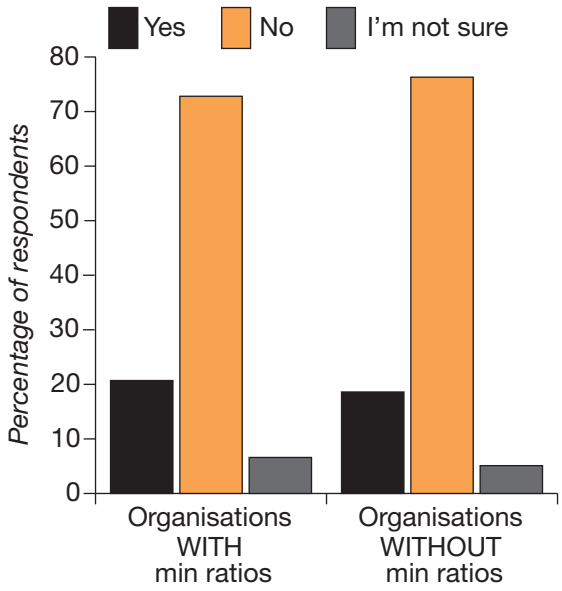
Adequate time: respondents from organisations with/without minimum protocols to address understaffing issues:



Safe, compassionate, dignified care

Similarly, when all respondents were asked if they thought their shift had an adequate number of staff to provide safe, compassionate, dignified care, the majority (73.2%) also answered no. When responses to this question were broken down by the same variables – whether or not respondents worked in organisations that had minimum staffing ratios or understaffing protocols in place – the result was roughly the same. Although an improvement could be seen in organisations that have attempted to address this issue already, the majority of respondents still felt that there were not enough staff present to provide safe, compassionate, dignified care. See the following two graphs:

Safe, compassionate, dignified care: respondents from organisations with/ without minimum nurse to patient ratios currently in place:

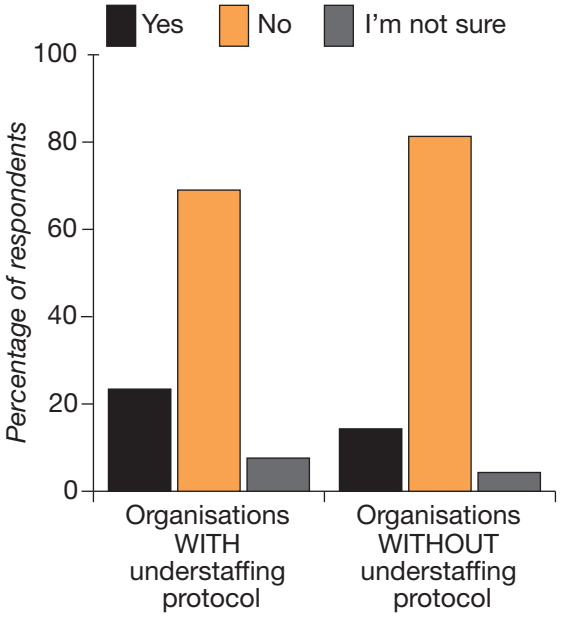


Organisations with minimum staffing ratios already in place reported roughly the same numbers as those without ratios. There was however a clear (if not massive) difference of 9.2% between how respondents felt depending whether they came from an organisation with understaffing protocols versus those without.

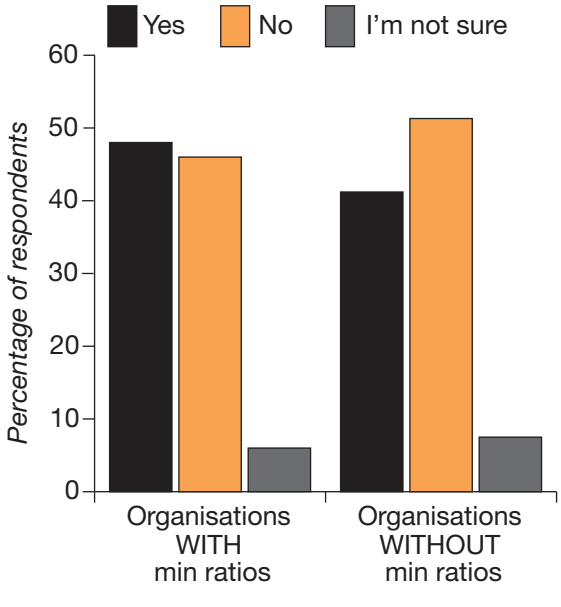
Skill mix

The presence of minimum ratios and understaffing policies in organisations had some limited effect on what respondents felt about their shift's skill mix. More respondents from organisations with understaffing protocols (15.1%) felt their shift had an adequate skill mix than those without understaffing protocols. 6.8% more respondents from organisations with staffing ratios in place felt they had an adequate skill mix than those without ratios.

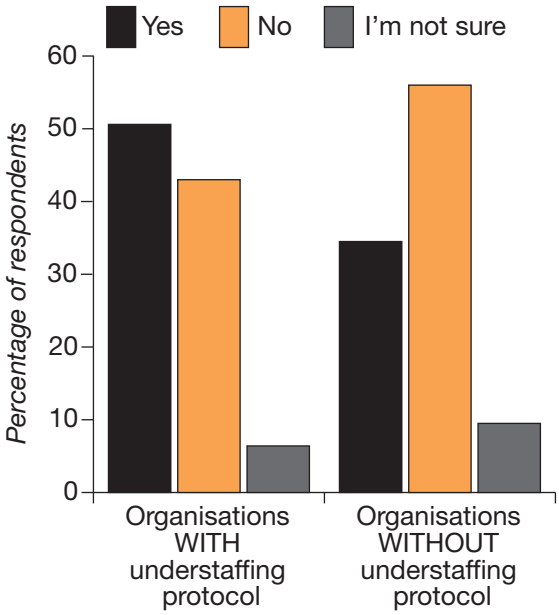
Safe, compassionate, dignified care: respondents from organisations with/ without minimum protocols to address understaffing issues:



Skill mix: respondents from organisations with/without minimum nurse to patient ratios currently in place:



Skill mix: respondents from organisations with/without minimum protocols to address understaffing issues:

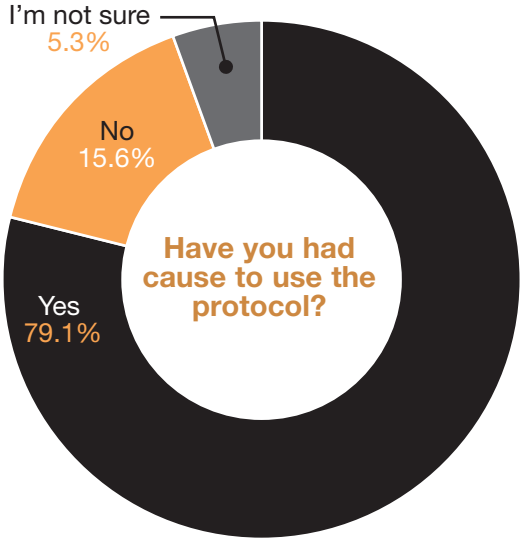


The results from each of these questions yields the same important question regarding staffing ratios and understaffing protocols – what is the point of putting into place minimum staffing levels that either won't be adhered to or are too low to begin with? The answer is that this is more proof that set minimum staffing levels need to be enforced from a greater authority than local management. Self-enforcement on staffing levels is clearly not working.

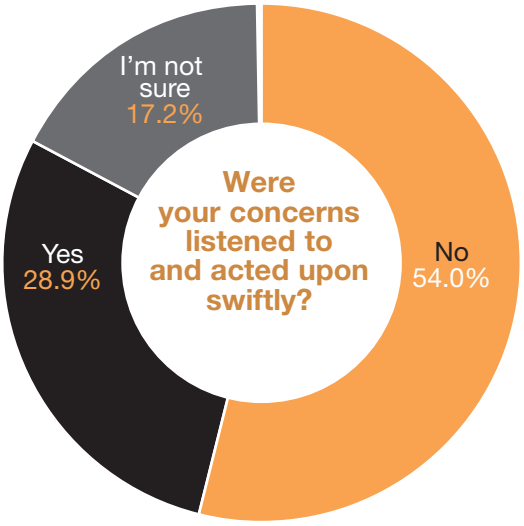
Respondents who worked for organisations with protocols to address understaffing issues in place were asked two follow-up questions:

- Have you had cause to use the protocol?
- Were your concerns listened to and acted upon swiftly?

Almost four out of five respondents reported they had used their employer's understaffing protocol at one point.



Unfortunately, of those who had used the protocol, less than a third felt their concerns had been listened to and acted upon swiftly.



These results are disappointing. Again – what is the point of a protocol that is going to be ignored except to produce unnecessary paperwork? Staff morale is at stake as well; not listening to staff or taking account of their opinions will always contribute to feelings of not being valued. A "take it or leave it" approach to staff management is never conducive to engagement and high morale.

"Whatever we say about staffing is ignored and we're told there are plenty of other jobs we could work in; Tesco's being given as an example."

Another issue these figures raise it that the large percentage of respondents who reported they were not sure is indicative of poor internal communication and feedback. An important part of any workplace process that requires a communication network is to feed information in both directions.

Respondents who worked for organisations with minimum staffing levels or with understaffing protocols tended to be overall slightly more in favour of set minimum nurse to patient ratios, legislation requiring ratios are maintained, as well as minimum ratios for healthcare assistants to nurses. For each of these questions, the percentage in favour of minimum ratios, legislation or HCA ratios was 1-5% higher among respondents from an organisation with a set minimum ratio or understaffing protocol.

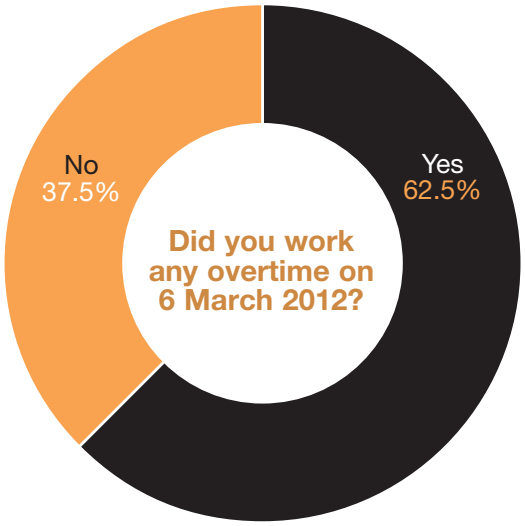
"Guidance from organisations such *Guidelines International Network* and *The Association for Perioperative Practice* is available for specialist areas but often ignored as it is guidance rather than legislation."

There were no occasions when respondents from an organisation which attempted to address problems of understaffing were less in favour of further protection than those from organisations with these. This implies that although some individual employers may not adhere to their own set ratios or follow their own protocols, even in such situations workers still have confidence this is the way forward. Having tested the use of minimum ratios and protocols, staff are answering with confidence in this solution.

Overtime

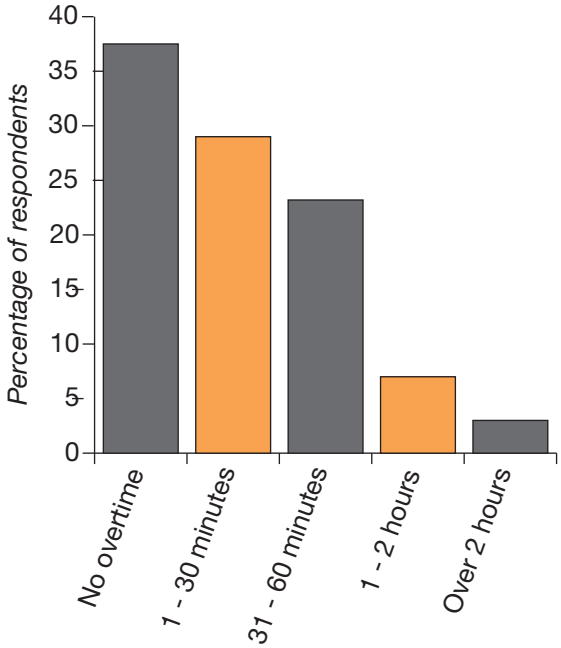
“ 12 hours is too long without proper breaks. 12 hours worked, but only paid for 11 hours. ”

Arising from the survey were issues surrounding overtime, which of course is directly linked to understaffing and burdensome workloads. On 6 March 2012, almost two thirds of staff worked overtime. A mere 37.5% of respondents worked their contract hours and nothing more. Over half of the respondents (52.2%) worked overtime of up to an hour. 10% of respondents worked overtime that lasted more than an hour.



“ We were one registered nurse short, however considering how busy the shift was this amount of staff still would not have been enough. None of the registered nurses on shift got a break at all. ”

How much overtime did you work?



The majority of this time was unpaid. Only one in 13 respondents were paid for their overtime on 6 March. Furthermore, respondents told us about the breaks they missed, the meal breaks they never ate and a regular upheaval of responsibilities that left many unhappy and stressed.

To rule out the possibility that this level of overtime was an anomaly, respondents were asked whether they considered their shift on 6 March 2012 to be representative of a "typical shift." Over two-thirds of respondents (67.9%) reported it was indeed typical. The 2011 NHS Staff Survey[8] similarly reported 65% of its respondents "working extra hours."

It is of greatest concern to UNISON that healthcare staff are not being afforded their breaks and are being forced to work overtime without pay. UNISON understands that sometimes in healthcare it will be necessary to work overtime; if a patient enters a critical condition at 17:40, it won't always be practical for the nurse to pack up and leave at 18:00.

This type of overtime stems directly from the healthcare workers' concern for patients. If they left immediately when their contracted hours finished, patient care could be put at risk. Employers are aware of this necessity as well. Refusing to pay overtime for such a commonplace and practical occurrence is placing the employee in a distinctly unfair position. If they stay they will work for free and if they leave they may be putting someone's life at risk.

"The qualified staff are torn between caring for the patients and the amount of paperwork we have to do, as any paperwork not done has to be finished after shift time ends and we don't get paid for it."

All workplaces and employers should pay their employees for the hours they work. There is currently an over reliance on the good will of staff which is now being taken for granted.

It is dangerous to the health of employees to work extended periods of time without breaks. No one should be expected to work an eight, 10 or 12 hour shift with only the *hope* of a meal break. All workplaces need to be in line with the Working Time Regulations, both for the sake of the staff as well as for the patients being cared for. It should be clear to anyone that a nurse who has had all his or her breaks and is leaving at the end of their shift will treat their patients with a higher standard than a nurse who has not eaten in the last 10 hours.

8 Department of Health, 2011, NHS Staff Survey

Bank and agency staff

> **“ If we short of staff, we are short of staff. ”**

A clear problem came to light from this research – many respondents were unhappy with the way that bank and agency staff are used in their organisation. The NHS continues to rely on the use of bank/agency staff as a short term fix. In general, the issues pertaining to bank and agency staff fall under one or more of the following categories.

Category one: Bank and/or agency staff are not always familiar with the workplace and therefore can’t contribute in the way a permanent staff member can.

> **“ It was hard working with agency staff. It feels like you’re working on your own because they don’t know the ward or the patients. ”**

Category two: Bank and/or agency staff don't function as 'part of the team' because they do not always have the specific skills required for the area, which creates more work for everyone else.

> **"The agency nurse continually needed guidance and assurance throughout the shift. She did not have some of the extended roles required to work in a very busy medical ward, therefore I had to carry out certain procedures/tests that she could not do while carrying out my own duties. I was in charge of the ward and I felt that I could not give my patients a high standard of care that they deserved as I was having to care for not only my 19 patients but to help with other unwell patients that the agency nurse was meant to be caring for."**

Category three: Bank and/or agency staff are expensive and not an efficient use of funds.

> **"We rely on agency staff, and when you total the cost of agency staff, that money could fund two or three more healthcare staff and we could use our own trained staff. This would give better care to the patients too."**

Bank and agency staff are not necessarily pleased with the situation either. It's not easy to be thrown into the deep end of a new workplace every day, or to be treated as a hindrance because your knowledge of that specific workplace is limited.

The use of bank and agency staff obviously needs to change. Issues arising from understaffing and unreasonably high workloads cannot simply be resolved with a quick fix.

If a staff member does not know where particular supplies are kept, the hierarchy and names of staff on the ward or the history of existing patients, then they may not be able to perform to the same speed or standard as the permanent employees. No one wins here – not the permanent staff who have to train a new bank or agency staff member every day, not the bank or agency staff member who has little stability in their working life, and certainly not the patient whose care is compromised by understaffing and a lack of continuity in their care.

Raising issues and blame

> **“ In a previous job I questioned the ratio stating it was unsafe: shortly afterwards I was dismissed before a 12 month contract clause expired. My ex-colleagues faced so much stress that one nurse who had worked the usual 14 hour day had to work through the night as well when the night nurse cancelled. The manager expected her to start medication the following morning. At my current workplace I am barely able to do more than administer medication, and chase up diary entries for the 18 to 20 clients I am responsible for. I am unable to engage in other aspects of care which then calls into question the role of the nurse and patient care is compromised. I have wanted there to be legislation in this area for a long time. ”**

Many respondents felt very strongly that they were stuck in a depressingly difficult situation: that they are asked to deliver a certain quality of care with unrealistic resources, but if they speak against it they are bullied and if they keep quiet but make a mistake they bear 100% of the blame.

> **“ I am concerned that the staffing ratios are often unsafe and feel that if I raise my concern that I will be bullied by management. ”**

> **“ If asking for help during ‘busy’ unsafe times you are made to feel inadequate and a trouble maker as the risk is not acknowledged from non emergency nurse practitioners who do not have the same level of legal accountability. ”**

UNISON condemns bullying, harassment and victimisation in the workplace, which can take many forms and may be quite subtle. All UNISON members are asked to report incidences of workplace bullying, harassment and victimisation to their local UNISON representative.

UNISON has recently produced a pack entitled *Be Safe* that members and activists can use in the event that their workplace has unsafe practices. This guidance gives advice on where to turn for help, how to use the Nursing and Midwifery Code of Conduct[10] to maintain your professional responsibility

10 Nursing and Midwifery Council, 2010, The Code

and report problems effectively within your organisation. You can access the packs from your local UNISON branch or download a form from the website at unison.org.uk/healthcare/nursing/index.asp

Respondents to the survey felt acutely aware that their employers would not be held to account for any mistakes contributed to by unreasonable workloads or lack of staff.

“ It is always busy and the staffing levels are hardly taken into consideration all. Staff are cut at the expense of patient care and when anything goes wrong the staff will be blamed for the decisions of those in authority. It is rather unfair. ”

“ Managers will try to get away with the minimum numbers they can. If there are any complaints about care on the ward, staffing numbers are never considered as a cause. Instead nurses are blamed for poor time management skills or failure to follow correct procedures. ”

A blame culture continues to exist in our service, which hurts healthcare workers as we've seen in the survey responses. Respondents felt they would be held completely accountable for all mistakes, regardless of any contributing circumstances. Working daily with that belief adds to stress, dissatisfaction and ultimately to worse patient care.

When things go wrong most NHS organisations investigate and manage the issue through a disciplinary procedure, rather than reviewing it independently. The NHS could learn from the aviation industry how to manage risk more effectively and review incidents independently. The aviation industry's model of incident review has led to fewer overall incidents and an improved system of staff management.

This is not about a no blame ever culture or that poor practitioners should not be held to account. It is however ensuring we look at all of the facts, including the circumstances leading up to an event, before making any conclusions. No nurse, HCA, midwife or health visitor goes to work intent on giving poor care. However poor care is sometimes the result of circumstances which are outside their control. In the NHS today if a nurse and doctor make the same type of drug error a nurse is more likely to be disciplined while the doctor would receive counselling.

Conclusions

> **“ It was very hectic and tiring and I wore a pedometer today for this survey... I walked over 15 miles on my shift!!! ”**

The survey shows that there are problems with understaffing on a national level, which means that patient care is suffering everywhere.

On a randomly chosen day the overwhelming feedback revealed there were not enough staff on the wards to deliver safe, compassionate and dignified care. The concerns were evenly divided across all groups, regions, shifts, roles, organisational types, fields, etc. This causes added concern as British and international research shows that high nurse to patient ratios are directly related to lower patient mortality.

Less than half of respondents felt their shift had the right skill mix. Tackling understaffing is not just about numbers - our survey found staff who were moved around to cover absences or assist in critical situations, were not best suited to the task. This is likely to get worse as managers save money in order to meet the government’s £20 billion of NHS cuts.

There was overwhelming support for set minimum nurse to patient ratios in order to deliver good patient care. More than three quarters supported legislation mandating staffing levels. In addition, the majority of respondents were in favour of a minimum healthcare assistant to nurse ratio.

There is no “one size fits all” nurse to patient ratio for every area of healthcare. Patient needs vary widely across the spectrum and so nurse to patient ratios need to reflect that. A low security psychiatric ward won’t have the same staffing requirements as an intensive care unit. Careful planning and examination is needed to determine appropriate and safe staffing ratios for individual units.

Even where organisations have a minimum nurse to patient ratio protocol or policy there are severe compliance problems. Staff are plucked from one ward and sent to another, transferring the problem from that place to another. Even with the best intentions, employers cannot be relied upon to self-police in this arena. Self-policed minimum staffing ratios may be ignored or overridden, or they may have been arbitrary or intentionally low to begin with. Protocols to address understaffing issues are used by staff, but then ignored by management.

Almost two-thirds of respondents worked overtime on 6 March 2012, and only one in 13 received payment for this work. Respondents also reported regularly skipping breaks and meals. Although UNISON recognises that some overtime may be necessary in a healthcare environment when a patient won’t suddenly recover from a critical condition merely because the carers’ shift ends, we strongly disagree with what appears to an institutional practice that takes advantage of workers who put the needs of their patients before themselves. The Working Time Regulations and Agenda for Change set out very clear boundaries for rests, meal breaks and extended hours and employers need to

enforce these rather than viewing the situation as an excuse to obtain free labour.

There is a widespread belief among permanent staff that bank and agency staff cannot be expected to perform to the same speed and standards as an employee who is familiar with the workplace. This situation increases pressure and workloads for permanent employees. Bank and agency staff have to live with instability and the stress of regularly entering a new working environment. There is a danger that the use of bank and agency staff will increase as the cuts bite harder, with permanent nursing staff being made redundant and employers searching for a "quick fix" to their budget woes.

Staff were very worried about getting the blame for incidents and mistakes, regardless of any contributing factors such as understaffing or unmanageable workloads. Concerns were also raised about the repercussions of whistleblowing and reporting incidents. Some respondents expected bullying or the loss of their job if they reported the problem.

UNISON condemns any form of bullying, harassment or victimisation in the workplace and has recently produced a new pack to aid healthcare workers address unsafe situations, entitled the *Be Safe* pack.

Annex one The web survey

Nurse/Patient Ratios on 6 March 2012

About your organisation

We cannot count your responses to this survey unless they are for 6 March - please do not fill it in for other dates! We will sadly have to delete your answers!

Thanks for coming through to UNISON's nursing ratios survey. The ratio of nurses to patients (how many patients there are per nurse, in other words) is an issue of utmost importance. International research as well as common sense tells us that the ratio of nurses to patients is going to have an effect on patient care.

In most areas of healthcare in the UK there are no set minimum nurse-to-patient ratios. A few areas (such as ITU and A&E) have set minimum ratios and some others follow the best practice from the Royal Colleges, but most areas operate without set minimum ratios.

Thanks for taking the time to record your organisation's nurse-to-patient ratio on 6 March 2012 and filling in this survey. With your help, UNISON will begin tackling this important issue. The survey has four pages and will take only a few minutes to complete. It's not mandatory to fill in every question, but it will help us if you do!

1. First, a few questions about your work. The information you enter won't be made public and we won't share it with anyone, but it will help us to follow up. What is the name of the organisation that you work for?

2. What type of organisation is it?

- ☐ Acute hospital
- ☐ Community
- ☐ District general hospital
- ☐ Foundation trust
- ☐ Learning disabilities
- ☐ Mental health
- ☐ Other (please specify)

Page 1

Nurse/Patient Ratios on 6 March 2012

3. What region is your organisation in?

- ◯ Eastern
- ◯ East Midlands
- ◯ Greater London
- ◯ Northern
- ◯ Northern Ireland
- ◯ North West
- ◯ Scotland
- ◯ South East
- ◯ South West
- ◯ Yorkshire & Humberside
- ◯ Cymru/Wales
- ◯ West Midlands

4. Thinking about the whole of your organisation (not just your site), approximately how many people does your organisation employ?

- ◯ Less than 500
- ◯ 500 – 2000
- ◯ More than 2000

5. What is your role?

- ◯ Registered nurse
- ◯ Health Care Assistant (HCA)
- ◯ Health visitor
- ◯ Midwife
- ◯ Other (please specify)

6. Are you a UNISON member?

- ◯ Yes
- ◯ Yes and I'm also a workplace representative or activist
- ◯ No and I belong to another union
- ◯ No and I don't belong to any union

Nurse/Patient Ratios on 6 March 2012

Staffing Ratios on 6 March 2012

The following questions will help us get an accurate picture of how your ward/unit/department was staffed on 6 March 2012. If you have anything additional to add, there is a box at the bottom of the page in which you can write.

Those of you on nightshifts may be wondering which shift to record - 5/6 March or 6/7 March? Please record the shift during which more hours fell on the 6th. This means if you work 22:00 - 6:00, then you should record the shift on 5/6 March. Or if you work 18:00 - 03:00, then record the shift on 6/7 March.

1. On 6 March 2012, which shift did you work?

- [ ] Early
- [ ] Late
- [ ] Long Day
- [ ] Night (starting any time after 10pm on 5 March)
- [ ] 9-5 Community staff shift
- [ ] Other (please specify)

2. How many hours is that shift contracted to be?

- ◯ 8 hours
- ◯ 10 hours
- ◯ 12 hours
- ◯ Other (please specify)

3. Did you work longer than those hours? Please tick all that apply.

- [ ] I worked my contracted hours and no more
- [ ] Additional time, less than 30 minutes
- [ ] Additional time, between 30 and 60 minutes
- [ ] Additional time, between 1 and 2 hours
- [ ] Additional time, more than 2 hours
- [ ] This time was unpaid
- [ ] This time was paid

Nurse/Patient Ratios on 6 March 2012

4. What type of ward/field were you working in on 6 March 2012?

- ☐ Care of the Elderly
- ☐ Children
- ☐ Community Care
- ☐ Community Mental Health (including Early Intervention Team, CAMHS, Forensic)
- ☐ Medical
- ☐ Mental Health: Inpatient
- ☐ Mental Health: Secure Unit (including Low, Medium and High)
- ☐ Obs & Gynae
- ☐ Orthopaedic
- ☐ Surgical
- ☐ Trauma
- ☐ Other (please specify)

5. These questions are relevant to an inpatient setting. About the ward's beds...

How many total beds are on the ward?

How many of these were closed beds?

How many beds were empty for the entire shift (not including the closed beds)?

6. These questions are relevant to an inpatient setting. About the patients...

How many total patients were there on the ward/unit during your shift?

How many admissions/referrals were there to the ward during your shift?

How many discharges were there from the ward during your shift?

How many patients were you looking after during your shift?

7. If you DO NOT work on a ward, what was your caseload on 6 March 2012?

8. Did you feel that you had an adequate amount of time to spend with each patient?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

Nurse/Patient Ratios on 6 March 2012

9. Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

10. NOT counting agency or bank staff, how many NMC registered nurses of each pay band were on the ward/unit during your shift? Please fill in the text boxes with numbers.

Band 5	
Band 6	
Band 7	
Band 8	

11. NOT counting agency or bank staff, how many HCA or other nursing support workers of each pay band were there on the ward/unit during your shift? Please fill in the text boxes with numbers.

Band 1	
Band 2	
Band 3	
Bnad 4	

12. How many BANK staff of each pay band were on the ward/unit during your shift? Please fill in the text boxes with numbers.

Band 1	
Band 2	
Band 3	
Band 4	
Band 5	
Band 6	
Band 7	
Band 8	

Nurse/Patient Ratios on 6 March 2012

13. How many AGENCY staff of each pay band were on the ward/unit during your shift? Please fill in the text boxes with numbers.

Band 1	
Band 2	
Band 3	
Band 4	
Band 5	
Band 6	
Band 7	
Band 8	

14. Were there any other staff physically present on the ward/unit for most of your shift? Who were they and how many? Please fill in the text boxes with numbers

Administrative or clerical	
Cleaning staff	
Doctor	
Food services staff	
Receptionist	
Other (please specify)	

15. Did you feel that you had an adequate skill mix on this shift?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

16. In your opinion, was this a typical shift? In other words, did everything run as usual or were half the staff off sick or was the unit filled with additional staff due to a recent massive accident, etc?

- ◯ It was slow.
- ◯ It was typical or as busy as normal.
- ◯ It was unusually busy.
- ◯ It was not a typical day because:

Nurse/Patient Ratios on 6 March 2012

17. Is there anything else you would like to add about the shift?

Nurse/Patient Ratios on 6 March 2012

Your place of work (ward/unit/etc)

1. Does the ward or team that you work on have minimum ratios for nurses-to-patient beds?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

2. If yes, what is the minimum nurse-to-patient ratio for your ward or team?

3. If there is a shortage of nurses, is there a workplace protocol/policy that addresses this?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

4. If you answered yes to the previous question, have you had cause to use it?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

5. If you answered yes to the previous questions, were your concerns listened to and acted upon swiftly?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

6. Do you think there should be a set national minimum nurses to patients ratio?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

Nurse/Patient Ratios on 6 March 2012

7. In your opinion, what should the minimum ratio of registered nurses to patients be in your area of work?

- ◯ 1 nurse to 7 patients
- ◯ 1 nurse to 6 patients
- ◯ 1 nurse to 5 patients
- ◯ 1 nurse to 4 patients
- ◯ 1 nurse to 3 patients
- ◯ Other (please specify)

8. What sort of impact do you think set minimum nurse-to-patient ratios would have?

- ◯ Positive
- ◯ Negative
- ◯ No impact
- ◯ I don't know

9. Do you think there should be legislation requiring a minumum nurses-to-patients ratio?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

10. Do you believe that minimum ratios should be set for healthcare assistants to nurses?

- ◯ Yes
- ◯ No
- ◯ I'm not sure

11. Is there anything else you would like to add? Have you had any experiences with staffing ratios that you would like to describe?

Nurse/Patient Ratios on 6 March 2012

Contact details

Thank you for taking the time to complete this survey! Your time and contribution will help us understand what the situation looks like nationally – and then UNISON can begin to tackle the issue of low staff-to-patient ratios.

If you have any further questions, please don't hesitate to contact the UNISON Health Group by emailing health@unison.co.uk. You can also visit us on our website at http://www.unison.org.uk/healthcare. If you are not a member of a trade union and would like more information about joining UNISON go to http://www.unison.org.uk/membership/.

1. We'd like to ask you for your contact details in case we have any questions about the day. These details will be kept confidential and used only for this purpose.

Name:

Email:

Phone:

Mobile:

2. Would you like to be kept updated on our campaign by email?

◯ Yes and I give permission for my email address to be used for this purpose

◯ No

3. It can be really helpful to members to read about similar situations in other workplaces. Would you be willing to be contacted by us to share your story as a UNISON case study. If we contact you, you can specify that you want the case study to be anonymous.

◯ I would be willing to be contacted by UNISON about being a case study.

◯ Please do not contact me about this.

4. Sometimes someone from the media will contact UNISON looking for a case study or member's story, at which point UNISON's Press Office likes to get in touch with willing members. Would you be willing to speak with UNISON's Press Office or with the media? Your contact details would not be given to any media representative without your prior consent. Please tick all of the options below that you might be willing to do.

☐ Write a letter to your local newspaper

☐ Be interviewed by a newspaper

☐ Speak on a radio programme

☐ Be interviewd on television

☐ I am willing to speak to UNISON's Press Office but not the media

☐ I do not want to be contacted about this

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