The Keys to Safe, Effective Staffing in the Real World

2016 Nebraska Nurses Association Annual Convention
Jennifer Mensik, PhD, RN, NEA-BC, FAAN
Insanity:
Doing the same thing over and over again
and expecting different results

— Albert Einstein
What should we know about staffing and scheduling?
Setting the Stage

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations (ANA, 2015).
A Nurse’s Primary Commitment

• The ANA Code of Ethics states, “because the nurse’s primary commitment is to the patient, it carries the greatest weight and priority and consequently it trumps all other loyalties” (ANA, 2015b, p. 26).
Match of registered nurse expertise with the needs of the recipient of nursing care services in the context of the practice setting and situation.

The provision of appropriate nurse staffing is necessary to reach safe, quality outcomes; it is achieved by dynamic, multifaceted decision making processes that must take into account a wide range of variables. (2012, p. 5)
National level: What is Going on Out There?
State Legislation as of 2015:

States that require hospitals to have nurse driven staffing committees responsible for plans and staffing policy: Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington. Additionally, Minnesota requires a Chief Nursing Executive or their designee to develop a core staffing plan.

States that require some form of disclosure and/or public reporting of staffing plan: Illinois, New Jersey, New York, Rhode Island, Vermont.
Regulatory and Accreditation Requirements

The CMS

• States in 42 Code of Federal Regulations (42CFR 482.23(b)) that it requires hospitals certified to participate in Medicare to “have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed”

The Joint Commission

• The requirement states that at least once a year, the administration of a hospital/organization must provide written reports on all system or process failures, the number and type of sentinel events, information provided to families/patients about the events, and actions taken to improve patient safety
Furthermore, a decade of research on California’s ratios has shown mixed results on the effectiveness of mandated ratios. (Tellez, 2012; Chapman, et al, 2009; Aiken et al, 2010; Spetz, et al 2013)

- Nurse to patient ratios by unit/specialist: California; Massachusetts requires ICU to have a 1:1 or 1:2 nurse to patient ratio depending on patient stability
A light at the end of the tunnel?

✓ CMS Measures:
  - NQF Endorsed
  - HQ #205 and #204
  - HPPD and Skill Mix

✓ Legislation:
  - The Registered Nurse Safe Staffing
  - Nursing Shortage Reform and Patient Advocacy Act
Research on overtime

- There are 14 states with known restrictions on the use of mandatory overtime:
  - Two additional states, California and Missouri, have provisions in regulations.

Overtime is also an issue due to increased nurse fatigue, working longer than 12 hours and increased job and patient satisfaction (Stimpfel, et al., 2012).
Clinical Outcomes

Adverse Outcomes

2% to 25% reduction in adverse outcomes, depending on the outcome (with higher staffing at all levels) (AHRQ, 2004)

Supplemental Staff

Initial research noted higher mortality rates with a higher use of supplemental nurses (Aiken, et al 2007), however, when controlling for the quality of the work environment, the association disappeared (Aiken, et al, 2013).

Better Workloads

Additionally, hospitals that did use supplemental nurses were noted to have more favorable patient to nurse ratios workloads than hospitals that use few or no supplement nurses, (Aiken, et al 2013).
What is Missed Care?

**Omission:**
Something that has been left out or excluded
Failure to do the right thing

**Commission:**
The act of doing something wrong

“Any aspect of required patient care that’s omitted in part or whole, or delayed, doesn’t come without consequences or adverse events” (2 p. 40).

However….Errors of omission are more common than errors of commission and often remain unreported (AHRQ)
Missed Care Outcomes

Rapid Response
Having a greater percentage of RNs in the staffing mix resulted in more rapid responses to patient needs (Dabney & Kalisch, 2015)

Timeliness
Higher staffing levels are correlated to less missed timeliness (Dabney & Kalisch, 2015)

Assessment was missed 44% of the time

Intervention was missed 73% of the time

Planning was missed 71% of the time
As nurses are being asked to do more with less, missed care has been shown to lead to moral distress in nurses due to feelings of guilt and frustration as a result of delayed or missed care (Winters, 2012).
Financial Outcomes

Length of Stay
Higher RN Staffing levels have been shown to reduce patient length of stays in hospitals!. Length of Stays have been shown to be reduced by 24-31%. (Marsolf, et al 2014; Kane, et al 2007; Staggs et al 2013).

Rehospitalization
Hospitals with higher nurse staffing had 25% lower odds of being penalized under the Affordable Care Act’s Hospital Readmission Reduction Program (HRRP) compared to similar hospitals with lower staffing (McHugh, et al 2013).

Revenue
Each additional patient-care RN employed (at 7.8 hours per patient day) is estimated to generate more than $60,000 annually in reduced medical costs and improved national productivity (Dall, Yaozhu, Seifert, Maddox, & Hogan, 2009).
Clinical Outcomes

Mortality Rate
Each additional patient per nurse was associated with a 7% increase in the likelihood of dying within 30 days of admission and a 7% increase in the odds of failure-to-rescue (Aiken, et al 2013).

Readmission
Higher RN nonovertime staffing decreased odds of readmission (OR = 0.56) (Weiss, et al 2011).

BSN
Further research has found that better outcomes were attributed in large part to highly qualified and educated nurses, including a higher proportion of baccalaureate prepared RNs (McHugh, et al 2012).
Certification was associated with better patient outcomes by nurses with baccalaureate education.

No effect of specialization was seen in the absence of baccalaureate education.

Which One First? Promote BSN or Certification?
Rural hospitals provide care to nearly 51 million people

Critical access hospitals account for 30% of all U.S. hospitals

Disproportionately rely on government payments

Rural Americans is a specific population with health disparities
Hospital Differences

- Rural
  - 50 or more beds
  - Fewer than 50
  - Distance from another hospital (30 miles)
  - Located beyond an area of 40,000 or more in population

- Critical Access
  - Rural Hospital Flexibility Program
    - Rural area
    - Provides 24 hour services
    - Average LOS less than 96 hours
    - More than 35 miles from a hospital or another CAH
    - 15 miles in mountainous terrain
  - May operate up to 25 beds
  - Swing beds
Mortality rates for heart attack, congestive heart failure or pneumonia have increased at critical access hospitals while those rates have declined in other acute care hospitals between 1998-2008.

(Chen, Normand, Wang, & Krumholz 2011)
Impact of Shortages on Staffing in CAH
When geographic regions experience RN shortages:

- Decrease their RN staffing levels
- Increase their LPN hours
- Resulting with a concurrent drop in hospital patient satisfaction

Hospital administrators generally agree that the RN shortage is a problem, but the majority do not believe it has negatively impacted patient care.

-Cramer, Jones, Hertzog, 2011
One Study Found….  

- Registered nurse staffing is highly variable  
- Overall mean RN-to-patient ratio among our CAH sample was within the norm for medical/surgical units  
- However, individual CAH data showed that 9 of 10 CAH’s reported days when the ratios were exceeded  
- On average, CAH met the recommended norm for staffing  

- RN to patient ratios do not adequately describe RN workload  
- CAH work environment is highly variable  

- The RN’s must:  
  - Constantly plan and adapt their care and skills to an environment that has wide fluctuations  

Cramer, Jones, Hertzog, 2011
And in the Outpatient Setting…

**Long Term Care**

- Higher RN hours were associated with fewer pressure ulcers (Lee, et al 2014).
- Licensed nurse turnover in nursing homes and quality of care deficiencies (Lerner, et al, 2014)
- Use of medication aides does not significantly reduce RN or LPN usage and did decrease the probability that a facility receive less total deficiency citations (Walsh, et al, 2014).

**Home Health and Hospice**

- improve nurse retention by improving the work environment in addition to ensuring manageable workloads to facilitate improved work life balance (Tourangeau, et al 2015).
- One study did suggest that hospices create float pools that provide flexibility in weathering workload variability (Cozad, et al).
Similar But Not Interchangeable Terms:

Staffing

Scheduling
Staffing Methodologies

- Acuity
- Combination
- Ratio
- Finance
Away from Commoditizing Nursing

Ratio

Even “staffing,” it still suggests nursing is a commodity, not a professional practice

Finance

Shift thinking from nurses as HPPD to nurses as a profession

Acuity

All nurses must change their thinking about their own practice and the practice of their staff
Do you know your care delivery model?

How can you innovate when you don’t know what you are innovating from?
Care Delivery Models: Structure

- Consistent and standardized structure
- Accountability and responsibility structure
- Defines how work is organized, how staff are deployed and who does what in providing patient care
- Provides organizations to the rules and structures
- Trust and mutual understanding of roles, skills and responsibility
Nursing Care Delivery Models

- Team-Based Nursing
- Modular Nursing
- Primary Nursing
- Functional Nursing

1. Is the care delivery model the same day to day or does it change?

2. Do you know what model of care you are providing on any given day?
Organizational Care Delivery Models

- ✓ Swing Bed
- ✓ 12 Bed Hospital
- ✓ Primary Care Team
- ✓ Transitional Care Model
- ✓ Planetree Patient Centered
- ✓ Hospital At Home
- ✓ Nurse Intensivist
**Full Authority for Everyone!**

- Does your facility policies restrict ANYONE’s practice?
- Who is the BEST person to do what is needed to provide the best patient care?
- Is nursing owning everything?
Variability

• Daily fluctuations in census can be as much as 30% (Litvak et al., 2005).

• Improving patient flow can have a significant impact on quality of care and patient satisfaction (Armony, et al 2015).
Natural Variability

Natural variability refers to the random factors that impact your unit. Although you cannot eliminate these random factors, you can manage them.

- Three subtypes to natural variability: clinical, patient flow, and professional.

Artificial Variability

Artificial variability refers to the way we schedule services and allocate resources, thus, our inability to manage effectively our beds and staff (IOM, 2010).

- Research has shown it has about the same impact on your patient flow as the ED does, which is considered to have natural variability (Litvak, 2004).

Build More Beds?

The average cost is $1.5-$2 million per bed (Bazuin, 2010).
Does Nursing Matter?

Then why is it so hard to get others to understand?
It’s About Operationalization!

Not by taking the schedule and making operations happen….

The care delivery model is **what** **drives** the operations, finance, quality, and everyone's satisfaction
Action Items:

1) Take the care delivery model, and turn it in to a schedule!
   • Giving time for all staff to fully perform their expected role
2) Understand and manage your Variability!
3) Review policies and procedures of care for different patient types!
4) Focus on education and certification!
   • Less staff means education level is even more important!
Questions?

Thank you!