The domino effect: Staffing for “what is” versus “what if”

By Maureen Kroning, EdD, RN

If you’ve ever worked as a nurse supervisor or nurse administrator, you’ve probably heard the saying, “We don’t staff for ‘what if.’” As a nurse supervisor with over 10 years of experience, I still don’t understand how we staff any other way. Unless we, as administrators, are looking into a crystal ball, how can we know what type of patients will walk in our hospital doors? Are we able to predict if a patient coming through our ED will need to be placed on a CCU or need emergency surgery in the OR? The answer is no, so why do hospitals staff for what their current census is? The answer is quite simple: it’s a case of economics.

Hospital administrators will tell you, it’s economically practical to schedule nurses based on the patient census at change of shift. Thus, staffing for “what is” the current patient census occurs. As hospital revenues fall, administrators stop investing in nursing, which is a bad short-term fix.1 Often, when we staff for “what is,” there’s insufficient nurses to accommodate an influx of patients, which creates an overwhelming domino effect that nurse supervisors are left to handle.

Staffing for “what is” the hospital’s current census creates a number of issues, many of which can have detrimental effects on both patient and nurse satisfaction and, more important, patient safety. According to the Agency for Healthcare Research and Quality (AHRQ), “Hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, and urinary tract infections.”2 When a hospital staffs for “what is,” there’s little to no room to accommodate an influx of admissions into the hospital. It’s important for healthcare administrators to understand what actually occurs in the hospital when nurse managers, nurse directors, and the CNO go home and the nurse supervisor is left to oversee operations.

Lining up the tiles
When the supervisor arrives for his or her shift, he or she receives report on each nursing unit. This report includes the patient census; patient issues or concerns; and staffing of RNs, LPNs, care partners or unlicensed assistive personnel, and administrative assistants. Even after careful discussion of what the staffing is for each unit, a variety of problems can arise during report such as staff members not showing up for numerous reasons (waking up late, sitting in traffic, bad weather, making a time change, and even forgetting they were on the schedule). This is when the nurse supervisor feels like he or she’s playing a chess game, which requires critical thinking to make some very calculated moves. This is often very difficult to do when the hospital is staffed for “what is” rather than “what if.”

As a nurse supervisor, every attempt is made to ensure sufficient staffing by calling staff members at home and asking them to come in, even if it means paying them overtime. It’s often necessary to receive permission from the hospital administrator to call in a staff member if overtime pay is involved because, let’s face it, healthcare is a big business. A study looking at nurse staffing hours and the quality of patient care in relationship to hospital discharges and ED readmission rates within 30 days of discharge found that when units had nonovertime staffing, the rates of hospital readmission were lower.3 The estimated cost of ED hospital readmissions within 30 days of discharge is $17 billion.4 This figure proves that it’s financially practical to have sufficient staff scheduled so that nurse supervisors don’t have to call in extra staff members and pay for overtime.

After change of shift, the nurse supervisor prioritizes issues such as patients who need higher levels of care units, patients waiting in the ED for
isolation or telemetry rooms, and any staff member or patient complaints. Nurse supervisors are aware that issues handled poorly can affect both patient and nurse satisfaction scores and patient safety.

**Knocking it all down**
Nurse supervisors must advocate for patient care and the rights of the unit nurses who count on their support to provide patients with safe, competent nursing care. As a nurse supervisor, it’s vital to make all attempts to ensure each nursing unit has sufficient staffing, but often the question arises, is current staffing enough for patients to receive safe and competent care? According to the Institute of Medicine (IOM), “When all types of errors are taken into account, a hospital patient can expect, on average, to be subjected to more than one medication error each day.” In addition, the IOM states, “One of the most effective ways to reduce medication errors is to move toward a model of healthcare where there is more of a partnership between the patient and the healthcare providers.” Nurses are the healthcare providers who spend the majority of time involved with direct patient care compared with other members of the healthcare team. So, how can we reduce medication errors when nurses are asked to care for a greater number of patients who now have a greater number of healthcare issues than ever before?

Patients today often have multiple health issues, an increased number of resistant infections, and increased acuity when hospitalized. According to the AHRQ, more than 90 million Americans have a chronic illness and many of those are living with more than one chronic illness. According to the CDC, 1.7 Americans have a healthcare-associated infection (HAI) and 1 out of 20 hospitalized patients will contract an HAI, which is a significant cause of both patient morbidity and mortality.

A patient with an HAI requires an isolation room and increased nursing hours. This presents a problem when there are limited isolation rooms and limited staff members to care for these patients. Insufficient nurse staffing can directly affect HAI infection rates due to the added time it takes to care for isolated patients. Nurses may rush certain tasks and slack on infection prevention methods when overwhelmed with the already busy patient workload. For the nursing staff in the ED, this situation can be extremely stressful. A patient infected with an HAI waiting in a busy ED puts other patients at risk. Although other nursing units can reach their maximum census, the ED’s doors remain open to ambulances and ongoing patient admissions.

There are times when it’s necessary to float staff members from one unit to a unit that’s in greater need of a nurse. This is something both the majority of clinical nurses and most nurse supervisors dread. Nurses feel most comfortable providing care on the units to which they’ve been assigned and floating a nurse can create anxiety, fear, frustration, dissatisfaction, and high turnover rates. Unfortunately, it may be the last option for a nurse supervisor if a staff member can’t be replaced.

**Picking up the pieces**
It isn’t uncommon in an acute care hospital setting to hear on the overhead speaker “trauma alert ED.” At this point, a nurse supervisor would ask, “Is there sufficient staffing or open beds to admit patients?” This is the time when nurse supervisors must prepare for “what if.”

Planning for “what if” scenarios is a vital part of a nurse supervisor’s job. We must ask ourselves, “Will the patient or patients coming in need critical care beds? If so, do we have enough nurses for the new patient census? Can we downgrade a patient who’s already in critical care and place him or her on another hospital unit? Is it safe to downgrade that patient? Will the downgraded patient be a good transfer and not create an increased nurse workload on the new unit? Can we call in more nurses to help? Will anyone want to come in today when it’s sunny and 80° outside? If we have to increase the nurse’s patient ratio, will patient safety be jeopardized?” It’s absolutely necessary to anticipate and plan for these important “what if” questions. Hopefully, when planning for patients who’ll be admitted, you don’t hear, “We can’t take the patient on our unit because we’re short staffed,” or “The patient’s acuity is too high for this unit.”

Hospital administrators need to ensure that hospitals are staffed appropriately and nurses aren’t asked to take on more higher-acuity patients than they can safely handle. It’s also important to advocate for safe nurse-patient ratios and nurses who have the skills necessary to provide safe and competent care. The AHRQ found that:

- There’s an association with lower nurse staffing and adverse patient outcomes.
- Patients have greater acuity, but nursing skill levels have declined.
- Nurse workload has increased due to greater patient acuity.
- Hiring more nurses doesn’t decrease the hospital’s profits.
- Increasing staff member ratios can result in both positive, quality patient care and improved nurse satisfaction levels.

Increasingly, we see healthcare facilities trying to address nurse satisfaction mainly to achieve excellence in nursing when applying for Magnet® recognition. According to
the American Nurses Credentialing Center, the components for achieving Magnet recognition include nursing excellence, quality patient care, and innovations in nursing practice. Patients today are consumers, who, when looking for medical care, demand healthcare facilities that are recognized for excellence in nursing.

So, what can hospital administrators do to confront the ongoing issue of insufficient staffing in many of our healthcare facilities? We need to look holistically at staffing issues and strive to create innovative solutions.

A long line of success
Nurse leaders must address the impact of low staffing ratios on both patient and nurse satisfaction. Nurse researchers need to continue to provide data that support the need for staffing ratios based not only on patient numbers, but also considerations of patient acuity. And hospital administrators need to listen, understand, and appreciate the suggestions that nurses have about how to improve staffing, such as paying out sick time not used at the end of the year, creating a per-diem float pool, and providing incentives and recognition to nurses who strive to improve both patient and nurse satisfaction. Let’s stop staffing for “what is” and recognize that we don’t practice our profession with a crystal ball. At any given time, “what if” can, and will, occur.

REFERENCES

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