

POSITION STATEMENT

SAFE NURSE STAFFING TO IMPROVE QUALITY OF CARE

It is the position of the ANA-Michigan that:

1. Optimal nurse staffing is essential for quality and safe patient care in all health care settings.
2. Determination of optimal nurse staffing requires a framework and policies that inform organizational decision making through analysis of the many factors that impact the delivery of safe patient care.
3. Optimal nurse staffing is a complex determination and cannot be achieved through application of simple patient to nurse ratios.
4. Safe nurse staffing models should be selected that most closely match the characteristics of the institution and include active and substantive input from the nurses who are closest to patient care.

Background

Medical errors are now the third leading cause of death in the United States (US). The persistent nature of medical errors is documented in the Institute of Medicine (IOM) report, *To Err Is Human*, which pointed to nearly 100,000 preventable deaths in US hospitals annually (IOM, 1999). This work shaped decades of research with focus on patient safety. Nurses are the largest clinical group of providers in hospitals and other health care settings; thus, nurses' impact on patient safety is significant. A large body of evidence exists documenting the relationship between nursing care, nurse staffing, and patient safety. Risks associated with suboptimal professional nurse staffing in the patient care setting include medication errors, compromised ability to "rescue" patients at risk for death, increased incidence of patient falls, hospital-acquired pressure ulcers, physical restraint use, and missed care.

Optimal nurse staffing is a complex process not being amenable to simple division or nurse patient ratios; straightforward ratios do not result in safe care. Moving toward a professional

model that empowers registered nurse (RN) decision-making regarding their practice requires a framework focused on the analysis of multiple factors affecting patient care delivery. To create a work environment that allows professional RNs to meet the demands and complexity of patient care, sufficient professional nursing staffing care models are crucial to the delivery of high quality safe patient care. Shifting the nursing culture towards a professional model that empowers RNs with decision-making involvement and includes a framework for organizations' decision making about staffing based on the analysis of multiple factors affecting patient care versus a one-dimensional standardized nurse-patient ratios approach is vital to "ensuring the right staff are in the right place at the right time" (Bolvin, 2017, p. 31). Harmonious with the American Nurses Association (ANA) position, ANA-MI is committed to creating dynamic solutions that support context dependent, optimal nurse staffing necessary to meet the needs of healthcare recipients.

This paper presents the outcomes evidence about recent approaches to nurse staffing and identifies the principles, concepts, and framework for

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determining optimal nurse staffing for safe patient care. While the referenced studies on safe nurse staffing are hospital-based, the principles and methods may also be applied to nurse staffing in other health care settings.

Evidence

The impasse between nurses and administrators about the solution to the complex issue of ensuring the delivery of safe care within the context of increasing patient acuity and fiscal constraints of hospitals has moved the issue of adequate staffing to the political arena (Hertel, 2012). In 2004, nurse staffing took center stage when California became the first state to mandate nurse-to-patient ratios in acute care settings. By 2009, 14 states had enacted nurse staffing legislation and, as of September 2010, 24 states have enacted or proposed legislation to mandate staffing ratios, staffing acuity systems, or staffing plans and committees (Douglas, 2010). Subsequent studies examining the relationship between mandatory staffing ratios and nurse satisfaction and patient safety and outcomes have demonstrated mixed results (Aiken et al., 2010; Bolton, et al., 2007; Hertel, 2012)

Research on nurse staffing ratios' impact on patient safety has demonstrated higher nurse to patient ratios are associated with decreased mortality rates, fewer failure to rescue events, and lower hospital-acquired pneumonia rates (Douglas, 2010). Mandated ratios in California were associated with lower mortality and better nurse retention; 74% of nurses reported they felt the quality of care had improved since mandated ratios (Aiken et al., 2010).

Conversely, individual studies and systematic reviews have reported difficulty in consistently detecting statistically significant associated improvements in a variety of nurse-sensitive

patient outcomes with increased nurse staffing (Hickam et al., 2003; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Lake & Chung, 2006; Lang et al., 2004; Seago, 2001: all as cited in Bolton et al., 2007). In a large-scale study, Bolton and colleagues (2007) examined patient outcomes from 2004 to 2006 in 185 hospitals in California compared to 2002 (pre-mandated staffing ratios) and found no statistical significance in the association between increased nurse staffing and key indicators of falls, hospital-acquired pressure ulcers, and restraint use rates (Bolton et al., 2007). The inconsistency in outcomes associated with increased nurse staffing underscores the complexity of determining optimal staffing.

A survey of administrators about strategies to accommodate mandated ratios lends to potential insight about why mandated ratios do not consistently result in improved patient safety and outcome measures. Respondents reported ancillary support staff layoffs (thus shifting non-RN work to the professional nurse) and use of contingent nurses to provide break coverage; both strategies could have a negative impact on patient safety and continuity of care (Douglas, 2010). Similarly, Bolton and colleagues (2007) found that with mandated staffing ratios came a change in staff mix with a reduction in care provided by LPN and other non-licensed staff, suggesting that administration leaders used RN hours to meet the regulatory staffing requirements. These approaches raise concerns about the unintended consequence of negating the potential positive impact of mandated higher RN to patient ratios by 1) effectively reducing RN time to attend to RN activities and 2) increasing the risk for mistakes related to the potential for communication errors during handoffs to contingent nurses along with variability of the skills and competencies of contingent nurses in unfamiliar settings.

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Definition of Safe Staffing, Core Components and Staffing Models

Definitions

The ANA defines staffing as ... “a match of registered nurse expertise with the needs of the recipient of nursing care services in the context of the practice setting and situation”(ANA, 2012, p. 6). Staffing is done in the present – day to day and sometimes shift to shift. Staffing work can be centralized (one department is responsible for staffing all the units) or decentralized (units manage their own staffing needs) or a combination of both.

Core Components

ANA Core Components of Nurse Staffing:

1. All settings should have well-developed staffing guidelines with measurable nurse-sensitive outcomes specific to that setting and healthcare consumer population, which are used as evidence to guide daily staffing.
2. RNs are full partners working with other healthcare professionals in collaborative, interdisciplinary partnerships.
3. RNs, including direct care nurses, must have a substantive and active role in staffing decisions to ensure the necessary time with patients to meet care needs and overall nursing responsibilities.
4. Staffing needs must be determined based on an analysis of healthcare consumer status (e.g., degree of stability, intensity, and acuity) and the environment in which the care is provided. Additional considerations include professional characteristics, skill set, and mix of the staff and previous staffing patterns that have been shown to improve outcomes.
5. Appropriate nurse staffing should be based on

allocating the appropriate number of competent practitioners to a care situation, pursuing quality of care indices, meeting consumer-centered and organizational outcomes, meeting federal and state laws and regulations, and attending to a safe, quality work environment.

6. Cost-effectiveness is an important consideration in delivery of safe, quality care.
7. Reimbursement structure should not influence nurse staffing patterns or the level of care provided.

Staffing Models

Shortcomings in current RN staffing models present opportunities for improvements that benefit patients, nurses, and healthcare organizations. No single staffing model is ideal in all care settings or situations. Staffing must be adjusted according to patient care needs within a specific unit or department. Fixed or rigid models do not provide flexibility essential to adapt to rapid and fluid changes in acute care environments.

There is a difference between staffing and scheduling. Schedules are planning documents that are future focused. Factors that affect a schedule include: historical census for a time period, the surgical schedule, and seasonal or predictable issues such as the flu season. Schedules must also accommodate vacations, maternity leaves, staff illness and institutional policies.

Various staffing models are used in healthcare settings. Three models follow; each has advantages and disadvantages.

1. Budget Based Staffing: the number of nurses is determined according to nursing hours per patient days. Total patient days are the average number of patients on a particular unit for a 24-hour period. Nursing hours refers to the total number of hours nurses work on that unit for a specific amount of time. This model does

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not take into consideration the actual number of patients, the “churn” in patients – admissions, discharges, transfers in 24 hours, or patient acuity.

2. **Staffing by Nurse to Patient Ratios:** This model dictates the number of patients one nurse can care for during a designated period of time. It does not take into consideration other unit staff such as CNA’s, housekeeping, unit clerks, etc. Also, it doesn’t take into account patient acuity or nurse driven care decisions. This model may also affect patient throughput from areas such as the Emergency Department, Labor and Delivery, and the ICUs.
3. **Staffing by Patient Acuity:** This model considers the acuity or complexity of each patient, which is often determined by the number of tasks and amount of time to complete them. Rather, this model should consider the full scope of nursing practice and time needed to maintain standards of care. This complex model also needs to consider individual patient characteristics such as age, diagnosis, comorbidities, socioeconomic status, cultural and family issues, and severity of illness.

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