PRINCIPLES for Nurse Staffing

INTRODUCTION

Adequate nurse staffing is critical to the delivery of quality patient care.[1] Identifying and maintaining the appropriate number and mix of nursing staff is a problem experienced by nurses at every level in all settings. Regardless of organizational mission, tempering the realities of cost containment and cyclical nursing shortages with the priority of safe, quality care has been difficult, in part, because of the paucity of empirical data to guide decision-making. Since 1994, the recognition of this critical need for such empirical data has driven many American Nurses Association (ANA) activities including identification of nursing-sensitive indicators, establishment of data collection projects using these indicators within the State Nurses Associations (SNAs) and the provision of ongoing lobbying at federal and state levels for inclusion of these data elements within state and national data collection activities. In 1996, the Institute of Medicine produced its report The Adequacy of Nurse Staffing in Hospitals and Nursing Homes (Wunderlich, et al./1996) in which it too recognized the need for such data. Despite these efforts, heightened and more immediate attention to issues related to the adequacy of nurse staffing is needed to assure the provision of safe, quality nursing care.

1 "...the recipients of nursing care are individuals, groups, families, or communities...the individual recipient of nursing care can be referred to as patient, client, or person. ... The term 'patient' is used throughout to provide consistency and brevity..." (ANA/1995. Nursing's Social Policy Statement).

POLICY STATEMENTS

- Nurse staffing patterns and the level of care provided should not depend on the type of payor.
- Evaluation of any staffing system should include quality of worklife outcomes as well as patient outcomes.
- Staffing should be based on achieving quality of patient care indices, meeting organizational outcomes and ensuring that the quality of the nurse's worklife is appropriate.

PRINCIPLES

The nine principles identified by the expert panel for nurse staffing and adopted by the ANA Board of Directors on November 24, 1998 are listed below. A discussion of each of the three categories follows the list.

I. Patient Care Unit Related

a. Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient needs.
b. There is a critical need to either retire or seriously question the usefulness of the concept of nursing hours per patient day (HPPD).
c. Unit functions necessary to support delivery of quality patient care must also be considered in determining staffing levels.

II. Staff Related

a. The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area.
b. Registered nurses must have nursing management support and representation at both the operational level and the executive level.
c. Clinical support from experienced RNs should be readily available to those RNs with less proficiency.

III. Institution/Organization Related

a. Organizational policy should reflect an organizational climate that values registered nurses and other employees as strategic assets and exhibit a true commitment to filling budgeted positions in a timely manner.
b. All institutions should have documented competencies for nursing staff, including agency or supplemental and traveling RNs, for those activities that they have been authorized to perform.
c. Organizational policies should recognize the myriad needs of both patients and nursing staff.

I. Patient Care Unit Related

There is a critical need to either retire or seriously question the usefulness of the concept of nursing HPPD. It is becoming increasingly clear that when determining nursing hours of care one size (or formula) does not fit all. In fact, staffing is most appropriate and meaningful when it is predicated on a measure of unit intensity that takes into consideration the aggregate population of patients and the associated roles and responsibilities of nursing staff. Such a unit of measure must be operationalized to take into consideration the totality of the patients for whom care is being provided. It must not be predicated on a simple quantification of the needs of the "average" patients but must also include the "outliers." The following critical factors must be considered in the determination of appropriate staffing (see Table I):

- Number of patients;
- Levels of intensity of the patients for whom care is being provided;
- Contextual issues including architecture and geography of the environment and available technology; and,
- Level of preparation and experience of those providing care.

Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient needs. The following specific patient physical and psychosocial considerations should be taken into account:

- age and functional ability
- communication skills
- cultural and linguistic diversities
- severity and urgency of admitting condition
- scheduled procedure(s)
- ability to meet health care requisites
- availability of social supports
- other specific needs identified by the patient and by the registered nurse

Unit functions necessary to support delivery of quality patient care must also be considered in determining staffing levels:

- unit governance
- involvement in quality measurement activities
- development of critical pathways
- evaluation of practice outcomes

TABLE I	
Matrix for Staffing Decision-Making	
Items	**Elements/Definitions**
Patients	Patient characteristics and number of patients for whom care is being provided
Intensity of unit and care	Individual patient intensity; across the unit intensity (taking into account the heterogeneity of settings); variability of care; admissions, discharges and transfers; volume
Context	Architecture (geographic dispersion of patients, size and layout of individual patient rooms, arrangement of entire patient care unit(s), and so forth); technology (beepers, cellular phones, computers); same unit or cluster of patients
Expertise	Learning curve for individuals and groups of nurses; staff consistency, continuity and cohesion; cross-training; control of practice; involvment in quality improvement activities; professional expectations; preparation and experience

II. Staff Related

The specific needs of various patient populations should determine the clinical competencies required of the nurse practicing. Role responsibilities and competencies of each nursing staff member should be well articulated, well defined and documented at the operational level (Aiken/1994). Registered nurses must have nursing management support and representation (first-line manager) at both the operational level and the executive level (nurse executive) (Aiken/1994). Clinical support from

experienced RNs should be readily available to those RNs with less proficiency (McHugh et al./1996). The following nurse characteristics should be taken into account when determining staffing:

- experience with the population being served
- level of experience (novice to expert)
- education and preparation, including certification
- language capabilities
- tenure on the unit
- level of control of practice environment
- degree of involvement in quality initiatives
- measure of immersion in activities such as nursing research which add to the body of nursing knowledge
- measure of involvement in inter-disciplinary and collaborative activities regarding patient needs in which the nurse takes part
- the number and competencies of clinical and non-clinical support staff the RN must collaborate with and supervise

III. Institution/Organization Related

Organizational policy should reflect an organizational climate that values registered nurses and other employees as strategic assets and exhibit a true commitment to filling budgeted positions in a timely manner. In addition, personnel policies should reflect the agency's concern for employees' needs and interests (McClure, et al./1983).

All institutions should have documented competencies for nursing staff, including agency or supplemental and traveling RNs, for those activities that they have been authorized to perform (JCAHO/1998). When floating between units occurs, there should be a systematic plan in place for cross-training of staff to ensure competency (JCAHO/1998). Adequate preparation, resources and information should be provided for those involved at all levels of decision-making. Opportunities must be provided for individuals to be involved to the maximum amount possible in making the decisions that affect them. (Williams and Howe/1994). Finally, any use of disincentives for reporting near misses and errors should be eliminated to foster continuous quality improvement (Leape/1994).

In addition, the organizational policies should recognize the myriad needs of both patients and nursing staff and provide the following:

- effective and efficient support services (transport, clerical, housekeeping, laboratory, and so forth) to reduce time away from patient care and to reduce the need for the RN to engage in "re-work" (Prescott et al./1991);
- access to timely, accurate, relevant information provided by communication technology that links clinical, administrative and outcome data;
- sufficient orientation and preparation including nurse preceptors and nurse experts to ensure RN competency;
- preparation specific to technology used in providing patient care;
- necessary time to collaborate with and supervise other staff;
- support in ethical decision-making;
- sufficient opportunity for care coordination and arranging for continuity of care and patient and/or family education;

- adequate time for coordination and supervision of UAP by RNs;
- processes to facilitate transitions during work redesign, mergers and other major changes in work life (Bridges/1991);
- the right for staff to report unsafe conditions or inappropriate staffing without personal consequence; and,
- a logical method for determining staffing levels and skill mix.

EVALUATION

Adequate numbers of staff are necessary to reach a minimum level of quality patient care services. Ongoing evaluation and bench marking related to staffing are necessary elements in the provision of quality care. At a minimum, this should include collection and analysis of nursing-sensitive indicators (ANA/1997) and their correlation with other patient care trends. It has been shown that the quality of work life has an impact on the quality of care delivered. Therefore, on an ongoing basis, the following trends should be evaluated:

- work-related staff illness and injury rates (Shogren and Calkins/1995)
- turnover/vacancy rates
- overtime rates
- rate of use of supplemental staffing
- flexibility of human resource policies and benefit packages
- evidence of compliance with applicable federal, state and local regulations
- levels of nurse staff satisfaction

Staffing should be such that the quality of patient care is maintained, the quality of organizational outcomes are met and that the quality of nurses' worklife is acceptable. **Changes in staffing levels, including changes in the overall number and/or mix of nursing staff, should be based on analysis of standardized, nursing-sensitive indicators. The effect of these changes should be evaluated using the same criteria.** Caution must be exercised in the interpretation of data related to staffing levels and patterns and patient outcomes in the absence of consistent and meaningful definitions of the variables for which data are being gathered.

RECOMMENDATIONS

Shifting the nursing paradigm away from an industrial model to a professional model would move the industry and organizations away from the technical approach of measuring time and motion to one that examines myriad aspects of using knowledge workers to provide quality care. This shift would spell the end to the "nurse-is-a-nurse-is-a nurse" mentality by focusing on the complexity of unit activities and level(s) of nurse competency needed to provide quality patient care. To facilitate this shift, the ANA makes the following recommendations:

- A distinct standardized definition of unit intensity must be developed. Factors to be taken into consideration in the development of such a definition include

  - Number of patients within the unit;
  - Levels of intensity of all of the patients for whom care is being

provided;
- Contextual issues including architecture and geography of the environment and available technology;
- Level of preparation and experience (i.e., competency) of those providing care.

- Data should be gathered to address the relationship between staffing and patient outcomes including but not limited to

  - Improvement in health status;
  - Achievement of appropriate self-care;
  - Demonstration of health-promoting behaviors;
  - Patient length of stay or visit;
  - Health-related quality of life;
  - Patient perception of being well cared for; and
  - Symptom management based on guidelines (Mitchell, et al./1997).

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