STAFFING PLANS: RESPONDING TO VARIATION

Until quite recently, "nurse staffing plan" would have been just another name for the schedule that showed who was working when. But extreme acuity, complex treatments, changing technology, and sub-specialization mean a simple rota pinned to a bulletin board is a thing of the past. In today's world of nursing, constructing nursing teams with the best mix of staff to look after patients is a must, because the evidence shows poor staff mix equals poor patient outcomes.

The goal of nurse staffing plans is to provide high-quality care to patients while making the workplace safe and rewarding. They are being promoted as an alternative to nurse-patient ratios, which are set by law in many parts of the U.S. but which critics call blunt instruments, since they don't take the context of the patient population into account. An overview of research on nurse staffing and patient safety, *Staffing for Safety*, published by the Canadian Health Services Research Foundation, says every organization should have effective, formal nurse staffing plans.

Acceptance of this new approach is spreading, but getting it put into practice is slow going. Staffing plans are just coming into being in the U.S. In this country, they don't really exist, but in spring 2006, the British Columbia Nurses Union and the provincial government signed a contract that included an agreement to study nurse workload as a first step to developing staffing plans for acute and residential care. By 2010, staffing plans – based on patient mix, with plans to manage vacancies and surges in demand – will be tested in several pilot projects in the province.

Mandatory ratios can't be fine-tuned

Nurse staffing plans consider the type of unit and the needs of its constantly changing patients, the experience levels of nurses and other staff who work there, and which other professionals and support services the organization can provide.

In contrast, nurse-patient ratios assign staff based on how many beds are occupied. They don't allow for important variations that affect care, workloads, and safety, such as how sick the patients are, what other health professionals are on the care team, or what support there is, whether it's technological or human resources, for that unit's work in the organization overall.

Both an art and a science

Creating a nurse staffing plan requires hard evidence – the science – such as data on the types of patients the unit treats, their outcomes, and how the unit ranks on standard measures of quality, such as infections, bed sores, and readmissions. Nurse staffing plans should also draw on both the experience of front-line nurses and the expertise of administrators – the art of drawing out peoples' knowledge.

Sharon Gale, executive director of the Massachusetts Organization of Nurse Executives, led the committee that developed a template for nurse staffing plans for the hospitals in the state. The Massachusetts Hospital Association wanted to avoid legislated nurse-patient ratios, which it felt would not serve its mix of academic health centres, community and rural hospitals, and elder-care centres.

"We knew that one-size-fits-all wasn't going to work with the mix of acuity, nursing education, and experience and other variants," says Ms. Gale.

The project is still in its early stages, but hospitals have developed staffing plans (available on the web at www.patientsfirstma.org). They list units' average number of patients, types of caregivers (registered nurse, licensed practical nurse, mental-health counsellor, unlicensed caregiver) and how many work in any shift. A separate chart lists "additional care team members," from clinical nurse specialists to intravenous therapy teams, pharmacists, and students.

The charts posted now are projections, showing anticipated patient needs. The next step is to compare them with real staffing over one year and analyse differences: were patients sicker than anticipated? Was there a shortage of RNs, so more practical nurses were hired? The results will be used to modify future plans. Factors that affect a plan include whether the unit has surgical or medical patients; whether there are specialist teams for respiratory, intravenous, and rehabilitation care; and what percentage of work is done by licensed practical nurses. While these are not ideal staffing plans, they are a great first step.

It's generally agreed a staffing plan should include ways of managing staff shortages or other problems. If a patient goes into cardiac arrest, for example, the anticipated amount of nursing needed on the unit quickly becomes irrelevant. Is back-up available to care for other patients when that happens? Staffing plans should include options for when there are not enough staff on shift, which can include giving floor staff the authority to refuse new admissions, call in nurses on overtime, or use an agency or a permanent staff "floater," assigned day-by-day or week-by-week to units as needed. Staffing plans are very promising as an idea; better uptake and more examples are needed to make that promise a reality.