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RETHINKING NURSE STAFFING MODELS

Changes in nurse staffing models and care delivery post-COVID-19

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RETHINKING NURSE STAFFING MODELS: Changes in nurse staffing models and care delivery post-COVID-19



The COVID-19 pandemic severely disrupted nurse staffing models. As hospitals struggled, nursing leaders repurposed staff, onboarded nursing students prior to graduation and utilized travel nurses. Yet, hospitals still needed staff. In response, health care organizations switched to team-staffing models and used telehealth to reduce the stress on hospital services. This virtual executive dialogue convened nurse executives to share ideas on future nursing staffing models and to discuss how their organizations persevered. ●

KEY FINDINGS

- 1 In a constantly changing environment, **increase leadership presence**, offer emotional support, seek staff input into decisions that put their own safety at risk, give frequent, transparent information and listen and give authentic voice to nursing staff concerns.
- 2 To meet staffing demands and help support those providing patient care, nurse leaders and educators put together training and precepting programs to **upskill and cross-train nurses** and implemented team-based models.
- 3 Nurse leaders can **diversify the workforce** to improve the patient experience and transcend siloed views of responsibilities by creating career paths for licensed practical nurses and registered nurses.
- 4 Organizational and operational pressures are leading to **nurse leader burnout**. There is a need to develop support programs for nurse leaders so that they can support staff.
- 5 **Technology provided new opportunities** to care for and positively engage patients and families and is now part of the toolkit. The hospital-at-home telehealth model is here to stay and holds particular opportunity to help patients with chronic disease.

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MODERATOR (*Terese Thrall, American Organization for Nurse Leadership*): **What did you learn from the pandemic related to workforce deployment?**

DEB ZIMMERMANN (*Virginia Commonwealth University Health*): We recognized early that seniors and populations living in congregate settings were at the highest risk of contracting COVID-19, and we had to build alliances and public health relationships beyond our health system. We reached out to skilled nursing facilities and local prisons to help with PPE, testing, and treating COVID-19-positive patients in place. We expanded virtual visits and weekly conference calls between leaders. We recognized that if we could work as a community, we would have enough resources.

Routine ambulatory visits and surgical cases were delayed which allowed for reassignment of those staff members to critical and inpatient care units. We adopted the Society of Critical Care Medicine tiered staffing model, an interdisciplinary team plan that included collaboration with physicians. That model worked.

Caring for COVID-19 patients who also had psychiatric disorders was a special challenge and our psychiatric nursing and medical teams expanded our rapid response and behavioral response teams to form a mobile response team.

I am no longer at VCU, however, Michael Bleich, PhD, R.N., FAAN, and I are working with AONL on a grant supported by Johnson & Johnson on innovations resulting from the pandemic and staffing. In a survey of over 100 nurse leaders, we found that many used the Society of Critical Care Medicine tiered staffing model. They were able to successfully care for larger volumes of critical patients using functional or team-based nursing. Interestingly, leaders brought licensed practical nurses (LPNs) back into the acute care environment, and some plan to keep them in acute care after the end of the pandemic.

CHRISTINE KIPP (*Southeast Georgia Health System*): I was at a large academic medical center when COVID-19 first hit. Effectively communicating with front-line workers in such a large environment was challenging, but I made it a priority. When I left that organization, the entire group mentioned how much they appreciated getting regular updates.

I'm now in a community two-hospital system. As the virus surged, it became clear that staff became easily frustrated with the constantly changing environment. Now our focus is on keeping our nurse leaders resilient so that they can adequately support staff.

LORAIN FRANK-LIGHTFOOT (*Novant Health*): Our surgical services team showed real creativity during surges last November and December as well as in January. We didn't cancel surgery; we were resourceful and moved patients to different locations. There were times when we would perform surgery in our major medical center and recover the patient in a smaller medical center with available beds. We moved surgical staff between buildings throughout the day to provide patients with the care they needed, when they needed it.

ELIZABETH MENSCHNER (*Riddle Hospital – Main Line Health*): We created an end-of-life care team. Volunteer clinicians would spend time at patients' bedsides facilitating video calls with their family members and simply being there so that critical care nurses could care for more acutely ill patients.

We then developed a proning team for that labor-intensive work, where we used noninvasive respiratory therapies instead of intubating patients.

We also leveraged technology. We use a remote monitoring system in many of our rooms for close observation, so patients can interact with staff without having to enter patient rooms so often.

MODERATOR: How do you see nurse staffing models evolving?

PAULA COE (*Allegheny Health Network*): We explored skill-mix initiatives and labor management even before the pandemic. We successfully brought LPNs back into a couple of care areas. We evolved into a tiered model with acute and critical care nurses at the bedside, and then used support nurses beyond that.

We had assumed that working in an electronic health record would limit some LPNs’ scope of practice, but we’re seeing value in the old, team-based nursing format. It provides more touchpoints to patients and better interaction, and promotes communication and collaboration among the team as opposed to just between the RN and nursing assistant. We need to assess, from a research perspective, the true impact of this method of care delivery.

ZIMMERMANN: There is greater opportunity for seamless academic progression and career ladders for LPNs. Supporting paths for LPNs to become RNs may facilitate diversification of the profession. We will need to understand past mistakes so we do not repeat history and disenfranchise the team.

COE: Right. How can we use LPNs better and how can they make the most impact? For example, rehab has been a great setting for them. But the areas in which you have a lot of drips and titration of meds — especially when the LPN has an assignment and there is already a nurse on staff — can limit LPNs and cause confusion.

LPNs have been successful in other areas. They collaborate with other nurses, care for wounds and even pass medications that do not require an

RN. We should elevate LPNs to be able to work at the top of their licenses, and to even take on care transition conversations instead of delegating that responsibility to case managers. We’ve become so siloed in our views of nurses’ responsibilities. Those views may change if we focus instead on improving the patient experience.

KAREN COX (*Chamberlain University*): In any hospital system, there are nurses who have been tapped to provide other important roles besides direct patient care (informatics, quality, etc.). But when they left their acute care positions, they didn’t have the opportunity to remain current.

If I were starting my career over as a brand new CNO, I would start a program where these nurses would complete an acute care readiness course every two years, and undergo one day of targeted simulation every year. To Paula’s point, they’re not going to be as clinically competent as dedicated acute care nurses, but they’ll be prepared and less anxious when the next disaster occurs.

MENSCHNER: I really like this idea but, for example, my previous employer was an academic medical center covered by several collective bargaining agreements, which limited clinicians to one role.

Some nurses leave direct care because of physical limitations, but there isn’t a reason why we couldn’t train them to have some kind of clinical readiness. They may not be able to do the physical piece, but what other things could they do?

MODERATOR: Have any of you had nurses who were no longer at the bedside return to deliver care?

MENSCHNER: I don’t know whether you would consider operating room nurses not having been

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— Paula Coe —
Allegheny Health Network

at the bedside, but certainly a clinical operating room, perioperative nurse is different from a bedside nurse. We put together a didactic training and precepting program for these nurses to help them transition to bedside care.

Some of these nurses had not been away from the bedside for long and could take full patient assignments. There were some who truly could only function in a patient care technician role, and then other nurses participated in a hybrid model where they supported the team in every capacity except for administering medication.

Our educators stepped up and put together a basic course, assigned staff from the operating room and other underutilized units to preceptors and treated them more or less as orientees.

MODERATOR: Does your organization have a telehealth strategy for nursing care, for screening and triaging patients? Did providing follow-up services to patients in the home change in response to the COVID-19 surges?

COE: There was a telehealth learning curve on the ambulatory side. We went from five to between 500 and 1,000 telehealth visits in a week's time. I don't think that this is going to go away. But I think that influx will remain on the ambulatory side as opposed to the inpatient side. There is a bigger push for the hospital-at-home model, particularly for diagnoses with higher readmissions. There is a lot of opportunity for telehealth to help patients with chronic disease. Because of how remote care is provided, readmission rates don't count, from an outcomes perspective, if they're within this hospital care model.

ZIMMERMANN: Telehealth grew exponentially with the onset of the pandemic. Because leaders held

daily operations briefings, telehealth clinicians were able to collaborate with information technology experts, reimbursement specialists and scheduling teams daily, establish systems for growth, and report back on their progress.

Collaboration between payors, the government relations teams and finance resulted in our ability to receive reimbursement and compensation of practitioners for telehealth visits. Now telehealth is the norm and regularly offered to patients as an option. Telehealth is here to stay, and we need to support its growth.

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Virginia Commonwealth
University Health

KIPP: Our community hospital system now uses a telehealth, hospital-in-the-home model. We follow up with COVID-19 patients and check in with them several times a day. We set up home monitoring for some of them to make sure that their health is being managed effectively.

MODERATOR: How is your organization managing nurses' stress and compassion fatigue?

MENSCHNER: Staffing still continues to be one of the biggest challenges. In addition to encouraging staff to rest and be mindful, we do a lot of leader rounding to ensure that staff know they can count on us. We periodically order meals for staff, and we've popped popcorn and put it in individual bags for them. We rounded for Valentine's Day with huge cookies. Feeding staff isn't always the answer but, every once in a while, it helps the spirit.

COE: Making sure our leaders are visible and accessible has been helpful. We also created additional relaxation rooms for staff with massage chairs, salt lamps and snacks — a place that nurses can sit and unwind.

We also brought our employee-assistance program

to them — especially in the critical care units — as opposed to having staff reach out and call. And when things slowed down, we purposefully asked staff questions related to their mental health. We went beyond ‘How are you doing while you’re here at the hospital?’ to ‘How are you doing as a person, as you deal with all the other stressors in your lives?’ That offered leaders an opportunity to engage with staff and get to know them more personally.

KIPP: I’m an interim staffer. Many nurse leaders — including the CNO — were at that burnout phase, which is part of the reason that I am in my current role.

The first thing I did was round over the holidays, round on the weekends, round on the off shifts. You can’t round too much. We have refocused our daily huddle to make sure that we are touching on all ongoing COVID-19 issues. The administrative team rounds with a coffee cart throughout the building a couple of times a week. It’s really more to show our support than it is about whatever’s on the cart.

COX: Many nurses feel their voices should be heard in more significant ways, including staffing considerations. If you have a shared governance model, reinvigorate it to make sure that the authentic voices of direct care nurses are represented, and that they truly have opportunities to access leadership that allows them to influence appropriate decision making.

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Nurses were already leaving acute care before the pandemic. The pandemic has exacerbated the turnover and every indication shows that this will continue. That’s why it’s critical to find ways to empower nurses — in big and small ways — to demonstrate that they are valued professionals. Examples of how to do this are in the American Association of Critical Care Nurses (AACN) healthy work environment standards and the American Nurses Credentialing Center (ANCC) Magnet Standards.

ZIMMERMANN: Our industry is about people caring for people. When the board and executive-level leaders recognize and value those at the point of care and include clinicians in decision making, an organization can move forward together and as one. This is possible even when the future is uncertain as it has been this past year.

The pandemic has underscored the value of nursing. It’s now up to us to have the courage to be part of the conversation, offer solutions, and communicate in terms that non-nurses can understand.

Healthcare is challenging and the pandemic has highlighted the need for change. It is up to us as nurses to make sure we have a seat at the table to ensure our voice is heard. ●

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