Safe Staffing Through New Models of Care

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Safety is the number 1 priority for nurse leaders, and ensuring safe staffing is critical. Safe staffing in an era of nurse shortages must be achieved by a radical change to the current models of care. Clinical organizations must innovate by implementing and testing new models of care while partnering with their local academic colleagues to develop a new body of evidence. There is a need to educate all stakeholders, including legislators, that mandated nurse-to-patient ratios are not the best solution to ensure that patients have access to excellent care and that nurses are able to practice in a professionally fulfilling environment. Of paramount importance to planning a preferred future for both those who receive and deliver care will be the engagement of nurses, advanced practitioners, educators, and researchers. Leaders from both academia and practice must come together in a partnership to support true transformation.

THE CASE FOR CHANGE

To nursing leaders, the safety of patients, nurses, and the entire health care team is paramount. There has been a trend among some stakeholders to believe that the only way to ensure safety is by promoting nurse-to-patient ratio mandates similar to those in California and Oregon. The purpose of this article is to address the consequences of applying historical assumptions to a changing health care environment and to propose a new way forward. The quest to automatically promote the nurse-to-patient ratio is not the solution. In fact, it prevents us from innovating in real time. We must resist the temptation to simply mandate ratios that correspond with old models of care. Instead, we need to focus on safe staffing by innovating with new models of care that leverage technology and the skills of an entire healthcare team. As professionals who believe in evidence, nurses should use research to determine how these team-based care models affect safety, quality, and the experience of patients and staff.

FACING FACTS

Multiple prognostications have been made that there will be a substantial shortfall of nurses by 2025. Their numbers differ, and the magnitude projected by most sources is staggering. One research and advisory company has predicted that the United States will experience a lack of 2.1 million nurses by 2025 (The Josh Bersin Co, 2022),[7] while the International Council of Nurses estimated the current shortage to be over 13 million worldwide (WHO, 2023). According to the nurse recruitment company

KEY POINTS

- Safety is the number 1 priority for nurse leaders, and ensuring safe staffing is critical.
- We must resist the temptation to simply mandate ratios that correspond with old models of care.
- Mandated nurse-to-patient ratios are not the best solution to ensure that patients have access to excellent care and that nurses are able to practice in a professionally fulfilling environment.
- Leaders from both academia and practice must come together in a partnership to support true transformation.

Sidebar

The 2022 AACN State-of-the-DNP report found a lack of clarity regarding the knowledge, skills, and competencies of DNP graduates and what distinguishes them from other nurses with advanced degrees (p. 27). Variations across degree programs in nursing education and the separation of nursing education and practice have no doubt contributed to this reality. Academic-practice integration could ensure that educational DNP (and other) graduates are ready to transition into practice roles and lead wherever they are for continuous quality improvement. AACN data also show worrisome declines in PhD enrollments [1] despite an increase in the number of programs. It is vitally important that the profession sustains a PhD-prepared workforce to discover new knowledge, translate science, disseminate new knowledge and innovations, and engage in interdisciplinary research.[1] The value of PhD preparation is recognized in academia and in practice with Magnet certification key components including new knowledge, innovations and improvements, and empirical outcomes. Integration of academia and practice in nursing would advance and strengthen education, practice and research to ensure that such issues as nurse staffing and safety are fully studied, demonstrated, evaluated, and achieved.

NSI, there was a 15.7% vacancy rate and a 22.5% turnover rate of hospital nurses in 2023 (NSI Nursing Solutions, 2023).[9] Most nursing schools nationwide are rapidly growing as mandated by institutional Boards of Trustees. However, with fewer students choosing college as a career path, resistance to taking on overwhelming student debt,[6] and a generational change in work ethic and culture, many nursing schools are experiencing less than adequate pipelines to fill classes.[13]

At the same time, the birth rate in the USA is the lowest in decades,[12] and the population is aging.[2] Simply put, the math does not work in our favor. Nurse leaders are working with their nursing colleagues to implement strategies for better hiring and retention of nurses. However, even the most successful strategy will not provide the number of nurses needed if we continue to work the same way we have for decades.

Nurses are calling for relevant technology, more automation, and significant modernization of the healthcare environment (Koopsmans, Damne, & Wagner, 2018). Many have lost joy in practice. One root cause of this could be the work itself: the model in which they are required to practice today.

THE OLD DAYS

Some argue that the only way to address the current vacancies is by having a nurse-to-patient ratio in all settings nationwide. It is not logical to assume that increasing the demand for nurses by mandatory ratios will increase the supply of nurses. In a 2018 study, researchers found that implementing a nurse-to-patient ratio mandate similar to California would require between 2286 and 3101 additional RN FTEs in 1 state alone.[8] Given the expected shortage of nurses, a mandated ratio based on current models of care would decrease access to care and cause increased waiting times in emergency departments, deteriorated patient flows, increased patient boarding, and ambulance diversions. None of these outcomes would support a safe environment for patients and nurses and could have detrimental effects on the health of individuals and populations.

Those supporting the mandated nurse-to-patient ratios quote important research completed more than two decades ago. Nurses have long appreciated that work because the results informed us of the risk of increasing nurse-to-patient ratios when the same nurse practices in a primary care or total patient care model. Today's care model is evolving to new team-based care models that allow nurses to work at the top of their licenses while utilizing new technology. The model of care is an essential factor in determining safe staffing practices, and the results of a study based on a particular model cannot be generalized to other models of care. Any change in variables, such as the work environment, would prevent this from being scientifically sound.

Laws or regulations that impose ratios based on a particular model of care are likely to erect significant barriers to innovation, inhibit team care, and prevent nurses and others from practicing to the top of their licenses. They are shortsighted because they assume that care models will remain unchanged despite environmental changes and technological advances. For example, in California, Title XXII stipulates that licensed nurse-to-patient ratios represent the maximum number of patients that should be assigned to one registered nurse at any time. Only licensed nurses who provide direct patient care can be included in the ratios.[5] In other words, it will be difficult to mitigate shortages and take advantage of new technologies, much less study their effects on patient safety and nursing job satisfaction when team care that includes new and different team members cannot be implemented.

A NEW DAY

Care models that utilize both virtual and onsite nurses and other team members are rapidly being developed nationwide. In most cases, these models are designed by the local nurses based on the type of teams they have implemented. For example, the Providence system Co-Caring model, developed by nurses for nurses, allows nurses to care for patients virtually, and in person in collaboration with a care partner. This model has significantly improved RN retention and joy in practice while offering significant operational efficiencies.[11] Similarly, the Virtually Integrated Care model, which has been in place for several years in CommonSpirit Health hospitals, has continued to demonstrate increased patient satisfaction, staff satisfaction and improved quality metrics.[14] These and other models continue to be studied to determine how they affect both patients and the care staff.

One study determined that virtual nurses helped bedside nurses prioritize care needs while emphasizing best practices.[13] In other studies, the use of nurses to perform virtual discharges [10] or communicate with patients virtually [3] were examined. An upper south academic health sciences center found that when virtual nurses were implemented in their eICU, there was a moderate increase in patient satisfaction resulting in a moderate increase in patient trust which appeared to be caused by more open communication from the virtual nurses than from those who were present in the ICU. Metrics utilized in this study supported implementation of the same technology for BSN student teaching laboratories. As a result, the teaching laboratories have been expanded through an academic partnership so that students can learn the model before graduation.[4]

There are a variety of new care models being implemented across the country. Many of these include virtual tools and new roles for nurses and other team members. The studies being done are just the beginning of research needed to determine how these prototypes affect safety, quality, and patient experience. Other scientific inquiry will demonstrate their impact on healthcare equity and access to care. Still other research will help nurse leaders in both practice and academia understand how these models influence the job satisfaction and professional growth of nurses and their teams.

The American Nurses Association recently recognized the role of the nurse who practices virtually. Nurse leaders and our professional organizations will need to have continued discussions about the implementation of innovative models that can then be researched as part of our profession's dedication to utilizing evidence for both our clinical and our operational effectiveness.

THE CALL TO ACTION FOR ALL NURSES

Since safe staffing is the cornerstone of safe patient care, we must find a path forward to achieve this. We must address the root cause of unsafe staffing, and we suggest that the answer can be found in addressing our models of care. It is imperative to be innovative and to explore new practice methods. This calls for bold, curious, and compassionate leaders. We urge all nursing leaders to engage with direct care nurses in conversations to determine the best models to serve their patients. This will require strong sponsorship from chief nurses and solid change management processes. We must find ways to inspire the entire team to engage in productive conversations that promote the diversity of thoughts.

Industries of every type have evolved over the years, and are changing rapidly with the addition of new technologies. We believe that nursing will always be an essential profession because humans will always need other humans that care for them with skill and compassion through evidence based practices. Education and Practice must work hand in hand to plan, implement, manage, and understand the evolution of nursing care. We must work together to prepare nurses for today and tomorrow and to use appropriate research methodologies to ensure that we are meeting our goals.

Nurse educators, clinicians, and researchers can harness their collective strengths to align their work and to solve long-standing issues that have sustained an education-practice gap. We need to address all factors that cause nurses to leave acute care, limit our ability to improve in the areas of care continuity and patient outcomes, and have been less than successful in containing health care costs. Deans and school of nursing faculty – educators, leaders, quality improvement scientists, and discovery scientists need to be full partners with practice in generating ideas, testing new models, designing and utilizing technologies, and redesigning the lived experiences of nurses. The hope and promise of competency-based nursing education requires academic-practice integration so that prelicensure and advanced nursing students learn leading edge and evidence-based content. They must have up to date experiences with nurse leaders, technology and emerging models of care so that they are prepared to work and lead across health care settings. Academic-practice integration is necessary to support the engagement of DNP students in leading needed improvement science work. It is also important in order to encourage PhD students in their work of discovery and outcomes focused on safe, effective, efficient models of care that improve nurses' ability to practice at top of knowledge, preparation and license and to optimize patient outcomes across the full continuum of care.

Success in educational and health care delivery models, supported by automation and increased use of technology, is rooted in partnerships between academic institutions and clinical health care delivery organizations. The practice and academic authors of this article believe in innovation in both education and practice. In the past, we mostly referenced this need to ensure that graduate nurses were prepared for practice. Today, we better understand that while this is still important, we must lead together. We could share faculty and nurse scientists to develop research protocols to test the various new care models to support both safe patient care and fulfilling nursing careers.

We agree that it is imperative that we promote the dissemination of substantial Doctorate in Nursing Program (DNP) projects with system-level impact. Academic entities can help to disseminate the outcomes from worthy DNP projects as well as PhD's research testing various models proposed empirically and, in some cases, being delivered.

Academic-Practice partnerships are the starting point but will need to quickly involve regulatory bodies, associations with the central mission of accreditation. We will also need to work with our finance colleagues and others on the funding of pilots, to ensure that they understand how the total cost of care is impacted and that mitigation of models will need to occur as the health care continues to evolve.

This evolution must be supported by a partnership where we share faculty and nurse scientists. We must develop research protocols to test the various new models for factors associated with the profession. The best research teams are those that are built interprofessionally with a variety of skills sets represented. In addition, it is time to recognize that nurses educated as DNPs and PhDs are both valuable in this work. PhDs need to empirically test the various models that are proposed and, in some cases, being delivered. DNP students and graduate DNPs can work with health care organizations and their nurse leaders to study the effects of these new models on both nurses and patients. Academic entities can move the needle forward to disseminate the outcomes from the DNP projects that are worthy. Research and studies can only help us build a body of knowledge when they are shared.

Nursing needs a strong partnership between academia and practice. In the past, we mostly referenced this need to ensure that graduate nurses were prepared for practice. Today we have a better understanding that while this is still important, we also need to lead the profession together. Nursing and our care models will evolve along with the environment, and as a profession proud of being both an art and a science, we must ensure that we are innovative and that we study our innovations to be sure they improve the lives of individuals we care for and those who care for them.

CONCLUSION

We are at a pivotal time in the history of healthcare. Nurse leaders must demonstrate courage, empathy, and compassion in these turbulent times. We support, promote, and call for safe staffing by implementing and testing new models of care while partnering with their local academic colleagues to develop a new body of evidence.

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