The leadership at Ohio-based West Chester Hospital revolutionized its nurse-staffing status quo by looking beyond strict nurse/patient ratios to a flexible model that adapt to patient acuity and volume surges.

In addition to managing patient volume and improving nurse satisfaction, the new model has substantially enhanced the ability of West Chester Hospital (WCH) to deliver on the patient-centered care promise, as indicated through its performance metrics. With the transition, the hospital's overall Press Ganey ranking increased from 79 in 2012 to more than 94 two years later, and its overall nursing ranking increased from approximately 45 to more than 70 during the same period.

The new model has also helped in terms of operational efficiency and patient safety. “The improved staffing ratios and nurse satisfaction have decreased nurse turnover by more than 50% over a two-year period, which allowed us to cut our agency RN hours from more than 3,000 in 2012 down to 0,” Baker explains. In terms of safety outcomes, during implementation of the nurse model, patient falls decreased from an average of 3.2 per 1,000 patient days to 2.5 per 1,000 patient days.

A division of the University of Cincinnati Health System, the 186-bed WCH previously relied on a conventional nurse-to-patient grid staffing model in which the ratios narrowly reflected the number of admitted patients, according to Patrick Baker, RN, vice president, patient care services and chief nursing officer for the hospital. What the ratios did not reflect, however, were many of the factors known to influence variability in nursing care, such as patient acuity, individual nurse characteristics, human factors and the nurse work environment.

The combination of these factors creates a level of complexity that isn’t addressed through traditional staffing models. At WCH, the grid was frequently misaligned with actual patient census and nurse workload. The legacy staffing system did not allow nurse managers to use their expert judgment or critical-thinking skills to optimize the nurse-patient ratios, which often left them feeling powerless to ensure adequate and safe staffing. It also perpetuated a short-staffed mentality among front-line nurses, contributing to higher turnover rates and lower job satisfaction—both of which have been shown to influence patient, nurse and system outcomes.

With an eye toward improving nurse engagement and the quality and experience of patient care, hospital leaders developed a staffing solution that promotes critical thinking and flexibility and empowers charge nurses to optimize nurse-patient ratio assignments.

Supported by the contingency approach to leadership, which centers on the belief that different situations demand different leadership considerations, the new model enables the flexing of nurse assignments based on myriad patient and nurse factors, including patient diagnoses, acuity and special needs; daily census; staff competency, education, training and skill mix; availability of current and projected resources; and unit turnover.

The primary focus of the new model is front-line nursing staff, with the specific goal of ensuring that the nurse-to-patient ratio never exceeds 1:5.

To achieve this, Baker and his team developed new staffing utilization guidelines and added permanent charge nurses and an admission nurse to the clinical staff. They replaced the traditional nurse manager role with a triad leadership team (clinical manager, clinical coordinator and unit educator) and implemented house-wide staffing reviews every 12 hours, at 4 p.m. and 4 a.m.
The charge nurses play a pivotal role in the model, Baker explains. They are responsible for leading their units 24 hours per day, seven days per week; they facilitate daily safety huddles; and, together with charge nurses from other units, they lead the 4 a.m. staffing huddle. “The charge nurses attend multidisciplinary rounds, assist with discharges, help manager productivity and assist with quality and core measures,” he says. The charge nurses do not have specific patient assignments, so that they can help patient care needs as acuity or unit census dictates.

Similarly, the admission nurse works primarily with the emergency department to assist at the point of entry, and also works clinically in the inpatient unit one day per week. “But if patient volume is high or there are a lot of patients with more than the usual nursing-care requirements, the admission nurse can leave the admission role and take on a full assignment on the inpatient unit,” Baker explains.

On a practical level, this flexible staffing scenario means that front-line nurses no longer have to operate with a short-staffed mentality. “They don’t come in and look at the census board like they used to, because they know they are never going to be assigned more than five patients,” Baker says, noting that this is a “big nurse satisfier.”

The staff utilization guideline spells out the staffing options based on unit needs, ranging from the “goal,” which is a ratio of one RN per four to five patients and a charge nurse with no fixed assignment, to full utilization of all unit resources, including five patients per RN, five patients per charge nurse, five patients per admission nurse and assistance from the nurse educator, clinical coordinator, clinical manager and director. “Typically, we fall somewhere in between, and the clinical leaders have the flexibility they need to arrange staff in the most efficient way they can,” Baker says.

In addition to being more satisfied with their jobs, the WCH nurses believe the new staffing model has positively influenced care delivery in their units. “We surveyed our inpatient nurses after implementation to evaluate whether the new staffing model was beneficial to both nursing and WCH patients, and the results showed that more than 80% of all inpatient nurses who responded to the survey strongly agreed or agreed that the model correlated with improved support of front-line nurses, leadership communication and the quality of care being delivered,” Baker says.

A comparison of WCH’s NDNQI® RN Satisfaction Overall scores for 2014 and 2015 indicates that nurses continue to feel positive about the nurse work environment, with improvements across all the relevant domains: adequate staffing, hospital affairs participation, mean practice environment scale (PES), foundation of quality control, manager leadership and nurse-doctor relationship.

To support the model and keep the hospital on track with nurse staffing gains, the leadership triad meets weekly, during which time the members review the inpatient dashboard and the “staffing at a glance” dashboard, which is updated daily and posted on all inpatient units to reinforce the team’s performance across staffing measures, particularly the allocation of resources needed to meet volume surges.

Despite the success of the WCH nurse staffing model, Baker considers it a work in progress. A current focus of the development team is the alignment of the nursing structure and processes with the components of the Magnet journey, including the implementation of a clinical ladder program and unit-based councils to promote shared governance.