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Successfully Deploying Your Valuable Resources:

Staffing Implications and Prioritization During Crisis

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Whether your facility is standalone or part of a multihospital system, meeting operational demand for patient care under routine circumstances can be challenging. Vacancies, prolonged recruitment time to fill positions, and unscheduled absences and leaves, combined with increased acuity and volume, can strain and overwhelm a facility's resources during noncrisis circumstances. This article explores the challenges of staffing during a crisis and patient surge, providing strategies that can be utilized to optimize resources.

An acute staffing crisis may arrive at any time and in many forms—fires, floods, hurricanes, earthquakes, and emerging diseases as examples—which can quickly overwhelm a facility's ability to provide safe, quality care. Evidence has shown that the frequency of recorded casualty-producing natural hazard events has increased 4-fold since the mid-1970s.[1] These events rapidly escalate the numbers of incoming patients, creating surge capacity challenges. Hick et al[2] define surge capacity as the ability to manage a sudden, unexpected increase in patient volume that would otherwise severely challenge or exceed the present capacity of the facility. Comprehensive strategies are needed to ensure operational demands are met as seamlessly as possible within the hospital's physical structure, while maintaining patient and staff safety.

KEY POINTS

- **Acute staffing crises arrive unexpectedly and, in many forms.**
- **Rapid assessment of currently available internal staffing resources is the first step of a 4-pronged approach for ensuring provision of patient care.**
- **Both standalone and multihospital systems may have limitations with effective deployment across units and campuses.**
- **When internal resources exceed capacity, leveraging supplemental staffing partners can provide additional support.**

FOUR-PRONGED APPROACH

During a crisis, the provision of safe patient care in physically secure environments is paramount. With the rapid surge of incoming patients, implementation of a coordinated approach will assist with prioritization of resources, including supplies, personnel, physical space, and management infrastructure.[3] A sequential 4-pronged approach that includes the rapid assessment of immediately available resources, optimization of internal staffing, operational considerations for staffing deployment, and leveraging supplemental staffing partners can provide a structural plan.[4] Although standalone facilities and multihospital systems have similarities, there may be limitations with internal resourcing for the stand alone requiring an acceleration of the 4 strategies.

1. Rapid Assessment of Immediately Available Resources

Avoidance of redundant workflows provides an effective mechanism for ensuring assessment of the physical environment and capacity, identifying where the resources are currently physically housed, and determining patient flow. This can be accomplished by establishing a centralized command center that provides a singular view and focus, and ensures a standardized approach to deployment of resources. Critical to success is the ability to have an ongoing 360-degree view of incoming patient volumes, physical cohorting,

and rerouting of admissions and transfers to where staffing is optimized. Standalone facilities should review or execute transfer agreements with surrounding nonaffiliated facilities for capacity management. Establishment of 1 number for calling in all items related to the event will also provide real-time data for rapid changes in decision-making.

Participation in the command center should be centered around leaders who can provide rapid decision-making and implementation of services needed to direct patient flow and provision of care. Senior leaders, representatives from nursing units, administrative supervisors, staffing specialists, human resources, information technology (IT), security, leaders of support services, and supply chain and emergency management each have a critical role during crisis. Multihospital systems may have a centralized staffing team, bed planning team, and transfer center team, who should also have a representative.

Partnering with IT and/or human resources (HR) to obtain reports of all currently active staff and subcontractors, and their physical locations on campus will assist with determining where to direct patients and create a secondary list of potential clinical staff to respond to the crisis. This list should also contain clinical competencies for primary and secondary areas of experience for floating. Multihospital systems may have a centralized group of staff with the ability to float across specialties and hospitals. Once the list is created, leaders should develop a floating strategy based upon experience and geography.

2. Optimizing Internal Staffing Resources

Once the physical location of clinical and nonclinical staff is identified, sick call and unscheduled absences should all be routed into the command center number. This provides real-time, line of sight for resource management while providing employee health tracking and infection control surveillance. Each facility needs to prepare for staffing needs above the capacity needs resulting from exposure furloughs, employee illness, or inability to physically report to the facility.

As the information surrounding patient surge is reported to the command center, clinical staff are deployed to higher volume, higher acuity areas, based upon competency. Leaders should review standardized staffing ratios or current care delivery models, as temporary changes may be appropriate. In the example of the current COVID-19 pandemic, the Centers for Medicare & Medicaid Services and state governors issued Emergency Declaration Blanket Waivers for Health Care Providers and licensing requirements outlined in the National Council of State Boards of Nursing. These declarations allowed the facilities to provide care with flexible policies and policies for the provision of care if they are not inconsistent with the state's emergency preparedness or pandemic plan.[5,6]

Consideration should be given to floating staff from other departments to assist with patient care such as physical therapists who can take vital signs, under the supervision of a registered nurse. Critical for patient and staff safety, visitors should be differentiated from hospital staff, because staff are also wearing personal protective equipment. Ensuring that unapproved visitors, such as the media or distressed family members, are managed through a detailed identification plan by security or police cannot be emphasized enough.

3. Operational Considerations for Facility-Based Staff Deployment

Staff floating to different specialty units or different campuses of a multihospital system will need access to additional items to effectively provide patient care. The command center, with IT representatives, HR representatives and pharmacy representatives, can rapidly complete user provisioning.

User provisioning for the electronic health record (EHR) should be prioritized to the top of items for review. Many EHRs include different access based upon specialties, departments, and facilities within a multihospital system. Staff floating outside of their previously assigned units/campuses will need urgent provisioning to provide care. Badge access to doors and parking should also be addressed.

Equipment considerations and supply chain support are recommended as next steps. Paramount for consideration is the standardization of equipment utilized for patient care across departments or campuses. Routine items such as infusion pumps, beds, automated medication and supply administration systems, and different infusion admixture concentrations, may result in missed care or delayed care because staff may not hold competencies for these components.

Floating of hours to designated worked cost centers or campuses and accuracy of financial accruals should also be addressed. Different facilities may not have the same timekeeping processes. Multihospital systems may have a centralized staffing team where these requirements are already in place. In hospital systems, pre-disaster preparation will promote system readiness for rapid initial deployment during surge at 1 or more campuses simultaneously.

4. Leveraging Supplemental Staffing Partners

When internal resources are unable to meet demand, supplemental support from staffing partner companies can assist facilities. Staffing companies have the infrastructure to rapidly recruit, credential, and deploy candidates nationally that meet the criteria for your facility. Most staffing companies provide nursing, allied, and nonclinical staffing support. An additional consideration is to obtain a staffing partner that can augment security officers on campus.

Leaders responsible for contracts should review current staffing agreements, relationships, rates, and requirements. Four levels of relationships may exist based upon contractual terms, including direct facility contracts; vendor management services; managed staffing programs (MSP); and technology based.[7]

Depending on the relationship currently in place, response to fill requests for supplemental staffing varies. Agreements with an MSP relationship and a direct relationship are routinely given first priority within the staffing companies. If the need arises to enhance the current relationship to a higher level of partnership, that can be done at any time prior to or during a crisis. Direct contracts can be given a time-limited exclusivity for orders during surge, with a revisiting of a more longer-term agreement once the crisis is resolved.

There are several advantages to enhancing a staffing partner relationship for the facility: 1 call for all needs—nursing, allied and nonclinical, with 1 invoice for all services; centralized procurement of profiles with full credentialing; and priority fulfillment of orders.

When large numbers of agency staff are being onboarded, abbreviated and expedited orientation to the organization and clinical unit will assist in the rapid deployment to patient care. These staff can have the ability to deploy across different units and different campuses. Fast-tracked facility badging, onboarding, and user provisioning by HR, IT, finance, and pharmacy should also be considered.

POST-ACUTE CRISIS CONSIDERATIONS

As the crisis begins to resolve, the command center will initiate reduction in its operations. As the facility starts to return to pre-crisis operations, preparations will shift focus to managing a slower influx of nonurgent patients that were not part of the surge. Emergency department visits may continue at crisis levels or possibly escalate, and previously cancelled surgeries will resume with potentially higher demand. Employee assistance programs for debriefing and destressing staff are recommended. HR and IT will need a rapid process of removing access from the systems as agency staff exit the organization.

Finally, sharing your experiences during a crisis with colleagues provides an opportunity for everyone to learn what worked well, and what did not, along with strategies that the organization identified along the way. The current COVID-19 pandemic has provided education from all the hospitals that were in the initial hotspots to those of us who followed in their wake.

REFERENCES

1. Watson SK, Rudge JW, Coker R. Health systems' "surge capacity": state of the art priorities for future research. *Milbank Q*. 2013;91(1):78-122.
2. Hick JL, Barbera JA, Kelen GD. Refining surge capacity: conventional, contingency, and crisis capacity. *Disaster Med Public Health Prep*. 2009;3(Suppl 1):S59-S67.
3. Hick JL, Koenig KL, Barbisch D. Surg capacity concepts for health care facilities: the CO-S-TR model for initial assessment. *Disaster Med Public Health Prep*. 2008;2(Supp 1):S51-S57.
4. Aznavorian R. Staffing Implications During Crisis. 2020. Tipton Healthcare. Available at: https://www.gotostage.com/channel/c639bf5aab6b4eb1b7c34d21e3401616/recording/7a25450330f64251888f58e3b00a063a/watch?source=CHANNEL. Accessed April 20, 2020.
5. Centers for Medicare & Medicaid. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. 2020. Available at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf. Accessed March 18, 2020.
6. National Council of State Boards of Nursing. State Response to COVID-19. 2020. Available at: https://www.ncsbn.org/State_COVID-19_Response.pdf. Accessed March 24, 2020.
7. *Staffing Industry Analysts. The Lexicon*. 2019. Available at: http://lexicon.staffingindustry.com/. Accessed April 19, 2020.

ADDITIONAL READING

Bailey KD, Trepanier S. *Leading Through COVID-19: Nurse Executive Perspective.* AONL Webinar; April 20, 2020. Available at: https://www.aonl.org/education/webinars/leading-through-covid-19-nurse-executive-perspectives. Accessed June 15, 2020.

McHugh MD. Hospital nurse staffing and public health emergency preparedness: implications for policy. *Public Health Nurs*. 2010;27(5):442-449.

Stangeland P. Disaster nursing: a retrospective review. *Crit Care Nurs Clin North Am*. 2010;22(4):421-436.

VanDevanter N, Raveis VH, Kovner CT, McCollum M, Keller R. Challenges and resources for nurses participating in a hurricane Sandy hospital evacuation. *J Nur Scholarsh*. 2017;49(6):635-643.

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