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There's No Substitute for Adequate Registered Nurse Staffing

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There's an unprecedented undercurrent in health care today. Feeling undervalued by their employers, hospital-based staff nurses are voting with their feet and leaving in droves.[1] The source of this perception of unappreciation results from the neglect of working conditions in hospitals, overwork, understaffing, and ultimately burnout.[2] During and immediately after the COVID-19 pandemic, front-line health care workers experienced morally and ethically impossible situations and yet were expected to function normally. Nationally, job satisfaction declined the most among hospital-based registered nurses (RNs).[3]

According to the 2022 National Sample Survey of RNs, "5% of the nursing workforce (~195,000 RNs) left the nursing workforce due to the pandemic. While 43% plan to return, 19% indicated that they did not intend to come back. The most common reasons given for leaving the workforce were high-risk working conditions (51%), feelings of being overworked or burned out (50%), inadequate staffing (39%), and unsatisfactory safety protocols (37%)."[4]

Instead of valuing the RN for the wealth of knowledge they bring and their contributions to successful patient recovery and various other successful organizational outcomes, hospitals seem to view the nursing workforce as a cost center—a high-cost commodity that can be substituted with lower-wage workers.

We commend Dr Karen Lasater et al[5] for their attempt to quantify the value that RNs contribute to patients, hospitals, and payers. Lasater et al[5] found that substituting RN positions in hospitals with licensed practical nurses (LPNs) and unlicensed assistive personnel (UAPs) who draw a lower wage would result in poorer patient outcomes and a negative return on investment for hospitals. They concluded that team nursing models of care are therefore objectionable—an unacceptable solution to the problems of staffing shortages and RN turnover affecting so many hospitals.

Perhaps not all alternate models of nurse staffing are dangerous per se. However, determining the right acute care staffing model has continued to elude the nursing profession. The COVID-19 pandemic forced nursing to innovate in the care models that are employed, essentially combining the best of what is known with what can realistically be tested. Because Lasater et al[5] specifically highlight concerns about the resurgence of the team nursing model, the following narrative is offered to further the conversation.

HISTORICAL BASIS OF TEAM NURSING

As inpatient care processes have evolved, so have the models of nursing care. The team nursing model emerged post-World War II when the United States was experiencing a nursing shortage, and it was argued that the model offered higher quality and continuity of care than its predecessor, the functional nursing model.[6] In functional nursing, each registered, technical, or practical nurse performed a function,

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such as medication passing or checking vital signs, for all of the patients in a given unit or ward. Thus, unskilled personnel were taught to perform a single skill and learned to do it efficiently. However, care was fragmented—no one person had a complete picture of the patient. This was remedied by the team nursing model, where an RN led a team, composed of other RNs, LPNs, and nursing assistants (NAs), in delivery of patient care.[6] Team nurses work collaboratively, share responsibility and support each other in the delivery of patient care.

Emergence of a different care model, primary nursing, occurred in the 1960s coinciding with a transition toward professionalism of nursing and reflected a shift toward staffing with primarily RNs.[6] In addition to cost considerations, the primary nursing model has been subject to inconsistent implementation and is in need of further research related to continuity and coordination of care.[7]

Inconsistent Implementation of Team Nursing

Our experience leads us to believe that the team nursing model has been operationalized differently across employers, often appearing more like the functional nursing model, where a charge nurse or assistant nurse manager creates patient assignments based solely upon division of tasks.[6] This misrepresentation of team nursing not only undermines the concept of team within the nursing work environment but may unintentionally bias the willingness to test a more acceptable team nursing model.

Where RNs are afforded the opportunity to practice to the full scope of their license with empowerment to lead and coordinate a team in the delivery of a group of patients' care while also maintaining accountability for that care, their rigorous nursing education and depth of knowledge are validated. Appropriate delegation and coordination of a team by an RN should, hypothetically, extend the work of the RN rather than replace the RN. Therefore, it may be beneficial to consider further what foundational structures would contribute to an effective team nursing model of care.

Ingredients for Effective Team Nursing

For a team nursing model to be effective, several foundational work environment elements must be present. These include adequate staffing with both RNs and support staff, workflows that optimize teamwork, support for the development of RN delegation competencies, and a culture of safety resulting in well-being for all team members. An appropriate staffing level for all members of the team is necessary. The success of a model that relies on teams of individuals with diverse educational preparation to deliver the highest quality of care requires an organizational commitment to maintain adequate staffing numbers. Expecting RNs to lead patient care teams with inadequate numbers of support staff not only creates a barrier to effective team functioning but devalues the RNs role as leader. Likewise, if the RN continually absorbs team member responsibilities due to understaffing, the other team members would likely feel unappreciated for their respective roles in patient care. For team nursing to work as intended, it requires adequate numbers of RN, LPN and NA staff, not necessarily fewer staff members.

RNs must be supported for practice at the high standards instilled throughout their education. As educators of students who graduate with a BSN or higher degree, we have concerns about perceived incongruencies between employer prioritization of task-driven behaviors to guide nursing practice versus delivery of optimal patient care through critical thinking-driven behaviors, care coordination, and patient advocacy. Some of our colleagues have shared that nursing workflows in the acute care environment are now driven more so by electronic health record task alerts than specific patient needs.

In addition, RNs must have a work environment that allows them to grow in their competencies of delegation, supervision, and coordination; all of which require skilled and effective communication. Success of the team model requires that the RN has not only training in delegation but also works for an organization with a professional practice model that prioritizes the organization's commitment to a healthy work environment represented by a culture of safety, teamwork, and well-being of all team members. In a team nursing model exemplar, newer RNs would be a member of the team without lead responsibility until the necessary practice and leadership competencies are achieved. Implementing such a model would likely have a positive impact on the retention of newer nurses who have previously been expected to "hit the ground running" with limited resources dedicated to their transition to practice. Further research is needed to determine whether a fully and correctly implemented team nursing model would have a positive impact on the retention of more experienced nurses who often desire greater autonomy and leadership in their practice.

Replace RNs? No Way!

As Lasater et al[5] so clearly point out, there is a danger in substituting lower-skilled caregivers for RNs in hospitals. We agree that this is a hazardous proposition for several reasons. First, as Naik et al[8] point out, patient complexity levels in hospitals have increased over time. Patients are living longer with more chronic diseases and complicated medication regimens. The American Hospital Association reported a significant increase in overall lengths of stay as well as Case Mix Indices in hospitals from 2019 to 2022.[9] Surely, hospitalized patients are in need of more highly skilled care rather than less. Second, partly because of the increased complexity of hospitalized patients, adverse event rates have increased such that 25% of all admissions can expect to have at least one adverse medical event during their hospitalization.[10] With this extremely high probability of adverse events, should the health care industry be considering lower-skilled replacements for RNs? Finally, over 30 years of research and systematic reviews continue to show reduced mortality in hospitals with greater RN staffing.[11,12] The increased complexity of inpatients combined with the high chance of

adverse events and the empirical evidence suggesting better care with more RNs should give pause to those considering models of care that replace RNs with less skilled caregivers.

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