

Evidence-Based Staffing and “Communityship” as the Key to Success

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- Evidence-based staffing • Communityship • Lean
- Zero-defect health care

Staffing can spell success or failure for the nurse leader at either the executive level or the frontline level. Effective staffing creates excellence in quality outcomes, nurse satisfaction, retention and safety, patient loyalty, and reputation of the organization. Financially, effective staffing affects the bottom line, and now that pay for performance, decreased tolerance for errors, and poor clinical outcomes are part of the reimbursement picture, interest in staffing is escalating. New research and evidence about the relationship of effective staffing to patient, nurse, and organizational outcomes are also available. Previously, leaders intuitively knew that staffing effectiveness was tied to patient outcomes, but it was difficult to quantify because the research was not available. That is no longer the case. Good evidence is available describing the relationship of evidence-based practice and the outcomes of staffing. The challenge is how to move from opinion-based staffing models to rapidly embedding evidence-based models that improve the quality of care available to patients.

APPLYING EVIDENCE-BASED DATA TO STAFFING

Although the use of evidence to drive quality is widely understood and used in clinical practice, this is less true when applying evidence to staffing practices. The importance of analyzing the needs of the patient and understanding the competencies of staff and the call to routinely evaluate staffing effectiveness on patients' outcomes have been highlighted in the literature.¹⁻³ The white paper, *Excellence and Evidence in Staffing; Essential Links to Staffing Solutions for Health care*,⁴ is the product of a summit on evidence-based staffing at which input from more than 50 health care leaders from community and academic hospitals, academia, professional nursing organizations,

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and industry was generated. This report provides a review of the literature and maps the research to substantiate 10 best practice recommendations. At the center of this work is a model for evidence-based staffing that demonstrates the importance of applying the available evidence to staffing by making evidence/science the foundation of the model. The paper also points out the importance of understanding staffing and its broad implications for the operational and financial performance of a health care organization. We now have significant evidence-based studies about staffing to base much of our practice on evidence. Clark⁵ notes that we now have the evidence to justify investments in nurse staffing and high-quality practice environments. Our challenge is to infuse this information throughout the organization so that integrated evidence-based decisions are made in every part of the organization that affects patient care.

EVIDENCE-BASED STAFFING AS AN INTEGRATED COLLABORATIVE PROCESS AND "COMMUNITYSHIP"

Historically the work of staffing has been considered the accountability of the Chief Nursing Officer (CNO) or designee. However, effective staffing is influenced by a great number of people and processes in the organization that are outside the direct responsibilities of the CNO. Malloch and Porter O'Grady⁶ describe how we are leaving the industrial age and moving into an age in which it is clearly recognized that the integration of the parts into the whole is necessary for success and in which the interdependence of parts is clearly seen and recognized. The CNO then has to see the role from this perspective and manage the interconnections between people and processes. These authors also note that the old world order was focused on the processes, actions, work, tasks, functions, and jobs. In the present and evolving world, outcomes, results, and sustainable accomplishments have replaced the process-oriented industrial age thinking. The nurse leader cannot achieve effective staffing without the ability to manage these issues with the teams of people inside and outside nursing who can achieve the desired outcomes. Freshman and colleagues⁷ note that the publication by the Committee on Quality of Health Care in America, Institute of Medicine,⁸ described health care quality as suffering from the inability to work collaboratively across disciplines. Uncoordinated, sequential action that focuses on efficiency within silos instead of collaboration across boundaries has led to a system that is unsafe and uncoordinated. Staffing is a primary example of this state of health care. We cannot be effective without seeing staffing as an integrated, system-wide process and having discussions about evidence, quality, efficiency, and nursing care, independent of others in the organization.

Mintzberg⁹ uses the term "communityship" to describe the style of leadership needed today. Mintzberg describes what he calls the harmful and pervasive leadership style we have been experiencing of leaders who sit in offices and announce the goals they want others to attain. They do not move out of their office and on to patient care areas to help people achieve these goals. The leader as isolated individualist must be morphed into a leader who is personally engaged and believes in distributed management. Mintzberg⁹(p141) uses the terms "just enough leadership" and "communityship" to describe an alternative to the top-down centralized bureaucratic style of leadership. Communityship is an excellent concept to describe the work that is necessary to create effective staffing outcomes.

From Mintzberg's point of view, community is about "...caring about our work, our colleagues, and our place in the world, geographic and otherwise and in turn being inspired by this caring." He uses the term communityship as the alternate to the

individualistic leadership model of the past. Companies such as Toyota and Pixar are examples of this style of leadership. An organization, according to Mintzberg, knows that it has arrived when its members reach out in socially responsible and mutually beneficial ways to each other.

Effective staffing takes a community. It requires that people reach out to each other over and through departmental firewalls to care for each other, for each other's work, and for the ultimate safety of patients and staff. When departments, such as finance, support departments, unions, pharmacy, and the nursing organization, can work across departmental lines to share the vision and execute evidence-based effective staffing, excellent outcomes can be achieved. The challenge is to measure outcomes by what happens to the patient, not by isolated department-specific numbers that include only compliance to budgeted numbers. The needed measure is the activities that have improved or worsened, based on the outcome of what the patient expects—zero-defect health care.

Staffing is an interactive system influenced by many people throughout the organization. Holds in the emergency department because of inadequate staffing in the intensive care units, lack of teamwork, staff turnover, unit turbulence, new physicians, inadequately stocked supplies, cumbersome computer systems, and unilateral decisions made in pharmacy, finance, or medical records are all examples of issues that affect staffing and the ability to achieve superior outcomes for patients. Effective evidence-based staffing is the result of interactive processes that cross many boundaries.

Moving an organization to an evidence-based model for staffing and for achieving the outcomes designated by the patient requires the integration of leaders and staff, a strong understanding of all of the interrelated forces at play, and a culture of collaboration and inclusion.⁴ The importance of the proactive leadership of nursing in this situation cannot be overstated. Moving staffing into a key strategic initiative, that of building communityship around staffing, takes vision and the ability to effectively translate that vision into terms that can be understood and embraced by everyone, from the executive team and the finance and support departments to the nurse delivering bedside care and the patient.

EXAMPLES OF COMMUNITYSHIP IN STAFFING

There are many leaders who implement staffing programs grounded in the best practices for excellence and use an evidence-based model. Their experience can provide guideposts for those seeking to convert to an evidence-based approach to staffing. Haley and Thering¹⁰ spoke about their transition to an evidence-based approach to staffing excellence as one that could not have been accomplished without the close working relationship that was developed between nursing and finance. They describe a healthy relationship with finance as one demonstrated by shared responsibility for financial outcomes of staffing practices. To achieve this relationship required spending time together and learning about each other's areas. It also required enabling the staffing decision makers and ensuring that they were knowledgeable about clinical, operational, and financial implications of staffing decisions. Bedside nurses also played a key role by becoming active participants in the staffing process. This process is highlighted as essential in the Best Practices defined in Excellence and Evidence in Staffing.⁴

This position of collaboration was also emphasized by Valentine and Doyle.¹¹ In a separate presentation about their journey to excellence in staffing, Doug Hughes, Director of Nursing, Paoli Hospital, pointed out the difference between quick fixes,

such as offering bonuses, and an investment in solutions that bring about sustainable change as the core of an excellence in staffing program.

Jeff Turner¹² described an example of Moore County Hospital's Chief Executive Officer (CEO), who has led, in partnership with nursing and others, a redesign of staffing practices that examines the underlying causes as the key to successful financial outcomes related to staffing. This CEO demonstrated a deep understanding of all of the forces at play related to staffing and the kind of informed leadership that can successfully lead the change to an evidence-based approach to staffing. Turner also points out the importance of the entire team as necessary to achieving the success that the Moore County Hospital is enjoying.

Suelyn Ellerbe,¹³ an early innovator in evidence-based staffing programs, has led the change that empowered evidence-based staffing at many organizations. Citing collaboration, education, organizational awareness, and increased sense of responsibility across all stakeholders as keys to success, she has been able to achieve remarkable financial and operational outcomes, saving her organizations millions of dollars.

Block¹⁴ notes that our organizations are plagued with fragmentation, disconnection, and detachment that make it virtually impossible for them to reach their full potential. For Block, leadership is conversation. Block also notes that we are most effective when we focus on others' gifts and not deficiencies. His asset-based conversations focus on possibilities among people and eliminate fragmentation. These examples demonstrate how leaders have taken the responsibility to have conversations with various other people in the organization to effectively eliminate fragmentation and change outcomes for patients.

INTEGRATED DECISION MAKING AND EFFECTIVE EVIDENCE-BASED NURSING ACROSS BOUNDARIES

When key stakeholders in the organization become familiar with evaluating decisions based on evidence and the effect on others in the health care process and the evidence, we will achieve a new level of integrated decision making that will create better outcomes. For example, decisions about information technology, clinical documentation, pharmacy processes, or renovation can positively or negatively affect effective staffing. When people who are not familiar with the staffing evidence make isolated decisions that radically affect nurse staffing, the organization is headed for a collision that produces poor patient outcomes and high costs. It will be impossible to reach staffing goals for efficiency and quality when decisions in another part of the organization can negatively affect the front line. A classic example is a process improvement effort in one department that decreases the workload and staff in that department but shifts the workload to the staff nurse without increasing nurse staffing. Just a few decisions like this in an organization will reduce the nurse's direct time at the bedside and will predictably, according to available evidence, create unwanted patient care outcomes, such as pressure ulcers or falls.

Unfortunately, it has been an all too common practice to reduce staff without taking their work out of the system. Processes such as applying Lean to hospitals¹⁵ will provide the processes needed to make changes rather than relying on opinion-based productivity improvement initiatives that do not really improve productivity and quality in the long run. Lean methodologies have been used in hospitals effectively to reduce waste, which is defined as any problem that interferes with people doing their work effectively or any activity that does not provide value for the customer, who is defined as the nurse in some situations and the patient in others. Examples of reducing waste and saving nursing time are projects that have reduced the time nurses devote to hunting and

gathering when supplies are not readily available because of stock-outs or when equipment are not available for immediate use, centralized rather than decentralized supplies that result in additional travel time for nurses, inefficient pharmacy procedures that result in endless phone calls and long patient waits, and nonnursing tasks delegated to nurses. Inefficient processes within nursing also create staffing issues for other departments. For example, an inefficient system of ordering missed medications from the pharmacy can result in the order being placed several times if the system cannot inform the nurse or pharmacist that the order has already been placed, and extra doses arrive on the unit. Hoarding of supplies and equipment by nurses, who because of their experience do not trust the supply system, results in incredible waste. When staffing reductions are made without looking at the root cause of inefficiencies across all systems and departments, then the decision only makes the inefficiencies worse. Lean technologies have much to teach everyone about intelligent redesign of processes.

The sole responsibility for staffing does not reside in the nursing department. Effective staffing is the result of integrated process improvement and decision making that creates synergy across boundaries and transparency across departmental borders.

COMMONALITIES OF SUCCESSFUL PROGRAMS

Reviewing these and many other examples surfaces some commonalities that can be helpful in supporting a move to an evidence-based approach to staffing.

- Involvement of stakeholder groups from all over the organization, including patients
- Strong understanding of interrelated forces
- Strong commitment to address underlying cause
- Education of all decision makers to a level of competency, not just those in nursing
- Shared responsibility for financial, operational, and clinical outcomes that create a feeling of integration and communityship.

Designing a program that embraces evidence-based staffing requires a strong understanding of the nurse staffing process and all of the complex interactive forces at play. Without a holistic, communityship view, there is risk in fixing something in one place only to find an unexpected consequence surface somewhere else in the system. Collaboration and participation across all stakeholder groups will lay the foundation for success and contribute to understanding the whole picture. It is the kind of collaboration that gives rise to new concepts like communityship. This thinking is fundamental to Magnet concepts. This new thinking becomes essential for realizing the operational, cultural, and financial outcomes necessary for achieving excellence in staffing. Investing in an environment in which participation and collaboration are embraced creates distributed ownership and accountability, which is a key success factor.

When there is a common understanding of the value that can be realized from taking an evidence-based and communityship approach to staffing, cooperation and innovation can thrive. Nurse executives must take an active role in promoting the understanding and value of evidence-based, communityship staffing within the executive team while also setting forth a vision for nursing. Nurse managers play a pivotal role in a successful staffing program, and investments in their understanding of not only the operational and clinical side of staffing but also the business side will yield high returns. Nurse managers who also embrace a communityship approach to leadership

will find it easier to motivate their staff, promoting participation and initiating best practices, particularly those that promote successful working across departments.

The underpinning of success is awareness promoted through education and the underlying belief that when people understand something they will make the best decisions. Nursing needs to learn the language of the finance department and of other departments, and these same nonnursing groups need to learn more about direct care delivery. When staffing decisions are made, they should be made with a full understanding of the downstream implications of those decisions. Whether it is a budget discussion or solving a staffing problem on a given shift, all these decisions add up to affect patients, the workforce, and the organization in which care is delivered. In situations in which excellence in staffing thrives as an organizational value, accountability for outcomes is shared among leadership, management, and staff across departments. All areas have the understanding and motivation to support informed decision making for their particular aspect of the staffing world and the knowledge of potential implications of that decision on the rest of the staffing continuum.

INCLUDING THE PATIENT IN COMMUNITYSHIP: MOVING FROM NUMBER-CENTRIC STAFFING TO PATIENT-CENTRIC STAFFING OUTCOMES

Historically, staffing revolved around numbers such as hours per patient day or ratios, and the outcomes were to determine the numbers and to meet these numbers. We are now in the middle of a transformation where we are not judged on our process or our numbers. Instead, we are judged on the outcomes, as measured by patient outcomes such as pressure ulcers and falls. The challenge is to switch our thinking to measuring staffing effectiveness not by how well the numbers were met, but how the numbers influenced the creation of a defect-free health care system in which there are no pressure ulcers and no falls with injuries. Numbers alone will not reach this goal. A serious cross-departmental evaluation of the waste that is inherent in the process of delivering care to patients is what is needed. Eliminating the waste that takes staff time and does not contribute to excellence in outcomes is absolutely necessary. We cannot be effective unless we actively and continually apply methods such as those discussed by Graban¹⁵ to improve processes and eliminate the waste that negates efficient and effective processes at the bedside. Cross-boundary interactions to constantly improve these processes must be embedded in the organization. Isolated department-only evaluation of staffing without assessing the downstream outcomes will not work.

Galbraith¹⁶ tells us that there are 3 levels of customer-centric organizations, light level, medium level, and high level. On the trajectory to reach the high level, he notes that there are customer-facing structures close to the top that have the power to be a strong voice of the customer. These customer-facing processes are empowered to help shape the company's process and outcomes around what the customer wants, not what the company wants to sell. Health care has been challenged to seriously become patient-centered and to give up its departmental, profession-centered, inward-looking way of delivering health care. This approach is a critical change that we need to make in the way we view effective staffing. The customer has a right to and is demanding defect-free health care. With pay for performance, hospitals will not be paid for defects, and with public reporting of nurse-sensitive outcomes, patient satisfaction, and other outcomes, the defects become clear. Customers are giving us a clear message that the days of producing what we want without looking at what the customer is demanding for are over. We must move as soon as possible into the communityship of effective staffing that includes the patient to achieve that outcome.

SUMMARY

Embracing a leadership style that is inclusive and that leverages the ideas and input at all levels of an organization is the foundation of building an approach to staffing that maximizes outcomes for patients, the workforce, and the organizations in which care is delivered. By engaging everyone involved and inviting participation, a structure of shared understanding is created, providing an environment that is positioned to achieve optimal results. Communityship offers a model for approaching leadership that is aligned with leveraging talent across an organization and developing a culture prepared to face the complex challenges of staffing and achieving new levels of performance that an evidence-based approach to staffing excellence can offer. We are challenged to create a zero-defect health care system. We can do this only by becoming patient-centric, embedding effective evidence-based staffing programs, and developing communityship as the method to get us there.

REFERENCES

1. American Association of Critical Care Nurses. AACN standards for establishing and sustaining healthy work environments. Aliso Viejo (CA): AACN; 2005.
2. American Nurses Association. Principles for nurse staffing. Washington, DC: American Nurses Association; 1999.
3. American Organization of Nurse Executives. Policy statement on staffing ratios. Washington, DC: The American Organization of Nurse Executives; 2003.
4. Douglas K. Excellence and evidence in staffing. 2008. Available at: <http://www.globalnursingnetwork.org>. Accessed July 15, 2009.
5. Clark S. Making the business case for nursing: justifying investments in nurse staffing and high quality practice environments. *Nurs Leadersh* 2007;5(4):34–8.
6. Malloch K, Porter O'Grady T. Evidence-based practice in nursing and health care. New York: Jones & Bartlett; 2006.
7. Freshman B, Rubino L, Chassiakos YR. Collaboration across the disciplines in health care. New York: Jones & Bartlett; 2009.
8. Committee on Quality of Health Care in America, Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. New York: National Academies Press; 2001.
9. Mintzberg H. Rebuilding companies as communities. *Harv Bus Rev* 2009;87(7/8): 140–3.
10. Haley S, Theron DM. Nursing/finance collaboration more than just staffing; a vehicle for controlled change. IdeaConnect Webcast 2009.
11. Valentine N, Doyle J. Partnering with nursing to achieve cost effective staffing ANI. In: Healthcare Finance Conference. 2007.
12. Turner J. Staffing redesign drives financial performance: CEO and innovative team partner for success. IdeaConnect Webcast 2009.
13. Ellerbe S. Video interview. 2008. Available at: <http://www.idealconnect2.com>. Accessed July 15, 2009.
14. Block P. Community: the structure of belonging. New York: Berrett-Koehler; 2009.
15. Graban M. Lean hospitals improving quality, patient safety, and employee satisfaction. New York: Productivity Press; 2009.
16. Galbraith J. Designing the customer-centric organization. New York: Jossey-Bass; 2005.