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WORKFORCE CASE STUDY

RESPONDING TO STAFFING NEEDS DURING A CRISIS

Yale New Haven Hospital | New Haven, Conn.

Nurse leaders at Yale New Haven Hospital (YNHH), a 1,541-bed academic medical center in New Haven, Conn., used alternate staffing models to grow and retain their nursing workforce during the COVID-19 pandemic. By encouraging teamwork and prioritizing the voice of the bedside nurse, YNHH ushered in a culture shift that fundamentally improved trust and communication organization wide. As a result, YNHH nurse leaders continue to develop new staffing models in various iterations to address ever changing, post-surge patient care needs.

Before the pandemic, YNHH's intensive care unit (ICU) volume encompassed 193 beds across 11 adult ICUs. In preparation for a surge in the need for ICU care, the organization expanded ICU capacity by 75%, to a total of 338 beds. Critical care nurses were already in short supply at YNHH, as they've long been at hospitals across the nation, but the pandemic intensified demand for their services. And in addition to the expected increase in volume, many of the treatments for COVID required 1:1 care creating additional need for resources.

YNHH employed 550 full, part-time, and casual critical care nurses prior to March 2020. Nurse leaders, including Ena Williams, senior vice president and chief nursing officer, tapped the organization's existing supply of more than 4,000 nurses to bridge the resource gap. In the span of a month, YNHH had exponentially increased the support available at the bedside, using a nursing team support model to optimize the ICU nurses' capacity to care for more patients.

Education, training, and deployment

In anticipation of the first ICU surge in early March, Williams assigned a member of the nursing leadership team, Jeannette Bronsord, executive director for surgical services, to oversee the design and development of a staffing model that would meet the growing demands of the ICU COVID-19 patient volume. Bronsord, and other nurse leaders convened a planning team, comprised of clinical nurses, nursing professional governance and education leaders, to empower ambulatory nurses, care associates, technicians and other clinical and non-clinical staff to support direct care nurses. It was important for the care model to be inclusive of many roles because despite curtailing non-emergent surgery and reducing ambulatory services, the organization did not furlough staff during the pandemic and the care model provided an opportunity to redeploy resources from across the organization. The team designed a model that educated, retrained and redeployed existing staff to help provide inpatient care in both the ICUs and general inpatient units.

Yale New Haven Hospital's then CEO, Marna Borgstrom (right), checks in with patient care team members deployed to the ICU.

Available nursing staff from non-inpatient settings such as ambulatory clinics, procedural areas and

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non-direct care roles (such as clinical informatics) were identified and stratified based on previous experience and competencies. Leaders divided nurses into groups based on how quickly they could be safely retrained and redeployed to the inpatient setting, taking into consideration their individual clinical backgrounds, expertise and levels of experience. Some nurses would be ready to deploy to independently care for a patient assignment while others would function in a support role.

Leaders assigned colors to these groups to differentiate their responsibilities. For example, a red nurse was a current ICU staff nurses (or nurse who had practiced critical care within the past 12 months and needed the least amount of retraining); orange nurses had previous ICU experience and valuable bedside skills but would not be expected to take an assignment independently. Blue nurses were medical surgical nurses and pink nurses provided support for in this setting and were identified using the same methodology as the ICU support nurses. Leaders had initially suggested using a number system, but bedside nurses found that method to be too hierarchical. Lastly, there was a teal support team members comprised of clinical staff across the organization providing support for patient care such as helping with donning and doffing and as members of the proning team.

ICU Nursing Team Structure: Roles and Responsibilities

Overview

The YNHH alternative staffing model calls for a variety of licensed and non-licensed nursing team members to support the critical care registered nurse—including progressive care nurses, med/surg nurses as well as a patient care assistant. The team composition can be scaled depending on the number of patients in the assignment and the patient care needs. As an example the staffing model calls for four nursing team members — including two intensive care unit registered nurses (RNs) and two progressive care nurses, med/surg nurses, and/or a patient care assistant — for every six ICU patients.

1. Whether used in the ICU or med/surg the nurse on the receiving unit functions as team leader and is accountable for team performance ensuring patient care needs are met. This leader regularly checks in with colleagues, manages care for patients with complex needs, and prioritizes communication.
2. The entire team is responsible delivering the best care possible to the assigned group of patients within their scope of practice and skill. They are also expected to document their care, and to communicate effectively with other team members.
3. Nurse leaders both sending and receiving staff are expected to ensure the employees receive adequate support for a successful transition to the inpatient area and ensure adherence to the Standards of Professional Behavior.

Nurse leaders identify the staff available in their units for redeployment and collaborate with YNHH's Center for Professional Practice (CPPE) to facilitate training and team shadowing within their departments. The releasing nurse leader also facilitates schedules ensuring alignment with inpatient care needs including PM shift and weekend coverage.

Nurse leaders on receiving units help incoming team members assimilate into the unit-based teams and implement a re-assignment etiquette. The re-assignment etiquette includes team member welcome and introductions, tours of the units, and sharing practical information such as the unit's phone extension, bathroom location and security codes, room numbers, break schedule and more.

Leaders also hired senior year nursing students who were completing clinical rotations as student nurse technicians. These nurses-in-training provided valuable support to existing staff and were actively recruited to work at YNHH following graduation.

Seeking out feedback and building trust

Distributing work in this way necessitated open communication on the part of leadership and among care teams. Williams and nurse leaders held informational forums with the nursing staff as the models were being created to explain how the care model was developed and could be implemented safely. Toolkits were developed to assist units receiving support staff and to help the charge nurses in how to best assign them with other team members. At the beginning of each shift, the team defined roles and responsibilities based on members' clinical expertise and practice scope. They filled out worksheets to safely assign care tasks to team members while also allowing for the clustering of care.

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Amid burnout and severe emotional distress, nurses voiced concerns about personal protective equipment (PPE) shortages, exposure risks and deployment to different practice settings. Williams ensured that leaders were available to listen to nurses' concerns and to raise those concerns in daily leadership meetings. In response, leaders listened to staff concerns and used that feedback to continuously improve YNHH's team-based staffing model.

Williams also ensured that bedside nurses were part of every major leadership decision At the onset of the pandemic William's committed to sustaining the YNHH nursing professional governance (NPG) structure that had been in place for years and ensured the voice of the clinical nurse remained active throughout the pandemic. NPG leaders at YNHH collaborated with informatics to develop an electronic platform to enable all nurses to share best practices, advances and resources across practice areas. The NPG team also worked with other interdisciplinary team members to address issues such as management of diabetic patients, meal delivery and engaged in new policies and procedures to support their colleagues. Williams ensured that NPG leaders could dedicate time to this work, which ultimately fostered trust among nurses and leaders.

Unexpected opportunities

The need to conserve PPE and cluster care necessitated the adoption of technology in the patient care areas and changing how staff communicated with patients and families through the use of portable video conferencing tools such as IPADs. Connecting the mobile phones between caregivers and the ability to observe and communicate with patients remotely in their rooms helped with workflow and conservation of PPE. This area remains an opportunity for further adoption and enhancement post the pandemic and efforts are underway across the health system.

Cataloguing the lists of available staff and corresponding clinical experience was time consuming but necessary for assignments in the alternate care model. Leaders would have benefited from a database that listed YNHH nurses' competencies and experience instead of having to source that information themselves and following the initial surge an electronic inventory was developed across the system.

Lessons learned

Nearly two years since the initial peak of the pandemic, YNHH nursing continues to use variations on its team-based staffing model helping both leaders and staff to embrace a truly team-based mindset, or, as Williams says, "functioning as one." For example, for the first-time in the hospital's history, leaders deployed nurses from surgical units to support obstetrics nurses. And

nurses without emergency department (ED) training aided ED nurses during a time of excessive volume by managing intravenous therapy, observing patients, assisting with meals or administering medication, among other tasks, to free up ED nurses.

Williams and other nurse leaders have sought volunteers from across the organization to support these areas in need during peak volumes. The success has been in part because they prioritized the volunteers' needs, especially when it came to scheduling. For example, leaders crafted flex shifts to suit nurses whose schedules could not accommodate a full traditional shift.

"We always wanted nurses to fit into our mold because that's just the way it was," Williams said. "Now, the market demands that we respond to their needs first. We've got to meet people where they are." At YNHH, this meant taking as many volunteer hours that nurses and other roles were available to give, even if those hours only amounted to a four-hour support role shift. This flexibility encouraged volunteers to sign up.

In addition to the value of teamwork, leaders learned that a flexible workforce is essential, especially in these uncertain times. They have also found that valuing nurses' feedback and addressing their needs makes for a committed, high-performing staff. Perhaps the strongest reminder is that it is always optimal to engage those closest to the problem or challenge when engaging in new practice, policy or change.