

Nurse Workforce Environment Staffing Councils:

An Innovative Approach

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To avoid unnecessary staffing legislation, nurse leaders are in a key position to guide policy makers. A key strategy to engage their staff can be implementing healthy work environment (HWE) councils that are empowered to make recommendations and decisions to drive policy at the organizational level and potentially across the health care continuum. In this article, the nurse's HWE is defined, the evolution of staffing legislation is reviewed, and an innovative approach regarding the HWE inclusive of nurse staffing is discussed.

In the quest to ensure safe registered nurse (RN) staffing, several states have enacted legislation. The driver for states to legislate policies was based on established literature that nurse staffing is associated with both nurse and patient outcomes.¹ Although examining the association between nurse staffing and patient outcomes has been studied, focusing primarily on staffing has inadvertently minimized the importance of a healthy work environment (HWE). A HWE is defined as one in which members of the health care team have good working relationships, nurses are involved in decision making, and the organization listens to and responds to patient care issues of concern identified by nurses.^{2,3} Extensive research over the last couple of decades reflects the gains in our understanding of the relationship between nurse staffing, the delivery of safe and quality care, and the HWE.⁴

To avoid unnecessary staffing legislation nurse leaders are in a key position to guide policy makers. This can be accomplished by sharing experiences and ideas, and crafting policy that will best address the needs of RNs to deliver safe quality care in their organizations. Notably, the Institute of Medicine report entitled *Keeping Patients Safe: Transforming the Work Environment for Nurses* validated the important role of nurse leaders in creating HWE that are conducive to patient safety.⁵ Nurse leaders must encourage RNs to see beyond a number and educate them that a HWE plays a significant role in the ability to provide quality care.⁶ A key strategy to engage their staff can be implementing HWE councils that are empowered to make recommendations and decisions to drive policy at the organizational level and potentially across the health care continuum. In this article, the nurse's HWE is defined, the evolution

of staffing legislation is reviewed, and an innovative approach regarding the HWE inclusive of nurse staffing is discussed.

HEALTHY WORK ENVIRONMENT

The HWE was conceptualized based on earlier research pertaining to the professional practice environment as well as the nurse practice environment. In the seminal work exploring why some hospitals are good places for nurses to work, the professional practice environment was cited, by both staff nurses and leaders, with the integral components of quality staff and staffing, autonomy, professional recognition, respect, and "the ability to practice nursing as it should be practiced."^{7(p.92)} After more than 30 years, the HWE is defined as an environment that is safe, empowering, and satisfying where amid all health care leaders, workers, and ancillary staff, "professionalism, accountability, transparency, involvement, efficiency, and effectiveness" exists.^{6,8(p.555)} A HWE enables employees to meet organizational goals, have personal satisfaction in their work, and have an economically and socially productive life.^{9,10} Nurses function fully within their abilities to provide for safe and quality patient care and support optimal health and safety for both patients and nurses.⁹ Also, a HWE is a collaborative and productive setting where the nurses and other health care staff are free from physical and psychosocial harm.^{6,11} HWEs are also associated with lower rates of adverse patient outcomes (i.e., failure-to-rescue).³

Implementing a HWE in hospitals is complex. In 1996, the Institute of Medicine issued a report on the adequacy of nurse staffing, recommending that research examining the relationship between quality of care and nurse staffing levels and mix should consider

organizational variables such as HWE.¹² In 2015, the American Nurses Association (ANA) recognized the importance of a HWE for staff and patients, and stated that the critical delivery of quality patient care relies on the identification and maintenance of appropriate number and mix of nursing staff. According to the ANA, when health care employers fail to recognize the relationship between nurse staffing and patient outcomes, laws and regulations become necessary.¹³

EVOLUTION OF STAFFING LEGISLATION

Several states have already passed staffing legislation to address staffing concerns in hospitals. This legislation tends to fall into 1 of 3 general categories: one, nurse-to-patient ratio; two, implementation of a staffing committee; and/or three, public reporting of nurse staffing levels. In 1999, California became the first state and only state in the country to pass legislation enacting minimum nurse-to-patient staffing ratios, at all times, in acute care hospitals, with the goal of improving the quality of patient care.¹⁴ Massachusetts passed a law specific to intensive care units requiring a 1:1 or 1:2 nurse-to-patient ratio depending on acuity of the patient.¹³

There have been several studies since the implementation of California's nurse-to-patient ratio mandates to examining the relationship between staffing and nurse-sensitive patient outcomes. Some evidence suggests that total nursing hours and skill mix affected some important patient outcomes such as patient mortality.³ However, the first 6 months' post-ratio evidence did not reveal statistically significant changes in patient safety, quality outcomes, incidence of patient falls, and prevalence of pressure ulcers.¹⁵ In 2013, Serratt¹⁶ conducted a systematic review of the empirical literature from the time the ratios were implemented in 2004 until 2012 to identify studies exploring patient-level outcomes. The findings from most of these studies do not support the assumption that increases in nurse staffing ratios would lead to better quality of care, improvements in patient safety, or increased patient satisfaction.¹⁶⁻¹⁸ Since California's implementation of nurse-to-patient ratios, no other states, to date, have replicated the staffing ratio requirements exactly like California.

The second legislative approach requires hospitals to have a nurse-driven staffing committee. Seven states require hospitals to have staffing committees responsible for plans (nurse-driven ratios) and staffing policy: Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington State. One state, Minnesota, requires a chief nursing officer (CNO) or designee to develop a core staffing plan with input from others, and whereas this is viewed as less stringent, it appears to be a modified version of a staffing committee. Staffing committees are made up of formal structures and processes that give clinical nurses a respected voice to determine human and environmental resources

needed to provide the best care to patients. It creates a forum for clinical nurses to participate in nurse staffing decision making. The committees create staffing plans that reflect the needs of the patient population and match the skills and experience of the staff. Although there are some differences among participating states' requirements, the common components in the staffing committee regulation is to have direct care RNs and leaders (e.g., nurse managers and chief nursing officers) develop nurse staffing plans.¹⁹⁻²¹

Since passage of the Nurse Staffing statute in 2009, Texas implemented hospital staffing committees consisting of 60% peer-selected, direct care nurses who meet at least quarterly to develop and evaluate the nurse staffing plan.²² Post-legislation, researchers found that after the implementation of staffing committees, there was an increase in RN and total nurse staffing, a decrease in LVN staffing, and an increase in RN skill mix among 313 acute care hospitals.^{22(p.79)} However, the effect of the increase in Texas total nurse staffing on nurse and patient outcomes has not been studied.

Finally, a third approach requires facilities to publicly report/disclose staffing patterns to a state agency or make the staffing information public. Five states require some form of disclosure and/or public reporting: Illinois, New York, Rhode Island, Vermont, and New Jersey. Massachusetts also provides public disclosure of staffing levels; however, their process is voluntary. Among these states that do mandate public reporting, New Jersey has the most transparent process for hospital providers and consumers. Beginning in 2008, NJ hospitals publicly disclosed direct care staffing levels within the facilities and reported staffing-level information to the NJ Department of Health and Senior Services pursuant to N.J.A.C. 8:43G. Interestingly, there were no press releases in NJ when the legislation was mandated, therefore, the public may be unaware about the purpose of this legislation. In preliminary analyses of NJ public reporting, RN staffing has improved among 10 of 13 nursing specialties.²³

AN INNOVATIVE APPROACH

The Organization of Nurse Leaders New Jersey (ONL NJ) recognized the HWE as a multidimensional concept with staffing as only one variable related to outcomes. Although there is evidence linking staffing ratios to outcomes,^{24,25} these nurse leaders realized that the HWE, nurse education and competency, and patient acuity also impact nurse and patient outcomes. Additionally, the Institute of Medicine report entitled *Keeping Patients Safe: Transforming the Work Environment for Nurses* validated the important role of nurse leaders in creating healthy work environments that are conducive to patient safety.⁵ When staffing legislation was recently introduced in New Jersey requiring specific staffing ratios for all nursing units within hospitals, ONL NJ members took the opportunity to meet with the New Jersey senators and

Table 1. Six Standards for Successful Establishment of a Healthy Work Environment

<i>Skilled communication</i>	The competency of being able to communicate effectively are equally as important as clinical skills
<i>True collaboration</i>	The process of true collaborations involves recognizing and valuing the unique knowledge and abilities of other health care team members and their contribution to quality patient care
<i>Effective decision making</i>	Throughout the organization, nurses must be involved in making decisions about their own practice and patient care
<i>Appropriate staffing</i>	The match between patient needs and nurse competencies must be a priority to improve patient outcomes and nurse satisfaction
<i>Meaningful recognition</i>	Mutual respect through mutual recognition must be implemented to promote the value each person brings to the organization
<i>Authentic leadership</i>	The success of a HWE is portrayed through the nursing leadership of an organization. Nurse leaders must embody the HWE standards and engage others and embrace each standard through daily activities

assemblymen/women to educate them about hospital nurse HWE and outcomes. When contemplating their recommendations for the legislators, ONL NJ elected for a proactive response to implement HWE councils at their respective hospitals. Inspired by the American Association of Critical Care Nurses (AACN) *Standards for Establishing and Sustaining Healthy Work Environments*,¹¹ 5 nurse leaders self-selected to pilot a nurse-driven framework for a HWE inclusive of nurse staffing in their organization. The councils were named the Nurse Workforce Environment Staffing Councils (NWESC).

AACN NURSES FRAMEWORK

In response to a growing body of evidence demonstrating the link between HWEs and patient safety, clinical outcomes, and staff retention, the AACN created the AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence.^{11,26} This framework supports the relationship between excellent nursing practice, quality of work environment, and appropriate staffing. The nurses, the patients, and their environment are interdependent to achieve a healthy patient environment and a healthy working environment for the nurses.¹¹ The framework also affirms the interdependence of the 6 standards, which are described in [Table 1](#), and include skilled communication; true collaboration; effective decision making; appropriate staffing; meaningful recognition; and authentic leadership ([Figure 1](#)).

NURSE WORKFORCE ENVIRONMENT STAFFING COUNCIL

The 5 CNOs with facilitation from ONL NJ, and 3 nurse researchers aimed to develop and implement NWESC at 5 participating hospital systems. The NWESCs were developed with the goal of ensuring optimal patient outcomes. Hence, each NWESC af-



Figure 1. Standards for Establishing and Sustaining Healthy Work Environments²

firm that every patient deserves high-quality nursing care that is grounded in competency, research, and best practices, and delivered in a safe and efficient manner; and nurses are central to the establishment of safe practice environments in which they collaboratively determine the resources needed to provide optimum quality nursing care that also enhances patient satisfaction. The overall purpose of the NWESCs was to provide a formal, collaborative structure and process that gives clinical nurses (staff nurses) a respected voice in the determination of human and environmental resources needed to deliver best care to patients. The objectives for the NWESCs are to establish a safe work environment in

Table 2. NWESC Structure, Responsibilities, and Resources NWESC

<i>Structure</i>	<ul style="list-style-type: none">• Council consists of nurse manager/leaders and clinical nurses, with at least 51% clinical nurses who spend at least 50% of their work time in direct patient care.• CNO or his/her delegate is the chairperson of the council and a voting member of the council.• Council must meet at least quarterly, and preferably, monthly
<i>Responsibilities</i>	<ul style="list-style-type: none">• Council members must go through a formal committee education/orientation process based on the AACN Standards for Establishing and Sustaining Healthy Work Environments.• The NWESC has formal, defined methods to communicate their work to the full nursing department.
<i>Resources</i>	<ul style="list-style-type: none">• The council has ready access to pertinent organizational data.

which nurses collaboratively determine the resources needed; to formally give clinical nurse care providers a voice in human resource allocation; and to provide a forum for participative leadership for nurse staffing decision making.

Before starting the NWESCs at the 5 pilot hospitals, the nurse leaders understood the importance of preparing the clinical nurses for participation on these councils based on the experience of nurse leaders in other states.²⁰ Hence, each NWESC consists of 51% clinical or direct care nurses and provides a forum for dialogue and discussion about the staffing between the nurse leaders and clinical nurses. The council provides an opportunity for the clinical nurses to discuss their unit work environment and for the nurse leaders to provide education on the budgetary process. The nurse leaders believe the NWESCs will create a healthier work environment, allow nurses to have a voice about their unit work environment, and foster professional autonomy, whereas legislating mandatory staffing ratios would dictate a static number of nurses along with considerable loss of professional autonomy.

In addition to ONL NJ, this approach is supported by a coalition of professional nursing leadership, including the New Jersey State Nurses Association, the NJ Council of Magnet Organizations, the NJ Council of Deans and Directors, and the NJ Nursing Leadership Council. ONL NJ nurse leaders initiated this pilot program to establish a NWESC made up of clinical nurses and nurse managers/nurse leaders at 5 hospital systems in New Jersey. The NWESC was integrated into the fabric of each organization, and as such, endorsed the use of equal participation of staff in collaboration with management to understand, review, and recommend nurse staffing patterns. The nurse leaders of this pilot project established the basic criteria for the NWESC (*Table 2*). The CNOs also solicited

nurse managers/leaders and clinical nurses' volunteers who were willing to participate in the pilot.

Prior to implementing the NWESC, 4 all-day education sessions were held for clinical nurse and nurse leader members. The first education session, held in October 2017, consisted of an overview of the NWESC pilot program, the council structure, legislation on staffing, research on the HWE, AACN standards for HWE, and a panel discussion with the nurse leaders from the 5 pilot hospitals. The second and third educational sessions were conducted in February and March 2018, and included in-depth discussions of the AACN standards for HWE standards along with networking and discussion of the NWESC's progress thus far at each hospital. The final education program in June 2018 was a workshop with each NWESC presenting a work activity they created based on 1 of the 6 elements of the AACN framework.

IMPLICATIONS FOR NURSE LEADERS

The HWE, inclusive of staffing, is central to both nurse and patient outcomes. Nurse leaders need to implement a NWESC in their organization, to avoid legislation that may be prescriptive. Nurse leaders need to be active in their professional organizations in order to stay up to date with the latest trends, evidence-based research, and changes in health care. Professional organizations, such as ONL NJ, provide nurse leaders with the medium and the opportunity for networking with colleagues about new ideas, processes, innovations, and challenges at their organization. Two years ago, nurse leaders gathered through ONL NJ, learned about impending legislation, and proactively took an approach to simultaneously address the HWE and staffing. These discussions led to the creation of forums in which to exchange ideas and to the development of the NWESCs.

In addition, nurse leaders must engage clinical nurses about the importance and key elements of a HWE.

Thus, education and empowerment of clinical nurses is also crucial in creating a HWE. As respected and trusted health care professionals, nurse leaders are positioned to drive transformative health care policy initiatives. Because nurses have the power to influence legislators on key issues that affect the shaping of health care policy, they must take the lead to meet and discuss the health care bills with their legislators. As ONL NJ learned when they met with their senators and assemblymen/women, who had backgrounds in fields other than health care, legislators were eager to listen to the nurse leaders' viewpoint and engage in dialog. Thus, when nurse leaders are current on proposed legislation and policy issues, they can, in a timely manner, directly impact and guide the future of their organization, rather than responding to legislation that may burden an already financially strained nursing budget.

CONCLUSION

Although legislation addressing RN staffing may appear to improve patient care, it may not have the desired effect it purports to achieve. Although many clinicians may view staffing legislation as a "quick fix," these RNs may not consider the unintended consequences. In this era of a changing health care system, a better approach would be to foster a HWE inclusive of skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership. Failure to consider these standards for establishing and sustaining a HWE will most likely lead to the inevitable burden on health care providers which in turn can trickle down and negatively affect patient care. In summary, taking an innovative approach, such as done by ONL NJ in establishing NWESC, will result in clinical nurses having a voice in establishing a HWE that can lead to an improvement in patient care and may prevent unnecessary regulation at both the state and national level.

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