Utilizing Nurse Staffing Committees to Engage Direct Care Nurses in Developing Alternative Shift Lengths

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Nurses working 12-hour shifts report higher job dissatisfaction, burnout, and fatigue than nurses working shorter shift lengths. This article describes the implementation of a new 9-hour shift staffing model created by leveraging the engagement of frontline nurses on a nurse staffing committee.

Nurse fatigue is a growing concern in health care organizations. One factor theorized as contributing to nurse fatigue is the use of 12-hour shifts. Even though nurses value the flexibility offered by 12-hour shifts, nurses working these hours report higher job dissatisfaction, burnout, and fatigue.[1-3] Changing nurse shift length seems daunting when nurses prefer this model, and yet the dissatisfaction and fatigue needs to be addressed.

NURSE STAFFING COMMITTEES

Staffing Committee Laws

Many states have enacted legislation around nurse staffing. Many organizations and nurse leaders are currently debating the issue around mandated staffing ratios. The impact of adequate nurse staffing on patient outcomes and overall quality outcomes is well researched. Fourteen states currently have nurse staffing legislation.[4] Seven states require hospitals to have nurse staffing committees, including Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington.[4] California is currently the only state mandating nurse–patient ratios throughout all units. Massachusetts has set mandated ratios for their intensive care units only. The American Nurses Association position statement says they support legislative models where nurses are empowered to create staffing plans.[4] The American Hospital Association, in their white paper "Reconfiguring the Bedside Care Team of the Future," mentions moving away from a ratio-based mindset due to the various factors impacting patient care.[5] This means creating teams to redefine the bedside care team. Nurse staffing committees composed of direct care staff are well positioned to meet the demands of these various factors when given the autonomy to develop initiatives to address them.

Texas currently has legislation requiring nurse staffing committees. The Health and Safety Code for the licensing of health facilities in Chapter 257 requires that organizations have a nurse staffing committee comprised of at least 60% registered nurses who provide direct patient care at least 50% of their work time and are selected by their peers.[6] The committee is charged to develop and recommend a nurse staffing plan, respond to staffing concerns, discuss and identify nurse-sensitive outcomes, evaluate the effectiveness of the staffing plans, and report to the hospital's governing body.

Engaging the Staffing Committee to Implement Change

Nurse staffing committees can have a significant impact on the ability to implement change in an organization. At Midland Memorial Hospital in Midland, Texas, the Nurse Staffing Advisory Council is a robust group of direct care nurses who work in partnership with the chief nursing officer and other nurse leaders within the organization to discuss and develop solutions for nurse staffing concerns. Involvement of the chief nursing officer and other unit directors who oversee the budget and nurse staffing are key success factors in engagement of direct care nurses. Many initiatives have been developed within this group.

The inpatient units were experiencing an increase in safe harbor submissions. Safe harbor is a type of peer review initiated by a registered nurse, license vocational nurse, and advanced practice nurse. The nurse initiates safe harbor before accepting an assignment when the nurse feels the task would put patients at harm, causing the nurse to violate the duty to the patients.[7] Complaints regarding nurse fatigue and staffing concerns were voiced to nursing leadership. A further review of the National Database of Nursing Quality Indicators (NDNQI) nurse satisfaction survey revealed the percentage of nurses working >13 hours on their last shift was 10.18%. This was above the mean of 3.88% of all comparison hospitals. On the question regarding nurses feeling each day on the job would never end, the response was 4.24, slightly above the mean of other comparison hospitals at 4.13. The responses ranged on

Table 1. NDNQI RN Satisfaction Survey Comparison (2016 vs. 2017)

NDNQI Question	Pre Survey Result 2016	Mean	Post Survey Result 2017	Mean 2
"I feel my day on the job will never end"	4.11	3.84	3.88	3.83
Job enjoyment	4.33	3.87	3.84	3.89
"I have to force myself to come to work"	4.89	4.08	3.88	4.03

a Likert scale from 1 = strongly disagree to 6 = strongly agree. The team felt there was room for improvement. Approximately 25% of nurses were working overtime. The chief nursing officer worked with the nurse staffing advisory council to develop an action plan. The plan included creating a workgroup to complete a literature review of research regarding shift lengths.

Two direct care nurses volunteered to be in the workgroup. Both participated in reviewing research and outcomes related to shift length. One nurse voiced how she was against any change in shift length away from the 12-hour model. However, after participating in and understanding the outcomes related to 12-hour shift work, she felt there needed to be an alternative. This change in perspective helped in communicating the changes to other direct care staff. With the information coming from their peer and not from leadership, the nurse was able to gain a momentum of support. After completion of the literature review, the 2 nurses helped to develop a presentation of the findings and then presented it to the nurse staffing advisory council. Out of this work, 1 of the nurses in the workgroup developed a 9-hour shift model. Armed with the data and the new staffing model, the other nurse from the workgroup took the information back to her unit-based council to present the findings. The unit-based council decided to trial the 9-hour shift model in their unit.

MAKING THE CHANGE

The Staffing Model

In May 2017, the small 12-bed oncology unit implemented the 9-hour shift staffing model. The model was ideal because it only increased the work week by 1 day, still allowing 3 days off each week. This was preferred to the 8-hour shift model requiring a return to the 5-day work week. Another benefit of the 9-hour shift model was a 1-hour overlap between shifts. The theory was the extra time would allow for completion of tasks and more time for bedside rounding.

Implementation

A quality improvement project implementing a 9-hour shift model started May 14, 2017, on the small 12-bed oncology unit. The aim of the project was to reduce job burnout and fatigue by decreasing the shift length for registered nurses working in an acute care facility. The director and clinical manager over the unit supported the project and were key in the successful implementation. All nursing staff working within the unit were scheduled the 9-hour shifts. Each staff member could choose their preferred shift. The shifts included day (7 a.m. to 4 p.m.), evening (2 p.m. to 11 p.m.), and night (10 p.m. to 7 a.m.). Initially, the evening shift needed additional assistance, so the internal float pool staff (resource team) was utilized. The resource team staff members also worked the 9-hour shift although their normal schedule was a 12-hour shift.

Outcomes

Several evaluation methods were used to determine the outcomes of the project. A comparison of the 2016 NDNQI RN Satisfaction Survey was made with the 2017 survey completed after the implementation of the 9-hour shift model. Three questions under the job enjoyment section of the survey were used (*Table 1*). Improvement was seen in 2 of the questions, including feeling each day on the job would never end and feeling like they had to force themselves to come to work. The job enjoyment question result decreased from the previous survey. All results were based on a Likert scale from 1 = strongly disagree to 6 = strongly agree.

The Maslach Burnout Inventory survey was administered during the 9-hour shift implementation. The Maslach Burnout Inventory measures perceived burnout, and the human services version is the most widely used.[8] The MBI Human Services Version consists of 3 scales including emotional exhaustion, depersonalization, and personal accomplishment. This survey has been used in other research measuring burnout and shift length, and is a well-known, validated survey.[2,8] A total of 8 nurses took the survey. All the nurses who left the unit were part of the 8 responses. For emotional

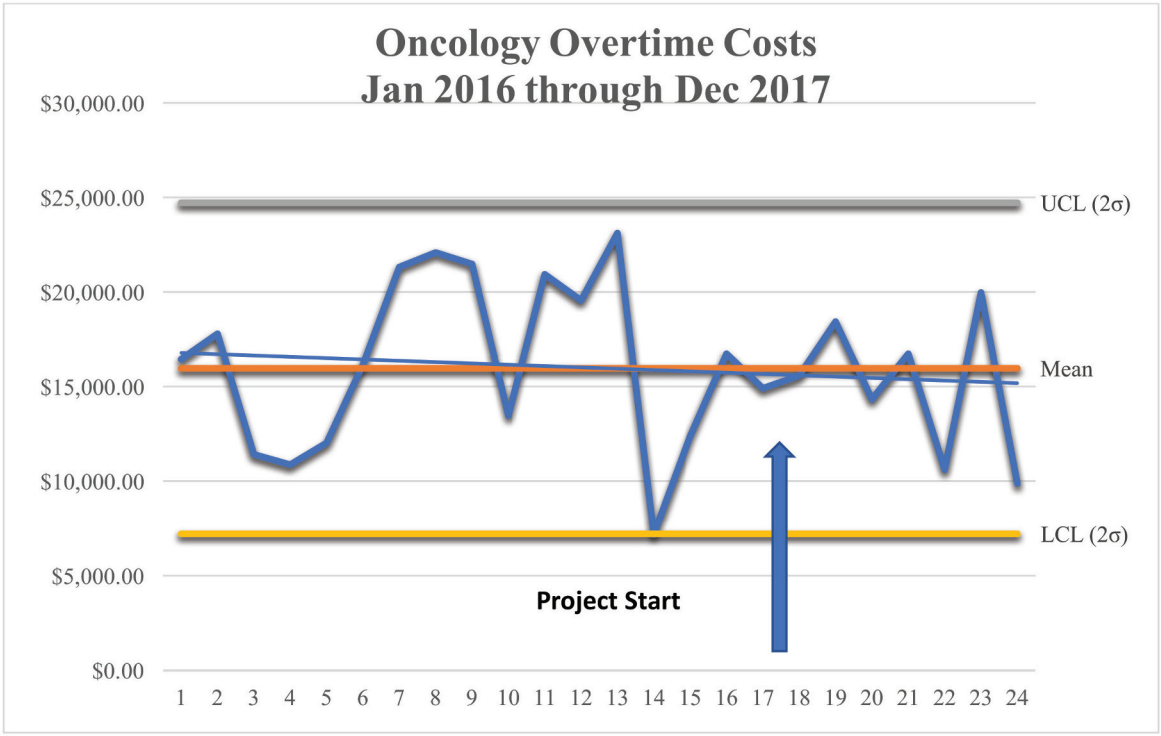

Figure 1. (Color Reproduction) Overtime Costs – 24 Month Comparison

exhaustion and depersonalization, the higher the score, the higher the burnout. For personal accomplishment, the lower the score, the higher the burnout.[8] The emotional exhaustion score was 18 out of a possible 54. The depersonalization score was 4 out of a possible 30. The personal accomplishment score was 40 out of a possible 48. Therefore, the perception of burnout by the nurses during the 9-hour shift model was low.

Nursing turnover during the implementation was high at 46%. Due to the small number of nursing staff, any turnover was significant. Five of the 11 nurses left for another role within the organization. Two of those nurses were promoted to a manager role. Another nurse left for a role that includes alternative shifts working four 10-hour days. Therefore, 3 of the 5 nurses left to work alternative shift lengths or salary positions. One consistent complaint during the project was the inability of nurses to pick up additional shifts to get overtime. Several discussed how this negatively impacted their financial situations.

Control charts were used to monitor overtime and salaries and wages during the project implementation (*Figures 1 and 2*). Overtime decreased; however, the changes were not statistically significant. Although not statistically significant, there is a clinical significance to the decrease in overtime. During the 9-hour shift model implementation, overtime was more in control than with the 12-hour shifts. Although overtime costs were lower and more controlled, salaries and wages saw a significant increase. Some of this was due to the use of additional premium paid staff (resource team) to account for the nurse turnover.

The actual time worked after the scheduled shift was lower after implementation of the 9-hour shift model. With the 12-hour shifts, nurses were staying up to 15 hours a day on average when scheduled. With the 9-hour shifts, nurses were staying only 10 hours a day on average when scheduled.

IMPLICATIONS

Nurse staffing committees, when used as intended, can create innovative and impactful changes in the work environment. At Midland Memorial Hospital in Midland, Texas, the use of the nurse staffing council to engage direct care nurses resulted in a change to shift length on a small 12-bed oncology unit. Although some nurses still preferred a 12-hour shift model, the implementation of the 9-hour shifts was successful. Perceived burnout was low during implementation although a cause–effect relationship cannot be made due to the lack of a pre-project Maslach Burnout Inventory survey. The small sample size should be considered when piloting new ideas. Overtime costs were more in control, and further research should be done to determine the financial impacts of changing shift length models. Other considerations include health impacts of shift lengths on nurses, patient satisfaction related to shorter shift lengths, and more research on patient outcomes when nurses work shorter shift lengths compared with 12-hour shifts or longer. Shift length is a complex issue. Although changing shift lengths helped reduce the nurse's perception of burnout, they did not like the decrease in ability to work overtime.

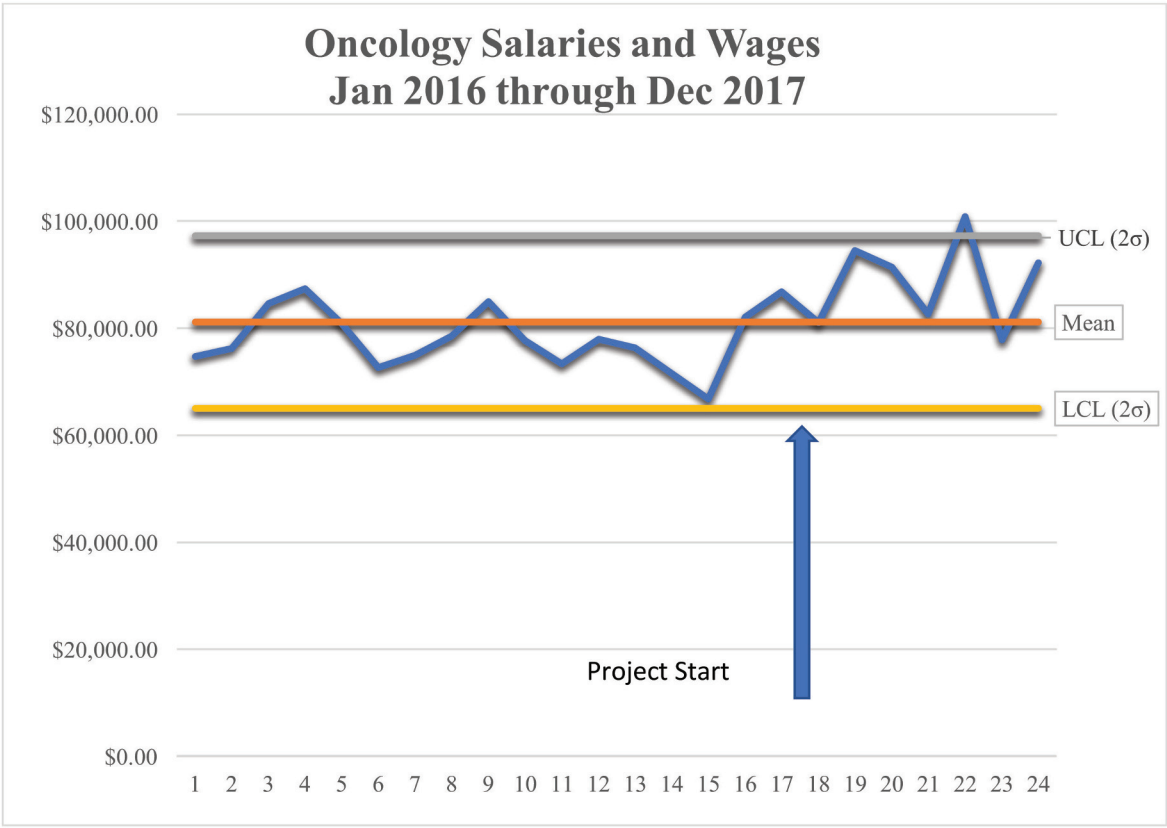

Figure 2 (Color Reproduction) Salaries and Wages Costs – 24 Month Comparison

CONCLUSION

Nurses prefer 12-hour shifts due to the flexibility they provide. However, nurse fatigue is a growing concern, and leaders need to develop processes to improve fatigue, burnout, and job dissatisfaction among nursing staff. Utilizing staffing committees where direct care nurses have opportunities to engage in staffing decisions is imperative to making impactful change.

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