White Paper

EMERGENCY PREPAREDNESS

Is Nurse Staffing the Weakest Link?

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fastaff
Travel Nursing

Emergency Preparedness: Is Nurse Staffing the Weakest Link?

Preparing for the unknown can be complicated; a hospital's best defense is creating emergency preparedness protocols for a wide variety of "what if" scenarios. One foreseeable need in the face of any public health emergency— from natural disasters to industrial accidents—is the ability to quickly add experienced nurses to existing hospital staff. The right staffing solution is crucial to effective disaster response.

The business of healthcare relies on predicting the unpredictable. Hospital executives and managers of various departments use budget forecasts, predictive modeling, and analyses of historical trends to plan strategically. They study seasonal variations in admissions rates and assess patient acuity daily to inform staffing decisions and aim for optimal nurse-patient ratios. And, quite often, they can pinpoint a formula that works well for them—at least, until disaster strikes.

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The ever-present possibility of a catastrophic event means hospitals must be nimble enough to respond quickly and appropriately to emergencies. This can leave budget-minded and patient safety focused executives in a vulnerable position, particularly if they are operating lean when it comes to nurse staffing. What happens when a hospital is staffed at (or just above) average capacity, and a public health emergency (PHE) befalls the community it serves? A PHE can be any type of unplanned event that results in significant illness, injury, or death—in other words, an event that expands patient volume rapidly. This includes acts of terrorism, natural or manmade disasters, infectious disease epidemics, industrial accidents, transportation related accidents, etc.

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The Agency for Healthcare Research and Quality (AHRQ) stresses that surge capacity—defined as a health system's ability *to expand quickly beyond normal services* to meet an increased demand for medical care in the event of a PHE—is critical to emergency preparedness.[1] As worries about bioterrorism and global pandemics have emerged in recent years, the emphasis on preparedness has grown. As a result, there have been efforts to "operationalize" surge capacity so health systems and communities can respond more effectively to disasters. An often-cited report by Barbish and Koenig from

2006 recommends a systems approach that strives to seamlessly integrate the four essential elements of surge capacity:

- Systems (policies and procedures)
- Structure (facilities and space)
- Stuff (equipment and supplies)
- Staff (trained personnel)[2]

When it comes to personnel, nurses are an essential component of emergency preparedness and disaster response. It makes sense that nurses are on the frontlines when a PHE strikes, as they are the largest workforce segment in the U.S. healthcare industry.[3] Nurses are necessary to triage incoming patients, support physicians on trauma teams and surgical teams, care for admitted patients, and potentially administer vaccines in the event of bioterrorism or an infectious disease epidemic. Both the AHRQ[4] and the Institute of Medicine (IOM)[5] state that effective public health and disaster response systems rely on hospital-based nursing personnel.

Yet, experts caution that nurse staffing is all too likely to become the weakest link in the emergency-preparedness chain.[6] And even under normal conditions in today's hospitals, it is routine for hospital departments to operate at the outer limits of their capacity. This makes them critically dependent on other departments, eliminating buffers that may have previously accommodated a temporary surge in demand. Operations experts call this condition of tight-coupling between systems and departments "going solid" and note that it can increase operational efficiencies when everything is in perfect sync.[7]

Case Study

EBOLA RESPONSE

In the summer of 2014, the lethal Ebola virus made its way to the U.S. and large city hospitals across the nation began preparing emergency response plans for a potential outbreak. Bellevue Hospital Center in New York City was among them, as one of eight hospitals in the state designated to treat Ebola cases. Bellevue's ICU unit was already staffed with Fastaff nurses and they trained alongside the hospital's go-to Ebola team, learning protocols and conducting drills on how to properly use personal protective equipment to prevent transmission of the highly infectious pathogen. In October, a physician contracted Ebola and began receiving highly specialized care in an isolation unit at Bellevue Hospital Center. Fastaff nurses continued to meet the challenge, participating in Ebola drills and remaining ready and willing to care for highly contagious patients in the event of a city-wide outbreak. They went the extra mile in emergency preparedness at a time when panic was at an all-time high.

However, going solid when nurses are understaffed can result in patient flow challenges, e.g., surgical patients being monitored at the Operating Room because the Recovery Room is understaffed or full,[8] or patients being boarded in the Emergency Department while waiting for a staffed bed to open in a Critical Care Unit.[9] When the ED is over capacity under normal conditions, it has no surge capacity in the event of a PHE.[10] In a nutshell, while going solid is often favored by hospital administrators as a way to operate more efficiently, it also raises the stakes during an emergency. Bottlenecks occur, forecasting and control become harder, clinicians may start making decisions based on the availability of beds, and the likelihood of medical errors increases.[11]

It's clear that nurse understaffing is not an option during a PHE and that hospitals need a standby plan for staffing to surge capacity. The AHRQ notes that disaster planning *must include a plan for pulling in previously*

untapped human resources and making sure they are adequately trained.[12] Experts recommend pulling in supplemental staff, including retired nurses and travel nurses, to meet a temporary demand for emergency medical care.[13/14] Yet it's important to note that retired community nurses available to help in the event of an emergency often cannot cover critical units, such as ICU, NICU, PICU, CVOR, OR, ED, and CVICU. Maintaining core staff for the existing patient population in these areas is crucial, particularly when nursing staff is being reassigned to meet increased demand for emergency services. Disaster response requires adding highly skilled nurses who can report to work immediately and hit the ground running in a specialty area, with little to no orientation—which is not always an easy staffing solution to come by.

The need to expand nursing staff quickly in the face of a PHE can be met by partnering with Fastaff, the pioneer and industry leader in Rapid Response® travel nurse staffing solutions. While planning for the unknown may seem like an impossible task—particularly for health organizations in rural or low-population areas—including Fastaff in an emergency preparedness plan can cover a wide variety of "what if" scenarios. For more than 25 years, Fastaff has delivered experienced nurses, ready to hit the ground running in hard-to-fill specialties for rapid deployment, often in 10 days or less. While a facility's needs will vary depending on the nature of a PHE, it will always be crucial to maintain proper staffing levels throughout the hospital. Fastaff nurses are highly specialized; more than half of the nurses in Fastaff's deep database work in a hard-to-fill specialty (see figure 1) and can provide continuous coverage in all of the most critical units, including the following:

- **Emergency Room:** This is the main point of entry in the event of a disaster. Experienced trauma nurses are critical for triage and to support physicians.

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Case Study

HURRICANE HARVEY

Following the devastation of Hurricane Harvey, and facing a dangerously high patient to nurse ratio in the NICU, a major hospital system contacted Fastaff to request a large number of experienced NICU III nurses in 48 hours. Fastaff interviewed and hired the nurses directly, including arranging transportation to Houston. Without yet knowing the full extent of the impact, the hospital needed operational flexibility with the contingent nursing staff, opting for two-week assignments rather than the traditional travel fixed length of 13-weeks. The first nurses arrived in Houston the following day, with the remaining nurses on the ground within 48 hours. Fastaff flew the nurses into Dallas, then transported via bus to Houston, where a National Guard helicopter carried them to the facility. The hospital's NICU III was kept fully operational 24/7 during the devastating flood.

- **Critical Care:** Intensive care units require highly skilled, specialized nurses to care for the most critical patients. They often call for a nurse-to-patient ratio of 1:1 or 1:2, making staffing a challenge when patient volume increases, particularly in rural hospitals.
- **Surgical Services:** During an emergency, all operating rooms and post-anesthesia monitoring areas may be in operation 24 hours a day, requiring additional surgical staff at every level.
- **Obstetrics and Neonatal:** Babies continue to arrive, even when obstetrics staff are reassigned during an emergency, and maternal hospitalizations have been known to rise during influenza pandemics.[15] Skilled staff is essential for NICU, LDRP, and MB/PP units when demand for these services surges.

In times of increased volume or increased demand for particular nursing specialties, operating with lean staffing can pose severe risk to a facility. Adding experienced nurses to existing core staff not only provides continuous, high-quality care, but also allows appropriate relief and rest for core staff throughout the PHE duration.

Planning to meet surge capacity with additional nursing staff should be at the forefront of all emergency protocols. The occurrence of a PHE is rare and hospitals may never use an emergency staffing contract. However, in the event a PHE happens, hospital executives will not have the time or resources to negotiate a contract or orient supplemental nurses to their staffing requirements. Preparing in advance by executing a staffing contract in the event of an emergency provides a trusted plan in the wake of chaos. To establish an emergency preparedness staffing plan, follow these easy steps:

1. **Email our client services team at HelpNow@Fastaff.com.**
2. **Initiate the insurance policy having a contract executed in the event of a PHE.**
3. **Let Fastaff evaluate your needs.**

Case Study

IMPERIAL SUGAR PLANT EXPLOSION

In February, 2008, a violent explosion ravaged the Imperial Sugar manufacturing plant in Port Wentworth, Georgia. As flames illuminated the night sky, local hospitals quickly assembled a response teams.[16] According to the Georgia Emergency Management Agency (GEMA), 62 people were taken by ambulance to local hospitals.[17] After initial triage, more than a dozen people with burns over 30 percent of their bodies were airlifted a burn unit located in Augusta; eight of these had burns over 60 percent of their bodies.[18]

With so many casualties arriving all at once, the facility opened three levels of burn units and triaged patients according to severity of condition. Lacking an adequate number of burn nurses to staff these units, the hospital contacted Fastaff. Several Fastaff Rapid Response® nurses arrived on site within days and worked extended shifts, providing intense coverage for the critical burn patients with no overtime costs to the hospital during the four-week assignment. The facility received the burn staff and expertise it needed, without becoming locked into the standard 13-week assignment length. By utilizing Fastaff nurses, it was able to provide multiple levels of care to the victims of the deadly explosion.

1. https://archive.ahrq.gov/news/ulp/btbriefs/btbrief7.pdf
2. Barbisch, D. F. and Koenig, K. L. (2006), Understanding Surge Capacity: Essential Elements. Academic Emergency Medicine, 13: 1098–1102. doi:10.1197/j.aem.2006.06.041 (https://www.ncbi.nlm.nih.gov/pubmed/17085738)
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2998349/#R64 (U.S. Department of Health and Human Services, 2006)
4. https://archive.ahrq.gov/about/nursing/readiness.htm
5. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2998349/#R36 (Institute of Medicine, 2003).
6. McHugh MD. Hospital nurse staffing and public health emergency preparedness: implications for policy. Public Health Nurs. 2010;27(5):442–9. doi: 10.1111/j.1525-1446.2010.00877.x. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2998349/ [PMC free article]
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11. http://gswong.com/?wpfb_dl=18 going solid and the dynamics of safety
12. https://archive.ahrq.gov/news/ulp/btbriefs/btbrief7.htm
13. Mchugh
14. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No2May09/Articles-Previous-Topics/Surge-Capacity.html
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16. http://www.cnn.com/2008/US/02/08/refinery.blast/index.html?iref=storysearch
17. CNN
18. CNN

"While travel nursing is often seen as an expensive proposition, Fastaff's flexible-length assignment model allows nurses to be deployed only for the time needed, rather than for the fixed 13-week assignment that is common among other agencies."

Figure 1

Hard-to-Fill Specialties

- ✓ **NICU** Including NICU III
- ✓ **L&D**
- ✓ **PICU**
- ✓ **ICU**
- ✓ **ER**
- ✓ **OR**
- ✓ **ED**
- ✓ **CVOR**
- ✓ **CVICU**
- ✓ **ENDO**
- ✓ **HEMO**
- ✓ **Cath Lab**
- ✓ **Pediatrics**
- ✓ **Ped ER**
- ✓ **Case Management**

Kathy Kohnke

With more than 17 years of experience as a former buyer of hospital contract labor, Kathleen Kohnke understands the importance of having a comprehensive emergency management plan ready to activate. Kohnke currently builds staffing strategies for hospital clients nationwide as Fastaff's vice president of client services. She's ready to be your trusted partner in contingency planning.

Kim Windsor, DHA, MSN, MBA, RN

With a well-rounded career in various aspects of healthcare, Dr. Windsor has become a prominent force in clinical operations, hospital administration, risk management, human resources and staffing. Evolving from a staff nurse to the vice president of nursing for a major health system for nearly nine years, Dr. Windsor provided leadership for critical care, operating room, emergency department, pharmacy and medical/surgical units. As the vice president of human resources, Dr. Windsor's experience spanned to cover employee relations, compensation, talent management, benefits and occupational health. With more than 13 years in the staffing industry, Dr. Windsor applied her clinical and human resources expertise to provide insight into identifying quality nursing solutions for hospital systems nationwide. Dr. Windsor is accomplished in her implementation of credentialing standards to meet or exceed qualifications by the Joint Commission, as well as program integrity, risk and managed service programs.


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