EDITORIAL

Care Capacity Demand Management: Safe staffing by numbers?

Whakahaere Tono Kahanga Taurima: He tiaki haumaru mā te tokomaha?

Rhonda McKelvie, RN, BSc(Hons), MN, PhD candidate (doctoral scholar) at Massey University, Palmerston North, NZ

Recently New Zealand (NZ) witnessed the first nursing strike in nearly 30 years – pay and safe staffing were the central concerns. Twelve years ago, the report by the Safe Staffing/Healthy Workplaces Committee of Inquiry (2006) recommended a mechanism for responding to excessive workloads and finding sustainable solutions to safe staffing issues. In 2009, the Care Capacity Demand Management (CCDM) programme began development, as an outcome of an agreement between the District Health Boards (DHBs) and the New Zealand Nurses Organisation (NZNO) to work together on safe staffing and healthy workplaces. Progressive implementation of CCDM into DHBs around the country has been met with varied interest, investment, and results. The August strike highlighted that safe staffing and patient safety remain a major and national issue for the nurses in our public health services.

I have spent a combined 10 years being part of developing and implementing CCDM (2009-2017) and now am researching what has, and has not, been accomplished (2016-2018). I would have to concur with nurses, the research, and the CCDM strategy, that safe staffing all comes down to numbers, but which numbers? Which numbers are the numbers that count?

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Thirty years of research on nurse staffing was built on the simple (and obvious) logic that more nurses at the bedside results in better outcomes for patients (Aiken, 2001). As the research projects grew in size and were published in highly ranked journals, the evidence of a relationship between nursing numbers and patient outcomes (Aiken et al., 2014; Shekelle, 2013) gathered significance; becoming the basis for campaigns for increasing nursing numbers the world over. However, this substantial body of research stops short of confirming the exact number of nurses required to guarantee patient safety, and little of the research translates easily into practical strategies for use in hospitals (Griffiths et al., 2016). As a result, a variety of approaches to nurse staffing have emerged. In NZ, the safe staffing project has produced campaigns, strategies, documents, and activities, including the CCDM programme. However, ten years into the development and implementation of CCDM there are still no widespread discernible increases in the number of nurses at the bedside in NZ hospitals.

The absence of discernible increases in nursing full time equivalents (FTEs) is not for lack of knowledge in the form of important numbers. Shift by shift, nurses on wards count numbers relating to staffing, patients in their allocations, patient care needs to be completed, nursing skills available, rationing of patient care, incidents, breaks missed, and nurses going home late. People operating

the hospital on the day of care collect the numbers of mauve, green, yellow, orange, and red traffic light colours in wards (in hospitals implementing CCDM), the number of sick calls from nurses, patient admissions and discharges, and the numbers of patients in the emergency department and how long they have been waiting. There are numbers associated with elective surgery, beds available across the hospital, outliers, patients whose length of stay exceeds the system predicted discharge date, and so on. Further up the hierarchy, numbers are collected to inform the overall commitment to the implementation and funding of CCDM, including personnel, software, hardware, data management, and determining the budget available for increasing nursing FTEs. We are literally drowning in numbers.

My experience and research reveals the most widespread outcome of CCDM implementation to be the requirement for almost all frontline nurses to generate numbers (Patient Acuity Hours Per Patient Day, HPPD). This data generation work must be done for every patient, on every shift, for managerial decision-making on staffing. This requirement is one of many that speeds up, intensifies and compresses nurses' knowledgeable intelligent work with patients. When nurses' work is compressed by time and volume, the quality of what can be achieved is reduced and work is (often) pushed into unpaid hours. This widespread consequential outcome of generating numbers is yet to yield tangible results for the vast majority of frontline nurses.

The numbers that count in healthcare are those that arise in the central Government's health policies (performance targets and dollars). These numbers speak over what frontline nurses know is going wrong with patient care on short-staffed shifts. All DHBs have committed to implementing CCDM by 2021. If past performance is the best predictor of future performance, this is the right time to take stock and determine what is needed to deliver tangible safe staffing results for frontline nurses.

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