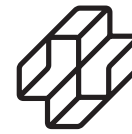


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Efficient Scheduling Starts with Good Hiring Practices

Ask Candace Smith, MPA, RN, about scheduling nurses efficiently, and she is likely to start quoting from business guru Jim Collins' book *Good to Great*: "With disciplined people, disciplined thought and disciplined action, you can really have an impact on process improvement."

Smith is referring to discipline in staffing practices. "When you hire into the shifts that you need, you'll have the right schedule," says Smith who is vice president of nursing/patient care services at Unity Health System in Rochester, N.Y. "And when you don't have the right schedule, you will have holes in your schedule, so you pay a lot of premium pay and overtime."

Unity Health has the numbers to show the value of disciplined staffing: The health system's medical/surgical units had been consistently over budget for decades—until Smith introduced new staffing protocols in late 2005.

"Since January [2006] we've been under budget every month, so it is doable," she says.

Hire for the Shifts You Need

As the nursing shortage drags on, it can be tempting to grab up good candidates as

they apply and hope they will fit into the schedule. Avoid the temptation, says Colleen Smith, MSN, CNAA, vice president of nursing at Middlesex Health System in Middletown, Conn.

"Let's say we have a lot of openings on nights and all our applicants want days," she says. "It's not going to be a realistic decision for either of us if we say, 'We'll take you on and wait for something on days to open up.'" That approach would be costly without solving the night-scheduling problem. It might also lead to friction if managers try to solve the issue by asking tenured nurses on day shifts to start rotating onto nights.

Communicate Expectations Clearly

Job candidates should understand scheduling rules before they accept a position, says Linda Groah, RN, MS, CNOR, CNAA, FAAN, executive director of the Associa-

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Efficient Nurse
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The Business of Caring

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tion of Perioperative Registered Nurses.

"I recommend that new hires sign a hiring agreement saying they agree to the organization's scheduling rules," she says.

Nurse managers at Unity Health send welcome letters to new hires. Each letter documents the work shift(s) the nurse is being hired to cover. The letter also states that the nurse will be expected to work three out of six holidays each year.

Written scheduling policies can also help clear up misperceptions related to shift coverage. For example, how many evenings can nurses who are hired to work days and evenings expect to work? "We have a really good policy that says if you're hired for days/evenings, it's 50 percent days and 50 percent evenings," says Unity Health's Candace Smith. "Having those policies in place is critical."

Candace Smith also advocates use of position control forms that help identify the staff mix needed for each shift (see the exhibit on page 4). These forms are

As the nursing shortage drags on, it can be tempting to grab up good candidates as they apply and hope they will fit into the schedule. Avoid the temptation.

typically available in staffing/scheduling software systems.

☑ Build in Flexibility

Middlesex's Colleen Smith encourages hospitals to offer a wide array of shift lengths and schedules to accommodate nurses' personal needs. "All eight- or 12-hour shifts can be limiting for organizations," she says. "It is often wiser to offer an array of options, such as weekend-only plans, four-hour shifts, six-hour shifts, and possibly 10-hour shifts, depending on the department."

Float pools also help. At Bronson Healthcare Group in Kalamazoo, Mich., a 75-member volume influx pool serves the

continued →

Special Issue Advisors

The following leaders provided advice and editorial support for this special issue of *The Business of Caring* on efficient nurse scheduling. Thanks so much for all of your help!

- > **Ginette Budreau, RN, MA, MBA**, senior associate director, nursing, University of Iowa Hospitals and Clinics
- > **Jill Fuller, RN, PhD**, chief nursing officer, Prairie Lakes Health System
- > **Donna Gellatly, MBA, FHFMA, CPA**, professor emeritus in Health Administration Program, Governors State University
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- > **Katie Harrelson, RN**, vice president, patient care services and chief nursing officer, Bronson Healthcare Group
- > **Candace Smith, MPA, RN**, vice president nursing/patient care services, Unity Health System

Do you have a special interest or affinity for budgeting?

The July 2007 issue of *The Business of Caring* will focus on budgeting. Please e-mail editor Maggie Van Dyke (mvandyke@hfma.org) if you would like to serve as a special advisor for this issue—or have an article idea. Thanks in advance.

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critical care and medical/surgical units. A slightly smaller float pool serves obstetrical and pediatric units. “The nurses call in about two hours before their shift to see where they are going to work that day,” says Cindy Ezelle, VIP manager.

Middlesex also has staff members who are hired to work at multiple locations. With three emergency department satellites in Middlesex’s service area, system leaders hired two mid-level providers to work

during busy ED hours: late morning until early evening.

Today, patient care needs and workforce shortages demand more creative scheduling solutions. Listening to new hires’ needs and clearly communicating the organization’s scheduling expectations will result in more satisfied employees and more efficient staffing, say nurse leaders. ☞

Nurse managers at Unity Health send welcome letters to new hires. Each letter documents the work shift(s) the nurse is being hired to cover. The letter also states that the nurse will be expected to work three out of six holidays each year.

Sample Position Control Form

By delineating the staff members hired for a nursing unit, a position control form helps nurse managers see what shifts have openings. This helps managers avoid hiring too many nurses for certain shifts and not enough for others.

2006 Nursing/Patient Care Services: Please include shift that staff was hired into									
Position Control Form									
Department: (department name here)					Manager: (manager name here)				
		Fixed Budget	0						
		Productive	0						
		Non-Productive	0						
		Total FTEs	0						
7125 Manager/Director			Total	0	7215 Patient Care Support			Total	0
FTE	Name	Fixed Budget			FTE	Name	Fixed Budget		
		Productive					Productive		
		Non-Productive					Non-Productive		
7140 Supervisors			Total	0					
FTE	Name	Fixed Budget			7230 Technicians			Total	0
		Productive			FTE	Name	Fixed Budget		
		Non-Productive					Productive		
7155 Professional			Total	0				Non-Productive	
FTE	Name	Fixed Budget							
		Productive							
		Non-Productive							
7185 Registered Nurses			Total	0	7260 Office/Clerical			Total	0
FTE	Name	Fixed Budget			FTE	Name	Fixed Budget		
		Productive					Productive		
		Non-Productive					Non-Productive		

Source: Unity Health System, Rochester, N.Y.

Interpreting FTE Statistics

The term “productivity measure” sounds like something used to track widgets on an assembly line. No one would compare patient care with a factory line. Yet in today’s cost-conscious environment, healthcare organizations need to be as efficient as possible. One way hospital executives keep an eye on productivity or efficiency is to track the number of full-time equivalent employees per occupied bed. If a hospital’s biggest competitor can run its cardiac program with significantly fewer FTEs, the competitor is in a better financial position to expand its facility, win managed care contracts, or lower its prices.

FTE Formulas

For productivity purposes, FTEs are often tracked using one of the following formulas. The first one is used primarily for acute inpatient care. The second formula—FTEs per adjusted occupied bed—is used when outpatient or clinic operations are also involved.

FTEs per Occupied Bed:

$\# \text{ of FTEs} \div \text{Average Daily Census}^* = \text{FTEs per Occupied Bed}$

FTEs per Adjusted Occupied Bed:

$\# \text{ of FTEs} \div \text{Average Daily Census} + (10\% \text{ of Total Outpatient Procedures and Clinic Visits}^{**} \div \text{Total Calendar Days}) = \text{FTEs per Adjusted Occupied Bed}$

* Average Daily Census = Beds in Service x Occupancy Rate. (ADC is also calculated by dividing the number inpatients at the time of midnight census by the number of calendar days. Newborns and patients in the emergency department or labor room are not included in the midnight census.)

** Many organizations assume that 10 outpatient or clinic visits equal one patient day.

Note: FTEs include both full-time and part-time employees. Let’s say a hospital considers a 40-hour week full time. Four part-time employees working a total of 48 hours a week would be equivalent to 1.2 FTEs.

Example: Facility ABC

Year Ended December 31, 2006:

> FTEs: 1,000	> Outpatient and Clinic Utilization: 150,000
> Beds in Service: 250	> Average Daily Census: 187.5 (250 x 0.75)
> Occupancy: 75%	

FTEs per Occupied Bed:

$1,000 \div 187.5 = 5.33 \text{ FTEs}$

FTEs per Adjusted Occupied Bed:

$1,000 \div 187.5 + (15,000 \div 365) = 4.37 \text{ FTEs}$

How do you know if your FTE stats are good or bad? One way is to compare your unit’s or hospital’s FTE stats from one period to another. There are also many external data sources that you can use to compare your facility with other similar institutions. For example, *The Almanac of Hospital Financial and Operating Indicators* published by Ingenix reports FTEs per occupied bed by geographic area, hospital bed size, bond rating, etc.

Many Variables Affect FTE Statistics

Take two Chicago-area hospitals. Both have 250 beds and 75 percent occupancy. One hospital reports 4.50 FTEs per occupied bed, and the other reports 6.30 FTEs. In both cases, the CEO is perfectly happy with the facility’s productivity. Why? Many other factors besides bed size and utilization affect the scheduling of personnel:

- 1 One facility may contract out many of its services (for example, housekeeping and dietary). The workers would be employees of the contractor rather than the hospital so their worked hours would not be included in the hospital’s FTE statistics.
- 2 One hospital may be a teaching facility with resident physicians’ hours included in the calculation. Additionally, the attending physicians may be employees of the facility rather than independent medical staff.
- 3 One hospital may be a specialized pediatric facility that requires additional personnel to support the care of children.
- 4 One facility may be an organization that runs its facility “lean” with fewer employees. Conversely, another facility may have a large cohort of volunteers who handle administrative duties such as “manning” the reception desks, delivering flowers and mail, running the parking lot, etc.
- 5 Case mix intensity and patient acuity levels determine both the number of employees needed on the nursing unit and the level of nursing skill.
- 6 Most important, one facility may have large outpatient and clinic operations, while the other facility has limited outpatient utilization.

How Did You Solve Your Biggest Scheduling Headache?

As every nurse manager knows, scheduling nurses is one of the most important—and trickiest—challenges in the hospital. It means balancing the hospital's financial expectations with nurses' preferences for certain shifts and units. It means complying with regulatory requirements and meeting the staff ratios needed to provide high-quality patient care. Inefficient scheduling increases the use of high-cost agency nurses, overtime pay, and RN turnover—all of which can quickly sink a nursing department budget.

Resourceful nurse managers have learned how to tackle thorny scheduling dilemmas. What do these solutions have in common? Teamwork, creativity, and leadership.

Case Study 1

Managing Surges and Low Census on Small Units

Matching on-duty staff to patient volume is particularly tricky on a small nursing unit. Nurse leaders at Prairie Lakes Hospital in Watertown, S.D., which has 70 staffed beds, frequently find themselves on a roller-coaster ride. A low census day is often followed by a surge—when extra nursing hands are needed on short notice to handle a spate of admissions, discharges, a crisis, or complex procedures.

Jill Fuller, RN, PhD, chief nursing officer at Prairie Lakes Healthcare System refuses to let the roller coaster run away with her budget. She relies on nurse productivity standards to determine true staffing needs.

Right Size the ICU Pod

When patient census is low on a small hospital unit, the minimum nurse staffing required may exceed the staffing levels needed to meet the hospital's internal productivity standards. Instead of letting unit designations dictate the number of nurses on duty, Fuller and her team place patients so that nurse-patient ratios will be met (see the exhibit on this page).

For example, the average daily census in Prairie Lakes' eight-bed ICU is only two patients, and the unit would be chronically overstaffed if the hospital's minimum ICU staffing requirement (two RNs on duty 24 hours a day) was maintained.

"The unit decided to 'right size the pod,'" Fuller says. "The goal is to maintain a constant census to justify the minimum staffing." Five to six patients are now treated in the ICU at all times to justify the two ICU RNs who must be on duty. In some cases, non-ICU patients are admitted onto the unit. On other days, an ICU patient who transfers to a lower level of care stays in the ICU bed and is reclassified as a medical/surgical patient. One RN cares for two ICU patients, while the other RN is assigned to four non-ICU patients, in keeping with the

hospital's nurse-to-patient ratios for the two different patient classifications.

Deb Pederson, RN, director of the critical care unit, says nurses like the arrangement because it reduces their need to float from one unit to another. The system also eliminates the need to move patients from one unit to another, decreasing the likelihood of medical errors related to hand offs.

"We've eliminated our need to move staff around because we put patients in the right place to begin with and keep them there," Pederson says.

Right Size the Med-Surg Pod

Prairie Lakes has med-surg beds on two floors: 30 beds on one floor and 22 beds on

continued →

Nurse Staffing Requirements for a "Mixed Use" Unit

Example for two ICU patients and four med-surg patients located in an ICU unit:

$$(2 \text{ patients} \times 14.5 \text{ hours per patient day}) + (4 \text{ patients} \times 7.5 \text{ hours per patient day}) = 59 \text{ nursing hours per day}$$

Source: Prairie Lakes Healthcare System

The Prairie Lakes Healthcare System uses productivity standards to determine the number of nurses needed for a specific patient mix. For example, the health system's ICU productivity standard is 11.0 hours per patient day, which is a blend of ICU patients at 14.5 hours per patient day and med-surg patients at 7.5 hours per patient day.

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Five to six patients are now treated in the ICU at all times to justify the two ICU RNs who must be on duty. In some cases, non-ICU patients are admitted onto the unit.

another. The average daily med/surg census is 28 patients, and for several years, the hospital's strategy was to only staff the 30-bed floor. If the census rose close to 30 patients, or bed turnover was delayed, the other floor would be opened to handle the overflow.

"Every time we would get to patient number 29 or 30, we'd have to open up this other unit," Fuller says. "Then we'd have two med-surg staff to one patient, which is a terrible staffing scenario."

The solution came from RNs who suggested keeping the overflow unit open with a controlled census and steady staff level. This allows for efficient use of the nursing staff. "We keep about 10 patients there—enough to justify keeping two nursing staff there," Pederson says.

While the bulk of the patients are still treated on the other floor, there is never a bed crunch because the overflow unit is always ready to accept more patients.

Right Size the Nurse Manager Function

About 40 percent of the time, Prairie Lakes operates with a low census and the right number of nurses to handle the patient load. But a surge of activity when extra nursing support is needed—even if lasts for only a short while—can wreak havoc. To avoid calling extra nurses in to handle temporary surges, every nurse manager is available for direct patient care.

"They come to work in scrubs every day prepared to assist with surge," Fuller says.

How Much Management for a Small Nursing Unit?

Management FTEs = 3% of total FTEs

Example: 15 FTEs in ICU X 0.03 = 0.45 FTE manager in ICU unit

Source: Prairie Lakes Healthcare System

Note: This formula is for 24/7 departments. The formula for Monday through Friday departments is management FTEs = 10% of total FTEs.

Nursing leaders at Prairie Lake Healthcare System use a productivity formula that was provided by a consultant to determine the proportion of time that nurse managers should spend in management activities versus direct patient care. The standard is indirectly related to "span of control" that is appropriate for managers.

This system allows every nursing unit to have a dedicated leader, rather than assign a leader to multiple units, which diffuses the leader's ability to be effective.

"We had to decrease management workload to make this work, so we got rid of a lot of committees and meetings and bureaucracy so that managers can shift into these roles," Fuller says.

In addition to helping the hospital financially, the scheduling system has a happy side effect, Fuller reports. "I think the staff has more respect for their managers, because they see them as working managers who can walk in their shoes if they need to," she says.

Jill Fuller, RN, PhD, is the CNO at Prairie Lakes Healthcare System in Watertown, SD (fullerj@prairielakes.com). Deb Pederson, RN, is director of the critical care unit at Prairie Lakes.

Case Study 2

Accommodating a Baby Boom

Jan Schoonveld, RN, manages a nursing unit in which 19 nurses are pregnant and, if things go as expected, most of them will leave work sometime before their due date. The majority will want to take 12-week maternity leaves. And several of them will prefer to return to work at less-than-full-time schedules.

Schoonveld's perspective: No big deal. Nurses on her 32-bed obstetrical unit at Community Hospital North in Indianapolis,

have had 77 babies in the last four years. When that baby boom began, Schoonveld took preemptive action. "I just said, 'I'm not going to live like this, where every pregnancy announced is a panic,'" she says.

Hiring Staff to Cover Maternity Leaves

Schoonveld has about 100 nurses in her roster, most of whom are in their childbearing years. Every maternity leave posed a challenge because Schoonveld had to press other nurses to take mandatory call duty.

"People were having to sign up for 24 to 32 hours of call per schedule," Schoonveld says. "That was an extreme staffing dissatisfier because you knew when you signed up that more than likely you were going to get called in."

Anticipating a high number of pregnancies in the next few years, Schoonveld sought and received approval to add five additional staff positions to cover maternity leaves. The unconventional approach has worked out well.

"In the long run it has paid itself back a thousand times," she says. "For two or three months there was a cost to doing it, but over the last four years we have managed our costs so much more effectively."

Because additional staff were hired, nurses do not have to overwork to cover for their colleagues. And new mothers who want to return to their jobs on a part-time basis are easily accommodated.

“I’ve been able to retain nurses,” she says. “And I’ve been able to let people take longer maternity leaves because I’m not paying other nurses time-and-a-half to cover for them.”

Additionally, the extra staff members allow Schoonveld to extend an unusual amount of flexibility to her nurses, something that working mothers greatly appreciate. When she has too many nurses scheduled for the patient census, Schoonveld does not dread picking up the phone to ask, “Are you interested in staying home?”

“The lure of getting to have a day off unexpectedly is just overwhelming,” she says. “That means more to them than the money.”

By the same token, if she needs extra nurses to accommodate a higher patient load or acuity level, it is not difficult to find staff members willing to come in. “It’s like, ‘Last week I got called off a day, so I have a day’s pay to make up and this works out

OK,’” Schoonveld says. “We might have to make six or eight phone calls to get to that person, but it’s a system that works for us.”

Use Float Nurses As Needed

Schoonveld also relies on a PRN (or as needed) pool of about 30 RNs. During busy times, these PRNs cover for up to three or four full-time employees per schedule.

The PRNs provide another level of flexibility in the schedule. Earlier this spring, for example, Schoonveld’s unit was expecting five nurses to start trickling back from their maternity leaves while four pregnant nurses were nearing their due dates. “If I don’t have my next four ready to go on leave, I’ve got people who are not so tied to making sure that they’re working ‘X’ amount of hours a week,” she says.

Jan Schoonveld, RN, is director of family rooms at Community Hospital North in Indianapolis, Ind. (JSchoonveld@ecommunity.com).

Anticipating a high number of pregnancies, Schoonveld sought and received approval to add five additional staff positions to cover maternity leaves. The unconventional approach has worked out well.

Case Study 3 Covering Specialty Surgical Calls

From 7 a.m. to 3 p.m. each weekend, Memorial Health University Medical Center, a 530-bed tertiary medical center in Savannah, Ga., is staffed to keep 20 operating rooms busy, and a trauma team is on hand in case the 21st room is pressed into service. Beginning at 3 p.m., the ORs start to close on a pre-set schedule so that, by 7 p.m., only three rooms are staffed.

continued →

Scheduling Around the Holidays

“It’s just a nightmare to schedule 60 nurses for holidays,” says Laura Carter-Esposito, RN, clinical nurse coordinator for a 21-bed medical intensive care unit at Rush University Medical Center in Chicago.

Holiday scheduling strategies differ based on diverse opinions about what constitutes “fair.” Before new nurses are hired, make sure to communicate how “fair” is defined on your hospital unit when it comes to scheduling holiday duty, nurse leaders say.

Give longevity its due. At Rush, Carter-Esposito has two holiday scheduling periods: winter (Thanksgiving through New Years Day) and summer (Memorial Day through Labor Day). At least six weeks before each “season,” she lists the holidays and the holiday eves on a poster and asks nurses to numerically rank the five days they most want to be off duty.

Armed with those requests, Carter-Esposito makes a schedule with this rule in mind: Longevity counts. Nurses who have worked for eight years or more work only one holiday in the summer and one in the winter. “It’s important to reward seniority,” she says.

Rotate major holidays. By contrast, Prairie Lakes Hospital in Watertown, S.D., uses a rotation system, managed by the staffing office, to determine the holiday schedule. Nurses working in departments that are staffed around the clock are required to work two out of the six major holidays each year; the holidays they work change each year, according to a formula.

“Using a rotation system is how we attempt to make working holidays ‘fair’ versus basing holiday schedules on seniority, status, or other factors,” says CNO Jill Fuller, RN, PhD.

Put guidelines in place. Bronson Healthcare Group, the parent of Bronson Methodist Hospital in Kalamazoo, Mich., recently issued new holiday-scheduling guidelines to make sure all units use the same protocols. “There was a lot of inconsistency from unit to unit,” says Nikki Romance, Bronson’s employee relations manager.

Half the nursing staff is assigned to work each major holiday on a schedule that rotates. Thus, no nurse is scheduled to work two consecutive holidays, and no one is asked to work Christmas, for example, two years in a row.

If fewer staff are needed on a given holiday, nurses are moved to another day during the week of the holiday. However, nurses who get pulled off the holiday are given credit for working their assigned holiday.

But as the number of RNs, surgical technicians, and nursing assistants on duty thins, the need for specialized skills does not. That's why Kathy Buckhaults, RN, clinical nurse manager at Memorial Health, maintains five separate surgical call teams for evenings, nights, and weekends.

The staff of 120 FTEs includes specialty groups for neurosurgery, orthopedic surgery, cardiac surgery, and eye surgery. For example, six nurses and six surgical technicians work on the orthopedics team. Another call team consists of generalists, who are called when additional ORs must be opened to accommodate heavy demand.

The solution to keeping those specialty call schedules covered? Buckhaults lets the staff members schedule themselves.

Self-Scheduling Rules

Each team set parameters for the number of evenings, nights, and weekends for

which each person must accept call duty. "Nobody wants to seem like a non-team player," Buckhaults says. "If you start seeing someone who takes advantage, the team members jump in and say, 'No way. You're either going to get kicked off the team and have to find another team, or you're going to pull your fair share.'"

Incentives for Unfavorable Shifts

One key to the strategy's success: Highly experienced, general nurses work nights and weekends. Memorial Health uses an incentive program that makes night and weekend shifts financially attractive, allowing the hospital to choose top nurses for those positions. The result: Specialty nurses on call duty know they will not be "abused" with unnecessary calls.

"A neurosurgery team is not going to come out at 3 a.m. to do a little procedure with a neuro doctor because these very talented, stronger OR nurses can handle that,"

Memorial Health uses an incentive program that makes night and weekend shifts financially attractive, allowing the hospital to choose top nurses for those positions.

Buckhaults says. "Having that real strong night and weekend team makes [specialty nurses] more comfortable signing up for call because there are weeks that go by and they don't even get called in."

The approach is working. "It really has been successful," she says. "In the last several months, I have been under budget in overtime call-back pay."

Kathy Buckhaults, RN, is clinical nurse manager at Memorial Health University Medical Center, in Savannah, Ga. (buckhka1@memorialhealth.com).



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How can we begin to develop a float pool?

Adam: When we began the float pool at University of Iowa Hospitals & Clinics, we conducted an analysis of our nurse staffing patterns: We reviewed the adult units to learn how many hours unit nurses were floating, how much overtime they were working, and how many hours were being worked by agency and travel nurses. From this, we determined that we would need 60 FTEs (consisting of a combination of part- and full-time employees) for the program.

We already had a small group of nurses in divisionally-based float positions, so they were the first members of our internal pool. Then, we slowly filled the rest of the positions by waiting until regular unit-nurse positions became vacant and hiring float nurses in their places.

These individuals were divided into five teams: ICU, step-down, oncology, general medical/surgical, and behavioral health. That way, we know that the nurses being sent to fill a vacancy on a unit already have a high level of competency in that area.

Of course, there is still quite a bit of variation within these groups of units. For example, brain cancer is treated differently than uterine cancer. However, these patients have many of the same needs and use many of the same hospital resources. Well-trained nurses can quickly learn about the specifics of these diseases. In fact, we often find that working in different units within their team's group gives float nurses a higher and broader level of competency.

How do we fill the float positions?

Adam: When we have positions to fill now, we look for nurses who have at least one year of experience, within the last three years, working on one of the units served by the float pool. Many of our float nurses are unit nurses looking for a new

challenge. We have also hired some nurses who have such experience at similar hospitals in our area. We haven't had many vacancies, but when we do need to fill positions, hiring for the float pool is handled by our nursing recruiter department and nursing human resources department. While we currently have only RNs in the pool, we are looking to add some nurse assistants as well.

How does scheduling work?

Adam: Float nurses at University of Iowa are scheduled in advance. So they always know *when* they are going to work; the variable is *where*. Float nurses call the staffing office one hour before their shifts start to find out where they have been placed for the day. In some cases, float nurses may switch units during a shift.

I oversee all five float teams, serving as the liaison to the individual units needing our services. When a unit is short-staffed, the manager contacts my staffing office clerks, and we determine how the float nurses can meet their staffing needs. Since the inception of the program, we have not had to call in any travel or agency nurses.

Our float employees receive an extra \$3 an hour, as compensation for the fact that their work assignments are more irregular than those of unit nurses. In addition, we will soon offer a bonus to any unit nurses who are required to float for part of a shift, as well as float nurses who have to float in a unit outside their usual team.

What challenges should we be prepared for?

Adam: If we could do it again, we would not wait until unit-nurse positions became vacant to hire new float nurses. Hiring ahead would have gotten the program off the ground more quickly.

Also, you must communicate the benefits of the pool to the unit nurses. When we first began our float pool, some staff felt that having a large

number of float positions would take experienced nurses off the units. We had to help them understand that the main benefit of the internal float pool is that the nurses would be experienced in patient care and in the workings of our organization. I talked to individual staff, unit managers, groups at unit meetings, and the union—persistent communication is the key. ☎

Julie Adam, RN, MSN, CNA-BC, is nurse manager of the Clinical Resource Unit, Procedural Sedation Team, and Nursing Staffing Offices at University of Iowa Hospitals & Clinics in Iowa City (Julie-Adam@uiowa.edu).

Finance-to-Nurse Interpreter

Direct versus indirect staffing costs:

Direct staffing costs are traceable to a specific service or department. These expenses are incurred for the sole benefit of an individual department. For example, direct staffing costs for a Well Baby Clinic would include a clinic nurse's salary and employee benefits.

In addition, there are many indirect expenses that are incurred to support this one clinic nurse. These expenses include a portion of the following:

- > The nursing director's and nursing administration staff's salaries and benefits
- > Nursing education costs
- > Payroll and human resource department costs
- > Costs associated with the employee cafeteria and parking lot

Productive versus nonproductive time:

As the term suggests, productive time is the amount of time that staff actually spend working—taking care of patients, documenting care, meeting with physicians, etc.

Nonproductive time covers the hours for which staff are paid but do not work. It includes paid time off (sick days, vacation, jury duty, and holidays). Some organizations also consider the time that employees spend attending educational seminars or engaged in activities away from the unit/department as nonproductive.

Online Nurse Scheduling and Staffing

Scheduling all shifts in a hospital with qualified nurses is a huge challenge, especially in these days of acute nursing shortages and staff-to-patient ratios. But recent technology advances offer a viable solution. Online nurse scheduling applications streamline the process across the hospital or health system, helping leadership manage countless staffing variables, fill shifts more efficiently, and control labor costs. Many online systems provide self-scheduling and shift bidding, which can help facilities reduce reliance on agency personnel, improve job satisfaction, and enhance recruitment and retention.

How do "online" systems differ from traditional staffing/scheduling software?

Briefly put, online scheduling means the application is Web-based or Web-enabled, so managers and nurses can access the system via the Internet or Intranet. In the past, hospitals were unable to coordinate staffing beyond a single site, or facility. With online functionality, schedules across the organization—for nurses and all other staff—can be posted and viewed.

Online applications are also easier to deploy and maintain than traditional packages, which require IT staff to load software on individual computers. Online systems are centrally distributed to all users via the Web, so minimal IT support is needed.

What are the benefits of online scheduling?

- > They permit managers to easily identify and fill vacancies with permanent, float, or per-diem staff, minimizing overtime and travel nurse costs.
- > They allow hospital leaders to plug in specific staffing or scheduling rules.
- > They provide facilitywide reporting capabilities that allow managers to evaluate staff levels for improved planning and budgeting.

- > They empower employees by permitting them to view schedules via the Web at the hospital or at home.
- > They allow employees to submit "unavailable" times and request time off electronically.

Advanced systems also feature self-scheduling, which gives staff greater control over their assignments. Some applications feature shift bidding, as well. Staffing managers set skill and pay criteria for open shifts, and post opportunities so staff can bid on shifts for which they are qualified.

What response do online solutions elicit from nurses and managers?

These systems typically receive high marks from all levels within healthcare organizations. One large health system in North Carolina implemented the technology in 2003, and has significantly reduced scheduling errors and ineffectual use of agency workers. Another used its system to audit agency charges, and saved 10-12 percent the first year by comparing actual hours worked against agency invoices. A user in Iowa created a program for an internal agency and significantly reduced its reliance on outside agency employees, saving \$200,000-\$300,000 per year.

Efficiencies realized through the online application freed up managers to pay closer attention to "big picture" issues—like staffing trends—which allows the hospital to use resources more effectively. Hospitals can rely upon the system, for instance, to monitor fluctuating staffing needs throughout the facility. Perhaps one department is sending staff home, while another needs additional support. Online systems allow the department with a staffing need to identify scheduled, available staff, rather than calling in another nurse and running the risk of incurring overtime or on-call hours.

Nurses like having unrestricted access to scheduling information. Self-scheduling and shift bidding give staff greater input to their assignments, and allow them to better balance their personal and professional lives.

What costs can a healthcare organization expect to incur?

Price tags attached to these systems vary a great deal, depending on functionality and the various modules that are included.

Research recently published by the California HealthCare Foundation found that online nursing scheduling and staffing applications serving a 300-bed hospital could range from \$60,000 to \$150,000, including implementation and support. (California HealthCare Foundation. *Adopting Online Nurse Scheduling and Staffing Systems*. September 2005.) Final costs are typically linked to the total number of end users.

What return on investment should users anticipate?

ROI will depend on how extensively the system is used throughout the enterprise, as well as staffing costs that existed before online staffing and scheduling was adopted.

Most healthcare organizations see significant savings within months by reducing

One large health system in North Carolina implemented the technology in 2003, and has significantly reduced scheduling errors and ineffectual use of agency workers. Another used its system to audit agency charges, and saved 10-12 percent the first year by comparing actual hours worked against agency invoices.

reliance on agency workers and minimizing overtime. One emergency department in Michigan, for instance, saved \$48,000 in overtime the year after it implemented an online scheduling application that integrated with the facility's time and attendance system. Reporting and analysis features support better budgeting and human resource planning.

"Soft" savings also become apparent as managers spend less time completing schedules and scrambling to assign nurses to hard-to-fill shifts. Consider a facility with 50 nurse managers, each of whom earns \$47 per hour. Online staffing can easily trim six hours during each of 13 scheduling periods—totaling 3,900 hours per year. This adds up to an equivalent of \$183,300 annual savings. These resources can then be invested in activities that directly impact patient care and the organization's bottom line.

What factors should healthcare facilities consider before purchasing an online staffing and scheduling system?

Most organizations find potential obstacles falling into one of three categories.

Does leadership truly support adoption of online staffing and scheduling across the organization? The facility must dedicate the resources to purchase and implement the

application. Plus, leadership must initiate communications and incentive programs to convince staff to convert to the new approach.

Will managers and staff actually use the online system? The benefits of online systems can be realized only when the system is deployed throughout the organization—and if staff is "sold" on the idea of using its full potential. One possible barrier is discomfort using computers. Other potential obstacles include resistance to change and "control" issues between management and staff. Organizationwide communication and comprehensive training can combat these problems. The North Carolina health system developed a multi-level training course for each department, which gave everyone a good understanding of how to

use the online system. Additional Web-based training was also offered to individuals and groups.

Can the IT department support the application? While minimal IT involvement is required to maintain these systems, the organization's IT department must be involved during selection and implementation. IT staff can help ensure that online scheduling systems integrate well with the technology infrastructure, and that firewalls and other internal security measures are correctly configured to allow trouble-free online access. ☎

Kerry Dominick, MSN, RN, is senior account executive, api Software, Inc. (kerry.dominick@apisoftwareinc.com). Kerry has more than 20 years experience working with automated scheduling systems.

Sample Scheduling Report							
Thursday, March 15, 2007 02:09 PM (Data gathered at 03/15/2007 02:09 PM)							
This report shows schedules starting 03/15/2007							
Facility: 1- General Hospital				Department: 3270 - 4 North/Surgical			
		Profile	Thu 03/15	Fri 03/16	Sat 03/17	Sun 03/18	Mon 03/19
Coverage	Day	CNA-4N	1.00	2.00	1.00	1.00	2.00
Need			2.00	2.00	1.00	1.00	2.00
Variance			-1.00	0.00	0.00	0.00	0.00
Coverage	Day	LPN-4N	2.00	2.00	3.00	4.00	2.00
Need			2.00	2.00	2.00	2.00	2.00
Variance			0.00	0.00	1.00	2.00	0.00
Coverage	Day	RN2-4N	2.00	1.00	1.00	1.50	1.88
Need			2.00	2.00	2.00	2.00	2.00
Variance			0.00	-1.00	-1.00	-0.50	-0.12
Coverage	Day	RNCH-4N	1.00	1.00	1.00	1.00	1.00
Need			1.00	1.00	1.00	1.00	1.00
Variance			0.00	0.00	0.00	0.00	0.00
Coverage	Evening	CNA-4N	1.00	2.00	1.00	1.00	2.00
Need			1.00	2.00	1.00	1.00	2.00
Variance			0.00	0.00	0.00	0.00	0.00
Coverage	Evening	LPN-4N	2.00	2.00	4.00	3.00	2.00
Need			1.00	1.00	2.00	2.00	1.00
Variance			1.00	1.00	2.00	1.00	1.00
Coverage	Evening	RN2-4N	3.00	2.50	3.00	3.00	2.66
Need			3.00	3.00	2.00	2.00	3.00
Variance			0.00	-0.50	1.00	1.00	-0.34

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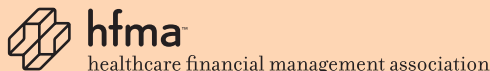
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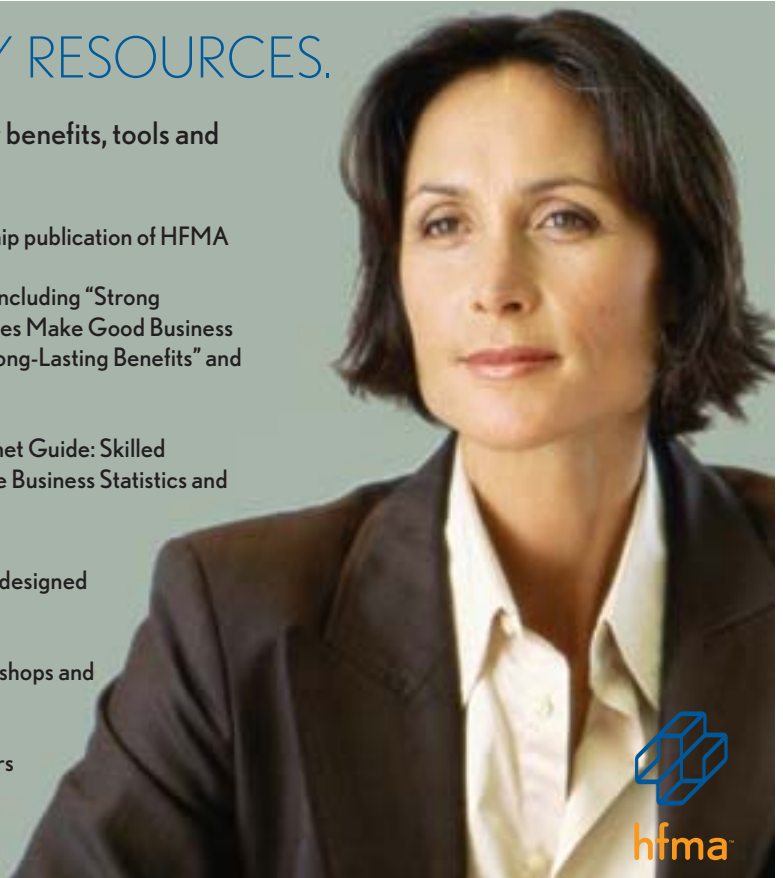
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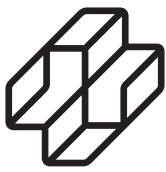
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