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Identifying ways that Institutional Staffing and Scheduling Committees engage nursing
staff in resource allocation at the unit and institutional levels

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A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

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Dedication Page

Dedicated to my family and the profession of nursing that has provided me so much in ways I could have never imagined.

Acknowledgments

I would first like to acknowledge Merle Mast who started this journey with me as committee chair. I would also like to thank Erica Lewis to lend her expertise and helped refine my theoretical model. My committee members Kathy Baker and Joy Harnage for their collaboration, guidance and support through completion. Finally I would like to acknowledge Melody Eaton for her compassion, support, feedback and mentoring through this entire journey. Melody anytime I think of this experience thoughts of you will quickly follow.

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Abstract

The American Nurses Association (ANA) recommends that at least fifty percent direct care providers are involved in staffing and scheduling decisions at the institutional level (ANA Staffing, 2015). This recommendation coincides with Magnet recommendations for the staff most impacted by staffing levels. Magnet organizations are recognized for superior nursing processes and quality patient care, which lead to the highest levels of safety, quality, and patient satisfaction (ANCC, 2015). Existing research, largely at the unit level, shows that registered nurses in acute care environments have higher general work satisfaction and morale when they are engaged in decision making around staffing (Ellerbe & Giansante, 2015; Brunges & Foley-Brinza, 2014; Hoffart & Willdermood, 1997). This descriptive design explores ways nursing staff are engaged by their staffing and scheduling committees to influence staff resource allocation on the unit and at the institutional level. Magnet facilities in Virginia with staffing and scheduling committees were asked to participate and complete a self-reported survey. The survey questionnaire was developed for the purpose of this project, and content validity tested with a resulting overall CVI of 0.86 (Appendix A). Questions included both Likert Scale and three opened ended questions related to the project aims. Data was analyzed, along with Content Analysis quantified to frequencies for three open-ended questions. Project results are intended to add to the literature, educate policymakers, and continue the conversation on how nursing can be part of the solution for the staffing and scheduling problems facing healthcare today.

CHAPTER I

Introduction

Staffing and Scheduling for Registered Nurses (RNs) remains a major concern for the healthcare industry. Staffing directly impacts patient mortality, and outcomes related to quality care. The financial state of healthcare institutions, creation of legislation and regulation at the state and federal level, nurse retention and nurse perceptions are linked to staffing and resource adequacy. Nurses are the largest and most trusted workforce in the American healthcare industry and they have the credentials to be one of the most influential voices in the decisions regarding healthcare policy (Steier, 2011).

The American Nurses Association's (ANA's) public policy platform calls for staff involvement in institutional level scheduling and staffing decisions. The ANA recommends that at least fifty percent direct care providers are involved in staffing and scheduling decisions at the institutional level (ANA Staffing, 2015). This recommendation coincides with Magnet recommendations for the staff most impacted by staffing levels to have a voice in the process. The American Nurses Credentialing Center (ANCC) Magnet Recognition Program is viewed around the world as the ultimate seal of quality and confidence. Magnet organizations are recognized for superior nursing processes and quality patient care, which lead to the highest levels of safety, quality, and patient satisfaction (ANCC, 2015).

A gap in the literature exists correlating Staffing and Scheduling Committee's influence on these variables, ultimately impacting the institution's ability to produce schedules meeting the needs of individual units. Furthermore, there is scant evidence in

the literature linking the activities of these committees to outcomes resulting in unit and institutional level staff nurse engagement.

Scheduling work assignments of employees for a specific period of time is normally done at a unit or departmental level and is based on the skill needs of the unit or department. Schedules are based on a number of factors to include but not limited to hours per patient day (HPPD), average daily census (ADC), discharges and patient days (Mensik, 2012). Scheduling in health care normally is associated with a number of staffing considerations that can be referred to as unit guidelines including but not limited to the following: shift, weekend responsibility, off shift responsibility, and number of hours worked per shift. Most of these guidelines are established at the institutional level, but can also be developed at the unit or departmental level. Staffing is based on the scheduling principles: call outs, patient acuity, patient census, admissions, transfers and discharges, predicted operating room volume and emergency department volume (Mensik, 2012). As these factors increase or decrease throughout a specific shift, adjustments can and should be made to staffing.

ANA published their support for the Registered Nurse Safe Staffing Act in 2011, which would require Medicare participating hospitals, through a committee comprised of at least 55% direct care nurses or their representatives, establish and publicly report unit-by-unit staffing plans.

The plan must establish adjustable minimum numbers of RNs and include input from direct care RNs or their exclusive representatives. ANA goes on to state that the plan must be based upon patient numbers and the variable

intensity of care needed while taking into account the level of education, training and experience of the RNs providing care. They must also take into account the staffing levels and services provided by other health care personnel associated with nursing care as they consider staffing levels recommended by specialty nursing organizations. It must also take into account unit and facility level staffing, quality and patient outcome data and national comparisons as available. The plan must take into account other factors impacting the delivery of care, including unit geography and available technology. Finally they need to ensure that RNs are not forced to work in units where they are not trained or experienced (Safe Staffing, 2011, NP).

RN's comprise the largest personnel costs of any hospital, simply based on the number of nurses necessary to operate a hospital. As hospitals continue to face decreased operating margins and the rise in labor costs, staffing will continue to be a major challenge. One solution is a workforce management system (Staffing and Scheduling Committee) to help contain labor costs by determining the appropriate staffing mix by shift per unit or department (Lanier, 2011). Adequate utilization of resources can decrease the personal costs associated with RN's, empowering the RN to impact outcomes (Finkler, Jones, & Kovner, 2013). Decreasing RN staffing is no longer a viable option with the introduction of value based purchasing and the IOM's report on Quality and Patient Safety (Finkler, Jones, & Kovner, 2013). The cost and benefits or cost-effectiveness of nursing care, specifically in the areas of pain and symptom management will continue to be researched in the future in response to the IOM's Future of Nursing Report (Finkler, Jones, & Kovner, 2013).

There is a lack of evidence associated with Staffing and Scheduling Committee's influence on staffing engagement at the institutional and unit level. The purpose of this descriptive study is to identify ways nursing staff are engaged by their staffing and scheduling committees to influence staff resource allocation on the unit and at the institutional level.

Background

At the federal level legislation has been created since 2008 to amend or introduce new staffing guidelines for the health care industry. In the 114th congress House or Representative Bill 2083(2015) and Senate Bill 1132 (2015) sought to amend title XVIII (Medicare) of the Social Security Act which requires Medicare participating hospitals to implement a hospital-wide staffing plan for nursing services within their organization. The amendment called for a plan that would require an appropriate number of registered nurses providing direct patient care in each unit and on each shift of the hospital to ensure staffing levels that: (1) address the unique characteristics of the patients and hospital units; and (2) result in the delivery of safe, quality patient care consistent with specified requirements (S. 1132, 2015; HR. 2083, 2015). H.R. 2083 (2015) and S. 1132 (2015) also sought to require each participating hospital to establish a hospital nurse staffing committee which would implement such a plan. Nationally legislation continues to be developed to amend or introduce new legislation.

In June 2006 the American Nurses Association (ANA), Washington State Nursing Association (WSNA), and the New York State Nursing Association (NYSNA) filed a lawsuit against the Department of Health and Human Services to enforce the condition of participation in the Medicare Program as they relate to RN staffing (Benoit, 2008). This

lawsuit directly speaks to Code 42 of Federal Regulations inability to provoke necessary change. The Center for Medicare and Medicaid Services has a code, 42 Code of Federal Regulations (42 CFR 484.1-484.55) which requires hospitals certified to participate in Medicare to have “adequate numbers of licensed registered nurse, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed” (Home Health Agencies-CMS, 2010). The presence of Code 42 continues to provoke little response from healthcare institutions in relation to staffing and scheduling. As a result ANA’s new policy platform and ANCC Magnet designation criteria are promoting current legislation for the requirement of staffing and scheduling committees to address this valuable resource allocation. (ANA Staffing, 2015; ANCC, 2015).

Identifying and maintaining the number and mix of nursing staff to patients, while factoring in patient acuity, is critical to the delivery of safe and quality care. An association between higher levels of experienced registered nurse staffing and lower rates of adverse patient outcomes to include mortality exists (Park, Blegen, Spetz, Chapman & De Groot, 2012; Peterson, 2013; West, et al., 2014). Some literature suggests that legislation and regulation is the only way to achieve adequate staffing, but in reality regulation has been in place for some time. According to the ANA on Safe Staffing, the state, (Ohio, New Hampshire and Nevada), staffing laws that have been created as a result of this regulation have three general approaches. One, they require hospitals to have a nurse driven staffing committee which create staffing plans reflecting the needs of the patient population and matching the skills and experience of the staff. Second, legislators should mandate specific nurse to patient ratios in legislation. Finally, they require facilities to disclose staffing levels to the public and/or regulatory body (ANA

Staffing, 2015). The ANA platform for Safe Staffing calls for a legislative model that recommends nurses to be empowered to create staffing plans that meet specific unit demands by creating staffing plans with staffing levels that are flexible and allow for changes. These changes are presented in the form of changes in intensity of patient's needs, the number of admissions, discharges and transfers during a shift, level of experience of nursing staff, layout of the unit, and availability of resources, (ancillary staff, technology etc.) (ANA Staffing, 2015).

In July 2002, The Joint Commission stated that staffing effectiveness is the appropriate level of nurse staffing that will provide for the best possible outcome of individual patients throughout a particular facility (Health Leaders Media, 2010). This requires hospital administration to track two patient outcome indicators such as falls and hospital acquired pressure ulcers, track data, and determine the variation in performance caused by the number, skill mix, or competency of the staff which becomes cumbersome. In June of 2009 this standard was suspended due to the debate that nurse staffing impacted patient outcomes. As a result interim staffing effectiveness standards of the The Joint Commission came into effect July 1, 2010 and will remain in effect while further research is conducted on staffing's impact on patient outcomes. This new requirement calls for administration of a hospital or organization to provide reports on an annual basis regarding all systems or process failures including those related to staffing, the number and type of sentinel events, information provided to families/patients about the events, and actions taken to improve patient safety (Health Leaders Media, 2010).

Problem Statement

Existing research, largely at the unit level, shows that registered nurses in acute care environments have higher general work satisfaction and morale when they are engaged in decision making around staffing (Alenius, Tishelman, Runesdotter, & Lindqvist, 2015; Choi, & Boyle, 2014; Wieck, Dols, Landrum, 2010). During the past decade, recent legislation and regulation in various states, ANA's safe staffing recommendations, and the Magnet recognition program all call for institutional level committees to plan and allocate staff resources. They also recommend nursing staff involvement in these committees (ANA, 2015; Mensik, 2012). To date, there are few reports from these committees demonstrating how they work. More specifically, little is known about how these institutional level committees influence staffing at the unit level through staff nurse engagement.

Objectives and Aims

- Identify ways staff are engaged by the institutional staffing and scheduling committee to influence staff resource allocation within the unit environment.
- Describe ways the institutional Staffing and Scheduling committee engages staff to influence staff resource allocation at the institutional level.

Limitations

There were three noted project limitations. As with any self-reported tool the risk of response bias does exist and individual reports cannot be independently verified (Polit & Beck, 2012). The survey had 55 questions 34 of which were for demographic purposes and this could have been a barrier to more participation with the survey section and open ended questions. If presented again less demographic questions would be requested. The

Three open ended questions resulted in short responses with little descriptive content. This hindered the ability to analyze theme based frequencies. The design of the questions may have been too defined resulting in a lower requirement for perception elaboration (Polit and Beck, 2012).

CHAPTER II

Literature Review

An overall review of the literature associated with staffing and scheduling is necessary to lay the foundation for the importance of this work. Staffing and scheduling's impact on patient care outcomes related to safety, quality and cost, and nurse satisfaction/retention were assessed but not included in this work on the Staffing and Scheduling Committees ability to engage staff at the institutional and unit level. A search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) electronic database identified 7,439 publications based on key terms 'nurse', 'staffing' and 'scheduling'. Once 'committee' was added to the search 102 items of literature were found. An additional search using CINAHL revealed 1,352 publications using key terms 'nurse' and 'engagement'. Once 'staffing and scheduling' were added 19 publications were found. Eighty two articles were reviewed for this literature review.

Staffing and Scheduling Committees

The formation and enactment of legislation addressing safe staffing is in process at both the state and federal level. The ANA, and its affiliate the ANCC who award magnet recognition to hospitals based on the quality of their nursing programs, are influencing future direction for safe staffing by advocating for the formation of Staffing and Scheduling Committees (ANA Staffing, 2015; ANCC, 2015).

The ANA's definition of a Staffing and Scheduling Committee at the institutional level requires staff involvement in the committee referenced in the Registered Nurse Staffing Act (S. 991, 2003). Dawson (2014) provided recommendations for developing Staffing and Scheduling Committees. First there should be nurse involvement in the design of work schedules, using a regular and predictable schedule so nurses can plan for work and personal responsibilities. Secondly, limiting work weeks to 40 hours within 7 days and work shifts to 12 hours at the most should be a guide. Thirdly, establishing at least 10 consecutive hours per day of protected time off duty in order for nurses to obtain 7 to 9 hours of sleep is essential. Fourthly, the elimination of mandatory overtime as a "staffing solution" should be mandated. The final recommendation is to promote frequent, uninterrupted rest breaks during work shifts and facilitating the use of naps during scheduled breaks should be considered.

Few innovative approaches have been studied in the last twenty years around scheduling and staffing. McKenna et al, 2011 found one exception was the formation of a Nursing Productivity Committee at a 640 bed, not-for-profit, Magnet designated, level II trauma center, community based hospital in California. At his hospital they analyzed their classification of productive and nonproductive hours, seeking improvements in staffing models, and scheduling processes. The group completing this work was referred to as a Nursing Productivity Committee which worked on multiple goals to review/revise staffing formulas for budgeted full-time equivalent (FTE) requirements and understand hours per patient day (HPPD). An important goal of the committee was to identify how staffing variances occur. The committee established standards for productive and nonproductive time using staff input to determine target HPPD on all nursing units.

Computerized staffing reports were analyzed to ensure accuracy and to determine opportunities for improvement. Collaborative Nursing Councils were utilized to address staff morale related to turnover and workload. The committee agreed to seek opportunities for cost savings, without adversely affecting patient care. The work of this Nursing Productivity Committee resulted in lower nurse-to-patient ratios, better control of labor costs, elimination of agency staff, increased staff satisfaction and the introduction of new technologies (McKenna et al., 2011).

Engagement

Another word for engagement that is used in the literature is 'buy-in'. Buy-in involves one's tangible or intangible return on one's investment (French-Bravo & Crow, 2015). Achieving buy-in does require timely, accurate and credible communication, as well as a thorough understanding of what is important to the employees who are impacted by the change. Credibility, vital to any form of communication, starts with being frank, honest, and up-front about the conditions that have stimulated the need for a change in the strategy (French-Bravo & Crow, 2015).

Understanding the history of engagement is valuable when exploring links between engagement with staff around staffing and scheduling at the institutional and unit level. Hackman and Oldham (1980) introduced a model of work re-design, and assert that if this re-design is done correctly it will lead to high internal work motivation and consequently increase employee engagement. Hackman and Oldham (1980) went on to say that the following three psychological states must be met to achieve high internal work motivation. First, the employee must see the work as meaningful. Second, the employee must take full responsibility for the outcomes of one's work resulting from

the increased autonomy. Finally, the employee has concrete knowledge of the results of one's work. Feedback about the outcomes of one's work is a major component of defining the work as meaningful and motivating (Hackman & Oldham, 1980). French-Bravo and Crow (2015) reemphasized this later in their discussion on engagement.

French-Bravo and Crow also illustrated how Kahn (1990) extended the work of Hackman and Oldham (1980) stating that three specific psychological conditions directly lead to employee buy-in. First, there is personal awareness of a return on one's personal investment of self in role performance. Second, there is personal awareness that it is safe to bring one's whole self to the role without negative consequences to self-image, status within the organization and with colleagues, or one's career trajectory within the organization. Finally, there is knowledge that one has the necessary physical, emotional, and psychological resources required for role performance (as cited in French-Bravo and Crow, 2015).

Leaders, who monitor staff engagement in their environments understand that temporary disengagement is much different from chronic disengagement. Often, when staff become chronically disengaged, they may need a complete change in work environments (French-Bravo & Crow, 2015). Porter-O'Grady and Malloch (2011) identified the need for managers to create a "culture of buy-in" to engage employees in the ongoing initiatives of the organization. They believe this is valuable because as the number of initiatives increase the individual interest of the nurse begins to decrease. Too many competing priorities can lead to frustration and burnout in nursing (Porter-O'Grady & Malloch, 2011).

Employees know that new initiatives require time and money. These same employees feel if they are deprived of adequate time to safely provide quality, cost effective, and goal directed patient care due to budget restraints, while the organization is introducing initiative after initiative, they are not being heard. Shared governance is one structure that can be used to address issues in an environment when trust and respect are present. Management should not be surprised when employees seem to be just going through the motions in an environment that does not have trust and respect present, shared governance enhances both trust and respect (French Bravo & Crow, 2015).

An illustration of shared governance as it relates to staffing can be seen in the work accomplished by unitbased forums or councils, allowing managers and staff to work together to improve both patient care and nursing satisfaction. These councils review staffing data regularly to ensure areas of improvement are identified and solutions to staffing issues are addressed quickly. Such partnerships between the staff and management ensure all members understand the complexity of nurse staffing and the methodology for providing needed resources (Ellerbe & Giansante, 2015). As unit-based forums or councils expand their knowledge and experience they become a valued asset to health care organizations. This concept of ‘value’ is supported by a study showing that hospitals perform better over time in virtually every measurable category when employees are engaged with what they are doing and committed to their jobs (Brunges & Foley-Brinza, 2014).

The power of engagement can be seen at Advocate Health Care (AHC), the largest integrated delivery network in Illinois, with 11 hospitals and over 250 sites of care. AHC implemented shared governance in its nursing, clinical, and non-clinical

departments to standardize their financial and staffing practices across the organization. The partnership formed at AHC was between their financial and staffing practices across the organization. Hospital administrators saw a need for change based on increased pressure on nursing to be accountable for financial decisions, necessity for financial education and greater collaboration between nursing and finance, and the beneficial shift in health care information technology towards data integration. Advocate Health Care followed the lead of like institutions such as Chapel Hill, NC and Northwestern Memorial Hospital in Chicago, IL who reported a \$4.9 million in productivity savings and \$7.6 million in turnover cost reduction over 2 years as a result of their educational programs for leadership on finance (Krive, 2013).

Another example was seen at the University of Florida Health Shands Hospital in Gainesville. The managers in the perioperative area initiated staff member scheduling to prevent nurses from being stressed and to ensure that nurses were able to take meal breaks during their shift. This group also was able to take into account staffing mix and match the right mix with the volume of patients to meet the unit needs. One innovative thing this group of staff nurses developed was a get a vacation, give a vacation program. In this program if a staff nurse wanted a vacation sometime during the 10 summer weeks that same nurse was asked to pick up three extra shifts during the corresponding schedule. If the individual nurse did not want to work the extra shifts they could give them away to staff that wanted extra shifts. This program allowed everyone to get a summer vacation that wanted one without adding undue stress to the unit's ability to schedule (Brunges & Foley-Brinza, 2014).

Employee engagement tools were used at Advocate Health Care, these tools included self-scheduling and shift trading. Both tools increased the utilization of hospital staff as opposed to agency or outside employees. The staffing application purchased also gave managers easy views of scheduling gaps and forecasting tools that alert them to upcoming needs early in the planning process (Krive, 2013). AHC found that shared governance allowed them to be innovative and take risks when the traditional models did not work.

Self-scheduling is one innovation put into place over the last two decades to enhance staff engagement. Self-scheduling is believed to increase RN satisfaction by increasing flexibility around scheduling. Abbott (1995) found that nurse managers spend 95% less time scheduling and this is a benefit from a cost perspective. Through self-scheduling, staff members experience an administrative side of the unit operations and team building. Abbott goes on to say that staff members have grown professionally and are more apt to negotiate and cover call-ins when needed. Hoffart and Willdermood (1997) found five factors that influenced a successful outcome in all cases of self-scheduling: committee structure, staff education, negotiation skills, development of guidelines and managerial support. Abbott (1995), and Hoffart & Willdermood (1997) discovered that nurses with good negotiating skills were able to work days and shifts they desired and thus expressed a higher level of satisfaction with self-scheduling more often than those who did not possess this skill set. Self-scheduling has not resulted in the mutual level of satisfaction once hoped for, as not all RN's possess the ability to negotiate and in return must settle for the shifts left over (Hoffart & Willdermood, 1997).

A connection with engagement between the staff RN, and nurse manager or leader exists. In the 1990s, restructuring of hospitals resulted in decreased management positions precipitating a decrease in visibility of leaders (Laschinger, Wong, & Greco, 2006). This created an emotional strain not only on the staff RN but the leader as well. In combination with decreased visibility there has been an increase in the acuity of patients, despite the demand for a decrease in length of stay. This increases the workload for the individual staff RN (Laschinger, Wong, & Greco, 2006). Staffing and Scheduling Committees have an opportunity to assess the engagement of the staff and their leadership. Through the years nursing has been perceived as a commodity regardless of the setting, resulting in nurses integrating multiple principles to guide their professional nursing practice (Nickitas, & Mensik, 2015). As healthcare continues to evolve into an accountable care era, staffing will continue to grow as a complex aspect of leadership. Nurse leaders need to become the driving force behind the innovation of integrated staffing models in all settings across the continuum of care, resulting in better financial, quality and nurse engagement outcomes (Nickitas & Mensik, 2015).

Nurse Managers continue to play a pivotal role in the engagement of their staff and this has been demonstrated throughout the literature. Work engagement is defined as “a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption” (Gray & Shirey, 2013, p. 337). Baylor University used an Employee Opinion Survey in 2010 to look at the engagement level of their 1497 staff nurses, resulting in 1182 responses, and a response rate of 79%. The engagement index looked at the following six questions to measure their employee’s level of engagement:

1. I would recommend my entity to others as a good place to work?

2. How would you rate Baylor Health Care System to work compared with other organizations you know about? 3. I intend to stay with Baylor Health Care System for at least another year? 4. I have a clear understanding of how my job contributes to my entity achieving its business objectives? 5. My entity provides information on how well we are performing against our financial goals (Gray & Shirey, 2013, p.339).

This study found staff nurses were significantly less engaged than nurse managers. This conclusion was indicated by the increased number of unfavorable responses by the staff nurse compared with their managers, indicating that nurse manager behaviors directly impact the engagement level of their staff (Gray & Shirey, 2013).

Engagement of the staff RN as a result of an institutional committee is not present in the literature, but clearly engagement of the staff RN is a factor in many of the measurable outcomes of nursing. Staffing and Scheduling Committees have a unique opportunity to impact the engagement of the staff RN for the entire organization by gathering, sharing and implementing these best practices. Schmalenberg and Kramer, (2009) found nine factors that positively affect the nurse's perceptions on the adequacy of staffing. These nine factors first include working as a team, the skill level and experience level and knowledge level of the nurses. Next, the ability of the RN to make autonomous clinical decisions, the availability of computerized documentation and order entry with collaborative documentation. Then, collaborative multidisciplinary relationships, including physicians, nurses control of nursing practice and their practice environment. Motivated assistive personnel with additional training and a team mentality. Finally, the degree of patient acuity and adequate support services.

To recap, this literature review indicates that institutions report higher retention and engagement scoring when nurses are actively involved in decisions affecting staffing and scheduling. Engaged staff have been shown to be more invested in developing best practices leading to improved outcomes related to a reduction in the following: hospital acquired pressure ulcers, patient falls with injury, development of pneumonia, and mortality rates. As staffing and scheduling committees develop throughout the nation, nurses seek to impact patient outcomes while being mindful of their institutions financial status. This project explored how staffing and scheduling committees engage the RN at the unit as well as the institutional level.

CHAPTER III

Theoretical Model

Donabedian's (1988) *Structure, Process* and *Outcomes* model was used to guide this project (Table 1). The Donabedian model is a conceptual model that has been used for evaluating quality in health care (Moore, L., Lavoie, A., Bourgeois, G., & Lapointe, J., 2015). The model consists of three core categories: "*Structure*," "*Process*," and "*Outcomes*" (Donabedian, 1988). *Structure* describes the context in which care is delivered such as hospital buildings, staff, financing, and equipment. *Process* denotes the transactions between patients and providers throughout the delivery of healthcare. Finally, *Outcomes* refer to the effects of healthcare on the health status of patients and populations (Donabedian, 1988).

Structure consists of all the variables that influence the care delivery model. This project explores structures in place including material resources (such as physical facility, finances, and equipment), the utilization of human resources, and organizational

structure (including Staffing and Scheduling Committees (SSC), and financial reimbursement). *Structure* is observable and easy to measure, resulting in the cause of problems identified in the process (Donabedian, 2003).

Understanding the constraints placed on nursing by the structure of the institution and the physical outline of any hospital leads to a better understanding of what the staffing and scheduling committee is able to impact. Hospitals come in many sizes with independent mission and vision statements. A hospital's mission and vision directly influences the nursing staffs' ability to impact their resources and engage at the unit staff level and institutional level decision making. An example of shared governance related to staffing can be seen in unit-based forums or councils. These councils review staffing data regularly to ensure areas of improvement are identified and addressed quickly (Ellerbe, & Giansante, 2015). These types of councils have a structure that facilitates collaboration between staff and managers to work to improve patient care and nurse satisfaction (Ellerbe & Giansante, 2015).

Donabedian (1980) defines *Process* as the result of actions that make up healthcare. Variables that are commonly included in process are diagnosis, treatment, preventive care, and patient education, and are inclusive of actions taken by patients and/or their family members as well. Donabedian (1980) further classifies *Process* as technical including how the care is delivered, or interpersonal processes, bringing a holistic approach to how care is delivered (Donabedian, 1980).

This project's variables link to Donabedian's (1980) focus on interprofessional processes and the belief that measurement of process could be correlated with the measurement of quality of care due to the fact that process contains the variables within

healthcare delivery (Donabedian, 2003). This project explores different aspects of how Staffing and Scheduling Committees empower staff to make unit and institutional decisions, whether they are involved in SSC leadership, have input in reporting to administration, decisions related to unit skill mix, and institutional decision making related to skill mix and staffing guidelines.

Current trends in staffing and scheduling have negatively influenced the RN's perception of staffing and resource adequacy, while decreasing retention and increasing turnover (Schubert, et al., 2013; Tervo-Heikkinen, Kiviniemi, Partanen, & Vehvilainen-Julkenen, 2009; Van den Heede, Florquin, Bruyneel, Aiken, Diya, Lesaffre, et al., 2013). The ANA platform for Safe Staffing calls for a model that empowers nurses to create staffing plans that meet specific unit demands by creating staffing plans with staffing levels that are flexible and allow for changes. The ANCC Magnet designation criteria promotes the requirement of staffing and scheduling committees. (ANCC, 2015).

Outcomes contains all the effects of healthcare on patients or populations, including changes to health status, behavior, knowledge, patient satisfaction and health-related quality of life. Healthcare's primary goal is to improve the quality of life for the public so this is often seen as the most important indicator of quality (Donabedian, A., 2003). This project demonstrates an indirect effect on outcomes by exploring the impact that staffing and scheduling committees have on nurse engagement with staffing decisions (both skill-mix and budgetary) at both the unit and organizational level.

Brunges and Floey-Brinza's, (2014) study demonstrated that hospitals perform better over time in virtually every measurable category when employees are engaged with what they are doing and committed to their jobs. Porter-O'Grady and Malloch (2011)

identified the need for managers to create a “culture of buy-in” to engage employees in the ongoing initiatives of the organization. Park, Blegen, Spetz, Champman and DeGroot’s (2012) showed that risk for patient mortality within 30 days of admission among surgical patients increased by an average of 7% for every additional patient in a nurses’ patient assignment. Nursing has a direct impact on measurable patient outcomes and these outcomes also factor into the financial status of the hospital.

Table 1. Illustrates the structure, process and outcomes for this project.

Donabedian Model		
Identifying ways that Institutional Staffing and Scheduling Committees engage nursing staff in resource allocation at the unit and institutional levels in VA Magnet facilities.		
Structure	Process	Outcomes
Material Resources: Physical facility, finances, and equipment	How does the Staffing and Scheduling empower staff to make institutional and unit decisions?	The impact of Staffing and Scheduling Committees.
<ul style="list-style-type: none"> • Number of beds in the facility • SSC’s role in budget for nursing personnel • Use of electronic scheduling system 	<ul style="list-style-type: none"> • Direct care nurses involved in SSC leadership • SSC’s reporting to administration • Direct care nurse’s input utilized by SSC • How SSC’s involve direct care nurses in the skill mix of nursing personnel at the unit level • How SSC’s involve direct care nurses in the skill mix of the nursing personnel at the institutional level • SSC’s determining staffing guidelines 	<u>Increased understanding of the following SSC’s functions:</u> <ul style="list-style-type: none"> • SSC’s efforts to improve staff engagement and satisfaction (qualitative question) • SSC’s engaged in developing new service lines • Direct care nurses involved in decisions regarding staffing for new service lines • SSC’s engaged in staffing decisions for new units • Direct care nurses involved in
Human Resources: Number of personnel and their qualifications.		
<ul style="list-style-type: none"> • SSC utilization of HPPD • RN Vacancy Rate • Agency nurse utilization • Use float staff • Use on non-licensed personnel 		
Organizational Structure: Staffing and Scheduling Committees (SSC), and		

financial reimbursement	at the unit level VS. Staff RN's having input into the SSC's to determine staffing guidelines at the unit level	budgetary and skill mix decisions
<ul style="list-style-type: none"> • Membership in SSC • Number of SSC members • SSC reporting mechanism • SSC member job classifications • SSC Nurse Manager representation • SSC Missions Statement • SSC Charter • SSC By Laws • SSC decision making data points • Use of centralized, decentralized, or combined staffing model • RN shifts worked (times and length) 		

Chapter IV

Project and Study Design

A description design was utilized to explore ways that nursing staff are engaged by their institutional Staffing and Scheduling committee to influence staff resource allocation within the unit environment and at the institutional level, from the point of reference of the committee's self-reported perceptions.

Setting, Sample and Resources

Virginia based Magnet hospitals were recruited to participate in this project during the spring of 2017. Virginia has twenty hospitals recognized by the American Nursing Credential Center as Magnet hospitals. The Virginia Magnet Consortium was

utilized to connect with an institutional representative for each Magnet facility in the state of Virginia. Participation in data collection was voluntary following informed consent. One email invitation was sent to the institutional representative through the Virginia Magnet consortium followed up by emails each week to the representative asking for support in the form of forwarding the survey link to members of their Staffing and Scheduling committees.

Snowball sampling was implemented by sending email requests to fellow graduate students at James Madison University in the Doctorate in Nursing Program and the Nursing Administration program. A request was made for them to participate in the survey if they were members of their Magnet facility Staffing and Scheduling committee and if not to pass it along to anyone they knew who was a member of a Staffing and Scheduling committee at a Magnet recognized facility (Research Methodology, 2017; Polit & Beck, 2012). Email communication between the researcher and his colleagues was facilitated by members of the School of Nursing faculty and the request to complete the survey by the 18th of April was established. The survey was closed on the 18th of April with 55 responses acquired at that time. The survey was designed using a Qualtric web-based survey. Refer to appendix (Appendix A) for the survey questions. All participants were at least 18 years of age, employed by the institutions being surveyed and a member of their organizations Staffing and Scheduling committee.

Study Population

The study population included all Magnet facilities that utilize Staffing and Scheduling committees representing a broader sample of facilities. “Do you have a Staffing and Scheduling Committee that has staff nurse participation at the institutional

level within your facility?” was used to identify sample facilities for this descriptive study. Based on the Virginia Magnet Consortium membership, institutions were recruited using email, email written requests and a phone calls to their respective Staffing and Scheduling representative.

Sources of Data

A survey questionnaire developed and administered via Qualtric utilized both Likert scale and open ended questions. Five recognized experts in Staffing and Scheduling were communicated with via email. Janet Haebler, MSN, RN with ANA, Mary Jo Assi, MS, RN, NEA-BC, FNP-BC with ANA, Teresa Haller, MSN, RN, MBA, NEA-BC with the University of Virginia, Kathy Baker, RN PhD, NE-BC with Virginia Commonwealth University and Karlene Kerfoot, PhD, RN, NEA-BC, FAAN with API at General Electric were asked and agreed to evaluate the survey using a Content Validity Index tool. Content validity was established on the topic of Staffing and Scheduling committees and staff engagement at the unit and institutional level with a resulting CVI score of 3.75 or 0.94 for the questions measuring the survey as a whole; and an overall CVI of 3.32 or 0.83. Based on expert opinion feedback questions 5, 13 and 18 were eliminated. Once these questions were eliminated the overall CVI increased to 0.86. The term staff nurse was also changed to direct care nurse.

The questionnaire consisted of demographic information with necessary definitions (questions 1-34), and a survey validated for content utilizing recognized experts in staffing and scheduling (questions 35-55). The survey consisted of Likert scale questions based on a scale of 1 = Never, 2 = Sometimes, 3 = Neutral, 4 = Regularly and 5 = Always, and three open ended questions for content analysis. The last three qualitative

questions added to survey were designed to evaluate the Staffing and Scheduling committee's accomplishments with engagement of the direct care nurse and future plans for engagement of the direct care nurse. The same five experts were asked to assess the questions to establish content validity.

Data Analysis

Descriptive analysis, using frequency percentages, explored ways that nursing staff are engaged by their institutional Staffing and Scheduling committee to influence staff resource allocation within the unit environment and at the institutional level, from the point of reference of the committee's self-reported perceptions. Data was aggregated providing privacy for individual institutions. Three open ended questions were analyzed using content analysis. Due to short participant responses and descriptive content, they were read, and scored for common words by the researcher and advisor individually, and then compared.

Ethics and Human Subjects Protection

All data has remained entirely confidential. The researchers conducting the analysis have not reported on individual hospital results. Only aggregate results from the Likert Scale questions and common themes frequencies gleaned from the open ended questions will be disseminated. Data has been kept in strict confidence. Only the student and faculty investigators have had access to the survey data. Any paper copies of data from the surveys have been stored by the researcher in a secured locked box at home controlled by the researcher. Participation in the project was entirely voluntary and after obtaining informed consent. Minimal risk based on the comfort level in answering the questions was present for the individuals completing the survey.

CHAPTER V

Results and Findings

Demographics

Participant demographics included an equal disbursement between all twenty Magnet recognized hospitals in the state of Virginia. Fifty five responses were received with twenty complete surveys being received. The author's assumption was that each Magnet facility had a Staffing and Scheduling committee made up of at least 4 to 5 participants. Thirty four of the 55 (61.82%) respondents answered yes to being a member of their institution's Staffing and Scheduling committee. Only these 34 respondents were invited to complete the survey. Anyone answering no to membership of an Institutional Staffing and Scheduling committee was redirected to the end of the survey. Seventeen of the 22 respondents (77.27%) acknowledged a direct reporting mechanism to their Chief Nursing Officer. Nine of 22 respondents (40.91%) reported being from an institution with 501-750 beds while 8 of 22 (36.36%) had more than 750 beds.

The following section of demographic points fall within the "Structure phase" of the authors Donabedian model framework. In response to the question *does your Staffing and Scheduling committee have a mission statement* the 22 respondents answered as follows 59.09% or 13 answered yes, 13.64% or 3 answered no, leaving 27.27% or 6 as unknown. In response to *does your Staffing and Scheduling committee have By Laws* 42.86% or 9 of 21 answered yes, while 38.10% or 8 answered no, leaving 19.05% or 4 as unknown. Fourteen out of 22 (63.64%) responded no to the committee having a functional role in the budget development for nursing services personnel.

In relation to data points used by the Staffing and Scheduling committee, also within the “Structure phase” of the author’s framework, the following was observed; out of 21 participants, 12 or 57.12% answered yes to the committee utilizing *Hours per Patient Day*, while 7 or 33.33% responded no. Six out of 22 or 27.27% identified their organizational RN vacancy rate as 10% to 14%, 3 or 13.64% as 14% to 17% and 5 or 23.72% as greater than 22.73%. Twenty one (95.45%) of the 22 respondents answered yes to *does your facility use agency nurses?* Fifteen (68.18%) of the 22 respondents answered yes to use of non-licensed agency personnel, while 6 (27.27%) responded no.

The final section of demographic questions that fell within the “Structure phase” of the author’s framework yielded a majority. In response to *does your facility re-assign, float, and/or move staff from one unit to another unit based on needs* 20 of the 22 (90.91%) respondents answered yes. All 22 respondents answered yes to using an electronic scheduling system. Seventeen (77.27%) of the 22 respondents answered no to having a centralized staffing model. Fifteen of 22 (68.18%) answered no to having a decentralized staffing model. Twenty (90.91%) of the 22 respondents answered yes to having a combined centralized/decentralized staffing model. Fifteen of 22 (68.18%) stated their nursing staff does rotate between shifts on a schedule, while 20 of 22 (90.91%) stated their nursing staff have permanent shifts.

Engagement

The survey questions designed and validated by experts to explore the level of engagement of the direct care nurse at the institutional and unit level are displayed below in Table 2. The seventeen questions looking for engagement had a response rate of at

least 19 for 5 of the questions with the remaining 12 questions receiving a response rate of 20.

Table 2. Engagement in Staffing and Scheduling

Question	Never	Sometimes	Neutral	Regularly	Always	Total Respondents
Direct care nurses are involved in the leadership of the Staffing and Scheduling committee? (Example; Chair or Co-Chair)	20% or 4	15% or 3	20% or 4	35% or 7	10% or 2	20
The Staffing and Scheduling committees reporting mechanism involves direct care nurses at the bedside level?	15% or 3	15% or 3	5% or 1	50% or 10	15% or 3	20
Your Staffing and Scheduling committees reporting mechanism reaches the administrative level (Example Chief Nursing Officer)?	10% or 2	5% or 1	5% or 1	55% or 11	25% or 5	20
Individual direct care nurse feedback is utilized when making staffing and scheduling decisions at the Staffing and Scheduling committee level?	0%	30% or 6	5% or 1	40% or 8	25% or 5	20
To what degree does the Staffing and Scheduling committee involve unit direct care nurses in unit level schedules and skill mix/staffing decisions?	15% or 3	20% or 4	10% or 2	40% or 8	15% or 3	20
To what degree does the Staffing and Scheduling committee involve unit direct care nurses in the skill mix of nursing personnel at the institutional level?	25% or 5	20% or 4	20% or 4	30% or 6	5% or 1	20
The Staffing and Scheduling committee has influence at the unit level on the skill mix of the nursing personnel?	10% or 2	25% or 5	20% or 4	35% or 7	10% or 2	20
The Staffing and Scheduling committee is	5.26% or 1	5.26% or 1	5.26% or 1	68.42% or 13	15.79% or 3	19

able to set scheduling guidelines at the institutional level intended to be followed at the unit level?						
The Staffing and Scheduling committee involves direct care nurses in setting scheduling guidelines at the institutional level?	10% or 2	20% or 4	10% or 2	45% or 9	15% or 3	20
The Scheduling guidelines referenced in the previous question are followed at the unit level?	0%	25% or 5	15% or 3	35% or 7	25% or 5	20
The Staffing and Scheduling committee is able to set staffing guidelines at the institutional level intended to be implemented at the unit level? (Example; how units float or reassign staff to cover needs)	10% or 2	10% or 2	0%	55% or 11	25% or 5	20
The guidelines referenced in the previous question are followed at the unit level?	5% or 1	40% or 8	5% or 1	40% or 8	10% or 2	20
The Staffing and Scheduling committee is engaged by hospital administration when developing new service lines? (Example; adding a medicine team of physicians would require more bedside RN's to render the care at the bedside)	36.84% or 7	21.05% or 4	26.32% or 5	5.26% or 1	10.53% or 2	19
The Staffing and Scheduling committee involves direct care nurses in decisions regarding staffing of new service lines?	52.63% or 10	15.79% or 3	15.79% or 3	15.79% or 3	0%	19
The Staffing and Scheduling committee is engaged by hospital administration when opening new units? (Example; opening a dialysis unit or a new Cath Lab would require more bedside RN's to	45% or 9	15% or 3	15% or 3	15% or 3	10% or 2	20

render the care at the bedside)						
Direct care nurses at your institution are involved in budgetary decisions regarding staffing and skill mix at the unit level.	42.11% or 8	26.32% or 5	15.79% or 3	10.53% or 2	5.26% or 1	19
To What degree does the unit staff nurse participate in Staffing and Scheduling committee reports to administration?	15.79% or 3	47.37% or 9	5.26% or 1	26.32% or 5	5.26% or 1	19

Results indicate that the Magnet Facilities surveyed are in Donabedian’s “Process phase” with varied levels of staff engagement by the institutional Staffing and Scheduling committee to influence staff resource allocation within the unit environment and at the Institutional level.

Staffing and Scheduling committees have direct care nurses in a leadership position categorically 35% regularly and 10% always. Of the participants, 68.42% indicated the Staffing and Scheduling committee is able to set guidelines intended to be followed at the unit level. Respondents also indicate that Staffing and Scheduling committees involve direct care nurses 45% of the time in setting guidelines at the institutional level. This represents the Staffing and Scheduling committees’ ability to engage direct nurses in the scheduling and staffing process. Brunges and Foley-Brinza (2014) spoke about the improvement over time in virtually every measurable outcome when employees are engaged with what they are doing. Direct care nurses are involved in the reporting mechanism regularly 50% of the time, and 55% believe their work reaches the Chief Nursing Officer level, which indicates solid “Process phase” within the Donabedian model framework. Ellerbe & Giansante (2015) addressed the need for partnerships with

staff and management to ensure all staff understand the complexity of staffing and the methodology needed for resource allocation.

The three qualitative questions resulted in the following findings. The questions did not produce as much descriptive content as anticipated so they were explored for common words and these are being reported out. For the first question “*Describe the Staffing and Scheduling committees’ biggest opportunity for growth or challenge in relation to staff engagement?*” there were 17 response. For five of the 17 respondents including more direct care nurses on the committee was perceived as the opportunity/challenge. Three of the respondents also felt communication to the direct care nurse allowing for improved insight and guidance was an additional opportunity/challenge. Within the “Structure and Process phase” of the Donabedian framework the ability of the Staffing and Scheduling committees to allow the direct care nurse to guide the principles of its work was important. The remaining 9 respondents had individual perceptions for their respective committee. As stated earlier Gray & Shirey (2013) found that management was more engaged than the direct care nurse, involving more direct care nurses could address this. Within the Structure and Process of the Donabedian framework the ability of the Staffing and Scheduling committee to allow the direct care nurse’s input to guide their scheduling and staffing principles was important.

The second question “*Describe the Staffing and Scheduling committee’s accomplishments in relation to staff engagement?*” yielded 5 responses for the implementation of an electronic scheduling system or the transparency it creates, and 3 responses for policy development and implementation. The remaining 9 respondents had individual comments with no notable theme. Krive (2013) found that the electronic

scheduling system allowed for forecasting tools that alerted management of needs earlier in the process. Electronic scheduling tools were also noted by Schmalenberg and Kramer (2009) as one of the 9 factors needed to positively affect the direct nurse's perception of adequacy of staffing. Electronic scheduling tools fall within the "Structure phase" of the Donabedian framework and based on the results of the survey are well utilized throughout the state.

The final question "*What is your Staffing and Scheduling committee currently working on or have plans to work on this year in relation to staff engagement?*" resulted in 17 responses as well. Nine of the 17 respondents mentioned policies or guidelines representing what their committees are currently developing to increase staff engagement. Five respondents discussed floating or reassignment in either their policy/guideline development statement or separately. Nickitas & Mensik (2015) stated that nurse leaders need to be innovative with staffing models in all settings to increase nurse engagement. Innovation falls within the "Outcomes phase" of the Donabedian framework and maturation of the committees surveyed is still needed. Based on 9 of the 17 responses, guidelines and policies are planned work of the committees over the next year representing the "Process phase" of the Donabedian framework.

Health Policy

Based on the respondents ANA's definition of a Staffing and Scheduling committee at the institutional level are being met. All respondents acknowledge direct care involvement with 11 out of 20 having a direct care nurse in a leadership position within the committee. McKenna et al, (2011) found only one innovation over the last twenty years in relation to staffing and scheduling, but based on the qualitative responses

incentivizing shifts is being evaluated. Dawson (2014) provided recommendations for Staffing and Scheduling committees, mostly rule based, the qualitative responses to the open ended questions resulted in guidelines and policies being the most common response in relation to future work and opportunity/challenge.

The ANA platform for Safe Staffing (2015) recommends empowerment of the direct care nurse in the creation of staffing plans to meet the unique demands from a legislative approach. Further research on the impact of these Staffing and Scheduling committees could support this call. Sixteen out of the 20 respondents felt they were empowered to set institutional guidelines to be implemented at the unit level regularly or always. Current legislation and regulation has not resulted in the development of Staffing and Scheduling committees, but additional exposure to the committee's ability to impact such a difficult topic as staffing could influence more prescriptive legislation development (ANA Staffing, 2015).

CHAPTER VI

Discussion

Recommendations/Implications

Project results add to the literature allowing for development of Staffing and Scheduling committees. ANA will be provided with the aggregate data and advocacy work will continue with ANA in order to implement the findings into future policy development, state by state engagement, and potential legislation. Institutional Staffing and Scheduling committees can benefit from the findings and focus on their individual policies. State legislation could also prove valuable. A collaborative approach to staffing and scheduling may be enhanced by the findings of this project.

Donabedian (1980) classifies *process* as technical including how care is delivered, or interpersonal processes, bringing a holistic approach to how care is delivered (Donabedian, 1980). Based on the author's results from the survey the "Structure phase" of each committee is established with one building the by-laws and charters necessary to complete this phase. The majority of the committees were also well established in the "Process phase" with little support for full maturation into the "Outcome phase". The innovation necessary to be engaged in service line and additional services being added to an institution was lacking.

Staffing and Scheduling committees should continue to be developed and allowed time for this evolution process. Senior leadership involvement at the Chief Nursing Officer level is a necessity as it is seen as a positive response by a majority of the participants. Legislation continues to be developed that may mandate staffing and scheduling parameters for the profession and the Staffing and Scheduling committee appears to be an alternative method to achieving safe staffing levels within our health care organizations. The direct care nurse is respected in these committees and add value to the discussion as they are facing the challenges that staffing and scheduling present on a regular basis. This work and other work like it should be shared with legislators allowing them an opportunity to see the value of an engaged Staffing and Scheduling committee. More work is necessary to link measurable outcomes along the lines of finance and quality with Staffing and Scheduling committees. Data is being used by Staffing and Scheduling committees but an opportunity for growth in this area is evident.

Conclusion

This Project did explore ways nursing staff are engaged by their staffing and scheduling committees to influence staff resource allocation on the unit and at the institutional level. Donabedian's (1980) model of structure, process and outcomes was used to guide the authors work. Strong support for the appropriate structure was demonstrated by the participating committees with the majority being well evolved into the process phase. Little support was found for maturation to the outcomes phase of the framework, and time should be awarded to the committees for this process to develop. Staff are the point of entry for patient centered outcomes and should be involved in the decision process that allocates the resources that impact them and their patients. Nurses are the largest and most trusted workforce in the American healthcare industry and they have the credentials to be one of the most influential voices in the decisions regarding healthcare policy (Steier, 2011).

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Appendix A (Survey Questions)

Survey

When answering questions 1 through 20 approach the question from the perspective of the Staffing and Scheduling Committee. Use a Likert Scale of 1 = Never, 2 = Sometimes, 3 = Neutral, 4 = Regularly and 5 = Always

1. Direct care nurses are involved in the leadership of the Staffing and Scheduling committee? (Example; Chair or Co-Chair)
 - 1 (Never)
 - 2 (Sometimes)
 - 3 (Neutral)
 - 4 (Regularly)
 - 5 (Always)

2. The staffing and scheduling committees reporting mechanism involves direct care nurses at the bedside level?
 - 1 (Never)
 - 2 (Sometimes)
 - 3 (Neutral)
 - 4 (Regularly)
 - 5 (Always)

3. Your Staffing and Scheduling committees reporting mechanism reaches the administrative level? (Example Chief Nursing Officer)
 - 1 (Never)
 - 2 (Sometimes)
 - 3 (Neutral)
 - 4 (Regularly)
 - 5 (Always)

4. Individual direct care nurse feedback is utilized when making staffing and scheduling decisions at the Staffing and Scheduling committee level?
 - 1 (Never)
 - 2 (Sometimes)
 - 3 (Neutral)
 - 4 (Regularly)
 - 5 (Always)

5. To what degree does the Staffing and Scheduling Committee involve unit direct care nurses in unit level schedules and skill mix/staffing decisions?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

6. To what degree does the Staffing and Scheduling Committee involve unit direct care nurses in the skill mix of nursing personnel at the institutional level?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

7. The Staffing and Scheduling committee has influence at the unit level on the skill mix of the nursing personnel?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

8. The Staffing and Scheduling committee is able to set scheduling guidelines at the institutional level intended to be followed at the unit level?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

9. The Staffing and Scheduling committee involves direct care nurses in setting scheduling guidelines at the institutional level?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

10. The scheduling guidelines referenced in question 9 are followed at the unit level?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

11. The Staffing and Scheduling committee is able to set staffing guidelines at the institutional level intended to be implemented at the unit level? (Example; how units float or reassign staff to cover needs)

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

12. The guidelines referenced in question 12 are followed at the unit level?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

13. The Staffing and Scheduling committee is engaged by hospital administration when developing new service lines? (Example; adding a medicine team of physicians would require more bedside RNs to render the care at the bedside)

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

14. The Staffing and Scheduling committee involves direct care nurses in decisions regarding staffing of new service lines?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

15. The Staffing and Scheduling committee is engaged by hospital administration when opening new units? (Example; opening a dialysis unit or a new Cath Lab would require more bedside RNs to render the care at the bedside)

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

16. Direct care nurses at your institution are involved in budgetary decisions regarding staffing and skill mix at the unit level.

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

17. To what degree does the unit staff nurse participate in Staffing and Scheduling Committee reports to administration?

- 1 (Never)
- 2 (Sometimes)
- 3 (Neutral)
- 4 (Regularly)
- 5 (Always)

For question 18, 19 and 20 please provide free text comments. No accomplishment or opportunity is too small.

18. Describe the Staffing and Scheduling committees' biggest opportunity for growth or challenge in relation to staff engagement?

19. Describe the Staffing and Scheduling committee's accomplishments in relation to staff engagement?

20. What is your Staffing and Scheduling Committee currently working on or have plans to work on this year in relation to staff engagement?