**EP9: Describe and demonstrate how direct care nurses participate in staffing and scheduling processes.**

The structures and processes for direct care nurse participation in staffing and scheduling at Riverside Medical Center varies somewhat from unit to unit. A transition from leader-controlled scheduling to a participative structure and process has been underway for several years. This transition is supported by our Vigilance Professional Practice Model concept of Transformational Leadership and Shared Decision-Making:

<table>
<thead>
<tr>
<th>CONCEPT</th>
<th>DESCRIPTION</th>
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<td><strong>Transformational Leadership and Shared Decision-Making</strong></td>
<td>Consistently and appropriately effects change through engagement, involvement, and participation of peers and colleagues, leading others where they need to be rather than where they want to go.</td>
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**Background**

For many years, direct care nurses’ participation in staffing and scheduling has been limited to requesting days off for vacations or other events. Nurses who are attending classes for advanced degrees or those needing specific days off every week would ask the nurse manager to avoid scheduling them for those days or shifts. Nurses could enter a note on the draft schedule. A draft schedule was (and is) a working document, which served as a blueprint for the final schedule.

Direct care nurses and other staff, such as CNAs and unit secretaries, would submit a Request for Time Off form to the team leader or the manager who coordinated schedules. The manager or team leader would either grant or deny a request. If too many requests for the same day off were received, the staff member who submitted the request first would receive the day off. After the requests were either granted or denied, the schedule would be completed.

Some nurse leaders have practiced a form of shared scheduling. An RN, which is the 2nd Med/Surg Nurse Manager, noted when she was a team leader on another unit, she always asked nursing about their scheduling preference. Preferences may have been three days in a row, three days at beginning of pay period, and three days at the end of the pay period; or who would work two days in a row then have one or two days off and work the third day. She knew the nurses who were willing to pick up overtime and not become upset if she scheduled them on additional days where she needed extra help. She considered this process a form of self- or shared scheduling. She was willing to work with the nurses in an attempt to develop schedules preferable to her staff.

Because Riverside Medical has a weekend program, this part of the schedule has been fairly straight-forward: the weekend nurse must meet the obligations outlined in an annual contract, which falls on the same schedule as our annual
performance appraisal for employees from staff level to manager level: July 1st to June 30th. (Directors and executive leaders’ appraisal year is from January 1st to December 31st.) The weekend program for the 2009-2010 appraisal year follows.

- Each weekend, an employee must work twenty-four (24) total hours per weekend, (24 of every 26 weekend shifts per quarter totaling 96 worked weekend shifts per year) AND get paid for eighteen (18) hours per shift. 24-hour obligation of hours worked must be per each Friday/Saturday/Sunday weekend (vs. per week). Unless approved by the Chief Nursing Officer or Vice President of the area, for purposes of this option, Weekend is defined as:
  - 12 hour shifts: anytime from Friday 5pm to Monday 5am;
  - 8 hour shifts: anytime from Friday 3pm to Monday 7am).
  - Weekend days off are defined as:
    - Finding a replacement
    - Unscheduled time off request for any reason
    - Scheduled time off request

**Staffing Practices and Direct Care Nurses**

Staffing practices at Riverside Medical Center were described in EP8. The role of direct care nurses in determining staffing plans is participatory. Riverside nursing leaders solicit direct care nurses’ input into staffing decisions. Direct care RNs are more aware of the factors that go into determining staffing plans, since we began using NDNQI data to guide staffing decisions.

**Transitioning to Self- and/or Shared-Scheduling**

For the last several years, a trend toward shared decision-making in scheduling and staffing has taken hold. Part of this process was giving nurses a choice in how they are scheduled to work. Several years ago, after several discussions among the team leaders and managers of each nursing unit, the group decided to pilot direct care nurse self-scheduling, with established guidelines. Because the nurses on each unit had different preferences, the guidelines were developed by the team leader and/or manager of each nursing unit and shared with their nurses. Although the guidelines were not consistent across units, an essential requirement was the guidelines be applied consistently within each unit. In addition, managers must adhere with all Riverside Human Resources polices and any federal labor laws. Following are implementation examples from several nursing units, the manager’s guidelines, the direct-care nurses’ responses to the new processes, related issues, and outcomes.

**2nd Medical/Surgical**

On 2nd Med/Surg, the manager had to determine what self-scheduling would look like: for instance, she needed to determine par levels of staff each day, how
many nurses could request off and still meet minimum staffing guidelines, how many times a nurse could request off in an eight week schedule, what nurses needed specific accommodations to meet school schedules, and how many weekends each nurse would need to work with a fully staffed weekend program in place. Many aspects needed consideration in order for this process to work, and work well. Within the weekend program guidelines, each nurse is entitled to one weekend off in a quarter. Therefore, each non-weekend nurse only had to work one weekend in an eight week schedule. The manager wrote the guidelines were shared them with her nursing staff. Each nurse still had the opportunity to request days off. The requests were either granted or not granted, and placed on the schedule. When the nurses received the schedule, the granted requests are marked in pen. The guidelines are:

- Each direct care nurse must schedule themselves one weekend in an eight week schedule,
- Two Fridays a month needed to be worked by each nurse
- There had to be seven nurses scheduled on each day.

Self-scheduling started in April, 2009. There have been instances since the inception of the process when nurses needed to be reminded of the guidelines. For example, nurses might schedule themselves on a day when there were already seven or more nurses scheduled. The latest revision to the guideline is that, each nurse, when filling out the schedule, must place the date when the request was made. Therefore, when a schedule change was made, the nurse who filled out the schedule last would be the one the manager talked to first about the scheduling issue. Not all nurses feel comfortable addressing scheduling issues with their peers and seek assistance form the team leader or manager. A new process was implemented recently by the manager: one direct care nurse from each shift is in charge of the schedule. If the nurse in charge of the schedule has questions related to the scheduling process, s/he will contact the manager.

**2ICU**

On 2ICU, self-scheduling is done by the direct care nurses for both shifts. A blank schedule is made available for nurses to complete. However, there have been issues when too many staff members chose to work the same day. This has occurred frequently and the manager had to back and make changes to the schedules. In order for the changes to be made, the manager had to contact the nurse and confirm the change was okay. This process led to the manager spending a lot of time rearranging a schedule that was supposed to have been done by the nurses, the manager presented this issue to the nurses and asked them determine a solution. The nurses chose a nurse on each shift to be the designated “owner” of the schedule. All nurses agreed this nurse would have the authority to make changes necessary to produce a complete and fair schedule.

**3rd Ortho/Neuro**
On 3rd Ortho Neuro, an LPN, who has worked at Riverside for 30 years, has been in charge of making schedules for 15 years. The manager asked the nurses to determine how they would like to implement self- or shared-scheduling. The nurses voted, and decided they wanted Denise to continue to do the schedule. The LPN, day team leader for 3rd Ortho/Neuro shared that all the nurses know Denise is fair when it comes to scheduling. They give her the requests for the days they want off and if there is an issue, she is very balanced in her decisions. So far, this process had worked well. While the nurses did not want to implement a self-scheduling structure, they were involved in making the decision to maintain the current process.

3rd Telemetry

Third telemetry has a “request book” that allows staff to request days off. One week before the schedule is given to the staff to do self scheduling, all requests are looked over by the manager of the unit and either granted or not. The schedule is then given to staff members to fill in. It generally only takes one week for the staff to fill in their dates and then the manager looks over the schedule. It was agreed by all staff that if changes needed to be made to meet minimal staffing they would be made by the manager without any calls to the staff.

4th Med/Peds

On 4th Med Peds, requests are taken first, then a schedule with the all the requests is distributed to nursing staff. The schedule is posted for a two-week period, giving all nurses the opportunity to add or change days. Once the two-week period is over, the schedule is given to the team leader, who then makes adjustments to ensure minimal staffing needs are met. This is a recent process, and nurses feel there are some issues to address.

4th Rehab

On the Rehab unit, self-scheduling has been in place for several years. There are fewer nurses who work this unit, which might make self-scheduling easier in some respects. When there are needed changes, there are fewer nurses to contact. This unit has a weekend program for days and nights. The only time a weekday nurse needs to float into a weekend is if a weekend nurses requests a weekend off. When the Rehab unit opened, this scheduling practice was initiated. There is very little turnover on the unit so many nurses who started the self-scheduling process are still working there.

5th Tele

At one point, 5th Tele had at one point done self-scheduling, but nurses voted to have the day and night team leaders resume handling the schedules. 5th Tele is a
large unit, and nurses felt it was more difficult to implement self-scheduling than to have a designated nurse handle it. Therefore, nurses give requests for days off to team leaders, and team leaders grant or do not grant the requests. The schedule is completed by the team leader and distributed to nurses. This was the process that nurses preferred.

**5ICU**

In 5ICU, the nurses had been doing self scheduling, but in the last six months, there have been many issues with how the staff had been scheduling themselves. The manager was continually making changes to the schedule to ensure minimal staffing levels were maintained. This involved calling nurses at home and asking the nurses to rearrange their days off. This took her more time than actually doing the schedule herself. The manager gave nurses the next two schedules to try and work out the issues. She found she still had the same issues. Therefore, at the end of the second schedule, the manager decided she would do the schedules for the unit. For the next two schedules, the manager completed the schedules after nurses had given her their requests for days off. Recently, two nurses asked the manager if a nurse from each shift could be in charge of the schedules. The unit nurses voted to try this. So far, this process is working well. There are still issues, but nurses feel there is better accountability in having direct care nurses complete the schedule.

**Perioperative and Procedural Areas**

Like the other inpatient nursing units, the nurses and leaders in perioperative and procedural areas use a variety of staffing and scheduling processes.

**Special Procedures Lab (SPL)**

The manager of the SPL does the monthly scheduled. The charge nurse for the currently day determines the staffing for the following day, which is usually a minimum of the manager (who does help with patient care) and two other nurses. Staffing is determined by hours (see next section on IVOing).

**Outpatient Surgery (OPS) and PACU**

Nurses are cross-trained in the OPS and PACU departments. They have one nurse who currently prepares the schedule. This responsibility used to be rotated amongst the staff, but the nurses decided they wanted a RN to do the schedule. They feel she does a great job and is fair. The manager reviews the schedule prior to disseminating it to verify requests off, shortages, and vacations. The nurses in these areas do not sign up for shifts. On-call times are rotated in the PACU by number equally. The holiday call is rotated as well, so nurses do not get the same holidays off or on for so many years in a row.
**O.R.**

In the Operating Room, a direct care nurse does the scheduling, including call.

**Electrographics (EKG) & Cardiac Rehab**

RNs in these areas can work in both departments. The manager or designee creates the schedule with input from her nurses (e.g., scheduling preferences).

1. Manager or designee does the schedule with input from the nurses—schedule preferences—etc.
2. IVO is by volunteer or in a rotation, if no one wants it off.

**The Issue of IVOing for Low Census**

For the last 15 years, the direct care nurses at Riverside have determined who would receive low census by dates – taking turns according to the last date IVOd (involuntary time off due to low census). Recently, the nurses on 2nd Med/Surg decided to try a new process for determining whose turn it was to take IVO. Managers discovered that nurses in 2ICU and the night nurses on 5th Telemetry were using this process. The team leader on 2nd asked the nurses on 2 ICU and 5 Telemetry what staff nurses thought the pros/cons were to this process. The new process tracked the number of hours worked, rather than the last day worked. This was especially useful for nurses who were IVOd a great deal in 2009 due to low census. We saw this trend with the economic recession.

This hourly version of determining turns for IVO for low census was explained in detail to the nurses on 2nd Med-Surg. The nurses on 2nd Med-Surg voted to determine which process would be used – dates or hours. The night shift nurses voted to use the new process, but the day shift nurses did not want to change how low census was handled for them. Recently, after initiating this process and only being in use for 2 weeks, the day shift nurses have seen how this process is a more accurate way of determining how many hours a nurse has been on call and will vote again to decide which process to use. Most of the other units at Riverside use either dates or hours to determine how low census is handled.

In OPS/PACU, the first nurses to be IVO’d are employees working over their FTE. Then they look at who would like low census for that day. If no one wants low census they then rotate IVO by date. So for example if Mary’s date was 05/21/10 and Suzie’s was 05/02/10, Suzie would be first for IVO. The call staff has first choice to work or not work so if it is their turn for IVO and they are on call that evening, they get to choose whether they want to work. They then will IVO the next person by date.
In the O.R., IVO is on a rotation basis. Names are kept in a file and when a nurse is IVO's, his/her name goes to the back of the file, and the name of the next nurse IVO'd is at the front of the file. In Electrographics and Cardiac Rehab, IVO is by volunteer or in a rotation, if no one wants that day off.

**Outcomes**

The outcomes related to direct care nurse participation in scheduling and staffing can be gleaned from the National Database of Nursing Quality Indicators (NDNQI) measure, Participation in Hospital Affairs. This NDNQI (2009, p. 11-12) indicator measures “the participatory role and valued status of nurses in a broad hospital context.” Survey questions reflect the following (those particularly applicable to this source of evidence are in italics):

- Career development/clinical ladder opportunity
- *Opportunity for staff nurses to participate in policy decisions*
- A chief nursing officer which is highly visible and accessible to staff
- A chief nursing officer equal in power and authority to other top-level hospital executives
- Opportunities for advancement
- *Administration that listens and responds to employee concerns*
- *Staff nurses are involved in the internal governance of the hospital (e.g., practice and policy committees)*
- *Staff nurses have the opportunity to serve on hospital and nursing committees*
- Nursing administrators consult with staff on daily problems and procedures

The NDNQI results in the graph below reveal a significant increase in nurses’ feelings of participation between 2008 and 2009. The rate of improvement is greater than that of the all comparison units in comparison hospitals. This improvement is most likely due to several factors:

- Increased involvement in committees and councils
- The shift to self- or shared-scheduling, and/or nurses’ voting on their units’ preferred scheduling practices
- The state mandate requiring hospitals to include direct care nurses in implementing acuity guidelines, at a 50% committee membership rate
Summary

Throughout the widespread implementation of self- or shared-scheduling, nurses form all levels had challenges to overcome. Although some units do not use self-scheduling, it was obvious from the perusal of many nursing departments that participative decision-making was the norm, and direct care nurses have a voice in determining how staffing and scheduling should be accomplished at Riverside Medical Center.

Reference
