

# Staffing and Productivity in the Emergency Setting

## Description

Emergency nurses are essential to the delivery of quality emergency care around the world. There are several factors to consider when evaluating the appropriate staffing of an emergency department (ED): 1) determination of the number of full-time equivalents (FTE) required to meet the needs of the department overall, 2) staffing for the day-to-day operations to ensure adequate care of the patients on each shift, and 3) efficient utilization of staff to meet productivity goals (productive hours worked divided by targeted, productive hours) (Connelly et al., 2017).

There are strategic (long-term) and tactical (short-term) drivers or objectives to consider when making ED staffing and productivity decisions. Strategic drivers include quality, safety, service, and cost (Shin et al., 2018). The Institute of Medicine, now known as the National Academy of Medicine, identified six performance characteristics to improve quality healthcare that remain relevant today: safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Evidence correlates quality of care to adequate nurse staffing and the educational preparation level of the nursing staff (i.e., associate, bachelor, masters, or doctorate) (Aiken et al., 2011; Cho et al., 2016; Ramsey et al., 2018). Tactical drivers include patient volume, acuity, length of stay, boarding/holding, and staff skill mix (provider, licensed, unlicensed, educational preparation, and experience) (Connelly et al., 2017; Moteri et al., 2024).

Studies show that specific levels of nurse staffing are associated with improved clinical and economic outcomes that meet or exceed the strategic and tactical drivers or objectives (Costa & Yakusheva, 2016; Wolf et al., 2017). Adequate nurse staffing improves patient and nurse satisfaction as well as reduces procedural and medication errors, patient mortality, hospital readmissions, and length of stay (Aiken et al., 2011; Blume et al., 2021; Nelson et al., 2018; Wolf et al., 2017). Increased staffing reduces adverse nurse-sensitive outcome quality indicators such as patient falls, pressure injuries, central line infections, and hospital-acquired infections (American Nurses Association, 2015). Additionally, nursing fatigue is reduced with correct nurse staffing, promoting safety, retention, and satisfaction (Aiken et al., 2011; Wolf et al., 2017).

Traditionally, and in other nursing departments, nursing unit staffing is based on nurse-to-patient ratios, where acuity and patient type are consistent. However, this method is insufficient in EDs because of volume and acuity variations (Wundavalli et al., 2019). For example, within the ED, at the onset of their care, high-acuity cardiac, stroke, or trauma patients may require care from multiple RNs at once, yet multiple low-acuity patients may be cared for by one RN while maintaining safety and satisfaction. In this way, nurse-to-patient ratios are ineffective when addressing ED staffing needs and a method reflective of ED dynamics is ideal. Community needs assessment, including situational, seasonal, or permanent changes in the community or population served, should also be important to incorporate into staffing decisions. Lastly, there is no evidence to support that nurse staffing ratios can be based solely on number of beds in the ED (Lordache et al., 2020).

The operational budget, staffing, and productivity are interdependent. To evaluate and optimize safe staffing for the ED, information is required related to the targeted matrices the institution has already adopted. Data gathered from the emergency department information systems (EDIS) on patient acuity, arrivals and discharges per hour, and volume per hour by day of week, as well as nurse satisfaction and

41 patient experience surveys, are important factors for consideration in the determination of appropriate  
42 staffing (Connelly et al., 2017).

### 43 **ENA Position**

44 It is the position of the Emergency Nurses Association (ENA) that:

- 45 1. Emergency nurses are essential to the delivery of safe, quality, cost-effective emergency care.
- 46 2. To facilitate safe emergency care, a minimum of two RNs be present whose primary responsibility is  
47 patient care in the ED at all times, regardless of the ED size, capacity, census, or acuity.
- 48 3. Emergency nurses support the use of evidence-based methods to determine staffing and productivity.
- 49 4. Emergency nurses play an active role in determining and evaluating nurse staffing guidelines.
- 50 5. When considering staffing needs in the ED and accounting for the fluid nature of the department,  
51 patient acuity, and volume, the use of nurse-to-patient ratios is not recommended.
- 52 6. ED staffing is based on staff mix of experience, education, and scope of practice; patient volumes and  
53 acuity; ED input, throughput, and/or output delay; and staff and patient safety.
- 54 7. Caregiver hours devoted to boarded patients are not included when calculating ED staffing.
- 55 8. The worked hours per patient visit (wHPPV) calculation methodologies allow for the separation of  
56 caregiver hours for both ED and boarded patients.
- 57 9. Ongoing systematic evaluation of staffing models and patient outcomes is essential to the delivery of  
58 quality emergency care.
- 59 10. Emergency nurses support further research regarding ED staffing models and their impact on patients,  
60 nurses, and healthcare systems.

### 61 **Background**

62 Healthcare costs continue to soar. Labor expenditures account for over 50% of hospitals' patient care  
63 costs. In 2022, because of contract travel nurses, there was a 213% increase in hourly wages for nurses.  
64 The number of travel nurse staffing was 19% in 2019 and rose to 60% in 2022. The cost per patient for  
65 labor was an increase of 24.7% American Hospital Association, 2022, 2023As good stewards of  
66 resources, nurse leaders manage all elements of operations, which includes staffing and productivity. Best  
67 practice when developing nurse staffing plans includes a multi-faceted approach, and consideration of  
68 many variables. Staffing plans balance labor cost without compromising patient safety, patient  
69 satisfaction, or staff satisfaction (Lordache et al., 2020; Ray et al., 2003; Wundavalli et al., 2019).

70 There are several models and algorithms available for establishing ED staffing requirements including  
71 worked hours per patient visit (wHPPV) (ENA, 2020; Graff et al., 2016; Lordache et al., 2020; Ray et al.,  
72 2003; Wundavalli et al., 2019). However outside of the "theoretical" ED, predictive staffing models can  
73 be problematic due to variations in census, patient acuity, nursing competencies, education time for initial  
74 and ongoing staff training, and nursing skill mix (ANA, 2020; Graff et al., 2016; Saaiman et al., 2021).

75 Also challenging staffing requirements is the presence of patients boarded in the ED and their extended  
76 time frames for care. Aside from consuming ED staff, boarded patients in the ED both represent and are a  
77 delay to patient flow, increasing patient mortality and morbidity; errors; delayed or missed physician  
78 orders; time to surgery; and poorer outcomes for cardiac, stroke, and sepsis patients; as well as decreased  
79 patient satisfaction (ENA, 2020). Any staffing model or algorithm should consider nursing skill and  
80 experience, and the proportion of unlicensed supportive personnel (ANA, 2020 20202020). Other factors  
81 influencing nurse staffing requirements include time needed for documentation; patient/family education;  
82 care coordination, supervision, and delegation activities based on effectiveness and efficiency of support  
83 personnel; and ethical decision-making (Wise et al., 2015).

84 In some settings, staffing ratios vary by type of hospital/ED and shift worked (Wise et al., 2015). For  
85 example, trauma center EDs tend to have more nurses per number of ED beds given their status as tertiary  
86 care centers and expanded catchment area for trauma patient referrals (ENA, 2015). Ultimately, the  
87 minimum acceptable requirement suggested by the Emergency Nurses Association's (ENA) Staffing  
88 Guidelines for safe, quality care in any ED is two registered nurses around-the-clock (ENA, 2015). A  
89 continuous core staff of two registered nurses at all times, regardless of how low the patient volume or  
90 acuity might be, is needed to function safely (ENA, 2019). The Staffing Guidelines use department-  
91 specific data for the calculation of full-time equivalents (FTEs) (ENA, 2019).

92 Worked hours per patient visit is a common method for calculating staffing and productivity. WHPPV is  
93 calculated by dividing the number of employee hours by the number of patient visits that occur within the  
94 same time period (ENA, 2020). Although wHPPV may be a good starting point for determining staffing  
95 need on an annualized basis, this calculation makes it difficult to adjust for the daily and seasonal  
96 variations in volume, acuity, and length of stay as well as boarded patients. In the use of a wHPPV  
97 productivity calculation, it is recommended that it allow for the separation of caregiver hours for ED  
98 patients and boarded patients to account for their varying workload and demand for resources (ENA,  
99 2020). Other considerations of non-productive employee hours, such as medical leave, vacation, etc. also  
100 need to be accounted for in staffing considerations. ENA's tool uses patient visits and length of stay as a  
101 proxy for patient acuity to determine the number of FTEs required per year in an ED (ENA, 2019).

102 Increasingly, ED managers can access department metrics to align nurse staffing with patient volume and  
103 acuity variations. Formulas for average hourly volume and average hourly nurse demand too are  
104 becoming available to objectively adjust staffing to meet demands without sacrificing the quality and  
105 safety of patient care (Ramsey et al., 2018).

106 A primary component outlined in the 2012 ANA's Principles for Nurse Staffing stated "direct care nurses  
107 must have a substantive and active role" in the determination and evaluation of nurse staffing guidelines  
108 (Wise et al., 2015). It is fundamental when conducting any evaluation of staffing and productivity to  
109 include the impact on emergency nurse safety, patient and staff satisfaction, and the recruitment and  
110 retention of qualified nurses (Aiken et al., 2012; Ray et al., 2003; Wise et al., 2015; Wolf et al., 2017; Yu  
111 et al., 2024). Nurse-sensitive indicators reflective of patient outcomes can include time required for direct  
112 and indirect care delivery, employee injury and illness rates, turnover, overtime, compliance with  
113 healthcare regulations, and patient and nurse satisfaction (ANA, 2015; Wise et al., 2015). Adequate ED  
114 staffing may be calculated by blocks of days or hours by using the number of beds in a department, the  
115 number of patients waiting for treatment, patient acuity, and nurse skill level or experience (Lee et al.,

116 2017; Lordache et al., 2020; Mehra et al., 2024; Wundavalli et al., 2019).

117 When nurse staffing is inadequate for any reason, emergency nurses may be unable to provide the care  
118 their patients require. The nurse may be unable to sufficiently provide emotional comfort and education to  
119 their patients, reassess vital signs, or provide pain medications (Ramsey, et al., 2018). There is also  
120 evidence of higher rates of work-related injuries and that patient deaths (unexpected cardiac arrest) occur  
121 more often when ED staffing is inadequate (Aiken, et al., 2011; Drennan et al, 2024; Ramsey et al.,  
122 2018). Patient care, nurse satisfaction, and nurse intention to leave are impacted by nurse staffing  
123 (Anderson, 2022; Drennan et al., 2024; Janhunen et al., 2020; Muir et al., 2023; Ramsey et al., 2018;  
124 Wolf et al., 2017). Wolf et.al (2017) reported the “moral distress” experienced by ED nurses regarding  
125 “the quality and safety of the nursing they feel is being compromised and sometimes unsafe ...especially  
126 regarding inadequate staffing.”. These findings suggest that staffing and productivity are complex issues.

127 California was the first state to enact legislation regulating nurse-to-patient ratios (Health facilities, 1999-  
128 2000; Johansen, 2014). Despite improved nurse-to-patient ratios in California however, the failure to  
129 rescue rate (deaths in patients who developed serious complications) did not improve (Shin et al., 2018).  
130 Improved staffing did decrease time to antibiotic administration and decrease the number of ED patients  
131 who left without being seen, but length of stay worsened (Aiken et al, 2012). It is possible that to remain  
132 budget neutral as the number of nurses were increased in California hospitals, the number of unlicensed  
133 assistive personnel (UAP) may have decreased, resulting in nurses being required to perform additional  
134 tasks previously performed by UAPs. It has also been suggested that California simply may not have been  
135 able to hire enough nurses to meet the mandate (Shin et al., 2018). Of the many states that have passed  
136 legislation to address RN staffing, the best approach is the use of staffing committees that have been  
137 implemented by seven states (Anderson, 2022).

138 As demonstrated by the effects of the COVID-19 pandemic, which resulted in sporadic, unpredictable,  
139 and increased ED demand, ED staffing guidelines are more difficult than ever to define in special  
140 circumstances. Under these conditions, it is important that EDs optimize staffing to account for high  
141 patient acuity, increased volume, and potential for boarding as well as nursing time to provide care that  
142 includes the donning and doffing of personal protective equipment (PPE), PPE cleaning and servicing,  
143 and personal hygiene (Wells et al., 2021). Further investigation regarding staffing for prolonged  
144 emergency conditions such as a pandemic or other disaster is clearly required.

## 145 **Resources**

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