Elite Learning
by Colibri Healthcare

## Podcast Transcript

# Making Sense of Dollars and Cents: Staffing Skills for Nurse Leaders

Before you take a seat at the healthcare leadership table, you'll need to be prepared with knowledge and skills that aren't typically taught in nursing school. In this series, you'll gain practical tips to help you develop – and showcase – your business acumen.

*This CE course is relevant to nursing and advanced practice nursing professionals.*

## Episode 1 – Remedies for Workforce Woes, Part 1

Why has it become so challenging to get – and keep – nurses at the bedside? An expert in healthcare finance examines the financial, clinical, and staffing effects of the COVID-19 pandemic.

## Episode 2 – Remedies for Workforce Woes, Part 2

Are you stumped for ways to avoid the high costs of travelers on your team – or to keep your current staff from jumping to the traveler life? A nurse-leader-turned-healthcare-finance-expert offers ideas, along with the initial how-to's for developing an effective staffing plan.

## Episode 3 – Remedies for Workforce Woes, Part 3

Stop struggling with staffing! Listen to learn the need-to-know considerations and formulas to ensure appropriate staffing for your department's – and patients' – needs.

### Guest

Pamela Hunt, MSN, RN, NEA-BC, FAAN

- Independent healthcare consultant specializing in productivity, quality and safety, improved organizational performance, caregiver engagement, leadership competence, talent development, and team building
- Associate Faculty, Indiana University School of Nursing and Kelly School of Business
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### Host

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## Transcript

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## Episode 1 – Remedies for Workforce Woes, Part 1

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FAITH ROBERTS, HOST: Hi, everyone. My name is Faith Roberts, and I'll be your host for this Elite Learning podcast series entitled Making Sense of Dollars and Cents: Finance, Budgeting, and Staffing Skills for Nurse Leaders. Throughout this series we'll discuss building skills that are central to a nurse leader's success, including return on investment, staffing (which will be covered today), capital (which we covered in session one), employee engagement and retention, and how all of this affects patient safety.

Finance remains for many of us something that is not easily a skill set – easily in our skill set. And we're positive that if you can take a moment for yourself with this series of podcasts covering all of these topics, that we can help ease some of that for you and show you that it is a skill set that can be developed, and absolutely one that you can feel comfortable with.

In my own practice as a nurse leader, whether a manager, director, executive director, I get it. This is not easy stuff for everyone. But if you were with us on session one, you've already seen how our speaker is able to take complexity and make it into a series of steps that all of us can master without getting too upset in the process.

So, for decades, many of us were isolated from the actual development of budget monthly reports. And then the end result of that was that nurses were not at the table when decisions were being made

Whether working within the constraints of a budget for a state entity or the detailed specifics of a donor grant, finance-related aspects of healthcare are a valuable component of a nurse leader's skill set. Today, a solid knowledge base of finance will help nurse leaders obtain what their area needs, as well as be open to creating different staff mixes based on their understanding of how a budget works.

Today's session for the nurse leader who is listening, who's wondering why they cannot get positions approved – today's session will talk about the actual staffing and scheduling; how we look at FTEs; and how with these skills and knowledge, we can be more creative in our staff mix.

So, there are certain trends that we see with finance. And one that I think about all the time is, over the years, when I ask people about finance, they kind of fall into three different groups: “I don't do numbers, my one up does it for me; lucky me.” For the group that says, “I have a peer who really likes this stuff, so they do mine for me.” And then finally, the person who says, “No one prepared me for this, and it was not covered in orientation. I'm responsible for a $5 million budget, and I don't even know how to find it on the accounting section of our leader site.”

So regardless of your circumstances or motivation, it's clear that to be a well-rounded and effective leader, finance and budgeting are among the skills a nurse leader must master.

Twenty years ago, I met today's guest, Pamela Hunt, at a national conference for nurse leaders. She had mesmerized an audience while speaking about a budget. I'm not kidding you; she was talking about a budget. Her knowledge of staffing, ROI, and how to build a case for capital purchase was unbelievable. Since then, Pam and I have traveled to many conferences and enjoy a close friendship.

Pamela Hunt is an expert on finance in healthcare. She speaks all over the country for professional organizations and state and national workshops, conferences. She's authored articles and co-authored books about finance in the world of healthcare. And in 2020, Pamela Hunt was named a fellow in the American Academy of Nursing. You can read more about her background education and experience in the notes that accompany this session.

Welcome, Pam. I'm looking forward to talking with you. But before we get started on the challenges and solutions of helping our workforce, and how we get those schedules put together, and what they cost to put together, I would love to hear your thoughts on why, for so long, putting a schedule together was taken out of

the nurse leader's hands and perhaps in many facilities done by a department that had nothing to do with patient care. In other words, all of the schedules for the facility followed a cyclical pattern, and did not allow for individual unit budgets, and leaders owning that budget.

PAMELA HUNT, GUEST: Well, thank you, Faith, for that definitely great set up to why this topic is important. And one of the reasons, to answer your question, one of the reasons that organizations thought the best process was to have a centralized scheduling, and that it was every schedule should look the same, is because we thought that that was efficient. Why wouldn't that be efficient? We know the average number of people that you need, what the skill mix is, we'll just plug in the numbers.

But when I teach finance, I want to inspire nurse leaders to understand that clinical decision making is involved in financial decisions. What? That doesn't make sense. Clinical decision making is necessary to make accurate financial decisions.

Let me tell you why. Any nurse leader can tell you that you cannot have all of your novice nurses on one shift together. Any nurse leader will tell you that you cannot have all of your senior nurses that like to work together on the same weekend rotation. So, while it looks like a numbers game, it's not a numbers game. It's a numbers game with clinical decision making, and with employee satisfaction sprinkled in there as well.

I think we're going to talk today about the challenges of what the workforce looks like today. And when we think about it – interesting, I just spoke with a hospital system this week, and what they want help in is they want help in unraveling some of the incentives that have been put into place.

So, you and I both know that where we're going to have to go with that is what keeps nurses outside of salary. And that this is a next talk coming up specifically; but when I think about one of the things that keeps nurses outside of salary, [it's] schedule. So being on a unit that has enough nurses, that has the right skill mix, that has the – and when I say right, I mean the skill mix that matches the needs of the patient and in that the schedule allows me to have a life outside of work – are elements that are going to keep nurses at the bedside.

So, does that answer your question of why it's more than just computer data entry?

ROBERTS: Absolutely, it does. It really helps to take a moment and remember that schedule has a dual focus. It is very much, we hope, a staff satisfier because it is so important to them. But I love that you started with it's about clinical decision making, and we have to have the right nurse for the patient. So, I appreciate that.

HUNT: OK. Well thanks again for that provocative question that gets us going in this subject, and maybe does a hook for those of you who are listening that think, I am not going to listen how to do a schedule. This does not excite me. Stay with me. Stay with me.

(SOUNDBITE OF MUSIC)

HUNT: So, I'm going to start with the question that's on everybody's mind right now. And I'm going to start with the question of where are the nurses? We are having a challenge like we've never seen in the history of our profession to deliver quality care in today's challenging times. I don't want to be a downer here, but I want to set the stage. I want to be realistic so that you understand that I understand the challenges that you're facing today in trying to get staff for your unit.

Let me just say some of the things that you already know. The reduction of surgery caused delays in urgent and semi-elective surgical interventions; we know that, so that this was a result of worsening patient care. Not only did that cause severe financial damage to our organizations, but we know that the patients that we see coming in on a surgical floor are much more acute and have higher acuity than what they did pre-pandemic because they've waited for their procedures.

Opening surgical capacity to protect from harm and reduce financial impact was necessary, but it certainly created capacity issues for all of our units. There's an estimated 7.3 million U.S. workers and family members that lost their employer-based health insurance in the last year, and therefore, access to care. So just realizing what we've been through.

Supply shortages. I don't have to tell you about supply shortages, but I want to inspire you to give yourself grace to the fact that why, why are supply shortages important to us besides workforce safety, patient safety? Supply shortages have taken an exorbitant amount of leader and staff time hunting, gathering, securing supplies that, pre-pandemic, were at our fingertips.

Pharmaceuticals, just our partners – and certainly pharmacists are our partners, but also the pharmaceutical industry –I think this is interesting for us to realize that the pandemic has caused a delay in generic competitor

agents so that they're not coming to the market. Resources have been spent elsewhere developing medications and vaccines for the pandemic virus. So, the top drug expenditures in 2020 were $22.1 billion, and it is estimated that that's only going to increase because of the delay in generic development over the next few years.
Studies predict that nursing staff will be better paid in the future, which we're seeing that. And there is so much chatter on social media right now about who should or who should not have input on staffing salaries. I'm not going there with you today. I'm going to talk about staffing. So that would be a whole other podcast if we talked about the value of nursing and staffing salaries.

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HUNT: So, some other impacts over time, especially I want to talk about clinics. So, outpatient areas, more than inpatient areas now. So over time, it's going to be reduced or eliminated in order to save cost. I think that in many organizations, networks, systems, clinics aren't maybe pressed as much to save cost as what maybe some inpatient areas are looked at. Because of the large expenditure in inpatient areas that over time, clinics are going to be looked at for their overtime to reduce or eliminate cost.
A lot of clinics are going to a model where the caregivers or the staff in that clinic must take vacation time for low-volume time. So, if the physician is taking a vacation and there's not enough partners in the practice to continue patient flow, the staff may have to take vacation at the same time as their practitioner. That's not common in the past in many areas.
And the increase in virtual visits impacts the number of in-clinic providers and caregivers needed. Virtual visits may not take front office staff like we are accustomed to. So, clinic change is coming down the pike for us.

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HUNT: Let's talk specifically about some staffing impacts. Pre-pandemic – so in 2019 – it was estimated that approximately 70,000 nurses are retiring annually. That was [A] pre-pandemic statistic. Nursing leadership will bear a disproportionate loss because of the greater percentage of nurse leaders that are reaching retirement age. Surgical services, and those procedural services, their pre-pandemic average age was 49.
Let's think of something else. Caregivers who did not need to work financially. Now some of you may think, who would do that? But there are caregivers, especially part time, that were picking up some part-time work because it's hard. Once you have worked as a nurse your whole career, take it from somebody who knows, that knows that they want to transition to part time, it's hard just to walk away.
So those caregivers who did not need to work financially are leaving that acute care environment. I don't have to tell you this. Agency wages are at an all-time high. Sign-on bonuses, we could go all across the board, I'm seeing sign-on bonuses as high as $55,000 for a med-surg nurse. $55,000 sign-on bonus for a med-surg nurse. Units are staffed with more temporary staffing than permanent staffing. What does that do to our philosophy in nursing, that you build a good team? And part of being a good team, and a strong team, and a high-functioning team is knowing each other's strengths and weaknesses. How does the fact that more of the staff working this shift are temporary than permanent impact the quality of care in your unit?
Models of care are being redesigned. We have revisited and rediscussed and re-researched such things as functional nursing, team nursing, how do we work, everyone worked to the top of their skill set. What's really in our nurse practice act that is a nursing responsibility, versus what can be delegated? Those questions are being re-evaluated as we search for ways to do this differently.

(SOUNDBITE OF MUSIC)

HUNT: I want to share with you some startling statistics, if what I already have shared isn't enough, right? Here's some startling statistics. RN vacancy rate. So currently, and let me give you a reference for this, there is an annual national healthcare retention and RN staffing report that comes out – so this report is 2021's report – and we're actually recording this podcast in 2022, February 2022 –so this is current data.
So currently, the RN vacancy rate stands at 9.9% for an average. That's one full percentage point higher than what we were in 2020. It directly – there is research out there, evidence-based research that this directly impacts quality outcomes, patient experience, and excessive labor cost. In 2019 – so just in 2019, two years

earlier – 23.7% of hospitals reported a vacancy rate of less than 10%. Listen to this. Today 35.8% of hospitals are reporting a vacancy rate over 10%; 62% of hospitals are reporting a vacancy rate that is higher than 7.5%.
Let's talk for just a minute. Remember, I couched this under startling statistics. This is kind of like – in my doctorate program, I had a professor that said you always want to start out with a startling statistic to get everybody's attention. I think this is getting our attention. RN turnover, so huge cost. Only 50% of hospitals actually track hospital cost related to RN turnover. So, if I inspire you to do anything, I want to inspire you to work with your HR department and your finance department to make sure that you're tracking RN turnover and putting that with a cost.
When you want to propose a program to create retention in your facility, reducing turnover is going to be your return on investment. So, it's really important to know what that turnover is. The average cost of one RN turnover – this is a national cost, again. I redirect you to the reference that will be in your program handouts: $28,000 to $51,000 average cost of an RN turnover. Of course, that $51 at the higher end of those departments that need higher orientation cost, and that lower turnover would be in those areas that don't need as much orientation.
Faith, what do you think about those statistics?

ROBERTS: Well, they are – the word you used is startling. I'll just go ahead and say scary. But I do have a question. Having worked in five states over my career, I noticed that what people refer to as turnover can change drastically from facility to facility. So, for instance, if I have a nurse on a med-surg unit, and he goes to see the ICU, places I've worked did not count that as turnover because they said we didn't lose that nurse to the organization.
So really what they were counting on were people who were actually going out the door. As a nurse leader in that facility, that was very frustrating because you saw a turnover. You were the leader of the med-surg unit that he just left, so you had feelings about not being able to have that statistic. When you say turnover, or it is coming out in these reports, what is the definition that they're utilizing for turnover?
HUNT: Yeah, so you bring up a really good point, Faith, and you also bring out a really frustrating topic. So, turnover in healthcare is oftentimes associated with just that leaving the organization. And I'll go a bit further than that. I will say that turnover and vacancy rate-– I'll go back to vacancy rate as well. I'm currently working with a hospital that we're working with the HR department to define vacancy rate differently than what they're currently defining it.
Vacancy rate – now I'm going to preface this with this is my opinion – vacancy rate is not how many open positions I have compared to the budget. Vacancy rate is looking at your last four pay periods and what was your average need of FTEs in that last four pay period, compared to how many FTEs you have on your staffing roster or your position control.
I say that because some people have – some individuals, leaders – have positions on their budget that they don't need. They never intend to fill those positions. So, it gives a false sense of vacancy. So, we're working [with] that HR department to say no, vacancy isn't the difference between the budget and the position control, that vacancy is the difference between the actual position control, or staffing roster, who I actually have, versus what my average current need is.

HUNT: So, I want to clarify vacancy right there. That is ideal. Because you want to make it real, right? You want it to be something that is meaningful. So now let's go to another. You are absolutely right, and most hospitals, most organizations create turnover data based on leaving the organization. If I could wave that magic wand, I would like to see turnover by unit, even though they do not leave the organization.
Now with that understanding – and I know this would take lots of resources – with that understanding, one of the things that we would have to take into consideration is that when somebody leaves, let's say that med-surg leader that we always love because they get the nurses in, they teach them organizational skills, and how to pass meds, and the very critical, very critical nursing practice, and then we snatch them up into the specialty areas, right?
So how do we reflect for that leader when that nurse goes from med-surg to a critical care department? We cannot accept total turnout for that and the cost, if you're tying that to dollars, because obviously that nurse is already oriented to the organization. They already have many, many skills mastered at that area. So, what would be ideal if there were enough HR resources to help us with tracking those inter-departmental turnovers and still putting cost to those so that we understand what that means as well.

I think also, Faith, to your point and to the question, not tracking those turnovers could hide some problems that need to be addressed, and maybe some skills and education that needs to occur. So, what I'm thinking of here is if we don't track those inter-departmental transfers, we could maybe not have visualization to a department leader who is losing a lot of caregivers, and maybe need some extra attention in that leader's skill set to understand why people are leaving, not only for a different nursing practice. Does that help?

ROBERTS: That helps a lot. Thank you very much.

HUNT: You are welcome. Those are great questions that we all struggle with. One more statistic here before I leave this turnover data, and again, these are all in your handouts, for each percentage change of RN turnover – remember, I said that there was 1% more vacancy rate one year from last year – for each percent of RN turnover, it will cost the average hospital $270,000 a year. One percent. This is your ROI for any retention plan that you want to put in place.

(SOUNDBITE OF MUSIC)

ROBERTS: OK, so Pam has gotten us started in developing a deep understanding of the staffing challenges facing today's nursing workforce, but there's much more to learn. In our next episode, she dives into not only the day-to-day – and often frustrating – challenges of staffing, but also a number of opportunities to overcome them. I hope you'll join us. This is Faith Roberts for Elite Learning.

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## Episode 2 – Remedies for Workforce Woes, Part 2

(SOUNDBITE OF MUSIC)

FAITH ROBERTS, HOST:  Welcome back, everyone. I'm Faith Roberts or Elite Learning, and I'm your host for this episode of our podcast series, Making Sense of Dollars and Cents: Finance, Budgeting, and Staffing Skills for Nurse Leaders.

We've begun to explore the development of skills that are central to a nurse leader's success. In our last episode, our guest, Pamela Hunt, walked us through the challenges — some historically based and some related to timely issues like the COVID-19 pandemic — that nurse leaders face with the financial aspects of scheduling and staffing. In other words, the money part. Together we've explored the link between clinical and financial decision making, and we've dived into nurse turnover and vacancy rates. In this and the following episode, Pam helps us understand the opportunities nurse leaders have to work through the challenges and potentially get more nurses at the bedside.

Pam is a go-to expert on matters of finance relating to healthcare and nursing with broad knowledge in staffing, ROI, and making a case for capital expenditures. You can learn about Pam's extensive background in the show notes that accompany this episode.

About those show notes, or handouts as Pam refers to them: She has provided detailed information and practical examples that will be helpful to you as you learn about the topics explored in this series. I encourage you to download the show notes from our web page at EliteLearning.com/podcasts. You can refer to them as you're following Pam or refer back to them when it's convenient for you.

Let's pick up from where we left off in our last episode, with Pam discussing more of the challenges and opportunities that come with staffing and scheduling.

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PAMELA HUNT, GUEST: Now here's something else that I want to bring to your attention because I'm going to talk about our partners. Oftentimes, we think about our workforce challenges today and what's causing us pain, and we don't think about other partners in the hospital. So, they are in recruitment difficulty index and days. What this tells us is that it is taking longer to recruit in days than it ever has in the past several years.

So, for example, this is an interesting one in particular, labor and delivery. So, everybody wants to work in labor and delivery, right? I mean, we always had a waiting list for labor and delivery. Their days to fill on an average

nationally have [gone] from 65 to 86 days to fill a position in labor and delivery. Another area that is experiencing something that they've not experienced in the past, and that's Peri-Op. Peri-Op no longer has a waiting list in some areas, and that's very, very foreign to them.
So, I'm going to go into some workforce challenges. So, what I want to say before I leave there, and because I foreshadowed it, and they say it in the future of our talk as well, when we talk about recruitment days to fill a position, we often think of our workforce challenges in nursing are get more nurses at the bedside.
But I want you to think a little further than that, and I want [you] to ask yourself, does my recruiting team – does the recruiting team at the organization that I work for – do they have enough people? Times are tough out there, and it takes more to recruit than it ever did. So, do we have enough HR partners to do the work that we need help with? I think that's a very important question to ask ourselves.

(SOUNDBITE OF MUSIC)

HUNT: So, here's just a few more projections and opportunities. Hospital growth continues. Remember when we were told 10 years ago that hospital beds were going to decrease? Well, we know that that's not the case, and the trend is that 40% of hospitals are projecting to increase their RN complement because [of] their bed growth in the next year.
Overtime, internal resource pools, and critical pay is at its all-time high. I know I talked about the high percentage of travel nurses. The travel nurse rates have jumped 200% over the last year. Hospitals are spending 62.5% more on travelers than they did at the beginning of 2020.
And here's another statistic that would be good to use for your ROI – and again, these are all cited in your handouts, as well as in the 2020 NSI report – for every 20 RN traveler positions eliminated, a hospital can save an average of $3 million.
So, what are our opportunities? I talked about talent acquisition team recruiters. Hospitals are expected to grow workforce; but often, we do not recognize the need to expand the recruitment team. What are your relationships with universities, clinical rotation offerings? I know, it's hard to find preceptors. It's hard to make time for students. But we've got to engage in clinical rotation for the universities to be the place of choice when these young graduates go into the workforce. Staff leaders serving as adjunct faculty to create connection with those new students, and what are your marketing efforts at the community events and at local schools?
Enhancing orientation and onboarding. Think about offering virtual, nonclinical components of orientation. And I'm currently working with a hospital that's offering Saturday and evening orientation. That may be hard, that may be a difficult adjustment for some of those areas that traditionally have not had nontraditional working hours, but we've got to meet them where they are. I don't know if you've all heard that term. I was introduced to that term about 18 months ago, and I've used it over and over. We've got to meet them where they are.
Varied shifts. We're looking at more four-hour shifts, eight-hour shifts, 10-hour shifts, 12-hour shifts. Now, I will tell you, all of us know, as we think about the workforce, all of us know that the period of time when a caregiver is handing off to a caregiver is one of the most critical times for patient safety. We're there to be at patient safety lapse. So, I do think we need to be sensitive to four-hour shifts and how we use those.
But my question, or my challenge is, is there opportunity to do a four-hour shift for somebody who it works with their lifestyle – I could name several, but it works with their lifestyle to come in and just be that nurse that, I don't mean just, but be that nurse that relieves nurses for lunch break so that nurses actually can have time away from the clinical practice and know that their patients are still being watched? So, think about those varied shift times.
Unlicensed personnel and how we're using them, and I'll talk about that a little bit later in the presentation, or in our talk together today. Offering temporary licensure for individuals who are currently licensed in another state. I currently practice in the state of Indiana, and we just a couple of years ago lobbied and were successful in becoming a compact state so that our license, someone, a nurse that is also licensed in another compact state, when they come to the state of Indiana, don't have to wait that long period to practice and get a license.
And financial wellness programs, making sure that you're paying attention to the financial health of your caregivers by offering those programs.

(SOUNDBITE OF MUSIC)

HUNT: I want to talk just a little bit about workforce opportunities as we talk about those travelers. And I'm going to introduce a term, maybe some of you have heard the term, maybe some of you experience the term.

And the term is travel resentment. I see this throughout the hospitals that I work with, is a lot of nurses, they're working alongside travelers, nurses who are traveling, and they know they need them. They are appreciative of their work. They're appreciative of the practice. But there's resentment.
So here are some ideas from across the country of what some organizations are doing. Some of this may fit for you, some of that may not. But I'm here to give you what I see across the country so you can take what works for you.
Offer money to the current staff first. So, if you have money to give, what retention incentives can you give to your current staff?
Current plan transparency. So, I think this is so important in leadership. What are we doing to retain our current staff? What are we doing to recruit permanent staff? Where do we stand in hiring? Make that visible, communicate it, and update it. What's the importance here? The team at the bedside want to know that you know what's going on and that you're doing something about it. They want to know that you're doing something about it to get them help.
There are some actions that I see being taken for current members leaving to travel. So, one of those is some places are not hiring travelers who live within a 50-mile radius of them. Some of them are not hiring travelers who have worked for the organization within the last year. So those are two options. Maybe your organization can tolerate that, maybe you can't. But those are two options that I see some places using.
And always, always, always involve current caregivers in those decisions. How are you using your professional practice councils and membership to help problem solve this? Nobody knows better than the people at the bedside, what's being said, and what ideas they might have for improvement.
Faith, what's your thoughts at this point?
ROBERTS: I appreciate the information, and certainly traveler – or travel resentment – is rampant for all the reasons you stated. We also have, all of us heard the urban legends; and the vast majority of traveling professionals do a good job, but one story can grow legs very quickly, [in] an organization that is stressed, as we all are in 2022.
My point is as you mentioned about the councils, as a leader, a nurse leader, I think it is in my purview that when HR and admin go together and make this report on retention, recruitment, what our plan is, that I take it to at least one staff council and say, tell me about this PowerPoint, this memo, what do you think? Because if the staff nurses throw it back and say, I don't even understand what that means, then it doesn't do us any good to communicate it.
And really, for many people who are stressed, the brief that you put forward, the shorter and just down to Earth it can be, graphics, percent, those are things that I want to look at it and say, oh my gosh, I didn't know that we didn't hire travelers within 50 miles. Oh my gosh, I didn't know this. Or I just heard this on a podcast. I wonder if my hospital would consider this? And earlier, what you said about clinics, I wonder if our place is talking about this?
So, I just feel like as leaders, we need to remind the people who are communicating, who are experts at communication. But I need the verbiage to be in the lingo of a nurse at the bedside, or as you said, next to the ED gurney, or getting ready to room the next patient for a diabetes test teaching. I want them to be able to say this is my facility taking care of nursing and helping us get through this.
So, I just think it's important. And I loved what you said about the councils because I think that is our test, our litmus test, for a reality check.
HUNT: Yeah, thank you for that addition and that emphasis on making sure that we're connecting to people, to the staff, the caregivers at the bedside. That transparency, as you said, when you said, you may have a staff nurse that says, oh my gosh, I didn't know we were doing that. And not only you may get a higher level of respect for leadership because we're sharing what we're doing, right? Or you may get a staff nurse that says that's not an incentive that's going to get anybody. Well, if that's the case, then we don't want to be doing it.
So, I always say great ideas around a boardroom table, when they get put into practice, sometimes don't look so great. So, we really need to have that connection to the bedside. So, thanks for reminding us at a deeper level of how important that is.

(SOUNDBITE OF MUSIC)

HUNT: So now hopefully at this point, I've got your attention. Got your attention about this is our current state, this is where we are. We're not going to roll over and say it's beyond repair because it's not. But when we, or as we come out of our current pandemic, and even in the current pandemic, we've got to be strategic about our

staffing. And we've got to understand that. I know we can develop a staffing plan right now, and you're going to tell me well, that's great, but there's no way I can – I don't have that much staff to fill that plan. I understand. But you got to know how much you need before you know what to ask for. Before you know how critical this need is to offer these incentives, you've got to have a plan. You've got to know what you need as the starting point. And it's a great measure in the future when you do start, when this does start turning around.
When these young graduates come out, and they want to come work for you. And they want to come work and take care of the patient population that you have responsibility for. That's going to happen, you guys. That's going to happen. And when that does happen, you need to know who you need, what skill mix, how many, to create the staffing plan that takes best care of your patients.

(SOUNDBITE OF MUSIC)

HUNT: So, let's talk about something that is on everybody's mind right now, and that is who's on the care team. It's different for every organization. I'm not here to tell you what's right or what's wrong. I'm here to tell you that we need to understand that there's a care team – includes RNs, it may include LPNs, or in some states, LVNs, nursing assistants, transporters, lift team members, phlebotomy. The care team includes case managers, pharmacists, social workers, physicians. All of those people are considered on our care team.
One of the most important questions – and at this point, before I go any further, I want to tell you that, I want to inspire you to look at your handouts that go along with this podcast because I'm going to walk you down a very logistical, very linear, very logical way to calculate how many FTEs you need on your staffing roster, and what skill mix those FTEs might need to be.
So, as I go through this, I'm going to talk to you about it, obviously. That's what a podcast is. But it's a lot of formulas. So, I'm going to inspire you to, if you can, get the handout, and refer to the handout along with me so that you can see the formulas in front of you.
So, when we're developing our staffing schedule, staffing schedules are developed as we talk in FTEs. And some of you out there may be listening to this because you understand that you don't have a lot of finance knowledge.
So let me just share with you what FTE stands for. That is an acronym. We love acronyms in healthcare, don't we? That's an acronym that we use for full-time equivalent. And a full-time equivalent is someone, or a combination of someone, that works 40 hours a week, or 80 hours a pay period. That's a full-time equivalent.
So, we estimate that a full-time equivalent works 2,080 hours per year. You can actually calculate it if you don't have a position control that does this for you. You can calculate how much any one person, how much of an FTE, any one person on your staffing roster, consumes, if you will, by taking the number of hours per day that they work, multiplying by the number of days that they work per week, and dividing that by 40 hours.
I always like to give an example when I'm talking about finance because I think it makes us understand it a little bit easier. If you have someone on your staffing roster that works 8 hours a day, and they work 3 days a week, they work 24 hours a week. You divide that by 40. That individual is actually 0.6 FTEs. If you have someone that works 12 hours a day, and they also work 3 days a week, that person works 36 hours a week. Divide that by 40, and they're actually a 0.9 FTE.
So, at this point, what I want to point out is this has nothing to do with the benefits that they're occurring. That 0.9 FTE most likely in most organizations is receiving full-time benefits. Do not make the mistake of saying, oh, that person's a 12-hours, 3-days-a-week, they're a 1.0. Because this has nothing to do with benefits. This has to do with how many hours they're going to be at the bedside. So don't make that mistake.

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HUNT: The first thing we're going to review is staffing plans for inpatient units. And the reason why I go over inpatient units first is because that still is the majority of where nursing practice occurs. And all of us are probably familiar with average daily census.
But I want to talk about is it average daily census, which would be the mean, is it the mode, or is it the median? And you're thinking right now, OK, I'm clicking off of this podcast. I'm not going to listen to statistics. This isn't for me. Don't click off.
So, when I talk about the mean, we know that that's the average. When I talk about the median, I'm going to remind you that's the number that falls in the middle of the number set. And when I talk about the mode, that's the number that occurs most frequently.

So, in your notes, handouts, you'll see an example of a unit that has census points for 30 days. And this is a unit that has a lot of procedures, so it goes from having 29 patients, 28 patients some days, down to 15 to 16 patients on the weekends. I had a unit like this in my area of responsibility.
So, this unit, if I looked at the mean, so I take the average, that's 23.6 as the average census for this unit. If I took the number that falls in the middle of the number set, the median is 25. And I take the mode, the most frequently occurring number, census was 28.
What I want to stress to you is that as a nurse leader, this is a great exercise, if you will, to do for your unit. And then you need to ask yourself this. If I staff at the mean or the median or the mode, how many days am I going to be absolutely staffed for what I need? How many days would I be overstaffed? And how many days would I be understaffed? And again, great example in your handouts.
And then you need to ask yourself, OK, is it more difficult for me to be understaffed and get people to come in? What's my other resources? Does my network, system, organization have an internal resource pool that I can pull from? How do I get people to come in if I am understaffed?
Look at the number of days that you're overstaffed and ask yourself, how big of a satisfier – does my organization float nurses to other areas if we're overstaffed? How big of a dissatisfier is that? What's my workforce's ability, or tolerance, to take days off float census days? And all of those questions, or the answers to all of those questions, goes into the answer for you, the nurse leader, of what is going to be my average, or what's going to be the number that I use to calculate my staffing for this unit.
See how it's not a cookie cutter? See how I can't tell you use your average daily census, use your median, use your mode? I can't tell you that, you guys. But I can tell you how to do this and make those decisions according to the team that you have responsibility for because you know them.

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ROBERTS: I know you appreciate as much as I do how Pam's approach recognizes that one size does not fit all when it comes to staffing and scheduling. And I know you'll find the practical examples and resources she has provided in the show notes to be exceedingly helpful as you work through staffing and scheduling decisions that suit the needs of your department or unit and patients. Be sure to download those examples and resources in the show notes for this episode, as well as an episode transcript, at EliteLearning.com/podcasts.
But we're not done with this complicated topic just yet. Pam has more best practice information and tips to share to help you through the intricacies of staffing and scheduling decision making. Don't miss the next episode in our continuing podcast series.
This is Faith Roberts for Elite Learning.

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## Episode 3 – Remedies for Workforce Woes, Part 3

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FAITH ROBERTS, HOST: Have you, as a nurse leader, wondered why inpatient units use midnight census, of all things, to calculate units of service? Have you struggled with determining hours-per-patient day for your department or unit?
Hi. I'm Faith Roberts, your host for this Elite Learning podcast series, Making Sense of Dollars and Cents: Finance, Budgeting, and Staffing Skills for Nurse Leaders.
We've been talking with Pamela Hunt, an expert in healthcare finance, about the challenges of and opportunities to getting more nurses at the bedside and ensuring a balanced schedule. Staffing and scheduling are complex subjects, and perhaps the least exciting responsibility on a nurse leader's plate. But knowing how to determine how many staff is needed in a department and when they're needed is a vital skill nurse leaders must demonstrate in today's data-centric healthcare industry. Make no mistake, you will be asked to justify your staffing numbers and mix. Pam is here to help us understand how to crunch the numbers and provide that justification.
You can read about Pam's background in the show notes that accompany this episode. In those notes, or handouts as Pam calls them, you'll also find practical information and resources. Download and refer to the show notes as you listen to Pam or refer back to them when it's convenient for you.

Let’s get back to Pam’s insightful discussion.

PAMELA HUNT, GUEST: I'm going to talk about units of service. And in the inpatient area, we mostly use midnight census, which drives all of us crazy, right? Because midnight census, what are you going to tell me if we were together? You would be screaming that midnight census does not reflect our admissions, discharges, and transfers. And you are absolutely right. We use midnight census because it's an easy data point to get to. But I'm going to show you later how to take care – how to account for those ADTs in your work activity. So, hang tight on that.

In surgery, you may use major and minor procedures, or you may use OR minutes. So, I have a great example of OR minutes, and how I was responsible for a surgery department that did both inpatient and outpatient surgeries then as outpatient surgery center. And we calculated our volume by the number of inpatient and outpatient total procedures.

An outpatient surgery center was built just across the street from us. Sixty-five percent of our outpatients went to the surgery center. We, of course, kept high anesthesia-risk patients. And so we downsized 65% of our staff, according to the 60 – we downsized staff according to the 65% that we're going to leave procedures.

When those procedures left and went across the street, we constantly were understaffed. And we didn't understand the why. And when we went back and did a deeper dive, we got it. You know what? It was 65% of the procedures that went across the street.

But if we looked at the number of OR minutes from patient in, to patient out of the room, only 11% of the OR minutes went across the street. Why? Because what went across the street was short procedures that did not take long case time, usually only required two people in the room and not three or four, not more scrubs at the table. So those cases were what stayed in the main OR. So really understanding your OR minutes.

Many nurse leaders are now responsible for areas, such as respiratory, such as the therapies, physical therapy. And they have their challenges as well because oftentimes their units of service are based on billable treatments, and some treatments are not billable. So being able to articulate how much time those non-billable treatments are taking is very important so that you don't look like those therapies are being nonproductive.

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HUNT: All right. Everybody, when I talked to [them], everybody wants to say, OK, Pam, I'm in med-surg department. What should my hours per patient day be? Or Pam, I'm in [a] critical care unit. What should my hours-per-patient day be? I can't tell you that. It's not like it's a secret, right? I mean, I'm not telling you because it's a secret.

But I'm not telling you because, again, it is so individualized to your department. Let me go through some things, questions you should be asking to come up with the answer of are my hours-per-patient day set correctly? Am I being benchmarked against a benchmark that is most like the unit that I have responsibility for?

So, here's some department variables. How many patients do you take care of? The larger your unit, the more efficient you can be. In a cardiovascular hospital that I had responsibility for, it was a very sweet setup. We had three separate halls on a floor, each had eight beds. It was quiet, it was perfect, as long as all eight beds were full.

But what happens when you have six patients? That's too many for one nurse. And a cardiovascular hospital, that's too few, or that's too many patients for one nurse, that's too few to be productive for two. However, the halls were so separate that you cannot really safely care for patients on two halls. So, when I say the bigger the unit, the more productive you can be, it's that economies of scale.

How about the level of intensity of the patient for who the care is being provided? That has impact on your hours-per-patient day. That's why obviously we see critical care areas have a higher hours-per-patient day than what med-surg areas do. The acuity is different.

How about contextual issues? The architecture and the geography of the unit. If I have to travel a long way because I'm on a 48-bed unit that only has one Pyxis, or I'm on a 48-bed unit that only has one storeroom, my hours-per-patient day are going to be higher.

I met a nurse leader years ago that put in nurse servers in every patient room, and she had the luxury of being a new-unit bill. And she put those nurse servers in so that they open to the hallway and into the room. And guess what? It wasn't nursing that supplied those nurse servers for linen and for commonly used supplies, but it was nurses who could access those in the patient room.

Their hours-per-patient day were phenomenally low because she removed all the hunting, gathering, and supplying of supplies to the patient room from the nursing workload. So, you have to know about the architecture of your department.
How about patient-specific variables? What's the age and functional ability of your patient? If you're in a unit that takes a lot of neuro patients that maybe have stroke, head trauma, it takes longer to communicate with those patients. It's going to be more hours-per-patient day.
What about if you are in an area that a lot of your patients do not speak the first language of most of your caregivers? It takes longer to communicate adequately with those patients.
How about the severity and the urgency of the admitting condition of your patients? That's a very important one. I was in a hospital once that had an admission unit. So, what the admission unit did was, in some ways, if you're a very lean thinker, you're going to say to yourself, that puts an extra step of movement in the patient process. And you're right.
But the patients went either as a direct admit or from the ER, unless they were going to critical care, they went to an admissions unit where the IV was started, the nursing history was completed, the first antibiotic was hung, the first respiratory treatment was completed, you get it. All that admission process was completed before they were admitted to the general, medical, surgical, or post-critical care unit. In that case, those med-surg units and post-critical care units had a lower hours-per-patient day than the average because their admission process was already done for them before that patient arrived to the unit.
How about our schedule procedures done on your unit? There are some organizations that do bedside G2 placements, bedside endoscopies, bronchoscopies, etc. And if you're in that situation, then your hours-per-patient day would be higher.

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HUNT: Something we often forget about, many of you that are listening may be from small hospitals. And in small hospitals, things can get more complicated. Sometimes we don't think about that, but that's the truth. Because in small hospitals, you may not have case management and social service support. Maybe those responsibilities are part of the RN at the bedside. So, in that case, your hours-per-patient day may be higher.
How about unit functions? If you want to build in time for unit governance to be done at the staff level, the caregiver involved in quality improvement activities, there's no better way to improve quality improvement on your unit than to have a bedside caregiver be the one doing audits or analyzing the data. Evaluation of practice outcomes being done by staff-level caregivers. And support, building in support in your unit for professionals to really guide those unlicensed personnel is important and adds to hours-per-patient day.
Here's some staff-related variables, and why this isn't cookie cutter, and I can't tell you what your med-surg hours-per-patient day should be. That when you look at your staff, ask yourself, what amount of time or experience has most of my caregivers had with the population that we serve? What's their education level, their preparation, and their certification? How long have they been on the unit? What's their level of control of their practice environment?
So that's where again, that professional practice council comes into play, if you will, because research shows, evidence shows that the more control, or the more input the bedside caregiver has on their practice environment, the more efficient and the better quality of care is delivered.
And the number of competencies. How many competencies are you required to have on your unit? That impacts your hours-per-patient day.
How about organization-related? How do you have support for transport? Do you have clerical support? Do you have housekeeping support? Do you have laboratory support? Or do your nurses, or nursing assistants, act as your phlebotomist?
How about access to timely and accurate information? How easy to use is your EMR? All of those components go into your hours-per-patient day.
So, at this point, I'm going to pause a minute and say when you are given your hours-per- patient day, make sure that you ask, who am I benchmarked against? Was I leveled, if you will, with an organization, or with organizations, that have like units and like challenges that I do? Because that then is going to tell you if that is a realistic hours-per-patient day to actually be your goal.

(SOUNDBITE OF MUSIC)

HUNT: So, once you've determined that hours-per-patient day, what we're going to go into now is how do I staff this unit? And all of us know, and probably many of you have done this before, you take whatever you've chosen – in the case example that I'm going to use for us today, your average daily census multiplied by your budgeted hours per patient day.

So, in the handouts that you're going to refer to when you're listening to this, I'm going to do a sample unit. And our hours-per-patient day that we've been budgeted for are 9.15, and our average daily census – that's the number that this leader has decided to use – is 20. So, 20 multiplied by 9.15 tells me that I need 183 nursing hours in a 24-hour period.

Now I want to take, my next step is to take that 24-hour need of 183 and divide it by the number of productive hours per shift. So, I'm probably most likely going to divide it by either an 8-hour shift or a 12-hour shift. And the next slide in your document, in your handout, will show you that if you divide that by 8, it gives you 22.9 eight-hour shifts. And if you divide that by 12, it gives you 15 3-hour shifts.

So now that I know how many shifts I need, the next important thing is to divide those FTEs, or those shifts, it calculates. And in your handout, you'll see a next slide that says how does the number of shifts calculate or relate to FTEs. And there's another slide that tells you it's the same. So, 183 hours per day times 5 days a week is 915 hours. And then you divide that by 40, it's 22.9 FTEs.

So now that I know I need 22.9 FTEs, the next important step – and again, this is in your notes, in your handouts for this session – you want to understand, as the nurse leader, OK, if I need 22.9 FTEs, how many of those do I need on each shift? And how many of those do I need to be RNs, or LPNs, or nursing assistants, or unit clerk, or any other skill mix that I'm deciding to use? So, let's talk about that a little bit.

First of all, in determining how many you need on days, evenings, or nights, or if it's a 12-hour, it would just be days and nights, you need to look at where your work occurs. So, if it's a med-surg unit, most of that work is that percentage on days, evenings, and nights, is going to be what we would call flatter, or more equal.

Now on days – or excuse me, it's going to be less equal. On days, there's two meal trays that are passed. You need to ask yourself, when do my physicians or hospitalists make rounds? When are most of the procedures done, so I would have an in and out if I have to transport the patient to another area, depending on who does that, when would that occur? When does therapies come? When does discharge rounds or quality rounds occur?

All of those kinds of activities need to be taken into consideration when you, the leader, are determining what percentage of the staff do you need on days, what percentage do you need on evenings, and what percentage do you need on nights.

Again, you don't want finance telling you that that's a nursing decision. It is a finance decision, if you will, a very logical decision, numbers-based, but based on clinical knowledge. So, you want to do the left side of the table of the handout that you will see first. So first you determine what percentage you want on the shift, days, evenings, nights.

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HUNT: Next, let's talk about skill mix. I hope everyone that's listening is well aware of the work that our colleague Linda Aiken and the team that she works with has done for years on the value of nursing. And their research shows us in, what I want to say, continues to show us over the years as they repeat these studies, that the higher the RN ratio, the lower the adverse outcomes for the patient. So patient falls, infection rates unexplained, or non-rescued patients unexplained death, patient and family satisfaction, and we know that those are all tied to a higher RN ratio.

We also know as business leaders of our organization that we pay RNs more than what we pay nursing assistants, than what we pay unit clerks, than what we pay licensed practical nurses. We also know in today's environment – you know this used to not be something I included, I include it now – we also know that we, right now, we can't get enough nurses even if we want to.

So, we've got to ask ourselves, according to the patients that I have responsibility for, according to the patients that my unit cares for, what skill mix can I provide that gets hands at the bedside and enables us to provide quality care for my patients? Maybe it's not ideal right now, skill mix, but it's the skill mix that you can provide the workforce for.

So, in the example at the top of the table that you see, you'll see skill mix. And for the example that I'm using, I put 50% RNs, 40% nursing assistants, and 10%-unit clerks.

And then it's a matter, once you decide that, once you as the leader decide your percentage on the shift and your skill mix, it's just a matter of doing the math. So, taking the number of FTEs and multiplying it by the percentage on days, evenings, and nights, and then multiplying that by the percentage on the shift.
And the handout will give you that math. I'm not going to go through that on the podcast. That would be pretty boring, even though I like this work. I get it, you guys. I'm not going to tell you the numbers on the podcast. But the next slide in your handout shows you that math completed, so that will be very helpful to you.
And then, I also have a slide that says math is great, right? Math is great. But once you do the math and it's pure, you might say to yourself, well, you know what? When I do the math, it comes out that I have a 0.4 FTE of a unit clerk on nights, and I don't need a unit clerk on nights.
If you have an 8-hour shift model from 11:00 PM to 7:00 AM, we don't do many orders or run to the lab or any copying or any admissions, discharges, transfer, some of those things that unit clerks do for us that help the care team, so I don't need that 0.4 FTE on nights. So, I'm going to take that 0.4 FTE, and I'm going to adjust it, and maybe I'm going to add it to my complement of RNs on night shift. So, this is where you take that, and there is a table that says make any adjustments needed.
Now at the end, you still have to end up, it still has to add up to the same number of FTEs that you calculated previously that you're approved for, based on your census that you're using, your census point that you're using, and your budgeted hours-per-patient day. But right now, how you mix them up in your table after the math, you can make some adjustments.

(SOUNDBITE OF MUSIC)

HUNT: Now another component to staffing that often kind of trips us up a little bit is, OK, that's great, that previous table tells me how to staff if I was open Monday through Friday; but most inpatient departments are not open Monday through Friday. So how do I get from transition to Monday through Friday to 7 days a week?
And the next slide in your handouts shows you the equations to account for that 7-day-a-week coverage.
So, in this case, the equation is you take the number of FTEs needed for that particular shift, multiplied by the number of hours worked per day, multiplied by the number of days to staff – so in this case, it would be 7 – and then divide that by 40. And that then gives you the number of FTEs that you need to staff 24/7.
So, you'll see that example in your handouts. You might be amazed about how that increases your number of FTEs. Because in the example in your handouts, before, just to cover for 24 hours, 5 days a week, you needed 22.9 FTEs. But when you perform the equation to account for 7 days a week, you need 31. So that's quite a jump, 22.9 to 31.7. So don't forget this step that's in the handouts to account for the 7-day-a-week coverage.

(SOUNDBITE OF MUSIC)

HUNT: All right. Let's go on. Productive versus nonproductive time. Many, many leaders right now are not being allowed to – well, I'm going to pause there. Before pre-pandemic, pre-pandemic – can you think back that far, everyone? Pre-pandemic, many leaders were not being allowed to hire above what they needed just to be productive. And that was so frustrating.
Because why is that frustrating to us? We know that people are going to take time off for family medical leave. People are going to take time off for vacations. There's going to be illness. We're going to send people to education. We know that we're going to have hours that are not going to be worked at the bedside, at the ED table, at the OR table. And I want to account for those so that I have coverage.
The reason why organizations oftentimes hesitate to allow you to hire above what you know you're going to need is because it is very difficult for some leaders to get people off the schedule when you're overstaffed. Currently today, that's hard for you to remember those days, isn't it? It's hard for you to remember the days that you were overstaffed.
But when we go back to that someday, and when you are saying, I need to hire above my FTE, and your administration is saying no, we're going to cover that with overtime, we're going to cover that with resource nurses, we're going to cover that with temporary staffing, we're going to cover that with you getting your part-time people to work more when other people are on vacation. And you're frustrated, you're going to know that the philosophy behind that is that when you're overstaffed, sometimes it's hard to tell people to go home or to float them to other units. And that's the reasoning behind that.
So, when I talk about nonproductive time, even though we're not able to hire for it, I think it's important for you to know what that is for your department. Productive time is hours worked. That's pretty straightforward.

Nonproductive time is vacation hours, sick-time hours, funeral leave, jury duty, education, holiday, all of those hours that are still paid hours, but not at the bedside.
What I often advise leaders to do is to take a look at your individual department – now, your HR department has a number of the average for the whole hospital, the average percentage of nonproductive time. But that includes departments that have very high turnover. It includes departments that have very low turnover.
So, I always advise the department leaders to annually take a look at your own department and say, how many nonproductive hours have we had in my department over the last year? And what percentage of that is of the total productive hours worked?
And again, in your handouts, there's those equations to look at of how to calculate non-productive time. You would take the total number of PTO hours in your department and divide it by the number of FTEs, and that actually tells you how many average hours per FTE that you would anticipate losing in nonproductive time of year. But if you take that number of hours of nonproductive time per FTE and divide it by 2,080 hours that you expect an FTE to work, that would give you the percentage of lost time.

(SOUNDBITE OF MUSIC)

HUNT: So, I know that sounds kind of complicated right now. But when you see it in your handout, you will understand how to do that for your individual department.
Faith, is that something that you've done before, or what your thoughts about nonproductive time?
ROBERTS: For me, it's about semantics. And I think that many of our listeners might be familiar with the term direct or indirect care. So, I just want to make sure that people understand, when we say indirect care, we're talking about nonproductive. We're talking about meetings. We're talking about everything you listed.
But when we're talking about productive, that is the same as direct care. In other words, I am delivering care to the person who needs it. A client, a resident, a patient, however you term them in your facility, but that is for that staff member who's giving direct care.
So, I just think that there's, well, there's been kind of two camps on how to define it. So, I just want to make sure people understand if they come from the direct care world, that that's what you are referring to now.
HUNT: That's a really good point. And thanks for including that. You would think that we could all call things the same thing, but we can't. It's like when I talk about nursing assistants, some people call them PCAs, some people call them PCTs. But why can't we just come up on some nomenclature that we, or that language that we all understand? But thank you so much for bringing that point in.
And you're [INAUDIBLE], direct care I'm at the bedside, on the unit, taking care of my patient. And non-direct doesn't mean it's not valuable. The nonproductive, indirect care doesn't mean it's not valuable. It just means you're not at the bedside.
ROBERTS: Absolutely.
HUNT: Yeah, good clarification. So, once you know your nonproductive, or indirect, percentage, then you would add that to your previous calculations of how many you needed for 7 days a week, how many FTEs you needed for 7 days a week in your department. You would add that nonproductive percentage on there, and that would tell you that if that number – if staff were available, if the workforce was available, and you were able to hire, this is the number of FTEs that you would want to hire to cover your department for your average daily census, or the census that you've chosen to staff for, for your budgeted hours-per-patient day, for 7 days a week, and to include nonproductive time.
Now, what I always inspire people to do is to go ahead and do this step. Calculate how many FTEs that would be. Because during times where you have higher vacation time, and you have therefore higher overtime, you can justify that by saying, well, actually, my nonproductive, or my indirect hours, were higher this time; and that's why you're seeing maybe my pay dollars were higher and my productivity was still good. So, you can use this data to help you with justifications along the way.

(SOUNDBITE OF MUSIC)

HUNT: So that is how we get to a staffing plan that we actually understand how many staff we need on our roster. In your handouts, again, there's some practice examples, and that example goes through a 12-hour shift. So, I invite you to look at that. It's the same math, but it's using a 12-hour shift model, instead of a[n] 8-hour shift model. So that will be really, really useful to you.

The other thing that's going to be available to you is an Excel spreadsheet that actually does these calculations for you. Can you imagine? So, once you know the why behind the calculations, it's not so important that how to do the math, as long as you know why you're doing the math. So those Excel spreadsheets that would be available to you will help you with that. And that's a real benefit.

(SOUNDBITE OF MUSIC)

HUNT: OK, before I go on to just a little bit about procedural areas, I want to just remind you the importance of a balanced schedule, ensuring that even when you're short staffed, which I know all of you are right now, ensuring that it's as evenly short staffed from day to day as it possibly can be.
You don't want to have one day that maybe your core number, let's just say, your core number is six nurses per shift. You don't want one day for you to have six nurses, and the next 2 days, for you to only have two nurses scheduled. You want to make it as even as possible.
And I tell a great real-life story. You know, I've been in this work long enough that I don't have to make anything up. These are real life stories.
So, I had a unit that had a core number of needing on day shift of 14 people. And it was Friday, and their census was high, and they actually needed 16 staff to cover. So, they needed two more than what their core was. But they only had 11 staff scheduled because it was Friday. I hope you're all grinning right now because you know cell scheduling. Cell scheduling doesn't mean there still doesn't need to be guardrails around cell scheduling. So, they only had 11 people scheduled because at the time the director had no guardrails. Nobody wanted to work Fridays.
But if I looked, and I did – and of course, they were calling and running incentive pay to get people to come in because they're 5 people short – but when I looked back on their schedule, on Monday they had 12 people scheduled. Their core was 14. Nobody likes to work Mondays either.
On Tuesday, they had 16 people scheduled. On Wednesday, they had 17 people scheduled. Their core was 14. Yeah, I'll work Wednesday. There's nothing going on Wednesday. There's nothing going on Wednesday. On Thursday, they had 14, so they were right at their core. And on Friday, they had 11.
If this schedule had been balanced, they had enough nurses to have 14 on every day. It just wasn't a balanced schedule. So, making sure that even if it's short, that it's balanced is so important.
Another big must-have in scheduling is taking, removing as much waste. When we talk about how are we going to redesign nursing for the future, and how are we going to get through – how are we going to provide the best quality care that we possibly can with the amount of staff that we have today – one of the ways that we have to come to the table with a stronger presence is removing waste.
I have already talked about supplies in the room. Who is stocking those supplies? Some of the units that I've worked with, they've constructed coffee and water stations so that visitors can get their own coffee and water – for those of you who are allowing visitors back into your inpatient units – they can access their own coffee and their own water and not to disrupt nursing staff to get those for them.
Equipment in the rooms. I had a responsibility for a 48-bed unit that only had seven Dynamaps. And over the course of 3 years, we made the business case to purchase a Dynamap for every room. Speeded care. We weren't hunting and gathering. We weren't wasting time waiting on each other. So, taking waste out of the environment. Making sure that if you do have more than one storeroom on a unit, they're both set up exactly the same. Very important.

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HUNT: We already talked about pictures telling the story, so process improvement, looking at rework, hunting and gathering, the distance traveled, additional handling, communication made easy, and the ordering process.
So, lessons for the leader: There are so many factors that influence why your department is different from another. Analyze the differences closely when trying to benchmark and when determining a model of care that is right for your patient population. Skill mix is very important, and it needs to match the patient. Costs should be considered. However, it should be secondary to the patient needs. And even if you're not allowed to hire for non-productive or indirect time, know what that loss is to your department.
So, in your handouts, for those of you who are in procedural areas, there is a whole section on procedural areas. And I just want to take a couple of minutes to highlight what's different because a lot of it is very much

the same. So, in procedural areas, especially in an OR or, like a Cath Lab, the equation you might want to use is the number of rooms multiplied by the number of hours that the room is available, or the number of hours that the room is utilized.
Why would I say or? Because it depends on your organization. Does your organization say you need to have that room available so that if anybody wants to move into it, if there's a trauma, if there's a bump case, we need to be able to open that room? Then, you need to say, OK, I need to have staff for that room. But instead, if your organization says, no, I want you to only staff for your average utilization, then you would staff for utilization instead of availability.
So, I want to bring that to your attention as you look over how you develop a staffing plan for procedural areas. The other thing that is different in procedural areas is you have more, what I say, fixed positions.
So, in procedural areas, you may have a scheduling secretary. You may have your own inventory clerk. You may have that person that runs the board, what we call the person that does all the air traffic control. You may have your own housekeeping. You may have your own educator. So those are positions that I call nonclinical functions that you actually need to add on in a procedural area, outside of the clinical component. So you'll see that in the handouts that are available to you.
Also, consideration for lunch relief is in there; and there's formulas of how to factor in. For all of you who work in procedural areas, I'm sure you've never heard, we always have a lunch slowdown. We always have slowdowns during lunch. There's some calculations in those handouts that are going to show you how to factor that in, so that you don't have a slowdown over lunch.
So, I want to include outpatient clinic practice before we leave each other. And outpatient clinic practice environments, your measurement of work, when we talk about the measurement of work – remember we had hours-per-patient day, or hours-per-OR minute – but in the clinic, that's hours-per-patient visit.
And this includes the time moving the patient, the assessment of the patient, the care of the patient in the room, and the follow-up needed outside the room. So don't forget, calling in those prescriptions, or if you're still calling in prescriptions instead of it being electronic. All of those functions that are necessary to take care of those patients.
You may want to observe at different levels of care. So maybe there's different levels of care in your practice that you could actually level these patients. And then you would go through the same process as we did for inpatients, of how many staff do I need, the average number of patients multiplied by the hours-per-patient visit, would be how many you need for the day; and it may be different by the day of the week. So remember that when you're looking at clinical practice.
There are step by step instructions in your handouts for outpatient clinics. And we want to do it right. We want to always know that we have the right people taking care of the patients. And that's what's most important to us.

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HUNT: So, as we look at this very, very complicated subject of staffing, we have talked over the last 90 minutes together about what's our current challenges. We've talked about travel nurses. We've talked about temporary staffing. We've talked about the importance of actually knowing how many staff we need in our departments. We've talked about how to calculate 7-day-a-week coverage. And we've talked about how to add nonproductive or indirect hours to that as well.
We've looped in procedural departments and highlighted how those are different, and you have those resources in your handouts. And we've included our outpatient clinic partners because we know that, in the future, you're going to be asked to have this kind of skill as well, and to really justify the amount of staff that you need to care for these patients.
And we want you in the outpatient clinics to have the right amount of staff and the right skill level, so that those patients do not come to the acute care areas because you've had time to address their needs in the clinic practice.
All right, it's been great to speak with you. This is a difficult subject to listen to without being in person, but I really appreciate the opportunity to reach out with a podcast to share with you the challenges of the workforce, and the solutions to those challenges. Thank you very much.
ROBERTS: Thank you, Pam. I think that that was a wonderful way to talk about just how important it is to be able to understand how you put your schedule together, what those staffing needs are. But also, how to be

able to validate for other people who may not understand how important certain things are on certain days of the week to certain units.
And I think the best part about podcasting is that this is intense stuff, of course, but the notes that come with this episode walk the person through every example you gave, and that's something that they can refer back to as they need to. And I don't know, for me, maybe I would listen to one of these podcasts, probably more intently knowing what the topic is.
And I think you helped all of us. I appreciate it very much, the new statistics to get us all on the same page. But it definitely is the way you can break it down, and make it interesting, and show us why, as a leader, I should know this. And I should not be dependent on someone else to teach it to me. I should be an expert on how the schedule for the area, or areas, that I lead, how they're staffed.
In today's world, we're all using different companies, as you pointed out. Hours-per-patient days, the questionnaires that leaders are asked to complete to get to that number. I appreciated hearing how people look at that. And then, I think it makes our questions more astute for our own finance departments when we return to work knowing this information.

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ROBERTS: You've been listening and learning about essential finance skills for nurse leaders in our continuing podcast series. Join Pam and I for our next episode, in which we shift our focus from justifying the recruitment of nurses to the bedside to keeping them there. We'll explore the link between finance and something we don't recognize nearly enough as having an impact on financial decision making, that is, employee engagement.
This is Faith Roberts for Elite Learning.

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