Nurse Staffing and Failure to Rescue

Kathleen Rice Simpson, PhD, RNC, CNS-BC, FAAN

There are multiple implications of not having enough nurses. When patient census and acuity exceed nurse staffing resources, a series of conscious and subconscious decisions are made by nurse leaders, charge nurses, and staff nurses to prioritize what patient care and unit operations absolutely need to be accomplished and what can wait. This is a dynamic process that involves ongoing reevaluation of the situation and "doing the best you can." These well-intended decisions, often made under pressure, have the potential to increase risk of patient harm if in the process of care allocation and reallocation, significant changes in patient conditions get overlooked.

Failure to rescue due to short-staffing is preventable patient harm.

Short-staffing can be acute or chronic. For some nurses, it is their routine work environment, whereas for others it is the result of unpredictable fluctuations in census. Artificial peaks in census and acuity caused by scheduling of elective procedures inconsistent with available staffing resources are a factor in some units.

Failure to rescue occurs when a generally healthy hospitalized patient develops complications, deteriorates, and subsequently suffers an adverse outcome. The complications and deterioration likely involve subtle (and sometimes not-so-subtle) signs and symptoms that are dismissed as not being concerning or that are missed entirely. Nurses are vital to preventing failure to rescue. There are four aspects of prevention; careful and accurate monitoring, timely identification of a problem, appropriate and timely intervention based on the problem, and activation of a team response as needed. Each requires time for direct patient observation. Short-staffing decreases the ability of the nurse to spend quality time at the bedside.

When labor nurses attempt to manage the needs of multiple patients, there is often a focus and dependence on electronic surveillance and views of the central screen displaying the fetal monitoring tracing and vital signs of all patients, rather than frequent direct bedside care, support, and interaction. It is important to remember that each woman in labor represents two patients, both of whom require assessment, care, and medical record documentation. If short-staffing results in the busy labor nurse unable to participate in one or more of the four aspects of failure to rescue prevention, the consequences can be a near miss or actual patient harm. For example, labor nurses caring for more than one woman receiving oxytocin may spend 30 to 45 minutes at the bedside of a woman during the initiation of epidural anesthesia and not be aware of the development of tachysystole and subsequent evolving fetal deterioration in their other patient. There may be only one nurse assigned to the obstetric triage unit but five women who have presented for care. Nurses may not be able to fully handoff care of their other patient while at the bedside assisting a woman during second-stage labor pushing. Nurses may be required to assume care of a new patient before completing the care of a woman during the 2-hour immediate postpartum recovery period. Each of these examples represents a potential failure to rescue; fetal compromise, maternal deterioration, pregnant woman discharged without establishment of fetal well-being with subsequent fetal demise, major postpartum hemorrhage requiring blood transfusion and admission to the intensive care unit, problems with newborn transition undetected, newborn suffocation, newborn being dropped. Labor nurses and mother–baby nurses can imagine numerous other examples of inadequate staffing and potential related adverse outcomes.

Preventable patient harm due to inadequate staffing is a major liability risk for hospitals and healthcare systems. The implications for the injured patient can be significant and long term. Nurses as the second victims of patient harm related to short-staffing should not be underestimated. The Association of Women's Health, Obstetric and Neonatal Nurses (2010) has published nurse staffing guidelines that include the most common types of patients and clinical situations encountered in the care of women and newborns. These guidelines should not be considered "something to strive for," "ideal but unattainable," or "not realistic," but rather the minimum to allow the provision of safe and quality care. Failure to rescue in the context of short-staffing is preventable patient harm. ✣

Kathleen Rice Simpson is a Perinatal Clinical Nurse Specialist in St. Louis, MO, and the Editor-in-Chief of MCN. *Dr. Simpson can be reached via e-mail at krsimpson@prodigy.net*

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Reference

Association of Women's Health, Obstetric and Neonatal Nurses. (2010). *Guidelines for professional registered nurse staffing for perinatal units.* Washington, DC: Author.