Critical care units at TMH include a 10-bed cardiovascular thoracic surgical unit, a 12-bed cardiovascular thoracic intermediate unit, a 9-bed coronary care unit, and a 16-bed intensive care unit. Depending on the number of patients and staffing on the critical care units, critical care nurses floated outside their assigned unit to the emergency room and medical-surgical units. When nurses floated outside critical care areas, problems included a lack of familiarity with supplies, unit layout, and staff culture; concerns of competencies, such as care of different populations of patients unique to the medical-surgical units, including oncology, orthopedics, and urology; and the unfamiliar flow of the emergency room. Because of the overall negative morale during times of floating, some concern existed that the amount of sick time used by the critical care nurses might have been related to floating outside the critical care area.

The staffing office and nursing supervisors were in charge of staffing, which incorporated a general medical-surgical float pool that used contract labor and supplemented the pool with critical care nurses. In fiscal year 2002, the TMH critical care units used 9.26 full-time employees worth

Floating a nurse outside his or her specialty area is a major cause of anxiety that decreases job satisfaction and morale. Most nurses, when hearing the word “float,” become apprehensive. They anticipate that they are going to have to work outside their comfort and safety zone, in an environment of uncertainty that is external to their area of expertise. Floating is a short-term solution to a long-term problem and is a practice that is loathed by many nurses. Floating is perceived as disruptive. Floating off regular units is considered a negative change. Floating of staff implies that nurses work as generalists, yet in today’s environment, care is highly specialized. Nurses must use their expertise and skills to make certain that the care demands of patients are met. Floating can be such a difficult and anxiety-producing experience that organizations are responding in a variety of ways, such as creating committees to improve this staffing arrangement.

These issues were reality for staff nurses in the critical care areas at The Miriam Hospital (TMH) in Providence, Rhode Island, a Magnet-accredited institution since 1998.
of contract labor at a cost of approximately $75/h. Knowing the non-critical care areas would continue to receive float nurses as needed from the staffing office, the critical care nurses decided to examine the floating issue that was decreasing satisfaction among nurses in their units and come up with a different strategy.

When challenged by the chief nursing officer to enhance nursing practice in this Magnet facility, the critical care nurses took full advantage of the opportunity and presented the issue of floating nurses out of critical care. The chief nursing officer then advised the nurses to identify solutions. At TMH, staff nurses are fortunate enough to work in a shared governance environment that fosters empowerment. It was decided to use empowerment and shared governance not only to develop a new floating/staffing plan for critical care but also to take on the responsibility and accountability that would be essential to implementing this plan.

Shared governance and empowerment are professional practices that may be entrusted to staff nurses by their experienced leaders and can provide nurses opportunities to increase productivity and broaden their nursing practice. Shared governance is a way to incorporate empowered work environments because it permits autonomy and decisional involvement. These professional practices can then be used as a long-term strategy to improve the culture of the work environment. Empowerment is an opportunity to take action that will produce positive results at the individual and organizational levels.

Nursing satisfaction has been linked to empowerment and autonomy, support of and recognition by supervisors, decision making, and communication with colleagues. A Staff Nurse Approach to Floating: Closed Staffing

At TMH, each nursing unit has a unit planning committee that consists of approximately 5 to 10 staff nurses from that unit. The committee provides all staff nurses, through their committee representatives, an opportunity to participate in decision making related to nursing and patient care issues relevant to, and of direct consequence to, the nurses.

Two committee members from the cardiovascular thoracic surgical unit came up with the idea of decentralized, clustered, closed staffing within the critical care units, with shared responsibility for staffing (critical care nurses would float and staff only within the critical care units). This arrangement not only would allow a core group of experienced and well-prepared critical care nurses to work within their specialty areas at all times but also would require these same nurses to increase their ownership of and accountability for staffing in the critical care units. These nurses then approached and met with members of the planning committees for the other 3 critical care units to discuss the plan. Previously, little collaboration related to staff matters occurred among the critical care units. After a few meetings, it was decided to ask the staff of all 4 units if they would be interested in the proposed idea. Involvement is essential to implement change and increase commitment. Nurses overwhelmingly agreed that decentralized, clustered, closed staffing in critical care (closed critical care staffing) should be attempted. The staffing office would continue to staff the noncritical care units with the medical-surgical float pool and agency/traveler nurses.

The nurse managers of all 4 critical care areas were notified of the plan, and all were supportive. A working group composed of 2 to 3 nurses from each critical care unit was formed. For the next 3 months, the closed staffing working group met every week and brainstormed for an hour. Ideas about floating and staffing responsibilities within critical care were discussed, and objectives were formulated to guide the processes involved in our proposal.

Objectives were as follows:

- Promote empowerment among the critical care staff nurses
- Increase collaboration between the staff nurses in the critical care units

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• Increase ownership, accountability/responsibility for staffing each critical care unit appropriately
• Decrease use of contracted labor in critical care
• Increase nurse job satisfaction regarding floating in critical care
• Decrease use of sick time in critical care

A literature search on floating, staffing, shared governance, and empowerment was completed and shared with the rest of the nurses in critical care.

**Presentation of Proposal and Development of Guidelines**

The working group presented a proposal, “Closed Critical Care Staffing” to the chief nursing officer and the nurse managers of the critical care units. The chief nursing officer asked the group to develop a set of guidelines that would be followed, one of which had to be no mandatory overtime for any nurse at any time. The working group and the chief nursing officer agreed to meet again in 1 month, and the working group proceeded to develop specific guidelines.

**Distinctions Between Charge Nurses and Host Unit Charge Nurses**

Distinctions were made between the role of the traditional “charge nurse” and a newly identified role of a “host unit” charge nurse. Each unit would take a turn at being the host unit for a month; the host unit charge nurse would be responsible for gathering all the numerical information on staff and patients from the charge nurses in the other critical care areas at specified check-in times. This information consisted of the number of nurses scheduled to work for the next 2 shifts, the number of patients expected to be on the unit, and the number of nurses each unit anticipated to have extra or be short. After receiving this information, the host unit charge nurse would communicate with the other critical care charge nurses to inform them if they were going to float or receive a nurse to or from another critical care area. If a unit or units were short staffed and no nurses were available to float, the charge nurse of the short-staffed units would either ask a staff nurse to stay past their shift and work into the next shift or call another staff nurse in to work. It was decided that charge nurses would assume responsibility for staffing their units on each shift and/or floating a nurse to another critical care unit if one of the units had a low number of patients.

**Guidelines for Closed Critical Care Staffing**

Specific guidelines were developed for day-to-day use (see Table). It was recognized that the challenge of fluctuations in the number of patients and their severity of illness would constantly need to be addressed. Nursing supervisors, who check in with the charge nurses at the beginning and end of each shift, would be kept informed of the charge nurses’ plan at all times before implementation of the change.

Staff nurses from all the critical care units were informed about the guidelines and were provided an opportunity to review and discuss the material. The nurses were keenly aware that this plan would require a great deal of responsibility and ownership on their behalf; they realized that they would need to be attentive at all times to the staffing needs of their particular unit. Nurses overwhelmingly agreed to all the guidelines, knowing that the result would mean not floating outside critical care and would increase their ownership of their individual units. Everyone knew that the guidelines would be challenging and that communication would be key.

The following month, the working group met again with the chief nursing officer and nurse managers to present the guidelines, which were accepted. It was agreed that a 1-year pilot study of closed critical care staffing would start in a month and that the working group would meet again with the chief nursing officer in 3 months.

A questionnaire about nurses’ feelings toward floating since the program’s inception was developed and distributed 6 months after the proposed program became practice. At the end of the 1-year pilot study, the task force developed a presentation for the chief nursing officer and nurse managers that specifically addressed how the objectives were met. At the end of the presentation, the chief nursing officer was asked to adopt the guidelines as an accepted staffing practice at TMH. The chief nursing officer agreed to implement the recommendations, and the pilot program was indeed changed to a practice. The following provides a summary of each objective and how the objective was met.

**Discussion of Objectives**

**Promote Empowerment Among Critical Care Staff Nurses**

The objective to promote empowerment among critical care staff
nurses became evident when the nurses of the critical care units were encouraged to design and implement this initiative. The feeling of taking some measure of control and responsibility for the staffing needs of the critical care units was a rewarding and fulfilling experience for staff members. This change enabled nurses to make their own decisions on the basis of patients’ acuity and enhanced the development of the charge nurse role, which had been limited to making out the assignments and controlling beds. The new role expanded to include not just staffing the charge nurse’s own unit but also assuming responsibility for the other critical care units related to appropriate staffing, communication to identify actual or potential problems or issues, and awareness of unit-based needs. The charge nurse must look ahead to the next shift and make decisions that are based on needs that may be due to unforeseen problems or issues.

**Increase Collaboration Between Staff Nurses in the Critical Care Units**

The objective to increase collaboration among staff nurses in the critical care units emerged as the charge nurses of all the critical care units met daily to discuss staffing needs and how best to satisfy the needs. This change enabled the nuances of each unit to be shared collectively, resulting in a better understanding of the needs of the whole versus simply the parts. Before closed staffing, the charge nurses conveyed their staffing needs to the staffing office and nurse supervisors who would then make the staffing decisions for all units. The charge nurses are now communicating with each other at least twice a shift, compared with previously just communicating with the staffing office.

### Table Guidelines for closed critical care staffing

<table>
<thead>
<tr>
<th>No mandatory overtime for any nurse, at any time.</th>
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<tbody>
<tr>
<td>The competencies of all critical care nurses will be considered, along with patients’ condition and acuity, when patient assignments are made out; the charge nurse will refer to each critical care unit’s competency checklist.</td>
</tr>
<tr>
<td>Each shift is to evaluate the following shift’s staffing.</td>
</tr>
<tr>
<td>Charge nurses from all critical care areas will meet at the host unit promptly at 8:30 AM to assess the staffing needs of the following shifts.</td>
</tr>
<tr>
<td>The host unit’s charge nurse will make check-in calls to the other critical care units at 1 PM, 4 PM, 9 PM, and 5 AM and keep all the staffing and census numbers.</td>
</tr>
<tr>
<td>The host unit’s responsibilities will rotate through each critical care unit every month.</td>
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<tr>
<td>When a staff nurse calls in sick, that nurse will call directly to her charge nurse. The charge nurse will then relay this information to the staffing office or nursing supervisor as soon as possible.</td>
</tr>
<tr>
<td>The charge nurse of the host unit will check with the staffing office to see what critical care float nurses are scheduled for the next 24 hours.</td>
</tr>
<tr>
<td>The critical care float nurse will be used by the unit that has the most need for a nurse; this need will be determined by collaboration between the host unit’s charge nurse and the charge nurses of the other critical care units.</td>
</tr>
<tr>
<td>When 1 unit is overstaffed and 1 unit is short staffed, a nurse from the unit that is overstaffed will float to the short-staffed unit.</td>
</tr>
<tr>
<td>When 1 unit is overstaffed and more than 1 unit is short staffed, those units in need of a nurse will make telephone calls to try to get a nurse into work; the unit that could not get a nurse to come in will be floated a nurse from the unit that is overstaffed.</td>
</tr>
<tr>
<td>All units will keep their own list of the float dates for their nurses, and everyone will float in turn.</td>
</tr>
<tr>
<td>When a nurse is floated, she will be assigned a buddy from the unit she floated to. The purpose of the buddy is to be a resource, providing assistance and guidance to the float nurse to aid in the acclimation to the unit.</td>
</tr>
<tr>
<td>When a unit is overstaffed and no other critical care unit is in need of another nurse, the charge nurse of the overstaffed unit will see if a nurse can be moved to another day that might be short staffed. If a nurse cannot be moved, then that overstaffed unit will offer voluntary time off to the nurse whose turn it is for voluntary time off.</td>
</tr>
<tr>
<td>Each unit will keep track of voluntary time-off dates, and the time off will be offered to a nurse on whichever unit is overstaffed.</td>
</tr>
<tr>
<td>If no one in the overstaffed unit wants time off, then the voluntary time off will be offered to the host unit first, then rotate with host unit rotation; a nurse from the overstaffed unit will then float to the unit that takes voluntary time off.</td>
</tr>
<tr>
<td>The host unit will have a list of the critical care float nurses’ dates for voluntary time off. The critical care float nurses’ dates will be included with the host unit’s dates, and these nurses will be given a chance for voluntary time off as any other nurse in the host unit.</td>
</tr>
<tr>
<td>We will continue to consult with the nursing supervisors and staffing office, keeping them informed of our decisions.</td>
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http://ccn.aacnjournals.org/
Increase Ownership, Accountability/Responsibility for Staffing Each Critical Care Unit

The objective to increase ownership, accountability/responsibility for staffing each critical care unit was inherent to the success of the project. All of the nurses were expected and allowed to take part in the responsibility of staffing their own units. All nurses calling in sick now call their individual unit’s charge nurse, rather than the staffing office as was previously done, and that specific unit’s nursing staff is required to find a nurse to fill in for the one who is sick. Each unit developed a weekly staffing sheet that identified what the staffing was for that particular week, and staff were encouraged to make themselves available to work if they were needed on other shifts. This arrangement ensured commitment to the success of the pilot study and gave each nurse a sense of pride and ownership for his or her unit.

Decrease Use of Contracted Labor

The objective to decrease the use of contracted labor was made possible by using creative staffing techniques and making compromises to fill in when another nurse was needed. These creative techniques and compromises included encouraging nurses to sign up for extra shifts or switch one shift for another in order to satisfy staffing needs. This change was extremely helpful in solving the staffing problem, and no one was required to stay. Also, nurses often compromised and agreed to come in an hour or two early and/or stay an extra hour or two to fill an unstaffed 4-hour shift. Because of leaves of absence, many unstaffed hours needed to be filled. Staff members were able to pick up overtime and/or change their schedule to meet the needs of the unit. This change in turn decreased the need for outside contracted labor and was fiscally beneficial to the hospital (see Figure).

Increase Nurses’ Job Satisfaction Related to Floating

The objective to increase nurses’ job satisfaction related to floating was demonstrated by the results of a simple questionnaire completed by the critical care nurses. Three questions addressed the nurses’ feelings toward the program and whether they want to continue with the program:

1. Knowing that you do not have to float outside critical care since closed staffing started, do you

![Figure](https://www.ccnaacnjournals.org/CRITICALCARENURSE/CRITICALCARENURSE.Vol28.No.6.DECEMBER2008.55/image)
2. Would you say that the overall morale regarding floating has improved, declined, or stayed the same since the start of closed staffing?

3. Do you think the concept of a host unit has improved the communication and sharing of responsibilities among the critical care units?

A total of 75% of the nurses questioned responded, and 100% of them stated that they had less anxiety related to floating now than before the pilot study. A total of 99% stated that overall morale had improved since the start of the pilot, and 100% believed that communication between the units had improved.

Decrease Use of Sick Time in Critical Care

No difference in use of sick time was noted. The inferred premise was that nurses would call in sick if they thought they would have to float off their unit. However, our experience suggests that nurses call in sick legitimately.

Evaluation and Changes: After the Pilot Study

A Closed to Critical Care Task Force was formed approximately 1 year after closed staffing was fully implemented. The primary purpose was to evaluate the program and to address issues that had arisen since implementation. For example, conflicts sometimes arose among the staff from unit to unit, such as not making the host unit check-in calls on time or a patient assignment that a staff nurse did not think was fair.

The task force has become an ongoing group and consists of 2 nurses from each critical care unit; meetings are held as needed. Additional challenges and decisions made include the following:

- A nursing supervisor liaison for the off shifts was designated to help with the closed staffing communication among the rest of the supervisors.
- Some units are more self-directed than other units about filling their staffing needs, and some require more guidance from nurse managers and supervisors than others do.
- Less experienced charge nurses require development of decision-making skills; the evening and night shifts have a higher number of new staff, so those shifts tend to be more dependent on supervisor involvement. Having the more experienced staff and/or the nurse manager mentor these new nurses is the first step. Allowing the new nurses to shadow the charge nurse and receive explanations of decisions made has also been helpful. Having an inexperienced nurse assume charge with the guidance of a preceptor has likewise generated positive outcomes.
- The increased workload for the charge nurses can be stressful. This workload and stress can be decreased if coworkers lend a hand and help with some of the charge nurses’ tasks. For example, if a staffing void needs to be filled and telephone calls need to be made, a fellow staff nurse can assist with these tasks.
- Trusting each nurse’s judgment related to staffing is progressing but requires continuous work. Each critical care unit has its own patient acuity levels; staff nurses naturally tend to think that their unit is busier than the others. It is a daily struggle to break away from unit-based thinking to thinking about the “whole.”

Conclusion

The idea of having closed critical care staffing started out primarily as a means to improve morale and satisfaction of nurses. Not only did morale and satisfaction increase, but in the process, critical care nurses have truly developed ownership and accountability for their units’ staffing. Staff nurses were empowered to make changes to enhance nursing practice. Nurses from each unit continue to do a tremendous job piecing together staffing and thinking “outside the box” with creative staffing ideas. Equally important, these previously separate and distinct units are developing into strong, cohesive, and knowledgeable teams. Improving communication, decision-making skills, and trustworthiness between the critical care units remains a constant challenge. It is understood that promotion of the task force will enhance continued discussion and collaboration. Effective communication is built on the cement of trust.9

Knowing that you do not have to float outside critical care since closed staffing started, do you have less anxiety when it is your turn to float?

Would you say that the overall morale regarding floating has improved, declined, or stayed the same since the start of closed staffing?

Do you think the concept of a host unit has improved the communication and sharing of responsibilities among the critical care units?

Staff nurses responded to this simple questionnaire about the program as follows:

100% YES
99% YES
100% YES

Since closed critical care staffing was implemented at TMH, the medical-surgical units now also follow a similar floating/staffing practice. Staff nurses have truly been empowered to exercise their professional judgment around staffing and floating issues. The key to success has been the investment that all nurses made to make this program work and thus avoid having to float outside critical care. Closed critical care staffing has been successful at TMH, which could serve as a model for others.

Acknowledgments
We would like to thank Rebecca Burke, RN, MS, CNAA, BC, Senior Vice President for Patient Care Services and CNO of The Miriam Hospital for empowering us, Cynthia A. Padula, PhD, RN, for her assistance with the article, and all the critical care nurses at The Miriam Hospital, for without their hard work, this practice would not have been possible.

Financial Disclosures
None reported.

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Crit Care Nurse 2008;28 51-57
American Association of Critical-Care Nurses
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