



Willing to Walk

A Creative Strategy to Minimize Stress Related to Floating

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Asking a nurse to float has traditionally been fraught with anxiety, fear, and frustration. Floating can result in nursing dissatisfaction and high turnover rates. The authors discuss a strategy to minimize nurse anxiety and enhance nurse autonomy. The strategy has been successful for more than 6 years and contributed to a positive trend in nursing satisfaction with a very low turnover rate.

For as long as many nurses can remember, floating has been a necessary evil of staffing. Approaching the nursing unit for the shift report can fill a nurse with anxiety, knowing that today is the day that he/she is being floated out of the unit. Floating, also referred to as pulling, is a staffing strategy that involves sending a nurse from his/her permanently assigned unit, or home unit, to a unit that needs staff. This need may occur because of staff calling off work, increased acuity on the unit that requires more staff than originally scheduled, a decrease in census, or other unforeseen circumstances. Floating is seen as a cost-effective means of staffing by using nurses already available and avoiding calling in nurses who are paid overtime or using agency nursing personnel. Although this is the general belief, there is little evidence to support this assertion.¹

There is much written describing the responses of nurses who are floated or pulled from their assigned units. Common descriptors elicited from nurses who are pulled include anxiety producing, stressful, dissatisfied, and disruptive.¹⁻⁴ These emotional responses stem from several factors. One of the most prevalent concerns voiced by nurses about floating is

the level of discomfort produced by going to an unfamiliar unit. Each unit has its own process for many nursing duties such as making assignments, storing supplies, completing tasks, contacting physicians, and responding in case of an emergency, to name a few. The unfamiliarity with the unit's processes results in taking more time to find supplies, locating equipment, and performing general nursing functions. Asking the floating nurse to deal with different or unfamiliar patient populations heightens the level of discomfort and anxiety, as the nurse may feel a sense of inadequacy in his/her level of competency to perform patient care. In addition, each unit has a culture that may be very different from the nurse's home unit culture, adding to the stress.⁵

When a nurse arrives on the unit, the reception from other nurses sets the tone for the shift. Some may be grateful to have the extra help, whereas others may be reluctant to share information with an "outsider," or they see a nurse who will require more help because of the unfamiliarity with the unit. In our experience, we have witnessed 2 distinct responses to the floating nurse. Some are given the difficult assignment or highest-acuity patients so that the "regular staff" can have a break from them. Other times, the receiving unit, thankful for the help, gives patient assignments that are less challenging. One approach causes increased tension and frustration, whereas the other results in both parties feeling more comfortable with the situation.

Background

Aultman Hospital is a Magnet®-designated level II trauma center licensed for 808 beds including adult intensive care, monitored step-down, acute care, and perinatal (neonatal ICU [NICU] and pediatrics).

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Inpatient units are staffed for 573 beds with an average daily census of 407 patients. Aultman employs more than 1,600 RNs. Nursing units are managed by a vice president/associate vice president and unit directors in service line divisions.

In the past, if RN staff was not needed on a particular unit because of decreased volume or acuity, 1 or more RNs were floated to another nursing unit to cover staffing. The unit to which a nurse was floated was within the same division, but this was still met with dislike and frustration. Nurses brought their concerns to our organizational “brown bag” meetings, which are small discussion groups of staff from various areas of the hospital facilitated by an executive representative. In a study completed by Wieck et al,⁶ recommendations for retaining intergenerational nurses were identified. One of these recommendations was to develop a plan to redesign the process of floating to cover staffing. Nurse floating is demonstrated through research to be a factor in nursing satisfaction and can contribute to turnover.⁷

In response to this clear message from staff nurses, the nurse executives and nurse managers met. After completing some literature reviews and benchmarking, the chief nursing officer (CNO) along with the leadership team came to a collaborative decision regarding floating RN staff off the unit. Bethune and Bumgarner’s 2003 presentation, “Floating: We’ve Stopped It... Can You?” at the Forum on Health Care Leadership Conference inspired this decision. The CNO shared the resolution to stop floating or pulling with all nurse managers and staff nurses during the second quarter of 2005. This decision initiated the development of a process that has demonstrated success in nursing satisfaction while supporting sound economic practices.

Willing to Walk: The Process

Floating, as it was previously done, was eliminated resulting in the “no-pull rule” and the “Willing to Walk” program. Patient volumes drive the need to pull nurses from one unit to another. When the census is high, creative staffing is required to cover needs in those high-census areas while addressing areas of low census as well. To meet the varying staffing needs on the units, nurses are asked to float only within a like nursing unit (ie, medical-surgical to medical-surgical) and only upon their agreement to do so. In the Willing to Walk program, nurses who agree to float, or are “willing to walk” from their home unit to another, indicate their preference for floating either within like nursing units only or to other areas in which they have demonstrated competency on an annual basis. The nurse is asked to float each time the need arises and may decline without consequence.

During times of low census, nurses who elect not to float have the option to take time off without pay or to use benefit time. Each nursing unit keeps a list that tracks days taken off by staff for low census. The nurse on a low-census unit is offered to float (or willing to walk) if he/she is at the top of the rotation to take a day off for low census. If we experience a time when no nurse agrees to float within the hospital, we have a safety net of float pool nurses who can fill the vacancy. The choice to walk or not provides nurses an opportunity to exercise autonomy, an important nursing satisfier and a characteristic of a Magnet facility.^{8,9} Through this process, nursing leadership at Aultman uses the skill and knowledge of the nursing staff to meet the changing needs on the nursing units.

Nurses must demonstrate the appropriate knowledge and skills to care for a particular patient population. This is particularly important when floating nurses from one patient care area to another. As an example, nurses who work on the oncology unit must be certified in administration of chemotherapy, whereas a critical-care nurse must have the critical-care skills required to care for patients in the medical ICU (MICU) or surgical ICU (SICU). Our MICU and SICU are considered sister units and float staff between the 2 as volumes and acuity require. The cardiovascular surgery ICU and critical-care unit (CCU) are sister units as well. This practice was noted in a national survey from the American Association of Critical-Care Nurses.¹⁰ In this survey, 55% of CCUs floated staff to a designated CCU.

To support staffing in areas where nurses require specialty skills, Aultman created a specialty float pool. This provides nurses the opportunity to function within a specialty while working on diverse units within a product line/specialty/division. Nurses in the medical-surgical float pool float to other medical-surgical units. The critical-care floats are used in the ICUs, step-down units, and the emergency department. Pediatrics, NICU, and the birth center (labor, delivery, and postpartum) are served by the perinatal float pool. Our long-term-care center has a float pool of nurses who cover rehabilitation and transitional care. Members of the float pool are considered regular staff and rotate weekends and shifts. The substantial benefit to being a float nurse is that every other holiday requirements are covered as on-call only.

Staffing

Aultman’s nursing units practice decentralized scheduling. Each unit develops its own staffing and scheduling practices to facilitate appropriate care delivery on the unit. Staffing is based on the ANA Principles

of Nurse Staffing,¹¹ considering volume, acuity, and nurse competency when making assignments. A staffing meeting that includes the staffing/scheduling coordinator and inpatient unit nurse managers is held prior to each shift. During this meeting, staffing needs are determined and addressed. If floating of personnel is required, the nurses in the appropriate areas are approached, and the request is made. At the beginning of the week, the float pool nurses are distributed to nursing units based on staffing needs. These assignments are reviewed daily during the staffing meeting and reassigned as needed.

Aultman values RNs as professionals and strategic assets. This value is demonstrated in our commitment to minimize the use of agency, supplemental, or traveling nurses. Although per-diem nurses have been and continue to be a staffing resource for hospitals, our use of per-diem nurses was eliminated in 2007 as concerns for maintaining competency levels in the fast-paced high-technology climate of healthcare became more prevalent. The use of the float pool and floating staff nurses as described previously has replaced the per-diem nurses with consistent staff who are competent to function in specific areas.

In addition to the Willing to Walk program and the specialty float pool, Aultman has one other process in place to minimize the use of agency nurses. We offer a financial incentive to any nurses who are less than a 1.0 full-time equivalent. The nurse commits to an extra 8-hour shift for either 4 or 8 weeks. This time is prescheduled so the nurse knows when he/she is required to work the extra time. A set dollar amount bonus, based on the overtime rate for a senior RN, is provided to the nurse upon signing an agreement to work the agreed-upon hours. If the volume or acuity is such that the extra shift is not needed that day, the nurse is required to fill a shift at another time to meet the required 4- or 8-week commitment. We have been able to avoid using agency nurses by using the float pool, extra shift incentive program, Willing to Walk program, and sister unit float coverage. The last agency RN was used in 2005 for 1 shift.

Outcomes

Figure 1 demonstrates the turnover rates for RNs at Aultman Hospital from 2004 to 2010. These are the rates at which nurses leave the hospital for any reason or transfer to other units. The benchmark is based on a >701-bed Magnet-designated hospital as found in the Average Magnet Organization Characteristics.¹² The turnover rates fluctuate somewhat each year, but remain below the average of 11% for Magnet organizations.

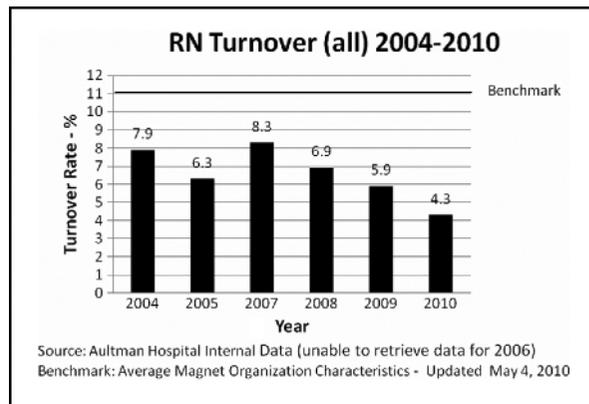


Figure 1. RN turnover 2004-2010.

Although there are several variables that should be considered when looking at turnover rates, nursing satisfaction is a significant one. Facilitating staff nurse autonomy and empowerment through a no-floating policy may be a factor that leads to improved nursing satisfaction. Our nursing satisfaction scores demonstrate high satisfaction. These data, as noted in Figure 2, are obtained through the National Database of Nursing Quality Indicators, which is owned by the American Nurses Association.

The Future of Nurse Staffing

One certainty in healthcare is that it is always changing and evolving. The methods used today to meet the needs of patients and healthcare consumers will differ in the future. One of the issues facing nursing leaders includes the projected need for 587,000 new RN jobs by 2016 related to retirement of the baby boomers and the increased aging population introduced into the healthcare delivery system.¹³ Retention of nurses is paramount to ensure adequate staffing and successful provision of quality care.

Public Policy

California now has a regulation mandating the staffing levels for nursing in hospitals, and other states are considering the same.¹⁴ Although the goal was to improve nurse-to-patient ratios with improved quality of care and decreased stress levels for nurses, it has not proven to be successful. In areas where there are already insufficient numbers of nurses, the mandate now forces nurses to work more hours and increases their level of fatigue and dissatisfaction.¹⁵

On June 12, 2008, Ohio's governor Ted Strickland signed House Bill 346, which relates to nurse staffing. Ohio hospitals are required to have a written evidence-based nursing services staffing plan, which is reviewed annually. In addition, all Ohio hospitals were required to develop a nursing care committee, consisting of the

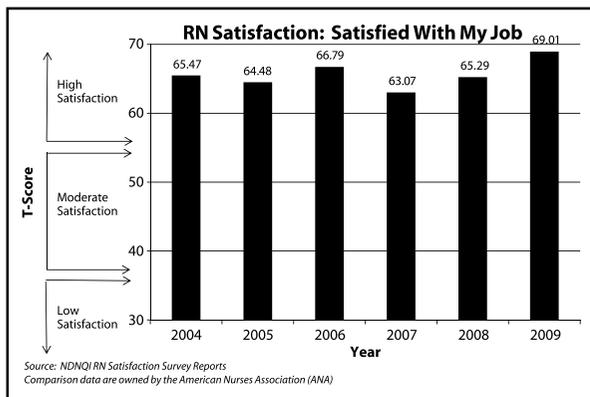


Figure 2. Nursing satisfaction.

CNO and direct care nurses, which represents all types of nursing care in the hospital to recommend and review the staffing plan.¹⁶ This kind of legislation is less restrictive in that it does not mandate staffing ratios but rather provides a mandate for guiding the development and maintenance of a staffing plan. Our facility already had a staffing plan in place prior to the legislation that included decentralized scheduling,

float pools, and Willing to Walk. The introduction of the nursing care committee was another mechanism for supporting nurses as they became more engaged in the staffing and scheduling process.

Leadership

A transformational leader who sees the importance of autonomy for nursing staff is a positive influence on retention and nurse satisfaction. By supporting the no-pull rule and the Willing to Walk program, the CNO has provided nurses with the ability to avoid the anxiety and frustration often felt from floating. Sellgren et al¹⁷ determined through their study of leadership behavior that a manager has an important role in influencing a creative work climate. A manager who is willing to support new ideas and processes from direct care staff helps build job satisfaction that can result in increased engagement and retention. The success of our current no-pulling practice has been sustained since 2005. The future cannot be predicted with any certainty, but best efforts at maintaining this practice can result in continued nurse satisfaction with minimal turnover.

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