

Nurse Staffing and Patient Outcomes in Inpatient Rehabilitation Settings

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In rehabilitation nursing, the patient classification systems or acuity models and nurse-staffing ratios are not supported by empirical evidence. Moreover, there are no studies published characterizing nursing hours per patient day, proportion of RN staff, and impact of agency nurses in inpatient rehabilitation settings. The purpose of this prospective observational study was to describe rehabilitation nurse staffing patterns, to validate the impact of rehabilitation nursing on patient outcomes, and to test whether existing patient measures on severity and outcomes in rehabilitation could be used as a proxy for burden of care to predict rehabilitation nurse staffing ceilings and daily nurse staffing requirements. A total of 54 rehabilitation facilities in the United States, stratified by geography, were randomly selected to participate in the study.

The total nursing hours per patient day (HPPD) in rehabilitation were reported at 8.1 hours, with the proportion of registered nurse (RN) staff at 50%, and nominal use of agency nurses reported across sites. This staffing level exceeds levels reported in long-term care but falls short of acute care settings. Nurse staffing levels varied by geographic region, with significantly higher nursing HPPD in the West, a finding not previously reported in the literature. Free-standing rehabilitation sites reported a smaller proportion of RN staff and used significantly more agency nurse hours when compared to hospital-based rehabilitation facilities. The patient mix, defined by the distribution of rehabilitation impairment categories (RICs) on each unit, significantly affected nurse staffing levels. As the percentage of each RIC increased, there was a significant increase in the total nursing HPPD and RN HPPD, but not in the non-RN HPPD; however, the RIC did not significantly impact the proportion of RNs. Positive nurse managers' perception of non-RN staff competency in rehabilitation nursing practice was most predictive of improved patient outcomes, defined as FIM™ gain and discharge FIM™ score. A shorter length of stay (LOS) was predicted by three variables: a higher proportion of nurses certified in rehabilitation (certified rehabilitation registered nurse, or CRRN™), decrease in RN years of rehabilitation experience, or decrease in average daily census.

We examined the possibility of using the average admission relative weight (AARW), a patient severity measure, to predict nursing staff ceilings. As the facilities' AARW increased, there was a positive trend for increases in full-time employee equivalents (FTEE), overall nursing HPPD, and RN and non-RN HPPD, although these findings were not statistically significant. We also examined the possibility of using

data from a commonly used patient outcome measure, the FIM™ instrument, as a proxy for the burden of care, to predict shift-by-shift nurse staffing needs. Nightshift was the most highly correlated with average daily FIM™ score; for every 10-point increase in the rehabilitation unit's average FIM™ score, there is a corresponding 3.7% decrease in the average night shift hours per day. Practical issues associated with use of the FIM™ instrument were also considered. All sites found the daily administration of the FIM™ instrument to be moderately burdensome. There were regional differences in burden perceptions, with the South and the Midwest finding completing the daily FIM™ instrument slightly less burdensome than the Northeast and West. In addition to burden, the proportion of missing data averaged 9.4% for each study day for the daily FIM™ ratings. Further research is needed to examine the utility of AARW and the FIM™ instrument as potential nurse staffing tools in rehabilitation settings.

Specific Aims

Existing evidence does not support patient acuity models, patient classification systems, and nurse staffing ratios in rehabilitation nursing. Some rehabilitation units have adapted staffing tools originally created for either acute care or long-term care, although these tools lack specificity for rehabilitation practice. Another strategy has been to design a facility-specific tool, but these tools lack validity and reliability. Diverse staffing strategies have resulted in wide variation in staffing methodologies across inpatient rehabilitation settings. Specific nurse-patient ratios, proportions of RN staffing, and the impact of agency nurses have not been reported for rehabilitation. In addition to a lack of evidence-based nurse

KEY WORDS

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