Introduction
Nurses play a critical role in maintaining the safety and structure of the inpatient environment, meeting patients' support needs, and working collaboratively to develop symptom management strategies. These dimensions of care are enacted and maintained by a nursing staff group of sufficient number and level of expertise. Corporate, state and federal and financial mandates are imposing constraints on safe and appropriate staffing. To assure patient/staff safety and the quality care patients deserve, principles of staffing have been established by the American Nurses Association (ANA). The American Psychiatric Nurses Association (APNA), as the largest professional organization representing psychiatric nurses, recognizes the need to mesh these ANA principles with the unique staffing considerations of inpatient psychiatric treatment.

Background
The work of nurses is caring for patients. For the past 60 years nursing staff, managers and administrators have recognized that good nursing care requires the availability of a sufficient supply of competent nursing personnel to address patient needs. The matching of nursing resources to patient needs is generally labeled staffing. Staffing a unit has demanded engineering a unique match of the amount of care nurses can provide a group of patient in specific settings with the amount of care this group of patients require to achieve optimal outcomes. Over the years staffing methods have evolved that use mathematical algorithms to determine the number of hours of nursing care required by a group of patients (Edwardson & Giovannetti, 1994). Recently the logic of these formulas and their underlying premises have been called into question, especially census based calculations or ones depending on hours of care per patient day (O’Brien-Pallas, & Giovannetti, 1993).

Over the past 15 years nurse researchers have developed new conceptual models of staffing and workload determination (Prescott, et al, 1991; O’Brien-Pallas, Irvine, Peereboom, & Murray, 1997; Verran & Reid, 1987). In these new models, the common premise is that effective nursing care requires the intellectual processing of information, in particular, the decision-making activities that are performed by nurses in their clinical analysis of the patient’s current situation (Verran & Reid, 1987). The amount of time and effort nurses spend in decision-making processes has a major impact on the total work nurses perform in caring for individual or groups of patients (Gallagher, Kany, Rowell, & Peterson, 1999). In this scheme of nursing care, three key components of staffing come to the fore: complexity of care, skill levels of staff, and the infrastructure of the hospital system.

The extent to which a nurse must engage in independent problem solving activities to achieve positive changes in patient health is represented by the concept complexity of care. Low complexity of care situations requires minimal independent thought by the nurse. These patients require care very similar to patients who have comparable problems
and the link between care activities and desirable outcomes is fairly clear. In contrast, high complexity of care situations are ones where nurses must continuously assess and evaluate a patient’s condition because the patient is unstable or is not responding to standard care in a predictable manner.

Complexity of care depends not only on a patient’s characteristics but also on the skill level of nurses assigned to care for a patient. Competent nurses, who through education and experience have the knowledge base from which to care for specific patient populations, can quickly assess patients’ needs and execute nursing activities that contribute to positive outcomes in patients (Verran & Reid, 1987). Conversely, nurses who are not familiar with the problems presented by their patients must expend a great deal of intellectual effort in the selection of appropriate nursing interventions.

Finally, the infrastructure of a health care system also influences staffing decisions. A hospital’s policies and procedures that organize care delivery within an institution, the physical layout of the work area, and the availability of financial support and equipment directly affect nurse’s work (Huber & Delaney, 1996; O’Brien-Pallas, et al., 1997). Within this structure, managers and administrators must assure processes are in place that facilitate care delivery to the greatest number of patients without excessive use of personnel or equipment. Moreover, since patients and the environmental conditions available to support efficient nursing care change over time, managers must be attuned to shifts in patient care needs and staffing capabilities.

As they face the introduction of these staffing concepts into the inpatient arena, managers and administrators will need macro system formulas to balance patient care delivery needs with resources, all within the framework of the financial realities of their system. Staffing recommendations should be grounded in the assessment of the complexity of care of patients made by nurses with knowledge of their patients and standards of care for their patient population (ANA, 1999). Systems will also require structures such as the Nursing Management Minimum Data Set (NMMDS) to integrate information about staffing, patients, nurse, and environmental factors that influence complexity of care associated with patient problems (Huber & Delaney, 1996).

These changes have particular relevance for nurses practicing in Psychiatric-Mental Health setting (Mark, 1985). Psychiatric-Mental Health (PMH) nursing is inherently complex. The nursing needs of patients who experience alterations in their cognitive processes are consistently more complex than patients who are alert, oriented and able to problem solve (Alexander & Mark, 1990). Because of their knowledge about the treatment of mental health disorders, PMH nurses are the best judges of the complexity of care associated with patients in psychiatric-mental health settings. They understand the needs of groups of individuals and also the need to identify actual or potential disruptions in the mental health of patients. Moreover, expert PMH nurses are particularly vital because they have the skills to quickly recognize the unusual or unpredictable patient situations and prevent negative and sentinel events such as incidents of violence, suicide or seclusion/restraint (Johnson & Hauser, 2001).
Outcomes of care associated with staffing

The goal for nurses who work at all levels within mental health care organizations is to use nursing resources that promote positive mental health outcomes in patients and prevent negative events that hamper the return of optimal functioning in patients with mental health problems. The challenge for inpatient psychiatric nursing will be to clarify clinical outcomes and then understand their relationship to staffing. There are few recent nursing studies of the outcomes of brief inpatient treatment and none of these studies tie outcomes to staffing levels (Tucker, Moore, & Luedtke 2000). Though some attention has been given to the relationship between staffing, incidents of violence and the use of physical restraint; to date, there is only weak evidence that levels of staffing relate to the use of seclusion/restraint or to the incidence of violence in any consistent manner (deCangas, 1993; Fisher, 1994; James, Fineberg, Shah & Priest, 1990; Lanza, Kayne, Hicks & Milner, 1994; Morrison & Lehane, 1995; Owen, Tarantello, Jones & Tennant, 1998; Shah, Fineberg & James, 1991; Way, Braff, Hafemeister & Banks, 1992).

Several investigators have found that the experience level of staff negatively correlates with the incidence of violence and/or the use of seclusion and restraint (Davis, 1991; Morrison & Lehane, 1995; Owen et al., 1998; Whittington & Wykes, 1994; Whittington, Shuttleworth & Hill, 1996). Further, the incidence of violence is seen to decrease on wards with good leadership and trained staff (Infantino & Mustingo, 1985; James, et. al, 1990, Katz & Kirkland, 1990; Morrison & Lehane, 1995; Owen et al., 1998; Rosenthal, Edwards, Rosenthal & Ackerman, 1992; Shah, et al., 1991; Whittington & Wykes, 1996). Thus the key to understanding the relationship of staffing to sentinel events might be the expertise and experience of a staff group rather than its relative size.

Recommendations

- We support the ANA staffing principles that hold the organization’s staffing plan should be created through consultation with nurses who have expert knowledge about the nursing care of patients with psychiatric-mental health problems.
- We underscore the ANA tenet that nurse administrators/executives must work in concert with front line staff to assure adequate resources are in place that support the practice of nursing and delivery of safe, effective care and to establish staffing guidelines that consider knowledge and experience of personnel in the distribution and assignment of nursing staff.
- We recognize that to date there has been scant study of workload/complexity of care measures focused on the unique needs of psychiatric clients, in particular, measures that incorporate nurses’ knowledge of these patients, their care requirements, and the skill level required to care for patients with varying intensity of need.

Therefore we propose the following efforts be initiated to set up an infrastructure of data that would ultimately help psychiatric nurses develop staffing principles for inpatient psychiatric units:
1. Expert psychiatric nurses must begin to define the key descriptors and domains of care for inpatient psychiatric clients such as their self care, information, transition, cognitive, safety and support needs.

2. Expert and Advanced Practice Psychiatric Nurses should work together to develop categories that mesh these care descriptors with patients at varying levels of complexity, incorporating the decision making and clinical judgment involved in caring for these groups of psychiatric patients.

3. Nurse administrators should explore data classification schemes such as the Nursing Management Minimum Data Set (NMMDS) to guide system wide data collection that will support staffing decisions, cost-benefit determinations and the linkage of human resource indicators with outcome/clinical service indicators.

4. We must begin to delineate the skill levels of beginner, novice, competent, and expert psychiatric nurses. This is a necessary step if we are to one, match caregiver competency with specific patient needs, and two, begin to build systems that recognize and reward expert nursing practice.

5. The process of developing staffing models would be facilitated by dissemination of staffing data by hospital systems that have developed complexity of care models that match psychiatric client's care requirements with provider skills.

6. In line with a recent JCAHO initiative, clinical outcomes of hospitalization are to be examined in light of staffing patterns and other human resource indicators. To meaningfully address this regulation, dialogue must begin on appropriate clinical service indicators and outcomes of inpatient psychiatric treatment.

7. APNA, in cooperation with other psychiatric nursing organizations, should determine the necessary components of databases so that the relationship between various components of staffing and patient outcomes can be explored.

8. With a data base of staffing patterns and outcomes, psychiatric nursing organizations can begin to examine relationships between staffing patterns, levels of expertise and sentinel events. The work of establishing such larger scale research should not preclude the necessary, on-going root cause analysis of sentinel events and their relationship to staffing patterns.

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References


