Spotlight On

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Is It Time to Pull the Plug on 12-Hour Shifts?

Part 2. Barriers to Change and Executive Leadership Strategies

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This article is part 2 of the series "Pulling the Plug on 12-Hour Shifts." In part 1 (March 2010), the authors provided an update on recent evidence that challenges the current scheduling paradigm that supports the lack of safety of long work hours. Part 2 describes the barriers to change and challenges for the nurse executive in moving away from the practice of 12-hour shifts. This is an executive-level analysis of barriers and recommends strategies for change. Translation of evidence into administrative practice requires examination of external environmental factors, internal system consequences, organizational culture, and measures of executive performance.

Hospital nurses are accustomed to working 12-hour shifts, and there is a high degree of satisfaction among nurses with this form of scheduling.[1-3] In part 1, Geiger-Brown and Trinkoff[4] presented evidence that 12-hour shifts increase the risk to nurses' health and safety (musculoskeletal disorders, needlestick injuries, drowsy driving, and inadequate sleep) as well as increasing the risk for errors and near-misses that threaten quality and reduce the safety of patient care. It has been 10 years since the IOM published *To Err Is Human*,[5] where the healthcare industry was forced to confront the fact that medical errors kill up to 98,000 patients in the American hospital system each year. In addition, the IOM report *Keeping Patients Safe: Transforming the Work of Nurses*[6] cited extended work hours as a source of nurse fatigue. Hospital nurses work in an affectively intense, decision-rich, and constantly changing clinical environment. Their job requires a high and unvarying level of accuracy and the capacity to adapt to ever-changing demands. The evidence tells us that extended working hours, compressed schedules, and working while fatigued and sleep deprived reduce vigilance and motivation and impair neurobehavioral functioning.[4] This calls into question the ethics of continuing with 12-hour shifts.[7] We believe that there is a visible mandate to move away from 12-hour shifts for nurses, and in this article, we examine the barriers to eliminating 12-hour shifts and recommend leadership strategies based on AONE's nurse executive competencies.

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Barriers and Strategies

The greatest barrier to moving away from 12-hour shifts is that many nurses like and expect this schedule, as it is the norm in many institutions.[8] Hospital nurse executives are held accountable for, and compensated based on, outcomes across a wide "dashboard" of performance measures. Among the myriad of dashboard indicators (financial targets, patient outcomes, climate, and culture indicators), the ones most likely to be affected by moving away from 12-hour shifts are nurse satisfaction and recruitment and retention rates. With the loss of qualified nurses, other performance measures could also be negatively affected. The evidence presented by Geiger-Brown and Trinkoff[4] poses 2 leadership challenges for the nurse executive: (1) the need to capture currently unmeasured aspects of the latent safety climate and (2) the need for large-scale organizational change that may be unwelcome, albeit

evidence based. The nurse executive must move the culture and infrastructure of the organization to discourage any nurse working in a haze of fatigue. This must be done while maintaining quality patient outcomes, nurse satisfaction, retention, and recruitment along with financial performance. One could argue this is a large and risky change, yet nurse executive must face the larger question—what do fatigue and sleep deprivation in the nurse have on achievement of patient outcomes, quality and safety, and the long-term health and wellness of the nurse?

It could be argued that, in recent years, the nursing shortage resulted in a 1-sided emphasis on simply recruitment and retention of nurses to fill the vacancies and achieve the appropriate nurse-patient staffing ratio. Achieving the targeted vacancy and retention is no longer enough; it is essential that responsibility is shared between nursing administrators and professional nurses to do everything possible for the nurse to be physically and mentally prepared to take on the responsibility of care. The airline and trucking industry and medical residency programs have recognized the impact of fatigue on the likelihood of making an error resulting in death and injury to the people they serve and have promulgated regulation to enforce work hours.[9,10] Nursing has not used regulation to enforce safe work; rather, it relies on self-regulation. It is critical that the nursing profession move beyond a focus on ratios and numbers and begin to apply research evidence to decision making to ensure that work environments are healthy, and scheduling practices are appropriate.

Including "fatigue risk" measures in the dashboard would begin to address this impact of scheduling practices on nurses and patient safety. Although individual fitness-for-duty testing to manage fatigue risk is not yet "ready for prime time," there are highly developed models from sleep and human performance scientists that are commercialized into software packages to assess workers' fatigue risk. These programs are used routinely in other safety-sensitive industries but have not been adopted in healthcare. Factors such as shift start time, duration of the shift, spacing and duration of work breaks, and individual employee factors such as age, commute time, and health status can all be contributors to the risk for fatigue-related errors. A dashboard indicator that assesses latent risk would include fatigue risk averages and negative outliers. When these software packages are adopted, we expect that the results will challenge executives to eliminated the practice of compressed work schedules (several 12-hour shifts in a row followed by a block of days off), especially on the night shift. The fatigue-risk benefit of eliminating 12-hour shifts will become apparent.

A nurse executive who tries to lead this change without working in concert with other local hospital executives is likely to face stiff competition, as nurses will continue to seek 12-hour shifts. Nurse executives need to create partnerships and develop consensus among area hospitals when introducing this change.[11] In addition, the nurse executive must consider the impact of changing from the 12-hour shift on internal hospital systems. There will be significant effects on workflow, interprofessional service delivery, financial measures, and budgetary planning and modeling, as well as on human resources policies and labor union relations. Nursing represents the largest number of employees in a hospital, and a single profession's shift back to 8-hour work shifts will have a ripple effect throughout all hospital systems. The nurse executive must engage the executive team to analyze the impact of the change on other departments, disciplines, and key stakeholders as well as on financial and human resource systems.[11] Resistance from unionized nurses will require shared implementation where the nurse executive and team work with the union representatives on a plan for change. Organized labor has roles in both health and economic welfare for nurses, and appealing to the former may reduce resistance—they are well aware of the research evidence on 12-hour shifts. Change could be introduced gradually to allow nurses to rearrange child care and family responsibilities. A pilot test of unit-based schedules to prevent long hours could be adopted.

Culture Change

Moving away from 12-hour shifts will require a real change in hospital culture. No nurse executive likes to believe that their institution accepts a work culture where coming to work exhausted, sick, or unprepared for the demands of patient care is tolerated. Yet, hospitals will allow nurses to "self-schedule" in ways that substantially increase fatigue risk or may ask nurses to accept "on call" or mandate overtime to cover open shifts so as not to use expensive supplemental staffing. The peer culture may discourage a nurse from staying home

when too fatigued to function. Because most sleep-deprived staff have little awareness of their neurobehavioral deficits, relying on nurses to self-regulate should take a backseat to administrators ensuring healthful work schedules that allow adequate sleep opportunity. The nurse executive's efforts to shift nursing administration practice to use evidence, even if that evidence is not popular, are the hallmark of leadership. This nurse executive is modeling a work culture where expectations support healthy, safe work environments.

The barriers to change are significant and require a level of leadership that is mindful of the impact on the nurse, patient, and services in the hospital as well the community, professional associations, and unions. Nurse executives can advance the use of evidence to create safe and quality-rich work environments.[12] The evidence is compelling, and the mandate is clear.[12]

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