Wave 62 – January – March 2020

Traveling Providers

Project Type:

90-day Innovation Project:	*30-day Innovation Project:*	*Content Development:*
A full wave to scan, test, and document recommendations in a formal deliverable	A short project to scan, provide research assistance, or design an expert meeting	A full wave of research support with the potential for continued support

Executive Summary:

This wave focused on the current status of safety in health care related to traveling providers. The research focused on travel nurses the agencies that recruit and deploy their services, and health systems that utilize travelers. The intent was to understand what measures are currently utilized to ensure safe, quality, and equitable care as the proportion of travel nurses has changed (especially as a result of the on-going covid-19 pandemic).

Ultimately, this effort found that hospitals and health systems, under the continued demands of the pandemic, systems for robust training, maintaining, evaluating, and improving safety, quality, and equity in care delivery by travel nurses are essentially non-existent. Additionally, early reports from the New England Journal of Medicine suggest that years of progress on improving important safety measures have experienced major setbacks during covid. It is currently unknown how the changing proportion of travel nurses affects safety, quality, and equity.

With that in mind, there are opportunities for IHI to advance safety, quality, and equity in this space. They are discussed in depth in this report. As a brief overview, ideas include:

- Convening health systems and travel agencies to build the will to improve the status of safety, quality, and equity for care delivered by travel providers.
- Curate IHI content specifically for travel nurses to help standardize baseline education and best practices for safety, quality, and equity
- Establish best practices for requirement, onboarding, coaching and development, and evaluation for travel nurses and the agencies and health systems with which they work.

Team:

Alex Anderson, John Whittington, Patricia McGaffigan

Intent & Aim:

In this wave, the innovation team intends to continue IHI's commitment to patient safety by understanding the opportunities, challenges, and concerns related to models of temporary staffing for health care providers. Appropriate and competent staffing is essential for patient safety and this effort also

compliments recent innovation team research efforts on patient safety and reinforces the principle of "Safety as One" (i.e., eliminating the separation between workforce safety and patient safety. Organizational alignment includes sharing data between human resources and patient safety teams).[1]

Goals for this wave include:

- Providing an overview of temporary staffing models with a special focus on temporary nurse staffing.
- Identifying best practices for patient and workforce safety with respect to temp nurse staffing
- Making recommendations from a systems perspective on key considerations for leaders utilizing temporary staffing models, agencies, and temporary staff.

Description of the Work:

During this innovation cycle, the team relied on traditional research methods including literature review and expert interviews. The following experts were interviewed during this wave:

Bruce Weinberg Assistant VP, Nursing Workforce Mgmt Ochsner Health System	**April Hansen** Group President, Workforce Solutions Aya Healthcare
Vicki Good, DNP, RN, CENP, CPPS Executive Director Mercy Health System	**Peter Griffiths, PhD, BA, RN, FEANS, FHEA** Professor of Health Services Research University of Southampton
Tina Gross, RN Travel Nurse Contracted with Aya Healthcare; Mass General Assignment	**Jess Perlo** Director, Joy in Work Institute for Healthcare Improvement
PK Scheerle Chief Executive Officer Nurses Everywhere	**Larson Hicks** Chief Executive Officer Sycamore Independent Physicians
James Quick (President) **Bambi Gore, MSN, FNP-BC** (VP and Chief Clinical Officer) SimpliFi Managed Services	**Earl Dalton, MHA** Chief Nursing Officer Health Carousel
Joanne Disch, RN, PhD, FAAN Professor ad Honorem University of Minnesota	

Background

Temporary staffing models are not new in US health care settings – dating back to the mid-1970s.[2] Typically, the proportion of temporary staff deployed by hospitals and health systems increases and

decreases based on changes in demand for health care services at individual hospitals and health systems as well as larger contextual changes to demand for health care services, such as seasonality. The pandemic has created an unprecedented burden on the health care work force.

Many hospitals and health systems face severe fluctuations in staff availability due to increases in patient volume, quarantine of covid-positive staff as well as staff resigning or retiring early for a host pandemic-related reasons and shifting trends in the workforce. Staffing shortages are leading to temporary and permanent closing of services for hospitals and health systems around the United States: Holy Cross Health in Fort Lauderdale temporarily closed its labor and delivery unit; University of Utah suspended about 20% of surgeries in the first week of 2022, Henry Ford Health System closed nearly 100 hospital beds.[3]

A shortage of health care providers – or the fear that a shortage is eminent – has loomed over the industry for decades. Sometimes these shortages relate to a drastic increase in demand for nursing. In the 1930s, technological, economic, and health care related events combined to increase the demand for nursing beyond the availability of registered nurses.[4] The pandemic continues to challenge nearly all health systems in their ability to fully staff a workforce capable of delivering safe, quality care. In a recent survey of rural hospitals: 99% reported staffing shortages, 96% reported the most difficulty in staffing nurses, nearly half had difficulty accepting new patients, 25% were forced to suspend certain services (including newborn delivery, chemotherapy, and colonoscopies), and another 20% reported their consideration of suspending similar services.[5]

To face this reality, hospitals are increasingly relying on temporary staffing models across many roles in the health care industry. Hospitals work with temporary (or floating) providers within their health system and contract directly with external staffing agencies to address staffing challenges, and many have created their own internal staffing agencies. The ten largest U.S. healthcare staffing firms account for 46 percent of the market, led by AMN Healthcare, CHG Healthcare, Cross Country Healthcare, Jackson Healthcare, and Aya Healthcare.[6] The evidence that temporary staffing provides similar levels of care as permanent staffing is mixed. A study involving 142 hospitals (covering 277 nursing units with 4,954 registered nurses) found that units where temporary nurses made up more than 15% of staff experienced higher rates of patient falls as well as higher rates of injuries to the nurses themselves compared to units with less than 15% temporary nursing staff. In the same study, units with 5-15% temporary nurses reported fewer medication errors than units with 0 temporary nurses.[7] A recently published study of two hospitals revealed that HAIs significantly increased during the COVID-19 pandemic were correlated with the use of overtime and agency nursing hours.[8] At the same time, studies of traveler provided care prior to the pandemic show similar levels of quality and safety for travelers and core staff. – experience level and educational attainment are the same; patient mortality tied to fail-to-rescue events were not correlated to levels of temporary staff; and, patient satisfaction remains the same.[9]

From an individual nurse perspective, temporary staffing agencies often provide a more desirable employment opportunity compared to permanent staffing. More flexibility in scheduling, higher hourly compensation, the ability to travel to new environments and cities, and access to additional perks, benefits, and job security make temporary staffing a desirable option for many registered nurses.[10]

Due to the complexities of staffing generally and the added difficulty of the on-going pandemic, temporary staffing models are likely to be in higher demand for the immediate future – and the proportion of staffing solutions that are comprised of temporary staff may persist for the long term. Concerns around safety, quality, and equity must remain top of mind. During this wave, we will seek to understand what best practices can be used to increase safety, quality, and equity while deploying temporary care providers.

Overview of Staffing Models and Providers

Hospitals and health systems have relied on a combination of employed providers and contracted temporary providers to meet staffing needs for generations. For the purposes of our research, we understand the following terms to be defined as:

- **Core Provider** – core providers are individuals who are part-time or full-time employees of an organization. They are W-2 employees with set wages/salaries and benefits and may or may not belong to a union. Core providers may work in a dedicated department with assigned patient care/unit responsibilities. Many health systems also employ core providers as floaters who are part-time or full-time staff that do not have a dedicated department but 'float' across teams, departments, and services based on fluctuating demands across the health system. Additionally, in many organizations, staff who are assigned to a unit may have voluntary or forced floating assignments as needs arise
- **Per Diem Provider** – per diem providers opt-in to specific shifts at specific times as they are made available by a hospital or health system. Per Diem providers are analogous to substitute teachers in education – single shift/single day stand-ins due to expected or unexpected vacancies on a care team. Per diem providers may work at one or more hospitals and health systems.
- **Travel Provider** – travel providers are individuals who are contracted-for-hire with time constrained contracts (13-weeks is a common minimum contract length for nurses) with hospitals and health systems. Travel providers are typically hired to work on a specific unit or department for the duration of their contract. It is common for travelers to sign consecutive contracts, moving from one assignment to the next, and they may take breaks between assignments. Travel nurses may accept contracted assignments in their hometown and may temporarily relocate to new cities and countries for assignments. Most travelers work directly with staffing agencies when accepting placements.
- **Agencies** – agencies serve as an intermediary between hospitals seeking short-term staff and the providers seeking short-term employment. Agencies typically provide most services associated with recruitment of providers. This includes candidate review and assistance in credentialing and licensing. Agencies are typically paid by the hospital or health system using a set percentage of the value of the contract.
- **Internal Agencies –** many health systems are developing internal agencies to manage a flexible workforce across their various hospitals and specialties that can respond to changing demand needs across the system.
- **Managed Service Provider (MSP)** – Managed Service Providers work primarily with hospitals and health systems to connect them to a range of other services the hospital or health system may need. Those services can range from temporary staffing for providers to contracted work for other services like IT. A hospital looking to fill several positions all at once may work directly with an MSP to streamline their contracting effort, since many hospitals contract with multiple external agencies at any given time.

Overview of safety issues in travel nursing

Data is just beginning to emerge highlighting the "substantial deterioration on multiple patient-safety metrics since the beginning of the pandemic."[11] The New England Journal of Medicine reports significant

declines in major patient safety measures – undoing meaningful progress in the years before the pandemic:

- CLABSI decreased 31% in the 5 years prior to the pandemic and saw a 38% increase in the second quarter of 2020 in US hospitals
- CAUTI, ventilator-associated events, and methicillin-resistant staphylococcus aureus all saw increases.
- Safety in post-acute care has worsened. Skilled Nursing Facilities saw 17.4% increase in falls causing major injury, and a 41.8% increase in the rate of pressure ulcers.

Based on our interviews, current knowledge comparing safety and quality metrics during the pandemic to pre-pandemic performance has been limited. Health systems are just starting to pause enough to look back at performance. One health system reported significant improvement on patient falls while seeing a fall in performance on pressure ulcers. A recently published study of two hospitals revealed that HAIs significantly increased during the COVID-19 pandemic were correlated with the use of overtime and agency nursing hours, although no information about experience levels of staff was provided.

The main drivers of these safety changes are not well established in the literature or amongst experts that we interviewed. NEJM discusses potential causes for these challenges – a massive influx of very ill patients, overwork staff, and over-utilized resources as well as the inability to perform the type of quality control processes like safety rounds, safety audits, and error reporting. Peter Griffiths, a leading expert in the relationship between nurse staffing and safety and quality performance, explained the difficulty of truly capturing the casual relationship between changes in the hospital environment and safety and quality performance. He described the general predictability of the types of challenges and the possible causes for them and the impossibility of pinpointing when and where those challenges will arise.

Griffith's work generally focuses on nurse staffing levels and performance. Prior to the pandemic, BMJ Quality & Safety published Griffith, et al's research showing a 3% increase in hospital mortality risk for every patient-day where RN staffing was below the ward's staffing mean. And, each additional hour of RN care available in the first 5 days of a patient stay was associated with a 3% reduction in hospital mortality risk.[12] It is widely believed and supported that nurse staffing levels affect safety and quality.[13] There is less available evidence on how the changing proportion of temporary providers may affects safety and quality performance.

Based on our research this wave, the following issues represent some of the safety and quality concerns of experts in the field:

- Establishing standard data systems to be able to track the relationship between patient and workforce safety, quality, and equity as the proportion of temporary staff changes on a team/unit.
- Team dynamics between travelers and core staff (ie. psychology safety, team communication and cohesion). Differences in workload, shift requirements, pay different, and short-term employment vs long-term commitment the hospital/patient panel were discussed.
- Lack of a systematic approach to on-boarding and orientation – especially to technology and information systems like the EHR and safety incident reporting systems.

A common theme throughout our interviews reflected the concern of nursing leaders within hospitals. The need to have trained nurses is so high, that doing the extra work of on-going evaluation, feedback, and continuing learning to support a culture of safety is extremely limited. As one expert interviewer noted, "any nurse is better than no nurse".

Challenges and Opportunities

Challenges

It is well established that the long-standing challenges of health care delivery have been amplified by the pandemic. The work burden to deliver care continues to increase while the joy in work/willingness to stay in the field continue to decrease. This creates a difficult feedback loop – more challenging work environments lead to lower staffing and lower staffing leads to more challenging work environments, and nurses feel undervalued, both professionally and monetarily. In a survey conducted by McKinsey & Company (see Figure 1), a safe work environment, work-life balance, caring and trusting teammates, doing meaningful work, and having a flexible work schedule were the top reasons nurses cited regarding their decision to stay in the profession.[14]

Since 2016, the average hospital turned over about **90 percent** of its workforce and **83 percent** of its RN staff. In 2020, the turnover rate for staff RNs was at **18.7 percent**, a **2.8 percentage point** increase from 2019.[15] Turnover within the nursing labor market may be at an all-time high.

- Veteran nurses are retiring early
- Early career nurses are leaving the roles and the profession after a short time (weeks to 2-years after starting).
- Nurses of all experience levels are transitioning into nursing roles outside of the hospital and/or to new care delivery settings.
- Nurses of all experience levels – and those who have flexibility and are not tied to their local areas (families, mortgages, education, benefits/pension plans through employers, community ties, etc.) – are leaving their roles to travel
- Nurses who are unable to relocate for temporary positions now have more options for flexible, temporary work in one or more organizations where travel is not requires.

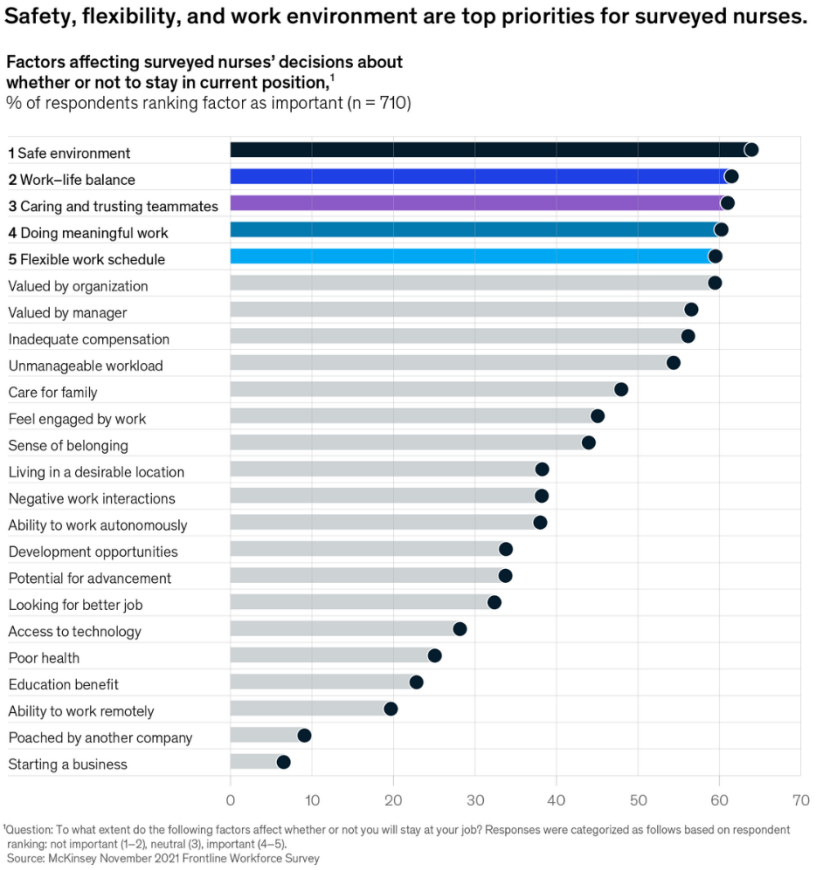

Figure 1 - Top Priorities for Nurses

At the same time, work burden on the health care workforce may also be at an all-time high:

- Imbalanced patient-ratios exacerbated by high patient volumes of patients with COVID, increases in patient acuity and other pandemic-impacts, and staffing shortages. This is a supply *and* demand issue: supply of staff is likely limited compared to pre-pandemic availability and demand is higher than pre covid.

- A growing proportion of task-oriented, non-valued added work (ie. data entry)

Work environments with worsening cultures of safety and other unsafe conditions that impact the physical and psychological safety of the workforce, including disrespect, physical and nonphysical violence from colleagues, patients, and visitors. Lack of trust, perceived lack of value of staff by administration and inequitable compensation between core and temporary staff. The demand for hospital care has always ebbed and flowed in a relatively predictable fashion (ie. flu season; holiday swell: both emergent from fireworks on the 4th of July and chronic for mental and cardiac health during the winter holiday season). One of the key challenges of the pandemic has been the unpredictable ways demand has fluctuated due to the novelty of the disease and the random emergence of variances. When these waves combine with the typical cycle of care demand, the workforce is placed under even more pressure.

This shapes one of the most pressing challenges in health care delivery – having the right mix of the right people to deliver care. Workforce resignations are generally at an all-time high, and are especially challenging in health care, with many leaders referring to health care staffing levels as a "crisis" across the industry and especially for nursing. Those who can realistically get out of health care are leaving at unprecedented rates. And, those who decide to continue nursing and *can* pursue traveling as an option are doing so at unprecedented rates. For those who decide to stay (many likely have no choice given the realities of being a working person with a specialized skillset) and do not have traveling as an option are left with fewer core colleagues and a rotating cadre of traveling and temporary providers who make substantially more money. At the same time, nursing teams are likely working with the largest team vacancy proportion of their careers. Further understanding of the relationship between staffing and turnover would help provide insight into the work environment using a simple set of measures including: % RN vacancy rate, % RN turnover, % traveling RN, and Net Promoter Score amongst nurses. Knowing the payer mix to see the correlation between higher payment ratios compared to turnover rates would provide insights about working environments based on socio-economic differences.

Impact of temporary staffing

While the evidence of actual safety and quality risks related to fluctuating staffing levels and employee type is scant and potentially multifactorial, in the two years since the pandemic has begun, a number of setbacks in safety have been documented.[16] We can only guess at the potential risks and actual harms that come with this sort of mismatch. A discussion of these challenges is included below.

Traveling providers are increasingly relied on to meet the demand for nurses. The need is great enough and the process for confirming contracts between nurses and hospitals is competitive enough, that matching/selection of nurses and hospitals is happening at a rapid pace, with pressure to fill positions and "confirm the contract as soon as possible", however the practices and extent of review of an individual candidate varies. And, the perspective of traveling nurses/their experience of the review process may differ than the ideal process described by agencies themselves. The agencies are primarily incentivized to place as many nurses as possible. Several challenges stand out:

- The vetting process for traveling nurses varies by provider/managed service provider (MSP). Nurses staffed through different agencies – and, likely, even from the same agencies – may have very different reviews/competency checks before starting
- The vetting process for travel nurses also varies, and in some cases is limited to validation of licensing, credentials, and prior work experience. The credential/licensing process is cumbersome and could be standardized.

- The entire matching process is challenging. A health system may work directly with agencies and/or may work with an MSP who then works with 150 or more agencies to identify an RN to fill their need. Health care organizations where staff are placed may or may not interview candidates prior to offering contracts.
- Onboarding when arriving at a new hospital system varies by hospital and varies in terms of effectiveness as preparing a nurse to delivery care.
    - Onboarding generally focuses on standard compliance training, often using videos, and may include shadowing time, which is typically limited.
    - May be limited with respect to foundational safety training. For example, some organizations may include training on safety reporting systems in their onboarding, while others may not.
    - Supplies and technologies are highly variable across facilities and even units, especially given shortages, and the lack of standardization creates additional risks for temporary staff.
- Developing psychological safety within a team, getting up to speed on team culture, being familiar with community/patient norms and important considerations – are all limited by the nature of temporary/travel nursing. Reports of tension between core and temporary staff, especially due to variation in salaries, may heighten risks to team performance, collaboration and communications.
- Real time coaching/training/teaching is limited. Responsibility for travel nurses' quality assurance/control is unclear. It is likely that travel nurses receive less attention than core nurses because staffing needs are especially urgent and time sensitive, and systems may not be as inclined to invest as heavily in a temporary worker who my leave at the end of a 13-week contract. The same may be true for a temporary worker who may have less motivation to fully engage with advancing care, versus providing care. Yet, experienced travel nurses have honed their skills and expertise, and many are more experienced than core staff. There is also the potential for temporary nurses to be hired into organizations if they have a positive experience with the organization.
- Actionable information about the safety and quality of care delivery is limited. While limited pre-pandemic data suggests that patient outcomes may suffer with high proportions of temporary staff, there is a dearth of recent data. Agencies have information about their rejection rate (ie. when a travel nurse or hospital cancels the contract before completion) but the depth of this information is limited. And, there are no robust measurement systems for travelers to evaluate the overall quality and safety of the care delivered by travelers compared to core staff, although many channel their feedback through social media platforms for travel nurses (Highway Hypodermics, Gypsy Nurse). Similarly, there needs to be a better understanding of how the proportion of travelers on a given team affects the safety/quality of care, and whether proportions of temporary staff are associated with measures of safety culture and work environments

Finally, it is possible the health care labor market will never return to pre-pandemic proportions of core and temporary staffing for nursing or other health care disciplines. The pandemic created the conditions where a larger proportion of nurses (who may or may not be representative of nurses) have completely changed their working relationship and their tolerance of the working conditions in health care, and it remains to be seen whether this shift will permanently affect the labor market for nursing.

Opportunities

For IHI

Regardless of the trajectory, traveling providers will be (as they always have been) a permanent fixture of the nursing labor market/nursing care delivery. As such, there are several opportunities for IHI to advance our mission and support the delivery of safe, quality care.

- Engage with nurses to provide capability building in safety, quality, equity, improvement
    - Build relationships directly with agencies/MSPs to offer access to on-demand IHI content (existing, repackaged, or new), and offer differentiated services to support the safety competencies and practices of staff.
    - Create an IHI Safety/Quality/Equity credential that can set apart nurses as well as set about the nurses that agencies contract with
    - Develop resources for nurses who are contemplating travel options that are focused on things to consider and do when making decisions from a safety lens (there's nothing on travel websites about this)
    - We should consider cultural orientation for travelers
- Engage with health systems and agencies to provide evaluation/improvement for travelers and the care they deliver
    - Travelers bring a lot of value-add to care delivery. Travelers were some of earliest vehicles for transferring best practices throughout hospitals (ie. travelers were in Seattle/ PNW for the first outbreak where they learned to treat in real time; then traveled to NYC and Boston for the next wave; each time bringing what worked and iterating in the new environment.
    - Support health systems who are seeking to test and scale new care delivery models and strengthen system resilience given the long-term outlook for staffing realities
    - Identify opportunities to hardwire practices and metrics to ensure that staffing solutions are designed through a lens of patient and workforce safety, quality, and equity, and support the wellbeing and retention of the workforce.
    - How can we harness that knowledge as standard practice?
    - Travelers are also not robustly evaluated in terms of quality care – how can we create meaningful measurement systems to know where we stand in terms of safety/quality/ equity and how we can improve
- Engage with hospitals and agencies to establish industry standard training to by-pass redundant and unusual compliance videos with a standard set of trainings that can be administered by the agency so the hospital can focus on more meaningful on-boarding focused on contextual awareness, relationship building with team, etc.
- Normalizing flexible staffing for core staff (ie. Floaters that can cap "high stress" shifts)
- Reintroduce training within industry (TWI) to help front line nursing supervisors do a better job of onboarding nurses. The job instruction module of TWI focuses on job breakdown analysis (i.e. a standardized package of ward-specific job junctions for nurses) which can be applied to various hospital departments. It would take an upfront commitment to develop this material. we could

work with health systems to develop some standard onboarding orientation for a variety of units (ED, OB, ICU, and med/surg wards).

- Develop on-boarding one-page – create a standard template for one-pager that has a few boxes with relevant information:
    - Technical Information Need to Knows
    - Culture/Context Information Need to Knows
    - Contact list for important issues (ie. when you need common info – who to go to?)
    - Etc.

For health care leaders of organizations, including nurse leaders:

- Evaluate current state:
    - Assess the state of your nursing workforce, including retention and attrition rates, data from exit interviews, compensation, current options for flexible staffing, and measures of nursing workforce safety and well-being
    - Review culture of safety and nurse engagement data, and performance of nurse sensitive quality indicators
- Create a response plan to attract, retain and advance the nursing workforce
- Conduct a comprehensive safety management system that addresses selection, onboarding, use, and support of the temporary nursing workforce
    - Standardize criteria for selection, monitoring and evaluation of staffing agencies and temporary nurses.
    - Consider monitoring systems and surveillance practices when thresholds for percent of temporary nurses increase
    - Policies and procedures to verify competencies of temporary staff
    - Mandate onboarding requirements to ensure that all temporary staff receive training and demonstrate competencies related to:
        - Require foundational safety training for any temporary worker, including a focus on the organization's commitment to and practices associated with a culture of patient and workforce safety
        - Patient and workforce safety reporting systems, and policies related to reporting near misses as well as non-harm and harm events
        - Expectations and practices related to safety huddles and patient rounding and escalation of risks to patient and workforce safety
        - Use and expectations related to electronic health record documentation and medication safety policies and procedures, including clear guidance related to high alert medications and system overrides
        - Resource checklist for temporary staff that include names and contact information for support during each shift

- Stratify data in workforce safety reporting systems to identify temporary workers
- Ensure a minimum number of in-person checkpoints with temporary staff and supervisor to include, at minimum, beginning, middle and end of temporary nurse assignments
- Ensure that all temporary nurses are meaningfully and equitably engaged in all initiatives to support patient and workforce safety, including staff meetings, safety huddles, patient and family centered rounds, staff communications and trainings
- Establish a buddy system with clearly defined roles and responsibilities and assign an buddy to every temporary nurse
- Ensure that patient assignments are equitably determined and aligned with the competencies of core and temporary staff.
- Ensure availability of resource nurses and other experienced staff across all shifts and on weekends.
- Engage patient safety leaders to review procedures for onboarding and support of temporary staff.
- Monitor unit and organization level data on culture of safety and engagement scores, health care-acquired infections, nurse-sensitive indicators, patient and family feedback on an ongoing basis.
- Build relationships directly with agencies/MSPs to offer access to on-demand IHI content (existing, repackaged, or new), and offer differentiated services to support the safety competencies and practices of staff.
- Develop resources for nurses who are contemplating travel options that are focused on things to consider and do when making decisions from a safety lens (there's nothing on travel websites about this)
- Test and scale innovate care delivery and staffing models to optimize use of available staff

For agencies:

- Establish standards for all temporary staff for mandatory training in patient and workforce safety as a requirement prior to first assignment
- Establish and transparently communicate agency- patient and workforce safety metrics
- Establish clear criteria for accepting contracts with organizations that address how patient and workforce safety, including processes, roles and responsibilities related to patient and workforce safety incidents and performance issues, and how temporary staff will be supported, in advance.

For Temporary/travel nurses

- Evaluate selection of agencies through the lens of their commitment and support of patient and workforce safety. Inquire about agency onboarding, training, and how agencies interface with organizations to monitor and address safety issues

- Honestly appraise clinical and technical skills and competencies and opportunities for improvement in your application and interview process with agencies.
- Request interviews with placement site/unit to identify alignment with your competencies as well as who is responsible for your clinical supervision and support prior to accepting any assignments
- Engage in safety huddles, rounds, staff meetings and trainings
- Report patient and workforce safety risks and incidents in alignment with the policies and procedures of the organization and agency
- Seek opportunities to share your clinical and improvement knowledge and expertise while on assignment.

Internal and external challenges for IHI and open questions

1. Does IHI have the strategic interest and capability to tailor or develop standardized trainings for temporary employees? How should IHI navigate the politics of engaging with motivated agencies and health systems in this space?
2. How does IHI navigate the external perception of IHI in relation to nursing: Why is IHI here now? Nursing has not traditionally been "IHI's Space." Can we match our experience with testing, implementing, scaling, and continuously improving solutions with our relationships to key nursing organizations who do not have this competency? While limited familiarity with IHI amongst nurses varies, IHI may have standing with nurse leaders.
3. Where does nursing fits in to IHI's current Safety Strategy direction. Nurses are the primary providers of care to patients in acute care settings and are central to patient and workforce safety.
4. How should this work be prioritized and move to a testing phase?
5. Who should hold responsibility for safety, quality, and equity of care delivery provided by traveling nurse – The health system? Agencies? MSP?)

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[6] Overview of the Temporary Healthcare Staffing Sector, Blue Pencil Strategies

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[8] Impact of COVID-19 on hospital acquired infections, American Journal of Infection Control, March 2022

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[12] Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study, The BMJ Quality & Safety, December 2018.

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