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There Are Not Nearly Enough Nurses To Handle The Surge Of Coronavirus Patients: Here's How To Close the Gap Quickly

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Recent analyses have raised concerns about whether the United States has enough hospital capacity for a surge of patients needing care for COVID-19 infections. But even if we can double or triple the number of intensive care unit (ICU) beds, we don't have enough nurses to staff them. As shown in exhibit 1, 3.3 million of the 4.0 million registered nurses (RNs) in the US are employed in nursing, and nearly 60 percent work in hospitals. About 15 percent of hospital-employed RNs, or nearly 290,000 nurses, work in critical care units—including adult, pediatric, and neonatal care. Doubling the number of ICU beds would outstrip the RN workforce trained in intensive care. How can we mobilize enough nurses to take care of hospitalized COVID-19 patients?

While some RNs working in other units can move into the ICU to help meet the needs of critically ill COVID-19 patients, nurses will continue to be needed in medical-surgical, pediatric, neonatal, and other departments. There are additional challenges. First, RNs may not be concentrated in the places hardest hit by the pandemic. We are seeing surges in some cities—Seattle, Washington, New York City, and San Jose, California, for example—and less urgent demand for COVID-19–related

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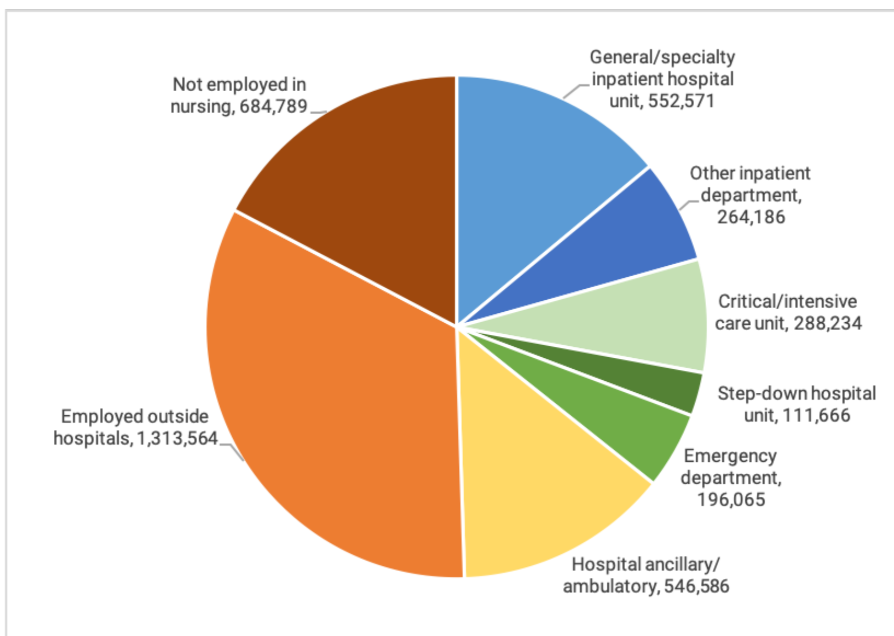
hospital care in other areas. Second, nurses are among the workers most vulnerable to infection because of their physical proximity to patients when providing care. Nurses who become infected will be unable to work. Third, about 15 percent of health care workers have children and no other family member in the household who can provide child care. With widespread closures of schools and child care facilities, nurses who are in this situation will find it difficult to work.

Exhibit 1: Where do registered nurses work?



Source: Author's analysis of the National Sample Survey of Registered Nurses, 2018.

How can we address this challenge? The following are steps we should take now to ramp up nursing capacity during the pandemic.

Incentivize Nurses To Serve In The Most Affected Areas

Financial incentives could help mobilize nurses to serve in areas of the country where they are most needed. Besides following the common practice of offering higher wages during a period of high demand, states and employers could extend student loan repayment programs to nurses who serve in the COVID-19 emergency. Employers should pay travel and housing costs for nurses who relocate to their communities for this purpose.

Reactivate Licenses And Allow Nurses To Practice Across State Lines

Nurse licensing boards can facilitate deployment of RNs to where they are most needed through expedited processing of license applications for nurses from other states. Massachusetts is one of several states promising to review and process licenses from other states within one day during the state of emergency. Washington State is allowing all nurses and other health professionals to work in the state if they are licensed in good standing in another state. States could authorize the rapid reactivation of licenses for nurses who have retired and allowed their licenses to expire. New York has reached out to recently retired nurses to recruit "reserve staff" who can be rapidly recertified to provide patient care. Even nurses who have been out of patient care for years could provide critically needed telephone triage and staff non-ICU units so that nurses in these units can transition to ICU care.

Relax Scope-Of-Practice And Oversight Laws

States should relax scope-of-practice restrictions to

boost the capacity of care teams serving low-acuity patients. Removing some restrictions during the pandemic would enable hospitals to transfer more RNs to critical care. For example, licensed practical/vocational nurses could be authorized to administer a wider range of low-risk medications in hospitals and have broader authority in nursing homes.

State regulations governing physician oversight of nurse practitioners and physician assistants should be relaxed during the emergency as well. For example, in some states there is a limit to the number of physician assistants a physician can supervise. Such restrictions could inhibit workforce expansion efforts in these states. Hospitals will need to work with state regulators to identify the safest and most effective regulatory approaches to improving health care workforce capacity under a state of emergency. These conversations should address the question of how long temporary scope-of-practice expansions should last.

Leverage The Skills Of Nursing Students

Nursing students can be deployed to use the clinical skills they have obtained to date. There are two cohorts of students to consider: those who are scheduled to graduate this spring and those at earlier stages of nursing education. Students who are near graduation already have obtained clinical skills required to care for COVID-19 patients in acute care units but may be blocked from graduating because many schools have found their clinical rotations cancelled due to COVID-19 concerns. Moreover, those who graduate may not be able to take licensing exams because testing sites for the national RN licensing exam were closed and will resume only with limited capacity. To leverage the critically

needed skills of this year's nursing graduates and almost-graduates, states should adopt the approach being used on an emergency basis in Georgia, where nursing students who have completed coursework but are waiting to take licensing exams are eligible for temporary RN licenses during the pandemic. This approach could be expanded so that students completing elective courses in the last semester of their RN programs could be offered interim licenses to provide nursing care before graduation.

Nursing students at earlier stages of their education also can provide important service during the COVID-19 pandemic. Many have already received hospital security clearances and have the skills needed to screen patients and serve as health care navigators to guide patients with mild illness to COVID-19 testing and resources for self-care. They also can support care within hospitals; for example, under emergency orders, Idaho is permitting nursing students who have completed a basic nursing course to work as unlicensed assistive personnel under the state's nurse apprenticeship program. Both near-graduation and early-stage nursing students should receive academic credit for clinical hours commensurate with their roles during the pandemic so that they can continue to advance toward the goal of obtaining permanent RN licensure after the emergency ends.

Provide New Child Care Options

To enable more nurses to participate in the workforce, communities should provide new child care options for nurses and other health professionals, as Quebec, Canada; Chicago, Illinois; and San Francisco, California, have done. In San Francisco, the Recreation and Parks Department is offering free child care for health care

workers. Some child care coverage has been offered by volunteers, such as at the University of Minnesota, where medical students are organizing volunteer babysitting for health care providers.

Take Care Of Health Care Workers' Personal And Emotional Needs

As pressure on the health care system increases, hospitals will need to help staff protect their families. Some cities, including San Francisco and in Malaysia, are working with hotels to provide lodging for health workers who want to avoid exposing their families to the coronavirus. Some restaurants are providing free meals to health care workers, including the San Diego Dining Group, Sweetgreen, UberEats, and restaurants in Chicago, Minnesota, and the Philippines.

State public health agencies and health care organizations also need to attend to the emotional and mental exhaustion health care workers are experiencing in the high-stress COVID-19 environment. The World Health Organization has provided guidance to health care organizations on how to support health care workers' mental health; suggested strategies include providing specified rest times, creating a buddy system, and offering mental health and psychosocial support services. Some hospitals are expanding their employee behavioral health services. Mental health providers in Philadelphia, Pennsylvania, are offering free telehealth counseling to health care workers, and states such as Missouri are creating telephone hotlines for those experiencing distress.

Improve Access To Personal Protective

Equipment

Besides making workforce changes to optimize nursing capacity, states need to take action to ensure that nurses and other clinicians have access to and use protective equipment, which has been in short supply in the early stages of the pandemic. Nearly 20 percent of employed RNs are 60 years and older—these nurses are at greater risk if they are infected with SARS-CoV-2. Asymptomatic RNs can be vectors of transmission if they lack protective equipment. Until a federal law was signed on March 18, industrial-grade N95 face masks could not be used in hospitals. Now, large and small businesses such as manufacturing plants and auto shops can donate masks, and manufacturing is ramping up to meet demand. In the meantime, crafters are sewing basic face masks to donate to health care workers. To meet the burgeoning demand, the federal government should rapidly deploy the Strategic National Stockpile of medical equipment, private companies should continue to donate their supplies, and industry should continue to ramp up production as quickly as possible.

Most of these recommended changes are allowed under existing law. With most states operating under a state of emergency, governors have wide-reaching latitude and many have already issued orders aimed at expanding the health care workforce during the pandemic. Hospitals and other health care organizations will need to rapidly develop processes to onboard nurses and deploy them to meet surging demand. Health care employers, other businesses, and cities also can collaborate to provide food, lodging, and other resources to nurses serving on the front lines.

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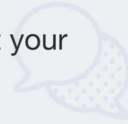

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Paul J. Nelson · 2 days ago

Historically, most fully trained nurses are not licensed. It would be most insightful to know why many nurses discontinue licensure or continue licensure but do not pursue meaningful employment that requires nursing licensure. I am suspicious that its not totally related to their role as family convoy (viz. social relations) leaders. See Antonucci 2019 for a full analysis of the family connected Convoy model.

Antonucci TC, Ajrouch KJ, Webster NJ & Zahodne LB. 2019. Social Relations Across the Life Span: Scientific Advances, Emerging Issues, and Future Challenges. Annu. Rev. Dev. Psychol. 1:313-36

https://doi.org/10.1146/ann...

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craigdawg ➦ Paul J. Nelson • a day ago

Paul, I respectfully ask you a question. I have been a Rn for 40 years
Have you been at the bedside and what are your credentials? Have you held the hand of a dying patient? I helped develop our novel disease unit If you would like to speak with me then I will take you to school. Walk in the shoes of a NURSE

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Pam Haylock • 3 days ago

Then, like now, "We must have nurses: Spanish influenza in America 1918-1919". Published by Rhonda Keen-Payne, in Nursing History Review, 8 (2000): 143-156. There are so many "right on" comparisons between the 1918 Flu

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