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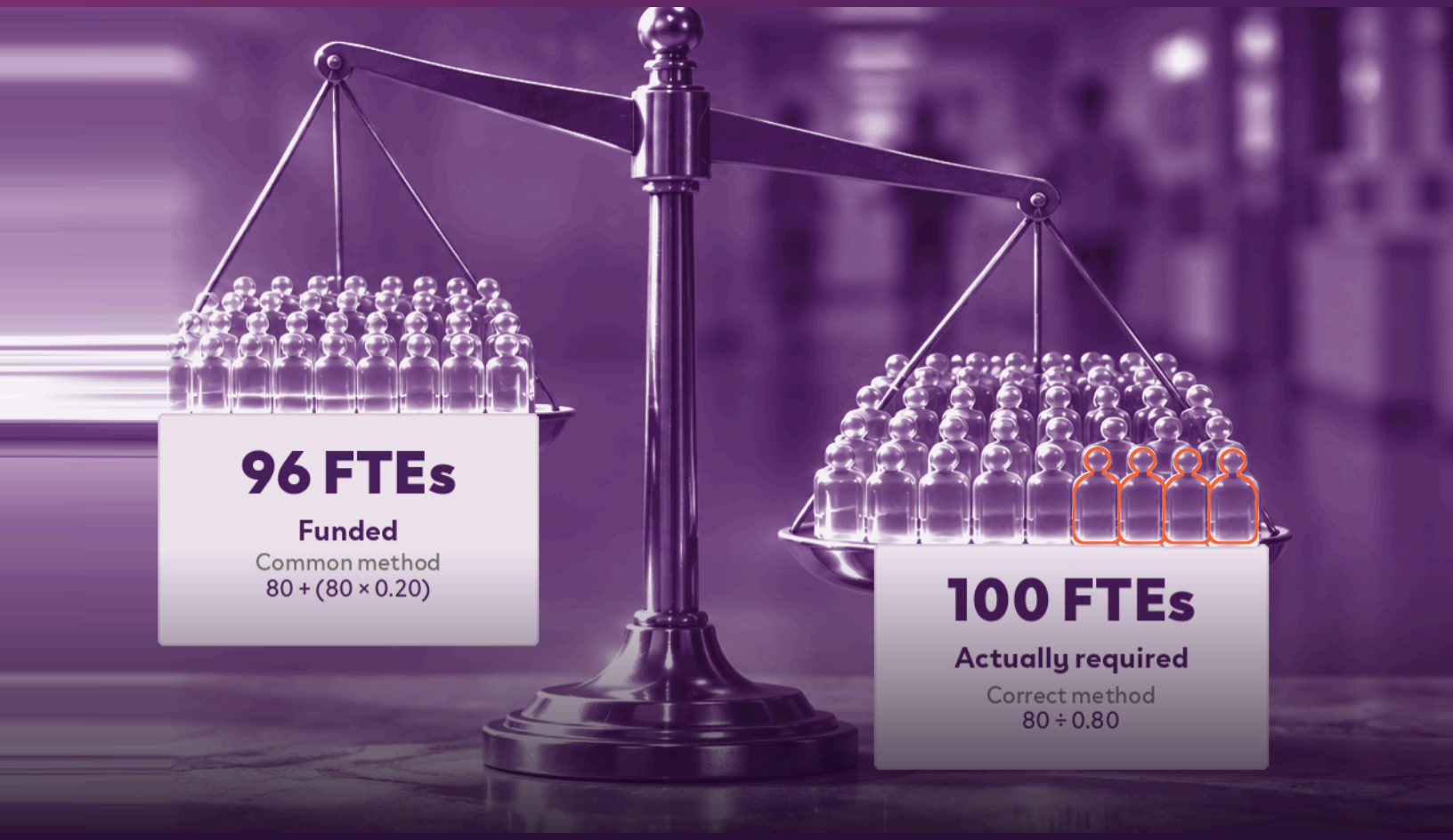
Nexus insights series · Bedside briefs

Why adequately staffed units are not adequately staffed.

Measuring nurse staffing against the evidence of 2026.



Akram Boutros, MD, FACHE
Co-founder and Chief Executive Officer, Nexus
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nexus BEDSIDE

Nursing budgets are short before the fiscal year begins.

Purpose

This brief summarizes six findings published in 2026 that change how nurse staffing is budgeted, measured and defended. It sets out what they ask of chief nursing officers, describes how Nexus Bedside addresses them, and closes with the questions every organization should put to any vendor in this category, including us.

What changed in 2026

The formula widely taught for converting required care hours into funded positions contains an arithmetic error, identified in a Johns Hopkins health finance textbook and traced through six decades of nursing literature. It understates the requirement by two to six percent before any staffing decision is made [1,2]. Budget variance analysis is not built to detect it [1].

There is no standard to check against. Three health systems interviewed in 2026 build the nursing budget on three different foundations and audit it on three different cadences [5]. Every nurse executive interviewed named patient acuity, and the surveillance work it generates, as the input their model cannot capture [5].

Measurement compounds the problem. The nurse-sensitive metrics CMS relies on count infections, falls, pressure injuries and restraints. Nurse scientists writing in *JAMA Internal Medicine* in October 2026 argue that these measures capture nursing only by its absence, which leaves the economic case for nursing permanently defensive [6,7].

On the units that hold most inpatients, the standard metric does not predict harm. A study of 1,269 units across 217 hospitals found that nurses' own shift-level judgment of staffing adequacy predicted falls on medical-surgical and stepdown units while registered nurse hours per patient day did not. In critical care the finding reversed [8,9].

The accreditation bar moved on January 1, 2026. The Joint Commission's National Performance Goal 12 requires hospitals to demonstrate that staffing adequacy is monitored and escalated as it changes. Retrospective justification no longer satisfies it [10].

Meanwhile the work that prevents harm carries no payment mechanism. Registered nurses cannot bill Medicare independently, while a framework advances that would assign billing codes to algorithmic analyses [11,12].

Key finding

Six independent findings converge on one unmeasured function: the continuous monitoring that produces no task, no charge and no budget line.

The formula understates the requirement, and no two systems count the same way.

A structural error in the conversion formula

William J. Ward Jr., associate professor of health finance and management at the Johns Hopkins Bloomberg School of Public Health, states the problem in his 2016 textbook: "Even those skilled in budget calculations often make the mistake of saying, 'Let's add 15% for nonproductive time.' But this approach is clearly incorrect and will always result in a budget that lacks sufficient staff" [2].

The arithmetic is short. A unit needs 80 productive full-time equivalents for direct care. Nonproductive time, covering paid time off, holidays, sick time and required education, runs at 20 percent of total paid time. A method documented across decades of nursing finance textbooks and continuing education multiplies the productive base by the nonproductive rate and adds the result: 80 times 0.20 gives 16 relief positions, a total of 96.

80 ÷ 0.80 = 100 total FTEs, not 96.

The correct method divides the patient care requirement by the patient care percentage.

The four missing positions are the relief staff's own nonproductive time: the additive method funds coverage for bedside nurses and leaves the coverage itself uncovered. That is 160 unfunded coverage hours a week per 100 positions, and a 500-FTE department is short 20 positions before a schedule is built [1,2].

Shortfall produced by the additive method

Nonproductive rate	Shortfall per 100 budgeted FTEs
6%	**0.4**
14%	**2.0**
20%	**4.0**
24%	**5.8**

The shortfall scales with the nonproductive rate, which is why it went undetected. At the 6 percent absence allowance in use when the formula first appeared in print, the gap was four tenths of one position per hundred, inside ordinary scheduling variance. Leave entitlements then grew for six decades. The formula did not change. The shortfall did.

A correction was on record even earlier, in a 1984 footnote to a foundational graduate text [3]. Neither that footnote nor Ward's 2016 warning took hold.

Robert Wingo, a nursing informatics specialist and fellow of the Commission for Nurse Reimbursement, has since documented how far the error travelled: more than thirty sources across sixty-six years, from a 1960 monograph through United Kingdom Department of Health guidance, an International Council of Nurses toolkit and a 2020 graduate textbook. Western Australia wrote it into a mandatory staffing law effective February 2026 [1,4].

It survives peer review because reviewers learned the method the same way the authors did, and it survives financial oversight because variance analysis never asks whether the budgeted count was correctly derived [1]. Appendix A gives the check.

Three systems, three methods.

There is no common methodology for building and auditing a nursing budget against which an organization can check its own. Three chief nursing officers described their methods in 2026 [5].

System	How the budget is built	How it is audited
Children's Hospital of Philadelphia	Hours per patient day, times volume, times average hourly rate, plus a replacement factor for leave and turnover	Monthly against actuals, from a real-time operations center showing patient location, staffing and unit status
VCU Health, Children's Hospital of Richmond	Benchmark data and a system productivity index, set annually with finance and operations	Annually, with a midyear business case process for additional funded positions
BayCare Health System	Quarterly forecasting on discharges, patient days, length of stay and case mix index	Annually, plus revision whenever capacity, volumes or care delivery change

Two practices worth adopting

Children's Hospital of Philadelphia found its own drift. Three intensive care units carrying comparably high-acuity patients had been budgeted at different hours per patient day, with no one having decided to fund them differently. All three were standardized at 20 of 24 hours.

The organization also examines variance in both directions. A unit running above budget logs a documented rationale. A unit running below budget is treated as the more serious finding, because funded care was not delivered [5]. Most variance reports flag only the first case.

What all three models miss

> "I wasn't always doing something physically, but I was always watching. You could turn your head for one second, and something can go wrong really quickly."
>
> Paula Agosto, RN, system chief nursing officer, Children's Hospital of Philadelphia [5]

Karen Webb at VCU Health said models built on historical staffing patterns or average census understate how complex patients have become, and flagged education, precepting and shared governance time as routinely underfunded. Jennifer Ransford at BayCare said staffing need is treated as more predictable than it is, because recruitment, retention, burnout and market competition move the numbers alongside acuity [5].

Key finding

The hardest input to budget is the one that generates no task, no order and no charge.

Current metrics capture nursing only by its absence.

What the nurse-sensitive measures capture

The nurse-sensitive metrics CMS relies on are hospital-acquired infections, falls, pressure injuries and restraint use. Each counts something that went wrong. Three nurse scientists, led by Lori Kennedy of UC Davis Health with Laura Beth Kalvas of Nationwide Children's Hospital and Martha Curley of the University of Pennsylvania School of Nursing, set out the consequence in *JAMA Internal Medicine* in October 2026 [6,7].

> "When nursing value is expressed only as harm incurred, the economic case for nursing investment becomes purely defensive."
>
> Kennedy, Kalvas and Curley, *JAMA Internal Medicine*, October 2026 [6]

A hospital can price a central line infection precisely. It has no way to price a nurse recognizing sepsis before the blood pressure falls and an intensive care transfer becomes necessary. One event enters the finance system. The other did not happen, so it is worth nothing.

HCAHPS is the closest existing proxy for nursing quality and was not designed for the purpose. Surveillance, symptom management and end-of-life care have no dedicated measure [6].

The authors build on the 2024 Blueprint for Change in Acute and Critical Care Nursing and its nine practice domains: safe healing environments, caring relationships, symptom assessment and management, delivery of physical, therapeutic, preventive and end-of-life care, surveillance, patient and family teaching, interprofessional coordination, advocacy, and care transitions.

Four candidate outcome measures are offered for testing: delirium-free days, time to physiologic stability, achievement of patient-defined goals, and a length-of-stay index [6,7]. This is a viewpoint rather than original research. Its value is the diagnosis rather than the measure set, which will take years to validate.

Where the staffing number fails

Penn Nursing's Center for Health Outcomes and Policy Research linked staffing metrics from the 2024 National Database of Nursing Quality Indicators to fall rates across 1,269 adult medical-surgical, stepdown and critical care units in 217 hospitals [8,9].

Unit type	What predicted falls	What did not
Medical-surgical and stepdown	Nurses' own shift-level assessment of staffing adequacy	RN hours per patient day
Critical care	RN hours per patient day	Nurse perception

On a medical-surgical floor, admissions, discharges, acuity swings and rapid responses move through a shift in ways a payroll average cannot represent. In an intensive care unit, where assignments are smaller and more stable, the ratio carries more of the information. The units where the standard metric fails are the units holding most inpatients.

The accreditation standard and the reimbursement asymmetry.

National Performance Goal 12

Effective January 1, 2026, The Joint Commission established nurse staffing as National Performance Goal 12. The standard sets no fixed nurse-to-patient ratios. It requires accredited hospitals to demonstrate that staffing plans are intentional, grounded in patient need and evaluated over time, and that adequacy is actively monitored and escalated when it slips. Static policies and retrospective justification do not satisfy it [10].

Read against the preceding finding

The evidence says the measure that predicts harm on medical-surgical units is shift-level and perceptual. The standard says adequacy must be monitored continuously and escalated as it changes. Most organizations have a monthly productivity report and a quarterly staffing committee.

The reimbursement asymmetry

Registered nurses generally cannot bill Medicare independently, and nursing is folded into the hospital's inpatient payment rather than reimbursed as a service. What changed in 2026 is the contrast. The American Medical Association has proposed a framework for clinically meaningful algorithmic analyses that could create a billing pathway for certain AI-generated analyses [11].

Sarah Gray, senior vice president of nursing impact at the American Nurses Association, set out three points in July 2026 that belong in every vendor conversation [11].

1. **Remote nursing and artificial intelligence are distinct.** In her words, "virtual care is not the same as AI care or AI-supported care." A nurse providing care remotely is practicing nursing. AI may support that work and does not constitute it.
2. **Technology often moves work rather than removing it.** The electronic health record became foundational and required enormous work from nurses as trainers, superusers and workflow designers, none of which created a source of nursing reimbursement. Time spent correcting outputs and documenting rejected recommendations belongs inside any return calculation.
3. **Nurses belong in the room before selection.** Involvement should begin with identifying the clinical problem and continue through design, testing, procurement and optimization. "You can spend the money cleaning up, or you can spend the money on the front end and have the buy-in of nurses."

A survey commissioned by the American Nurses Enterprise found that competitive compensation and investments in safety, well-being, recruitment and retention were strongly associated with higher hospital operating margins. Its methodology was not published alongside the coverage, so treat it as directional [12].

Key finding

The accreditation standard now requires continuous evidence of a condition that existing instruments were never built to measure.

Every finding points to the same unmeasured function.

Taken together, the six findings describe a specific position. The budget is probably short by two to six percent before the year starts, and the variance reports are not built to detect it. No peer benchmark exists, because peer institutions build the number differently. On the units holding most inpatients, the staffing metric does not predict the harm the organization is accountable for. The accreditor now requires continuous demonstration of something existing instruments were not designed to measure. And the clinical work that prevents the harm generates no revenue.

The connecting element is the continuous observation and interpretation that lets a nurse notice change before it becomes an event. The research literature calls this surveillance, and lists it as the fifth of the nine practice domains with no dedicated measure. Nexus calls it monitoring, and this brief uses each term in its place. It is what a medical-surgical nurse is implicitly assessing when asked whether staffing was adequate, and what hours per patient day fails to capture.

It is also the first function to degrade when an assignment grows, and its degradation is invisible until a patient falls or decompensates. A nurse assigned six patients is not watching six patients. She is watching one at a time, in rotation, with gaps. The gaps are where harm occurs. No budget line, metric or billing code represents them.

Key finding

Monitoring is a continuous function assigned to clinicians whose attention is necessarily intermittent.

Correcting the formula does not fill the positions.

The first response to a shortfall of four positions per hundred should be to correct the budget. Appendix A does that, it costs nothing, and it should be done whatever else an organization decides. The reasonable next question is why that is not the end of the matter, and the honest answer has three parts.

Funded is not filled

The national registered nurse vacancy rate ran 8.6 percent in 2025, with the average hospital carrying 43 unfilled positions against its budgeted count and more than one hospital in three above 10 percent [15]. Adding four funded positions to a unit that cannot fill the ones it already has moves the gap from the budget to the schedule. It does not close it.

Turnover resets the clock

Registered nurse turnover ran 17.6 percent for the year. Each departure left the position empty for an average of 78 days, and more than one in five newly hired nurses left within the first year [15]. A correctly funded unit at that turnover is still short for much of the year, and each orientation diverts a preceptor from the assignment while it lasts.

More intermittent attention is not continuous observation

This is the structural point, and it is the one that matters most. Monitoring degrades because attention is divided, not only because headcount is low. A sixth nurse added to a unit still divides attention across an assignment. More staff narrows the gaps in observation and does not close them, because closing them is a question of how attention is organized rather than how many people hold it. Short of one-to-one assignment, which no medical-surgical unit can fund, more intermittent observers do not produce continuous unit-wide monitoring.

On simply asking the nurses

The Penn finding invites a cheaper conclusion: if nurses' judgment predicts falls better than the metric, ask the nurses. That is correct and it should be done, because it costs nothing and the 2026 accreditation standard rewards it. Detecting inadequate staffing and resolving it are different problems. A shift-level adequacy question tells an organization that Tuesday was unsafe. It does not say so at two o'clock on Tuesday, when something can still be changed, and it does not supply the capacity to respond. National Performance Goal 12 asks for monitoring and escalation, which is a real-time loop rather than a retrospective survey.

Where hiring is the better answer

If a unit is staffed below a safe assignment, hire. If the gap is work that requires hands rather than eyes, hire. If leadership is not prepared to redesign roles and standard work, hire, because this model underperforms when treated as a substitute for adequate staffing rather than a change to how the work is organized.

Key finding

Correct the budget first. It costs nothing and no vendor is required. The remaining problem is that funded positions go unfilled and that divided attention does not aggregate into continuous observation.

The Clinical Care Transformation Engine.

Nexus Bedside is an operating system for the inpatient unit. It installs a permanent coordination layer that keeps patient awareness continuous, aligns the care team to the work across more than 200 workflows configured to the unit, and reports against contractually defined outcomes. It functions as a care transformation engine rather than a technology overlay, which is why it addresses a budgeting and measurement problem rather than a tooling problem.

On headcount, plainly

The model does not reduce budgeted nursing positions. It redistributes the work inside them. The return appears as premium labor that is no longer needed, vacancies that close because nurses stay, and bedside hours returned to direct care. It does not appear as a lower funded FTE count, and any organization that adopts it in order to cut established positions should expect the clinical results described in section 08 not to follow.

The Co-Caring Model

The Co-Caring Model differentiates bedside and remote nursing responsibilities. The **Bedside Hybrid Nurse** retains direct patient care with a redesigned assignment, so that time in the room is spent on work requiring physical presence.

The **Virtual Hybrid Nurse** is a registered nurse co-caring for the same patients remotely, handling admissions and discharges, patient and family education, documentation and second-nurse medication verification, while maintaining the continuous visual awareness a bedside assignment cannot sustain.

Both nurses are employees of the health system. Nexus does not supply clinical staffing, so the model introduces no parallel chain of clinical accountability and is not a labor outsourcing arrangement. A third role, the **Clinical Success Partner**, is a Nexus employee embedded on the unit before and after go-live, responsible for workflow design, training and adoption until the model is permanent.

NOOR, the AI layer, operates within the model rather than as the product itself. It communicates with patients and staff, surfaces early clinical risk, and supports task routing and workflow prioritization. It does not offer clinical advice, and that boundary is enforced in the product rather than asserted in policy.

Crystal Ball maintains real-time awareness of the room, including detection of agitation and escalating behavior, with a function that brings the Virtual Hybrid Nurse into the room immediately. For workplace violence, that function often separates an incident from a near miss. On the distinction Sarah Gray drew for the American Nurses Association, a licensed nurse is practicing nursing here, supported by AI [11].

> "The technology capabilities enhance the overall operations of the department, allowing the bedside team to focus more on advanced clinical tasks and create meaningful connections with patients."
>
> Chief nurse executive at the reference site, quoted by KLAS Research [13]

What the model looks like on a shift.

The assignment does not grow. The work inside it changes.

Point in the shift	Bedside Hybrid Nurse	Virtual Hybrid Nurse
Handoff	Receives report, lays eyes on every patient, sets priorities for the shift	Joins the same handoff having already reviewed overnight events, and pulls the chart work forward
Admission	Physical assessment, lines and equipment, settling the patient and family	History, medication reconciliation, consents and admission documentation, without the bedside nurse leaving the room
Through the shift	Direct care, procedures, response to change	Continuous awareness across the rooms, flags deterioration and movement, triages call bells that do not require hands
High-risk administration	Administers at the bedside	Provides the second verification without pulling a second nurse off the floor
Behavioral escalation	Responds with the team, with warning	Alerted to agitation by the vision layer, enters the room by video before it escalates
Discharge	Physical discharge and final assessment	Teaching, teach-back, instructions and paperwork

What this is designed to change

Two things move. The first is where the bedside nurse's hours go: documentation, verification and education shift to a colleague who is not carrying a physical assignment, which returns time to direct care without adding a position.

The second is that monitoring becomes continuous rather than intermittent, with the vision layer holding awareness across the unit and a licensed nurse interpreting what it surfaces and responding. That is the function section 04 identifies as unmeasured and section 05 argues cannot be produced by adding staff, because it is a property of how attention is organized rather than of how many people hold it.

Key finding

The bedside assignment stays the same size. What leaves it is the work that never required physical presence.

How the model addresses each finding.

Finding	How the model responds
The budget is structurally short	No vendor can correct an organization's formula, and Appendix A does so at no cost. What the model changes is what each funded position is able to cover, by removing work from the bedside assignment rather than asking a short unit to absorb more.
No two systems count the same way	The unit is instrumented before go-live, so the baseline is measured rather than benchmarked against a peer group that counts differently.
Metrics capture nursing only by its absence	Continuous monitoring produces a record of what was watched and what was caught, not only of what went wrong. That is the raw material any measure of this function requires. Nexus does not claim to have solved the measurement problem; it generates the data a solution depends on.
The staffing number fails on medical-surgical units	Deployments concentrate in acute medical-surgical and stepdown environments, which is where hours per patient day was found not to predict falls [8].
Accreditation requires continuous demonstration	The platform generates a continuous, unit-level, timestamped record of coverage and escalation. Whether that record satisfies a surveyor is a question for the organization's accreditation team against the standard's own text.
Nursing work is financially invisible	Contracting is tied to outcomes rather than licenses, which converts unit performance into a financial instrument inside the agreement. It does not create a billing code.

What the model has demonstrated, and what it has not.

KLAS Research published an Emerging Insights Case Study on Nexus Bedside in April 2026, based on interviews with five individuals at one academic medical center running a six-month pilot [13]. KLAS notes that these reports reflect initial feedback from early adopters. It is one site and not a controlled study.

The result that matters most to nursing leadership

Against a national picture of 17.6 percent registered nurse turnover, 78 days to fill a vacancy and more than one in five new hires leaving inside a year [15], the reference site reported a **67 percent reduction in nursing turnover within the unit** and a 20 percent reduction in its vacancy rate over the pilot [13]. A unit that holds its staff does not spend the year absorbing a structural shortfall through premium labor and suppressed education time. The unit was a 32-bed step-down and medical-surgical neurosciences unit carrying a case mix index above 2.5, over six months.

67%
Reduction in nursing turnover within the unit

20%
Reduction in the vacancy rate

Zero
Falls with injury during the pilot; 27% reduction in total falls

100%
Reduction in medication errors requiring a nurse dual sign-off

26%
Reduction in length of stay

8%
Increase in unit occupancy

16%
Increase in patient-reported satisfaction after care

> "We can see where virtual nursing, and ultimately virtual nursing with AI, can augment nurses' ability to spend more time with patients."
>
> Chief nursing executive at the reference site, quoted by KLAS Research [13]

What changed for the bedside nurse.

The KLAS findings describe outcomes. The figures below describe the mechanism, which is where the bedside nurse's hours went. These are Nexus operating data from inpatient deployments rather than KLAS findings, and are reported without attribution to a named site.

+46%
Direct care minutes per patient day

+102%
Direct bedside care per nurse shift

−68%
Bedside nurse time in the EMR

−29%
Contingent RN hours

+120%
Discharges completed within two hours

+66%
Medication communication

15
Virtual Hybrid Nurse interactions per patient per day, on average

99.9%
Patients opting in to the model

+34%
Nurse engagement scores

The first three figures answer the argument in section 05 directly. Direct care minutes per patient day rose 46 percent and direct bedside care per nurse shift doubled, without adding a budgeted position, because documentation and verification moved to a colleague not carrying a physical assignment. Time in the electronic record fell by roughly two thirds.

The contingent hours figure is where the economic benefit appears. A 29 percent reduction in agency and premium labor is the form the return takes when headcount holds and vacancies close, which is the mechanism described in section 06.

The interaction figure shows how continuous monitoring translates into direct contact. A patient on one of these units is seen by the Virtual Hybrid Nurse an average of 15 times a day, on top of bedside care. That is not a camera in a corner. It is a licensed nurse present at a frequency no bedside assignment could sustain.

The opt-in rate speaks to the question nursing leadership raises first. Patients are asked, and 99.9 percent agree to the model. The consent process itself is set out in section 09.

Key finding

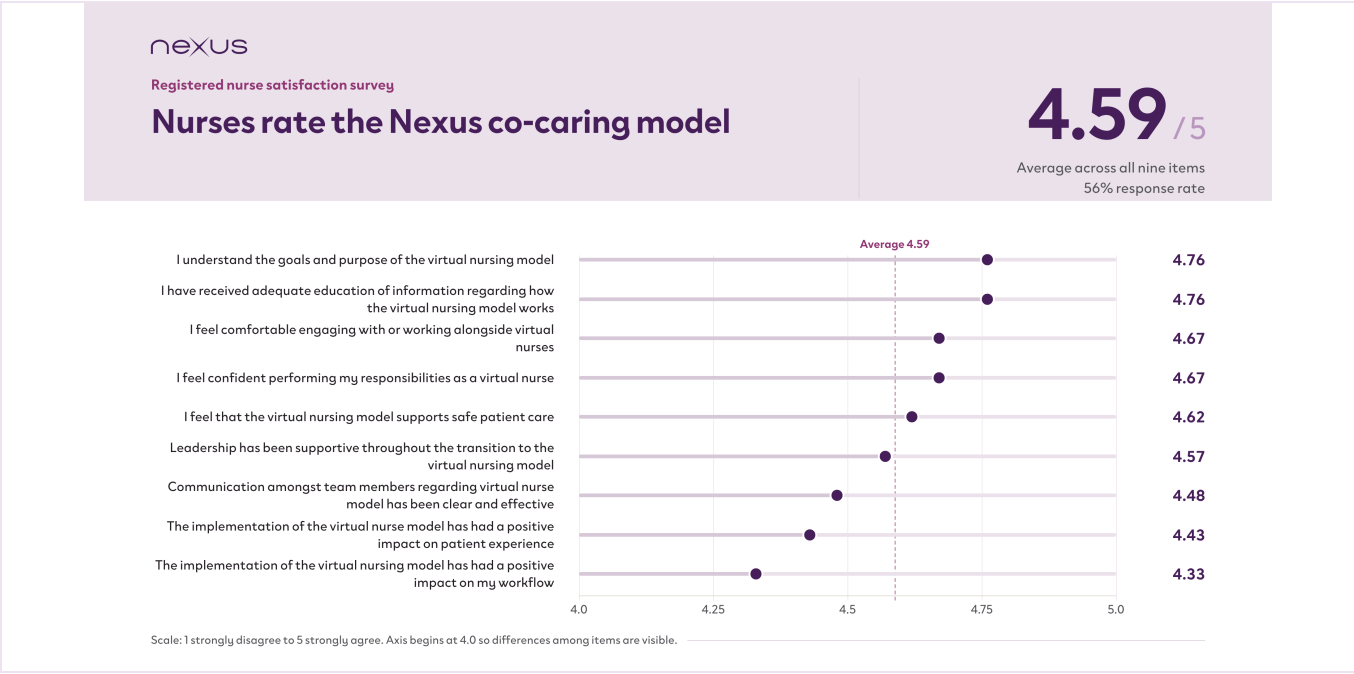
Direct care minutes per patient day rose 46 percent with no increase in budgeted positions. The time came out of documentation, not out of the staffing plan.

What cannot yet be demonstrated

1. Nexus Bedside has three customers, all academic health systems. There is no community hospital evidence.
2. No validated measure of surveillance exists. The framework that would make this provable is a 2026 proposal, not a standard [6].

What the nurses report.

The more useful evidence for a chief nursing officer is what happened to the nurses who worked the new model, because that is where the American Nurses Association's warning about shifted burden either proves out or does not. The most recent registered nurse satisfaction survey covered nine items on a five-point agreement scale, with a 56 percent response rate, and averaged 4.59 [14].



Registered nurse satisfaction survey, nine items, five-point agreement scale, 56 percent response rate [14]. Survey instrument wording is reproduced as originally fielded.

Nurses rated their understanding of the model's purpose and the adequacy of their education highest, both at 4.76. Comfort working alongside remote colleagues and confidence in the remote role scored 4.67, and support for safe patient care 4.62.

The lowest-scoring item, at 4.33, was whether the model had a positive impact on the respondent's own workflow. The second-lowest score, at 4.43, concerned the model's impact on patient experience. Those scores are reported because they are the honest test of the ANA's warning, and because the workflow impact score is meaningfully lower than every other item. It remains a positive score, and it is the clearest available signal of where the model still costs the bedside nurse something.

> "Our nurses are the heart of patient care. This model gives them the tools and support they need to provide the best possible care while taking care of themselves."
>
> Stefanie Beavers, DNP, RN, NEA-BC, chief nurse executive

> "My favorite aspect of working with Nexus Bedside is the level of respect they have for what the frontline nurses and care teams experience, and how the vendor helps drive the technology and the innovation."
>
> Director of nursing at the reference site, quoted by KLAS Research [13]

Privacy, licensure, integration and shared governance.

Four questions come up before clinical results in every nursing leadership conversation. They are answered here rather than left to a later call.

Patient privacy and consent

Patients consent to the model on admission, as part of the admission consent process, and may opt out at any point. Across inpatient deployments 99.9 percent accept. Room hardware is disclosed rather than concealed: depending on the room, a camera bar beneath the television, a wall-mounted unit or a pan-tilt-zoom camera, each visible and each identified to the patient.

The platform operates under HIPAA with business associate agreements in place. Data is encrypted with AES-256 at rest and in transit, the security program is aligned to NIST and ISO 27001, and Nexus holds a SOC 2 Type II attestation covering the platform [13]. Retention periods, and the access and audit rules governing who may view a feed, are specified by the organization rather than by Nexus, and are set during future-state design.

Licensure and clinical accountability

Both the bedside and the remote nurse are employees of the health system, licensed and credentialed through its existing processes and accountable within its existing nursing structure. Nexus supplies no clinical staffing and holds no clinical accountability for care decisions. Delegation boundaries and, where remote coverage crosses state lines, licensure arrangements are agreed with nursing leadership during future-state design rather than assumed.

EHR integration

Nexus holds one of only four Epic-native consultant access agreements worldwide. In practice that means the orchestration runs inside the Epic workflow rather than bolted alongside it: Nexus reads from the record and writes back to it. Device readings, documentation and task completions land in Epic as the system of record, allowing clinicians to remain in one environment. The most immediate consequence for nursing is that dual documentation disappears, which is where a large share of the reduction in nurse time in the electronic record comes from.

The platform remains EHR-agnostic and also integrates with Oracle Health through HL7 and FHIR. Organizations evaluating this should know that in the April 2026 KLAS study, deeper Epic integration was the improvement the interviewed customer most wanted to see [13]. The access agreement is what answers it, and it also shortens go-live by roughly two months.

Shared governance and Magnet

The model redesigns nursing roles and standard work, which has implications for shared governance structures and for the documentation a Magnet appraiser reviews. KLAS records that organizations succeeding with the model committed nursing and clinical leadership to redesigned roles, standard work and governance from the outset rather than treating governance as a downstream task [13]. Governance design belongs in the future-state phase, with nursing leading it.

What an engagement involves.

How Nexus contracts

Nexus Bedside contracts on a hybrid model. A fixed daily per-bed fee covers platform deployment, embedded operations and 24/7 support. A performance component is tied to outcome thresholds established with the organization before go-live, covering patient safety, workforce stability, throughput and financial performance. Underneath it sits the Contribution Guarantee: a contractually defined floor on the net contribution the engagement produces, recalculated on a fixed cycle through the term and reconciled by a joint finance committee.

Why the structure is built this way

The American Nurses Association cautions that technology often shifts work onto nurses rather than removing it, and that the time spent absorbing it belongs inside any return calculation [11]. The conclusion Nexus draws is that the response is not a better projection model. It is to place vendor revenue behind the outcome, so that the organization is not asked to believe a forecast.

Implementation

A first deployment runs roughly 90 to 120 days across six phases: executive alignment, observe and diagnose, future-state design, build and prepare, go-live and stabilization, and performance validation before any scale decision. The constraint is organizational rather than technical, and four conditions sit outside what Nexus can supply.

1. Executive accountability for unit-level performance, held jointly across the chief executive, operating, nursing and financial officers. Where this has been absent, the model has underperformed.
2. Nursing and clinical leadership committed to redesigned roles, standard work and governance, rather than to incremental optimization of the current model.
3. Initial deployment units with engaged local leadership. The charge nurse and unit director matter more to the outcome than the technology.
4. Cross-functional readiness across clinical, information technology and operations for a 90-day architecture.

> "Pick the right unit, get the right nursing leader, and get the right medical director who are going to be open to change. Make those people be the cheerleaders behind the innovation."
>
> Chief nursing executive at the reference site, quoted by KLAS Research [13]

Twelve questions for any vendor in this category, including us.

The category is crowded and the claims are difficult to compare. These questions apply to every vendor evaluated, and Nexus Bedside expects to answer them.

On the model

1. Is the remote clinician a licensed nurse practicing nursing, or software performing tasks? Ask for the distinction in writing. The line the American Nurses Association draws is the right test [11].
2. Does the model reduce budgeted nursing positions? Get the answer in writing before it reaches the nursing staff or the bargaining unit, because they will ask it first.
3. What is the consent, recording, retention and access policy for anything placed in a patient room, and will the vendor put it in the contract?

On evidence

1. How many sites, how many patients, over what period, and who collected the data? Establish whether results come from the vendor's measurement or from the client's own finance office.
2. What are the lowest scores in the vendor's nurse satisfaction data? A vendor presenting only averages is concealing the item that matters.
3. Which deployment went badly, and why? Every vendor has one.

On economics

1. Does the return calculation include the work the technology creates: training, consent, output monitoring, overrides, and documentation of rejected recommendations? If not, the model is incomplete [11].
2. What happens financially if the outcomes do not materialize? Distinguish a commitment from a projection, and read how the figure is calculated and how disputes are resolved.
3. Is the pricing a license fee indifferent to results, or is a meaningful portion contingent on them?

On internal readiness

1. Run the audit in Appendix A on your own budget first. The baseline should be known to be correct before anything is measured against it.
2. Ask your accreditation team what evidence they intend to present for National Performance Goal 12, and whether a vendor's record would contribute to it [10].
3. Ask bedside nurses on one medical-surgical unit whether staffing was adequate on their last three shifts, and compare their answers with the staffing report. The 2026 evidence suggests the nurses will be closer to the truth [8].

The audit takes thirty seconds per unit.

This check requires no software and no vendor.

Step 1 Find the unit's total budgeted full-time equivalents and its productive percentage. The productive percentage is 100 percent minus the nonproductive rate. At an 18 percent nonproductive rate, the productive percentage is 0.82.

Step 2 Multiply total budgeted FTEs by the productive percentage.

Step 3 Compare the result with the productive FTE requirement the budget was built from, meaning the direct care hours the staffing plan calls for.

If the two match, the budget funds the care it claims to fund. If the result is lower, the gap represents direct care the unit was never funded to deliver. To correct the budget, divide the required productive FTEs by the productive percentage rather than adding a percentage allowance.

Total FTEs = patient care FTEs ÷ patient care percentage

Worked example at an 18 percent nonproductive rate

A unit requires 64 productive FTEs for direct care.

Method	Calculation	Result
Additive method	64 × 0.18 = 11.5 relief FTEs	**75.5 total**
Check	75.5 × 0.82 = 61.9 productive, against a requirement of 64	**Short 2.1**
Correct method	64 ÷ 0.82	**78.0 total**
Check	78.0 × 0.82 = 64.0	**Whole**

The difference is 2.5 positions on a single unit, or roughly 100 hours of coverage per week that nobody planned for. The result is a budgeting finding rather than an indictment of a finance partner, who almost certainly learned the method from the same sources everyone else did. If a gap appears, it has existed for years and has been absorbed somewhere: in premium labor, deferred education, paid time off staff could not take, or shifts that ran short. Finding out which is the useful next step.

Key finding

A budget that passes this check funds the care it claims to fund. One that fails it was short before the fiscal year began.

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Start with your own numbers.

Appendix A costs nothing and takes thirty seconds a unit. Whatever an organization decides about any vendor, the baseline should be known to be correct first. If it would be useful to work through what the Co-Caring Model looks like on one of your units, Nexus will do that on a single unit before any commitment is discussed.

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