

Review Article

Team nursing as a strategic response to the global nursing workforce shortage: challenges, opportunities and future directions

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ABSTRACT

The global nursing workforce shortage threatens patient safety, healthcare quality, workforce sustainability, and progress toward universal health coverage. Although expansion of nursing education and recruitment remains essential, increasing workforce numbers alone cannot provide an immediate solution to persistent shortages, maldistribution, burnout, turnover, skill-mix imbalances, and increasing clinical complexity. Team nursing, a collaborative care-delivery model in which nursing personnel with complementary competencies provide coordinated care under registered nurse leadership, has re-emerged as a potentially valuable workforce strategy. This narrative review examines the contemporary relevance of team nursing, its potential contribution to workforce optimization, associated implementation challenges, and future directions. Current evidence suggests that appropriately designed team nursing may improve workload distribution, optimize skill utilization, support novice nurses, strengthen collaboration, and increase organizational flexibility. However, poorly implemented models may contribute to fragmented care, communication failures, role ambiguity, inappropriate delegation, and excessive supervisory burden. Team nursing should therefore not be interpreted as a substitute for adequate staffing or as a mechanism for replacing registered nurses with less-qualified personnel. Its effectiveness depends on acuity-informed staffing, competency-based delegation, clear accountability, stable team composition, supportive leadership, and structured communication. Future models should integrate real-time workload assessment, digital coordination, competency mapping, and continuous outcome monitoring while preserving registered nurse accountability. Team nursing may serve as a pragmatic component of broader workforce reform, but its success depends on context-sensitive implementation, protection of professional nursing expertise, and rigorous evaluation.

Keywords: Nursing workforce, Nursing shortage, Team nursing, Skill mix, Workforce planning, Patient care

INTRODUCTION

Nurses constitute the largest professional group within the health workforce and are central to the delivery of safe, continuous, coordinated, and person-centred care. Despite sustained expansion of the global nursing workforce, shortages remain a major threat to health-system resilience. The global nursing workforce increased from approximately 27.9 million in 2018 to 29.8 million in 2023; however, the estimated shortage remained approximately 5.8 million nurses in 2023 and is projected to remain substantial through 2030.¹ These aggregate figures conceal profound inequalities in workforce availability between and within countries.^{1,2}

The nursing workforce crisis is not simply a numerical deficit. Geographic maldistribution, international migration, workforce ageing, inadequate educational capacity, poor working environments, burnout, turnover, absenteeism, skill shortages, and unequal deployment all contribute to the problem.^{2,3} Simultaneously, population ageing, multimorbidity, chronic disease, technological complexity, emerging infections, humanitarian emergencies, and increasing patient expectations are expanding both the volume and complexity of nursing work. Consequently, many health systems face a dual challenge: an inadequate supply of nursing personnel and an increasing demand for highly complex nursing care.

The causes of workforce shortage are interconnected and operate at individual, organizational, educational, and policy levels. A systematic review identified high workload, inadequate staffing, poor working conditions, limited professional development, and organizational factors among the major contributors to nursing workforce shortages.⁴ These pressures are particularly important because workforce instability can become self-perpetuating: shortages increase workload, workload contributes to burnout and intention to leave, and attrition further intensifies shortages.

Inadequate registered nurse staffing has consistently been associated with poorer patient outcomes. Longitudinal evidence indicates that lower registered nurse staffing is associated with increased risks of adverse outcomes, while inadequate staffing contributes to missed nursing care.^{5,6} Missed or rationed nursing care represents an important pathway through which workforce constraints may affect safety, quality, and patient experience.^{7,8}

Burnout further compounds workforce instability. Systematic evidence has associated nurse burnout with poorer patient safety, reduced quality of care, lower patient satisfaction, and adverse organizational outcomes.^{9,10} The workforce shortage may therefore create a reinforcing cycle in which inadequate staffing increases workload and burnout, subsequently contributing to turnover and further workforce instability.

Conventional responses have focused primarily on expanding nursing education, increasing recruitment, improving retention, and strengthening national and international workforce planning. These interventions are indispensable but often require substantial investment and long implementation periods. Health services simultaneously require operational strategies that can improve the deployment of existing personnel without compromising patient safety or professional standards.

One such strategy is team nursing. In this model, nursing personnel with complementary competencies provide coordinated care to a defined group of patients under registered nurse leadership. Rather than requiring one nurse to independently perform every aspect of care for several patients, responsibilities are distributed according to patient needs, professional scope, verified competence, and clinical complexity.¹¹

Team nursing is not a new concept. However, renewed workforce shortages, heterogeneous skill mixes, rapid onboarding of novice personnel, increased use of support workers, and the need for flexible staffing during periods of high demand have restored interest in the model. Contemporary team nursing should not be regarded as a return to simple task allocation. Its potential value lies in combining professional accountability with competency-based delegation, shared situational awareness, structured communication, and adaptive workload distribution.

The model nevertheless remains controversial. Supporters argue that it can improve collaboration, workload distribution, mentoring, and skill utilization. Critics caution that poorly designed team nursing may fragment care, weaken continuity, increase communication failures, create role ambiguity, and become a mechanism for substituting registered nurses with less-qualified workers.¹¹ These competing perspectives indicate that team nursing should be examined as a complex organizational intervention rather than a simple staffing technique.

This narrative review examines team nursing as a potential strategic response to the global nursing workforce shortage. It explores the contemporary workforce context, conceptual foundations of team nursing, mechanisms through which the model may support workforce optimization, potential benefits for patients and nurses, implementation risks, requirements for safe adoption, opportunities for digital transformation, and priorities for future research and policy.

METHODS

A narrative review approach was used to synthesize contemporary and foundational evidence concerning team nursing, nursing workforce shortages, skill mix, models of nursing care delivery, delegation, workforce sustainability, missed nursing care, burnout, patient safety, and digitally supported workforce management.

Relevant literature was identified through searches of PubMed/MEDLINE, Scopus, CINAHL, and Google Scholar. Authoritative reports and policy documents from international health and nursing organizations were also considered. Search concepts included combinations of “team nursing,” “nursing workforce shortage,” “nurse staffing,” “skill mix,” “nursing care delivery model,” “delegation,” “nurse retention,” “burnout,” “missed nursing care,” “workforce sustainability,” “digital nursing,” “artificial intelligence,” and “patient outcomes.”

Priority was given to peer-reviewed systematic reviews, integrative reviews, observational studies, implementation studies, and recent authoritative workforce reports. Earlier literature was retained when necessary to explain the conceptual development of team nursing, workload, and skill-mix models. Reference lists of relevant publications were examined to identify additional literature.

Because the objective was interpretive synthesis rather than estimation of a pooled intervention effect, formal meta-analysis was not undertaken. The literature was synthesized thematically across the contemporary workforce crisis, conceptual foundations of team nursing, workforce optimization, patient and staff outcomes, implementation challenges, digital transformation, implications for resource-constrained settings, and future research priorities.

As this review used publicly available literature and did not involve human participants or identifiable personal data, ethical approval was not required.

THE GLOBAL NURSING WORKFORCE SHORTAGE: BEYOND A NUMERICAL DEFICIT

The nursing shortage is frequently described as a numerical gap between the number of nurses available and the number required. Although useful for workforce planning, this definition does not fully represent the complexity of the crisis. Health systems may simultaneously experience inadequate staffing, unequal geographic distribution, turnover, vacancies, absenteeism, insufficient specialist competence, and poor retention of early-career nurses.¹⁻⁴

The latest global workforce assessment demonstrates both progress and persistent inequality. Although the global nursing workforce has expanded, shortages remain concentrated in countries with lower nurse densities and fewer resources for education and employment.¹ This uneven distribution means that national workforce totals may conceal severe shortages in rural, remote, conflict-affected, and underserved communities.

The crisis is further intensified by increasing care complexity. Ageing populations require greater support for multimorbidity, frailty, rehabilitation, long-term care, and palliative care. The increasing burden of non-communicable diseases requires sustained monitoring,

education, and self-management support. Emergency preparedness, infectious disease outbreaks, disasters, and climate-related health threats create additional workforce pressures.^{2,3}

Poor staffing has direct implications for the completion of nursing care. Evidence indicates that inadequate staffing is associated with missed care, while missed care is associated with adverse events and lower perceived quality.^{6,7} Rationing or omission of necessary nursing care has also been associated with falls, medication errors, pressure injuries, infections, and readmissions.⁸ These findings demonstrate that workforce strategies must be evaluated according to patient outcomes rather than efficiency alone.

A sustainable response therefore requires action at several levels. Governments must expand education and employment capacity; health systems must improve retention and working conditions; and healthcare organizations must improve the way available nursing competencies are deployed. Team nursing is primarily relevant to this third dimension. It cannot create personnel who do not exist, but it may influence how existing knowledge, skills, and time are organized.

EVOLUTION AND CONTEMPORARY RELEVANCE OF TEAM NURSING

Team nursing emerged during the mid-twentieth century in response to shortages of professional nurses and the need to coordinate workers with different levels of preparation. In its classical form, a registered nurse served as team leader and coordinated the activities of nursing personnel caring for a defined group of patients.

The subsequent development of primary nursing reflected concerns regarding fragmentation and the importance of continuity and individual professional accountability. Nevertheless, team-based models remained common in environments where patient needs exceeded the capacity of individual assignment models or where the workforce included personnel with diverse competencies.

Contemporary team nursing differs conceptually from simple task allocation. The central purpose is not to divide patients into a collection of procedures. Rather, the model should organize complementary competencies around the needs of a defined patient group while maintaining clear registered nurse accountability for assessment, planning, coordination, escalation, and evaluation.

An integrative review of team nursing and delegation found both positive and negative outcomes for patients, nurses, and organizations and highlighted the importance of delegation education.¹¹ This mixed evidence is important because it suggests that the outcomes of team nursing are highly dependent on implementation. The label “team nursing” alone does not indicate whether a model is safe or effective.

The contemporary workforce is increasingly heterogeneous. Clinical teams may include registered nurses, specialist nurses, advanced practice nurses, newly qualified nurses, nursing assistants, technicians, students, and other support personnel. Workforce effectiveness therefore depends not only on staff numbers but also on the configuration and interaction of available competencies.¹²

The coronavirus disease 2019 pandemic demonstrated both the potential value and risks of team-based surge models. Critical care services used tiered or team-based approaches to integrate nurses with different levels of critical care experience. One critical care surge model organized critical care and non-critical care nurses according to competency tiers.¹³ Qualitative evidence from intensive care settings also demonstrated that alternative staffing models required careful attention to role clarity, supervision, communication, and the burden placed on experienced nurses.¹⁴

These experiences reinforced an important principle: team nursing may increase operational flexibility, but flexibility is safe only when professional accountability, competence, and supervision are preserved.

HOW TEAM NURSING MAY ADDRESS WORKFORCE CONSTRAINTS

Optimization of available skill mix

One of the strongest arguments for team nursing is that nursing activities vary considerably in the expertise and clinical judgement required. Registered nurses may spend substantial time performing activities that can safely be undertaken by appropriately trained personnel. A competency-based team model can redistribute suitable responsibilities while allowing registered nurses to focus on comprehensive assessment, complex decision-making, recognition of deterioration, care planning, patient education, coordination, and evaluation. Skill-mix optimization should not be confused with indiscriminate substitution. Registered nurse staffing remains important for patient outcomes.⁵ Evidence also indicates that changes in workforce composition can alter care processes and the availability of professional nursing attention.¹⁵ Team nursing should therefore enhance the use of registered nurse expertise rather than reduce its availability.

The conceptual distinction between staff mixes and skill mix is important. Workforce effectiveness depends not only on the number of personnel but also on their competencies, experience, role boundaries, and capacity to work together.¹² A team with a larger headcount may still have insufficient clinical capability if professional expertise is inadequate.

Improved workload distribution

Workload imbalance contributes to fatigue, dissatisfaction, missed care, and turnover. Individual

patient allocation can become particularly difficult when one nurse is assigned several patients with high acuity or rapidly changing needs. Team nursing may allow workload to be redistributed as clinical conditions change. However, patient numbers alone are an inadequate measure of workload. Nursing workload is influenced by patient condition, staffing levels, work-system design, interruptions, admissions, discharges, infection-control requirements, documentation, and coordination demands.¹⁶ Safe team nursing therefore requires acuity-informed allocation rather than simple numerical assignment.

Dynamic redistribution may be particularly valuable in emergency departments, medical-surgical units, step-down areas, and periods of sudden demand. The team structure can allow personnel to respond collectively to deterioration, admissions, transfers, and high-intensity procedures.

Support for novice and early-career nurses

Transition from education to independent clinical practice is a vulnerable period. Newly qualified nurses may experience workload pressure, limited confidence, and insufficient access to experienced support. Transition difficulties may contribute to stress and intention to leave, particularly when organizational support is inadequate.^{17,18}

A stable team structure can provide real-time supervision, shared decision-making, mentoring, and rapid escalation. Novice personnel can participate within their verified scope while gradually developing competence. This may be particularly valuable in units experiencing rapid recruitment or workforce turnover. However, the developmental benefit depends on whether experienced nurses have sufficient capacity to supervise.

Assigning a full patient workload to the team leader while simultaneously expecting extensive oversight may increase workload and risk. Supervisory work must therefore be recognized as genuine clinical workload.

Organizational flexibility and surge capacity

Health systems must respond to fluctuating demand caused by seasonal pressures, disasters, outbreaks, mass-casualty incidents, sudden absenteeism, and changes in patient acuity. Team nursing may provide a flexible structure for integrating redeployed staff and personnel with different levels of experience.^{13,14}

During surge conditions, experienced nurses may coordinate teams that include personnel from other specialties. Competency mapping can identify which activities each member can safely undertake. This may increase operational capacity while preserving escalation pathways.

Nevertheless, emergency adaptations should not become permanent justifications for inadequate staffing. Team nursing may increase flexibility, but it cannot eliminate the relationship between staffing and patient outcomes.⁵

Potential contribution to workforce retention

Poor practice environments, inadequate support, excessive workload, and burnout contribute to workforce instability.^{4,9,10} Team nursing may reduce professional isolation and strengthen collegial support when teams are stable and appropriately led. Shared responsibility may increase collective efficacy during demanding shifts.

Nurses who can access timely assistance may experience greater practical and professional support than those working in isolated assignment structures. Positive work environments and organizational support are important components of retention strategies.^{19,20} Conversely, poorly designed team nursing may worsen retention if registered nurses are held accountable for excessive numbers of patients or required to supervise inadequately prepared personnel. The relationship between team nursing and retention is therefore conditional rather than automatic. The principal mechanisms through which team nursing may contribute to workforce resilience, together with corresponding risks and safeguards, are summarized in Table 1.

Table 1: Potential contributions and risks of team nursing in workforce-constrained health systems.

Strategic domain	Potential contribution	Major risk	Required safeguard
Skill mix	Better use of complementary competencies	Inappropriate substitution of registered nurses	Competency-based role allocation
Workload	Shared distribution of care demands	Hidden overload within the team	Acuity-informed workload assessment
Novice support	Real-time supervision and mentoring	Excessive dependence on team leaders	Protected supervisory capacity
Flexibility	Rapid response to fluctuating demand	Normalization of crisis staffing	Minimum safe staffing standards
Communication	Shared situational awareness	Information loss between team members	Structured huddles and handovers
Retention	Greater collegial support	Increased supervisory burden	Stable teams and supportive leadership
Patient care	Multiple observation opportunities	Fragmentation of care	Clear registered nurse accountability

POTENTIAL BENEFITS FOR PATIENTS, NURSES, AND HEALTH SYSTEMS

The potential advantages of team nursing extend beyond staffing efficiency. Effective teamwork may improve communication, enable rapid recognition of deterioration, and create multiple opportunities for patient observation. Different team members can contribute complementary perspectives when shared situational awareness is maintained. Team nursing may support continuity at the team level. Although a patient may interact with several caregivers, a stable team can maintain a shared understanding of the patient's condition and care plan. This requires reliable handover, clear documentation, and an identifiable registered nurse responsible for oversight.

The model may also improve the use of professional nursing expertise. When suitable activities are safely delegated, registered nurses may have greater capacity for complex assessment, clinical reasoning, patient education, discharge planning, and coordination. The quality of delegation is therefore central to the model rather than an administrative detail.¹¹ From an organizational

perspective, team nursing may facilitate onboarding, workforce integration, and flexible deployment. It may be particularly useful when a service includes nurses with widely varying levels of experience. Rather than assigning inexperienced personnel independently, organizations can integrate them within teams led by experienced nurses. However, these benefits should not be assumed. The relationship between staffing models and outcomes is influenced by patient population, leadership, organizational culture, professional scope, and baseline staffing adequacy. A systematic review of staffing methodologies found considerable heterogeneity and did not identify a single universally optimal approach for all clinical settings.²¹ Team nursing should therefore be adapted to context and evaluated locally.

CHALLENGES AND RISKS OF TEAM NURSING

Fragmentation of care

Fragmentation is one of the most important concerns. When several workers perform separate components of care without effective coordination, patients may receive

completed tasks but lack holistic nursing attention. Important changes may be overlooked when no professional maintains a comprehensive understanding of the patient. This risk is greatest when team nursing degenerates into functional nursing, in which care is organized around isolated tasks. Contemporary team nursing should therefore preserve holistic assessment and ensure that an identifiable registered nurse retains oversight of the overall plan of care.

Communication failures

Team nursing increases the number of communication interfaces. Information can be lost between the team leader and members, during handovers, when responsibilities change, or when staff are redeployed. Communication failures are particularly consequential in complex clinical environments where patient conditions change rapidly. Effective implementation therefore requires deliberate communication architecture. Brief safety huddles, standardized handovers, shared care plans, closed-loop communication, and explicit escalation criteria are essential. Evidence on nursing teamwork emphasizes the importance of communication, coordination, shared mental models, and supportive team processes.^{22,23} Digital communication tools may assist but cannot compensate for unclear accountability. Technology should reinforce rather than replace direct professional communication.

Role ambiguity and inappropriate delegation

Uncertainty regarding responsibility for assessment, medication administration, documentation, escalation, patient education, and evaluation can threaten safety. Delegation must be based on verified competence, professional scope, patient condition, and the predictability of the activity. The registered nurse remains responsible for professional judgement and must understand legal and regulatory boundaries. Organizations should establish explicit competency frameworks and ensure that delegation education is incorporated into implementation.¹¹

Excessive burden on team leaders

The team leader occupies a pivotal position. Poorly designed models may create an unrealistic combination of responsibilities: managing complex patients, supervising staff, coordinating admissions and discharges, resolving operational problems, communicating with other professionals, and completing documentation. Leadership workload must therefore be included in staffing calculations. Team leaders require preparation in delegation, conflict management, prioritization, communication, supervision, and situational awareness.

Risk of normalizing inadequate staffing

The most important ethical concern is that team nursing may be used to conceal rather than address staffing

shortages. Organizations may introduce team-based models primarily to reduce registered nurse numbers despite increasing patient complexity. Evidence consistently indicates that registered nurse staffing matters for patient outcomes.⁵ Team nursing should not be presented as evidence that staffing levels are no longer important. The model should improve the organization of available personnel rather than legitimize unsafe workforce reductions.

Skill-mix dilution

Workforce shortages and financial pressures may encourage substitution of registered nurses with less-qualified personnel. However, a larger number of workers do not necessarily compensate for reduced professional expertise. Workforce composition can influence care delivery, professional interaction, and patient outcomes.^{12,15} The appropriate question is therefore not simply “How many workers are present?” but “Does the team collectively possess the competence required by the patients?” This distinction is central to safe implementation.

REQUIREMENTS FOR SAFE AND EFFECTIVE IMPLEMENTATION

Team nursing should be introduced as a planned organizational intervention rather than an informal response to staff shortages. The first requirement is a comprehensive assessment of the clinical environment, including patient acuity, dependency, workflow, staff competence, experience, and available support systems.

Second, team composition should be based on complementary competence. A numerical headcount does not adequately represent team capability. Two teams with identical numbers of personnel may have markedly different capacities depending on professional qualifications, clinical experience, specialist competence, and familiarity with the unit.

Third, accountability must be explicit. Every patient should have an identifiable registered nurse responsible for oversight of assessment, planning, coordination, escalation, and evaluation, even when specific activities are delegated.

Fourth, team leaders require formal preparation. Clinical expertise alone does not automatically confer competence in team coordination. Training should address delegation, communication, workload prioritization, conflict resolution, supervision, and escalation.

Fifth, team stability should be prioritized where possible. Frequently changing team membership can undermine trust, familiarity, and shared mental models. Effective teamwork depends on relational as well as technical processes.^{22,23}

Finally, implementation should be evaluated using both patient and workforce outcomes. Relevant indicators include mortality, clinical deterioration, falls, medication errors, pressure injuries, infections, missed nursing care,

patient experience, nurse satisfaction, burnout, turnover, overtime, and cost. A practical framework for translating these principles into implementation is presented in Table 2.

Table 2: Framework for implementing contemporary team nursing.

Implementation component	Key question	Recommended action
Patient assessment	How complex and unstable are the patients?	Use acuity and dependency measures
Workforce assessment	What competencies are available?	Maintain current competency mapping
Team design	How should personnel be grouped?	Create complementary and stable teams
Leadership	Who coordinates the team?	Appoint prepared registered nurse leaders
Delegation	Which activities can be allocated safely?	Match responsibilities to verified competence
Communication	How will information be shared?	Use huddles and structured handovers
Escalation	How will deterioration be managed?	Establish explicit escalation pathways
Digital support	How can workload be made visible?	Use real-time coordination systems
Evaluation	Is the model improving outcomes?	Monitor a balanced outcome dashboard

AN ADAPTIVE TEAM NURSING FRAMEWORK

A central limitation of conventional workforce planning is its reliance on headcount. Safe nursing care depends not only on how many personnel are present but also on what they can do, the complexity of patients, the quality of leadership, and the effectiveness of coordination. To address this limitation, this review proposes an Adaptive Team Nursing Framework. The framework conceptualizes team capability as the interaction of six domains: patient acuity, workforce competence, registered nurse leadership, workload distribution, communication, and continuous outcome feedback. The framework is based on the principle that team composition should not remain static when patient needs and workforce capacity change. At the beginning of a shift, patient acuity and staff competence should inform team design. During the shift, changes in deterioration risk, admissions, discharges,

workload, and staff availability should trigger redistribution of responsibilities. At the end of the care cycle, patient and workforce outcomes should inform future team design. The proposed operational sequence is summarized in Table 3.

The proposed framework differs from traditional static team nursing in three important ways. First, it treats team capability rather than headcount alone as the primary unit of workforce planning. Second, it requires continuous adaptation to changes in patient acuity and workload. Third, it integrates patient outcomes and workforce outcomes into the same feedback system. The framework should not be interpreted as a validated clinical tool. Rather, it is a conceptual model derived from the literature synthesized in this review and is proposed as a foundation for future implementation research and empirical testing.

Table 3: Adaptive team nursing framework for workforce-constrained health systems.

Stage	Core process	Operational requirement	Expected outcome
1. Assess	Determine patient acuity and dependency	Standardized acuity assessment	Accurate estimation of care demand
2. Map	Identify available staff competence	Verified competency profile	Visibility of team capability
3. Configure	Build complementary nursing teams	Registered nurse-led allocation	Appropriate skill distribution
4. Coordinate	Establish shared priorities	Safety huddle and care plan	Shared situational awareness
5. Deliver	Allocate care according to competence	Clear delegation and accountability	Efficient and safe care delivery
6. Adapt	Rebalance workload as conditions change	Real-time communication	Responsiveness to clinical change
7. Evaluate	Review patient and workforce outcomes	Balanced outcome dashboard	Continuous model improvement

DIGITAL TRANSFORMATION AND THE FUTURE OF TEAM NURSING

The future of team nursing is likely to be increasingly data enabled. Electronic health records, mobile communication platforms, predictive analytics, and real-time staffing systems may improve coordination. Digital dashboards can provide information on patient acuity, pending activities, deterioration risk, admissions, discharges, and workload.

Technology may also support competency mapping. Organizations could maintain dynamic profiles of verified staff competencies, specialty experience, and training. This information could assist team leaders in assigning responsibilities more safely. Artificial intelligence may support elements of nursing workflow, decision support, documentation, monitoring, and resource management. However, implementation requires attention to evidence quality, usability, professional autonomy, data governance, and the risk of increasing rather than reducing workload.^{24,25}

In workforce management, data-driven systems may eventually assist with dynamic allocation by integrating patient complexity, staffing competence, workload, and anticipated demand. Such systems could identify emerging workload imbalances or support changes in team composition. The aim should be augmentation of professional judgement rather than automated replacement of clinical leadership.^{25,26} Digital transformation also creates risks. Excessive alerts, fragmented platforms, poor interoperability, surveillance concerns, algorithmic bias, and increased documentation burden may undermine teamwork. Technology should therefore be designed around clinical workflow and evaluated for its effects on patient outcomes and nursing workload.²⁴⁻²⁶ The future model should be adaptive rather than static. Team composition and responsibilities should change in response to patient acuity, clinical deterioration, admissions, discharges, and available competence. This approach can combine human leadership with real-time information while maintaining professional accountability.

FROM STAFFING NUMBERS TO TEAM CAPABILITY

Traditional workforce planning frequently emphasizes nurse-to-patient ratios and headcount. These measures remain important, but they do not fully describe the ability of a team to meet patient needs. Team capability can be conceptualized as the interaction of staffing numbers, competence, experience, patient acuity, leadership, communication, technology, and organizational support. This perspective helps avoid the false assumption that workers are interchangeable.

A workforce of sufficient numerical size may still be unsafe if it lacks experienced leadership or appropriate

specialist competence. Conversely, a highly skilled team may still become unsafe when workload exceeds human capacity. Team capability therefore does not replace minimum staffing standards; it complements them. The need to protect safe nurse staffing has become increasingly prominent in workforce policy. Safe staffing approaches emphasize that staffing decisions should account for patient needs, workforce composition, working conditions, and the broader care environment rather than relying on a single isolated metric.²⁷⁻³²

This distinction is central to the strategic use of team nursing. The model is beneficial when it improves alignment between patient needs and collective competence. It becomes harmful when it is used to dilute professional expertise or transfer excessive accountability to a small number of registered nurses.

Future directions

The future of team nursing should move beyond static task allocation toward adaptive, competency-based, and patient-centred team design. Five priorities are particularly important. First, workforce planning should incorporate patient acuity and verified competence rather than relying exclusively on headcount.

Second, team leaders should receive formal preparation and protected coordination capacity. Third, digital systems should support real-time workload visibility without increasing unnecessary documentation. Fourth, organizations should measure patient and workforce outcomes simultaneously. Fifth, team nursing should be integrated with broader strategies for education, recruitment, retention, healthy work environments, and safe staffing.^{33,34}

At the policy level, regulators and professional organizations should establish clear standards for delegation, accountability, and skill mix. At the organizational level, implementation should involve frontline nurses and patients. At the research level, stronger comparative, economic, and implementation evidence is required.

The central strategic shift should be from viewing team nursing as a response to insufficient numbers toward viewing it as a method of organizing collective capability. Such a shift can preserve the model's flexibility while reducing the risk that it becomes a justification for unsafe staffing.

Global workforce reform must ultimately combine improved organization of existing personnel with sustained investment in education, employment, leadership, retention, and equitable distribution.^{1,35} Team nursing should therefore be positioned as one component of a wider workforce strategy rather than a stand-alone solution.

CONCLUSION

The global nursing workforce shortage requires both long-term investment and immediate improvement in the organization of existing nursing resources. Team nursing offers a potentially valuable strategy because it can combine complementary competencies, distribute workload, support novice personnel, and improve operational flexibility. Its value, however, depends on how it is designed and implemented. Team nursing is not a substitute for adequate numbers of qualified nurses and should not become a mechanism for professional dilution or permanent crisis staffing. Poorly implemented models may increase fragmentation, communication failures, role ambiguity, and supervisory burden. In contrast, competency-based teams supported by clear accountability, effective leadership, acuity-informed allocation, structured communication, and continuous outcome monitoring may strengthen workforce resilience.

The future of team nursing lies in adaptive and digitally supported models that recognize team capability, rather than headcount alone, as a critical dimension of workforce planning. The Adaptive Team Nursing Framework proposed in this review offers a conceptual pathway for linking patient acuity, workforce competence, registered nurse leadership, dynamic workload allocation, communication, and outcome feedback. However, empirical validation is required before its effectiveness can be established. Used within a broader strategy of investment, retention, education, healthy practice environments, and safe staffing, team nursing may help health systems respond more effectively to workforce constraints while preserving the fundamental goals of nursing: safe, coordinated, person-centred, and professionally accountable care.

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