

What's Being Done About Nurse Staffing?

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Question

An emergency department (ED) nurse asks a question about staffing.

What patient-to-nurse ratios are considered "safe"? At the hospital where I work in the ED, the patient-to-nurse ratio is often 5:1. At another facility where I worked, the ratio was 4:1 unless the patient was critical; then at times it could be 1:1, and a float nurse or the charge nurse would pick up the other patients for the time needed. Is a 5:1 patient-to-nurse ratio in the ED common, and is it considered safe?



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This question is being debated in hospitals, state legislatures, Congress, and among nurses. The basic questions—"What is appropriate staffing and who should make that decision?"—are being asked in all types of units, including EDs.

Nurses in several parts of the country have been protesting inadequate staffing. In January, organized protests took place in California and Pennsylvania. In March, nurses at a Philadelphia-area hospital had a walk-out over staffing issues. Nurses at Kaiser in California and in St. Louis picketed their own hospitals last year to draw attention to staffing levels they said put patients at risk.

Editor's Note: Don't miss our companion article, "[Nurses Are Taking Washington, DC](#)," to learn about a rally/march by nurses for safe staffing planned for May 5, 2017.

What Do Nurses Say?

In a Medscape survey conducted in the fall of 2016, drawing up to 6100 responses to one or more of a series of questions, 53% of nurse respondents said that at the end of a typical shift, they *did not feel satisfied* about the care they had provided. And 57% believe that *patient care is suffering*. The nurses (who were not limited to a single response) also believe short staffing affects staff, patients, and families in these ways:

- Nurse morale is lower 63%
- Patient satisfaction is lower 54%
- Nurses transfer or quit 47%
- More mistakes are made 39%
- Physicians/other staff complain 29%
- Documentation is incomplete 15%

Only 4% reported that short staffing had no effect, and 1% reported that during times of short staffing, patients and families were less demanding on the nursing staff.

When asked, "What typically happens when the unit is short-staffed?" the nurses answered:

- Agency nurses are called in 91%
- Nurses on duty must take a heavier load 67%
- Additional nursing assistants are assigned to unit 46%
- Nurses are "floated" in 40%
- Nurses work voluntary overtime 34%
- Routines are altered to reduce workload 15%
- Managers, supervisors step in to help 14%
- PRN/part-time nurses are called in 14%
- Nurses work mandatory overtime 12%
- Patients are discharged/transferred 6%
- The unit is closed to admissions 6%
- Procedures are postponed 3%

The most recent shift of 75% of the respondents was a 12-hour shift, and 44% had worked overtime, either before or after their scheduled shift. During their most recent shift, 61% handled one to three admissions, discharges, or transfers.

Patients, patients' families, nurses, and hospital administrators experience short staffing in very different ways—something like this:

- Patient: "I pushed my call button 15 minutes ago. No one has come. My pain is bad. The nurse told me not to get out of bed by myself. I'm trapped in bed. I'm scared."
- Nurse: "I have six patients. One is just out of surgery and needs frequent vital signs and pain medication. One has a wound infection and needs a complicated dressing change. One needs help getting to the bathroom, and if she doesn't get help, she may fall. One needs to be discharged, and one needs my admission assessment and all of the paperwork that goes along with that. There are new orders on my sixth patient. I have to start an IV and arrange for a psychiatric evaluation. I hear a call bell going off, but I can't leave the patient I am with right now."
- Patient's visiting family member: "My mother needs to go to the bathroom, but no one is answering her call light. The nurse isn't very good."
- Hospital administrator: "We need to keep nursing costs down."

A Matter of Life and Death

There is no one-size-fits-all solution to the problem of making sure that staffing is sufficient to satisfy all concerned. All organizations and businesses struggle with staffing. Too many people on the payroll, and a business won't survive the labor costs. Too few, and the customers get frustrated with the lack of service and go elsewhere. However, when the business is a hospital, the customers—hospitalized patients—can't just get up and go elsewhere. Nursing services—medications, intravenous fluids, dressing changes, and attention to deteriorating vital signs—can't be put off for a day, much less an hour or two. Adequate staffing truly is a matter of life and death.

Research has confirmed that adequate staffing is linked to a reduction in:

- Medication and other errors;
- Patient mortality, hospital readmissions, and length of stay;
- Number of preventable events such as patient falls, pressure ulcers, central line infections, healthcare-associated infections, and other complications related to hospitalizations;
- Patient care costs (through avoidance of unplanned readmissions); and
- Nurse fatigue, thus promoting nursing safety, nurse retention, and job satisfaction, which all contribute to safer patient care.^[1]

One recent study examined the relationship between patient mortality and day-to-day, shift-to-shift variations in unit level staffing. The researchers found that the risk for patient death increased 2% each time a patient was exposed to shifts with below-target registered nurse staffing.^[2]

How do hospitals determine how many nurses will be working on any given day? Traditionally, hospitals have set staffing in one or more of these ways:

- Allocating nurses based on nursing hours per patient day;
- Applying nurse-patient ratios; and
- Assessing patient characteristics to staff based on acuity.

Here's how the nurses responded in the 2016 Medscape survey to the question: "To the best of your knowledge, does your unit or hospital have any of the following?" (Nurses could choose more than one answer.)

• Unit nurse-to-patient ratio guidelines	45%
• Hospital nurse-to-patient ratio guidelines	24%
• A hospital- or unit-based staffing committee	11%
• I don't know	20%
• State staffing guidelines for all hospitals	8%
• Other staffing resource	8%

Policy and Legislative Solutions

Some hospitals are developing and testing methods of fine-tuning their staffing to patient needs, with nurses' input. An innovative approach has been generated by Indiana University Ball Memorial Hospital, in which a new patient-acuity tool promotes equitable nurse patient assignments.^[3]

However, the approach by the Indiana University hospital is not widespread. Outsiders, and especially those who are or will be patients, have no way of knowing what hospital administrators are doing about staffing. Some lawmakers and regulators believe that there is a public policy need to ensure the safety of vulnerable hospitalized patients. So, the current health policy landscape includes attempts to regulate nursing staffing. These attempts come in the form of proposed or adopted legislation, union contracts and advocacy by professional organizations, and efforts by payers to tie patient outcomes to payment. The efforts spring, in part, from nurses asking for help when they believe hospital administration isn't listening to them.

Attempts at Staffing Legislation

Legislation on nursing staffing has fallen into three categories: (1) setting ratios of nurses to patients; (2) requiring hospitals to have committees to set staffing policy and resolve problems, and/or (3) requiring public disclosure of staffing levels. Ohio State Senator Mike Skindell (D-Lakewood) introduced a bill into this session's legislature to limit the number of patients a hospital can assign to a nurse.^[4] Senate Bill 55, called the Patient Protection Act, would establish minimum ratios of direct-care registered nurses to patients in hospitals and prohibit retaliatory actions by hospitals against registered nurses who refuse to follow a policy that is contrary to the legislation. Specifically, the bill requires the following nurse-to-patient ratios:

- 1:1 for a patient in an operating room, a patient receiving conscious sedation, a patient in a trauma or critical care unit, unstable newborns, and patients requiring resuscitation;
- 1:2 in intensive care;
- 1:3 in pediatric units and for pregnant women who are not in active labor;
- 1:4 in medical-surgical and psychiatric units; and
- 1:5 in rehabilitation units, skilled nursing, and well-baby nurseries.

For other patients and units, a hospital-wide committee would establish ratios and implement them. Ratio requirements would be set after considering the severity of a patient's illness, the need for patient advocacy, the patient-care delivery system, and the hospital's physical layout. The bill would require hospitals to post ratio requirements in public view.

The bill also requires that nurses assigned to a unit be competent to work there. It prohibits mandatory overtime to meet the requirements, prohibits the use of cameras or monitors as substitutes for an actual nurse, and provides some protections to nurses who refuse to follow a policy they believe to be in violation of the legislation.

A nurses' union worked with Senator Skindell in drafting the bill. The Ohio Nurses Association does not support the bill, saying that the solution goes beyond staffing ratios.

New Jersey has similar legislation on the table.^[5] If readers are surprised that the Ohio Nurses Association does not support a bill that mandates a level of nurse staffing, it is instructive to read the American Nurses Association's (ANA's) position on legislation regulating staffing:

The American Nurses Association (ANA) supports a legislative model in which nurses are empowered to create staffing plans specific to each unit. This approach aids in establishing staffing levels that are flexible and account for changes; including intensity of patient's needs, the number of admissions, discharges and transfers during a shift, level of experience of nursing staff, layout of the unit, and availability of resources (ancillary staff, technology etc.) Establishing minimum upwardly adjustable staffing levels in statute may also aid the committee in achieving safe and appropriate staffing plans.

The ANA endorsed a bill in the US Senate's 2015-2017 session (SB 1132, introduced by Senator Jeff Merkley, D-Oregon) that would have:

- Required each hospital participating in Medicare to implement a hospital-wide staffing plan for nursing services furnished in the hospital;
- Required the plan to require that an appropriate number of registered nurses provide direct patient care in each unit and on each shift of the hospital to ensure staffing levels that: (1) address the unique characteristics of the patients and hospital units; and (2) result in the delivery of safe, quality patient care consistent with specified requirements;
- Required each participating hospital to establish a hospital nurse staffing committee that shall implement such plan;
- Specified monetary and other penalties for violation of the requirements; and
- Set forth whistleblower protections against discrimination and retaliation involving patients or employees of the hospital for their grievances, complaints, or involvement in investigations relating to such plan.

That bill would have broadened the current federal requirement, which says that hospitals participating in Medicare must "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed."^[6] However, "adequate" is not defined.

The ANA said "H.R. 2083/ S.1132 presents a balanced approach to ensure adequate RN staffing by recognizing that direct care nurses, working closely with managers, are best equipped to determine the staffing level for their patients." That bill did not pass by the end of the session in January 2017 and is dead, as of this writing.

The essential elements of staffing legislation, in the ANA's view and according to a white paper, "Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes,"^[7] dated November 2015, are flexibility to adjust to patient complexity, a rise in admissions, discharges and transfers, and the physical layout of the unit.

Current State Staffing Laws and Regulations

Fourteen states have statutes or regulations addressing nursing staffing. They are California, Connecticut, Illinois, Massachusetts, Minnesota, Nevada, New Jersey, New York, Ohio, Oregon, Rhode Island, Texas, Vermont, and Washington. Seven states—Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington—require hospitals to have staffing committees responsible for planning and policies. California has minimum nurse-to-patient ratios. Massachusetts requires 1:1 or 1:2 nurse-to-patient ratios in intensive care. Minnesota requires that a chief nursing officer develop a staffing plan with input from others. Five states—Illinois, New Jersey, New York, Rhode Island, and Vermont—have requirements for some form of public reporting of staffing levels.

It is noteworthy that two states that already have laws regulating staffing—Ohio and New Jersey—are going at it again. Ohio already requires that hospitals have staffing committees and is now considering setting

specific nurse-to-patient ratios. New Jersey already requires public reporting of staffing levels and is also going for required nurse-to-patient ratios.

Washington State passed a bill in 2008 that required:

- Every hospital to establish a nurse staffing committee;
- At least one half of the members of the nurse staffing committee are registered nurses currently providing direct patient care;
- Up to one half of the members of the nurse staffing committee are hospital management representatives;
- Staff nurses who participate on the committee must be scheduled during work time, compensated at the appropriate rate of pay, and relieved of all other work duties;
- Hospitals must post the nurse staffing plan and the nurse staffing schedule for that shift on that unit, as well as the relevant clinical staffing for that shift in a public area on each unit;
- The staffing plan and current staffing levels must be made available to patients and visitors upon request;
- Hospitals may not retaliate or intimidate an employee for performing any duties or responsibilities in connection with the nurse staffing committee; and
- Hospitals may not retaliate or intimidate an employee, patient, or other individual who notifies the nurse staffing committee or the hospital administration of his or her concerns on nurse staffing.^[7,8]

It appears that the law did not solve the problem, at least in some Washington hospitals. Some hospitals, in trying to supply adequate staff, weren't allowing their staff to take breaks. In May 2015, the state nurses' association sued CHI Franciscan Health on behalf of nurses at St. Joseph Medical Center in Tacoma for back pay for missed break time since 2012. Under a December 2016 settlement, nurses at St. Joseph will get \$5 million in back pay for missed break time. The suit was brought under a Washington law requiring employers to provide employees with rest and meal breaks. (Not all states have such laws.) The settlement also requires that the organization hire 26 nurses to cover patient care during breaks.^[9,10]

Some outside organizations—non-hospitals—have applied pressure for adequate staffing in an indirect way. For example, the National Committee for Quality Assurance (NCQA), an organization that advocates for quality of care, tracks and reports patient satisfaction data for hospitals. Patient satisfaction is linked in research studies to adequate staffing. Medicare now tracks readmission rates of hospitals and penalizes those with high readmission rates. Rate of readmission has been linked by researchers to inadequate staffing. The Joint Commission—the organization that accredits hospitals—has a requirement that nursing administration have a core staffing plan.

What Will Hospitals Do?

Finding a compromise to the competing interests of patient safety and profit is complicated. Here are the factors that affect staffing needs, in addition to numbers of patients:

- Patient complexity, acuity, and stability;
- Number of admissions, discharges, and transfers;
- Skill level and experience of professional nurses and other staff;
- Physical space and layout of the nursing unit;
- Availability of and proximity to resources;
- Technological support and functionality of medical records system;
- Physician expertise;
- Physical, emotional, and educational needs of the patients; and
- Characteristics of the unit.

Here are some of the solutions that have been proposed:

- Mandated nurse-to-patient ratios;
- Public reporting of staffing data to promote transparency;
- Penalizing institutions that fail to comply with minimal safe staffing standards;
- Requiring hospitals to have staffing committees that include staff nurses;

- Empowering nurses to create staffing plans and provide daily input, and even hourly input, on needs and then implementing the plans and responding to the documented needs; and
- Using patient acuity tools so that nurses can demonstrate the staffing they need.

Hospitals already are highly regulated. No hospital wants to be told how many people it has to hire. Yet it is in the public interest to have enough nurses on duty at hospitals so that patients can feel secure that they will get their medication on time and will be rescued if their condition takes a turn for the worse.

Do you have an opinion about nurse staffing and how it should be regulated? Please share your thoughts in the comments.

Web Resource

Mitchell PH. Nurse Staffing – A Summary of Current Research, Opinion and Policy. 2013. Ruckelshaus Center, Washington State University.

Editor's Recommendations

- [Why Nurse Staffing Matters: A Moral Imperative](#)
- [The More RNs, the Higher the Patient Survival](#)
- [Nurses Are Taking Washington, DC](#)

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