CE Home Study Course

Collective Patient Advocacy Trailblazers, Part 2
The Road to Ratios

This home study is part two of a two-part continuing education series. The first installment appeared in the September 2012 issue of National Nurse and is required reading for successful completion of this home study course. You can also find the first part online through the “media” and “nurse magazine” links at www.nationalnursesunited.org.

Part I examined the impact of healthcare restructuring on safe patient care standards, which prompted the historic enactment of the California Nurses Association (CNA)-sponsored legislation, AB 394 (Kuehl). Known as the California Safe Staffing Law, it established first-in-the nation minimum, specific, and numerical direct-care registered nurse-to-patient staffing ratios by clinical unit for acute-care hospitals. This landmark law has set the stage for the introduction of two pieces of legislation by National Nurses United to improve and expand nursing care and patient protection standards at the federal level: HR 2187 (Schakowsky), Nurse Staffing Standards for Patient Safety and Quality Care Act, and SB 992 (Boxer), the United States Nursing Shortage Reform and Patient Advocacy Act. Part II continues with a discussion of legislative intent to establish clearly defined, legally protected and enforceable ratios, duties, and rights of all direct-care RNs to act as patient advocates in the exclusive interests of patients.

Description
This CE course examines selected national and international roots of direct-care nurses’ historic struggle to achieve autonomous control of their working conditions, education, licensure, and professional practice standards. Protecting and promoting the legacy passed on to us by pioneering nurse activists is our responsibility in order to safeguard the future of the nursing profession. The ability of direct-care registered nurses to assure the best achievable patient outcomes should not be subordinate to the healthcare industry’s for-profit business enterprise. RNs will learn the background, development, and implementation of important healthcare laws, including landmark safe staffing legislation that is evidence-based on specific numerical nurse-to-patient ratios.

RNs will learn about their rights to collectively pursue enforcement strategies to ensure facility compliance with legal requirements to increase staffing based on explicit and transparent indicators which include patient acuity and severity of illness. RNs will learn the rationale and importance of protecting their rights to form and join a strong, all-RN professional and labor organization for the purposes of collective bargaining over wages, hours, and working conditions—rights protected by current federal law.

RNs will gain an appreciation of the historic significance and importance of professional union representation to protect their license and advance their professional interests as community advocates. This protection is imperative when RNs exercise their duty to take action, as circumstances require, to prevent injury or harm to patients when patient needs or wishes for treatment and care are not respected or provided, due to short-staffing or an early discharge to achieve a market-driven length-of-stay goal. RNs have a duty to act to change administrative policies that are not congruent with their professional values, ethics, education, and experience, and engage in legislative advocacy to protect their ability to provide safe, therapeutic, and effective patient care.

Objectives: Upon completion of this home study RNs will be able to:

- List four workplace hazards identified by the Occupational Safety and Health Administration that can be mitigated by the implementation of safe staffing ratios
- Describe the essential principals of safe staffing and other RN and patient protections included in the National Nursing Shortage Reform and Patient Advocacy Act/Nurse Staffing Standards for Patient Safety and Quality Care Act (S 992 /HR 2187).
- Compare and contrast evidence-based patient and nurse outcomes between California and outcomes in other states without current ratio legislation, including Pennsylvania and New Jersey
- Name two factors identified by the Institute of Medicine that increase the risk of nursing errors
- Identify and describe two advocacy actions RNs can take to reduce the risk of patient harm and poor outcomes

Key Components of the California Nurse-to-Patient Ratio Law

Background: The Impact of Healthcare Restructuring on Safe Patient Care and Staffing Standards
In the beginning of the 1990s, hospitals, in response to managed care, began to restructure,
merge, and consolidate in a very rapid fashion. They also redesigned and reconfigured staffing patterns. Reports of hiring freezes and layoffs of RNs in hospitals led to increasing concerns among California RNs about the threats to safe, therapeutic, and effective patient care in hospitals.

Hospitals were implementing a variety of nursing care delivery models involving major down-substitutions, reducing the proportion of RNs to other nursing personnel by replacing them with lesser-trained and, at times, untrained and lower-salaried personnel at a time when the increasing complexity and acuity of hospital patient care caseloads called for more skilled nursing care provided by registered nurses. As a result, patient care staffing standards sharply deteriorated in hospitals. Patients and RNs experienced these negative effects every day. The key reasons for RN dissatisfaction were “excessive workload” and “oppressive working conditions.”

Hospitals hired consulting firms who were paid hundreds of millions of dollars to implement “work redesign models.” Although based on a manufacturing model, these schemes carried names such as “patient-focused care” or “patient-centered care.”

The emphasis was on fragmenting the nursing process into a series of “tasks” and shifting registered nurses away from hands-on care to serve as “team leaders” of licensed and unlicensed assistive personnel (UAPs) who would be either assigned to the patient or perform the tasks.

Studies have shown that there are a substantial number of injuries to patients due to treatment mistakes and other errors resulting from substandard care. The removal of the RN as a safety net from the bedside has compounded the problems since landmark studies have identified RNs as the major interceptors of errors.

**Safe Staffing Legislation:** After extensive and aggressive lobbying
and highly visible mobilization campaigns for the adoption of CNA-sponsored enabling legislation known as Assembly Bill No. 394, authored by Assemblywoman Sheila Kuehl, Gov. Gray Davis signed the bill into law on Oct. 10, 1999.

The California Nurses Association brought 2,500 RNs and supporters to the steps of the Capitol in Sacramento, presented more than 14,000 letters in support, and commissioned an opinion poll showing 80 percent public support for the bill. It became news all over the world with headlines such as, “California to Set Level of Staffing for Nursing Care. Mandate first in Nation” (the New York Times) and “California is the first State to Require Hospital-Wide Nurse-to-Patient Ratios” (the Wall Street Journal)

In the preamble to AB 394, the California Legislature found and declared all of the following:

1) Healthcare services are becoming complex and it is increasingly difficult for patients to access integrated services.

2) Quality of patient care is jeopardized because of staffing changes implemented in response to managed care.

3) To ensure the adequate protection of patients in acute-care settings, it is essential that qualified registered nurses and other licensed nurses are accessible and available to meet the needs of patients.

4) The basic principles of staffing in the acute-care setting should be based on the patients’ care needs, the severity of condition, services needed, and the complexity surrounding those services.

Adoption of Nurse-to-Patient Staffing Ratios

The legislation mandated that the Department of Health Services (DHS) must adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and hospital unit for all acute-care facilities.

In adopting the nurse-to-patient ratio regulations, DHS was required to take into consideration the regulations dealing with RN scope of practice and existing staffing and patient classification system regulations.

Minimum Ratios Plus flexing Up Based on Patient Acuity

Once the minimum number of RNs has been allocated, additional staff shall be assigned in accordance with a documented patient classification system (PCS) for determining nursing care requirements.

New PCS-Required Patient Care Indicators

a. Severity of Illness
b. Need for specialized equipment and technology
c. Complexity of clinical judgment needed to design, implement, and evaluate the patient care plan
d. Ability for self care
e. Licensure for personnel required for care

Conflict of Law

In case of conflict between the enabling legislation and any provision or regulation defining the scope of nursing practice, the existing scope of practice regulations shall control.

Limits Utilization of UAPs: The new law also addresses major concerns about a disturbing trend which surfaced as a result of the restructuring of the healthcare industry, namely, the creation and proliferation of a new category of healthcare worker known as unlicensed assistive personnel (UAPs). Hospitals are now prohibited from assigning UAPs to perform nursing in lieu of RNs or from allowing UAPs, under the direct supervision of a registered nurse, to perform functions that require a substantial amount of scientific knowledge and technical skills, including:

- Administration of medication
- Venipuncture or intravenous therapy
- Parenteral or tube feedings
- Invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning
- Assessment of patient condition
- Educating patients and their families concerning the patient’s healthcare problems, including post-discharge care
- Moderate complexity laboratory tests

Is the LVN in the Count for the Purpose of the Ratios?

The answer is a resounding NO. According to the California LVN practice act, the scope of practice or legal authority to perform specific nursing functions of the LVN is very restricted in that it is dependent on the clinical supervision of the RN or MD. The LVN’s scope is limited to performing basic nursing services requiring technical and manual skills and prohibits the performance of many aspects of the nursing process, such as, patient assessments, the formulation of a nursing diagnosis, the design of a care plan, the implementation of complex clinical interventions, the evaluation of the patient’s response to the treatment, and the performance of patient education/teaching.

Due to their limited and restricted scope of practice, for the purpose of the ratios LVNs are not in the count. The LVN cannot have a primary patient care assignment. The patients assigned to the LVN are the patients of the supervising RN. For example, when a direct-care RN is assigned to provide clinical supervision of a patient “assigned” to the LVN, the direct-care RN has the responsibility under the law to carry out the nursing process on all assigned patients, regardless of how the LVN is utilized within the assignment. Therefore if a direct-care RN on a medical/surgical unit is assigned five patients, the maximum allowed under the ratios, and an LVN, under the clinical supervision of the direct-care RN, is also assigned five patients during a shift, the direct-care RN is then legally responsible for all 10 patients. This is known as the “doubling factor.” Such an assignment is in violation of the maximum allowed for a medical/surgical unit.

A New Era: Safe, Therapeutic, and Effective Patient Care

For decades, the California Nurses Association has described quality as the delivery of safe, therapeutic, and effective patient care and has been a long-standing proponent of protecting and promoting the RN scope of practice and patient advocate role.

The new staffing standards based on scope of practice, minimum ratios, and patient acuity is the most comprehensive and effective approach to improve patient protection in acute-care facilities, to provide effective therapeutic interventions, and to secure RN scope of practice and patient advocacy role.
DHS Staffing Study and Survey of Random Selected California Hospitals

After the ratio law was passed, the California Department of Health Services (DHS) in 2000 began its research to help determine what the numerical ratios should be.

First the DHS used data collected by the Office of Statewide Health Planning and Development (O SHPD). This data on “Productive Hours per Patient Day” (PHPD) over 24 hours by employee classification, cost center, number of beds, and number of admissions and discharges is collected every year from all acute-care hospitals in California.

DHS identified important limitations to the usefulness of the data for the purpose of developing staffing minimums. These were that PHPD includes hours not spent at the bedside, and measurement of census at midnight may leave out some patients who were admitted and discharged after midnight and before midnight the following day. The additional work required to admit and discharge patients is not captured although these activities increase staffing demands. DHS also stated that because all patient days are not alike, not all nurses are alike, and the PHPD reflects average staffing over 24 hours and does not reflect staffing variations at different times.

DHS then partnered with the University of California to gather in 2001 empirical real-world data about the acute-care workforce.

DHS chose 17 experienced facility surveyor registered nurses who were in an enforcement role in the field. These RNs received training on the purpose of the study and the process. They were provided with contact information when technical questions came up while doing the survey.

All the visits were unannounced.

The team studied a sample of the 495 hospitals in California. The sample visited included 10 academic medical centers, 10 Kaiser Permanente hospitals, 20 small and rural hospitals, 10 other public hospitals, 30 other private hospitals, and 10 state facilities for a total of 90 hospitals.

Other DHS RN staff worked with the research team to develop a study tool to capture how hospital units were actually staffed.

The forms sorted the hospital units into categories of unit types. A script was developed that was read to hospital administrators which included definitions of each unit type.

A “nurse staffing form” was filled out on each unit for the current time, the previous 24 hours, and the preceding seven days. This included the number of patients, numbers of discharges and admissions, and the number of RNs, LVNs, and unlicensed staff on duty.

In addition, the same data was requested for 10 specific dates during the first three months of 2001.

The study provided DHS with a portrait of nurse staffing as it was occurring in general acute-care hospital units. It provided retrospective data for the week before the study and the 10 randomly selected 24-hour periods over the first three months of 2001.

The numerical staffing ratios were ultimately predicated on an analysis of this staffing data.

CNA’s Campaign for Safe Staffing Ratios

The safe staffing law did not come easily. It required massive lobbying and highly visible campaigns by the California Nurses Association and thousands of RNs across the state.

In 1992 and 1993, the California Nurses Association sponsored with Jackie Speier AB 1445, the first legislative attempt in the United States to establish nurse-to-patient ratios. The bill didn’t make it out of committee.

In 1996 CNA sponsored Proposition 216, a patient protection ballot initiative that included the requirement that the Department of Health Services (DHS) set ratios in healthcare settings. RNs collected the required signatures. Although the proposition didn’t win, it was successful in raising awareness among RNs and the public of the need for safe staffing.

In 1996 DHS added to Title 22 regulations requiring orientation, nursing in-service education, competency validation for the unit, and staffing by a validated acuity system. Unfortunately, most hospitals continued to staff by numbers/census rather than patient needs.


In 1999 CNA sponsored AB 394, authored by Assemblywoman Sheila Kuehl. Nurses and patients wrote more than 14,000 letters in support and delivered them to lawmakers and the governor. CNA rallied tens of thousands of nurses at the Capitol in Sacramento and the governor’s Los Angeles office. Gov. Gray Davis signed AB 394 on Oct. 10, 1999. California is the first state in the U.S. to agree to safe RN staffing standards. This drew praise throughout the nation as well as internationally.

Mandated, Minimum, Numerical Nurse-to-Patient Ratios by Unit Type

In California, DHS defines hospital units and appropriate patient population for the purposes of licensing and certification of healthcare facilities and for monitoring compliance with existing public health and safety regulations. Because the literature describes the most common factor underlying preventable complications/failure-to-rescue as “triage error” or admission to a unit other than one that provides the optimal and safe level of care required by the patient, it’s instructive to include a review of unit/patient population definitions upon which the California nurse-to-patient ratio law and staffing standards are predicated.

Hospital Unit Definition

Hospital unit means a critical care unit, burn unit, labor and delivery room, post-anesthesia recovery service area, emergency department, operating room, pediatric unit, step-down/intermediate care unit, specialty care unit, telemetry unit, general medical care unit, sub-acute care unit, and transitional in-patient care unit. The regulation addressing the emergency department shall distinguish between regularly scheduled core staff licensed nurses and additional licensed nurses required to care for critical care patients in the emergency department.

(Note: This home study incorporates excerpts of relevant ratio sections of AB 394 together with highlights from the final Statement of Reasons (FSOR) submitted by the DHS. The FSOR can be downloaded in its entirety by accessing the web link listed in the bibliography.)
Title 22 Section 70217, Mandated Minimum Numerical Nurse-to-Patient Ratios by Unit Type Section 70217 (a).

Nursing Service Staff

1. The licensed nurse-to-patient ratio in a critical care unit* shall be 1:2 or fewer at all times. “Critical care unit” means a nursing unit of a general acute-care hospital which provides one of the following services: an intensive care service, a burn center, a coronary care service, and acute respiratory service, or an intensive care newborn nursery service.

   DHS/FSOR: Critical care unit means a unit that is established to safeguard and protect patients whose severity of medical conditions requires continuous monitoring and complex intervention by licensed nurses. “Intensive care newborn nursery service” was added to the list of critical care units to clarify that it is included as a critical care unit. It is DHS’ intent that the phrases “intensive care units” and “critical care units” may be used interchangeably. Intensive care units are mandated to have a minimum nurse-to-patient ratio, of 1:2 or fewer, at all times. The 1:2 ratio standard has become the minimum ratio for critical care units, with many patients in those units requiring staffing at 1:1 and even 2:1.

2. The surgical service operating room shall have at least one registered nurse assigned to the duties of the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-occupied operating room. The scrub assistant may be a licensed nurse, and operating room technician, or other person who has demonstrated current competence to the hospital as a scrub assistant, but shall not be a physician or other licensed health professional who is assisting in the performance of surgery.

   DHS/FSOR: This provision makes explicit the requirement for a registered nurse (RN) to function as the circulating assistant in the surgical service operating room. The most critical period of care for surgical patients occurs in the operating room. The instability inherent in the patients’ condition while undergoing surgery necessitates the registered nurse’s level of skill for ongoing assessment and evaluation, while assisting the surgical team. The ongoing assessment includes minute-by-minute vigilance and availability for immediate response to emergent patient changes on the part of the circulating registered nurse.

3. The licensed nurse-to-patient ratio in a labor and delivery suite of the perinatal service shall be 1:2 or fewer active labor patients at all times. When a licensed nurse is caring for antepartum patients who are not in active labor, the licensed nurse-to-patient ratio shall be 1:4 or fewer at all times.

   DHS/FSOR: This is based on the patients’ need for critical care during the end of labor and through the delivery process. The 1:2 ratios conform to the ratios for the other critical care units in the hospital.

4. The licensed nurse-to-patient ratio in a postpartum area of the perinatal service shall be 1:3 or fewer at all times. When a licensed nurse is caring exclusively for women in active labor only, antepartum patients who are not in active labor only, post-partum women only, or mother baby couplets only shall be the same ratios as stated in subsection (3) and (4) above for those categories of patients.

5. The licensed nurse-to-patient ratio in a combined labor/delivery/postpartum area of the perinatal service shall be 1:3 or fewer at all times that the licensed nurse is caring for a patient combination of one woman in active labor and a postpartum mother and infant. The licensed nurse-to-patient ratio for nurses caring for women in active labor only, antepartum patients who are not in active labor only, post-partum women only, or mother baby couplets only shall be the same ratios as stated in subsection (3) and (4) above for those categories of patients.

6. The licensed nurse-to-patient ratio in a pediatric unit shall be 1:4 or fewer at all times.

   DHS/FSOR: The word “unit” was added because current regulations differentiate between the pediatric service and the pediatric unit. Other hospitals which admit pediatric patients but do not have pediatric units would admit the pediatric patients to a mixed unit, and that ratio, in concert with the patient classification system (PCS) would dictate the appropriate staffing level.

7. The licensed nurse-to-patient ratio in the post-anesthesia recovery unit of the anesthesia service shall be 1:2 or fewer at all times, regardless of the type of anesthesia the patient received.

   DHS/FSOR: DHS concurs with the California Society of Anesthesiologists which wrote, “The CSA supports the proposed DHS nurse-to-patient ratio of 1:2 or fewer for patients in the post-anesthesia recovery unit. The most critical phase for a patient recovering from anesthesia, whether it is general, regional, or intravenous, is the immediate period following surgery and anesthesia, before they are transitioned to an inpatient setting or discharged to a lower level of care.”

8. In a hospital providing basic emergency medical services or comprehensive emergency medical services, the licensed nurse-to-patient ratio in an emergency department shall be 1:4 or fewer at all times that patients are receiving treatment. There shall be no fewer than two licensed nurses present.

   DHS/FSOR: At least one of the licensed nurses shall be a registered nurse in the emergency department. The ratio of one registered nurse to four patients is based on the need for continuous patient assessment and intervention during emergent situations.
9. The licensed nurse-to-patient ratio in a step-down unit shall be 1:3 or fewer at all times. A “step-down unit” is defined as a unit which is organized, operated, and maintained to provide for the monitoring and care of patients with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. Step-down patients are those patients who require less care than intensive care, but more than that which is available from medical/surgical care. “Artificial life support” is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. “Technical support” is defined as specialized equipment and/or personnel providing for invasive monitoring, telemetry, or mechanical ventilation, for the immediate amelioration or remediation of severe pathology.

DHS/FSOR: “Artificial life support” and “technical support” are defined in regulation in order to differentiate the types of equipment and nursing care that would commonly be required by patients in step-down units, and, by extension, the degree of illness or impairment experienced by patients in this unit type.

10. The licensed nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times. “Telemetry unit” is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals.

DHS/FSOR: “Telemetry unit” was defined in the original proposed regulations as a unit designated for the electronic monitoring, recording, retrieval, and display of cardiac electrical signals. The final proposed definition was expanded in response to the requests of many public comments to improve clarity. The definition was expanded because the original language was so broad as to be confusing operationally. Many patients require monitoring of cardiac signals, including women in active labor, babies in utero, intensive care patients, surgical patients, and others. The added language will minimize confusion. It limits telemetry patients to those who are in stable condition, thus distinguishing them from step-down and ICU patients. It further defines telemetry unit as dedicated to patients having or suspected of having a cardiac condition or disease requiring specific monitoring and care. This definition is consistent with existing practice, is more precise, and will minimize confusion.

Cardiac monitoring, which in the past was reserved to critical care units, is now used routinely in non-critical care settings to improve patient care and provide a more accurate and continuous assessment of cardiac function for those patients whose underlying disease state, e.g. conduction disturbances or arrhythmias, makes monitoring appropriate. The ratio is necessary because patients on telemetry require licensed nurses to be readily available to expeditiously detect and treat the irregularities that the monitor identifies.

11. The licensed nurse-to-patient ratio in medical/surgical care units shall be 1:5 or fewer at all times (beginning in 2005). A medical/surgical unit is a unit with beds classified as medical/surgical in which patients, who require less care than that which is available in intensive care units, step-down units, or specialty care units receive 24-hour inpatient general medical services, post-surgical services, or both general medical and post-surgical services. These units may include mixed patient populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit.

DHS/FSOR: This ratio is also proposed to apply to those medical/surgical units that serve diverse patient populations and age groups. These units, which for purposes of the DHS on-site study were identified as “mixed units,” were found to contain patients with diseases, injuries, acuity levels, and care needs that closely approximated patients in more traditional medical/surgical units. The PCS will continue to coexist with the minimum ratio in these mixed units to require an increase in nurse staffing in response to increased patient acuity and/or the needs of the specific patient population, e.g. pediatric patients. The words “who require care appropriate to a medical/surgical unit” were added to clarify that mixed and medical/surgical units provide the same level of care and that the care level is necessitated by patients’ needs.

12. The licensed nurse-to-patient ratio in a specialty care unit shall be 1:4 or fewer at all times. A specialty care unit is defined as a unit which is organized, operated, and maintained to provide care for a specific medical condition or a specific patient population. Services provided in these units are more specialized to meet the needs of patients with the specific condition or disease process than that which is required on medical/surgical units, and is not otherwise covered by “unit definition.”

DHS/FSOR: Specialty care units, those units which are organized, operated, and maintained to provide care for a specific patient population, are very varied, depending on the hospital, its location, its size, and the patient population it serves.

Specialty care units are often found in large, urban hospitals and academic medical centers serving unique patient cohorts. While “specialty care unit” is not currently a supplemental service nor a licensing term, this is the generally understood meaning of the term. The specific specialties served by these units run the gamut from orthopedics to HIV/AIDS to metabolic transplants, and require more specialized skills and comprehensive care than is normally available in medical/surgical units. Minimum staffing, of course, will vary according to the needs of the patients, and will increase in response to the PCS. The most commonly found specialty care unit in California’s hospitals is the oncology unit, and, therefore, that is the unit type that was included in the DHS on-site study.

13. The licensed nurse-to-patient ratio in a psychiatric unit shall be 1:6 or fewer at all times. For purposes of psychiatric units only, “licensed nurses” also includes licensed psychiatric
technicians in addition to licensed vocational nurses and registered nurses.

DHS/FSOR: The severity of psychiatric disorders varies in acuity. Psychiatric technicians, like LVNs, practice under the direction of a physician, psychologist, registered nurse, or other professional personnel, and are not independent practitioners.

14. Identifying a unit by a name or term other than those used in this subsection does not affect the requirement to staff at the ratios identified for the level or type of care described in this subsection.

DHS/FSOR: This provision was added to allow providers maximum flexibility in the naming of their units. Some hospitals give units names that are perceived to be less troubling for patients and their families than the regulated unit names. For example, intensive care newborn nurseries may be named the “Special Care Nursery,” and an oncology unit may be called the “Camellia Care Unit.” This provision ensures that, while providers may use unit names that they believe will be best received by the population they serve, the use of those names does not affect nor avoid the requirement to comply with the staffing regulations that are based on the type of care provided, and not merely the name of the unit.

As a direct-care registered nurse in a general, acute-care hospital, having comprehensive knowledge about the DHS findings and reasons for adopting these specific minimum numerical nurse to patient ratios is imperative to your role as a patient advocate. These ratios constitute the minimum allowable at all times, and the law further requires that staffing must be flexed up/augmented based on the individual acuity of your patient.

The Same Ratios Apply at all Times
This requirement applies to all shifts, meals, breaks, and excused absences. This provision has been challenged in court by the California Hospital Association (CHA). As an interested party, having written and being the sponsor the legislation, CNA had a vested interest in the outcome of the lawsuit filed by CHA against DHS and in order to aggressively defend the “at all times” requirement, CNA intervened in the lawsuit. (See “Gimme a break!” article on page 13).

No Averaging
There shall be no averaging of the number of patients and the total number of licensed nurses on the unit during any one shift nor over any period of time.

If You Build It, They Will Come
One of the claims by the hospital industry in its attempts to block the introduction of ratios was that there were not enough nurses to fulfill the staffing mandates of the ratio. California registered nurses knew differently; they had seen their colleagues leave, citing the heavy workload and stress as their reasons for doing so. Direct-care RNs were convinced that if ratios were mandated, that their colleagues would return to the acute-care hospital setting.

In fact after the ratios were introduced, California increased the number of actively licensed RNs by more than 120,000 RNs—tripling the average annual increase prior to its enactment. The total amount of RNs in California in April 2010 was 357,209 compared with 246,068 in 1999. This increase in numbers was seven times more than the total number state health officials said would be needed to fulfill the ratios for general medical/surgical units.

RNs who had let their licenses become inactive changed status to active, citing the ratios and attendant decreased workload as the primary reason for returning to the nursing workforce.

Pre-ratio landscape
According to the Joint Commission for Accreditation of Hospitals, “Higher-acuity patients plus fewer nurses to care for them is a prescription for danger.” This was the picture in California prior to ratios introduction.

As acuity of patients and complexity of care increased during the 1990s, the hospital industry failed to increase the number of RNs in the acute-care setting. RNs, frustrated with the lack of support and respect from administration and burnt out with excessive workloads, were leaving the profession, citing overwork and the inability to provide the type of care they were educated and wished to provide as the main reasons for leaving.

A study conducted in 2001 by Peter D. Hart Research Associates showed that the majority of nurses (74 percent) said they would stay at their jobs if changes were made. Top among the identified desirable changes were: increased staffing, less paperwork, and fewer administrative duties. Other common reasons cited for leaving the profession were to find work that was less stressful and less physically demanding.

There is consensus amongst researchers on the topic that insufficient staffing raises the stress level of nurses, impacting job satisfaction, and driving many nurses to leave the profession. This reflected the situation in California. Rapid turnover of RNs was common, leaving patients with fragmented care and further stress for the RNs left in the acute-care setting.

CNA: RNs Waged Victorious Fight Against the Attack on the Ratios
The California Nurses Association’s historic first-in-the-nation safe staffing RN ratios law took 12 years to win and it has been in effect since January 2004 despite continued efforts of the hospital industry and Governor Schwarzenegger to have it overturned or otherwise weakened. In 2003, the California Hospital Association filed a lawsuit to stop the regulations, but it failed in court. (See “Gimme a break!” article on page 13) When Governor Schwarzenegger decided to roll back CNA’s staffing ratios and called nurses a “special interest who don’t like me because I’m always kicking their butt,” CNA ignited a broad, grassroots movement that led to a sweeping November 2005 electoral defeat for the governor’s special election initiatives. (See “The Nurses vs. Schwarzenegger” article) Two days after his initiatives lost at the polls, Schwarzenegger dropped his year-long fight against the ratios. Safe RN ratios have improved quality of care and nurse recruitment and retention in California hospitals.
Nursing turnover is very costly both in terms of quality of care and the bottom line of hospitals

According to PriceWaterhouseCoopers (2007) the average hospital is estimated to lose about $300,000 per year for each percentage increase in annual nurse turnover. Given, as reported in the *Sacramento Business Journal* (2008), that after the introduction of the ratios, California’s major hospital chains’ RN vacancy rates fell below 5 percent, it would appear that the hospital industry in California had cause for celebration. Compare this 5 percent rate in California with Texas, a state with no mandated ratios, where the turnover rate hovers around the 20 percent mark. The national average ranges from about 15 to 25 percent.

**We built it and they did come**

As direct-care RNs predicted, the ratios brought their colleagues back to the workplace, improved quality of care and nurses’ morale. Far from bankrupting hospitals, ratios actually improved their bottom lines. Everybody gained, especially the patients who are RNs’ first concern.

**From the Bedside to the Statehouse and Beyond**

National ratios legislation, the National Nursing Shortage Reform and Patient Protection Act of 2011, SB 992 (Boxer), builds on the success of the California experience after implementation of landmark first-in-the-nation nurse-to-patient ratio law that has successfully addressed the shortage of direct-care RNs by improving working conditions, making them safer for patients and nurses. Among the many provisions included in the legislation are uniform, national, professional standards that include minimum, specific, and numerical direct-care RN-to-patient staffing ratios for each clinical unit in acute-care hospitals. For the full text, visit the NNU website at www.nationalnursesunited.org/issues/entry/ratios and scroll down for the link to SB 992.

**Legislative Purpose:**

- To address the nationwide shortage of hospital direct-care registered nurses; provide minimum safe patient protection standards—such as safe staffing ratios—for short-term and long-term acute-care hospitals in the United States; protect direct-care registered nurse as patient advocate; create registered nurse education grants and living stipends to recruit and retain direct-care registered nurses.
- To create a hospital nursing service environment that will immediately attract new RNs and provide the foundation for ultimate restoration of the hospital direct-RN workforce; and
- To establish clearly defined, legally protected, and enforceable duties and rights to direct-care registered nurses as advocates exclusively for the interests of patients.
- Whistle-blower protections that encourage patients, RNs, and other healthcare workers to notify government and private accreditation entities of suspected unsafe patient conditions that will greatly enhance the health, welfare, and safety of patients.
- The essential principles of staffing in the acute-care hospital settings must be based on patient’s individual acuity and needs; severity of conditions; services needed; and complexity surrounding those services.

The Nurse Staffing Standards for Patient Safety and Quality Care Act of 2011, HR 2187 (Shakowsky), is the companion legislation on the House of Representatives side. It establishes new federal staffing standards for hospitals that will improve the safety and quality of care. The bill establishes minimum direct-care registered nurse-to-patient staffing ratios with a mechanism to account for the increased needs of patients based upon acuity of care. It would be enforced through the Public Health Service Act and improve the quality of care in all hospitals receiving federal funding, such as Medicare-Medicaid participating hospitals and hospitals under the Department of Veterans Affairs, Department of Defense, and the Indian Health Service. For the full text, visit the NNU website at www.nationalnursesunited.org/issues/entry/ratios and scroll down for the link to HR 2187.

**Setting the Stage for National Professional Standards**

Use of a reliable and valid patient classification system (PCS) for staffing by acuity has received widespread attention in the literature. Staffing plans can vary widely from hospital to hospital, often lacking in specificity, accountability, and transparency. Many nurses suspect that their hospital’s staffing plans serve as a kind of internal public relations program to justify inadequate staffing based on budget constraints or profit-margin incentives. In any event, it is clear that if the state or federal government is to use acuity as a basis for setting staffing ratios, it must utilize a consistent system of determining acuity across all acute-care facilities. And RNs must have the explicit right to advocate in the exclusive interests of the patients entrusted to their care, without fear of retaliation from their

**National Proposed RN-to-Patient Ratios**

<table>
<thead>
<tr>
<th>Intensive/critical care</th>
<th>1:2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal intensive care</td>
<td>1:2</td>
</tr>
<tr>
<td>Operating room</td>
<td>1:1</td>
</tr>
<tr>
<td>Post-anesthesia recovery</td>
<td>1:2</td>
</tr>
<tr>
<td>Labor and delivery</td>
<td>1:2</td>
</tr>
<tr>
<td>Ante partum</td>
<td>1:3</td>
</tr>
<tr>
<td>Well baby nursery</td>
<td>1:6</td>
</tr>
<tr>
<td>Postpartum couplets</td>
<td>1:3</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1:3</td>
</tr>
</tbody>
</table>

| Emergency room         | 1:3 |
| ICU patients in the ER  | 1:2 |
| Trauma patients in the ER| 1:1 |
| Step-down & telemetry  | 1:3 |
| Medical/surgical       | 1:4 |
| Other specialty care   | 1:4 |
| Psychiatric            | 1:4 |
| Rehabilitation unit & skilled nursing facilities | 1:5 |
| Acute respiratory units| 1:2 |
| Burn units             | 1:2 |
| Intermediate care nursery | 1:4 |
| Combined labor and delivery, and postpartum | 1:3 |
employers. National ratios legislation proposed by NNU includes the following:

1. Direct-Care Registered Nurse Patient Advocacy—Professional Duty of Patient Advocacy
   • Professional obligation and right: An RN has the professional obligation and therefore the right to act as the patient’s advocate.
   • Protection for the refusal of unsafe patient assignments: The direct-care RN is always responsible for providing safe, therapeutic, and competent nursing care to assigned patients. If the direct-care RN is not clinically competent to perform the care required for a patient(s) to be assigned for nursing care, she/he should not accept the patient care assignment(s).
   Such refusal to accept a patient care assignment is an exercise of the direct-care registered nurse’s duty and right of patient advocacy.
   • Free speech, whistle-blowing, patient protection: All direct-care RNs responsible for patient care in a hospital facility shall enjoy the right of free speech.

2. Minimum, Specific, and Numerical Direct-Care Registered Nurse-to-Patient Staffing Ratios by Clinical Unit For All Units At All Times For Acute-Care Hospitals
   • A patient classification system (PCS) to determine additional staff, based on a National Acuity Tool developed by CMS.
   • Direct-care LV/PN ratios study and its effect on patient care in hospitals.

3. Registered Nurse Workforce Initiative
   Purpose: Achieve immediate short-term mitigation and remedy of the nationwide nursing shortage.
   • Basic educational assistance benefit and living stipend
   • Creation of an education assistance entitlement program for eligible associate and baccalaureate degree applicants.
   • Preceptorship and mentorship demonstration project to provide additional support to nurses entering the workforce

4. Enforcement
   • Action by the Secretary: Administrative action. The Secretary shall receive, investigate, and attempt to resolve complaints of violations.
   • Fines for violating employee and patient rights: Acute-care hospitals that violate employee or patient rights under this act shall be subject to civil penalties—$25,000.00
   • Fines for violating employee and patient rights: Any individual employed by a hospital that violates employee or patient rights under this act shall be subject to civil penalties—$20,000.00
   • Fines for violating ratios—$25,000.00

Setting the Stage for National Standards: CMS Development of National Acuity Tool
Clinical restructuring has resulted in the elimination of a significant patient safety net provided by a transparent, direct-care RN-operated and assessment-controlled acuity system. Now, the newly restructured and mostly proprietary and costly patient classification systems (PCS) institutionalize a fraudulent staffing methodology and practice for the hospital nursing service which wholly disregards patient needs and adheres to hospital budget and revenue generation mandates. The inevitable result has been a steady increase in patient loads for direct-care RNs far beyond the bounds of competent, safe, therapeutic, and effective hospital nursing care.

The proliferation of these fraudulent patent classification systems, concealment of determinative methodologies from responsible direct-care RNs and government regulators under “proprietary seal,” and intended use in providing “scientific” justification for a reduced and overburdened direct-care registered nursing staff with excessive patient loads have effectively disabled state regulation and enforcement of safe hospital nursing staffing standards. A uniform national standard is necessary to restore effective enforcement authority by state licensing authorities and provide a basis for federal support of state enforcement through mandatory conditions of participation.

For this reason, SB 992 (Boxer) and HR 2187 (Schakowsky) will set a uniform national standard. The Centers for Medicare and Medicaid Services (CMS) shall develop a National Acuity Tool that provides a method for establishing nursing staffing requirements above the minimum staffing ratios.

This acuity tool shall provide a method for establishing nursing staffing requirements above the minimum staffing ratios, using the existing CMS computer-based “open source” acute-care...
hospitals to meet the needs of patients who require nursing care. The National Acuity Tool shall be the basis for the charge to every acute-care facility for use of the National Acuity Tool. The National Acuity Tool shall remain a publicly owned tool.

The National Acuity Tool shall include, but is not limited to the following elements:

1. A method to predict nursing care requirements of individual patients as determined by direct-care registered nursing assessments of individual patients, including:
   - Severity of the patient's illness including secondary diagnosis
   - The need for specialized equipment and technology
   - The complexity of clinical judgment needed to assess, plan, implement, and evaluate the patient care plan
   - The ability for self-care, including motor, sensory, and cognitive deficits
   - The need for advocacy intervention
   - The licensure of the personnel required for care
   - The patient care delivery system
   - The unit's geographic layout
   - Generally accepted standards of nursing practice, as well as elements reflective of the unique nature of the acute-care hospital's patient population.

2. A method that provides for sufficient direct-care registered nursing staffing to ensure that all of the following elements of the nurse staffing process are performed in the planning and delivery of care for each patient: assessment, nursing diagnosis, planning, intervention.

3. A method to ensure that the patient care needs of individual patients are the exclusive determinant of direct-care registered nursing staffing, and that fiscal and budget considerations are not used for and do not influence the prediction or determination of direct-care registered nursing staffing levels.

4. An established method by which the amount of nursing care needed for each category of patient is validated.

5. A mechanism by which the accuracy of the nursing care validation method can be tested.

6. A method for validation of the reliability of the National Acuity Tool.

The National Acuity Tool shall be fully transparent in all respects, including disclosure of detailed documentation of the methodology used by the system to predict nursing staffing, each factor used in the methodology, each assumption and value used in the methodology with an explanation of the scientific and empirical basis for each such assumption and value, and certification that the methods for testing and validating the accuracy and reliability of the system.

Each hospital shall include an evaluation and report on at least an annual basis by a committee of direct-care registered nurses who have provided and provided direct patient care in the units covered by the patient classification system.

**Review and Consideration for Healthy Public Policy**

The evidence evaluated here suggests that patient satisfaction, nurse satisfaction, and optimal patient outcomes are influenced by ensuring that there are an effective number of direct-care registered nurses to meet the needs of patients who require nursing care. Effective RN-to-patient ratios, not creative and illusory staffing committee schemes, are required for prevention, care planning, initial and ongoing assessment and evaluation of the treatment plan, patient education, and restoration to the optimal level of health and well-being attainable in the exclusive interests of the patient.

The social good and public benefit of increasing RN-to-patient ratios compels nurses and other social advocates to demand healthy social policy and financial accountability when it comes to solving our current crisis in healthcare. This is congruent with our vision of advocacy for an expanded and improved Medicare-for-all program, with a single standard of excellent care for all.

State nursing practice acts and registered nursing board implementing regulations, practice standards, and professional license guidelines generally impose a “fiduciary responsibility” on registered nurses who accept assignment to a direct care RN-to-patient relationship in which nursing care is provided. The fiduciary obligation infers a duty of loyalty to the patient to provide care in the exclusive interests of the patient without compromise or surrender to interests of health facility employers, physician practice groups, healthcare systems, managed care organizations, or health insurers/HMOs. The fiduciary relationship and related professional fiduciary duties of direct-care registered nurses to assigned patients are fundamental public health and safety regulations created to protect patient safety.

The hospital industry and its political cronies have continued their dangerous agenda to control the availability, access, and quality of healthcare services for purposes of profit and surplus revenue generation against the interests of patients and healthcare consumers. However, it is the nation’s direct-care RNs who will continue to honor the public’s trust in them. Nurses recognize the importance of collective patient advocacy for maintaining the integrity of professional nursing standards of care.

**Selected Overview of the Scientific Evidence for Safe Staffing Ratios**

The Agency for Healthcare Research and Quality (AHRQ) is one of three organizational focuses for Department of Health and Human Services (HHS), along with the National Institutes of Health and the Centers for Disease Control. AHRQ’s mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for Americans.

AHRQ focuses on quality improvement and patient safety. In this capacity, AHRQ in October 2012 lauded the nurse-to-patient ratios in a “policy innovation profile” titled “State-Mandated Nurse Staffing Levels Alleviate Workloads, Leading to Lower Patient Mortality and Higher Nurse Satisfaction.”

AHRQ is well respected and influential in shaping healthcare policy. Its praise regarding the effectiveness of the ratios is welcome news to RNs and patients across the country and will bolster efforts to establish federally mandated nurse-to-patient ratios.

**AHRQ defined the problem that ratios solved thus:** Heavy patient workloads for nurses have been associated with poor patient outcomes and low job satisfaction. Yet few states require hospitals to maintain minimum nurse-to-patient ratios, leaving nurses to care for a significant number of patients at a time.

**AHRQ categorically stated that the ratios have been a success:** The legislation has increased staffing levels and created more reasonable workloads for nurses in California hospitals, leading to fewer patient deaths and higher levels of job satisfaction than in
other states without mandated staffing ratios. Despite initial concerns from opponents, the skill mix of nurses used by California hospitals has not declined since implementation of the mandated ratios.

Not only did AHRQ deem the nurse-to-patient ratios a success, it is actively encouraging other states to follow California’s lead and adopt ratios. As part of its report on the ratios, AHRQ published a “how to” on establishing nurse-to-patient ratios, the key points of which are listed below.

### Getting Started with This Innovation

- **Leverage existing research:** Significant research exists on the negative impact of heavy nurse workloads on patient outcomes and on appropriate minimum staffing ratios. Those interested in enacting minimum staffing ratios can use this research to convince legislators of the merits of such mandates and/or to speed up the adoption process.
- **Secure buy-in by emphasizing benefits to patients and bottom line:** Unless they buy in to the need for minimum ratios, hospitals will likely spend significant time and money trying to fight them. Supporters can minimize their resistance by emphasizing the expected positive impact on patient outcomes (including lower patient mortality), costs (through reductions in adverse events and associated legal liability), nurse turnover, and hospital reputation.

### Sustaining This Innovation

**Push for legislation rather than other types of policies:** Legislation mandating minimum staffing ratios is required to ensure long-term sustainability, since such legislation will be more difficult to modify than general hospital policies or professional association recommendations.

**Require ongoing reporting:** Legislation alone does not ensure compliance over time. As a result, hospitals should be required to report staffing ratios on an ongoing basis so as to create accountability and allow for monitoring and oversight.

**Support nursing education:** Financial support for education can help ensure a steady stream of new nurses into the workforce, which helps hospitals meet the staffing requirements.

### Nursing Advocacy: fighting the Good fight for Our Patients and Our Practice

In California, the only state with a guaranteed RN-to-patient ratio law, the ratios have constantly come under attack. Just this year, the California Hospital Association and its partner, United Healthcare Workers West (SEIU-UHW), aggressively moved to dismantle the ratios. They jointly proposed to “suspend” the ratios during RNs’ meal and break periods. This “suspension” would effectively destroy the ratios. California judge Gail Ohanesian ruled back in 2004 that eliminating ratios during meals and breaks would “make the nurse-to-patient ratios meaningless.” This proposal is nothing more than a thinly veiled attempt to provide California’s hospital corporations with higher profits—after raking in more than $20 billion in profits between 2004 and 2010!

Patient advocacy supporters of the ratios believe that nurses and patients everywhere should demand guaranteed ratios. RNs, community advocates, and good government groups strenuously oppose this assault on the ratios in California by the hospital industry and its union partner, SEIU-UHW. Their proposed language would be a major set back in the progress made in California as a result of the first-in-the-nation nurse-to-patient ratios and, as Judge Ohanesian

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**About National Nurses United**

National Nurses United (NNU) is the largest professional association and labor organization of direct-care registered nurses (RNs) in the United States. Our members represent direct-care RNs working in every state in the country, including advanced practice registered nurses (APRNs). Nearly 95 percent of our membership works in acute-care hospitals and/or critical access hospitals. Our mission is to provide safe, therapeutic, and effective care in the exclusive interests of our patients and to expand the voice of direct-care RNs and patients in the planning, development, implementation, and evaluation of public policy as it relates to the healthcare needs of our patients.

NNU was founded in 2009, unifying three of the most active, progressive organizations in the United States and the major voices of 185,000 unionized nurses: the California Nurses Association/National Nurses Organizing Committee, United American Nurses, and Massachusetts Nurses Association.

Combining the unparalleled record of accomplishments for nurses and patients embodied in the proud history of those nurses associations, which for some span more than 100 years, the establishment of NNU brought to life the dream of a powerful, national movement of direct-care RNs.

At its founding convention in December 2009, NNU adopted a call for action premised on principles intended to counter the national assault by the healthcare industry on patient care conditions and standards for nurses, and to promote a unified vision of collective action for nurses with campaigns to:

- Advance the interests of direct-care nurses and patients across the U.S.
- Organize all direct-care RNs “into a single organization capable of exercising influence over the healthcare industry, governments, and employers.”
- Promote effective collective bargaining representation to all NNU affiliates to protect the economic and professional interests of all direct-care RNs.
- Expand the voice of direct-care RNs and patients in public policy, including the enactment of safe nurse-to-patient ratios and patient advocacy rights in Congress and every state.
- Win “healthcare justice, accessible, quality healthcare for all, as a human right.”
so wisely observed, would be an attack of the ratios themselves. Nurses and patients everywhere in America deserve guaranteed nurse-to-patient ratios.

At a time when RNs and patients everywhere in America desperately need improved staffing to save lives, the growing movement to win ratios nationally is critically important. Nurses are the last line of defense in safeguarding the public health, safety, and well-being against ongoing attacks aimed at deregulation and elimination of safe staffing and other important, long-standing public health and safety laws.

As scholar and nurse educator Adelaide Nutting observed, “The hospitals where we work are in a real sense battlefields where men and women and children are fighting for their lives. In their struggle and their dire need of help they have come to us, trusting us to throw our strength and skill in upon their side, to fight with them the unseen enemy.”

**Implications of the California Safe Nurse Staffing Mandate for the People of the United States**

The CNA/NNOC/NNU professional practice and patient advocacy model definition of “quality” in nursing practice is as follows: Competent, safe, therapeutic, and effective care provided in the exclusive interest of the patient. This model ensures that RNs always act in their patients’ best interests. This is not only the moral obligation of the nurse, inherent within the social contract between the public and the profession of nursing, but it is also an RN duty and right. As direct-care nurses, we have a vested interest, on behalf of our patients and our profession, to be accountable for the provision of care according to the true art and science of nursing as described by florence Nightingale.

Evidence-based practice can be defined as the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of healthcare. The best research evidence is produced by the conduct and synthesis of numerous, high-quality studies. Improved staffing has a significant and positive correlation with improved patient outcomes; research has shown quality of care is improved when staffing is adequate.

The most critical barrier to the health, welfare, and safety of patients in acute-care settings is the lack of a uniform, mandated safe staffing standard, based on individual patient acuity with minimum, numerical and specific direct-care registered nurse-to-patient ratios, including the lack of a protected right to advocate in the exclusive interest of the patient without fear of retaliation.

**RN Template for Problem Solving**

NNU contracts have created new standards for RNs and patient protection. A crucial part of quality patient care is ensuring adequate hospital staffing to avoid putting patients at risk and driving nurses out of the profession. Union representation provides RNs with the tools to have a real voice in patient care decisions, which we use to create safer healthcare facilities to protect our patients, our licenses, and ourselves.

The professional practice/performance committee (PPC) is a staff RN-controlled committee with the authority to research, analyze, and document unsafe practice issues. The PPC has the authority to recommend specific actions to management to resolve problems and power to make real changes. The PPC is an elected, staff-RN committee with representatives from every major nursing unit that meets in the facility on paid time and tracks conditions of concern to RNs through an independent documentation system called the Assignment Despite Objection (ADO). The PPC is a forum through which nurses and nursing concerns can be translated into effective action. If your facility does not have a PPC, you should discuss your concerns with your peers, provide education, develop a written action plan, and organize collectively to hold your facility accountable for maintaining safe RN-to-patient ratios at all times.

**The National Nurses United Action Plan**

The California experience with establishing strict numerical minimums for RN to patient staffing, with mandated staffing up with additional staff based on the patient’s severity of illness and complexity of care needs, is an evidence-based and validated strategy for reducing adverse patient outcomes and improving the quality of care. The fact remains that the quality of our nation’s healthcare system remains under scrutiny and an enormous research base has emerged documenting the link between increased RN staffing levels and better patient outcomes achieved by having effective ratios of RNs present and available to perform vital surveillance functions. Researchers have established the connection between organizational context of care, failure-to-rescue, nurse, and patient outcomes.

The nurse surveillance function is heavily dependent upon human resource decisions made by hospital management, so safe staffing cannot be left to chance; it must be guaranteed by law. The importance of enacting SB 992 (Boxer), the United States Nursing Shortage Reform and Patient Advocacy Act, and HR 2187 (Schakowsky), the Nurse Staffing Standards for Patient Safety and Quality Care Act, so that all patients will have a universal standard of access to safe, therapeutic, and effective nursing care, and all RNs will be protected in the exercise of their rights and duties as patient advocates, cannot be overemphasized. If our nation is serious about cost-effectiveness, improved outcomes, equal opportunity, and equal protection rights, then safe RN staffing becomes an imperative.

Healthcare is a human right, and it is a responsibility of our government, led by the nation’s direct-care nurses, to ensure that right by working to enact an improved and expanded Medicare for All healthcare system.

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RN Trailblazers: Ratios, Rights and Representation

For continuing education credit of 5.0 hours, please complete the following test, including the registration form at the bottom, and return to: NNU/Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the complete home study no later than March 15, 2013 in order to receive your continuing education credit.

1. One of the key safety components of AB 394 is to ensure that patients had access to registered nurses. The safe staffing law directed the Department of Health Services to consider the RN Scope of Practice and Standards of Competent Performance in developing the minimum nurse-to-patient ratios.
   - True
   - False

2. The California ratio law has had a positive impact on recruitment and retention of RNs and has dramatically improved patient outcomes.
   - True
   - False

3. As a result of the increased complexity of critical care, and the use of sophisticated technology, the 1:2 RN-to-patient ratio in the intensive care unit setting is designated as the maximum number of patients which can be assigned to a competent RN at any one time. The ratio of RNs must be increased based on the patient’s severity of illness, level of dependency, and the experience of the nurses providing the care.
   - True
   - False

4. Step-down, telemetry, and medical/surgical units’ minimum nurse-to-patient ratios are the same since there is no distinction between the level and complexity of care.
   - True
   - False

5. Whether the minimum nurse-to-patient ratio in the post-anesthesia care unit will be 1:2 or fewer at all times depends on the type of anesthesia the patient received.
   - True
   - False

6. RNs on a break are not counted for the purpose of compliance with the ratios; this means the RN on a break has transferred direct-care responsibilities to another RN whose assignment does not exceed the applicable ratios.
   - True
   - False

7. The judge’s ruling in the lawsuit filed by the California Hospital Association (CHA) against the Department of Health Services (DHS) was in favor of the hospital industry, stating that ratios do not apply during meals and breaks because, despite the evidence cited in the ratio law, the hospital administrators must have flexibility to assign more patients per nurse “at all times.”
   - True
   - False

8. Patient advocacy demands that RNs must always side with their managers and agree to double up on their assignments during meal and break time, or agree to transfer and discharge their patients to a lower level of care than is safe in the professional judgment of the RN, in order to protect their hospital’s budget and operating margin.
   - True
   - False

9. A hospital may take legitimate action against an RN for disclosing unsafe patient care conditions to government regulatory agencies, such as the Department of Health Services, because it may harm their patient satisfaction ratings.
   - True
   - False

10. The United States Nursing Shortage Reform and Patient Advocacy Act (SB 992, Boxer) and the Nurse Staffing Standards for Patient Safety and Quality Care Act (HR 2187, Schakowsky) are evidence-based companion bills based on existing California law that will expand nursing care and patient protection standards to the federal level.
   - True
   - False

11. One of the characteristics of a profession is that professionals have power over the practice of their discipline, which is often referred to as professional autonomy. A key element of nursing power is the ability to use one’s independent, professional clinical judgment to meet the individual needs of the patient.
   - True
   - False

12. The right and duty of the registered nurse to use independent professional clinical judgment to act as a “whistle-blower” and challenge an unsafe patient care assignment and assert the need for additional qualified staff is an important advocacy and patient safety tool.
   - True
   - False

13. Many direct-care RNs have the perception that their individual hospital’s acuity tool/patient classification system (PCS) and staffing plans and “committees” are not meeting their patients’ needs for safe staffing. For this reason, SB 992 (Boxer) directs the Centers for Medicare and Medicaid Services (CMS) to develop a National Acuity Tool that provides a method for establishing nurse staffing requirements above the minimum staffing ratios, which uses the existing CMS computer-based “hospital assigned DRG codes and patient severity of illness levels” program.
   - True
   - False

14. According to California regulations, a “telemetry unit” is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals. The minimum staffing ratio for a telemetry unit is 1:4.
   - True
   - False

15. Environmental and organizational factors in hospital settings associated with patient and family assaults on healthcare workers, lateral violence, higher error rates, increased patient morbidity/mortality, and other hostile working conditions leading to increased nurse turnover/burnout include understaffing (especially during admission, transfer, discharge, and meal times); a high patient-per-nurse ratio; and unrealistic/high-acuity patient workloads.
   - True
   - False

Name: __________________________________________

Address: ______________________________________________________________________________________

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Day phone with message machine: _____________________________ Email: _______________________________

RN license #: ______________________________Job Classification: ______________________________________