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3. Misleading “patient satisfaction” goals that substitute budget-driven scripting and rounding for actual care

(continued on page 8)
Regardless of age, experience, work environment, or geography, nurses are united in their love of minimum RN-to-patient staffing ratios because, at the end of the day, we all care about one thing: patient safety. As the healthcare industry steps up its relentless pursuit of profits, we nurses know that we are often the last line of defense for patients between life and, well, death.

But there needs to be enough of us nurses around so that we can do our jobs. And that’s why laws establishing minimum, numerical RN-to-patient staffing ratios are so critical, whether at the state or national level. Penalties for breaking the law are needed, too! If we hear one more proposal for a toothless “hospital staffing committee” that invites a few nurses to come and sing kumbaya with managers, we just might have a brain aneurysm.

No, we need real, honest-to-god ratios. In this issue, we have prepared a special section focusing on everything you ever needed to know about staffing ratios. Currently, California is the only state in the nation with hospital-wide ratios set by law, so we devote some space to examining how nurses there won that legislation and have had to defend it at every turn. We also cover which other states are trying to pass ratio bills, what bills NNU is proposing at the federal level, and even what RNs internationally are doing to win safe staffing standards. The studies show that ratios are a win-win: they help save lives and save the hospital money at the same time. And don’t miss the second part of our continuing education home study on ratios and complete the test for five contact hours! We hope that this special focus on ratios brings you up to speed on what’s happening and motivates you to get involved in securing safe ratios where you live and work. Because you know, as we like to say, we’re all going to end up in that hospital bed some day.

In other matters, the 2012 general elections are over and, overall, the results were good news for nurses and working people. Many NNU-backed candidates won, and some critical state ballot measures shook out the way we wanted. Check out the news section for details and more.

But our work is not over. There’s still a long road ahead toward rebuilding our country, winning healthcare for all Americans, holding the officials we just elected accountable, and fighting the corporatization of everything. Starting on the cover and continuing inside, NNU’s executive director RoseAnn DeMoro lists these among at least 101 reasons for RN unity. What’s your reason? Get involved, and let’s find out.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents

Letter from the Council of Presidents

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10 Safety in Numbers
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22 Collective Patient Advocacy Trailblazers, Part 2: The Road to Ratios
In part two of this two-part CE home study, learn about California’s first-in-the-nation RN-to-patient staffing ratio law and efforts to pass this landmark patient safety measure at the national level.
Sutter RNs Strike for Sixth Time

California

On Nov. 1, Sutter Health RNs at seven hospitals at four medical centers in the San Francisco Bay Area went on a one-day strike for the sixth time in their push to secure a fair contract for RNs and maintain safety standards for patients. Nurses have been stepping up their fight against Sutter by calling strikes in conjunction with other actions, as the hospital chain continues to demand deep, unprecedented concessions from its nurse workforce. The strike involved about 3,200 RNs as well as several hundred respiratory, X-ray, and other technicians.

“We can see that pressure does work, and it’s going to take even more pressure,” said Elena Ballock, an emergency room RN at Eden Medical Center in Castro Valley and member of the bargaining committee. “It’s really important now to be even more organized and to kick it up a notch.”

Sutter has proposed more than 100 takeaways in patient care conditions, RN standards, and workplace rights, including stripping part-time nurses of health benefits, attacking RN professional standards such as continuing education, and undermining union principles such as seniority. Many of the provisions were hard won by nurses over many contract negotiations and have been in place for decades. Giving into Sutter is widely considered to be a regression in the nursing profession and standards which could not be recouped for generations. “We have been in negotiations going on 18 months and during this time hospital management has repeatedly misrepresented us as nurses and has shown a lack of respect for the hardworking women and men who are the backbone of our hospital,” said Ann Gaebler, an Alta Bates RN. “As staff nurses, we have a responsibility to fight to maintain standards of care for our patients.”

RNs are also protesting widespread cuts in patient care services. Despite posting nearly $4.2 billion in profits since 2005 and paying dozens of top executives, including CEO Pat Fry, compensation packages worth millions of dollars, Sutter across Northern California has cut back on or eliminated many services, such as pediatrics, skilled nursing, psychiatric units, dialysis, infusion therapy, sub-acute units, and cardiac cath labs, as well as cutting off services such as mammogram screenings and bone marrow transplants. The corporation is also currently building a massive, 300,000-square foot administrative office in Roseville and spending tens of millions of dollars on a questionable computerized electronic medical records system.

A settlement is possible, as RNs point to recent agreements reached quickly at Sutter facilities in San Mateo and Burlingame, Santa Rosa, Lakeside, Santa Cruz, Roseville, and Auburn after hospital management withdrew their demands for concessions.

“What they’re trying to do is going to set us back 20 years if they win this fight,” said Bob Auen, an intensive care unit RN at Eden. “This strike is not just for us, but the entire nursing community. We have worked hard for the standards that we have. Don’t let anyone tell you that you don’t deserve it. You deserve it!” —Staff report

Clockwise from top left: RNs at Alta Bates Summit during a strike rally; RNs at Sutter Delta show their strike spirit; RNs at Sutter Solano on the picket line.
Massachusetts Ban Against Forced Overtime Takes Effect

The law protects nurses by informing them of their rights, said Kelly-Williams. The union has also created a page on its website with an online form for nurses to report any instances where they have been mandated to work overtime. MNA will share its data with the appropriate agencies.

The dangers and costs of mandatory overtime have been well documented in a number of scientific studies published in the last decade, which included findings that nurses working mandatory overtime are three times more likely to make costly medical errors. Over a decade ago, MNA nurses went on strike at St. Vincent Hospital in Worcester and Brockton Hospital—for 49 and 104 days respectively—to stop this dangerous practice.

After a period of relative stability, nurses have seen hospitals revert back to mandatory overtime as their primary staffing tool. In the past two years, this practice has been at the core of contentious negotiations at Tufts Medical Center and Morton Hospital in Taunton (where nurses voted to go on strike over the issue), Baystate Franklin Medical Center, and Cape Cod Hospital.

Barbara Tiller, a nurse at Tufts Medical Center, where nurses almost went on strike over this issue in 2011, explained how her employer and others across the state were cutting staffing and relying on forced overtime. “We were the poster children for what the Legislature in their wisdom sought to prevent with the passage of a state law to ban mandatory overtime,” Tiller explained. “Now, thanks to this law, we have a means of holding hospitals accountable for providing safe conditions to ensure safe patient care.”

—David Schildmeier
Minnesota RNs Oppose Uniform Policy

MINNESOTA

INNESOTA Nurses Association members “Got the Red Out” on Oct. 25 to show MNA solidarity against a uniform policy Allina Health is attempting to force on nurses. The action took place as MNA was entering an arbitration hearing (arbitration is a legal phase of the grievance process nurses take to protect their union rights). Allina implemented the uniform policy without bargaining with the union.

RN Shellie Marvin described the issue in detail on Facebook. Despite nurses requesting to bargain, management refused. The nurses’ contract requires the employer to bargain over working conditions; what one wears to work is a working condition. Past practice and policy was scrubs for nurses. The employer unilaterally decided nurses had to wear a uniform color and refused to bargain over it.

“The employer gave us $75 or less (based on FTE—I work 6VE 12 hr. shifts every pay period and I got $50) each to replace the scrubs we already owned,” write Marvin. “Most of us could not even buy scrubs for two consecutive shifts—much less enough to get us through a ‘week’ without doing laundry. When I work three 12-hour shifts I do not want to do laundry in between. We would have been willing to DISCUSS but they were not. It is about respecting our contract conditions.”

Bargaining Unit Chair Eric Tronnes was proud of his colleagues for fully utilizing the tools available with a union contract. “Today, we combined our legal efforts with collective member action,” said Tronnes. “This autocratic implementation is a glaring disregard for the obligation and respect to bargaining over mandatory subjects impacting nurses working conditions. Members stood together to greet the employer and the arbitrator to show them the power, support for one another and unity.”

Nurses from Allina system throughout the state as well as other MNA nurses participated in the action. —Jan Rabbers

2012 Election Postmortem

NATIONAL

NU REGISTERED NURSES and other working people scored big victories across the country in November’s federal and state elections, delivering an unmistakable message to Wall Street, billionaires, and corporate interests that “America is not for sale,” said RoseAnn DeMoro, NNU executive director.

DeMoro noted that working people and unions played an essential role in reelecting President Obama, bringing populist candidates such as Massachusetts’s Elizabeth Warren and Wisconsin’s Tammy Baldwin to Congress, and thwarting a major attack on unions in California through the defeat of Proposition 32. “The power of working people overcame the efforts to overwhelm our political process with massive spending by the 1 percent, and to prevent people from voting through disgraceful voter suppression efforts,” said DeMoro. “The votes of women are a direct repudiation of attacks on women’s health and rights. The alliance of workers and communities of color in this election is an affirmation of the future for our diverse nation.”

At the federal level, the vast majority of NNU-backed candidates for the U.S. House of Representatives and U.S. Senate won their races.

At the state level, many NNU-supported candidates won. In Maine and Minnesota, those winning candidates helped tip the balance of power in those legislatures toward nurse-friendly majorities. In California, voters passed Proposition 30, which raised funds for schools and other public services mainly through a small tax increase on the state’s wealthiest citizens, and voted down Proposition 32, an attack on the political power of unions. In Minnesota, voters defeated both Amendment 1, which would have banned same-sex marriage, and Amendment 2, a voter suppression measure that would have required voters to present photo identification. Unfortunately, despite a valiant effort by RNs and other supporters, an amendment in Michigan that would have protected collective bargaining in the state constitution did not pass.

But nurses’ work is not over. The challenge now is to hold our elected officials accountable. “Main Street communities are still hurting,” said DeMoro. “The president and Congress should stand with the people who elected them and reject any cuts in Social Security, Medicare, or Medicaid, strengthen Medicare by expanding it to cover everyone, and insist that Wall Street begin to repay our nation for the damage it caused our economy with a small tax on stock market speculation, the Robin Hood Tax.” For more election details, please visit www.NationalNursesUnited.org. —Staff report
California
SAN BERNARDINO
In late September, RNs working for San Bernardino County settled a two-year contract that not only did not give up any concessions but also managed to make some improvements in patient safety standards—a rare feat in a difficult bargaining environment where many public-sector unions have agreed to major wage and benefit cuts. The RNs fought off these threats and even voted to authorize a strike to show the county they would not tolerate a rollback of their standards.

SANTA MONICA
Some 500 registered nurses at Saint John’s Health Center ratified their first contract in late October, ending a long-running dispute at the hospital since they voted to join CNA in May 2011. Key to the two-year agreement are provisions that the nurses say will enhance patient protections, as well as economic gains, no reductions in nurses’ health coverage or pensions, and other contract protections that the RNs say will promote quality of care and retain RNs at Saint John’s.

Florida RNs discussed plans for ratios and lift team legislation at their statewide meeting in October.

Florida
At the statewide meeting in Tampa on Oct. 25, delegates from all 12 facility unions in Florida and from metro committees around the state discussed and then passed two motions on 2013 political action. The first was to sponsor and campaign for the Employment Safety and Safe Patient Handling Act, and the second to sponsor and campaign for the Florida Hospital Patient Protection Act. The state Legislature’s session opens on March 5, 2013. During the upcoming legislative session, NNOC-Florida will concentrate on mobilizing contact by nurses and patients with as many state lawmakers as possible through phone banking, personal handwritten letters, and office visits to discuss the issues. All facilities unions also reported on the most important issues they are tackling either through their grievance procedures or professional practice committees.

Minnesota
Dressed as mindless zombies, nurses took to Main Street in Bagley, Minn. on Halloween to call attention to Sanford Health hospital administration’s proposals that they say are “scary” when it comes to protecting patient safety. “In an unprecedented move, Sanford management came in and threw out a union contract that had been in place for decades,” said Rachel Lewis, an LPN at Sanford Bagley Medical Center. “This contract existed for a reason—it kept our patients safe and gave nurses a voice in the workplace. Our nurses are also being forced to work 14-to-16 hour shifts at times because management isn’t providing us with the ancillary staff needed for non-patient care duties.” A group of 30 Bagley LPNs and RNs have been bargaining with Sanford officials since April 2012 for a new contract.

During the Halloween event, Bagley-area nurses dressed in costume as mindless zombies, and a witch stirred a cauldron with the sign, “What’s Sanford Got Brewing?” Nurses greeted trick-or-treaters, handed out candy, and talked with Bagley residents about the situation with Sanford. “This is our community, and it’s our family, friends and neighbors who stand to suffer if Sanford has its way with this contract,” Lewis said. “We need to make sure they understand what’s at stake.”

Washington, D.C.
Echoing a similar, recent takeover of dialysis operations at a hospital in Maine, MedStar Health recently announced the outsourcing of the hospital’s inpatient dialysis unit to the Colorado-based for-profit dialysis provider DaVita. Nurses were immediately concerned about this transaction since nurses in the dialysis department have more than 200 years of combined dialysis experience. Even more disturbing to nurses is DaVita’s focus on profit, possibly at the expense of patient safety. In 2011, DaVita raked in over $1.1 billion in profits. During this time, the CEO of DaVita, Kent Thiry, a former employee of Mitt Romney’s Bain and Co., earned $17.5 million in compensation.

While the profit motivation of DaVita and its CEO is enough cause for concern, nurses are also alarmed by a new study that suggests that patients dialyzed by for-profit dialysis chains are at increased risk of death.

MedStar nurses sprung into action to advocate for patients by demanding increased scrutiny of the takeover. Nurses passed out flyers outside the hospital on two separate occasions even though hospital administration attempted to use their security detail to harass and intimidate nurses. Nurses even distributed handbills at the Brookland Metro Station to encourage mass transit users to support nurses in their defense of quality patient care. —Staff report
101 Reasons For RN Unity

Why it’s a critical time to take our RN movement to the next level

If there was ever a critical moment for building a powerful, effective movement of all registered nurses to protect the interests of patients and nurses, that time has surely come. Here are 101 reasons for RN unity. All reflect the way in which nurses, their patients, practice, families, and communities are under attack.

Let’s call this a partial list. Add your own reasons. I welcome your thoughts.

1. Budget-driven short staffing, regardless of patient need
2. Erosion of RNs’ ability to practice in the exclusive interest of patients rather than maximizing profits
3. Misleading “patient satisfaction” goals that substitute budget-driven scripting and rounding for actual care
4. Time spent on the caring process considered “non-productive” time
5. Needed patient services cut based on corporate business models to increase profit margins
6. “Evidence-based” medicine eroding care based on individual patients’ needs
7. Hospitals cutting back on basic equipment and supplies needed to provide good care
8. RNs being required to float to specialty units without proper clinical expertise or orientation
9. Replacement of specialist RN care with generalist RN care
10. Efforts to roll back California’s nurse-to-patient ratio law
11. Hospital industry’s nationwide campaign against nurse-to-patient ratios
12. Medical redlining, i.e. hospitals cutting services for lower-income patients and communities
13. Long waits for emergency care
14. Patients being shifted from hospitals to outpatient and home settings where care is provided by non-RNs or family members
15. Laws and regulations that sacrifice patient safety to the bottom line and erode RN practice
16. Lack of protection for non-union RNs who advocate for better patient care
17. Deskillings of the nursing process by routinizing it, i.e. by fragmenting and standardizing it
18. Standardized clinical protocols that limit RN judgment
19. Manipulation of hospital census numbers to short staff and reduce RN hours
20. Speed-up through understaffing
21. RNs being denied meal and rest breaks via short staffing and manager coercion
22. Support staff cuts
23. Mandatory overtime
24. Attacks on RNs’ hard-won scheduling options
25. Increased employer discipline of nurses on pretexts
26. Exposure to antibiotic-resistant and other hospital-acquired infections
27. Hospitals failing to provide protective equipment or inform nurses of exposure to infected patients
28. Unsafe lift policies and other hazardous working conditions that increase injuries
29. Employers’ failure to enact measures to protect staff and patients from workplace violence
30. Lack of mentorship for new RNs
31. Lack of protection for non-union RNs who blow the whistle on unsafe hospital conditions or billing fraud
32. Crises of conscience for nurses unwilling to work in unsafe settings
33. Nurses leaving the profession due to stress, burnout, or employer-created hostile environment
34. Increased management control through workplace surveillance technologies
35. Surveillance of nurses’ use of social media, such as Facebook and YouTube
36. Use of information technology to displace RNs and override RN professional judgment
37. Technology-driven speed-up
38. Use of information technology to downgrade patient acuity to justify short staffing
39. Electronic charting that forces the RN to focus on a computer rather than on the patient
40. Telemedicine displacing hands-on patient care
41. Medical errors caused by electronic medical record systems and other health information technologies
42. RNs being scapegoated for medical errors actually caused by technology
43. Employers’ isolation of individual RNs through technology adoption and other tactics, undermining senses of unity and community
44. Loss of institutional memory of what nursing was prior to the advent of health IT and other management innovations
45. Federal government tying reimbursement to adoption of health information technology
46. Cuts in or elimination of employer-paid pensions (defined-benefit plans)
47. Employers eliminating health benefits or reducing them by increasing out-of-pocket costs, among other changes
48. Reduction of sick leave so nurses are forced to work when sick, a risk to themselves and patients
49. Employers not paying overtime
50. Two-tier wage and benefit structures that pit new RNs against more experienced RNs
51. Reductions in paid continuing education leave for RNs
52. Unpaid hospital internships and preceptorships
53. Attacks on RNs’ hard-won seniority rights
54. Loss of contract-based due process and freedom of speech rights in the workplace
55. Lack of protection against unjust firing or other discipline for non-union RNs
56. Multi-tier healthcare system based on ability to pay
57. Skyrocketing insurance premiums, co-insurance, co-pays, and deductibles
58. Hospitals and physicians making medical decisions based upon insurance coverage
59. Poorer health barometers (such as lower life expectancy) than countries with national health systems

60. Patients delaying preventive care or necessary treatment due to high cost, leading to medical complications

61. Hospital price gouging, billing additional charges for labs, services, and personnel, often without advance patient consent

62. “Non-profit” hospital chains exploiting tax-exempt status for financial gain that vastly exceeds what they provide in community benefits or charity care

63. Medical credit screening being used to track patients based on ability to pay, including requiring advance payment from those least able to pay

64. Healthcare tourism, i.e. patients going out of the county for care

65. Federal government tying reimbursement to “patient satisfaction” scores

66. Hospitals subcontracting travel nurses from outside companies rather than employing RNs directly

67. Increased mergers and acquisitions by big corporate hospital chains resulting in fewer independent and locally-controlled hospitals

68. Hospital and emergency room closures

69. Privatization of public health facilities and services

70. Profitable hospital units being moved to independent medical specialty centers to extract concessions from unions based on budgetary considerations or to justify closing a hospital completely

71. Establishment of for-profit non-acute medical specialty centers to increase profits by evading public oversight

72. Private equity firms buying hospitals to squeeze them for profits, then leaving them drowning in debt

73. Inadequate funding for county and state hospitals and clinics

74. Private hospitals dumping low-income patients on underfunded public hospitals

75. Nurse executive organizations claiming to speak and legislate on behalf of direct-care RNs

76. “Nurse leaders” disdainful of direct-care nursing

77. Differentiated practice and ANA campaign for requiring BSNs

78. State nursing boards being stacked with employer representatives to reverse RN licensure and practice protections

79. Push for national Compact State Licensure to lower standards for all RNs to lowest state requirements

80. Expansion of scope of practice for LVNs/LPNs and unlicensed staff at the expense of RN scope and jobs, as well as patient safety

81. Layoffs and hiring freezes dictated by budget goals, not patient need

82. Hospitals trying to erode the public’s trust in RNs with ad campaigns attacking RNs as overpaid or unreasonable

83. Loss of collective voice through erosion of union rights

84. Non-RN unions seeking to represent RNs, resulting in low priority for RN practice and workplace needs

85. Weak and partner healthcare unions undermining RNs by accepting concession-ary contracts

86. Cuts in nursing programs and reduced access for low-income nursing students

87. Private nursing education increasing debt for new RNs

88. Unemployment among nursing school graduates

89. Corruption of the democratic process by corporate/wealthy spending on lobbying and elections

90. Elimination of public regulatory oversight

91. Nurses supporting extended family members due to the economic crisis

92. Declining health due to economic crisis job loss, home foreclosure, high medical bills, and poor nutrition

93. Environmental degradation increasing preventable illnesses

94. Budget cuts for Medicaid and public health programs

95. Campaigns to cut and privatize Medicare and Social Security

96. Deep, widespread cuts in mental health services

97. Anti-union “right-to-work” laws being extended to more states

98. Weak labor law penalties for employers who violate worker rights

99. Growth of healthcare anti-union industry, including management attorneys, consultants, and strike replacement firms

100. Prevalence of labor-management partnerships in which unions advocate for employers and against the interests of workers and the public

101. Lack of nurses and women generally in leadership roles

RoseAnn DeMoro is executive director of National Nurses United.

The Case for a Stronger National Nurses Movement

Over the past few years, we have seen a sharp escalation of employer assaults, especially on patient protections and nurses’ health coverage and retirement security, as well as on other standards nurses have fought for decades to achieve.

This escalation has coincided with the economic crisis, growing income disparity, and increased political and economic clout for the one percent on Wall Street and in corporate board rooms, including those of hospitals, nursing homes, and other healthcare employers.

The signs are widespread—from uncompromising demands for unprecedented concessions in bargaining to legislative attacks on collective bargaining rights in state after state, to increased discipline and threats against even long-term nurses, to more coercion of nurses and other employees seeking democratic union rights.

We know the pressure on those without a union voice for protection, the disparities and denials of rights they face daily, and the sacrifice demanded of them are far worse.

In the 25-plus years I have been honored to be a director in an RN organization, what has echoed loudly and profoundly for me is how unjust the daily struggle is for RNs and how little they can take home after a lifetime of caring for others.

It is disgraceful when supervisors tell RNs they do not need a union, that their professional status will be reward enough. It’s a lie, a horridious lie with deadly consequences perpetrated by supervisors who are doing the bidding of rich corporate officers and investors. And these supervisors come and go with good bonuses while the RN is so often left with nothing.

All RNs must demand a decent life with fair compensation to support themselves and, increasingly, their families, with good health coverage, a secure retirement plan, and a therapeutic, effective work environment where they can fully advocate for their patients, which means safe working conditions free of harassment and intimidation.

For far too many RNs across this land, every day is a struggle to fight for decent care for their patients, themselves, and their communities.

For that reason, and because we are fighting the clock against aggressive employers who increasingly put their bottom line ahead of nurses, patients, and our communities, and because we live in a society where worker rights and a caring culture often look like endangered species, we need to take the next step.

We have no time to lose in building National Nurses United and unifying all nurses behind one, powerful voice and movement.—RAD
Ratios.

The first time you heard that word you were probably in grade school, learning fractions. Or maybe you were baking a cake and needed to figure out the correct proportion of flour to sugar.

Now, as a registered nurse who is part of National Nurses United’s movement of direct-care nurses, ratios have come to mean a safe staffing standard that has the potential to transform our working conditions for the better and ensure our patients are getting the care and attention that they deserve—and that we were educated to give.

In this issue’s special focus on ratios, we approach the topic from many angles. Since California is currently the only state to have RN-to-patient ratios across acute-care hospital units, we examine the law there, from its origins, to efforts to defend and enforce it, to its effects on the RN workforce, to current attacks against it. We also look at efforts to pass ratios in individual states and at the national level, as well as internationally. And don’t miss part two of the continuing education home study that delves into the nitty gritty of the rationale behind ratios regulations.

We hope you will be informed and inspired to take action to help win ratios where you live and work. Your license and your patients depend on it.
The 10-year legislative and regulatory struggle to enact ratios in California was actually not the first instance of nurse-to-patient staffing ratios developed and won by nurses. After intense lobbying and political pressure from the Australian Nursing Federation (ANF) Victorian Branch, the Victorian Ministry for Health, which is responsible for the operation of acute-care hospitals in that state, adopted the union-backed nurse-to-patient ratios effective Dec. 1, 2000. For medical/surgical units, those ratios varied from 1:4 to 1:6, with more patients permitted on the night shift. For emergency departments, the ratio was 1:3 at all times, and triage and charge nurses were not counted in the ratios.

The Victorian government also committed to and funded reentry and refresher programs for nurses who wished to return to the workforce. The results were impressive. In 1999, Victoria’s hospitals had approximately 20,000 full-time-equivalent nursing positions, with 1,300 of those positions vacant. By October 2001, there were an additional 2,650 full-time-equivalent nurses employed in Victoria’s hospitals—with half that number filling the vacancies and the other half as additional staff to meet the ratio requirements.

The result of the mandated, fixed nurse-to-patient ratios have been similar to the results in California: Improved recruitment and retention of nurses, reduced reliance on expensive agency staff, improved patient care, increased job satisfaction for nurses, more workplace stability, and reduced stress (ANF Victoria Work/Time/Life Survey, 2003).

Bolstered by the success of the ANF in Victoria, the New South Wales Nurses’ Association (NSWNA) began its own campaign to establish ratios. In 2002, the group issued a report titled “Stop Telling Us to Cope.” NSWNA waged a long and comprehensive campaign involving the commissioning of reports and studies, lobbying politicians, and using print, TV, and radio ads to inform the public. Despite this and the public pressure that followed, the government remained intransigent. NSWNA then stepped up its campaign and took a vote in 2010 among members on whether to strike over the ratios issue. The members said yes, and the vote further galvanized the campaign. In an innovative move that attracted a lot of public and media attention, the nurses rented a train and quickly renamed it the strike train.

This pressure by NSWNA improved its bargaining position with the government, and in 2010, RNs won ratios in surgical medical wards, palliative care, and in patient acute mental health units in 2010.

As with the California ratios, there is aggressive opposition from conservative political groups, the hospital industry, and even the government against ratios in Australia. In March 2012, after a well-crafted nine-month campaign, Victorian nurses and midwives stopped the Victorian government from replacing nurses with health assistants as part of the ratios, saved the state’s unique nurse/midwife patient ratios, and achieved some improvements to the ratios. Australian Nursing Federation (ANF) Victorian Branch Secretary Lisa Fitzpatrick proudly announced that patients admitted to rehabilitation wards would now benefit from an improved nurse-to-patient ratio of 1:7 on the evening shift to 1:5 in recognition of the enormity of nurses’ workloads in this specialty. ANF also secured annual funding to work towards a 1:3 ratio in day oncology units.

In the United Kingdom, nurse-to-patient ratios have been discussed for a number of years, mainly on an academic level. Prior to 2012, there had been no real push from organizations representing the nursing profession to pursue mandated nurse-to-patient ratios. 2012 was the year that all changed.

The Royal College of Nurses (RCN), with 400,000 members, is the largest organization of registered nurses in the world. At its 2011
general membership meeting, delegates voted to pursue mandated nurse-to-patient ratios.

Meanwhile, a damning report on unnecessary patient deaths at one large hospital facility had brought the UK public’s attention to the issue of declining nursing care standards. The study highlighted the deleterious effects of poor staffing ratios on patient care. As in many U.S. states without nurse-to-patient ratios, UK RNs consistently report not being able to provide care up to the standard they would wish, with poor staffing being cited as the top reason.

In March 2012, the RCN issued a policy briefing on mandatory nurse staffing levels, citing the growing body of evidence that ratios are effective in providing better patient care and improving recruitment and retention of RNs. The RCN made its first public proclamations that it would be pursuing mandated nurse-to-patient ratios through legislation. The RCN began a campaign to publicize the situation to the UK public, knowing as nurses do everywhere that they enjoy the public’s trust in healthcare matters.

The House of Lords discussed the issue as part of a larger debate on a major new health and social care bill. It was proposed by the House of Lords that a maximum number of patients per nurse should be mandated across the UK.

UNISON is Britain’s largest public-sector union with more than 1.3 million members. At its 2011 conference, a representative from the New South Wales Nurses Association in Australia described the impact of their successful campaign to introduce legally enforceable, nurse-to-patient ratios. UK nurses were energized after hearing how RNs had led the fight and how successful ratios were in Australia.

Following the tabulation and publication of the results of the survey, UNISON made the following statements:

- UNISON will work with other organizations, including patient bodies, to identify a UK model of nurse-to-patient ratios for different specialties. We will aim to use international evidence as a benchmark.
- UNISON will campaign for national legislation to enshrine minimum nurse-to-patient ratios in all healthcare settings. We will be discussing this with [members of Parliament] to encourage them to support our position and to make sure that they are helping their local NHS staff achieve staffing levels that enable them to deliver safe, compassionate, and dignified care.

In late October 2012, UNISON invited an NNU representative and representative from the Australian Nursing Federation to address its nursing conference and help strategize for its own campaign to establish nurse-to-patient ratios through legislation in the UK.

In addition to Australia and the UK, South Korean nurses from the Korean Health and Medical Workers Union have been in contact with the California Nurses Association and National Nurses United for several years and showed interest in many of our initiatives and methods, particularly the establishment of nurse-to-patient ratios. CNA/NNU staff have visited Korea to educate KHMU members on their ratios fight, and Korean nurses have also attended NNU conventions to talk about their own fight to establish ratios.

In 2012, Korean nurses successfully pushed for a ratios bill that was introduced into the Korean Legislature by 20 lawmakers, mostly members of the United Progressive Party (which was formerly the Labor Party). It will be reviewed by various committees this year but is not likely to pass due to the government’s focus on South Korea’s November presidential election. The ratios bill will be reintroduced next spring and if a “liberal” presidential candidate wins, it is likely to pass and be signed into law.

The Korean ratios would not only be for registered nurses but would also ensure that the following healthcare professions have mandated ratios: certified nursing assistants, radiology technicians, laboratory technicians, physical and occupational therapists, pharmacists, nutritionists, and dietary workers. —Gerard Brogan, RN

Australian RNs campaigning for ratios rented a train, picking up RNs at each stop on their way to a huge rally for safe staffing standards.
Gimme a break!

Hospitals target meal and rest periods as a way to undermine the ratios

Ever since minimum RN-to-patient staffing ratios took effect in California in 2004, the hospital industry has repeatedly zeroed in on meal and rest breaks as a spot at which to chip, chip, chip away at the standards.

The requirement that minimum ratio standards be in place at all times, including meals and breaks, has been in place for nearly 40 years in the ICUs, neonatal intensive care units, and operating rooms of California.

Yet just before implementation of the nurse-to-patient ratios in the remainder of hospital units in 2004, the California Hospital Association (CHA) filed a lawsuit claiming that the Department of Health Services’ (DHS) “at all times” interpretation was inconsistent with the language of the regulation and was not clearly stated as a requirement during the lengthy rulemaking process. Hospitals want to be allowed to make nurses cover each other’s patient assignments during breaks, effectively doubling each RN’s patient load during these times and violating the minimum staffing standards set by ratios.

In a key ruling preserving the integrity of ratios, Sacramento Superior Court Judge Gail Ohanesian ruled that same year that CHA was aware of the requirement to maintain the minimum nurse-to-patient ratios at all times, including meal and rest breaks, and that it was the only reasonable interpretation of the nurse-to-patient regulation. Judge Ohanesian stated that “[a]ny other interpretation would make the nurse-to-patient ratios meaningless.” [Emphasis added] She went further in characterizing CHA’s arguments against meal and break replacement as “an attack on the ratios themselves.”

Furthermore, Title 22, Section 70217 makes clear that “assist” and “relieve” do not have the same meaning. The “assigned” nurse must remain responsible for the provision of direct patient care, requiring the assigned nurse’s presence on the unit. If the assigned nurse were not present, another nurse would not be “assisting” but instead would be taking over and assuming the assigned nurse’s responsibilities.

In her ruling, Ohanesian very clearly spells out that the practice of nurses doubling up on patients during breaks is a no-no. “When a nurse takes a break during a shift, the hospital must reassign the nurse’s patient to another nurse and...reassigned patients must not cause the relieving nurse’s patient ratio to exceed the applicable ratios set forth in the regulation,” she wrote.

Under California law, employers are prohibited from staffing an employee for more than five hours per day without providing the employee with a meal break of at least 30 minutes. Employees working between 10 and 12 hours per day are entitled to take two 30-minute breaks under California Labor Code, Section 512 (a). Nurses are not exempt from this law. Although the second break can be waived by mutual consent, the first one cannot. In addition, paid rest breaks of 10 minutes must be provided for every four hours worked. Overtime and premium pay for missed breaks have been the subject of collective bargaining and are often negotiated into contracts that provide the union with the power to assure compliance. Currently, state law provides that most hospital employers must pay a penalty equal to the amount of the employee’s hourly base rate of pay for each meal or rest period that the employer does not provide, up to two hours per shift.

Not just anyone can provide meal and break relief for direct-care nurses. California’s Title 22, Section 70217, Nursing Service Staff, states that only licensed nurses providing direct patient care shall be included in the ratios.

When a nurse administrator, nurse supervisor, nurse manager, charge nurse, or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the staffing count in determining compliance with the ratios.

To give an example, let’s consider the role of charge nurses and what happens if they relieve direct-care RNs during meal and rest breaks. The primary duty of the charge nurse is to provide indirect patient care. Charge nurses coordinate unit work flow; facilitate patient admissions, discharges, and transfers; monitor unit processes and outcomes; and arbitrate conflicts—as well as numerous other indirect nursing activities. The charge nurse acts as an expert
Ratios take time, but are worth it.

Winning ratios in California did not happen overnight. It took years of education, lobbying, organizing, and fighting to get the law finally passed in 1999. Then it took another five years of advocacy and input into the state Department of Health Services to ensure realistic and safe numerical ratios were adopted. And it takes constant vigilance to enforce the ratios and fend off efforts to undermine them or repeal the ratios entirely.

1976 California Nurses Association (CNA) wins first state-mandated ratios of 1:2 for intensive care units.
1993 CNA proposes the first hospital-wide ratio legislation in the United States, AB 1445.
1996 CNA works with consumer protection groups to put Proposition 216 on the state ballot, a measure that would have offered protections for patients against HMOs as well as establishing minimum staffing ratios for hospitals. The measure did not pass, but helped dramatically raise awareness among the public for minimum staffing standards.
1996 CNA-sponsored ratio bill, AB 695, wins approval in the Legislature for the first time. RNs flood the state Capitol with letters, calls, and postcards. Gov. Pete Wilson vetoes the bill after extensive lobbying by the hospital industry.
1998 AB 394 is introduced by Assemblymember Sheila Kuehl. CNA presents 14,000 letters in support and commissions an opinion poll showing 80 percent public support for the bill. After 2,500 CNA RNs rally at the Capitol, the Legislature passes AB 394 and Gov. Gray Davis signs it into law. The bill directs the California Department of Health Services to determine specific ratios.
2002 In a joint press conference with the CNA Board of Directors, Gov. Davis presents the ratios that are ultimately adopted. The hospital industry’s proposal of 1:10 for medical surgical, telemetry, and oncology units is soundly defeated.
2004 On Jan. 1, RN staffing ratios become effective in all California acute-care hospitals. A California Superior Court rejects a hospital industry lawsuit arguing that ratios don’t apply during meals and breaks, ruling that ratios must be maintained at all times.

State of the Union
RNs across the country are working to win ratios

As the first state in the union to win ratios legislation, California provides an important flagship for this critical safe staffing standard. But in addition to national ratios legislation NNU has proposed, RNs around the country are actively organizing their colleagues, the public, and lawmakers to pass ratio bills in individual states so that patients, no matter where they live, can be cared for safely. These bills are largely modeled upon the safe staffing law, AB 394, passed in California in 1999.

Florida

The Florida Hospital Patient Protection Act has been introduced in the Florida Legislature every year since 2009. It would mandate RN-to-patient ratios at all times, guarantee the right of patient advocacy, and provide whistle-blower protection. More than 3,000 community supporters have signed pledges to support the legislation and 22 municipalities have passed resolutions calling on their legislative delegations to pass this important, life-saving law.

Illinois

RNs in Illinois have proposed ratios legislation multiple times, most recently in 2012 with the Nursing Care and Quality Improvement Act. The bill would establish minimum RN-to-patient staffing ratios and codify the right of nurses to act as patient advocates.

Massachusetts

In 2006 and 2008, Massachusetts nurses were successful in passing the Patient Safety Act through the state House of Representatives by overwhelming margins, but continue to fight to get similar action by the state Senate. The Patient Safety Act calls upon the Department of Public Health to set a safe limit on the number of patients...
assigned to a nurse at one time, based on an evaluation of evidence-based research. In addition, the bill calls for staffing to be adjusted based on acuity and the patient's needs and includes language to improve reporting of nurse-sensitive measure so that meaningful quality of care comparisons can be made.

**Michigan**

Michigan RNs have been working on passing minimum staffing ratios since 2004. In February and March 2012, two pieces of “Safe Patient Care” legislation, SB 1019 and HB 5426, were introduced at the state level that would require hospitals to develop and implement a written staffing plan that provides enough nurses to meet the individual needs of patients, and also establish numerical RN-to-patient staffing ratios.

**Minnesota**

The 2012 Staffing for Patient Safety Act would set a maximum patient assignment for registered nurses based on factors including nursing intensity and patient acuity, and would require hospital administrators to work directly with nurses to ensure that adequate resources are provided to keep patients safe. It would also increase the transparency surrounding the staffing process.

**Pennsylvania**

In 2011, Pennsylvania RNs worked to get SB 438 and HB 1874 introduced in the state Senate and House, respectively. The bills would establish minimum RN-to-patient ratios, based on the California law, along with whistle-blower protections. Only direct-care nurses can be counted in the ratios, and the ratios would cover all shifts. Nothing would preclude any facility from implementing higher nurse staffing levels.

**Texas**

As far back as 2007, Texas RNs have been organizing and lobbying legislators to pass the Texas Hospital Patient Protection Act, a bill that would set minimum RN-to-patient staffing ratios, explicitly state the right of RNs to act as patient advocates, and provide real whistle-blower protections. Texas nurses have marched on the Capitol multiple times for ratios, and continue to strategize for passage of this important law. The Texas Legislature only convenes in January of odd-numbered years, so nurses are preparing and mobilizing for a 2013 effort to pass ratios.
Nurses v. Schwarzenegger

RNAs have no tolerance for assault on ratios, telling governor to keep his "hands off!"

"Perhaps some one should have warned Governor Schwarzenegger that nurses are no pushovers." This was the lead to an article published in Time magazine March 7, 2005. The story reported that the governor had been locked for months in a furious feud with the state's RNs over his decision to suspend new state rules that limited the number of patients a nurse must care for.

The firestorm ignited when Schwarzenegger in November 2004 issued emergency regulations claiming that, because ERs and hospitals were closing, the mandate for medical and surgical ratios to be reduced from 1:6 to 1:5 that was to be effective Jan. 1, 2005, must be delayed for three years. He also suspended ratios in emergency departments when under "historical saturation" conditions, which is every minute of the day.

RNAs responded in protest, but Schwarzenegger unwittingly fanned the flames during a statewide women's conference in Long Beach, Calif. that December. During his keynote speech, when California Nurses Association RNs unfurled a banner that read "Hands Off Our Ratios," the governor dismissively responded, "Pay no attention...They are the special interests...The special interests don't like me in Sacramento because I am always kicking their butt."

Nurses said, "Game on." By the time the dust settled more than a year later, the score was nurses 6, Arnold zero.

The recipe for the fight to protect California's safe staffing required 10,000 nurses, a $300 million statewide special election, and 371 days to simmer.

Schwarzenegger underestimated the reaction his move to sabotage the ratios would provoke. Buoyed by his celebrity and huge donations from corporate coffers, the governor thought he could sweep aside nurses and their concerns for patients. Instead his actions, and the nurses' reaction, led to an energized, creative campaign spearheaded by RNs, who staged 107 separate protests and actions in little more than a year.

The campaign not only saved the state's RN-to-patient ratios, but served to invigorate labor in California while sinking Schwarzenegger's approval rating by nearly half. When Schwarzenegger made his decision to go after the ratios, his approval stood at 70 percent, he had an unmatched fundraising base including significant support from the hospitals, HMOs, and drug companies, and faced little public opposition.

Within weeks of the announcement of his emergency regulations, CNA sponsored a radio ad focused on RNs and why the ratio law would bring nurses back to the bedside.

And on Dec. 1, 2004, California nurses mobilized in force. More than 2,500 RNs travelled to Sacramento and circled the state Capitol, demanding "Safe ratios now!" Many of the nurses had never been politically active before, but became passionate about their "special interest"—patients and their safety.

In addition, CNA filed suit in court on Dec. 21, 2004, challenging the validity of Schwarzenegger's emergency regulations.

By now, the state news media were following the drama of "RNs versus The Terminator." A headline on one story in the Economic Times in New Delhi, India read "Nurses Body Slam Arnold."

Throughout the spring and summer of 2005, CNA seized the initiative through a hectic protest schedule that sometimes included three or four protests a week. CNA sponsored a cable TV ad that ran during a film biopic of Schwarzenegger, and dogged him with creative billboards across California.

At each and every fundraising event that Schwarzenegger attended, he was greeted by a group of nurses, leading to the absurd sight of the "Last Action Hero" sneaking in the back door of events because he was afraid to be confronted by nurses at the front door.

The CNA campaign was also marked by street theater and "street heat" as RNs protested in very public places as well. RNs, joined by...
makes clear that the legislation was intended to protect a specific segment of the general population, namely, ‘patients,’ and more specifically, ‘patients in acute-care settings.’ The Court cannot simply ignore this language in interpreting the meaning of the statute. Accordingly, it is the Court’s interpretation that considerations of nursing shortages and economic impacts are outside the scope of the rulemaking because such considerations are inconsistent with the fundamental purposes of the statute to ensure that nurses be accessible and available to meet the needs of ‘patients in acute-care settings.’ Respondent DHS was under a non-discretionary statutory mandate to adopt nurse-to-patient staffing ratios without consideration of nurse availability or economic impacts to the hospitals.”

In other words, the stated grounds for DHS’ decision to enact the emergency regulations were fundamentally inconsistent with the purposes of the ratios law. The Legislature made fundamental policy decisions that quality of patient care is jeopardized because of staffing changes implemented in response to managed care, and that to ensure the adequate protection of patients in acute-care settings, it is essential that qualified registered nurses and other licensed nurses be accessible and available to meet the needs of patients. Staffing in the acute-care setting should be based on the patient’s care needs, the severity of condition, services needed, and the complexity surrounding those services—not whether hospitals claimed they were having money problems.

The ruling also said “the Legislature implemented this policy through an explicit statutory mandate directing DHS to adopt regulations establishing minimum, specific, and numerical nurse-to-patient ratios by licensed nurse classification and by hospital unit for all acute-care hospitals. Even if DHS believes changes to the policy of AB 394 would be desirable from a public health and safety standpoint, neither DHS nor this Court has the authority to change the statutory mandate. Only the Legislature has that power.” Schwarzenegger’s administration appealed the decision.

Schwarzenegger gambled on a comeback. He called for a special election, hoping to pass four measures cloaked as “reform” that were actually intended to increase his power over the state budget and Legislature and erode the voices of his sharpest critics: nurses, teachers, and firefighters.

And so the CNA campaign continued, including a protest outside a Rolling Stones concert in Boston where the governor was holding a $100,000-a-seat fundraising affair. Rumor has it that the nurses’ presence prompted Mick Jagger to shout from the stage, “We love nurses!”

As the campaign entered its final weekend, actor Warren Beatty, who had addressed the CNA convention in September, and his wife and actor Annette Benning joined CNA for a “Truth Squad” bus tour that shadowed the governor’s campaign caravan and reached out to small towns and communities.

With the nurses’ campaign still fresh in their minds, voters turned out on Nov. 8 and pulled the “no” lever eight times. The defeat of every single measure on the ballot was widely seen as a personal rejection of Schwarzenegger and his year of attacks on nurses, teachers, and firefighters which all began with his effort to roll back staffing changes implemented in response to managed care, and decisions that quality of patient care is jeopardized because of staffing changes implemented in response to managed care.

The banner that “kickstarted” the California nurses’ war against Arnold Schwarzenegger in 2004.

other concerned groups, stood at the gates to the governors’ mansion on Superbowl Sunday and engaged in mock ceremonies at Oscar night parties.

Chicago, New York, Phoenix. Wherever the governor travelled outside the state, there were the nurses, including in a driving snowstorm in Washington D.C. As the Los Angeles Times wrote “Everywhere Gov. Arnold Schwarzenegger goes these days, there’s a crowd. But they’re not looking for his autograph.”

Lauded as one of the most innovative political campaigns of all time, nurses even followed the governor online, putting him up for auction on eBay. By now, the nurses were in good company as teachers, firefighters, and thousands of other Californians targeted by Schwarzenegger in his attack on public employee pensions joined with RNs in persistently and creatively protesting the governor and his policies.

Under siege by the most respected members of our communities, Schwarzenegger’s public image changed from adored celebrity to just another politician who, in the words of a CNA billboard, “wheels and deals” while nurses “heal.”

By early summer, Schwarzenegger was in a political crisis: His approval rating had dropped to just 37 percent.

He also suffered another setback when a judge ruled against him and CNA was successful in securing a permanent injunction on June 21, 2005 against his emergency ratios regulations. The ruling, issued by Superior Court Judge Hersher, commanded the state Department of Health Services to set aside each of the emergency regulations establishing minimum, specific, and numerical nurse-to-patient ratios by licensed nurse classification and by hospital unit for all acute-care hospitals. Even if DHS believes changes to the policy ofAB 394 would be desirable from a public health and safety standpoint, neither DHS nor this Court has the authority to change the statutory mandate. Only the Legislature has that power.” Schwarzenegger’s administration appealed the decision.

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On Nov. 10, Schwarzenegger admitted defeat and pulled his appeal of the court decision striking down his emergency regulations. California’s ratio law was safe (for now) and America’s RNs had a new model of organizing to inspire them. —Gerard Brogan, RN
Talk is cheap, write it down
The ADO is a powerful tool to fix staffing

Does this sound familiar? It’s Christmas Eve and you’re working the evening shift in the coronary intensive care unit. There are nine patients, but only five of you. One patient is on medically ordered direct observation, another patient from the cath lab requires near constant care, and a third has a post-coronary artery stent insertion. All three should really have an RN dedicated solely to their care. So then which of you will get stuck with three critically ill patients, or another patient on top of the one who should have a 1:1? You know such an assignment jeopardizes not only the patients, but your license and livelihood. So what do you do?

This untenable situation could have unfolded almost anywhere across the country, but it actually happened in 2009 at John H. Stroger Hospital, the main facility of Chicago’s Cook County Health and Hospitals System, one of the country’s largest public healthcare systems.

Years before, the Stroger nurses, when confronted with an unsafe patient assignment, might have just suffered through the shift without saying anything and prayed that no one died on their watch. Or they might have called the nursing supervisor to object, to which the supervisor would have invariably said, “Do the best you can” (or worse). But now the RNs had one more thing they could do. They documented the incident. They filled out an ADO.

ADO stands for the assignment despite objection form and, when used consistently and throughout the hospital, can be an incredibly powerful tool for nurses to combat short staffing and dangerous working conditions. Tailored to the laws of each state, ADOs provide a written account of a situation that you, as a registered nurse, objected to because, in your professional judgment, it was unsafe. The situation can be too many patients or being floated to a unit where you have no expertise or feel rusty in your skills. The RN keeps a copy, the hospital receives a copy, and the union gets a copy to use in collecting data to spot trends and patterns. The ADO form is admissible in court and may be the only proof an RN has that she or he warned management about unsafe conditions in case something goes wrong with the patient. In states with staffing ratios laws and facilities that have minimum ratios written into their contracts, ADOs are critical for enforcing those standards. In recent years, NNU facilities have also introduced the technology despite objection (TDO) form to document instances where hospital health information technologies have posed barriers for RNs in providing safe care.

In the case of Stroger Hospital, the RNs there were in the middle of an ADO drive. After joining the National Nurses Organizing Committee in 2005, nurses were introduced by the union to the ADO form. But it was a new thing and RNs were not regularly filling them out because they didn’t understand how powerful of a tool they could be in fixing staffing issues.

In 2009, Stroger RN and professional practice committee member Dorothy Ahmad and PPC chair Jim Safrithis, RN decided to start an “ADO drive” to educate their colleagues about how to use ADOs. They put together a PowerPoint slideshow to show RNs how to fill out the form and began presenting it every chance they got.
They told RNs to keep the forms in their locker and helped them understand that the form would help protect their license in case anything ever happened.

After the PPC collected ADOs, it would generate patient care reports based on the documentation and present them at meetings of the healthcare system’s board of directors during public comment periods. “Nurses started filling them out and managers started paying attention because they knew we were making reports and taking them downtown to the county board,” said Ahmad, a critical care nurse. “The hospital supervisors were not giving the commissioners an accurate picture. Our reports said, ‘No, this is not true. This is actually what’s happening.’ We were able to put a little fear in those supervisors.”

Once the ADO drive kicked into full gear, staffing improved greatly and nursing supervisors actually made efforts to correct unsafe staffing situations. “Before, they would just hang up the phone on you,” said Ahmad. And the ADO drive helped prevent layoffs that were proposed by the hospital at one point because nurses were able to show that more, not less, staffing was desperately needed.

Today, staffing is still not ideal, but nurses are routinely using ADOs and understand that they have the power to improve unsafe conditions. “It’s caught on. Nurses understand that this is their protection,” said Ahmad. “Instead of something that’s just verbal, if something happens, I have this piece of paper to prove I called you and told you I opposed this unsafe assignment. The ADOs have really been successful in making management understand that staffing is a shared responsibility. Our attitude to managers is, ‘You’re going to write me up? I’m writing YOU up!’” – Lucia Hwang

Studies show ratios not only save lives, but save money

Multiple research articles demonstrate how improved nurse-to-patient ratios reduce complications, shorten hospital length of stay, improve patient outcomes, increase nurse satisfaction, and reduce the high costs of nurse turnover. Improved nurse-to-patient ratios make economic sense for hospitals in response to the current crisis in healthcare spending. RN-to-patient ratios have been demonstrated to produce significant long-term savings for hospitals by reducing patient costs.

- (2012) “State-mandated nurse staffing levels alleviate workloads, leading to lower patient mortality and higher nurse satisfaction.” Agency for Healthcare Research and Quality (AHRQ)
  Fewer patient deaths: 30-day mortality rates were 10 to 13 percent lower in California than in other states.

- (2011) “Quality and cost analysis of nurse staffing, discharge, preparation, and postdischarge.” Health Services Research
  Investment in nursing care hours better prepares patients for discharge. Cost analysis projected total savings from increase in RN staffing and decrease in RN overtime of $11.64 million and $544,000 annually.

  Fewer RNs is associated with increased mortality and decreased reimbursements, which reinforces the need to match staffing with patients’ needs for nursing care.

  Decreased nurse staffing is associated with adverse outcomes in intensive care unit patients.

- (2009) “The economic value of professional nursing.” Medical Care
  Adding 133,000 RNs to the acute-care hospital workforce across the United States would produce medical savings estimated at $6.1 billion in reduced patient care costs.

  The odds of pneumonia occurring in surgical patients decreased with additional registered nurse hours per patient day. Each additional case of hospital-acquired pneumonia increased the cost per surgical case by an average of $1,029.

  Preventing medical errors reduces loss of life and could
reduce healthcare costs by as much as 30 percent. Increased staffing reduces the likelihood of post-discharge adverse events, making it possible for the hospital to break even on the additional investment in nursing.

- **2008** “Overcrowding and understaffing in modern health-care systems: key determinants in penicillin-resistant staphylococcus aureus transmission.” *Lancet Infectious Disease*
  Understaffing of nurses is a key factor in the spread of methicillin-resistant staph infection (MRSA).

- **2008** “Patient Safety and Quality: An Evidence-Based Handbook for Nurses” United States Department of Health and Human Services, AHRQ Publication No. 08-0043
  Improved RN staffing ratios are associated with a reduction in hospital-related mortality, failure to rescue, and lengths of stay.

- **2008** “Patient Safety and Quality: An Evidence-Based Handbook for Nurses” United States Department of Health and Human Services, AHRQ Publication No. 08-0043
  Every additional patient above four assigned to an RN is associated with a 7 percent increase in the risk of hospital-acquired pneumonia, a 53 percent increase in respiratory failure, and a 17 percent increase in medical complications.

- **2007** “Nurse staffing level and nosocomial infections: Empirical evaluation of the case-crossover and case-time-control designs.” *American Journal of Epidemiology*
  When the number of patients per RN per shift in the ICU decreased from 3.3 to less than 1.6, there was an associated 43 percent odds reduction of nosocomial sepsis. Analysis showed a 30 percent reduction in odds for nosocomial pneumonia with higher RN staffing in the ICU.

- **2007** “Hospital workload and adverse events.” *Medical Care*
  A 0.1 percent increase in the number of patients assigned per nurse led to a 28 percent increase in the adverse event rate. Hospital administrators should allow nursing supervisors the leeway to institute policies that accommodate a larger on-call pool to “flex up” to a safe number of nurses.

- **2007** “Nurse working conditions and patient safety outcomes.” *Medical Care*
  Patients cared for in hospitals with higher RN staffing levels were 68 percent less likely to acquire a preventable infection, according to a review of outcome data of 15,000 patients in 51 U.S. hospitals.

- **2007** “Staffing level: a determinant of late-onset ventilator-associated pneumonia.” *Critical Care*
  A higher number of assigned patients per RN is associated with increased risk for late-onset ventilator-associated pneumonia. VAP prolongs length of stay by up to 50 days, duration of mechanical ventilation by five to seven days, and generates substantial extra costs, in the order of $10,000 to $40,000 per episode.

- **2006** “Are patient falls and pressure ulcers sensitive to nurse staffing?” *Western Journal of Nursing Research*
  Compared to patients whose nurse had three or fewer patients, the likelihood of falling was three times higher for patients whose nurse had four to six patients and was seven times higher when the nurse had seven or more patients.

- **2006** “Nurse staffing in hospitals: Is there a business case for quality?” *Health Affairs*
  Increasing the hours and raising the proportion of nurses who are RNs would result in a $5.7 billion savings and save 6,700 lives and four million days of patient care in hospitals each year.

- **2006** “Charting Nursing’s Future: Balancing Nursing Costs and Quality of Care for Patients.” RWJF Issue Briefs
  More registered nurses working on a hospital unit and reduction of RN overtime hours correlated with fewer readmissions, ER visits post-discharge, and reduced costs.

- **2005** “Improving nurse to patient staffing ratios as a cost-effective safety intervention.” *Medical Care*
  As a patient safety intervention, patient-to-nurse ratios of 4:1 are reasonably cost effective.

- **2005** “A case-control study of patient, medication, and care-related risk factors for inpatient falls.” *Journal of General Internal Medicine*
  Increasing the nurse-to-patient ratio is associated with a decreased risk of falling.
If you build it, they will come

After ratios took effect, RNs returned to the bedside

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, so what was the point of having an unrealistic law? California registered nurses knew differently; they had seen their colleagues leave the bedside in droves, citing the heavy workload and stress as their reasons for doing so. Direct-care RNs were convinced that if ratios were set by law, that their colleagues would return to the acute-care hospital setting.

In fact, after the ratios were introduced, California increased its number of actively licensed RNs by more than 120,000 RNs — tripling the average annual increase prior to its enactment. The total number 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 and surgical units.

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

The picture in California prior to ratios was not pretty. According to the Joint Commission for Accreditation of Hospitals, “Higher acuity patients plus fewer nurses to care for them is a prescription for danger.” 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, some 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 RNs remaining in the acute-care setting.

Ratios were also expected to dramatically reduce nursing turnover, which is very costly both in terms of quality of care and the bottom line of hospitals. According to PriceWaterhouseCoopers in 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 2008 by the Sacramento Business Journal, that the RN vacancy rate for California’s major hospital chains fell below 5 percent after the introduction of ratios, 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.

As direct care RNs predicted, the ratios brought their colleagues back to the bedside, improved quality of care and nurses’ morale, and, far from bankrupting hospitals, actually improved their bottom lines. Everybody gained, not least of which were the patients, who are always the RNs’ first concern.

RN Growth in California

More than 130,000 New Licenses Since RN Ratio Law Signed

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<th>Year</th>
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*RN Active Licenses as of May 21, 2012, California Board of Registered Nursing.
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 (OSHPD). 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.

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.

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.

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 nurse is caring for 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 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.

DHS/FSOR: In a combined labor/delivery/postpartum area of the perinatal service, the minimum nurse-to-patient ratio is to be 1:2 or fewer at all times when a nurse is caring exclusively for women in active labor.

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
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 1:6 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 a 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 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.

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 v. 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.

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.
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

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### National Proposed RN-to-Patient Ratios

<table>
<thead>
<tr>
<th>Setting</th>
<th>Ratio</th>
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</thead>
<tbody>
<tr>
<td>Intensive/critical care</td>
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</tr>
<tr>
<td>Neonatal intensive care</td>
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<tr>
<td>Operating room</td>
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<tr>
<td>Post-anesthesia recovery</td>
<td>1:2</td>
</tr>
<tr>
<td>Labor and delivery</td>
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<tr>
<td>Ante partum</td>
<td>1:3</td>
</tr>
<tr>
<td>Well baby nursery</td>
<td>1:6</td>
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<tr>
<td>Postpartum couplets</td>
<td>1:3</td>
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<td>Pediatrics</td>
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<tr>
<td>Emergency room</td>
<td>1:3</td>
</tr>
<tr>
<td>ICU patients in the ER</td>
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<tr>
<td>Trauma patients in the ER</td>
<td>1:1</td>
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<tr>
<td>Step-down &amp; telemetry</td>
<td>1:3</td>
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<td>Medical/surgical</td>
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</tr>
<tr>
<td>Other specialty care</td>
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<tr>
<td>Psychiatric</td>
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</tr>
<tr>
<td>Rehabilitation unit &amp; skilled nursing facilities</td>
<td>1:5</td>
</tr>
<tr>
<td>Acute respiratory units</td>
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</tr>
<tr>
<td>Burn units</td>
<td>1:2</td>
</tr>
<tr>
<td>Intermediate care nursery</td>
<td>1:4</td>
</tr>
<tr>
<td>Combined labor and delivery, and postpartum</td>
<td>1:3</td>
</tr>
</tbody>
</table>
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.

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

Types of Patient Advocacy
National Nurses United members in all 50 states participate in necessary and appropriate actions and exercises of social, collective patient and professional advocacy to protect the public health. RNs must safeguard patient care standards from erosion, restructuring, degradation, deregulation, and abolition by the large healthcare corporations, hospital chains, HMOs, insurance companies, pharmaceutical corporations, and other powerful economic institutions and interests

Individual Advocacy: Any time an RN intervenes on the patient’s behalf, the RN is being an advocate. RNs are accountable for patient outcome. The RN must be cognizant of and alert to circumstances requiring advocacy. Advocacy circumstances occur when the RN promotes and protects the patient’s interest, such as patient safety (insisting the hospital comply with the safe staffing by scope, ratios, and patient’s individual acuity standards) or the patient’s wishes (honoring the patient’s directive not to engage in heroic measures—no code).

Collective Advocacy: Any time RNs engage in concerted activities on their patients’ behalf, the RNs demonstrate their united power of collective patient advocacy. Such a show of power can range from the activities of facility-based professional practice committees (PPCs) or other union activist committees to mass demonstrations.

Social Advocacy: Any time RNs engage in collective patient advocacy activities to protect the socio-economic conditions and healthcare needs of society at large, the RNs engage in social advocacy.

As corporate healthcare is becoming more the norm, now creating a healthcare crisis, the RN’s advocacy role has become increasingly important; it has evolved to include collective patient and social advocacy.
hospital-assigned DRG codes and patient severity of illness levels program. The total and ongoing cost of developing and maintaining 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 nursing 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 provide 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—and 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

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.

**References**


California Code of Regulations, Title 22, Section 70217 Nursing Service Staff. (2005).
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: ________________________________

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