This home study is a two-part continuing education series. Part I will examine 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: SB 992 (Boxer) The United States Nursing Shortage Reform and Patient Advocacy Act; and HR 2187 (Schakowsky) Nurse Staffing Standards for Patient Safety and Quality Care Act. Part II will continue 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. Look for the second installment and the CE test to appear in an upcoming issue of National Nurse.

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 based on severity of illness and complexity of care. 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 engaging in patient and social advocacy activities, including organizing campaigns and collective bargaining actions.

RNs will gain an appreciation of the historic significance and importance of collective advocacy in unity to protect their licenses 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 to 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 principles of safe staffing, and 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/H.R. 2187).
• Compare and contrast evidence-based patient and nurse outcomes between California and outcomes in other states without current safe staffing ratio laws, including Pennsylvania and New Jersey
• Name two factors identified by the Institute of Medicine (IOM) 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

Patient and Social Advocate Trailblazers: Pioneering Advocates for the Nursing Profession

Since its inception, the profession of nursing has adopted a holistic approach toward health promotion and the prevention of illness and injury. Florence Nightingale founded modern nursing on the tenet that the role of the nurse was primarily to modify the environment of care in ways that enhanced health and healing. In Nightingale’s view, any factor that can affect the health of the patient and the health of the public was relevant to nursing practice. Nightingale wrote: “In dwelling upon the vital importance of sound observation, it must never be lost sight of what...
observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort."

Lillian Wald, the founder of public health nursing, wrote: “The nurse makes her (sic) contribution to human welfare unified and harmonized with those powers which aim at care and prevention.” Wald believed that nursing, as an ideal, should accept a commitment to social causes and to the development of humanity’s mind, body, and spirit. Societal and patient needs, rather than institutionally ordained policies and procedures, should determine the art and science of modern nursing practice. She theorized that the essence and “being” of nursing was a collective achievement and identity, rather than a characteristic of the individual nurse.

This group identity (which Wald called the “spirit of nursing”) was a virtue of nursing that enabled the profession, as a collective, to achieve the anticipated outcomes of nursing practice. Prophetically,
In describing the historic barriers to nursing’s transition from subordinate handmaidens to autonomous professionals, Lavinia Dock, a nurse and political activist, wrote that the nursing sisters of the old religious orders who were “closely confined in shackles of mental subjugation and social renunciation” held no hopes of creating a social order, but rather gave their lives to an unquestioning service of devotion and obedience.

Dock, using the terms truth and justice, urged that nurses become internally motivated and identify with nursing’s commitment to compassion rather than follow a set of rules or behavioral ethics. She maintained that obedience for either the sake of obedience or for a worthless cause deteriorated character, “preventing initiative, independent thought, and self-reliant action.”

Moreover, Dock, referring to expected nurse behavior within hospitals, indignantly maintained that ethics encompassed more than etiquette; it required assertiveness and persistence in advocacy. She wrote, “If nurses walked in the spirit of truth and justice principles, the slavishness of obedience and moral cowardice of subordination would be unnecessary.”

The spirit of nursing for Wald (born of German-Jewish parents) has been likened to the Hebrew understanding of “zedakah,” which literally means righteousness; it is also translated as compassion. Compassion was not merely a sentiment; it was to be expressed in doing works of mercy, assuring justice and equal opportunity for everyone in America’s melting pot. Compassion was not a favor to the poor, but something to which patients had a right. And for the nurses, it was an opportunity reflected in public service and public health nursing.

In the early 1900s, the physician-owned hospital boom started, and the physicians needed nurses to staff them. Nurses of the day owed a loyal allegiance to the institutions or physicians who trained and/or hired them rather than the patients or families. Working conditions were not conducive to safe and therapeutic care or the professional development of nurses. Nursing became focused on tasks in order to care for large numbers of patients.

The practice of nursing within the hospital bureaucracy was merely a reflection of their general position in society as women from a working-class background. Many women were not well educated, nor were they socialized to discuss power or exert advocacy, power, and influence openly.

“The woman question” is a phrase often used in connection with social change in the latter half of the 19th century, which questioned the fundamental roles of women and their right to be in control of their own person, children, property, legal, medical, financial, and other civil rights that we now tend to take for granted. Historically, access to and the content of nursing education has not been fully under the control of nurses. The continued lack of control over both the content and context of nursing work suggests that power remains an elusive attribute for many nurses.

Lillian Wald feared the loss of the “spirit” of nursing. In 1908, 15 years after the establishment of the Henry Street Settlement House, Wald confronted Metropolitan Life Insurance Company’s technocratic focus on money and efficient outcomes. She lamented that “the lovely spirit of nursing” might be eroded if nursing colluded with the marketing schemes of business. Wald sensed that the high ideals of improving humanity and the reality of bureaucracy would be at odds.
Since the mid-19th century, the movement of women into the public and political spheres had been gaining in momentum and popularity. Unique contributions that helped shape the informed outrage and passion for women's rights and civil rights were made by nurse activists who were also deeply engaged in the struggle for improvements in nursing education and the establishment of professional associations to control standards of practice. They expanded the role of nurses to include an understanding of caring beyond a warm interaction between the nurse and individuals in need of care that embraced a social responsibility for their holistic welfare.

Dock observed, “Many matrons and sisters aligned with the governors who were unwilling to stand forth in opposition to their employers.” As a result, from the first decade of the century onward, physicians and hospital administrators have remained in positions of dominance and control over nursing and healthcare.

In 1903 a few nursing leaders were concerned with the many problems that were plaguing nurses in the modern world. They questioned the serious and long-term effects of women’s subjugation to men, and how male dominance in the health field would have a major impact on the professional development of nursing. Their pleas for caution went unheeded and many nurses became accomplices to their own subordination. The warnings of Lavinia Dock, Agnes Karll, and other pioneering advocates for the profession of nursing went unheeded by other nurse “leaders.” In the second decade of the century, nurses were allowed to become non-voting members of the American Hospital Association. They served on joint committees with physicians and administrators, expecting their oppressors to help them solve nursing problems. They sought approval from men, not liberation.

In 1903, **Agnes Karll** founded the Professional Organization of German Nurses (POGN). Karll served on the International Council of Nurses (ICN) with Lavinia Dock. An enlightened German contemporary of Wald and Dock, she too advocated for nurses to organize into unions to assert and defend their rights to control their working conditions. Lavinia Dock described Karll as a woman with dominating strength and intense energy, whose loving kindness and compassion were directed by an intellect keen, searching, and forceful. Karll believed nurses had to broaden their perspective to give up the subservient and short-sighted morality learned in the religious motherhouses. Karll abhorred any physical exploitation or spiritual restriction on nurses. In her eyes, good nursing care required not only technical skills, but a developed personality and a broad mind that would be able to grasp the social needs of the time.

According to Dock, Agnes Karll believed the most important role of future nurses would be to serve as “apostles of hygiene,” and promoters of social progress; not just to take care of the physical needs of patients. In her book, *A Short History of Nursing*, Dock described that the policy of the International Council of Nurses was to bring together, in international union, nurses who, in their homelands, had developed, or who were endeavoring to develop, professional self-government. She states, “As nurses belonging to motherhouses could not organize independently, this was a revolutionary principle...In other words, the International then stood for the emancipation of women workers and the attainment of a completely free professional status, as necessary for the elevation of nursing.”

Karll was concerned about nurses who idealistically undertook professional responsibility at very young ages, only to confront the harsh reality of the work which quickly destroyed their personalities. After a few years, she observed how the nurses were overworked and exhausted; often forced to abandon their profession with disabled bodies and a broken spirit. She devoted herself to the betterment of nurses’ social and working conditions. Karll was a strong advocate of nurses’ insistence on keeping control of their work in their own hands. She travelled extensively, speaking to nurses, city officials, women, and physicians about her new idea of an independent nursing association. Karll and many of her ICN contemporaries believed that nurses have a compelling obligation, inherent in the profession’s broad social responsibility, to apply their skills to identify the preventable components of illness and injury and work to change the course of potentially harmful situations.

In her book *A Short History of Nursing*, Dock wrote that there has always been a tension within unions between servicing members and fulfilling the wider social mission of labor to serve the needs of all working people, whether they are organized or not. The POGN had a tense relationship with the motherhouses and many other traditional associations which felt threatened by the new independent and assertive professional advocacy organization. POGN nurses were challenged by some influential physicians because they called themselves “sisters.” The use of this title, which expressed public respect for the work of the nurse, was defended by one of the board members, who argued that independent professional nurses were forming a sisterhood as well. On behalf of the profession, Agnes Karll proclaimed, “The only practical remedy for all abuses is self organization.”

**The Lady with the Lamp: Theory, Research, and Evidence**

The therapeutic nature of the nurse-patient relationship is grounded in an ethic of caring. Florence Nightingale envisioned nursing as an art and a science: a blending of the humanistic, creative, and caring presence with scientific, evidence-based knowledge, exquisite skills, and integrity in practice. Trust is the moral center of the nurse-patient relationship.

Being morally accountable and responsible for one’s judgment and competency is central to the nurses’ role. This concept is inherent in the social contract between the public and the profession of nursing. The patient’s expectation of help and caring creates an obligation of trustworthiness on the part of the nurse. Trust is the confident expectation that the nurse can be relied upon to act as the patient’s advocate to secure what is best, in the exclusive interest of the person seeking help.
With regard to nursing education, Florence Nightingale said, "The most important practical lesson that can be given to nurses is to teach them what to observe." The so-called "Lady with a Lamp" was a keen observer. She was well educated in science and math; what many people don’t know is that she was an expert statistician. Her skill at collecting, evaluating, and analyzing data illuminated and informed her observations as much as the light from any lamp she carried while tending to soldiers in the Crimea.

Observation is the first step in the nursing process and the scientific method. Nightingale’s *Notes on Nursing* (1860) and *Notes on Hospitals* (1863) contain some of the statistical work with which she methodically demonstrated a decline in hospital mortality rates in conjunction with her sanitary reforms. Notably she was among the first researchers who considered different geographic and demographic variables when analyzing data on patient mortality as published by the Registrar-General in the principal hospitals in England.

Nightingale’s research generated institutional and ideological resistance to change, which led her to admonish her critics by stating: "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm." The predominant institutional values and commitments were being informed and guided by economics, technology, and administrative theory instead of what it means to be human, to be vulnerable, to be ill, to be cured, and to be cared for. Today, the dominant business and economic model of market-based healthcare has coopted the language of business and industry and devalued the art and science of healing.

**What RNs have begun in the name of patient protection, let no man put asunder!**

In the last chapter of her book, *A Short History of Nursing*, Lavinia Dock stated, “Though we share some of our traditions with other workers, our conception of the true nurse is not that of a saint nor a soldier nor yet that of a semi-doctor, nor of a charity worker...The great nursing leaders, whose example we want to keep always before us, were first of all great nurses, but with all their tenderness and devotion, they were vigorous, forceful, persistent men and women, with clear vision and judgment, and with fearless courage.”

She also observed that the hospital of the past was the outcome of “humane and ennobling ideals of service” (without being servile) to one’s community. However, Dock noted that there were those elements who desired to control and dominate the hospital, in pursuit of personal ambition and fame, “who’ve abused it to clear commercial uses.” In the present day, we once again find ourselves engaged in a values-based conflict against self-serving hospital industry administrators and healthcare corporations whose quest for power, profit, privilege, and prestige challenges our caring, compassion, and courage as nurses.

**The Birth of the California Nurses Association**

As hospitals grew in size and complexity in the United States, voluntary associations were created to promote public health, welfare, and education. Nursing reformers during the progressive era saw an opportunity to establish nursing as a recognized profession with a status for scientifically trained and educated nurses separate from the rigid control of hospital and physicians. In 1901, Illinois, New Jersey, Virginia, and New York were among the first states that organized state nurses associations with a goal of developing nurse practice acts. However early practice act legislation was often seriously flawed and contained permissive language and guidelines rather than mandated standards for practice. Untrained persons could still “practice” as nurses for pay as long as they did not claim to be “registered” nurses.

In April of 1903, a group of nurses in California formed a fledgling association during a meeting in San Francisco at Children’s Hospital. Within a few years these first leaders achieved several landmarks. California enacted its first Nursing Practice Act and began to standardize and upgrade nursing education requirements. Procedures for professional licensure and registration of California’s nurses were initially overseen by the University of California’s Board of Regents.

The effort to secure professional standards in nursing education and legal protection, such as obtained in other professions and skilled occupations, entailed continuous dealing with state or provincial legislatures throughout America, and has absorbed much of the attention of nurses’ associations from 1900 to the present day. State societies were formed to bring a united pressure upon legislatures, and the process of growing educational opportunities for nurses was greatly influenced by an inquiry into the conditions of nursing and nursing education influenced by Florence Nightingale’s work.

In the United States, the first preparatory course in nursing theory was introduced by Adelaide Nutting at the Johns Hopkins Hospital in 1901. By 1907 she became the first nurse appointed to a professorship and the first nurse to occupy a chair on a university faculty at Columbia University. Working nurses throughout the country saw a link between recognition of their skills and improved living and working conditions. During this time, hospital construction surged and the care of acute patients and child-bearing women had moved from the home to hospitals. In an address to a group of nursing students, Nutting observed: “We may have great and imposing buildings, the last word in hygienic and sanitary appliances, dazzling operation rooms and laboratories, but that stricken human being lying there has many needs that none of these can satisfy.”

The framework of this historical context provides a relevant background from which to discuss the impact of registered nurse staffing levels on the morbidity and mortality of patients in acute-care hospitals. It also points forward to the present day and the historic achievement of modern nurses, who mobilized in unity, collectively, as an insistent wave of advocacy, to take control of their professional practice and change their working conditions, for the benefit of patients and their profession.

**Back to the Future of Nursing: From Loyal Subordinates to Autonomous Advocates**

**The Evolution of the California Nursing Practice Act**

There are at least three types of power that nurses need to be able to make their optimum contribution. The various types of power can all be categorized as stemming from nurses’ control in three domains: control over the content of practice, control over the context of practice, and control over competence. These support the nurse’s right to professional autonomy and right to assert control of their working conditions.

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. Autonomy is necessary to exert advocacy power and it has been defined as “the freedom to act on what one knows.” A key element of nursing power, therefore, is the ability to use one’s independent professional clinical judgment to meet the individual needs of the patient. The RN’s ability to maintain control of the nursing process and working conditions in the
environment of care is paramount to achieving the optimal patient outcomes for which the nurse is held accountable.

During the 1973-74 legislative session, the CNA proposed major revisions of the Nursing Practice Act, demanding the California Legislature recognize that the practice of nursing was dynamic and constantly evolving and to explicitly recognize the existence of overlapping functions between physicians and registered nurses and permits additional sharing of functions within organized healthcare systems that provide for collaboration between physicians and registered nurses. In exchange for such broad authority, the profession agreed to represent the patient’s interest and to consistently demonstrate competency.

The statute defines the practice of nursing to mean those functions, including basic healthcare, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including “[d]irect and indirect patient care services.” Subsequent to adoption of the Nursing Practice Act, the Board of Registered Nursing (BRN) adopted a regulation establishing “Standards of Competent Performance” for registered nurses.

Standards of Competent Performance

Primary nursing came into great use as the modality for the delivery of nursing care in the 1980s. The primary nurse follows all the steps of the nursing process and uses this position of authority and autonomy to assess, plan, administer and evaluate nursing interventions on behalf of the patient and families. Because primary nurses collaborate with other RNs and health practitioners about the needs of their primary patients, primary nurses become patient advocates within the healthcare delivery system.

In 1986 the BRN further clarified the Nursing Practice Act by incorporating the nursing process as the model for delivery of nursing care and by explicitly defining the duty and the right of the registered nurse as patient advocate.

The Standards of Competent Performance provide that a registered nurse shall be considered competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological, and physical sciences in applying the nursing process, as demonstrated in a number of circumstances. The nursing process is the process used to organize and deliver appropriate nursing care; it is based on the model of the scientific method of inquiry.

Under the statute and regulations, registered nurses (“RNs”) are required to (1) formulate a nursing diagnosis through observation of the client’s physical condition and behavior and interpretation of information obtained from the client and others; (2) formulate a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client’s safety, comfort, hygiene, and protection, and for disease prevention and restorative measures; (3) evaluate the effectiveness of the care plan through observation of the client’s physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members; and (4) act as the client’s advocate, as circumstances require, by initiating action to improve healthcare or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about healthcare before it is provided.

From coast to coast, registered nurses have begun to raise their voices to protest rapidly eroding care standards and unsafe staffing levels that put both nurses and patients at risk. In today’s environment of managed care and corporate medicine, registered nurses have become accustomed to fighting at the bedside, every hour of every day for their patients’ survival as well as their own, desperately trying to provide the care that patients need against all odds.

Passing the Baton: The History of Safe RN Staffing Ratios in California

Background and Significance: Registered nurses are a critical component in guaranteeing patient safety and the highest quality healthcare. Yet, beginning with a 1996 study entitled “Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?,” a series of Institute of Medicine (IOM) reports initiated massive shifts in attention and effort to study hospital staffing and patient outcomes. During the following decade, there was an undercurrent of tension between hospital administrators and staff nurses regarding how many nurses are enough, what their roles should be, and how to recruit and retain them. Hospitals, with an eye on the bottom line, spent most of the 1990s reducing their RN workforce through layoffs and attrition.

Reengineering and restructuring undertaken by hospital management has been designed to emulate industrial models of productivity improvement rather than address nurses’ concerns about fundamental flaws in the redesign of clinical care services and fragmentation of the hospital workforce. Many nurses began speaking out and reporting that staffing in hospitals was deteriorating and unsafe.

In September of 1994, CNA presented written and oral testimony for consideration by the Institute’s Committee on Adequacy of Nursing Staffing. The association presented several key points:

• The adequacy of nursing staffing is an important factor in protecting patient safety and maintaining positive patient outcomes.
• Inadequate levels of nurse staffing and/or inappropriate skill mix of nurse providers have been long-standing and complex problems with a cyclically recurring pattern over a period of many years.
• Research has shown that higher levels of staffing and higher ratios of RNs to total nursing personnel are significantly related to better outcomes of care.
• RNs caring for patients with too few or the wrong mix of personnel deal with “near misses” often on a daily basis.
• “Near misses” are not just occasional events or expected human mistakes. Instead, they are largely preventable or correctable events that result from too few or inappropriately assigned personnel to assess and handle patient care needs appropriately.
• The concept of “near misses” encompasses a wide range of potentially dangerous situations which nurses, if present, detect, prevent, correct, or attenuate.

CNA’s testimony, drawn from survey reports and letters submitted by thousands of RNs and members of the public, documented the real risks that Californian RNs and their patients face every day due to unsafe hospital staffing as a result of hospital restructuring. The survey reports and letters were submitted by CNA to the California Department of Health Services detailing specific incidents of unsafe staffing and extensive narratives on “near misses” and adverse outcomes. A summary of the survey results identified the following:

• Staffing has worsened.
• Current staffing does not allow time for unexpected events—which occur regularly.
• Overall patient acuity has increased.
• Changes in skill mix and/or layoffs of hospital personnel have had a negative effect on patient care.
• Nurses have witnessed inappropriate transfers of patients who were too sick to be sent home or to a less acute-care area of the hospital.

The IOM Committee, at the time, refused to recognize the importance of RN staffing levels and skill mix on quality of patient care in hospitals regardless of existing empirical evidence. Dr. Patricia Prescott published the evidence in 1993 after conducting a comprehensive review. Overall she found substantial evidence linking RN staffing levels and mix to important mortality, length of stay, cost, and morbidity outcomes. Increased RN core clinical staffing was shown to reduce mortality, length of stay, cost, complication rates, and improve both RN and patient satisfaction.

However, the IOM reports were not the first set of clear statements of concern regarding hospital safety and quality. Nor were these reports the first efforts at calling attention to the need for data, public reporting, and the consideration of healthcare quality in light of payment for care. More than 140 years earlier, Florence Nightingale, the founder of modern nursing, raised these same issues. In spite of the passage of well over a century between Nightingale and the release of the IOM reports, seemingly little attention was paid in the interim to creating safer healthcare environments.

Three comparisons of Nightingale’s concerns and recommendations with those expressed in the IOM reports illustrate similar problem identification as well as a shared view regarding the building blocks essential to creating solutions. First, in her publication, Notes on Hospitals, Nightingale identified the paradox of the problem at hand: “In practice a hospital may be found only to benefit a majority and to inflict suffering on the remainder.” Well over a century later, To Err Is Human reports, “… a person should not have to worry about being harmed by the health system itself.” Nightingale goes on to say, “Even admitting to the full extent the great value of hospital improvements of recent years, a vast deal of suffering, and some at least of the mortality, in these establishments is avoidable.” Similarly, To Err Is Human notes, “A substantial body of evidence points to medical errors as a leading cause of death and injury.”

Finally, in a search for solutions and with an eye toward measurement, developing evidence, public reporting, and linking payment with quantifiable performance, Nightingale theorized, “It is impossible to resist the conviction that the sick are suffering from something quite other than the disease inscribed on their bed ticket—and the inquiry ... arises in the mind, what can be the cause?” Related to this, To Err Is Human notes, “Sufficient attention must be devoted to analyzing and understanding the causes of errors in order to make improvements.”

By 2001, two-thirds of U.S. nurses were reporting that their hospitals did not have enough nurses to provide high-quality care, and 45 percent said the quality of care had deteriorated significantly in the previous year. A Commonwealth Fund survey of doctors published that year found that doctors ranked nurse staffing levels of hospitals as one of their most serious concerns in being able to provide top-quality healthcare. A subsequent survey of physicians revealed 64 percent rated hospital nursing staff levels as fair to poor. Patients and their families were also expressing dissatisfaction with their care and an increasing number began bringing private-duty nurses with them to the hospital.

Hospital-based errors leading to the deaths of up to 98,000 patients per year were viewed as scandalous by many. The Institute of Medicine, which produced the report, studied all conceivable variables related to deterioration of patient care conditions except RN staffing ratios according to the Institute for Health and Socio-economic Policy. Hospitals began implementing a variety of nursing care delivery systems, involving so-called “transformational care” and “clinical work redesign” schemes to reconfigure staffing patterns. This clinical restructuring reduced the proportion of RNs to other nursing and/or unlicensed “assistive” personnel and led to increased concerns among direct-care RNs about the threats to their ability to provide safe, therapeutic, and effective patient care.

As hospitals signaled to nursing schools that fewer nurses were needed, school budgets were slashed and training programs for RNs were curtailed. This was occurring when the increasing complexity and acuity of hospital caseloads called for even more skilled nursing care provided by registered nurses. Hospitals hired consulting firms, paying them hundreds of millions of dollars to implement work role redesign models with an emphasis on shifting registered nurses away from hands-on care to serve as “team leaders” of the lower-paid, lower-skilled licensed and unlicensed assistive personnel.

Guided by market-driven goals of cost-cutting and profit-making rather than assurance of quality care, health firms began to implement restructuring programs in the corporate, clinical, and technological arena. Although based on a manufacturing model that devalues the intellectual work of nursing by breaking up the nursing process into a series of “tasks,” these schemes are often referred to as “patient-centered” or “patient-focused” care.

Patient care staffing standards sharply deteriorated in hospitals across the country as hospitals cut vital services. Administrators failed to staff available beds in order to maximize their profitability. Patients and nurses experience the effect every day with unsafe staffing levels. Many nurses fled the profession due to unsafe staffing, mandatory forced overtime, and double shifts. They feared the conditions would cause them to harm patients and they feared losing their license when required to delegate complex care to lower-skilled workers. Today, it is still legal for RNs in 49 states to be assigned 10 to 16 patients, or more, at a time!

Workplace Hazards and Risk of Patient and Nurse Harm

Although there are five categories of workplace hazards found in hospitals, the U.S. Department of Labor’s Occupational Safety and Health website lists “stress, workplace violence, shift work, inadequate staffing levels, heavy workload, financial constraints and increased productivity demands/speed up, increased intensity of work, exposure to occupational violence and increased patient acuity” in the “psychological hazard” category. This category is defined as: “Factors and situations encountered or associated with one’s job or work environment that create or potentiate stress, emotional strain, and/or other interpersonal problems.” Implications for the quality and efficacy of the healthcare an organization provides have been a particular focus on investigations of stress and burnout. Both generally and specifically are related to psychological aggression, hostile work environments, horizontal violence, and bullying.

Stress and burnout in nurses negatively affects patients’ perception of the quality of their care and also contributes to a higher likelihood of medical errors. Stress-related attrition exacerbates already inadequate RN-to-patient ratios and can generate considerable labor costs for healthcare organizations. A survey of turnover in acute-care facilities found that replacement costs for nurse positions were equal to or greater than two times their annual salaries. All of these factors are cited in the literature as being associated with or potentiated by too few staff and/or an insufficient number of appropriately licensed, clinically competent RN staff present and available.
to provide a high standard of safe, therapeutic, and effective patient care. Research has shown these risks can be mitigated by increasing the proportion of RNs available to care for patients.

As consumers, we expect specific standards for clean air and water, limits on classroom sizes, and staffing ratios for airlines, day care centers, and nursing home staff. Hospital patients and the registered nurses who care for them should also be entitled to minimum safety standards and public protection. High-acuity patients, a high number of patients per nurse, changes in skill mix, models of care delivery, technology, organizational restructuring, fatigue, frequent interruptions, and workflow redesign continue to occur. Each of these changes in the RN practice environment potentiates the risk of patient harm, nurse burnout, and low nurse and patient satisfaction, according to the Institute of Medicine (2004).

The 1996 Congressionally mandated Institute of Medicine study concluded that evidence-based standards were insufficient to guide hospitals, nurses, and policymakers in prescribing hospital nurse staffing. Pronovost (1995) and his associates helped fill this void by creating an evidence base for establishing nurse staffing standards. Their study examined the relationship between nurse-to-patient ratios in the intensive care units (ICUs) of Maryland hospitals and the risk for complications after abdominal aortic surgery. They found that patients in hospitals where ICU nurses care for three or more patients have significantly increased risk for medical complications compared with patients in hospitals where ICU nurses care for one to two patients. Of interest, California adopted an ICU nurse-to-patient maximum staffing ratio of one RN to two patients in 1976. It was signed into law by then-governor Jerry Brown. Pronovost et al. had provided evidence to validate that standard. On the other hand, the researchers noted that employing fewer nurses to care for patients would end up costing hospitals more. Inadequate nurse staffing levels lead to increased resource use, particularly in the form of longer lengths of stay, thus negating expected labor savings. Having an ICU nurse-to-patient ratio of less than 1:2 during the day increased mean ICU days by 49 percent.

The findings of a 20-hospital study conducted by Aiken, et al. of inpatient AIDS care are similar to those of Pronovost and colleagues. She found substantial variation across hospitals in risk-adjusted 30-days-from-admission mortality among patients with AIDS, as well as substantial differences in nurse-to-patient ratios. After accounting for other important factors, Aiken and her colleagues estimated that staffing up with an additional nurse per patient day cut the odds of dying by more than half.

The researchers also found that the hospitals that had the most favorable nurse-to-patient ratios had significantly shorter overall lengths of stay as well as fewer ICU days. Thus, the overall cost of care was no greater in hospitals with more favorable nurse-to-patient ratios. These findings add to the evidence presented by health economist Dr. Uwe Reinhardt in his compelling essay, “Spending More through ‘Cost Control’: Our Obsessive Quest to Gut the Hospital.” Reinhardt showed that flawed accounting practices in healthcare often result in managerial and policy decisions that adversely affect patients without reducing costs. More than a decade of research suggests that the organizational climate in which care takes place is as important as staffing in determining patient outcomes.

The effects of excellent nurse staffing can be undermined in organizations that restrict nurses’ autonomy to act within their scope of expertise, that provide inadequate administrative support, or that fail to give nurses authority commensurate with their high level of responsibility for patient well-being. Recent restructuring and reengineering of hospitals have adversely affected nurses’ practice environments and contributed to the current perception of an acute shortage of hospital nurses. Numerous studies in the United States continue to document publicly that patient deaths are tied to a lack of sufficient numbers of nurses to meet their complex needs. In addressing the nursing shortage, the industry focus has been on incentives such as signing bonuses, tuition reimbursement and relocation fees, without addressing the underlying dissatisfaction created by the barriers to practicing the work nurses love: the hands-on work of providing care for another that Nightingale described as a physical, spiritual, moral, and artistic profession informed by science.

When nurses leave organizations as fast as they are hired, money is wasted, experience is lost, and patient care deteriorates. What good is it to have an industrial model of treatment and cure or physical care when nurses and practitioners alike are disenchanted, leading to moral distress, burnout, and poor patient outcomes?

Nurses strive to find the time to help the patient and the patient’s family make sense of the illness and the pain that has fallen upon them against a system whose dictates require that caring is a luxury the bottom line will not tolerate. One nurse after another today leaves her shift with a crisis of conscience knowing that all that should have been done to heal the patient is no longer possible. The consequences for the public are enormous.

Poor staffing levels mean a patient may go hours without seeing a registered nurse. Is it any wonder under such circumstances that the Institute of Medicine (2003) reported that preventable medical errors claim the lives of as many as 98,000 patients every year – more than from highway accidents, breast cancer, or AIDS? Many nurses have chosen not to continue to work in hospitals or to leave the profession entirely, creating a growing alarm about a new nursing shortage that the healthcare industry itself largely created by reckless cost cutting and restructuring measures.

The brave souls who remain as nurses are attempting to use every resource available to fight back for their patients and the dignity of their profession, which is so dramatically needed in a society with an aging population, new resistant diseases, and 50 million people without health insurance. Nurses across the country are insisting on changes in hospital conditions that will ensure safer standards, protect patients, and encourage nurses to return to the hospital setting. RNs have been forced to picket and even strike to promote the well-being and safety of their patients. Gone are the days when nurses will quietly accept the destruction of the healthcare system and their profession.

**The Road to Achieving Ratios and Staffing-Up Based on Patient Needs**

As early as 1992, the California Department of Health Services (DHS) considered proposing regulations requiring staffing ratios for registered nurses in acute-care hospitals. However, at that time, DHS determined not to impose minimum ratios and instead opted for regulations requiring that hospitals implement a Patient Classification System (“PCS”). The PCS was intended to ensure that the number of nursing staff was aligned to the healthcare needs of the patients, while still allowing the provider flexibility for the efficient use of staff. The PCS regulations provide a framework to establish nursing staff allocations based on nursing care requirements for each shift and each unit.

The PCS system requires the establishment of a method to predict nursing care requirements of individual patients. This method
must address the amount of nursing care needed, by patient category and pattern of care delivery, on an annual basis, or more frequently, if warranted by the changes in patient populations, skill mix of the staff, or patient care delivery model. The PCS system also requires (1) a method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift; (2) a method to discern trends and patterns of nursing care delivery by each unit, each shift, and each level of licensed and unlicensed staff; (3) a mechanism by which the accuracy of the nursing care validation method described above can be tested; (4) a method to determine staff resource allocations based on nursing care requirements for each shift and each unit; and (5) a method by which the hospital validates the reliability of the patient classification system for each unit and for each shift.

Following the adoption of the PCS, DHS spent more than four years working with nursing and hospital organizations, including the California Nurses Association, to develop the final PCS regulations, which became effective on January 1, 1997. Although it does not appear that any formal studies were conducted to determine the effectiveness of the PCS, it was the perception of many direct-care RNs that the PCS was not meeting the patients’ needs for staffing, CNA claimed this perception was supported by a 1998 survey conducted by the DHS itself.

According to the Senate Health and Human Services Committee, as reported by the Senate Rules Committee: “In 1998, the DHS surveyed over 160 acute-care hospitals during the Consolidated Accreditation and Licensing Survey and found that most of the hospitals surveyed were not in compliance with Title 22 patient classification. 61% of the facilities were out of compliance with Title 22 with 87% deficient in the specific sections that require the facility to establish a PCS and to staff based on patient needs. It became clear that the majority of facilities were not complying with Title 22.”

Consequently, CNA concluded that the PCS was not meeting its intended purpose, and sponsored AB 394 to require the establishment of minimum, numerical licensed RN-to-patient ratios. AB 394 is the first RN-to-patient acute-care staffing ratio law in the United States.

There Ought to Be A Law! Organized Nurses and Patient Needs Versus the Hospital Association Bottom Line

the California nurses association sponsored AB 394 to ensure safe staffing for patients in California. AB 394 was introduced by California Assemblywoman Sheila Kuehl and it was passed by the Legislature after extensive and aggressive lobbying and highly visible mobilization campaigns by RNs as advocates for the adoption of this important patient safety legislation. It was signed into law by Governor Davis on October 10, 1999, adding section 1276.4 to the Health and Safety Code (HSC). This law is the nation’s first law mandating RN staffing ratios for acute-care hospitals.

In adopting the new bill, the Legislature declared that the accessibility and availability of nurses is essential “to ensure the adequate protection of patients in acute-care settings.” The Legislature clearly believed that the quality of patient care was related to the number of licensed nurses at the bedside, and wished to ensure a minimum, adequate number. The California Department of Health Services (DHS) was charged with determination of and implementation of the staffing ratios.

Previous attempts had been made to obtain mandated ratios in California. The first attempt was in 1993 when AB 1445 was introduced into the Assembly, but the bill died in committee. In 1996, CNA sponsored an HMO reform ballot initiative, Proposition 216, which included a requirement for the DHS to set ratios in healthcare settings. In 1997, AB 695 passed the Legislature, but it was vetoed by then-Governor Wilson after an aggressive anti-reform lobbying campaign financed by the hospital and insurance industry.

AB 394 was introduced in February 1999. It immediately encountered strong opposition. The Assembly Committee on Health reported the hospital industry’s opposition to legislatively mandated nurse-to-patient ratios for acute-care hospitals in its April 6, 1999 report on AB 394:

“The California Healthcare Association (CHA) opposes the bill because it legislates nurse staffing levels for hospitals based on ratios. CHA believes the public policy of the state should be to require hospitals to base nurse staffing levels on the specific care needs of the patients as measured each shift for every unit, not on staffing ratios.” As a matter of fact, such regulations were already, and continue to be, in effect – an inconvenient truth, perhaps for an industry that all but ignores them.

The CHA also argued that the “nursing shortage” would make it very difficult for hospitals to recruit and hire the nurses needed to meet the ratios.

In California, based on the legislative findings, the statute expressly directed the DHS to adopt, for acute-care health facilities, “regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit.” (Health & Safety Code § 1276.4(a).)

The legislation also, and importantly, expressly provides that the ratios are to be minimums, and that the existing Patient Classification System (PCS) shall remain in place. The minimum nurse-to-patient ratios were intended to set the baseline licensed staffing requirements for each unit type without disturbing the existing PCS staffing requirements which may require supplemental staffing as circumstances warrant. Accordingly, the legislation provides that notwithstanding the minimum nurse-to-patient ratios, “[a]dditional staff shall be assigned in accordance with the documented patient classification system for determining nursing care requirements.” (Health & Safety Code § 1276.4(b).)

The statute further directs that the minimum staffing ratio regulations shall be adopted “in accordance with the department’s licensing and certification regulations, as stated in Sections 70053.2, 70215, and 70217 of Title 22 of the California Code of Regulations, and the professional and vocational regulations in Section 1443.5 of Title 16 of the California Code of Regulations.” (Health & Safety Code § 1276.4(a).) These sections describe or explain the professional obligations of registered nurses in the provision of healthcare.

For example, section 70053.2 describes the Patient Classification System. Section 70215 provides that a registered nurse must provide, among other things, ongoing patient assessments as defined in the Nursing Practice Act, and the planning, supervision, implementation, and evaluation of nursing care to each patient in accordance with the elements of the nursing process. Section 70217(6) likewise provides that nursing personnel shall assist the administrator of nursing services, provide direct patient care, and provide clinical supervision and coordination of care given by licensed vocational nurses and unlicensed nursing personnel.

And, as discussed above, section 1443.5 of Title 16 describes the applicable nursing “Standards of Competent Performance.” The statute provides that “in case of conflict between this section and any provision or regulation defining the scope of nursing practice, the scope of practice provisions shall control.” (Health & Safety Code § 1276.4(b).)
The Beginning of a Nationwide Nurses Movement

Establishing safe RN staffing ratios is part of a nationwide movement to protect patients. California was the first state to mandate staffing ratios, but a number of other states have made similar attempts. From 1996 to 2001, Massachusetts, New Jersey, New York, and Pennsylvania introduced legislation targeting some form of mandated staffing ratios. Since the healthcare industry’s self-imposed and market-led restructuring efforts began in earnest, spurred by the failed Clinton health plan, more than 20 states have proposed bills/regulations to protect patients. There is little doubt that the legislative push to ensure patient safety will continue.

California has been one of the most negatively impacted states by the healthcare industry’s restructuring programs and the widely acknowledged problems of the nation’s managed care experiment. Other states are also feeling these effects and NNU nurses are collectively pursuing ratio legislation, based on the successful law passed in California. Among the basic principles for staffing California’s AB 394 sets out are patient care needs and the severity of the patient’s condition or illness. AB 394 directed the DHS to “adopt regulations that establish minimum, specific, and numerical” nurse-to-patient ratios for patients in acute-care hospital units.

In addition, the legislation mandates that the nurse-to-patient ratios shall “constitute the minimum number” of nurses allocated; and, “additional staff shall be assigned in accordance with a documented patient classification system (PCS) for determining nursing care requirements.” The PCS must include “the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care.”

Patient Classification Systems: Time to Re-Tool the Acuity Tools

Most patient classification systems (PCS) were developed in the 1960s for the purpose of forecasting staffing needs on patient care units. They were also used as administrative tools to project or monitor unit workload. It became very clear from the outset that “maximum flexibility” and “efficient use of staff” became the cornerstone of hospital administration “maximum flexibility” and “efficient use of staff” became the cornerstone of hospital administration, the PCS was intended to assure that the number of nursing staff granted supreme flexibility by converting the average needs of a group of patients on a specific unit to meeting the individual needs of each patient. It also codified some of the concepts identified in the Patient Intensity for Nursing Index (PINI), which is a valid measure of the volume or amount of care and the complexity of nursing care delivered to patients (Prescott). According to Prescott, “Severity of illness refers to the patient’s medical condition and how ill the patient is in terms of the abnormality and instability of his physiological parameters.” In addition, “Clinicians recognize that all patients with the same diagnosis are not equivalent and that more severely ill patients require more care than less severely ill patients.”

In summary, one of the key Patient Classification System provisions is that it must meet the nursing care needs of individual patients that reflect the assessment made by the direct-care registered nurse assigned to the patient. Moreover, one of the most important factors the RN must consider is the type of licensure mandated to provide the required care. It is outside the LVN scope of practice to have an individual patient care assignment. LVNs must be assigned to an RN and are only allowed to provide basic nursing care functions and those interventions with routine and predictable outcomes that are within their scope of practice and level of competence for patients who are stable and not medically fragile.

When a direct-care RN is assigned to provide clinical supervision of patients assigned to the LVN/LPN, the direct-care RN has the responsibility under the law to carry out the nursing process on all of the results can be other than intended. Winters (2006) and colleagues have argued, for example, that the widespread use of rapid response teams, for which the evidence is equivocal, might be exposing facilities to “financial and reputational risks.” They asserted that if other options already well-supported by the evidence, such as increased nurse staffing—were pursued first, the complications suffered by the patients that these teams treat might be prevented!

Been There, Done That! Direct-care RN Criticisms of Existing PCS

The PCS does not adequately measure the domain of nursing practice as defined in the California Nursing Practice Act and the Standards of Competent Performance. The latter mandates that the nursing process is the required standard/model for delivery of nursing care by a competent RN.

There are numerous reliability and validity issues. There was, and still is, a significant disagreement among direct-care RN staff in classifying individual patients while utilizing an existing PCS tool, resulting in the inability to validate the staffing requirements. In addition, the PCS instrument/tool did not capture what it was intended to measure, which is individual patient acuity. In most instances, the individual patient acuity does not exist or is ignored, and staffing is driven by budget and census.

The focus of the PCS tool was on the amount or volume of nursing care (nursing care hours) required and not on the complexity of nursing care needed by an individual patient.

PCS tools are designed to control RNs’ decision-making and professional judgment. This rigid computerized system fails to permit the direct-care RN to override the system when, based on his or her professional judgment, an individual patient requires more care than that allowed by the PCS/acuity tool.

It reduces the profession of nursing to lists of tasks, procedures, and patient characteristics.

California’s safe staffing law, AB 394, put a halt to the DHS-granted supreme flexibility by converting the average needs of a group of patients on a specific unit to meeting the individual needs of each patient. It also codified some of the concepts identified in the Patient Intensity for Nursing Index (PINI), which is a valid measure of the volume or amount of care and the complexity of nursing care delivered to patients (Prescott). According to Prescott, “Severity of illness refers to the patient’s medical condition and how ill the patient is in terms of the abnormality and instability of his physiological parameters.” In addition, “Clinicians recognize that all patients with the same diagnosis are not equivalent and that more severely ill patients require more care than less severely ill patients.”
the assigned patients, regardless of how the LVN/LPN is used within the assignment. Direct-care RNs cannot assign nursing/patient care tasks to subordinates such as LVNs/LPNs, unlicensed assistive personnel/nurses aides, and medical assistants in the acute-care hospital setting when there is no statutory or legal authorization allowing them to do such tasks. The direct-care RN retains accountability for the competent provision of all nursing care provided to a patient.

**Safe Staffing Essentials**

Only licensed nurses providing direct patient care are included in the ratios because the intent of the statute is to ensure that nurses are “accessible and available to meet the needs of the patient.” While nurse administrators, nurse managers, and nurse supervisors have vital supportive, supervisory, and oversight responsibilities, it is not their role to be readily available and accessible to directly meet the needs of the patients when they are functioning in their administrative or supervisory positions.

The ratios are the same minimum standard for every shift. They represent the least staffing the California Department of Health Services (DHS) believes is compatible with safe, quality patient care in the acute-care setting. Because of the pressures of managed care and the increasing complexity of acute-care services, people who are hospitalized now tend to require more intense and sophisticated care for fewer days. When combined with the flexible shift scheduling in hospitals (i.e. eight-, 10-, and 12-hour shifts may be available on the same unit), it is no longer feasible to reduce nursing staff during evening, night, or weekend hours.

The ratios represent the maximum number of patients assigned to any one nurse at any one time. It is DHS’ intent not to permit averaging the numbers of patients and nurses during a single shift, nor averaging over time. This prohibition of averaging is consistent with the way existing ICU and NICU nurse-to-patient ratios have been interpreted and enforced since they were put in place over 26 years ago. The 1:2 ratios in those units have historically been interpreted to mean that an individual nurse in an ICU may not have a patient assignment that exceeds two patients at any time.

RNs have a duty to recognize circumstances that cause harm to their patients and activities and decisions that in their professional judgment are against the interest of their patients. RNs have the right to advocate in the exclusive interest of their patients and must be able to do so without fear of retaliation or reprisal. Direct-care RNs are inseparably linked to patient safety. Safe staffing standards based on the patient’s acuity allows the direct care RN to observe subtle changes in the patient condition, recognizing the early signs and symptoms of the beginning of a patient’s decline. These can only be detectible through the direct-care RN’s physical presence and her/his ability to directly observe the changes in the patient’s physical and cognitive status.

Decisions about nurse staffing levels should be based on sound evidence and health policy science to reduce the risk of preventable complications and ensure optimum patient outcomes. The strength of the empirical, peer-reviewed research findings of Dr. Linda Aiken and her colleagues’ 2010 study supports the immediate implementation on a national scale of California’s landmark RN-to-patient ratio law as a benchmark in order to protect the public. The evidence is clear and convincing that minimum RN-to-patient ratios, with staffing-up based on the patient’s acuity and severity of illness, is the most important and cost-effective safety measure for ensuring therapeutic and effective patient outcomes.

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

In 2002, Dr. Linda Aiken and her associates published a study that proved the relationship between patient-to-nurse ratios, patient mortality, failure to rescue (deaths following complications) among surgical patients, and factors related to nurse retention and burnout. Dr. Aiken stated, “Because of the importance of the nurse-patient relationship various entities have, over time, advanced proposals designed to ensure that there are sufficient numbers of nurses to meet patient needs. One such proposal has been and is minimum staffing ratios.”

The 2002 Aiken study was published in the *Journal of the American Medical Association*, a widely respected, peer-reviewed journal which contributed to its credibility and acceptance by medical and nursing professionals. The study estimated the probability of death and “failure to rescue” for each patient under various patient-to-nurse ratios. The odds of patient mortality increased by 7 percent for every additional patient beyond four in the average nurse’s workload in the hospital; the difference from four to six patients per nurse and from four to eight patients per nurse would be accompanied by 14 percent and 31 percent increases in mortality respectively.

Their findings at the time suggested that officials in California’s Department of Health Services were wise to reject ratios of 10 patients per one nurse in medical and surgical units proposed by the hospital industry stakeholder groups, including the California Healthcare Association, the American Nurses Association-California, and the California Association Nurse Leaders. The outlandish recommendation by hospital industry trade groups was surprising only in the fact that the Department of Health services had already determined that the appropriate ratio, based on Office of Statewide Health Planning and Development (OSHPD) data, showed that 75 percent of California’s hospitals were already staffed at a level of 1:5.6 or higher for medical/surgical units.

That same study showed that approximately 50 percent of all hospitals were meeting the 1:5 ratios in their medical/surgical units. However, the fact that the administrative and executive nursing leaders aligned themselves with the bottom-line business interests of their institutional employers, thereby putting profits above patient needs, was shocking. Many of these administrators retain RN licensure, but they have no direct line of accountability for the provision of patient care or patient outcomes. Their intellectual dishonesty, coupled with a failure to advocate in the exclusive interests of patients, would appear to constitute unprofessional behavior by any reasonable standard.

Dr. Linda Aiken and her colleagues have noted that RNs constitute an “around-the-clock” surveillance system in hospitals for early detection and prompt intervention when patients’ conditions deteriorate. “The effectiveness of nurse surveillance is influenced by the numbers of RNs available to assess patients on an ongoing basis.” “The association of nurse staffing levels with the rescue of patients with life-threatening conditions suggests that nurses contribute importantly to surveillance, early detection, and timely interventions that save lives.” According to the Institute of Medicine’s 2003 study, cutting RN-to-patient ratios to 1:4 nationally could save as many as 72,000 lives annually!

Another plain way to illustrate the significance of that statistic is to consider that when a hospital imposes a workload of eight patients per RN, we know that by refusing to accept the scientifically recommended ratio of four patients per RN, then, despite the staff RN’s
best effort, one out of every four patient deaths happens unnecessarily. Just like the family of that fourth patient, we think it’s wrong to double the workload of RNs when you know that’s going to happen. Replications of Dr. Aiken’s initial study in Canada, England, and Belgium have produced similar findings. Other studies by the nation’s most respected scientific and medical researchers affirm the significance of California’s RN-to-patient ratios for patient safety. A meta-analysis of 90 studies commissioned by the Agency for Healthcare Research and Quality (AHRQ) in 2007 has subsequently concluded “there is an evident association between nurse staffing and patient outcomes.”

As the Institute of Medicine’s 2003 study put it, “research now documents what physicians, patients, other healthcare providers and nurses themselves have long known: How well we are cared for by nurses affects our health and sometimes can be a matter of life and death.”

In 2010, researchers Aiken, Sloan, Cimiotti, Clarke, Flynn, Seago, Spetz, and Smith released the results of their much-anticipated study on the “Implications of the California Nurse Staffing Mandate for other States.” Their findings show that hospital nurse staffing ratios are associated with lower mortality and nurse outcomes predictive of better nurse retention in California. Dr. Aiken is the director of the Center for Health Outcomes and Policy Research at the University Of Pennsylvania School Of Nursing. Dr. Aiken’s research studies have focused on the impact of modifiable organizational attributes on patient outcomes and workplace stability in hospitals.

The researchers in this study surveyed more than 22,000 RNs in California, Pennsylvania, and New Jersey. Had New Jersey hospitals and Pennsylvania hospitals matched California’s 1:5 ratios in surgical units, they would have had 14 percent and 11 percent fewer patient deaths respectively. Far fewer California RNs miss changes in their patients’ conditions because of their workload than New Jersey or Pennsylvania RNs. California RNs are more likely to stay at the bedside and less likely to report burnout or intend to leave the profession than nurses in Pennsylvania or New Jersey. Their findings appear to justify the trust the public invests in RNs. The researchers stated RNs’ reports of workloads and staffing have shown them to have considerable reliability and have better predictive validity than the American Hospital Association measures of nurse staffing.

According to Aiken, et al., the California mandates can be viewed as a benchmark against which to compare hospitals within California and between California and other states:

“From a policy perspective, our findings are revealing. The California experience may inform other states that are currently debating nurse ratio legislation including Massachusetts (Coalition to Protect Massachusetts Patients 2008) and Minnesota (Ostberg 2008), or other strategies for improving nurse staffing, such as mandatory reporting of nurse staffing, as enacted in New Jersey (New Jersey Division of State Health Facility Services (2004); Rainer 2005) and Illinois (Keeler and Pickel 2008), and mandating the process by which hospitals determine staffing as in Oregon (Oregon Revision of Statutes 2005.)”

She further asserts, “Our results suggest that the California hospital nurse staffing legislation represents a credible approach to reducing mortality and increasing nurse retention in hospital practice.”

Social, Economic, and Political Patient Advocacy

Research has demonstrated that legislated, transparent, numeric, minimum RN-to-patient staffing ratios, with staffing up based on the acuity and severity of illness of the patient, is a credible, evidence-based approach to improving nurse and patient outcomes. Rather than decreasing the number of RNs, hospitals should increase the ratios of RNs to patients, because RNs’ higher level of knowledge and experience has been shown to reduce patient mortality and reduce the overall costs of care.

From a hospital and business perspective, improved RN-to-patient ratios have a synergistic and demonstrated economic value for hospitals in terms of lower liability and improved reputation by reducing adverse outcomes such as decreased blood-borne infection rates, patient falls, decubitus ulcers, ventilator-acquired pneumonia, and medication errors. In instances where there is not a clear business case for increased nurse-to-patient ratios, there is a compelling social case that can be made due to the reduced adverse outcomes and avoided additional hospital days.

From a patient and social advocacy perspective, improved RN-to-patient ratios have economic and non-economic benefits for patients and their families in terms of decreased pain and suffering from preventable complications, decreased lengths of stay, lost days from work, and increased patient satisfaction. Increasing nurse staffing is associated with fewer in-hospital deaths under all options. Needleman (2006) and his colleagues concluded that 70,000 deaths could be avoided by raising the hospital nurse staffing threshold to the 75th percentile overall.

Rather than weakening or lowering safe staffing standards, a more appropriate strategy would be for government, i.e., Centers for Medicare and Medicaid Services (CMS), and other payers to increase reimbursement rates to hospitals that comply with the safe staffing standards, instead of tying reimbursement to unproven customer satisfaction surveys. Under current reimbursement systems, the incentive and financial reality for hospitals is for them to staff at levels below where the benefit to society equals the cost to employ the additional nurses.

A strong reason for employers to oppose an RN-led comprehensive healthcare delivery models and safe staffing ratios is to retain unfettered control of the practice environment for their own benefit. Such employers exercise coercive and punitive powers to influence the development of behaviors and skills that reflect business strategy and organizational design. Salary and pay-for-performance schemes are designed to communicate these messages of strategy and control to generate compliance with organizational policies. Scripting, rounding, shared governance, pursuit of “magnet” status, and patient satisfaction schemes are methods by which healthcare organizations can push industry-aligned, performance-based competencies as a substitute for professional clinical nurses’ skills, expertise, and practice-based competencies.

End of Part I.

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