In our special focus on ratios, get the latest on everything NNU has done, is doing, and will do to win this critical safe staffing standard for the nation. From the history of California’s law to what the most current studies say to how hospitals are trying to undermine ratios, here’s everything you need to know about 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.

UNISON decided to hold a one-day survey to take a snapshot of what the ratios actually were in the UK. On March 6, 2012, RNs across the country documented their workloads.

The results of this survey were not a surprise. UNISON members reported that they were unable to care for patients in the way they felt they should have, and many felt unable to give safe, dignified compassionate care. This was the case even though the majority of members reported working more than their contractual hours on that day, a practice they said was normal. Ninety percent of the respondents to the survey were in favor of legislation to set minimum nurse-to-patient ratios.

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 professionals have mandated ratios: certified nursing assistants, radiology technicians, laboratory technicians, physical and occupational therapists, pharmacists, nutritionists, and dietary workers. —Gerard Brogan, RN
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.
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The Department of Public Health (DPH) requires that when a nurse takes a break during shift, the hospital must reassign the nurse’s patients to another nurse. Furthermore, break relief RNs must give report when handing over patients to the returning RN. It is important that RNs understand that break relief is taking over an assignment.

When charge nurses act as the break relief nurse, they must be present and available to continue the care of the assigned patients as required by law. In this instance, there can be no conflict between attending to the needs of the now-assigned patients under their break relief duties and their duties as charge nurse. Therefore, charge nurses relieving another nurse for purposes of breaks must either abandon their patients or their charge nurse duties since they cannot fulfill both roles simultaneously.

Licensed vocational nurses (LVNs) are not authorized under their scope of practice to relieve an RN for meals and breaks or other routine absences. The restrictions on the scope of practice of LVNs also apply at all times, including instances when RNs are providing meal and break relief. In addition, the patient’s need for an ongoing assessment by a registered nurse does not cease to exist when the RN who is assigned to the patient is absent from the unit during a meal or break.

Therefore, RNs are not authorized under the Nursing Practice Act to transfer responsibility of clinical management of their patients to LVNs during meals, breaks, and other absences from the unit.

Nurse administrators and managers who have demonstrated current competence may relieve licensed nurses during meals, breaks, and other routine, expected absences from the unit. However, nurse administrators and managers are excluded from doing so when they engage in activities other than direct patient care. —Hedy Dumel, RN, JD

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 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

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.

1998 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.

1999 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.
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

RN s 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.

RNs 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
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 with licensed nurses be accessible and available to meet the needs of ‘patients in acute-care settings.’

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

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 the ratios to please his corporate hospital donors.

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.

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.

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

[Graph showing RN growth in California from 1991 to 2012, with a peak of 375,924 RNs as of May 2012]