RNs have the power.

Use it this November.

Election coverage on pages 5, 6, 9, 13
Letter from the Council of Presidents

L A B O R  D A Y  h a s  c o m e  a n d  g o n e  a n d  w e  a r e  i n  f u l l  p o l i t i c a l  c a m p a i g n  s e a s o n .  W e  k n o w  y o u r  e y e s  w a n t  t o  g l a z e  o v e r  a s  s o o n  a s  y o u  s e e  a n o t h e r  t e l e v i s i o n  a d  t e l l i n g  y o u  t o  v o t e  f o r  t h i s  o r  t h a t  p e r s o n ,  o r  y e s  o n  t h i s  a n d  n o  o n  t h a t .  T r u s t  u s ,  o u r s  d o  t o o .  B u t ,  a s  r e g i s t e r e d  n u r s e s ,  w e  o w e  i t  t o  o u r s e l v e s  a n d  o u r  p a t i e n t s  n o t  t o  c h e c k  o u t  o f  t h e  p o l i t i c a l  p r o c e s s .  I t  i s  m o r e  i m p o r t a n t  t h a n  e v e r  t h a t  n o w.

RNs educate themselves about the candidates, issues, and what’s at stake. For example, Michigan RNs have been working nonstop to help pass Proposal 2, an initiative that would protect collective bargaining rights in the state Constitution and put an end in their state to the endless anti-worker legislative attacks by right-wing, corporate groups. Our executive director, RoseAnn DeMoro, discusses these coordinated “right to work” attacks in her column in this issue. In Minnesota, nurses are backing candidates who will support safe staffing ratio legislation and guard the RN’s scope of practice against efforts by hospitals to dilute it. In California, RNs are spreading the word against Proposition 32, yet another attempt to hamstring unions’ ability to engage in the political process. Check out this issue’s news section for more, and for a list of our federal endorsements for Congressional races.

We also want to celebrate a number of great victories this past month. First, kudos to Massachusetts RNs for helping to pass a ban against mandatory overtime. Second, about 600 nurses in West Virginia and Ohio with three Community Health Services hospitals voted to join the National Nurses Organizing Committee/NNU. And third, nurses at four HCA-affiliated hospitals in Texas just won their first contracts! The naysayers said it couldn’t be done, but they were wrong.

Finally, something we RNs may not think about much every day (except for maybe the public health nurses and ER nurses), but our feature story this issue explores the magnitude of the dental health crisis in this country. By all accounts, it is even harder for patients to access dental care than medical care in this country. It’s mindboggling how many people are in severe pain because of their teeth and how dental disease hurts all other areas of their lives, from their overall health to their job prospects. We need Medicare for all pronto, and we need that Medicare to cover dentistry.

Remember, an RN’s patient advocacy never stops at the bedside. Get out there and vote, and we challenge you to step it up a notch by phone banking, door knocking, and talking to your church, your PTA, or your neighborhood group about where nurses stand on the issues and candidates on your ballots this November.

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

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Rotten to the Core
Oral health is a key factor in overall health, yet millions more Americans suffer from lack of dental care than even medical care. Only an improved Medicare for all would solve our country’s dental crisis. By Heather Boerner

Collective Patient Advocacy Trailblazers: The Road to Ratios
In the first part of this two-part CE homestudy, learn about the pioneering nurses whose advocacy laid the foundation for modern nursing practice acts and safe RN-to-patient staffing ratios. Submitted by the Joint Nursing Practice Commission, DeAnn McEwen, RN, and Holly Dumpel, RN, JD
On Aug. 30 and 31, some 600 registered nurses at three hospitals in West Virginia and Ohio voted to join the National Nurses Organizing Committee/National Nurses United, making them NNU’s most newly unionized RNs in those states.

NOC/NNU will represent 200 RNs at Bluefield Regional Medical Center in Bluefield, W. Va., 150 RNs at Greenbrier Valley Medical Center in Ronceverte, W. Va., and 250 RNs at Affinity Medical Center in Massillon, Ohio. All three facilities are owned by Community Health Systems, a hospital chain based in Brentwood, Tenn.

RNs said they want a stronger voice, by acting together, to make improvements in patient care, working conditions, and economic standards for their patients, their colleagues, and their community.

“I’ve always had an interest in nurse representation pretty much my whole career,” said Pam Gardner, an ICU RN at Affinity Medical Center with 21 years of nursing experience. She said that she joined the union because she learned over the years that one person speaking up tends to get ignored and no issues get resolved. Now, as a group, Gardner said, “Everyone is excited about the opportunity that we have with NNU. We know it’s going to take a lot of work, but we’re looking forward to the future now.”

Tracey Paxton, a medical-surgical RN at Greenbrier Valley Medical Center, said that she and her colleagues wanted to organize to fight for better, safer staffing ratios. On her unit, RNs usually start with at least six patients and it’s not uncommon to be assigned seven or up to eight. In addition, the acuity of individual patients is often not taken into consideration.

“We really just felt like we could make a change and do better,” said Paxton. “With those numbers, it’s hard to give the care you’d like to give. It would be incredible what we could do with better working conditions.”

With these recent votes, NNU, since its founding in December 2009, has won representation for more than 13,000 RNs in 12 states. Overall, NNU now has some 180,000 members in all 50 states.

At each of the newly represented hospitals, the next step for nurses will be to talk to their colleagues about issues they wish to address together in negotiating with management, elect a team of nurse negotiators, and begin working for a first NNU collective bargaining contract. —Staff report
RNs on Offense to Protect Michigan Bargaining Rights

MICHIGAN

If you’re watching TV in Michigan, there’s a good chance you’ll see MaryAnn Beauchamp-Sayraf.

The Michigan Nurses Association member, a registered nurse at the University of Michigan Health System, looks straight into the camera to deliver straight talk about collective bargaining: “Collective bargaining protects nurses, and that protects patients.”

Every MNA member is focused on spreading that message to make sure that Proposal 2, which will permanently add collective bargaining rights to the Michigan Constitution, passes when voters go to the polls Nov. 6.

This is how MNA and other labor and citizen groups are fighting back against more than a year of steady assaults against workers by Michigan legislators acting on behalf of greedy corporations and CEOs. The battle in Michigan is in the national spotlight, with observers waiting to see whether workers can overcome the unlimited secret money and lies from the other side that are eroding workers’ power in some states.

Getting on the ballot was a victory in itself after Michigan’s Chamber of Commerce, attorney general, and even governor sued to block it – despite nearly 700,000 citizens signing petitions to put it before voters.

Corporate special interests have spent millions and will spend millions more to try and silence our voice to negotiate for fair wages, benefits, and working conditions that benefit us all,” said Cheryl Weston, RN and MNA member who works at McLaren Lapeer Region Medical Center in Lapeer.

“Opposition to amending the constitution is intense and well funded,” said Beauchamp-Sayraf, who spoke to thousands of fellow workers at a Labor Day rally in Detroit, firing them up about Proposal 2. “It is up to us to share our message with friends, neighbors, coworkers, and family to ensure that our voices are heard and interests of working people are protected.”

John Karebian, MNA executive director, said fighting for the proposal in Michigan isn’t just a campaign to the MNA – it’s part of a movement. He pointed out that the push to erode benefits and working standards in hospitals continues while they post record profits.

“Collective bargaining is the most powerful voice for fair treatment of all employees and the most effective check on corporate power,” Karebian said. “If the government takes away our right to unionize, who will speak on behalf of workers? Not the corporations, the wealthy, and the people addicted to political power – they will continue to look out for themselves. Working people deserve better than that.” —Dawn Kettinger

Menorah RNs in Kansas Approve First Contract

KANSAS

The 325 registered nurses of HCA-affiliated Menorah Medical Center in Overland Park, Kansas in early September ratified a first contract that recognizes the RN voice in patient care matters, improves staffing standards, and offers economic incentives that recruit and retain quality RNs.

“This contract touches many bases for us,” said Pam Darpel, an RN who works in labor and delivery at Menorah. “It includes provisions that recruit and help keep not only experienced nurses, but nurses new to the profession.”

Darpel, who has worked eight years at Menorah and more than 30 years in the profession, also said, “It is a positive for everyone: patients, nurses, our hospital, the community.”

The contract follows an agreement reached by more than 500 RNs at Kansas City’s Research Medical Center in June and came just days after four Texas hospitals ratified their contracts with Nashville-based HCA, the largest for-profit hospital chain in the country.

The agreement eliminates the wage cap on the most experienced nurses and sets a wage standard that will help recruit and keep RNs, with guaranteed annual wage increases in each of the three years of the agreement. These increases are higher than average wage increases most Kansas RNs are receiving, and the (continued on page 6)
As nurses know, the November elections are not just about who will win the presidency, but also which Congress- members will represent our interests on Capitol Hill. As a national RN union, National Nurses United has identified candidates whose backgrounds and track records are in line with our nurses’ values of caring, compassion, and community. These candidates have received NNU’s endorsement, and we encourage you to support them at the polls. Always remember, however, that political activism doesn’t stop with voting; to keep our representatives accountable, we need to keep constant pressure on them to do the right thing with our phone calls, letters, and direct action.

Federal Candidates With NNU’s Seal of Approval

PRESIDENT
Barack Obama

ARIZONA
Raul Grijalva (3)

CALIFORNIA
Jared Huffman (2)
Ami Bera (7)
Barbara Lee (9)
George Miller (11)
Pete Stark (15)
Julia Brownley (26)
Otto Lee (22)

Judy Chu (32)
Joe Baca (35)
Janice Hahn (36)
Jerry Tetalman (49)

ILLINOIS
David Gill (13)

MAINE
Cynthia Dill (Senate)
Chellie Pingree (1)

MASSACHUSETTS
Elizabeth Warren (Senate)
Jim McGovern (3)
Joe Kennedy III (4)
Stephen Lynch (9)
Bill Keating (10)

MICHIGAN
Gary McDowell (1)

MINNESOTA
Mike Obermueller (2)
Keith Ellison (5)
Rick Nolan (8)

VERMONT
Bernie Sanders (Senate)

WASHINGTON, D.C.
Phil Mendelson
Michael Brown

MINNESOTA
Mike Obermueller (2)
Keith Ellison (5)
Rick Nolan (8)

VERMONT
Bernie Sanders (Senate)

WASHINGTON, D.C.
Phil Mendelson
Michael Brown

higher compensation will serve to attract experienced nurses in the Kansas City-area market.

The contract also establishes a professional practice committee (PPC), an elected RN committee comprising nurses who work directly at the bedside, charged with making recommendations to the Chief Nursing Officer on improving patient care. Also addressed in the contract are patient acuity-based staffing levels – RN-to-patient staffing levels and acuity established in policy and enforceable by a newly-negotiated staffing committee. Bedside RNs will serve on the committee with management to review staffing issues in the hospital, ensure compliance with staffing matrices, and to recommend changes.

“Quality patient care is the winner under this contract,” said Carolyn Lusby, RN, who works in medical/telemetry at the hospital and is a member of the RN bargaining team. “It was our goal to have the input we need to carry out our professional practice.” With regard to the staffing committee, preceptor program, and other agreements reached, she said, “I was glad to have had the chance to help develop contract language that will allow bedside RNs to work together with management to improve patient care.” —Staff report

California RNs Say “Yes” to Prop. 30, and “No, No, No!” to Prop. 32

On this November’s ballot, California nurses are urging a yes vote on Proposition 30, which would raise billions of dollars to save public schools and other safety net programs from devastating cuts by temporarily raising taxes on the state’s wealthiest households.

At the same time, RNs are strongly opposing Proposition 32, an initiative that would stifle their voices as patient advocates and of all workers by preventing their unions from efficiently collecting dues for political causes. Those restrictions would not apply to corporations and political action committees because of loopholes in how the measure is written. Prop. 32 is sponsored and bankrolled by right-wing business interests, including billionaires such as the Koch brothers and Charles Munger.

For more information, please visit www.yeson30andnoon32.com.
In a landmark win for nurses, patients, and three Texas communities, registered nurses in El Paso, Corpus Christi, and Brownsville on Sept. 5 ratified their first-ever collective bargaining agreements. The contracts make significant strides for working conditions for RNs, patient care standards, and quality of care at the four facilities. The agreements cover RNs at Corpus Christi Medical Center; two El Paso facilities, at Las Palmas Medical Center and Del Sol Medical Center; and one at Valley Regional Medical Center in Brownsville.

RNs are excited about the important improvements in patient care protections they bargained and the enhanced professional and economic standards that they say will help keep experienced RNs at the bedside. “Texas took a big step forward in terms of patient care standards with these agreements,” said Fred Flores, RN, of Corpus Christi Medical Center’s emergency department.

“This is a victory for quality healthcare at Las Palmas, and at the other HCA-affiliated hospitals and the communities they serve,” said Ann James, RN, of the intensive care unit at Las Palmas Medical Center in El Paso. Nashville-based HCA is the largest operator of for-profit hospitals in the United States and, with these agreements, now has nurses at 19 affiliated hospitals covered by collective bargaining agreements with National Nurses United affiliates: 10 in Florida hospitals, two in California, as well as one each in Nevada, Missouri, and Kansas.

In each of these hospital contracts, RNs were able to negotiate the establishment of professional practice committees (PPCs), an elected committee composed of staff RNs charged with making recommendations to management on improving patient care. Along with PPCs, the contracts also include patient acuity-based staffing levels, with RN-to-patient staffing levels and acuity established in policy and now enforceable by newly negotiated staffing committees. The four Texas RN staffing committees are a hallmark of these HCA-affiliated hospital contracts, where bedside RNs will serve on committees with management to review staffing issues in the hospital, ensure compliance with staffing matrices, and recommend changes.

“It took time,” said Adriana Soto, RN, who works the Progressive Care Unit at Valley Regional Medical Center. “But in the end we were able to reach a settlement that will solidify our RN organization, and provides our patients in Brownsville with quality care.” “For us, having an acknowledged role in the standards, for patient care, is a must-win in a contract,” said Maria Navarro, RN, of Del Sol Medical Center’s labor and delivery. “We are professionals who work at the bedside and patients count on us. Management gains from our expertise. We need to be able to share it and management needs to be listening. We have achieved that in our new contract.”

Procedures for resolving employment disputes were a high priority for the RNs, such as just cause protections, appropriate grievance and floating procedures, and seniority protections in layoffs and job bidding. All were addressed in the new agreements. —Staff report

Clockwise from top left: Las Palmas Medical Center; Corpus Christi Medical Center; Valley Regional Medical Center; and Del Sol Medical Center.

Four Texas HCA-Affiliated Hospitals Win First Contracts

TEXAS

SEPTEMBER 2012
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NATIONAL NURSE 7
On Aug. 6, 2012, in a Massachusetts Statehouse ceremony held in Nurses Hall and packed with nurses, healthcare advocates, labor associates, and legislators, Gov. Deval Patrick signed a sweeping health reform bill that included a ban on the common hospital practice of using mandatory overtime (MOT) rather than providing safe registered nurse staffing levels in acute-care hospitals. The inclusion of the ban on MOT in this major piece of legislation has served to highlight it as a major success for nurses in Massachusetts.

“This is a landmark achievement in our state’s efforts to control costs, while maintaining safe, quality patient care,” said Donna Kelly-Williams, RN, president of the MNA/NNU. “Forcing nurses to work when they are exhausted endangers patients and leads to costly, preventable medical errors and complications. The practice of mandatory overtime is indefensible by any patient safety standard, and yet hospitals continue to increase their use of this practice. This legislation will put an end to that.”

MNA filed a bill to ban mandatory overtime at the beginning of the past 2010-2012 legislative session. In recent months, MNA ramped up its work with legislative leaders in both branches to incorporate the mandatory overtime ban in the payment reform bill.

Under the law, a hospital will be prohibited, except in the case of a declared emergency, from requiring nurses to work beyond their scheduled shift, and no nurse would be required to work more than 12 hours in a 24-hour period. Should a hospital assign a nurse to work a mandatory overtime shift, the new law requires that they report such incidents to the Massachusetts Department of Public Health, along with the justification for the assignment. These reports become public documents.

The law also includes an anti-retaliation measure, which prohibits hospitals from discriminating against or terminating nurses who refuse to accept a work assignment in excess of the specified limitations. Nurses can refuse overtime without fear of retribution or discipline by their employer. Moreover, even in the event of an emergency, before mandating overtime, hospitals must make a good-faith effort to cover the overtime on a voluntary basis.

The law also sets maximum shift lengths for nurses. Hospitals are prohibited from regularly scheduling a nurse to work more than 12 hours in a 24-hour period. Hospitals are further prohibited from permitting a nurse to work more than 16 consecutive hours in a 24-hour period. In the event a nurse works 16 consecutive hours, the hospital must provide that nurse with at least eight hours of consecutive off-duty time immediately following the 16-hour shift.

The dangers and costs of mandatory overtime have been well documented in a number of scientific studies published in the last decade, which included findings that nurses working mandatory overtime are three times more likely to make costly medical errors; and that overtime for nurses was associated with an increased risk of catheter-related urinary tract infections and bedsores, both preventable medical complications. In 2002, the Institute of Medicine issued a report linking mandatory overtime and the understaffing of nurses to thousands of patient deaths each year, and called for an all-out prohibition of the practice.

Over a decade ago, MNA nurses went on strike at St. Vincent Hospital in Worcester and Brockton Hospital – for 49 and 103 days, respectively – to stop the dangerous practice of mandatory overtime. After a period of relative stability, nurses have seen hospitals revert back to the dangerous practice of mandatory overtime as their primary staffing tool. In the past two years alone, this practice has been at the core of contentious negotiations at Tufts Medical Center (where the nurses voted to go on strike over the issue), Baystate Franklin Medical Center, Cape Cod Hospital, and Quincy Medical Center.

“Twelve years ago, the nurses at St. Vincent Hospital were forced to strike to protect our patients from the dangerous practice of mandatory overtime,” said Marie Ritacco, a registered nurse at St. Vincent Hospital in Worcester. “Patients will now be protected from being subjected to a nurse who is too fatigued to practice safely. Nurses can no longer be forced to work excessive hours and put our patients and our licenses at risk.”

Stay tuned for updates on progress by state agencies in implementing the specific provisions of the law, including the ban on MOT. But for now, Massachusetts nurses are celebrating this seminal accomplishment. —David Schildmeier
Key Issues at Stake for Minnesota RNs this November

This November, Minnesota nurses have the ability to determine who will make key decisions about their union, their practice, and their patients.

Every seat—House and Senate—in the Minnesota Legislature is up for election. Federally, voters will also choose a new president, senators, and congresspersons.

“It’s really about what type of state Legislature we want to have,” said MNA President Linda Hamilton, RN. “For instance, we can have a Legislature that takes a real look at the challenge of unsafe staffing inside our state’s hospitals. Or, we can have a Legislature that is more interested in divisive social issues and protecting corporate interests ahead of everyday people.”

Along with the legislative issues that directly impact Minnesota nurses, this fall’s election is an opportunity to help working families prosper through education, job creation, and investment in our communities, according to Andrea Ledger, MNA’s director of political and legislative action.

“This election is going to shape our state and our country’s immediate and long-term future,” she said. “Of particular concern to our membership, politicians play a huge role in shaping healthcare in general and the nursing profession in particular. For example, there will be a large push by Minnesota nurses this fall urging state leaders to pass legislation aimed at curbing unsafe staffing levels inside our state’s hospitals. We also anticipate bills moving in the state legislature that could negatively impact the risk to our patients,” Ledger added. “Finally, we’re expecting to see efforts to erode Minnesota’s nursing standards and increase the risk to our patients,” Ledger added.

“There are also expectations of legislation being introduced regarding national nurse licensure, which would erode Minnesota’s nursing standards and increase the risk to our patients,” Ledger added. “Finally, we’re expecting to see efforts to amend the Nurse Practice Act by expanding the scope of practice for licensed practical nurses (LPNs). Our nurses feel this action would not only put nurse and patient safety at risk, but that it’s also a corporate health-care maneuver to get more work for less money while pitting LPNs and RNs against one another in the workplace.”

Julia Donnelly, one of MNA’s political and community organizers, notes that as an organization with 20,000 members, MNA’s nurse leaders don’t expect every single member to see eye-to-eye on political issues.

“But when our nurse leaders approach the political process and decide which candidates MNA should officially endorse, there’s a clear-cut process and a defined goal in place,” she said. “We want to endorse legislators and politicians who are pro-nurse, and who are champions for the issues that are most important to our membership.”

Ledger adds that MNA typically returns a very bipartisan list of endorsed candidates during each election cycle.

“We’ve never shied away from endorsing candidates on both sides of the aisle,” she said. “Again in 2012, we have a truly bipartisan list of candidates that our organization is endorsing.”

There is an in-depth, detailed explanation of the candidate screening and endorsement process on the MNA website, but the short version is this: MNA nurse leaders look closely at a candidate’s position on issues that directly affect nursing, healthcare, and working families. Questionnaires are sent to prospective candidates as part of the screening process. After those forms are filled out and returned, a group of MNA nurse leaders evaluates each one before meeting with individual candidates for face-to-face interviews.

“We realize and respect everyone’s right to vote for whomever they’d like,” Donnelly said. “At MNA, our nurse leaders use the Code of Ethics for Nurses as a guiding principle. It directs nurses to advance the profession through active involvement in nursing and healthcare policy, and to participate in social reform through political action.”

Since its founding 1905, the Minnesota Nurses Association has earned a reputation of respect inside the state Capitol. In 1907, for instance, its members helped secure the first law for state registration and licensing of nurses.

In 1959, efforts by MNA members stamped the Nurse Practice Act with an indelible mark, changing the licensure requirement from permissive to mandatory. As a result, Minnesota patients became assured that it was illegal to practice as a registered nurse without meeting standards and passing a licensing exam.

During the past 100-plus years, MNA members have also campaigned effectively for important statutes regarding safe needles, prescribing authority for nurse practitioners, mandatory overtime prevention, and MinnesotaCare, to name just a few legislative landmarks.

“This is an extremely important election season for so many different reasons,” Hamilton said. “And our nurse leaders realize that. We’ve set up phone banks, and our goal is to talk to every single MNA member about the important issues facing nurses, their profession, and their patients. We’re hoping more nurses will volunteer their time to help us reach out and make sure everyone is informed.”

If you’re interested in learning more about MNA and its role in the legislative process, or if you’d like to volunteer for the phone banks, please visit the MNA website at http://mnnurses.org/policy-and-advocacy.

—John Nemo
For more than a year now, NNU nurses have been pushing for Congress to adopt a tax on Wall Street. Now, thanks largely to their work, there is a concrete proposal to rally behind.

The U.S. Robin Hood Tax campaign cheered on Sept. 24 the introduction in Congress of a bill that would impose a tax on Wall Street speculation. Introduced by Rep. Keith Ellison, HR 6411, the Inclusive Prosperity Act, would raise up to $350 billion in annual revenues that would be used to breathe new life into Main Street communities across America, as well as international health, sustainable prosperity, and environmental programs.

The legislation establishes what is popularly known as the Robin Hood Tax, a 0.5 percent tax on the trading of stocks (or 50 cents on every $100 of trades) and lesser rates on trading in bonds, derivatives, and currencies. It marks the return of a sales tax on financial transactions that had been in place from 1914 to 1966, and targets the high-risk, high-speed trading that currently dominates the markets.

“The American public provided hundreds of billions to bail out Wall Street during the global fiscal crisis, yet bore the brunt of the crisis with lost jobs and reduced household wealth,” said Rep. Ellison in a press statement. “This is a phenomenally wealthy nation, yet our tax and regulatory system allowed the financial titans to amass great riches while impoverishing the systems that enable inclusive prosperity. A financial transaction tax protects our financial markets from speculation and provides the revenue needed to invest in the education, health, and communities of the American people.”

The legislation’s goal is to raise meaningful tax revenue dedicated to strengthening the social safety net for low- and moderate-income families, and by expanding investments to protect health, rebuilding infrastructure, and creating good-paying jobs. The tax can also target international needs, including AIDS treatment, research, and prevention, and provide other critical assistance.

“Congressman Ellison is showing great leadership for our country,” said Jean Ross, RN, co-president of National Nurses United. “HR 6411 is a critical step to generate the revenue for the healing and recovery our Main Street communities across the nation so desperately need. This is a small, commonsense tax, already in place and working wonderfully well in dozens of countries across the world. I pay a sales tax when I buy a pair of shoes, and so should Wall Street on its transactions. America is ready for the Robin Hood tax.”

Robert Pollin, an economist and codirector of the Political Economy Research Institute at the University of Massachusetts-Amherst, agreed, saying the Robin Hood Tax would be “the equivalent of sales taxes that Americans have long paid every time they buy an automobile, shirt, baseball glove, airline ticket, or pack of chewing gum, eat at a restaurant, or have their hair cut.”

The Robin Hood Tax also helps to control the volume of speculation engulfing the financial markets, where risky bets are causing instability and sidelining billions in funds that might otherwise be directed to a productive economy. And the tax assists in curtailing speculation in food and fuel markets, where bets on these essentials are causing spikes in prices and serious shortages.

The introduction of HR 6411 came on the eve of the one-year anniversary of Occupy Wall Street. Robin Hood Tax campaigners joined Occupy activists at a labor solidarity event at Zuccotti Park in New York City, then visited offices of financial institutions to demand imposition of the Robin Hood Tax. More than 100 organizations endorse the Robin Hood Tax, as well as world leaders, celebrities, and businesspeople, and the list continues to grow.

—Staff report
Earlier this year, San Mateo County public health RN Laarni San Juan decided to enter a White House Asian and Pacific Islander Caucus Congressional Institute contest for essays reflecting the API psyche and sensibility. She was surprised to learn her essay was among five finalists chosen. While she did not ultimately win the top prize, she was honored to attend the White House awards ceremony and already feels like a winner for her advocacy in physical and mental health.

I am proud to be an Asian American in the United States. I am especially proud to be a Filipina American. I live each day with the values, vision, and goals that my family before me instilled: work hard, enjoy the fruits of labor, pray, and be thankful.

I graduated as a nurse 18 years ago and I am extremely appreciative that I am in a profession where I am able to exercise those very family values and most importantly, give back.

I am a public health nurse. You might ask, “What is that?” Most have heard of emergency room nurses, ICU nurses, labor and delivery nurses. Public health nurses work for government county agencies. We are in the communities and we help those who need it most: high-risk populations, youth, elderly, the low-income, marginalized, immigrants, the incarcerated, domestic violence victims, the drug-addicted, the impoverished. We come face to face with the very communities that often experience injustices from ill-resourced systems.

Public health nurses help to link those who need health insurance, to advocate for those with meek voices, and to educate about basic, primary prevention.

I feel fortunate to bring these gifts to the individuals I meet on a daily basis. I know that my brown skin is a window through which my patients can connect with me. “She is Asian. She is one of us. She can understand what I’m trying to ask and say.”

I reassure patients that they do not have to explain nor feel the need to justify, because I do understand their message. I understand the pain, the suffering, the anxieties, and the joy behind the gestures and the words.

I know that my skill as a nurse helps to further understand and clarify the disease processes, illnesses, or social ills. I put myself in their situation and explain in a way like I would explain to my 78-year-old mother whose primary language is Tagalog. When I do not know the answers, I let... (continued on page 12)
California

A group of Filipino nurses at Delano Regional Medical Center in September won a $975,000 settlement against the Bakersfield-area hospital for a language discrimination suit charging that hospital management harassed and intimidated the healthcare workers for speaking Tagalog. It is believed to be the largest language discrimination settlement in the U.S. healthcare industry. “They were always telling us, ‘Ssssh. English only. English only.’ I felt embarrassed, ashamed,” said Elnora Cayme, a Delano employee for 27 years, to the Los Angeles Times. “I was so angry we were being followed by housekeepers and security guards. I asked the guard why he did that and he said, ‘We were told to watch you and report you.’” (Delano RNs are not represented by CNA/NNU.)

Pennsylvania

Nurses from across Pennsylvania submitted their stories of workplace violence to the state’s House of Representatives health committee for a hearing in September on the Health Care Facilities Workplace Violence Prevention Act, or HB 1992. In addition, PASNAP President and emergency room RN Patricia Eakin testified before the committee, painting a diverse and far-reaching picture of the violence that RNs face every day at work.

HB 1992 has strong bipartisan support and would require Pennsylvania hospitals and other healthcare facilities to take proactive steps to protect nurses and other healthcare workers from suffering violence on the job. It would also create a system by which incidences could be reported and the health facility would be held accountable.

Texas

In late September, Texas RNs successfully secured a sponsor, Sen. Jose Rodriguez, for their state’s Patient Protection Act, a 2013 bill that would establish safe RN-to-patient staffing ratios. In addition, Texas and Florida RNs are also working toward sponsoring safe lift legislation next year to reduce the number of injuries for both RNs and patients by eliminating manual lifting and maneuvering of patients. In early September, a group of RNs from both states visited the James A. Haley Veterans’ Hospital in Tampa, Fla. to learn more about their safe lift program.

From top: Texas RNs with Sen. Jose Rodriguez (center), who has agreed to sponsor their 2013 Patient Protection Act establishing safe staffing ratios; Florida and Texas nurses visited a Tampa VA facility to learn more about their safe lift program.

When we give the best of ourselves, healthy outcomes prevail.

—Laarni San Juan, RN
Exposing “right to work” laws

A growing threat to nurses, patients, and a healthy America

ANY RN who has had to confront a manager while standing up for a patient, a colleague, or herself can attest to the power of workplace unity and collective action.

It's one major reason that since the NNU was founded less than three years ago, more than 13,000 RNs in 35 hospitals in 11 states have voted to join our national nurses' movement.

With their union, NNU nurses are able to act together to push for better staffing and other improvements in patient safety, as well as protect their own livelihood, health coverage, and retirement security.

But the power of NNU to fight to protect the interests of our members, other nurses, patients, and the public is in jeopardy.

The latest threat is the spread of laws promoted by extremist corporate interests like the Koch brothers and the American Legislative Exchange Council (ALEC) under the guise of promoting worker rights.

A centerpiece of their efforts is what is deceptively labeled “right to work” laws, which prohibit unions from negotiating agreements with employers that require everyone in a work setting who benefits from union representation to contribute their fair share in union dues.

Thus far, 23 states have such laws. ALEC, the Koch brothers, and others like them hope to extend them to at least half a dozen other states after November.

Michigan unions, with the Michigan Nurses Association in the forefront, are seeking to preempt such a law in Michigan with a state initiative, Proposal 2, that would permanently protect collective bargaining rights for all Michigan workers and guarantee workers the basic right to have a voice in the workplace.

But proponents of these attacks have a bigger prize in mind as well. At its recent convention in Tampa, the national Republican Party adopted a platform calling for a national “right-to-work” law (along with other anti-union legislation) that would certainly be pursued under a Romney presidency.

For nurses, a lot is at stake.

Without a union, nurses have little recourse when hospital employers impose cuts in patient protections and RN standards, or retaliate against individual RNs who advocate for their patients.

One way to measure the impact is pay. According to RN NursesSalary.org, average hourly compensation is $40.67 for an RN in California, compared to $28.30 for an RN in North Carolina. In California, nearly half of hospital RNs are members of the California Nurses Association. By contrast, only a handful of North Carolina RNs, those in an NNU VA hospital, are union members.

CNA/NNU power in California has translated into not only higher pay, but better retirement plans and a long list of workplace safety and other improvements that are merely a dream to nurses in other states. And, due to the power of CNA-member RNs, California enacted mandatory RN-to-patient staffing ratios.

Nurses, of course, are not the only ones who benefit from representation. New York, with the highest per capita percentage of union membership in the United States, more than one-fourth of all workers, ranks fifth nationally in average income. North Carolina, with the lowest national average of union membership, just 2.9 percent of workers, places 38th in personal income.

There are other factors, from urbanization to home prices to overall cost of living, that contribute to income data, but the unionization rates go well beyond mere coincidence.

In states not saddled with “right to work” laws, incomes and living standards are higher, and the gains unionized workers have won for themselves, their families, and their communities is a major reason why.

It is well known that overall union membership has declined precipitously in recent decades (except for NNU), a time period that also includes a dramatic growth in income inequality and deteriorating real wage growth for American workers.

A Labor Day 2012 report by the Economic Policy Institute argued that the decline of union representation from 1973 to 2011 – with workers having less power to raise standards – accounted for one-third of the growth in male wage inequality and one-fifth of wage inequality for women.

When you hear political candidates talk about “redistribution,” that is exactly what has happened since 1973: a redistribution of national wealth and resources to the corporate board rooms and the wealthiest Americans.

Overall, said EPI, union members receive a “wage premium”—an increase due to collective bargaining contracts—of 17 percent for men, 9 percent for women.

Corporate America is also well acquainted with these numbers, thus the reason why ALEC, the Koch brothers, their lobbyists in organizations like the Chamber of Commerce and the American Hospital Association, and the politicians they influence, have pushed so hard to roll back unions.

They’ve done so by a decades-long attack on democratic labor rights that make it harder for workers to join unions and easier for employers to intimidate workers considering unionization. They’ve done it through court decisions like Citizens United that give big corporations and millionaires and billionaires greater ability to dominate elections. And they’ve done it with legislation like “right to work” laws.

As the Michigan nurses have shown, we will not be silent in attacks on our members, their rights, and their ability to protect and improve their lives and the quality of life for their families and communities.

Learn more about the Michigan campaign at www.minurses.org/legislation/poj and follow the NNU website at www.nationalnursesunited.org for more on what you can do to join this fight.
At 4:58 a.m. on a dark, cold, drizzly Sunday in March, a voice boomed over a bullhorn, carrying down the ramp leading to the upper deck of the Oakland Coliseum, a sports arena, in Oakland, Calif. Hundreds of sleepy, cold people propped up against the curving walls, sitting heavily on folding stools and swathed in blankets, sleeping bags, hoodies, and scarves craned their heads toward the sound.

“If you don’t have a number right now, we are out of numbers,” the crackling voice said. “We have given out 800 numbers.”

Minutes later, 59-year-old Toni Coffey approached a man with a bushy white mustache and baseball cap. “Where do I get a number?” she asked breathlessly. “Are there any left?”

The man shook his head. The numbers, handed out on worn slips of paper, gave the people standing here entry to a Remote Area Medical health clinic, in which volunteer RNs, nurse practitioners, doctors, dentists, and eye specialists treated people for free. The clinic had been going on for three days, and today was its last day. More than 85 percent of RAM patients are there for dental care.

Coffey looked shocked, her eyes going wide. She had been here two days ago to get eyeglasses, and she had made it in time to nab a number. Demand, it seemed, had grown in the last 48 hours. Guess that cavity and the broken tooth that she’s picked at until it was nothing but a nub of nerve endings were going to have to wait for another day. Too bad, too, since Coffey had had a heart attack two years ago and had been having heart valve troubles. Dental care could have gone a long way toward keeping her heart healthy.

“I would have dealt with it sooner,” she said with regret, “if I’d had dental insurance.”

Quietly, she trudged off down the ramp and back into the night.

Like Coffey, about one in three Americans have no access to dental care. Unable to get in the door at a dentist’s office because they don’t have insurance, unable to pay even sliding scale costs at health clinics because of low incomes, ineligible for dental services through Medicaid which, in many states (including California) no longer covers adults, their choices are the emergency room, charity, extractions, ongoing infections, worsened overall health, and, in some dire cases, death.

Indeed, research shows that oral disease is disastrous for overall health. Dental bacteria contribute to heart problems like Coffey’s, stroke, uncontrolled diabetes, low birth weight in babies, and pneumonia.

“The mouth is an essential body organ, essential for eating, breathing, communicating, sensing, and protecting the body,” Burt Edelstein, DDS and professor of dental medicine and health policy and management at Columbia University College of Dental Medicine, told a Senate subcommittee hearing on the dental crisis in February. “When it’s not healthy, the impact is both immediate in terms of pain and infection, and chronic in terms of exacerbation of medical conditions.”

But many Americans simply cannot afford dental care. Dental insurance often requires patients to pay 50 percent of the cost, usually upfront, before they can even sit in a dental chair. And those are the insured. A Kaiser Family Foundation study on Medicaid and the uninsured estimates that there are three times as many people without dental coverage as medical coverage, and 30 percent of children with health insurance have no dental insurance. Dentists, unlike general medical providers working in hospitals or government health facilities, are not obligated to serve people without insurance or the ability to pay.

What we’re left with, then, is almost nothing, not even a safety net, for patients suffering from dental illnesses. Individual states struggle to cobble together...
their own solutions to the problem. Meanwhile, providers are drowning in demand for their services, children are sick and missing school, adults are losing job opportunities, and everyone knows it’s not enough. Given the failings of the current system, only an expanded and improved Medicare-for-all model that offers the whole range of dental care services, from preventative measures and cleanings, to fillings and dentures, can stem the epidemic of dental disease plaguing American adults and children. As the experts know, investing in dental health is an investment in overall health. “We aren’t going to be able to drill and fill our way out of this problem,” Edelstein warned. “Most important is coverage for all.”

In the Morton Hospital emergency room in Taunton, Mass., where Linda Condon has been an RN for 26 years, “it’s an everyday thing” to see patients complaining of dental problems that cause mouth pain, trouble swallowing, earaches, and migraines.

“I’ve seen some pretty nasty swollen faces,” she said. “It’s frustrating, because you know they’ll be back in a few weeks with the same issue.”

It should be no surprise that the ER, the walk-in clinic of the poor, underinsured, and uninsured, is where people with dental pain go – even though ERs are ill equipped to help. Nationwide, Americans made more than $30,000 visits to ERs in 2009 for dental problems, according to a February 2012 Pew Center on the States issue brief. That’s a 16 percent increase over 2006. Of those visits, almost none resulted in complete treatment of the problem.

And while dentists don’t have to see patients without dental insurance or the ability to pay, ERs take all comers, and often charge Medicare and Medicaid. The tab is extraordinary. A 2010 study in the Journal of Evidence Based Dental Practice found that ER visits just for cavities cost about $110 million in 2006. This doesn’t include the cost of treating dental abscesses or visits to community clinics. And with 10 million people losing their dental insurance between 2008 and 2009, according to the National Association of Dental Plans, it’s a good bet the number will continue to rise.

What happens when someone visits the ER for an oral health problem? First, understand that by the time a tooth hurts, it’s likely been infected for years. A toothache means the enamel and bone may have ceded to bacteria, which then burrows into nerve endings in the root and, sometimes, creates a painful pocket of pus that can, if left untreated long enough, infect the bone of the jaw and travel into the ear and brain.

If the infection gets into the blood, it can kill – and it has. In 2009, 12-year-old Deamonte Driver in Maryland died from sepsis due to a dental abscess that had polluted his blood. In 2011, 24-year-old Kyle Willis from Ohio died after visiting an ER to deal with his own dental abscess. He got a prescription for pain medication and antibiotics. He could only afford one. He chose the pain medications and died.

At an ER, all staff can do is administer a pain block – injecting pain killer the way a dentist would to numb teeth before treatment – and give people prescriptions for pain medications and antibiotics. Such treatment for a cavity costs, on the mean, about $1,500 in 2006 – compared to $104 to fill a cavity in a dental clinic. In extreme cases, hospitals will admit patients and drain the abscess and provide prescriptions for antibiotics and pain medications. Such admissions usually run about $16,000 each.

If people had other options, they wouldn’t visit an ER. Condon hears it all the time. Every time she counsels a repeat ER patient with mouth pain to find a dentist, she hears the same thing: “I tried to follow up with a dentist, but they want half the money down in cash. I don’t have that money.”

Out of self-preservation, hospitals around the country have created lists of local dentists willing to see patients on a sliding scale or willing to take Medicaid.

Condon refers people to Boston’s Tufts University School of Dental Medicine, which has a reduced-cost dental clinic. But it’s 40 miles away, and many patients don’t have cars, the time off, or the money to pay even the sliding scale rate.

So they come back to the ER, Condon helps them, and both parties wonder when and how it will end.
dentists at Sharing and Caring Hands, a nonprofit that includes a shelter, a soup kitchen, showers, a teen center and children’s area, and free medical and dental clinics.

Cozart is the office manager, grant writer, volunteer coordinator, health educator, outreach worker, and dental hygienist for the approximately 1,600 children and adults who come through her clinic every year. She’s very clear that, when it comes to adults, she’s in the dental pain business.

“For the past six years, pretty much all we’ve done is focus on people in pain,” she said. “Most teeth we deal with are beyond the point where they could be saved. And even if they could be saved with a root canal and a crown, our patients don’t have the resources to do that. Their option, pretty much, is to have the tooth out.”

She’d rather not pull teeth and teach prevention. Better to focus on people who haven’t yet experienced dental rot, she figures. She spends a day a week across the street at the children’s shelter, offering cleanings, applying sealants, and teaching good dental hygiene.

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Medicare, which covers elderly Americans, doesn’t cover primary dental services, either. Neither does VA healthcare, unless it is considered necessary treatment for a service-related medical condition.

What that means, then, is that a wide swath of Americans are losing their teeth to unnecessary dental pain and extractions – hurting their ability to work, get jobs, and earn a living.

“Do you ever go into a dollar store and notice how many people don’t have teeth?” asked Judith Feinstein, director of the Maine Department of Oral Health. “Have you ever wondered how many people are working there because they don’t have front teeth? I’ve noticed that a lot. People have trouble with employment because of how they look, because of how unwell they are. There are consequences to lack of dental care. Dental care and oral health is not optional. They are consequential.”

Marine vet Don Davison was too late to get a number and only gained access to a free RAM clinic after NNU RNs intervened. He had been so desperate to get his remaining six, infected teeth pulled that he tied his teeth to his dog’s collar and threw a hot dog for it to chase.

But for adults, her clinic focuses on extractions. In fact, she said, “It’s always a challenge to keep enough dentists as volunteers to be able to keep up with the demand for extractions.”

That’s pretty much the universal answer to adult dental pain. While Medicaid doesn’t require states to provide reimbursement for adult preventative dental treatments like cleanings and sealants, 23 states did cover emergency dental care in 2009. Translation: extractions. Lots of them.

Medicare, which covers elderly Americans, doesn’t cover primary dental services, either. Neither does VA healthcare, unless it is considered necessary treatment for a service-related medical condition.

But even that can’t meet the kids’ sometimes extraordinary dental needs, said Hancock Middle School counselor Amanda VanHorn.

“It seems like every year there’s been a pretty significant dental case for which we’ve had to utilize outside resources,” she said. “Thank goodness both me and another counselor in the district have pretty good relationships with our dentists.”

During the 2010-2011 school year, it was a 13-year-old boy whose mouth was so swollen with dental pain that he had a hard time lifting his head off his desk. Another year, it was a girl who never opened her mouth, wouldn’t talk in class, and wouldn’t smile. It turned out she was missing two of her front teeth from previous extractions.

For the former, VanHorn and another counselor found a dentist to fix the boy’s tooth. In the latter case, VanHorn talked to her own personal dentist, who agreed to give the girl braces for a year and do two implants. Now the girl smiles, VanHorn said. She sings in the school chorus.

“She ended up trying out for American Idol in St. Louis,” said VanHorn. “The only reason she did it was because of her teeth.”

But even that pales compared to this year’s crisis. In December 2011, a girl came to VanHorn in a panic about her teeth. Eventually,
VanHorn realized the worry was because the girl’s mother had just died due to sepsis from a dental abscess. The family declined to speak for this story.

“The student was worried that she had teeth problems, too,” said VanHorn. “So I went back to the same dentist and she ended up having six cavities. The dentist filled those and sees her on a regular basis now.”

The problem, of course, is that these children’s treatment and quality of life – everything from their willingness to participate in school life to their fundamental health – depends on the goodwill of local dentists. Though Medicaid covers children, 16 million low-income children nationwide go without seeing a dentist every year and only 20 percent of dentists accept Medicaid because the reimbursement is so low.

CHILDREN ALSO DON’T SEE THE DENTIST in Pershing County, located in the dusty northwest of Nevada, though for a different reason. Pershing County is the size of the state of Massachusetts and has a population of 6,753 people.

“There’s nothing but sage brush between me and the next community, 70 miles away,” quipped Deb Pontius, the district’s sole school nurse and director of the state chapter of the National Association of School Nurses. There’s 40 miles of ranching valley in the county, but the rest is open desert, with no services and no dentists until you reach Reno, 100 miles to the west. Residents are Native American, Latino immigrants, and white. There’s a tiny African-American population. About 14 percent of the child-aged population lives below the poverty line, according to the 2010 Census.

Like the kids at Hancock Place School District, the 650 kids in Pontius’s district rely on the charity of local dentists. The problem is that the community can’t support a full-time dentist. One dentist comes to the town of Lovelock twice a week. He doesn’t take Medicaid. There are free and reduced-price clinics in Reno, but many of Pontius’ students’ families don’t have cars, don’t have jobs, and, if they have jobs, risk losing them for taking unexcused days off. The clinics are first come, first served, so if they arrive too late, they may have to come back the next day.

The residents of Pershing County are just some of the 47.8 million Americans nationwide who live in areas with a dentist shortage. According to the Pew Center on the States issue brief on the dental crisis, the country would need 6,645 more dentists to have a sufficient supply.

“There was a dental van that went to towns 40 miles around Reno,” she said, “I made a lot of noise about that. I did get that to come out here.”

Now the van, which can do cleanings and fillings, comes to her county twice a year. It’s a huge victory, but a tenuous one. The van is funded by a three-year grant that expires this year.

Minneapolis is the first state in the country to create such alternatives. Called advanced dental therapists, these professionals can practice without the direct supervision of a dentist and can do fillings, root canals, extractions, and crowns, among other things. Alaska also allows dental therapists to practice in rural tribal areas. But it’s still too soon to know how or whether these therapists can meet the tremendous need for dental care.

Some experts are advocating that a wider range of medical providers start paying more attention to oral health issues by learning

**Hitting a Nerve**

A full third of Americans have no access to dental care, and not all of this is due to the high cost of dental care. It’s also due to a federally documented shortage of dentists in 4,000 areas of the country.

Why such a shortage? Some of it is economics, but a larger reason stems from dental associations. During the 1980s recession, the American Dental Association lobbied for and caused the closure of dental schools around the country, fearing that a glut of dentists would drive down prices and hurt profitability. When the dean of one dental school objected, says Shelly Geshan, executive director of the Pew Children’s Dental Campaign, the ADA lobbied for and forced his removal from his job.

That mentality continues today. Just about any place where people are trying to find new ways to provide dental care for the people who need it, there’s a dental association fighting to block it. Consider these examples:

**ALABAMA**

Sarrell Dental Centers treats Medicaid patients who otherwise don’t get services. In 2010, the Alabama Dental Association considered lobbying for rules against Sarrell similar to those proposed against Gregory Folse (see Louisiana), arguing that private dentists couldn’t compete against nonprofit Sarrell. The U.S. Federal Trade Commission launched an investigation into whether the Alabama Dental Association was engaging in unfair competition and deceptive acts in its tactics.

**KANSAS**

Earlier this year, Kansas Gov. Sam Brownback signed a law that allows dental hygienists an expanded role to deal with tooth decay. What the bill, supported by the state’s dental association, does not do is address the 93 counties in the state without a single dentist. A broader bill designed to allow advance practice dental therapists similar to the ones in Minnesota failed in the Legislature after the dental association lobbied heavily against it.

**LOUISIANA**

When dentist Gregory Folse started treating seniors in nursing homes and children in schools, the Louisiana Dental Association asked for and got the state Board of Dentistry to write up rules for dental clinics that would have required Folse—the only dentist operating in this manner in the state at the time—not only to get written consent from his young patients’ guardians before an exam and treatment, but also to speak to and receive verbal consent from every guardian before doing any work on a child. The Federal Trade Commission objected to the rules. In 2010, the dental association again sought to limit Folse’s work through new rules. The association’s argument was that Folse’s practice would cut down market share for dentists in the state—dentists who didn’t serve Medicaid-covered children.

**MINNESOTA**

When in 2009 the Minnesota state Legislature approved a new mid-level dental provider, it was no thanks to the Minnesota Dental Association. In the years-long battle to alter the Dental Practices Act in that state to accommodate this new provider, the Minnesota Dental Association raised hundreds of thousands of dollars to fight the law. The result is two new practitioners, one of which can only work under a dentist’s supervision, undermining the need for dental care in areas without dentists. —Heather Boerner
How to do a basic risk assessment on patients, oral health education, and even some basic services. "You know, in my own mind, there are 3 million nurses," said Marcia Brand, deputy administrator of the Health Resources and Services Administration at the U.S. Department of Health and Human Services, at a June 19 public forum on dental care access hosted by the Kaiser Family Foundation. "If you get each of them to take that moment to look in someone's mouth, you know, and understand what they're seeing and then be able to make the appropriate referrals, we'll go a long way to ensuring that the 3-year-old doesn't end up in a situation where he or she has to have his teeth extracted."

In the meantime, though, Pontius scrapes together whatever she can to help her students get the care they need. "I'm calling Child Protective Services because the whole front of this kid's mouth is completely rotted away," said Pontius. "These are permanent teeth, not baby teeth. These kids are going to grow up with permanent tooth damage."

Calling CPS is a drastic measure, often taken when the parents themselves are toothless and "don't see it as a problem," Pontius said. But the problem is almost always money and access.

For the rest, she does what she can. At least once a week, she sees a kid with a toothache. Like adults in the ER, many of the kids are repeat. And like providers across the country, she has resorted to the palliative care she knows isn't a solution until the mobile dentist can visit.

"We do ice and Orajel," she said. "That's about it."

Some corporate dental chains, such as Kool Smiles, are opening up dental clinics because they see money to be made off of providing Medicaid-covered dental services to children. But as a Frontline documentary released in June, "Dollars and Dentists," reveals, these types of businesses put the bottom line first, often recommending unnecessary dental procedures for higher reimbursements, and performing substandard work. Other chains, such as Aspen Dental, are targeting adults and convincing them to put expensive dental work onto healthcare credit cards that they have little hope of ever paying off. In both cases, these corporations, often owned by private equity firms or business investors, stand to profit off the pain and desperation of patients who cannot access traditional dental services.

"Do I get my cavity filled or do I buy milk for my kids? No question. I get the milk."

Back in the pre-dawn hours at the Oakland Coliseum, smokers were hanging out at the lip of the ramp, risking the drizzle for a cigarette that might keep them awake. Some chugged energy drinks. A little boy in a yellow slicker paced up and down the ramp moaning that he'd probably happen. He'd arrived at 2:30 a.m. to get a number. She just wanted to get her own and her kids' teeth cleaned. She was number 389.

On the far wall, Mari Johnson, 41, was sitting in a blue camp chair, a hood up over her hair and a Raiders scarf wrapped around it to keep out the cold. She pulled the sleeves of her jacket over her bare hands. She'd driven her three boys to her cousin's house at 2:30 a.m. so she could come get a number to get a cavity filled. Out of 800, she was number 549.

Three years ago, Johnson wouldn't have been here. She had a good job and dental insurance. "I had braces," she announced with a combination of pride and anger. "I loved to smile. I'd give a big 'Cheese!' smile. But then, my face swelled up and I had to get my teeth out."

What changed? Three years ago, her husband died, and her night job was no longer practical. Now she and her sons live on Social Security. Johnson went back to school to become a certified nurses aide, but she's not working now.

A year and a half ago, her lower left jaw started to ache. She stopped eating on that side — still doesn't. Then the headaches started. Then they got worse. Her ear started hurting.

"I was asking people for Vicodin," she said, only half joking.

Finally in the fall, she went to the ER at Kaiser Permanente Medical Center in Oakland, where they gave her antibiotics and a referral to a local clinic that would pull her tooth on a sliding scale. She didn't head to the clinic until her face swelled. In October, the clinic pulled her tooth for $482. She's finally got that debt paid down to $152, but she can't go back until her debt is below $100. Meanwhile, the tooth next to the one that was extracted developed a cavity. She needs a cap, for a front tooth that had a root canal on it a while ago. But that's going to cost her $1,400, even at the clinic, and RAM only allowed her to have one procedure done that day. "Necessity over beauty," she quipped.

The cavities will cost $152 each to fill. But $304 is a lot of money for her, the equivalent of groceries for the month, her electric bill, and half her water bill.

"Do I get my cavity filled or do I buy milk for my kids?" she drawled. "No question. I get the milk."

The woman next to her sucked her teeth in understanding. She was there to have a cavity filled, too, even though she hates the dentist. If she hadn't heard about this clinic on the news, she said, "I had no plan for what to do about it. Probably keep using Orajel to relieve the pain."

"MediCal [California's Medicaid program] will take care of your kids, but only until they're 18 and independent adults," the woman scoffed. "Then, their teeth can just fall out of their heads."

By now, Johnson was nodding and smiling and laughing in compulsion. "I'm not going to have my kids looking stupid so I can look good, so I can look beautiful," she joked, cupping her hands around her face, as if for her close up.

Still, she doesn't want to lose teeth. She worries about having a sunken spot in her cheek when they have to take out the upper teeth that once rested on the tooth she had extracted — something the dentist warned her would probably happen.

"All the men in my family are bald and toothless," she said. "I do worry about that happening for me. Because I'm a girl. I love my smile."

And she can't help but think that our country can do better than have people show up in the dead of night just so they can have their teeth looked at.

"I love Obama," she said, "but we're in the United States of America. We shouldn't have to do this."
Collective Patient Advocacy Trailblazers: The Road to Ratios

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.

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...”

Submitted by the Joint Nursing Practice Commission, DeAnn McEwen, RN, and Hedy Dumpel, RN, JD
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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,
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.

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.

Societal and patient needs, rather than institutionally ordained policies and procedures, should determine the art and science of modern nursing practice.

— Lillian Wald
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 and Wald understood that to change the status quo, the profession needed to exert collective advocacy power in unity. They recognized the barriers to autonomy and fought to prevent encumbrance of their professional practice by the male/physician-dominated hierarchy and their matron enablers existing in hospitals. 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 patient’s “humanism was mechanized, his organic whole was fractured into parts, his basic physiological and technical needs were reduced to a checklist on paper. Thus he became an automated patient.” — Marram et al.

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 solders in the Crimean.

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 principle 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 science, technology, and management as the norm for health and health care alike. The solution to this is to fully restore 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 in 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 healthcare 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 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 cut. 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 potential 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 thebottom 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 the 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(j) 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(h).)
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 cost-containment schemes. DHS required clinical alignment (PCS based on individual patient acuity/severity of illness), but that was soon manipulated into fiscal alignment, or staffing based on budget and patient census. There was no room for differentiating patient acuity and individual nursing care needs. Most problematic was the PCS override of the RN’s individual professional clinical judgment.

The majority of commercially available patient classification systems utilize a “closed” proprietary method for converting patient acuity/care hours calculated by the direct-care RNs into staffing and skill mix. The PCS was intended to assure that the number of nursing staff was aligned with the healthcare needs of the patients, while allowing the hospital administration “maximum flexibility” for “efficient” use of staff. Since 1977, RNs engaged in direct, patient-care services have been critical of the various “home grown” and/or commercial systems and how they were used by their hospital employers. Commercial systems that measure patient acuity or workload use a variety of definitions for and measures of staffing and workload. Most focus on patient contributors, not work-environment contributors. Thus, research results using their data may be inconsistent and inconclusive.

When initiatives are undertaken or imposed in an effort to improve patient safety or care quality also increase workload, 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.” 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 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 reprimal. 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 intent 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 Revision of Statutes 2005; Rainer 2005) and Illinois (Kevin and Stickler 2007), 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 unproved 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 power 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.

References

California Code of Regulations, Title 22, Section 70217 Nursing Service Staff. (2005).
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AFTER ALL THE VOTES ARE COUNTED, nurses will still be fighting to protect Social Security, Medicare, and Medicaid—three crown jewels of a civil society and a humane America. No cuts. No privatization. No retreat.

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