

Mandated Nurse Staffing Ratios- Is This A Nursing Panacea?

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Statement

Appropriate nurse staffing is critical to the delivery of safe, efficient patient care. Nurse staffing legislation will undoubtedly force hospitals to increase the number of registered nurses at the bedside. Is simply counting the number of patients each RN cares for, however, the appropriate way to improve patient safety and health care quality?

Introduction

A great deal of research has been done with respect to nursing care and patient outcomes. There seems to be consensus that nursing care does indeed affect patient safety as well as overall quality of care. Statistics related to mortality, adverse events, and "failure to rescue" (describing mortality following a complication) are some of the indicators that have been studied. The indicators used to determine safety and quality of patient care focus predominantly on the occurrence of adverse events as the sole measure. Researchers continue to analyze whether there is in fact a relationship between the number of nurses at the bedside and quality of patient care.

Research

Numerous studies with varying methodologies and conclusions have been completed. Most studies confirm that a greater number of registered nurses does equate to more positive patient outcomes. The Agency for Healthcare Research and Quality (AHRQ) performed a review of 26 studies examining the relationship between nurse staffing levels and various measures of patient safety. The researchers concluded that, in many instances, low nurse staffing levels have higher rates of poor patient outcomes.¹

A comprehensive study by Needleman and colleagues analyzed medical and surgical patients from 799 hospitals in 11 states; no significant relationship between nurse staffing and mortality was identified.² Another study by the same group found correlations between nurse staffing patterns and the rates of several

adverse events, including urinary tract infections, upper gastrointestinal bleeding, pneumonia and cardiac arrest among medical patients.³

Aiken and colleagues reviewed death rates for surgical patients and calculated that each additional patient assigned to the average nurse workload increased both the likelihood of patient mortality and "failure to rescue" (mortality following a complication) by 7%.⁴

In a composite study, Tourangeau and associates assessed the impact nurses have on patient mortality by reviewing and summarizing the conclusions from at least 15 different research investigations and manuscripts. They targeted studies such as Aiken and Needleman's, which specifically focused on the relationship between nursing care and patient outcomes. Additionally, they reviewed other criteria such as: interactions between nursing and medical staff; professional practice environment; experience and education of the nursing staff and level of support received by the staff nurses from their supervisors.⁵

Conclusions from their research determined that many of the studies actually provided conflicting evidence. More importantly, they argue that focusing solely on the incidence of adverse events shifts the emphasis away from examining system issues and organizational structure, which lead to these adverse events.⁶

Legislation

42 Code of Federal Regulations (42 CFR 482.23(b)) requires CMS hospitals to have adequate number of nurses and other nursing personnel to provide nursing care to all patients as needed. However, it does not describe what that entails; nor does it discuss how the hospitals are to ensure that it occurs.⁷

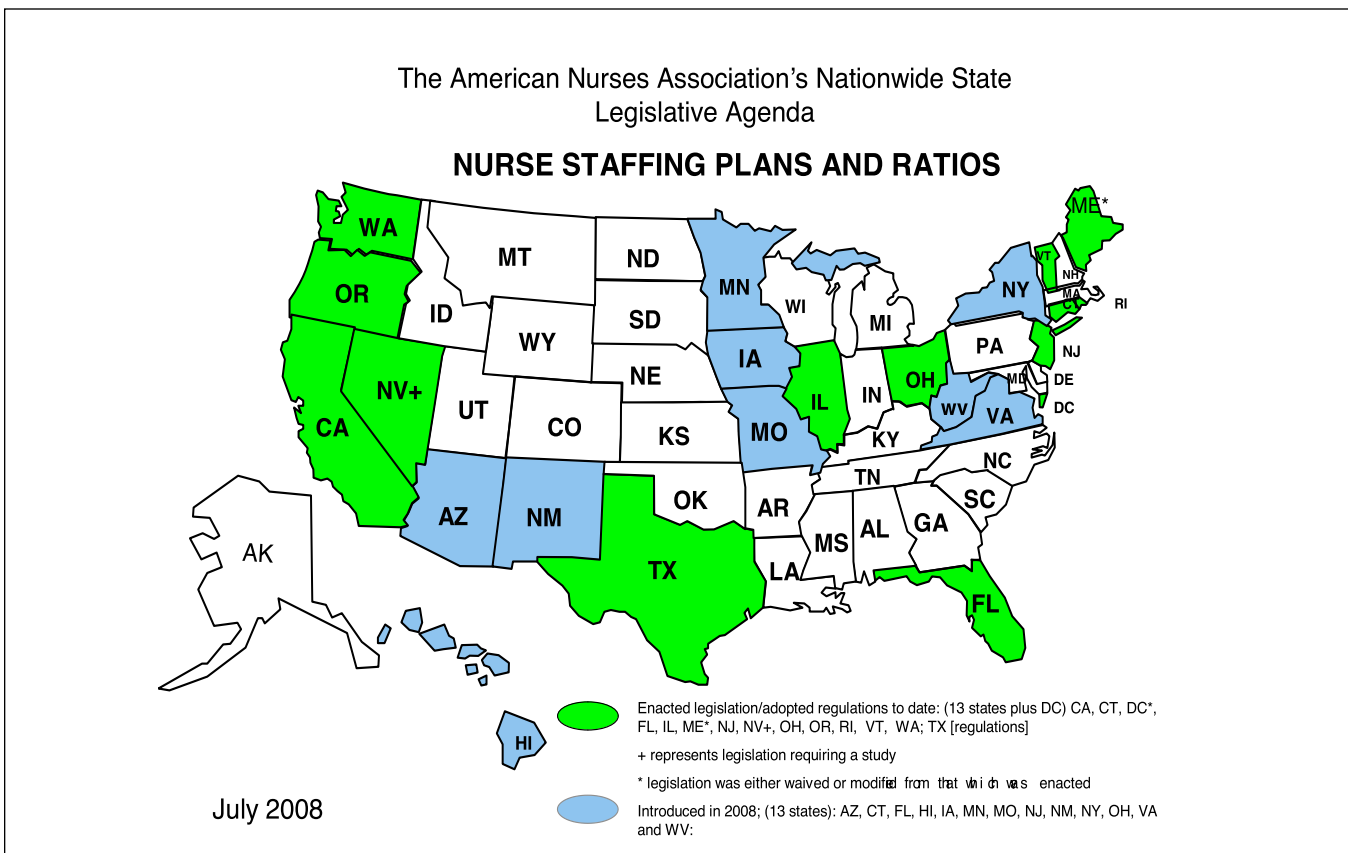
Each state must determine what best suits the needs of its constituents. States have utilized varying methods in their attempt to meet the federal regulations. Although proposals are varied, the following three general approaches to assure sufficient nurse staffing have been proposed by the American Nurses Association.⁸

- The first is to require and hold hospitals accountable for implementation of **nurse staffing plans**, with input from practicing nurses, to assure safe nurse to patient ratios are based on patient need and other criteria.
- The second approach is for legislators to mandate specific **nurse to patient ratios** in legislation or regulation.
- The third approach is a **combination** of nurse staffing plans and legislated nurse to patient ratios. Enhancing these approaches includes a provision for making staffing information available to the public.

Thirteen states have introduced some form of legislation to address nurse staffing. As of July 2008, eleven states (CA, CT, FL, IL, ME, NJ, OH, OR, RI, TX, VT) plus the District of Columbia have enacted legislation and/or adopted regulations addressing nurse staffing. Additional laws regarding nurse staffing are being considered in at least 25 states.⁹

The American Nurses Association (ANA) and state nurses associations are promoting legislation to hold hospitals accountable for the development and implementation of valid and reliable nurse staffing plans.¹⁰

ANA's recommendation allows hospitals the flexibility of tailoring nurse staffing to the specific needs of patients based on factors including how sick the patient is, the experience of the nursing staff, technology, and support services available to the nurses. This flexibility does not negate the accountability of hospitals to ensure safe and effective nurse staffing. States are looking at enforcement measures ranging from termination or suspension of a facility's license and public disclosure of violations to fees, penalties and private right of action suits.¹¹



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California's initiative

In 1999, California was the first state in the nation to enact legislation describing the number of patients each nurse could care for. California Ratio Law (AB394) was enacted in 2004. The plan had a four-year total implementation deadline of January 1, 2008.¹²

A unique collaborative between the American Nurses Association and the Association of California Nurse Leaders (CalNOC) conducted a study based on comparing pre-ratio data (2002) with 2004 data and 2006 data. The study found that the imposition of mandatory ratios has had no impact on the most accepted nurse-sensitive quality measures.¹³ "The California experiment in mandated ratios has increased patient access to licensed professional nurses in hospitals but has not yet improved their safety from falls or assurance that they will emerge from acute care with less likelihood of a hospital-acquired pressure ulcer".¹⁴

Following the implementation of California's staffing legislation staffing ratios did increase significantly throughout most of California. The true "safety net" hospitals with the most vulnerable patient populations however were far less likely to achieve mandated ratios.¹⁵ How then do the hospitals that are unable to recruit nursing staff meet the mandated requirements? This certainly requires more consideration.

California's legislation requiring RN staffing ratios be adjusted had great impact on other direct care providers (LVN and nurse's aides) as well. Nurse to patient staffing ratios require hospitals to adjust the number of RNs on staff. Since there is no increased financial reimbursement for the hospital to provide this care, the only alternative for administrators is to decrease FTEs elsewhere. Inevitably, the bedside staff RNs are required to perform non-nursing duties to continue caring for their patients.¹⁶ If filling the staffing mix with only RNs forces administrators to remove nursing assistants and technicians, the RN's workload will ultimately include such non-nursing duties as emptying the trash, changing linens or performing patient transportation. How can this improve the quality of patient care?

Considerations

Attention must also be given to how nurse-staffing data is applied. The current measure of hours per patient day (HPPD) is an "average" number of patients, and in most hospitals, that number is obtained using the midnight census. There is no consideration for patient age, functionality, co-morbidities, cultural, social, or severity indices. A policy statement from ANA Board of Directors expert panel in 1998 discusses consideration to revise and or remove the current HPPD (hours per patient day) standard for determining patient census.¹⁷

There may be other indicators that should be identified beside the number of patients a nurse is caring for. One study found that nurses working beyond their 12-hour shift were three times more likely to make medical errors than during an 8-hour shift.¹⁸ Finding such as these were so significant, it actually prompted the IOM (Institute of Medicine) in 2004 to recommend nursing shifts be limited to 12-hours in any 24-hour period.¹⁹

The guidelines currently consider only RNs in the ratio. Neither LPNs nor CNAs or other staff members are included in determining staffing. Additionally, there is no consideration for other RN personnel in the mix, including department managers, educators, or even charge nurses.²⁰

RN available workforce

Statistical evidence shows there is a shortage of nurses; a decrease in the number of people applying to and attending nursing programs and an increase in the number of people leaving the field of nursing. In addition, the population is aging and more people are requiring nursing care.

According to The Joint Commission, 41 percent of acute care facilities are using sign on and recruitment bonuses to recruit nurses.²¹ Traditional travel agencies are currently managing increased volume and hospitals are recruiting travelers from outside of the US, including Canada, the United Kingdom, the Philippines and Asia.²²

Even if nurse staffing was mandated and/or hospitals were ready to fill all the available RN positions, where would additional RN recruits come from? Current literature regarding the nursing shortage and the retirement figures of the baby boomer generation looming makes the nurse-staffing picture even more ominous. In fact, the present situation may well continue over the next two decades. A Federal Government study predicts that hospital nursing vacancies will reach 800,000, or 29 percent, by 2020.²³ The number of nurses is expected to grow by only 6 percent by 2020 while demand for nursing care is expected to grow by 40 percent.

The most recent research shows a jump of 100,000 RNs, or 9 percent, in the hospital RN workforce between 2001 and 2002 because of increased demand, higher pay, and a weakening economy.²⁴ However, the average age of over 70 percent of the nursing workforce is currently over 50 years of age.

Recommendations

The American Nurses Association recommends hospitals require nurses to be an integral part of the nurse staffing plan development and decision-making process to ensure appropriate hospital staffing.²⁵

Legislators must provide resources for nurse education. In addition, nurses, especially the hospital nurse executives, must participate in public policy. Nurse leaders must let their representatives know their concerns. Nurses at all levels should actively participate in their professional organizations. Regulations regarding nursing licensure should be simplified. Many states have adopted the Nurse Licensure Compact that allows mutual recognition by another state board for registered nurses to practice across state lines.²⁶ If all states were to join the compact, it would eliminate travel obstacles and delays, thus providing a larger nursing supply to areas with fewer RNs.

Hospitals need to focus on nurse recruitment and retention. It is incumbent upon hospital administrators

and legislators to provide opportunities for those to enter and then remain in the profession. Today's youth need education and encouragement to consider nursing as a career. Novice nurses may prefer work shifts that accommodate work-life balance. Veteran nurses may need more creative scheduling or positions that are physically less demanding, perhaps shorter shifts for older nurses or those with physical disabilities

More focus should be given to the overall health and well being of the staff including such basics as access to nourishment and time away from the patient care area to eat; and providing exercise equipment or health focused programs on site.

Consideration must be given to the utilization and education of other licensed care providers. LPN/LVN and other caregivers are available and their roles should be maximized in the acute care setting, rather than eliminating their positions.

Hospital administrators must include staff nurses in the discussion and development of staffing policies and staffing plans. Nurse managers must be attuned to the staff they oversee.

More emphasis should be given to the process of incident review, ensuring that it is for the good of the patient and never used for punitive reasons. Other factors affecting nurse workload need to be considered.

The recommendations from Tourangeau, et.al include:²⁷

- Maximizing the proportion of RN and baccalaureate prepared nurses in the hospital staffing mix.
- Implementing strategies to strengthen collaborative relationships between RN and physician staff
- Sustaining clinical nursing support systems to enhance the delivery of patient care
- Developing hospital environments that strengthen professional practice (e.g. Magnet) for staff nurses and leadership knowledge.

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Conclusion

It may still be unclear how the ultimate measure of patient safety and quality outcomes can be obtained. What is clear, however, is that state officials, legislators, health care organizations, colleges and the nursing community must work together for solutions. A requirement mandating hospital administrators to simply "count" the number of patients a nurse can care for does not seem to be an appropriate or realistic solution. Consideration must be given to identification of nurse sensitive indicators beyond patient ratios; establishment of consistent data collection; lobbying at state and federal levels for research and financial support; and agreement by all hospital administrators that adequate nursing care remains the key to safe patient care.

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