Policy Brief: Patient Safety Ratio and Nurse Staffing

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Nurse staffing and patient to nurse ratio is one of the determining factors of patient safety and a topic that has been discussed since the late 1900s. Staffing needs were under the discretion of individual hospitals until the 1990s (Serratt, Meyer & Chapman, 2014). National scrutiny was placed out of concern when the hospitals reduced the number of registered nurses in order to reduce the financial cost during that period (Serratt, Meyer & Chapman, 2014). The concerns regarding staff reduction related to quality care and patient safety triggered lobbying efforts and studies to be conducted by American Nurses Association (ANA) and national publications. The federal regulation (42CFR 482.23(b)) was created in June 1986 and was amended throughout the years based on evidence based research and health care changes.

The existing regulation, (42CFR 482.23(b)), requires hospitals to "have adequate   
numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed” (“Nurse Staffing”, 2015). ANA critiques the regulation of its nebulous language and states that the Congress has continuously failed to enact a federal law. Until this day, only a few states have taken action to adopt the staff ratio regulation at varying degrees. In the recent years, nurse staffing and patient ratio has become an important topic in healthcare due to the enactment of Affordable Care Act (ACA) and the aging U.S. population (ANA, 2015). The aging population and the ACA healthcare reform increased the number of patients requiring healthcare.

The intended audience of this policy brief are both state and federal policy makers to help them understand the reality of hospital understaffing, patient safety, and inform them about current evidence base studies surrounding registered nurse (RN)-to-patient ratios. Although patient safety is regarded as one of six priorities by the National Quality Strategy (NQS), it is not being properly enforced through bills and regulations. The journal by Serrat, Meyer, and Chapman (2014) studied the current situation regarding the enforcement of hospital nurse staffing regulations within the United States. The authors have concluded that although the regulations are a progress in addressing staffing inadequacy, it lacks the enforcement language making it difficult to enforce and monitor the regulations. The journal article recommends implementation of explicit and funded enforcement measures, monitoring, reporting, evaluation of hospital’s nurse staffing (Serratt, Meyer & Chapman, 2014).

Since the enactment of the first federal regulation, the ANA has collected resources, supporting evidence on benefits of nurse staffing, and advocated and lobbied for legislation which can be found in their website. Of the three general approaches in state staffing laws, the ANA supports legislative model where nurses are empowered to create staffing plans specific to each unit (“Nurse Staffing”, 2015). This approach allows for flexible staffing changes and takes the unit’s and patient’s specific needs into account rather than mandating fixed ratios or a one-size-fits-all approach (“Legislation Mandating Nurse Staffing Plans and Ratios Remains Controversial”, 2015). It is imperative that policy makers acknowledge that different factors influence nurse staffing and patient safety. Every unit is different in the size of the unit, patient population, level of acuity, and experiences of the nurses. The nurses understand their limitations and know the number of patients they can safely handle and the nursing staff should have the ability to determine their RN to patient ratio.

Currently, there are only 14 states that have addressed the nurse staffing in hospitals regulation with California being the only state to establish minimum RN-to-patient ratios.

Of the 14 states, 7 states require hospitals to have responsible staffing and 5 states require some form of disclosure and/or public reporting (“Nurse Staffing”, 2015). California is the only state that stipulates a required minimum nurse to patient ratios and the California Nurses Association advocated and lobbied this bill for 13 years to pass it in 2004 (Blitchok, 2018). Under the law nurses may care for no more than six psychiatric patients, five medical-surgical unit patients, four pediatric patients, three labor and delivery patients, and two intensive care unit patients (“California Nurse Ratio Law Saves Lives, Improves Nurse Morale, Study Finds”, 2010).

The California law requiring minimum RN to patient ratio has resulted in lower mortality from common surgeries, increased quality of care, lower burnout rates, better nurse retention, and improvement in nurse morale (Aiken, et. al, 2010). In the journal by Aiken, et. al. (2010), the authors also compared the nurses and their workload in three different states: California, New Jersey, and Pennsylvania. The study’s findings revealed that there were decrease in nurses’ burnout, job dissatisfaction, and reports of better quality of care when the nurses’ workloads matched the California-mandated ratios in all three states (Aiken, et. al, 2010). If the same mandate was implemented in New Jersey or Pennsylvania, both New Jersey and Pennsylvania hospitals would have had 14 percent and 11 percent fewer surgical deaths during the study period (Aiken, et. al, 2010).

ANA surveyed nearly 220,000 RNs about their work condition and found that 54% of nurses do not have sufficient time with patients. Additionally, 43% of the nurses have been working extra hours due to short staffing, and 20% have stated that admissions, transfers, and discharges were affected by understaffing (“Legislation Mandating Nurse Staffing Plans and Ratios Remains Controversial”, 2015). Working condition, understaffing, nurse fatigue, and mandatory overtime are closely associated with patient outcomes and have negative impact on safety and quality of patient care. The study by Stone et. al. (2007) revealed that units with higher staffing had lower incidence of patient complication and the increased overtime was associated with higher rates of complications. The authors conclude that improving working conditions will likely promote patient safety and future researchers and policymakers should consider all working condition variables (Stone, et. al, 2007). Nurse staffing should not be held in the balance of state rights and the legislation should be applied at a federal level given that it influences healthcare quality, patient safety, patient mortality, and hospital readmissions.

Recently, I had a chance to experience what it is like to care for five “couplets”, mother and baby for my preceptorship. Five couplets mean there are 10 patients, five mother and five newborns, that a nurse has to to assess and care for during the 12-hour shift. The nurses in the unit has said they have had to care for five couplets and they have expressed not feeling comfortable taking on 10 patients. This ratio is higher than the California law sets the RN to postpartum couplets ratio at 1:4. The experience of having the high RN to patient ratio as a student nurse was overwhelming. We’ve started the shift with four couplets but got a new admission at midnight and it was a stressful shift. My preceptor and I did not have a chance to take a break and had to manage, assess, educate, medicate, chart on EHR, and file admission paperwork for our five couplets. The workload was overwhelming but the charge nurse did not have the ability to call in another nurse due to the hospital policy. This is an example of everyday reality in the clinical setting. The nurses do not have the power to decide the RN to patient ratio and have to take on more patients than they are comfortable. The lack of autonomy due to healthcare regulations adds on to the level of stress and fatigue nurses experience in the workplace.

Policy makers can address the nurse staffing by amending the current bills and regulations. Amendments could be made under (42CFR 482.23(b)) to add guidelines as to how the “adequate number” should be defined. The data collected from recent research conducted in California shows that the ratio set by the state government works. It can be used as a baseline to successfully implement the regulations on a federal level. Regulation on transparency of nurse-to-patient ratios and having it visible for visitors on the unit can also be added to the policy. It will help enforce measures and monitor the appropriate RN to patient ratio. Additional bills were introduced in the congress to address the nurse to staff ratios. Nurse Staffing Standards for Patient Safety and Quality Care Act of 2015 (H.R. 1602) introduced in 2015 was written to establish federal nurse-to-patient staffing ratios in all hospitals by unit. It required Health and Human Services (HHS) to develop a transparent method for establishing nurse staffing requirements above minimum ratios. In this bill, nurses were given autonomy to object to, or refuse to participate in, any assignment if it would violate minimum ratios with no repercussions from the hospital employer (Schakowsky, 2015).

Although it was not passed in 2015, it was reintroduced as (H.R.2392) to the house by The Illinois congresswoman Jan Schakowsky in 2017. Congresswoman Schakowsky understood the struggles the nurses face when they are not given autonomy to provide quality are to their patients. The combination of increased workload and lack of autonomy due to failed enactment of current regulations can be dangerous to patients and nurses. Understaffing decreases nurses’ job satisfaction, retention rate, and increases stress, burnouts, and fatigue. It will take decades before the state legislation passes a bill requiring appropriate RN to patient ratio. Recommendations could be made that the regulation be passed in a federal level to accelerate the process in protecting the healthcare professionals and patients.

Reference

Aiken, L. H., Sloane, D. M., Cimiotti, J. P., Clarke, S. P., Flynn, L., Seago, J. A., & ... Smith, H.

L. (2010). Implications of the California Nurse Staffing Mandate for Other States. *Health*

*Services Research*, *45*(4), 904-921. doi:10.1111/j.1475-6773.2010.01114.x

ANA (2015). Optimal Nurse Staffing to Improve Quality of Care and Patient Outcomes:

Executive Summary. *Avalere Health LLC.* Retrieved February 11, 2018 from:

http://nursingworld.org/HomepageCategory/NursingInsider/Archive-1/2017-NI/June17-

NI/NurseStaffing-DownloadWhitePaper.html

Blitchok, A. (2018). Proposed federal RN ratios - what you can do about it. Nurse.org. Retrieved

February 10, 2018 from: https://nurse.org/articles/federal-staffing-ratios/#

California Nurse Ratio Law Saves Lives, Improves Nurse Morale, Study Finds. (2010, May 26).

Retrieved February 10, 2018, from https://www.rwjf.org/en/library/articles-and-

news/2010/05/california-nurse-ratio-law-saves-lives-improves-nurse-morale-stu.html

Legislation Mandating Nurse Staffing Plans and Ratios Remains Controversial. (2015, February

26). Retrieved February 10, 2018, from https://www.ons.org/practice-resources/clinical-

practice/legislation-mandating-nurse-staffing-plans-and-ratios-remains

Nurse Staffing. (2015, December). Retrieved February 08, 2018, from http://www.nursingworld.

org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-StaffingPlansRatios

Stone, P., Mooney-Kane, C., Larson, E., Horan, T., Glance, L., Zwanziger, J., & Dick, A. (2007).

Nurse working conditions and patient safety outcomes. *Medical Care*, *45*(6), 571-578.

Schakowsky, J. (2015, April 07). H.R.1602 - 114th Congress (2015-2016): Nurse Staffing

Standards for Patient Safety and Quality Care Act of 2015. Retrieved February 11, 2018,

from https://www.congress.gov/bill/114th-congress/house-bill/1602

Serratt, T., Meyer, S., & Chapman, S. A. (2014). Enforcement of Hospital Nurse Staffing

Regulations Across the United States: Progress or Stalemate?. *Policy, Politics & Nursing*

*Practice*, *15*(1/2), 21-29. doi:10.1177/1527154414532502