

# Charting Nursing's Future

A Publication of the Robert Wood Johnson Foundation

Reports on Policies That  
Can Transform Patient Care

## Facts and Controversies about Nurse Staffing Policy: A Look at Existing Models, Enforcement Issues, and Research Needs

**W**ith the rapid growth of managed care in the mid-1990s, hospitals faced severe financial pressure. To save money, many hospital administrators began to restructure nurse staffing, cutting wages and jobs of registered nurses (RNs) and hiring lower-paid licensed vocational nurses (LVNs) and ancillary staff to fill in the gaps. In response, nurses—especially in states with shortages, such as California—began to campaign for policies to improve nurse-to-patient

staffing levels (see fig. 1). This brief examines state-mandated nurse staffing ratios as a policy model, including in-depth coverage of California's ratio experience, and explores two other staffing models: patient classification systems and pay-for-performance concepts. It also presents a diversity of views from experts; notes enforcement and research needs; and offers a set of tips for policymakers considering nurse staffing measures.

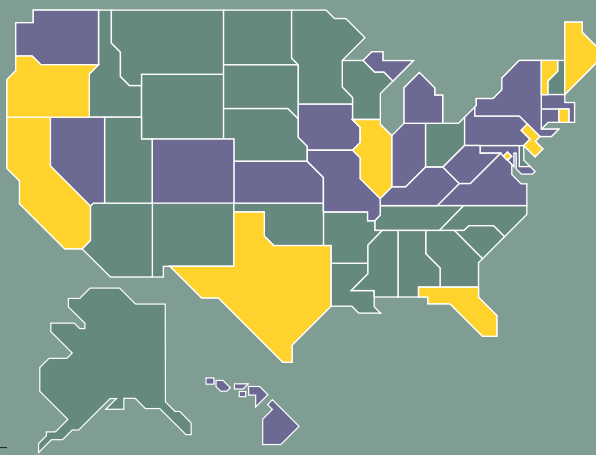
Figure 1 Nurse Staffing Plans and Ratios: A State Policy Snapshot

**Enacted Legislation and/or Regulations**  
CA, DC\*, FL, IL, ME†, NJ, OR, RI, TX, VT

**Introduced but Have Not Enacted Any Legislation and/or Regulations**  
(Measures are pending in some states)  
CO, CT, HI, IA, IN, KS, KY, MA, MD, MI, MO, NV, NY, PA, VA, WA, WV

\* DC later waived a ratio law due to an existing nursing shortage.

† ME recommended a collection of nurse-sensitive indicators in lieu of ratios.



Source: Adapted from "The American Nurses Association Nationwide State Legislative Agenda," last updated June 30, 2007. For more information, or to respond to this data, visit [www.nursingworld.org/gova/state.htm](http://www.nursingworld.org/gova/state.htm).

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## The Value of Nursing



Getty Images

Two nurses document their fulfillment of medication orders from a secure medications cart in a hospital. Nurses have a critical role to play in preventing medical errors. A study of medication errors made by physicians, pharmacists, and others in two hospitals over a six-month period found that nurses were responsible for intercepting 86 percent of medical errors before the mistakes affected patients. This is no small blessing: an Institute of Medicine (IOM) study indicated that medical errors kill between 44,000 and 98,000 Americans each year—more deaths per year than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516). Many of these deaths are caused by medication errors.

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## Changes in Patient Acuity and Their Effects on Nurse Staffing

The importance of nursing to patients and to health care can hardly be overstated. The 5.1 million nursing care workers in the United States make up more than half (about 54 percent) of the entire health care work force. Nursing workers care for patients in virtually all locations in which health care is given—hospitals, nursing homes, ambulatory care settings (such as clinics or physicians' offices), schools, employee workspaces, and private homes. When patients enter the health care system, a nurse is often the first worker they encounter; when they are discharged, their instructions for further care are most often given by nurses.

A relatively new body of research is emerging that is beginning to document a truth that nurses themselves, as well as doctors, patients, and other health care workers have known for a long time: that the quality of nursing care patients receive influences patient health and safety and can sometimes be a matter of life or death.

Since the managed-care revolution of the 1990s, nursing has also come to be seen as a key labor market and, since there are so many nurses, a very costly one. In the mid-1990s, managed care was growing rapidly; hospitals faced financial pressure, so they began to restructure nurse staffing to stabilize finances.

Nursing is the largest cost center in a hospital. "When costs had to be cut," says Jack Needleman, PhD, associate professor in the department of health services at UCLA's School of Public Health, "[hospital administrators] looked to their largest line item, and it was labor, particularly nursing. Many began cutting costs in ways that did not involve nurses in the process. In these environments, nurses' distrust of management often grew."

Restructuring has changed the ways in which nurses' work is organized. Many of these changes have been focused on increasing efficiency—many say at the expense of patient safety and care—and have been implemented in ways that have damaged trust between nursing staff and management.

For example, the primary work of nursing includes patient assessment, performed at admission and discharge and periodically throughout a patient's hospital stay. Before managed care, patient stays were longer, with more time between the labor-intensive processes of admission and discharge, allowing nurses to have a more balanced workload and spend more time with patients. Now, however, patients come to the hospital in conditions requiring more care. "Patient turnover is ramped up, and nurses are required to perform more admissions and discharges," says Joanne Spetz, PhD, assistant adjunct professor of community health systems at the University of California–San Francisco. Nurses are not able to spend quality time on their patients despite the fact that, in general, patients require more nursing care before their discharges than they did 20 or 30 years ago.

The increase in patient loads and the concurrent decrease in the number of nurses to care for those patients has increased nurses' burdens and fostered job dissatisfaction.

To remedy the factors that have caused their members such difficulty and dissatisfaction, nursing unions in some states have made policies that advance the nurse staffing issue at the bargaining table and in the legislature. Unions believe such policies will better guarantee patient safety.

Many clinicians and policymakers think of nurse staffing ratios as a new solution to staffing problems. However, ratios have been standard practice in the ICU for the past 30 years or more. An ICU nurse-to-patient ratio of 1:2 has been the minimum practice standard and has been widely adopted as state-level policy since the mid-1970s, with ICUs required to "staff up"—add more nurses—as patient conditions warrant. But this policy was instituted before the managed care revolution, and the ICU ratio has not been adjusted as patients have gotten sicker. The typical 1970s ICU patient is now cared for on a step-down unit at a ratio of about one nurse to four patients, or on a regular medical-surgical unit at ratios between 1:5 and 1:8.



**“Ensuring that the proper number of nurses are working at a given time enhances patient safety and improves the quality of life for nurses and patients. Enacting nurse staffing policy that guarantees appropriate and safe staffing levels is one sure way to improve quality of care in our health care facilities.”**

Representative Lois Capps (D-CA)

“The ICU patient of the 1970s is today’s medical-surgical patient,” says Marilyn Chow, RN, DNSc, FAAN, vice president of patient care services at Kaiser Permanente (KP). “That we’re struggling to make medical-surgical ratios one-to-five doesn’t make sense.”

While ratios, particularly state-mandated ratios, remain very controversial, there is a consensus developing among leading experts that maintaining the status quo in the nursing workplace may jeopardize patient safety and quality of care.

## Three Models of Nurse Staffing Policy

In the mid-1990s, nurses responded to hospital restructuring by becoming more assertive in seeking institutional and state policy changes. The first ballot proposition containing fixed minimum ratios was introduced in California in 1996.

The IOM report *Keeping Patients Safe* found that hospital restructuring initiatives that were intended to save money by increasing efficiency (at the expense of patient safety) were often poorly managed and excluded nurses from decision making. Poor communication has also been identified as a factor that both contributes to medical errors and reduces nurses' trust of hospital administration. According to the Joint Commission, about 70 percent of serious adverse events in 2005 were attributed to the inability of hospital staff to communicate effectively, a cause that far outstripped the 11 other root causes of such events. The IOM committee concluded that, due to restructuring and poor communication, "[l]oss of trust in hospital administration is widespread among nursing staff."

California's nursing unions, particularly the California Nurses Association (CNA), used staffing policy as a bargaining chip. After 10 years, they secured fixed ratio legislation—"a huge victory for the union," says Joanne Spetz, and a precedent from which other nurse associations are learning (see p. 5 story on the California law).

Adequate staffing levels constitute a critical factor in the nursing workplace environment. The question that remains is how best to ensure them. Three alternatives exist or are being considered: ratios, patient classification, and pay-for-performance.

### Fixed Minimum Ratios

*How the model works:* Facilities are required to staff to a certain fixed minimum nurse-to-patient ratio.

Fixed minimum nurse-to-patient ratios permit the government, usually at the state level, to set a staffing

"floor" for each acuity unit (see fig. 2). This policy model has been adopted by only two jurisdictions in the world—the states of California in the United States, and Victoria, Australia—so data on its effectiveness is limited.

The idea behind fixed ratios, Spetz says, is that regulators will set the "optimal" minimum ratio by identifying "the point at which the marginal benefit and the marginal cost" of staffing are equal. To fix nurse staffing, she says, we cannot just add nurses until we wind up with no mortality—it's not practicable.

Spetz explains the idea of "marginal cost and benefit": "The optimal level of nurse staffing is not simply the number of nurses that would avert the most deaths. We probably would get great health outcomes if we had two or even four nurses taking care of every patient—but that's rather extreme. However, maybe you could get *nearly* as good an outcome with one nurse per patient, or even one nurse for every three patients, combined with a better infection control system, or a new chemotherapy system." No one knows what the optimal ratio is, because no one has yet identified the point at which marginal costs and benefits are equal.

Nurses, nurse leaders, health plan executives, and researchers interviewed for this brief said that many nurses are comforted by ratio policy because it guarantees a minimum staffing level on which nurses can depend. It has been argued that fixed ratios

improve staffing standards, especially for hospitals that severely understaff.

However, not much research or data exist about ratios' efficacy. Many researchers and some nurses—particularly the American Nurses Association (ANA) and its affiliates—believe fixed ratios treat a symptom of the nurse staffing problem, rather than treating causes. "To set good nurse staffing policy," says Rose Gonzalez, MPS, RN, ANA's government affairs director, "there should be a plan created with the experts, and the experts are the ones on the ground—the nurses in the units."

Some hospitals and hospital associations argue that facilities may not be able to afford to hire additional nurses to meet the required ratios without receiving extra payments, but these have not been provided for in existing ratio policy. Nurses and researchers alike are concerned about reports of hospitals firing ancillary staff to compensate for the costs of hiring additional nurses. Also, shortage conditions may exert pressure on hospitals to reduce capacity in order to maintain ratios.

Figure 2

### A Sampling of California Nurse-to-Patient Ratios (by Acute Care Hospital Unit)

Hospital Unit	Nurse:Patient Ratio
Medical/Surgical Care	1:6 <i>1:5 in 01/05</i>
Psychiatric	1:6
Telemetry	1:5 <i>1:4 in 01/08</i>
Emergency	1:4
Pediatric	1:4
Step-Down	1:4 <i>1:3 in 01/08</i>
Critical Care	1:2
Intensive Care	1:2
Neonatal Intensive Care*	1:2
Postanesthesia Recovery	1:2

\*Requires staffing by RN only; in the emergency room, triage must be performed by an RN, and RNs must be assigned to critical trauma patients; otherwise, California legislation allows that 50 percent of staffing ratios may be accomplished by staffing with LVNs.

Source: California regulation "70217.Nursing Service Staff," R-37-01, August 20, 2003. The full text, which includes all ratios, is available as a PDF file from [www.dhs.ca.gov/](http://www.dhs.ca.gov/). Enter "R-37-01" into the search window to access the PDF file.

For further information, see the policy brief titled "Nurse-to-Patient Ratios: Research and Reality" by Katharine Kranz Lewis, RN, MSN, MPH, accessible at: <http://masshealthpolicyforum.brandeis.edu/publications/pdfs/25-Mar05/IssueBrief25.pdf>

### Patient Classification Systems

*How the model works:* Patient classification systems use computer software to determine nurse staffing for each shift. Nurses assess patient acuity on the various units, nurse managers input acuity, and the program outputs the number of nurses needed. Some states have used this model for several decades and still call it “patient-acuity systems.”

California facilities use ratios in conjunction with patient classification: units are required to provide staff at the minimum ratio or higher and must “staff up” if required by patient classification. Other states use patient classification systems without ratios: staffing is simply set by the nurse manager using the facility’s software.

Proponents say this system recognizes variety among patient needs and bases staffing levels on those needs, not just on facilities’ budgetary limits. Some nurses argue that this model allows them to have some (if limited) decision-making input, since classification depends on patient assessment—one of nurses’ primary skills and tasks.

However, researchers say nurses who use the classification software don’t really understand how the programs work. No universal standards exist for the software: there is no standardization (even within states, much less state-to-state) among tools. Some are homegrown, while others are proprietary. All these factors mean that nurses may not trust the results.

Because the tools lack transparency, and because floor nurses don’t have much true decision-making input into the process, some nurses doubt these systems provide enough staff.

Questions also have been raised about how these systems can be manipulated by exaggerating acuity to justify more staff, resulting in inaccurate record keeping and giving nurse executives and administrators

“Ratios alone are not the solution. For ratios to work best, you also need to look at things like infrastructure; a workplace culture that supports nursing and good patient care; good teamwork with physicians, pharmacists, social workers, and other staff; and the physical design of facilities.”



Marilyn P. Chow, RN, DNSc, FAAN, vice president of patient care services, program office, Kaiser Permanente, and national program director for the Robert Wood Johnson Executive Nurse Fellows Program

a skewed picture of their units’ activities. “Acuity is sometimes inflated to get more nurses on the floor,” Spetz says. “So then the unit’s records are wrong, and nurse executives can’t use them to analyze trends. Many [California] hospitals have essentially dropped acuity and are staffing to the ratios. One-to-five is often richer than what the acuity tool calls for anyway.”

### Pay-for-Performance: Concepts and Proposals

*How this model would work:* Policy-makers have proposed this model in recent years. Insurance companies and government health care programs would provide greater payments to hospitals that meet or exceed quality standards. Facilities’ payments would thus be linked to outcomes, providing an incentive to boost staffing.

Questions still abound:

- What results should be rewarded?
- What role does nursing play in the improvement of patient care quality? Can measures be developed that are adequately nursing-sensitive? (One example: the

National Quality Forum [NQF] endorsed 15 national voluntary consensus standards for nursing-sensitive care in 2004.)

- How large should payments be?
- Without incentives, will other factors of high-quality care suffer?

Some researchers think states can take steps toward pay-for-performance—for example, by enacting policies requiring facilities to publicize their staffing levels and/or outcomes based on key recommendations made in the IOM report *Crossing the Quality Chasm*. Peter I. Buerhaus, Valere Potter Professor and director of the Center for Interdisciplinary Health Workforce Studies at Vanderbilt University School of Nursing, advocates developing measures around the IOM’s six aims for high-quality patient care (safe, timely, effective, efficient, equitable, and patient-centered) and publicizing the results: “These are very direct, measurable goals—you can get your hands around them. And it’s not the kind of thing that would take a decade—we could measure nursing’s contributions to each of these aims by the end of this decade.”

Buerhaus also suggests hospitals organize their staffs into teams made up of nurses, physicians, pharmacists, administrators, and medical records workers. “This would help to better prepare nurses for the potential of pay-for-performance affecting their practice by getting everybody at the table. . . . Not only nursing’s but everybody’s boat will rise over a team approach focusing on meeting these aims.”

#### For More Information

- American Nurses Association, [www.ana.org](http://www.ana.org)
- Institute of Medicine, [www.iom.edu](http://www.iom.edu)
- NQF’s 15 national voluntary standards on nursing-sensitive care, <http://216.122.138.39/nursing/#measures>

# Fixed Minimum Ratios: The California Experience

To date, more than two dozen states have introduced nurse staffing legislation or regulations—some containing ratios—yet only 10 states have actually enacted measures, according to the ANA. California remains the only state to have passed a ratio law. Governor Gray Davis signed the law in 1999 after about 10 years of intense pressure by nursing unions. It was not California's first ratio policy for acute care hospitals: a 1:2 ratio for intensive and coronary care units was adopted in the 1976–1977 session.

## Outrage on Both Sides

The consideration of government-mandated ratios and the law's signing sparked an acrimonious debate over nurse staffing policy, which occurred within the context of a looming severe nursing shortage:

- Nurses became indignant that workloads skyrocketed while staffing levels stagnated.
- Hospital administrators claimed the patient classification system was guaranteeing an acceptable minimum staffing level.

Davis's receptivity toward unions and toward the idea of ratios helped the law pass. By all accounts, however, the levels of outrage between the CNA and the California Healthcare Association (CHA), the hospitals' organization, may have increased. "The debate heightened animosity between union nurses and administration in some areas," says Dorel Harms, MHA, RN, FACHE, CHA's senior vice president for clinical services. "This was a concern for many because if you're unhappy at work it's going to show up in how you do your work."

"Kaiser enacted a change in philosophy from striving to provide adequate care at the lowest cost to excellent care at an acceptable cost. Talk about great strategy—that was just brilliant on their part."

Joanne P. Spetz, assistant adjunct professor, Community Health Systems, University of California–San Francisco

## Wrangling over the Ratios

Wide and angry debate took place about what the final ratios should be. For medical-surgical units:

- CHA called for 1:10;
- CNA, the union with the most California nurses, called for 1:3;
- and the Nurse Alliance of Service Employees International Union (SEIU) called for 1:4.

The state's Department of Health Services ultimately proposed 1:6 beginning in January 2004, enriching it to 1:5 in January 2005 (see fig. 2).

## How the Ratio Law Works

The law, which took effect in its current form in 2005, is actually an extension of prior policy: early 1990s regulations put a patient classification system in place. The ratio law requires hospitals to staff to the minimum ratio level unless the patient classification system calls for increased staffing—then they must "staff up."

California's patient classification policy has been criticized because it provides no standards or guidance for the classification tools, thus allowing facilities to develop systems of questionable validity. The policy also has no strong enforcement provisions, allowing facilities not to comply.

For its part, California's ratio policy has been criticized as a "one-size-fits-all" policy allowing little nurse input and little flexibility to bend with the countless variables that affect nurse staffing. The CNA argues that the patient-classification system allows nurses' input, and that the ratios provide different staffing levels

for different units, according to both ratios and patient needs.

## Voluntary Institutional Policy

Meanwhile, two years before the ratio regulations went into effect, Kaiser Permanente (KP) anticipated the law and worked with nursing unions through its labor management partnership to implement a voluntary

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Kristien Petersen/Petersen Fotografie

Two nurses in an intensive care unit (ICU) oversee a patient's care. Research is beginning to draw strong associations between nurse staffing levels and quality of care, as well as nurse job satisfaction. Many researchers, nurses, and hospital administrators are creating progressive staffing policies that nurture these conditions.

1:4 ratio in KP's medical-surgical units, drawing all kinds of nurses to their facilities.

"We knew the regulations were coming," Chow says. "We listened to our labor partners, who said the ratio should be one-to-four. . . . We have tried to become an organization of choice. We care about our staff and working conditions, and the nurses were saying, 'This is what we think is safe.'"

## For More Information

- California Healthcare Association, [www.calhealth.org](http://www.calhealth.org)
- California Nurses Association, [www.calnurses.org](http://www.calnurses.org)
- Nurse Alliance of SEIU, [www.nurseallianceca.org](http://www.nurseallianceca.org)
- California Department of Health Services, [www.dhs.ca.gov](http://www.dhs.ca.gov)

# The Need to Address a Critical Lack of Research and Evaluation

Seven years after California's nurse staffing law was signed, there is no clear picture of the policy's effectiveness because no provision was included for evaluation. To put an end to the flurry of lawsuits filed by CHA and CNA after the ratios were finalized, the court prohibited the California Department of Health Services (DHS) from changing the ratios based on anything but quality of inpatient care. As a result, DHS has put on hold a follow-up on-site observational study to evaluate compliance with the ratio

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Nicolas Russell/The Image Bank/Getty Images

A nurse answers the phone next to a pile of clerical paperwork. Nurses' primary work includes assessing and educating patients and managing and providing care, yet some hospitals have tried to save money by cutting back on support staff, often requiring nurses to carry out many non-nursing tasks. Many nurses are being asked (and paid) to do non-nursing work, taking them away from their appropriate duties, says Holly DeGroot, PhD, RN, FAAN, CEO of Catalyst Systems, developer of a proprietary staff activity database and patient classification system.

policy. In fact, DHS now questions its entitlement to spend considerable public funds on an evaluation whose results it is barred from using. The court dictated that "we can't even look at access to care," says Gina Henning, RN, PHN, a DHS analyst who has been involved with the implementation of ratios.

"We don't have any measures to show quality improvement [as a result of the ratios] in California," says Buerhaus. "Costs are up; there are

lots of hassles, and everyone is fighting with each other instead of working together to solve the problems."

The Robert Wood Johnson Foundation's Interdisciplinary Nursing Quality Research Initiative (INQRI, pronounced "inquiry") aims to increase understanding of how nursing affects quality of care. INQRI programs are studying ways to improve nursing-sensitive measures, and ways these measures can be used to create public policy to link nursing quality with improving patient care.

## Focusing on Work Environment

Nurses have been demanding higher staffing for at least 15 years and have gotten minimal response from administrators, so "it's wound up with this basically union-driven push for standards [ratios]," says Linda Aiken, PhD, RN, director of the Center for Health Services and Policy Research, University of Pennsylvania School of Nursing. Surveys of nurses have suggested that wages are less a source of dissatisfaction than their working conditions—overwork and lack of trust between nurses and management. Experts would like nurse staffing levels to be improved as part of a comprehensive overhaul of nurses' working conditions.

"We know from our research that the problem is poor practice climates that make working as a nurse unproductive, and an environment so caustic that hospitals can't keep them," Aiken says.

## The Question of Ancillary Staff

Because of the great variation in the numbers and kinds of ancillary staff hired from facility to facility, it's almost impossible to calculate a ratio that will work for all facilities. Non-nursing staff whose jobs impact nurses' work include:

- greeters,
- housekeeping staff,
- respiratory technicians,
- physical therapists,
- and pharmacy technicians.

"The question of nurse staffing hasn't been studied enough on the unit level," says Christine T. Kovner, PhD, RN, FAAN, a nursing researcher and professor at New York University College of Nursing. "You could have 10 nurses on the same kind of unit at two different hospitals, and the outcomes would be different at each."

There are reports that some California facilities have tried to save money by laying off ancillary workers.

"We need to create a practice environment in a hospital context that's more satisfying to nurses, and allows them to be more productive in their work. And you can't really solve the problem of poor working conditions solely through ratios."

Linda Aiken, PhD, RN, director, Center for Health Services and Policy Research, University of Pennsylvania School of Nursing

## Ratios' Unintended Results

Is the net gain in nursing job vacancies caused by California's ratio mandates prompting an unintended migration of experienced nurses away from inner-city and public institutions toward health care facilities and systems with more resources? The California HealthCare Foundation (CHCF) has awarded a \$160,000 grant to Joanne Spetz to study this question. "We have a very strong interest in the safety net and whether unintended consequences have impacted safety-net hospitals," says David O'Neill, JD, FACHE, senior program officer at the CHCF.

### For More Information

- Interdisciplinary Nursing Quality Research Initiative (INQRI), [www.inqri.org](http://www.inqri.org)
- California HealthCare Foundation, [www.chcf.org](http://www.chcf.org)
- Joanne Spetz, [jojo@itsa.ucsf.edu](mailto:jojo@itsa.ucsf.edu)

## The Need to Incorporate Enforcement Provisions

Limited available data suggest that many California hospitals are not yet in compliance.

- In the first 10 months of 2004, just 30 percent of hospitals inspected for regular licensing review were reportedly in compliance.
- At the end of 2005—the first year ratios took effect—it was reported that more than half of hospitals inspected for alleged ratio violations were out of compliance.

But this data is being questioned because so few hospitals have been inspected for ratio compliance.

Neither California nor states with patient classification systems have provided for strong enforcement mechanisms. Withdrawal of Medicare/Medicaid payments is practically the only financial incentive for facilities to adhere to the ratios. Government payers such as Medicare and Medicaid require that hospitals adhere to all federal policies; they can deny payment to noncompliant facilities and can ask for retroactive repayment if chart reviews show noncompliance.

California's 2006 law allows DHS to fine hospitals up to \$25,000 when a situation of noncompliance with a law

or regulation poses "immediate jeopardy" to patients—having caused, or having the likelihood of causing, serious injury or death to a patient. To date, the DHS has not policed hospitals to ensure they comply with the ratios, but rather has assumed compliance unless a complaint or a self-report is filed that indicates a facility is not complying. Complaints are filed with DHS and exemptions or waivers can be requested (e.g., for rural hospitals that have particular difficulty hiring more nurses to meet the ratios). DHS's ability to conduct inspections is hampered by chronic state budget deficits, but it does monitor cited hospitals.

Two very new federal nurse staffing bills, H.R. 2122 and 2123, proposed in May 2007, not only call for ratios similar to those passed in California but also provide opportunities for extra Medicare payments for facilities that comply with ratios and whistle-blower protection for nurses who may feel threatened by reporting unsafe staffing levels in their own facilities. The ANA and SEIU endorse these bills.

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Kristien Petersen/Petersen Fotografie

A chief nursing officer (CNO), left, works on a staffing plan with an administrative nurse coordinator—a registered nurse who oversees workflow and staffing. CNOs are the senior nurse-leaders in hospitals, typically reporting to their CEOs and overseeing hundreds or even thousands of nurses and other employees. Studies have shown that, more than most other work improvements—including pay raises—nurses desire safe conditions and increasing trust in their work environments.

## Factors that Improve the Workplace Environment for Nurses

Studies show that nurses' dissatisfaction with their jobs derives less from their wages than from the following workplace conditions. The experts interviewed for this brief say progressive nurse staffing policy would do well to take these issues into account.

### Increasing Nurses' Authority

Though having enough nurses to care for patients is important to patient care, the level of decision-making authority nurses are given on the job is also important. Some nursing advocates believe that, even if staffing policy is implemented, if nurses are not given enough decision-making authority, the policy may not work well.

### Increasing Trust between Nurses and Management

An acrimonious atmosphere makes nurses leery of returning to the profession. More than most other conditions—including increased wages—nurses want a more trusting work environment.

### Reorganizing Nurses' Work

"In the majority of hospitals, it's not the number of nurses that's the issue, it's how they're utilized," says Holly DeGroot, PhD, RN, CEO of Catalyst Systems, developer of a proprietary staff activity database and patient classification system. "In California in 2004, medical-surgical nurses spent 34 percent of their time caring for

patients and families and the rest in other lower order and non-nursing activities. If you add more nurses without also reorganizing the way they work, that simply results in more nurses not spending enough time caring for patients."

### Prohibiting Mandatory Overtime

Experts suggest that progressive policy would prohibit mandatory overtime and double shifts—even at two different workplaces. Though this recommendation is often not palatable to unions, which wish to protect their members' earning capacity, it may well improve patient safety.

## Dueling Staffing Bills in Massachusetts

The Massachusetts legislature will consider two competing nurse staffing bills during its 2007–2008 session: House Bill 2059 and Senate Bill 1244. While both bills are known as Patient Safety Acts, contain substantial nursing workforce development initiatives, and ban mandatory overtime, the bills differ on other strategies for ensuring safe, quality patient care. One extends the California ratio model, while the other rejects ratios in favor of public disclosure and quality improvement mechanisms.

House Bill 2059 would empower the Department of Public Health (DPH) to establish ratios and provisions for standardizing patient classification systems in hospitals statewide. Hospitals would have some degree of flexibility in implementing the ratios since each unit would have two ratios: a standard and an outer patient limit that could allow for increasing a nurse's patient load if acuity levels were low. The bill also calls for workplace improvements such as prohibiting the delegation of nursing duties to non-nursing staff; requiring the orientation of float nurses, and strongly discouraging the understaffing of other critical health care workers such as LPNs and unlicensed assistive personnel—provisions that reflect lessons learned from California's ratio experience, says Representative Christine E. Canavan, RN (D-Brockton), the bill's chief sponsor.

"A large number of RNs in Massachusetts don't want to work at the bedside because of adverse working conditions," says Canavan. "This is currently the only bill fighting the problem where the problem lies: retention of nurses in hospitals. There is a symbiotic relationship between working conditions and quality of

care: if you improve working conditions, you improve patient care."

The Massachusetts Nurses Association, part of the Coalition to Protect Massachusetts Patients, supports H.2059. The coalition includes 124 health care, patient advocacy, labor, senior, education, and social justice groups ([www.massnurses.org](http://www.massnurses.org)). Hospital executives, the Massachusetts Hospital Association, the Massachusetts Organization of Nurse Executives ([www.massone.org](http://www.massone.org)), and some 35 other groups—primarily professional societies, health care provider associations, and business groups—oppose H.2059. Many of these groups are supporting Senate Bill 1244.

"Instead of arbitrarily requiring a set number of patients for whom nurses would care, and hoping that that produces safe care, we want to measure patient outcomes and hold hospitals to high standards," says Richard T. Moore (D-Uxbridge), S.1244's chief sponsor. "The standards would be nurse-sensitive measures that have been cited and validated nationally."

This bill requires hospitals to publicly post and submit their staffing plans to DPH for possible random audits and to create—through their quality improvement programs—a process to monitor and report performance data on no less than three nurse-sensitive measures (one of which would be patient care hours per patient day). A nursing center within DPH would select the measures for statewide use, aggregate the hospital data, and report annually on hospital-specific results as well as industry trends and best practices. To prevent fatigue, S.1244 would cap nurses' work hours by shift, day, and week. (Visit [www.mass.gov/legis](http://www.mass.gov/legis) for bills.)

### Tips for Policymakers

#### Avoid using ratios as a panacea

Policymakers and practitioners should regard ratios not as a magic bullet for all nurse staffing problems, but rather as one possible part of a larger policy picture that ought to include improvement of nurses' workplaces.

#### Assess the link between nursing quality and patient care

So far, available research only suggests that patient care is linked with the quality of nursing patients receive. Funding is needed for further research to study this critical link.

#### Standardize classification systems

A number of states employ patient-classification systems to determine optimum nurse staffing. Experts suggest that, to work best, these systems should employ standardized software that has been independently verified and is transparent to those who use it—nurses themselves.

#### Provide stronger enforcement provisions

Nurse staffing policies should incorporate provisions to give their state's department of health authority to impose fines or other financial penalties on facilities out of compliance with the policy.

#### Consider capacity

Policymakers must ask themselves whether there are enough nurses in their states to meet the requirements of the policies they are considering.

#### When considering policy, listen to a diversity of nurses' opinions

Policymakers must hear the voices of both union and nonunion nurses, professional associations, and labor unions.

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**Acknowledgments:** Thanks to Tamra E. Merryman, RN, MSN, FACHE, vice president, Center for Quality Improvement and Innovation, University of Pittsburgh Medical Center (UPMC) and participating staff at UPMC Shadyside for the photographs on pages 5 and 7. Thanks also to Janet Haebler, MSN, RN, associate director, state government affairs, ANA, for her generous assistance with the cover map.



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