


Safe Staffing Legislation

A Case for Improved Quality of Care Through More Accurate Staffing

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To improve care delivery and reduce healthcare costs, states first began legislating safe nurse staffing standards in 1990, when California initiated its staff ratio law. Factors contributing to the advent of safe staffing legislation include the rising cost of staffing, an increased focus on patient safety initiatives and the movement towards evidence-based care and data-driven staffing. The ruling by the Center for Medicare and Medicaid Services (CMS) to no longer reimburse for care in the case of “never” events, or hospital acquired conditions, has also played a role.

The intent of safe nurse staffing legislation is to maintain the appropriate mix of registered nurses (RNs) staffing, ensure adequate nurse surveillance so there are no failures to rescue and provide appropriate clinical interventions. Essentially, the goal is to make sure the right nurse is with the right patient at the right time, providing the right care.

Insufficient nurse staffing is a growing concern for today’s nurses. Due to increased care needs for higher acuity patients and the growing gap between the number of available nursing positions and the number of RNs qualified and willing to fill them, many healthcare organizations are operating with lower than desired staffing levels. In fact, in a survey of nearly 15,000 RNs by the American Nurses Association (ANA) in 2009, 71.9 percent of respondents said they do not believe the staffing on their unit or shift is sufficient and more than one third said they knew of someone who left direct nursing due to concerns about safe staffing.¹

Similarly, a 2007 PricewaterhouseCoopers study found that the second and third highest factors for nurse dissatisfaction and turnover were nursing workload assignment and inadequate staffing.² In addition to the patient safety issues created by inadequate staffing, nurse turnover creates significant financial liabilities for hospitals. Notably, the researchers concluded that for every 350 RN full-time equivalents (FTEs) in a nursing personnel budget, a 1 percent turnover rate costs the average hospital approximately \$300,000 annually.

It has also been well documented that caregiver workload directly impacts quality of care and patient outcomes. In a major study of surgical patients, risk of patient mortality within 30 days of admission increased by an average of 7 percent for each additional patient assigned to a nurse, and inadequate staffing was found to be a contributing factor in 24 percent of all unanticipated events that resulted in patient death, injury or permanent loss of function.³ The same study concluded that a higher proportion of hours of registered nursing care per day is associated with better outcomes for those who are hospitalized and that those improved outcomes can result in significant cost-savings.

Although there is no general consensus among healthcare professionals as to what constitutes safe staffing, it can be broadly defined as “having the appropriate number of staff with a suitable mix of skill levels available at all times to ensure that patient care needs are fulfilled and hazard-free working conditions are maintained.”⁴ In addition, safe staffing optimally requires the absence of negative consequences and minimal errors consistent with benchmarked data.

Many states have enacted or proposed safe staffing legislation in an attempt to improve the overall working conditions and patient outcomes within hospitals. The appendix on page 5 provides a summary of the proposed and current legislation in each state. Different states have taken different approaches to the safe staffing legislation, and there have been two bills proposed at the federal level. This white paper will examine three different approaches to safe staffing legislation, and the pros and cons of each method.

Approach 1: Mandated Ratios

THE CALIFORNIA EXPERIENCE

California became the first state to establish minimum nurse-to-patient ratios for hospitals with the passage of its staff ratio law (AB 394) in 1999. Final regulations to implement the law were issued in the summer of 2003 and hospitals were required to meet the staffing ratios as of January 1, 2004.



Since implementation of the legislation, nurses have had mixed feelings about the mandated ratios. Although the number of RN hours per patient have increased, staff nurses have become increasingly dissatisfied due to lack of autonomy and inadequate breaks that the legislation has created. In many instances, unit support services have been reduced and less focus is being placed on assistive nursing personnel and ancillary services. In addition, the use of traveling nurses has increased, ER diversions occur more frequently and 11 hospitals have closed or are closing.

A collaborative study by the ANA and the Association of California Nurse Leaders (CalNOC) compared pre-ratio data (2002) with 2004 and 2006 data and determined that the establishment of mandated nurse-to-patient ratios has not impacted nursing-sensitive outcomes or significantly reduced falls or the incidence of pressure ulcers.⁵ A similar study by the California Health Care Foundation in 2009 concluded that the quality of healthcare had not changed significantly since the implementation of staffing ratios.⁶ The researchers noted that many hospitals were having difficulty in absorbing the costs associated with mandated ratios, had been forced to reduce budgets or services, and were experiencing increased emergency room bottlenecks.

With this method, specific nurse-to-patient ratios are established by legislation or regulation. This approach is controversial since legislating mandated fixed ratios reduces staffing function to only one dimension and does not account for variances in patients' needs, differences among patient care units and the experience level and preparation of staff. Consider the following assumptions, many of which haven't proven to be accurate:

- **Regulated staffing will improve outcomes.** Regulation alone is not sufficient to ensure positive patient outcomes. Factors such as patient acuity and staff skill mix must be accounted for when staffing to ensure that the appropriate level of care is being provided.
- **“Optimal” staffing is a known quantity.** Since patient needs and census frequently change, it is difficult to determine “optimal” staffing levels without an efficient and accurate way of evaluating patient care needs and determining the hours by skill mix required for each shift.
- **An adequate supply of nurses is available.** While more nurses are re-entering the workforce due to the current economic situation, shortages still exist in some facilities. In addition, long-term projections indicate that the nursing shortage will grow during the next decade—to about 260,000 nurses by 2020—as the economy improves and the current, aging workforce retires.
- **Patient care settings are similar.** To accurately determine nurse staffing requirements, staffing should be tailored to the specific needs of various patient populations and different patient care units.
- **Equipment is similar (and functioning).** The level of technology residing within different facilities can vary substantially. In addition, not all staff members may be equally skilled in operating the available equipment.
- **Patients with the same condition or in the same unit always have similar care needs.** While two patients may be hospitalized for the same primary condition (e.g., gastric ulcer), the care needs of each patient may differ significantly due to underlying conditions or disease such as diabetes or heart disease and other circumstances, such as their ability to perform self-care, patient/family dynamics, etc.
- **Nurse competencies are equal.** Although there has been a move to standardize clinical competency in an effort to improve patient safety, reduce variation in nursing practice and improve the quality of patient care, not all nurses possess the same skill sets and experience levels can vary widely.

PROS: Provides a floor rather than a ceiling for nurse-to-patient ratios, ensuring care levels do not drop below the minimum ratio.

CONS: Does not take all of the applicable variables into account and reflects a one-dimensional number that is to be used by all organizations and units, regardless of the differences in staff and patient care needs.

Approach 2: Acuity-Based Nurse Staffing Plans

PROPOSED FEDERAL LEGISLATION

Safe staffing is also being addressed at the federal level. On May 6, 2009, the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2009 (H.R. 2273) was introduced by Rep. Janice Schakowsky (D-IL). Created primarily to amend the Public Health Service Act, the legislation requires hospitals to implement a staffing plan and meet specific registered nurse-to-patient staffing ratios. The current status of this bill is:

- Sixteen co-sponsors
- No activity since it was introduced
- Referred to the Subcommittee on House Energy and Commerce and the Subcommittee on House Ways and Means

On May 13, 2009, Sen. Barbara Boxer (D-CA) introduced S. 1031, a bill with language and objectives similar to H.R. 2273. The current status of this bill is:

- No co-sponsors
- No activity since it was introduced
- Referred to the Senate Health, Education, Labor and Pensions Committee

It is uncertain whether either of these bills will ever make it out of committee and continue forward towards becoming law.

This approach requires input from practicing nurses to make sure that safe nurse staffing levels are based on patient needs and other relevant criteria. Hospital-wide staffing committees are often assigned to develop unit specific plans and associated policy. This approach takes into account skill mix and patient acuity and can involve the use of patient classification systems.

Acuity-based nurse staffing plans is the methodology endorsed by the ANA. The ANA supports legislated nurse staffing ratios, but only where the ratio itself is set at the unit level with input from the direct care nurses rather than a specific number mandated by legislation. Rather than a “one formula fits all” approach, the staffing plan should be tailored to the specific needs of each unit. With acuity-based staffing, the staffing plan can take the following factors into consideration:

- Number of patients and acuity level of patients as determined by the application of an acuity system, on a shift-by-shift basis
- Anticipated ADTs of patients that impact direct patient care during each shift
- Specialized experience required of direct care registered nurses on a particular unit
- Staffing levels and services provided by other health care personnel in meeting direct patient care needs not required by a direct care registered nurse
- Level of technology available that affects the delivery of direct patient care
- Level of familiarity with hospital practices, policies and procedures by temporary agency direct care registered nurses used during a shift
- Obstacles to efficiency in the delivery of patient care presented by physical layout

The state of Illinois is spearheading this effort, with several other states following their lead. Texas, Oregon, Washington and Ohio either have similar laws or are seeking to enact them.

PROS: *Provides the framework for a comprehensive, data-driven nurse staffing plan.*

CONS: *Leaves a lot to subjective interpretation, which can make enforcement challenging.*

Approach 3: Reporting and/or Public Disclosure

This approach requires facilities to disclose staffing levels to the public and/or a regulatory body. Many states require hospitals to publically post staffing and scheduling information for each shift and unit, providing a new level of transparency to patients and staff members. Cumulative information, such as ‘report cards’ or ‘grades’ can allow patients to compare the staffing plans and policies at multiple healthcare providers before selecting a care team.

PROS: *Gives the public access to staffing information, allowing them to be informed consumers.*

CONS: *Publishing staffing plans without evaluating the effectiveness of those staffing plans or a recourse for staffing plans that do not represent safe staffing levels is ineffective.*

Being Prepared for Safe Staffing Legislation

The advent of safe staffing legislation has required hospitals to reassess and restructure existing staffing processes and procedures. Hospitals must not only actively involve direct caregivers in the staffing process but must also provide evidence of variance management and conduct annual reviews of staffing plans, related data and associated outcomes. In addition, they must maintain the appropriate mix of RN staffing at all times to ensure adequate nurse surveillance and appropriate clinical interventions.

Here's a step-by-step look at the process for laying the foundation for safe staffing:

- 1. Know your actual ratios** – This is the foundation of safe staffing. It's important to understand all of the following variables, how they impact one another and how they impact the nurse-to-patient ratios:
 - a. Patient-care related variables** – both individual and aggregate patient needs should be considered.
 - b. Staff-related variables** – this includes skill mix, competencies and experience levels.
 - c. Organization-related variables** – what technology and equipment is used, what is the availability of support staff such as transport teams and housekeeping.
- 2. Be prepared to adjust scheduled staffing every shift to match patient care needs** – This requires matching patient acuity information with staffing and scheduling information so that actual patient care needs are matched with available staff resources to ensure the best quality of care.
- 3. Understand, manage and document the variances between actual and needed staffing** – When instances of under- or over-staffing occur, it's important to understand and document why so that your organization can take steps to prevent isolated occurrences from becoming everyday practice.

Because a wide variety of data is necessary to build the business case for safe staffing, including length of stay, patient injury, patient mortality, nurse retention, nurse qualifications, nurse staffing and nurse surveillance costs, many hospitals are turning to automated patient classification systems. These systems are designed to enable managers to perform regular monitoring of patient and unit acuity levels and generate detailed staffing reports.

Data-driven prospective patient classification systems analyze each department's clinical workload and, based on patient needs, identify the most effective combination of staff credentials and skill mix for the upcoming shift and at designated staffing intervals. As a result, each nurse is assigned the optimal number of patients based on current patient acuity levels, workload capacity and required patient care, helping to ensure equitability in patient assignments. Automated patient classification systems also facilitate generation of the reports required to meet state and federal legislative requirements—a factor which will become increasingly important as more states adopt safe staffing legislation.

Summary

Recognizing and understanding the legislation that's happening in your state and across the country empowers you to advocate and implement the safe staffing initiatives that make the most sense for your organization. Whether it has been legislated in your state or not, safe staffing is a necessity. A solid safe staffing plan requires knowledge about the staff available, the facility/technology resources, patient needs and evidence about the variables that play a key role in safe staffing.

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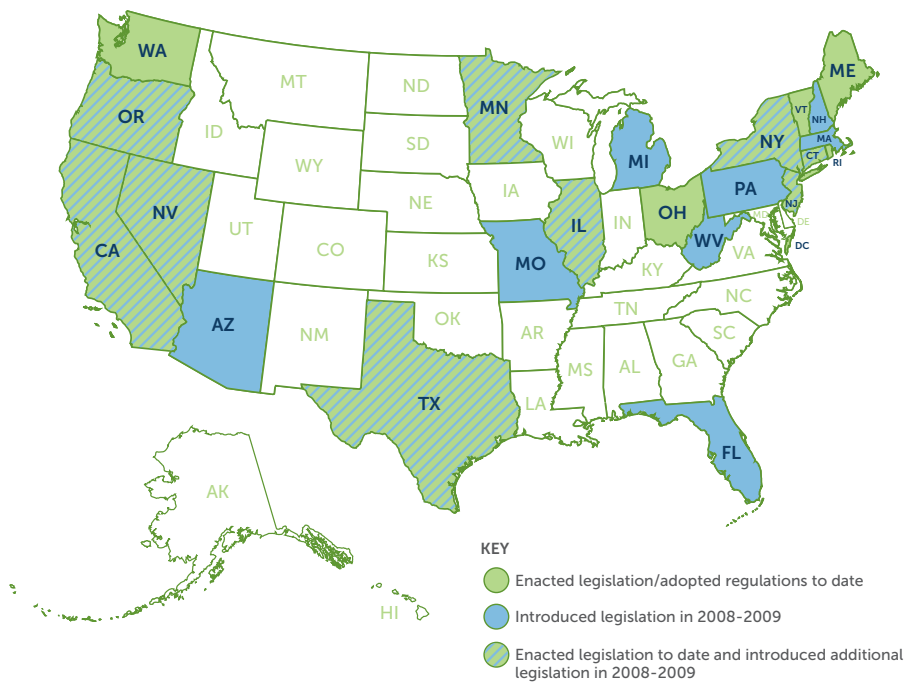
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In addition to the intended positive impact on patient care and outcomes, safe staffing legislation is important to healthcare organizations for practical reasons. Organizations such as the State Department of Health Services, The Joint Commission and the Center for Medicare/Medicaid require hospitals to adhere to safe staffing legislation in order to receive accreditation and certification. Additionally, hospitals meeting or exceeding standards of excellence may be eligible for recognition such as Magnet® status or the Baldrige Award.

Safe staffing is about more than legislation. It goes to the core of what healthcare providers do – it provides a foundation for providing high quality patient care in an environment that values and respects the role of the healthcare professionals that provide that care.

Appendix

Current and Pending State Safe Staffing Legislation as of September 2009



Following is a summary of state safe staffing legislation as of February, 2010.

California - (1986): Patient classification systems are required to identify nursing care requirements on individual patients. **(1999)** Unit specific nurse-to-patient ratios are to be used in all nursing units in all California hospitals.

Connecticut (2008): Each hospital must establish a nurse staffing committee to develop, oversee and evaluate a nurse staffing plan for each unit.

District of Columbia (2004): Waived the enactment of 2002 staffing ratios due to the nursing shortage.

Illinois:

- **(2003)** Legislation requires a hospital report card that includes reporting on patient outcomes, nursing staffing plans, orientation and training.
- **(2007)** Patient Acuity Staffing Plan provides flexibility for meeting ever changing patient care needs. Each hospital must establish a nurse staffing committee to develop, oversee and evaluate a nurse staffing plan for each unit.

ADDITIONAL RESOURCES

Following are some additional resources if you are interested in additional information about staffing legislation:

- H.R. 2273: <http://www.govtrack.us/congress/bill.xpd?bill=h111-2273>
- S.1031: <http://www.govtrack.us/congress/bill.xpd?bill=s111-1031>
- American Nurses Association (ANA): www.safestaffingsaveslives.org

Maine (2004): Enacted legislation to remove requirements for established staffing systems. Concluded that the best approach to nurse staffing is through the standardization of staffing plans and acuity tools. Minimum staffing ratios are not expected to be implemented in the foreseeable future.

Minnesota (2009): Adopted a legal provision under which health care facilities must consider staffing levels and their impact upon an adverse event when conducting root cause analysis of the event.

Nevada (2009): Enacted legislation requiring health care facilities with a population of 100,000+ and 70+ beds to establish a staffing committee comprised of 50% direct care nurses to develop staffing plans that include minimum nurse-to-patient ratios. Written report is to be submitted to either the Legislative Committee on Healthcare (odd years) or the Director of the Legislative Counsel Bureau (even years).

New Jersey (2005): Enacted legislation requiring general hospitals or nursing facilities to complete and post daily staffing information for each unit and each shift.

New York (2009): Requires health care facilities to make available to the public information on nurse staffing and patient outcomes.

Oregon (2002, 2005): In 2005, enacted legislation that strengthened the landmark patient protection that became law in 2002. Requires a written, hospital-wide plan for nurse staffing, including the number, qualifications and categories of nurse staffing needed. Plan must be developed by an equal number of direct care nurses and managers and be consistent with nationally recognized evidence-based standards and guidelines.

Ohio (2008): Each hospital must establish a nurse staffing committee to develop, oversee and evaluate a nurse staffing plan for each unit. Copies must be made available as requested by staff and the public.

Rhode Island (2005): Requires a staffing plan be developed to specify needed staff and skill mix for each unit and each shift. Plan is to be submitted annually to the department of health.

Texas (2002, 2009): 2002 regulations require hospitals (under the authority of the CNO and in accordance with an advisory committee comprised of nurse members) to adopt, implement and enforce a written staffing plan, with patient outcomes used to determine the adequacy of the plan. SB 476 (2009) requires an increased nursing voice in staffing plan and prohibits mandatory overtime.

Vermont (2006): Enacted legislation that adds a provision to the Bill of Rights for Hospital Patients requiring public access to information related to nurse staffing ratios.

Washington (2008): Each hospital must establish a nurse staffing committee to develop, oversee and evaluate a nurse staffing plan for each unit. Public posting of staffing plan and nurse staffing schedules is required.

¹ American Nurses Association, Safe Staffing Poll on SafeStaffingSavesLives.org. July 2009.

² PricewaterhouseCoopers' Health Research Institute, What Works: Healing the Healthcare Staffing Shortage, July 2007.

³ Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., and Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, 288(16), 1987-1993.

⁴ AFT Healthcare Program and Policy Council, October 1995.

⁵ "Mandated Nurse Staffing Ratios in California: A Comparison of Staffing and Nursing-Sensitive Outcomes Pre- and Post regulation; Policy, Politics, & Nursing Practice; (Vol. 8, No. 4); March 2008.

⁶ California Healthcare Foundation. Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care. February 2009.



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