There are some stormy seas ahead as we consider the issue of Nursing Ratios. Currently, there is a nation-wide debate concerning the use of Nursing Ratios to staff nursing units. Over 20 state legislatures over the past two years have introduced legislation relating to this issue. So far only California has passed legislation. This staffing ratio debate originated in California, where a coalition of nursing unions banded together to encourage the state legislature to adopt nursing ratios across the board as the basis to staff all nursing units of a similar specialty. The issue is not so much the use of staffing ratios to determine staffing levels as it is to legislatively mandate them. Should the government be allowed to intrude on the day to day management decisions of a hospital?

In 1999, the California state legislature considered passage of AB (Assembly Bill) 394 which proposed setting minimum staffing levels (nurse to patient ratios) in all California hospitals. This bill was pushed by the United Nurses Association of California and the Union of Healthcare Professionals(1), divisions of the AFL-CIO, as a “full employment” statute, couched in the clothing of “improved patient care.” Stories of unsafe care and compromised patient safety promoted by these unions, prompted the California legislature to consider these ratios as staffing mandates. The California Legislature couldn’t agree on the monetary penalties associated with the failure to comply with these ratios, so the fines are minimal, but the cost of the experiment is high, as will be discussed during this presentation.

There is currently a US Senate Bill called the "Registered Nurse Safe Staffing Act of 2005" in Congress that ties acuity and staffing minimums to Medicare regulations. It carries monetary fines for willful, knowing violations of the regulations and gives whistle blower protections.
The major underlying concept of these ratios is that “all patients within a specialty are alike,” regardless of the patient’s day of stay, the shift during which the care is being rendered, the type of unit on which the patient is receiving care, and the hospital in which the patient is found. For example, regardless if the patient is a special case at Johns Hopkins or recovering from a leg wound at Heber Valley Community Hospital, the ratio would be the same if they are housed on a medical/surgical unit. All nursing care hours requirements eventually equate to some ratio. The key is to provide a mix-sensitive set of ratios or hours per patient day for each distinct set of homogeneous patients.

The purposes of this presentation are (1) to explore the efficacy of nursing ratios, and (2) to examine an alternative to the ratio method of nurse staffing.

With the recent advent of using Nursing Ratios to staff nursing units in California, the timing is appropriate to discuss whether or not this “cookie cutter” approach will work nation-wide, or whether we should consider other alternatives.
Frank Overfelt has been active in the healthcare industry since 1976. He has been a manager for the Kaiser Permanente Management Engineering program, Director of Management Engineering for Intermountain Healthcare, Senior manager with KPMG Peat Marwick and president of three consulting firms, specializing in patient classification and workload measurement.
Sequence of the discussion:

• The ratios issue and its origins will be presented.

• Current and pending legislation on the state and national level will be provided

• Pros and cons of ratios will be discussed

• Financial Impact of ratios in California will be documented.

• The Position of SHS on ratios will be presented.

To provide a context for the discussion, I will present a brief background of how nurse staffing has evolved since the 70's. I have been working with nurse staffing systems since the mid-70's, and will detail how nursing units have been staffed during the last 30 years. I will also present a brief history of the inception of nursing ratios in California, and how those ratios became law, effective January 1, 2004.
Mandated Nursing Ratios – The Pros and Cons

- Presentation Format, cont.
  - Why Nursing Ratios?
  - Legislation Relating to Mandatory Staffing Ratios
  - Cost of Mandated Ratios - The California Experience
  - SHS Position on Mandatory Ratios
  - Conclusions & Discussion

The presentation is divided into three parts:

1. A discussion of why nursing ratios have evolved and what they are intended to do
2. Legislation relating to Mandatory Staffing Ratios at the state and national level
3. Cost of mandate ratios in the State of California
4. SHS' position on mandated ratios
The earliest means of setting nurse staffing requirements was a technique called work sampling. Work sampling was done by a third party observer, who made “rounds” every 15 minutes to observe which of a number of activities was being performed by each nurse present on the nursing unit. Work sampling was done on each shift. A productivity percentage was established for each skill level of care providers. A trained observer would also pace rate each individual (to determine at what pace the individual was working, 100% being normal).

Then, based on the number of hours worked by all staff present divided by the average census during that shift, an HPPS (hours per patient shift) was generated. This HPPS was factored times the productivity percentage observed for each skill level, then increased by a factor of 1.15 to take into account PFD (personal time, fatigue, and delay). The resulting net HPPS was then determined to be the appropriate HPPS by which to staff the unit for that particular shift. A total of all three shifts' HPPS was added to provide the productive HPPD (hours per patient day) for the unit.
Work sampling still works to determine a self-generated “benchmark.” However, it is not sensitive to the variation in patient types. Nor does it necessarily tell us what skill mixes work best. And, lastly, other than being observed, the nurses play no role in the process.

After years of experience with a very “flat” basis for staffing using work sampling and focusing solely on the nurse, the concept of staffing by patient type began to evolve, with heavy focus on the patient rather than on the nurse.

At first there were simple, limited criteria sets which evolved accounting virtually for only activities of daily living (ADL). Typically, these simpler systems were also tied to workload measurement studies. The classification system established the “acuity” of the patient, and workload measurement established the hours of care requirements. More elaborate schemes evolved that attempted to roll together both concepts (patient classification and workload measurement). With these systems, the nurse would fill out lines of check marks or “bubbles” in order to determine how many hours of care were required.
In the 1990's, benchmarking became a popular twist to establish staffing requirements everywhere in a hospital on a macro level. The concept is easy: find a base of hospitals, come up with macro hours per workload unit, and assume that all similar hospitals in the group are homogeneous. No one has to go through the horrendous task of collecting data. It's cheap and provides a starting point for further investigation.

Benchmarks are perhaps better used as guidelines to identify if hours of care are in the ballpark of other institutions after the workload measurements are done. Few make the effort to identify a valid answer that takes into account all the unique features of a specific environment. The sad outcome, if one stops at benchmarking, is that no one learns anything about processes; they only acquire answers.

Thus evolved nursing ratios: one size fits all, every hospital is the same, every unit of the same specialty is the same, and all patients are the same.
Mandated Nursing Ratios – The Pros and Cons

Current and Pending Legislation

2005 STATE LEGISLATION
Florida  Hawaii
Illinois  Iowa
Missouri  New York
Rhode Island  Vermont
West Virginia

During this legislative year, 2005, the following states have bills introduced in their various state houses, which would in some form or another call for legislatively mandated ratios:

Illinois - House Bills: HB 2544 and HB 2548, introduced 2/18/2005
Missouri - House Bill 802, introduced 3-15-2005
- Senate Bill 527, introduced 3-01-2005
Florida - HB 1117, introduced 2-23-2005
- SB 351, introduced 2-10-2005, to study mandatory ratios
- SB 1176, introduced 2-07-2005
New York - SB 2965, introduced 3-02-2005
Hawaii - HB 538, introduced 1-24-2005, incorporated in mandatory overtime
Iowa - HB 283, introduced 2-11-2005, combined with no mandatory overtime
Rhode Island - SB 747, introduced 2-17-2005
Vermont - SB 95, introduced 1-25-2005
West Virginia- HB 3115, introduced 3-21-2005
<table>
<thead>
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<th>Status</th>
<th>Legislative Actions</th>
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<tbody>
<tr>
<td>Florida</td>
<td>Died in Committee</td>
<td>- HB 1117 and SB 1176 med/surg max of 4 patients to 1 nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- SB 351 to study mandatory ratios</td>
</tr>
<tr>
<td>Illinois</td>
<td>Died</td>
<td>- HB 2544 and HB 2548 med/surg max of 4 patients to 1 nurse</td>
</tr>
<tr>
<td>Iowa</td>
<td>Introduced HB 283</td>
<td>- HB 283 med/surg max of 4 patients to 1 nurse combined with no mandatory overtime</td>
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<tr>
<td>Missouri</td>
<td>Died in both Houses</td>
<td>- HB 802 and SB 527 med/surg max of 5 patients to 1 nurse</td>
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</table>
Mandated Nursing Ratios – The Pros and Cons

Status (cont.)

2005 STATE LEGISLATION

New York - Introduced SB 2965; SB 4865

In Health Committee

New York

- SB 2965 med/surg max of 6 patients to 1 nurse
- SB 4865 med/surg max of 4 patients to 1 nurse
Mandated Nursing Ratios – The Pros and Cons

Status (cont.)

2005 STATE LEGISLATION

Rhode Island - SB 747 Died

Vermont - SB 95, did not pass

West Virginia - HB 3115 died

Rhode Island - SB 747 med/surg max of 5 patients to 1 nurse

Vermont - SB 95 med/surg max of 4 patients to 1 nurse

West Virginia - HB 3115 med/surg max of 4 patients to 1 nurse
At the national level, legislation is still very active
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION
House of Representatives
HR 1222, introduced Mandatory Ratios – co-sponsored by 17 Republicans and 14 Democrats

Of the national legislation the most dangerous is House Resolution 1222, which is co-sponsored by 17 Republicans and 14 Democrats
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION

Highlights of HR 1222
– Would require compliance within two years in Urban areas, and four years in rural areas

This legislation goes well beyond the California law, which I will highlight for you.
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION

Highlights of HR 1222 (cont)
– Mandates the following ratios:
  – 1:1 in OR’s and Trauma ED
  – 1:2 in Critical Care, L&D and PACU
  – 1:3 in Antepartum, ED, Peds, Step Down, Tele.
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION
Highlights of HR 1222 (cont)
– Mandates the following ratios:
  – 1:5 in Rehab
  – 1:6 in Postpartum (3 couplets) and well-baby nurseries

California’s so-called Safe Staffing Law only required a 1:6 ratio in medical surgical units, then went to 1:5. HR 1222 will require a 1:4 ratio.
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION
US Senate
   S 71, introduced as Safe Staffing and Patient Care Act of 2005; tied to Medicare Reimbursement
Mandated Nursing Ratios – The Pros and Cons

Current Status

NATIONAL LEGISLATION
US Senate
S 71:
–Based upon an acuity system
–Follows somewhat the guidelines of AONE
–Requires compliance to minimum ratios
Senator Inouye’s legislation mellowed out considerably, requiring only that a staffing system be in place.
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios??
  – Patient Safety?
  – Nursing Job Satisfaction?
  – Enhanced Outcomes?

The state of California is a heavily unionized state. The nursing unions in California are very powerful. Like hospitals everywhere, California hospitals are under pressure to cut costs. With a nursing shortage, they turned to unlicensed assistive personnel (UAP) to pick up some of the workload. RN Union memberships began to drop. The contention was that in some hospitals in California, RN’s were assigned 12 patients (although in the 50 hospitals I have ever worked in I have never observed that situation in an acute care setting).

In a press release from the National Academies, dated November 4, 2003, a quote was made that “some hospital nurses may be assigned up to 12 patients per shift”, as if this were a more standard practice (2) This is the type of generality being presented by reputable groups to justify staffing ratios.

The major arguments set forth by the advocates of nursing ratios are that fixed ratios must be adhered to in order to assure:
  • Patient safety
  • Nursing job satisfaction
  • Enhanced patient outcomes
• Why Nursing Ratios?? (cont.)

– Patient Safety ?
  • Major argument is that fixed ratios will improve patient safety.
  – E.g., Aides forget to report issues of patient care/safety to the RN. RNs with too heavy an assignment will overlook certain aspects of care.

Patient safety is a major consideration for justifying a mandatory number of RNs per patient.

  • When an RN has to manage a UAP he/she is distracted from his/her duties as an RN.
  • The UAP is not always able to assess what a change in vitals signs means.
  • Patient safety will improve, if fewer patients are assigned to the RN and the RN is allowed to render all care.
  • The UAP sometimes forgets to mention changes in the patient’s condition.

All of these issues are valid and must be addressed. But, they are certainly not reasons to abandon the concept of utilizing UAP’s.
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios?? (cont.)

– Nursing Job Satisfaction?
  • According to a survey of nurses in Pennsylvania hospitals, the lower the ratio of patients to nurses, the greater the job satisfaction.

Studies have shown that job satisfaction increases commensurate with the fewer number of patients assigned a nurse, but is there a “magic number” of patients to nurse; an optimal ratio, and does it vary by circumstance?
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios?? (cont.)

– Nursing Job Satisfaction?
  • According to the Pennsylvania survey, increasing the patient to nurse ratio by one more patient increased job dissatisfaction 15% to 23%.

A study of Pennsylvania hospitals (3) showed that job satisfaction deteriorates as the nurse is assigned more patients.
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios?? (cont.)

– Enhanced Outcomes?

• The same Pennsylvania study “modeled” the impact of staffing ratios on patient deaths

The same Pennsylvania hospital study also showed that the death rate can be decreased by reducing the number of patients a nurse must care for. The table on the next slide illustrates the results of this modeling.
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios?? (cont.)

– Enhanced Outcomes?
  • Additional deaths/1000 patients

<table>
<thead>
<tr>
<th>Patient to Nurse Ratios</th>
<th>All Patients</th>
<th>With Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>6:1, not 4:1</td>
<td>2.30</td>
<td>8.70</td>
</tr>
<tr>
<td>8:1, not 6:1</td>
<td>2.60</td>
<td>9.50</td>
</tr>
<tr>
<td>8:1, not 4:1</td>
<td>5.00</td>
<td>18.20</td>
</tr>
</tbody>
</table>

The table shows that as the patient assignment per nurse increases from 4:1 to 6:1, the number of deaths per 1000 is 2.3. If the ratio increases from 6:1 to 8:1, then the number of deaths per 1000 rises to 2.6. If the ratio increases from 4:1 to 8:1, the rate of deaths per 1000 escalates to 5.0.

The idea is to arrive at an acceptable balance in patient assignment based upon objective criteria, which adequately describe patient dependency, not arbitrary legislature-imposed ratios.
Mandated Nursing Ratios – The Pros and Cons

• Why Nursing Ratios?? (cont.)

– Enhanced Outcomes?

• From a study published in May 30, 2002 in the New England Journal of Medicine, entitled “Nurse-Staffing Levels and the Quality of Care IN Hospitals”, it was determined that “...the association between staffing levels and 25 outcomes in medical and surgical patients showed an association in eight of those outcomes.” “Because of the large number of comparisons, however, it is possible that some of the associations we found may be false positives.” “The level of staffing by nurses is an incomplete measure of the quality of nursing care in hospitals.” The sample size of hospitals was 799.
Mandated Nursing Ratios – The Pros and Cons

- Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?

  - Involves unit direct caregivers in the daily staffing decisions
    - Ratios – NO
  
  - Matches staff availability to patient care requirements
    - Ratios – NO

As stated previously, nursing judgment is one of the major factors to determine good staffing assignments. In a pure ratio setting, nursing judgment is completely missing. It is replaced by legislative mandate, far removed from the here and now of patient care situations. In a dependency system, nursing judgment is an essential factor in making the final staffing decisions and patient assignments.

In matching patient care requirements to staffing availability, ratios mandate a fixed ratio and allow no flexibility for any period of time. Supplemental nurses must be brought in from wherever to support the ratio, not the patient care requirements of a given patient.
Mandated Nursing Ratios – The Pros and Cons

• Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?

  – Used to Budget nursing resources
    – Ratios – YES

  – Can Forecast nursing resource requirements
    – Ratios – YES
Mandated Nursing Ratios – The Pros and Cons

• Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?
  – Correlates nursing resources to patient outcomes
    – Ratios – YES
  – Manages resources objectively within each unit and throughout the house
    – Ratios – YES
Mandated Nursing Ratios – The Pros and Cons

• Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?

  – Account for variability of patients within a unit
    – Ratios – NO

  – Accounts for variability among homogeneous units
    – Ratios – NO

A ratio system is completely blind to the variability of patients within a given nursing unit. A patient is a patient is a patient. Anyone who has ever stepped into a nursing unit will know that this premise is false.

Patient care varies among medical/surgical units due to a concentration of certain diagnoses. A ratio system simply treats each similar unit as the same, regardless of patient case mix.
Mandated Nursing Ratios – The Pros and Cons

- Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?
  - Account for the variability of patients from hospital to hospital
    - Ratios – NO
  - Aid in resource management to ensure long-term viability of the institution
    - Ratios – NO

Under the ratio concept, every hospital (of like specialty) is the same. A medical surgical unit at UCLA Medical Center (a level I trauma center) gets the same hours of care as Redwood City Hospital (a community hospital).

The ratio system requires that every patient gets the same level of care every minute of every day, including during lunches, breaks, and transports off the unit. In a 1:5 ratio system, hospitals will have to either cut off staffing at 25 beds (any multiple of five) and close beds from 26-29, or staff an extra nurse to always maintain the 1:5 ratio.
Mandated Nursing Ratios – The Pros and Cons

• Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?

  – Incorporate facility design into the staffing requirements
    – Ratios – NO

  – Help resolve the nursing shortage issue
    – Ratios – NO

It is a known fact that there are variations in the efficiency of design of a nursing unit. Nursing units with charting modules at the room (so the nurse can remain at or near the bedside) are more efficient than units with central nursing stations. Ratios totally ignore any efficiencies or inefficiencies in design.

Ratios do not resolve the nursing shortage issue. The ratio system exacerbates it by creating a greater shortage. California will have to hire 5,000 more nurses to oblige the legislation (4).
Mandated Nursing Ratios – The Pros and Cons

• Using Time-tested Rationale for Setting Staffing Requirements, How do Mandated Ratios Compare?

– Better identify patients who require more nursing care.
  – Ratios – NO

– Reduce RN time spent in patient care activities, where a license is not required.
  – Ratios – NO

The ratio concept states that every patient should receive the same level of care. It does not identify those patients who require more care than others.

With the legislated mandate that RNs take over all bedside activities and the majority of other activities, something will of necessity have to give. Under a ratio system, tasks which are identified by skill level following the concept that tasks should be delegated to the lowest possible qualified individual will no longer be done by patient care extenders. Nurses should not be saddled with activities which can safely be delegated to a lesser skilled trained individual. The RN should be able to make this decision, not a distant legislature.
The American Organization of Nursing Executives in a meeting of their Board of Directors in December, 2003 approved a Policy Statement on Mandated Staffing Ratios in which the statement essentially opposes mandated ratios as being an inappropriate way to establish staffing requirements on nursing units (5). Quoting from the AONE policy statement; “Dr. Peter Beurhaus, the Valerie Potter Professor of Nursing and Senior Associate Dean for Research at Vanderbilt University School of Nursing, and a leading researcher, who has studied the relationship between nurse staffing and patient outcomes (states) that legislation to mandate fixed ratios carries a high potential of leading to the economic and political devaluation of the nursing profession and fails to effectively deal with the issues surrounding nurse staffing” (6). The AONE has determined that the following factors should be considered when establishing staffing requirements:

- Ergonomics of the units (layout and design)
- Technology on the units (EMR, CPOE, Med Administration, Automated Supply Cabinets)
- Ancillary Support (does the Pharmacy deliver the meds to the patient pod; linen restocked routinely, etc.)
AONE Policy on Staffing

- Staffing decisions should accommodate for (cont):
  - Education and orientation of the staff
  - Variability of the patients (dependency)
  - Turn over of the unit (ADT)

Nurse staffing should also take into consideration these factors:

- The education and orientation of the staff (how experienced are they)

- Variability of the patients (using some form of classification system, tied to patient outcome)

- Turnover of the unit (one of the most time consuming activities of a nurse is the admission and discharge of a patient)
Not only does the mandatory ratio system not enhance patient care, it burdens an already overburdened healthcare system with more costs.

According to the California Department of Health Service (DHS), this law will add $1B annually to health care costs when fully implemented (Media Release, September 2, 2004).

The average cost per hospital to comply with the “Safe Staffing Law” ranges from $3 million to $5.3 million dollars. (Governance Institute, Jan 04 Poll results)
Hospitals in California will need to hire an additional 5,000 nurses in the face of a nursing shortage, where they can’t find nurses now. By 2010, California will need an additional 109,600 RNs over the 275,000 now employed. Only 5,000 RNs graduate each year from nursing schools in California. There is a declining number of baccalaureate nursing programs in California.

Commencing January 1, 2005, the mandated ratio for medical/surgical units was to have changed from 1:6 to 1:5. Governor Schwarzenegger stalled this implementation much to the chagrin of the CNA.

The DHS of California has the following three recommendations posted on its website as suggestions to meet the ratios; 1) Elective surgeries may have to be delayed; 2) Physicians will need to discharge their patients sooner; and 3) new admissions will need to be delayed. 51% of California hospitals operate in the red (California Healthcare Association Summary report, dated September 1, 2004). Reducing a hospital’s lifeblood (revenue) by following these DHS suggestions appears to be counterproductive to the long term survival of hospitals.
Mandated Nursing Ratios – The Pros and Cons

• Cost Impact of California’s AB 394
  – Cost of penalties for non-compliance:
    • Mandatory closing of units
    • Potential loss of Medicare/Medicaid revenue
    • Daily fines of $50 for non compliance
  – Costly litigation

The bill, AB 394, imposes penalties upon hospitals, if at anytime the actual ratio of patients to caregivers exceeds the mandated ratio, even during lunches, breaks, and transports. Members of the California Nurses Association have been requested to report non-compliance (refer to CNA Ratios Audit Form in Appendix C.). Hospitals could be held criminally liable for continuously violating a regulation.

This bill will also present numerous opportunities for attorneys to litigate. If an undesirable outcome can be linked to failure to comply to mandated regulations, floodgates will open on lawsuits.
Mandated Nursing Ratios – The Pros and Cons

• Current Outcomes of this Experiment:
  – Six Hospitals in LA County have closed in 2004
  – A total of eight hospitals throughout the state have closed in 2004.
  – Two more closures were planned by Dec 31, 2004 (Did happen)
  – 85% of all hospitals could not meet ratios every unit, every shift

During the first year of the bill’s enactment the following outcomes resulted:
  • Eight hospitals have closed throughout California
  • Two more hospitals are planned to close by December 31, 2004; one of them seeing 100,000 ED visits per year.
  • Another hospital in LA plans to shutter its trauma service within 90 days.
  • 85% of all hospitals could not meet the ratios on every unit on every shift during a six month survey conducted by the CHA.

These results are shown on the California Hospital Association’s website.
Mandated Nursing Ratios – The Pros and Cons

• Current Outcomes of this Experiment:
  – Higher requirement for RNs
  – Greater hostility between CHA and CNA
  – Deteriorating relations between competing nursing unions (CNA and UNA)
  – Diminished patient care (closed units/beds)

The already existing nursing shortage is being exacerbated by the mandating of ratios. California hospitals have an RN vacancy rate of 15%.

As previous stated the CNA wants its members at every hospital to report non-compliance. In this instance the employee is encouraged to whistle-blow on the employer, creating a tense relationship between the two.

The CNA is the RN union and the United Nurses Association is the union for the LVNs. They are now at odds with each other as the CNA interprets the ratio as meaning RN to patient, not licensed to patient.

Although the legislation was intended to improve patient care, how can limiting access to care because of closed beds, Emergency Department drive-bys, and deferral of elective services improve patient care? Yes, there needs to be some optimized staffing level, but mandated ratios are not it.
The American Organization of Nursing Executives has issued a policy statement through its Board Directors clarifying their opposition to mandated staffing ratios (refer to AONE Website, www.AONE.org, Advocacy and Policy, Position Statements, Policy on Mandated Ratios). In this policy statement it clearly states that mandated ratios “only serve to increase stress on a healthcare system that is overburdened by an escalating national and international shortage of registered professional nurses and has the potential to create a greater risk to public safety”.

Movement is afoot to lobby Governor Arnold Schwarzenegger to modify, if not rescind this legislation. Before other states attempt to initiate this type of legislation, this unfortunate part of California history should be carefully evaluated. There are other more viable options to settle the nurse staffing question. Now, we have national legislation to worry about relating to nursing ratios, introduced as HR 1222.
Mandated Nursing Ratios – The Pros and Cons

• SHS Position on Mandated Staffing Ratios (cont.)
  – Support JCAHO staffing requirements as part of industry-imposed considerations in setting staffing levels in hospitals.
  – Educate SHS membership in all factors, which should be considered in developing flexible, mix-sensitive staffing requirements in all departments of all hospitals.
Mandated Nursing Ratios – The Pros and Cons

• SHS Position on Mandated Staffing Ratios (cont.)
  – Educate hospital administrators through conferences, mailers, education forums, etc. to involve their management engineering staff and/or outside consultants in a collaborative effort with nursing to development empirically founded, mix sensitive staffing requirements for all hospital departments and most particularly nursing.
Mandated Nursing Ratios

• Questions
Mandated Nursing Ratios – The Pros and Cons

• Bibliography


Nursing Ratios –
Is there a better Alternative?

• Bibliography


Mandated Nursing Ratios – The Pros and Cons

• Bibliography (cont)

5) AONE Policy Statement on Mandated Ratios, December, 2003

6) IBID

7) California Department of Health Services Website
Mandated Nursing Ratios – The Pros and Cons

• Bibliography (cont)

8) Policy Statement on Mandated Staffing Ratios approved by the AONE Board of Directors, December, 2003
Appendix A

Highlights of the Safe Staffing Law

• Nurse ratio regulations apply to all licensed staff (RN’s & LVN’s)
• Continuous compliance is required 24 hrs per day, no averaging.
• LVN’s cannot comprise more than 50% of workforce in a given day on a given shift on a given unit.
Mandated Nursing Ratios – The Pros and Cons

Appendix A (cont.)

Highlights of the Safe Staffing Law

• Clinically competent nurses must relieve breaks, meals, etc.
• Hospitals must continue to use a patient classification system
• Every hospital must have a written staffing plan
# Instructions:

1. Select those criteria which apply to the patient.
2. Three (3) of the sections are required to be selected: Diet, Bath, and Mobility.
3. All other sections are optional (dependent on patient care requirements).
4. Only one (1) criterion may be selected per section.
5. If more than 1 criteria in a criteria group applies, select the one with the highest dependency value.
6. Add the points for each patient and enter into the Total Points box at the bottom of the Classification Tool.
7. Find the class level in Point Range that matches the Total Points for a patient and enter into Class Level box.
8. After all classifications are completed, record the total number of patients by class level in Shift Census column.

## Classification Criteria

<table>
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<tr>
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<th>Description</th>
<th>Points</th>
<th>Class</th>
<th>Description</th>
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<tr>
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<td>Independent (NPO or Self Feed)</td>
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<td>1</td>
<td>Independent (Self Help, Nurse Washes Back)</td>
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<td>2</td>
<td>Cut &amp; Assist (Sips/Ice Chips, Assist w/Tray/Partial Feed)</td>
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<td>2</td>
<td>Partial Assistance (Partial Bath-Nurse Assist 50%)</td>
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</tr>
<tr>
<td>3</td>
<td>Total Feed or Tube Feeding</td>
<td>13</td>
<td>3</td>
<td>Complete Bath/Multiple Bath</td>
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<tr>
<td>4</td>
<td>Independent (Up ad lib/BRP w/o help)</td>
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<td></td>
<td>Routine w/Meds or Piggyback (&lt;3 IV Meds/8Hrs)</td>
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<td>Complex IVs (Intravenous/PB &gt;=4 IV Meds/8 Hours), PCA, TLC</td>
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<td></td>
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<td></td>
<td>Incentive Spirometer (Routine)</td>
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<td>Suctioning Q 30 min or More Often</td>
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<td></td>
<td>Observation/Assessment/Proc. Q1-2 Hrs &amp; or PostOp/Postpartum Vital Signs</td>
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## Total Score

<table>
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**APPENDIX B Med/Surg Classification Form**

Date:___/___/___ | Forecasting for: Day / Eve / NOC

**Point Range**  | **Skill**  | **Class**
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**Name & Room Number**

---

**BATH**

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<tr>
<th>Class</th>
<th>Description</th>
<th>Points</th>
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<tbody>
<tr>
<td>1</td>
<td>Independent (NPO or Self Feed)</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Cut &amp; Assist (Sips/Ice Chips, Assist w/Tray/Partial Feed)</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Total Feed or Tube Feeding</td>
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<tr>
<td>4</td>
<td>Independent (Self Help, Nurse Washes Back)</td>
<td>14</td>
</tr>
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**MEDICAL THERAPY**

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<td>Routine w/Meds or Piggyback (&lt;3 IV Meds/8Hrs)</td>
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<td>2</td>
<td>Complex IVs (Intravenous/PB &gt;=4 IV Meds/8 Hours), PCA, TLC</td>
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<td>3</td>
<td>Chemo/Epidual/Perepheral/Paralytic Agents w/wo Sedative Drips</td>
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<td>4</td>
<td>Incentive Spirometer (Routine)</td>
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<td>Suctioning Q1-2 Hours</td>
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<td>6</td>
<td>Suctioning Q 30 min or More Often</td>
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<td>7</td>
<td>Observation/Assessment/Proc. Q1-2 Hrs &amp; or PostOp/Postpartum Vital Signs</td>
<td>27</td>
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<td>8</td>
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<td>28</td>
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**Total Score**

<table>
<thead>
<tr>
<th>Class Level</th>
<th>Description</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Is your unit complying with the ratios? Let us know.
Complete our Ratios Audit Form today

CNA has been auditing California hospitals to determine which are, and which are not, abiding by the new state law requiring all hospitals to provide minimum RN staffing ratios.

We are asking all RNs in non CNA-represented hospitals to help us with this audit. Please fill out the form below and submit today. We have compiled and studied all responses received up to January 30, 2004. Click here to read our press release on the results. Thank you to all those who took the time to send us information on how the ratios are being adhered to in their facilities and units. We are continuing to compile data and will be publishing further results periodically.

Please help us in our efforts to monitor the ratios.
Fill in the form below today and encourage your RN colleagues to do the same.

With the audit, we hope to provide a more detailed answer for patients and their families to assess how their local hospitals are faring on compliance with the law.

Your name is requested by CNA so we can contact you if clarification is needed. All names and contact information will be kept confidential.

-
Appendix C

Name: 

City:  

Area Code:  

Telephone number:  

Email address:  

Facility:  

Unit:  

Shift:  

Date:  

1. What is the current staffing in your unit, RNs to patients?
### Appendix C

2. Does the facility/unit have the same staffing on nights/p.m. as on days?  Yes ☐  No ☐

3. How is the facility using LVNs in the ratios on your unit?

<table>
<thead>
<tr>
<th>Using LVNs as part of the ratio count:</th>
<th>Yes ☐  No ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Assigning patients directly to LVNs (doubling the RN patient assignment):</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>b) Permitting LVNs to assess patients:</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>c) Using LVNs for break relief:</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>d) Allowing LVNs to give shift report:</td>
<td>Yes ☐  No ☐</td>
</tr>
</tbody>
</table>

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Appendix C

4. Is the facility using new grads without proper orientation to meet the ratios? Yes ☐ No ☐

5. Is the facility using mandatory overtime to meet the ratios? Yes ☐ No ☐

6. Has the facility laid off CNAs or other staff? Yes ☐ No ☐

7. Is the facility closing beds or units or threatening to do so? Yes ☐ No ☐

8. Has staffing improved in the facility with implementation of the ratios? Yes ☐ No ☐

Please share your comments on the ratios with us:

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