Nurse–Patient Staffing Ratios
Where are we headed, and why?

It’s been 14 years since California passed the first statewide legislation requiring minimum nurse-to-patient staffing ratios in its acute care hospitals and more than nine years since those laws began to go into effect. Although that pioneering step has been considered a success—a wealth of data connect inadequate nurse staffing in hospitals to compromised patient care, job burnout, and high turnover rates—the questions of just what constitutes adequate staffing levels and who should make that determination have been nearly constant points of debate. Since California passed its legislation, no other state has successfully implemented comprehensive minimum staffing ratios.

THE CALIFORNIA CASE STUDY
Staffing ratios on medical–surgical units in California were set at one nurse to six patients in 2004; in March 2005 that ratio improved to one to five, and in 2008 the regulations expanded to include other specialty units.

“We have evidence that if other states staffed at the levels that California does, thousands of lives could be saved,” says Linda H. Aiken, PhD, RN, FAAN, director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania.

Deborah Burger, RN, copresident of both the California Nurses Association and National Nurses United (NNU), says that if legislators across the country have taken a wait-and-see-how-it-goes-in-California approach to staffing policy, the way before them should now be clear. “Nurses from other states come to work in California, and they talk about how wonderful it is to get their assigned work done [during their shifts],” she says. “They can go home and feel like everyone got the right tests, the right medicine, the education they need.” This stands in stark contrast to nursing in some other states. “Some nurses on med–surg floors are responsible for 10 to 15 patients,” she says. “[Those patients] only get out of the hospital alive because family members help, because nurses don’t take breaks, because they stay late to catch up on work.”

HAPPIER NURSES, HEALTHIER PATIENTS—MAYBE
Numerous studies support the claim that California’s law has led to more hiring, increased job satisfaction, less burnout, and better retention of nursing staff—and it was a factor in resolving the nursing shortage in the state. But is there proof that all of that adds up to better outcomes for patients?

Aiken thinks so. She coauthored a study in the August 2010 issue of Health Services Research that compared nurse workloads and patient outcomes in California with those in New Jersey and Pennsylvania, two states without mandated minimum nurse–patient ratios. She and her colleagues found that nurses in California care for an average of one less patient each than nurses in New Jersey and Pennsylvania, and those lower ratios were associated with significantly lower mortality. Specifically, they estimated that there would have been 13.9% fewer surgical deaths in New Jersey and 10.6% fewer surgical deaths in Pennsylvania, if the hospitals had staffing ratios equivalent to those in California.

But another study, by Mark and colleagues in this April’s issue of the same journal, found that outcomes after implementation of the California law were mixed. Although failure-to-rescue rates decreased significantly more in some California hospitals than in comparison hospitals in other
states, the rates of hospital-acquired infection increased significantly more and there were no statistically significant changes in the rates of respiratory failure or postoperative sepsis. Although the authors acknowledge that the increases in infections could be related to increased detection of these events rather than to actual increases in their numbers and that the lack of observed effects on other adverse events could be related to limitations of their study, they state that further research is needed before other states or the federal government follow California’s legislative lead.

Barbara A. Mark, PhD, RN, FAAN, the Sarah Frances Russell professor at the University of North Carolina School of Nursing in Chapel Hill and an author of that study, calls mandated staffing ratios a “blunt instrument” aimed at solving complex problems. “How do you measure the acuity of patients? In nursing, we don’t have a universal measure to determine this,” Mark told AJN. “Other differences that have impact include support systems and the extent to which tasks and charting are automated. These differ from hospital to hospital, and it’s difficult to determine safe staffing levels without considering them.”

THE BATTLE RAGES ON

This legislative session, Michigan, New York, Texas, Florida, New Jersey, Iowa, Minnesota, and the District of Columbia have debated minimum nurse-to-patient staffing ratio bills modeled after California’s law. As nursing unions have aggressively supported these efforts, so hospitals and industry lobbyists have been fighting them with at least as much zeal.

Some of the bills have died or been stalled in committee; and in Minnesota, a highly contentious minimum staffing ratio bill evolved into a compromise plan that was signed into law on May 9. It requires hospitals to file staffing plans with the Minnesota Hospital Association and the Minnesota Department of Health to study nurse staffing levels and their effects on patient outcomes. According to state representative Joe Atkins, one of the sponsors of the bill, the compromise made the most sense to lawmakers, who were getting different accounts of the state of health care in Minnesota during the hearings.

“We had many nurses testifying to some very challenging [staffing] situations that were threatening patient safety,” he says, and that such problems were common. “Then hospital [representatives] were testifying that we had the best hospitals in the country, the best patient protections in the country.”

By January 15, 2015, the department will submit its study to legislators. In the meantime, patients in the state will have access for the first time (through a Web site) to publicly disclosed nurse staffing information at hospitals.

“There was a lot of agreement on both sides of the aisle about transparency,” says Andrea Ledger, director of political and legislative action at the Minnesota Nurses Association. She is careful to note, though, that a minimum standard is still the ultimate goal for her group.

A FEDERAL SOLUTION?

The evolution of the staffing legislation in Minnesota might predict what’s to come at the federal level. Senator Barbara Boxer (D-CA) proposed federal minimum nurse-to-patient ratios in April (S 739), with complementary legislation (HR 1907) in the House of Representatives from Jan Schakowsky (D-IL). Both bills are modeled after California’s ratio law and are being celebrated by nursing unions.

But not everyone considers the matter settled. The American Nurses Association (ANA) supports a model in which nurses create staffing plans specific to their units, in contrast to the one-size-fits-all design of mandated staffing ratios. The ANA helped to craft a different federal bill introduced this spring: the Registered Nurse Safe Staffing Act of 2013 (HR 1821), sponsored by representatives David Joyce (R-OH) and Lois Capps (D-CA), who is a nurse.

The bill would require hospitals to establish committees to create nurse-staffing plans based on factors like the number of patients on a unit, patient acuity, the experience of RNs on a unit, support staff, and other resources. It would also require public reporting of nurse staffing levels in hospitals that participate in Medicare.

If federal legislation on nurse staffing is to pass, the Joyce–Capps bill might have a better chance at success than a strict ratio mandate, says Aiken, who suspects that private hospitals won’t accept mandated minimum staffing ratios from the federal government. But she explains that this plan, which would require hospitals to report staffing levels through Medicare’s Hospital Compare Web site, is not only useful for patients but is also consistent with the federal government’s current requirement that hospitals make their performance on certain measures public—which could ultimately lead to an incentive plan to get hospitals to safer staffing levels.

Which way Congress will go remains to be seen, but the Joyce–Capps brand of legislation has had some success at the state level. So far, seven states (Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington) have passed laws that are similar. Those states’ laws require hospital-wide committees to determine staffing levels—and give nurses a voice in the process.—Laura Wallis ▼