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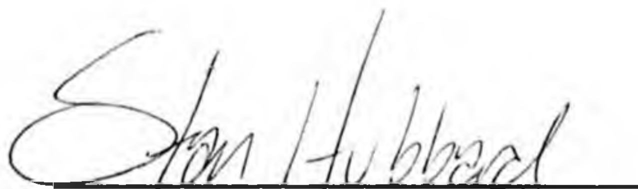


Signature of Camera Operator

Date

SB
28

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

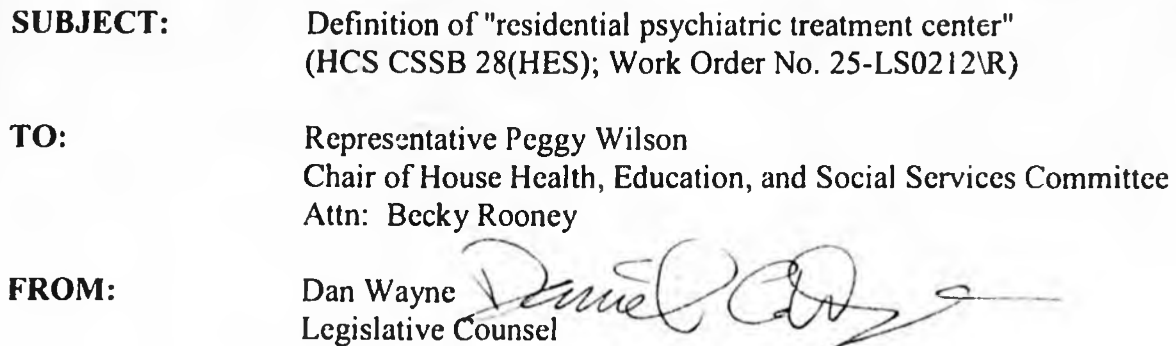
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 5, 2008

SUBJECT: Definition of "residential psychiatric treatment center"
(HCS CSSB 28(HES); Work Order No. 25-LS0212\R)

TO: Representative Peggy Wilson
Chair of House Health, Education, and Social Services Committee
Attn: Becky Rooney

FROM: Dan Wayne
Legislative Counsel



Enclosed is HCS CSSB 28(HES), in a draft version. Conceptual amendment 4 adopted by the committee called for insertion of the phrase "at a residential psychiatric treatment center," which appears in the enclosed draft on page 3, lines 15 and 16. The term also appears in the list of institutions that are defined or "health care facilities" in AS 18.20.449(2). To clarify the amendment, I've supplied a definition of the term "residential psychiatric treatment center" on page 6, line 7 of the enclosed draft. This definition is the same as the definition of the term in AS 18.07.111.

If this disposition is acceptable, I'll have the HCS prepared and delivered to you in final. If not acceptable, I'll rerun the bill in final form omitting the definition.

DCW:med
08-255.med

Enclosure

2

HOUSE COMMITTEE REPORT

4.6-08

(7)
Date Referred to Committee: April 2, 2008

FURTHER REFERRALS: Finance

Date of Committee Action: 4-5-08

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: CSSB 28(FIN)

CS FOR SENATE BILL NO. 28(FIN) LIMIT OVERTIME FOR REGISTERED NURSES

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

Recommends it be replaced with [✓] HCS or [ ] CS for CSSB 28 (HES)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR____ [X] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to ____________Committee
[ ] Letter of Intent____________Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

NEW FISCAL NOTES (*Assigned by Chief Clerk's Office)

List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS FISCAL NOTES

List by Dept(s):	FN#	Fiscal	Indet.	Zero
HSS	4			✓
	6			✓
	8			✓
	9			✓
	10	✓		
	11			✓

1 FN 5¢

Signing with recommendations	Printed Last Name	DP (3)	DNP (1)	NR	AM (1)
[signature]	CISSNA	✓			
[signature] Gardner	GARDNER	x			
Bob Roses	ROSES		X		
Paul K Seaton	SEATON	X			
Chair: Peggy Wilson	WILSON				X
Chair:					

Amendment 1

Offered in the **House HESS Committee** By:Representative Gardner

Fairclough
Keller
Rogers
Wilson

To Bill Number SB 28 Version: W

Date: 4 5 · 08

Page 3, line 4 after the words:

natural disasters,

ADD: weather,

passed

Amendment 2

Offered in the **House HESS Committee** By:Representative FAIRCLOUGH Roses Gardner, KELLER

To Bill Number CS SB 28(FIN) Version: 25-LS0212\W

Date: 4-5-08

PAGE 2, LINE 11 + 12 AFTER THE WORDS:
"may not be required"

DELETE: "or coerced, directly or indirectly,

Passed

Amendment 3

Offered in the House HESS Committee

By: Representative FAIRCLOUGH
Gardner

To Bill Number

CS SB 28 (FIN)

Version: 25-LS0212\W

Date: 4-5-08

PAGE 3, LINE 8 & 9

DELETE: (4) "a nurse fulfilling on-call time that is agreed upon by the nurse and a heath care facility before it is scheduled."

RENUMBER

Withdrawn

conceptual
Amendment 4

Offered in the **House HESS Committee** By:Representative Seaton

To Bill Number CSHB 28 Version: T

Date:

Page 3 line 16
insert after contract
"at a residential psychiatric treatment
center"

S-Y
C-Y
G-Y
R-N
W-N

Passed

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 28

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

Sponsor Statement

SB 28, known as "The Alaska Safe Nursing and Patient Care Act," modeled somewhat after H.R. 791, 109th Congress, prevents Alaska registered and licensed practical nurses from being forced to work mandatory overtime, i.e., work beyond an agreed to, predetermined, regularly scheduled shift, and it protects patients from the dangers caused by overworked nurses. Too often Alaska's nurses are overworked, underpaid, and undervalued. This bill will improve the lives of nurses and their families and enhance the quality of patient care in communities across the state. SB 28 will let nurses decide if they can provide safe, quality care while working overtime. SB 28 would strictly limit the use of mandatory overtime for nurses to situations in which an official state of emergency is declared by federal, state or a local government, flight nurses in medical transport, or other stated exceptions. It would, however, allow nurses to voluntarily work overtime when they feel they can continue to provide safe, quality care. The legislation also prevents retaliation by employers against nurses who in good faith allege violations or who are forced or feel compelled into working hours beyond what they believe safe for quality care. SB 28 requires that health care facilities monitor and report voluntary and mandatory overtime and on-call hours semi-annually and pay penalties for knowing violations.

SB 28 limits mandatory overtime for registered nurses and licensed practical nurses in healthcare facilities. The nurse may not be required or coerced directly or indirectly to work:

a) beyond an agreed to, predetermined, regularly scheduled shifts or on-call time;
b) beyond 80 hours in a 14-day period;
c) to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

This bill provides the additional benefit of encouraging nurses to train and stay in this worthy profession where there is already a severe and growing shortage of nurses nation-wide.

Rev. 3/25/08

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: CSSB 28(L&C)
(S) Publish Date: 1/23/08

Identifier (file name): SB028CS(HES)-DOA-DOP-11-28-07
Title: Limited Overtime for Registered Nurses
Sponsor: Senator Davis
Requester: (S)Health, Education & Social Services

Dept. Affected: Administration
RDU: Central Administrative Services
Component: Personnel
Component Number: 56

(Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Interagency Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost: 0.0

POSITIONS

POSITIONS							
Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB28 would place limits on hours worked per day, hours worked per week, and mandatory overtime hours worked by registered nurses and licensed practical nurses.

This bill will have no fiscal impact on the division of Personnel.

Prepared by: Nicki Neal, Director
Division: Division of Personnel
Phone 907-465-4429
Date/Time 11/28/2007 11:44 a.m.

Approved by: Kevin Brooks, Deputy Commissioner
Department of Administration
Date 11/29/2007

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 6
Bill Version: CSSB 28(L&C)
(S) Publish Date: 1/23/08

ID(File name) SB028CS(HES)-DHSS-DPH-12-20-07
Dept. Affected: Health & Social Services
Title: RELATING TO MANDATORY OVERTIME FOR NURSES IN HEALTH CARE FACILITIES
RDU: Public Health
Component: Nursing
Sponsor: DAVIS
Requester: SENATE (L&C)
Component No. 288

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: ________

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill sets limitations for nurses working overtime hours beyond the scope of their regular duties. While the language in the bill makes it applicable to public health nurses, it would have a very limited effect on the Division of Public Health Section of Public Health Nursing. Most Public Health Nurses, as salaried employees, are not overtime eligible.

The mandated semi-annual report to the Department of Labor and Workforce Development wou'd typically require no effort because public health nurses rarely work "in excess of a predetermined and regularly scheduled shift that is agreed upon by the nurse and a health care facility." Normal itinerant schedules, even though they often involve more than a 7.5-hour day, are always predetermined and agreed upon. In addition, the bill exempts reporting requirements for unforeseen emergencies requiring extra work. There is no projected fiscal impact on the Section of Public Health Nursing.

Prepared by: Jay Butler, Chief Medical Officer — Phone 269-8126
Division: Public Health — Date/Time 12/11/2007
Approved by: Karleen Jackson, Commissioner — Date 12/20/2007
Agency: Department of Health and Social Services

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 8
Bill Version: CSSB 28(L&C)
(S) Publish Date: 1/23/08

ID(File name) SB028CS(HES)-DHSS-APH-12-20-07
Dept. Affected: Health & Social Services
Title RELATING TO MANDATORY OVERTIME FOR NURSES IN HEALTH CARE FACILITIES
RDU Alaskan Pioneer Homes
Component Pioneers Homes
Sponsor DAVIS
Requester SENATE (L&C)
Component No. 2671

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: ________

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 28 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of SB 28 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor.

The division has determined that passage of this bill will have zero fiscal impact. Situations requiring overtime are adequately addressed by utilizing on-call RNs and requesting voluntary overtime.

Prepared by: Dave Cote
Phone (907) 465-5737
Division Alaska Pioneer Homes
Date/Time 12/04/2007
Approved by: Karleen Jackson, Commissioner
Date 12/20/2007
Agency Department of Health and Social Services

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 9
Bill Version: CSSB 28(FIN)
(S) Publish Date: 3/25/08

Identifier (file name): SB028CS(HES)-CED-OL-01-11-08
Title: Limit Overtime For Registered Nurses

Sponsor: Davis
Requester: Senate Labor & Commerce

Dept. Affected: DCCED
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation amends various provisions of AS 18.20, Hospitals and Nursing Facilities, to add specifications regarding overtime for registered nurses. This is not expected to impact the operations of the division.

Prepared by: Jenifer Strickler, Chief
Division: Corporations, Business, and Professional Licensing
Phone (907) 465-2144
Date/Time 1/12/08 11:50 AM

Approved by: Emil Notti, Commissioner
Commerce, Community, and Economic Development
Date 1/12/2008

(Revised 10/05/2006 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 10
Bill Version: **CSSB 28(FIN)**
(S) Publish Date: 3/25/08

Identifier (file name): **SB028CS-DOLWD-WH-01-24-08**
Title: Limit Overtime for Registered Nurses
Sponsor: Senator Davis
Requester: Senate FIN

Dept. Affected: Labor and Workforce Development
RDU: Labor Standards and Safety
Component: Wage and Hour
Component Number: 345

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	71.3		71.3	71.3	71.3	71.3	71.3
Travel	3.0		3.0	3.0	3.0	3.0	3.0
Contractual	19.1		19.1	19.1	19.1	19.1	19.1
Supplies	3.8		0.5	0.5	1.8	0.5	0.5
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**97.2**	**0.0**	**93.9**	**93.9**	**95.2**	**93.9**	**93.9**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
1002 Federal Receipts							
1003 GF Match							
1004 GF	97.2		93.9	93.9	95.2	93.9	93.9
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**97.2**	**0.0**	**93.9**	**93.9**	**95.2**	**93.9**	**93.9**

Estimate of any current year (FY2008) cost: None

POSITIONS

	FY 2009	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Full-time	1		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The bill requires the Department of Labor and Workforce Development to investigate complaints, collect evidence, interview witnesses, subpoena records and make determinations regarding "mandatory overtime" worked by licensed practical nurses and registered nurses. It also requires the Commissioner of Labor to request the Office of the Attorney General to represent the department and the complainant upon reaching a determination of employer retaliation. The anticipated workload will require a full-time Wage & Hour Investigator I position funded with General Funds. Costs include $71.3 for salary and benefits and $25.9 in various associated position costs including $3.3 of one-time position costs for basic office equipment and $10.0 for legal costs associated with representation by the Department of Law.

Prepared by: Grey Mitchell, Director
Division: Labor Standards & Safety
Phone (907) 465-4855
Date/Time 1/24/08 8:17 AM

Approved by: Click Bishop, Commissioner
Department of Labor and Workforce Development
Date 1/24/2008

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number: 11
Bill Version: CSSB 28 (FIN)
(S) Publish Date 3/25/08

ID(File name) SB028CS(FIN)-DHSS-API-03-25-08
Dept. Affected: Health & Social Services

Title RELATING TO MANDATORY OVERTIME FOR NURSES IN HEALTH CARE FACILITIES
RDU Behavioral Health
Component Alaska Psychiatric Institute

Sponsor DAVIS
Requester SENATE (FIN)
Component No. 311

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2008) cost: ________

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

SB 28 establishes limitations on overtime for Registered Nurses (RNs) in health care facilities, provides penalties for violations, and requires reporting of any overtime, with the overtime designated as voluntary or mandatory by the RN. The intent of SB 28 is to eliminate mandatory overtime for RNs unless the overtime is due to a grave and unforeseen event. Under the bill, use of mandatory overtime in excess of the bill's limitations will result in a report to the Department of Labor. It is difficult to estimate the cost for nurse mandatory overtime because nursing vacancies, census and other factors can fluctuate. However, in FY07, DHSS spent $167,968.08 hiring relief nurses to fill in during staff shortages, and there were 97 episodes of mandatory overtime that required 468.5 hours of overtime by nursing staff. On the aggregate, the API Nursing staff is loyal to the hospital mission and aware of the public safety issues related to the population served. There has never been a grievance filed over the use of mandatory overtime and it would be speculation to estimate any level of potential fines incurred as a result of this legislation.

Prepared by: Melissa Stone, Director
Phone 269-3410
Division Behavioral Health
Date/Time 03/25/2008
Approved by: Karleen Jackson, Commissioner
Date 03/25/2008
Agency Department of Health and Social Services

(Revised 11/19/2007 OMB)

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (9'7) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 28

"An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

Sectional Analysis

Note: As a preliminary matter, this sectional analysis should not be considered an authoritative interpretation of the bill; the bill itself is the best statement of its contents.

Section 1. Adds a temporary law section on legislative findings and intent concerning administration of overtime provisions in the nursing profession.

Section 2. Adds an "Article 4" to AS 18.20, that includes the following sections:

Sec. 18.20.0400. Subsection (a) prohibits the use of direct or indirect coercion to cause a nurse in a health care facility to:

(1) work beyond a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility;
(2) work beyond 80 hours in a 14-day period; or to
(3) accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

Subsection (b) requires that the nurse shall not have less than 10 consecutive hours of off-duty time immediately following the end of work on a predetermined and regularly scheduled shift agreed to by the nurse and the health care facility.
Subsection (c) lists exceptions to subsection (a).

Sec. 18.20.410 Prohibits any kind of retaliation against a nurse for exercising rights or reporting violations under the other sections of the bill should they become law.

Sec. 18.20.420 Requires a health care facility to provide an anonymous process by which a patient or a nurse may make a complaint about staffing levels and patient safety that relates to overtime work by nurses and to limitation on overtime work by nurses under AS 18.20.400.

Sec. 18.20.430 Requires the Commissioner of Labor and Workforce Development to administer the overtime limitations for nurses established by the bill and adopt regulations for implementing and enforcing them. It establishes a complaint procedure, and a schedule of penalties to be imposed upon a health care facility if a complaint under the established procedure leads to the Commissioner finding a "knowing" violation of the new limitations on nursing overtime. "Knowingly" is defined in the same section when "the facility is either aware that its conduct is of a nature prohibited by the overtime provision or aware that the circumstances described in the overtime prohibition exist;" or in proving the existence of a particular fact that the "facility is aware of a substantial probability of its existence, unless the facility reasonably believes it does not exist."

Sec. 18.20.440 Provides the procedure for semiannual reporting requirements by health care facilities for each nurse, including the number of overtime hours that were mandatory, voluntary, or on-call. On-call hours are further identified as mandatory or voluntary.

Sec. 18.30.449 Defines key words, including "health care facility," "nurse," "on-call," and "overtime."

Section 3. Requires that if the bill becomes law the filing of the first semi-annual reports under AS 18.20.440 must be filed before February 1, 2008 for the period July 1, 2007 through December 31, 2008.

Section 4. requires that the reporting requirements of AS 18.20.440 take effect July 1, 2007.

Section 5. provides for an effective date of January 1, 2008 for parts of the bill not made effective on July 1, 2007.

CS for Senate Bill 28 (FIN): "Safe Nursing & Patient Care Act"

What Does CSS*B (FIN) 28* Do?

- Protects patients and nurses in a health care facility by limiting forced overtime unless needed for an emergency.
- **Nurses cannot work more than 14 consecutive hours without 10 hours of rest**, or be forced to work more than 80 hours in a 14-day period. **Nurses can volunteer to work additional shifts beyond this limit, so long as the nurse does not work more than 14 consecutive hours without 10 hours of rest.**
- **Exceptions are allowed for unforeseen emergencies**, school nurses, medivac flights, certain on-call situations, and weekend Baylor plans by agreement.

Why is *CSSB28 (FIN)* Needed?

- **Purpose of bill is to promote patient safety and better working conditions for nurses.**
- **Nurses in Alaska are working an excessive amount of overtime without adequate rest.** Nurses often work well beyond 12 consecutive hours, or come back within 2-4 hours of completing a 12-hour shift. In other cases, nurses are working several 12-day shifts over consecutive days.
- In most cases, **this is forced or mandated through a practice called "mandatory call", which the hospitals freely admit is used.** In some cases, this is accomplished by pressure tactics designed to get nurses to "volunteer' for overtime hours. Suggestions of patient abandonment or assertions that nurses will be letting down co-workers are not uncommon.
- ***SB 28* will help with nurse recruitment and retention by prohibiting excessive amounts of overtime.** The nurse workforce is aging – a ban on excessive overtime will keep these nurses working longer.
- A recent phone survey by AaNA documents that not all of the new UA nursing school graduates are being hired. **The bill will not exacerbate the so-called shortage – there are additional graduates available to fill positions.**
- **Data suggests many hospitals are using overtime as a staffing tool.** Hospitals are not hiring all available graduates and maintain vacancy rates of between 7% to 25%. It appears that many hospitals are trying to avoid hiring Full-Time Equivalent (FTE) employees.
- 83% of the Alaska RN workforce is over 40 years of age and 53% is over the age of 50. **We need to conserve the workforce we have, and at the same time not scare away the 17% of the workforce that is under age 40.** People with young families are not going to stay in the profession if they are constantly being forced to work.

t/ 907-274-0827
f/ 907-272-0292
3701 E. Tudor Rd, Suite 208
Anchorage, AK 99507
www.aknurse.org

Mandatory Overtime Legislation: A positive approach to improved patient care for the State of Alaska

January 2008

Executive Summary

Robert Steinbrook, MD, begins his report in the New England Journal of Medicine about nurses this way: "Nursing is an embattled profession." (2002). Since the Institute of Medicine Report (IOM) in 1996 and this article in 2002, many states have taken positive steps to stop the hemorrhaging of seasoned, experienced professional registered nurses from the workforce and to add more, younger energetic people to the mix. The same can be said of other health professionals such as pharmacists, certain physician specialties, and health care professionals in general. How the states are accomplishing this is through positive legislative efforts evidencing a sincere desire for improved working conditions and health care environments.

In the nursing profession, states that have passed legislation in four main target areas are having the most success in retaining and drawing registered nurses to employment. The four legislative areas include but are not limited to: banning mandatory overtime, safe patient handling, staffing ratio systems, and increasing scholarship funds.

In this context, we will discuss the necessity of banning mandatory overtime and/or mandatory call as a first step in advancing the retention of professional registered nurses in the State of Alaska.

Background

The population in Alaska as well as the rest of the United States is aging. Registered nurses (RN's) are aging as well. In 2000, the average age of the RN was 45. Today that age is 46 and remains 95 percent female; in Alaska, the average age is 48 (2007 Alaska Senate Testimony by AaNA). At the same time, the IOM report concluded that "women are finding other choices". Dr. Steinbrook quoted Frank Sloan of Duke University and co-chair of the committee of the IOM that reported on nursing as saying, nursing "is a very stressful job with a very flat career path." Dr. Steinbrook continued by noting RN's are discontented for many reasons including inadequate levels of staffing for both nurses and support staff and excessive workloads. That discontent goes beyond the RN's according to the April 2002 report of the American Hospital Association's Commission on Workforce for Hospitals and Health Systems. That report notes, "Most health care professionals entered their profession to make a difference through personal interaction with people in need. Today many in direct patient care feel tired and burned out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment."

Linda H. Aiken of the University of Pennsylvania School of Nursing notes that, "There is a sense that nursing is becoming an impossible job, and that nurses have no control over things that are required to provide good patient care. Yet nurses are accountable for the health and welfare of their patients." Combine this feeling with an aging work force and the future looks bleak. In 2000, only 9 percent of RN's were less than 30 years of age, as

compared with 25 percent in 1980. According to Buerhaus et al in their 2000 JAMA article, by 2020 a shortage of more than 400,000 RN's is possible. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

Ann Converso, Vice-President of the UAN, when addressing the 6th International Conference on Occupational Stress and Health, March 2, 2006 noted: **"In one of the latest Institute of Medicine reports, they found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24 hour period or more than 60 hours per week."**

Through it all, the worst case scenario is a tired, over-extended health care professional administering care to a patient.

Statement of the Problem

In October of 2007, the Alaska Statewide Nurses Conference was held in Anchorage. Over 120 nurses attended over a three day period representing RN's from Kotzebue to Ketchikan. Every staff nurse in attendance agreed that mandatory overtime is a curtailment to the working environment. Over 50 nurses (a majority of the staff nurses present) indicated that not only have they been asked to work overtime in the past three months, many indicated they had to take mandatory call. Several nurses indicated that "not only does it mess with your family life; you really worry about patient safety when you're so exhausted." In the instance of mandatory call, the RN may or may not be called to work, but must curtail personal/family time above and beyond the normal work time just in case they're needed for work. In many cases, the callback occurs within a few hours of completing a regular-12 hour shift – resulting in working more than 14 hours within a 24-hour period. Most facilities do provide incentives for on-call pay and on-call return to work status, but it continues to remain a way to staff facilities across the state without hiring more RN's.

Upon further questioning of the staff nurses at the Statewide Conference, 100 percent indicated that mandatory overtime, if used and maintained in their workplace, would cause them to leave the profession early and/or look for employment elsewhere. Several nurses with spouses in other professions noted their spouses have time curtailments in their work areas for safety, especially pilots and truck drivers. "You'd think the same people who set those limits would worry if their grandmother was in the hospital being treated by someone who had been there for over 14 hours." one nurse said. At meetings held between AaNA members, staff, hospital managers and administrators during the fall and winter of 2007, no one could say overtime does not exist and no one could guarantee mandatory overtime or mandatory call didn't occur at times.

In her testimony to the House Ways and Means Committee in Washington, D.C., Mary Foley, President of the American Nurses Association, stated, "By far the riskiest result of understaffing is the abuse of mandatory overtime as a staffing tool" (2002). According to a study published by the American Association of Nurse Executives, 61 percent of respondent RN's said they had observed increases in overtime or double shifts during the past year (2002).

Solutions

Around the country, **California, Washington, Oregon, Missouri, Texas, Connecticut, Illinois, Maine, Minnesota, New Hampshire, New Jersey, and West Virginia have all passed legislation limiting nurses to 12 hour shifts with mandatory rest periods prior to another work time. Rhode Island's legislature just passed the same legislation on an override of a governor's veto.** New York and Pennsylvania are poised to pass the legislation this year. Congress has HR2122 and S1842 pending with the support of the United American Nurses and the American Nurses Association.

"In the long term, the future of the nursing profession is related to its ability to attract more young nurses, to support the careers of current nurses, and to create more jobs for nurses with higher wages, and greater responsibilities. Such efforts can be successful only if the positions students are training to fill are sufficiently attractive, as compared with the alternatives in other fields." (Steinbrook, 2002)

In Alaska we are on the cusp of a legislative effort to begin making a true commitment to the professional registered nurse. **The current version of Senate Bill 28 actually provides for an extended work period up to 14 hours to assist hospitals that routinely schedule nurses for 12-hour shifts. The legislation also provides for an exemption from this limitation to address legitimate, unforeseeable emergencies. The Alaska Nurses Association urges the passing of this legislation as an effort to retain nurses in the state, increase the incentives to new nurses, and most importantly assist with improved patient safety.**

References

Health Policy Report

Nursing in the Crossfire

Robert Steinbrook, M.D.

What is exceptional in nursing is the nature of the work: the continuous and intimate association with pain and not infrequent contact with death. . . . Not every man or woman would feel themselves able to undertake the duties of a nurse.

Brian Abel-Smith,
A History of the Nursing Profession, 1960.[1]

NURSING is an embattled profession. Many nurses who work in hospitals feel that they are overworked and often unable to provide good patient care. The young people who traditionally have embarked on careers in nursing are increasingly choosing other fields, such as medicine or business, in which the pay and working conditions are better. Nurses who begin their careers in hospitals frequently leave for other positions. As the population ages, the demand for nurses is expected to grow rapidly. But because relatively few young people are entering nursing, severe shortages are anticipated by the end of the decade — unless this trend is reversed.

A 1996 Institute of Medicine report concluded that, although higher levels of staffing by nurses in nursing homes were linked to higher-quality care, the overall data for hospitals were not good enough to "isolate a number-of-RNs effect."[2] In this issue of the *Journal*, Needleman and colleagues[3] report that, in the United States, a higher proportion of hours of nursing care provided by registered nurses (registered-nurse–hours) and a greater number of registered-nurse–hours per day are associated with better outcomes for hospitalized patients. Among medical patients, these outcomes were a shorter length of stay and lower rates of urinary tract infection and upper gastrointestinal bleeding. A higher proportion of registered-nurse–hours was also associated with lower rates of pneumonia, of shock or cardiac arrest, and of death from five causes considered together — pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis. The findings for surgical patients were similar, although fewer significant associations were found. The study found no evidence of an association between a greater number of hours of care per day provided by licensed practical nurses or hours of care per day provided by nurses' aides and better outcomes.

The study by Needleman et al. focuses attention both on the effect of nursing care on health outcomes and on efforts to increase the level of staffing by registered nurses in hospitals[4-6]; such efforts include instituting minimal staffing ratios and prohibiting mandatory overtime, except in emergencies. In this report, I discuss some of the key issues for the nursing profession.

BACKGROUND

The problems facing registered nurses are longstanding.[7,8] Registered nurses represent the largest single health care profession in the United States. People usually become registered nurses by completing an associate's-degree program at a community college, a diploma program administered at a hospital, or a baccalaureate degree program at a college or university and then obtaining a state license. During the past 25 years, the number of diploma programs has sharply declined. A 2000 survey of registered nurses who had recently completed their initial nursing education showed that more than half had graduated from an associate's-degree program and about two fifths from a baccalaureate program.[9] Licensed practical nurses account for about one quarter of the nurse work force. They typically have a high-school diploma and are trained in a one-year program at a technical or vocational school or a community or junior college.

Every four years, the National Sample Survey of Registered Nurses provides a statistical snapshot of the profession.[9] In 2000, there were an estimated 2,694,540 persons with a license to practice as registered nurses in the United States. An estimated 82 percent were employed in nursing, and of these, 28 percent were working on a part-time basis. Of the registered nurses employed in nursing, 1,300,323 (59 percent) worked in hospitals. The unemployment rate for registered nurses was about 1 percent.[10] An estimated 95 percent of the nurses were women, 72 percent were married, and 87 percent were white. Their average age was 45 years. Thirty-four percent reported their highest level of education as an associate's degree, 22 percent as graduation from a nursing diploma program, 33 percent as a bachelor's degree, and 10 percent as a master's or doctoral degree. Seven percent were practicing or prepared to practice in an advanced practice role, such as clinical nurse specialist, nurse anesthetist, nurse midwife, or nurse practitioner.

Between 1983 and 2000, the staffing levels of registered nurses in hospitals increased by 37 percent (Fig. 1). The staffing levels of licensed practical nurses decreased by 46 percent. The average daily census of hospitalized patients fluctuated but decreased overall. Through 1993, the ratio of registered nurses to patients increased, but it may merely have kept pace with increases in the severity of patients' conditions.[11] Although the ratio of registered nurses to hospitalized

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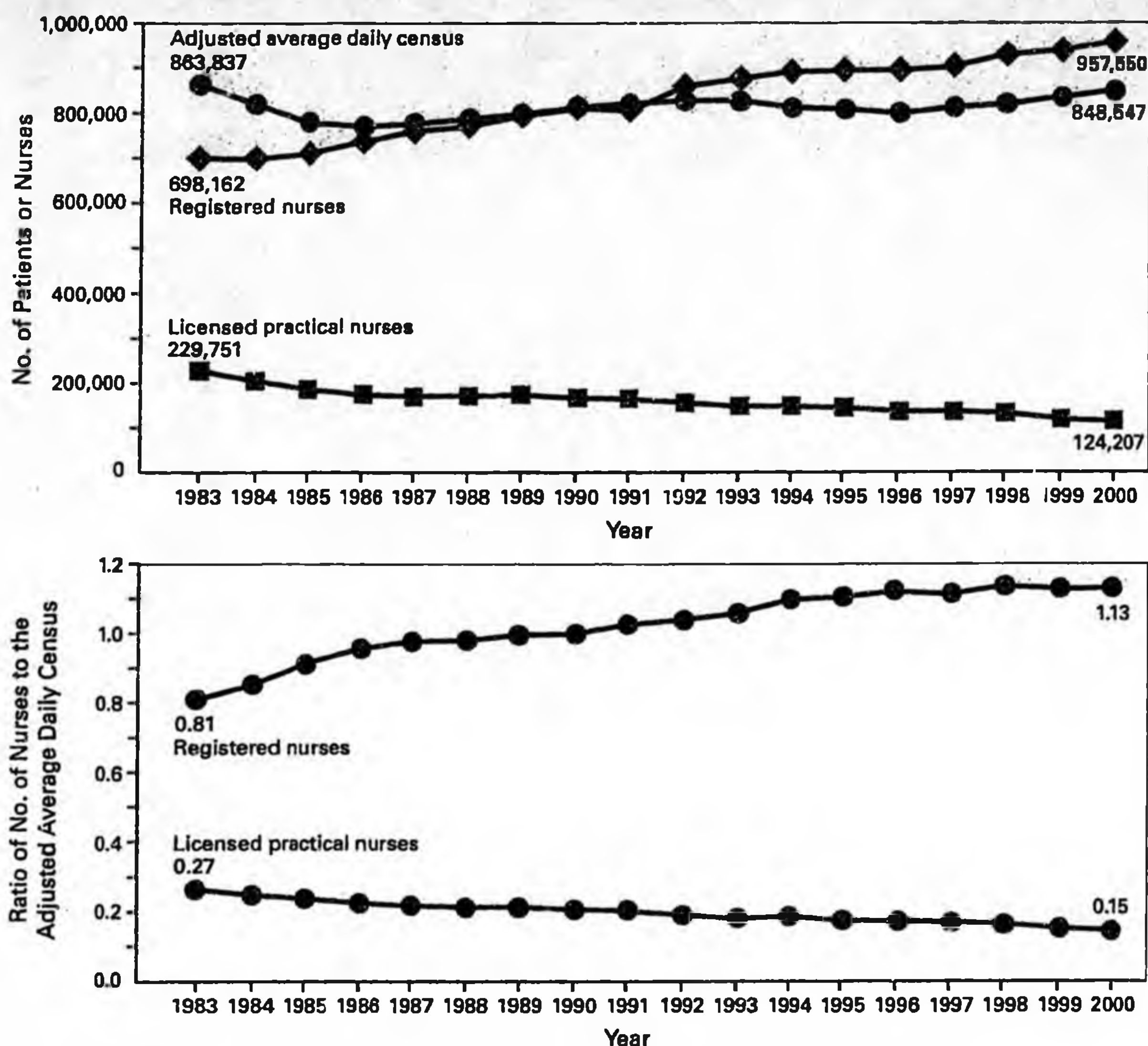

Figure 1. Levels of Staffing by Nurses in Registered Community Hospitals in the United States, 1983 to 2000.

Absolute numbers are shown in the top panel, and ratios in the lower panel. The number of hospitalized patients, the number of registered nurses, and the ratio of registered nurses to patients have increased. The number of licensed practical nurses and the ratio of licensed practical nurses to patients have decreased. The number of registered nurses and the number of licensed practical nurses shown are full-time equivalents. The adjusted average daily census was calculated by dividing the number of inpatient-days by the number of days in the reporting period. Registered community hospitals (short-term general and specialty hospitals that are registered with the American Hospital Association) are included; federal hospitals are not included. Data are from the American Hospital Association, Health Forum, AHA Annual Survey of Hospitals, 1983–2000.

patients remained relatively constant between 1994 and 2000, there are no recent data on staffing that adjust for the severity of patients' illnesses as well as their shorter lengths of stay.

DISSATISFACTION AMONG NURSES

Nursing "is a very stressful job with a very flat career path," according to Frank Sloan of Duke University, who was the cochair of the committee of the Institute of Medicine that reported on nursing in 1996.[2] "Women are finding many other choices." Registered nurses are discontented for many reasons, including inadequate levels of staffing for both nurses and support staff and excessive workloads. Because hospitalizations are shorter, nurses spend a higher percentage of their time admitting and discharging patients and teaching them what they need to do after they go home. The discontent is part of a broader malaise that

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also affects physicians and others who work in hospitals. According to the April 2002 report of the American Hospital Association's Commission on Workforce for Hospitals and Health Systems, "Most health care workers entered their professions to 'make a difference' through personal interaction with people in need. Today, many in direct patient care feel tired and burned-out from a stressful, often understaffed environment, with little or no time to experience the one-on-one caring that should be the heart of hospital employment."[12]

According to Linda H. Aiken of the University of Pennsylvania School of Nursing, "There is the sense that nursing is becoming an impossible job, and that nurses have no control over things that are required to provide good patient care. Yet nurses are accountable for the health and welfare of their patients." The perception is that physicians and hospital administrators often treat registered nurses as workers, not as clinicians and peers, and when possible seek to replace them with less skilled and cheaper personnel, such as licensed practical nurses and aides.

Nurses who begin their careers in hospitals frequently leave for other positions. A large survey of nurses in Pennsylvania, conducted in 1998 and 1999, found that 41 percent were dissatisfied with their present job and that 23 percent of those surveyed were planning to leave this job within the next year.[13] Only about a third agreed with the statements that "there are enough registered nurses to provide high-quality care," "there are enough staff to get the work done," and "the administration listens and responds to nurses' concerns." In a national survey of working nurses conducted in 2001 and 2002, 29 percent of the respondents said they were dissatisfied with their current position; 23 percent were dissatisfied with being a nurse.[14]

Financial Issues

In recent years, wages for registered nurses have been relatively flat as compared with the rate of inflation (Fig. 2). In 2000, the average annual salary of a registered nurse employed full-time was $46,782.[9] Between 1980 and 1992, real annual salaries for registered nurses increased by nearly $6,000. Between 1992 and 2000, however, they increased by only about $200.

Organizing Nurses

Working conditions have been a key issue in recent nursing strikes,[4] such as a bitter two-month strike at the Oregon Health and Science University that ended in February.[15] The ferment within the profession has led to increased interest in collective bargaining. For example, the California Nurses Association has an alliance with the United Steelworkers union. In 2000,

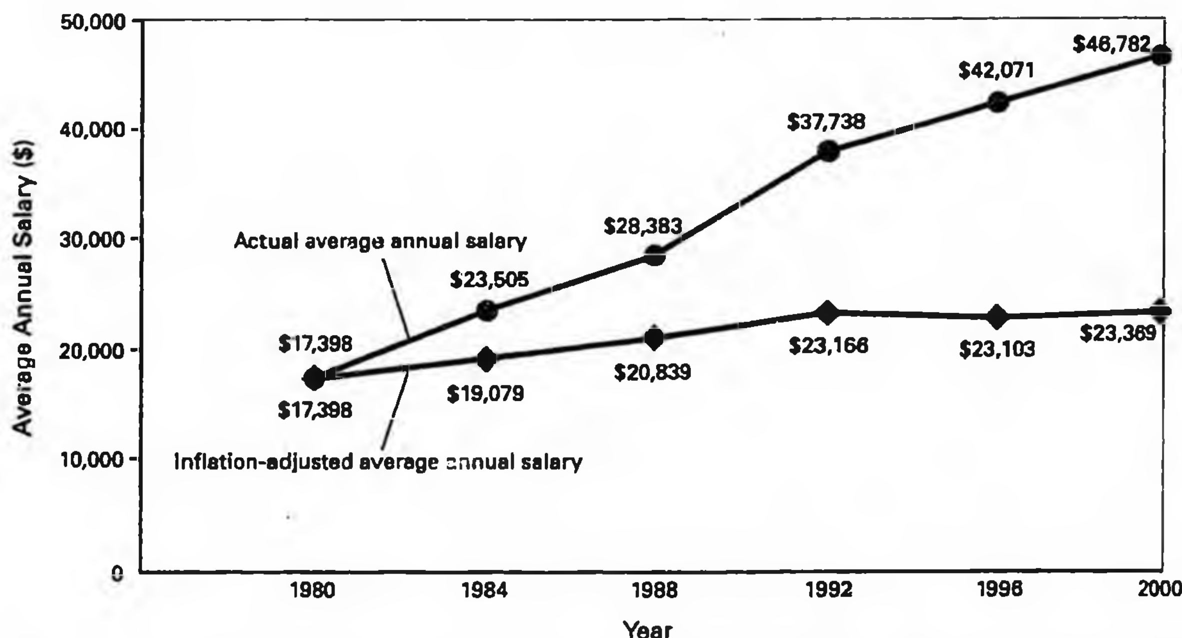

Figure 2. Actual and Inflation-Adjusted Average Annual Salaries of Full-Time Registered Nurses in the United States, 1980 to 2000. Adapted from the National Sample Survey of Registered Nurses, March 2000.[9]

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17 percent of registered nurses who were employed in nursing were members of a union, and 19 percent were covered by a collective bargaining agreement.[16] Although these percentages are similar to those for 1990 and 1995, the number of union members has increased — from about 275,000 in 1990 to about 350,000 in 2000 — because of the growth in the number of nurses.

There is also a schism between two groups that represent registered nurses. The American Nurses Association, the largest group, has been criticized for being too moderate. The California Nurses Association, a particularly aggressive and politically active group, left the American Nurses Association in 1995. The Massachusetts Nurses Association left in 2001. State nurses associations in California, Massachusetts, Maine, Missouri, and Pennsylvania are forming a new group, the American Association of Registered Nurses. This group will compete with the American Nurses Association in representing nurses at the national level.[17]

SHORTAGES OF NURSES

Since World War II, hospitals in the United States have coped with cyclical shortages of nurses. The shortages have generally been related to economic factors. When the overall economy declines, married nurses and working mothers, who represent a substantial portion of the workforce, are more likely to seek work or increase their hours; in better economic times they may be less likely to work or may only work part-time.[12] As in other fields, higher wages and better jobs encourage more nurses to seek employment.

In the 1990s, the growth of managed care slowed employment growth for registered nurses in hospitals, particularly in states such as California.[18,19] There was a surplus of registered nurses; some nurses lost their jobs, and some new nurses were unable to find jobs. Although hospitals were still hiring more registered nurses (Fig. 1), it seemed that they might need fewer in the long term. Enrollment in nursing schools declined (Fig. 3).

Measuring the Shortages

Shortages of hospital nurses are sometimes difficult to evaluate.[20] Among the potential measures of a shortage are reports by hospital officials or nurses, the vacancy rate for nursing positions, the turnover

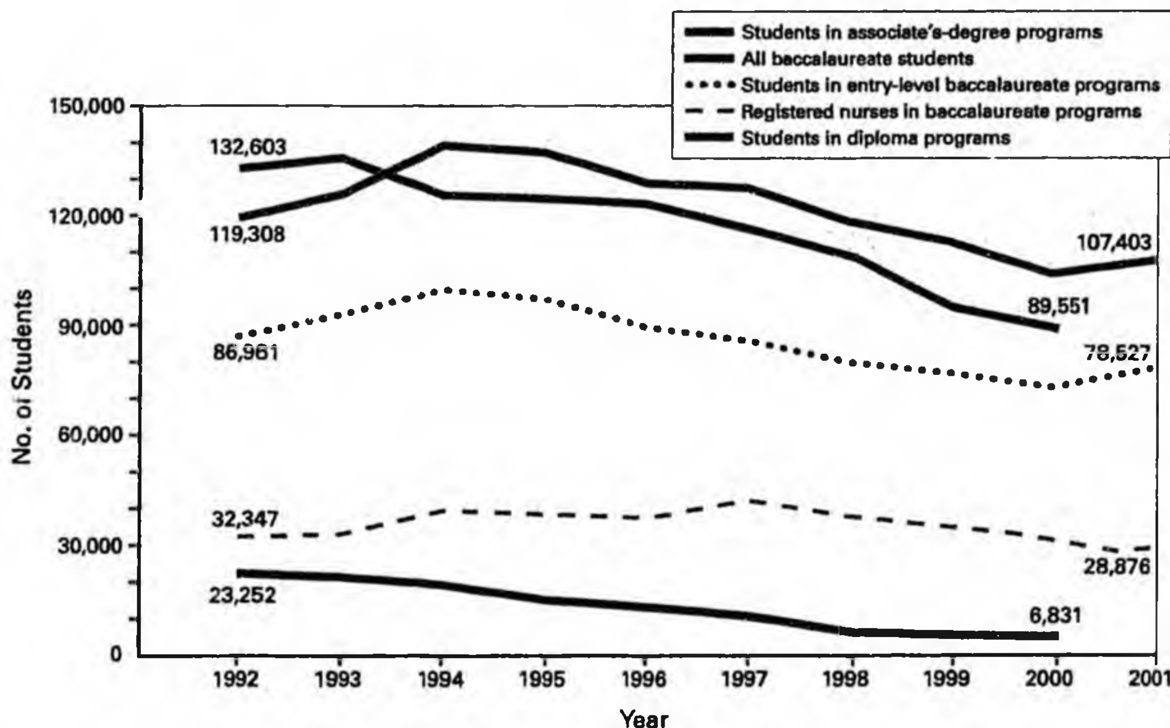

Figure 3. Enrollment in Educational Programs to Train Registered Nurses in the United States.

Baccalaureate programs for registered nurses allow nurses who have a nursing diploma or associate's degree to earn a bachelor's degree. The number of all baccalaureate students is the number of students in entry-level programs plus the number of registered nurses in baccalaureate programs. Data for baccalaureate programs are from the American Association of Colleges of Nursing. Data for associate's-degree and diploma programs are from the National League for Nursing; their data for 1997 through 2000 are preliminary.

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rate for these positions, the number of nurses at a hospital after adjustment for the number of inpatients and the case mix, and the supply of registered nurses per 100,000 population. Although there is no gold standard, a recent study found the strongest relations between reports by hospital officials or nurses of a moderate or severe nursing shortage and job-vacancy rates.[20] Differences in the supply of nurses per capita did not predict which regions would have a majority of hospitals reporting shortages.

The number of employed registered nurses per capita varies widely from state to state (Fig. 4). In 2000, the national average was 782 employed nurses per 100,000 population. California had only 544, whereas Massachusetts had 1194 and Pennsylvania had 1010.[9] These variations have been cited as evidence of regional shortages of nurses, particularly in states with a low supply of nurses, such as California,[21] Nevada,[22] and Texas.[23] The demand for hospital-based nurses, however, reflects many factors, including the number of hospital beds, the average length of stay, the specific medical services offered, population growth, and the number of elderly residents. Although Florida has 785 nurses per 100,000 population — about the national average — the supply has been considered inadequate because the state has the highest percentage of elderly persons in the nation.[24] Because a low supply of nurses may reflect a low demand — not an unmet demand — for hospital-based nurses, the importance of the variations in and of themselves is uncertain.

The Current Shortage

The current shortage of nurses began in 1998 in intensive care units and operating rooms.[25] It has since spread to labor-and-delivery units and general medical and surgical wards. The shortage is widespread throughout the country.

In 2001, the mean vacancy rate for registered-nurse positions at a given hospital was 13 percent. Fifteen percent of hospitals reported vacancy rates of 20 percent or more.[26] Mean vacancy rates were 11 percent in the Northeast and Midwest, 13 percent in the South, and 15 percent in the West. There were about 126,000 vacant positions nationwide.[27] Eighty-two percent of hospitals reported that it was more difficult to recruit registered nurses in 2001 than it had been in 1999; 1 percent said that it was less diffi-

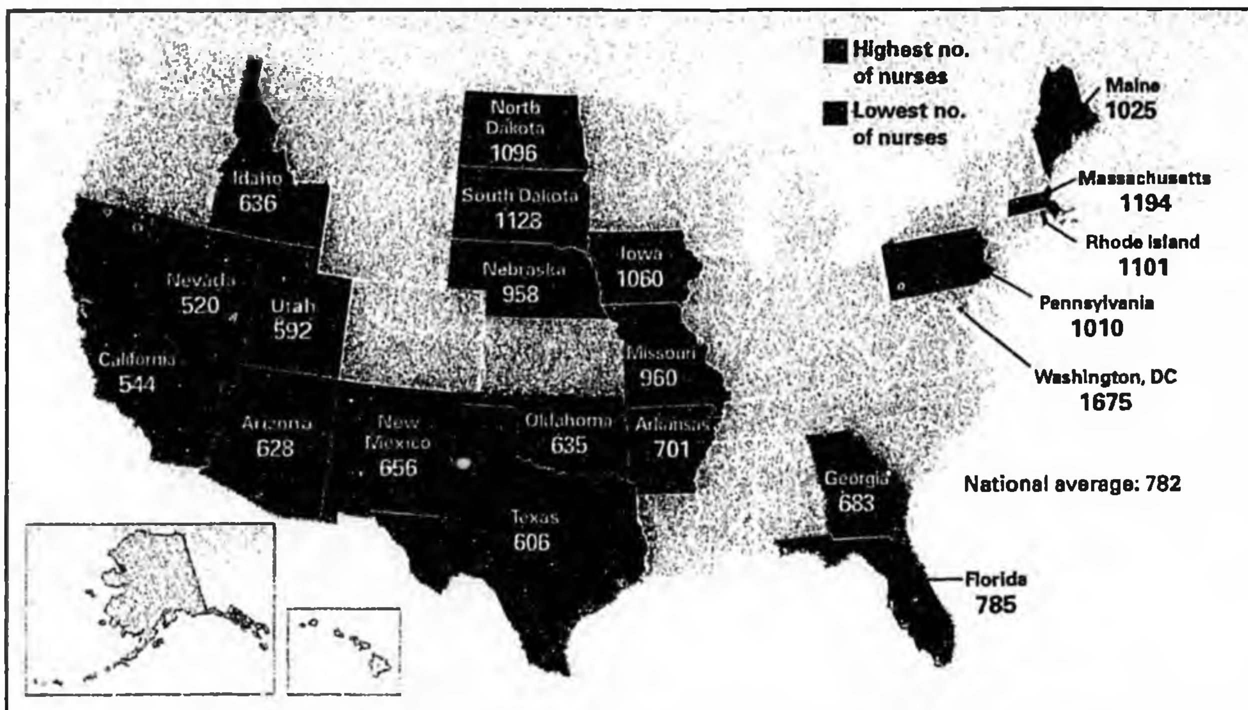

Figure 4. Employed Registered Nurses per 100,000 Population.

Both nurses who work full-time and those who work part-time are included. Data are from the National Sample Survey of Registered Nurses: March 2000.[9]

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cult.[26] According to a 2001 survey of chief executive officers of hospitals, 84 percent of hospitals had shortages of registered nurses; the next most frequently cited job categories with shortages were radiology and nuclear imaging (71 percent) and pharmacy (46 percent).[12] Of registered nurses working in nursing who were surveyed in 2001 and 2002, 95 percent thought there was a shortage of nurses, and 88 percent thought that the supply of registered nurses working in patient care in their community was lower than the demand.[14] National data about the current shortage of nurses are corroborated by reports from various states, including California,[6,21] Florida,[24] Maryland,[28] Nevada,[29] New York,[30] and Texas.[23]

The current shortage of nurses, albeit severe, may be similar to cyclical shortages that have occurred during the past 50 years. Better wages and better jobs, as well as better marketing of nursing schools and of nursing as a career, increased availability of training programs, and changes in the general economy, may encourage more students to enter nursing programs and bring more current nurses back into the job market. If these short-term factors are addressed, the current shortage should abate.

The Long-Term Shortage

Many predictions of long-term shortages or surpluses of physicians or other health care workers have turned out to be wrong. Nevertheless, there is the potential for a long-term shortage of nurses. This possibility reflects changing demographic and other factors, such as the decreased attractiveness of careers in health care to those entering employment and the dissatisfaction of people who currently work in hospitals.[11,31] According to the workforce commission of the American Hospital Association, shortages of nurses and other employees "reflect fundamental changes in population demographics, career expectations, work attitudes and worker dissatisfaction. The shortages will not disappear with the current or the next economic downturn."[12]

Both the registered-nurse workforce and the general population are rapidly aging. As members of the "baby boom" generation begin to retire, the demand for nurses is expected to increase rapidly.[32] Between 2000 and 2010, the occupation of registered nurse will be one of the five occupations with the greatest growth in the number of jobs, according to the Bureau of Labor Statistics. It is projected that during this period, there will be 1,000,400 job openings for registered nurses, including 561,000 new positions.[33]

Younger nurses are more likely than older nurses to work in hospitals. In 2000, only 9 percent of registered nurses were less than 30 years of age, as compared with 25 percent in 1980 (Fig. 5). About a third of registered nurses were 50 years of age or older.[9] A related issue is that nursing, particularly in a hospital, can be physically demanding and lead to occupational injuries, particularly for older nurses.[3] By 2020, a shortage of more than 400,000 registered nurses is possible.[32] One analysis concluded: "The evidence suggests a not-too-distant collision between the aging and shrinking RN workforce and the increasing demand driven (among other things) by the expanding population of Medicare beneficiaries."[34]

MINIMAL NURSE-STAFFING RATIOS

In 1999, the California legislature, prompted by concern about the effects of decreased levels of staffing by nurses on the quality of care, required the state Department of Health Services to establish minimal staffing ratios of nurses to patients according to the types of licensed-nurse classification and hospital unit.[35,36] In January 2002, Governor Gray Davis announced the proposed ratios (Table 1).[37] The actual regulations are likely to be finalized later this year, after public comments and hearings, and to take effect by July 2003.

The staffing ratios have been the subject of sharp disputes between the California Nurses Association, which worked for years to pass the legislation, and the California Healthcare Association, which represents hospitals in the state and has opposed the approach.[38] The nurses' association advocated a minimal ratio of 1 nurse to 3 patients on medical–surgical units; the hospital association advocated a minimal ratio of 1:10.

The proposed ratios include a minimum of one nurse to six patients on general medical–surgical units (Table 1). This minimum would change to one nurse to five patients 12 to 18 months after the regulations go into effect. Although most of the nurses are likely to be registered nurses, the extent to which licensed practical nurses could be su[illegible]tituted is not yet clear. For labor-and-delivery units, the minimal staffing ratio is one nurse to two patients. Intensive care units are already subject to a minimum of one nurse to two patients. The ratios are meant to be minimums; hospitals are expected to increase levels of staffing when patients require additional care.

Complying with the Ratios

California has 470 hospitals, according to the California Healthcare Association. Fifteen percent of hospitals with medical–surgical units would not be in compliance with the initial ratio if it took effect now, and 36 percent would not be in compliance with the final ratio, according to Joanne Spetz of the Center for California Health Workforce Studies at the University of California, San Francisco.[39] Fifteen percent of hospitals with labor-and-delivery units would not be in compliance with the proposed ratio.

Spetz predicted that the cost of implementing the

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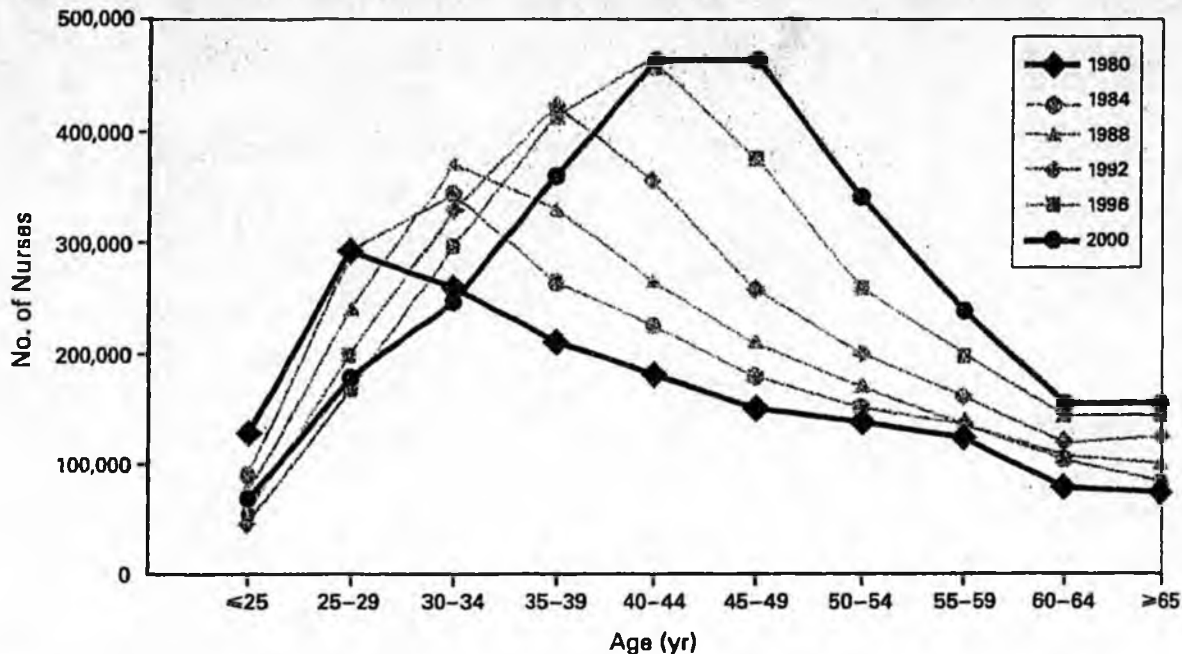

Figure 5. Age Distribution of Registered Nurses in the United States, 1980 through 2000.
Adapted from the National Sample Survey of Registered Nurses: March 2000.[9]

recommendations would be "rather small," because many hospitals would have to hire few, if any, additional nurses. She estimated the annual per-hospital increase in expenditures for nursing as $143,846 (1.0 percent) for the initial ratios and $217,210 (1.7 percent) for the final ratios.[39] The California Healthcare Association has not prepared per-hospital estimates. It has estimated that if 5000 additional registered nurses are required statewide, the annual cost might be $400 million. It is possible, however, that the costs of hiring additional nurses may be offset if patients have fewer complications and adverse events and therefore leave the hospital sooner.

Reaction to the Ratios

According to Rose Ann DeMoro, the executive director of the California Nurses Association, minimal nurse-staffing ratios "are a dramatic step forward for hospitals in California" and will help to "create conditions in hospitals for nurses to return." Jan Emerson, vice president of external affairs at the California Healthcare Association, said that although "the hospital industry agrees with the notion that more nurses is probably a good thing," the minimal staffing ratios could have "serious unintended consequences." These include an inability to find qualified registered nurses, which may force hospitals to eliminate beds and reduce access to care. The proposed ratios also raise practical issues, such as whether the level of staffing is required around the clock.

The new American Association of Registered Nurses is encouraging other states to enact similar legislation. Mary Foley, the president of the American Nurses Association, said that her organization was "not opposed to the California bill but did not support it enthusiastically." She said that, although "10 to 12 patients per nurse is horrible," safe medical and nursing care is "not just a matter of numbers." Aiken, of the University of Pennsylvania School of Nursing, predicted that unless a "floor" for staffing is established, "we are not going to be able to stop the flight of nurses from hospitals. . . . If it is feasible to implement the ratios, a lot of other states may follow."

MANDATORY OVERTIME

Some people like to work overtime, because they can make more money or take other time off. Others prefer to work on a regular schedule. Although it might seem inefficient and expensive for an employer to hire too few employees and then pay higher wages for overtime, this approach reduces the number of permanent employees and is one way to cope with vacancies.

Overtime has unique aspects in health care. Physi-

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TABLE 1. PROPOSED MINIMAL NURSE-STAFFING RATIOS FOR HOSPITAL UNITS IN CALIFORNIA.*

HOSPITAL UNIT	PROPOSED RATIO OF NURSES TO PATIENTS
Intensive or critical care†	1:2
Neonatal intensive care†	1:2
Intermediate care nursery†	1:4
Labor and delivery	1:2
Postanesthesia care	1:2
Emergency department	
General	1:4‡
Critical care	1:2
Trauma	1:1
Pediatrics	1:4
Step-down with telemetry	1:4
Specialty care (oncology)	1:5
General medical-surgical	1:6§
Behavioral health or psychiatric	1:6

*Data are staffing ratios proposed by the California Department of Health Services in January 2002[37] under Assembly Bill 394, which was signed into law in 1999.[35] The actual regulations — which have yet to be finalized — are to take effect in 2003. Although most of the nurses are expected to be registered nurses, the proposed ratios do not specify when licensed practical nurses can be used. Not all types of hospital units are listed.

†Minimal nurse-to-patient ratios are already in place for these units by California statute, regulations, or both.

‡Triage, radiology, or other specialty nurses are considered to represent an additional workforce; they are not included in this ratio.

§This ratio is an initial ratio; a ratio of 1:5 is to be phased in 12 to 18 months after the effective date of the regulations.

cians and nurses have professional obligations to care for their patients and not abandon them. Although overtime is essential in emergencies, there is concern that hospitals, like other businesses, are using it instead to compensate for inadequate levels of staffing. Exhausted nurses, like exhausted physicians, can pose safety risks. "By far the riskiest result of ur 'rstaffing is the abuse of mandatory overtime as a stanung tool," Foley of the American Nurses Association stated in congressional testimony in March of this year.[40] Many nurses, she said, are being required to work some mandatory or unplanned overtime every month or face dismissal for insubordination or being reported to the state board of nursing for abandonment of patients.

In the recent national survey of working nurses,[14] 61 percent of respondents said they had observed increases in overtime or double shifts during the past year. Forty-eight percent said that "the amount of overtime required" had increased, 6 percent said it had decreased, and 45 percent said it had remained the same. Forty-five percent said working overtime was "strictly voluntary," 32 percent said it was "voluntary but feels like it is required," and 20 percent said it was "required" (Buerhaus P, Vanderbilt University School of Nursing: personal communication). A national survey of oncology nurses, conducted in 2000, had similar findings (Buerhaus P: personal communication).[41]

As of early May 2002, six states had enacted laws that ban or limit mandatory overtime, except in emergencies — Maine,[42] Maryland,[43] Minnesota,[44] Oregon,[45] New Jersey,[46] and Washington.[47] The Washington law prohibits hospitals from requiring nurses who care for patients from working more than 12 hours in a 24-hour period or more than 80 hours in a period of 14 consecutive days. Many of the other laws have similar provisions. More states are likely to enact such laws, which are backed by the American Nurses Association and other nursing organizations.

POTENTIAL SOLUTIONS

A major goal of minimal nurse-staffing ratios or the prohibition of mandatory overtime is to improve the quality of care. These measures may exacerbate shortages in the short term because hospitals will most likely have to hire more registered nurses. However, if they help to make hospitals more attractive places to work, they may make it easier to recruit nurses. Their actual effects will not be clear for at least several years.

The potential solutions to the shortage of nurses and related problems include expanding enrollment in nursing schools and bringing more men and members of minority groups into the profession.[21,34] They also include developing incentives to encourage nurses who work part-time to work more hours, offering better salaries, providing more regular work hours, and restructuring hospitals to make the work environment more attractive. In its recent report, the workforce commissio f the American Hospital Association emphasized the need to make hospital work more meaningful and rewarding.[12] Still other approaches, such as recruiting more nurses from overseas[48] or encouraging affluent patients to hire their own nurses,[49] are less likely to have broad effects. Some combination of these approaches is likely to be most effective.

Financial incentives may be particularly important. Many hospitals are paying nurses signing bonuses of $1,000 to $5,000 or more and are temporarily filling vacant positions with registry or traveling nurses.[14,26] In Boston, Tufts–New England Medical Center has agreed to raise nurses' pay 18 to 23 percent over a period of 23 months.[5] Nurses at the Oregon Health and Science University will receive at least a 20 percent raise over a three-year period.[50]

The American Nurses Credentialing Center, a subsidiary of the American Nurses Association, has developed the "magnet nursing services recognition pro-

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gram" for hospitals that meet quality standards and provide nurses with more responsibilities, autonomy, and opportunities to participate in policy decisions. Studies suggest that nurses in such hospitals have greater job satisfaction, and the hospitals are less likely to have difficulty hiring and retaining nurses.[51] As part of the new contract for nurses, the Oregon Health and Science University agreed to seek "magnet" status.

Enrollment in associate's-degree programs for nurses decreased through 2000, according to preliminary data (Fig. 3). One encouraging sign, however, is that enrollment in baccalaureate programs, which appeal to younger students,[52] has increased[53] (Fig. 3). The increase — in 2001 — ended a six-year period of declining enrollment. The Nurse Reinvestment Act would authorize federal funding for scholarships and loan repayments for nurses who agree to work after graduation in areas where there are shortages, as well as for public-service announcements that would promote nursing as a career.[54] The Bush administration has announced the availability of grants and has proposed extending loan-repayment programs.[55] In California, Governor Davis has proposed a $60 million initiative for the nurse workforce that expands training programs for nurses.[56]

THE FUTURE

Nurses who work in hospitals are apprehensive about the future. Hospitals employ many more registered nurses than physicians and cannot function without them. At a time of serious financial constraints, however, they must often choose between hiring more nurses and launching or maintaining other programs that may improve patient care, such as computerized order-entry systems.[57] Some of the issues raised by nurses about hospital staffing reflect their interest in their own financial and job security. Yet there is ample evidence of a broader unease.

Many tensions will be difficult, if not impossible, to resolve, particularly if additional funds do not become available. For example, within the nursing profession, higher-quality care may mean a better-educated workforce, with a higher percentage of nurses with bachelor's or advanced degrees. Such a workforce, however, would expect more responsibility and greater independence and would be more expensive to hire and retain.

In the long term, the future of the nursing profession is related to its ability to attract more young nurses, to support the careers of current nurses, and to create more jobs for nurses with higher wages and greater responsibilities. Such efforts can be successful only if the positions students are training to fill are sufficiently attractive, as compared with the alternatives in other fields. "Nursing is a worthy career," said Foley, the president of the American Nurses Association. "It should not be considered secondary or inferior. We want nursing back on the list of career choices for bright young men and women who are looking at health care."

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UAN gives a voice to the issues that are important to staff nurses. Here's what UAN staff nurses are saying to the media, Congress and the public:

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FOR IMMEDIATE RELEASE: March 2nd 2006

UAN VP Converso's remarks to the Sixth International Conference on Stress and Health

THE OCCUPATIONAL SAFETY AND HEALTH IMPACTS OF INADEQUATE STAFFING AND MANDATORY OVERTIME ON REGISTERED NURSE

Ann Converso, RN, Vice President
United American Nurses, AFL-CIO

The Sixth International Conference on Occupational Stress and Health
March 2, 2006

Long hours of work, mandatory overtime, and inadequate staffing cause extreme stress to nurses, impacting their physical and mental health. They also ultimately affect the quality of patient care. Like many other industrialized nations, the United States is experiencing a severe shortage of nurses that will intensify as the baby boom

generation ages, with shortages currently in at least 30 states according to the Health Resources and Services Administration. The Bureau of Labor Statistics estimates that the United States will need an additional 1.1 million registered nurses by 2014.

At the same time, health care costs continue to rise. Managed care compels hospitals to discharge patients more rapidly, resulting in higher patient acuity levels. Hospitals attempt to control labor costs by reducing the number of registered nurses they employ. But cutting the number of nurses at the bedside is counterproductive as overworked nurses get injured or burned out and leave the professionóexacerbating the shortage of nurses.

A 2003 study by Aiken with Clarke, Sloane, Sochalski, and Silber found that higher emotional exhaustion and greater job dissatisfaction were strongly associated with higher nurse-to-patient ratios. Each additional patient per nurse correlated to a 23 percent increased risk of burnout, as well as a 15 percent increase in the risk of job dissatisfaction. Among the nurses surveyed in this study, 43 percent reporting job burnout and dissatisfaction stated that they intended to leave their current position within the year. When the United American Nurses surveyed hospital nurses in 2002 about staffing and job satisfaction issues, a third said they were likely to leave the profession within five years due to frustration about inadequate staffing and mandatory overtime.

How bad is the situation? Unfortunately, we do not have systematic national data on nurse-to-patient ratios and the hours worked by nurses. We are looking forward to a NIOSH study on the combined influence of shift work and overtime on nursesí health and safety.

In the interim, some studies on patient safety have shed light on nurse-to-patient ratios and hours of work. Patient safety has gotten a lot of attention since the Institute of Medicine announced in 1999 that approximately 98,000 people in the United States die annually due to hospital errors. In 2003, the IOM surveyed the literature on factors in the nursing profession and the impact on patient safety. They concluded that there is ample evidence that leaner nurse staffing and long work shifts are associated with errors and adverse reactions, such as post-operative infections, pneumonia, urinary tract infections, and increased length of hospital stay.

The IOM found that while the average registered nurse-to-patient ratio in medical-surgical units is one-to-six, 23

percent of hospitals reported that day shift registered nurses in medical-surgical units were responsible for seven to twelve patients. Night shift nurse-to-patient ratios are likely to be even poorer. In contrast to those staffing ratios, Aikenís study found that for each additional patient over four in a nurseís workload, the risk of death increased by seven percent for surgical patients.

The Institute of Medicine also found that work shifts longer than twelve hours per day endanger patient safety due to fatigue, causing reduced attention span and capacity to catch errors. However, the same study found that 27 percent of full-time hospital and nursing home nurses reported working more than 13 consecutive hours one or more times per week. The IOM recommends that states prohibit nurses from working more than 12 hours in a 24-hour period or more than 60 hours per week.

However, available data suggest that hospital staff nurses are working longer hours, with fewer breaks, with little time for recovery between shifts. A 2004 study by Rogers with Hwang, Scott, Aiken, and Dinges on the impact of long working hours on patient safety reveals excessively long work shifts among hospital nurses. In this study, 393 Registered nurses were asked to log their actual work times over a four-week period, providing 5,317 work shifts over 28 consecutive days to analyze.

- On average, the nurses in the study worked 55 minutes beyond their scheduled shift, of 8.5 or 12.5 hours. (An extra 30 minutes for the handover period at the end of shifts is already built into the schedule.)

- Nurses reported leaving work at the end of the scheduled shift less than 20 percent of the time during the study.

- Although 31 percent of the shifts were scheduled for 12.5 or more hours, the percentage of shifts that the nurses actually worked 12.5 or more hours was 39 percent.

- Fourteen percent of the respondents reported working 16 or more consecutive hours at least once during the four-week period. The longest shift recorded was 23 hours, 40 minutes.

- Almost two-thirds of the nurses worked overtime ten or more times during the period, and a third reported working overtime each day during the 28-day period.

- Not surprisingly, the risk of making an error increased with longer work hours and was three times higher when nurses worked 12.5 or more hours. Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.

In addition to the pressure that registered nurses face to work overtime, many are required to be on call, especially those in specialized units. There is also anecdotal evidence that 24-hour shifts are becoming more common, particularly in emergency departments and on units where nurses self-schedule.

Beyond long work shifts and mandatory overtime, nurses face other scheduling issues that cause fatigue and stress as a result of being shift workers in a 24-hour-a-day industry. Nurses working night shifts struggle against their circadian rhythm, our biological tendency to sleep at night and be active during the day. The circadian rhythm makes it difficult to get enough restorative rest during the day and often requires night shift workers to miss out on activities with family and friends. Bureau of Labor Statistics injury data indicate that the risk of injury for all workers is substantially higher during the night shift than during the day or evening shifts. Risk of injury is nearly three times greater very early in the morning than at mid-afternoon, the low and high points of the circadian cycle.

Nurses have an even harder time if they work rotating schedules which prevent them from getting adequate rest between shifts. They are not just tired from not having enough sleep between shiftsótheir bodies have not had enough time to recuperate from the previous shift.

So what happens to these nurses who work such long hours and difficult schedules? We know that long hours of work, night shifts, or rotating shifts increase nursesí risk of musculoskeletal injuries by reducing the recovery time between shifts that nurses need to allow their backs to rest and heal. Nurses develop musculoskeletal injuries through the cumulative effect of repetitive actions, lifting

and transferring patients, moving heavy, awkward equipment, and stretching to work in poorly designed spaces. The Bureau of Labor Statistics, which ranks occupations sustaining the most musculoskeletal injuries, ranked registered nursing eighth among all jobs in 2003. Fifty-two percent of registered nurses have chronic back pain and 38 percent have pain severe enough to require leave from work. Research by Lipscomb, Trinkoff, Geiger-Brown, and Brady in 2002 found that:

- Registered nurses working twelve or more hours per shift were at increased risk for musculoskeletal disorders compared to those working eight-hour shifts.

- Registered nurses working twelve or more hours per day and 40 or more hours per week doubled their odds of getting a back, neck, or shoulder injury.

- Registered nurses working nights or weekends also significantly increased their risk of musculoskeletal injuries, due in part to lower staffing levels on those shifts.

- Registered nurses working rotating shifts had twice the number of reported accidents as those working day or night shifts only.

- Another study by Gold found that nurses working rotating shifts had twice the number of reported accidents or errors related to sleepiness than nurses who worked only a day or an evening shift.

Of course, nurses face a number of occupational hazards beside musculoskeletal disorders. In one study by Macias, the number of needlestick injuries and incidents of biological fluid exposure increased in the last two hours of twelve-hour shifts, but no increase in these incidents was found in the last two hours of eight-hour shifts.

Other research indicates that as health care workersí work hours increase, car crashes and occupational accidents increase. Ninety-six percent of Intensive Care Unit nurses reported car crashes or near misses while driving home

after a night shift in a study by Novak and Auvil-Novak in 1996.

We know less about the cardiovascular impacts or psychological stress caused by inadequate staffing and long working hours among nurses, although there has been research indicating that shifts longer than eight hours increase the incidence of smoking. Overtime has been associated with unhealthy weight gain among nurses. Overtime, shifts over eight hours, and night shifts and rotating shifts longer than eight hours have been associated with higher alcohol consumption among nurses.

However, we do knowóbecause nurses have been voting with their feet, whether through strikes or by leaving hospital employment or the professionóthat the environment they work in is stressful. In a 1999 study bv the Minnesota Nurses Association, an affiliate of United American Nurses, registered nurses expressed escalating frustration and concern about their ability to provide safe care to patients under short staffing situations. They reported a decrease in organizational support and peer support.

What is the solution? Hospitals are not going to solve this problem on their ownóotherwise, it would already be fixed. Nurses who are on the frontlines must be part of the solution and have a voice in decision-making. UAN nurses have negotiated a variety of remedies through contract language, such as:

- a prohibition on mandatory overtime,
- specific nurse-to-patient ratios,
- the authority to close a department to new admissions when staffing ratios are too high to be safe for patients,
- and the power to determine staffing levels based on patient acuity rather than just the number of patients.

However, contract language is not enoughówe need a legislative solution for all nurses, not just those who have

union representation, and the state legislatures are beginning to address the issues.

Ten states have passed laws prohibiting the use of mandatory overtime for registered nurses and 14 other states have introduced legislation or are considering legislation on mandatory overtime. Illinoisí law ensures that a nurse will work no longer than four hours beyond the scheduled shift and requires an eight-hour rest period between shifts. Oregonís law prohibits hospitals from mandating nurses to work beyond 48 hours in a week or more than 12 consecutive hours in a 24-hour period.

Legislation requiring hospitals to develop and implement nurse staffing plans and include input from nurses has been passed in five states. Going beyond staffing plans, California enacted a nurse-to-patient ratio law in 1999, requiring one nurse for every six patients in medical-surgical units when it which went into effect in 2001. The law also provided that the ratio would be strengthened to one nurse for every five medical-surgical patients in 2005.

The United American Nurses supports two federal bills which would prohibit mandatory overtime and create minimum staffing ratios. The Safe Nursing and Patient Care Act of 2005, introduced by Senator Edward Kennedy, Democrat of Massachusetts and Representative Pete Stark, Democrat of California, would set strict limits on mandatory overtime for nurses. Nurses could not be forced to work beyond their scheduled shift, except in the event of a state of emergency declared by a local, state, or federal government. The bill also provides nurses with whistleblower protections.

UAN also supports the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2005, sponsored by Representative Janice Schakowsky, which would establish federal minimum staffing nurse-to-patient ratios in all hospitals that receive federal funding, except during a declared emergency. This bill gives registered nurses and other health care workers a real voice in providing quality, safe health care. The bill also provides real penalties to hospitals that fail to comply and nurse whistleblower protections.

There are some people who say that staffing ratios wonít work6that hospitals canít hire nurses who donít exist6and that employing more registered nurses will increase health care costs even faster. But preliminary evidence from California and the state of Victoria in Australia, where ratios have been implemented, show that nurses who left

the profession will return, students will apply for nursing school, and nurses who are stressed will stay.

And a 2006 study by Needleman with Buerhaus, Stewart, Zelevinsky, and Mattke indicates that there is a business case for staffing ratios. They found that increasing the use of RNs to care for patients reduced costs by reducing patient complications and deaths and reducing patientsí time spent in the hospital.

Nursing, unlike other professions that impact public safety such as pilots and air traffic controllers, has been operating for generations without rules preventing them from working under unsafe conditionsóworking understaffed and fatigued. That needs to changeóconditions have only been getting worse due to the huge changes in health care and will worsen even more with the shortage of nurses. Nurses have been pushed too faróand we will no longer tolerate working understaffed and exhaustedóit is unsafe for our patients and it is unsafe for us.

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United American Nurses, AFL-CIO
8515 Georgia Ave. Suite 400 | Silver Spring, MD 20910 Tel: 301.628.5118 | Fax: 301.628.5347

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Tim Lamkin

From: Dana Owen
Sent: Wednesday, May 02, 2007 12:11 PM
To: Jane Alberts; Patricia Walker; Thomas Obermeyer; Tim Lamkin
Subject: FW: SB 28 Limiting Mandatory Overtime for RN's

'.ooks like this went to all L&C Committee members, but not staff. Here's your copy.

Dana

From: bkgettys [mailto:bkgettys@gci.net]
Sent: Tuesday, May 01, 2007 11:24 PM
To: Sen. Johnny Ellis; Sen. Gary Stevens; Sen. Bettye Davis, Sen. Lyman Hoffman; Sen. Con Bunde
Cc: dao@aknurse.org; mshickey@gci.net; Sen. Fred Dyson
Subject: SB 28 Limiting Mandatory Overtime for RN's

Dear Senator Ellis and Honorable Senators of the Senate Labor and Commerce Committee;

My name is Kathleen A. Gettys and I am a registered nurse on the Progressive Care Unit at Providence Alaska Medical Center. I hold the office of President for the Providence Registered Nurses Bargaining Unit. I was disappointed not to be given the opportunity for my voice to be heard at the Senate Labor and Commerce Committee hearing on April 26th, 2007 regarding SB 28 and the use of mandatory overtime for registered nurses in Alaska. I was unable to be there in person secondary to responsibilities associated with the bargaining unit's commitment to patient safety.

Today, overtime whether voluntary or mandatory is the most common method facilities use to cover staffing insufficiencies. The Institute of Medicine (IOM) has estimated as many as 98,000 hospitalized Americans die each year as a result of errors in their care. The IOM illustrated that mandatory overtime is a serious contributing factor to medical errors. The IOM's *Save a 100,000 Lives Campaign* stated, "All overtime by nurses should be eliminated." A Study by Health Affairs in July of 2004 revealed that the likelihood of making an error was three times higher when RN's worked shifts lasting 12.5 hours or more.

RN's at PAMC recognize the potential hazards of long working hours. We are currently in the beginning of the arbitration phase in order to settle a dispute pertaining to RN's who are not receiving their contractual breaks and lunches. Every time RN's who work twelve-hour shifts do not receive their allotted meal periods they enter in to a 12.5-hour work day. Again, 12.5 hours is correlated with the increased likelihood of making an error. The question has been posed, "Who will care for the patients if overtime cannot be mandated?" Time and time again RN's are forced to choose between themselves and the safety of their patients. The reality is we **do not abandon** our patients or our co-workers. RN's will not leave their posts if we feel our patients will not be protected.

Unlike many other industries where public safety is a concern, healthcare is exempt from federal regulations that limit the use of overtime. If we do not want a pilot flying a plane for more than twelve hours, why would you want a nurse to care for you when long working hours have clearly illustrated the likelihood of a medical error? RN's are compared to pilots monitoring their instruments. "Nurses constitute an around the clock surveillance system and are responsible for detection and prompt intervention when a patients condition deteriorates" (Aiken, Journal of American Medical Association, 2002).

I have heard the question...How many times does mandatory overtime occur versus did the RN voluntarily agree to overtime? Unfortunately, there are no studies involving RN's that account for the use of voluntary overtime. It only takes one time of an extended work shift to increase the likelihood of making an error.

I have heard that some institutions believe SB 28 is the union just "posturing for power." I am proud to be a union nurse, however, it is **NOT a union issue**, but rather a **PATIENT SAFETY** issue. I am a nurse first. If I stepped out of the union leadership role, I would still carry the torch to eliminate mandatory overtime for RN's. Strictly

limiting mandatory overtime for nurses is a critical step in improving the quality of healthcare for Alaskans and reducing the number of medical errors.

As members of the Senate Labor and Commerce Committee, would your constituents support a practice such as mandatory overtime or long working hours that jeopardizes their opportunity to receive safe and quality healthcare?

I would think that any institution that delivers care to Alaskans should recognize the relationship between extended duty hours and patient safety. I urge Alaska State legislators to support SB 28 and place public safety first concerning the use of mandatory overtime for RN's.

Respectfully,

Kathleen A. Gettys, RN, BSN, BA
President, Providence Registered Nurses Bargaining Unit

RECEIVED
MAR 19 2007

Dear Senator Davis

I am a member of ASEA/AFSCME Local 52 (Alaska State Employees Association), and I work in a 24-hour facility, where mandatory overtime is assigned to staff on a regular and reoccurring basis. The impact of these mandatory assignments is wearing each and every one of us out and is impacting the quality of care we provide our patients.

I am asking you to support the passage of Senate Bill 28 limiting mandatory overtime. Continuation of mandatory overtime assignments has long-range implications and negative results. This is not just about workers rights, forcing employees to work overtime, but the inability of employees to provide quality care. Mandatory overtime puts the safety and well-being of patients and employees at risk.

Forcing employees to work long shifts results in inattentive and exhausted staff, medication errors security lapses, and consequently harm to residents. With respect to the employees themselves, the impact of forced overtime leads to injuries on the job, medical and mental health problems, low morale and ultimately the decision to seek employment elsewhere. The turnover in staff at State run facilities where mandatory overtime assignments have become routine is nothing short of shocking.

Again, please support passage of SB No. 28. Also, please support expanding the bill to cover all employees that provide direct patient care including, but not limited to, Certified Nurse Assistants and Psychiatric Nurses Assistants. For your information, a limit on mandatory overtime has been placed on commercial truck drivers, airline pilots, and bus drivers. If we limit mandatory overtime for these employees then how can we not understand and expect these same limits be applied to employees that care for the aged and infirm in our society. I strongly urge you to support this bill, if for no other reason that some day you may need these same employees to take care of you or one of the people you love.

Thank you for your consideration on this issue.

Sincerely:

W. Sollenberger

I understand that you are a sponsor of this bill - Thank you - it is needed by our nursing staff (long overdue!)

Address: 1811 Talkeetna St.
City & Zip: Anchorage AK
Phone number: 269-7163 (wk)
Department: H-SS
Work location: API · Psychology Dept.

ANA
AMERICAN NURSES ASSOCIATION

Mandatory Overtime

Position

ANA opposes the use of mandatory overtime as a staffing tool.

Background

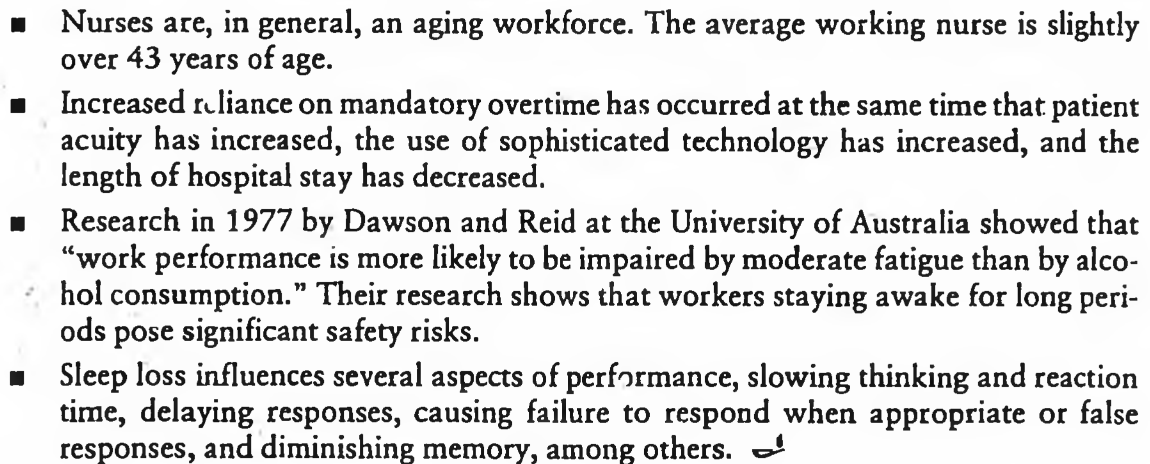
Nurses report a dramatic increase in the use of mandatory overtime as a staffing tool and fear potential consequences for the safety and quality of care provided to their patients. Today, overtime (mandatory and voluntary) is the most common method facilities use to cover staffing insufficiencies. In fact, some employers have described mandatory overtime as a staffing model and have actually coined the term "mandation" to define the methodology. Many nurses contend employers insist they work an extra shift (or more) or face dismissal for insubordination and being reported to the state board of nursing for patient abandonment.

Federal regulations place limits on the amount of time that can be worked in other industries in which the work directly affects public safety (e.g., aviation and transportation). Those regulations also set requirements for defined periods of time that workers must rest or be off duty before returning to work. Health care is exempt from such overtime regulations.

A few United American Nurse bargaining units have been successful in negotiating limits on mandatory overtime. In fact, concerns about the effects of mandatory overtime were central concerns in recent strikes in Washington, D.C., Minnesota, and New York.

Rationale

The American Nurses Association (ANA) is concerned about the impact of mandatory overtime on the ability of our nation's acute care nurses to provide high-quality health care services. ANA believes that the elimination of mandatory overtime for the nation's nurses is a critical step in efforts to improve the quality of health care and reduce medical errors. Following are a few facts about the dangers of forced overtime:



- Nurses are, in general, an aging workforce. The average working nurse is slightly over 43 years of age.
- Increased reliance on mandatory overtime has occurred at the same time that patient acuity has increased, the use of sophisticated technology has increased, and the length of hospital stay has decreased.
- Research in 1977 by Dawson and Reid at the University of Australia showed that "work performance is more likely to be impaired by moderate fatigue than by alcohol consumption." Their research shows that workers staying awake for long periods pose significant safety risks.
- Sleep loss influences several aspects of performance, slowing thinking and reaction time, delaying responses, causing failure to respond when appropriate or false responses, and diminishing memory, among others.

2207 E. Tudor, Suite 34
Anchorage, AK 99507
(907) 274-0827
FAX (907) 272-0292
www.aknurse.org

What will legislation regulating mandatory overtime really do?

The mandatory overtime legislation being suggested does not prohibit nurses from working overtime. It will discourage an employer from assigning mandatory overtime and will prohibit an employer from threatening or retaliating against a nurse who refuses overtime. It will support the nurse who believes patient care would be compromised if that nurse is forced to work overtime. We must be able to count on the professional nurses who are providing care to make the judgment call about whether or not they are safe to practice.

Basic Facts on Mandatory Overtime

In the United States there has been an overall increase in overtime hours for all American workers over the last two decades. Almost one third of the workforce regularly works more than 40-hours a week and one fifth work more than 50 hours. It has been no different in health care where working overtime is becoming an every day occurrence. "Time after Time: Mandatory Overtime in the US Economy" Briefing Paper. January 2002. 1

"Mandatory overtime hours" are those hours above an agreed upon, predetermined, regularly scheduled shift, that the employer makes compulsory (as opposed to voluntary) with the threat of job loss or reprisals such as discharge, discipline, demotion or assignment to unattractive tasks or work shifts or in some cases licensure removal, retaliatory reporting, and charges of "abandonment". RN schedules are often 12, 10 or 8 hour shifts and some nurses do not get overtime for staying additional time unless they have reached 40 hours in one week. For example, a RN could work their regular 8 hour shift, but then be mandated to work an additional 8 hours for a total of 16, but not qualify for overtime pay.

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1 - 18 page report available at http://www.epinet.org/briefingpapers/120/bp120.pdf

A recent study, published in July 2004, shows a strong link between medical errors and the long work hours of nurses and it has called on congress to take action on the Safe Nursing and Patient Care Act (H.R. 745, S. 373), which would strictly limit the use of mandatory overtime for nurses. 5

Ann E Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges did an important study called, "The Working ours Of Hospital Staff Nurses And Patient Safety", which was published in the July/August issue of Health Affairs6

This study found that the risk of making an error was three times higher when nurses had to work shifts that were longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours in a week. Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled. Fatigue related to working overtime was identified as the cause of approximately 12% of the absences reported by a random sample of Canadian staff nurses.

This reported outcome reinforced the findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses" (7), which also said that nurses' long working hours pose a serious threat to patient safety.

...And Because We Are Losing Nurses

Mandatory overtime is one of the main reasons nurses leave nursing. Recent studies indicate that one in five nurses are considering leaving nursing. When polled on their reasons for leaving, mandatory overtime is always listed in the top ten reasons. In the face of a severe nursing shortage, we need to keep nurses at the bedside.

Surveys have shown that the exodus of registered nurses, therapists, technologists, technicians and service and maintenance workers is directly attributable to difficult working conditions, including inadequate staffing, mandatory overtime and insufficient compensation. This is not expected to improve over the next decade because as well as leaving the bedside, much fewer numbers of people are looking to nursing as a career.

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5 Safe Nursing and Patient Care Act of 2003 (Introduced in Senate) [S.373.IS]
Safe Nursing and Patient Care Act of 2003 (Introduced in House)[H.R.745.IH]
http://thomas.loc.gov/cgi-bin/thomas

6 . Available for purchase at http://www.healthaffairs.org/ .

7 http://www.iom.edu/project.asp?id=4671

Retaliation by Employers

Nurses do suffer retaliation from employers for refusing to accept overtime hours. There are reports from all over the country. According to a report, The Minnesota Nurses Association has documented complaints from nurses who were threatened by their employer. These nurses were told that if they would not work additional shifts, they would be reported to the State Board of Nursing for "patient abandonment". While the Board does not view the refusal to accept additional shifts because of fatigue as "patient abandonment", the fear of such a complaint often compels nurses to work against their better judgment. Another form of retaliation is more direct and involves simply firing or suspending the nurse who refuses overtime. In this situation, the nurse is forced to choose between their ethical obligation to the patient to provide quality care and their livelihood. This is a choice that nurses should not have to make.

What is this term ABANDONMENT?

According to the New Jersey Board of Nursing, the term "patient abandonment" should be differentiated from the term "employment abandonment," which becomes a matter of the employer-employee relationship and not that of the Board of Nursing. It should be noted that from a regulatory perspective, in order for patient abandonment to occur, the nurse must have first accepted the patient assignment and established a nurse-patient relationship, then severed that nurse-patient relationship without giving reasonable notice to the appropriate person (supervisor, employer) so that arrangements can be made for continuation of nursing care by others. Providing appropriate nursing personnel to care for patients is the responsibility of the employer. Failure of a nurse to work beyond his/her scheduled shift, refusal to accept an assignment, refusal to float to another unit, refusal to report to work, and resigning without notice are examples of employment issues and not considered by the New Jersey Board to constitute patient abandonment.

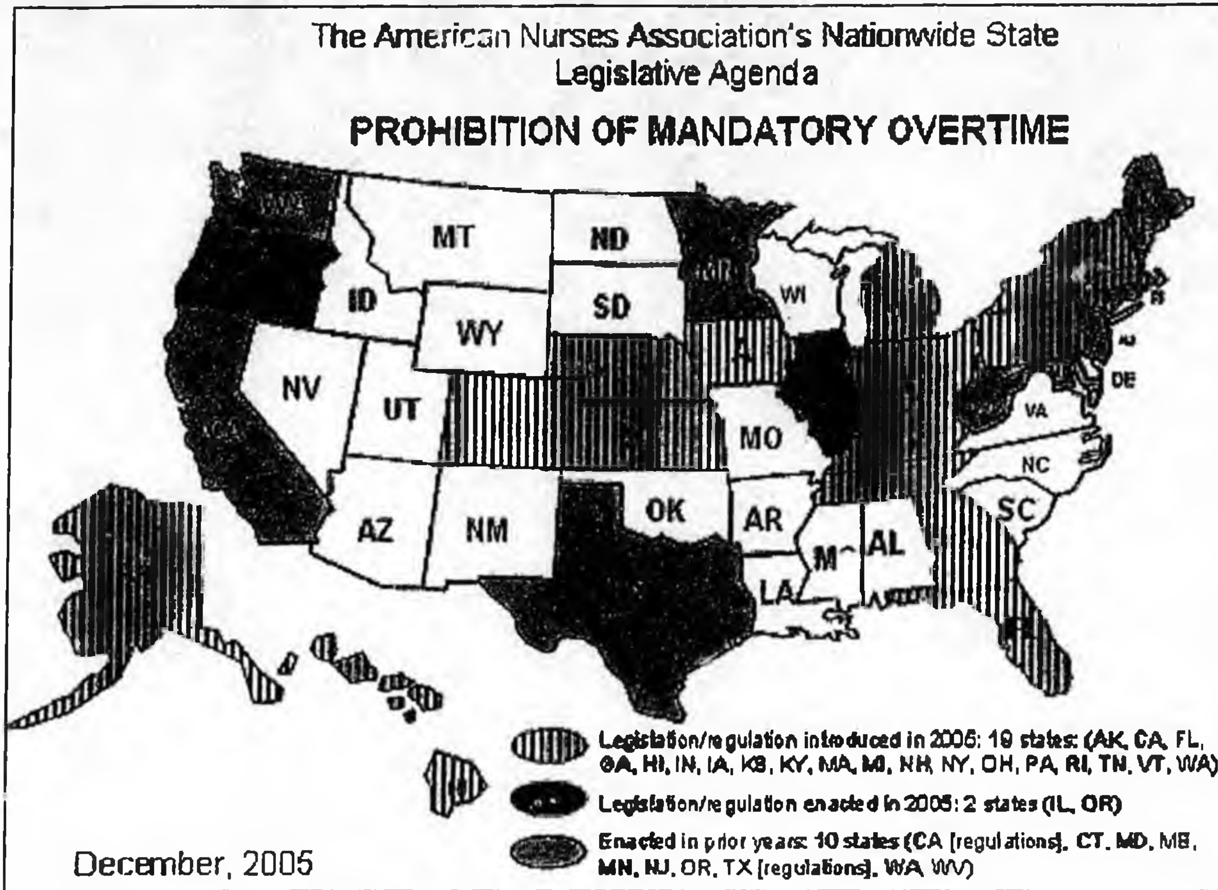
What are other states doing?

In 2003, three states, LA, NV and WV enacted legislation requiring the establishment of study committees to further explore the issue. 22 other states introduced prohibition of mandatory overtime legislation/regulation designed to set maximum hours of work per day/week with protected right of refusal for work time requested in excess of predetermined maximums.

Approximately 28+ states have completed or initiated steps toward legislation to restrict mandatory overtime for RNs, LPNs and, in some cases, all health care workers. In 2004, WV enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. CT enacted legislation that prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances (emergency etc). Legislation was also introduced in FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT, and WA.

ANA State Government Relations

2005 Legislation: Mandatory Overtime (updated 12/05)



Background:Mandatory Overtime

Mandatory overtime is a difficult problem for RNs and health care facilities. Because of inadequate RN staffing, employers have used mandatory overtime to staff facilities often as a cost savings factor. Nurses are concerned about the health effects of long term overtime and the quality of care being provided. Research indicates that risks of making an error were significantly increased when work shifts were longer than 12 hours, when nurses worked overtime, or when they worked more than 40 hours per week[1].

As part of the American Nurses Association's (ANA) Nationwide State Legislative Agenda on the nurse staffing crisis, State Nurses Associations support the enactment of mandatory overtime legislation in state legislatures and regulatory agencies. ANA is also pursuing the enactment of federal legislation to prohibit mandatory overtime. The Safe Nursing and Patient Care Act of 2005 (HR

not to exceed 40 hours per week. **TX** regulations require hospitals to develop policy and procedures for mandatory overtime. **WA**'s new language states that acceptance of mandatory overtime by a nurse is strictly voluntary and refusal is not grounds for adverse actions against the nurse.

Legislation enacted in 2001 in **ME** would prevent a nurse from being disciplined for refusing to work more than 12 consecutive hours except in certain circumstances and must be given 10 consecutive hours off following overtime. **OR** enacted legislation prevents a nurse from being required to work more than 2 hours beyond a regularly scheduled shift or 16 hours in a 24 hour time period. Regulations adopted in **CA** prior to 2001 prevent an employee scheduled to work a 12 hour shift from working more than 12 hours in a 24 hour period except in a health care emergency.

[1] Rogers A, et al. The working hours of hospital staff nurses and patient safety. *Health Affairs* 2004;23(4):202-12.

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AMERICAN ASSOCIATION of CRITICAL-CARE NURSES
101 Columbia, Aliso Viejo, CA 92656-4109
Phone: 949/362-2000 800/899-2226
Fax 949/362-2020
E-mail aacninfo@aacn.org Web
www.aacn.org

Mandatory Overtime

A Statement from The American Association of Critical-Care Nurses (AACN)

BACKGROUND

Mandatory overtime is identified as a workplace issue and a patient safety issue. Mandatory overtime is the practice of hospitals and health care institutions to maintain adequate numbers of staff nurses through forced overtime, usually with a total of twelve to sixteen hours worked, with as little as one hour's notice. With mandatory overtime nurses are unable to refuse the required extra hours due to 1) fatigue, or 2) feeling that she/he would be unable to deliver adequate, safe patient care. This does not include overtime mandated in an unforeseen emergency, such as a mass casualty situation, or a sudden snowstorm. "On call" time is not included in this definition, unless the nurse's on call time is immediately before or after a scheduled shift, and it would force him or her to work a double shift.

THE ISSUE

The dramatic changes in the health care environment that have impacted nursing practice in recent years have come as managed care programs grew in dominance and federal Medicare and Medicaid reimbursements declined (Berens, M.J.). With the nursing shortage continuing, the growing trend is for hospitals to use mandatory overtime as a common staffing practice (ANA, June 2000).

Mandatory overtime may cause or lead to increased stress on the job, less patient comfort and mental and physical fatigue that can contribute to errors and "near-misses" with medications and case-related procedures. This is occurring as patient acuity has increased. The practice of mandatory overtime ignores the responsibilities nurses may have at home with children, other family members, or other obligations. Being forced into excessive overtime can cause an exhausted

RN to practice unsafe patient care, jeopardizing her nursing licensure status. Impact is felt at the level of the bedside nurse in three major areas identified through current literature: medication errors, quality patient care, and nurses' legal liability.

Medication Errors - The Institute of Medicine's report *To Err is Human: Building a Safer Health System* (IOM, 12/1999) states the deaths from medication errors that take place both in and out of hospitals, more than 7000 annually, exceed those from workplace injuries. In a separate report, investigation by the Chicago-Tribune states that since 1995, at least 1,720 hospital patients have died and 9,548 others have been injured because of mistakes made by RN's across the country (Associated Press, 9/10/2000).

Quality Patient Care - As the nurse-to-patient ratio worsens, and as patient acuity increases, hospital management is free to demand that nurses work mandatory sixteen-hour shifts, with one-hour notice (MNA, 4/3/2000). In a 1989 article published in the Journal of Occupational Health and Safety, the author stated, "Once a shift exceeds twelve consecutive hours, acute fatigue sets in. A worker may still be able to perform routine tasks, but his brain waves exhibit a pattern of stage one alpha sleep. Errors made in this stage are frequently major, since the worker tends to perform the opposite of the correct action."

Legal Liability - Nurses practice under each state's Nurse Practice Act, which govern nursing practice. Most nurse practice acts state that nurses are held accountable for the safety of their patients. Thus, if a nurse accepts a patient assignment and something untoward happens to that patient, the nurse is liable under her license. Once a nurse accepts an assignment, her license can be in jeopardy if she is unable to deliver safe patient care.

Implications of Change - If mandatory overtime is legally banned in all states, hospitals and health care institutions will have to look at real remedies for understaffed facilities such as:
1) Hiring more RN's, and
2) Utilizing strategies to recruit and retain more nurses.

ANA's recent study, *Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting* (3/2000), tracks five adverse outcomes measures that can be mitigated if adequate patient staffing is provided: hospital length of stay, nosocomial pneumonia, postoperative infections, pressure ulcers, and nosocomial urinary tract infections. With sufficient nurse staffing, time is available for more thorough patient assessment and interventions to improve outcomes.

The American Academy of Nursing (AAN) conducted research in the 80's, which has had several follow-up studies since, which reinforce the original findings of researcher Linda Aiken. Her research affirmed that specific organizational variables create a milieu that not only attracts nurses, but also create practice environments that provide better outcomes for patients. "Magnet facilities" have higher nurse-staffing levels, and lower mortality and morbidity rates, shorter length of stay, and lower utilization of ICU days. In the 1999 follow-up research,

a lower incidence of needlestick injuries among nurses was also noted. If mandatory overtime is allowed to continue, one could easily project:

1) Increase in medication errors,
2) Decrease in safe, quality patient care,
3) Decrease in patient satisfaction,
4) Increase in hospital length of stay,
5) Increase in mortality and morbidity,
6) Decrease in recruitment of new nurses,
7) Decrease in retention of nurses, and
8) Increase in legal liability issues against nurses.

LEGISLATIVE HISTORY

February 12, 2003 - Senator Edward M Kennedy re-introduced **S. 373, the Safe Nursing and Patient Care Act of 2003**, which amends title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare program. A companion bill, H.R. 745 was again re-introduced in the House by Representative Pete Stark. The bills are currently in committee.

November 14, 2001- Senator Edward M Kennedy, introduced **S. 1686 "The Safe Nursing and Patient Care Act of 2001"** which was referred to the Committee on Finance. The bill would amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program. and referred to the House Committee on Education and the Workforce and to the Subcommittee on Workforce Protections.

September 15, 2000- H.R. 5179 "The Registered Nurses and Patients Protection Act" was introduced into the U.S. House of Representatives by Rep.Tom Lantos (D-Calif.). The bill would amend the Fair Labor Standards Act so that no RN would be required to work beyond eight hours in any workday or 80 hours in any 14-day work period. This legislation was not acted on in the 106th Congress and Lantos reintroduced the bill **(H.R. 1289)** in the 107th Congress where it was referred to the House Committee on Education and the Workforce and to the Subcommittee on Workforce Protections.

AACN's POSITION

AACN believes that mandatory overtime is not an acceptable means of staffing a hospital, because it may place nurses and their patients at increased risk of being involved in medical errors. Instead, nurses should be able to decide whether working overtime will affect their ability to care safely and effectively for patients. They should have the option of refusing overtime assignments and not be forced into working beyond their capacity to provide optimal care. AACN supports this legislation and will continue to work to educate the public on the negative impact that mandatory overtime can have on patient safety.

WHAT YOU CAN DO

Work with the administrators in your facility to develop systems that support the delivery of quality care and a safe work environment.

Let your legislators know that this bill has strong support of nurses. Discuss with him or her:

Your concern that mandatory overtime is not an acceptable means of staffing a hospital because it can place nurses and their patients at increased risk for making errors.

The fact that studies have shown that when a worker (especially a health care worker) exceeds 12 hours of work, and is fatigued, the likelihood of their making an error increases. The IOM report on medication errors substantiates these findings, where the experts who compiled the report specifically recommended that safe staffing and limits on mandatory overtime are a component to preventing medication errors.

Explain RN accountability for the delivery of safe care and that nurses should not be forced into working beyond his or her capacity to provide optimal care without the right to refuse that assignment.

3/01
Revised 3/03

American Association of Critical-Care Nurses
101 Columbia, Aliso Viejo, CA 92656-4109
1-800-899-2226 or 949-362-2000 (Phone) 949-362-2020 (Fax) email: info@aacn.org
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Last Update: 02/26/2004

109TH CONGRESS
1ST SESSION

H. R. 791

To amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 14, 2005

Mr. STARK (for himself and Mr. LATOURE TE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide for patient protection by limiting the number of mandatory overtime hours a nurse may be required to work in certain providers of services to which payments are made under the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Safe Nursing and Pa-
5 tient Care Act of 2005".

1 (5) The dangers with mandatory overtime are
2 made clear by numerous studies. A November 2003
3 Institute of Medicine report, Keeping Patients Safe:
4 Transforming the Work Environment of Nurses,
5 concluded that limiting the number of hours worked
6 per day and consecutive days of work by nursing
7 staff, as is done in other safety-sensitive industries,
8 is a fundamental safety precaution. The report went
9 on to specifically recommend that working more
10 than 12 hours in any 24-hour period and more than
11 60 hours in any 7-day period be prevented except in
12 case of an emergency, such as a natural disaster.
13 (6) Another study published in the July/August
14 2004 Health Affairs Journal, The Working Hours of
15 Hospital Staff Nurses and Patient Safety, found
16 that nurses who worked shifts of twelve and a half
17 hours or more were three times more likely to com-
18 mit an error than nurses who worked standard shifts
19 of eight and a half hours or less. The study also
20 found that working overtime increased the odds of
21 making at least one error, regardless of how long the
22 shift was originally scheduled.
23 (7) That same study also illustrates how nurses
24 are being forced to work more and more overtime.
25 The majority of nurses surveyed reported working

1 (A) in subparagraph (U), by striking
2 "and" at the end;
3 (B) in subparagraph (V), by striking the
4 period and inserting ", and"; and
5 (C) by inserting after subparagraph (V),
6 the following:
7 "(W) to comply with the requirements of
8 subsection (k) (relating to limitations on man-
9 datory overtime for nurses)."; and
10 (2) by adding at the end the following new sub-
11 section:
12 "(k) LIMITATIONS ON MANDATORY OVERTIME FOR
13 NURSES.—For purposes of subsection (a)(1)(W), the re-
14 quirements of this subsection are the following:
15 "(1) PROHIBITION ON MANDATORY OVER-
16 TIME.—Except as provided in this subsection, a pro-
17 vider of services shall not, directly or indirectly, re-
18 quire a nurse to work in excess of any of the fol-
19 lowing:
20 "(A) The scheduled work shift or duty pe-
21 riod of the nurse.
22 "(B) 12 hours in a 24-hour period.
23 "(C) 80 hours in a consecutive 14-day pe-
24 riod.
25 "(2) EXCEPTIONS.—

1 "(A) RIGHT TO REPORT.—
2 "(i) IN GENERAL.—A nurse may file a
3 complaint with the Secretary against a
4 provider of services who violates the provi-
5 sions of this subsection.
6 "(ii) PROCEDURE.—The Secretary
7 shall establish a procedure under which a
8 nurse may file a complaint under clause
9 (i).
10 "(B) INVESTIGATION OF COMPLAINT.—
11 The Secretary shall investigate complaints of
12 violations filed by a nurse under subparagraph
13 (A).
14 "(C) ACTIONS.—If the Secretary deter-
15 mines that a provider of services has violated
16 the provisions of this subsection, the Secretary
17 shall require the provider to establish a plan of
18 action to eliminate the occurrence of such viola-
19 tion, and may seek civil money penalties under
20 paragraph (7).
21 "(4) NURSE NONDISCRIMINATION PROTEC-
22 TIONS.—
23 "(A) IN GENERAL.—A provider of services
24 shall not penalize, discriminate, or retaliate in
25 any manner with respect to any aspect of em-

1 State professional disciplinary agency because
2 the nurse refused to comply with a request to
3 work mandatory overtime.

4 "(C) GOOD FAITH.—For purposes of this
5 paragraph, a nurse is deemed to be acting in
6 good faith if the nurse reasonably believes—

7 "(i) that the information reported or
8 disclosed is true; and

9 "(ii) that a violation has occurred or
10 may occur.

11 "(5) NOTICE.—

12 "(A) REQUIREMENT TO POST NOTICE.—
13 Each provider of services shall post conspicu-
14 ously in an appropriate location a sign (in a
15 form specified by the Secretary) specifying
16 rights of nurses under this section.

17 "(B) RIGHT TO FILE COMPLAINT.—Such
18 sign shall include a statement that a nurse may
19 file a complaint with the Secretary against a
20 provider of services who violates the provisions
21 of this subsection and information with respect
22 to the manner of filing such a complaint.

23 "(6) POSTING OF NURSE SCHEDULES.—A pro-
24 vider of services shall regularly post in a conspicuous
25 manner the nurse schedules (for such periods of

1 The Secretary shall publish on the Internet site of
2 the Department of Health and Human Services the
3 names of providers of services against which civil
4 money penalties have been imposed under this para-
5 graph, the violation for which the penalty was im-
6 posed, and such additional information as the Sec-
7 retary determines appropriate. With respect to a
8 provider of services that has had a change in owner-
9 ship, as determined by the Secretary, penalties im-
10 posed on the provider of services while under pre-
11 vious ownership shall no longer be published by the
12 Secretary on such Internet site after the 1-year pe-
13 riod beginning on the date of change in ownership.
14 "(8) RULE OF CONSTRUCTION.—Nothing in
15 this subsection shall be construed as precluding a
16 nurse from voluntarily working more than any of the
17 periods of time described in paragraph (1), so long
18 as such work is done consistent with professional
19 standards of safe patient care.
20 "(9) DEFINITIONS.—In this subsection:
21 "(A) MANDATORY OVERTIME.—The term
22 'mandatory overtime' means hours worked in
23 excess of the periods of time described in para-
24 graph (1), except as provided in paragraph (2),
25 pursuant to any request made by a provider of

1 "(ix) a federally qualified health cen-
2 ter.
3 "(E) DECLARED STATE OF EMERGENCY.—
4 The term 'declared state of emergency' means
5 an officially designated state of emergency that
6 has been declared by the Federal Government
7 or the head of the appropriate State or local
8 governmental agency having authority to de-
9 clare that the State, county, municipality, or lo-
10 cality is in a state of emergency, but does not
11 include a state of emergency that results from
12 a labor dispute in the health care industry or
13 consistent understaffing.
14 "(F) STANDARDS OF SAFE PATIENT
15 CARE.—The term 'standards of safe patient
16 care' means the recognized professional stand-
17 ards governing the profession of the nurse in-
18 volved.".
19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect 1 year after the date of enact-
21 ment of this Act.
22 **SEC. 4. REPORTS.**
23 (a) STANDARDS ON SAFE WORKING HOURS FOR
24 NURSES.—

1 a study to determine the extent to which feder-
2 ally operated medical facilities have in effect
3 practices and policies with respect to overtime
4 requirements for nurses that are inconsistent
5 with the provisions of section 1866(k) of the
6 Social Security Act, as added by section 3.

7 (B) FEDERALLY OPERATED MEDICAL FA-
8 CILITIES DEFINED.—In this subsection, the
9 term "federally operated medical facilities"
10 means acute care hospitals, freestanding clinics,
11 and home health care clinics that are operated
12 by the Department of Veterans Affairs, the De-
13 partment of Defense, or any other department
14 or agency of the United States.

15 (2) REPORT.—Not later than 6 months after
16 the date of the enactment of this Act, the Director
17 of the Office of Management and Budget shall sub-
18 mit to Congress a report on the study conducted
19 under paragraph (1) and shall include recommenda-
20 tions for the implementation of policies within feder-
21 ally operated medical facilities with respect to over-
22 time requirements for nurses that are consistent
23 with such section 1866(k), as so added.

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UAN
UNITED AMERICAN NURSES, AFL-CIO

8515 Georgia Avenue
Suite 400
Silver Spring, MD 20910
301-628-5118/fax 301-628-5347

Legislative Issue Brief

Safe Nursing and Patient Care Act of 2005 (H.R. 791/S. 351) -- Legislation to Strictly Limit Mandatory Overtime

ISSUES: Strictly limiting mandatory overtime for nurses is a critical step in improving the quality of health care and reducing medical errors. In its 1999 report "To Err is Human", the Institute of Medicine (IoM) estimated that as many as 98,000 hospitalized Americans die each year as a result of errors in their care. In a recent IoM study (2003) of nurses' role in patient safety, the report concluded that "evidence revealed that typical work environment of nurses is characterized by many serious threats to patient safety." The IoM report identifies long hours for nurses as one of the critical problems – "the long hours of some nurses represents on of the most serious threats."

Unlike many other major industries where public safety is a concern, health care is exempt from regulations which limit the use of overtime as a staffing tool. Mandatory overtime puts patients and nurses at risk for medical errors, as well driving registered nurses out of patient care. The effects of mandatory overtime were central issues in major RN strikes in Washington, D.C., Minnesota, Ohio, New York and Hawaii.

The UAN supports and is working on legislation that would eliminate mandatory overtime for registered nurses except in true emergencies.

STATUS: Senator Edward Kennedy (D-MA) and Representative Pete Stark (D-CA) have introduced the **"Safe Nursing and Patient Care Act of 2005"** **(H.R. 791/S. 351)** in the House and Senate. This legislation would:

- Set strict, new federal limits on the ability of health facilities to require mandatory overtime from nurses. Nurses would use their own professional judgment in deciding to volunteer for overtime But, forced mandatory overtime would only be allowed when an official state of emergency was declared by federal, state or local government;

- Provide HHS with the authority to investigate complaints from nurses about violations. It also grants HHS the power to issue civil monetary penalties of up to $10,000 for violations of the act and to increase those fines for patterns of violations;
- Require facilities to post notices explaining these new rights and to post nurse schedules in prominent workplace locations. Nurses would also receive anti-discrimination protections against employers who continue to force work hours for nurses beyond what a nurse believes is safe for quality care;
- Require the Agency on Healthcare Research and Quality to report back to Congress with recommendations for developing overall standards to protect patient safety in nursing care.

ACTION NEEDED: For those members of Congress who have not cosponsored H.R. 791/S. 351 as of yet, the UAN strongly urges them to do so. If members have already cosponsored this legislation, the UAN urges them to work for the final passage of H.R. 791/S. 351.

POLICY RATIONALE:

- A 2001 report by the General Accounting Office, Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors, concluded: [T]he current high levels of job dissatisfaction among nurses may also play a crucial role in determining the extent of current and future nurse shortages. Efforts undertaken to improve the workplace environment were reduce the likelihood of nurses leaving the field and encourage more young people to enter the nursing profession.......

- Current projections are that the nurse workforce in 2020 will have fallen 20 percent below the level necessary to meet demand.

- There currently exist government standards that limit the hours that pilots, flight attendants, truck drivers, railroad engineers and other professions can safely work before consumer safety is endangered. However, no similar limitation currently exists for our nation's nurses who are caring for patients.

use this vs Other.

ANA Press Release October 23, 2002

CONTACT: Carol Cooke, 202-651-7027 or Cindy Price, 202-651-7038
m=realnews@ana.org, www.nursingworld.org/mrealnews

JAMA Article Links Hospital Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize Principles for Nurse Staffing to address problem

Washington, DC -- A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurse (RN) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality rose 7 percent for every additional patient added to the average nurses's workload. The difference between four to six and four to eight patients-per-nurse was accompanied by a 14 percent and 31 percent increase in mortality respectively. The study from the University of Pennsylvania affirms the critical role RNs play in patient safety when able to make direct assessments and life-saving interventions.

"This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate," said Barbara A. Blakeney, MS, APRN,BC, ANP, president of the American Nurses Association (ANA). "It is an important contribution, but, frankly, this is something that nurses have known for years," she said. "Nurses make the critical, cost-effective difference in providing safe, high-quality patient care," she added. Blakeney pointed to ANA's own report, Nurse Staffing and Patient Outcomes in the Inpatient Hospital Setting," which was released in May 2000. The study looked at hospital and Medicare data in nine states in five categories of adverse outcomes: length of hospital stay, hospital-acquired pneumonia, postoperative infection, bed sores and hospital-acquired urinary tract infections. All five measures were markedly lower with higher levels of RN involvement in patient care. Two other studies published this year, one in the New England Journal of Medicine and one by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), also found direct links between nurse staffing levels and better patient outcomes.

Today's JAMA article also reported that patient load had a direct impact on nurse retention rates. Adding one patient-per-nurse to a hospital's staffing level increased nurse burnout by 23 percent and job dissatisfaction by 15 percent. The data indicate that more than 40 percent of nurses who reported high burnout and job dissatisfaction intended to leave their job within the next year.

"Inappropriate staffing is the number one concern of nurses today," Blakeney said. "Nurses already face great stress and challenges on the job. They must care for greater numbers of patients than ever before and patients in hospitals are more acutely ill than in the past. Adequate nurse staffing is critical to the delivery of quality patient care because it allows nurses time for appropriate assessment of patients and their needs and initiation of suitable interventions."

Blakeney emphasized that nurses are dissatisfied because of a lack of control over their work environment which prevents them from delivering high-quality nursing care. In addition to the

right number and mix of direct-care staff for hands-on care, other resources are necessary to support RNs' ability to deliver the best possible care. ANA has developed and strongly encourages the use of its Principles for Nurse Staffing, which include: nurse control over the practice environment; effective and efficient support services; readily available and current patient information; sufficient orientation and mentoring for new staff and new nursing graduates; education in the use of new technology; and sufficient time for collaboration, planning, coordination and delivery of care that meets both patient and family needs. Research has shown that hospitals which incorporate much of the philosophy embedded in the Principles for Nurse Staffing into their organizational culture and practice have higher rates of satisfaction and retention among nursing staff, and better outcomes for patients.

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistle-blower protections for nurses, mandate collection of workforce and nursing-sensitive quality data, establish patient staffing systems and provide funding for nursing education.

In addition, hospitals that utilize nursing "best practices" can apply for designation as "Magnet" facilities a recognition made by the American Nurses Credentialing Center, a subsidiary of ANA. Hospitals that have achieved "Magnet"status have higher retention rates for nurses and improved patient outcomes.

Many of the issues touched on in the JAMA study have been addressed in Nursing's Agenda for the Future (www.NursingWorld.org/naf). The plan, which was released in April, is the result of an in-depth strategic planning process that involved leaders from more than 60 national nursing organizations. It reflects the brain trust of nursing and includes strategies to address basic issues, such as recruitment, as well as more complex issues, such as the economic value of nursing.

The authors of the new JAMA study said that improving nurse staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse ($42,000 to $64,000) are correct.

"Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," by Linda H. Aiken, et. al, appears in the October 23/30, 2002 issue of JAMA. The study, funded by the National Institute of Nursing Research of the National Institutes of Health, looked at 232,342 patients between the ages of 20 and 85 who underwent general surgical, orthopaedic, or vascular procedures in 168 Pennsylvania hospitals from April 1, 1998, to Nov. 30, 1999.

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ANA is the only full-service professional organization representing the nation's 2.7 million Registered Nurses through its 54 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

ANA Press Release October 23, 2002

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Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction

Linda H. Aiken, PhD,RN; Sean P. Clarke, PhD,RN; Douglas M. Sloane, PhD; Julie Sochalski, PhD,RN; Jeffrey H. Silber, MD,PhD

JAMA 2002;288:1987-1993.

Context The worsening hospital nurse shortage and recent California legislation mandating minimum hospital patient-to-nurse ratios demand an understanding of how nurse staffing levels affect patient outcomes and nurse retention in hospital practice.

Objective To determine the association between the patient-to-nurse ratio and patient mortality, failure-to-rescue (deaths following complications) among surgical patients, and factors related to nurse retention.

Design, Setting, and Participants Cross-sectional analyses of linked data from 10 184 staff nurses surveyed, 232 342 general, orthopedic, and vascular surgery patients discharged from the hospital between April 1, 1998, and November 30, 1999, and administrative data from 168 nonfederal adult general hospitals in Pennsylvania.

Main Outcome Measures Risk-adjusted patient mortality and failure-to-rescue within 30 days of admission, and nurse-reported job dissatisfaction and job-related burnout.

Results After adjusting for patient and hospital characteristics (size, teaching status, and technology), each additional patient per nurse was associated with a 7% (odds ratio [OR], 1.07; 95% confidence interval [CI], 1.03-1.12) increase in the likelihood of dying within 30 days of admission and a 7% (OR, 1.07; 95% CI, 1.02-1.11) increase in the odds of failure-to-rescue. After adjusting for nurse and hospital characteristics, each additional patient per nurse was associated with a 23% (OR, 1.23; 95% CI, 1.13-1.34) increase in the odds of burnout and a 15% (OR, 1.15; 95% CI, 1.07-1.25) increase in the odds of job dissatisfaction.

Conclusions In hospitals with high patient-to-nurse ratios, surgical patients experience higher risk-adjusted 30-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.

Author Affiliations: Center for Health Outcomes and Policy Research, School of Nursing (Drs Aiken, Clarke, Sloane, and Sochalski), Leonard Davis Institute of Health Economics (Drs Aiken, Clarke, Sochalski, and Silber), Department of Sociology (Dr Aiken), Population Studies Center (Drs Aiken, Sloane, and Sochalski), and Departments of Pediatrics and Anesthesia, School of Medicine (Dr Silber), University of Pennsylvania, Philadelphia; and Center for Outcomes Research, Children's Hospital of Philadelphia, Philadelphia, Pa (Dr Silber).

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Number 22 Volume 346:1715-1722

May 30, 2002

Nurse-Staffing Levels and the Quality of Care in Hospitals

Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., Soeren Mattke, M.D., M.P.H., Maureen Stewart, B.A., and Katya Zelevinsky

ABSTRACT

Background It is uncertain whether lower levels of staffing by nurses at hospitals are associated with an increased risk that patients will have complications or die.

Methods We used administrative data from 1997 for 799 hospitals in 11 states (covering 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients) to examine the relation between the amount of care provided by nurses at the hospital and patients' outcomes. We conducted regression analyses in which we controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each hospital's patients, and other variables.

Results The mean number of hours of nursing care per patient-day was 11.4, of which 7.8 hours were provided by registered nurses, 1.2 hours by licensed practical nurses, and 2.4 hours by nurses' aides. Among medical patients, a higher proportion of hours of care per day provided by registered nurses and a greater absolute number of hours of care per day provided by registered nurses were associated with a shorter length of stay ($P=0.01$ and $P<0.001$, respectively) and lower rates of both urinary tract infections ($P<0.001$ and $P=0.003$, respectively) and upper gastrointestinal bleeding ($P=0.03$ and $P=0.007$, respectively). A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia ($P=0.001$), shock or cardiac arrest ($P=0.007$), and "failure to rescue," which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis ($P=0.05$). Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections ($P=0.04$), and a greater number of hours of care per day provided by registered nurses was associated with lower rates of "failure to rescue" ($P=0.008$). We found no associations between increased levels of staffing by registered nurses and the rate of in-hospital death or between increased staffing by licensed practical nurses or nurses' aides and the rate of adverse outcomes.

Conclusions A higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care for hospitalized patients.

Source Information

From the Department of Health Policy and Management, Harvard School of Public Health, Boston (J.N., S.M., M.S., K.Z.); the Vanderbilt University School of Nursing, Nashville (P.B.); and Abt Associates, Cambridge, Mass. (S.M.).

Address reprint requests to Dr. Needleman at the Harvard School of Public Health, Department of Health Policy and Management, Rm. 305, 677 Huntington Ave., Boston, MA 02115, or at needlema@hsph.harvard.edu.

JAMA study: High RN workloads impact mortality

Nurse researchers add more evidence to growing body of work on nurse staffing

In a new study looking at nursing care, University of Pennsylvania (Penn) researchers have determined that patients who have common surgeries in hospitals with the worst nurse staffing levels have up to a 31 percent increased chance of dying. Further, more nurses at the bedside could save thousands of patients' lives every year, report researchers in the Oct. 23-30 issue of the Journal of the *American Medical Association (JAMA).*

The researchers found that every additional patient in a hospital nurse's average workload increased the risk of death in surgical patients by seven percent. Patients with life-threatening complications also were less likely to be rescued in hospitals where nurses' patient loads were heavier.

"Nurses reported greater job dissatisfaction and emotional exhaustion when they're responsible for more patients that they can safely care for," said Pennsylvania State Nurses Association member Linda Aiken, PhD, RN, FAAN, director of the Center for Heath Outcomes and Policy Research at Penn's School of Nursing. Aiken, along with colleagues, conducted the study. "Failure to retain nurses contributes to avoidable patient deaths."

ANA President Barbara Blakeney, MS, APRN,BC, ANP, said: "This new study is dramatic because it highlights the fact that people can die when nursing care is inadequate. It is an important contribution, but frankly, this is something that nurses have known for years. Nurses make the critical, cost-effective difference in providing safe, high quality patient care."

Specifically, the Penn nursing researchers found that:

* If all hospitals in the nation staffed at eight patients per nurse rather than four, the risk of hospital deaths would increase by 31 percent, roughly translating to as many as 20,000 avoidable deaths in the United States annually.

* Having too few nurses may actually cost more because of the high costs of replacing burned-out nurses and the higher cost of caring for patients with poor outcomes.

* Adding two patients to a nurse already caring for four increases the risk of death by 14 percent.

The report, "Hospital Nurse Staff and Patient Mortality, Nurse Burnout and Job Dissatisfaction," concluded that, "When taken together, the impacts of staffing on patient and nurse outcomes suggest that by investing in registered nurse staffing, hospitals may avert both preventable mortality and ... problems with low nurse retention in hospital practice."

The study, funded by the National Institute of Nursing Research of the National Institutes of Health, examined data collected from 168 hospitals, 232,342 surgical patients, and 10,184 nurses in Pennsylvania from 1998 to 1999. They examined data on relatively common, general, orthopedic surgeries and vascular surgeries, excluding cardiac operations such as coronary bypass.

Nurses' Solutions to the Nurse Staffing Shortage
UAN National Sample Survey of Staff RNs

Key Findings and Talking Points for CMAs

The United American Nurses has conducted a national poll exclusively of hospital staff RNs on the front lines of direct patient care to spotlight their experience and expertise about the critical staffing shortage and how to solve it.

Lake Snell Perry and Associates, a leading national political and public policy research firm, designed and administered this survey which was conducted by phone using professional interviewers in November 2002. The survey reached 600 licensed hospital staff nurses who provide direct patient care.

1. **Problems in today's hospitals**

   The nursing shortage is the top problem in hospitals today. Eight of ten nurses feel there is a serious shortage in their hospital.

   When asked about the two biggest problems facing them, nurses identify the staffing shortage and inadequate wages as top concerns.

   Other problems include:
   Workload issues
   Nurse to patient ratios
   Stress and fatigue
   Lack of respect and recognition
   Long hours
   Support from the administration
   Quality of patient care
   Turnover rate and retaining nurses

   Time for patient care has decreased, according two-thirds of those surveyed (67%), and nearly four in ten nurses (38%) say less than half their day is spent on direct patient care. 31% say administrative reports and documentation take more than half their day.

2. **Why nurses leave the profession.**

   Work-related stress, patient load, and inadequate pay are the top three reasons nurses leave the profession.
   Three out of ten nurses say it's unlikely they will be a hospital staff nurse in five years.
   The majority of nurses surveyed feel their hospital is doing only a fair to poor job attracting and retaining nurses.

3. **Solutions to the Nursing Shortage**

   The best solutions are:
   Increased pay (82%),
   Reduced nurse patient ratios (85%)

Collectively, staff nurses have a lot of experience. Over a third (35%) have worked as a staff nurse for more than 20 years and 65% have more than 10 years experience. Only 12% have 5 years or less experience. The other side of that coin is that the lower percentages of less experienced nurses reflects fewer people entering the nursing profession now and foreshadows future shortages.

An overwhelming number (86%) say they would be confident having someone close to them receive care at the hospital in which they work. The fact that one of every ten (13%) said they would not is a strong reminder that patients need to choose hospitals carefully.

When asked about how good a place to work their hospital is, just over half (52%) said it was too good a place to work to leave. However, four out of ten (41%) said their hospital isn't a great place to work, but they probably would not leave and 5% said it was so bad a place to work that they definitely intend to leave.

# # #

From: Moe Chaudry [mailto:MChaudry@sitkahospital.org]
Sent: Wednesday, April 02, 2008 3:51 PM
To: Rep. Peggy Wilson; Rep. Berta Gardner; representative; Rep. Sharon Cissna; Rep. Bob Roses; Rep. Paul Seaton; Rep. Anna Fairclough
Subject: Senate Bill 28

April 2, 2008

Representative Wilson, Chair House HESS
Representative Roses
Representative Seaton
Representative Keller
Representative Cissna
Representative Fairclough
Representative Gardner

Dear Representative Wilson & Members of the House HESS Committee:

I am writing to express my strong opposition to Senate Bill 28, "An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

As a small rural hospital, Sitka Community Hospital relies on temporary nurses to fill the staffing gaps so that our regular staff nurses don't have to work mandatory overtime. Simply put, we don't use mandatory overtime.

Hospitals are by far the most regulated industry in the country, and what we don't need is unnecessary regulation like SB 28. We are acutely aware of the problems of nurses working too many hours which is why we choose not to have mandatory overtime. Instead of focusing on legislation like this, we must continue to work with the State to graduate as many nurses as we can. Doing this will truly help close the nursing shortfall gap.

SB 28 is unnecessary legislation. SB 28 would limit the ability of facilities to manage the workforce and to respond to the varying demands of patient care. It would impose onerous and unnecessary financial penalties on facilities that are already struggling to survive financially. Additionally, SB 28 imposes onerous reporting requirements around the use of overtime; and introduces legislation where good management practices are all that is needed.

I would like to respectfully request that you not move SB 28 forward from this Committee. Thank you for taking the time to listen to my comments on Senate Bill 28. If you have any questions, or would like any information, please don't hesitate to contact me.

Sincerely,

Moe Chaudry, CEO
Sitka Community Hospital
209 – Moller Avenue
Sitka, AK 99835
907-747-1738

426 Main St •Juneau, AK • 99801

Alaska State Hospital and Nursing Home Association

Why Mandatory Nurse Overtime Legislation is Unnecessary in the State of Alaska

March 2008

WHO DOES ASHNHA REPRESENT?

The ***Alaska State Hospital and Nursing Home Association*** represents 24 acute care hospitals (tribal, military, private & community owned), 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 nursing facilities. We believe ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters.

WHY ASHNHA's MEMBERS OPPOSE PASSAGE OF SB 28:

- No evidence has been presented that Alaska's hospitals or nursing homes are routinely requiring nurses to work mandatory overtime beyond agreed upon shifts and on-call scheduling as defined in local labor agreements.

- ASHNHA has tracked mandatory overtime usage for four years running and those reports show that use of mandatory overtime is a rare occurrence with all but 2 facilities reporting **ZERO** use of mandatory overtime over this time frame (see attached chart).

- No evidence has been presented that any of the ongoing monitoring systems operated by federal, state or independent private agencies has identified use of mandatory overtime as a problem related to delivery of excellent patient care.

- No other occupation in Alaska workforce has its work schedule limits set by the Alaska Legislature. This is a major labor precedent with no basis to support taking this action.

- Work hours and scheduling are appropriately a local employer responsibility to negotiate with its employees. This is being done in every community in a responsible manner with equal concern to employee and patient concerns.

- ASHNHA's members have worked to reduce the nursing shortage problem in Alaska by contributing substantial funding over the last four years to help support an expanded nursing program at the University of Alaska. This program is now graduating 200 nurses annually compared to 100 nurses before the program's expansion.

- SB 28 would impose a new reporting burden for Alaska facilities. These reports would have to be filed semi-annually and must contain detailed work hour information for each staff nurse employed by the facility as well as each contract nurse.

- SB 28 would override collective bargaining agreements and place work scheduling decisions in the hands of the nurse rather than management.

A

ASHNHA 2004 and 2005 NURSE OVERTIME SURVEY RESUL¯S - VERSION 'D' (February 13, 2006)

Facility		Nurses in Union?	Shortage Better or Worse?	Length of Shift (Hrs)	Nurse Vacancy Rates		Mandatory OT Usage- Total Hrs		On-call Policy		Temp Nursing Hours Needed to Fill Vacancy		# of OT grievances filed
					2004	2005	2004	2005	Require	# times /month	2004	2005	
Alaska Regional Hospital	No	Yes	Worse	8,10,12	4 to 6%	4 to 6%	NONE	NONE	Certain Units	varies	37000 hrs	56000 hrs	NONE
Alaska Native Medical Center	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Alaska Pioneer Homes (All Six Facilities)	No	Yes	Worse	7.5	unknown	unknown	unknown	unknown	No	NONE	NONE	NONE	unknown
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	20%	30%	unknown	46 hrs.	No	NONE	NONE	NONE	unknown
Bartlett Regional Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Bassett Army Community Hospital	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Central Peninsula General Hospital	No	Yes	Worse	12	14%	11%	NONE	NONE	Certain Units	7-8 X	3744 hrs	5616 hrs	NONE
Cordova Community Medical Center		No	No Chg.	12	10%	20%	NONE	NONE	Certain Units	varies	1872 hrs	3744 hrs	NONE
Denali Center Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Fairbanks Memorial Hospital	No	No	No Chg.	8, 10, 12	7%	7%	NONE	NONE	Certain Units	varies	5144 hrs	12175 hrs	NONE
Heritage Place Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Kanakanak General Hospital		REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Ketchikan General Hospital	No	Yes	Better	12	12%	8%	NONE	NONE	Certain Units	10 X	10000 hrs	10000 hrs	NONE
Maniilaq Health Center		REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Mary Conrad Center Nursing Home	No	No	Worse	8, 10, 12	15%	5.55%	NONE	NONE	No	NONE	NONE	NONE	NONE
Mat-Su Regional Medical Center	No	No	No Chg.	8 & 12	10%	12%	unknown	unknown	Certain Units	7 X	1400 hrs	1000 hrs	NONE
Mt. Edgecumbe SEARHC Hospital	No	No	Worse	8, 10, 12	15%	15%	NONE	NONE	Certain Units	8 X	4200 hrs	4200 hrs	NONE
North Star Behavioral Health System	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Norton Sound Regional Hospital		REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Petersburg Medical Center		No	Worse	8 & 10	5%	5%	unknown	NONE	Yes	4 X	NONE	NONE	NONE
Providence Alaska Medical Center	No	Yes	Worse	8, 10, 12	4.36%	4.76%	NONE	NONE	Certain Units	NA	NONE	NONE	NONE
Providence Extended Care Center	No	No	Worse	8, 10, 12	20.83%	20.75%	NONE	NONE	No	NONE	NONE	NONE	NONE
Providence Kodiak Island Medical Center		Yes	No Chg.	12	10%	10%	NONE	NONE	Certain Units	NA	unknown	4000 hrs	NONE
Providence Seward Medical & Care Center		No	No Chg.	8 & 12	unknown	5%	NONE	NONE	Yes	3 X	NONE	NONE	NONE
Providence Valdez Medical Center		REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Sitka Community Hospital		No	No Chg.	12	20%	20%	NONE	NONE	Certain Units	varies	5847 hrs	4738 hrs	NONE
South Peninsula Hospital	No	Yes	No Chg.	8,10,12	6%	3%	NONE	NONE	Certain Units	15 X	144 hrs	1056 hrs	NONE
USAF 3rd Medical Group--Elmendorf	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Wildflower Court Nursing Home	No	No	No Chg.	8 & 12	0%	0%	NONE	NONE	No	NONE	1040 hrs	80 hrs	NONE
Wrangell Medical Center		No	No Chg.	8 & 12	0%	0%	unknown	NONE	Yes	55 hrs	NONE	NONE	NONE
Yukon Kuskokwim Delta Regional Hospital	No	No	Better	8 & 10	40%	28%	NONE	NONE	Certain Units	NONE	34000 hrs	26208 hrs	NONE
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											104391 hrs	128817 hrs	$24.17

B

ASHNHA 2006 and 2007 NURSE OVERTIME SURVEY RESULTS - (February 13, 2008)

Facility		Nurses in Union?	Shortage Better or Worse?	Length of Shift (Hrs)	Nurse Vacancy Rates		Mandatory OT Usage- Total Hrs		On-call Policy				# of OT grievances filed
					2006	2007	2006	2007	Require	# times /month			
Alaska Regional Hospital	No	Yes	Worse	12	n/a	31%	0	0	Certain Units	OR, PACU			
Alaska Native Medical Center	No	No	Worse	12	6.80%	7.7$%	0	0	Certain Units	OR, PACU			
Alaska Pioneer Homes (All Six Facilities)	No	Yes	Better	7.5	4-11%	n/z	0	0	No	0			
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	10%	12%	748	524.75	No	N/A			
Bartlett Regional Hospital	No	Yes	N/C	8, 12	14%	14%	120	108	Certain Units	OR, PACU			
Central Peninsula General Hospital	No	Yes	Worse	12	10%	10%	0	0	Certain Units	7-8x			
Cordova Community Medical Center		No	N/C	12	20%	10%	0	0	Certain Units	3x			
Denali Center Nursing Home	No	No	Better	8,10,12	0%	0%	0	0	0	n/a			
Fairbanks Memorial Hospital	No	No	N/C	8,10,12	4-9%	4-9%	0	0	No	n/a			
Heritage Place Nursing Home	No	Yes	N/C	8, 12	5%	6%	0	0	No	n/a			
Kanakanak General Hospital													
Ketchikan General Hospital		Yes	Better	8, 12	10%	7%	0	0	Certain Units	1-6x	11,700	9,500	
Maniilaq Health Center													
Mary Conrad Center Nursing Home	No	No	Better	8	unk	0.00%	unk	0	Yes	1x	n/a	0	
Mat-Su Regional Medical Center	No	No	Better	8,10,12	2%	2%	0	0	Certain Units	varies			
Mt. Edgecumbe SEARHC Hospital	No	No	Worse	8,10,12	30%	25%	0	0	Certain Units	4			
North Star Behavioral Health System	No	No	N/C	8	6%	10%	0	0	No	n/a			
Norton Sound Regional Hospital													
Petersburg Medical Center		No	N/C	12	13%	13%	0	0	Certain Units	1 or 2			
Providence Alaska Medical Center	No	Yes	Worse	8,10,12	6.70%	8.10%	0	0	Certain Units	3 Dept			
Providence Extended Care Center	No	No	Worse	8,10,12	14.80%	8.50%	0	0	no				
Providence Kodiak Island Medical Center		Yes	Worse	8,10,12	11%	8%	0	0	Certain Units	n/a			
Providence Seward Medical & Care Center		No	Worse	8,10,12	4.30%	11%	0	0	na	na			
Providence Valdez Medical Center		No	Worse	8,10,12	12.50%	36%	0	0	na	na			
Sitka Community Hospital		No	N/C	12	18%	21%	0	0	Certain Units	varies			
South Peninsula Hospital		Yes	N/C	8,10,12	n/a	n/a	n/a	n/a	Certain Units	10, 12			
USAF 3rd Medical Group–Elmendorf	No												
Wildflower Court Nursing Home	No	No	N/C	8, 12	0%	0%	0	0	No	0			
Wrangell Medical Center		No	N/C	8 & 12	0%	0%	None	NONE	Certain Units	55 hrs			
Yukon Kuskokwim Delta Regional Hospital	No												
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											[illegible]	[illegible]	$24.17