SB

28

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/16/07

FURTHER: (Labor and Commerce) Finance

Date of 5-Day Notice: 3/29/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4/18/07

Health, Education and Social Services Committee considered SENATE BILL NO. 28

SB 28 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."

and recommends:

[✓] be **replaced** with [ ] **SCS** or [✓] **CS** SB 28 (HES)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[✓] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FEN#
AOM	4/2			✓	
CED	4/4			✓	
LWF	3/30	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FEN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC.	AMEND.
	Elton	✓			
	Thomas			✓	
	Dyson				✓
	Cowdery				✓
CHAIR:	BDAVIS	✓			

25-LS0212\K
Chenoweth/Wayne
3/21/07

CS FOR SENATE BILL NO. 28( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DAVIS

A BILL

FOR AN ACT ENTITLED

"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."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. The legislature finds that

(1) it is essential that registered nurses and licensed practical nurses providing direct patient care be available to meet the needs of patients;

(2) quality patient care is jeopardized by registered nurses and licensed practical nurses who work unnecessarily long hours in health care facilities;

(3) registered nurses and licensed practical nurses are leaving their profession because of workplace stresses, long work hours, and depreciation of their essential role in the delivery of quality and direct patient care;

(4) it is necessary to safeguard the efficiency, health, and general well-being

of registered nurses and licensed practical nurses, and the health and general well-being of the persons receiving care from registered nurses and licensed practical nurses in health care facilities;

(5) it is necessary that registered nurses and licensed practical nurses be made aware of their rights, duties, and remedies concerning hours worked and patient safety; and

(6) health care facilities should provide adequate and safe nurse staffing without the need for or use of mandatory overtime.

*** Sec. 2.** AS 18.20 is amended by adding new sections to read:

Article 4. Overtime Limitations for Nurses.

Sec. 18.20.400. Limitations on nursing overtime. (a) Except as provided in (c) of this section, a nurse in a health care facility may not be required or coerced, directly or indirectly,

(1) to work beyond a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility;

(2) to work beyond 80 hours in a 14-day period; or

(3) to accept an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

(b) Except as provided by (c) of this section, after working a predetermined and regularly scheduled shift that is agreed to by the nurse and the health care facility as authorized by (a)(1) of this section, a nurse in a health care facility shall be allowed not less than 10 consecutive hours of off-duty time immediately following the end of that work.

(c) Subsection (a) of this section does not apply to

(1) a nurse voluntarily working overtime on an aircraft in use for medical transport, so long as the shift worked is allowable under regulations adopted by the Board of Nursing based on accreditation standards adopted by the Commission on Accreditation of Medical Transport Systems;

(2) a nurse on duty in overtime status because of an unforeseen emergency situation that could otherwise jeopardize patient safety; in this paragraph, "unforeseen emergency situation" means an unusual, unpredictable, or unforeseen situation caused by an act of terrorism, disease outbreak, natural disaster, or a declared

national, state, or local emergency, but does not include a situation in which a health care facility has reasonable knowledge of increased patient volume or inadequate staffing because of some other cause, if that cause is foreseeable;

(3) a nurse fulfilling on-call time that is agreed upon by the nurse and a health care facility before it is scheduled;

(4) a nurse voluntarily working overtime so long as the work is consistent with professional standards and safe patient care and does not exceed 14 consecutive hours;

(5) a nurse voluntarily working beyond 80 hours in a 14-day period so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care;

(6) the first hour on overtime status when the health care facility is obtaining another nurse to work in place of the nurse in overtime status.

Sec. 18.20.410. Prohibition of retaliation. A health care facility may not discharge, discipline, threaten, discriminate against, penalize, or file a report with the Board of Nursing against a nurse for exercising rights under AS 18.20.400 - 18.20.449 or for the good faith reporting of an alleged violation of AS 18.20.400 - 18.20.449.

Sec. 18.20.420. Health care facility complaint process for overtime work by nurses. A health care facility shall provide for an anonymous process by which a patient or a nurse may make a complaint about staffing levels and patient safety that relate to overtime work by nurses and to limitations on overtime work by nurses under AS 18.20.400.

Sec. 18.20.430. Enforcement, offenses, and penalties. (a) The commissioner shall administer AS 18.20.400 - 18.20.449 and adopt regulations for implementing and enforcing AS 18.20.400 - 18.20.449.

(b) A complaint alleging a violation of AS 18.20.400 - 18.20.449 must be filed with the commissioner within 30 days after the date of the alleged violation. The commissioner shall provide a copy of the complaint to the health care facility named in the filing within three business days after receiving the complaint.

(c) If the commissioner finds that a health care facility has knowingly violated an overtime provision of AS 18.20.400 - 18.20.449, the following civil penalties shall

apply:

(1) for a first violation of AS 18.20.400 - 18.20.449, the health care facility shall receive a reprimand;

(2) for a second violation of AS 18.20.400 - 18.20.449 within 12 months, the health care facility shall receive a reprimand and shall be assessed a penalty of $500;

(3) for a third violation of AS 18.20.400 - 18.20.449 within 12 months, the health care facility shall receive a reprimand and shall be assessed a penalty of not less than $2,500 but not more than $5,000;

(4) for each violation of AS 18.20.400 - 18.20.449 after a third overtime violation of AS 18.20.400 - 18.20.449 within 12 months, the health care facility shall receive a public reprimand and shall be assessed a penalty of not less than $5,000 but not more than $25,000.

(d) As an employer, a health care facility violates an overtime provision of AS 18.20.400 - 18.20.449 "knowingly" 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; however, when knowledge of the existence of a particular fact is required in order to establish that the violation was knowing, that knowledge exists when the facility is aware of a substantial probability of its existence, unless the facility reasonably believes it does not exist.

(e) In this section, "commissioner" means the commissioner of labor and workforce development.

Sec. 18.20.440. Report requirements. A health care facility shall file a semiannual report with the section in the Department of Labor and Workforce Development responsible for research and analysis. The report for the six-month period ending June 30 must be filed before the following August 1, and the report for the six-month period ending December 31 must be filed before the following February 1. The report must include, for each nurse employed by the health care facility or under contract with the health care facility, the number of overtime hours worked, the number of overtime hours that were mandatory, the number of overtime hours that were voluntary, the number of on-call hours, the number of on-call hours

that were mandatory, and the number of on-call hours that were voluntary.

Sec. 18.20.449. Definitions. In AS 18.20.400 - 18.20.449,

(1) "health care facility" means a private, municipal, state, or federal hospital; psychiatric hospital; independent diagnostic testing facility; residential psychiatric treatment center; skilled nursing facility; kidney disease treatment center (including freestanding hemodialysis units); intermediate care facility; ambulatory surgical facility; Alaska Pioneers' Home or Alaska Veterans' Home administered by the Department of Health and Social Services under AS 47.55; correctional facility administered by the Department of Corrections or the Department of Health and Social Services; private, municipal, state, or federal facility employing one or more public health nurses; long-term care facility; or primary care outpatient facility;

(2) "nurse" means an individual licensed to practice registered nursing or practical nursing under AS 08.68 who provides nursing services through direct patient care or clinical services and includes a nurse manager when delivering in-hospital patient care;

(3) "on-call" means a status in which a nurse must be ready to report to the health care facility and may be called to work by the health care facility;

(4) "overtime" means the hours worked in excess of a predetermined and regularly scheduled shift that is agreed to by a nurse and a health care facility.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. The first report required to be filed under AS 18.20.440, enacted in sec. 2 of this Act, shall be filed before February 1, 2008, for the period July 1, 2007, through December 31, 2007.

*** Sec. 4.** AS 18.20.440, enacted in sec. 2 of this Act, and sec. 3 of this Act take effect July 1, 2007.

*** Sec. 5.** Except as provided in sec. 4 of this Act, this Act takes effect January 1, 2008.

The Current Staffing and Emerging Nursing Shortages

Position

ANA urges Congress to develop appropriate responses to the current nursing shortage and the inevitable consequences of a rapidly aging and diminishing nurse workforce.

Background

A fundamental shift has occurred in the registered nurse (RN) workforce over the last two decades. As occupational opportunities for young women have expanded, and the working conditions for nurses have deteriorated, the number of young people entering nursing has declined. The number of students entering nursing school has dropped consistently and dramatically over the last five years.

The lack of young people in nursing has resulted in a steady and dramatic increase in the average age of the U.S. nurse. Today, the average working RN is over 43 years old. The average age of working RNs is projected to continue to increase before peaking at age 45.5 in 2010. At that time, large numbers of nurses are expected to retire, and the total number of nurses in America will begin a steady decline.

At the same time, the need for nursing services is expected to continue to increase. America's demand for nursing care is expected to balloon over the next 20 years as a result of the aging of the population, advances in technology, and various economic and policy factors. The Bureau of Labor Statistics ranks nursing seventh highest in projected job growth in the United States. The demand for RNs is expected to increase by 22% by 2008.

This demand, coupled with the imminent retirement of today's aging nurse, will place severe stresses on the health care system. A recent study published in the *Journal of the American Medical Association* estimates that the overall number of nurses per capita will begin to decline in 2007, and that by 2020 the number of nurses will fall nearly 20% below requirements.

Rationale

RNs comprise the largest group of health care professionals in the United States, with more than 2.7 million nurses employed in health care organizations. Nurses literally underpin the health care system. The current nursing shortage (which is small in comparison to the projections for the next two decades) is creating a health care crisis in the nation's hospitals and skilled nursing facilities. Following are a few reports of the effects of this shortage:

1. In November 2000, 10% of the surgical beds at Johns Hopkins Hospital were empty as a direct result of the nursing shortage, causing delays and cancellations of surgeries.
2. Higher nursing costs are the main reason that Moody's Investor Services and Fitch are projecting continued financial hardships for the nation's nonprofit hospitals.

3. In August 2000, the Maryland Hospital Association reported that nearly 15% of the nursing jobs in that state were vacant, up 33% from January of the same year. Georgia reported a 13% vacancy rate in 1999, and expects the percentage to have increased in 2000.

4. Hospitals currently estimate that it costs between $30,000 and $50,000 to fill each nursing vacancy.

§

ANA believes that efforts to attract new candidates into the nursing profession will be fruitless unless problems with the current work environment are addressed. The following position papers provide ANA's positions on staffing and mechanisms to address the nursing shortage.

- Adequate nursing facility staffing
- Appropriate acute care staffing
- Nurse Education Act

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

Core Message

The nursing shortage is the biggest problem in hospitals today. Solving the problem requires radical change. To retain experienced nurses and attract hundreds of thousands of new nurses, hospitals must provide sharply higher pay, lower patient ratios, safe working conditions and recognize nurses as professionals central to excellent patient care. Nurses must demand those changes and refuse to accept less.

The nursing shortage is the biggest problem in hospitals today.

- At least 126,000 needed to fill current vacancies, and the number increases each year.
- Estimates range as high as one million by 2010.
- 80% of nurses surveyed say there's a serious nursing shortage in their hospital. An additional 9% say there's a shortage, though not as serious.
- Three out of ten nurses surveyed say it's unlikely that will be a staff nurse in five years. Many will retire, but others, especially younger nurses, expect to leave hospitals for less stressful jobs.

Radical changes are required to solve the nursing shortage.

- Pay – at least $70,000 per year. Currently hospital staff nurses average $46,000 per year. Six out of ten nurses surveyed earned less than that amount, as did more than half (55%) with more than ten years experience.
- Lower patient ratios and more time for patient care – There's ample solid evidence that lower patient ratios result in better patient outcomes. Hospitals seem unaware of that. Two out of three nurses say they have less time for patient care and four of ten spend less than half their day on direct patient care.
- Safe working conditions – nursing is dangerous work, with risk of disease and personal injury. Responsibility for too many patients adds to the risk and stress. One third of those surveyed cited stressful working conditions as the top reason nurses leave the profession.
- More control of patient care – Top-down decisions on patient care issues are the norm in hospitals today. Staff nurses are rarely consulted about decisions affecting them and the patients for whom they're responsible. Nurses surveyed said being able to determine staff ratios and work loads and being consulted before decisions are made are important to them, yet those are the issues over which they have the least control.

Nurses demand a cure.
The nursing shortage can't be cured without treating the underlying causes.

Nurses have identified the solutions. Nurses are working to implement them. Our union is committed to achieving them. Now we need responsive support from America's hospitals, not Band-Aids, bromides and placebos.

Swift and sweeping change is needed to make nursing financially and professionally attractive. Without it there's little hope of retaining experienced nurses and no hope of recruiting the hundreds of thousands of new nurses needed over the next decade.

# # #

The following is background information for CMAs:

UAN polls front-line nurses on causes and solutions for the nursing shortage.

This is a national poll exclusively of Registered Nurses on the front lines of direct patient care – the 1.3 million staff nurses who care for patients around the clock in public and private hospitals (and HMOs) all across the country.

> **(All staff nurses are RNs, but not all RNs are staff nurses. Of the 2.6 million licensed RNs, about 1.3 million are currently employed as hospital staff nurses.)**

UAN's goal in doing the poll was to spotlight staff nurses' experience and expertise about the critical nursing shortage and how to solve it.

The U.S. Departments of Labor, Health and Human Services, various federal agencies, the American Hospital Association, the Joint Commission on Accreditation of Health Care Organizations and others have reported on the extent, causes and possible solutions for the nursing shortage. This poll reflects the experience and ideas of the nurses themselves.

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%)

Safer working conditions (65%)

Other highly rated solutions include greater autonomy and control for staff nurses (66%), financial incentives for nursing school students (58%) and bringing RNs back to staff nursing (54%).

Less effective measures, say nurses, are signing bonuses, ad campaigns, and career guidance in school.

The least effective measures are mandatory overtime, overseas recruiting and hiring temporary nurses.

Hospitals are failing to implement the best solutions for the nursing shortage and are instead pursuing the least effective.

4. Pay is an important solution

Six out of ten nurses surveyed make less than $46,000 per year. *Pay clearly doesn't measure up to the responsibilities and demands of the job for new nurses nor for those with many years experience.*

82% of all nurses surveyed say increased pay is the best solution for the nursing shortage. Two thirds say they make less money than they should for the demands of the job – *a remarkably high response in view of the historical inclination among nurses to put patient care issues far ahead of compensation.*

Low pay makes nursing an unattractive career choice initially, and for experienced nurses pay is no incentive to stay.
55% with more than ten years experience make less than $46,000.
63% with six-ten years experience make less than $46,000
77% of nurses with less than five years experience make less than $46,000.

The extent of the salary gap is even more dramatic when long experience is taken into account. Nearly two-thirds (65%) of the nurses surveyed have more than ten years experience as a staff nurse, and more than a third (35%) have more than twenty years experience.

($46,782 was the average annual salary reported for all RNs in March 2000. RNs employed as hospital staff nurses earned only $42,133.)
Pay is better in many kinds of jobs. Editors and reporters, funeral directors, tile setters, and 115 other occupations all earn more than registered nurses, according to the most recent National Compensation Survey published by the U.S. Department of Labor's Bureau of Labor Statistics.

5. Is there any good news? Some.

Mandatory overtime appears to be a less serious problem for nurses than in the past. 71% of nurses surveyed said they had some or a lot of control over refusing mandatory overtime. However, 24% – one in four – said they had only a little control in refusing overtime.

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.

# # #

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).

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 actu lly 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.

ANA Press Release October 23, 2002

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

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.

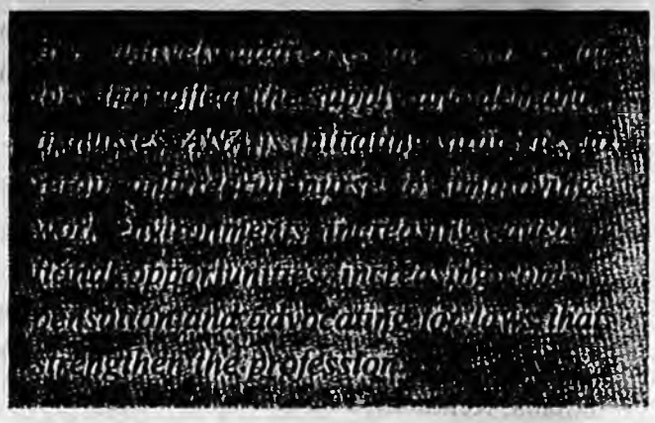
The authors of the new JAMA study said that improving nurse staffing may not only save patient lives and decrease nurse turnover but also reduce hospital costs, if recently published estimates of the costs of replacing a hospital medical and surgical general unit and a specialty nurse ($42,000 to $64,000)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

###

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.

CORE ISSUE: Nursing Shortage



In 2003, ANA continued spearheading work surrounding "Nursing's Agenda for the Future" (NAF), the strategic plan developed by national nursing organizations to address the interrelated factors that have created a growing shortage of nurses. Since NAF's inception in 2001, nursing organizations have submitted more than 200 proposals to move the plan forward. Among the activities enacted in 2003 are "Handle with Care" (see "Health and Safety"), a proactive, multifaceted campaign launched by ANA to promote safe patient handling and prevent musculoskeletal disorders among nurses. Also, NAF's steering committee determined that substantiating the economic value of nursing was the "quantum leap" effort best able to move NAF forward. In 2003, a request for proposals to perform the research necessary to quantify the economic value of nursing was developed, and by the year's end, a series of research proposals was under consideration with the expectation that some, if not all, of the research may be completed by late 2004 or early 2005. So far, 10 CMAs have contributed financially toward completion of this quantum leap project in amounts ranging from $200 to $5,000. Other ongoing strategic planning continued among ANA and the other NAF organizations in 2003, and ANA provided a detailed progress report on NAF activities in the fall. ANA's philanthropic arm, the American Nurses Foundation, worked to initiate fundraising activities for the "Invest in Nursing Capital Campaign," which aims to raise $25 million and will ultimately fund the activities and initiatives of NAF.

Political influence used to address shortage

ANA was ranked in the top 10 percent of groups with influence in health care according to a study published in the Capitol Hill newspaper, *The Hill*, in fall 2003. ANA's clout was evident earlier in the year when it successfully urged for the formation of the House Nursing Caucus, which ended the year with 75 members. After a year in which 85 percent of its endorsed candidates were elected, ANA-PAC continued its successes by raising more than $334,621.64 in 2003, including a record-breaking $73,180 in contributions at the ANA House of Delegates in June. In late 2003, the PAC unveiled its "Give $20.04 for 2004" campaign and aims to fund as many nurse-friendly candidates for office in 2004 as possible.

Members of the ANA-PAC Board in 2003 included Greer Glazer, PhD, RN, CNP, FAAN, chair; Mary Foley, MS, RN, vice chair; JoAnne Penn, MA, RN,BC; Patricia Holloman, BSN, RN, CNOR; Mary Behrens RN, MSN, FNP-C; Linda Gobis, JD, RN, FNP; Alexia Green, PhD, RN, FAAN; Susan King, MS, RN; Rose Marie Martin, BSN, RN, OCN; Erin Murphy, BSN, RN; and Betty Smith-Campbell, PhD, RN, ARNP.

Believing that one path to addressing the nursing shortage is funding for nursing education, the ANA fought hard to increase appropriations for nursing education for fiscal year (FY) 2003. As a result, in February, Congress funded nurse education programs, including the "Nurse Education Act" and the "Nurse Reinvestment Act," at $113.5 million, an increase of 25 percent over the previous fiscal year. At the same time, the administration submitted its FY 2004 budget, which contained only $98.3 million in funding for nurse education programs. ANA immediately began educating members of Congress about the continuing need to invest in nursing and worked closely with Senators Barbara Mikulski (D-MD) and Susan Collins (R-ME) to garner support for its request for $175 million in funding. ANA also spearheaded an effort to rally other provider groups to support this increase and delivered a letter to House and Senate appropriators in May signed by ANA and nine other health care groups. In December, ANA

achieved victory when the House voted on an omnibus budget package for FY 2004, including $143 million for nurse education, $30 million more than the prior year and a 60 percent increase over FY 2002. The Senate passed the package in early January 2004.

In addition, as a result of ANA's collaborative efforts through its "Nationwide State Legislative Agenda," several states succeeded in securing funding for nurse education. These included Arkansas, Arizona, California, Colorado, Florida, Georgia, Hawaii, Iowa, Illinois, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Nebraska, Nevada, Oregon, Rhode Island, South Dakota, Texas, Virginia, West Virginia and Wyoming.

ANA President Barbara Blakeney told a House subcommittee in October that the nursing shortage will affect the ability of VA facilities to meet veterans' health care needs. UAN Vice President Ann Converso, RN, (right) who sits on the ANA Board of Directors, also testified.

Other Initiatives

- ANA continued to promote the Magnet™ Recognition Program as a tool for addressing the nursing shortage, because it encourages the development of and rewards hospital environments that retain nurses. ANA applauded the Institute of Medicine for highlighting the Magnet™ Program in its report on the link between the work environment and patient safety (see "Nurse Staffing"). At the end of 2003, close to 90 acute care hospitals have earned Magnet recognition.

- ANA fought efforts by non-nursing organizations to address the nursing shortage by calling for nurse immigration standards to be scaled back. Specifically, the ANA opposed the "Rural and Urban Health Care Act," introduced in the House in March, which would greatly expand the current H-1C temporary nurse visa and in the process, would remove many of the important safeguards that had originally been built into this visa program, including those that protect foreign nurses from exploitation by their sponsoring employers. ANA also expressed concerns about the ethical implications of the legislation, which could result in aggressive recruiting in developing nations. ANA alerted members of Congress to its concerns about the bill and called on Congress to address the problems behind the U.S. nursing shortage, particularly the health care industry's failure to maintain a work environment conducive to safe, quality nursing practice and the retention of experienced nurses.

- The nursing shortage is one of many nursing issues that continued to drive ANA's international activities in 2003. ANA continues to serve as the U.S. representative to the International Council of Nurses, which dealt with such issues as the nursing shortage, vulnerable and victimized populations and SARS in 2003. ANA President Barbara Blakeney also was appointed to the U.S. delegation attending the annual World Health Assembly in Geneva, Switzerland, in May and was appointed to serve on the Labor Advisory Committee for Trade Negotiations and Trade Policy.

- ANA continued its nurse recruitment efforts as part of the "Nurses for a Healthier Tomorrow" (www.nursesource.org) coalition, which developed a new campaign focused on nursing faculty recruitment in 2003. The theme for the campaign is: "Nursing education ... pass it on" to illustrate that through teaching, nurse educators are "passing on" the nursing education they've received as well as the practical experience they have gained in clinical work. In addition to print ads, posters and Web content will be developed to support the campaign.

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.

ANA Press Release October 23, 2002

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

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.

###

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.

SETTING THE STANDARD FOR

SAFE AND EFFECTIVE PATIENT CARE

IN NEW JERSEY

Health Professionals
and Allied Employees

HPAE/AFT/AFL-CIO

[redacted]

From: Charlie Franz [ccf@sphosp.com]
Sent: Tuesday, April 03, 2007 5:05 PM
To: Sen. Bettye Davis
Cc: Sen. Fred Dyson; Sen. Joe Thomas; Sen. John Cowdery; Sen. Kim Elton
Subject: Senate Bill 28: Nurse Mandatory Overtime

Dear Senator Davis & Committee Members:

I am writing as the CEO of South Peninsula Hospital to express my strong opposition to the provisions of Senate Bill 28. South Peninsula Hospital 22-bed community hospital with a 25-bed co-located nursing home. Our hospital has a negotiated labor agreement with Teamsters Local 940 that covers all members of the hospital's staff except managers and confidential employees. Our negotiated agreement details all aspects of our relationship with our nursing staff including the use of mandatory overtime.

The Union agreed to the inclusion of a provision for mandatory overtime in our labor agreement because as our partners in providing health care our staff recognizes that occasionally situations arise where mandatory overtime may be required to provide safe patient care. When such a need arises, there are provisions for how the overtime is assigned, paid and the maximum duration of the overtime. We use contract nursing staff in a few departments to augment the regular employees and it is a very rare occasion when we actually use mandatory overtime.

South Peninsula Hospital has worked diligently with other members of Alaska State Hospital & Nursing Home Association to reduce the nursing shortage in Alaska. We have contributed substantial resources over the last several years to help support an expanded nursing program at the University of Alaska. This program has doubled its annual out put of nurses.

The proponents of SB-28 have not presented evidence that hospitals or nursing homes are imposing any amount of unreasonable mandatory overtime on nursing staff. SB-28 is not needed; limits the ability of hospitals to negotiate labor contracts to manage the workforce and respond to the varying demands of patient care; imposes onerous and unnecessary financial penalties on hospitals that are already struggling to survive financially; and introduces legislation where good management practices are all that is needed.

Please vote against this unnecessary piece of legislation.

Charles Franz

Charles C. Franz, MSW, FACHE
Chief Executive Officer
South Peninsula Hospital
CCF@SPHOSP.com

[redacted]

From: Moe Chaudry [MChaudry@sitkahospital.org]
Sent: Tuesday, April 03, 2007 3:58 PM
To: Sen. Bettye Davis; Sen. Fred Dyson; Sen. Joe Thomas; Sen. John Cowdery; Sen. Kim Elton
Subject: SB 28 - Nurse Mandatory Overtime Bill

TRANSMITTED VIA ELECTRONIC MAIL

April 3, 2007

Senator Bettye Davis, – Chair
Senate HES Committee

Senator John Cowdery
Senator Fred Dyson
Senator Kim Elton
Senator Joe Thomas

Re: Senate Bill 28: Nurse Mandatory Overtime

Dear Senator Davis & Committee Members:

I am writing this letter as the CEO of Sitka Community Hospital, in opposing the imposition of mandatory overtime on nursing staff under Senate Bill 28. Sitka Community Hospital is 12-bed critical access hospital with a 15-bed co-located nursing home. Our hospital, along with other hospitals in Alaska, do not use mandatory overtime as a tool to address nursing shortages or nursing gaps

When nursing shortages exist, we purchases temporary nursing services to supplement staff nursing hours rather than imposing mandatory overtime. This practice has avoided the need to rely on mandatory overtime to fill gaps in nursing staff schedules. SB-28 legislation is not needed and would place Sitka Community Hospital in an unfair position when negotiating work hour agreements with our nursing staff.

Sitka Community Hospital, along with other members of Alaska State Hospital & Nursing Home Association have worked hard 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.

In my humble opinion, proponents of SB-28 have not presented any evidence that hospitals/nursing homes are imposing mandatory overtime on nursing staff. I believe SB-28 is an unneeded legislation. I urge you not to move this bill forward from this Committee.

Sincerely,

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB028-DOA-DOP-4-2-07
Bill Version: SB028
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: Limit Overtime for Registered Nurses
RDU: Central Administrative Services
Component: Personnel
Sponsor: Senator Davis
Requester: (S) Health, Education & Social Services
Component No.: 56

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	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
Contractual	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
Equipment	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
Grants & Claims	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
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	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
1004 GF	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
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (Specify Type--Do not abbreviate)	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**

Estimate of any current year (FY2007) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

SB 28 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: Dianne Kiesel
Phone: 465-4429
Division: Division of Personnel & Labor Relations
Date/Time: 4/2/07 7:00pm
Approved by: Kevin Brooks, Deputy Commissioner
Date: 4/2/07 7:30pm
Agency: Department of Administration

Banner Health
Denali Center
Fairbanks Memorial Hospital

1650 Cowles Street
Fairbanks, AK 99701
Phone 907-452-8181
Fax 907-458-5324
www.fmhdc.com

April 2, 2007

Senator Joe Thomas
State Capitol
Juneau, AK 99801

RE: SB28

Senator Thomas:

Thank you for representing the Interior in the Senate. We appreciate your leadership and commitment and look forward to working with you in the years to come. I may not be able to testify in person so I am sending my comments to you in writing. Although I can see that the intent of this legislation is to protect nurses and patients, and I appreciate the attention of our Senators to these important healthcare issues, I must respectfully testify against SB28 as unnecessary legislation. I would like to raise several points herein for your consideration.

I believe that any real concerns that SB28 attempts to address are covered adequately by other laws, regulations, and professional standards. There are already appropriate protections in place for both healthcare workers and for patient safety, including OSHA, Fair Labor Standards Act, and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

JCAHO standards require that hospitals monitor staffing effectiveness. Fairbanks Memorial Hospital does so by tracking staff overtime and other staffing measures in relation to any clinical errors and other patient safety measures. We practice evidence based medicine in the nursing profession, which means we endeavor to use proven "best practices" from around the nation in our care and our staffing models.

Also, I think there are details in the proposed legislation which make it unfavorable to nurses working in an acute care environment. Our organization has flexible scheduling options to include numerous shift choices for full time and part time nurses. Many nurses prefer to work 12 hour shifts with the typical schedule being 7:00a – 7:30p for example. A full time nurse would typically work 3 of these shifts in a week. They prefer to have their days scheduled back to back (i.e.: Mon, Tues, Wed) allowing them to group their days off together. The proposed language requiring 12 hours between shifts would significantly limit this possibility and be a disservice to nurses.

Banner Health
Denali Center
Fairbanks Memorial Hospital

1650 Cowles Street
Fairbanks, AK 99701
Phone 907-452-8181
Fax 907-458-5324
www.fmhdc.com

We have policies and practices in place to address the situations we believe this legislation targets. Our hospital does not have mandatory overtime, except for true emergencies as described in the proposed legislation.

Lastly, we believe that these issues should not be legislated but left to the hospitals and nurses to address through Shared Decision Making processes or good faith bargaining. This has proved successful in our facility as we share a common vision of a safe environment for the patient and appropriate work-life balance for the professional nurse.

Again, we respect your efforts to further these admirable objectives but respectfully recommend that this SB28 is not necessary or desired.

Sincerely,

Jim L. Lynch
Director of Human Resources
Fairbanks Memorial Hospital
907-458-5575

cc: Senator Bettye Davis

Appendix

A Summary of Recent Research Supporting the Need for Staffing Ratios and Workload Limitations in Healthcare.
AFT Healthcare, March 2003

Effect of nurse staffing on mortality rates and other patient outcomes.

- After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7% increase in the likelihood of patients dying within 30 days of admission and a 7% increase in failure to rescue. (Aiken, Linda et. al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," Journal of the American Medical Association, Vol. 288, No. 16, October 23/30, 2002, pps. 1987-1993.)

- A study of medication errors in two hospitals over a 6-month period found that nurses were responsible for intercepting 86 percent of all medication errors made by physicians, pharmacists and others involved in providing medications for patients before the error reached the patient. (Leape, L. et. al, "Systems analysis of adverse drug events." Journal of the American Medical Association 274 (1): 35-43)

- Nurse staffing is a predictor of risk-adjusted mortality. In studying 2190 hospitals, it was found that 10.7% of the variance in patient mortality was explained by nurse staffing ratios. ("A Matter of Life and Death," Modern Healthcare, Special Supplement, September 30, 2002, pps. 16-20.)

- Nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors. (Joint Commission for the Accreditation of Healthcare Organizations, 2002.)

- Study found a ten percent increase in the proportion of RNs as a percentage of total hospital staff was associated with five fewer patient deaths for every 1000 discharged patients. (Tourangeau, Ann E., et. al., Nursing-Related Determinants of 30-day Mortality for Hospitalized Patients, Canadian Journal of Nursing Research, 2002, vol. 33., No. 4, 71-88.)

- Seventy percent of radiology techs, seventy-nine percent of respiratory therapists and seventy-one percent of certified nurse assistants say that the quality of patient care is suffering because of increased workloads or poor staffing in their professions. (National Survey. Peter D. Hart Research Associates, April 2002)

- In a study of data from eleven states, higher nurse staffing levels were related to lower instances of urinary track infections, pneumonia, upper gastrointestinal bleeding and shock in medical patients and lower rates of "failure to rescue" in major surgery patients. (Needleman, J.; Buerhaus, P.; Mattke, S; Stewart, S.; and Zelevinsky, K. Nurse Staffing and Patient Outcomes in Hospitals. U.S. Department of Health and Human Services: February 2001.)

- Higher nurse:patient ratios were strongly associated with lower mortality rates in dedicated AIDs units. Patient satisfaction was strongly associated with organizational control of care by bedside nurses. (Aiken, L.H.; Sloane, D.G.;Lake E.T.; Sochalski, J.; and Weber A.L. Organization and outcomes of inpatient AIDS care. Medical Care, 37(3): 760-772, 1999.)

- More nursing hours and higher skill mix are related to lower rate of pressure ulcers, pneumonia and urinary tract infections. (Lichtig, L.K.; Knauf, R.A.; and Milholland, K. Some impacts of nursing on acute care hospital outcomes. J of Nursing Admin, 29(2): 25-33, 1999.)

- Mortality rates decrease as staffing levels per occupied bed increase for registered nurses, medical residents, registered pharmacists, medical technologists and total hospital personnel. (Bond, C.A., et al. Health care professional staffing, hospital characteristics and hospital mortality rates. Pharmacotherapy, 19(2), 1999.)

- The higher the percentage of RNs, the more satisfied patients were with nursing care, pain management, education and overall care. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)

- An ICU nurse:patient ratio of less than 1:2 during evenings was associated with increased length of stay in the hospital. An ICU nurse:patient ratio of less than 1:2 during the day was associated with increased number of days in the ICU. (Pronovost, P.J. et.al. Organizational characteristics of intensive care units related to outcomes of abdominal aortic surgery. Journal of the American Medical Association, 281(14), 1999.)

- The more FTE RNs per adjusted patient day, the smaller the incidence of urinary tract infections and pneumonia after major surgery. A significant relationship was also found between FTE RNs and thrombosis and pulmonary compromise after major surgery. (Kovner, C. and Gergen, P.J. Nurse staffing levels and adverse events following surgery in U.S. hospitals. Image: J of Nursing Scholarship, 30(4), 1998)

- The higher the RN skill mix (up to 87.5% RNs) the lower the incidence of adverse occurrences (medical errors, patient falls, skin breakdown, patient and family complaints, respiratory and urinary tract infections, and deaths.) (Blegen M.A.; Goode, C.J.; and Reed, L. Nurse staffing and patient outcomes. Nursing Research, 47(1): 4350, 1998. Also: Blegen M.A. and Vaughn, T. A multisite study of nurse staffing and patient occurrences. Nursing Economics, 16(4): 96, 1998.)

- In a study of data from three states (NY, CA and MA), researchers found that as RN staffing increased, the number of patients suffering from pressure ulcers decreased. A higher proportion of RNs was also significantly associated with lower length of stay. (American Nurses Association. Implementing Nursing's Report Card: A Study of RN Staffing, Length of Stay and Patient Outcomes. Washington, DC: American Nurses Publishing. 1997)

- Increasing patient census and decreasing nursing hours per patient day are strongly correlated with increased nosocomial infection rates. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-8, 1997.)

- Hospitals with higher RN:patient ratios and a higher percentage of RNs had lower than predicted patient mortality rates. (Aiken, L.; Smith H.; and Lake, E.T. Lower Medicare mortality among a set of hospitals known for good nursing care. Medical Care, 32(8): 771-787, 1994.)

- Hospitals with a higher proportion of RNs had lower severity-adjusted mortality rates. (Krakauer H.; Bailey R.C.; Skellan, K.J.; Steward J.D.; Harts A.J.; Kuhn, E.M.; and Rimm, A.A. Evaluation of the HCFA model for the analysis of mortality following hospitalization. Health Serv Res, 27(3): 317-35, 1992.)

- The percentage of RNs per adjusted admissions was a significant predictor of lower mortality. (Manheim, Larry M. et. al. Regional Variations in Medicare Hospital Mortality. Inquiry 29:55-66, Spring, 1992)

- Patients on units where staffing fell below computed requirements had higher incidences of clinical complications (infections, gastrointestinal, neurologic) (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998. Also: Behner, K.G.; Fogg, L.; Frankenbach, J. and Roberston, S. Nursing resource management: Analyzing the relationship between costs and quality in staffing decisions. Health Care Management Review, 15 (4): 63-71, 1990.)

- Hospitals with a higher percentage of RNs and hospitals with a higher staffing level (measured by nurse-to-patient ratio), had lower adjusted mortality rates. (Hartz, A.J.; Krakauer, H.; Kuhn, E.M.; Young, M.; Jacobsen, S.J.; Gay, G.; Muenz, L.; Katzoff, M.; Bailey, R.C.; and Rimm, A.A. Hospital characteristics and mortality rates. New England Journal of Medicine, (321): 1720-25, 1989.)

- Hospitals with better-than-predicted death rates demonstrated respect for nursing judgment wherein it was a routine policy for the unit charge nurse to cancel major elective surgery if nursing staff was inadequate. (Knaus, W. et. al., An Evaluation of Outcome from Intensive Care Units in Major Medical Centers., Canadian Critical Care Nursing Journal, June/July, 1987.)

Working conditions affect patient care.

- ICU mortality rates were highest when the ICU staff was "overworked" as defined by the level of occupancy in the ICU and the average number of nurses per occupied bed. The mortality rate was significantly lower in patients who were treated during times of moderate workload. (Tarnow-Mordi, W.O.; Hau, C.; Warden, A.; and Shearer, A.J. Hospital mortality in relation to staff workload: A 4-year study in an adult intensive care unit. The Lancet, 356(9225): 185, 2000.)

- Higher rates of patient falls occurred when nurses reported more stress and more absenteeism. (Dugan, J.; Lauer, E.; Bouquot, Z.; Dutro, B.K.; Smith, M.; and Widmeyer G. Stressful nurses: The effect on patient outcomes. J Nurs Care Quality, 10(3): 46-58, 1996.)

- The less satisfied nurses were with the time they had to do their work, the more likely a patient was to develop a nosocomial infection. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)

- Admission during a period with a lower regular nurse-to-patient ratio and a higher pool nurse to patient ratio was associated with increased risk for bloodstream infection. (Robert, J.; Fridkin, S.K.; Blumberg, H.M.; Anderson, B.; White, N.; Ray, S.F.; Chan J.; and Jarvis, W.R. The influence of the composition of the nursing staff on primary bloodstream infection rates in a surgical intensive care units. Infection Control and Hospital Epidemiology, (21): 12-17, 2000.)

Improving patient outcomes by staffing correctly leads to lower costs.

- Statistical model shows that when nursing units are understaffed the additional costs associated with patients who develop complications are greater than the labor savings due to understaffing. (Behner, K.G.; Fogg, L.F; Fournier, L.C.; Frankenbach, J.T.; and Robertson, S.B. Nursing resource management: Analyzing the relationship between between costs and quality in staffing Decisions. Health Care Manag Rev, 15(4): 63-71, 1990.)

- While immediate personnel costs are less with short staffing, long term costs were higher because patients with complications often stay longer in the hospital and require other expensive treatments. (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998.)

- Institutions attempting to decrease costs through health care worker reductions may, in the final analysis, incur higher costs as a result of higher rates of nosocomial infection, longer hospital stays and use of expensive antimicrobials and increased mortality. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-48, 1997.)

Staffing ratios and workload limitations help recruit and retain registered nurses and other health professionals.

- Applications for registered nurse licenses in the state of California increased over 60% in the three years after passage of the nurse-patient ratio law. (Sacramento Business Journal, 1/19/04)

- Hi-Desert Hospital in Joshua Tree, CA went from fifty percent vacancy rate in its nursing staff to one percent vacancy rate six months after establishing ratios of 1:4 on day shift and 1:5 on second shift. ("A Favorable RN-to-Patient Staffing Ratio is an Effective Recruitment Tool," Patient Care Staffing Report, October, 2001.)

- Each additional patient per nurse (above 4) is associated with a twenty-three percent increase in the odds of nurse burnout and a fifteen percent increase in the odds of job dissatisfaction. (Aiken, Linda, et. Al. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction." Journal of the American Medical Association, October 23/30, 2002)

- Ninety-one percent of certified nurse assistants, seventy-eight percent of respiratory therapists and sixty-eight percent of radiology techs say that improving staffing ratios would help recruit and retain members of their profession. (Peter D. Hart Research Associates, April, 2002)

- In a national survey of nurses, eighty-three percent of respondents said that improving staffing ratios would "very effective" in improving job satisfaction, recruiting and retaining quality nurses. (Peter D. Hart Research Associates, March, 2001)

ASHNHA Position on Senate Bill 28 - April 3, 2007
Prepared by: Rod Betit, President/CEO

WHO DOES ASHNHA REPRESENT?

The *Alaska State Hospital and Nursing Home Association* represents 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 nursing facilities. Nine of our 24 acute care hospitals also include nursing home beds. 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. ASHNHA's membership evaluates health care legislation weekly and has authorized the position expressed here.

ASHNHA's POSITION ON SB28: OPPOSED TO SB 28

While ASHNHA's membership has always appreciated Senator Davis' important work on health care legislation, the overwhelming response by ASHNHA membership to SB 28 is that this legislation is unnecessary and would place facility management in an unfair position when negotiating work hour agreements with their nursing staff. ASHNHA's members rarely use mandatory overtime to address nursing shortages. Rather, nursing shortages are managed through use of voluntary overtime and hire of temporary nursing staff. Patient safety is always foremost in ASHNHA's members' minds, and CEOs would not allow use of nurse staffing practices that would jeopardize patient care or would place nurses in working conditions that would put them in untenable situations.

SUPPORTING TESTIMONY:

➲ The attached chart compares 2004 and 2005 overtime usage in some of ASHNHA's facilities. With the exception of API, ASHNHA's members do not use mandatory overtime to fill their nursing gaps. With respect to API, the 2006 Legislature provided additional funding to improve starting salary levels to allow API to reduce mandatory overtime usage in the future.

➲ In all facilities except API, when nursing shortages exist facility management uses a combination of voluntary overtime and temporary nursing staff rather than imposing mandatory overtime (see 'pink' columns on attached chart). This practice nas avoided the need to rely on mandatory overtime to fill gaps in nursing staff schedules except in rare situations.

➲ In addition, 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.

➲ Proponents of SB28 have not presented any evidence that facilities are imposing mandatory overtime on nursing staff. Nor have complaints of unsafe patient care been filed with the Alaska Department of Health & Social Services licensing section asserting that facilities have improperly used nursing staff.

➲ Passage of SB 28 would adversely impact delivery of patient care in several important ways including:

1. "Sec. 18.20.400(a) Limitations on nursing overtime" would place the decision to accept overtime assignments in the hands of the nurse rather than with management. Generally, collective bargaining agreements give management the right to prescribe reasonable work rules, develop qualifications for all new and existing positions,

establish work schedules, assign work and work times, create, eliminate or modify positions, and establish and/or modify locations and standards of work. SB 28 would place management in an unfair position when negotiating work hour agreements acceptable to all parties, and could potentially affect the facility's ability to provide safe patient care by placing staffing decisions with the judgment of the nurse versus maintaining these as management rights and responsibilities.

2. "Sec. 18.20.400(d) would define an 'unforeseen emergency' to exclude all 'foreseeable' events. This is a vague standard that cannot be reasonably applied given the variety of staffing challenges that arise in a facility on any given day. While facilities are generally able to fill these staffing gaps using voluntary overtime and temporary nursing staff, there may occasionally be a need for some mandatory overtime to meet patient care needs. Management should have the discretion to exercise that option within the scope of the bargaining agreement negotiated for that facility.
3. "Sec 18.20.430. Report Requirements" would impose a whole new set of onerous reporting requirements for 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 hired during the reporting period. The time needed to compile these reports would be significant and simply not justified given the responsible manner in which Alaska's facilities have handled the use of mandatory overtime.

➲ In summary, SB 28 is unnecessary legislation. SB 28 would limit the ability of facilities to negotiate labor contracts to manage the workforce and 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; imposes onerous reporting requirements around the use of overtime; and introduces legislation where good management practices are all that is needed.

➲ ASHNHA's membership respectfully requests that you not move SB 28 forward from this Committee.

Thank you for the opportunity to testify and express ASHNHA's members concerns around this legislation.

This Testimony is on Behalf of the Following Alaska Health Care Facilities
Alaska Regional Hospital, Alaska Native Medical Center, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Acute Care Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, North Star Behavioral Health, and Wildflower Court Nursing Home.

ASHNHA 2004 and 2005 NURSE OVERTIME SURVEY RESULTS - 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		[redacted]		# of OT grievances filed
					2004	2005	2004	2005	Require	# times /month	[redacted]	[redacted]	
Alaska Regional Hospital	No	Yes	Worse	8,10,12	4 to 6%	4 to 6%	NONE	NONE	Certain Units	varies	[redacted]	[redacted]	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	[redacted]	[redacted]	unknown
Alaska Psychiatric Institute	No	Yes	Worse	8,10,12	20%	30%	unknown	46 hrs.	No	NONE	[redacted]	[redacted]	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	[redacted]	NONE
Cordova Community Medical Center	[redacted]	No	No Chg.	12	10%	20%	NONE	NONE	Certain Units	varies	1672 hrs	[redacted]	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	6144 hrs	[redacted]	NONE
Heritage Place Nursing Home	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Kanakanak General Hospital	[redacted]	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	[redacted]	[redacted]	NONE
Maniilaq Health Center	[redacted]	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	[redacted]	NONE
Mat-Su Regional Medical Center	No	No	No Chg.	8 & 12	10%	12%	unknown	unknown	Certain Units	7 X	[redacted]	[redacted]	NONE
Mt. Edgecumbe SEARHC Hospital	No	No	Worse	8, 10, 12	15%	15%	NONE	NONE	Certain Units	8 X	[redacted]	[redacted]	NONE
North Star Behavioral Health System	No	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Norton Sound Regional Hospital	[redacted]	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Petersburg Medical Center	[redacted]	No	Worse	8 & 10	5%	5%	unknown	NONE	Yes	4 X	NONE	[redacted]	NONE
Providence Alaska Medical Center	No	Yes	Worse	8, 10, 12	4.36%	4.76%	NONE	NONE	Certain Units	NA	NONE	[redacted]	NONE
Providence Extended Care Center	No	No	Worse	8, 10, 12	20.83%	20.75%	NONE	NONE	No	NONE	NONE	[redacted]	NONE
Providence Kodiak Island Medical Center	[redacted]	Yes	No Chg.	12	10%	10%	NONE	NONE	Certain Units	NA	unknown	[redacted]	NONE
Providence Seward Medical & Care Center	[redacted]	No	No Chg.	8 & 12	unknown	5%	NONE	NONE	Yes	3 X	NONE	[redacted]	NONE
Providence Valdez Medical Center	[redacted]	REPORT NOT RECEIVED IN TIME TO INCLUDE IN THIS ANALYSIS											
Sitka Community Hospital	[redacted]	No	No Chg.	12	20%	20%	NONE	NONE	Certain Units	varies	5847 hrs	[redacted]	NONE
South Peninsula Hospital	No	Yes	No Chg.	8,10,12	6%	3%	NONE	NONE	Certain Units	15 X	144 hrs	[redacted]	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	[redacted]	NONE
Wrangell Medical Center	[redacted]	No	No Chg.	8 & 12	0%	0%	unknown	NONE	Yes	55 hrs	NONE	[redacted]	NONE
Yukon Kuskokwim Delta Regional Hospital	No	No	Better	8 & 10	40%	28%	NONE	NONE	Certain Units	NONE	34000 hrs	[redacted]	NONE
TOTAL Temporary Nursing Hours Purchased by Non-exempt Facilities											104391 hrs	[redacted]	$24.17

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB28-COM-OL-04-04-07
Bill Version: SB 28
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Limit Overtime For Registered Nurses
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Davis
Requester: Senate HES
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
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**
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						
1156 Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2007) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

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: Chris Wyatt, Administrative Manager
Phone (907) 465-2572
Division: Corporations, Business, and Professional Licensing
Date/Time 4/4/07 10:11 AM
Approved by: Emil Notti, Commissioner
Date 4/4/2007
Agency: Commerce, Community, and Economic Development

(Revised 9/18/2006 OMB)

AaNA
Alaska
Nurses
Association

Dangers of Mandatory Overtime: **FATIGUE and ERRORS**

Or why you should support Senate Bill 28
(Often referred to as the
Alaska Safe Nursing and Patient Care Act)

AaNA
Alaska
Nurses
Association

Danger – Might As Well Of Had a Drink!

The long hours worked by some nurses pose some of the most serious threats to patient safety. Prolonged periods of wakefulness can produce effects that are similar to the effects produced by alcohol intoxication. This may include decreases in reaction time and the speed of mental processes.

Danger – Close to Intoxication

Periods of wakefulness in excess of 16 hours can produce performance decrements equivalent to a blood alcohol concentration (BAC) level of .05 percent. Alcohol intoxication is defined as .05 percent BAC in several western industrialized nations although the level in the U.S. varies from .08 to .10 among the states.

Danger – Patient Safety at Risk

The Report also found the following:

The impact of hours worked, duration of work, and overtime in this study were shown to have a statistically significant impact on patient safety.

AaNA
Alaska Nurses Association

Danger –

likely to make at least one error

"The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more...." and "working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled."

AaNA
Alaska Nurses Association

Source

Michigan Nurses Association Public Policy Associates, Incorporated –

The Costs of Mandatory Overtime for Nurses,

August 2004

AaNA
Alaska
Nurses
Association

Danger – Nosocomial Infections!

Threats to patient safety that are likely to result from extensive nursing overtime include the following:

- **Nurses being less alert to changes in patients'condition**
- **Nurses having slower reactions**
- **Medication errors – adverse drug events**
- **Increase in nosocomial infections**
- **Increase in decubiti**

AaNA
Alaska
Nurses
Association

Link Found

The authors of this study conclude that these findings imply a link between poor working conditions (long hours and overtime, mandatory or otherwise) and patient safety. In response to this and other admonitions concerning the elimination of mandatory overtime for nurses, almost half of the states in the nation have either enacted or introduced legislation concerning this issue.

Not A "Bargaining Issue"! This is a Public Safety Issue

The Alaska public has a right to expect when they walk into a healthcare facility, that the nurse taking care of them is properly rested and alert.

(And that their RN hasn't been working 16 hours that day already.)

Not A "Bargaining Issue"! This is a Public Safety Issue

At registration, a member of the public should not have to request a copy of the most recent Collective Bargaining Agreement to see how successful their nursing staff has been in negotiating reasonable working conditions.

AaNA
Alaska
Nurses
Association

Washington State Passes Law in 2002

Anne Piazza, lobbyist for WSNA testified before Representative Peggy Wilson's special House HESS committee in January 2006:

"The State of Washington passed a law to prohibit mandatory overtime for nurses with the cooperation of the WSNA, other nursing unions, and the Washington Hospital Association."

AaNA
Alaska
Nurses
Association

Washington State

The goal of this legislation is first, and foremost, to protect the safety and quality of patient care.

Washington State

Mandatory overtime puts patients, nurses and the profession at risk. Many health care facilities have turned to the use of mandatory overtime as a common practice to fill longstanding staffing and scheduling problems.

Shifting the entire burden to employees when there is a labor shortage is not the answer to attracting qualified persons to the profession.

Washington State

One of the reasons that the nursing shortage as it exists today is because qualified nurses are not working in the field or leaving the profession because they can no longer work the long hours or safely taken care of their patients. Forced overtime is adding to that shortage.

AaNA
Alaska
Nurses
Association

Washington State

Since 2002, the Washington state nurses have seen a reduction in forced overtime. They are not aware of any hardship suffered by hospitals in complying with the law....

Anne Piazza

AaNA
Alaska
Nurses
Association

Institute of Medicine Report

The Institute of Medicine estimates between 44,000 to 98,000 hospital deaths can be attributed to medical errors each year. Mandatory overtime is a serious contributing factor to medical errors. The final recommendation of the IOM is that all overtime, voluntary and mandatory/ involuntary done by nurses should be curtailed.

AaNA
Alaska Nurses Association

Massachusetts Study

Research from the University of Massachusetts shows a strong link between working overtime and sustaining a work-related injury. This was found to be true for all occupations… working longer hours (12 hours a day or more) was associated with a 37 percent increase in risk.

(Chantal Britt, Bloomberg, "Overtime, Long Houses Increase Illness, Injury Risk, Study Shows," August 22, 2006.)

AaNA
Alaska Nurses Association

States Which Ban or Limit Forced Overtime

California
Connecticut
Maine
Maryland
Minnesota
New Jersey
Oregon
Texas
Washington
West Virginia
Illinois

California

Regulations adopted in California 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.

Connecticut

Connecticut enacted legislation banning a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances such as participating in a surgical procedure until the procedure is completed, public health emergency, etc.

Maine

Legislation enacted in 2001 in **Maine** 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.

Maryland

Maryland lawmakers ruled in 2002 that an employer may not require a nurse to work more than the regularly scheduled hours according the predetermined work schedule.

Minnesota

in 2002, a **Minnesota** law was implemented prohibiting action against a nurse who refuses mandatory overtime because it would jeopardize patient safety.

New Jersey

New Jersey enacted legislation to prevent a health care facility from requiring an employee to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, not to exceed 40 hours per week.

Oregon

In 2005, Oregon's mandatory overtime law, originally enacted in 2001, was amended to prohibit a hospital from requiring a nurse to work more than 48 hours in a week or more than 12 consecutive hours in a 24-hour period.

Texas

Texas regulations passed in 2002 require hospitals to develop policy and procedures for mandatory overtime.

Washington

Washington State'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.

West Virginia

In 2004, **West Virginia** enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime.

AaNA Alaska Nurses Association

Illinois

Passed in 2005, **Illinois legislation** allows hospitals to mandate a nurse to work overtime only in unforeseen emergent circumstances.

AaNA Alaska Nurses Association

Additional States Lining Up

There is legislation banning the use of mandatory overtime pending in the following states:

Alaska	**Florida**	**Georgia**
Hawaii	**Iowa**	**Michigan**
Missouri	**New York**	**Ohio**
Pennsylvania	**Rhode Island**	**Tennessee**
Vermont	**Nevada**	**Massachusetts**

AaNA
Alaska
Nurses
Association

Support Alaska Senate Bill 28

Your nurse will always be there for you in time of an unforeseen emergency situation, disease outbreak, natural or man-made disaster.

Your nurse will be able to voluntarily work overtime so long as the work is consistence with professional standards of safe patient care and does not exceed 14 consecutive hours.

AaNA
Alaska
Nurses
Association

Support Alaska Senate Bill 28

But with SB 28, a nurse will be able to say, "Stop, I can't do this anymore tonight." That same nurse could say, "I have worked my shift; I'm tired; and possibly I'm not as swift as I would otherwise be if I had some rest. My patients could possibly be at risk if I push on any longer."

Knowing his or her own limits, the nurse can refused to be assigned the forced overtime in the first place. Our nurse would now be able to do this without fear of reprisal or loss of job.

AaNA
Alaska
Nurses
Association

We Urge Your Support for SB28

It's common sense

It will protect the individual patient

It will protect the Registered Nurse

It will even protect the healthcare facility

It will enhance the nursing profession

It will help recruit nurses

It will help retain nurses

It's good public policy

Thank you.

AaNA
Alaska
Nurses
Association

3701 E. Tudor Rd., Suite 208, Anchorage, AK 99507

Power Point Presentation prepared by
Dianne O'Connell, M.Div.
Executive Director

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."

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 concerning working hours for nurses:

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) (see below):

Exceptions to subsection (a):

(1) **"a nurse voluntarily working overtime on an aircraft in use for medical transport . . . ."**
(2) **"a nurse on duty in overtime status because of an unforeseen emergency situation that could otherwise jeopardize patient safety . . . ."**
(3) **"a nurse fulfilling on-call time that is agreed upon by the nurse and a health care facility before it is scheduled;**
(4) **a nurse voluntarily working overtime so long as the work is consistent with professional standards and safe patient care and doe not exceed 14 consecutive hours;**
(5) **a nurse voluntarily working beyond 80 hours in a 14-day period so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care;**
(6) **the first hour on overtime status when the health care facility is obtaining another nurse to work in place of the nurse in overtime status."**

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.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note: **SB28-DOLWD-WH-03-30-07**
Bill Version: **SB 28**
() Publish Date:

Revision Date/Time (Note if correction):
Title: **Limit Overtime for Registered Nurses**

Department: **Labor and Workforce Development**
RDU: **Labor Standards and Safety**
Component: **Wage and Hour**

Sponsor: **Senator Davis**
Requester: **Senate HES**

Component Number: **345**

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	68.2	68.2	68.2	68.2	68.2	68.2
Travel	3.0	3.0	3.0	3.0	3.0	3.0
Contractual	8.9	8.9	8.9	8.9	8.9	8.9
Supplies	3.8	0.5	0.5	1.8	0.5	0.5
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**83.9**	**80.6**	**80.6**	**81.9**	**80.6**	**80.6**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	83.9	80.6	80.6	81.9	80.6	80.6
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**83.9**	**80.6**	**80.6**	**81.9**	**80.6**	**80.6**

Estimate of any current year (FY2007) cost: None
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

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 overtime worked by registered nurses. There are currently approximately 5,000 registered nurses working in Alaska and this is projected to be a rapidly growing occupation. The anticipated workload will require a full-time Wage & Hour Investigator I position funded with General Funds. Costs include $68.2 for salary and benefits and $15.7 in various associated position costs including $3.3 of one-time position costs for basic office equipment.

Prepared by: **Grey Mitchell, Director** Phone: **465-4855**
Division: **Labor Standards & Safety** Date/Time: **3/30/07 2:34 PM**
Approved by: **Click Bishop, Commissioner** Date: **3/30/2007**
Agency: **Department of Labor and Workforce Development**

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."

Additional facts and justification for SB 28

I. Unregulated mandatory overtime leads to insidious and pervasive harm to nurses, patients, the profession, and health care facilities.

- Mandatory overtime hours are compulsory (as opposed to voluntary) and above an agreed upon, predetermined, regularly scheduled shift. Many nurses are told they are expected to "voluntarily" work a number of overtime shifts due to a shortage of nurses in a particular shift, discipline, or facility, such as emergency room, surgery, or mental health shifts in private or state institutions.
- Many nurses fear reprisals if they do not consent, accede, or acquiesce to work overtime shifts when they are exhausted or planning time off for their families or their own wellbeing. The threat of reprisals may not be overt or express, and includes but is not limited to assignment to unattractive tasks or work shifts, poor performance evaluations, denial of salary increases or promotion, discipline, or demotion, or discharge. In extreme cases, reprisals can include retaliatory reporting to the nursing board, licensure suspension or revocation actions, and charges of "patient abandonment."
- Many registered nurses are leaving the profession because of workplace stress, long work hours, and mandatory overtime.
- Fewer women, the traditional care givers, are choosing nursing as a career, since opportunities have opened up in many other less demanding professions.
- The Institute of Medicine and National Council of State Boards of Nursing estimated in 1999 that 1 million medical errors per year resulted in 44,000-120,000 fatalities, costing $69 billion, or $575,000 per death, and sleep deprivation and fatigue contributed significantly to the risk of human errors. According to the National Institute for Occupational Safety and Health, when staff plan to work additional shifts on a voluntary basis, they are more likely to be prepared and to get plenty of rest immediately prior to working extended shifts. However, when an employer requires mandatory overtime, this usually occurs with little or no prior notice. The results often are high levels of fatigue and increased errors. These errors can result in life-threatening situations for both

the patient and the nurse, including back injuries for the nurse, patient medication errors, and even death. At the same time, health care facilities and nurses are subjected to increased liability.

II. The nursing shortage increases mandatory overtime which often can be used as a routine staffing tool to limit needed new hires.

- There is a shortage of 430,000 nurses nationwide and this number is expected to increase to over 1 million sometime after 2010 due to increasing retirements and departures of an aging nursing population (average age 43) and fewer replacements.
- Greatest nursing shortages in Alaska are found in state institutions which usually do not have pay rates competitive with private health care facilities. State nursing pay increases of 15% in July, 2006 reportedly still do not match pay rates in private health care facilities.
- While some large private health care facilities can afford to pay premium rates to hire all the permanent full-time and temporary "traveling nurses" positions they need, they still use mandatory overtime as a "staffing tool" to limit placing more nurses on the payroll. It is less costly to pay mandatory overtime than to hire permanent employees with contractual rights and benefits. State institutions, on the other hand, often cannot attract enough qualified nurses due to lower pay.
- The physician shortage in Alaska also exacerbates the nurses' mandatory overtime problem, because nurses are under more pressure to work longer hours and shoulder more responsibility when physicians are not available.

III. Compensation of "time and one-half" is no long a deterrent to employers' use of mandatory overtime hour, nor is it a great incentive to employees who are constantly fatigued by the extra work hours.

- Public policy dictates that the legislature must protect registered and licensed practical nurses and their patients from work abuses in a health care system which can easily subsume their individual wellbeing into corporate and bureaucratic strictures. Some overtime may always be necessary, but when it becomes a pattern or planned mandatory practice, it defeats the purpose of the Fair Labor Standards Act (FLSA) of 1938. The main objective of the act was to eliminate "*labor conditions detrimental to the maintenance of the minimum standards of living necessary for health, efficiency and well-being of workers.*"
- The FLSA was made applicable to hospitals, nursing homes, or other residential care facilities in the 1961 amendment determining "enterprise coverage." The FLSA created a monetary penalty, *i.e.*, time and one-half for overtime, directed against employers who did not spread their existing work among a greater number of employees. State law covers the same workers as regards overtime. The FLSA was premised on the economic theory that if overtime became too expensive, it would force employers to hire more people instead of working the few to exhaustion.
- Now 70 years after enactment, the FLSA operates in a larger, stronger, and more diverse economy with other pressures on business besides capital and labor. Thus, the monetary penalty of time and one-half for overtime hours is no longer a major deterrent to employer abuse of mandatory overtime hours for nurses.
- Nurses, on the other hand, can only offer or withhold their labor in controlling their working conditions and quality of life. Working mandatory or voluntary overtime hours for extra pay has decreasing appeal to nurses who regularly must work extended overtime shifts. At some point, enough is enough. The fatigue and lack of personal or family time becomes increasingly onerous, while the safety and care of patients declines.

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.

Alaska Nurses Association

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.

---

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

Why do nurses care so much about the issue of mandatory overtime?

Mandatory overtime contributes to poor quality patient care because fatigue and loss of concentration ability, which results from excessive overtime, increases the likelihood of errors. According to a study by the National Institute for Occupational Safety and Health (NIOSH), when staff plan to work additional shifts on a volunteer basis, they are more likely to be prepared and get plenty of rest immediately prior to working the extended shift. However, when overtime is mandated by an employer, this occurs with little or no prior notice. The result is high levels of fatigue and thus increased errors. 2

Why Should We Worry About Mandatory Overtime for Nurses? Patient Safety...

For nurses, these errors or mistakes may cause life threatening situations for both patient and the nurse (from back injuries to med errors to client deaths). With these mistakes and errors, there is also the chance of law suits with loss of licenses and increases in malpractice insurance rates. The evidence is very strong that prolonged work hours and fatigue affect worker performance. The Agency for Healthcare Research and Quality (AHRQ), a division of U.S. Department of Health and Human Services was authorized to contract with the IOM to study nurse work hours and health care errors. 3

The study and subsequent large report by the Institute of Medicine, provides compelling evidence that nurses' working long hours has an adverse effect on patient safety.

The Institute of Medicine estimates between 44,000 to 98,000 hospital deaths can be attributed to medical errors each year. Mandatory overtime is a serious contributing factor to medical errors. The final recommendation of the IOM is that all overtime, voluntary and mandatory/involuntary done by Nurses should be curtailed. 4

---

2 Occupational Health and Safety Administration (OSHA) http://www.osha.gov. National Institute for Occupational Safety and Health(NIOSH) http://www.cdc.gov/niosh. Spurgeon A, Harrington JM, Cooper CL. Health and safety problems associated with long working hours: a review. Occupational and Environmental Medicine. 1997 June, 54(6):367-75. Tucker P, Barton J, Folkard S. Comparison of eight and 12 hour shifts: impacts on health, wellbeing, and alertness during the shift. Occupational and Environmental Medicine. 1996 Nov, 53(11):767-72. Lawrence Mishel, Jared Bernstein and John Schmitt. The State of Working America 2000-2001. Economic Policy Institute. Washington, D.C. 2001. pp. 454.

3 This decision can be viewed at http://www.nap.edu/openbook/0309090679/html/23.html#pagetop .

4 See brief article and/or order the study at: http://www.iom.edu/project.asp?id=4671 http://www.iom.edu/report.asp?id=16173

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 Hours 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.

---

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

In Addition, It is Impacting the Nurses' Health

Mandatory overtime has also been associated with unhealthy weight gain, increased use of alcohol and tobacco and lower levels of functional ability and job performance. The effect on family life is harder to quantify, but may be even worse. Many healthcare workers who are forced to work mandatory overtime say that the time away from their families has cause marital and child care problems and a general decline in the emotional well-being of the family. Mandatory overtime strongly affects workers' relationships with spouses, children and friends.

Where Should the Burden of Proof Lie?

The burden of proof should be on the health care industry to show that the current system of not restricting the hours health care professionals can work is safe. The Patient Safety Foundation has a statement of principle on its Web site that states that "[e]very health care institution has an ethical obligation to protect the safety of patients by providing staff in sufficient numbers and with adequate skills to deliver quality care."

Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations, in his testimony to the US Senate, 8, outlined strategies he believes are crucial to a "true culture of safety," including creating a blame-free environment, reinforcing the systems approach to prevent medical errors, investing in information infrastructure, establishing performance incentives and enacting patient safety legislation. He also noted in his testimony that "health care professionals who work under continuous high stress will make errors." 9 The JCAHO Report on adverse conditions faced by nurses (including mandatory overtime) refers to nurses as "canaries in a coal mine."10

---

8 See: U.S. Congress. Senate. Committee on Governmental Affairs. Patient safety: instilling hospitals with a culture of continuous improvement. Washington, DC. 107th Cong, 2nd Sess; 2003. Available at: http://www.senate.gov/~gov_affairs/061103witnesspsi.htm, accessed 6/3/2003

Testimonies given before the Permanent Subcommittee on Investigations on June 11, 2003. Witnesses were: Goeltz, Bagian of the VA, O'Leary of JCAHO, Clancy of AHRQ, Page of Fairview, Krawisz of NPSF, Mandernach of Minnesota DoH, and Delbanco of Leapfrog Code: ADM; GEN / CA: 2003 Jun 1

9 see
http://www.jcaho.org/about+us/public+policy+initiatives/health+care+at+the+crossroads.pdf
10 ibid. page 47

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.

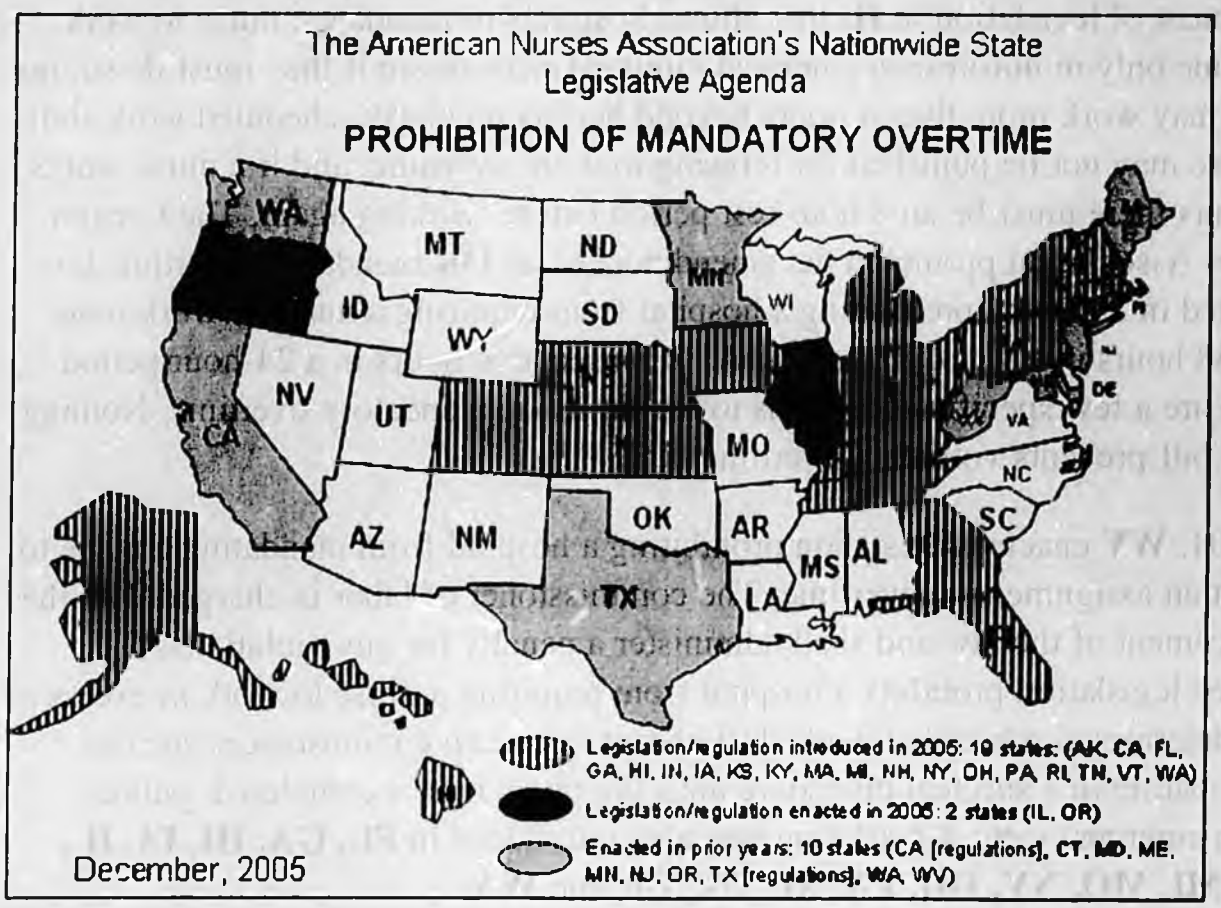
What are other states doing?

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

.791/S 351) www.anapoliticalpower.org has been introduced in the House and Senate and would prohibit the requirement that a nurse work more than 12 hours in a 24 hour period and 80 hours in a consecutive 14 day period, except under certain circumstances.

In 2005, legislation to prohibit mandatory overtime was enacted in **IL** and **OR** law was amended. The Illinois Nurses Association was instrumental in the enactment of legislation in **IL** that allows hospitals to mandate a nurse to work overtime only in unforeseen emergent circumstances. Even if they must do so, no nurse may work more than 4 hours beyond her/his regularly scheduled work shift. A nurse may not be punished for refusing to work overtime, and if a nurse works 12 hours there must be an 8 hour rest period before working again. The Oregon Nurses Association promoted the amendment of an **OR** mandatory overtime law (enacted in 2001) by prohibiting a hospital from requiring a nurse to work more than 48 hours in a week or more than 12 consecutive hours in a 24-hour period. There are a few specific exceptions to the limits on mandatory overtime. Nothing in the bill prevents voluntary overtime.

In 2004, **WV** enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. The commissioner of labor is charged with the enforcement of the law and shall administer a penalty for any violations. **CT** enacted legislation prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances such as participating in a surgical procedure until the procedure is completed, public health emergency etc. Legislation was also introduced in **FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT,** and **WA.**

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.

In 2002, the following states enacted prohibition of mandatory overtime legislation: **MD** law states that an employer may not require a nurse to work more than the regularly scheduled hours according the predetermined work schedule. There are some exceptions including an emergency situation that could not be reasonably anticipated and if a nurse has critical skills and expertise that are required for the work. **MN** law prohibits action against a nurse who refuses mandatory overtime because it would jeopardize patient safety. **NJ** enacted legislation prevents a health care facility from requiring an employee to work in excess of an agreed to, predetermined and regularly scheduled daily work shift,

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.

» Return to ANA 2005 State Legislative Trends Report

AACN Public Policy

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

[redacted] 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

Last Update: 02/26/2004

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

AACN*Public Policy*

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 jeoparoy 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

Last Update: 02/26/2004

ANA AMERICAN NURSES ASSOCIATION **Press Releases**

Send This Page

FOR IMMEDIATE RELEASE

February 10, 2005

CONTACT:
Cindy Price, 301-628-5038
Carol Cooke, 301-628-5027
m=realnews@ana.org

ANA Applauds Bill Prohibiting Use of Forced Overtime Among Nurses

U.S. House of Representatives measure would ensure safer patient care, greater protections for RNs

Silver Spring, MD - The American Nurses Association (ANA) today hailed the Safe Nursing and Patient Care Act of 2005, a bill introduced by Rep. Pete Stark (D-CA) and Rep. Steven LaTourette (R-OH) that would strictly limit the practice of forcing nurses to work overtime.

The proposed legislation would address the current nurse staffing crisis in the U.S. by strictly limiting mandatory overtime among nurses, a dangerous practice that has contributed to a recent exodus of nurses from the nation's hospitals and a decline in safe, quality patient care. ANA has been at the forefront of the push for this legislation and worked collaboratively on its development with members of Congress and other organizations representing nurses.

"Study after study has shown that the use of forced overtime among nurses endangers nurses and their patients," said ANA President Barbara Blakeney, MS, RN. "The Safe Nursing and Patient Care Act would prevent health care facilities from forcing exhausted nurses to work extra shifts, an unsafe practice that puts both patients and nurses at risk," she added.

As evidence, Blakeney pointed to "The Working Hours of Hospital Staff Nurses and Patient Safety," a study published in the July/August 2004 issue of *Health Affairs*, which found that the risk of making an error greatly increased when nurses worked shifts longer than 12 hours, when they worked significant overtime or when they worked more than 40 hours per week. This study reinforced findings of the 2003 Institute of Medicine Report, "Keeping Patients Safe: Transforming the Work Environment of Nurses," which found that nurses' long working hours pose a serious threat to patient safety.

If passed, the Safe Nursing and Patient Care Act would:

- Prohibit health care facilities that receive Medicare funding from requiring a registered nurse (RN) or licensed practical nurse (LPN) to work beyond an agreed to, predetermined, regularly scheduled shift. In no instance could a nurse be required to work more than 12 hours in a 24-hour period or for more than 80 hours in a two-week period.

- Include nondiscrimination protections for nurses who refuse overtime and for nurses who provide information and/or cooperate with investigations about the use of overtime.

- Include an exception in the case of a declared national, state or local emergency. Such an

emergency would be in response to a disaster, not to a staffing deficiency resulting from management practices.

- Provide for a study by the Department of Health and Human Services on the maximum number of hours that may be worked by a nurse without compromising patient safety.

The ANA has warned that mandatory overtime is dangerous for patients and nurses, and that the practice is exacerbating a growing nursing shortage that is expected to worsen dramatically over the next 10 years.

To counter staffing insufficiencies that are already occurring, many health care facilities have increasingly imposed mandatory overtime. Typically, an employer may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment, a charge that could lead to a loss of license. At the same time, ethical nursing practice prohibits nurses from engaging in behavior they know could harm patients, thus leading to a dilemma for many nurses.

"The good news is that we have had some success in prohibiting forced overtime at the state level," Blakeney noted. "So far, 10 states - California, Connecticut, Maine, Maryland, Minnesota, New Jersey, Oregon, Texas, Washington and West Virginia - have either banned or severely limited the use of mandatory overtime, and similar measures have been introduced in 15 other states. But because the trend of forced overtime amongst nurses is such a significant threat to patients' and nurses' safety, we must protect nurses across the nation. That is why we have called on Congress to protect the public by taking federal action."

###

The American Nurses Association is the only full-service professional organization representing the nation's 2.7 million Registered Nurses (RNs) through its 54 constituent member associations. The 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.

###

» Return to Press Releases

Search Contact ANA Join/Renew Membership Members Only Online CE
NursingInsider Special Offers nursesbooks.org

NursingWorld Home
Learn About Issues
Track Legislation
Vote Scorecard
Search for Legislators
Capitol Update
Join N-STAT
In the Agencies
ANA-PAC
Inside ANA
Sitemap
Contact GOVA
GOVA Home

Search NW

ANA State Goverment Affairs

★ANA State Information for 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 - 1996
★Political Internet Resources
★Nurse State Legislators

Mandatory Overtime

Background

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 791/S 351) www.anapoliticalpower.org has been introduced in the House and Senate and would prohibit the requirement that a nurse work more than 12 hours in a 24 hour period and 80 hours in a consecutive 14 day period, except under certain circumstances.

Activities / Actions

In 2006, hours-worked legislation was introduced in AK, CA, DC, FL, GA, HI, IA, IL, KS, MA, MI, MN, MO, NH, NY, OH, PA, RI, TN, VT, WV, and WI, none of which passed to date.

In 2005, legislation to prohibit mandatory overtime was enacted in IL and OR law was amended. The Illinois Nurses Association was instrumental in the enactment of legislation in IL that allows hospitals to mandate a nurse to work overtime only in unforeseen emergent circumstances. Even if they must do so, no nurse may work more than 4 hours beyond her/his regularly scheduled work shift. A nurse may not be punished for refusing to work overtime, and if a nurse works 12 hours there must be an 8 hour rest period before working again. The Oregon Nurses Association promoted the amendment of an OR mandatory overtime law (enacted in 2001) by prohibiting a hospital from requiring a nurse to work more than 48 hours in a week or more than 12 consecutive hours in a 24-hour period. There are a few specific exceptions to the limits on mandatory overtime. Nothing in the bill prevents voluntary overtime.

In 2004, WV enacted legislation prohibiting a hospital from mandating a nurse to accept an assignment of overtime. The commissioner of labor is charged with the enforcement of the law and shall administer a penalty for any violations. CT enacted legislation prohibits a hospital from requiring a nurse to work in excess of a predetermined scheduled work shift except in certain circumstances such as participating in a surgical procedure until the procedure is completed, public health emergency etc. Legislation was also introduced in FL, GA, HI, IA, IL, MA, MI, MO, NY, OH, PA, RI, TN, VT, and WA.

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.

In 2002, the following states enacted prohibition of mandatory overtime legislation: MD law states that an employer may not require a nurse to work more than the regularly scheduled hours according the predetermined work schedule. There are some exceptions including an emergency situation that could not be reasonably anticipated and if a nurse has critical skills and expertise that are required for the work. MN law prohibits action against a nurse who refuses mandatory overtime because it would jeopardize patient safety. NJ enacted legislation prevents a health care facility from requiring an employee to work in excess of an agreed to, predetermined and regularly scheduled daily work shift, 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.

Staff RNs work hours and errors/near errors

A major study done on Staff Registered Nurses' work hours and errors and near errors in the acute care setting has just been published in the July/August 2004 issue of the journal *Health Affairs*. You may access the article at www.healthaffairs.org, under Datawatch, or through a library. The complete citation is listed below. This summary of the article is being sent to the Constituent Member Associations (CMA) in anticipation that news agencies will seek comments from CMA leaders. If you have any questions about the study or its implications, do not hesitate to contact Patricia Rowell, RN, PhD, Senior Policy Fellow, Department of Nursing Practice and Policy at 202-651-7058.

A Review of Research Findings

Rogers, A.E., Hwang, W., Scott, L.D., Aiken, L.H. and Dinges, D.F. (2004). The working hours of hospital staff nurses and patient safety". *Health Affairs*, 23, 202-212.

The July/August issue of *Health Affairs* has published the study, "Working hours of hospital staff nurses and patient safety", by Ann E. Rogers, et al. This study, funded by the Agency for Healthcare Research and Quality (AHRQ), has been supported by the American Nurses Association (ANA) through its assistance to Dr. Rogers and her team in obtaining ANA members to serve as research subjects. This article reports on one part of the research but most importantly that part that discusses findings from ANA members. The 393 members who participated have contributed to a very important study for nursing.

This study's sample size and the research design are good, therefore, lending credence to the study.

The importance of this part of the study lays in its documentation of long working hours as the norm; rates of errors and near errors; and the relationship between these two conditions. The following are the major findings:

- "The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more." (p.206)
- "Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled." (p.206)
- "...there is a trend for increasing risks when nurses work overtime after longer shifts with the risks being significantly elevated for overtime following a twelve hour shift." (p.207)
- "...working more than forty hours per week and more than fifty hours per week significantly increased the risk of making an error." (p.207)
- "...work schedules of hospital staff nurses are unpredictably prolonged." (p.207)
- "...double shifts (or longer) are not confined to rare emergencies." (p. 207)

- "Although the occurrence of errors did not increase significantly until shift durations exceeded 12.5 hours per day, risks began to increase when shift durations exceeded 8.5 hours." (p. 208)
- "The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety." (p. 210)

Authors' recommendations:

- "Because more than three-fourths of the shifts scheduled for twelve hours exceeded that time frame, routine use of twelve-hour shifts should be curtailed and overtime-especially that associated with twelve-hour shifts-should be eliminated." (p.210)

It should be noted that this study's findings are similar to those of similar studies with other work groups (e.g., pilots, air traffic controllers, resident physicians, etc.). The underlying concept that, regardless of profession, human physiology limits how long a person can function and be safe, must be attended to.

Par:/products/Rogers'Art704
7/7/04

contact Dr. Wilder
contact ALPA - exec. committee

2.2, 5.4, and 6.3).

- The American Nurses Association maintains the deterioration in working conditions for nurses is the primary cause of staff vacancies being reported by hospitals and nursing facilities – not a systemic nursing shortage. In fact, data from the Health Resources and Services Administration's (HRSA) 2000 national sample survey of RNs show that more than 500,000 licensed nurses have chosen not to work in nursing. This available labor pool could be drawn back into nursing if they found the employment opportunities attractive enough.

- Governmental standards have been established to place limits on that amount of time that can be worked in aviation, railroads, and trucking. No requirements exist for nurses who care for those who are ill and most vulnerable.

- Legislators across the country are responding to constituents concerns regarding the devastating effects of mandatory overtime. In 2001 alone, 16 states introduced legislation to prohibit mandatory overtime, while legislation was enacted in Oregon and Maine.

- While stress can be quantified, fatigue cannot. Numerous factors and conditions including individual physiology, nutrition, age, experience and work complexity levels must be considered when evaluating fatigue. Academicians have not yet developed a clear or precise formula for determine when fatigue affects work performance. For this reason, determination of fatigue has and continues to remain highly subjective. Nurses must be allowed to use their personal and professional judgment to determine their own fatigue levels and its impact on quality of care.

Talking Points on Mandatory Overtime

The American Nurses Association and the Alaska Nurses Association support legislation to prevent employers from requiring nurses to work mandatory overtime.

- Mandatory overtime is defined as work hours imposed on a nurse in excess of an agreed upon, predetermined work schedule. It does not include an unforeseen declared national, state or municipal emergency or disaster.

- Poor working conditions are driving nurses away from the bedside. Since the proliferation of managed care and the cost containment strategies of the 1990's, nursing staffs have been dramatically cut. Nurses are caring for greater numbers of patients than ever before who are sicker than in the past. To make matters worse, more and more hospitals are forcing nurses to work overtime.

- Nurses are reporting a dramatic increase in the use of mandatory overtime. According to a 2001 American Nurses Association survey of 5,000 nurses from across the country, over two-thirds of nurses work mandatory or unplanned overtime. Mandatory overtime is having a negative impact on quality of patient care, working conditions and the bottom line.

- The use of mandatory overtime is a bad business practice. Lack of control over one's work and schedule results in high stress levels according to the National Institute for Occupational Safety and Health (NIOSH). Job stress is detrimental to an employee's health and has been linked to cardiovascular disease, muscle and skeletal disorders, depression and burnout. It leads to unsafe patient care. According to the American Institute of Stress, 60 to 80% of industrial accidents are due to stress. In addition, job stress costs U.S. industry $300 billion annually through absenteeism, employee turnover, insurance fees and diminished productivity.

- Nurses, as professionals licensed by the state, have the autonomy to determine how their work will be performed and are responsible for that work. This mandate is articulated in the Nurse Practice Act and enforced by the Board of Nursing. These professional obligations are undermined when a nurse is forced to work mandatory overtime. Nurses who challenge employers by exerting professional and ethical judgements are likely to be terminated. Since nurses have few avenues to challenge mandatory overtime and could face licensure censure or revocation for providing less than adequate care because of stress, legislators must step in to protect the professional judgement of nurses and protect their patient's right to safe, quality care.

- Mandatory overtime is unethical because it violates a nurses duties and obligations to herself, society and professional practice. It directly undermines professional nursing practice by creating situations where harm can occur to both patients and nurses resulting in moral distress for the nurse. Mandatory overtime eliminates professional judgement and autonomy while still requiring professional accountability. Several provisions in the *Code of Ethics for Nurses* speak directly to this as an unethical practice. (See sections

The impact of overtime and long work hours on occupational injuries and illnesses: new evidence from the United States

A E Dembe, J B Erickson, R G Delbos and S M Banks

Occup. Environ. Med. 2005;62;588-597
doi:10.1136/oem.2004.016667

ORIGINAL ARTICLE

The impact of overtime and long work hours on occupational injuries and illnesses: new evidence from the United States

A E Dembe, J B Erickson, R G Delbos, S M Banks

Occup Environ Med 2005;62:588–597. doi: 10.1136/oem.2004.016667

See end of article for authors' affiliations

Correspondence to: Associate Professor A Dembe, Center for Health Policy & Research, University of Massachusetts Medical School, 222 Maple Avenue, Higgins Building, Shrewsbury, MA 01545, USA; Allard.Dembe@umassmed.edu

Accepted 8 March 2005

Aims: To analyse the impact of overtime and extended working hours on the risk of occupational injuries and illnesses among a nationally representative sample of working adults from the United States.

Methods: Responses from 10 793 Americans participating in the National Longitudinal Survey of Youth (NLSY) were used to evaluate workers' job histories, work schedules, and occurrence of occupational injury and illness between 1987 and 2000. A total of 110 236 job records were analysed, encompassing 89 729 person-years of accumulated working time. Aggregated incidence rates in each of five exposure categories were calculated for each NLSY survey period. Multivariate analytical techniques were used to estimate the relative risk of long working hours per day, extended hours per week, long commute times, and overtime schedules on reporting a work related injury or illness, after adjusting for age, gender, occupation, industry, and region.

Results: After adjusting for those factors, working in jobs with overtime schedules was associated with a 61% higher injury hazard rate compared to jobs without overtime. Working at least 12 hours per day was associated with a 37% increased hazard rate and working at least 60 hours per week was associated with a 23% increased hazard rate. A strong dose-response effect was observed, with the injury rate (per 100 accumulated worker-years in a particular schedule) increasing in correspondence to the number of hours per day (or per week) in the workers' customary schedule.

Conclusions: Results suggest that job schedules with long working hours are not more risky merely because they are concentrated in inherently hazardous industries or occupations, or because people working long hours spend more total time "at risk" for a work injury. Strategies to prevent work injuries should consider changes in scheduling practices, job redesign, and health protection programmes for people working in jobs involving overtime and extended hours.

A growing body of evidence suggests that long working hours adversely affect the health and wellbeing of workers. Studies have associated overtime and extended work schedules with an increased risk of hypertension,[1 2] cardiovascular disease,[3–9] fatigue,[1 10–13] stress,[14–17] depression,[18 19–20] musculoskeletal disorders,[21–23] chronic infections,[24] diabetes,[25] general health complaints,[26–28] and all-cause mortality.[29] Several reviews and meta-analyses have been published summarising these research findings.[30–34] Systematic reviews generally have concluded that long working hours are potentially dangerous to workers' health. However, existing research is sparse and inconsistent in many areas.

Comparatively few studies have examined the impact of long work hours on workers' risk for occupational injuries and illnesses. Some studies have detected evidence of a relation between long working hours and an increased risk of occupational injuries among workers in specific occupations and industries, including construction workers,[35] nurses,[36] anaesthetists,[37] veterinarians,[42] other healthcare professionals,[43 44] miners,[45] bus drivers,[46] long distance truck drivers,[47] fire-fighters,[48] and nuclear power plant workers.[49] In one of the only studies involving the manufacturing sector, an increased risk of severe hand injuries was found for Hong Kong factory workers working more than 11.5 hours per day.[50] A large scale cross-industry study of 1.2 million German workers' compensation records found that the risks of non-fatal and fatal workplace accidents increase during the latter portion (after the eighth hour) of a long work shift.[51 52] Similar findings of an increased risk of work injuries during the latter portion of long shifts has also been observed in studies from Scandinavia and the United Kingdom.[53 54] Other researchers have investigated the affect of successive long shifts and the length of rest breaks between shifts as possible risk determinants for industrial accidents.[55]

Nevertheless, researchers' understanding of the impact of long working hours on workplace injuries remains incomplete and equivocal. Several investigations have found no evidence of an association,[56–59] or have observed a protective effect.[60 61] Authorities have noted that many existing studies have serious methodological shortcomings, including small sample sizes, unique industry specific circumstances that limit generalisability of the findings, and the failure to account for potential confounding factors. For example, jobs performed during long working shifts might be inherently more dangerous, or people working in extended-hour schedules might have different personal characteristics (for example, age, gender, or underlying health status) that affect their injury risk. Additionally, the vast majority of existing studies have been performed in Europe, Asia, and Scandinavia. Or ly a handful of studies have been conducted in the United States, and none of them have involved large sample sizes or study populations representing a mix of industries and occupations.

This article reports on a study of the impact of overtime and extended working hours on the risk of occupational injuries and illnesses among a nationally representative sample of working adults from the United States. The study spans 13 years and draws on information contained in 110 236 job records. Multivariate analyses are employed to

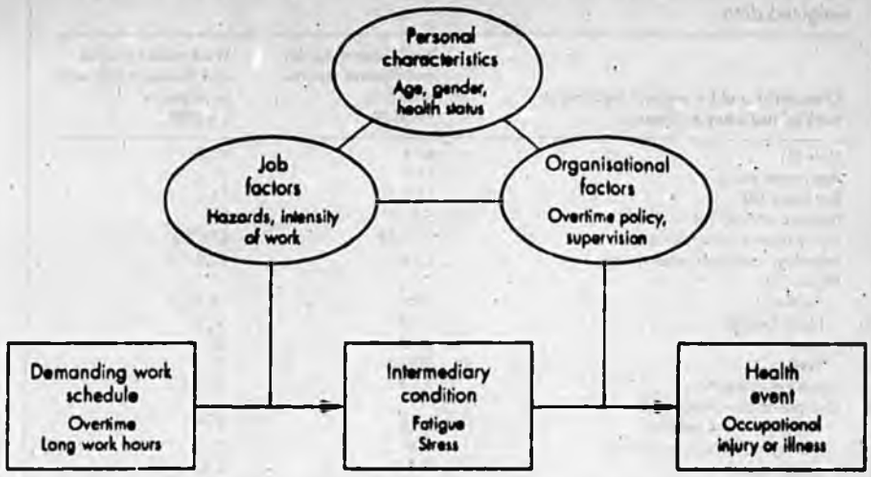


Figure 1 Conceptual model of the relationship between demanding work schedules and occupational injuries and illnesses (adapted from Schuster and Rhodes[42]).

control for the influence of workers' age and gender, region, industry sector, and occupation. The study is based on the hypothesis that working overtime or an extended work schedule increases the likelihood of reporting an occupational injury or illness compared to workers having less demanding schedules. Moreover, we hypothesise that the risk of injury increases with increasing volume of work performed in the demanding schedule.

The conceptual basis for this study is adapted from a theoretical model proposed by Michel Shuster and Susan Rhodes in 1985.[42] In this model, overtime and long hours of work are presumed to affect the risk of workplace accidents by precipitating various intermediary conditions in affected workers, such as fatigue, stress, and drowsiness. The pathway linking a demanding work schedule to the intermediary condition and ultimately to a workplace accident can be mediated by a variety of individual and environmental factors, including personal characteristics (for example, age, gender, health status, job experience), job factors (for example, intensity of work, exposure to hazards), and organisational factors (for example, overtime policy, supervision) (see fig 1). Our study analyses the association between exposure to overtime and extended work schedules and the incidence of reported work related injuries and illnesses, adjusting for the influence of several mediating factors, including age, gender, occupation, industry sector, and geographical region. The specific mechanisms by which fatigue, stress, or other intermediary conditions bring about a workplace accident are not investigated in this report.

METHODS

Data for this study comes from the National Longitudinal Survey of Youth (NLSY), which is sponsored by the US Bureau of Labor Statistics and administered by the Ohio State University Center for Human Resource Research.[43] The NLSY cohort is comprised of 12 686 men and women who were 14–22 years of age when first surveyed in 1979. Follow up interviews with NLSY respondents have been conducted annually from 1979 to 1994, and biannually since 1996. Because of NLSY funding restraints, no questions concerning work related incidents were included in the 1991 survey and therefore this year of data was excluded.

The NLSY collects information on respondents' socio-demographic characteristics, household composition, education, training, detailed work histories, job and employer characteristics, income and assets, health insurance status, incidence of work related injuries and illnesses, episodes of work disability, and respondents' social and domestic functioning. The survey's sampling strategy was designed to be representative of the non-institutionalised civilian segment of young people living in the United States in 1979 and born between 1 January 1957 and 31 December 1964.[44] Additionally, NLSY over-sampled civilian Hispanic, black, and economically disadvantaged white youth to help detect variations in employment and health conditions according to respondents' race, ethnicity, and socioeconomic status. Subjects for the survey were selected based on the results of 57 000 household screening interviews conducted by the National Opinion Research Center (NORC) at the University of Chicago.[45] NLSY provides sampling weights for each response to reflect the national distribution of Americans in this age range.

This study examined the experience of these individuals between 1987 and 2000. Attempts were made to re-interview every remaining cohort member at each survey. Survey response rates for those years (excluding deceased respondents) ranged from 91.0% for the 1988 survey to a high of 92.5% in 1989 and a low of 83.4% in 2000. During that period, 10 793 members of the cohort reported working in at least one job. Among employed cohort members, 52.2% were male, 13.2% were black, and 6.7% were of Hispanic ethnicity (weighted percentages). A job record was created for each position held by an individual during each survey period, with a "job" defined as a cohort member being employed in a particular position for a specific employer with a position start date and (if applicable) end date provided. If an individual held more than one position at a time (for example, for different employers), another job record was created to reflect the individual's experiences in the positions held concurrently. Changes occurring within a position (for example, changes in job activities) did not result in the creation of a new job history record, but a new record was created when a worker changed positions (for example, a machinist becoming a supervisor). A total of 110 236 job records were available for analysis, encompassing a total of 89 729 person-years of accumulated working time. Each job record contained extensive self-reported information about the characteristics of the job including the date of beginning work in the job, the end date (if applicable), job responsibilities and activities, occupational category, employer's industry sector, job location, customary work schedule, usual daily job starting and ending times, commuting time, and

Table 1 Characteristics of the workers reporting work related injuries and illnesses, weighted data

Characteristics of the workers reporting a work related injury or illness	Work related injuries and illnesses reported in all jobs n = 5139	Work related injuries and illnesses in jobs with an exposure* n = 2799
Male (%)	61.1	67.7
Age (mean years)	31.7	32.3
Black race (%)	11.2	11.2
Hispanic ethnicity (%)	6.8	7.0
Family income (mean dollars)	$33419	$35502
Schooling completed (mean years)	12.6	12.6
Region (%)		
Northeast	16.6	16.9
North Central	31.0	31.6
South	31.8	32.4
West	20.6	19.1
Urban residence (%)	27.4	29.5
Occupation classification (%)		
Professional and technical	11.0	9.7
Managers, officials, proprietors	9.8	10.5
Sales workers	2.4	2.5
Clerical	11.1	9.4
Craftsmen, foreman	19.6	17.6
Machine operators	20.0	22.6
Labourers, except farm	9.3	9.0
Service workers	15.1	16.5
Other	1.7	2.2
Industry classification (%)		
Agriculture, forestry, and fisheries	3.7	3.7
Mining	1.1	1.7
Construction	11.6	9.8
Manufacturing	23.3	25.5
Transportation and communication	7.7	8.6
Wholesale and retail trade	18.5	18.7
Finance, insurance, real estate	2.2	1.7
Business and repair services	6.3	6.9
Personal services	3.1	2.8
Entertainment and recreational	1.5	1.9
Professional and related services	14.6	11.6
Public administration	6.3	7.0
Worker covered by union contract	20.8	23.0
Worker dislikes the job	15.8	16.1
Annual wages (mean dollars)	$21265	$23439

Some individual workers reported more than one injury and thus their characteristics are counted more than once in this table.
*Jobs with any of the four types of exposures.

information about overtime work and the receipt of overtime pay.

For the purposes of this study, five exposure categories were specified:

- *Extended hours per week*: Jobs in which the respondent reported regularly working 60 or more hours per week were considered to have this exposure.
- *Extended hours per day*: Jobs in which the respondent reported regularly working 12 or more hours per day were considered to have this exposure.
- *Overtime*: For the 1988–93 survey years, the individual's job was considered to have this exposure if the worker responded "yes" to the question: "Did you work overtime at this job?'. The NLSY survey did not define the meaning of "overtime"; interpretation of that term was left up to the discretion of the respondent. Owing to changes in the NLSY questionnaire, from the 1994 to 2000 survey years, the individual's job was considered to have this exposure if the worker responded "yes" to the question: "At this job, did you usually receive overtime pay?'.
- *Extended commute time*: Jobs in which the respondent reported regularly commuting two or more hours per day to and from the workplace were considered to have this exposure.
- *Overtime or extended hours*: This was a derived summary exposure variable. A worker's job was considered to have this exposure if it contained any of the preceding four exposures.

The exposure categories were not mutually exclusive and so a particular job potentially could have one or more exposures.

The primary outcome of interest in this study was the self-reported incidence of a work related injury or illness. This was based on a respondent's affirmative response to the following question:

> "I would like to ask you a few questions about any injuries or illnesses you might have received or gotten while you were working on a job. Since [date of last interview] have you had an incident at any job that resulted in an injury or illness to you?"

During the 13 year study period, 5139 work related injuries and illnesses were reported. Of those, 2799 occurred in jobs having exposure to at least one of the four exposure categories. Table 1 summarises characteristics of the effected workers and their injuries. For the purposes of this analysis, we assumed that the reported injuries were independent

Table 2 Job records with reported work related injuries or illnesses that were included in the regression analysis compared to those that were excluded, weighted data

Variable	Job records included n = 4765	Job records excluded* n = 374	p value
Gender (% male)	62.6	61.8	0.78
Race (e.g. % black)	23.4	19.8	0.44
Marital status (% married)	53.2	48.7	0.08
Region (e.g. % Southern)	33.5	35.6	0.30
Urban (%)	24.2	24.3	0.94
Occupation (e.g. operatives)	22.1	21.3	0.74
Industry (e.g. % manufacturing)	23.2	24.4	0.46
Injury (e.g. % musculoskeletal)	34.0	35.6	0.16
Satisfaction (% likes job)	83.3	84.2	0.66
Age (mean)	29.3	31.3	<0.01
Family income (mean $1000s)	30.4	30.5	0.97
Family size (mean)	3.20	3.03	0.29
Education (mean years)	12.1	12.4	0.05
Salary (mean $1000s)	15.5	20.2	<0.01

*An additional 174 excluded job records containing a second or subsequent injury have not been included in this comparison because they are a subset of the included jobs.

from one another. Also, we assumed that a distinct worker may suffer more than one injury, and in that circumstance, the worker's characteristics (in table 1 and the subsequent analyses) would be counted more than once. These presumptions reflect typical patterns of acute injury occurrence and accident reporting in industrial settings. For example, it would not be uncommon for a particular worker to fall and sprain an ankle on one occasion and then subsequently (perhaps even in the same year) suffer a different injury (for example, a cut finger) without there being a specific causal connection between the two events.

Crude (unadjusted) occupational injury and illnesses incidence rates for each of the five exposure categories (for each survey period) were calculated by dividing the total number of work related injuries and illnesses reported in jobs having each type of exposure by the total accumulated person-time worked in those jobs. The crude incidence rates for each exposure category were plotted graphically for every NLSY survey year from 1988 to 2000 to depict trends over time and to visually portray the relative difference in rates between jobs with and without each type of exposure (that is, the relative rate ratio). Information about commuting time was only collected in NLSY survey years 1988, 1993, and 1994, and thus trend lines for that exposure category were not graphed.

Rate ratios, reflecting the relative risk of reporting the occurrence of an occupational injury or illness, were calculated by dividing the incidence rate for the accumulated person-time in jobs with an exposure by the incidence rate for accumulated person-time in jobs without that exposure. So, for example, in a particular survey period, if 300 injuries were reported to have occurred in jobs containing a total of 3000 person-years with an exposure and 200 injuries were reported to have occurred in jobs containing a total of 4000 person-years without that exposure, then the crude rate ratio would be 2.0, calculated as follows:

- (300 injuries/3000 exposed person-years) ÷ (200 injuries/4000 unexposed person-years) = 10.0 injuries per 100 exposed person-years ÷ 5.0 injuries per 100 unexposed person-years = rate ratio of 2.0

To adjust for the influence of selected covariates, multivariate analyses were performed to calculate hazard ratios for each exposure category using Cox proportional hazards regression techniques, which are used to analyse the effect of multiple risk factors over the time preceding the occurrence of an event. The multivariate analyses included all accumulated person-time of exposure preceding the first injury in a particular job during a survey period, disregarding subsequent injuries and associated exposure time in that job during the period. Of the total number of work related injuries reported (5313), only 174 (3.3%) were the second or subsequent injury in a job during a survey period and thus were excluded from the analyses. Other job records were excluded because of insufficient information about the specific date of injury or time spent on a job, resulting in the exclusion of an additional 370 injuries, and the absence in some records of sample weights, resulting in the exclusion of an additional four injuries (and the associated exposure time). We performed a comparison of the job records with injuries used in the regression analysis (4765) to the 374 records with missing data to determine if those included and excluded were significantly different. The 174 "subsequent injury" records were not included in this comparison because by definition they had the same job characteristics as those included in the 4765 job records with first injuries. Our comparison showed that the records excluded from the analysis were very similar to those included (table 2).

As a result of these methodological considerations, there was a total of 109 087 job records and 4765 injuries used in the Cox proportional regression analyses of hazard ratios compared to 110 236 job records and 5313 injuries used in the crude analyses of incidence rates and rate ratios. Sample weights were applied to derive nationally representative estimates for individuals in the NLSY age range (14–22 years old as of 1979; 22–43 years old during the study period from 1987 to 2000).

Each regression model included the accumulated person-time for one of the five exposure categories as the primary independent variable, the reporting of a work related injury or illness as the dependent variable, and age (continuous variable), gender (M/F), region (Northeast, South, North Central, West), occupational grouping (high risk/low risk), and industry grouping (high risk/low risk) included as covariates. "High risk" occupations included US Census (1970) Occupation Classification Codes 401–575, 601–715, and 740–785 (craftsmen, foremen, operatives, and labourers), and "high risk" industries included US Census (1970) Industrial Classification Codes 067–077 and 107–398 (construction and manufacturing sectors).[49] The occupation and industry codes selected for inclusion in the "high risk" categories have traditionally higher than average occupational injury and illness incidence rates as reported by the US Bureau of Labor Statistics.[50] We tested the proportional hazards assumption and it held for every variable used in the regression model with the sole exception of region. However,

Table 3 Types of injuries and illnesses reported by workers in jobs with and without exposure, percent distribution, weighted data

Type of injury or illness	Injuries and illnesses in jobs with an exposure n = 2799	Injuries and illnesses in jobs without exposure n = 2339
Musculoskeletal conditions	34.9	34.4
Fractures	7.8	7.4
Cuts and bruises	25.0	24.9
Burns	3.3	3.3
Other traumatic injuries	12.2	11.6
Peripheral nervous system diseases	2.8	2.7
Other occupational diseases	9.2	10.2
Miscellaneous	4.8	5.5

in our analysis, region was considered only as a potential confounder. We did not draw or report any conclusions in this study about the effect of region on the propensity for injury. Thus, based on the general applicability of the assumption for all of the primary exposure variables and the main outcomes variable (injury) used in the analyses, we applied the Cox proportional approach and reported the results accordingly.

Crude incidence rates and rate ratios were calculated with SAS (version 8.0) statistical software.[47] The ProQuest software system was used to create a database of jobs and person-time exposure records,[48] and Cox proportional regression analyses were performed on that database using Stata SE (version 7) statistical software.[49] Because the hazard ratio calculations were based on a sample rather than the NLSY's entire target universe (Americans aged 14–22 as of 1979), the results were subject to sampling error. To account for sampling effect, 95% confidence intervals around the hazard ratios were estimated by applying Taylor approximation techniques using SUDAAN (version 7.5) analytical software.[71]

RESULTS

Table 3 summarises the types of injuries and illnesses reported, among people working in jobs with and without exposure. Most reported work related conditions were either musculoskeletal disorders (34.7% of all reported injuries) or cuts and bruises (25.0%).

The unadjusted incidence rate for the entire duration of the study was 7.50 reported injuries per 100 worker-years for people in jobs with exposure to extended hours per week, 29% higher than the rate among those in jobs without exposure to extended hours per week (5.81 reported injuries per 100 worker-years). Similarly those in jobs with exposure to extended hours per day had an incidence rate 38% higher than those in jobs without that exposure (7.97 *v* 5.77 injuries per 100 worker-years), those in jobs with exposure to overtime had an incidence rate 84% higher than those in jobs without that exposure (7.49 *v* 4.06 injuries per 100 worker-years), and those in jobs with exposure to extended commute time had an incidence rate 7% lower than those in jobs without that exposure (6.90 *v* 7.46 injuries per 100 worker-years).

Incidence rates for each type of exposure varied by survey year, with a general downward trend in injury rates observed from 1988 to 2000 for all exposed and non-exposed groups (fig 2). Between 1988 and 2000, rates among the various exposure categories decreased by 54–69%. There were some fluctuations observed in the relative gap between exposed and unexposed groups during the study period, but no notable trends in the relative difference between groups over time were detected.

There was a strong positive relation observed between the magnitude of exposure for extended hours per week and extended hours per day and the corresponding injury incidence rate (fig 3). For extended hours per day, every additional five hours per week over 40 was associated with an average increase of approximately 0.7 injuries per 100 worker-hours. For extended hours per day, every additional 2 hours per day over 8 was associated with an average increase of approximately 1.2 injuries per 100 worker-hours.

Table 4 summarises the unadjusted rate ratios and 95% confidence intervals for each exposure category and the unadjusted hazard ratios calculated using first injuries only through the Cox proportional method. The ratios and confidence intervals calculated by each method were generally quite similar. The final adjusted hazard ratios calculated by the Cox proportional methods, after adjusting for age, gender, occupation, industry, and region, are presented in table 5. The results of the adjusted analysis indicates that the association between exposure and the risk of injury was only slightly affected by the influence of those covariates. This analysis found that, after adjusting for those factors, jobs with extended hours per day have a 37% higher injury hazard rate compared to jobs without that exposure. Similarly, working in a job with extended hours per week was associated with a 23% higher injury hazard rate, working in a job with overtime was associated with a 61% higher injury hazard rate, and working in a job with any overtime or extended hours schedule was associated with a 38% higher injury hazard rate. No association was detected between working in a job with extended commute time and the injury hazard rate.

DISCUSSION

This study of nationally representative data from the United States adds to the growing body of evidence indicating that work schedules involving long hours or overtime substantially increases the risk for occupational injuries and injuries. Unlike previous studies, our investigation had the advantage of covering a large variety of jobs, and controlling for the potential confounding affect of age, gender, occupation, industry, and region. We analysed nearly 100 000 job records extending over a 13 year period, and employed several statistical techniques for quantifying the extent of risk. The results of this study suggest that jobs with long working hours are not more risky merely because they are concentrated in inherently hazardous industries or occupations, or because of the demographic characteristics of employees working those schedules. Our findings are consistent with the hypothesis that long working hours indirectly precipitate workplace accidents through a causal process, for instance, by inducing fatigue or stress in affected workers. However, our findings are also consistent with other hypotheses and thus we cannot be certain of a causal connection based on this study alone.

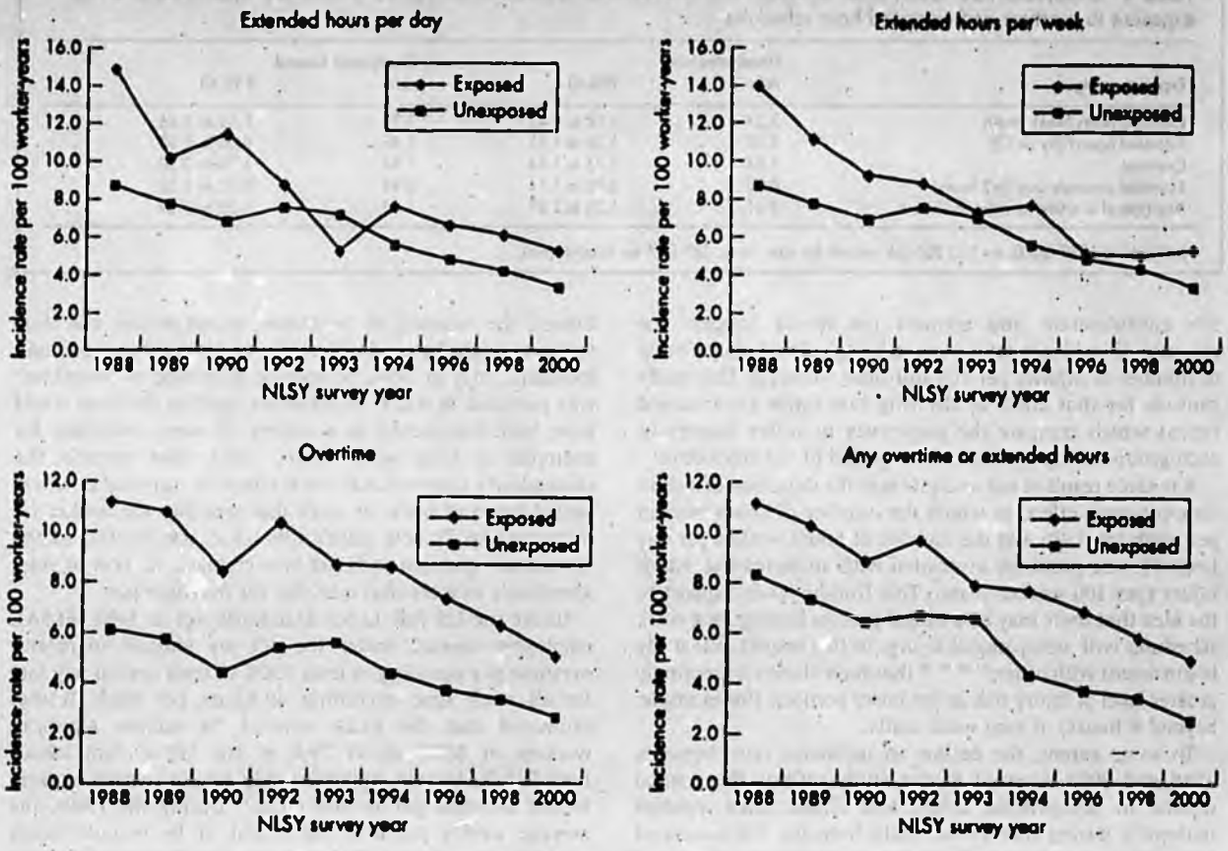


Figure 2 Trends in incidence rates of reported work related injuries and illnesses in jobs with and without exposure, by exposure category. NLSY survey periods 1988, 1989, 1990, 1992, 1993, 1994, 1996, 1998, and 2000. Note: NLSY changed the wording for the question regarding overtime in 1994, thereby potentially affecting the trend lines for "overtime" and "any overtime or extended hours".

Our comparison of injury incidence rates for workers in jobs with and without exposure was normalised by using a common denominator of 100 worker-years, thus avoiding a common methodological flaw that has afflicted some previous studies in this field. For example, workers who, on average, work longer hours (for example, 2500 hours per year) can be expected to experience more injuries than those who work shorter hours (for example, 2000 hours per year), even if the underlying risks to both groups are actually the same, because the former group spends more time "at risk" for injury. Many studies that have observed more injuries among persons who work longer hours have failed to take

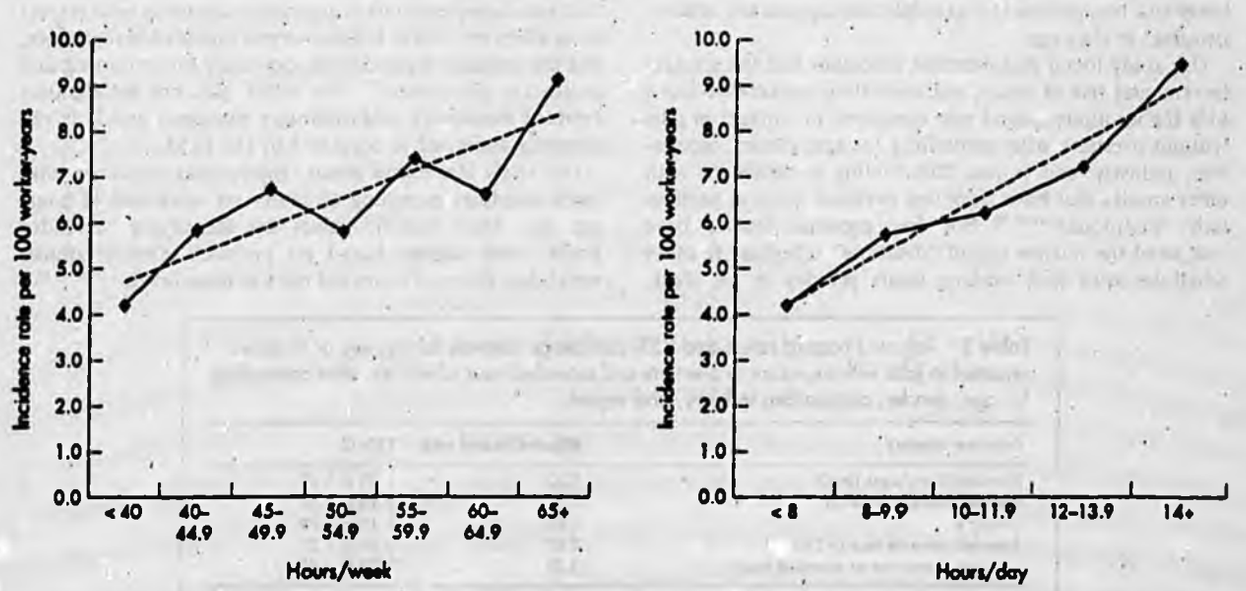


Figure 3 Trends in incidence rates of reported work related injuries and illnesses in jobs with and without exposure, for two exposure categories (hours/week and hours per day), by amount of exposure. NLSY aggregated data covering 1987–2000.

Table 4 Unadjusted rate ratios, hazard ratios, and 95% confidence intervals for injuries or illnesses reported in jobs with exposure to overtime and extended hour schedules

Exposure category	Unadjusted rate ratio	95% CI	Unadjusted hazard ratio	95% CI
Extended hours/week (≥60)	1.29	1.18 to 1.42	1.29	1.15 to 1.46
Extended hours/day (≥12)	1.38	1.26 to 1.51	1.46	1.30 to 1.63
Overtime	1.84	1.75 to 1.94	1.84	1.70 to 2.00
Extended commute time (≥2 hours)	0.93	0.75 to 1.14	0.94	0.72 to 1.22
Any type of overtime or extended hours	1.41	1.35 to 1.48	1.48	1.38 to 1.59

NLSY data, 1987–2000. n=110 236 job records for rate ratios, 109 087 for hazard ratios.

this consideration into account (as would happen, for instance, if incidence rates were to be calculated on the basis of number of injuries per 100 full-time workers). This study controls for that effect by deriving rate ratios (and hazard ratios) which compare the propensity to suffer injuries in each group during a standardised period of "at risk" time.

A notable result of our analysis was the detection of a clear dose-response effect, in which the number of hours worked per week (over 40) and the number of hours worked per day (over 8) were positively associated with an increasing risk of injury (per 100 worker-years). This finding lends support to the idea that there may be a causal process linking long work schedules with occupational injury. In this respect, our study is consistent with others[21–23 34 70] that have shown increasingly greater level of injury risk in the latter portions (for example, beyond 9 hours) of long work shifts.

To some extent, the decline in incidence rates between 1988 and 2000 observed in our study reflects the general decline in occupational injury and illness rates reported nationally during that period. Data from the US Bureau of Labor Statistics (BLS) indicate that occupational injury and illness rates (all case, private industry) decreased by 29% during that period, from an average of 8.6 to 6.1 reportable cases per 100 workers.[72] That decline has been attributed to various possible causes, including safer workplaces and a shift from manufacturing to service oriented jobs, which typically have lower average incidence rates.[73] Another factor that may help to explain the relatively larger (54–69%) rate decreases observed in our study is the aging of our cohort, who were 23–31 years old in 1988 and 35–43 years old as of 2000. Younger workers generally have higher incidence rates than older ones, in part because workers tend to move into lower risk occupations (for example, managerial and administrative) as they age.

Our study found that overtime schedules had the greatest incremental risk of injury, with overtime workers having a 61% higher injury hazard rate compared to workers in jobs without overtime, after controlling for age, gender, occupation, industry, and region. This finding is consistent with other studies that have identified overtime work as particularly hazardous.[22 29 30 74] But few previous studies have compared the relative risk of "overtime" schedules to other schedules with long working hours per day or per week. Indeed, the meaning of "overtime" is not precise, and thus the term might be used differently in different contexts and locations. Prior to 1994, no specific definition of "overtime" was provided to NLSY respondents, and so the term could have been interpreted in a variety of ways: referring, for example, to long work hours, work that exceeds the respondent's conventional work schedule, unusual or unexpected hours of work, or work that qualifies the worker for overtime pay. To help clarify this issue, the wording of the "overtime" question in NLSY was changed in 1994 to refer specifically to work that qualifies for overtime pay.

Under the US Fair Labor Standards Act of 1938 (FLSA), employees covered under the act are entitled to receive overtime pay equalling at least 150% of their regular pay rate for all work time exceeding 40 hours per week. It was estimated that the FLSA covered 74 million American workers in 2000, about 79% of the US civilian labour force.[75 76] On average, approximately 20% of covered workers receive overtime pay in any week.[77] During the 1990s, the average weekly overtime hours put in by manufacturing workers covered by FLSA grew by 25%.[78] Workers exempt from FLSA coverage include most administrative, professional, executive, supervisory, and outside sales personnel who are paid on a salaried basis. New regulations recently promulgated by the US Department of Labor have extended the FLSA exemptions to an additional 8 million white-collar workers.[79]

In the USA, approximately 19–33% of overtime work is mandatory (also called "compulsory", "forced", or "involuntary").[78 80] Mandatory overtime is overtime work required by employers, often under the threat of job loss or other penalty if the worker fails to comply. Several studies have suggested that mandatory overtime is especially hazardous with respect to its affect on worker fatigue, stress, impaired performance, and the potential for accidents, especially in the nursing and healthcare professions.[78] The NLSY did not differentiate between mandatory and voluntary overtime, and it is not currently addressed or regulated by the FLSA.

Our study also found greater injury risks associated with work schedules exceeding 60 hours per week and 12 hours per day. These specific values for identifying "extended hours" were chosen based on previous research studies which had detected increased risks at those levels.[6 11 23 30 61 62]

Table 5 Adjusted hazard ratios and 95% confidence intervals for injuries or illnesses reported in jobs with exposure to overtime and extended hour schedules, after controlling for age, gender, occupation, industry, and region

Exposure category	Adjusted hazard ratio	95% CI
Extended hours/week (≥60)	1.23	1.05 to 1.45
Extended hours/day (≥12)	1.37	1.16 to 1.59
Overtime	1.61	1.43 to 1.79
Extended commute time (≥2 hours)	0.87	0.59 to 1.23
Any type of overtime or extended hours	1.38	1.25 to 1.51

NLSY data, 1987–2000, n=109 087 job records.

Main messages

- Working in jobs with schedules that routinely involve overtime work or extended hours increases the risk of suffering an occupational injury or illness.
- Overtime schedules had the greatest relative risk of occupational injury or illness, followed by schedules with extended (≥12) hours per day and extended (≥60) hours per week.
- The risk of injury was found to increase with the increasing length of the work schedule, even after controlling for the entire amount of working time spent "at risk" for injury.
- Multivariate analyses indicated that the increased injury risks are not merely the result of the demanding work schedules being concentrated in riskier occupations or industries.
- These results are consistent with the hypothesis that long working hours indirectly precipitate workplace accidents by inducing fatigue or stress in affected workers.

Policy implications

- This study supports initiatives of the European Union and other governments to regulate the length of working schedules.
- Proposals in the United States to modify the Fair Labor Standards Act should examine the impact of those proposed changes on the injury risks associated with overtime work.
- Strategies for preventing workplace injuries and illnesses should consider changes in work organisation and job design addressing the length of work schedules and the performance of overtime work.

However, increased risks also have been detected at other work-hour levels by a variety of researchers and there is as yet no consensus criterion for the precise amount of work that is considered to be hazardous. In an attempt to create uniform labour standards, the European Union issued a Working Time Directive in 1993 that limited normal working hours to no more than 48 per week (averaged over a four month period) and specified other requirements related to rest breaks, shift work, and overtime. Some European nations (for example, the UK) have introduced provisions for workers to voluntarily opt out of these requirements or to otherwise provide flexibility in their implementation.

Study limitations

This study was based on self-reported information from NLSY cohort members regarding their employment and injury/illnesses experiences. Respondents were asked to recall information from the time of the previous interview, which in most cases was one year (for the 1988–1994 surveys) or two years (for the 1996–2000 surveys). There were no means to externally validate their responses. Our results, therefore, may be subject to potential inaccuracies related to the inability of respondents to recall information correctly. At the same time, the NLSY has advantages in this regard compared to other self-reported surveys in that the cohort had been surveyed regularly since 1979 and thus was quite familiar with the questionnaire, the response process, and the information required. Also, the NLSY was not designed to be a survey about work related injuries and illnesses or demanding work schedules—its primary objective was to evaluate participants' long term labour market transitions and wage history. The survey thus avoids problems of information bias that typically plague attempts to ask injured workers about their working conditions and job exposures. Unlike data sources related specifically to the field of occupational safety and health, it is unlikely that respondents to the NLSY will intentionally or unintentionally be attempting to justify the legitimacy of a work related disorder, establish its compensability under workers' compensation laws, or establish the employer's culpability for the injury. All of those issues are unrelated to the main concerns of NLSY and thus the data obtained presumably will be less susceptible to contamination by such considerations.

A strength of the study is its ability to control for the potential confounding affects of age, gender, occupation, industry, and region. However, many other potential covariates—such as workers' education and income levels, family composition, and health status—were not considered in the analysis, and thus their influence was not assessed. Our methods for considering the risks imposed by workers' occupation and the employer's industry classification may have masked more subtle differences related to particular job assignments within a broader occupational classification or specific industry group.

Because the study was based on secondary analysis of existing national data, we were also limited in our ability to evaluate other potentially important aspects of the dynamics underlying the risks of long working hours. For example, we did not have information available on the time of day the injury occurred, the kinds of job activities being performed, or the specific cause of the injury. However, information was available about the type of shift generally worked on each job (day, night, evening, split, or rotating shift) and thus we were able to consider the influence of shift work on injury risk and the combination affect of working both an unconventional shift schedule and long working hours. Those results will be reported in a separate publication.

Policy implications

The ultimate reason for conducting this research is to prevent occupational injuries and illnesses, promote overall worker health, and minimise the adverse consequences to affected workers. Most authorities believe that effective prevention of workplace injuries and illnesses requires a multifaceted approach that combines comprehensive hazard identification and control, ergonomic job design, worker training, medical surveillance, competent supervision, and a workplace culture and organisation that promotes optimal safety and health.

The results of this study suggest that special attention needs to be paid to establishing protective measures for people working overtime. For example, intensive accident hazard identification and control procedures (for example, periodic safety inspections) could be focused towards jobs in which employees work overtime schedules. Other protective approaches might include changes in work organisation (for example, periodic rest brakes, redesigning processes to avoid the need for overtime assignments, and employing more people to work fewer hours each), employer sponsored health promotion programmes (for example, counselling and education about the risks of long work schedules, periodic medical surveillance examinations for "at risk" workers, and ergonomic redesign to decrease job demands), and individual coping and behavioural practices (for example, maintaining good sleep and nutrition, getting daily physical exercise and regular medical care, avoiding drugs and alcohol, and seeking

supportive services when needed). Our study was not aimed at assessing the effectiveness of these interventions in decreasing the risk of injury, and additional research is needed in this regard.

ACKNOWLEDGEMENTS

The authors would like to express our appreciation to Robert Reville, Carol Bigelow, Sylvia Spencer, Simon Folkard, Lonnie Golden, Gordon Smith, Jay Himmelstein, and Robin Clark for their suggestions and assistance in this study. We are indebted to Rainer Noess for his technical expertise, which includes software and technical support related to the ProQuest database system. Preliminary results of this study were presented at meetings of the American Public Health Association, the National Institute for Occupational Safety and Health (NIOSH), and the National Institute for Child Health and Human Development. This study was conducted with the support of a research grant (#R01-OH07576) from NIOSH.

Authors' affiliations

A E Dembe, S M Banks, University of Massachusetts Medical School, USA

J B Erickson, R G Delbos, Environ Health Sciences Institute, USA

Competing interests: This study was based on secondary analysis of publicly available national survey data and did not involve any direct contact with human subjects. It received an exemption from the institutional review board at the University of Massachusetts Medical School. The conduct of the study and preparation of this article has involved no competing interests for any of the authors.

REFERENCES

1 Hayashi T, Kobayashi Y, Yamaoka K, *et al*. Effect of overtime work on 24-hour ambulatory blood pressure. *J Occup Med* 1996;38:1007–11.
2 Iwasaki K, Sasaki T, Oka T, *et al*. Effect of working hours on biological functions related to cardiovascular system among salesmen in a machinery manufacturing company. *Ind Health* 1998;36:361–7.
3 Buell P, Breslow L. Mortality from coronary heart disease in Californian men who work long hours. *J Chron Dis* 1960;11:615–26.
4 Emdad R, Bältic K, Theorell T, *et al*. What prevents professional drivers from following physicians' cardiologic advice? *Psychoth Psychosom* 1998;67:226–40.
5 Kageyama T, Nishikido N, Kobayashi T, *et al*. Long commuting time, extensive overtime, and sympathodominant state assessed in terms of short-term heart rate variability among male white-collar workers in the Tokyo megalopolis. *Ind Health* 1998;36:209–17.
6 Liu Y, Tanaka H. The Fukuoka Heart Study Group. Overtime work, insufficient sleep, and risk of non-fatal acute myocardial infarction in Japanese men. *Occup Environ Med* 2002;59:447–51.
7 Russek HI, Zohman BL. Relative significance of heredity, diet and occupational stress in coronary heart disease of young adults. *Am J Med Sci* 1958;235:266–75.
8 Sokejima S, Kagamimori S. Working hours as a risk factor for acute myocardial infarction in Japan: case-control study. *BMJ* 1998;317:775–80.
9 Uehata T. Long working hours and occupational stress-related cardiovascular attacks among middle-aged workers in Japan. *J Hum Ergol* 1991;20:147–53.
10 Åkerstedt T, Fredlund P, Gillberg M, *et al*. A prospective study of fatal occupational accidents-relationship to sleeping difficulties and occupational factors. *J Sleep Res* 2002;11:69–71.
11 Park J, Kim Y, Chung H, *et al*. Long working hours and subjective fatigue symptoms. *Ind Health* 2001;39:250–4.
12 Proctor SP, White RF, Robins TG, *et al*. The effect of overtime work on cognitive function in automotive workers. *Scand J Work Environ Health* 1996;22:124–32.
13 Rosa R. Extended workshifts and excessive fatigue. *J Sleep Res* 1995;4:51–6.
14 Kirkcaldy BD, Trimpop R, Cooper CL. Working hours, job stress, work satisfaction and accident rates among medical practitioners, consultants and allied personnel. *International Journal of Stress Management* 1997;4:79–87.
15 Lehmkuhl L. Health effects of long work hours. "32 Hours" Organization Report. http://www.wan.net/32hours/Health%20Effects%20v2.htm, 1999.
16 Maruyama S, Kahno K, Morimoto K. A study of preventive medicine in relation to mental health among middle-management employees. Part 2. Effects of long working hours on lifestyles, perceived stress and working-life satisfaction among white-collar middle-management employees. *Nippon Eiseigaku Zasshi (Japanese Journal of Hygiene)* 1995;50:849–60.
17 Smith A, Johal S, Wadsworth E, *et al*. Stress and health at work, part IV: Interim findings of the Bristol survey. *Occup Health Rev* 1999;80:28–31.
18 Golombok N, Walters B. Work hours, schedule inflexibility, and stress in dual-earner spouses. *Can J Behav Sci* 1992;24:290–302.
19 Glass J, Fujimoto T. Housework, paid work, and depression among husbands and wives. *J Health Soc Behav* 1994;35:179–91.
20 Shields M. Long working hours and health. *Health Rep* 1999;11:33–48.
21 Bergqvist U, Wolgast E, Nilsson B, *et al*. Musculoskeletal disorders among visual display terminal workers: individual, ergonomic, and work organizational factors. *Ergonomics* 1995;38:763–76.
22 Fredriksson K, Alfredsson L, Koster M, *et al*. Risk factors for neck and upper limb disorders: results from 24 years of follow up. *Occup Environ Med* 1999;56:59–66.
23 Lipscomb JA, Trinkoff AM, Geiger-Brown J, *et al*. Work-schedule characteristics and reported musculoskeletal disorders of registered nurses. *Scan J Work Environ Health* 2002;28:394–401.
24 Rosenstock S, Andersen L, Vallentin C, *et al*. Socioeconomic factors associated in Helicobacter pylori infection among Danish adults. *Am J Public Health* 1996;86:1539–44.
25 Kawakami N, Araki S, Takatsuka N, *et al*. Overtime, psychosocial working conditions, and occurrence of non-insulin dependent diabetes mellitus in Japanese men. *J Epidemiol Community Health* 1999;53:359–63.
26 Ettner S, Grzywacz J. Workers' perceptions of how jobs affect health: a social ecological perspective. *J Occup Health Psychol* 2002;6:101–13.
27 Siu O, Donald I. Psychosocial factors at work and workers' health in Hong Kong: an exploratory study. *Bull Hong Kong Psychol Soc* 1995;34/35:30–56.
28 Worrall L, Cooper C. Working patterns and working hours: their impact on UK managers. *Leadership Organ Develop J* 1999;20:6–10.
29 Nylen L, Voss M, Floderus B. Mortality among women and men relative to unemployment, part time work, overtime work: a study based on data from the Swedish twin registry. *Occup Environ Med* 2001;58:52–7.
30 Caruso C, Hitchcock E, Dick R, *et al*. *Overtime and extended work shifts: recent findings on illnesses, injuries, and health behaviors*. Publication no. 2004-143. Cincinnati: US Centers for Disease Control, National Institute for Occupational Safety and Health, 2004.
31 Cooper C. Can we live with the changing nature of work? *J Manag Psychol* 1999;14:569–72.
32 Harrington JM. Health effects of shift work and extended hours of work. *Occup Environ Med* 2001;58:68–72.
33 Kodz J, Davis S, Lain D, *et al*. *Working long hours in the U.K.: a review of the research literature, analysis of survey data, and cross-national organizational case studies*, Employment Relations Research Series No. 16. Department of Trade and Industry, 2001.
34 Sparks K, Cooper C, Fried Y, *et al*. The effects of hours of work on health: a meta-analytic review. *J Occup Organ Psychol* 1997;70:391–408.
35 Spurgeon A. *Working time: its impact on safety and health*. Geneva: International Labour Organization, http://www.ilo.org/public/english/protection/condtrav/publ/wtwo-as-03.htm, 2003.
36 Spurgeon A, Harrington J, Cooper C. Health and safety problems associated with long working hours: a review of the current position. *Occup Environ Med* 1997;54:367–75.
37 Van der Hulst M. Long workhours and health. *Scand J Work Environ Health* 2003;29:171–88.
38 White J, Berwick J. *Working long hours*. Sheffield, UK: Health and Safety Laboratory, http://www.hse.gov.uk/research/hsl_pdf/2003/hsl03-02.pdf, 2003.
39 Lowery J, Borgerding J, Zhen B, *et al*. Risk factors for injury among construction workers at Denver International Airport. *Am J Ind Med* 1998;34:113–20.
40 Macias DJ, Hafner J II, Brillman JC, *et al*. Effect of time of day and duration into shift on hazardous exposures to biological fluid. *Acad Emerg Med* 1996;3:605–10.
41 Gander P, Merry A, Millar M, *et al*. Hours of work and fatigue-related error: a survey of New Zealand anesthetists. *Anaesthesic Intensive Care* 2000;28:178–83.
42 Trimpop R, Kirkcaldy B, Athanasou J, *et al*. Individual differences in working hours, work perceptions and accident rates. *Work and Stress* 2000;14:181–8.
43 Kirkcaldy B, Trimpop R, Cooper C. Working hours, job stress, work satisfaction and accident rates among medical practitioners, consultants and allied personnel. *International Journal of Stress Management* 1997;4:79–87.
44 Simpson C, Severson R. Risk of injury in African-American hospital workers. *J Occup Environ Med* 2000;42:1035–40.
45 Duchon J, Smith T. *Extended workdays in mining and other industries: a review of the literature*. Minneapolis: United States Department of the Interior, Bureau of Mines, Information Circular, Twin Cities Research Center, 1994.
46 Meijman T. Mental fatigue and the efficiency of information processing in relation to work times. *Int J Ind Ergon* 1997;20:31–8.
47 McCartt A, Rohrbaugh J, Hammer M, *et al*. Factors associated with falling asleep at the wheel among long-distance truck drivers. *Accident Anal Prev* 2000;32:493–504.
48 Lusa S, Hakkanen M, Luukkonen R, *et al*. Perceived physical work capacity, stress, sleep disturbance and occupational accidents among firefighters working during a strike. *Work and Stress* 2002;16:264–74.
49 Baker K, Olson J, Morisseau D. Work practices, fatigue, and nuclear power plant safety performance. *Human Factors* 1994;36:244–57.
50 Ong C, Kogi K. Shiftwork in developing countries: current issues and trends. In: Scott AJ, ed. *Shiftwork*. Philadelphia: Hanley and Belfus, 1990:417–28.
51 Hennecke K, Tiedemann S, Nachreiner F, *et al*. Accident risk as a function of hour at work and time of day as determined from accident data and exposure models for the German working population. *Scand J Work Environ Health* 1998;24:43–8.
52 Nachreiner F, Akkermann S, Hennecke K. Fatal accident risk as a function of hours into work. In: Hornberger S, Knauth P, Costa G, Folkard S, eds. *Arbeitswissenschaft in der betrieblichen Praxis 17: Shiftwork in the 21st Century*. Frankfurt: Peter Lang, 2000:19–24.
53 Åkerstedt T. Work injuries and time of day—national data. *Shiftwork International Newsletter* 1995;12:2.

54 Folkard S, Akerstedt T. Trends in the risk of accidents and injuries and the implications for models of fatigue and performance. *Aviation Space Environ Med* 2004;75:A161–7.
55 Tucker P, Folkard S, Macdonald I. Rest breaks reduce accident risk. *Lancet* 2003;361:680.
56 Akerstedt T, Fredlund P, Gillberg M, *et al*. A prospective study of fatal occupational accidents-relationship to sleeping difficulties and occupational factors. *J Sleep Res* 2002;11:69–71.
57 Johnson M, Sharit J. Impact of a change from an 8-hour to a 12-hour shift schedule on workers and occupational injury rates. *Int J Ind Ergon* 2001;27:303–19.
58 Kirkcaldy B, Levine R, Shephard R. The impact of working hours on physical and psychological health of German managers. *Eur Rev Appl Psychol* 2000;50:443–9.
59 Nolting H, Berger J, Schiffhorst G, *et al*. Psychischer Stress als Risikofaktor für Arbeitsunfälle im Krankenhaus [Job strain as a risk factor for occupational accidents among hospital nursing staff]. *Gesundheitswesen* 2002;64:25–32.
60 Voss M, Floderus B, Diderichsen F. Physical, psychosocial, and organisational factors relative to sickness absence: a study based on Sweden Post. *Occup Environ Med* 2001;58:178–84.
61 Laundry B, Lees R. Comparison of reported workplace morbidity in 8 and 12 hour shifts in one plant. *J Soc Occup Med* 1989;39:81–4.
62 Schuster M, Rhodes S. The impact of overtime work on industrial accident rates. *Ind Rel* 1985;24:234–46.
63 US Department of Labor, Bureau of Labor Statistics. *NLSY79 users' guide 2001*, http://www.bls.gov/nls/79guide/nls79usg.htm, 2004.
64 Frankel M, Williams H, Spencer B. *Technical Sampling Report, National Longitudinal Survey of Labor Force Behavior*. Chicago: NORC, University of Chicago, 1983.
65 United States Department of Commerce, US Census Bureau. *1970 census occupation and industry classification codes*, http://www.ipums.umn.edu/usa/volii/97indus.html; and http://www.bsc.ohio-state.edu/scf/coc.htm, 2004.
66 United States Department of Labor, Bureau of Labor Statistics. (1998–2000). *Industry injury and illness data series*. Washington, DC: Bureau of Labor Statistics, http://www.bls.gov/iif/oshsum.htm#02Illness%20Data, 2004.
67 *SAS 8.0 Manual*. Cary, NC: SAS Institute Inc, 2001.
68 *ProQuest Manual*. Goshen, MA: SoftWhere, Inc, http://www.softwhere.net, 2004.
69 State Corporation. *State user's guide*. College Station, TX: State Press, 2003.
70 Shah B, Barnwell B, Bieler G. *SUDAAN user's manual, release 7.5*. Research Triangle Park, NC: Research Triangle Institute, 1997.
71 Folkard S, Lombardi D. Modelling the impact of the components of long work hours on injuries and "accidents". Presentation at the National Institute of Justice and CDC/NIOSH Conference on Impact of Long Working Hours. Baltimore, MD, 29–30 April, 2004.
72 US Department of Labor, Bureau of Labor Statistics. *Occupational injury, illness, and fatality data*, http://www.bls.gov/iif/home.htm, 2004.
73 Johnson D. The case of the falling injury rate. *Industrial Safety & Hygiene News Online*. Posted 15 May 2000. http://www.ishn.com/CDA/ArticleInformation/features/BNP__Features__Item/0,2162,2963,00.html, 2000.
74 Van der Hulst M, Geurts S. Associations between overtime and psychological health in high and low reward jobs. *Work Stress* 2001;15:227–40.
75 Golden L, Jorgenson H. *Time after time: mandatory overtime in the U.S. economy*. Economic Policy Institute Briefing Paper.http://www.epinet.org/content.cfm/briefingpapers_bp120, 2002.
76 US Department of Labor, Employment Standards Administration, Wage and Hour Division. The "new economy" and its impact on executive, administrative, and professional exemptions to the Fair Labor Standards Act (FLSA). Washington, DC: Department of Labor, 2001:4–45.
77 United States General Accounting Office. *Fair Labor Standards Act: white collar exemptions in the modern work place*. Report to the Subcommittee on Workforce Protections, Committee on Education and the Workforce, US House of Representatives, Washington, DC: GAO HEHS-No, 99-164. September, 1999.
78 Hetrick R. Analyzing the recent upward surge in overtime hours. *Monthly Labor Rev* 2000;123:30–3.
79 Eisenbrey R, Bernstein J. *Eliminating the right to overtime pay*, Economic Policy Institute Briefing Paper.http://www.epinet.org/content.cfm/briefingpapers_fsa_jun03, 2003.
80 Institute for Workplace Studies. *Overtime and the American worker*. Ithaca: Cornell University School of Industrial and Labor Relations, [illegible].
81 Krause N, Lynch J, Kaplan G, *et al*. Predictors of disability rate[illegible]. *Scand J Work Environ Health* 1997;23:403–13.
82 Iwasaki K, Sasaki T, Oka T, *et al*. Effect of working hours on biological functions related to cardiovascular system among salesmen in a machinery manufacturing company. *Ind Health* 1998;36:361–7.

Answers to questions on *Genetic screening and occupational and environmental exposures* by P Vineis *et al*, on pages 657–662

(1) c; (2) a and b; (3) b and d; (4) c and d; (5) d

Long work hours and occupational injuries: new evidence on upstream causes

D Loomis

Occup. Environ. Med. 2005;62;585-
doi:10.1136/oem.2005.021014

Occupational injuries

Long work hours and occupational injuries: new evidence on upstream causes

D Loomis

Commentary on the paper by Dembe *et al* (see page 588)

Epidemiological research on the causes of occupational traumatic injuries presents interesting practical and conceptual challenges. On a superficial level, the causation of injuries seems deceptively simple, because the agent of injury—energy—is already known. One of the problems researchers face, however, is that the transfer of potentially harmful energy to a human host is difficult to observe because it takes place very quickly and is rarely recorded or documented in databases. New studies are beginning to take up these challenges with innovative approaches like the case-crossover design.[1] Another challenge, perhaps conceptually more difficult, is that because the agent of injury is known, its discovery is not an important research problem. Instead, it is the "upstream" causes[2] of injury—the events and circumstances that bring people into contact with the agent—that are of interest. Some studies published recently in this journal have investigated potential causes upstream of the injured worker, ranging in proximity from the organisation of workplaces[3] to the structure of the national economies.[4]

In this issue, Dembe and colleagues[5] use individual-level data from a national longitudinal survey in the United States to investigate another upstream risk factor for occupational injury: extended work time. The authors' analyses of this large database show the rate of injury increasing quantitatively with the number of hours worked on a daily or weekly basis. Among people who worked more than 12 hours per day or more than 60 hours per week, the rate of injury and illness was roughly 30–40% higher than among those working fewer hours. Working overtime was associated with a still higher rate of injury, about 60–80% greater than among people who did not work overtime. These associations were statistically significant and remained after adjustment for age, gender, occupation, industry, and region.

These findings draw attention to the potential importance of a pervasive trend in the current labour market. In the United States, the average number of hours worked by all employed people and the average number of overtime hours for manufacturing workers have been on the increase since the 1970s.[6] American workers—and many others around the world—have been working longer as global competition has intensified. If the findings of this new study represent the US experience, the implications would be alarming: the combination of lengthening work weeks and injury rates that increase with extended time on the job could result in an increase in the rate of injury for the entire workforce. Such an increase has not been observed, however. Instead, as Dembe *et al* show in fig 2, the overall rates of occupational injury and illness have been declining with time.[6]

Ecological trends in working hours and injury rates make a good starting point for looking upstream, but they clearly do not tell the whole story and the potential adverse effects of longer work schedules are far-reaching enough to motivate more research. One possible explanation for the apparent conflict between national trends and the findings Dembe *et al* report is that longer hours may only result in greater risk for a subset of workers—perhaps those with greater potential exposure to the agent of injury. Studies investigating the effects of extended work hours by occupation and industry might lead to insights about who is at risk when working hours increase. It is also possible that the reported results do not generalise to the entire labour force. The survey on which the study is based was designed to be statistically representative of people living in the United States in 1979 who were born between 1957 and 1964—a large group in absolute numbers, but a small proportion of the workforce at the time of the study, whose jobs and health experience may not be typical. It would be useful to learn whether similar relationships are seen in other cohorts, for US workers generally, and in other countries. The current paper also leaves unanswered questions about time related aspects of the relationship between injury risk and work schedules. The data shown in fig 2 of the paper suggest that the greatest differences in risk between workers exposed and not exposed to extended hours occurred in the 1980s, but in later years injury rates for exposed workers declined more rapidly, erasing much of the difference by 2000. However, the analysis simply compares average rates during the entire study period and does not account for this potential interaction between calendar time and exposure. Future studies might analyse temporal trends in both injury rates and working hours in the hope of learning whether the effect of longer work hours still exists and whether it is likely to persist in the future.

Good research tends to raise questions as well as answer them, and in this respect Dembe and his colleagues have succeeded admirably. Their paper on the impact of overtime and long work hours presents provocative findings and should stimulate further investigation of this important issue, looking both upstream at the factors that drive the trends towards longer work schedules and downstream toward possible mechanisms of injury.

Occup Environ Med 2005;62:585.
doi: 10.1136/oem.2005.021014

Correspondence to: Prof. D Loomis, Department of Epidemiology, CB-7435 School of Public Health, University of North Carolina, Chapel Hill, NC 27599, USA; dana.loomis@unc.edu

Competing interests: none declared

REFERENCES

1 Sorock GS, Lombardi DA, Hauser R, *et al*. A case-crossover study of transient risk factors for occupational acute hand injury. *Occup Environ Med* 2004;61:305–11.
2 Anon. Population health: looking upstream. *Lancet* 1994;343:429–30.
3 Gimeno D, Felknor S, Burau KD, *et al*. Organisational and occupational risk factors associated with work related injuries among public hospital employees in Costa Rica. *Occup Environ Med* 2005;62:337–43.
4 Loomis D, Richardson DB, Bena JF, *et al*. Deindustrialisation and the long term decline in fatal occupational injuries. *Occup Environ Med* 2004;61:616–21.
5 Dembe AE, Erickson JB, Delbos RG, *et al*. The impact of overtime and long work hours on occupational injuries and illnesses: new evidence from the United States. *Occup Environ Med* 2005;62:588–97.
6 US Department of Labor, Bureau of Labor Statistics. http://www.bls.gov/home. Accessed 25 April 2005.

Opposition to Mandatory Overtime

Summary: Shortages of available or experienced nurses have added another dimension to inadequate staffing brought about through purposeful restructuring, downsizing and substitution of unlicensed assistive personnel (UAP) for registered nurse staff in hospitals. The use of mandatory overtime as a solution to nurse staffing shortages is rampant today, and is pushing nurses beyond their capacity to work safely and to provide appropriate, quality care to patients. Nearly half of the respondents to a recent ANA staffing survey reported mandatory overtime being used to cover staffing shortages (ANA Staffing Survey, 2001). In addition, inadequate staffing is a source of nurses' job dissatisfaction, further contributing to the problem of recruitment and retention of nurses, and with the attraction of new talent to the profession. The absence of prohibitions or limitations on overtime work may contribute to health care errors, as well as work-related illnesses and injuries among nursing staff. ***ANA opposes the use of mandatory overtime as a staffing tool.*** Only individuals are capable of determining their capacity to work beyond their predetermined, regular work schedules. No employee of a health care facility should be required or forced to work overtime. Individual nurses are expected to exercise their critical judgment in determining their ability to provide safe patient care.

Background

Nurses report a dramatic increase in the use of mandatory overtime to solve staffing problems and fear potential consequences for safety and quality of care for their patients. Nurses are fully cognizant and concerned about inadequate staffing. In addition, they are also resentful that they bear the personal, professional and legal burden for this problem that is perceived by nurses as a violation of their human rights. This practice causes the nurse to assume accountability and liability for potentially unsafe situations and/or loss of their employment.

Little research has been done to comprehensively evaluate overtime and its relationship to productivity, quality and safety provided in hospitals or the incidence of work place accidents, injuries and stress-related illnesses among nurses. There is limited research evaluating implications of extended/overtime work on health status health care workers (Samkoff and Jacques, 1991). The available research has, however, indicated a relationship between extended shifts and fatigue and generalized performance (Galinsky, et. al., 1993; Sawin and Scerbo, 1995; Pilcher and Huffcutt, 1996; Spurgeon, Harrington and Cooper, 1997). The absence of a solid research foundation on extended hours of work on nurses makes it easier to abuse the hours of work -- especially when work revolves around the care of vulnerable human beings with needs that span the full 24 hours in a day.

Nurses believe employer dependence on the use of mandating last-minute overtime, or of using peer pressure as a negative motivator, alleviates a sense of urgency or necessity to proactively find safer and more appropriate staffing. In fact, in some areas, (mandatory) overtime is used as a component of staffing models and the phrase "mandation" has been coined to define the methodology. Many nurses contend employers insist they stay for an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing (BON) for patient abandonment.

Provision 5 of the ANA *Code of Ethics for Nurses with Interpretive Statements* (2001), notes that "The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth." Interpretative Statement 5.4 continues and further states that "Where patterns of institutional behavior or professional practice compromise the integrity of all its nurses, nurses should express their concern or conscientious objection collectively to the appropriate body or committee. In addition, they should express their concern, resist, and seek to bring about a change in those persistent activities or expectations in the practice setting that are morally objectionable to nurses and jeopardize either patient or nurse well-being."

Definitions:

Overtime is . . .
the hours worked in excess of an agreed upon, predetermined, regularly scheduled full-time or part-time work schedule, as determined by contract, established work scheduling practices, policies or procedures.

Patient abandonment is . . .

a unilateral severance of the established nurse-patient relationship without giving reasonable notice to the appropriate person so that arrangements can be made for continuation of nursing care by others. Refusal to accept an assignment (or a nurse-patient relationship) does not constitute patient abandonment.

A number of state boards of nursing have issued advisory opinions or positions on what does, and does not, constitute abandonment. Included among them are: Alabama, California, Michigan, Ohio and Oregon. In each state's comments, abandonment is defined, and matters that are subject to discipline by the state board are differentiated from those that should be handled by the employer. In a unique approach, the South Carolina BON has issued an advisory opinion stating that 12 hours of work should be a maximum expectation when considering the nurse's ability to ensure safe patient care delivery. The Michigan BON noted that nurses who exercise critical judgement in rejecting a request to work overtime because they believe they cannot safely provide care are not abandoning their patients (*The Michigan Nurse*, April 2001). In addition to action taken by individual BONs, the Delegate Assembly of the National Council of State Boards of Nursing, Inc. (NCSBN) passed a resolution which "recognizes the professional responsibility of nurses to accept or decline overtime assignments based on their self assessment of ability to provide safe care."

The American Nurses Association remains very concerned about the impact of mandatory overtime on the ability of the nation's nurses to provide high quality health care services. ANA believes that the elimination of mandatory overtime for the nation's nurses is a critical success factor in efforts to improve the quality of health care and improved working conditions for nurses.

References

(2001). Saying no to mandatory overtime. *The Michigan Nurse*, 74(4), 7.

Aiken, L. (1998). Powerful nurses protecting patients. *Nursing Standard*, 13(7.)

Allen, D. (2000). Where do the hours go? *Nursing Standard*, 14(18).

American Nurses Association, (2001) Code of Ethics for Nurses with Interpretive Statements. Washington, DC: American Nurses Publishing.

American Nurses Association. (2001). Nationwide State Legislative Agenda on Staffing. Washington, DC: American Nurses Association.

American Nurses Association. (2001) Analysis of American Nurses Staffing Survey. Washington, DC: American Nurses Association.

European Council Directive on Working Time. (93/104/EC)

Federal Motor Carrier Safety Regulations, (2000). 49 CFR § 395.1.

Federal Aviation Administration, Department of Transportation, (2000) Crewmember Flight Time and Duty Period Limitations and Rest Requirements, 14 CFR § 135.269.

Galinsky, TL, Rose, RR, Warm, JS and Dember, WN. (1993). Psychophysical Determinants of Stress in Sustained Attention. *Human Factors*, 35(4), 603-614.

Guant, JA. (1980, July) The relationship between overtime and safety. Professional Safety, 11-15.

Hayashi, T, Kobayashi,Y, Yamaoka, K, and Yano, E. (1996). Effect of Overtime Work on 24-Hour Ambulatory Blood Pressure *Journal of Emergency Medicine*, 38(10).

Iskra-Golec, I, Folkard, S, Marek, T, and Noworol, C. (1996). Health, well-being and burnout of ICU nurses on 12- and 8-h shifts. *Work & Stress*, 10(3), 251- 256.

Kirkcaldy, BD, Trimpop, R, and Cooper, CL. (1977). Working Hours, Job Stress, Work Satisfaction, and Accident Rates Among Medical Practitioners and Allied Personnel. *International Journal of Stress Management*, 4(2).

Kohn, LT, Corrigan, JM & Donaldson, ML. (1999). To err is human: Building a safer health system. Washington, DC: National Academy Press.

McGall, TB. (1988). The Impact of Long Working Hours on Resident Physicians. New England Journal of Medicine, 318(12), 775-778.

Medical Facilities–Minimum Standards, (1999). 10 NYCRR § 405.4.

National Council of State Boards of Nursing, Inc. (2001, August 22). Press Release: *NCSBN Promotes Safe Patient Care at Annual Delegate Assembly*. Chicago, IL: National Council of State Boards of Nursing, Inc.

Pilcher, JJ and Huffcutt, AI. (1996). Effects of Sleep Deprivation on Performance: A Meta-Analysis. *Sleep* 19(4), 318-326.

Rosa, RR. (1995). Extended workshifts and excessive fatigue. *Journal Sleep Research 4*, Supplement 2, 51-56.

Samkoff, JS and Jacques, CHM. (1991). A Review of Studies Concerning Effects of Sleep Deprivation and Fatigue on Residents' Performance. *Academic Medicine*, 66(11), 687-693.

Sawin, DA and Scerbo, MW. (1995). **Effects of Instruction Type and Boredom Proneness in Vigilance: Implications for Boredom and Workload.** *Human Factors*, 37(4), 752-765.

Smith, L, Folkard, S, Tucker, P and Macdonald, I. (1998). Work shift duration: A review comparing eight hour shift systems. *Occupational and Environmental Medicine*, 55, 217-229.

Sokejima, S and Kagamimori, S. (1998). Working hours as a risk factor for acute myocardial infarction in Japan: case-control study. *British Medical Journal*: 317, 775-780.

Spurgeon, M, Harrington, JM and Cooper, CL. (1997). Health and safety problems associated with long working hours: a review of the current position. *Occupational and Environmental Medicine*, 54(6), 367-375.

Wunderlich, GS, Sloan, FA and Davis, CK. (1996). *Nursing Staff in Hospitals and Nursing Homes ~ Is It Adequate?* Washington, DC: National Academy Press.

Effective Date: October 17, 2001
Status: Position Statement
Originated By: Congress on Nursing Practice and Economics
Adopted By: ANA Board of Directors

Related Past Actions:
2000 HOD Opposing the Use of Mandatory Overtime as a Staffing Solution (Action Report)

The Working Hours Of Hospital Staff Nurses And Patient Safety

Both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch.

by Ann E. Rogers, Wei-Ting Hwang, Linda D. Scott, Linda H. Aiken, and David F. Dinges

ABSTRACT: The use of extended work shifts and overtime has escalated as hospitals cope with a shortage of registered nurses (RNs). Little is known, however, about the prevalence of these extended work periods and their effects on patient safety. Logbooks completed by 393 hospital staff nurses revealed that participants usually worked longer than scheduled and that approximately 40 percent of the 5,317 work shifts they logged exceeded twelve hours. The risks of making an error were significantly increased when work shifts were longer than twelve hours, when nurses worked overtime, or when they worked more than forty hours per week.

SEVERAL TRENDS IN HOSPITAL USE and staffing patterns have converged to create potentially hazardous conditions for patient safety. High patient acuity levels, coupled with rapid admission and discharge cycles and a shortage of nurses, pose serious challenges for the delivery of safe and effective nursing care for hospitalized patients.[1] While systematic national data on trends in the number of hours worked per day by nurses are lacking, anecdotal reports suggest that hospital staff nurses are working longer hours with few breaks and often little time for recovery between shifts.[2] Scheduled shifts may be eight, twelve, or even sixteen hours long and may not follow the traditional pattern of day, evening, and night shifts. Although twelve-hour shifts usually start at 7 p.m. and end at 7 a.m., some start at 3 a.m. and end at 3 p.m. Nurses working on specialized units such as

Ann Rogers (aerogers@nursing.upenn.edu) is an associate professor in the School of Nursing and in the Center for Sleep and Respiratory Neurobiology, School of Medicine, University of Pennsylvania, in Philadelphia. Wei-Ting Hwang is an assistant professor in the Department of Biostatistics and Epidemiology, Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania School of Medicine. Linda Scott is an associate professor in the Kirkhof College of Nursing, Grand Valley State University, in Grand Rapids, Michigan. Linda Aiken is the Claire M. Fagin Leadership Professor of Nursing and a professor of sociology at the University of Pennsylvania. David Dinges is a professor in the Division of Sleep and Chronobiology, Department of Psychiatry, Center for Sleep and Respiratory Neurobiology, University of Pennsylvania School of Medicine.

DOI 10.1377/hlthaff.23.4.202

surgery, dialysis, and intensive care are often required to be available to work extra hours (on call), in addition to working their regularly scheduled shifts. Twenty-four-hour shifts are becoming more common, particularly in emergency rooms and on units where nurses self-schedule.

No state or federal regulations restrict the number of hours a nurse may voluntarily work in twenty-four hours or in a seven-day period.[3] Even though state legislatures in approximately nineteen states have considered bans on mandatory overtime for nurses and other health care professionals, bills prohibiting mandatory overtime for nurses have passed only in California, Maine, New Jersey, and Oregon. No measure, either proposed or enacted, addresses how long nurses may work voluntarily.[4] The recent Institute of Medicine (IOM) report, *Keeping Patients Safe*, explicitly recommends that voluntary overtime also be limited.[5]

The well-documented hazards associated with sleep-deprived resident physicians have influenced changes in house staff rotation policies.[6] In contrast, although shift-working nurses have been the focus of numerous studies, it is not known if the long hours they work have an adverse effect on patient safety in hospitals.[7] The purpose of this paper is to examine the work patterns of hospital staff nurses and to determine if there is a relationship between hours worked and the frequency of errors.

Study Data And Methods

■ **Sample.** A cover letter explaining the study and eligibility criteria was mailed to a random nationwide sample of 4,320 members of the American Nurses Association (ANA) during the winter of 2002; 1,725 nurses expressed interest by returning their completed demographic questionnaire to the Survey Research Institute at Temple University in Philadelphia. Two logbooks covering a two-week period each, instructions for completing the logbooks, and postage-paid envelopes were mailed to 891 eligible subjects (unit-based hospital staff nurses working full time). Three hundred sixty-two subjects returned both logbooks, and thirty-one completed only one of the two logbooks, for a return rate of approximately 40 percent. The Institutional Review Board at the University of Pennsylvania approved this study, and subjects were paid $140 for their participation.

■ **Subjects.** The sample of 393 registered nurses (RNs) was predominantly female (92 percent), Caucasian (79 percent), middle-aged (mean age 44.8 ±8.8 years, range 22–66), and experienced (mean 17.2 ±10.0 years). Only 26.3 percent of the participants reported less than ten years' experience, while 41.9 percent reported twenty or more years. All participants worked full time (at least thirty-six hours per week) as hospital staff nurses. Half reported working in hospitals with more than 300 beds; only 11 percent reported working in a hospital with less than 100 beds. The majority of participants were employed at hospitals located in urban (56 percent) or suburban (19 percent) areas. The remaining participants worked in hospitals located in small towns (18 percent) or rural areas (7 percent). The characteristics of

nurses in the study sample did not differ significantly from those of nurses in the 2000 National Sample Survey of Registered Nurses (NSSRN) in terms of sex, age, marital status, and work environment (hospital size, urban/rural location, and type of hospital unit).[8] Our sample has slightly more nurses who identified their ethnicity as Asian (10.7 percent) than among participants in the NSSRN (3.8 percent).

■ **Instruments.** Spiral-bound logbooks were used to collect information about hours worked (both scheduled and actual hours), time of day worked, overtime, days off, and sleep/wake patterns. Subjects completed seventeen to forty items per day; all forty questions were completed only on days the nurses worked. Questions regarding errors and near errors were included, and space was provided for nurses to describe any errors or near errors that might have occurred during their work periods. On days off, nurses were asked to complete the first seventeen questions about their sleep/wake patterns, mood, and caffeine intake. All items in the logbook and the logbook format itself were pilot-tested before this study began.

Logbooks (both paper and electronic) have been used to collect data during field studies of pilots' cockpit alertness for more than ten years, and from various other groups of subjects including air traffic controllers, flight controllers during space shuttle missions, and emergency room physicians.[9] Data recorded about sleep patterns in these logbooks compare well with data recorded using objective measures such as wrist actigraphy or ambulatory polysomnography.[10]

Although logbooks are not often used to collect information about medical errors, there is some evidence that daily, anonymous, end-of-shift reporting of errors in a logbook is a valid approach to ascertaining the nature and prevalence of nursing errors. During a one-month study period of medication errors at a large military hospital, nurses completed formal incident reports on only 6 percent of the medication errors and 15 percent of the near errors that they reported using daily, anonymous coupons.[11] Another study found that resident physicians also were more likely to report potential injuries to patients using a confidential e-mail system with daily prompts about reporting than they were to complete traditional incident reports.[12]

■ **Analysis.** Data from demographic questionnaires and logbooks were summarized using descriptive statistics and frequency tables. The duration of scheduled and actual work hours per shift was calculated and aggregated per nurse and per week. Cutpoints for classifying shift durations were chosen as 8.5 hours and 12.5 hours because "eight-hour" and "twelve-hour" shifts are usually scheduled to allow for a half-hour handover period at the end of the shift. A work shift was classified as an overtime shift if the actual work hours were longer than the scheduled hours or if the nurse reported that the shift was "scheduled overtime."

A binary response for making an error during a worked shift was used as the primary outcome in analyses. When a nurse caught him/herself before making an error during a shift, a binary near-error variable was reported and treated as the secondary outcome. Errors and near errors were codified into categories by study

investigators, based on the descriptions provided in logbooks (for example, medication administration, procedural, transcription). The univariate associations between the risk of making an error or a near error and (1) the actual duration of the shift, and (2) overtime were estimated separately using logistic regression models. The effect of overtime was also examined by stratifying shifts by their expected duration. Since multiple work shifts from the same nurse contributed to this analysis, procedures based on Generalized Estimating Equation (GEE) were used to determine the odds ratio (OR) while accounting for the nonindependence between repeated measurements.[13] Significance tests were two-sided with alpha = .05. Multivariate analyses also were conducted to evaluate the adjusted associations between errors (or near errors), work hours, and overtime, while controlling for other variables including age, hospital size, and type of hospital unit. For the week-level data, logistic regression models were performed to assess if working more than forty hours or fifty hours would increase the probability of making one or more errors (or near errors) in a week.

Study Results

Data collected on 5,317 work shifts revealed that hospital staff nurses worked longer than scheduled daily, and generally worked more than forty hours per week. Half of the shifts worked exceeded ten and a half hours. Although 31 percent of the scheduled shifts were scheduled for durations greater than or equal to 12.5 hours, there were 2,057 shifts (39 percent) where nurses worked at least 12.5 consecutive hours (Exhibit 1). Fourteen percent of the respondents reported working sixteen or more consecutive hours at least once during the four-week pe-

EXHIBIT 1
Description Of Work Patterns Of Full-Time Hospital Staff Nurses, 2002

Variable	Number of shifts	Percent
Number of shifts	5,317	100.0
Scheduled shifts[a]		
Up to 8.5 hours	2,452	46.6
8.5–12.5 hours	1,183	22.5
12.5 or more hours	1,623	30.9
Actual shifts[b]		
Up to 8.5 hours	771	14.5
8.5–12.5 hours	2,484	46.8
12.5 or more hours	2,057	38.7
Number of overtime shifts	4,292	81.4
Number of mandatory overtime shifts	360	6.8

SOURCE: Authors' analysis of survey results.

[a] Scheduled shift hours were missing from 59 shifts. Mean length (hours): 10.3 (standard deviation, ±2.3); range: 1.0–22.5 hours.

[b] Actual work hours were missing from 5 shifts. Mean length (hours): 10.8 (SD, ±2.5); range: 1.2–23.7 hours.

riod. The longest shift worked was twenty-three hours, forty minutes.

Nurses reported leaving work at the end of their scheduled shift less than 20 percent of the time during the study period. Although overtime was reported at the end of all types of shifts, the proportion of shifts involving overtime was significantly higher ($p = .0001$) when eight-hour shifts (85 percent) were compared to shifts scheduled for eight to twelve hours (79 percent) and twelve hours or longer (78 percent). Overall, our participants worked, on average, fifty-five minutes longer than scheduled each day, and all participants worked beyond their scheduled work shift (overtime) at least once during the twenty-eight-day data-gathering period. Almost two-thirds of the nurses worked overtime ten or more times during that period, and a third reported working overtime each day they worked during that period. There were 360 shifts where nurses reported being mandated to work overtime and another 143 shifts where they described being "coerced" to work voluntary overtime. Even though nurses worked approximately four days per week, averaging 40.2 (±12.9) hours per week (range 8–97.2 hours per week), one-quarter worked more than fifty hours per week for two or more weeks of the four-week period.

There were 199 errors and 213 near errors reported during the data-gathering period. More than half of the errors (58 percent) and near errors (56 percent) involved medication administration. Other errors included procedural errors (18 percent), charting errors (12 percent), and transcription errors (7 percent). Approximately 6 percent of the errors and 29 percent of the near errors reported lacked sufficient information for categorization. Thirty percent of the nurses reported making at least one error, and 32 percent reported at least one near error. One nurse reported eight errors, while another nurse reported nine near errors.

Our analysis showed that work duration, overtime, and number of hours worked per week had significant effects on errors. The likelihood of making an error increased with longer work hours and was three times higher when nurses worked shifts lasting 12.5 hours or more (odds ratio = 3.29, $p = .001$) (Exhibit 2). Working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled (OR = 2.06, $p = .0005$). Our data also

EXHIBIT 2
Association Of Errors Or Near Errors With Nurses' Work Duration, 2002

Work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 8.5	771	12	1.6	1.00	20	2.6	1.00
8.5–12.5	2,484	77	3.1	1.85 (.06)	94	3.8	1.44 (.18)
12.5 or more	2,057	103	5.0	3.29 (.001)	97	4.7	1.80 (.04)
Total	5,312	192	3.5		211	4.0	

SOURCE: Authors' analysis of survey results.

NOTES: Five shifts with four errors cannot be classified because of missing work durations. OR is odds ratio.

suggest that there is a trend for increasing risks when nurses work overtime after longer shifts (OR = 1.34, 1.53, and 3.26 for scheduled eight-hour, eight-to-twelve-hour, and twelve-hour shifts, respectively), with the risks being significantly elevated for overtime following a twelve-hour shift ($p = .005$) (Exhibit 3). Although the effects of working prolonged shifts were clearly associated with errors, there was no interaction between scheduled shift duration and overtime ($p = .17$). Finally, working more than forty hours per week and more than fifty hours per week significantly increased the risk of making an error (Exhibit 4). Results were somewhat similar for near errors (Exhibits 2–4).

Nurse and employment characteristics were also examined as potential confounders in the multivariate models. Our results suggest that the relationships of errors or near errors and work hours and overtime were not affected by age, hospital size, or type of hospital unit.

Discussion

This study represents one of the first nationwide efforts to quantify hospital staff nurse work hours and work patterns, and to determine whether extended staff nurse work hours contribute to errors and near errors. Our findings confirm that the work schedules of hospital staff nurses are unpredictably prolonged. All nurses reported working longer than scheduled at least once, and the majority reported working longer than scheduled ten times or more in a twenty-eight-day period, as well as working more than forty hours per week. Almost one-sixth of the sample reported working sixteen or more consecutive hours at least once during the period, which suggests that double shifts (or longer) are not confined to rare emergencies. Mean daily overtime durations were slightly higher than those

EXHIBIT 3
Association Of Errors Or Near Errors With Nurses' Scheduled Work Duration And Overtime, 2002

Scheduled work duration (hours)	Number of shifts	Shifts with one or more errors			Shifts with one or more near errors		
		Number	Percent	OR (p value)	Number	Percent	OR (p value)
Up to 8.5							
No OT	377	8	2.1	1.00	15	4.0	1.00
OT	2,075	65	3.1	1.34 (.42)	76	3.7	0.90 (.74)
8.5–12.5							
No OT	246	6	2.4	1.00	3	1.2	1.00
OT	937	36	3.8	1.53 (.36)	42	4.5	2.32 (.08)
12.5 or more							
No OT	360	6	1.7	1.00	8	2.2	1.00
OT	1,263	70	5.5	3.26 (.005)	67	5.3	2.34 (.03)
Total	5,258	191	3.6		211	4.0	

SOURCE: Authors' analysis of survey results.

NOTES: Fifty-nine shifts with five errors and two near errors cannot be classified because of missing scheduled work durations. OR is odds ratio. OT is overtime.

EXHIBIT 4
Association Of Errors Or Near Errors With The Number Of Hours Worked Per Week By Nurses, 2002

Hours worked	Number of weeks	Weeks with one or more errors			Weeks with one or more near errors		
		Number	Percent	OR (*p* value)	Number	Percent	OR (*p* value)
More than 40							
No	743	64	8.6	1.00	75	10.1	1.00
Yes	681	101	14.8	1.96 (<.0001)	92	13.5	1.42 (.03)
Total	1,424	165	11.6		167	11.7	
More than 50							
No	1,110	112	10.1	1.00	120	10.8	1.00
Yes	314	53	16.9	1.92 (.0001)	47	15.0	1.46 (.03)
Total	1,424	165	11.6		167	11.7	

SOURCE: Authors' analysis of survey results.
NOTE: OR is odds ratio.

reported in two small observational studies (fifty-five minutes, compared with forty-two and forty-five minutes, respectively).[14]

Although the occurrence of errors did not increase significantly until shift durations exceeded 12.5 hours per day, risks began to increase when shift durations exceeded 8.5 hours. Since errors are relatively rare, it is possible that this study lacked sufficient power to detect the effects of work hours or overtime on errors when nurses were scheduled to work shorter shifts (less than 12.5 hours). Certainly the trend toward increasing errors with longer work durations is consistent with other studies that have demonstrated that extended work periods are associated with increased accidents and neuropsychological deficits among nurses and have contributed to at least two hospitalwide epidemics of Staphylococcus aurous.[15] Investigations of these epidemics showed that nurses, who were fatigued and stressed by high patient caseloads and understaffing, made frequent mistakes and procedural errors. Despite the lack of information about accident rates involving nurses, probed performance tests reveal that nurses working twelve-hour simulated shifts make more frequent errors on grammatical reasoning tasks and medical record reviewing.[16]

There are already hints that the fatigue associated with working twelve-hour shifts is contributing to absenteeism and job dissatisfaction among RNs. Fatigue related to length of shift or the potential of overtime at end of shift, or both, was identified as the cause of approximately 12 percent of the absences reported by a random sample of Canadian hospital staff nurses. Not only did RNs report an unusually high number of sick days year (7.4 days, compared with 3.2 for other workers), but also nurses working twelve-hour shifts reported significantly higher absenteeism rates than nurses working traditional eight-hour shifts. Nurses who worked twelve-hour shifts also expressed lower levels of job satisfaction than nurses working eight-hour shifts.[17]

Inasmuch as the probability of making an error because of long work hours or

"The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety."

overtime was not altered significantly by the age or experience of the nurses, or by the type of unit or hospital size, other factors may be important. More specifically, physiological factors such as fatigue, system variables such as increased work intensity, or a combination of fatigue and increased work intensity may contribute to the errors and near errors we observed. It is also possible that heavy workloads themselves may increase the risk of making an error.

The use of mandatory overtime to cover staffing vacancies is a controversial and potentially dangerous practice.[18] More than one-quarter of nurse participants (28.7 percent) reported working mandatory overtime at least once during the data-gathering period, a percentage that is quite similar to that reported in two surveys of more than 47,000 nurses and in a "Quick Poll" posted on the American Association of Critical Care Nurses Web site.[19]

Mandatory overtime is generally defined as nurses' being told that they could be fired, be subjected to disciplinary proceedings, or lose their nursing license if they refused to stay beyond their regularly scheduled shift or come in to work on their day off.[20] Although not actually threatened with job loss or disciplinary proceedings, many nurses also report feeling that there will be repercussions if they refuse to work extra hours or that overtime "is voluntary but feels like it is required."[21] Perhaps that is why approximately 60 percent of the participants in the American Nurses Association Staffing Survey (N = 4,258) reported being "forced to work voluntary overtime."[22]

Our data are derived from the self-reports of a relatively small number of hospital staff nurses and may not be representative of the work schedules and clinical practices of other U.S. hospital nurses. However, the demographic characteristics of our nurse sample and our findings about hours worked are consistent with data reported by hospital staff nurses in the NSSRN, a probability-based sample.[23] In addition, the percentage of staff nurses who identified twelve-hour shifts as their usual shift pattern (60.6 percent) is quite similar to Marlene Kramer and Claudia Schmalenberg's report that almost two-thirds of the 279 staff nurses they interviewed worked twelve-hour shifts.[24]

Although our response rate was lower than that usually reported for surveys of nurses, this study required more effort than the usual survey; subjects were asked to respond to between seventeen and forty items every day for twenty-eight days.[25] Given the subject burden, it is possible that responders were more invested than nonresponders were in documenting a relationship between the hours they worked and effects on patient safety. However, the amounts of overtime reported varied, with some nurses indicating minimal overtime and others reporting extremely long shift durations or working more than fifty hours per week, or both.

Perhaps more important, the major unit of analysis for this study was the actual work shift (N = 5,317) rather than the nurse (N = 393).

The definition of *error* was not specified in the survey instrument. Nevertheless, all incidents described by participants were obvious deviations from current standards of practice. Reported medication errors clearly fell into the categories familiar to all nurses: wrong patient, wrong medication, wrong dose, wrong route (such as intravenous, oral), wrong time, and errors of omission.[26] Nurses were asked whether they made an error, not to assess whether it led to harm.

By not collecting data that could identify where participants worked, we reduced the fears usually associated with reporting errors. Studies have shown that nurses typically underreport errors because they fear repercussions, including disciplinary action by employers and regulatory agencies. As a result, only those errors considered potentially life-threatening, or approximately 5 percent of significant errors, are usually reported.[27] Errors that are considered "minor" or are intercepted before reaching the patient are almost never reported.[28] In fact, near errors are now considered nonreportable events by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[29]

The errors nurses reported in this study occurred in the context of well-documented deficiencies in nurses' practice conditions in U.S. hospitals, deficiencies that nurses have been reporting for well over a decade.[30] The long and unpredictable hours documented here suggest a link between poor working conditions and threats to patient safety. As advocated by the IOM report on medical errors, safer patient care is more likely to result from changes in the environment in which health care is provided than from blaming health care professionals, who may be providing the best care possible under poor circumstances.[31]

Hospital staff nurses' long hours may have adverse effects on patient care; we found that both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours. Because more than three-fourths of the shifts scheduled for twelve hours exceeded that time frame, routine use of twelve-hour shifts should be curtailed, and overtime—especially that associated with twelve-hour shifts—should be eliminated. Additional research with larger samples, inclusion of other variables such as workload and patient acuity, and more precise measurements of error is suggested.

Financial support for this study was provided by the Agency for Healthcare Research and Quality (R01 HS11963-01) and a Robert Wood Johnson Foundation Investigator Award in Health Policy Research (Linda Aiken). Christina Gaughan and Douglas M. Sloane provided valuable statistical consultation.

NOTES

1. L.H. Aiken, J. Sochalski, and G.F. Anderson, "Downsizing the Hospital Workforce," *Health Affairs* 15, no. 4 (1996): 88–92; L. Unruh, "Nursing Staff Reductions in Pennsylvania Hospitals: Exploring the Discrepancy between Perceptions and Data," *Medical Care Research and Review* 59, no. 2 (2002): 197–214; and Joint Commission on Accreditation of Healthcare Organizations, *Healthcare at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis* (Oakbrook Terrace, Ill.: JCAHO, 2002).
2. American Nurses Association, *Analysis of the American Nurses Association Staffing Survey* (Warwick, R.I.: Cornerstone Communications Group, 2001); California Nurses Association, "Mandatory Overtime Is Detrimental to Patient Care and the Health of Nurses," 20 April 2001, www.calnurse.org/cna/patient/nursespeak.html (21 April 2004); and *Nurse Week*/American Association of Nurse Executives Institute for Patient Care Research and Education, National Survey of Registered Nurses, 2002, www.nurseweek.com/survey (8 March 2004).
3. A.E. Rogers, "Work Hour Regulation in Safety-Sensitive Industries," in *Keeping Patients Safe: Transforming the Work Environment of Nurses*, ed. A. Page (Washington: National Academies Press, 2004), 314–358.
4. Ibid.
5. Page, ed., *Keeping Patients Safe*.
6. D.M. Gaba and S.K. Howard, "Fatigue among Clinicians and the Safety of Patients," *New England Journal of Medicine* 347, no. 16 (2002): 1249–1255; M.B. Weinger and S. Ancoli-Israel, "Sleep Deprivation and Clinical Performance," *Journal of the American Medical Association* 287, no. 8 (2002): 955–957; S.K. Howard et al., "Stimulation Study of Rested versus Sleep-Deprived Anesthesiologists," *Anesthesiology* 98, no. 6 (2003): 1345–1355; I.R. Holzman and S.H. Barnett, "The Bell Commission: Ethical Implications for the Training of Physicians," *Mt. Sinai Journal of Medicine* 67, no. 2 (2000): 136–139; and Association of American Medical Colleges, *AAMC Policy Guidance on Graduate Medical Education*, 2002, www.aamc.org/hlthcare/gmepolicy/start.htm (12 May 2002).
7. See, for example, J. Barton and S. Folkard, "The Response of Day and Night Nurses to Their Work Schedules," *Occupational Psychology* 64, no. 3 (1991): 207–218; G. Clissold et al., "A Study of Female Nurses Combining Partner and Parent Roles with Working a Continuous Three-Shift Roster: The Impact of Sleep, Fatigue, and Stress," *Contemporary Nurse* 12, no. 3 (2002): 294–302; N. Kurumatani et al., "The Effects of Frequently Rotating Shiftwork on Sleep and the Family Life of Hospital Nurses," *Ergonomics* 37, no. 6 (1994): 995–1007; and P. Totterdell et al., "Recovery from Work Shifts: How Long Does It Take?" *Journal of Applied Psychology* 80, no. 1 (1995): 43–57.
8. E. Spratley et al., *The Registered Nurse Population: National Sample Survey of Registered Nurses, March 2000* (Washington: Health Resources and Services Administration, 2001).
9. P.F. Gander et al., "Flight Crew Fatigue I: Objectives and Methods," *Aviation, Space, and Environmental Medicine* 69, no. 9 (Suppl.) (1998): B1–B7; M.R. Rosekind et al., "NASA Airlog: An Electronic Sleep/Wake Diary," *Sleep Research* 25 (1996): 525; T.D. Luna, J. French, and J.L. Mitcha, "A Study of USAF Air Traffic Controller Shiftwork: Sleep, Fatigue, Activity, and Mood Analyses," *Aviation, Space, and Environmental Medicine* 68, no. 1 (1997): 18–23; S.M. Kelly et al., "Flight Controller Alertness and Performance during MOD Shiftwork Operations," in *Seventh Annual Workshop in Space Operations, Applications, and Research* (Houston: Space Technology Interdependency Group, 1993), 405–416; and R. Smith-Coggins et al., "Rotating Shiftwork Schedules: Can We Enhance Physician Adaptation to Night Shifts?" *Academic and Emergency Medicine* 4, no. 10 (1997): 951–961.
10. Gander et al., "Flight Crew Fatigue I"; and Luna et al., "A Study of USAF Air Traffic Controller Shiftwork."
11. P.A. Patrician, L.R. Brosch, and J.A. Williams, "Medication Errors and Nursing Staffing: What's the Connection?" (Paper presented at the AcademyHealth Annual Research Meeting, Nashville, Tennessee, 29 June 2003).
12. A.C. O'Neil et al., "Physician Reporting Compared to Medical-Record Review to Identify Adverse Events," *Annals of Internal Medicine* 119, no. 5 (1993): 370–376.
13. K.-Y. Liang and S.L. Zeger, "Longitudinal Data Analysis using Generalized Linear Models," *Biometrika* 73, no. 1 (1986): 13–22.
14. A.L. Tucker and A.C. Edmondson, "Managing Routine Exceptions: A Model of Nurse Problem Solving Behavior," in *Advances in Health Care Management*, ed. G.T. Savage, J.D. Blair, and M.D. Fottler (Greenwich, Conn.: JAI Press, 2002), 87–113; and A.L. Tucker and A.C. Edmondson, "Why Hospitals Don't Learn from Failures: Organizational and Psychological Dynamics That Inhibit System Change," *California Management Review* 45, no. 2 (2003): 55–72.

15. R.R. Rosa, "Extended Workshifts and Excessive Fatigue," *Journal of Sleep Research* 4, Suppl. 2 (1995): 51–56; K. Reid and D. Dawson, "Comparing Performance on Simulated Twelve Hour Shift Rotation in Young and Older Subjects," *Occupational and Environmental Medicine* 58, no. 1 (2001): 58–62; K. Hanecke et al., "Accident Risk as a Function of Hour at Work and Time of Day as Determined from Accident Data and Exposure Models for the German Working Population," *Scandinavian Journal of Work and Environmental Health* 24, Suppl. 3 (1998): 43–48; T. Akerstedt, "Work Injuries and Time of Day—National Data" (Proceedings of a Consensus Development Symposium, "Work Hours, Sleepiness, and Accidents," Stockholm, Sweden, 8–10 September 1994), 106; B. Russell et al., "An Outbreak of Staphylococcus Aureus Surgical Wound Infection Associated with Excess Overtime Employment of Operating Room Personnel," *American Journal of Infection Control* 11, no. 2 (1983): 63–67; and P.M. Arnow et al., "Control of Methicillin-Resistant Staphlococcus Aureus in a Burn Unit: Role of Nurse Staffing," *Journal of Trauma* 22, no. 11 (1982): 954–959.

16. M.E. Mills, B. Arnold, and C.M. Wood, "Core 12: A Controlled Study of the Impact of Twelve-Hour Scheduling," *Nursing Research* 32, no. 6 (1983): 356–361.

17. L.R. Zboril-Benson, "Why Nurses Are Calling In Sick: The Impact of Health-Care Restructuring," *Canadian Journal of Nursing Research* 33, no. 4 (2002): 89–107.

18. M.S. Bosek, "Mandatory Overtime: Professional Duty, Harms, and Justice," *JONA's Healthcare, Law, Ethics, and Regulation* 3, no. 4 (2001): 99–102; K.L. Capitulo, M.L. Ankner, and J. Miller, "Professional Responsibility versus Mandatory Overtime," *Journal of Nursing Administration* 31, no. 6 (2001): 290–292; and L.L. Curtin, "The Case against Mandatory Overtime," *Seminars for Nurse Managers* 10, no. 4 (2002): 274–278.

19. J. Robson, "Nurse Survey Validates Testimony on Mandatory Overtime Bill," 2 May 2002, www.legis.state.wi.us/senate/sen15/news/inthenews/pr2002-33.htm (28 February 2004); *NurseWeek*/American Association of Nurse Executives Institute for Patient Care Research and Education, National Survey of Registered Nurses; and American Association of Critical Care Nurses, "AACN Online: Quick Poll Archive," www.aacn.org/AACN/Surveys.nsf/parchivelist?OpenForm (12 May 2004).

20. M.P. Campbell, Pennsylvania State Nurses Association, Testimony before the House Labor Relations Committee, on Mandatory Overtime, 30 October 2003, www.psna.org/HotIssues/testimony/MOTestimony.htm (28 February 2004); and M. Foley, "Statement for the Committee on Ways and Means Subcommittee on Health regarding Improving Patient Safety" (Washington: American Nurses Association, 24 January 2002).

21. Campbell testimony; and R. Steinbrook, "Nursing in the Crossfire," *New England Journal of Medicine* 346, no. 22 (2002): 1757–1766.

22. ANA, *Analysis of the American Nurses Association Staffing Survey.*

23. Spratley et al., *The Registered Nurse Population.*

24. M. Kramer and C. Schmalenberg, "Staff Nurses Identify Essentials of Magnetism," in *Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses*, ed. M.L. McClure and A.S. Hinshaw (Washington: ANA, 2002), 25–59.

25. D.A. Asch, M.K. Jedrziewski, and N.A. Christakis, "Response Rates to Mail Surveys Published in Medical Journals," *Journal of Clinical Epidemiology* 50, no. 10 (1997): 1129–1136.

26. T.M. Pape, "Applying Airline Safety Practices to Medication Administration," *Medsurg Nursing* 12, no. 2 (2003): 77–93; and B. Kozier et al., *Fundamentals of Nursing* (Upper Saddle River, N.J.: Prentice Hall, 2000).

27. L.L. Leape, "Out of Darkness: Hospitals Begin to Take Mistakes Seriously," *Health Systems Review* 29, no. 6 (1996): 21–24.

28. Ibid.; J. Gladstone, "Drug Administration Errors: A Study into the Factors Underlying the Occurrence and Reporting of Drug Errors in a District General Hospital," *Journal of Advanced Nursing* 22, no. 4 (1995): 628–637; and D.S. Wakefield et al., "Perceived Barriers in Reporting Medication Administration Errors," *Best Practices and Benchmarking in Healthcare* 1, no. 4 (1996): 191–197.

29. JCAHO, *Sentinel Event ALERT*, 11 May 1998, www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea_4.htm (12 May 2004).

30. Secretary's Commission on Nursing, *Final Report* (Washington: U.S. Department of Health and Human Services, December 1988); Page, ed., *Keeping Patients Safe*; and JCAHO, *Healthcare at the Crossroads.*

31. L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington: National Academies Press, 1999).

Background Articles

UNITED AMERICAN
NURSES, AFL-CIO

2002

The Associated Press

June 1, 2001, Friday, BC cycle

SECTION: Business News

LENGTH: 980 words

HEADLINE: Shortage spurs more **nurses** to strike and unionize

BYLINE: By THERESA AGOVINO, AP Business Writer

BODY:
It was a scenario that **nurse** Linda Warino had come to dread: Too many patients. Not enough **nurses.** No volunteers to work overtime.

About once a week - and she only works three days a week - she said she was required to work beyond her 12-hour shift. It led her and her colleagues in Youngstown, Ohio, to walk off their hospital jobs in a demand for better conditions and pay. They have been on strike now for 31 days. Warino, a **nurse** for 28 years, said it wasn't just long hours or salary issues that prompted the 770 **nurses** at Youngstown's Forum Health hospital system to act. They feared patient care was suffering.

"Let's be real. In your 14th or 15th hour you are not as good as you are in your first, second or third hour," she said.

Dissatisfaction with pay and increasingly stressful work conditions, aggravated by a shortage of **nurses** at hospitals across the country, is spurring job actions and the formation of **nurses' unions** at more hospitals.

Minneapolis this week faced the threat of what was being called the largest such strike ever, involving 7,700 **nurses** at a dozen hospitals. Agreements were reached at five of the hospitals by Thursday, but 5,400 **nurses** at the remaining seven hospitals still were set to strike early Friday.

The hospitals had recruited more than 3,000 replacement **nurses,** who were flying in from around the country.

"A strike of this size shows this isn't one woman with a gripe. It shows this is a very serious problem," said Cheryl Johnson, president of United American **Nurses,** which represents more than 100,000 **nurses. "If nurses** don't have safe and good working conditions, no one gets the kind of care they deserve."

Across the country, there have been seven nursing strikes so far this year, and two are still under way. There were 10 last year and 21 in 1999. By comparison, there were just four strikes in 1995.

Last year, 19 percent of the country's 1.3 million hospital **nurses** were unionized, up from 17 percent in 1999 and 16 percent in 1990. The UAN is now campaigning to unionize **nurses** in 18 more hospital systems.

The increased **union** activity is coming at a time when hospital finances are being squeezed by lower reimbursements from both private and government insurers. A third of

all hospitals operate at a loss, according to the American Hospital Association.

Hospital administrators acknowledged that **nurses** work very hard, and that the work is getting harder as the age of the average patient rises and the incidence of chronic and serious diseases, including AIDS, increases. At many hospitals, cutbacks mean not only fewer **nurses** but also less support staff for non-medical duties such as delivering meals.

Warino, in Youngstown, described her situation this way, "There are less **nurses** on the unit so there is more stress. When I come home at night now I don't feel the same satisfaction I once did. Now I come home at night and hope I didn't make any mistakes."

But hospital managers say there are scant funds for generous raises or for hiring more staff. **Nurses'** annual salaries range from an average $37,622 in Iowa to $55,296 in California.

The nationwide shortage at hospitals is occurring despite a 39 percent increase in the number of registered **nurses** nationwide in the last five years, to 2.74 million. More of these **nurses** - about two out of five - are choosing not to work in hospitals or nursing homes. They opt for easier, better-paying jobs at health maintenance organizations or pharmaceutical companies.

The Department of Health and Human Services predicts a shortage of 400,000 **nurses** by 2020.

"How are **unions** going to solve the nursing shortage," asks Pamela Thompson, executive director of the American Organization of **Nurse** Executives, a division of the American Hospital Association. "The hospital environment is tough, and **unions** are just a third voice entering when **nurses** and hospital executives should be working together to solve issues of patient care."

Still, hospitals have anted up to keep **nurses** from striking or to lure them back when they have.

After striking for 49 days against the Washington Hospital Center in Washington, D.C. last year, **nurses** forced the end of mandatory overtime and won a 15 percent raise over three years. A strike also ended mandatory overtime at St. John's Hospitals in Oxnard and Camarillo, Calif., where **nurses** won a 22 percent raise over three years and a greater voice in management.

A threatened strike prompted the elimination of mandatory overtime at Aliquippa Community Hospital in Pennsylvania. And **nurses** at Crouse Hospital in Syracuse, N.Y. won raises of between 21 and 40 percent. In Minneapolis, hospitals were agreeing this week to raises of as much as 19 percent over three years.

Union organizers contend that victories like these will improve work conditions and lure more **nurses** back into hospitals.

Still, Johnson concedes it isn't easy to get **nurses** to unionize. Hospitals actively discourage organization, she said, and **nurses** don't want to do anything that could be perceived as hindering patient care.

At Shore Memorial Hospital in Somers Point, N.J., the vote among its 403 **nurses** to unionize won by just 29 votes.

The **nurses** say they were upset about an increase in the number of patients under each **nurse's** care, and also were worried by rumors that mandatory overtime was coming.

"We really felt we needed a voice," said Barbara Francesco, who has spent 20 of her 22 years as a **nurse** at Shore Memorial

Francesco said veteran **nurses** also were upset that the hospital seemed to be spending more money on recruiting new **nurses** than on the ones it already had. She said she had not received a raise in three years.

"The salaries simply have to go up if we are going to attract young people to the profession. We also need to reward **nurses** we have," Johnson said.

GRAPHIC: AP Photo MNMIT101

LOAD-DATE: June 2, 2001

◀ prev Document 17 of 151 next ▶

The Sunday Oregonian

January 13, 2002 Sunday SUNRISE EDITION

SECTION: EDITORIAL; Pg. F01

LENGTH: 1555 words

HEADLINE: NURSING AN AILING PROFESSION

SOURCE: MARY PITMAN KITCH - The Oregonian

BODY:
Their career has lost its luster, but **nurses** find themselves in high demand, offering priceless care and invaluable skills Fifty years ago, nursing was cool. Little girls were reading the adventures of Cherry Ames. Biographies of Clara Barton and Florence Nightingale flew off the shelves with wings and halos attached, glossing over the fact that both were tough, driven women -- defiant geniuses -- 10 percent angel and 90 percent pain in the neck.

In 1950, Americans polled by Gallup picked nursing, far and away, as their top-recommended career for young women. Teaching and secretarial work trailed a distant second and third.

Fasten your seat belts. You know what happens next. The planet tilted. Feminism, a force that had been gathering strength for two centuries, exploded into our consciousness, altering forever our ideas about what's possible for both sexes and hurtling women into new careers. But this new tilt put a sadder spin on what had once been women's work -- **nurse,** teacher, housewife. It was still invaluable, of course. But was it valued?

Nursing was no longer cool. These supreme caretakers in white had become second-class citizens. Today, their standard-bearers are the strikers at **Oregon** Health & Science University.

Thirty years ago, guidance counselors around the country were throwing fits, with the best possible motives, when bright high-schoolers wanted to go into nursing. At West High School in Bremerton, Wash., in 1970, counselors were appalled when Kathleen Sanford, a senior with a 4.0 GPA, told them her plans. "Bright girls do not go into nursing," they warned her.

Sanford didn't listen. Lured by a scholarship, she entered a prestigious Army **nurse** trainee program at Walter Reed Hospital in Washington, D.C., where she discovered how wrong her counselors had been. Bright girls did go into nursing. Sanford's professors were brilliant, her fellow students impressive. The work was emotionally fulfilling and intellectually challenging.

Today, high school counselors might still harbor some prejudice against nursing, or at least **nurses** think they do, but there's no need to steer top students away from the field: The students steer themselves away.

Nurses steer their own kids away, not because of the profession's image, but because of the working conditions and lack of respect.

"I love nursing, but if my daughters showed signs of liking medicine I would encourage them to be doctors, not **nurses,**" a veteran **nurse** in the Portland-area confided last week.

"(Nursing) used to be rewarding -- now it's frustrating."

It's frustrating, in part, because **nurses** think they're not doing a good job. A University of Pennsylvania survey of 43,000 acute-care **nurses** revealed that two-thirds thought staffing levels in their hospitals were too low to provide adequate care.

Nurses in the study reported levels of dissatisfaction four times as high as the "normal" level reported by other professionals. One in five of the **nurses,** and one in three of those younger than 30, said they intended to leave their jobs within the next year. Needed more than ever Talk about bad timing. Even as the career of nursing has sunk in American esteem, demand for **nurses** is becoming feverish.

The average **nurse** is already over 40. In **Oregon,** it's 47. As baby boom **nurses** retire, baby boom patients will be in their peak illness years. By 2020, it's estimated we'll need another 400,000 **nurses.**

Already, some families are stationing themselves at loved ones' bedsides. Some experts predict a future where American families begin to shoulder nursing care, as they do in Chinese hospitals.

Is this what we want? Or can we reverse the trend and entice more women, more men and more minorities into the field? Across the country, only 6 percent of **nurses** are men. If they were to begin flooding into the profession, that in itself could cure the shortage, nursing expert Peter Buerhaus of Vanderbilt University has written.

Making the field more attractive to men would help complete the feminist transformation that began 50 years ago. That "first wave" of feminism opened many doors to women. But what feminist Betty Friedan has called the "second wave" is needed to bring equal stature to the caretaking jobs so many women left behind.

Those jobs tend to be the invisible scaffolding and support systems of our lives, utterly taken for granted -- until, like **nurses,** they're about to disappear. Feeling overworked, unappreciated "This (OHSU **nurses'** strike) feels a little like the battered wife who is finally standing up to her abusive husband and saying, 'No more!' She needs support . . . but (critics tell her to sit down), she is his wife -- she must be quiet."

Revealing, isn't it? When a **nurse** and friend of mine, who doesn't work at OHSU, e-mailed me last week about the strike, she cast the **nurses'** battle as an old-fashioned feminist struggle: Abusive man vs. timidly emerging woman.

Is my friend being melodramatic? Perhaps, but here's the reality: Hospital **nurses** feel abused. They're literally speed-walking to keep up with their workloads. They're skipping meals, overseeing far sicker patients, many who once would have been in intensive care, and going home flat-out exhausted, as well as scared and depressed about the quality of care they delivered.

At home, they steel themselves for a barrage of calls, begging them to please, please come in and work extra shifts. In theory, they can say no. But if they do, they're saying no not only to their bosses, but also to their buddies. That makes it tough.

At the same time -- even though hospital **nurses** today manage pain, manage medications, manage high-tech equipment, manage crises, manage floors, even manage hospitals -- many **nurses** still feel they're brushed off like servants by doctors and hospital administrators.

The stereotype of **nurses** as doctor's helpers -- what **nurses** call their "handmaiden"

problem -- is completely out of synch with the career's reality. Yet, it's as prevalent today as ever before. Salary a complex figure So what is a **nurse** worth? According to www.salary.com, a typical Portland-area "charge" **nurse,** who has some supervisory responsibilities on a hospital floor, earns a median base salary of $50,254 a year. Half of all such **nurses** earn from $43,170 to $59,515.

That looks pretty decent, if you're writing her paycheck. But everything looks different if you're lying in a hospital bed. You might want to give her a raise.

It also looks different if you're a single parent. "I deeply enjoy my profession, what I do and what I have done with it," one Portland **nurse** said in an e-mail. But she'd advise her daughter against nursing because, "It's extremely difficult to raise a family on the pay."

Look, every hospital patient understands that a good **nurse** is priceless. Even hospital administrators know that. Funny how "invaluable" has a way of coming down to "beyond valuation." Sorry, but we can't afford to pay you what you're worth.

In a technical sense, the hospitals may be right. One-third of U.S. hospitals are losing money, says Rick Wade, vice president for communications with the 4,800-member American Hospital Association. All hospitals are under pressure to control costs, and 50 percent of their costs go for labor, the bulk for **nurses.**

Still, hospitals' knee-jerk response to the nation's 2 million **nurses** -- sorry, but we can't afford to pay you in accordance with the principles of supply and demand -- seems a bit lame. Maybe even a bit of a bluff.

If hospitals can't find enough **nurses,** they face the prospect of shutting down units -- which would definitely affect their bottom lines. Given the global nursing shortage, **nurses** would seem to hold a formidable card -- they can go anywhere.

Nursing is one of the world's most versatile, portable careers. A **nurse** unhappy with one hospital can jump to another hospital, a doctor's office, a psychiatric clinic, a public health office or a school. She can work her way around the globe. Even cruise ships employ **nurses.**

Remember Kathleen Sanford, the Bremerton **nurse?** She went on to earn two master's degrees and a doctorate in business administration. Today she's in charge of nursing at Harrison Memorial Hospital in Bremerton and heads a small affiliated hospital there, as well.

Sanford holds onto her **nurses** because she constantly engages them, asks them what their financial priorities are, given the budgetary restrictions of the hospital. In her experience, money cuts two ways in nursing, anyway, because some **nurses** cut back their hours if they get paid more.

Still, there's no doubt money is one key to resolving the shortage, money for shift differentials, night child care, money for nursing scholarships and the creation, perhaps, of a new nursing corps.

But what **nurses** really want, above all else, is a say. Unlike doctors, who are experts in diagnosing disease, **nurses** are experts in delivering care, hour after hour. They have life-and-death responsibilities for their patients.

They have earned our respect.

It's time for hospitals to pay them that much, at least. And it's time -- it's way past time -- for nursing to be cool again.

Mary Pitman Kitch is an associate editor at The Oregonian. You can reach her at 503-294-4010 or at marykitch@news.oregonian.com.

LOAD-DATE: January 15, 2002

◀ prev Document 4 of 11 next ▶

July 24, 2001 Tuesday SOONER EDITION

SECTION: HEALTH, Pg.C-6 PERSONAL REFLECTION< NURSING

LENGTH: 966 words

HEADLINE: RX FOR BETTER CARE: UNIONIZED **NURSES**

BYLINE: PAUL F. CLARK

BODY:
The clerk who checked me out at Kaufmann's department store the other day was, until recently, a registered **nurse** at a local hospital, as was the manager of the Motel 6 down the street. They are among many **nurses** who have fled a profession in crisis. If you are not a **nurse,** or a member of another health-care profession, you may not think this is anything to be concerned about.

Think again.

There are few professions that have the potential to affect our well-being more than the nursing profession. Most of us encounter our first **nurse** seconds after we are born. If we become critically ill, the person who will be at our bedside to get us through the worst moments is likely to be a **nurse.** And when we are at death's door, we will be fortunate if a **nurse** is present to comfort and reassure us. Imagine not having a **nurse** to turn to at these critical times. I recently attended a world congress of 5,000 **nurses** from more than 100 countries in Copenhagen, Denmark. From the Albanian **nurses** to the Zambian **nurses,** the concern, frustration and anxiety was palpable. Among the most disenchanted were the **nurses** from the United States.

To be certified to practice in this country, today's registered **nurse** must have mastered a complex body of knowledge drawn from basic science, medicine and biomedical technology and demonstrated competence in a wide range of clinical skills. They then have the opportunity to take jobs in hospitals and nursing homes, putting in long hours, working nights and weekends, making life-and-death decisions and earning modest wages. This is what **nurses** have always done with little complaint.

But what has many RNs so upset today is their belief that our current health system's devotion to the financial bottom line is preventing them from providing optimal, or even adequate, care to their patients. HMOs and insurance companies rake in profits by forcing health-care providers, such as hospitals, to cut costs. Hospitals, in turn, must squeeze more productivity from their **nurses.** Thus, we see widespread understaffing, with fewer and fewer **nurses** being asked to care for more and more patients. We see an increase in mandatory overtime that compels **nurses** to work 12-, even 16-hour shifts, reducing their ability to provide high-quality patient care and disrupting their personal lives. And we see **nurses** increasingly being pulled (or floated) from their usual assignments to work in areas of the hospital where they may not have adequate training.

The resulting dissatisfaction and disillusionment is reaching epidemic proportions. Not surprisingly, **nurses** are leaving the profession, or reducing the hours they work, at unprecedented rates. In 2000, only 58.5 percent of registered **nurses** in this country worked full time.

This has resulted in what many are calling a "**nurse** shortage." But this is a misnomer.

There are currently more than 100,000 openings for RNs in this country; however, there are approximately 500,000 trained **nurses** not currently practicing. Rather than a shortage of **nurses,** we have a shortage of nursing jobs with sufficiently attractive working conditions and compensation either to bring **nurses** back or to bring potential **nurses** into the profession.

The flood of **nurses** leaving their jobs sets in motion a vicious cycle in which fewer **nurses** are available to work, leading to more understaffing, resulting in more mandatory overtime and more burned-out **nurses,** which, of course, results in more **nurses** leaving their jobs.

However, many who continue in the profession are responding in a different way. They are shedding the largely passive role **nurses** have played in the health-care system of the past and assuming a more aggressive, activist role. There is precedent for this.

Florence Nightingale, the patron saint of **nurses,** has commonly been portrayed as a selfless handmaiden of healing, when in reality she was a fire-breathing feminist and patient advocate who tried to raise the stature of her profession and questioned the medical establishment of her time. This is the role model **nurses** are beginning to embrace.

In Copenhagen, **nurses** engaged in formal and informal discussions about how to improve health care around the world. Very often, the delegates came to the same conclusion -- **nurses** can best fulfill their traditional role as patient advocates by banding together to fight for better working conditions and a greater voice in health-care decisions.

More **nurses** in the United States and elsewhere have found **unions** to be the most effective way to gain a greater voice in workplace and public policy decisions. In the United States, only 9 percent of working **nurses** belong to **unions** (in the Scandinavian countries it is above 90 percent), but this is rapidly changing. Nursing is one of the most active areas for **union** organizing today. Unionized **nurses** are winning reductions in mandatory overtime and floating through collective bargaining. They are lobbying Congress and state legislatures for bans on forced overtime and for passage of minimum staffing standards.

Patients and other health-care professionals should not be alarmed by this trend. In fact, they should support it. It is a time of rapid change for the American health-care system and physicians, administrators, government bureaucrats, elected officials, HMOs, and insurance companies all have seats at the table of health-care reform. For a truly patient-centered system to emerge from this process, however, **nurses** must have a seat as well.

If **nurses** can channel the intelligence and energy they put into patient care every day into the reshaping our health-care system, we will all be better off. And if they need to join **unions** to do so, we, as potential patients, should say "**Nurses** of the World, Unite!"

NOTES:
Paul F. Clark is professor in the Department of Labor Studies and Industrial Relations at Penn State University.

GRAPHIC:
Drawing: Stacy Innerst/Post-Gazette:

LOAD-DATE: July 24, 2001

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. LATOURETTE) 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

---

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Safe Nursing and Patient Care Act of 2005".

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) The Federal Government has a substantial interest in assuring that the delivery of health care services to patients in health care facilities is adequate and safe.

(2) Research, including a study published in the Journal of the American Medical Association (in the October 23–30, 2002 issue), documents that higher nurse staffing levels result in better patient outcomes. However, health care facilities report substantial difficulties in recruiting and retaining sufficient nursing staff, as evidenced by the fact that approximately 500,000 licensed nurses are not practicing nursing.

(3) Job dissatisfaction and overtime work are contributing to the departure of nurses from their profession, as documented by the Government Accountability Office in a July 2001 report. Yet, health care providers continue to make use of mandatory overtime as a staffing model.

(4) The widespread practice of requiring nurses to work extended shifts and forgo days off frequently causes nurses to provide care in a state of fatigue which contributes to medical errors and results in other consequences that compromise patient safety.

(5) The dangers with mandatory overtime are made clear by numerous studies. A November 2003 Institute of Medicine report, Keeping Patients Safe: Transforming the Work Environment of Nurses, concluded that limiting the number of hours worked per day and consecutive days of work by nursing staff, as is done in other safety-sensitive industries, is a fundamental safety precaution. The report went on to specifically recommend that working more than 12 hours in any 24-hour period and more than 60 hours in any 7-day period be prevented except in case of an emergency, such as a natural disaster.

(6) Another study published in the July/August 2004 Health Affairs Journal, The Working Hours of Hospital Staff Nurses and Patient Safety, found that nurses who worked shifts of twelve and a half hours or more were three times more likely to commit an error than nurses who worked standard shifts of eight and a half hours or less. The study also found that working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled.

(7) That same study also illustrates how nurses are being forced to work more and more overtime. The majority of nurses surveyed reported working

overtime ten or more times in a twenty-eight day period and one-sixth reported working sixteen or more consecutive hours at least once during the period. Nurses reported being mandated to work overtime on 360 shifts and on another 143 shifts they described being "coerced" into working voluntary overtime.

(8) While no Federal standards currently restrict mandatory nurse overtime, many States are considering such laws and several States, including California, Connecticut, Maine, Maryland, Minnesota, New Jersey, Oregon, Washington, and West Virginia, have enacted laws or prescribed regulations.

(9) Federal limitations on mandatory nurse overtime will ensure that health care facilities throughout the country operate in a manner that safeguards public safety by helping assure the delivery of quality nursing care and facilitating the retention and recruitment of nurses.

SEC. 3. LIMITATIONS ON MANDATORY OVERTIME FOR NURSES.

(a) PROVIDER AGREEMENTS.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking "and" at the end;

(B) in subparagraph (V), by striking the period and inserting ", and"; and

(C) by inserting after subparagraph (V), the following:

"(W) to comply with the requirements of subsection (k) (relating to limitations on mandatory overtime for nurses)."; and

(2) by adding at the end the following new subsection:

"(k) LIMITATIONS ON MANDATORY OVERTIME FOR NURSES.—For purposes of subsection (a)(1)(W), the requirements of this subsection are the following:

"(1) PROHIBITION ON MANDATORY OVERTIME.—Except as provided in this subsection, a provider of services shall not, directly or indirectly, require a nurse to work in excess of any of the following:

"(A) The scheduled work shift or duty period of the nurse.

"(B) 12 hours in a 24-hour period.

"(C) 80 hours in a consecutive 14-day period.

"(2) EXCEPTIONS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the requirements of paragraph (1) shall not apply to a provider of services during a declared state of emergency if the provider is requested, or otherwise is expected, to provide an exceptional level of emergency or other medical services to the community.

"(B) LIMITATIONS.—With respect to a provider of services to which subparagraph (A) applies, a nurse may only be required to work for periods in excess of the periods described in paragraph (1) if—

"(i) the provider has made reasonable efforts to fill the immediate staffing needs of the provider through alternative means; and

"(ii) the duration of the work requirement does not extend past the earlier of—

"(I) the date on which the declared state of emergency ends; or

"(II) the date on which the provider's direct role in responding to the medical needs resulting from the declared state of emergency ends.

"(3) REPORT OF VIOLATIONS.—

"(A) RIGHT TO REPORT.—

"(i) IN GENERAL.—A nurse may file a complaint with the Secretary against a provider of services who violates the provisions of this subsection.

"(ii) PROCEDURE.—The Secretary shall establish a procedure under which a nurse may file a complaint under clause (i).

"(B) INVESTIGATION OF COMPLAINT.—The Secretary shall investigate complaints of violations filed by a nurse under subparagraph (A).

"(C) ACTIONS.—If the Secretary determines that a provider of services has violated the provisions of this subsection, the Secretary shall require the provider to establish a plan of action to eliminate the occurrence of such violation, and may seek civil money penalties under paragraph (7).

"(4) NURSE NONDISCRIMINATION PROTECTIONS.—

"(A) IN GENERAL.—A provider of services shall not penalize, discriminate, or retaliate in any manner with respect to any aspect of em-

ployment, including discharge, promotion, compensation, or terms, conditions, or privileges of employment, against a nurse who refuses to work mandatory overtime or who in good faith, individually or in conjunction with another person or persons—

"(i) reports a violation or suspected violation of this subsection to a public regulatory agency, a private accreditation body, or the management personnel of the provider of services;

"(ii) initiates, cooperates, or otherwise participates in an investigation or proceeding brought by a regulatory agency or private accreditation body concerning matters covered by this subsection; or

"(iii) informs or discusses with other employees, with representatives of those employees, or with representatives of associations of health care professionals, violations or suspected violations of this subsection.

"(B) RETALIATORY REPORTING.—A provider of services may not file a complaint or a report against a nurse with the appropriate

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

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

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

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

"(5) NOTICE.—

"(A) REQUIREMENT TO POST NOTICE.—Each provider of services shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying rights of nurses under this section.

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

"(6) POSTING OF NURSE SCHEDULES.—A provider of services shall regularly post in a conspicuous manner the nurse schedules (for such periods of

time that the Secretary determines appropriate by type or class of provider of services) for the department or unit involved, and shall make available upon request to nurses assigned to the department or unit the daily nurse schedule for such department or unit.

"(7) CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—The Secretary may impose a civil money penalty of not more than $10,000 for each knowing violation of the provisions of this subsection committed by a provider of services.

"(B) PATTERNS OF VIOLATIONS.—Notwithstanding subparagraph (A), the Secretary shall provide for the imposition of more severe civil money penalties under this paragraph for providers of services that establish patterns of repeated violations of such provisions.

"(C) ADMINISTRATION OF PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

The Secretary shall publish on the Internet site of the Department of Health and Human Services the names of providers of services against which civil money penalties have been imposed under this paragraph, the violation for which the penalty was imposed, and such additional information as the Secretary determines appropriate. With respect to a provider of services that has had a change in ownership, as determined by the Secretary, penalties imposed on the provider of services while under previous ownership shall no longer be published by the Secretary on such Internet site after the 1-year period beginning on the date of change in ownership.

"(8) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as precluding a nurse from voluntarily working more than any of the periods of time described in paragraph (1), so long as such work is done consistent with professional standards of safe patient care.

"(9) DEFINITIONS.—In this subsection:

"(A) MANDATORY OVERTIME.—The term 'mandatory overtime' means hours worked in excess of the periods of time described in paragraph (1), except as provided in paragraph (2), pursuant to any request made by a provider of

services to a nurse which, if refused or declined by the nurse involved, may result in an adverse employment consequence to the nurse, including discharge, discipline, loss of promotion, or retaliatory reporting of the nurse to the State professional disciplinary agency involved.

"(B) OVERTIME.—The term 'overtime' means time worked in excess of the periods of time described in paragraph (1).

"(C) NURSE.—The term 'nurse' means a registered nurse or a licer ,ed practical nurse.

"(D) PROVIDER OF SERVICES.—The term 'provider of services' means—

"(i) a hospital (as defined in section 1861(e));

"(ii) a psychiatric hospital (as defined in section 1861(f));

"(iii) a hospital outpatient department;

"(iv) a critical access hospital;

"(v) an ambulatory surgical center;

"(vi) a home health agency;

"(vii) a rehabilitation agency;

"(viii) a clinic, including a rural health clinic; or

"(ix) a federally qualified health center.

"(E) DECLARED STATE OF EMERGENCY.—The term 'declared state of emergency' means an officially designated state of emergency that has been declared by the Federal Government or the head of the appropriate State or local governmental agency having authority to declare that the State, county, municipality, or locality is in a state of emergency, but does not include a state of emergency that results from a labor dispute in the health care industry or consistent understaffing.

"(F) STANDARDS OF SAFE PATIENT CARE.—The term 'standards of safe patient care' means the recognized professional standards governing the profession of the nurse involved.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of enactment of this Act.

SEC. 4. REPORTS.

(a) STANDARDS ON SAFE WORKING HOURS FOR NURSES.—

(1) STUDY.—The Secretary of Health and Human Services, acting through the Director of the Agency for Healthcare Research and Quality, shall conduct a study to establish appropriate standards for the maximum number of hours that a nurse, who furnishes health care to patients, may work without compromising the safety of such patients. Such standards may vary by provider of service and by department within a provider of services, by duties or functions carried out by nurses, by shift, and by other factors that the Director determines appropriate. The Director may contract with an eligible entity or organization to carry out the study under this paragraph.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) and shall include recommendations for such appropriate standards of maximum work hours.

(b) REPORT ON MANDATORY OVERTIME IN FEDERALLY OPERATED MEDICAL FACILITIES.—

(1) STUDY.—

(A) IN GENERAL.—The Director of the Office of Management and Budget shall conduct

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

(B) FEDERALLY OPERATED MEDICAL FACILITIES DEFINED.—In this subsection, the term "federally operated medical facilities" means acute care hospitals, freestanding clinics, and home health care clinics that are operated by the Department of Veterans Affairs, the Department of Defense, or any other department or agency of the United States.

(2) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Director of the Office of Management and Budget shall submit to Congress a report on the study conducted under paragraph (1) and shall include recommendations for the implementation of policies within federally operated medical facilities with respect to overtime requirements for nurses that are consistent with such section 1866(k), as so added.

○

Testimony of Kathleen A. Gettys, RN, BSN, BA
HB 271
House Finance Committee
April 7th, 2006

Good Morning Mr. Chairman and members of the House Finance Committee. My name is Kathleen Gettys and I am a registered nurse on the Progressive Care Unit at Providence Alaska Medical Center. I serve as President of the Providence Registered Nurses Bargaining Unit.

Today overtime, whether voluntary or mandatory is the most common method facilities use to cover staffing insufficiencies. Eleven states have passed regulations to address the issue of mandatory overtime. However, some states that have passed mandatory overtime legislation have seen a marked increase in "mandatory call" for non-traditional call units such as medical-surgical floors. Nurses working in specialized units such as surgical services, endoscopy, cardiac catheterization units and dialysis are often required to take call in addition to working their regularly scheduled shifts.

Strictly limiting mandatory overtime for nurses is a critical step in improving the quality of health care and reducing the number of medical errors. 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. In the IOM's "Save a 100,000 Lives Campaign," it stated that all overtime by nurses should be eliminated. A study conducted by Health Affairs in July of 2004 revealed when RN's worked greater than twelve hours it resulted in both errors and near errors. The likelihood of making an error was three times higher when RN's worked shifts lasting 12.5 hours or more.

Unlike many other industries where public safety is a concern, healthcare is exempt from federal regulations which limit the use of overtime as a staffing tool. There currently exists government standards that limit the hours that pilots, flight attendants, truck drivers, air traffic controllers and railroad engineers can safely work before consumer safety is endangered. However, no similar limitations exist for our nation's nurses who are caring for patients. 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 occurring? Like a pilot monitoring instruments, nurses constitute an around the clock surveillance system and are responsible for detection and prompt intervention when a patients condition deteriorates.

As members of the House Finance Committee, I know all of you, as well as nurses, can appreciate our fiduciary responsibilities to ensure safe and affordable healthcare for Alaskans. The most immediate financial impact of the stress and fatigue of extended shifts is manifested in absenteeism and turnover among the nursing staff. Mandatory overtime may appear in the short term to be a cost savings, but long term financial impacts in the form or turnover resulting in training dollars lost, low productivity, longer

patient stays and higher rates of treatment of errors perpetuate costly solutions. The cost of serious care errors, such as hospital acquired infections add an approximately $22,000 to $28,000 in costs per patient when you add up additional care, tests, pharmaceuticals and extended hospital stays.

Any practice or policy such as imposing mandatory overtime increases the medical liability front. We are all aware of juries that have awarded in the upwards of hundreds of thousands of dollars in medical malpractice cases. We can thus hypothesize that improved working conditions could have a cost savings in liability losses and the reduced need to treat medical errors.

I ask the members of the House Fina Committee, would your constituents support a practice such as mandatory overtime that would jeopardize their opportunity to receive safe, quality and affordable healthcare?

Alaskan nurses have proven over and over that we will remain at your bedside and do not need to be "mandated" to deliver our ministries of healing. At the same time, do not allow employers to exploit us as nurturers and caregivers. Allow Alaskan nurses to exercise their professional judgment whether or not they are safe to practice and protect the publics right to safe, quality care.

I urge Alaska State legislators to support HB 271 and place public safety first concerning the use of mandatory overtime for RN's.

v 907-274-[illegible]
f 907-272-[illegible]

[illegible] East Tudor Rd, Suite 34
Anchorage, AK 99507-1044
www.[illegible].org
[illegible]@[illegible].org

April 27, 2005

Representative Peggy Wilson
State Capitol
Room 108
Juneau, AK 99801

Dear Representative Wilson,

Let me take this opportunity to thank you on behalf of the Alaska Nurses Association and its labor program for your sponsorship of House Bill 271, "an act relating to limitations on overtime for registered nurses in health care facilities..."

I have been an RN for 26 years and have tried to work within the health care system to improve patient care. We really need to provide a safe environment for patients as well as to address the needs of the professional trying to deliver this quality care. Unfortunately, our voices as nurses often seem to go unheard. To have you, a registered nurse, in the Alaska House of Representatives, a person who both understands these issues and is able to vocalize them on our behalf, is quite a step and we are quite pleased.

As you know, hospitals and health care facilities in this country are using mandatory overtime to staff hospitals everyday. Here in Alaska, the problem is currently most acute at the Alaska Psychiatric Institute but that does not mean that with the growing nursing shortage, the problem could not become much larger affecting patient care in all of our major hospitals if it is not addressed now.

It is appropriate for the state to notify hospital administrations today that whatever staffing problems loom on the horizon, involuntary, mandatory overtime will not be tolerated as a long term solution. There is no better way than imposing mandatory overtime to drive the nurses we still have out of the profession for good.

The Alaska Nurses Association and the Providence Registered Nurses Bargaining Unit are proud to stand up for their nursing colleagues at the Alaska Psychiatric Institute and elsewhere who are being forced to work multiple additional shifts in a given week. This practice is unsafe for patients and unsafe for nurses. Ultimately, it is unsafe for our community.

Again, we want to thank you for your support and indicate our strong support for House Bill 271.

Sincerely,

Donna Phillips

Donna Phillips, RN, BSN
Member, Alaska Nurses Association Board of Directors
Chair, AsNA Labor Council
Treasurer and Membership Chair,
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 backed by our nursing staff (long overdue!)

Address: 8811 Talkeetna St.

City & Zip: Anchorage AK

Phone number: 269-7163 (wk)

Department: H-SS

Work location: API - Psychology Dept

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.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: SB28-COM-OL-04-04-07
Bill Version: SB 28
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Limit Overtime For Registered Nurses
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Davis
Requester: Senate HES
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
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**
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						
1156 Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2007) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

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: Chris Wyatt, Administrative Manager — Phone (907) 465-2572
Division: Corporations, Business, and Professional Licensing — Date/Time 4/4/07 10:11 AM
Approved by: Emil Notti, Commissioner — Date 4/4/2007
Agency: Commerce, Community, and Economic Development

Banner Health
Denali Center
Fairbanks Memorial Hospital

1650 Cowles Street
Fairbanks, AK 99701
Phone 907-452-8181
Fax 907-458-5324
www.fmhdc.com

April 2, 2007

Senator Joe Thomas
State Capitol
Juneau, AK 99801

RE: SB28

Senator Thomas:

Thank you for representing the Interior in the Senate. We appreciate your leadership and commitment and look forward to working with you in the years to come. I may not be able to testify in person so I am sending my comments to you in writing. Although I can see that the intent of this legislation is to protect nurses and patients, and I appreciate the attention of our Senators to these important healthcare issues, I must respectfully testify against SB28 as unnecessary legislation. I would like to raise several points herein for your consideration.

I believe that any real concerns that SB28 attempts to address are covered adequately by other laws, regulations, and professional standards. There are already appropriate protections in place for both healthcare workers and for patient safety, including OSHA, Fair Labor Standards Act, and the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

JCAHO standards require that hospitals monitor staffing effectiveness. Fairbanks Memorial Hospital does so by tracking staff overtime and other staffing measures in relation to any clinical errors and other patient safety measures. We practice evidence based medicine in the nursing profession, which means we endeavor to use proven "best practices" from around the nation in our care and our staffing models.

Also, I think there are details in the proposed legislation which make it unfavorable to nurses working in an acute care environment. Our organization has flexible scheduling options to include numerous shift choices for full time and part time nurses. Many nurses prefer to work 12 hour shifts with the typical schedule being 7:00a – 7:30p for example. A full time nurse would typically work 3 of these shifts in a week. They prefer to have their days scheduled back to back (i.e.: Mon, Tues, Wed) allowing them to group their days off together. The proposed language requiring 12 hours between shifts would significantly limit this possibility and be a disservice to nurses.

Banner Health
Denali Center
Fairbanks Memorial Hospital

1650 Cowles Street
Fairbanks, AK 99701
Phone 907-452-8101
Fax 907-458-5324
www.fmhdc.com

We have policies and practices in place to address the situations we believe this legislation targets. Our hospital does not have mandatory overtime, except for true emergencies as described in the proposed legislation.

Lastly, we believe that these issues should not be legislated but left to the hospitals and nurses to address through Shared Decision Making processes or good faith bargaining. This has proved successful in our facility as we share a common vision of a safe environment for the patient and appropriate work-life balance for the professional nurse.

Again, we respect your efforts to further these admirable objectives but respectfully recommend that this SB28 is not necessary or desired.

Sincerely,

Jim L. Lynch
Director of Human Resources
Fairbanks Memorial Hospital
907-458-5575

cc: Senator Bettye Davis

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 2, 2007

SUBJECT: CSSB 28( ), draft version "K": reply to question of Tom Obermeyer concerning application of nursing overtime exemptions in proposed AS 18.20.400(c) (Work Order No. 25-LS0212\K)

TO: Senator Bettye Davis

FROM: Jack Chenoweth
Assistant Revisor

In the above-captioned draft, proposed subsection (a) of AS 18.20.400 would set three general limitations on overtime that nurses employed in a health care facility may work.[1] Both terms -- "nurse" and "health care facility" -- are defined later in the bill draft. Proposed subsection (b) mandates a 10 consecutive hour period of off-duty time in one of the three limitation circumstances, that being when a nurse and the facility have agreed to "a predetermined and regularly scheduled shift."

---

[1] Specifically, those three limitations are:

(1) work beyond a predetermined and regularly scheduled agreed to shift;

(2) work beyond 80 hours in a 14-day period; or

(3) accepting an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

Proposed subsection (c) sets out a series of six exceptions[2] to the three general limitations of (a) which I view as intended to soften or mitigate the firm limitations of (a) in extraordinary circumstances. As a matter of drafting the bill in response to directions given by your office, these six exceptions are set out as "stand alone" exceptions, each being independently applicable to the three circumstances described in subsection (a) and no one of the six being an exception to any of the others set out in (c). First, the nature of your requests with respect to the content of the bill indicates that intent: the request indicated that there were to be a set of general or overarching limits on overtime (those are the ones identified in (a)) and there were also to be a series of authorized exceptions to those limitations that could be applicable to each limitation and to all of them, depending on the situation at hand. Second, as a matter of interpretation of the language, a court would likely interpret (c)(1) - (6) based on an understanding that each of these six exceptions operates on its own with respect to any or all of the limitations in (a) but, in the absence of any authorization, not as to any of the other exceptions.

If we had understood that, as Tom has suggested, the exceptions in (c)(4) and (c)(5) should also somehow be applicable to any of the exceptions set out in (c)(1) - (c)(3), we surely would have prepared the material differently. So, for example, if the exception in (c)(2) -- "a nurse [working] in overtime status because of an unforeseen emergency situation that could otherwise jeopardize patient safety" -- were to be further modified by application of the "14 consecutive hour rule" of (c)(4) or the "10 hour mandatory break" requirement of (c)(5), those two exceptions could have been specifically incorporated into the text of (c)(2), so that it might have been spelled out in detail, to read: "a nurse on duty in overtime status because of an unforeseen emergency situation that could otherwise jeopardize patient safety, so long as the work is consistent with professional

---

[2] These are the six exceptions:

(1) a nurse voluntarily working overtime on an aircraft in use for medical transport, so long as the shift worked is allowable under regulations adopted by the Board of Nursing based on accreditation standards adopted by the Commission on Accreditation of Medical Transport Systems;

(2) a nurse on duty in overtime status because of an unforeseen emergency situation that could otherwise jeopardize patient safety, with a definition of "unforeseen emergency situation" provided;

(3) a nurse fulfilling on-call time that is agreed upon by the nurse and a health care facility before it is scheduled;

(4) a nurse voluntarily working overtime so long as the work is consistent with professional standards and safe patient care and does not exceed 14 consecutive hours;

(5) a nurse voluntarily working beyond 80 hours in a 14-day period so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care;

(6) the first hour on overtime status when the health care facility is obtaining another nurse to work in place of the nurse in overtime status.

standards and safe patient care and does not exceed 14 consecutive hours, and so long as that work is not for more than 80 hours in a 14-day period and so long as the nurse does not work more than 14 consecutive hours without a 10-hour break and the work is consistent with professional standards and safe patient care."

JBC:ljw
07-186.ljw

Don Burrell

From: Kathy Smith [ketb7@gci.net]
Sent: Friday, April 13, 2007 7:14 PM
To: Sen. Bettye Davis
Cc: mshickey@gci.net
Subject: RE: senate bil 28

Dear Senator Davis,

I am writing to encourage you to do everything within your power to get Senate Bill 28 through all of the channels it needs to go through in order to get it passed ASAP.

I am a Registered Nurse working in a critical care setting in an Anchorage Hospital. I work 12 hour shifts, 36 hours a week, and am considered full time. I like working the twelve hour shifts, and I love nursing at the bedside. I care very much for my patients and their families, however, I am not willing to stand by silent, and allow the corporate side of medical care to dictate what hours I have to work beyond the 36 hours a week I already work.

I give my job everything I have, and the result is that at the end of my work day, I am emotionally spent and physically exhausted. I have been asked, begged, cajoled, and made to feel guilty for refusing to work several more hours into the next shift, or coming back the next day (or night) for an extra shift, or two or three or more. I find myself monitoring my incoming phone calls on my days off because almost without exception, the hospital will call to beg or cajole, to get me to work more hours for them.

Their issue is being short of staff. That is not my problem. If the non-medical corporate side of medical care would care more about their employees that work at the bedside of their paying customers, and make changes that would help their employees to do a more efficient job for them, they might be able to keep enough staff employed that all of the shifts would be covered with adequate staffing. However, I don't see that happening anytime soon. The bean counters are so far removed from the real issues of health care that they can't/won't see the issues we nurses deal with on a constant basis. It is an old story: I believe it was an Egyptian Pharoah that said to one of his "managers" about the slaves who labored for him, "Tell them I want more bricks, but give them less straw".

Well, we nurses are the slaves, the corporate managers are Pharoah, and we are "making all the bricks" we can make, less most of the straw we need to do the best job we can. Please help us help you. You may be my next patient. I want to do the best job I can to elicit a speedy, uneventful recovery. I can't do the job that I need to

do if I am tired from my regular 12 hour shift, and am forced to work more hours beyond those first 12 hours, and am not able to think clearly. Please think about that as you work to bring about legislation that is safe for all of us who live, work and play in Alaska.

Sincerely,

Kathryn E. Smith, RN and registered voter.

Don Burrell

From: Lerwick, Marita A [Marita.Lerwick@providence.org]
Sent: Friday, April 13, 2007 6:36 PM
To: Sen. Bettye Davis
Cc: mshickey@gci.net
Subject: Bill 28

April 13, 2007
Senator Bettye Davis

Dear Senator Bettye Davis:
I am writing this in support for our Senate Bill 28, limiting the use of mandatory overtime for nurses. I have been a critical nurse for 26 years. This is a tremendous responsibility, often being on your feet with no breaks for hours titrating complicated medications, ventilators, Dialysis machines, and Inta Aortic Balloon pumps just to keep your patient alive. WORKING PAST 12 HOURS IS UNSAFE FOR THE NURSE AND PATIENT. This is a public safety issue, designed to protect patients and nurses. Life and death decisions cannot be made when one is tired, that is when medication errors occur and possible harm to the patient. The Alaska Railroad will not let their workers work past 12 hours, but nurse taking care of critically ill patients can? That does not make sense. Eleven other state's have already enacted similar legislation. Thankyou, Sincerely, Marita Lerwick R.N CCRN, CSC

Don Burrell

From: Lorayne E [lorayne@gci.net]
Sent: Saturday, April 14, 2007 2:10 AM
To: Sen. Bettye Davis
Subject: SB 28 thank you

RECEIVED
APR 16 2007

Thank you for supporting us.

I am a registered nurse working full time in a busy emergency department in Anchorage. I work 12-hour shifts that our administration has mandated. I am urging you to support Senate Bill 28, limiting the use of mandatory overtime for nurses. Studies have shown that med errors increase after working an extended 12-hour shift or forty hours per week.

Nurses are working in a continuum of admitting patients, discharging patients, receiving and carrying out Dr.-patient orders and changes in medicine doses and treatments. This does not stop for break time, lunchtime or go home time at 5PM. It is a never ending 24 hours a day for seven days a week continuum of high level energy care that requires an alert mind and body.

My personal experience is that often after 10 hours of working, medication doses can be difficult to calculate due to fatigue. Small print on medicine bottles that have similar names make concentration difficult, especially with any level of fatigue. The fatigue increases with the hours worked.

Nurses work in a fast paced environment. During a 12-hour shift, nurses may have one 15minute break and a 30-minute break. A 12-hour shift itself is really 12.5 hours, not just 12 hours even adding more to the fatigue factor

I am urging you to support HB 28 and limit overtime. Support this for your nursing care safety and mine. Thank you.

Lorayne Embretson RN
337-1771
--
Lorayne

Don Burrell

From: Joshua Meals [shua@gci.net]
Sent: Friday, April 13, 2007 8:56 PM
To: Sen. Bettye Davis
Subject: RN's

Dear Senator,

Please, enforce this bill. It's hard enough working 12 hour shifts (I write this as I have just worked 13 hours), and I can't imagine being forced to work mandatory overtime. What are we, a third world country? If this goes into effect, it will be Alaska setting the stage for failure. Let me repeat...it will be the state of Alaska setting the stage for failure. I know you will do your best to enforce this bill. Imagine your husband in a critical care unit with a nurse who has been by his side for greater than 15 hours...we start getting tired at about 7 hours, fyi.

Do your best.

Joshua Meals, RN.
Eagle River, Alaska

Don Burrell

From: Lisa Hudok [hudok2000@gci.net]
Sent: Monday, April 16, 2007 9:27 AM
To: Sen. Bettye Davis
Subject: SB 28

Please continue to support this bill - keep an emphasis on getting at least 10 hours of rest between shifts. Mandatory overtime or mandatory call can place nurses in a position of working to many consecutive hours.

As a RN at PAMC I have seen the effects of working to many consecutive hours, especially when we factor in the age of the average nurse and the acuity of patients being seen. The body and the brain begin to show signs of draining after 8 hours, this is not a new concept.

Supporting public safety. Represent the care givers.

Thank you, Lisa Hudok RN

Don Burrell

From: Drew Feild [fishman@gci.net]
Sent: Sunday, April 15, 2007 11:33 PM
To: Sen. Bettye Davis
Subject: Support of SB 28

Dear Sen. Davis,

Thank you for sponsoring SB 28 to limit the use of mandatory overtime for nurses. As a nurse working 12 hour shifts, I can assure you this is a bill that has the potential to ensure that patient safety is preserved for the people we care for on a daily basis. I'm currently docked 30 minutes for the one meal break I get in that 12 hour period and I'm not permitted to eat at my station. While I'm not hypoglycemic, my waning blood sugar combined with the fatigue of a very physical 12-hour day raise risk I could make an error that would result in my patients being harmed. Stretch that day even further and the risk rises greatly.

There is a real nursing shortage in this city and state, I know. But this is a matter of economics for the healthcare facilities, simply solved by increasing the financial inducements to work and offering a conducive environment. Mandatory overtime does not a conducive environment make. If mandatory overtime is allowed to be utilized more extensively, more nurses will become burned out and leave the work force. This will increase the amount of overtime needed from remaining staff.

Couple this with the fact that healthcare facilities require nurse to carry their own liability insurance. They rarely if ever back a nurse who makes a mistake, even when staffing policies contribute to the chain of events that caused an error. Situations like this only create incentive to leave nursing, not stay.

Please ensure SB 28 gains passage and the Governor's signature. Thank you.

Andrew P. Feild
2301 Banbury Drive
Anchorage, AK 99504

Don Burrell

From: ROBERT O'CONNOR [maddienpups@msn.com]
Sent: Sunday, April 15, 2007 4:46 PM
To: Sen. Bettye Davis
Subject: senate bill 28

please support senate bill 28!!!! Nurses are so overwhelmed with higher acuity patients that burnout and low morale are prevalent at Providence Alaska Medical Center. Please give us your support by supporting this bill.thank you for your time. Tanya OConnor RN,BSN,CCRN

Don Burrell

From: Mark Meuser [mmeuser2004@yahoo.com]
Sent: Sunday, April 15, 2007 8:42 AM
To: Sen. Bettye Davis
Subject: SB28

Dear Senator Davis,
I am writing to express my OPPOSITION to SB28 limiting the use of mandatory overtime for nurses in Alaska. I am a staff nurse working full time in a large hospital in Anchorage. As any administrator will tell you, nurses are in very short supply nation wide as well as in Alaska. Mandating hours limits our options for providing patient care. Who will provide care for our states residents if nurses are limited by government mandates. This should be an issue addressed by individual institutions rather than state government.
Sincerely,
Mark Meuser RN

Don Burrell

From: Tara Orley [sorenorley@gci.net]
Sent: Saturday, April 14, 2007 7:50 PM
To: Sen. Bettye Davis
Cc: Sen. Lesil McGuire; mshickey@gci.net
Subject: Senate Bill 28

Dear Senator Davis,

I was encouraged and excited when I saw Senate Bill 28 that you are sponsoring. I certainly hope you will your continue to support this much needed bill.

I would like to share with you why this bill is so important to the safety of Alaskans who are in need of the services of one of Alaska's many fine hospitals. I have worked as an RN in the acute care setting for the past 28 years, with 25 of those at the same hospital in Alaska. Over that time I have seen an increasing number of excellent nurses leave the profession due to excessive long hours which jeopardize the safety of the patients and have the secondary effect of burnout by the nurses and a loss of quality of life for the nurses and their families. Alaska is already facing a nursing shortage and bills like this are needed to help reduce the shortage since it is obvious self regulation by hospitals is not dealing with the issue of mandatory overtime. In the critical care settings where I have worked, I have seen the hospitals continue to reduce the number of nurses they have scheduled for a shift and when the already overextended nurses are unable to complete all of their duties in their scheduled shift they are forced to work overtime under great pressure. When nurses are rushed and fatigued from working too many hours they are prone to make mistakes. These may range from giving the wrong medication to missing a critical change in status, all of which can lead to severe negative consequences for the patient. I am convinced that the hospitals will not truly try to deal with this problem until they are forced by bills like the one you are sponsoring. No one wants a loved one to be in a hospital setting being cared for by a nurse who has been on duty for 15 hours straight while at the same time trying to take care of yet other critical patients. I am sure you do not. Most nurses are in the profession because they love what they do and are very conscientious. They do not want to give their patients substandard care, but when you have been working for 15 hours straight on a dead run all day, all the dedication in the world may not prevent this overly fatigued nurse from making a mistake that will harm someone's loved one. Because they are so conscientious and concerned for the safety of their patients they come to the conclusion that this problem is not going to be fixed and the only way they can keep their sanity is to leave the very profession they love so much. What a waste for someone, so well trained, with so many years of experience, so very dedicated and devoted to leave nursing. I see continually increasing numbers of nurses in my area leave the profession mainly as a result of mandatory overtime and forcing nurses to work when it is unsafe to do so.

There is no doubt in my mind that the hospitals will try to get you to change your mind. They will come up will all sorts of reasons why this is a bad bill, but in the end they will all just be excuses. If you give in to these excuses, hospitals will continue these unsafe practices and still fail to understand why so many hard working, diligent nurses are leaving the profession. Please continue you sponsorship of Senate Bill 28.

Very truly yours,

Waltara Orley RN, BSN, CCRN

Don Burrell

From: Lisa Wahl-Hermosillo [lisarn@acsalaska.net]
Sent: Saturday, April 14, 2007 5:50 PM
To: Sen. Bettye Davis; Sen. Bettye Davis
Cc: mshickey@gci.net
Subject: SB 28

April 14, 2007

Dear Senator Bettye Davis,

Thank you for supporting nurses in Alaska with the safety and efficacy necessary for public health.
Primary prevention and health promotion means intervening at the lowest level possible, to prevent problems from happening in the first place, such as immunizations and safety belts. Requiring down time between long shifts for adequate rest and sustenance of health care workers is good common sense. People who are driving cars and overly tired are proven to be as impaired as the inebriated driver. Tired nurses forced to work beyond their capacity are just as problematic. Ethical and professional issues of risk management dictate that we ensure our nurses the right to rest, in the interest of public safety.

I am an emergency department nurse. Life and death is the norm, not the exception, multiple times daily. We are a proud and driven lot, willing to face anything at any time to save lives. At the end of a good day (12.5 hour shifts), with a good night's sleep, we get up and do it again, and again, and again. The emotional, mental, and physical exhaustion is wearing. I wore a pedometer to work for a while, and found I average 12-14 miles daily. I have been hit, spit on, urinated on, kicked, fallen on, bled on, defecated on, cursed, felt up, ignored, loved, appreciated, and blessed. Babies have died in my arms. Homeless people beg me not to turn them out into the subzero night. Addicts come to us as their last hope. Body parts in bags are carried in by their owners, hoping we can reattach them. Mothers are miscarrying. Some days I feel like the whole world is having chest pains! We need our breaks to keep the cloak of compassion from falling to the ground, a burned out memory.

Please let me know who else would be interested in my earnest support of this fundamental legal guide to positive outcomes.

Mrs. Lisa Wahl-Hermosillo, RN, BSN, MSN, ANP, FNP
Past secretary, Alaska Nurse Practitioners Association
2906 Lily St. #A
Anchorage, AK 99508
lisarn@acsalaska.net

Don Burrell

From: Christine Potter [christyp@gci.net]
Sent: Saturday, April 14, 2007 2:49 PM
To: Sen. Bettye Davis
Cc: donnaphill@acsalaska.net
Subject: senate bill 28

Dear Senator Davis,
This note is to express my support of senate bill 28. This is an important bill for all Alaskans. Everyone will be, or have a loved one hospitalized at some point in their lives. It is imperative that the nurses caring for them are able to effectively and safely do their job. When a nurse is forced to work mandatory overtime, patient care is compromised. Mistakes are more common when people are forced to work longer than their twelve hour shift. Please do not let this bill die, your or my life may depend on it.
Thank you,
Christine Potter
Advanced Nurse Practitioner

Don Burrell

From: carol goss [carolgoss@yahoo.com]
Sent: Saturday, April 14, 2007 2:40 AM
To: Sen. Bettye Davis
Subject: Senate Bill 28

Please continue to support Senate Bill 28. I am a nurse at API and have been required to work at least 16 hours in a row. During this time I am extremely tired which causes great concern for medication and judgment errors. Nurses should not be forced to work more hours than they are scheduled -- this is an extremely unsafe practice which needs to be stopped. This is a practice which is being used daily at API. I watched the committee discussing the bill on TV last week and found it very disconcerning that the question " has there been a lawsuit yet" kept coming up. Does there have to be a lawsuit to stop something that is unsafe for patients and staff. Again please continue to support this bill.

Thank you, Carol Widman
8461 Brookridge Drive
Anchorage, Alaska 99504
(907) 333-8797

February 7, 2008

Senator Bettye Davis
State Capitol
Room 30
Juneau, AK 99801-1182

Re: SB 28 Mandatory Overtime for Nurses

Dear Senator Davis:

As a professional registered nurse at Providence Hospital in Valdez, I wanted to bring to your attention our issues with mandatory and excessive overtime.

We sign a sheet for two to three shifts a pay period for mandatory call since we work short staffed. One individual recently worked up to 8 days in a row after working 6 days in a row. Those are 12 hour shifts! I myself have worked 4 on, one off, and 4 on. Again these are 12 hour shifts. And, I often work well beyond my 12 hours in a day; one instance was a 15 hour day then having to return at night.

At times I've been so fatigued; I've been worried about my safety and the patient's safety. I'm apprehensive to call management about my worries because they don't bring on more staff, and I am not in a union setting.

I've been working in Valdez since October of 2007. Before that I was in New Mexico working as an RN for 4 years. I never experienced mandatory overtime or mandatory call. I can honestly tell you, I would not have begun working for Providence had I known about the overtime. I could have easily taken a travel assignment which would have made things easier on me and my family.

Please support the professional registered nurses in the state of Alaska by passing SB 28 as soon as possible.

Sincerely,

Tina Gonzales RN

Tina Gonzales