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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. Alken, 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 risk 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

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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 other 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 (50 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 of 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 (μ value)	Number	Percent	OR (μ 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	1.48 (.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 aureus*.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

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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.

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Background Articles



UAN

**UNITED AMERICAN
NURSES, AFL-CIO**

2002

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.

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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.

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Pittsburgh Post-Gazette

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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.

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Safe Nursing and Pa-
5 tient Care Act of 2005".

1 **SEC. 2. FINDINGS.**

2 The Congress finds as follows:

3 (1) The Federal Government has a substantial
4 interest in assuring that the delivery of health care
5 services to patients in health care facilities is ade-
6 quate and safe.

7 (2) Research, including a study published in the
8 Journal of the American Medical Association (in the
9 October 23–30, 2002 issue), documents that higher
10 nurse staffing levels result in better patient out-
11 comes. However, health care facilities report sub-
12 stantial difficulties in recruiting and retaining suffi-
13 cient nursing staff, as evidenced by the fact that ap-
14 proximately 500,000 licensed nurses are not prac-
15 ticing nursing.

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

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

1 (5) The dangers with mandatory overtime are
2 made clear by numerous studies. A November 2003
3 Institute of Medicine report, *Keeping Patients Safe:
4 Transforming the Work Environment of Nurses*,
5 concluded that limiting the number of hours worked
6 per day and consecutive days of work by nursing
7 staff, as is done in other safety-sensitive industries,
8 is a fundamental safety precaution. The report went
9 on to specifically recommend that working more
10 than 12 hours in any 24-hour period and more than
11 60 hours in any 7-day period be prevented except in
12 case of an emergency, such as a natural disaster.

13 (6) Another study published in the July/August
14 2004 *Health Affairs Journal*, *The Working Hours of
15 Hospital Staff Nurses and Patient Safety*, found
16 that nurses who worked shifts of twelve and a half
17 hours or more were three times more likely to com-
18 mit an error than nurses who worked standard shifts
19 of eight and a half hours or less. The study also
20 found that working overtime increased the odds of
21 making at least one error, regardless of how long the
22 shift was originally scheduled.

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

1 overtime ten or more times in a twenty-eight day pe-
2 riod and one-sixth reported working sixteen or more
3 consecutive hours at least once during the period.
4 Nurses reported being mandated to work overtime
5 on 360 shifts and on another 143 shifts they de-
6 scribed being "coerced" into working voluntary over-
7 time.

8 (8) While no Federal standards currently re-
9 strict mandatory nurse overtime, many States are
10 considering such laws and several States, including
11 California, Connecticut, Maine, Maryland, Min-
12 nesota, New Jersey, Oregon, Washington, and West
13 Virginia, have enacted laws or prescribed regula-
14 tions.

15 (9) Federal limitations on mandatory nurse
16 overtime will ensure that health care facilities
17 throughout the country operate in a manner that
18 safeguards public safety by helping assure the deliv-
19 ery of quality nursing care and facilitating the reten-
20 tion and recruitment of nurses.

21 **SEC. 3. LIMITATIONS ON MANDATORY OVERTIME FOR**
22 **NURSES.**

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

25 (1) in subsection (a)(1)—

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

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

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

7 "(W) to comply with the requirements of
8 subsection (k) (relating to limitations on man-
9 datory overtime for nurses)."; and

10 (2) by adding at the end the following new sub-
11 section:

12 "(k) LIMITATIONS ON MANDATORY OVERTIME FOR
13 NURSES.—For purposes of subsection (a)(1)(W), the re-
14 quirements of this subsection are the following:

15 "(1) PROHIBITION ON MANDATORY OVER-
16 TIME.—Except as provided in this subsection, a pro-
17 vider of services shall not, directly or indirectly, re-
18 quire a nurse to work in excess of any of the fol-
19 lowing:

20 "(A) The scheduled work shift or duty pe-
21 riod of the nurse.

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

23 "(C) 80 hours in a consecutive 14-day pe-
24 riod.

25 "(2) EXCEPTIONS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the requirements of paragraph (1)
3 shall not apply to a provider of services during
4 a declared state of emergency if the provider is
5 requested, or otherwise is expected, to provide
6 an exceptional level of emergency or other med-
7 ical services to the community.

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

13 “(i) the provider has made reasonable
14 efforts to fill the immediate staffing needs
15 of the provider through alternative means;
16 and

17 “(ii) the duration of the work require-
18 ment does not extend past the earlier of—

19 “(I) the date on which the de-
20 clared state of emergency ends; or

21 “(II) the date on which the pro-
22 vider’s direct role in responding to the
23 medical needs resulting from the de-
24 clared state of emergency ends.

25 “(3) REPORT OF VIOLATIONS.—

1 “(A) RIGHT TO REPORT.—

2 “(i) IN GENERAL.—A nurse may file a
3 complaint with the Secretary against a
4 provider of services who violates the provi-
5 sions of this subsection.

6 “(ii) PROCEDURE.—The Secretary
7 shall establish a procedure under which a
8 nurse may file a complaint under clause
9 (i).

10 “(B) INVESTIGATION OF COMPLAINT.—
11 The Secretary shall investigate complaints of
12 violations filed by a nurse under subparagraph
13 (A).

14 “(C) ACTIONS.—If the Secretary deter-
15 mines that a provider of services has violated
16 the provisions of this subsection, the Secretary
17 shall require the provider to establish a plan of
18 action to eliminate the occurrence of such viola-
19 tion, and may seek civil money penalties under
20 paragraph (7).

21 “(4) NURSE NONDISCRIMINATION PROTEC-
22 TIONS.—

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

1 employment, including discharge, promotion, com-
2 pensation, or terms, conditions, or privileges of
3 employment, against a nurse who refuses to
4 work mandatory overtime or who in good faith,
5 individually or in conjunction with another per-
6 son or persons—

7 “(i) reports a violation or suspected
8 violation of this subsection to a public reg-
9 ulatory agency, a private accreditation
10 body, or the management personnel of the
11 provider of services;

12 “(ii) initiates, cooperates, or otherwise
13 participates in an investigation or pro-
14 ceeding brought by a regulatory agency or
15 private accreditation body concerning mat-
16 ters covered by this subsection; or

17 “(iii) informs or discusses with other
18 employees, with representatives of those
19 employees, or with representatives of asso-
20 ciations of health care professionals, viola-
21 tions or suspected violations of this sub-
22 section.

23 “(B) RETALIATORY REPORTING.—A pro-
24 vider of services may not file a complaint or a
25 report against a nurse with the appropriate

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

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

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

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

11 “(5) NOTICE.—

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

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

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

1 time that the Secretary determines appropriate by
2 type or class of provider of services) for the depart-
3 ment or unit involved, and shall make available upon
4 request to nurses assigned to the department or unit
5 the daily nurse schedule for such department or
6 unit.

7 “(7) CIVIL MONEY PENALTY.—

8 “(A) IN GENERAL.—The Secretary may
9 impose a civil money penalty of not more than
10 \$10,000 for each knowing violation of the provi-
11 sions of this subsection committed by a provider
12 of services.

13 “(B) PATTERNS OF VIOLATIONS.—Not-
14 withstanding subparagraph (A), the Secretary
15 shall provide for the imposition of more severe
16 civil money penalties under this paragraph for
17 providers of services that establish patterns of
18 repeated violations of such provisions.

19 “(C) ADMINISTRATION OF PENALTIES.—
20 The provisions of section 1128A (other than
21 subsections (a) and (b)) shall apply to a civil
22 money penalty under this paragraph in the
23 same manner as such provisions apply to a pen-
24 alty or proceeding under section 1128A(a).

1 The Secretary shall publish on the Internet site of
2 the Department of Health and Human Services the
3 names of providers of services against which civil
4 money penalties have been imposed under this para-
5 graph, the violation for which the penalty was im-
6 posed, and such additional information as the Sec-
7 retary determines appropriate. With respect to a
8 provider of services that has had a change in owner-
9 ship, as determined by the Secretary, penalties im-
10 posed on the provider of services while under pre-
11 vious ownership shall no longer be published by the
12 Secretary on such Internet site after the 1-year pe-
13 riod beginning on the date of change in ownership.

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

20 “(9) DEFINITIONS.—In this subsection:

21 “(A) MANDATORY OVERTIME.—The term
22 ‘mandatory overtime’ means hours worked in
23 excess of the periods of time described in para-
24 graph (1), except as provided in paragraph (2),
25 pursuant to any request made by a provider of

1 services to a nurse which, if refused or declined
2 by the nurse involved, may result in an adverse
3 employment consequence to the nurse, including
4 discharge, discipline, loss of promotion, or retal-
5 iatory reporting of the nurse to the State pro-
6 fessional disciplinary agency involved.

7 “(B) OVERTIME.—The term ‘overtime’
8 means time worked in excess of the periods of
9 time described in paragraph (1).

10 “(C) NURSE.—The term ‘nurse’ means a
11 registered nurse or a licensed practical nurse.

12 “(D) PROVIDER OF SERVICES.—The term
13 ‘provider of services’ means—

14 “(i) a hospital (as defined in section
15 1861(e));

16 “(ii) a psychiatric hospital (as defined
17 in section 1861(f));

18 “(iii) a hospital outpatient depart-
19 ment;

20 “(iv) a critical access hospital;

21 “(v) an ambulatory surgical center;

22 “(vi) a home health agency;

23 “(vii) a rehabilitation agency;

24 “(viii) a clinic, including a rural
25 health clinic; or

1 “(ix) a federally qualified health cen-
2 ter.

3 “(E) DECLARED STATE OF EMERGENCY.—
4 The term ‘declared state of emergency’ means
5 an officially designated state of emergency that
6 has been declared by the Federal Government
7 or the head of the appropriate State or local
8 governmental agency having authority to de-
9 clare that the State, county, municipality, or lo-
10 cality is in a state of emergency, but does not
11 include a state of emergency that results from
12 a labor dispute in the health care industry or
13 consistent understaffing.

14 “(F) STANDARDS OF SAFE PATIENT
15 CARE.—The term ‘standards of safe patient
16 care’ means the recognized professional stand-
17 ards governing the profession of the nurse in-
18 volved.”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect 1 year after the date of enact-
21 ment of this Act.

22 **SEC. 4. REPORTS.**

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

1 (1) STUDY.—The Secretary of Health and
2 Human Services, acting through the Director of the
3 Agency for Healthcare Research and Quality, shall
4 conduct a study to establish appropriate standards
5 for the maximum number of hours that a nurse, who
6 furnishes health care to patients, may work without
7 compromising the safety of such patients. Such
8 standards may vary by provider of service and by de-
9 partment within a provider of services, by duties or
10 functions carried out by nurses, by shift, and by
11 other factors that the Director determines appro-
12 priate. The Director may contract with an eligible
13 entity or organization to carry out the study under
14 this paragraph.

15 (2) REPORT.—Not later than 2 years after the
16 date of the enactment of this Act, the Secretary
17 shall submit to Congress a report on the study con-
18 ducted under paragraph (1) and shall include rec-
19 ommendations for such appropriate standards of
20 maximum work hours.

21 (b) REPORT ON MANDATORY OVERTIME IN FEDER-
22 ALLY OPERATED MEDICAL FACILITIES.—

23 (1) STUDY.—

24 (A) IN GENERAL.—The Director of the Of-
25 fice of Management and Budget shall conduct

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

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

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

○

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 of turnover resulting in training dollars lost, low productivity, longer

Testimony of Kathleen A. Gettys, RN, BSN, BA
HB 271
Page two

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 Finance 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 public's 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.



907-374-0807
907-372-0800

2267 East Tudor Rd, Suite 14
Anchorage, AK 99507-1044
www.alanurses.org
chanurto@alnanurses.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, RN, BSN
Member, Alaska Nurses Association Board of Directors
Chair, ANA Labor Council
Treasurer and Membership Chair,
Providence Registered Nurses Bargaining Unit

TOTAL P.01

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

Address: 1811 TALKBETNA ST.

City & Zip: ANCHORAGE AK

Phone number: 269-7163 (wk)

Department: H-SS

Work location: APL - Psychology Dept

I understand that you are
a sponsor of the bill -

Thank you -
It is needed by our nursing staff
(long overdue!)

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 one 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

1050 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,

A handwritten signature in black ink, appearing to read "J. Lynch".

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 exceptions² 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.

Senator Bettye Davis

April 2, 2007

Page 3

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

RECEIVED
APR 16 2007

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 Pharaoh 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 Pharaoh, 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

RECEIVED
APR 16 2007

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

DISCLAIMER:

This message is intended for the sole use of the addressee, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the addressee you are hereby notified that you may not use, copy, disclose, or distribute to anyone the message or any information contained in the message. If you have received this message in error, please immediately advise the sender by reply email and delete this message.

Don Burrell

From:

Sent:

To:

Subject:

RECEIVED
APR 16 2007

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

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

RECEIVED
APR 16 2007

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. Bettve 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

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