

ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SL&C 12605

Copyright 2002 The Sunday Oregonian  
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](http://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 60 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 Kathieen 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.



Copyright 2001 P.G. Publishing Co.  
Pittsburgh Post-Gazette

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.

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 service; 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.

○

# **NURSING SHORTAGE**



10 August 2000, the Maryland Hospital Association reported that nursing jobs in that state were down 10% from January of the same year.

# 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 75% 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

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 45 years old. The average age of working RNs is projected to continue to increase before peaking at age 47.7 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 30 years as a result of the aging of the population, advances in medicine, and various economic and policy factors. The Bureau of Labor Statistics ranks nursing 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 retirement of today's aging nurses, 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 2002 and that by 2020 the number of nurses will fall nearly 50% below requirements.

BACKGROUND

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.

## **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 Health 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.

JAMA Article Links Hospital Staffing and Patient Mortality, Nurse

Burnout and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize strategies for Nurse Staffing in Addressing the 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 nurse workload. The difference between four to six and four to eight patients-per-nurse was accounted for by a 13 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, APT, 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 linked to low 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 turnover by 23 percent and job dissatisfaction by 13 percent. The data indicates 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 now have eyes 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

ANA

**ANA Press Release October 23, 2002**

**CONTACT: Carol Cooke, 202-651-7027 or Cindy Price, 202-651-7038**

**m=realnews@ana.org, www.nursingworld.org/mrealnews**

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

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

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

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

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

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

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

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

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistleblower 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](http://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

## 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 \$334,621,641 in 2003, including a record-breaking \$7,7180 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 Bennett, RN, MSN, FNP-C; Linda Gobis, JD, RN, FNP; Alexa Green, PhD, RN, FAAN; Susan King, MS, RN; Rose Marie Martin, BSN, RN, OCNP; Eric Murray, BSN, RN; and Betty Smith-Campbell, PhD, RN, ARNP.

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 CMAAs 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.

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](http://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 Matzke, 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](mailto: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 Health 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 Institutes of Nursing Research of the National Institutes of Health, examined data collected from 168 hospitals, 232,342 surgical patients, and 18,184 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.

Baron and Job Dissatisfaction

ANA's Blakeney calls on hospitals to utilize principles for Nurse Staffing to address program

Washington, DC - A study published today in the Journal of the American Medical Association (JAMA) found that Registered Nurses (RN) staffing levels have a significant effect on preventable hospital deaths among surgical patients. According to researchers, the odds of patient mortality increased 7 percent for every additional patient added to the average nurse 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 assessment 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 Hospital Setting, which was released in May 2000. The study looked at hospital and Medicare data 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 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 turnover by 33 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

**ANA Press Release October 23, 2002**

**CONTACT: Carol Cooke, 202-651-7027 or Cindy Price, 202-651-7038**  
**[rn=realnews@ana.org](mailto:rn=realnews@ana.org), [www.nursingworld.org/mrealnews](http://www.nursingworld.org/mrealnews)**

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

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

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

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

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

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

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

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

ANA is advocating for a comprehensive set of strategies to address the nurse staffing crisis, including state and federal legislation that would limit mandatory overtime, provide whistleblower 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](http://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



HPAA/AA/AFU CIO

**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.)

patients, registered pharmacists, medical technologists and total hospital personnel (Kohn, J.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. (Prohovost, 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)

...staffing for 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 Robertson, 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-Mordl, 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.)

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)

# **LETTERS OF SUPPORT**

**Testimony of Kathleen A. Gettys, RN, BSN, BA**  
**HB 271**  
**House Finance Committee**  
**April 7<sup>th</sup>, 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. Getty, 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.



☎ 907-274-0007  
☎ 907-273-0003

2347 East Tudor Rd, Suite 14  
Anchorage, AK 99507-1947  
www.alaskanurses.org  
alnanurses@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 will 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

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:

H Sollenbeger

Address: 1811 TALKETTNA 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 this 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.



✓ 907-274-0827  
# 907-272-0292  
3701 E. Tudor Rd, Suite 208  
Anchorage, AK 99507  
[www.aknurse.org](http://www.aknurse.org)

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

January 2008

## **Executive Summary**

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

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

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

## **Background**

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

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