

Studies Show that Mandatory Nurse Ratios Are Not the Answer

DC hospitals' foremost concern is the well-being and safety of the patients they serve. The one-size-fits-all approach inherent in legislatively mandated staffing ratios fails to recognize the complexity and diversity of all healthcare environments.

California's experience with mandated nursing ratios has resulted in many unintended and negative consequences for patients, nurses, and other employees. If mandated ratios were the answer, other states would have adopted them...yet not one has done so. In fact, various nationally recognized studies, including those on California's nurse-to-patient ratios, illustrate the significant consequences for nurses, patients and hospitals.

Impact on Patients

- **Inflexibility does not meet patients' needs.** "The night shift and patients waiting to be discharged were both cited as examples of situations requiring fewer nurses than the ratios prescribe. On the other hand, caring for patients with complex conditions, such as multiple and chronic illnesses, was cited as an example of an area where the staffing ratios fell short of meeting the patient's needs." – *California HealthCare Foundation, 2009*¹

"Our findings suggest that nurse staffing models that facilitate shift-to-shift decisions on the basis of an alignment of staffing with patients' needs and the census are an important component of the delivery of care." – *New England Journal of Medicine, 2011*⁴
- **No evidence of improved patient outcomes.** "We do not find persuasive evidence that the regulation change improved patient safety in the affected hospitals." – *Centre for Market and Public Organisation Bristol Institute of Public Affairs, January 2012*⁵

"So far, the studies on the situation in California do not support the primary position of the pro-ratio movement, that ratios will improve quality." – *Nursing Economics, 2010*³

"...trends in rates of decubitus ulcer, failure to rescue, and deep vein thrombosis, were not changed."
– *California HealthCare Foundation, 2009*¹
- **Overly simplistic.** "Mandated nurse staffing ratios without mechanisms to help achieve ratios may force hospitals, especially safety-net hospitals, to make tradeoffs in other services or investments with unintended negative consequences for patients."
– *Journal of Hospital Medicine, 2008*⁶

- **Poorer emergency room experience.** “Some interviewees reported that the ratios affected patients in their emergency departments. In those hospitals, emergency department waiting times increased, patients occasionally had to be held in the emergency department due to lack of staffing, or in rare cases, the emergency departments were put on diversion so patients had to be transported to other hospitals.” – *California HealthCare Foundation, 2009¹*
- **Costs passed on to patients.** “The insurers interviewed for this study indicated that hospitals have cited the minimum ratios as one reason for rising costs, and that these costs are likely passed on to the consumer.” – *California HealthCare Foundation, 2009¹*

Impact on Hospitals

- **Difficulty finding quality nurses.** “Most hospital leaders reported difficulty finding specialty nurses or experienced nurses holding bachelor’s or master’s degrees, noting that new graduates are not appropriate for some positions.” – *California HealthCare Foundation, 2009¹*
- **Increased costs and budget cuts.** “[Hospital] leaders reported difficulties in absorbing the costs of the ratios, and many had to reduce budgets, reduce services or employ other cost-saving measures.” – *California HealthCare Foundation, 2009¹*
- **Dismissal of ancillary staff.** “Since the passage of [California] Bill 394 in 1999, three studies found no significant impact on nursing effectiveness. To accommodate mandatory staffing ratios, California hospital administrators have made difficult decisions and changes. These include reduced hiring and dismissal of ancillary staff, holding patients longer in the emergency room, hiring more agency and per diem nurses, and cross training nurses to cover breaks.” – *MEDSURG Nursing, 2011²*
- **Limits innovation and technology.** “Suppose a new technology or a drug is developed that could decrease the workload or number of RNs needed to produce patient care. Yet, because nurse staffing ratios lock in the number and compositions of nurses, hospitals are unable to modify their nurse staffing to achieve greater efficiency offered by implementing such innovations.” – *Nursing Outlook, 2009⁷*

- **Increased safety concerns.** “One of the biggest challenges cited in the survey is meeting the “at all times” requirement. This requirement has many issues; it requires float RNs to cover breaks. These brief inserts into care situations raise a variety of concerns – increased handover communications requirements with potential for error, variations in skills and competencies, variations in continuity — all safety issues.” – *Nursing Economics, 2010³*

Impact on Nurses

- **Loss of autonomy and flexibility.** “The combination of meal break and staffing regulations was perceived as reducing the ability of staff nurses to use their professional judgment in determining the best time to take a break, and interviewees believed that nurses found this loss of autonomy frustrating.” – *California HealthCare Foundation, 2009¹*
- “If there is agreement that the expert professional nurse has an essential role in staffing, then whatever solution we stand behind must give the nurse the power to make staffing decisions and to override models, including ratios, when they don’t make sense and to have the authority to use their expertise in the best interest of patients, the care team, and the hospital... Why would nurses want to hand over their power to make staffing decisions to the government?” – *Nursing Economics, 2010³*
- **Lower job satisfaction.** “Passage of this [California] legislation led to changes in nurse staffing levels; RN workloads increased and RN job satisfaction decreased.” – *MEDSURG Nursing, 2011²*
 - **More work.** “A reduction in ancillary staff support was reported at several of the [California] hospitals. These reductions resulted in additional primary care duties for the RNs, such as giving baths to patients. Hospital managers reported hearing from their RN staff that they were unhappy with these additional job tasks and the shift in their role in patient care.” – *California HealthCare Foundation, 2009¹*

¹California HealthCare Foundation. “Assessing the Impact of California’s Nurse Staffing Ratios on Hospitals and Patient Care.” February 2009.

²Tevington, P. *MEDSURG Nursing*. “Mandatory Nurse-Patient Ratios.” September/October 2011.

³Douglas, K. “Ratios—If It Were Only That Easy.” *Nursing Economics*. March/April 2010.

⁴Needleman, J. et al. “Nurse Staffing and Inpatient Hospital Mortality.” *New England Journal of Medicine*. 2011;364:1037-45.

⁵Cook, A., et al. “The Effect of a Hospital Nurse Staffing Mandate on Patient Health Outcomes: Evidence from California’s Minimum Staffing Regulation.” Working Paper No. 12/283. Centre for Market and Public Organisation Bristol Institute of Public Affairs. January 2012.

⁶Conway, P., et al. “Nurse staffing ratios: Trends and policy implications for hospitalists and the safety net.” *Journal of Hospital Medicine*. 2008;3:193–199.

⁷Buerhaus, Peter. *Nursing Outlook*. “Avoiding mandatory hospital nurse staffing ratios: An economic commentary.” March/April 2009.

Mandatory Nurse Ratios Are Not the Answer



“Ratios are a bankrupt idea, and their widespread implementation could slowly bankrupt the [nursing] profession. I would not want to be associated with a profession that allowed itself to be dummed down to the point where it self-inflicted onto the profession the very notion it abhors: a nurse is a nurse is a nurse.”

— Peter I. Buerhaus, PhD, RN,
FAAN, Senior Advisor to President
Obama’s Healthcare Taskforce¹

Washington, D.C. hospitals are already held accountable for achieving a high standard of quality, safety and adequate staffing levels by national and local organizations, such as The Joint Commission, the Centers for Medicare and Medicaid Services and the D.C. Department of Health. Many hospitals in the District also voluntarily pursue additional accreditations and certifications from national organizations, such as the American Heart Association, the American Stroke Association and the National Accreditation Program for Breast Centers, to name a few.

District hospitals at-a-glance.

- DC hospitals provide more than 500,000 emergency room visits annually.
- DC hospitals provide 650,000 inpatient days of care through 120,000 inpatient admissions annually.
- DC hospitals employ more than 27,000 people, and support an additional 45,000 jobs elsewhere in the District’s economy through the “ripple effect” of employee and hospital spending.

How does hospital staffing work?

All District hospitals have processes in place to appropriately staff each unit based on individual patient needs and the training, experience and capabilities of their nurses, nursing assistants, case workers, nurse managers, physicians, and other caregivers. To ensure safe, high-quality care, hospital staffing models are developed and implemented to continuously adjust staffing on the basis of patient need and the experienced judgment of nurses on the floor. Staffing is a collaborative process; a mandated, fixed ratio does not allow that flexibility and innovation in a care team.

Mandated ratios have unintended consequences.

Mandated ratios offer a simplistic formula that does not take into account the numerous factors that impact the level of staff a patient should receive.

California is the only state to mandate ratios, and the impact is notable, including:

- Reduction of non-nursing personnel
- Reduction or elimination of services
- Diversions of patients — reduced access including closing of hospitals
- Patients facing longer waits in the emergency room
- Hospital reductions in budget and employees
- Nurses losing autonomy and flexibility

One size does not fit all.

Mandated ratios have not been proven to help make significant improvements in patient safety outcomes. The District must stay focused on implementing thoughtful, sustainable and proven solutions if we are to continue to make significant improvements in health care.

Hiring more nurses will not improve quality.

There is no evidence that supports the assumption that mandated staffing ratios improve quality of care. Because ratios must be maintained at all times, nurses cannot leave the work unit, meet with family members in the waiting room, or transport a patient to another unit without violating the ratio. California hospitals have to either turn patients away or over-staff units, causing an increased dependence on nurses hired by temporary agencies. Finally, no one provider is responsible for patient safety. It is not just a nursing issue, but also a responsibility of all hospital personnel — physicians, techs, transporters, housekeeping, and many others. Ensuring safety and quality in a hospital is a responsibility of every member of the hospital staff.

National nursing organizations do not support mandated ratios.

The American Organization of Nurse Executives (AONE) and the American Nurses Association (ANA) both do not support mandated staffing ratios. It is AONE's position that "Because staffing is a complex issue composed of multiple variables, mandated staffing ratios, which imply a 'one size fits all' approach, cannot guarantee that the healthcare environment is safe or that the quality level will be sufficient to prevent adverse patient outcomes." The American Nurses Association says it has "real concerns about the establishment of fixed nurse-to-patient ratio numbers."

**Mandated ratios will cost District hospitals
more than \$90,000,000
annually, resulting in unintended consequences.**