ashhra
AMERICAN SOCIETY FOR HEALTHCARE HUMAN RESOURCES ADMINISTRATION OF THE AMERICAN HOSPITAL ASSOCIATION

American Hospital Association

Ensuring Patient Safety and Quality of Care

Issue

Legislation has been introduced that would mandate staffing ratios for registered nurses as well as other allied health care workers. While the proponents of this legislation contend that ratios further quality of care, the evidence is inconclusive and there are many countervailing arguments.

Many factors influence a hospital's staffing plan to ensure patients receive appropriate care, including the experience and education of its registered nurses (RNs), the availability of other caregivers, patients' needs and the severity of their illnesses and the availability of technology. A major consideration, however, is the availability of registered nurses and other health care workers. The U.S. is experiencing a long term health care workforce shortage. Mandated staffing ratios ignore this reality and undermine a hospital's ability to provide quality care according to specific patient needs.

AHA/ASHHRA View

The AHA and ASHHRA believe that legislatively mandated nurse-patient ratios in hospitals only will serve to increase the stress on an already overburdened health care system and potentially create a greater public safety risk. Imposing staffing ratios will likely result in the denial of access to care.

Hospitals and nurses and other allied healthcare workers have the same objective – provide the best patient care available. Imposing staff ratios further exacerbates the real issue, which is the long-term shortage of nurses and other health care workers. According to AACN's report on *2008-2009 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*, U.S. nursing schools turned away 49,948 qualified applicants from baccalaureate and graduate nursing programs in 2008 due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Almost two-thirds of the nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into their programs. Scarce resources should be directed to address this issue.

Further, a one-size-fits-all approach to staffing – whether on the federal or state level – fails to take into account the unique nature of a local community and its patients. Mandated nurse-patient ratios are based on one staffing variable – a simple head count of the nurses and patient populations. That approach fails to take into account more significant variables, including the patient's need, complexity of the patient's condition, the education and experience of the nurses, the availability of adequate support services and the environment in which the care is delivered. Also, new technologies to facilitate patient care are constantly being introduced.

Staffing needs are and should continue to be driven by patient needs, which may vary hour-to-hour, day-to-day. Hospitals need flexibility to make sure they can put qualified caregivers in the right place when they are needed.

To ensure quality care, hospitals and health systems have many safeguards in place. Quality assurance mechanisms, independent accreditation procedures and other safeguards provide an opportunity for nurses and other health care workers to voice concerns over quality of patient care. Most hospitals are evaluated every three years by the Joint Commission – an independent review group – and are required to meet state and federal health care standards. Hospitals are dedicated to ensuring the best care possible, and hospital leaders would rather close than offer services that fail to meet the highest quality standard. Still, patient safety and quality care require flexibility, and nurse staffing needs to be able to quickly respond to the changing condition of a patient in an instantaneous manner. Federally mandated staffing ratios do not take these variables into account.

There is no reliable evidence that staffing ratios improve quality of care. A literature review conducted for the California Department of Public Health noted that only a handful of studies and reviews had demonstrated consistent relationships between staffing levels for licensed nurses and the quality of patient care and none identified an ideal staffing ratio for hospitals (Kravitz, 2002, and Spetz, 2000).

There have been several studies conducted evaluating California's mandated nurse staffing ratios, implemented in 2004. There is no question that, to date, the literature on the impact of nurse staffing ratios has been mixed. A study published in 2009, *Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care*, shows that while the ratios were intended to improve patient outcomes, there is no evidence that this has occurred as a result of the mandated ratios. In addition, hospital leaders had to redirect resources from other services and programs to fund the mandated ratios. Limiting a hospital's ability to make these adjustments is not a viable solution as it would only serve to increase the cost of healthcare. This study, along with another, *"California's Minimum-Nurse-Staffing Legislation and Nurses' Wages," Health Affairs, 10 February 2009)* were inconclusive on the impact of nurse ratios on improved patient care but did document that minimum nurse ratios are associated with higher wages and, ultimately, higher health care costs.

A more recent study, "*Implications of the California Nurse Staffing Mandate for Other States"* may be cited as evidence that staffing ratios "are associated with lower mortality and nurse outcomes predictive of better nurse retention." However, it is important to recognize that the study does not take into account that patient safety/quality of care initiatives may have been occurring in the hospitals at the same time the survey of nurses for this study was conducted. The study is also limited by the fact that researchers did not compare quality in California hospitals before and after the implementation of staffing ratios, rather they used other states' quality measures to draw their conclusion. Significantly, the study also does not purport to determine that California's specific numeric ratios are the "right" ratio for every patient in every hospital every day. The numeric ratios that exist in California today were the result of political compromise, not scientific investigation.

Mandatory staffing ratios assume that all hospitals provide care in much the same way. This is not true now and is certainly not true for the future. Changes in health care delivery, including emerging technology, will continue to develop. Hospitals and health care providers need flexibility to adapt to this rapidly changing environment.

According to another noted researcher on nurse staffing issues, Peter Buerhaus of Vanderbilt University, inflexible nurse staffing ratios are at odds with the nimbleness and flexibility that will be required of nurses as they adapt to the many changes which will occur as a result of health care reform. According to Buerhaus, nurses will need to take on many new care delivery and management roles as today's health care delivery system evolves. Inflexible staffing arrangements, such as prescribed nurse ratios, may only serve to make this transition more difficult.