

## Mandatory Nurse-Patient Ratios

The issue of mandatory nurse-patient ratios remains widely controversial among many vested stakeholders, including nurses, patients, physicians, unions, nursing organizations/lobbyists, researchers, employers (in particular, hospitals), and federal and state governments (Douglas, 2010). Support for mandatory nurse-patient ratios is drawn from the belief that regulated registered nurse (RN) staffing will increase positive patient outcomes, decrease nursing shortages, and increase nurse recruitment and job satisfaction (Unruh, 2008). According to Blakeman Hodge and colleagues (2004), better RN staffing results in higher quality patient care (e.g. decreased hospitalization). What are the implications of mandatory nurse-patient ratios? What are the alternatives?

### Background

In the early 1990s, health care financing and hospital restructuring led to a decrease in licensed caregivers and an increase in unlicensed caregivers (service aides). At the same time, managed care requirements led to increased patient acuity and decreased hospital lengths of stay. Mandatory nurse-patient ratios became law in California in 1999 with the passage of California Assembly Bill 394, which mandated minimum, specific, and numerical nurse-patient ratios in hospitals. Passage of this legislation led to changes in nurse staffing levels; RN workloads increased and RN job satisfaction decreased. Retaining and recruiting RNs became more difficult for hospitals (Blakeman Hodge et al., 2004). Additionally, the state of California was reported to have one of the lowest nurse populations in the nation (Buchan, 2005). These factors, combined with negative media attention related to patient care, gained the attention of stakeholders such as the Institute of Medicine (Buerhaus, 2010a). However, the successful lobbying for Bill 394 was due to the combined efforts of the California Nurses Association (CNA), California Hospital Association, and the Service Employees International Union over several years (Blakeman Hodge et al., 2004). Although motivated differently, these stakeholders influenced the bill's passage. Each stakeholder submitted nurse-patient ratio recommendations to the California Department of Health Services. The final bill, which was to be implemented in 2004, mandated a nurse-patient ratio of 1:5 in medical-surgical units (smaller ratios were assigned to specialty units) (Buchan, 2005). Citing financial reasons, California

TABLE 1.  
State Staffing Regulations

States with Legislative Staffing Plans	States with Mandated Public Disclosure
Nevada	New York
Texas	New Jersey
Ohio	Vermont
Connecticut	Rhode Island
Illinois	Illinois
Washington	
Oregon	

Governor Arnold Schwarzenegger sought to delay this bill until 2008. However, he was overruled by a lawsuit filed by the CNA in 2005. The victory by CNA mandated the 1:5 nurse-patient ratios in medical-surgical units which are still in force (Longest, 2006).

### Alternatives

Bill 394 is one type of state legislation pertaining to staffing requirements. Two other types of state regulation identified by the American Nurses Association include reporting/public disclosure and staffing plans/committees. Currently, seven states have legislated staffing plans. Additionally, five have legislated public disclosure/public reporting (see Table 1) (DeVandry & Cooper, 2009).

With use of staffing plans/committees, hospital administrators and nursing staff jointly determine and implement staffing plans that will produce the best patient outcomes. Although there are some pronounced differences among participating states' requirements, the majority of committees are required to include staff nurses and leaders (e.g., nurse managers and chief nursing officers) as well as hospital administrators. Potential problems arising from such committees include conflicting ideas between nursing staff and administrators, increased financial costs, and lack of consistent implementation of staffing plans by hospitals. States participating in public reporting/disclosure either must report staffing patterns to a state agency or make the staffing information public (DeVandry & Cooper, 2009).

As an RN in a state that participates in public reporting, I can attest to my hospital's participation. In front of each nursing station, a daily census sheet is displayed with the census and staffing. However, most patients and their families seem oblivious to the daily census sheet. Instead, patients often ask their individual nurses how many patients they are assigned. Despite the positive

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attributes of planning committees and public reporting/disclosure (e.g., increased nursing involvement and organizational accountability), problems remain in their successful implementation and overall effectiveness.

## **Current Legislation/Priority Setting**

Although California remains the only state with mandated nurse-patient ratios, 17 states have introduced similar legislation (Buerhaus, Donelan, DesRoches, & Hess, 2009). Bill A660 of the New Jersey Legislature was introduced on January 12, 2010, and referred to the Assembly of Health and Senior Services Committee (State of New Jersey 214th Legislature 2010). The identical bill, S963, was introduced on February 4, 2010, and referred to the Senate Health, Human Services, and Senior Citizen Committee. These bills call for specific, minimum nurse-patient ratios in both hospital and ambulatory units as follows:

- 1:6 in medical-surgical units (reduced to 1:5 after the first year) and behavioral units.
- 1:4 in step-down, telemetry, or intermediate care units and for non-critical emergency rooms.
- 1:2 for critical or trauma patients (e.g., intensive care units and burn units) and post-anesthesia units.
- 1:1 for every patient under anesthesia.

Pediatric and maternal health specialties have diverse and explicitly detailed requirements. Additionally, these bills attempt to include some fundamentals of staffing committees (e.g., staff nurse involvement) (State of New Jersey 214th Legislature, 2010).

The continued interest in mandatory staffing bills such as A660/S963 is related to several critical issues. Studies have associated increased RN staffing with an increase in patient safety, quality of care, and patient satisfaction (Aiken, Clark, & Sloane, 2002; Dall, Chen, Seifer, Maddox, & Hogan, 2009; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007), as well as a decrease in patient length of stay, and nurse burnout and turnover (Douglas, 2010). In addition, health care delivery has undergone dramatic changes (e.g., increased managed care) with economic implications. Increased regulation by federal agencies such as the Centers for Medicare and Medicaid Services (CMS) has had a major impact on hospital reimbursement. In 2008, CMS established new regulations linking Medicare hospital payment to patient outcomes (Buerhaus et al., 2009). Eight conditions (e.g., falls with injury and catheter-associated urinary tract infections) were cited as *never conditions*, creating additional medical costs that will no longer be reimbursed. Finally, the nation's increasing nursing shortage, which is partly due to an aging nursing workforce with fewer graduates to replace retiring nursing personnel, has affected hospital staffing negatively (DeVdry & Cooper, 2009).

## **Social, Ethical, Economic, and Environmental Implications**

Research support for adequate staffing and balanced workloads of nurses as essential to achieve good patient,

nurse, and financial outcomes has led 17 states to introduce mandatory nurse-patient ratio legislation (Unruh, 2008). However, lessons can be learned from Bill 394 and serious implications need to be addressed if other states are to follow California's lead. Primarily, no empirical evidence supports the specific numbers assigned through mandatory ratios with better patient outcomes (Blakeman Hodge et al., 2004). Passing legislation with possible far-reaching effects on nurses, patients, hospitals, and other stakeholders without sufficient evidence is potentially dangerous. Additionally, once passed into law, legislation is difficult to change if research disproves its effectiveness and public and private support of the nursing profession could be affected negatively (Buerhaus, 2010b). Another major concern with mandatory nurse-patient ratios is ignorance of critical factors, such as nurse education, skills, knowledge, and years of experience. In Bill 394, only 50% of the mandated nurses must be RNs, which implies minimal differentiation between licensed professional nurses and RNs (Chapman, 2009). Mandatory staffing ratios also ignore other critical criteria necessary for adequate staffing decisions, including patient acuity and required treatments, length of stay, team dynamics of staff, physician preferences, environmental limitations, variations in technology, and availability of ancillary staff (Douglas, 2010). Finally, mandatory ratios are inflexible and do not allow for the dynamic changing of patient needs that nurses recognize and for which they should have input (Douglas, 2010).

Since the passage of Bill 394 in 1999, three studies (Bolton et al., 2007; Donaldson et al., 2005; Greenberg, 2006) found no significant impact on nursing effectiveness (Douglas, 2010). 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 (Douglas, 2010). This has increased economic costs for employers (e.g., increased bonuses necessary for nursing recruitment) and has led to increased workload for nurses (e.g., having to perform more non-nursing tasks) (Chapman, 2009). To accommodate mandatory staffing ratios, employers also have used other tactics to save money, including decreased funding for supplies (e.g., equipment), environmental changes (e.g., upgrading to single patient rooms), and educational costs (e.g., tuition reimbursement) (Buerhaus, 2010a). Additionally, employers may choose simply to be non-compliant with regulations and pay a fee (e.g., \$50 per patient per day) that is less costly than adhering to assigned mandates (Buchan, 2005). Through strict adherence to mandates, and with no input from nurses related to changes in patients' needs, employers may impact patient care quality and adversely affect nurses' workload and autonomy. Ignoring the dynamic interaction of technology, capital, and economic and labor supply variables may impose the increased cost of labor on hospitals, taxpayers, and nurses themselves (Buerhaus, 2010a). Finally, allowing governmental intervention and entanglement through

inflexible mandates may decrease nurses' power and ability to advocate for evidence-based practices for best patient outcomes (Douglas, 2010).

## Policy Modification and Nurse Involvement

While California remains the only state with mandated nurse-patient ratios, increased legislative activity within the last 2 years demonstrates some stakeholders (e.g., nursing unions and state governments) are lobbying actively for mandatory nurse-patient ratios (DeVdry & Cooper, 2009). Nurses will be challenged to become more knowledgeable about what is best for their profession and their patients, and to consider more action (e.g., political lobbying and advocacy).

The most powerful stakeholders and lobbyists for the profession of nursing are the American Nurses Association (ANA) and the American Hospital Association, which are both opposed to mandatory nurse-patient ratios (Rajecki, 2009). The ANA (2010a) acknowledged determination of appropriate nurse staffing levels is problematic due to budget realities, nursing shortages, and apparent lack of data to guide and make adequate staffing decisions. However, mandatory nurse-patient ratios do not consider many critical factors (e.g., patient acuity). Implementing legislation with a single focus does not empower nurses to use their expertise for best patient outcomes, and fails to make health care facilities accountable (ANA, 2010b; DeVdry & Cooper, 2009). Instead, the ANA supports legislation with recommended guidelines for establishing nurse staffing based on critical factors (census, patient acuity, nursing experience, available supportive resources). The Registered Nurse Safe Staffing Act of 2009 (S. 54) is a possible solution (DeVdry & Cooper, 2009). Two critical components of the bill require staff nurses to be involved actively in the development of unit-based staffing plans and hold hospitals accountable for their proper implementation (ANA, 2010a). In effect, this bill combines the use of staffing plans and public reporting. The ANA (2010a) support of safe staffing and S. 54 is based on belief in the need for an organizational environment that values both patients' individuality and nurses' skills/knowledge to create and implement high-quality patient care. This environment should encompass necessary organizational outcomes (e.g., financial stability), and nursing workload and satisfaction. It also should produce safe, quality, and evidence-based patient care.

Having the support of the ANA for S. 54 instead of mandatory ratio legislation is a positive and necessary first step toward successful policy making/policy modification. However, much more work is needed by the nursing profession for its successful implementation. First, the profession must produce quality research to support its nursing plans and utilize evidence-based tools for proper application (e.g., patient acuity systems [PAS]). Tools such as PAS usually are computerized and customized to enable nurses to document interventions and select attributes from departmental lists. After an acuity level is determined, appropriate staffing recommendations are

calculated (Beck, 2009). Second, nurses at all levels need to become involved in lobbying. Increased involvement must begin at an individual level (e.g., joining a professional nursing organization or writing to a legislator) and also include group efforts (e.g., research or attending political rallies). Nurses must recognize their worth, and advocate in an effective manner for what is truly best for themselves and their patients. Third, nurses must be able to work cooperatively and competently with other stakeholders involved in determining appropriate nurse staffing (e.g., hospital administrators and physicians) to increase stakeholder support and foster a climate that continues to promote nursing at private and public levels (Buerhaus, 2010b). Finally, the nursing profession must obtain the political knowledge and power employed by other powerful special interest groups (e.g., American Medical Association) to ensure their employers will be held accountable for obligations imposed on them by governmental laws.

## Conclusion

The premise behind mandatory nurse-patient ratios is that minimum, specific, guaranteed nurse staffing will produce better patient outcomes and alleviate nurse workloads and increase job satisfaction. However, this has not been proven (DeVdry & Cooper, 2009). The American Nurses Association advocates legislation that will empower nurses to create valid, reliable unit and patient-specific staffing plans, and require public reporting as outlined in The Registered Nurse Safe Staffing Act (ANA, 2010a). Passage of this bill would promote the value of the nursing profession and facilitate evidence-based practice. In addition, it would limit governmental involvement and allow nurses to utilize their knowledge, expertise, and skills to provide effective care. **MSN**

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