PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Massachusetts considering patients-per-nurse limits

Nurses claim staffing levels can affect patient safety

Depending on who you ask, the state of Massachusetts is either: a) on the verge of; or b) seriously considering following California's lead and limiting the number of patients who can be assigned to nurses. Potential legislation has been working its way, in a series of fits and starts, through the state legislature.

The sooner, the better, says **Julie Pinkham**, RN, MS, executive director of the Massachusetts Nurses Association (MNA), a strong proponent of such limits, who says it has been clearly demonstrated that assigning too many patients to nurses can have a direct impact on patient safety.

"Every piece of research we have seen says that the number of patients a nurse has is directly related to morbidity and mortality," she says. "Linda Aiken was the first one to quantify that." (Aiken's article in the October 2002 *Journal of the American Medical Association* found that "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."[1]) "This research validated what nurses have been saying to us."

Pinkham adds that "another paper by Jack Needleman found a direct correlation between patient outcomes and the number of patients per nurse."[2]

Because of these findings, says Pinkham, nurse-patient ratios must be looked at in terms of delivery of care. "Registered nurse assignment of patients is not unlike any other type of care we do — like cancer screenings, for example," she asserts. "Look at it this way: Insurance companies, after doing their research, decide whether or not the money they are investing in a treatment is worthwhile — if it is efficacious. If it is, we expect it to be covered. But in nursing care, even though we have a direct correlation between a nurse having more than four patients and increased risk, one hospital will give you 8-to-1 and another 4-to-1."

She notes that research also shows that improving nurse-to-patient ratios can be cost-effective, as well as safer.[3] "This last one finally puts it in perspective," she says. "Imagine going to a hospital, having a stroke, but the hospital is saying that even though research shows you should be treated with a certain protocol, they are not going to do it?" she poses. "That's why we're saying we need to have a limit in place — and that it needs to be directly linked to patient outcomes. Patients also need to understand what the limit is, and that, for example, their nurse should only have three additional patients."

Easier said than done

While the issues are clear to Pinkham's organization, and the Massachusetts Hospital Association (MHA) is certainly supportive of improving patient safety, incorporating those goals into legislation that both groups can support is not that easy.

"Essentially, everyone agreed there should be a limit on the number of patients assigned to an RN," says Pinkham. "We have been negotiating a waiver for financially strapped hospitals [who say they cannot afford additional staff], and what the 'ideal' number should be."

But, counters **Daniel P. Moen**, president and CEO at Heywood Hospital in Gardner, MA, and board chairman-elect of the MHA, "There has not really been any in-depth discussion on waivers [for financial concerns]. Before we get to that point, we

have major concerns as to whether these guidelines are based on research and evidence."

Pinkham says the state Department of Public Health will have public hearings and set standards and limits, and that there would be an acuity system to adjust those limits up and down. "The final regulations will be developed over a period of 12 months, once the legislation passes," she reports.

"Our biggest concern right now is that this is still a piece of legislation that addresses RNs only," says Moen. "Our board feels strongly that any type of legislative guidelines on staffing need to include the whole direct care team — LPNs, CNAs, and perhaps other types of providers like mental health and rehab units that need to be counted in the staffing pattern."

> "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients."

The target issue of the MNA, says Pinkham, is retention, while supply was the key concern of hospitalists. This latter concern is natural in light of the current nursing shortage, but it may not be as big a challenge in Massachusetts, she notes.

"We have the highest ratio of nurses per capita in the nation, and every single [nursing] school is full," Pinkham concedes. "But after three years, these nurses tend to leave the bedside; if we do not set a limit on working conditions, we will continue to lose these people."

She goes on to report that a number of nurses who have left the bedside "have told us they would return if the situation changed."

The numbers game

What exactly are the appropriate standards that should be established? "The limits in our bill for the ICU were no more than two patients per RN, which is also the recommendation of the Institute of Medicine and hard to negotiate around — and that's almost 50% of all beds," says Pinkham. "In med/surg, we say it should be 4-to-1." The bottom line, Pinkham says, is that "we have to have some leap of faith that the Department of Public Health will not abandon all scientific recommendations out of hand."

But Moen is not comfortable with hard-and-fast numbers. "We are very strong on the point that if there are going to be guidelines there needs to be flexibility around them," he shares. "What we're saying is, certainly hospitals and patients differ, and a one-size-fits-all approach ties management's hands as far as using the resources of the organization."

For example, Moen notes, when there is a huge influx of patients and conditions change rapidly, a hospital needs to maintain flexibility. "Or, for example, if you have a patient who is just about to be discharged, they may require only minimal staffing.

"We are not agreeing to something that's a hard-and-fast ratio by another name," he continues. "In reality, you will probably find that most ICUs are staffed that way [with two patients per nurse], but you can have an ICU where there are four patients but two are boarders — they are there for other reasons. In that case, should you have to adhere to that same level?"

Other states following suit?

The legislative moves in Massachusetts may only be the beginning of a developing national trend, says Pinkham. "I believe there are 14 states working on similar legislation," she reports. "And New York's may be even more aggressive than ours."

The states that pushed this type of legislation, she explains, were those that saw the highest penetration of managed care. "They saw big pressure to reduce LOS [length of stay], there were a lot of hospital closures and they really consolidated patients into a small number of beds," Pinkham says. "Since then, we've seen an increase in acuity. Now, we have the sickest of patients and an exodus of nurses from the bedside; it's a perfect storm."

As for whether the legislation becomes reality in Massachusetts, the jury is still out. "Everybody wants to see mandatory overtime go away, but only if it's done in some way that gives hospitals the flexibility they need to protect patients," insists Moen. "We've made a commitment to stay at the table, but we have certain lines we just won't cross; short of that, we are open for discussion."

References

1. Aiken LH, Clarke SP, Sloane DM, et al. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA* 2002; 288(16):1,987-1,993.

2. Needleman J, Buerhaus P, Mattke S, et al. Nurse staffing levels and the quality of care in hospitals. *N Eng J Med* 2002; 346:1,715-1.722.

3. Rothberg M. Improving nurse-to-patient staffing ratios as a cost-effective safety intervention. *Med Care* 2005; 543:785-791. ■