



# The Nurse-Patient Ratio: *Five Years Later*

FROM STATE HOUSES OF LEGISLATURE TO THE NURSE ON THE FLOOR, THIS IMPORTANT DEBATE CONTINUES

BY GENEVIÈVE M. CLAVREUL, RN, PHD

**IN THE LATE '90S, THE CALIFORNIA** Nurses Association sponsored a bill that would ensure safe staffing for patients in California. Known as AB394, the bill was the third attempt made to obtain mandated ratios in the state. The first was in 1993, but the bill died in committee. A second bill came around in 1997 and was passed through the legislature, but eventually vetoed by Gov. Pete Wilson. Things changed

in the fall of 1999, however, and then-Gov. Gray Davis signed AB394 into law, the nation's first directive mandating nurse staffing ratios for acute-care hospitals.

The California Department of Health Services (DHS) was given the task of determining and implementing the staffing ratios over a period of several years. During that time, nurses, legislators, media and the public at large were



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bombarded by a variety of messages from both proponents and opponents of the law. Some said hospitals will close; other said patients should be afraid to go to the hospitals where it wasn't yet implemented; many hoped nurse satisfaction would increase, thus keeping more nurses at the bedside.

#### THE RATIO EFFECT

To date only two studies have been conducted that specifically focused on the outcomes and/or results of this law, and both were published in the nursing journal *Policy, Politics & Nursing Practice*. The first was in 2005 and its primary focus was on the impact of the nurse-patient ratio on incidence of patient falls and prevalence of pressure ulcers.

The results revealed no significant changes and they were not able to find compliance with the ratio per shift or unit, but they seemed to show an overall compliance with the law.

The second study was published earlier this year and focused more specifically on nurse satisfaction, which was revealed to have improved between 2004 and 2006. The authors stipulated that the improvements were not associated with the degree to which the hospitals were expected to increase staffing.

#### MASSACHUSETTS AND THE NURSE-PATIENT RATIO

Even though the studies concluded that more studies are needed to fully determine the effect of mandating staff ratios, both sides of the nurse-patient ratio debate have latched onto them. Each side has used the effect and efficacy of nurse-patient ratios to argue the case for and against legislation brought before state houses throughout the country.

Earlier this summer, the Massachusetts House of Representatives passed a bill very similar to California's law. Meanwhile the Massachusetts Senate proposed and passed a bill that would allow individual hospitals, in conjunction with nurse input, to develop a nurse-patient staffing plan specific to that hospital. The customized plan would then be publicly posted and would allow the state's Department of Health (DPH) to monitor and audit and, where appropriate, penalize hospitals for failure to comply with their own staffing plan.

Both plans have a deep attachment to either the passage or defeat of their legislation. They each built coalitions to help them press their cause and argument.

Ultimately neither bill passed since both houses failed to agree upon a compromise prior July 31, 2008, the end of

the legislative session. As with California, emotions and rhetoric surrounding the Massachusetts legislation ran high, and dire predictions were announced should either bill pass.

#### ACUITY-BASED VS. “COOKIE CUTTER” SYSTEMS

As a nurse who is very outspoken (imagine that) on all things nursing, my readers may remember my earlier column on the nurse-patient ratio that was published in 2004. [Editor's note: This article is available at WorkingNurse.com.] My position on the mandated ratio law hasn't changed. I am a firm believer in the acuity-based patient assignment system. Though many nurses and their supporters seem to prefer the more cookie-cutter approach of the ratio, my experience has taught me that it can and is subject to manipulation. I use the term “cookie cutter” to describe the mandate because even though it has been based on outcomes from nursing research, in my opinion, it ultimately removes the individual nursing judgment from the patient assessment system.

Advocates of the nurse-patient ratio laws will often argue that the law is simply a “floor,” not a “ceiling,” and that the ratio can be adjusted based on patient acuity. However, I have rarely seen this put into practice. Perhaps it is believed that the “law is being met” even when the patient acuity might demand a different assignment.

For example, not that long ago a RN working in ICU at a hospital in the Los Angeles area shared how she had started her shift with one patient and, as the shift progressed, the charge nurse assigned her an additional newly admitted patient. The RN, who had many years of experience under her belt, informed the charge nurse that the patient assignment was inappropriate since both patients were highly unstable and a 1:1 ratio was more appropriate for each. The charge nurse disagreed with the RN's assessment and said that the law's requirements had been met. So the RN had to assume the care of the two patients and, sadly, one died on her watch.

I later learned that she was fired, and when asked if she had filed an incident report about the unsafe patient assignment, she replied, “Why bother?” The charge nurse who made the initial assignment had defended her decision; therefore she felt her complaint would fall on deaf ears.

I was somewhat surprised by her response since I know that there had been an extensive educational campaign to educate nurses on the nurse-patient ratio laws, and several



The hospital industry asserted that nurse-patient ratios would force closures. Some dismissed this as alarmist, but in Los Angeles County 11 hospitals closed during this period. Is there a link?



hospitals had even developed a reporting mechanism for their nurses to report violations of the law.

Then again, this could be another example of the “human factor” — just as one can easily point the finger at the health-care industry for ignoring reasonable patient assignments, one can never underestimate the impact that one nurse can have on another — people sometimes just do unwise things, regardless of what common sense, training or laws suggest they should do.

### BETWEEN THE BATTLE LINES

Presently, the movement to regulate patient assignment is making its way across our country. My research revealed 12 states that have or are considering legislation that would mandate a minimum nurse-patient ratio in hospitals. 14 states are considering legislation that attempts to address nurses’ concerns about staffing. Oregon (the only state so far) has enacted legislation that requires an acuity-based staffing plan, and I look forward to reading the research on the state’s experience.

I foresee a heated battle in the states with a mandated nurse-patient ratio, especially in light of the two studies that have been published on the subject matter. I read a letter to the editor of the *Salem News* (a local paper in Massachusetts) claiming that the 2002 had been “academically discredited,” and when I learned of this accusation I asked another University of California at San Francisco (UCSF) professor to shed light on this accusation.

The person I chose to contact, since I know her, was Joanne Spetz, the author of the 2008 study mentioned earlier in this column. She expressed a common conundrum often faced by researchers. She said the study had not been “academically dis-

credited,” but questions had been raised about its methodology.

Just because an organization disagrees with the results of a study, the funding source, or even the researchers themselves does not mean that the results of said research should be discarded. It is imperative that we — especially those of us who advocate so passionately for nursing, don’t engage in such destructive behavior. That’s for the spin doctors, lobbyists and politicians. Labeling research done by hospitals, clinics or fellow nurses with whom we may not agree as being tainted or discredited does not move the nursing profession forward.

### FACT OR FICTION?

That said, we still must consider the bias of sponsored research, which is why researchers often make a habit of disclosing both their affiliations, possible conflicts of interests, and the sources of funding. So long as this information is clearly disclosed, we should be cautious about making accusations and assumptions.

For example, when I read the 2008 study authored by Ms. Spetz, I thought it odd that Bay Area RNs had been oversampled (this was disclosed in the study) since the Bay Area has a more unionized RN workforce than elsewhere in our state. So I emailed her and asked about it, to which she explained that it had been done at the request of and with funding from a specific foundation.

No doubt the oversampling was weighted statistically to not have an effect on the overall outcome, and it’s not uncommon for studies to use such a process to balance studies when such “side tracks” are taken. This serves as a good example of the slippery slope we can go down if we choose to accept such practices.

It is critical as the nurse-patient ratio debate continues that we seek out all research related to the effects of California’s law and separate fact from fiction. However, to do so we must be willing to allow both sides to present their concerns and their studies. For example, one of the big selling points currently being promoted by supporters of mandated ratio laws is that nurses have flocked back to the bedside.

If truth be told, there has been a documented 90,000 new RN licenses issued since AB394 was signed into law. However, a nearly equal number of RNs have left the state during this same period. Of even greater concern is a recent revelation that a large number of RNs have not renewed their license at the first renewal opportunity.

I learned of this unsettling statistic from Ms. Spetz, who led me to understand that California’s Board of Registered Nursing



(BRN) has asked her to study this development. I, for one, look forward to learning the results of this study because our state can ill-afford nurses flocking into California to get their licenses if an equal number are going to flock out.

It is equally important that we study the assertion made by the hospital industry (which occurred early in the implementation) that the law would cause hospital closures. Proponents of the nurse-patient ratio law have dismissed such claims as alarmist talk, but I know that in the Los Angeles County area we've had 11 hospitals close during this period. Some have claimed they closed because they could not meet the mandated ratios while others intimated that the ratios were a contributing factor.

I'm no naïf when it comes to healthcare and its politics, so I know that there are many reasons why hospitals face closure. Though I'm not sure how much AB394 impacted these decisions, I for one would like to know whether AB394 was a contributing factor or not. This could have wide-ranging impacts if similar models are adopted nationwide.

#### THE FUTURE OF NURSING

Why nurses stay or leave the bedside is not a simple answer and goes beyond a mandated nurse-patient ratio. It is easy for nurses to latch onto this as the answer to all our woes, just as we often hear the phrase, "If nurses were only compensated more fairly there would be no nursing shortage."

The nursing shortage is a spectrum of challenges that need to be addressed if we ever hope to solve it. Some feel that the cookie-cutter approach is part of the answer. I'm convinced that such decisions are best left to the bedside nurse and not legislators and bean counters. We are taught the skills needed to do patient assessments and we should be in a position to put our education, training and skills into action. **WN**

*Editor's Note: To access the studies mentioned in this article, go to this article archived on WorkingNurse.com and click on the links.*



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