SAFE STAFFING STANDARDS: MYTHS AND MISCONCEPTIONS

The staffing crisis in Pennsylvania hospitals is not new, and the cause is not a shortage of available RNs. In truth, our current staffing crisis is the culmination of a decades-old strategy of intentional nurse understaffing by some hospital administrators in an ultimately misguided and counterproductive effort to reduce overall costs. Short nurse staffing doesn't reduce overall hospital costs. Likewise, safe RN staffing doesn't increase them. That's a myth – just one of the many surrounding safe staffing standards.

MYTH: We don't have a staffing crisis, just a temporary challenge because of the pandemic.
FACT: Just because hospitals are saying this doesn't make it true: Listen to bedside nurses, who have been shouting for years – long before the pandemic – that there's a nurse staffing crisis. Listen to the *legislature*.

To quote a 2015 report of the Pennsylvania Joint State Government Commission – the neutral research arm of the Pennsylvania State Legislature: "…though Pennsylvania has no shortage of nurses, the nurse staffing levels across PA hospitals are highly variable and [that variability] has persisted over the last 14 years." That variability, the report goes on to say, has a serious negative impact on patient care. It cries out for a minimum standard.

MYTH: We have a shortage of nurses in Pennsylvania.
FACT: We have plenty of licensed RNs in Pennsylvania. What we don't have – and haven't for many years – is enough RNs willing to risk their licenses to work in the conditions at the bedside. Currently, there are approximately 233,000 Registered Nurses in PA, yet only about 149,000 are employed.

MYTH: We won't be able to meet the ratios (nursing shortage part 2) – this isn't going to bring us more nurses (won't solve the staffing crisis)
FACT: Hospitals said the same thing when ratios were proposed in California, but they in fact were able to meet the ratios. According to Linda Aiken, Ph.D., R.N., the foremost expert on nurse staffing in the U.S.: "One of the best natural experiments [on mandated safe staffing standards] occurred when California enacted mandated nurse-to-patient ratios. When the law was implemented on January 1, 2004, the hospitals that were not in compliance with the staffing ratios had to change on that day and they did. Almost 15 years later, California still has the best nursing-staffed hospitals in the country. Plus, the state has seen steeper declines in [patient] mortality and greater improvements in other indicators than other states."

FACT: In the decade after the ratio law was signed, the number of actively licensed RNs in California grew by more than 110,000 RNs, tripling the average annual increase that was occurring prior to the law being passed. The state had been facing a nursing shortage, but after mandating safe staffing standards in 2004, the nursing shortage gradually but consistently improved as well, and California has enjoyed a nurse surplus since 2013.

FACT: Actually, research has shown that minimum standards are the only thing that will fix the staffing crisis. Fifteen states currently address nurse staffing in hospitals in laws/regulations: Eight states

require hospitals to have staffing committees and staffing policies; five require some form of disclosure and/or public reporting; and California and Massachusetts mandate nurse/patient ratios (California, by unit; Massachusetts, in ICU only). In a recent analysis of hospital-level data from 2003 to 2018 provided by the American Hospital Association, researchers found that only mandated staffing ratios led to a significant increase in RN staffing. Neither of the other two legislative models had any effect in increasing RN staffing.

MYTH: Safe nurse staffing standards would simply cost hospitals too much money.

FACT: Minimum staffing standards will actually save Hospitals money. Such standards would require some hospitals to hire additional RNs, but the increased costs of the additional staff would be more than offset by the money saved by the reduction in negative outcomes (including missed care, hospital-acquired infections, hospital readmissions, medical errors, wrong-site surgeries, failure to rescue, and death) that would result from proper staffing. A recent study on the implementation of ratios in Queensland, Australia, found that cost savings due to reduced lengths of stay for patients and fewer readmissions were estimated to be more than twice the costs of additional staffing.

A 2009 study published in Medical Care estimated that adding 133,000 RNs to the U.S. hospital workforce (the number of RNs needed to increase nursing staff to the 75th percentile) would result in medical savings of $6.1 billion in healthcare spending alone. Combining these savings with the value of increased productivity when RNs help patients recover more quickly, the study authors estimate the addition of 133,000 RNs would result in an economic value of $57,700 for each additional RN.

PLUS: Negative patient outcomes due to short staffing aren't the only monetary cost incurred by hospitals. As short-staffing leads to nurse burnout and more and more nurses leaving the bedside, hospitals have to hire, train, and support new RNs, which is much more costly than simply retaining nurses. In fact, the cost of replacing a single nurse can run up to $80,000.

MYTH: Safe nurse staffing standards won't lead to improvements in patient outcomes – the evidence isn't there.

This is simply not true. There are literally decades of studies and broad consensus in the academic literature that improvements in nurse staffing lead to improved patient outcomes. To name just one, one of the most expansive studies on the subject, in 2014, The Lancet published the largest international study to date, involving hundreds of thousands of patients in 300 hospitals across nine countries. The study found that patients in hospitals with better nurse staffing levels were less likely to die than those in poorly staffed hospitals. In fact, with each additional patient added to a nurses' average workload, a patient's risk of dying increased by 7 percent. In a 2021 study of 87 hospitals in Illinois, researchers found that the risk of death for patients in medical-surgical units increased by 16 percent for every additional patient in the average nurse's workload.

Linda Aiken, Ph.D., R.N., the foremost expert on nurse staffing in the U.S., specifically analyzed the results of the safe minimum staffing standards mandate in California, comparing data from California with the same data from Pennsylvania and New Jersey. The 2015 Pennsylvania Joint State Government Commission report summarized her results: "The study found that California nurses on average care for two fewer patients in general surgery units than nurses in Pennsylvania and New Jersey. Fewer patient assignments mean fewer California RNs miss changes in patient conditions because of their workload and ultimately translate into fewer patient deaths. The study found that New Jersey hospitals would have 14 percent fewer deaths if they matched California's 1:5 ratios in surgical units; Pennsylvania hospitals would have 11 percent fewer deaths." In Pennsylvania that would mean 264 fewer surgical deaths each year.

The 2021 Queensland study referenced earlier found that the introduction of mandated nurse-to-patient ratios, instituted in July 2016 in 27 hospitals across Queensland, Australia, saved almost 150 lives in the first year, and helped avoid 255 readmissions and 29,200 hospital days (for an estimated savings of between $55.2 million to $83.4 million Australian dollars). The study found that the reduction of one patient per nurse was associated with a 9% less chance of a patient dying in the hospital, a 6% less chance of readmission within seven days, and a 3% reduction in length of stay. One less patient on a nurse's caseload was also associated with a 7% reduction in burnout.

Study after study has shown that nurse-to-patient ratio is perhaps the most robust indicator of the overall quality of healthcare that hospital patients receive. There are others, of course, but all are linked with nurse staffing, and all vary widely in PA.

MYTH: Government interference in the healthcare sector is never the answer – doctors, and administrators in the facilities know best.

FACT: When there is a persistent safety problem in our hospitals – that is absolutely the state's concern. The 2015 report by the nonpartisan research arm of the PA General Assembly that found that the nurse staffing levels across Pennsylvania are highly variable and [that variability] has persisted over the last 14 years" also found that "patients exposed to even short durations of understaffing [such as from shift to shift] were at much higher risk of poor outcomes, including mortality." That means every Pennsylvanian is at risk when unsafe staffing levels are allowed to persist in the commonwealth.

Putting in place minimum safety standards is something the government does all the time in all industries including Hospitals. Nurse staffing is simply a blind spot where there has never been a minimum standard. Minimum staffing standards exist in nursing homes, childcare, drug and alcohol facilities, etc.

MYTH: Ratios are too rigid, every hospital is different, and we need the flexibility to respond to conditions in our hospitals in order to provide the best care.

FACT: This is something you will hear over and over again from the hospital associations. The implication is that they want flexibility in order to provide MORE/BETTER care than what is prescribed by the ratios. But that is absolutely not the case – the ratios in the law are MINIMUM STANDARDS, not maximums. They are a floor. In fact, the law not only does not prevent hospitals from increasing care above the ratios, it actually requires hospitals to assess specific conditions using an "acuity tool" that they will develop and to provide higher levels of care where warranted.

What the hospitals really want is the flexibility to go BELOW the minimums standards contained in the law. They want to be able to do LESS, not more.

MYTH: Hospitals will close if they're forced to follow safe staffing standards.

FACT: Every industry faced with possible regulation uses this type of scare tactic to avoid basic common sense safety standards. The fact is, hospitals didn't close in California, and they didn't close in Queensland when ratios were put into place. In fact, the opposite occurred – hospitals saved money and revenue increased.

According to the Institute for Health and Socio-Economic Policy, not one California hospital closed because of ratio implementation. In fact, hospital income rose dramatically in California after ratios were implemented, from $12.5 billion from 1994 to 2003, to more than $20.6 billion from 2004 to 2010.

MYTH: Rural hospitals are different. They are smaller, have fewer acute patients, and are struggling to survive. The same ratios that might make sense at an academic medical center or larger city hospital could force rural hospitals out of business.

FACT: Research shows that poor staffing directly leads to clear negative patient outcomes, regardless of hospital size or location. Minimum safety standards are needed in all hospitals, whether small, medium or large, rural or urban. Why should patients in small rural hospitals be subjected to increased risk of mortality and other negative outcomes due to a lack of basic standards?

The point of mandated minimum safe staffing standards in Pennsylvania is to establish a minimum standard of care based on patient-care units across the state. Those units are similar across all hospitals, no matter what their size or location. There might be fewer patients in a med-surg unit in a small community hospital than in a large urban hospital, but med-surg patients require the same type of care and attention to care no matter where they are seeking it.

If small, rural hospitals have funding issues, that is a problem that should absolutely be addressed, but it is a problem that exists outside of safe staffing standards legislation. Minimum safe staffing standards reduce negative outcomes and increase nurse retention, both of which save money for all hospitals, large and small.