

Patient Protection and Registered Nurse Retention: Model Legislation Addressing Inadequate Registered Nurse Staffing in Hospitals

Abbey Pirie Anderson

Follow this and additional works at: <https://digitalcommons.law.umaryland.edu/jhclp>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Abbey P. Anderson, *Patient Protection and Registered Nurse Retention: Model Legislation Addressing Inadequate Registered Nurse Staffing in Hospitals*, 25 J. Health Care L. & Pol'y 91 (2022).

Available at: <https://digitalcommons.law.umaryland.edu/jhclp/vol25/iss1/4>

This Article is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized editor of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

PATIENT PROTECTION AND REGISTERED NURSE RETENTION: MODEL LEGISLATION ADDRESSING INADEQUATE REGISTERED NURSE STAFFING IN HOSPITALS

ABBIEY PIRIE ANDERSON*

I. INTRODUCTION

“To do what nobody else will do, a way that nobody else can do, in spite of all we go through; that is to be a nurse.”¹ Perhaps that is why registered nurses (RNs) are described as both the heart and the backbone of the healthcare industry.² RNs are the glue that binds a hospital together and enable it to serve its purpose: saving lives.³

The public recognizes the significant role RNs play in the healthcare industry, specifically regarding patient interactions.⁴ For eighteen years in a row, Americans ranked RNs’ honesty and ethics highest in a list of professions polled by Gallup.⁵ With such prestigious perceptions, the assumption might be that there are plenty of RNs already in the field and a plethora in school waiting to join their ranks. The reality, however, is that the United States, like many other

© 2022 Abbey Pirie Anderson

* Juris Doctor Candidate, Belmont University College of Law, 2022. Thank you to Professor Jeffrey Usman for your sound advice through this note writing process. Thank you to all of the editors for the *Journal of Health Care Law and Policy* for your hard work and valuable feedback. Finally, to all of the Registered Nurses out there, thank you for doing what you do.

1. *Inspirational Quotes Every Nurse Should Read*, SCRUBSMAG (May 7, 2014), <https://scrubsmag.com/inspirational-quotes-every-nurse-should-read/> (quoting Rawsi Williams, a Registered Nurse and attorney).

2. Pam Clifton, *Nurses: The Heart of Healthcare*, DAILY J. ONLINE (May 12, 2020), https://dailyjournalonline.com/lifestyles/health-med-fit/nurses-the-heart-of-healthcare/article_dfbbe0da-ff7a-55a4-9d90-1a30e67ebfe6.html; *Staff Nurses*, ANA ENTER., <https://www.nursingworld.org/resources/individual/staff-nurses/> (last visited Dec. 7, 2020).

3. Jack Needleman et al., *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 NEW ENG. J. MED. 1715, 1715 (2002) (quoting Lewis Thomas).

4. See generally RJ Reinhart, *Nurses Continue to Rate Highest in Honesty, Ethics*, GALLUP (Jan. 26, 2020), <https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx> (finding that Americans have consistently ranked nurses as the most honest and ethical profession in an annual Gallup survey).

5. *Id.* (stating 85% of Americans ranked nurses’ honesty and ethical standards as high or very high).

countries, previously faced a nursing shortage and several states will experience a shortage in the future.⁶ RN fatigue and burnout is one of the factors that contributes to the shortage.⁷

Working as an RN in a hospital is demanding physically, mentally, and emotionally, which contributes to fatigue and burnout.⁸ Each shift for an RN begins with taking a patient's vital signs: heart rate, blood pressure, oxygen saturation, and respirations.⁹ Next, the RN performs an assessment: auscultate the heart, lungs, and bowels; palpate pulses; check for edema and skin issues; and monitor output in chest tubes or other drains.¹⁰ Then, the RN administers the patient's medications.¹¹

Throughout the shift, the RN continues to monitor the patient's vital signs and reassess the patient, assist the patient to the bathroom or on walks in the hallway, discuss the patient's condition with the care team, and document it all.¹² As the RN performs these tasks, the RN establishes rapport with the patient and the family, so the RN can ensure that the patient's emotional, spiritual, and physical needs are met.¹³ An RN performs these tasks for each patient that the RN is assigned, so an RN will go through these steps many times throughout each shift.¹⁴ In addition to these more routine tasks, RNs must respond to medical

6. WORLD HEALTH ORG. [WHO], *State of the World's Nursing Report—2020*, at 3, CC BY-NC-SA 3.0 IGO (2020) (estimating that the global nursing shortage was 5.9 million nurses in 2018). The National Center for Health Workforce Analysis reported a shortage of 110,700 RNs for the year 2000. STEVEN SIMOENS, MIKE VILLENEUVE & JEREMY HURST, OECD HEALTH WORKING PAPERS NO. 19: TACKLING NURSE SHORTAGES IN OECD COUNTRIES 18 (OECD 2005). The Health Resources and Services Administration projects that seven states in the United States will experience RN shortages in 2030, while others will have a surplus. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, SUPPLY AND DEMAND PROJECTIONS OF THE NURSING WORKFORCE: 2014-2030 9 (2017). Four states are projected to have a deficit of greater than ten thousand RNs. *Id.* at 4.

7. See *Fact Sheet: Nursing Shortage*, AM. ASS'N COLL. NURSING, <https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet.pdf> (Sept. 2020) (finding that more than 75% of RNs surveyed believe "the nursing shortage presents a major problem for the quality of their work life, the quality of patient care, and the amount of time nurses can spend with patients").

8. See generally The Joint Comm'n, *Developing Resilience to Combat Nurse Burnout*, QUICK SAFETY, July 2019, at 1 (explaining that nurses today accomplish a myriad of tasks and responsibilities often at a high personal cost which can result in nurses feeling overwhelmed or burnout).

9. Stephanie Behring & Emma Geiser, *What Kind of Work Does a Registered Nurse Do?*, ALL NURSING SCHOOLS, <https://www.allnursingschools.com/registered-nursing/job-description/> (last visited Dec. 18, 2020).

10. *Assessing patients effectively*, 8 AM. NURSING STUDENT 1, 6 (2006).

11. Behring & Geiser, *supra* note 9.

12. *Id.*

13. See generally Callie Malvik, *What Does a Registered Nurse Do? Understanding Their Impact*, RASMUSSEN COLL. (Aug. 24, 2020), <https://www.rasmussen.edu/degrees/nursing/blog/what-does-a-registered-nurse-do/> ("RN nurses are an integral part of a support system that requires them to wear many hats—from working with new technology to educating patients and providing life-saving procedures.").

14. *Id.*

emergencies as they arise throughout a shift, which can add significantly more stress to that RN's already heavy workload.¹⁵

This work cycle illustrates why RNs might experience fatigue, especially where a hospital unit is poorly staffed. The fewer RNs on the shift, the greater the number of patients assigned to each RN. The stress associated with the amount of work required of RNs on inadequately staffed units, coupled with RN perception that patient care suffers, leads to burnout.¹⁶

RN burnout is problematic because it is a major contributor to RN resignation and can decrease the quality of patient care.¹⁷ High rates of RN resignation are expensive for hospitals due to the recruiting and training efforts that must be employed to combat RN turnover.¹⁸ Additionally, when experienced RNs leave a hospital, they take their knowledge and skills with them, meaning that patients will not receive care from the most qualified care providers.¹⁹ RN burnout also decreases the quality of patient care because burnout negatively impacts RNs' physical and mental health.²⁰ When RNs are thus afflicted, it is more difficult for them to deliver quality care.²¹

Studies also show that inadequate staffing decreases the quality of care that patients receive, which may lead to adverse patient outcomes.²² Adverse patient outcomes range from patient safety issues, such as, falls and hospital associated

15. *Id.*

16. Matthew D. McHugh & Chenjuan Ma, *Wage, Work Environment, and Staffing: Effects on Nurse Outcomes*, 15 (3-4) POL'Y, POL., & NURSING PRAC. 72, 77 (2014). See also Linda H. Aiken et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288 J. AM. MED. ASS'N 1987, 1992 (2002) [hereinafter *Aiken I*] (finding that RNs in hospitals with the highest RN-to-patient ratios were more than twice as likely to experience burnout and almost twice as likely to report job dissatisfaction compared to RNs in hospitals with the lowest RN-to-patient ratios).

17. See *Aiken I*, *supra* note 16, at 1990, 1993; see generally Sara Heath, *How Does Provider Burnout Impact Patient Care Quality, Care Access?*, PATIENTENGAGEMENTHIT (Sept. 6, 2018), <https://patientengagementhit.com/news/how-does-provider-burnout-impact-patient-care-quality-care-access> (assessing how provider burnout will affect patient care quality).

18. Cheryl Bland Jones, *The Costs of Nurse Turnover: Part I: An Economic Perspective*, 34 J. NURSING ADMIN. 562, 562 (2004) (explaining that when nurse turnover occurs, healthcare organizations experience loss of future returns, productivity losses, and financial losses).

19. Karen S. Hill, *Improving Quality and Patient Safety by Retaining Nursing Expertise*, THE ONLINE J. OF ISSUES IN NURSING (Aug. 2, 2010), <https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No3-Sept-2010/Articles-Previously-Topic/Improving-Quality-and-Patient-Safety-.html>.

20. See generally Heath, *supra* note 17 (finding that provider burnout has reached staggering levels, causing healthcare professionals to consider the impact on patient quality care and access).

21. *Id.*

22. See *Aiken I*, *supra* note 16, at 1990 (finding that nurse staffing had a "pronounced effect" on mortality and mortality following complications for the surgical patients studied).

infections (HAIs)²³ to increased mortality rates.²⁴ Adequate RN staffing can increase patient satisfaction,²⁵ increase patient safety,²⁶ and reduce mortality rates.²⁷

Nevertheless, hospitals have failed to adequately staff RNs, and solutions to this deficiency have proven challenging to arrive at on the federal level.²⁸ Accordingly, the key to combatting adverse patient outcomes and RN burnout related to inadequate staffing—without risking the economic viability of hospitals—lies with turning to the state legislatures.²⁹ This note proposes a statutory model for implementing safe staffing legislation for adoption at the state level. Part II identifies the various nursing care providers in the hospital setting.³⁰ Part III provides an overview of the current federal and state legislation that govern RN staffing in hospitals.³¹ Part IV explains the negative impacts of inadequate RN staffing, including adverse patient outcomes and RN burnout.³² Part IV also demonstrates that state-mandated RN-to-patient ratios is not the right answer to ameliorating staffing issues.³³ Part V proposes the Hospital RN Safe Staffing Act, which offers a workable, balanced approach to ensuring appropriate RN staffing.³⁴ Part VI explores the potential benefits and financial implications of the proposed Act.³⁵

II. NURSING CARE PROVIDERS IN THE HOSPITAL SETTING

Initially, it is important to understand the differences between various healthcare providers that perform nursing care in the hospital setting. Nurses and

23. Gordon West et al., *Staffing Matters-Every Shift*, 112 AM. J. NURSING 22, 25 (2012); Brett G. Mitchell et al., *Hospital Staffing and Health Care-Associated Infections: A Systematic Review of the Literature*, 44 JOINT COMM'N J. ON QUALITY AND PATIENT SAFETY 613, 619 (2018).

24. See *Aiken I*, *supra* note 16, at 1991.

25. Linda H. Aiken et al., *Implications of the California Nurse Staffing Mandate for Other States*, 45 HEALTH SERVS. RES., 914, 914 (2010) [hereinafter *Aiken II*].

26. Mitchell, *supra* note 23, at 619; Needleman, *supra* note 3, at 1719; West et al., *supra* note 23, at 25; Linda H. Aiken et al., *Hospital Nurse Staffing and Patient Outcomes*, 29 REVISTA MÉDICA CLÍNICA LAS CONDES 322, 324 (2018) [hereinafter *Aiken III*].

27. *Aiken III*, *supra* note 26, at 324.

28. See *generally Nurse Staffing*, AM. NURSES ASS'N, <https://www.nursingworld.org/practice-policy/nurse-staffing/> (last visited Dec. 18, 2020) (finding that evidence demonstrates that appropriate nurse staffing contributes to improved patient outcomes and greater satisfaction for patients and staff); see also *Nurse Staffing Advocacy*, AM. NURSES ASS'N, <https://www.nursingworld.org/practice-policy/nurse-staffing/nurse-staffing-advocacy/> (last updated July 2019) (highlighting key findings demonstrating how optimal nurse staffing is essential to providing quality patient care).

29. See *generally Nurse Staffing Advocacy*, *supra* note 28.

30. See *infra* Part II.

31. See *infra* Part III.

32. See *infra* Part IV.

33. See *infra* Part IV.

34. See *infra* Part V.

35. See *infra* Part VI.

nursing assistants differ in their educational requirements, job duties, and salaries.³⁶ The nursing roles include Nurse Practitioners (NPs), RNs, Licensed Practical Nurses (LPNs) or Licensed Vocational Nurses (LVNs), and Certified Nursing Assistants (CNAs).³⁷

NPs are the highest level of nurse in the healthcare setting³⁸; they are required to complete a master's or doctoral program.³⁹ NPs' job duties more closely resemble that of a physician than those of a traditional RN and include: ordering, performing, and interpreting diagnostic tests; prescribing medications; and diagnosing and treating health conditions.⁴⁰

RNs are the most common type of nurse found in the hospital setting.⁴¹ There are two different educational paths to choose from in becoming an RN: a two-year Associate Degree in Nursing or a four-year Bachelor of Science Degree in Nursing.⁴² The job duties and scope of practice are the same for an associate-prepared RN as that of a bachelor-prepared RN.⁴³ However, some employers prefer candidates who have received a Bachelor of Science Degree. These RNs typically receive a higher salary than RNs who have an Associate Degree.⁴⁴ RNs perform a variety of tasks including conducting assessments, administering medications and treatments, and educating patients.⁴⁵

LPNs/LVNs have the lowest education requirements and the lowest salary.⁴⁶ LPNs/LVNs must complete an accredited practical nursing program which typically takes about one year.⁴⁷ Their job duties are more limited than those of RNs and include more basic nursing care, such as taking vitals and

36. *Registered Nurse vs. Licensed Practical Nurse*, ALL NURSING SCHOOLS (Nov. 4, 2016), <https://www.allnursingschools.com/articles/registered-nurse-vs-licensed-practical-nurse/>.

37. *Id.*; *What's a Nurse Practitioner (NP)?*, AM. ASS'N OF NURSE PRACTITIONERS, <https://www.aanp.org/about/all-about-nps/whats-a-nurse-practitioner> (last visited Dec. 18, 2020); *Licensed Practical Nurse (LPN) vs Certified Nursing Assistant (CNA)*, PRAC. NURSING.ORG, <https://www.practicalnursing.org/lpn-vs-cna> (Aug. 23, 2021).

38. See Sarah Jividién, *Nursing Ranks & Levels Explained*, NURSE.ORG (May 12, 2020), <https://nurse.org/education/nursing-hierarchy-guide/> (explaining that nurse practitioners receive a master's degree with a post-master's certificate).

39. See *What's a Nurse Practitioner (NP)?*, *supra* note 37.

40. *Id.*

41. See Behring & Geiser, *supra* note 9.

42. *Registered Nurse Career Guide*, NURSE.ORG (Sept. 2, 2020), <https://nurse.org/resources/registered-nursing/>.

43. *ADN and BSN Nursing Pathways: What are the Differences*, NURSINGLICENSURE.ORG, <https://www.nursinglicensure.org/articles/adn-vs-bsn/> (last visited Nov. 17, 2021).

44. *Registered Nurse Career Guide*, *supra* note 42.

45. *Registered Nurse vs. Licensed Practical Nurse*, *supra* note 36.

46. See *Licensed Practical and Licensed Vocational Nurses*, U.S. DEP'T OF LAB. BUREAU OF LAB. STAT., <https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm> (Sept. 8, 2021) (stating that the typical entry-level education is postsecondary nondegree award and 2020 median pay was \$48,820 per year).

47. *Registered Nurse vs. Licensed Practical Nurse*, *supra* note 36.

assisting patients with hygiene.⁴⁸ They also perform certain nursing tasks under the supervision of an RN, such as administering medications and inserting catheters.⁴⁹

Another potential member of a patient's care team is a CNA.⁵⁰ Unlike LPNs/LVNs, CNAs are not considered "nurses."⁵¹ CNAs need a high school diploma or a GED certificate, and then must complete a four to twelve-week program.⁵² CNAs work under the supervision of RNs and LPNs/LVNs to assist those nurses in caring for their patients.⁵³ CNAs assist patients with hygiene, take vitals, and serve and feed patients.⁵⁴

III. CURRENT RN STAFFING LEGISLATION AT THE FEDERAL AND STATE LEVELS

Unfortunately, the federal regulation that addresses RN staffing in hospitals provides an approach that offers little guidance to hospitals.⁵⁵ Throughout the years, there have been legislative attempts by Congress to more closely regulate RN staffing, but no such bill has passed both houses to become law.⁵⁶ Though attempts to address RN staffing have failed at the federal level, many states have passed their own legislation addressing RN staffing in hospitals.⁵⁷ This Part III discusses the existing federal regulation, Congressional attempts to strengthen RN staffing regulation, and states' approaches to safe staffing legislation.

A. 42 C.F.R. § 482.23(b)

The federal regulation currently dictating RN staffing⁵⁸ requires a hospital to maintain "adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed" to participate in Medicare.⁵⁹ The regulation, however, does not define

48. *Id.*

49. *Licensed Practical Nurse (LPN) vs Certified Nursing Assistant (CNA)*, *supra* note 37.

50. *Id.*

51. *The Difference Between LPN and CNA*, CHRON., https://docs.google.com/spreadsheets/d/107ndo_07TDayJtYvRNHD00UwWB-31nOv85pcAjQtk4/edit#gid=1944364648 (Oct. 9, 2020) ("A certified nursing assistant provides basic care to patients under the supervision of an LPN or registered nurse. The CNA works as a part of a health care team and has a limited scope of practice.").

52. *Licensed Practical Nurse (LPN) vs Certified Nursing Assistant (CNA)*, *supra* note 37.

53. *Id.*

54. *Id.*

55. Condition of participation: Nursing services, 42 C.F.R. § 482.23(b) (2019).

56. *See generally Nurse Staffing Advocacy*, *supra* note 28.

57. *Id.*

58. Condition of participation: Nursing services, 42 C.F.R. § 482.23(b) (2019).

59. *Id.*

“adequate numbers.”⁶⁰ The Centers for Medicare & Medicaid Services (CMS)—the federal agency responsible for overseeing Medicaid, Medicare, and Health Insurance Exchanges⁶¹—has provided some interpretive guidance.⁶² In one of its manuals, CMS instructs hospitals to consider the layout and size of the hospital, the number of patients, the intensity of the illness and the needs of the patients, the support staff available, and the training and experience of personnel in determining whether there are adequate numbers of RNs.⁶³ The CMS manual does not, however, explain who is responsible for making these assessments or how each factor should affect the number of RNs.⁶⁴

Due to this nebulous language and the significant impact RNs have on the quality of care, there have been legislative attempts at both the federal and state levels to clarify the definition of and provide a means for ensuring “adequate numbers” of RNs.⁶⁵

B. Federal Attempts to Clarify 42 C.F.R. § 482.23(b)

Despite a series of proposals being set forth, Congress has failed to pass legislation that would further define what qualifies as an adequate number of RNs. A series of safe staffing bills have been introduced in the Senate nine times and in the House six times without making it out of the committee phase.⁶⁶ The proponents of these measures initially and repeatedly sought to “provide for patient protection” by amending Title XVIII of the Social Security Act to require hospitals to adopt staffing systems or form staffing committees.⁶⁷ In more recent

60. *Id.*

61. *We’re Putting Patients First*, CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), <https://www.cms.gov/> (last visited Dec. 20, 2020).

62. *See* CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), CMS MANUAL SYS. PUB. 100–07, STATE OPERATIONS MANUAL (2020) (CMS program operating instructions for state administration of Medicare and Medicaid).

63. *See* CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), *supra* note 62.

64. *Id.*

65. *Nurse Staffing Advocacy*, *supra* note 28.

66. Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, S. 1357, 116th Cong. (2019); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, H.R. 2581, 116th Cong. (2019); Safe Staffing for Nurse and Patient Safety Act of 2018, S. 2446, 115th Cong. (2018); Safe Staffing for Nurse and Patient Safety Act of 2018, H.R. 5052, 115th Cong. (2018); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, S. 1063, 115th Cong. (2017); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, H.R. 2392, 115th Cong. (2017); Registered Nurse Safe Staffing Act of 2014, S. 2353, 113th Cong. (2014); Registered Nurse Safe Staffing Act of 2013, H.R. 1821, 113th Cong. (2013); Registered Nurse Safe Staffing Act of 2011, S. 58, 112th Cong. (2011); Registered Nurse Safe Staffing Act of 2011, H.R. 876, 112th Cong. (2011); Registered Nurse Safe Staffing Act of 2009, S. 54, 111th Cong. (2009); Registered Nurse Safe Staffing Act of 2007, S. 73, 110th Cong. (2007); Registered Nurse Safe Staffing Act of 2007, H.R. 4138, 110th Cong. (2007); Registered Nurse Safe Staffing Act of 2005, S. 71, 109th Cong. (2005); Registered Nurse Safe Staffing Act of 2003, S. 991, 108th Cong. (2003).

67. S. 2446; H.R. 5052; S. 2353; H.R. 1821; H.R. 876; S. 58; S. 54; H.R. 4138; S. 73; S. 991.

years, proponents of these measures proposed amending the Public Health Service Act to establish specific RN-to-patient ratios.⁶⁸

Specifically, the proposed Registered Nurse Safe Staffing Acts of 2003, 2005, 2007, and 2009 would have required hospitals to adopt “staffing systems” that established minimum RN-to-patient ratios.⁶⁹ Additionally, hospitals would have been required to appoint a committee, comprised of at least 50% RNs, charged with evaluating the staffing system annually.⁷⁰

The Registered Nurse Safe Staffing Acts of 2011, 2014, and 2018 would have required hospitals to form staffing committees comprised of at least 55% RNs.⁷¹ The staffing committees would have been responsible for developing and monitoring implementation of a staffing plan, evaluating and modifying the plan, and setting overtime requirements.⁷² The staffing plan would establish adjustable minimum numbers of RNs based upon a number of factors and input from RNs.⁷³

More recently, the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Acts of 2017 and 2019 took a different approach to promoting patient care.⁷⁴ These bills proposed amending the Public Health Service Act to establish specific RN-to-patient ratios.⁷⁵ Under these bills, each hospital must develop a staffing plan, with input from RNs, that includes minimum RN-to-patient ratios for each hospital unit provided in the bill.⁷⁶

Despite professional nursing organizations imploring Congress to pass some form of safe staffing legislation, no such federal legislation exists.⁷⁷

C. State Attempts to Supplement 42 C.F.R. § 482.23(b)

In response to Congress’ consistent failure to provide safe staffing legislation, many states have taken the initiative to institute their own safe staffing legislation.⁷⁸ About half of the states, however, continue to operate with

68. S. 1357; H.R. 2581; S. 1063; H.R. 2392.

69. S. 54; H.R. 4138; S. 73; S. 71; S. 991.

70. S. 54; H.R. 4138; S. 73; S. 71; S. 991.

71. S. 2446; H.R. 5052; H.R. 1821; S. 2353; S. 58; H.R. 876.

72. S. 2446; H.R. 5052; H.R. 1821; S. 2353; S. 58; H.R. 876.

73. S. 2446; H.R. 5052; H.R. 1821; S. 2353; S. 58; H.R. 876.

74. *See generally* Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, S. 1357, 116th Cong. (2019); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, H.R. 2581, 116th Cong. (2019); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, S. 1063, 115th Cong. (2017); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, H.R. 2392, 115th Cong. (2017).

75. S. 1357; H.R. 2581; S. 1063; H.R. 2392.

76. S. 1357; H.R. 2581; S. 1063; H.R. 2392.

77. *Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act*, NAT’L NURSES UNITED, May 2021, at 1 (“There are no federal mandates regulating the number of patients a registered nurse can care for at one time in U.S. hospitals.”).

78. *See Nurse Staffing Advocacy*, *supra* note 28 (indicating that states have stepped in to regulate in the absence of Congressional action because optimal nurse staffing is essential to patient care).

42 C.F.R. § 482.23(b) as their only requirement for staffing hospitals.⁷⁹ Among the states that have acted, four general approaches have emerged: (1) designated RN-to-patient ratios; (2) formation of staffing committees who develop a staffing plan coupled with reporting requirements; (3) development of a staffing plan only; or (4) reporting requirements only.⁸⁰

1. RN-to-Patient Ratios

In the first approach, legislators stipulate specific RN-to-patient ratios in statutes or their accompanying regulations.⁸¹ Each shift, RNs are assigned certain patients, meaning that the RN is responsible for the care of those patients during that shift.⁸² RN-to-patient ratios set the maximum number of patients one RN may be assigned for that shift.⁸³ For example, if the RN-to-patient ratio in a medical/surgical (“med/surg”) unit was 1:6, then an RN could be assigned no more than six patients.⁸⁴

Although some professional nursing organizations advocate for minimum RN-to-patient ratios,⁸⁵ California is the only state to mandate such ratios for each type of hospital unit.⁸⁶ Similar bills have been introduced in Ohio and Minnesota, but the legislation remains pending.⁸⁷

79. *Id.*

80. *Id.* Additionally, several states mention staffing in statutes and regulations but do not mandate committees, ratios, or reporting. *See* LA. ADMIN. CODE tit. 48, § 9513 (2017); MO. REV. STAT. § 197.289 (2017); 10 A N.C. ADMIN. CODE 13B.1912 (2017); OKLA. ADMIN. CODE § 310:667-15-3 (2020); WIS. ADMIN. CODE DHS § 124.13 (repealed 2020); 048.0061.12 WYO CODE R. § 13 (LexisNexis 2021). Rather, similar to 42 C.F.R. § 482.23(b), the legislation requires hospitals to ensure an adequate number of RNs without providing specific instruction on how to do so. *Id.*

81. *Nurse Staffing Advocacy*, *supra* note 28.

82. *RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals*, NAT’L NURSES UNITED, <https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/Ratios-A-Necessary-Solution-to-the-Patient-Safety-Crisis-in-US-Hospitals.pdf> (last visited Dec. 20, 2020) [hereinafter *RN Staffing Ratios*]

83. *Id.* at 2–3.

84. *See generally* CAL. CODE REGS. tit. 22, § 70217 (2013) (requiring specific licensed nurse-to-patient ratios representing the maximum number of patients assigned to one licensed nurse at any one time based on the particular service or unit).

85. *RN Staffing Ratios*, *supra* note 82, at 2–3.

86. *See* CAL. HEALTH & SAFETY CODE § 1276.4 (West 2019); CAL. CODE REGS. tit. 22, § 70217 (2013) (regulating California State Department of Public Health adopt regulations that “establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all health facilities”). California also requires the administrator of nursing services to develop a staffing plan that specifies staffing requirements for RNs and other licensed and unlicensed personnel within each hospital unit and the patient care requirements for that unit. CAL. CODE REGS. tit. 22, § 70217 (2013).

87. H.R. 629, 133rd Gen. Assemb., Reg. Sess. (Ohio 2019); S.F. 2901, 2019 Leg., 91st Sess. (Minn. 2019).

Massachusetts sets an RN-to-patient ratio of 1:1 or 1:2, depending on patient stability, in its Intensive Care Units (ICUs).⁸⁸ Several other states also mandate ratios for certain types of hospital units in their state administrative or regulatory codes.⁸⁹ For example, Virginia sets an RN-to-patient ratio of 1:4 for infants requiring close observation, and 1:8 for infants requiring only routine care.⁹⁰ Several states set RN-to-patient ratios in pediatric units, including Florida, New Jersey, Ohio, and Tennessee.⁹¹ Finally, Arizona and New Jersey set ratios for RNs working with high acuity patients in ICUs and post-operative cardiac patients, respectively.⁹²

2. Staffing Committees

The second approach requires hospitals to form staffing committees, which is a group within the hospital comprised primarily of RNs that creates a flexible staffing plan for each unit within the hospital.⁹³ The staffing plan provides instructions for ensuring appropriate staffing based on the patient population served, the experience of the RNs, and other unit-specific measures.⁹⁴

Seven states utilize the staffing committee approach to determine what constitutes an adequate number of RNs.⁹⁵ Two of these states mandate that the staffing plan set minimum RN-to-patient ratios,⁹⁶ while the other four states call for the staffing plan to establish the minimum number of RNs and other staff

88. MASS. GEN. LAWS ANN. ch. 111, § 231 (West 2019).

89. See, e.g., ARIZ. ADMIN. CODE § R9-10-221(5)(A) (2019); FLA. ADMIN. CODE ANN. r. 59C-1.044 (2018); N.J. ADMIN. CODE § 8:33E-2.4 (2019); N.J. ADMIN. CODE § 8:43A-24.17 (2017); OHIO ADMIN. CODE 3701-84-62(H) (2020); TENN. COMP. R. & REGS. 1200-08-30-.03(2)(f) (2016); 12 VA. ADMIN. CODE § 5-410-444(F)(7)(a)-(c) (2019).

90. 12 VA. ADMIN. CODE § 5-410-444(F)(7)(a)-(c) (2019).

91. Florida sets an RN-to-patient ratio in pediatric dialysis units at 1:1. FLA. ADMIN. CODE ANN. r. 59C-1.044 (2018). New Jersey establishes RN-to-patient ratios in pediatric dialysis units based upon the weight of the pediatric patient. N.J. ADMIN. CODE § 8:43A-24.17 (2017). Ohio provides guidance on RN-to-patient ratios in PICUs, stating that the ratio should “usually [range]” from 2:1 to 1:3. OHIO ADMIN. CODE 3701-84-62(H) (2020). Tennessee sets an RN-to-patient ratio in Pediatric Intensive Care Units (“PICUs”) ranging from 4:1 to 1:3 depending on patient stability. TENN. COMP. R. & REGS. 1200-08-30-.03(2)(f) (2016).

92. Arizona sets an RN-to-patient ratio in ICUs at 1:2. ARIZ. ADMIN. CODE § R9-10-221(5)(A) (2019). New Jersey sets graduated RN-to-patient ratios for post-operative cardiac patients. N.J. ADMIN. CODE § 8:33E-2.4 (2019).

93. *Nurse Staffing Advocacy*, *supra* note 28.

94. *Id.*

95. CONN. GEN. STAT. § 19a-89e (2019); 210 ILL. COMP. STAT. 85/10.10 (2021); NEV. REV. STAT. § 449.242 (2020); OHIO REV. CODE ANN. § 3727.51–3727.52 (West 2017); OR. REV. STAT. § 441.154 (2019); TEX. HEALTH & SAFETY CODE ANN. § 257.004 (West 2009); WASH. REV. CODE § 70.41.410 (2008).

96. CONN. GEN. STAT. § 19a-89e(c)(A) (2019); 210 ILL. COMP. STAT. 85/10.10(c)(1) (2021).

necessary on each unit or shift.⁹⁷ The difference is that the former dictates how many patients each RN may be assigned, while the latter requires only a certain number of staff to be present on the unit or shift.⁹⁸ Conversely, Washington does not dictate whether the staffing plan should implement ratios or designate a minimum number of staff.⁹⁹ Additionally, all seven states require hospitals to report on the establishment of and compliance with their staffing plan to a designated state agency.¹⁰⁰

3. *Staffing Plans*

Three states require hospitals to develop a staffing plan, but do not mandate the formation of staffing committees.¹⁰¹ In Minnesota, the Chief Nursing Officer (CNO), or his or her designee, must develop a core staffing plan for each hospital unit.¹⁰² Similarly, Rhode Island requires each hospital to submit an annual core staffing plan to the Rhode Island Department of Health, but the statute does not indicate who is responsible for developing the plan or what criteria to base it on.¹⁰³ Both Minnesota and Rhode Island require hospitals to submit their staffing plans to a state agency.¹⁰⁴ Finally, Kentucky requires healthcare facilities to develop a care delivery model that includes a staffing plan.¹⁰⁵

4. *Mandatory Reporting*

In the final approach, states require hospitals to report certain staffing statistics without requiring them to comply with specific RN-to-patient ratios,

97. NEV. REV. STAT. § 449.2421(2.) (a)(1)–(2) (2017); OHIO REV. CODE ANN. § 3727.52(B)(1) (West 2017); OR. REV. STAT. § 441.155(2)(f) (2019); TEX. HEALTH & SAFETY CODE ANN. § 257.003(b)(2)(A) (West 2009).

98. NEV. REV. STAT. § 449.2421(2.) (a)(1)–(2) (2017); OHIO REV. CODE ANN. § 3727.52(B)(1) (West 2017); OR. REV. STAT. § 441.155(2)(f) (2019); TEX. HEALTH & SAFETY CODE ANN. § 257.003(b)(2)(A) (West 2009); CONN. GEN. STAT. § 19a-89e(c)(A) (2019); 210 ILL. COMP. STAT. ANN. 85/10.10(c)(1) (2021).

99. WASH. REV. CODE § 70.41.420(3)(a) (2017).

100. CONN. GEN. STAT. § 19a-89e (2019); 210 ILL. COMP. STAT. 86/25 (2021); NEV. REV. STAT. § 449.242 (2017); OHIO REV. CODE ANN. § 3727.54 (West 2017); OR. REV. STAT. § 441.157 (2019); TEX. HEALTH & SAFETY CODE ANN. § 257.005 (West 2009); WASH. REV. CODE § 70.41.425 (2017).

101. See generally KY. REV. STAT. ANN. § 216B.160 (West 2020); MINN. STAT. § 144.7055 (2021); 23 R.I. GEN. LAWS § 23-17.17-8 (2021) (requiring hospitals to develop a staffing plan without mandating the formation of staffing committees).

102. MINN. STAT. § 144.7055 (2021); MINN. STAT. § 144.7055(2)(b) (2021) (dictating that, “[t]he core staffing plan shall specify the full-time equivalent for each patient care unit for each 24-hour period[.]”).

103. 23 R.I. GEN. LAWS § 23-17.17-8 (2017).

104. MINN. STAT. § 144.7055 (2021) (requiring hospitals to submit their staffing plan to the Minnesota Hospital Association). 23 R.I. GEN. LAWS § 23-17.17-8 (2017) (requiring hospitals to submit their staffing plan to the Rhode Island Department of Health).

105. KY. REV. STAT. ANN. § 216B.160 (West 2020).

form staffing committees, or submit staffing plans.¹⁰⁶ For example, in New Jersey, hospitals must post the number of RNs, LPNs/LVNs, CNAs, and other licensed or registered health care professionals on each shift, as well as the methods used for determining and adjusting staffing levels.¹⁰⁷ Additionally, New York hospitals must disclose “nursing quality indicators” to the public and state agencies upon request.¹⁰⁸ Finally, Vermont requires hospitals to “make public” the maximum patient census and numbers of RNs, LPNs/LVNs, and CNAs on each shift.¹⁰⁹

IV. THE ADVERSE EFFECTS OF INADEQUATE RN STAFFING AND THE INADEQUACIES OF MANDATED RN-TO-PATIENT RATIOS

The existing state of safe staffing legislation is problematic. The nebulous language of 42 C.F.R. § 482.23(b) leaves states with little guidance on what adequate staffing is and even less direction on how to achieve it.¹¹⁰ Additionally, Congress has failed to pass any of the proposed legislation aiming to both further define adequate staffing and provide guidance on how to achieve it.¹¹¹

While many states have instituted their own safe staffing legislation, the majority of states have yet to pass any form of safe staffing legislation. Of those states that have passed some form of safe staffing legislation, many have not implemented the best approach. States that lack safe staffing legislation face two major risks: (1) adverse patient outcomes; and (2) RN burnout.¹¹² State statutes that set mandated RN-to-patient ratios are problematic because they set rigid standards that cannot work for all hospitals across a state.¹¹³ Finally, states that

106. N.J. STAT. ANN. § 26:2H-5g (West 2020); N.Y. PUB. HEALTH LAW § 2805-t (McKinney 2009); VT. STAT. ANN. tit. 18, § 1854 (2015).

107. N.J. STAT. ANN. § 26:2H-5g (West 2020).

108. N.Y. PUB. HEALTH LAW § 2805-t (McKinney 2009).

109. VT. STAT. ANN. tit. 18, § 1854 (2015).

110. See generally 42 C.F.R. § 482.23(b) (2019) (describing staffing requirements).

111. See Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, S. 1357, 116th Cong. (2019); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2019, H.R. 2581, 116th Cong. (2019); Safe Staffing for Nurse and Patient Safety Act of 2018, S. 2446, 115th Cong. (2018); Safe Staffing for Nurse and Patient Safety Act of 2018, H.R. 5052, 115th Cong. (2018); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, S. 1063, 115th Cong. (2017); Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act of 2017, H.R. 2392, 115th Cong. (2017); Registered Nurse Safe Staffing Act of 2014, S. 2353, 113th Cong. (2014); Registered Nurse Safe Staffing Act of 2013, H.R. 1821, 113th Cong. (2013); Registered Nurse Safe Staffing Act of 2011, S. 58, 112th Cong. (2011); Registered Nurse Safe Staffing Act of 2011, H.R. 876, 112th Cong. (2011); Registered Nurse Safe Staffing Act of 2009, S. 54, 111th Cong. (2009); Registered Nurse Safe Staffing Act of 2007, S. 73, 110th Cong. (2007); Registered Nurse Safe Staffing Act of 2007, H.R. 4138, 110th Cong. (2007); Registered Nurse Safe Staffing Act of 2005, S. 71, 109th Cong. (2005); Registered Nurse Safe Staffing Act of 2003, S. 991, 108th Cong. (2003).

112. See *Aiken I*, *supra* note 16, at 1990–92. See also McHugh & Ma, *supra* note 16, at 77.

113. Heidi J. Keeler & Mary E. Cramer, *A Policy Analysis of Federal Registered Nurse Safe Staffing Legislation*, 37 J. NURSING ADMIN. 350, 352 (2007).

require only mandatory reporting miss out on input from their frontline RN staff.¹¹⁴

A. *Failure to Have an Adequate Number of RNs Leads to Adverse Patient Outcomes*

Inadequate staffing of RNs is linked to a variety of adverse patient outcomes ranging from diminished quality of patient experience to increased risk of patient mortality.¹¹⁵

In 1999, the Institute of Medicine (IOM) released a landmark report, *To Err is Human*, revealing medical error and safety concerns in the healthcare industry.¹¹⁶ At that time, the IOM estimated that as many as 98,000 Americans died each year due to medical error.¹¹⁷ While the report gave four key recommendations, it also called for additional research to discover the sources and causes of errors committed in healthcare.¹¹⁸ In response to the report and the extensive media coverage it received, both the healthcare industry and federal government allocated funds to a range of patient safety efforts and research.¹¹⁹

Considering RNs provide more direct patient care than any other healthcare professional, nursing became an area of interest for patient safety research.¹²⁰ Many researchers focused their attention on RN hospital staffing. They asked whether the number of RNs staffed by a hospital affected the quality of patient care.¹²¹ Twenty years ago, the answer was yes,¹²² and today the answer remains yes.¹²³

Higher levels of staffing by RNs with reduced workloads, which can be accomplished through safe staffing legislation, is linked to a variety of positive

114. See AM. NURSES ASS'N, ANA'S PRINCIPLES FOR NURSE STAFFING, 4–5 (2019) (ebook) (stating that nurses are essential to the successful delivery of healthcare); see also *AACN Guiding Principles for Appropriate Staffing*, AM. ASS'N OF CRITICAL-CARE NURSES (Sept. 2018), <https://www.aacn.org/policy-and-advocacy/guiding-principles-for-staffing> (stating that registered nurses within a healthcare system must have an active role in staffing decisions).

115. See *Aiken II*, *supra* note 25, at 914 (explaining that increased numbers of RNs increase patient satisfaction scores); see also *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (explaining that increased numbers of RNs with decreased workloads is associated with a decrease in patient mortality).

116. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN* 1 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., National Academy Press, 2000).

117. *Id.*

118. *Id.* at 5–6.

119. H. T. Stelfox et al., *The “To Err is Human” Report and the Patient Safety Literature*, 15 *QUALITY SAFETY HEALTH CARE* 174, 174 (2006).

120. *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114.

121. See *Aiken I*, *supra* note 16, at 1987.

122. Needleman et al., *supra* note 3, at 1720.

123. SAUDI PATIENT SAFETY CTR. & INT'L COUNCIL OF NURSES, *WHITE PAPER ON NURSE STAFFING LEVELS FOR PATIENT SAFETY AND WORKFORCE SAFETY* 4 (2019).

patient outcomes,¹²⁴ including increased patient satisfaction,¹²⁵ increased patient safety,¹²⁶ and reduced mortality rates.¹²⁷

First, higher percentages of RNs in hospitals with lower RN-to-patient ratios increases patient satisfaction.¹²⁸ These hospitals report fewer complaints from patients and family members and fewer instances of verbal abuse by patients and staff.¹²⁹ Positive patient experience is important not only because every patient desires and deserves to be treated with respect and compassion, but also because a patient's experience can affect clinical outcomes for that patient.¹³⁰ Positive patient experiences with hospital staff help foster a trusting relationship between a patient, the patient's family, and the patient's caregivers.¹³¹ This trusting relationship encourages patients to become active participants in their treatment and to comply with recommended treatment plans.¹³² Organizations that focus on patient experience can decrease patients' length of stay, improve patients' pain control and emotional health, and decrease unnecessary errors, such as medication errors and falls.¹³³

Next, increased RN staffing levels increase patient safety.¹³⁴ Increased RN staffing levels correlate with a decreased risk of acquiring an HAI¹³⁵ and lower rates of urinary tract infections in surgical patients.¹³⁶ Additionally, increased RN staffing levels in critical care units are associated with a lower risk of falls in

124. *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (“Evidence indicates that, in the presence of a healthy work environment, a reduction in RN workload is associated with reduced mortality and failure to rescue, reduced hospital readmission rates, and fewer other adverse events such as medication errors, hospital-associated pressure injuries, and patient falls with injury.”). *See also* Kelly L. Wiltse Nicely et al., *Lower Mortality for Abdominal Aortic Aneurysm Repair in High-Volume Hospitals is Contingent upon Nurse Staffing*, 48 HEALTH SERVS. RES. 972, 974 (2013) (stating that RN staffing also plays a role in the outcomes of “patients undergoing general, vascular, and orthopedic operations, surgical oncology patients, and patients hospitalized with Acquired Immunodeficiency Syndrome (AIDS), acute myocardial infarction (MI), congestive heart failure, chronic obstructive pulmonary disease, pneumonia, stroke, and septicemia”).

125. *Aiken II*, *supra* note 25, at 914.

126. *See* Mitchell et al., *supra* note 23, at 619; Needleman et al., *supra* note 3, at 1719; West et al., *supra* note 23, at 25; *Aiken III*, *supra* note 26, at 324.

127. *Id.* at 324.

128. *Aiken II*, *supra* note 25, at 914.

129. *Id.*

130. *The Impact of Improved Patient Experiences*, NRC HEALTH (May 12, 2017), <https://nrchealth.com/impact-improved-patient-experiences/>.

131. *Id.*

132. *Id.*

133. *Id.*

134. *See generally* Mitchell et al., *supra* note 23 (finding that increased nurse staffing relates to a decrease in patient acquisition of health care-associated infections (HAIs)); *see also* Needleman et al., *supra* note 3 (finding an association between nursing care provided by RNs and better care for hospitalized patients).

135. Mitchell et al., *supra* note 23, at 619. Approximately one in every twenty-five patients in an acute care hospital has an HAI, and HAIs are associated with increased morbidity and mortality. *Id.* at 613.

136. Needleman et al., *supra* note 3, at 1719.

those units.¹³⁷ Finally, hospitals with more RNs with reduced workloads receive fewer reports of workload causing RNs to miss changes in a patient's condition.¹³⁸

Improving these patient safety factors can reduce the length of patient stays and keep patients from becoming sicker while in the hospital.¹³⁹ HAIs are infections that patients acquire from the healthcare setting and include catheter-related bloodstream infection (CLABSIs), *Clostridium difficile* (C.diff) infection, catheter-related urinary tract infections (CAUTIs), Methicillin-resistant *S. aureus* (MRSA) infections, and surgical site infections (SSIs).¹⁴⁰ Patients who acquire an HAI not only require extended hospital stays to treat the infection, but are also 60% more likely to require admission to a hospital's intensive or critical care units, five times more likely to be readmitted to the hospital after discharge,¹⁴¹ and twice as likely to die compared to patients that do not acquire an HAI.¹⁴²

Falls can also complicate a patient's recovery by necessitating additional treatment for injuries which can increase a patient's length of stay.¹⁴³ 30–50% of in-hospital falls result in injury,¹⁴⁴ including serious injuries such as fractures and head trauma.¹⁴⁵ Even falls that do not result in physical injury can undermine a patient's recovery by instilling anxiety and fear in the patient.¹⁴⁶ This fear of falling may make a patient reluctant to participate in physical activity resulting in further loss of strength and independence.¹⁴⁷

Ultimately, improving RN staffing means saving lives by reducing risk-adjusted patient mortality rates and decreasing deaths.¹⁴⁸ Increasing RN staffing

137. West et al., *supra* note 23, at 25. In critical care units, the probability of a patient fall with injury increases by 51% for every one-hour decrease in nursing care hours on a shift. *Id.*

138. *Aiken II*, *supra* note 25, at 914.

139. See generally *Healthcare-Acquired Infections*, PATIENT CARELINK, <https://patientcarelink.org/improving-patient-care/healthcare-acquired-infections-hais/> (last visited Dec. 30, 2020) (noting that patients with infections spend an average of 6.5 additional days in the hospital); see also THE JOINT COMM'N, *Preventing Falls and Fall-Related Injuries in Health Care Facilities*, SENTINEL EVENT ALERT, Sept. 28, 2015, at 1 (discussing longer hospital stays and additional treatment after patient falls).

140. *Healthcare-Acquired Infections*, *supra* note 139.

141. *Id.*

142. *Id.*

143. THE JOINT COMM'N, *supra* note 139, at 1.

144. *Id.*

145. *Falls*, AGENCY FOR HEALTHCARE RSCH. AND QUALITY: PATIENT SAFETY NETWORK (Sept. 7, 2019), <https://psnet.ahrq.gov/primer/falls#>.

146. *Id.*

147. *Id.*

148. *Aiken III*, *supra* note 26, at 324. Researchers created 25,000 patient pairs (the patients within the pair underwent the same surgery and had the same co-morbid conditions and other surgical risk factors) "and compared the outcomes . . . for the matched patients in well nurse resourced hospitals versus poorly nurse resourced hospitals. *Id.* Patients in well nurse resourced hospitals were significantly less likely to

can substantially decrease risk-adjusted mortality rates for surgical patients, especially those who develop post-operative complications.¹⁴⁹ More RNs with smaller workloads also mean fewer deaths for surgical patients.¹⁵⁰ A study compared the state of nursing in California several years after the state enacted mandatory RN-to-patient ratios to New Jersey and Pennsylvania, which had no safe staffing legislation.¹⁵¹ The researchers predicted the probabilities of dying in a New Jersey or Pennsylvania hospital if the average RN-to-patient ratio matched the mandated ratios in California¹⁵²; there could have been “13.9% fewer surgical deaths in New Jersey and 10.6% fewer surgical deaths in Pennsylvania.”¹⁵³

The life-saving benefits of having more RNs with smaller workloads extends beyond surgical patients.¹⁵⁴ One study “found that an increase in staffing equivalent to one full-time RN was associated with a [9%] decrease in deaths in ICU patients . . . and a [6%] decrease in death in medical patients.”¹⁵⁵ The main difference between med-surg units and ICUs is the level of care provided on the unit.¹⁵⁶ ICUs are equipped to care for patients with imminent, life-threatening health issues and for patients immediately post-operative from major

die at every patient risk level.” *Id.* In separating hospitals into the well-resourced and poorly resourced groups, the researchers controlled for technological disparities and other hospital characteristics. *Id.* This helped ensure that the results reflected the impact of RN staffing on the patient outcomes, rather than other differences between the hospitals. *Id.*

149. See *Life Saving and Mortality*, EMORY HEALTHCARE, <https://www.emoryhealthcare.org/about/quality-report/life-saving-and-mortality.html> (last visited Dec. 16, 2020) (defining risk adjusted mortality rates as quality data that “compare patients’ actual mortality rates to their expected mortality rates, based on patients’ severity of illness”); *Aiken I*, *supra* note 16, at 1991 (finding that “the odds of patient mortality [for surgical patients] increased by 7% for every additional patient in the average nurse’s workload in the hospital” and moving “from 4 to 6 and from 4 to 8 patients per nurse would be accompanied by 14% and 31% increases in mortality respectively”); *Aiken III*, *supra* note 26, at 323 (studying mortality rates in the United States, Canada, England, Belgium, South Korea and various other European countries and again finding “each one patient added to a nurse’s workload is associated with a 7 percent increase in risk-adjusted mortality following general surgery”).

150. *Aiken II*, *supra* note 25, at 917.

151. *Id.* Researchers compared RN-to-patient ratios and related outcomes in California hospitals with hospitals in New Jersey and Pennsylvania. *Id.*

152. *Id.* at 916–17. RN workloads in California two years after implementation of the mandated RN-to-patient ratios was lower than that of New Jersey or Pennsylvania. *Id.* RNs in California cared for an average of one fewer patient each, and the disparity was greater in med-surg units. *Id.* On med-surg units, nurses “in California on average care[d] for over two fewer patients than nurses in New Jersey and 1.7 fewer patients than nurses in Pennsylvania.” *Id.*

153. *Id.* at 917.

154. See generally *RN Staffing Ratios*, *supra* note 82 (summarizing research showing that safe nurse staffing levels improve patient outcomes in the areas of mortality, adverse events, complications, failure to rescue, quality of care, costs, and length of stay).

155. *Id.* at 3 (citing Kane et al., *The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis*, 45(12) MED. CARE 1195, 1195–1204 (2007)).

156. *Id.*

surgeries.¹⁵⁷ Med-surg units are for lower acuity patients that do not require as intensive monitoring and treatment.¹⁵⁸ A variety of patients can be admitted to med-surg floors, such as patients recovering from minor surgeries, patients with infectious illnesses, and patients suffering from chronic health conditions.¹⁵⁹

Why do patient outcomes improve with increased RN staffing? The answer is simple: RNs perform more direct patient care than any other medical professional on a patient's care team and thus have more opportunities to monitor and interact with patients.¹⁶⁰ This surveillance role is essential to early detection of patient illness and complications where timely intervention can save lives.¹⁶¹

Although "monitoring" and "surveillance" are synonyms, they have distinct meanings when used in the context of RN activities.¹⁶² Monitoring is, "an assessment process in which clinicians observe, measure, and record patient data."¹⁶³ This includes fundamental nursing duties such as taking vital signs, measuring intake and output, and performing focused assessments of the heart, lungs, and other body systems.¹⁶⁴ Surveillance is the process by which an RN analyzes the data obtained through monitoring and interprets the relevant findings.¹⁶⁵ Failure to adequately perform surveillance can result in a delayed diagnosis or treatment and inadequate or inappropriate management of a patient's condition.¹⁶⁶ These delays and mismanagement can result in adverse patient outcomes, such as admission to ICUs, cardiac arrest, increased length of stay, and even death.¹⁶⁷

The more patients an RN has, the less time the RN has to spend with each individual patient, and thus, fewer opportunities to monitor them.¹⁶⁸ The decline in a patient's medical condition outside of the ICU is typically a progressive deterioration in condition, rather than a sudden event.¹⁶⁹ Patients frequently exhibit signs of deterioration in a patient's condition through alterations in baseline respiratory, cardiac, and neurological function and abnormal vital

157. *Id.*

158. *Id.*

159. *Id.*

160. *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114.

161. *Aiken I*, *supra* note 16, at 1993.

162. Karen K. Giuliano, *Improving Patient Safety Through the Use of Nursing Surveillance*, *HORIZONS* 34, 35 (2017).

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.*

168. *See generally Aiken II*, *supra* note 25, at 918 (explaining that patients who visit hospitals that meet the benchmark set by the California nurse staffing mandates are likely to experience better outcomes).

169. Giuliano, *supra* note 162, at 37.

signs.¹⁷⁰ Every opportunity an RN has to monitor his or her patient is an opportunity to detect one of these signs and implement the proper responses,¹⁷¹ and the fewer patients an RN is assigned, the greater the amount of time the RN has to monitor each patient.¹⁷²

B. Failure to Have an Adequate Number of RNs Leads to RN Burnout

Recognizing that “patient safety and nurses’ wellbeing are two sides of the same coin,”¹⁷³ researchers extended their studies to discover the effects of staffing on RNs.¹⁷⁴ Inadequate staffing can result in RN burnout which negatively impacts RNs’ emotional and physical well-being.¹⁷⁵ This burnout often leads to job dissatisfaction and turnover.¹⁷⁶

First, increased RN workloads contribute to RN burnout.¹⁷⁷ RNs “in hospitals with the highest [RN-to-patient] ratios are more than twice as likely to experience job-related burnout compared with RNs in hospitals with the lowest ratios.”¹⁷⁸ For each additional patient an RN is assigned to care for, the amount of work that RN is responsible for increases exponentially.¹⁷⁹ Depending on the unit the RN works on, the RN must check the patient’s vital signs anywhere from every four hours to every fifteen minutes.¹⁸⁰ The RN on a med-surg floor must

170. *Id.*

171. *See generally id.* at 34 (explaining the importance of monitoring and surveillance to improve patient safety and health outcomes).

172. *See Aiken II, supra* note 25, at 918 (finding that the higher proportion of nurses in a hospital, the “less likely nurses are to report that their workload causes them to miss changes in patients’ conditions...”).

173. SAUDI PATIENT SAFETY CTR. & INT’L COUNCIL OF NURSES, *supra* note 123, at 4.

174. *See Aiken I, supra* note 16, at 1988 (estimating the impact of nurse staffing proportions on RN burnout and satisfaction).

175. *AACN Guiding Principles for Appropriate Staffing, supra* note 114.

176. *Id. See also Aiken II, supra* note 25, at 913–18 (comparing the state of nursing in California several years after the state enacted mandatory RN-to-patient ratios with states that had no safe staffing legislation). The study found that lower workloads for RNs “translate[d] into better evaluations of their work environment.” *Id.* at 911. California RNs reported less burnout and less job dissatisfaction than RNs in either New Jersey or Pennsylvania. *Id.* at 916. 29% of RNs in California reported experiencing burnout, whereas, 34% and 36% percent of RNs reported burnout in New Jersey and Pennsylvania respectively. *Id.* at 913. 20% of RNs in California reported job dissatisfaction, whereas, 26% and 29% percent of RNs reported job dissatisfaction in New Jersey and Pennsylvania respectively. *Id.* Ultimately, the study concluded that the higher the proportion of RNs with patient assignments in compliance with the California-mandated ratios (lower RN-to-patient ratios than in the other states), “the lower the nurse burnout and job dissatisfaction, the less likely nurses [were] to report the quality of their work environment as only fair to poor. . . and the less likely nurses [were] to intend to leave their jobs.” *Id.* at 918.

177. *See Aiken I, supra* note 16, at 1992.

178. *Id.*

179. *See generally* Behring & Geiser, *supra* note 9 (explaining the responsibilities of an RN for each patient they are assigned).

180. Jordan C. Yoder et al., *A Prospective Study of Nighttime Vital Sign Monitoring Frequency and Risk of Clinical Deterioration*, 173 J. AM. MED. ASS’N 1554, 1554 (Sept. 2013); Kati Kleber, *What Do ICU Nurses Do?*, FRESHRN (Feb. 13, 2018), <https://www.freshrn.com/what-does-an-icu-nurse-do/>.

perform a head-to-toe assessment on the patient once per shift, but in the ICU, RNs perform this assessment every four hours.¹⁸¹ During a head-to-toe assessment the RN checks each major body system of the patient: neurological, cardiovascular, pulmonary, gastrointestinal, integumentary, and genitourinary.¹⁸² The RN also must administer medications, monitor labs, implement new orders, ambulate the patient, monitor intake and output, document everything, and perform any other tasks the patient requires.¹⁸³ With all of the work that is necessary to adequately care for one patient, it is unsurprising that one study found that “an increase of one patient per nurse to a hospital’s staffing level increased burnout by . . . 23%.”¹⁸⁴

Additionally, the unsustainable workloads caused by inadequate staffing negatively impact RNs’ emotional and physical well-being.¹⁸⁵ Inadequate staffing is strongly associated with emotional exhaustion and RN burnout.¹⁸⁶ RNs experiencing burnout can suffer from a range of symptoms, including “irritability, insomnia, headaches, back pain, weight gain, depression, and high blood pressure.”¹⁸⁷ Also, lower staffing levels are associated with an increased risk of needlestick injuries for RNs.¹⁸⁸

RN burnout and its side-effects contribute to job dissatisfaction.¹⁸⁹ RNs “in hospitals with the highest [RN-to-patient] ratios are almost twice as likely to be dissatisfied with their jobs compared with nurses in hospitals with the lowest ratios.”¹⁹⁰ A 2019 Joint Commission survey asked more than two-thousand healthcare partners whether they experienced burnout in their position: 15.6% of

181. Kleber, *supra* note 180.

182. *Id.*

183. *Id.*

184. *Aiken I, supra* note 16, at 1990.

185. SAUDI PATIENT SAFETY CTR. & INT’L COUNCIL OF NURSES, *supra* note 123, at 12.

186. DEP’T FOR PRO. EMPS., SAFE STAFFING: CRITICAL FOR PATIENTS AND NURSES 2 (2019).

187. *Id.*

188. Sean P. Clarke et al., *Effects of Hospital Staffing and Organizational Climate on Needlestick Injuries to Nurses*, 92 AM. J. OF PUB. HEALTH 1115, 1117 (2002) (“Nurses working in hospital units with poorer work climates and lower staffing levels were substantially more likely to report the presence of risk factors associated with needlestick injuries.”).

189. See Am. Ass’n of Critical-Care Nurses, *Collaborating on the Future of Nurse Staffing*, BOLD VOICES, Dec. 2019, at 10 [hereinafter *Collaborating on the Future*]. See also Am. Ass’n of Critical-Care Nurses, *Cultivating Resilience Against Nurse Burnout*, BOLD VOICES, Dec. 2019, at 11 [hereinafter *Cultivating Resilience*] (explaining that nurses are in need of better work environments and more autonomy in their role to combat nurse burnout).

190. *Aiken I, supra* note 16, at 1992. Finding “[a]n increase of one patient per nurse to a hospital’s staffing level increased job dissatisfaction by . . . 15%.” *Id.* at 1990.

all RNs in the survey answered in the affirmative.¹⁹¹ These RNs cited staffing challenges as one of the leading causes of RN burnout and job dissatisfaction.¹⁹²

Both burnout and job dissatisfaction are significant sources of job resignation.¹⁹³ A survey conducted in 2018 by the American Association of Critical Care Nurses indicated that poor staffing is highly influential for RNs considering leaving the profession.¹⁹⁴ Of the RNs that responded they might leave the profession, 50% said that better staffing would make them reconsider.¹⁹⁵ This association between higher RN-to-patient ratios and increased burnout persists regardless of average wage.¹⁹⁶

RN burnout resulting in RN resignation is deeply problematic for hospitals because it is a major drain on hospitals' finances and may result in reduced quality of care.¹⁹⁷ Estimations of exactly how much RN turnover costs hospitals vary, but some estimate that RN turnover costs the average hospital as much as \$8.1 million annually.¹⁹⁸

Burnout can also negatively impact the quality of patient care.¹⁹⁹ Because RNs suffering from burnout may experience impaired memory, fatigue, and lack of attention, their recall and attention to detail might consequently decrease.²⁰⁰ This increases the risk of adverse patient safety events and medical errors.²⁰¹ Also, RNs experiencing burnout may exhibit agitated or aggressive attitudes toward their patients and colleagues.²⁰² This can harm both patient satisfaction and care team collaboration, which are key components of quality care.²⁰³

191. *Cultivating Resilience*, *supra* note 189, at 11 (citing The Joint Comm'n, *Developing Resilience to Combat Nurse Burnout*, QUICK SAFETY, July 2019).

192. *Id.* (citing The Joint Comm'n, *Developing Resilience to Combat Nurse Burnout*, QUICK SAFETY, July 2019).

193. *See Aiken I*, *supra* note 16, at 1993. Specifically, 43% of RNs who reported high burnout and job dissatisfaction also reported that they intended to leave their current job within the next year, but only 11% of RNs who reported no burnout and job satisfaction also reported that they intended to leave. *Id.* at 1990.

194. *Collaborating on the Future*, *supra* note 189.

195. *Id.*

196. McHugh & Ma, *supra* note 16, at 77 ("The significant association between more favorable nurse work environments and nurse outcomes, net of wage effects, implies that wages are important, but they do not account for the better outcomes associated with the work environment and nurse staffing.").

197. AVALERE HEALTH LLC, *OPTIMAL NURSE STAFFING TO IMPROVE QUALITY OF CARE AND PATIENT OUTCOMES* 9 (2015).

198. Ann Kutney-Lee et al., *Nurse Engagement in Shared Governance and Patient and Nurse Outcomes*, 46 *J. NURSING ADMIN.* 605, 610–11 (2016).

199. *See generally* Heath, *supra* note 17 (explaining how RN burnout is so problematic because it is a major contributing factor to RN resignation and can decrease the quality of care patients receive).

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

Finally, when RNs leave the profession due to burnout, they leave behind hospital units who lose that RNs valuable experience and knowledge.²⁰⁴ The maxim “practice makes perfect” is as applicable to the nursing profession as it is to a professional athlete.²⁰⁵ As an RN spends more time in the hospital setting, he or she gains more exposure and has opportunities to perfect various nursing tasks.²⁰⁶ Also, each time an RN interacts with a patient, he or she gains valuable knowledge about the diagnosis and treatment of that condition or disease.²⁰⁷ Thus, when an experienced RN leaves the profession, not only do patients lose the opportunity to be cared for by someone more likely to be familiar with their ailment, but the other RNs on the unit lose a useful source of information and guidance.²⁰⁸

C. State Mandated RN-to-Patient Ratios Do Not Account for the Diversity in the Healthcare Setting

State mandated RN-to-patient ratios are problematic because they cannot account for the diversity amongst hospitals within a state.²⁰⁹

Some critics of federally mandated RN-to-patient ratios rightly argue they are problematic because they create a one-size-fits-all approach that fails to account for the unique geographic, financial, and labor considerations that exist from state to state.²¹⁰ However, this problem also extends to mandated RN-to-patient ratios at the state level because these considerations for hospitals vary within a state.²¹¹

Hospitals today vary in functionality, size, location, ownership, and specialization.²¹² Hospitals function differently within the respective communities they serve.²¹³ For instance, a level one trauma center is appropriate for treating life-threatening, trauma-induced injuries such as car accidents and

204. See Hill, *supra* note 19 (finding that the loss of experience nurses results in the loss of that knowledge and has implications for patient care).

205. See *generally id.* (explaining that more knowledge gained by nurses from experiential practice in the field is essential for nurses to gain expertise and progress into safer levels of practice).

206. *Id.*

207. *Id.*

208. *Id.*

209. See *AACN Guiding Principles for Appropriate Staffing, supra* note 114 (stating there is “no one-size-fits-all answer”); see *generally* Keeler & Cramer, *supra* note 113, at 352 (discussing the different effect of mandated RN-to-patient ratios on rural versus urban hospitals).

210. Keeler & Cramer, *supra* note 113, at 352.

211. See *generally* *What are the Different Types of Hospitals?*, GALLAGHER HEALTHCARE (Mar. 22, 2018), <https://www.gallaghermalpractice.com/blog/post/what-are-the-different-types-of-hospitals> (explaining that RN-to-patient ratios in state hospitals vary from state to state based upon the funding and resources they receive which is determined by factors such as the communities the hospitals serve, location, size, ownership, functionality, and purpose of the different hospitals).

212. *Id.*

213. *Id.*

gunshot wounds; while a hospital lacking a trauma certification is not equipped to treat these types of injuries.²¹⁴ However, a hospital that lacks a trauma certification is still perfectly capable of treating other issues such as heart attacks, strokes, or infectious diseases.²¹⁵

Hospitals also vary in their size and location.²¹⁶ Hospitals are either small (fewer than 100 beds), medium (100 to 499 beds), or large (500 or more beds).²¹⁷ If a hospital is located in a large metropolitan area, it is considered an urban hospital, while a hospital in a rural community is a rural hospital.²¹⁸ Urban hospitals tend to serve a high volume of patients and offer a multitude of services.²¹⁹ They typically have access to advanced equipment and can offer a variety of treatment options.²²⁰ Rural hospitals, by contrast, serve smaller communities and have limited access to advanced technology, procedures, and techniques.²²¹ They tend to provide more basic care and will transfer patients to urban hospitals if a patient's condition exceeds the rural hospital's capabilities.²²²

Hospitals also differ in their ownership structure.²²³ A hospital may be owned by a large healthcare system, a few investors, or receive funding from the federal government.²²⁴ Within these various ownership structures, hospitals can be categorized as either for-profit or nonprofit.²²⁵ Hospitals can also choose to be a teaching institution by opening its doors to train future doctors and RNs.²²⁶

To show the diversity of hospitals within a state, take Texas for example. For non-federal, acute care hospitals in 2020, the total number of hospital beds per hospital ranged from less than 10 to greater than 1,600.²²⁷ In 2017, Texas had 565 acute care hospitals, 75% of which were located in metropolitan areas.²²⁸ Due to the size of these hospitals, metropolitan hospitals, in 2017, retained 91% of the total hospital beds in Texas.²²⁹ Of the 421 metropolitan area hospitals, 66% were for-profit, 27% were nonprofit, and 7% were public.²³⁰

214. *Id.*

215. *Id.*

216. *Id.*

217. *What are the Different Types of Hospitals?*, *supra* note 211.

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

223. *What are the Different Types of Hospitals?*, *supra* note 211.

224. *Id.*

225. *Id.*

226. *Id.*

227. *Individual Hospital Statistics for Texas*, AM. HOSP. DIRECTORY, https://www.ahd.com/states/hospital_TX.html (last updated July 26, 2021).

228. TEX. DEP'T OF STATE HEALTH SERVS., ACUTE CARE HOSPITALS 2017, at 1 (Jan. 2018).

229. *Id.*

230. *Id.*

These differences can affect how a hospital is staffed.²³¹ For instance, rural hospitals typically see fewer patients than metropolitan hospitals due to their smaller size and lower population density.²³² Because of this low volume, Emergency Departments in rural areas are less likely to have specialized staffing.²³³ Additionally, rural hospitals may face more financial difficulties because they have higher rates of uninsured patients and patients on Medicare and Medicaid.²³⁴ The finances of for-profit and nonprofit hospitals also look different.²³⁵ Nonprofits do not have to pay the taxes that for-profit hospitals do, so for-profit hospitals must be more cost efficient.²³⁶ Thus, for-profit hospitals may have to cut more costs during difficult times, which can include payroll spending.²³⁷ Even if all of the hospitals within a state had identical numbers of beds and similar finances, the hospitals would still differ because a unit at one hospital is not run in the same way, staffed by the same RNs, or equipped with the same technology as a similar unit at another hospital.²³⁸

State-mandated RN-to-patient ratios cannot account for variations amongst hospitals.²³⁹ For instance, hospital A might have an ICU where most RNs are new to the profession or the unit, while hospital B has an ICU where most RNs are experienced. Because experienced RNs tend to be able to move quicker while maintaining patient safety, the ICU at hospital B could safely staff fewer RNs than the ICU at hospital A.²⁴⁰ Additionally, hospital A might offer a more advanced treatment, such as extracorporeal membrane oxygenation (ECMO) that requires intense observation, while hospital B does not offer ECMO.²⁴¹ Once again, this means that the ICU in hospital B could safely staff fewer RNs than

231. See generally *What are the Different Types of Hospitals?*, *supra* note 211 (discussing staffing variations across different types of hospitals).

232. *Id.*

233. *Rural Hospitals*, RURAL HEALTH INFO. HUB, <https://www.ruralhealthinfo.org/topics/hospitals#emergency-department> (last updated Mar. 31, 2020).

234. Samantha Scotti, *Tackling Rural Hospital Closures*, NAT'L CONF. STATE LEGISLATURES (June 2017), <https://www.ncsl.org/research/health/tackling-rural-hospital-closures.aspx>.

235. Christopher Cheney, *Top 5 Differences Between NFPS and For-Profit Hospitals*, HEALTHLEADERS (June 20, 2017), <https://www.healthleadersmedia.com/finance/top-5-differences-between-nfps-and-profit-hospitals> (discussing five differences between the finances of for-profit and nonprofit hospitals).

236. *Id.*

237. *Id.*

238. See generally *id.* (discussing differences in management between nonprofit and for-profit hospitals).

239. See *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (stating there is “no one-size-fits-all answer”); see generally Keeler & Cramer, *supra* note 113, at 352 (discussing the different effect of mandated RN-to-patient ratios on rural versus urban hospitals).

240. See generally Hill, *supra* note 19 (citing evidence that patients treated by experienced RNs tend to have better health outcomes than those treated by novice RNs).

241. See generally Am. Thoracic Society, *What is ECMO?*, 193 AM. J. OF RESPIRATORY CRITICAL CARE MED., 2016, at 9–10 (explaining that ECMO is an intensive procedure that requires frequent interventions and close observation).

the ICU at hospital A because the patients at hospital B require less intensive monitoring.

Variation across hospitals and their units supports the conclusion that state-mandated RN-to-patient ratios are ineffective unless they account for unit-specific factors such as unit turnover, technology support, and interprofessional collaboration.²⁴² Data also suggest that state-mandated RN-to-patient ratios do not lead to better health outcomes. For instance, a study examining the effects of Massachusetts's mandated ICU ratios found that the ratios were not associated with lower patient mortality or fewer complications.²⁴³

State-mandated RN-to-patient ratios may also have a negative impact on RNs' perception of hospital leadership. In California, a state that pairs state-mandated RN-to-patient ratios with a staffing plan, a study found that the ratios negatively affected some RNs' perceptions of managerial support.²⁴⁴ These RNs felt that their unit managers' focus on complying with the mandated ratios shifted their managers' focus to ensuring the correct number of RNs were on the unit, rather than focusing on matching the experience and competence of the RN staff to the appropriate patient, based on acuity levels.²⁴⁵

In sum, state-mandated RN-to-patient ratios are not the solution to inadequate hospital staffing because hospitals and their units vary significantly and because ratios are not likely to lead to better health outcomes and may unintentionally harm workplace morale.²⁴⁶

V. PROPOSED HOSPITAL RN SAFE STAFFING ACT

A. *The Hospital RN Safe Staffing Act*

The following is a model statute that state legislatures should implement to aid in achieving adequate staffing of RNs in hospitals. The Hospital Registered Nurse Safe Staffing Act ("the Act") requires hospitals to form a committee tasked with developing a staffing plan that will guide the hospital in making its staffing decisions. By combining the input of RNs with hospital leadership, hospitals will be able to better determine the staffing needs within each unit of the hospital. The section regarding reporting and regulatory requirements will

242. Margo Halm, *The Influence of Appropriate Staffing and Healthy Work Environments on Patient and Nurse Outcomes*, 28 AM. J. OF CRITICAL CARE NURSING 152, 154–55 (2019).

243. *Id.* at 154.

244. CAL. CODE REGS. tit. 22, § 70217 (2003); Karen S. Cox et al., *Nurses' Work Environment Perceptions When Employed in States With and Without Mandatory Staffing Ratios and/or Mandatory Staffing Plans*, 6 POL'Y, POL.S., & NURSING PRAC. 191, 194–95 (2005).

245. See generally Cox et al., *supra* note 244, at 194 (noting that nurses in states with mandatory staffing ratios reported less positive perceptions of manager support).

246. See *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114; See generally Keeler & Cramer, *supra* note 113, at 352 (arguing that one-size-fits-all federal mandate on RN staffing ratios would be ineffective because of variations among hospitals).

require some modification to fit within the particular governmental structure of a state.

Section 1: The Hospital Registered Nurse Staffing Committee

(a) For each hospital, there shall be established a hospital Registered Nurse staffing committee.²⁴⁷

(1) Each committee shall consist of at least, but is not limited to, the following:

(A) A nurse manager or assistant nurse manager from each hospital nurse specialty or unit;²⁴⁸

(B) A direct care Registered Nurse from each hospital nurse specialty or unit and for which the following provisions apply;²⁴⁹

(i) These direct care Registered Nurses shall be elected by the licensed and unlicensed staff who provide direct patient care on the unit that the member will represent;²⁵⁰

(ii) For purposes of this section, a float pool shall qualify as a hospital nurse specialty or unit;

(C) One certified nursing assistant, appointed by hospital administration;

(D) A member from the hospital's board, or a board member's designee, who is not also a nurse manager or direct care Registered Nurse.²⁵¹

(2) A hospital Registered Nurse staffing committee shall meet at least quarterly.²⁵²

(3) A hospital Registered Nurse staffing committee meeting must allow the participation of:²⁵³

(A) The hospital nurse staff, including licensed and unlicensed care providers, as observers; and

(B) Upon invitation, other observers or presenters.

(b) Participation on the hospital Registered Nurse staffing committee by a hospital employee as a committee member is part of the employee's work time, and the hospital shall compensate that member for that time accordingly. The hospital shall relieve a committee

247. OR. REV. STAT. § 441.154 (2015).

248. *Id.*

249. *Id.*

250. NEV. REV. STAT. § 449.242 (2020).

251. *See generally* Ann M. Annis et al., *Factors Associated with the Implementation of a Nurse Staffing Directive*, 47 J. NURSING ADMIN. 636, 643 (2017) (finding that senior leadership participation in staffing plans was significantly associated with staffing plans' overall success).

252. TEX. HEALTH & SAFETY CODE ANN. § 257.004 (West 2009).

253. OR. REV. STAT. § 441.154 (2015).

member of other work duties during times in which committee meetings are being held.²⁵⁴

(c) A hospital Registered Nurse staffing committee shall develop a written hospital-wide staffing plan in accordance with Section 2. The committee's primary goal in developing the staffing plan shall be to ensure that the hospital is staffed to meet the health care needs of patients. The committee shall review and modify the staffing plan in accordance with Section 3.²⁵⁵

Section 2: The Staffing Plan

(a) Each hospital shall implement the written hospital-wide staffing plan for nursing services that has been developed and approved by the hospital Registered Nurse staffing committee under Section 1.²⁵⁶

(b) Each hospital shall submit its staffing plan to [the department] on an annual basis and at any time in which the plan has been modified.²⁵⁷

(c) The staffing plan must set the minimum number of Registered Nurses required on specified shifts for each hospital unit, provided that at least one Registered Nurse and one other licensed or unlicensed care provider is on duty in a unit when a patient is present.²⁵⁸

(d) Factors to be considered in the development of the staffing plan should include, but are not limited to:²⁵⁹

- (1) The level of experience and specialty certifications or trainings of nursing personnel providing care;
- (2) The census, including total numbers of patients on the unit during each shift and activity such as patient discharges, admissions, and transfers;
- (3) The types of patients who are treated in each unit, including the nature and intensity of the care that those patients require;
- (4) The skill mix of the available nursing personnel;
- (5) The availability of specialized equipment and technology for each unit;
- (6) The architecture and geography of each unit, including but not limited to: placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;
- (7) The staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;
- (8) The availability of other personnel supporting nursing services on the unit;

254. HEALTH & SAFETY § 257.004.

255. § 441.154.

256. OR. REV. STAT. § 441.155 (2015).

257. See WASH. REV. CODE § 70.41.420 (2017). Which governmental body a state chooses to oversee implementation of and continued observance of the Act will vary from state to state.

258. § 441.155.

259. § 70.41.410.

2022] PATIENT PROTECTION AND REGISTERED NURSE RETENTION 117

- (9) Strategies to enable Registered Nurses to take meal and rest breaks as required by law; and
 - (10) The hospital's finances and resources.
- (e) The hospital shall use the staffing plan.²⁶⁰
- (1) as a tool when developing the Registered Nurse staffing budget; and
 - (2) to guide the hospital in assigning Registered Nurses hospital wide.

Section 3: Review of the Staffing Plan by the Hospital Registered Nurse Staffing Committee

- (a) A hospital Registered Nurse staffing committee established pursuant to Section 1 shall review the staffing plan developed by the committee under Section 2 at least semi-annually.²⁶¹
- (b) In reviewing a staffing plan, a hospital Registered Nurse staffing committee shall consider:
- (1) Patient outcomes;²⁶²
 - (2) The percentage of shifts for each hospital unit during which staffing differed from what is required by the staffing plan;²⁶³
 - (3) Complaints and concerns presented to the committee from the hospital staff;²⁶⁴ and
 - (4) Any other matter determined by the committee to be necessary to ensure that the hospital is staffed to meet the health care needs of patients.²⁶⁵
- (c) Upon reviewing a staffing plan, a hospital Registered Nurse staffing committee shall:²⁶⁶
- (1) Report to the hospital board whether the staffing plan ensures that the hospital is staffed to meet the health care needs of patients; and
 - (2) Modify the staffing plan as necessary to ensure that the hospital is staffed to meet the health care needs of patients.

Section 4: Department Investigations²⁶⁷

- (a) The department shall investigate a complaint submitted under this section for violation of one or more of Sections 1, 2, and 3 of this act

260. TEX. HEALTH & SAFETY CODE ANN. § 257.003 (West 2009).

261. OR. REV. STAT. § 441.156 (2015); § 70.41.420.

262. § 441.156.

263. *Id.*

264. WASH. REV. CODE § 70.41.420 3(c), (7)(a)–(c) (2017).

265. OR. REV. STAT. § 441.156 (2)(g) (2015).

266. § 441.156(2).

267. *See* WASH. REV. CODE § 70.41.425 (2021) (outlining department investigation procedures for complaints submitted for a hospital's failure to comply with the nurse staffing committee requirements).

following receipt of a complaint with documented evidence of failure to:

- (1) Form or establish a hospital Registered Nurse staffing committee;²⁶⁸
 - (2) Conduct a semi-annual review of a Registered Nurse staffing plan;²⁶⁹
 - (3) Submit a Registered Nurse staffing plan on an annual basis and provide updates; or²⁷⁰
 - (4) Staff the minimum number of Registered Nurses as required by Sections 2(c) and (d).²⁷¹
- (b) The department may not investigate a complaint under this subsection (a)(4) in the event of unforeseeable emergency circumstances, or if the hospital, after consultation with the Registered Nurse staffing committee, documents that it has made reasonable efforts to obtain staffing to meet required assignments but has been unable to do so.²⁷²
- (1) For purposes of this section, “unforeseeable emergency circumstance” means:²⁷³
 - (A) Any unforeseen national, state, or municipal emergency;²⁷⁴
 - (B) When a hospital disaster plan is activated;²⁷⁵
 - (C) Any unforeseen disaster or other catastrophic event that substantially affects or increases the need for health care services; or²⁷⁶
 - (D) When a hospital is diverting patients to another hospital or hospitals for treatment, or the hospital is receiving patients who are from another hospital or hospitals.²⁷⁷
- (c) After an investigation conducted under (a) of this subsection, if the department determines that there has been a violation, the department shall require the hospital to submit a corrective plan of action within forty-five days of the presentation of findings from the department to the hospital.²⁷⁸

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

272. *Id.*

273. § 70.41.425.

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.*

(1) In the event that a hospital fails to submit or submits but fails to follow such a corrective plan of action in response to a violation or violations found by the department based on a complaint filed pursuant to subsection (1) of this section, the department may impose, for all violations asserted against a hospital at any time, a civil penalty of one hundred dollars per day until the hospital submits or begins to follow a corrective plan of action or takes other action agreed to by the department.²⁷⁹

B. Implementing the Hospital RN Safe Staffing Act

The legislation implementing RN staffing committees (“staffing committees”) tasked with developing RN staffing plans (“staffing plans”) is not uniform from state to state.²⁸⁰ A few points of divergence amongst the states are: (1) the composition of the staffing committee; (2) the types of providers the staffing plan must designate a minimum for; and (3) the reporting requirements and government enforcement of the legislation.²⁸¹ Thus, the proposed Act combines portions of the safe staffing legislation of various states to form the best approach. Because the governmental structure of every state is different, there are aspects of the proposed Act that will vary from one state to another.

279. § 70.41.425.

280. See, e.g., CONN. GEN. STAT. § 19a-89e (“Registered nurses employed by the hospital whose primary responsibility is to provide direct patient care shall account for not less than fifty per cent of the membership of each hospital’s staffing committee.”); ILL. COMP. STAT. § 85/10.10 (2021) (“Nursing care committee” means an existing or newly created hospital-wide committee or committees of nurses whose functions, in part or in whole, contribute to the development, recommendation, and review of the hospital’s nurse staffing plan established pursuant to subsection.”); NEV. REV. STAT. §§ 449.242, 449.2421 (2020) (“The documented staffing plan must include, without limitation: (a) A detailed written plan setting forth: (1) The number, skill mix and classification of licensed nurses required in each unit in the health care facility, which must take into account the experience of the clinical and nonclinical support staff with whom the licensed nurses collaborate, supervise or otherwise delegate assignments.”); OHIO REV. CODE ANN. §§ 3727.51-3727.55 (West 2008) (“Each hospital shall convene a hospital-wide nursing care committee not later than ninety days after the effective date of this section or, if the hospital is not treating patients on the effective date of this section, ninety days after the hospital begins to treat patients.”); OR. REV. STAT. §§ 441.152, 441.154-441.156, 441.164-441.165 (2021) (“The Nurse Staffing Advisory Board is established within the Oregon Health Authority, consisting of 12 members appointed by the Governor.”); TEX. HEALTH & SAFETY CODE ANN. §§ 257.003-257.005 (West 2009) (“The governing body of a hospital shall adopt, implement, and enforce a written nurse staffing policy to ensure that an adequate number and skill mix of nurses are available to meet the level of patient care needed.”); WASH. REV. CODE § 70.41.410-70.41.420 (2021) (“By September 1, 2008, each hospital shall establish a nurse staffing committee, either by creating a new committee or assigning the functions of a nurse staffing committee to an existing committee. At least one-half of the members of the nurse staffing committee shall be registered nurses currently providing direct patient care and up to one-half of the members shall be determined by the hospital administration.”).

281. *Id.*

1. *The Staffing Committee Excludes LPNs/LVNs and Includes a Member of the Float Pool and a Board Member*

The Act does not require hospitals to include LPNs/ LVNs on the staffing committee. LPNs/LVNs are being shifted out of the hospital setting;²⁸² only 15% of LPNs/ LVNs working in the United States are employed by hospitals.²⁸³ If a hospital does employ LPNs/LVNs, the Act requires that units include LPNs/LVNs in voting for the unit's RN representative, so LPNs'/LVNs' interests will still be considered by the staffing committee. Additionally, the Act sets a floor and not a ceiling for composition of members of the staffing committee. Therefore, if a hospital employs LPNs/LVNs, that hospital could provide for LPN/LVN membership on the committee.

The Act requires two members not included in every state's staffing committee: a float pool representative and a member of the board. RNs working as a member of the float pool do not belong to any one particular unit.²⁸⁴ Rather, a hospital's house supervisor assigns RNs from the float pool to units most in need of additional staffing on a daily basis.²⁸⁵ These RNs also deserve representation on the staffing committee, not only because they are RNs, but because they can offer the staffing committee a unique perspective. Float pool RNs tend to prefer certain hospital units over others because some units function more smoothly than others.²⁸⁶ Thus, these RNs can more readily identify the differences that make one unit function more efficiently than another.²⁸⁷

The Act also requires a member of the hospital's board to be on the staffing committee. For the staffing committee to be as successful as possible, the RNs on the committee need to feel that the hospital's leadership support and fully intend to implement the committee's staffing plan.²⁸⁸ Studies show that "executive-level championship and commitment" are "critical to ensuring program success" when implementing a new program.²⁸⁹ Additionally, it is

282. *LPN Jobs Increasing but not in Hospitals*, EVERY NURSE (Oct. 20, 2018), <https://everynurse.org/lpn-jobs-increasing-but-not-in-hospitals/>.

283. *Licensed Practical and Licensed Vocational Nurses*, U.S. BUREAU OF LAB. STATS., <https://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses.htm#tab-3> (last modified Sept. 8, 2021).

284. *See Pros and Cons to Being a Float Nurse*, HOST HEALTHCARE: BLOG (Oct. 8, 2020), <https://www.hosthealthcare.com/blog/pros-and-cons-to-being-a-float-nurse/> (describing how float nurses switch between departments depending on department need).

285. *Id.*

286. *See generally id.* (describing how float nurses often encounter unpredictable new protocols and practices).

287. *See generally id.* (explaining that since float nurses are always "starting over" with each new assignment and location, they encounter unpredictable protocols and different approaches to patient care).

288. *See generally* Annis et al., *supra* note 251, at 638, 643 (describing results from a web-based survey to chief nurse executives that showed "lack of support from leadership," including engagement and buy-in, was a barrier to implementing [staffing methodology] in their facilities").

289. *Id.* at 643.

crucial that at least one committee member be a person who understands the hospital's financial status.²⁹⁰ In a study examining the success of the Illinois Nurse Staffing by Acuity Law, CNOs reported on the success of their hospital's staffing committee.²⁹¹ A common theme amongst the Illinois CNOs was that the majority of their staff lacked knowledge regarding the budget and hospital finances."²⁹² A hospital board member will be able to supply the staffing committee with this crucial financial knowledge.

2. *The Act Does Not Require That the Staffing Plan Provide a Minimum Number of LPNs/LVNs or CNAs*

The Act requires that the staffing plan provide for the minimum number of RNs necessary on a unit for a given shift but does not require that the staffing plan provide minimums for other staff members.²⁹³ Not all hospitals employ LPNs/LVNs.²⁹⁴ While the majority of hospitals employ CNAs, not every hospital hires CNAs to a particular unit.²⁹⁵ Some hospitals assign CNAs to units on a daily basis depending on staffing needs for that day, similar to the way an RN float pool functions.²⁹⁶ Thus, requiring the staffing plan to specify the minimum number of LPNs/LVNs or CNAs per unit per shift may conflict with the employment structure of some of the hospitals within a state.

Additionally, LPNs/LVNs and CNAs cannot perform all the tasks that an RN can because LPNs/LVNs and CNAs have a more limited scope of practice than RNs.²⁹⁷ To ensure that patients receive all of the care that they require, the

290. See generally Therese Fitzpatrick et al., *Nurse Staffing: The Illinois Experience*, 31 NURSING ECON. 221, 226–27 (2013) (describing results from a survey administered to chief nursing officers (CNOs) showing that most staff lacked knowledge regarding the budget and budget process, and consequently, staff stepping into committee roles spent time learning about unit-based and hospital-wide financial plans).

291. See *id.* at 224–25 (documenting that at least 24.3% of surveyed CNOs reported their committees were effective or highly effective).

292. *Id.* at 226.

293. See generally 210 ILL. COMP. STAT., § 85/10.10 (c)(1) (2021) (“Every hospital shall implement a written hospital-wide staffing plan...that provides for minimum direct care professional registered nurse-to-patient staffing needs for inpatient care unit.”).

294. *LPN Jobs Increasing but not in Hospitals*, *supra* note 282 (“[T]he number of LPNs working in hospitals fell 47 percent between 1984 and 2005.”).

295. See generally *What is a CNA? Job Description and Career Guide.*, W. GOVERNORS UNIV. (Aug. 17, 2020), <https://www.wgu.edu/blog/what-cna-job-description-career-guide2008.html> (“Nursing homes and adult care facilities are often the most common places where nursing assistants are needed. Rarely nursing assistants. . . . nursing care facilities employ[y] the largest number of certified nursing assistants at 38%.”).

296. See *id.* (describing how certified nursing assistants perform many duties and perform a variety of physical and complex tasks for patient care in a variety of settings); *Pros and Cons to Being a Float Nurse*, *supra* note 284 (describing how float nurses switch between departments).

297. See *Registered Nurse vs. Licensed Practical Nurse*, *supra* note 36 (describing how LPNs provide basic nursing care related to patient comfort, and alternatively, RNs primarily administer medication, treatments, and offer educational advice to patients); *What is a CNA? Job Description and Career Guide*,

Act only tasks the staffing committee with setting the minimum number of RNs because only RNs can perform every nursing-related intervention that a patient may need.²⁹⁸

3. *Reporting Requirements and Government Enforcement Will Vary from State to State*

Section 2 of the Act requires hospitals to submit their staffing plan to “the department”;²⁹⁹ Section 4 provides for investigation and penalization of hospitals that violate the Act. Because every state has their own, unique administrative bodies that handle healthcare, “the department” in charge of accepting staffing plans and investigating complaints will vary by state.

A state adopting the Act might also adjust when the department will investigate a hospital and the resulting penalties for failing to comply with the Act. States could set specific criteria for the types of complaints that will result in an investigation. For instance, Washington will only investigate complaints of “a continuing pattern of unresolved violations for a minimum sixty-day continuous period.”³⁰⁰ Also, a state may want to consider hospital compliance outside of investigating complaints, such as by requiring hospitals to conduct audits every few years.³⁰¹

Another area of divergence is the penalty states impose for violations. The \$100 per day penalty that is suggested by the Act is a relatively inconsequential penalty, so states should not go below this fine, but could certainly impose a harsher penalty. For instance, Oregon imposes civil penalties of up to \$5,000 per violation.³⁰² Another tactic is rating hospitals on their compliance and publishing this information for the public to see.³⁰³

Ultimately, it is important that some state agency is tasked with ensuring that hospitals comply with the Act, but states can use discretion in how best to implement this oversight.

supra note 295 (“A certified nursing assistant helps patients with direct health care needs, often under the supervision of a nurse.”).

298. See *Registered Nurse vs. Licensed Practical Nurse*, *supra* note 36 (describing that RN job duties include: administering medication and treatment to patients, coordinating plans for patient care, performing diagnostic tests and analyzing the results, instructing patients on how to manage illness after treatment, and overseeing LPNs and nursing aids (who provide basic care such as checking vitals and ensuring patient comfort)).

299. See *supra* text accompanying notes 256–266.

300. WASH. REV. CODE § 70.41.425 (2017).

301. OR. REV. STAT. § 441.157 (2015). The Oregon Health Authority audits its hospitals for compliance with their staffing plans every three years. *Id.*

302. OR. REV. STAT. § 441.175 (2019).

303. NEV. REV. STAT. § 449.2425 (2020).

VI. THE ACT IS A FINANCIALLY FEASIBLE SOLUTION FOR IMPROVING PATIENT OUTCOMES AND RN BURNOUT

A state statute that requires hospitals to form staffing committees tasked with developing a staffing plan is the best option for safe staffing legislation. Since the staffing plan would require each hospital unit to set the minimum number of RNs necessary on the unit while accounting for the unique practice environment of the individual units, the Act promotes positive patient outcomes and contributes to decreasing RN burnout without imposing a great financial burden on hospitals.³⁰⁴ Additionally, unlike state-mandated RN-to-patient ratios, the committee format creates a forum for interorganizational communication which allows RNs to contribute to the development, implementation, and evaluation of the staffing plan that will dictate how their units operate.

Finally, the Act recognizes that extenuating circumstances may make it impossible for a hospital to comply with the staffing plan. Section 4 excuses a hospital from investigation for failure to comply with the staffing plan in the event of an “unforeseeable emergency circumstance.”³⁰⁵ The current Covid-19 pandemic is an example of an unforeseeable emergency circumstance that could prevent a hospital from complying with its staffing plan but would not result in an investigation or fine.

A. *The Act Promotes Positive Patient Outcomes and Reduces RN Burnout*

The Act can benefit patients and RNs by ensuring that there are an adequate number of RNs staffed on a unit and by opening communication channels amongst RNs and between RNs and hospital leadership.

1. *The Act Ensures There Will Be an Adequate Number of RNs on a Unit*

Inadequate staffing of RNs is linked to a variety of adverse patient outcomes, including decreased patient experience, decreased patient safety, and increased risk of patient mortality.³⁰⁶ When staffing is inadequate, the amount of time RNs have available to monitor and surveil patients decreases, which increases the likelihood of adverse patient outcomes.³⁰⁷ The Act addresses this

304. *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114; Damian Everhart et al., *The Effects of Nurse Staffing on Hospital Financial Performance: Competitive Versus Less Competitive Markets*, 38 HEALTH CARE MGMT. REV. 146, 147 (2013).

305. *See supra* text accompanying note 272.

306. *See Aiken II*, *supra* note 25, at 914 (explaining that increased numbers of RNs increase patient satisfaction scores). *See also AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (explaining that increased numbers of RNs with decreased workloads are associated with a decrease in patient mortality).

307. *See generally* Giuliano, *supra* note 162, at 34–35, 39 (finding that patient monitoring and surveillance “improve the quality of care, prevent or reduce adverse events, and ensure equitable access to quality of care”).

by requiring staffing committees to set a minimum number of RNs necessary on a unit during each shift.

The Act provides factors that the staffing committee should consider in setting the minimum number of RNs and acknowledges that no one knows what it takes to care for patients on a unit better than the RNs that work on that unit.³⁰⁸ RNs know approximately how much time it takes to deliver quality care to their patients, which will help determine the number of RNs that need to be on the unit to enable RNs to spend that time with their patients.³⁰⁹ Thus, it is imperative that RNs have a voice in determining this minimum number.³¹⁰ Because the staffing committee's members include RNs from every unit of the hospital, the Act ensures that the RNs will be the primary decision-makers in setting these minimum numbers. Therefore, the Act promotes positive patient outcomes by implementing a system that helps identify what an adequate number of RNs is and incentivizes hospitals to staff RNs at that level.

Inadequate staffing also plays a role in RN burnout.³¹¹ Inadequate staffing leads to unsustainable workloads that negatively impact RNs' emotional and physical wellbeing.³¹² RNs working in hospitals with the worst RN-to-patient ratios are more likely to be dissatisfied with their jobs.³¹³ The Act addresses this by requiring staffing committees to set the minimum number of RNs necessary on a unit each shift.³¹⁴ RNs know how many nurses they need on the unit to adequately care for their patients versus the staffing level at which they feel overwhelmed and unsupported.³¹⁵ By giving RNs the power to set the minimum number, RNs will have more reasonable workloads.³¹⁶ This, in turn, will help RNs feel that they can complete their work competently and compassionately, which is the goal of any RN. Therefore, the Act decreases RN burnout by

308. See generally *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (explaining appropriate nurse staffing ensures an effective match between patient and family needs and a nurse's knowledge, skills, and abilities).

309. See generally *id.* (stating that “[n]urses assess, develop, deliver, and optimize plans of care,” making them the “linchpin” of the hospital healthcare team).

310. See *id.* (arguing that collaboration between nurses and other health care executives and leaders “can produce optimal patient outcomes, lower nurse turnover, higher patient and family satisfaction, and improved financial viability for hospitals”).

311. *Id.*

312. SAUDI PATIENT SAFETY CTR. & INT’L COUNCIL OF NURSES, *supra* note 123, at 12.

313. *Aiken I*, *supra* note 16, at 1990, 1992 (finding “[a]n increase of one patient per nurse to a hospital’s staffing level increased job dissatisfaction by . . . 15%”).

314. See *supra* text accompanying note 258.

315. See generally *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (describing how nurses experience stress when staffing resources do not meet patient care demands); see also Kutney-Lee et al., *supra* note 198, at 610 (describing how nurse involvement in institutional decision-making “are more likely to provide better patient experiences, superior quality of care, and have more favorable nurse job outcomes”).

316. *Id.*

ensuring that there are an adequate number of RNs to perform the work on the unit.

2. *The Committee Format Increases Communication Amongst RNs and Between RNs and Hospital Management*

The Act promotes positive patient outcomes and decreases RN burnout through increased communication amongst RNs and hospital management.³¹⁷ Hospitals that have strong employee engagement are more likely to provide a higher quality of patient care and have higher levels of RN satisfaction.³¹⁸ The Act's staffing committee brings together RNs from different units and unit managers to collaboratively discuss staffing and other challenges to patient care; this structure offers RNs the opportunity to participate in institutional decision-making.³¹⁹

Although the patient population varies from unit to unit in a hospital, many patient safety issues are common throughout the hospital.³²⁰ Because RNs from one unit rarely interact with RNs from another unit, there can be a lack of inter-unit communication within a hospital.³²¹ The staffing committee provides a forum for RNs and managers to come together to discuss patient safety issues and share interventions that have been beneficial for their unit.³²²

The mandatory members of the staffing committee required by the Act also bring together hospital employees from many levels of the hierarchical structure. Without the staffing committee, many of these employees would never be in a room together to share their ideas and collaborate on solutions.³²³ Getting RNs from a variety of units in a room to collaborate with hospital leaders can decrease

317. See generally Kutney-Lee et al., *supra* note 198, 610–11 (finding that when nurses are involved in institutional decision-making, nurses are less likely to report poor quality of care and patient safety and less likely to report job dissatisfaction and burnout).

318. *Id.* at 608.

319. See generally *id.* (discussing the importance of nurses engaged in institutional decision making).

320. See generally *Patient Safety*, WORLD HEALTH ORG. (Sept. 13, 2019), <https://www.who.int/news-room/fact-sheets/detail/patient-safety> (explaining what patient safety is and why it is important in hospitals across the world).

321. See generally *Working as a Registered Nurse (RN)*, REGISTEREDNURSING.ORG, <https://www.registerednursing.org/guide/working-rn/> (Oct. 30, 2020) (describing various workplace units RNs can choose to work). While RNs are hired by a hospital, they spend the vast majority of their time working on one unit or in one specialty. Therefore, an RN working on a telemetry floor will rarely cross paths with an RN working on a Labor and Delivery floor. *Id.*

322. See generally Fitzpatrick et al., *supra* note 290, at 225, 228 (discussing the benefits of staffing committees for facilitating communications).

323. See SAUDI PATIENT SAFETY CTR. & INT'L COUNCIL OF NURSES, *supra* note 123, at 9 (citing AM. HOSP. ASS'N CTR. for HEALTH CARE GOVERNANCE, 2014 NATIONAL HEALTHCARE GOVERNANCE SURVEY REPORT (2014)) (discussing the underrepresentation of RNs in the hospital board). Nurse administrators are underrepresented on hospital boards and only 5% of RNs are represented on the hospital board. *Id.* Thus, including a board member on the staffing committee provides an avenue for communication that likely would not otherwise exist. *Id.* at 10.

RNs' reports of poor quality of care and patient safety, increase RNs' confidence in patients' ability to care for themselves after discharge, and improve RNs' perception of managements' response to patient problems.³²⁴

Additionally, if a hospital is unable to hire enough RNs to comply with the staffing plan, despite reasonable efforts to do so, this increased intra-organizational communication facilitates creative problem-solving.³²⁵ A staffing committee can explore solutions beyond hiring more RNs, such as purchasing new equipment or sharing equipment between units, reassigning assistive personnel (LPNs/LVNs and CNAs) to the most in-need units, increasing training for assistive personnel, and cross-training staff for floating to other units.³²⁶

While there is substantial evidence supporting a relationship between RN staffing levels and the quality of patient care,³²⁷ studies have also found that the positive relationship between improving RN staffing and improving patient outcomes is influenced by the quality of the RN's work environment.³²⁸ Thus, addressing an issue with staffing numbers will be less effective in improving patient outcomes in the absence of a positive practice environment.³²⁹

A positive practice environment is also associated with less RN burnout.³³⁰ Factors that affect the quality of a practice environment extend beyond workload and include issues such as communication, shared decision-making, interprofessional collaboration, and meaningful recognition.³³¹ RNs view their practice environment more favorably when they have greater opportunity for dialogue with other members of the nursing staff and hospital leadership.³³² This communication gives RNs a voice in deciding what nursing care on their unit should be like, as well as addressing potential problems on the unit.³³³

The required formation of the staffing committee by the Act brings RNs in regular contact with nurse managers and hospital leadership. This increases intra-organizational communication and shared governance that promotes a positive practice environment and job satisfaction, and ultimately leads to less RN burnout and turnover and better patient outcomes.³³⁴

324. Kutney-Lee et al., *supra* note 198, at 610.

325. Cox et al., *supra* note 244, at 194.

326. Fitzpatrick et al., *supra* note 290, at 225.

327. SAUDI PATIENT SAFETY CTR. & INT'L COUNCIL OF NURSES, *supra* note 123, at 4.

328. E.g., Halm, *supra* note 242, at 154.

329. *Id.*

330. *Id.*

331. *Id.*

332. See Cox et al., *supra* note 244, at 194 (finding that dialogue between staff nurses and nursing leadership increases positive nurse perceptions of work environment).

333. *Id.*

334. *Id.* at 195; Halm, *supra* note 242, at 152, 154.

3. *The Act Provides a Flexible Approach to Staffing*

The Act requires a staffing committee to develop a staffing plan at the hospital unit level. By focusing down to the unit level, the staffing plan is tailored to meet the needs of each particular unit within the framework of that particular hospital.³³⁵

Although a hospital unit may be classified as a med-surg unit or an ICU, units within those classifications are very different.³³⁶ Units vary in patient acuity, unit activity (such as number of admissions, discharges, and transfers), the amount of experience and certifications of RNs and support staff, geography of the unit, and technology and equipment available.³³⁷ An RN who works on a unit is intimately familiar with the inner-workings of that unit: the types of patients admitted; the amount of time it takes to admit, discharge, and transfer patients; the names of the most experienced and least experienced RNs; the places where supplies are kept; the rooms unruly patients are assigned to; and the location of vein finders, bladder scanners, and other technology.³³⁸ Therefore, the Act requires the staffing committee to include members from every hospital unit and instructs the staffing committee to consider a variety of unit-specific factors in developing the staffing plan.

B. The Act Does Not Impose a Great Financial Burden on Hospitals

The biggest push-back against implementing safe staffing legislation is cost.³³⁹ Hospitals fear that compliance with safe staffing mandates will require them to expand their RN workforce and/or prevent the hospital from reducing the number of its RNs to reduce costs.³⁴⁰ This concern is aggrandized; decreasing adverse patient outcomes and RN burnout can save hospitals money.³⁴¹

335. AM. NURSES ASS'N, *supra* note 114, at 13–14.

336. See generally Lisette Hilton, *Med-surg Nursing Carries a Unique Appeal*, NURSE.COM, <https://resources.nurse.com/med-surg-nursing-carries-unique-appeal> (last visited Jan. 11, 2020) (explaining that RNs in a med-surg unit may have sub-specialty and may work with a variety of doctors, patients, and diagnosis). A med-surg unit might be predominately patients from one type of specialty: gastroenterology, pulmonology, or neurology. *What is Med Surg Nursing?*, HOST HEALTHCARE (Nov. 13, 2020) <https://www.hosthealthcare.com/blog/what-is-med-surg-nursing/>. An ICU may focus on med-surg, cardiac, or neurology patients. *Id.*

337. *Nurse Staffing Advocacy*, *supra* note 28.

338. See Kutney-Lee et al., *supra* note 198, at 608 (stating the knowledge and insights of staff nurses are invaluable to improve efficiency and optimize resources for hospitals.).

339. See generally Daniel Eaton, *The Importance of Safe Patient Staffing for Nurses and the Benefit for Grads*, WOLTERS KLUWER (Sept. 18, 2020) <https://www.wolterskluwer.com/en/expert-insights/importance-of-safe-patient-staffing-for-nurses-and-benefit-for-grads> (noting the misconception of hospital management that safe staffing legislation increases cost).

340. AVALERE HEALTH LLC, *supra* note 197, at 8 (rejecting the notion that reducing nurse labor cuts can resolve cost issues). As of 2015, RNs accounted for 40% of hospitals' operating costs. *Id.* This makes staff reduction an appealing target for cutting costs in the short term. *Id.*

341. *Id.* at 9.

As discussed previously, reducing the number of RNs can negatively impact the quality of patient care and increase RN burnout and turnover.³⁴² Both reduced quality of care and RN turnover are expensive for hospitals, so the cost of additional RNs can be offset by reducing adverse patient outcomes and reducing RN turnover.³⁴³

Safe staffing is cost-effective since improved patient outcomes reduces Hospital-Acquired Conditions (HACs) and readmissions.³⁴⁴ Safe staffing reduces costly HACs while patients are admitted to the hospital.³⁴⁵ HACs include falls, pressure ulcers, and HAIs, which contribute to increased intensive care admissions and length of stay.³⁴⁶

In 2016, there were over 48,000 HACs nationwide which cost more than \$2 billion to treat.³⁴⁷ HACs are expensive for hospitals because CMS does not reimburse hospitals to treat injuries and illnesses associated with HACs.³⁴⁸ So, if a patient on Medicare comes to the hospital with pneumonia and falls and breaks his leg during his stay, CMS will reimburse the hospital for treatments related to pneumonia, but not for any interventions related to treating the broken leg.³⁴⁹ With the high cost necessary to treat HACs and the lack of CMS reimbursement, hospitals spent an average of \$41,917 per HAC patient in 2016.³⁵⁰ HACs increased patient length of stay by an average of 8.71 days and increased the mortality risk per patient by 72.32%.³⁵¹

RNs' involvement in surveillance, discharge planning, post-op care, infection prevention, and analgesic administration helps prevent HACs, complications, and medical errors. At the very least, RNs can detect and initiate

342. AACN *Guiding Principles for Appropriate Staffing*, *supra* note 114.

343. AVALERE HEALTH LLC, *supra* note 197, at 9.

344. *See generally id.* at 10–13 (finding that safe staffing reduces readmissions and prevents HACs).

345. *Id.* at 12–13. *See Hospital Acquired Condition Reduction Program (HACRP)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program> (Feb. 11, 2020). HACs can be especially expensive for hospitals with a high number of HACs due to the Hospital-Acquired Condition Reduction Program, which requires the Secretary of Health and Human Services (HHS) to reduce payments by 1% to hospitals that rank in the worst-performing 25% of hospitals. *Id.*

346. AVALERE HEALTH LLC, *supra* note 197, at 13. The average hospitalization cost for an older adult who fell in the hospital was \$17,500 in 2013. *Id.* The average charge per hospital stay of a patient who developed a pressure ulcer was \$37,800. *Id.* On a national scale, the numbers are staggering: falls cost the U.S. healthcare system \$34 billion in 2013; pressure ulcers cost the U.S. healthcare system \$9.1–\$11.6 billion annually; HAIs cost U.S. acute care hospitals \$28.4–\$45 billion in 2011. *Id.*

347. IBM WATSON HEALTH, HOSPITAL-ACQUIRED CONDITIONS LEAD TO AVOIDABLE COST AND EXCESS DEATHS 2 (2018).

348. *Hospital-Acquired Conditions (Present on Admission Indicator)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/> (Oct. 3, 2019).

349. *Id.*

350. IBM WATSON HEALTH, *supra* note 347, at 3.

351. *Id.* at 3–4.

treatment for HACs and complications quickly.³⁵² Thus, if RNs are inadequately staffed, they cannot involve themselves deeply in patient care and prevent these costly adverse outcomes.³⁵³ One study examining the cost of care for geriatric patients hospitalized with hip fractures found that the hospital cost per patient increased \$1505.75 for every 20% reduction in staff below the unit's average.³⁵⁴ This means that staffing a unit above that unit's average can decrease costs, while staffing a unit below its average can increase costs.³⁵⁵

Inadequate staffing is also linked to increased readmission rates.³⁵⁶ When RNs are understaffed, they may not have time to properly educate their patients on the patient's condition and necessary home care.³⁵⁷ For example, each additional Medicare beneficiary with heart failure, myocardial infarction, or pneumonia added to an RN's average caseload increases the patient's odds of readmission within thirty days by 6–9%.³⁵⁸

Readmissions are expensive for hospitals because CMS does not fully reimburse hospitals for excess readmissions.³⁵⁹ The Hospital Readmissions Reduction Program (HRRP) established by the Affordable Care Act (ACA) seeks to improve health care by linking the payment for services to the quality of those services.³⁶⁰ Section 3025 of the ACA required the Secretary of HHS to establish the HRRP and reduce payment to hospitals for excess readmissions.³⁶¹

Safe staffing is also cost effective in the context of reducing RN burnout and turnover.³⁶² In 2019, the average cost of turnover for a bedside RN working in a hospital was \$44,400, with a range from \$33,300 to \$56,000.³⁶³ On a larger scale, this means that the average hospital lost somewhere between \$3.6–\$6.1 million in turnover costs;³⁶⁴ other sources estimate that turnover costs the average hospital as much as \$8.1 million annually.³⁶⁵ Turnover costs include the costs of

352. See Marita Titler et al., *Cost of Care for Seniors Hospitalized for Hip Fracture and Related Procedures*, 55 NURSING OUTLOOK 5, 11–12 (2007) (noting that nurse staffing below the average is associated with increased cost and more RN hours per patient is associated with decreased cost).

353. *Id.*

354. *Id.* at 10.

355. See *id.* (finding the relationship between RN-to-patient dip in proportion and hospital costs). Also, for heart failure patients a 20% decrease in available RN care increased cost by \$1589.30. *Id.*

356. AVALERE HEALTH LLC, *supra* note 197, at 11.

357. *Id.*

358. *Id.*

359. *Hospital Readmissions Reduction Program (HRRP)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program> (Aug. 24, 2020).

360. *Id.*

361. *Id.*

362. AVALERE HEALTH LLC, *supra* note 197, at 9.

363. NSI NURSING SOLUTIONS, 2020 NSI NATIONAL HEALTH CARE RETENTION & RN STAFFING REPORT 1 (2020).

364. *Id.*

365. Kutney-Lee et al., *supra* note 198, at 610–11.

termination, unfilled positions, advertising and recruiting, new staff hiring, and new staff training and orientation.³⁶⁶ Advertising and recruiting costs vary from hospital to hospital, but can include expenses for hiring an RN recruiter, placing ads in a newspaper or a professional journal, or offering sign-on bonuses.³⁶⁷

It takes an average of eighty-five days to fill an RN vacancy.³⁶⁸ Once the vacancy is filled, hospitals must pay to onboard and train the new RN.³⁶⁹ When an RN starts a new job, the RN will receive an official orientation.³⁷⁰ The length of orientation depends on the RN's experience level and the unit the RN will be working on.³⁷¹ For a specialized unit such as the Emergency Department, orientation can last up to three months.³⁷² Orientation, especially for RNs new to the profession, typically involves both classroom and on-the-unit training.³⁷³ Classroom training includes refreshing knowledge the RN should have learned during his or her Associate or Bachelor program, as well as hospital-specific information, such as employee benefits and hospital policies.³⁷⁴ Once the RN finishes the classroom segment, he or she is partnered with an experienced RN Preceptor who teaches the RN the skills necessary to care for patients on that unit.³⁷⁵ Typically, the Orientee works with the Preceptor to care for the Preceptor's assigned patients.³⁷⁶

Costs associated with the RN's orientation include paying the employees who conduct the classroom education component and any materials associated with that classroom orientation.³⁷⁷ For the on-the-unit training, hospitals often compensate RN Preceptors for performing orientation duties.³⁷⁸ Also, the hospital must pay both the Preceptor and the Orientee during this training period,

366. AVALERE HEALTH LLC, *supra* note 197, at 9.

367. Beth Greenwood, *The Average Recruitment Cost*, CHRON, <https://work.chron.com/average-recruitment-cost-3664.html> (last visited Dec. 31, 2020).

368. *The High Cost of Nurse Turnover*, U. OF N.M. (Nov. 30, 2016), <https://rnbsnonline.unm.edu/articles/high-cost-of-nurse-turnover.aspx>.

369. *Id.*

370. JEAN MCGRATH-BROWN, *NOW THAT NURSING ORIENTATION IS OVER 4* (2013).

371. *Id.*

372. *Id.*

373. *Id.* at 4–5.

374. *See generally id.* (explaining that typically, Associates and Bachelors programs include courses on basic RN skills that are further discussed and re-emphasized during specific RN classroom training for individual hospitals upon hiring RNs).

375. *Id.* at 5.

376. *See* MCGRATH-BROWN, *supra* note 370, at 4–5.

377. *See generally id.* (indicating that existing staff and faculty facilitate new RNs' orientation programs, and therefore are compensated by the hospital for their added workloads).

378. Lisette Hilton, *Precepting is Crucial in Retaining New Nurses and Helping Them Succeed*, NURSE.COM (Feb. 12, 2020), <https://www.nurse.com/blog/2020/02/12/precepting-crucial-retaining-new-nurses-helping-them-succeed/>.

even though the Orientee is not caring for any patients on his or her own.³⁷⁹ Additionally, early in the Orientee's training, the hospital may have to schedule extra staff because a new Preceptor-Orienteer pair can rarely handle a full patient load, due to the time it takes for the Preceptor to pause and explain nursing interventions to the Orientee.³⁸⁰

Additionally, the committee format facilitates moderation in staffing decisions. A staffing committee approach brings frontline RNs into the room with someone who understands the hospital's budget.³⁸¹ This assists the staffing committee in expanding the RN staff only where necessary, and allows the staffing committee to explore solutions beyond hiring more RNs, such as alterations to practices or processes.³⁸²

A 2013 study surveyed the CNOs of Illinois hospitals after the state legislature passed safe staffing legislation mandating the formation of staffing committees, who are tasked with developing a staffing plan.³⁸³ At the time of the survey, most of the staffing committees had been in place for a year or less.³⁸⁴ Despite their short tenure, several of the staffing committees had already made or proposed changes that went well beyond hiring additional staff.³⁸⁵ Many organizations implemented practice and process changes that would cost the hospital little, if any, money: changes in break time, introduction of walking rounds for shift change, revisions to the charge nurse role, and revised staffing for patient admissions and discharges.³⁸⁶

Thus, fears that legislation like the Act will bankrupt hospitals is hyperbolic.³⁸⁷ Hospitals can offset the cost of additional staff by reducing

379. See generally MCGRATH-BROWN, *supra* note 370, at 4–5 (clarifying that Orientees are still under employment by hospitals during training period, and therefore are paid for hours spent training).

380. See generally Hilton, *supra* note 378 (suggesting that since Preceptors need to provide constant feedback to Orientees and employ multiple teaching styles, they likely will take longer to provide routine care).

381. See Fitzpatrick et al., *supra* note 290, at 227 (maintaining that requiring a board member to serve on the staffing committee is ideal because that person serves a dual role: channeling communication between the staffing committee and the other board members and providing the other staffing committee members with a financially focused perspective). Adding someone from a hospital's financial department whose sole employment purpose is to understand the hospitals' financials could also be helpful. *Id.*

382. *Id.* at 225.

383. *Id.* at 223.

384. *Id.*

385. *Id.* Unsurprisingly, the majority (71.4%) of the CNOs surveyed reported that his or her hospital's staffing committee was still evolving, but 24.3% reported that the committee was effective or highly effective, and only 4.3% reported that the committee was somewhat or not effective. *Id.*

386. *Id.* The authors note that RNs also got involved in educating productivity consultants on how care was delivered at the hospital, the budget process, reviewing policies related to sick coverage, and developing an acuity system. *Id.*

387. AVALERE HEALTH LLC, *supra* note 197, at 8.

adverse patient outcomes and RN turnover, as well as by implementing policy and practice changes that benefit RNs without costing the hospital money.³⁸⁸

VII. CONCLUSION

Research indicates that inadequate RN staffing in hospitals results in adverse patient outcomes and RN burnout.³⁸⁹ Yet, staffing is an issue in many hospitals³⁹⁰ that remains insufficiently addressed by the federal government.³⁹¹ Many state legislatures have passed some sort of legislation dealing with RN staffing,³⁹² but only seven states are currently implementing the best approach: staffing committees.³⁹³

The Hospital RN Safe Staffing Act provides state legislatures a foundation for improving staffing in their states. It proposes that every hospital within the state form a staffing committee comprised of direct care RNs and hospital leadership. The staffing committee will develop a staffing plan that sets the minimum number of RNs necessary on each unit per shift. This approach addresses the issue of inadequate staffing while simultaneously opening channels of communication between RNs and hospital management.

Improving staffing and communication promotes positive patient outcomes and decreases RN burnout.³⁹⁴ Because decreasing adverse patient outcomes and RN turnover can save hospitals money, the Act provides a financially feasible method for achieving safe staffing.³⁹⁵

388. See Fitzpatrick et al., *supra* note 290, at 225 (describing that where hospitals institute policies like increased break times, clear staffing lists, and teams, RN turnover decreases while maintaining hospital budgets.).

389. See *Aiken I*, *supra* note 16, at 1990–92 (arguing that reducing the number of patients each nurse sees could result in significantly fewer preventable deaths, and also reduces the rates of job-related burnout and job dissatisfaction); see also McHugh & Ma, *supra* note 16, at 77 (describing a study showing that nurses working in hospitals with better staffing have lower rates of job dissatisfaction).

390. *Nurse Staffing*, *supra* note 28.

391. See generally 42 C.F.R. § 482.23(b) (2019) (requiring only that nursing services have adequate numbers of professionals, with alternative staffing plans reviewed once every three years).

392. See *Nurse Staffing Advocacy*, *supra* note 28 (demonstrating that 15 states have legislation to address nurse staffing in hospitals); see also KY. REV. STAT. ANN. § 216B.160 (West 2001) (stating that hospitals must provide staffing plans for licensed and unlicensed personnel); MINN. STAT. § 144.7055 (2013) (reporting that a chief nursing executive for each reporting hospital must develop a core staffing plan for every unit); 23 R.I. GEN. LAWS § 23-17–12.8 (2010) (declaring that nursing staff levels must be posted in a public place within the hospital facility).

393. CONN. GEN. STAT. § 19a-89e (2019); 210 ILL. COMP. STAT. § 85/10.10 (2021); NEV. REV. STAT. § 449.242 (201); OHIO REV. CODE ANN. § 3727.51–3727.52 (2008); OR. REV. STAT. § 441.154 (2021); TEX. HEALTH & SAFETY CODE ANN. § 257.004 (2009); WASH. REV. CODE § 70.41.410 (2008).

394. See *AACN Guiding Principles for Appropriate Staffing*, *supra* note 114 (describing how appropriate nurse staffing provides higher-quality patient care, healthy work environments, and lower levels of staff turnover).

395. See Kutney-Lee et al., *supra* note 198, at 608 (describing that because nurses are less likely to report negative outcomes when they are involved in decision-making, hospitals are likely to avoid costly penalties and receive reimbursement for patient care).