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California's experience raises questions

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RE "NURSING ratios save money and lives": As a California registered nurse with more than 35 years of experience, I would have to respectfully disagree with Suzanne Gordon's conclusions in her July 9 op-ed. California's mandated patient-nurse ratio has yet to be fully studied, and its impact hasn't been fully analyzed. Many questions remain. For example, even though California has issued about 90,000 new RN licenses since the passage of the mandate, a nearly equal number of licensed RNs have left our state, and of greater concern is that a large number of RNs do not renew their license after issuance (which means they're not practicing in California). Many California nurses such as me fought the cookie-cutter mandate promoted by the California Nurses Association and its supporters. We advocated for a more sound nursing approach, the acuity-based patient assignment. Simply put, this system allows nurses to assess the patient, the severity of the illness, the complexity of treatment, and the nurse's skill sets to make the nurse-patient assignment. This use of the nurse's intellect, skills, and training is what nursing and good patient care are all about.

I urge the Massachusetts Legislature to review all the literature, not just what is cherry-picked for them by their aides, lobbyists, and special interests (including unions).

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Nursing ratios save money and lives

By Suzanne Gordon
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BEFORE ITS legislative session ends in July, the Massachusetts Senate has an opportunity to protect hospital patients as well as the nurses who care for them by approving the Patient Safety Act that was passed overwhelmingly in the House a month ago.

The ratios bill would require that the Massachusetts Department of Public Health implement enforceable limits on the number of patients a registered nurse can be assigned, thus providing patient protection in all acute care hospitals. As the Senate debates this measure, it should consider the positive effects that legally mandated nurse-patient ratios have had where they've already been enacted - in California and Australia.

In California, since 2005, no nurse on medical surgical floors can be assigned more than five patients at a time. On equivalent units in Victoria - the second largest state in Australia - the minimum required staffing for every 20 patients is five RNs, backed up by a "charge nurse" who has no patient load of her own and is thus free to assist other RNs.

In both California and Victoria, ratios were originally introduced because excessive RN workloads were putting both nurses and patients in jeopardy, while adding to overall healthcare costs. More than 60 studies have documented that hospital understaffing results in more patient deaths, plus more preventable complications like pneumonia, urinary tract and catheter infections, and medication errors. A study done in 2005 by Michael B. Rothberg in the journal Medical Care put a price tag on these problems, concluding that a nurse who had time to prevent a case of pneumonia "saved $22,390 to $28,505, or $4,225 to $5,279 per additional hospital day." When nurses prevent an adverse drug event, they save the patient from an "added 2.2 hospital days at a cost of $3,344." On the other hand, if understaffing leads to complications after surgery, the resulting patient stay can be 8.1 days longer than normal, adding nearly $11,000 to the total expense.

Unmanageable workloads have also created an exodus of nurses into other fields or nonpatient-care jobs. According to a study by L.J. Hayes that appeared in the Journal of International Nursing Studies, hospital nurse turnover in 2006 - outside of California - ranged from 15 to 36 percent per year.

A study by economist Joanne Spetz, just published in the nursing journal Politics, Policy, & Nursing Practice, finds that ratios in California have increased RN job satisfaction and reduced turnover. According to Spetz, nurses are happier at work because they now get to spend more time at the bedside - particularly on patient education - which has a positive impact on nurse turnover and thus on the quality of care.

Researchers at the University of Pennsylvania have compared nurses in California with those in Pennsylvania and New Jersey - states without minimum staffing requirements. California RNs reported greater job satisfaction, leading to less burnout.

Ratio foes claim that ratios will cripple hospital functioning and force ERs to shutter their doors, because not enough RNs are available to meet the new requirements.

The hospital industry in California cited similar dire consequences in its bid to thwart full implementation of ratio legislation. In 2005, however, the state supreme court found no evidence that any hospital or ER there had closed due to new staffing mandates as opposed to the usual reasons for a shutdown (poor management, precarious finances, and consolidation of several nearby facilities).

Easing the nursing workload gives RNs who have dropped out of the active nursing workforce an incentive to return and encourages those already employed to stay. In Victoria, the government lured more than 7,000 inactive nurses back into the workforce. In California, nurses in hospitals that have fully complied with the new standards say ratios have had the same effect and many of those who reported they wanted to leave the profession say they will now stay.

Further legislative inaction on the issue of safe staffing in Massachusetts will only prolong an unacceptable status quo that drives nurses out of their profession, leaving too many hospital patients under-protected. If we want there to be enough nurses to care for the waves of baby boomers who will soon fill our hospitals, the time to act is now.

Suzanne Gordon is co-author of "Safety in Numbers: Nurse-to-Patient Ratios and the Future of Health Care."