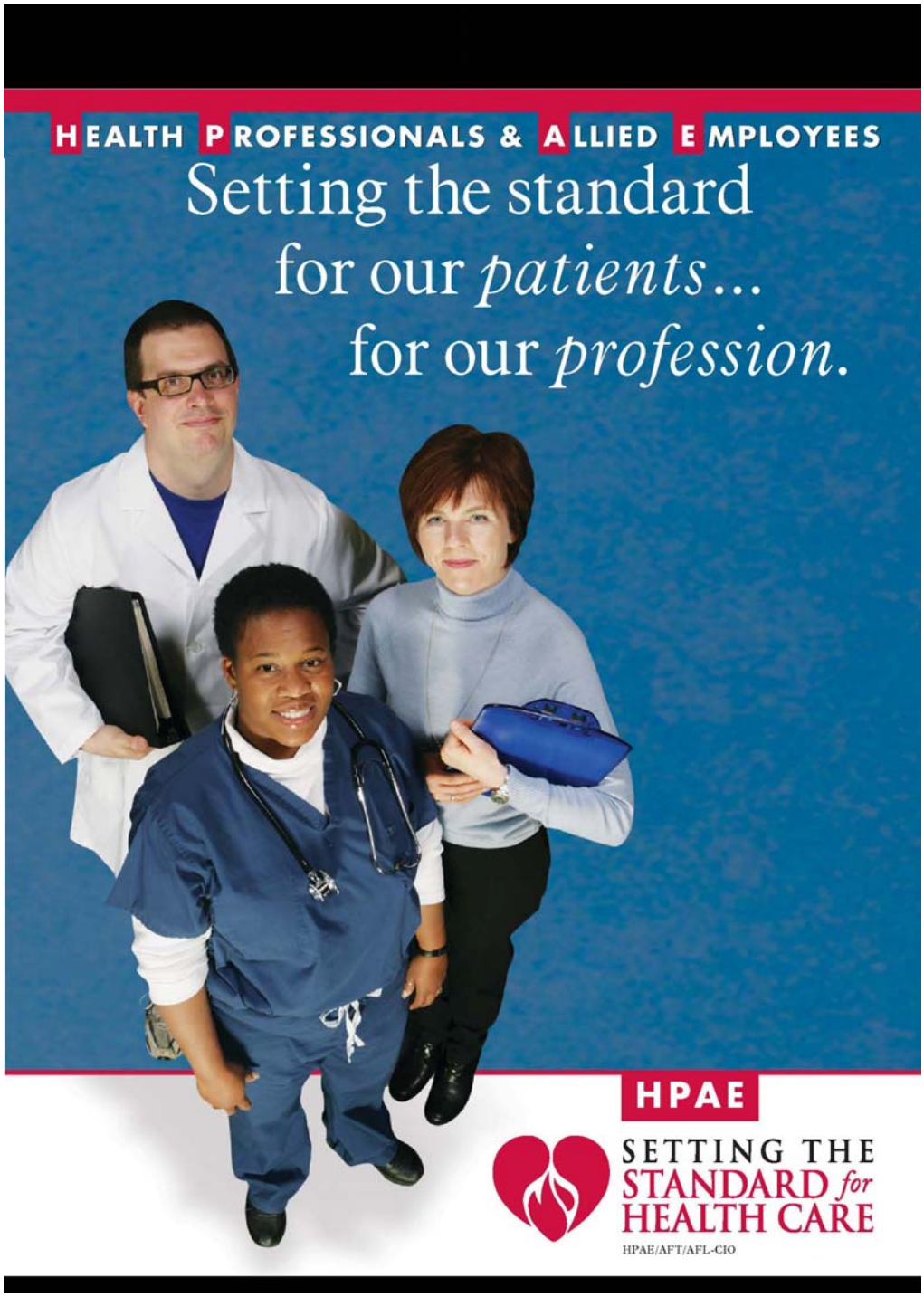


SETTING THE STANDARD FOR

SAFE AND EFFECTIVE PATIENT CARE

IN NEW JERSEY

Health Professionals and Allied Employees

HPAE/AFT/AFL-CIO

Providing Access, Accountability and Safety in NJ's Health Care System

Summary

While some might consider New Jersey's health care environment highly-regulated, in reality, control over quality, staffing and the allocation of precious healthcare dollars is largely in the hands of individual hospitals, operating in a competitive environment, and accountable more to bondholders and private payers than to patients and the public. As a result, New Jersey residents' access to safe and affordable health care is imperiled.

While hospitals are facing cuts in reimbursement levels, accountability for the millions of public dollars going to healthcare is sorely lacking. Possible conflicts of interest and self-dealing within hospital boards are largely unregulated, and have the potential to divert public dollars to private gain.

Although our health care system is based on employer-financed coverage, employers both large and small are turning their backs on their responsibility to provide health insurance for their workers. A majority of our uninsured adults and children are, in fact, members of working families. While New Jersey spends up to $1 billion on programs to provide care for the uninsured, these expenditures are no match for rising health care costs or federal budget cuts. When patients finally do access the system, they are sicker and require more care and attention.

Even having health insurance is no longer a guarantee of access to quality health care, and consumers still have little recourse when care is denied or delayed. When patients finally do reach the hospital door, they often wait hours to be seen and hours more to get from the Emergency Room to a bed.

Nurses and other health care workers who deliver medications, monitor and assess patients' conditions, answer call buttons, perform lab tests, keep rooms clean and free of infection, and keep patients comfortable and safe are working short-staffed, with too many patients to care for at one time.

Rising infection rates and medical errors, both associated with chronic understaffing in our hospitals, are alarming to patients and caregivers alike, and exact an enormous human and economic toll. Hospital-acquired infections like C. difficile are a costly problem in the United States. Each year nearly 2 million patients pick up an infection while in the hospital, and about 90,000 of them die from that infection, the CDC estimates.[1]

Despite numerous studies showing the direct link between nurse staffing and patient outcomes, staffing levels vary widely from hospital to hospital, and are largely unregulated. Until very recently, this critical quality information was unavailable to patients and the public.

Despite evidence that workplace hazards are contributing to the exodus of nurses and other health professionals, safety and health protections for hospital workers do not reflect either the severity of the hazards they face, or their rate of injury, among the highest of any occupation.

Frustrated by feeling they are not able to provide the care their patients need and deserve, and suffering themselves from exhaustion and injury, health care workers are leaving the bedside and their professions.

The Health Professionals and Allied Employees, AFT/AFL-CIO, (HPAE), New Jersey's largest union of Registered Nurses and healthcare professionals is issuing this report because we believe that the voices of New Jersey healthcare professionals need to be heard in the debate over quality healthcare.

This Report updates "Setting the Standard for Safe and Effective Patient Care in New Jersey", that we issued in March 2004. Since then, HPAE has won:

- Staffing Disclosure Legislation, requiring hospitals and nursing homes to post and report to the NJ Department of Health and Senior Services the nurse to patient ratio on all units and all shifts, as well as numbers of other direct patient care professionals;
- Minimum nurse-to-patient ratios in our collective bargaining agreements with Cooper Medical Center, Englewood Hospital and Medical Center, Jersey Shore Medical Center, Pascack Valley Hospital, and the University of Medicine and Dentistry of New Jersey.

Patient safety cannot be assured without safe staffing. Without state and hospital policies that help us recruit and retain the most qualified and experienced nurses and health professionals, we cannot provide safe staffing. We cannot ensure access to quality care until our health care institutions are both adequately funded and appropriately accountable to the public they serve.

This report and its recommendations are designed to involve the public as well in the debate over the quality of our health care system. Without serious change, patients and caregivers are the ones who will pay, with compromised care and deteriorating working conditions.

RECOMMENDATIONS

- ONE, provide access to quality health care through increased funding and coverage for the uninsured;
- TWO, increase support for our health care institutions – and hold them accountable for expenditures of public dollars;
- THREE, ensure that all hospitals are staffed with adequate numbers of appropriately trained and qualified nursing and health care staff;
- FOUR, improve policies to recruit and retain experienced healthcare staff through fair compensation and retirement security;
- FIVE, prevent injuries and illness to both health care workers and their patients through health and safety programs at all health care institutions.

Issue: Funding, Access, Accountability, Transparency

During a February 6, 2006 public hearing of the NJ Senate Labor Committee, Senator Joseph Vitale (D-Middlesex) reported that New Jersey spent more than $1 billion for Family Care and Charity Care for the poor and uninsured in 2005. Many of the recipients of these programs were working families. In fact, low-income children with one parent working and low-income adults with at least one full-time worker in the family are more likely to be uninsured than those with no full-time workers.[2]

Nevertheless, despite these programs and expenditures, more than 1 million New Jerseyans still lack health insurance, including an estimated 250,000 children.[3]

The challenge of providing access to affordable, safe health care for more than one million New Jersey residents is deepened by federal budget cuts and the unwillingness of many companies to provide health insurance for their employees.

While a million New Jerseyans cannot access health care, not-for-profit hospital executives and trustees remain free to engage in self-dealing--directing costly contracts and professional services business to associates, family members and friends. A 2005 national survey by the Governance Institute, a healthcare education and research company, found that:

Two-thirds of not-for-profit hospitals and system boards don't turn to an outside auditor for review of board members' conflicts of interest;
40% lack written policies stating that willfully violating conflict of interest rules constitutes grounds to dismiss trustees or directors;
35% don't require board members responsible for audit oversight to be independent; and
65% have no written policy that addresses physicians' competition or conflicts of interest.[4]

The Solution

HPAE is joining with other citizen groups and elected officials in supporting:

- Establishment of a State Healthcare Access Commission, to study plans to expand health care coverage to all New Jersey residents;
- Disclosure by companies of the number of employees who are eligible for family care (S539/Buono);
- Legislation to require companies who do not provide a minimal amount of paid healthcare coverage for employees to pay into a state fund to provide coverage. (S477/Sweeney/Vitale)
- Enforcement of recently enacted public disclosure of hospital staffing law.

While HPAE recognizes that hospitals face a very real financial challenge providing care for the under- and uninsured, any increase in charity care funding or other financial support to hospitals must be tied to requirements that hospitals strengthen governing boards' independence and improve safeguards against conflicts of interest among directors and trustees.

The Shortage: Driven from the Bedside and Out of the Profession

Serious shortages of health professionals continue to plague the nation's hospitals. According to national statistics, eighty-nine percent of hospitals report a shortage of registered nurses. The numbers are daunting for other professions as well.[5]

Title	% of Hospitals Reporting Shortage
Registered Nurse	89%
Radiology/Nuclear Imaging	76%
Pharmacy	67%
Lab/Medical Technology	54%
Nurses'/Clinical Aide	20%

In New Jersey, the average RN vacancy rate in 2002 was 14%, projected to reach 18% for RNs and 17% for LPNs by 2006. By 2020, the RN vacancy rate is expected to reach 30%.[6,7] According to figures from the U.S. Department of Health and Human Services, New Jersey ranks 9th highest among the states in the nursing shortage.[8]

The data for other health professions is equally sobering. According to a 2001 American Hospital Association study, average vacancy rates in radiology were 18%, laboratory vacancies were 12%, and in pharmacies, the rate was 21%.[9]

The shortage of nurses and other health professionals is in fact a very distinctive sort of shortage - a shortage of nurses and health professionals willing to work under the conditions prevailing in many New Jersey hospitals. Government statistics show there are nearly 500,000 RNs in the U.S. who have chosen not to work in the nursing profession. In New Jersey, the 20,000 licensed RNs not employed in nursing make up nearly 24% of the state's RN population.[10]

Hospitals would have us believe that inadequate and dangerous staffing levels are the result of a shortage of nurses, pharmacists, respiratory therapists and other health professionals – a shortage that they can do almost nothing about. These statements are misleading. The current shortage of willing nurses and healthcare workers is the result of years of cost-cutting by hospitals, under-staffing, unsafe working conditions, and a lack of retirement security.

Where are the Nurses and Health Care Workers?

The shortage of nurses is generally attributed to the aging of the nurse workforce and the fact that fewer young people have entered the profession in the past several years.

While age and demographics do play a role, the current shortage began in the early '90s when hospitals chose to lay off nurses and other health professionals in response to the economic pressures of managed care. For the staff that remained, the working conditions became intolerable, thereby beginning a vicious cycle in which bad working conditions lead to increased burnout and job dissatisfaction, prompting more nurses to leave, and exacerbating the shortages.

Among nurses, higher emotional exhaustion and greater job dissatisfaction have been shown to be strongly associated with higher patient-to-nurse ratios. Researchers found that nurses in hospitals with the highest patient-to-nurse ratios are more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs as nurses in hospitals with the lowest ratios. Furthermore, nurses in high ratio hospitals were four times as likely to report they intended to leave their current job within a year as nurses in low ratio hospitals.[11]

The American Organization of Nurse Executives recently reported that 83% of nurses surveyed agreed that improved working environments would help solve the nurse shortage. Other surveys have reported similar results.[12]

The lack of retirement security also leads nursing and health professionals to leave their professions. In a nationwide survey of registered nurses, 58% of respondents cited improved retirement benefits as a very effective tool for nurse retention and recruitment.[13] According to one hospital industry executive, retirement plans "are the benefits employees are looking for when they go to a new employer, or the benefits are a reason to stay".[14]

"Nurses are leaving the bedside to work for drug companies, insurance companies and sometimes moving out of the profession altogether...A job where they won't have to worry that a patient did not receive the care they should have because the nurse simply was physically and emotionally unable to care for such a large number of patients."
—Jean Lucas R.N.C., Cooper Hospital

Despite the acknowledged importance of retirement benefits to staff retention, healthcare employers spend less on benefits than other non-manufacturing employers. Healthcare employers contributed, on average, 30% less to employee pensions than manufacturing employers contributed to their employees in 2002.[15]

A 2003 American Hospital Association study found that only 66% of hospital systems and 50% of stand-alone hospitals offer defined benefit pension plans. Defined benefit plans are traditional plans funded entirely by the employer, which guarantee level of benefits upon retirement and are fully insured. Only six years earlier, 87% of systems and 72% of stand-alone hospitals offered these plans.[16] As the stock market has floundered, hospitals have been switching to defined contribution plans, which are uninsured plans in which the employee bears all the risk and the final payout depends upon the health of the employee's investments.

Cost pressures throughout the healthcare system are enormous. Hospitals need to do everything they can to use their resources efficiently. The research shows that high turnover and burnout rates for healthcare professionals are wasteful and expensive.

While much of the public policy debate continues to focus on recruitment, HPAE has focused many of its efforts on the reasons why nurses and other professionals are leaving health care. Our high turnover rates among nurses and health professionals and poor retention due to understaffing, unsafe patient care and working conditions, and lack of retirement security is therefore the focus of this report and its recommendations.

Patient Safety and Staffing

Too few caregivers lead to more medical errors, more infections, more complications and more preventable patient deaths. A growing body of research demonstrates clear links between the level of staffing and the quality of patient care.

The consequences of chronic understaffing continue to jeopardize patient safety and patient satisfaction at too many of our health care facilities. For more than a decade, nurses have been warning that understaffing compromises patient care. The crisis is worsening, as the growing ranks of the uninsured, along with managed care restrictions and the aging of the population, means that patients are sicker and require more care and attention when they finally enter the hospital.

A survey of New Jersey registered nurses found nearly 80% of respondents described their facility as short-staffed, with a majority reporting there were not enough nurses on their own unit to provide quality care to all their patients. RNs who reported staff shortages said understaffing reduced the amount of patient education and support they could provide (77%); caused delays in basic care (68%); and caused more medical errors (40%).[17]

"There is now clear evidence that high nursing turnover is associated with increased patient mortality. This growing problem has the potential to eventually undermine the safety and quality of care for millions of patients."
-- Dennis S. O'Leary, JCAHO President, Aug. 7, 2002

Other hospital professionals have been sounding a similar alarm. A 2002 nationwide survey of respiratory therapists, radiology technologists and certified nursing assistants asked participants to identify the two biggest problems facing their profession. All three groups ranked inadequate staffing as the number one problem in the workplace. A majority of professionals in all three fields reported that poor staffing and increased workloads caused the quality of care patients received to suffer. Substantial proportions in all three professions reported that staffing shortfalls might have placed patients at risk.[18]

Numerous research studies document the serious—even deadly consequences of understaffing, and the personal and economic toll it takes.

A landmark study from the University of Pennsylvania found that for each additional patient over four in a nurse's workload, the risk of death increases by 7% for surgical patients. Patients in hospitals with nurse-to-patient ratios of 8:1 have a 31% greater risk of dying than those in hospitals with four patients per nurse.[19]

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) — the organization responsible for certifying quality conditions in most of the nation's hospitals — has reported that nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors.[20]

In a now famous report, the prestigious Institute of Medicine revealed that nationally, medical errors cause an estimated 98,000 deaths and cost an estimated $17 billion annually.[21] A subsequent study released by HealthGrades Inc, a health care quality firm, revised these figures to an estimated 195,000 in-hospital deaths each year caused by preventable errors, at a $6 billion annual cost to Medicare.[22]

That number would be even higher without the vigilance of nurses at the bedside.
In fact, a study of medication errors revealed that nurses are responsible for intercepting 86% of medication errors made by physicians and others before the error reaches the patient.[23]

A growing body of research is establishing a relationship between nurses' working environments, including staffing, and negative patient outcomes, including: longer lengths of stay; hospital-acquired pneumonia and urinary tract infections; shock or cardiac arrest; upper gastrointestinal bleeding; and other preventable complications.[24]

"One night the Special Care Nursery had only one Registered Nurse to care for all the babies—the rest of the nurses were attending Cesarean sections in the delivery room to care for the newborns, and there was no nursing assistant or secretary. One of the "preemies" didn't get fed for 5 hours because there just wasn't enough staff."
- A South Jersey Registered Nurse

Staffing and Infection Rates

Hospital acquired infections (HAIs) are a growing, and even deadly health care problem, whose rising incidence rates may reflect, in part, deteriorating staffing levels. HAIs are infections that patients develop during the course of receiving treatment for other conditions. Several studies have found pneumonia rates among surgical patients to be especially sensitive to nurse staffing levels, attributable to the heavy responsibility RNs have for respiratory care in surgical patients.[25] Afflicting nearly 2 million patients each year, almost 90,000 of whom die from these infections, HAIs are responsible for $4.5 billion in excess health care costs annually.[26]

Low registered nurse staffing levels also have been associated with the spread of disease during outbreaks, and staffing shortages, especially of nurses, have been identified as one of the major factors expected to constrain hospitals' ability to deal with future disease outbreaks.[27]

Consumers Want Safe Staffing

Consumers are echoing caregivers concerns. A 2004 national survey commissioned by the National Consumers League found that nearly half of consumers with recent direct hospital experience (either those hospitalized themselves or those with an immediate family member hospitalized within two years prior) believe that safety was compromised by a lack of available nurses. One in eight believed safety was extremely or very compromised. More than one-third of respondents reported not receiving important elements of care in a timely fashion.[28]

In another survey of U.S. hospital patients and their families, given a choice, 39% of patients and 41% of family members said having more nurses would have the most positive impact on the quality of care, ahead of doctors, upgrading facilities or improving admissions procedures. The survey was conducted in 2004 by Rasmussen Reports, LLC, an independent research firm, on behalf of Hudson Healthcare.

In New Jersey, the public clearly understands the need to limit the number of patients a nurse is required to care for at any one time, as well as the public's right-to-know the quality and staffing levels of their hospitals. Seventy-eight percent (78%) of the New Jersey public surveyed by the Eagleton Institute of Politics think that RN staffing levels have a great impact on their health and recovery in the hospital. More than 79% agreed that nurse-to-patient ratios should be established by law, and 70% wanted hospital staffing levels made public.[29]

In a 2005 editorial, the Camden Courier-Post, while applauding then Governor Codey's signing of the state's staffing disclosure law, called on the NJ legislature to move quickly to pass legislation setting nurse-to-patient ratios in hospitals.[30]

"In x-ray, the phone rings three times in a row. There is a man in the ER having a massive heart attack. There is a newborn on maternity who is in respiratory distress. Both need a portable chest x-ray. The operating room cannot start surgery without a tech. I cannot leave the patient I have. I am forced to choose who to prioritize. If there were enough staff, all these patients would get proper care".
-- Vinnie Fedor RT, Radiologic Technologist, Bayonne Medical Center

The Financial Costs of Understaffing and Deteriorating Working Conditions

In a healthcare system struggling to contain costs, ironically, the cost-cutting measures responsible for the hospital staffing crisis have wound up costing the healthcare system billions of dollars in preventable errors and complications; increased lengths of stay and readmission rates; higher cost-per-discharge; and decreased return on assets. High staff turnover also is increasing staff replacement costs, productivity losses and temporary staffing costs. [31]

A 2002 study by the Voluntary Hospital Association found that on average it costs $46,000 to replace one medical/surgical nurse and about $64,000 to replace a critical care nurse. A hospital with 600 employees and a turnover rate of 20% would spend $5.52 million/year on turnover. Cutting the turnover rate to 15% would result in direct savings of $2.38M per year for that hospital.[32] With a national turnover rate of nearly 21% in the healthcare industry, the savings would be enormous.

Understaffing has other economic effects. Another study, conducted by the American Hospital Association, finds that high vacancy rates have a profound impact on hospital services, including emergency department overcrowding (38%); diverted emergency department patients (25%); closed beds (23%); increased wait times for surgery (19%); delayed discharge and increased length of stay (12%) and cancelled surgeries (10%).[33]

Where hospitals have improved their staffing levels and invested in retaining their experienced caregivers, they are witnessing a decline in vacancy and turnover rates and related costs. The University of Kentucky's 450-bed Chandler Medical Center credits an improved retirement plan, minimum staffing ratios, and a ban on mandatory overtime with cutting their nurse vacancy rate down to 5-6% and eliminating the need for agency and travel nurses.[34]

"Hospital administrators who want to improve the quality of care at their institutions should think about investing in nurses. As safety interventions go, they are remarkably cheap."
- Michael Rothberg, MD, co-author of a national study of nurse staffing published August 2005 in *Medical Care*,

The State of California was the first to establish ratios by law in 1999, and the regulations became effective January of 2004. However, in advance of the law's implementation, some hospitals and hospital systems in California adopted ratios. Hi-Desert Medical Center in Joshua Tree, California witnessed a dramatic drop in their nurse vacancy rate—from 50% to less than 1%—after instituting staffing ratios on their medical-surgical units in 2001.

Kaiser Permanente Northern California, part of the largest not-for-profit health plan in the nation, also adopted a 4:1 patient-to-nurse staffing ratio on its medical/surgical units, well in advance of California regulations. As a result, Kaiser saw a 71% increase in new hires and a 47% decrease in voluntary terminations. Recently, the California Bureau of Registered Nursing reported a 60% increase in applications for nurse licenses since passage of the ratios law in 1999.

There is initial evidence that establishing these ratios dramatically reduces nursing burnout, turnover and vacancy rates. **In other words, mandatory safe staffing levels keep nurses at the bedside.**

Staffing and Continuity of Care

Hiring temporary staff from outside agencies is another common, albeit risky and expensive approach to meeting workload fluctuations. Nationwide, nearly 60% of hospitals hire nurses from temporary agencies or traveling nurse companies, a practice that permanent nursing staff in hospitals oppose when used as a substitute for recruiting and retaining permanent staff. The Institute of Medicine cautions that the use of agency nurses can represent a threat to patient safety and "should be avoided", because they are unfamiliar with a facility's policies and procedures, information systems, patient care technology, and layout.[35]

Solutions: Legislation, Hospital Contracts and Public Policy

In New Jersey, HPAE, Senator Joseph Vitale (D-Middlesex) and Assemblyman Robert Gordon (D-Bergen) are sponsors of legislation mandating safe staffing standards for registered nurses in hospitals, ambulatory surgery facilities and State developmental centers and psychiatric hospitals.

S810/A754, call for minimum nurse to patient "ratios" in each hospital unit and require hospitals to have approved systems for increasing staffing levels above the minimum when necessary.

Minimum ratios as required by S.810/A754
1 RN: 6 patients in medical/surgical unit
(dropping to 1:5 after one year)
1 RN: 4 patients in stepdown, telemetry or intermediate care unit
1 RN: 4 patients in emergency department
1 RN: 2 patients in emergency critical care service
1 RN: 1 patient in emergency trauma service
1 RN: 6 patients in behavioral health or psychiatric unit
1 RN: 2 patients in critical care, intensive care, neonatal or burn unit
1 RN: 1 patient under anesthesia in an operating room
1 RN: 2 patients in post-anesthesia recovery room or unit
1 RN: 2 patients in labor and delivery unit;
1 RN: 4 patients in a postpartum unit where mother and infant share the same room;
1 RN: 6 patients in a mothers-only unit
1 RN: 4 patients in a pediatric or intermediate care nursery;
1 RN: 6 patients in a well-baby nursery

HPAE is also supporting A2052, sponsored by Assemblyman Herb Conaway, which would require the NJ Department of Health and Senior Services to monitor hospitals or nursing homes when their use of temporary agency nurses reaches or exceeds 40%.

To stop the flow of nurses from the bedside and to preserve the safety of patient care, HPAE continues to advocate for minimum nurse-to-patient ratios in our collective bargaining agreements. In the past few years, a number of HPAE-represented hospitals have initiated nurse-to-patient ratios unit-by-unit or hospital wide, including: Bayonne Medical Center, Pascack Valley Hospital, Cooper University Hospital, Jersey Shore Medical Center and University Hospital/UDMNJ.

Worker and Patient Safety: Hazards and Violence in Healthcare Settings

Hospital workers face an alarming array of hazards on the job: disabling back injuries from lifting patients; broken bones from combative patients; HIV and hepatitis from needlesticks; and exposure to infectious diseases, such as tuberculosis, and to toxic chemicals, including pesticides, disinfectants, and hazardous drugs.

In a 2005 survey of 11,000 members of HPAE, 42% of respondents reported having suffered a work-related injury or illness. The most recent government data for New Jersey reveals that the rate of workplace injuries and illnesses for hospital workers is higher than most other industries. If we look only at those injuries and illnesses that lead to days away from work, job transfer, or work restrictions, once again the rate for hospital workers in New Jersey is higher than other industries.[36]

Rate Of Workplace Injuries in NJ per 100 full-time workers

Industry	Rate	Lost Time
Hospital Workers	8.3	4.4
Service Sector	3.5	1.9
Construction	5.6	3.1
Manufacturing	5.0	2.6
Mining	5.9	1.9

Because the environment in which healthcare workers deliver care is the same environment in which patients receive care, patients and caregivers share many of the same exposures. In addition, hazardous working conditions interfere with the provision of care. In an online survey conducted by the American Nurses Association, 75 percent of respondents indicated that unsafe working conditions interfere with their ability to deliver quality care.[37]

Safety and health hazards and inadequate staffing exacerbate one another, and hazardous working conditions contribute to the nursing and other professional shortages. Inadequate staffing increases the risk of injury to caregivers, for example, by forcing them to work alone or to forego time-consuming safety precautions. Injured caregivers may be out of work for days, weeks or even months and their workload simply spread out among their remaining co-workers, contributing to burnout and increasing the likelihood of injury. Ultimately, on the job hazards lead caregivers to leave their professions. In the ANA online survey cited above, 88 percent reported that health and safety concerns influence their decision to continue working in the field of nursing and the kind of nursing work they choose to perform.[38]

Unsafe Working Conditions: The Human Toll

Every day, nurses and other frontline caregivers are injured while manually lifting, transferring and repositioning patients. These "patient handling" injuries endanger patients, often put an end to a nurse or caregiver's work at the bedside, and are costly.

One study found that the cumulative weight lifted by a nurse in one typical 8-hour shift is equivalent to 1.8 tons,[39] and nursing personnel consistently rank among the top ten occupations for work-related musculoskeletal disorders, according to data from the Bureau of Labor Statistics. While the rates of other injuries are falling, musculoskeletal injuries are increasing among hospital workers, a result of inadequate staffing, the increasing acuity of hospital patients--who are therefore more dependent and require more assistance with lifts and transfers, and the increasing prevalence of obesity.

In the same 2005 survey of HPAE members cited above, 30% of respondents reported having suffered an ergonomic injury in the past five years.

The findings of a 2006 Peter Hart national survey of

hospital-based Registered Nurses and Radiology Technologists, commissioned by the American Federation of Teachers, underscore the prevalence of the problem and its implications for nursing and health professional shortages:

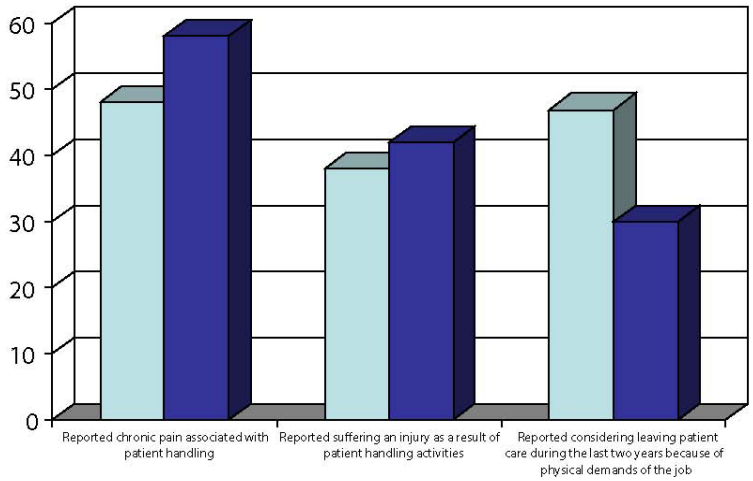
- 39% of RNs rated " the stress and physical demands of the job" as the biggest problem with being a nurse today, up from 28% in 2003;
- 48% of RNs and 58% of Techs reported having experienced chronic pain associated with patient handling activities;
- 38% of RNs and 42% of Techs reported suffering an injury as a result of patient handling activities;
- 47% of RNs and 30% of Techs reported having considered leaving patient care during the past two years specifically because of the physical demands of their job.

In the same Peter Hart survey, 82% of RNs and 85% of Techs said they would support state regulations requiring hospitals to adopt safety programs that provide appropriate lift equipment and training.

Other studies have documented the impact of musculoskeletal injuries on the nursing shortage:

- 12% of nurses identified back pain as a contributory factor in their decision to "leave for good";
- 20% of nurses transferred to a different unit, position or employment because of low back pain, and 12% considered leaving the profession;
- 38% suffered occupational-related back pain severe enough to leave work;
- 6%, 8%, and 11% of RNs changed jobs for neck, shoulder and back problems, respectively.[40]

Manual patient handling also has negative consequences for quality of care, patient safety, and patient comfort, including fear; pain; damage to the shoulder from manual lifting techniques; hip fractures from being dropped; bruising of arms; loss of dignity during lifting procedures; increased dependency; skin tears and pressure area damage.[41]



The Financial Costs of Unsafe Working Conditions

Manual patient handling injuries have significant costs to the healthcare system as well, including workers compensation lost time and medical payments; lost productivity; costs related to replacing injured employees; training costs; overtime payments to remaining staff; administrative costs; liability costs related to patient injuries, and loss of morale among staff.

Research has established that implementing a Safe Patient Handling program, including the use of patient handling equipment, training on how to use the equipment, and institutional policies that limit manual lifting to emergent or life-threatening situations is the most effective strategy for reducing the injuries and costs associated with patient lifts and transfers.[42]

Several studies have shown that Safe Patient Handling programs are cost-effective as well, with facilities implementing these programs able to recoup the cost of equipment and training in under four years—even sooner if indirect costs are factored in.[43]

The Solution: Safe Patient Handling to Protect Workers and Patients

In New Jersey, HPAE is leading the fight for safe patient handling programs in hospitals.

HPAE is working with members of the New Jersey legislature on a bill that would set statewide standards for the creation of joint labor management committees to develop, implement and evaluate effective safe patient handling programs, including equipment purchase, training, and policies and protocols for patient lifts and transfers.

At the same time, HPAE is working with hospital managements to create Safe Patient Handling programs. Joint labor-management committees at a number of facilities are meeting with equipment vendors and beginning to develop policies and protocols. Several facilities are working with HPAE to develop grant-supported joint labor-management training on health and safety committees and safe patient handling.

In February 2006, HPAE hosted a Safe Patient Handling meeting with over 40 union and management participants from 8 HPAE-represented hospitals. Participants heard from leaders of a model program in Connecticut; learned about equipment financing options and about making "the business case" for safe patient handling, and got hands-on experience with state-of-the-art equipment.

"Two years ago I herniated discs in my lower back lifting the leg of a 600 pound patient. Had the proper equipment and adequate staff been available to adequately care for this patient, I most likely would not be in the situation I am now. After taking care of patients for 23 years, I am unable to provide the necessary care for my husband who is paraplegic. When we approached Cooper University Hospital, they agreed to work collaboratively with HPAE to help correct the problem of work related injuries. Together we have established goals through the Safe Patient Handling and Movement Task Force. By providing caregivers with the equipment and education necessary to move patients safely, the incidence of work related injuries will decrease dramatically and it will be extremely cost effective for the employer.
- Jean Lucas, RN

Assaults and Violence on the Rise

Assault and threatening behavior have become daily occurrences in our hospitals and health care facilities, jeopardizing not only the safety and security of healthcare workers, but also that of patients and visitors.

Caregivers are kicked, punched in the face, bitten, choked, hit with chairs and other objects, and threatened. The risk of violence in the healthcare workplace is on the rise, due to:

- Increasing numbers of patients frustrated by long waits for care and other barriers to prompt access;
- Understaffing; and
- The increasing presence of gang members, drug or alcohol users, trauma patients and distraught family members.[44]

In a 2005 survey of 11,000 HPAE members, more than 30% of respondents reported being physically or verbally assaulted or threatened on the job in the past 5 years. In a 2006 Peter Hart national survey of hospital-based Registered Nurses and Radiology Technologists commissioned by the American Federation of Techers, 52% of Registered Nurses and 31% of Techs reported having personally experienced violence or physical harassment from patients or their families.

The incidence of injury from nonfatal assaults among health care workers is more than four times the rate among private sector workers overall,[45] although it is widely acknowledged that violent incidents are seriously underreported, due in part to the persistent perception within the health care industry that assaults are part of the job.

"We have had the two recent issues of violence against nurses. I think it happens more often than we realize and I think lack of security, lack of proper staff and lack of proper training adds to the problem. We are trying so hard to treat our patients as guests or customers we have forgotten how to keep our staff safe. I'm hopeful that our union's program on violence prevention will help our staff and management address the problem. "
- Pam Reinhardt, RN

Violence in health care facilities thwarts the recruitment and retention of staff; creates additional costs for health care facilities, including workers compensation costs, disruption to operations, legal expenses, and property damage; and destroys the trust our patients should have in the safety of their hospital or nursing home.

Solution – Legislation and Public Policy

In New Jersey, HPAE is leading the fight for violence prevention in healthcare facilities. With no federal or state laws or regulations to prevent workplace violence, HPAE is looking to the state legislature and collective bargaining to address the issue. Working with members of the state legislature, HPAE is supporting legislation that would set statewide violence prevention standards for healthcare facilities.

These standards include the creation of joint labor management violence prevention committees, ongoing risk assessment, improved security and – where necessary – additional security personnel, and other plans to improve reporting of workplace violence and increase overall safety, for patients and staff, in healthcare facilities.

HPAE is also working with hospital managements to improve safety for caregivers and patients, including arranging for crisis intervention training for staff that regularly work with combative patients, and participating in a task force addressing various aspects of caregiver and patient safety

Conclusion

Nursing and health professionals were among the first to recognize the dangers of putting patient care decisions in the hands of insurance companies and for-profit health systems. The result has been a widening lack of access to affordable and safe patient care provided by qualified staff.

The current and growing staffing shortages in our hospitals are not caused by a lack of healthcare professionals – in New Jersey alone there are 20,000 Registered Nurses who are currently not practicing their profession. The crisis in staffing is caused by a growing unwillingness of nurses and healthcare professionals to work under the conditions prevailing in hospitals around the state and around the nation.

When it comes to staffing in healthcare, many studies have been done, much research completed, many conclusions drawn. The crisis is significant and getting worse. What matters now is what we do next.

As concerned healthcare professionals, who understand what it's like to work in hospitals and who know what it would take to keep experienced caregivers at the bedside, we have five recommendations.

These recommendations come from those who know firsthand the reasons why they stay in the profession: to serve the public, to care for and heal their patients. Without these changes, we will continue to lose our best nurses and caregivers, and it will be our patients who will pay the heaviest price.

RECOMMENDATIONS

- ONE, provide access to quality health care through increased funding and coverage for the uninsured;
- TWO, increase support for our health care institutions – and hold them accountable for expenditures of public dollars;
- THREE, ensure that all hospitals are staffed with adequate numbers of appropriately trained and qualified nursing and health care staff;
- FOUR, improve policies to recruit and retain experienced healthcare staff through fair compensation and retirement security;
- FIVE, prevent injuries and illness to both health care workers and their patients through health and safety programs at all health care institutions.

Endnotes

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Appendix

A Summary of Recent Research Supporting the Need for Staffing Ratios and Workload Limitations in Healthcare.
AFT Healthcare, March 2003

Effect of nurse staffing on mortality rates and other patient outcomes.

- After adjusting for patient and hospital characteristics, each additional patient per nurse was associated with a 7% increase in the likelihood of patients dying within 30 days of admission and a 7% increase in failure to rescue. (Aiken, Linda et. al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction," Journal of the American Medical Association, Vol. 288, No. 16, October 23/30, 2002, pps. 1987-1993.)

- A study of medication errors in two hospitals over a 6-month period found that nurses were responsible for intercepting 86 percent of all medication errors made by physicians, pharmacists and others involved in providing medications for patients before the error reached the patient. (Leape, L. et. al, "Systems analysis of adverse drug events." Journal of the American Medical Association 274 (1): 35-43)

- Nurse staffing is a predictor of risk-adjusted mortality. In studying 2190 hospitals, it was found that 10.7% of the variance in patient mortality was explained by nurse staffing ratios. ("A Matter of Life and Death," Modern Healthcare, Special Supplement, September 30, 2002, pps. 16-20.)

- Nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors. (Joint Commission for the Accreditation of Healthcare Organizations, 2002.)

- Study found a ten percent increase in the proportion of RNs as a percentage of total hospital staff was associated with five fewer patient deaths for every 1000 discharged patients. (Tourangeau, Ann E., et. al., Nursing-Related Determinants of 30-day Mortality for Hospitalized Patients, Canadian Journal of Nursing Research, 2002, vol. 33., No. 4, 71-88.)

- Seventy percent of radiology techs, seventy-nine percent of respiratory therapists and seventy-one percent of certified nurse assistants say that the quality of patient care is suffering because of increased workloads or poor staffing in their professions. (National Survey. Peter D. Hart Research Associates, April 2002)

- In a study of data from eleven states, higher nurse staffing levels were related to lower instances of urinary track infections, pneumonia, upper gastrointestinal bleeding and shock in medical patients and lower rates of "failure to rescue" in major surgery patients. (Needleman, J.; Buerhaus, P.; Mattke, S; Stewart, S.; and Zelevinsky, K. Nurse Staffing and Patient Outcomes in Hospitals. U.S. Department of Health and Human Services: February 2001.)

- Higher nurse:patient ratios were strongly associated with lower mortality rates in dedicated AIDs units. Patient satisfaction was strongly associated with organizational control of care by bedside nurses. (Aiken, L.H.; Sloane, D.G.,;Lake E.T.; Sochalski, J.; and Weber A.L. Organization and outcomes of inpatient AIDS care. Medical Care, 37(3): 760-772, 1999.)

- More nursing hours and higher skill mix are related to lower rate of pressure ulcers, pneumonia and urinary tract infections. (Lichtig, L.K.; Knauf, R.A.; and Milholland, K. Some impacts of nursing on acute care hospital outcomes. J of Nursing Admin, 29(2): 25-33, 1999.)

- Mortality rates decrease as staffing levels per occupied bed increase for registered nurses, medical residents, registered pharmacists, medical technologists and total hospital personnel. (Bond, C.A., et al. Health care professional staffing, hospital characteristics and hospital mortality rates. Pharmacotherapy, 19(2), 1999.)

- The higher the percentage of RNs, the more satisfied patients were with nursing care, pain management, education and overall care. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)

- An ICU nurse:patient ratio of less than 1:2 during evenings was associated with increased length of stay in the

hospital. An ICU nurse:patient ratio of less than 1:2 during the day was associated with increased number of days in the ICU. (Pronovost, P.J. et.al. Organizational characteristics of intensive care units related to outcomes of abdominal aortic surgery. Journal of the American Medical Association, 281(14), 1999.)

- The more FTE RNs per adjusted patient day, the smaller the incidence of urinary tract infections and pneumonia after major surgery. A significant relationship was also found between FTE RNs and thrombosis and pulmonary compromise after major surgery. (Kovner, C. and Gergen, P.J. Nurse staffing levels and adverse events following surgery in U.S. hospitals. Image: J of Nursing Scholarship, 30(4), 1998)

- The higher the RN skill mix (up to 87.5% RNs) the lower the incidence of adverse occurrences (medical errors, patient falls, skin breakdown, patient and family complaints, respiratory and urinary tract infections, and deaths.) (Blegen M.A.; Goode, C.J.; and Reed, L. Nurse staffing and patient outcomes. Nursing Research, 47(1): 4350, 1998. Also: Blegen M.A. and Vaughn, T. A multisite study of nurse staffing and patient occurrences. Nursing Economics, 16(4): 96, 1998.)

- In a study of data from three states (NY, CA and MA), researchers found that as RN staffing increased, the number of patients suffering from pressure ulcers decreased. A higher proportion of RNs was also significantly associated with lower length of stay. (American Nurses Association. Implementing Nursing's Report Card: A Study of RN Staffing, Length of Stay and Patient Outcomes. Washington, DC: American Nurses Publishing. 1997)

- Increasing patient census and decreasing nursing hours per patient day are strongly correlated with increased nosocomial infection rates. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-8, 1997.)

- Hospitals with higher RN:patient ratios and a higher percentage of RNs had lower than predicted patient mortality rates. (Aiken, L.; Smith H.; and Lake, E.T. Lower Medicare mortality among a set of hospitals known for good nursing care. Medical Care, 32(8): 771-787, 1994.)

- Hospitals with a higher proportion of RNs had lower severity-adjusted mortality rates. (Krakauer H.; Bailey R.C.; Skellan, K.J.; Steward J.D.; Harts A.J.; Kuhn, E.M.; and Rimm, A.A. Evaluation of the HCFA model for the analysis of mortality following hospitalization. Health Serv Res, 27(3): 317-35, 1992.)

- The percentage of RNs per adjusted admissions was a significant predictor of lower mortality. (Manheim, Larry M. et. al. Regional Variations in Medicare Hospital Mortality. Inquiry 29:55-66, Spring, 1992)

- Patients on units where staffing fell below computed requirements had higher incidences of clinical complications (infections, gastrointestinal, neurologic) (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998. Also: Behner, K.G.; Fogg, L.; Frankenbach, J. and Roberston, S. Nursing resource management: Analyzing the relationship between costs and quality in staffing decisions. Health Care Management Review, 15 (4): 63-71, 1990.)

- Hospitals with a higher percentage of RNs and hospitals with a higher staffing level (measured by nurse-to-patient ratio), had lower adjusted mortality rates. (Hartz, A.J.; Krakauer, H.; Kuhn, E.M.; Young, M.; Jacobsen, S.J.; Gay, G.; Muenz, L.; Katzoff, M.; Bailey, R.C.; and Rimm, A.A. Hospital characteristics and mortality rates. New England Journal of Medicine, (321): 1720-25, 1989.)

- Hospitals with better-than-predicted death rates demonstrated respect for nursing judgment wherein it was a routine policy for the unit charge nurse to cancel major elective surgery if nursing staff was inadequate. (Knaus, W. et. al., An Evaluation of Outcome from Intensive Care Units in Major Medical Centers., Canadian Critical Care Nursing Journal, June/July, 1987.)

Working conditions affect patient care.

- ICU mortality rates were highest when the ICU staff was "overworked" as defined by the level of occupancy in the ICU and the average number of nurses per occupied bed. The mortality rate was significantly lower in

patients who were treated during times of moderate workload. (Tarnow-Mordi, W.O.; Hau, C.; Warden, A.; and Shearer, A.J. Hospital mortality in relation to staff workload: A 4-year study in an adult intensive care unit. The Lancet, 356(9225): 185, 2000.)

- Higher rates of patient falls occurred when nurses reported more stress and more absenteeism. (Dugan, J.; Lauer, E.; Bouquot, Z.; Dutro, B.K.; Smith, M.; and Widmeyer G. Stressful nurses: The effect on patient outcomes. J Nurs Care Quality, 10(3): 46-58, 1996.)

- The less satisfied nurses were with the time they had to do their work, the more likely a patient was to develop a nosocomial infection. (Moore, K.; Lynn, M.R.; McMillen, B.J.; and Evans, S. Implementation of the ANA report card. J of Nursing Admin, 29(6): 48-54, 1999.)

- Admission during a period with a lower regular nurse-to-patient ratio and a higher pool nurse to patient ratio was associated with increased risk for bloodstream infection. (Robert, J.; Fridkin, S.K.; Blumberg, H.M.; Anderson, B.; White, N.; Ray, S.F.; Chan J.; and Jarvis, W.R. The influence of the composition of the nursing staff on primary bloodstream infection rates in a surgical intensive care units. Infection Control and Hospital Epidemiology, (21): 12-17, 2000.)

Improving patient outcomes by staffing correctly leads to lower costs.

- Statistical model shows that when nursing units are understaffed the additional costs associated with patients who develop complications are greater than the labor savings due to understaffing. (Behner, K.G.; Fogg, L.F.; Fournier, L.C.; Frankenbach, J.T.; and Robertson, S.B. Nursing resource management: Analyzing the relationship between between costs and quality in staffing Decisions. Health Care Manag Rev, 15(4): 63-71, 1990.)

- While immediate personnel costs are less with short staffing, long term costs were higher because patients with complications often stay longer in the hospital and require other expensive treatments. (Flood, S.D. and Diers, D. Nurse staffing, patient outcome and cost. Nursing Management, 19(5): 34-43, 1998.)

- Institutions attempting to decrease costs through health care worker reductions may, in the final analysis, incur higher costs as a result of higher rates of nosocomial infection, longer hospital stays and use of expensive antimicrobials and increased mortality. (Archibald, L.K.; Manning, M.L.; Bell, L.M.; Banerjee, S.; and Jarvis, W.R. Patient density, nurse-to-patient ratio and nosocomial infection risk in a pediatric intensive care unit. Ped Infectious Dis J, 16(11): 1045-48, 1997.)

Staffing ratios and workload limitations help recruit and retain registered nurses and other health professionals.

- Applications for registered nurse licenses in the state of California increased over 60% in the three years after passage of the nurse-patient ratio law. (Sacramento Business Journal, 1/19/04)

- Hi-Desert Hospital in Joshua Tree, CA went from fifty percent vacancy rate in its nursing staff to one percent vacancy rate six months after establishing ratios of 1:4 on day shift and 1:5 on second shift. ("A Favorable RN-to-Patient Staffing Ratio is an Effective Recruitment Tool," Patient Care Staffing Report, October, 2001.)

- Each additional patient per nurse (above 4) is associated with a twenty-three percent increase in the odds of nurse burnout and a fifteen percent increase in the odds of job dissatisfaction. (Aiken, Linda, et. Al. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction." Journal of the American Medical Association, October 23/30, 2002)

- Ninety-one percent of certified nurse assistants, seventy-eight percent of respiratory therapists and sixty-eight percent of radiology techs say that improving staffing ratios would help recruit and retain members of their profession. (Peter D. Hart Research Associates, April, 2002)

- In a national survey of nurses, eighty-three percent of respondents said that improving staffing ratios would "very effective" in improving job satisfaction, recruiting and retaining quality nurses. (Peter D. Hart Research Associates, March, 2001)

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