SAFE STAFFING FACT SHEET

New York patients are at risk. Healthcare administrators are forcing nurses to take on 9, 10, or even more patients at once.

There is a solution: legislated safe nurse-to-patient ratios. Safe nurse ratios save lives – and can help save money for our healthcare system. NYSNA supports legislation that will require all acute care facilities to meet minimum nurse-to-patient staffing ratios. The bill would also require all residential healthcare facilities to comply with minimum care hours for registered nurses, licensed practical nurses and certified nurse aides.

1 Safe Staffing Saves Lives

- The number of patients assigned to a nurse has a direct impact on our ability to appropriately assess, monitor, care for and safely discharge our patients.
- Outcomes are better for patients when staffing levels meet those established in California. Research demonstrates lives are saved, quality of care is improved and hospital stays are shorter in other states, when hospitals meet the CA staffing benchmarks (*Health Services Research,* 2010).
- Hospitals which routinely staff with 1:8 nurse-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse-to-patient ratios (*Journal of the American Medical Association*, 2002).
- The odds of patient death increases by 7% for each additional patient the nurse must take on at one time (*Journal of the American Medical Association*, 2002).

2 Safe Staffing Reduces Adverse Patient Outcomes in Hospitals and Nursing Homes

- When registered nurse staffing is increased by only 5%, the number of adverse events, including pressure ulcers, catheter-associated urinary tract infections, hospital-acquired injuries, air embolism, blood incompatibilities, vascular catheter-associated infections and mediastinitis following coronary bypass graft, are reduced by 15.8% (*Quality Management in Health Care*, 2010).
- Hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrest, urinary tract infections and upper gastrointestinal bleeds; all leading to longer hospital stays, increased post-surgical 30-day mortality rates and increased rates of failure-to-rescue, i.e. death of a surgical patient following a hospital-acquired complication (*Agency for Healthcare Research and Quality Pub. No. 04-0029*, 2004).
- In nursing homes, safe nurse staffing levels have a positive impact on both facility processes and on resident outcomes, for example, fewer facility deficiencies for poor quality and improved functional status of the residents (*Health Services Research*, 2012).
- There is a correlation between unsafe staffing and high nurse turnover and in nursing homes, research has also shown that as nurse turnover increases, the quality of resident care declines which results in more frequent use of restraints, urinary catheterization, and psychoactive drugs; increased risk of contractures, pressure ulcers and other adverse patient outcomes (*Gerontological Nursing,* 2008).

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SAFE STAFFING FACT SHEET

3 Safe Staffing is a Cost-Effective Way to Improve Patient Care and Can Lead to Savings for Hospitals and our Healthcare System

- In California, hospital income rose dramatically after ratios were implemented, from $12.5 billion from 1994 to 2003, to more than $20.6 billion from 2004 to 2010. Not one California hospital closed because of ratio implementation.
- When compared to other 'life-saving' interventions, nurse staffing is a cost-effective way to improve patient care (*Nursing Administration Quarterly,* 2011).
- Safe nurse staffing reduces turnover in hospitals. Inadequate staffing levels are correlated with nursing turnover and poor patient satisfaction. These costs and the negative consequences of poor staffing increase the cost of care (*Nursing Administration Quarterly,* 2011).
- The average cost to replace an RN ranges from approximately $82,000 (if turnover vacancies are filled by experienced RNs who need fewer hours of training) to $88,000 (if vacancies are filled by new RNs who need more hours of training) (*The Journal of Nursing Administration,* 2008).
- Nurse understaffing in hospital intensive care units increases the risk of pneumonia and other preventable infections that can add thousands of dollars to the cost of care and may lead to avoidable deaths. Hospital-acquired pressure ulcers alone are estimated to cost $8.5 billion per year. (*Agency for Healthcare Quality and Research Pub. No. 04-0029,* 2004).
- The Centers for Medicare and Medicaid Services is reducing or eliminating payments for care after adverse events including: hospital-acquired infections, pressure ulcers, falls and avoidable re-admissions. This year, hospitals begin experiencing the effect of Medicare's new Value-Based Purchasing program, with more than 1,400 getting penalized based on quality of care (CMS.gov, 2013).

4 Research Establishes Ratios and Hours of Care

- The hospital nurse-to-patient ratios specified in the Safe Staffing for Quality Care Act are based on peer-reviewed academic research, evidence-based recommendations from scholarly entities and lessons learned from California's experience implementing nurse staffing ratios. The minimum care hours specified for nursing homes are also based on research evidence and the recommendations of the Institute of Medicine's report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004).

Proposed Ratios

These ratios are specified in the current version of the Safe Staffing for Quality Care Act

Unit	Ratio
All intensive care	1:2
Emergency critical care	1:2
Trauma emergency unit	1:1
Operating room	1:1
Post-anesthesia care	1:2
Labor – stage 1	1:2
Labor – stages 2 & 3	1:1
Antepartum	1:3
Non-critical antepartum	1:4
Newborn nursery	1:3
Intermediate care nursery	1:3
Postpartum couplets	1:3
Postpartum mother-only	1:4
Well-baby nursery	1:6
Pediatrics	1:3
Emergency department	1:3
Step-down & telemetry	1:3
Medical/surgical	1:4
Acute care psychiatric	1:4
Rehabilitation units	1:5