Safe Staffing Fact Sheet

Amidst a global pandemic, healthcare administrators are forcing nurses and caregivers to take on 9, 10, or even more patients at once. Assigning nurses and caregivers too many patients to care for puts patients at risk.

The solution is a safe minimum staffing standard to which hospitals are held accountable. Safe staffing saves lives—and can help save our healthcare system money.

1 Safe Staffing Saves Lives

- The number of patients assigned to a nurse and caregiver 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 the benchmarks established in California. Research demonstrates lives are saved, quality of care is improved and hospital stays are shorter *(Health Services Research, 2010).*
- A direct correlation has been found between poor staffing and higher COVID-19 fatality rates in New York nursing homes *(Nursing Homes' Response to COVID-19 Pandemic, 2021).*
- Hospitals which routinely staff with 1:8 nurse- and caregiver-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse- and caregiver-to-patient ratios *(Journal of the American Medical Association, 2002).*
- The odds of patient death increases by 7% for each additional patient the nurse and caregiver 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 and caregiver 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 and caregiver 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 staffing standards 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 and caregiver turnover. In nursing homes, research has shown the quality of resident care declines as staff turnover increases, resulting 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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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 safe staffing standards 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 and caregiver staffing is a cost-effective way to improve patient care. *(Nursing Administration Quarterly, 2011)*
- Safe staffing reduces turnover in hospitals. Inadequate staffing levels are correlated with staff turnover and poor patient satisfaction. The average cost to replace an RN ranges up to $88,000. *(Nursing Administration Quarterly, 2011; The Journal of Nursing Administration, 2008)*
- Safe staffing in hospital intensive care units saves lives. A nurse-to-patient ratio of 1 RN to 1.5 patients (or less) is independently associated with a lower risk of in-hospital death. Higher nursing care hours per ICU patient day significantly contribute to prevention of Central Line-Associated Bloodstream Infections. *(Critical Care Medicine, 2014; Nursing Care, 2013)*
- When regular (non-overtime) staffing is higher on a unit, patients report higher quality discharge teaching and are less likely to be readmitted within 30 days—saving patients and their insurers $608 per patient hospitalized. *(Health Services Research, 2011)*
- Increased staffing helped hospitals reduce penalties for avoidable readmissions. For Medicare patients with heart attacks, heart failure or pneumonia, this study found hospitals with high nurse and caregiver-staff ratios had 25% lower odds of being penalized and 41% lower odds for the maximum penalty for readmissions by CMS *(Centers for Medicare & Medicaid Services). (Health Affairs, 2013) based on quality of care (CMS.gov, 2013).*

4 Research Establishes Minimum Standards and Hours of Care

- The hospital minimum nurse-to-patient staffing standards are based on peer-reviewed academic research, evidence-based recommendations from scholarly entities and lessons learned from California's experience implementing nurse and caregiver 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

The nurse-to-patient ratios specified are predicated upon maintenance of essential direct care partners of the interdisciplinary team. Existing practice and patterns of staffing of LPNs, CNAs, PCTs and other direct care personnel shall not be reduced in the implementation of the RN to patient ratios.

Higher acuity in many hospital units dictates additional essential direct care partners and therefore each staffing plan shall include all members of the interdisciplinary direct care teams. The Commissioner, New York State Department of Health, shall issue regulations and minimum direct care staff to patient ratios necessary to support the provision of quality care.

Below are the specific nurse-to-patient ratios.

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—Stage 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

Nursing Homes/Residential Health Care Minimum of Hours of Patient Care Per Patient Per Day (HPPD)	
Certified Nurse Aides	2.8 hours
LPN or RN	1.3 hours
Of which RN minimum	0.75 hours