NEW YORK STATE PUBLIC EMPLOYEES FEDERATION

RESPONSE TO NEW YORK STATE DEPARTMENT OF HEALTH INQUIRY ON NURSE STAFFING RATIOS

11/1/2019

Proposals on staffing ratios and best practices for safety and quality care

On July 15, 2019 a team of New York State Public Employees Federation (PEF) nurses and staff were interviewed by the Department of Health as a part of its charge by Governor Cuomo to study a need for New York State to adopt safe nurse staffing ratios. The following recommendations are offered by PEF:

Preferred plan for mandatory staffing ratios in hospitals and nursing homes:

PEF supports **the following proposed staffing ratios plan. The ratios set a floor, not a ceiling. Facilities should be required to make a staffing plan that addresses changes in patient acuity by staffing as patient needs dictate. The ratios are the maximum number of patients assigned to any RN "at all times" during a shift – not an average.**

1. **<u>Proposed/preferred minimum staffing levels by unit type</u>**

- Trauma Emergency 1:1
- Operating Room 1:1
- All Intensive Care 1:2
- Emergency Critical Care 1:2
- Post Anesthesia Care 1:2
- Labor – 1st Stage 1:2
- Labor – 2nd & 3rd Stage 1:2
- Antepartum 1:3
- Non-critical Antepartum 1:4
- Newborn Nursery 1:3
- Intermediate Care Nursery 1:3
- Post-partum Couplets 1:3
- Post-partum mother – only 1:4
- Well-baby Nursery 1:6
- Emergency Department 1:3
- Step-down & Telemetry 1:3
- Pediatrics 1:3
- Medical/Surgical 1:4
- Acute Care Psychiatric 1:4
- Rehabilitation & Sub-Acute 1:5

Additional ratios for Medical/Surgical services are 1:4

- Unit of 20 patients = 5 RNs. This will allow one RN to provide coverage for 2.5 hours of lunch breaks.

- Unit of 16 patients = 4 RNs + 2 hours coverage for lunches; 1 RN covers for 2 hours
- No coverage is needed for 15 minute breaks

"AT ALL TIMES" – Best Practices for Safe Staffing and Quality Patient Care

The Long Island Stony Brook Medicine facility has 603 beds and 22 Operating Suites in their main Operating Room Department and one suite off site in the Cardiology Department. Douglas Begent is a Teaching and Research Center Nurse 3 (Clinician and OR Scheduler) who is a member of the team leadership that orchestrates the daily functions. Doug is a co-designer of a "**Daily Room Assignment Sheet"** (see attached). This chart is a layout of the role each nurse plays in each specific operating room; when they are scheduled to take a morning break, a lunch break and who will cover them.

HOURS OF OPERATION

- 22 rooms are scheduled to run from 0700 to 1700
- 16 rooms are scheduled to run from 1700 to 1900
- 12 rooms are scheduled to run from 1900 to 2100
- A skeleton crew is in house from 2100 to 0700 – surgeries are scheduled to be finished by 9p and rarely will have one that is prolonged into the night. There is coverage for urgent or emergent situations.
    - 2100 to 2300 - 2 teams (to work two operating rooms) are available
    - 2300 to 0700 – 0 to 2 teams may be available

NOTE: On-call nurses are ready to return to the hospital within 20 to 30 minutes when more hands are needed. The Operating Room is a closed unit – no one floats in; no one floats out

STAGGERED HOURS

Nurses work 8 hour shifts, 10 hours shifts and 12 hours shifts. They can be:

0700 to 1500
0700 to 1700
0700 to 1900
0900 to 1700
0900 to 1900
1900 to 0700

0700 - Staffing to start the day is about 48 registered nurses capable of scrubbing in or circulating. This number has an 8% to 10% cushion for the 2 -4 daily sick calls and other unscheduled absences; or if someone has to leave before the shift is over. Not counted in the direct care numbers are 3-4 educators available for staff assistance and 10 T&R 3's who, in

addition to their administrative responsibilities, will do direct care if needed for unanticipated traumas and other emergencies.

0900 – 5 nurses arrive to work and begin covering 15 minute morning breaks. This may take two hours and then they begin to cover 45 minute lunch breaks. These nurses also have room assignments themselves and will begin to relieve nurses who may be exiting for various reasons.

Additional staff in the room can be Teaching and Research Center Nurses in training. They are not counted in the numbers.

2. **Proposed/preferred minimum staffing levels in "O" agencies which include:**

   - the Office of People With Developmental Disabilities (OPWDD)
   - the Office of Alcohol and Substance Abuse (OASAS)
   - the Office of Mental Health (OMH)
   - the Office of Children and Family Services (OCFS)
   - the Department of Corrections and Community Services (DOCCS)

Ensuring proper RN staffing levels on inpatient units and wards is vital, given increasing severity of illness of institutionalized patients and the mounting evidence that nurse staffing levels influence outcomes. The risk for adverse outcomes rise as the ratio of patients to nursing staff increases. Aligning staffing based on patient needs and acuity is an important consideration for risk mitigation and safety (Delaney & Johnson, 2006). Patient acuity is determined at the unit level by evaluating the patient's status against defined criteria or patient attributes – factors that have historically required higher or lower levels of care. The impact of patient acuity on staffing needs also varies according to unit flow (admissions and discharges), unit location, and unit function. Patient acuity is not static but must be reevaluated routinely through the shift to ensure that staffing is appropriate to meet the needs of the patient population (1).

It is PEF's position that all wards and units should have a minimum of two RN's plus ancillary staff. For group homes the ratio should be 1:20 and 1:15 for family care, depending on the acuity, age and geographic location of the individuals.

3. ***PEF*** **recommends the support of legislation that strengthens Labor Law 167 "Restrictions on Consecutive Hours of Work for Nurses".**

   "A large body of literature has demonstrated that extended-work duration results in healthcare worker fatigue. Fatigue-related cognitive impairment, in turn, has been linked to adverse events and errors for patients and for healthcare workers. Analyses here suggest that working more than 40 hours per week and working voluntary paid overtime are both significantly related to adverse events and errors in patients and nurses. In this study of 11,516 Pennsylvania RNs, reports of falls, nosocomial infections,

and work injuries were all associated with greater length of average work-work; however, the likelihood of reporting occasional or frequent medication errors and at least one needle stick injury in the past year had the strongest and most consistent relationships with the work hour and voluntary paid overtime variables." (2)

Overtime is an important issue because it has implication for the safety of both patients and nurses. When the quality of life for nurses is constant fatigue and their license is in jeopardy, many will not make long term commitments to their employer. Overtime use as a staff supplement undermines a mission of providing safe care by skilled practitioners. New York State agencies violate the Labor Law with excessive mandatory overtime. Some have resorted to mandating people from home and pre-scheduling mandatory overtime. (See Addendum for overtime use in two agencies B).

(1) https://www.apna.org/files/public/StaffingPositionStatement_Full_JAPNA.pdf

APNA Position Statement: Staffing Inpatient Psychiatric Units
Journal of the American Psychiatric Nurses Association 2012 18: 16

(2) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2910393/

The Effect of Work Hours on Adverse Events and Errors in Health Care
Danielle M. Olds and Sean P. Clarke

On-Call For a Staffing Supplement not a Staffing Replacement!

PEF recommends On-Call use as defined in our Collective Bargaining Agreement with New York State:

STANDBY ON-CALL ROSTERS

"Nurses who are required to be available for immediate recall and who must be prepared to return to duty within a limited period time shall be listed on standby on-call rosters. Recall assignments from such rosters shall be equitably rotated, insofar as it is possible to do so, among those employees qualified and normally required to perform the duties. Compensation to standby will be equal to a percentage of the daily rate for each 8 hours or part thereof that the employee is scheduled to remain and do remain available for recall. In the event the employees are actually recalled to work, they will receive appropriate overtime for recall compensation as provided by law. Employees who are recalled from a standby roster shall not be assigned "make-work" during such recall.

The use of on-call rosters make sense to supplement a critical service that is faced with unforeseen spikes in patient acuity, i.e. multiple trauma patients come into the ER or an emergency need for cardiac catherization when staff is already occupied. On-call is meant to be

used for specific coverage for specific units and departments and should be used on a regular basis for staffing shortages.

PEF's Position on the Nurse License Compact

After much discussion and weighing the pros and cons, the nursing leadership concludes that travel nurses are not the solution to staffing. It is a temporary fix at a higher cost than providing competitive benefits and a respectable wage. By doing this, the State will solve its recruitment and retention difficulties. The compact, while in theory seems like a great ides, it undermines the profession of nursing by costly privatization without a definitive solution to staffing. PEF supports New York State's continuance of established licensing standards and an investment in their own and recommends to DOH that membership in a compact not be sought after in New York State.