

# afl-cio<sup>MINNESOTA</sup>

## The HEAL Act

Healthcare workers are on the frontlines of the fight to improve care and working conditions in our hospitals and other care settings. These workers know that healthcare in Minnesota should be about taking care of each other.

Now, our healthcare system is suffering from a corporate greed crisis. While hospital CEOs take massive paychecks, they slash hospital staffing levels, charge patients more, and close clinics and hospitals in our communities. When workers speak up for patient safety and their own rights, they all too often they face management retaliation.

Lawmakers need to pass the Healthcare Employee Anti-Retaliation and Labor (HEAL) Act (HF4200) this year to guarantee protections against retaliation for healthcare workers and include those care workers in the conversation about how to improve safe patient care in our care settings. The HEAL Act would:

### Protect workers from retaliation

When healthcare executives cut staff levels, care conditions worsen for patients. But when care workers raise these concerns, they often face retaliation, including unfair scheduling, being sent home without pay, or being denied time off. Healthcare workers seek protections when they take action to hold hospital executives accountable to safe patient care, while codifying protections against discrimination in care delivery.

### Include workers' voices to improve patient outcomes

Care workers are the ones by patients' sides every day in our hospitals; when patients experience adverse events like bedsores or falls, often due to low staffing levels by executives, those bedside care workers need to be included in the process and protected in discussions about what went wrong and why to improve patient care going forward.

Minnesota lawmakers made historic steps forward for working people and families last year; **now lawmakers must guarantee protections for care workers on the frontlines of the fight to improve our healthcare system for workers, patients, and families.**



Chair and committee members:

As organizations representing the voices and concerns of more than 300,000 working Minnesotans, we are proud of the work our members do every day to keep our schools, our businesses, and our state running.

Our members are also the people who keep our healthcare system working for Minnesotans. When you or your loved one shows up to a hospital, nursing home, or other care setting, it is working Minnesotans who greet you at the door, make sure you have a sanitary room and nutritious meal, and provide the care at the bedside that allows you to heal and recover in your most vulnerable hours.

It is these workers who have made Minnesota's healthcare system one of the strongest in the nation. But too often, when workers raise their voices and speak up in the workplace to protect care and working conditions for all of us, they face retaliation from their managers and healthcare executives. That is why our workers urgently need S.F. 4444/H.F. 4200, the Healthcare Employee Anti-Retaliation and Labor (HEAL) Act, and why we ask for your support.

As healthcare executives continue to slash staff levels with their focus on executive compensation and the bottom line, the need for workers willing to speak up and refuse the race-to-the-bottom in healthcare has never been greater. Rather than work with their employees to adjust staffing levels, shift patients to even out assignments, or work assignments to protect care and working conditions, managers and executives lash out at workers and exacerbate the debilitating shortage of staff in our care settings.

Retaliation can be obvious, as when workers face termination or suffer open hostility from their supervisors; however, more often, retaliation takes place in subtle ways. When healthcare workers tell managers they need more staff to protect safe patient care, and all too often, those managers respond by sending that worker home without pay, leaving even fewer workers to care for more patients. Other times, managers refuse scheduling or leave requests, pass workers over for promotions, or blacklist workers from other job opportunities. Then, in the unfortunate cases when something does go wrong at the bedside, hospital managers and executives sit down to decide what happened – and who to blame – without those who were there and without being present on the floor themselves. Under such deteriorating working conditions, it is no surprise that workers are being driven from the care roles that they want to work in, and where they are desperately needed.

This retaliation has a silencing effect that puts us all at risk. If workers stay silent or leave their jobs because they are ignored and ostracized by their managers, patients are left to suffer the consequences alone. Quality care depends on workers who care. To keep workers at the bedside and in other vital roles in our care settings, we need to protect those workers who fight for us.

Thank you for your consideration of this important legislation, and we hope our 300,000 members can count on your support this legislative session.





March 12, 2024

Professional Distinction

Personal Dignity

Patient Advocacy

Senator Bobby Joe Champion, Chair  
Senate Committee on Jobs and Economic Development  
95 University Avenue W.  
St. Paul, MN 55155

Representative Jay Xiong, Chair  
House Workforce Development Finance and Policy Committee  
100 Rev Dr Martin Luther King Jr Boulevard  
St. Paul, MN 55155

Chair Champion, Chair Xiong, and Committee Members,

On behalf of the Minnesota Nurses Association (MNA), I am writing to you today to express MNA’s strong support for SF3588/HF3446, which would provide unemployment insurance eligibility for striking workers. As a labor union whose members have experienced extended strikes in the past, our 22,000+ members know exactly how important this is for workers who are forced to make the difficult decision to go on strike for reasons such as to address working conditions, patient safety issues, or worker benefits.

The right to strike is a key component to where labor unions get their power. Unfortunately, many workers are unable to even consider going on strike due to the impacts it would have on their family if the strike were to go on for weeks. This inability to engage in striking to improve working and patient conditions also tends to disproportionately impact BIPOC workers, as well as women – who make up the majority of MNA’s members. Heads of single-income families also tend to have nearly impossible financial hurdles to overcome for them to stand in solidarity with their colleagues. Ensuring that striking workers are eligible for UI benefits will provide more equitable bargaining and strength to go into a strike should it be necessary.

Additionally, this legislation would discourage the types of anti-worker efforts and wasteful spending that the major health systems deploy during strikes. For example, in 2016, Allina Health spent nearly \$105 million hiring temporary nurses – many of them from out-of-state – rather than negotiating in good faith at the bargaining table to avoid slashing worker benefits.

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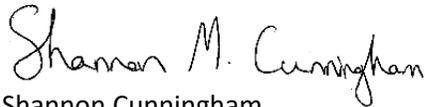


AFL-CIO

Our state and national economy have long been rigged in favor of corporations, including many of the tax-exempt (“nonprofit”) corporations – the big health systems – that have effectively taken over the state healthcare delivery system through mergers and other consolidation. Last session, the Minnesota Legislature took many steps forward to protect and expand workers' rights and protections in our state. These were big strides in rebalancing the major economic misalignment in our state, but we know more is needed.

Expanding UI benefits to striking workers would be a huge lift for workers and would provide more protection, and security, for anyone who is forced to make the difficult decision – a decision no one ever *wants* to make – to go on strike. We hope that members of the committees, and all legislators in both chambers, will support this important piece of legislation.

Sincerely,

A handwritten signature in black ink that reads "Shannon M. Cunningham". The signature is written in a cursive, flowing style.

Shannon Cunningham  
Director of Governmental and Community Relations  
Minnesota Nurses Association

# A Quantitative Study on the Factors that Promote and Hinder Nurses Willingness to Report Wrongdoing to Healthcare Leadership.

<b>Authors:</b>	Azhari, Reem
<b>Source:</b>	Chicago School of Professional Psychology 2014; Ph.D. 122 p-122 p. (1p)
<b>Publication Type:</b>	Doctoral Dissertation - research
<b>Language:</b>	English
<b>Major Subjects:</b>	Leadership Nurse Attitudes Patient Advocacy Whistle Blowing
<b>Minor Subjects:</b>	Human; Quantitative Studies; Registered Nurses; Summated Rating Scaling; Survey Research
<b>Abstract:</b>	<p>As healthcare becomes more complex, patients need nurses who can advocate for their safety. This quantitative study on patient advocacy sought to understand if significant relationships existed amongst factors contributing to nurses' willingness to report wrongdoing. Factors measured were management support, knowledge of the reporting process, and experiencing and witnessing retaliation after reporting wrongdoing. Three hundred and forty one nurses from the Association of Perioperative Registered Nurses (AORN) were surveyed using a 45 question survey consisting of closed ended questions, as well as Likert-type statement questions. Inferential statistical data analysis was performed and confirmed that significant relationships do exist amongst the factors measured. Due to these findings this study may be used to further explore empirical evidence linking those factors to nurses' willingness to report wrongdoing. The outcomes of this study also confirm that healthcare leadership must focus on increasing emotional intelligence as well as the communication strategies of their healthcare leadership teams. This is evident in the data showing that nurses know how to report wrongdoing, yet fear doing so due to lack of confidence on the part of their management team as well as fears of retaliation. Further studies may be warranted in the area of patient advocacy to determine if this data can be replicated across a multi-cultural and multi-generational workforce.</p>
<b>ISBN:</b>	9781321176483
<b>Document Number:</b>	UMI Order AAI3636182

**Entry Date:** 20150206

**Revision Date:** 20150923

**Accession Number:** 109774691

# Barriers to Speaking Up About Patient Safety Concerns.

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**Source:** Journal of Patient Safety (J PATIENT SAF), Dec2020; 16(4): e230-e234. (5p)

**Publication Type:** Journal Article - research, tables/charts

**Language:** English

**Major Subjects:** Patient Safety  
Communication  
Organizational Culture  
Teamwork  
Nurse Attitudes  
Attitude of Health Personnel

**Minor Subjects:** Human; Descriptive Statistics; Nursing Staff, Hospital -- Psychosocial Factors; Medical Staff, Hospital -- Psychosocial Factors; Surveys; Leadership; Multimethod Studies; Qualitative Studies; Quantitative Studies; Coefficient alpha; Thematic Analysis; Content Analysis; Male; Female; Fear; Feedback; Occupational Safety

**Abstract:** Objectives: We sought to examine the association between willingness of health-care professionals to speak up about patient safety concerns and their perceptions of two types of organizational culture (ie, safety and teamwork) and understand whether nursing professionals and other health-care professionals reported the same barriers to speaking up about patient safety concerns. Methods: As part of an annual safety culture survey in a large health-care system, we asked health-care professionals to tell us about the main barriers that prevent them from speaking up about patient safety concerns. Approximately 1341 respondents completed the anonymous, electronic survey. Results: A little more than half (55%) of the participants mentioned leadership (fear of no change or retaliation) and personal (ie, fear of negative feedback or being wrong) barriers concerning why they would not speak up about patient safety concerns. The remaining participants (45%) indicated they would always speak up. These findings about barriers were consistent across nurses and other health-care professionals. Safety culture (SC) and teamwork

culture (TC) scores were significantly more positive in those indicating they would always speak up (SC = 89%, TC = 89%) than in those who provided reasons for not speaking up (SC = 63%, TC = 64%) ( $t_{1205} = 13.99, P < 0.05$ , and  $t_{1217} = 13.61, P < 0.05$ , respectively). Conclusions: Health-care professionals emphasized leadership and personal barriers as reasons for not speaking up. We also demonstrated an association between not speaking up and lower safety and teamwork culture scores.

**Journal Subset:** Health Services Administration; Peer Reviewed; USA

**ISSN:** 1549-8417

**MEDLINE Info:** *NLM UID:* 101233393

**Entry Date:** 20201208

**Revision Date:** 20201208

**DOI:** [10.1097/PTS.0000000000000334](https://doi.org/10.1097/PTS.0000000000000334)

**Accession Number:** 147345722

Name

[REDACTED]

Personal Email

[REDACTED]

Facility

[REDACTED]

Date

02/2024

Unit

[REDACTED]

Shift

Evenings

Are you staffed via an electronic staffing program that predicts the staff necessary for your unit?

No

Person(s) Notified

Manager

Name of Person(s) Notified

[REDACTED]

What Response did the supervisor/manager give you?

Nursing supervisor was in support of us getting another nurse, but that has to be approved through the manager on call. Discussed situation w/ manager on call [REDACTED]. She moved it up the chain of command. Received a call back from manager that our request for another nurse was denied. Manager on call's response: We'll just have to make it work within our grid [with our current number of staff]; put down more fall mats and re-instate ROBS cameras (that were just weaned off earlier that day).

Did anyone attempt to discourage you from filling out this form?

No

Were you bullied regarding your concern for short /unsafe staffing?

No

RNs on duty

6

RNs scheduled

5

RNs needed

7

LPNs on duty

0

LPNs scheduled

0

LPNs needed

0

UAPs on duty

4

UAPs scheduled

4

#### UAPs needed

4

#### What made your shift unsafe?

- Too many patients/clients
- High acuity
- Charge nurse took patients over and above what staffing grid provides

#### How was the unsafe staffing situation rectified?

- It was not rectified
- Closed the unit to admissions
- Other (resolution)

#### Resolution Other

charge nurse took a 4 patient assignment for 12 hours

#### What impact did this have on patient care?

- Inability to answer call lights

#### What impact did this have on the nurse/s and other support staff?

- Nurse experienced increased stress
- Nurse experienced increased anxiety
- Nurse experienced fatigue
- Missed meal break

#### Action Taken

- Move up the chain of command with phone calls
- Refused the assignment
- Refused additional clients/visits

#### Additional Action Taken

- Notify nurses on the next shift

# BMJ Open Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study

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**To cite:** Lasater KB, Aiken LH, Sloane D, *et al*. Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study. *BMJ Open* 2021;**11**:e052899. doi:10.1136/bmjopen-2021-052899

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2021-052899>).

Received 27 April 2021

Accepted 09 November 2021



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## ABSTRACT

**Objective** To evaluate variation in Illinois hospital nurse staffing ratios and to determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals.

**Design** Cross-sectional analysis of multiple data sources including a 2020 survey of nurses linked to patient outcomes data.

**Setting:** 87 acute care hospitals in Illinois.

**Participants** 210 493 Medicare patients, 65 years and older, who were hospitalised in a study hospital. 1391 registered nurses employed in direct patient care on a medical–surgical unit in a study hospital.

**Main outcome measures** Primary outcomes were 30-day mortality and length of stay. Deaths avoided and cost savings to hospitals were predicted based on results from regression estimates if hospitals were to have staffed at a 4:1 ratio during the study period. Cost savings were computed from reductions in lengths of stay using cost-to-charge ratios.

**Results** Patient-to-nurse staffing ratios on medical-surgical units ranged from 4.2 to 7.6 (mean=5.4; SD=0.7). After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by 16% for each additional patient in the average nurse's workload (95% CI 1.04 to 1.28; p=0.006). The odds of staying in the hospital a day longer at all intervals increased by 5% for each additional patient in the nurse's workload (95% CI 1.00 to 1.09, p=0.041). If study hospitals staffed at a 4:1 ratio during the 1-year study period, more than 1595 deaths would have been avoided and hospitals would have collectively saved over \$117 million.

**Conclusions** Patient-to-nurse staffing ratios vary considerably across Illinois hospitals. If nurses in Illinois hospital medical–surgical units cared for no more than four patients each, thousands of deaths could be avoided, and patients would experience shorter lengths of stay, resulting in cost-savings for hospitals.

## INTRODUCTION

Despite substantial evidence that high registered nurse (RN) workloads are related to patient mortality—among other adverse patient outcomes<sup>1–4</sup>—no US states, except for California,<sup>5</sup> have implemented minimum

## Strengths and limitations of this study

- Study design, staffing and outcome measures are similar to previously published studies evaluating the link between nurse staffing and patient outcomes.
- Staffing measures collected as prepolicy implementation baseline data to quantify the scope of the variation in staffing within Illinois state, and the impact of staffing variation on the public's health.
- Patient-to-nurse staffing measures are derived directly from staff nurses on medical and surgical units.
- Patient outcomes are risk-adjusted 30-day mortality and hospital length of stay.
- The cross-sectional study design precludes causal statements about the relationship of nurse staffing and patient outcomes.

hospital nurse staffing requirements. While many US states have pursued legislation to regulate hospital nurse staffing levels, support for such regulation is dampened for three primary reasons: (1) lack of prepolicy data documenting significant variation of hospital nurse staffing ratios across the state debating staffing regulation, (2) lack of local, timely evidence demonstrating variation in nurse staffing adversely affects patient outcomes and (3) an underdeveloped business case to justify the fiscal investments required to staff greater numbers of nurses at the bedside.

In this study, we address each of these three concerns using 2020 data from a large sample of 87 hospitals in Illinois where legislation to mandate patient-to-nurse staffing ratios is actively being debated (HB 2604 *Safe Patient Limits Act*).<sup>6</sup> We project the number of deaths and hospital days that could be avoided, if Illinois hospitals staffed medical–surgical nurses at the 4:1 patient per nurse ratio proposed in the legislation. Because reductions in patient length of stays have economic implications



for hospitals, we estimate the potential cost savings to hospitals through reduced lengths of stay if hospitals moved to the 4:1 staffing ratio.

This is the first study to report local and timely evidence about staffing variation in a large sample of hospitals across Illinois, and the consequences of staffing variation for patient outcomes and costs of care to directly inform public policy efforts actively under consideration. The main objectives of this study are to evaluate variation in Illinois hospital nurse staffing ratios and to determine whether higher nurse workloads are associated with mortality and length of stay for patients, and cost outcomes for hospitals.

## Background

Nurses are the around-the-clock surveillance system of hospitals; closely monitoring changes in patients' clinical condition and administering treatments and care as appropriate. When nurses care for fewer patients at time, they are able to spend more time at each patient's bedside, and as a result, patients are less likely to experience an adverse outcome such as a hospital-acquired infection,<sup>7</sup> poor glycaemic control,<sup>8</sup> readmission<sup>9</sup> and even death.<sup>10–14</sup> The clinical benefits of nurse staffing have primarily been studied in adult medical and surgical populations, but have also been observed in special populations including babies in neonatal intensive care units<sup>15</sup> and children;<sup>16</sup> and may also be key to reducing racial disparities in outcomes.<sup>9,17–19</sup> The benefits of better nurse staff extend to nurses as well; with nurses in better-staffed hospitals reporting less burnout, less job dissatisfaction and being less likely to intend to leave their employer.<sup>10,20</sup>

An emerging body of research evidence articulates the human and economic consequences of adverse patient outcomes that result from hospital nurse understaffing. For example, an analysis of hospital nurse staffing among New York hospitals found that if hospitals staffed medical–surgical units with four patients per nurse, as opposed to the average hospital ratio of 6.3 patients per nurse, then thousands of deaths could have been avoided and many hundreds of millions of dollars saved through shorter lengths of stay and avoided readmissions.<sup>21</sup> The same study<sup>22</sup> showed that improving nurse staffing in New York hospitals would have reduced deaths among sepsis patients more than a policy passed earlier that mandated adherence to a standardised set of services for sepsis patients. A study of adult medical patients showed that patients in hospitals with better nurse resources had better outcomes including less mortality, fewer readmissions and shorter lengths of stay—at no difference in cost, when compared with similar patients in hospitals with poorer resources.<sup>23</sup> These study findings have been corroborated in surgical patients;<sup>24,25</sup> and find that improving nurse staffing would avoid adverse outcomes with sizeable cost savings to hospitals.<sup>26</sup>

Despite the social and economic case for improving hospital nurse staffing, California remains the only US state to have implemented required staffing standards.

Passed in 1999 and implemented in 2004, the California legislation resulted in improved staffing, with the greatest improvements observed among safety-net hospitals.<sup>27</sup> Compared with other states which did not implement safe staffing requirements, patients in California hospitals experienced lower mortality and failure-to-rescue rates.<sup>5,28</sup> The California experience serves as an example of a successfully implemented and sustained state-wide policy mandate for safe hospital staffing and patient care.

## DATA AND METHODS

### Design

This observational study of hospitals and patients uses multiple linked data sources including Medicare patient claims data, American Hospital Association (AHA) data of hospital characteristics and a survey of RNs to provide data on hospital nurse staffing ratios on medical and surgical units.

### Patient sample

The patient sample includes persons insured by Medicare who were 65 years and older (the qualifying age for Medicare—the US federal government health insurance programme) and who were admitted to an acute care hospital in Illinois in 2018. Data on Medicare patients were obtained from the Centers for Medicare and Medicaid Services (CMS) MEDPAR files. Patients admitted for psychiatric reasons and drug/alcohol use were excluded, as were patients with lengths of stay greater than 60 days. Each unique patient was assigned an index hospitalisation, created by selecting the first admission during the study period. The analytic sample included only these index hospitalisations, which accounted for roughly half of all the Medicare hospitalisations in Illinois during the study period.

### Hospital sample

Short-term acute care and critical access hospitals that had medical and surgical direct care nurses who responded to the survey of nurses were included. The survey of nurses was sent via email to all actively licensed RNs in the state of Illinois (n=168001). Data collection ran from 16 December 2019 to 24 February 2020. Nurse responses were anonymous, but nurses were asked to report the name of their employer, thus allowing responses from nurses working in the same hospitals to be aggregated together to create hospital-level measures of patient-to-nurse staffing ratios. Our data collection method relies on nurses as key informants of their hospital.<sup>29</sup> Thus, while we directly survey nurses, our interest is in hospital-level organisational measures, in this case, patient-to-nurse staffing ratios.

The nurse response rate was 18% of the 168001 RNs surveyed, which is anticipated considering endemic difficulties with survey response rates<sup>30</sup> and the fact that our sampling frame consisted of 100% of licensed nurses in the state, only a fraction of whom are employed in

hospitals, which was the focus of our study. A similar survey conducted in other states yielded comparable response rates. In the broader multistate study, the survey implemented a double-sampling approach to evaluate for potential non-response bias. The results demonstrated that nurse reports of patient-to-nurse staffing ratios were no different among nurses who responded to the main survey and those that responded to the non-respondent survey.<sup>29</sup> Thus despite an 18% response rate, evidence suggests that even if non-response bias were present, it likely does not affect the validity of the resultant staffing estimates.

Because this is a study of hospitals and the patients in them, the nurse survey response rate is of somewhat lesser importance than the degree to which the survey achieved adequate representation of hospitals (via a high hospital response rate) and the patients in them. We excluded hospitals that were long-term rehabilitation hospitals, psychiatric facilities or free-standing children's hospitals. Based on the remaining acute care hospitals, our analytic sample of 87 hospitals represented 86.5% of Medicare index admissions in the state and roughly two-third of the short-term acute care hospitals in Illinois. We have less representation of critical access hospitals since we were not able to obtain data from enough nurses in those small facilities to reliably estimate staffing ratios.

### Patient-to-nurse staffing

Surveyed nurses were asked to report whether they were working in direct patient care or indirect care positions (eg, management); which type of unit they worked on and how many patients they were assigned to care for on their most recent shift. Only data from direct care RNs who reported working their most recent shift on a medical or surgical unit were used to create our measure of staffing. Responses were then aggregated to create a hospital-level measure of medical–surgical patient-to-nurse staffing. The survey also asked nurses to report how many patients they could safely care for in their job setting.

### Patient outcomes

Patient outcome measures included 30-day mortality and hospital length of stay. 30-day mortality was defined as a death occurring 30-days from date of admission and included deaths that occurred outside of the hospital. Hospital length of stay was defined as total number of days in the hospital during the index admission.

### Cost outcomes

Cost savings were estimated using Medicare-specific cost-to-charge ratios using patient-level charge data from the MEDPAR files. Cost savings from reductions in length of stay were computed by first estimating the predicted reduction in patient days if hospitals staffed at the 4:1 ratio, then applying the reduction to total charges and then converting to costs using the hospital-level Medicare-specific cost-to-charge ratios from CMS Impact Files.

### Risk-adjustment

Hospital risk-adjustment variables included hospital size, defined by number of beds, from the AHA Annual Survey. Patient covariates included patient age, sex, Elixhauser comorbidities,<sup>31</sup> dummy variables for diagnostic-related groups—and in models estimating effects of staffing on length of stay, patient discharge disposition status.

### Statistical analysis

Descriptive statistics were used to show medical–surgical nurse staffing ratios, and the numbers of patients and nurse survey respondents in the 87 study hospitals. Patient characteristics (eg, age, sex, transfer status, comorbidities) as well as percentage of patients who died within 30-days of admission and average (and SD) length of stay are reported. We also show percentages of nurses who reported that the number of patients they cared for during their last shift exceeded the number of patients they felt they could safely care for. Prior to accounting for confounding factors, we show variation in patient mortality rates and lengths of stay among hospitals with different staffing levels (ie, <5, 5≤6, ≥6 patients per nurse).

Multilevel random-effects logistic regression models and zero-truncated negative binomial regression models were used to estimate the association between nurse staffing with 30-day mortality and length of stay, respectively. These associations were estimated before and after accounting for potentially confounding hospital and patient characteristics. Using adjusted estimates from our regression models, we estimated how many deaths could have been avoided and how much money could have been saved (from shorter lengths of stay) were hospitals to staff medical–surgical nurses at the levels proposed in the legislation (4:1 patients per nurse). STATA was used to perform the analyses. This study received IRB approval from the University of Pennsylvania (Protocol #834307).

### Patient and public involvement

No patient involved.

## RESULTS

Our analytic sample included 210 493 Medicare beneficiaries in 87 Illinois hospitals (table 1). Staffing estimates were derived from an average of 16 direct care medical–surgical nurse respondents per hospital, with as many as 68 nurse respondents in larger hospitals. Medical–surgical staffing ratios ranged from 4.2 to 7.6 patients per nurse, with the lower bound just above the four patients per nurse proposed in the legislation. The average staffing ratio in Illinois hospitals was 5.4 and somewhat higher (5.6) among smaller hospitals than larger hospitals (5.3).

Among the study patients, 5.8% died within 30-days of admission and the average length of stay was 4.1 days, with a SD of 3.7 days (online supplemental table 1). Forty percent of the patients were 80 years of age or older, and 56% were female. The most common comorbidities included hypertension, fluid and electrolyte

**Table 1** Hospital size, numbers of patients and nurse respondents and patient-to-nurse staffing ratios among 87 Illinois study hospitals

Hospital characteristics	Number of hospitals	Percent of hospitals	Medical-surgical staffing (patients per nurse)			Range in staffing		
			Mean	SD	Median	Minimum	Maximum	
<b>Hospital size</b>								
≤100 beds	9	10.3	5.6	0.8	5.2	4.2	6.5	
101–250 beds	32	36.8	5.5	0.8	5.3	4.4	7.6	
>250 beds	46	52.9	5.3	0.6	5.2	4.2	6.7	
<b>Total</b>	<b>87</b>	<b>100.0</b>	<b>5.4</b>	<b>0.7</b>	<b>5.3</b>	<b>4.2</b>	<b>7.6</b>	
<b>Patients discharged from 87 study hospitals</b>								
<b>Number</b>	<b>210493</b>		<b>2420</b>	<b>1821</b>	<b>1933</b>	<b>100</b>	<b>11470</b>	
<b>Nurses completing surveys in 87 study hospitals</b>								
<b>Number</b>	<b>1391</b>		<b>16</b>	<b>12.9</b>	<b>12</b>	<b>5</b>	<b>68</b>	
<b>Medical-surgical nurses</b>								

**Table 2** Percent of nurses reporting that the number of patients assigned to them during the last shift exceeded the number they could safely care for

Number of patients assigned on last shift	Whether number assigned exceeds number RN reports could safely care for		
	Does not exceed % (no.)	Exceeds % (no.)	Total % (no.)
Four or fewer	82.7 (253)	17.3 (53)	100 (306)
Five	41.6 (211)	58.4 (296)	100 (507)
Six or more	33.0 (142)	67.0 (288)	100 (430)
<b>Total</b>	<b>48.8 (606)</b>	<b>51.2 (637)</b>	<b>100 (1243)</b>

Note. 148 of the 1391 nurses did not provide a response about how many nurses they could safely care for. Thus, the analytic sample in table 2 is 1243 nurses for whom the relevant data were available. RN, registered nurse.

disorders, chronic pulmonary disease and renal failure. Nurses reported safety concerns related to the number of patients they cared for during their last shift (table 2). Half of nurses (51.2%) reported that their patient assignment during their last shift exceeded the number they assessed they could safely care for. Two-thirds of nurses (67.0%) who were assigned 6 or more patients assessed that workload was unsafe. Most nurses (82.7%) who were assigned four or fewer patients assessed that patient assignment constituted a safe workload.

Prior to adjusting for confounding variables of the hospitals and patients, we found that patient mortality and lengths of stay in hospitals varied with different nurse staffing ratios (table 3). The average 30-day mortality rate among hospitals with an average staffing ratio of <5 patients per nurse was lower (5.6%) compared with mortality among hospitals where nurses cared for between 5≤6 patients (6.1%) and ≥6 patients (6.1%). Lengths of stay were shorter in hospitals where nurses cared for fewer patients at a time (4.0 days in hospitals with <5 patients per nurse, vs 4.1 days in hospitals with 5≤6 patients per nurse, vs 4.5 days in hospitals with ≥6 patients per nurse).

Table 4 presents the effect of nurse staffing on mortality and length of stay. After adjusting for hospital and patient characteristics, the odds of 30-day mortality for each patient increased by a factor of 1.16 (or 16%) for each additional patient added to the average nurse's workload (OR 1.16, 95% CI 1.04 to 1.28; p 0.006). The odds

**Table 3** Average mortality and lengths of stay for patients in hospitals with different patient-to-nurse staffing ratios

Patient-to-nurse ratio	N	30-day mortality Mean (SD)	Length of stay Mean (SD)
<5	24	5.6% (1.4%)	4.0 (0.55)
5≤6	44	6.1% (1.2%)	4.1 (0.52)
≥6	19	6.1% (2.0%)	4.5 (1.27)
<b>Total</b>	<b>87</b>	<b>6.0% (1.5%)</b>	<b>4.2 (0.77)</b>

**Table 4** Effect of medical–surgical patient-to-nurse staffing on patient outcomes

Patient outcome	Coefficient	Unadjusted models	Fully adjusted models
30-day mortality	OR (95% CI)	1.15 (1.06 to 1.26)	1.16 (1.04 to 1.28)
	P> z	0.001	0.006
Length of stay	Incident rate ratio (95% CI)	1.00 (0.95 to 1.06)	1.05 (1.00 to 1.09)
	P> z	0.909	0.041

Note. 30-day mortality outcomes are estimated from 196270 patients and excludes DRGs with <5 cases and admissions by transfer. Hospital controls included number of beds. Patient controls included age, sex, comorbidities and dummy variables for DRG. Length of stay outcomes are estimated from 210493 and excludes DRGs with zero deaths and patients transferring in or out. Hospital controls included number of beds. Patient controls included age, sex, comorbidities, dummy variables for DRG and discharge disposition of death or transfer. DRG, diagnostic-related groups.

of staying in the hospital a day longer at all intervals increased by a factor of 1.05 (or 5%) for each additional patient in the nurse’s workload (IRR 1.05, 95% CI 1.00 to 1.09, p 0.041).

Using these results from the adjusted regression models, we estimated the number of deaths that would have been avoided if hospitals staffed at the four patients per nurse recommendation in the proposed policy (as opposed to the observed ratio which was greater than four patients per nurse in all hospitals and nearly eight patients per nurse in some of them). Roughly 1595 deaths could have been avoided among Medicare beneficiaries in the study hospitals during the 1-year study period. Improving staffing ratios to the 4:1 ratio was projected to reduce patient lengths of stay by over 40 000 days. These reductions in lengths of stay would collectively save Illinois hospitals over \$117 million per year (table 5).

**Table 5** Deaths avoided and cost savings from shorter lengths of stay with 4:1 staffing ratios

Variables used to estimate deaths avoided and cost savings	Mortality	Length of stay
Number of patients at risk of experiencing outcomes	196270	210493
Observed number of patients who died	11370	
Number of patients expected to die with 4:1 patient/nurse ratio	9775	
Difference between observed and expected deaths	1595	
Observed number of patient days		867694
Expected number of patient days with 4:1 patient/nurse ratio		826784
Difference between observed and expected patient days		40910
Observed total charges		\$11 798 193 318
Projected reduction in total charges		\$486 714 034
Projected cost savings		\$117 557 590

Note. Data from 84 short-term acute care hospitals were used in the projection of cost savings from reduced lengths of stay. Three critical access hospitals were excluded from the cost-saving analyses reported in table 5 because critical access hospitals do not report cost-to-charge ratios needed to compute cost savings.

## DISCUSSION

Studying a large sample of 87 acute care hospitals in Illinois, we found considerable variation in medical–surgical nurse staffing ratios, ranging from 4.2 to 7.6 patients per nurse. The average hospital staffing across the state (outside intensive care settings) was 5.4 patients per nurse, which is nearly 1.5 patients above the recommended staffing levels proposed in the HB 2604 *Safe Patient Limits Act*.<sup>6</sup> Half (51.2%) of nurses reported their patient assignment during their last shift was unsafe; and among nurses assigned four or fewer patients, only 17.3% found that staffing ratio to be unsafe.

Staffing conditions were associated with adverse health outcomes for Medicare patients, including mortality and longer lengths of stay. Each additional patient in a nurse’s workload increased the odds of patient death by 16%. If the study hospitals had been staffing medical–surgical nurses at the proposed ratio during the 1-year study period, we projected that 1595 deaths would have been avoided just among Medicare patients. Had our study considered patients of all ages who would benefit from improved nurse staffing, we anticipate considerably more deaths would have been avoided.

The odds of Medicare patients staying in the hospital a day longer increased by 5% for each additional patient in the nurse’s workload. Hospitals would have collectively saved over \$117 million annually from length of stay reductions just among Medicare patients—cost savings which could be reinvested into financing safer nurse staffing ratios. These findings are consistent with other research conducted in New York hospitals<sup>32</sup> and internationally<sup>33 34</sup> which show that patients in hospitals with better nurse staffing have shorter lengths of stay as well as fewer readmissions, both of which translate to avoided costs. Studies conducted in Queensland Australia and Chile demonstrate that the magnitude of the cost savings associated with better nurse staffing were in excess of the costs of hiring more nurses;<sup>33 34</sup> a



illustration of the value proposition for increasing nurse staffing.

In the current study, estimates of avoidable deaths and cost savings are conservative. Our analysis used roughly half of the annual Medicare hospitalisations in Illinois state since we restricted the sample to index hospitalisations. Other studies show that patients of all ages benefit from improved hospital nurse staffing.<sup>16 35</sup> Thus, if the staffing policy were to be enacted, the human and economic benefits would likely be much greater. Additionally, our cost savings analysis is conservative because it does not account for the savings that may be realised from reductions in nurse burnout and turnover that result from chronic understaffing. In a previously published paper on nurse staffing in Illinois hospitals, we showed that hospital understaffing is associated with poor nurse outcomes including burnout, job dissatisfaction and intent to leave.<sup>20 36</sup> Nurse burnout has been linked with worse patient outcomes including mortality and longer lengths of stay<sup>37</sup> and intent to leave is associated with turnover.<sup>38–40</sup> Turnover of nurses is cost consequential for hospitals, with estimates of replacing a single bedside nurse ranging from \$20 561<sup>41</sup> to \$88 000.<sup>42</sup> Although evidence demonstrates that cost savings can be achieved—via shorter lengths of stay and reduced readmissions—from staffing more nurses at the bedside, future research could expand the scope of the economic consequences of improving nurse staffing in terms of other patient and nurse outcomes with their associated cost savings.

### Strengths and limitations

This study uses hospital medical–surgical nurse staffing data collected in 2020 to inform current staffing policy debates in Illinois. Rarely is timely, rigorous and objective evidence, analysed by an independent team of researchers, available to inform policy in this way. Reporting lags in claims data meant that the most recent available data on patients were from 2018. Although the hospital staffing and patient data do not coincide, hospital nurse staffing has changed little in the last decade.<sup>43</sup> Thus, the staffing estimates obtained in 2020 likely resemble those in 2018. While our study included most large and medium size hospitals in Illinois, which account for most hospitalised patients in the state, smaller hospitals including critical access hospitals are underrepresented in the study. The cross-sectional study design precludes causal statements about the relationship between nursing staffing and patient outcomes.

### Implications for policy decision-making

A recent US Harris Poll<sup>44</sup> suggests that 90% of the US public favour requiring hospitals to meet minimum safe nurse staffing standards. Our study finds uneven nurse staffing among Illinois hospitals which poses unfavourable consequences for patients and hospitals. If Illinois enacted the *Safe Patient Limits Act*, our analysis suggests thousands of deaths per year could be avoided.

Additionally, hospitals could save substantially through reductions in patients' lengths of stay associated with improving nurse staffing. These savings could be reinvested into the costs of employing additional nurses.

Enacting the *Safe Patient Limits Act* would likely create opportunities for more nurses to enter the workforce, raising questions about where these nurses would be drawn from. There is currently no widespread shortage of actively licensed RNs. Nurse graduations are at an all-time high, with enough nurses entering the workforce annually to more than replace retirements.<sup>45</sup> California, the only state to enact nurse staffing ratio mandates similar to what is being proposed in Illinois, has successfully implemented the ratios despite have a lower nurse-to-population ratio compared with Illinois (11.3 RNs per 1000 population in California; 16.7 RNs per 1000 population in Illinois).<sup>46</sup> Finally, the Nurse Licensure Compact, which is state legislation to permit nurses to hold a multistate US license is currently under consideration in Illinois.<sup>47</sup> Passing such legislation would enable nurses licensed in any of the 34 states currently in the Compact to practice in any other Compact state, without the burden of having to obtain an additional license. Such legislation permits greater mobility of nurses to practice across state lines. Thus, trends in the nursing workforce and the opportunity for Illinois to join the Nurse Licensure Compact suggest it is unlikely that passing mandated safe nurse staffing legislation would result in nursing shortages that would negatively affect access to care or care quality.

### CONCLUSIONS

Nurse staffing on medical and surgical units in Illinois hospitals averaged 5.4 patients per nurse and ranged from as few as 4.2 patients per nurse to as many as to 7.6. These estimates suggest that few Illinois hospitals are currently meeting the minimum staffing levels which would be required by the *Safe Patient Limits Act* currently under consideration. We found that each additional patient in a nurses' workload was associated with 16% higher odds of death and longer lengths of stay. If Illinois hospitals staffed medical and surgical units at the ratio proposed in the legislation, we project thousands of deaths could be avoided each year and patients would experience shorter lengths of stay resulting in hundreds of millions of dollars in cost-savings for hospitals.

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**Acknowledgements** The authors wish to acknowledge Tim Cheney for his contributions to data management and analysis.

**Contributors** All authors meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE). KBL, LHA, BM, MA and MDM contributed to the original idea and design of the study. KBL, LHA, RF, BM, MA and MDM contributed to the collection of data. KBL and DS conducted the data analysis. All authors contributed to the interpretation of the data and preparation of the submitted manuscript. All authors approved the submitted manuscript. KBL is responsible for the full overall content as the guarantor and accepts full responsibility for the conduct of the study, had access to the data, and controlled the decision to publish.

**Funding** This study was supported by funding from the National Council of State Boards of Nursing (Lasater, PI), and National Institute of Nursing Research, National Institutes of Health (R01NR014855, Aiken, PI; T32NR007104, Aiken, Lake, McHugh, MPls).

**Disclaimer** The researchers are solely responsible for the findings and their interpretation and do not necessarily represent the views or conclusions of NCSBN or NINR.

**Competing interests** None declared.

**Patient consent for publication** Not required.

**Ethics approval** The study was approved by the University of Pennsylvania Institutional Review Board (IRB) (PROTOCOL #834307).

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** No data are available.

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# The courage to speak out: A study describing nurses' attitudes to report unsafe practices in patient care.

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- Source:** Journal of Nursing Management (J NURS MANAGE), Sep2019; 27(6): 1176-1181. (6p)
- Publication Type:** Journal Article - research, tables/charts
- Language:** English
- Major Subjects:** Patient Care -- Standards  
Registered Nurses -- Psychosocial Factors  
Patient Advocacy -- Psychosocial Factors  
Nurse Attitudes -- Evaluation  
Adverse Health Care Event  
Mandatory Reporting  
Whistle Blowing -- Legislation and Jurisprudence
- Minor Subjects:** Human; Male; Female; Adult; Middle Age; Descriptive Research; Convenience Sample; Questionnaires; Patient Safety; Organizational Culture; Work Experiences; Work Environment; Fear; Nursing Leaders; Nurse Managers; Professional Role; Support, Psychosocial
- Abstract:** Aim: To identify workplace factors that influence patient advocacy among registered nurses (RNs) and their willingness to report unsafe practices. Background: A prior study by Black illustrated that 34% of respondents were aware of conditions that may have caused patient harm but had not reported the issue. The most common reasons identified for failing to report issues were fear of retaliation and a belief that nothing would prevail from the reports. Method: Using Black's study as a model, reporting data were collected from a sample of RNs actively practicing in acute care hospitals. Results: While reasons for reporting are consistent with Black's study, data suggest that a nurse's experiences

and working environment are prime factors in their willingness to report patient care issues. Conclusion: Although RNs may not have personally experienced workplace retaliation, fear of retaliation when reporting unsafe patient care practices still exists. Nursing leadership's ability to facilitate a culture of safety by proactively addressing unsafe practices fosters a level of comfort for patient advocacy and willingness to report issues. Education, professional associations and existing protection laws are available resources which contribute to organizational support systems. Implications for Nursing Management: The findings of this study are consistent with the literature in that organizations need to create a supportive workplace environment whereby, through collective input and leadership, reporting protocols are in place that empower RNs to report unsafe conditions. Direct care nurses are positioned, especially well to identify and speak up regarding conditions that may result in near misses or actual adverse events. Therefore, it is the responsibility, and duty, of nursing management to create and facilitate reporting systems that will be utilized without fear of retaliation and that will contribute to a culture of safety and patient advocacy.

**Journal Subset:** Core Nursing; Double Blind Peer Reviewed; Editorial Board Reviewed; Europe; Expert Peer Reviewed; Nursing; Peer Reviewed; UK & Ireland

**ISSN:** 0966-0429

**MEDLINE Info:** *NLM UID:* 9306050

**Entry Date:** 20190914

**Revision Date:** 20230330

**DOI:** [10.1111/jonm.12789](https://doi.org/10.1111/jonm.12789)

**Accession Number:** 138570826

**Publisher Logo:** **WILEY** Blackwell



03/10/24

**RE: HF 4200**

Members of the House Labor and Industry Finance and Policy Committee,

Medical Alley represents a global network of more than 800 leading health technology and care companies including representation from all corners of the state of Minnesota. Our mission is to activate and amplify healthcare transformation.

Recognized worldwide as a leader in healthcare innovation, Minnesota sets a standard for excellence – impacting local communities and influencing global health outcomes and advancements. With access, affordability, and quality as top priorities, Medical Alley and our partners are committed to developing solutions which drive meaningful change and save lives.

It is with these guiding principles that we express concern about House File 4200's impact on access to care. Under the language of this bill, hospital management would lose its authority to engage in an accountability process should a nurse decline a patient care assignment. Allowing an individual nurse to make this type of decision creates an uneven standard for care, resulting in inequitable delivery and possible delays. Patients experiencing episodes of mental illness or those who are victim to substance abuse may not have access to the care they need, exacerbating their illness.

Not only would access to care for patients in need of care be jeopardized under this proposal, but it could allow an individual nurse to establish a staffing framework for the hospital by deciding which patients he or she will see, thereby assigning further patients to other caregivers and increasing their workloads. This decision should be the hands of hospital administration in order to properly balance the needs of the staff with the needs of the patients.

Important safeguards are already in place for hospital staff who believe they do not have the capacity to care for a patient to request further assistance. State law protects whistleblowers who believe they are working in unsafe conditions and prevents employer retaliation.

We ask committee members to prioritize access to care and oppose House File 4200.

Sincerely,

A handwritten signature in black ink that reads 'Peter Glessing'. The signature is written in a cursive style and is positioned above a light gray rectangular box.

**Peter Glessing**  
*Senior Director of Policy and Advocacy*  
Medical Alley



March 12, 2024

Minnesota House of Representatives  
Labor and Industry Finance and Policy Committee  
HF 4200

Dear Committee Members,

The Minnesota Business Partnership is a membership organization comprised of the top business leaders from Minnesota's largest employers, employing almost half a million workers across the state. Health care availability, access, and equity are incredibly important to our members, and I want to express our concerns regarding HF 4200.

Ensuring the safety and well-being of patients is the top priority for Minnesota hospitals. Hospitals are already short-staffed and fewer individuals are training to enter the health care workforce. Allowing a nurse to decline a patient care assignment based on professional judgement raises serious concerns on health equity and the treatment of patients with conditions such as a mental illness or substance abuse issues. This could adversely affect patients and is an improper interference with a hospital's role to determine their own patient and staff needs. This also interferes with the chain-of-command reporting process hospitals already have in place where a nurse who feels they need additional help can request it.

Our shared goal is for patients to have access to the highest quality of care possible. We look forward to working together to find solutions that help solve our health care workforce shortage without impacting the quality and availability of patient care.

Sincerely,

Abby Loesch  
Health Policy Director  
Minnesota Business Partnership