HIMSS Position Statement
Legislatively Mandated Patient to Nurse Ratios
Adopted by the HIMSS Board of Directors June 9, 2006

Prologue

For over 45 years, members of HIMSS have focused on providing visionary leadership for the optimal use of health information technology and management systems for the betterment of healthcare. Founded in 1961 as a professional society primarily focused on management engineering (ME) in healthcare, HIMSS has continually valued the profession devoted to establishing workload measures and the optimization of workload to staffing relationships. In the 1980s, to meet the ever-growing needs of the industry it serves, HMSS expanded its vision and scope to include information systems and technologies.

Today, HIMSS is made up of over 20,000 individual and 300 corporate members employing more than 1.2 million people focused on transforming healthcare. Though the majority of individual members are information systems professionals, a sizeable number of management engineers, process improvement engineers, and like disciplines remain a major component of HIMSS. With the advent of electronic health record (EHR) and other technologies, the industry must understand of how operations in general – and staffing in particular – are affected. HIMSS has a significant responsibility in assisting the nursing profession, represented by nursing informatics practitioners and other clinical constituents, in the identification of appropriate staffing/patient ratios.

Statement of Position

HIMSS supports hospitals voluntarily applying flexible, evidence-based patient-to-nurse ratios, which are customized to each institution's unique parameters. HIMSS does not support legislatively-mandated staffing ratios.

Call to Action

A major chasm exists among health care professionals for the support of or opposition to legislatively-mandated patient-to-nurse ratios. Legislatively-mandated ratios establish uniform ratios that apply across all hospitals according to the specialty of services offered within the nursing units of those hospitals. For example, all medical surgical units in all hospitals would be required to have the same patient-to-nurse ratio regardless of their case mix, physical layout and design, technological support, and other unique characteristics or mission (teaching vs. non-teaching, specialty versus non-specialty, etc.) and respective nursing units.

Advocates of legislatively mandated ratios primarily cite improvements in patient safety, patient outcomes and nursing satisfaction identified in research done by University of Pennsylvania researchers at 168 Pennsylvania hospitals in 2000.[1] However, there is no evidence to support the claim of improved patient safety and clinical outcomes. On the

contrary, recent research conducted by the California Nursing Outcomes Coalition (CalNOC) found no difference in the before and after affects of mandatory ratios in the State of California for two patient safety and quality of care indicators. CalNOC concluded that the mandatory ratios have had no significant impact in the rate of patient falls or prevalence of pressure ulcers in patients in approximately 68 hospitals, even though there have been significant increases in the proportion of licensed staffing resulting from the passage of the California Safe Staffing Act of 1999.[2]

The causes of patient safety, of improved clinical outcomes and of improved working conditions for nurses will not be resolved by legislatively-mandated, fixed, universal ratios solely. Those opposing legislating ratios do so not out of opposition to ratios but rather to the inflexibility that that legislation imposes. Opponents of legislatively-mandated ratios support improved staffing assignments for nursing, but cite numerous dependencies that must be taken into account to determine safe and effective staffing levels at a given organization. These dependent variables range from the hospital type, specialization, and physical layout, to nurse education and competencies, level of ancillary support staff, and the extent of technological support – all of which require local management input to determine appropriate nurse staffing, and thus negate a fixed ratio imposed by legislated mandates.

HIMSS joins other health care organizations and regulatory agencies in opposing legislatively mandated patient to nurse ratios. HIMSS supports the position of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Organization of Nurse Executives (AONE)[3], the Society for Health Systems (SHS)[4], the American Association of Critical-Care Nurses (AACN), and other professional societies and organizations of healthcare professionals on the need to develop improved staffing practices for the benefit of patients, nurses and other allied professionals. The JCAHO, recognized as the gold standard in hospital accreditation, states: "Current (legislatively) mandated ratios, related legislative proposals, and other nurse staffing initiatives are aimed primarily at adding to the supply of nurses. However, these efforts do not address other critical issues, such as nurse competency, skill mix in relation to patient acuity, and ancillary staff support." The JCAHO has endorsed "new standards that will require health care organizations to assess their staffing effectiveness by continually screening for potential issues that can arise from inadequate or ineffective staffing."[5] The AACN states, "Relying on staffing ratios alone ignores variances in patient needs and acuity." AACN further states ". . .staffing is a complex process with the goal of matching the needs of patients…with the skills and competencies of nurses."[6]

A study done in 799 hospitals, although recognizing that staffing has a significant effect on clinical outcomes and patient safety on eight of 25 outcomes, reported "it is possible that some of these associations we found may be false positives."[7] "The level of staffing by nurses is an incomplete measure of the quality of nursing care in hospitals."[8] The chief researcher in this project has stated that "legislation to mandate fixed ratios carries a high potential of leading to the economic and political devaluation of the nursing profession, and fails to effectively deal with the issues surrounding nurse staffing."[9]

HIMSS Position

1. HIMSS does not support legislatively-mandated nurse to patient ratios that are fixed and universal.

2. HIMSS supports hospitals voluntarily applying flexible evidence-based ratios informed by research and local knowledge.

3. HIMSS supports the Magnet-Hospital Recognition Program®, the essence of which indicates that a hospital has achieved excellence in nursing practice, including staffing appropriately.

4. HIMSS recommends that as the mechanism for enforcing best practice and safety, the management responsibility for evaluating staffing effectiveness be left in the hands of the local organizations that deliver care, along with required reporting to a national organization, (e.g. JCAHO), that screens reports for potential inappropriate or ineffective staffing.

5. HIMSS supports the development and use of engineered approaches and IT tools to facilitate routine monitoring of hospital and patient outcomes, to reduce redundant, repetitive charting, and to eliminate other activities, which take a nurse away from the bedside; and which approaches and tools are sensitive to levels of staffing by nurses and covariates (physical layout, skill mix, experience levels, availability of technology, patient turnover, acuity, etc.) that may lead to variation in outcome. HIMSS supports improvement in patient safety, not by legislatively mandated staffing ratios, but by using innovative technology to improve operational efficiency. "The ideal nursing care delivery system enables staff to increase their productivity, job satisfaction, and the quality of care they provide by spending more of their time in direct care activities. Such a system must include information technology supported by the nurse's own critical thinking and the nursing process flow"[10]

6. HIMSS acknowledges flexible, engineered patient-to-nurse ratios must:
   - Define an objective, repeatable, and tested method to set staffing levels, including the incorporation of real time data, which accounts for census throughput information, quality of care indicators, case mix acuity, and skill and competency of staff members.
   - Involve the major hospital stakeholders in developing the staffing model – including administrators, nursing leadership and staff, support and ancillary departments.
   - Incorporate effectiveness of staffing against ongoing patient-family satisfaction, as well as nursing satisfaction surveys.
   - Match clinical staffing to the specific needs of patients based on patients' degree of illness (acuity), age, and ability to perform activities of daily living.
   - Reflect the dependency of the patient upon nursing assistance, and take into account the absence or presence of family support during the hospital stay.
   - Take into account the unique features of each hospital such as:

- Physical layout of the nursing unit, operating rooms, emergency department and support departments.
- Technology available to staff that supports documentation, including electronic medical records, medication administration procedures, automated supply cabinets, and computerized practitioner order entry.
- The frequency of patient turnover on the nursing units (admissions, discharges and transfers.)
- The role of the hospital as either teaching or non-teaching, designation as a trauma center, and any specializations within the hospital.

o Adjust staffing by shift and day based on variations in census and patient care requirements.
o Reflect the patient care delivery model of the hospital with respect to provision of nursing care and skill mix of nursing providers.

HIMSS calls on federal and state governments to resist the urge to pass legislation that mandates fixed, universal patient-to-nurse ratios.

Closing Remarks

HIMSS believes any federal or state legislation which contains a requirement to establish mandatory patient-to-nurse ratios fails to account for the real and significant factors in the hospital setting that directly impact staffing requirements. Though attractive in theory, legislation does not ensure improvement of patient safety, clinical outcomes and nursing satisfaction. To date, legislatively-mandated patient-to-nurse ratios are not linked either to improved patient safety or enhanced clinical outcomes[11], yet the experience of CalNOC suggests that they are associated with significant and unnecessary increases in cost.[12] Carefully developed, customized, flexible ratios unique to each institution's parameters should be encouraged. HIMSS pledges to provide educational opportunities to legislatures and other policy makers on the need to account for quality staffing factors in the development of staffing requirements.

"Now is the time to galvanize the industry by bringing together key stakeholders, removing barriers, and using innovative solutions to support the work of nurses. Nurses, administrators, and industry leaders must work together to transform the delivery of patient care."[13]

---

[1] L.H. Aiken, S.P. Clarke, D.M. Sloane, J. Sochalski, J.H. Silber. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA 288 (2000) 2948-2954

[2] Impact of California's Licensed Nurse-Patient Ratios on Unit Level Staffing and Patient Outcomes, Policy, Politics, & Nursing Practice, Vol. 6 No. 3, August, 2005, 198-210

[3] Refer to Policy Statement of American Organization of Nurse Executives on Mandated Ratios, December, 2003.

[4] Refer to Position Paper on Mandated Staffing Ratios of the Society for Health Systems, August, 2005.

[5] "Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis", Joint Commission on Accreditation of Healthcare Organizations, May 2005.

[6] American Association of Critical-Care Nurses, AACN Standards for Establishing and Sustaining Healthy Work Environments, A Journey to Excellence, Aliso viejo,CA, Staffing Standard, pp 25-27. www.aacn.org.

[7] Needleman J., Buerhaus P., Mattke S., Stewart M. Zelevinsky K., "Nurse staffing and quality of care in hospitals in the United States", N Engl J Med; 346(22): 1715-1722, May 2002

[8] IBID
[9] Refer to Policy Statement of American Organization of Nurse Executives on Mandated Ratios, December, 2003
[10]" Improved Operational Efficiency Through Elimination of Waste and Redundancy" Sensmeier J, Raiford R, Taylor S, Weaver C, Nursing Outlook, Volume 51, Issue 3, Pages S30-S32 (May 2003) http://www.nursingoutlook.org/article/PIIS0029655403000940/fulltext
[11] "Impact of California's Licensed Nurse-Patient Ratios on Unit Level Staffing and Patient Outcomes", Policy, Politics, & Nursing Practice, Vol. 6 No. 3, August, 2005, 198-210
[12] "The Impact of Mandated Ratios on RN Staffing and Patient Outcomes", Donaldson and Barnes, AONE 2006 Conference, Orlando, FL
[13] " Improved Operational Efficiency Through Elimination of Waste and Redundancy" Sensmeier J, Raiford R, Taylor S, Weaver C, Nursing Outlook, Volume 51, Loc Cit