

PUBLIC PROTECTION THROUGH SAFE NURSE STAFFING PRACTICE



Purpose:

To assist nurses in understanding safe staffing practice

Objectives:

After reading this article and online references, the nurse should be able to: Identify responsibilities of nurses regarding patient/client safety and safe staffing practice.

Hello, I'm a new LPN. I was licensed for the first time a month ago. Since then, I've been working in a nursing home on the 11 p.m. to 7 a.m. shift. I have been routinely assigned to the same 33 residents, and barely complete that assignment. Yesterday my DON told me that because of staff changes I will be assigned to almost 70 residents. I can't take care of all those residents. Is this safe? What can I do?" This is the essence of a recent call received by the Board of Nursing (BON.)

This nurse said she expected to be assisted by two Nurse Aides; that within her assignment several residents were ordered to receive tube feedings and IVs during the shift; and that some residents frequently experience complications. The LPN stated that prior to this employment, she had no other experience working in a healthcare setting in any capacity other than during her nursing school clinicals. She stated her RN supervisor for this assignment would be on-call, not on-site, and that 2 other LPNs would have other resident assignments during her shift. The LPN stated that the Director of Nursing (DON) for the facility had refused to negotiate any change to this assignment. Unfortunately, this situation is not a unique call received by the BON.

Here is an example of another frequent call received by BON consultants: "I have worked an 8 (or 10 or 12) hour shift and am scheduled to work the same hours again tomorrow. My nurse manager (or sometimes unlicensed office manager) has just informed me that I will have to be on-call for the time between my sched-

uled shifts. The nurse routinely scheduled for the on-call shift usually is called in to work for several hours. I don't see how I can work my schedule and the on-call shift, too. The manager says I must do it."

Other examples of questions involving staffing received by the BON are: "How many consecutive hours can my employer require me to work?" "Can my employer ask me to work 20 hours in a 24 hour time period?" "Is there a recommended or required patient to nurse ratio?" In response to these questions, the nurses involved (administrators, managers, staff) are asked to consider if the assignment is safe. Is it safe for the patients? Is it safe for the nurse? Is it safe for the agency? Based on the situation, what is in the best interest of all involved parties?

Introduction

The Institute of Medicine (IOM) in its 1996 report *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate*, stated: "the preponderance of evidence from a number of studies using different types of quality measures has shown a positive relationship between nursing staff levels and quality of nursing home care." (p.153). In *To Err is Human: Building a Safer Health System* (2000), the IOM estimated that as many as 98,000 hospitalized Americans die each year, not as a result of their illness or disease, but as a result of errors in their care. The Agency for Healthcare Research and Quality (AHRQ) concluded in the report *Making Health Care Safer: A Critical Analysis of Patient Safety Practices* (Seago, 2001) that "leaner nurse staffing is associated with increased length of stay, nosocomial infection (urinary tract infection, postoperative infection, and pneumonia), and pressure ulcers..." (p. 430).

Aiken, Clark, Sloane, Sochalski, & Silber, (2002) reported that 2.8 million licensed nurses and 2.3 million nursing assistants were providing patient care in this country and represented approximately 54 percent of all health care workers. These nurses and nursing assistants provided patient care in virtually all locations in which health care is delivered, including hospitals, nursing homes, ambulatory care settings such as clinics or physicians' offices,

private homes, schools, and employee workplaces. When people are hospitalized, residing in a nursing home, having a baby, or learning to manage a chronic condition in their own home, at some of their most vulnerable moments, nurses are the health care providers they are most likely to encounter; spend the greatest amount of time with; and, along with other health care providers, depend upon for their recovery. Therefore, their performance has the potential to directly affect patient safety.

The IOM publication *Keeping patients safe: Transforming the work environment of nurses* (2004) states, "The committee finds strong evidence that nurse staffing levels, the knowledge and skill levels of nursing staff, and the extent to which workers collaborate . . . affect patient outcomes and safety." The report further states, "Creating work environments for nurses that are most conducive to patient safety will require fundamental changes throughout many health care organizations (HCOs) in the ways work is designed and personnel are deployed, and how the very culture of the organization understands and acts on the science of safety."

These reports confirm the important relationship between staffing and the quality of patient care. Other studies cite considerations other than insufficient staffing that effect patient safety. These include nurse burnout, job dissatisfaction, staff turnover, and impairment through illness and fatigue.

The American Nurses Association (ANA) report *Implications of Fatigue on Patient and Nurse Safety* (2001b) addresses the issue of nurses and their professional obligation to maintain patient and personal safety. A nurse's competency may be impacted by personal illness, fatigue, or the nurse's ability to cope with personal stress. An assignment that may be appropriate for a nurse to accept on one date may not be acceptable at another time.

The study *Extended Work Shifts and the Risk of Motor Vehicle Crashes Among Interns* (Barger, Cade, Ayas, Cronin, Rosner, Speizer, & Czeisler, 2005) focused on medical interns and their driving. The study determined that extended duration work shifts posed a serious and preventable safety hazard for the physicians and other motorists. This and similar studies supported a national change in the maximum



North Carolina Nursing Law and Rules hold all nurses accountable to assure assignments they give or accept are safe for the public/patients

number of consecutive hours an intern or resident may work and be on-call.

Geiger-Brown and Trinkoff, (2010) studied 80 RNs who worked three successive 12-hour shifts, day or night. The study found the average total sleep time between 12-hour shifts was 5.5 hours (day) and 5.2 hours (night). The study found lapses of attention among nurses working successive 12-hour shifts. The lapses ranged from zero to 48 lapses per vigilance test. A primary role of the nurse is to maintain a vigilant presence and detect subtle changes in patients' conditions in order to head off complications. This study verified that impaired vigilance can reduce a nurse's effectiveness and thus patient safety. Rogers, Hwang, Scott, Aiden & Dinges (2004) stated that, "both errors and near errors are more likely to occur when hospital staff nurses work twelve or more hours at a stretch." The longest shift reported in this study was 23 hours, 40 minutes!

Nursing Law and Rules

Co-workers may find themselves needing to confront a nursing colleague who is too fatigued to work, yet volunteers to accept more work hours. Employers/supervisors have an equal role in addressing the issue of fatigue among their nursing staff. Regardless of the number of hours worked, all nurses are required to consider their level of fatigue when deciding whether to accept any assignment. This is particularly true when considering extending beyond their regularly scheduled work day or week, including a mandatory or voluntary overtime assignment. The North Carolina Board of Nursing (NCBON) in its Position Statement "Staffing and Patient Safety" (2010) addresses the issues of extended work hours, short staffing, and the roles of the RN and LPN, including nurse managers and administrators.

Professional nursing associations represent and advocate for nurses. These associations set the standards of nursing care in general or for their specific specialties. Most state and national nursing associations/organizations

have addressed the issues of: staffing, consecutive and total hours worked, impairment and fatigue.

The NCBON interprets the NC Nursing Practice Act (NPA) and NC Administrative Code (NCAC) (also known as Rules) as they relate to patient safety and the responsibility of each professional nurse in the example scenarios and others like them. The NPA (2009) defines nursing as providing in part "...sustained, vigilant, and continuous care of those acutely or chronically ill... and the supportive and restorative care given to maintain the optimum health level of individuals, groups, and communities..." The NPA further states that nurses are required to implement treatment and pharmaceutical regimens as prescribed, and to provide for the maintenance of safe and effective nursing care whether rendered directly or indirectly.

More specifically 21 NCAC 36 .0224(d) (2) (Rules) delineating the RN components of practice state that the nurse is responsible to implement "nursing interventions and medical orders consistent with 21 NCAC 36 .0221(c) and within an environment conducive to client safety." The same is true for the LPN components of practice 21 NCAC 36 .0225.

The Rules state that the responsibilities which a nurse can safely accept "are determined by the variables in each nursing practice setting." In part, the variables include the nurse's own qualifications, the complexity and frequency of nursing care needed by a given client population, the qualifications and number of staff, and the accessible resources.

The NCBON was established to protect the public by regulating the practice of nursing through the laws and rules enacted by the state. Therefore, the NCBON establishes an individual relationship with each nurse to whom it issues a license. Some of the first questions asked by NCBON staff when presented with an event or concern include: How did this event affect public/patient safety? What action(s) would have been in the best interest

of the patient? What was each nurse's (staff, manager, administrator) responsibility, and did they meet it?

Manager/Administration roles

The nurse manager responsibilities listed in the Rules include: continuous availability for direct participation in nursing care, onsite when necessary; assessing the capabilities of personnel in relation to client status; delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions; and, accountability for nursing care given by all personnel to whom the nurse has assigned and delegated care. This means that the nurse who assigns or delegates nursing activities is responsible to make provisions for patients to receive safe, competent care.

The nurse manager is responsible to verify the competency of each nurse when making an assignment. This requires assurance that the assigned nurse has the knowledge, skill, and ability, and the staff and facility support, to safely and satisfactorily fulfill the assignment in the time scheduled. It is important to note that an assignment includes the timely and accurate documentation of the nurse's activities and the outcomes; therefore, consideration must be given to allotting sufficient time within the assignment for the nurse to complete this responsibility.

Nursing administrators' (Chief Nursing Officers [CNO], Directors of Nursing [DON], etc.) responsibilities specified in the NCAC (Nursing Rules) also relate to staffing and patient safety. They include: the identification, development and updating of standards of nursing care; appropriate allocation of human resources to promote safe and effective nursing care; and, development of a method to validate qualifications, knowledge, and skills of nursing personnel.

Some questions for nurse managers and administrators to answer when faced with a staffing dilemma include: for the assignment under consideration, what nursing activities must be completed and documented during the scheduled shift? What activities may be delegated to available unlicensed assistive personnel? What activities may be completed at another time? What would make this a safe assignment? In fulfilling their respective responsibilities, is each involved nurse (staff, manager, and administra-



tor) providing safe, competent nursing care to all patients?

Competency

In the scenario involving the newly licensed LPN assigned almost 70 residents, what are some issues that need to be considered? One involves the competency of the nurse being asked to accept the assignment. In this instance competency would be based, in part, on the nurse’s lack of overall experience and recent orientation to the facility and to this population of clients. The nurse manager by giving the assignment and the newly licensed LPN by accepting the proposed assignment would be saying they both believe the nurse to be competent to safely assess and evaluate care of a large number of patients and to complete all nursing interventions and medical orders required by the assignment. We know based on the call that the LPN did not feel safe or competent to complete the assignment as given.

Other questions in this long term care scenario for all three levels of nurses (staff, manager, and administrator) to answer are: What is the stability of each resident, both physically and psychologically? Are the complexity and frequency of the nursing interventions appropriate for the licensure level (LPN, RN) assigned? When involving an LPN, is the available RN supervision adequate to support patient safety?

Supervision and Support

Regarding an LPN assignment, RN supervision and its adequacy for a specific resident population on a specific date and shift must be considered. Just a few years ago residents in long term care facilities were more medically stable. They required fewer and less complex nursing interventions. That is not the case in long term care settings today. Rule 21 NCAC 36 .0225(a) states that the degree of RN supervision required by an LPN is based on the stability of the assigned patients’ medical conditions (acute or not); the complexity and frequency of nursing care needed; and the resources available. If patients’ conditions are unstable, or their nursing interventions are frequent or complex, direct on-site RN supervision is required.

Another key issue in making and accepting an assignment is the support resources (staff) assigned to assist the nurse in completing a specific assignment? What is the support staff’s

experience? Four nurse aides (NAs) may be assigned to assist a nurse, each having little to no experience working in healthcare or in the specific facility. Or, 2 NAs with several years experience working for the agency may be assigned. Experience and competency matter when assigning staff resources. These are questions to consider when making and accepting an assignment.

Returning to the scenario in the long term care facility, what changes would make the assignment a reasonable solution? Nurses (staff, manager, and administrators) often think in terms of “all or nothing” when making a decision regarding accepting an assignment. A better alternative would be to ask, what changes would make this assignment safe for the involved residents, safe for the nurse, and safe for the agency? Some possible solutions include: assigning another nurse to work for 3 hours during the shift; assigning an additional NA for the shift; assigning a medication nurse or a medication aide (long term care) to the unit for the shift. The NCBON suggests that all 3 levels of nurses negotiate an outcome satisfactory to all.

Options

Nurses frequently report to the Board that their DON or nurse manager offers only the option to accept the assignment or be terminated. Nurses also report that their employer threatens to report them to the Board for abandonment or neglect. The Board’s Position Statement – Staffing and Patient Safety (2010) states that “abandonment can only occur after the licensed nurse (RN or LPN) has come on duty for the shift and accepted his/her assignment.”

The NCBON interprets accepting an assignment as taking and accepting report thereby accepting responsibility for the care of the clients. Punching the time clock or accepting the unit or narcotic keys is not considered accepting an assignment. It may be only after hearing the report that an on-coming nurse identifies she/he cannot safely accept the assignment. This may be because they deem the assignment to be unsafe (e.g., an unreasonable number of patients, the stability of the patients and the complexity of care required is too great, or they are not competent in a specific activity). If a nurse has not accepted an assignment they will not be charged by the NCBON with abandonment.

Neglect is defined by the NCBON as failing

to provide services to a client who is in need of nursing care, without making reasonable arrangements for the continuation of such care. Again, a nurse who has not accepted an assignment cannot be charged with neglect.

It is important to distinguish that a nurse’s attitude of not liking or wanting an assignment is not seen as a sufficient reason for not accepting an assignment!

Many callers to the Board ask about “staffing ratios.” North Carolina has no legally defined nurse/patient ratios. Staffing ratios may be established by some agencies in practice settings (e.g., ED, ICU) where the complexity and frequency of interventions remains at a high level. However, the same may not be true on a rehab unit or in a long term care facility where the stability/acuity, complexity, and frequency of interventions may vary from day to day or shift to shift. Professional nursing organizations may offer suggestions regarding staffing patterns or ratios as part of their defined standards of practice. The Board’s response is that each nurse must meet their responsibilities as stated in law and rules. Suggestions offered in this article are meant to be a guide to the safe resolution of staffing issues.

Conclusion

Healthcare facilities in this economy are under pressure to reduce expenses. Nurse managers and administrators may feel torn by conflicting professional obligations. They may be faced with the challenges of understaffing and excessive overtime vs. hiring new employees and rotating shifts. These practices have been shown to lead to deteriorating working conditions and a threat to patient safety. All nurses have a responsibility to examine and institute scheduling practices that promote safe work hours, adequate break time, and minimal rotation of shifts.

The Code of Ethics for Nurses with Interpretive Statements (ANA, 2001a) states that “the nurse’s primary commitment is to the patient, whether individual, family, group, or community.” It further states that when nurses are placed in a position where a conflict of interest arises they “must examine the conflicts arising between their own personal and professional values, the values and interests of others who are also responsible for patient care and health care decisions as well as the interests of patients.”

So, the question to be asked at the end of the day by each nurse is; Did I provide safe,



competent care and protect my patients today? Did I offer/accept a safe and reasonable assignment? Did some of my decisions based on budget constraints risk patient or nurse safety? Do facility policies and procedures allow nurses to delegate appropriate tasks to unlicensed assistive personnel (i.e. nurse aides, etc.)?

A common goal for all nurses should be to provide or accept work schedules that allow for adequate rest and recuperation between work assignments and to provide an appropriate staffing system that fosters a safe and healthful environment for both nursing staff and patients. The Future of Nursing: Leading Change, Advancing Health (IOM, 2010) encourages nurses to develop leadership at every level, generate evidence, and be at the table. An old adage says, "If you're not part of the solution, then you're part of the problem."

Required reading for successful course completion can be found on the BON's website www.ncbon.com click on practice.

BON Position Statements * Accepting an Assignment * Delegation and Assignment of Nursing Activities * Staffing and Patient Safety * BON Joint Statement with the Division of Health Service Regulation --- Nursing work Environments

Nursing Law and Rules

- G.S. 90-171.20 North Carolina Nursing Practice Act, (4) (7) & (8)
- G.S. 90-171.37 North Carolina Nursing Practice Act, (3) (4) (5) (6) (8)

21 NCAC 36 .0224 Components of Practice for the Registered Nurse (RN Rules), (a)(c) (d) (i) (j) (k)

21 NCAC 36 .0225 Components of Practice for the Licensed Practical Nurse (LPN Rules),

(a) (d) (d)

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EARN .85 CONTACT HOURS

INSTRUCTIONS

- Read the article and on-line reference documents. There is not a test requirement, although reading for comprehension and self-assessment of knowledge is encouraged
- **RECEIVE CONTACT HOUR CERTIFICATE:**
 - o Go to www.ncbon.com and select "Events, Workshops & Conferences," then select "Board Sponsored Workshops." Scroll down to the link titled: Public Protection through Safe Nurse Staffing Practice. Register, complete and submit the evaluation, and print your certificate.

o Registration deadline is March 15, 2013

PROVIDER ACCREDITATION

The North Carolina Board of Nursing will provide .85 contact hours for this continuing nursing education activity.

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