

Nurse Staffing Advocacy

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ANA collaborated with Avalere to explore using optimal nurse staffing models to achieve improvements in patient outcomes. We highlight key findings that show how optimal staffing is essential to providing quality patient care. We also explore staffing models to expand thinking beyond nurse-to-patient ratios.

With a new perspective and additional insights, you'll be able to identify key factors that influence nurse staffing, such as:

- Patient complexity, acuity, or stability.
 - Number of admissions, discharges, and transfers.
 - Professional nursing and other staff skill level and expertise.
 - Physical space and layout of the nursing unit.
 - Availability of technical support and other resources.
- [Learn ANA's 7 Core Components of Nurse Staffing](#)

Identifying and maintaining the appropriate number and mix of nursing staff is critical to the delivery of quality patient care. Numerous studies reveal an association between higher levels of experienced RN staffing and lower rates of adverse patient outcomes.

When health care employers fail to recognize the association between RN staffing and patient outcomes, laws and regulations become necessary.

A Federal regulation has been in place for some time, 42 Code of Federal Regulations (42CFR 482.23(b)) which requires hospitals certified to participate in Medicare to "have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed". This nebulous language and the continued failure of Congress to enact a federal law, [The Registered Nurse Staffing Act](#), has resulted in states taking action to ensure there is optimal nurse staffing appropriate to patients' needs.

State staffing laws tend to fall into one of three general

approaches:

The first is to require hospitals to have nurse driven **staffing committees** that create staffing plans that are reflective of the needs of the patient population, and match the skills and experience of the staff.

The second approach is for legislators to **mandate specific nurse to patient ratios** in legislation or regulation.

A third approach is requiring facilities to **disclose** staffing levels to the public and/or to a regulatory body.

ANA supports a legislative model in which nurses are empowered to create staffing plans specific to each unit. This approach aids in establishing staffing levels that are flexible and account for changes including:

- intensity of patient's needs,
- the number of admissions, discharges, and transfers during a shift,
- level of experience of nursing staff,
- layout of the unit,
- and availability of resources (e.g., ancillary staff, technology).

Establishing minimum, upwardly adjustable staffing levels in statute will also help the committee in achieving safe and appropriate staffing plans.

States with Staffing Laws

15 states currently addressed nurse staffing in hospitals in law / regulations: **CA, CT, IL, MA, MN, NV, NJ, NY, OH, OR, RI, TX, VT,** and **WA**.

8 states require hospitals to have staffing committees responsible for plans (nurse-driven ratios) and staffing policy – **CT, IL, NV, NY, OH, OR, TX, WA**.

CA is the only state that stipulates in law and regulations a required minimum nurse to patient ratios to be maintained at all times by unit. **MA** passed a law specific to ICU requiring a 1:1 or 1:2 nurse to patient ratio depending on stability of the patient.

MN requires a CNO or designee develop a core staffing plan with input from others. The requirements are similar to Joint Commission standards.

5 states require some form of disclosure and / or public reporting – **IL, NJ, NY, RI, VT**

Other limited efforts

NM (2012) charged specific stakeholder groups to recommended staffing standards to the legislature; the department of health is to collect information

about the hospitals that adopt standards and report the cost of implementing an oversight program.

NC (2009) requested a study in the use of mandatory overtime as a staffing tool. No subsequent action taken.

DC and **ME** (2004) – passed legislation; later amended from original intent; staffing mandate removed.

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