NYSNA

Safe Staffing Toolkit

Safe Staffing Summit ■ July 24, 2012
A message from the Staffing Steering Committee co-chairs

Everyday, our patients count on us to be their advocates. Now, hundreds of nurses just like you are taking that advocacy to the next level – by getting active in our campaign to win safe nurse-to-patient ratios.

In healthcare facilities big and small, nurses are starting Safe Staffing Task Forces – to build a mighty army of nurses advocating for better staffing in our facilities, in our communities, and in Albany.

We created this manual to help give you the tools to win this campaign.

Tell your story

The research behind safe staffing legislation backs up what we know from our own nursing experience: safe staffing saves lives.

We need to combine that research with our own stories to win the hearts and minds of the public and policymakers.

As a nurse, you speak with authority. When you tell your story, community leaders, the press, and lawmakers listen.

A new approach

Winning safe staffing legislation requires us – working nurses like you – to change our relationship to NYSNA and what we expect from it.

This campaign has got to be ours – led by nurses at the bedside.

The role of NYSNA staff is to give us the tools to help us succeed. Our staff will be there to help us every step of the way. But it is up to us to take the lead and be the face and voice of the campaign.

Unleash the power of nurses

Imagine thousands of nurses coming together to advocate for safe staffing.

That’s the kind of force we need to win safe staffing. We can do it, by getting involved. Every member has a role to play: some big, some small, all important.

Together, we know that we will succeed.
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Winning safe staffing starts with you.

Every nurse has a role to play in this campaign: some big, some small, all important. Here are the key components of our coordinated campaign to win safe staffing.

■ Safe Staffing Task Force
   In our facilities, nurses are building Safe Staffing Task Forces to coordinate our campaign and help other members get involved – in the hospital, in the community, and in Albany.

■ Organizing for safe staffing in your facility
   Safe staffing can’t wait for the politicians in Albany. In our facilities, members are protesting improper assignments, documenting staffing problems, and taking action to correct them.

■ Advocating in our communities
   Nurses and NYSNA can’t win safe staffing on our own. We need allies to build power and majority support in the state. We are reaching out to patients, community groups, religious institutions, advocacy groups, and other unions – to help them with their causes and to seek their help with ours.

■ Telling our story in the press
   Your stories are one of our most powerful tools. We need to keep telling our stories in the press.

■ Persuading lawmakers – and turning up the heat in Albany
   Nurses are organizing grassroots delegations to visit lawmakers, tell our stories, and seek their support. And we will turn up the heat on politicians who try to stall this legislation.

   We will work to build the coalition we need to pass the bill in the Assembly and the Senate, and then have the governor sign it.

   After we get this law passed, we’ll have to keep it enforced. It’s a cycle – the strength we build to get it passed will then be needed to enforce it in each workplace.
Part 1: Ratio basics

What’s in the Safe Staffing for Quality Care Act

The Safe Staffing for Quality Care Act is legislation proposed in both the New York Assembly and Senate that would establish safe nurse-to-patient ratios. (See page 33 for the text of the law.)

Here’s what’s in the bill as written now. The terms of the bill could change – for better or worse – and it’s up to us to push for the best possible language in any amendments.

- **Nurse ratios**
  - The bill establishes nurse to patient ratios by unit. No nurse can be assigned responsibility for more patients than the specific ratio. Hospitals that violate the law will face civil penalties.

- **Staffing for acuity**
  - The ratios set a floor, not a ceiling. Hospitals are required to make a staffing plan that addresses changes in patient acuity by staffing as patient needs dictate.

- **Hospitals cannot count assistive personnel toward ratios**
  - Assistive personnel do not count toward the licensed nurse-to-patient ratios. Hospitals are required to provide a sufficient level of assistive personnel.

- **Public disclosure**
  - Hospitals must disclose staffing levels to the public.

- **No averaging**
  - The ratios are the maximum number of patients assigned to any RN at all times during a shift – not an average.

- **Floats**
  - The law requires hospitals to staff units using nurses with a demonstrated competence in that clinical area, and who have undergone an orientation for that clinical practice.

- **Nursing homes**
  - In nursing homes, the bill phases in minimum staff-to-patient care hours for RNs, as well as LPNs and CNAs, and requires public disclosure of staffing levels.

  Additional legislation is needed to ensure adequate nurse staffing in schools, for home care, and in dialysis clinics not located within a hospital. NYSNA will advocate for laws to protect every patient.

### Proposed Ratios

These ratios are specified in the current version of the Safe Staffing for Quality Care Act.

<table>
<thead>
<tr>
<th>Department</th>
<th>Ratio</th>
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<tbody>
<tr>
<td>All intensive care</td>
<td>1:1</td>
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<tr>
<td>Emergency critical care</td>
<td>1:1</td>
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<tr>
<td>Trauma emergency unit</td>
<td>1:1</td>
</tr>
<tr>
<td>Operating room</td>
<td>1:1</td>
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<tr>
<td>Post-anesthesia care</td>
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</tr>
<tr>
<td>Labor – stage 1</td>
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<tr>
<td>Labor – stages 2 &amp; 3</td>
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<td>Newborn nursery</td>
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<tr>
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<tr>
<td>Step-down &amp; telemetry</td>
<td>1:3</td>
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<tr>
<td>Medical/surgical</td>
<td>1:4</td>
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<tr>
<td>Acute care psychiatric</td>
<td>1:4</td>
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<tr>
<td>Rehabilitation units</td>
<td>1:5</td>
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</table>
5 reasons we need nurse-to-patient ratio legislation

1 Safe Staffing Saves Lives.
The evidence of study after study has found that safe staffing saves lives – and improves patient outcomes overall.

2 Every patient deserves an RN.
Unsafe staffing levels mean that we have to make hard choices about how much time we spend with an individual patient. We need the staffing to make sure that every patient gets the care they need, when they need it.

3 Patients before profits.
Without a safe staffing law, our healthcare system allows the profits of private insurers to be put ahead of the needs of our patients. A private-insurance dominated system has led to understaffing, and patient outcomes have suffered. We need the state of New York to step in to ensure adequate staffing levels – and to make sure that every New Yorker gets the same level of care, regardless of their ability to pay.

4 Hospitals won’t police themselves.
Some hospital administrators claim that they are the best judge of the staffing levels our patients deserve. But hospitals across New York are understaffing and putting patients at risk. We need the state of New York to step in to set a limit on the minimum number of nurses for every patient. Every New Yorker deserves that.

5 We can’t afford unsafe staffing.
Hospitals will say they can’t afford safe staffing. We know from personal experience that they can’t afford unsafe staffing. Over the long term, safe staffing levels help hospital finances by reducing nurse burnout and turnover, reducing hospital-acquired infections and injuries, and improving patient outcomes. The move toward insurance-reimbursement models that reward positive patient outcomes will only reinforce this trend.

Our mission as nurses
Working with patients is the job of nurses. And our mission as nurses is to take care of our patients safely. Please, I ask you: help us rally for safe patient ratios.

Kagren Gayle, RN
New York-Presbyterian
The evidence-based case for nurse-to-patient ratios

Study after study has found that nurse staffing levels have a significant impact on patient outcomes and hospital financial performance.

Safe nurse-to-patient ratios:

- Save lives.
- Reduce adverse outcomes for patients.
- Help recruit and retain nurses.
- Save hospitals money by avoiding unreimbursed expenses for avoidable adverse outcomes, averting death and malpractice litigation, and reducing nurse turnover.

Safe staffing saves lives – and will save hospitals money

“Evidence of the favorable effects of better nurse staffing can be found not only in the comparison of nurse reports from better and poorer staffed hospitals but also in differences between these hospitals in the severity-adjusted likelihood that the patients being treated in these hospitals will be discharged alive.”

“When we use the predicted probabilities of dying from our adjusted models to estimate how many fewer deaths would have occurred in New Jersey and Pennsylvania hospitals if the average patient-to-nurse ratios in those hospitals had been equivalent to the average ratio across California hospitals, we get 13.9 percent (222/1,598) fewer surgical deaths in New Jersey and 10.6 percent (264/2,479) fewer surgical deaths in Pennsylvania.”


This paper examines primary survey data from 22,336 hospital staff nurses in California, Pennsylvania and New Jersey and state hospital discharge databases. The authors compare nurse workloads among the three states and how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workload across the hospitals in the three states.
“...there was a significant association between mortality and exposure to below-target [staffing] or high-turnover [of patients] shifts. For all hospital admissions, the risk of death increased with exposure to an increased number of below-target shifts.”

“We estimate that the risk of death increased by 2% for each below-target [staffing] shift and 4% for each high-turnover [of patients] to which a patient was exposed.”


This study analyzes data from a large tertiary academic medical center involving 197,961 admissions and 176,696 nursing shifts of 8 hours each in 43 hospital units to examine the association between mortality and patient exposure to nursing shifts with RN staffing 8 hours or more below the staffing target. They also examined the association between mortality and high patient turnover.

“We estimated that more than 6,700 in-hospital patient deaths could be avoided by raising nurse staffing.”


This study is based on results from a previous study conducted by the same authors, that analyzed data from 799 non-federal, acute care hospitals in 11 states and identified an association between nurse staffing and (1) lengths of stay, urinary tract infections, upper gastrointestinal bleeding, hospital-acquired pneumonia, shock, or cardiac arrest among medical patients and (2) failure-to-rescue, defined as the death of a patient with 1 of 5 life-threatening complications – pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis or deep vein thrombosis – among surgical patients. This study simulates the effects of three options to increase nurse staffing.

“... labor costs were higher with 4:1 [4 patients to 1 nurse] ratios than 8:1; however, more deaths occurred with the 8:1 ratio. They estimated that labor costs were $64,000 per life saved when dropping the number of patients from 7:1 to 6:1. When compared to other ‘life-saving’ interventions ... nurse staffing is a cost-effective intervention that should be a part of the financial strategic planning for acute care hospitals.”


This paper describes a practice/academic collaborative initiated to promote the translation of staffing research into decision-making through the development of an evidence-based staffing tool. Reports of previous research on nurse staffing and patient financial outcomes are summarized.

“Increasing RN staffing by one RN FTE/patient day was associated with a positive cost-savings ratio in different clinical settings. The monetary benefit of saved lives per 1,000 hospitalized patients was 2.3 times higher than the increased cost of one additional RN FTE/patient day in ICUs, 1.8 times higher in surgical units, and 1.3 times higher in medical units.”

“...we estimated that an increase by one RN FTE in ICUs would save 327,390 years of life in men and 320,988 in women with a productivity benefit (present value of lifetime future earnings) of $4 billion to $5 billion. The productivity benefit from increased staffing in surgical patients would be larger: $8 billion to $10 billion.”


In this study, the authors analyzed the savings-cost ratio of increased RN-to-patient ratios for patients in ICUs and patients in surgical and medical units based on a meta-analysis of 27 published observational studies that reported adjusted odds ratios of patient outcomes in categories of RN-to-patient ratio.
Safe staffing improves patient outcomes and reduces avoidable accidents and costs

“While inadequate staffing levels place heavy burdens on the nursing staff ... there is also a considerable financial cost to be considered.”

“For example, the cost of care for patients who developed pneumonia while in the hospital rose by 84 percent. Treating pneumonia raised total treatment costs by $22,390 - $28,505, while the length of stay increased 5.1 – 5.4 days and the probability of death rose by 4.67 – 5.5 percent. Pressure ulcers, another category of adverse patient even sensitive to nursing care, are estimated to cost $8.5 billion per year.”


This report summarizes the findings of AHRQ-funded and other research on the relationship of nurse staffing levels to adverse patient outcomes.

“Hospital-acquired infections (infections related primarily to intravenous and urinary catheters) were reduced when the TotHPD [total hours per day of nursing care] in general adult units and in the ICU were higher. In addition, the occurrence of postoperative sepsis was reduced by higher levels of RN skill mix in the ICU.”


This paper examines data from approximately 1.1 million adult patient discharges and staffing for 872 patient care units from 54 hospitals of the University HealthSystem Consortium, which is an alliance of 116 academic medical centers and 271 of their affiliated hospitals representing approximately 90% of the nation’s non-profit academic medical centers. The authors analyzed the data to determine the relationship between nurse staffing in general and intensive care units and patient outcomes, and also to determine whether safety net status affected this relationship.

“...we found an association between the proportion of total hours of nursing care provided by registered nurses or the number of registered-nurse-hours per day and six [adverse] outcomes among medical patients. These were the length of stay and the rates of urinary tract infections, upper gastrointestinal bleeding, hospital-acquired pneumonia, shock or cardiac arrest, and failure to rescue (the death of a patient with one of five life-threatening complications — pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis).”


This study examines administrative data from 1997 for 799 hospitals in 11 states (covering 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients) to examine the relation between the amount of care provided by nurses at the hospital and patients’ outcomes. They conducted regression analyses which controlled for patients’ risk of adverse outcomes, differences in the nursing care needed for each hospital’s patients, and other variables.
“... data analysis revealed that in the months of the study when nursing units had higher RN non-overtime staffing, the odds of patient readmission were lower. One SD [standard deviation] size increase in RN non-overtime staffing (0.75 hours-per-patient-day) was directly associated with a 0.44 reduction in the odds of an unplanned/related readmission for a 4.4 percentage point reduction in probability of readmission.”

“In this study sample, there was a direct, negative association between RN hours to which patients were exposed during hospitalization and the odds of subsequent readmission. Among patients hospitalized on the same nursing unit, those who were discharged when RN non-overtime staffing was higher were less likely to subsequently be readmitted.”


The authors examined data from a sample of patients who were at least 18 years of age, spoke English or Spanish, were hospitalized on a medical–surgical unit, and discharged directly home with or without home health services and without hospice care. Equivalent numbers of subjects were randomly selected within each of 16 participating medical–surgical units of four hospitals within a single health care system in the Midwestern United States.

“... higher nurse staffing levels have been associated with fewer of the hospital-acquired conditions and infections that the Centers for Medicare and Medicaid Services no longer pays for...”


Comparing the changes in staffing in California to other states (including New York) and the nation as a whole is necessary to determine the effect on staffing attributable to the state’s law. This paper analyzes hospitals’ registered nurse staffing, nursing skill mix, and a number of control variables in all adult, nonfederal, acute care hospitals in the United States during the period 1997-2008. The primary data source for hospital characteristics was the American Hospital Association Annual Survey for those years.

“...an increase of 1% in RN percentage in staffing reduced the number of adverse events [pressure ulcers, catheter–associated urinary tract infections and hospital-acquired injuries, air embolism, blood incompatibilities, vascular catheter-associated infections and mediastinitis following coronary bypass graft; which, if present, reduce reimbursement by CMS] by 3.4%, and a 5% increase in the RN percentage would decrease the number of adverse events by 15.8.”

“...every 1-hour increase in RN hours was expected to decrease LOS [length of stay] by 16.54%. Likewise, for every 1% increase in the percentage of RNs, LOS would be reduced by 4.18%.”

“Findings from the study are consistent with others reported in the literature and demonstrate the importance of improving staffing, particularly the number of RN hours and the percentage of RNs in the skill mix of medical-surgical units... Because the average costs per patient day is $1817 in US hospitals, a reduction in the LOS can lower costs for hospitals. When lower lengths of stay are combined with decreases in the number of adverse events, a net financial gain can be anticipated.”


This research examines the predictive relationships between nurse staffing and patient outcomes in nearly 35,000 patients from 11 medical-surgical units, in 4 urban and rural community hospitals of the Catholic Health Initiatives Corporation (a national, nonprofit organization), across 3 states. The data were extracted from administrative databases over a 2-year period.
Safe nurse staffing saves money by improving nurse retention and reducing staff turnover

“The higher proportion of nurses in hospitals whose patient assignment is in compliance with the benchmark set on California-mandated ratios, the lower the nurse burnout and job dissatisfaction, the less likely nurses are to report the quality of their work environment as only fair or poor, the less likely nurses are to report that their workload causes them to miss changes in patients’ conditions, and the less likely nurses are to intend to leave their jobs.”


This paper examines primary survey data from 22,336 hospital staff nurses in California, Pennsylvania and New Jersey and state hospital discharge databases. The authors compare nurse workloads among the three states and how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workload across the hospitals in the three states.

“... inadequate staff levels can lead to errors, delays, and missed care. Inadequate staffing levels are also correlated with nursing turnover and poor patient satisfaction. These costs and the negative consequences of poor staffing will increase the cost of care even though budgeted staffing goals are met.”


This paper describes a practice/academic collaborative initiated to promote the translation of staffing research into decision-making through the development of an evidence-based staffing tool. Reports of previous research on nurse staffing and patient and financial outcomes are summarized.

“... FY [fiscal year] 2007 per RN turnover cost would range from approximately $82,000 (ie, if turnover vacancies are filled by experienced RNs who have a shorter new-employee learning curve) to $88,000 (ie, if vacancies are filled by new RNs who have a longer learning curve).”


This paper uses nurse turnover data from a previous study to demonstrate how nurse turnover costs can be adjusted using relevant data from the Consumer Price Indices (CPIs). A previously developed method was modified to reflect current practices in health care organizations as well as changes in the CPI data calculation procedures.

“However, high nurse turnover and vacancy rates result in higher nurse-to-patient ratios—and nurses burned out by high patient loads leave the bedside, increasing turnover rates even more. One study reported that hospitals with a nurse-to-patient ratio of 1:7 had an average turnover rate of 18%, while rates at hospitals with a ratio of 1:4 averaged only 9%.”


The authors are the designers and managers of the UHC/AACN Nurse Residency Program™. The University HealthSystem Consortium is an alliance of 116 academic medical centers and 271 of their affiliated hospitals representing approximately 90% of the nation’s non-profit academic medical centers. The American Association of Colleges of Nursing is the national body for America’s baccalaureate- and higher degree nursing education programs.
“Failure to retain nurses is costly and wasteful. Every percentage point increase in nurse turnover costs an average hospital about $300,000 annually. Hospitals that perform poorly in nurse retention spend, on average, $3.6 million more than those with high retention rates.”

“HRI estimates that reduction in turnover can save an illustrative hospital up to $3.6 million annually. Based on an average hospital of 350 full-time-equivalent nurses, every percent increase in increased nurse turnover costs an average hospital about $300,000 annually.”


This paper studies the evolving issue of the predicted healthcare staffing shortage – both nurses and physicians. The authors conducted more than 40 in-depth interviews with thought leaders and executives representing hospitals, academic associations, nursing schools and the business community. They also conducted a literature review of reports and guidance from associations, regulators, and academia to summarize current challenges and best practices.

**Safe staffing saves lives and money in nursing homes**

“More RN direct care time per resident per day…was associated with fewer pressure ulcers, hospitalizations, and UTIs: less weight loss, catheterization, and deterioration in the ability to perform ADLs (activities of daily living)…”


This study examines the time nurses spend in direct care and how it affects outcomes in long-stay (two weeks or longer) nursing home residents. The authors examined secondary data from the National Pressure Ulcer Long-term Study as well as primary data collected from resident medical records.

“Nurse staffing levels have been documented to have a positive impact on both the process and the outcomes of nursing home care, such as fewer pressure ulcers, improved functional status, better mortality rates, and fewer deficiencies for poor quality.”

Harrington, C., Olney, B., Carrillo, & Kang, T. (2012). Nurse staffing and deficiencies in the largest for-profit nursing home chains and chains owned by private equity companies. *Health Services Research, 47*(1), 106-128.

This study compares staffing levels and deficiencies of the 10 largest U.S. for-profit nursing home chains with 5 other ownership groups before and after purchase by 4 private equity companies. The data were collected for the 2003-2008 period and controlled for facility characteristics, resident acuity and market factors.

“High turnover rates have also been related to both poor staff morale and low staffing levels. Elevated turnover rates are associated with adverse clinical outcomes in nursing facilities [nursing homes], including substantially increased rates of infectious disease and acute care hospitalizations, both which can lead to higher (and potentially avoidable) Medicare and Medicaid expenditures.”

“… as RN turnover increased [in nursing homes] from low (0% to 20%) to moderate (21% to 50%) levels, quality declined, as measured by more frequent use of restraints, urinary catheterization, and psychoactive drugs; increased risk of contractures and PUs [pressure ulcers]; and more survey deficiencies.”


This article synthesizes literature, including published reports, expert opinion, and peer reviewed studies, on staffing levels, and quality of care in nursing homes.
Part 2: Telling our story

10 tips for telling your story

What you say matters. The press, the public, and lawmakers all respect what you have to say.

Our stories as nurses are one of the most powerful tools we have to advocate for safe staffing.

Here are some tips to help deliver the most powerful message:

1 Tell a story. Think about a time when having more staff would have led to a better outcome for the patient – and tell that story.

We need to win the battle of hearts and minds – and nurses’ stories move people more powerfully than the facts on their own.

2 Keep the focus on patient care. We know that short staffing hurts nurses as well as patients. But we need to keep the focus on patient care to win the broadest possible support for this legislation.

3 Keep it to the point. We’ve all seen the press take what people say out of context. Your best protection is to keep what you have to say short and to the point.

4 Practice. Whether you’re meeting with a neighborhood leader, talking to the press, or meeting with your Assemblyperson, practice what you’re going to say with other nurses or NYSNA staff. It’s especially important to practice answering the hard questions they may ask you.

5 Get help. You’re not on your own. NYSNA’s communications staff can help you tell your story.

6 Be an advocate. Our job is to advocate for our patients – in our facilities, and in the public.
Some nurses are reluctant to talk publicly about what happens in their unit—yet if that information could help improve care on your unit, you have a professional responsibility to raise it with lawmakers.

You can be specific without breaking patient confidentiality. Omit any details that could be used to identify the patient—like date admitted or discharged, name, or out-of-the-ordinary specifics about their case.

Seek a personal connection. All of our listeners will be our patients at some point. Ask them about their experience, and what kind of care they want to receive.

8 Ask other nurses to tell their story by writing a letter to the editor, speaking to a leader in their community, or talking to a lawmaker. The more voices advocating for this law, the stronger we are.

9 Put in lay terms that the public will understand. Steer clear of nursing or medical jargon.

10 Get creative. Think about ways you can take your story to the public that you haven’t tried before—and do it. The press and the public are more likely to notice things they haven’t seen before.

To brainstorm creative actions, get in touch with NYSNA’s communications department at mobilizer@nysna.org.
Part 3: Getting members involved

Building a Safe Staffing Task Force in your facility

Every nurse has a role to play in our campaign to win safe staffing – some big, some small, all important.

Members won’t get involved if they aren’t asked. That’s why nurses have set a goal of building Safe Staffing Task Forces in every NYSNA facility.

Here’s what a Task Force does:

- **Educates members about the goals of the campaign** – and what they can do to be a part of it. Pledge cards are available from NYSNA to sign up members and find out what they’re willing to do.

- **Documents staffing problems on hospital units**, and brings members together to solve them.

- **Works with patients and community leaders to educate the public** about staffing issues.

- **Organizes delegations of nurses from the hospital to visit lawmakers** – in district and in Albany – to win their support for safe staffing legislation.

- **Asks members for their ideas and suggestions** for the campaign, and also answers their questions and addresses their concerns. We need to build the same sense of teamwork we see in action every day on the job.

Layoffs hurt patient care

The recent layoffs here at Westchester Medical Center – they laid off 132 nurses right before Christmas – has severely impacted staffing and patient care at the bedside.

Juliane Hatzel, RN
Westchester Medical Center
Getting members involved

▷ Hold regular meetings for your Safe Staffing Task Force. Keep meetings business-like. Make room for discussion but also make specific plans and assignments.

▷ Don’t confuse meetings with activity. Meetings aren’t activity. They are to plan activity.

▷ Make person-to-person contact the heart of your facility’s safe staffing campaign. Talking to nurses, members of the community, and lawmakers one-on-one is the most powerful organizing tool there is. Petitions and flyers are tools for getting people to talk. They’re no substitute.

▷ Ask supporters who can’t come to meetings to help. Many nurses are more likely to help on the floor where they work than to come to a meeting. Ask them how they want to be involved.

▷ Start small. Don’t overwhelm someone, especially when you are first trying to get them involved.

▷ Be specific. Specific requests with a definite beginning and end are less intimidating. “Can you fill out the Staffing Snapshot for your unit and shift for the next week?” is better than “We need people who will report about staffing.”

▷ Ask people to do things they do well – especially at first. As their confidence grows, so will their participation. Explain why you are asking them to help. “You’re respected by the nurses on your unit, that’s why I’m asking you to …”

▷ Tell each person how their job fits in with the rest. “We’re trying to get someone on every unit and shift to report back to us about staffing. Can you cover your unit for the next two weeks?”

▷ Respect members’ abilities and boundaries. Try to get people to take on more responsibility and get more involved— but also respect and appreciate what they are willing to do. Not everyone will participate the same amount or in the same way.

▷ Don’t give up on people. If you think someone is a potential asset to our effort, keep talking to them and asking them to get involved. One “No” doesn’t mean “Never.”

▷ Say “Thank you.”

How we built a Rapid Response Network

By Karine Raymond, RN
Montefiore Medical Center
Executive Committee

It’s 8 pm. I want to go home.... There’s a stack of fliers that need distributing. My feet are killing me....

The Executive Committee at Monte needed a real-time, cost effective tool for communicating with the members at any time. Texting became that tool.

During our negotiations, members enthusiastically provided their private cell phone numbers as a means of communication with their local union leadership.

It took time to collect and input the numbers. But it was an invaluable tool.

For the first time I remember, members felt connected and included in the process.

The Executive Committee responded to questions, concerns and issues within seconds.

We could refute erroneous communications from management quickly. Management no longer had an upper-hand in communicating with our members.
Part 4: Organizing at work

Organizing members for safe staffing where you work

We can’t wait on Albany for safe nurse-to-patient ratios. We can start pushing for – and winning – better staffing on our units right now.

Some NYSNA contracts include strong language on staffing. Others don’t. But no matter what your contract says, you can still bring members together to advocate for better staffing.

In this section, we’ll walk you through four steps to organize for safe staffing where you work.

**Step 1: Document the problem**

**Step 2: Decide what you’re asking for**

**Step 3: Make your case to management**

**Step 4: Try new forms of pressure**

Always and often:

- Ask other members to help with each step of the process.
- Be creative.

Find what works

This is a guide to organizing – not grievance writing. You’ll need to work with your LBU leaders, members of your Safe Staffing Task Force, and NYSNA staff to draft grievances and information requests that fit your contract language – and to figure out what works best in your facility.
**Step 1: Document the problem**

Too often, management is quick to dismiss nurses when we raise staffing issues. We need to be able to show them the units that are worst-staffed and back up our arguments with the facts.

**POAs and other documentation tools**

Many nurses already document staffing problems regularly, when they fill out Protest of Assignment forms.

The upside of using POAs is that so many members already fill them out. The downside is that they only record staffing levels at their worst. POAs don’t necessarily give you a complete picture of what staffing is like on a unit over a period of time – and you may miss units or shifts where members aren’t filling them out.

In other hospitals, nurses are documenting staffing levels with a new tool, a Staffing Snapshot, to record staffing over a longer period of time and identify the worst-staffed units. (See a sample on page 21.)

Whether you use POAs, the Staffing Snapshot, or both, you need to build your case over time across shifts and units. It’s harder for management to dismiss us when we’re able to show where staffing is a chronic, long-term problem.

**What to monitor**

Here are things to record to build up your case:

- Your unit’s census and the number of nurses on your shift.
- Discharges and admissions.
- Any sick calls.
- Patient acuity.
- Floats to and from your unit.

Keep track of positions that have been eliminated that management hasn’t filled when a nurse leaves.

After you file a grievance on staffing, you can submit an information request for the hospital’s staffing plan, and their actual staffing numbers. You’ll want to compare that information with your own survey, to see if it matches.

**St. Charles nurses take a snapshot**

Nurses at St. Charles Hospital on Long Island are recruiting one nurse on each unit and each shift to fill out the Staffing Snapshot every day.

Once a month, they sit down and compare the staffing numbers they collect with information provided by the hospital – and build a case for more nurses on the worst-staffed units.

Documenting staffing problems is one of the most immediate ways to get more members involved in our staffing campaign.

"Administration wants to blame nurses for staffing problems – even when they don’t plan for the usual number of sick calls," says Tracy Kosciuk, an RN at St. Charles.

"If you want to improve staffing, you have to do the work, collect the info, and build up your case."
Step 2: Decide what you’re asking for

Which demand is more likely to get management to fix the problem? “Staffing is a problem everywhere.” Or “We need one more nurse on the night shift in the ICU.”

You have to break down your big goal – improving staffing overall – into smaller, specific, winnable goals.

A good demand is:
- **Clear** to the members and to management. You need to tell management exactly what the problem is – and exactly how to fix it.
- **Specific.** Start by focusing on the units or shifts where staffing problems are the worst or are most easily addressed.
- **Winnable.** Members will get involved – and stay involved – when they see that they can make a difference.

You should get the same members who helped document the problem help identify the solution and prepare your case with management.

Fill vacant positions

When nurses retire or quit, is management filling those positions?

Demanding that these positions be filled can be a good place to start – especially if there’s no change in census, and fewer nurses are taking care of more positions.

Management’s blame game

Management often tries to shift the blame onto our co-workers. They say staffing problems are caused by nurses calling out sick.

You need to be prepared for this argument. Look at the average numbers of sick calls on your unit over a period of time.

Is management staffing at a level to cover the average number of sick calls? If not, you can use that to fire back when they try to blame you and your co-workers for short staffing.

Pay attention to the night shift

“I work the night shift – and sometimes we see the ratios of patients to nurses as high as 15 to one! Some nurses feel the burnout. We need safe ratios – our patients deserve the best care.”

Shonique Huger, RN
Bronx Lebanon Hospital
Step 3: Make your case to management

Now it’s time to take your case to management – and ask for specific improvements to staffing. A well-documented case is important – but not enough. Management needs to see that nurses on your unit are united behind your demand.

■ Be prepared. Outline your argument in advance, including any relevant contract language, POAs and other staffing documentation.

■ Review the information provided by the hospital and make note of any mistakes or problems – like if management says they are staffing a unit, but chronically floating nurses away from it.

■ Anticipate management’s arguments, like blaming staffing problems on sick calls. And make sure you have the documentation to back up your counter-argument. What’s the average level of sick calls – and is management taking that into account on each unit?

■ Show management that the members back your demand. A petition or a class action grievance is a good place to start.

■ Set a deadline for management to respond. Let management know that you will take more action if they don’t meet your demands – and be prepared to follow up with real escalation.

■ It’s your voice that matters. Your NYSNA staff rep has a valuable role to help you get ready for your meeting with management. They can help you document the problem, prepare your demand, and anticipate management’s counter-arguments.

But don’t let your rep do all the talking when you meet with management. We are our best advocates. And management will take notice when they see that more and more nurses are getting involved and playing a leading role in our fight for safe staffing.

Before the meeting, divide up the roles so that you can be sure more than one nurse speaks up.

Why filing a grievance is not enough

Grievances are an important tool in our fight for safe staffing. They make the official record. They give us the legal right to demand hospital documentation on staffing. And they make our proposed remedy crystal-clear.

But filing a grievance won’t solve the problem. Management has too much power to slow or stall the grievance procedure, and arbitrators take too long to make their decisions.

Grievances are most effective when they are backed up by members who are willing to take action for change in the workplace.
Step 4: Escalate

When you ask management to make staffing improvements, set a deadline for them to act. If they don’t agree to your improvements by then, it’s time to escalate.

Escalation could be a silent sign of solidarity – like wearing buttons or stickers. Or your action could be more in-your-face, like bringing a whole group of members into the boss’s office – to ask her why she won’t agree to your reasonable request.

But consider your next move carefully: you don’t want to escalate too fast. Members will stop participating – and management may not budge.

Here are some tips for careful escalation:

- **Be visible** with stickers, buttons, petitions, and other public activities. Management will feel more heat. And members are more likely to participate, and keep participating, when they see their friends and co-workers participating.

- **Take small steps.** The more members who participate, the stronger our efforts will be. If you go from zero to 60 MPH too fast, members will drop off. They’re more likely to stick with it if you slowly ratchet up the pressure.

- **Acknowledge members’ concerns.** If more than a few members say an action is too militant, it’s time to take a step back.

- **Leave yourself room to escalate again.** There’s always a new tactic to try to pressure the employer. Don’t take your message to the press and the public on day one – save these when you’ve exhausted your options in the hospital.

- **When you win – declare victory!**
Sample Staffing Snapshot: front page

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<tr>
<th>Unit:</th>
<th>Date:</th>
<th>Shift:</th>
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**List Nurse Names Below; Answer with Numbers, if none enter "0"**

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<th>Nurse 1</th>
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<th>Nurse 3</th>
<th>Nurse 4</th>
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**NYSNA Daily Staffing Information Collection**

- **Patients Assigned at Start of Shift:**
  - List Name: [ ]
  - Patients: [ ]

**TURN OVER**

- **New Patient Cts:** [ ]
- **Discharges:** [ ]
- **Admissions:** [ ]
- **Nurse:** [ ]
- **On 1:1:** [ ]
- **In/Cut:** [ ]
- **Transfers:** [ ]

You can download this staffing snapshot form to document overall hospital staffing by unit and shift from www.nysna.org/safestaffing.
Sample petition

Emergency Department RN Assaulted at Queens Hospital
Nurses Demand Immediate Action on Workplace Violence

“On Monday, April 23, 2012, a QHC Emergency Department nurse was assaulted, her neck badly bruised from the attack. She wanted to press charges, but a high-level nursing manager told security staff and police to drop the matter, as “he would take care of it.”

This is an outrage. We, the undersigned QHC RN’s, demand the following immediate actions:
1) File charges against the perpetrator,
2) Direct managers and Hospital Police to follow their own protocol for handling violent incidents.
3) Take steps to prevent future workplace violence in the Emergency Department, Psychiatry and other units with higher than average incidents of workplace violence, including the addition of sufficient staff -- both RNs and ancillary/security.

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Part 5: Building alliances

You already have more influence than you think

The fight for safe staffing ratios will take a huge concerted effort on our part – and we’re going to need a lot of help. We need to build strong community and political support networks. You already have more influence than you think.

The best way to get community support is to start where you already have relationships. Start with people you know – your own circle of neighbors, friends and family.

Take an inventory: “My brother-in-law happens to be a union electrician.” “My next-door neighbor is a teacher.” “My retired aunt knows everybody in her neighborhood.” “My traveling buddies are well-connected.” “My church Fellowship Committee meets next Sunday.”

Since you know these people and speak to them regularly, these are the people to start with to build community support for safe staffing.

Talk up our campaign with your family and friends. Most people – or a relative - have been hospitalized and appreciate the importance of good nursing care. Ask them to help – by writing a letter to their lawmaker, or by telling their own story of being a patient.

Keep your contacts up-to-date on the fight for staffing ratios. Email them an article or give them an flyer on the issue. Then, ask them to sign on to a petition or call a legislator. Maybe even join in to visit a local targeted politician. Can they get their own friends, neighbors and co-workers to do the same?

Get your co-workers to inventory their own personal circles and reach out to them. Work those contacts.

Take it up a notch in the larger community. You’ll want to pair the nurturing of your personal circles with outreach to the broader community, for example:

- Other local unions in your facility: Do they have chapter meetings? Can NYSNA make a presentation? Would they circulate a petition?

- Area Labor Federations and Central Labor Councils – NYSNA has delegates in almost every ALF and CLC in New York. Have a delegate make a presentation at a delegate meeting; ask for help with picket lines and petitions later.
NYSNA members march against the New York Police Department’s ‘Stop and Frisk’ policy.

Building community alliances is a two-way street where we connect our issues to the issues that matter to the people we serve.

**Health care facility Community Advisory Boards** – Be there regularly. You can pick up a lot of information as well as educate the members on safe staffing. Find out when and how you can make a presentation.

**Local merchant’s or business associations** – neighborhood business owners get sick, too.

**Health Fairs** – many politicians and civic organizations hold health fairs in their communities. We should be there, too. They appreciate NYSNA’s participation. We can talk to people, distribute information and get signatures on petitions while we are doing blood pressure screenings. Street fairs are a good place to meet allies, too.

- **Be inclusive and creative.**

  They should all be informed about safe staffing ratios. Don’t withhold the information from anyone. Include them in your campaign plans. People can help in a number of ways: signing a petition, sending a letter (you provide the draft and get a copy), signing a letter to the editor, going with you on a lobbying appointment, or making phone calls.

  - **Don’t drop the ball.** Remember, these are relationships we want to keep.

  Be there for them and their organizations as well.

  Keep folks in the loop. Let them know when we have a win, or if there are changes in the campaign.

  Include them in the victory celebration. After all, when we win it will benefit the whole community – which is the whole point.

  They’ll appreciate the follow-up and we’ll gain long-term allies.
Part 6: Passing the law

How we’re going to win in Albany

The Safe Staffing for Quality Care Act – the bill to establish safe nurse-to-patient ratios – has a lot of hurdles to clear before it becomes a law. Every hurdle becomes an opportunity for the healthcare industry to try and stop this bill. We need to build a powerful coalition of nurses, patients, community leaders, and lawmakers to pass this legislation and get it signed into law.

To win this fight, we have three main tasks ahead of us:

1. **Supporting our allies.** Many legislators already understand that safe staffing is the right thing to do. Every chance we get, we have to reinforce that message with them and provide them with opportunities to meet our members and community supporters.

2. **Winning over new allies.** Other legislators are new to healthcare issues, or have been confused by industry materials intended to make the issue confusing to legislators and the public. Our job is to present them with the evidence about our position and to provide them with exposure to our members and our supporters so they will vote the right way.

3. **Isolating hard-line ‘No’ votes.** Some legislators will never support our bill – because of their financial ties to the hospital industry, or some anti-labor bias. We need to find ways to make their ‘No’ vote an issue in their communities so when voters go to the polls, they understand their legislator is not a friend to patients and nurses.

That’s why each of us matters so much in this fight. Your visit to your legislator, together with your co-workers and community allies, makes a real difference.

Meeting them in their district office, right in the community where they live, has real impact.

Inviting legislators to come meet members at an event hosted by your local bargaining unit is a tremendous sign of the support our bill has.

You, your co-workers and our community supporters are our most powerful advocates.

We have the facts and the experience to convince lawmakers that we are right.

Now it’s up to all of us to win over their hearts and minds – and get this bill passed.

Our patients deserve this law

It’s all about patient care. When we don’t have enough nurses, the patient is going to suffer. That’s why we need to pass this law.

Karen Faraci, RN
Catskill Regional Medical Center
Making the most of a visit to your lawmaker

You can send letters and make phone calls. But the most effective way to lobby your lawmaker is to speak with them in their office.

Lawmakers are being asked to support different laws by different groups all the time. Nurses and community supporters talking to them about safe staffing makes a lasting impression.

■ **Find out where they stand.** NYSNA’s Governmental Affairs Department can let you know where the legislator stands on safe staffing legislation – and if they need extra support, or are still on the fence.

■ **Plan what you will say.** If several people are attending the meeting, choose one person to be the spokesperson for the group, and practice what you will say.

■ **Know what the opposition is saying.** Anticipate the arguments against your point of view and be ready to refute them.

■ **Bring as many members as you can from their district.** Seeing people who can vote them in – or vote them out – has a lot of influence on elected officials.

■ **Go for the head and the heart.** NYSNA has collected all the research showing that safe staffing legislation improves patient outcomes. Bring a copy with you. But also tell your story. You are a powerful advocate for our patients and our profession.

■ **Arrive for your appointment on time.**

■ **Ask for specific commitments and actions from the legislator.**

■ **Thank the legislator for meeting with you** and remind the legislator that you are available as a resource on healthcare issues.

■ **Follow up.** Write a letter to your legislator thanking them for their time. Remind the legislator of the bill you discussed and the commitments they made during the meeting.

■ **Report back.** We will establish a report-back system so that we can carefully monitor our progress.

This goes beyond party lines

“This is not a Republican problem. This is not a Democratic problem. This is a nursing problem.”

Seth Dressekie, RN
Woodhull Hospital
Scheduling in-district visits to your lawmaker

- **Schedule appointments as far as in advance as possible.** Legislators will usually give you between 15 and 30 minutes for a visit.

- **Plan for when they are in town.** From January to May, it is best to schedule your in-district meeting for Thursdays and Fridays because legislators spend the beginning of the week in Albany for session. In June, legislators are only back in their districts on Fridays. The legislature typically schedules a break late in February and April, so it may be possible to meet with your legislator in-district on a Monday-Wednesday at these times.

- **Ask with whom you will meet,** as well as or besides your legislator. While it is preferable to meet with your legislators, you may be asked to speak to a member of the staff. Legislative staff members often have considerable knowledge and influence and can provide significant insight into your legislators’ views.

- **Make sure they know you are a NYSNA nurse.**

- **Know what issues you plan to discuss,** in case asked.

- **Confirm your appointment.** Before your visit (at least one week in advance), confirm your appointment by calling your legislator’s office.

- **To get contact information for your lawmaker,** contact NYSNA’s Governmental Affairs office at (800) 724-6976 x 283 or legislative@nysna.org.

Taking action online

You can find out who represents you in the State Senate and Assembly – and send them an email – all from NYSNA’s Legislative Action Center, available on the front page of [www.nysna.org](http://www.nysna.org).

You’ll need a NYSNA User ID to login. To get your own unique ID, or if you have any other questions about the Legislative Action Center, call NYSNA’s Governmental Affairs office at (800) 724-6976, ext. 283, or email legislative@nysna.org.
Ratio myths vs. facts

Opponents of the Safe Staffing for Quality Care Act are already spreading myths about the law. They said the same thing when the nation’s first ratio law went into effect in California. Here are some of the myths – and what the facts say.

**Myth: Hospitals will not be able to comply with ratios**

**Facts: California hospitals did comply with nurse-to-patient ratios**

“Our findings suggest that registered nurse staffing in California hospitals increased considerably as a consequence of the implementation of the state’s nurse staffing mandate.”


This study analyzes data collected for the American Hospital Association Annual Survey for the years 1997-2008. The survey collects data from approximately 85% of the 6000 adult, nonfederal, acute care hospitals in the United States. The research goal was to assess the effect of California’s policy on changes in hospital staffing and skill mix.

“Compliance with nurse staffing ratios in medical/surgical units was found to be 90% prior to the implementation and 97% in the first two quarters of 2004.”


This study utilizes data from the California Hospital Annual Financial Disclosure Reports, which receives data from all California, licensed, nonfederal hospitals. Data from 2 fiscal years are analyzed, one year prior to the ratios implementation (FY 2000) and one year following the ratio implementation (FY 2006). The purpose of the analysis is to identify and describe changes in nurse and non-nursing staffing that may have occurred as a result of the enactment of the mandated nurse-to-patient ratios.

“Nurse workloads in California hospitals in 2006, 2 years after the implementation of mandated nurse staffing ratios, were significantly lower than in New Jersey and Pennsylvania hospitals. Nurses in California care for an average of one fewer patient each, and these lower ratios have sizeable effect on surgical patient mortality.”


This paper examines primary survey data from 22,336 hospital staff nurses in California, Pennsylvania and New Jersey and state hospital discharge databases. The authors compare nurse workloads among the three states and how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workload across the hospitals in the three states.
Myth: The costs of ratios will close hospitals.  
Facts: Hospitals have not closed as a result of ratios.

“Implementation of the staffing regulations could not be tied to changes in hospital finances; rather, changes in Medicare and Medi-Cal payment rates and demands to address seismic building requirements had far greater effects on finances.”

“In fact, it is likely that the staffing requirements had at most a marginal impact on hospital financial stability. Several of the nursing executives and managers reported that the staffing legislation made it easier to secure additional funding or avoid budget cuts within their own hospitals, particularly for hiring nursing staff.”


This study combined quantitative analysis of several data sets with qualitative analysis of interviews conducted at 12 hospitals. Quantitative analysis of the impact of the regulations on staffing, fiscal, and health outcomes were conducted for 140 general, acute-care hospitals from 1999-2007.

Myth: The mandated ratios will not actually translate into an increase in the hours of nursing care per patient.  
Facts: RN nursing hours did increase for California patients

“…the implementation of mandated nurse-to-patient ratios achieved the policy aim of reducing the number of patients assigned per licensed nurse and increased the number of worked nursing hours per patient day in acute care hospitals.”


This synthesis examines 12 studies of the impact of California’s ratios on patient care cost, quality, and outcomes in acute care hospitals.

“…the mean total RN hours of care per patient day increased by 20.8% on medical/surgical units…”


This study utilizes data from the California Hospital Annual Financial Disclosure Reports, which receives data from all California licensed, nonfederal hospitals. Data from 2 fiscal years are analyzed, one year prior to the ratios implementation (FY 2000) and one year following the ratio implementation (FY 2006). The purpose of the analysis is to identify and describe changes in nurse and non-nursing staffing that may have occurred as a result of the enactment of the mandated nurse-to-patient ratios.
**Myth: Nursing skill mix will decline.**

**Facts: The nursing skill mix increased in California.**

“The skill mix in California hospitals did not decrease following implementation of the staffing mandate as feared. In fact, it increased three percentage points.”


This study analyzes data collected for the American Hospital Association Annual Survey for the years 1997-2008. The survey collects data from approximately 85% of the 6000 adult, nonfederal, acute care hospitals in the United States. The research goal was to assess the effect of California’s policy on changes in hospital staffing and skill mix.

“... skill mix increased in California hospitals.”


This study combined quantitative analysis of several data sets with qualitative analysis of interviews conducted at 12 hospitals. Quantitative analysis of the impact of the regulations on staffing, fiscal, and health outcomes were conducted for 140 general, acute-care hospitals from 1999-2007.

**Myth: Non-nurse ancillary support services will be reduced.**

**Facts: RN hours rose and non-nurse staff hours were stable.**

“...unit-based support staff and other non-nurse staff mean productive hours per patient day or per service were not reduced. These findings suggest most hospitals did make upward adjustments to RN staffing in response to the mandated nurse-to-patient ratios....However, this adjustment did not decrease use of non-nurse staff....”


This study utilizes data from the California Hospital Annual Financial Disclosure Reports, which receives data from all California licensed, nonfederal hospitals. Data from 2 fiscal years are analyzed, one year prior to the ratios implementation (FY 2000) and one year following the ratio implementation (FY 2006). The purpose of the analysis is to identify and describe changes in nurse and non-nursing staffing that may have occurred as a result of the enactment of the mandated nurse-to-patient ratios.
Nurse-to-patient ratios improve patient outcomes and increase nurse retention.

“Outcomes are better for nurses and patients in hospitals that meet a benchmark based on California nurse staffing mandates whether [or not] the hospitals are located in California … the higher the percentage compliance with benchmark based on California ratios, regardless of the hospital state location, the less likely nurses are to report complaints from patients or families, verbal abuse of nurses by staff or patients, quality of care that is poor or only fair, and lack of confidence that their patients can manage after discharge.”


This paper examines primary survey data from 22,336 hospital staff nurses in California, Pennsylvania and New Jersey and state hospital discharge databases. The authors compare nurse workloads among the three states and how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workload across the hospitals in the three states.

“The sample’s overall job satisfaction increased significantly as the years passed, concurring with previous studies and suggesting the nurse-to-patient ratios law was associated with improvements in nurse satisfaction.”


This study is a secondary data analysis of survey data from the California Board of Registered Nursing Surveys from 1997 (before ratio implementation), 2004 (at the time of the implementation), 2006 (mid-term, post-implementation), and 2008 (long-term, post-implementation). The California Board of Registered Nurse Surveys collect and evaluate nursing workforce data to understand changes in the state’s workforce.
AN ACT to amend the public health law, in relation to enacting the “safe staffing for quality care act” and to amend the state finance law, in relation to moneys deposited into the improving quality of patient care fund

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1  Section 1. Short title. This act shall be known and may be cited as the “safe staffing for quality care act”.
2  S  2. Paragraphs (a) and (b) of subdivision 2 of section 2805 of the public health law, paragraph (a) as amended by chapter 923 of the laws of 1973 and paragraph (b) as added by chapter 795 of the laws of 1965, are amended to read as follows:
3     (a) Application for an operating certificate for a hospital shall be made upon forms prescribed by the department. The application shall [contain] INCLUDE the name of the hospital, the kind or kinds of hospital service to be provided, the location and physical description of the institution, a DOCUMENTED STAFFING PLAN, AS DEFINED IN SECTION
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EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.
TWENTY-EIGHT HUNDRED TWENTY-FOUR OF THIS ARTICLE, and such other information as the department may require.

(b) An operating certificate shall not be issued by the department unless it finds that the premises, equipment, personnel, DOCUMENTED STAFFING PLAN, rules and by-laws, standards of medical care, and hospital service are fit and adequate and that the hospital will be operated in the manner required by this article and rules and regulations thereunder.

S 3. The public health law is amended by adding nine new sections 2823, 2824, 2825, 2826, 2827, 2828, 2829, 2830 and 2831 to read as follows:

S 2823. POLICY AND PURPOSE. THE LEGISLATURE FINDS AND DECLARES ALL OF THE FOLLOWING:

1. HEALTH CARE SERVICES ARE BECOMING COMPLEX AND IT IS INCREASINGLY DIFFICULT FOR PATIENTS TO ACCESS INTEGRATED SERVICES;
2. THE QUALITY OF PATIENT CARE IS JEOPARDIZED BECAUSE OF NURSE STAFFING SHORTAGES AND IMPROPER UTILIZATION OF NURSING SERVICES;
3. TO ENSURE THE ADEQUATE PROTECTION OF PATIENTS IN HEALTH CARE SETTINGS, IT IS ESSENTIAL THAT QUALIFIED REGISTERED NURSES AND OTHER LICENSED NURSES BE ACCESSIBLE AND AVAILABLE TO MEET THE NEEDS OF PATIENTS; AND

S 2824. SAFE STAFFING; DEFINITIONS. THE FOLLOWING WORDS AND PHRASES, AS USED IN THIS ARTICLE, SHALL HAVE THE FOLLOWING MEANINGS UNLESS THE CONTEXT OTHERWISE PLAINLY REQUIRES:

1. “ACUTE CARE FACILITY” SHALL MEAN A GENERAL HOSPITAL, AND SHALL ALSO INCLUDE ANY CHRONIC DISEASE HOSPITAL, MATERNITY HOSPITAL, OUTPATIENT DEPARTMENT, EMERGENCY CENTER OR SURGICAL CENTER, AND SHALL ALSO INCLUDE ANY FACILITY THAT PROVIDES HEALTH CARE SERVICES PURSUANT TO THE MENTAL HYGIENE LAW, ARTICLE NINETEEN-G OF THE EXECUTIVE LAW OR THE CORRECTION LAW IF SUCH FACILITY IS OPERATED BY THE STATE OR A POLITICAL SUBDIVISION OF THE STATE OR A PUBLIC AUTHORITY OR PUBLIC BENEFIT CORPORATION.
2. “ACUITY SYSTEM” SHALL MEAN AN ESTABLISHED MEASUREMENT INSTRUMENT WHICH (A) PREDICTS NURSING CARE REQUIREMENTS FOR INDIVIDUAL PATIENTS BASED ON SEVERITY OF PATIENT ILLNESS, NEED FOR SPECIALIZED EQUIPMENT AND TECHNOLOGY, INTENSITY OF NURSING INTERVENTIONS REQUIRED, AND THE COMPLEXITY OF CLINICAL NURSING JUDGMENT NEEDED TO DESIGN, IMPLEMENT AND EVALUATE THE PATIENT’S NURSING CARE PLAN; (B) DETAILS THE AMOUNT OF NURSING CARE NEEDED, BOTH IN NUMBER OF DIRECT-CARE NURSES AND IN SKILL MIX OF NURSING PERSONNEL REQUIRED, ON A DAILY BASIS, FOR EACH PATIENT IN A NURSING DEPARTMENT OR UNIT; AND (C) IS STATED IN TERMS THAT READILY CAN BE USED AND UNDERSTOOD BY DIRECT-CARE NURSES. THE ACUITY SYSTEM SHALL TAKE INTO CONSIDERATION THE PATIENT CARE SERVICES PROVIDED NOT ONLY BY REGISTERED PROFESSIONAL NURSES BUT ALSO BY LICENSED PRACTICAL NURSES, SOCIAL WORKERS AND OTHER HEALTH CARE PERSONNEL.
3. “ASSESSMENT TOOL” SHALL MEAN A MEASUREMENT SYSTEM THAT COMPARES THE STAFFING LEVEL IN EACH NURSING DEPARTMENT OR UNIT AGAINST ACTUAL PATIENT NURSING CARE REQUIREMENTS IN ORDER TO REVIEW THE ACCURACY OF AN ACUITY SYSTEM.
4. “DIRECT-CARE NURSE” AND “DIRECT-CARE NURSING STAFF” SHALL MEAN ANY NURSE WHO HAS PRINCIPAL RESPONSIBILITY TO OVERSEE OR CARRY OUT MEDICAL REGIMENS, NURSING OR OTHER BEDSIDE CARE FOR ONE OR MORE PATIENTS.
5. “DOCUMENTED STAFFING PLAN” SHALL MEAN A DETAILED WRITTEN PLAN SETTING FORTH THE MINIMUM NUMBER AND CLASSIFICATION OF DIRECT-CARE NURS-
ES REQUIRED IN EACH NURSING DEPARTMENT OR UNIT IN AN ACUTE CARE FACILITY FOR A GIVEN YEAR, BASED ON REASONABLE PROJECTIONS DERIVED FROM THE PATIENT CENSUS AND AVERAGE ACUITY LEVEL WITHIN EACH DEPARTMENT OR UNIT DURING THE PRIOR YEAR, THE DEPARTMENT OR UNIT SIZE AND GEOGRAPHY, THE NATURE OF SERVICES PROVIDED AND ANY FORESEEABLE CHANGES IN DEPARTMENT OR UNIT SIZE OR FUNCTION DURING THE CURRENT YEAR.

6. “NURSE” SHALL MEAN A REGISTERED PROFESSIONAL NURSE OR LICENSED PRACTICAL NURSE LICENSED PURSUANT TO ARTICLE ONE HUNDRED THIRTY-NINE OF THE EDUCATION LAW.

7. “NURSING CARE” SHALL MEAN THAT CARE WHICH IS WITHIN THE DEFINITION OF THE PRACTICE OF NURSING PURSUANT TO SECTION SIXTY-NINE HUNDRED TWO OF THE EDUCATION LAW, OR OTHERWISE ENCOMPASSED WITH THE RECOGNIZED STANDARDS OF NURSING PRACTICE, INCLUDING ASSESSMENT, NURSING DIAGNOSIS, PLANNING, INTERVENTION, EVALUATION AND PATIENT ADVOCACY.

8. “SAFE STAFFING REQUIREMENTS” SHALL MEAN THE PROVISIONS OF SECTIONS TWENTY-EIGHT HUNDRED TWENTY-THREE THROUGH TWENTY-EIGHT HUNDRED THIRTY-ONE OF THIS ARTICLE AND ALL RULES AND REGULATIONS ADOPTED PURSUANT THERETO.

9. “SKILL MIX” SHALL MEAN THE DIFFERENCES IN LICENSING, SPECIALTY AND EXPERIENCE AMONG DIRECT-CARE NURSES.

10. “STAFFING LEVEL” SHALL MEAN THE ACTUAL NUMERICAL NURSE TO PATIENT RATIO WITHIN A NURSING DEPARTMENT OR UNIT.

11. “UNIT” SHALL MEAN A PATIENT CARE COMPONENT, AS DEFINED BY THE DEPARTMENT, WITHIN AN ACUTE CARE FACILITY.

12. “NON-NURSING DIRECT-CARE STAFF” SHALL MEAN ANY EMPLOYEE WHO IS NOT A NURSE OR OTHER PERSON LICENSED, CERTIFIED OR REGISTERED UNDER TITLE EIGHT OF THE EDUCATION LAW WHOSE PRINCIPAL RESPONSIBILITY IS TO CARRY OUT PATIENT CARE FOR ONE OR MORE PATIENTS OR PROVIDES DIRECT ASSISTANCE IN THE DELIVERY OF PATIENT CARE.

S 2825. COMMISSIONER AND COUNCIL; POWERS AND DUTIES. THE COMMISSIONER SHALL:

1. PROMULGATE, AFTER CONSULTATION WITH THE COUNCIL, THE RULES AND REGULATIONS NECESSARY TO CARRY OUT THE PURPOSES AND PROVISIONS OF THE SAFE STAFFING REQUIREMENTS, INCLUDING REGULATIONS DEFINING TERMS, SETTING FORTH DIRECT-CARE NURSE TO PATIENT RATIOS, SETTING FORTH NON-NURSING DIRECT-CARE STAFF TO PATIENT RATIOS AND PRESCRIBING THE PROCESS FOR APPROVING ACUITY SYSTEMS, WHICH MAY INCLUDE A SYSTEM FOR CLASS APPROVAL OF ACUITY SYSTEMS; AND

2. ASSURE THAT THE PROVISIONS OF SAFE STAFFING REQUIREMENTS ARE ENFORCED, INCLUDING THE ISSUANCE OF REGULATIONS WHICH AT A MINIMUM PROVIDE FOR AN ACCESSIBLE AND CONFIDENTIAL SYSTEM TO REPORT THE FAILURE TO COMPLY WITH SUCH REQUIREMENTS AND PUBLIC ACCESS TO INFORMATION REGARDING REPORTS OF INSPECTIONS, RESULTS, DEFICIENCIES AND CORRECTIONS PURSUANT TO SUCH REQUIREMENTS.

3. ESTABLISH A COMMITTEE TO ADVISE IN THE DEVELOPMENT OF REGULATIONS, INCLUDING REGISTERED PROFESSIONAL NURSE TO PATIENT STAFFING REQUIREMENTS AND NON-NURSING DIRECT-CARE STAFF TO PATIENT RATIOS THAT ARE NOT SPECIFIED IN THIS ARTICLE. THE COMMITTEE SHALL ADVISE THE COMMISSIONER ON THE EFFICACY OF ACUITY SYSTEMS SUBMITTED FOR APPROVAL, AND REVIEW AND MAKE RECOMMENDATIONS ON APPROVAL OF STAFFING PLANS PRIOR TO THE GRANTING OF AN OPERATING CERTIFICATE BY THE DEPARTMENT. THE COMMITTEE SHALL HAVE THIRTEEN MEMBERS. NO LESS THAN SIXTY PERCENT OF THE MEMBERS OF THE COMMITTEE SHALL BE REGISTERED PROFESSIONAL NURSES. THE COMMITTEE SHALL INCLUDE REGISTERED PROFESSIONAL NURSE DIRECT CARE PROVIDERS, REPRESENTATIVES OF ACUTE CARE FACILITIES, AND REPRESENTATIVES OF NURSING PROFESSIONAL ASSOCIATIONS AND RECOGNIZED OR CERTIFIED COLLECTIVE BARGAINING...
1. REPRESENTATIVE OF NURSES AND OF NON-NURSING DIRECT-CARE STAFF. THE
GOVERNOR SHALL APPOINT THE CHAIR AND SIX OTHER MEMBERS, TWO MEMBERS
SHALL BE APPOINTED BY THE SPEAKER OF THE ASSEMBLY, ONE MEMBER SHALL BE
APPOINTED BY THE MINORITY LEADER OF THE ASSEMBLY, TWO MEMBERS SHALL BE
APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE AND ONE MEMBER SHALL
BE APPOINTED BY THE MINORITY LEADER OF THE SENATE.

S 2826. STAFFING REQUIREMENTS. 1. STAFFING REQUIREMENTS. EACH ACUTE
CARE FACILITY SHALL ENSURE THAT IT IS STAFFED IN A MANNER THAT PROVIDES
SUFFICIENT, APPROPRIATELY QUALIFIED DIRECT-CARE NURSES IN EACH DEPART-
MENT OR UNIT WITHIN SUCH FACILITY IN ORDER TO MEET THE INDIVIDUALIZED
CARE NEEDS OF THE PATIENTS THEREIN. AT A MINIMUM, EACH SUCH FACILITY
SHALL MEET THE REQUIREMENTS OF SUBDIVISIONS TWO AND THREE OF THIS
SECTION.

2. STAFFING PLAN. THE DEPARTMENT SHALL NOT ISSUE AN OPERATING CERTIF-
ICATE TO ANY ACUTE CARE FACILITY UNLESS SUCH FACILITY ANNUALLY SUBMITS
TO THE DEPARTMENT A DOCUMENTED STAFFING PLAN AND A WRITTEN CERTIFICATION
THAT THE SUBMITTED STAFFING PLAN IS SUFFICIENT TO PROVIDE ADEQUATE AND
APPROPRIATE DELIVERY OF HEALTH CARE SERVICES TO PATIENTS FOR THE ENSUING
YEAR. THE DOCUMENTED STAFFING PLAN SHALL:

(A) MEET THE MINIMUM REQUIREMENTS SET FORTH IN SUBDIVISION THREE OF
THIS SECTION;

(B) BE ADEQUATE TO MEET ANY ADDITIONAL REQUIREMENTS PROVIDED BY OTHER
LAWS, RULES OR REGULATIONS;

(C) EMPLOY AND IDENTIFY AN APPROVED ACUITY SYSTEM FOR ADDRESSING FLUC-
TUATIONS IN ACTUAL PATIENT ACUITY LEVELS AND NURSING CARE REQUIREMENTS
REQUIRING INCREASED STAFFING LEVELS ABOVE THE MINIMUMS SET FORTH IN THE
PLAN;

(D) FACTOR IN OTHER UNIT OR DEPARTMENT ACTIVITY SUCH AS DISCHARGES,
TRANSFERS AND ADMISSIONS, AND ADMINISTRATIVE AND SUPPORT TASKS THAT IS
EXPECTED TO BE DONE BY DIRECT-CARE NURSES IN ADDITION TO DIRECT NURSING
CARE;

(E) INCLUDE A PLAN TO MEET NECESSARY STAFFING LEVELS AND SERVICES
PROVIDED BY NON-NURSING DIRECT-CARE STAFF IN MEETING PATIENT CARE NEEDS
PURSUANT TO SUBDIVISION ONE OF THIS SECTION; PROVIDED, HOWEVER, THAT THE
STAFFING PLAN SHALL NOT INCORPORATE OR ASSUME THAT NURSING CARE FUNC-
TIONS REQUIRED BY LAWS, RULES OR REGULATIONS, OR ACCEPTED STANDARDS OF
PRACTICE TO BE PERFORMED BY A REGISTERED PROFESSIONAL NURSE ARE TO BE
PERFORMED BY OTHER PERSONNEL;

(F) IDENTIFY THE ASSESSMENT TOOL USED TO VALIDATE THE ACUITY SYSTEM
RELIED ON IN THE PLAN;

(G) IDENTIFY THE SYSTEM THAT WILL BE USED TO DOCUMENT ACTUAL STAFFING
ON A DAILY BASIS WITHIN EACH DEPARTMENT OR UNIT;

(H) INCLUDE A WRITTEN ASSESSMENT OF THE ACCURACY OF THE PRIOR YEAR’S
STAFFING PLAN IN LIGHT OF ACTUAL STAFFING NEEDS;

(I) IDENTIFY EACH NURSE STAFF CLASSIFICATION REFERENCED IN SUCH PLAN
TOGETHER WITH A STATEMENT SETTING FORTH MINIMUM QUALIFICATIONS FOR EACH
SUCH CLASSIFICATION; AND

(J) BE DEVELOPED IN CONSULTATION WITH A MAJORITY OF THE DIRECT-CARE
NURSES WITHIN EACH DEPARTMENT OR UNIT OR, WHERE SUCH NURSES ARE REPRES-
ENTED, WITH THE APPLICABLE RECOGNIZED OR CERTIFIED COLLECTIVE BARGAINING
REPRESENTATIVE OR REPRESENTATIVES OF THE DIRECT-CARE NURSES AND OF OTHER
SUPPORTIVE AND ASSISTIVE STAFF.

3. MINIMUM STAFFING REQUIREMENTS. (A) THE DOCUMENTED STAFFING PLAN
SHALL INCORPORATE, AT A MINIMUM, THE FOLLOWING DIRECT-CARE NURSE-TO-PA-
TIENT RATIOS:
(I) ONE NURSE TO ONE PATIENT: OPERATING ROOM AND TRAUMA EMERGENCY UNITS AND ALL CRITICAL CARE AREAS INCLUDING EMERGENCY CRITICAL CARE AND ALL INTENSIVE CARE UNITS AND MATERNAL/CHILD CARE UNITS FOR THE SECOND OR THIRD STAGE OF LABOR;
(II) ONE NURSE TO TWO PATIENTS: MATERNAL/CHILD CARE UNITS FOR THE FIRST STAGE OF LABOR, AND POSTANESTHESIA UNITS;
(III) ONE NURSE TO THREE PATIENTS: ANTEPARTUM, EMERGENCY ROOM, PEDIATRICS, STEP-DOWN AND TELEMETRY UNITS AND UNITS FOR NEWBORNS AND INTERMEDIATE CARE NURSERY UNITS;
(IV) ONE NURSE TO THREE PATIENTS: POSTPARTUM MOTHER/BABY COUPLETS (MAXIMUM SIX PATIENTS PER NURSE);
(V) ONE NURSE TO FOUR PATIENTS: NON-CRITICAL ANTEPARTUM PATIENTS, AND MEDICAL/SURGICAL AND ACUTE CARE PSYCHIATRIC UNITS;
(VI) ONE NURSE TO FIVE PATIENTS: REHABILITATION UNITS; AND (VII) ONE NURSE TO SIX PATIENTS: WELL-BABY NURSERY UNITS.

FOR ANY UNITS NOT LISTED IN THIS PARAGRAPH, INCLUDING PSYCHIATRIC UNITS, AND ACUTE CARE FACILITIES OPERATED PURSUANT TO THE MENTAL HYGIENE LAW OR THE CORRECTION LAW, THE DEPARTMENT SHALL ESTABLISH BY REGULATION THE APPROPRIATE DIRECT-CARE NURSE-TO-PATIENT RATIO.

(B) THE NURSE-TO-PATIENT RATIOS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION SHALL REFLECT THE MAXIMUM NUMBER OF PATIENTS THAT MAY BE ASSIGNED TO EACH DIRECT-CARE NURSE IN A UNIT DURING ONE SHIFT. A NURSE, INCLUDING A NURSE ADMINISTRATOR OR SUPERVISOR, WHO DOES NOT HAVE PRINCIPAL RESPONSIBILITY AS A DIRECT-CARE NURSE FOR A SPECIFIC PATIENT SHALL NOT BE INCLUDED IN THE CALCULATION OF THE NURSE-TO-PATIENT RATIO.

4. LICENSED PRACTICAL NURSES. IN ANY SITUATION IN WHICH LICENSED PRACTICAL NURSES ARE INCLUDED IN THE DOCUMENTED STAFFING PLAN, ANY PATIENTS ASSIGNED TO THE LICENSED PRACTICAL NURSE SHALL ALSO BE INCLUDED IN CALCULATING THE NUMBER OF PATIENTS ASSIGNED TO ANY REGISTERED PROFESSIONAL NURSE WHO IS REQUIRED BY LAW, RULE, REGULATION, CONTRACT OR PRACTICE TO SUPERVISE OR OVERSEE THE DIRECT-NURSING CARE PROVIDED BY THE LICENSED PRACTICAL NURSE.

5. SKILL MIX. THE SKILL MIX SHALL NOT INCORPORATE OR ASSUME THAT NURSING CARE FUNCTIONS REQUIRED BY SECTION SIXTY-NINE HUNDRED TWO OF THE EDUCATION LAW OR ACCEPTED STANDARDS OF PRACTICE TO BE PERFORMED BY A REGISTERED PROFESSIONAL NURSE ARE TO BE PERFORMED BY A LICENSED PRACTICAL NURSE OR UNLICENSED ASSISTIVE PERSONNEL, OR THAT NURSING CARE FUNCTIONS REQUIRED BY SECTION SIXTY-NINE HUNDRED TWO OF THE EDUCATION LAW OR ACCEPTED STANDARDS OF PRACTICE TO BE PERFORMED BY A LICENSED PRACTICAL NURSE ARE TO BE PERFORMED BY UNLICENSED ASSISTIVE PERSONNEL.

6. ADJUSTMENTS. THE MINIMUM STAFFING REQUIREMENT AND NURSE-TO-PATIENT RATIO SET FORTH IN THIS SECTION SHALL BE ADJUSTED AS NECESSARY TO REFLECT THE NEED FOR ADDITIONAL DIRECT-CARE NURSES NECESSARY TO ENSURE ADEQUATE STAFFING OF EACH NURSING DEPARTMENT OR UNIT, IN ACCORDANCE WITH AN APPROVED ACUITY SYSTEM.

7. DEPARTMENT REGULATIONS. NOTHING IN THIS SECTION SHALL BE DEEMED TO PRECLUDE THE DEPARTMENT BY RULE OR REGULATION FROM ESTABLISHING AND REQUIRING A DOCUMENTED STAFFING PLAN TO HAVE HIGHER NURSE-TO-PATIENT RATIOS THAN THOSE SET FORTH IN THIS SECTION.

8. NOTHING CONTAINED IN THIS SECTION SHALL BE DEEMED TO ALTER, AFFECT THE VALIDITY OF, MODIFY THE TERMS OF, OR IMPAIR ANY COLLECTIVE BARGAINING AGREEMENT.

S 2827. COMPLIANCE WITH STAFFING PLAN AND RECORDKEEPING. 1. AS A CONDITION FOR THE MAINTENANCE OF AN OPERATING CERTIFICATE, EACH ACUTE CARE FACILITY SHALL AT ALL TIMES STAFF IN ACCORDANCE WITH ITS DOCUMENTED STAFFING PLAN AND THE STAFFING STANDARDS SET FORTH IN SECTION
TWENTY-EIGHT HUNDRED TWENTY-SIX OF THIS ARTICLE; PROVIDED, HOWEVER, THAT
NOTHING IN THIS SECTION SHALL BE DEEMED TO PROHIBIT ANY SUCH FACILITY
FROM IMPLEMENTING HIGHER DIRECT-CARE NURSE-TO-PATIENT STAFFING LEVELS,
NOR SHALL THE REQUIREMENTS SET FORTH IN SUCH SECTION TWENTY-EIGHT
HUNDRED twenty-six of this Article be deemed to supercede or replace any
Higher requirements otherwise mandated by law, rule, regulation or
contract.

2. FOR PURPOSES OF COMPLIANCE WITH THE MINIMUM STAFFING REQUIREMENTS
STANDARDS SET FORTH IN SECTION TWENTY-EIGHT HUNDRED TWENTY-SIX OF THIS
ARTICLE, NO NURSE SHALL BE ASSIGNED, OR INCLUDED IN THE NURSE-TO-PATIENT
RATIO COUNT IN A NURSING UNIT OR A CLINICAL AREA WITHIN AN ACUTE CARE
FACILITY UNLESS THAT NURSE HAS AN APPROPRIATE LICENSE PURSUANT TO ARTI-
CLE ONE HUNDRED thirty-nine of the Education Law, has received prior
ORIENTATION IN THAT CLINICAL AREA SUFFICIENT TO PROVIDE COMPETENT NURS-
ing CARE TO THE PATIENTS IN THAT UNIT OR CLINICAL AREA, AND HAS DEMON-
STRATED CURRENT COMPETENCE IN PROVIDING CARE IN THAT UNIT OR CLINICAL
AREA. ACUTE CARE FACILITIES THAT UTILIZE TEMPORARY NURSING AGENCIES
SHALL HAVE AND ADHERE TO A WRITTEN PROCEDURE TO ORIENT AND EVALUATE
PERSONNEL FROM SUCH SOURCES TO ENSURE ADEQUATE ORIENTATION AND COMPETEN-
CY PRIOR TO INCLUSION IN THE NURSE-TO-PATIENT RATIO. IN THE EVENT OF AN
EMERGENCY STAFFING SITUATION IN WHICH INSUFFICIENT STAFFING MAY LEAD TO
UNSAFE PATIENT CARE, NURSES MAY BE TEMPORARILY ASSIGNED TO A DIFFER-
ENT UNIT OR CLINICAL AREA, PROVIDED THAT SUCH NURSES SHALL BE ASSIGNED
PATIENTS APPROPRIATE TO THEIR SKILL AND COMPETENCY LEVEL. THE FACILITY
SHALL ESTABLISH A CONSISTENT PLAN FOR ADDRESSING EMERGENCY STAFFING
SITUATIONS AND MONITOR OUTCOMES. EMERGENCIES ARE DEFINED AS NATURAL
DISASTERS, DECLARED EMERGENCIES, MASS CASUALTY INCIDENTS OR OTHER EVENTS
NOT REASONABLY ANTICIPATED AND PLANNED FOR AND NOT REGULARLY OCCURRING
WITHIN THE FACILITY.

3. AS A CONDITION FOR THE MAINTENANCE OF AN OPERATING CERTIFICATE,
each acute care facility shall maintain accurate daily records showing:
(A) THE NUMBER OF PATIENTS ADMITTED, RELEASED AND PRESENT IN EACH
NURSING DEPARTMENT OR UNIT WITHIN SUCH FACILITY;
(B) THE INDIVIDUAL ACUITY LEVEL OF EACH PATIENT PRESENT IN EACH NURS-
ing DEPARTMENT OR UNIT WITHIN SUCH FACILITY; AND
(C) THE IDENTITY AND DUTY HOURS OF EACH DIRECT-CARE NURSE IN EACH
NURSING DEPARTMENT OR UNIT WITHIN SUCH FACILITY.

4. AS A CONDITION FOR THE MAINTENANCE OF AN OPERATING CERTIFICATE,
each acute care facility shall maintain daily statistics, by nursing
department and unit, of mortality, morbidity, infection, accident, inju-
ry and medical errors.

5. ALL RECORDS REQUIRED TO BE KEPT PURSUANT TO THIS SECTION SHALL BE
MAINTAINED FOR A PERIOD OF SEVEN YEARS.

6. ALL RECORDS REQUIRED TO BE KEPT PURSUANT TO THIS SECTION SHALL BE
MADE AVAILABLE UPON REQUEST TO THE DEPARTMENT AND TO THE PUBLIC;
PROVIDED, HOWEVER, THAT INFORMATION RELEASED TO THE PUBLIC SHALL COMPLY
WITH THE APPLICABLE PATIENT PRIVACY LAWS, RULES AND REGULATIONS, AND
THAT IN FACILITIES OPERATED PURSUANT TO THE CORRECTION LAW THE IDENTITY
AND HOURS OF STAFF SHALL NOT BE RELEASED TO THE PUBLIC.

§ 2828. WORK ASSIGNMENT POLICY. 1. GENERAL. AS A CONDITION FOR THE
MAINTENANCE OF AN OPERATING CERTIFICATE, EACH ACUTE CARE FACILITY SHALL
ADOPT, DISSEMINATE TO DIRECT-CARE NURSES AND COMPLY WITH A WRITTEN WORK
ASSIGNMENT POLICY, THAT MEETS THE REQUIREMENTS OF SUBDIVISIONS TWO AND
THREE OF THIS SECTION, DETAILING THE CIRCUMSTANCES UNDER WHICH A
DIRECT-CARE NURSE MAY REFUSE A WORK ASSIGNMENT.
2. MINIMUM CONDITIONS. AT A MINIMUM, THE WORK ASSIGNMENT POLICY SHALL PERMIT A DIRECT-CARE NURSE TO REFUSE AN ASSIGNMENT:

(A) FOR WHICH THE NURSE IS NOT PREPARED BY EDUCATION, TRAINING OR EXPERIENCE TO SAFELY FULFILL THE ASSIGNMENT WITHOUT COMPROMISING OR JEOPARDIZING PATIENT SAFETY, THE NURSE’S ABILITY TO MEET FORESEEABLE PATIENT NEEDS OR THE NURSE’S LICENSE; OR

(B) WOULD OTHERWISE VIOLATE THE SAFE STAFFING REQUIREMENTS.

3. MINIMUM PROCEDURES. AT A MINIMUM, THE WORK ASSIGNMENT POLICY SHALL CONTAIN PROCEDURES FOR THE FOLLOWING:

(A) REASONABLE REQUIREMENTS FOR PRIOR NOTICE TO THE NURSE’S SUPERVISOR REGARDING THE NURSE’S REQUEST AND SUPPORTING REASONS FOR BEING RELIEVED OF AN ASSIGNMENT OR CONTINUED DUTY;

(B) WHERE FEASIBLE, AN OPPORTUNITY FOR THE SUPERVISOR TO REVIEW THE SPECIFIC CONDITIONS SUPPORTING THE NURSE’S REQUEST, AND TO DECIDE WHETHER TO REMEDY THE CONDITIONS, TO RELIEVE THE NURSE OF THE ASSIGNMENT, OR TO DENY THE NURSE’S REQUEST TO BE RELIEVED OF THE ASSIGNMENT OR CONTINUED DUTY;

(C) A PROCESS THAT PERMITS THE NURSE TO EXERCISE THE RIGHT TO REFUSE THE ASSIGNMENT OR CONTINUED ON-DUTY STATUS WHEN THE SUPERVISOR DENIES THE REQUEST TO BE RELIEVED IF:

(I) THE SUPERVISOR REJECTS THE REQUEST WITHOUT PROPOSING A REMEDY OR THE PROPOSED REMEDY WOULD BE INADEQUATE OR UNTIMELY,

(II) THE COMPLAINT AND INVESTIGATION PROCESS WITH A REGULATORY AGENCY WOULD BE UNTIMELY TO ADDRESS THE CONCERN, AND

(III) THE EMPLOYEE IN GOOD FAITH BELIEVES THAT THE ASSIGNMENT MEETS CONDITIONS JUSTIFYING REFUSAL; AND

(D) RECOGNITION THAT A NURSE WHO REFUSES AN ASSIGNMENT PURSUANT TO A WORK ASSIGNMENT POLICY AS SET FORTH IN THIS SECTION SHALL NOT BE DEEMED, BY REASON THEREOF, TO HAVE ENGAGED IN NEGLIGENT OR INCOMPETENT ACTION, PATIENT ABANDONMENT, OR OTHERWISE TO HAVE VIOLATED ANY LAW RELATING TO NURSING.

S 2829. PUBLIC DISCLOSURE OF STAFFING REQUIREMENTS. EVERY ACUTE CARE FACILITY SHALL:

1. POST IN A CONSPICUOUS PLACE READILY ACCESSIBLE TO THE GENERAL PUBLIC A NOTICE PREPARED BY THE DEPARTMENT SETTING FORTH A SUMMARY OF THE SAFE STAFFING REQUIREMENTS APPLICABLE TO THAT FACILITY TOGETHER WITH INFORMATION ABOUT WHERE DETAILED INFORMATION ABOUT THE FACILITY’S STAFFING PLAN AND ACTUAL STAFFING MAY BE OBTAINED;

2. UPON REQUEST, MAKE COPIES OF THE DOCUMENTED STAFFING PLAN FILED WITH THE DEPARTMENT AVAILABLE TO THE PUBLIC; AND

3. UPON REQUEST MAKE READILY AVAILABLE TO THE NURSING STAFF WITHIN A DEPARTMENT OR UNIT, DURING EACH WORK SHIFT, THE FOLLOWING INFORMATION:

(A) A COPY OF THE CURRENT STAFFING PLAN FOR THAT DEPARTMENT OR UNIT,

(B) DOCUMENTATION OF THE NUMBER OF DIRECT-CARE NURSES REQUIRED TO BE PRESENT DURING THE SHIFT, BASED ON THE APPROVED ADOPTED ACUITY SYSTEM, AND

(C) DOCUMENTATION OF THE ACTUAL NUMBER OF DIRECT-CARE NURSES PRESENT DURING THE SHIFT.

S 2830. ENFORCEMENT RESPONSIBILITIES. THE DEPARTMENT SHALL NOT DELEGATE ITS RESPONSIBILITIES TO ENFORCE THE SAFE STAFFING REQUIREMENTS PROMULGATED PURSUANT TO THIS ARTICLE.

S 2831. ENFORCEMENT AND PENALTIES. 1. CIVIL PENALTY. ANY PERSON, REGARDLESS OF WHETHER THAT PERSON POSSESSES AN OPERATING CERTIFICATE, WHO HAS COMMITTED A VIOLATION OF ANY OF THE PROVISIONS OF THE SAFE STAFFING REQUIREMENTS, INCLUDING FAILURE TO CORRECT A SERIOUS VIOLATION (AS DEFINED BY REGULATION) WITHIN THE TIME SPECIFIED IN A DEFICIENCY
CITATION, MAY BE ASSESSED A CIVIL PENALTY BY ORDER OF THE DEPARTMENT OF
UP TO FIVE HUNDRED DOLLARS FOR EACH DEFICIENCY FOR EACH DAY THAT EACH
DEFICIENCY CONTINUES; PROVIDED, HOWEVER, THAT AN ACUTE HEALTH CARE
FACILITY THAT FAILS TO COMPLY WITH THE REQUIREMENTS OF SECTION
TWENTY-EIGHT HUNDRED TWENTY-SIX OF THIS ARTICLE MAY BE ASSESSED A CIVIL
PENALTY BY ORDER OF THE DEPARTMENT OF UP TO TEN THOUSAND DOLLARS FOR
EACH DAY OF NON-COMPLIANCE. CIVIL PENALTIES SHALL BE COLLECTED FROM THE
DATE SUCH FACILITY RECEIVES NOTICE OF VIOLATION UNTIL THE DATE SUCH
VIOLATION IS CORRECTED.

2. CIVIL PENALTY FOR INTERFERENCE WITH REPORTING OBLIGATIONS. ANY
PERSON OR ACUTE CARE FACILITY THAT FAILS TO REPORT OR FALSIFIES INFORMA-
TION, OR COERCES, THREATENS, INTIMIDATES OR OTHERWISE INFLUENCES ANOTHER
PERSON TO FAIL TO REPORT OR TO FALSIFY INFORMATION REQUIRED TO BE
REPORTED UNDER THE SAFE STAFFING REQUIREMENTS, MAY BE ASSESSED A CIVIL
PENALTY OF UP TO TEN THOUSAND DOLLARS FOR EACH SUCH INCIDENT.

3. PRIVATE RIGHT OF ACTION FOR VIOLATIONS OF SECTION TWENTY-EIGHT
HUNDRED TWENTY-EIGHT OF THIS ARTICLE. ANY ACUTE CARE FACILITY THAT
VIOLATES THE RIGHTS OF AN EMPLOYEE PURSUANT TO AN ADOPTED WORK ASSIGN-
MENT POLICY UNDER SECTION TWENTY-EIGHT HUNDRED TWENTY-EIGHT OF THIS
ARTICLE MAY BE HELD LIABLE TO SUCH EMPLOYEE IN AN ACTION BROUGHT IN A
COURT OF COMPETENT JURISDICTION FOR SUCH LEGAL OR EQUITABLE RELIEF AS
MAY BE APPROPRIATE TO EFFECTUATE THE PURPOSES OF THE SAFE STAFFING
REQUIREMENTS, INCLUDING BUT NOT LIMITED TO REINSTATEMENT, PROMOTION,
LOST WAGES AND BENEFITS, AND COMPENSATORY AND CONSEQUENTIAL DAMAGES
RESULTING FROM THE VIOLATION TOGETHER WITH AN EQUAL AMOUNT IN LIQUIDATED
DAMAGES. THE COURT IN SUCH ACTION SHALL, IN ADDITION TO ANY JUDGMENT
AWARDED TO A PREVAILING PLAINTIFF, AWARD REASONABLE ATTORNEYS' FEES AND
COSTS OF ACTION TO BE PAID BY THE DEFENDANT. AN EMPLOYEE’S RIGHT TO
INSTITUTE A PRIVATE ACTION PURSUANT TO THIS SUBDIVISION SHALL NOT BE
LIMITED BY ANY OTHER RIGHT GRANTED BY THE SAFE STAFFING REQUIREMENTS.

S 4. Section 2801-a of the public health law is amended by adding a new subdivision 3-b to read as follows:

3-B. IN CONSIDERING CHARACTER, COMPETENCE AND STANDING IN THE COMMU-
NITY UNDER SUBDIVISION THREE OF THIS SECTION, THE PUBLIC HEALTH COUNCIL
SHALL CONSIDER ANY PAST VIOLATIONS OF STATE OR FEDERAL RULES, REGU-
LATIONS OR STATUTES RELATING TO EMPLOYER-EMPLOYEE RELATIONS, WORKPLACE
SAFETY, COLLECTIVE BARGAINING OR ANY OTHER LABOR RELATED PRACTICES,
OBLIGATIONS OR IMPERATIVES. THE PUBLIC HEALTH COUNCIL SHALL GIVE
SUBSTANTIAL WEIGHT TO VIOLATIONS OF THE PUBLIC HEALTH LAW PROVISIONS
CONCERNING NURSE STAFF AND SUPPORTIVE STAFF RATIOS.

S 5. Section 2805 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. IN DETERMINING WHETHER TO ISSUE OR RENEW AN OPERATING CERTIFICATE
TO AN APPLICANT SEEKING TO OPERATE, OR OPERATING, A HOSPITAL IN ACCORD-
ANCE WITH THIS ARTICLE, THE COMMISSIONER SHALL CONSIDER ANY PAST
VIOLATIONS OF STATE OR FEDERAL RULES, REGULATIONS OR STATUTES RELATING
TO EMPLOYER-EMPLOYEE RELATIONS, WORKPLACE SAFETY, COLLECTIVE BARGAINING
OR ANY OTHER LABOR RELATED PRACTICES, OBLIGATIONS OR IMPERATIVES. THE
PUBLIC HEALTH COUNCIL SHALL GIVE SUBSTANTIAL WEIGHT TO VIOLATIONS OF THE
PUBLIC HEALTH LAW PROVISIONS CONCERNING NURSE STAFF AND SUPPORTIVE STAFF
RATIOS.

S 6. Subdivisions 2 and 4 of section 97-aaaa of the state finance law, as added by chapter 24 of the laws of 2002, are amended to read as follows:

2. Such fund shall consist of all moneys received from civil penalties assessed in actions commenced pursuant to section seven hundred forty-
one of the labor law AND CIVIL PENALTIES ASSESSED PURSUANT TO SECTION TWENTY-EIGHT HUNDRED THIRTY-ONE OF THE PUBLIC HEALTH LAW.

4. Moneys in the account, following appropriation by the legislature, shall be expended by the department of health for the purpose of improving the direct treatment and care of patients in facilities providing health care services that are licensed pursuant to article twenty-eight or thirty-six of the public health law or which operate and provide health care services under the mental hygiene law, the education law, or the correction law. THE DEPARTMENT SHALL GIVE SUBSTANTIAL WEIGHT TO FUNDING INITIATIVES TO IMPROVE STAFFING RATIOS IN HEALTH CARE FACILITIES OR TO REDUCE THE USE OF EXCESSIVE OVERTIME AMONG NURSING STAFF.

S 7. The public health law is amended by adding a new section 2895-b to read as follows:

S 2895-B. NURSING HOME STAFFING LEVELS. 1. DEFINITIONS. AS USED IN THIS SECTION, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS:

(A) “ADVISORY COUNCIL” MEANS THE ADVISORY COUNCIL ON NURSING HOME STAFFING CREATED IN SUBDIVISION TWO OF THIS SECTION.

(B) “CERTIFIED NURSE AIDE” MEANS ANY PERSON INCLUDED IN THE NURSING HOME NURSE AIDE REGISTRY PURSUANT TO SECTION TWENTY-EIGHT HUNDRED THREE-J OF THIS CHAPTER.

(C) “STAFFING RATIO” MEANS THE QUOTIENT OF THE NUMBER OF PERSONNEL IN A PARTICULAR CATEGORY REGULARLY ON DUTY FOR A PARTICULAR TIME PERIOD IN A NURSING HOME DIVIDED BY THE NUMBER OF RESIDENTS OF THE NURSING HOME AT THAT TIME.

2. ADVISORY COUNCIL ON NURSING HOME STAFFING. THERE IS HEREBY CREATED IN THE DEPARTMENT AN ADVISORY COUNCIL ON NURSING HOME STAFFING TO STUDY AND MAKE RECOMMENDATIONS RELATING TO THE STAFFING STANDARDS UNDER THIS SECTION. THE ADVISORY COUNCIL SHALL BE APPOINTED BY THE COMMISSIONER AND SHALL BE COMPOSED OF REPRESENTATIVES OF NURSING HOME OPERATORS, CONSUMERS, AND NON-ADMINISTRATIVE NURSING HOME EMPLOYEES AND THE PUBLIC. THE ADVISORY COUNCIL SHALL, FROM TIME TO TIME, REPORT TO THE GOVERNOR, THE LEGISLATURE, THE PUBLIC AND THE COMMISSIONER ANY RECOMMENDATIONS REGARDING STAFFING LEVELS IN NURSING HOMES.

3. STAFFING STANDARDS. (A) THE COMMISSIONER, IN CONSULTATION WITH THE ADVISORY COUNCIL, SHALL, BY REGULATION, ESTABLISH STAFFING STANDARDS FOR NURSING HOME MINIMUM STAFFING LEVELS TO MEET APPLICABLE STANDARDS OF SERVICE AND CARE AND TO PROVIDE SERVICES TO ATTAIN OR MAINTAIN THE HIGHEST PRACTICABLE PHYSICAL, MENTAL, AND PSYCHOSOCIAL WELL-BEING OF EACH RESIDENT OF THE NURSING HOME. THE COMMISSIONER SHALL ALSO REQUIRE BY REGULATION THAT EVERY NURSING HOME MAINTAIN RECORDS ON ITS STAFFING LEVELS, REPORT ON SUCH RECORDS TO THE DEPARTMENT, AND MAKE SUCH RECORDS AVAILABLE FOR INSPECTION BY THE DEPARTMENT.

(B) EVERY NURSING HOME SHALL:

(I) COMPLY WITH THE STAFFING STANDARDS UNDER THIS SECTION; AND

(II) EMPLOY SUFFICIENT STAFFING LEVELS TO MEET APPLICABLE STANDARDS OF SERVICE AND CARE AND TO PROVIDE SERVICE AND CARE AND TO PROVIDE SERVICES TO ATTAIN OR MAINTAIN THE HIGHEST PRACTICABLE PHYSICAL, MENTAL, AND PSYCHOSOCIAL WELL-BEING OF EACH RESIDENT OF THE NURSING HOME.

(C) SUBJECT TO SUBDIVISION FIVE OF THIS SECTION, STAFFING STANDARDS UNDER THIS SECTION SHALL, AT A MINIMUM, BE THE STAFFING STANDARDS UNDER SUBDIVISION FOUR OF THIS SECTION.

(D) IN DETERMINING COMPLIANCE WITH THE STAFFING STANDARDS UNDER THIS SECTION, AN INDIVIDUAL SHALL NOT BE COUNTED WHILE PERFORMING SERVICES THAT ARE NOT DIRECT NURSING CARE, SUCH AS ADMINISTRATIVE SERVICES, FOOD PREPARATION, HOUSEKEEPING, LAUNDRY, MAINTENANCE SERVICES, OR OTHER ACTIVITIES THAT ARE NOT DIRECT NURSING CARE.
4. STATUTORY STANDARD. BEGINNING TWO YEARS AFTER THE EFFECTIVE DATE OF THIS SECTION, EVERY NURSING HOME SHALL MAINTAIN A STAFFING RATIO EQUAL TO AT LEAST THE FOLLOWING:

(A) FROM 2.4 TO 2.8 HOURS OF CARE PER RESIDENT PER DAY BY A CERTIFIED NURSE AIDE;

(B) FROM 1.15 TO 1.3 HOURS OF CARE PER RESIDENT PER DAY BY A LICENSED PRACTICAL NURSE OR A REGISTERED NURSE; AND

(C) FROM 0.55 TO 0.75 HOURS OF CARE PER RESIDENT PER DAY BY A REGISTERED NURSE.

5. PHASE-IN. (A) THE COMMISSIONER SHALL MAKE THE FIRST REGULATIONS UNDER SUBDIVISION THREE OF THIS SECTION WITHIN ONE YEAR AFTER THIS SECTION BECOMES A LAW.

(B) IF THE COMMISSIONER DETERMINES THAT COMPLIANCE WITH THE STATUTORY STANDARD UNDER SUBDIVISION FOUR OF THIS SECTION IS NOT REASONABLY FEASIBLE FOR NURSING HOMES BY THE TIME SPECIFIED IN THAT SUBDIVISION, THE COMMISSIONER MAY DELAY THE IMPLEMENTATION OF THAT STAFFING STANDARD FOR A PHASE-IN PERIOD NOT TO EXCEED FIVE YEARS AFTER THIS SECTION BECOMES A LAW. IF THE COMMISSIONER DELAYS IMPLEMENTATION OF THAT STAFFING STANDARD, THE COMMISSIONER SHALL PHASE IN, OVER THE PHASE-IN PERIOD, STAFFING STANDARDS THAT GRADUALLY INCREASE IN EACH OF THE YEARS OF THE PHASE-IN PERIOD UNTIL THE STAFFING STANDARD MEETS AT LEAST THE STATUTORY STANDARD UNDER SUBDIVISION FOUR OF THIS SECTION.

6. PUBLIC DISCLOSURE OF STAFFING LEVELS. (A) A NURSING HOME SHALL POST INFORMATION REGARDING NURSE STAFFING THAT THE NURSING HOME IS REQUIRED TO MAKE AVAILABLE TO THE PUBLIC UNDER SECTION TWENTY-EIGHT HUNDRED FIVE-T OF THIS CHAPTER. INFORMATION UNDER THIS PARAGRAPH SHALL BE DISPLAYED IN A FORM APPROVED BY THE DEPARTMENT AND BE POSTED IN A MANNER WHICH IS VISIBLE AND ACCESSIBLE TO RESIDENTS, THEIR FAMILIES AND THE STAFF, AS REQUIRED BY THE COMMISSIONER.

(B) A NURSING HOME SHALL POST A SUMMARY OF THIS SECTION, PROVIDED BY THE DEPARTMENT, IN CLOSE PROXIMITY TO EACH POSTING REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION.

S 8. If any provision of this act, or any application of any provision of this act, is held to be invalid, or ruled by any federal agency to violate or be inconsistent with any applicable federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act.

S 9. This act shall take effect on the one hundred eightieth day after it shall have become a law, provided that any rules and regulations, and any other actions necessary to implement the provisions of this act on its effective date are authorized and directed to be completed on or before such date.
Now it’s up to all of us.

We need to build a powerful force of nurses, patients, community leaders, and lawmakers to advocate for safe nurse-to-patient ratios. This campaign is powered by thousands of nurses like you. Get involved, and ask other nurses to get involved too. Share your ideas, your questions, and your concerns. Together we will win safe nurse-to-patient ratios – for our patients and our practice.