BC NURSES’ UNION BELIEVES THAT:

> British Columbians expect and deserve safe, competent care from nurses in hospitals, residential care facilities and the community. Fewer patients per nurse and more direct nursing care hours are associated with better care and improved outcomes. While hospitals cannot control patient severity and complexity, nurse staffing can be better planned and a mechanism to improve it is urgently needed.

> Mandated nurse-patient ratios resolve patient safety concerns and excessive workloads for nurses. They represent minimum requirements for nurse staffing and are flexible with respect to patient acuity, nursing expertise and other workload variables.

> Mandated nurse-patient ratios create safer care, more satisfied nurses and save healthcare dollars—as we know from California, Japan and Australia. Saskatchewan successfully completed a pilot project so we know this approach can work in Canada.

BACKGROUND: WHY MANDATED NURSE-PATIENT RATIOS? (MNPR)

Current workloads for nurses are untenable. BC nurses are striving to provide high quality care despite excessive demands and workloads based on greater numbers of patients with more complex needs. An important part of a larger approach towards increased quality of care, MNPR are a simple and transparent way of setting minimum safe working conditions. Besides MNPR, BCNU recognizes that nursing workplaces require other appropriate resources including clerical support, allied healthcare providers and equipment. We also call for effective front-line nursing leadership and prohibition of mandatory overtime. Collecting data on nurse-sensitive patient outcomes will be a useful way to evaluate MNPR once they are established. The public has the right to know nurse staffing levels in each workplace and to demand safe ratios.

Peer-reviewed literature on MNPR is divided. While critics of MNPR identify problems with this approach, alternatives they propose are not being implemented. Studies show that administrators experience difficulty ensuring that ratios are in effect “at all times” but creative scheduling resolves this. Rarely mentioned in the literature are key social issues related to the value of nurses. When nurses are valued, patients and the healthcare system benefit.

Richer staffing of regulated nurses produces lower failure to rescue rates among surgical patients, lower inpatient mortality rates (by 10 to 14%) and shorter hospital stays for medical patients.

MNPR are designated minimum staffing standards and are flexible; more nursing staff may be required based on these and other factors:

> Patient/resident/client clinical acuity
> Nursing expertise
> Nature and complexity of care needed
> Skill mix (RN, LPN, Care Aides etc)
> Available support staff
> Physical layout

Regulated nurses require enough time to: assess those under their care; develop, evaluate, revise and implement care plans; educate their patients, families, caregivers; and plan for discharge. A workload measurement tool, which takes into account a variety of factors related to those above, is a useful instrument in assessing appropriate staffing numbers and skill mix. Synergy is one such tool that has been successfully used by BC and Saskatchewan nurses.

Enforceable MNPR put quality of service and working life on centre stage. They are an important part of a larger approach to improving patient outcomes, nurses’ work life and saving healthcare dollars.

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i California’s legislation was passed in 1999 and implemented in 2004. In 2006, Japan put MNPR in place. Victoria, Australia has had MNPR since 2001 and New South Wales, Australia passed legislation for MNPR in 2011.

ii Failure to rescue is a nurse-sensitive measure that points to hospitalized patient outcomes. When regulated nurses have enough time at the bedside to observe patient deteriorations, FTR rates are lower, as regulated nurses take remedial action for patients who need interventions.
PATIENT OUTCOMES: SAFE STAFFING SAVES LIVES

Higher levels of regulated nurses (LPNs, RNs, RPNs) are associated with better outcomes, including lower: mortality, rates of failure to rescue, urinary tract infections, upper gastrointestinal bleeding, hospital-acquired pneumonia, shock and cardiac arrest, and shorter length of stay for medical patients.3

Surgical patients with pneumonia exhibit an average of 74% increase in total length of stay, costing between $22,390 to 28,505 (US) per patient.4 With more RNs on the job, recovering surgical patients have a lower likelihood of pneumonia (2.17% to 1.33%). Furthermore, greater levels of education amongst nurses have been shown to improve outcomes.5

Patient satisfaction surveys before and after MNPR indicate significant improvements in patients’ perceptions of their care, particularly the attention they received from nursing staff.6

NURSE OUTCOMES: SAFE STAFFING IS SUSTAINABLE

Despite robust evidence that points to the need for implementation of formal staffing plans, nurse staffing decisions are often made on an ad-hoc basis.7 Extreme workload pressures on nurses have resulted in overworked, injured and ill nurses with low rates of job satisfaction. In 2008, $320m was paid for BC nurses who required long term disability support; in 2008, $320m was paid for BC nurses who required long term disability support; in 2010 this figure rose to $427m.8 An injured nurse's replacement costs ranging from $21,514 to $67,100 per nurse.13

Low retention of nurses is very costly, with replacement costs ranging from $21,514 to $67,100 per nurse.15

Finally, a noteworthy study of 11 US states concluded that increasing RN hours and raising the proportion of RNs would save 6700 lives, $5.7 billion and 4 million days of patient care in hospitals each year. Increasing RN staffing would produce net short-term cost savings of $242 million.14

BCNU’S RATIO GUIDELINES

Determining safe staffing levels requires constant evaluation. Numbers will
BCNU Position Statement on MANDATED NURSE-PATIENT RATIOS

fluctuate according to the needs of patients, clients and residents. The ratios outlined below are based on ratios successfully implemented in other jurisdictions and reflect minimum requirements which will require adjustment upward for patient acuity and other factors. These nurse-patient ratios apply 24 hours a day, 7 days a week.

The following ratios do not include many areas in which nurses work, such as psychiatry, ambulatory care, dialysis, tertiary facilities, residential care, rural settings and community worksites. These areas will require further consideration and research due to their uniqueness.

Antepartum.................................1:4
Dialysis........................................1:2
Emergency Roomiv ..........................1:3
  > ICU Patients in ER......................1:1
  > Triage.................................1:1
Intensive/Critical Care.................1:2
  > Ventilated..............................1:1
Labour and Delivery
  > During delivery ........................1:1
  > During labour:
    active 1st–4th stage)......................1:1
Medical/Surgical..........................1:4
Neo-natal Intensive Care...............1:1
Operating Room..........................2:1
Pediatrics–
  General Medical Wardiv ...............1:4
  > Pediatric Oncology .................1:2
  > Pediatric Surgery....................1:3
Post-Anesthesia Recovery
  (conscious)................................1:2
Post-Anesthesia Recovery
  (unconscious).............................1:1
Postpartumv ................................1:4
Step Down and Telemetry...............1:3

iii In some cases, such as extreme trauma, ratios of 3:1 are required.
iv With higher acuity, 1:3 is the standard for a regional facility.
v The mother is one patient and the baby is another patient. Furthermore, more regulated nursing staff are required to care for high-needs newborns such as twins, triplets and premature infants.

RESIDENTIAL CARE

For residential care facilities, BCNU recommends that a minimum of one full-time RN director of nursing and one RN supervisor is on site, providing direct care supervision, at all times (24 hours per day, 7 days per week). In facilities with 100 or more beds, a full-time RN assistant director of nursing and a full time RN director of in-service education are mandatory. In facilities with less than 100 beds, these positions are to be proportionally adjusted for size.

Total nursing staff hours are to be 4.55 per resident day.15 Mandated minimum staffing levels are 1 regulated nurse for every 25 residents. BCNU recognizes and underscores the high value of direct care provided by regulated nursing staff, given the benefits to health status. When regulated nurses have increased resident contact, failure to rescue rates decrease—as deteriorations in health status are easier to detect. BCNU calls for more bedside nursing as a means of improving residents’ outcomes.

COMMUNITY NURSING: (HOME CARE NURSING, PUBLIC HEALTH AND SO FORTH)

Staffing requirements for home care nursing and public health, unfortunately, are not well documented in retrievable literature. Some health units in BC use a point system to allocate workload which might provide a foundation for determining ratios. Further exploration is required but given the complex needs of clients who are quickly discharged from hospital and still require treatments and close monitoring, it’s imperative to set safe staffing levels.

TAKING ACTION TO IMPROVE BC’S HEALTH

BCNU is aware of problems with half-measures: no public disclosure; no enforcement; no rights for the nurse as patient advocate; no whistle-blower protection; RN and other staff interchangeability; and staffing based solely on patient classification systems without ratios as a minimum safety standard. MNPR, when carried out in a comprehensive manner, will set a new standard in BC.

Patient advocacy is an important part of the nursing role. Simple, transparent and enforceable MNPR are a vital step towards excellence in patient care. Our healthcare system will improve when front line care improves. The cost of not implementing ratios is far too great. In the interests of patients, the public, nurses and employers, it is time to bring about MNPR.

FOR MORE INFORMATION

Please contact your BCNU Regional Chair to discuss these issues. Go to www.bcnu.org or look in your Update magazine for a list or representatives.