I want to thank the Patient Safety Commission for allowing me this opportunity to testify on behalf of the Service Employees International Union (SEIU) on patient safety.

My name is Cynthia Ann Paul; I am the Legislative Director for the Service Employees International Union here in Michigan. Today, I am speaking on behalf of the 1.7 million members of SEIU nationwide (37,000 members here in Michigan) who utilizes our health care system and more than 800,000 (16,000 here in Michigan) health care workers.

As largest and fastest growing union of health care workers in the country, SEIU has been committed to achieving **quality care** and **patient safety** in all health care facilities. A recent study by the Institute of Medicine of the National Academies (IOM) further bolsters the measures SEIU has been promoting in the legislatures and at the bargaining tables over the last decade; that **better nurse-to-patient ratios**, **limits on mandatory overtime** and **nurse involvement in decision-making at every level** are needed to improve patient safety in our nation's hospitals and nursing homes.

There is a growing body of evidence confirming that inadequate staffing levels in health care facilities is leading to tens of thousands of preventable injuries, infections, and deaths each year. One study of 168 hospitals in Pennsylvania found that for each additional patient over four in a registered nurse's workload, the risk of death increased by 7 percent for surgical patients. Patients in hospitals with the lowest nurse staffing levels (eight patients per nurse) have a 31 percent greater risk of dying than those in hospitals with four patients per nurse. On a national scale, staffing differences of this magnitude could result in as many as 20,000 unnecessary deaths annually. These findings are contained in the article "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," and appear in the October 23-30 issue of *JAMA*. Another major study published in the May 30, 2002 *New England Journal of Medicine* shows a clear relationship between inadequate registered nurse staffing in America's hospitals and the risk of deadly complications. In hospitals with higher nurse staffing, there were 9 percent fewer patient complications compared to hospitals with lower staffing.

The most recent study done by the Institute of Medicine (IOM) of the National Academies (IOM), entitled **"Substantial Changes Required in Nurses' Work Environment To Protect Patients From Health Care Errors"** found that the environment in which nurses work is a breeding ground for medical errors and will continue to threaten patient safety until it is substantially transformed. To bring about this transformation to increase patient safety and reduce medical errors, the IOM specifically recommended:

1) Nurse staffing levels should be raised in all health care facilities, hospital intensive care units should increase internal oversight over staffing levels, nursing home staffing standards should be updated, and report cards on hospitals and nursing homes should include information about staffing levels.

2) State regulators should prohibit nurses from working more than 12 hours per day and more than 60 hours per week.

3) Hospitals should avoid using temporary agencies to fill nurse-staffing shortages.

4) Health care organizations should put more resources into orientation and ongoing education programs for nurses.

5) Health care institutions should involve nurse leaders in all levels of management and solicit input from nursing staff on decisions about work design and implementation.

Minimum nurse-to-patient ratios reduces the risk of medical errors and complications by ensuring that nurses have enough time to properly carry out treatments prescribed by physicians, continually assess and monitor patients—and modify interventions accordingly, as well as provide education to help speed recovery and prevent relapses.

In the long run, it will reduce the cost of medical errors and high turnover rates. Understaffing is taking such a huge financial toll on our health care system that Congress cannot afford not to set safe staffing standards. The Institute of Medicine estimates the national cost of preventable medical errors and complications to be $17 billion a year. In addition, the high turnover rate associated with understaffing dramatically increases hospitals' expenditures for recruitment, training, overtime, and temporary and agency staff. Because it costs a hospital roughly twice as much to replace a nurse as it does to retain one, safe staffing levels will save money as well as lives.

A particularly devastating side effect of the understaffing crisis is the **abuse of mandatory overtime by many health care employers**. Health care workers are often mandated to work back-to-back eight-hour shifts or four extra hours on top of a 12-hour shift to fill gaps in staffing. This of course threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also places an incredible stress on family lives of health care workers, particularly when last minute changes have to be made to find childcare or care for elderly parents. Health care workers stretched to the limit, they experience higher levels of stress, chronic

fatigue, and work-related injuries. These intolerable work practices lead to further burnout and undermine health care worker's sense of professionalism and are driving them out of our hospitals and nursing homes. These deteriorating staffing levels and working conditions are causing many health care workers to leave the profession and fewer younger people to enter it. This issue is further compounded by health care facilities placing workers "on-call", instead of having undisturbed rest time and/or time with their families many health care workers find themselves at the beckoning call of their work pagers.

For more information on how mandatory overtime correlates to the increase number of medical errors and near medical errors, I have enclosed the study entitled "The Working Hours of Hospital Staff Nurses and Patient Safety. I strongly encourage you to add this to you list of studies to read.

While there are some people trying to focus this debate solely on hospitals, there is however a related and equally serious problem in nursing homes. While RN's make up only a small fraction of the nursing home workforce, and they are usually managerial positions, most of the staff in nursing homes are certified nurse assistants (CNAs) and, to a lesser extent, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs).

Just like in hospitals, there is a serious problem retaining workers in nursing homes. Turnover rates for direct care workers in nursing homes are nearly 100 percent, creating a revolving door of caregivers, which renders continuity of care impossible. Workers are leaving due to heavy workloads. They simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt, and burnout. Moreover, low wages, lack of health insurance coverage, and high injury rates also make nursing home work unsustainable for many workers. And just like nurses, more and more people who have become certified to work as nurse aides are leaving the profession.

In an effort to remedy these problems on a national level, the SEIU Nurse Alliance is calling upon Congress to enact federal legislation for safe staffing and restrictions on mandatory overtime that provides as follows:

Minimum Bedside Patient/Nurse Staffing Standards

1. Establish safe staffing standards covering all acute care and psychiatric hospitals, emergency room facilities, and ambulatory and outpatient facilities that receive Medicare funds.
2. Require each health care facility to develop a staffing plan that:

- Establishes minimum staffing requirements based on number of patients, level of acuity, and intensity of care needed to ensure good patient outcomes.
    - Establishes the specific nursing staff and skill mix needed to carry out the requirements. The skill mix must assure that all elements of the nursing process - assessment, nursing diagnosis, planning, intervention, evaluation, and patient advocacy - are performed in the planning and delivery of care for each patient.
    - Is developed in consultation with the direct-care nursing staff.
3. Require public disclosure of staffing plans, including both mandated and actual staffing levels.

Ban Mandatory Overtime-

1. Set maximum hour limits for nurses, as is done in the transportation industry where public safety is at risk.
2. Except where a formally declared state of emergency has been declared, employers are prohibited from requiring mandatory overtime of nurses that would exceed:
    - A daily limit of previously determined work schedules or 12 hours in a 24-hour period.
    - 80 hours in a 14 consecutive day period.
3. Licensed nurses providing direct care may voluntarily work overtime as long as their hours do not exceed:
    - More than 16 hours in a 24 hour period without an intervening 8 hour non-work period; or
    - More than 7 consecutive days without at least one consecutive 24-hour off duty period within that time.
4. Negotiated provisions in union contracts that exceed these protections will prevail.

SEIU is on the record of supporting the federal **Nurse Staffing Standards for Patient Safety and Quality Care Act of 2004 (H.R. 4316),** which establishes minimum registered nurse-to-patient staffing ratios to improve patient safety and quality of care and to address the nursing shortage that has left our nation's hospitals critically understaffed.

The bill can be summarized as follows:

1. By January 2007, two years later for rural hospitals, hospitals will be expected to develop and implement nurse staffing plans that meet newly established minimum direct care registered nurse-to-patient ratios, adjust staffing levels based on acuity of patients and other factors, and ensure quality care and patient safety.

2. A hospital would be required during each shift, except during a declared emergency, to assign a direct care registered nurse to no more than the following number of patients in designated units:

   - 1 patient in an operating room and trauma emergency unit;
   - 2 patients in all critical care units, intensive care, labor and delivery and postanesthesia units;
   - 3 patients in antepartum, emergency, pediatrics, step-down and telemetry units;
   - 4 patients in intermediate care nursery, medical/surgical and acute care psychiatric care units;
   - 5 patients in rehabilitation units; and
   - 6 patients in postpartum (3 couplets) and well baby nursery units.

3. Based on the outcome of a required study, staffing requirements will be established for licensed practical nurses and will be required to be implemented in all hospitals by January 2007.
4. Hospitals will be required to develop staffing plans no later than January 1, 2006 and must involve **direct care nurses and other health care workers or their representatives in the development and the annual re-evaluation of those plans**.
5. The plans must **identify and employ an approved acuity system** that will establish guidelines by which the hospital must increase staffing above the required minimums based on patient need.
6. The plans must also factor in an appropriate **skill mix of other health care workers** to ensure that staffing levels account for patient care needs that do not require a direct care registered nurse.
7. Beginning in 2007, plans must at least comply with minimum ratio standards, but may need to meet higher standards based on hospital specifics.
8. Uniform **notices** stating the requirements of this bill including the actual direct care nurse-to-patient ratios for each unit must be **posted in a visible, conspicuous and accessible location** for both patients and direct care staff.
9. Hospitals that **fail to comply with the nurse staffing plan** requirements could face a range of **corrective actions, including civil monetary penalties and loss of funds.**
10. It provides whistleblower protection for nurses by securing a nurse's **right and obligation to refuse assignment** if doing so threatens the safety and health of a patient by violating the minimum ratios as set forth in this bill or if a nurse is not professionally prepared to fulfill an assignment. The bill also provides protections to any hospital employee who reports a violation of this Act.

11. It allows for hospitals to receive **additional Medicare reimbursement** related to costs incurred related to compliance with this bill. Such reimbursement will be based on recommendations by Medicare Payment Advisory Commission (MedPAC).

California has already passed a law requiring fixed minimum staff-to-patient ratios in hospitals. In January 2002, based on input from nurses and industry groups, the state's Department of Health Services (DHS) issued its proposed statewide staffing standards. Similar legislation is being considered in Illinois, Florida, Iowa, Colorado, Kentucky, Massachusetts, Missouri, Nevada, New Jersey, New York, Oregon, Pennsylvania, and other states.

SEIU also supports the federal **Safe Nursing and Patient Care Act (H.R. 745/S. 373).** This legislation prohibits hospitals from requiring a nurse to work in excess of the scheduled work shift or duty period, 12 hours in a 24-hour period, or 80 hours in a consecutive 14-day period. Mandatory overtime limitations would be lifted during a formally declared emergency or disaster. Eight states have already enacted similar mandatory overtime and many others are considering it.

State Legislation Adopted Limit Mandatory Overtime-

Connecticut- Passed in May 2004. It regulates the number of overtime hours a hospital nurse may work. Although a nurse may volunteer for additional hours, she/he cannot be penalized for refusing additional hours.

Maine- New legislation provides explicit job protection to nurses who refuse to work more than 12 consecutive hours excluding emergency cases that would affect patient care.

Maryland- A bill signed into law in May 2002 prohibits mandatory overtime for nurses except in emergencies, and protects nurses who refuse overtime work.

Minnesota- Lawmakers passed SF 2463, which limits the amount of overtime nurses can be required to work and prevents hospitals and clinics from discriminating against or dismissing nurses who turn down overtime. RNs and LPNs are not obligated to work an extra shift beyond a 12-hour workday except in emergency situations.

New Jersey- Lawmakers passed S 2093 prohibiting health care facilities from mandating employees to work more than 8 hours a day or 40 hours a week, barring unexpected emergency situations. Overtime can be worked

on a voluntary basis and employees are strictly protected from discrimination or dismissal for refusing overtime work.

Oregon- A bipartisan bill was passed ensuring that nurses cannot be required to work more than two hours of overtime beyond a scheduled shift or more than 16 hours in a 24-hour period.

Washington- Legislation passed in 2002 prohibits health care facilities from requiring employees to perform overtime work except during declared emergencies. The bill also protects employees who refuse overtime work against disciplinary actions or dismissal.

West Virginia- Beginning May 17, 2004, nurses who work more than 12 hours must be allowed at least 8 hours off.

Here **in Michigan**, bi-partisan legislation has been introduced and numerous work groups have been conducted dealing with the issues of staffing levels and mandatory overtime in health care facilities over the last couple legislative sessions. Unfortunately, most of these bills have never seen the light of a committee hearing, let alone any movement in the legislative process. Staffing and mandatory overtime legislation introduced this legislative session include:

- **SB 669 & 5049**- Sponsored by Senator Jacobs and Representative Wojno, requires hospitals to come up with an acuity based staffing plan.
- **SB 1190**- Sponsored by Senator Patterson requires hospitals to come up with an acuity based staffing plan covering only registered nurses, furthermore, it expressly prohibits hospitals from mandating overtime in order to meet the requirements of their staffing plan.
- **SB 128**- Sponsored by Senator George prohibits anyone not the nursing staff from being counted in the staffing ratio for nursing homes.
- **SB 140**- Sponsored by Senator Leland raises the minimum number of direct care hours from 2.25 to 3 in nursing homes. It also creates tight definition of “direct care provider” and prohibits staff that is not providing direct care from being counted in the ratio. Furthermore, it consolidates the current three-shift ratio of 1-8 (day time), 1-12 (evening) and 1-15 (nighttime) into a 1-15 daily average.
- **HB 5591-** Sponsored by Representative Wojno prohibits hospitals from mandating nurses work over their scheduled shift or 40 hours in a 7-day period.

- **HB 5776-** Sponsored by Representative Steward prohibits hospitals from working nurses more than 12/day or 60 hours in a 7-day period.

SEIU has been at the forefront of these workgroups and legislation introduction. In particular, we have had letter-writing campaigns on the both the state and national level concerning staffing and mandatory overtime and have held lobby days before the state and federal legislatures on these issues. When I talk with my members who work in hospitals and nursing homes, these are the most important issues to them.

Another critical factor to improving patient safety is to allow for health care workers to have a stronger voice and more **involvement** in decision-making in health care facilities. The IOM report urges health care organizations to involve nurse leaders in **all levels of management** and to solicit input from nursing staff on decisions about work design and implementation. Because nurses are in prime positions to help pinpoint inefficient work processes that could contribute to errors, identify causes of nursing staff turnover, and determine appropriate staff levels for each unit. Health care workers input should be solicited and encouraged and earnestly used by health care facilities-if they truly wish to improve patient safety.

Once again I would like to thank the Patient Safety Commission for allowing me the opportunity to testify about ways to improve patient safety.