**PONL Position Statement on Nurse Staffing Practices and Ratios, April 2023**

The Pennsylvania Organization of Nurse Leaders (PONL) is strongly committed to nurse staffing practices that support the provision of safe patient care. PONL endorses the autonomy of each healthcare organization to establish appropriate strategies to deliver high levels of patient care by providing safe, effective, and collaborative staffing practices. PONL is adamantly opposed to any legislation that would mandate nurse-to-patient ratios for all healthcare organizations.

PONL believes best nurse staffing practices include the following:

* Chief nursing officers of health systems, hospitals, community-based settings, etc. have ultimate accountability and responsibility for safe and effective nurse staffing within their jurisdiction.
* Multiple factors must be considered in determining safe staffing needs, including skill and competency level of staff, professional benchmarking standards, availability of support staff, patient volume, patient acuity, admission/discharge/transfer activity, patient educational needs, unit geography/space, support technology, case mix, and discharge planning. **No legislative mandate on nurse patient ratios can take all of these factors into account.**
* Mandated staffing ratios discount the ability to plan for unexpected staffing needs, and this is a critical component of any staffing plan.
* The most effective way to attain superior patient outcomes and enhance nurse satisfaction is for nurse leaders and nursing staff to continually and openly communicate, assess, plan, execute and evaluate nurse staffing strategies used in the provision of patient care.
* Nurse leaders are encouraged to use national benchmark staffing standards from professional specialty organizations and other reputable sources, such as the National Database of Nursing Quality Indicators (NDNQI), to develop staffing plans that are evidence-based, proactive, fiscally responsible, and continually evaluated to result in optimal and safe patient care.
* Nurse leaders are encouraged to use ongoing research that identifies accurate, easy to use patient acuity systems (PAS) that incorporate patients’ direct needs, activities occurring on individual nursing units, unit geography, and education and experience of the nursing staff.

**Current State**

Legislating a pre-determined number of nurses assigned to patients does not take into consideration resources, acuity of the patients, skill set of the staff, technology, and work environment available within an organization, or the nursing shortage (Wynendaele, et al., 2019). According to Wynendaele, et al., (2019), “Evidence‐based decision‐making linking nurse staffing with staff‐related outcomes is a much-needed research area. Although multiple studies have investigated this phenomenon, the evidence is mixed and fragmented.” Without true research that investigates and compares California’s nurse staffing ratios with like organizations, advancement of nursing ratios remains speculative at best.

Decisions regarding what constitutes “safe staffing” have multiple moving parts such as intensity of patients' needs, “environmental turbulence” (admissions, discharges, and transfers taking place during a shift), level of experience of nursing staff, layout of the unit, and availability of resources, such as ancillary staff and technology. Current operational staffing within organizations is calculated using a variety of approaches for safe and effective care, which includes shift-by-shift measurement of patient needs and deployment of qualified staff because no single approach applies to all healthcare settings (Griffiths, et al., 2021; Sharma & Ritu, 2020).

If nurse staffing ratios were the answer to patient care, then why is there only one state, California, that has implemented them? In December 2020, southern California abandoned their legislatively mandated staffing ratios for a period of time during the COVID-19 pandemic, due to a shortage of nurses and influx of patients. Organizations found it impossible to maintain the ratios. The governor absolved organizations from following the mandated ratios to maintain healthcare and access to nursing care. Hospital officials declared, "We are simply out of nurses, out of doctors, out of respiratory therapists" (Dembosky, 2020). The state of California asked the federal government for staff, including 200 medical personnel from the U.S. Department of Defense, and their attempt to hire contract nurses from temporary staffing agencies and other states was not possible due to heavy demands for nurses across the United States (Dembosky, 2020).

A registered nurse staffing ratio bill will have major fiscal implications. The Massachusetts Health Policy Commission’s (HPC) 2018 *Analysis of Potential Cost Impact of Mandated Nurse-to-Patient Staffing Ratios* found that the implementation of nurse-to-patient ratios would cost providers an estimated $676 to $949 million in annual increased costs, yet would “net relatively minimal savings, and have an insignificant impact on quality” (Kacik, 2018). In addition, the Massachusetts HPC’s (2018) analysis of mandated nurse staffing ratios to two different scenarios indicated that hospitals would have to hire 2,286 or 3,101 additional full-time registered nurses. With these figures in mind, staffing ratios will be not only a burden to Pennsylvania healthcare organizations, but to the citizenry as well. In their November 2018 election, Massachusetts put the question of ratios into the hands of the people and 70.8% of voters rejected a nurse-to-patient staffing ratio ballot measure (Kacik, 2018).

With the current nursing shortage and projections for the shortage to continue, there are simply not enough licensed nurses to go around. The United States will likely experience a deficit of 450,000 registered nurses by 2025 (McKinsey, 2022) and the U.S. Bureau of Labor Statistics projects a national need of 1.1 million new registered nurses by 2030. A 2022 national survey conducted by the American Nurses Foundation found that 89% of nurses reported their organization was experiencing a staffing shortage (ANA, 2022). Pennsylvania hospitals report a 31% vacancy rate of staff nurses in 2022 – among the worst of all states in the nation – with 84% identifying the major barrier of finding enough qualified candidates (HAP, Jan 2023).

Nurse staffing is not “one-size fits all” because daily staffing needs vary among organizations from large urban medical centers to community-based organizations, and critical care access hospitals. As a result, individualized staffing methods must be employed; “staffing templates used by larger, urban facilities are not useful because of the fluctuations in patient acuity and available support from ancillary personnel and peers” (Seright & Winters, 2015).

**Industry Positions**

* The American Organization for Nursing Leadership (AONL) Policy Statement on Nurse Staffing maintains that “mandated nurse staffing ratios are a static and ineffective tool that cannot guarantee a safe health care environment or quality level to achieve optimum patient outcomes.”
* The American Nurses Association (ANA, 2023) believes that “staffing plans must be conducive to adjustment to reflect changes in evidence and outcomes, care scenarios, and the needs of the population served, all of which can vary from hour to hour, shift to shift, and day to day.
* The Hospital & Healthsystem Association of Pennsylvania (HAP, Apr 2023) states that “healthcare teams make complex, real-time, evidence-based decisions with consideration for individual patients, groups of patients, provider skills, and other factors. Pre-set ratios replace this professional judgment, reduce these complex decisions to out-of-context numbers, and put treatment processes in the hands of the government.”

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