



In Setting Safe Staffing Levels, Nurses Know Best

by Cindy Zolnierek, MSN, RN

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About the author: Cindy Zolnierek has a broad base of varied nursing experience in hospital practice environments and is currently the director of practice for the Texas Nurses Association.

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Educational goal/purpose

The purpose of this educational activity is to provide nurses in hospital settings with current information about the Safe Hospital Staffing Act (SB 476), the new Texas law that addresses safe staffing for effective patient care.

Learning objectives

Upon completion of this learning activity the nurse should be able to:

1. Identify evidence supporting the relationship between adequate staffing and patient outcomes.
2. Discuss two approaches considered by legislatures to achieve adequate nurse staffing.
3. Outline three factors that can influence the adequacy of staffing.
4. Define three nurse sensitive patient outcomes that can be used to evaluate the adequacy of staffing.
5. Describe key provisions in the Safe Hospital Staffing Act (SB 476) that increase the influence of nursing in developing, monitoring, evaluating, and reporting staffing plans.
6. Describe provisions in the Safe Hospital Staffing Act that assure hospital accountability for the adequacy of staffing.

Introduction

It's no secret that safe staffing is one of the main concerns of nurses working in acute care hospitals, and for good reason. Nurses care about their patients' outcomes, and nurse staffing levels are inextricably linked to such outcomes. In addition, when staffing levels are inadequate, nurses can experience fatigue and burnout, and exhausted nurses are more prone to commit errors affecting patient safety. Therefore, nurses, hospitals, and the public have a vested interest in assuring adequate staffing in hospitals. But what is "adequate" or "safe" staffing, and who should define the criteria for making that determination?

Several states have grappled with this issue in their legislature. Two basic approaches have been considered: mandated fixed nurse

to patient ratios and mandated nurse staffing plans. Only California, the first state to legislate nurse staffing requirements (1999), has passed mandated fixed nurse to patient ratio legislation in which the number of patients a nurse may be assigned is determined by regulation. In contrast, the mandated staffing plan approach typically involves nurses (e.g., representatives from various clinical areas) and leadership (e.g. management, infection control, quality, education) in developing staffing plans to guide patient care assignments. At least eight states have passed legislation mandating nurse staffing plans, including Texas. In fact, Texas was the first state to adopt regulations requiring hospitals to establish nurse staffing plans and the first state to actually implement nurse staffing requirements in 2002 (California did not implement its mandated ratio law until 2004).

Senate Bill 476 was passed by the Texas legislature this past legislative session and will become effective on September 1, 2009. SB 476 builds upon existing Hospital Licensing Rules (§133.41), enhances the role of direct care nurses in determining staffing plans, and promotes greater hospital accountability for adequate staffing. Nurses informed about new staffing requirements will be in the best position to collaborate with others in their hospital to achieve staffing plans that meet the needs of patients and promote a positive work environment. The purpose of this article is to provide nurses with current information about Texas' Safe Hospital Staffing Act.

Background

Staffing concerns peaked during the 1990s – a decade of turmoil in the health care industry as managed care changed the rules for payment of health care. More services were shifted to outpatient settings. Hospitals struggled financially and responded with efforts to reduce costs of providing care. Re-engineering of patient care resulted in new patient care delivery models, e.g. "patient focused care", that made greater use of nurse extenders – unlicensed assistive personnel. Such models reduced the utilization of registered nurses in hospitals and hospital vacancy rates declined, nursing schools reduced enrollments, and the nursing shortage abated. While, there was unrest among nurses who felt new delivery models did not provide an adequate level of professional nurse staffing, there was very little hard evidence to support this belief.

In response to nurses' concerns, Congress directed the Department of Health and Human Services to ask the Institute of Medicine (IOM) to study the relationship of quality of nursing care, patient outcomes, and nursing outcomes (e.g. work-related stress and injuries) related to nurse staffing levels and skill mix. The final report, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, published in 1996 (Wunderlich, Davis, & Sloane), was unable to reach any conclusions regarding these relationships due to the overwhelming lack of data related to quality and outcomes of hospital care. Final recommendations identified the need to generate quality information as a priority:

The committee concludes... that high priority should be given to obtaining empirical evidence that permits one to draw conclusions about the relationship of quality of inpatient care and staffing levels and mix (p. 8).

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The American Nurses Association (ANA) had begun development of a “nursing report card” to identify quality indicators for nursing care in the early 1990s. The IOM report commended the ANA for these efforts. Further, the IOM rejected the notion of mandated fixed nurse to patient ratios, instead endorsing ongoing efforts to develop improved methods of matching patient acuity with appropriate staffing.

Indeed, quality was assuming an increasingly important role in the nineties. By 1997, ANA’s Nursing Care Report Card for Acute Care (1995) evolved into the National Database of Nursing Quality Indicators (ANA, 2009) with over 1200 current hospital participants. Hospitals initiated total quality management and continuous quality improvement programs in attempt to improve work processes. Finally, in 1999 the IOM released a landmark report, *To Err Is Human*, shocking the nation by suggesting that nearly 100,000 lives were lost each year due to medical errors. A hospital focus on quality became obligatory.

Meanwhile, a nursing shortage was quietly festering. A decade of reduced enrollments and fewer nurse graduates left the profession with aging nurses moving toward retirement just as baby boomers were expected to create the largest demand for health care the nation has ever seen. The new millennium would face an increased demand for professional nurses while supplies had declined – a perfect storm.

Nursing and Quality Outcomes

The IOM reports stimulated a number of studies evaluating the relationship of nurse staffing to patient outcomes. While most nurses intuitively know that professional nursing care is important to patient outcomes, the IOM report revealed the lack of research to support this conclusion. Outcomes believed to be most directly related to nursing care (e.g. nurse sensitive patient outcome measures including pressure ulcers, falls, certain infections and complications) were identified and refined through the NDNQI project. As more hospitals began measuring patient outcomes thought related to nursing care, more data was available to be collected and related to nurse staffing.

Research linking patient outcomes to nurse staffing began to emerge in the late 1990s. By the early 2000s, credible studies demonstrated that greater numbers of registered nurses (RNs) were directly related to patient outcomes such as shorter lengths of stay (LOS) and lower complication rates (e.g. urinary tract infections, upper gastrointestinal tract bleeding, pneumonia, shock, cardiac arrest, and failure to rescue) (Needleman et al., 2002). The flip side also held true: fewer nurses were related to poorer outcomes (e.g. increased chance of dying within 30 days of admission and increased chance of failure to rescue) (Aiken et al., 2002). An analysis of statistical significance across 28 studies considering patient outcomes and RN staffing confirmed the existence of a direct relationship between RN staffing and patient mortality, LOS, and adverse events (Kane et al., 2007). However, researchers stopped short of recommending a specific nurse to patient ratio and instead suggested that a number of other hospital factors – commitment to high quality of care, effective nurse retention strategies, physician practice patterns and collaboration with nurses, nurse job satisfaction and perceptions of autonomy and governance, and other variables – lead to improved patient outcomes. The researchers concluded that strategies addressing both the care delivery

system as well as nurse staffing will provide the greatest benefit to the patient.

Renowned expert on the topic of RN staffing and patient outcomes, Linda Aiken PhD, RN, FAAN, would likely agree. At the 2009 NDNQI conference in Dallas, TX, she stated that the nurse’s practice environment was emerging as a variable at least as important as the nurse to patient ratio. She indicated that medical-surgical nurses providing care for eight patients could achieve the same outcomes as nurses providing care to four patients when the practice environment provided appropriate support to the RN, e.g. collaborative interdisciplinary relationships, appropriate support staff and technology, etc.

While virtually every study conducted has supported the positive influence of RN staffing on patient outcomes, not one study has suggested an ideal nurse to patient ratio. This is because there are a number of other variables – characteristics of the nurse, patient, hospital, and practice environment – that affect the “ideal” ratio. “A nurse is a nurse is a nurse” does not hold true – nurses vary in their experience and expertise and this will affect their ability to safely manage a patient assignment. A nurse with 10 years of experience in medical-surgical nursing would be able to manage a more complex patient assignment than new graduate nurse who just completed orientation. Patients also differ in their care requirements – a patient who was just transferred from intensive care will likely need a different level of nursing care than a patient who is ready to be discharged home. Likewise, hospitals differ – a telemetry unit in quaternary medical center that provides heart transplants and bypass surgery is much different from a telemetry unit in a small rural hospital that does not provide cardiology procedures. Finally, characteristics of the practice environment will affect appropriate assignments (e.g. use of technology to optimize efficient nursing care, collaborative relationships with physicians and ancillary staff, streamlined work processes to eliminate redundancy, involvement of nurses in practice decisions and problem solving, number and type of support staff). In order to provide the right staffing levels and mix, all of these components must be considered.

Legislative and Regulatory Approaches

The evidence relating adequate nurse staffing to patient outcomes is well established. As individual legislatures and regulatory agencies consider the best way to achieve adequate staffing, two basic approaches have been adopted: mandatory fixed ratios and mandatory staffing plans.

In the 1990s as changes in inpatient nurse staffing occurred, California considered a legislative solution – a bill mandating nurse to patient ratios was introduced in the early 1990s. The bill, finally passed in 1999, directed the Department of Health Services to promulgate hospital licensing rules to designate the number of patients a licensed nurse could be assigned to care for in various inpatient hospital units. The rules were implemented in 2004; LVNs may account for up to 50% of the licensed nurse to patient ratio.

The beginning of the new millennium brought with it the threat of a nursing shortage unlike any experienced before. The Texas Nurses Association (TNA) identified the threatening ramifications of a severe nursing shortage to health care and pulled together a group of stakeholders to prepare to address the shortage. An effective response would require both increasing the production of nurses, which

had dwindled during the 1990s, as well as improving the nurse’s practice environment. Recognizing this, in 2002 as a part of addressing the nursing shortage, TNA and the Texas Hospital Association (THA) jointly petitioned the Department of State Health Services (DSHS) to strengthen its rule governing nurse staffing in hospitals. As a result, the Texas Department of State Health Services adopted hospital nurse staffing rules which set standards for staffing in hospitals. As a result, the Texas Department of State Health Services adopted hospital nurse staffing rules which set standards for staffing including a process requiring significant input from direct care nurses through a nurse staffing advisory committee. These rules were updated in 2007 increasing the proportion of direct care nurses on the committee to 50%.

Following Texas’ lead, several other states increased oversight of nurse staffing in hospitals. In 2002, Oregon became the first state to pass legislation requiring the mandated staffing plan approach. Other states followed: Illinois (2007), and Connecticut, Washington, and Ohio in 2008, and Nevada in 2009 (see Table). Each of these states achieved staffing requirements through a process involving stakeholders including the state nurses and hospital associations.

Although legislation mandating nurse to patient ratios has been introduced in several states in recent years, none, except California have adopted this approach. Besides being unsupported by research, a key reason mandated fixed nurse to patient ratios have not been successful is the inflexibility of this approach – it assumes all nurses, patients, and hospitals are equal, therefore one number will fit all situations. For example, if the required ratio on a telemetry unit is one nurse to four patients and there are eight patients, each nurse must be assigned four patients, even if, based on patient acuity and nurse expertise it would be more appropriate to assign three patients to one nurse and five patients to the other. Secondly, it fails to account for dynamic changes in the inpatient practice environment, and there is no flexibility to respond to changes in patient conditions requiring redistribution of resources. For example, a 25 bed medical-surgical unit is full and staffed with five nurses each with their ratio of five patients. One patient develops a gastrointestinal bleed and requires a nurse to be at the bedside constantly to run fluids, transfuse blood, etc. until the patient can be transferred to intensive care. The nurse cannot redistribute his patients to other staff (e.g. one patient to each of the other four nurses) because each nurse is already at ratio.

A Success Story: The Safe Hospital Staffing Act

Senate Bill 476 represents background work of TNA’s Staffing Task Force (2007-2008) who evaluated implementation of existing regulations and current issues in nurse staffing, and made recommendations via a resolution at the TNA 2008 House of Delegates. The resolution directed TNA to support the role of the direct care nurse in shared decision making around staffing decisions, explore ways to strengthen the Hospital Nurse Staffing Rules, and to support strategies to evaluate compliance and effectiveness of the staffing rules. TNA’s Governmental Affairs Committee pursued these directives. Safe staffing approaches implemented in other states were reviewed and compared to identify best practices for potential adoption in Texas. A decision to move from staffing regulations (licensing rules) to statute (law) was determined to be the appropriate next step in strengthening Texas’ nurse staffing requirements. A proposal addressing issues

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Table I



Comparison of Recent State Legislation Mandating Hospital Nurse Staffing Plans

	Oregon 2001, 2005a HB2800	Illinois 2007 HB346	Ohio 2008 SB867	Washington State 2008 HB3123	Connecticut 2008 HB 5902	Nevada 2009 AB 121	Texas 2009 SB476
1. Where Staffing Addressed							
In statute	✓	✓	✓	✓	✓	✓	✓
In regulations only							
2. Role of Hospital Board							
Adopts polices governing							✓
Receives plan evaluation							✓
Ensures state regulations governing staffing met							✓
3. Committee Composition							
Standing committee that reports to hospital board							✓
50% staff nurses	✓	✓	✓	✓	✓	✓	60%
Staff nurses elected by staff nurses	✓			✓			✓
CNO on Committee			✓				✓
Meets on paid time				✓			✓
4. Committee Role							
Develops plan for hospital	✓			✓		✓	
Advisory		✓	✓		✓		✓
Weight to be given to recommendation		Significant regard & weight	Significant consideration	If plan not adopted, CEO provides written explanation			Significant consideration
Evaluates Plan							✓
Reports to Hospital Board							✓
5. Plan Components							
Factors to be considered in developing plan set out such as census, admissions/ discharges, skill mix, etc.	✓	✓	✓	✓		✓	Base on multiple pt & nurse considerations
Plan sets minimum staffing levels on per unit basis	✓	✓	✓		✓	✓	✓
Plan reflects current standards established by private accreditation organizations or governmental entities	✓		✓	✓			✓
Plan is Unit-Based		✓	✓	✓	✓	✓	✓
Plan is Shift-Based	✓			✓			✓
Process for adjusting plan	✓	✓	✓		Must provide flexibility		✓
Contingency plan for unexpected coverage needs	✓	✓	✓		Identify practice for use of temporary personnel		✓
6. Input & feedback from nurses							
Process for input			✓	✓	✓		✓
Process for response				✓			✓
7. Non-retaliation and whistleblower protections for nurses reporting staffing concerns							
				✓			✓
8. Process for how nurses can initiate procedure to limit hospital admissions							
	✓						
9. Review & evaluation of plan							
Annual			✓		Hospital must define process for		
Semi-annual		✓		✓			✓
Nurse sensitive outcome measures used to evaluate				✓			Committee selects
Committee does evaluation							✓
10. Posting requirements							
Staffing plan		✓	✓	✓			
Staffing - plan levels							✓
Staffing – actual levels				✓			✓
Staffing schedules				✓			
Posted for nurses		✓	✓	✓			✓
Posted for public		✓	✓	✓			
11. Budget considerations							
Plan used as component of setting staffing budget				✓			✓
Finances may be considered in developing plan				✓			
12. Acuity model required							
		✓	✓				Method for adjusting based on patient needs
13 Enforcement/Accountability							
Hospitals must report variances to committee							✓
Hospitals report selected data about plan to state					Must make plan available to state	Written report of efficacy of committee	✓

NV: Applies only to hospitals >70 beds in counties with populations of 100,000 or more
 RI: Only requires hospitals submit a core-staffing plan to the department of health in January of each year.
 VT: Provides for public access to nurse to patient ratio information under patients' Bill of Rights
 NJ: Requires posting of staffing information each shift; information is reported and made available to public quarterly.

identified by TNA members was drafted. THA was identified as a key stakeholder – any changes to existing regulations were most likely to succeed if they reflected negotiations with a major stakeholder. Negotiations with THA ensured over 6 months to solidify an agreed proposal which THA could actively support. The resultant legislation, SB 476 carried by Senator Jane Nelson (R-Flower Mound) and identical House Bill 591 carried by the two nurses in the House – Donna Howard (D-Austin), former critical care nurse, and Susan King (R-Abilene), a practicing surgical nurse – was actively supported by 18 Texas nursing organizations as well as THA and passed both chambers unanimously. SB 476 was signed by the Governor on June 19 and will become effective September 1, 2009.

Provisions for Safe Staffing

While SB 476 builds upon the existing Nurse Staffing Rules currently within the Hospital Licensing regulations, several key changes strengthen the nursing's influence and the hospital's accountability for adequate staffing.

The hospital's governing board becomes responsible for nurse staffing through a requirement that the board adopt a policy that designates a process for developing, implementing and enforcing a unit and shift based staffing plan. A hospital governing board is responsible for overseeing the mission, plans and policies of the organization. They are responsible for ensuring the organization has adequate resources and complies with applicable rules and regulations. Ultimately, the board is accountable to its owners – stockholders if for-profit and the public with nonprofits. Participation of the governing board is significant because the hospital administrator or chief executive officer (CEO) reports to the board. SB 476 bumps the significance of nurse staffing to the highest level of authority in a hospital—its governing board.

By requiring the staffing plan to be not only developed, but also implemented and enforced, the board cannot merely adopt a policy to sit in a three ring binder on the shelf until the next Joint Commission survey. Instead the plan must be fully executed. Further, the plan must:

- reflect current national standards, such as those developed by the Emergency Nurses Association, American Association of Critical Care Nurses, and Association of Women's Health, Obstetric and Neonatal Nurses
- set minimal staffing levels for each patient care unit, each shift, based on multiple nurse, patient, and hospital considerations (for example experience and expertise of the nurse, acuity and intensity of the patient, scope of services of the hospital) and the nursing assessment
- include a method of adjusting the plan to meet patient needs (for example an acuity system that measures which patients may need more intense nursing care or additional nursing time)
- include a contingency plan in the event patient care needs exceed resources (for example plans to access additional staff through outside agencies, plans to reduce admissions by diverting ambulance traffic from the emergency department, or plans to triage ICU patients for transfer to stepdown units)

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- give significant consideration to staffing plan recommended by committee

The nurse staffing committee is strengthened by enabling direct care nurses to select their representatives, involving the chief nursing officer (CNO) as a committee member, and requiring the committee to report directly to the hospital board. Since 2002, Texas hospitals have been required to have staffing committees that included direct care nurses, representation from multiple areas of nursing practice, and a nurse from infection control, quality assurance, or risk management. This membership was intended to provide the committee with the knowledge and expertise needed to monitor and evaluate the hospital's staffing plan. Now, all direct care nurses will have a greater voice on the committee through the direct care nurses they select to represent them. Direct involvement of the CNO on the committee will strengthen the status of the committee and supports a collaborative shared decision making process. Finally, the proportion of direct care nurses was increased to 60% from 50%.

The nurse staffing committee has primary responsibility for recommending, monitoring, and evaluating the nurse staffing plan. While the staffing committee's responsibility has been somewhat unclear in the past, the committee now has a more defined role in developing a recommended plan that must be given significant consideration when the hospital adopts the final plan. The committee also has a powerful voice in its responsibility for evaluating the effectiveness of the plan. The hospital board remains involved as the nurse staffing committee provides at least semi-annual reports as to the adequacy of the staffing plan.

- The nurse staffing committee reviews, assesses, and responds to staffing concerns expressed to the committee. Existing Hospital Licensing Rules require staffing committees to actively solicit input from direct care nurses but does not provide process for response. Now, the committee must consider feedback, particularly staffing concerns, and respond back to those registering concerns. Individuals who provide input to the committee are protected from retaliation. This protection is in addition to existing patient advocacy protections for nurses currently provided in the Nursing Practice Act (§301.4025 and 301.352).
- The hospital must use the staffing plan to guide hospital wide nursing assignments and report variances between actual and desired staffing levels to the committee. The committee considers these variances in the semiannual evaluation of the adequacy of the staffing plan. For example, if endoscopy is consistently requiring additional staff in the afternoon, the staffing committee might evaluate whether the variance is related to increased volume (additional cases), acuity (more complex procedures or complicated recovery), changes in throughput (cases beginning and finishing later), or some other reason. The committee may consider recommending an adjustment to the original staffing plan (adding staff, modifying start/end times of shifts, changing scheduling practices, etc.).
- The nurse staffing committee is responsible for selecting nurse sensitive patient outcome measures (such as pressure ulcers, patient

falls, nosocomial infections) for evaluating the effectiveness of the staffing plan (see Staffing Matters, p. 9). This is a significant decision – because direct care nurses know their patients and their hospital, they know best which measures will most likely be linked to staffing issues. Not only will the committee select the patient outcomes measures, the committee will also apply this information in determining the adequacy of staffing. For example, if an increase in hospital acquired pressure ulcers (HAPU) on a particular unit corresponds with staffing changes – such as an influx of new graduate nurses to fill vacancies left by retiring senior nurses – the committee may determine that the staffing plan was based on a level of staff expertise that no longer exists on that unit. Therefore, the planned staffing levels need to be adjusted to reduce the occurrence of HAPU.

- The nurse staffing committee submits a report directly to the hospital board twice a year. The report includes the committee's evaluation of the effectiveness of the staffing plan and aggregate variances between planned and actual staffing. Significant or frequent variances may indicate that the hospital is not using the staffing plan to guide the assignment of nurses hospital wide as intended and is not complying with the statute. This process enables the hospital board to stay informed of staffing issues affecting the quality of patient care and to take action as necessary.

Additional hospital accountability for establishing an adequate staffing plan includes required reporting. The hospital must have a process to make the staffing plan and current staffing levels available to nurses on each patient care unit, each shift. Nurses will be immediately aware of staffing variances and can report concerns to the committee. The hospital must also consider the staffing plan as a component in setting the nurse staffing budget – staffing cannot be solely driven by budget, rather the budget must consider what is needed for adequate staffing. Finally, the hospital will report certain nurse staffing information to the Department of State Health Services as part of its annual hospital survey process.

Conclusion

Texas' Safe Hospital Staffing Act provides a structure and process for nurses and hospitals to work together in designing staffing plans to provide for the unique needs of their patient population. A successful staffing committee will need the support of hospital leadership as well as direct care nurses. Leadership will need to promote shared decision making and collect and provide data regarding staffing variances, patient outcomes, and finances to direct care nurse committee members. Direct care nurses will need to be willing to serve as representatives for their peers, share staffing concerns, and participate in problem solving efforts with the committee. A shared goal of achieving the most appropriate staffing considering characteristics of the specific hospital, nurses, and patients should guide committee decision making. An engaged hospital board will seriously consider staffing committee reports in the context of patient safety and quality care. The eventual effectiveness and success of the committee will be demonstrated in the patient outcomes achieved – the evidence is indisputable: adequate staffing is a prerequisite to positive patient outcomes. ★

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TNA Staffing Committee members:

- Mary Clark Robinson, PhD, RN-BC, Chair
- Mari Grace Cuellar, BSN, RN
- Candice Ward-Herman, MSN, RN, C-NE
- Judith Ann Krupala, MSN, RN, C-NE, FNP-BC
- Martha Helen Myers, RN
- Denise Neill, PhD, RN
- Elizabeth Sjoberg, JD, RN
- Wilma Powell Stuart, PhD, MA, RN
- Cindy Diamond Zolnierok, MSN, RN

TNA Governmental Affairs Committee members:

- Victoria England, MBA, RN, Chair
- Bobbie Ogg, MSN, RN
- Pat Morrell, MSN, RN
- Nancy Goodman, MSN, RNC
- Stan Harmon, MSN, RN, FNP-C
- Regina Jones Johnson, DrPH, MSN, RN
- Michelle Newsom, RN
- Lillian Sanchez, MSN, RN
- Shirley Morrison, MSN, RN, CS, OCN
- Jennifer Cook, PhD, MSN, MBA, RN
- Jessica Oliveti, RN
- John Crossley, RN, PhD, MBA, MSN, CNAA
- Susy Sportsman, PhD, RN
- Poldi Tschirch, PhD, RN
- Ruth Stewart RN, MS, FAAN
- Margie Dorman-O'Donnell, MSN, RN
- Fran Martin, MS, RN