Evaluation of Nurse Perception of the Implementation of the Oregon Nurse Staffing Law

Prepared by

Jean Ann Seago, PhD, RN, FAAN

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Executive Summary

In 1999 California became the first state to enact legislation that created mandatory nurse to patient ratios in acute care hospitals, expressly for the purpose of improving patient safety and improving nurse work environment. Although it was not implemented until 2004, the legislation had a galvanizing effect on other state policymakers who began to question whether ratios were the wave of the future. "To date, 15 states (CA, CT, IL, ME*, MN, NV, NJ, NY, NC, OH, OR, RI, TX, VT, WA) plus the District of Columbia* have enacted legislation and/or adopted regulations addressing nurse staffing. States have utilized varying approaches: mandated ratios; hospital staffing committee responsible for creating staffing plans, and disclosure; or a combination of the three."

In 2001, Oregon enacted a new law related to nurse staffing in acute care hospitals. The original law had an effective date of Oct 1, 2002[1]; rules were filled Dec 10, 2002[2]; audits were conducted in 2003 and 2004 by the Oregon Health Care Licensing and Certification Department of the Department of Human Services[2]; a revision of the law occurred in 2005[3]; and the current law is published in the 2009 Oregon Revised Statutes Chapter 441-441.106-441.192[4]. The people of Oregon decided to create a mechanism for a hospital nurse staffing committee (HNSC) to develop nurse staffing plans in each acute care hospital. This study will assess whether and/or how well the legislation is working.

The study design is a descriptive case study (qualitative method) using semi-structured interviews and focus groups. Aggregate descriptive information of the participating hospitals is included for clarity and context but is not be used to identify either the organization or individual participants. Data were collected using open-ended semi-structured interviews and focus groups. The analysis seeks insights into how a person within a given context makes sense of a phenomenon; in this case how individual nurses and managers experience and describe the HNSC and implementation of the Oregon staffing legislation.

There are 57 acute care hospitals in Oregon[5]. The initial plan was to select 6 (approximately 10%) hospitals but was revised to include a 7th hospital from the rural group. The addition of another rural hospital was made because of the variety and number of rural hospitals. The seven hospitals were selected using a purposeful stratified methodology taking into account hospital size, geographic location, union status, profit status, and affiliation.

The 57 acute care hospitals were categorized as 12 large (> than 150 beds), 14 mid-size (< than 150 but > than 50 beds), and 31 critical access/rural/small (< than 50 beds) facilities. Thirty-five of the 57 hospitals have RNs who are represented by unions (ONA and Oregon Federation of Nurses and Health Professionals). Within the State there are nonprofit and for profit hospitals, hospitals that have a religious affiliation, hospitals that are part of a larger organization, teaching hospitals, and hospitals located in different regions.

Three hospitals were selected from the 31 critical access/rural/small facilities; one that has a union and two that do not. Two hospitals each were selected from the large and mid-size group; one represented and one not represented in each size category. Also included in this sample were teaching hospitals, for profit and nonprofit hospitals, hospitals that were part of a chain, hospitals with religious affiliation, and hospitals from various regions of the State. In order to ensure sampling adequacy, a second group of hospitals was selected based on the same characteristics and matched with the first group of hospitals. The plan was that the second group of hospitals would be used if the first hospital declined to participate in the study.

The most significant theme of the study is the wide variation among facilities in the way the staffing legislation is viewed, interpreted, understood, appreciated, and implemented. In four of the participant facilities, the law was viewed as positive or moderately positive; in the other three facilities the law was viewed as negative. The overall view of the law did not relate to hospital size, location, union status, affiliation, or profit status. However, the theme that emerged was that the chief nursing officer's (CNO's) view of the legislation was the prevailing view expressed by the managers and staff nurses who participated.

The following themes emerged related to the specifics of the legislation. All facilities had staffing plans and HNSC in place. All facilities had equal numbers of direct care RNs and managers on the committees; all facilities had representation from the acute care units or unit clusters in the hospital. Direct care representatives were not always elected by the peer group; in some cases the managers had to plead with the staff nurses to get someone to attend the meetings. All facilities had some form of monitoring plan to evaluate the staffing plan but most groups had only been functional for 1-2 years so had not yet done an evaluation. The facilities had staffing plan(s) that included information about the scope of service that was provided in the different units and the population of patients that were admitted. Determining whether the plan

was sufficient for patient care was often triggered by complaints from the direct care nurses. Facilities included RN, LVN, and nurse aide competency in the staffing plan and the minimum number of nurses was generally based on national standards, particularly minimum staffing for ICU, OB, PACU, and ED.

Most facilities did not have a formal mechanism to include patient acuity in the staffing decisions; rather acuity/work intensity was addressed in relation to a variance from the core schedule on an "as needed" basis. This method may or may not violate OAR 333-510-0045 (4)(f). With rare exception, HNSC had neither reviewed nor approved the core schedule. Also, the HNSC had not been part of creating minimum numbers of staff (including skill mix) for different shifts. Most facilities reported that the matrices were created by managers with the CNO and negotiated based on the facility budget. This seems to violate OAR 333-510-0045 (4)(h), however further exploration of the policies would be needed for this to be determined. Only one facility's participants mentioned that they had a mechanism to limit admissions to a unit or divert patients to other facilities in times of short staffing or high patient acuity. This could be a violation of OAR 333-510-0045 (4)(g) but facilities generally provided reasons for why this could not be done. All facilities had on-call mechanisms but not all could use temporary staffing agencies because of geographic distance.

Consistent themes emerging from the responses to the study questions included the need for more education of the HNSCs on how to implement the legislation (specifically how to create staffing plans). The one agreed-upon benefit of the HNSCs was that it gave nurses "a voice".

The intent of the people who drafted and voted into law HB 2800 was that the nurses and managers who were closest to actually providing direct care to hospital patients would have a say in how the staffing was done. However, managers have a fiscal responsibility to the organization as part of their job requirements that direct care registered nurses do not have. So there has to be a balance between the resources that are available to the organization and the needs of the staff and patients in the organization. In addition, hospitals are hierarchical structures (some of the strictest hierarchies are in hospitals) and managers have the right and responsibility to hire and fire employees, including staff nurses. So, in order for staff nurses and managers to discuss issues on a somewhat "equal" basis, the thought (and reality) of the hierarchy must be suspended; this suspension is difficult, if not impossible. Simply requiring equal numbers of

staff nurses and managers on a committee is not enough. The environment of the committee must be created in such a way that both managers and staff feel mutual respect and support in having discussions, having disagreements, and being able to resolve the disagreements in a functional manner. Generally, the only person who can create such an environment is the Chief Nurse; perhaps the CNO cannot do that alone but I would argue that a supportive environment cannot be created without the CNO. Therefore, the implementation of the law is vulnerable to the thinking and attitude of the CNO and perhaps this is as it should be.

It is possible to follow the "letter of the law" and have a non-functional and ineffective Hospital Nurse Staffing Committee. It is also possible to have a functional and effective committee. What seems to make a difference between an organization that has a functional versus one that has a non-functional committee is whether the Chief Nurse views the legislation in a positive way and is able to use the legislation to enhance his/her work. It also seems that with that positive view there typically exists a mutual respect by and for staff nurses, managers, and the Chief Nurse. Even if the requirements of the law have not been fully implemented in these functional committees, there is a belief that further work is necessary and will be accomplished.

Another way that it is possible for a committee to follow the law is by the use of threats and intimidation, although I would not say that this creates a functional committee. However, it does provide a way for staff nurses to have a say in how staffing is done in the organizations. In those organizations with Chief Nurses who view the legislation as negative, redundant, or onerous, the committee members may become adversarial or complacent or withdraw from the process. All these behaviors (positive and negative) were displayed in our sample participants.

Like most legislation, this law had unintended consequences and has not been enacted in exactly the way the lawmakers intended. While enacting the law and staying within the prescribed rules, some organizations experienced positive changes and some organizations had not. In my opinion, this is <u>not</u> because the law was poorly conceived or written. It is because, as one of the participants said, "You can't legislate judgment". In organizations that are as people-intense as hospitals and that depend on the good judgment of many individuals, it is nearly impossible to create a law that will work in all of them.

Introduction

The 1990s were a difficult period for workers in many disciplines and occupations in the US. Downsizing was a preferred strategy of many organizations; hospitals and healthcare organizations were no exception and registered nurses were significantly affected by lay-offs[6]. During this time, RNs began to complain of too few workers and too much work leading to dissatisfaction with the work environment[7-9]. Additionally, during the 1990s nurse wages were flat after accounting for inflation[10]. Beginning in 1998 a shortage of registered nurses (RN) nationwide was beginning to be recognized and policy makers started to seek ways to increase the RN workforce[11, 12].

In 1999 California became the first state to enact legislation that created mandatory nurse to patient ratios in acute care hospitals, expressly for the purpose of improving patient safety and improving nurse work environment[13]. Although it was not implemented until 2004, the legislation had a galvanizing effect on other state policymakers who began to question whether ratios were the wave of the future[14]. "To date, 15 states (CA, CT, IL, ME*, MN, NV, NJ, NY, NC, OH, OR, RI, TX, VT, WA) plus the District of Columbia* have enacted legislation and/or adopted regulations addressing nurse staffing. States have utilized varying approaches: mandated ratios; hospital staffing committee responsible for creating staffing plans, and disclosure; or a combination of the three."[15].

In 2001, Oregon enacted a new law related to nurse staffing in acute care hospitals. The original law had an effective date of Oct 1, 2002[1]; rules were filled Dec 10, 2002[2]; audits were conducted in 2003 and 2004 by the Oregon Health Care Licensing and Certification Department of the Department of Human Services[2]; a revision of the law occurred in 2005[3]; the current law is published in the 2009 Oregon Revised Statutes Chapter 441-441.106-441.192[4]; and the Administrative Rules are published in the Oregon State Archives 2009[16]. The people of Oregon decided to create a mechanism for a hospital nurse staffing committee (HNSC) to develop nurse staffing plans in each acute care hospital (Tables 1 & 2).

Table 1

ORS 441.162 Written staffing plan for nursing services[4]

(1) A hospital shall be responsible for the implementation of a written hospital-wide staffing plan for nursing services. The staffing plan shall be developed, monitored, evaluated and modified by a hospital staffing plan committee. To the extent possible, the committee shall:
(a) Include equal numbers of hospital nurse managers and direct care registered nurses;
(b) Include at least one direct care registered nurse from each hospital nurse specialty or unit, to be selected by direct care registered nurses from the particular specialty or unit. The hospital shall define its own specialties or units; and
(c) Have as its primary consideration the provision of safe patient care and an adequate nursing staff pursuant to ORS chapter 441.
(2) The hospital shall evaluate and monitor the staffing plan for effectiveness and revise the staffing plan as necessary as part of the hospital's quality assurance process. The hospital shall maintain written documentation of these quality assurance activities.
(3) The written staffing plan shall: (a) Be based on an accurate description of individual and aggregate patient needs and requirements for nursing care and include a periodic quality evaluation process to determine whether the staffing plan is appropriately and accurately reflecting patient needs over time.
(b) Be based on the specialized qualifications and competencies of the nursing staff. The skill mix and the competency of the staff shall ensure that the nursing care needs of the patients are met and shall ensure patient safety.
(c) Be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations and recognize differences in patient acuteness.
(d) Establish minimum numbers of nursing staff including licensed practical nurses and certified nursing assistants required on specified shifts. At least one registered nurse and one other nursing staff member must be on duty in a unit when a patient is present.
(e) Include a formal process for evaluating and initiating limitations on admission or diversion of patients to another acute care facility when, in the judgment of the direct care registered nurse, there is an inability to meet patient care needs or a risk of harm to existing and new patients.
(4) The hospital shall maintain and post a list of on-call nursing staff or staffing agencies to provide replacement for nursing staff in the event of vacancies. The list of on-call nurses or agencies must be sufficient to provide replacement staff.
(5)(a) An employer may not impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment pursuant to a staffing plan developed or modified under subsection (1) of this section unless the employer first provides notice to and, on request, bargains with the union as the exclusive collective bargaining representative of the nursing staff in the bargaining unit.
(b) A staffing plan developed or modified under subsection (1) of this section does not create, preempt or modify a collective bargaining agreement or require a union or employer to bargain over the staffing plan while a collective bargaining agreement is in effect.

Table 2:
OAR 333-510-0045 Nursing Services Staffing[16]

(1) Each hospital must be responsible for the implementation of a written hospital-wide staffing plan for nursing services. The nurse staffing plan must be developed, monitored, evaluated and modified by a hospital nurse staffing plan committee in accordance with these rules. To the extent possible, the committee must: a) Be comprised solely of equal numbers of hospital nurse managers and direct care registered nurses as its exclusive membership for decision making; (b) Include at least one direct care registered nurse from each hospital nurse specialty or unit, to be selected by direct care registered nurses from the particular specialty or unit as the specialty or unit as defined by the hospital; and (c) Have as its primary consideration the provision of safe patient care and an adequate nursing staff pursuant to ORS chapter 441.
(2) The hospital nurse staffing committee must document: (a) How its members were chosen to reflect fair and knowledgeable representation; (b) How the input of each member in decision making is assured; (c) The committee process and procedures, including how and when meetings are scheduled, how committee members are notified of meetings, how the meetings are conducted, how unit staff input is acquired, who may participate in the decision making and how decisions are made; (d) Plans for how it will monitor, evaluate and modify the nurse staffing plan over time; and (e) Meeting proceedings (meeting minutes).
(3) The written staffing plan must: (a) Be based on an accurate description of individual and aggregate patient needs and requirements for nursing care; (b) Include at least an annual quality evaluation process to determine whether the staffing plan is appropriately and accurately reflecting patient needs over time; (c) Be based on the specialized qualifications and competencies of the nursing staff; (d) Ensure that the skill mix and the competency of the staff meet the nursing care needs of the patient; (e) Be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, such as, but not limited to, The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN); (f) Recognize differences in patient acuteness; (g) Include a formal process for evaluating and initiating limitations on admission or diversion of patients to another acute care facility when, in the judgment of the direct care registered nurse, there is an inability to meet patient care needs or a risk of harm to existing and new patients; and (h) Establish minimum numbers of nursing staff personnel including licensed nurses and certified nursing assistants on specified shifts, with no fewer than one registered nurse and one other nursing care staff member on duty in a unit when a patient is present.
(4)(a) The hospital nurse staffing committee must monitor, evaluate, modify, and re-approve the nurse staffing plan according to the schedule described in the nurse staffing plan. (b) If the hospital nurse staffing committee is unable to reach agreement on a re-approval of the nurse staffing plan, any nurse on the committee may request the Department to assist in resolving the impasse.

(c) The Department may require a hospital to: (A) Provide written documentation describing those portions of the modified nurse staffing plan that have been developed and approved by the nurse staffing committee; (B) Present a written plan for assisting the hospital nurse staffing committee in resolving outstanding differences including the scheduling of timely meetings, arranging for meeting facilitation and setting timelines; and (C) Implement those modifications to the nurse staffing plan that have been approved by the nurse staffing committee. (d) If a hospital is unable to resolve differences and adopt a modified plan within 60 days from the time the Department is notified of the impasse, it may request a 60 day Planning Process Extension. (e) To be granted the extension, a hospital must: (A) Employ a mediator within 30 days to assist in working out a compromise; and (B) Provide evidence that such a mediator will include nurse staffing expertise in the deliberative process.
(5) The hospital must maintain and post a list of on-call nursing staff or staffing agencies that may be called to provide qualified replacement or additional staff in the event of emergencies, sickness, vacations, vacancies and other absences of the nursing staff and that provides a sufficient number of replacement staff for the hospital on a regular basis. The list must be available to the individual responsible for obtaining replacement staff.
(6) When developing the on-call list, the hospital must explore all reasonable options for identifying local replacement staff. These efforts must be documented. (7) When a hospital learns about the need for replacement staff, the hospital must make every reasonable effort to obtain registered nurses, licensed practical nurses or certified nursing assistants for unfilled hours or shifts before requiring a registered nurse, licensed practical nurse, or certified nursing assistant to work overtime. Reasonable effort includes the hospital seeking replacement at the time the vacancy is known and contacting all available resources as described in section (5) of this rule. Such efforts must be documented.
(8) A hospital may not require a registered nurse, licensed practical nurse, or certified nursing assistant to work: (a) Beyond the agreed-upon shift; (b) More than 48 hours in any hospital-defined work week; or (c) More than 12 consecutive hours in a 24-hour period, except that a hospital may require an additional hour of work beyond the 12 hours if: (A) A staff vacancy for the next shift becomes known at the end of the current shift; or (B) There is a risk of harm to an assigned patient if the registered nurse, licensed practical nurse or certified nursing assistant leaves the assignment or transfers care to another.
(9) Each hospital must have a system to document mandatory overtime. The procedure must be clearly written, provided to all new nursing staff, and be posted in a conspicuous place. The procedure must ensure that both the employee and management are involved. (10)(a) Time spent attending hospital-mandated meetings, and hospital-mandated education or training must be included as hours worked for purposes of section (8) of this rule. (b) Time spent on call but away from the premises of the employer may not be included as hours worked for purposes of section (8) of this rule. (c) Time spent on call or on standby when the registered nurse, licensed practical nurse or

certified nursing assistant is required to be at the premises of the employer must be included as hours worked for purposes of section (8) of this rule.

(11) The provisions of sections (7) through (10) of this rule do not apply to nursing staff needs:

(a) In the event of a national or state emergency or circumstances requiring the implementation of a hospital disaster plan;

(b) In emergency circumstances, such as but not limited to:

(A) Sudden unforeseen adverse weather conditions;

(B) An infectious disease epidemic of staff; or

(C) Any unforeseen event preventing replacement staff from approaching or entering the premises; or

(c) If a hospital has made reasonable efforts to contact all of the on-call nursing staff or staffing agencies on the list described in section (5) of this rule and is unable to obtain replacement staff in a timely manner.

(12) A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon scheduled shift or an agreed-upon extended shift without authorization from the appropriate supervisory personnel as required by the Oregon State Board of Nursing OAR, chapter 851.

(13) A hospital must post a notice summarizing the provisions of ORS 441.162, 441.166, 441.168, 441.174, 441.176, 441.178, and 441.192, in a conspicuous place on the premises of the hospital. The notice must be posted where notices to employees and applicants for employment are customarily displayed.

(14) Upon request of a hospital, the Department may grant variances in the written staffing plan requirements based on patient care needs or the nursing practices of the hospital. Such request for a variance must be in writing and must state the reason for seeking a variance, verification that the nurse staffing plan committee has reviewed the request for variance, and how granting the variance will meet patient needs or the nursing practices of the hospital. A variance must be posted along with the notice required in ORS 441.180.

(15) Nothing in section (4) of this rule relieves a hospital from complying with ORS 441.162 or 441.166.

Like many organizations, the Oregon Nurses Association (ONA) was interested in determining the effectiveness of the nurse staffing legislation in the state. Partnering with the Oregon Nurse Staffing Collaborative (ONSC) [http://www.oahhs.org/quality/nurse-staffing.html & http://www.oregonrn.org/displaycommon.cfm?an=1&subarticlenbr=33], ANA , ONA and with support of the Oregon Association of Hospitals and Health Systems (OAHHS) and the Oregon Nurse Staffing Collaborative, the ONA created a study proposal that asked the questions: 1) are hospitals adhering to the law? and 2) is the law having an impact on nurse satisfaction, nurse staffing, and/or patient safety and quality. The proposal described a plan that specifically sought to determine:

- Experiences, benefits, and challenges of establishing and maintaining a hospital nurse staffing committee (HNSC),
- Experiences, benefits and challenges of developing, sustaining, evaluating and modifying nurse staffing plans for clinical units,
- Policies that were developed as the result of the legislation,
- Perceptions of the impact of the legislation on nurse staffing, quality and safety of patient care, and nurse retention, turnover, and satisfaction.

The purpose of this report is to describe the results of the study including methods, sample, findings, interpretations and conclusions.

Background

In order to effectively describe the study results, it is necessary to explicate how U.S. acute care hospitals and medical centers typically manage nurse staffing. Acute care nurse staffing can be thought of in two general parts; the first part involves creating a schedule for staffing a nursing unit/ward for a period in the future (4-8 weeks) (sometimes called a staffing plan or part of a staffing plan); the second part involves last minute staffing replacement related to unscheduled absences of nurses or other care workers or changing patient volume and acuity.

The anticipated future staffing of a nursing unit is called the schedule and posted for nurses and others to see in advance of when it begins. It may be a fixed schedule (called a staffing pattern in many of the contracts in ONA), meaning a nurse would generally have the same days off in a repeating sequence during the length of the schedule; or variable schedule. However, most union contracts (and in hospitals with no union) and associated customs generally dictate

that nurses work every other weekend and are off every other weekend. In union hospitals the timing of the posting of the schedule is based on the contract and in non-union hospitals it is posted in advance based on nursing policies. The core schedule (master schedule, set schedule, fixed schedule) is typically based on a plan of staffing called the matrix (aka. grid, pattern, or guidelines) which is usually created using the relevant range of patient census for the unit. For example, if there are X number of patients (often regardless of status, acuity) then there are X number of nursing staff (often regardless of experience, competency, etc).

The matrix is a document that provides a plan for how to staff the unit as the patient census varies. It is often created as a stepped-fixed plan[17] and assumes a minimum and maximum number of patients in the unit. For example, in an intensive care unit in California, where there are ratios set by law, the nurse: patient ratio is never leaner than 1 nurse: 2 patients (so it could alternatively only be 1 nurse: 1 patient or 1 nurse: 2 patients). If the ICU has 12 beds but, on average has eight patients, two of whom are 1:1 patients (greater work intensity or acuity) with the other 6 being (average intensity or acuity) 1:2 patients, the matrix/core staffing would require having 5 RNs per shift (24 hours a day/7 days a week). The manager would attempt to create a schedule with no fewer than 5 RNs per shift; then the shift supervisor would make adjustments as required (adding or cancelling nurses).

In a medical-surgical unit in California, the ratio law always requires 1 nurse: 5 patients or richer. The stepped-fix plan means that if there are 10 patients in the unit, there must be 2 nurses; if there are 15 patients in the unit, there must be 3 nurses. However, if there are more than 10 but less than 16 patients, there will also be 3 nurses. The “step” of the step-fixed method is added for every 5 patients and if there are patients on the margin (11-14 patients), a third nurse must also be added.

In other states, the ratios are not determined by law; rather they are determined by managers using several pieces of data. Managers typically use historical information about the unit and staffing, which includes the average daily census (ADC) in the unit and the average hours of patient care provided by nurses (so, in the ICU a 1 nurse:1 patient gets 24 nursing hours per patient day and the 1 nurse:2 patient gets 12 hours per patient day[HPPD] of care). The average daily census is typically determined by taking the midnight census of the unit (a snapshot of the 24 hours) for each day in the year and dividing that number by 365 days. The average numbers

of hours of nursing care are calculated by taking the number of hours worked by nurses during the day and dividing it by the average daily patient census for a day. So, if there are 3 nurses working on each of 3 eight-hour shifts that would be 72 nursing hours worked per 24 hours. If there is an average of 15 patients in the unit at midnight, then the average hours per patient day (HPPD) would be 4.8 hours (72/15). That means that, on average, each patient receives 4.8 hours of nursing care in that 24 hour period. Individual patients may receive more or less hours, but this is the average for the group of patients. The average can be calculated for a shift, for 24 hours, or other timeframes and can be created by unit, groups of units, or the entire hospital.

HPPD is a common metric that is used to estimate efficiency of nursing units and is often used as a way to create an annual budget for a unit and to provide ongoing assessment (variance) of how well the manager adheres to the budget[17]. In the last three decades there have been many efforts to account for patient acuity instead of simply using the midnight census (volume) in trying to predict workload and therefore the staffing needs for upcoming shifts. However, the patient classification systems that have been developed have not, for the most part, been a satisfactory way to either obtain more resources when needed or help in predicting workload[18]. Although most hospitals still use patient classification/patient acuity systems (PCS), both managers and staff nurses typically admit that they are useless in making assignments, staffing for the next shift, or creating staffing schedules. The aggregated data from the PCS may assist the nurse executive in demonstrating an increase/decrease in patient acuity over time and provide evidence to negotiate for changes in the budget for nursing units/departments.

Some hospitals use the HPPD exclusively and others track hours as well as dollars per patient day (DPPD) for the budget. Nurse Managers of units are given activity reports at the end of each payroll period to see if there is a variance from the predicted budget. The variance reports may be only for hours or may be for both HPPD and dollars per patient day. Because the labor budget makes up the majority of the nursing unit budget, there is a great deal of pressure on nurse managers and executives to stay within the HPPD or DPPD for the unit. This is often monitored aggressively on a shift by shift basis.

Nurse Managers generally negotiate once a year for their unit matrix and core staffing, often using the full time equivalent (FTE) and HPPD as the mechanisms. FTEs are used to create positions in a unit budget in hospitals and the industry standard for an FTE is 2080 hours/year.

Generally, productive time (time spent being paid and actually delivering patient care versus nonproductive time such as vacation, sick leave, education leave, etc.) is 80-85% of the 2080 hours. Therefore, a manager can only count on 1664-1768 productive hours/FTE of actual direct patient care. Additionally, hospitals are 24 hours/day 365 days/year operations, so additional staff must be hired to account for that time; and each direct nurse must be replaced when s/he is not at the bedside. So, because hospital operation continues 365 days a year and 24 hours a day, the need to provide nonproductive time to benefited employees, and the need to "backfill" each position when the nurse is not providing direct care, nurse managers must hire approximately 1.75 FTEs for every full time equivalent position in an acute care hospital[17]. Unfortunately, many nurse managers, nurse directors, nurse executives, and hospital administrators either do not understand or chose to ignore this critical fact and systematically under budget nursing units.

Hospital administrators can increase or decrease the number of nurses working on the unit by increasing or decreasing the HPPD and/or FTEs, and thus increase or decrease the matrix and core staffing (the number of nurses scheduled per day based on the average daily census) of a unit. Hospitals vary widely in how much control or input staff nurses, nurse managers, nurse directors, or chief nurse executives have in creating and/or changing the matrix. Hospitals also vary widely in whether dollars are the primary factor in nurse staffing decisions or whether and how other factors (patient care intensity, patient acuity, nurse workload, union demands) are used in the creation of the nursing budget.

The second major part of nurse staffing is having a plan to address last minute unscheduled absences or higher than planned patient census, acuity, or work intensity. Nurse Managers typically have overall responsibility for developing the staffing matrix, the staffing schedule, and a plan for how to replace staff members when there are unscheduled absences or higher patient workload; but managers are usually physically present in the hospital during regular business hours. Nursing shift supervisors work during non-business hours (evening, nights, and weekends) and face the problem of staffing nursing units when there are last minute insufficient numbers or too many nurses to provide care for the patients who are already in the hospital. The shift supervisors rely on the matrix and the staffing plan provided by the nurse manager to determine how to allocate available staff resources for each unit (and for which the unit is budgeted), given a certain number of patients. The shift supervisor further relies upon the charge

nurses (nurses who manage the workload for one unit for one shift), staff nurses, and their own judgment to determine if the unit needs additional or fewer resources (nurses and/or assistants).

For additional necessary resources (either because of unscheduled absences, higher than planned census or acuity, higher workload, or rapid influx of patients), shift supervisors rely on temporary staffing agencies, internal pools of non-pre-assigned nurses, "floating" nurses from one unit to another, moving patients from one unit to another, bringing in "on call" nurses (those who are being paid to wait by the phone at home in case they are needed), mandatory overtime of staff who are at work, and calling in the nurse manager to work a shift. Ideally, the unit staffing has been settled before a shift supervisor reports for duty on a particular shift; however, s/he is still tasked with dealing with unexpected changes during her/his shift and arrangements for staffing for the following shift. A detailed staffing plan for a unit will guide the actions of the shift supervisor by prioritizing steps that happen when there is a need for additional staff members. Resources for unscheduled absences or unplanned workload vary tremendously by hospital and shift supervisors make rapid decisions with the resources available to them.

There are several obvious problems with the way nurse staffing matrices and schedules are created and managed and in the way nursing units are budgeted and have positions allocated; 1) the midnight census that is used in calculating ADC is an unreliable indicator of number of patients for the 24 hours and for estimating workload[19-21], 2) the false assumption that the average is a good measure of both number of patients (census) and workload (HPPD), 3) the false assumption that nurses are interchangeable, 4) the systematic under budgeting of nursing units because of inaccurate calculation of necessary FTEs, and 5) ignoring the shortened length of stay (LOS) and rapid patient turnover (i.e. admissions, discharges, and transfers (ADTs) in hospitals on every nursing unit, 6) ignoring the increasing regulatory requirements that have been assigned to staff nurses, and 7) the false assumption that technology (CPOE, EMR, bar-coding, etc) would reduce the need for nurses when it has actually increased the time for machine/technology management and therefore the need for more nurses[22, 23]. Hospitals vary widely in whether they address all, part, or none of these problems, as well as countless other nurse staffing issues, beliefs, and fallacies.

The state of Oregon created legislation that assumes the people who are best able to make decisions about nurse staffing are the nurses who work daily on the nursing units and the nurse

managers who have responsibility for those units. This study will assess whether and/or how well the direct care nurses and nurse managers perceive that the legislation is working.

Method

The study design is a descriptive case study (qualitative method) using semi-structured interviews and focus groups. Aggregate descriptive information of the participating hospitals is included for clarity and context but is not be used to identify either the organization or individual participants. The philosophical background of the study is interpretive phenomenology and thematic analysis is used to capture and describe emerging themes, patterns, and meanings. Data were collected using open-ended semi-structured interviews and focus groups. The analysis seeks insights into how a person within a given context makes sense of a phenomenon[24]; in this case how individual nurses and managers experience and describe the HNSC and implementation of the Oregon staffing legislation.

The chief nursing officer (CNO) of each sample hospital was interviewed individually using semi-structured questions; direct care RNs who were members of the HNSC were interviewed in one focus group and the managers/directors HNSC members were interviewed in a separate focus group. The focus groups were audio recorded for playback by the interviewer during data analysis. The CNO and both focus groups were interviewed using the same questions.

Procedure

Each of the 57 Oregon acute care hospitals was contacted by a joint letter from the ONSC, ONA, and the Oregon Association of Hospitals and Health Systems (OAHHS) explaining the study and encouraging participation, if selected. The seven primary sample hospitals were then contacted by this researcher through an email that explained the study in further detail and sought their consent to participate in the study. After 10-14 days, this researcher contacted the sample hospitals' CNOs by telephone or email to determine if the hospital was able to participate in the study. The interviews with the CNO and each focus group were then scheduled for 60-90 minutes. All the interviews in one hospital were scheduled on one day. Hospital CNOs were assured that neither the hospital staff nor the facility would be identified by name in the final report.

Sample

There are 57 acute care hospitals in Oregon[5]. The initial plan was to select 6 (approximately 10%) hospitals but was revised to include a 7th hospital from the rural group; this decision was made because of the variety and number of rural hospitals in the State. Oversampling of the category seemed prudent in order to provide more information about this group of hospitals. The seven hospitals were selected using a purposeful stratified methodology with the intent of obtaining diverse and comprehensive data. The sampling method took into account hospital size, geographic location, union status, profit status, and affiliation.

The 57 acute care hospitals were categorized as 12 large (> than 150 beds), 14 mid-size (< than 150 but > than 50 beds), and 31 critical access/rural/small (< than 50 beds) facilities. Thirty-five of the 57 hospitals have RNs who are represented by unions (ONA and Oregon Federation of Nurses and Health Professionals). Within the State there are nonprofit and for profit hospitals, hospitals that have a religious affiliation, hospitals that are part of a larger chain of hospitals, teaching hospitals, and hospitals located in different regions.

Three hospitals were selected from the 31 critical access/rural/small facilities; one that has a union and two that do not. Two hospitals each were selected from the large and mid-size group; one represented and one not represented in each size category. Also included in the sample were teaching hospitals, for profit and nonprofit hospitals, hospitals that were part of a chain, stand-alone hospitals, hospitals with religious affiliation, and hospitals from various regions of the State. In order to ensure sampling adequacy, a second group of hospitals was selected based on the same characteristics and matched with the first group of hospitals. The plan was that the second group of hospitals would be used if the first hospital declined to participate in the study.

Of the seven hospitals in the first group that were contacted, four agreed to participate. For the three first group hospitals that declined, their selected pairs from the second group hospital list were contacted and all consented to participate. Scheduling for the interviews and focus groups for each hospital was completed through the CNOs' offices. Registered Nurse direct care staff and managers who were currently participating or had participated in the HNSC were contacted and asked to participate.

Results

The results of the study are organized by the semi-structured interview and focus group questions. The responses are aggregated in order to maintain the confidentiality of the participants and organizations.

1. **Describe the make-up of the HNSC. Are there separate committees for each clinical unit, one organization committee, or both? Who leads the committee? How often do you meet?**

All participant hospitals had a HNSC. The committees were composed of ½ direct care RNs and ½ managers, although one group reported that their committee had more direct care RNs than managers and another reported that if there were too many managers in attendance, the extra managers moved their chairs away from the table and sat against the wall during the meeting. Along with a hospital committee, some facilities also had unit committees or subcommittees that met and made staffing recommendations regarding specific units. Several committee members commented that the unit committees were in a better position to make decisions about staffing than the hospital committee.

There was variation in the leadership of the committees; in some the CNO was the committee chair, co-chair, or "facilitator"; in others there was a manager and direct care nurse who co-chaired the group and the CNO was a member (some CNOs were voting and some non-voting members). Generally, the CNO's office provided administrative support for agendas, minutes, scheduling and other functions. All hospitals had at least one staff nurse representative from individual units or unit clusters and some large units had 2 representatives. In some hospitals staff members and the staff co-chair were elected by their peers; in others the CNO or manager had to persuade staff members to attend the committee. In some but not all hospitals, there was representation from Home Health, Hospice, and Rehabilitation units; one committee included a representative from the Human Resources department and most had a shift supervisor as a member.

The committee meetings ranged from monthly to twice yearly, with some meeting quarterly and others every two months. Several participants indicated that the frequency of meetings depends on the number of issues to be discussed. Several participants brought binders of staffing

documents that had been created for the hospital as a whole and some had binders for individual units or unit clusters, particularly the large hospitals.

2. Establishing and maintaining a HNSC: Describe positive and negative experiences including benefits and obstacles.

All participants indicated that their committees had some difficulty getting started and some members indicated that there was still uncertainty about the purpose of the group. Several hospital participants said that their committee was "new" and was still working out what to do and how to function effectively. Several hospitals described a change in the focus and perceived importance of the committee when there was a change in executive leadership in the hospital. Some committees had been functioning at some level for as long as 5 years and other had only started 1-2 years ago. All participants said the groups were still evolving; educating members about staffing and staffing issues (productivity targets, FTEs, budget restrictions) took a significant amount of time.

Benefits from establishing and maintaining the committee included:

- Created a more formalized staffing plan for units particularly for shift supervisors;
- Created a system to allow nurses to "say what they can do" when they are sent to another unit;
- Increased empathy among staff in other departments; staff learn about other departments; exposed staff nurses to the reality of staffing;
- Leadership/management group became more collaborative;
- Gave staff nurses a "voice" (this was said by almost every group);
- Staff members bring concerns of unit staff to the committee;
- Committee members communicate well; staff works well with managers;
- There is an annual review/revision of the staffing plans;
- Having minutes from meetings readily accessible was important;
- Created definitions of terms related to staffing;
- CNO gets more information about staffing issues; managers get input from staff nurses;
- Some success in increasing staffing numbers;
- Some groups have worked together to make difficult decisions;

- Some staff members expressed that they enjoyed calling in the “State” and winning by forcing managers to follow the state law;
- In some groups, staff felt that the meetings were a positive experience;
- Some CNOs felt that the committee meetings could be used to teach leadership skills;
- Some CNOs found the law helpful to them; they promoted the law and explained reasons for having law;
- Some managers found that the law and the HNSC have “elevated the conversation”; it has resulted in the education and empowerment of staff nurses; it has given tools to staff nurses and managers.

Barriers to establishing and maintaining the committee included:

- A lack of follow-through on problem solutions and on decisions;
- A lack of follow-up communication between members and staff nurse colleagues; the committee reaches only a small number of staff nurses;
- A lack of communication about decisions to shift supervisors and the staffing office clerk/coordinator;
- A lack of “buy-in” by staff about committee decisions;
- Cancelled meetings because there was no chair present;
- Staff nurses felt intimidated when sitting with managers and CNO (even though there are equal numbers of staff and managers);
- Some felt there was a of lack of progress and the meetings were irrelevant;
- Staff nurses do not know how to state an issue (i.e. bring up anecdotes from only their experience);
- Managers refused to discuss an issue because the budget is the “bottom line”;
- Some committees are only informational, not decision-making; there was no authority to make changes (this was mentioned in most groups);
- Getting staff nurses to participate in the committee;
- Losing institutional memory when key people leave or when there is committee member turnover;
- Staffing matrices based only on the number of patients;
- The law is not effective; it was written by people who do not know about staffing;

- Some staff nurses do not have a culture of accountability;
- When minutes of meetings are not available;
- Some executive managers felt like they had to contrive something for the committee to do because there were no issues;
- Some groups are divisive; they are not run professionally; there is more emotion than fact; some managers feel attacked; there is no collaboration and no discussion; managers are uncomfortable listening to others "battle"; managers hate the meeting; negative people dominate and there is no control of behavior; managers find it hard to get staff nurses to attend; the meetings are "killing everyone";
- Some staff have felt managers try to "steam-roll" or "bulldoze" them; managers do an "end-run" or try to "slip in" changes; they want to do "pointless studies"; they try to "push the envelope" or "maneuver around" the law; in the past members have become frustrated, angry, sarcastic, they make distracting comments, shout, pound the table, leave the room; managers have cried; some staff think managers believe they are lazy if they ask for help.

3. Developing, sustaining, evaluating, and modifying a nurse staffing plan for each clinical unit: Describe positive and negative experiences including benefits and obstacles.

Each participant hospital had a hospital staffing plan. In smaller hospitals, the hospital staffing plan included all units but in larger hospitals each unit or group of similar units had a staffing plan. The plans included guidance in the case of understaffing, overstaffing, "floating", "flexing", call-offs, call-ins. In most hospitals, the staffing plans were being or going to be reviewed annually; typically the plans did not include the staffing matrix for units. The committees had been involved in creating certain staffing policies but in the majority of hospitals, the HNSC had neither reviewed nor approved the staffing matrices for the units. In some hospitals there was intent to begin to review the staffing matrices but in others creation or change of the staffing matrices was entirely the prevue of the managers and CNO. This seems at odds with OAR 333-510-0045 (3)(h) "The written staffing plan must: …Establish minimum numbers of nursing staff personnel including licensed nurses and certified nursing assistants on specified shifts,…." Most facilities could adhere to this rule by including the matrices in the staffing plan for approval by the committee.

The researcher specifically asked participants how the HNSCs resolved disagreements within the group. Some participants said they never had disagreements; others said that the group talked until they reached consensus; some participants stated that if they could not reach consensus either the issue "would just go away and not come back on the agenda" or the manager would take some action; some committees voted when there was a disagreement; others had an "informal" vote; and still others were not aware they could or should vote. Most participants described their committees as functioning primarily for informational or reporting purposes and few participants felt that their groups had decision-making authority.

Benefits from developing, sustaining, evaluating, and modifying a nurse staffing plan for each clinical unit included;

- Policies about "floating", "flexing", and "cross-training" staff nurses;
- A policy about "primary" (a nurse who is able to take any patient assignment in the unit) and "secondary" (a nurse who can take a patient assignment of lesser acuity patients) nurses for a unit;
- A unit binder that provides orientation to staff from other units;
- Beginning to create an evaluation tool for the floating/flexing experience for the affected nurse and the receiving unit;
- Policies that "back up" the shift supervisor and staff nurses;
- Better treatment of "flexed" staff;
- A daily "huddle" with department representatives to discuss staffing and bed management which helps communication;
- Increased staffing in some medical surgical units, EDs, & OB units (particularly following national standards by having two staff members in ED, OB, and ICU);
- Staffing matrices are based on census, acuity, and national standards; in some organizations the matrices are approved by a unit staffing council and then the change is reported to the HNSC; in other facilities the matrices are not taken to HNSC;
- Law has "teeth" but there is reluctance to address disagreements/conflicts;
- One facility had updated the OB master schedule and all master schedules would now be reviewed annually; not all facilities review the matrices annually;
- In some facilities there are guaranteed hours (only 1 call-off day/pay period);

- There was discussion of issues with the staffing office (call-offs, cancelations, stand-by, floating, communication);
- There was discussion in the HNSC of whether a stand-by (on call) nurse is required to float (the decision was not clear to participants); discussion of paying employees a minimum amount if they report to work and are then sent home;
- Discussion in HNSC regarding lengths of shifts, type of overtime rule to use (8/80 or 40/40), interdepartmental handoffs, nurse preceptor program, acuity systems, overtime, low census times, cancellation, extra shift sign-up, premium pay, primary/secondary nurses, "closed" units (those that do all staffing internally), voluntary "floating", having an "admission" nurse, "docking" (being put on call);
- Some HNSCs are a "sounding board" for the CNO and for staff; compromise has happened in difficult decisions;
- In one facility managers "round" on staff; have "5 minute" frustration forms that staff can compete and that are discussed in the HNSC;
- One facility has an ADT unit that is opened as needed and staffed with float pool RNs;
- There were discussions of dealing with budget variance and oversight of staffing plans;
- In some facilities, the charge nurses make the decisions about staffing for the next shift.

Barriers of developing, sustaining, evaluating, and modifying a nurse staffing plan for each clinical unit included

- Inconsistent communication (managers and shift supervisors);
- Inconsistent implementation of policies (flex);
- Committee meetings are sometime not relevant;
- Shift supervisor makes staffing decisions and charge nurse makes assignments;
- Some staff nurses do not know or care about other departments;
- Some managers feel the HNSC has not "jelled";
- Some managers say that the budget is not something they can control;
- In some sites, if staff vote against something, they have to find an alternative;

- Some managers believe that the changes since the law would have happened anyway;
- Early in the process the staff viewed the law as a way to get more staff; when that did not happen they "disengaged";
- In most facilities, the HNSC has no authority to make changes; they only make recommendations/suggestions to managers;
- Some staff nurses do not ask for changes in staffing because they do not know who to ask;
- In one facility, acuities are completed but no one knows why (staffing is all about the budget); staff can give input on the staffing plan but only within the limits of the budget;
- One facility has a hiring freeze and that was not discussed in HNSC;
- The focus is on meeting "the letter of the law"; it is a mandate;
- In some facilities, managers feel stupid because policies vary and they may not know all the variations; managers do not speak in HNSC; they feel attacked; they hate the meeting; there is constant "bullying" behavior in the meetings; neither staff nor managers want to attend;
- One group of managers felt that changes/problems in staffing should be solved at the department level; the meetings were not productive; staff have power to change staffing but have no fiscal responsibility;
- There is discussion of missed meals but there is no resolution—just told to "fill out a form";
- Although HNSC gives nurses a voice, it is hard for nurses to find a voice.

4. Describe any new policies that have been implemented related to the new HNSC.

Several hospitals described policies, procedures, or administration/management rules that had been added, modified or influenced by the HNSC. Some of the issues mentioned included:

- Call-off, standby, cancelling;
- Primary/secondary nurses for unit;
- Flexing and floating;
- Call-offs being limited to 8 hours/pay period;

- High census/low census;
- Evaluation tool for flexing;
- HNSC bylaws; charters; strategic plans;
- Hospital capacity;
- Waivers for minimal staffing requirements;
- In some facilities, staffing plans included plan of care, scope of service, staffing mix, staffing matrices, ADTs, population, census, evaluation, patient outcomes, staff outcomes, what to do is there is insufficient staffing, acuity how and when to close to admissions;
- Hospital wide staffing plan,
- Structures and standards related to staffing;
- Swing beds (acute care to rehab);
- Premium pay and extra shift availability;
- On call for specialty units (PACU, ICU, OB);
- Changing length of shifts (8 to 12 hours shifts),
- Breaks and meals.

5. **What is your perception about the impact of the Oregon Nurse Staffing Law on**
    a. **Patient safety, quality and care,**
    b. **Nurse staffing,**
    c. **Nurse satisfaction, retention, and turnover?**

There were varying perceptions about the impact of the staffing law, even among participants in the same facility. Comments included:

- It has codified the ability of the nurses to refuse an assignment;
- It has improved staffing in some areas (ICU, OR, OB);
- It “feels” like patient safety has improved;
- Increased nurse satisfaction;
- Not sure if improvement was the law or some other factor (union, different CNO, magnet journey);
- Some staff did not know about the law;
- Managers are following acuity more; less resistance when asking for extra staff;

- Communication seems better;
- Perhaps better weekend staffing;
- Without the law, there would not be a HNSC;
- Improved night shift staffing;
- No impact on patient safety, staffing, or nurse satisfaction;
- HNSC can be a support to individual nurses;
- Law has no teeth—no consequences;
- Law has teeth but nurses do not address conflicts;
- Increased nurse satisfaction by giving nurses a voice;
- HNSC could be incorporated into the PNPC (professional nurse practice council); there is no need for both;
- Managers would have made the changes without the law;
- Law has not helped;
- Improved patient safety in ED by increasing staffing;
- Improved nurse satisfaction;
- Improved nurse staffing;
- Not sure if there has been improved patient safety;
- Staff feel more supported and there is a rationale for taking a stand on staffing;
- Empowers nurses; they can now be proactive about solving issues;
- Gives nurses a voice; not making final decisions but HNSC provides a forum for issues;
- In the HNSC nurses have a voice to higher level managers;
- Greater transparency among units;
- Builds management accountability;
- Has brought no added value; other groups were already doing this work;
- Increased cost because of having HNSC meetings;
- Good to learn what happens in the staffing office;
- Hard to see any impact when meetings are so infrequent
- Allowed bedside nurses to have a voice;

- Maybe it helps small or rural hospitals;
- Some facilities have negative confrontational meetings that prevent constructive dialogue;
- Some committees are not dynamic; staff can provide input;
- Law has improved patient care quality and some success increasing staffing;
- Law is 75% good and 25% difficult;
- Positive impact on staffing, nurse satisfaction and patient safety and quality;
- HNSC is now a priority and better structured;
- In some facilities CNO receptive to all issues;
- Some staff feel more valuable; the CNO seeks staff input; meetings are productive; enjoy meetings;
- Should have made nurses feel more satisfied but nurses are less satisfied; there was an increase in staffing; no impact on patient safety; overall a negative experience;
- Medical surgical nurses are more satisfied; clinic nurses are very negative;
- Some staff and managers do not want to go to meetings because they are so negative;
- Nurses are aware of their rights; HNSC is not able to enforce staffing plans; the committee does not function in an effective way; staff are made to feel lazy if they ask for more staff;
- Positive impact on nurse staffing; negative impact on nurse satisfaction; a staff nurse has requested secret ballot but that has not been allowed;
- Nurses are “owning” their practice; HNSC gives you flexibility; you cannot legislate judgment but the law allows for more professional judgment;
- Law has formalized what was being done; it provides a formal way to document staffing needs in addition to the budget;
- Law has elevated the conversation to include national standards; educating staff; empowering staff; you can be proactive; the manager still has to justify variance of budgeted staffing and you must have data and comparison numbers to increase staffing;
- Law has had limited impact on nurse satisfaction; “Hawthorne effect” on patient safety and quality;

- There is oversight by DHS but not much penalty; not making a difference yet; need more education of staff;
- Promotes dialog between manager and small group of staff; managers vary a great deal; there is provision for a mediator;
- There are so many levels of nurses, the mechanism for the implementation of the statute is not clear and people need help with implementation.

6. Any further thoughts or comments?

This question was a way to end the discussion and allow for any other thoughts and comments by the participants. Comments included;

- The law has not added value; nurses had a voice already;
- Critical access hospitals have a different (and more generous) funding mechanism for Medicare patients;
- Some of us feel strongly that nurses should be compensated for certification and education;
- Some charge nurses are empowered to make last minute staffing decisions;
- Managers are not sure how to deal with disrespectful behavior, conflict, and confrontational staff in the HNSC meetings;
- Managers round regularly on staff; MDs and RNs round together on patients;
- It is not hard to get people on the committee;
- HNSC meetings allow discussion of frustrations and hopefully problem resolution;
- Staff do not want to attend meetings because meetings are so confrontational;
- HNSC has the potential for being a useful tool but it is not now; we need a more definite goal; we only have it to meet the state law;
- One staff member said, “I am not sure if the committee is run professionally”;
- We are still learning about the law and we need to be sure we understand it; we are still becoming familiar with it so we can see how it fits into our larger goals;
- The next step is to try to link patient outcomes with staffing; we need to be more specific than just saying we need more staff;
- Nurses are tired of having one more task;

- Staff nurses do not know how to do a staffing plan; they do not know the potential for staff input; we need to know how to find data; we need to understand that this law gives you a way to change your job.

Interpretations and Conclusions

The most significant theme of the study is the wide variation among facilities in the way the staffing legislation is viewed, interpreted, understood, appreciated, and implemented. In four of the participant facilities, the law was viewed as positive or moderately positive; in the other three facilities the law was viewed as negative. The overall view of the law did not relate to hospital size, location, union status, affiliation, or profit status. However, the theme that emerged was that the CNO's view of the legislation was the prevailing view expressed by the managers and staff nurses who participated.

The following themes emerged related to the specifics of the legislation. All facilities had staffing plans and HNSC in place. All facilities had equal numbers of direct care RNs and managers on the committees; all facilities had representation from the acute care units or unit clusters in the hospital. Some rehabilitation, home care, hospice, or clinics chose not to participate in the HNSC. Direct care representatives were not always elected by the peer group; in some cases the managers had to plead with the staff nurses to get someone to attend the meetings. All facilities had some form of monitoring plan to evaluate the staffing plan but most groups had only been functional for 1-2 years so had not yet done an evaluation. The facilities had staffing plan(s) that included information about the scope of service that was provided in the different units and the population of patients that were admitted. Determining whether the plan was sufficient for patient care was often triggered by complaints from the direct care nurses. Facilities included RN, LVN, and nurse aide competency in the staffing plan and the minimum number of nurses was generally based on national standards, particularly minimum staffing for ICU, OB, PACU, and ED.

Most facilities did not have a formal mechanism to include patient acuity in the staffing decisions; rather acuity/work intensity was addressed in relation to a variance from the core schedule on an "as needed" basis. This might be a failure to adhere to OAR 333-510-0045 (3)(f) "The written staffing plan must:…Recognize differences in patient acuteness…."; however, patient acuity measures are notoriously poor at predicting staffing needs for an upcoming shift. So variance from the core staffing on an "as needed" basis might be a workable solution. This would depend on the philosophy of the nursing executive.

With rare exception, HNSC had neither reviewed nor approved the core schedule. Also, the HNSC had not been part of creating minimum numbers of staff (including skill mix) for different shifts. Most facilities reported that the matrices were created by managers with the CNO and negotiated based on the facility budget. Again this seems to violate OAR 333-510-0045 (3)(h).

Only one facility's participants mentioned that they had a mechanism to limit admissions to a unit or divert patients to other facilities in times of short staffing or high patient acuity. This violates OAR 333-510-0045 (3)(g) "The written staffing plan must:…Include a formal process for evaluating and initiating limitations on admission or diversion of patients to another acute care facility when, in the judgment of the direct care registered nurse, there is and inability to meet patient care needs or a risk of harm to existing and new patients…" However, because of geographic location, some rural facilities cannot divert patients or limit admissions; and some urban facilities are also unable to limit admissions, at least through the Emergency Department, because of county Emergency Services rules. All facilities had on-call mechanisms but not all could use temporary staffing agencies because of geographic distance.

Consistent themes emerging from the responses to the study questions included the need for more education of the HNSCs on how to implement the legislation (specifically how to create staffing plans) and the one agreed upon benefit of the HNSCs was that it gave nurses "a voice". Themes specific to the individual questions are discussed separately.

1. **Describe the make-up of the HNSC. Are there separate committees for each clinical unit, one organization committee, or both? Who leads the committee? How often do you meet?**

The make-up of all the HNSCs was ½ managers and ½ staff nurses. Each facility had an overall hospital committee and some had unit staffing committees also. Leadership of the committees varied and included not having a chair, CNO as chair, CNO/staff nurse as co-chairs, or manager/staff nurse as co-chairs. HNSC meetings varied from monthly to twice yearly with most meeting monthly or quarterly. Generally, the facilities that viewed the legislation positively had effectively functioning groups and had more frequent meetings. One participant said it is hard to remember what happened or raise current issues because the meetings are too infrequent.

In the more positive facilities, the CNO generally conceptualized the legislation as a way to allow him/her to better do his/her job and more effectively negotiate with superiors for the needs

of the nurses and patients. In these facilities there was a general attitude of mutual respect expressed among the CNO, the managers, and the staff nurses. In some of the positive facilities, the staff nurses and managers attributed the effective functioning of the HNSC to the leadership of the CNO; in some facilities with poorly functioning committees, there was usually an expression of hoping or wishing for different executive nurse leadership.

1. **Establishing and maintaining a HNSC: Describe positive and negative experiences including benefits and obstacles.**

The most consistent theme related to benefits of establishing and maintaining a HNSC was that it gave nurses a voice. Some managers and staff nurses felt it elevated the conversation around staffing and helped to educate and empower nurses; some CNOs and staff nurses appreciated the chance to communicate directly with each other. Another theme was that having the HNSC provided a way to formalize practices that had been in existence but now had organizational approval in the form of policies or standard practices. The committee provided a way for staff nurses and managers to better understand the functioning of other departments and be able to see similarities and differences to issues in their own departments. Some groups felt that they had worked together to make difficult staffing problems while others liked the idea of being able to call in the State Department of Health Services and force the organization to follow the law.

An important theme when discussing barriers to maintaining the HNSC was that staff nurses frequently felt intimidated when disagreeing with their manager or the CNO in the group. There were also some facilities that had difficulty getting staff nurses to participate. Some participants attributed this reluctance to poor functioning of the group, disrespectful communication within the group, or a feeling that the meetings were irrelevant and made no progress. There were some groups in which the managers refused to discuss any staffing issue that could impact the budget. There was a feeling that there was no point in discussing budget issues because the budget was always the priority.

Inability or reluctance to discuss ways to resolve conflicts was a theme that surfaced. Additionally, many participants were not aware that the HNSCs were supposed to have decision-making authority and most reported that committees did not have decision-making authority; rather they met for informational or reporting purposes only. Some committees reached

agreement by "talking to consensus", having an "informal" vote, or having a formal vote. Some committee participants said they never had a disagreement or if there was an unresolved issue there was no mechanism for resolving a conflict. Typically, the issue just "went away and did not come back." One participant had asked to vote by secret ballot but that request was denied. Other participants did not know they were supposed to have decision-making authority and did not know they could vote. It is not clear whether this is a conscious violation of OAR 333-510-0045 (4)(b) or simply a lack of understanding and education about the Administrative Rules regarding the legislation.

2. Developing, sustaining, evaluating, and modifying a nurse staffing plan for each clinical unit: Describe positive and negative experiences including benefits and obstacles.

The staffing plans included guidance in the case of understaffing, overstaffing, "floating", "flexing", call-offs, call-ins. A consistent theme in developing, sustaining, evaluating, and modifying the nurse staffing plan was that the staffing plans generally did not include the core staffing schedule or the matrix for the units. The committees had been involved in creating certain staffing policies that are part of the staffing plans; but most HNSC had neither reviewed nor approved the staffing matrices for the units. OAR 333-510-0045 (3)(h) directs the committee to have a written plan to establish minimum numbers of nursing staff personnel on specific shifts. It is not clear how a hospital could comply with this rule unless the core staffing and the staffing matrices are approved by the committee.

Some CNOs or managers mentioned that this was the next step in the work of the committee. Other participants said the staffing matrices were negotiated between the managers and the CNO and were only brought to the HNSC for information. Still others said that the unit staffing matrices were decided in a unit committee or council which included the unit manager. In one facility, the HNSC voted on and decided any core scheduling changes using threats and force if necessary. In another facility, the HNSC generally was asked to approve changes in the core schedule that had first been requested by a unit council and second had been discussed and negotiated between the CNO and the unit manager and staff members together.

An important theme related to barriers to developing, sustaining, evaluating, and modifying the nurse staffing plan was the reality that the core staffing schedule and the staffing matrix were

created within the confines of the budget; since staff nurses have no specific fiscal responsibility nor authority, managers and the CNO create the core staffing schedule. This appears to be a conflict between the hierarchical and bureaucratic structure of hospitals and the attempt to legislate the use of professional direct care nurse judgment in making staffing decisions. It is not clear how or if the authors of the Administrative Rules thought about resolving this conflict in responsibilities and authority.

Another theme is related to last minute staffing changes. The shift supervisor and/or charge nurse make decisions about last minute staffing variations (sick calls, high acuity, and low census). Many variables are taken into account during those last minute decisions, including the needs of patients, budget, availability of replacement staff nurses, and the ability/competency of the nursing staff. The overall objective is balancing the staffing in the entire facility to provide safe care for all the patients, some satisfaction and safety for the direct care staff, and ultimately trying to be fiscally responsible. However, in some facilities the charge nurses have a great deal of input toward the final decision; even though the final decision is made by a shift supervisor. In other facilities, the shift supervisor or (non-nursing) staffing coordinator make the decision without any or with very little input from the charge nurse or direct care nurses. The feeling of being valued by both charge nurse and direct care nurse in these different situations is quite different.

3. Describe any new policies that have been implemented related to the new HNSC.

The overall theme in response to this query is that the HNSC participated in the clarification, definition, revision, or creation of policies and procedures related to staffing. There were rare examples when the work of the HNSC committee resulted in an increase in core staffing/scheduling. Primarily however, the work of the committees centered on discussions of "floating," "flexing," primary and secondary nurses, call-off, call-ins, standby, and cancelling. All facilities indicated they had a scope of service (required by other credentialing agencies) that had been incorporated into the staffing plans. Only one facility's participants mentioned closing units to admissions. Some facilities indicated that because of their location, they were unable to close to admissions.

4. What is your perception about the impact of the Oregon Nurse Staffing Law on
   a. Patient safety, quality and care,
   b. Nurse staffing,

c. Nurse satisfaction, retention, and turnover?

The prevailing theme of the response about the impact of the law with some variation was that there had been no discernable impact. Some participants felt the law had resulted in increased nurse satisfaction by giving nurses a voice. Some felt that there had been an increase in staffing in select units which might relate to improved patient safety. Other participants could not determine if changes had been associated with the law or other factors within the organization. Another theme was that the law had led to the codification or formalization of practices that had existed but now had more strength because of organizational approval.

5. Any further thoughts or comments? Thank you for your time and thoughtfulness.

One theme that emerged was that that everyone needed help in understanding how to implement the legislation in a useful and effective way. There had been a number of problems that had resulted in a delay in creating the HNSC; as a result the committees were still struggling with a purpose and with understanding how to do the work that was required. There was turnover in the committee memberships (both managers and staff) which made it difficult to sustain activity and action. One comment was that the HNSC has the potential for being a useful tool but it is not now; a more definite goal and direction were needed. Another comment was, "Staff nurses do not know how to do a staffing plan; they do not know the potential for staff input; we need to know how to find data; we need to understand that this law gives you a way to change your job".

Certainly, the lawmakers intended that the people who were closest to providing direct care had decision-making ability to determine nurse staffing. However, the complexity of today's hospitals makes that difficult to accomplish. The CNOs, managers, and hospital executives cannot ignore their financial responsibilities, nor can they ignore the demands of patient care providers. These needs have to be balanced and the varying skills of the management teams contribute to the variation in legislation effectiveness seen in this study.

Final Thoughts

The intent of the people who drafted and voted into law HB 2800 was that the nurses and managers who were closest to actually providing direct care to hospital patients would have a say in how the staffing was done. However, managers have a fiscal responsibility to the organization as part of their job requirements that direct care registered nurses do not have. So there has to be

a balance between the resources that are available to the organization and the needs of the staff and patients in the organization. In addition, hospitals are hierarchical structures (some of the strictest hierarchies are in hospitals) and managers have the right and responsibility to hire and fire employees, including staff nurses. So, in order for staff nurses and managers to discuss issues on a somewhat "equal" basis, the thought (and reality) of the hierarchy must be suspended; this suspension is difficult, if not impossible. Simply requiring equal numbers of staff nurses and managers on a committee is not enough. The environment of the committee must be created in such a way that both managers and staff feel mutual respect and support in having discussions, having disagreements, and being able to resolve the disagreements in a functional manner. Generally, the only person who can create such an environment is the Chief Nurse; perhaps the CNO cannot do that alone but I would argue that a supportive environment cannot be created without the CNO.

It is possible to follow the "letter of the law" and have a non-functional and ineffective Hospital Nurse Staffing Committee. It is also possible to have a functional and effective committee. What seems to make a difference between an organization that has a functional versus one that has a non-functional committee is whether the Chief Nurse views the legislation in a positive way and is able to use the legislation to enhance his/her work. It also seems that with that positive view there typically exists a mutual respect by and for staff nurses, managers, and the Chief Nurse. Even if the requirements of the law have not been fully implemented in these functional committees, there is a belief that further work is necessary and will be accomplished.

Another way that it is possible for a committee to follow the law is by the use of threats and intimidation, although I would not say that this creates a functional committee. However, it does provide a way for staff nurses to have a say in how staffing is done in the organizations. In those organizations with Chief Nurses who view the legislation as negative, redundant, or onerous, the committee members may become adversarial or complacent or withdraw from the process. All these behaviors (positive and negative) were displayed in our sample participants. Therefore, the implementation of the law is vulnerable to the thinking and attitude of the CNO and perhaps this is as it should be.

Like most legislation, this law had unintended consequences and has not been enacted in exactly the way the lawmakers intended. While enacting the law and staying within the prescribed rules, some organizations experienced positive changes and some organizations had not. In my opinion, this is not because the law was poorly conceived or written. It is because, as one of the participants said, "You can't legislate judgment." The written staffing plans may be similar or the same but the implementation of these plans vary. In organizations that are as people-intense as hospitals and that depend on the good judgment of many individuals, it is difficult, if not impossible, to create a law that will work seamlessly in all of them.

References

1. Oregon 71st Legislative Assembly. Oregon Legislative Assembly 2001 Summary of Major Legislation, HB 2800. 64. Available at: http://www.leg.state.or.us/comm/commsrvs/2001sml.pdf. Accessed June 7, 2010.
2. Oregon Health Care Licensure and Certification. HOSPITAL NURSE STAFFING INFORMATION and REPORTS. http://www.oregon.gov/DHS/ph/hclc/nursestaffing.shtml. Accessed June 7, 2010.
3. Oregon 73rd Legislative Assembly General Session. A-Engrossed House Bill 2800: State of Oregon; 2005.
4. Oregon Legislative Assembly. Oregon Revised Statutes Chapter 441 — Health Care Facilities 2009 Edition-ORS 441.106-441.192. 2009:http://www.leg.state.or.us/ors/441.html. Accessed June 7, 2010.
5. Oregon Office for Health Policy and Research. Oregon's Acute Care Hospitals Capacity, Utilization and Financial Trends 2005 to 2007. http://www.oregon.gov/OHPPR/RSCH/docs/Hospital_Report/Hospital_Report_2009.pdf. Accessed June 8, 2010.
6. The Public Manager. Federal workforce downsizing during the 1990s: a human capital disaster. http://goliath.ecnext.com/coms2/gi_0199-567751/Federal-workforce-downsizing-during-the.html. Accessed June 8, 2010.
7. Ponte PR, Fay MS, Brown P, et al. Factors leading to a strike vote and strategies for reestablishing relationships. *Journal of Nursing Administration.* 1998;28(2):35-43.
8. Fletcher M. Seasons of discontent: from rotating job actions to illegal walkouts, it's been two long years of nursing unrest. *Canadian Nurse.* 2000;96(5):23-28.
9. Foley BJ, Kee CC, Minick P, Harvey SS, Jennings BM. Characteristics of nurses and hospital work environments that foster satisfaction and clinical expertise. *J Nurs Adm.* May 2002;32(5):273-282.
10. Buerhaus PI, Staiger DO. Managed care and the nurse workforce. *Jama.* 1996;276(18):1487-1493.
11. Spetz J. Hospital nurse wages and staffing, 1977 to 2002: cycles of shortage and surplus. *J Nurs Adm.* Sep 2004;34(9):415-422.
12. Buerhaus PI, Donelan K, Ulrich BT, Norman L, Dittus R. Is the shortage of hospital registered nurses getting better or worse? Findings from two recent national surveys of RNs. *Nurs Econ.* Mar-Apr 2005;23(2):61-71, 96, 55.
13. Moore JD, Jr. Nurse ratios are Calif. law. Hospitals lose battle, hope for best as they await regulations [news]. *Modern Healthcare.* 1999;29(42):2, 16.
14. Conway PH, Tamara Konetzka R, Zhu J, Volpp KG, Sochalski J. Nurse staffing ratios: trends and policy implications for hospitalists and the safety net. *J Hosp Med.* May 2008;3(3):193-199.
15. American Nurses Association. Safe Staffing Saves Lives. http://www.safestaffingsaveslives.org/WhatisANADoing/StateLegislation.aspx. Accessed June 8, 2010.
16. Oregon State Archives. Department of Human Services, Public Health Division, Division 510, Patient Care and Nursing Services in Hospitals. http://arcweb.sos.state.or.us/rules/OARs_300/OAR_333/333_tofc.html#505. Accessed January 8, 2010.
17. Finkler S, Jones C, Kovner C. *Financial management for nurse managers and executives.* . 3rd ed. Philadelphia, PA; Edinburgh: Elsevier Saunders; 2007.
18. Seago JA. A comparison of two patient classification instruments in an acute care hospital. *J Nurs Adm.* May 2002;32(5):243-249.

19. Unruh LY, Fottler MD. Patient turnover and nursing staff adequacy. *Health Serv Res.* Apr 2006;41(2):599-612.
20. Duffield C, Diers D, Aisbett C, Roche M. Churn: patient turnover and case mix. *Nurs Econ.* May-Jun 2009;27(3):185-191.
21. Duffield C, Roche M, O'Brien-Pallas L, Catling-Paull C. Implications of staff 'churn' for nurse managers, staff, and patients. *Nurs Econ.* Mar-Apr 2009;27(2):103-110.
22. Kossman SP. Perceptions of impact of electronic health records on nurses' work. *Stud Health Technol Inform.* 2006;122:337-341.
23. Poissant L, Pereira J, Tamblyn R, Kawasumi Y. The impact of electronic health records on time efficiency of physicians and nurses: a systematic review. *J Am Med Inform Assoc.* Sep-Oct 2005;12(5):505-516.
24. Chan G, Brykczynski K, Malone R, Benner P. *Interpretive Phenomenology in Health Care Research* Indianapolis, IN: Sigma Theta Tau International 2010.

Appendix

1. The proposal

Oregon/ANA Nurse Staffing Study Proposal

February 1, 2010

Purpose

The purpose of this study is to develop case studies to describe experiences of nurses regarding the establishment of Hospital Nurse Staffing Committees (HNSC) as defined by ORS 409.090, ORS 441.055, OAR 333-501-0005, and OAR 333-510-0001 in 2009, in 7 Oregon acute care hospitals. The case studies will specifically explore;

- Experiences, benefits, and challenges of establishing and maintaining a HNSC,
- Experiences, benefits and challenges of developing, sustaining, evaluating and modifying nurse staffing plans for clinical units,
- Policies that were developed as the result of the legislation,
- Perceptions of the impact of the legislation on nurse staffing, quality and safety of patient care, and nurse retention, turnover, and satisfaction.

The nurses of interest in the study are the members of the HNSC (direct care RNs & nurse managers/nurse directors) and the chief nurse officers. The principal clients for this study are the Oregon Nurse Staffing Collaborative (ONSC), the Oregon Association of Hospitals and Health Systems (OAHHS), the Oregon Nurses Association (ONA), the Oregon State Legislature, and the American Nurses Association (ANA).

Method

There are 58 acute care hospitals in the State that are described in the State of the State 2008 Hospital Reports, Oregon Health Forum and the Office of Oregon Health Policy and Research Oregon's Acute Care Hospitals Capacity, Utilization, and Trends 2005 to 2007 (April 2009).

The study design is a descriptive case study qualitative method using semi-structured interviews. Descriptive information of each hospital will be included for clarity and context.

Selection details as follows:

- Seven hospitals were selected using a purposeful stratified methodology that will provide diverse and comprehensive data.
- Hospitals were categorized as 12 large, 14 mid-size, and 31 critical access/rural/small facilities. Additionally, 35 of the 57 hospitals have RNs who are represented by unions (ONA and Oregon Federation of Nurses and Health Professionals).
- Three hospitals were selected from the 31 critical access/rural/small facilities; one that is union represented and two that are not.
- Two hospitals were selected from both the large and mid-size group; one union represented and one not represented in each size category. Teaching hospitals, hospitals that are part of a chain, hospitals with religious affiliation, and hospitals from various areas of the state were included in both groups.
- Secondary hospitals for each primary hospital selected were identified as a back up strategy. To insure sampling adequacy, the secondary hospitals were chosen because they had characteristics that were similar to the primary hospitals in the sample.

Interview details as follows:

- The hospital staff interviewed will include the CNO, the direct care RNs, and managers/directors who are members of the HNSC. A one-on-one interview with the CNO will be arranged; the direct care RN HNSC members will be interviewed in one focus group and the managers/directors HNSC members will be interviewed in a second focus group.

2. The recruitment documents

February 1, 2010

Dear Nurse Executive:

The Oregon Nurse Staffing Collaborative (ONSC) continues to expand its work, add new members to the group, and design and complete projects which advance our practice related to nurse staffing. During 2010, we have placed high priority on a project to complete external review of Oregon's Nurse Staffing Law. The American Nurses Association (ANA) issued a request for proposal in the fall of 2009 which addressed this goal. A proposal was developed, sent forward and we were successful in securing $20,000 to fund the project. This letter is intended to alert you to the project.

The ONSC, Oregon Nurses Association (ONA), Oregon Association of Hospitals and Health Systems (OAHHS), and ANA have several purposes for undertaking this project:

- To understand the challenges and successes of Oregon hospitals in complying with the nurse staffing legislation
- To share best practices and provide a report to the 2011 Oregon State Legislature.
- Assist the ANA with their federal efforts to address nurse staffing issues in US acute care hospitals.

Briefly, the project design consists of a nurse researcher from UCSF, Dr. Jean Ann Seago, who will begin contacting a 10% sample of Oregon's acute care facilities – critical access, mid-sized, large urban – to ask whether those facilities would like to participate in the project. Initial contact of the sample facilities will occur within 2-3 weeks of receipt of this letter. The 2-3 week interval provides you an opportunity to ask questions about the project. If the sample facilities agree to participate, a visit will be arranged.

During the hospital visit, Dr. Seago will interview the administrative and the nursing staff members of your hospital nurse staffing committee (HNSC) in groups, as well as interviewing you, the chief nursing officer. The estimated time for these activities is 4-6 hours. Please be assured that the identity of both the facilities and the individuals who participate in the project will be protected. Your organization will be described generally but not in a way that would specifically identify the hospital. The results of the project will be compiled in a report that will be provided to all Oregon acute care hospitals, to the ONSC, the ONA, the OAHHS, the Oregon State Legislature, and ANA.

The reason the Oregon/ANA study is designed in the manner described above is because as a state, we do not have outcome data related to nurse staffing .While we work collectively to address our lack of outcome data, we sought an acceptable alternative methodology.

Please find attached a document that explains the project in detail. If you have questions or concerns about the project, please feel free to contact your ONA, OAHHS, or ONSC representatives or contact Dr. Seago directly at jean.ann.seago@nursing.ucsf.edu or 415-502-6340. She will address your specific questions about the Oregon/ANA nurse staffing project.

Thank you for your consideration and support.

Sincerely,

Diane Waldo

Diane Waldo, MBA. BSN, RN, CPHQ, CPHRM, LNCC
Director of Quality and Clinical Services
Oregon Association of Hospitals and Health Systems

Sue B. Davidson

Sue B. Davidson, PhD, RN, CNS
Asst Exec Dir Nursing Practice Educ & Research
Oregon Nurses Association

March 2, 2010

Dear Nurse Executive :

Several weeks ago you received a letter describing a research study being conducted by The Oregon Nurse Staffing Collaborative (ONSC), entitled the **Oregon/ANA Nurse Staffing Study**. The Collaborative is pleased to announce that your hospital has been selected as a participant in this study. We sincerely hope that you will agree to be part of this research effort.

The ONSC, Oregon Nurses Association (ONA), Oregon Association of Hospitals and Health Systems (OAHHS), and ANA have several purposes for undertaking this study:

- To understand the challenges and successes of Oregon hospitals in complying with the nurse staffing legislation
- To share best practices and provide a report to the 2011 Oregon State Legislature.
- Assist the ANA with their federal efforts to address nurse staffing issues in US acute care hospitals.

The study design is qualitative and will include focus groups and structured interviews with results being analyzed using content analysis. I am the researcher who will be collecting and analyzing the data. I am a Professor from the University of California, San Francisco, and you can find more information about my credentials at http://nurseweb.ucsf.edu/www/ffseagj.htm. With the assistance of Ms. Waldo and Dr. Davidson, I have created a purposive sample of 12% of Oregon's acute care facilities. The hospitals were selected to include critical access, mid-sized, large urban; those with unions and those without unions; and hospitals that were geographically dispersed around the State. Your hospital was selected because you meet these inclusion criteria. This email is your initial contact to ask you to participate. I will contact you in 10-14 days to answer any questions you may have and determine if you agree to participate. If you agree, I will arrange a convenient time to visit your hospital to conduct the focus groups and structured interviews.

During the study visit, I will interview the administrative and the nursing staff members of your hospital nurse staffing committee (HNSC) in focus groups of 8-10 individuals, as well as interviewing you, the chief nursing officer. The estimated time for each focus group/structured interview is 90 minutes and

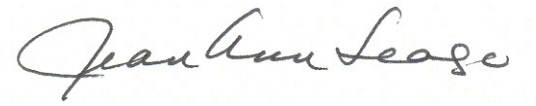
the total time for these activities is estimated at 4-6 hours, depending on the number of focus groups that are needed.

Please be assured that the identity of both the facilities and the individuals who participate in the project will be protected. Your organization will be described generally but not in a way that would specifically identify the hospital. The results of the study will be compiled in a report that will be provided to all Oregon acute care hospitals, to the ONSC, the ONA, the OAHHS, the Oregon State Legislature, and ANA.

Please find attached a document that explains the study in further detail. If you have questions or concerns, please feel free to contact your ONA, OAHHS, ONSC representatives, or me at jean.ann.seago@nursing.ucsf.edu or 415-502-6340. Otherwise, we can discuss any questions you have when I contact you again.

Thank you for your consideration and support and I look forward to working with you on the **Oregon/ANA Nurse Staffing Study**.

Sincerely,



3. FG Questions

Structured Interview/Focus Group Questions

1. Describe the make-up of the HNSC. Are there separate committees for each clinical unit, one organization committee, or both? Who leads the committee? How often do you meet?
2. Establishing and maintaining a HNSC: Describe positive and negative experiences including benefits and obstacles.
3. Developing, sustaining, evaluating, and modifying a nurse staffing plan for each clinical unit: Describe positive and negative experiences including benefits and obstacles.
4. Describe any new policies that have been implemented related to the new HNSC.
5. What is your perception about the impact of the Oregon Nurse Staffing Law on
    a. Patient safety, quality and care,
    b. Nurse staffing,
    c. Nurse satisfaction, retention, and turnover?
6. Any further thoughts or comments? Thank you for your time and thoughtfulness.

Focus Group Ground Rules

1. Participation is voluntary.
2. Only first names will be used.
3. Please speak one at a time.
4. Avoid side conversations with your neighbors.
5. I need to hear from everyone during the course of the session but you don't have to answer every question.
6. We will observe the no smoking rule during this session.
7. There are no wrong answers-you cannot fail during this session.
8. Say what's true for you, and have the courage of your convictions.
9. Don't let the group sway you, and don't sell out to group opinion or to a strong talker.
10. It is OK, however, to change your mind during the course of the session because of something you hear or see.
11. Allow people to finish thoughts without interruption.
12. Listen with respect.


Oregon Association of Hospitals and Health Systems
Cedar Hills Hospital
Providence St. Vincent Medical Center (WA County)
Oregon Health & Science University
Shriners Hospital for Children
Legacy Good Samaritan Medical Center
Legacy Emanuel Medical Center
Providence Portland Medical Center
Vibra Specialty Hospital
Adventist Medical Center
Legacy Mount Hood Medical Center
Providence Hood River Memorial Hospital
Columbia Memorial Hospital
Providence Seaside Hospital
Tuality Healthcare
Tillamook County General Hospital
Providence Newberg Medical Center
Willamette Valley Medical Center
Silverton Hospital
Santiam Memorial Hospital
Samaritan North Lincoln Hospital
West Valley Hospital
Salem Hospital Regional Health Services
Samaritan Pacific Communities Hospital
Samaritan Albany General Hospital
Good Samaritan Regional Medical Center
Samaritan Lebanon Community Hospital
Peace Harbor Hospital
Sacred Heart Medical Center, University District
Sacred Heart Medical Center at Riverbend
McKenzie-Willamette Medical Center
Lower Umpqua Hospital
Cottage Grove Community Hospital
Bay Area Hospital
Coquille Valley Hospital
Southern Coos Hospital & Health Center
Mercy Medical Center
Curry General Hospital
Three Rivers Community Hospital
Providence Medford Medical Center
Rogue Valley Medical Center
Ashland Community Hospital
Sky Lakes Medical Center
Kaiser Sunnyside Medical Center
Providence Milwaukie Hospital
Providence Willamette Falls Medical Center
Legacy Meridian Park Medical Center
Mid Columbia Medical Center
Mountain View Hospital
St. Charles Medical Center Redmond
St. Charles Medical Center Bend
Pioneer Memorial Hospital (H)
Pioneer Memorial Hospital (P)
Good Shepherd Medical Center
St. Anthony Hospital
Grande Ronde Hospital
Wallowa Memorial Hospital
Blue Mountain Hospital
St. Elizabeth Health Services
Harney District Hospital
Holy Rosary Medical Center
Lake District Hospital
Clatsop
Columbia
Tillamook
Washington
Multnomah
Hood River
Clackamas
Yamhill
Polk
Marion
Lincoln
Benton
Linn
Lane
Douglas
Coos
Curry
Josephine
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Klamath
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5. The law and rules

Oregon Revised Statutes - 2007

ORS 441.160-441.182

HOSPITAL NURSING SERVICES

441.160 Definition for ORS 441.162 to 441.170. As used in ORS 441.162 to 441.170, "hospital" includes a hospital as described in ORS 442.015 and an acute inpatient care facility as defined in ORS 442.470. [2001 c.609 §1]

Note: 441.160 to 441.192 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 441 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

441.162 Written staffing plan for nursing services. (1) A hospital shall be responsible for the implementation of a written hospital-wide staffing plan for nursing services. The staffing plan shall be developed, monitored, evaluated and modified by a hospital staffing plan committee. To the extent possible, the committee shall:

(a) Include equal numbers of hospital nurse managers and direct care registered nurses;

(b) Include at least one direct care registered nurse from each hospital nurse specialty or unit, to be selected by direct care registered nurses from the particular specialty or unit. The hospital shall define its own specialties or units; and

(c) Have as its primary consideration the provision of safe patient care and an adequate nursing staff pursuant to ORS chapter 441.

(2) The hospital shall evaluate and monitor the staffing plan for effectiveness and revise the staffing plan as necessary as part of the hospital's quality assurance process. The hospital shall maintain written documentation of these quality assurance activities.

(3) The written staffing plan shall:

(a) Be based on an accurate description of individual and aggregate patient needs and requirements for nursing care and include a periodic quality evaluation process to determine whether the staffing plan is appropriately and accurately reflecting patient needs over time.

(b) Be based on the specialized qualifications and competencies of the nursing staff. The skill mix and the competency of the staff shall ensure that the nursing care needs of the patients are met and shall ensure patient safety.

(c) Be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations and recognize differences in patient acuteness.

(d) Establish minimum numbers of nursing staff including licensed practical nurses and certified nursing assistants required on specified shifts. At least one registered nurse and one other nursing staff member must be on duty in a unit when a patient is present.

(e) Include a formal process for evaluating and initiating limitations on admission or diversion of patients to another acute care facility when, in the judgment of the direct care registered nurse, there is an inability to meet patient care needs or a risk of harm to existing and new patients.

(4) The hospital shall maintain and post a list of on-call nursing staff or staffing agencies to provide replacement for nursing staff in the event of vacancies. The list of on-call nurses or agencies must be sufficient to provide replacement staff.

(5)(a) An employer may not impose upon unionized nursing staff any changes in wages, hours or other terms and conditions of employment pursuant to a staffing plan developed or modified under subsection (1) of this section unless the employer first provides notice to and, on request, bargains with the union as the exclusive collective bargaining representative of the nursing staff in the bargaining unit.

(b) A staffing plan developed or modified under subsection (1) of this section does not create, preempt or modify a collective bargaining agreement or require a union or employer to bargain over the staffing plan while a collective bargaining agreement is in effect. [2001 c.609 §2; 2005 c.665 §2]

Note: See note under 441.160.

441.164 Variances in staffing plan requirements. Upon request of a hospital, the Department of Human Services may grant variances in the written staffing plan requirements based on patient care needs or the nursing practices of the hospital. [2001 c.609 §3]

Note: See note under 441.160.

441.166 Need for replacement staff. (1) When a hospital learns about the need for replacement staff, the hospital shall make every reasonable effort to obtain registered nurses, licensed practical nurses or certified nursing assistants for unfilled hours or shifts before requiring a registered nurse, licensed practical nurse or certified nursing assistant to work overtime.

(2) A hospital may not require a registered nurse, licensed practical nurse or certified nursing assistant to work:

(a) Beyond the agreed-upon shift;

(b) More than 48 hours in any hospital-defined work week; or

(c) More than 12 consecutive hours in a 24-hour time period, except that a hospital may require an additional

hour of work beyond the 12 hours if:

(A) A staff vacancy for the next shift becomes known at the end of the current shift; or

(B) There is a potential harm to an assigned patient if the registered nurse, licensed practical nurse or certified nursing assistant leaves the assignment or transfers care to another.

(3)(a) Time spent in required meetings or receiving education or training shall be included as hours worked for purposes of subsection (2) of this section.

(b) Time spent on call but away from the premises of the employer may not be included as hours worked for purposes of subsection (2) of this section.

(c) Time spent on call or on standby when the registered nurse, licensed practical nurse or certified nursing assistant is required to be at the premises of the employer shall be included as hours worked for purposes of subsection (2) of this section.

(4) The provisions of this section do not apply to nursing staff needs:

(a) In the event of a national or state emergency or circumstances requiring the implementation of a facility disaster plan;

(b) In emergency circumstances identified by the Department of Human Services by rule; or

(c) If a hospital has made reasonable efforts to contact all of the on-call nursing staff or staffing agencies on the list described in ORS 441.162 and is unable to obtain replacement staff in a timely manner. [2001 c.609 §4; 2005 c.665 §1]

Note: See note under 441.160.

441.168 Leaving a patient care assignment. A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon shift or an agreed upon extended shift without authorization from the appropriate supervisory personnel. [2001 c.609 §5]

Note: See note under 441.160.

441.170 Civil penalties; suspension or revocation of license; rules; records; compliance audits. (1) The Department of Human Services may impose civil penalties in the manner provided in ORS 183.745 or suspend or revoke a license of a hospital for a violation of any provision of ORS 441.162 or 441.166. The department shall adopt by rule a schedule establishing the amount of civil penalty that may be imposed for any violation of ORS 441.162 or 441.166 when there is a reasonable belief that safe patient care has been or may be negatively impacted. A civil penalty imposed under this subsection may not exceed $5,000. Each violation of a nursing staff plan shall be considered a separate violation. Any license that is suspended or revoked under this subsection shall be suspended or revoked as provided in ORS 441.030.

(2) The department shall maintain for public inspection records of any civil penalties or license suspensions or revocations imposed on hospitals penalized under subsection (1) of this section.

(3) The department shall conduct an annual random audit of not less than seven percent of all hospitals in this state solely to verify compliance with the requirements of ORS 441.162, 441.166 and 441.192. Surveys made by private accrediting organizations may not be used in lieu of the audit required under this subsection. The department shall compile and maintain for public inspection an annual report of the audit conducted under this subsection.

(4) The costs of the audit required under subsection (3) of this section may be paid out of funds from licensing fees paid by hospitals under ORS 441.020. [2001 c.609 §6]

Note: See note under 441.160.

441.172 Definitions for ORS 441.172 to 441.182. As used in ORS 441.172 to 441.182:

(1) "Affiliated hospital" means a hospital that has a business relationship with another hospital.

(2) "Hospital" means:

(a) An acute inpatient care facility, as defined in ORS 442.470; or

(b) A hospital as described in ORS 442.015.

(3) "Manager" means a person who:

(a) Has authority to direct and control the work performance of nursing staff;

(b) Has authority to take corrective action regarding a violation of law or a rule or a violation of professional standards of practice, about which a nursing staff has complained; or

(c) Has been designated by a hospital to receive the notice described in ORS 441.174 (2).

(4) "Nursing staff" means a registered nurse, a licensed practical nurse, a nursing assistant or any other assistive nursing personnel.

(5) "Public body" has the meaning given that term in ORS 30.260.

(6) "Retaliatory action" means the discharge, suspension, demotion, harassment, denial of employment or promotion, or layoff of a nursing staff, or other adverse action taken against a nursing staff in the terms or conditions of employment of the nursing staff, as a result of filing a complaint. [2001 c.609 §9]

Note: See note under 441.160.

441.174 Retaliation prohibited. (1) A hospital may not take retaliatory action against a nursing staff because the nursing staff:

(a) Discloses or intends to disclose to a manager, a private accreditation organization or a public body an activity, policy or practice of the hospital or of a hospital that the nursing staff reasonably believes is in violation of law or a rule or is a violation of professional standards of practice that the nursing staff reasonably believes poses a risk to the health, safety or welfare of a patient or the public;

(b) Provides information to or testifies before a private accreditation organization or a public body conducting an investigation, hearing or inquiry into an alleged violation of law or rule or into an activity, policy or practice that may be in violation of professional standards of practice by a hospital that the nursing staff reasonably believes poses a risk to the health, safety or welfare of a patient or the public;

(c) Objects to or refuses to participate in any activity, policy or practice of a hospital that the nursing staff reasonably believes is in violation of law or rule or is a violation of professional standards of practice that the nursing staff reasonably believes poses a risk to the health, safety or welfare of a patient or the public; or

(d) Participates in a committee or peer review process or files a report or a complaint that discusses allegations of unsafe, dangerous or potentially dangerous care.

(2) Except as provided in subsection (3) of this section, the protection against retaliatory action in subsection (1) of this section does not apply to a nursing staff, unless the nursing staff, before making a disclosure to a private accreditation organization or a public body as described in subsection (1)(a) of this section:

(a) Gives written notice to a manager of the hospital of the activity, policy, practice or violation of professional standards of practice that the nursing staff reasonably believes poses a risk to public health; and

(b) Provides the manager a reasonable opportunity to correct the activity, policy, practice or violation.

(3) A nursing staff is not required to comply with the provisions of subsection (2) of this section if the nursing staff:

(a) Is reasonably certain that the activity, policy, practice or violation is known to one or more managers of the hospital or an affiliated hospital and an emergency situation exists;

(b) Reasonably fears physical harm as a result of the disclosure; or

(c) Makes the disclosure to a private accreditation organization or a public body for the purpose of providing evidence of an activity, policy, practice or violation of a hospital or an affiliated hospital that the nursing staff reasonably believes is a crime. [2001 c.609 §10]

Note: See note under 441.160.

441.176 Remedies for retaliation. (1) A nursing staff aggrieved by an act prohibited by ORS 441.174 may bring an action in circuit court of the county in which the hospital is located. All remedies available in a common law tort action are available to a nursing staff if the nursing staff prevails in an action brought under this subsection and are in addition to any remedies provided in subsection (2) of this section.

(2) In an action brought under subsection (1) of this section, a circuit court may do any of the following:

(a) Issue a temporary restraining order or a preliminary or permanent injunction to restrain a continued violation of ORS 441.174.

(b) Reinstate the nursing staff to the same or equivalent position that the nursing staff held before the retaliatory action.

(c) Reinstate full benefits and seniority rights to the nursing staff as if the nursing staff had continued in employment.

(d) Compensate the nursing staff for lost wages, benefits and other remuneration, including interest, as if the nursing staff had continued in employment.

(e) Order the hospital to pay reasonable litigation costs of the nursing staff, including reasonable expert witness fees and reasonable attorney fees.

(f) Award punitive damages as provided in ORS 31.730.

(3) Except as provided in subsection (4) of this section, in any action brought by a nursing staff under subsection (1) of this section, if the court finds that the nursing staff had no objectively reasonable basis for asserting the claim, the court may award costs, expert witness fees and reasonable attorney fees to the hospital.

(4) A nursing staff may not be assessed costs or fees under subsection (3) of this section if, upon exercising reasonable and diligent efforts after filing the action, the nursing staff moves to dismiss the action against the hospital after determining that no issue of law or fact exists that supports the action against the hospital. [2001 c.609 §11]

Note: See note under 441.160.

441.178 Unlawful employment practices; civil action for retaliation. (1) A hospital that takes any retaliatory action described in ORS 441.174 against a nursing staff commits an unlawful employment practice.

(2) A nursing staff claiming to be aggrieved by an alleged violation of ORS 441.174 may file a complaint with the Commissioner of the Bureau of Labor and Industries in the manner provided by ORS 659A.820. Except for the provisions of ORS 659A.870, 659A.875, 659A.880 and 659A.885, violation of ORS 441.174 is subject to enforcement under ORS chapter 659A.

(3) Except as provided in subsection (4) of this section, a civil action under ORS 441.176 must be commenced within one year after the occurrence of the unlawful employment practice unless a complaint has been timely filed under ORS 659A.820.

(4) The nursing staff who has filed a complaint under ORS 659A.820 must commence a civil action under ORS 441.176 within 90 days after a 90-day notice is mailed to the nursing staff under this section.

(5) The commissioner shall issue a 90-day notice to the nursing staff:

(a) If the commissioner dismisses the complaint within one year after the filing of the complaint and the dismissal is for any reason other than the fact that a civil action has been filed.

(b) On or before the one-year anniversary of the filing of the complaint unless a 90-day notice has previously been issued under paragraph (a) of this subsection or the matter has been resolved by the execution of a settlement agreement.

(6) A 90-day notice under this section must be in writing and must notify the nursing staff that a civil action

against the hospital under ORS 441.176 may be filed within 90 days after the date of mailing of the 90-day notice and that any right to bring a civil action against the hospital under ORS 441.176 will be lost if the action is not commenced within 90 days after the date of mailing of the 90-day notice.

(7) The remedies under this section and ORS 441.176 are supplemental and not mutually exclusive. [2001 c.609 §12; 2001 c.609 §12a]

Note: See note under 441.160.

441.180 Hospital posting of notice. (1) A hospital shall post a notice summarizing the provisions of ORS 441.162, 441.166, 441.168, 441.174, 441.176, 441.178 and 441.192 in a conspicuous place on the premises of the hospital. The notice must be posted where notices to employees and applicants for employment are customarily displayed.

(2) Any hospital that willfully violates this section is subject to a civil penalty not to exceed $500. Civil penalties under this section shall be imposed by the Department of Human Services in the manner provided by ORS 183.745. [2001 c.609 §13]

Note: See note under 441.160.

441.182 Rights, privileges or remedies of nursing staff. (1) Except as provided in subsection (2) of this section, nothing in ORS 441.176 and 441.178 shall be deemed to diminish any rights, privileges or remedies of a nursing staff under federal or state law or regulation or under any collective bargaining agreement or employment contract.

(2) ORS 441.176 and 441.178 provide the only remedies under state law for a nursing staff for an alleged violation of ORS 441.174 committed by a hospital. [2001 c.609 §14]

DEPARTMENT OF HUMAN SERVICES, PUBLIC HEALTH DIVISION

DIVISION 510

PATIENT CARE AND NURSING SERVICES IN HOSPITALS

333-510-0001

Applicability

These rules apply to all hospitals, regardless of classification.

Stat. Auth.: ORS 409.050 & 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HD 21-1993, f. & cert. ef. 10-28-93; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0002

Definitions

As used in OAR 333-510, the following definitions apply:

(1) "Direct Care Nurse" means a nurse who is routinely assigned to a patient care unit, who is replaced for scheduled and unscheduled absences and includes charge nurses if the charge nurse is not management services.

(2) "Evidence Based Standards" means standards that have been scientifically developed, are based on current literature, and are driven by consensus.

(3) "Hospital" has the same meaning given in ORS 442.015.

(4) "Mandatory Overtime" is any time that exceeds those time limits specified in ORS 441.166 unless the registered nurse, licensed practical nurse or certified nursing assistant voluntarily chooses to work overtime.

(5) "Nurse Manager" means a registered nurse who has administrative responsibility 24 hours a day, 7 days a week for a patient care unit, units or hospital and who is not replaced for short-term scheduled or unscheduled absences.

(6) "On Call" means a scheduled state of availability to return to duty, work-ready, within a specified period of time.

(7) "On Call Nursing Staff" means individual nurses or nursing service agencies maintained by a hospital that are available and willing to cover nursing staff shortages due to unexpected nursing staff absences or unanticipated increased nursing services needs.

(8) "Potential Harm" or "At Risk of Harm" means that an unstable patient will be left without adequate care for an unacceptable period of time if the registered nurse, licensed practical nurse, or certified nursing assistant leaves the assignment or transfers care to another.

(9) "Safe Patient Care" means nursing care that is provided appropriately, in a timely manner, and meets the patient's health care needs. The following factors may be, but are not in all circumstances, evidence of unsafe patient care:

(a) A failure to implement the written nurse staffing plan;

(b) A failure to comply with the patient care plan;

(c) An error that has a negative impact on the patient;

(d) A patient reports that his/her nursing care needs have not been met;

(e) A medication not given as scheduled;

(f) The nursing preparation for a procedure not accomplished on time;

(g) Registered nurses, licensed practical nurses or certified nursing assistants practicing outside their scope of practice;

(h) The daily unit-level staffing does not include coverage for all known patients, taking into account the turnover of patients;

(i) The skill mix of employees and the relationship of the skill mix to patient acuity and intensity of the workload is insufficient to meet patient needs; or

(j) An unreasonable delay in responding to a patient's (or a family member's request on behalf of a patient) request for nursing care.

(10) "Standby" means a scheduled state of being ready to be called to work within a hospital-designated timeframe.

Stat. Auth.: ORS 409.050 & 441.055
Stats. Implemented: ORS 441.160 - 441.192
Hist.: PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0010

Patient Admission and Treatment Orders

(1) No patient, including patients admitted for observation status, shall be admitted to a hospital except on the order of an individual who has admitting privileges. The admitting physician or nurse practitioner shall provide sufficient information at the time of admission to establish that care can be provided to meet the needs of the patient. Admission medical information shall include a statement concerning the admitting diagnosis and general condition of the patient. Other pertinent medical information, orders for medication, diet, and treatments shall also be provided, as well as a medical history and physical.

(2) Within 24 hours of a patient’s admission, a hospital shall ensure that:

(a) The patient’s medical history is taken and a physical examination performed, unless:

(A) A medical history and physical examination has been completed within 30 days prior to admission, as provided in the medical staff rules and regulations; or

(B) The patient is readmitted within a month's time for the same or related condition, as long as an interval note is completed.

(b) The patient is given a provisional diagnosis.

(3) Even if a medical history or physical examination at the time of admission is not required under section (2) of this rule, a hospital shall ensure that any changes crucial to patient care are noted in an admission note.

(4) Visits from licensed health care providers shall be according to patient's needs. Initial and ongoing assessments shall be performed for each patient and the results and observations recorded in the medical record.

(5) A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) or nurse practitioner with admitting privileges shall be responsible, as permitted by the individual's scope of practice for

the care of any medical problem that may be present on admission or that may arise during an inpatient stay.

(6) No medication or treatment shall be given except on the order of a licensed healthcare professional authorized to give such orders within the State of Oregon.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11-1980, f. & ef. 9-10-80; HD 5-1981, f. & ef. 3-30-81; Renumbered from 333-023-0172; HD 29-1988, f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-072-0015(1); HD 2-1993, f. & cert. ef. 3-11-93; HD 21-1993, f. & cert. ef. 10-28-93, HD 30-1994, f. & cert. ef. 12-13-94; HD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0020

Nursing Care Management

(1) The nursing care of each patient, including patients admitted for observation status, in a hospital shall be the responsibility of a registered nurse (RN).

(2) The RN will only provide services to the patients for which she/he is educationally and experientially prepared and for which competency has been maintained.

(3) The RN shall be responsible and accountable for managing the nursing care of his/her assigned patients. She/he shall only assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. The responsible RN shall ensure that the following activities are completed:

(a) Document the admission assessment of the patient within four hours following admission and initiate a written plan of care. This shall be reviewed and updated whenever the patient's status changes.

(b) Develop and document within eight hours following admission a plan of care for nursing services for the patient, based on the patient assessment and realistic, understandable, achievable patient goals consistent with the applicable rules in OAR 851-045.

(c) Observe and report to the nurse manager and the patient's physician or other responsible health care provider authorized by law, when appropriate, any significant changes in the patient's condition that warrant interventions that have not been previously prescribed or planned for:

(A) When the RN questions the efficacy, need or safety of continuation of medications being administered to a patient, the RN shall report that question to the physician or other responsible

health care provider authorized by law authorizing the medication and shall seek further instructions concerning the continuation of the medication.

(4)(a) A hospital shall maintain documentation of certification of certified nursing assistants (CNAs), which shall be available on request to Division personnel.

(b) A nursing assistant who works in a hospital must be certified prior to assuming nursing assistant duties in accordance with OAR 851-062.

(c) A hospital shall maintain documentation that CNAs whose functions include administration of non-injectable medications, are qualified. This documentation shall be available on request to Division personnel.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11-1980, f. & ef. 9-10-80; HD 5-1981, f. & ef. 3-30-81; Renumbered from 333-023-0172; HD 29-1988, f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-072-0015(7); HD 21-1993, f. & cert. ef. 10-28-93; HD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0030

Nursing Services

(1) The hospital shall provide a nursing service department, which provides 24-hour onsite registered nursing care, 7 days per week.

(2) The nursing services department shall be under the direction of a nurse executive who is a registered nurse, licensed to practice in Oregon.

(3) All nursing personnel shall maintain current certification in cardiopulmonary resuscitation.

(4) For the purposes of these rules, "circulating nurse" means a registered nurse who is responsible for coordinating the nursing care and safety needs of the patient in the operating room and who also meets the needs of the operating room team members during surgery.

(5) The duties of a circulating nurse performed in an operating room of a hospital shall be performed by a registered nurse licensed under ORS 678.010 through 678.410. In all cases requiring anesthesia or conscious sedation, a circulating nurse shall be assigned to, and present in, an operating room for the duration of the surgical procedure unless it becomes necessary for the circulating nurse to leave the operating room as part of the surgical procedure. While assigned to a surgical procedure, a circulating nurse may not be assigned to any other patient or procedure.

(6) Nothing in this section precludes a circulating nurse from being relieved during a surgical procedure by another circulating nurse assigned to continue the surgical procedure.

Stat. Auth.: ORS 409.050, 441.055
Stats. Implemented: ORS 441.160 - 441.192
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11-1980, f. & ef. 9-10-80; HD 5-1981, f. & ef. 3-30-81; Renumbered from 333-023-0172; HD 29-1988, f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-072-0015(2); HD 21-1993, f. & cert. ef. 10-28-93; HD 2-2000, f. & cert. ef. 2-15-00; PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0040

Nurse Executive

(1) The nurse executive position shall be full-time (40 hours per week). Time spent in professional association workshops, seminars and continuing education may be counted as his/her duties in considering whether or not he/she is full-time. If the nurse executive has responsibility for direct patient care activities, sufficient time must be available to devote to administrative duties. For hospitals with attached long-term care facilities, the nurse executive may function as the nurse executive for both the hospital and the long-term care facility.

(2) The nurse executive shall have had progressive responsibility in managing in a health care setting.

(a) The nurse executive shall be a registered nurse licensed in Oregon. In addition, the nurse executive must have a baccalaureate degree, other advanced degree, or appropriate equivalent experience, with emphasis in management preferred.

(3) The nurse executive shall have written administrative authority, responsibility, and accountability for assuring functions and activities of the nursing services department and shall participate in the development of any policies that affect the nursing services department. This includes budget formation, implementation and evaluation. The nurse executive shall ensure the:

(a) Development and maintenance of a nursing service philosophy, objective, standards of practice, policy and procedure manuals, and job descriptions for each level of nursing service personnel;

(b) Development and maintenance of personnel policies of recruitment, orientation, in-service education, supervision, evaluation, and termination of nursing service staff or ensure it is done by another department;

(c) Development and maintenance of policies and procedures for determination of nursing staff's capacity for providing nursing care for any patient seeking admission to the facility;

(d) Development and maintenance of a quality assurance program for nursing service;

(e) Coordination of nursing service departmental function and activities with the function and activities of other departments; and

(f) Ensure participation with the administrator and other department directors in development and maintenance of practices and procedures that promote infection control, fire safety, and hazard reduction.

(4) Whenever the nurse executive is not available in person or by phone, she/he shall designate in writing a specific registered nurse or nurses, licensed to practice in Oregon, to be available in person or by phone to direct the functions and activities of the nursing services department.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HD 29-1988, f. 12-29-88, cert. ef. 1-1-89; HD 21-1993, f. & cert. ef. 10-28-93; HD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0045

Nursing Services Staffing

(1) Each hospital must be responsible for the implementation of a written hospital-wide staffing plan for nursing services. The nurse staffing plan must be developed, monitored, evaluated and modified by a hospital nurse staffing plan committee in accordance with these rules. To the extent possible, the committee must:

(a) Be comprised solely of equal numbers of hospital nurse managers and direct care registered nurses as its exclusive membership for decision making;

(b) Include at least one direct care registered nurse from each hospital nurse specialty or unit, to be selected by direct care registered nurses from the particular specialty or unit as the specialty or unit as defined by the hospital; and

(c) Have as its primary consideration the provision of safe patient care and an adequate nursing staff pursuant to ORS chapter 441.

(2) The hospital nurse staffing committee must document:

(a) How its members were chosen to reflect fair and knowledgeable representation;

(b) How the input of each member in decision making is assured;

(c) The committee process and procedures, including how and when meetings are scheduled, how committee members are notified of meetings, how the meetings are conducted, how unit staff input is acquired, who may participate in the decision making and how decisions are made;

(d) Plans for how it will monitor, evaluate and modify the nurse staffing plan over time; and

(e) Meeting proceedings (meeting minutes).

(3) The written staffing plan must:

(a) Be based on an accurate description of individual and aggregate patient needs and requirements for nursing care;

(b) Include at least an annual quality evaluation process to determine whether the staffing plan is appropriately and accurately reflecting patient needs over time;

(c) Be based on the specialized qualifications and competencies of the nursing staff;

(d) Ensure that the skill mix and the competency of the staff meet the nursing care needs of the patient;

(e) Be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, such as, but not limited to, The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);

(f) Recognize differences in patient acuteness;

(g) Include a formal process for evaluating and initiating limitations on admission or diversion of patients to another acute care facility when, in the judgment of the direct care registered nurse, there is an inability to meet patient care needs or a risk of harm to existing and new patients; and

(h) Establish minimum numbers of nursing staff personnel including licensed nurses and certified nursing assistants on specified shifts, with no fewer than one registered nurse and one other nursing care staff member on duty in a unit when a patient is present.

(4)(a) The hospital nurse staffing committee must monitor, evaluate, modify, and re-approve the nurse staffing plan according to the schedule described in the nurse staffing plan.

(b) If the hospital nurse staffing committee is unable to reach agreement on a re-approval of the nurse staffing plan, any nurse on the committee may request the Department to assist in resolving the impasse.

(c) The Department may require a hospital to:

(A) Provide written documentation describing those portions of the modified nurse staffing plan that have been developed and approved by the nurse staffing committee;

(B) Present a written plan for assisting the hospital nurse staffing committee in resolving outstanding differences including the scheduling of timely meetings, arranging for meeting facilitation and setting timelines; and

(C) Implement those modifications to the nurse staffing plan that have been approved by the nurse staffing committee.

(d) If a hospital is unable to resolve differences and adopt a modified plan within 60 days from the time the Department is notified of the impasse, it may request a 60 day Planning Process Extension.

(e) To be granted the extension, a hospital must:

(A) Employ a mediator within 30 days to assist in working out a compromise; and

(B) Provide evidence that such a mediator will include nurse staffing expertise in the deliberative process.

(5) The hospital must maintain and post a list of on-call nursing staff or staffing agencies that may be called to provide qualified replacement or additional staff in the event of emergencies, sickness, vacations, vacancies and other absences of the nursing staff and that provides a sufficient number of replacement staff for the hospital on a regular basis. The list must be available to the individual responsible for obtaining replacement staff.

(6) When developing the on-call list, the hospital must explore all reasonable options for identifying local replacement staff. These efforts must be documented.

(7) When a hospital learns about the need for replacement staff, the hospital must make every reasonable effort to obtain registered nurses, licensed practical nurses or certified nursing assistants for unfilled hours or shifts before requiring a registered nurse, licensed practical nurse, or certified nursing assistant to work overtime. Reasonable effort includes the hospital seeking replacement at the time the vacancy is known and contacting all available resources as described in section (5) of this rule. Such efforts must be documented.

(8) A hospital may not require a registered nurse, licensed practical nurse, or certified nursing assistant to work:

(a) Beyond the agreed-upon shift;

(b) More than 48 hours in any hospital-defined work week; or

(c) More than 12 consecutive hours in a 24-hour period, except that a hospital may require an additional hour of work beyond the 12 hours if:

(A) A staff vacancy for the next shift becomes known at the end of the current shift; or

(B) There is a risk of harm to an assigned patient if the registered nurse, licensed practical nurse or certified nursing assistant leaves the assignment or transfers care to another.

(9) Each hospital must have a system to document mandatory overtime. The procedure must be clearly written, provided to all new nursing staff, and be posted in a conspicuous place. The procedure must ensure that both the employee and management are involved.

(10)(a) Time spent attending hospital-mandated meetings, and hospital-mandated education or training must be included as hours worked for purposes of section (8) of this rule.

(b) Time spent on call but away from the premises of the employer may not be included as hours worked for purposes of section (8) of this rule.

(c) Time spent on call or on standby when the registered nurse, licensed practical nurse or certified nursing assistant is required to be at the premises of the employer must be included as hours worked for purposes of section (8) of this rule.

(11) The provisions of sections (7) through (10) of this rule do not apply to nursing staff needs:

(a) In the event of a national or state emergency or circumstances requiring the implementation of a hospital disaster plan;

(b) In emergency circumstances, such as but not limited to:

(A) Sudden unforeseen adverse weather conditions;

(B) An infectious disease epidemic of staff; or

(C) Any unforeseen event preventing replacement staff from approaching or entering the premises; or

(c) If a hospital has made reasonable efforts to contact all of the on-call nursing staff or staffing agencies on the list described in section (5) of this rule and is unable to obtain replacement staff in a timely manner.

(12) A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon scheduled shift or an agreed-upon extended shift without authorization from the appropriate supervisory personnel as required by the Oregon State Board of Nursing OAR, chapter 851.

(13) A hospital must post a notice summarizing the provisions of ORS 441.162, 441.166, 441.168, 441.174, 441.176, 441.178, and 441.192, in a conspicuous place on the premises of the hospital. The notice must be posted where notices to employees and applicants for employment are customarily displayed.

(14) Upon request of a hospital, the Department may grant variances in the written staffing plan requirements based on patient care needs or the nursing practices of the hospital. Such request for a variance must be in writing and must state the reason for seeking a variance, verification that the nurse staffing plan committee has reviewed the request for variance, and how granting the variance will meet patient needs or the nursing practices of the hospital. A variance must be posted along with the notice required in ORS 441.180.

(15) Nothing in section (4) of this rule relieves a hospital from complying with ORS 441.162 or 441.166.

Stat. Auth.: ORS 409.050, 441.055
Stats. Implemented: ORS 441.160 - 441.192
Hist.: OHD 2-2000, f. & cert. ef. 2-15-00; OHD 3-2001, f. & cert. ef. 3-16-01; OHD 20-2002, f. & cert. ef. 12-10-02; PH 22-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06; PH 21-2006, f. & cert. ef. 10-6-06; PH 11-2009, f. & cert. ef. 10-1-09

[**Note**: The nurse staffing rules related to audits and investigations have been moved to OAR 333-501-0035 and 333-501-0040.]

333-510-0050

Inservice Training Requirements for Nursing

(1) The nurse executive or her or his designee shall coordinate all inservice training for nursing. Each year the inservice training agenda shall include at least the following:

(a) Infection control measures;

(b) Emergency procedures including, but not limited to, procedures for fire and other disaster;

(c) Application of physical restraints (if the facility population includes any patient with orders for restraints); and

(d) Other special needs of the facility population.

(2) Training for procedures for life-threatening situations, including cardiopulmonary resuscitation shall be provided every two years.

(3) The facility, through the nurse executive, shall assure that each licensed or certified employee is knowledgeable of the laws and rules governing his or her performance and that employees function within those performance standards.

(4) Documentation of such training shall include the date, content and names of attendees.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HD 29-1988, f. 12-29-88, cert. ef. 1-1-89; HD 21-1993, f. & cert. ef. 10-28-93; OHD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

333-510-0060

Patient Environment

(1) A hospital shall provide for each patient:

(a) A good bed, mattress, pillow with protective coverage, and necessary bed coverings;

(b) Items needed for personal care; and

(c) Separate storage space for clothing, toilet articles, and other personal belongings.

(2) In multiple-bed rooms, opportunity for patient privacy shall be provided by flame retardant curtains or screens. In hospitals caring for pediatric patients, cubicle curtains or screens are not required for beds assigned these patients.

(3) No patient shall be admitted to a bed in any room, other than one regularly designated as a bedroom or ward. The placing of a patient's bed in a diagnostic room, treatment room, operating room or delivery room is expressly prohibited, except under emergency circumstances.

(4) No towels, wash cloths, bath blankets, or other linen which comes directly in contact with the patient shall be interchangeable from one patient to another unless it is first laundered.

(5) Temperature-controlled pads shall be so covered that the patient cannot be harmed by excessive heat or cold and carefully checked as to temperature and leakage. Electrical heating pads, blankets, or sheets shall be used only on the written order of the physician or other health care practitioner authorized by law.

(6) The use of torn or unclean bed linen is prohibited.

(7) In facilities caring for pediatric patients, an emergency signaling system for use by attendants summoning assistance and a two-way voice intercommunication system between the nurses' station and rooms or wards housing pediatric patients shall be provided.

Stat. Auth.: ORS 441.055
Stats. Implemented: ORS 441.055 & 442.015
Hist.: HB 183, f. & ef. 5-26-66; HB 209, f. 12-18-68; HD 11-1980, f. & ef. 9-10-80; Renumbered from 333-023-0170; HD 5-1981, f. & ef. 3-30-81; Renumbered from 333-023-0172; HD 29-1988, f. 12-29-88, cert. ef. 1-1-89, Renumbered from 333-072-0010 & 333-072-

0015(3) thru (6); HD 21-1993, f. & cert. ef. 10-28-93; HD 2-2000, f. & cert. ef. 2-15-00; PH 11-2009, f. & cert. ef. 10-1-09

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