Nurse Staffing:
Are Fixed Ratios the Answer?

By Cindy Zolnierek, MSN, RN

Staffing involves a process of matching and providing staff resources for patient care requirements. By definition, staffing is resource intensive comprising the largest component of hospital operational budgets. In a time of nursing shortage, safe and appropriate staffing becomes especially challenging. The need to define and ensure effective staffing is of primary concern to nurses and nursing, and it is critical for quality patient care.

While a focus on quality was evident in the late '80s and early '90s, e.g., adoption of programs such as Total Quality Management, hospitals were quickly pulled back to the basics of safety when the Institute of Medicine (IOM) released in 1999 its groundbreaking report To Err is Human (Kohn, et al.). This report revealed shocking and disturbing insight into the prevalence of medical errors in health care and the morbid results of those errors. Measurements of quality shifted away from an interest in structure and process, and instead targeted outcomes: patient, staff, and financial.

Discussions of nurse staffing followed these trends. Where creative models of care to reduce costs dominated dialogue around nurse staffing in the 1990s, attention was cued to staffing outcomes following the IOM report. Initially, outcomes data related to nurse staffing was sparse. In the mid- to late-1990s, the American Nurses Association (ANA) lead nursing efforts to identify measures that would link availability of nursing services to quality (ANA, 2008b). These efforts culminated in the development of the National Database of Nursing Quality Indicators™ (NDNQI®). The NDNQI® provided one of the first databases of patient and nurse outcome indicators and it is currently the only national database containing unit level data regarding nurse sensitive indicators. This database includes measures believed to be directly related to nursing care and patient outcomes, such as (Montalvo, 2007):

- Nursing hours per patient day
- Patient falls (with or without injury)
- Pressure ulcer prevalence
- Restraint prevalence
- RN satisfaction
- Skill mix (percent of total nursing hours supplied by RNs, LVNs, UAPs, agency staff)
- Voluntary nurse turnover
- Nurse vacancy rate
- Nosocomial infections

Because the NDNQI® provides unit level data, it enables comparisons across like units and like hospitals, e.g., a telemetry unit in one small community hospital can compare its pressure ulcer and vacancy rates to a similar unit in another community hospital.

For the first time, patient outcomes could be specifically mapped to nursing care—not just by morbidity or medical complications, but by outcomes that are specifically amenable to nursing management and intervention. This database became a powerhouse of information for researchers interested in studying relationships between nursing staff and targeted outcomes: patient, staff, and financial.

(Continued on page 3)
1: Patty Shanabeger  
Phone: 915/400-6837  
Email: psshanaber@epcc.edu

2: Paula Antognoli  
Phone: 806/351-5103

3: Sandi McDermott  
Phone: 972/566-7187  
Email: sandi.mcdermott@hcachcare.com  
District Staff: Renee James  
Phone: 817/249-5071  
Email: tna3@usapathway.com  
Web site: www.tna3.org

4: Colleen Hines  
Phone: 972/348-1614  
Email: cmhteh@sbcglobal.net

5: Deanna Eichler  
Phone: 915/490-6837  
Email: deichler@seton.org  
Web site: www.tna3.org

6: Ellarene Duis  
Phone: 210/705-6266  
Email: gdasher@satx.rcom  
Web site: www.texasnurses.org/districts/09/

7: Joanne Gelsthorpe  
Phone: 254/690-8881  
Email: joannagelesthorpe@hot.rr.com  
Web site: http://www.tnadistrict7.org/

8: Gayle Dasher  
Phone: 972/566-7187  
Email: sandi.mcdermott@hcachcare.com

9: Lucinda Campbell-Law  
Phone: 281/649-3000 ext 2492  
Email: lcampbell@hbu.edu  
District Staff:  
Melanie Truong  
Email: tna9@tnadistrict9.org  
Web site: www.tnadistrict9.org

10: Barbara Hills  
Phone: 254/690-8881  
Email: bobhills@grandcom.net

11: Connie Beddingfield  
Phone: 940/521-5406  
Email: cbeddingfield@hcahealthcare.com

12: Patricia Morrell  
Phone: 936/212-7222  
Email: patricia.morrell@mhbh.org

13: Vacant

14: Joe Lacher  
Phone: 956/882-5089  
Email: jzlacher@utb.edu

15: Andrea Kerley  
Phone: 325/670-4230  
Email: akerley@hendrick.health.org  
Web site: www.texasnurses.org/districts/15/

16: Martha Sleutel  
Phone: 325/942-2060 ext 258  
Email: martha.sleutel@angelo.edu

17: Nancy Goodman  
Phone: 361/825-2607  
Email: nancy.goodman@tamucc.edu  
Web site: www.texasnurses.org/districts/17/

18: Patty Freier  
Phone: 806/797-8120  
Email: pfreier@cvhs.org  
Web site: www.texasnurses.org/districts/18/

19: Kleanthe Caruso  
Phone: 903/526-5701  
Email: anthecaruso@yahoo.com  
Web site: www.texasnurses.org/districts/19/

20: Kathleen Elliott  
Phone: 361/552-3063  
Email: stormybill@yahoo.com

21: Sherrie Harris  
Phone: 432/381-2429  
Email: sherre@clearwire.net

22: Toni McDonald  
Email: mitchm@consolidated.net

23: Shirley Aycok  
Phone: 903/646-3745  
Email: saycock@gsmc.org

26: Carolina Huerta  
Phone: 956/383-7365  
Email: chuerta@utpa.edu

27: Patsy Cornelius  
Phone: 903/832-5565 ext. 3301  
Email: pcornel@txarkana.edu

29: Sally Durand  
Phone: 281/756-3634  
Email: sdrand@alvincollege.edu

40: Belinda Richey  
Phone: 800/862-2022 ext. 129  
Email: brichey@texasnurses.org

Texas Nursing Voice is published quarterly—October-December, January-February-March, April-May-June, and July-August-September—by Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, TX 78757-1292.

Editorial Office: TEXAS NURSING Voice, 7600 Burnet Road, Suite 440, Austin, TX 78757-1292  
512.452-0645, E-mail: tvnvcirculation@texasnurses.org

Address changes:  
Send address changes to Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, TX 78757-1292  
E-mail: tvnvcirculation@texasnurses.org

Advertising:  
P.O. Box 216, Cedar Falls, Iowa 50613  
319.277-2414, E-mail: sales@aldpub.com

Texas Nurses Association and the Arthur L. Davis Agency reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by Texas Nurses Association (TNA) of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. TNA and the Arthur L. Davis Publishing Agency shall not be held liable for any consequences resulting from purchase or use of an advertiser’s product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect the views of the staff, board, or membership of TNA or those of the national or local associations.

Copyright © 2008 by Texas Nurses Association.
Nurse Staffing: Are Fixed Ratios the Answer? (Continued from page 1)

characteristics and patient outcomes (Dunton, 2007).

With the increasing availability of information about preventable errors and complications of hospital care, particularly those related to nursing care, hospitals were called to higher levels of accountability for patient outcomes. Such that, in the fall of 2007, the Center for Medicare and Medicaid Services (CMS) announced that it would no longer reimburse hospitals for nursing-related, preventable complications occurring during a patient’s hospital stay (The George Washington University, 2007). Non-reimbursable conditions include hospital-acquired pressure ulcers, certain injuries, some infections (catheter related, surgical site), blood incompatibility, air embolism. Other insurers have already announced plans to follow this lead (Fuhrmans, 2008).

Measures of structures and processes (characteristics of nurses and staffing) are important because they influence patient outcomes. However, the ultimate measure of quality is the patient outcomes themselves. Regardless of what was planned or intended, did it make a difference? Was the goal achieved? The new millennium marked a new era for research investigating characteristics of individual nurses (education, experience, fatigue) and characteristics of nurse staffing (nurse-to-patient ratios, hours of nursing care, skill mix) as they may relate to patient outcomes. The evidence linking nursing workforces characteristics (nurse-to-patient ratios, hours of nursing care, skill mix) to patient outcomes is convincing (ANA, 2008a; Unruh, 2008). Kane, 2007)—see related stories page 8. A relationship does indeed exist and adequate staffing is certainly a necessary factor in achieving desired patient outcomes. However, the complexity of these characteristics and their interaction within the hospital environment make it extremely difficult to define a template as simple as a nurse-to-patient ratio to ensure appropriate staffing (Unruh, 2008; Kane, 2007).

Nursing workload and variables within the hospital environment and culture also have a significant impact on the ability of the nurse to provide safe and appropriate care (Unruh, 2008; Kane, 2007). Further research is needed to better describe these relationships and provide guidance for effective staffing models.

Many factors go into preventing hospital-acquired ulcers, failure to rescue, falls, infections. It is the right number of nurses, as well as the right match of nurse and patient characteristics. It is the right number of nurses AND the appropriate workload. It is the right number of nurses AND the right kind of resources (expert/specialty nurses such as wound specialists, support and assistive staff) to support the nurse in the particular environment. It is the right number of nurses AND the right kind of culture—one that supports collaborative, interdisciplinary practice and encourages nurses to identify and report problems and barriers to providing care. Quality patient care will result from “right” staffing and “right” assignments tailored to the uniqueness of patients, nurses, and hospitals. Further research demonstrating what is “right” will assist all nurses in achieving desired patient outcomes.

References


The Texas Nurses Association (TNA) initiated legislation in 2007—Senate Bill 993 (SB 993)—which made substantial changes to mandatory reporting and nursing peer review (NPR). Following passage of SB 993, the Board of Nursing (BON) charged its Nursing Practice Advisory Committee, chaired by TNA member John Grossley, PhD, RN, with re-evaluating the BON rules. As a result, the rules regarding incident-based nursing peer review (Rule 217.19) and safe harbor nursing peer review (Rule 217.20) were substantially rewritten. The most significant changes to the rules (as currently published in the Texas Register and expected to be adopted by the BON on 4/17/08 without additional changes) are outlined below.

**Definitions**

A definition section is added to both of these rules:

- **Assignment.** A definition of assignment is introduced as:

  The designated responsibility for the provision or supervision of nursing care for a defined period of time in a defined work setting. This includes, but is not limited to, the specified functions, duties, practitioner orders, supervisory directives, and amount of work designated as the individual nurse’s responsibility. Changes in the nurse’s assignment may occur at any time during the work period.

  The key point is that changes during the work period, such as a significant change in patient condition requiring close monitoring, or change in availability of assistive personnel during the shift, could result in a change in the original assignment in that the work required of the nurse has substantially changed. This definition is important because a nurse must evoke safe harbor prior to accepting an assignment. If substantial changes in required work occur during the work period, a new assignment may exist, and the nurse may have the opportunity to evoke safe harbor if other conditions are met.

- **Good faith, bad faith, malice.** The definition of good faith is expanded and definitions for bad faith and malice are added. The nursing peer review process is based upon good faith among all parties. That is, action taken is supported by what is reasonable, factual, legal. The person is not taking action recklessly, knowingly misrepresenting facts, or out of personal animosity (bad faith). Action does not reflect an intent to harm (malice). When a nurse requests safe harbor, it must be done in good faith. When a nurse reports a nurse for violating her duty to the patient, it must be done without malice. The individuals participating in the nursing peer review process must operate from good faith.

**Incident Based Nursing Peer Review**

- **Informal NPR workgroup.** Key changes to incident-based NPR include a provision allowing the use of an informal workgroup which requires less resources and offers a simpler process than the full committee. An informal workgroup is essentially a subgroup of the NPR committee who meets with the nurse and makes a recommendation to the NPR committee chair for ratification. The nurse must agree to the use of the workgroup and may reject the workgroup’s decision and request a review by the full NPR committee.

- **Due process limitations.** The revised rules clarify situations in which due process does not apply. The facility is not required to provide due process to the nurse when NPR is conducted solely to review external factors related to an incident. This occurs when an employer has made a mandatory report to the BON and the NPR committee is not reviewing the behavior of the nurse. If impaired practice is suspected during nursing peer review, the NPR process is suspended and the nurse is reported to the BON or TPAPN (Texas Peer Assistance Program for Nurses).

- **Impaired nursing practice.** The revised rules provide more direction on handling the review of nurses who have impaired practice. All reports to TPAPN by third parties (e.g. the facility), will be reviewed by the BON to determine appropriateness for the peer assistance program. Nurses who self-report to TPAPN and fail to successfully complete the program are referred to the BON.

- **Value of NPR determinations.** The rules clarify that NPR committee determinations cannot be overruled by the nurse administrator. That is, even if the nurse administrator takes action contrary to the finding of the NPR committee, that action does not nullify the committee’s decision. This rule strengthens the value of the committee’s findings.

**Safe Harbor Peer Review**

The process for evoking safe harbor was revised to clarify and simplify the process for nurses.

- **Invoking safe harbor.** To activate safe harbor protections, the nurse must make the request in “good faith,” in writing, and before engaging in the conduct. The request can be made at one of three permissible times: when the conduct is requested, or when the assignment changes to the extent that a “new assignment” occurs, or when the nurse refuses to engage in the requested conduct.

- **Initial and comprehensive written request.** The initial “quick” written request requires minimal basic information: nurse’s name and signature, date, time, location, name of person requesting the conduct, brief explanation of why safe harbor is requested.

(Continued on page 6)
Approaches to Nurse Staffing: Two Texas Hospital Exemplars

About the Hospitals

• Memorial Hermann Baptist Hospital Beaumont (MHBHB) in Beaumont, TX is a not-for-profit community based hospital in an urban setting. With over 400 inpatient beds, MHBHB offers a full spectrum of services including women’s health, behavioral health, and rehabilitation. In 2007, MHBHB achieved both the Nurse-Friendly™ hospital designation of Texas Nurses Association, and Magnet™ designation in recognition of excellence in nursing services. The patient care delivery model is based on the particular patient characteristics and needs in the various nursing units and includes a modified team approach as well as modified primary models (e.g., in rehabilitation).

• Harris Methodist Walls Regional Hospital is a member of Texas Health Resources. Walls Regional Hospital is a not-for-profit general hospital located in the rural community of Cleburne, Texas. Licensed for 110 beds, this small hospital averages daily census of 35 and offers general medical/surgical care as well as ICU, pediatrics, and women’s health services. A busy 17-bed ED contributes to wide variations in census, particularly in winter when inpatients may number over 60. Walls Regional received designation as a Nurse-Friendly hospital in May 2006. The care delivery model reflects the availability of resources in the community, as well as patient needs, and includes all levels of staff: RNs, LVNs, and nurse techs.

In Texas, hospital nursing services are required to have a staffing plan for provision of patient care. That requirement is directed by a 2002-adopted rule of the Texas Department of State Health Services known as the hospital staffing rules which requires hospitals to establish a Nurse Staffing Advisory Committee that can identify and respond to concerns about staffing adequacy. The rules require that 50% of staffing committee membership be direct care registered nurses who spend at least 50% of their time directly caring for patients. The plan is to be written, based on standards of care and consider critical factors that affect a nurse’s ability to effectively carry out a patient assignment—such as, physical environment, patient volume and acuity, experience of the nurse, hospital culture and so on.

Since asking nurses at the bedside for input seems like a totally logical approach for determining plans for staffing, TEXAS NURSING Voice editorial staff decided to ask a couple of hospitals how the nurse staffing advisory committees were affecting appropriate staffing within the facilities. One of the hospitals—Memorial Hermann Baptist Hospital Beaumont (MHBHB)—is a 400-bed urban facility that offers a full spectrum of services. The other —Harris Methodist Walls Regional Hospital—is a 110-bed facility in the rural community of Cleburne, TX.

Gerald Bryant, MSN, RN, chief nursing officer, and Candice Herman, MSN, RN, CNA, BC, director of research and professional development, represented Memorial Hermann Baptist Hospital in the discussion. Cindy Plonien, MSN, RN, chief nurse executive, agreed to share the Walls Regional perspective. Here’s what we asked and what they told us:

At your facility, what is the role of the Nurse Staffing Advisory Committee?

MHBHB: Bryant and Herman explained that the Nurse Staffing Advisory Committee was first established at MHBHB as a subcommittee of the Quality Council. When the organization moved to a shared governance structure, the Staffing Committee was moved into that structure and now gains its authority from the Nursing Leadership Coordinating Council. Committee members are recruited to represent all inpatient care areas through formal hospital communications (e.g., newsletters, forums, staff meetings), as well as good, old-fashioned word of mouth. Seventy per cent of the membership is direct care nurses. Nurses with an interest in serving on the Committee are presented to the Leadership Council who selects the final members.

In addition to staff nurses, a quality management nurse participates on the Committee and presents National Database of Nursing Quality Indicators™ (NDNQI®) data. An infection control nurse shares information as well. The assistant CNO attends Committee meetings and presents additional information on safety and staffing effectiveness. This information is used by the committee to determine when staffing adjustments may be necessary.

Walls Regional: “Chaired by the CNE,” Cindy Plonien explained, “the Committee is comprised of staff nurses, an educator, a risk manager, nurse coordinators, and nurse managers. Only staff nurses are eligible to vote. The Committee meets physically every other month for 60 minutes and has online meetings on alternate months. The Committee is very active in reviewing outcome indicators, such as falls, and evaluating relationships to staffing so recommendations can be made. They also consider policy issues.”

“For example,” Plonien continued, “the existing policy for flexing staff was 30% of staff. The new policy is for 35% of part-time, full-time, and full-time staff to be flexed in that order. A nurse polled the staff on her unit and proposed that part-time and full-time staff be equally flexed off as they are regularly scheduled and benefited staff. After considering the request, the Committee agreed to make a policy change.”
Approval of Nurse Staffing: Two Texas Hospital Exemplars (Continued from page 6)

The Committee also reviews staffing variances and completes mortality reviews to look for relationships between staffing and outcomes, according to Plonien. And it serves as a venue for continued learning regarding professional practice issues, changes implemented by the BON and governmental affairs.

Can you give us an example of a time that the Committee utilized outcomes or nurse sensitive indicators to evaluate the adequacy of the plan?

MHBB: Gerald Bryant cited a recent staffing change in the Emergency Department where volume (number of patients per shift) continued to increase. Considering the increased volume, a decision was made to increase staffing and as a result, a new, full-time RN position was added to the ED.

Another example cited Bryant in which the Committee considered data in recommending a change involved the loss of staff in the ICU. Several experienced staff had moved out of state within a short period of time leaving the ICU struggling for adequate coverage. A nurse Committee member from the progressive care unit, which was fully staffed to the point that some staff lost hours when the volume fell, suggested that nurses from progressive care be cross trained to care for less intense ICU patients. A plan to cross train nurses was developed and implemented. Staff were very pleased about the availability of an alternative to being flexed off, and appreciated the opportunity to learn new skills. Because of this opportunity, some staff decided to complete specialty training and transfer to the ICU. This was a win for everyone—especially the patients, summarized Bryant.

Feedback drives changes in recruitment and staffing at MHBB, further explained Bryant. Recruitment incentives in the form of staff bonuses for new hire referrals were established for high-need areas such as the ICU.

A final example of MHBB using outcomes for evaluating staffing plans involved the nursing sensitive indicator: hospital-acquired pressure ulcers (HAPU). Nursing decided to engage an indicator: hospital-acquired pressure ulcers (HAPU). Nursing decided to engage an

MHBB: “Actually,” relayed Bryant, “there has been very little [concern] expressed directly to the Committee.” He said further: “Staff on the Committee are very proactive in identifying changes and needs. The organization supports direct communication between staff and their managers.”

“Progress and innovation are a must for the best patient care,” said Bryant. The organization offers staff an internal Web page as an anonymous option for voicing concerns. Concerns related to staffing are considered by the Committee.

Walls Regional: “It hasn’t happened very often,” stated Plonien. “One nurse, who had worked in a physician office setting for several years, expressed a concern that others were not having. In the end, it was felt that nurse’s unfamiliarity with inpatient med/surg care was the real issue.”

“We haven’t had any requests for Safe Harbor recently,” said Plonien. “Our hospital system is looking at revising our patient acuity system to better measure/quantify intensity of care required.”

How do you orient nurses to the Nurse Staffing Advisory Committee and the process for voicing staffing concerns?

MHBB: “I provide an explanation of our shared governance model to all nurses during

Magnet Workshop – May 1-2, 2008
Co-Hosted with the Medical City Hospital and Medical City Children’s Hospital, Dallas Texas
The American Nurses Credentialing Center (ANCC), official home of the Magnet Recognition Program® for nursing excellence, offers workshops designed to help organizations better understand how to achieve Magnet recognition.

Being Good Isn’t Good Enough—You Need to Be Magnet
The Magnet Recognition Program® was developed by the ANCC to recognize healthcare organizations that provide the very best in nursing care. When U.S. News & World Report publishes its annual showcase of “America’s Best Hospitals,” being a Magnet facility contributes to the total score for quality of inpatient care. Seven of the top ten medical centers according to U.S. News & World Report were Magnet designated organizations. (July 17, 2006)

Learn What It Takes to Become Magnet!
The Magnet Recognition Program® application process involves a rigorous review and analysis of a healthcare organization’s commitment to implementing the Forces of Magnetism, the key evaluation criteria. A team of professionals with expertise in evaluating nursing care and administration appraises the quality of a hospital’s services for patient care delivery. The appraisers review detailed documentation from applicant organizations and conduct extensive interviews to assess the management philosophy, the advocacy practice of the nursing leadership, and the caliber of nursing care offered to the community.

You Can’t Afford to Miss This Workshop
Save time and energy. Get organized and prepared for your application. Go on your journey to nursing excellence. The American Nurses Credentialing Center is the largest and most prestigious nurse credentialing organization in the United States.

The Magnet Recognition Program® was developed by the American Nurses Credentialing Center to recognize health care organizations that provide exceptional nursing care and uphold the tenets of professional nursing practice. It is the “gold standard” for excellence in nursing.

At ANCC, we are passionate about helping you on your journey to nursing excellence.
Recent Study Affirms Relationship Between RN Staffing and Patient Outcomes

Researchers from the University of Minnesota School of Public Health reported conclusions from a study supported by the Agency for Healthcare Research and Quality. Kane and colleagues (2007) conducted a meta-analysis of 28 studies which examined the relationship of RN staffing and patient outcomes in acute care hospitals. Meta-analysis is a statistically based method of synthesizing data from multiple studies. Results of a meta-analysis can be particularly convincing because they tend to represent large sets of data.

This meta-analysis specifically looked at the association between RN-to-patient ratios and patient outcomes. The researchers conclude that “there is a statistically and clinically significant association between RN staffing and adjusted odds ratio of hospital-related mortality, failure to rescue, and other patient outcomes” (p. 1202). However, there is no evidence to support a fixed standard RN-to-patient ratio, due in part to the effect of the other structure and process factors within the hospital environment which also affect outcomes. These factors include such things as hospital volume, nurse-physician collaboration, and characteristics of the nurse (skill, education, experience, leadership), patient, and hospital. The authors recommend that future research consider these contextual factors when investigating the relationship of staffing and outcomes. ★

Reference

Literature Review Re: Impact of Staffing Levels

A recent article in the American Journal of Nursing (Unruh, 2008) reports the results of a systematic review of the literature regarding the impact of nurse staffing on patient, nurse, and financial outcomes. The author considers 21 studies evaluating nurse staffing and patient outcomes — research which demonstrates a definite link although variability in the data lends itself to some inconsistencies in findings (e.g., different ways of measuring nurse staffing: ratios, skill-mix, hours per patient day).

The impact of nurse staffing on nurse outcomes (e.g., job satisfaction, injury, exhaustion) was considered in 23 studies reviewed; findings suggest relationships, but, again, inconsistencies may be related to design and measurement differences among the studies.

Financial outcomes related to nurse staffing (RN skill mix) were even less certain in the 18 studies reviewed. Some researchers reported increased costs associated with an RN-rich skill mix, others present cost neutral results, and still others indicated increased costs. Again, differences in measures and variables among the studies (in one study operating expenses were increased although net profits were not affected; some studies considered the cost effectiveness of reduced complications, length of hospital stay, and nurse turnover while others did not) make the results inconclusive.

Unruh summarizes that although scientific evidence does not support specific nurse to patient ratios, “the evidence clearly shows that adequate staffing and balanced workloads are central to achieving good patient, nurse, and financial outcomes.” (p. 69). She recommends further research to isolate the impact of various factors on specific outcomes. ★

Reference

Do you have any advice for nurse leaders who are struggling to set up effective Nurse Staffing Advisory Committees?

MHBHB: It needs to be a part of your philosophy and culture, explained the Memorial Hermann Baptist nurses. “It works well for us because it is embedded in shared governance,” they explained. “When there is an issue, we go to the person who is doing the work and ask their opinion. Nurses are reasonable. They understand you can’t have a one-nurse-to-two-patients ratio on a med-surg unit. They want safe staffing, alternatives, and resources to meet their patients’ needs. Leadership is responsible for addressing problem trends and facilitating resolutions.”

Their final advice: “Don’t give up and don’t take it personally.”

Walls Regional: Simply put, Plonien answered, “Do it. The biggest challenge has been figuring out a way to get consistent representation from staff nurses. Managers or coordinators may need to relay them of their patient assignment in order to free them up to attend. We also moved to online meetings every other month to make it easier for them to be involved.”

Further advice from Plonien: “Whatever you do, figure out a way to make it work. Nurses also need to see value in the Committee—it must be meaningful and they must feel that they can make a difference. Every decision or change the Committee implements, demonstrates and reinforces Nurse Power. Power to positively impact patient care. Practice councils such as staffing effectiveness committees promote professional practice and leadership, as well as scholarship in nursing.” ★
Both direct care and supervisory nurses are concerned about appropriate staffing, however, each sees staffing situations from different perspectives. What constitutes ‘appropriate’ is not black-and-white, and varies according to patient, nurse and environmental characteristics.

Nurse availability for appropriate staffing may be challenged by vacancies related to the nursing shortage or unplanned patient volume or acuity calling for additional staff. The immediate dilemma for most nurses in a questionable staffing situation is whether to accept an assignment. Both the direct care nurse and the assigning (supervisory) nurse may be in an uncomfortable situation in determining the appropriateness of an assignment. For both, the question is whether the request meets the standards set for safe patient care.

The Texas Board of Nursing (BON) defines criteria for making and accepting assignments within the Standards of Nursing Practice (Rule 217.11). The assignments must consider patient safety and be consistent with the nurse’s education, experience, knowledge and physical and emotional ability. Guidelines can be useful in evaluating a particular assignment and determining its appropriateness. The Texas Nurses Association (TNA) has developed a set of questions to assist the nurse in thinking critically about a nursing assignment, and clarifying what about the assignment is discomforting.

### Considering the Request

#### 1. What is the assignment?
Clarify what is being asked. Do not assume. Be certain about what it is that you are asked to do and consider what about the request may not be consistent with the standard or might violate your duty to the patient.

#### 2. What are the characteristics of the patients being assigned?
Go beyond the number of patients assigned. Critically assess the needs of each patient: age, condition, stability, risk, and other factors which contribute to the level of care required. Also, consider the resources available to meet their needs.
- Who is available on the unit or within the facility that can be a resource for the assignment? (e.g., charge nurse, nurse educator, nurse manager).
- Do you anticipate discharges and/or admissions that will impact your workload?

#### 3. What is the geography of the assignment?
- Are the assigned patients in close enough proximity for efficient management, or are they at opposite ends of the hall or on different units?
- If there are geographic difficulties, what resources are available to manage the situation?
- If I must go to another unit to provide care, who will monitor patients left on the unit who cannot receive my immediate attention?

#### 4. Is the assignment temporary? When other staff is located to assist, will I be relieved?
Some assignments may be safely managed on a short-term basis but not for a full shift.

#### 5. Do I have the experience and knowledge to manage the patients for whom I am being assigned and care?
- If the answer to this question is no, the nurse has an obligation to articulate her/his limitations.
- Is this a unit that I am familiar with? If this is a “float” assignment, am I familiar with the patient population, technology, and unit environment?
- Is there a “buddy system” in place so I know who I can go to with questions or for support?
- If there has been no orientation or “buddy system,” has the patient load been modified accordingly?

#### 6. Can I take the assignment in good faith?
Taking action in “good faith” means there is a reasonable factual or legal basis for the action. The person is not acting out of malice or personal animosity.
- For example, a nurse who worked on a telemetry unit until taking a position in post-partum four months ago is asked to float to an understaffed telemetry unit. She requests safe harbor and refuses to float. This action would not be considered good faith because it is reasonable to expect a nurse to float to a unit she/he is familiar with and has been oriented to.
- A med/surg nurse who refuses a request to accept an assignment in a NICU because she/he hasn’t been oriented and is not competent with the patient population or environment would be acting in good faith.

#### 7. Is this an ongoing staffing pattern?
If the assignment is being made due to a crisis, the decision to accept assignment may be based on that immediate need. However, if the staffing pattern is an ongoing problem, the nurse has an obligation to identify unmet standards of care that are occurring as a result of ongoing staffing inadequacies. This situation should be reported to the unit manager and nursing staffing advisory committee.

### Working Toward a Solution

Both the nurse making the assignment and the nurse accepting the assignment have the same obligation under the standards set by the Texas BON. A review of the standards set by the BON is a useful starting point for the nurse faced with an assignment conflict because the standards level the playing field for both the direct care nurse and the supervising nurse. The standards can guide both individuals as they state their rationale for the assignment or for consideration of refusal.

Guidelines for questioning a patient assignment follow.

- Reference the Standards of Nursing Practice set by the BON.
- Be familiar with the process and requirements for Safe Harbor Nursing Peer Review
- Safe Harbor must be evoked in writing before accepting the assignment.
- By requesting Safe Harbor, you alert the supervisor to the seriousness of your concerns.

The BON rules require that the nurse and supervisor collaborate in attempt to identify an acceptable assignment.

- Safe Harbor affords the nurse specific protections from the BON and employer.
- Nursing Peer Review follows a Safe Harbor request.

To collaborate with the nursing supervisor in attempt to identify an acceptable assignment:

1. **Come together:** request that you and the person making the assignment and any other person essential to resolving the problem, go to a place without distractions to discuss the concern. This will provide for open private discussion.

2. **“Seek first to understand and then to be understood,”** and strive for a clear mutual understanding of how each person sees the situation. Hear the other person’s perspective and repeat it back to them. Then, state your understanding of the situation and request. For example, here is a real life assignment which required modification:

   - **Assigned nurse statement of the case:** “In speaking to you about the assignment, I don’t know how I will be able to provide safe care for these patients. As I understand this assignment, I am being asked to accept 6 patients. I am also the team leader for my section of the unit and as leader I must coordinate any complications, which occur during the shift. I am also being asked to do remote monitoring of a child on chemotherapy on the adjoining unit. If the child on the adjoining unit has an untoward cardiac reaction to chemotherapy I am to leave the unit to provide care.”

   - **Request for assigning nurse’s statement of the case and a re-statement of yours:** “If I am correct in my understanding so far, can you help me better understand your thinking about this assignment? Are there any management insights you could share regarding how you would handle this assignment?”

   - **Then, listen to the response.** In this real life case, a restating of the assignment and the concerns of the nurse resulted in the child who was receiving chemotherapy being assigned to a monitor bed for the duration of the chemotherapy.

   - **If insistence upon the assignment had continued, a restatement of the situation might go like this:** “So, from your perspective I should leave the unit if a problem arises on the other unit with the chemotherapy? How will my remaining 6 patients be handled while I am off the unit? What is the expectation of the adjoining unit regarding my role in caring for the chemotherapy patient if a problem arises?”

   - **Each time, your requests for clarification should allow the other person to provide rationale for the assignment and thoughts** (Continued on page 10)
on how the care could be managed. The nurse making the assignment may have identified strategies to support safe patient care that you are not aware of.

3. Use synergy to come to an agreement about the best way to manage the problem. Ask, “How can my concerns be addressed?”
   - Temporarily assign the chemotherapy patient to a monitor bed or;
   - Get assurance that if you must leave the unit to assist the adjoining unit with a cardiac problem, your patients would be temporarily reassigned to the supervisor or another nurse while you were away.
   - Identify that the adjoining unit only requires your assistance in the initial management and coordination of a transfer of the child to Pedi-ICU in the event of a problem, and that the Pedi-ICU is aware of the possibility of transfer and is holding a bed in the event of a problem.
   - The pediatric residents are aware of the child and are on call to the unit to assist with the coordination of care.

Addressing a questionable staffing assignment is stressful for all parties. The above guidelines can bring clarity to the assignment and allow for a principled and professional discussion about practice concerns. If all parties operate from a good faith framework and attempt to fully understand the concerns and limitations of the situation, a satisfactory resolution is likely to occur.

The Texas Immunization Stakeholder Working Group (TISWG) had its first quarterly meeting of the year in February. It was established following the 78th Texas Legislature to focus on improving state immunization rates with a special focus on children. TISWG brings together, under the Department of State Health Services (DSHS), a collaboration of various organizations whose purpose is to work together to develop a road map to assist the Immunization Branch set priorities and implement plans to increase the vaccination rates in the state. Members of the work group represent federal, state, and local agencies and programs; schools; health care providers; parents; employers; insurance/health plans; vaccine manufacturers; and those from the private sector.

During the February meeting, attendees discussed four major topics: influenza immunization; the adolescent/adult immunization program business plan; increasing the 4th DTaP coverage in children; and initiatives coming out of the Immunization Branch.

National and statewide trends in influenza beg the question as to whether we need to change our paradigm related to influenza. Currently, the focus is giving the vaccine to high-risk populations—the very young, the elderly, and those with special health care needs. The concern is that everyone runs the risk of a vaccine failure. It is estimated that 1.2 million Texans contract influenza every year. Not all of them fall into the high-risk categories. Changes need to occur in the health care infrastructure that promote yearly vaccines for everyone, that provide multiple access points for getting the vaccine at a reasonable cost to both the providers and patients/clients; that address health disparities; that dispel the myths associated with the vaccine; and that support surveillance programs that monitor the flu types, the geography of the disease spread, and the degree of disease activity.

Based on this information, the stakeholder group has started to develop an influenza immunization roadmap for the next five years that addresses the possible Centers for Disease Control and Prevention (CDC) recommendation of a universal flu vaccine. How would the public be notified and educated? How would compliance be monitored? How would vaccine delivery on such a massive scale be accomplished? How would the program be sustained and maintained? These are just a few of the questions that TISWG is trying to answer in its roadmap.

One of the top three priorities established for 2008 by TISWG is to develop a plan to address the low immunization rates among the adolescent population of Texas. The Adolescent/ Adult Immunization Program business plan, due to be finalized in Spring 2008, includes the use of regional coordinators to better organize services, a marketing plan with catchy slogans like—“vaccinate for life”—and, toolkits for primary care providers.

The national standard for vaccinating children between the ages of 15 to 18 months with the 4th DTaP is 90%. Texas’ rate is 81%. In an effort to increase compliance and raise the rate, the Immunization Branch has a two-pronged approach. The first is surveying parents in an effort to identify barriers to getting the 4th DTaP vaccine. Not surprisingly, barriers include lack of transportation, payment issues, lack of knowledge and patient teaching, and fear of the health care system and health care providers. Once all the data is compiled and analyzed, the Immunization Branch will develop a plan to alleviate those barriers.

A second initiative related to the 4th DTaP is the multi-media immunization campaign launched late 2007. In 2008, the focus is on primary care providers (physicians, nurse practitioners, etc.) and day cares. The campaign highlights the need to assess, vaccinate and document, and is using ads in journals, mass mailings, written materials to be distributed through the office settings, and videos in English and Spanish.

Recent legislation authorizes the use of ImmTrac, the statewide immunization registry, as a statewide reporting and tracking system for medication, antiviral, and vaccine administration during emergency events. Also, the implementation of the “Texas Vaccine Education Online” program was announced. The web-based education site provides access to a collection of 21 immunization-related educational modules. Topics include an ImmTrac overview, childcare immunization requirements, vaccine preventable diseases, and many others. The site can be accessed at: www.dshs.state.tx.us/immunize.

Two exciting opportunities for TISWG were also unveiled. The first was the development and implementation for study of a core curriculum on immunizations for Medical Assistants in Texas. Medical Assistants have the highest level of contact with pediatric patients and their families in primary care settings, yet they have minimal vaccine knowledge. The results of this initial study found that by integrating the Texas Medical Assistant program curriculum, knowledge and attitudes related to vaccines increased. The potential benefits of incorporating core immunization curriculum into Medical Assistant education would include increased vaccine rates, promotion and reminders to parents, safer vaccine administration, and prolonged life expectancies.

The second exciting opportunity was the report that representatives from DSHS and TISWG have been working with the “Immunisation Alliance of Western Australia” to establish a consortium in Western Australia based on the TISWG model. TISWG goes international!

These are busy times for TISWG and its collaborative members. The Texas Nurses Association remains committed to the Group and the work it is doing to improve the health of all Texans.

Website Resources
DSHS Immunization Branch: http://www.ImmunizeTexas.com
TISWG: http://www.dshs.state.tx.us/immunize/partners/tiswg.shtm
A Common Thread 2008
Clinical & Practical Tools for Supporting Human Resilience

December 5-6, 2008
Westin DFW Airport, Dallas, Texas

Highlights
- Potential for 13.5 total CE hrs (including 4.25 ethics hrs)
- Nursing & social work CE tracks
- Innovative content
- Surviving & thriving with life limiting illness
- Sexuality & sexual dysfunction
- Managing money in a healthcare crisis
- Life habits for improved well-being
- Ethical challenges of caregiving in an aging society
- Practical ethics in everyday practice
- Helping patients communicate effectively with the health care team
- Law, medicine, & ethics as they apply to pain & issues at the end of life
- Confronting biases & disparities in pain management
- Complementary medicine with holistic approaches
- Trade show
- Location convenient to Grapevine Mills Mall

The American Cancer Society, the Texas Partnership for End-of-Life Care, and the Nurse Oncology Education Program invite you to participate in our 5th annual professional education conference, A Common Thread, December 5-6, 2008, in Dallas, Texas. In five short years, A Common Thread has become the premier palliative & end-of-life care conference synonymous with a quality educational experience for Texas health professionals. Continuing education credits will be offered to both nurses & social workers.

Please visit us online at www.toner.org. Online registration available beginning April 15, 2008.

Presented by

Contact: Helen Ross Petty
MMIP & Assoc.
1831 Verbena Drive
Austin, Texas 78750
Phone: 512-590-0975
Fax: 512-331-1479
hpetty@austin.rr.com

Find Nursing Jobs. Post Job Opportunities.

In the TNA Career Center, job seekers can:
- Post an anonymous resume. It's fast, easy and FREE.
- Access premium job postings. Search and submit resumes.
- Receive automated e-mail job alerts based on your own criteria.

Find a great job!

In the TNA Career Center, employers can:
- Post nursing positions.
- Become a featured employer.
- Access a career center tailored for nursing!

Hire and be hired at the TNA Career Center.
www.texasnurses.org
“There aren’t enough caffeinated energy drinks in the world to get me through the overtime I have to work. Instead of limiting hours, they want to lecture us on fatigue.”

TNA’S CONNECTED, SO YOU DON’T HAVE TO BE WIRED.

Too much overtime isn’t safe for nurses or their patients. That’s why in 2001, TNA negotiated hospital staffing rules to improve the practice environment, including policies to limit or eliminate mandatory overtime and floating. Built by Texas nurses for Texas nurses, no other organization knows how to lobby for change in the Texas Legislature like TNA. After all, we’ve been doing it for more than 100 years.
Nurse staffing was affirmed by Texas Nurses Association in 2007 as a critical, top-of-mind advocacy issue with which most nurses identify.

In multiple, TNA-held focus groups during the summer of 2006, participants identified that staffing continues to be a primary issue for direct care nurses. Participants were unaware of, or did not understand, hospital licensing rules (in place since 2002) concerning nurse staffing.

Additionally, one of the advocacy processes available to nurses in Texas concerned about safe staffing—Safe Harbor Nursing Peer Review—was viewed by some nurses as cumbersome to evoke. Through its strategic planning efforts, the TNA Board of Directors identified that this issue demanded focused attention in 2008, and appointed a Staffing Committee to:

1. Serve as the oversight body for TNA’s grant from the Center for American Nurses to produce resources for direct care nurses related to understanding staffing regulations and identifying strategies for self advocacy;
2. Review research and studies concerning outcomes related to staffing;
3. Identify areas of research still needed to complete the picture of how outcomes are related to staffing; and
4. Identify innovative ways staffing might be addressed with an unstable nurse workforce.

Much of the work of the Staffing Committee is included in this publication of the TEXAS NURSING Voice and addresses these objectives.

The Committee conducted a thorough literature review, including two summary analyses by Kane, et al., and Unruh. The information was conclusive that a multiple of variables impact staffing and outcomes, not merely nurse-to-patient ratios. The Committee worked to create a model that would represent a picture of these variables and their inter-relationships, all of which must be considered in staffing to provide the right care to the right patient, at the right time. That model is presented as Figure 1 in the Staffing CNE (see page 18).

The Staffing Committee will propose a resolution on staffing to the TNA House of Delegates in April in support of evidence-based approaches to staffing plans. The resolution reflects the research of the Committee and affirms the critical nature of “right” staffing resources. It directs TNA to advocate for and support the role of the direct care nurses in development, implementation and evaluation of staffing plans.

TNA recognizes the members of the committee for their commitment and contributions:

- Mary Robinson, PhD, RN-BC—Chairwoman
  Harris Methodist Southwest
  Fort Worth
- Viola L. Hebert, MA, BSN, RN
  Harris County Hospital District
  Tomball
- Mari Grace Cuellar, BSN, RN
  Christus Spohn Hospital Beeville
  Beeville
- Candice Ward Herman, MSN, RN, CNA, BC
  Memorial Hermann Baptist Hospital
  Beaumont
- Martha Helen Myers, RN
  St. David’s North Austin Medical Center
  Austin
- Judith Ann Krupala, RN
  Cuero Community Hospital
  Cuero
- Denise Neill, PhD, RN
  University of Houston—Victoria
  Victoria
- Elizabeth Sjoberg, JD, RN
  Texas Hospital Association
  Austin
- Wilma Stuart, PhD, MA, RN
  Shannon Medical Center
  San Angelo, TX

★
Earn FREE CNE Credit!

Requirements for Successful Completion

1. Read the article.
2. Take the test on page 22, and complete the Registration/Evaluation Form. To receive CNE Certificate of Successful Completion, mail the completed form WITH A SELF-ADDRESSED STAMPED ENVELOPE to: Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin, TX 78757 OR
3. To take the test ONLINE, go to http://tnacne.texasnurses.org and follow the prompts to submit your test answers, complete registration/evaluation form, and print your CNE certificate for 1.0 Contact Hour.
4. In order to receive the 1.0 contact hour, you must pass the test with 80% or greater.
5. DEADLINE for submitting is October 1, 2008.

Accreditation

The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Disclosure to participants

• Successful completion: Once successful completion is verified, a “Certificate of Successful Completion” will be awarded for 1.0 Contact Hour.
• Conflict of interest: A conflict of interest occurs when an individual has an opportunity to affect or impact educational content with which he or she may have a commercial interest of financial relationship. All planning committee members and presenters are required to disclose any potential or actual conflicts of interest with any commercial entity that may have an interest in the activity’s educational content. The planners and presenter of this CNE activity disclose that they are employed by the Texas Nurses Association.
• Commercial support: This activity does not receive any commercial support.
• Non-endorsement of products: TNA/F’s ANCC accreditation status refers to the continuing education activity only and does not imply either TNA/F’s or ANCC’s real or implied endorsement of any product, service, or company referred to in this educational activity.
• Off-label product use: This educational activity does not include any information about off-label use of a product.

Questions?? Email cne@texasnurses.org or phone 512-452-0645.

Educational goal/purpose

The purpose of this educational activity is to promote an understanding of Texas regulations that support nurse self and patient advocacy related to patient assignments.

Learning objectives

Upon completion of this learning activity the nurse should be able to:
1. Identify provisions in the Texas Hospital Licensing Rules, Texas Nursing Practice Act, and Texas Board of Nursing Rules that govern nurse staffing, safe harbor, and whistle blower protections.
2. Discuss factors influencing the nurse-patient assignment within a hospital setting.
3. Describe a process for voicing and resolving concerns regarding patient assignments.
4. Outline the steps for declaring safe harbor and subsequent process for resolution.

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

Introduction

The approximate 280,000 registered nurses (RN) and licensed vocational nurses (LVN) practicing in Texas all practice under the authority of the Texas Nursing Practice Act (NPA), Chapter 301 of the Texas Occupations Code. The NPA defines the practice of nursing, including standards of practice and unprofessional conduct. The Texas Board of Nursing (BON) is the oversight agency for nurses and requires that licensed nurses be knowledgeable about laws governing their practice (Rule 217.11).

This continuing education module discusses the rules and regulations affecting nursing practice, particularly the nurses’ responsibility and authority to advocate for patients, as well as themselves. These requirements are included in the Hospital Licensing Rules (Section 133.41(o) of the Department of State Health Services Rules), Nursing Peer Review Law (Section 303.005), the Nursing Practice Act (Section 301.352), and BON Rules.

Background

Concerns around patient assignments often grow out of concerns about staffing. Ask an acute care nurse about her number one practice concern and “safe staffing” is the predictable response. Nurses at all levels of the organization—direct care, as well as administrative—share concerns about safe staffing because of the value they place on providing quality care to patients. Why, then, are there differences and conflicts about what constitutes “safe staffing” when all nurses want the same thing: quality patient care?

(Continued on page 16)

† NOTE: This CNE is based on the republished rules which are expected to be adopted without additional changes on April 17, 2008. Revisions to the BON Rule 217.20 on Safe Harbor Peer Review were recommended by the Board’s Nursing Practice Advisory Council and were published for public comment in the Texas Register in November 2007. In response to comments received, the Board made significant changes to the proposed rules, and republished them in the Texas Register on February 15, 2008 for additional comment.
Despite growing interest and research linking staffing and patient outcomes, hard and fast rules for staffing have not been identified by research. American Nurses Association (2005) offers Principles for Nurse Staffing (see Table I) which suggest that staff, patient, and organizational variables need to be considered in nurse staffing. In a meta-analysis of 28 studies examining the relationship between nurse staffing and patient outcomes, Kane and colleagues (2007) conclude that there is a clinically and statistically significant relationship between RN staffing and patient outcomes, however, an optimal staffing level could not be defined (see related article, page 8). Likewise, Unruh (2008) conducted a review of recent research linking nurse staffing and patient outcomes, concluding that the nursing workload—not merely number of assigned patients—was critical to achieving positive nurse and patient outcomes.

Eight patients may be equally divided between two nurses, and still not achieve a balanced workload that enables each nurse to appropriately respond to his/her four patients. Depending upon the nature of the patients’ care requirements and the nurses’ skill, experience, and knowledge base, a more appropriate and clinically effective strategy may be for one nurse to assume care for five of the more stable patients and one nurse to provide for the three remaining patients with greater nursing care needs. Rules that prescribe strict numbers for nurse-patient assignments fail to account for such variables impacting the appropriateness of an assignment.

Complex and interactive factors such as the environment, hospital culture, nurse characteristics, and patient volume, create unique situations that demand judgment and flexibility in determining appropriate staffing and assignments. A “one size fits all” staffing model fails to consider these complex issues. So, how can appropriate staffing levels be designed?

Case Study #1:
Carrie began her nursing career two years ago as an RN on 3 North, a general surgical unit. When she interviewed for a position, she took a list of questions with her, as her professor advised. Included on that list was, “What is the staffing plan for the unit?” The unit manager interviewing her was able to describe to her satisfaction a typical patient care assignment and available support staff and resources, so she took the job. Although Carrie has been frustrated when staffing is tight due to an uncovered sick call, she has always felt confident in her ability to provide required care to her patients.

Requirements for Texas Hospitals
In Texas, hospital nursing services are required to have a staffing plan for the provision of care to patients. A staffing plan defines the number and types of staff (skill mix) that the hospital intends to provide to care for a certain number, type, and acuity of patients. The staffing plan should drive the number of positions needed (e.g., number of staff RNs, LVNs, and CNAs), as well as the scheduling practices for a particular unit (number of nurses scheduled on days/nights, weekdays/weekends). The staffing plan outlines staff resources for anticipated patient needs (number, type, acuity). Actual staffing is adjusted, up or down, when actual patient needs differ from what was expected. Though not ideal, when position vacancies exist or when the volume or acuity of patients present greater care needs than planned, actual staffing may include the use of overtime or

Table I
American Nurses Association Principles for Nurse Staffing


Patient Care Unit Related
• Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient needs.
• There is a critical need either to retire or seriously question the usefulness of the concept of Nursing Hours Per Patient Day (NHPDD).
• Unit functions necessary to support delivery of quality patient care also must be considered in determining staffing levels.

Staff Related
• The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area.
• Registered nurses must have nursing management support and representation at both the operational and executive level.
• Clinical support from experienced RNs should be readily available to those RNs with less proficiency.

Institution/Organization Related
• Organizational policy should reflect an organizational climate that values registered nurses and other employees as strategic assets and exhibits a true commitment to filling budgeted positions in a timely manner.
• All institutions should have documented competencies for nursing staff, including agency or supplemental and traveling RNs, for those activities that they have been authorized to perform.
• Organizational policies should recognize the myriad needs of both patients and nursing staff.

(Continued on page 17)
traveler/agency nurses to meet patient demands. However, under the hospital nurse staffing rules, overtime cannot be a planned strategy for meeting staffing needs. Floating of appropriately trained staff may also be necessary to ensure adequate staffing.

In 2002, the Texas Department of State Health Services (TDSHS) detailed specific requirements for hospital staffing by adopting a new rule [Section 133.41(o)] herein referred to as the hospital nurse staffing rules. These rules require staffing plans to be written and based on standards of care (view the actual rule on TNA’s Web site http://www.texasnurses.org/displaycommon.cfm?an=1&subarticlenbr=244).

Recognizing that the processes for staffing and making patient assignments are complex, the rules demand consideration of critical factors affecting the ability of a nurse to effectively carry out a patient assignment.

These critical factors include patient characteristics, patient intensity, scope of services, context of care, and nursing characteristics (see Table II—Factors Affecting the Nurse-Patient Assignment). An unlimited number of combinations, interactions and variations of factors are possible—e.g., a particular group of patients on one hospital unit requires “X” number of nurses because of the geographical layout of the unit, location of supplies, availability of support services and resources, and experience of staff; the same group of patients in another hospital with different geography, resources, and staff characteristics may require “Y” number of nurses to achieve the same level of quality care.

Table II
Factors Affecting the Nurse-Patient Assignment

<table>
<thead>
<tr>
<th>Environment:</th>
<th>Community: Nurse shortage, payment systems, population characteristics (health, economic, social, ethnic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital:</td>
<td>Mission and values, occupancy levels and fluctuations, programs and services offered, vacancy and turnover rates, staff characteristics, financial health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Scope of Services</th>
<th>Context of Care</th>
<th>Nurse Characteristics</th>
<th>Staffing Plan</th>
<th>Nursing Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acuity/Severity of illness</td>
<td>• Variability of patients across the unit</td>
<td>• Physical environment</td>
<td>Individual:</td>
<td>Budgeted and intended number and type of staff for a certain number and type of patients for a certain period of time.</td>
<td></td>
</tr>
<tr>
<td>• Intensity of care required</td>
<td>• Turnover: number of admissions, discharges, length of stay</td>
<td>• Unit geography</td>
<td>• Educational preparation</td>
<td>• Nursing philosophy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Kinds of treatment/procedures provided on unit</td>
<td>• Distribution of patients</td>
<td>• Experience</td>
<td>• Principles of model (e.g., continuity of assignment)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Availability of technology</td>
<td>• Specific competencies</td>
<td>• Team, primary, functional, blended</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unit culture (are you on your own, or does the team help each other out?)</td>
<td>• Familiarity with the unit and patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staff overall:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number of new grads vs. experienced nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number of floated staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number of agency/traveler staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number of staff working overtime</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Staff mix (RNs, LVNs, CNAs, secretary, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Number of students, preceptees, orientees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The factors themselves are also dynamic: changes in patient condition affect intensity of care required; unexpected admissions from the emergency department change resource demands; changes in availability of equipment or supplies may impact the time needed to provide care. This variability is embedded in a community and hospital environment which

(Continued on page 18)
further influences the nurse-patient assignment and outcomes of care. The relationship of all of these variables is depicted in Figure 1: Individualized Patient Staffing Model which was developed by the Texas Nurses Association’s Staffing Committee (see related article, page 14). Nurse administrators need to consider all these variables, as well as the interaction of variables, when establishing a staffing plan and determining staffing levels for patient care units.

But, what if a nurse believes the staffing levels are not adequate?

**Case Study #1—continued:**

Recently, a surgeon began using a high-risk surgical procedure for terminal oncology patients. Although Carrie had attended the unit in-service and completed the competency, she found it challenging to manage her patient assignment when it included one of these particular patients as they tended to be much more unstable than the unit’s general population. She believed the overall patient assignment should be lighter, in acuity or number, when these particular post-op patients were included. She raised this concern to Marcia, a staff nurse who represents med/surg units on the Nurse Staffing Advisory Committee.

The Texas Hospital Nurse Staffing Rules require hospitals to establish a Nurse Staffing Advisory Committee (“Staffing Committee”), responsible for “soliciting and receiving input from nurses on the development, ongoing monitoring, and evaluation of the staffing plan” [Hospital Licensing Rules, Section 133.41(o) (2)(H)]. Direct care RNs, nurses who spend at least 50% of their work time directly caring for patients, must comprise at least 50% of Staffing Committee membership.

Hospitals are required to utilize the Staffing Committee to identify and respond to concerns about the adequacy of staffing, and must provide feedback to nurses on how concerns are addressed. Individual hospitals are to establish policies and procedures for the functioning of the Staffing Committee and to orient all nurses to the process for reporting concerns about staffing. All hospitals must be licensed, therefore all acute care hospitals must have a Staffing Committee. If you are not familiar with your hospital’s Staffing Committee, or how to raise concerns about staffing, speak to your manager.

Nurses who have reasonable cause to believe that the staffing situation exposes patients to a substantial risk of harm by not conforming to regulatory or accreditation standards, may report their concerns to the TDSHS, [http://www.dshs.state.tx.us/HFP/complain.shtm](http://www.dshs.state.tx.us/HFP/complain.shtm), who oversees hospital adherence to licensing rules, and, for

(Continued on page 19)
accredited hospitals, to The Joint Commission (http://www.jointcommission.org). Individuals making a report in good faith within the facility or to outside regulatory or accrediting agencies such as TDSHS or The Joint Commission are protected from retaliation or discrimination for making a report (NPA Sections 301.4025 & 301.413; Health and Safety Code, Section 161.143). These regulations are known as ‘whistle-blower protections.’

**Case Study #1—continued:**

Marcia, Staffing Committee member, heard similar concerns from two other nurses in addition to Carrie, staff nurse. Eric, the nurse manager, was aware of staff concerns and noticed an increased incidence of medication errors for this group of high-risk patients. He wonders if the errors might be related to the high acuity of these patients, which had not been fully anticipated. Eric speaks with the director of quality improvement who sits on the Staffing Committee and requests that she take his data to the committee meeting and evaluate adequacy of staffing when several of these high-risk patients are on the unit.

The Staffing Committee meets, reviews the concerns and med error data, and recommends that individual assignments be adjusted to account for the high patient acuity. Eric meets with his clinical director to work out a plan to adjust individual assignments, and staffing when needed, to ensure staffing resources are better matched for the needs of these special patients. Eric will continue to monitor medication errors and staff satisfaction to see if these changes have the desired effect. Eric and Marcia then report the Staffing Committee’s recommendation and Eric’s action back to Carrie.

Because adequate staffing is critical to patient care and outcomes of that care, the Nurse Staffing Advisory Committee is also responsible for evaluating the effectiveness of the staffing plan itself. When actual staffing levels are not consistent with the staffing plan, variance reports are considered by the Committee. Additionally, specific outcomes such as nursing-sensitive patient outcomes (e.g., falls, pressure ulcers, infections) and operational outcomes (e.g., work injury rates, staff turnover rates) must be correlated to the staffing plan and included in the evaluation (see Table III—Outcomes of Care).

The hospital is accountable for an effective staffing plan—one that provides the number, competency, and skill mix of staff to meet the needs of its specific patient population within its unique environment. Effective means that patients receive the level of care they require. Poor patient outcomes may indicate that the staffing plan has not adequately addressed patient needs.

**Nurses’ Duty to the Patient**

Direct care nurses are in a position to determine patient care needs through their assessment of the patient and development of a plan of care. Direct care nurses understand their duty to the patient based on this assessment and plan, and Standards of Nursing Practice. The Standards of Nursing Practice (BON Rule 217.11) and Unprofessional Conduct (Rule 217.12) outline the minimum acceptable standards expected of a nurse. They reflect the nurse’s direct duty to the patient which always supercedes the nurse’s responsibility to the facility. Failure to meet standards may result in action against the nurse’s license.

The Standards of Nursing Practice include responsibilities of the nurse (RN and LVN) such as:

- Knowing and conforming to applicable laws.
- Implementing a safe practice environment.
- Providing accurate and complete documentation.
- Respecting patient rights to privacy and confidentiality.
- Participating in patient/family education and counseling.
- Obtaining instruction/​supervision as necessary.
- Obtaining orientation/​training for unfamiliar care situations/​equipment.
- Notifying the appropriate supervisor when leaving a patient assignment.
- Maintaining professional boundaries of the nurse-patient relationship.
- Reporting unsafe care.
- Providing nursing services without discrimination.
- Instituting appropriate interventions to stabilize condition or prevent complications.
- Clarifying orders.
- Implementing measure to prevent exposure to infections.
- Collaborating with the patient and health care team.
- Consulting and making referrals to community agencies for continuity of care.
- Being responsible for own continuing competence and professional growth.
- Making assignments that consider patient safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made.
- Accepting only those nursing assignments that take into consideration patient safety and that are commensurate with educational preparation, experience, knowledge, and physical and emotional ability.

These standards apply to all nurses: supervisory and direct care. Additional standards specific to the LVN scope of practice include:

- Assisting in the determination of predictable health care needs of clients within health care settings.
- Utilizing a systematic approach to provide individualized, goal-directed nursing care.
- Assigning specific tasks, activities and functions to unlicensed personnel commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made and maintaining appropriate supervision of unlicensed personnel.
- Performing other acts that require education and training as prescribed by

(Continued on page 20)
Staffing: Strategies for Self and Patient Advocacy
(Continued from page 19)

board rules and policies, commensurate with the LVN’s experience, continuing education, and demonstrated licensed vocational nurse competencies.

The BON also defines unprofessional conduct (Rule 217.12). Unprofessional conduct includes dishonorable behaviors which are likely to deceive, defraud, or injure patients or the public, such as: failure to comply with accepted standards, improper oversight/supervision, misconduct (falsifying records, patient neglect or abuse, violating professional boundaries), false employment information, diverting narcotics, criminal conduct, etc. The BON can take action against a nurse’s license for engaging in unprofessional behaviors.

Case Study #2
George has worked on the telemetry unit of a community hospital for just over a year. He was recently accepted to the critical care internship program offered by the hospital and can’t wait to begin the experience. When he reports to work the night shift, Kaye, the supervisor, informs him that he will be floated to the ICU because they are short staffed. He is anxious but decides that he will give it his best shot—“a tele nurse may be better than no nurse,” he tells himself. When he arrives, the charge nurse, Tom, tells him that he will have to take two, fresh post-op CABG patients. “You’ll have plenty of other nurses to help you out if you need it,” Tom says.

George is very uncomfortable with the assignment and believes the assignment would violate his duty to the patient because he lacks knowledge and experience with critical patients. He believes the assignment would place the patients at risk and tells Tom that he wants to request “safe harbor.” George writes his request on the back of a physician’s progress note. See Figure 2: George’s Request for Safe Harbor.

Role of Safe Harbor Nursing Peer Review
So what happens if a nurse believes his patient assignment may violate his duty to the patient? If a nurse believes, in good faith, that s/he is being asked to accept an assignment that would violate his/her duty to the patient, the nurse may request Safe Harbor Nursing Peer Review (see Table IV—About Safe Harbor). Good faith means the action is supported by a reasonable factual or legal basis; facts surrounding the situation are not misrepresented and the person is not acting out of malefic, personal animosity, or a conflict of interest. Safe Harbor is a process that protects the nurse from employer retaliation and licensure sanction when making a good faith request for nursing peer review of an assignment because the nurse believes that accepting the assignment would result in violation of the nurse’s duty to the patient. The nurse’s duty to the patient is defined in the Standards of Nursing Practice and definition of unprofessional conduct (above).

The nurse has the right to refuse to engage in certain conduct while awaiting the Safe Harbor Nursing Peer Review Committee’s determination. A decision to refuse must be based upon the belief that no reasonable nurse would engage in the conduct (accept the assignment), as in for instance:

Situation A—the nurse is unable to provide the care requested at a minimally competent level such that the patient(s) would be exposed to an unjustifiable risk of harm; or

Situation B—the requested behavior would constitute unprofessional or criminal conduct such as fraud, theft, patient abuse, falsification.

If a nurse refuses an assignment because it is beyond the nurse’s scope, the nurse and supervisor must collaborate and attempt to reach agreement on an acceptable assignment. One of the goals of Safe Harbor Nursing Peer Review is to promote communication and problem solving around patient assignments to achieve mutually satisfactory outcomes that enhance the delivery of safe patient care.

George’s Request for Safe Harbor
2/12/08 1850 When I arrived at work today, Kaye Olsen RN supervisor told me to float to the ICU. I’ve been there, Tom Chang RN charge nurse gave me an assignment of 2 fresh post-op CABG patients. I am a tele nurse and have never taken care of an ICU patient, let alone a fresh CABG which are very unstable. I have not been oriented to the ICU and am not a competent ICU nurse. I believe this assignment would place these patients at risk for harm because I do not have the knowledge or skill to care for them. I believe by accepting this assignment I would violate my duty to the patient.

George Medina RN

Figure 2: When requesting Safe Harbor, a nurse who believes a particular patient assignment may violate his/her duty to the patient should provide the individual who made the assignment with a written request for Safe Harbor, such as demonstrated above in George’s Request for Safe Harbor.

Table IV
About Safe Harbor

Safe Harbor must be requested prior to engaging in the assignment (conduct) and at one of the following times:

1. When the assignment is made.
2. When the initial assignment changes to the point that the nursing care or supervision now required are so different from the original assignment that the nurse believes in good faith that patient harm may result (e.g., after a nurse accepts a patient assignment, a post-op patient becomes severely hypotensive requiring rapid infusion of fluids and transfusion of several units of blood. Because of the unexpected monitoring and intervention needs of this patient, the nurse does not believe she can meet the care requirements of all the patients originally assigned to her and fears that patient harm may result. She requests Safe Harbor and the charge nurse adjusts her assignment by assuming care for two of her other patients.)
3. When the nurse refuses to engage in the assignment.

Some behaviors, such as those in Situation B, explicitly violate stated conduct standards. For example, any reasonable nurse would consider conduct such as patient abuse as unprofessional conduct in violation of their duty to the patient, and would refuse to engage in the conduct. However, there are situations in which reasonable nurses might differ about what is their duty to the patient (Situation A)—Safe Harbor Nursing Peer Review was designed for just these situations.

In the nursing peer review process, a committee of nurses reviews the specific situation and decides as to the nurse’s duty to the patient in that particular circumstance. Unless any reasonable nurse would agree that the request places patients at an unjustifiable risk of harm, or the request is consistent with unprofessional conduct, the nurse may engage in the behavior with the protection of Safe Harbor awaiting the Nursing Peer Review
Committee’s determination. Normally, it is in the patient’s best interest for the nurse to accept the assignment with Safe Harbor protection.

If the Nursing Peer Review Committee determines that the behavior does indeed violate the nurse’s duty to the patient, the protections of Safe Harbor expire and the nurse must cease the behavior within 48 hours of notification of the decision; that is, the nurse should refuse to continue to engage in the behavior. If the Committee determines that the behavior does not violate the nurse’s duty to the patient, the nurse may continue to engage in the conduct.

A nurse who believes that a particular patient assignment may violate his/her duty to the patient may refuse Safe Harbor Nursing Peer Review by providing the individual who made the assignment with a written request (see Table V—Requesting Safe Harbor). A request for Safe Harbor is intended to stimulate dialogue, problem solving, and identification of alternatives that settle the nurse’s concerns, and enable patients to be safely cared for. Strategies that may promote a mutually satisfactory solution include clarifying expectations, modifying the assignment, or providing additional resources.

Case Study #2—continued:

One outcome—Tom notifies Kaye that George refused his assignment. Kaye directs Tom and George to meet her in the ICU conference room. Kaye listens to George’s concerns and agrees that the assignment as proposed is not suitable. Kaye requests that the ICU staffing and patient assignments, and identifies an opportunity to change assignments such that George would be assigned two R/O MI patients who were to be transferred to tele as soon as beds become available.

Kaye also identifies a resource nurse to assist George within the ICU environment. George no longer believes the assignment violates his duty to the patients, and he accepts the assignment and withdraws his request for Safe Harbor. The supervisor documents the situation, discussion with George and Tom, and resultant modified assignment agreeable to all parties, and forwards the document to the chair of the Nursing Peer Review Committee.

But, suppose the case study played out differently…

Alternate outcome—Tom notifies Kaye, nursing supervisor, that George refused his assignment. Kaye directs Tom and George to meet her in the ICU conference room. Kaye listens to George’s concerns and looks over the ICU staffing and patient assignments. She reassigns one of the CABG patients to Tom, who now has two unstable patients in addition to charge duties. Kaye tells George, “That’s the best I can do,” and that he will have to care for the remaining patient. George does not believe he is able to provide care at a minimally competent level and that the assignment places the patient at an unjustifiable risk of harm. He believes by accepting the assignment he would violate his duty to the patient. He speaks to the ICU nurse from the previous shift regarding his concern and she agrees that the patient care needs of the particular patient would be “way over his head.” He maintains his request for safe harbor, refuses the ICU assignment, and offers to float to another unit.

In the second scenario, a mutually acceptable solution is not reached and the nurse decides not to engage in the assignment while awaiting the Nursing Peer Review Committee’s determination. A decision to not engage in requested conduct while awaiting peer review should not be made lightly, and it is recommended that the nurse validate his belief with another “reasonable nurse” whose judgment he respects.

George is legally protected from retaliation for requesting safe harbor in good faith. However, if George does not engage in the assignment while awaiting nursing peer review, he could be at risk of personnel action for his decision if the Nursing Peer Review Committee disagrees with him and determines that the request did not violate his duty to the patient. For this reason, unless the request constitutes unprofessional conduct, the nurse and patient are usually better served by an acceptance of the original or modified assignment under Safe Harbor Nursing Peer Review protections. If the Nursing Peer Review Committee agrees with George, and determines that the request did violate his duty to the patient, the nurse administrator would have difficulty substantiating personnel action against George.

Because of the potential risk for both nurse and patient that is normally associated with a nurse’s decision to not engage in an assignment awaiting peer review, the BON proposed rules that specifically require the nurse and supervisor to collaborate in attempting to identify an acceptable assignment. The results of this collaborative effort must be documented and maintained in the nursing peer review records. The first outcome scenario for Case Study #2 represents a successful example of this process. Circumstances in which a nurse feels the need to request Safe Harbor when given an assignment often reflect other situations in which implementation of the staffing plan failed—e.g., “short staffing” due to uncovered sick calls, existing vacancies, number or acuity of patients that exceed available staffing resources, etc. Ongoing feedback from direct care nurses to the Nurse Staffing Advisory Committee as to the adequacy and effectiveness of the staffing plan will assist the committee in evaluating whether the staffing plan is achieving intended results: quality patient outcomes and staff satisfaction. Information regarding the changing nature of the patient population that may affect patient care requirements and outcomes, as discussed in Case Study #1, is very important for Staffing Committee consideration. Also, changes in staff composition—new hires, new grads, new procedures/equipment requiring new competencies—will impact adequacy and effectiveness of staffing levels.

Summary

Advocacy is central to the nurse’s role. Provision 3 of the Code of Ethics for Nurses with Interpretive Statements states: “The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.” As advocates, nurses have a duty directly to the patient. This duty is further outlined in the BON Standards of Nursing Practice and requires the nurse to use judgment in making and accepting assignments that consider patient safety and are commensurate with the nurse’s knowledge, experience, and ability.

Texas has a number of rules and regulations governing nursing practice in the hospital environment. The Texas staffing rules direct hospitals to consider the complex factors that determine adequate and effective staffing in

(Continued on page 22)
each unique hospital environment. Nurses have a formal mechanism to advocate for appropriate staffing within their facility through the Nurse Staffing Advisory Committee. Nurses have a formal mechanism to protect their employment and licensure through Safe Harbor Nursing Peer Review in situations where they believe their duty to the patient may be threatened. In addition, if these internal mechanisms fail to resolve concerns, nurses may report staffing concerns to TDSHS and The Joint Commission (for accredited hospitals) for further scrutiny. Nurses have a responsibility to their patients to utilize these mechanisms—on a short-term basis to ensure their duty to the patient is protected, and for the long term to promote the improvement in the quality and effectiveness of staffing plans. ★

References

Test for CNE Credit
Staffing for Self and Patient Advocacy

1. What regulation defines nursing practice in Texas and provides nurses with the authority to practice nursing?
   a. Code of Ethics for Nurses
   b. Texas Nursing Practice Act
   c. Texas Board of Nursing
   d. Texas Nurses Association

2. Research examining the relationship between nurse staffing and patient outcomes...
   a. reveals the need for a defined staffing plan with a specific skill mix (RNs, LVNs and CNAs)
   b. specifies an ideal RN-to-patient ratio to achieve optimal patient outcomes
   c. demonstrates a significant relationship between RN staffing and patient outcomes but fails to define optimal staffing levels
   d. cannot support the development of staffing plans to achieve quality patient outcomes

3. A nurse staffing plan...
   a. represents the intended number and type of staff for a certain number and type of patients
   b. assists managers in planning the number of staff to be scheduled each shift and day
   c. is required by hospital licensing rules
   d. all of the above

4. The Texas licensing rules require hospitals to consider which of the following critical factors in developing nurse staffing plans?
   a. patient acuity, physical environment, experience of staff
   b. turnover of patients, availability of support staff, scope of services provided
   c. number of nurses, number of patients
   d. all of the above

5. Texas licensing rules require acute care hospitals to establish a Nurse Staffing Advisory Committee for all of the following functions EXCEPT:
   a. determine staff needs for individual units
   b. consider the relationship between staffing and patient outcomes
   c. solicit and respond to concerns of staff about the adequacy of staffing
   d. provide feedback to nurses as to how their concerns are being addressed

6. Nurses who believe their staffing concerns have not been adequately addressed by the Nurse Staffing Advisory Committee may report their concerns directly to:
   a. the unit manager/director
   b. The Joint Commission
   c. the Texas Department of State Health Services
   d. all of the above

7. The nurse's duty to accept only those assignments that are consistent with the nurse's educational preparation, experience, knowledge, and physical and emotional ability is an example of:
   a. The Joint Commission accreditation standards
   b. Hospital licensing rules
   c. Standards of Nursing Practice
   d. Texas State Department of Health Services rules

8. All of the following statements regarding safe harbor are true, EXCEPT:
   a. a nurse may not be retaliated against for requesting safe harbor
   b. safe harbor applies only to RNs
   c. the nurse must evoke safe harbor before engaging in the assignment
   d. safe harbor protects the nurse from discipline by the facility and the Board of Nursing

9. A nurse may declare safe harbor:
   a. if at least 10 nurses are employed by the facility
   b. if the nurse believes the assignment or request would violate the nurse's duty to the patient
   c. if the request is made in "good faith"
   d. all of the above

10. A nurse should refuse an assignment, or to engage in requested conduct, after requesting safe harbor when:
    a. the nurse feels overwhelmed with the assignment or request.
    b. the assignment or request is made by someone who does not understand the special circumstances making it inappropriate.
    c. the requested behavior would constitute unprofessional or criminal conduct.
    d. all of the above
1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D
9. A B C D
10. A B C D

**Passing grade of 80% is achieved on the post-CNE test, certificates of successful completion will be sent in 4 to 6 weeks.**

**Staffing: Strategies for Self and Patient Advocacy**

**TEST QUESTION ANSWER/REGISTRATION/EVALUATION FORM**

Send by mail with a self-addressed stamped envelope or complete online and print certificate of successful completion at http://tnacne.texasnurses.org.

**TEST QUESTION ANSWERS** (circle answer)

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D
9. A B C D
10. A B C D

**ACTIVITY EVALUATION**

**Purpose of this activity:** The purpose of this educational activity is to promote an understanding of Texas regulations that support nurse self and patient advocacy related to patient assignments.

Please complete this evaluation questionnaire. Your responses will be used to revise this activity and to plan future educational activities. Circle the number/response that best fits your evaluation of the activity.

1 = Not at all  2 = Somewhat  3 = Almost completely  4 = Completely

1. Rate your achievement of these objectives:
   a. Identify provisions in the Texas Hospital Licensing Rules, Texas Nursing Practice Act, and Texas Board of Nursing Rules that govern nurse staffing, safe harbor, and whistle-blower protections.
   b. Discuss factors influencing the nurse-patient assignment within a hospital setting.
   c. Describe a process for voicing and resolving concerns regarding patient assignments.
   d. Outline the steps for declaring safe harbor and subsequent process for resolution.

2. Rate the effectiveness of the teaching/learning materials.

3. Were the objectives relevant to the overall purpose?

4. How long, in minutes, did it take you to complete this activity? (Circle one)
   0-30 minutes
   31-60 minutes
   61-90 minutes
   More than 90 minutes

5. List two (2) ways you will integrate what you learned in this activity into your practice and/or employment environment.

6. Were the following disclosed prior to the beginning of this activity?
   a. Requirements for Successful Completion
   b. Conflicts of Interest
   c. Commercial Support
   d. Non-Endorsement of Products
   e. Off-Label Use of Products

   Yes No

7. Did you notice any bias that was not disclosed in this activity? If "Yes," please describe:

   Additional comments:

---

**REGISTRATION INFORMATION**

Name:

Address:

City: State: ZIP:

Phone:

Date of Birth (MM/DD): ___/___/_____

E-mail:

Check one: __ RN  __ LVN  __ Student  __ Other:

Mail this completed form to:

Texas Nurses Association
7600 Burnet Road, Suite 440
Austin, Texas 78757

Please include a self-addressed, stamped envelope. If all fields are completed on the form and a passing grade of 80% is achieved on the post-CNE test, certificates of successful completion will be sent in 4 to 6 weeks.
New Trends in Foreign Nurse Recruitment

By Diane E. Scott, RN, MSN
Reprinted with permission from the Center for American Nurses*

Last year, the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, released the 2004 National Sample Survey of Registered Nurses, which collected data on the actively licensed Registered Nurse population as of March 2004. This most recent edition of the survey revealed that over 100,791 (3.5 percent) of the Registered Nurses (RNs) practicing in the United States received their basic nursing education outside of the U.S. While this percentage reflected only a slight increase since 2000, foreign-educated nurses are now licensed in all 50 States and the District of Columbia.

According to the American Hospital Association, 17% of hospitals recruit from abroad to fill nursing vacancies. While the percentage of hospitals looking toward employing foreign-educated nurses (FENs) as part of the solution for the nursing shortage is increasing, questions still arise over the best means to recruit and orient this unique nursing population.

To address some of these issues, the Center for American Nurses interviewed Wanano “Winnie” Fritz, RN, MS, the Chief Nursing Officer and Director of International Operations of HCCA International, a company which specializes in international nurse recruitment and hospital management.

Ms. Fritz’s experiences, both domestic and international, have given her a wealth of cultural and clinical expertise in nursing and management roles in the United States, Thailand, Germany, Russia, and Vietnam. Notably, she was employed for nearly 17 years by King Hussein of Jordan as both the Dean of a School of Nursing and a Health Systems Planner before joining HCCA in 2005.

The Center: Are there ethical issues involved with recruiting foreign educated nurses?

Ms. Fritz: The answer is yes, there can be ethical concerns for both the nurse and the nursing profession. Professional nursing organizations appropriately caution us to not deplete resources in specific countries where there are already serious shortages. For example, in the U.S., we have 8-10 RNs per 1000 population. In South African nations, there are only 1 to 1000. But as a general position, the International Council for Nursing states: “Nurses have a right to migrate and denounces unethical recruitment.” In addition many of the foreign-educated nurses genuinely want to work in the United States.

The Center: What are the reasons that foreign educated nurses want to come work in the United States?

Ms. Fritz: With the increased accessibility to the internet and other media from the United States, foreign-educated nurses are much more exposed to the potential personal and financial benefits and mechanisms to become a nurse in the United States. Many of the foreign-educated nurses obtain a U.S. nursing license to fulfill multiple professional and personal goals. Numerous foreign-educated nurses desire the opportunity to work in clean, safe high-tech hospitals.

The economic advantage for nurses working in the United States usually goes beyond their personal financial gain; it carries through to their extended families back in their home country. It has been my experience that most foreign educated nurses will send up to 33% of their salary back to their home country to support their parents, siblings, and other family members. The governments of the foreign countries welcome the influx of financial assistance and are often very accommodating in assisting the nurses who are seeking to enhance their careers in the United States.

The Center: Where do most of the foreign-educated nurses come from?

Ms. Fritz: According to the U.S. Department of Health and Human Services, 50% come from the Philippines, 20% from Canada and 8% from the United Kingdom. 22% come from all other sources. In addition, over half of the foreign-educated nurses were estimated to have baccalaureate or higher degrees.

The Center: What are the advantages of hiring a foreign-educated nurse?

Ms. Fritz: Many (FENs) are highly motivated to be a nurse in the U.S. and usually have dedicated from 2 to 4 years of their lives to reach this goal. In addition, the nurse usually has already demonstrated persistence and adaptability in navigating the immigration and licensure processes.

As U.S. hospitals care for an increasingly diverse patient population, the foreign-educated nurse is also an asset as we work to be culturally competent and provide culturally appropriate care. Finally, the foreign-educated nurse can be a more permanent solution than temporary staffing options since many want to integrate permanently into a hospital and community, resulting in retention rates as high as 85%.

The Center: How would a prospective employer approach the recruitment of foreign-educated nurses?

Ms. Fritz: When choosing a recruitment partner, choose carefully. In the past, there were only about 30 or 40 companies recruiting nurses from overseas, now there are over 200. The Joint Commission has implemented a certification process which is helping to address some of the quality issues in selecting a reliable recruiting partner, so I highly recommend making sure the recruitment company is certified.

It behooves a healthcare organization to know how long the agency has recruited internationally and learn how many nurses they have brought to work in the U.S. It is just as important to learn the satisfaction rate of their client hospitals as well as their ethics in their practices. I also believe it is important for a recruiting organization to “give back” to the countries of origin.

Some large healthcare systems recruit directly; but most use third-party recruiters because of the complexity of the credentialing, education, licensure, and immigration processes.

The Center: Are there ethical issues involved with recruiting foreign educated nurses?

Ms. Fritz: The answer is yes, there can be ethical concerns for both the nurse and the nursing profession. Professional nursing organizations appropriately caution us to not deplete resources in specific countries where there are already serious shortages. For example, in the U.S., we have 8-10 RNs per 1000 population. In South African nations, there are only 1 to 1000. But as a general position, the International Council for Nursing states: “Nurses have a right to migrate and denounces unethical recruitment.” In addition many of the foreign-educated nurses genuinely want to work in the United States.

The Center: What are the reasons that foreign educated nurses want to come work in the United States?

Ms. Fritz: With the increased accessibility to the internet and other media from the United States, foreign-educated nurses are much more exposed to the potential personal and financial benefits and mechanisms to become a nurse in the United States. Many of the foreign-educated nurses obtain a U.S. nursing license to fulfill multiple professional and personal goals. Numerous foreign-educated nurses desire the opportunity to work in clean, safe high-tech hospitals.

The economic advantage for nurses working in the United States usually goes beyond their personal financial gain; it carries through to their extended families back in their home country. It has been my experience that most foreign educated nurses will send up to 33% of their salary back to their home country to support their parents, siblings, and other family members. The governments of the foreign countries welcome the influx of financial assistance and are often very accommodating in assisting the nurses who are seeking to enhance their careers in the United States.

The Center: Where do most of the foreign-educated nurses come from?

Ms. Fritz: According to the U.S. Department of Health and Human Services, 50% come from the Philippines, 20% from Canada and 8% from the United Kingdom. 22% come from all other sources. In addition, over half of the foreign-educated nurses were estimated to have baccalaureate or higher degrees.

The Center: What are the advantages of hiring a foreign-educated nurse?

Ms. Fritz: Many (FENs) are highly motivated to be a nurse in the U.S. and usually have dedicated from 2 to 4 years of their lives to reach this goal. In addition, the nurse usually has already demonstrated persistence and adaptability in navigating the immigration and licensure processes.

As U.S. hospitals care for an increasingly diverse patient population, the foreign-educated nurse is also an asset as we work to be culturally competent and provide culturally appropriate care. Finally, the foreign-educated nurse can be a more permanent solution than temporary staffing options since many want to integrate permanently into a hospital and community, resulting in retention rates as high as 85%.

The Center: How would a prospective employer approach the recruitment of foreign-educated nurses?

Ms. Fritz: When choosing a recruitment partner, choose carefully. In the past, there were only about 30 or 40 companies recruiting nurses from overseas, now there are over 200. The Joint Commission has implemented a certification process which is helping to address some of the quality issues in selecting a reliable recruiting partner, so I highly recommend making sure the recruitment company is certified.

It behooves a healthcare organization to know how long the agency has recruited internationally and learn how many nurses they have brought to work in the U.S. It is just as important to learn the satisfaction rate of their client hospitals as well as their ethics in their practices. I also believe it is important for a recruiting organization to “give back” to the countries of origin.

Some large healthcare systems recruit directly; but most use third-party recruiters because of the complexity of the credentialing, education, licensure, and immigration processes.

The Center: Are there ethical issues involved with recruiting foreign educated nurses?

Ms. Fritz: The answer is yes, there can be ethical concerns for both the nurse and the nursing profession. Professional nursing organizations appropriately caution us to not deplete resources in specific countries where there are already serious shortages. For example, in the U.S., we have 8-10 RNs per 1000 population. In South African nations, there are only 1 to 1000. But as a general position, the International Council for Nursing states: “Nurses have a right to migrate and denounces unethical recruitment.” In addition many of the foreign-educated nurses genuinely want to work in the United States.

The Center: What are the reasons that foreign educated nurses want to come work in the United States?

Ms. Fritz: With the increased accessibility to the internet and other media from the United States, foreign-educated nurses are much more exposed to the potential personal and financial benefits and mechanisms to become a nurse in the United States. Many of the foreign-educated nurses obtain a U.S. nursing license to fulfill multiple professional and personal goals. Numerous foreign-educated nurses desire the opportunity to work in clean, safe high-tech hospitals.

The economic advantage for nurses working in the United States usually goes beyond their personal financial gain; it carries through to their extended families back in their home country. It has been my experience that most foreign educated nurses will send up to 33% of their salary back to their home country to support their parents, siblings, and other family members. The governments of the foreign countries welcome the influx of financial assistance and are often very accommodating in assisting the nurses who are seeking to enhance their careers in the United States.
States completes a survey tool to determine how she makes decisions. I want to find out how she will accommodate unconventional and unique patient situations, physician interactions, and peer relations, and having a well designed tool can help predict how they may react when encountering real patient situations in this culture.

While all foreign-educated nurses must also take the NCLEX exam for licensure, simply passing the test does not always determine critical thinking skills. My team uses patient vignettes in our verbal interviews with the nurses to get a much deeper assessment of their ability to critically think through situations. The face-to-face interviews are also very helpful in determining the extent of her English speaking skills as well.

The Center: How can a FEN be best oriented after she arrives to the United States?

Ms. Fritz: The greatest challenge for a foreign-educated nurse is clarity of speech. While all are required to pass an English exam, accent reduction is sometimes also needed. Recruiters and hospitals assist the foreign-educated nurse by coaching her to listen to talk radio and audio books. Preceptors and colleagues can also help by monitoring phone calls or having the foreign-educated nurse take formal accent reduction courses.

As for clinical competencies, it is important to choose a recruitment company that assesses and validates competency of the individual foreign-educated nurse prior to their arrival to the United States, including clinical skills, equipment familiarity, and U.S. cultural practice.

The Center: What about orientation to the community?

Ms. Fritz: The orientation to the community is important and should include, at minimum, securing and settling in a safe, appropriate, and furnished apartment; organizing transportation; teaching shopping, taxes, and banking; and processing payroll and benefits documents. An experienced recruitment company will provide this as well teaching U.S. culture, laws, and manners.

The recruitment and integration of the foreign-educated nurse can truly be a win-win situation for all concerned if the above elements are considered. Foreign-educated nurses benefit from their professional “dreams being fulfilled” and their families receiving funds to improve their lives in the home countries. Our diverse patient populations benefit by the culturally diverse nurse population. And healthcare organizations gain permanent staff members who remain as flexible, confident, and competent nurses.

★

*The Center for American Nurses is committed to helping nurses develop both professionally and personally. The Center offers solid evidence-based solutions-powerful tools-to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Whether it’s learning how to handle conflict, gaining continuing education credits, knowing your legal rights, or skillfully managing your money, The Center’s resources add traction, moving you toward the best life a career in nursing can offer.

New Trends in Foreign Nurse Recruitment
(Continued from page 24)
STEPS FOR JOINING TEXAS NURSES ASSOCIATION

To be eligible for membership in Texas Nurses Association, you must have received a license to practice as a registered nurse in a state, territory, possession or District of Columbia of the United States, and not have your license under suspension or revocation in any state.

1. FIND YOUR DISTRICT
Locate your county of residence OR county of employment. The large black circled number within the indicated boundaries, is your district.

2. SELECT YOUR TYPE OF MEMBERSHIP
from the options that follow. Then, using the chart below, match your TNA District, type of membership and preferred method of payment to determine correct dues.

Full Membership - Full rights and privileges of membership (all nurses employed more than an average of 20 hours a week).

Reduced Dues Membership - Pay 50% of annual dues (all nurses who are unemployed or working less than 20 hours a week, licensed RNs who are full-time students, new graduates from basic nursing education programs joining within 6 months of graduation, and RNs 62 years-of-age or older who are working and receiving Social Security).

Special Membership - Pay 25% of annual dues (nurses over 62-years-of-age and not employed, or 100% disabled).

3. COMPLETE APPLICATION
Complete this Application for Membership, and mail with check or fax (512.452.0646) with credit card information. Secure, online membership payment with credit card is also available at www.texasnurses.org.

TEXAS NURSES NETWORK
A grand alternative to tri-level TNA-ANA-District membership, this state-only membership is a great first step in supporting the nursing profession and connecting with peers. While it doesn't carry voting privileges, it will keep you abreast of important nursing issues, and includes professional involvement opportunities and product/event savings. With dues a flat $99 per year – or $9.25 per month – TNN is a simple, affordable connection to professional involvement in Texas.

MEmBERSHIP DUES RATES - 2008

<table>
<thead>
<tr>
<th>Districts</th>
<th>M-Full Membership Dues</th>
<th>R-Reduced Membership Dues</th>
<th>S-Special Membership Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,7,10,11,19,20</td>
<td>$289.00</td>
<td>$225.41</td>
<td>$154.00</td>
</tr>
<tr>
<td>2,6,17,18,21</td>
<td>$284.00</td>
<td>$220.50</td>
<td>$152.00</td>
</tr>
<tr>
<td>13,14,15,16,18</td>
<td>$291.00</td>
<td>$227.75</td>
<td>$156.50</td>
</tr>
<tr>
<td>11,12</td>
<td>$280.00</td>
<td>$220.41</td>
<td>$151.00</td>
</tr>
<tr>
<td>5,7,20,22</td>
<td>$346.00</td>
<td>$278.50</td>
<td>$195.00</td>
</tr>
<tr>
<td>2</td>
<td>$356.00</td>
<td>$280.25</td>
<td>$200.00</td>
</tr>
<tr>
<td>3</td>
<td>$360.00</td>
<td>$283.00</td>
<td>$203.00</td>
</tr>
<tr>
<td>4</td>
<td>$324.00</td>
<td>$278.36</td>
<td>$182.10</td>
</tr>
</tbody>
</table>

Please charge to my:
- American Express
- MasterCard
- Visa

ENTRY OF INFORMATION REQUIRED FOR PAYMENT BY CREDIT CARD

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Card Number</td>
<td></td>
</tr>
<tr>
<td>Exp. Date</td>
<td></td>
</tr>
</tbody>
</table>

To provide monthly electronic payments to American Nurses Association (ANA):
(1) This is to authorize ANA to withdraw annual dues and any additional service fee from my checking account each month on or after the 15th day of each month; (2) which is designated by the enclosed check for the first month's payment; (3) ANA is authorized to change the amount by giving the undersigned thirty (30) days written notice prior to deduction date as designated above. ANA will charge a $3.50 fee for any returned drafts.

Signature Date

EDDP AUTHORIZATIONS

EDDP Authorization for TNA
To provide monthly electronic payments to Texas Nurses Association (TNA): (1) This is to authorize TNA to withdraw 3/12 of my annual dues and any additional service fee from my checking account each month on or after the 15th day of each month; (2) which is designated by the enclosed check for the first monthly payment; (3) which is designated to change the amount by giving the undersigned thirty (30) days written notice; (4) which is designated to cancel the authorization upon request by TNA of written revocation of termination twenty (20) days prior to deduction date as designated above. TNN will charge a $3.50 fee for any returned drafts.

Signature Date

EDDP Authorization for Texas Nurses Network
To provide monthly electronic payments to Texas Nurses Network (TNN):
(1) This is to authorize TNN to withdraw 3/12 of my annual dues and any additional service fee from my checking account each month on or after the 15th day of each month; (2) which is designated by the enclosed check for the first monthly payment; (3) TNN is authorized to change the amount by giving the undersigned thirty (30) days written notice; (4) which is designated to cancel the authorization upon request by TNN of written revocation of termination twenty (20) days prior to deduction date as designated above. TNN will charge a $3.50 fee for any returned drafts.

NOTE: If you are applying for either TNA/ANA or TNN membership, $30.00 of your membership dues is for a subscription to TEXAS NURSES. If you are not renewing your membership renewal, you will not receive TNN. However, if you are renewing your TNA membership, $30.00 is included in your membership renewal. If you are renewing your TNA membership and reapplying to the American Nurses Association dues are not deductible as a charitable contribution for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying is not deductible as a business expense. The non-deductible percentage of dues for either District/ TNA/ANA members or TNN members is 23%.

To be completed by TNA

App. Form Date

To be completed by TNA

App. Form Date