

# Concern for Safe Staffing Form Annual Report 2015



*Nurses put the care in healthcare*

## Authors



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Carrie Mortrud is a Registered Nurse who worked at Abbott Northwestern Hospital (ANW) for nine years. The majority of her nursing career was spent in cardiac telemetry and cardiac ICU.

Carrie has been a union leader her entire career. She served as a steward at ANW Hospital and as an MNA staff member.

Carrie used her expertise as an RN to become a lobbyist for the Minnesota Nurses Association in the fall of 2005. She worked to strengthen the Overtime Law for nurses, helped pass the Safe Patient Handling Law, and worked on numerous other nursing and health care legislative issues, including a safe patient staffing standard.

She is currently MNA's Policy Project Specialist, where she spends a majority of her time helping nurses explain the issue of nurse staffing to management and lawmakers. She helps educate the public and works to highlight how important appropriate nurse staffing is to better patient outcomes, safety, and quality care.



### **Mathew Keller, RN, BSN, JD**

Mathew Keller is a proud graduate of the University of Minnesota nursing program. Mat was a Densford scholar during his time there and started a group then known as Men Enjoying Nursing (M.E.N.). Mat practiced for several years as an army nurse, and then went on to

the University of Minnesota Law School in order to become a better proponent for the nursing profession. After law school, Mat worked for Haemonetics, a medical device company.

Mat's current role is as the Regulatory and Policy Nursing Specialist for the Minnesota Nurses Association, where he works full time to research and advocate on issues affecting nurses, and through them, their patients. Mat was recently published in the book "Nurses Making Policy: From Bedside to Boardroom."

## EXECUTIVE SUMMARY

Registered Nurse members of the Minnesota Nurses Association (MNA) have documented their concerns with unsafe nurse staffing via Concern for Safe Staffing (CFSS) forms for more than 20 years. Nurses document in CFSS forms when patients are harmed, or when, in the nurses' professional opinion, patients did not receive the safe and quality care they deserved due to substandard staffing. Concern for Safe Staffing forms allow nurses to efficiently document patient care breakdowns in 17 categories, including (but not limited to) delays in cares, treatments, or assessments; delays in medication administration; unanswered patient call lights; incomplete discharge instructions; and overtime that results in nurses working longer than 16 consecutive hours.

MNA continually works to update and streamline the CFSS form in order to ensure accuracy in reporting as well as a correct depiction of unsafe staffing and its impacts. In April 2014, MNA added several categories of patient care breakdowns to the CFSS form and added checkbox functionality to the electronic version of the form.

In order to ensure accurate year-over-year reporting in light of the April 2014 changes, all CFSS paper forms submitted from January through March 2014 were hand-screened and analyzed individually to determine if they met the criteria for any of the new categories.

Our year-over-year analysis of Concern for Safe Staffing forms revealed that nurse-reported instances of unsafe staffing increased by 32.93 percent from 2014 to 2015. Nurses documented 2,062 incidents of unsafe staffing in 2014, compared to 2,741 in 2015. While the submission and collection of CFSS forms do not, and cannot, rise to the analytical level required of academic research, CFSS forms taken as a whole provide valuable insight and evidence of the impact, relative growth, and potential trending in incidents of unsafe staffing.

An analysis of 2015 CFSS reports yields important insights into trends in unsafe staffing. For example, the second most commonly reported breakdown in patient care in 2015 was an "inability to answer patient call lights," which nurses reported 1,504 times. While some might view this breakdown in care as a minor issue, nurses know that when patient needs are not addressed in a timely manner, adverse events occur: patients fall, develop pressure ulcers; and in serious instances, can even pass away from a failure to be rescued through timely emergency interventions.

Nurses documented 406 instances of patients leaving the hospital from frustration with staffing before they were seen in the emergency room, or against medical advice (AMA) if they were admitted as inpatients. Each of these incidents represents a patient who did not receive needed care and a hospital that lost potential revenue.

Nurses reported 882 times that a patient's medication was delayed because the nurse was caring for too many pa-

tients at once. Delays in medication administration hamper a patient's medical treatment, and delayed pain management in particular has the potential to allow "breakthrough" pain, which has a strong negative impact on patient outcomes and requires considerably greater amounts of pain medication to correct.

Nurses also reported 356 incidents of having to provide "incomplete discharge instructions" or "rushed teaching to patients" in order to prioritize other patient care needs in light of unsafe staffing. Unfortunately, when patients do not know how to properly perform necessary self-cares, they often end up back in the hospital.

*\*This report contains actual quotes from CFSS forms as written by Minnesota Registered Nurses in 2014-2015.*

## INTRODUCTION

Too often, nurses find themselves in situations where staffing is inadequate to the point that it negatively impacts patient safety and quality of care. In order to document such incidents, an elected member group of the Minnesota Nurses Association created the Concern for Safe Staffing form (CFSS).

CFSS forms are a rich source of data that provide insight into the incidence of unsafe staffing, as well as the multitude of ways in which unsafe staffing impacts patient care. The forms also prompt nurses to inform their managers of unsafe staffing. This tool for nurses helps begin difficult conversations with hospital administrators regarding the quality of patient care.

CFSS forms also document the steps nurses took to address unsafe staffing as well as the communication that occurred between nurses and their employers.

A record of staffing concerns from frontline nurses serves to identify trends and issues in unsafe staffing. CFSS forms should be useful to policy makers in regulatory agencies as well as the Minnesota Legislature.

Although no document can protect a nurse's liability, written documentation of a nurse's concern for safe staffing may have probative value in demonstrating that staffing decisions, rather than a nurse's abilities and performance, was at the root of any negative patient event.

In some situations, it may be necessary for a Registered Nurse to refuse an assignment based on legal, clinical, and ethical standards of nursing practice. In such instances, CFSS forms document the procedures followed by the refusing nurse as well as the justification on the basis of patient safety and quality of care.

***“High fall risk patient took herself back from the bathroom by herself because her call light had been ringing for so long.”***

*– CFSS Report*

## History

The Concern for Safe Staffing form was created in the early 1990s as a triplicate, paper form. The nurse kept one copy, submitted one to management, and sent one to the Minnesota Nurses Association.

In the first few years, some CFSS forms were reviewed at least quarterly by the union in conjunction with employers, in the hopes that temporary and permanent staffing changes could be achieved. Nurses earnestly participated in such workgroups in the interest of improving patient care, but staffing issues continued seemingly unabated.

Disappointed but determined to fulfill their role as patient advocates, MNA nurses began revising the CFSS form and renewed efforts to bring to light the quality and safety issues that repeatedly put nurses and patients at risk.

MNA also reached out to regulatory bodies for help. As discussions occurred, however, it became apparent that there is no regulatory system or body charged with holding health-care facilities accountable for providing the staffing resources nurses need to deliver safe, quality care. Nurses are still professionally, legally, and ethically bound to provide safe care and serve as a patient advocate.

## Incident Reports, Adverse Health Events, Sentinel Events

There are currently three methods in which negative patient care incidents and outcomes are captured and reported: hospital Incident Reports, Adverse Health Event reports, and Sentinel Events. These reports each have varying and overlapping standards, requirements for fulfillment, and objectives. Similarly, while MNA CFSS forms may serve as a useful adjunct in instances where the above incidents overlap with unsafe staffing, CFSS forms do not serve as a replacement for reports by a regulatory agency.

Incident Reports capture and count negative patient care events. Incident Reports are internal forms filed by healthcare professionals who have made errors in care. These reports are submitted to a hospital's quality management department, which conducts an investigation and review into the incident and determines what, if any, changes are necessary. Incident Report information is shared with the Minnesota Department of Health (MDH) in aggregate form.

Adverse Health Event reporting addresses untoward medical events occurring in a clinical patient setting. The Minnesota Adverse Health Events Reporting Law, passed in 2003 and modified in 2004, provides a snapshot of efforts in hospitals, community behavioral health hospitals, and outpatient surgi-

cal centers at preventing adverse events. The law requires that these facilities disclose when one of any 29 reportable events occur and requires MDH to publish annual reports of adverse events by facility. MDH's annual reports also include the results of root cause analyses into adverse events' precipitating factors. In 2009, MNA worked with the Minnesota Legislature to strengthen the Adverse Event law in order to require a review of staffing levels as a component of any given adverse event's root cause analysis.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tracks Sentinel Events, which it defines as patient safety events that reach a patient and result in death, permanent harm, or severe temporary harm with intervention required to sustain life. Hospitals are encouraged, but not required, to report sentinel events to JCAHO in order for JCAHO to provide support and assistance in analyzing, responding to, and learning from sentinel events.

## CFSS Form

Nurses are well-positioned to address patient safety and quality of care concerns before Incident Reports, Adverse Health Event reports, or Sentinel Event reports become necessary. CFSS forms are one such way nurses seek to address quality of care concerns before patient safety is impacted. CFSS forms follow the essence of the above reports and guide nurses to document an incident's impact on patient care, to provide an analysis of the cause of the incident, to document the actions undertaken to correct the incident, and to formulate a plan to address future incidents. CFSS forms also ask that nurses document staff-centric information such as skill mix, staff familiarity with the unit, type of patient care unit, and the number of hours worked.

## CFSS Revisions

MNA has continually updated and revised the CFSS form to make it easier for nurses to use and analyze data collected by the forms:

- In 2010, an electronic version of the CFSS form was created to simplify submissions, increase efficiency, and allow for better data interpretation and reliability.
- In April 2014, the form was changed to include more information and data regarding substandard care, delayed care, or missed patient care.

## MNA Advocacy for Safe Patient Care Now and in the Future

In March 2015, MNA submitted thousands of CFSS forms to the Minnesota Department of Health in order to raise awareness of the issue of staffing and to engage the department's insight into how to improve the form and better address the issue.

MNA continues to work with regulatory agencies to understand how information gathered by CFSS forms could improve the quality and safety of patient care.

Just as the Minnesota Adverse Health Events reporting system is regularly enhanced and the information it collects is regularly reviewed, MNA CFSS forms regularly bear scrutiny in the name of improving their utility in improving patient safety and quality of care.

In 2015, MNA began categorizing the data collected by CFSS forms in order to enhance our analysis of unsafe staffing. CFSS forms now contain 17 categories, which for the purposes of this report, are organized into four common groupings:

- Negative patient outcomes or near misses
- Temporary fixes or unacceptable administrative responses
- Temporary nurse solutions
- Staffing by ratios versus acuity

This report sheds new insight into unsafe staffing in Minnesota by documenting and analyzing the many instances in which RNs reported their concerns for their patients. Unsafe nurse staffing is a serious and pervasive threat to patient care in Minnesota. The evidence provided by this report ought to serve as a catalyst for public policy interventions aimed at ensuring that nurses care for a safe number of patients at one time and that patients receive the care they so desperately need and deserve.

***“2 patients taken off 1:1 watches.  
High risk for falls. Patients are  
very high acuity.”***

*- CFSS Report*

## CONCERN FOR SAFE STAFFING FORM CATEGORIES

In order to better track and analyze CFSS form submissions, MNA created 17 categories that delineate the impact of unsafe staffing.

The 17 categories include:

- Delays in treatment/cares or incomplete assessments
- Delays in medications
- Inability to answer call lights
- Patient fall or safety at risk/compromised
- Incomplete discharge teaching or rushed teaching
- Patient left against medical advice (AMA) or without being seen
- Inappropriate or no response from management
- Extreme overtime (more than 16 hours in a row in a 24-hour period or consecutive double shifts by staff)
- Unit is short staffed or below the staffing target by 25 percent or more
- Pulled a new nurse off orientation early to fill the staffing need
- Sent staff untrained to either the unit/patients or equipment to fill the staffing need
- Sent the wrong skill level of staff
- Management worked the shift
- Closed unit to admissions or transfers
- Refused the unsafe assignment
- Advocated until the right number of staff was provided
- Management staffed by ratios versus acuity

The above categories are each grouped into one of four main headings:

- A) Negative patient outcomes or near misses (delays in treatment or cares or incomplete assessment; delays in medications; inability to answer call lights; patient fall or safety at risk/compromised; incomplete discharge or rushed teaching; and patient left AMA or without being seen at all).
- B) Temporary fixes or unacceptable administrative responses (no response by management; excessive overtime; unit short-staffed 25 percent or more; unqualified staff used to fill staffing need; management worked the shift).
- C) Temporary nurse solutions (unit closed to admissions; refused unsafe assignment; advocated until correct staffing obtained).
- D) Staffing by ratios versus acuity.

The data entered on CFSS forms (as well as nurses' documentation of their communications with management) has provided abundant data documenting the systemic crisis of unsafe staffing. The following is a complete description of each category.

***“Not enough chemotherapy trained staff to care for the amount of chemotherapy to be given.”***

*– CFSS Report*

### Negative Patient Outcomes or Near Misses

#### Delays in Treatment/Cares or Incomplete Assessments

Delays in treatment/cares or incomplete assessments occur when patients do not receive nursing care in a timely manner. The care that is delayed can range from missed walks in the hallway to delayed IV site rotation to delayed dressing changes—the common denominating factor being a negative impact on a patient's quality of care. Likewise, when patient assessments are incomplete or delayed, nurses can miss emerging patient issues that require prompt treatment, such as a potential pressure ulcer “hot spot,” a chest drainage system set to the wrong pressure, or a patient who displays a change in the level of consciousness. Overall, when delays in cares, treatments, or assessments occur, a patient's underlying medical conditions are not being properly treated and patients often experience direct harm and/or extended hospital stays (Lewis, Heitkemper, & Dirksen, 2004).

#### Medication Delays

The preparation, administration, and assessment of medications constitutes a major role of the Registered Nurse. In one study, researchers found that one patient alone can often receive up to 18 medications per day and that nurses administer nearly 50 medications per shift (Mayo, 2004).

Nurses follow the “Six Rights” in administering medications, which help ensure that the right patient receives the right medication at the right dose, by the right route, with the right documentation, and at the right time (Perry, Potter, & Ostendorf, 2014).

With regard to the right time, nursing literature specifies that medications should be administered within 30 minutes of their scheduled time (Perry, Potter, & Ostendorf, 2014). If nurses have too many patients and cannot deliver or administer medications on time, the physician's orders are not being

executed as intended and patient care suffers. As the Institute for Safe Medication Practices puts it, “time-critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacological effect,” ([www.ismp.org/tools/guidelines/acutecare](http://www.ismp.org/tools/guidelines/acutecare), 2011).

Medication delays have an even greater impact on a patient’s experience of pain. Pain is a complex, multi-dimensional experience. It is a common refrain in the nursing profession that “pain is whatever the patient says it is, whenever he says it is” (Lewis, Heitkemper, & Dirksen, 2004).

The consequences of untreated pain include physiological problems apart from human suffering. When a patient’s pain is left untreated, it can impair recovery from acute illness or surgery and can even cause immunosuppression and sleep disturbances. As the literature shows, untreated pain can also increase morbidity as a result of respiratory dysfunction, increased heart rate and cardiac workload, increased muscular contraction and spasm, decreased gastrointestinal motility and transit, and increased catabolism (Lewis, Heitkemper, & Dirksen, 2004).

When a patient’s pain is not properly assessed, treated, and managed in a timely manner, it can cause physical deterioration that may increase the length of the patient’s stay in the hospital, increase the patient’s suffering, render future pain more difficult to treat. These consequences ultimately cost the healthcare system more money.

### **Incomplete Discharge or Rushed Teaching**

Incomplete discharge or rushed teaching occurs when patients are discharged without receiving the training and instructions they need in order to maintain their health outside the hospital. Discharge planning begins on admission and is a critical component of patient care at the hospital as well as after the patient leaves. Proper discharge instructions and education promote the patient’s continued healing and help prevent re-hospitalization (Pope, 2008).

Evidence shows that poor communication, which can occur when nurses are rushed, can lead to errors, misunderstandings, and, ultimately, poor outcomes (Pope, 2008). Patients rank proper discharge teaching as a top safety and quality care issue. As patients are discharged earlier and earlier, they need and deserve proper teaching and guidance in performing self-cares in order to be successful in healing outside of the hospital.

### **Responses to Call Lights**

An important component of the nurse’s role is to address patients’ needs as they emerge. Oftentimes, these needs are communicated through the use of call lights.

All patient care staff are expected to make sure a patient’s call light is within reach upon exiting a patient’s room (Perry, Potter, & Ostendorf, 2014). However, it doesn’t matter whether a patient’s call light was within reach if no one is available to respond when the patient uses it. In some instances, CFSS reports showed this led to avoidable patient falls and other incidents. For example, when some patients tired of waiting for help to go to the bathroom, they took themselves to disastrous effect.

### **Patient Falls/Safety at Risk**

Patient falls are a negative patient outcome that nurses document on CFSS forms. Falls are the most common type of inpatient accident with approximately 1 million incidents in the U.S. each year (Oliver, Healey, & Haines, 2010). Unless a fall produces a serious injury or death, it does not rise to the level of reportable events under the Adverse Health Care Event reporting requirement ([www.health.state.mn.us/patientsafety/ae/adverse27events](http://www.health.state.mn.us/patientsafety/ae/adverse27events), 2014).

Patient safety at risk is also noted in many CFSS forms. This occurs when, in the nurse’s professional judgment, staffing was so short it put patient safety in jeopardy. CFSS forms documented patient safety at risk in instances such as a physician ordering that a patient have a 1:1 attendant at all times, only to have the order to go unfilled because of crisis-level unsafe staffing. This can lead to patients getting out of bed without help and/or pulling out tubes or catheters (leading to falls), patients wandering off the unit in a confused state, and needless exposures to infection secondary to the reinsertion of lines, tubes, or catheters.

### **Patients Leave AMA or Without Being Seen**

Lastly, nurses report on CFSS forms incidents when patients leave the hospital due to lack of staff. This occurs when patients leave their inpatient hospitalization prior to discharge from a physician or before they even receive care in the emergency room. Every patient who leaves the hospital prior to being seen represents lost income for the hospital. Moreover, studies have shown that patients who leave against medical advice end up costing themselves and the healthcare system more in the long run: their odds of death within 90 days are 250 percent higher than expected (Garland, et al., 2013); they are readmitted at rates 20-40 percent higher than other patients (Glasgow, Vaughn-Sarrazin, & Kaboli, 2010); and their overall hospital costs upon readmission are 56 percent higher than expected (Aliyu, 2002).

## Temporary Fixes and Unacceptable Administrative Responses

MNA nurses documented incidents in seven categories that exemplify temporary fixes or unacceptable responses from hospital administration. Short-term fixes in these categories are unreasonable and oftentimes dangerous. One nurse, for example, reported working 20 straight hours without relief.

### No Response/Unacceptable Solutions

“No response” or an “inappropriate response” from managers nearly doubled from 2014 to 2015. Comments such as “oh well,” “nobody is dying so it’s not unsafe,” “there’s pies to eat, did you see I brought pies,” and “we are just going to cross our fingers and pray” are actual responses nurses received from their managers after requesting additional staff to relieve unsafe staffing. No management response at all is also included in this category. Nurse supervisors, nurse managers, chief nursing officers and nurses in charge of patient care services have a responsibility to provide the right number of properly trained staff to safely care for patients at their hospitals. This responsibility is codified in the Minnesota Nurse Practice Act, which lists as grounds for discipline “unprofessional conduct, including... any nursing practice that may create unnecessary danger to a patient’s life, health, or safety” MN Stat. § 148.261 Subd. 1(6). Studies show short staffing is a nursing practice that creates unnecessary danger to a patient’s life, health, or safety; and ignoring staff nurse requests for the right staff to meet patient care needs represents an unacceptable risk to patient safety.

*“4-6 RN’s working double  
16-20 hr. shift several since  
Friday. Very tired.”*

*- CFSS Report*

### Overtime

Overtime is an accepted practice in today’s work environment, no matter what the job. For many, another person’s life and well-being are not at the receiving end of those extra hours—but for nurses they are. Using overtime as a staffing solution has become an all-too-common practice for hospitals that take advantage that there is no law limiting the number of hours a nurse can work in any given day or over any given number of days. In fact, studies have shown that nurses leave work at the end of their scheduled shifts only 15.7 percent of the time and work an average of 49 to 55 minutes extra each shift, despite studies that show 75 percent of nurses already work 12-hour shifts (Rogers, Hwang, Scott, Aiken, & Dinges, 2004).

Nurses documented in CFSS forms many instances where they were pressured and ultimately required to work for more than 16 hours in a row. Some nurses reported working 17, 18, and even 22 hours in a row due to administrative aversions to providing the proper quantity and quality of nursing staff. Some nurses also documented working multiple double shifts in a row. Studies show that the incidence of errors almost doubles when nurses are unexpectedly asked to work past the end of their scheduled shifts (Stimpfel AW, 2013).

### Leaving a Unit Short-Staffed

Leaving a shift understaffed by 25 percent or more is an unacceptable occurrence pervasive enough to be reported in CFSS forms. In a 2011 article in the *New England Journal of Medicine*, researchers found that each time a patient is exposed to a shift that is below target in Registered Nurse staffing, the patient’s risk of mortality increases by 2 percent (Needleman J, 2011). Thus, in instances where staffing remains below target for an entire weekend, a patient has potentially seen his or her risk of mortality increase by 16 percent (2 percent times eight shifts from 3 p.m. Friday through 7 a.m. Monday). Also noteworthy is a study that found a patient’s mortality within 30 days of hospital admission is increased by 7 percent for each additional patient added to the nurses’ workload (Aiken LH, 2014). This is alarming in light of the fact that understaffing at levels greater than 25 percent is likely to cause an increase in nurse workload of not just one patient, but several patients—an unacceptable increase in the risk of patient mortality.

### Reducing or Stopping Nurse Orientation

Temporarily stopping or cutting a nurse’s orientation short is an unfortunate stopgap measure utilized with increasing frequency in order to solve staffing problems. Orientation is a time when a nurse new to the unit or hospital (or even new to nursing) is assigned to another nurse in order to “learn the ropes” of a particular unit and patient population. This is a very critical time for learning.

When a hospital prematurely stops or shortens a nurse’s orientation and asks her or him to take a patient assignment alone, other nurses on the unit are already managing too many patients at once and are likely unable to provide needed assistance, support, and guidance. This is unsafe for patients. Cutting orientation short should only be done because the nurse has demonstrated all the necessary competencies and requirements for working in a given patient care unit, not because there aren’t enough nurses to work the shift.



### Untrained Staff Used Improperly

In many instances, hospital administrators utilized improper staff as a stopgap measure to ease unsafe staffing. For example, administrators have required obstetric nurses to work in the emergency department; nurses trained in medical surgical to work in oncology; and, as one CFSS form detailed, even a nurse with no experience in the field to administer chemotherapy to patients. Expecting nurses who do not have experience on a particular unit or with the specific equipment in a patient care area puts patients as well as nurses at risk.

Competency is a professional responsibility that should not be compromised. In an online continuing education course, author Kristin Davies defines competency as “the knowledge, skills, ability and behaviors that a person possesses in order to perform tasks correctly and skillfully” (O’Shea, 2002). Competency is an ongoing process that starts with initial development of the need to maintain skills and knowledge (Davies, 2014).

Studies have shown that the health and safety of patients are at risk when float nurses are unfamiliar with patient diagnoses, treatment plans, and care interventions (Davies, 2014). Before being asked to float to a different unit, administrators must ensure that a nurse has the appropriate knowledge and skills to care for a particular patient population.

### Management Works the Shift

Nurses cited numerous instances when managers offered to help by working side-by-side with staff nurses on a short-staffed unit. Although managers performing bargaining unit work is a potential union grievance, staff nurses generally welcome the additional help in the interest of patient safety (assuming that the manager is qualified to perform the work, has maintained professional competencies, and has learned new equipment, documentation systems, and protocols). Unfortunately, CFSS forms showed that oftentimes, nurse managers were unqualified to fill staffing needs.

### Nurse Solutions

Staffing crises placing patient safety at risk force nurses to make many difficult decisions, including temporary, last-ditch attempts to stabilize hospital units in order to give the best possible patient care.

One of these solutions is temporarily closing a nursing care unit to admissions and transfers. This is done in order to regain safety and order for the patients already admitted to and in the care of nurses on the unit.

Another short-term solution is to refuse patient assignments that place patient safety at risk. For instance, asking nurses to take on more patients than they can safely care

for at one time places patients at risk of harm. Therefore, a nurse has an ethical obligation to refuse the assignment. Such refusals may be documented on CFSS forms. The authority and, indeed, the obligation, to refuse unsafe assignments rest in Minnesota statute §148.171 Subd. 15(17), which vests in professional nurses ultimate accountability for the quality of care they deliver. The best-case scenario for nurse solutions to unsafe staffing is when nurses or administrators find ways to increase staffing, such as obtaining qualified nurses from other units to make sure the correct number of properly trained staff can deliver safe, quality care.

*“Had to close the nursery for the shift. Eventually I called someone from nights myself and got them to come in at 7:00 p.m. so we could open the nursery and take admits.”*

*– CFSS Report*

### Staffing by Ratios Versus Acuity

While nurses believe that hospitals must ensure a minimum level of safe patient care by limiting the number of patients nurses care for at once, it is noteworthy that oftentimes, hospital administration staffs units only by the number of patients in a unit, rather than by patient acuity.

## CFSS REPORT 2015 TOTALS

CFSS Submissions For 2015	Category Subtotal
Management response-NONE or inappropriate	2140
Delays in cares or treatments or incomplete assessments	1926
Inability to answer call lights	1504
Delay in medications	882
Unqualified staff-wrong skill mix	661
Temporary solution-closed unit	461
Patient left AMA or w/o being seen	406
Incomplete discharge or rushed teaching	356
Short staffed >25% of what is needed	254
Unqualified staff-not trained to unit or equipment	253
Patient falls or patient safety at risk	228
Unqualified staff-nurse pulled off orientation early	215
Temporary solution-obtained the appropriate number of staff	136
Management staffs by ratios	74
Temporary solution-refused the assignment	57
Management works the shift	50
Extreme overtime >16 hrs. in 24 hrs. or multiple doubles in a row	23
<b>Category Subtotal</b>	<b>2741</b>

MNA nurses filed 2,741 CFSS forms during the 2015 calendar year. There have been no changes to the form since April 2014. Nurses file a CFSS form by going to the MNA website and filing the form electronically, which can then be emailed and/or printed and given to their supervisors. The electronic version comes to MNA and is entered into a database for monthly reporting. In 2015, the MNA mobile app, which allowed filing from a smartphone, was discontinued.

By far, the biggest incident reported in 2015 was “delays in cares or treatments or incomplete assessments.” This includes patients’ needs going unmet, scheduled treatments coming late or missed all together, and routine checks being rushed or skipped that resulted in a lack of time to perform a patient assessment. In 1,926 reported incidents, nurses said they could not get to patients in a timely or scheduled manner or they did not have time to assess a patient completely.

Similarly, nurses reported 1,504 incidents of being unable to answer call lights because of the staffing situation. They reported taking care of too many patients at one time to be able to respond in a timely manner, sometimes even in emergencies. While this is a common patient complaint, this figure demonstrates how serious this situation is. More than four times per day, a patient call light went unanswered in a Minnesota hospital.

In 882 reported incidents, a patient’s medication was delayed. Minnesota facilities have varying policies and procedures that dictate what a “late” or “delayed” medication delivery is. The CFSS form relies on the nurse’s judgment based on her/his education and training. Most nurses designate a medication delay as an incident where administering the medications was 30 to 60 or more minutes late. Other nurses follow their facilities’ policy, which may not consider a medication delayed until it’s two hours or more past due. Many nurses struggle with this, as they believe medicine and nursing should determine medical and nursing care, not facility policy.

Nurses reported 406 incidents in 2015 when, because of staffing, a patient chose to leave a facility due to an unreasonable delay in treatment and care. Often, this situation occurred in emergency room settings.

In 356 instances in 2015, patients left the hospital without having received complete discharge instructions or training in the self-care skills needed to recover at home.

The ideal solution to unsafe staffing, finding the “appropriate number of staff” for the patient census and acuity level, was documented as an outcome in only 136 of the 2,741 CFSS forms. Other temporary solutions, including closing the unit, nurses refusing a patient assignment, or management helping to work the shift were documented 568 times. Conversely,

nurses documented “none” or “inappropriate” as a management response to nurses reporting unsafe staffing 2,140 times.

The factors underlying unsafe staffing vary, but a growing reason appears to be the wrong skill mix of staff. In 661 incidents, nurses reported staffing was affected because, for example, a nursing assistant was sent to fill an LPN or RN staffing need. In 253 cases, nurses who were unfamiliar with a unit or who weren’t trained to care for the type of patients on a unit were sent to fill in. Similarly, in 215 cases, a new nurse was pulled off orientation early and given a patient assignment as a way to fill a staffing need.

*“Management pulled nurse off orientation for the night and gave her a patient assignment of 3 patients.”*

*- CFSS Report*

## 2014 - 2015 DATA COMPARISON ANALYSIS

MNA nurses submitted 2,741 CFSS forms in 2015, a 32.93 percent increase over the previous year. Other than a modification to improve the form’s ease of use in April 2014, there have been no other changes to the distribution of CFSS forms. While a more user-friendly form may account for a slight uptick in the number of CFSS forms completed, it almost certainly does not account for a 32.93 percent increase. Regardless, the 2015 reporting year saw big increases in unsafe staffing over 2014. Three categories also experienced a decrease in reporting.

More often than not, unsafe staffing yields multiple consequences at once. Accordingly, each CFSS form can potentially document several consequences and impacts of unsafe staffing. In 2014, nurses submitted 2,062 CFSS forms that described 6,875 instances of negative patient care consequences in any of the 17 patient impact categories. In 2015, nurses submitted 2,741 forms with 9,626 instances of negative patient care consequences. Thus, while the year-over-year increase in nurse-reported unsafe staffing was 32.93 percent, the negative patient consequences of such staffing increased by 40 percent— suggesting that unsafe nurse staffing is beginning to overwhelm healthcare facilities’ capacity to compensate for it using other strategies. If this trend is perpetuated in future years, it would indicate that unsafe staffing has reached a breaking point. The frequency has overcome the ability of the healthcare system to adjust for them while maintaining proper patient safety and quality of care.

Another potential contributing factor to the disparate increase in incidents of negative patient consequences is a concomitant rise in documented “serious” understaffing. From

2014 to 2015, nurses reported an increase of 86.76 percent in incidents of seriously understaffed units. Units are considered seriously understaffed when nurses report them to be over 25 percent short of the staff needed in order to safely care for patients.

The second-largest year-over-year increase in negative patient consequences was patients receiving incomplete discharge information or rushed discharge teaching. Nurses reported 72.82 percent more of these incidents in 2015. The number of reports citing this issue indicates that at least one patient per day is heading for home after a hospital stay without the skills to perform necessary self-cares.

Similarly, patients who did not receive any or all of their care occurred approximately once per day, as nurses reported a 55 percent increase in patients leaving facilities without being seen. Nurses determined that in their professional judgment, the patient likely left due to frustration with staffing and the attendant lack of timely, quality care, rather than other reasons.

More patients experienced delays in cares or incomplete assessments in 2015 compared to 2014. The number of CFSS forms citing this category of patient consequence rose by 41 percent in 2015. This is a separate category from medication delays or an inability to answer call lights, but those categories also rose 36 and 38 percent, respectively. Again, these increases outpace the overall year-over-year increase in CFSS forms.

Another change from 2014 to 2015 was in the responses nurses received from managers when attempting to address unsafe staffing. These responses are separated into three categories: none or inappropriate responses, managers working on the floor, and managers obtaining the proper staff. No response or an inappropriate response was cited more than 2,100 times in 2015, a 43 percent increase over the previous year.

Interestingly, managers working the shift, including sometimes accepting a patient assignment, decreased by 40 percent from 2014. On the other hand, the incidence of managers obtaining the appropriate level of staffing increased by 49 percent. While a positive development to be sure, it’s one partially offset by the relatively low frequency with which this occurred—136 times in 2015.

Nurses took a more active role in addressing unsafe staffing in 2015. They closed the unit from accepting new admissions 75 percent more times than in 2014. They refused unsafe assignments 54 percent more in 2015. These incidents however, were a rarity, occurring only 57 times throughout the year.

The number of patient falls or instances where patient safety was determined to be at risk decreased in 2015 by 36 percent. This coincides with Minnesota’s Adverse Health Events Report issued this winter that also described a decrease in patient falls.

## CATEGORIES WITH THE LARGEST INCREASES

Many CFSS form categories saw increases above the 33 percent year-over-year increase in form submissions. While all are noteworthy, some of the more alarming increases involved negative patient outcomes, unacceptable administrative solutions, and temporary fixes.

- The number of patients subjected to delays in cares/treatments or not receiving a complete assessment upon admission or as ordered by the physician escalated by 41.41 percent.
- The incidence of patients leaving the hospital against medical advice due to frustration from lack of care, or leaving the hospital without being seen at all after presenting to the emergency department, increased by 55.56 percent.
- Patients receiving incomplete discharge instructions or rushed teaching increased by 72.82 percent.
- The unacceptable administrative solution of sending the wrong skill mix or not sending the properly licensed staff to fill a specific staffing need rose by 70.80 percent.
- Instances where a nurse was taken off of orientation prematurely in order for the nurse to fill a staffing need increased by 73.39 percent.
- Instances where a shift was left short-staffed by 25 percent or more increased by 86.76 percent.
- Instances of nurses refusing unsafe assignments increased by 54.05 percent.
- Staff nurses closed their units 72.29 percent more. Closing units to patients and refusing patient assignments is not something nurses take lightly. However, in order to provide proper care to the patients already assigned to them, nurses have an ethical, professional, and legal responsibility to refuse assignments that place patient safety at risk.

## LIMITATIONS

There are several limitations to the Concern for Safe Staffing form itself as well as the method in which it is collected. Perhaps the biggest limitation in the utility of CFSS forms is that MNA nurses almost certainly do not fill out a CFSS form every time they experience understaffing. In a 2014 survey, 56 percent of the 500 Minnesota nurses surveyed reported experiencing a situation in the last six months where they were not able to provide the care their patients required due to understaffing (margin of error +/- 4.4 and 95 percent level of confidence).

Extrapolating those results to approximately the at-large membership of 20,000 MNA nurses, one would expect nurses to file 11,200 reports of unsafe staffing every six months. There are numerous potential explanations for this disparity. Nurses in some instances may be hesitant to confront their supervisors or may fear that submitting a CFSS form will “send the wrong signal” and be seen as evidence of a poor attitude. Some in the profession may view documenting unsafe staffing as a personal admission of failure, as the nurse who submits a CFSS form is admitting that the care provided suffered. Perhaps the biggest reason nurses do not submit as many CFSS forms as there are instances of unsafe staffing, however, is that nurses experiencing unsafe staffing simply don’t have the time to fill out a form.

For that very reason, CFSS forms themselves are purposefully limited in scope. Nurses are able to utilize checkboxes throughout the form to document the situation they are experiencing. If a particular situation does not fit neatly into the checkboxes, the nurse is able to write in a free text box, but many do not.

Another limitation in the collection of CFSS forms is potential underreporting of the impact of unsafe staffing. Nurses by and large are trained, habituated, and required to maintain the same standard of care no matter the circumstances. Delivering anything but the very best of nursing care is viewed as a personal failure. In nursing culture, failures have been historically viewed as unacceptable, as they represent potential patient harm—anathema to nurses who got into the profession in order to help and care for others. Perceived failures also represent a source of potential discipline from the employer or even the Board of Nursing. Minnesota law vests the RN with ultimate accountability for the quality of care delivered. Thus, it stands to reason that nurses may be hesitant to report actual or potential harm to a patient under their care, no matter the underlying cause.

Lastly, several checkboxes in the form itself are subjective in nature and may differ from nurse to nurse. For example, what constitutes “inadequate patient pain management” may be different from nurse A to nurse B. Along these same lines, what constitutes unsafe staffing may differ from nurse to nurse. Suffice to say, however, that CFSS submissions generally cite facilities that fall short of their own staffing grid.

***“Call lights going off and unable to answer.”***

*- CFSS Report*

## Ideas for Future Refinement

Nurse safety, rather than being only an ethical issue, is also critical to providing safe, quality patient care. As violence in the workplace rises and patients as well as nurses are put at risk, MNA ought to respond by tracking nurse safety. The 2015 Prevention of Violence against Healthcare Workers law addressing this issue is a great start to tracking and monitoring instances where nurse safety is at risk; however, short staffing can also be a precipitating factor for incidents of violence against nurses. If the CFSS tracked incidents of workplace violence, it would provide useful information and insight into the extent of harm to nurses.

Likewise, MNA ought to track how often a physician order for 1:1 sitting with a patient is not fulfilled. Too often, when a staff member fills a 1:1 staffing need, he or she is not replaced by other personnel on the floor. Providers do not order these 1:1s lightly, but fulfilling such orders should not have to automatically result in other patients on the unit experiencing a diminished quality of care as staff take on even more patients.

In addition, MNA should revise its CFSS form in order to better track an emerging trend of charge nurses increasingly taking on patient assignments in addition to their charge nurse duties. Anecdotal evidence indicates this is an increasing problem. Charge nurses serve as a unit resource and are generally charged with assigning patients to nurses in the oncoming shift, coordinating patient flow, relieving staff nurses for breaks, and perhaps most importantly, operating as a safety valve in addressing emerging patient care issues (e.g. cardiac emergencies) and fluctuations in patient acuity on the unit. When charge nurses are required to take on patient assignments, nurses and patients lose an invaluable barrier separating them from potential adverse events as the charge nurse is drawn away from her essential role in addressing and preventing emergencies.

Engaging in academic research to verify and quantify the patient impact of care breakdowns in CFSS form categories is another potential refinement to improve the forms' utility. For example, the startling 2015 increase in incidents of incomplete patient education is a ripe target for research into the long-term impact of unsafe staffing. Do patients with nurses who report unsafe staffing through CFSS forms experience different health outcomes than patients with nurses who do not? Insofar as incomplete patient education can be a precipitating factor in hospital readmissions, one would believe that discharge instruction does impact health outcomes, but there is no readily available literature that bears out this hypothesis.

Lastly, determining how the data and information collected in CFSS forms can be better articulated and presented to administrative agencies in order to serve as a trigger for regulatory intervention. Naturally, this will require a collaborative effort between MNA and the regulatory bodies tasked with protecting the patients.

MNA looks forward to working with the Minnesota Board of Nursing, the Minnesota Department of Health, and the Minnesota Legislature, among others, in order to tackle the worsening issue of unsafe staffing.

***“Patient who cannot walk jumping out of bed. Patient screaming in pain for 40 minutes, blood products running, and unable to reassess.”***

*– CFSS Report*

## Future Trends

Increases in four categories of patient care breakdowns outpaced the overall increase in the number of CFSS forms submitted. This suggests that breakdowns in these categories represent the trends of the future. These categories include:

- Incomplete discharge instructions, which increased 72.8 percent.
- Incidents of patients leaving AMA or without being seen increased 55 percent.
- Instances of nurses new to their units or new to the profession being pulled off their orientation before they completed it increased 73.39 percent.
- Incidents where staff were unqualified or had the wrong skill mix for a given patient staffing situation increased by 70.8 percent.

Each of these four categories represents a serious risk to patient safety. Patients are increasingly left in the care of overburdened staff with the wrong skill mix inside the hospital while receiving inadequate training and education in how best to maintain their health when they get outside the hospital. That these categories sustained such tremendous increases in their overall incidence is troubling.

Equally troubling is the overall growth in nurse-reported incidents of unsafe staffing from 2014 to 2015. As this report details, unsafe staffing has reached a breaking point, and demands to be addressed by the regulatory and legislative policymakers charged with keeping Minnesotans safe.

## CONCLUSION

As the multitude of Concern for Safe Staffing forms show, Minnesota nurses have serious concerns regarding their patients' safety and quality of care. Too often, those responsible for staffing decisions respond to nurses' concerns in ways that are unreasonable and even frightening. In ignoring nurse concerns for safe staffing, administrators ignore the weight of academic research demonstrating that when nurses work short-staffed, patients suffer.

Hospitals will continue to use a variety of justifications for unsafe staffing that do not work—a new documentation system that's supposed to save time, a nursing shortage that prevents them from filling open positions, or cost pressures that force them to keep staff costs low. These explanations ought to be seen for what they are—excuses.

Incidents of unsafe staffing have been and will continue to rise. As hospitals seek to cut costs, they will ask nurses to take on more and more patients. ICU nurses who used to care for one patient at a time will care for two and then three. Charge nurses who used to serve as a resource to other nurses will be asked to take full patient loads. Overnight nurses will continue to take on patient loads that are almost double that of their daytime colleagues.

There is no nursing shortage. Minnesota nursing schools are graduating two RNs for every new job opening in the state. On top of RN graduates from Minnesota nursing schools, the state is licensing even more RNs: 4.5 for every new job opening. But as the public continues to buy into the myth of the nursing shortage, hospitals will continue to use it as an excuse to justify their staffing crises.<sup>1</sup>

At the end of the day, patients pay the same whether their nurse is caring for three other patients at once or seven other patients at once. This creates a perverse incentive for hospitals to cut costs by squeezing nursing care—the biggest reason a patient is in the hospital to begin with.<sup>2</sup>

Through it all, nurses will do their work with a smile on their faces, “doing the best I can,” as so many CFSS forms relayed, and attempting to deliver the highest level of care possible under the circumstances. But that care has been and will continue to suffer.

Patients and nurses need help holding hospitals accountable for unsafe staffing. The perverse cost incentive hospitals use to minimize nursing care while maximizing patient loads must be offset by public demand to hold hospitals accountable. Minnesota's regulatory bodies with a charge to protect the public ought to review each incident of unsafe nurse staffing for what it is: patient harm, a near miss, mistreatment of a vulnerable minor or adult, or a never event. Minnesotans should not have to suffer

from crisis-level skeleton crews of nursing staff in order for this problem to be addressed.

Minnesota hospitals are also making more money than they ever have. In 2014, Minnesota's hospitals posted income over expenses of \$628.7 million. And yet they tell nurses that they can't afford to give patients the level of nursing care that patients need and deserve.<sup>3</sup>

Nurses report hospitals continue to staff by ratios based on patient census rather than acuity while ignoring the seriousness of patients' conditions. This can drastically alter the number of patient assignments for each nurse and have catastrophic effects for patients. Whether it's a high-risk fall patient or violent-prone psychiatric patient, some people need one devoted nurse all the time. When alerted to this by nurses, more often than not, hospital managers stick to their hard-and-fast ratio rather than acknowledge that more staff is needed. This is ironic in light of the Minnesota Hospital Association's arguments against MNA's Safe Patient Standard bill: to wit, that ratios are inflexible and do not allow professional staff nurses at the ground floor to make staffing decisions on the basis of patient acuity (Public Testimony on House File 1654, 2015). If hospitals did not already staff on the basis of patient census and ratios only, such arguments against the Safe Patient Standard bill might hold merit.

As nurses know through experience, when it works to a hospital's financial benefit, hospital administrators dismiss nurses' requests for additional staff on the basis of unit staffing grids (i.e. ratios), regardless of the heightened patient acuity that renders such ratios irrelevant. In these instances, nurses' professional judgment is ignored and patient acuity in relation to staff skill level is not taken into consideration, to the detriment of patients and their quality of care.

MNA nurses are proud patient advocates. We look forward to working with legislators and regulatory bodies in order to address the pervasive and dangerous issue of unsafe staffing for our profession, for our communities, for our state, and, above all, for our patients.

<sup>1</sup> <http://mnnurses.org/blog/nursing-shortage-part-2/>

<sup>2</sup> Patients who do not need nursing care can be seen on an outpatient basis

<sup>3</sup> <http://www.startribune.com/minnesota-s-largest-hospital-systems-saw-big-jump-in-2014-income/321081861/>

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# Sample CFSS Form



## Concern for Safe Staffing Form

### Facility

Name				Email	
Assisted By					
Date		Unit		Shift	
Person(s) Notified					
Name(s)					
Response					

	RN	LP	UAP
On Duty			
Scheduled			
Needed			

#### Explanation of what made your shift unsafe (choose all that apply):

- Too many patients
- High acuity
- Wrong skill mix
- Inadequate orientation of training to unit/equipment
- Nurse fatigue due to missed breaks or OT
- Not enough qualified staff

Other (please specify):

#### How was the unsafe staffing situation rectified (choose all that apply)?

- It was not rectified
- Obtained correct # of staff
- Obtained correct skill mix of staff
- Refused assignment/I was reassigned
- Closed the unit to admissions
- I was provided the necessary training or preceptor

Other (please specify):

#### What impact did this have on patient care?

- Increased length of stay for patients
- Inability to answer call lights
- Patients left without being seen
- Incomplete admissions
- Incomplete discharge planning/teaching
- Incomplete assessments
- Inability to provide face to face hand off
- Delay in treatment
- Inadequate patient pain management

Other (please specify):

