# Concern for Safe Staffing Form
# Annual Report 2016


*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 intensive care.

Carrie has been a union leader her entire career. She served as a steward at ANW Hospital and as a member of the Minnesota Nurses Association (MNA) staff.

Carrie used her expertise as a Registered Nurse to become a lobbyist for MNA 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 healthcare legislative issues, including a Safe Patient Standard.

She is currently MNA's Policy Project Specialist. 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.

** Throughout this report real quotes taken from CFSS forms are highlighted in blue text.*

**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 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 the Regulatory and Policy Nursing Specialist for MNA, 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*.

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# EXECUTIVE SUMMARY

Registered Nurse members of the Minnesota Nurses Association (MNA) have documented their concerns with short staffing via Concern for Safe Staffing (CFSS) forms for more than 20 years. Short staffing occurs when there are not enough nursing staff scheduled or available to care for patients on a specific hospital unit at one time. 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 deserve due to short staffing. CFSS forms allow nurses to efficiently document patient care breakdowns in 17 categories, including, but not limited to, delays in cares, treatments and medications or incomplete assessment and admissions; unanswered patient call lights; incomplete discharge instructions; and overtime that results in nurses working longer than 16 consecutive hours (double shift) or multiple nurses working consecutive double shift days.

***"Pull training nurse off of training and see if she is willing to work the floor as a RN?"***

*– CFSS Report, 1/17/16*

MNA continually works to update and streamline the CFSS form in order to ensure accuracy in reporting as well as provide a correct depiction of short staffing and its impacts. In April 2014, MNA added several categories of patient care breakdowns to the CFSS form and added check box functionality to the electronic version of the form. In 2015, keywords and phrases nurses use to describe the short staffing scenarios were identified, and each form was reviewed to ensure accuracy when categorizing the information.

Our year-over-year analysis of CFSS forms revealed that nurse-reported instances of short staffing continue to increase at a disturbing rate. Reports increased by 9.45 percent, despite more than 22 percent of the MNA membership who are eligible to submit these forms were out on strike in 2016 for one week in June and six weeks in the fall. Nurses documented 3,000 incidents of short staffing in 2016, compared to 2,062 in 2014 and 2,741 in 2015. That is a 45 percent increase in shifts that were short staffed and, as a result, unsafe from 2014-2016.

An analysis of the 2016 CFSS reports yields important insights into trends in short staffing. Several CFSS form categories saw increases above the 9.45 percent year-over-year increase in submissions. These categories represent reports that document negative patient outcomes, unacceptable administrative solutions to resolve short staffing, and temporary solutions by nurses to protect patients already in their care.

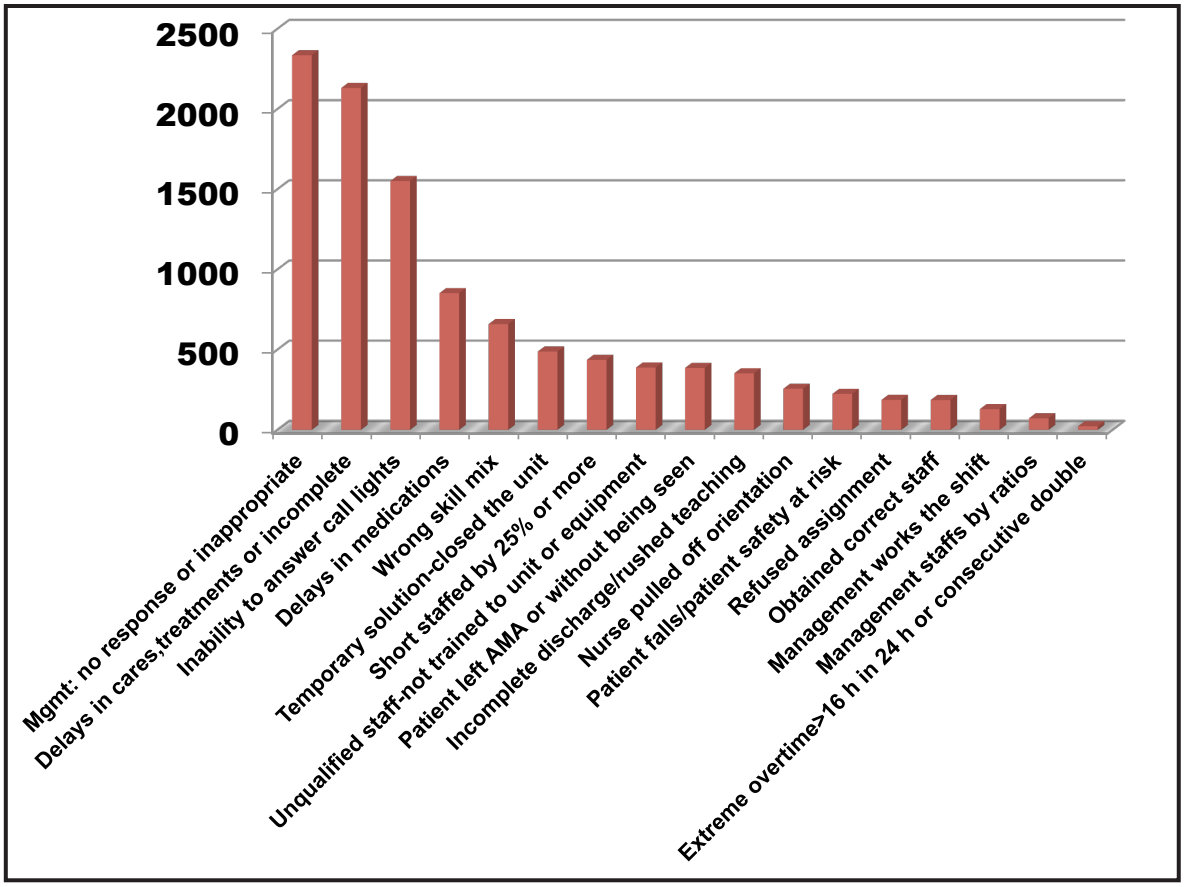
A few categories with significant changes are highlighted here.

- "Delays in care or treatment or incomplete assessments" occurred 2,131 times in 2016, an 11 percent increase.
- An "inability to answer patient call lights" was reported 1,551 times. More than half the time, patient call lights were not answered within a reasonable time.
- Instances when a nurse was prematurely taken off orientation in order to fill a short staffing need experienced a 19 percent increase in 2016.
- Nurses reported they were successful in getting the right number and skill mix of nursing staff when there was short staffing only 186 times.
- Unqualified staff was used to resolve the short staffing problem 388 times in 2016. More than once a day a nurse was floated to a unit where she or he was not trained to work. This includes either not knowing the care practices for the patient population or equipment used to care for them.
- Instances when a shift was left short staffed by 25 percent or more increased by 72 percent, which is a 221 percent increase since 2014.
- In 2016, hospital management working the short staffed shift increased by 158 percent.
- Patients did not receive their scheduled medication at the time it was ordered to be given 852 times in 2016. Nurses reported nearly 50 percent of the time patients' medications were not administered according to the physician's orders.
- Hospital administration chose to resolve the short staffing issue by substituting a worker who was not skilled to the level that was necessary 659 times.
- Nurses refusing unsafe assignments rose by 228 percent in 2016. Nurses realize more and more that, in order to protect the patients in their care, they must refuse to accept assignments that are unsafe.

## Recommendation

At a minimum, Minnesota patients deserve to be protected when they enter the hospital. Minnesota needs to set a minimum number of nurses that will be scheduled to work every day and every shift so that there are enough of them available to care for patients properly.

## CFSS SUBMISSIONS




# INTRODUCTION

When nurses are forced to work short staffed, patients suffer. Short staffing is defined as not enough nursing staff scheduled or available to care for patients at one time on a specific hospital unit to the point that patient safety and quality of care are endangered. The research shows that short staffing increases patient mortality, results in increased adverse events and medication errors, and is associated with poor quality of care. Improving nurse staffing while controlling for variables, however, significantly cuts risk of mortality, lowers the incidence of medication errors and other adverse events, cuts patient readmission rates, reduces nursing-sensitive negative outcomes, and even saves hospitals and insurance companies money. Study after study has shown this and created a consistent record of findings. Unfortunately, short staffing is an all-too-common problem in Minnesota. In order to track and combat short staffing, the Minnesota Nurses Association (MNA) has developed a reporting tool known as the Concern for Safe Staffing (CFSS) form.

Too often, nurses find themselves in short staffing situations, and their only recourse is to document these incidents in CFSS forms that are subsequently tracked and analyzed by MNA.

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

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 nurse as well as the justification on the basis of patient safety and quality of care.

A record of staffing concerns from frontline nurses serves to identify trends and issues in short staffing. CFFS forms should be useful to 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 a staffing decision (rather than a nurse's abilities or performance) was at the root of any negative patient event. After all, the goal of any reporting is to alert decision-makers to identifiable trends and problems so appropriate actions can be taken to resolve them.

## History

The CFSS 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 MNA.

In the first few years, some CFSS forms were reviewed at least quarterly by MNA in conjunction with the employer 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.

In the early to mid-2000's, MNA nurses revised the CFSS form again 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 healthcare 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 patient advocates.

## CFSS Revisions

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

- 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.
- In 2015, key words were identified as nurses repeatedly used specific terms to describe the short staffing problem, the nursing staff's ability to adjust to the patient care needs, and solutions nurses used to fix the short staffing problem.

## Patient Care Reports

There are three official methods to capture negative patient care incidents and outcomes: Hospital Incident Reports; Adverse Health Event Reports; and Sentinel Events. These reports 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 incident overlaps with short staffing, CFSS forms do not serve as a replacement for reports by a regulatory agency.

Hospital Incident Reports capture and count negative patient care events. These are internal forms filed by healthcare professionals who have made errors in care when a patient or visitor sustains an injury while in the hospital. 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 and 2009) provides a snapshot of efforts in hospitals, community behavioral health hospitals, and outpatient surgical centers to prevent adverse events. The law requires that these facilities disclose when one of any 29 reportable events occur and mandates MDH to publish annual reports of adverse events by facility. MDH also includes the results of root cause analysis in the precipitating factors of adverse events. 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 (TJC) is a nonprofit organization that accredits more than 20,000 healthcare programs and organizations in the United States. Most state governments recognize TJC accreditation as a condition of licensure and the receipt of Medicare and Medicaid reimbursements. TJC 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 TJC in order for the agency to provide support and assistance in analysis, response, and education from sentinel events.

***"1:1 with baby in active withdrawal, with having no experience with this type of birth before."***

*– CFSS Report, 1/15/16*

## CFSS Forms

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 way nurses seek to address quality of care concerns before patient safety is impacted. CFSS forms follow the essence of the above official reports and guide nurses to document the impact on patient care, provide an analysis of the cause, document the actions undertaken to correct the problem, and 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.

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

In March 2015, MNA submitted thousands of CFSS forms to MDH in order to raise awareness of nurse concerns with short staffing and to seek 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.

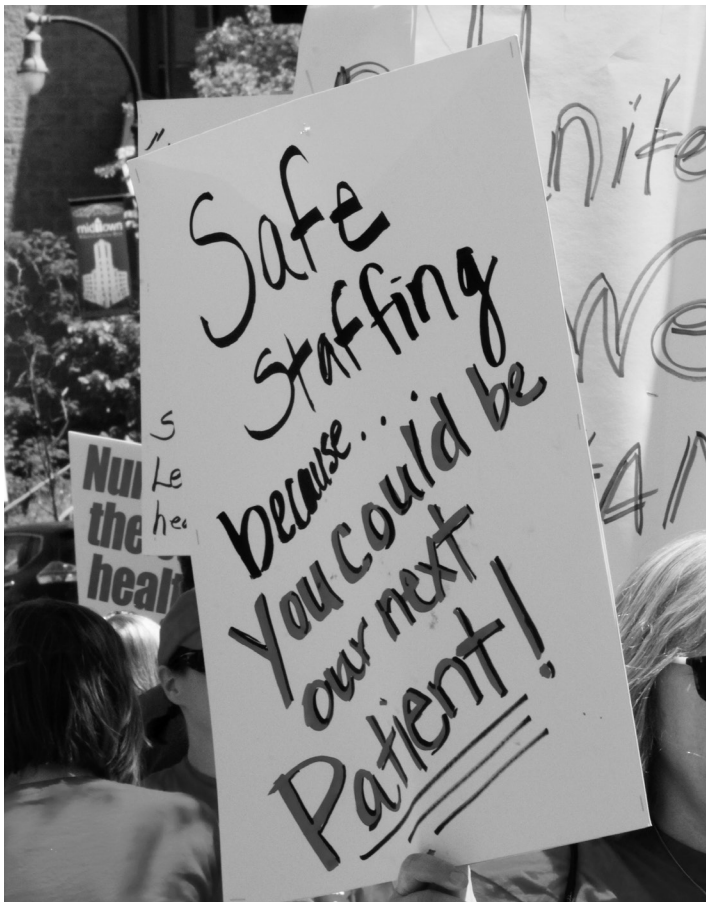
Just as the Minnesota Adverse Health Events reporting is regularly reviewed, MNA CFSS forms are regularly scrutinized in order to make them more useful to improve patient safety and quality care.

In 2015, MNA began categorizing the data collected by CFSS forms in order to enhance our analysis of short staffing. This was carried forward into 2016. The 17 categories can be clustered into four main groups:

- Negative patient outcomes or near misses
- Temporary last minute fixes by administration
- Temporary nurse solutions
- Staffing by ratio versus acuity

In June 2016, more than 4,000 nurses engaged in a one-week labor strike and again in September of 2016 for five weeks. As a result, MNA created a public website where nurses, patients, and patient's friends or family could report unsafe care and short staffing. The site remains open and available so that short staffing can be tracked and submitted to the appropriate regulatory agency. MNA nurses believe that all patients deserve to be safely cared for in a hospital that is not short staffed.

This second annual report shares insight into short staffing in Minnesota by documenting and analyzing the many instances in which RNs reported concerns for their patients. Short staffing is a serious and pervasive threat to patient care in Minnesota. Many patients have told MNA they would like to know if and when their local hospital is short staffed. The need for transparency and the evidence presented here should serve as catalysts for change in healthcare policy. Nurses need to know they will care for only a safe number of patients at one time and that their patients will receive the quality care they need and deserve.




## 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 short staffing.

- 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)
- Unit was short staffed or below the staffing target by 25 percent or more
- Pulled a new nurse off orientation early to fill the short staffing need
- Staff untrained to either the patient population or equipment

- 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 rather than patient acuity or nursing intensity

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

1) 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)
2) 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)
3) Temporary nurse solutions (unit closed to admissions; refused unsafe assignment; advocated until correct staffing obtained)
4) Staffing by ratios rather than patient acuity or nursing intensity

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 short staffing. The following is a complete description of each category.

## Negative Patient Outcomes or Near Misses

### Delays in Treatment/Cares or Incomplete Assessments

Delays in treatments/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 intravenous (IV) site rotations or delayed dressing changes. The common denominating factor is 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 care, 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 constitute 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 medication, 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 medication 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, 2011).

Medication delays have an even greater impact on a patient's experience of pain. Pain is complex and multi-dimensional. 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 or increase the patient's suffering, thereby rendering 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 at admission and serves as a critical component of patient care at the hospital and after the patient leaves for home. 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, misunderstanding, 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 nurses' 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.

### 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 one million incidents in the U.S. each year (Oliver, Healey, & Haines, 2010). Unless a fall produces a serious injury or death, however, 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.html).

Risk to patient safety is also noted in many CFSS forms. This occurs when, in the nurse's professional judgement, staffing was so short it put patient safety in jeopardy. CFSS forms documented instances such as a physician ordering that a patient has a 1:1 attendant at all times, only to have the order not executed because of short staffing. This can lead to patients getting out of bed without help and/or pulling out invasive tubes or catheters (leading to falls or injuries); patients wandering off the unit in a confused state; and needless exposure to infection secondary to the reinsertion of lines, tubes, or catheters.

### Patients Leave AMA or Without Being Seen

Lastly, nurses report incidents on CFSS forms 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—including 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).

***"Patient needing a 1:1 sitter, numerous near miss falls, unable to answer lights resulting in patient being incontinent."***
*– CFSS Report, 1/19/16*

## Unacceptable Administrative Responses and Temporary Fixes

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.

### No Response/Inappropriate Responses

"No response" or an "inappropriate response" from managers increased 9 percent from last year. Comments such as, "oh well," "there is no one else", "I'm not sure what you expect me to do about it", or "work with what you have" are actual responses from nurse managers, nurse supervisors, or on call hospital administration when short staffing was identified. 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. Their 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."

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.

### 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 of no limits to the number of hours a nurse can work in any given day or over any given number of days. 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 49-55 minutes extra each shift, despite studies that show 75 percent of nurses already work 12-hour shifts (Rodger, 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 because there was no one to responsibly give report to and hand off care for their patients. 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 Seriously Short Staffed

Leaving a shift short staffed by 25 percent or more is an unacceptable occurrence pervasive enough to be reported in CFSS forms. For example, if a unit typically needs 12 nurses for a hospital census of 36 patients, but only 7 nurses are on duty, that is seriously short staffed. 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 short staffed or below the goal for the number of Registered Nurses, 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). Another noteworthy study found that a patient's risk of mortality increases 7 percent during the first 30 days of admission for each additional patient added to the nurse's workload (Aiken LH, 2014). If a nurse's load is typically four patient assignments, for example, but she is then given five, six, or seven patients routinely, then the risk of dying for each of those patients rises 7, 14, 21 percent, respectively. This is alarming because short staffing by 25 percent or more 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.

***"Too many residents to take care of safely, causing imminent harm and danger. 2 falls, (1 resulted in a fracture) call lights not answered timely."***

*– CFSS Report, 10/2/16*

### Reducing or Stopping Nurse Orientation

Temporarily halting or terminating the orientation of a new nurse because of short staffing is an unfortunate and unsafe stopgap measure utilized with increasing frequency. Orientation is a critical time when a new nurse (including new to the unit or hospital) is assigned to a more senior nurse to learn the ropes of a particular unit and patient population.

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. It is also likely that short staffing has also forced the charge nurse, who would normally be relied on to help the new nurse, to already assume primary care of a patient(s). This is unsafe. 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

In many instances, hospital administrators utilized improper staff as a stopgap measure to resolve short staffing. For example, administrators have required obstetric (O.B.) nurses to work in the emergency department (E.D.). There are very specific training and certifications that qualify nurses to work in both of these areas of nursing specialties, according to most hospital policies and national nursing standards. According to CFSS forms, some nurses trained in medical/surgical units have been required to work in oncology or care for mental health patients who are being held in the emergency department waiting for a bed on a mental health ward. Expecting nurses who do not have experience on a particular unit or with the specific equipment to safely work in a patient care area puts patients as well as nurses at risk.

Competency is a professional responsibility that should not be compromised. Nurse educator 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). Before being asked to float to a different unit, administrators must ensure that a nurse has the appropriate knowledge and skill to care for a particular patient population.

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 intervention (Davies, 2014).

### Wrong Skill Mix

Another irresponsible tactic is using the wrong skill level to fill a short staffing need. Nurses report technicians being sent to a unit to do nursing care, a nursing assistant offered as a replacement for a nurse, and even nurses having to forgo registered nursing care to perform technician tasks.

### Management Works the Shift

Despite labor contracts, 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 system and protocol). 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 in a short staffing scenario.

### Closing the Unit

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 the unit and in the care of the nurses on that unit.

### Refusing an Unsafe Assignment

Another short-term solution is to refuse patient assignments because accepting another patient will place the safety of other patients at risk. For instance, asking nurses to take on more patients than they can safely care for at one time places patient safety 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(7), which vests in professional nurses' ultimate accountability for the quality of care they deliver. This solution saw the largest increase in utilization. This simply demonstrates the professional and ethical dilemma nurses face all too frequently. Hospital management forces nurses to make the difficult choice of refusing nursing care to a new patient because they are already struggling to provide care to their current patients.

### Obtaining the appropriate staff

The best-case scenario for nurse solutions to short staffing is for nurses or administrators to find ways to increase staffing, such as obtaining qualified nurses from other units or calling in extra staff to make sure the correct number of properly trained staff can deliver safe, quality care. This works assuming the unit where the nurse is "borrowed from" is overstaffed or there are nurses on call who are willing to come in and help.

***"It is very dangerous for a person that doesn't consistently mix chemo to make that many meds under a lot of pressure from a busy day and being short staffed."***

*– CFSS Report, 12/14/16*

## Staffing by Ratios Versus Acuity or Intensity

Nurses believe that hospitals must ensure a minimum level of safe patient care by limiting the number of patients nurses care for at one time. Oftentimes, hospital administration staffs units only by the number of patients in a unit, rather than by the patients' acuity (how sick they are) or by nursing intensity (how much nursing care their needs require). MNA nurses find it extremely frustrating and hypocritical when hospital administrators staff by ratios when it benefits their bottom line but refuse to consider permanent staffing like this to ensure a minimum level of patient and nurse safety and a minimum level of quality care.

# CFSS 2016 TOTALS COMPARED TO 2015 AND 2014

MNA nurses filed 3,000 CFSS forms during the 2016 calendar year, a 9.45 percent increase over the previous year. There have been no changes to the forms since April 2014. When the specialty or number of nurses on duty is too low, nurses alert hospital management and administration in the hopes they will immediately help resolve the problem. Registered Nurses then file a CFSS form by going to the MNA website and filing the form electronically. The forms can then be emailed or printed and given to their supervisors, or both, for local review at a more appropriate time. The electronic version comes to MNA and is entered into a database for monthly reporting, tracking, and analyzing. The most troubling statistic is management's pure disregard for the nurses' request for help when a shift is short staffed. Three years in a row, management not responding to nurses' requests is the number one reported problem. In 2016, nurses reported 2335 times their appeal for assistance fell on deaf ears.

By far, the most frequently reported direct patient care delivery problem in 2016 was "delays in cares or treatments or incomplete assessments." Nurses reported 2,131 times that patients' cares were delayed, skipped all together, or nurses didn't have the time to complete an assessment to determine what care was even necessary.

***"Call lights not answered timely, residents pain management not resolved. Inadequate supervision of resident. Toileting, turning/ positioning inadequate, not according to protocol for cares."***

*– CFSS Report, 10/12/16*

Similarly, nurses reported 1,551 times that they were unable to answer patients' call lights because of short staffing. 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 some call lights go off for capricious or personal care needs, nurses don't know what is behind the call light until it's too late.

While this year's reports of delayed medications are down 3 percent from 2015, they still remain high. Incidents of patients' medications not given as scheduled or prescribed because of short staffing represents 28 percent of the total reports filed. This included instances when patients had to wait extended periods of time for pain medication. Research defines a medication delay as an incident when administering the medication was late 30-60 minutes or more. Other nurses follow their facility's 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.

Incidents of patients leaving a hospital against medical advice (AMA) or without being seen at all also saw a decrease in incidents reported. In 2016, nurses reported patients left the facility without being seen or AMA because of short staffing 386 times. This was down from 406 reported incidents in 2015 or a 5 percent decrease. It is a positive sign for hospitals and especially for patients.

Patients being rushed through discharge with teaching done hastily because of short staffing, and patients falling in the hospital because of short staffing also saw declines, but by slim margins, 1.1 percent and 1.7 percent, respectively. One of the biggest concerns patients have is whether they will be able to take care of themselves once discharged. Rushing through a patient's discharge instructions is not the best way to reassure a patient or family that they will indeed be "okay" once they are on their own. Technology that has moved patients through their acute care hospital stays more quickly has done nothing to reassure them mentally and emotionally that they will be able to care for themselves once discharged. In fact, the quick progression has increased fears rather than assuaged them.

## 2015-2016 Data Comparison Analysis

An important factor to consider in this year's analysis is that nearly 25 percent of MNA nurses eligible to file the forms were on strike a total of seven weeks in 2016. Even so, the number of reports submitted increased by almost 10 percent. More often than not, short staffing yields multiple consequences at once. Accordingly, each CFSS form can document several consequences and impacts of short staffing. In 2015, nurses submitted 2,741 forms with 9,626 instances of negative patient care consequences. In 2016, nurses submitted 3,000 forms with 10,654 instances of negative patient care consequences. Thus, while the year-over-year increase in nurse-reported short staffing was 9.45 percent, the negative patient consequences of such staffing increased by 11 percent. Clearly, healthcare facilities are overwhelmed by short staffing. If this trend continues, it will indicate that short staffing has reached a tipping point and is endangering patient safety and quality of care.

Again, this year, another contributing factor to the increase in the number of incidents of negative patient consequences is a concomitant rise in documented "serious" understaffing. Patient care is seriously short staffed when nurses report the unit is more than 25 percent short of the staff needed to safely care for patients.

From 2015 to 2016, nurses reported 72 percent more incidents of seriously understaffed units. While serious short staffing represents 14 percent of the total occurrences reported in 2016, that's a 72 percent increase over last year and a 221 percent increase from 2014. Nurses are not able to progress patients through their nursing care plans when this situation arises. They are merely trying to keep people safe from harm. Too often they must prioritize which patient they will focus on keeping safe.

The second-largest year-over-year increase was nurses reporting they worked with equipment or patient populations they were not trained to handle. Unfortunately, hospital administration has repeatedly used this tactic. Imagine a plumber being told to pour a concrete foundation or a roofer told to mason a wall. It's a sign that the hospital is desperate and doesn't have extra staff to help. This category saw a 53 percent increase. Nurses cited 129 times in 2016 (a 158 percent increase over the previous year) instances when managers offered to help by working side-by-side with staff nurses on a short staffed unit.

While seven categories saw drops in reported incidents, those decreases were minimal. The greatest decrease was only 4.93 percent, which was in the category of patients leaving against medical advice (AMA). The seven categories with decreases were: unqualified staff-wrong skill mix (0.30 percent); incomplete discharge or rushed teaching (1.12 percent); patient falls or patient safety at risk (1.75 percent); management staffing by ratios (2.70 percent); delay in medications (3.40 percent); and extreme overtime greater than 16 hours in a 24-hour period or multiple 16-hour shifts in a row by the same nurse (4.35 percent). The decreases in these numbers would appear to be good for patients. Any decrease in poor quality and unsafe care should be seen as an improvement, but, as patient advocates, nurses would expect that the overall number of CFSS forms filed would go down. This would represent better patient care and less short staffing.

## 2014-2016 Data Comparison Analysis

| Top Reported Incidents | Years reported |
|---|---|
| 1. Management Not Responding | 2014, 2015, 2016 |
| 2. Delays in Care or Treatments | 2014, 2015, 2016 |
| 3. Inability to Answer Call Lights | 2014, 2015, 2016 |
| 4. Delays in Medications | 2014, 2015, 2016 |
| 5. Unqualified Staff Sent to Fill Need | 2014, 2015, 2016 |

In our comparison of the reports from 2014, 2015, and 2016, the top five most frequently reported incidents remained the same year-over-year and in the same order.

1. Consistently, the most reported complaint was management not responding or inappropriately responding to short staffing in 2014, 2015, and 2016
2. Patients experiencing delay in care or treatments or incomplete assessments
3. Inability to answer patient call lights
4. Delays in medications
5. The wrong skill mix or wrong level of trained staff sent to resolve the short staffing

Clearly, this demonstrates that hospital management and administration do not work with nurses proactively to fix short staffing and that negative patient outcomes remain in the top five categories as incidents experienced during short staffing.

## Categories with the Largest Increases

Patients having to wait extended periods of time to receive primary cares or assistance with activities of daily living; having to wait prolonged periods of time for treatments to be performed or initial beginning of the shift assessments; or new admission assessments rose 10.64 percent from last year.

Instances where a nurse was taken off orientation prematurely in order to fill a short staffing need saw a 19.07 percent increase in 2016. Administration believed 256 times last year that it would be an acceptable practice to suspend a new (to the profession or to a specific patient population) nurse's orientation for the day and assign that nurse to care for patients independently. When short staffing rises to this level of crisis there are even fewer resources available to assist that orienting nurse who has questions or when a patient "goes south." Nurses should only be pulled off their orientation schedule early when it is mutually agreed that further orientation is unnecessary because of the nurse's proficiency, not for short staffing purposes.

One category with a positive increase for patients was management agreeing to temporary solutions and nurses receiving the correct staff necessary. Sometimes nurses are successful in efforts to resolve short staffing when hospital man-

agement validates their concerns and works with the nursing staff to obtain the correct number necessary for the patients' safety. Nurses temporarily resolving the short staffing by advocating for the right staff rose by 36.76 percent. The downside to this is usually the time nurses have to spend justifying more staff. Frequently in 2016, this request was simply to fill a physician's order that was already in place. For example, when patients become confused and cannot be left alone in their rooms, a sitter (1:1) is ordered. Rather than sedate or restrain these patients, it is "best practice" to provide a staff person to sit in the room with the patient during the shift or time of confusion until the patient is determined to be safe while not attended. Too many times these orders for 1:1's were not filled at the beginning of the shift or the staff person reassigned from their normal role was not replaced, which leaves other duties abandoned. While this temporary solution is a positive one, it would be of value to know how much time is spent trying to resolve it.

Unqualified staff either not trained to the unit they are assigned or not trained to specific equipment experienced a 53.36 percent increase in reports this past year. This unacceptable administrative solution puts both patients and nurses at risk and should be eliminated.

Instances when a shift was left short staffed by 25 percent or more increased by 71.65 percent.

Management working the short staffed shift increased by 158 percent. This most definitely is a positive albeit temporary solution for short staffing. This is assuming that managers have remained competent in their skills and can safely care for patients and manage patient flow on the unit. Technology, medications, and patient care can change so rapidly nurses often realize their managers would like to help but are unable because they are no longer proficient in patient care. One limitation is that the form does not specifically ask if the manager is indeed competent. It is just assumed that if they accept the work, they are not putting patients in danger by caring for them.

Finally, the largest increase reported was in nurses exercising their professional responsibility to not accept an unsafe patient assignment. This protects the nurse and her license but more importantly protects the patients. Nurses refusing unsafe assignments rose by 228.07 percent in 2016. Nurses realize more and more that, to keep their license to practice and to protect the patients in their care, they must refuse to accept the additional patients management attempts to force on them because of short staffing.

# LIMITATIONS

Each year, MNA, through elected member groups and member education, makes every effort to reduce known limitations and identify new ones.

Likely the biggest limitation in the utility of the CFSS forms is that MNA nurses most certainly do not fill out a CFSS form every time they experience short staffing. As mentioned in last year's report, a survey conducted in 2014 revealed that nurses only fill out a form at a rate of 1 in 10 instances of short staffing. This inconsistency in filing forms has been anecdotally confirmed by nurses. Clearly, they understand the importance of data yet often experience obstacles or plain exhaustion that prevent them from filing CFSS forms. In some instances, nurses report fear of retaliation for filing a CFSS form or believe it is a reflection of their ability as a nurse. Some nurses may view documenting short staffing as a personal admission of failure, as the caregiver who submits a CFSS form is admitting that the care provided suffered.

Nurses by and large are trained, habituated, and required to maintain the same standard of care no matter the circumstances. In nursing culture, failure to properly care means potential patient harm—a cardinal sin for those who swear to help and care for others. Perceived failure also represents a source of potential discipline from the employer or even the Minnesota Board of Nursing. Minnesota law leaves the RN with ultimate accountability for the quality of care delivered. Therefore, hesitancy by nurses to report actual or potential harm to their patient is quite understandable.

In an effort to make the CFSS form more user friendly, the checkboxes that were created also present subjectivity. The checkbox functionality identifies items such as the main problems causing the short staffing issue and subsequent negative patient outcomes. However, this simplicity opens up the data to user interpretation, and, therefore, subjectivity remains a limitation. For example, delays may be perceived by one nurse differently than his or her co-worker.

There are other categories that obviously need to be added as they have great impact on nurses' abilities to fulfill their duties as well as protect patient safety and well-being. Examples would be tracking nurse safety during short staffing, regardless of the charge nurse forced to take a patient assignment, and tracking when 1:1 orders are being overridden by non-medical staff.

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 incidence of short staffing.

## IDEAS FOR FUTURE REFINEMENT

As violence in the workplace escalates, particularly in acute care facilities as well as in the field with clients, nurse safety is critical to providing safe, quality care. MNA will consider including nurse safety in the CFSS form along with patient safety. Short staffing can be a precipitating factor for incidents of violence against nurses.

A common physician order for patient safety is the order for a 1:1 in place of pharmaceutical or physical restraints when a patient is not safe to be left alone. Typically, this is due to a patient's instability or competency to move about the room independently or because of efforts to continually pull at IV lines, breathing tubes, etc. While sitters are expensive for hospitals, it is the preferred, best practice over administering medications to sedate or tying a patient to the bed. What's alarming is a growing trend of not fulfilling the doctor's sitter order. The MNA CFSS form does not specifically track this, but nurses often comment in the text boxes about patient safety or injury because the supervisor did not assign a staff to fill the physician order for a 1:1. This is startling evidence of a nursing administrator practicing medicine without a medical license. The only professional who can discontinue a physician's order is another physician. This is an unacceptable practice and needs to be reported to regulatory agencies every time it occurs. This obviously creates compromised care for the other patients.

In addition, the practice of routinely assigning the unit charge nurse primary patient care is a category MNA will likely add to the form. As mentioned earlier, the charge nurse on a patient care unit is to be the "pilot" or director of the unit for a specific shift. Charge nurses are generally tasked 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 or "Code Blues") and fluctuations in patient acuity on the unit. When charge nurses take on patient assignments and are drawn away from their essential role in addressing and preventing emergencies, patients lose an invaluable barrier separating them from potential adverse events.

Participating in academic research to verify and quantify the patient impact of care breakdowns in CFSS form categories is another potential refinement to improve the form's utility.

***"Patient 1:1 with violent history was given to ICU nurse who had an ICU tele already, told he did not need to be a 1:1."***

*– CFSS Report, 11/2/16*

## FUTURE TRENDS

Nurses reported having to refuse assignments a record 187 times last year, a 228 percent increase from 2015 and a 405 percent increase from 2014. This exemplifies how much more nurses are fighting back to do what is in their patients' best interests.

Another area of concern is the number of times nurses reported that their shift was staffed 25 percent less than what was needed.

- In 2014, it was reported 136 times
- In 2015 nurses reported it 254 times (87 percent increase)
- In 2016, 436 times, (72 percent increase)

From 2014 to 2016 this category experienced a 221 percent increase.

Nurses report short staffing for a variety of reasons. One growing cause is staff are floated to units for which they are not properly trained. In 2016, nurses' reports of this occurring increased 53 percent. Nurses were sent to work in units or departments in which they were not properly trained 388 times in 2016—compared to 253 in 2015.

## A NURSING SHORTAGE VS A STAFFING SHORTAGE

Many times, nurses' requests for help during times of short staffing are met with responses from management stating there is no help available. They claim a "nursing shortage" is the problem. This begs a discussion of the difference between a nursing shortage and a staffing shortage. A nursing shortage is when the supply of nurses is not sufficient to fulfill the demand for nurses in open and available nursing positions. On the other hand, a staffing shortage occurs when there are not enough nurses scheduled to work at one time to care for the patients who need care or are looking to get care. In 2015, Minnesota nursing schools graduated 3,329 new Registered Nurses. Other nurses were granted the privilege to work in Minnesota through licensure by endorsement, which is offered to nurses from other states. Adding those new licensees, Minnesota added a total of 7,376 new nurses in 2015 (the last year for which data is available). According to data from the MN Department of Employment and Economic development, (DEED) there were 1,554 nursing jobs posted in Minnesota in 2015 due to retirement and new job openings. Minnesota graduated 3,329 new Registered Nurses for 1,554 jobs (a 2:1 ratio for every job opening) and licensed even more (nearly a 5:1 ratio).

Looking ahead, long term projections for new RN positions in Minnesota due to retirement and new job openings are not much higher than what were added in 2015. We can assume the state will need 2,010 new nurses each year going forward, according to the occupational resource Projections Central (http://www.projectionscentral.com/Projections/LongTerm). Meanwhile, the number of Registered Nurses who graduate from Minnesota schools and who come to the state from elsewhere and obtain licensure will continue its upward trajectory.

In Minnesota, the problem is not a nursing shortage. It's a staffing shortage. 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, which is, after all, the biggest reason a patient is admitted in the first place.

# CONCLUSION

As the number of CFSS form submissions continues to rise, it shows 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 irresponsible and downright frightening. As hospital administrators continue to ignore the nurses' concerns, they are ignoring the weight of academic research demonstrating that, when nurses work short staffed, patients suffer.

There's an ever-expanding list of excuses and justifications for short staffing patient care units in Minnesota hospitals. Administrators' methods are endless. During the time this report was being written, a Minnesota nurse submitted a 2017 CFSS form detailing how 19 mental health patients were being held in that hospital's Emergency Department (E. D.) because the mental health unit was so short staffed. Minnesotans and their elected officials should be outraged. This is not appropriate care. When wait times exceed nine hours, patients needing emergent physical care should be given the option to go to another facility to receive care. As this report shows, incidents of short 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. We have already seen nurses in Intensive Care Units pressured to take two to three patients when best practices say 1:1 care is necessary. We know charge nurses who used to serve as a resource to other nurses are now routinely assigned primary patient care thereby eliminating their ability to be the resource.

| Year | Top CFSS Reported Incident | Amount Reported |
|---|---|---|
| 2016 | Management Not Responding | 2,335 |
| 2015 | Management Not Responding | 2,140 |
| 2014 | Management Not Responding | 1,491 |

Administrations should staff hospital units safely and appropriately. For example, build staffing costs into nursing budgets. Until a law is passed to insist on this, nurses will have to continue to plead with hospital administration and management for the appropriate skill and right number of nursing staff for each shift that is shorted. Those protests are successful in just a few instances. Unfortunately, in 2016, when shifts were short, nurses reported receiving the appropriate staff only 186 times–only 6 percent of the time. In many instances, management either responded flippantly or didn't even bother to respond to nurses' pleas. Management was unresponsive, unsupportive, or uncooperative 77.80 percent of the time. Three years in a row this was the number one reported problem. Nurses reported 2,335 times administration did not resolve the staffing problem. It is time to legislate a minimum staffing standard.

# CFSS YEAR-END REPORT DATA FOR 2014–2016

| | 2014 | 2015 | 2016 | PERCENT CHANGE 2014 TO 2016 | PERCENT CHANGE 2015 TO 2016 |
|---|---|---|---|---|---|
| Delays in care or treatments or incomplete assessments | 1362 | 1926 | 2131 | 56.46% | 10.64% |
| Delay in medications | 646 | 882 | 852 | 31.89% | -3.40% |
| Inability to answer call lights | 1085 | 1504 | 1551 | 42.95% | 3.13% |
| Incomplete discharge or rushed teaching | 206 | 356 | 352 | 70.87% | -1.12% |
| Management staffs by ratios | 114 | 74 | 72 | -36.84% | -2.70% |
| Management works the shift | 84 | 50 | 129 | 53.57% | 158.00% |
| Management response - NONE or inapproriate | 1491 | 2140 | 2335 | 56.61% | 9.11% |
| Extreme overtime >16 hrs. in 24 hrs. or multiple doubles in a row | 19 | 23 | 22 | 15.79% | -4.35% |
| Patient falls or patient safety at risk | 357 | 228 | 224 | -37.25% | -1.75% |
| Patient left AMA or without being seen | 261 | 406 | 386 | 47.89% | -4.93% |
| Short staffed >25% of what is needed | 136 | 254 | 436 | 220.59% | 71.65% |
| Temporary solution - closed unit | 263 | 461 | 488 | 85.55% | 5.86% |
| Temporary solution - refused the assignment | 37 | 57 | 187 | 405.41% | 228.07% |
| Temporary solution - obtained the approriate number of staff | 91 | 136 | 186 | 104.40% | 36.76% |
| Unqualified staff - nurse pulled off orientation early | 124 | 215 | 256 | 106.45% | 19.07% |
| Unqualified staff - not trained to unit or equipment | 212 | 253 | 388 | 83.02% | 53.36% |
| Unqualified staff - wrong skill mix | 387 | 661 | 659 | 70.28% | -0.30% |
| **TOTAL** | **2062** | **2741** | **3000** | **45.49%** | **9.45%** |

MNA Minnesota Nurses Association
An Affiliate of National Nurses United

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