

Concern for Safe Staffing Form Annual Report 2017



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EXECUTIVE SUMMARY

This is the third annual analysis and report of the Concern for Safe Staffing (CFSS) forms on the continuing issue of short staffing in Minnesota hospitals. Registered Nurse members of the Minnesota Nurses Association (MNA) have documented their concerns with short staffing using 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 nurse's professional opinion patients did not receive the safe and quality care they require due to short staffing.

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. 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 shifts) or multiple nurses working consecutive double-shift days.

Our year-over-year analysis of CFSS forms revealed that nurse-reported instances of short staffing continue to increase. The number of reports filed increased by 1.8 percent. Nurses documented 3,054 incidents of short staffing in 2017, compared to 2,741 in 2015 and 3,000 in 2016. That is an 11 percent increase in shifts that were short staffed and as a result, unsafe, from 2015 to 2017.

An analysis of the 2017 CFSS reports yields important insights into trends in short staffing. 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 below.

- "Delays in care or treatment or incomplete assessments" occurred 2,105 times in 2017.
- An "inability to answer patient call lights" was reported 1,510 times.
- Unqualified staff were used to resolve the short staffing problem 354 times in 2017.
- 349 instances when a shift was left short-staffed by 25 percent or more.
- Patients did not receive their scheduled medication at the time it was ordered to be given 823 times in 2017.
- In 2017, hospital administration chose to resolve the

short staffing issue by substituting a worker who was not skilled to the level that was necessary 676 times.

- Nurses refusing unsafe assignments rose to 280 incidents in 2017. 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 to ensure patients are cared for safely and properly.

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. Conversely, improving nurse staffing while controlling for variables 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. Multiple studies have shown this and produced a consistent record of findings. Unfortunately, short staffing is an exceedingly common problem in Minnesota. In order to track and combat short-staffing, the Minnesota Nurses Association 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 are a rich source of data that provide insight into the incidence of unsafe, short staffing, as well as the multitude of ways patient care is impacted. The forms prompt nurses to inform their managers of high risk situations because of short staffing. This helps nurses begin difficult conversations with hospital administrators regarding the quality of patient care.

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. CFSS 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 and performance) was at the root of a 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 the Minnesota Nurses Association.

In the first few years, some CFSS forms were reviewed 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-2000s, MNA nurses revised the CFSS form again and renewed efforts to bring to light the quality and safety issues that repeatedly put patients and nurses at risk.

MNA also reached out to regulatory agencies 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. This is the nurse's dilemma. They 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.

- 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.

Incident Reports capture and count negative patient and visitor care events, (also called PVSRs). Incident Reports are internal forms filed by healthcare professionals who have made

errors in patient care or when a 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) 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 Medicare and Medicaid reimbursement. 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 for the agency to provide support and assistance in analysis, response, and education.

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

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 2017. The 17 categories can be clustered into four main groups:

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

In 2017, nurses in Minnesota resorted to closing units to new admissions and transfers to their floor and refusing patient assignments because short staffing situations jeopardized patient safety. In 2017, nurses reported closing units 517 times, which is up 5.94 percent over calendar year 2016. There were 280 incidents of nurses refusing patient assignments for safety reasons, a year-to-year increase of 49.73 percent. It is the hospital administration's responsibility to make sure that the facility has the right number, right skill mix, right skill level, and right training of staff for the patients who rely on them for care. Nurses will continue to do the right thing and refuse work that creates an unsafe environment for the patients they care for.

This third 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 that they will care for only a safe number of patients at one time and 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.

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)
- 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
- 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 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; pulled a new nurse off orientation early; sent the wrong skill mix of staff)
- 3) Temporary nurse solutions (unit closed to admissions; refused unsafe assignment; advocated until correct staffing obtained)

- 4) Staffing by ratios versus 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 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 intravenous (IV) site rotations or delayed dressing changes. The common denominator 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 helps 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 and 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. Often 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 Healthcare event reporting requirement (MDH).

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, injuries, and infections); patients wandering off the unit in a confused state; and needless exposure to infection second to the reinsertion of lines, tubes, or catheters.

Patients Leave Against Medical Advice (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 AMA 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).

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 often dangerous.

Year	Top CFSS Reported Incident	Total
2015	Management not responding	2,140
2016	Management not responding	2,335
2017	Management not responding	2,372

No Response/Unacceptable Solutions

"No response" or an "inappropriate response" from managers increased again this 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", were reported 2,372 times. 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". 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. 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. Another person's life and well-being are usually not negatively affected by those extra hours, but for nurses they are. Using overtime as a staffing solution has become an all-too-common practice for hospitals. There is no law that limits the number of hours a nurse can work in any given day or over any 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 many instances when they were required to work for more than 16 consecutive hours because no nurse was available to assume the patient care assignment. 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 short staffed 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 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 multiplied by 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 nurses' workload (Aiken LH, 2014). If a nurse's load is typically a four patient assignments, for example, but she is then given five, six, or seven patients routinely, each patient's mortality risk 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.

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 already forced the charge nurse, who would normally be relied on to help the new nurse, to assume primary care of a patient(s). 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

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. Nurses report that some nurses trained in medical/surgical units have been required to work in oncology departments or care for mental health patients who are being held in the emergency department waiting for a bed on 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. In an on-line 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). Before being asked to float to a different unit, administrators must ensure that the 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 mix to fill a short staffing need. Nurses report technicians being sent to a unit to do nursing care or a nursing assistant offered as a replacement for a nurse or 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 often, nurse managers were unqualified to fill staffing needs.

Nurse Solutions

Staffing crises 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 example, asking nurses to take on more patients than they can safely care for at one time harms patient safety. 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 simply demonstrates the professional and ethical dilemma nurses face all too frequently. Hospital management force nurses to make the difficult choice of refusing nursing care to a new patient because they are already struggling to provide care to the ones in their care already.

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. This works assuming the unit where the nurse is “borrowed from” is over staffed or there are nurses on call who are willing to come in and help.

Staffing by Ratios Versus Acuity or Intensity

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 often, 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 2017 TOTALS COMPARED TO 2016 AND 2015

MNA nurses filed 3,054 CFSS forms during the 2017 calendar year—a 1.8 percent increase over the previous year. When the specialty or number of nurses on duty is too low for patient safety, nurses alert hospital management and administration in the hope they will immediately resolve the problem. Registered Nurses then complete a CFSS form on the MNA website and file it electronically. The form may be emailed or printed and provided to a supervisor for local review at a more appropriate time. There have been no changes to the forms since April 2014.

When MNA receives the electronic version, the information is entered into a database for monthly reporting, tracking, and analysis. As noted in the chart, the most troubling statistic is management and administration's pure disregard for the nurses' requests for help when a shift is short staffed. Four years in a row, management not responding to nurses' requests is the number one reported problem. In 2017, nurses reported that their appeals for assistance fell on deaf ears 2,372 times.

Year	Top CFSS Reported Incident	Total
2015	Management not responding	2,140
2016	Management not responding	2,335
2017	Management not responding	2,372

By far, the most frequently reported direct patient care delivery problem in 2017 was "delays in cares or treatments or incomplete assessments." Nurses reported 2,105 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.

Similarly, nurses reported 1,510 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 incidents in which medications were delayed are down 3.5 percent from 2016, they still remain high. Incidents of patients' medications not given as scheduled or prescribed because of short staffing represent 27 percent of the total reports filed. This includes instances when patients had to wait extended periods of time for pain medication. Most nurses designate a medication delay as an incident when administering the medication was 30-60 minutes late.

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 medical and nursing standards 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 decreased. In 2016, nurses reported patients left the facility without being seen or AMA because of short staffing 346 times. This is down from 386 reported incidents in 2016 or a 10.36 percent decrease. It is a positive sign for hospitals and especially for patients.

Patients falling in the hospital because of short staffing also appreciated a decline. There were 224 reports of patient falls due to short staffing in 2016, but only 192 incidents reported in 2017. This represents a 14.29 percent decrease.

One of the biggest concerns patients have is whether or not they will be able to take care of themselves once discharged. Patients being rushed through discharge with teaching done hastily because of short staffing experienced a very minimal increase (one additional incident reported or 0.28 percent more). 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 processes patients more quickly through the healthcare system which undoubtedly benefits their physical health. However, this rapid processing has caused mental and emotional strain in patients because they are not reassured they can care for themselves at home. In fact, the quick progression has increased fears rather than assuaged them.

2016-2017 Data Comparison Analysis

An important factor to consider in this year's analysis is which categories experienced double digit percent changes. Nurses reported that they or their colleagues had to work extreme overtime only four times. Extreme overtime which is defined as exceeding 16 consecutive hours in a 24-hour period or multiple, unplanned consecutive 12-16-hour days, saw an 81.82 percent decrease. Likewise, inexperienced Registered Nurses being removed from their orientation prematurely because of short staffing also realized a significant decrease. In 2016, nurses reported that new staff nurses had been temporarily removed from their pre-scheduled orientation in order to fill a staffing need 256 times whereas in 2017 this was only reported 58 times. This is a 77.34 percentage decrease. It's remarkable to see both of these categories realizing a decrease, especially one of this magnitude. This improves patient care because nurses are not making critical decisions regarding

patient care while they are exhausted or unsuitably oriented to a department. Nursing management working a shift that was short also showed a 50.39 percent decrease. Staff nurses appreciate support and assistance from nursing management, but those managers must be competent in safe patient care to be helpful. Often, nursing management has been so far removed for so long that they are not current with new equipment, procedures, and care. This decrease also benefits patients.

Finally, nurses reporting that they refused an assignment because it was unsafe recognized a 49.73 percent increase. Nurses need to recognize the limits of what is an appropriate workload in order to give safe care versus accepting any and all assignments disregarding skill, acuity, and nursing intensity. Refusing an assignment ultimately benefits care as nurses are acting in the patient's best interest and advocating for better, safer patient care. In 2016 nurses refused patient assignments 187 times, but last year nurses reported 280 incidents of refusing an assignment. It is a nurse's professional, moral, and ethical responsibility to refuse assignments that place patients at risk because it is unsafe.

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. In 2017 nurses submitted 3,054 forms reporting 10,220 instances of negative patient care.

What is noteworthy is that the number of forms submitted increased slightly, however, the total of incidents reported is down from 2016. While the year-over-year increase in nurse-reported short staffing was 1.8 percent, the negative patient consequences of such staffing decreased by 4 percent. Short staffing is still overwhelming healthcare facilities' capacity to compensate for it using other strategies. If this trend continues, it will indicate that short staffing has reached a tipping point and is endangering patient safety and quality of care.

Another contributing factor to negative patient consequences is "serious" understaffing. This year nurses reported 349 incidents when patient care was compromised because of severe short staffing. This is a decrease from 2016, which is good for patients but not good enough. Patient care is compromised when units are seriously short staffed, which is defined as a unit is more than 25 percent short of the staff needed to safely care for patients.

From 2016 to 2017, nurses reported 19.95 percent fewer incidents of seriously understaffed units. Serious short staff-

ing represents 11 percent of the total occurrences reported in 2017. Nurses are not able to progress patients through their nursing and medical care plans when this situation arises. They are merely trying to keep people safe from harm and too often have to even prioritize who they will focus on keeping safe.

Nurses reporting that they or another nurse were either untrained to the patient population or untrained to use the required equipment where they were assigned to work realized a decrease in reported incidents in 2017. Nurses reported 354 times (or 12 percent of the reports filed) that a lack of training placed patients at risk. In 2016, it was 388 incidents or 13 percent. Unfortunately, hospital administration has repeatedly sent untrained RNs to care for patients as if any nurse can deliver safe care to any type of patient. 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 the appropriate staff to help.

While some categories saw drops in reported incidents, many of these decreases were minimal. Delays in medications, inability to answer call lights, and delays in cares decreased by only by 3.4, 2.6, and 1.2 percent, respectively. Of course, any decreases are good for patient safety, but these numbers are woefully bleak. The categories that saw decreases were:

- extreme overtime
- nurses pulled off orientation prematurely
- management filling in and working the shift
- management staffing by ratios
- short staffed by greater than 25 percent
- patient falls, patients leaving AMA
- staff not trained to equipment or the patient care unit
- delays in medications
- incomplete discharge or rushed teaching
- delays in cares or treatments.

One category that realized a decrease that does not translate into safer care for patients is a temporary solution-obtaining the right number of staff. Sometimes nurses are able to argue their position to the point management actually provides the requested amount of staff. Unfortunately in 2017, that amount decreased by 9.7 percent.

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.

2015-2017 Data Analysis Comparison

In our comparison of the reports from 2015, 2016, and 2017, 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 responding inappropriately to short staffing in 2015, 2016 and 2017.
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. Consequently negative patient outcomes remain in the top five categories as incidents experienced during short staffing.

Top Reported Incidents	Years reported
Management Not Responding	2015, 2016, 2017
Delays in Care or Treatments	2015, 2016, 2017
Inability to Answer Call Lights	2015, 2016, 2017
Delays in Medications	2015, 2016, 2017
Untrained Staff Sent to Fill Need	2015, 2016, 2017

Categories with the Largest Increases

The categories which experienced increases are: incomplete discharge or rushed teaching, management not responding, the wrong skill mix expected to fill staffing need, closing the unit to admissions and transfers, and nurses refusing to take on more patients than they can care for safely. Three of these categories represent reports resulting in negative patient outcomes while the other two actually protect patients already receiving care in the hospital. When nurses exercise their contractual right to close a unit to further admissions or transfers, patients already on the unit are more likely to receive safe care. Furthermore, when nurses exercise their legal and professional right to refuse additional patients above and beyond what is safe for them, they are protecting patients.

One of the biggest concerns patients have is whether or not they will be able to take care of themselves once discharged. Patients being rushed through discharge with teaching done hastily because of short staffing increased minimally, one additional incident reported for a 0.28 percent increase.

Management not even responding to the nurses or responding with less than helpful answers realized a small increase. In 2,372 incidents reported, management did not help resolve the short staffing situation.

Another category with an increase is the assumption that a non-nurse can deliver nursing care. For example, nurses have reported medical technicians and nursing assistants performing tasks outside their training. Nurses reported 676 times that the wrong skill mix was provided in the short staffing situation.

Two other growing categories were nurses closing their units and nurses refusing to take on more patients than what is safe. In 2017, nurses reported closing their units 517 times for a 5.94 percent increase and refusing the unsafe assignment 280 times for a 47.73 percent increase. Nurses have a huge responsibility to recognize their limitations and to advocate for patient safety. If this means a new patient gets re-directed to another facility, it may delay care by minutes. However, it may ensure that they actually get safe care at another location rather than the nurse irresponsibly assuming an additional patient that puts all patients already admitted and receiving care at risk. Each year, more nurses realize that to keep their license and to protect the patients in their care, they must refuse to accept the additional patients that management attempts to force on them because of short staffing.

“If (refusing an unsafe assignment) means a new patient gets redirected to another facility it may delay care for a few minutes. However, it may ensure that they actually get safe care at another location rather than the nurse irresponsibly assuming an additional patient that puts all patients already admitted and receiving care at risk.”

LIMITATIONS

Several limitations to the CFSS form remain, such as interpretation of the category and the method in which it is collected. However, each year, MNA makes every effort to reduce those 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 over and over again as staff and member leaders speak with nurses about short staffing. Clearly, nurses 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, MNA added checkboxes. However, these also present subjectivity. The checkbox functionality identifies items such as the main problems causing the short staffing issue and subsequent negative patient outcomes. 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, charge nurse forced to take a patient assignment, and tracking when 1:1 sitter orders are being overridden by non-medical staff.

While 2017 saw roughly the same number of CFSS forms submitted by nurses, it's apparent that many of the categories

went down in reporting. This could be a result of improvements in short staffing consequences, but the analysis shows that nurses may be taking less time and being less thorough filling out CFSS forms. MNA has polled nurses to know that fatigue and job dissatisfaction are common reasons for members to not fill out a CFSS form, but these feelings may be leading to quicker, less completely documented incidents as well. This theory deserves further attention, and, as such, rises or falls in categories reported should be viewed through this lens.

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 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 “sitter” 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 free text boxes or comment section about patient safety or injury because the supervisor did not assign a staff to fill the physician order for a 1:1 sitter. This is a startling revelation because it is 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.

FUTURE TRENDS

The fact that nurses reported having to refuse assignments a record 280 times last year, a 49.73 percent increase from 2016 and a 391.23 percent increase from 2015, exemplifies how much more nurses are fighting back to do what is in their patients’ best interests.

Another way nurses are being forced to protect patient safety is by temporarily closing their unit to admissions and transfers until the unit is stabilized enough to assume care for more patients. In 2017 nurses reported closing their unit 517 times. While it is a small increase at 5.94 percent, it is still an increase from the 488 times it was reported in 2016 which was a 5.85 percent increase over 2015.

After beginning the shift short, obtaining the appropriate number of staff to safely care for patients is a rare occurrence. This often requires great negotiating skill and perseverance to secure the right skill and number of staff to ensure safety. Unfortunately, this category experienced a 9.68 percent decrease. This means that almost 10 percent fewer times when nurses in charge were able to advocate and obtain the right staff to care for patients on their unit.

CONCLUSION

The number of Concern for Safe Staffing reports by Minnesota Nurses Association (MNA) bedside nurses has been consistently on the rise. MNA nurses reported more than 3,000 unsafe staffing incidents in 2017, nearly 2 percent more than the previous year. Breaking it down, throughout Minnesota, MNA nurses filed 8.4 unsafe staffing reports a day.

RNs demands consistently fall on deaf ears. In fact, of the 3,054 total unsafe staffing reports received in 2017, 2,372 (77.67 percent) reported Management Response to be “None or Inappropriate”—an increase from 2016. Over the past four years, management and administration’s pure disregard for help when a shift is short staffed has been the most frequently reported problem. Those responsible for staffing decisions have shown they are not reasonable, responsible, or concerned by bedside nurses’ reports, and the incontrovertible research—that unsafe staffing increases patient risk of harm.

Based on 2017 data, nurses acted to keep their patients safe by refusing an assignment if that additional assignment endangered patients’ health (up 49.73 percent) or closed a unit to new patient admits (up 5.94 percent); the result of hospital administration’s failure to safely staff its nursing units. Refusing an assignment or closing a unit are only temporary solutions. Proper staffing needs to be in place prior to the start of each shift.

Unsafe staffing situations resulted in 2105, reported delays in patient care or treatment, or incomplete assessments and 823 reported delays in medication, a decrease of 1.22 percent and 3.40 percent respectively from 2016. There were 1,510 reported instances of inability to answer call lights due to unsafe staffing situations, a decrease of 2.64 percent from 2016. The 193 instances of reported patient fall or patient

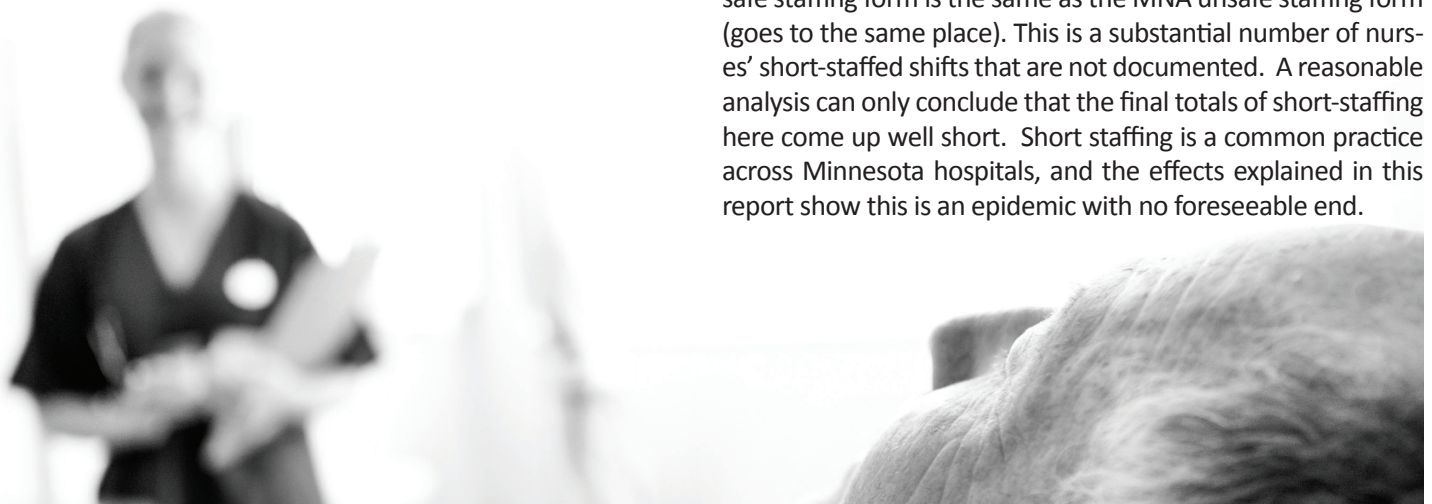
safety at risk is a decrease of 14.29 percent from 2016. The decreases noticed in the following categories; improved patient care or treatment, delay of assessments, delay in medication administration, inability to answer call lights, and patient falls or other patient safety risks may be the result of nurse’s refusal of an assignment or closure of a unit because of unsafe staffing situations. Clearly, safer patient-to-nurse ratios allow nurses to better care for their patients.

One of the most frequent complaints by patients is incomplete discharge or rushed teaching. From 2016 to 2017, this number basically remained flat with only one additional report (from 352 in 2016 to 353 in 2017).

Analysis shows a decrease in temporary solutions- number of staff, down 9.68 percent from 2016, meaning nurses are not getting adequate staffing when requested. To compound the issue the number of unqualified staff or the wrong mix of staff, increased by 2.58 percent.

When hospitals seek to increase their bottom line, patients suffer the consequences. Inadequate nurse staffing increases patient risk of harm; longer hospital stays; medication errors; injuries; increased duration, types of infections; and even death. Patients suffer, but so do nurses. They must carry the burden of heavier workloads and the moral and ethical implications of not being able to care for their patients adequately.

As mentioned, it’s a limitation of this report that MNA does not receive reports from the approximately 20 percent of non-MNA hospitals in Minnesota, which include the University of Minnesota Hospital and the Veterans Administration Hospital. Also, some hospitals have their own unsafe staffing form which nurses report filing either one or the other (hospital or MNA form), or misunderstanding that their hospitals unsafe staffing form is the same as the MNA unsafe staffing form (goes to the same place). This is a substantial number of nurses’ short-staffed shifts that are not documented. A reasonable analysis can only conclude that the final totals of short-staffing here come up well short. Short staffing is a common practice across Minnesota hospitals, and the effects explained in this report show this is an epidemic with no foreseeable end.

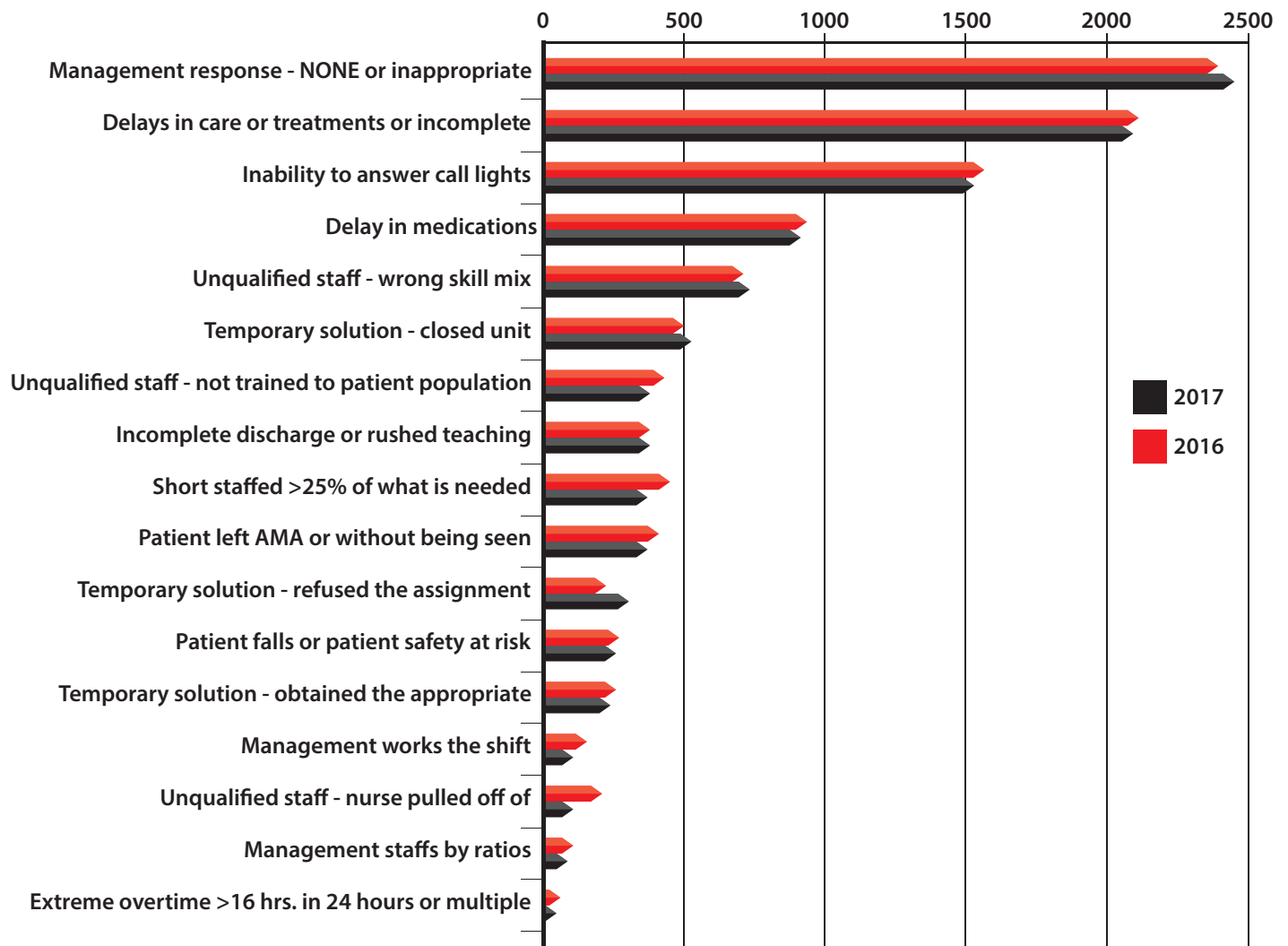


CFSS YEAR-END REPORT DATA FOR 2014 – 2017

	2014	2015	2016	2017	Percent Change 2014 to 2017	Percent Change 2015 to 2017	Percent Change 2016 to 2017
Delays in care or treatments or incomplete assessments	1362	1926	2131	2105	54.55%	9.29%	-1.22%
Delay in medications	646	882	852	823	27.40%	-6.69%	-3.40%
Inability to answer call lights	1085	1504	1551	1510	39.17%	0.40%	-2.64%
Incomplete discharge or rushed teaching	206	356	352	353	71.36%	-0.84%	0.28%
Management staffs by ratios	114	74	72	49	-57.02%	-33.78%	-31.94%
Management works the shift	84	50	129	64	-23.81%	28.00%	-50.39%
Management response - NONE or inappropriate	1491	2140	2335	2372	59.09%	10.84%	1.58%
Extreme overtime >16 hrs. in 24 hrs. or multiple doubles in a row	19	23	22	4	-78.95%	-82.61%	-81.82%
Patient falls or patient safety at risk	357	228	224	192	-46.22%	-15.79%	-14.29%
Patient left AMA or without being seen	261	406	386	346	32.57%	-14.78%	-10.36%
Short staffed >25% of what is needed	136	254	436	349	156.62%	37.40%	-19.95%
Temporary solution - closed unit	263	461	488	517	96.58%	12.15%	5.94%
Temporary solution - refused the assignment	37	57	187	280	656.76%	391.23%	49.73%
Temporary solution - obtained the appropriate number of staff	91	136	186	168	84.62%	23.53%	-9.68%
Unqualified staff - nurse pulled off of orientation early	124	215	256	58	-53.23%	-73.02%	-77.34%
Unqualified staff - not trained to unit or equipment	212	253	388	354	66.98%	39.92%	-8.76%
Unqualified staff - wrong skill mix	387	661	659	676	74.68%	2.27%	2.58%
Total	2062	2741	3000	3054	48.11%	11%	1.80%

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Nurses put the care in healthcare