

Responses to Arguments Against Safe Staffing Legislation

Updated June 2024

PATIENT SAFETY & ACCESS TO CARE

- ❖ **CLAIM:** Staffing ratios are inflexible and don't account for patient acuity or for nurse skill level.

Responses

- **Ratios are the floor, not the ceiling.** Holding hospitals accountable to what should be the minimum standard for patient safety does not prevent staffing plans that improve upon the bare minimum.
 - By setting the floor, **staffing ratios are inflexible in the same way that the minimum wage is inflexible**, preventing employers from lowering standards but not from competing to recruit and retain workers with better standards.
- **All effective safe staffing policies**, including the Oregon law and California regulations setting minimum staffing ratios, **require** each hospital to establish a staffing committee made up of at least half direct-care nursing staff to create **a hospital-wide staffing plan that meets the minimum ratios and includes adjustments for patient acuity, nurse skill level, and other factors** unique to the individual facility or unit.
 - In fact, California staffing regulations require a hospital-wide staffing committee comprised of at least half direct-care nurses to implement a patient classification system for determining nursing care needs of individual patients, and the system must be reviewed at least annually.¹

- ❖ **CLAIM:** Staffing ratios will limit the flexibility needed to respond to natural disasters, future pandemics and other emergencies.

Responses

- Effective safe staffing legislation seeks to penalize hospitals for violations of staffing plans that are predictable and preventable, **not for a reasonable response to an unforeseeable emergency.**
- Effective safe staffing legislation includes provisions for adjusting staffing plans during emergencies and requires longer-term adjustments to staffing plans in the case of ongoing emergencies (such as a pandemic) to be implemented through a hospital-wide staffing committee with direct-care professionals.²

- The Oregon safe staffing law allows for a hospital to adjust a staffing plan due to unforeseeable emergent circumstances but limits the deviation from the written staffing plan to no more than 90 days without the approval of the staffing committee.³
 - **This limitation allows for immediate response to an emergency without compromising standards of patient care in the long term.**

❖ **CLAIM:** Safe staffing requirements will lead to longer wait times for emergency care.

Responses

- **There is no evidence of this happening.**
 - The one piece of “evidence” of this is a remark in a 2009 report from the California Health Care Foundation⁴ **based exclusively on interviews with only 23 hospital executives. This claim in the report is not substantiated by any data** because, as the report states, “Very few hospitals had conducted any analysis of data related to ratios.”
 - For a more thorough debunking of this source, please refer to our companion piece to this document “Debunking Sources Used in Arguments Against Safe Staffing Legislation.”
- Here’s what the evidence *does* tell us about how patients are impacted by unsafe staffing.
 - Each additional patient added to a nurse’s workload can result in:
 - 5 percent lower likelihood of surviving in-hospital cardiac arrest⁵
 - 7 percent higher likelihood of 30-day in-hospital mortality⁶
 - 48 percent higher likelihood of readmission within 30 days for pediatric patients⁷
 - **Understaffing causes longer wait times in the emergency department.**
 - One 2010 study found that when nurse patient loads exceeded California’s mandated ratios, emergency department wait times were 21 minutes longer, causing patients to wait 37 percent longer.⁸

❖ **CLAIM:** Safe staffing laws could force emergency department diversions and EMTALA (Emergency Medical Treatment and Labor Act) violations

Responses

- **There is no evidence of this happening.**
 - The source commonly cited to support this claim is a **2009 report** from the California Health Care Foundation⁹ **based exclusively on interviews with only 23 hospital executives. This claim in the report is not substantiated by any data** because, as the report states, “Very few hospitals had conducted any analysis of data related to ratios.”
 - For a more thorough debunking of this source, please refer to our companion piece to this document “Debunking Sources Used in Arguments against Safe Staffing Legislation.”
- Diversions due to understaffing are not a violation of EMTALA.
 - Current rules from the Centers for Medicare & Medicaid Services regarding EMTALA specifically state: “The hospital may direct the ambulance to another facility if it is in

“diversionary status,” that is, it does not have the staff or facilities to accept any additional emergency patients.¹⁰

- **EMTALA exists to protect patients from the impacts of understaffed emergency departments.**
 - The real problem is that hospitals want to have it both ways. They want to treat patients while understaffing for the sake of revenue, banking on the commitment of nurses to patients to do more than they can safely handle. Staffing ratios help to protect patients by ensuring that hospitals aren't skirting standards of care, at the expense of patients and nurses.

RECRUITMENT & RETENTION

- ❖ **CLAIM:** The California ratio law has not improved recruitment or retention.

Responses

- A 2010 study found that nurse staffing ratios mandated in California to be predictive of better nurse retention in addition to being associated with better patient and nurse outcomes.¹¹
- Data from the 2022 National Sample Survey of Registered Nurses shows that about 20.5 percent of all licensed RNs in the nation are not currently employed in nursing. While we cannot link it directly to the staffing law, it is worth noting that **California's nursing workforce participation rate is higher than the national average**, with only 18.6 percent of RNs not employed in nursing.¹²
- Opponents of safe staffing legislation often claim there is a lack of sufficient evidence supporting the efficacy of staffing ratios while ignoring the consistent evidence that nurses and health professionals, who are experts in their own work and working conditions, overwhelmingly support legally enforceable staffing ratios.

- ❖ **CLAIM:** After staffing ratios were enacted in California, hospitals' reliance on travel nurses increased. When there is a large demand for travel nurses in one state, it diverts nurses from the rest of the country, causing ratios in other states to increase.

Responses

- There is no evidence showing an increase in use of travel nurse labor in California following implementation of its staffing regulations.
- Hospital-wide staffing committees should have the authority to review usage of travel and temporary nursing staff and create adjustments to staffing plans as needed. Strong collective bargaining agreements may include this review process, underscoring the importance of union representation even in states with the best safe staffing laws.
- Workers moving between states based on demands of the job market is not unique to healthcare or nursing. Suggesting that states attracting nurses with better working conditions harms patients in other states only encourages a race to the bottom for hospital working conditions and patient care.

- ❖ **CLAIM:** Under a ratio law, nurses will have to take on tasks below their scope of practice and education, leading to more dissatisfaction and higher vacancies.

Responses

- **There is no evidence of this happening.**
 - A 2011 study found that between 2002 and 2008, skill mix in California hospitals increased at an identical rate to hospitals in other states, indicating that the 2004 implementation of the ratio law did not impact skill mix.¹³
 - A 2010 study found that two-thirds of staff nurses in California say the ratio law makes them more likely to stay at their jobs, and nearly three-fourths agree the law has improved the quality of care in the state.¹⁴
- **Nurses currently report high levels of job dissatisfaction and burnout and frequently cite safe staffing ratios as a desired solution** to this problem.
 - In 2021, more than half of RNs said they experienced burnout a few times a week or every day.¹⁵
 - In a 2023 study, 45 percent of physicians and 87 percent of nurses identified improved nurse staffing as an effective intervention to address high levels of burnout.¹⁶
 - More than 195,000 RNs left work during the COVID-19 pandemic. Among these nurses, 39 percent identified inadequate staffing as a primary reason they left.¹⁷

- ❖ **CLAIM:** If mandated ratios were better, we would have nurses flocking to California just as they flocked everywhere to earn more money as travelers during the pandemic; California would not rely on travel nurses, and RN satisfaction there would be sky high.

Responses

- RNs in California and in hospitals with staffing ratios consistent with those mandated in California routinely report lower rates of intention to leave their position, lower rates of burnout and higher confidence in the quality of patient care they provide.¹⁸
- Data from the 2022 National Sample Survey of Registered Nurses shows that about 20.5 percent of all licensed RNs in the nation are not currently employed in nursing. While we cannot link it directly to the staffing law, it is worth noting that **California's nursing workforce participation rate is higher than the national average**, with only 18.6 percent of RNs not employed in nursing.¹⁹
 - This roughly 2 percentage point difference equates to about 7,900 more RNs participating in California's workforce than would be consistent with the national average.
 - This is still true when accounting for potential retirees with active licenses. Nationally, 14.2 percent of licensed RNs under 65 are not employed in nursing, whereas only 13.3 percent of licensed RNs in California are not employed in nursing. This difference equates to about 3,580 more RNs under 65 in California's nursing workforce than would be consistent with the national average participation rate.
- The idea that if staffing ratios improved working conditions, many more nurses would relocate to California is an inaccurate and reductive understanding of labor markets and is very far

removed from the reality of how most people choose where to live and work. There are innumerable factors in a person's decision about where to live, but this argument assumes that each nurse disregards all other considerations and chooses where to live and work based solely on a state's hospital staffing standards.

COST & FEASIBILITY

- ❖ **CLAIM:** We cannot implement safe staffing policies because there is a shortage of nurses and healthcare professionals.

Responses

- **We do not have a shortage of people qualified to do the work, but rather a shortage of people willing to work under current conditions.**
 - There are nearly 530,000 licensed RNs under the age of 65 in the U.S. who are not currently employed in nursing.²⁰
 - Federal data from the Health Resources and Service Administration suggests²¹ that many states do not have a shortage of RNs and are not predicted to have a shortage in the future, yet hospitals in these areas face chronic understaffing.
- **Unsafe staffing is causing workers to leave the profession.**
 - More than 195,000 RNs left work during the COVID-19 pandemic. Among these nurses, 39 percent identified inadequate staffing as a primary reason they left.²²
 - In a 2022 survey, 15.2 percent of nurses with 10 or fewer years of experience said they planned to leave nursing in the next five years, and 44.8 percent of nurses with more than 10 years of experience said they were considering retiring or leaving their position in the next five years.
 - In the same survey, 23.2 percent of nurses cited concerns about unsafe staffing and their work environment.²³
 - **Without safe staffing protections, efforts to recruit and grow the healthcare workforce are like pouring water into a leaking bucket.**
- Investing in safe staffing now is about **investing in a sustainable future** for the healthcare workforce.
 - Insufficient staffing **disproportionately drives newer and younger nurses out of the healthcare workforce.**
 - In a 2024 study identifying the motivating factors of nurses who left the healthcare workforce during the COVID-19 pandemic (2018-2021), 21 percent cited inadequate staffing as a leading factor. **Among nurses under the age of**

30, 40 percent cited insufficient staffing as a leading factor in their decision to leave the healthcare workforce.²⁴

- In a meta-analysis of 17 relevant studies, researchers found that in better nurse work environments characterized by adequate staffing and resources, **nurses had a 28-32 percent lower probability of job dissatisfaction, burnout or intention to leave their job.**²⁵
- By implementing proven strategies to retain staff, such as improving nurse staffing, hospitals can mitigate the high costs of turnover.
 - **Each percent change in RN turnover will cost/save the average hospital \$380,600 per year**, according to a 2023 report from NSI Nursing Solutions.
 - The same report found the average cost of turnover for a bedside RN was \$52,350 in 2022, up 13.5 percent from 2021.²⁶

❖ **CLAIM:** Hospitals cannot afford to implement safe staffing.

Responses

- Because safe staffing levels decrease rates of readmission and infections, **many studies have found safe staffing to produce significant cost savings for hospitals.**
 - A 2021 study estimated that an average staffing ratio of 4:1 in medical-surgical units would result in a \$720 million annual cost savings for hospitals in the state of New York due to a reduction in hospital days and readmissions.²⁷
 - A 2012 study found that if hospitals in Pennsylvania reduced the average level of nurse burnout by 30 percent, they could prevent more than 6,000 infections, saving up to \$69 million annually.²⁸
- By focusing on retaining staff with safe and sustainable working conditions, hospitals could see significant savings by reducing turnover.
 - Each percent change in RN turnover will cost/save the average hospital \$380,600 per year, according to a 2023 report from NSI Nursing Solutions.²⁹
 - The same report found the average cost of turnover for a bedside RN was \$52,350 in 2022, up 13.5 percent from 2021.
- **It's not about what hospitals can afford; it's about what choices they are willing to make.**
 - In just one example, Hartford HealthCare reports over \$172 million net income from operations alone in 2021.³⁰
 - In 2020, Hartford HealthCare CEO Jeffrey Flaks received nearly \$2.6 million in total compensation, including nearly \$950,000 in bonus and incentive pay alone.³¹
 - Compare this to the average salary of \$88,530 for a registered nurse in Connecticut, according to 2021 data from the U.S. Bureau of Labor Statistics.³²

❖ **CLAIM:** Staffing ratios will cause dismissal of support staff from the increased cost of nurse staffing and increase nursing salaries. These costs will also be passed on to patients.

Responses

- **Effective safe staffing legislation includes protections for support staff and a voice for all members of the care team** in safe staffing for their positions.
 - The new Oregon staffing law requires that each hospital establish a staffing committee for technical staff as well as service staff, each charged with creating hospital-wide staffing plans to meet patient care needs.³³
 - The new Oregon staffing law also establishes a minimum staffing ratio for certified nursing assistants (CNAs).³⁴
- Because safe staffing levels decrease rates of readmission and infections, **many studies have found safe staffing to produce significant cost savings for hospitals.**
 - A 2021 study estimated that an average staffing ratio of 4:1 in medical-surgical units would result in a \$720 million annual cost savings for hospitals in the state of New York due to a reduction in hospital days and readmissions.³⁵
 - A 2012 study found that if hospitals in Pennsylvania reduced the average level of nurse burnout by 30 percent, they could prevent more than 6,000 infections, saving up to \$69 million annually.³⁶
- Hospital executives threatening to make harmful and unnecessary decisions like these in response to safety measures underscores the reason we need legally enforceable ratios rather than trusting hospitals to do the right thing.

❖ **CLAIM:** Rural and critical access hospitals cannot be held to the same standards as institutions with more resources. Mandated ratios would significantly strain and/or shut down these facilities.

Responses

- **Effective safe staffing legislation includes flexibility** for critical access hospitals, rural hospitals and sole community hospitals.
 - For example, the new safe staffing law in Washington allows flexibility in documentation, reporting, and meeting requirements for staffing committees in these kinds of facilities.³⁷
 - In addition to specific flexibility for these kinds of facilities, effective safe staffing legislation also establishes a process for adjusting standards and staffing plans in emergency events with the input and leadership of direct-care healthcare professionals.³⁸
- Proposed at the national level, the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act includes a longer implementation period of staffing ratios for rural hospitals, acknowledging this difference. Under the act, rural hospitals would have four years to implement ratios compared with two years for other hospitals.³⁹

ADVANCING THE NURSING PROFESSIONS

❖ **CLAIM:** Staffing ratios override a nurse's professional judgment.

Responses

- If hospitals were concerned with protecting a nurse’s professional judgment, they would support nurses having the **right to refuse an unsafe assignment** and to tell management when extra staffing is needed.
 - For example, under Connecticut’s new safe staffing law, an RN may object to or refuse an assignment if they are “not competently able based on education, training or experience ... without compromising the safety of a specific patient.”⁴⁰
 - **This new standard in Connecticut would be the policy of every hospital if they were truly concerned with protecting a nurse’s professional judgment.**
 - **Understaffing doesn’t allow a nurse to exercise their professional judgment** by forcing them to spend less time with patients than they may need. Under current conditions, nurses are forced to make impossible decisions every day between which urgent patients they need to prioritize when there are not enough nurses to meet every need.
 - In the professional judgment of an overwhelming majority of nurses supported by decades of peer-reviewed research, safe staffing ratios will improve patient care and working conditions for healthcare professionals.
- ❖ **CLAIM:** Mandatory ratios limit innovation and technological advances (specifically, the Mayo Clinic has interest in developing and implementing tech to do some basic nursing functions and cited this as part of its opposition to a safe staffing bill introduced in Minnesota).

Responses

- **Effective safe staffing legislation does not prevent innovation;** it requires that innovations are implemented **in collaboration with direct-care staff** who have the expertise needed to ensure these innovations will **benefit patient care and not just the hospital’s bottom line.**
 - Oregon’s new safe staffing law specifically allows hospitals to deviate from the statutory staffing ratios “in pursuit of innovative care models that were considered by the [nurse staffing] committee, by allowing other clinical care staff to constitute up to 50 percent of the registered nurses needed to comply with the applicable nurse-to-patient ratio. The staffing in an innovative care model must be reapproved by the committee every two years.”⁴¹
- In response to advances like those cited by the Mayo Clinic, specific ratios could be revisited and adapted through rulemaking and implemented through collaborative staffing committees. However, **refusing to implement an evidence-based solution to unsafe staffing** levels now because of a hypothetical future innovation is cynical at best, and it **puts patients at risk.**

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- ³ Oregon H.B. 2697 Sec. 24 (3)
<https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2697/Enrolled>
- ⁴ California Health Care Foundation, 2009: <https://www.chcf.org/wp-content/uploads/2017/12/PDF-AssessingCANurseStaffingRatios.pdf>
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- ²¹ See HRSA workforce projections dashboard for projections for specific states and/or years: <https://data.hrsa.gov/topics/health-workforce/workforce-projections>
- ²² Health Resources and Services Administration, 2022 National Sample Survey of Registered Nurses: <https://data.hrsa.gov/topics/health-workforce/nursing-workforce-dashboards>
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³³ Oregon H.B. 2697 Sections 3 and 4

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³⁴ Oregon H.B. 2697 Section 8

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³⁸ See [Oregon H.B. 2697](#) Sec. 24 (3) and [Washington SB 5236](#) Sec. 2 (11)(a)

³⁹ Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act full bill text:

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