Good afternoon: I am Ernest Klein, Executive Director of the Indiana State Nurses Association. Thank you for this opportunity to present some information to you.

I would like to state first of all that I will often use the word “nurse” and “nursing” but I will be speaking specifically about Registered Nurses. I am sure though that LPNs share many of the same concerns. I will also be talking about national trends, but be assured that these issues are happening in Indiana.

As this Commission is aware, health care institutions across the state are experiencing a crisis in direct care staffing, and we are standing on the precipice of an unprecedented shortage of nurses. This emerging shortage of nurses is very real and very different from any experienced in the past. The concept of supply and demand is not working this time. Usually when there is a demand for nurses such as in the late 1980’s, salaries go up and the supply increases. This time, in spite of increased salaries and huge sign-on bonuses, the supply of nurses is not increasing. Projections show that these current shortages are just a minor indication of the systemic shortages that will soon confront our health care delivery system.

1. REASONS FOR THE IMMEDIATE CRISIS

The current staffing crisis is directly attributable to several factors. The last ten years have seen dramatic changes in the manner in which health care is delivered. As a consequence of the tightening of the reimbursements for health care, many facilities and institutions took various means to decrease their health care costs. After almost a decade of constant health system changes, reorganization, reengineering, and changes in reimbursement and funding mechanisms, the overall environment of health care has deteriorated to such an extent that we are now faced with a crisis in a shortage of direct care providers. As RNs typically represent the largest single expenditure for hospitals (averaging 20 percent of the budget), we were some of the first to feel the pinch. Lesser-skilled, lower-salaried assistive staff were hired as replacements; and RN salaries decreased in both actual and real terms. During this restructuring, experienced and highly paid nurses were eliminated from the workforce through layoffs, early retirement buy-outs, and attrition with resulting relocation into positions that were not direct care. The overall impact of the changes in the 1990s was to increase pressure on staff nurses who were required to oversee unlicensed aides while caring for a larger number of sicker patients.

The result is that the environment or working conditions for those remaining in the nursing workforce worsened, forcing many frustrated and exhausted nurses to leave positions of direct care. These nurses surely did not recommend a nursing career to others.

A recent survey by the American Nurses Association revealed that nearly 55 percent of the nurses surveyed would not recommend the nursing profession as a career for their children or friends. In fact, 23 percent of the respondents indicated that they would actively discourage someone close to them from entering the nursing profession. A large multi-national survey recently conducted by the University of
Pennsylvania's Center for Health Outcomes and Policy Research shows that America's nurses are particularly dissatisfied with their jobs. More than 40 percent of nurses in American hospitals reported being dissatisfied with their jobs, as compared to 15 percent of all workers. In addition, this report shows that 43 percent of American nurses score higher than expected on measures of job burnout. ANA statistics show that nurses typically burn out and leave hospital bedside nursing after just four years of employment.

2. A DWINDLING SUPPLY OF NURSES

As the word about downsizing became generally known, the nursing profession ceased to be a career of choice for many. Today's staffing crisis is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce, and the impending health care needs of the baby boom generation. As new opportunities have opened up for young women and new stresses have been added to the profession of nursing, fewer people have opted to choose nursing as a career. Nursing school enrollments have dropped precipitously and the faculty core has been reduced.

The Division of Nursing, U.S. Department of Health and Human Services, has predicted that by the year 2010, the number of nurses will not meet the demand for nurses. In fact, the years following 2010 show a dramatic widening between the supply of registered nurses in relation to the demand for registered nurses.

The average age of working nurses is 43.3 years. We can anticipate that over the next ten to fifteen years these nurses will be aging and/or retiring. They will be retiring at a time when our population will be generally older and in greater need of nursing care.

Assuming that we can attract students to the nursing profession, there is a significant problem with respect to the aging of the nursing faculty. According to the American Association of Colleges of Nursing (AACN), nursing school associate professors and assistant professors are an average age of 52.1 and 48.5 years. This problem is even more acute at the doctoral level where, in 1996, the average age of new doctoral recipients was 45 years. Both the aging of the nursing faculty and overall flat enrollment in doctoral programs that produce nurse educators will impact the capability of nursing schools to educate sufficient numbers of registered nurses to meet future demand.

3. WORKPLACE CONDITIONS

Years of discontent have led us to a situation in which an alarming number of our experienced RNs have chosen to leave the profession. The 2000 National Sample Survey of Registered Nurses shows that a large number of nurses (500,000 nurses--more than 18 percent of the nurse workforce) who have active licenses are not working in nursing. In Indiana it is estimated that 24 percent of RNs are not employed in nursing.

The Indiana Hospital and Health Association reports there are some 1,200 openings for RNs in hospitals across Indiana. We have all been hearing about the difficulties encountered in finding nurses to take these positions. I often hear from staff nurses who tell me that the reason for these vacancies is dissatisfaction with the work environment. The Congressional Research Service, in a report this past May, suggests that there is a misdistribution of labor rather than a shortage per se. Nurses are, understandably, reluctant to accept positions where they will face unsafe conditions, inappropriate staffing levels, be confronted by mandatory overtime, inappropriately rushed through patient care activities, and face retaliation if they report unsafe practices.
Safety
This means that the workplace must be safe. It should be safe from violence, from bloodborne pathogens (needlestick safety), and from occupational hazards. Findings from the Health and Safety Survey released by the American Nurses Association on September 7 revealed that fewer than 20 percent of nurses responding felt safe in their current work environment. Seventeen (17) percent of nurses responding had been physically assaulted in the past year and more than half (56.6 percent) were threatened or experienced verbal abuse. The implementation of a federal law to require the use of safer needle devices has made a significant impact; however, almost 20 percent of nurse respondents revealed that their facilities still do not provide safe needle devices for injections, IV insertions, and phlebotomy procedures. An even greater percentage (39 percent) confirmed that their facilities continue to use powdered latex gloves, a hazard known to cause severe allergic reactions in patients and workers with latex allergies. Continued exposure to latex is a significant factor in developing an allergy. Additionally, nurse respondents stated that more than half the facilities in which they worked didn’t have lifting and transfer devices readily available for moving patients. Use of lifting devices can significantly decrease nurses’ risk of back injuries.

Mandatory Overtime as a Staffing Tool
Nurses across the state are also expressing concerns about the increase in the use of mandatory overtime as a staffing tool. Employers may insist that a nurse work an extra shift (or more) or face dismissal for insubordination as well as being reported to the state board of nursing for patient abandonment. Our concerns about the use of mandatory overtime are directly related to patient safety. We know that sleep loss influences several aspects of performance, leading to slowed reaction time, failure to respond when appropriate, false responses, slowed thinking, and diminished memory. In fact, 1997 research by Dawson and Reid at the University of Australia showed that work performance is more likely to be impaired by moderate fatigue than by alcohol consumption. Their research shows that significant safety risks are posed by workers staying awake for long periods. It only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not being required to work a 16-hour shift. Nurses are placed in a unique situation when confronted by demands for overtime. Ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients. At the same time, RNs face the loss of their license--their careers and livelihoods--when charged with patient abandonment.

Whistleblower Protection
In addition, nurses must be able to speak out about quality-of-care problems without fear of retaliation or loss of their jobs. Patient advocacy is the heart of nurses’ professional commitment. In turn, patients depend on nurses to ensure that they receive proper care. Patients must be assured that nurses and other health care professionals, acting within the scope of their expertise, will be able to speak for them without fear of retaliation. Whistleblowing by nurses usually results from concern about issues that jeopardize the health or safety of patients or occupational safety and health violations that place the employee at risk. Although they are responsible for patient care and well-being, nurses often are powerless when another health care provider performs unethical or life-threatening practices. This lack of protection prevents many nurses (because of fear of reprisal) from taking the risk of trying to protect public health and safety. Reprisal has included dismissal, harassment, and blacklisting.

Adequate Staffing
The safety and quality of care provided in the nation's health care facilities is directly related to the number and mix of direct-care nursing staff. More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of patients. Studies show that when there are
more nurses, there are lower mortality rates, shorter lengths of stay, better care plans, lower costs, and fewer complications. In fact, four HHS agencies--the Health Resources and Services Administration, Health Care Financing Administration, Agency for Healthcare Research and Quality, and the National Institute of Nursing Research of the National Institutes of Health--recently sponsored a study on this very topic. The resulting report, released on April 20, 2001, found strong and consistent evidence that increased RN staffing is directly related to decreases in the incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and decreased hospital length of stay. In addition to the important relationship between nurse staffing and patient care, several studies have shown that one of the primary factors for the increasing nurse turnover rate is dissatisfaction with workload/staffing. ANA's recent survey states that 75 percent of nurses surveyed feel that the quality of nursing care at the facility in which they work has declined over the past two years. Out of nearly 7,300 respondents, over 5,000 nurses cited inadequate staffing as a major contributing factor to the decline in quality of care. More than half of the respondents believed that the time they have available for patient care has decreased. The University of Pennsylvania research shows that 70-80 percent of more than 43,000 registered nurses surveyed in five countries reported that there are not enough RNs in hospitals to provide high quality care. Only 33 percent of the American nurses surveyed believed that hospital staffing is sufficient to "get work done." This survey reflects similar findings from a national survey taken by the Henry J. Kaiser Family Foundation (1999) that found that 69 percent of nurses reported that inadequate nurse staffing levels were a great concern. The public at large should be alarmed that more than 40 percent of the nurses who responded to the ANA survey stated that they would not feel comfortable having a family member cared for in the facility in which they work.

We strongly encourage acute care facilities to implement and use a valid and reliable staffing plan based on patient acuity. Adequate staffing levels allow nurses the time that they need to make patient assessments, complete nursing tasks, respond to health care emergencies, and provide the level of care that these patients deserve.

4. NON-SOLUTIONS

Unlicensed Personnel
Some facilities might suggest that the nursing shortage can be met by allowing the use of more unlicensed assistive personnel. De-skilling the workforce actually raises health care costs. Allowing unlicensed assistive personnel to perform nursing tasks for which they have not been trained or educated is harmful to patient care. Nurses at the bedside are essential to quality care. Increasing the ratio of nurses to patients has been shown to reduce medication errors, pressure ulcers, incidence of pneumonia, post-operative infections, and mortality rates. Unlicensed assistive personnel play an important role in providing support services to ensure that nurses have the time to provide nursing care; however, they cannot be used to replace nursing skills.

Immigration
I have deep concerns about the use of immigration as a means to address the emerging nursing shortage. We have been down this road many times before without success. The influx of foreign-trained nurses only serves to further delay debate and action on the serious workplace issues that continue to drive American nurses away from the profession. There are serious ethical questions about recruiting nurses from other countries when there is a worldwide shortage of nurses. The removal of foreign-trained nurses from areas such as South Africa, India, and the Caribbean deprives their home countries of highly trained health care practitioners upon whose skills and talents their countries heavily rely.
5. SUPPORT FOR NURSING EDUCATION

Nursing education programs must be expanded to accommodate new students and make higher education more accessible. Scholarships to offset tuition and other expenses are essential. Nursing education must also reflect ethnic, cultural, and racial diversity. Teachers of nursing are needed to replace those who are nearing retirement. It will do us no good to recruit students and then not have any faculty to teach them. Support for graduate education will assist nurses who are preparing to teach. There are efforts now underway at the federal level [Nurse Reinvestment Act (S. 706, H.R. 1436) and the Nursing Employment and Education Development Act (S. 721)]. These education initiatives will help boost nursing school enrollments and will encourage existing nurses to go back to school to increase their levels of education. The combination of scholarships, loan repayments, and innovative recruitment techniques contained in these bills are much needed. We must begin to address this now; results will not be seen for three to five years.

6. DATA COLLECTION

I have not talked to you today about Indiana’s specific numbers. The reason for that is there is no consistent and systematic collection and analysis of such data. In 1995, the Indiana General Assembly assigned the Health Care Professional Development Commission (HCPDC) the responsibility to study health care professional supply, need, and distribution in the State and to make recommendations. Over the past six years the HCPDC has only collected and published manpower data for Registered Nurses (1997), Physicians (1997), and Dentists and Dental Hygienists (1998). It was assigned the task but not funded. The Commission's work has been accomplished only because of the financial support from the State Health Commissioner who has designated funding from the Indiana State Department of Health budget and because of the cooperation from the Health Professions Bureau.

There must be a systematic way to collect and analyze ongoing data about the supply and demand for nurses (and other health care workers) in Indiana. The data generated and the knowledge about Indiana's population, numbers of schools of nursing and attendance, types of health issues, etc., could be used to identify strategies that are particularly relevant to our State and tailored to the particular needs of the State's population and health care systems.

7. RECRUITMENT AND RETENTION

In 1982 a study was done of 41 hospitals to identify and describe variables that created an environment that attracted and retained well-qualified nurses who promoted patient care. These institutions were called “magnet” hospitals and served to attract and retain professional nurses who experienced a high degree of professional and personal satisfaction through their practice. These healthcare facilities that excel in patient care and in the recruitment and retention of nurses are designated by the American Nurses Credentialing Center as Magnet Nursing Services Recognition Program for Excellence in Nursing Service. At these facilities:

- Nursing professionals' knowledge is respected in the development of policies.
- Nurse practice committees that include direct care nurses are involved in establishing staffing plans based on patient acuity and need.
- Nurses do not face retaliation or intimidation for questioning policies or working to change practices that negatively impact on patient care.
- Nurses are not forced to work overtime to fill gaps in staffing schedules. Nurses are supported in continuing their professional development.
8. CONCLUSION

Any strategy to increase the number of nurses must also include a discussion of retaining and returning nurses to the direct care workplace. This means that working conditions must be improved. The elimination of practices such as short staffing, mandatory overtime as a staffing tool, and a disregard for the principles of nursing practice could stop the present erosion of the nursing workforce.

Just ten years ago we were emerging from the nursing shortage of the late 1980's. Nursing workforce issues had caught the attention of the highest reaches of the Reagan and Bush Administrations. HHS Secretary, Doctor Otis Bowen, established a Commission on Nursing which released recommendations in 1988 on methods to improve the work environment for nurses. These 16 recommendations, released in December 1988, are still very relevant today—they include issues such as the need to adopt innovative nurse staffing patterns, the need to collect better data about the economic contribution that nurses make to employing organizations, the need for nurse participation in the governance and administration of health care facilities, and the need for increased scholarships and loan repayment programs for nursing students. Perhaps if these recommendations had been fully implemented, we would not be here today.

ISNA maintains the current staffing crisis will remain and worsen if changes in the workplace are not immediately addressed. The profession of nursing will be unable to compete with the myriad of other career opportunities available in today's economy unless we improve working conditions. Improvements in the environment of nursing care combined with aggressive and innovative recruitment efforts will help avert the impending shortage of nurses. The resulting stable nursing workforce will support better health care for all Hoosiers.