ISNA President presents written testimony to the Indiana Commission on Excellence in Health Care's Patient Safety Subcommittee

I am Sandra Fights, President of the Indiana State Nurses Association. Thank you for the opportunity to submit written concerns regarding patient safety and medical errors. Our members are Registered Nurses who are working and teaching in every health care sector across the State.

Numbering more than 62,000, nurses are the largest health care work force in the State. From the certified nurse midwives who attend delivery, to hospice nurses who provide end-of-life care, to staff nurses who care for us during times of acute injury or illness, nurses are integral to health care across the human lifespan. We touch patients and manage teams of medical professionals in hospitals, clinics, community health centers, offices, nursing homes, and patient's homes. We are the ones who will ultimately implement and be impacted by new patient safety initiatives. Therefore, nurses have a substantial contribution to make to the developing debate on medical errors. The issue of patient safety has always been the cornerstone of nursing. The Code of Ethics for Nurses clearly states that "as an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy." The American Nurses Association (ANA) has been active in the debate on medical errors, both prior to the release of the Institute of Medicine (IOM) study “To Err is Human” and since its publication.

The Changing Health Care Delivery System

The landmark IOM report “To Err is Human” (1999) described a fractured health care system that is prone to errors and detrimental to safe patient care. This problem is readily apparent to the nurses who have been caught inside the topsy-turvy world of our rapidly changing health care delivery system. We have seen market forces, reimbursement changes, and new technologies revolutionize health care. Unfortunately, these changes have not always resulted in better patient care. In the past decade, the advent of managed care and changes in Medicare reimbursement have exerted downward pressure on provider margins. As a result, health care facilities have employed radical cost reduction programs. Throughout the 1990s, new models of health care delivery were implemented; and highly trained, experienced – and, therefore, higher paid -- personnel were eliminated or redeployed. As RNs typically represent the largest single expenditure for hospitals (averaging 20 percent of the budget), we were among the first to feel the pinch. Often lesser-skilled, lower-salaried assistive staff were hired as our replacements. Nationally, nurses’ wages were cut and RN employment in the hospital sector decreased. Accordingly, it was only five short years ago when nurses were being laid off. While nurses were being laid off, the public sector “told” new prospects that nursing was a bad career choice, thus compounding the current shortage.
At the same time, advances in medical technology have resulted in truly amazing treatments and procedures. These advances are extending and improving the quality of our lives. They are also increasing the complexity of health care. Just think of premature infants in neonatal units or the burn victims from the recent terrorist attacks. These patients are able to survive and thrive when only a few years ago they could not. Nurses in these units manage patients who are supported by heart-lung bypass machines, ventilators, and constant drug infusers. Patients such as these require constant monitoring, as even minute changes can quickly lead to disaster. Thus, today's nurses are engaged in painstaking, complicated care more often and with fewer supports than ever before.

In sum, recent changes in health care delivery have increased the pressure placed on staff nurses who are now required to oversee unlicensed aides while caring for a larger number of sicker patients. At the same time, the elimination of nurse managers has decreased the support, advocacy, and resources necessary to ensure that staff nurses can provide optimum care.

The Failures of the Culture of Blame

In addition to the changes described above, the recent increase in competition within and among health care providers as well as the upswing in public concerns about the quality of health care have lead institutions to focus on their marketability. ISNA is concerned that many institutions have responded to this pressure by creating a punitive atmosphere that continues to assign and emphasize individual blame for errors, misjudgments, and patient dissatisfaction. These facilities assume that the appropriate way to deal with patient care problems is to increase the oversight and discipline of health care workers as opposed to identifying and resolving central system problems. Although a range of sanctions are available to punish providers held responsible for committing medical errors, these measures are rarely credited with much success. Professional licensing boards are often backlogged and sometimes criticized for failure to take appropriate disciplinary action. Legal avenues reach only a fraction of the injuries caused by health care error. Most importantly, regulatory and legal sanctions are only imposed after mistakes have been made and do very little to prevent them in the first place.

This is not to say that providers and practitioners who are negligent or incompetent should not be removed from clinical practice. Certainly, we must be able to deal with people who are unable to practice safely. ISNA maintains that mechanisms for individual accountability should be maintained.

The Role of Appropriate Staffing

ISNA maintained that 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 patient outcomes. Studies show that where there are more nurses, there are lower mortality rates, shorter lengths of stay, better care plans, lower costs, and fewer
complications. In fact, four Department of Health and Human Services (DHHS) agencies--the Health Resources and Services Administration (HRSA), Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS), the Agency for Healthcare Research and Quality (AHRQ), and the National Institute of Nursing Research (NINR) of the National Institutes of Health (NIH)--recently sponsored a study on this 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.

CMS, the IOM, the General Accounting Office, and numerous professional and consumer organizations have found similar evidence regarding the relationship between nurse staffing and patient care in nursing facilities. An ongoing study commissioned by CMS has detailed the relationship between insufficient nurse staffing and increases in bedsores, urinary tract infections, sepsis, and weight loss in nursing home residents.

A recent staffing survey by the American Nurses Association involving 7,300 RNs reinforces the connection between adequate staffing and quality of care. This report shows that 75 percent of respondents felt that the quality of nursing care at their facility has declined over the past two years. More than 5,000 nurses (68 percent) cite inadequate staffing as a major contributing factor to the decline in quality of care. More than half believe that the time they have available for patient care has decreased. The public at large should be alarmed that more than 40 percent of the respondents to the ANA survey state that they would not feel comfortable having a family member cared for in the facility in which they work.

The Indiana State Nurses Association maintains that something must be done to address staffing concerns. Adequate staffing levels allow nurses the time they need to make patient assessments, complete nursing tasks, respond to health care emergencies, and provide the level of care that these patients deserve. Adequate staffing also increases nurse satisfaction and reduces turnover. For these reasons, ISNA supports efforts to require acute care facilities to implement and use valid and reliable staffing plans based on patient acuity as a condition of participation in the Medicare and Medicaid programs. In addition, we support efforts to enact upwardly adjustable, minimum nurse-to-patient staff ratios in skilled nursing facilities.

The Critical Problem of Mandatory Overtime

By far the riskiest result of understaffing is the abuse of mandatory overtime as a staffing tool. Nurses across Indiana have expressed concerns about the dramatic increase in the use of mandatory overtime. ISNA hears that employers are insisting 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. The use of mandatory overtime is not as uncommon or isolated as some would have you believe. In fact, the term “mandation” has been coined by the health care industry to describe this staffing tool. A recent ANA survey (sample size 4,826) revealed that two-thirds of nurses are being required to work
some mandatory or unplanned overtime every month. 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 workers who stay awake for long periods pose significant safety risks. Thus, it only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not forced to work overtime. 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 their livelihoods--when charged with patient abandonment. Absent legislation, nurses will continue to confront this dilemma. For this reason, ISNA supports the Safe Nursing and Patient Care Act of 2001 (H.R. 3238, S. 1686) which would ban the use of mandatory overtime through Medicare provider agreements. ISNA and ANA support working through the Medicare system because we believe that the abusive use of overtime promotes poor patient care and, therefore, is a matter of public health safety. Just as limits on work hours for airline pilots, flight attendants, and truck drivers are enacted through transportation law, we believe that this matter should be handled through health law. The Safe Nursing and Patient Care Act is a fair, measured response to the abuse of mandatory overtime.

Patient Advocacy and Whistleblower Protections

In addition, ISNA maintains that nurses must be able to speak out about quality-of-care problems without fear of retaliation or the loss of their jobs. Patient advocacy is at the heart of nurse's 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 reprisal.

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. Yet, even though we are responsible for patient care and well-being, nurses are often powerless when another health care provider performs unethical or life-threatening practices. Retribution and dismissal for whistleblowing are not uncommon. In fact, there have been a number of legal cases involving nurses who have been retaliated against for "blowing the whistle" on their employers. Current whistleblowing laws remain a patchwork of incomplete coverage. For example, the False Claims Act contains a whistleblower provision that applies only in cases of fraud or misuse of federal funds. The Emergency Treatment and Labor Act (EMTALA) includes protections for patient advocacy but only for personnel working in the emergency department of a hospital. The Whistleblower Protection Act of 1989 only applies to federal employees (e.g., VA nurses). This confusing, incomplete coverage leaves many nurses fearing reprisals such as dismissal, harassment, and blacklisting. This lack of a blame-free
reporting system prevents many nurses from taking the risk of trying to protect their patient's health and safety. In order to allow nurses to function as successful patient advocates, effective whistleblower protections for nurses who report unsafe patient care must be enacted.

Where to Start?

ISNA supports many of these initiatives; however, the central issues of staffing, overtime, and whistleblower protections must not be lost in this debate.

Medication errors serve as a good example. The IOM estimates that medication errors increase hospital costs by about $2 billion per year. Disturbingly, the IOM also estimates that the number of lives lost to preventable medication errors alone represents over 7,000 deaths annually--more than the number of Americans injured in the workplace each year. The U.S. Pharmacopoeia, which has tracked medication errors since 1991, recently reported on the first full year of an internet-based reporting mechanism for medication errors and near misses. The analysis of 6,224 reports revealed that most errors occur in the administration of medications--the delivery to the patient. U.S. Pharmacopoeia reports that, "the primary contributing factors to medication errors were distractions and workload increases, many of which may be a result of today's environment of cost containment." We could not agree more. While we support innovations such as information technology designed to reduce medication errors, we understand that these efforts will not be successful if the broader system issues are not addressed as well. In the end, any system that requires a nurse to work a 16-hour shift while caring for too many critically ill patients in a ward where he or she is not supported by adequate staff is destined to failure.

Conclusion

I have been a registered nurse for more than 20 years. I have been a staff nurse and I am currently on the faculty of St. Elizabeth School of Nursing, Lafayette. My husband is also a Registered Nurse. I know something about nurses. We are called to the profession by a desire to provide compassionate care to people in need. Believe me, no one becomes a nurse for the money. We are driven by a desire to provide safe, high-quality health services. We will remain in patient care as long as this is possible.

As long as unreasonable schedules, dangerous understaffing, and fears of institutional reprisal keep nurses from meeting this calling, many will continue to leave the bedside. Nurses do not want to be a part of a health system that fails to meet the needs of patients. We should begin by improving the environment for nursing.

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