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ANA COMMENDS IOM REPORT OUTLINING CRITICAL ROLE OF NURSING WORK ENVIRONMENT IN PATIENT SAFETY

Study reinforces call to eliminate mandatory overtime; improve staffing levels, work environment

Washington, DC – The American Nurses Association (ANA) applauded the Institute of Medicine (IOM) for a report, released yesterday, which shows a clear link between the nursing work environment and patient safety, and recommends improvements in health care working conditions that would lead to safer patient care.

The study, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, builds on the recommendations made in the groundbreaking *To Err is Human* IOM study, released in 2000, which found that as many as 98,000 patients per year die as a result of medical errors.

“ANA has long contended that improved patient safety and quality of care cannot be achieved without investing in and valuing nursing,” said ANA President Barbara Blakeney, MS, APRN,BC, ANP.

“This study provides even more evidence that urgent action is needed to improve nurses’ working conditions, and that by doing so patients will be protected from preventable errors.”

Based on the study’s findings and recommendations, Blakeney noted that Congress needs to take urgent action on several pending legislative measures that would improve the nursing work environment. These include bills that 1) mandate safe nurse/patient ratios, 2) severely limit the unsafe practice of mandatory overtime, and 3) provide sufficient funding for nursing workforce development.

“Nurses and patients across America are calling on Congress to take action that will improve nursing care in this country and hold health care facilities accountable for the staffing decisions they make,” said Blakeney.

The study notes upfront that the typical nurse’s work environment poses “many serious threats to patient safety – in all four of the basic components of all organizations – organizational management practices, workforce deployment practices, work design, and organizational culture.”

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The study also finds that because “multiple components and processes” of health care organizations create situations that increase the risk of medical errors, “multiple, mutually reinforcing changes in nurses’ work environments” are needed to combat the problem. Chief among those changes are that a “culture of safety” in nursing needs to be “created and sustained.”

ANA agreed wholeheartedly with the study’s finding that many hospitals are not staffed with adequate numbers of nurses, a practice that endangers patients, and the finding that unsafe work practices and workspace design pose threats to patient safety. ANA further agreed with the report’s conclusions that “piecemeal approaches” will not work, that additional research is necessary and that this research must be part of an ongoing process.

In particular, ANA supported the report’s recommendation to limit the number of hours a nurse can work to 12 hours in any 24-hour period and 60 hours in any seven-day period – the same limits being proposed by the Safe Nursing and Patient Care Act of 2003 (H.R. 745, S. 373). As evidence, ANA pointed to a study conducted by Dr. Ann Rogers at the University of Pennsylvania, in partnership with ANA, which was outlined in the IOM report. Dr. Rogers’ study found that once shift duration exceeded 12 consecutive hours, error rates increased significantly.

“This study indicates that the elimination of ‘mandatory overtime’ is essential to safe patient care and healthier nurses,” said Blakeney. And mandatory overtime could be eliminated if Congress were to pass the Safe Nursing and Patient Care Act.”

ANA also agreed with the report’s overall call for more visible leadership role for nurse managers. “However, it is ANA’s consensus that nurse leaders must also actively seek direct-care nursing staff and support them to have a greater voice and additional opportunities to participate in decision making,” Blakeney said. “In short, wherever and whenever possible, frontline nurses must be engaged in any decisions that affect their work life and patient care.”

Blakeney was particularly adamant about the need for a greater link between management practice, the work environment and safety, and she pointed to one potential solution that was also highlighted in the IOM report – the American Nurses Credentialing Center (ANCC) Magnet Recognition Program, which focuses on excellence in nursing services – as a means of achieving safer patient care.

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Currently, close to 90 acute-care hospitals have earned Magnet recognition. Facilities designated by ANCC as “Magnets” have proven track records for retaining nurses, even during shortages, because they put a high premium on nursing leadership. Average nurse retention in Magnet facilities is twice as long as that of non-Magnet institutions. Furthermore, patients in Magnet facilities experience fewer negative outcomes, shorter lengths of stay, and increased satisfaction with their health care services.

ANA further supported the recommendation that hospitals and nursing homes directly involve nursing staff at the unit level in determining and evaluating staffing needs. This is a recommendation that ANA has long been making, and it is outlined in ANA’s *Principles for Nurse Staffing*. ANA published the principles in 2000 to assist nurses in determining appropriate staffing. Used as guidelines, the principles not only take into account the number of patients but also look at other staffing considerations, such as the experience level of unit nurses, the severity of patients’ conditions, and the availability of support services and resources. In addition, the principles are the basis of proposed federal legislation, S.991, the Registered Nurse Safe Staffing Act, introduced in the Senate last May.

Finally, while agreeing that the report speaks to creating a culture of safety in nursing care, Blakeney advised the committee to “take on a broader view” of the overall work environment with an eye toward “creating a work culture where excellence in nursing care – and not simply patient safety – can survive and thrive.” This atmosphere exists in Magnet facilities, which have been shown to recruit and retain more nurses while also providing excellent and demonstrably safer nursing care, she added.

“The nation currently is experiencing a nursing shortage, with more than one million new nurses needed by 2010,” Blakeney noted. “Many studies have confirmed that a lack of adequate nurse staffing does result in greater patient mortality. This latest study not only builds on these other studies but it also strengthens the link between nursing care, the work environment and greater patient safety. It is now up to key decision makers to take action and devote the resources necessary to implement these recommendations – in order to recruit and retain nurses and keep patients safe.”

In addition to *To Err is Human*, the IOM’s recommendations also follow those from a second report: *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). This report focuses on patients’ experiences and how “microsystems” of care, including nursing units, should be modified to reduce errors. The current report differs by focusing primarily on health care organizations and their work environments.

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