Perspectives on Staffing

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Oregon Nurse Staffing Law

Is It Working?

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In 2001, Oregon enacted a law mandating the creation of hospital nurse staffing committees to oversee staffing in acute care hospitals. The study design is a descriptive case study (qualitative method) using semistructured interviews and focus groups to assess the law requiring hospital nurse staffing committees to monitor nurse staffing in Oregon. One significant theme of the study was the wide variation among facilities in the way the staffing legislation is viewed, interpreted, understood, appreciated, and implemented. Another was that the chief nursing officer's view of the legislation tended to be the prevailing view expressed by the managers and staff nurses from those same organizations. A significant difference between a functional versus nonfunctional committee was whether the chief nurse viewed the legislation in a positive way and was using the legislation to enhance his/her work.

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In 2001, Oregon enacted a new law related to nurse staffing in acute care hospitals.[1] Elements of the law include the requirement that each acute care hospital establish a hospital nurse staffing committee (HNSC) with equal numbers of hospital nurse managers and direct care RNs, to develop nurse staffing plans that are based on an accurate description of individual and aggregate patient needs, requirements for nursing care, and specialized qualifications and competencies of the nursing staff. Other components of the regulation include the establishment of minimum numbers of nursing staff including LPNs and certified nursing assistants (CNAs) required on specified shifts; staffing plans to include a formal process for evaluating and initiating limitations on admission or diversion of patients; that staffing plans are developed, monitored, evaluated, and modified by a hospital nurse staffing plan committee in accordance with these rules; that plans be consistent with nationally recognized evidence-based standards and guidelines; and that any nurse on the committee may request the Oregon Department of Human Services to assist in resolving an impasse if the HNSC is unable to reach agreement on approval of the nurse staffing plan.[1-4] This article discusses a study that was developed to assess the effectiveness of the legislation as measured by the presence of a positively viewed HNSC from the perspective of staff nurses, nurse managers, and the chief nursing officers (CNOs).

Design and Methods

The study design is a descriptive case study using data collected from semistructured interviews and focus groups.[5] Aggregate descriptive information regarding participating hospitals is included to provide context for categorizing the hospitals; however, neither the organization nor individual participants are identified. The researchers were the only ones aware of the identities of the hospitals, and the corresponding author was the only person who met with participants. The research team categorized the hospitals using the criteria described in the section on samples. Data were analyzed using interpretive phenomenology and

thematic analysis to capture and describe emerging themes, patterns, and meanings.[5] The purpose of the analysis described was to provide insights into how a person in a given context makes sense of a phenomenon, in this case, how individual nurses, managers, and CNOs experience and describe the HNSC and implementation of the Oregon staffing legislation. "Effectiveness" of the legislation was described in the focus groups and structured interviews, but data were not collected using a quantitative scale.

Sample

Of the 57 acute care hospitals in Oregon,[6] 7 hospitals (12.3%) were included in the sample with a mix of rural (57%; n = 4) and urban (43%; n = 3) facilities represented. The 7 hospitals were selected using a purposeful stratified methodology, taking into account hospital size, geographic location, union status, profit status, and affiliation. In sample selection, all acute care hospitals in Oregon (n = 57) were categorized as large (>150 beds; 21%; n = 12), midsize (<150 but >50 beds; 25%; n = 14), and 31 critical access/rural/small (<50 beds; 54%; n = 31) facilities. Thirty-five of the 57 hospitals (61%) have RNs represented by unions. Characteristics of the hospitals in the state include nonprofit and for profit, those with a religious affiliation, organizations that are part of larger systems, teaching hospitals, and hospitals located in both rural and urban areas.

Several organizations in the sample (n = 7) had more than 1 of the descriptor characteristics; thus, the total is more than 7 (Table 1). To ensure sampling adequacy, a second group of hospitals was selected based on the same characteristics in case hospitals in the original cohort declined to participate. This project was not submitted to a formal institutional review board because it was constructed as an informal assessment. After analysis of the outcomes, the study team decided to move forward with this publication. Efforts made to ensure the anonymity of participants and organizations included destroying all notes and recordings of the interviews and focus groups after analysis; only the primary researcher had access to the notes and recordings; there were no identifying characteristics of the organizations or individuals in the report or manuscript; participation was voluntary and could be withdrawn at anytime; and individuals were told at the beginning of the focus groups that they could decline to participate or withdraw from the group at any time.

Results

The study demonstrated wide variation among facilities in the way the staffing legislation is viewed, interpreted, understood, appreciated, and implemented.

In 4 of the participant facilities (57%), the law was viewed as positive or moderately positive; in the other 3 facilities (43%), the law was viewed as negative. No trends were noted related to hospital size, location, union status, affiliation, or profit status. Across all organizations, the CNO's view of the legislation was the prevailing view expressed by the managers and staff nurses who participated.

The following themes emerged related to aspects of the legislation:

- All facilities had staffing plans and HNSC in place.
- All facilities had equal numbers of direct care RNs and managers on the committees.

Table 1. Organizational Characteristics in Sample (n = 7)

Hospital	Union	For Profit	Part of a Chain	Religious Affiliation	Large (L), Medium (M), Small (S)	Teaching	Urban
Hospital 1					M		
Hospital 2	a			a	M		
Hospital 3					S		
Hospital 4			a		L	a	a
Hospital 5		a	a		S		
Hospital 6	a				S		
Hospital 7	a				L	a	a

[a]Several organizations had more than 1 descriptor; therefore, the number in total is more than 7.

- All facilities had representation from the acute care units or unit clusters in the hospital.
- Direct care representatives were not always elected by the peer group; in some cases, the managers had to solicit staff nurses to attend the meetings.
- All facilities had some form of monitoring plan to evaluate the staffing, but most groups had been functional only for 1 to 2 years, so evaluations had not been fully conducted.
- The facilities had staffing plan(s) that included information about the scope of service that was provided in the different units and the population of patients that were admitted.

Determination as to whether the plan was sufficient for patient care was often triggered by complaints from the direct care nurses. Facilities included RNs, LPNs, and CNA competencies in the staffing plans, and the minimum number of nurses was generally based on national standards, particularly minimum staffing for different practice settings.

Most facilities did not have a formal mechanism to include patient acuity in the staffing decisions; rather, acuity/work intensity was addressed in relation to a variance from the core schedule on an as-needed basis. This method may not be in concert with the intent of the legislation. With rare exception, most HNSCs had neither reviewed nor approved the core schedules. Also, the HNSCs had not been part of creating minimum numbers of staff (including skill mix) for different shifts in most facilities. The majority of the facilities reported that the matrices were created by managers with the CNO and influenced by the facility budgets.

Further exploration of the policies is indicated to see if this practice meets the intent of the regulation. Only 1 of the 7 facility participants (14%) mentioned that they had a mechanism to limit admissions to a unit or divert patients to other facilities in times of short staffing or high patient acuity. This could be interpreted as a violation of the regulation; however, facilities generally provided reasons for why this could not be done. All facilities had on-call mechanisms; but not all could use temporary staffing agencies because of geographic distance.

Consistent themes emerging from the responses to the study questions included the need for more education of the HNSC members regarding how to implement the legislation including how to create staffing plans. One common benefit cited in all facilities was that the HNSCs gave nurses "a voice."

Discussion

HB 2800 was drafted into legislation to ensure that the nurses and managers who were closest to providing direct care to hospital patients would have input about how the staffing was planned and implemented. Historically and currently, managers have fiscal responsibilities as part of their job requirements that direct care RNs do not. One of the challenges of a management role in nursing is to balance available resources with the needs of the staff and patients. Hospitals are hierarchical structures, and managers have the right and responsibility to hire and fire employees, including staff nurses. In order for staff nurses and managers to discuss issues on a somewhat level field, the rules and perceptions of hierarchical management may need to be reviewed or amended, if not suspended. Because of the hierarchical structure in many organizations, simply requiring equal numbers of staff nurses and managers on a committee is not enough. The environment of the committee must be created in such a way that both managers and staff feel mutual respect and support in having discussions, voicing differences in opinions, resolving issues, and developing solutions to resolve differences. Chief nursing officers tend to most dramatically influence the nursing culture. This influence was also recognized by participants in the study.

In a state like Oregon with a prescriptive staffing law, are the views of staff nurses, managers, and CNOs positively influenced by these guidelines or unaffected? Exploration of the influence of regulation on practice, nurse satisfaction, and patient outcomes requires further study. From this informal review, the influence of the CNO is highly predictive of positive acceptance of regulations. In organizations where the CNO views the staffing legislation as negative, redundant, or onerous, the committee members reported feelings of complacency or a desire to withdraw from the process. All these behaviors, both positive and negative, were displayed among our study participants. All laws have unintended consequences.

While enacting staffing regulations in Oregon and staying under the prescribed rules, some organizational participants reported positive outcomes and perceptions, and some organizations did not. One participant reflected, "You can't legislate judgment." In organizations that are people and culture dependent such as hospitals, the good judgment of many individuals, including the CNO, will influence the success or failure of this and any regulation.

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