

WHERE WILL YOUR CAREER TAKE YOU?



from THE FLOOR

the Nurse/Patient Ratio

The New Year heralds many things, and this year brings legislation mandating a patient/nurse ratio in California. But after the confetti stops falling, did we get what we want?

We now have a panacea for thousands of nurses in California, however, the

ratio really can't be enforced. (At the writing of this article the companion bill for enforcement is stalled in the legislature, having been defeated at least once already).

As my children are fond of saying, "why am I not surprised?" Having been a

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nurse for almost 30 years, most of those years spent in the NICU/PICU, I am used to working with a strict nurse/patient ratio. ICU's and a few other areas of nursing have always been under the control of an "acuity" system. Actually, all nursing is supposed to be, but we all know this isn't always the case. For this reason, I knew in my heart that legislating a nurse/patient ratio was probably an exercise in futility.

Why this attitude, you may ask? First, hospitals and J.C.A.H.O. already require the development of an acuity tool to assess the patient and assign nurse/patient ratios. Second, I hate to see laws passed for the sake of passing laws. Do California nurses need reliable nurse/patient ratios?—yes. Do these ratios need to be enforceable?—yes. Do we need legislation?—probably not.

Let's dissect the problem. How is the nurse/patient ratio determined? In theory, each hospital has in place an acuity procedure. It can be as simple as if the patient has x, they are a 1; if the patient has x & y, they are a 2, and so forth. The more complicated the care required for the

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patient, usually the higher the number assigned. Then depending on the number the nurse has an allotment of patients. For example, a nurse can have a total of 2, 3, 4 or even 10 patients that are ranked 1, but a nurse can only have a total of 1 patient if that patient is ranked 6 or 7.

The system is simple, until the human factor is taken into account. That factor is the Charge Nurse, who usually makes the assignments. In most cases the Charge Nurse is a floor nurse who has the duty of being Charge Nurse on a shift. She is usually not trained as a manager. She is often unwilling to take the risk of rocking the boat. Tomorrow she will be a floor nurse again and someone else will be the Charge Nurse, so she'll be at the mercy of a different Charge Nurse, and so on.

Any management expert will tell you that this is a formula for disaster. A recent incident at a local area hospital will serve as a good example of this problem.

I showed up for work one night at a “Not Quite Out in the Sticks” hospital (which was listed as one of the top 100 hospitals in the nation). As usual, the NICU was short staffed—nothing new there, especially since this unit suffers from numerous nurses calling in sick. A recent survey found that nurses were as likely to call in sick because they were just “plain sick and tired” as they were due to actual illness.

The Charge Nurse for the night gives me my assignment. Three neonates, one is ranked a 5 and two are ranked at 4. By visually assessing the number of IV's they each have, the order for lipids and TPN, the nasal cannulas, I know that I'm being assigned 3 patients that are all 5's. This is before I discover that the 2 of the neonates ranked 4 are also having severe Brady's and apnea. This is an unsafe patient assignment. So much so that one of the infant's IV infiltrated and he was burned from the medication being delivered via the IV.

The nurse assigned his care, who I had relieved, was not only devastated, but frustrated as well. The injury under normal circumstances was probably avoidable, but with the patient load assigned, it was an accident waiting to happen.

As I stated earlier, I have been a nurse for 30 years. It was my RN license that kept a roof over the heads of my four children, mother, and dog when my husband and I divorced—so I place a high value on it. Unwilling to risk my license, I alerted the Charge Nurse of the unsafe patient load. Her response to me was... “Well this was the ranking that has been in place for several days”. My response to her was, “Just because it was ranked wrong in the first place doesn't mean we have to perpetuate the error.”

A Charge Nurse who had been trained in management, and who was assigned solely as a Charge Nurse, would have been better prepared to deal with the problem, or may have had at her disposal a wider array of “management tools” to help solve the problem. For example, she may have prefaced the unusually heavy assignment with words of encouragement and support, such as:

“We are really short staffed this evening, and with your many years of experience I thought that you would be up to this challenge” or “I know that this is a heavy assignment, but I am here to help when you need it.”

She did, however, send the Transport RN to change the ranking of one of my patients from a 5 to a 4. The nurse in the bay next to me leaned over, winked, and whispered, “Now don't you feel better.”

The above is a good example of how, even with an acuity system in place, the nurse/patient ratio is ignored. To believe it could be legislated was a pipe dream. Nurses, Hospital Administration, and Unions would better serve the patients and nurses if we took different, more effective action.

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Here is a quick and dirty solution to part of the problem:

STEP ONE: Make Charge Nurse a middle management position. This is a good way to reward competent and interested nurses who are ready to begin moving from the bedside, but who might not be ready to tackle the Head Nurse position.

STEP TWO: The Charge Nurse does not get assigned a patient load. Instead, like the Head Nurse, she would take on the care of patients when and where necessary. Her primary focus, however, would be to come to the aid of the nurses on the floor and do admitting when necessary. With this method a floor nurse on occasion could be assigned a slightly higher than normal patient load, for example, caring for 3 patients ranked 5, because the Charge Nurse would be there to help when needed.

STEP THREE: Train the Charge Nurse in management techniques. The Charge Nurse position needs to be a stable position, not a position that is rotated among floor nurses. By assigning the Charge Nurse position a stable "rank" there is more likely to be a constant continuum of care and fairness of assignment.

STEP FOUR: Compensate the Charge Nurse, not necessarily with money, although a pay increase is always appreciated. Compensation could also come as a benefit package, designated parking, extra paid time off, paid CEU classes or additional University level classes.

Is this the solution to the Nursing Shortage – NO. However, I feel it is one step in the direction of mitigating the problem. One of the biggest reasons why nurses leave the field is that they feel poorly treated, such as when they are asked to work an unfair assignment. **WN**

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