Safe Nurse Staffing: Looking Beyond the Raw Numbers
Appropriate nurse staffing is critical to patient safety and well-being. Inadequate nurse staffing levels are known to influence the rate of heart attacks, falls, medication errors and respiratory infections, as well as overall mortality. According to one study of surgical outcomes, a patient’s risk of dying within 30 days of admission increased by 7 percent for every patient added to a nurse’s workload past a certain point.¹

A recent survey of nurse staffing trends by the American Nurses Association (ANA) found that 54 percent of nurses in adult medical and emergency units report spending insufficient time with patients, and 43 percent of nurses work extra hours due to short-staffing or excessively busy units. In 20 percent of the cases examined, low staffing had a negative impact on unit admissions, transfers and discharges.² Understaffing also depletes morale, leading to higher levels of absenteeism and staff turnover.

Nurse staffing levels are affected by a range of external factors, including cyclical shortages of registered nurses (RNs), nursing school capacities, immigration policies, changing patient needs and expectations, increased competition for healthcare dollars and the general state of the economy. The recession has mitigated staffing problems for some hospitals and other healthcare organizations by decreasing the demand for elective treatment and motivating older nurses to return to full-time practice. However, organizations should not be lulled into complacency. Industry analysts caution that long-term projections indicate the nursing shortage will widen over the next decade as the economy improves and many nurses reach retirement age.

Legislative efforts addressing inadequate nurse staffing range from mandated nurse-patient ratios to state reporting programs. However, given the diversity of healthcare organizations and the complexity of nurse staffing issues, “one-size-fits-all” solutions are unlikely to emerge. An effective staffing model must take into account such variables as patient acuity, unit layout and ancillary support in determining the appropriate number, skills, experience, specialized training and education of nurses on a given unit.

Sound nurse staffing is more than a numbers game. It also requires a long-term organizational commitment to empower and appreciate nurses. This edition of VantagePoint® examines some of the issues surrounding nurse staffing and offers strategies designed to help organizations withstand periodic nursing shortages, improve patient outcomes and reduce liability exposure.

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Staffing Standards and Requirements

In crafting their nurse staffing plans, healthcare organizations must first consider pertinent regulations and standards, such as the following:

Staffing ratios. A decade ago, California became the first state to establish fixed nurse-to-patient ratios for comparable units in every hospital.3 While static ratios – e.g., one nurse for every four patients – have helped reduce unsafe workloads, they are costly to implement and ignore the variability of patient populations. Furthermore, as victims of the economic downturn lose their health insurance coverage and delay preventive care, staff in emergency rooms, hospitals and ambulatory care centers must prepare for patients being admitted in graver condition and needing more acute care. Compliance problems at a critical time can lead to unnecessary emergency room diversions, delays in surgeries and even temporary hospital closures, which can place patients at risk.4

State-imposed ratios of more recent date appear more sensitive to variations in patient acuity and are generally limited to specialty areas.5 Typical ratios are listed below:

- 1:1 in operating room and trauma emergency units
- 1:2 in critical care areas, including emergency critical care, intensive care, labor and delivery, and post-anesthesia units
- 1:3 in emergency rooms and in antepartum, pediatric, step-down surgical and telemetry units
- 1:4 in intermediate care nursery, specialty care, medical, surgical and acute care psychiatric units
- 1:5 in rehabilitation units
- 1:6 in postpartum and well-baby units

For an overview and descriptive map of legislative mandates as compiled by the ANA, see “Nurse Staffing Initiatives” on page 8.

Public reporting. Reporting of nurse staffing levels, patient mix and outcomes has become an important method of ensuring compliance with standards and promoting transparency in operations. State reporting programs are on the rise, with most sharing certain features. These include

- amending the state’s “Bill of Rights for Hospital Patients” to allow public access to information related to nurse staffing ratios
- requiring hospitals to compile and post staffing information for each unit on a daily basis
- mandating quarterly reporting of staffing information to state health commissioners for purposes of public dissemination
- creating a “hospital report card,” which reports patient outcomes, staffing levels, and nurse orientation and training programs

5 Proposed mandatory staff ratios, such as those in an Illinois bill (SB224), are similar to the ratios already implemented by other states over the past several years.
National standards. Staffing standards designed to ensure the safety of both patients and employees are available from a variety of sources. The Joint Commission, for example, requires accredited organizations to determine staffing levels based on internal data and experience. The assessment process incorporates 21 nurse-sensitive clinical and human resources indicators, such as adverse drug events, patient falls, misuse of overtime, staff turnover rate, patient and family complaints, and staff injuries. For more information, see the Joint Commission’s “Health Care at the Crossroads: Strategies for Addressing the Evolving Nurse Crisis,” which is available at http://www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health_care_at_the_crossroads.pdf.


Finally, other national organizations, such as the American Hospital Association and a number of professional nursing associations (listed in Resources, page 14), have formulated their own staffing recommendations. Healthcare administrators should seek to create a staffing program that incorporates a wide range of input, yet is tailored to the organization’s specific mission and aligned with its enterprise-wide goals.

CNA HealthPro Nurse Claims Study

The recently published “CNA HealthPro Nurse Claims Study: An Analysis of Claims with Risk Management Recommendations 1997-2007” examines the malpractice experience of CNA-insured nurses and presents a wide range of preventive measures. Among the study’s key findings:

- Death was by far the most frequent injury type, occurring in approximately 38.2 percent of the claims.
- Sixty percent of the claims involved nurses within the adult medical/surgical specialty, and about 18 percent involved gerontology specialists.
- Obstetrics/gynecology claims were the costliest, with an average paid indemnity of $335,375, followed by pediatric/neonatal claims at $248,486.
- Allegations of improper or untimely nursing technique appeared in approximately 28 percent of all claims, involving over $7 million paid in total indemnity.

To read the study in full and learn more about nursing-related professional liability, visit www.cna.com or www.nso.com, the Web site of the Nurses Service Organization.
**Nurse Staffing Strategies**

Organizations face the challenge of reconciling their own needs and resources with a wide variety of external staffing mandates and standards. One proven approach is to create a Nurse-Management Staffing Committee, which reports directly to the organization’s governing board and is charged with the development of safe, practical and patient-centered staffing policies. (See “Major Elements of a Nurse Staffing Plan,” page 11.) Once convened, the committee can begin the process of designing policies that maximize nurses’ contributions while minimizing risk, as indicated below:

1. **Incorporate qualitative factors into the staffing plan.**

   Formal staffing plans offer a flexible alternative to fixed nurse-patient ratios. Written plans should extend beyond raw numbers, ensuring that each patient is cared for by nurses with appropriate skills and experience. Supported by a written, predetermined strategy, organizations can more easily address nursing shortages and ensure that staffing decisions reflect multiple factors, such as
   - patient diagnoses, acuity and special needs
   - daily census and patient population trends
   - staff competency, education, training and skill mix
   - access to medical personnel and support staff
   - available resources, both current and projected
   - satisfaction levels of patients and employees
   - unit turnover, including admissions, discharges and transfers

   Staffing models will vary, based on such fundamental organizational realities as
   - location (urban, suburban or rural)
   - enterprise-wide culture (top-down vs. team-focused)
   - type of facility (public vs. private, academic vs. non-teaching)
   - market share (major or minor)
   - regional designation (trauma, perinatal or other service specialization)

   The following important factors should also be taken into account:

   **Physical layout.** Equipment accessibility and the placement of patient rooms, treatment areas, nursing stations and medication preparation areas significantly affect nursing efficiency. Well-designed units are associated with higher levels of nurse satisfaction, retention and productivity.

   **Technological support.** Use of electronic medical records, automated pharmaceutical administration procedures, standardized supply cabinets and computerized physician order entry systems helps minimize errors and reduces paperwork demands, allowing nurses to spend more time at the bedside.
Direct care resources. Licensed practical nurses, technicians, assistive personnel and other care team members are critical to a nurse’s ability to deliver safe, quality care. Written staffing plans should indicate the availability per shift of the following staff resources:

- admissions nurse
- clinical nurse specialist
- clinical pharmacist
- hospitalist
- intensivist
- interns/residents
- intravenous therapy team
- monitor technician
- nursing students
- patient transport team
- rapid response team
- rehabilitation services
- respiratory therapy support
- social services/crisis RN
- staff educator
- unit clerical support
- unit nurse management
- wound care specialist

The staffing plan drafting process can serve as a means of initiating discussion between nurses and other healthcare providers and leaders on such topics as professional development and personnel needs. See “Major Elements of a Nurse Staffing Plan,” page 11, for a checklist of constituents of an effective staffing protocol.

2. Create the right mix of training and experience.

As described in the “CNA HealthPro Nurse Claims Study: An Analysis of Claims with Risk Management Recommendations 1997-2007” (available at www.cna.com), plaintiff’s lawyers have begun to pursue claims that focus on the nurse as a clinician responsible for exercising independent judgment, rather than simply taking orders. Organizations are therefore encouraged to protect themselves by hiring highly trained nurses in essential specialties, such as emergency care, obstetrics, pediatrics and critical care. Studies show that by adding specialty RNs to the staffing mix, hospitals can reduce various adverse outcomes – including urinary tract infections, pneumonia, shock and upper gastrointestinal bleeding – by between 3 and 12 percent.6

When establishing the nurse mix for a given unit, staffing coordinators should be aware of each nurse’s ability to solve problems, perform complex functions, communicate effectively and behave professionally – critical skills that typically develop over time. Inexperienced staff members who lack these skills are more likely to cause errors or fail to observe potential hazards. Therefore, in addition to education, training and certification, the following factors should be considered in staffing decisions:

- level of clinical experience
- years on the job
- tenure on the unit
- past clinical work in a designated setting
  - or with a specific patient population

- supervisory experience and skills
- foreign language capabilities
- extent of continuing education
- familiarity with organizational policies and procedures
- involvement in quality initiatives
- committee participation and other collaborative professional activities

3. **Examine nursing-sensitive outcomes.**

Organizations should routinely analyze staffing levels in relation to adverse occurrences. The following patient outcomes are deemed “nursing-sensitive” because they tend to improve or decline in relation to changes in the quantity or quality of nursing care:

- urinary tract infections
- central line catheter-associated bloodstream infections
- pneumonia
- shock
- falls (with or without injury)
- restraint prevalence
- upper gastrointestinal bleeding
- longer hospital stays
- failure-to-rescue occurrences
- 30-day mortality rates

Nursing-sensitive outcomes alone do not convey the full impact of nurse staffing on patient safety. Patient acuity, hospital type, available support staff and other factors must be included in any attempt to define the complex relationship between nurse staffing and quality of care. Nursing-sensitive findings can, however, be helpful in making daily decisions regarding the staffing needs of different units. For information about the ANA’s National Database of Nursing Quality Indicators®, which collects nurse-sensitive data by type of unit, see [https://www.nursingquality.org/](https://www.nursingquality.org/).

4. **Address the underlying causes of staff turnover.**

To thrive at a time of rising competition and cyclical nursing shortages, healthcare organizations must focus on staff retention. A hospital employing 600 nurses at an average salary of $46,000 per nurse per year, with a turnover rate of 20 percent, will spend about $5.5 million dollars a year in replacement costs, according to the Voluntary Hospitals of America.7

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Nurse Staffing Initiatives

Several states have enacted legislation and/or adopted regulations addressing nurse staffing. In general, these state initiatives variously combine such elements as joint nurse-management staffing committees, mandatory staffing ratios, public reporting requirements and evidence-based nursing staffing plans. The laws also frequently contain provisions to protect whistleblowers and prohibit mandatory overtime.

The American Nurses Association (ANA) is working with state groups to promote legislation that holds hospitals and other healthcare providers accountable for establishing sound staffing plans. Through its “Safe Staffing Saves Lives” campaign (www.safestaffingsaveslives.org), the ANA advocates nationwide development and implementation of appropriate nurse staffing mandates.

The following map, adapted from the ANA’s Nationwide State Legislative Agenda, displays those states where nurse staffing plans and ratios have been enacted and introduced as of March 2009:

The original map can be accessed at http://www.safestaffingsaveslives.org/WhatisANADoing/StateLegislation/NurseStaffingPlansMap.aspx.
In January 2009, S. 54: Registered Nurse Safe Staffing Act of 2009 was introduced in Congress. The measure would establish minimum staffing ratios for certain Medicare-participating hospitals. It would also require hospitals to

- accept staffing policy input from registered nurses (RNs) within participating healthcare organizations
- incorporate staffing guidelines stipulated by nursing specialty organizations
- take into account patient numbers and acuity, as well as the resources available on individual units, including ancillary support services
- consider caregivers’ level of experience and training, and prohibit RNs from working in areas where they lack proven competence

The bill would ensure compliance by

- establishing procedures for receiving and investigating complaints regarding understaffing and other concerns
- allowing the secretary of the U.S. Department of Health and Human Services to impose civil monetary penalties for violations of the proposed regulations
- including whistleblower protections for RNs and others who may file a complaint regarding staffing
- requiring hospitals to post the number of licensed and unlicensed staff providing direct patient care on a daily basis for each shift, specifically noting the number of RNs
- mandating the collection, maintenance and submission of pertinent data in order to analyze and reinforce the link between patient acuity and staffing decisions

To track the status of this legislation, visit http://www.govtrack.us/congress/bill.xpd?bill=s111-54.
Unfavorable working conditions and low wages have historically factored into licensed nurses’ decisions to seek employment elsewhere. The following interventions can help reduce the risk of experiencing a nursing exodus:

- Minimize the paperwork burden that detracts from time spent on patient care.
- Limit the use of mandatory overtime to emergency situations.
- Diversify the nursing workforce in terms of gender, age and ethnicity to broaden the employment base and lessen the impact of nursing shortages.
- Adopt effective ergonomic and information technologies designed to reduce the risk of injury and improve workflow.
- Offer fair and competitive compensation and benefit packages commensurate with education and experience.

5. Focus on empowering and valuing nurses.

Nurses perform better when permitted to fully utilize their expertise and skills, and to exercise their own judgment regarding patient assignment.\(^8\) This level of empowerment can be achieved only in the context of transformational leadership and associated practices, including shared governance, continuous learning, professional autonomy and career advancement tracks. On the other hand, retaliatory actions taken against nurses who disclose unlawful or unsafe practices weaken management’s relationship with staff and create a more passive and demoralized workforce.

Some experts believe that effective nurse empowerment requires an overhaul of the current reimbursement system, which perpetuates the view of nursing as a fixed cost rather than a valuable asset. If hospitals were reimbursed at a higher level for higher-acuity patient care based on diagnosis, the additional revenue would allow them to hire additional and more experienced nurses. For more information, see “Nursing Intensity Billing: Key to Safer Staffing?” on page 14.

A shortage of approximately 260,000 nurses is likely to develop by 2020.\(^9\) State staffing mandates alone cannot resolve this looming crisis, which threatens to compromise patient care and substantially increase liability exposure. Individual hospitals and health systems must work collaboratively with nurses to create and implement staffing and employment policies that meet changing patient needs, leverage nurses’ knowledge and capabilities, and minimize risk.


\(^9\) This number, large as it is, is significantly lower than previous estimates, due to the economic climate. See Evans, K. “Nursing Shortage Eases with Recession’s Help,” Wall Street Journal, June 12, 2009. The article, which cites a recent study lead-authored by Peter Buerhaus and published in the journal Health Affairs, is available online at http://online.wsj.com/article/SB124477098713308767.html.
### Nurse Staffing Committee

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1. Do direct care nurses and hospital management participate in a joint committee to make decisions about nurse staffing, with at least half the membership consisting of direct care registered nurses (RNs)?

2. Does the nurse staffing committee base its decisions on evidence-based principles, as determined by accrediting organizations, professional associations and government entities?

3. Are all types of nursing represented on the committee, including the following?
   - critical care
   - medical-surgical
   - perioperative (i.e., operating room and post-anesthesia care unit)
   - labor and delivery
   - postpartum/newborn nursery/neonatal intensive care unit
   - ambulatory surgery
   - observation unit
   - resource pool

4. In addition to direct care nurses, are other relevant stakeholders and departments represented on the committee, including the following?
   - chief nurse executive
   - clinical directors/nurse managers (minimum of three)
   - support staffs
   - human resources
   - information technology
   - finance

5. Does the committee consult with nurses in all inpatient care units, using the following mechanisms, among others?
   - online and paper surveys
   - staff-specific unit meetings, forums and open discussions
   - e-mail solicitation of opinions
   - grand rounds on clinical units
   - dissemination of the draft plan for employee comment

6. Does the committee develop, evaluate and modify the staffing plan in conjunction with the nurse executive team?

### Plan Fundamentals

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1. Does the staffing plan advance the organization’s mission of delivering quality care by
   - emphasizing patient safety?
   - setting optimum patient-to-nurse ratios?
   - accounting for variations among units and services?
   - identifying staffing constraints within the hospital’s region, such as the number and qualifications of available nursing candidates?
   - supporting the care delivery model utilized in nursing units, such as a primary or team-based care model?
   - complying with human resources policies and procedures?

2. Does the staffing plan focus on improving quality of patient care, clinical outcomes, staff retention and job satisfaction?

3. Are staffing patterns and support based on patient volume, acuity and needs, rather than type of payer?

4. Does the staffing plan accommodate budgetary realities without compromising patient care?

5. Is the staffing plan in strict compliance with federal, state and local staffing laws and/or regulations?
### Key Elements of a Nurse Staffing Plan (continued)

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<th>Plan Components</th>
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<tr>
<td>1. Does the staffing plan define the following terms?</td>
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<td>- nursing staff</td>
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<td>- assistive nursing personnel</td>
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<td>- direct and indirect patient care activities</td>
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<tr>
<td>- patient acuity</td>
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<td>- complexity of care</td>
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<td>- quality of care</td>
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<td>- retaliatory action</td>
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<td>- hospital workweek</td>
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<td>2. Does the staffing plan identify the needs of each unit, ward and service department by analyzing the following criteria?</td>
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<td>- patient population and average daily census</td>
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<td>- patient acuity</td>
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<td>- length of stay</td>
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<td>- specialty needs</td>
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<td>- physical environment and available technology</td>
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<td>- staff competencies and skill mix</td>
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<td>- specialty certification or training of nursing personnel</td>
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<td>- availability of specialized or intensive care equipment</td>
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<td>- nursing-sensitive outcomes</td>
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<td>- evidence-based staffing standards</td>
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<td>3. Does the staffing plan articulate optimal nurse-to-patient ratios, required skills, staffing models (such as primary care or team approach) and resources for each unit, ward and/or service department?</td>
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<td>4. Does the staffing plan utilize an evidence-based method for calculating work hours, such as the following?</td>
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<td>- hours per patient day (i.e., direct care hours provided to a patient in a designated clinical area over 24 hours)</td>
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<td>- hours per unit of service (i.e., hours allocated per inpatient day, observation visit, surgical procedure or other type of service)</td>
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<td>5. Does the plan prohibit working more than 48 hours in a hospital-defined workweek?</td>
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<td>6. Does the plan prohibit working more than 12 consecutive hours in a 24-hour period?</td>
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<td>7. Does the plan prohibit requiring an RN, licensed practical nurse or certified nursing assistant from working beyond an agreed shift in non-emergency situations?</td>
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<td>8. Are exceptions to overtime prohibitions – including natural disasters, facility emergencies and situations where a patient could be harmed due to the lack of a replacement nurse at the end of a shift – clearly defined in written policy?</td>
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<td>9. Is time spent in orientation, training sessions, and educational and required meetings considered hours worked?</td>
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<td>10. Is time spent on-call or on standby while on hospital premises considered hours worked?</td>
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<td>11. Does the staffing plan allow for some fluctuation in nurse availability by shift and day, based on variations in census and patient care requirements?</td>
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<td>12. Does the plan provide options for nurses when staffing arrangements are inadequate, such as authorization to call agency nurses if needed?</td>
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<td>13. Is a skills mix evaluation performed whenever an outside agency nurse is retained?</td>
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<td>14. Are criteria for voluntary and mandatory overtime delineated, and are occurrences noted on an overtime approval form?</td>
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<td>15. Does the plan outline corrective actions to be taken when staffing parameters are not satisfied?</td>
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### Plan Distribution and Posting

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1. Is a copy of the staffing plan and any subsequent changes provided to each member of the hospital’s nursing staff free of charge?

2. Is a notice posted in a conspicuous location informing the public that the staffing plan is available and explaining how to obtain a copy?

3. Is the following information posted on each unit: annual staffing plans, patient census, shift-based and total clinical staff numbers, and the name of the nursing supervisor on duty?

### Plan Audit and Review

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1. Does the nurse staffing committee review the staffing plan annually to determine whether it encourages the provision of sound, cost-effective nursing care in compliance with prevailing laws and standards?

2. If negative trends in inpatient care outcomes or nurse well-being emerge, does the staffing plan dictate more frequent data review and creation of an action plan to address the problems?

3. Does the staffing plan require the measurement of the following nursing-sensitive indicators, among others?
   - nosocomial infections
   - patient falls, with or without injury
   - pressure ulcer rate
   - pain assessment and intervention
   - restraint use
   - peripheral intravenous infiltration
   - patient leaving against medical advice
   - urinary tract infections
   - pneumonia cases
   - shock occurrences
   - upper gastrointestinal bleeding
   - longer hospital stays
   - failure-to-rescue events
   - 30-day mortality

4. Are actual staffing levels evaluated periodically, using patient outcomes and benchmarking data?

5. Does the committee examine whether the use of staff floating and float pools minimizes nurse staffing deficiencies?

6. Are nurse staffing levels adjusted in response to changes, such as new services, variations in patient population or an increased number of beds?

7. Is the use of mandatory overtime regularly evaluated?

8. Are efforts made to reduce the need for overtime by improving staffing policies?

9. Are the following nurse staffing trends evaluated on an ongoing basis?
   - work-related staff illness and injury levels
   - turnover and vacancy rates
   - mandatory and voluntary overtime
   - utilization of supplemental staffing
   - nurse job satisfaction, including such critical areas as working conditions, compensation and benefits
Nursing Intensity Billing: Key to Safer Staffing?

Professor John Welton, PhD, RN, has suggested that nurse staffing could be enhanced by directly linking the cost of inpatient nursing care to hospital reimbursement. His plan involves adjusting Medicare and private insurance payment by creating a separate nursing bill for time and costs, distinct from room and board charges. By knowing the appropriate level of nursing care for a specific diagnosis and adjusting charges accordingly, hospitals could secure sufficient revenue to maintain safe staffing.

Incorporating variable nursing costs directly into the billing and reimbursement system would align payment with expenses and also provide a new source of nursing data. Access to accurate nursing intensity and cost data creates an incentive for hospitals to optimize staffing levels and discourages excessive staff cutbacks to improve the bottom line. Ultimately, such a method could lead to a national consensus regarding the volume and type of direct nursing care required for patients with varying acuities and diagnoses.

For more information, see the article by Welton titled “Mandatory Hospital Nurse to Patient Staffing Ratios: Time to Take a Different Approach” in The Online Journal of Issues in Nursing, September 2007, Volume 12:3. It is available for viewing at http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANA Periodicals/OJIN/TableofContents/Volume122007/No3Sept07/MandatoryNursetoPatientRatios.aspx.

Resources

Professional Nursing Associations:

- Academy of Medical-Surgical Nurses (AMSN), at www.medsurgnurse.org
- American Association of Critical-Care Nurses (AACN), at www.aacn.org
- American Association of Neuroscience Nurses (AANN), at www.aann.org
- American Association of Spinal Cord Injury Nurses (AASCIN), at www.aascin.org
- American Nephrology Nurses’ Association (ANNA), at www.annanurse.org
- American Nurses Association (ANA), at http://www.nursingworld.org/
- American Organization of Nurse Executives (AONE), at http://www.aone.org/aone/about/home.html
- American Psychiatric Nurses Association (APNA), at www.apna.org
- American Society of PeriAnesthesia Nurses (ASPaul), at www.aspan.org
- American Society of Plastic Surgical Nurses (ASPSN), at www.aspsn.org
- Association of Child Neurology Nurses (ACNN), at www.acnn.org
- Association of Pediatric Gastroenterology and Nutrition Nurses (APGNN), at www.apgnn.org
- Association of Pediatric Hematology/Oncology Nurses (APHON), at www.apon.org
- Association of periOperative Registered Nurses (AORN), at www.aorn.org
- Association of Rehabilitation Nurses (ARN), at www.rehabnurse.org
- Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), at www.awhonn.org
- Emergency Nurses Association (ENA), at www.ena.org
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CNA School of Risk Control Excellence
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- National Association of Orthopaedic Nurses (NAON), at www.orthonurse.org
- National Gerontological Nursing Association (NGNA), at www.ngna.org
- National League for Nursing (NLN), at www.nln.org
- Oncology Nursing Society (ONS), at www.ons.org
- Pediatric Endocrinology Nursing Society (PENS), at www.pens.org/
- Society of Gastroenterology Nurses and Associates, Inc. (SGNA), at www.sgna.org
- Society of Otorhinolaryngology and Head-Neck Nurses (SOHN), at www.sohnnurse.com
- Society of Urologic Nurses and Associates (SUNA), at www.suna.org
- Wound, Ostomy and Continence Nurses Society (WOCN), at www.wocn.org

Other Organizations:
- Agency for Healthcare Research and Quality (AHRQ), at http://www.ahrq.gov/
- American Hospital Association (AHA), at http://www.aha.org/
- American Nurses Credentialing Center (ANCC), at http://www.nursecredentialing.org/
- National Quality Forum (NQF), at http://www.qualityforum.org/
CNA HealthPro, 333 S. Wabash Avenue, Chicago, Illinois 60604

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