**Mandatory nurse staffing ratios well intended but misguided**

* Written by Ann Harrington, MPA, BA, BSN, RN, NEA-BC
* Executive Director/New York Organization of Nurse Executives and Leaders
* <https://www.democratandchronicle.com/story/opinion/guest-column/2021/02/09/essay-mandatory-nurse-staffing-ratios-well-intended-but-misguided/4449155001/>

Effects of the COVID-19 pandemic on hospitals, nursing homes and healthcare workers, has resulted in a resurgence of promoting mandatory nurse staffing ratios. The Safe Staffing for Quality Care Act (A.108, Gunther/S.1168, Rivera) prescribes mandatory numbers of patients per nurse for most types of hospital units and in nursing homes. This one-size-fits-all approach is well-intended but misguided.

Mandatory nurse staffing ratios are intended to increase quality of patient care, improve patient and nurse satisfaction and outcomes of care. California legislated mandated nurse ratios in 2004 and none of these outcomes has been realized consistently. Additionally, in many instances, care has been denied to patients due to the need to close units that are unable to achieve ratios.

Proponents of mandated ratios cite evidence to support the concept. In reality, research findings support better outcomes with more nursing care hours and a better-educated RN workforce. *There is no proven magic number of patients per nurse.* Enacting specific ratios, maintaining them around-the-clock, without allowing flexibility to meet changing needs, is the wrong approach. And in the face of the financial devastation caused by the pandemic, rigid staffing ratios would cause insurmountable hardship for many facilities.

Staffing in healthcare organizations must be flexible to meet constantly changing needs, and must take into account the many differences among organizations.

* No two patients – even of the same age and diagnosis – have the same care needs.
* Patient populations in large specialty hospitals and academic medical centers differ greatly from those in rural and critical access hospitals.
* Nurses differ in education preparation, clinical experience, and tenure, and may or may not hold specialty certification.
* The mix of professional/non-professional/ancillary and support staff differs among facilities.

Rigid staffing ratios will not account for these important differences.

Hospitals and nursing homes might consider a collaborative approach to creating flexible, evidence-based staffing models, guided by the American Nurses Association (ANA) Principles for Nurse Staffing, (2019). Collaboration can be achieved through staffing committees composed of direct care nurses, paraprofessional care staff, organized labor, and nursing and facility leaders. Committees would also monitor and report outcomes to guide the need for adjustment.

Healthcare organizations are all committed to providing patient and caregiver safety. However, a simple solution to such a complex matter is not the answer. Members of the public should be aware of the myriad of issues that lie beneath the call for mandated ratios, and the unanticipated effects that could result if the bill becomes law.