# California Nurse

OFFICIAL BULLETIN OF THE CALIFORNIA NURSES ASSOCIATION

JANUARY/FEBRUARY 2005


## A Ratio Roundup

Butt kicking, protests, and a lawsuit

Next face-off is January 18 hearing

## Ratios do save lives, maybe even yours

One RN's story

Don't Miss Out on Our New CE Series! See page 19

California Nurse

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146

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# Letter from the President

Well, 2005 is already here and, boy, do we have our work cut out for us.

After just 10 months of full-fledged ratios, Gov. Arnold Schwarzenegger bought into the hospital industry's cries of wolf and put the kibosh on what we RNs know is the single biggest advance in recent years for both our practice and our patients.

But I know if any group can turn this situation around, it's us nurses. As you'll read in this month's news section, a recent Gallup poll ranked us (again) as the most honest and ethical profession. The public trusts us and knows we have their best interests in mind, so we can and must leverage that power.

And since Schwarzenegger issued his emergency order in early November, we've mobilized an astounding number of RNs at every event we've organized to protest his actions and hold his feet to the fire. In addition to these rallies, thousands of CNA members, and even non-members, have taken the time to write thoughtful and passionate letters describing to Schwarzenegger and the editors of their local newspapers how ratios save lives.

I want to thank each and every one of you who have written, called, or attended a rally. Believe me, your outspokenness and your presence matters. It builds our case in the court of public opinion, and that's something Schwarzenegger pays attention to, even when he doesn't care much about facts and common sense. In this issue of *California Nurse*, you can find an update of our activities through December and where we stand in defending the ratios. The next big event is Jan. 18, when the Department of Health Services will hold hearings to take public testimony on the ratios. If you can attend, please contact your labor rep and see this issue's back cover for more details.

Last but certainly not least, take a moment to read Kelly Di Giacomo's gripping first-person account of how ratios recently saved her life. Di Giacomo, an RN and CNA board member, has always supported ratios, but now finds herself with a much fuller appreciation of these critical regulations now that she has experienced their benefits from the patient side.

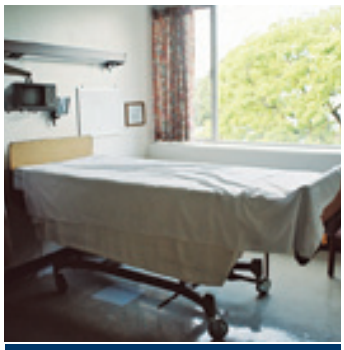
As I said, our work is cut out for us, but I'm confident we can prevail if we act collectively. Let's all resolve to get involved with CNA and do everything in our power to make sure the new year really does turn out to be a happy one for our profession and our patients. That's one New Year's resolution you'll want to keep.

Deborah Burger

Deborah Burger, RN
CNA President

# Contents

6 | Showdown with Arnold



11 | Brush with Death

12 | Behind the Mask

14 | On Board

## Cover Story


**6 Ratio Roundup**

After Gov. Schwarzenegger started chipping away at RN-patient ratios, RNs across the state showed him who the real action figures are as they staged rallies, bird-dogged him in public, and filed a lawsuit for good measure.

*By Lucia Hwang*


## Features


**11 This Time, It's Personal**

Kelly Di Giacomo's recent brush with death reminded her that ratios really do save lives.

*By Kelly Di Giacomo, RN*

**12 Not Up Front**

The hospital industry helps create a group posing as patient advocates to confuse the public.

*By Lucia Hwang*

**14 Eyes Wide Open**

RN board member Trande Phillips is determined to protect nursing as she knows it.

*By Lucia Hwang*


## Departments


**4 News Briefs**

Nurses top polls for honesty and ethics.

**5 That Does Not Compute**

Supporters of health savings accounts say they are the answer to the uninsured. But HSAs are really just the answer to corporations' quest to snag an ever-bigger slice of the pie at the expense of workers.

*By Rose Ann DeMoro*

**20 CE: The California Nursing Practice Act**

Safe Staffing Standards by Scope, Ratio, and Acuity, Part II: (continued)

*Submitted by the Joint Nursing Practice Commission and Hedy Dumpel, RN, JD*



January/February | 2005



**MARK YOUR CALENDARS AND CALL YOUR COLLEAGUES**

**The next main event in the fight to defend ratios is a California Department of Health Services hearing on Jan. 18 in Sacramento. DHS wants to make the emergency rules permanent, and this is the only opportunity for public input, so it is crucial that RNs attend to testify why the ratios must remain intact. Please see the back cover for details.**

# Public ranks nurses #1 for honesty and ethics

If there was ever any doubt that the public puts incredible trust in nurses, just look to a recently released Gallup poll survey on America's most honest and ethical occupations. Once again, nurses ranked number one, with almost 80 percent of responders rating the group "very high" or "high" for honesty and ethical standards.

Nurses have consistently swept the top spot in the annual survey since the field was added in 1999 – except in 2001, when in the aftermath of the Sept. 11 attacks, firefighters won that honor.

"Often RNs don't realize how highly they are respected by the public, which keeps them from exercising their power," says Rose Ann DeMoro, executive director of CNA. "They have enormous power."

Interestingly, nurses outranked both doctors and pharmacists in the survey.

Other public service professions, such as grade school teachers and military officers, scored high on the survey. Those scoring lowest were car salespeople, lawyers, and advertising professionals.

The results stem from telephone interviews with over 1,000 adults conducted in November, and have a margin of sampling error of three percentage points.

*—Staff Report*

## Percentage of poll participants who said "high" or "very high" in rating the honesty and ethical standards of people in these fields

| | | | |
|---|---|---|---|
| 1. Nurses | 79 | 12. Local officeholders | 26 |
| 2. Grade school teachers | 73 | 13. Nursing home operators | 24 |
| 3. Druggist, pharmacists | 72 | 14. State officeholders | 24 |
| 4. Military officers | 72 | 15. TV reporters | 23 |
| 5. Medical doctors | 67 | 16. Newspaper reporters | 21 |
| 6. Police officers | 60 | 17. Business executives | 20 |
| 7. Clergy | 56 | 18. Congressional reps | 20 |
| 8. Judges | 53 | 19. Lawyers | 18 |
| 9. Day care providers | 49 | 20. Advertising practitioners | 10 |
| 10. Bankers | 36 | 21. Car salespeople | 9 |
| 11. Auto mechanics | 26 | | |

source: The Gallup Organization

# Calling all ER RNs

**We need your help monitoring if, when, and how Gov. Schwarzenegger's decision to weaken patient ratios in emergency departments is damaging patient care and staffing. For example:**

Has your department recently decided to cut RN staff?
Have your managers stopped recording actual, specific RN assignments for each patient?
Is your hospital routinely declaring unexpected surges in patients as a pretext for ignoring the ratios?
Have wait times increased for patients and are any people leaving without receiving treatment?
Is your department following ratios?

If you've witnessed any of the above or some other deterioration in ER care due to the Governor's actions, please contact us today. It is critical that we document the negative effects of the ratio changes if we hope to restore ratios in ERs. **E-mail California Nurse's editor, Lucia Hwang, at lhwang@calnurses.org, or call her at (510) 273-2249.**

**Rose Ann DeMoro**
**CNA Executive Director**

# That Does Not Compute

## Under the industry's perverse logic, health savings accounts are supposed to make healthcare affordable by making everyone pay more.

***By Rose Ann DeMoro***

Health savings accounts, or HSAs, have emerged as the hot new approach to "universal" healthcare. HSAs become effective Jan. 1, 2005, so expect a heavy PR blitz from the Bush administration, their greatest supporter.

These accounts allow employees to deduct pre-tax income for use in paying medical expenses and must be paired with high-deductible health plans that insure for "catastrophic" illnesses. These plans have much lower premiums and remain with the individual regardless of employer. Employers are attracted to HSAs and the catastrophic plans because they may reduce health benefit costs.

This approach may be the purest form yet of the principle, "all the healthcare you can afford," and constitute the ultimate in cost shifting to workers. The premise of HSAs is that individuals should pay more for their healthcare, rather than paying health insurance, so they will not be "insulated" from the true cost. Proponents say explicitly that if individuals have to pay more, they will "use" less healthcare and costs will decrease.

Since the catastrophic insurance plans have very high deductibles, the cost of every visit to the doctor, dentist, optometrist, and pharmacy will come out of the pockets of the worker, in addition to paying a monthly premium. Only after $2,500 or perhaps $1,500 in expenses does insurance actually start kicking in for healthcare.

> **"This approach may be the purest form yet of the principle, 'all the healthcare you can afford,' and constitute the ultimate in cost shifting to workers... Proponents say explicitly that if individuals have to pay more, they will 'use' less healthcare and costs will decrease."**

The fallacies of HSAs include:

- Viewing healthcare as a commodity. Healthcare is not and cannot be treated as a commodity, since use is primarily determined by need and cannot be avoided. When use is deferred, the cost of care is more expensive, and the health consequences worse.
- Believing "overuse" is to blame for high costs. "Overuse" by individuals is not the driving force increasing healthcare costs: the fight for profits among corporate healthcare sectors – hospitals, insurance companies/HMOs, and drug companies – causes costs to increase.
- Assuming that HSAs will work for everyone. Those who need healthcare the most will avoid HSAs (if they can), burdening the public programs and traditional insurance, destroying community rating of health insurance and making even HMO premiums much more expensive and bankrupting Medi-Caid, if not Medi-Care.
- Thinking that HSAs will benefit everyone equally. The healthiest and wealthiest will be the biggest beneficiaries of HSAs, precisely those least affected by the healthcare crisis.
- Trusting that HSAs will be affordable. For uninsured families who currently cannot afford health insurance, HSAs offer little or no cost reductions for their routine healthcare expenses since they are less able to put money into the savings account. Nor are they a truly affordable option in the case of a major illness, since premiums for even just a catastrophic plan will likely be too expensive for families.

But HSAs do offer businesses and the free market ideologues an ideal program: "universal coverage" not tied to jobs where the cost is shifted from corporations to workers. The profits of insurance companies, pharmaceuticals, and hospitals remain robust.

The HSA motto should be: "Let all patients be savvy consumers, or die trying." ■

*Rose Ann DeMoro is executive director of the California Nurses Association.*

# Ratio Roundup

Governor Schwarzenegger's attempt to derail ratios spurred California RNs into a month of activism. The hospital industry responded with television ads and a front group. The next face-off is a Jan. 18 DHS hearing.

*By Lucia Hwang*


One of the many picket signs held by RN protesters at the Dec. 1 Capitol rally

After a media-grabbing, action-packed month of protests and legal maneuvers intended to pressure Gov. Arnold Schwarzenegger to leave nurse-patient ratios alone, the state's RNs are gearing up for the next main event: a hearing in Sacramento before the California Department of Health Services on Jan. 18.

DHS is expected to make permanent these emergency regulations Schwarzenegger issued on Nov. 4, and in order to do so, must hold this one hearing to take public testimony and comment. Hundreds of RNs refuse to let the Schwarzenegger administration negate years of hard work passing the law, and then determining the ratios, without directly expressing their outrage. They will be journeying to the capital to tell DHS why they oppose its sudden decision to excuse hospital emergency departments from ratios and to delay better 1:5 staffing in medical surgical units for a full three years. [Please see back cover of this issue for details on how to attend.]

The hope among RN leaders is that Schwarzenegger will suffer so much public and political pressure that he will retreat from his attempts to undermine the law. DHS may decide after the emergency regulations expire in early March to leave the rules intact. Or the agency might settle on a compromise position where, perhaps, phase in of the richer 1:5 medical surgical ratio is delayed for one year instead of three. CNA obviously prefers that Schwarzenegger back off entirely and, as the picket signs say, keep his "hands off" the ratios.

A huge rally, some say CNA's largest, on Dec. 1 at the State Capitol kicked off the campaign to put the heat on Schwarzenegger. Nearly 3,000 RNs from northern California, the Bay Area, and even a large contingent from southern California and inland desert communities, traveled by car, by bus, and by plane to meet at the north steps to share their anger and dismay with the rollback in patient safety protections. Elected officials who opposed Schwarzenegger's changes to the ratios also spoke. Many RNs discussed how the implementation of specific ratios on Jan. 1, 2004, had improved their worklife, their practice, and ensured patients were receiving more care and attention.

One such RN was Verna Barry. Barry, a medical-surgical RN with Good Samaritan Hospital in San Jose, was really looking forward to the new year when the maximum number of patients she was responsible for was supposed to drop from six to five. With that change, she thought she would again have the chance to provide her patients the kind of emotional support she had entered nursing to give.

"The community my hospital serves is very diverse and the patients have such diverse cultural needs," Barry says. "Right now, I have patients laying there afraid, when it would help them so much just to have someone hold their hand and listen to them. When you're afraid, you

Verna Barry, RN from San Jose's Good Samaritan Hospital

**"Right now, I have patients laying there afraid, when it would help them so much just to have someone hold their hand and listen to them. When you're afraid, you don't remember things as well, like how to use the pain button, or you may have more pain or loss of sleep. But we just don't have the time right now."**

don't remember things as well, like how to use the pain button, or you may have more pain or loss of sleep. But we just don't have the time right now." She says her practice has already changed for the better by going to a 1:5 ratio; she now has time to teach patients before they are discharged how to properly use equipment and take care of wounds so that fewer develop infections or are readmitted.

Just a week after the Dec. 1 rally, southern California RNs crashed a corporate-sponsored, star-studded women's conference hosted by Maria Shriver, Schwarzenegger's wife, to protest the Governor as he gave opening remarks. While RNs protested outside, a small group of RNs who had purchased tickets to the event smuggled in pieces of a banner that read "Nurse to Patient Ratios Save Lives, Hands Off Our Ratios." After they maneuvered toward the front of the crowded, football field-length convention hall, they unfurled the banner near television cameras and started chanting "Safe staffing saves lives." As security guards forced them out, Schwarzenegger glibly told the crowd not to pay attention to the nurses because they were special interests, and that "special interests don't like me because I'm always kicking their butts."

Schwarzenegger's crass comment immediately catapulted the ratio issue into the media limelight, and RNs rode the momentum and publicity for the rest of the month. Hundreds of offended nurses wrote to Schwarzenegger, chastising him for his depiction of nurses, and also to their local newspapers' editorial pages.

The California Healthcare Association, the hospital industry's lobbyists, came to Schwarzenegger's defense by running in the state's major media markets what's believed to be a $1 million campaign of 30-second television ads featuring a physician and a registered nurse who commend the Governor for his actions. CNA learned the RN speaking in the ad, Carrie Fox, is not a bedside nurse. After Schwarzenegger published his scheduling calendar in late December, CNA also learned that


RNs Teresa Gwinn (L) and Lonzetta Braddy from Arrowhead Regional Medical Center

**"As security guards forced them out, Schwarzenegger glibly told the crowd not to pay attention to the nurses because they were special interests, and that 'special interests don't like me because I'm always kicking their butts'."**

hospital industry representatives enjoyed a private, one-hour meeting with his chief of staff, Pat Clarey, on Nov. 16. The tv ads began running not long after.

In addition to the ads, the hospital industry has been busy supporting other so-called independent groups to agree with Schwarzenegger in order to make it appear as if most healthcare workers sided with the Governor and only CNA disputed the emergency regulations. One such group is Californians for Patient Care, a supposed patient advocacy organization. [See "Not Up Front" on p. 12 for more details.]

The latest salvo in the battle is a lawsuit filed by CNA against Schwarzenegger and other top DHS officials in Sacramento County Superior Court on Dec. 21. In it, CNA argues that Schwarzenegger abused his authority when he issued the emergency orders and asks the court to nullify them. [See "CNA Takes Ratio Rollback to Court" on p.13.]

"By using emergency regulations to rewrite legislation corporate interests don't like, the governor has made a power grab," said Rose Ann DeMoro, CNA executive director. "If this order stands, the Governor would have a green light to overturn all regulations or laws enacted for the public interest without legislative review or meaningful public participation."

If you'd like to give public input into the ratio rollback at the DHS hearing Jan. 18, see this issue's back cover for details. ■

*Lucia Hwang is editor of* California Nurse.

# SAFE STAFFING LAW


**Thousands of RNs from all over California converged on the Capitol Dec. 1 in a huge rally to protest Governor Schwarzenegger's emergency order to suspend major provisions of the RN-patient staffing ratio regulations.**

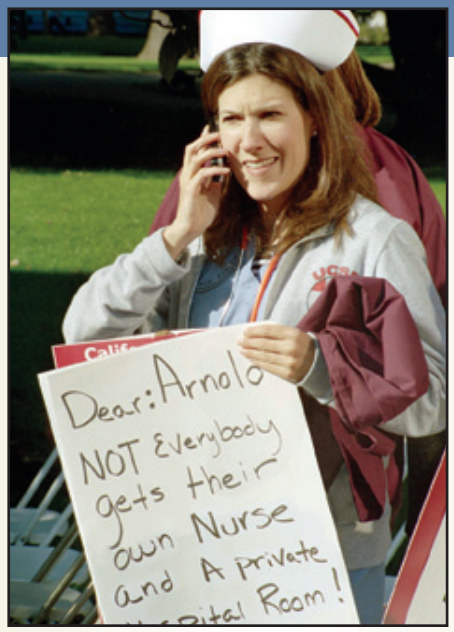
# RATIO RALLY

**The Dec. 1 rally coincided with a one-day strike of many Northern California Sutter hospitals over staffing and contract disputes. After the rally at the Capitol, RNs marched over a mile to Sutter General Hospital to join the picket lines.**



**Many RNs wrote homemade signs to show the Governor how they felt about his attack on the ratios.**








# WHICH WAS THE REAL WOMEN'S CONFERENCE?




# SOUTHERN CALIFORNIA RNS RALLY DEC. 7

**IN LONG BEACH, RNS CRASHED SCHWARZENEGGER'S OPENING SPEECH TO A CORPORATE-SPONSORED, CELEBRITY-STUDDED CONFERENCE INTENDED TO EMPOWER WOMEN. IT WAS HERE THAT ARNOLD REMARKED THE NURSES WERE MAD BECAUSE HE WAS ALWAYS "KICKING THEIR BUTTS."**


PHOTOS: TAD REYES

# This Time, it's Personal

## One RN's recent brush with death reminded her ratios really do save lives

***By Kelly Di Giacomo, RN***

Kelly Di Giacomo, RN

I've been a huge supporter of RN-to-patient ratios ever since CNA started the movement for such regulations and have been on the front lines in fighting the Governor's recent tampering of them. Our mantra has always been, "Ratios save lives." We chant it at rallies. I say it to the press whenever I'm interviewed. We RNs all know it every time we notice something about one of our patients that we wouldn't have caught if we had a larger patient assignment. But the truth of that statement never really hit home for me until ratios saved *my* life.

In early December, I was admitted into the hospital for major abdominal surgery. The last thing I remember before the surgery was getting a pre-med in my IV and moving onto the operating table. When I woke up, I could hear a bunch of people around me saying, "She stopped breathing. She turned blue." When I opened my eyes, they had formed a circle around my bed. "What happened?" I asked.

It turns out that after my surgery, which went just fine, I was sent from the recovery room to the intensive care unit, where for 20 years nurses by law have cared for a maximum of only two patients at a time. One of the nurses gave me some Demerol for pain, and I responded badly. Alarms started beeping as I quickly quit breathing, my heart rate plummeted, and I turned blue. The nurse immediately called for help and the staff jumped into emergency mode, rushing to hook me up to machines to breathe for me and dosing me with Narcan, a drug used to reverse the effects of narcotics. Shortly after, I woke up.

The rest of my hospital stay passed uneventfully. It was only after I had been home two days that the gravity of my experience sank in. My first epiphany was thinking, You know, I could have died. I wasn't breathing. That's as close as anybody can come to death.

My second epiphany was that the reason I wasn't dead was because of ratios. My surgeon had sent me to the better-staffed ICU instead of the medical-surgical ward. ICU beds are always precious, and the vast majority of patients who've undergone my type of surgery are usually sent to med-surg. I have a feeling it's only because I'm familiar with some of the recovery room nurses that they were able to persuade my surgeon to send me to ICU.

My mind swirled with What ifs? What if I had gone to med-surg? The ratios in med-surg units are one nurse to six patients. They were supposed to go down to five patients on Jan. 1, 2005, but Schwarzenegger postponed that improvement. Just doing the math, with six patients the nurse assigned to me could have devoted only 10 minutes out of each hour to my care – not counting the time she needs to move between rooms, fill out patient charts, and take some breaks for herself.

What would have been the likelihood that on a med-surg floor my nurse was right at my bedside when I stopped breathing? Not good. The nurse would probably have given me the Demerol and walked away to deal with another patient. She would have returned later to assess my breathing and pain level and found me dead.

It's my kind of case that highlights how important it is to physically have enough nurses at patients' bedsides. I was completely unconscious and could not have rung my call light or cried out for help. Med-surg floors also typically do not have special monitoring equipment so no alarms would have tipped her off. Observing the fact that I wasn't breathing required my nurse to be in my room often, continually monitoring me. In ICU, where I was, the RN could do that. In med-surg, not a chance.

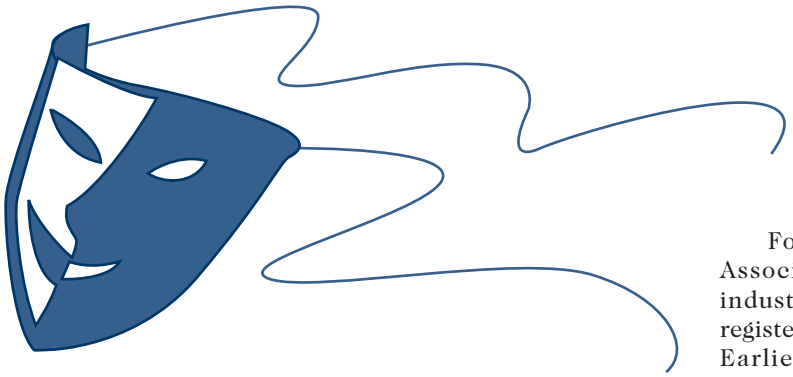
> **"Observing the fact that I wasn't breathing required my nurse to be in my room often, continually monitoring me. In ICU, where I was, the RN could do that. In med-surg, not a chance."**

I've now found that I depend on this safety law in more ways than one, but we could lose it in a heartbeat. That's something I and the people of California can't afford to let happen. ■

*Kelly Di Giacomo, RN, works in the cardiac unit at Kaiser Permanente's Roseville Medical Center and serves on the CNA Board of Directors.*

# Not Up Front

## Industry Hides Behind Patient Advocacy Group



At the Dec. 1 Sacramento rally, thousands of RNs attended to show Gov. Arnold Schwarzenegger their collective disapproval of any rollback in RN-patient ratios. But one RN milling about the crowd carried a very different message. She worked the media circuit, trying to convince journalists covering the event

> "CPC shared the exact same mailing address as the Sacramento offices of prominent lobbyist law firm Foley & Lardner."

that many nurses not only accepted, but supported suspending ratios in emergency departments and the better 1:5 ratio in medical-surgical wards until 2008.

Her name was Kristine Yahn, RN, MBA, and she is executive director of Californians for Patient Care, a non-profit group that says it represents patient interests.

What Yahn probably failed to include in her introduction was the important information that Californians for Patient Care was a hospital industry front group formed in October 2004. Corporate records on file with the California Secretary of State showed that CPC shared the exact same mailing address as the Sacramento offices of prominent lobbyist law firm Foley & Lardner, *California Nurse* learned later. Contact information CPC provided for service of process (the official contact used to deliver, say, lawsuits) listed Foley's Los Angeles address.

Foley & Lardner's ties to the California Healthcare Association, the group that lobbies for the hospital industry, are no secret and well documented. Foley is registered with the state as one of CHA's official lobbyists. Earlier this year, Foley represented CHA in its unsuccessful lawsuit against the Department of Health Services for its requirement that ratios apply "at all times." And according to CHA's website, Foley is a top corporate donor to its political action committee. Foley's contributions of over $5,000 in campaign year 2004 have earned the firm membership in the PAC's "Presidents' Club."

When *California Nurse* contacted Yahn by e-mail for an explanation of why she shared the law firm's address and whether her group was affiliated with the hospital industry or CHA, she did not directly answer our questions. Instead, she replied by e-mail that CPC's office was at a different location than the one listed with the Secretary of State, and attached a general fact sheet about her organization.

In a signed opinion piece by Yahn in the Dec. 12, 2004 *San Francisco Chronicle*, however, Californians for Patient Care is described as "an organization supported in part by the hospital industry."

When we contacted George Steffes, Foley's head lobbyist in California, for comment about the relationship between the two organizations, he said he had never heard of Californians for Patient Care and was not aware that the two shared the same address.

So just who is Kristine Yahn? According to newspaper articles and other sources, Yahn has held a variety of positions at hospitals. Most recently, she appears to have been chief nursing officer and senior vice president of Kaweah Delta Hospital in Visalia. Yahn also serves on the advisory board of the California Institute for Nursing and Health Care, a group whose fundraising was spearheaded by the California Healthcare Association, according to its 2003 annual report.

***—Lucia Hwang***

# CNA Takes Ratio Rollback to Court


When RNs first heard Gov. Arnold Schwarzenegger suspended major portions of the ratio regulations in November, many did not understand how he could suddenly interfere with years of careful rulemaking by the Department of Health Services and other stakeholders. "Can he legally do that?" was a common reaction from nurses.

No, he can't, argues CNA in a lawsuit filed Dec. 21 in Sacramento Superior Court against Schwarzenegger and top DHS officials.

The lawsuit cites several reasons why the Schwarzenegger administration's actions were illegal and the court should set aside the emergency regulations.

Among them is the charge that the Schwarzenegger administration unconstitutionally overstepped its authority when on Nov. 4 it issued emergency regulations essentially lifting ratios in emergency departments, and delaying the phase in of better 1:5 ratios in medical surgical units. The California Constitution invests the three branches of government with separate powers; the Legislature makes law while the Governor implements law. The suit alleges that the emergency regulations were a back door attempt by Schwarzenegger to make law, and defy the Legislature's intent to establish minimum RN staffing ratios when it passed AB 394 in 1999. Furthermore, the law specifies that DHS must wait five years after adoption before it can change any initial implementing regulations and, even then, must report any proposed changes to the Legislature. DHS in this case did neither.

The suit also asserts that DHS did not meet the necessary standards for issuing an emergency regulation. In order to do so, DHS has to provide evidence supporting a state of emergency that immediately threatens the public peace, safety, or welfare. The suit contends that DHS's citation of newspaper articles about hospital closures and e-mails from hospital administrators was not adequate proof of an emergency. While the hospital industry has enthusiastically blamed the ratios for hospital closures and loss of beds, the Governor failed to produce any corroborating evidence to back up that claim. In fact, DHS actually admits in one document that it "does not have data to support or refute … claims that have been made about problems caused or exacerbated by the current nurse-to-patient ratios."

The lawsuit further points out that the very reason the Legislature put the ratios in place was to insulate RN staffing from the financial interests of hospitals; that staying at 1:6 in med-surg is not good enough because DHS already determined that 1:5 is the "leanest staffing permitted on any shift" for patient safety; and that hospitals have already shown they cannot be trusted to staff appropriately without formal regulations. To see the lawsuit text, visit our website at www.calnurses.org.

***—Staff Report***


## Get Connected

### Sign up for CNA's Action E-mail Alert Network It's Easy

*2 ways to sign up*

**Go to the CNA website – www.calnurses.org.**

On the home page, go to the patient advocacy section on the right side of the site

Click on the "sign up for action alerts"

You will be directed to a sign-up form that will ask for your member number.

Fill in the required fields and move to next step

The final step requires you to provide your e-mail address and zip code

**Congratulations, you are now wired !**

■

**Don't know your member number?**

You can find it several ways:

Check the label on the *California Nurse* magazine above your name

If you receive a monthly or annual bill, check the top of the invoice

E-mail Membership at Membership@calnurses.org

Call Membership Department at 510.273.2200 to give them your e-mail address.

Once your e-mail address is entered into the member data base, you are automatically signed up.

*Stay Current*

# Eyes Wide Open

## Trande Phillips has seen the future of corporate-controlled nursing and it's not pretty. How she's fighting back.

*By Lucia Hwang*

Trande Phillips, RN speaking at press conference in Oakland

When board member Trande Phillips, RN first ventured beyond the borders of California in the late 90s to visit nurses in other states, she was appalled at how bad conditions were for RNs and patients elsewhere in the country.

In Chicago, she witnessed a lone RN with three LVNs taking care of 12 patients in an ER department.

In Texas, she learned that hospitals blackballed outspoken nurses by keeping an underground list among themselves.

In New Mexico, she found pharmacy technicians straight out of high school and with just a little training were administering drugs to patients.

"It just shocked me," says Phillips, who is chair of national outreach for CNA's board and has traveled extensively throughout California and the U.S. to organize RNs and help other nurse unions gain independence from the American Nurses Association. "I said, 'We've got to stop this.'"

Despite these differences, Phillips also observed that the basic ways in which hospitals were run – the clinical practices, the equipment, the diagnostic related groups (DRGs), the charting and scheduling software – were the same, and the companies running them were the same.

Without national RN-patient ratios and a strong national staff nurse union, concluded Phillips, nurses throughout the country and even in California would ultimately lose their practice and their identity. Hospitals would play to the lowest common denominator; if a hospital corporation can get away with routinely staffing one RN to 10 patients at its Kansas hospital, why wouldn't it chip away at staffing in its California hospital to achieve the same cost savings?

The threat to RN practice and American healthcare, says Phillips, has pushed her to be active with CNA, and should motivate other RNs, too. "The corporations have brainwashed people into accepting the minimum care," says Phillips. "Nurses have to fight this idea. We come from doing what is right to keep people healthy."

Part of the reason Phillips feels so passionately about nursing is that that's all she's ever wanted to do, for as long as she can remember. Growing up in Evanston, Ill., one of the running jokes in her family was that she would get excited when one of her relatives was sick enough to go see the doctor, because then she would get to follow the nurse around during the visit. "I always wanted to be that person to help someone get well, or if they weren't going to get well, to help them through that time," says Phillips.

Another fundamental part of Phillips' beliefs is that the U.S. needs a universal system where everyone is guaranteed the best healthcare that we can collectively provide. Throughout public school in Evanston, Phillips says it pained her to see how friends from lower income families often went without healthcare while friends from affluent families were whisked to the doctor without a thought.

> **"The corporations have brainwashed people into accepting the minimum care. Nurses have to fight this idea. We come from doing what is right to keep people healthy."**

"My friends who had money got treated right away, but my friends who didn't have money, their parents would say, 'Oh, let's try this cough medicine first and then see what happens,'" remembers Phillips. "And they'd still cough and I'd tell them they had to go to the doctor, but they'd say they couldn't because they didn't have the money. My friends with money who needed glasses would go get them. But I had other friends who, for years, they squinted."

Another episode in her career cemented her belief that everyone deserves the same quality healthcare. Upon graduating from nursing school in Chicago, Phillips took a job at a private hospital where some wealthy patients could hire the hospital's RNs for additional private duty. The disparity was too glaring. "There

were all these people who needed care, and then these other people had their own individual nurses," she says. "I wanted to be a nurse who took care of everybody. It shouldn't matter how much people make."

After living all over the U.S. and even for a time in southern Italy, Phillips and her family finally settled in the Bay Area. She eventually started working nights at Kaiser Walnut Creek Medical Center in 1983, where she mastered her way through a variety of units before ending up in pediatrics about five years ago. Today she is her hospital's professional practice committee chair, a nurse rep, and serves on Kaiser's bargaining team – among several other roles.

She first got involved in CNA in the early 90s, when it was still dominated by the nursing elite. She had filed a grievance and felt it had been handled rather poorly by the union. When she complained to the organization, she quickly discovered they didn't care much about staff nurses like her and their issues.

Phillips decided to run for the board of directors and soon joined up with other likeminded RNs who also wanted to reform CNA into a group that would fight for the concerns of bedside nurses. In 1992, they were successful in gaining, by one vote, a staff RN majority of seats on the board. "The big thing back then was nobody could ever be sick," laughs Phillips. "And we had to be careful in crosswalks." Over the next decade, they would lead the evolution of CNA into its current form today.

> **"Rather than complain, just do one thing with CNA. Attend a rally, do some phone banking, make a phone call, write a letter."**

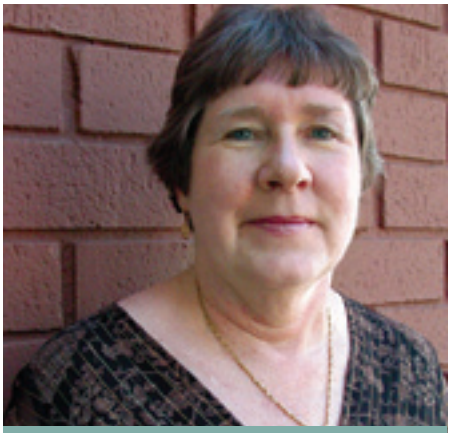
One of the toughest challenges Phillips says she encounters today, as CNA continues to organize RNs and work toward a single payer system with a single standard of care, is empowering nurses to overcome apathy and purely self-interested thinking.

"Nurses complain constantly at the local level," says Phillips, "but don't take those concerns from talk into action. Then when I ask them what they have done to make a difference, they say, 'What can I do? I'm just one person' or 'I'm busy. I work another job. I have to pick up the kids. I home school'."

For Phillips, the answer is getting involved with their union. By joining collective efforts, their contribution will have an even stronger effect. "CNA is a group that had made huge differences by getting legislation passed and electing progressive officials," says Phillips. "Rather than complain, just do one thing with CNA. Attend a rally, do some phone banking, make a phone call, write a letter." ■

*Lucia Hwang is editor of* California Nurse.


Trande Phillips, RN at a Department of Health Services hearing in fall 2002



## PROFILE

**Name:** Trande Phillips

**Facility:** Kaiser Walnut Creek Medical Center

**Unit:** Pediatrics

**Nursing for:** 33 years

**On CNA board since:** 1993

**Sign:** Taurus

**Pet nursing peeve:** When nurses complain, but don't act.

**Favorite work snack:** Coffee, since she's worked nights for 20 years.

**Last work accomplishment:** Policing enforcement of the ratios.

**Color of favorite scrubs:** Red

**Favorite hobby:** Traveling, reading, enjoying her pets.

**Favorite song, movie or book:** Tony Hillerman mysteries set in the Navajo Nation and the American Southwest

**Special talent unrelated to nursing:** Needlepoint

# 2005 CNA Election Positions

**CNA members in good standing are hereby notified of and encouraged to submit their names as candidates for the following offices and positions to be filled in a membership election conducted in spring 2005, the results of which shall be read at the House of Delegates in September, 2005.**

All members in good standing seeking office or position in this election shall file a consent-to-serve and biographical sketch, including a list of organizational experience, present employment, and position. Such forms for consents-to-serve and biographical sketches are available from and should be mailed to the CNA Administrative Office, Attention: 2005 Elections, 2000 Franklin Street, Oakland, CA 94612. They must be returned by Feb. 15, 2005.

### CNA OFFICERS
CNA President
CNA Vice President
CNA Secretary
CNA Treasurer

### CNA BOARD DIRECTORS
Region 1
Region 2
Region 3
Region 4
Region 5A
Region 5B
Region 6A
Region 6B
Region 7
Region 8A
Region 8B
Region 8C
Region 9A
Region 9B
Region 9C
Region 9D
Region 10A
Region 10B
Region 10C
Region 11A
Region 11B
Region 11C
Region 12A
Region 12B
Region 12C
Region 12D

### CNA BALLOT COMMITTEE
5 positions

### JNPC AT-LARGE POSITIONS NP/CNS
Nursing Administrator
Nursing Educator

### HOUSE OF DELEGATES
(Number of delegates based on the region's membership at the time of apportionment)

Region 1: 19
Region 2: 21
Region 3: 11
Region 4: 14
Region 5: 26
Region 6: 41
Region 7: 37
Region 8: 75
Region 9: 57
Region 10: 50
Region 11: 54
Region 12: 58

### REGION OFFICERS/BOARD/ COMMISSIONERS

### REGION 1
GR Commissioner
NP Commissioner

### REGION 2
GR Commissioner
NP Commissioner

### REGION 3
GR Commissioner
NP Commissioner

### REGION 4
President
Vice President
Secretary
Treasurer
GR Commissioner
NP Commissioner

### REGION 5
President
Vice President
Secretary
Treasurer
GR Commissioner
NP Commissioner

### REGION 6
President
Vice President
Secretary/Treasurer
Region Directors: 6
GR Commissioners: 4
NP Commissioner

### REGION 7
GR Commissioner
NP Commissioner

### REGION 8
President
Vice President
Treasurer
Directors: 8
GR Commissioner
NP Commissioner

### REGION 9
President
Vice President
Secretary
Treasurer
Directors:
- Humboldt, Del Norte, Mendocino, and Lake counties: 1
- Sonoma and Marin counties: 3
- Napa and Solano counties: 3
- Contra Costa County: 5

GR Commissioner
NP Commissioner

### REGION 10
President
Vice President
Treasurer
Ballot Committee: 5
Directors:
- Seat 1 – Monterey-Salinas area
- Seat 2 – Monterey-Salinas area
- Seat 3 – Watsonville-Santa Cruz area
- Seat 4 – Watsonville-Santa Cruz area
- Seat 5 – Santa Clara and San Benito counties
- Seat 6 – Santa Clara and San Benito counties
- Seat 7 – Santa Clara and San Benito counties
- Seat 8 – Santa Clara and San Benito counties
- Seat 9 – Santa Clara and San Benito counties
- Seat 10 – Santa Clara and San Benito counties
- Seat 11 – Santa Clara and San Benito counties
- Seat 12 – Santa Clara and San Benito counties
- Seat 13 – Region 10 at-large
- Seat 14 – Region 10 at-large
- Seat 15 – Region 10 at-large

GR Commissioner
NP Commissioner

### REGION 11
GR Commissioner
NP Commissioner

### REGION 12
GR Commissioner
NP Commissioner

CALIFORNIA NURSES ASSOCIATION

# Consent-to-Serve and Biographical Sketch

This form must be postmarked on or before **February 15, 2005** and mailed to CNA Headquarters Office, 2000 Franklin Street, Oakland, CA 94612; Attn: 2005 Elections. Please complete all sections of this form. Faxes will not be accepted, as an original signature is required. Terms of office are for the 2005/2007 biennium.

## CANDIDATE FOR

- ❑ **CNA House of Delegates: Region** _____
- ❑ **CNA President**
- ❑ **CNA Vice-President**
- ❑ **CNA Treasurer**
- ❑ **CNA Secretary**
- ❑ **CNA Board of Directors: Regional sub-grouping** _____
- ❑ **Other** (*please note region for regional positions*) _____

Please check contact preferences _____ **Mail** _____ **Phone** _____ **E-mail**

**Name** (*please print*)_____ **Region** _____

**Address** (*Home*)_____

**City** _____ **Zip**_____

**Phone** (*Home*) (____)_____ (*Cell*) (____)_____ **Email**_____

**Employer** _____ **City** _____

**Department** _____ **Shift** _____

## RN EXPERIENCE

How long have you been an RN? _____ years.

(*List present employment first*)

**1**. Employer_____ City _____ Department _____

Title_____ Time: From (*Year*)_____ To (*Year*)_____

**2**. Employer _____ City _____ Department _____

Title_____ Time: From (*Year*)_____ To (*Year*)_____

## CNA EXPERIENCE

Starting with present or most recent experience, list activities and positions held.

Collective Bargaining _____

Organizing New Facilities _____

State _____

National _____

Other _____

## MEMBERSHIP INFORMATION

I have been a member of the California Nurses Association since _____(year).

*I am willing to accept the responsibilities of this position.*

Date: _____ Signature: _____

## MEMBER'S STATEMENT OF INTEREST (CNA OFFICER OR BOARD OF DIRECTORS ONLY)

Please write a brief statement (150 words maximum) indicating how your involvement would help increase the power of Registered Nurses and the California Nurses Association to advocate for RNs, patients, and a just healthcare system. (Statements will be truncated after 150 words.)

Date: _____ Signature: _____

**Learn how** some new technologies threaten the professional judgment of RNs. Make the connections between budget-driven staffing and the larger financial incentives of our current system. Share your experiences of healthcare restructuring with other nurses from your community.

**Attend CNA's** new CE series and become part of an RN-led movement for healthcare reform. Bring your colleagues and leave educated and inspired!

## 2005 Dates and Locations · All Class Times are 9:00 a.m. – 4:00 p.m.

### Bay Area

**Fremont**
**January 10**
Fremont Marriott
46100 Landing Parkway
Fremont 510-413-3700

**Vallejo**
**January 13**
Hiddenbrooke Golf Club
1095 Hiddenbrooke Parkway
Vallejo 707-558-1153

**Walnut Creek**
**January 18**

**January 18th class cancelled**

**Santa Clara**
**January 20**
Marriott
2700 Mission College Blvd
Santa Clara 408-988-1500

**San Rafael**
**January 21**
Four Points by Sheraton
1010 Northgate Drive
San Rafael 415-453-6200

**Oakland**
**February 3**
CNA Education Center
2000 Franklin Street
Oakland 510-273-2000

**Santa Rosa**
**February 7**
Hilton
3555 Round Barn Blvd
Santa Rosa 707-523-7555

**Millbrae**
**February 8**
Westin SFO Airport
1 Old Bayshore Highway
Millbrae 650-692-3500

**San Jose**
**March 14**
Wyndham San Jose
1350 North First Street
San Jose 408-453-6200

**Concord**
**March 15**
Hilton
1970 Diamond Blvd
Concord 925-827-2000

**Oakland**
**March 16**
CNA Education Center
2000 Franklin Street
Oakland 510-273-2000

**San Mateo**
**March 17**
Marriott
1770 South Amphlett Blvd
San Mateo 650-653-6000

### Southern California

**W. Los Angeles**
**January 24**
Holiday Inn Brentwood
170 North Church Lane
Los Angeles 310-476-6411

**Los Angeles**
**January 25**
Best Western Mayfair
1256 West 7th Street
Los Angeles 213-484-9789

**Long Beach**
**January 26**
Long Beach Marriott
4700 Airport Plaza Drive
Long Beach 562-425-5210

**San Diego**
**February 21**
Shelter Pointe Hotel & Marina
1551 Shelter Island Drive
San Diego 619-221-8000

**Escondido/**
**San Marcos**
**February 23**
Hampton Inn San Marcos
123 East Carmel Street
San Marcos 760-736-9249

**Irvine**
**February 25**
Irvine Marriott
1800 Von Karman Ave
Irvine 949-553-0100

**Arcadia/**
**Monrovia**
**March 7**
Four Points by Sheraton
700 W Huntington Drive
Monrovia 626-357-5211

**San Bernardino**
**March 8**
Hilton
285 East Hospitality Lane
San Bern. 909-889-0133

**Lancaster**
**March 11**
Park Plaza
44916 10th Street West
Lancaster 661-948-0961

### Central California

**Stockton**
**January 31**
Residence Inn (Marriott)
3240 West March Lane
Stockton 209-472-9800

**Santa Cruz/**
**Scotts Valley**
**February 15**
Hilton Scotts Valley
6001 La Madrona Drive
Scotts Valley 831-440-1000

**San Luis Obispo**
**February 17**
Holiday Inn
1800 Monterey Street
S. Luis Obispo 805-544-8600

**Salinas**
**February 18**
Laurel Inn
801 West Laurel Drive
Salinas 831-449-2474

**Bakersfield**
**March 1**
Doubletree
3100 Camino Del Rio Court
Bakersfield 661-323-7111

**Fresno**
**March 2**
Piccadilly Inn Airport
5115 East McKinley Ave
Fresno 559-251-6000

### Sacramento/North

**Auburn**
**February 1**
Shiloh Center
905 Lincoln Way
Auburn 530-885-7103

**Sacramento**
**February 2**
Sheraton
1230 J Street
Sacramento 916-447-1700

**Eureka**
**February 11**
Red Lion Eureka
1929 Fourth Street
Eureka 707-445-0844

**Roseville**
**March 3**
Homewood Suites
401 Creekside Ridge Court
Roseville 916-783-7455

**Redding**
**March 22**
Red Lion Redding
1830 Hilltop Drive
Redding 530-221-8700

**Chico**
**March 23**
Holiday Inn
685 Manzanita Court
Chico 530-345-2491

**Elk Grove**
**March 24**
Holiday Inn
9175 West Stockton Blvd
Elk Grove 916-478-9000

# RNs in the Midst of the Healthcare Crisis

## Join us at CNA's innovative new CE series

## CNA CE Class Registration Form

**Please register me for the class indicated below. A completed form is necessary to insure registration. On-site registration is not recommended and on a space-available basis. Please print legibly:**

Name: _____

Street: _____

City: _____ Zip: _____

Day Phone (ans. machine): ( _____) _____

Email: _____

Name of Employer/Facility: _____

Job Classification: _____

Social Security #: 0 0 0 - 0 0 - ____ ____ ____ ____

RN License #: _____

(for processing CE certificate only)

### Check box indicating your date and location selection:

**Bay Area**
- ❑ Fremont January 10
- ❑ Vallejo January 13
- ❑ Santa Clara January 20
- ❑ San Rafael January 21
- ❑ Oakland February 3
- ❑ Santa Rosa February 7
- ❑ Millbrae February 8
- ❑ San Jose March 14
- ❑ Concord March 15
- ❑ Oakland March 16
- ❑ San Mateo March 17

**Southern California**
- ❑ W. Los Angeles January 24
- ❑ Los Angeles January 25
- ❑ Long Beach January 26
- ❑ San Diego February 21
- ❑ Escondido February 23
- ❑ Irvine February 25
- ❑ Arcadia March 7
- ❑ San Bernardino March 8
- ❑ Lancaster March 11

**Central California**
- ❑ Stockton January 31
- ❑ Santa Cruz February 15
- ❑ S. Luis Obispo February 17
- ❑ Salinas February 18
- ❑ Bakersfield March 1
- ❑ Fresno March 2

**Sacramento/North**
- ❑ Auburn February 1
- ❑ Sacramento February 2
- ❑ Eureka February 11
- ❑ Roseville March 3
- ❑ Redding March 22
- ❑ Chico March 23
- ❑ Elk Grove March 24

| Fee: | Advance | Late |
|---|---|---|
| Direct-Care and Staff RNs: | $30 | $40 |
| Non-members: | $45 | $55 |

❑ Enclosed is my check in the amount of $ _____
❑ Payment by credit card
❑ Late fee of $10 applied

Registration by credit card only may be faxed to: 510-663-2761 Attn: NP/CE.

❑ Visa ❑ MasterCard ❑ American Express

Credit Card #: _____

Expiration date: __ __/ __ __Signature: _____

Checks or faxes received within one week of the class may delay confirmation information.

Go to www.calnurses.org and click on the Continuing Education link to see a brochure with full registration and fee information.

# The California Nursing Practice Act

## Safe Staffing Standards by Scope, Ratio, and Acuity, Part II (continued)

***Submitted by the Joint Nursing Practice Commission and Hedy Dumpel, RN, JD***


This is a continuation of Part II of the *California Nurse* home study dealing with the planning, development, and implementation of healthcare laws and policies on safe staffing standards based on scope of practice, minimum numerical ratios, and the flexing up of staffing based on the direct-care RN assessment of individual patient acuity/severity of illness and required nursing care needs.

In addition, Part II is further divided into three subparts, Parts A, B, and C. Part II B, review of the Jan. 1, 2004 actual minimum numerical nurse-to-patient ratios for each hospital unit, appeared in the November 2004 edition of *California Nurse.*

**Part II C** addresses the flexing up of staffing, implementation of the new laws, as well as judicial review of the hospital industry's challenge regarding the application of the ratios during meals, breaks, and other routine, expected absences from the unit.

*Hedy Dumpel, RN, JD, is Chief Director of Nursing Practice and Patient Advocacy for the California Nurses Association*

**PART II C. Title 22 Section 70217 (b) Mandated Flexing up of Staffing Based on the Direct-Care RN Assessment of Individual Patient Acuity/Severity of Illness and Required Nursing Care Needs.**

### INTRODUCTION

Patient Classification Systems were developed in the 1960s for the purpose of forecasting staffing needs on patient care units. They were also used as administrative tools to project or monitor unit workload.

In 1992, the Department of Health Services (DHS) considered proposing regulations requiring staffing ratios for registered nurses in acute care hospitals. Instead, DHS opted for regulations requiring that hospitals have a patient classification system (PCS) in place. The PCS was intended to assure that the number of nursing staff was aligned with the healthcare needs of the patients, while allowing the hospital maximum flexibility for efficient use of staff. The final regulations became effective on January 1, 1997.

It became very clear from the onset that "maximum flexibility" and "efficient use of staff" became the cornerstone of hospital cost-containment schemes. DHS required clinical alignment (PCS based on individual patient acuity/severity of illness), but that was soon manipulated into fiscal alignment or staffing based on budget and patient census. There was no room for differentiating patient acuity and individual nursing care needs. Most problematic was the PCS override of the RN's individual clinical judgment.

The majority of commercially-available patient classification systems utilize a "closed" proprietary method for converting patient acuity/care hours calculated by the direct-care RNs into staffing and skill mix. (See Managed Care Descriptions of Selected PCS terms)

Since the 1997 effective date, RNs engaged in direct patient care have criticized the various systems and the use of those systems by hospitals.

**Direct-care RN criticisms of PCS:**

- The PCS does not adequately measure the domain of nursing practice as defined in the Nursing Practice Act and the Standards of Competent Performance. The latter mandates that the nursing process is the required standard/model for delivery of nursing care by a competent RN.

- There are numerous reliability and validity issues. There was, and still is, a significant disagreement among direct-care RN staff in classifying individual patients while utilizing an existing PCS tool, resulting in inability to validate staffing requirements. In addition, the PCS instrument/tool did not capture what it was intended to measure, which is individual patient acuity. In most instances, the individual patient acuity does not exist or is ignored, and staffing is driven by budget and census.

- The focus of the PCS tool was on the amount or volume of nursing care (nursing care hours) required and not on the complexity of nursing care needed by an individual patient.

- PCS tools are designed to control RNs' decision-making and professional judgment. This rigid computerized system fails to permit the direct-care RN to override the system when, based on his or her professional judgment, an individual patient requires more care than that allowed by the PCS/acuity tool.

- It reduces the profession of nursing to lists of tasks, procedures, and patient characteristics.

AB 394 (Kuehl), the enabling legislation, put a halt to this DHS-granted supreme flexibility by converting the average needs of a group of patients on a specific unit to meeting the **individual needs of each patient**. It also codified some of the concepts identified in the Patient Intensity for Nursing Index (PINI), which is a valid measure of the volume or amount of care and the complexity of nursing care delivered to patients. (Prescott)

According to Prescott, "Severity of illness refers to the patient's medical condition and how ill the patient is in terms of the abnormality and instability of his physiological parameters." In addition, "Clinicians recognize that all patients with the same diagnosis are not equivalent and that more severely ill patients require more care than do less ill patients."

On the concept of the complexity of care, Prescott sums it up as follows: complexity of care "is based on the amount and type of knowledge and skill needed to perform tasks and procedures and also on the factors that complicate implementation of the nursing process associated with patient care." Further, "complexity of care has been included in other classification systems only to the degree that complexity is related to time. While it is true that more complex things often take longer to do than less complex tasks or procedures, **complexity of care is analytically distinct from the time it takes to do something.**" (Emphasis Added)

### SECTION I. New Patient Classification Systems Mandates

~~(a)~~ **(b)‡ In addition to the requirements of subsection (a)**, the hospital shall implement a patient classification system as defined in section 70053.2 above for determining nursing care needs of individual patients that reflects the assessment, made by a registered nurse as specified at subsection 70215(a)(1), of patient requirements and provides for shift-by-shift staffing based on those requirements.

The ratios specified in **subsection (a) shall constitute the minimum number of registered nurses, licensed vocational nurses, and in the case of psychiatric units, licensed psychiatric technicians, who shall be assigned to direct patient care. Additional staff in excess of these prescribed ratios, including non-licensed staff, shall be assigned in accordance with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan, the ability for self-care, and the licensure of the personnel required for care.** The system developed by the hospital shall include, but not be limited to, the following elements:

(1) Individual patient care requirements.

(2) The patient care delivery system.

(3) Generally accepted standards of nursing practice, as well as elements reflective of the unique nature of the hospital's patient population.

**DHS/FSOR: 70217(b)** The phrase, "In addition to the requirements of subdivision (a)" was added here to make clear the Department's intent that the ratios are minimums only, and will co-exist with PCS, which will dictate increased staffing when patients' needs warrant it, based on assessments on each shift. The language added repeats the statutory language defining the elements of basic principles of staffing in general acute care hospitals. It is being repeated in response to the requests of many public comments, including the Board of Registered Nursing which believed it was needed for clarity. It also clearly describes the legislative intent for the nexus between the proposed ratio regulations and the patient classification systems. It is necessary to emphasize that the proposed licensed nurse-to-patient ratios are a required minimum staffing standard and additional nursing staff above this minimum is required when such additional nursing staff is dictated by the hospital's patient classification system.

~~(b)~~ **(c)‡** A written staffing plan shall be developed by the administrator of nursing service or a designee, based on patient care needs determined by the patient classification system. The staffing plan shall be developed and implemented for each patient care unit and shall specify patient care requirements and the staffing levels for registered nurses and other licensed and unlicensed personnel. In no case shall the **staffing level for licensed nurses fall below the requirements of subsection (a).** The plan shall include the following:

(1) Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis.

(2) The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis.

(3) The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis.

**DHS/FSOR: 70217(c)** The statement, "In no case shall the staffing level for licensed nurses fall below the requirements of subsection (a)" was added to require that the staffing plan

that is developed and implemented for each unit be based first on the PCS, using the ratios only to designate the minimum safe staffing level.

~~(4)~~ **(d)‡ In addition to the documentation required in subsections (c)(1) through (3) above, the hospital shall keep a record of the actual registered nurse, licensed vocational nurse and licensed psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis. The hospital shall retain:**

(1) The staffing plan required in subsections (c)(1) through (3) ~~shall be retained~~[1] **for the** time period between licensing surveys, which includes the Consolidated Accreditation and Licensing Survey process, and

**(2) The record of the actual registered nurse, licensed vocational nurse and licensed psychiatric technician assignments by licensure category for a minimum of one year.**

**DHS/FSOR:** Additional language was added to propose an additional requirement for recordkeeping for all shifts and for all units. Hospitals are already required to retain a record of the staffing requirements determined by the patient classification system, the actual staff and staff mix provided, and the variance between the two, documented on a day-to-day, shift-by-shift basis. Each licensed nurse's assignment and licensed psychiatric technician's assignment is also documented every shift. This proposed regulation will require the hospitals to retain the documented licensed nurses' and licensed psychiatric technicians' actual assignments, ensuring that the specific nursing personnel will be linked to the specific patients. These records shall be retained by the hospital for a minimum of one year.

This is necessary because, without this new provision, it would be impossible for DHS or the public to know retrospectively whether the facility complied with these proposed regulations and would therefore make enforcement of these proposed regulations virtually impossible. Therefore, this recordkeeping requirement is necessary for the health and safety of California's citizens. Health and Safety Code (HSC) Section 1278 states that, "Any officer, employee, or agent of the state department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time **to secure compliance with, or to prevent a violation of, any provision of this chapter.**" (Emphasis added.) Without this requirement, agents of the state department would only know in the aggregate the numbers of patients and nurses on each shift, and could calculate the average staffing, but would be unable to assess whether a violation occurred, or prevent a violation of these proposed regulations which implement and make specific HSC 1276.4. For example, if HDS received a complaint about inadequate staffing on a shift of a psychiatric unit, an investigation for compliance would be necessary. Without this requirement the only information that would be available would be that which is already required by the PCS at subsections 1-3: the numbers of staff required, the number of staff provided, etc., and the nurse-to-patient staffing could appear to be adequate on average. However, if one or more of the patients had required 1:1 staffing, then the staffing ratio would be non-compliant, but would have appeared appropriate under current recordkeeping requirements. This requirement will enable DHS to secure compliance with provisions of this chapter, in accord with statute. Although this recordkeeping is an expansion of existing record keeping requirements, it will not add any significant cost to providers, including state-run facilities. It will not significantly add costs to Medi-Cal, nor will it have a significant, statewide adverse economic impact directly affecting businesses in the state of California.

~~(e)~~ **(e)‡** The reliability of the patient classification system for validating staffing requirements shall be reviewed at least annually by a committee appointed by the nursing administrator to determine whether or not the system accurately measures patient care needs.

~~(d)~~ **(f)‡** At least half of the members of the review committee shall be registered nurses who provide direct patient care.

~~(e)~~ **(g)‡** If the review reveals that adjustments are necessary in the patient classification system in order to assure accuracy in measuring patient care needs, such adjustments must be implemented within thirty (30) days of that determination.

~~(f)~~ **(h)‡** Hospitals shall develop and document a process by which all interested staff may provide input about the patient classification system, the system's required revisions, and the overall staffing plan.

~~(g)~~ **(i)‡** The administrator of nursing services shall not be designated to serve as a charge nurse or to have direct patient care responsibility, except as described **in subsection (a) above**.

**DHS/FSOR: 70217(i)** The phrase "except as described in subsection (a) above" was added to clarify that the nurse administrator may have a patient care assignment if that nurse administrator has demonstrated current competence to the hospital in providing care on a particular unit. This may be for the purpose of relieving staff nurses during breaks, meals, and other routine, expected absences from the unit as described in subsection (a).

~~(h)~~ **(j)‡** Registered nursing personnel shall:

(1) Assist the administrator of nursing service so that supervision of nursing care occurs on a 24-hour basis.

(2) Provide direct patient care.

(3) Provide clinical supervision and coordination of the care given by licensed vocational nurses and unlicensed nursing personnel.

~~(i)~~ **(k)**‡ Each patient care unit shall have a registered nurse assigned, present, and responsible for the patient care in the unit on each shift.

~~(j)~~ **(l)**‡ A rural General Acute Care Hospital as defined in Health and Safety Code Section 1250(a), may apply for and be granted program flexibility for the requirements of subsection 70217(g) (i) and for the personnel requirements of subsection (h) (j)(1) above.

~~(k)~~ **(m)**‡ Unlicensed personnel may be utilized as needed to assist with simple nursing procedures, subject to the requirements of competency validation. Hospital policies and procedures shall describe the responsibility of unlicensed personnel and limit their duties to tasks that do not require licensure as a registered or vocational nurse.

~~(l)~~ **(n)**‡ Nursing personnel from temporary nursing agencies shall not be responsible for a patient care unit without having demonstrated clinical and supervisory competence as defined by the hospital's standards of staff performance pursuant to the requirements of subsection 70213(c) above.

~~(m)~~ **(o)**‡ Hospitals which utilize temporary nursing agencies shall have and adhere to a written procedure to orient and evaluate personnel from these sources. Such procedures shall require that personnel from temporary nursing agencies be evaluated as often, or more often, than staff employed directly by the hospital.

~~(n)~~ **(p)**‡ All registered and licensed vocational nurses utilized in the hospital shall have current licenses. A method to document current licensure shall be established.

**(q) The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care.**

**DHS/FSOR: 70217(q)** This provision was added to clarify that the Department expects hospitals to plan for routine fluctuations in patient census. This planning should include, but not be limited to, an evaluation of the number of patients in other areas of the hospital waiting for an inpatient bed, consideration of how many patients are customarily admitted to individual units on a day-to-day, shift-by-shift basis based on historical information for that type of unit, the season of the year, day of the week, and time of day, etc. The PCS projects needed staff for the upcoming shift and hospitals have systems in place that indicate how additional staff will be obtained when needed. Hospitals commonly use such systems as the maintenance of a pool of on-call employees, providing part-time employees with additional work hours, and the use of nurse registries to augment staffing above scheduled staff. 22 CCR currently requires that each patient's nursing care needs must be determined by the PCS, and documented on a day-to-day, shift-by-shift basis.

In the event of a change in patient census that could not reasonably have been foreseen by the hospital, this states the Department's intent to give the hospital needed flexibility while the hospital makes prompt, diligent efforts to return each unit to the minimum required staffing ratios. The requirement cannot be more specific because the broad range of circumstances that could befall a hospital is beyond the Department's ability to anticipate. The timing and the appropriateness of the response may vary according to the circumstances and the nature of the unanticipated changes. These changes could include such diverse events as earthquakes and other natural disasters, instances of bioterrorism, and other healthcare emergencies. DHS's meaning of "healthcare emergencies" is defined for the sake of clarity and in response to the requests of many public comments

### SECTION II. 70455. Comprehensive Emergency Medical Service Staff.

(a) A full-time physician trained and experienced in emergency medical service shall have overall responsibility for the service. The physician, or her or his designee, shall be responsible for:

(1) Implementation of established policies and procedures.

(2) Providing continuous staffing with physicians trained and experienced in emergency medical service. Such physicians shall be assigned to and be located in the emergency service area 24 hours a day.

(3) Providing experienced physicians in specialty categories to be available in-house 24 hours a day. Such specialties include but are not limited to medicine, surgery, anesthesiology, orthopedics, neurosurgery, pediatrics, and obstetrics-gynecology.

(a) The most senior resident in any of the specialties may be considered an experienced physician.

(4) Maintenance of a roster of specialty physicians immediately available for consultation and/or assistance.

(5) Assurance of continuing education for all emergency service staff including physicians, nurses, and other personnel.

(b) All physicians, dentists, and podiatrists providing services in the emergency room shall be members of the organized medical staff.

(c) A registered nurse qualified by education and/or training shall be responsible for nursing care within the service.

(d) All registered nurses shall have training and experience in emergency lifesaving and life support procedures.

**(e) A registered nurse trained and experienced in emergency nursing care shall be on duty at all times.**

**DHS/FSOR:** This proposed requirement is added to cause the minimum requirements for comprehensive emergency medical service staff to conform to the current minimum requirements for basic emergency medical service staff. Current regulations at 22 CCR 70415(d) require that there shall be a minimum of one registered nurse on duty in basic emergency departments at all times, but there is no such requirement for comprehensive emergency departments. Basic emergency departments provide more limited services than those provided in comprehensive emergency departments. This proposed regulation will conform the minimum standard for nurse staffing at the more comprehensive level of care to the minimum standard in current regulation at the more limited level of care. Nurse staffing requirements for the comprehensive level of care will then be consistent with the requirements for the basic level of care. While this language is being added for consistency, it does not create a new requirement for nurse staffing in these units, because these units are already required to have a registered nurse on duty assigned to triage patients at all times.

### SECTION III. Implementation of Nurse-to-Patient Staffing Ratios for General Acute Care Hospitals

Since the Jan. 1, 2004 effective date there have been numerous questions posed to DHS regarding the implementation of the new ratio and acuity provisions.

The following lists several Frequently Asked Questions (FAQs) and answers related to the implementation of the new nurse-to-patient ratio regulations for General Acute Care Hospitals.

#### Enforcement of the Ratios

***Q: How will DHS approach enforcement of the ratios?***

**A**: DHS will enforce the provisions of these regulations in the same general manner as it has enforced the ratios that have existed for 28 years for Intensive Care and Critical Care Units. There are two ways in which the department will verify compliance with the regulations.

Compliance with the regulations may be verified during a periodic survey. Although DHS does not automatically verify compliance with the ratio requirements during a survey, observation or interview may lead to concerns about staffing and cause DHS to verify compliance with the ratios and other staffing-related requirements.

Compliance with the regulations may also be verified by investigating a complaint that is specific to staffing or staffing ratios. Although there is no statutory timeframe within which DHS must initiate an on-site investigation to respond to a complaint against a General Acute Care Hospital, by existing policy DHS will initiate an investigation within 48 hours if a credible allegation of serious and immediate jeopardy to patients is received. If the allegation does not constitute serious and immediate jeopardy, the complaint will be investigated during the next periodic survey or along with the next "serious" complaint.

Should a violation of the ratio requirements occur, DHS will issue a deficiency to the hospital and require an acceptable plan of correction. DHS may verify that the plan of correction has been implemented and the deficiency corrected during any subsequent complaint investigation or periodic survey.

There is no penalty or monetary fine for a violation of the ratio regulations. However, should the DHS conclude that the violation of the ratios is so severe that it poses an immediate and substantial hazard to the health or safety of patients, DHS may order the hospital to reduce the number of patients or close a unit until additional staffing is obtained.

***Q: When patients are off the floor for procedures and therapy, some nurses will not have their full complement of patients. Utilizing existing staff, nurses would be asked to do tasks for those remaining patients under the care of the licensed staff who have gone on a break. Any thoughts on coverage?***

**A**: A nurse who temporarily does not have his/her full complement of patients may certainly assist with tasks for patients assigned to another staff nurse.

However, the nurse can never be given an assignment that exceeds the ratio for the maximum number of patients the nurse can care for on the unit on which she/he works. So, if two medical/surgical nurses each had six patients, and two patients assigned to each nurse were temporarily off the unit for procedures, one nurse could assist the other nurse's patients with time-limited tasks as their needs arose. However, one nurse could not assume the other nurse's full assignment while that nurse went on a break, because the nurse remaining on the unit would then be responsible for the care of eight patients during the break period, and that would be a violation of these regulations.

***Q: On documentation of staffing by patient – has the DHS considered documentation by exception only? Meaning the form is only completed when the hospital is out of compliance.***

**A**: It must be possible for DHS to verify the licensed nurse's assignments to ensure that no individual nurse's assignment exceeds the maximum number of patients permitted for that unit type at any time. The regulations require that the hospital retain the nurse assignments, by staff licensure category, on a day-to-day, shift-by-shift basis, for a minimum of one year. This is necessary because, without this new provision, it would be impossible for DHS or the public to know retrospectively whether the facility complied with these proposed regulations and would therefore make enforcement of these proposed regulations virtually impossible.

There is no special form required for compliance with the record keeping regulation. Whatever the hospitals' current procedure is for documenting nurses' shift assignments will be acceptable to the Department as long as the nurses' patient assignments are documented and retained for one year.

For example, it would be acceptable for a hospital to require nursing staff to leave their daily assignment worksheets at the hospital at the end of their shift. The hospital could also retain the charge nurse's assignment sheet, with admission and discharge notes. The decision to keep these documents on separate pieces of paper, in a binder or a notebook, electronically, or in some other form is entirely the prerogative of the hospital. The Department will accept any form or format that meets the regulatory requirements. However, charting by exception is not acceptable because it would not allow the Department to independently verify staffing assignments.

***Q: On PCS – The proposed ratios represent a minimum staffing level and patients with higher acuity, such as an agitated brain injury patient or an impulsive CVA patient is assessed at a higher acuity and therefore requires more nursing hours or a lower ratio than 1:6, possibly 1:4 or 1:3.***

**A**: That is correct. Current regulations include PCS, mandated at 22 CCR 70053.2 and 70217(b) to (q). These regulations require that hospitals have a system to determine nursing care needs based on individual patient care requirements. The PCS will co-exist with the mandated minimum ratios to increase staffing as patient acuity increases.

***Q: Patient acuity is assessed each shift by a professional nurse and may change from shift to shift. How will the proposed regulations address this issue?***

**A**: Patients' acuity varies on all units. That does not change the essential character of the unit. All patients must receive the amount of nurse staffing their acuity demands regardless of their placement on a specific unit, as determined by the PCS. The hospitals must have a system for determining the nursing staff needs of the patients.

## SECTION IV. Judicial Review of the Ratios Applying "At All Times" Including Meals, Breaks and Other Routine, Expected Absences from the Unit

In December 2003, less than a few days before the ratios' effective date, the California hospital industry filed a lawsuit against the DHS asserting that the regulation mandating that the ratios apply "at all times" is invalid. Specifically, the hospital industry (California Healthcare Association) challenged DHS interpretation that every time a nurse goes on a break or is otherwise not physically present for a short period of time, it would be necessary to reassign the patients who have been assigned to the nurse to a different nurse and recalculate the ratios. (See *California Nurse* June 2004 issue)

On May 24, 2004 Judge Gail Ohanesian issued her ruling emphatically rejecting the California Healthcare Association's (CHA) arguments and ruled against all the judicial relief requested by the CHA.

### Excerpts from the court's ruling reaffirming safe staffing ratios

The CHA petition for writ of mandate was denied; the request for injunctive relief was also denied.

On CHA request for declaratory relieve the court issued the following ruling: "A judgment shall issue declaring that neither DHS' interpretation of the regulation nor the written regulation itself are invalid on the ground that they require that **when a nurse takes a break during a shift, the hospital must reassign the nurse's patient to another nurse and the reassigned patients must not cause the relieving nurse's patient ratio to exceed the applicable ratios set forth in the regulation.** (Emphasis Added)

DHS interpretation of the "at all times is not an underground regulation. DHS has clearly stated that "at all times" means that nurses away from their units during breaks would not be counted for purposes of compliance with the minimum ratios.

DHS' interpretation of this regulation is not at all inconsistent with the regulation's plain language.

DHS' interpretation of section 70217, applying the ratios to break periods, it not new and it is consistent with the plain language of the regulation. Any other interpretation would make the nurse-to-patient ratios meaningless.

Section 70217 makes it clear that "assist" and "relieve" do not have the same meaning. The "assigned" nurse must remain responsible for the provision of direct

patient care. That requires the assigned nurse's presence of the unit.

CHA contends that the regulation is contrary to the purpose of the authorizing statute. This contention is without merit.

There is ample evidence in the rulemaking file which supports the adoption of the regulation, the ratios, and the regulation's requirement that the ratios be maintained "at all times."

Furthermore, DHS shall recover its costs, including those recoverable pursuant to a memoranda of costs. The Court ordered the DHS counsel to prepare a formal judgment consistent with the Court's ruling and submit it to the Court for signature.

**In conclusion:** One of the key PCS provisions is that it must meet the nursing care needs of individual patients that reflect the assessment, made by a direct-care registered nurse. Moreover, one of the key factors the RN must consider is the type of licensure mandated to provide the required care. It is outside the LVN scope of practice to have an individual patient care assignment. LVNs must be assigned to an RN and are only allowed to provide shared nursing functions within their scope of practice and level of competence. The only license in the count is the license of the RN.

### REFERENCES

Prescott, P., **Nursing Intensity: Needed Today for More than Staffing,** Nursing Economics, November-December 1991, Vol. 9, No. 6.

Department of Health Services, **Nurse-to-Patient Regulations,** available at: http/www.dhs.ca.gov/Inc/NTP (September 15, 2004).

Idelson, C., **Shutting the Back Door**, California Nurse, June 2004.

### NOTE

‡) The strikeouts show how the DHS language was changed.

## MANAGED CARE GLOSSARY
## Selected Descriptions of PCS Terms

*NOTE: The following are selected managed care/hospital industry descriptions.**

**Fiscal validity:** A condition that exists when average Nursing Care Hours (NCH) required are aligned with the unit's budget.

**Hours per patient day (HPPD):** A "universal" term the healthcare community utilizes, stating in numbers the budgetary resources allocated for the delivery of care per patient per day (24 hours).

**Matrix:** A staffing guideline/grid using Patient Care Hours (PCH) and census to determine appropriate numbers of staff and skill mix for a 24-hour period. It is broken down into staffing guidelines for each shift on the unit.

**Nursing care hours (NCH):** The number of hours required for nurses to render care per patient in a 24-hour period.

**Patient care hours (PCH):** The number of hours required to complete nursing tasks/ordered care per patient in a 24-hour period.

**Patient classification system (PCS):** A system that will determine the amount of nursing care required by a group of patients.

**Prospective staffing:** A staffing system that anticipates or projects patient care needs for the next shift.

**Reliability:** The extent to which a PCS instrument yields the same result on repeated trial by various staff.

**Retrospective staffing:** A staffing system that uses actual care delivered on the previous shift to predict staffing needs for the next shift.

**Skill mix:** The mixture of licensed and non-licensed staff, generally expressed as a percentage. This is determined by facility and unit policy.

**Validity:** Refers to the extent to which a PCS instrument measures what it is intended to measure. A nursing workload measurement/classification system is designed to measure the nursing workload associated with the care required of a particular patient population.

**Variance:** The difference between staffing required as defined by the PCS and the staffing provided. May be expressed as a percentage.

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Continuing Education Home Study Course

# CONTINUING EDUCATION TEST

## The California Nursing Practice Act
## Safe Staffing Standards by Scope, Ratio, and Acuity, Part II C

**For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and mail to CNA Attention: NP/Home Study CE, 2000 Franklin Street, Oakland, CA 94612 postmarked no later than March 30, 2005.**

### TEST QUESTIONS:

1. Any hospital can declare a state of emergency during the influenza season, and may suspend the ratios so long as they make a reasonable effort to come into compliance.
   **True / False**

2. By allowing hospitals maximum flexibility, the DHS prevented manipulations of the acuity systems and encouraged responsible cost containment measures.
   **True / False**

3. DHS's requirement that staffing records be maintained for one year is unduly burdensome and hospitals should only keep records in instances where they are out of compliance.
   **True / False**

4. Factors that complicate implementation of the nursing process have no bearing on the license allowed in the count; under this scenario LVNs may be given an individual patient care assignment.
   **True / False**

5. Hours per patient day (HPPD) is an appropriate number assigned to determine the time required to complete nursing tasks and shall remain the cap regardless of patient acuity.
   **True / False**

6. Absence from the unit has no impact on whether or not an RN, who is on a meal break, is in the count, since the RN remains accountable and liable for the duration of her/his shift.
   **True / False**

7. Severity of illness and complexity of care are mutually exclusive and have no influence on the ultimate patient outcome.
   **True / False**

8. The initial patient classification systems used retrospective tools to determine individual patient needs.
   **True / False**

9. The 2004 court decision on the "at all times" requirement basically ruled that hospitals shall be in compliance with the ratios at a minimum at the start of each shift since they only have to cover for meals/breaks.
   **True / False**

10. There is no sound reason why RNs should be able to override the staffing requirements including skill-mix determined by any computerized patient classification system.
    **True / False**

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# January 18 DHS Hearing in Sacramento

# SAY NO TO GOVERNOR'S RATIO ROLLBACK


Join us in Sacramento Jan. 18 to protest and give testimony against Governor Schwarzenegger's recent ratio rollbacks. His order, made at the request of the California Healthcare Association (the lobbying arm of the hospital industry), puts tens of thousands of Californians at risk for mortality, medical errors, and infections.

In order for the Governor's emergency order to become law, he must hold one public hearing. The Department of Health Services is holding the hearing on Jan. 18. The voices of direct-care RNs from hospitals throughout California must be heard.

## CNA CALLS ON THE GOVERNOR TO:

1. **Maintain the 1:4 minimum ratio in the Emergency Room at all times**
2. **Implement the 1:5 ratio in Medical–Surgical Departments on January 1, 2005**

## CALL AND E-MAIL THE GOVERNOR'S OFFICE:

Call 916-445-2841, extension 7 during business hours and leave a message saying:
"I am a Registered Nurse from (City) and I am offended by your remarks about nurses and I oppose your attack on the safe staffing ratio law."
E-mail the governor at governor@governor.ca.gov and cc CNA at press@calnurses.org.

# January 18 DHS Hearing

## DHS Hearing and Rally on Ratio Rollbacks

## Tuesday, January 18, 2005

**Sacramento Convention Center, Exhibit Hall D, 1400 J Street, Sacramento**
**Hearing Starts at 10:00 AM and continues all day — CNA Rally at 12:30 PM**

**CNA buses and air travel available — sign up with your CNA labor rep.**
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