

CODE RED



Understaffed. Overworked. Unsafe for everyone.

**The urgent need for
Safe Staffing legislation in New Jersey.**





Message from HPAE's President

The State of Our Healthcare System: A Gathering Catastrophe

Understaffing is driving our healthcare system to the brink of collapse. That is why HPAE, New Jersey's largest union of healthcare workers, is pushing the state legislature to pass a law in Trenton this year mandating enforceable staffing ratios.

The problem is clear – frontline healthcare workers continue to migrate out of bedside nursing at an alarming rate because of untenable working conditions. Driven in large part by working short-handed, this unsafe work environment has led to tremendous burnout in the profession as many more leave healthcare due to stress. And when healthcare workers suffer – the unavoidable result is patient care suffers.

If we do not come up with multifaceted programs to solve this issue, with a focus on both recruitment and retention- including safe staffing legislation, there will be dire consequences on the delivery of care for all New Jerseyans. Most certainly we must recruit new nurses into the field to help alleviate the critical shortage, but this is not enough. We must also provide incentives to not only lure back nurses who have left the field, but also to retain nurses who remain at the bedside. We must stop the current migration out of the field.

HPAE has long championed staffing legislation to improve staffing at healthcare facilities. But lobbyists for corporations that own hospitals – both for profit and non-profit – that are laser-focused on their profits, have successfully beaten back legislative solutions to the issue.

Through our contracts with employers, HPAE has tried to solve some of the most vexing problems locally. For instance, HPAE Local 5058 members at Jersey Shore University Medical Center surveyed members in 2022 who were frustrated with, among other things, the hospital's inability to staff adequately and the problems created.

These local leaders then brought the survey results to their employer at the bargaining table, as well as many members to testify at bargaining to the severity of understaffing. Armed with proposals to address issues around safety, recruitment, and retention, Local 5058 prevailed in gains toward better staffing within their hospital.

We will continue to bargain with individual employers going forward, but we need to solve this crisis with systemic change to end the exodus of nurses and other healthcare professionals from the industry.

In 2022, HPAE released the results of a multi-phase statewide survey we undertook to better understand the experiences, challenges, and needs of hospital nurses in these unprecedented times.

We confirmed overworked and poorly compensated New Jersey nurses are leaving the profession in droves, saying hospital safety is on the decline. Some of the staggering findings in this statewide survey on the staffing crisis include:

- Nearly a third of nurses have left the bedside (hospitals) in the past three years.
- Of those nurses that remain at the bedside, 72% have considered leaving recently.
- Newer nurses are the most likely to consider leaving the bedside (95% of those with five years of experience or less).
- The number one reason nurses are leaving hospitals is poor staffing.
- The second is related to the first: burnout and stress.

This should be a wake-up call, not just to these healthcare corporations, but to our legislators and regulators. Deep into the third year of a global pandemic that has shaken and changed every corner of our society, we must do things differently.

The uncomfortable truth is hospitals are now simply health-care “corporations” with only one goal: profits. For years, staffing has been a line item in a budget, cut to its lowest number to maximize those profits. Because of this, hospitals were already short-staffed with the onset of the pandemic. The pandemic itself only exacerbated a crisis that began with budget decisions of down-staffing made by these hospital corporations.

“It’s the money. It’s the hospitals, these companies want money, so they don’t wanna pay enough nurses. And so we’re short-staffed. And so no one wants to do that kind of job where you’re in an unsafe environment.”¹

It may be understandable why corporations and their lobbyists would resist anything adding to their costs and reducing their profits. But what is truly incomprehensible is why our legislators would go along with the shortsighted focus on profits and fail to see the urgency of solving a crisis with the very lives of patients at risk.

Staffing is an asset with patient outcomes improving dramatically with higher numbers of nurses and other healthcare workers. Research by Linda Aiken, Matthew McHugh and others is clear: in places where staffing is better, patients benefit. California, the only state with enforceable staffing ratios, bears this out. A 2010 study from NIH showed “Hospital nurse staffing ratios mandated in California are associated with lower mortality and nurse outcomes, predictive of better nurse retention in California.” What more proof do we need? The solution is clear... it is the political will that is in doubt.

Our healthcare system is in crisis as we continue to lose these dedicated “healthcare heroes” to burnout and stress. Patients will suffer. We must stop the bleed. The answer must start with an enforceable safe staffing law in New Jersey and nationally.



Debbie White, RN
President, HPAE

*Aiken, Linda, et.al. “Implications of the California Nurse Staffing Mandate for Other States.” Health Services Research, 2010 Aug; 45(4):904-921.

Introduction

As frontline caregivers and nurses, we know safe staffing is crucial to the health and well-being of our patients and our ability to provide quality, professional care. It is also crucial to patient satisfaction, nursing retention and safety, and hospital reimbursement levels.

One study estimating the costs of increases in nurse staffing levels found that it's "cost neutral" for hospitals. Due to fewer avoidable adverse events, shorter lengths of stay, and shorter readmissions, additional labor costs are completely offset.³

New Jersey's current nurse staffing regulations have not been updated since 1987 and fail to cover broad areas such as medical-surgical units and emergency departments. Since 1987, technology, reduced hospital stays, and patient acuity⁴ have undergone drastic changes, but our regulations have remained stagnant, unchanged, and unenforced. Hospitals are left to their own devices, with little oversight or enforcement.

Hospitals will argue they need flexibility, and call staffing ratios 'one size fits all'. Nurses will tell you hospitals already use a staffing 'matrix', but too often the numbers are based on budgets, and who is available, rather than what patients need. In addition, the ratios HPAAE proposes follow national nurse practice guidelines, for example, in ICU, and post-operative recovery care.

"Today, when I visit a hospital, clinic or health department and ask staff how they're doing, many tell me they feel exhausted, helpless and heartbroken. They still draw strength from their colleagues and inspiration from their patients, but in quiet whispers they also confess they don't see how the health workforce can continue like this. Something has to change, they say."

– Vivek H. Murthy, U.S. Surgeon General²

Frequently, nurses are working under conditions with so many patients they fear putting their license at risk if an adverse event occurs. Nurses know from experience when something bad happens, there must be someone to blame. Because they are doing direct patient care in life-or-death circumstances, overloading nurses with patients creates a perfect storm for errors not of their own making. Yet, they could be the one facing blame and loss of their license, when, in fact, the reason the mistakes were made was because they were working short-staffed and overwhelmed.

The confluence of understaffing for greater profits pre-pandemic and the COVID-19 pandemic has shown all of us that healthcare systems in the United States are on the brink of structural failure. An already burned-out workforce, subjected to the trauma of the pandemic, caused many to then make the decision to leave the workforce. If New Jersey does not enact enforceable staffing ratios it will only continue to perpetuate what is turning into a public health and humanitarian crisis within its healthcare infrastructure.

Why New Jersey Needs Better Staffing Ratios: Saving Lives, Reducing Errors

Currently New Jersey has few staffing regulations and only for critical care units (CCU) and intensive care units (ICU) that have been in effect since 1987. Most are woefully inadequate and outdated given present healthcare needs and services. For example, the industry recommendation for ICU/CCU is 1 nurse to 2 patients,⁶ but New Jersey’s regulations post 1 nurse to 3 patients. All other units not covered by any staffing ratios force nurses to work under unsustainable conditions, involuntarily placing their patients at risk. Compared to California’s mandated staffing ratios, New Jersey has next to no regulation limiting the number of patients per nurse (see Table 1).

“The staffing is absolutely unsafe. I was recently in a three-patient assignment and another patient coded and I was pulled away from my patients to assist with the code. I am frequently in a three-patient assignment and our patients are suffering. We are unable to turn patients to reposition them appropriately and have had two falls due to poor staffing. Recently a nurse started TTM – [targeted temperature management] on a patient but had another patient in their assignment. These conditions are incredibly unsafe and make me not want to come to work. Every day I come to work I am putting my license on the line by working through unsafe conditions. My license is how I make a living to feed my family and pay my mortgage. If I lose my nursing license, I lose a lot of things in my life.”⁵

Table 1: California RN to Patient Staffing Ratios vs New Jersey RN to Patient Staffing Ratios

Type of Care	CA RNs to Patients	NJ RNs to Patients
Intensive/Critical Care	1:2	1:3
Neo-natal Intensive Care	1:2	1:2
Operating Room	1:1	1:1
Post-anesthesia Recovery	1:2	1:3
Labor and Delivery	1:2	No*
Antepartum	1:4	No
Postpartum couplets	1:4	No
Postpartum women only	1:6	No
Pediatrics	1:4	No
Emergency Room	1:4	1:ER Dept*
ICU Patients in the ER	1:2	No
Trauma Patients in the ER	1:1	No
Step Down, Initial	1:4	No
Step Down, 2008**	1:3	No
Telemetry, Initial	1:5	No
Telemetry, 2008**	1:4	No
Medical/Surgical, Initial	1:6	No
Medical/Surgical, 2008**	1:5	No

*The hospital shall have in place a protocol to increase nurse staffing based on volume and acuity.

**2008 refers to an amendment to the CA staffing ratios affecting specific facilities.

Source: California Nurses Association and N.J.A.C. 8:43G.

With too many patients at higher acuity levels due to patients deferring care and the ongoing COVID-19 pandemic contributing to the severity of patient conditions, nurses are overworked and understaffed. The increased level of stress has led to nurse burnout, with more nurses leaving the bedside or considering leaving the profession.

Studies show repeatedly that understaffing compromises patient care and safety:

- A one-patient increase in a nurse’s workload increases the likelihood of an in-patient death within 30 days of admission by 7 percent.⁸
- Mortality risk decreases by 9 percent for ICU patients and 16 percent for surgery patients with the increase of one full time RN per patient day.⁹
- Nurse staffing shortages are a factor in one out of every four unexpected hospital deaths or injuries caused by errors.¹⁰
- In a 2021 study, each additional sepsis patient per nurse was associated with 19% higher odds of in-hospital mortality.¹¹
- A recent study of New York hospitals showed significant decreases in patient deaths would occur if patient care was limited to a ratio of 4 patients to 1 nurse: 4,370 deaths (authors’ conservative estimate) would likely have been avoided in New York just among Medicare patients during the two-year study.¹²

“Staffing ratios are absolutely absurd in the ED. There are too many patients for the ED to function regardless of staffing most days. The ED staff is literally dropping like flies with little to no replacements making the environment hostile and extremely unsafe. The ED nurses RISK THEIR ACTIVE LICENSE plus PATIENTS LIVES everyday they come to work. It shouldn’t be this way.”⁷

Having fewer nurses increases the likelihood of medication errors, hospital acquired infections, and other complications due to impossible patient loads:

- A study of medication errors in two hospitals found nurses were responsible for intercepting 86% of all medication errors made by physicians, pharmacists and others before the error reached the patient.¹³
- Lower nurse staffing levels led to higher rates of blood infections, ventilator-associated pneumonia, 30-day mortality, urinary tract infections and pressure ulcers.¹⁴

As nurse staffing levels increase, patient risk of hospital acquired complications and hospital length of stay decrease, resulting in medical cost savings, improved national productivity, and lives saved.¹⁵ Under California’s mandated staffing ratios, patients receive on average two to three more hours of registered nurse care than patients in states without ratios.¹⁶

Occupational safety decreases with fewer staff as well:

- One study showed occupational injuries for RNs and LPNs were higher in California before mandated staffing ratios. Once implemented, injury rates dropped significantly: 32% for RNs and 34% for LPNs.¹⁷
- Physical and verbal workplace violence of patient/visitor toward nurses/staff increases with less staffing, adding to an already stressful work environment.¹⁸ Workplace violence is not only a danger to nurses, but also to patients due to work disruptions and staff distractions.

“We have had more nurses leave my unit in the last year than I have seen in my entire career! We are constantly training brand new nurses to work in an ICU. I believe since April we trained over 30 new nurses and many of them leave. It’s hard for the experienced nurses to constantly be training new staff and then having them leave to go work at our sister hospitals for more money! Many days we have no secretaries and only one housekeeper who leaves at 3. Nurses are cleaning equipment, moving patients, and answering the phone, answering the door and screening visitors.”¹⁹

Nurses are often required to take on duties not related to direct nursing care due to shortages of other staff as well. Having to transport patients, clean, deliver or clear meals, keeps nurses from providing the care they are required to provide. Nurses are increasingly expected to absorb new tasks without any lessening of their current duties, creating a chronic problem: forcing them to do more with fewer resources (staff).

Burnout is the biggest threat to healthcare workers. When the corporate healthcare business model is to extract more work out of fewer people for greater profits in a caring profession, the breaking point may take longer to reach but the physical and emotional toll it takes on staff is unconscionable. Prior to the COVID-19 pandemic, female nurses were at twice the risk of dying by suicide as women in the general population; researchers expect that has increased with the advent of the pandemic.²⁰

Safe Staffing Saves Money: Debunking the Cost Factor

A leading argument against staffing ratios made by hospital corporations is in relation to cost.

Hospital operators always drag out the “it will cost too much to maintain staffing ratios” trope. Investigative reporting has shown that hospital corporations have been cutting staffing levels for decades due to an obsession with increased profits.²² A 2022 study called the shortage of hospital nursing care as “...largely the result of chronic nurse understaffing by design.”²³ When New Jersey non-profit hospital corporations are reaping tens and even hundreds of millions of dollars in profit each year, it is highly unlikely that adding a few nurses into the rotation will cause financial hardship.²⁴

“Every day that I work is overwhelming for the nurses and staff, and unsafe for patient care. It is draining and exhausting. Nurses, myself included, are in literal tears during the shift because of how overwhelming it is. Yet, hospital management does not seem to care about this. They provide us with the poor patient survey results and want to know what we, the nurses, can do to improve the scores. We are already giving everything we have! We have become transport, EVS, and kitchen staff, just to name a few.”²¹

“I don’t believe they actually care about patient safety or any employee whatsoever. All they really care about is money and it shows in the way they treat their employees and the fact that they don’t care if a unit is so short-staffed patient care is compromised. I feel upper management will ask what they can do to improve things just to try to make employees think they care but never actually listen or care what employees give as feedback. They are fully aware there are issues but do nothing about it.”²⁵

“I came into this career with a strong desire to help others, to care for them when under extreme health crises, but I find I am constantly playing beat the clock: there is an expectation that I will save as many lives as possible with as little help as possible and just suck it up. I am imploring you to support safe staffing legislation. No one’s health should be put at risk, whether the patient or the nurse, for the sake of profit.”²⁶

Studies show that because increased staffing reduces readmissions, infections, medical errors, and death, costs decline because of decreased length of stays and avoided readmissions.²⁷

Research shows when California increased staffing to meet mandated ratios “hospitals saw sustained improvement in staffing including in safety-net hospitals which often operate on razor-thin margins.”³⁰ Frequently hospital corporations say the extra cost of staffing with ratios may force them to end some services or close altogether – in twenty years, no hospital in California has closed due to mandated increased staffing.³¹

A 2021 study over two years showed projected cost savings for hospitals in New York state of \$720 million if ratios of four patients to one nurse had been mandated.²⁸ Another study estimated \$6.1 billion would be saved in reduced patient care if 133,000 nurses were added to the U.S. hospital workforce.²⁹

“The ER is a disaster zone. The expectation to provide adequate care for six-plus patients when, in some cases, that includes multiple ICU patients in addition to four other patients on top of that who are the highest acuity and require a room and not to be left sitting in the hallway is dangerous and unrealistic. Staff is exhausted, burnt out, and truly in fear for their licenses.”³²

One way hospitals have compensated for cutting staff is through the hiring of agency nurses when there are no other options for coverage. Prior to the pandemic, agency nurses made up just 2% of hospitals’ total labor costs (but at twice the hourly wage rate) in 2019.³³ In 2022, agency nurses made up 11% of hospital labor expenses, more than five times greater than pre-pandemic levels.³⁴

Some of this increase is due to the inflated costs charged by staffing agencies during the pandemic – travel nurse wages increased 106%, more than three times that of hospital employee nurses, during the pandemic³⁵ – but the shortage of nurses created prior to the pandemic by employers placed a greater demand on travel nurses as hundreds of thousands of patients flooded hospitals with COVID-19. This means travel nurses cost hospitals far more than if they had hired more full-time staff nurses prior to the pandemic which would have mitigated some of the need for agency nurses during the influx of severely ill patients.

“A nurse should not work in fear of losing their license due to unsafe work conditions. We feel like that every day. Two nurses responsible for 40 or more patients as well as the constant flow of new patients? No lunch breaks? Large room assignments? This is not safe!! No wonder why amazing, experienced nurses are leaving when other area hospitals are offering over \$100 an hour extra to staff the hospital to make it safer and help patient care.”³⁶

Changes in Medicare reimbursement and the Affordable Care Act now penalize low patient satisfaction scores and high readmission or infection rates and medical errors—all directly linked to unsafe nurse staffing. Safe staffing would lower, if not eliminate, the penalties hospitals incur, saving individual hospitals millions of dollars a year.

The fines from Centers for Medicare & Medicaid Services (CMS) seem to be nothing more than the cost of doing business for wealthy hospital corporations. In 2015, New Jersey hospitals paid approximately \$23 million in penalties with 97% of NJ hospitals getting charged by Medicare; more New Jersey hospitals were penalized than in any other state in the country.³⁷ Between 2015 and 2022, up to 64 hospitals have faced CMS penalties (New Jersey has approximately 72 hospitals with several specialty hospitals exempt from CMS penalties).³⁸

With more nurses to care for patients CMS patient scores would increase, while readmission and infection rates would go down. Patient satisfaction increases on units characterized as having adequate staff, where patients were more than twice as likely to report high satisfaction with their care, and their nurses reported significantly lower burnout.³⁹ There was a ten-point difference in the percentage of patients who would definitely recommend the hospital they were treated in – depending on whether patients were in a hospital with a good work environment for nurses.⁴⁰

It is also important to keep in mind hospitals increasingly share in the rewards of lower patient care costs. The Affordable Care Act established several payment mechanisms to return patient care cost savings back to hospitals, like accountable care organizations and payment incentive programs to lower costs and improve outcomes. In this light, safe nurse staffing levels should be seen as a long-term investment in patient outcomes rather than a short-term cost. One of the main goals of healthcare reform is to keep patients out of the hospital for costly and avoidable readmissions.

“One of the main reasons for not being able to take a break has to do with short-staffing. The demands of our patients cannot be unmet. As nurses we guarantee some of the basic aspects of health for our patients, like nutrition, rest, and removal from constant stressors, and yet we as caregivers are not assured the same while on the job. If we do not have enough nurses on a shift, we all suffer without breaks and no time to eat anything. If we don’t have quiet time to re-balance the emotional and physical demands of our job while on duty, it will make it more difficult to provide the high-quality care we as nurses’ demand of ourselves.”⁴¹

“When it comes to teaching new hires, the hospital doesn’t care if they learn proper, evidence-based practice, because if they did, they would provide more than one nurse educator for a unit that staffs close to 80 nurses. They would provide more than two assistant nurse managers for each shift that staffs with close to 17 nurses most days. Give us the resources we need to succeed and to treat our patients better. Enough with cutting corners and saving a buck, it takes money to make money. Show your nurses, the absolute backbone of the organization, that you value them.”⁴²

Additionally, fewer work related injuries occur with more nurses on duty,⁴³ which save on worker compensation claims, employer worker compensation rates, and overtime pay for filling hours of injured workers. A study of the impact of California’s staffing mandate on occupational injuries among registered nurses (RNs) and licensed practical nurses (LPNs) found RN injury rates were reduced by 32% and rates were reduced 34% for LPN injuries.⁴⁴ Reducing injury rates by a third would make significant financial savings not just for employers but also for worker compensation funds.

The U.S. spends twice as much on healthcare than any other high-income country, and yet has worse outcomes.⁴⁵ The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, and the highest maternal and infant mortality.⁴⁶ Yet we pay more than any other high-income country – for worse results.⁴⁷ It is perverse that hospital corporations choose to understaff in order to maximize profits when patients are paying with their lives for that choice. Staffing ratios will lower costs and improve patient outcomes for the people of New Jersey.

“As an ER nurse there are no nurse-to-patient ratios. While an ICU nurse might have 2–3 patients who require critical care, my average assignment is 6–7 patients. Of those I can have multiple critical care patients. Not too long ago we were short-staffed. I had 12 beds assigned to me in the ER... It was me, 12 patients and a secretary. The ER never closes.”⁴⁸

The Deep Pockets of Opposition to Staffing Ratios

One of the biggest obstacles to getting staffing ratio legislation passed are the deep pockets of hospital interest groups and lobbyists to defeat any measures. In 2018, Massachusetts had a ballot question for voters to decide if the state should adopt nurse staffing ratios. It was reported that hospital groups spent \$25 million to defeat the ballot initiative, largely through a campaign that peddled fear and chaos of possible hospital closures and cuts to services to the Massachusetts citizenry.⁴⁹

Hospitals promised a grim reality with passage of the Massachusetts ballot question, but once it was defeated, within a couple of months some hospitals across the state closed much needed units such as emergency rooms, inpatient mental health patient services, and inpatient pediatric units.⁵⁰ The fear-based arguments about regulating staffing ratios worked for the hospitals’ opposition campaign but were disingenuous and harmful to patient care.

In New Jersey, between 2015 and 2022 the New Jersey Hospital Association (NJHA) made 507 significant regular contributions to members of the Assembly, Senate, Governor, and both the NJ State Republican and Democratic parties.⁵¹ Donations range from \$60 to an individual to \$17,500 to the NJ Democratic Assembly Campaign Committee.⁵² In total, NJHA spent almost \$700,000 during this time.⁵³ This does not include any political contributions made by individual hospital executives or hospitals under separate cover.

HPAE will reliably expect well-financed opposition to any staffing legislative push, but the facts will bear us out: fewer patients per nurse will make for safer and better outcomes for New Jerseyans. The State’s citizenry and healthcare workforce deserve to have the focus placed on safety for all with humane working conditions that will ensure better patient outcomes and keep nurses at the bedside.

“I am disgusted and sickened by how obvious the differences are when working on units that make money for the hospital (PACU, SICU, etc) versus units that don’t make as much money for the hospital (ED). Administration should be ashamed of themselves ... The ED had patients lying on the waiting room floor because there were no beds in the hospital ... It’s all about the money. No one cares about us or the patient.”⁵⁴

Department of Health Enforcement Needed

Enforcement of any new staffing ratios will fall under the aegis of New Jersey’s Department of Health (NJ DOH). The few current staffing ratios are governed under N.J.A.C. 8:43G, the New Jersey Hospital Licensing Standards. It is incumbent on NJ DOH to make sure the regulations for staffing are followed. This will require a strong, well-funded NJ DOH to hire and maintain a workforce to respond to complaints, conduct inspections, and follow up on understaffing violations. HPAE recommends the following for proper oversight and enforcement:

- The reinstatement of regular hospital inspections and immediate, thorough complaint inspections by the New Jersey Department of Health (NJ DOH). This requires:
 - Increased NJ DOH staff for inspections
 - The right of hospital staff to accompany inspectors, and the right for consumers or staff to receive all information related to the complaint
 - Posting complaint and inspection results on the NJ DOH website

“Our labor nurses, it is unbelievable the amount of patients they’ll have at one time. I mean, you have babies that deliver in the bed without a person in the room. The father comes out and says, “I can see the head.” Pre-term babies! Just people literally running from room to room, a physician that can’t even make it from room to room, let alone the nurse. You have a nurse that’s got a patient hemorrhaging and she’s still got five other patients.”⁵⁵

HPAE has hundreds, if not thousands, of Notice of Unsafe Staffing forms, filed by our members each time a hospital unit falls short on meeting its current staffing obligations. The hospitals do not willingly meet the current staffing requirements, despite what is reported to the state. New Jersey needs more comprehensive legislation so nurses will have legal recourse in the form of NJ DOH oversight and inspections.

Conclusion: Staff Ratios Work

California has legislation requiring increased nurse staffing levels that has created more reasonable workloads for nurses in California hospitals. This has led to fewer patient deaths and higher levels of job satisfaction than in other states without mandated staffing ratios⁵⁶ Hospital nurse staffing ratios mandated in California are associated with lower mortality and nurse outcomes predictive of better nurse retention in California.⁵⁷ Mandated staffing ratios have been in effect in California for 20 years, saving countless lives.

By making a safer work environment, California’s staffing mandate has saved hospitals money by diminishing clinical disruption brought on by constant turnover.⁵⁸ Hospital staffing remains stable even during economic downturns, maintaining patient safety – hospital staffing in California remained largely unaffected during the Great Recession due to mandated ratios, while staffing in states without ratios declined further.⁵⁸

A recent Harris poll showed 90% of the public surveyed favored requiring safe nurse staffing standards in both hospitals and nursing homes.⁶⁰ We have experienced the worst pandemic of our lives for the past three years. Our healthcare workers were overworked and burnt out before the pandemic. They risked their lives and families' lives to help us; many of them died. They became our healthcare heroes. Please, it's time to listen to nurses who are asking for standards so that they can do the job they were trained to do – save lives.


Registered Nurses are asking elected officials to step in and act: pass a law now to improve and update New Jersey's safeguards for nurse staffing in hospitals. Assure nurses they can go to work each day, knowing they will have the resources to provide the highest quality of care to their patients. Give patients the assurance the price of their safety is not measured against the amount of profit a hospital makes by keeping lower staff levels. As noted in the President's message- the solution to this crisis is clear... it is only the political will that is in doubt.

Safe Staffing in the News

Opinion

Doctor: New Jersey's healthcare workforce shortage is getting worse | Opinion

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The New York Times

CALLING IT QUILTS

Nurses Are Burned Out. Can Hospitals Change in Time to Keep Them?

The pandemic has pushed already stressed nurses away from hospitals.


By Bradford Pearson
Bradford Pearson found subjects for this article from an online request from The Times

Health

N.J. is desperate for new nurses, report says. Who will fill the void as departures escalate?

Published: Jan. 18, 2023, 6:15 p.m.

LYDIA POLGREEN



Nurses Are Burned Out and Fed Up. For Good Reason.

Jan 18, 2023, 7:16 a.m. ET

The Coming Collapse of the U.S. Health Care System

BY ROBERT GLATTER AND PETER PAPANAKOS

JANUARY 10, 2023 3:16 PM EST



The New York Times

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