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NURSE STAFFING ISSUES: FROM CONFLICT TO COLLABORATION

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ABSTRACT

The proliferation of managed care, the growth of for-profit hospitals, and other factors have dramatically changed the face of health care in the United States. Hospitals have responded to these competitive pressures by reducing the size of their nursing staffs and reengineering nurses' jobs to reduce costs. For nurses, these efforts have engendered significant concerns regarding job security, inadequate staffing, and excessive workloads. In this study, relevant contract provisions were analyzed to determine how nursing unions have used the collective bargaining process to resist hospitals' efforts to reduce staffing levels and reengineer jobs. Suggestions for union and hospital negotiators are discussed.

Medicare's implementation of diagnosis-related groups (DRGs), prospective reimbursement, the proliferation of managed care, the growth of for-profit hospitals, and the decline of urban public teaching hospitals have dramatically changed the face of health care in the United States. One of the dominant responses to these challenges exhibited by hospitals has been industry consolidation, in the form of mergers, acquisitions, joint ventures, and other networking alliances [1-3]. The resultant vertical and horizontal integration has enabled hospitals to penetrate into new markets, thereby helping them expand their patient bases. Hospitals have

also achieved cost savings by reducing the duplication of services and minimizing others provided to patients, as they shift work to other settings where overhead is lower. These other settings include outpatient clinics, home health care, and follow-up office visits [1-3]. Labor costs are generally the largest operating cost incurred by hospitals, and nursing typically accounts for 50 percent of labor costs, or 20 percent to 30 percent of hospitals' total operating expenditures [3]. For these reasons, it may not be surprising that hospitals' efforts to reduce costs include nursing staff reductions and the reengineering of nursing jobs. On the union side, however, these efforts have engendered significant concerns regarding job security, inadequate staffing, and excessive workloads [1, 3-5].

In this study, we examined how nursing unions have used the collective bargaining process to resist hospitals' efforts to reduce staffing levels and reengineer jobs. To accomplish this objective, relevant collective bargaining provisions were examined. This analysis is important because unions currently represent 14.7 percent of all nurses employed in the United States [6]. Consequently, they are in a position to influence the working conditions of many nursing professionals. Furthermore, to the degree that the standards set in the unionized sector are adopted in the nonunionized sector, unions' efforts to improve nurses' working conditions will assume even greater importance.

COLLECTIVE BARGAINING PROVISIONS PERTAINING TO STAFFING

No-Layoff Guarantees

Given the labor-intensive nature of hospital operations, many administrators believe layoffs provide an effective means for reducing costs. From the union's perspective, layoffs constitute the greatest threat to its institutional security and to its members' job security. Conversely, unions perceive a stable or growing membership base as necessary to ensure adequate patient care and its members' economic well-being.

Where unions possess substantial bargaining power, they have successfully negotiated collective bargaining provisions that restrict management's capacity to lay-off nurses. The agreement between Presbyterian Hospital and the New York State Nurses Association is illustrative:

> An employee hired before January 1, 1993 shall not be laid off during the term of this agreement. An employee hired in a bargaining unit position before January 1, 1998 shall not be subject to layoff during the term of this agreement, except in the event of closure of beds for longer than three months, or a reduction in total number of inpatient discharges/outpatient visits in the affected unit for a period of no less than forty-five (45) consecutive days [7, p. 12].

It is important to note that this layoff restriction is absolute for nurses hired before January 1, 1993. For nurses hired after that date, layoffs are permitted, but only if beds are closed or there is a prolonged reduction in occupancy. In such a circumstance, the hospital retains some flexibility to adjust staffing levels in accordance with patient census. At the same time, the layoff and replacement of nurses by lower-paid staff as a means to lower costs would not be permitted.

Where unions have been unable to negotiate job guarantees, they have negotiated compensation for nurses who are laid off or terminated. The Kaiser Foundation Hospitals and the Oregon Federation of Nurses and Health Care Professionals negotiated the following severance benefits for terminated nurses:

> The severance allowance will be determined by full years of service. Eligible employees will receive one (1) week severance allowance for each full year of service, but a minimum of one (1) week, maximum of fifteen (15) weeks. . . .
>
> Employees receiving severance allowance shall receive continuation of Employer-paid medical and dental benefits for the same number of weeks as their years of service with a minimum of one (1) month beyond termination and maximum of six (6) months [8, p. 75].

Minimum Staffing Requirements

No-layoff guarantees do not ensure adequate staffing levels. For example, if current staffing levels are inadequate to ensure reasonable workloads and quality patient care, a no-layoff guarantee will merely avoid exacerbating the problem. Accordingly, unions have negotiated contractual commitments to maintain staffing levels that are adequate for ensuring quality patient care.

Some contracts specify particular staffing ratios that must be maintained. For example, the agreement between the American Red Cross, Southeastern Michigan, and the Michigan Council of Nurses and Health Care Professionals specifies minimum staffing levels for a given patient load:

> The staffing ratio shall be three (3) donors for every one (1) nurse per six (6) hour shift. A minimum of three nurses qualified to perform pheresis procedures shall be scheduled whenever such procedures are to be performed Monday through Friday at 100 Mack Avenue. In the event an odd number of nurses are assigned, the following ratio schedule shall be followed for each six (6) hour shift:
>
Number of Donors	Number of Nurses
1-10	3
11-13	4
14-16	5
17-19	6
Increase in increments of three	Increase in increments of one [9, p. 63].

Alternatively, these restrictions may be based on patient acuity as well as patient load:

> The acuity method shall be the method of staffing . . . the employer agrees to sustain average nursing staff levels as listed below:
>
Critical Care	all shifts 1:1
Progressive Care	1:6 days; 1:8 evenings; 1:8 nights
Psychiatry	1:8 days; 1:8 evenings
Special Care	intermediate 1:3, intensive 1:2 all shifts unless the 1:1 protocol is applicable
Mother Baby	1:3 couples' days; 1:4-5 couples' evenings; 1:5-6 couples' nights; or 1:6-7 babies; 1-10 babies' nights. There shall be at least one admissions nurse on all shifts
Pediatrics	1:6 days; 1:6 evenings; and 1:7 nights; traditional nursery staffing to be 1:4 [10, p. 7].

Some collective bargaining agreements demonstrate an even stronger commitment to ensuring adequate staffing levels. These agreements require management to contribute to a nursing fund if specified staffing levels are not maintained. The collective bargaining agreement negotiated by the Board of Trustees of Lansing General Hospital, Osteopathic, and the Office of Professional Employees International Union, Local 459, is illustrative:

> If the actual R.N. minutes provided through staffing is less than the projected R.N. minutes for three or more consecutive days on a particular unit and shift, the hospital shall allocate $250.00 to a registered nurses staffing account, not to exceed a cap of $50,000.00 per year. The contribution shall be owed for the third day and every consecutive day thereafter where actual minutes do not meet the projections. A unit and shift will not have violated the provisions if all the following occur:
>
> a. There are two or more R.N.'s staffing the unit;
> b. The total R.N. and L.P.N. minutes meet or exceed the minutes projected for both;
> c. The unit and shift is not more than one R.N. short from the projections. Except in unforeseen emergencies, the hospital shall not assign an R.N. in orientation on a unit if a probationary R.N. is the only other R.N. on the unit, if so the Hospital shall contribute $250.00 to the R.N. staffing account [11, pp. 44-46].

Some contractual provisions make management's commitment to quality patient care and adequate staffing levels explicit; yet the determination of what constitutes adequate staffing levels is left solely to the discretion of management. The following collective bargaining agreements are illustrative:

> The Department of Health Services Management agrees that the maintenance of adequate nursing staff is an essential element of safe patient care. Management further agrees that registered nurses are able to perform more effectively with support of ancillary staff. The Department of Health Services will have a staffing plan; registered nurses will assess their patients each shift where

> appropriate to determine the severity of illness. The severity of illness will be used by management to help determine staffing needs [12].

The contract negotiated by the Riverside Osteopathic Hospital and the Michigan Council of Nurses and Health Care Professionals, Local 79, SEIU, provides that:

> The parties agree and recognize that appropriate patient care is the primary objective of both parties. In providing patient care, the Hospital shall establish nurse-patient ratios, staff mix, and staffing guidelines designed to adequately meet patient care needs. Such guidelines will provide for reasonable workloads and will take into account patient acuity, nursing personnel competencies, and staff mix [13, p. 47].

Unlike the previous provision, this contract specifically requires that the staffing guidelines provide for reasonable workloads. As such, this language permits the nurses to grieve the hospital's mandatory staffing guidelines when disagreements arise regarding what constitutes a reasonable workload.

Joint Union-Management Staffing Committees

Joint union-management committees have been established where the parties believe that for certain problems, cooperative efforts are more likely to generate mutually beneficial outcomes. Recognizing that staffing levels critically affect the delivery of patient care and that cooperation between nurses and managers is needed to satisfy managements' cost concerns and patients' needs, some nursing unions and employers have contractually agreed to establish joint committees to address staffing issues. These committees provide an alternative to the extremes of management having exclusive authority to determine staffing levels or the union contractually specifying nurse-patient staffing ratios.

Many collective bargaining agreements contain provisions establishing joint staffing committees. The authority vested in these committees and in the parties, however, varies. Though not common, some collective bargaining agreements empower union representatives with substantial decision-making authority. The contract between Sparrow Hospital and the Michigan Nurses Association is illustrative:

> If the employer develops plans to implement workplace restructuring efforts that involve significant changes in: the type and amount of patient care to be given, the types of personnel which should be used to deliver the needed care, assigning responsibilities for patient care, and the job responsibilities of bargaining unit employees, notice shall be given to the Union. The specific principles and mechanisms to address changes are currently being discussed between the parties, but it is generally understood that any work redesign and/or staffing committees shall be equally representative of the Employer and bargaining unit membership. Throughout the planning, implementation and evaluation of the process and staffing in general, the Employer,

> employees and the Union shall remain committed to the preservation of excellence.
>
> The willingness of the parties to reach these understandings has led to the creation of the Mutual Gains Committee which will consist of five employer representatives and five union representatives. The Union representatives shall be elected from the bargaining unit by the membership. All decisions regarding significant workplace restructuring which directly affect employees shall be reached through a consensus process between the Employer and the Union. When a consensus is reached, the changes agreed to will be implemented only after ratification by a simple majority of the employees in the affected unit [14, p. 90].

Under these provisions, two conditions must be satisfied before management can alter the type and amount of patient care to be given and personnel used to deliver care. First, consensus must be reached by the union-management committee, which includes an equal number of union and management representatives. Second, once the committee agrees to support the restructuring effort, it can be implemented only if a majority of the employees in the affected bargaining unit support the change. Given these constraints, only in an atmosphere of strong labor-management cooperation would the hospital be able to implement substantial changes in staffing.

Most collective bargaining agreements establishing joint union-management staffing committees reserve to management controlling authority over employment and staffing. The agreement between Cook County and the Illinois Nurses Association (INA) is illustrative:

> 1. The purpose of the Joint Staffing Sub-Committee will be to review, evaluate and make recommendations regarding staffing issues and recruitment and retention. The Sub-Committee will be provided with information and education to evaluate staffing issues (including periodic reports, staffing records, and other pertinent information relative to the issue(s)) and make recommendations for change. It will be provided with information relevant to nurse recruitment and retention. It will have no more than 6 representatives from the Association (inclusive of INA staff) and no more than 6 Divisional Directors of Nursing (inclusive of the Director of Nursing) or their designees. It will meet at least monthly.
>   a. Recommendations from this committee will be made to the Director of Nursing. Members of the Committees may meet with the Director of Nursing regarding her response and with the Hospital Director and with the Chief Administrative Officer of Health Services.
>   b. These solutions and programs will not contradict language in this contract and will not preclude nurse representatives from exercising their rights under other provisions of this contract [15, p. 35].

Under the terms of this agreement, the committee is only a mechanism for providing input and does not possess final decision-making authority. In this facility, union representatives take up their recommendations with the director of

nursing. Subsequently, the director of nursing discusses union concerns with the hospital director and with the hospital's chief administrative officer. At the same time, it is implicit that the hospital director is authorized to accept or reject the committee's recommendations.

On the other hand, the joint committee's lack of final decision-making authority does not preclude the union from grieving staffing issues. The right to grieve such issues is explicitly acknowledged in the INA Cook County agreement, as it recognizes that the programs and activities of the Joint Staffing Committee do not operate to waive the right of nurse representatives to exercise their rights under the agreement.

In contrast, the collective bargaining agreement between the Regents of the University of Michigan and the Michigan Nurses Association recognizes that actual staffing levels are not subject to the arbitration process. Specifically, this contract states:

> A joint meeting, with the Association and the University, will be held every 3-6 months with the Directors from Ambulatory Care, to discuss and share data on workload, for the purpose of monitoring and measuring activity for projected growth. The actual staffing levels or the inclusion of other management tools are not subject to the arbitration procedure [16, p. 21].

Limits on Nonnursing Duties

Nursing-care delivery systems in hospitals are evolving. Some of the team-based, patient-focused models that have been implemented make extensive use of nurses' aides or assistants (NA). By definition, these employees have less formal education and training than RNs and LPNs. They are also paid less. Other models integrate various duties such that RNs perform what were heretofore the responsibilities of NAs [3].

Many RNs believe these changes may compromise the quality of patient care. This is especially true if NAs are used instead of RNs in cases involving patients with complicated or serious medical conditions. Many managers have also recognized that using RNs to perform duties that do not require their advanced education and training may not be the most cost-effective use of human resources. Thus, lower-paid NAs could be used to perform these less-demanding tasks. These considerations have led some parties to negotiate contractual provisions restricting the work that nurses should perform. For example, Liberty Medical Center and the Professional Staff Nurses Association agreed that nurses should not perform the following tasks/duties:

> Clean bathtubs/showers, straighten supply closets, clean sinks, clean equipment not in operation, make unoccupied beds, fill out routine lab requisitions, schedule clinic appointments, empty trash, empty linen hampers, stock soap, call for repairs, stock paper towels, remove unoccupied beds, transfer ambulatory patients . . . follow up on undelivered supplies, check patients'

> clothing and valuables, transport bodies to morgue, bring charges to medical records, serve/collect meal trays, enforce visiting rules, and order routine supplies [17, p. 47].

In other cases, the parties have agreed that nurses will perform such duties only during emergency situations:

> The parties further agree that certain required auxiliary services, which are necessary for providing total patient care, are routinely assigned to other Hospital employees. Such activities include the delivery of meals, housekeeping after patient discharge, cleaning service rooms of a ward and delivery of non-prepackaged drugs to a ward. Such duties will not be expected to be performed by a Registered Nurse except in the case of emergency [13, p. 23].

Restrictions on Overtime Work

Overtime work affords hospital administrators flexibility in staffing their facilities. This is often a useful tool for adapting to fluctuating occupancy rates. Many nurses and nursing unions, however, believe that managers use overtime as a substitute for maintaining adequate staffing levels. In response to these competing interests and beliefs, collective bargaining agreements frequently contain language that delineates the rights of management to mandate overtime and the rights of nurses to refuse it. As the following examples illustrate, the rights of the parties vary significantly.

The collective bargaining agreement between the Marquette General Hospital and the Michigan Nurses Association restricts management's authority to require overtime for nurses who are off duty and not on standby status. In this way, the union protects its members' vacations, personal time, and childcare arrangements. On the other hand, nurses who are on duty or scheduled to work may be required to work overtime:

> The Hospital shall not have the right to require overtime from employees who are off-duty and not scheduled or not assigned to take standby or report to work [18, p. 9].

In other cases, as reflected in the contract between Mercy Hospital of Buffalo and the Communications Workers of America, unions have restricted mandatory overtime to emergency situations:

> Mandatory overtime may only be considered in cases of an unusual event or crisis situation. Should such an event occur after all other alternatives, including management staffing and use of emergency personnel, have been tried and still have failed to meet patient care needs, the appropriate manager shall call the Administrator or Administrator on-call and the designated Union representative, to seek authorization for the mandatory overtime assignments. The following shall then apply:

A. The least senior qualified employee shall be designated to work the assignment.
B. Such employee shall be paid for all hours worked on such assignment at a rate of time and one half the employee's regular rate of pay.
C. The assignment shall generate a meeting between the Union and appropriate Vice President and manager within forty-eight (48) hours to review the incident to:
   1. Verify the crisis state of the event.
   2. Attempt to resolve the problem to prevent such future events.
   3. Determine the appropriateness of the penalty, if applicable, and pay the employee at the rate of double time for avoidable events.
   4. Review any anticipated disciplinary action. Refusal of mandatory overtime assignments shall not be just cause for termination [19, pp. 71-72].

This provision authorizes the use of mandatory overtime only in emergency situations. Moreover, such actions are closely monitored and scrutinized, and the refusal of a mandatory overtime assignment is not just cause for termination. It may, however, be just cause for lesser forms of disciplinary penalties.

In the case of Sparrow Hospital and the Michigan Nurses Association, the contract language affords management the right to compel overtime. In doing so, however, the employer must give adequate notice and attempt to distribute overtime equitably to all employees:

> When overtime is necessary an employee is obligated, as a condition of employment, to work beyond the normal schedule if requested. Notice will be given to the employee as far in advance as possible and a conscientious effort will be made to equitably distribute overtime to all employees in the affected job classification [14, p. 61].

Nurse Codes of Ethics

Some contractual provisions indirectly address staffing levels. The Community Health Center of Branch County, Coldwater, Michigan and the Staff Council of Nurses of Branch County incorporated a code of ethics into their contract. It provides that:

> The employer recognizes that the Registered Nurse subscribes to a code of ethics and will support the nurse in his/her compliance with this code. The nurses' code of ethics reads as follows:
>
> The nurse acts to safeguard the patient when his/her care and safety are affected by the incompetence, unethical, or illegal conduct of any person. The nurse uses individual competence as a criterion in accepting delegated responsibilities and assigning nursing activities to others [20, p. 9].

The contract between Cook County and the Illinois Nurses Association similarly provides that:

> It is also understood and affirmed that professional RNs have responsibilities to patients that transcend some aspects of the usual employment relationship. RNs will not be expected to ignore these responsibilities or the Code of Ethics of their profession [15, p. 35].

These contract clauses do not specifically address the issue of staffing levels. They do, however, preclude nurses from working in conditions that threaten the safety of patients or interfere with nurses' professional responsibilities to promote and safeguard patient care. Accordingly, if the hospitals maintain staffing levels that threaten the safety of patients or inhibit the delivery of competent patient care, nurses may file grievances claiming that these staffing levels breach the ethical duties and responsibilities guaranteed for them by their collective bargaining agreements.

CONCLUSION

Nurses and hospital administrators have several objectives in common. These include the desire to provide patients with high-quality care and success for the health-care institution employing them. Yet, while both nurses and hospital administrators are commonly concerned about professional issues linked to patient care, unions have objectives that are unique to their institutional goals and interests. Unions seek to maintain sufficient numerical strength to survive and represent their members effectively. As a result, they seek input and at times veto power over management efforts to restructure and reduce costs, both of which may have a negative impact on their members' job opportunities and income. At the same time, pressure on management to attain cost reductions is ever-present, as hospitals must operate within the framework of managed care, an economically impoverished client base in urban areas, prospective reimbursement, and DRGs. These concerns underlie management resistance to union efforts to limit management discretion when making staffing decisions.

This analysis of contract language illustrates the wide variety of outcomes that occur as unions and employers negotiate over staffing. Some contracts afford management exclusive authority to lay off, determine staffing levels, accept or reject the recommendations of joint union-management staffing committees, assign nonnursing duties to RNs, and compel overtime work. In other cases, unions have negotiated contractual provisions that limit management's discretion over staffing by restricting their authority to lay off, prescribing minimum staffing levels, prohibiting nurses from performing nonnursing functions, and prohibiting compulsory overtime work except in emergency situations.

While the focus of health care is shifting away from hospital nursing to nursing at the patient's side (in a continuum of care), more nurses still work in hospital in-patient settings than in any other setting [3]. Moreover, nursing services are central to the provision of hospital care, especially given the increased complexity

of patients' illnesses. These changes, coupled with continuing pressures to contain costs, make it imperative for hospitals to find innovative ways to redesign the delivery of health care. These restructuring efforts must reduce costs without compromising the quality of patient care. They must also reinvent the roles and responsibilities of nursing personnel. This includes planning for patient care before patients are admitted to the hospital and after they are discharged, as well as for the care they need during their hospital stays. Finally, nursing is a hazardous occupation. During the past 15 years, the rates of illness and injury have increased about 52 percent and 62 percent, respectively. As such, these initiatives must be designed to ensure the safety of nursing personnel [3].

Nursing unions may believe that restructuring efforts will be detrimental to them and to their members. Recognizing this, the parties may be able to reduce the incidence or magnitude of conflict by bargaining in a more integrative manner. Within this framework, employers should be open to negotiating the establishment of joint union-management committees to address organizational design and staffing issues. The rationale for including the input of nursing personnel in these efforts is self-evident. Such involvement brings to the table the expertise needed in developing such changes. Staff commitment to the decisions made will also increase when rank-and-file members understand that their representatives have been a party to negotiating the changes. Furthermore, overall morale within the organization will not be threatened by the speculation and rumors that inevitably arise when change is effected through a top-down approach. Through an approach that uses as the measure of success the resolution of problems—not employer or union control over outcomes—employers and unions may build the mutual trust and confidence necessary to secure both financial viability for the organization and favorable working conditions for employees.

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