

Protecting Our Front Line

Ending the
Shortage of
Good Nursing
Jobs and the
Industry-created
Unsafe Staffing
Crisis

December 2021



**National
Nurses
United**

www.NationalNursesUnited.org

INTRODUCTION

In this report, National Nurses United (NNU) describes how the hospital industry has driven registered nurses (RNs) from the bedside. As the largest union and professional association of registered nurses with more than 175,000 members working at the bedside in nearly every state in the nation, NNU proposes steps that Congress and the executive branch must take to keep RNs at the bedside, encourage licensed RNs not currently providing direct patient care to return to the bedside, and improve patient care in U.S. hospitals. This report begins with an executive summary, followed by sections detailing how pre-pandemic hospital industry practices of unsafe staffing and poor working conditions have driven nurses away from the bedside. Next, the report details the hospital industry's failure to prepare for the pandemic despite repeated, urgent calls from RNs, and hospital employers' active transgressions that resulted in the horrific conditions nurses experienced during the pandemic. Finally, the report discusses legislative and regulatory actions to address both retention and recruitment of bedside registered nurses, calling on Congress and the executive branch to act immediately to end the industry-created unsafe staffing crisis by ensuring safe and optimal working conditions for nurses and by supporting programs to create a culturally competent and diverse pipeline of nurses into bedside care. Lastly, the report offers concluding remarks on the pandemic's effects on nurses, their coworkers, and their patients.



TABLE OF CONTENTS

Executive Summary: A Shortage of Good Nursing Jobs, Not a Shortage of Nurses	4
Part I. Hospital Industry Practices Drive Nurses Away From the Bedside	9
The Hospital Industry Intentionally Adopts Policies of Understaffing	9
Hospital Employers Put Nurses in Danger of Injury and Illness on the Job	10
The Hospital Industry Devalues RNs’ Professional Practice and Restricts Their Autonomy.....	11
The Hospital Industry’s Resistance to Hiring RNs with Associate Degrees in Nursing Exacerbates the Staffing Crisis and Undermines RN Workforce Racial and Ethnic Diversity.....	12
Part II. Hospital Industry Practices During the Covid-19 Pandemic Caused Nurses Detrimental Mental Health Effects, Profound Moral Distress, and Moral Injury	14
The Failure of the Hospital Industry to Prepare for Covid-19 Surges Caused High Rates of Infection, Illness, and Death in Nurses.....	14
<i>The Hospital Industry Failed to Prepare for Covid-19 Patient Surges</i>	14
<i>The Hospital Industry’s Failure to Prepare for Patient Surges Resulted in High Covid-19 RN Infection and Death Rates</i>	15
The Hospital Industry’s Active Transgressions Against RNs Compounded Its Failure to Prepare for the Pandemic, Adding Insult to Injury	16
Unsafe Working Conditions During the Pandemic Severely Impacted RN Mental Health	18
Crisis Standards of Patient Care, Rationing, and Unnecessary Death Caused RNs Extreme Moral Distress, Injuring Them Further	21
Hospital Industry Transgressions and Incomprehensible Patient Illness and Death Caused RNs Profound Moral Injury	23
Part III. Solutions: Nurse Retention Measures	25
Require Minimum, Numerical, Safe RN-to-Patient Staffing Ratios	25
Issue Enforceable Occupational Health and Safety Standards to Ensure that Nurses are Safe on the Job	27
Strengthen Union Protections and the Right to Organize for Nurses and Other Workers	29
Provide Paid Sick, Family, and Precautionary Leave for Workers	31
Adopt Pandemic Risk and Effects Mitigation Measures to Respond to the Ongoing Covid-19 Pandemic and to Prepare for Future Pandemics	32
Part IV. Solutions: Measures to Strengthen and Support the RN Workforce Pipeline	37
Create a Long-Term, Dedicated Funding Stream for Tuition-Free Nursing Programs at Public Community College	37
Increase Funding for the Nursing Workforce Diversity Program	38
Increase Funding for the Nurse Corps Scholarship and Loan Repayment Programs.....	39
Improve the Nursing Workforce Diversity Program	40
Improve the Nurse Corps Scholarship Program (NCSP)	40
Improve the Nurse Corps Loan Repayment Program (NCLRP).....	41
Conclusion	43
Endnotes	44

EXECUTIVE SUMMARY: A SHORTAGE OF GOOD NURSING JOBS, NOT A SHORTAGE OF NURSES

For decades, the hospital industry has operated on a model with one goal: maximize net revenue. These profits come at the expense of both patient care as well as worker health and safety. A hospital is not a factory, and health care workers are not machines. After years of industry neglect and intentional policies of short-staffing, registered nurses (RNs) and their patients are facing a crisis of unsafe staffing and unsafe working conditions, exposed by the Covid-19 pandemic but dating back far longer.

There is no shortage of RNs. As of Nov. 6, 2021, the National Council of State Boards of Nursing reported that there are more than 4.4 million RNs with active licenses,¹ yet according to the U.S. Bureau of Labor Statistics, there are only 3.2 million people who are employed as RNs, with 1.8 million employed in hospitals.² In addition, except for a handful of states, there are sufficient numbers of registered nurses to meet the needs of the country's patients, according to a 2017 U.S. Department of Health and Human Services (HHS) report on the supply and demand of the nursing workforce from 2014 to 2030.³ Moreover, HHS

projected that most states (43) would have surpluses in 2030.⁴ **Again, there is no shortage of RNs. Rather, there is a shortage of good, permanent nursing jobs where RNs are fully valued for their work at the bedside through safe patient staffing levels, strong union protections, and safe and healthy workplaces.**

Importantly, registered nursing can be a pathway to good union jobs for people from Black, Indigenous, people of color (BIPOC) communities and underserved communities, but hiring and educational policies by the hospital industry have restricted the pipeline of nurses from socioeconomically diverse and underserved communities. **Although there is no general nursing shortage, the lack of racial, ethnic, cultural, linguistic, and socioeconomic diversity within the current nursing workforce reflects the need for increasing the numbers of and support for socioeconomically diverse registered nurses from BIPOC communities and other underserved communities.** Racial and socioeconomic diversity within the nursing workforce is crucial for both improving our nation's health and achieving health equity.⁵

What is understaffing or short-staffing?

An intentional practice in which hospital management does not schedule an appropriate number of registered nurses, with the appropriate clinical experience, to safely care for patients in a hospital unit, driven by a desire to increase hospital profits. Employers do not maintain a robust pool of nurses from which they can increase staffing when patient loads increase, repeatedly cancel or "call-off" nurses who are scheduled to work, and are slow to fill permanent RN positions.

HOSPITALS PROFIT: To reduce labor costs and to increase profits, the hospital industry deliberately refuses to staff our nation's hospitals with enough nurses to care for patients safely and optimally, harming both nurses and patients in the process. Even before Covid-19, the hospital industry had driven nurses away from direct nursing care at the bedside by adopting policies that result in high patient caseloads and unsafe working conditions, such as intentional understaffing of units across the hospital. Further, hospitals consistently fail to protect nurses from health and safety hazards in the hospital including infectious diseases, workplace violence, and musculoskeletal injury. Because hospital employers fail to protect nurses on the job and fail to provide nurses with the staff and resources needed for them to give safe, therapeutic care, nurses face moral distress, preventable dangers, and job dissatisfaction, leading many nurses to leave the bedside — or to leave the nursing profession altogether — to protect themselves, their nursing licenses, their families, and their patients. All the while, the profit margins of hospitals continue to grow at the expense of nurse safety and patient care.

PATIENTS SUFFER: Unsafe staffing levels and poor working conditions make it impossible for nurses to meet their ethical and professional obligations as RNs to provide safe, effective, and therapeutic nursing care. Studies have shown that adequate staffing levels through RN-to-patient ratios result in better patient outcomes, and health and safety programs not only protect workers, but improve the health and safety of patients as well.

NURSES LEAVE: Hospital employers' utter disregard for the lives of nurses, their patients, and their families during the pandemic has resulted in both a physical and psychological toll on nurses. The failure by hospital employers to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. As a result, many nurses are leaving the bedside. If hospitals protected nurses with safe working conditions and safe staffing rather than pushing nurses to do more and more with less and less, we could keep more nurses at the bedside.



What are mandatory minimum RN-to-Patient Ratios?

Believe it or not, there are no federal mandates regulating the number of patients a registered nurse can care for at one time in U.S. hospitals. As a result, RNs are consistently required to care for more patients than is safe, compromising patient care and negatively impacting patient outcomes. Mandatory minimum RN-to-patient ratios would require that hospitals adequately staff every unit. This will improve patient care and reduce nurse turnover.



THERE'S A SOLUTION TO THIS CRISIS. To end the nurse staffing crisis and to bring nurses back to the bedside, NNU calls on Congress and the Biden administration to adopt federal policies that value the vital work of direct patient care RNs and that ensure employers meet their legal obligations to provide safe and healthy workplaces.

First, the federal government should take measures to ensure the retention of nurses at the bedside by valuing the lives of nurses through quality, permanent jobs. This must include passage of the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, which would establish mandatory, minimum RN-to-patient ratios. It must also include optimal workplace safety protections, fair wages, and robust union rights — including conditioning future pandemic relief funding for the hospital industry on implementing nurse retention measures.

Second, the federal government should take measures to recruit nurses from underserved communities by vigorously funding nursing education and job placement in a manner that realigns our health care system to meet the needs of patients rather than the aims of the hospital industry's bottom line, and that ensures the nursing workforce reflects the racial, ethnic, cultural, linguistic, and socioeconomic diversity of patients. The unprecedented crisis of the Covid-19 pandemic provides the opportunity to fight for the protections, pay, and dignity that nurses deserve.

NNU PROPOSALS TO END THE INDUSTRY-CREATED NURSE STAFFING CRISIS

SOLUTIONS: CONGRESSIONAL ACTIONS

Nurse Retention Measures

- » Pass the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (S. 1567, H.R. 3165 in the 117th Congress)
- » Pass the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195 in the 117th Congress)
- » Pass the Protecting the Right to Organize (PRO) Act (S. 420, H.R. 842 in the 117th Congress)
- » Pass the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117th Congress)
- » Increase funding for OSHA enforcement programs and OSHA hiring of health care sector inspectors
- » Pass legislation mandating paid sick, family, and precautionary leave for nurses and other workers

Pandemic Risk Mitigation Measures

- » Pass legislation requiring hospitals and government to maintain and report on personal protective equipment (PPE) and medical supply stockpiles
- » Pass legislation expanding Defense Production Act of 1950 (DPA) powers over PPE and medical supply chains during public health emergencies
- » Pass legislation prohibiting the reuse and extended use of single-use PPE

Pandemic Effects Mitigation Measures

- » Pass legislation to establish presumptive eligibility for workers' compensation and disability and death benefits for nurses
- » Pass legislation providing free crisis counseling and mental health services to nurses
- » Pass legislation on educational debt cancellation for nurses

“They call us heroes and treat us like zeroes!”

Throughout the pandemic, there has been a jarring contradiction between the saccharine and excessive celebration of nurses as heroes for risking their and their families' lives and the utter disregard of nurse safety by the hospital industry. The disposability of nurses during the pandemic could be plainly observed as the hospital industry refused to provide necessary optimal personal protective equipment; sick or quarantine leave and pay; Covid-19 tests for employees; mandated excessive hours and unsafe shifts; demanded nurses work even if they had been exposed to Covid-19 or were recovering from it; and disciplined nurses who spoke out about unsafe conditions for workers and their patients.⁶

For hospital employers, the Covid-19 pandemic has become the ready excuse to waive their legal duties as employers to protect nurses and other workers who provide essential, life-sustaining labor, and who have a duty to provide optimal, therapeutic care to their patients. Registered nurses are a critical public health resource.

- » Pass legislation establishing social support programs for nurses (e.g., programs providing free childcare, alternate housing, meals, and transportation)
- » Pass legislation to provide nurses essential worker pay

Measures to Strengthen and Support the RN Workforce Pipeline

- » Create a long-term, dedicated funding stream for tuition-free nursing programs at public community colleges
- » Increase funding for the Nursing Workforce Diversity Program
- » Increase funding for the Nurse Corps Scholarship and Loan Repayment Programs

SOLUTIONS: EXECUTIVE AND REGULATORY ACTIONS

Nurse Retention Measures

- » The Centers for Medicare and Medicaid Services (CMS) should require that hospitals meet minimum safe RN-to-patient ratios as a condition of participation in Medicare
- » Issue a permanent OSHA standard on Covid-19 based on the Covid-19 Health Care Emergency Temporary Standard
- » Issue an OSHA standard on infectious disease
- » Issue an OSHA standard on workplace violence prevention in health care and social service settings
- » Issue an OSHA standard on safe patient handling
- » Issue an OSHA directive to improve enforcement activities in the health care sector
- » Hire and train more OSHA inspectors with health care sector expertise
- » Adopt CMS rules to penalize hospitals that cannot ensure labor peace
- » Support the PRO Act (S. 420, H.R. 842) and the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117th Congress)
- » Issue an executive order or take regulatory action to provide all federal workers and federal contractors paid sick, family, and precautionary leave

Pandemic Risk Mitigation Measures

- » Require hospitals and government to maintain and report on PPE and medical supply stockpiles through CMS regulation
- » Fully invoke and exercise Defense Production Act of 1950 powers to coordinate the manufacture and distribution of PPE and medical supplies
- » Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19
- » Require hospitals to adopt Covid-19 infectious disease precautions, including:
 - › Patient isolation, screening, universal masking, and more
 - › Free vaccines and testing of workers and patients
 - › Contact tracing and communication about Covid-19 cases

Pandemic Effects Mitigation Measures

- » Establish presumptive eligibility for disability and death benefits for nurses and workers' compensation for federally employed nurses
- » Require hospitals to provide free crisis counseling and mental health services of the nurse's choosing
- » Take executive action on nurse educational debt cancellation
- » Provide essential worker pay for nurses who are federal employees or contractors

Measures to Strengthen and Support the RN Workforce Pipeline

- » Improve the Nursing Workforce Diversity Program
- » Improve the Nurse Corps Scholarship Program
- » Improve the Nurse Corps Loan Repayment Program

PART I. HOSPITAL INDUSTRY PRACTICES DRIVE NURSES AWAY FROM THE BEDSIDE

In recent decades, the hospital industry has deliberately deprioritized patient care and nursing health and safety in order to maximize profits. As a result, nurses and their patients are facing a crisis of unsafe staffing and unsafe working conditions that has resulted in nurses fleeing the unbearable working conditions in acute-care hospitals. Nurses are pursuing nursing work in other settings, leaving the profession for other types of work, or retiring. As discussed below, the hospital industry's devaluation of RNs began long before the Covid-19 pandemic through inadequate health and safety protections; understaffing; deskilling; and the substitution of unpaid family care,⁷ unlicensed, or lower-licensed care to reduce labor costs.

THE HOSPITAL INDUSTRY INTENTIONALLY ADOPTS POLICIES OF UNDERSTAFFING

The unsafe staffing crisis is part and parcel of the hospital industry's attempt to squeeze profits out of nurses and their patients. With an eye on reducing costs and increasing profits, the hospital industry purposely adopted models from the manufacturing industry — like bare-bones staffing that makes nurses unable to safely care for patients and “just-in-time” supplies that arrive precisely when needed — to limit spending on human and other resources. Hospital employers spent much of the mid- to late-1990s reducing their RN workforce through layoffs and attrition in attempts to reengineer and restructure health care services to emulate industrial models of productivity improvement.⁸ Hospitals regularly understaff units with fewer numbers of nurses than are actually required to safely and optimally care for the numbers of admitted patients and their severity of illness.⁹ Rather than scheduling sufficient numbers of nurses to ensure that each RN has a manageable patient load to safely provide all needed care and maintaining a robust pool of nurses from

which to draw when patient loads increase unexpectedly, hospitals routinely opt for bare-bones staffing. Hospitals often cancel or “call off” nurses who are scheduled to work and are slow to fill permanent RN positions. Even during Covid-19 surges, hospitals have canceled contracts with travel or agency nurses and laid off nurses,¹⁰ instead requiring the remaining nursing staff to work mandatory overtime or to assign more patients than can be cared for safely and therapeutically. For example, two HCA Healthcare hospitals in California sought staffing waivers to allow them to assign more patients to an RN than California law allows after one of the hospitals had summarily cut short traveler contracts and failed to book per diem staff who were available to work. Fortunately for nurses and patients alike, the state denied HCA's staffing waiver request and revoked another that was in place after hearing the experiences of NNU members working in HCA facilities.

The dangerous application of “just-in-time” models to health care.

“Just-in-time” supply chain management is a business model that attempts to have supplies arrive precisely when needed by (1) eliminating labor and other operating costs associated with putting things away in storage closets and warehouses and pulling them as needed, (2) freeing up the space used by the storage closet for other purposes, and (3) eliminating the need for warehouses which reduces real estate purchase or lease costs. Hospitals inappropriately apply this manufacturing industry model to health care, placing nurses and patients in danger.

HOSPITAL EMPLOYERS PUT NURSES IN DANGER OF INJURY AND ILLNESS ON THE JOB

Hospitals regularly fail to take preventive measures known to protect nurses from occupational hazards such as workplace violence,¹¹ back and other musculoskeletal injuries,¹² and infectious diseases, including Covid-19.¹³ Working conditions have dramatically deteriorated during the pandemic as hospitals continue to fail to take protective measures that the science of industrial hygiene has long known can prevent workplace exposure to airborne viruses, such as SARS-CoV-2, the virus that causes Covid-19.¹⁴

Nurses face high rates of workplace violence and back injuries. According to the U.S. Bureau of Labor Statistics (BLS), in 2020, registered nurses in private industry in the United States experienced a rate of 18.2 nonfatal violence-related injuries per 10,000 full-time employees.¹⁵ The violence-related injury rate for registered nurses is more than four and a half times higher than the violence-related injuries for workers overall in the same year.¹⁶ Compared to pre-pandemic violence-related injury rates, the rate of workplace violence injuries for RNs in private industry has increased by 30 percent.¹⁷ With respect to back injuries, RNs in the United States experienced a rate of 53.0 nonfatal musculoskeletal disorders and a rate of 30.1 nonfatal back injuries per 10,000 full-time employees in 2020. RN musculoskeletal disorder rates are nearly twice as high than the rate for workers overall, and RN back injuries are more than twice as high as the rate for workers overall.¹⁸

Further, when hospital employers intentionally adopt policies of understaffing, this places RNs at higher risk of occupational injuries and illnesses. When hospital employers treat nurses as expendable by failing to staff appropriately and providing key health and safety protections, this comes at a cost: Nurses are forced to leave the bedside workforce after experiencing preventable injuries or illnesses on the job. Several studies show that poor RN staffing levels led to higher rates of nurse occupational injury.

- » An increased patient load per nurse was associated with significantly higher likelihood for neck, shoulder, and back musculoskeletal disorders.¹⁹
- » The risk for workplace violence injuries was twice as high for lower-staffed hospitals as compared to higher-staffed hospitals.²⁰
- » Nurses from units with low staffing and poor organizational climates were twice as likely as nurses on well-staffed and better organized units to report risk factors for needlestick injuries and near misses.²¹

Finally, during the ongoing Covid-19 pandemic, RNs are more likely to be exposed to and infected with Covid-19 when they work under unsafe conditions without adequate personal protective equipment, isolation precautions, testing, contact tracing, and the full range of precautions, further sidelining them from caring for patients.

THE HOSPITAL INDUSTRY DEVALUES RNS' PROFESSIONAL PRACTICE AND RESTRICTS THEIR AUTONOMY

The hospital industry devalues RNs' professional practice and restricts their autonomy in myriad ways. Most notably, the industry focus on patient satisfaction scores and the routinization that breaks holistic nursing care into discrete tasks have been particularly troublesome for nurses. Both trends are driven by the industry goal of maximizing net revenue and restricts the autonomy nurses have to use their knowledge and experience to care for their patients.

In its preoccupation with patient satisfaction scores, the hospital industry typically focuses on managing patients' perception of their clinical care rather than on improving their clinical care, which ultimately degrades RNs' professional practice.²² The Centers for Medicare and Medicaid Services (CMS) began requiring hospitals to report their patient satisfaction scores using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey as mandated by the Deficit Reduction Act of 2005, though hospitals began surveying patients for marketing purposes prior to the CMS requirement. Reporting survey data was required to receive full Medicare reimbursement but was not affected by how the hospital scored on the surveys. In October 2012, CMS began calculating hospital incentive payments based in part on how the hospital scores on HCAHPS patient satisfaction surveys, as required by the Patient Protection and Affordable Care Act of 2010.

To improve patient satisfaction scores, and thus maximize CMS incentive payments, many hospitals have adopted rigid customer service practices such as scripting of nurse-patient interactions. Unfortunately, scripting comes at the expense of RN autonomy, their professional practice, and, in some cases, appropriate clinical treatment.²³ As the name suggests, scripting requires nurses to use specific language when talking to patients.²⁴ For example, the AIDET model for patient interactions, developed by

management consultant the Studer Group, is used widely in the hospital industry. AIDET stands for "Acknowledge, Introduce, Duration, Explanation, Thank you."²⁵ Looking at some of the ways AIDET is implemented reveals both how rigidly controlled RN-patient interactions can be and how they are designed to manage patients' perceptions of their care. As part of the "Acknowledge" step, staff may be directed to "[f]ollow the 10 and 5 Rule: at 10 feet, look up and acknowledge, make eye contact, and smile; at five feet, verbally greet and offer assistance if necessary."²⁶ According to one description of the AIDET model: "Staff members trained in AIDET are encouraged to use the words 'excellent' and 'thank you' liberally."²⁷ For example, some scripts require nurses to ask: "Is there anything I can do to make your stay more excellent?" to prompt patients to rate the hospital as excellent on surveys.²⁸ As part of the Duration step, staff are encouraged to "[u]nder-promise and over-deliver" and told: "There are two types of time: real and perceived. Understand both."²⁹

Nurses are stilted and inauthentic while using a script to interact with their patients. Scripting of nurse-patient interactions also leads to substantial dissatisfaction among nurses who are disrespected and devalued when their employer focuses on financial returns rather than sufficient staffing and resources. It also undermines the nurse-patient relationship, which is essential to optimizing health care outcomes, when patients are treated as "customers," rather than patients. These excerpts from RN letters responding to an article about patient satisfaction metrics capture this sentiment:

Instead of institutions spending money to hire consultants to teach nurses customer service, strategies need to be developed by the nursing leadership to get nurses back to the bedside and alleviate patient concerns that nurses aren't spending enough time with them. Nurses can best recognize and address these concerns when given the chance to develop meaningful relationships with their patients.³⁰

Organizations need to focus more on providing the resources, staffing, and education necessary to enhance patient outcomes. By ensuring that quality care is delivered, patient satisfaction initiatives will be successful.³¹

Additionally, most hospitals require RNs to follow instructions from algorithms embedded in electronic health records, often leaving nurses with little discretion to exercise their professional judgment even when it is in the best interest of their patient.³² Rather than providing patient care, they spend much of their time entering information into these systems and then adjusting for the systems' failures to account for the complexity of the hospital environment.³³ The hospital industry's routinization of RN work, coupled with legislative and regulatory moves to weaken RN's scope of practice, enables employers to break apart nursing care, which is an inherently holistic practice, into discrete tasks that can be parceled out to unlicensed and lower-licensed staff, thus reducing labor costs. These hospital industry practices were taken directly from the manufacturing industry's practices of assembly lines and the deskilling of work. Whatever the merits or demerits of these practices in the manufacturing sector, they are unsuited to hospitals and the art and science of healing.

The routinization of RN work fragments patient care and endangers patients.³⁴ These hospital policies first decouple RNs' knowledge and clinical expertise from the holistic practice of directly assessing patient needs, implementing needed care, and regularly evaluating the patient's condition. Then, these practices allocate tasks to staff without sufficient education and clinical experience. Under these "team-based care" models, RNs spend less time at the bedside where they can get to know a particular patient's needs and use their professional judgment to ensure that the patient's needs are met. Instead, they spend more time on paperwork and monitoring the work of other staff, leaving RNs demoralized and alienated.³⁵

THE HOSPITAL INDUSTRY'S RESISTANCE TO HIRING RNS WITH ASSOCIATE DEGREES IN NURSING EXACERBATES THE STAFFING CRISIS AND UNDERMINES RN WORKFORCE RACIAL AND ETHNIC DIVERSITY

Hospitals have increasingly adopted the arbitrary hiring practice of excluding nurses with associate degrees in nursing (ADNs) from consideration for open nursing positions, dramatically reducing the pool of potential nurses available to provide patient care. Hospitals more frequently require that RNs have a bachelor's degree of nursing and fail to hire RNs with ADNs regardless of how many years of experience they have providing bedside nursing care as an RN. Additionally, requiring RNs to have bachelor of science in nursing (BSN) degrees doubles the amount of education time required — from two years to four years — for a nurse to be licensed.³⁶

A review of the RN education and examination requirements demonstrates that fulfilling licensure prerequisites should serve as the entry point to bedside nursing practice. RN licensure does not depend on whether a nurse has an ADN or BSN. Becoming an RN is a two-fold process: graduating from a nursing program approved by a state board of nursing and passing the National Council Licensure Examination (NCLEX). All RNs must fulfill both classroom science-based education requirements and hands-on clinical experience requirements. Both ADN and BSN programs have similar core curricula for in-class education, with differences between the two largely oriented around RN career paths such as teaching, research, health policy, and management in BSN programs and a greater focus on bedside patient care in ADN programs. Turning to clinical experience, ADN and BSN nursing programs also require a similar number of clinical hours.³⁷ Additionally, state boards of nursing that specified a minimum number of clinical hours for ADN and BSN degrees nearly always specified an identical

number of hours for both programs.³⁸ After meeting educational prerequisites to becoming an RN, the final licensure requirement for all U.S. nurses is to pass the NCLEX exam which “has been designed as a legally defensible, psychometrically sound examination to measure student readiness for entry-to-practice.”³⁹ Of note, first-time passage rates of the NCLEX exam, a widely accepted outcome measure for nursing education, are similar for graduates of both ADN and BSN programs.⁴⁰

Not only does requiring a BSN for employment as a bedside RN slow the RN education pipeline, the additional financial and time requirements for nursing students to obtain a BSN over an ADN also undermines racial, ethnic, and other socioeconomic diversity in the nursing workforce. Among the RN workforce, only non-Hispanic white, Native Hawaiian, and other Pacific Islander RNs meet or exceed their representation in the general U.S. population.

Latinx and Black nurses are most underrepresented, with the gap between the percentage of the population at approximately 8.1 percent for Latinx RNs and 4.7 percent for Black RNs.⁴¹ Additionally, a review of the RN graduates from 2015 to 2019 shows that more American Indian/Alaskan Native, Black, and Latinx RNs graduated with an ADN than a BSN, averaging respectively 1.64, 1.58, and 1.45 ADN graduates for every BSN graduate compared to white and Asian RNs respectively averaging 1.11 and 0.80 ADN graduates for every BSN graduate. Finally, requiring a BSN compared to an ADN for employment undermines nursing as an avenue of upward economic mobility for the working class, particularly women of color, as well as those with child or elder care responsibilities who may find it more difficult to meet the time or financial commitment required for a BSN.



PART II. HOSPITAL INDUSTRY PRACTICES DURING THE COVID-19 PANDEMIC CAUSED NURSES DETRIMENTAL MENTAL HEALTH EFFECTS, PROFOUND MORAL DISTRESS, AND MORAL INJURY

Nurses' working conditions have deteriorated further since the pandemic began. With the onset of the pandemic, the hospital industry compounded the issues discussed above by its flagrant refusal to protect nurses from exposure and infection from Covid-19, treating RNs as disposable. Nurses caring for Covid patients experience both high rates of infections and deaths and high rates of acute stress, anxiety, depression, and post-traumatic stress as well as moral distress and moral injury, causing them to leave the bedside at high rates.

THE FAILURE OF THE HOSPITAL INDUSTRY TO PREPARE FOR COVID-19 SURGES CAUSED HIGH RATES OF INFECTION, ILLNESS, AND DEATH IN NURSES

The Hospital Industry Failed to Prepare for Covid-19 Patient Surges

NNU sent its first letter to hospital management at all hospitals where the union represents nurses in January 2020, requesting information on their pandemic response plans and urging them to plan for predictable staffing needs, including hiring and training more nurses to work in critical care departments. We have continued to urge them to do so throughout the pandemic in words and deeds — including numerous worksite actions. NNU publicly sounded the alarm on hospitals' lack of preparation in late February 2020, identifying concerns with “optimal staffing, equipment, and supplies” as well as a widespread lack of planning for isolating patients with confirmed or suspected Covid-19 infections.⁴² In March 2020, NNU filed more than 125 complaints with Occupational Safety and Health Administration (OSHA) in 16 states, charging hospitals with failing to provide safe workplaces as required by law. Once again, NNU focused on hospitals'

failure to provide lifesaving PPE, but also addressed other health and safety issues such as failure to isolate patients who had, or may have had, a Covid-19 infection.⁴³

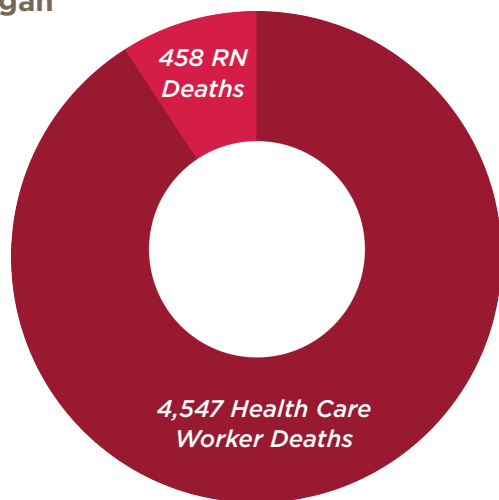
The hospital industry's “just-in-time” model that tightly manages inventory has been disastrous during the Covid-19 pandemic.⁴⁴ Although infectious disease surges are unpredictable, they are inevitable. Hospitals should have been better prepared, especially in the instance of Covid-19 because the initial outbreak in China in late 2019 should have rung alarm bells in U.S. hospitals and with federal and state governments. Yet because employers prioritized profits over preparedness, RNs were forced to choose between staying on the job and caring for their patients, who are also at risk of infection from nurses' lack of PPE,⁴⁵ or staying home to protect themselves and their families. For months into the pandemic,

What is moral distress and moral injury?

Moral distress arises when one knows the right thing to do, but institutional constraints and broader sociopolitical contexts make it nearly impossible to pursue the right course of action.⁴⁶

Moral injury is the deleterious long-term, emotional, psychological, behavioral, spiritual, and/or social effects that may result from potentially morally injurious events, such as perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment.

Figure 1. **Known Covid-19 Deaths of RNs and Health Care Workers Since Pandemic Began**



very few nurses, even those working directly with confirmed Covid-19 patients, had access to appropriate PPE on an as-needed basis. Instead, nurses were forced to go without or to wear PPE manufactured for a single use for days on end. Some nurses were forced to use garbage bags when their employer ran out of surgical gowns.⁴⁷ Those who did have access to PPE in the pandemic's early stages generally had to fight for it. Although PPE was a key issue for nurses, it was far from the only issue. Employers also failed to screen and test patients for Covid-19,⁴⁸ to notify nurses of a Covid-19 exposure,⁴⁹ and to provide testing and sick leave while awaiting test results. This is not an exhaustive list of their failings.

The Hospital Industry's Failure to Prepare for Patient Surges Resulted in High Covid-19 RN Infection and Death Rates

Although this is certainly an undercount, as of Nov. 3, 2021, at least 1,037,183 health care workers in the United States have been infected with SARS-CoV-2, the virus that causes Covid-19, including thousands of nurses, and at least 4,547 health care workers have died from Covid-19 and related complications, including 458 RNs.⁵⁰

There have been racial disparities in the impacts of Covid-19 on the RN workforce.

Among RNs who have died from Covid-19 and whose race and ethnicity are known, 50.1 percent are white, 22.0 percent are Filipinx, 17.6 percent are Black, 7.6 percent are Latinx, 2.1 percent are other Asian (non-Filipinx), and 0.7 percent are Native American.⁵¹ In sum, nurses of color comprise 49.9 percent of the nurse deaths⁵² but only 24.1 percent of the RN workforce.⁵³ In addition, only 4.0 percent of the RN workforce are Filipinx⁵⁴ and only 12.4 percent are Black, thus these nurses are dying at far greater rates than their white colleagues.⁵⁵ In a report focusing on U.S. Filipinx health care workers, STAT news explains the increased risk of Filipinx health care workers compared to other health care workers as due to a higher likelihood of working in hospital settings treating Covid-19 patients rather than in other health care settings.⁵⁶

Similarly, sociologist Adia Wingfield contends that Black nurses may be at higher risk based on their desire to give back to their communities and others in need as they are more likely to work in underfunded health care facilities serving communities where Covid-19 is ravaging Black, Latinx, low-income, and/or uninsured patients and lacking sufficient equipment and staff.⁵⁷ A study of frontline health care workers in the United States and the United Kingdom confirms the significant racial and ethnic disparities among RNs who die from Covid-19. This study found that Black, Asian, Latinx, and other health care workers of color contracted Covid-19 at nearly twice the rate of non-Hispanic, white health care workers.⁵⁸ It also found that non-white health care workers reported having to reuse PPE or having inadequate access to PPE at 1.5 times the rate of non-Hispanic white health care workers, even after adjusting for exposure to patients with Covid-19.⁵⁹ Additionally, the Office of the Inspector General for the U.S. Department of Health and Human Services, reporting on the hospital industry's response to the pandemic, confirmed that "widespread shortages of PPE put staff and patients at risk[.]"⁶⁰ Thus many, perhaps most, RN infections and deaths could have been prevented but for the utter failure of their employers to provide them appropriate personal protective equipment.

THE HOSPITAL INDUSTRY'S ACTIVE TRANSGRESSIONS AGAINST RNS COMPOUNDED ITS FAILURE TO PREPARE FOR THE PANDEMIC, ADDING INSULT TO INJURY

The hospital industry's widespread disregard for nurses' well-being throughout the course of the pandemic is undeniable. Moreover, the industry's misdeeds extend beyond mere negligence; it actively opposed measures that would protect nurses from exposure to Covid-19 or compensate them if they contract the virus.

The most egregious active transgression against RNs by the hospital industry is the failure to follow the precautionary principle and provide nurses with optimal respiratory protection. Rather than admitting the failure to prepare for the pandemic or advocating for government assistance to supply optimal levels of respiratory protection, the hospital industry shored up arguments for denying nurses respirators, claiming that respiratory protection was unnecessary except for specific surgical and aerosolizing procedures (e.g., intubation) and, at the beginning of the pandemic, denying outright that the virus was airborne, then shifting to downplaying the evidence for airborne transmission or claiming that the evidence was inconclusive as recently as March 11, 2021.⁶¹ Yet since the pandemic began, numerous studies have demonstrated that the virus is airborne,⁶² thus making respirators critical to preventing

infections among health care workers.⁶³ Regardless, given any uncertainty about Covid-19's mode of transmission, employers should have adhered to the precautionary principle, which holds that we ought not wait until we know for certain that something is harmful before action is taken to protect people's health.⁶⁴ The hospital industry's active opposition to providing nurses with respiratory protection exemplifies a failure to recognize nurses' innate value as human beings.

Hospital employers actively opposed nurses who pled with them and the government for PPE on the front lines of the pandemic. When RNs attempted to secure needed PPE by asking for donations on social media, speaking with the press, and holding public protests to expose their employers' failures, employers responded with disparagement and abuse. Some employers prohibited workers from speaking out⁶⁵ and fired workers for doing so.⁶⁶ Other employers went so far as to prohibit RNs from bringing in their own respirators⁶⁷ and even "yank[ed] masks off workers' faces[.]"⁶⁸ In cases where employers capitulated to nurses' collective demand for respirators, some continued to deny that respirators were necessary to protect nurses from Covid-19, asserting that they were providing respirators to make RNs feel more comfortable, not to prevent exposure to the virus. And even then, many employers forced nurses to reuse respirators with multiple patients, and often on multiple shifts, even though this practice is known to be unsafe and to contribute to the spread of infectious diseases.

In the legislative arena, the American Hospital Association (AHA), representing hospitals that employ a majority of RNs, vigorously opposed the inclusion of a requirement for OSHA to issue an emergency temporary infectious disease standard requiring respiratory protection in H.R. 6201, the Families First Coronavirus Response Act, and in H.R. 6800, the Health and Economic Recovery Omnibus Emergency Solutions Act.⁶⁹ Contrary to scientific consensus, the AHA denied the need for respirators as recently as March 11, 2021 in Congressional testimony:

Given any uncertainty about Covid-19's mode of transmission, employers should have adhered to the precautionary principle, which holds that we ought not wait until we know for certain that something is harmful before action is taken to protect people's health.

The CDC continues to hold that COVID-19 is primarily spread through close contact, not airborne transmission, except when doing certain aerosolizing procedures. ... For health care workers, CDC continues to recommend as appropriate the use of facemasks unless workers are performing aerosolizing procedures or procedures that require very close contact with patients with suspected or confirmed COVID-19 infection.⁷⁰

As stated, the AHA relied on weak CDC guidance in its March 11 testimony — guidance that state hospital associations lobbied for. At the onset of the pandemic, the CDC called for precautions against airborne transmission of SARS-CoV-2. However, concurrently with the urging of California and Washington state hospital associations,⁷¹ the CDC began downgrading its guidance from airborne to droplet precautions and removed the requirement to provide respirators to health care workers except for during aerosol-generating procedures. Finally, in May 2021, the CDC unambiguously acknowledged that Covid-19 is an airborne infectious disease and updated guidance on respirator use stating: “The supply and availability of NIOSH-approved respirators have increased significantly over the last several months. Health care facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices[.]”⁷²

RNs advocated for more than a year and a half for OSHA to issue the Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS). OSHA issued the Covid-19 Health Care ETS in June 2021 despite opposition from the hospital industry.⁷³ This exceedingly important step by the federal government provided mechanisms for nurses to challenge their employers’ continued refusal to recognize the science of Covid-19 and the need for the full range of precautions against aerosol transmission of the virus, including optimal respiratory protections. Since the issuance of the ETS, nurses have campaigned to ensure the hospital industry fully complies with ETS requirements, filing numerous OSHA complaints over failures to provide appropriate respiratory protection

and other compliance issues. However, Arizona, Utah, and South Carolina failed to implement Covid-19 standards that are at least as effective as the federal Covid-19 Health Care ETS as they are required to do as state-run OSHA plans. NNU filed an official “Complaint About State Program Administration” against Arizona with federal OSHA, which is now considering taking over enforcement for these three noncompliant states.

NNU continues to vigorously advocate for nurses and their patients to protect them from the ramifications of the hospital industry’s lack of preparedness for Covid-19 and their active resistance to implementing appropriate health and safety protections. Even with the OSHA ETS on Covid-19 for health care settings, many nurses continue to lack appropriate respiratory protection, according to NNU’s latest survey covering June and July 2021.⁷⁴ More than 5,000 RNs from all 50 states, D.C., and Puerto Rico responded. Approximately 60 percent of RNs working in hospitals reported wearing a respirator each time they interacted with a Covid-positive patient, down from nearly 75 percent in our March 2021 survey. In addition, 62 percent reported using surgical masks, which are inadequate to protect health care workers caring for Covid-19 patients, when caring for patients suspected of having Covid-19, or patients awaiting test results.

Lastly, hospital employers opposed RNs’ workers’ compensation claims, taking calculated steps to insist that the thousands of nurses infected because of employers’ reprehensible behavior did not contract the virus on the job. Through their own refusal to test nurses, other health care workers, and patients for Covid-19, employers manufactured a situation where nurses would almost certainly lack the direct evidence of workplace exposure needed to prove a workers’ compensation claim. As nurses became sick, hospital employers went so far as to issue blanket statements that most nurses were infected in the community despite the much higher infection rates among nurses and the fact that many nurses remained isolated from family, friends, and the community at large out of fear they might spread Covid-19.⁷⁵

UNSAFE WORKING CONDITIONS DURING THE PANDEMIC SEVERELY IMPACTED RN MENTAL HEALTH

Hospital employers' lack of planning and reprehensible behavior have also dramatically and detrimentally affected RN mental health. The intense internal conflict and dissonance nurses have been experiencing during the Covid-19 pandemic is driven by the tension between taking care of themselves or their families, on the one hand, and caring for their patients, on the other.⁷⁶ For some, the tension between sheltering in place with their families and their calling to care for their patients has led to traumatic stress, anxiety, and depression.⁷⁷ The lack of proper PPE, discussed above, played a fundamental role in this tension. Nurses fear contracting the virus themselves, particularly if their age or a medical condition make them more vulnerable to serious illness or death. In addition, motivated by love and concern, some worry about the effect that contracting Covid-19 would have on their children, spouses, and elderly family members who depend on them, especially if they succumbed to the illness.⁷⁸

For many RNs, their greatest fear is carrying the disease home and infecting their families — especially if any of their family members is in a high-risk group for serious illness or death.⁷⁹ Nurses and other health care workers spoke out early in the pandemic about their fears for their families. For example, the *Washington Post* quoted a nurse from New York describing her experience and that of her coworkers:

“There is a tremendous amount of fear and guilt that we could bring this home and hurt people that we love,” said Jane Gerencser, a nurse who has been working 12-hour shifts tending to coronavirus patients at a Westchester Medical Center Health Network hospital in New York state. “We have had colleagues who lived with elderly parents, who unfortunately have gotten sick and have had their parents get sick and passed.”⁸⁰

News reports and journal articles describe the extreme measures that health care workers

who, knowing that they were at high risk of Covid-19 infection, took to protect their families from being exposed. The *Washington Post* article cited above details “meticulous cleansing rituals” health care workers practice to protect family members from infection from virus on their persons or clothing.⁸¹ An article from the *Journal of Medical Ethics* describes the “highly burdensome measures” one nurse took to protect her family: “stripping naked” and depositing her clothes in the washer, wiping down all the surfaces she’s touched with disinfectant, showering, disinfecting more surfaces — all before greeting her family.⁸² Even after taking these precautions, she maintained her distance by staying “6 feet away from everyone [she] love[s.]”⁸³ Some nurses avoided their families completely by using separate bathrooms; sleeping in spare rooms, attics, tents, or their cars; and eating their meals alone. Those who could afford it opted for hotel rooms or rented RVs.⁸⁴

Regardless of whether they sleep at home, many nurses have been separated from their families for extended periods of time.⁸⁵ Talisa Hardin, a nurse working on a unit for persons under investigation for Covid-19, testified about her experience before the Select Subcommittee on the Coronavirus Crisis of the House Oversight Committee:

For me, the lack of protections in my unit have forced me to send my daughter away to live with my mother during the course of the pandemic. I don’t want to pass this virus on to my daughter or my mother. ... It has been more than five weeks since I last saw my daughter in person, and I don’t know when I’ll see her again. It has been deeply devastating for both of us to take these precautions. My daughter is so frustrated by the situation that she consistently asks me to come home and has recently asked me to quit my job. She follows the news, and she knows that I am at a heightened risk of contracting COVID-19 because my hospital is not giving me the protections I need. She is worried, she is scared, and she is experiencing separation anxiety.⁸⁶

Many nurses sent their children away voluntarily to protect them.⁸⁷ Others were forced to give up custody of their children, at least temporarily, when noncustodial parents took them to court, fearing their children might become infected with Covid-19.⁸⁸

Similarly, family members frequently experienced their own psychological distress and trauma related to the risks a nurse faces on the job, which in turn may exacerbate nurses' moral distress.⁸⁹ In a *New York Times* article titled "What Happens If You and Daddy Die," discussing the effects nurse exposure to the virus has on family members, the author notes that "[c]hildren of doctors and nurses have kept anguished journals, written parents goodbye letters and created detailed plans in case they never see their moms or dads again[.]"⁹⁰ Family members — especially children — may ask health care workers to leave their jobs.⁹¹

In some cases, nurses cannot meet the responsibilities to their families and also care for their patients. When nurses isolate to protect their families or work for weeks without a day off, others must assume the responsibilities they set aside, for example, assisting with childcare, homeschooling, meal preparation, and other household chores. This creates a hardship for both the nurses and their families at a time when the negative psychological impacts of the pandemic increased — particularly among health care workers but also in the general population.⁹² More importantly, at a time when family members needed to draw comfort from one another due to the stress and anxiety of the pandemic, extended sheltering in place, and physical distancing, nurses' separation from their families deprived them of this comfort. Additionally, family members have the added worry about their loved ones working on the pandemic's front lines. Thus, entire families have made tremendous sacrifices, even if they have not lost a loved one to Covid-19.

Although conditions have improved for many nurses since the first year of the pandemic, patient surges continue to wax and wane across the country. The pandemic's widespread adverse mental health effects among nurses continue and may persist for years.

Common, interrelated themes in the mental health research among U.S. health care workers include fear of contracting Covid-19, fear of infecting family members, tension between caring for themselves and families versus going to work and taking care of patients, long hours and heavy workloads, lack of knowledge about the virus, and lack of treatment options.⁹³ A *JAMA Viewpoint* piece published in early April 2020 reported health care worker concerns based on semi-structured "listening sessions" with U.S. nurses, doctors, and other clinicians.⁹⁴ Their chief anxieties included access to appropriate PPE, exposure to Covid-19, infecting family members, and clinical knowledge in treating a novel virus along with several related concerns about meeting family responsibilities while working long hours treating patients. A study based on 657 completed surveys of health care workers treating Covid-19 patients in a New York City hospital at the height of its April 2020 surge, April 9 to April 24, quantifies the level of distress they experienced. (Table 1) RNs showed high levels of acute stress (64 percent), depression (53 percent), and anxiety (40 percent). In contrast, attending physicians had lower rates than RNs across the board: acute stress (40 percent), depression (38 percent), and anxiety (15 percent). In sum, RNs experienced much higher levels of distress than attending physicians in all three areas by significant margins: 24 percent, 15 percent, and 25 percent, respectively.

Table 1. Top Sources of Distress Among All New York City Hospital Survey Respondents, April 2020

Top sources of distress	Percentage of respondents
Infecting family members with Covid-19	74%
Lack of control in the clinical setting	70%
Lack of PPE and lack of Covid-19 testing	68%
Loneliness	65%

Finally, a study based on a small May 2021 survey of RNs and licensed practical nurses who cared for Covid-19 patients, based largely in the upper Midwest, found that 58.7 percent showed a risk of PTSD based on their score on the Trauma Screening Questionnaire.⁹⁵ This study did not link these scores to specific work- or home-related experiences.

NNU has been conducting surveys of RNs throughout the pandemic.⁹⁶ A survey of nurses during the period Oct. 16 to Nov. 9, 2020 with responses from across the United States (and some responses from U.S. territories) found that 70 percent of hospital RNs feared getting Covid-19 and 80 percent feared that they would infect a family member. (Table 2) Large majorities also reported experiencing higher levels of insomnia, anxiety, stress, and depression than they did before the pandemic.⁹⁷ The most recent survey of nurses covers the period June 1 to July 21, 2021 with responses from all 50 states, Washington, D.C., and Puerto Rico. (Table 3) Although their experiences show some improvement, the pandemic clearly continues to negatively affect the mental health of hospital RNs with 42 percent fearing they will contract Covid-19, 50 percent fearing they will infect a family member, and 34 feeling traumatized by their experiences caring for patients. In comparing their current mental state to prior to the pandemic, 35 percent are having more difficulty sleeping, 54 percent feel stressed more often, and 42 percent feel sad or depressed more often.

News reports, particularly during the earlier surges, demonstrate that U.S. health care workers are also experiencing stigmatization which may contribute to adverse mental health issues. The CDC identifies Asian Americans, Pacific Islanders, and Black Americans among those who may be subject to stigmatization and discrimination in the current pandemic.⁹⁸ Anti-Asian racism adds another layer of trauma, anxiety, and depression on nurses of Asian and Pacific Islander descent who are overrepresented in the U.S. health care workforce,⁹⁹ particularly Filipinx and Filipinx-American nurses.¹⁰⁰ Similarly for Black health care workers, the anti-Black racism and white supremacy espoused by President Trump, and rampant

Table 2. Large Percentages of RNs Fear Contracting and Passing Covid-19

Hospital RN responses	Percentage of respondents
Feared contracting Covid-19	70%
Feared they would infect a family member	80%

Table 3. Indicators of Distressed Mental Health Condition Among Hospital RNs

Hospital RN responses	Percentage of respondents
Feared contracting Covid-19	42%
Feared they would infect a family member	50%
Felt traumatized by experiences caring for patients	34%
Had more difficulty sleeping, compared to prior to the pandemic	35%
Felt stressed more often, compared to prior to the pandemic	54%
Felt sad or depressed more often, compared to prior to the pandemic	42%

in communities around the country currently, compounds the already substantial detrimental mental health impact of providing patient care during the pandemic. Moreover, this comes on top of higher baseline levels of stress and emotional exhaustion Black health care workers may experience from defending their patients against racist attitudes and treatment from other health care workers.¹⁰¹ Taken together, the cumulative effects are causing some Black health care workers to experience debilitating depression and trauma.¹⁰²

CRISIS STANDARDS OF PATIENT CARE, RATIONING, AND UNNECESSARY DEATH CAUSED RNS EXTREME MORAL DISTRESS, INJURING THEM FURTHER

Widespread rationing and crisis standards of care have been in use across the country during patient surges. The negative impact this has on patient care was recently confirmed by a study in *Annals of Internal Medicine* covering the months of March to August 2020. The study found that 23.2 percent of Covid deaths during that time period were likely due to patient surges that stretched resources too thin, despite greater understanding of the Covid-19 disease process and improvements in treatment that should have decreased mortality rates.¹⁰³ An increase in the number of patients assigned per nurse was a major factor in the study's calculations of excess mortality.

RNs have experienced extreme moral distress from witnessing the unnecessary death caused by the lack of preparation for surges in Covid-19 cases by the hospital industry, the premature easing of mitigation measures such as masking and social distancing, and the elimination of shelter-in-place orders. Ethics professor Andrew Jameton introduced the concept of *moral distress* in 1984, stating: “*Moral distress* arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.”¹⁰⁴ He elaborated on this concept by breaking it down into three components: “(a) the psychological distress of (b) being in a situation in which one is constrained from acting (c) on what one knows to be right.”¹⁰⁵ Drawing on the work of Varcoe et al., this report broadens part (b) of the definition to include “influences beyond those that would be considered institutional to broader socio-political contexts[.]”¹⁰⁶

Large percentages of hospital RN respondents across multiple NNU surveys have reported worsening staffing conditions during the pandemic.¹⁰⁷ Burdened by a heavy patient load, nurses must witness the suffering and needless death of patients who might have been saved

by appropriate nursing care or medical intervention. Thus, working under crisis standards of patient care leads to profound moral distress and moral injury as well as adverse mental health effects.¹⁰⁸ Crisis standards include rationing care — through insufficient numbers of RNs or staffing with RNs outside their scope of practice or areas of competency — and rationing resources such as PPE, ICU beds, ventilators, and medications.¹⁰⁹ The Hastings Center’s “Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic” states:

In a public health emergency featuring severe respiratory illness, triage decisions may have to be made about level of care (ICU vs. medical ward); initiation of life-sustaining treatment (including CPR and ventilation support); withdrawal of life-sustaining treatment; and referral to palliative (comfort-focused) care if life-sustaining treatment will not be initiated or is withdrawn.¹¹⁰

These decisions are driven by an insufficient number of RNs with ICU experience as well as shortages of beds, medications, equipment, and other medical resources which, in turn, are driven by the lack of pandemic planning, decades-long underfunding of public health, and a privatized, market-based health care system.

Under crisis standards of patient care, nurses face two challenges around staffing: being assigned far more patients than they can care for safely and working outside their areas of competency. Typically, staffing in an ICU requires one experienced ICU nurse to care for **no more than** two patients. It is well established that patient mortality decreases with higher RN-to-patient ratios.¹¹¹ Yet, with staffing for ICUs in short supply during pandemic surges, some hospitals are reassigning nurses who work in other areas of the hospital to the ICU. The Society of Critical Care Medicine has created a crisis ICU staffing model for hospital use that “encourages hospitals to adopt a tiered staffing strategy in pandemic situations such as COVID-19,” using one experienced ICU nurse to oversee

three non-ICU nurses who each care for two patients. Thus, by proxy, the experienced ICU nurse is caring for six patients (two patients for each non-ICU nurse).¹¹²

This attempt to divide the labor between an experienced ICU RN who oversees non-ICU nurses who then carry out nursing “tasks” is untenable and dangerous. The knowledge needed to provide patient care cannot be divorced from the hands-on practice of providing the care — including directly assessing the patient’s needs; determining, planning for, and implementing needed care; and subsequent evaluation. The experienced ICU nurse may experience moral distress because she knows that her patients are at increased risk of death because she has more patients than she can care for safely.¹¹³ In contrast, the non-ICU nurse, lacking the necessary clinical knowledge and experience, may suffer moral distress out of fear of inadvertently harming a patient, thereby violating the most basic ethical principle of medicine and nursing: nonmaleficence (doing no harm).¹¹⁴ In a first-person essay for the STAT news site, RN Jaclyn O’Halloran describes the effect this had on nurses in the Massachusetts hospital where she works: “We are assigned

to work in unfamiliar units, with patients who are outside our expertise, without any training. We’re lost.”¹¹⁵ She adds that many nurses “are scared they’ll make a deadly mistake.”¹¹⁶ Research confirms the detrimental effect working under crisis standards of patient care may have on nurses during the Covid-19 pandemic: “Nurses’ and other professional grief may also be compounded by being unable to care for families and patients as they might wish. Burnout, moral distress and moral injury has been identified as a significant issue in critical care professionals[.]”¹¹⁷

Patient surges and crisis standards of patient care continue to be implemented nearly two years after the first case of Covid-19 was identified in the United States. As Covid-19 surges, the number of patients explodes, and nurses increasingly fall ill with the disease and sometimes die.¹¹⁸ With these overwhelming experiences come moral distress, moral injury, and damaging effects on nurses’ mental health. Although vaccines have eased deaths among RNs, too many are still experiencing avoidable infections, illness, and death because of their employers’ failure to provide necessary safeguards.



HOSPITAL INDUSTRY TRANSGRESSIONS AND INCOMPREHENSIBLE PATIENT ILLNESS AND DEATH CAUSED RNS PROFOUND MORAL INJURY

In considering the effect the pandemic is having on RNs, it is helpful to view their experiences along a “continuum of morally relevant life experiences and corresponding responses” such that morally relevant life experiences progress from moral frustration to moral distress to moral injury corresponding to moral challenges, moral stressors, and morally injurious events, respectively.¹¹⁹ Drawing on work by subject matter experts,¹²⁰ we use the following definition of *moral injury*: the deleterious long-term, emotional, psychological, behavioral, spiritual, and/or social effects that may result from potentially morally injurious events, such as perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment. The discussion in this section will demonstrate that many RNs have experienced profound moral injury during the pandemic.

Note that a person’s role in a potentially morally injurious event will affect their emotional response. In unpacking the concept of moral injury, trauma experts Litz and Kerig explain that those who experience moral injury as a perpetrator of an immoral act or from failing to prevent an immoral act typically respond with internalizing emotions such as guilt and shame, whereas those who experience moral injury as a witness who was unable to prevent an immoral act typically respond with externalizing emotions such as anger and resentment.¹²¹ It is crucial for those affected by potentially morally injurious events to ascribe the blame to the responsible party and not inappropriately take responsibility for failing to prevent a transgression if it was not within their power to do so. Although we have demonstrated that nurses are not the perpetrators of moral injury, they may internalize shame and guilt, nevertheless.

It is paramount that RNs learn to process these emotions and ascribe blame to the appropriate institutions and sociopolitical contexts — and then to fight together to change them.¹²² It is the role of government to change this paradigm altogether so that neither patients nor nurses are put in this position again and that nurses are given the resources they need to fully heal from their effects.

Based on our definition of moral injury, hospital employers are guilty of “perpetrating or failing to prevent acts that transgress deeply held moral beliefs and expectations in a high-stakes environment.” For example, hospital employers, often through trade associations such as the AHA, were active *perpetrators* in opposing an OSHA emergency temporary standard and *failing* to provide appropriate PPE, to test and isolate patients, or to notify workers of Covid exposures. They violated “deeply held moral beliefs and expectations” such as: human beings have innate value and should be protected from harm, people’s health and lives should have priority over making a profit, and it is wrong to lie by commission or omission. Both nurses and patients have “expectations” that the hospital industry will meet moral, legal, and regulatory requirements to maintain a safe and healthy workplace that protects workers and patients. Finally, hospitals are clearly “high-stakes environments,” particularly during the Covid-19 pandemic. As news reports document, too many workers and patients contracted Covid-19 in the hospital, some have died, while others have infected loved ones.¹²³

Therefore, we can expect nurses to sustain moral injury at alarming rates. The risk factors identified by Williamson et al., as well as examples of how nurses may experience moral injury as a result are laid out in Table 4 below.¹²⁴ Williamson et al. are not alone in their concern about the impact of the Covid-19 pandemic on frontline health care workers. Numerous experts expect significant numbers of these workers to experience moral distress and, potentially, long-term moral injury.¹²⁵

Table 4. Moral Injury Risk Factors Experienced by Nurses

Moral injury risk factors ¹²⁶	How RN experiences may embody these risk factors
<p>Increased risk of moral injury if there is loss of life to a vulnerable person (e.g., child, woman, elderly)</p>	<ul style="list-style-type: none"> » A child, vulnerable family member, or friend dies, particularly if infected by the nurse or if the person dies without the nurse being present. » A patient or coworker dies because a nurse wearing contaminated PPE infects them with Covid-19. » A vulnerable patient (e.g., a child or elderly person) under a nurse's care dies. This may be exacerbated if the patient dies alone or if the nurse is: <ul style="list-style-type: none"> › Working in an area outside of the nurse's competency due to Covid-19-related crisis staffing; or › Working under crisis standards of patient care in which insufficient staffing, medical equipment, or supplies are a proximate cause of the death.
<p>Increased risk of moral injury if leaders are perceived to not take responsibility for the event(s) and are unsupportive of staff</p>	<ul style="list-style-type: none"> » A nurse works without appropriate health and safety protections (e.g., insufficient PPE or poor patient isolation protocols) because: <ul style="list-style-type: none"> › Employer denies the need for airborne protections; or › Employer prioritizes profits over worker safety.
<p>Increased risk of moral injury if staff feel unaware or unprepared for emotional/psychological consequences of decisions</p>	<ul style="list-style-type: none"> » A nurse working under crisis standards of patient care in which insufficient staffing, medical equipment, or supplies are a proximate cause of a patient's death. » A nurse caring for patients who are separated from their families because of visitor restrictions.
<p>Increased risk of moral injury if the potentially morally injurious event (PMIE) occurs concurrently with exposure to other traumatic events (e.g., death of loved one)</p>	<ul style="list-style-type: none"> » A nurse, family member, friend, or coworker develops a severe case of Covid-19. » A family member, coworker, or friend dies from Covid-19. » Racism, racial and police violence, or death in the society in which the nurse lives. » A nurse experiences stigma and discrimination.
<p>Increased risk of moral injury if there is a lack of social support following the PMIE.</p>	<ul style="list-style-type: none"> » A nurse is isolating from family and friends to avoid transmitting Covid-19. » An excessive workload keeps a nurse from accessing social support.

PART III. SOLUTIONS: NURSE RETENTION MEASURES

To ensure the ongoing retention of RNs in bedside care jobs, the federal government must adopt enforceable hospital standards on minimum safe RN-to-patient staffing ratios, strong union protections, and safe and healthy working conditions for nurses. There are several concrete legislative and regulatory measures that Congress and the executive branch must support to ensure that hospitals provide good nursing jobs with safe staffing and safe working conditions.

REQUIRE MINIMUM, NUMERICAL, SAFE RN-TO-PATIENT STAFFING RATIOS

CONGRESSIONAL ACTION »

Congress must pass the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (S. 1567, H.R. 3165 in the 117th Congress), which would establish federally mandated safe RN-to-patient ratios limiting the number of patients a registered nurse can care for at one time in U.S. hospitals.¹²⁷

EXECUTIVE AND REGULATORY ACTION »

The executive branch, through the Centers for Medicare and Medicaid Services (CMS), should require that hospitals meet minimum safe RN-to-patient ratios as a condition of participation in Medicare.

To support safe staffing at our hospitals, Congress and the executive branch must champion legislative and regulatory measures that would establish minimum, numerical RN-to-patient ratios in hospitals. Hospitals have no excuse for a staffing crisis they have created. The solution that hospitals can start implementing today is to immediately staff up every unit, on every shift, and create a safe, sustainable work environment where nurses are confident about their ability to provide the best nursing care possible for their patients.

California's success with implementation of its mandated minimum RN-to-patient staffing

ratios law belies industry arguments that there are not enough RNs to comply with mandated RN-to-patient ratios. A study of RN patient loads after the implementation of the state's ratios law found that California hospitals were nearly always in compliance with the ratios just two years after the law's effective date and that California RNs had substantially safer patient loads than RNs in comparison states.¹²⁸ Additionally, studies have shown that minimum RN-to-patient staffing ratios mean better patient outcomes, safer and healthier RNs, lower rates of burnout (also called moral distress), and higher RN job satisfaction.

- » A study linking staffing levels and mortality rates in medical-surgical units found that New Jersey hospitals would have had 13.9 percent fewer patient deaths and Pennsylvania 10.6 percent fewer deaths if they matched California's staffing ratios in medical-surgical units.¹²⁹
- » After implementation of California's RN staffing ratios law, there were significant increases in RN staffing levels in the state, particularly in hospitals with lower staffing pre-implementation, and RN full-time employment grew significantly faster than 15 comparison states (nearly 8 percent).¹³⁰
- » A 2015 study found that the California RN staffing ratios law was associated with a 31.6 percent reduction in occupational injuries and illnesses among RNs working in hospitals in California.¹³¹
- » A survey of California nurses after the implementation of California's ratios law also found that California nurses reported significant improvements in working conditions and job satisfaction.¹³²
- » In a 2018 survey of more than 50,000 RNs, California RNs reported lower rates of "burnout" [researcher's terminology], a key factor in nurse retention. Among survey respondents who had left a job due to burnout, the most frequently cited the reasons for their burnout were "a stressful work environment [...] and inadequate staffing."¹³³

Together, these and other studies demonstrate that the provision of safe and therapeutic patient care depends on RNs having safe patient workloads. In short, California’s safe nurse staffing mandate positively impacts both patient care and the working environment for nurses, improving occupational safety for nurses, and increasing job satisfaction and nurse retention.

Importantly, mandated numerical RN-to-patient ratios should be the preferred government enforcement measure to achieving safe nurse staffing levels at hospitals. A recent study, published in October 2021, compared the impact of California’s state law on mandatory numerical RN-to-patient staffing ratios to other state approaches on nurse staffing laws.¹³⁴ The study found that California’s RN-to-patient ratios mandate resulted in a statistically significant increase in hospital RN staffing while two other approaches — state law requiring reporting of nurse staffing levels and state law requiring hospital staffing committees — had little or no impact on RN staffing levels. In short, mandatory minimum RN-to-patient ratios is the only approach that has been shown to have a positive effect on RN staffing levels.

Finally, as part of CMS’ regulatory authority to establish health and safety standards for hospitals that participate in federal health programs, CMS should add minimum, numerical RN-to-patient ratios as part of its nurse staffing adequacy requirements in its Conditions of Participation (CoPs) agreements with Medicare- and Medicaid-certified providers. Medicare-participating hospitals include nearly all hospitals in the United States and must meet CoPs regarding patient health and safety standards as required under § 1891(e) of the Social Security Act, 42 U.S.C. § 1395x. Current hospital CoPs require that nursing service have “adequate numbers of licensed registered nurses, licensed practical (vocational) nurses,

and other personnel to provide nursing care to all patients as needed” and that “[t]here must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.”¹³⁵ Additionally, CMS hospital certification procedures for evaluating whether hospitals meet CoPs on nurse staffing adequacy currently include a determination of adequate numbers of nurses based on the number of patients.¹³⁶ Nonetheless, the “adequacy” requirement in hospital CoPs includes so little specificity as to be almost meaningless. Moreover, CMS relies on the hospital-funded, non-governmental organization The Joint Commission to conduct Medicare and Medicaid accreditation surveys. Consequently, The Joint Commission, which has a clear conflict of interest, is an inappropriate hospital watchdog for CMS.¹³⁷

Updating CoPs to include detailed standards for Medicare- and Medicaid-certified hospitals is not new to CMS. Indeed, CMS exercised such regulatory authority in November 2021 when it issued regulations to add Covid-19 health care staff vaccination requirements for the vast majority of Medicare- and Medicaid-certified providers.¹³⁸ (Although as of the publication of this report federal district courts have blocked enforcement of the CMS rule on Covid-19 vaccination of health care staff pending appeal, CMS has long-included nurse staffing requirements in hospital CoPs.) CMS has the authority to mandate numerical RN-to-patient staffing ratios for hospitals through Medicare- and Medicaid-certified hospital provider CoPs on nurse staffing adequacy, and CMS has recent precedent in establishing such detailed standards in CoPs. Thus, NNU urges CMS to amend hospital CoP regulations to include mandated, minimum numerical RN-to-patient staffing ratios for hospitals.

ISSUE ENFORCEABLE OCCUPATIONAL HEALTH AND SAFETY STANDARDS TO ENSURE THAT NURSES ARE SAFE ON THE JOB

CONGRESSIONAL ACTION »

Congress must pass legislation requiring that OSHA issue workplace health and safety standards to protect nurses from preventable injury and illness on the job and increasing funding for OSHA enforcement programs, including:

- » *Passing the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1195 in the 117th Congress)*
- » *Increasing funding for OSHA enforcement programs and OSHA hiring of health care-sector inspectors*

EXECUTIVE AND REGULATORY ACTION »

The executive branch, through OSHA, must issue enforceable workplace health and safety standards to protect nurses from injury and illness on the job, including:

Issuing a permanent OSHA standard on Covid-19. A permanent standard on Covid-19, based on the Covid-19 Health Care Emergency Temporary Standard, that follows the precautionary principle and includes requirements on optimal PPE and other precautionary protocols necessary to prevent aerosol transmission of Covid-19.

- » *Issuing an OSHA standard on infectious disease. An infectious disease standard that includes protections against aerosol-transmissible diseases.*
- » *Issuing an OSHA standard on workplace violence prevention in health care and social service settings. A workplace violence prevention standard.¹³⁹*
- » *Issuing an OSHA standard on safe patient handling. A standard on safe patient handling to prevent back and other musculoskeletal injuries.*

- » *Issuing an OSHA directive to improve enforcement activities in the health care sector.*
- » *Hiring and training more OSHA inspectors with health care sector expertise.*

Nurses and other health care workers experience **preventable** workplace injury and illnesses, which can result in nurses taking time off to recover or leaving the profession altogether because of temporary disability or illness, permanent disability, or even death. The Occupational Safety and Health Administration must issue permanent enforceable standards on Covid-19, infectious disease, workplace violence prevention, musculoskeletal injury, and other workplace hazards. These occupational health and safety standards would provide nurses and other health care workers with enforceable tools to ensure hospitals are protecting them from workplace hazards.

In the absence of enforceable workplace health and safety standards from OSHA, employers have failed to adequately protect nurses and other health care workers from Covid-19, other infectious disease, workplace violence, back injuries, and other occupational hazards in health care settings. Employers have legal obligations under the Occupational Safety and Health Act (OSH Act) to provide workers safe and healthful workplaces and Congress tasked OSHA with ensuring “so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources...” including by passing mandatory standards.¹⁴⁰

Importantly, where serious occupational hazards persist despite voluntary measures, OSHA is **required** under the OSH Act to establish mandatory workplace health and safety standards. Congress envisioned in the passage of the OSH Act that all workplace safety standards promulgated by OSHA be highly protective. It recognized that OSHA’s leadership would be necessary in creating uniform standards across the nation, requiring, where conflicts existed among occupational standards, that “the Secretary [of Labor] promulgate the standard which assures the

greatest protection of the safety or health of the affected employees.”¹⁴¹

The Covid-19 pandemic is far from over and OSHA should act to make the Covid-19 Health Care Emergency Temporary Standard (Covid-19 Health Care ETS) permanent.¹⁴² NNU has urged OSHA to move expediently to promulgate a final standard on Covid-19 in health care and to update and to reissue the Covid-19 Health Care ETS until such time as a final standard can be issued.¹⁴³ Variants of concern continue to emerge and spread around the world. Only 24 percent of the world population and just 1.3 percent of people in low-income countries are fully vaccinated for Covid-19, and governments around the world failed to establish comprehensive public health programs to track, trace, and isolate Covid-19 cases.¹⁴⁴

As explained in NNU’s letter to the U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA, the Covid-19 Health Care ETS has supported nurses and other health care workers in holding their employers accountable to protect them and their patients from Covid-19.¹⁴⁵ Through collectively organizing and communicating directly with their employers regarding the requirements of the Covid-19 Health Care ETS, union nurses have won improvements to Covid-related health and safety hazards in their facilities, including gaining access to the employer’s written Covid-19 policies and procedures and Covid-19 logs, getting nurses on Covid-19 units fit-tested for N95 filtering facepiece respirators for the first

time, and returning all PPE to patient care units instead of locking up and rationing this equipment. In order to provide protections to nurses and other health care workers in an ongoing manner, OSHA should issue a permanent Covid-19 standard for health care settings, based on the Covid-19 Health Care ETS.

Additionally, OSHA enforcement efforts must be dramatically scaled up and enhanced to ensure that standards, once issued, can be effectively enforced in both this administration as well as future administrations. While recognizing that the Biden administration has dramatically scaled up OSHA’s enforcement program since taking office in January 2021, Congress must increase funding to hire more OSHA inspectors and to improve OSHA enforcement efforts, and the executive branch should issue a directive to improve enforcement activities in the health care sector where OSHA enforcement historically has been lacking, including through inspector training and programs to hire inspectors with particular experience in health care settings. During the Trump administration, OSHA opened inspections for a slim fraction of complaints filed during the pandemic. As of Jan. 20, 2021, federal OSHA had received 12,831 complaints from workers since the beginning of the pandemic and reported opening a mere 357 inspections in response to complaints (2.8 percent). Under the Biden administration, inspections in response to complaints have risen dramatically, nearly five-fold to 13 percent.¹⁴⁶



STRENGTHEN UNION PROTECTIONS AND THE RIGHT TO ORGANIZE FOR NURSES AND OTHER WORKERS

CONGRESSIONAL ACTION »

Congress must pass legislation to strengthen the collective bargaining rights of nurses and their rights to collectively organize a union and to engage in protected concerted activity to improve their working conditions, including:

- » *Passing the Protecting the Right to Organize (PRO) Act (S. 420, H.R. 842 in the 117th Congress).*
- » *Passing the VA Employee Fairness Act (S. 771, H.R. 1948 in the 117th Congress).*

EXECUTIVE AND REGULATORY ACTION »

The executive branch, through executive order and through regulatory action, must take steps to strengthen and protect the rights of nurses to collectively organize a union and to engage in protected concerted activity to improve their working conditions, including by:

- » *Adopting CMS rules to penalize hospitals that cannot ensure labor peace. The Centers for Medicare and Medicaid Services (CMS) should adopt regulations to subject hospital employers that cannot demonstrate that they can ensure labor peace with a 1 percent Medicare payment reduction penalty each year.*
- » *Supporting the PRO Act and VA Employee Fairness Act. The executive branch should provide its full support for the PRO Act and the VA Employee Fairness Act.*

Union advocacy and representation allow RNs to focus on caring for patients. The benefits of unionization for nurses have never been clearer than during the Covid-19 pandemic. Since the pandemic began, unionized nurses have been able win access to PPE and other worker and patient protections through their union, while nurses in non-union hospitals have found it

more challenging to secure the protections they need. Yet current labor law does far too little to protect and allow workers to exercise our right to join a union. To promote retention of nurses at the bedside and on the front lines of the Covid-19 pandemic, Congress must pass the Protecting the Right to Organize (PRO) Act, which would enhance workers' rights to organize a union and act together to advocate for safe working conditions, to improve their wages and benefits, and to protect their workplace rights through collective bargaining and concerted activity.¹⁴⁷ The PRO Act would ensure that nurses can fully exercise their right to act collectively through their union and have a voice on the job to ensure safe working conditions that prevent death, illness, and injury for themselves, their coworkers, and their patients. The PRO Act is an important step to protecting workers' rights to organize a union and to stop employers' attacks so that every worker can organize without fear of retaliation.

Moreover, certain clinical professionals, including registered nurses, who work at the U.S. Department of Veterans Affairs (VA) caring for veterans have limited collective bargaining under Section 7422 of Title 38 of the U.S. Code. This statute restricts the ability of RNs at the VA to speak out about poor working conditions and patient care issues and to resolve disputes with management. As a result, the quality of patient care can deteriorate and problems in VA facilities can go unaddressed. These statutory limitations to VA nurses' rights to organize must be amended to give VA nurses and other clinicians full collective-bargaining rights, ultimately improving both working conditions for nurses and improving patient care in VA hospitals. The 2021 fiscal year report by the VA Office of the Inspector General found that 73 percent of facilities surveyed had a severe shortage of nurses and that a severe shortage of nurses has been identified every year since 2014.¹⁴⁸ Thus, it is crucial to rectify this matter swiftly and ensure VA nurses have full collective bargaining rights.

Finally, the executive branch, through CMS, must take regulatory action to support unionization of nurses and other hospital workers, which not only would strengthen nurses' ability

to advocate for better working conditions but also, as shown through research literature, improve patient outcomes.¹⁴⁹ Hospital employers are the beneficiaries of federal government health care dollars through Medicare and Medicaid and should be required to show they respect workers' organizing rights.¹⁵⁰ Despite the hospital industry's reliance on federal health care dollars for its continued existence,¹⁵¹ the hospital industry engages in the same kind of union-busting efforts as employers in any other industry, subjecting workers to relentless pressure, fear, and intimidation and spending millions upon millions of dollars in the process — federal health care dollars that should be going to safe patient staffing and care. Thus, to ensure bedside nurses' rights to join together in advocating for safe and healthy working conditions, CMS could impose a 1 percent Medicare payment reduction penalty per year if a hospital engages in conduct deleterious to labor peace, capping penalties at 3 percent, as with other CMS programs that reduce hospital payments for failing to meet certain Medicare standards.



PROVIDE PAID SICK, FAMILY, AND PRECAUTIONARY LEAVE FOR WORKERS

CONGRESSIONAL ACTION »

Congress must pass legislation mandating paid sick, family, and precautionary leave for nurses and other workers.

EXECUTIVE AND REGULATORY ACTION »

The Biden administration, through executive order and through regulatory action, should ensure that all federal workers and federal contractors are entitled to paid sick and family leave beyond the Covid-19 public health emergency.

Paid sick, family, and precautionary leave are essential for nurses' and all workers' ability to stay healthy, take care of their families, and avoid spreading infectious diseases in the workplace. The absence of these critical supports for workers has undermined public health efforts during the Covid-19 pandemic and damages workers' health even outside of pandemic conditions.

The importance of paid sick and family leave has become indisputable during the Covid-19 pandemic and so has the need for paid precautionary leave to quarantine and isolate at home. Paid time covering isolation after every work-related exposure is essential to combating this pandemic. However, federal Covid-19 legislation that Congress passed in 2020 explicitly excluded nurses and other health care workers from mandatory workplace benefits for emergency paid sick and family leave. Congress and the executive branch should ensure that any further legislation on paid sick, family, or precautionary leave includes health care workers. For nurses who are exposed to Covid-19 because of inadequate workplace health and safety protections, their ability to isolate without fear of losing their incomes or their jobs is critical to the safety of their families, patients, communities, and coworkers. No worker should have to use their accrued sick or other paid leave to cover a workplace exposure that occurred because their employer failed to protect them. No nurse should ever have to

choose between their livelihood and the risk of further spreading Covid-19 or other infectious diseases.

Beyond the Covid-19 pandemic, paid sick and family leave are essential to allow workers to recover from illnesses or injuries, prevent the spread of diseases, and care for new children and ill family members while remaining in the workforce. While most union nurses have paid leave guaranteed in their collective bargaining agreements, many workers — including non-union nurses — lack sufficient paid sick and family leave to cover illnesses and injuries that they and their family members may suffer. The Bureau of Labor Statistics (BLS) March 2021 employee benefits survey reported that only 35 percent of RNs in the civilian workforce overall have paid family leave.¹⁵² Additionally, although RNs have high rates of reported access to some form of paid sick leave (93 percent), only 25 percent of RNs have access to paid sick leave with no consolidation of their leave plan with other forms of time off such as vacation or personal leave.¹⁵³

Congress and the executive branch should take steps to guarantee paid leave to all workers. NNU urges Congress to pass legislation requiring paid sick days and paid Family Medical Leave Act (FMLA) leave for all workers and to make any additional appropriations necessary to fund paid FMLA leave for federal workers, extending eligibility for paid FMLA leave permanently beyond the Covid-19 pandemic emergency. The executive branch should build on President Obama's executive order requiring up to seven days of paid leave for federal contractors.¹⁵⁴ The administration must issue similar executive orders requiring paid sick and FMLA leave for federal workers and contractors on a permanent basis, and the Office of Personnel Management and the Office of Federal Contract Compliance Programs must issue rules requiring paid sick and FMLA leave, respectively, for federal employees and for federal contractors.

ADOPT PANDEMIC RISK AND EFFECTS MITIGATION MEASURES TO RESPOND TO THE ONGOING COVID-19 PANDEMIC AND TO PREPARE FOR FUTURE PANDEMICS

CONGRESSIONAL ACTION »

In addition to the other measures listed in this report, NNU urges Congress to pass legislation on workplace protections that we describe in “Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity.”¹⁵⁵

Pandemic Risk Mitigation Measures:

- » *Pass legislation requiring hospitals and government to maintain and report on PPE and medical supply stockpiles*
- » *Pass legislation expanding Defense Production Act of 1950 powers over PPE and medical supply chains during public health emergencies*
- » *Pass legislation prohibiting the reuse and extended use of single-use PPE*

Pandemic Effects Mitigation Measures:

- » *Pass legislation to establish presumptive eligibility for workers’ compensation and disability and death benefits for nurses*
- » *Pass legislation providing free crisis counselling and mental health services to nurses*
- » *Pass legislation on educational debt cancellation for nurses*
- » *Pass legislation establishing social support programs for nurses during public health emergencies (e.g., programs providing free childcare, alternate housing, meals, and transportation)*
- » *Pass legislation to provide nurses essential worker pay*

EXECUTIVE AND REGULATORY ACTION »

In addition to the other measures listed in this report, NNU urges the executive branch to implement other regulatory policies on workplace protections for nurses that we describe in “Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity.”¹⁵⁶

Pandemic Risk Mitigation Measures:

- » *Require hospitals and government to maintain and report on PPE and medical supply stockpiles through CMS regulation*
- » *Fully invoke and exercise Defense Production Act of 1950 powers to coordinate the manufacture and distribution of PPE and medical supplies*
- » *Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19*
- » *Require hospitals to adopt Covid-19 infectious disease precautions, including:*
 - › *Patient isolation, screening, universal masking, and other measures*
 - › *Free vaccines and testing of workers and patients*
 - › *Contact tracing and communication about Covid-19 cases*

Pandemic Effects Mitigation Measures:

- » *Establish presumptive eligibility for disability and death benefits for nurses and workers’ compensation for federally employed nurses*
- » *Require hospitals to provide free crisis counseling and mental health services of the nurse’s choosing*
- » *Take executive action on nurse educational debt cancellation*
- » *Provide essential worker pay for nurses who are federal employees or contractors*

Congress and the executive branch must take the measures listed above to ensure that hospitals are able to retain nurses by providing nurses good, permanent jobs with safe working conditions and strong enforceable workplace protections. As NNU describes in our white paper “Deadly Shame: Redressing the Devaluation of Nurse Labor Through Pandemic Equity,” there are protective measures that the federal government could adopt and enforce immediately to start mitigating this unequal risk of contracting and transmitting Covid-19 borne by our nurses and their families during the Covid-19 pandemic. These pandemic mitigation policies can be conceptualized into two broad categories — risk mitigation and effects mitigation. Risk mitigation measures are policies that reduce the risk of exposure to Covid-19 and other infectious disease borne by our nurses, other health care workers, and their families. Risk mitigation measures protect workers from exposure in the first place. In contrast, effects mitigation measures are policies that government can implement to redress the impact of nurses’ exposure to or contraction of Covid-19 or other infectious disease. These measures support nurses and their families who are exposed to or contract Covid-19. This framework reflects the fact that valuing and protecting the lives of nurses and other health care workers during this pandemic requires a range of interventions.

Importantly, risk mitigation measures and effects mitigation measures should never be treated as substitutes for one another. Remedying the impact of Covid-19 exposure through additional pay or other compensation and benefits does not excuse an employer or the government from their legal and moral obligations to provide safe workplaces for nurses and other essential workers. Measures that may remedy the physical, mental, financial, or other effects of forced occupational exposure to Covid-19 must not be treated as trade-offs for measures that would prevent workplace exposure at the outset and would protect the lives and health of nurses, patients, and their families and communities. These effects mitigation measures do not excuse government from its legal and moral obligation to establish and

enforce worker protection laws. This is particularly true when infectious disease science has long demonstrated that the risk of occupational exposure to aerosolized diseases, like Covid-19, can be reduced significantly.

Pandemic Risk Mitigation Measures

Adopting Optimal PPE and Other Medical Supply Chain Measures. Throughout the pandemic, many nurses across the country have not had the necessary PPE to provide care to their patients safely. This failure to ensure that PPE stock and supply is immediately accessible at each facility leaves nurses exposed to Covid-19, which has had deadly consequences for nurses, their patients, and their families. Hospital employers’ rationing of PPE and other medical supplies left nurses unprotected from Covid-19 and other infectious disease, pushing nurses away from the bedside due to unnecessary exposure and preventable illness and death.

- » **Require Employer and Government Maintenance of PPE and Medical Supply Stockpiles:** To ensure that nurses are never again left unprotected while caring for patients, hospitals and government must always be prepared for potential public health emergencies by maintaining stockpiles of PPE and medical supplies. Congress and the executive branch must end “just-in-time” supply practices for PPE and medical supplies by requiring hospitals and government at all levels to maintain PPE and medical supplies stockpiles.
- » **Fully Exercise Defense Protection Act of 1950 Powers:** The DPA must be fully invoked on day one of public health emergencies to dramatically ramp up production and distribution of medical equipment and PPE in needed quantities to consistently provide optimal protections against Covid-19 or other infectious disease exposures of nurses and other health care workers. The executive branch must use DPA authorities to create a comprehensive medical supply chain management system that is coordinated, efficient, and transparent. The DPA can be used to engage in identification of manufacturing facilities that can increase

their capabilities or can transition manufacturing functions to produce critical medical supplies and PPE.

- » **Rescind all CDC and other federal agency crisis standards that allow the reuse and extended use of single-use PPE and that do not fully recognize aerosol transmission of Covid-19:** Federal guidance and hospital policies during the pandemic have not fully recognized aerosol transmission of Covid-19 or, through crisis standards, allowed for the use of non-protective equipment, the reuse of single-use PPE, and for the extended use of single-use PPE. CDC guidance has allowed hospitals to adopt crisis standards that reuse or extend the use of single-use PPE. Every time that single-use PPE is reused, nurses and patients are put at increased risk of exposure. Congress must pass legislation and federal agencies must issue regulations prohibiting hospitals from the reuse or extended use of single-use PPE. These measures could be enforced through OSHA standards, CMS regulation of Medicare- and Medicaid-certified providers, or FDA PPE and medical product use and certification standards.

Covid-19 and Other Infectious Disease Control Precautions (Patient Isolation, Testing, Screening, Universal Masking, Contact Tracing, Ventilation, and Additional Measures). NNU advocates for a comprehensive infection control public health program that practices multiple measures of infection control. As outlined in NNU's scientific brief on Covid-19 infection control measures, research literature has shown that multiple measures in a layered approach are necessary to stop and slow the spread of Covid-19.¹⁵⁷ Patient isolation, testing, screening, masking, contact tracing, ventilation and air filtration, vaccines, and other measures would reduce nurses' exposure to Covid-19. Preventing nurses' exposure to Covid-19 in the first place would ensure that nurses are not pulled away from the bedside because of entirely preventable workplace exposure to and infection, illness, or death from Covid-19. To protect nurses from exposure to Covid-19, hospitals should be required to screen all patients — irrespective of vaccination status — using a combination of

testing, symptom screening, and epidemiologic history. NNU urges that Congress and the executive branch require hospitals have designated Covid-19 units and isolate Covid-19 patients in airborne infection isolation rooms (AIIRs), which reduce the possibility that infectious viral particles will be transported to other areas of the hospital. These kinds of measures to prevent patient or visitor transmission of Covid-19 to nurses can be adopted in future pandemics. Legislative and regulatory measures must be taken to authorize and mandate that OSHA or CMS require that hospitals implement such measures during this and future pandemics.

Pandemic Effects Mitigation Measures

Establish Presumptive Eligibility for Workers' Compensation Claims and Disability and Death Benefits for Nurses. Congress and the executive branch should establish programs that would presumptively compensate nurses who are injured on the job or who contract illnesses (including Covid-19) with workers' compensation, disability, and death benefits. These kinds of benefits would mitigate the high risk of injury or illness that nurses face on the job. Presumptive eligibility for such benefits programs would mean that nurses would not bear the legal and evidentiary burden of proving that they were injured on the job or became ill as result of workplace exposures to infectious disease such as Covid-19 or other hazardous materials. NNU urges that Congress and the executive branch establish and enforce programs that provide nurses with presumptive eligibility for workers' compensation claims as well as for short-term disability, long-term disability, and death benefits for issues such as infectious and respiratory disease (including Covid-19), cancer, post-traumatic stress disorder, and musculoskeletal injuries.

For nurses, relief from the burden of proving that an injury or illness was work-related is exceedingly important in the context of the current pandemic. As a matter of public policy, it would recognize that by virtue of being deemed essential during the pandemic, nurses have an undue risk of exposure to Covid-19. Workers' compensation for nurses should include not only payment for medical care but

also for time off during any necessary quarantine and medical treatments, payment for temporary housing if needed to prevent exposure to household members, and necessary PPE.

Importantly, disability and death benefit presumptions as well as state-based workers' compensation presumptions already exist for certain male-dominated professions such as EMTs, paramedics, firefighters, and police officers. Although states manage workers' compensation laws for private sector and state public employees, Congress also has established programs that provide public safety officers with presumptive death and disability benefits for certain injuries and illnesses. In 2020, Congress passed legislation which extended existing federal programs providing public safety officers presumptive death and disability benefits to Covid-19-related claims. Meanwhile, workers in health care settings, such as nurses, are not entitled to workers' compensation presumptions and do not have federal programs that provide disability or death benefits. This is despite the fact that nurses treat the same patients in hospitals that public safety officers are treating in the field. Congress and the executive branch must establish and provide similar workers' compensation, disability, and death benefits programs presumptively for nurses. Additionally, the executive branch must provide nurses employed by the Veterans Health Administration, other federal agencies, or federal contractors with presumptive workers' compensation for Covid-19 as well as other infectious diseases and injuries.

Provide Free Crisis Counseling and Mental Health Services for Nurses. Considering the psychological trauma, moral distress, and moral injury that nurses are facing on the front lines of the pandemic, Congress and the executive branch should ensure that employers provide nurses with crisis counseling and mental health services. Congress and the executive branch must also supplement and, in some cases, directly provide crisis counseling and mental health services to nurses. Given that much of the psychological trauma and moral distress is attributable, at least in part, to the actions and inactions of health care industry employers to protect nurses and their

patients, it is exceedingly important that any crisis counseling or mental health services are provided by entities other than the nurses' employer. Employee assistance programs and employer-sponsored wellness programs are not sufficient and, indeed, may contribute to stress and psychological trauma if the very entity that causes stress and trauma is the only option for nurses to receive free counseling or mental health services.

Cancel Educational Debt for Nurses. Nurses who work at the bedside providing direct patient care to members of their community put themselves at risk of exposure to infectious disease, including deadly viruses such as SARS-CoV-2. For the risk that nurses bear to illness, injury, and death from their work at the bedside and for their services to their patients and communities, Congress and the executive branch should take legislative and regulatory steps to cancel any educational debt of nurses. In the Higher Education Act (HEA), Congress has granted the U.S. Secretary of Education authority to modify student loan debt owed under federal student loan programs. Congress conferred upon the education secretary general authority to "enforce, pay, compromise, waive, or release any right, title, claim, lien, or demand, however acquired, including any equity or any right of redemption."¹⁵⁸ A reasonable interpretation of the statute provides the executive branch's education secretary with the authority necessary to cancel federal educational loan debt for nurses. No nurse who has risked their own and their families' health and safety due to hospital employer and government failures to protect them from preventable injury and illness, including during the Covid-19 pandemic, should continue to be burdened with educational debt.

Establish Government Programs On Free Childcare, Alternate Housing, Meals, and Transportation. To help nurses prevent the spread of infectious disease during public health emergencies to their families and communities, Congress and the executive branch must also establish federal programs to provide nurses and other essential workers with free childcare, alternate housing, meals, and transportation. It has been widely documented

that nurses and other health care workers with vulnerable family members or children paid for their own hotel rooms or other accommodations to protect their family members.¹⁵⁹

Provide Essential Worker Pay for Nurses.

While nurses always deserve fair and equitable wages, an essential worker pay differential is specifically meant to compensate workers who have been excluded from governmental orders and public health guidance to stay at home because their work has been deemed “essential” or “critical” and, thus, are being forced to risk exposure to Covid-19 that is higher than government has prescribed as safe. More simply put, because the labor of nurses and other essential workers is vital to our collective well-being, coupled with the fact that working during a pandemic adds complexity and danger for them and their families compared to those sheltering at home, these workers deserve to be paid more.

Sometimes the term “hazard pay” is mistakenly used to describe this kind of mitigation measure, but using this term to describe an essential worker pay differential or premium is a misnomer. Hazard pay, by regulatory definition of the U.S. Department of Labor, is meant to compensate a worker from exposure to a hazard that cannot be mitigated.¹⁶⁰ But the science of industrial hygiene has known for decades how to protect workers from infectious disease and other occupational injury in health care settings, and, as such, we know how to reduce occupational exposure to Covid-19, other infectious disease, and workplace hazards for nurses. Extra pay to nurses as essential workers should not be treated as trade-off for safe workplaces, especially when we know the risk of exposure can be reduced.

Congress or the executive branch must provide essential worker pay to nurses who are federal workers or federal contractors. The executive branch must issue executive orders requiring essential worker pay for federal employees and federal contractors, and Congress must extend current statute providing pay premiums for some federal workers who are exposed to virulent biologicals to all nurses who work for the federal government or federal contractors.

Certain federal workers are entitled to a pay premium of up to 25 percent for work duty “involving unusual physical hardship or hazard.”¹⁶¹ This kind of pay differential is available if a federal worker is exposed to or must “work with or in close proximity” to “virulent biologicals[.]”¹⁶² However, the statute providing federal workers with pay premium for hazardous work does not apply to Veterans Health Administration nurses.

Congress must also adopt legislation on essential worker pay for private-sector nurses. For example, a U.S. House of Representatives Covid-19 legislative package in 2020, the HEROES Act (H.R. 6800), would have provided a “pandemic premium pay” to “essential workers.” The legislation would have created a federal fund, called the Covid-19 Heroes Fund, that would provide “essential workers” a \$13 per hour premium on top of regular wages.

Require Free Covid-19 Testing, Treatments, and Vaccines for All. With the existence of new Covid-19 treatments or vaccines that are safe and effective, it is critical that our public health infrastructure is improved to allow for the efficient, safe, and equitable rollout of these treatments or vaccines. Any vaccine that is scientifically shown to be safe and effective should be available at no cost to all people who would like to receive the vaccine. The administration must also ensure that the necessary administrative and health care supports are in place to ensure timely follow-up care, if needed, for any patient who has received a vaccine.

The United States must also play a leadership role in ensuring that any treatment or vaccine is made available equitably in the rest of the world. Covid-19 and other infectious diseases do not recognize borders, and our nation has the opportunity to play an important role on the world stage to ensure that low and middle-income countries have access to these treatments and vaccines for free or at a low cost. Ending the pandemic is not only the right thing to do as the wealthiest country in the world, but it is also an essential step in eliminating the patient surges that harm patients and RNs.

PART IV. SOLUTIONS: MEASURES TO STRENGTHEN AND SUPPORT THE RN WORKFORCE PIPELINE

NNU urges Congress and the executive branch to provide robust funding for the programs discussed below, most of which are funded as Nursing Workforce Development programs under Title VIII of the Public Health Service Act.¹⁶³ Moreover, Congress and the executive branch should continue to monitor RN education and employment closely and adjust funding as necessary to ensure that patients receive the care they need from a diverse group of culturally and linguistically competent RNs. NNU strongly urges Congress and the Biden administration to adopt the mutually reinforcing policies detailed below to rapidly increase the number and diversity of RNs providing direct patient care at the bedside.

NNU has long advocated for more funding for public nursing schools and incentives to recruit nursing faculty. To ensure a diverse and sustainable nursing workforce, Congress should increase funding for nursing workforce programs that reduce the financial barriers to becoming a nurse imposed by the exorbitant expense of private programs and the lack of admission slots in public nursing programs. NNU believes that federal nursing workforce funding should be increased dramatically and dedicated to ensuring that the direct-care registered nurse workforce, providing the bulk of inpatient hospital care, remains robust and sustainable. Although current federal funding for nursing workforce development is edging upwards, it remains insufficient — apart from the major one-time boost in funding from the American Rescue Plan Act which added \$200 million for the Nurse Corps Scholarship and Loan Repayment Program. Given the importance of the RN workforce to the health of our nation, increased spending on nursing workforce development above the amounts typically funded should become the norm, not the exception.

CONGRESSIONAL ACTION »

CREATE A LONG-TERM, DEDICATED FUNDING STREAM FOR TUITION-FREE NURSING PROGRAMS AT PUBLIC COMMUNITY COLLEGES

NNU urges Congress to pass legislation creating long-term dedicated funding streams for tuition-free nursing programs at public community colleges and to give funding priority to public community colleges located in health professional shortage areas (HPSAs) and medically underserved areas and populations (MUAs/MUPs). Tuition-free nursing programs, particularly if coupled with stipends to cover living expenses, diminish the financial and time constraints that are the most common barriers to higher education. With sufficient in-person (not simulated) pre-licensure clinical training, nurses with associate degrees in nursing (ADNs) can be ready for entry-level nursing positions in two years. New RNs then need to be paired with preceptors to make the transition to professional practice.

Locating community colleges in HPSAs and MUAs/MUPs will facilitate local nursing students becoming RNs in these areas and populations. Linking community colleges with local pre-licensure clinical training and post-licensure job placement in public hospitals and critical shortage facilities increases the likelihood that RNs working in these areas will be culturally competent and share values that reflect the communities in which they work. Finally, as many HPSAs and MUAs/MUPs have higher percentages of underrepresented BIPOC community members,¹⁶⁴ locating nursing programs in these areas would tend to serve a more racially and ethnically diverse student population. In turn, increasing tuition-free access to nursing programs could lead to greater RN diversity and improve racial, ethnic, and other disparities in health care access, leading to greater health

equity. Additionally, many HPSAs and MUAs/ MUPs are in rural areas with lower RN compensation rates.¹⁶⁵ Providing free community college relieves RNs from the burden of student loan debt, thereby reducing financial pressure to avoid hospitals in underserved areas and to seek employment in urban or more affluent areas where RN salaries are higher.

INCREASE FUNDING FOR THE NURSING WORKFORCE DIVERSITY PROGRAM

First, NNU urges Congress to increase funding for the Nursing Workforce Diversity Program (NWDP) as a crucial step to improving health care access and achieving health equity for BIPOC, rural communities, and medically underserved communities. As discussed above, numerous racial and ethnic groups are underrepresented in the RN workforce, particularly Latinx and Black RNs but also Asian, American Indian, and Alaskan Native RNs. NNU urges Congress, at minimum, to adopt the funding levels reported by the House Committee on Appropriations for fiscal year 2022 which reflects a \$6.5 million increase over fiscal year 2021 and an \$8 million increase over fiscal year 2020.¹⁶⁶

Second, NNU believes it is important to include the voice of labor in the nursing workforce diversity discussion and, as the country's largest union and professional association of direct-care registered nurses, we are well suited to provide that voice. NNU requests that Congress amend 42 U.S.C. § 296m to include National Nurses United in the list of organizations in Section (b).



INCREASE FUNDING FOR THE NURSE CORPS SCHOLARSHIP AND LOAN REPAYMENT PROGRAMS

As noted above, the American Rescue Plan Act dramatically increased funding by adding \$200 million in fiscal year 2021 for the Nurse Corps Scholarship and Loan Repayment Programs compared to funding ranging \$87-\$89 million since 2018 and in the low \$80 million range prior to that.¹⁶⁷ Yet these programs remain underfunded.

» Nurse Corps Scholarship Program (NCSP)

The NCSP has three funding tiers. Tier 1, the highest preference tier, includes students who maintain full-time enrollment in an accredited nursing program leading to an RN license and/or a nurse practitioner program. Tier 2 includes students who maintain full-time enrollment in an accredited graduate nursing program to become a certified registered nurse anesthetist or clinical nurse specialist. Tier 3 includes students accepted or enrolled part-time in an accredited diploma, undergraduate, or graduate nursing program. The NCSP is highly competitive with far more applicants for scholarship awards than available funding.¹⁶⁸ The lack of funding of NCSP historically has limited awards to Tier 1. NNU advocates for increasing NCSP funding to a level that ensures that all eligible applicants applying to the scholarship or loan repayment programs are fully funded until all those residing in the United States have equitable access to high-quality care across the full range of health care services, and then adjusting the funding to a level sufficient to meet ongoing need for health care professionals.

» Nurse Corps Loan Repayment Program (NCLRP)

The NCLRP provides RNs and advanced practice RNs up to 85 percent repayment of qualifying educational loans in exchange for full-time employment teaching at an eligible nursing school or working at a critical shortage facility. As with the NCSP, lack of funding for the NCLRP has severely limited the number of awards. The NCLRP is “highly competitive” with more applicants than available funding, with application rates of eight to nine times the number of awards given.¹⁶⁹ For example, in 2020 HRSA received 6,223 applications but only provided 456 initial awards and 291 continuation awards. The high number of nurses who apply for NCLRP support but are turned down due to lack of funding demonstrates that RNs, NPs, and APRNs are ready to fulfill unmet needs in critical shortage facilities and schools of nursing but may need federal support because of their student debt obligations.



EXECUTIVE AND REGULATORY ACTION »

IMPROVE THE NURSING WORKFORCE DIVERSITY PROGRAM

The NWDP provides grants “to increase nursing education opportunities for individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses).”¹⁷⁰ To ensure a representative, culturally and linguistically competent nursing workforce, NNU urges the Health Resources and Services Administration (HRSA), which implements the NWDP, to allocate sufficient funding for research to gather data to better identify racial and ethnic minorities that are underrepresented among registered nurses. This research should include collecting and disaggregating workforce and patient data for Asian, Asian American, and Pacific Islanders and for gender oppressed and gender non-conforming people. Finally, in accordance with Section (b) of 42 U.S.C. § 296m, NNU seeks to work with the Health and Human Services Secretary to ensure a diverse RN workforce by increasing nursing education opportunities. NNU believes it is important for labor to participate in the nursing workforce diversity discussion and that we are well suited to provide that voice.

IMPROVE THE NURSE CORPS SCHOLARSHIP PROGRAM (NCSP)

- » **NNU strongly urges HRSA to simplify and ease the ways in which applicants to the NCSP can adjust the expected family contribution based on their actual financial circumstances, including based on their independent status, if they are not dependents on another’s income tax filings, have supported themselves in the prior year, or based on other relevant circumstances.**

The NCSP awards scholarships, based on need, for students to attend an accredited school of nursing in exchange for a minimum two years of employment in a critical shortage facility after graduation.¹⁷¹

In addition, as will be required when the FAFSA Simplification Act is fully implemented, HRSA should affirmatively inform applicants that they may pursue adjustments to the expected family contribution based on their individual and family circumstances.

- » **NNU urges HRSA to increase NCSP funding, particularly for ADN students, as well as devoting some Tier 1 funding to part-time students to enable those with child or elder care responsibilities to attend school.**

In fiscal year 2019, approximately 68 percent of NCSP awards went to bachelor’s degree students, 27 percent to master’s degree students, while only 5 percent went to associate degree students, and no awards were made to diploma students.¹⁷²

- » **In addition, NNU strongly urges HRSA to substantially increase funding for NCSP “career pathway” awards which received only \$2 million of the \$89 million in funding in the fiscal year 2021 budget.**

Career pathway funding provides scholarships to unlicensed assistive personnel (e.g., certified nursing assistants and home health aides) as well as licensed practical/vocational nurses so that they can become registered nurses. These individuals have both experience and a demonstrated commitment to providing health care which deserves recognition and preferential funding. Moreover, their experience, demonstrated commitment to caring for others, and pursuit of additional education strongly indicates their intention to remain in the health care workforce.¹⁷³ Finally, licensed practical/vocational nurses are likely to have completed some of the coursework necessary to becoming a licensed RN, potentially reducing the time from degree completion to entering the workforce.

IMPROVE THE NURSE CORPS LOAN REPAYMENT PROGRAM (NCLRP)

- » In defining funding preference tiers in the NCLRP, NNU advocates that HRSA use HPSA critical shortage facility scores and absolute debt levels rather than a debt-to-salary ratio, as using the debt-to-salary ratio creates an incentive for paying lower wages.

NCLRP’s highest priority should be the placement of nurses in critical shortage areas. Moreover, NNU urges the executive branch to treat NCLRP loan repayment as nontaxable. Finally, NNU urges HRSA to include in NCLRP loan forgiveness all loans that a nurse obtained for training in vocational or practical nursing for coursework required to become an RN as well as loans that have been consolidated/refinanced with ineligible non-qualifying debt or loans of another individual if the eligible qualifying debt can be disaggregated from the ineligible non-qualifying debt.

- » To address the shortage of nursing faculty, NNU urges HRSA to increase NCLRP funding for faculty teaching positions. Funding for faculty teaching positions has been minimal historically and accounted for less

than 10 percent of the NCLRP fiscal year 2021 budget.

According to the American Association of Colleges of Nurses (AACN), a nursing faculty shortage is limiting teaching capacity. The AACN attributes the shortage to budgetary limits, faculty retirements, and competition from clinical jobs with better compensation. Increasing funding for faculty service positions could increase teaching capacity, which is crucial to ensuring that we continue to educate future generations of nurses.¹⁷⁴

- » NNU also urges HRSA to prioritize placing NCLRP applicants in faculty positions in schools that have at least 50 percent of students from a disadvantaged background, followed by prioritizing the placement of applicants by absolute applicant debt levels rather than debt-to-salary ratio.

For faculty positions, the NCLRP prioritizes applicants with a higher debt-to-salary ratio and placement at a nursing school where 50 percent of students are from a disadvantaged background, as shown in the funding tiers table (Table 5). Insufficient funding has limited awards for teaching to the first three tiers shown. Increasing funding for the NCLRP would also allow awards to fulfill need in all four preference tiers.

Table 5. **Funding Tiers for Teaching at a School of Nursing**

Funding Preference Tiers	Debt-to-Salary Ratio	Schools of Nursing (SON)
Tier 1	≥100%	SON with at least 50 percent of students from a disadvantaged background
Tier 2		All other SON
Tier 3	<100%	SON with at least 50 percent of students from a disadvantaged background
Tier 4		All other SON

Table 6. **Funding Tiers for RNs, NPs, and APRNs**

Funding Preference Tier For RNs, NPs and APRNs	Debt-to-Salary Ratio	CSF Primary Care or Mental Health HPSA Score
Tier 1	≥100%	25-14
Tier 2	<100%	25-14
Tier 3	≥100%	13-0
Tier 4	<100%	13-0

» In addition to increasing funding, NNU urges HRSA to prioritize NCLRP awards by HPSA scores, followed by prioritization based on an applicant’s absolute debt levels rather than a debt-to-salary ratio in awarding loan repayment funds.

Similarly, the NCLRP prioritizes those with a higher debt-to-salary ratio and working at a primary or mental health critical shortage facility with a high HPSA score, as shown in the funding tiers table (Table 6). Lack of funding for the NCLRP has limited awards to Tier 1, leaving RNs, NPs, and APRNs with a lower debt-to-salary ratio without student debt support. This is especially troubling with respect to Tier 2, as it funds critical shortage facilities with high HPSA scores.



CONCLUSION

The hospital industry has long engaged in profit-driven policies that result in unsafe staffing levels and poor working conditions. The industry's ongoing failure to protect the health and safety of nurses and patients during the Covid-19 pandemic is a continuation of these policies. The Covid-19 pandemic has become a convenient excuse to ignore their legal duties as employers to protect the nurses that are the backbone of our health care system.

Nurses have been treated as disposable during the pandemic through the hospital industry's refusal to provide necessary optimal personal protective equipment, imposition of long work hours, refusal of sick or quarantine leave and pay, failure to provide employees Covid-19 tests, demanding that nurses work even if they have been exposed to or are recovering from Covid-19, and disciplining nurses who speak out about unsafe conditions for workers and their patients.¹⁷⁵ Consequently, RNs have experienced high rates of Covid-19 infection, resulting in severe illness, lingering physical health effects, and death. The failure by hospital management to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses severe moral distress and moral injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion resulting in many nurses leaving the bedside to protect themselves, their nursing licenses, their families, and their patients.

Additionally, understaffing forces nurses to make morally distressing choices about how to allocate their available time for nursing care, and unsafe working conditions force nurses to make a morally distressing choice to provide patient care or protect their own health and safety. Moreover, crisis standards of patient care implemented during the pandemic have caused profound moral distress and injury for nurses as well as myriad adverse mental health effects¹⁷⁶ and are harmful to patients' health and well-being. The hospital industry's flagrant

disregard for the lives of nurses, their patients, and their families during the pandemic has taken both a physical and psychological toll on nurses, driving them to nursing jobs outside of the hospital setting or to leave the profession entirely.

Even with the widespread availability of Covid-19 vaccines, hospital industry policies continue to create abhorrent working and patient care conditions that drive nurses from the bedside. The pandemic is far from over and multiple infectious disease precautions, in addition to vaccines, are necessary. Although fewer RNs are contracting Covid-19, breakthrough infections continue to occur. Workplace exposure to Covid-19 continues to place nurses and their family members at risk, particularly for nurses who have young children or other family members who cannot yet be vaccinated, immunocompromised family members, or are immunocompromised themselves. Finally, there are regions in the country where hospitals are still operating under crisis standards of patient care.

National Nurses United urges Congress and the executive branch to support bold legislative and regulatory action to retain the current RN workforce and to encourage new nurses to enter the profession. Retaining the current RN workforce requires regulatory and legislative measures to ensure good, permanent, jobs with safe patient staffing, optimal workplace health and safety protections, fair wages, and robust union rights, including conditioning future pandemic relief funding for the hospital industry on implementing nurse retention measures. Encouraging future generations to enter the RN workforce requires vigorously funding nursing education and job placement programs. These actions should also focus on realigning our health care system to meet the needs of patients rather than the aims of the corporate hospital industry, and ensuring that the nursing workforce reflects the racial, ethnic, cultural, and socioeconomic diversity of our patients.

ENDNOTES

- 1 National Council of State Boards of Nursing. Nov 6, 2021. "Active RN Licenses, A Profile of Nursing Licensure in the U.S." National Council of State Boards of Nursing. <https://www.ncsbn.org/6161.htm> As the National Council of State Boards of Nursing data excludes Michigan RNs, the number reflects the number of RNs employed in Michigan. The Michigan data comes from U.S. Bureau of Labor Statistics. 2021. "May 2020 Occupational Employment and Wages." U.S. Department of Labor. <https://www.bls.gov/oes/home.htm>.
- 2 U.S. Bureau of Labor Statistics. 2021. "May 2020 Occupational Employment and Wages." U.S. Department of Labor. <https://www.bls.gov/oes/home.htm>.
- 3 Health Resources and Services Administration. 2017. "National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030." U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf>.
- 4 Ibid.
- 5 Agency for Healthcare Research and Quality. 2019. "National Healthcare Quality and Disparities Report." U.S. Department of Health and Human Services. <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2019qdr-cx061021.pdf>.
National Advisory Council for Nurse Education and Practice. 2013. "Achieving Health Equity through Nursing Workforce Diversity." U.S. Department of Health and Human Services. <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/2013-eleventhreport.pdf>.
Phillips J, Malone B. 2014. "Increasing Racial/Ethnic Diversity in Nursing to Reduce Health Disparities and Achieve Health Equity." *Public Health Rep.* 129 Suppl 2(Suppl 2):45-50. <https://pubmed.ncbi.nlm.nih.gov/24385664/>.
- 6 National Nurses United. 2020. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.
- 7 For example, see article by Bean M, Masson G. Oct 4, 2021. "The less-discussed consequence of healthcare's labor shortage." *Becker's Hospital Review*. <https://www.beckershospitalreview.com/patient-safety-outcomes/the-less-discussed-consequence-of-healthcare-s-labor-shortage.html>. S
- 8 Aiken L et al. 2000. "Hospital Restructuring: Does it Adversely Affect Care and Outcomes?" *J Nurs Adm.* 30(10):457-65. doi:10.1097/00005110-200010000-00003.
DeMoro D. 2000. "Engineering a Crisis. How Hospitals Created a Shortage of Nurses." *Revolution.* 1(2):16-23. PMID: 12018079.
Gordon S. 1997. "What Nurses Stand For." *Atlantic Monthly.* 279(2):81. <https://www.theatlantic.com/magazine/archive/1997/02/what-nurses-stand-for/376776/>.
Norrish B, Rundall T. 2001. "Hospital Restructuring and the Work of Registered Nurses." *Milbank Q.* 79(1):55-79. doi:10.1111/1468-0009.00196.
Shogren E et al. 1996. "Issues Update: Restructuring May Be Hazardous to Your Health." *Am J Nursing.* 96(11):64-66.
- 9 Lasater K et al. 2021. "Chronic Hospital Nurse Understaffing Meets COVID-19: An Observational Study." *BMJ Quality & Safety.* 30:639-647.
- 10 Pajer N. Jan 26, 2021. "What Frustrates Nurses the Most Right Now in the COVID-19 Pandemic." *Huffington Post*. https://www.huffpost.com/entry/what-is-frustrating-nurses-covid-pandemic_I_600f0a4fc5b6a46978d3844c.
- 11 Silver-Greenberg J et al. Jun 8, 2020. "Hospitals Got Bailouts and Furloughed Thousands While Paying C.E.O.s Millions." *New York Times*. www.nytimes.com/2020/06/08/business/hospitals-bailouts-ceo-pay.html.
- 12 National Nurses United. 2021. "Injury to None: Preventing Workplace Violence to Protect Health Care Workers and Their Patients." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0221_HS_WPV_InjuryToNone_Brief.pdf.
- 13 Zwerdling D. Feb 18, 2015. "Hospital to Nurses: Your Injuries are not Our Problem." *NPR*. <https://www.npr.org/2015/02/18/385786650/injured-nurses-case-is-a-symptom-of-industry-problems>.
- 13 National Nurses United. "Deadly Shame..." (2020).

- 14 See *ibid.* and the results from NNU's sixth survey of RNs on Covid-19. National Nurses United. Sep 27, 2021. "National Nurse Survey Reveals That Health Care Employers Need to Do More to Comply with OSHA Emergency Temporary Standard." National Nurses United. <https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers..>
- 15 U.S. Bureau of Labor Statistics. 2020. "Occupational Injuries and Illnesses and Fatal Injuries Profiles." U.S. Department of Labor. https://www.bls.gov/iif/oshwc/osh/case/cd_r100_2020.htm.
- 16 In 2020, the violence-related injury rate for workers overall in the U.S. was 4.0 per 10,000 full-time employees compared to the rate for RNs at 18.2 per 10,000 full-time employees. *Ibid.*
- 17 In 2019, the violence-related injury rate for RNs in private industry in the U.S. was 14.0 per 10,000 full-time employees. U.S. Bureau of Labor Statistics. 2019. "Occupational Injuries and Illnesses and Fatal Injuries Profiles." U.S. Department of Labor. https://www.bls.gov/iif/oshwc/osh/case/cd_r100_2019.htm. For a discussion of the increase in workplace violence during the Covid-19 pandemic, see National Nurses United. Nov 2021. "Workplace Violence and Covid-19 in Health Care: How the Hospital Industry Created an Occupational Syndemic." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_WPV_HS_Survey_Report_FINAL.pdf.
- 18 In 2020, the musculoskeletal disorder rate for workers overall was 26.9 per 10,000 full-time employees and the back injury rate for workers overall was 13.6 per 10,000 full-time employees. U.S. Bureau of Labor Statistics. "Occupational Injuries..."(2020).
- 19 Lipscomb J et al. 2004. "Health Care System Changes and Reported Musculoskeletal Disorders Among Registered Nurses." *Am J Public Health*. 94(8):1431-36. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448467/>.
- 20 Lee S et al. 1999. "Work-related Assault Injuries Among Nurses." *Epidemiology*. 10(6):685-91. <https://pubmed.ncbi.nlm.nih.gov/10535781/>.
- 21 Aiken L et al. 2002. "Hospital Nursing Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." *JAMA*. 288(16):1987-93. <https://pubmed.ncbi.nlm.nih.gov/12387650/>.
- 22 Johansen M. 2014. "Conflicting Priorities: Emergency Nurses Perceived Disconnect Between Patient Satisfaction and the Delivery of Quality Patient Care." *Journal of Emergency Nursing* 40(1):13-19.
- Moffatt-Bruce S et al. 2015. "Facing the Tension between Quality Measures and Patient Satisfaction." *American Journal of Medical Quality* 30(5):489-490.
- Numerous articles have been written about the conflicts between patient satisfaction scores and quality health care. For example, see Tevis S et al. 2014. "Can Patients Reliably Identify Safe, High Quality Care?" *Journal of Hospital Administration* 3(5):150.
- 23 *Ibid.*
- 24 Nelson R. 2012. "Patient Satisfaction Metrics: Customer Service or Quality Care?" *Am J Nursing*. 112(8):18-19.
- 25 Studer Group. 2021. "AIDET Patient Communication." <https://www.studergroup.com/aidet..>
- 26 Welch S. Dec 15, 2015. "AIDET: A Popular Way of Improving Patients' Care Experience." *ACEP Now*. <https://www.acepnow.com/article/aidet-a-popular-way-of-improving-patients-care-experience/>.
- 27 *Ibid.*
- 28 Nelson R. "Patient Satisfaction Metrics..." (2012).
- 29 Welch S. "AIDET..." (Dec 15, 2015).
- 30 Tardiff C. 2012. "Patient Satisfaction Metrics." Letter to the editor. *Am J Nursing*. 112(12):12.
- 31 Miller J. 2012. "Patient Satisfaction Metrics." Letter to the editor. *Am J Nursing*. 112(12):12.
- 32 Hospitals' restriction of professional judgment affects other clinicians besides RNs. For example, physicians at a California hospital contend that the system to which the hospital belongs has standardized clinical guidelines through a shared electronic health record system that are "often driven by cost considerations" and that the guidelines "often [conflict] with their own judgment of best medical practices." Wolfson B. Apr 13, 2012. "Orange County Hospital Seeks Divorce From Large Catholic Health System." *Kaiser Health News*. <https://khn.org/news/article/orange-county-hospital-seeks-divorce-from-large-catholic-health-system/>.
- 33 Hong J et al. 2021. "Disappearing Expertise in Clinical Automation: Barcode Medication Administration and Nurse Autonomy." *J Am Medical Informatics Association: JAMIA* 28(2):232-238. doi:10.1093/jamia/ocaa135.

- 34 See discussion of the literature, MacKinnon K, Butcher DL, Bruce A. 2018. "Working to Full Scope: The Reorganization of Nursing Work in Two Canadian Community Hospitals." *Global Qualitative Nursing Research*. 11. doi:10.1177/2333393617753905.
- 35 See *ibid.*
Pine A. 2014. "On Caring: Solidarity Anthropology (or, How to Keep Health Care from Becoming Science Fiction)." In Stryker R, González R. "Up, down, and Sideways: Anthropologists Trace the Pathways of Power." *Berghahn Books*.
- 36 Counter-intuitively, the hospital industry's insistence on hiring nurses with bachelor's degrees rather than nurses with associate degrees seems to have been replaced hypocritically with a willingness to use licensed practical nurses with less education and clinical experience. For example, the American Hospital Association (AHA) offers the following solution to the RN staffing crisis: "Team-based staffing: One RN supervises a team of licensed practical nurses, aides and other support staff caring for a group of patients." Although AHA mentions both ADNs and BSNs in this white paper, nowhere does AHA advocate hiring more ADNs, yet the report seems to celebrate the expansion of BSN programs. However, that discussion is beyond the scope of this report. American Hospital Association. 2021. "2022 Health Care Talent Scan." American Hospital Association. 14. <https://www.aha.org/system/files/media/file/2021/10/AHA-Health-Care-Talent-Scan-2022.pdf>.
- 37 Smiley R. 2019. "Survey of Simulation Use in Prelicensure Nursing Programs: Changes and Advancements, 2010-2017." *J Nurs Reg*. 9(4):48-61.
- 38 National Council of State Boards of Nursing. 2013. "Member Board Profiles: Educational Programs." National Council of State Boards of Nursing. https://www.ncsbn.org/Educational_Programs_Entry_into_Practice.pdf.
- 39 Spector N et al. 2018. "Board of Nursing Approval of Registered Nurse Education Programs." *J Nursing Regulation*. 8(4):22-31.
- 40 *Ibid.*
- 41 NNU calculations based on Health Resources and Services Administration, National Center for Health Workforce Analysis. 2019. "2018 National Sample Survey of Registered Nurses: Brief Summary of Results." U.S. Department of Health and Human Services. <https://data.hrsa.gov/DataDownload/NSSRN/GeneralPUF18/nssrn-summary-report.pdf>; and
U.S. Census Bureau. 2019. "QuickFacts." <https://www.census.gov/quickfacts/fact/table/US/PST045219-nc-est2019-sr11h>.
- 42 National Nurses United. Feb 28, 2020. "Nation's Hospitals Unprepared for COVID-19." National Nurses United. <https://www.nationalnursesunited.org/press/nations-hospitals-unprepared-covid-19>.
- 43 National Nurses United. Mar 27, 2020. "National Nurses United is Stepping Up Pressure On Hospital Employers Across the United States to Provide Safer Facilities." National Nurses United. <https://www.nationalnursesunited.org/press/national-nurses-united-stepping-pressure-hospital-employers-across-united-states-provide>.
- 44 O'Leary L. Mar 19, 2020. "The Modern Supply Chain is Snapping." *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2020/03/supply-chains-and-coronavirus/608329/>.
- 45 Jewett C. Nov 4, 2021. "Patients Went Into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News*. <https://khn.org/news/article/hospital-acquired-covid-nosocomial-cases-data-analysis/>.
- 46 This definition is a composite that comes primarily from Morley G et al. May 2019. "What is 'Moral Distress'? A Narrative Synthesis of the Literature." *Nurs Ethics*. 26(3): 646-62. doi:10.1177/0969733017724354. Citing Jameton A. 1984. *Nursing Practice: The Ethical Issues*. Prentice-Hall. With additional material from Varcoe C et al. Mar 2012. "Moral Distress: Tensions as Springboards for Action." *HEC Forum*. 24(1): 51-62. doi:10.1007/s10730-012-9180-2.
- 47 Coleman J. Mar 26, 2020. "Photo Shows NY Hospital Staff Using Trash Bags as Protective Gear." *The Hill*. <https://thehill.com/policy/healthcare/489622-photo-shows-staff-using-trash-bags-as-protective-gear-in-hospital-system>.
- Sanchez T. Apr 2, 2020. "Coronavirus: Nurses are Wearing Trash Bags at One Bay Area Hospital Facing a Protective Equipment Shortage." *San Francisco Chronicle*. <https://www.sfchronicle.com/bayarea/article/Coronavirus-Nurses-are-wearing-trash-bags-at-one-15172777.php>.
- 48 Jewett C. Nov 4, 2021. "Patients Went Into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News*. <https://khn.org/news/article/>

- hospital-acquired-covid-nosocomial-cases-data-analysis/.**
- 49 Gold J, Hawryluk M. May 13, 2020. "Hospital Workers Complain of Minimal Disclosure After COVID Exposures." *Kaiser Health News*. <https://khn.org/news/hospital-workers-complain-of-minimal-disclosure-after-covid-exposures/>.
- 50 The data on infection and death rates in this paragraph is from an unpublished update as of November 29, 2021, of National Nurses United. Updated Mar 2021. "Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 3,200 Health Care Worker Deaths and Jeopardize Public Health." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/O321_Covid19_SinsOfOmission_Data_Report.pdf.
- 51 Ibid.
- 52 Ibid.
- 53 U.S. Bureau of Labor Statistics. Jan 2020. "Household Data, Annual Averages, Employed Persons by Detailed Occupation, Sex, Race, and Hispanic or Latino Ethnicity." U.S. Department of Labor. <https://www.bls.gov/cps/cpsaat11.pdf>.
- 54 The U.S. Bureau of Labor Statistics does not disaggregate Filipinx RNs from Asian RNs. This statistic comes from McFarling U. Apr 28, 2020. "The Pandemic is Taking an Outsized Toll on Filipino American Nurses." *STAT*. <https://www.statnews.com/2020/04/28/coronavirus-taking-outsized-toll-on-filipino-american-nurses/>.
- 55 U.S. Bureau of Labor Statistics. "Household Data..." (Jan 2020).
- 56 McFarling U (Apr 28, 2020).
- 57 Wingfield A. May 14, 2020. "The Disproportionate Impact of Covid-19 on Black Health Care Workers in the U.S." *Harvard Business Review*. <https://hbr.org/2020/05/the-disproportionate-impact-of-covid-19-on-black-health-care-workers-in-the-u-s>.
- 58 Nguyen L et al. Jul 31, 2020. "Risk of COVID-19 Among Front-Line Health-Care Workers and the General Community." *Lancet*. 5(9): E475-E483. doi:10.1016/S2468-2667(20)30164-X.
- 59 Ibid.
- 60 Grimm CA. Apr 3, 2020. "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23-27, 2020." Office of the Inspector General. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/oei-06-20-00300.pdf>.
- 61 American Hospital Association. Mar 11, 2021. "Statement of the American Hospital Association for the Workforce Protections Subcommittee of the Committee on Education and Labor of the U.S. House of Representatives 'Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.'" American Hospital Association. <https://www.aha.org/testimony/2021-03-11-aha-statement-clearing-air-science-based-strategies-protect-workers-covid-19>.
- 62 Studies on COVID-19 airborne transmissibility include:
- Bourouiba L. Mar 26, 2020. "Turbulent Gas Clouds and Respiratory Pathogen Emissions: Potential Implications for Reducing Transmission of COVID-19." *JAMA*. 323(18):1837-38. doi:10.1001/jama.2020.4756.
- Lednicky et al. 2020. "Viable SARS-CoV-2 in the Air of a Hospital Room With Covid-19 Patients." *International J Infectious Diseases*. 100:476-482. doi: 10.1016/j.ijid.2020.09.025.
- van Doremalen N et al. Apr 16, 2020. "Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1." *N Engl J Med*. 382:1564-67. doi:10.1056/NEJMc2004973.
- Santarpia et al. Jul 21, 2020. "The Infectious Nature of Patient-Generated SARS-CoV-2 Aerosol." Preprint. *medRxiv*. doi: 10.1101/2020.07.13.20041632.
- Wolfel R et al. Apr 1, 2020. "Virological Assessment of Hospitalized Patients with COVID-2019." *Nature*. 581: 465-69. doi:10.1038/s41586-020-2196-x.
- For additional studies, see National Nurses United's COVID-19 bibliography at this link: <https://www.nationalnursesunited.org/covid-19-bibliography>.
- 63 Studies on the need for respirators to protect health care workers from COVID-19 infections include:
- Chen W et al. Jul 2020. "To Protect Healthcare Workers Better, To Save More Lives." *Anesth & Analg*. 131(1): 97-101. doi:10.1213/ANE.0000000000004834.
- Feldman O et al. Apr 27, 2020. "Exposure to a Surrogate Measure of Contamination from Simulated Patients by Emergency Department Personnel Wearing Personal Protective Equipment." *JAMA*. 323(20): 2091-93. doi:10.1001/jama.2020.6633.
- Liu M et al. Jun 10, 2020. "Use of Personal Protective Equipment Against Coronavirus

- Disease 2019 by Healthcare Professionals in Wuhan, China: Cross Sectional Study.” *BMJ*. 369:m2195. doi:10.1136/bmj.m2195.
- For additional studies, see National Nurses United’s COVID-19 bibliography at: <https://www.nationalnursesunited.org/covid-19-bibliography>.
- 64 An open letter to the World Health Organization from 239 scientists also invokes the precautionary principle but does not make any recommendations for health care settings. See Morawska L, Milton D. Jul 6, 2020. “It Is Time to Address Airborne Transmission of Coronavirus Disease 2019 (COVID-19).” *Clinical Infectious Diseases*. 71(9):2311-2313. doi:10.1093/cid/ciaa939.
- 65 Gallegos A. Mar 25, 2020. “Hospitals Muzzle Doctors, Nurses on PPE, COVID-19 Cases.” *Medscape*. <https://www.medscape.com/viewarticle/927541>.
- Scheiber N, Rosenthal B. Apr 27, 2020. “Nurses and Doctors Speaking Out on Safety Now Risk Their Job.” *The New York Times*. <https://www.nytimes.com/2020/04/09/business/coronavirus-health-workers-speak-out.html>.
- 66 Perkins T. Apr 27, 2020. “These Workers Spoke Out. Their Hospitals Fired Them.” *HuffPost*. https://www.huffpost.com/entry/hospitals-fire-doctors-nurses-covid-19_n_5ea2fcb1c5b6f9639813d50b.
- Scheiber N, Rosenthal B (Apr 27, 2020).
- 67 Lacy A. Mar 24, 2020. “Kaiser Permanente Threatened to Fire Nurses Treating COVID-19 Patients for Wearing Their Own Masks, Union Says.” *The Intercept*. <https://theintercept.com/2020/03/24/kaiser-permanente-nurses-coronavirus/>.
- 68 Whitman E. Mar 20, 2020. “‘Taking Masks Off Our Faces’: How Arizona Hospitals Are Rationing Protective Gear.” *Phoenix New Times*. <https://www.phoenixnewtimes.com/news/arizona-hospitals-rationing-masks-protective-gear-banner-11459400>.
- 69 American Hospital Association. May 14, 2020. “Letter to Nancy Pelosi.” American Hospital Association. <https://www.aha.org/system/files/media/file/2020/05/web-AHALettertoHouseonHEROESAct051420final.pdf>.
- Mason D, Friese C. “Protecting Health Care Workers Against COVID-19 — and Being Prepared for Future Pandemics.” *JAMA Health Forum*. Mar 19, 2020. <https://jamanetwork.com/channels/health-forum/fullarticle/2763478>. Citing Kopp E. “Hospitals Want to Kill a Policy Shielding Nurses from COVID-19 Because There Aren’t Enough Masks.” *Roll Call*. Mar 3, 2020. <https://www.rollcall.com/2020/03/13/hospitals-want-to-kill-a-policy-shielding-nurses-from-covid-19-because-there-arent-enough-masks/>.
- 70 American Hospital Association. Mar 11, 2021. “Statement of the American Hospital Association for the Workforce Protections Subcommittee of the Committee on Education and Labor of the U.S. House of Representatives ‘Clearing the Air: Science-Based Strategies to Protect Workers from COVID-19 Infections.’” American Hospital Association. <https://www.aha.org/testimony/2021-03-11-aha-statement-clearing-air-science-based-strategies-protect-workers-covid-19>.
- 71 California Hospital Association. Mar 12, 2020. “Letter to the California Congressional Delegation.” California Hospital Association. https://www.calhospital.org/sites/main/files/file-attachments/ca_delegation_-_covid-19_requests_-_final.pdf.
- Gollan J, Shogren E. May 12, 2020. “31,000 and Counting.” *Reveal*. <https://revealnews.org/article/31000-and-counting/>. Cites to Letter from Washington Congressional Delegation to CDC Director Redfield. March 4, 2020. <https://www.documentcloud.org/documents/6884965-WA-Delegation-Letter-to-Redfield.html>.
- For an in-depth discussion of CDC’s problematic position on airborne transmission of Covid-19 and health care workers’ need for respiratory protection, see NNU’s white paper: National Nurses United. “Deadly Shame...” (2020).
- 72 Centers for Disease Control and Prevention. Updated Sep 16, 2021. “Strategies for Optimizing the Supply of N95 Respirators.” Centers for Disease Control and Prevention. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html>.
- 73 Frederick J. Jun 28, 2021. “AHA letter to OSHA on COVID-19 Health Care Emergency Temporary Standard.” American Hospital Association. <https://www.aha.org/lettercomment/2021-06-29-aha-letter-osha-covid-19-health-care-emergency-temporary-standard>.
- 74 For additional information on hospitals’ ongoing failure to protect employees and patients, see National Nurses United. “National Nurse Survey...” (Sep 27, 2021).
- 75 For example, see Hanna J, Kaufman E. Mar 27, 2020. “More than 150 employees at 4 Boston Hospitals Have Tested Positive for Coronavirus.” *CNN*. <https://www.>

- [cnn.com/2020/03/26/health/boston-coronavirus-hospitals-employees-test-positive/index.html](https://www.cnn.com/2020/03/26/health/boston-coronavirus-hospitals-employees-test-positive/index.html) and Pohl J et al. Apr 2, 2020. "Medical Employees Say They're Getting COVID-19 on the Job. Here's Why Hospitals Push Back." *Sacramento Bee*. <https://www.sacbee.com/article241692061.html>.
- 76 Cox J. Apr 28, 2020. "What Happens if You and Daddy Die?" *The Washington Post*. <https://www.washingtonpost.com/graphics/2020/local/children-doctors-nurses-coronavirus-death/>.
Cox J et al. Mar 18, 2020. "'Dad, Are You Okay?': Doctors and Nurses Fighting Pandemic Fear Infecting Their Families?" *The Washington Post*. https://www.washingtonpost.com/local/dad-are-you-okay-doctors-and-nurses-fighting-pandemic-fear-infecting-their-families/2020/03/18/8beefc66-689b-11ea-b313-df458622c2cc_story.html.
Forgrave R. Mar 21, 2020. "Mask Shortage Hits Home: One Nurse's Story of Looking for Protective Masks." *Star Tribune*. <https://www.startribune.com/mask-shortage-hits-home-one-nurse-s-story-of-looking-for-protective-masks/568983442/>.
Greenberg N et al. Mar 26, 2020. "Managing Mental Health Challenges Faced by Healthcare Workers During COVID-19 Pandemic." *BMJ*. 368:m1211. doi:10.1136/bmj.m1211.
Luis C, Vance C. May/June 2020. "A Pandemic Crisis: Mentoring, Leadership, and the Millennial Nurse." *Nursing Economic\$*. 38(3):152-63.
McConnell D. Jun 2020. "Balancing the Duty to Treat with the Duty to Family in the Context of the COVID-19 Pandemic." *J Med Ethics*. 46(6):360-63. doi:10.1136/medethics-2020-106250.
Sacharczyk T. Mar 25, 2020. "Nurse Seeks Balance Between Caring for Patients and Her Family." *NBC 10 News*. <https://turnto10.com/news/local/nurse-seeks-balance-between-caring-for-patients-and-her-family>.
- 77 Greenberg N et al (Mar 26, 2020).
Janssen S. Apr 6, 2020. "Moral Injury in Health Care and COVID-19." *Social Work Today*. https://www.socialworktoday.com/archive/exc_040620.shtml.
Stoycheva V. "For Health Workers, COVID-19 Can Be a Moral Injury Pandemic." *Psychol Today*. Apr 13, 2020. <https://www.psychologytoday.com/us/blog/the-everyday-unconscious/202004/health-workers-covid-19-can-be-moral-injury-pandemic>.
- 78 McFarling U (Apr 28, 2020); Sacharczyk T (Mar 25, 2020).
79 Ibid.
80 Guarino B. Apr 16, 2020. "Nurses, Doctors Take Extreme Precautions to Avoid Infecting Family Members." *The Washington Post*. <https://www.washingtonpost.com/health/2020/04/16/nurses-doctors-are-taking-extreme-precautions-avoid-bringing-coronavirus-home/>.
81 Ibid.
82 McConnell D (Jun 2020).
83 Ibid.
84 Cox J (Apr 28, 2020).
Cox J et al. (Mar 18, 2020).
Forliti A. Apr 5, 2020 "Doctors, Nurses Leave Homes to Protect Families from Virus." *Associated Press*. <https://apnews.com/8697a4883bf8799aa235c393ed505bfe>.
Guarino B (Apr 16, 2020).
Lee YJ. Apr 4, 2020. "Sleeping in the Attic: How a NYC Nurse is Trying to Keep Her Family Safe from the Coronavirus as She Works on the Front Lines." *Business Insider*. <https://www.businessinsider.com/nyc-nurse-shieldingfamily-coronavirus-exposure-2020-4>.
McFarling U (Apr 28, 2020).
85 Forliti A (Apr 5, 2020).
Hardin T. May 21, 2020. "Written Testimony." Briefing, Heroes of the Coronavirus Crisis: Protecting Front-line and Essential Workers During the Pandemic, before Select Subcommittee on the Coronavirus Crisis of the House Oversight Committee. <https://coronavirus.house.gov/subcommittee-activity/briefings/heroes-coronavirus-crisis-protecting-frontline-and-essential-workers>.
McFarling U (Apr 28, 2020).
86 Hardin T (May 21, 2020).
87 Ibid.
Nguyen J. Mar 17, 2020. "Nurse Sends Her Kids to Live with Grandparents While She Fights Coronavirus." *Channel 933*. <https://channel933.iheart.com/content/nurse-sends-her-kids-to-live-with-grandparents-while-she-fights-coronavirus-new-york/>.
White D. Apr 8, 2020. "Hospital Workers Send Kids Away, Live in Campers to Protect Family During Coronavirus." *The Kansas City Star*. <https://www.kansascity.com/news/coronavirus/article241859741.html>.

- 88 Twohey M. Apr 7, 2020. "New Battle for Those on Coronavirus Front Lines: Child Custody." *The New York Times*. <https://www.nytimes.com/2020/04/07/us/coronavirus-child-custody.html>.
- 89 Cox J (Apr 28, 2020); Cox J et al. (Mar 18, 2020); Forgrave R (Mar 21, 2020); Hardin T (May 21, 2020).
- 90 Cox J (Apr 28, 2020).
- 91 For example, see Hardin T (May 21, 2020) and Kunkle F. Jul 27, 2020. "Head of Baltimore ICU Dies of Coronavirus, Surrounded by His Staff and Husband." *The Washington Post*. https://www.washingtonpost.com/local/head-of-baltimore-hospitals-icu-dies-of-coronavirus/2020/07/27/3831bfb8-d052-11ea-8d32-1ebf4e9d8e0d_story.html.
- 92 American Public Health Association. May 11, 2020. "APHA Sounds Alarm over Mental Health in Midst of COVID-19 Pandemic." American Public Health Association. <https://www.apha.org/news-and-media/news-releases/apha-news-releases/2020/apha-sounds-alarm-on-mental-health>.
- Panchal N et al. Aug 21, 2020. "The Implications of COVID-19 for Mental Health and Substance Abuse." Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.
- American Psychological Association. May 2020. "Stress in America™ 2020." American Psychological Association. <https://www.apa.org/news/press/releases/stress/2020/report>.
- 93 Studies of health care workers in other countries had similar findings as studies of U.S. health care workers.
- 94 Shanafelt T et al. Apr 07, 2020. "Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic." *JAMA*. 323(21): 2133-34. doi:10.1001/jama.2020.5893.
- 95 Hernandez J et al. 2021. "Traumatic Stress Among Frontline American Nurses During the COVID-19 Pandemic: A Survey Study." *Traumatology*. Advance online publication. doi:10.1037/trm0000320.
- 96 Press releases with survey information are available online. See:
National Nurses United. Mar 05, 2020. "Survey of Nation's Frontline Registered Nurses Shows Hospitals Unprepared For COVID-19." National Nurses United. <https://www.nationalnursesunited.org/press/survey-nations-frontline-registered-nurses-shows-hospitals-unprepared-covid-19>.
- National Nurses United. May 20, 2020. "New Survey of Nurses Provides Frontline Proof of Widespread Employer, Government Disregard for Nurse and Patient Safety, Mainly Through Lack of Optimal PPE." National Nurses United. <https://www.nationalnursesunited.org/press/new-survey-results>.
- National Nurses United. Jul 28, 2020. "National Nurse Survey Reveals Devastating Impact of Reopening Too Soon." National Nurses United. <https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-devastating-impact-reopening-too-soon>.
- National Nurses United. Nov 12, 2020. "National Nurse Survey Exposes Hospitals' Knowing Failure to Prepare for a Covid-19 Surge During Flu Season." National Nurses United. <https://www.nationalnursesunited.org/press/national-nurse-survey-4-exposes-hospitals-knowing-failure-prepare-covid-19-surge>.
- National Nurses United. Mar 10, 2021. "National RN Survey Highlights Continued Hospital Failures to Prioritize Nurse and Patient Safety During Pandemic." National Nurses United. <https://www.nationalnursesunited.org/press/fifth-survey-of-national-nurses-highlights-continued-hospital-failures>.
- National Nurses United. "National Nurse Survey..." (Sep 27, 2021).
- 97 National Nurses United. "National Nurse Survey..." (Nov 12, 2020).
- 98 Centers for Disease Control and Prevention. Last Reviewed Jul 22, 2021. "Reducing Stigma." U.S. Department of Health and Human Services. <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/reducing-stigma.html>.
- Ruiz N et al. Jul 1, 2020. "Many Black, Asian Americans Say They Have Experienced Discrimination Amid the COVID-19 Outbreak." *Pew Research Center*. <https://www.pewsocialtrends.org/2020/07/01/many-black-and-asian-americans-say-they-have-experienced-discrimination-amid-the-covid-19-outbreak/>.
- 99 Hawkins D. Jun 15, 2020. "Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity." *Am J Ind Med*. 1-4. doi:10.1002/ajim.23145.
- 100 David E. Apr 15, 2020. "Five Ways COVID-19 Might Be Affecting Filipino Americans." *Psych*

- Today. <https://www.psychologytoday.com/us/blog/unseen-and-unheard/202004/5-ways-covid-19-might-be-affecting-filipino-americans>.
- Lee J, Yadav M. May 21, 2020. "The Rise of Anti-Asian Hate in the Wake of Covid-19." *Items, Insights from the Social Sciences, Social Science Research Council*. <https://items.ssrc.org/covid-19-and-the-social-sciences/the-rise-of-anti-asian-hate-in-the-wake-of-covid-19/>.
- 101 Wingfield A. (May 14, 2020).
- 102 Wiley M. Jun 24, 2020. "I Feel So Overwhelmed': COVID-19 and Police Violence Takes a Toll on Black Health Care Workers." *KQED*. <https://www.kqed.org/news/11825898/i-feel-so-overwhelmed-covid-19-and-police-violence-takes-a-toll-on-black-health-care-workers>.
- 103 Kadri S et al. 2021. "Association between caseload surge and COVID-19 survival in 558 US hospitals, March to August 2020." *Annals of Internal Medicine* 174.9:1240-1251. <https://www.acpjournals.org/doi/10.7326/M21-1213>.
- 104 Morley G et al. May 2019. "What is 'Moral Distress'? A Narrative Synthesis of the Literature." *Nurs Ethics*. 26(3): 646-62. doi:10.1177/0969733017724354. Citing Jameton A. 1984. *Nursing Practice: The Ethical Issues*. Prentice-Hall.
- 105 Ibid.
- 106 Varcoe C et al. Mar 2012. "Moral Distress: Tensions as Springboards for Action." *HEC Forum*. 24(1): 51-62. doi:10.1007/s10730-012-9180-2.
- 107 National Nurses United. "National Nurse Survey..." (Jul 28, 2020).
National Nurses United. "National Nurse Survey...." (Nov 12, 2020).
National Nurses United. "National RN Survey..." (Mar 10, 2021).
National Nurses United. "National Nurse Survey..." (Sep 27, 2021).
- 108 Griffin K et al. Jul 1, 2020. "Hospital Preparedness for COVID-19: A Practical Guide From a Critical Care Perspective." *Amer J of Resp and Crit Care Med*. 49(4):342-43. doi:10.1164/rccm.202004-1037CP.
Rosenbaum L. Mar 18, 2020. "Facing Covid-19 in Italy — Ethics, Logistics, and Therapeutics on the Epidemic's Front Line." *N Engl J Med*. 382:1873-75. doi:10.1056/NEJMp2005492.
Greenberg N et al. (Mar 26, 2020).
Williamson V et al. Apr 2, 2020. "COVID-19 and Experiences of Moral Injury in Front-Line Key Workers." *Occup Med (Lond.)*. 70(5):317-319. doi:10.1093/occmed/kqaa052.
- 109 Rosenbaum L (Mar 18, 2020).
Ridderbusch K. Apr 22, 2020. "For Hospital Chaplains, Coronavirus Has Shifted Spiritual Care." *U.S. News and World Report*. <https://www.usnews.com/news/healthiest-communities/articles/2020-04-22/coronavirus-shifts-spiritual-care-for-hospital-chaplains>.
- 110 Berlinger N et al. Mar 16, 2020. "Ethical Framework for Health Care Institutions and Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic." *The Hastings Center*. <https://www.thehastingscenter.org/ethicalframeworkcovid19/>.
- 111 Kane R et al. Dec 2007. "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systematic Review and Meta-Analysis." *Medical Care*. 45(12):1195-204. doi:10.1097/mlr.0b013e3181468ca3.
National Nurses United. Jun 2019. "RN Staffing Ratios: A Necessary Solution to the Patient Safety Crisis in U.S. Hospitals." National Nurses United. https://act.nationalnursesunited.org/page/-/files/graphics/0619_Ratios_Booklet_NNU.pdf.
Sakr Y et al. Mar 2015. "The Impact of Hospital and ICU Organizational Factors on Outcome in Critically Ill Patients." *Crit Care Med*. 43(3):519-26. doi:10.1097/CCM.0000000000000754.
- 112 Halpern NA, Tan KS. May 13, 2020. "United States Resource Availability for COVID-19." *Soc Crit Care Med*. <https://sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19>.
- 113 Jansson M et al. Jun 2, 2020. "The Proportion of Understaffing and Increased Nursing Workload are Associated with Multiple Organ Failure: A Cross-Sectional Study." *J Adv Nurs*. 76:2113-24. doi:10.1111/jan.14410.
Kane R et al. (Dec 2007); National Nurses United. "RN Staffing Ratios..." (Jun 2019); Sakr Y et al. (Mar 2015).
- 114 Lin Z et al. Apr 23, 2020. "Psychological Burden in Health Care Professionals in Chinese Cities During the Coronavirus Disease 2019 (COVID-19) Outbreak." *SSRN preprints with The Lancet*. doi:10.2139/ssrn.3576782. <https://ssrn.com/abstract=3576782>. Citing Chen R et al. Feb 2006. "Effects of a SARS Prevention Programme in Taiwan on Nursing Staff's Anxiety, Depression and Sleep Quality: A Longitudinal Survey." *Int J Nurs Stud*. 43: 215.

- O'Halloran J. May 6, 2020. "I'm a Nurse in a COVID-19 Unit. My Hospital's Leaders Frighten Me More Than the Virus." *STAT*. <https://www.statnews.com/2020/05/06/nurse-frightenedhospital-administrators-more-than-covid-19>.
- Zaka A et al. Jun 2020. "COVID-19 Pandemic as a Watershed Moment: A Call for Systematic Psychological Health Care for Frontline Medical Staff." *J Health Psychol*. 25(7):883-87. doi:10.1177/1359105320925148.
- 115 O'Halloran J (May 6, 2020).
- 116 Ibid.
- 117 Pattison N. Apr 2, 2020 "End-of-Life Decisions and Care in the Midst of a Global Coronavirus (COVID-19) Pandemic." *Intensive Crit Care Nurs*. 58:102862. doi:10.1016/j.iccn.2020.102862. Citing Vincent L et al. Nov 2019. "Burnout Syndrome in UK Intensive Care Unit Staff: Data from All Three Burnout Syndrome Domains and Across Professional Groups, Genders and Ages." *J. Intensive Care Soc*. 20(4):363-69. doi:10.1177/1751143719860391 and Colville G et al. Aug 2019. "A Survey of Moral Distress in Staff Working in Intensive Care in the UK." *J. Intensive Care Soc*. 20(3):196-203.
- 118 Emanuel E et al. May 28, 2020. "Fair Allocation of Scarce Medical Resources in the Time of Covid-19." *N Engl J Med*. 382:2049-55. doi:10.1056/NEJMs2005114.
- 119 Litz B, Kerig P. Jun 2019. "Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications." *J Traumatic Stress*. 32(3):341-49.
- 120 Farnsworth J et al. Oct 2017. "A Functional Approach to Understanding and Treating Military-Related Moral Injury." *J Contextual Behav Sci*. 6(4):391-97. doi:10.1016/j.jcbs.2017.07.003.
- Litz B et al. Dec 2009. "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy." *Clin Psychol Rev*. 29:695-706. doi:10.1016/j.cpr.2009.07.003.
- Litz B, Kerig P (Jun 2019).
- Shay J. 2014. "Moral Injury." *Psychoanalytic Psychology*. 31(2):182-91. doi:10.1037/a0036090.
- Varcoe C et al. (Mar 2012).
- 121 Litz B, Kerig P (Jun 2019).
- 122 Williamson et al. distinguish between moral injury and mental health issues, including PTSD. They acknowledge that potentially morally injurious events "can lead to negative thoughts about oneself or others (e.g., 'I am a monster' or 'my colleagues don't care about me') as well as deep feelings of shame, guilt or disgust." In their view, these types of thoughts and feelings may be partially responsible for psychological problems such as PTSD, depression, and anxiety, but moral injury in and of itself is not a psychological disorder. Williamson V et al. (Apr 2, 2020). Citing Williamson V et al. 2018. "Occupational Moral Injury and Mental Health: Systematic Review and Meta-Analysis." *The British Journal of Psychiatry*. 212(6):339-346.
- 123 Jewett C. (Nov 4, 2021).
- Le Mignot S. Jun 23, 2020. "Suburban Nurse Gets COVID-19, Infects Her Family After Hospital Says Don't Wear Mask." *CBS Chicago*. <https://chicago.cbslocal.com/2020/06/23/suburban-nurse-gets-covid-19-infects-her-family-after-hospital-says-dont-wear-mask/>.
- Worcester S. Jul 31, 2020. "Higher Death Rate in Cancer Patients with Nosocomial COVID-19." *Medscape*. <https://www.medscape.com/viewarticle/934977>.
- 124 Williamson V et al. (Apr 2, 2020). Citing Griffin B et al. Jun 2019. "Moral Injury: An Integrative Review." *J Trauma Stress*. 32: 350-62. doi:10.1002/jts.22362 and Williamson V et al. (Jan 9, 2020).
- 125 Mantri S et al. Jul 17, 2020. "Identifying Moral Injury in Healthcare Professionals: The Moral Injury Symptom Scale-HP." *J Relig Health*. doi:10.1007/s10943-020-01065-w.
- Greenberg N et al. (Mar 26, 2020); Jannsen S (Apr 6, 2020); Stoycheva V (Apr 13, 2020); Williamson V et al. (Apr 2, 2020).
- 126 Williamson et al. (Apr 2, 2020).
- 127 See National Nurses United. 2021. "Nurse Staffing and Standards for Hospital Patient Safety and Quality Care Act." Fact Sheet. National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0421_Ratios_Federal_FactSheet.pdf.
- 128 Aiken L et al. 2010. "Implications of the California Nurse Staffing Mandate for Other States." *Health Services Research*. 45(4):204-21. <https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01114.x>.
- 129 Ibid.
- 130 Harless D. 2019. "Reassessing the Labor Market Effects of California's Minimum Nurse Staffing Regulations." *Health Economics*. 28(10):1226-31. <https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.3924>.

- 131 Leigh J et al. 2015. "California's Nurse-to-patient Ratio Law and Occupational Injury." *Int Arch Occup Environ Health*. 88(4):477-84. <https://pubmed.ncbi.nlm.nih.gov/25216822/>.
- 132 Spetz J. 2008. "Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations." *Policy Polit Nurs Pract*. 9(1):15-21. <https://pubmed.ncbi.nlm.nih.gov/18390479/>.
- 133 Shah M et al. 2021. "Prevalence of and Factors Associated with Nurse Burnout in the US." *JAMA Netw Open*. 4(2):e2036469. doi:10.1001/jamanetworkopen.2020.36469.
- 134 Han X et al. Oct 2021. "Alternative Approaches to Ensuring Adequate Nurse Staff: The Effect of State Legislation on Hospital Nurse Staffing." *Medical Care*, 59(10):S463-S470. https://journals.lww.com/lww-medicalcare/Fulltext/2021/10001/Alternative_Approaches_to_Ensuring_Adequate_Nurse.11.aspx. (Note that while the study correctly notes that California's RN-to-patient ratios statute allows for RN and licensed practical nurse staffing ratios, implementing regulations effectively permit only RNs to fulfill nurse staffing ratios because of limitations in licensed practical nurse scope of practice).
- 135 42 CFR § 482.23(b).
- 136 Centers for Medicare & Medicaid Services. Feb 21, 2020. "State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals." U.S. Department of Health and Human Services. Rev. 200 at A-0392. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.
- 137 For a detailed analysis of conflicts of interests of Medicare-approved Accrediting Organizations, see National Nurses United's comments to CMS's Request for Information on "Medicare Programs: Accrediting Organizations Conflict of Interest and Consulting Services; Request for Information," 83 Fed. Reg. 65,331 (Dec. 20, 2018). National Nurses United. Feb 2021. "NNU Comments, Medicare Program: Accrediting Organizations Conflict of Interest and Consulting Services; Request for Information." Comment ID CMS-2018-0158-0122, <https://www.regulations.gov/comment/CMS-2018-0158-0122>.
- 138 See Centers for Medicare & Medicaid Services. Nov 5, 2021. "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination." U.S. Department of Health and Human Services. Fed. Reg. 61,555-627.
- 139 See National Nurses United. "Injury to None..." (2021).
- 140 Occupational Safety and Health Act, 29 U.S.C. § 651.
- 141 29 U.S.C. § 655(a).
- 142 See World Health Organization. 2021. "Weekly Epidemiological Update on COVID-19 - 17 August 2021." World Health Organization. <https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19--17-august-2021>.
- 143 See National Nurses United. Nov. 3, 2021. NNU Letter to U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/NNU_Letter_to_DOL_Permanent_Health_Care_Covid-19_Standard_11032021.pdf.
- 144 Ritchie H et al. 2021. "Coronavirus Pandemic (COVID-19)." <https://ourworldindata.org/covid-vaccinations>. Citing Mathieu, E et al. 2021. "A Global Database of COVID-19 Vaccinations." *Nat Hum Behav*. Lal E. Jan 2, 2021. "Fragmented Health Systems in COVID-19: Rectifying the Misalignment Between Global Health Security and Universal Health Coverage." *The Lancet*. 397(10268):61-7. [https://www.thelancet.com/article/S0140-6736\(20\)32228-5/fulltext](https://www.thelancet.com/article/S0140-6736(20)32228-5/fulltext).
- 145 See NNU Letter to U.S. Secretary of Labor and Assistant Secretary of Labor for OSHA (Nov. 3, 2021).
- 146 Under the Biden administration, as of November 7, 2021, federal OSHA received 3,794 complaints from workers and reported as having opened 493 inspections in response to complaints (13%). Occupational Safety and Health Administration. Nov 8, 2021. "COVID-19 Response Summary." U.S. Department of Labor. <https://www.osha.gov/enforcement/covid-19-data>.
- 147 Protecting the Right to Organize Act of 2021, S. 420, 117th Cong. (Sen. Murray); Protecting the Right to Organize Act of 2021, H.R. 842, 117th Cong. (Rep. Scott).
- 148 VA Office of the Inspector General. 2021. "OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2021." Department of Veterans Affairs. <https://www.va.gov/oig/pubs/VAOIG-21-01357-271.pdf>.
- 149 See, e.g., Dube A et al. 2016. "Nurse Unions and Patient Outcomes." *ILR Rev*. 69(4):803-33. doi: 10.1177/0019793916644251.

- Ash M, Seago J. 2004. "The Effect of Registered Nurses' Unions on Heart Attack Mortality." *ILR Rev.* 57(3):422-42. doi:10.1177/001979390405700306; and Dean A et al. 2020. "Mortality Rates from COVID-19 Are Lower in Unionized Nursing Homes." *Health Affairs.* 39:11. doi:10.1377/hlthaff.2020.01011.
- 150 A hospital's commitment to labor/management partnership should not suffice to demonstrate a hospital's commitment to labor peace, as such a partnership should only occur once a union has been selected by hospital employees, to determine whether employees wish to establish such partnership through collective bargaining.
- 151 Definitive Healthcare. 2020. "2020 Trend Report: Breaking Down U.S. Hospital Payor Mixes" Definitive Healthcare. <https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes>.
- 152 Bureau of Labor Statistics. Mar 2021. "Employee Benefits in the United States, March 2021." U.S. Department of Labor. <https://www.bls.gov/ncs/ebs/benefits/2021/employee-benefits-in-the-united-states-march-2021.pdf>.
- 153 Ibid.
- 154 White House. Sep 7, 2015. "Executive Order: Establishing Paid Sick Leave for Federal Contractors." <https://obamawhitehouse.archives.gov/the-press-office/2015/09/08/executive-order-establishing-paid-sick-leave-federal-contractors>.
- 155 National Nurses United. "Deadly Shame..." (2020).
- 156 Ibid.
- 157 National Nurses United. May 2021. "Scientific Brief: Multiple Measures, Including Masks, Needed to Curb Covid-19." National Nurses United. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0521_Covid19_H%26S_MultipleMeasures_ScientificBrief.pdf.
- 158 20 U.S.C. § 1082(a)(6). Although this section is specific to the HEA Federal Family Education Loan Program (FFELP), the Education Secretary has long relied on this statutory authority to carry out all Direct Loan Programs under Title IV of the HEA, and Congress has acquiesced to such interpretation of the statute. For a more detailed analysis of the Education Secretary's authority to "compromise" federal educational debt, see the Letter from Legal Services Center of Harvard Law School To Senator Elizabeth Warren. Sept. 2020. "Cancellation of Federal Student Loan Debt." Available at <https://policymemos.hks.harvard.edu/links/letter-legal-services-ctr-harvard-law-school-sen-elizabeth-warren-re-cancellation>.
- 159 For example, see: Cox J et al. (Mar 18, 2020); Lee YJ (Apr 4, 2020); McFarling U (Apr 28, 2020).
- 160 See 5 CFR § 550.902 et seq.
- 161 5 U.S.C. § 5545(d).
- 162 5 Code Fed. Reg. Part 550, Subpart I, Appendix A.
- 163 The exception is the tuition-free nursing programs in public community colleges which would be a new program. Both the Biden administration and Congressional Democrats support two years of tuition-free community college. See, for example, in the House Build Back Better Act, House Committee on Labor and Education. 2021. Build Back Better Act: Investing in Students, Families, and Workers." Fact Sheet. <https://edlabor.house.gov/imo/media/doc/2021-09-09%20E&L%20BBB%20Mark%20Up%20Fact%20Sheet%202.pdf>; and Biden's American Families Plan, White House Press Release. Apr 28, 2021. "FACT SHEET: The American Families Plan." <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/>.
- NNU has long supported tuition-free education for all at public colleges and universities. For example, NNU is a long-time supporter of the Inclusive Prosperity Act introduced most recently in 2019 which would impose a small tax on stock market speculation to pay for social programs including free college tuition. National Nurses United. May 22, 2019. "RNs Applaud Reintroduction of Robin Hood Tax Act to Raise Money for Education, Health Care, and Vital Social Programs." National Nurses United. <https://www.nationalnursesunited.org/press/rns-applaud-reintroduction-robin-hood-tax-act-raise-money-education-health-care-and-vital>.
- 164 Health Resources & Services Administration. Feb 2021. "What is Shortage Designation?" U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation>. Taylor J. 2019. "Racism, Inequality, and Health Care for African Americans." The Century Foundation. <https://tcf.org/content/report/racism-inequality-health-care-african-americans/>.

- 165 Probst J et al. Oct 2019. "Rural Registered Nurses: Educational Preparation, Workplace, and Salary." Rural and Minority Health Research Center. https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/ruralregisterednurses.pdf.
- 166 U.S. House of Representatives. Committee on Appropriations. Jul 19, 2021. "Report Together with Minority Views to Accompany HR. 4502." 117th Cong. <https://www.congress.gov/117/crpt/hrpt96/CRPT-117hrpt96.pdf>.
- 167 Health Resources and Services Administration. 2021. "Justification of Estimates for Appropriations Committees, Fiscal Year 2022." U.S. Department of Health and Human Services. <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf>.
Health Resources and Services Administration. 2019. "Justification of Estimates for Appropriations Committees, Fiscal Year 2020." U.S. Department of Health and Human Services. <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf>.
Health Resources and Services Administration. 2017. "Justification of Estimates for Appropriations Committees, Fiscal Year 2018." U.S. Department of Health and Human Services. <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-2018.pdf>.
- 168 Health Resources and Services Administration. 2021. "Nurse Corps Scholarship Program, School Year 2021-2022, Application & Program Guidance." U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-sp-guidance.pdf>.
- 169 Health Resources and Services Administration. 2021. "Nurse Corps Loan Repayment Program, Fiscal Year 2021, Application & Program Guidance." U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/nursecorps-lrp-guidance.pdf>.
- 170 42 U.S.C. § 296m(a).
- 171 Health Resources and Services Administration. "Nurse Corps Scholarship Program..." (2021).
- 172 Health Resources and Services Administration. 2020. "Nurse Corps Loan Repayment and Scholarship Programs Report to Congress for Fiscal Year (FY) 2019." U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/about-us/reports-to-congress/nurse-corps-report-congress-fy19.pdf>.
- 173 Yoo B et al. 2016. "The Effect of Prior Healthcare Employment on the Wages of Registered Nurses." *BMC Health Services Research*. 16(1):1-12. doi:10.1186/s12913-016-1667-0.
- 174 American Association of Colleges of Nursing. Sep 2020. "Nurse Faculty Shortage." Fact Sheet. <https://www.aacnnursing.org/Portals/42/News/Factsheets/Faculty-Shortage-Factsheet.pdf>.
- 175 National Nurses United. "Deadly Shame..." (2020).
- 176 See NNU's sixth survey of RNs on Covid-19 which included the effects on nurses of stressors and mental health impacts of the pandemic. National Nurses United. Sep 27, 2021. "National Nurse Survey Reveals That Health Care Employers Need to Do More to Comply with OSHA Emergency Temporary Standard." National Nurses United. <https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers>.

SAVE
Safe Staffing NOW
LIVES



**National
Nurses
United**

www.NationalNursesUnited.org