A Union of Professionals
AFT Nurses and Health Professionals

Poor Staffing Leads to Injuries and Illness for Healthcare Workers

Healthcare workers know from their own experience that inadequate staffing leads to occupational injuries and stress. Although a great deal of research has focused on the impact of poor staffing on patient safety, the impact of poor staffing on healthcare workers' injuries and illnesses has received too little attention. One study conducted after California passed the staffing ratio law found that **registered nurses in California hospitals suffered 31.6% fewer injuries and illnesses** per 10,000 RNs compared to RNs in all other states. **Licensed practical nurses had 38.2% fewer injuries and illnesses** compared to LPNs in other states.[1] Much more research is needed to provide evidence that better staffing will reduce healthcare workers' injuries and illnesses. Examples of existing studies are listed below by type of exposure.

Even without extensive research, leaders can make the case that poor staffing puts healthcare workers at risk of injury and illness. Unions can insist on conducting root cause analysis of incidents in labor-management committees (for example, the health and safety or staffing committee). Information on staffing levels and staffing mix should be included in the analysis. Showing that staffing was inadequate and a contributing factor in an incident pushes back on blaming the worker for their injury. Unions can also compare injury and illness data with staffing records to identify whether injuries are higher when units are poorly staffed.

Workplace Violence

Violence against healthcare workers is serious and rising while staffing continues to get worse. Healthcare and social services workers experience 76% of all reported workplace violence injuries in the American labor force.[2] The number of actual assaults is likely to be much higher. One study of psychiatric staff found that 85% of workplace violence incidents are never reported.[3]

Over the 15 years between 2006 and 2020, the rate of reported assaults grew by:

- 173% in private hospitals
- 95% in private psychiatric hospitals and substance use facilities
- 63% in home health agencies[4]

COVID-19 added fuel to the flames—the rate of reported assaults climbed 25% in one year alone from 2019 to 2020.[5]

The Occupational Safety and Health Administration and National Institute for Occupational Safety and Health have identified understaffing as a risk factor for workplace violence.[6] [7] Descriptive studies show that poor staffing increases the risk of violence.[8] [9] Long wait times and inadequate attention can lead to escalating behavior in some patients and visitors. In some cases, workers are too busy to notice or respond

to patients and visitors growing increasingly irate. Poor staffing also increases the risk of serious injury when too few workers are available to safely restrain violent patients or when staff work in isolation.

More research is needed to investigate the relationship between understaffing and workplace violence. Two studies found that a higher staffing rate was associated with higher rates of assaults on staff and other patients in psychiatric units.[10] [11] Critics of the studies argued that the researcher was comparing reported incidents of workplace violence, not the actual number of assaults, noting the high probability of underreporting in poorly staffed facilities.

OSHA, NIOSH, and researchers have noted the critical importance of workplace violence prevention programs that train frontline staff and managers to report all incidents of workplace violence and all "near-misses" in order to develop evidence-based prevention strategies.[12] Unfortunately, healthcare workers often do not report incidents of workplace violence, because they find themselves blamed for their assault. Unions can insist on a labor-management process to conduct root cause analysis after every workplace violence incident and near miss, including information on staffing conditions leading up to the assault.

Safe Patient Handling and Movement in Response to Musculoskeletal Injuries

Healthcare workers continue to suffer high rates of musculoskeletal injuries due to the cumulative impact of manual lifting and transferring of patients. The rate of injuries in hospitals from lifting and overexertion was 15.1 and 18.9 in nursing and residential care facilities, compared to 8.1 for all other industries in 2020.[13] The solution—adequate access and training to use safe patient handling equipment—has been well-established.

Many advocates for safe patient handling and movement equipment continue to focus on changing healthcare workers' behavior, blaming continued high rates of injury on workers' stubborn refusal to use the equipment consistently. However, one study found that time constraints, including understaffing, were a barrier to use of assistive devices. **Staffing levels was cited as a barrier by 79 percent of the nursing staff surveyed.** Workload and availability of equipment were reported by 78 percent of the respondents and having to respond quickly to emergent patient needs was cited by 73 percent.[14] Even so, the authors of the study continued to recommend training and a supportive culture as a solution, rather than naming understaffing as a key reason healthcare workers find themselves without enough time to use assistive devices. Healthcare workers find themselves blamed for their injuries, when inadequate staffing plays a role in actions that lead to injuries.

Labor-management committees can use surveys and root cause analysis to identify and address hurdles to using safe patient lifting equipment consistently, including time constraints related to staffing.

Needlestick and Sharps Injuries

In a study examining the relationship between needlestick and sharps injuries and staffing, researchers found that shifts with **fewer nursing care hours per shift, lower RN skill mix, and a lower percentage of experienced staff were associated with higher rates of needlestick injury**.[15]

Health and safety committees can look at trends in the needlestick injury log or in the OSHA 300 log to see which units and which times or shifts have the highest frequency of needlestick injuries. Although OSHA requires names to be redacted from the 300 log for needlestick injuries, the job title must be listed, telling us which workers are at highest risk. This data can be compared to staffing information to see if low staffing results in more needlestick injuries.

Fatigue

Research on fatigue among nurses has focused on the impacts of shift work, including extended shifts and overtime, night shifts and rotating shifts, and inadequate recovery time between shifts. All these factors have been shown to lead to chronic sleep deprivation. In the short term, sleep deprivation causes fatigue, reduced cognitive function, increased risk of errors, such as needlestick injuries, unsafe driving, and patient safety errors. Over the longer term, chronic sleep deprivation can cause cardiac, gastrointestinal, and metabolic illnesses**.** Chronic lack of sleep has been shown to foster proinflammatory activity and immunodeficiency, putting workers at higher risk for infection. [16]

When facilities are understaffed, nurses and other healthcare workers are under pressure to work overtime and accept additional shifts without adequate rest periods between shifts. One study of hospital nurses working successive 12-hour shifts found that the majority slept less than six hours between shifts.[17] Other research has found that people working rotating shifts sleep up to four hours less when they work at night. [18]

The relationship between understaffing and fatigue is cyclical. Poor staffing and mandatory overtime lead to fatigue, which can lead to burnout and more healthcare workers choosing to leave the bedside to protect their health and mental health. This leads to more understaffing. In the past, research on the impacts of mandatory overtime and extended work shifts helped to win passage of state laws prohibiting mandatory overtime. **More research is needed to show how patterns of understaffing lead to more demand for overtime and additional shifts**. Research is also needed to show long-term mental health impacts of fatigue and overwork, as well as physical health impacts.

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[2] BLS, SOII, 2020, Table R8.

[3] Bensley, Lillian, et al., "Injuries due to assaults on psychiatric hospital employees in Washington State," *American Journal of Industrial Medicine*, 31 no.1 (1997): 92-99.

[4] BLS SOII, 2000, 2006, 2020, Table R8.

[5] BLS SOII, 2019, 2020, Table R8.

[6] Centers for Disease Prevention and Prevention, National Institute for Occupational Safety and Health, "Violence," *Occupational Hazards in Hospitals*, 2002. Violence_10-03 (cdc.gov).

[7] U.S. Department of Labor, Occupational Safety and Health Administration, 2015, Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (osha.gov).

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[13] BLS, SOII, 2020, Table R8.

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[16] Trinkoff, A. M. et al. Nurses are more exhausted than ever: What should we do about it?" *American Journal of Nursing*, 2021 Dec; 121(12)18-28.

[17] Geiger-Brown, J. et al. "Sleep, sleepiness, fatigue, and performance of 12-hour shift nurses. *Chronobiology International*, 2012; 29(2)211-9.

[18] Trinkoff, A. M. et al. Nurses are more exhausted than ever: What should we do about it?" *American Journal of Nursing*, 2021 Dec; 121(12)18-28.