



Get the facts about Registered Nurse
staffing and patient safety

More than 1,000 preventable deaths every day

An estimated 440,000 avoidable deaths take place in American hospitals each year due to adverse events that proper nursing care can often prevent.* These can include surgical-site infections, bloodstream infections, shock or cardiac arrest, ventilator-acquired pneumonia, gastrointestinal bleeding, deep venous thrombosis (blood clots) after surgery, patients falls, missed diagnoses, and missed, delayed or incorrect medication.

Here's just a few of the dozens of scientific studies showing the link between low registered nurse staffing and higher rates of serious patient complications and death in our hospitals:

People who go into cardiac arrest while hospitalized are **5 percent less likely to survive** for each additional patient assigned to their nurse.

Medical Care, January 2016

ICU patients are **3.5 times more likely to die** when the nurse-patient ratio is higher than 1 to 2.5. *Critical Care Medicine, August 2015*

Stroke patients are up to **35 percent more likely to die** on units with fewer nurses on duty.

PLOS Medicine, August 2014

Adding one surgical patient to a nurse's workload increases the **likelihood of patient death within 30 days of admission by 7 percent.**

The Lancet, 2014

Hospitals with better nurse staffing levels had **25 percent lower** odds of being penalized for preventable readmissions.

Health Affairs, October 2013

Death rates are 60 percent lower for patients with aortic abdominal aneurysm in hospitals with better nurse-to-patient ratios.

Health Services Research, June 2013

Likelihood of readmission for children within 30 days of surgery is 48 percent higher when just one child is added to the staffing ratio.

BMJ Quality & Safety in Health Care, May 2013

Patients in hospitals with higher RN staffing levels were **68 percent less likely to acquire an infection.**

Medical Care, June 2007

*"A new, evidence-based estimate of patient harms associated with hospital care," *Journal of Patient Safety, September 2013*