California Nurses Association
National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-287-5021

SACRAMENTO
Government Relations
980 9th Street
Suite 700
Sacramento CA 95814
phone: 916-446-5019
fax: 916-446-3880

Via electronic mail to CHCQRegulations@cdph.ca.gov.

May 20, 2025

Mandi Posner, Deputy Director
Center for Health Care Quality
California Department of Public Health
1615 Capitol Avenue, Sacramento, CA 95899-7377

RE: Comments on Questions for Stakeholder Meeting – Acute Psychiatric Hospital Regulations AFL-25-16

Dear Deputy Director Posner:

California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses (RNs) who provide direct patient care in California including nurses who work in acute psychiatric hospitals (APHs), writes to you in response to questions posed at the May 13, 2025, Stakeholder Meeting on Acute Psychiatric Hospital Regulations held by the California Department of Public Health (CDPH). By fully implementing safe registered nurse-to-patient ratios throughout acute psychiatric care facilities in California, CDPH can ensure all Californians can access high-quality behavioral health care services. To this end and to protect behavioral health patients, RNs, and other health care workers in our acute psychiatric care facilities, CNA urges that CDPH issue emergency regulations mandating unit-specific minimum numerical registered nurse-to-patient ratios in acute psychiatric facilities throughout the state.

On April 15, 2025, CNA sent a letter to Governor Gavin Newsom urging the issuance of CDPH emergency regulations establishing mandatory minimum registered nurse-to-patient staffing ratios for APHs. We reiterate this request that CDPH issue emergency regulations on APH registered nursing staffing ratios, and CNA urges CDPH to implement the proposed regulations that we attached to our letter to Governor Newsom. CNA's proposed regulatory language for emergency rulemaking on APH minimum safe nurse staffing standards is attached to these comments as Attachment 1, and CNA's April 15, 2025, letter to Governor Newsom is attached to these comments to as Attachment 2. RN staffing ratios in California acute psychiatric facilities must be implemented without delay to prevent further patient harm and preserve thousands of lives.

As registered nurses, CNA members know that one of the most effective ways to protect patients is through safe and effective staffing. Staffing levels of RNs that facilitate safe,

competent, therapeutic, and effective care are vital to the safety of patients in our hospitals. For decades, research has demonstrated that safe RN-to-patient staffing ratios are associated with lower mortality, lower nurse burnout, and better nurse retention.[1] The only way to ensure that all hospitals—including APHs—have safe staffing levels that are consistently adhered to is through legally mandated minimum RN-to-patient ratios. California's legislature recognized this in 1999 when it passed Assembly Bill No. 394 (A.B. 394) (Kuehl) and mandated that California's health services agency promulgate regulations on mandatory minimum numerical nurse staffing ratios for all hospitals in the state, including general acute care hospitals (GACHs) and APHs.

Although state regulators should have issued APH nurse staffing ratios promptly after A.B. 394 went into effect over two decades ago, the recently exposed dire state of patient care in APHs emphatically demonstrates the urgent need to issue these regulations. For these reasons, the reasons set forth in CNA's April 15, 2025, letter to Governor Newsom, and the reasons below, CNA urges CDPH to promptly issue emergency regulations establishing APH minimum numerical registered nurse-to-patient staffing ratios.

1. What is the method used by acute psychiatric hospitals to determine real-time staffing needs?

To determine real-time staffing needs, CDPH should require that APHs start with minimum RN-to-patient ratios and staff additional RNs based on patient need as assessed by the direct care registered nurse. This said, given the differences in staffing among APHs, there currently does not appear to be a consistent method to ensure a safe staffing baseline in APHs. Indeed, research has shown that despite concerns about workplace violence, staffing levels, and use of seclusion and restraint, increases in RN staffing in acute psychiatric settings have not kept pace with increases in general acute care settings.[2] In Attachment 2 to these comments, CDPH will find a complete list of research literature specifically supporting safe staffing levels for inpatient psychiatric patients, which CNA sent to Governor Newsom on April 15, 2025.[3]

Recent news reports of serious patient harm, including death and sexual assault, demonstrate that some for-profit APHs are severely understaffed, confirming research that shows

[1] *See* Lasater K., Muir K. J., Sloane D., McHugh M., Aiken, L. (2024). "Alternative Models of Nurse Staffing May Be Dangerous in High-Stakes Hospital Care." *Med Care*, 62(7): 434-40. https://doi.org/10.1097/MLR.0000000000001990.

[2] Staggs, V. (2019). National trends and variation in nurse staffing on inpatient psychiatric units. *Research in nursing & health*, 42(5): 410-415.

[3] CNA included a list of research literature in support of APH registered nurse-to-patient staffing standards to our April 15, 2025, letter to Governor Newsom. We have attached the April 15 letter in its entirety to these comments as Attachment 2.

RN staffing levels are lower in for-profit facilities.[4] In contrast, CDPH regulations mandating RN-to-patient ratios would establish a minimum staffing standard that would apply to all APHs.

Critically, a registered nurse's patient assessment should be the basis for the final decision making on staffing needs, which should be reflected in CDPH's regulation on APH registered nurse staffing standards. While some APHs may use a patient classification system (PCS), these systems alone cannot determine staffing needs. PCSs are a method for establishing staffing requirements by unit, patient, and shift, as defined by section 70053.2 of title 22 of the California Code of Regulations. Notably, however, in general acute care hospitals (GACHs), the PCSs are often adjusted to conform to a budget rather than to patient acuity and patient treatment needs.[5] Because even the best PCS cannot capture all relevant issues to real time staffing needs, CDPH should ensure in its APH nurse staffing regulation that an RN must directly assess each patient to determine their needs.

CDPH should adopt, as has been required under the Health and Safety Code section 1276.4 for over twenty years, RN-to-patient ratios in APHs that set a minimum standard to protect patients and staff in the inpatient APH setting. In its regulation, CDPH should require that APHs assign additional staff based on patient needs as determined by the assessment of the assigned RN. These minimum protective standards "level the playing field" to ensure a safe staffing baseline for every patient in every APH regardless of ownership type.

2. What is the minimum nurse to patient ratio needed for a unit that cares for adults? Is the minimum staffing the same for every shift? How should other mental health workers be included in the nursing ratio? Please explain.

- **CDPH Should Require a Minimum 1:6 Staffing Ratio—Which Must be a <u>Registered Nurse</u>-to-Patient Ratio—For Acute Adult Psychiatric Patients to Ensure That APH Patients Receive Competent, Therapeutic Care in a Safe Environment.**

As the sponsor of the 1999 enabling legislation requiring the establishment of both GACH and APH minimum RN-to-patient ratios, CNA urges CPDH to adopt a minimum RN-to-

[4] Palomino, J. and Dizkies, C. (Feb 26, 2025). "The Mystery shocked San Francisco. This is the story of the 15-year-old-girl found dead in a driveway." *San Francisco Chronicle*. https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-jazmin-pellegrini-death/;
Palomino, J. and Dizkies, C. (Mar 5, 2025). "California is embracing psychiatric hospitals again. Behind locked doors, a profit-driven system is destroying lives." *San Francisco Chronicle*. https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-crisis/;
Palomino, J. and Dizkies, C. (Mar 19, 2025). "Violence and neglect plague a Bay Area psychiatric hospital. California has left its patients in danger." *San Francisco Chronicle*. https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-patients/.
Staggs, V. (2019), *supra*, at note 2.

[5] Kolakowski, D. (2016). Constructing a nursing budget using a patient classification system. *Nursing Management*, 47(2), 14-16.

adult psychiatric patient ratio of 1:6 or fewer at all times. To ensure that acute psychiatric patients in APHs have the same standard of care as acute psychiatric patient in GACHs, CDPH must adopt, at a minimum, a registered nurse staffing ratio of 1:6.[6] **In other words, CPDH should adopt a minimum nurse staffing standard that requires the following: Every psychiatric patient admitted to an APH must be assigned to a registered nurse who has responsibility for all professional nursing care duties for no more than 6 patients.**

CDPH should further limit the number of patients that are assigned to the RN in units in which patients have higher acuity or are at risk of harm to themselves or others. Examples of such units include units for patients who are at risk of harm to themselves or others, dual diagnosis units for patients with substance use disorder and another psychiatric diagnosis, geriatric units, and units for patients with both medical and psychiatric needs. For example, for patients at risk of harm to themselves or others, the GACH ratio of 1:1 registered nurse-to-patient ratio for critical trauma patients should be adopted. Patients in the APH setting are entitled to staffing protections that, at the very least, mirror those in GACHs. To the greatest extent possible, CDPHs APH staffing requirements should mirror the unit-specific numerical ratios and other implementation standards for GACHs found in California Code of Regulations, title 22, section 70217. CNA's proposed regulatory language for APH staffing standards, which is attached here as Attachment 1, has been adopted from the GACH rulemaking, adapted to reflect the inpatient psychiatric units and unit types found in APHs.

CDPH has been statutorily required to adopt APH nurse staffing ratios for over 25 years. CDPH is required by Health and Safety Code section 1276.4, subdivision (a) to adopt regulations that "establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit" for all GACHs, APHs, and special hospitals. Section 1276.4, subdivision (b) of the Health and Safety Code further clarifies that, "These ratios shall constitute the minimum number of registered and licensed nurses that shall be allocated."

Importantly, as enumerated in statute, these nurse staffing ratios must be adopted in accordance with hospital licensing and certification requirements as well as registered nursing practice standards, including regulations on the registered nurse nursing process and registered nurse competency. These regulations include California Code of Regulations, title 22, sections 70053.2, 70215, and 70217 and title 16, section 1443.5 as they were in effect when A.B. 394 was signed into law on October 10, 1999.

Specifically, as enumerated in Health and Safety Code section 1276.4, subdivision (a), CDPH must adopt registered nurse to patient ratios in accordance with each of the following:

[6] Cal. Code Regs., tit. 22, § 70217, subd. (a)(13).

- **California Code of Regulations, title 22, section 70053.2**, describing the hospital licensing and certification requirements around the use of a PCS. Section 70053.2 defines the PCS, in part, as a method for establishing staffing requirements by unit, patient, and shift based upon the requirements of individual patients.
- **California Code of Regulations, title 22, section 70215,** establishing the role of the RN in the planning and implementing of patient care through the nursing process.
- **California Code of Regulations, title 22, section 70217,** further describing the PCS and the duties of the assigned RN.[7]
- **California Code of Regulations, title 16, section 1443.5**, establishing registered nurse standards of competency.

As described in more detail below, the above statutory references to regulations on hospital licensing and registered nurse scope of practice, in effect, establish the registered nurse as responsible for the ongoing assessment of each and every patient admitted to an APH and responsible for all the specific RN roles in determining appropriate nursing care plans and staffing needs of patients.

- **Because the Nurse Staffing Ratio Statute Requires the Assessment of an RN to Determine the Nursing Care Needs of Individual Patients, APH Nurse Staffing Ratios Must be Registered Nurse-to-Patient Staffing Ratios.**

In accordance with the statutory mandate to implement staffing standards that meet the individualized care needs of patients, the APH nurse staffing ratios must be registered nurse-to-patient ratios. Taken together, the expressly stated standards in the nurse staffing ratios enabling legislation, A.B. 394 (1999), require that a registered nurse, consistent with their scope of practice, exercise their independent professional judgment to provide an ongoing assessment of the individual care needs of each patient and to ensure that the delivery of care reflects the nursing process.[8]

First, the APH nurse staffing ratios enabling legislation expressly identifies its legislative purpose of meeting individualized care needs of patients. Section 1 of A.B. 394 enumerates the statutory purpose of Health and Safety Code section 1276.4, expressly stating that staffing in

[7] CDPH's predecessor agency implemented GACH regulation on mandatory minimum nurse staffing ratios in California Code of Regulations, title 22, section 70217, repealing the previous regulatory text that was in effect when A.B. 394 was signed into law in October 1999. See Former California Code of Regulations, title 22, section 70217 filed Nov. 26, 1996, became operative 12-26-96 (Cal. Reg. Notice Register 96, No. 48). Amended Sept. 26, 2003, and became operative Jan. 1, 2004 (Cal. Reg. Notice Register 2003, No. 39).

[8] See Stats. 1999, ch. 945, Section 1(d), A.B. 394 (Kuehl).

acute care settings must be "based on the patient's care needs, the severity of condition, services needed, and the complexity surrounding those services[.]"[9]

Second, A.B. 394 goes on in section 2 to recognize that individualized patient care needs can only be determined through the ongoing assessment of the assigned registered nurse and in accordance with nursing scope of practice.[10] Specifically, A.B. 394, as codified in Health and Safety Code section 1276.4, subdivision (a), requires that CDPH "shall adopt" the nurse staffing ratio regulations "in accordance with" several expressly listed hospital licensing and certification requirements and registered nurse competency requirements, including the following requirements:

- Pursuant to California Code of Regulations, title 22, section 70215, subdivision (a)(1) (as it was in effect in Oct. 1999), the nurse staffing ratios must be based on a determination of nursing care needs of individual patients that reflects the registered nurse's ongoing assessment of each patient's care requirements and that provides for shift-by-shift staffing based on those requirements.[11] Section 70215, subdivision (a) expressly states that "[a] registered nurse shall directly provide" the ongoing patient assessment.
- Pursuant to California Code of Regulations, title 22, section 70215, subdivision (b), the nurse staffing ratios "shall" provide sufficient nurse staffing to ensure that the planning and delivery of patient care "reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission." In accordance with nursing scope of practice, the demonstrated ability to apply the nursing process determines the competency of registered nurses and the nursing process is a duty and function that can only be applied by a competent registered nurse.[12]
- Pursuant to California Code of Regulations, title 22, section 70217, subdivision (a) (as it was in effect in Oct. 1999), the nurse staffing ratios must be determined in accordance with individual patient care requirements and generally accepted standards of nursing practice, and must be reflective of unique patient populations.[13]
- Pursuant to California Code of Regulations, title 16, section 1443.5, the nurse staffing ratios must be consistent with the standards of competency of registered nurses.

---

[9] Stats. 1999, ch. 945, Section 1(d), A.B. 394 (Kuehl).

[10] See Cal. Code Regs., tit. 22, § 70215.

[11] Former California Code of Regulations, title 22, section 70217 filed Nov. 26, 1996, became operative Dec. 26, 1996 (Cal. Reg. Notice Register 96, No. 48). Change without regulatory effect amending subsection (a)(1) filed Jan. 9, 2013, pursuant to section 100, title 1, California Code of Regulations (Cal. Reg. Notice Register 2013, No. 2).

[12] See Cal. Code Regs., tit. 16, § 1443.5.

[13] Former California Code of Regulations, title 22, section 70217 filed Nov. 26, 1996, became operative Dec. 26, 1996 (Cal. Reg. Notice Register 96, No. 48). Amended Sept. 26, 2003, and became operative Jan. 1, 2004 (Cal. Reg. Notice Register 2003, No. 39).

Taken as a whole, in order for CDPH to adopt nurse staffing ratios in accordance with California Code of Regulations, title 22, sections 70053.2, 70215, and 70217 and title 16, section 1443.5, the nurse staffing ratio must be a registered nurse staffing ratio that ensures that the registered nurse can directly provide an ongoing patient assessment of their individual care needs while meeting registered nurse competency standards and applying the nursing process.

Importantly, considering that the nursing process and ongoing patient assessment can only be provided by a registered nurse, the nurse staffing ratios must be registered nurse staffing ratios to ensure that staffing standards do not result in a conflict with nursing scope of practice. Indeed, Health and Safety Code section 1276.4, subdivision (h) directs CDPH, in its adoption of the nurse staffing ratios, to ensure that scope of nursing practice controls if there is a conflict between statute and any provision or regulation defining the scope of nursing practice.

Finally, litigation over nurse-to-patient ratio regulations for GACHs confirmed the role of RNs in the nurse staffing ratio. The California Superior Court summarized the role of RNs in the licensed nurse ratios statute under Health and Safety Code, section 1276.4 in its final decision in *California Nurses Association v. Schwarzenegger et al.*, which was the litigation regarding the implementation of GACH nurse-to-patient ratios regulation. Judge Judy Holzer Hersher's final decision in the case confirms that RN scope of practice controls where there may be a conflict between the nursing ratios statute and any nursing scope of practice regulation.

> These sections [of the California Code of Regulations referenced in Health and Safety Code section 1276.4(a)] describe or explain the professional obligations of **registered nurses** in the provision of health care. For example, section 70053.2 describes the Patient Classification System. Section 70215 provides that an [sic] nurse must provide, among other things, ongoing patient assessments as defined in the Nursing Practice Act, and the planning, supervision, implementation, and evaluation of nursing care to each patient in accordance with the elements of the nursing process. Section 70217(j) likewise provides that nursing personnel shall assist the administrator of nursing services, provide direct patient care, and provide clinical supervision and coordination of care given by licensed vocational nurses and unlicensed nursing personnel. And, as discussed above, section 1443.5 of Title 16 describes the applicable nursing "Standards of Competent Performance." The statute [Health & Safety Code section 1276.4, subdivision (h)] provides that "in case of conflict between this section and any provision or regulation defining the scope of nursing practice, the scope of practice provisions shall control."[14]

[14] *California Nurses Association v. Schwarzenegger et al.,* (Super. Ct. Sacramento County, 2005, No. 04S01725), (granting CNA's petition in its final decision on June 7, 2005, at p. 8, emphasis added).

- **CDPH Must Not Adopt, in the APH Nurse Staffing Ratio, Dangerous Status Quo APH Staffing Mixes That Do Not Require Minimum RN Staffing and RN Patient Assignment.**

In adopting minimum nurse staffing ratios for APHs, CDPH should not merely codify the demonstrably dangerous status quo staffing mix at APHs that largely relies on licensed vocational nurses and psychiatric technicians without appropriate minimum RN staffing and RN assignment to each patient. The current staffing mix in APHs has resulted in a failure to protect patients, which has prompted the current discussion regarding APH staffing ratios and the May 13, 2025, CDPH stakeholder meeting. The suggestion by hospital representatives during the May 13 stakeholder meeting that the APH staffing ratio should be composed of 50 percent RNs and licensed vocational nurses (LVNs) and 50 percent psychiatric technicians (PTs) and unlicensed mental health workers would dangerously codify the current failing staffing mix at APHs.

The status quo staffing mix has led to unnecessary patient deaths, sexual assaults, other negative patient outcomes, and unsafe working conditions for nurses and other mental health workers in APHs, and it is clearly failing patients. This is evidenced by the *San Francisco Chronicle*'s series of investigative articles and the *Los Angeles Times'* database documenting patient deaths, sexual assaults, and other incidents resulting from inadequate staffing.[15] Moreover, research has shown that staffing standards that allow substitution of non-RNs are insufficient and produce worse outcomes for patient care, including in APH settings.[16]

Currently, California has a minimum acute psychiatric staffing standard of 1:6 nurse-to-patients in GACH psychiatric units, which as discussed throughout these comments must be implemented as a registered nurse-to-patient staffing ratio. There is no reason to deviate from this ratio to provide a lower standard of care in APHs. Moreover, similar to GACHs, CDPH should adopt minimum RN-to-patient ratios that further limit the number of patients that are assigned to the registered nurse for patients in higher acuity units. For example, for patients at risk of harm to self or others, the GACH ratio of 1:1 registered nurse-to-patient ratio for critical trauma patients should be adopted. Again, CNA has included additional unit-specific ratios in proposed regulatory language in Amendment 1.

---

[15] Palomino, J. and Dizikes, C. (Mar 19, 2025), *supra*, at note 4.
Karlamangla, S. and Lee, I. (Updated Jun 8, 2021). "Search our database of deaths and assaults at California psychiatric facilities." *Los Angeles Times*. https://www.latimes.com/projects/psychiatric-hospital-deaths-incidents-database/.

[16] Dall'Ora, C. et al. (2023). The association between multi-disciplinary staffing levels and mortality in acute hospitals: a systematic review. *Human Resources for Health*, 21(1): 30.
Park, S. et al. (2020). Nurse staffing and health outcomes of psychiatric inpatients: a secondary analysis of national health insurance claims data. *Journal of Korean Academy of Nursing*, 50(3): 333-348.

- **While Other Mental Health Workers Play Important Supplemental Care Roles in APHs, it is Inappropriate for CDPH to Include Them in the Nurse Staffing Ratio.**

For the purposes of the nurse staffing ratio, it is inappropriate to include other mental health workers. First, because only registered nurses can be assigned patients, any nurse staffing ratio functions to establish a registered nurse-to-patient staffing ratio. Although other mental health workers, including LVNs, PTs, and unlicensed mental health workers, may supplement psychiatric patient care, **every psychiatric patient admitted to an APH must be assigned to a registered nurse who has responsibility for all of the professional duties required for nursing care**. The implementation of GACHs nurse staffing ratios makes clear that "[a] patient is counted in the nurse-to-patient ratios when the patient *is assigned* to a licensed nurse for care."[17]

Because each patient must be assigned to an RN and because an RN must perform the ongoing patient assessment, the APH staffing ratio, as implemented, must be an RN-to-patient ratio. As discussed further below, the scope and duty of RNs require ongoing assessment and observation by an RN that cannot be delegated to other mental health workers, particularly given the high acuity and complexity of care required for acute psychiatric patients. Under the Nurse Practice Act, the RN has a statutory duty of care to perform ongoing patient assessment. This RN duty is clearly defined in section 2725, subdivision (b)(4) of the Business and Professions Code and in California Code of Regulations, title 22, section 70215. The RN must be face-to-face with the patient to perform assessments, observe the signs and symptoms of psychiatric illness, and evaluate the reactions to treatments, such as medication that has been administered for exacerbations (i.e., worsening or intensification) of acute psychiatric illness.

- **The High Acuity and Complex Care Needs of APH Patients Require Registered Nurses with the Appropriate Competency, Education, and Scope of Practice.**

Because patients in acute inpatient settings, including APH patients, have high acuity and complexity of care that require an RN's scientific knowledge and scope of practice, CDPH must ensure that minimum nurse staffing ratios are minimum registered nurse staffing ratios.[18] The need for RN staffing for APH patients is demonstrated both by Medi-Cal's inpatient psychiatric patient medical necessity criteria[19] and registered nurses' "Standards of Competent

[17] See California Department of Health Services. "Nurse-to-Patient Staffing Ratios for General Acute Care Hospitals, Frequently Asked Questions." R-37-01 (Jan. 2004), at 8 (emphasis added) (A copy of the FAQs distributed by the California Department of Health Services when the GACH ratios were first implemented is available upon request).

[18] See Cal. Code Regs., tit. 16, § 1443.5.

[19] Cal. Code Regs., tit. 9, § 1820.205. Private sector hospital admission criteria typically are not publicly available and often come from a proprietary database.

Performance" in carrying out the nursing process.[20] CDPH must ensure that no more than 6 patients can be assigned to a registered nurse to ensure that they are able to provide the required care and oversight required by statute and regulation. Moreover, CDPH, in the APH nurse staffing ratios regulation, should further limit the number of patients assigned to a registered nurse for patients with high acuity. CNA has included additional unit-specific ratios in proposed regulatory language attached in Attachment 1.

First, Medi-Cal's medical necessity criteria for reimbursement for psychiatric inpatient hospital services demonstrate APH patients' high acuity and complexity of care and the need for RN staffing.[21] Medi-Cal's medical necessity criteria for APHs begins by requiring that a patient have a specific psychiatric diagnosis.[22] Medi-Cal specifies eighteen psychiatric diagnoses that include disruptive behavior and attention deficit disorders; feeding and eating disorders of infancy or early childhood; substance induced disorders, only with psychotic, mood, or anxiety disorder; and schizophrenia and other psychotic disorders.[23] Many of these psychiatric diagnoses also have significant physical health impacts, which demonstrates the high diagnostic and treatment complexity of APH patient care.

Under Medi-Cal's medical necessity criteria, **patients can only be admitted to APHs if they cannot be safely treated at a lower level of care**, demonstrating a higher level of acuity compared to patients in non-acute settings and the need for RN care.[24] Patients admitted to APH settings under Medi-Cal's criteria also require psychiatric inpatient hospital services for reasons that include that they "[r]epresent a current danger to self or others, or significant property destruction"; "[p]resent a severe risk to [their] physical health" or that they require admission for "[f]urther psychiatric evaluation," "[m]edication treatment," or other treatment that requires inpatient hospitalization.[25] For continued inpatient psychiatric hospitalization, Medi-Cal requires that the patient continues to meet the medical necessity criteria, has a serious adverse reaction to medication or other treatment, develops new indications that meet the medical necessity criteria, or needs continued medical evaluation or treatment that require inpatient hospitalization.[26] Patients admitted under these criteria are clearly high acuity and require complex and multi-dimensional care that requires the scope of practice of an RN.

According to the National Health Law Program, in California, "[P]rivate plans are more likely to apply medical necessity determinations that, while generally accepted in the behavioral health space, are more stringent than the Medi-Cal medical necessity criteria." In Hernández-Delgado, H. and Lewis, K. (2023, May 21). "Crosswalk Between Coverage of Behavioral Health Services in Medi-Cal and Private Plans in California." https://healthlaw.org/wp-content/uploads/2024/05/Crosswalk-BH-FINAL.pdf.

[20] Cal. Code Regs., tit. 16, § 1443.5.
[21] Cal. Code Regs., tit. 9, § 1820.205.
[22] See Cal. Code Regs., tit. 9, § 1820.205, subd. (a)(1).
[23] Cal. Code Regs., tit. 9, § 1820.205, subd. (a)(1).
[24] See Cal. Code Regs., tit. 9, § 1820.205, subd. (a)(2)(A).
[25] Cal. Code Regs., tit. 9, § 1820.205, subds. (a)(2)(B)(1) and (a)(2)(B)(2).
[26] Cal. Code Regs., tit. 9, § 1820.205, subd. (b).

Second, the APH staffing ratio must be an RN staffing standard, because the high acuity and complexity of patients in any inpatient acute care setting requires the care of an RN who has the appropriate education, competency, and scope of practice. With respect to RN competency standards, only an RN has the scientific knowledge to perform the nursing process required for the high acuity and complex patients in any inpatient hospital setting. The RN competency standard requires that the RN have "the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process[,]"[27] which is crucial for the care of APH patients who, based on admission criteria, have complex needs and high acuity. All of the diagnoses included in the medical necessity criteria have social aspects and many—such as eating disorders and substance induced disorders combined with a psychotic, mood, or anxiety order—include biological and physical aspects.[28] In some cases, it may be unclear whether a patient with an altered mental status has a behavioral, substance-based, or physical issue or some combination of the three. Only an RN has the educational background to apply social, biological, and physical sciences, through the nursing process, to high acuity and complex APH patients.

- **The Nursing Process Requires that the Registered Nurse-to-Patient Ratio be 1:6 or Fewer Patients at All Times.**

In adopting nurse staffing ratios for APHs, CDPH must ensure that RNs are staffed at sufficient levels to meet the nursing care needs of APH patients due to their high acuity as well as diagnostic and treatment complexity. The ratio must provide sufficient RN staffing to ensure that the planning and delivery of patient care reflects all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy.[29] We describe each of the steps in the nursing process here, which underscores the need for the assignment and sufficient staffing of registered nurses to meet the care needs of patients.

Only RNs must be counted towards the APH nurse staffing ratios because patient care in the inpatient acute care setting requires the ongoing application of the nursing process, which can only be performed by the RN. The registered nurse initiates the nursing process at the time of admission, yet providing patient care requires ongoing use of the nursing process throughout the patient's stay.[30] In addition to a thorough assessment, formulation of a nursing diagnosis, and creating a nursing plan at admission, RN statutory and regulatory duties include conducting ongoing assessments, implementing the care plan through specific nursing interventions,

[27] Cal. Code Regs., tit. 16, § 1443.5.
[28] Cal. Code Regs., tit. 9, § 1820.205, subd. (a)(1).
[29] See Cal. Code Regs., tit. 16, § 1443.5 and Cal. Code Regs., tit. 22, § 70215.
[30] See Cal. Code Regs., tit. 16, § 1443.5 and Cal. Code Regs., tit. 22, § 70215.

evaluating the effects of the nursing interventions, and modifying the nursing care plan as needed.[31]

Enumerating the steps in the nursing process demonstrates the breadth and depth of the RN's responsibilities and underscores why the APH staffing ratio must be an RN-to-patient ratio.[32] First, the RN performs the nursing assessment.[33] Second, the RN formulates a nursing diagnosis based on this assessment, which includes observation of their physical condition and behavior, as well as interpretation of information obtained from the patient and others, including the health team.[34] Third, the RN collaborates with the patient, the patient's family or other representative (when appropriate), and other staff involved in the patient's care such as psychiatrists, psychologists, and social workers.[35] Fourth, the RN implements the plan by performing the nursing interventions described in the care plan, including explaining the health treatment to the patient and family and performing other nursing interventions such as administering medication.[36] Fifth, the RN evaluates the effect of the interventions on the patient and modifies the care plan, if needed.[37] The nursing process requires the RN to perform ongoing assessments to evaluate any modifications and to ensure that the care plan continues to meet the patient's needs.[38] Finally, the RN must document all of this information in the patient's medical record.[39]

The RN's duty of patient advocacy also demonstrates why the APH ratio must be an RN-to-patient ratio. In addition to carrying out the nursing process, the RN may need to advocate for their patients.[40] RN patient advocacy includes acting on the patient's behalf "to improve health care or to change decisions or activities which are against the interests or wishes of the [patient], and by giving the [patient] the opportunity to make informed decisions about health care before it is provided."[41] Finally, when it is time for the patient to be discharged, the RN teaches the patient, and their family or representative when appropriate, how to care for the patient's health needs.[42]

As discussed above, the nursing process is both complex and comprehensive. The nursing process in units with patients who have higher acuity will require more attention from the

[31] Cal. Code Regs., tit. 16, § 1443.5 and Cal. Code Regs., tit. 22, § 70215.
[32] See Cal. Code Regs., tit. 16, § 1443.5 and Cal. Code Regs., tit. 22, § 70215.
[33] Cal. Code Regs., tit. 22, § 70215, subd. (a)(1).
[34] Cal. Code Regs., tit. 16, § 1443.5, subd. (1) and Cal. Code Regs., tit. 22, § 70215, subd. (b).
[35] Cal. Code Regs., tit. 16, § 1443.5, subd. (2) and Cal. Code Regs., tit. 22, § 70215, subd. (c).
[36] Cal. Code Regs., tit. 16, § 1443.5, subd. (3) and Cal. Code Regs., tit. 22, § 70215, subd. (a)(2).
[37] Cal. Code Regs., tit. 16, § 1443.5, subd. (5) and Cal. Code Regs., tit. 22, § 70215, subds. (a)(2), (a)(3), and (b).
[38] Cal. Code Regs., tit. 16, § 1443.5, subd. (5) and Cal. Code Regs., tit. 22, § 70215, subd. (a)(1).
[39] Cal. Code Regs., tit. 22, § 70215, subds. (a)(1) and (d).
[40] Cal. Code Regs., tit. 16, § 1443.5, subd. (6) and Cal. Code Regs., tit. 22, § 70215, subd. (b).
[41] Cal. Code Regs., tit. 16, § 1443.5, subd. (6).
[42] Cal. Code Regs., tit. 16, § 1443.5, subd. (3) and Cal. Code Regs., tit. 22, § 70215, subd. (a)(3).

registered nurse. High-acuity patients require a more intensive care plan, more frequent assessments and evaluations, and greater collaboration with health care professionals. **For these reasons, CDPH should adjust the minimum registered nurse ratio to further limit the number of patients that are assigned to the RN in units with higher acuity patients; CNA has included additional unit-specific ratios in proposed regulatory language attached in Attachment 1.**

- **The Ability of a Registered Nurse to Delegate Does Not Support Assigning Patients Above the Minimum 1:6 Registered Nurse-to-Patient Ratio and Does Not Support the Inclusion of Non-RNs in the 1:6 Ratio.**

While RNs may delegate nursing care tasks, the limitations of the scope of practice of other mental health workers obviate both assigning more patients to the RN and including non-RNs in the nurse staffing ratio. Although some nursing interventions may be delegated to other staff in implementing the nursing care plan, this delegation is subject to limitations based on non-RN staff's "licensure, certification, level of validated competency, and/or regulation."[43] Licensure as an LVN or PT does not require the educational background in social, biological, and physical sciences that is required for licensure as an RN. Thus, LVNs and PTs are not authorized to formulate a nursing diagnosis, develop a care plan, evaluate its effectiveness in patients, or many of the other things an RN does in applying scientific knowledge to provide patient care as required by the RN competency standards.

Moreover, there are explicit statutory limits on what an RN can delegate to unlicensed personnel, which makes it inappropriate to include non-RNs in the nurse staffing ratio. Specifically, the Business and Professions Code prohibits an APH from "assign[ing] unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills […]."[44] Among the list of "functions" that must be performed by an RN are administering medication, assessing a patient's condition, and educating patients and their families about a patient's health care issues and post-discharge care.[45]

Significantly, delegation may do little to reduce an RN's workload because the assigned RN is still responsible for the delegated nursing interventions and must oversee the delegation to the non-RN. Specifically, the RN must oversee all delegatees performing nursing interventions[46] and assess the patient and evaluate the effectiveness of the delegated nursing interventions while

[43] Cal. Code Regs., tit. 22, § 70215, subd. (a)(2). Also see Cal. Code Regs., tit. 16, § 1443.5, subd. (4).
[44] Bus. & Prof. Code § 2725.3, subd. (a).
[45] Bus. & Prof. Code § 2725.3, subds. (a)(1), (a)(5), and (a)(6).
[46] See Cal. Code Regs., tit. 16, § 1443.5, subd. (4) and Cal. Code Regs., tit. 22, § 70215.

continuing to perform all aspects of the nursing process that cannot be delegated. Finally, RNs will be able to delegate fewer nursing interventions in units in which patients have higher acuity or are at risk of harm to themselves or others. Thus, the minimum registered nurse ratio should further limit the number of patients that are assigned to the RN in higher acuity units.

In sum, RNs must be staffed at sufficient levels to provide safe, competent, therapeutic, and effective patient care in accordance with their statutory and regulatory duties. Unless regulations limit the RN-to-patient ratio to six or *fewer* patients, based on the RN's judgement and patient acuity, RNs will be placed in the untenable position of being forced to delegate or leave care undone. The results of understaffing in APHs have been widely publicized. Neither including non-RNs in the ratio nor using the option of delegation as a justification for increasing an RN's patient assignment will resolve the issues currently plaguing APHs. RNs cannot simply formulate a nursing diagnosis and care plan, then delegate care to others and check back at the end of the shift.

- **RNs are Key to Ensuring Patient Safety in the APH Setting and Minimum RN-to-Patient Ratios Must Ensure that Units are Staffed at Sufficient Levels to Protect Patients.**

When adopting APH nurse staffing ratios, CDPH must also ensure that RNs are staffed at sufficient levels to monitor patients for signs of adverse reactions to medications, prevent suicides, limit and de-escalate patient aggression, reduce the use of restraints and seclusion, and ensure patient safety should restraints or seclusion become necessary. CDPH should adopt minimum registered nurse ratios that limit the number of patients assigned to fewer than six patients for patients who require a more intensive care plan, more frequent assessments and evaluations, or greater collaboration with health care professionals. For those at greatest risk or in need of intensive care, CDPH should adopt a 1:1 registered nurse to patient ratio. Risks to patient safety in APHs affect not only the individual but may also affect other patients, staff, and the general public. RNs are key to ensuring patient safety in APHs because of their critical role in providing direct patient care.[47]

Many APH patients are taking one or more medications or are admitted for medication treatment, which requires monitoring and ongoing assessment by an RN to ensure patient safety. Unlike LVNs and PTs, an RN is equipped by education and clinical experience to evaluate whether a patient's behavior is related to a physical condition and how medication may be exacerbating or improving the behavior or physical condition. Moreover, adverse reactions in

[47] De Santis, M. et al. (2015). Suicide-specific safety in the inpatient psychiatric unit. *Issues in mental health nursing*, 36(3): 190-199.

hospitalized psychiatric patients are common and have a high rate of preventability.[48] Preventing adverse drug reactions is an especially crucial component of psychiatric nursing care given the unique challenges in the psychiatric inpatient setting, such as the difficulty of distinguishing antipsychotic-induced conditions from underlying anxiety.[49]

Given the high risk of suicide for APH patients, minimum RN staffing is required to ensure that patients are appropriately assessed through the nursing process for these risks. Many patients in APH are at high risk of suicide, and the rate of death by suicide among patients in these settings is estimated to be 50 to 72 times greater than the general population.[50] Preventing these deaths requires intensive monitoring and direct assessment to identify risk factors and warning signs.[51] Shared decision making, educating patients on the treatment process, and communication and coordination among care providers are all crucial to suicide prevention.[52] As discussed above, these functions fall squarely within the RN nursing process and competency standard.[53] The RN competency standard helps ensure that RNs can appropriately identify and respond to patients at high risk of suicide.[54]

Additionally, because patients in APH settings may lose behavioral control and pose an imminent risk of harm to themselves or others, minimum RN staffing is required to ensure that any nursing interventions, including seclusion or restraint, are done in a manner that is safe and effective for the patient. Importantly, federal Centers for Medicare and Medicaid Services rules govern most APH's use of restraint and seclusion, requiring that the least restrictive restraint or seclusion is used and discontinued at the earliest time possible.[55] Research has shown more frequent registered nurse assessments can decrease duration of mechanical restraint episodes.[56] As the most restrictive intervention, only appropriately trained staff with a duty to patient care

---

[48] Thomas, M., Boggs, A., DiPaula, B., and Siddiqi, S. (2010). Adverse drug reactions in hospitalized psychiatric patients. *Annals of Pharmacotherapy*, 44(5): 819-825.

Rothschild, J. et al. (2007). Medication safety in a psychiatric hospital. *General hospital psychiatry*, 29(2): 156-162.

See Iuppa, C., Nelson, L., Elliott, E., & Sommi, R. (2013). Adverse drug reactions: a retrospective review of hospitalized patients at a state psychiatric hospital. *Hospital pharmacy*, 48(11): 931-935).

[49] Iuppa, C., *supra*, at note 4848.

[50] Madsen, T., Agerbo, E., Mortensen, P., & Nordentoft, M. (2011). Predictors of psychiatric inpatient suicide: a national prospective register-based study. *The Journal of clinical psychiatry*, 72(2): 15139.

See Gupta, M., Esang, M., Moll, J., & Gupta, N. (2023). Inpatient suicide: epidemiology, risks, and evidence-based strategies. *CNS spectrums*, 28(4): 395-400.

[51] Gupta, M., Esang, M., Moll, J., & Gupta, N. (2023), *supra*, at note 50.50

[52] Ibid.

[53] Cal. Code Regs., tit. 16, § 1443.5, subds. (2), (3), and (6) and Cal. Code Regs., tit. 22, § 70215, subds. (a), (b), and (c).

[54] See Manister, N. et al. (2017). Effectiveness of nursing education to prevent inpatient suicide. *The Journal of Continuing Education in Nursing*, *48*(9), 413-419.

[55] 42 C.F.R. § 482.13(e) et seq.

[56] Allen, D. E., Fetzer, S. J., & Cummings, K. S. (2020). Decreasing duration of mechanical restraint episodes by increasing registered nurse assessment and surveillance in an acute psychiatric hospital. *Journal of the American Psychiatric Nurses Association*, *26*(3), 245-249.

should be able to seclude or restrain the patient to ensure their safety and prevent injury to other patients and staff. These interventions, which can lead to death or severe injury if improperly administered, are emergency measures that require ongoing direct observation and assessment by RNs.

A recent report by Disability Rights California regarding College Hospital, a for-profit APH in Cerritos, demonstrates the severe risks to a patient when improperly trained APH staff overuse and over rely on physical and chemical restraints or seclusion.[57] The investigation reported how the hospital's staff used restraints far more often and far longer than other facilities in the state, often without justification, finding that the hospital failed to make appropriate and regular assessments necessary to determine appropriate behavioral health interventions. Sufficient RN staffing is necessary to ensure proper patient assessment and the least restrictive intervention when restraint and seclusion is even considered.

Importantly, minimum registered nurse-to-patient ratios will increase the accessibility of registered nurses to patients and improve patient care. The recent *San Francisco Chronicle* series on the violence and chaos at a for-profit APH, Aurora Behavioral Healthcare Santa Rosa, is evidence that the current staffing mix, which has low RN hours per patient days (HPPD), simply is not working.[58] As the investigative series reported, when the police arrived at the APH, they found no one in charge and too few employees to keep watch, let alone care for the 18 children who were supposed to be receiving therapy and mental health treatment.[59]

Given the *San Francisco Chronicle* reports, it is not surprising that Aurora Behavioral Healthcare Santa Rosa, in 2023, had only 1.9 RN HPPD and unlicensed health workers constituted 66.2% of the entire nursing staff (Table 1). [60] The only other California APH with a higher proportion of unlicensed staff is Aurora Vista Del Mar at 75.6% unlicensed mental health workers (Table 1).[61] The 2023 RNHPPD at Aurora Vista Del Mar is correspondingly low. When comparing two other APHs that are nonprofits to the two for-profit Aurora APHs, the differences in RN staffing based upon RNHPPD is dramatic (Table 1).

---

[57] Diaz, R. et al. (Mar 21, 2025). "Let Me Go: Excessive Restraint of Patients at College Hospital." Disability Rights California, Investigations Unit. https://www.disabilityrightsca.org/drc-advocacy/investigations/let-me-go-excessive-restraint-of-patients-at-college-hospital.

Palomino, J. and Dizikes, C. (May 19, 2025). "California watchdog finds for-profit psychiatric hospital abused patients." *San Francisco Chronicle.* https://www.sfchronicle.com/california/article/forprofit-psychiatric-hospital-restraints-20263627.php.

[58] Palomino, J. and Dizikes, C. (Mar 19, 2025), *supra*, at note 4.

[59] Ibid.

[60] See Table 1. Data from the Department of Health Care Access and Information. Annual Financial Reports Jan-Dec 2023. https://reports.siera.hcai.ca.gov/.

[61] Ibid.

Table 1. Select APH RN Hours Per Patient Days, 2023[62]

APH Facility Name	RN Productive Hours	Patient Days	RN HPPD
Aurora Behavioral Healthcare Santa Rosa APH	62898	33262	1.9
Aurora Vista Del Mar (Ventura) APH	12543	12690	1.0
Langley Porter Psychiatric Institute APH San Francisco	80630	6357	12.7
Antelope Valley D/P APH Lancaster	35624	3175	11.2

At Langley Porter Psychiatric Institute and Antelope Valley APH, CNA is the collective bargaining representative of RNs and has been able to implement RN-to-patient ratios through the collective bargaining process even though these APHs are not covered by the GACH registered nurse staffing ratios. These APHs, in which RNs have union representation, set a standard of compliance that CDPH should support and require for all APHs. Moreover, the *Los Angeles Times* database of deaths and assaults at California psychiatric facilities[63] reports that no suicides or deficiencies were documented for either Langley Porter Psychiatric Institute or Antelope Valley APH while all Aurora facilities, including Aurora Behavioral Healthcare Santa Rosa had suicides and deficiencies.[64] While recognizing that there are many environmental precautions that APHs must take to eliminate suicides in the inpatient setting, the recurring theme in the suicides that are reported in the *Los Angeles Times* database is that the deaths were due to improper monitoring by staff.[65]

- **CDPH's APH Staffing Ratios Must Not Enable Facilities to Lower Their Staffing Standards.**

CNA is concerned that CDPH's failure to adopt minimum registered nurse-to-patient ratios will have the unintended consequence of permitting for-profit facilities and even some nonprofit facilities that currently have the highest levels of RN staffing to lower RN staffing

[62] Aurora Behavioral Healthcare Santa Rosa was selected in this table because it was highlighted in the *San Francisco Chronicle* series. Aurora Vista Del Mar APH was selected because it had the highest percentage of unlicensed staffing of all APHs in 2023. In contrast, the two other facilities in this table had the highest level of RN staffing of all of the APHs and were not selected because of their nonprofit status. However, the richest RN HPPD in for-profit APHs were 7.5 RN HPPD in Mission Oaks Hospital D/P APH and AHMC Seton with 6.4 RN HPPD. Nine nonprofit APHs had RN staffing that exceeded the best staffed for-profit APH. CNA's data tables can be made available to CDPH upon request but all 2023 data is available at the Department of Health Care Access and Information in healthcare facility "Financial & Utilization Reports" at https://reports.siera.hcai.ca.gov/.

[63] The *Los Angeles Times* reviewed thousands of pages of inspection reports, coroner's reports, death certificates and court documents to assemble a database of more than 400 cases of deaths, assaults and other incidents that have occurred across California's 154 psychiatric facilities since 2009.

See Karlamangla, S. and Lee, I. (Updated Jun 8, 2021), *supra*, at note 15.

[64] See Palomino, J. and Dizikes, C. (Mar 19, 2025), *supra*, at note 4 (describing reports of suicide at Aurora Behavioral Healthcare Santa Rosa).

[65] Karlamangla, S. and Lee, I. (2021), *supra*, at note 15**Error! Bookmark not defined.**.

standards and reduce the number of RNs available to care for patients in APHs. When CDPH determines the minimum staffing ratios that are necessary for and consistent with safe patient care in APHs, the APHs with the best staffing standards should be the model.

The assertion by some hospital representatives at the May 15 stakeholder meeting that there is a lack of evidence supporting specific ratios in APHs is specious. A similar industry's critique was raised when California was considering the adoption and implementation of GACH staffing ratios over twenty years ago. Since adoption of registered nurse staffing ratios throughout California GACHs, studies clearly have demonstrated the patient care benefits of California's registered nurse staffing standards in comparison to states without these patient protections as well as the protective effect of minimum RN staffing standards during an economic downturn.[66] Additionally, studies have found a 30% decline in RN and LVN occupational injuries and illnesses with the adoption of GACH registered nurse staffing ratios.[67]

Importantly, RN-to-patient staffing ratios in APHs will support the retention of RNs in these facilities. Mandatory minimum RN-to-patient ratios create a workplace environment that helps to reduce the moral injury associated with the inability to provide a safe level of professional care to patients. RNs experience moral distress when they are unable to provide the care they know their patients need when a facility is understaffed. Regular exposure to moral distress results in moral injury. This moral injury is also referred to as "burnout", a state of mental, physical, and emotional exhaustion. A 2010 study found that units with higher levels of psychiatric registered nurse staffing, along with other organizational factors, led to lower levels of psychiatric registered nurse burnout.[68]

Finally, a 2020 research study of safe acute psychiatric registered nurse staffing standards in Korea referenced the California GACH acute psychiatric standard of 1:6 nurse-to-patient ratio as well as Japan's inpatient psychiatric unit ratios which were 1:3 or 1:4.[69] The Korean study's dataset included 70,136 inpatients who were 19 years old and admitted for behavioral disorders due to use of alcohol, schizophrenia, schizotypal and delusional disorders and mood disorders to 453 hospitals for at least 2 days.[70] Better patient outcomes in inpatient psychiatric units were

---

[66] Aiken L. et al. (Aug 2010). Implications of the California nurse staffing mandate for other states. *Health Serv Res*, 45(4):904-21. doi: 10.1111/j.1475-6773.2010.01114.x.

Dierkes A. et al. (2022). The impact of California's staffing mandate and the economic recession on registered nurse staffing levels: A longitudinal analysis. *Nurs Outlook*, 70(2): 219-227. doi: 10.1016/j.outlook.2021.09.007.

[67] Leigh J, Markis C, Iosif A, Romano P. (May 2015). California's nurse-to-patient ratio law and occupational injury. *Int Arch Occup Environ Health*, 88(4):477-84. doi: 10.1007/s00420-014-0977-y.

[68] Hanrahan, N., Aiken, L., McClaine, L., & Hanlon, A. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. *Issues in mental health nursing*, 31(3): 198-207.

[69] Park, S. et al. (2020), *supra*, at note 1616.

[70] Ibid.

associated with higher RN-to-patient ratios including: shorter length of stay, lower risk of re-admission, less psychiatric emergency treatment, and less use of hypnotics.[71]

- **Minimum RN Staffing Ratios Should Be Required at All Times and on Every Shift.**

When adopting nurse staffing standards for APHs, CDPH must apply—as it does for GACHs—minimum RN-to-patient staffing ratios at all times and on every shift.

First, because APHs provide 24-hour care, by definition,[72] CDPH must require that APHs meet minimum staffing ratio protections at all times. The RN-to-patient ratio must be enforced "at all times" because even existing regulation for APH states: "All hospitals shall maintain continuous compliance with the licensing requirements."[73] As described by CPDH's predecessor department in the rulemaking for GACH staffing ratios, "continuous compliance" means "at all times."[74] Additionally, the existing statutory language in section 71215, subdivision (c)(3) of the Health and Safety Code, which describes psychiatric nursing service staffing, requires a registered nurse on duty *at all times*. In litigation over the implementation of the GACH nurse staffing ratios, Superior Court Judge Gail Ohanesian stated in response to the California Healthcare Association's (now California Hospital Association) arguments against the "at all times" requirement:

> DHS' interpretation of section 70217 [of the Health and Safety Code], applying ratios to break periods, is not new and it is consistent with the plain language of the regulation […] Any other interpretation would make the nurse-to-patient ratios meaningless.[75]

Second, research supports the benefit of RN staffing ratios in psychiatric units. One study has shown a significant association between units that were staffed with higher numbers of psychiatric registered nurses relative to the number of patients and reduced burnout or moral injury among RNs, thereby having a positive effect on RNs capacity to sustain safe and effective patient care environments.[76]

---

[71] Ibid.

[72] Health & Saf. Code, § 1250, subd. (b).

[73] Cal. Code Regs., tit. 22, § 71127.

[74] *California Healthcare Association v. California Department of Health Services et al.,* (Super. Ct. Sacramento County, 2004, No/ 03CS01814) (May 24, 2004) (California Department of Health Services stated during GACH ratios rulemaking that, "The minimum standard is just that, a minimum, and patients' health and safety must be protected at all times. Current regulation 22 CCR 70129 requires, 'All hospitals shall maintain continuous compliance with the licensing requirement.' Continuous compliance means 'at all times.'").

[75] Id. at 5.

[76] Hanrahan, N., Aiken, L., McClaine, L., & Hanlon, A. (2010), *supra*, at note 68.

Like GACHs, there should be minimum staffing for every shift, and just as in the GACH setting, APHs hire for both 8-hour and 12-hour shifts. Safe staffing is needed both during day shifts and night shifts. For the day shift, patients may require additional staffing based upon the increased likelihood of patient-to-patient interactions as well as the need for additional care based on the care plan developed by RNs and other health care professionals. During late shifts, in particular, there are fewer professional resources present and the ability of late shift RNs and other staff to protect patients and maintain the therapeutic environment is critical. Safe staffing at all times is particularly important in APHs because of the risk of suicide. A study by Perlis, et al. found that the incidence of suicide varied by time of day and was higher between midnight and 6:00 a.m. Based on the amount of time a person was awake, the mean hourly rate of suicide from 6:00 a.m. to 11:59 p.m. was 2.2 percent compared to 10.3 percent between the hours of midnight and 5:59 a.m. The peak incident rate of 16.4 percent was from 2:00 a.m. to 2:59 a.m. Finally, the observed frequency of suicide was 3.6 times higher than expected overnight between midnight and 5:59 a.m..[77]

3. Is there a need for different staffing levels depending on the age of patients, such as children or adolescents? How should other mental health workers be included in the nursing ratio? Please explain.

Based on the developmental differences between children and adolescents and adult patients, CDPH must increase staffing for younger patients such that the minimum RN-to-patient ratio must be 1:4 for children and adolescents. The minimum RN-to-patient ratio in GACH pediatric and adolescent settings is 1:4 because of these differences based on patient age and CDPH should adopt the same ratio for APHs.[78]

Importantly, most children and adolescents in APHs have experienced high levels of trauma and may require more frequent RN assessments and greater collaboration with other health care professionals. **For these reasons, CDPH should adopt a minimum RN-to-patient ratio that further limits the patient assignment for children and adolescents with higher acuity. CNA has included additional unit-specific ratios in proposed regulatory language in Attachment 1.**

In addition to their different developmental needs, pediatric and adolescent patients often have special psychiatric needs that require more intensive monitoring than adults. RNs must have regular patient interactions to provide care and plan activities appropriate to the age and mental health status of the child or adolescent. RNs have the education and clinical skills necessary to assess a patient's functioning in a variety of situations and create a nursing plan that includes the

[77] Perlis, M. et al. (Oct. 2016). Suicide and sleep: Is it a bad thing to be awake when reason sleeps? *Sleep Med Rev*, 29: 101-7. doi: 10.1016/j.smrv.2015.10.003.

[78] Cal. Code Regs., tit. 22, § 70217, subd. (a)(6).

appropriate nursing and mental health staff. Additionally, RNs' education and clinical skills ensure that they are able to collaborate effectively with other licensed professionals such as psychiatrists, psychologists, and social workers.

When APH adolescent units are understaffed, patients are at tremendous risk of harm and death. Research has shown critical differences between adolescents and adults in suicidal behavior. Adolescents are at a high risk for attempted suicide and, tragically, have an elevated attempted suicide rate compared to adults.[79] Indeed, *San Francisco Chronicle*'s investigation of an APH in the Bay Area found that patients in a designated adolescent unit suffered sexual assault and died by suicide because the hospital did not employ enough staff to monitor patients.[80]

In APH settings, aggressive behavior from adolescent patients frequently arises, prompting registered nurses to intervene and ensure safety for patients and staff. [81] Research has shown that RNs are critical for reducing the risk of violent incidents in acute psychiatric settings for children and adolescents. One study over the course of 16 years showed that the total number of registered nursing staff was the most significant factor associated with a decreased risk of violent incidents in acute inpatient units for children and adolescents.[82] The study also found that substituting nursing assistants for registered nurses increased the risk of violence and suggested that registered nurses were more successful in de-escalation.[83]

Additionally, depending on the severity of the situation, nursing interventions to treat patient aggression may include behavioral management techniques, medication administration, as well as seclusion and restraint as the most restrictive intervention.[84] In these cases, CDPH should adopt minimum registered nurse-to-patient ratios below 1:4 and, in some cases, 1:1. In particular, the minimum registered nurse-to-patient ratio for the use of seclusion or restraints should be 1:1. A recent study found that when a registered nurse decides that a seclusion room is necessary to keep the child or others safe, the child needs the RN to remain in close proximity to help calm them by keeping communication open, thereby avoiding retraumatizing the child. This

---

[79] Brière, F. et al. "Adolescent suicide attempts and adult adjustment." *Depress Anxiety*, 32(4): 270-276 (Nov. 2014). https://pmc.ncbi.nlm.nih.gov/articles/PMC4373969/.

[80] Palomino, J. and Dizikes, C. (Mar 19, 2025), *supra*, at note 4.

[81] Panagiotou, A., Mafreda, C., Moustikiadis, A., & Prezerakos, P. (2019). Modifiable factors affecting inpatient violence in an acute child and adolescent psychiatric unit: A 16-year retrospective study. *International journal of mental health nursing*, *28*(5), 1081-1092.

As cited in Adrian, M., & McCaffrey, G. (2024). Pediatric psychiatric inpatients' perspectives of aggression management: Discernment in the doorway. *Journal of child and adolescent psychiatric nursing*, 37(3), e12477.

[82] Panagiotou, A., Mafreda, C., Moustikiadis, A., & Prezerakos, P. (2019), *supra*, at note 8181.

[83] Ibid.

[84] Dosreis, S., Barnett, S., Love, R., Riddle, M., & Maryland Youth Practice Improvement Committee. (2003). A guide for managing acute aggressive behavior of youths in residential and inpatient treatment facilities. *Psychiatric Services*, 54(10): 1357-1363.

nursing intervention requires the RN to stand by the door and inform the child of their whereabouts, coach the child to practice their coping skills through the door, encourage the child by observing calm behavior, and enter the room with the child as soon as it is safe to do so.[85]

In sum, due to developmental and other differences, CDPH should adopt a minimum registered nurse-to-patient ratio 1:4 and, based on patient acuity, further limit patient assignments including a minimum registered nurse-to-patient ratio for the use of seclusion or restraints of 1:1.

4. **Which factors are considered when determining additional staffing requirements above the minimum ratios. Do you include the following?**
    a. **Patient acuity, for example, risk of harm to self or others.**
    b. **The results of an environmental risk assessment completed to ensure the patient receives care in a safe setting pursuant to the Code of Federal Regulations section 482.13(c)(2).**
    c. **The need for active clinical care including assessment, treatment, and discharge planning**

All the considerations listed by CDPH in Question 4 are important in determining additional staffing requirements above the minimum ratios. However, additional staffing will always come down to the RN's direct assessment of each patient on the unit. The registered nurse patient assessment should be the basis for the final decision making on staffing needs above the minimum ratio. As the legislature identified and declared in 1999 when it passed A.B. 394, the principles of staffing in the acute care setting should be based on the patient's care needs, the severity of condition, services needed, and the complexity surrounding those services; each of these—each of these factors are included in the RN assessment.

Importantly, CDPH should include in its factors for staffing above the minimum ratio factors that require intensive care and monitoring. This includes the patient's ability to self-care in relation to their acute mental health crisis as well as the risk of harm to self or others. The ability of patients to self-care is important because, as the *Los Angeles Times* database of APH deaths demonstrates, approximately half of deaths in APHs are attributable to suicide with more than 50 of 100 deaths from suicide from 2009 to 2021.[86] State investigators found that these APH suicides generally resulted from a failure by hospital staff to appropriately monitor or treat patients.

[85] Adrian, M. & McCaffrey, G. (2024). Pediatric psychiatric inpatients' perspectives of aggression management: Discernment in the doorway. *Journal of child and adolescent psychiatric nursing*, 37(3): e12477.

[86] See Karlamangla, S. and Lee, I. (2021), *supra*, at note 15**Error! Bookmark not defined.**.

CPDH should consider the high risk of suicide in APHs as a special need of patients served when establishing APH registered nurse staffing ratios. Indeed, Health and Safety Code section 1276.4, instructs CDPH to consider "special needs of the patients served in the psychiatric units" when adopting RN-to-patient ratios. It bears emphasizing that suicide in the inpatient setting is a "never" event that is preventable and that results from errors that should never happen.[87] For example, in 2018, a patient diagnosed with schizophrenia who was admitted to the hospital because of a suicide attempt killed himself by swallowing an object that blocked his airway, according to coroner's records.[88] Appropriate monitoring could have prevented his death. Again, suicide in the inpatient setting is a "never" event that is preventable and that results from errors and understaffing that should never happen. In another incident, a hospital failed to closely monitor a patient which resulted in an assault by another patient when staff were distracted by another activity. These incidents illustrate the importance of recognizing, when CPDH establishes minimum safe RN-to-patient staffing ratios, patient acuity in the APH setting that includes the risk of harm to self or others.

5. General Acute Care Hospitals have a process wherein a committee reviews and validates the system used to determine staffing requirements at least annually, should Acute Psychiatric Hospitals have a similar process? Please explain.

As described above in our response to Question 2, the minimum numerical RN-to-patient ratios must be in effect at all times and must be the baseline requirement for any nurse staffing standard regardless of whether there is a committee review or validation of a patient classification system. Additionally, the RN's direct assessment of each patient and their needs should be the basis for the final decision making on staffing needs for additional staffing above the minimum ratio.

It bears repeating that even the best PCS cannot capture all relevant issues that RNs would identify through their direct assessment and professional judgment to inform staffing needs above the minimum ratio. At best, a PCS is based on estimates of an average, presumably similar, patient and not on the actual patients in an APH. Even though individual patient data may be entered into the PCS, the PCS includes standard values and weights for each value entered.

Moreover, in its APH nurse staffing regulations, CPDH must ensure that the RN's direct assessment of each patient and their staffing needs determines staffing above the mandatory minimum staff ratios and not a PCS. As described above, direct care registered nurses have a licensing mandate to advocate for the patients under their care and do not have the conflict of

[87] National Quality Forum. (n.d.). "List of Serious Reportable Events (aka SRE or 'Never Events')." https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx#sre3.

[88] Karlamangla, S. and Lee, I. (2021), *supra*, at note 15**Error! Bookmark not defined.**.

interests that management, which may control a PCS or review committee, may have, particularly in APHs that are owned by private equity. Staffing should be established based on patients' needs, not driven by management bonuses tied to net revenue.

If a review committee is used by an APH, just as in GACHs, at least half of the members of any PCS review committee must be registered nurses who provide direct patient care. This is important because direct care registered nurses are responsible 24 hours a day for developing and implementing the nursing plan.

6. Do you have any further recommendations for the Department to consider when drafting acute psychiatric hospital nurse to patient ratio regulations?

In drafting APH nurse ratios regulation, CNA urges CDPH to consider the risks of admitting children and youth into the same unit, particularly in units with adult patients. The risks of admitting youth to an adult psychiatric ward have been well recognized.[89] However, the current APH regulations fail to require separate units for children and for adolescents, leaving these patients vulnerable to assault and other harms if admitted to an age-inappropriate unit. Children, adolescents, and adults should each have their own unit in APHs, and this should be reflected in the ratios adopted.

In contrast, GACHs have supplemental service requirements for pediatric units when a hospital has more than 8 beds licensed to care for young patients.[90] These regulations include general age parameters for admission to the pediatric unit.[91] CDPH should ensure that APHs have similar protections for young patients.

Although the Health and Safety Code's ratios statute does not address the need for these protections for children and adolescents, CDPH can use its authority to adopt standards that protect children and adolescents by ensuring that each age group has its own unit separate from each other and from adults. This is an important step in preventing children and adolescents from being re-traumatized in an APH.

Additionally, adolescents present unique challenges not only because of their near adult size and strength but also because of the special role that peer relationships play in this age group.[92] A key constituent of the therapeutic setting for adolescents is the opportunity for social

---

[89] Worrall, A. et al. (2004). Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity. *Bmj*, 328(7444): 867.

[90] Cal. Code Regs., tit. 22, § 70537, subd. (c).

[91] Cal. Code Regs., tit. 22, § 70537, subd. (d).

[92] Kennedy, J. et al. (2020). Predictors of change in global psychiatric functioning at an inpatient adolescent psychiatric unit: A decade of experience. *Clinical child psychology and psychiatry*, 25(2): 471-482.

interaction with peers within communal areas as well as in school, community meetings, and during specific group activities. In fact, one study showed that relationships that were established with peers on the unit predicted a better outcome at discharge.[93]

Developmental theory recognizes adolescents increasingly value their peer relationships over and above other key relationships in their lives.[94] Neuroscientific investigations have found that adolescence is a time of particular brain sensitivity to cues in the social environment; social signals can motivate certain behavioral patterns and have a major impact on the adolescent's life course.[95]

In sum, there is ample evidence that children, adolescents, and adults should each have their own units, which CDPH should consider when drafting the APH nurse staffing ratios regulation.

- **Conclusion.**

For all of the above reasons and for the reasons described in CNA's April 15, 2025, letter to Governor Newsom, CNA urges CDPH to adopt our proposed regulatory language, through emergency regulations, which would establish mandatory, minimum, safe registered nurse-to-patient staffing ratios for California's acute psychiatric hospitals.

If you or your office have any questions, please contact me, CNA Government Relations Director Puneet Maharaj, at pmaharaj@calnurses.org or CNA Government Relations Assistant Director Carmen Comsti at ccomsti@calnurses.org.

Sincerely,

Puneet Maharaj
Government Relations Director
California Nurses Association/National Nurses United

Cc: Dr. Erica Pan, Director & State Public Health Officer, California Department of Public Health
Susan Fanelli, Chief Deputy Director Health Quality & Emergency Response, California Department of Public Health

[93] Ibid.
[94] Ibid.
[95] Ibid.

California Nurses Association
Comments to CDPH on APH RN Staffing Ratios Regulation – May 20, 2025

ATTACHMENT 1:

CNA Proposed Emergency Regulations – Acute Psychiatric Hospital Safe Staffing Ratios and Standards

Title 22 of California Code of Regulations is amended as follows:

§ 71211. Psychiatric Nursing Service Definition.

Psychiatric nursing service means the performance of those services directed toward meeting the objectives of an individual planned therapeutic program supervised and coordinated by a registered nurse in conjunction with the treatment plan, nursing care and other health professional care.

§ 71213. Psychiatric Nursing Service General Requirements.

(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or

(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

~~(a)~~ (b) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

~~(b)~~ (c) The responsibility and the accountability of the nursing service to the medical staff and hospital administration shall be defined.

~~(c)~~ (d) There shall be a written organized staff education program which shall include orientation and in-service education and training.

(1) There shall be written objectives, plans for implementation and an evaluation mechanism.

~~(d) There shall be a written patient care plan developed for each patient in coordination with the total mental health team. This plan shall include goals, problems/needs and approach and shall be available to all members of the mental health team.~~

(e) There shall be a written nursing audit procedure and evidence that audit procedures are in effect.

~~(f) There shall be a method for determining staffing requirements based on assessment of patient needs. This assessment shall take into consideration at least the following:~~

~~(1) The ability of the patient to care for himself.~~

~~(2) His degree of illness.~~

~~(3) Requirements for special nursing activities.~~

~~(4) Skill level of personnel required in his care.~~

~~(5) Placement of the patient in the nursing unit~~.

~~(g) There shall be documentation of the methodology used in making staffing determinations. Such documentation shall be part of the records of the nursing service and be available for review.~~

~~(h) There shall be a written staffing pattern which shall show:~~

~~(1) Total numbers of staff including full-time and full-time equivalents.~~

~~(2) The available nursing care hours for each nursing unit.~~

~~(3) The categories of staff available for patient care.~~

~~(i) There shall be a record retained for six months of the written staffing pattern available for review by the Department at any given time.~~

§ 71213.1 Planning and Implementing Psychiatric Patient Care.

(a) A psychiatric registered nurse shall directly provide:

(1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.

(2) The planning, supervision, implementation, and evaluation of the psychiatric nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed mental health staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.

(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

(c) The psychiatric nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other psychiatric and mental health disciplines involved in the care of the patient.

(d) Information related to the patient's initial psychiatric nursing assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

~~§ 71215. Psychiatric Nursing Service Staff.~~

~~(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:~~

~~(1) Master's degree in psychiatric nursing or related field with experience in administration; or~~

~~(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or~~

~~(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.~~

~~(b) The director of nurses shall not be designated to serve as charge nurse.~~

~~(c) Sufficient registered nursing personnel shall be provided to:~~

~~(1) Assist the director of nurses for evening and night services and when necessary for day services.~~

~~(2) Give direct nursing care based on patient need.~~

~~(3) Have a registered nurse on duty at all times.~~

~~(4) Plan, supervise and coordinate care given by licensed vocational nurses, psychiatric technicians and other mental health workers.~~

~~(d) Each nursing unit shall have a registered nurse, licensed vocational nurse or psychiatric technician on duty at all times.~~

~~(e) Licensed vocational nurses and psychiatric technicians may be utilized as needed to assist registered nurses in ratios appropriate to patient needs.~~

~~(f) Mental health workers may be utilized as needed to assist with nursing procedures.~~

§ 70215 Psychiatric Nursing Service Staff.

(a) Hospitals shall provide staffing by registered nurses, licensed vocational nurses, and psychiatric technicians within the scope of their licensure in accordance with the following nurse-to-patient ratios. Staffing for care not requiring a registered nurse, licensed vocational nurse or a psychiatric technician is not included within these ratios and shall be determined pursuant to the patient classification system.

No hospital shall assign a licensed nurse or psychiatric technician to a nursing unit or clinical area unless that hospital determines that the licensed nurse or psychiatric technician has demonstrated current competence in providing care in that area and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.

Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to a registered nurse, licensed vocational nurse or psychiatric technician at any one time. "Assigned" means having responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number of patients and the total number of licensed nurses and psychiatric technicians on the unit during any one shift nor over any period of time. Only licensed nurses and psychiatric technicians providing direct patient care shall be included in the ratios.

Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other registered nurse,

licensed vocational nurse or psychiatric technician is engaged in activities other than direct patient care, that person shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Registered Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit.

Nothing in this section shall prohibit a licensed nurse or a psychiatric technician from assisting with specific tasks within the scope of his or her practice for a patient assigned to another nurse. "Assist" means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited.

(1) The registered nurse-to-patient ratio in an adult acute psychiatric unit shall be 1:6 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(2) The registered nurse-to-patient ratio in a pediatric acute psychiatric unit shall be 1:4 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(3) The registered nurse-to-patient ratio in an adolescent acute psychiatric unit shall be 1: 4 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(4) The registered nurse-to-patient ratio in a geriatric acute psychiatric unit shall be 1:6 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(5) The registered nurse-to-patient ratio in a psychiatric critical care unit shall be 1:2 or fewer at all times. "Critical care unit" means a nursing unit or isolation unit of an acute

psychiatric hospital including but not limited to a supplemental service psychiatric intensive care service as described in Section 71403(a)(3).

(6) The registered nurse-to-patient ratio in a post anesthesia recovery unit of the supplemental service anesthesia service, as described in Section 71403(a)(1), shall be 1:2 or fewer at all times, regardless of the type of anesthesia the patient received.

(7) In a psychiatric emergency triage/admission (ETA) unit, only psychiatrists, physicians, registered nurses, licensed clinical social workers, and psychologists shall be assigned to triage patients. Only registered nurses shall be assigned to provide direct psychiatric nursing patient care in the ETA unit. In an acute psychiatric hospital providing psychiatric ETA the registered nurse-to-patient ratio in shall be 1:4 or fewer at all times that patients are receiving treatment or being evaluated for admission to an inpatient unit. There shall be no fewer than two psychiatric registered nurses physically present in the psychiatric emergency unit when a patient is present.

The registered nurse assigned to triage patients shall be immediately available at all times to triage patients when they arrive for ETA. When there are no patients needing ETA, the registered nurse may assist by performing other psychiatric nursing tasks. The psychiatric registered nurse assigned to ETA psychiatric patients shall not be counted in the psychiatric registered nurse-to-patient ratio.

When registered nursing staff are attending psychiatric critical care patients in the ETA, the registered nurse-to-patient ratio shall be 1:2 or fewer psychiatric critical care patients at all times. A patient in the ETA unit shall be considered a critical care patient when the patient meets the criteria for admission to a critical care or isolation service area within the hospital.

(8) The licensed nurse-to-patient ratio in a supplemental service skilled nursing service psychiatric unit, as described in Section 71403 (a)(7) shall be 1:5 or fewer at all times. For purposes of supplemental service psychiatric skilled nursing service units “licensed nurses” includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed vocational nurses or psychiatric technicians on the skilled nursing service unit. Additional staff will be provided based upon a patient classification system.

(9) The licensed nurse-to-patient ratio in a supplemental service intermediate care unit service, pursuant to Section 71403(a)(4) shall be 1:6 or fewer at all times. For purposes of supplemental service psychiatric skilled nursing service units "licensed nurses" includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed seventy-five percent of the licensed nurse staff on the intermediate care nursing service unit. Additional staff will be provided based upon the patient classification system.

(10) In a supplemental service outpatient clinic pursuant to Section 71403 (a)(5) of an acute psychiatric hospital, a direct care psychiatric registered nurse shall be present and available at all times to provide psychiatric nursing services. Additional staff will be provided based upon a patient classification system.

(11) Identifying a unit by a name or term other than those used in this subsection does not affect the requirement to staff at the ratios identified for the level or type of care described in this subsection.

(b) In addition to the requirements of subsection (a), the hospital shall implement a patient classification system for determining psychiatric nursing care needs of individual psychiatric patients that reflects the assessment, made by a psychiatric registered nurse as specified at subsection 70213.1 (a)(1), of patient requirements and provides for shift-by-shift staffing based on those requirements. The ratios specified in subsection (a) shall constitute the minimum number of psychiatric registered nurses, psychiatric licensed vocational nurses, and psychiatric technicians, who shall be assigned to direct patient care. Additional staff in excess of these prescribed ratios, including non-licensed mental health staff, shall be assigned in accordance with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the psychiatric illness, the potential for self-harm or harm to staff, equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the psychiatric patient care plan, the ability for self-care, and the licensure of the personnel required for care. The system developed by the hospital shall include, but not be limited to, the following elements:

(1) Individual psychiatric patient care requirements for inpatients and outpatients.

(2) The psychiatric patient care delivery system.

(3) Generally accepted standards of psychiatric nursing practice, as well as elements reflective of the unique nature of the hospital's patient population.

(c) A written staffing plan shall be developed by the administrator of nursing service or a designee, based on patient care needs determined by the psychiatric patient classification system. The staffing plan shall be developed and implemented for each psychiatric patient care unit and shall specify psychiatric patient care requirements and the staffing levels for psychiatric registered nurses and other licensed and unlicensed personnel. In no case shall the staffing level for licensed nurses or psychiatric technicians fall below the requirements of subsection (a). The plan shall include the following:

(1) Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis.

(2) The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis.

(3) The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis.

(d) In addition to the documentation required in subsections (c)(1) through (3) above, the hospital shall keep a record of the actual psychiatric registered nurse, psychiatric licensed vocational nurse and psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis. The hospital shall retain all of the following:

(1) The staffing plan required in subsections (c)(1) through (3) for the time period between licensing surveys, which includes the Consolidated Accreditation and Licensing Survey process.

(2) The record of the actual psychiatric registered nurse, psychiatric licensed vocational nurse and psychiatric technician assignments by licensure category for a minimum of one year.

(e) The reliability of the patient classification system for validating staffing requirements shall be reviewed at least annually by a committee appointed by the nursing administrator to determine whether or not the system accurately measures patient care needs.

(f) At least half of the members of the review committee shall be psychiatric registered nurses who provide direct patient care.

(g) If the review reveals that adjustments are necessary in the psychiatric patient classification system in order to assure accuracy in measuring psychiatric patient care needs, such adjustments must be implemented within thirty (30) days of that determination.

(h) Hospitals shall develop and document a process by which all interested staff may provide input about the psychiatric patient classification system, the system's required revisions, and the overall staffing plan.

(i) The administrator of psychiatric nursing services shall not be designated to serve as a charge nurse or to have direct patient care responsibility, except as described in subsection (a) above.

(j) Psychiatric registered nursing personnel shall:

(1) Assist the administrator of nursing service so that supervision of psychiatric nursing care occurs on a 24-hour basis.

(2) Provide direct patient care.

(3) Provide clinical supervision and coordination of the care given by licensed vocational nurses, psychiatric technicians and unlicensed mental health nursing personnel.

(k) Each patient care unit shall have a psychiatric registered nurse assigned, present and responsible for the patient care in the unit on each shift at all times.

(l) Unlicensed mental health personnel may be utilized as needed to assist with simple psychiatric nursing procedures, subject to the requirements of competency validation. Hospital policies and procedures shall describe the responsibility of unlicensed mental health personnel and limit their duties to tasks that do not require licensure as a registered nurse, a licensed vocational nurse, or a psychiatric technician.

(m) Psychiatric Nursing personnel from temporary nursing agencies shall not be responsible for a patient care unit without having demonstrated clinical and supervisory competence as defined by the hospital's standards of staff performance for psychiatric registered charge nurses.

(n) Hospitals which utilize temporary nursing agencies shall have and adhere to a written procedure to orient and evaluate personnel from these sources. Such procedures shall require that personnel from temporary nursing agencies be evaluated as often, or more often, than staff employed directly by the hospital.

(o) All registered nurses, licensed vocational nurses and psychiatric technicians utilized in the hospital shall have current licenses. A method to document current licensure shall be established.

(p) The acute psychiatric hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A psychiatric healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate psychiatric medical interventions and care.

§ 71217. Psychiatric Nursing Service Equipment and Supplies.

There shall be adequate and appropriate equipment and supplies related to the scope and nature of the needs anticipated and the services offered.

§ 71219. Psychiatric Nursing Service Space.

Office space shall be provided for the director of nurses.

California Nurses Association
Comments to CDPH on APH RN Staffing Ratios Regulation – May 20, 2025

ATTACHMENT 2:

CNA Letter to Governor Gavin Newsom, Acute Psychiatric Hospital Safe Registered Nurse-to-Patient Staffing Ratios (April 15, 2025)

California Nurses Association
National Nurses United
OUR PATIENTS. OUR UNION. OUR VOICE.

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-287-5021

SACRAMENTO
Government Relations
980 9th Street
Suite 700
Sacramento CA 95814
phone: 916-446-5019
fax: 916-446-3880

Via electronic mail to leg.unit@gov.ca.gov.

April 15, 2025

Governor Gavin Newsom
c/o Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor Gavin Newsom
State Capitol, 1021 O Street, Suite 9000
Sacramento, CA

RE: Emergency Regulations on Acute Psychiatric Hospital Safe Mandatory Minimum Registered Nurse-to-Patient Ratios

Dear Governor Newsom:

California Nurses Association/National Nurses United (CNA), representing more than 100,000 registered nurses (RNs) who provide direct patient care in California including nurses who work in acute psychiatric hospitals (APHs), writes to you about the distressing understaffing crisis in our state's psychiatric facilities. CNA applauds your ongoing work and dedication to expanding and prioritizing behavioral health care for patients across California. By fully implementing safe registered nurse-to-patient ratios throughout acute psychiatric care facilities in California, your administration has the ability to lead our state to an historic victory in this imperative effort to ensure all Californians can access high-quality behavioral health care services. To this end and to protect behavioral health patients, RNs, and other health care workers in our acute psychiatric care facilities, CNA urges you to order by executive action that the California Department of Public Health (CDPH) issue emergency regulations mandating unit-specific minimum numerical registered nurse-to-patient ratios in acute psychiatric facilities throughout the state.

As nurses, CNA members know that one of the most effective ways to protect patients is through safe and effective staffing. Staffing levels of registered nurses that facilitate safe, competent, therapeutic, and effective care are vital to the safety of patients in our hospitals. For decades, research has demonstrated that safe nurse-to-patient staffing ratios are associated with lower mortality, lower nurse burnout, and better nurse retention.[1] The only way to ensure that all

[1] See Lasater K., Muir K. J., Sloane D., McHugh M., Aiken, L. (2024). "Alternative Models of Nurse Staffing May Be Dangerous in High-Stakes Hospital Care." *Med Care*, 62(7): 434-40. https://doi.org/10.1097/MLR.0000000000001990.

hospitals—including APHs—have safe staffing levels that are consistently adhered to is through legally mandated minimum registered nurse-to-patient ratios. California's legislature recognized this in 1999 when it passed A.B. 394 (Kuehl) and mandated that California's health services agency promulgate regulations on numerical nurse staffing ratios for all hospitals in the state, including APHs.

While California's general acute care hospitals (GACH) safe staffing regulations have successfully been in effect for over two decades, state regulators have yet to promulgate rules to mandate minimum safe nurse staffing ratios for our patients in acute psychiatric hospitals. Although our state should have issued APH safe nurse staffing ratios promptly after A.B. 394 went into effect, the recently revealed dire state of patient care in APHs emphatically demonstrates the urgent need to issue these regulations. For these and the reasons below, CNA urges you to promptly order the emergency promulgation of APH minimum numerical registered nurse-to-patient staffing ratios.

- **Over Two Decades Have Passed Since State Law Mandated that Safe Nurse-to-Patient Ratios be Enacted for Acute Psychiatric Hospitals.**

California's experience demonstrates that mandatory minimum registered nurse-to-patient ratios in our GACHs have increased patient safety and quality of care. Implementing this necessary protection is sound, life-saving healthcare policy, which our state legislature determined over 25 years ago for both general acute care hospitals and acute psychiatric hospitals.

In October 1999, the California legislature passed A.B. 394 (Kuehl), which was signed by Governor Davis, to mandate that the California Department of Health Services, now CPDH, promulgate regulations to establish unit-specific mandatory minimum numerical nurse-to-patient staffing ratios for all acute care hospitals in the state, including APHs. With A.B. 394, a new Health and Safety Code, § 1276.4, went into effect, requiring that the state public health agency adopt rules to establish not only safe nurse-to-patient ratios for general acute care hospitals but also for acute psychiatric hospitals.

The enactment of A.B. 394 in 1999 was followed by a three-year rulemaking process and years of litigation over the establishment and adoption of safe nurse-to-patient ratios in general acute care hospitals. In January 2004, California's safe staffing regulations for GACHs went into effect under Cal. Code Regs., Title 22, § 70217. With the promulgation of these regulations, our state became the first jurisdiction in the country to legally mandate unit-specific minimum numerical nurse-to-patient ratios throughout general acute care hospitals. However, as

gubernatorial administrations changed after the adoption of staffing ratios for GACHs, the legislative mandate that CDPH also promulgate minimum nurse-to-patient staffing ratios for APHs has yet to be fulfilled.

Today, it has been over two decades since California's regulations on GACH safe nurse staffing ratios went into effect and over 25 years since the state legislature passed law to ensure that all hospitals in the state have minimum safe nurse-to-patient ratios to protect our patients and health care workers, but no regulations ensuring that safe nurse-to-patient staffing ratios are established and enforced in acute psychiatric hospitals have been proposed or promulgated.

- **The Understaffing Crisis in California APHs Impedes the State's Goals to Expand Access to Behavioral Health Care.**

As a critical part of California's efforts to expand access to behavioral health care, acute psychiatric facilities in our state are meant to provide important, lifesaving care for Californians with behavioral health needs on a 24-hour inpatient basis. However, without the necessary safeguards of mandatory minimum nurse-to-patient staffing ratios, acute psychiatric hospitals have been permitted to make decisions on staffing levels based on budgeting and revenue rather than safe and effective patient care. For example, without regulatory mandates to provide minimum numerical staffing ratios, APHs may engage in nurse staffing cuts to save money, thereby adversely affecting patient outcomes.

Today, in California, there are 119 facilities that are licensed as acute psychiatric hospitals—43 facilities that are standalone acute psychiatric hospitals and 76 acute care hospitals that provide acute psychiatric services as a "distinct part" that are licensed as acute care hospitals.[2] In total, these 119 facilities licensed as APHs are licensed to provide care for over 14,000 beds throughout the state. Of these facilities, 52 are for-profit APHs, 41 are non-profit APHs, and 26 have public (state, county, health district, or University of California) or exempt ownership.

However, a recent *San Francisco Chronicle* investigative series on the current state of APH's in our state, "Failed to Death", revealed shocking stories of assault, abuse, and neglect in the care of vulnerable behavioral health patients resulting from inadequate staffing in our acute

[2] See Cal Health Find Database, California Department of Public Health, https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx (Accessed Mar. 18, 2025).

psychiatric hospitals.[3] Journalists Joaquin Palamino and Cynthia Dizikes were puzzled by the lack of staffing standards for APHs despite our quarter-century old legislation that directed CDPH to adopt numerical minimum staffing standards for all California hospitals. Palamino and Dizikes wrote:

> [F]or-profit psychiatric hospital operators have taken advantage of lax state staffing regulations to generate hundreds of millions of dollars in earnings. Although California law required CDPH to set minimum nurse-to-patient ratios in psychiatric hospitals, the agency has failed to do so, contributing to understaffing, violence and deadly neglect.[4]

The investigative series cite numerous deficiency notices that were given by CDPH to for-profit APH operators for staffing inadequacies resulting in patient harm but describe no evidence of improvement in hospital staffing standards. But the inability of CDPH to enforce failures in safe staffing in APHs does not come as a surprise given that the Department can only enforce regulations that are in effect. With virtually no staffing standards in effect in APHs, CDPH has limited tools to ensure safe staffing at APHs despite the statutory mandate in Health and Safety Code, § 1276.4 to adopt minimum numerical licensed nursing standards to protect patients in all hospital settings.

Additionally, Palomino and Dizikes describe the dangerous working conditions in APHs, which is driving nurses and other psychiatric workers to leave these facilities. They described the dangerous understaffing conditions and extreme risks for workplace violence at Aurora Behavioral Healthcare Santa Rosa that lead to a riot in the facility where police were called after "patients were kicking, scratching and spitting on employees as staff members struggled to pin them down and quell the riot" and "[a] girl ripped a block of sheetrock from the wall and hurled it at workers."[5] The report goes on to describe how hospital administrators were nowhere to be found leaving only a handful of underprepared staff to desperately try to care for their adolescent patients.

---

[3] Joaquin Palomino and Cynthia Dizikes, "Violence and neglect plague a Bay Area psychiatric hospital. California has lefts its patients in danger," *San Francisco Chronicle* (Mar. 19, 2025), https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-patients/.

Joaquin Palomino and Cynthia Dizikes, "California is embracing psychiatric hospitals again. Behind locked doors, a profit-driven system is destroying lives," *San Francisco Chronicle* (Mar. 5, 2025), https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-crisis/.

Joaquin Palomino and Cynthia Dizikes, "The mystery shocked San Francisco. This is the story of the 15-year-old girl found dead in a driveway," *San Francisco Chronicle* (Feb. 26, 2025), https://www.sfchronicle.com/projects/2025/california-psychiatric-hospitals-jazmin-pellegrini-death/.

[4] Palomino and Dizikes (Mar. 19, 2025), supra, note 3.

[5] *Id.*

The stories from Aurora Behavioral Health Care underscores that improvement in the staffing levels and working conditions will be an essential element of both ensuring that patients receive the high-quality care that they deserve and retaining RNs and other licensed health care workers to continue their work in the environment of inpatient behavioral health care. Given the current understaffing and lack of enforceable mandatory minimum numerical nurse-to-patient ratios at APHs, increasing the numbers of behavioral health patients admitted to California's acute psychiatric hospitals does not equate with and ultimately impedes the state's goal of improving access to behavioral health care.

- **For-Profit APHs are Dangerously Understaffed Compared to Public and Unionized APHs.**

Another important revelation from the *San Franciso Chronicle* investigative series is the dangerously low staffing standards at for-profit APHs when compared to their public and non-profit APH counterparts.

Evaluating data on the number of registered nurse hours per patient day (RN HPPD) in 2023 among APHs, provides a stark picture of the wide-ranging levels of RN staffing in APHs throughout the state. For example, the University of California San Francico (UCSF) operated APH, Langley Porter Psychiatric Institute, provided the highest number of RN HPPD at 12.68 while 27 APHs provided less than 3 RN HPPDs in 2023.[6] By comparison, UCSF Langley Porter provided nearly seven times as many RN staffing hours for patients than Aurora Behavioral Healthcare Santa Rosa, the APH analyzed in the *San Francisco Chronicle* series, which only provided 1.89 RN HPPD in 2023.[7] Notably, while UCSF Langley Porter is not lawfully mandated to comply with the GACH psychiatric unit nurse-to-patient ratios, registered nurses at UCSF Langley Porter are unionized workers, represented by CNA. Unionization has allowed RNs to speak without fear of retaliation regarding understaffing and thereby uphold higher staffing levels.

Additionally, the use of unlicensed staff in for-profit APHs and many non-profit APHs mirrors the staffing of GACH hospitals during the 1990s, prior to the adoption of GACH nurse-to-patient ratios, where some hospitals dangerously increased levels of unlicensed staff to substitute RNs.[8] For example, today, UCSF Langley Porter staffs with 60.3% registered nurses and only has 20.5% unlicensed staff. In contrast, Aurora Behavioral Healthcare Santa Rosa's

[6] Department of Health Care Access and Information (HCAI), "Financial & Utilization Reports," https://reports.siera.hcai.ca.gov/ (Accessed April 8, 2025).
[7] *Id*.
[8] See A.B. 394 (Kuehl), Senate Floor Analysis (Sept. 3, 1999).

APH utilizes only 32.3% registered nurses but utilizes 66.2% unlicensed staff.[9] Examining APHs across the state, for-profit APHs tend to have dramatically lower RN HPPDs when compared to publicly owned or operated APHs and tend to staff more unlicensed personnel.[10]

Only through the implementation of mandatory minimum nurse-to-patient staffing ratios at APH can California reverse this dangerous trend of understaffing at for-profit APHs and use of woefully unprepared and unlicensed staff, which jeopardizes both the quality of care and safety of patients at APHs.

- **Safe Nurse-to-Patient Staffing Ratios Have Saved Lives in California's General Acute Care Hospitals.**

After over two decades California's implementation of its nurse-to-patient ratios law, both California nurses' experience and the research literature indisputably demonstrate that legislative and regulatory mandates on minimum nurse-to-patient staffing improves patient care and saves lives. Research has shown overwhelmingly that safe staffing levels and ratios help improve patient outcomes in mortality, adverse events, complications, failure to rescue, quality of care, costs, and length of stay.[11] Safe staffing levels also help decrease nurse burnout and job dissatisfaction.[12] In short, lawfully mandated minimum nurse staffing levels at general acute care hospitals in California have been proven to save lives and enhance patient care.

A seminal study from 2010 on the impact of California's ratios compared California hospitals' post-implementation of the state's minimum nurse-to-patient ratios law to hospitals in New Jersey and Pennsylvania.[13] The study found, unsurprisingly, that if New Jersey and Pennsylvania had matched California's ratios in medical surgical units, New Jersey would have 13.9 percent fewer patient deaths and Pennsylvania 10.6 percent fewer deaths. Compared to states without ratios, the study found that California RNs reported having more time to spend with patients and that hospitals were more likely to have enough RNs on staff to provide quality patient care. The study also found that California nurses were significantly less likely than their New Jersey and Pennsylvania counterparts to report that workload causes them to miss changes in patient conditions.

---

[9] See HCAI, note 7.

[10] *Id*.

[11] See also National Nurses United. "The Science of Ratios." National Nurses United (Accessed Apr. 10, 2025). https://www.nationalnursesunited.org/science-of-ratios (compiling research literature on the successful implementation of mandatory minimum general acute care hospital nurse-to-patient staffing ratios in California).

[12] Bae S., Mark B., Fried B. (2010). "Impact of nursing unit turnover on patient outcomes in hospitals" *J of Nurs Scholarship*, 42(1): 40-49. https://pubmed.ncbi.nlm.nih.gov/20487185/.

[13] Aiken L. (2010). "The California nurse staffing mandate: implications for other states." LDI Issue Brief, 15(4): 904-921. https://pubmed.ncbi.nlm.nih.gov/20614653/.

A later study from 2016 that compared hospitals in Pennsylvania, New Jersey, Florida, and California confirmed the earlier findings that California's improved nurse-to-patient staffing ratios improved patient care.[14] This study focused on hospitals that saw ten or more cardiac arrest events during the time under study and found that for every additional patient assigned to a nurse, the likelihood of a patient surviving cardiac arrest decreased by five percent per patient.

The success of California's nurse-to-patient ratios law confirms what other more general studies on nurse staffing have long shown. For example, a 2013 meta-analysis of twenty-eight prior studies found a consistent relationship between higher RN staffing and lower hospital related mortality.[15] These are just a small sample of studies that reaffirm California's statutory mandate that minimum numerical registered nurse-to-patient ratios be established by regulation for all hospitals, including APHs, in our state.

- **Research Literature Demonstrates that Safe Nurse Staffing Levels Saves Lives in Acute Psychiatric Facilities and Units.**

In addition to the body of research about the importance of safe RN staffing in proving high-quality, effective patient care in hospitals generally, there are numerous studies that support the importance of RN staffing in the acute psychiatric hospital setting. Findings in the research literature include:

- Readmission rates for psychiatric disorders within 30 days were reduced with high levels of nurse staffing.[16]
- Nurse communication involves interpersonal approaches and modalities that exemplify highly developed communication and personal skills designed specifically for the acute inpatient mental health units.[17]

[14] McHugh M. et al. (2016). "Better Nurse Staffing and Nurse Work Environments Associated With Increased Survival of In-Hospital Cardiac Arrest Patients." *Med Care*, 54(1): 74-80. https://pubmed.ncbi.nlm.nih.gov/26783858/.

[15] Shekelle P. (2013). "Nurse-patient ratios as a patient safety strategy: a systematic review." *Ann Intern Med*, 158(5): 404-09.

[16] Han K., Kim S. J., Jang S., Hahm M., Kim S. J., Lee S. Y., Park E. (Oct. 2015). "The outcomes of psychiatric inpatients by proportion of experienced psychiatrists and nurse staffing in hospital." *Psych Research*, 229(3): 880-86. https://www.sciencedirect.com/science/article/abs/pii/S0165178115005089.

[17] Cleary M., Hunt G., Horsfall J., Deacon M. (2012). "Nurse-Patient Interaction in Acute Adult Inpatient Mental Health Units: a Review and Synthesis of Qualitative Studies." *Issues in Mental Health Nurs*, 33(2): 66-79. https://www.tandfonline.com/doi/full/10.3109/01612840.2011.622428.

- Increases in mental health staffing led to a reduction in suicide-related events for patients.[18]
- Lower nurse staffing results in nursing care left undone.[19]
- The nurse-to-patient staffing ratio in inpatient psychiatric settings was strongly and significantly related to the rate of work-related injuries experienced by hospital staff. Higher numbers of RNs to patients were associated with fewer work-related injuries.[20]

Attached to this letter as Attachment 1 is a complete list of research literature specifically supporting safe staffing levels for inpatient psychiatric patients.

- **Safe Staffing Ratios in GACHs have Improved Nurses' Health and Safety.**

Numerical nurse-to-patient ratios in GACHs improved not just patient safety but also improved nursing work environments and nurses' health and safety. Improved working conditions and safe staffing levels in hospitals have attracted and retained nurses to practice in the state.

California's success with implementation of its mandated minimum nurse-to-patient staffing ratios law belies industry arguments that there are not enough RNs to comply with mandated nurse-to-patient ratios. Numerous studies demonstrate that California's ratios have resulted in California nurses caring for fewer patients at a time, positively impacting both the working environment and patient care. The comparative study of California to New Jersey and Pennsylvania also found that California's ratios have positively affected nurses' overall work environment and their corresponding ability to deliver patient care. Overall, compared to their nurse counterparts in New Jersey and Pennsylvania, nurses in California care for an average of one fewer patients and reported more favorable outcomes with respect to every work environment measure analyzed, including reasonable workload, adequate support staff, and enough RNs to provide quality patient care.[21]

---

[18] Feyman Y, Figueroa S., Yuan Y., et al. (Apr. 2022). "Effect of mental health staffing inputs on suicide-related events." *Health Serv Research,* 58(2): 375-82. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14064.

[19] Gehri B., Ausserhofer D. et al. (Apr. 2024). "Nursing care left undone in psychiatric hospitals and its association with nurse staffing: A cross-sectional multi-centre study in Switzerland." *Psych and Mental Health Nurs*, 31(2): 215-27. https://onlinelibrary.wiley.com/doi/full/10.1111/jpm.12978.

[20] Hanrahan N., Kumar A., Aiken L. (Jun 2010). "Adverse Events Associated With Organizational Factors of General Hospital Inpatient Psychiatric Care Environments." *Psych Services*, 61(6). https://psychiatryonline.org/doi/full/10.1176/ps.2010.61.6.569.

[21] *Id*.

A different 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.[22] A more recent 2015 study, which examined occupational injury and illness rates before and after the California RN staffing ratio law was passed, also showed what RNs already know—safe staffing improves RN health and safety.[23] Other research supports these findings that RN staffing ratios mean safer RNs. These findings include:

- 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.[24]

- An increased patient load per nurse was associated with significantly higher likelihood for neck, shoulder, and back musculoskeletal disorders.[25]

- Risk for workplace violence injuries was twice as high for lower-staffed hospitals compared to higher-staffed hospitals.[26]

Safe working conditions allow nurses to focus on their patients rather than taking time off to heal themselves. In sum, safe patient workloads and safe working conditions for RNs go hand-in-hand to ensure nurses are able to provide safe and therapeutic patient care.

- **Safe Nurse Staffing Levels Improves Nurse Retention and Results in Hospital Savings.**

The experience of California in GACH also has demonstrated that the specter of outsized costs to industry to implement minimum nurse-to-patient ratios was unfounded. Improved nurse job satisfaction and patient outcomes that resulted from the implementing nurse staffing ratios reduced spending on temporary RNs and overtime costs and also resulted in savings from lower RN turnover.[27]

---

[22] 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/.

[23] Leigh J., Markis C., Losif A., Romano P. (2015). "California's nurse-to-patient ratio law and occupational injury." *Int Arch Occup Environ Health*, 88(4): 477-84. https://pmc.ncbi.nlm.nih.gov/articles/PMC6597253/.

[24] Clarke S., Sloane D., Aiken L. (2002). "Effects of hospital staffing and organizational climate on needlestick injuries to nurses." *Amer J Pub Health*, 92(7): 1115-19. https://ajph.aphapublications.org/doi/10.2105/AJPH.92.7.1115.

[25] Lipscomb J., Trinkoff A., Brady B., Geiger-Brown J. (2004). "Health care system changes and reported musculoskeletal disorders among registered nurses." *Amer J Pub Health*, 1431-36. https://pmc.ncbi.nlm.nih.gov/articles/PMC1448467/.

[26] Lee S., Gerberich S., Waller L., Anderson A., McGovern P. "Work-related assault injuries among nurses." *Epidemiology*, 10(6): 685:91. https://pubmed.ncbi.nlm.nih.gov/10535781/.

[27] Bland-Jones C. (2008). "Revisiting Nurse Turnover Costs, Adjusting for Inflation." *J of Nursing Admin*, 38(1): 11-18. https://pubmed.ncbi.nlm.nih.gov/18157000/.

Minimum safe nurse-to-patient ratios both attract and retain registered nurses in direct care positions in our hospitals. After the implementation of California's ratio law, nurses in California experienced burnout at significantly lower rates than those in New Jersey and Pennsylvania, and reported less job dissatisfaction.[28] Both burnout and job dissatisfaction are precursors to turnover. More recently, the Texas Center for Nursing Workforce Studies published research on hospital nurse staffing vacancy and turnover rates for registered nurses, which showed RN turnover rates in California to be dramatically lower than states without ratios, such as Florida and Texas.[29]

Studies on the cost of RN turnover can put an actual number on the savings potential of implementing safe nurse-to-patient staffing ratios. According to a PricewaterhouseCoopers' report on nursing workforce recruitment and retention, the estimated cost of replacing one RN in 2007 was between $40,000–$85,000.[30] The report goes on to state that, "Every percentage point increase in nurse turnover costs an average hospital about $300,000 annually."[31] Considering the costs of nurse turnover, it is evident that implementing safe registered nurse-to-patient staffing ratios saves individual hospitals from both the expense and clinical disruption of a rapid turnover of its nursing staff.

An improved nurse working environment, likewise, translates into savings from improved patient outcomes[32] and shorter patient lengths of stay.[33] A 2009 study estimated that adding 133,000 RNs to the U.S. hospital workforce—the number of RNs needed to increase nursing staff to the 75th percentile—would produce medical savings of $6.1 billion, not including the value of increased productivity when nurses help patients recover more quickly.[34] Combining medical savings with increased productivity, the addition of 133,000 RNs would result in an economic value of $57,700 for each additional RN.[35] Mandatory minimum nurse-to-

---

[28] Aiken (2010), supra, note 13.

[29] Texas Center for Nursing Workforce Studies (2016). "Hospital Nurse Staffing Study, Vacancy and Turnover." Texas Department of State Health Services, Publication #: 25-14909. https://www.dshs.texas.gov/sites/default/files/chs/cnws/HNSS/2016/2016HNSS_Vacancy-and-Turnover.pdf.

[30] PricewaterhouseCoopers' Health Research Institute (2007). "What Works: healing the healthcare staffing shortage." PricewaterhouseCoopers. https://heller.brandeis.edu/council/pdfs/2007/PwC%20Shortage%20Report.pdf.

[31] *Id*.

[32] Encinose W. & Hellinger F. (2008). "The Impact of Medical Errors on Ninety-Day Costs and Outcomes: An Examination of Surgical Patients." *Health Serv Research*, 43(6): 2067-85. https://pmc.ncbi.nlm.nih.gov/articles/PMC2613997/.

[33] Needleman J., Buerhaus S., Mattke M., Stewart M., Zelevinsky, K. (2002). "Nurse-staffing levels and the quality of care in hospitals." *NEJM*, 346(22): 1715-22. https://pubmed.ncbi.nlm.nih.gov/12037152/.

[34] Dall T. (2009). "The Economic Value of Professional Nursing." *Medical Care*, 47(1): 97-101. https://journals.lww.com/lww-medicalcare/fulltext/2009/01000/the_economic_value_of_professional_nursing.14.aspx.

[35] *Id*.

patient staffing levels are feasible, resulting in better nurse workloads and hospital savings from lower turnover and improved patient outcomes.

Tellingly, the implementation of California's ratios law for GACHs attracted, and continues to attract, nurses to practice in our state. There is a significant difference between the number of RNs with active licenses before the implementation of GACH minimum staffing ratios and today. California has added nearly 300,000 RNs with active licenses since 1999. In 1999, California had 244,105 registered nurses with active licenses[36] and as of April 1, 2025, there are 542,896 registered nurses with active licenses.[37] The number of licensed GACH beds in California has been remarkably stable since the GACH staffing ratios regulations when into effect on January 1, 2005. From 2004 to 2013, there was virtually no numerical change in the number of licensed GACH beds with 81,179 licensed beds in 2004 and 81,729 in 2013, meaning that there are even higher numbers of RNs to patient beds in California GACHs today.[38]

Implementing minimum nurse-to-patient ratios in GACHs not only improved nursing workforce retention but also resulted in savings for hospitals by reducing turnover rates and costs associated with negative patient outcomes. Likewise, implementation of safe nurse-to-patient staffing ratios in APH would have a similar impact of improving patient care and working conditions, retaining a dedicated and skilled behavioral health workforce, and ultimately saving money for hospitals from reduced worker turnover and improved patient care.

- **Executive Action is Needed to Ensure that Safe Nurse-to-Patient Staffing Ratios are Promulgated by CDPH Promptly as Emergency Regulations.**

The evidence overwhelmingly demonstrates that in the face of an epidemic of preventable medical errors and constant reports of workplace violence at APHs, RN staffing ratios in California acute psychiatric facilities must be implemented without delay to prevent further patient harm and preserve thousands of lives. Attached to this letter as Attachment 2, CNA has included proposed regulatory language for an emergency rulemaking on APH minimum safe staffing standards.

---

[36] California Board of Registered Nursing (1999). "The BRN Report – Winter 1999." California Department of Consumer Affairs. https://www.rn.ca.gov/pdfs/forms/brn299.pdf.

[37] California Board of Registered Nursing (2025). "The BRN Report – Winter 2025." California Department of Consumer Affairs. https://www.rn.ca.gov/pdfs/forms/brnwinter2025.pdf; California Board of Registered Nursing (Apr. 1, 2025). "Monthly Statistics." Department of Consumer Affairs. https://www.rn.ca.gov/consumers/stats.shtml (Accessed Apr. 11, 2025).

[38] California Health Care Foundation (2015). "California Hospitals: An Evolving Environment." California Health Care Almanac, at 3. https://www.chcf.org/wp-content/uploads/2017/12/PDF-CaliforniaHospitals2015.pdf.

Fortunately, the work of developing regulatory language for nurse-to-patient ratios compliant with the statutory mandate in Health and Safety Code § 1276.4 and necessary for staffing ratio enforcement has already been done by CDPH under our GACH safe nurse staffing standards in Cal. Code Regs., Title 22, § 70217. The GACH rulemaking on minimum nurse-to-patient ratios was the largest rulemaking in department history and spanned more than 10,000 pages.[39] CNA's proposed regulatory language below for APH staffing standards has been adopted from the GACH rulemaking, adapted to reflect the inpatient psychiatric units and unit types found in APHs.

Patients in the APH setting are entitled to staffing protections that, at the very least, mirror those in GACHs. To the greatest extent possible, the proposed regulatory language mirrors the unit-specific numerical ratios and other implementation standards found in Cal. Code Regs., Title 22, § 70217. CNA's recommendations for pediatric/adolescent care numerical ratios mirror the GACH pediatric minimum nurse-to-patient ratio language since the population has unique developmental needs and differences than the adult/geriatric psychiatric unit population. Additionally, some APHs have supplemental services for skilled nursing facility (SNF) and/or intermediate levels of care, which are not units included in the GACH staffing ratio regulation. For these supplemental services, we have recommended APH staffing standards that recognize the unique needs of this behavioral health population and the fact that they are provided on a 24-hour basis by the APH.

Importantly, the need for highly developed communication and personal skills designed specifically for the acute inpatient psychiatric patient merits a registered nurse-to-patient ratio of RNs that is not diluted by other licensed staff. Licensed vocational nurses and licensed psychiatric technicians can play an important role in acute psychiatric care but the utilization of other licensed health care staff must supplement and not replace the minimum RN-to-patient ratios. Additionally, unlicensed staff are also an important component of care in the inpatient care setting, but the GACH rulemaking did not provide specific guidelines for unlicensed staff and Health and Safety Code § 1276.4 did not direct the Department to establish such guidelines.

Finally, in our proposed regulatory language on APH minimum registered nurse-to-patient ratios, we have used the accepted format for regulatory change by underlining new language and strikethrough of regulatory language to be deleted or repealed.

[39] See California Department of Health Services (2003). Rulemaking File for Nurse to Patient Ratios By Unit Type in General Acute Care Hospitals (R-37-01). Office of Administrative Law File No. 03-0828-02S.

- **Conclusion**

For all the above reasons, CNA urges you to issue an Executive Order directing the California Department of Public Health to promulgate, through emergency regulations, mandatory minimum safe nurse-to-patient staffing ratios for California's acute psychiatric hospitals.

If you or your office have any questions, please contact me, CNA Government Relations Director Puneet Maharaj, at pmaharaj@calnurses.org or CNA Government Relations Assistant Director Carmen Comsti at ccomsti@calnurses.org.

Sincerely,

Puneet Maharaj
Government Relations Director
California Nurses Association/National Nurses United

cc: Richard Figueroa, Deputy Cabinet Secretary, Office of the Governor Gavin Newsom
Kimberly Johnson, Secretary, California Health and Human Services Agency
Paula Villescaz, Deputy Legislative Affairs Secretary, Office of the Governor Gavin Newsom
Corrin Buchanan, Undersecretary, California Health and Human Services Agency
Brendan McCarthy, Deputy Secretary of Program & Fiscal Affairs, California Health and Human Services Agency
Dr. Erica Pan, Director & State Public Health Officer, California Department of Public Health
Susan Fanelli, Chief Deputy Director Health Quality & Emergency Response, California Department of Public Health

ATTACHMENT 1:
Research Literature on Staffing in Acute Psychiatric Facilities & Units

Studies on staffing ratios generally improving psychiatric or behavioral health patient outcomes or care

Han, Kyu-Tae, Sun Jung Kim, Sung-In Jang, Myung-Il Hahm, Seung Ju Kim, Seo Yoon Lee, and Eun-Cheol Park. 2015. "The Outcomes of Psychiatric Inpatients by Proportion of Experienced Psychiatrists and Nurse Staffing in Hospital: New Findings on Improving the Quality of Mental Health Care in South Korea. *Psychiatry Research*. 229(3): 880-86. https://www.sciencedirect.com/science/article/abs/pii/S0165178115005089.

Park, Suin, Shoee Park, Young Joo Lee, Choon-Seon Park, Young-Chul Jung, and Sunah Kim (2020). "Nurse Staffing and Health Outcomes of Psychiatric Inpatients: A Secondary Analysis of National Health Insurance Claims Data." *Journal of Korean Academy of Nursing*. 50(3): 333-48. https://koreascience.kr/article/JAKO202019550427759.page.

Studies on staffing ratios in psychiatric units or psychiatric facilities improving patient outcomes or care

Bowers, Len and Martin Crowder (2012). "Nursing Staff Numbers and their Relationship to Conflict and Containment Rates of Psychiatric Wards – A Cross Sectional Time Series Poisson Regression Study." *International Journal of Nursing Studies*. 49(1): 15-20. https://pubmed.ncbi.nlm.nih.gov/21813126/.

Butler, Michelle, Timothy Schultz, Phil Halligan, Ann Sheridan, Leigh Kinsman, Thomas Rotter, Jonathan Beaumier, Robyn Gail Kelly, and Jonathan Drennan (2019). "Hospital Nurse-Staffing Models and Patients- and Staff-Related Outcomes." *Cochrane Database of Systematic Reviews.* https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD007019.pub3/full.

Cleary, Michelle (2012). "Nurse-Patient Interaction in Acute Adult Inpatient Mental Health Units: A Review and Synthesis of Qualitative Studies." *Issues in Mental Health Nursing*. 33(2). https://www.tandfonline.com/doi/full/10.3109/01612840.2011.622428.

Coleman, James C., and Gordon L. Paul (2001). "Relationship Between Staffing Ratios and Effectiveness of Inpatient Psychiatric Units." *Psychiatric Services*. 52(10). https://psychiatryonline.org/doi/full/10.1176/appi.ps.52.10.1374.

Cutler, Natalie Ann, Jenny Sim, Elizabeth Halcomb, Lorna Moxham, and Moira Stephens (2020). "Nurses' Influence on Consumers' Experience of Safety in Acute Mental Health Units: A Qualitative Study." *Journal of Clinical Nursing.* 29(21-22): 4379-86. https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.15480.

Desmet, Karel, Piet Bracke, Eddy Deproost, Peter Goossens, Joeri Vandewalle, Lieke Vercuysse, Dimitri Beeckman, Ann Van Hecke, Lise-Marie Kinnaer, Sofie Verhaeghe (2023). "Patient-Reported Outcomes of the Nurse-Patient Relationship in Psychiatric Inpatient Hospitals: A Multicentered Descriptive Cross-Sectional Study." *Psychiatric and Mental Health Nursing*. 30(3): 568-79. https://onlinelibrary.wiley.com/doi/abs/10.1111/jpm.12895.

Feyman, Yevgeniy, Stuart M. Figueroa, Yingzhe Yuan, Megan E. Price, Aigerim Kabdiyeva, Jonathan R. Nebeker, Merry C. Ward, Paul R. Shafer, Steven D. Pizer, Kiersten L. Strombotne (2022). "Effect of Mental Health Staffing Inputs on Suicide-Related Events. *Health Services Research*. 58(2): 375-82. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14064.

Gehri, Beatrice, Dietmar Ausserhofer, Franziska Zuniga, Stefanie Backnick, Rene Schwendimann, and Michael Simon. 2023. "Nursing Care Left Undone in Psychiatric Hospitals and Its Association with Nurse Staffing: A Cross-Sectional Multi-Centre Study in Switzerland." *Journal of Psychiatric and Mental Health Nursing*. 31(2): 215-27. https://onlinelibrary.wiley.com/doi/full/10.1111/jpm.12978

Hanrahan, Nancy P., Aparna Kumar, and Linda H. Aiken (2010). "Adverse Events Associated with Organizational factors of General Hospital Inpatient Psychiatric Care Environments." *Psychiatric Services*. 61(6). https://psychiatryonline.org/doi/full/10.1176/ps.2010.61.6.569

Okumura, Yasuyuki, Nayoa Sugiyama, Toshie Noda, and Nobuo Sakata (2018). "Association of High Psychiatrist Staffing with Prolonged Hospitalization, Follow-Up Visits, and Readmission in Acute Psychiatric Units: A Retrospective Cohort Study Using a Nationwide Claims Database." *Neuropsychiatric Disease and Treatment*. Pages: 893-902. https://www.tandfonline.com/doi/full/10.2147/NDT.S160176.

Staggs, Vincent (2012). "Nurse Staffing, RN Mix, and Assault Rates on Psychiatric Units." *Research in Nursing & Health*. (36)1: 26-37. https://onlinelibrary.wiley.com/doi/abs/10.1002/Nur.21511.

Wang, Limin, Han Lu, Xu Dong, Xiuxiu Huang, Bei Li, Qiaoqin Wan, Shaomei Shang (2020). "The Effect of Nurse Staffing on Patient-Safety Outcomes: A Cross Sectional Survey. *Journal of Nursing Management*. 28(7). https://www.magonlinelibrary.com/doi/full/10.12968/bjon.2017.26.3.172.

Yurtbasi, Miriam K, Glenn Melvin, Christine Pavlou, and Michael Gordon (2021). "Nurse and Patient Factors: Predicting Seclusion in Adolescent Psychiatric Units." *Journal of Child and Adolescent Psychiatric Nursing*. 34(2): 112-19. https://onlinelibrary.wiley.com/doi/abs/10.1111/jcap.12306.

ATTACHMENT 2:

PROPOSED EMERGENCY REGULATION –

ACUTE PSYCHIATRIC HOSPITAL SAFE STAFFING RATIOS AND STANDARDS

Title 22 of California Code of Regulations is amended as follows:

§ 71211. Psychiatric Nursing Service Definition.

Psychiatric nursing service means the performance of those services directed toward meeting the objectives of an individual planned therapeutic program supervised and coordinated by a registered nurse in conjunction with the treatment plan, nursing care and other health professional care.

§ 71213. Psychiatric Nursing Service General Requirements.

(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or

(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

~~(a)~~ (b) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

~~(b)~~ (c) The responsibility and the accountability of the nursing service to the medical staff and hospital administration shall be defined.

~~(c)~~ (d) There shall be a written organized staff education program which shall include orientation and in-service education and training.

(1) There shall be written objectives, plans for implementation and an evaluation mechanism.

~~(d) There shall be a written patient care plan developed for each patient in coordination with the total mental health team. This plan shall include goals, problems/needs and approach and shall be available to all members of the mental health team.~~

(e) There shall be a written nursing audit procedure and evidence that audit procedures are in effect.

~~(f) There shall be a method for determining staffing requirements based on assessment of patient needs. This assessment shall take into consideration at least the following:~~

~~(1) The ability of the patient to care for himself.~~

~~(2) His degree of illness.~~

~~(3) Requirements for special nursing activities.~~

~~(4) Skill level of personnel required in his care.~~

~~(5) Placement of the patient in the nursing unit~~.

~~(g) There shall be documentation of the methodology used in making staffing determinations. Such documentation shall be part of the records of the nursing service and be available for review.~~

~~(h) There shall be a written staffing pattern which shall show:~~

~~(1) Total numbers of staff including full-time and full-time equivalents.~~

~~(2) The available nursing care hours for each nursing unit.~~

~~(3) The categories of staff available for patient care.~~

~~(i) There shall be a record retained for six months of the written staffing pattern available for review by the Department at any given time.~~

§ 71213.1 Planning and Implementing Psychiatric Patient Care.

(a) A psychiatric registered nurse shall directly provide:

(1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.

(2) The planning, supervision, implementation, and evaluation of the psychiatric nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed mental health staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.

(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

(c) The psychiatric nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other psychiatric and mental health disciplines involved in the care of the patient.

(d) Information related to the patient's initial psychiatric nursing assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

~~§ 71215. Psychiatric Nursing Service Staff.~~

~~(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:~~

~~(1) Master's degree in psychiatric nursing or related field with experience in administration; or~~

~~(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or~~

~~(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.~~

~~(b) The director of nurses shall not be designated to serve as charge nurse.~~

~~(c) Sufficient registered nursing personnel shall be provided to:~~

~~(1) Assist the director of nurses for evening and night services and when necessary for day services.~~

~~(2) Give direct nursing care based on patient need.~~

~~(3) Have a registered nurse on duty at all times.~~

~~(4) Plan, supervise and coordinate care given by licensed vocational nurses, psychiatric technicians and other mental health workers.~~

~~(d) Each nursing unit shall have a registered nurse, licensed vocational nurse or psychiatric technician on duty at all times.~~

~~(e) Licensed vocational nurses and psychiatric technicians may be utilized as needed to assist registered nurses in ratios appropriate to patient needs.~~

~~(f) Mental health workers may be utilized as needed to assist with nursing procedures.~~

§ 70215 Psychiatric Nursing Service Staff.

(a) Hospitals shall provide staffing by registered nurses, licensed vocational nurses, and psychiatric technicians within the scope of their licensure in accordance with the following nurse-to-patient ratios. Staffing for care not requiring a registered nurse, licensed vocational nurse or a psychiatric technician is not included within these ratios and shall be determined pursuant to the patient classification system.

No hospital shall assign a licensed nurse or psychiatric technician to a nursing unit or clinical area unless that hospital determines that the licensed nurse or psychiatric technician has demonstrated current competence in providing care in that area and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.

Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to a registered nurse, licensed vocational nurse or psychiatric technician at any one time. "Assigned" means having responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number of patients and the total number of licensed nurses and psychiatric technicians on the unit during any one shift nor

over any period of time. Only licensed nurses and psychiatric technicians providing direct patient care shall be included in the ratios.

Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care. When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other registered nurse, licensed vocational nurse or psychiatric technician is engaged in activities other than direct patient care, that person shall not be included in the ratio. Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Registered Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit.

Nothing in this section shall prohibit a licensed nurse or a psychiatric technician from assisting with specific tasks within the scope of his or her practice for a patient assigned to another nurse. "Assist" means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited.

(1) The registered nurse-to-patient ratio in an adult acute psychiatric unit shall be 1:6 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(2) The registered nurse-to-patient ratio in a pediatric acute psychiatric unit shall be 1:4 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(3) The registered nurse-to-patient ratio in an adolescent acute psychiatric unit shall be 1: 4 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(4) The registered nurse-to-patient ratio in a geriatric acute psychiatric unit shall be 1:6 or fewer at all times. Additional registered nurses, licensed vocational nurses, psychiatric technicians and unlicensed mental health staff shall be assigned to provide additional psychiatric staffing for psychiatric patients determined to be a harm to themselves or others or based upon the patient classification system.

(5) The registered nurse-to-patient ratio in a psychiatric critical care unit shall be 1:2 or fewer at all times. "Critical care unit" means a nursing unit or isolation unit of an acute psychiatric hospital including but not limited to a supplemental service psychiatric intensive care service as described in Section 71403(a)(3).

(6) The registered nurse-to-patient ratio in a post anesthesia recovery unit of the supplemental service anesthesia service, as described in Section 71403(a)(1), shall be 1:2 or fewer at all times, regardless of the type of anesthesia the patient received.

(7) In a psychiatric emergency triage/admission (ETA) unit, only psychiatrists, physicians, registered nurses, licensed clinical social workers, and psychologists shall be assigned to triage patients. Only registered nurses shall be assigned to provide direct psychiatric nursing patient care in the ETA unit. In an acute psychiatric hospital providing psychiatric ETA the registered nurse-to-patient ratio in shall be 1:4 or fewer at all times that patients are receiving treatment or being evaluated for admission to an inpatient unit. There shall be no fewer than two psychiatric registered nurses physically present in the psychiatric emergency unit when a patient is present.

The registered nurse assigned to triage patients shall be immediately available at all times to triage patients when they arrive for ETA. When there are no patients needing ETA, the registered nurse may assist by performing other psychiatric nursing tasks. The psychiatric registered nurse assigned to ETA psychiatric patients shall not be counted in the psychiatric registered nurse-to-patient ratio.

When registered nursing staff are attending psychiatric critical care patients in the ETA, the registered nurse-to-patient ratio shall be 1:2 or fewer psychiatric critical care patients at all times. A patient in the ETA unit shall be considered a critical care patient when the patient meets the criteria for admission to a critical care or isolation service area within the hospital.

(8) The licensed nurse-to-patient ratio in a supplemental service skilled nursing service psychiatric unit, as described in Section 71403 (a)(7) shall be 1:5 or fewer at all times. For purposes of supplemental service psychiatric skilled nursing service units "licensed nurses" includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed 50 percent of the licensed vocational nurses or psychiatric technicians on the skilled nursing service unit. Additional staff will be provided based upon a patient classification system.

(9) The licensed nurse-to-patient ratio in a supplemental service intermediate care unit service, pursuant to Section 71403(a)(4) shall be 1:6 or fewer at all times. For purposes of supplemental service psychiatric skilled nursing service units "licensed nurses" includes psychiatric technicians in addition to licensed vocational nurses and registered nurses. Licensed vocational nurses, psychiatric technicians, or a combination of both, shall not exceed seventy-five percent of the licensed nurse staff on the intermediate care nursing service unit. Additional staff will be provided based upon the patient classification system.

(10) In a supplemental service outpatient clinic pursuant to Section 71403 (a)(5) of an acute psychiatric hospital, a direct care psychiatric registered nurse shall be present and available at all times to provide psychiatric nursing services. Additional staff will be provided based upon a patient classification system.

(11) Identifying a unit by a name or term other than those used in this subsection does not affect the requirement to staff at the ratios identified for the level or type of care described in this subsection.

(b) In addition to the requirements of subsection (a), the hospital shall implement a patient classification system for determining psychiatric nursing care needs of individual psychiatric patients that reflects the assessment, made by a psychiatric registered nurse as specified at subsection 70213.1 (a)(1), of patient requirements and provides for shift-by-shift staffing based on those requirements. The ratios specified in subsection (a) shall constitute the minimum number of psychiatric registered nurses, psychiatric licensed vocational nurses, and psychiatric technicians, who shall be assigned to direct patient care. Additional staff in excess of these prescribed ratios, including non-licensed mental health staff, shall be assigned in accordance

with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the psychiatric illness, the potential for self-harm or harm to staff, equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the psychiatric patient care plan, the ability for self-care, and the licensure of the personnel required for care. The system developed by the hospital shall include, but not be limited to, the following elements:

(1) Individual psychiatric patient care requirements for inpatients and outpatients.

(2) The psychiatric patient care delivery system.

(3) Generally accepted standards of psychiatric nursing practice, as well as elements reflective of the unique nature of the hospital's patient population.

(c) A written staffing plan shall be developed by the administrator of nursing service or a designee, based on patient care needs determined by the psychiatric patient classification system. The staffing plan shall be developed and implemented for each psychiatric patient care unit and shall specify psychiatric patient care requirements and the staffing levels for psychiatric registered nurses and other licensed and unlicensed personnel. In no case shall the staffing level for licensed nurses or psychiatric technicians fall below the requirements of subsection (a). The plan shall include the following:

(1) Staffing requirements as determined by the patient classification system for each unit, documented on a day-to-day, shift-by-shift basis.

(2) The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis.

(3) The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis.

(d) In addition to the documentation required in subsections (c)(1) through (3) above, the hospital shall keep a record of the actual psychiatric registered nurse, psychiatric licensed vocational nurse and psychiatric technician assignments to individual patients by licensure category, documented on a day-to-day, shift-by-shift basis. The hospital shall retain all of the following:

(1) The staffing plan required in subsections (c)(1) through (3) for the time period between licensing surveys, which includes the Consolidated Accreditation and Licensing Survey process.

(2) The record of the actual psychiatric registered nurse, psychiatric licensed vocational nurse and psychiatric technician assignments by licensure category for a minimum of one year.

(e) The reliability of the patient classification system for validating staffing requirements shall be reviewed at least annually by a committee appointed by the nursing administrator to determine whether or not the system accurately measures patient care needs.

(f) At least half of the members of the review committee shall be psychiatric registered nurses who provide direct patient care.

(g) If the review reveals that adjustments are necessary in the psychiatric patient classification system in order to assure accuracy in measuring psychiatric patient care needs, such adjustments must be implemented within thirty (30) days of that determination.

(h) Hospitals shall develop and document a process by which all interested staff may provide input about the psychiatric patient classification system, the system's required revisions, and the overall staffing plan.

(i) The administrator of psychiatric nursing services shall not be designated to serve as a charge nurse or to have direct patient care responsibility, except as described in subsection (a) above.

(j) Psychiatric registered nursing personnel shall:

(1) Assist the administrator of nursing service so that supervision of psychiatric nursing care occurs on a 24-hour basis.

(2) Provide direct patient care.

(3) Provide clinical supervision and coordination of the care given by licensed vocational nurses, psychiatric technicians and unlicensed mental health nursing personnel.

(k) Each patient care unit shall have a psychiatric registered nurse assigned, present and responsible for the patient care in the unit on each shift at all times.

(l) Unlicensed mental health personnel may be utilized as needed to assist with simple psychiatric nursing procedures, subject to the requirements of competency validation. Hospital

policies and procedures shall describe the responsibility of unlicensed mental health personnel and limit their duties to tasks that do not require licensure as a registered nurse, a licensed vocational nurse, or a psychiatric technician.

(m) Psychiatric Nursing personnel from temporary nursing agencies shall not be responsible for a patient care unit without having demonstrated clinical and supervisory competence as defined by the hospital's standards of staff performance for psychiatric registered charge nurses.

(n) Hospitals which utilize temporary nursing agencies shall have and adhere to a written procedure to orient and evaluate personnel from these sources. Such procedures shall require that personnel from temporary nursing agencies be evaluated as often, or more often, than staff employed directly by the hospital.

(o) All registered nurses, licensed vocational nurses and psychiatric technicians utilized in the hospital shall have current licenses. A method to document current licensure shall be established.

(p) The acute psychiatric hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A psychiatric healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate psychiatric medical interventions and care.

§ 71217. Psychiatric Nursing Service Equipment and Supplies.

There shall be adequate and appropriate equipment and supplies related to the scope and nature of the needs anticipated and the services offered.

§ 71219. Psychiatric Nursing Service Space.

Office space shall be provided for the director of nurses.