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Conditions of Nursing Practice in Hospitals and Nursing Homes Before COVID-19: Implications for Policy Action

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**Background:** The COVID-19 pandemic has stimulated interest in potential policy solutions to improve working conditions in hospitals and nursing homes. Policy action in the pandemic recovery period must be informed by pre-pandemic conditions.

**Purpose:** To describe registered nurses’ (RNs’) working conditions, job outcomes, and measures of patient safety and care quality in hospitals and nursing homes just before the pandemic.

**Methods:** Cross-sectional study using descriptive statistics to analyze survey data from RNs in New York and Illinois collected December 2019 through February 2020. A total of 33,462 RNs were included in the final analysis. Before the pandemic, more than 40% of RNs reported high burnout, one in four were dissatisfied with their job, and one in five planned to leave their employer within 1 year. Among nursing home RNs, one in three planned to leave their employer. RNs reported poor working conditions characterized by not having enough staff (56%), administrators who did not listen/respond to RNs’ concerns (42%), frequently missed nursing care (ranging from 8% to 34% depending on the nursing task in question), work that was interrupted or delayed by insufficient staff (88%), and performing non-nursing tasks (82%). Most RNs (68%) rated care quality at their workplace as less than excellent, and 41% gave their hospital an unfavorable patient safety rating.

**Conclusion:** Hospitals and nursing homes were understaffed before the COVID-19 pandemic, and many RNs were dissatisfied with their employers’ contribution to the widespread observed shortage of nursing care during the pandemic. Policy interventions to address understaffing include the implementation of safe nurse staffing standards and passage of the Nurse Licensure Compact to permit RNs to move expeditiously to locales with the greatest needs.

**Keywords:** Nurse staffing, Nurse Licensure Compact, NLC, hospitals, nursing homes, COVID-19 pandemic, care quality, patient safety, nurse staffing standards

The COVID-19 pandemic put an unprecedented strain on hospitals and nursing homes, requiring registered nurses (RNs) to provide care to critically ill patients under extraordinary circumstances. Indeed, recent evidence describes the moral injury and emotional toll the pandemic has taken on frontline RNs (Al Maqbali, et al., 2021; Havaei et al., 2021; Lake et al., 2021; Rushton et al., 2021; Ulrich et al., 2020). Growing concern about job-related burnout among RNs and nursing care shortages have stimulated stakeholder interest in policy actions that may be effective in addressing the pressing healthcare challenges amid the ongoing pandemic. However, future policy interventions must consider the pre-pandemic conditions that set the stage for today’s most pressing healthcare challenges.

In this study, we leveraged a large survey of RNs working in hospitals and nursing homes to describe job-related outcomes, working conditions, and nurse reports of patient safety and quality of care in the pre-pandemic period. Data from RNs were collected in the weeks preceding the first wave of the COVID-19 pandemic, enabling this study to uniquely contribute an evaluation of working conditions and nurse workforce concerns that existed prior to the pandemic. We also evaluate RNs’ healthcare policy views related to policy interventions for ensuring safe, high-quality care for patients.

**Literature Review**
As around-the-clock healthcare providers in hospitals and nursing homes, RNs are well-positioned to evaluate patient safety and quality of care in their organization. A large body of evidence validates nurse reports of safety, quality, and working conditions with patient outcomes of all kinds, including mortality, readmission, and patient satisfaction (Aiken et al., 2012; Aiken, Sloane, et al., 2018; Lasater, McHugh, et al., 2020; Martsolf et al., 2014; Pearson et al., 2006; Sloane et al., 2018). Over decades of research, RNs have consistently identified poor work environments and nurse understaffing as threats to the provision of safe, high-quality patient care. Indeed, empirical evidence from hospitals and nursing homes demonstrates that in settings where RNs (a) care for greater numbers of patients at time,
lack clinical autonomy in practice, (c) have unsupportive leadership that does not respond to RNs’ concerns, and (d) poor collegial relationships with physicians, patients are more likely to experience poor health outcomes and RNs are more likely to report burnout, job dissatisfaction, and intent to leave (Aiken et al., 2011; Kutney-Lee et al., 2013; Lake et al., 2019; McHugh et al., 2011; McHugh & Ma, 2014; Needleman et al., 2002; Needleman et al., 2011; Schlak et al., 2021; White et al., 2019; White et al., 2020).

Evidence from panel studies of changes in hospitals over time suggest that improving nurse working conditions may be an intervention target for improving patient safety, quality of care, and nurse job-related outcomes. For example, a study of 737 hospitals between 2006 and 2016 showed that among the hospitals that improved their work environments and staffing, RNs reported improvements in patient safety and care quality (Sloan et al., 2018). Although improving nurse work environments and patient-to-nurse staffing ratios may be key to improving patient outcomes, the evidence suggests that only one in five U.S. hospitals have meaningfully improved their work environments over a 10-year period, whereas approximately 75% of hospitals got worse (Aiken, Ceron, et al., 2018). Improving hospital work environments over time was not only associated with more favorable care quality and safety for patients, but it was also associated with less burnout and job dissatisfaction among RNs (Aiken, Ceron, et al., 2018).

Most of the evidence characterizing relationships between nurse work environments and patient-to-nurse staffing ratios has been generated in the hospital setting, although significant challenges exist in nursing homes, which were also hard-hit by the pandemic. One study found that RNs working in nursing homes reported higher rates of burnout and more job dissatisfaction as compared with RNs working in hospital settings (McHugh et al., 2011). Another study found nursing home RNs’ reports of burnout and job dissatisfaction were linked with higher amounts of missed nursing care, and the authors concluded that improved work environments and staffing adequacy may attenuate these effects (White et al., 2019). Nursing homes with poor nurse work environments have been linked to higher rates of pressure ulcers and more hospitalizations among residents as well as greater burnout and job dissatisfaction among RNs (White et al., 2020).

The cumulative evidence generated in both hospital and nursing home settings suggests that although interventions to improve hospital work environments and patient-to-nurse staffing ratios may be key to addressing quality, safety, and nurse workforce concerns, progress was slow prior to the pandemic. Under the onslaught of the COVID-19 emergency, nurse working conditions have only further deteriorated. Large-scale policy intervention is warranted to support organizational improvements in both hospital and nursing home settings.

**Methods**

**Study Design and Data**

Data for this cross-sectional study were derived from an emailed survey of all actively licensed RNs in New York and Illinois collected between December 16, 2019, and February 24, 2020 (i.e., RN4CAST-NY/IL). The RN4CAST-NY/IL survey included RNs in New York and Illinois because at the time the survey was conducted, these two states were considering policy legislation to require hospitals and nursing homes to meet minimum safe staffing requirements. The survey asked RNs to report on their working conditions—including staffing, work environments, quality of care, and patient safety—as well as nurse-specific information, including measures of their job-related burnout, job dissatisfaction, intent to leave their employer, and views on healthcare policy actions that could improve quality and safety in healthcare.

The survey took approximately 10 to 15 minutes to complete. Follow-up reminders to complete the survey were sent approximately twice per week for 7 weeks. The overall response rate of the RN4CAST-NY/IL was 18%, reflective of endemic difficulties with survey response rates (National Research Council, 2013) as well as our very large sampling frame consisting of 100% of RNs in two states—some of whom were not actively employed, were retired, or were working in settings other than hospitals and nursing homes. Because the survey included all actively licensed RNs, we have no way of knowing what the response rate was among RNs of interest in this study—i.e., those employed in hospitals and nursing homes. Nevertheless, this approach of surveying RNs via state licensure lists and using RNs as informants of workplace conditions has been demonstrated to yield unbiased estimates of RN working conditions (Lasater et al., 2019).

**Sample**

RN4CAST-NY/IL. The RN4CAST-NY/IL survey included RNs in any position of employment (e.g., direct care staff nurse, nurse manager) were included.

**Variables**

Our study describes pre-COVID nurse reports of job outcomes, quality of patient care, patient safety, working conditions, healthcare policy views, and demographic characteristics of RNs in hospitals and nursing homes. Nurse demographics included age, sex, race/ethnicity, years of experience as an RN, and educational preparation. Nurse job outcomes included measures of job dissatisfaction, burnout, and intent to leave their employer. Job dissatisfaction was measured using RNs’ response to the following question on a 4-point Likert scale, “Overall, how satisfied are you with your job?” RNs who responded either “somewhat dissatisfied” or “very dissatisfied” were defined as being dissatisfied with their job. Burnout was defined using the Emotional Exhaustion subscale of the Maslach Burnout Inventory (Maslach et al., 1997), with “high burnout” defined as a score of 27 or greater (Firth et al., 1989). Intent to leave was a dichotomous variable based on the
Nurse reports of organizational quality and work environments were described in Table 2. Less than one-third (31.8%) of RNs gave significant policy views of these RNs, as well as statistical differences between hospital and nursing home RNs, are reported in Table 1. A large proportion of RNs in both hospitals and nursing homes reported being burned out (41.2% and 44.3%, respectively, p < 0.001) and dissatisfied with their jobs (24.6% and 28.0%, respectively, p < 0.001). Roughly one in five (20.7%) hospital RNs and one in three (30.0%) nursing home RNs (p < 0.001) intended to leave their employer within 1 year.

Most RNs (74.0%) reported being in favor of policies that would allow RNs to practice across state lines without obtaining additional licenses, with favorable views significantly higher among nursing home RNs (76.3%) than hospital RNs (73.7%). The vast majority (more than 90%) of RNs rated improving patient-to-nurse staffing, reducing burnout among RNs, and improving the working conditions of RNs to be of very high importance for ensuring high quality and safe patient care. Hospital RNs were more likely than nursing home RNs to rate staffing as having very high importance (95.1% vs 92.1%, p < 0.001), but nearly all RNs in both settings rated staffing as highly important to quality and safety.

Nurse reports of organizational quality and work environments are described in Table 2. Less than one-third (31.8%) of RNs gave their organization an excellent rating on quality of care, with significantly worse quality ratings among nursing home RNs (18.0% gave an excellent rating) as compared to hospital RNs (33.6%, p < 0.001).
Only 36.2% of hospital RNs would “definitely recommend” their organization to a family member or friend needing care, compared to as few as 29.4% of RNs in nursing homes (p < 0.001). Among hospital RNs, 12.3% were very confident that their organization would solve problems in clinical care identified by RNs, and 8.8% were very confident that patients and their caregivers could manage care after discharge.

With respect to RNs’ evaluations of their work environments, 15.0% of hospital RNs and only 12.6% of nursing home RNs rated their environment as excellent (p < 0.001). Most RNs did not agree that there were enough staff to get the work done (55.8%). Additionally, 41.8% of RNs disagreed that administration listens and responds to RNs’ concerns about patient care, 30.6% disagreed that there was a clear philosophy of nursing that pervaded the patient care environment, 29.0% disagreed that their nurse manager is a good manager and leader, and 19.0% disagreed that there was a lot of teamwork between RNs and physicians.

Hospital RNs’ reports of patient safety are described in Table 3. Nearly 41% of RNs gave their hospital an unfavorable patient safety grade (C, D, or F), and 31.4% gave an unfavorable grade on infection prevention. Culture of patient safety ratings were poor, with high percentages of RNs reporting that mistakes are held against them (46.5%), that things “fall between the cracks” when transferring patients from one unit or care setting to another (40.5%), and that important patient care information is often lost during shift changes or when another provider is covering their patients (35.4%). More than one-third (36.0%) of RNs disagreed that staff felt free to question the decisions or actions of those in authority, 26.1% of RNs disagreed that the actions of management show that patient safety is a top priority, 23.7% disagreed that they were given feedback about changes put into place based on event reports, and 11.5% disagreed that they discussed ways to prevent errors from happening again.

Most hospital RNs reported that operational failures were common in their hospital, including having work that was interrupted or...
delayed by insufficient staff (88.3%), performing non-nursing tasks such as transportation or housekeeping (81.5%), missing supplies or broken equipment (79.6%), missing medications (66.1%), missing, incomplete, or incorrect physician/provider orders (65.4%), electronic documentation system challenges (54.3%), and missing, late, or wrong diet (51.7%). Hospital RNs reported that on their most recent shift, they did not deliver necessary nursing care to patients because of a lack of time. Missed nursing care included comforting/talking with patients (33.6%), teaching/counseling patients and family (27.4%), adequately surveilling patients (21.0%), administering medications on time (18.5%), and administering treatments and procedures on time (15.3%).

**Discussion**

Before the COVID-19 pandemic, RNs’ working conditions in hospitals and nursing homes were poor. High percentages of RNs in hospitals and nursing homes reported being burned out, dissatisfied with their jobs, and intending to leave their employer within a year. RNs rated patient safety and quality of care in these settings unfavorably. Since the RN4CAST-NY/IL survey was conducted, other research has described the physical and emotional impact of the pandemic on RNs (Al Maqbali et al., 2021; Fernandez et al., 2020; Lake et al., 2021) and detailed the workforce challenges amid the pandemic (Denny-Brown et al., 2020; Behrens & Naylor, 2020). Understanding the pre-pandemic conditions in hospitals and nursing homes, as described in the present study, provides context for the pandemic’s impact on nurse working conditions, job-related outcomes, patient safety, and

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**TABLE 2**

| Nurse-Reported Organizational Quality and Work Environment Ratings |
|---------------------------------------------------------------|
| **Variable**                                                   | All Registered Nurses (N = 33,462) | Hospital Nurses (n = 29,859) | Nursing Home Nurses (n = 3,603) | p     |
|----------------------------------------------------------------|----------------------------------|------------------------------|-------------------------------|-------|
| **Organizational Quality**                                     |                                  |                              |                               |       |
| Excellent rating of quality of care                            | 8,966 (31.8)                     | 8,359 (33.6)                 | 607 (18.0)                    | <0.001|
| Definitely would recommend facility to friends/family          | 9,988 (35.4)                     | 8,998 (36.2)                 | 990 (29.4)                    | <0.001|
| Very confident in management to solve problems                 | 3,063 (12.3)                     |                              |                               |       |
| Very confident that patients and their caregivers can manage  | 2,121 (8.8)                      |                              |                               |       |
| their care after discharge                                     |                                  |                              |                               |       |
| **Nurse Work Environment (single measure)**                   |                                  |                              |                               | <0.001|
| Excellent                                                      | 4,710 (14.7)                     | 4,261 (15.0)                 | 449 (12.6)                    |       |
| Good                                                           | 13,264 (41.4)                    | 11,933 (42.0)                | 1,331 (37.4)                  |       |
| Fair                                                           | 10,169 (31.8)                    | 8,952 (31.5)                 | 1,217 (34.2)                  |       |
| Poor                                                           | 3,863 (12.1)                     | 3,302 (11.6)                 | 561 (15.8)                    |       |
| **Nurse Work Environment (five subcomponents)**                |                                  |                              |                               |       |
| Enough staff to get the work done                              |                                  |                              |                               | <0.001|
| Strongly disagree/somewhat disagree                            | 16,185 (55.8)                    | 13,943 (54.4)                | 2,242 (66.5)                  |       |
| Strongly agree/somewhat agree                                  | 12,821 (44.2)                    | 11,691 (45.6)                | 1,130 (33.5)                  |       |
| Administration listens and responds to employee concerns       |                                  |                              |                               | <0.001|
| Strongly disagree/somewhat disagree                            | 12,251 (41.8)                    | 10,985 (42.4)                | 1,266 (37.2)                  |       |
| Strongly agree/somewhat agree                                  | 17,048 (58.2)                    | 14,910 (57.6)                | 2,138 (62.8)                  |       |
| A clear philosophy of nursing that pervades the patient care  |                                  |                              |                               | 0.002 |
| environment                                                    |                                  |                              |                               |       |
| Strongly disagree/somewhat disagree                            | 8,883 (30.6)                     | 7,775 (30.3)                 | 1,108 (32.9)                  |       |
| Strongly agree/somewhat agree                                  | 20,134 (69.4)                    | 17,877 (69.7)                | 2,257 (67.1)                  |       |
| A nurse manager who is a good manager and leader               |                                  |                              |                               | <0.001|
| Strongly disagree/somewhat disagree                            | 8,400 (29.0)                     | 7,567 (29.6)                 | 833 (24.8)                    |       |
| Strongly agree/somewhat agree                                  | 20,564 (71.0)                    | 18,037 (70.5)                | 2,527 (75.2)                  |       |
| A lot of teamwork between nurses and physicians                |                                  |                              |                               | 0.002 |
| Strongly disagree/somewhat disagree                            | 5,536 (19.0)                     | 4,828 (18.8)                 | 708 (21.0)                    |       |
| Strongly agree/somewhat agree                                  | 23,573 (81.0)                    | 20,915 (81.3)                | 2,658 (79.0)                  |       |

Note. Due to missing data, the number of all registered nurses ranged from 28,964 to 29,299. For hospital nurses, the range was 25,604 to 25,895. For nursing home and long-term care nurses, the range was 3,360 to 3,404.

a Included neutral responses of neither agree nor disagree.
### TABLE 3

**Hospital Nurses’ Reports of Patient Safety and Organizational Support**

| Variable                                      | n (%)       |
|-----------------------------------------------|-------------|
| **Overall Safety**                           |             |
| Overall grade on patient safety              |             |
| Favorable (A or B)                           | 14,529 (59.1) |
| Unfavorable (C, D, or F)                     | 10,056 (40.9) |
| Overall grade on the prevention of infections|             |
| Favorable (A or B)                           | 17,016 (68.6) |
| Unfavorable (C, D, or F)                     | 7,799 (31.4)  |

**Patient Safety Culture**

Nurses agree that:
- Mistakes are held against them: 11,525 (46.5)
- Things “fall between the cracks” when transferring patients from one unit or care setting to another: 9,968 (40.5)
- Important patient care information is often lost during shift changes or when another provider is covering my patients: 8,723 (35.4)

Nurses disagree that:
- Staff are free to question the decisions or actions of those in authority: 8,874 (36.0)
- Actions of management show that patient safety is a top priority: 6,407 (26.1)
- They are given feedback about changes put into place based on event reports: 5,829 (23.7)
- They discuss ways to prevent errors from happening again: 2,828 (11.5)

**Operational Failures**

Work is interrupted or delayed by:
- Insufficient staff: 17,860 (88.3)
- Performing non-nursing tasks (e.g., transportation, housekeeping): 16,358 (81.5)
- Missing supplies or broken equipment: 16,145 (79.6)
- Missing medications: 13,115 (66.1)
- Missing, incomplete, or incorrect physician/provider orders: 13,137 (65.4)
- Electronic documentation system problems or errors: 10,787 (54.3)
- Missing, late, or wrong diet: 8,969 (51.7)

**Missed Nursing Care**

Nursing tasks that were necessary but left undone:
- Comfort/talk with patients: 10,024 (33.6)
- Teach/counsel patients and family: 8,177 (27.4)
- Adequately document nursing care: 6,873 (23.0)
- Address ambulation or range of motion: 6,860 (23.0)
- Participate in team discussions of patient’s care: 6,526 (21.9)
- Adequate patient surveillance: 6,272 (21.0)
- Address oral hygiene: 5,996 (20.1)
- Develop or update patient plan of care: 5,967 (20.0)
- Administer medications on time: 5,518 (18.5)
- Prepare patient and families for discharge: 4,645 (15.6)
- Administer treatments and procedures on time: 4,577 (15.3)
- Provide skin care: 4,484 (15.0)
- Coordinate patient care: 3,749 (12.6)
- Pain management: 2,472 (8.3)

*Note.* Percentages may not total 100% because of rounding.

*Derived from the Agency for Healthcare Research and Quality’s Hospital Survey on Patient Safety Culture.*

*Nursing tasks were necessary but left undone during their most recent shift due to a lack of time.*
care quality and informs the large scale of policy action that will be required to address these long-standing problems in healthcare.

Policy actions that were relevant in the pre-pandemic period continue to be relevant today but carry greater urgency. For example, an existing pre-pandemic policy intervention may have alleviated the need for emergency state policy action during the COVID-19 public health crisis. During the first surges of COVID-19, governors in some states (e.g., New York) used their temporary emergency powers to waive licensure requirements for RNs coming from other states to help with the COVID surge (National Council of State Boards of Nursing, 2020b, 2022). Such emergency powers would not have been necessary had those states been part of the Nurse Licensure Compact (NLC)—a state-level policy that enables RNs licensed in any NLC state to practice in other NLC states via a multistate license. At the time of this publication, 36 U.S. states have already implemented the NLC, and two states and one territory have enacted legislation but are awaiting implementation (National Council of State Boards of Nursing, 2022). However, large states that bore the brunt of the pandemic early on still have not passed the NLC—including New York and California. Additionally, during the pandemic, state boards of nursing experienced substantially delayed processing of applications for licensure, pointing to another vulnerability of our healthcare system in a time of a healthcare or other national emergency. Further adoption of the NLC could facilitate greater mobility of the much-needed nursing workforce across the United States to meet the demand for nursing care (National Council of State Boards of Nursing, 2020b). Such a policy has wide support among RNs and the general public.

Our study found that the majority of RNs in hospitals (73.4%) and nursing homes (76.3%) have favorable views of policies such as the NLC that would permit RNs to practice in other states without having to seek state-by-state licenses. A national Harris Poll found that the majority (72%) of the public is also supportive of such legislation (NursesEverywhere, 2020).

Another problem that pre-dated the pandemic is that most RNs report not having enough staff to provide safe care. Understaffing of RNs is a threat to patient safety because high patient-to-nurse staffing ratios are associated with more missed nursing care in hospitals (Ball et al., 2018) and nursing homes (White et al., 2019) and worse outcomes for both patients and RNs (Aiken et al., 2002; Aiken et al., 2011; Aiken, Cetón, et al., 2018; Brooks Carthon et al., 2012; Brooks Carthon et al., 2021; Lasater, Aiken, et al., 2020; Lasater, Sloane, et al., 2020; Lasater, Aiken, Sloane, French, Anusiewicz, et al., 2021; Lasater, Aiken, Sloane, French, Martin, et al., 2021; McHugh et al., 2016; McHugh et al., 2021). Safe nurse staffing legislation is an evidence-based policy intervention that could be adopted at either the state or federal level to ensure there are enough RNs in hospitals and nursing homes to safely care for patients.

In the United States, California is the first (and so far only) state to implement minimum safe hospital nurse staffing requirements (Aiken et al., 2010). Under California’s policy, patients in the state receive on average 3 hours per day more nursing care than patients hospitalized in other states (Dierkes et al., 2021). Other studies of the California example demonstrate the staffing legislation has been associated with better nurse job outcomes (e.g., less burnout and job dissatisfaction) and better patient outcomes (e.g., lower mortality) (Aiken et al., 2010). The greatest improvements in nurse staffing were observed among safety-net hospitals (McHugh et al., 2012), which suggests that nurse staffing policies may not only enhance outcomes for patients but may make the distribution of nursing care more equitable for all patients. California has achieved safe staffing minimums despite having fewer RNs per capita (11.3 per 1,000 population) than most other U.S. states (United States Census Bureau, 2021), suggesting the limiting factor to achieving safe staffing has little to do with the supply of RNs. In fact, data from the National Council of State Boards of Nursing indicate that the United States has never had as many new entrants to nursing as it did in 2021 (National Council of State Boards of Nursing, 2020a).

Nursing studies in New York and Illinois, as well as a policy evaluation of staffing legislation in Queensland, Australia, provide empirical evidence that staffing minimums not only save lives but generate cost savings to hospitals through shortened lengths of stay and avoided readmissions (Lasater, Aiken, Sloane, French, Anusiewicz, et al., 2021; Lasater Aiken, Sloane, French, Martin, et al., 2021; McHugh et al., 2021). In the present study, we found that most RNs in hospitals (95.1%) and nursing homes (92.1%) support improving patient-to-nurse staffing as an intervention to ensure safe and high-quality care to patients. This finding is in line with a Harris poll of the public, in which more than 90% of respondents agreed that hospitals and nursing homes should be required to meet safe minimum staffing standards for RNs (NursesEverywhere, 2020).

Limitations

Our study included RNs from two large states—New York and Illinois—and caution is warranted in generalizing our findings to the nation as a whole. Our RN survey has important strengths, including that it provides detailed information from a very large sample of more than 33,000 RNs on their healthcare policy views, job-related outcomes, and organizational quality. Data were collected just before the COVID-19 pandemic and included one of the hardest-hit regions of the country during the first wave—New York City. Our data also include measures from both hospital and nursing home RNs, whereas most of the research to date has focused on hospitals (Fernandez et al., 2020). Although we present data regarding the percentage of RNs who hold favorable views of the NLC, we did not directly evaluate the impact of NLC implementation on workforce mobility, nurse job outcomes, or patient outcomes.

Conclusion

The COVID-19 pandemic has brought to light longstanding threats to healthcare quality and safety in the United States. Our findings show that RNs in hospitals and nursing homes reported poor working conditions, high burnout, and poor patient safety and care quality before...
the COVID-19 pandemic. These findings are a sobering reminder of what returning to the pre-pandemic “normal” would mean, and now we know the serious vulnerabilities of our healthcare system during a national emergency if those vulnerabilities are not addressed. State and federal policy action informed by rigorously generated evidence is needed to rebuild the nurse workforce in U.S. hospitals and nursing homes in the aftermath of the COVID-19 pandemic.

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Funding for this work was provided by the National Council of State Boards of Nursing (NCSBN) (Lasater, PI).