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Nursing Demotion in Italy: Causes and Discussion on The Negative Impacts It Has on Nurses and Nursing Work

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ABSTRACT

Nursing demotion is a phenomenon, often underestimated, which is observed very frequently in Italy and which has not yet been sufficiently studied. In this paper, the authors analyzed the phenomenon of nursing demotion "by tacit consent" from a legislative point of view and with respect to the negative impact it determines on Nurses and on Nursing work. The results of this analysis made it possible to establish that nursing demotion "by tacit consent", as well as being illegal, also negatively affects the quality of care.

Keywords: nursing demotion, Italy, ius variandi, quality of care.

ACRONYMS USED IN THIS WORK:

ASL = Local Health Company
DLgs = Legislative Decree.
DM = Ministerial Decree.
DPR = Decree of the President of the Republic.
DPCM = Decree of the President of the Council of Ministers (or Prime Minister).
ISTAT = National Institute of Statistics.
LEA = Essential levels of Assistance.
OMS = World Health Organization, WHO.
OSS = Care Worker or Social Health Operator.
OTA = Technical Operator Assigned to Assistance
SSN = National Health Service.
SSR = Regional Health Service.

1.0 – INTRODUCTION

Italy is one of the founding countries of the current European Union, famous throughout the world for having enshrined some important fundamental principles on which health care is based. We are talking about the

National Health Service (SSN), established by Law 833/1978 which guarantees, with universality, equality and equity, access to health services in implementation of art. 32 of the Italian Constitution, which states: "The Republic protects health as a fundamental right of the individual and the interest of the community, and guarantees free medical care to the indigent. Nobody can be obliged to a specific health treatment except by law. The law cannot in any case violate the limits imposed by respect for the human person". According to WHO research carried out in 2000, Italy had the second-best health system in the world in terms of spending and access to public care for citizens (Italy was second only to France) [1]. In 2014, a ranking drawn up by Bloomberg, Italy was third in the world for efficiency and spending [2]. Thanks to Law 833/1978, the "health" was in fact understood not only as an individual good but above all as a community resource: the SSN applies this principle by promoting, maintaining and recovering the psycho-physical health of the entire population by organizing health services on the national territory in a capillary way to ensure compliance with the so-called "essential levels of assistance" (LEA). The Italian Constitution protects the health of citizens by providing legislative powers both at national and regional level: LEAs are identified at the state level, while the Regions plan and manage health care in full autonomy within the territorial area of their competence [3]. To achieve these objectives, Law 833/1978 has identified some organizational principles on which the internal SSN is based. The first organizational principle on which the NHS is organized concerns the centrality of the assisted person, and in particular "the duty of health planning to put the protection of citizens' health (which is the main reason for the establishment of the SSN) before all choices, compatibly with economic resources" [3]. Another important principle concerns the enhancement of the professionalism of health workers: "The professionalism of doctors and Nurses, not only in a technical sense, but also as the ability to interact with patients and relate to colleagues in teamwork, is crucial for the quality and appropriateness of performance" [3]. These principles can be respected only if health services are organized by providing adequate human (as well as economic) resources to guarantee the essential levels of assistance (LEA), i.e., all the services and health services that the SSN is required to provide free of charge or through payment of a participation fee (ticket) to citizens. To verify the disbursement of the LEA, the "LEA Committee" was created, which "...has the task of verifying the disbursement of the LEA in conditions of appropriateness and efficiency in the use of resources, as well as the congruity between the services to be provided and the resources made available by the SSN" [3]. The enhancement of the professionalism of healthcare professionals is, therefore, one of the most important principles on which the entire SSN is based [3], and it is clear that if for various reasons this principle cannot be applied (or is applied discontinuously), health planning will disappear. Currently, one of the major problems encountered in the health sector is the chronic shortage of nursing staff which is added to the chronic shortage of support staff (care worker; in Italian "OSS" or Social Healthcare Operator): a situation that really makes it is very difficult to properly plan regional health activities and, above all, to guarantee LEAs. Unfortunately, this situation has progressively worsened over the last 28 years, becoming the main cause of nursing demotion "by tacit consent", ie that form of demotion that is implemented without the employer having informed the nursing staff in writing. In this work, a broad discussion will be carried out on nursing demotion "by tacit consent" to try to understand the phenomenon both statistically and in terms of legislation to identify the causes and consequences that this phenomenon has on nursing staff and nursing care. Some solutions will also be proposed.

1.2 – THE NURSING PROFESSION

The Nursing Profession was officially born in Italy in 1994 thanks to the Ministerial Decree (DM) n. 739 which will allow it to be included within the health professions. Through Ministerial Decree 739/1994, Italian Nurses abandon their old status of simple executors (auxiliary profession) and become intellectual professionals (art. 2229 and art. 2230 of the Civil Code). The field of activity of the Nurse (Article 1, paragraph 2, Law 42/99) is determined by Ministerial Decree 739/1994, the Code of Ethics and the didactic regulations of basic and post-basic training [4]. In order to carry out his profession, the Nurse also has the obligation to be registered with the National Federation of Nursing Professions Orders (FNOPI) and to obtain training credits annually as part of the mandatory professional updating. Thanks to Ministerial Decree 739/1994, the Nurse becomes a health professional who acquires the burden of legal responsibility for his work: liability that can be of a

penal, civil and disciplinary nature. The Nurse's specific technical areas of expertise concern preventive, curative, palliative and rehabilitative nursing care. The main functions of the Nurse are: disease prevention, assistance to the sick and disabled of all ages and health education. Ministerial Decree 739/1994 highlights the importance of the relational aspect of the Nursing Profession compared to the past: understood not only as part of an educational function aimed at health education, but also as training in the workplace. The Nurse participates in identifying the health needs of the person and the community, recognizes the fundamental role of teamwork within which the Nursing Profession plays a fundamental role, being the Nurse the professional who first interfaces with the patient/user when he/she goes to any healthcare facility. The Nurse's exclusive ability to identify nursing care needs is also recognized, from which the team will be able to formulate nursing diagnoses and identify the objectives to be achieved. The entire problem-solving process is continuously evaluated by the nursing team to understand if the results obtained are in line with those expected [4]. In paragraph 3 of Ministerial Decree 739/1994 it is specified that the Nurse: "*for the performance of his duties, he makes use, where necessary, of support staff*". It is therefore clear that Ministerial Decree 739/1994 gives full decision-making autonomy to the Nurse whether or not the presence of support staff is necessary to achieve the care objectives. In confirmation of this, the Nurse's Code of Ethics emphasizes the importance of evaluating the nursing work context for the protection of the assisted person: Art. 31 states that the Nurse evaluates the organizational, managerial and logistical context in which the assisted person to be protected is located [5]. From this it follows that the employer must make support staff available to the Nurse based on the care needs identified by the nursing team and not by other professionals. What has just been stated represents a legislative constraint (and therefore contractual) to which the employer must follow up.

1.3 – THE DEMOTION IN ITALY (2008-2009)

The term "demotion" refers to the assignment of the worker to tasks included in a lower level of employment than that agreed in the individual employment contract or to that corresponding to the tasks most recently performed. The employer, within the scope of his managerial powers, may assign the worker to lower duties only in the cases strictly provided for by law, or by art. 2103 of the Civil Code, in the formulation recently amended by art. 3 of the Legislative Decree (DLgs) n. 81/2015 (so-called Jobs Act) and in the other cases provided for by special legislation. Art. 2103 of the Civil Code expressly legitimizes the demotion of the worker in three cases [6]:

1 in the event that the change in corporate organizational structures affects the position of the worker (art. 2103, paragraph n. 2 of the Civil Code);

2 in the case of provision by the collective agreement applied to the employment relationship (art. 2103, paragraph 4 of the Civil Code);

in the case of provision by an individual agreement to change the duties stipulated in the so-called protected locations, which responds to the interest of the worker: to maintain employment, to acquire a different professionalism or to improve one's living conditions (art. 2103, paragraph 6 of the Civil Code).

ISTAT (National Institute of Statistics) disseminates for the first time the data on the distress of individuals in working relationships. The data considered are those of 2008-2009, certainly not recent, but still interesting: this is the first national study carried out by ISTAT on the problem of demotion. The data show that of the 29,128,000 workers, 9% (2,633,000 workers) say they have suffered, in the course of their life, from harassment or demotion or deprivation of duties

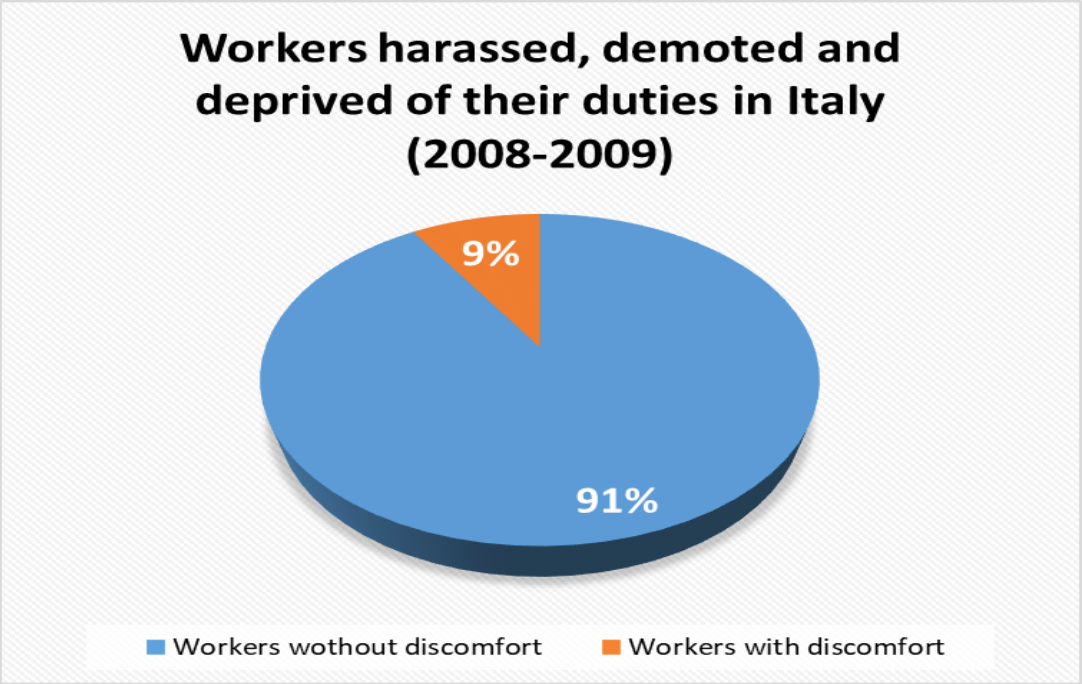

Fig. 1 – Workers harassed, demoted and deprived of their duties between 2008 and 2009 in Italy. Credits: ISTAT.

(**Fig. 1**). 6.7% experienced this situation at least in the last 3 years and 4.3% in the last 12 months considered. Women underwent such treatments with 9.9% during their working life. A greater number of workers (7,948,000), on the other hand, experienced situations of hardship, characterized by continuous frequency and duration. Among these, at least 198,000 workers can be defined as high-risk, since they have been subjected to oppressive behavior several times a month, but for a duration of less than 6 months [7]. In the specific problem of demotion, the data is interesting. There are structural differences among the victims of demotion. The demotion actions affect women more than men (8.2% against 6.4%). The differences between genders are smaller for the victims who have suffered them in the last 3 years, until they disappear for those who have suffered them in the last 12 months. Women victims of demotion are, in general, younger than males (85% are under the age of 55, compared to 79% of males). Among graduates and high school graduates, the percentage is higher than those with a lower educational qualification: more than 4% against, respectively, 2.6% and 1.4%). This means that the higher the education, the greater the demotion in our country [6]. The demotion occurred mostly in Southern Italy (3.9%, against the national 3.3%; **Fig. 2**) and in particular Campania reaches 10.9% and in Puglia 4.5%. In the center, Lazio has the highest share of workers who declared they had suffered demotion (4%). In general, higher rates of demotion (5.3%, against 3.3% of the national average) are found in metropolitan areas. The ISTAT study also tells us that in that period (last 3 years), the situations of demotion involved in 5.8% of cases (85,000 workers), with the deprivation of assigned tasks. The distribution of demotion regarded professional activities (6.8% against 4.5% nationally). Victims mainly operate in the private sector [7].

1.4 – Consequences of demotion on the worker

The consequences of demotion in the workplace are: individual economic loss (27%), more than 40% of victims no longer invest in their work, are unmotivated and want to leave.
From the point of view of health and relationships, despite the fact that 52.9% of victims did not report consequences in terms of psychophysical well-being, a complex symptomatic picture emerges

that goes from more widespread reactions such as anger (21.4%) and anxiety (14.4%) to very serious forms such as depression (8.0%),

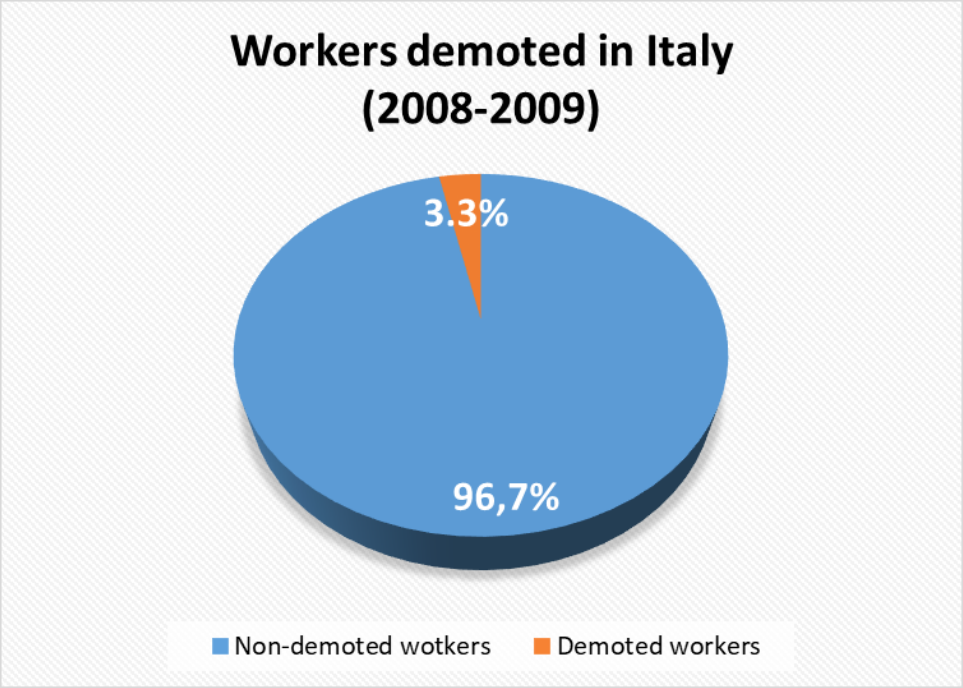

Fig. 2 – Workers demoted in Italy between 2008-2009.
Credits: ISTAT.

physical ailments such as gastritis (8.0%), headache (6.5%), precordial pain (4, 8%) and disorders inherent in the ability to manage daily life peacefully (insomnia, apathy, dizziness). Furthermore, the consequences do not spare the sphere of relationships either, which represents one of the areas targeted in the victim's working life. Due to constant harassment and demotion, the individual is intractable in family and friends and has frequent quarrels due to his nervousness (11.3%) [7]. The damages suffered on mental and physical health, as well as those affecting relationships, are reported more by female victims, while the consequences with respect to the way of working are felt above all by males. The differences between the two genders cancel out, however, for economic damage [7]. To complete the picture of the consequences, the victims were asked what the outcome of the continuous harassment and the situations of demotion and deprivation of tasks had been. Only in a quarter of the cases the episodes ended without special interventions. In 16.1% of cases the victim resigned (21.5% for the demoted or deprived of their duties), in 5.2% was fired (7.2% for the demoted) and 2.2% of the victims the contract was not renewed. In about 8% of cases there was a transfer or a request for transfer to another office; finally, in 6.8% of cases the perpetrators no longer work with the victims. It is mainly women who resign (22.4% against 10.9% of male colleagues). The share of those fired, on the other hand, is the same between the two sexes. For 31.1% of males, the episodes of victimization ended without particular reasons, an event reported by 17.2 of females. [7]

2.0 – NURSING DEMOTION

To understand what is meant by the term "nursing demotion" it is necessary to remember what the term "job" means. The term "job" refers to a task, an assignment carried out in the performance of a job. The demotion, therefore, consists in assigning to the worker tasks lower than those for which he

was hired or even the subtraction of previously performed tasks. Therefore, by "nursing demotion" we mean the deprivation of the Nurse from the contractually agreed tasks, assigning him to lower tasks, or subtracting (totally or partially) qualitatively (and sometimes even quantitatively) relevant tasks. Until a few years ago, nursing staff could refer to art. 2103 of the Civil Code which governed the exercise of the so-called *jus variandi*, i.e. the power that the employer had to vary the duties with respect to those assigned during the hiring phase. The rule provided that the Nurse was to be assigned to the duties for which he had been hired or to those corresponding to the higher category he had acquired, or to duties equivalent to the last ones actually performed, without any reduction in pay and voiding any contrary agreement with the exception of cases in which the Nurse became incapacitated due to injury or illness (Law n. 68/1999; DLgs no. 151/2001) [8].

Therefore, the *jus variandi* was configured both horizontally with the attribution of equivalent tasks, and vertically with the conferment of tasks of a higher nature. Art. 2103 of the Civil Code stated: "*The employee must be assigned to the duties for which he was hired or to those corresponding to the higher category he subsequently acquired or to duties equivalent to the last ones actually performed, without any reduction in salary...*". More recently, the DLgs n. 81/2015 amended art. 2103 of the Civil Code by reviewing downwards the duties attributable to the Nurse (**Fig. 3**): "*the worker must be assigned to the duties for which he was hired or to those corresponding to the higher position he has subsequently acquired or to duties attributable to the same level and legal category of classification of the last actually carried out. In the event of a change in the corporate organizational structure that affects the position of the worker, the same can be assigned to tasks belonging to the lower level of classification as long as they fall within the same legal category*". In this case, a real change in pejus of art. 2103 of the Civil Code, which is even configured as an overcoming of the *jus variandi* as, through the DLgs 81/2015, lower tasks are provided for. In the current state of the rules, also given the recent ruling of the Court of Brindisi (1307/2017), it can be said that the employer can assign the Nurse to lesser duties only if three conditions coexist:

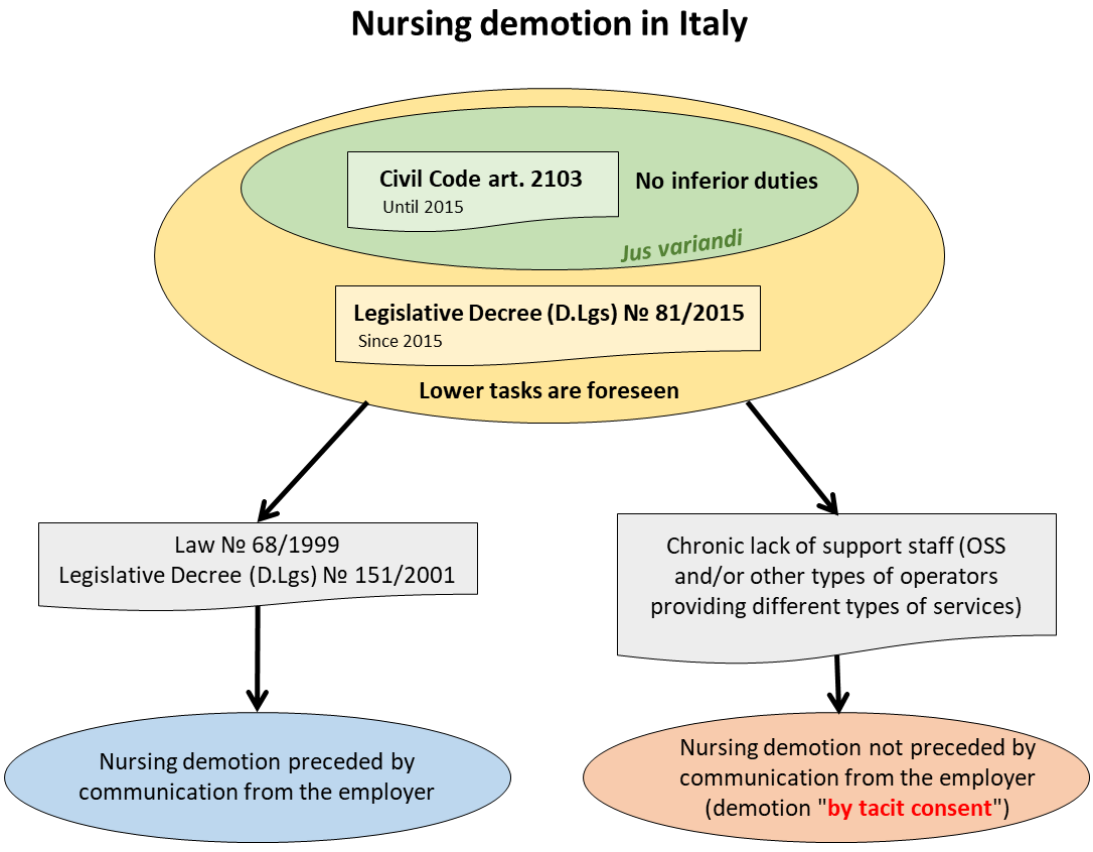

Fig. 3 – Nursing demotion in Italy.
Credits: Gabriele Cataldi.

1) that the corporate organizational structures have undergone a change affecting the position of the Nurse;
2) that it is a short-term and occasional commitment;
3) that this commitment allows, however, the performance of the Nurse's duties in a prevalent manner;

It being understood that the Nurse is notified by the employer in writing. These reasons allow the employer to assign lower tasks to the nursing staff in the event that the corporate organizational structures are changed, but provided that this provision is occasional, of short duration and that allows the Nurse to perform his duties in prevalent way [9]. In addition, the Court of Cassation, with ordinance n. 16594 of 3 August 2020 stated that the employee's tolerance to demotion does not constitute acquiescence to the demotion itself. In other words, the employer must always communicate to their employee the assignment of less qualifying tasks than their level of employment (demotion) [9]: this means that otherwise the employee cannot be demoted. Except for the cases provided for by the legislation (Law n.68/1999; DLgs no.151/2001), nursing demotion is, in the vast majority of cases, an illegal phenomenon because it exists with the tacit consent of the Nurse: in fact, the employer, is always required to inform the employee in writing about the provision (DLgs 81/2015); if this is not the case, the provision is void. Yet, nursing demotion “by tacit consent” is a phenomenon that has persisted for 28 years without finding an effective form of contrast. How come?
According to the authors, the main cause can be traced to the working conditions in which the Nursing Staff operates: these conditions are affected by the chronic absence of support staff (OSS) and staff dedicated to other activities, such as cleaning the environments, the transport of material, the transport of patients, etc., and that this situation cannot be solved quickly. Furthermore, in healthcare environments it is now a consolidated idea that the Nurse should be responsible for all those activities that are not carried out by support staff, auxiliaries, walkers, etc. Obviously, this is an all-Italian anomaly; in fact, no law has ever established that nursing staff must replace support staff or staff dedicated to other types of hospital services if these are absent or if they are not provided for in the hospital staffing plan. Yet, this situation has persisted in Italy at least since 1994, that is, since the Nursing Profession was officially born. In fact, through the DM 739/1994 we passed from technical nursing to intellectual nursing and no legislation has ever established that the duties of the Generic Nurse (DPR N. 225/1974) should be taken over by the Professional Nurse. For this reason, even if delayed, through the State-Regions Agreement of 22 February 2001, the figure of the Social Health Operator (OSS) was created to whom the hygienic-domestic activities that the Generic Nurse had been assigned to.
To this is added another factor which partially contributes to supporting nursing demotion “by tacit consent”; we are talking about the lack of and often approximate knowledge that one has (also in the healthcare environment; among the various types of health professions) regarding the Nursing Profession: a symptom of an underlying cultural immaturity that afflicts our society and which still sees, 28 years after the issue of DM 739/1994, the Italian Nurses as factotums, mere executors, “serie B” professionals compared to other professionals: as if the current "Nursing" was still the one defined by the DPR 225/1974. Unfortunately, this “way of thinking” is not only an integral part of an unconscious society which is often the victim of disinformation; it is also a way of thinking (let's call it this way) that has invaded many university institutions: it would be interesting to ask many Italian universities why, in the context of the Degree Courses in Nursing, the making of the bed and other activities are still envisaged in the educational programs that have no longer been in nursing competence since 1994. Also because of this, the Nursing Profession has lost and continues to lose decorum and prestige. The authors believe that serious measures must be taken against all those universities that, within the framework of the Degree Course in Nursing, establish educational programs that are not in line with current legislation (DM 739/1994; Law 42/1999; Agreement State-Regions 2001; art. 2229 of the Civil Code; art. 2230 of the Civil Code, etc.), with what was stated by the IPASVI College on May 16, 1994 (protocol 85/UL/94 - Competences of the Nurse and OTA), and with what the Supreme Court has been able to clarify for decades.

But what is meant by "inferior duties" or "inferior activities"? These terms mean all those work activities that must be carried out by personnel who have a qualification (and a contractual position and a salary) lower than the Nurse. These are activities attributed to the Social Health Operator (OSS, or Care Worker) through the State-Regions Conference of February 22, 2001, or to workers belonging to companies that offer various types of services (not nursing care) in the health sector. An example are:

- **hygienic-domestic activities attributed to the OSS (also defined as "basic care")**: rearrangement of the beds; rearrangement of bedside tables; replacement of bed linen; change of toilet paper and detergents; performing hygienic care for patients; execution of evacuative enemas (not equipped with a probe); arrangement of patients' personal effects inside the wardrobes and bedside tables; emptying of urine bags; use of parrots and pans; cleaning of parrots and pans also including the use of bedpan / parrot washers; preparation and distribution of food; emptying of bedside tables and wardrobes after the patients are discharged; sanitation of the bed, sanitation of bedside tables and wardrobes, removal of linen from the beds of discharged patients; removal of patients' personal effects outside the ward and placing them in the cupboards; transport of patients in non-serious conditions to diagnostic services and/or outpatient clinics; transport and reordering of material stored in the warehouse; closure of treated hospital waste containers (ROT) [11] [12]; transport or replacement of treated hospital waste (ROT) [11] [12]; closing and replacement of bags containing dirty linen; transport of hospitalized patients from one department to another; decontamination, cleansing, rinsing, drying and sterilization of surgical instruments [12]; collection of the patient from the acceptance office and accompanying him to the inpatient ward; transport of paper documents (medical records, paper requests of various types to offices/services); transport of biological samples (blood samples, swabs, urine samples, etc.); transport of diagnostic tools (for example: transportable ultrasound system);
- **activities attributed to the walker**: transport of paper documents (medical records, paper requests of various types to offices/services); transport of biological samples (blood samples, swabs, urine samples, etc.); transport of diagnostic tools (for example: transportable ultrasound system);
- **activities attributed to personnel belonging to companies that provide transport services in hospitals**: transport of hospitalized patients from one ward to another and/or from ward to services and vice versa;
- **activities carried out by personnel belonging to companies that provide cleaning services for hospitals**: sanitation of premises (including furnishings) previously occupied by positive Covid patients;
- **activities attributed to personnel belonging to companies that provide technical services in hospitals**: moving of furnishings from one room to another or from one department to another (relocation);
- **activities attributed to personnel belonging to unarmed security services**: opening of the entrance doors of the health facility during the night to facilitate the entry of patients transported on a stretcher who must be hospitalized; sorting of visitors at the entrance of the departments/services and verification of the Covid19 European green certification (green pass) during the pandemic: this task is entrusted to public officials, in the exercise of their functions as indicated by the Decree of the President of the Council of Ministers (DPCM) of 17 June 2021. The staff belonging to the health section are in charge of a public service and do not currently have the status of a public official. Therefore, he cannot be appointed to verify the green certification) [13];
- **activities attributed to the Nurse without any legal reason**: reordering of the documentation present in the Medical Record (the "reordering" of the clinical documentation is not a nursing activity as it is an activity that should be carried out by those who have taken medical records from the Medical Record and have not reordered it). Art. 7 of the Decree of the President of the Republic (DPR) n. 128/1969 provides that for the entire duration of the hospitalization, the

person in charge of keeping and storing the medical record is the Doctor (in particular, the head of the operating unit where the patient is hospitalized) [14].

This list represents a summary of the inferior activities that Nursing Staff carry out by tacit consent more or less continuously since 1994 in all those healthcare facilities where the presence of support staff (OSS) is not foreseen (or is foreseen discontinuously) and/or personnel dedicated to transport, cleaning, surveillance services, etc. It is important to remember that all the inferior activities deriving from the demotion "by tacit consent" that require the (unauthorized) removal of the Nurse from his workplace (ward, clinic, diagnostic services, etc.) determines a contractual and disciplinary offense of the same which can be sanctioned by the employer with a suspension from service without pay. In the most serious cases, the crime of aggravated fraud can be configured. In addition to this, the removal of a Nurse from their workplace (albeit under the "tacit consent" demotion regime) leads to inadequate management of clinical risk (DM March 5, 2003) and these crimes are configured:

- crime of abandonment of incapable persons (art. 591 of the Criminal Code);
- conduct in contrast with art. 1 of DM 739/1994 which specifies that the main function of the Nursing Profession is the assistance of the sick [15] [16];
- behavior seriously detrimental to the duty of care that the worker must comply with during the execution of the employment contract (art. 2104 and art. 2105 of the Civil Code);
- conduct in contrast with art. 2229 and art. 2230 of the Civil Code which indicate which functions are legally attributed to intellectual professionals (the Nurse, in fact, is an intellectual).

In addition, the Nurse's Code of Ethics updated on 21 June 2019 provides that:

- the Nurse does not replace other professionals;
- the Nurse has a protective position towards the assisted citizen.

These points of the Code of Ethics expire from the moment in which the Nurse is demoted. The demotion, in fact, forces the Nurse to replace other professional figures by dedicating a (more or less important) part of his time to non-nursing activities, no longer allowing him to have a “protective position” towards patients (this is also in contrast with the DM March 5, 2003).
More specifically, the Nurse's Code of Ethics provides that in art. 1 the Nurse must act responsibly; art. 2 states that the Nurse must act for the good of the person; art. 3 states that the Nurse looks after and takes care of the assisted person; art. 4 states that the Nurse guarantees that the assisted person is never abandoned (also with reference to art. 591 of the Criminal Code); art. 30 states that the Nurse participates in the definition of care and organizational models, also in terms of the fair allocation of resources and enhancing the nursing function; art. 32 clarifies that the Nurse promotes the best safety conditions for the assisted person; art. 37 states that the Nurse, due to his high level of professional responsibility, abides by the relevant guidelines and good clinical-care practices, and monitors their correct application; art. 47 clarifies that the Nurse complies with the administrative, legal and ethical regulations and obligations concerning the profession, also in compliance with the guidelines of the Professional Order; art. 49 states that the deontological rules contained in the Code of Ethics are binding and that their non-observance is sanctioned by the Professional Order [17]. Furthermore, the demotion determines the impossibility of safeguarding the decorum, prestige and image of the Nursing Profession (art. 28, 46, 49 and 53 of the Nurse's Code of Ethics).
From the data presented so far it is clear that demotion “by tacit consent” in addition to identifying itself as an offense for the employer, at least determines an inadequate management of clinical risk in the nursing field, which gives rise to a series of criminal and civil responsibilities for the Nurses punished with imprisonment from six months to five years (art. 591 of the Criminal Code). Furthermore, nursing demotion "by tacit consent" is in contrast with the rules of the Nurse's Code of Ethics: art. 1-4, 28, 30, 32, 37, 46, 47 and 53 are, in fact, inapplicable resulting in an offense in accordance with the provisions of art. 49. Jurisprudence has precisely established what nursing responsibilities are, but within the Nursing Profession the topic is poorly known [18]:

- the Supreme Court, with sentence 2541/2015 established the responsibility and autonomy of the Nurse ("the Nurse evaluates the patient's condition and assesses the need for the doctor's intervention");
- the Balduzzi Law 189/2012: establishes professional responsibility, and in particular "the health care practitioner who in carrying out his/her business adheres to guidelines and good practices accredited by the scientific community is not liable under criminal law for slight negligence";
- criminal liability is sanctioned through the Gelli-Bianco Law 24/2017. In particular, "the healthcare professional who causes, through inexperience, the patient's death or injury, will be criminally liable in the event of gross negligence. This is not expected if it is demonstrated that, in professional practice, he has followed guidelines and good practices";
- art. 590 Sexies of the Criminal Code determines the cause of non-punishment and establishes that it does not apply if there has been negligence due to carelessness on the part of a health worker of the surgical team in the performance of the tasks assigned to him.

From this it follows that the nursing staff is required to know their role and to take care of their legal duties as they may find themselves criminally liable for what is or is not done during their work.
If the nursing staff is systematically engaged in lower duties (demotion) that are not part of the area of competence of the Nursing Profession it is obvious that they will have to neglect a more or less important part of the nursing care, and the judge will condemn this conduct if a patient dies due to incorrect nursing management of clinical risk [18]. This is especially true if the Nurse is demoted "by tacit consent", in fact in this case the employer has not formally authorized the Nurse to perform inferior tasks (in fact, a written communication is required) and if a death of a patient due to the negative consequences induced by nursing demotion on clinical risk management and health care in general, it is the Nurse who pays the consequences: no other professional has, in fact, the skills to be able to adequately assist a patient. In altre parole, l'Infermiere professionista intellettuale non può essere sostituito da altre figure professionali, tantomeno deve svolgere compiti (e non funzioni) che sono ascritti ad altre figure di supporto [19]; è l'infermiere che si avvale, ove necessario, di figure di supporto (OSS, camminatori, etc.) e non viceversa.

The authors, between June 15, 2022 and September 3, 2022 administered an anonymous online questionnaire on the famous social network "Facebook" to understand the extent of nursing demotion in Italy. They could answer the questionnaire Nurses from all over Italy registered on the social network. A total of 51 Nurses responded, collecting 813 votes. The most significant results are listed below.

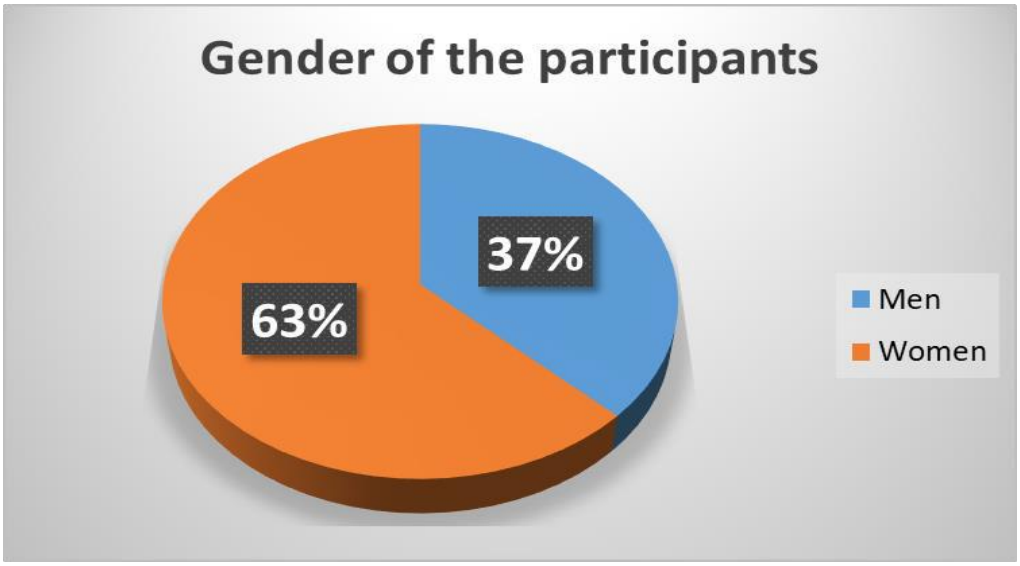

Fig. 4 – Gender of the participants.

The sample of Nurses who answered the questionnaire is predominantly women (63%), while men represent 37% (**Fig. 4**). 65% of the sample declares to work for public health; 23% for private healthcare; while 12% prefer not to answer (**Fig. 5**). 75% of respondents to the questionnaire state that they have worked for more than 3 years, while only 1.8% declare that they have worked for less than 3 years.

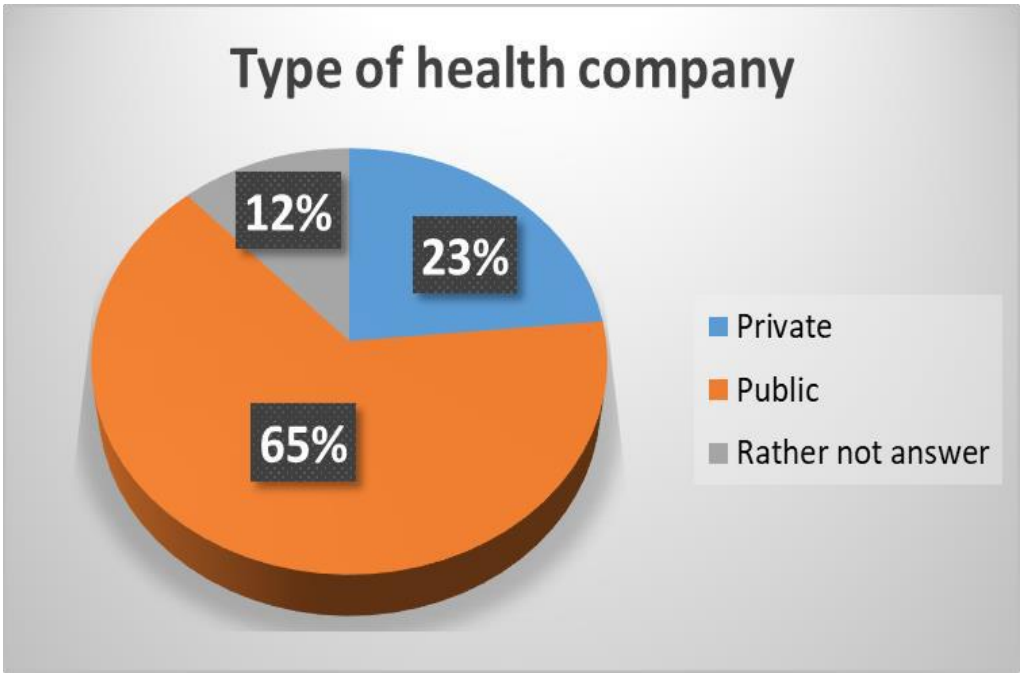

Fig. 5 – Type of health company.

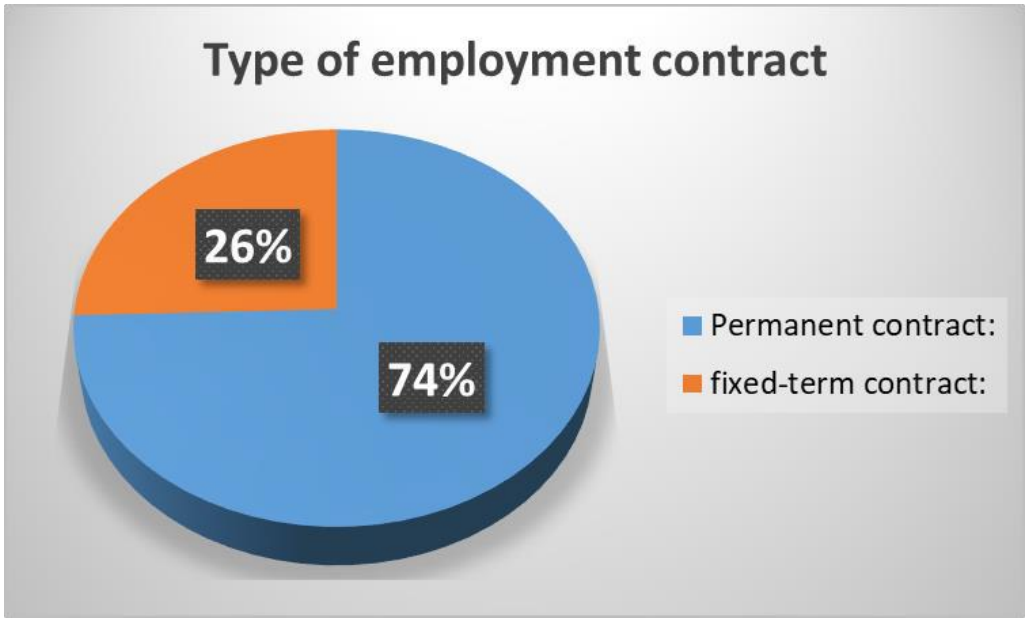

Fig. 6 – Type of employment contract.

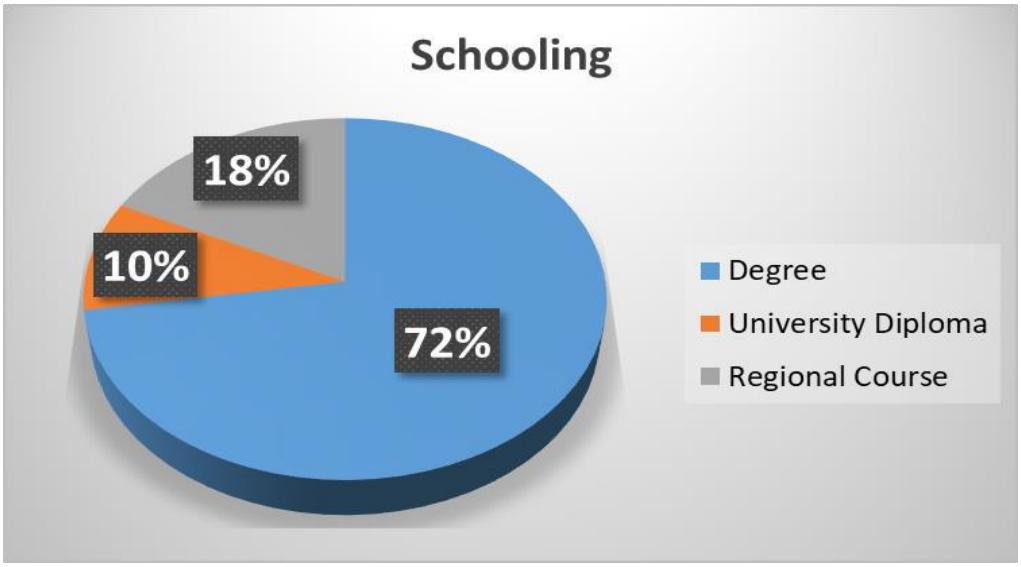

Fig. 7 – Schooling.

74% of the Nurses who answered the questionnaire declared they had a permanent contract; instead, 26% declare that they have an expiring contract (**Fig. 6**). 72% of the Nurses who participated in the survey have a degree qualifying for the Nursing Profession (Degree in Nursing); 18% holds a University Diploma (DU), while 10% holds the qualification obtained through a regional course (**Fig. 7**).

A worrying fact comes from the answers that the participants in the questionnaire gave regarding the problem of demotion "by tacit consent". 51% of Nurses state that they have been demoted for more than 6 months: a disconcerting figure if compared with the 3.3% referring to the total number of workers (in all sectors) demoted in Italy (ISTAT 2008-2009); while 49% prefer not to make statements on the matter (**Fig. 8**). It is clear that within the Nursing Profession, just talking about demotion is difficult. As for the support staff (OSS), 12% of the Nurses participating in the questionnaire stated that in their working reality there is no support staff for the nursing work; 8% replied that it is foreseen intermittently; 43% replied that there is never any support staff during the night shift; 10% report that support staff are present very rarely, while only 27% of Nurses report that support staff are present regularly (**Fig. 9**).

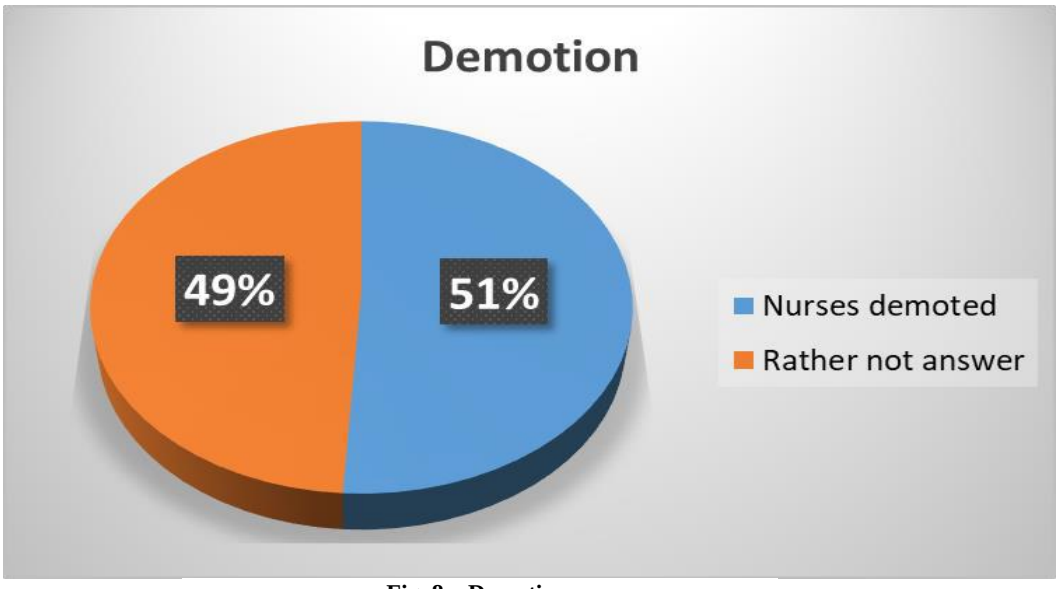

Fig. 8 – Demotion.

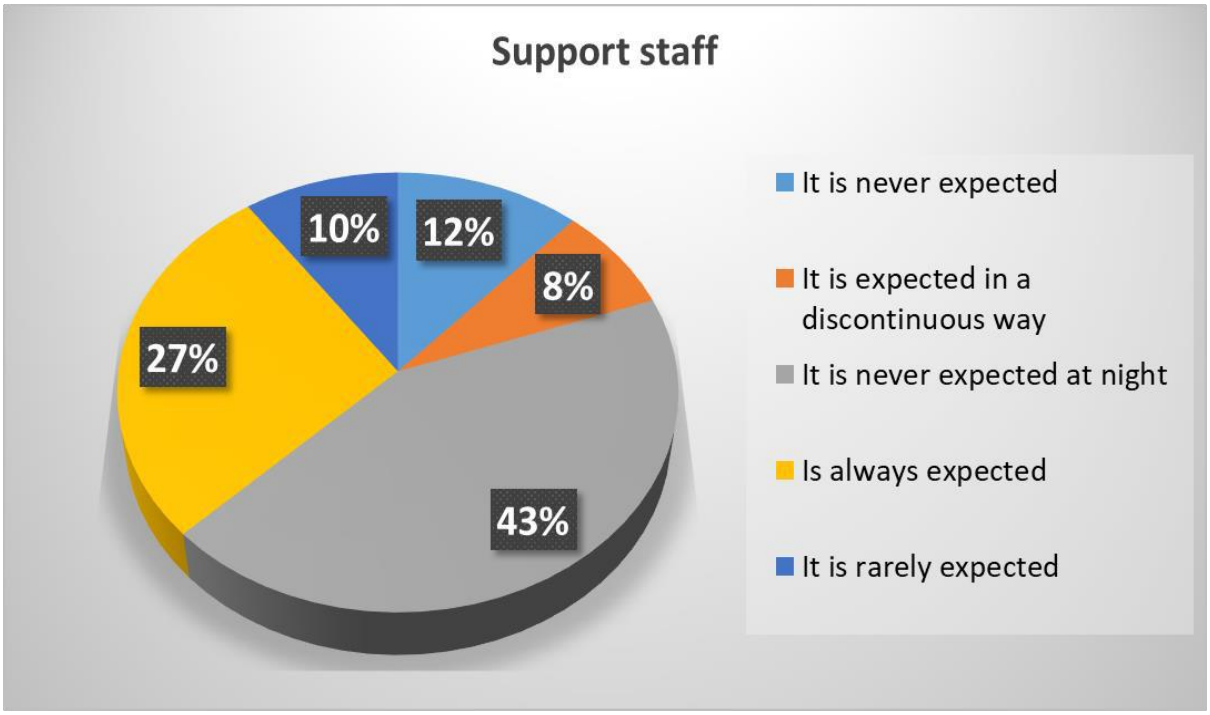

Fig. 9 – Support staff.

This is a series of responses that evidently confirm the existence of a serious problem linked to the failure to apply the 2001 State-Regions Agreement and to the checks that the Region should carry out to verify the presence of nursing support staff in the 24 hours in accredited public and private health facilities. 62% of Nurses say they work in a condition of chronic shortage of Nurses.
What makes this situation particularly worrying is that 60.7% of Nurses say their superiors are aware that Nurses are demoted "by tacit consent", and 66.6% say their managers do not they are interested in the professionalism of the subordinate staff. In fact, 47% of the participants declared that they never have the time necessary to adequately assist their patients; 27.4% of participants said they feel frustrated every time they have to go to work; while 39.2% said they were under pressure regarding the use of their working time. 52.9% of Nurses say they are under pressure in the workplace to do their jobs faster. 29.4% of Nurses say they are afraid to talk about work problems while on duty. 27.4% of Nurses look at their profession with negativity.

From the analysis of the data, it is clear that nursing demotion "by tacit consent" is more evident during the night. Lack of support staff or presence in a discontinuous or rare way represents a problem for 73% of the Nurses who answered the questionnaire: a figure that is worse than the percentage of demoted Nurses (51%) detected through a direct question (Fig. 8); this suggests that among the 49% of Nurses who did not respond (**Fig. 8**), there are 22% of Nurses who actually undergo demotion "by tacit consent".
From this it follows that Nurses do not like to speak openly about demotion, not even anonymously: a fact that is compatible with the perceived reality in the healthcare environment. This also confirms the fact that only 51 Nurses answered the questionnaire in a period of two and a half months. The causes are most likely to be attributed to the great heterogeneity of information relating to nursing demotion "by tacit consent" that each individual Nurse possesses; it is mostly an underestimated phenomenon, of which there is not much scientific literature available and not even updated statistical data. Added to this is the incorrect knowledge of the regulations governing demotion in Italy (DLgs 81/2015) and

the regulations that determine the professional profiles of the professions involved (DM 739/1994 and State-Regions Agreement of 2001). In fact, DLgs 81/2015 states that a Nurse can only be demoted if (**Fig. 10**):

- there is a written form of the provision by the employer: in other words, it is not legal to demotion a Nurse "by tacit consent" as he must receive written communication of the provision from his employer, under penalty of nullity;
- a change is underway in the corporate organizational structures that affect the position of the Nurse.

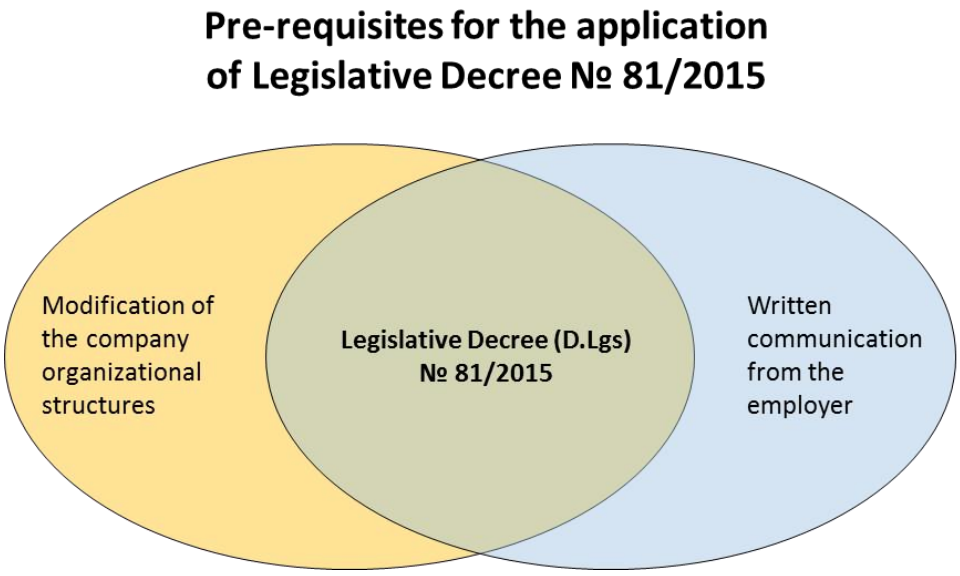

Fig. 10 – Pre-requisites for the application of Legislative Decree n. 81/2015.

Therefore, there are pre-requisites for a Nurse to be demoted (**Fig. 10**). In any case, a written communication from the employer is mandatory and it is necessary that the company where the Nurse works has changed the organizational structures that affect the nursing staff. What has just been stated outlines a condition of legality on which the demotion provision can be planned and adopted until the new corporate organizational structures no longer affect the nursing staff: obviously it must be a finite and not infinite period of time.
As can be easily guessed, Nursing demotion must be a momentary condition that must have a limited duration in time. Furthermore, since the demotion is mainly linked to a corporate organizational reorganization, it is evident that this condition cannot occur frequently and, above all, on the majority of health facilities present on the Italian territory.

Further indications about the seriousness of the nursing demotion "by tacit consent" come from the sentences of some Courts and the Court of Cassation.
"*The demotion mortifies the Nurse and creates irreparable damage to professional dignity*". The Supreme Court of Cassation affirms this once again with sentence no. 00359-22. There were three ordinances (n.21924, n. 21942 and n. 23183) [20] with which, in the month of July 2022, the Cassation rejected the appeals filed by various healthcare companies against the sentences pronounced by the Court of Appeal of Cagliari. [21]
The numerous collective actions organized by professionals to protect their dignity and professional image (harmed by the aforementioned companies), therefore, have once again been validated by the Supreme Court. Yes, because for years, even in Sardinia, Nurses have been obliged, due to the very serious and perpetual shortage of support staff, to carry out activities typical of the "lower" categories

(according to the contractual declaration). The Nursing Staff was forced, in addition to an almost incurable professional mortification, also and above all to sacrifice their real responsibilities and to leave out the entire nursing process by embracing activities such as:

- the rearrangement of the bed,
- answering calls (bells),
- transport of patients on stretchers.

As explained in the ordinance of 11 July no. 21942, "a structural condition of lack of personnel in charge of carrying out basic tasks had emerged, which had led the nurses to carry out the lower tasks, such as: making beds, distributing food, cleaning and changing pans and parrots, the personal hygiene of bedridden patients, their handling. From the evidential framework it emerged that the use of professional nurses was not limited, as deduced by the appellant company, to rare cases, coinciding with particular clinical needs but was instead constant and essential, in light of the serious lack of basic care personnel". [21]
Also, in the ordinance of 11 July no. 21924, it is clearly explained that: "*The quantitative significance of the service relating to the lower qualifications was such as to exclude that their performance could be considered as an ancillary obligation, which by its nature had to have a marginal importance and be functionally linked to the main obligation*". [21]
But that is not all. Other suggestions come through the ordinance of 25 July n. 23183: "*The Territorial Court has ascertained the occurrence of non-pecuniary damage to the professional image and dignity of workers through evidence based on presumptions, based on the concrete circumstances of the demotion and, in particular, on its frequency and public character*". Furthermore, the disputed "*lack of proof of the change in lifestyle" is to be considered completely irrelevant, "since the damage to the professional image is highlighted and not an existential damage*".
On the self-image that the demoted Nurse "by tacit consent" gives to the outside (or to other professionals and citizens) the Supreme Court, in the ordinance of 11 July no. 21924, is crystal clear: "*The qualitative and quantitative consistency of the demotion made it possible to deduce, on the basis of common experience, that the promiscuous exercise of duties belonging to the profile to which they belong and of duties of even a much lower level was suitable to generate in patients a confusion of roles, for which the user expected (and demanded) from the Nurse also the disqualifying tasks: personal discomfort and inner suffering were proven, due to the appearance created on the outside*". [21]

The Supreme Court of Cassation, sixth civil section with sentence no. 00359-11/0722. The Court of Appeal of L'Aquila, with the contested sentence, in reform of the first degree ruling, sentenced the ASL n.2 Abruzzo (Lanciano-Vasto-Chieti) to assign the Nurse to the duties of the position held, corresponding to category D, precisely with the profile of Nurse; it also ascertained the disqualification suffered by the employee for the period from July 2012 to July 2017, condemning the ASL to pay compensation for the damage to be calculated in the amount of 10% of the monthly salary gradually accrued in the period, in addition to the interest from the judicial request. [21]
In summary, the Court did not agree with the defective thesis of the first judge according to which there would be no proof of the "prevalence" of the performance of the lower duties of the OSS (category B) with respect to nursing; in fact, he observed, on the basis of the preliminary findings, how "*it appears that the nurse* (...) *certainly in the last 5 years* (...) *has performed, in addition to his professional functions, also orderly and permanently all the tasks that are typical of the figure of the OSS, since auxiliary staff are not available in sufficient numbers to guarantee the primary needs of patients*". [21] The Territorial Court, then, regarding the damage from demotion requested, considered "*the existence of the damage to professional dignity proven on the basis of the elements that can be inferred from the documents in the case, in consideration of the duration (5 years) for which it was carried out, alongside the activity corresponding to the professional classification, also the activity corresponding to the lower classification; to the nature of this last activity (purely manual compared to the intellectual nature of that of the nurse), of the fact that this lower activity is carried out in the*

presence of all patients who, therefore, see the Nurse perform the tasks of workers classified in lower category". The Court has drawn the conviction of the proof of the damage consisting in the mortification of the image and professionalism of the Nurse. ASL no. 2 Abruzzo then filed an appeal with the Supreme Court of Cassation with 3 reasons which are deemed inadmissible by the same Court and consequently sentence no. 238/19 of the Court of Appeal of L'Aquila. [21]

The Court of Rome establishes the boundaries of nursing demotion by stating that "*The Nurse who is mainly used to carry out tasks that do not fall within his professional framework, but who finds himself for long periods (in this case over ten years) to carry out tasks of the lower staff with a non-nursing classification, with evident damage to their professional image, have the right to be compensated*". The Court of Rome, first labor section (sentence no.6954/2019 of 11 July), sentenced the Gemelli Foundation to pay compensation for the damage. According to the Court, in fact, the damage was quantified at € 60,775 and corresponds to 25% of the monthly salary of a Nurse who was demoted for ten years: assigned to various departments, he appealed against the hospital he belongs to for having carried out in a marginal and hasty way the duties of his professional qualification and in a prevalent way (for at least 90% of his work shift) direct assistance to patients as hygienic-domestic tasks (raising and lowering the back of the bed, offering a bottle, turn on a mobile phone, take sheets and blankets, take care of the patient's personal hygiene, etc.). [21]

The Labor Judge of the Court of Catania, Giuseppe Giovanni Di Benedetto, in 2022 issued a sentence of compensation for 14 Nurses belonging to the Anesthesia and Intensive Care Ward. Professionals have been awarded a demotion damage of € 400,000 for having performed lower tasks (within the competence of the SDGs) in the last 10 years.

The sentence of October 6, 2015 n. 1302, the Court of Cagliari, in line with other decisions of the same Court, deciding an appeal lodged by a group of Nurses employed by a healthcare company, established that demotion (assignment of lower tasks) and professional disqualification (deprivation and/or limitation of typical duties of the membership profile), in addition to constituting a serious contractual breach, can be the cause of non-pecuniary damage that can be compensated.

The sentence n. 3190 of April 27, 2021 (General Role 3190/2020) issued by the Court of Catania establishes compensation for damages in favor of some Nurses for having been demoted. Although the company defended itself by stating that some tasks of the OSS are in collaboration with the Nurse, the Judge disagrees that the OSS is a manual profession while nursing is a scientific profession.

Sentence no. 52/2016 of February 9, 2016 issued by the Labor Judge of the Court of Caltanissetta recognizes the right role of Nurses, condemning the ASP to pay compensation for damage caused by the demotion inflicted on its Nurses.

The sentence n. 556 of May 28, 2020 issued by the Court of Latina sentenced the ASL to compensate a Nurse with the sum of almost 20,000 euros for having used her for disqualifying tasks and not included in the Ministerial Decree 739/1994. The company had contested the groundlessness of the request, arguing that the general obligation of assistance of the Nurse towards the patient was not limited to well-defined limits and that, in the absence of support staff, it could not interrupt the necessary assistance to the patient. patient well-being. The Judge of the Court of Latina accepted the nurse's appeal, and ascertained the disqualification suffered by the applicant in the time interval from 2013 to 2017, sentenced the ASL to compensation of 19.739 euros, and to assign the applicant to the tasks provided for the job title.

It should be remembered that the Supreme Court with its sentence no. 1078 of February 9, 1985, clarified that the hygienic-domestic tasks do not belong to the then Professional Nurse, now a Graduate Nurse, but to other auxiliary and support staff.

2.1 – THE DEMOTION AFFECTS THE NURSING CARE

In the previous chapters it has already been stated that the DLgs 81/2015 allows the employer to demotion the Nursing staff, but only in the case in which:

- there is a change in the corporate organizational structure that affects the Nurse's working position;
- there is written communication from the employer;
- it is a short-term commitment;
- is an occasional measure that allows, however, the performance of the Nurse's duties in a prevalent manner.

On this last point, however, many perplexities arise: how can a demoted Nurse mainly carry out their duties in those health facilities where the management policy does not provide for the presence (or provides for it intermittently) of support staff (OSS) and/or personnel providing hospital services of various types? It is evident that a demoted Nurse must devote a more or less important part of their time to non-nursing activities, causing a discontinuity in the care process and, therefore, an important dilation of care response times. In many contexts, in fact, the chronic shortage of nursing staff, combined with the chronic shortage of support staff, would not allow the performance of the Nurse's duties "predominantly".
In support of this, we find the *Health at a Glance 2021 Report* of the Organization for Economic Co-operation and Development (OECD) which states that in Italy the need for Nurses would be equal to 8.8 Nurses per 1000 inhabitants, compared to current 6.2 Nurses per 1000 inhabitants [22]. To worsen this situation we find the high heterogeneity of the Italian Regional Healthcare which does not provide a single standard for the definition of nursing staff and support staff with reference to the complexity of care and the actual number of patients assisted in relation to the beds activated (employment rate): a situation that has been at a standstill for over 25 years. This is also due to the different regional distribution of funding for healthcare made available by the financial laws [23]. Yet, according to the Organization for Economic Co-operation and Development (OECD) *Health at a Glance 2021 Report*, the key role that Nurses play in providing care in hospitals, long-term care facilities and Nurses in the community is again highlighted during the COVID-19 pandemic, but their scarcity remains the result of a number of factors that politics does not seem to care about [24]: the working conditions of nursing staff demoted "by tacit consent" are aggravated by the fact that the Nurse will not only have to take on the lower duties but will also have to carry out "predominantly" their work: a condition that, according to the authors, is in fact inapplicable as it is in clear contrast with the same DLgs 81/2015, as well as with the DM 739/1994, with the DM March 5, 2003 and with the Nurse's Code of Ethics. In other words, the demoted Nurse no longer has a position of guarantee towards the citizen as regards his professional function, his ethics and his competence with respect to the service provided [19].

In terms of nursing care, demotion "by tacit consent" determines some critical issues:

- inadequate management of clinical risk (DM March 5, 2003);
- general worsening of the quality of nursing care;
- extension of care response times;
- increased risk of error.

The reasons can be traced back to:

- ❖ subtraction of time dedicated to nursing care:
    - removal of nursing units from the care process;

- work overload:
  - increased work stress;
  - increase in cases of sickness in Nurses;
  - reduction of attention;
  - inability to finish some assistance activities on time and consequent work overload for the Nurses of the next shift;
- demotivation of the nursing staff:
  - increased frustration;
  - burnout syndrome;
  - impossibility of safeguarding the decorum, prestige and image of the Nursing Profession (art. 28, 46, 49 and 53 of the Nurse's Code of Ethics).

By "clinical risk" we mean the probability that a patient is the victim of an adverse event, that is, suffers any "*damage or discomfort attributable, even if involuntarily, to medical care provided during the period of hospitalization, which causes an extension of the period of hospitalization, worsening of health conditions or death*" (Kohn, IOM 1999). To manage clinical risk in the most appropriate way, it is essential to assess the presence of managerial decisions and wrong organizational choices, with particular reference to organizational errors (latent errors) (Fig. 11) (DM of March 5, 2003). Patient safety therefore derives from the ability to design and manage organizations capable of both reducing the likelihood of errors occurring (prevention) and recovering and containing the effects of errors that occur in any case (protection). Therefore, if the organization of health services plays an important role in the generation of an accident or not, it is evident that where "by tacit consent" is provided for the removal of nursing units from the care process (even discontinuously) to perform inferior tasks (demotion "by tacit consent"), it will not be possible to adequately manage the clinical risk in accordance with the provisions of the DM of March 5, 2003. This is one of the main reasons it makes nursing demotion "by tacit consent" illegal. The subtraction of time from the care process inevitably generates a general worsening of the quality of care and an expansion of care response times: all factors that contribute to making clinical risk management inadequate. In fact, the reduction of the Nurse's attention to care priorities represents an organizational factor (often latent), the substrate from which serious errors can be generated.
The demotion "by tacit consent" always determines a latent organizational instability as it occurs every day, becoming a problem that is not fought but which we live with. If we then add to this the chronic lack of nursing and support staff (even in a discontinuous way) where there is no planning of departmental activities proportional to the nursing resources available and to those of the support staff, it is evident that the risk of generating serious errors increases tenfold.
Another factor that affects the efficiency of care is determined by the degree of motivation (or demotivation) of the nursing staff. When a Nurse goes to work knowing that he will have to carry out inferior activities "by tacit consent" and that this situation has been going on for years and will not find a solution in the near future, then demotivation and frustration will certainly take over because the professional is resigned, he does not have the possibility to safeguard the decorum, prestige and image of the profession he represents (art. 28, 46, 49 and 53 of the Nurse's Code of Ethics). In addition, the Nurse knows well that he will have to work in a condition of work overload with all the risks that this situation determines in terms of clinical risk management. What has been said so far favors the onset of burnout syndrome.

An overworked nursing team that is in a chronic condition of demotion "by tacit consent" becomes ill more often evidently, and in many realities the chronic shortage of nursing staff forces Nurses to work double shifts continuously to reach the minimum legal number of Nurses in service which obviously does not correspond to the ideal standard but to the minimum staffing equipment capable of guaranteeing only the administration of the therapy and the management of emergencies/emergencies.

While considering the different economic resources and the different political management of Health in the regional context, in Italy this minimum organic endowment of the nursing staff is often used to plan the normal ward activities and guarantee the LEA and any other activity (surgery, etc.) almost as if it were the "ideal standard" and not an important limitation. Yet, the DM of March 5, 2003 suggests that every health service should have a plan to deal with situations in which a reduction in staff could occur, precisely to avoid the occurrence of serious errors.

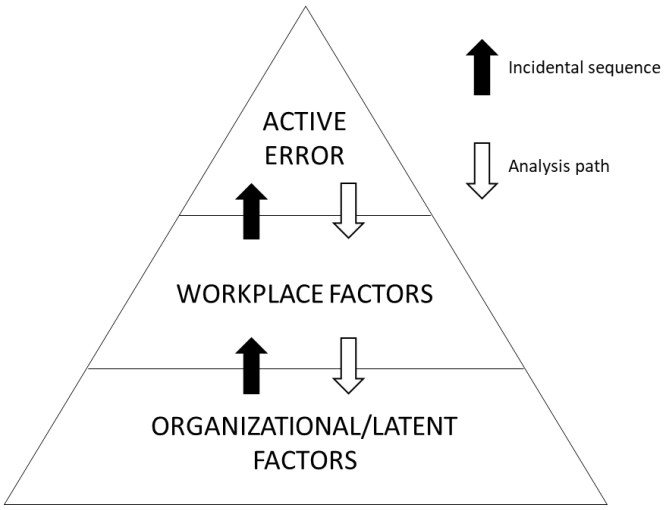

Fig. 11 – Reactive analysis of an accident.
Credits: Reason, 1991.

3.0 POSSIBLE SOLUTIONS

Speaking of solutions, it is possible to counteract nursing demotion "by tacit consent" only by fully respecting the current legislation (including DLgs 81/2015, which obliges the employer to communicate the provision to the Nurse in writing) and the binding nature of the deontological rules of the Nursing Profession:

- Art. 47, Obligation to respect the rules; Nurse's Code of Ethics: «*The Nurse complies with the administrative, legal and regulatory requirements and obligations deontological, which concern the profession, also following the guidelines of address of the Professional Order*».

- Art. 49, Binding nature of the ethical rules; Nurse's Code of Ethics: «*The deontological rules contained in this Code of Ethics are binding for all members of the Order of Nursing Professions; there their inobservance is sanctioned by the professional association taking into account the voluntariness of the conduct, the gravity and the possible repetition of the itself, in contrast with the decorum and professional dignity*».

- Art. 53, Professional Orders. Code of Ethics; Code of Ethics of the Nurse: «*Any other behavior that violates the decorum and professional dignity is punishable from the Order*».

From the three articles of the Nurse's Code of Ethics that have been mentioned in the previous lines, it is clear that the deontological rules have a binding nature for the Nurse, and their inobservance is sanctioned by the Professional Order. From this it follows that DLgs 81/2015 (which regulates the application of demotion), forcing the Nurse to comply with art. 1-4, 28, 30, 32, 37, 46, 47, 49 and 53 of the Nurse's Code of Ethics (even for a limited period of time), exposes him to disciplinary

sanctions by the Professional Order. This makes DLgs 81/2015 and the deontological nature of the Nurse, in fact, incompatible.
This incompatibility must be resolved as soon as possible at the institutional level: in the opinion of the authors, a substantial modification of DLgs 81/2015 is necessary; a change that fully considers the ethical nature of the nursing profession. On this last point, and with reference to DLgs 81/2015, a position taken by the National Federation of Nursing Professions Orders (FNOPI) is desirable.
But we come to the solutions to be adopted to counter the demotion "by tacit consent". Assuming that this type of demotion is illegal as the employer is always obliged to communicate the provision in writing to the Nurse, according to the authors the simplest solution capable of reducing in a concrete way the cases of demotion "for tacit consent" of the nursing staff is to organize health services through a serious and real assessment of the needs of human resources. If nursing demotion "by tacit consent" exists because it is not possible to make use of support staff for assistance activities or other types of personnel (pertaining to companies that offer various types of services, not nursing care, in the health environment), it is obvious that it is essential to hire a number of human resources adequate to the needs of each individual service (wards, clinics, territorial services, etc.); this is to allow the Nurse to do their job which, we remember, is to assist the sick.
This solution certainly provides for greater economic investments to be allocated to regional healthcare than those currently used (as today the number of nurses present in service is not adequate for the care needs provided for by the LEA), but it is also true that the minimum organizational requirements defined at the regional level for accreditation to the Regional Health System establish that the type and number of health personnel to be assigned to a specific service must be chosen based on the needs of the service itself. Service outsourcing contracts (not nursing care) also take these needs into account. It would also be desirable to have a general review of health expenditure for contracts (contracts and sub-contracts) stipulated with companies that provide various types of services (not nursing care) in the health sector, also with a view to a revision of the contracts themselves for understand if the services provided comply with the agreements defined at the conclusion of the contracts, or to understand if after a period of time (generally a few months or years) it is necessary to strengthen a certain service compared to another: the needs in the health sector can also change in substantially in a short time (see for example the COVID pandemic). Certainly, to implement all this it is essential that at the regional or national level the health system is able to carry out an effective re-evaluation of the resources available in the face of acquired needs, especially since the objectives (LEA) undergo a change over time.
Another consideration should be made on turnover, i.e. on the replacement of health care personnel who leave the productive health sector (retirement, illness, etc.) through new hires: the balance between those who leave and those who enter, if the objectives (LEA) remain unchanged, it must always be even, never negative. For this purpose, a clear and simple national guideline would be needed through which to calculate the optimal needs for nursing and support staff (OSS) taking into account:

- average percentage of staff absences (illness, leave, rest, etc.);
- care complexity / case-mix;
- objectives (LEA);
- optimal employment rate of 98-99% (lower employment rates are not realistic);
- average ministerial weight;
- type of shift and hours performed per shift;
- DM March 5, 2003;
- DM 739/94 and the Nurse's Code of Ethics;
- State-Regions Agreement 2001.

By "optimal needs" we mean the minimum number of health workers (Nurses and OSS) per work shift capable of ensuring compliance with the LEA and adequate management of clinical risk (as established by the DM March 5, 2003). This standard must be calculated considering only healthcare personnel without functional limitations.

Another solution, albeit more drastic, is represented by the following: if at a central or regional level there is a lack of economic funds to hire an adequate number of human resources and allow the nursing staff to no longer be demoted "by tacit consent" then it is essential reduce available beds or services: in this way the human resources available will be adequate because they will be distributed in a smaller volume of health services. In practice, this solution allows to reduce the availability of health services while increasing the quality of care with all the benefits of the case.

No less important are the organizational responsibilities of the SSR managers: to counteract the demotion "by tacit consent" of the nursing staff, disciplinary measures against managers (at all levels, regional and local) should be tightened in the event that non-compliance is ascertained on an organizational level (also including failure to communicate with one's direct superior) which cause the persistence of demotion conditions "by tacit consent" of the nursing staff. In this way, at the managerial level, the lack of support staff for nursing work or personnel who guarantee other types of services would represent a serious problem to be solved in the shortest possible time (even through new hires) and not a condition to be ignored. which only the nursing staff must take care of through DLgs 81/2015.

Last but not least, it represents the repeal or amendment of DLgs 81/2015: this solution would counteract nursing demotion "by tacit consent" which is, in fact, illegal because:

- the employer must always communicate the provision to his employee in writing;
- the Nurse's Code of Ethics is incompatible with the pejorative nature of the *ius variandi* introduced through DLgs 81/2015.

Other incompatibilities concern:

- the DM March 5, 2003,
- the Gelli-Bianco Law 24/2017,
- the Balduzzi Law 189/2012,
- art. 591 of the Criminal Code,
- the DM 739/1994,
- art. 2104, 2105, 2229 and 2230, of the Civil Code,
- the art. 1-4, 28, 30, 32, 37, 46, 47, 49, 53, of the Nurse's Code of Ethics,

with the State-Regions Conference of 22 February 2001.

4.0 – CONCLUSIONS

According to the FNOPI (National Federation of Nursing Professions Orders) in Italy there are about 63,000 nurses (27,000 in Northern Italy, 13,000 in Central Italy, 23,500 in Southern Italy and the Islands). The CENSIS (Center for Social Investments Studies) instead quantified the shortage of nursing staff at almost 300,000 units. According to the CREA Health Report (University of Tor Vergata, January 2022) in Italy there are between 237,282 and 350,074 Nurses against a surplus of almost 29,000 Doctors. The latest OASI 2021 report from Bocconi University highlighted that about 101,000 more nurses would be needed. (25). This is due to the lack of a serious strategy adopted at the political level (regional and/or national) to fill the chronic shortage of nursing staff and support staff (OSS, etc.) which has led, in an increasing way, to make the nursing demotion "by tacit consent" an anomaly so deeply rooted and so frequent in the Italian healthcare context that many professionals and managers accept it as a normality. Yet, nursing demotion "by tacit consent", as well as being illegal (because the employer must always inform the Nurse of the provision in writing) determines a series of situations that are clearly in contrast with:

- the DM March 5, 2003,
- the Gelli-Bianco Law 24/2017,
- the Balduzzi Law 189/2012,

- art. 591 of the Criminal Code,
- the DM 739/1994,
- art. 2229 and 2230 of the Civil Code,
- art. 2104 and 2105 of the Civil Code,
- the art. 1-4, 28, 30, 32, 37, 46, 47, 49, 53, of the Nurse's Code of Ethics,
- with the State-Regions Conference of 22 February 2001.

On the care level, demotion "by tacit consent" determines critical issues that, according to the authors, cannot be legally supported since they determine:

- inadequate management of clinical risk (DM March 5, 2003);
- general worsening of the quality of assistance;
- dilation of assistance response times;
- increased risk of error.

On the care level, therefore, the demotion “by tacit consent” determines a (more or less important) subtraction of the time dedicated to assistance while, on the professional level, it causes profound frustration for the nursing staff who are forced to work in conditions risky and in the impossibility of safeguarding the dignity, prestige and image of the profession he represents (art.28, 46, 49 and 53 of the Code of Ethics for Nurses): this is a series of situations that, once again , make clinical risk management inadequate.

Nursing demotion “by tacit consent” does not arise by chance but is the result of the inadequate evaluation / management of human/economic resources destined for health services which generates the total or partial lack of non-nursing staff dedicated to specific activities:

- domestic-hygienic (OSS),
- various types of transport services (patients, aids, documentation, etc.),
- cleaning services,
- security services (green certification control personnel, etc.)
- driver (remember that driving ambulances or medical cars is not the responsibility of the Nurse) [26];
- bag holder.

By “total lack” we mean the complete absence of nursing support staff (or personnel assigned to other types of services; see the chapter “Nursing demotion”) within departments or health services. By “partial lack” we mean the presence of staff to support nursing work (or staff assigned to other types of services) in a discontinuous way: for example, not during the night; or it means the presence of support staff for nursing work but not the presence of staff assigned, for example, to the transport of patients and/or various material (walkers). From this point of view, Italy is a very heterogeneous country

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It is therefore evident that in order to counteract nursing demotion by “tacit consent” it is necessary:

- comply with the laws in force with particular reference to the regulations governing the nursing profession and, last but not least, the Nurse's Code of Ethics;
- amend DLgs 81/2015 to make it compatible with the ethical nature of the nursing profession.
- guarantee the minimum organizational and human resource requirements at least in those regions that have regulated the exercise of health and social-health activities (see for example the “Annex C - Minimum authorization requirements for the exercise of health and socio-health activities” of the Lazio region);

- allocate more economic funds to health services if those currently available do not allow the hiring of an adequate number of health professionals (and not) able to guarantee the minimum organizational requirements for health services;
- reduce the number of beds available in the event that the funds allocated to health services are insufficient to hire an adequate number of personnel capable of guaranteeing the minimum organizational requirements of health services.

According to the authors, these are solutions to be adopted to counteract nursing demotion "by tacit consent" and reduce the negative consequences that this system determines on care activities. To this must be added greater controls on the organizational functions and on the feedback that managers must collect to perform an objective assessment of the quality of the services provided according to the organization of health services and human resources available.

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