Testimony in Support of SB 469
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Senate Committee on Health Care
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Chair Monnes Anderson and Members of the Committee:

This testimony is being presented to you from the perspective of my experience as the author of the original staffing bill, HB 2800 which passed in 2001, my role as an ONA staff member working with nurses across the state and my current clinical practice in a Portland-area emergency department. I have practiced nursing for 43 years with almost all of that time in hospitals. I have held positions as staff nurse, manager and director and understand well the complexities of adequately staffing a facility.

In discussing the need to make changes to the current law, I feel it is important to focus on the reason that a hospital exists. That is to provide safe quality care to its patients.

Before addressing some of the concerns that have been raised regarding this proposal, I would like to briefly summarize the bill before you.

1. The primary provision of the bill is to clarify and make explicit the original intent of the legislation in 2001, that the staffing committee has authority over the staffing plan for the facility. Repeatedly, nurses have experienced situations in which the staffing plan approved by the committee has been rejected or ignored by hospital administrators and the facilities' budget is often used as rationale. I know of no group of direct-care registered nurses who advocate for a lavish staffing plan and ignore the cost-efficient use of resources that should be part of the business plan of any hospital. Unfortunately, many hospital administrators view nurse staffing, which is the largest portion of a hospital staff budget, as a place where costs can be reduced without a negative effect on quality and efficiency. Most of these individuals are not clinicians and have no real understanding of the complexities of providing care or the increased burden of recent technology, such as poorly designed electronic medical records that impose much greater documentation requirements and are inefficient.

   In addition to clarifying that the committee has final authority on staffing, the bill requires the committee to meet regularly, and opens committee meetings to observers. It requires that minutes be taken and are available to staff.

   Language concerning the staffing committee process is necessary because many staffing committees meet infrequently, their members are not able to attend due to patient care assignments, and selection of the committee members is not democratic. If

the staffing committee is to be effective, it must meet often enough to assess the status of the staffing plan and make adjustments that match changes in the patient population. The specific requirements for information that the committee must use in making decisions is necessary so that objective data can be available to the committee.

2. The addition of a direct-care staff member who is not a registered nurse to the staffing committee acknowledges the important role that assistive staff, such as certified nursing assistants, play in staffing a hospital. Nursing units cannot function efficiently or use staff resources appropriately without these staff members. The -1 amendment would make this person a voting member of the staffing committee, and part of the 50 percent of the committee that is currently represented by direct-care registered nurses.

3. The bill establishes a Nurse Staffing Advisory Board to the Oregon Health Authority. This new board is not a regulatory board but provides necessary advice to the state agency regarding implementation of the law and trends occurring in facilities across the state. One major role for this advisory group is to recommend the staffing ratios that would be imposed if a hospital staffing committee comes to an impasse and fails to agree on a staffing plan. The composition of the advisory board includes members of the public as well as nurses, hospital administrators and a labor organization. The addition of public members is consistent with other boards in the state and the mission of those boards to protect the public.

4. Section 6 makes several changes to mandatory overtime including breaks between the end of one shift and the beginning of another. Mandatory overtime is clarified to be hours beyond the agreed upon and prearranged shift. This change is critical because several hospitals believe that a facility can require any nurse to work a 12 hour shift. That was never the intent or language of the law and this change clarifies that.

   A 10 hour break after the end of a 24 hour period in which a nurse works 12 hours or more is also critical for patient safety. Fatigue in and of itself has been shown to be associated with increased errors and this provision protects against the imposition of a short break between shifts.

   Some facilities have required on-call time or mandatory overtime to accommodate convenience for providers. For example, scheduling non-emergent elective surgical cases in the evening has resulted not only in long shifts but also has implications for other units in the hospital that are not prepared nor have bed capacity for patients who should have been a part of the planned surgical schedule.

   Section 6 retains the exemptions from mandatory overtime limits that are necessary to ensure that patients can be served by the facility. Such exemptions are during a

disaster, epidemic illness or when a sudden staff vacancy occurs. This bill does not make changes to voluntary overtime.

5. Section 7 addresses transparency for the public in posting staffing for each unit.

6. Enforcement provisions are significantly improved in Section 9 of the bill. The number and frequency of audits is increased to recognize the limitations of the current law. Some hospitals have rarely been audited. In order to ensure compliance with the law in the public interest, oversight needs to be improved. Provisions in Section 10 strengthen the response to staffing complaints. Unfortunately, for reasons that are not clear, the agency has failed to take timely action on complaints over the last several years. The delay after complaint filing in one case was more than a year and months in many others. Another new requirement is that the state complete a follow-up audit after a hospital has been found to be in violation of the law, to ensure that the hospital has implemented the required plan to address the violations. The state agency does not currently conduct such a review. Other parts of this section strengthen the quality of complaint investigation and give the state additional tools to employ to ensure that they have access to all information that can be helpful in an investigation. This section follows questions from the state agency and others about whether the state currently has authority to interview witnesses and inspect staffing reports on actual staffing.

7. Finally, Section 11 of the bill relates to public accountability. Increasingly, the health care system and its providers are being asked and required to have greater accountability to the public. For example, outcomes of complaints against nurses are publicly available on the Oregon State Board of Nursing's website. ONA believes that the responsibility of a hospital is to its patients and its community and its accountability should be no less than that of individual providers. Thus, public posting of audit results and complaint investigations is a part of this proposal.

At this point I would like to address some of the issues and concerns that have been raised about this proposal.

This bill has been misrepresented as a California-style set ratio bill which it is not. In SB 469, set ratios would only take effect if a hospital staffing committee cannot come to agreement and then those ratios would be temporary. Further, ratios that could be imposed by the state would be recommended by a work group consisting of nurses and hospital representatives—based on national standards—and adopted through the administrative rule process. Again, ONA has consistently supported collaboration in the facility process but given the current circumstances, in some cases, it might be necessary for external standards to be imposed which, while not a perfect solution, offer some degree of certainty.

Some have said that this bill has been introduced because there are a very small number of hospitals where staffing has been acutely inadequate and the internal committee process has failed. Nothing could be farther from the truth and Dr. Carl Brown will present ONA's verifiable

data to you. I personally have worked with nurses in a small hospital that is located in a community which has seen dramatic population growth. At the same time the hospital has a state-approved variance which allows a nurse to be left alone in the emergency department because the hospital has agreed to provide back up from either a floating nurse or the nursing supervisor. Unfortunately, neither of those positions are readily available due to the demands of the rest of the facility. This has resulted in patients not receiving timely care and a dangerous inability to immediately address emergent needs.

In another facility, a mental health unit was established having been moved from another larger facility. Despite the certainty of an increased number of unstable patients in crisis, and after numerous proposals by the emergency department staff, no staffing plan changes to address the emergent population were accepted by the hospital administration. Only recently has the facility begun to provide sufficient staff for this very acute patient population.

Finally, I also have personal experience in my own clinical setting. The facility hired an outside consulting organization allegedly to assist us in implementing a new triage system. However, after time a member of that organization became an interim manager of our unit and announced that the staffing would be reduced. When reminded that there is a law and that specialty standards are required to be a part of the staffing plan, he rejected the authority of the law over the objections of the staffing committee. Only after the state found the department in violation of the law—many months after staffing was reduced—was staffing restored.

It has been asserted by some that the Oregon Nurse Staffing Collaborative (ONSC), which is a voluntary group of direct-care registered nurses and nurse managers established by the Oregon Nurses Association and the Oregon Association of Hospitals and Health Systems, should have been consulted about any decision to introduce legislation. The ONSC has served a valuable role in offering educational programs and engaging with the staff from the Health Care Regulation and Quality Improvement program (a department within the state public health system). It was never intended to be a policy committee and that has been clarified by its co-chair who is a registered nurse staff member of the hospital association. The ONSC has discussed compliance issues but has no authority to act on behalf of any facility or either organization.

Cost concerns have also been expressed related to some provisions of the bill. While there will be increased costs to the state due to additional auditing requirements, other provisions of the bill impose no new work for the agency. In fact, the agency has its own internal time line requirements for investigating complaints and has repeatedly failed to meet those timelines. Additionally, representatives of the state agency reported to the ONSC in November that it was increasing its investigator positions to meet the requirements of existing law. ONA believes that both the audit and complaint investigation process are a necessary component of hospital regulation just as nurses are regulated by the State Board of Nursing.

In the interest of Oregon's hospitalized patients and the registered nurses who provide care to them, I urge the committee to support SB 469.