Oregon Nurses Association
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Good afternoon. My name is Sue Davidson, PhD, RN, CNS. I am an Independent Nursing Practice Consultant; previously, I was Asst. Executive Director of Professional Services at Oregon Nurses Association. Thank you for the opportunity to provide testimony to you today. I would like to focus on three important competencies of the nurse, and the effect of these competencies on nurse staffing,

In 2005 (HB 2800), the nurse staffing bill challenged hospitals and nurses not only to search for staffing improvements, but also to strengthen the linkage between staffing and patient outcomes. That law also required a collaboration between staff and administrative nurses. Acute care hospitals have been required to hold meetings of their Hospital Nurse Staffing Committee. An evidence base for nurse staffing at ONA has grown. Why then the need for SB 479? It is needed because there are still significant gaps in nurse staffing at the unit-, department, and organization level. Last, but not least, the linkage between the nurse and the nurse staffing has suggested that as the nursing is sufficient/safe, so will the outcomes of care fall into acceptable or excellent levels. .

The players in the issue of nurse staffing - the hospital, the clinical unit, and the nurse - are interwoven into a matrix vulnerable to numbers of patient admissions, transfers in, transfer out, and discharges. There are three important competencies that the nurse uses to respond to his/her nurse staffing: practice knowledge/competency, vigilance, and presence.

Sufficient knowledge and competency in nursing: This means that the nurse caring for a group of patients has enough clinical knowledge and skill to see presenting or emerging

abnormal signs, symptoms, and/or behaviors of the patient; this information forms the basis of the nurses' plan for care for the patients in his/her assignment. Nursing care entails a range of interventions that are performed by the nurse, or the nurse and patient together. For example, this may include walking a patient in the hall, or ensuring the patient get's enough oral fluid, or doing a dressing change, or assessing a patient's mental status. The nurses is thinking about these findings, comparing them to the previous day's symptoms and to expected norms for this patient and his/her diagnoses. This example of nursing knowledge/competency is the first line of defense to prevent unexpected deterioration - or, to identify improvement and healing. This competency is knowledge and time dependent, e.g., the nurse needs the time to do it. Consider, then, what happens when a unit is understaffed, assignments are shuffled or combined, and the time for this competency is lost. Given data from reports of nurse staffing, we know that nurses' hurry and worry as they attempt to practice "less" with limited time.(ONA, Staffing Report and Documentation Form™). Multiply this competency and the knowledge of the nurse by his/her 5 patients and you can begin to see how numbers of patients and time can affect this competency. In summary, this competency is enhanced by the presence of knowledegable colleagues and unit leaders, and by ongoing clinical level continuing nursing education, and time-based nursing care plans.

Vigilence (assessment): This competency is used at various intervals of time to assess each patient in an assignment. The purpose is to ensure that subtle emerging signs and symptoms of significant change are noticed. Vigilence is a cognitive skill based on standard and specific knowledge of the diagnosis, patient profile, and other factors in each individual patient. Vigilence depends on "eyes-on" assesment, as well as knowledge of the illness trajectory each patient is on during the shift. It is part of the plan a nurse makes at the beginning of a shift so that checking on some patients may be frequent, whereas with other patients, "eyes on" checking may be less frequent. Vigilence means that early response can

occur when a patient's needs emerge unexpectedly. A children's hospital in Boston has completely revamped it's care model to a vigilence model following an sentinal event of a child (Institute for Healthcare Improvement, 2012). In summary, development of the vigilence competency is achieved by the presence of knowledgeable clinical leaders and/or educators. It is a competency that every nurse should possess, regardless of clinical unit or setting.

Presence:

This competency is the most directly linked to the safety of patients on any given shift. It means that the nurse is physically in the presence of his/her patients on a shift. It is the way nurses see that things are OK, or things are changing in the patient, that a patient may be unstable, unpredictable, something has emerged that wasn't there before. What is seen while in the presence of a patient may require reassessment, may require a calll to the physician, may require confirmation with another nurse, may require notification of the family. Seasoned nurses refer to "....a sixth sense" and often will notice very subtle signs of deterioration very early on. In summary, presence is directly linked to safe patient care. It may be the one competency which nurses say has been weakened by insufficient numbers of staff, by a focus on non-clinical measures, and a focus on economics vs value of nursing care.

When there are not enough nurses on a shift, it means that presence, vigilence, and use of knowledge and competency is compromised. In short, it means that there will be gaps in care of assigned patients. Quantitative and qualitative data held by the Oregon Nurses Association's repository of reports on staffing confirm the linkage between presence and missed nursing care. When presence is prohibitive due to nurse staffing, nursing care is compromised, insufficient, and the likelihood of negative outcomes rises.

In summary, where nurse staffing has been developed to meet the needs of patients, and where the nurse staffing plan of a unit or in a hospital is required to be based on these

competencies, and the likelihood of safe patient care should rise. SB 479 calls for strategies to enhance Oregon's acute care clinical environments. Basing those enhancements on these principles is a win-win for patients and for nurses.