Testimony in Support of SB 469
Monica Meier RN, BSN, OCN, CCRN-CMC
Klamath Falls, Oregon

Senator Monnes Anderson and Members of the Committee:

It is my privilege to address you today in regard to the update in the Nurse Staffing Law. I am a registered nurse of 25+ years working in an acute care hospital in Klamath Falls. My job is in the flex team or float pool where nurses report for duty on a shift and are at that time assigned to a unit where they are needed. We are trained to take care of patients in all units from the emergency room, pediatrics, critical care, to medical, and surgical.

After the HB 2800 passed in 2005, our hospital developed a staffing committee where the ratios of nurses to patients and staffing matrix for each nursing unit were reviewed or created based on specialty. I would like to share three accounts of my nursing care experience to enable understanding of a day in life of a my job in nursing; experiences of staffing committee with current staffing law and the benefits of updates to this staffing law.

First account:
I report for duty on the progressive care unit this day. The patient population there are admitted for chest pain, heart failure, and cardiovascular disease. This 84 year old man was admitted the previous day for chest pain and "possible heart attack" He had know CAD (had bypass surgery over 10 years previous, aortic stenosis (which is where the heart valve which blood goes out to the circulation in the body is thicken, stiff and difficulty opening. Prostate cancer with bone metastasis was another complicated factor – which means the cancer has invaded his pelvis and hips. These morbidity and mortality issues make his illness crucial situation. (morbidity and mortality translate to death and disability) At report: he had an episode of chest pain during the night and after my usual morning tasks of nursing assessments, giving medications, reviewing labs and vitals signs, mobilizing patients up at bedside for breakfast, etc. This patient c/o chest pain and is clutching his chest around 10am. I applied oxygen, did nursing assessment, vital signs, medication to treat pain and just being at bedside 1:1 for a period of time providing reassurance, close monitoring of vital signs, and comfort. I asked about his disease (one way nurses asses to what degree patient's understand there own illness/situation) and his life at home. He tells of his wife who is a "brittle diabetic" who is on dialysis which requires 3 day a week trips to Klamath Falls, they live in a small community in California. She is on oxygen 24/7 but able to care for herself and do cooking and together they do the housekeeping. They are fortunate to have 2 grown children in the community to assist them and the patient's health is pretty good in that he has minimal pain with bone metastasis of his prostate cancer, initial treatment was 8 years ago and this past 6 months his on an oral medication to keep his disease at bay; minimal pain with occasional narcotic pain medications. The heart specialist watches the heart valve functions he states and he has been taking the same medications for his heart for many years without any symptoms of chest pain, SOB, or problems until yesterday. After his pain resolves I contact the cardiologist on the case via phone and review with them the labs, EKG – cardiac tracing, pt condition, symptoms. I use my bold voice and discuss with him the possibility of urgent angiography where patients go to the cardiac cath lab and dye study is done to determine the heart's arteries for blockages and PCI – coronary interventions are done to open and clear the diseased vessels. He was clear with me that this procedure had risks and after all this patient had metastatic prostate cancer, and aortic valve disease that was progressing., age 84, and kind of the "why should I bother with this?" attitude. I stated because he needed to be well to care for his wife, articulating the social situation and he added that "yes, I talked

with this guy's children yesterday and I don't think they "get it" in the seriousness of the situation. He agreed that he would do an echo cardiogram and evaluate the patient again on rounds. I expressed my experience as an oncology RN and that his disease was very stable, and there were now transthorasic procedures now for aortic valve replacements done @ OHSU and was that something he would be a candidate for?

By noon, the patient was feeling better, weaned off his oxygen, had him up and ambulated to BR and in the chair at bedside he was strong, denied pain in back or hips with activity, no SOB and brighten up mentally with his family's visit. His wife was a bit younger and though on oxygen seemed very much able to care for her self and in talking with the 2 children with the cardiologist conversation yesterday; they were feeling a family crisis, worried that dad would no longer be able to drive and take mom to dialysis 3 days a week, and would he need care at home? The cardiologist rounded, exam pt and stated he had gone to the office and pulled his file there – pt had stable disease with his cancer for 8+ years now and the heart pump on the echo was strong, the valve was a little worse; but he was going to do urgent angiogram if he had more chest pain; but planned the procedure for tomorrow if he didn't. I went home feeling concerned that I may have "bullied" this doctor into the right thing or maybe something not beneficial and was concerned about the outcome. The next day I was in the critical care unit with patient assignment and this man game to the ICU after cardiac cath for a short time due to arterial line placement and B/P management; but the cardiologist sought me out and proudly reported he has done successful angioplasty and stenting of one of his arteries and he had completed a left and right heart cath diagnostics because he was sending his data to OHSU in hopes that they would consider him for the trans thoracic value replacement. Pt and family were very pleased, he did well, home and I do not know if he had the valve or not. This story is a an example of a day in the life of a nurse and how much more we do with patient care than giving medications, starting IV's, and checking vital signs. I want you to remember that I had 4 other patients I was caring for in the unit while managing this patient. I was proud to feel part of "The right thing to do" for this patient. These situations are what keeps us struggling each shift with staffing shortages, difficult patients, difficult families, difficult physicians; which keeps me practicing as a registered nurse for over 25 years, and protects me from burn out or compassion fatigue.

Second Account:
The next week I attended a staffing committee meeting. The room was full of birthing center and pediatric RN staff to advocate for core staffing change in caring for Pediatric patients. With many small community hospitals; the pediatrics area opens and closes frequently as infants and children are hospitalized for short times and specific situations. Typically RSV virus (a respiratory illness – that can be very serious is some infants) The RN staff now would be alone on a unit with 1 other qualified staff person often with 1 or 2 patients (typically this type – RSV) The staffing operations director had difficulty staffing the unit with a C.N.A with this RN due to availability of pediatrics trained staff, Most C.N.A. Staff didn;t know how to take vital signs on an infant or recognize that a heart rate of 160-200 per minute was normal if baby was crying, upset, cranky. RR of 32-40 was normal; but 15 like an adult and HR of 70 would be alarming! The decision was made outside of the staffing committee (which is truly the situation staffing committee was created for) the second person could be an U/S – clerical staff or a PSA (sitter- safety assistant) Both were able to call for help using the phone for the RN; and both had a HC provider CPR card which this director felt was all that was essential. A pediatric RN was sent to open the pediatric area and when the qualified second person arrived she was not comfortable at the bedside with an infant (never sat with an infant before) and didn't have any skills at the desk in entering orders or answering the phone. When questioned about calling a code blue or contacting help she was very unsure. This safety concern/situation had prompted this meeting after RN's researched and found the staffing matrix had changed with no knowledge or input from staff that cared for these

patients. The outcome of the meeting was that the Pediatrics nurses would do immediate training to the C.N.A. Staff in the flex team or float pool and now twice yearly does training with all C.N.A.'s to be competent caring for pediatrics. The Resp therapy staff assist at the bedside at intervals for the RN to be able to have 1-2 short 10 min breaks during the 12 hour shift and lunch coverage was planned as well. The medical/surgical nurses had a lot of concern when their C.N.A staff was pulled from them and sent to be on a unit with 1 patient when there were 6-8 on med/surg would be effected by this. I will never forget the professionalism in the pediatric RN clearly acknowledging that this would be a consequence; apologized but pressed that "Its the right thing to do" The Med/Surg RN staff agreed and other problem solving done to ensure good staffing for them as well. This account is an example of how the hospital did implement the process and staffing changes needed; but with the current bill and law had NO obligation to do so. (Cost issue – not really) Not ALL staffing problems are cost

Third Account:
In the development of the past and current staffing bill/law much research is done in regard to nurse staffing from industry standards such as specialty areas. The ENA (Emergency Nurses Association) and AACN (American Association of Critical Care Nurses) for example have published guidelines, recommendations, or models for safe staffing. But many areas of nursing do not. In my job working as an oncology nurse in the treatment room. ONS (Oncology Nursing Society) has no standards for staffing or position statement published. Without the current law; the treatment room which has an open area of 12-15 recliner chairs where outpatients in the hospitals cancer center can be a very unsafe place for patients if RN staffing is not adequate. There are 3 medications, Rituxin, Taxol, and Oxiliplatinol which are given commonly and frequently there that have high risk for anaphylaxisis and hypersensitivity reactions. I have personally provided bag/value/mask breathing to a patient in the treatment room after a patient's 6th dose of the infusion (no issues the other 5) within 10 minutes was restless, coughing, and airway/throat closure created a true emergency situation. The immediate, competent care of 2 Registered Nurses in the treatment room averted a serious complication. The patient was treated and transported by EMS to the EM and after an overnight observation had no ill effects following. Each time a discussion in regard to having only 1 RN present in the treatment room; we constantly refer to this situation which would make it unsafe for an RN to be alone there.

Updates to the staffing law will ensure that these staffing committees will be convened when any staffing matrix s are changed or created and bedside nurses will have the avenue to advocate for patient safety in a meaningful and legal way. Hospital nurse managers and administrators will have a legal obligation to "do the right thing"!

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