

Hello Chair Nosse, Vice Chairs Nelson and Diehl, and Members of the Committee:

For the record, my name is Chelsea Bruenn. I am a Registered Nurse and have worked as an RN for 16 years. I currently work at Kaiser Westside Medical Center, and I am a member of the Oregon Federation of Nurses and Health Professionals (OFNHP). I have participated in my Hospital's Nurse Staffing Committee for 4 years. **I am writing in strong opposition to HB 4074.**

Oregon's staffing law is not perfect, but it is working. The real problem is not the law—it's hospital administrators refusing to work in partnership to pass staffing plans. We have yet to pass staffing plans for the majority of our hospital units, including all the medical/surgical units, the intensive care unit, the operating room, the recovery room and the emergency department. Management refuses to pass a plan for our surgical recovery room (PACU) unless the plan reflects a nurse-to-patient ratio of 1:3, while Oregon law places the PACU ratio at 1:2. Kaiser management refuses to include the mandated Oregon nurse-to-patient ratio in this plan, thus we remain at an impasse. The management co-chair of our committee has openly stated they have no interest in passing staffing plans beyond those already approved by our committee, even as the hospital accrues up to \$5,000 per day in penalties. Their position indicates they would rather pay fines than find real solutions to indicate safe staffing.

As nurses, we know safe staffing cannot be reduced to a simple nurse-to-patient ratio. Acuity and intensity tools must be incorporated into our staffing plans to reflect the resources needed to care for each individual patient – and the law even directs us to use them. If those resources are not available, then the nurse's assignment should reflect this. However, hospital management refuses to pass staffing plans that treat a patient like anything more than a ratio. It doesn't matter if the patient can walk, talk and feed themselves versus a paralyzed patient who is unable to eat, drink or even move their own extremities without assistance. Including acuity and intensity tools in staffing plans is essential to accurately reflect patient needs and hold hospitals accountable. Management resists this because simple ratios alone are easier and potentially cheaper.

Patients today present with increasingly complex and acute conditions, yet nurses are expected to care for them with fewer resources than ever before. Although certified nursing assistant (CNA) staffing ratios exist, not every patient is assigned CNA support. On our medical/surgical units, each with a capacity of up to 24 patients, CNA coverage extends for up to 14 patients during a standard day shift. As a result, up to 10 patients on a unit may receive no CNA assistance at all.

In addition to their primary clinical responsibilities, nurses are frequently required to assume duties associated with other hospital roles when those positions go unfilled. These additional duties include patient transportation, prescription medication delivery, meal ordering and delivery, telemetry (or heart) monitoring, as well as unit secretary functions. When a CNA is not assigned to a patient's care team, the nurse must also absorb all CNA-related tasks.

Even under current law, safely caring for 4 patients can be a struggle. Increasing nurse-to-patient ratios to 1:5, ignoring the need for acuity standards, or delaying enforcement until 2030 will only make things worse—and patients will suffer.

Legislators, I implore you to stand with us in opposition of HB 4074, for our nurses, for our patients, for our families and friends, and for the communities we all serve.

Thank you,

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