Oregon Association of Hospitals and Health Systems

Legislative Testimony

Advocating for Oregon's Hospitals & the Patients They Serve

Committee: Senate Health Care
Bill: SB 469
Date: Feb. 16, 2015

Good Afternoon Chair Monnes-Anderson and members of the committee.

My name is Carol Bradley. I am a masters prepared registered nurse and have practiced nursing for over 40 years, including many years as a staff nurse, clinical nurse specialist, director, and chief nursing officer. I am past president of the Association of California Nurse Leaders, and the American Organization of Nurse Executives. I have served as a hospital governing board trustee, and two terms as a trustee for the California Hospital Association.

Today, I am speaking as a board member of the Oregon Association of Hospitals and Health Systems; as a board member of the Northwest Organization of Nurse Executives and as a nurse leader who is committed to safe staffing.

I am currently employed as the Senior Vice President and system Chief Nursing Officer for Legacy Health in Portland Oregon. In that role, I represent and lead a nursing staff of over 3700 registered nurses across the continuum of care helping Legacy fulfill its mission of good health for our people, our patients, our communities, and our world.

I think it is important for you to know that Legacy's nursing staff is not represented by a union, similar to many other hospitals across Oregon such as Salem and Adventist.

Legacy nurses are accustomed to speaking for themselves on practice issues and making decisions with nursing leadership in a collaborative process. I believe that our long-standing non-union status is a result of an organizational culture within Legacy that respects and gives voice and autonomy to our professional nursing staff. They are empowered to manage their own practice environment, and we have many ways of working collaboratively with our nursing staff, including our staffing committees which are functioning well at all of our hospitals as well as our system wide staffing committee.

We also have a health system leadership team that recognizes our nurses for the important contributions they make in service to our patients, families and the communities we serve. I am privileged to work as an advocate for nursing, our health system, and the association that represents Oregon's hospitals and for that reason I am here to speak in opposition to SB 469 as it is currently written.

Prior to joining Legacy Health 5 years ago, I spent 25 years of my nursing career in California. I worked in CA hospitals before, during and after the implementation of mandated staffing ratios. I have first-hand experience trying to manage patient care in an environment with rigidly defined staffing ratios. You may not be aware that while the ratio law was passed in 1999, it took almost 5 years to implement because of the complications it created in how patient care and staffing was managed. Ironically, the CA law does not require or involve nursing staff in determining staffing needs.

It is also worth noting that across our nation, after almost 15 years, California remains the only state that has chosen staffing ratios as a solution to nurse staffing concerns; only 13 states have legislated some type of staffing law and only 7 of those have chosen to adopt a staffing committee approach in law.

There were and continue to be many unintended negative consequences of the CA staffing law:

- Because of the rigidity of the regulatory interpretation of the law, many hospitals were forced to reduce other support personnel in lieu of registered nurses, regardless of patient needs. This meant that nurses were once again performing many nonprofessional duties previously provided by other personnel.
- The continuity of care was constantly interrupted, because the nurse assigned to patients was changed continually due to any off unit activity. This resulted in significant challenges for handoffs and communication.
- In some hospitals, the ratio language, which was always presented as a minimum standard, became the fixed staffing resulting in staffing reductions in some hospitals or units. It handicapped nurse leaders in advocating for staffing based on fluctuations in acuity.
- Lastly, nursing staff relationships and the team culture of units was strained because of the pressure to meet the intent of the law. Normal socialization patterns of nursing units were disrupted because of the laws strict language.
- But let's return to Oregon.

I concur that the original vision of the existing Oregon staffing law is not being achieved and the operationalization of staffing committees can be improved. This conclusion was acknowledged in the 2010 study on the Oregon staffing law conducted by Dr. Jean Seago. However, this study looked at only 7 of Oregon's 57 hospital's staffing committees.

This report supports the importance of providing the Oregon Health Authority (OHA) with the necessary resources and support to fulfill its original role to oversee the implementation and effectiveness of our staffing committees. Legislation is not the solution for addressing isolated problems at a few hospitals. It is time to do a more extensive evaluation of the current laws implementation.

As written, the proposed language in this bill does not provide any material support or improvement to our staffing processes, in fact, it simply adds more bureaucracy that has no real value or impact on how nurse staffing is accomplished in our hospitals. It also locates the ultimate authority for staffing decision- making to an external state panel far from the very nurses and hospital leadership who are ultimately responsible for patient care within their facility. This is a clear attempt to force staffing ratios on Oregon's hospitals and remove staff input from this process.

Nursing is a knowledge profession; as such we are accustomed to using evidence to guide our decision making. Anecdotal stories may get everyone emotionally committed to the topic, but data and facts are the only valid way to improve our current staffing law. I ask that you reconsider this bill and request that all stakeholders develop a collaborative solution to improving the current law. We all need to understand what problem or problems with the existing law are we are solving. We have a staffing collaborative in place; why was this group not engaged in this effort? We have a nursing leadership organization who was not involved. We also have a hospital association, a significant stakeholder who was not consulted or involved in this process.

In summary, I would like to close by sharing with you what I have come to know about nurse staffing and what makes it work:

Nurse staffing is a complicated and dynamic process. It cannot be improved by treating nurses as numbers and patients as widgets. In hospitals today, there is a constant ebb and flow of patients with constantly changing needs and acuity. In my health system our patient volumes can fluctuate as much as 100-150 patients in one day. We rely on and trust the expertise and professional judgment of our unit based nurse leaders and staff to assess and determine staffing needs based on the patient needs they are seeing within their unit.

Patient care is a team sport. A variety of support staff are necessary to ensure that nurses are able to practice at the top of their license. While hospitals choose different configurations of support staff to provide patient care, optimal staffing is not just about the RN but includes a variety of other caregivers to ensure safe and appropriate care.

All nurses are not the same. Our nursing staff is very diverse; composed of nurses with different education, knowledge and skills, and varying degrees of experience and capacity to care for patients. As a responsible nurse leader, I would never consider giving the same patient care assignment to a new graduate nurse and a seasoned critical care nurse with many years of experience. Never.

These are the very reasons why I am opposed to much of the language that is proposed in this revision of our current law.

Our staffing committees are made up of nurse leaders and nursing staff who are committed to a systematic and safe staffing system based on evidence and national benchmarks, often provided by specialty nursing organizations. They are effective. Staffing decision making belongs within our hospitals, on our nursing units with the wisdom and insight of our experienced nurses.

Thank you.