My name is Joshua Holt, I have been a Registered Nurse since 2010 and moved to Oregon in 2013 to open the Kaiser Westside Medical Center. I am an elected leader of the approximately 2,300 members of the Kaiser RN Bargaining Unit representing RNs and their work in a territory that covers two acute care hospitals, a residential psychiatric unit, and many outpatient clinics representing every medical specialty and service from Longview, Washington to Eugene, Oregon.

I have spent my professional career as a bedside nurse in Med-Surg and Critical Care departments in multiple hospitals in Missouri, Nevada, Washington, and Oregon. What I can tell you is that it is standard practice in healthcare that patient care isn't what actually drives the healthcare industry. It's the bottom line. Patient and worker safety play a second-fiddle to the cost of doing business. Repeatedly, nurses are told that their judgement on what is a safe assignment for providing high-quality care doesn't matter, if there is a bed to place a patient, that bed is going to get filled and you are going to take on the responsibility of making sure that they get treatment at the same level of care as what you would have if you were adequately staffed.

We are supposedly lucky in Oregon that we have legislation that requires hospitals to have staffing plans that are jointly developed between direct care staff and administrators. The reality is this is a sham. With an equal representation of voting members of committees that adopt these plans, establishing written parameters for minimum staffing that is based on actual evidence, national professional association guidelines, and with consideration for worker legislation and collective bargaining agreements is impossible. Management members of the committee are not authorized by their bosses to allow plans to get adopted that aren't already approved by the non-clinical spreadsheet operators in the finance office.

So what does that mean? It means that, at baseline when there isn't a pandemic or blizzard or wildfires, just normal operating times, if minimum staffing requires a Nurse-to-patient assignment of 4 nurse to 1 patients (1:4), in order to get rest and meal breaks, you must hand over your assignment to another nurse that already has a 1:4 assignment. This makes a doubled-up assignment of 1:8. In the ICU where the standard ratio may be 1:2, that's a 1:4 assignment.

In nursing, we do not babysit. We assume care for patients. When I take on another nurse's assignment for their breaks ***I*** have accepted that assignment until I have handed them back. Their care and responsibility for them falls under ***me*** with ***my*** license. In a 12-hour shift, by law and contract, we are expected to have three (3) 15-minute rest breaks and one (1) 30-minute meal break. Well so is my "buddy." And so are the nurses that come on the next shift. If you add that up, despite minimum staffing being established, a patient in a single 24-hour day has been in a doubled-up less-than-minimum assignment for **FIVE HOURS**.

We don't just watch patients, we are continuously assessing, monitoring, escalating concerns with a patient population that has become increasingly sick and complex. A doubled-up assignment, simply, **IS NOT SAFE**.

And yet, hospital administrators in Oregon are permitted, in practice, to ignore not only best-practices for safe staffing and provisioning of care, but to outright defy whatever staffing plans you can manage to get adopted. Why? Because Oregon law fails to mandate that the Oregon Health Authority actualy penalize these organizations. They get placed in a bureaucratic loop of writing “plans of correction” and submitting and resubmitting. Yet they don’t even follow their own correction plans. When brought forward, escalated, and acted against, healthcare administrators report that the staffing plans are “just guidelines” and that “we need to be good stewards of our money” and play on professional healthcare workers emotions by suggesting that inferior care is better than no care - or worse, care somewhere else. Continuously, team lead nurses are required to be assessing “productivity” using a metric of HPPD, or payroll Hours Per Patient Day, and instead of using clincial judgement to have staffing based on the acuity and intensity needs of patient care, restrict decisions on how much to staff based on budgetary metrics. There are many cases when additional staff, per the judgement of those caring for the patients, are needed and in fact there are staff that want to work extra or that have been sent home on-call to be brought back, but the budget doesn’t support it.

And that’s just for the RNs, and we do not operate alone. It takes a robust, comprehensive team of experienced professional, technical, and service staff to provide high-quality care for patients and the only thing that is a priority to staff is the Nurses, putting every other duty onto RNs who are already overworked, burnt-out, morally injured, understaffed, and quitting in droves because they cannot handle the working conditions.

We need the law to change. We need the Legislature to mandate OHA to assess serious penalties when staffing is inadequate. We need “buddy breaking” to end. We need patient and worker focused staffing laws.

Time and time again, I have heard professionals say that if they have a heart attack or a stroke, they hope it is while they are on vacation in California. Is it because if they have to be a patient in the hospital, they want to do so in sunnier weather? No. It’s because they know hospitals in California are significantly more likely to have adequate numbers of staff to respond to their critical needs because the law requires the employers to provide safe levels of staff and that doubled-up assignments do not exist.

Please. Hear what those of us who care for you and your families and want to be at your bedside when you need us are saying. We need the law to change to provide safer care in Oregon. Please support this bill and mandate the OHA have the authority and unequivocal instruction to enforce it.