Date: February 26, 2023
To: House Committee On Behavioral Health and Health Care
From: Rae Kaigler, RN

Re: Support for House Bill 2697

Chair Nosse, Vice Chairs Goodwin and Nelson, and Members of the House Committee On Behavioral Health and Health Care,

I'm a labor & delivery nurse in Portland, and I present here a couple stories to illustrate the dangerous understaffing situation that hospital management choices have caused.

First, I had a patient in room two, who had experienced a precipitous home delivery of a baby at full term the night before her scheduled cesarean delivery, and the baby had unfortunately died. She arrived via ambulance with her dead baby, who had been coded both on-site at her house and during transport. It was unclear if her baby had died shortly after delivery or had been stillborn. When I took over her care, she was a few hours postpartum and held her baby in her arms. Over the next two days and two nights, she had consistent nursing care between myself on days and another nurse on nights. She and her husband were able to keep their baby with them throughout the duration of their stay. I helped my patient to bathe her baby, cut locks of hair as keepsakes, and took photographs for her. I helped her bathe herself and sat with her while she cried. I spent hours in the room with her and her husband, providing emotional support alongside postpartum nursing care. On the day she went home, she expressed to me that the care she received during her stay had lifted her up to be able to take her first steps toward healing and that she was deeply grateful to have had two nights and two days to hold her daughter. It was important to her that I be the one to take her daughter away to the morgue.

On the second day that I cared for my patient in room two, I was assigned a second patient due to understaffing. The second patient was in room 12, and she was also losing her baby, who had anomalies incompatible with life due to a rare genetic condition. This was this patient's second baby to have developed the same genetic condition. She was terminating her pregnancy and the report that I received in the morning was that she was getting painful and beginning to look like she was in labor. I expressed to the charge nurse that the dual assignments were untenable, as the patient in room 12 seemed likely to deliver and the patient in room two needed emotional support and I felt it was important that I be the nurse to discharge her. I was told that there was no alternative due to our staffing. When I met my second patient, she was indeed laboring. She got an epidural, but was unable to get comfortable. It was only after a second epidural was placed that she finally became comfortable and I went to check in on the patient in room two. She was ready to leave the hospital and to say goodbye to her baby, but requested that I be the one to take her baby from her. As I was doing this, I was paged to room 12, where my second patient was feeling pressure

and nearing delivery. A second nurse jumped into room 12 and the patient delivered shortly after. I made it to the delivery, but was paged back to room 2 shortly after because the patient was requesting to go home (and we needed the room) and there were loose ends that needed tied up prior to discharge. While I discharged her, a third nurse took over care of room 12 as she had a postpartum hemorrhage. When I returned to room 12, there was a shift change and I gave a report to a fourth nurse to care for the patient in room 12.

The discrepancy between the nursing care received by the patients in room two and room 12 in similarly vulnerable and nightmarish situations has stuck with me for months. I feel it may be the biggest single cause of moral injury that I have incurred from chronic understaffing. Though my patient in room 12 technically had sufficient nursing care, I feel that I abandoned her, though I can think of no alternative action that would have prevented this. Prior to being forced to leave her, she told me that I was the best nurse that she'd ever had because I was so attentive and thorough. I'm sure this is why this story sticks with me—she was aware that she was receiving good nursing care, so she must have also been aware that her nurse was not available during the most poignant and dangerous moments of her hospitalization. She must've been aware that she had become a patient of the collective, or the charge nurse, or whoever was sitting at the desk and available for a moment.

My second story begins two days into a stretch off from work when I received a call from work about a baby that was being prepared for discharge but missing documentation of newborn medications. I had been a flex nurse the day this baby was born and the charge nurse asked if I remembered any specifics. My initial thought was that someone else must have given the medications to the baby, but as I pieced my memory bits together, I realized that this baby simply had not gotten medications. In fact, this baby had not gotten a newborn assessment, sepsis score, handoff, care plan, or much of our standard newborn care.

My recollection of the day is that it had been a very busy shift when I was paged to the operating room for vaginal delivery of late preterm twins. I'd already attended two c-sections and three vaginal deliveries and it was late afternoon. The twins were born and one went directly to the Neonatal Intensive Care Unit (NICU) after a difficult breech birth. The other stayed with the parents; however, she was consistently showing signs of increased work of breathing and I was assessing her frequently. About half an hour before shift change, we brought the mother and baby back into her labor room and I paged the NICU nurse to the bedside to assess the baby's breathing with me. While we were evaluating the baby, we were both paged for an urgent c-section. It was 10 minutes before the shift change. The NICU nurse told the primary nurse to have NICU come assess the baby at least once more prior to transfer to the Mother Baby Unit. I felt certain that the baby would end up in the NICU. We hurried to the operating room and when my relief nurse came, I filled her in on the operating case and told her that NICU would need to see the twin in room five and likely admit her. I didn't consider that the

baby had not had standard newborn care beyond close assessment of vitals and breathing.

I missed this care on a day that I worked 12 hours without a meal or breaks. I believe that if we'd had either enough staff for an operating room flex and a floor flex, or enough staff for meals and breaks, this baby would have received the standard of care.

Please help nurses do their jobs by passing HB 2697.

Sincerely,

Rae Kaigler, RN at a Portland-area hospital