Submitter: Foley Galvin

On Behalf Of:

Committee: House Committee On Behavioral Health and Health Care

Measure: HB2697

Members of the Committee, thank you for this opportunity to testify in support of House Bill 2697.

My name is Foley Galvin and I am an ER nurse at Sacred Heart Riverbend Hospital in Springfield, a Level II Trauma Center, a Comprehensive Stroke Center, and an Accredited Chest Pain Center, serving 8 counties across Southern and Western Oregon.

I am here today to attest that safe staffing ratios save lives, decrease patient wait times, and increase ER throughput and efficiency.

In nursing school we are taught to use Evidence Based Practices. In other words, to give the best possible care based on what the data suggests. To that point, I would like to submit for the record two articles documenting the improved outcomes that result from proper staffing ratios.

The first article states that-

“ED care time was, on average, 32% longer when the nurse was out-of-ratio, and WT increased by 10% for those waiting” (Chan et al., 2010).

The second study concludes that–

"Using a minimum staffing level of 1 RN to 4 patients may be adequate in smaller, lower-acuity EDs, especially if there [is] technician support… However, it may be inadequate for larger, higher-acuity EDs with regular crowding, especially if one takes into account the additional time involved in nonclinical activities and interruptions." (Henneman et al., 2015)

Current staffing shortages are not limited to nurses. Also understaffed is ancillary support such as pharmacists, CNAs and techs, transporters, social workers and care managers, phlebotomists and environmental services or housekeeping. When nurses lack this support, they are expected to fill all these roles for the patient. When out of ratio, the ER is unsafe and nurses are forced to ration patient care. Nurses are then also unable to perform non-clinical tasks such as updating family members on a patient's condition, assisting a patient to the bathroom, and even basic care tasks such as feeding patients.

As we know, the Covid pandemic limited patient's access to primary care, Urgent Care, home healthcare, and hospice services. These effects continue today. Just last week, I triaged a patient in the ER who came exclusively to be placed on hospice, after they had been turned away by hospice for lack of capacity. These patients often turn to the ER as their last option for care, and we are expected to do more with less. More patients, fewer nurses, and more responsibilities on the front lines.

The bill before the committee is both promising for patients and feasible for our healthcare system. In fact, these measures have already been implemented at Riverbend. I applaud Riverbend for coming to the table in a collaborative way to support ER nurses with a staffing plan that calls for 1 nurse per 3 patients. We are doing this today. House Bill 2697 would ensure that this proven, effective standard of care is broadly adopted and that patient safety comes first.

Thank you.

Chan, T.C., Killeen, J.P., Vilke, G.M., Marshall, J.B. and Castillo, E.M. (2010), Effect of Mandated Nurse–Patient Ratios on Patient Wait Time and Care Time in the Emergency Department. Academic Emergency Medicine, 17: 545-552. https://doi.org/10.1111/j.1553-2712.2010.00727.x

Henneman, P. L., Shin, S. Y., Brun, Y., Balasubramanian, H., Blank, F., & Osterweil, L. J. (2015). Using Computer Simulation to Study Nurse-to-Patient Ratios in an Emergency Department. The Journal of Nursing Administration, 45(11), 551–556. https://www.jstor.org/stable/26813342