Testimony on behalf of Tammy Dunker, of Massadona CO, in Opposition to HB22-1401

House Health & Insurance Committee, May 2, 2022

To the Ladies and Gentlemen of the committee, thank you for allowing me to testify to the serious concerns pertaining to HB22-1401.

We all know that our entire country has suffered nursing shortages for many years now. This first was acknowledged back in 2012 well before the likes of Covid. Then our governor put mandatory requirements for healthcare workers to be vaccinated further exacerbating our shortages for those that were forced to leave their careers.

This bill being brought before you does nothing to help solve this problem. In fact, it suggests fining hospitals $10,000.00 if nursing ratios are not met. There is no hospital that is holding back from hiring nurses intentionally. Furthermore, many small rural low bed census hospitals who struggle with staffing would now be asked to form yet another committee consisting of 60% RN's. I can only offer our Rural hospital as an example. We currently employee 12 RN's that would mean 7 of them will be pulled away from patient care for these committee meetings. We can ill afford this. We cannot continue to use one mistake to fix another and expect a different outcome. I fail to see how this bill will get us more nurses.

Finally requiring a nursing plan be posted to a hospital website quarterly, again will take someone to do this and monitor as well as open hospitals to legal risks. I implore you to vote against this bill. Thank you for your time.

Good afternoon, Chair and Committee Members. My name is Mary Satre and I am a licensed RN representing myself as a nurse educator who has worked with nursing students for more than 12 years. I have been a baccalaureate qualified RN since 1977.

I am with clinical students for a 12 ½ hour shift today (Monday 4/2/22) so am submitting my testimony in writing.

I am asking you, as Committee Members, to advocate for the strongest possible role for the bedside RN in staffing committee decision making – including strong and deliberate representation of all clinical units – and to hold hospitals accountable to the public for safe and effective minimum staffing requirements. The codification of Chapter 4 facility licensing regulations for Colorado is a HUGE step toward making our Colorado healthcare system safer for nurses and for those they care for.

The incredible emotional and physical stress and anxiety endured by bedside nurses is real and predates the COVID pandemic, which has served at long last to draw public and corporate attention to the situation. Having lived and worked it for a long time, I sometimes feel hypocritical as I prepare to send newly qualified nurses into such a work environment. The strain on the staff RNs with whom they work to complete their clinical experience is obvious to them in increasingly overwhelming ways. These nurses, dealing with unreliable numbers shift by shift, pay that is one quarter of what a travelling nurse can earn, and a growing level of acuity in the patients they care for – a load that was significantly affected by the COVID surges endured by our local hospitals – are acting out in passive aggressive ways with comments and attitudes that are not lost on students who are eager to enter this arena and take on the challenges. It is not surprising that many do not linger in their new work beyond the first year. They see nursing for what it has become: unsafe, unsettling, and unfulfilling. For decades, nurses have asked for better staffing and basic protections that trusted and intensively educated and prepared professionals are due.

You have an opportunity to make this happen for all of us. Please support this bill with its proposed amendments as described by my colleagues who are fortunate enough to be here with you today, in person or virtually.

Thank you!

Mary Satre, MSN, MBA, RN

Good afternoon Chair and Committee Members, I am Hannah Warnecke, a licensed RN and I represent myself as a hospital clinical bedside ICU RN for 2 years.

It is absolutely critical that something change surrounding current staffing practice in hospitals. I am asking committee members to support HB22-1401, and in any amendments made to this bill, please keep patient safety top of mind.

Hospitals, my place of work included, have repeatedly demonstrated that without a law to hold them accountable, they will not consistently staff units in a way that prioritizes safety. There are shortages we are all working through, but it is most important to note that there are other times where staff are forced by administration to run short to "improve productivity metrics" and some staff are put on-call while others are pushed to work at 150% capacity. This is not safe, and not acceptable. Among the many safety concerns, some of the many things I have observed when running short staffed include patients having to wait over 3 hours to be changed out of soiled diapers, bedbound patients not being turned adequately enough because it is so challenging for 2 RNS to have time to go into the same room together, having no staff available to respond to a bed alarm in a timely manner telling us an unsteady patient is getting out of bed and at risk of falling, call lights going unanswered for 10 min to an hour (sometimes its an emergency, sometimes its not, but until someone has time to check, we have no way to know, and when no one is there to hear the call light go off because all RNs are in rooms, then there are times there are delayed responses to emergencies), no staff out at the station to listen for IV pumps beeping to tell us that life-sustaining medications maintaining a patients blood pressure are about to run out, having less time to help less experienced nurses and having to delay the care that they need help providing, not answering the phone when the lab is calling with a critical result or a specialty doctor is calling, because all staff are in rooms trying to execute tasks as efficiently as possible and are robbed of the time to do the surveillance that appropriate staffing ratios provide. It is that surveillance that allows for safety and excellence to flourish in healthcare, and at this time it is profoundly lacking. It is that surveillance that creates quality, effective, fiscally responsible care. Not only does better staffing reduce burnout and turnover saving the tens of thousands of dollars that recruiting and training a new nurse requires, it also reduces error and omissions that extend hospital stays and increase costs. It allows for nurses to personalize care in a way that improves patient experience and outcomes.

We need to support hospitals to give them the tools to adequately staff their units, and to hold them accountable in making meaningful use of these resources.

We need standardized ratios, we need staffing committees that utilize bedside RNs, we need staffing transparency, and we need ways to report concerns to the state about unsafe staffing practices.

As I am working a 12 hour shift on the day of this hearing I am grateful for the chance to submit written testimony and thank the Committee for their time. Thank you.

Good afternoon Chair and Committee Members, I am Hannah Warnecke, a licensed RN and I represent myself as a hospital clinical bedside ICU RN for 2 years.

It is absolutely critical that something change surrounding current staffing practice in hospitals. I am asking committee members to amend HB22-1401 to include enumerated staffing ratios and support all other components of this necessary legislation. In any consideration regarding this bill, please keep patient safety top of mind.

Hospitals, my place of work included, have repeatedly demonstrated that without a law to hold them accountable, they will not consistently staff units in a way that prioritizes safety. There are shortages we are all working through, but it is most important to note that there are other times where staff are forced by administration to run short to "improve productivity metrics" and some staff are put on-call while others are pushed to work at 150% capacity. This is not safe, and not acceptable. In the intensive care unit, where nurse to patient ratios should be 1:1 or 2:1 depending on acuity, adding an additional patient to either of those assignments means patients are being robbed of anywhere from 4-6 hours of attention that they are owed in their critically ill state. Among the many safety concerns, some of the many things I have observed when running short staffed include patients having to wait over 3 hours to be changed out of soiled diapers, bedbound patients not being turned adequately enough because it is so challenging for 2 RNS to have time to go into the same room together, having no staff available to respond to a bed alarm in a timely manner telling us an unsteady patient is getting out of bed and at risk of falling, call lights going unanswered for 10 min to an hour (sometimes its an emergency, sometimes its not, but until someone has time to check, we have no way to know, and when no one is there to hear the call light go off because all RNs are in rooms, then there are times there are delayed responses to emergencies), no staff out at the station to listen for IV pumps beeping to tell us that life-sustaining medications maintaining a patients blood pressure are about to run out, having less time to help less experienced nurses and having to delay the care that they need help providing, not answering the phone when the lab is calling with a critical result or a specialty doctor is calling, because all staff are in rooms trying to execute tasks as efficiently as possible and are denied the time to do the surveillance that appropriate staffing ratios provide. It is that surveillance that allows for safety and excellence to flourish in healthcare, and at this time it is profoundly lacking. It is that surveillance that creates quality, effective, fiscally responsible care. Not only does better staffing reduce burnout and turnover saving the tens of thousands of dollars that recruiting and training a new nurse requires, it also reduces error and omissions that extend hospital stays and increase costs. It allows for nurses to personalize care in a way that improves patient experience and outcomes.

We need to support hospitals to give them the tools to adequately staff their units, and to hold them accountable in making meaningful use of these resources.

We need standardized ratios, we need staffing committees that utilize bedside RNs, we need staffing transparency, and we need ways to report concerns to the state about unsafe staffing practices.

I am grateful for the chance to submit written testimony and thank the Committee for their time.

Denver Health Chief Nursing Officer Kathy Boyle Testimony HB-1401 5.2.22

HI, I'm Kathy Boyle, Chief Nursing Officer at Denver Health and have worked in my role here for over 13 years. My clinical specialty was High Risk Labor and Delivery and I was a flight nurse. I am proud to lead and support almost 1800 nurses who practice in a wide variety of settings across our care continuum at Denver Health. On our inpatient units and the Emergency Departments, each shift a Charge RN oversees staffing with the support of the nurse manager and the Administrative Clinical Coordinator (ACC, formerly known as "House Supervisor"). We are proud of our Shared/Professional Governance model in which staff participated in choosing a "councilor" model in 2016 when we revitalized our model. Each inpatient unit selects nursing staff to be part of their Area Based Council (ABC). The council assists with unit operations, decision-making and unit-based projects.

Over the past 13+ years, all units have utilized nursing staffing plans based on professional nursing standards for that nursing practice area. Unit staffing needs are reviewed in meetings including all Charge RNs and the ACC, 4 times per day at 9 AM, 4 PM, 9 PM and 4 AM. Charge RNs adjust unit needs based on patient volume, patient acuity and staff competency and experience. Units use an on-call system and/or Float Pool staff to support unit staffing needs beyond the base schedule and to cover "sick calls".

As CNO I participated in the development and revision of Chapter 4 Nursing Services nurse staffing standards. Colorado Hospital Association (CHA), the Colorado Nurses Association (CNA), Colorado Organization for Nurse Leaders (CONL), Chief Nursing Officers/Executives (CNO/CNE) from across Colorado, and others met for over 18 months in 2020 and 2021 to develop language and negotiate details related to inpatient and emergency department staffing. In good faith we agreed to the language and standards and we are now in the process of implementing those regulations.

I am disappointed that after over 18 months of diligent work on Chapter 4 regulations, the introduction of HB-22-1401 reflects that hospitals are not following those agreed upon Chapter 4 regulations, when indeed we are in the process of following each standard.

The October 15, 2021 Chapter 4 rules require the use of a staffing committee model with at least 50% frontline nurses to oversee the master staffing plans. At Denver Health, the Nurse Council, including staff nurses and charge nurses, agreed to include master staffing plan oversight and monitoring as part of their committee role. The annual review of staffing plans with each individual nurse is in process and started with education through our learning management system with a review of the Chapter 4 regulations, the Denver Health Inpatient Master Staffing Plan Guideline, the staffing plan spreadsheet for each unit, and an attestation of staff completion. We are over 91% complete in this process and nurse managers will complete individual staff reviews during the second quarter of 2022. The Nurse Council is accountable for reviewing staffing plans annually and as changes occur. In fact, we will be reviewing a change in staffing plans for 2 units in May. As CNO, I have reported annually to the hospital governing body regarding staffing and the Nurse Council will now create that report with me and including patient and staff outcomes.

While I have not seen the forthcoming amendments based on conversations I have been part of with CHA, I believe those amendments would address some of my concerns at this time.

However, I would raise the point again that I am greatly disappointed to be in this position now as we spent over 18 months in rule making on this issue in 2020 and 2021.

Thank you for your time and consideration of my concerns.

Kathy

Kathy Boyle, PhD, RN, NEA-BC

Chief Nursing Officer

Denver Health

303-602-4957

Kathy.boyle@dhha.org

House Health & Insurance
05/02/2022 01:30 PM
HB22-1401 Hospital Nurse Staffing Standards
Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Barbara adams For Self	Staff to patient ratios are directly related to patient care, satisfaction, and safety. It needs to be said that the bill needs to be amended to include safe staffing ratios based on acuity per unit. Requiring a nurse to take on more than safe levels has been shown to increase errors, falls, safety events, and near misses. In my time working with covid patients, our ratios were 1:3. As time went on, it because 1: 4 and then 1:5. As those rations rose, staff was not able to monitor patients as effectively. You can see the importance of adequately monitoring covid patients. Their vital signs and labs must be closely monitored to watch for the body's compensation. This is marked by increased respiratory and heart rate and decreased oxygenation. If caught quickly, we can oxygenate appropriately and decrease the risk of needing intubation. If not, the body begins to overcompensate and eventually tires out. This leads to higher oxygen needs and increases the likelihood of the patient needing ICU-level care. Falls occur when staffing is not appropriate because there are not enough hands on deck to answer call lights in a timely fashion. Covid patients are more likely to have falls due to decreased oxygen levels in the brain leading to confusion, weakness, and IV lines/ tubing to trip on. Near misses and misses occur due to the number of tasks the nurse is assigned, those greatly increase with the ratios do not reflect the acuity. 5 independent patients, continent and have no IV fluids are going to take much less time than 5 patients that are dependent, incontinent, and have IV antibiotics. To assign the first set of patients to one nurse and expect the same level of care to be given to the second 5 patients of another nurse is absurd. The second set of patients is going to require more hands-on care and closer monitoring and it is unsafe to have an assignment of 5 at that point.
Heather Vincent-Richichi None Medical Intenstive at Denver Health	Hello, I just wanted to offer my perspective on the nurse staffing and ratios that I have observed in my role as nurse manager of the MICU over the past four years. In my time at Denver Health, we have always been supported in maintaining our 2:1 ICU ratios. We make staffing decisions based on patient acuity and safety. We are supported in further limiting our ratio to 1:1 when the patient acuity dictates. When the Covid pandemic led to an increase in patients, the time-consuming workload of donning PPE, and being stuck in one patients' room for lengthy periods of time, the staff clearly communicated that we needed additional support. Denver Health leadership responded with the

	addition of travel nurse staff which allowed us to not only maintain our normal ratios but to staff 1-2 additional resource nurses on each shift as support and an extra set of hands. Throughout my time here Denver Health has supported our nursing staff with safe and appropriate ratios. Thank you, Heather Vincent-Richichi
William Needham Against Self	Mandating staff ratios is detrimental for multiple reasons. It dismisses a variety of other factors in the context of patient care which include (but are not limited to) nurse experience level, patient acuity or severity of illness, and available ancillary services. Nurses & Nurse Leaders are very skilled in adapting to changes in the care environment. Part of that includes diverting less busy nursing/resources to situations that require more nursing help/support. As these situations evolve and are dynamic, Nursing/resources could need to be arranged multiple times in the course of just a few hours. Mandating nurse ratios may sound good at face value, but it will limit or eliminate the Nurse and Nurse Leader's greatest skill.
Samantha Ginsburg Amend Self	I am Samantha Ginsburg, a licensed PCCN RN and I represent myself as a hospital clinical bedside RN for 3 years. I am here today asking you as Committee members to amend this bill. I remember going to a lecture in the education center of my hospital at the end of 2019, with the infection prevention head leading a discussion on how the hospital would reorganize to address this incoming virus on the way across the sea. I remember looking around at my coworkers, enjoying the comradery and spirit--urge to fight and take action for our patients and community--that was palpable throughout the room. As I think back to that day, very few of those employees still work at the hospital, including the IP (infection prevention) team. Some of them don't even work in Healthcare anymore. We didn't know at the time that everything would change for the worse for the patients and the people who cared for them. With a pandemic at our feet and a need to take care of our patients, hospitals as well as our social system has been stretched to its limits. We continue to have the same amount of patients without the staff to safely care for them. These "abnormal staffing conditions" have become the expectation, also known as unsafe staffing. Leading to people quitting as they make choices to leave what is dangerous for their patients, their families, their backs--their livelihoods. I have yet to meet one nurse who went into the profession because they want to do a disservice to their patients--but that is what happens every day when we walk into the hospital and are told to work our bodies harder, to do more, and with less help.

	As a charge nurse and leader in my community, I often find myself struggling to answer why. Why do we have an extremely sick floor that specifically targets sick patients--and it's okay to have one nurse responsible for 5 patients? Would I want my family member to be that stretch point? There have been so many occasions where, in order to keep 4 patients safe, I had to ignore the 5th. Safety, in a hospital setting where we are trying to figure out and heal those who are sick, give peace to those who won't get better... safety has to come first.
Elizabeth Marnell Amend Self	I am writing to you today as a nurse serving in Colorado. I worked the floor during COVID and have seen our health care system at its worst. I have gone home with bruises on my face from 12 hour days in a respirator unsure if I would bring a deadly virus home to my family. We abstained from family events because of my career and as a result missed the last change at Thanksgiving or Christmas with my father in law. We did it because we knew we could be dangerous to our family. Despite these sacrifices there is a looming problem in American healthcare today. There is not enough staff. The ratio of patients to staff is DANGEROUS. And there is ample research that demonstrates that a standard med/surg nurse who has more than 4 patients will see a 7-10% increase in mortality amongst their patients. This is evidence based practice. The foundation of nursing practices is evidence based. And the evidence shows that without proper ratios patient outcomes are worse. But this costs hospitals money so they do not staff the floors properly. And they make nurses take unsafe ratios. I have worked with 5 high acuity patients during both day and night shift. The threat of a 6th patient is ever looming over us. I have taken 6 patients. That puts all my patients at risk. That increases the chance of medical errors being made. It does not give me enough time with each patient and things will be missed- which might lead to someone's death. This is not why I became a nurse. Nursing is harmful and patients suffer because we do not have safe staffing ratios. But ratios without consideration of acuity of the patients is just a useless number. The bill before us today does not address the issue of ratios much less acuity. And realizing we must start somewhere I feel that ratios for the safe staffing and practice of nursing care must be included in this bill. Committees at each hospital need to be able to back up nurses when they say they have an unsafe amount of patients. Safe Harbor laws that prevent the hospitals from retaliating against a nurse who refuses to take more because their workload is unsafe also need to be enacted. The field of nursing is dangerous. Our patients are in danger because filling the hospital and making as much money as possible wins out against patient safety. This must stop. Please amend the bill to add ratios- ratios based on acuity per unit. Respectfully, Elizabeth RN
Michelle Shiao	Madam Chair and Committee Members,

Against Self	I have been a registered nurse for over 20 years in both Indiana and Colorado. I feel strongly that HB 1401 is the wrong approach for Colorado nurses. The bill could be disastrous for our profession and for the care of millions of Coloradoans. I am opposed to HB 1401. The nursing profession includes highly intelligent and educated people that have worked incredibly hard over the last two years to combat Covid. We have proven to be flexible, innovative and adaptable. The very idea of having these highly intelligent individuals be hyper regulated by the government is frankly tragic. HB 1401 regulates our ability to be creative and innovative to move patient care forward in a positive way. Our nurses are tired, however they are resilient. HB 1401 attempts to be a fix all with one broad stroke of the pen. The bill is inflexible. As nurses we are taught to be flexible and "one size does not fit all". They know BEST how to staff their departments, not the government. Everyone needs to be supporting these nurses, not tying their hands. The nurses have rallied around our patients more than ever over the last two years, and I am asking that you rally around them now in opposition of HB 1401. Nurses have given their all in these last two years. Nurses have been innovative and creative, we need to encourage more of this because Coloradoans deserve this. HB 1401 ultimately limits access to care for patients across the state by tying our hands with the bill as written. Patients and their loved ones deserve to understand the impact of this bill as written. Please honor our nurses by voting in opposition to HB 1401. Our nurses, patients and their loved ones deserve a NO vote. Respectfully submitted, Michelle Shiao, DNP, RN, CENP, NE-BC

House Health & Insurance
04/27/2022 01:30 PM
HB22-1401 Hospital Nurse Staffing Standards
Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Jessica Zielinski Amend Self	Good Afternoon Chair and Committee Members, I am Jessica Zielinski, a licensed RN and I represent myself as a hospital clinical bedside RN for one year. I am writing today to ask you to amend this bill to strengthen the role of the bedside nurse in staffing committee decisions. In the last two years, an already tenuous situation was made far worse by COVID. In the unit on which I currently work, we are heavily staffed by nurses with less than 5 years experience, as many of our experienced nurses have moved away from bedside nursing or left for travel nursing jobs. As I watch more and more experienced staff RNs leave bedside nursing due to burnout from high staffing ratios, I wonder who I'm going to ask for help when I know something is wrong with my patient but I don't know quite how to fix it. A unit with a high percentage of newly graduated nurses is minimally functional, and does not provide safe patient care for current patients, nor the opportunity to learn from more experienced nurses to develop the clinical judgement that is a hallmark of high-quality patient care. Additionally, we are still running staffing ratios that are much higher than those pre-COVID. Not only does this cause burnout among current nurses, it is unsafe for patients. When I have a patient load with multiple unstable patients, it is important to notice subtle changes, to intervene before serious decline. When I am extremely busy because of my patient load, I am terrified that I will miss these subtle changes because I do not have the time to adequately assess and spend time with each patient. When staffing decisions are made by those without clinical experience, patient acuity is often disregarded. It is one thing to take care of 5 stable patients on an ortho floor; it is completely different to take care of 5 unstable patients who are running drips that require close monitoring of vital signs. Bedside nurses understand the importance of reviewing patient ratios in terms of patient acuity, and should be closely involved in making staffing ratio decisions. It is in every patient's best interest to hold hospitals publicly accountable for safe nurse to patient ratios. Thank you for your time, and for addressing this critically important issue.
kayleigh miller Amend Self	Hello, my name is Kayleigh, I am a registered nurse and I represent myself as a hospital clinical bedside RN for just over a year. I am sharing today in hopes that the committee will amend this bill. It is my hope that this legislation will: Strengthen hospital accountability with public reporting and strengthen the role of bedside RN in staffing committee decision making. Hospitals claim that patient safety is their number one goal, yet hospital beds remain full, while staffing is meager, leaving

	nurses to pick up the greater responsibility for more patients and not giving proper care to any of them. When hospital corporations choose to think only about the money, however, this leaves nurses stretched thin, and understaffed, and leaves patient's without the proper care that they need, leading to longer hospital stays, more frequent mistakes, and unintended instances of neglect. Safe nursing ratios are at the heart of patient safety and high quality patient care. Hospitals need to be held accountable to staff floors appropriately in order to keep patients safe. Yet, I find that it is the norm, not the exception, that leaves nurses stretched thin, caring for too many patients. In my time as a nurse I've seen how the current system lends itself to incentivize lower staffing ratios. Under the proposed legislation, I firmly believe that this would not be remedied, rather we would continue under a broken system that does a disservice to patients, and the people who serve them. Without clear and firm outside pressure hospital administrations will not be forced to address this issue. Every nurse's intent is to treat every patient like family, yet with the current system we cannot give the care that we desire to give. Please help us accomplish this by helping establish firmer boundaries that hold hospitals accountable. Thank you for your time.