



March 24, 2021

Ohio House Commerce & Labor Committee  
Chairman Dick Stein  
Ohio Statehouse  
1 Capitol Square  
Columbus, OH 43215

RE: House Bill 163 – Nurse Overtime

Dear Chairman Stein, Vice Chair Johnson, Ranking Member Lepore-Hagan, and members of the House Commerce & Labor Committee:

My name is Shelly Malberti and I am a registered nurse. I am a former Board member of the Ohio Nurses Association Board, an Associate Professor of Nursing at Cuyahoga Community College, and a former Chief Nursing Officer. I have held various level positions in health care including staff nurse, nurse manager, and Chief Nursing Officer (CNO) of a specialty hospital.

Before I begin, I want everyone to know that I understand the importance of making a profit. Paying for salaries, overhead, benefits and other expenses require organizations to make money. To ensure an organization's sustainability, all members of the establishment must, in some way, contribute to the company's bottom line to ensure efficiency and keep costs under control. However, intentionally cutting nursing budgets and encouraging nursing managers and supervisors to short staff and use mandatory overtime as a tool to increase profits places patients at risk and is an unacceptable practice; yet one that happens every day in hospitals throughout the United States.

So, my focus here today is to discuss the importance of eliminating mandatory overtime in hospital throughout the state of Ohio. I want to clarify that this bill does not eliminate the use of overtime. This bill does not eliminate the hospital's ability to flex staff. This bill does allow nurses to say – I cannot safely work additional hours over and above the hours that I have just completed. I think by now, many of you of heard the personal stories from nurses whom have been witness to or directly involved in negative outcomes due to the fatigue associated with being forced to work when too tired to make safe, clinically sound decisions. Keep in mind that a nurse working extra hours is not the same as working extra hours at a desk job. I know, I've done both. Sitting at my desk reviewing financial statements or writing policy and procedure does not have the same or even remotely close physical, intellectual, or emotional demands of the registered nurse at the bedside.

Today, I would like to shift the conversation to accountability and responsibility of the hospitals to ensure safe and adequate staffing. The complexity of nursing units in today's hospitals require adequate resources to ensure safe nursing practice. If the hospital accepts patients into their care, then why are they not held accountable to ensuring that the resources are available to care for these patients? Mandatory overtime is not a staffing solution. It is not even a band aid. Putting a band aid over a hemorrhage is an ineffective treatment.



The elephant in the room is - Budgeting decisions are made that directly impact staffing. Individuals within the organization are often aware of these decisions yet they fail to act to correct the nurse staffing issues. For example, I remember when we were implementing the electronic medical record (EMR). EMRs were new to the industry at that time, and nurses needed an extensive amount of training. We had a written plan for the hospital and each nurse would need to spend 4 hours per month in classroom training with a simulated EMR. The rollout would take several months – I think it was 6 months. I was reviewing my annual budget and noted that we had not added this additional expense into my salary requirements for my unit. I brought it to the attention of the hospital’s Chief Financial Officer. I was told – don’t worry about that, we will get creative with staffing when the time comes. Well, we moved forward with our eyes wide open and without a plan for staffing. Each month my unit schedule was short approximately 100 hours of nursing time. What do you think happened? I had suggested signing traveling nurses to cover those hours. The request was denied. I suggested contracting with a local agency so we could have consistent staffing. It was denied. The nurses proposed a voluntary on-call schedule, where they would be paid a nominal fee if they signed up for holes in the schedule. If they were not called in, they would be paid that nominal amount (I think it was \$3 or \$5/hr). If they were called in, they would be paid time and a half for the entire shift they signed up for. It was denied.

We just moved forward, trying to fill holes in the schedule hour by hour. Sometimes it would take 3 nurses to cover a 12-hour shift (each working 4 hours), which by the way – nothing ever gets done. You can pass some meds and you’re done for the day. Nobody was monitoring the patient for vague changes in his or her condition. The little changes in patient conditions went unnoticed because no one had the patient an hour ago. The nurses did not have the time to assess and establish baseline assessments. You know the little changes – respirations that became a little faster, and a little more labored. Heart rate that was a little faster. Skin that was a little different in color. All of these changes went unchecked. We will never know the true impact of this decision.

I would like to provide another example of why we need this law. A few years ago, I was employed as a Chief Nursing Officer (CNO) of a specialty hospital for an organization that owns several hospitals throughout the United States. I reported directly to a regional supervisor, who was also a nurse. During my tenure, we would have weekly financial conference calls, and during the call the CNOs’ were often reminded of their responsibility to *tow the company line*, and if unable to do so, we were told in no uncertain terms that the organization could and would find someone else that to do it for them. Also note, that conversations regarding short staffing were always encrypted. No one overtly said, “my nurses are too fatigued to continue to work these hours”. So, I say to you - when you meet with hospital executives, no one is going to say these staffing issues exist or these issues are wide spread, but they are. Nurse managers and CNOs are not going to verbalize their concerns for many reasons - fear of job stability, or fear of liability. It is the elephant in the room. I am free to talk about it because my job is no longer on the line. I no longer have the fear of retaliation.

Also during my tenure as CNO, incentive packages such as weekender program was eliminated, citing cost. This program paid nurses more per hour but in return they had to work every weekend. This type of program was very popular with working parents. In fact, I had a list of nurses waiting for an open weekender position. My weekend staff was a group of well-trained nurses who were more experienced and autonomous than the weekday staff. I preferred my novice staff to work weekdays when resources and mentorship were readily available. However, the organization cited high costs and eliminated the program. Several nurses left due to the changes. I am confident the cost of recruitment and training



associated with filling these vacancies far surpassed the cost of the weekender program. But the organization chose, instead, to work short-staffed or use overtime to fill holes in the schedule.

I would also like to share that use of mandatory overtime and lack of nursing resources is not a new problem, but one that has continued to get worse over the past few decades. When I begin my career in 1986, we occasionally had staffing issues. Nurses pitched in and worked extra. But over the years, working conditions have continued to deteriorate. Nurses have left the bedside and the ones who remain can no longer handle the unfathomable demands. Even in today's global pandemic, I am confident that Ohio nurses are not surprised by the publicized staffing issues as a result of COVID-19. The pandemic has merely exposed and exacerbated an already existing problem.

In 2008, Ohio passed its first safe staffing legislation requiring hospitals to have written nursing services staffing plans that included input from staff nurses. I was working as a manager when the hospital held the first meeting. The conference room was bursting at the seams with nurses eager to have input into staffing plans. I was so excited. I remember telling my director, "Look at all these nurses. They want to be involved. Isn't this exciting?" She responded by saying, "You better watch what you say. If someone hears you, they are going to think you're a union girl and that will be career limiting." That was and continues to be the culture in our hospitals. It existed then and it exists now. Patient advocacy, patient safety, nurse advocacy and nurse safety is not a welcome message especially if it may require a financial investment.

I would like to thank you for the opportunity to provide written testimony and share my experiences today. I respectfully request your support in protecting Ohio's patients and nurses with the passage of HB 163.

Sincerely,

Shelly Malberti, DNP, RN  
Past Vice President  
Ohio Nurses Association