HB 285 – Nurse Workforce & Safe Patient Care Act
Proponent Testimony by Regina Miller, RN

Chair Swearingen, Vice Chair Gross, Ranking Member Somani, and members of the Health Provider Services Committee.

My name is Regina Miller, and I've been a nurse for 19 years. I recently left the ER, an area that is frequently understaffed. You may not think this impacts you, but here's how it does:

1. Increased Patient Wait Times

- **Delayed Triage:** Insufficient staff means patients wait longer to be assessed, delaying critical interventions. Conditions like heart attacks, strokes, or sepsis may go unnoticed in the backlog.
- **Higher LWBS (Left Without Being Seen) Rates:** Prolonged wait times frustrate patients, leading some to leave before receiving care. This can result in worsening conditions and avoidable re-admissions.

2. Compromised Patient Safety

- **Delayed Identification of Critical Conditions:** Inadequate staffing can lead to rushed or incomplete assessments, increasing the risk of overlooking life-threatening conditions.
- **Increased Medical Errors:** Overburdened staff are more prone to errors in prioritization, medication administration, or documentation, with severe repercussions for patient health.

3. Reduced Quality of Care

- **Decreased Time for Patient Assessment:** In busy triage settings, nurses may not have enough time to thoroughly assess each patient, leading to misclassification of acuity levels.
- **Reduced Patient Satisfaction:** Long wait times, poor communication, and perceived inattention contribute to lower patient satisfaction scores, which can negatively affect hospital ratings and funding.

4. Increased Stress and Burnout Among Staff

- **Higher Workload:** Insufficient staffing forces existing personnel to handle more patients without adequate breaks, leading to burnout, fatigue, and higher turnover—a vicious cycle of understaffing.
- **Morale Issues:** Constantly working in an understaffed environment causes frustration, disengagement, and a decline in teamwork, further impacting patient care.

5. Overflow into Other Units (e.g., PACU)

- **Delayed Transfers:** Insufficient staffing in the ER creates bottlenecks that delay patient flow into other units, including the PACU. Patients "boarded" in the ER face increased risks of hospital-acquired infections and compromised care quality.
- **Strained Communication:** Poor staffing disrupts coordination between departments, leading to miscommunication and delays in patient transfers.

6. Increased Risk of Sentinel Events

- **Patient Deterioration:** Delays in triaging critically ill patients can result in adverse events, preventable complications, or even death. Inadequate monitoring and delays in treatment heighten these risks.
- **Legal and Financial Consequences:** Hospitals face potential legal repercussions, fines, and increased liability insurance costs if poor staffing contributes to adverse outcomes.

Addressing these issues requires hospital administrators to prioritize adequate staffing levels, provide support resources, and ensure robust training for triage staff.

As an ER nurse, I never once received a lunch break during my 12-hour shifts. I was very good at my job, but I had to leave due to the aftermath of COVID-19 and the moral distress of not being able to care for patients adequately. It's a wonder there are any nurses left at all.

Please support **HB 285** to ensure safe staffing standards and protect both patients and healthcare workers.

Sincerely,

Regina Miller, RN