HB 285 – Nurse Workforce & Safe Patient Care Act
Proponent Testimony by Gina Omolo RN

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

As a nurse for 30 years, I have worked without safe staffing ratios for patient safety and nurses' safety. I remember one time I was working a step-down unit at a public hospital and we had beds without patients in it. Staffing was 2 RNs and 1 PCT we shared with another unit. Our staffing guidelines were 3-4 per RN, but that was dependent on what the nursing supervisor said was available and if they thought the acuity was stable for 3-4 or more patients per shift. Sometimes an RN would have up to 7 patients per shift. So this night we had 10 patients with 3 open beds. As the night progressed, we received admissions. I tried to divert one of the admissions to ICU due to the patient was going into organ failure and it was denied. At the time of that patients arrival, a trached and vented pt had a resp rate of 60 and we had a patient that had a cardiac cath that was on bedrest due to the cath sheath from the groin was recently pulled. The cardiac cath patient was a wanted person by authorities so his goal was to leave before midnight. Needless to say, he started bleeding from his artery after getting up and trying to leave. It was a blood bath with a drop in MAP. All of this was occurring between 7pm-11pm on a 7p-7a shift. When called for help there was no help available. Respiratory was not available, the nursing supervisor wasn't available. Our staff on-call was given 7p-12p off and possible call in after 12am. I was able to convince the nursing supervisor that the admission needed to go to ICU, doctors order was obtained, and the patient was admitted on my unit because she came to my unit first and then transferred. Her care was delayed while trying to take care of priority patients. When she was a priority patient as well. Very dangerous night for practicing nursing. And there are more examples available of unsafe nursing due to lack of staffing ratios.

If we had staffing ratios we would have had 3 RNs with a 4th one available to come in for acuity and/or staffing ratios. Which would have been manageable taking care of these very sick patients.

Another concern or maybe the biggest concern is business administration using staffing models that is driven by the dollar mainly. Another example during COVID, there were 6 ECMOs available, there were only 8 nurses trained to manage ECMOs in the hospital. The nurses worked 3 day 12-hour shifts per week. The nursing manager was told by administration to use all the ECMOs because they were getting $25000/day for ECMO patents. The manager said no because she didn't have enough nurses trained to manage ECMO patients and training to manage ECMO patients requires experience and long training. It was a patient safety issue. But the business administration continued to bully the nurse manager to use all the ECMOs available. She resisted and was blackballed by the organization to the point she had to leave the organization for standing up for patient safety verses the business administrations greed for the dollar.

Ohioans deserve better. We are talking about people, someone's father/mother, son/daughter, spouse. Nurses did not go to nursing school to work for billion-dollar organizations to sustain moral injury while trying to provide the right care for the patients entrusted to us to care for. Lack of support from the organization that has continuously put the bottom line as profit over patient safety and nurses safe nursing practice causes burnout and nurses to leave the profession. Literature shows a couple of things, nurses leave due to burn out and with the number of nurses we have

licensed, there shouldn't be a nursing shortage. Bad business practices from organizations have caused nurses to leave nursing. Not the patients, not the skills required to manage patients in all settings.

In Solidarity,

Gina Omolo RN