HB 285 – Nurse Workforce & Safe Patient Care Act
Proponent Testimony by Caitlin Cannady, BSN, RN, CCRN

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

My name is Caitlin Cannady and I have been a bedside nurse for over 11 years in Ohio. During this time I have worked both dayshift and nightshift in many units including Medical-Surgical, Intermediate, and Critical Care. On those units, I have taken on a multitude of roles including charge nurse, preceptor, rapid-response nurse, evidence-based council member, and unit-based council member just to name a few. Most recently, I have been certified as a critical care nurse. This accomplishment validates my level of knowledge and expertise with critical care patients and embodies my dedication to maintaining excellence in my nursing practice.

I can attest that nurses are leaving the bedside in droves due to burnout related to staffing ratios in the wake of the pandemic. In the organization I work for, staffing ratios can be as high as 1:6-7 in med-surg, 1:4 in intermediate, and 1:3 in critical care. While these ratios are considered a "flexed" assignment and are avoided when possible, the reality is that it happens far more often than should be acceptable. There is an incorrect assumption that night-shift nurses can take more patients than day-shift nurses because the patients will be asleep. This is often not the case as it does not take into account the tasks that need to be completed, charting that needs to be done, and patients who are confused or having trouble sleeping in the hospital. The critical care and intermediate patients require around-the-clock care that is not conducive to sleeping through the night. Emergencies can happen at any hour and often do happen in the middle of the night. Patient ratios should not be based on shift, but rather based on acuity.

The pandemic pushed nursing ratios higher due to the influx of patients and the severity of their acuity. Pre-covid, a nurse would have only one patient that was proned and paralyzed. During the pandemic, and even after, it was not uncommon to have two. Smaller hospitals had to adapt to keeping and providing care for the critically ill patients they would normally send to a larger hospital as everyone was at max capacity. Nurses who were not accustomed to the acuity of those patients not only had to adapt to the increased acuity, but also to the increased patient ratio. We did what we had to do during that crisis to survive, but hospital systems realized if we did it once then surely we can do it again and again. My colleagues and I lived in survival mode, which is not sustainable long term. The pandemic has changed the face of bedside nursing whether we want to admit it or not. So many of the nurses I worked with have since left bedside nursing because staffing never recovered to pre-pandemic levels. There are even nurses who did not work through the pandemic who are leaving the profession altogether because of the needless stressful nature of the job.

Evidence-based practice supports the correlation between an increased nurse-to-patient ratio with an increase in sentinel events. An increase in falls can be directly linked to staffing shortages as there is not anyone available to answer call lights in a timely manner, take a patient to the toilet, or respond to a bed alarm. I have seen this time and again as a rapid-response nurse. Acute changes in patient conditions have not been noticed promptly leading to patients requiring higher levels of care. It is safe to say that patient safety suffers the most when nurses are overworked.

In summary, it is imperative for the good of our patients that we enforce safe staffing and hold hospitals accountable. This bill will ensure that hospitals must comply with what evidence has already proved: safe staffing ratios can save patient lives.

Thank you for your time.

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