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21 DR. SIMMER: The Commission welcomes its next
22 participant, number seven, Virginia Hosbach.
23 MS. HOSBACH: Thank you for the opportunity
24 to share my perspectives. I'm sorry for my voice.
25 But I am here as a family member, as a nurse, and as a

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1 faculty member. I have taught for 26 years in
2 different schools of nursing.
3 But as a family member, I'd like to talk
4 about a situation that happened with my father-in-law
5 in a southeast Michigan trauma one emergency room. He
6 was admitted on a Monday morning at 10 a.m. with
7 shortness of breath, with a history of COPD,
8 congestive failure, and diabetes.
9 His immediate assessment and care was
10 adequate but by Monday evening he was still in the
11 emergency room. They did not have any beds, so they
12 put him in ER holding.
13 During the night and the next day, his health
14 situation declined. His shortness of breath became
15 much more severe. And when my husband got there on
16 Friday -- or, I'm sorry, on Tuesday about five
17 o'clock, he couldn't get anyone in that emergency room
18 to look at his dad, who was now nonresponsive. This
19 man walked -- or came in the emergency room talking
20 and he was no longer responsive.
21 He called me. I was an hour away. And I
22 said, "I'll be right there." And I called the
23 emergency room desk and said somebody please go
24 re-assess him because his mental status changes have
25 been profound. And they told him and they told me

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1 that they had paged the cardiac residents.
2 When I got there, his level of consciousness
3 was very diminished. He was not coherent. His blood
4 glucose was okay. I talked to the staff and said,
5 "What is happening here?" And they told me they
6 called the cardiac residents. I said, "You told me
7 that an hour ago. This man needs to be re-assessed.
8 Something is happening neurologically, metabolically,
9 or cardiac, but something is going on. This man was
10 talking yesterday."
11 I also reminded them as ER professionals they

12 should be the epitome of assessment. Their skill sets
13 should be unbelievable if they're going to work in the
14 emergency room.
15 They called the attending finally and he
16 ordered a CAT scan. In the meantime, finally with a
17 lot of pushing on my part, they brought down the
18 medical ICU resident. The medical ICU resident took a
19 history from me and drew blood gases. Then they did
20 the CAT scan, and the gas results came back and my
21 father-in-law's CO-2 was well over a hundred and he
22 was in carbon dioxide narcosis. He was on a vent in
23 minutes and he was within minutes of a respiratory
24 arrest.
25 From a safety perspective, I did write a very

1 long letter to the institution and to the players that
2 I felt needed to know that there was a process flaw
3 and a staffing flaw here.
4 From a safety perspective, I believe patients
5 in emergency room holding should not have their care
6 on hold, that the staffing should not compromise their
7 well-being because an ICU bed or a step-down bed or a
8 regular medical bed is not available.
9 I think that from a perspective of ER holding
10 that the staff should see these patients as high
11 acuity and render the appropriate care. And once
12 again, because a patient is in holding doesn't mean
13 their care should be in holding.
14 The second issue I'd like to present to this
15 board is the fact that we have talked a lot about
16 patient education, and we do push patient teaching and
17 documentation, but my challenge to you is to somehow
18 mandate, ask you to mandate that we assess learning,
19 because if we don't assess learning and document it,
20 how will we verify patient and family understanding so
21 that there can be follow-up at home, whether it be on
22 medication, administration, wound care, injections,
23 whatever, because one must never assume that something
24 taught is something learned.
25 And the third issue is about the nursing

1 shortage. I would like you to be on notice that we
2 are, in the different school of nursing in Michigan,
3 are turning away hundreds of qualified applicants that

4 could be and would be very, very good nurses if they
5 could get into a school, but because of the faculty
6 shortages, because of the clinical arena shortages,
7 because we're not looking outside of the box in terms
8 of doing things such as they're using at the Community
9 College up here with affiliations with active clinical
10 faculty -- or clinical nurses, we are going to
11 continue to have a shortage.
12 But truly I would say for every nurse that
13 gets into a nursing program, two are turned away, in
14 the last data that I saw.
15 80 -- there are 80 million baby-boomers
16 working today. Many of them, many of our nurses, are
17 baby-boomers. We are being replaced by only 46
18 million Gen-X'ers. So just by the sheer numbers of
19 the generational differences, replacing our nurses is
20 going to be even more critical than it is today.
21 It's been said that recruitment in middle
22 school is a really great time to encourage young folks
23 to consider being healthcare professionals. Anything
24 that we can do to promote our healthcare professionals
25 to that population would be beneficial, but, again, we

1 have many, many people who would make excellent nurses
2 based on their grade point averages but they can't get
3 into nursing programs. Thank you.
4 DR. SIMMER: Thank you.