

4 And now we would like to welcome participant
5 number 15, Lori Clairmont.

6 MS. CLAIRMONT: Good afternoon. I'm Lori
7 Clairmont, a registered nurse, and I'd like to speak
8 to my experiences as a midnight charge nurse.

9 It's not uncommon at all to spend at least
10 two hours at the beginning of my shift trying to staff
11 my shift and the next shift coming on. It's a source
12 of huge frustration for the charge nurses, and it
13 takes us away from providing our staff with the
14 support they need, especially in light that we have a
15 lot of new graduates. This makes for a
16 less-than-ideal situation.

17 And if we don't find the staffing, we rarely
18 have to have someone stay over mandatorily, but
19 someone normally buckles and will stay an extra four
20 hours to get us through, which puts our nurses working
21 double shifts, up to 16 hours, and they get tired. So
22 that's -- it's a huge problem that we do every single
23 day.

24 The unit I work on is a telemetry unit and we
25 work with stroke patients, and I'm also concerned that
1 at nighttime they decrease our staffing. It is busier
2 during the day, more patient care and therapies, but
3 there's also more eyes around during the day; family
4 members and the therapists working.

5 It's on the average night we have
6 approximately three RNs and one aide to 17 patients.
7 Our stroke patients most of the time do not realize
8 their deficits. It puts them at an incredibly high
9 risk for injuries. Falls are very frequent. And a
10 lot of times it takes more than one of us to assist
11 them, whether going to the bathroom or taking care of
12 incontinence or whatever other problem that they have.

13 If there's only three people on the floor and
14 an aide, and it takes two or three of us in one room,
15 that leaves 16 patients unattended. It's a huge
16 problem, and, again, it's very frustrating.

17 We recently lost three experienced nurses due
18 to burnout. When I staff the unit, I have to consider
19 the experience of my nurses when I am selecting what
20 patients to give to them and who gets maybe the number
21 of patients.

22 A lot of times one or two nurses will have to
23 have six patients as opposed to five or four. And,
24 unfortunately, I have to rely on the nurses that are

25 more experienced and organized to handle the heavier
1 loads, and they're getting tired.

2 The nurses that left, one of them went to a
3 different kind of nursing, and two of them just went
4 to different facilities, but it was a huge loss to our
5 unit that it really could have been prevented.

6 I have brought this to my manager, and she
7 says she's really bound by her budget and the staffing
8 matrix, that I don't know where they came up with it,
9 but it's definitely not adequate what we have.

10 To speak to the cost, like Judy said and I've
11 heard other people say, if our patients suffer a fall,
12 it's very common for them to have concussions, broken
13 hips, broken arms, you know, the complications are
14 huge, and that increases their length of stay and
15 sometimes compromises them to the point where they
16 can't go back home independently at all and possibly
17 puts them in a nursing home or some other skilled
18 facility, so it costs, too. I guess that's all.

19 DR. SIMMER: Okay. Thank you.

20 Yes, Bev.

21 MS. McDONALD: We know that there's all kinds
22 of work being done on adequate staffing levels. I
23 would just like -- you're telling us three RNs and an
24 aide on a midnight shift for 17 patients, stroke
25 patients, pretty much. So I would just like you to
1 share with us what you think would be an adequate
2 level of staffing for 17 stroke patients on the
3 midnight shift.

4 MS. CLAIRMONT: When I'm assigning patients,
5 I think that the stress level of my staff really goes
6 up when I have to assign more than five patients to a
7 nurse.

8 We are considered one of the critical care
9 units in that we have telemetry and we do hang cardiac
10 drips, which require more frequent monitoring, more
11 frequent blood pressures and stuff. And I'm not
12 unreasonable asking for, you know, maybe three or
13 four, like some of the units, but I think five would
14 be the maximum that would be safe, approximately five
15 to one.

16 MR. BISSONNETTE: You identify the relative
17 youthful experience of the nurses on the midnight
18 shift. Is there any experienced nurse, for example,
19 such as a midnight shift supervisor available to you?

20 MS. CLAIRMONT: The house supervisor who is

21 available is also in charge of assigning the beds of
22 the patients and finding staffing. She assists us,
23 although she's very frequently not able to help much.
24 And, no, she is not available at all for consulting
25 about patient care.

1 If -- I'm the charge nurse. I oversee 53
2 patient beds. And if I have a question that I can't
3 answer, I frequently will call another unit to see if
4 there's someone who might have a little bit more
5 insight than I do, or we rely on the doctors, who
6 aren't always pleasant in the middle of the night.
7 But our house supervisor really is too busy to be
8 available to us.

9 MR. BISSONNETTE: Okay. Now I have a
10 follow-up question, of course. You're identifying
11 yourself as a charge nurse for 53 beds, yet it's a
12 17-bed telemetry stroke unit. How did we get to 53
13 beds?

14 MS. CLAIRMONT: I'm sorry, I forgot that. I
15 oversee two units actually at night. There's a
16 medical unit that makes up the remainder of the beds
17 that does not have a charge nurse at night. I
18 oversee -- during the day and afternoon they have
19 their own charge nurse but at nighttime it wasn't
20 cost-effective so I manage both units. So my own
21 stroke unit has an actual capacity of 23, and I think
22 we average around 17. The other 31 patients come from
23 the medical side.

24 MR. BISSONNETTE: And I'll stop that line of
25 questioning before I become provocative and not
1 clarifying.

2 A different topic, and that is related to
3 what you mentioned concerning how the staffing matrix
4 was developed and not quite understanding how that
5 occurred. And you also identified giving input to
6 your nurse manager.

7 I'm then assuming, perhaps wrongly so, that
8 there's no evident opportunity for the bedside nurse
9 to have an impact on the staffing plan. Is that a
10 correct assumption?

11 MS. CLAIRMONT: I feel that way. They try to
12 make it feel otherwise and they try to say that we
13 have input, but I really don't feel that we do. And
14 she was very clear that she was bound by her budget
15 and could not provide us with more staff, even aides.
16 I asked, you know, if we couldn't have licensed staff

17 like you said on the midnight shift, just eyes. Sick
18 people don't sleep. And when it's dark and they're
19 confused and don't know their deficits, you know, even
20 just eyes to help watch them.

21 Restraints are becoming -- our manager is
22 constantly promoting them right now because it's
23 cheaper than a safety companion, and a lot of times we
24 don't even have safety companions available. So we're
25 turning to restraining patients, which also isn't an
1 ideal situation.

2 DR. SIMMER: What is a safety companion?

3 MS. CLAIRMONT: A safety companion is an
4 unlicensed person who frequently just sits in the room
5 and is there to notify the nurse or to intervene
6 before the patient would attempt to get up and fall or
7 pull out any kind of IV lines or catheters, disrupt
8 any surgical equipment.

9 DR. SIMMER: Thank you. Okay. I think
10 that's all the questions. Appreciate your testimony,
11 and the testimony of others as well, and we will
12 recess until there's more testimony to be heard.
13 Thank you.