

9 MS. JOHNSON: My name is Mary Johnson, and
10 good afternoon. I am a faculty member from the
11 University of Michigan, School of Nursing. I am
12 teaching in the program that is here in Traverse City.
13 It's an outreach program that's been here for many
14 years, since the 1970s.

15 Today I am reading a testimony written by
16 another faculty member and a colleague of mine, Mary
17 Pat Randall. She was unable to be here today and
18 she -- I am going to read it for her.

19 She is a registered nurse also and she is
20 from Interlochen, Michigan, and is a nursing
21 instructor at the University of Michigan RN studies
22 program here in Traverse City.

23 She is currently teaching a course called
24 Healthcare Delivery Systems, so it's a nice fit with
25 your charge.

1 She is also a health advocate, a consultant
2 for the Michigan Nurses Association and Northern
3 Region Community Out-Reach coordinator for the
4 Michigan Council for Maternal and Child Health. So
5 she wrote this not just as a nurse and patient safety
6 expert but also as a daughter, a mother, a friend and
7 a patient.

8 From her perspective, she sees a healthcare
9 situation in this state which is, in her word,
10 terrifying. And the rest of this will be a direct
11 quote from her testimony.

12 Whether in major university centers or small
13 town rural hospitals, I have observed the same three
14 critical failings: Inadequate RN staffing, defective
15 systems, and dysfunctional attitudes.

16 I shall briefly outline these causes, provide
17 research data to support my findings, and make
18 specific and doable recommendations for healing our
19 state's desperately ill healthcare structure.

20 Cost is often cited as a reason in our
21 hospital's struggle to provide safe environments for
22 patients. While it is true we have suffered
23 significant cut-backs and the amount of uncompensated
24 care has sky-rocketed, the boardroom response to cost
25 savings has been completely illogical. Cutting
1 nursing department budgets costs money.

2 I find it most curious that we are spending
3 millions of dollars on technology to prevent human
4 error when it is humans, registered nurses, who

5 intercept 86 percent of errors in hospitals.

6 According to the Institute of Medicine's
7 report, "Keeping Patients Safe," the primary role of
8 an RN in a hospital setting is surveillance and rescue
9 of patients. When the RNs are not present in adequate
10 numbers, those errors are simply not caught.

11 I have watched it happen. For want of a
12 simple urinalysis, my mother had a stroke; or want of
13 a simple response, a friend suffered incapacitating
14 pain. For want of a simple blood test, I almost
15 hemorrhaged to death.

16 In every instance it was a lack of nursing
17 care that ultimately cost the hospital and harmed
18 patients.

19 The major increase in cost to a hospitalized
20 patient is determined by that patient's length of
21 stay. The major factor impacting the length of stay
22 is adequate RN staffing. Nurses save hospitals money
23 as well as patients lives.

24 Nurses and other healthcare workers do commit
25 errors, but the IOM, Institute of Medicine, study
1 shows that 90 percent of those errors are the result
2 of, "blatant system conditions," not active failures
3 of individuals.

4 In my experience, such system defects include
5 insufficient nurse-to-patient staffing ratios, work
6 environments which position healthcare staffs so that
7 they cannot succeed, fragmented service delivery
8 designs, poor checks and balances between
9 professionals, a love affair with sexy and expensive
10 technology over the simple and human care,
11 inappropriate assignment of professional tasks to
12 nonprofessional personnel and vice-versa.

13 The shortage of nurses contributes
14 significantly to the patient crisis, but just as
15 dangerous is the shortage of respect for nurses in the
16 practice of nursing.

17 As long as time is not allowed for nurses to
18 complete assignments, assessments, as long as nurses
19 are expected to work at a frenetic pace, as long as
20 nursing judgement is not valued, patients' lives are
21 in serious jeopardy.

22 I have observed that our hospitals are now
23 more than ever plagued by what I call "medical
24 arrogance." Physicians and others overrule patients'
25 claims to allergies of medicines, ignore requests by

1 nursing for changes in the plan of care, and insist
2 that their order is the final word.

3 According to the report, "Hospital Quality:
4 Ingredients for Success," those hospitals where nurses
5 are viewed as peers to physicians have the highest
6 success rates. Teamwork and patient advocacy must be
7 encouraged in order to ensure patient safety.

8 Another scary trend is the decrease in
9 respect for patients by all healthcare workers.
10 Patients' rights to refuse are ignored. Patients'
11 complaints are deemed irrelevant, and patients are
12 conned into accepting tests and treatments that they
13 do not want.

14 Particularly troubling is the common wisdom
15 now that every patient should have a family member
16 with them in a hospital for their own protection.

17 I have discovered that even when a family
18 member has a master's degree in nursing, works with
19 the Michigan Surgeon General, and has won several
20 health advocacy awards, that protection is still an
21 elusive goal.

22 I believe the Governor should immediately
23 declare a state health care emergency in Michigan.

24 The number of patients dying, grievously
25 harmed or left unproductive due to poor RN staffing,
1 unsafe systems, and defective attitudes and hospitals
2 is untenable.

3 Times of crisis require quick and innovative
4 responses, and these are some recommendations that I
5 make to you, and there are six of them.

6 While 87 percent of current RNs are already
7 in the work force, only 2 percent remaining of those
8 13 percent are seeking employment.

9 There is a cadre of retired RNs, many of whom
10 are willing to volunteer in healthcare if only they
11 can do actual nursing care. So, in other words, they
12 really probably wouldn't work delivering flowers to
13 patients. It's not what we have in mind.

14 Someone, of course, would have to cover their
15 liability insurance. Volunteer RN corps could be
16 covered by hospital policies and trained by hospital
17 education departments to provide assessments and
18 surveillance as well as to intercept errors,
19 complementing, not replacing, staff in emergency
20 rooms, preoperative centers, and outpatient clinics.
21 These RNs could play a vital role in protecting

22 patients and supporting families.

23 And I add that I think that that is a very
24 unique idea and one that we might look at a little bit
25 more seriously.

1 Number two, years ago, nursing shift
2 supervisors used to be available to charge nurses to
3 serve as, quote, "clinical detectives." They
4 discovered errors and rescued patients in complicated
5 situations.

6 Those supervisors now spend much of their
7 time finding beds for patients and the nurses to care
8 for them. If these supervisors can now be freed up
9 for this clinical detective role, maybe trained RNs
10 can be designated on each shift to serve in that
11 capacity.

12 Number three, computerized systems are only
13 as good as the data entered into them. Priority
14 should be given for a thorough assessment of patients
15 by RNs to ensure accurate databases.

16 Medication administration scanning programs
17 should include not just patient units but also the
18 emergency departments, operating rooms, and radiology.

19 Number four. Every healthcare provider with
20 hospital privileges should be required to maintain
21 up-to-date simple, universal, one-page data sheet on
22 his or her patients, including diagnoses, medications,
23 drug allergies and intolerances.

24 Until computerized patient information via
25 card chips or the ethernet is a reality, this sheet
1 could be quickly faxed and e-mailed to emergency
2 rooms, medical specialists or regional hospital
3 centers if needed.

4 Number five, respect for patients, families,
5 nurses and all healthcare workers must be so
6 fundamental that jobs and hospital privileges are at
7 risk if standards are not met.

8 This parameter should be included in patient
9 error and risk reports via patient satisfaction
10 surveys.

11 Harmed patients should be invited to tell
12 their stories to hospital CEOs and board members so
13 that a continuous quality improvement can be based on
14 actual occurrences and have the highest priority.

15 And lastly, every hospital in the state
16 should be challenged to immediately and voluntarily
17 establish unit staffing committees with the authority

18 to determine and deliver safe nurse/patient ratios as
19 described in Senate Bill 1190.

20 Incentives, rewards and recognition could be
21 coordinated through the Governor's office to give this
22 initiative the emphasis it needs.

23 Why are we waiting to be legislated and
24 mandated when logical fiscal policy and volumes of
25 research data clearly indicate that our current
1 staffing patterns, system designs, and unprofessional
2 attitudes in hospitals are just too costly in dollars
3 and lives.

4 Entering a hospital in this state should not
5 be terrifying. It should be safe and comforting.
6 Michigan citizens deserve better and we deserve it
7 now. Thank you, Mary Pat Randall.