PRESENTATION #1: RECRUITMENT AND RETENTION

Good afternoon. My name is Greg Suhl. I've worked for 34 years at Washoe Medical Center as a registered nurse, including 25 years in my current position in the intensive care nursery. I'm also a member of Operating Engineers, Local 3, which represents 750 Washoe nurses.

While my presentation here and later in the agenda draws from my particular experience at Washoe Medical Center, I want to emphasize that Washoe is not exceptional by any means. In hospital after hospital, across Nevada and nationally, we experience the same kinds of problems in nurse recruitment, retention, and staffing. This is not about singling out any particular institution, but rather about our working together to transform an industry.

Our hospitals have not learned how to retain nurses. In the past five months, Washoe Medical Center has lost 107 nurses out of a 750 total. If that rate is typical at Washoe, and I believe that it is, it means that one-third of the hospital's nurses are turning over annually. My figures are based on data from the hospital's Human Resources office, and refer to permanent nurses only; it does not include the traveling nurses.

This kind of turnover rate is appalling, a tragedy. And it is a preventable tragedy. The high turnover in the nursing profession will cease when the healthcare industry becomes committed to good healthcare practices and good employment practices. When hospitals offer nurses good pay, good benefits, professional respect, and staffing ratios conducive to quality care, then more nurses will stay and the shortage will wither away.

Last weekend, one of my colleagues in an intensive care unit described a scene that is not so unusual at our hospital. A recently graduated nurse—early 20s, just a few months on the job—came out of a patient's room and commented, "I have got to be away from the bedside within five years." The conditions faced by our new nurses, inappropriately thrust into the most intensive units, scream to be addressed.

The hospital's layer of seasoned nurses has been shrinking; and the new nurses aren't sticking around long enough to gain much experience. Often, they'll stay around for 6-12 months, allowing them to learn a few basics. Then they'll go looking for better employment at another hospital, or often leave the profession altogether.

Until and unless we address such trends in the hospitals, we're spinning our wheels. Here in Nevada, we've so far addressed the nursing shortage by a focus on the recruitment end—for example, by the legislative effort to double the number of nursing school students. What good does it do to educate new nurses when hospital conditions send them packing faster than we can train them? In fact, as Senator Matthews observed in a previous hearing, the state is having difficulty doubling its school enrollments because of a lack of qualified instructors. There just aren't enough experienced nurses remaining in the profession.

Therefore, I applaud the work of this committee to study nurse staffing practices and to explore legislative remedies. By holding the hospitals accountable to professional standards and practices, you will help to bring dignity to the nursing profession and will lay the basis for strong recruitment as well as retention.

A couple of comments about staffing. When we speak of staffing ratios, we need to account not only for the **number** of patients per nurse, but the **acuity** of those patients. Acuity refers to the severity of illness. Most hospitals have

acuity scales—a 1 through 5 rating, for example—to help guide staffing assignments. So, for example, in my own intensive care nursery, the assignment of two high-acuity babies per nurse is a full workload, whereas a nurse in orthopedics might reasonably handle six patients. But you cannot set a single ratio for a unit and expect it to apply in all cases. It depends on the acuities of each patient on a particular day.

At Washoe, department managers and charge nurses pay the greatest attention to patient acuity at the beginning of a nurse's shift when our patient load is first assigned. Then, if we are fortunate, our assignments—both in terms of the numbers of patients and the acuity of patients—will be reasonable and professionally sound.

In many units, however, reasonableness and safety fly out the window over the course of a nurse's shift. The patients are rolled in, assigned to a nurse in a flurry of activity, and questions of acuity are left perhaps for the charge nurse to consider when she prepares her assignments for the next shift.

What can the legislature do to protect patient safety at that moment in time, in the middle of a nurse's shift when that other patient is assigned, and when no single ratio or standard can possibly tell us what is the right thing to do?

For me, part of the answer must lie in respect for the professional judgment of the licensed nurse. We urgently need legislation that allows the nurse to refuse what he or she considers to be an unsafe assignment, and he or she must be able to do so without putting her job at risk. I will address this matter in greater detail in my later presentation on refusal of work assignments.

Thank you for your time.