

February 28, 2014

Good Afternoon Esteemed Leaders:

My name is Sandy Byrnes. I am a Registered Nurse in the Critical Care Unit at UConn Medical Center, located in Farmington, CT., and a Nurse Practitioner student at Southern CT State University.

I am here before you today to testify in support of Bill #5384 An Act Concerning Reports of Nurse Staffing Levels.

As you may be aware, for the past decade there has been numerous evidenced based studies that correlate with preventable patient errors that is linked to the use of forced overtime. Nurses are forced to work past 12.5 hours, show an increase in fatigue, show a slower reaction time to effectively recognize signs and symptoms of a patient's worsening condition, show a clouding of judgment in delivering safe care, show increased irritability, show that nurses received lower job performance scores, and show an increase in avoidable medication and procedure errors leading to preventable death statistics. Furthermore nurses were 80% more likely to be involved in motor vehicle crashes due to driving while fatigued especially when nurses were forced to work past their 12.5 hours of shift work consecutively.

Since 2004 Connecticut has in place a restricted mandatory overtime bill, which was designed to limit the use of mandatory overtime, which is the common practice of administrators to mandate staff to satisfy scheduling shortages that administrators had ample time to fill. This practice continues, a decade after passage of this bill. This loophole gives administrators the advantage to not be in compliance with the law, and to not seek alternative measures, such as utilizing agency personnel, instituting an on call system, or hiring more staff to have greater resources to pull from. It has been said, at my institution, that it is easier to mandate staff that are already present. Additionally, nursing staff that work in highly intense areas such as Critical Care or the operating room are exempt from this law, which is a cause of significant safety issues for the patient.

From personal experience, I have been mandated after working 12.5 hours of my shift and required to come back for a middle slot, 11 p.m. to 3:30 a.m. and then to come back at 7 a.m. to do my scheduled 12.5 hours, only to be mandated again. I have been mandated at the time clock after punching out. I have been threatened with retaliatory measures, when expressing to managers that I could not perform past my level of endurance and that imposing this forced overtime jeopardizes the health and safety of patients.

These concerns fall on deaf ears, management shows concern to provide staffing numbers, not for providing safe quality care to the patient. There is an additional disconnect and lack of concern for the staff forced to perform their required duties when it is communicated that the safety of patients will be jeopardized in forcing the nurse to carry out duties past their endurance and for what is humanely possible.

The laws loophole for administrators needs to be closed. Every staffing shortage is considered and treated as an emergent catastrophic event, which has afforded administrators this continued practice. There is no concern for the safety of the nurse or for the patients. There is currently, no tracking, no accountability and no imposing of fines to deter administrators from this continued practice or for employers to seek alternative measures.

The IOM report: Keeping patients: Transforming the work environment of nurses, "recommends that policies be adapted to prevent nurses in direct patient care from working more than 12 hours, in a 24 hr. period." Additionally all nursing professional organizations are also in support of this bill.

In 2011 the FAA passed laws to guard against operational errors for their pilots and air traffic controllers, increasing rest time between shifts to 9 hrs. This was instituted in direct relation to an increase in 2010 fatigue related catastrophes involving a high loss of life and near misses that could have been avoided.

Truck drivers are limited as to the amount of drive time they are allowed to do in a 24 hour period. Again catastrophic incidences involving a high loss of life were responsible for this change.

Page 3 -

Literature states that over 98,000 hospital related deaths occur every year due to medical errors. Prohibiting mandatory overtime will help to reduce these unnecessary deaths and the lawsuits that have come from avoidable errors.

Our nation is facing a significant nursing shortage, not rectifying this very important issue to present and future nurses limits retention of current bedside nurses, and lacks willingness for potential nurses to want to get into the profession.

Patient safety is just as important as ensuring the safety of the public, they are one and the same. When the margin for operator error is exponentially increased with the use of forced overtime, the safety and wellbeing of the public is compromised.

Prohibiting mandatory overtime, with no ambiguous language, that provides for a provision that mandation will only be used in the event of a true emergency situation, such as a blizzard or terrorist attack, holding administrators accountable and imposing fines when employers mandate for reasons not supported by the proposed bill, and instituting a reportable mandatory event to authorities that can track and enforce the law.

Requiring employers to see alternative measures to be in place, when staff shortages occur is an additional consideration.

I would be happy to answer any questions at this time.

Thank you for your time.

Sincerely,

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