Montefiore Medical Center Patient Care Chronicle

Presented by:

The Registered Professional Nurses at Montefiore Medical Center

January, 2019

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Montefiore Medical Center Protest of Assignment (POA) and Patient Care Chronicle
January 1, 2018 through December 31, 2018

Executive Summary:

The **Montefiore Medical Center** is a member of the **Montefiore Health System**. Montefiore serves as a tertiary care referral center for patients from across the New York City metropolitan area and beyond, and offers a full range of healthcare services to two million residents throughout the neighboring counties of Westchester and the Bronx, one of the most diverse and poorest urban communities in the United States. Comprised of four hospitals with 1,491 beds, Montefiore has 93,000 annual hospital admissions. (http://www.montefiore.org/montefiore-overview).

The **New York State Nurses Association (NYSNA)** is a union of over 42,000 frontline nurses standing together for strength at work, our practice, safe staffing, and healthcare for all. NYSNA is New York's largest union and professional association for registered nurses, representing ***over 3,214 registered professional nurses at Montefiore Medical Center*** for collective bargaining and nursing practice rights.

At Montefiore Medical Center's Moses and Weiler Campus, during the time period of **January 1, 2018 to December 31, 2018, POA documentation** in seven (7) specialty unit areas revealed registered nurses had filed **individually and/or collectively** more than **nine hundred and seventy six (976)** protests of assignment (POAs) supported by over **five thousand four hundred and five (5405)** signatures of registered professional nurses that raises questions regarding the hospital's promise and advertisement to adequately protect its patient population, as well as the general public, and in the face of Montefiore Medical Center's **mission** to heal, to teach, to discover, and to advance the health of the communities (they) serve.[1]

These POAs also raise questions regarding Montefiore Medical Center's ability to adequately operationalize its guiding **vision** that "we combine our clinical care with research to deliver the most current treatments available to our patients, with the highest ethical standards, we are challenging the limits of medicine.[1] Notably, the New York Code of Rules and Regulations, 405.2(b)(1) requires the hospital to have "…***a governing body legally responsible for directing the operation of the hospital in accordance with its mission."***

Protest of Assignment: Documentation of Practice Situations

A registered nurse receiving an assignment that in her/his professional judgment places the patient(s) at risk has an obligation under law and ethics to take action. In acting in the interest of the patient, the nurse is required to notify the administrator on duty to whom she/he is reporting to and who has the authority to make staffing decisions.

The ***NYS Nurse Practice Act*****,** the ***Code of Ethics for Nurses*****,** and the mandates under the ***NYS Board of Regents Rules*** related to *Unprofessional Conduct* hold the nurse responsible and accountable to her/his patients for the quality of the nursing care provided. However, the responsibility and accountability for the overall level of care ultimately resides with the hospital/agency, including all hospital and nursing administration staff.

Protest of Assignment forms are used when nurses are expected to assume responsibilities and accountabilities that exceed their experience and educational preparation and/or the volume of care is more than the nurse can, in her/his professional judgment, safely administer. Protest of Assignment forms are also used when the nurse has been given an assignment that is beyond the legal scope of nursing practice under the NYS Nurse Practice Act.

For any single situation, multiple forms may be completed if there are multiple nurses who feel care is compromised. More frequently, however, due to time constraints, and is the case within Montefiore, multiple nurses will file one form objecting to the conditions under which the nurse(s) must practice. This singular form, then, represents multiple nurses' levels of analysis of the patient care situation.

Protest of Assignment Summary

Protests of assignments filed at Montefiore Medical Center that are reflected in this report indicate, among other issues, inadequacies in staffing, lack of appropriate training for the additional complex services required by its patients, and a case load that is overwhelmingly high in both volume and acuity, and lack of ability to adequately document the provision of care. This raises questions about whether there are sufficient resources to safely provide the quality of care that is mandated by the laws and regulations in NYS.[2] Those conditions documented in the POAs challenge the dedicated registered nurses who work tirelessly to protect and advocate for the patients, families, and communities they serve.

POAs generally serve to notify management of its potentially inadequate or absent efforts to:

- Protect the public per the requirements of NYS Public Health Law Article 28 and state regulations, including Title 10 Part 405 of the New York Codes, Rules and Regulations ("NYCRR"), "Hospitals – Minimum Standards";
- Follow Code of Federal Regulations related to the Centers for Medicare and Medicaid reimbursement Conditions of Participation;
- Follow standards of care as indicated by facility policy and procedures; individual competencies; certification expectations; evidenced based research in the areas of retention and turnover in , ICU / CCU / PICU / NICU, pediatrics, medical / surgical units, psychiatric units, telemetry/stepdown units, maternal/child units, labor and delivery units, and Emergency Departments where specialized orientation programs are utilized;
- Follow Joint Commission Standards for leadership;
- Support the staffing guidelines developed in accordance with standards of practice and Joint Commission reports, and to provide minimum staffing levels required to safely care for the volume[3]and acuity[4] of the patients.

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[1]Retrieved from: http://www.montefiore.org/about-mission·

[2] In addition to the duty to care and advocate for their patients, nurses must assume many other collective responsibilities. These include advocating for: themselves; improved nursing standards; a safe work environment that is conducive to the delivery of quality patient care; a work environment that facilitates and supports the standards of nursing practice and the nurse practice act; and, community and national health care needs. Ketter, J. (1997). Nurses and strikes: A perspective from the United States. Nursing Ethics, 4(4), 323 – 329.

[3]"Volume" is a function of the time of patient arrival, time of admission request, and time of patient departure from the ED. In preparing this analysis, all patients were classified as admitted or discharged. Patients classified as discharged included those who were discharged back to their usual place of residence, left without being seen by a physician, left against medical advice, eloped before their final disposition, or died in the ED before an order for admission. Patients classified as admissions included admissions to inpatient units and transfers to other inpatient settings. Retrieved from http://home.gwu.edu/~nolsen/patientflowacademergmed.pdf

[4]"Patient acuity" is the measurement of the intensity of care required for a patient accomplished by a registered nurse. In preparing this analysis, there were six categories of acuity considered, ranging from minimal care (f) to intensive care (VI). Retrieved from http://www.websters-online-dictionary.org/definitions/acuity.

POAs are Consistent with Results of Published Industry Report Cards

The **976 POAs** filed at the Montefiore Medical Center document repetitive and consistent problems related to insufficient numbers of nursing staff throughout all hospital departments, but particularly in the Med/Surg, ED, CCU/ICU/NICU/PICU, Maternity/GYN/Labor & Delivery, and Stepdown/Telemetry units. The POAs indicate that the numbers of RNs assigned to the units are consistently inadequate and this influences the inability of the nurse to meet the immediate and persistent needs of the patient population in direct violation of laws, standards of practice, and hospital policies. The POAs document the following correlating negative patient outcomes (See Table 1):

- Inability to deliver nursing care in a timely manner
- Inability to deliver nursing care in a safe practice environment
- Inability to administer medications in a timely manner
- Inability to deliver nursing care in accordance with industry and legal standards of practice
- Inability to deliver nursing care in accordance with health and safety and infection control practices

POAs are Consistent with New York State Department of Health Citations Issued from October 1, 2014 through December 31, 2017

The New York State Department of Health licenses hospitals. The Department conducts inspections of the quality of care, monitors incidents, and investigates complaints. When these investigations reveal deficiencies, citations result, and in particularly serious cases the Department initiates enforcement actions. These typically result in the assessment of monetary fines or the implementation of specific sanctions.

The New York State Department of Health issued **43 citations from 15 inspections at the Montefiore Jack Weiler Hospital of Einstein College Division** from October 1, 2014 through December 31, 2017. This report documents that Montefiore inspections resulted in a citation from the New York State Department of Health in **33% of the inspections.** A sampling of citations issued from 2011 to 2017 appear below (New York State Department of Health, Health Profiles, Retrieved at https://profiles.health.ny.gov/hospital/view/106809#inspections (Chart 1)

Chart 1: NYS DOH Citations Montefiore Einstein Division 2011 - 2017

August 11, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on August 25, 2017. Plan of correction approved on October 12, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: timely referral of grievances

August 11, 2017 **Complaint Investigation, Follow-up/Revisit, Licensure Survey**
Status: Statement of deficiencies issued on August 25, 2017. Plan of correction approved on September 25, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: restraint or seclusion

March 22, 2017 **Complaint Investigation, Licensure Complaint Survey**
Status: Statement of deficiencies issued on July 5, 2017. Plan of correction approved on July 25, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: care in safe setting
Patient rights: free from abuse/harassment
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient safety
Use of restraint or seclusion

September 6, 2017 **Complaint Investigation, Licensure Complaint Survey**
Status: Statement of deficiencies issued on September 20, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient safety

May 19, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on June 6, 2017. Plan of correction approved on July 5, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Compliance with laws
Patient rights
Patient rights: care in safe setting
Quality improvement activities

April 11, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on April 26, 2017. Plan of correction approved on May 30, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control
Infection control program
Patient rights: care in safe setting

May 27, 2015 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on December 9, 2015. Plan of correction approved on January 15, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Delay in examination or treatment
Medical screening exam

December 21, 2016 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on January 17, 2017. Plan of correction approved on February 2, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Medical screening exam

October 14, 2016 **Complaint Investigation, State Licensure, Licensure Co Survey**
Status: Statement of deficiencies issued on March 27, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Governing body. Compliance with laws.
Patient rights: participation in care planning

August 25, 2016 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on May 11, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control program
RN supervision of nursing care

February 4, 2015 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on November 20, 2015. Plan of correction approved on December 31, 2015. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Emergency room log

August 27, 2015 **Complaint Investigation, State Licensure, Licensure Co Survey**
Status: Statement of deficiencies issued on December 8, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Emergency services policies
Protecting patient records

January 16, 2015 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on February 9, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Nursing care plan
Patient rights: privacy and safety
Patient rights: restraint or seclusion

September 8, 2011 **Complaint Investigation, State Licensure, Licensure Co Survey**
Status: Statement of deficiencies issued on March 13, 2015. Plan of correction not approved or not required.

Citations Issued

Admission/discharge.

The New York State Department of Health issued **44 citations from 14 inspections at the Montefiore Henry & Lucy Moses Division** from October 1, 2014 through December 31, 2017. This report documents that Montefiore inspections resulted in a citation from the New York State Department of Health in **33% of the inspections.** A sampling of citations issued from 2015 to 2017 appear below (New York State Department of Health, Health Profiles, Retrieved at https://profiles.health.ny.gov/hospital/view/102937#inspections (Chart 2)

Chart 2: NYS DOH Citations Montefiore Moses Division 2015 - 2017

August 11, 2017 **Complaint Investigation, Follow-up/Revisit, Licensure Survey**
Status: Statement of deficiencies issued on August 25, 2017. Plan of correction approved on September 25, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: restraint or seclusion

March 22, 2017 **Complaint Investigation, Licensure Complaint Survey**
Status: Statement of deficiencies issued on July 5, 2017. Plan of correction approved on July 25, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: care in safe setting
Patient rights: free from abuse/harassment
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient safety
Use of restraint or seclusion

August 11, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on August 25, 2017. Plan of correction approved on October 12, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: timely referral of grievances

September 6, 2017 **Complaint Investigation, Licensure Complaint Survey**
Status: Statement of deficiencies issued on September 20, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient safety

May 19, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on June 6, 2017. Plan of correction approved on July 5, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Compliance with laws
Patient rights
Patient rights: care in safe setting
Quality improvement activities

April 11, 2017 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on April 26, 2017. Plan of correction approved on May 30, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control
Infection control program
Patient rights: care in safe setting

May 27, 2015 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on December 9, 2015. Plan of correction approved on January 15, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Delay in examination or treatment
Medical screening exam

December 21, 2016 **Complaint Investigation Survey**
Status: Statement of deficiencies issued on January 17, 2017. Plan of correction approved on February 2, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Medical screening exam

January 26, 2017 **Recertification Survey**

Status: Statement of deficiencies issued on February 6, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Advocate/team responsibilities

Data submission - reapproval

Notification of removal to optn

Organ receipt

Patient and living donor care

Removal from waiting list

October 14, 2016 **Complaint Investigation, State Licensure, Licensure Co Survey**

Status: Statement of deficiencies issued on March 27, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Governing body. Compliance with laws.

Patient rights: participation in care planning

August 25, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on May 11, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control program

RN supervision of nursing care

February 4, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on November 20, 2015. Plan of correction approved on December 31, 2015. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Emergency room log

August 27, 2015 **Complaint Investigation, State Licensure, Licensure Co Survey**

Status: Statement of deficiencies issued on December 8, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Emergency services policies

Protecting patient records

January 16, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on February 9, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Nursing care plan

Patient rights: privacy and safety

Patient rights: restraint or seclusion

POAs are consistent with 2018 Leapfrog Report

The 2018 Leap Frog Report aligns with the POA complaints. Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) uses national performance measures from the Centers for Medicare &

Medicaid Services (CMS), the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the American Hospital Association's Annual Survey and Health Information Technology Supplement. Taken together, those performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade includes 28 measures, all currently in use by national measurement and reporting programs. The Leapfrog Hospital Safety Grade methodology has been peer reviewed and published in the Journal of Patient Safety. The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system. Montefiore Medical Center's overall **Leapfrog Grade at both the Einstein and Moses Campus' is a C.** A sampling of the Leapfrog findings that are consistent with the more than **976 POAs** appears below:

* This Leapfrog Report aligns with the Montefiore RNs POA complaints of insufficient numbers of qualified staff and acuity and case load too high resulting in:

- Inability to deliver nursing care in a safe practice environment
- Inability to deliver nursing care in accordance with industry and legal standards of practice
- Inability to deliver nursing care in accordance with health and safety and infection control practices
- Inability to document in accordance with standards of practice in nursing

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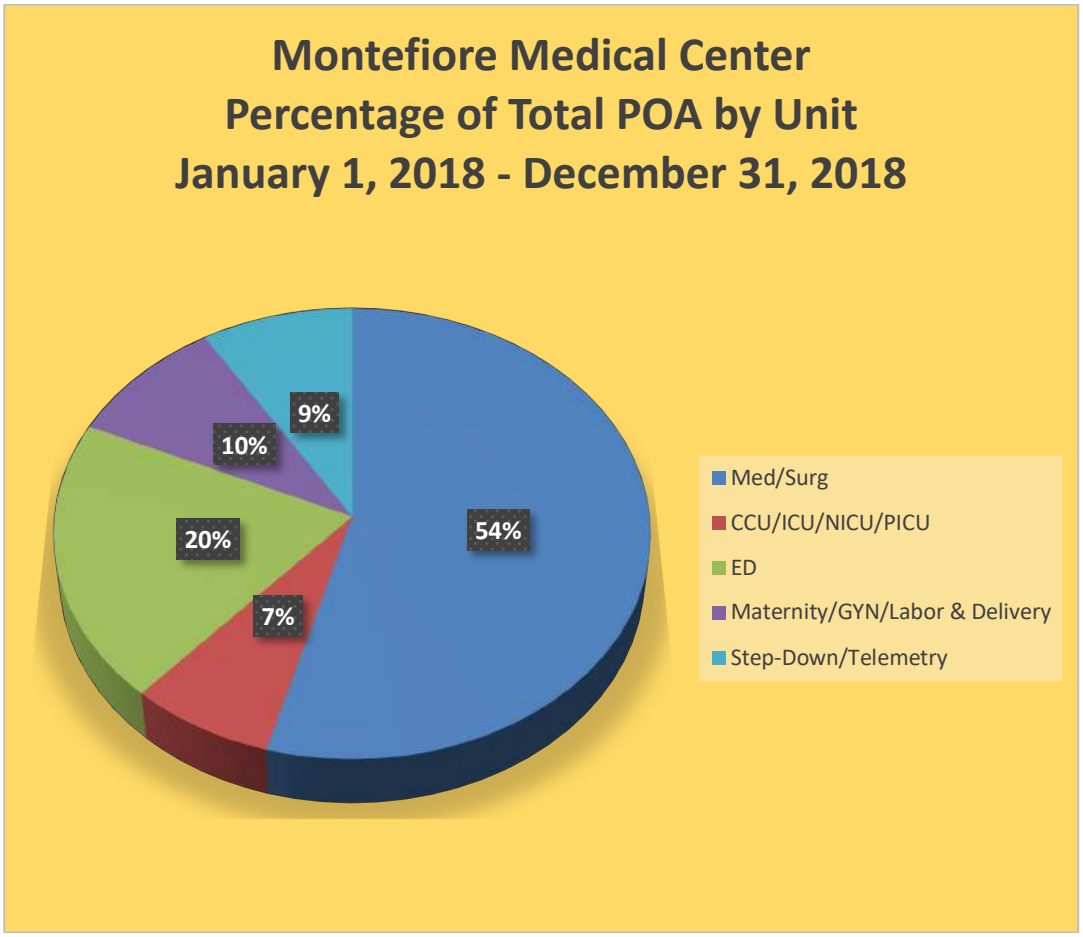
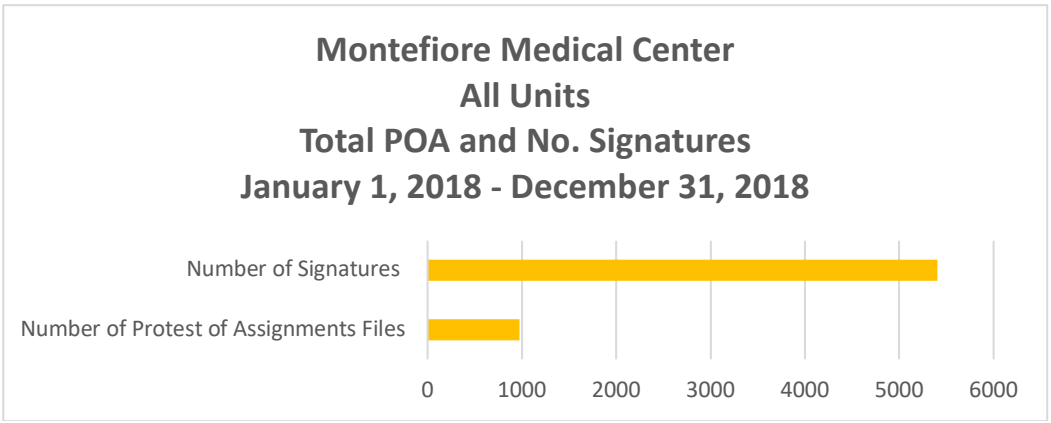
- Inability to document in accordance with standards of practice in nursing

Figure 1: Montefiore Medical Center: Percentage of POA by Specialty Unit, Numbers of POA filed and Number of Signatures





Protest of Assignment Report
Montefiore Medical Center
January 1, 2018– December 31, 2018

The nine hundred and seventy six (976) protests of assignment (POAs) supported by over five thousand four hundred and five (5405) signatures filed in the specialty areas documented at the Montefiore Medical Center between January 1, 2018 through December 31, 2018 (Figures 2, 3) indicates that there are consistent hospital-wide issues that include:

- Inadequate staffing for acuity, admission volume, discharges and caseloads
- Lack of appropriate orientation, training and competency in complex services
- Inadequate time for patient care and documentation
- Addressing patient acuity higher than usual
- Inadequate number of qualified staff to meet the immediate needs of the patient population
- Overwhelmingly high volume of admissions and discharges
- Lack of resources needed to provide quality care, such as supplies, equipment or medications

Figure 2: Percentage of Total POAs Filed by Reason

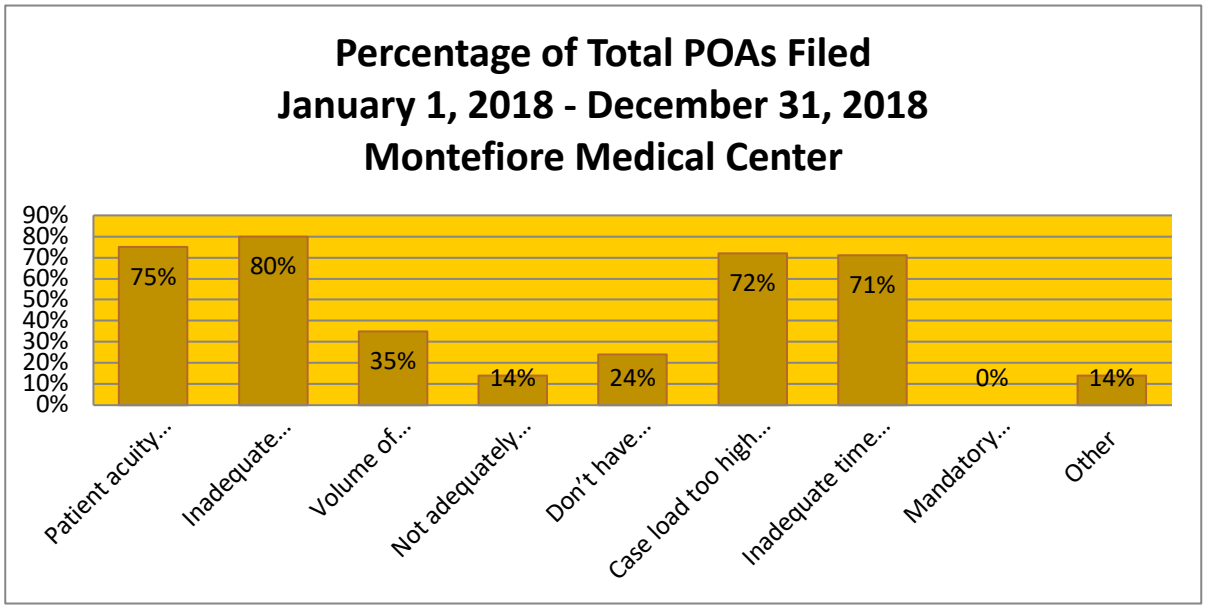
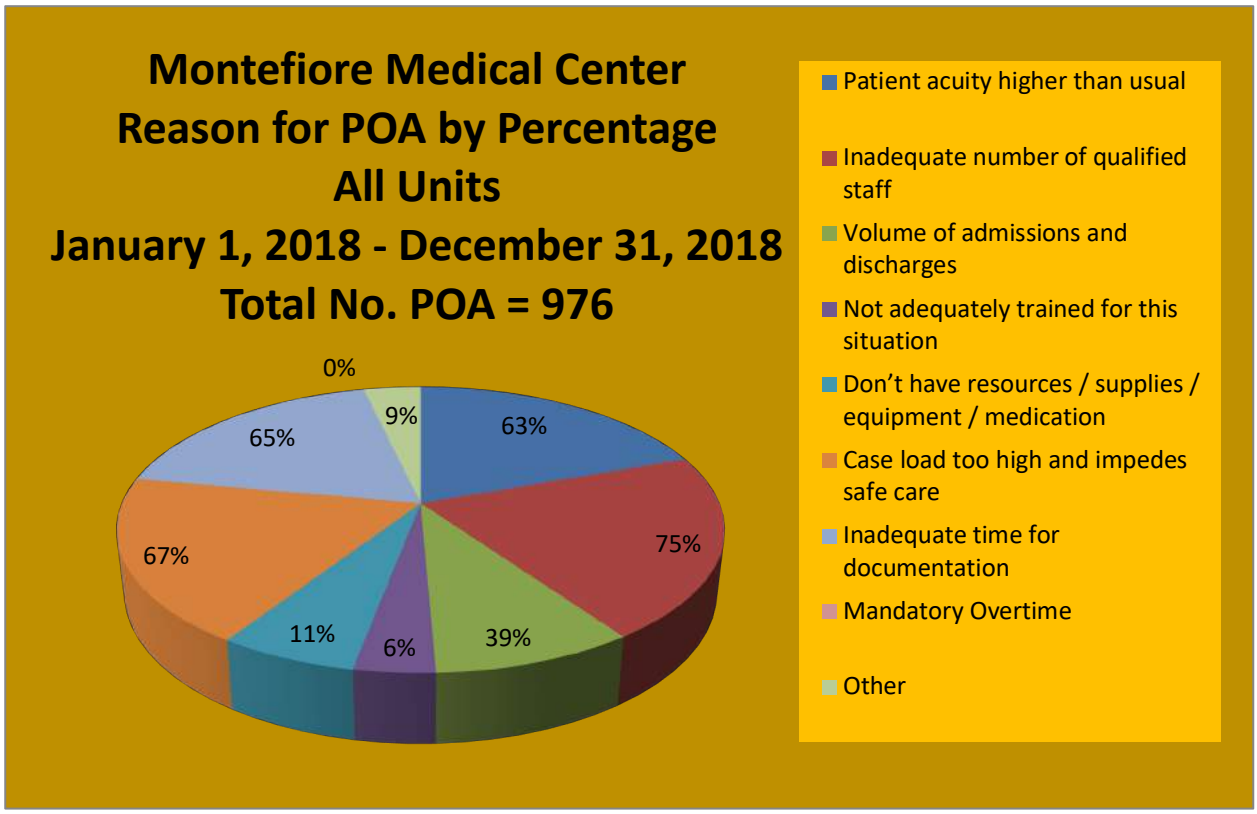


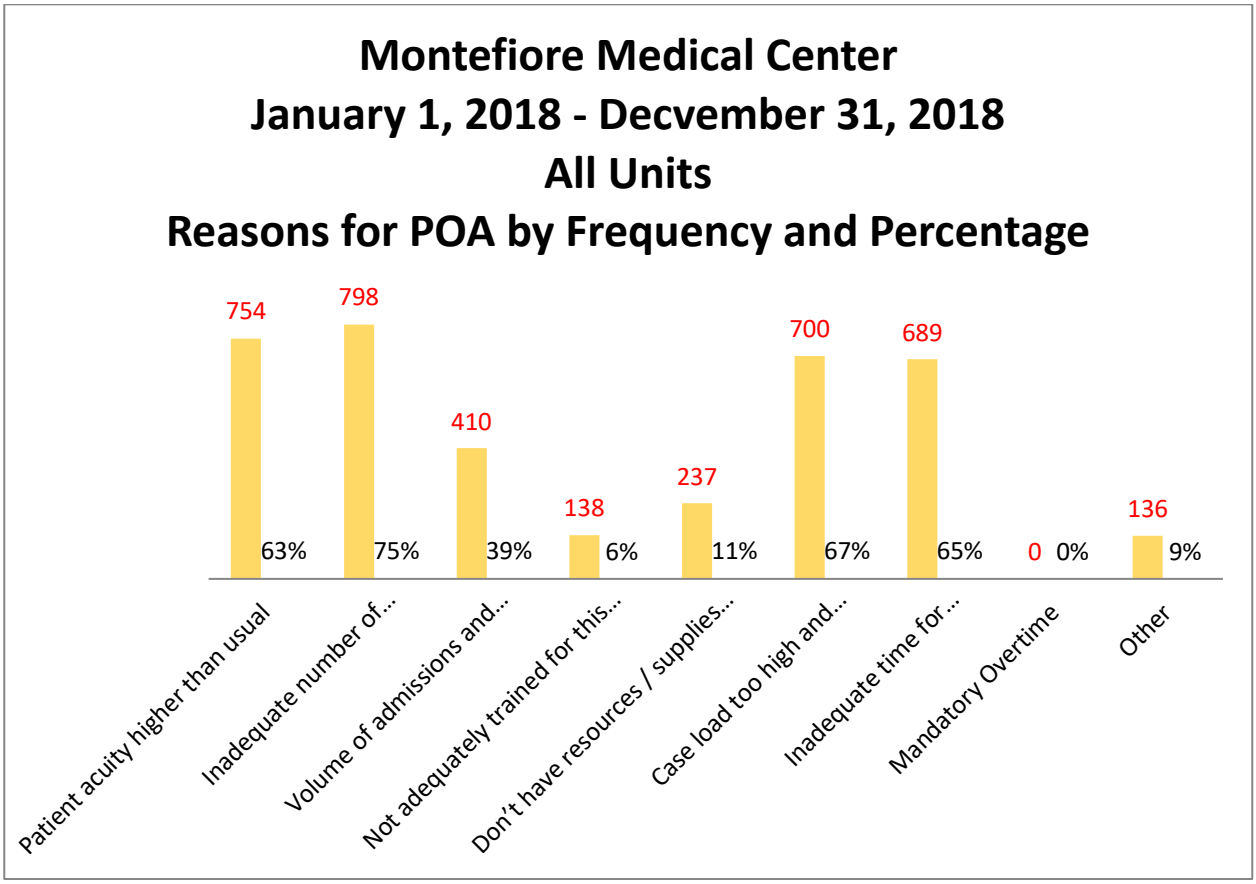
Figure 3: Most Frequent Reason for Protest of Assignment



The 976 hospital-wide POAs filed at Montefiore Medical Center between January 1, 2018 and December 31, 2018 documents the following perceived inadequacies and unsafe conditions:

- Nurses are protesting their assignments because of the inability to adequately address the patient acuity, given the staffing assignment. Higher patient acuity comprises over 63% of the protests filed throughout the hospital.
- Nurses are protesting their assignments because of the inadequate numbers of qualified staff needed to address the acuity, admission volume, discharges, and caseloads. Inadequate numbers of qualified staff comprises over 75% of the protests filed throughout the hospital.
- Nurses are protesting their assignments because the numbers of patients assigned to the nurse impedes safe delivery of care. The unsafe nurse-to-patient ratio comprises over 67% of the protests filed throughout the hospital.
- Nurses are protesting their assignments because the volume of admissions and discharges (39% of the protests) and patient caseload (67% of the protests) leave them with inadequate time for documentation. Inadequate time for documentation comprises over 65% of the protests filed throughout the hospital.
- In addition to the reasons noted above, nurses have identified "other" reasons for the filing of the POA in 9% of the protests filed throughout the hospital.

Figure 4: Reason for Protest of Assignment by Frequency and Percentage



* The most common reason indicated for the Protest of Assignment was "inadequate number of qualified staff" followed closely by "patient acuity higher than normal" and "caseload too high to provide safe care". The second and third reason logically follows the first. In addition to reflecting an inadequate number of trained RNs to provide care, inadequate qualified staff also applied to situations where the absence of staff of a specific job category resulted in registered nurses covering those jobs, or care being delayed because the work of another job classification was not done, such as housekeeping, nursing assistants, etc. These data also denotes the high patient acuities increasingly common in managed care environments that make it impossible for quality, safe care in the absence of an adequate number of qualified staff and staff mix.

The 976 hospital POAs in the specialty areas outlined filed at the Montefiore Medical Center January 1, 2018 through December 31, 2017 document "other reasons" for the filing of the POA (Table 1). In most cases, "Other Reasons" could reasonable be categorized into one of the listed existing reasons:

Insufficient # of Staff, Insufficient # of Qualified Staff, & High Acuity: (multiple occurrences) Unit at full capacity, high suicidal risk, patient elopments, multiple patients with history of violence, charge nurse (who is supposed to manage the floor) directly responsible for seven patients, nursing attendants not showing up for work, use of float attendants without psychiatric experience, incidences of patient violence that must be de-escalated, multiple patients on behavioral care plans, multiple medically unstable patients on psychiatric unit (unstable diabetes, heart conditions),
Insufficient # of Staff, High Acuity: Unable to meet organizational goals, unable to give medication on time, not enough time to teach patients, not enough time for documentation, call bells not answered in a timely manner, family members and patients dissatisfied with care, 99% of patients at high fall risk, multiple patients on wound care, multiple vented patients, multiple patients requiring enhanced observation and sitters, no CNA on floor, nurses doing everything. **(repetitive and consistent response)**
Health & Safety: MD on the unit is aggressive and combative toward staff
Insufficient # of Staff, High Acuity: Only 4 nurses on the unit. Multiple patients on BIPAP, 1 vented patient, 1 trach patient, patients on Levophed, 1 patient on constant observation for suicide attempts, multiple (3) hallway patients, multiple patients needing glucose monitoring every 4hours and complete care, several patients attempting to elope. **(repetitive and consistent response)**
Insufficient # of Staff and High Acuity: Multiple incontinent patients, multiple feed assistance patients, multiple pressure ulcers and multiple patients on isolation precautions, our CNAs have been pulled from the floor, leaving us with only 1 assistant. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Patients on insulin drips requiring glucose monitoring and VS monitoring every hour, patients with trachs, vents, tub feedings, incontinence, multiple patients on isolation. We only have one CNA and there is a patient on 1:1 constant observation. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Multiple GI bleeds, patients with trach care, patient waiting for liver transplant, patients on unit that belong in ICU and waiting for a bed that is currently not available, other patients on the unit inappropriately placed who below in stepdown, multiple BIPAPs, drips, blood transfusion.
Insufficient # of Staff: Unit currently with 28 patients, 2 admissions to come, 1 patient constantly climbing out of bed and trying to put his head between the bed rails, 9 complete care patients, charge nurse taking a full patient load, only 1 CNA on the floor.
Insufficient # of Staff and High Acuity: Monitoring a hallway patient with perianal bleeding, no privacy.
Not Adequately Trained: Staff on unit not trained to have patients on cardiac drips that require constant monitoring. No ACLS staff.
Insufficient # of Staff: Pulled nursing assistants to float to another unit **(repetitive and consistent response)**
Volume of Admissions and Discharges: High influx of admissions and transfers (8 admissions), RNs moving patients, CBI, trach, multiple isolation patients, BIPAP patients, multiple patient needing pain management, many complete care patients, 3 hallway patients, charge RN with full assignment.
Health & Safety: Impeding Safe Care: RN directed by administration to accept a patient with a diagnosis of thoracic aneyrysm with no monitoring of vitals via monitor. **NO MONITOR AVAILABLE, NO STEPDOWN BED AVAILABLE,** patient's blood pressure is increasing as time progresses 142/101, 157/94, now 172/100. Patient in need of telemonitoring.
Insufficient # of Staff, High Acuity: Unit census was 21 at start of shift with 2 admissions to be received. Now census is 26 with an additional 2 patients en route. A total of 11 admissions will be received on this shift. No CNAs on floor. 1 ventilated patient, 2 with trach, 1 on restraints, 3 isolations, multiple incontinent patients, 3 pressure ulcers, 1 blood transfusion, all call bells ringing but nurses are busy with

admissions, over 20 patients on fall risk.
Insufficient # of Staff, High Acuity: 32 high acuity patients, patient population over bed census, hallway patients, multiple patients with EOC, ventilator, BIPAP, fall risk, wound care, complete care, frequent BP monitoring, pain management, post-op patients. Charge nurse with full assignment. No CNA on the floor.
Patient Acuity High: Patient acuity requiring more time to complete tasks. Multiple patients require complete care, on drips, in particular norepinephrine, which requires close monitoring and titration. Multiple patients with pressure ulcers who are incontinent and need frequent changes and would dressings due to soiled dressings, constant turning and positioning. Most patients are at risk for falls. **(repetitive and consistent response)**
Insufficient # of Staff: RN became ill and she was not replaced. We are expecting a 4th hallway patient and one **HALLWAY PATIENT ACTIVELY SEIZING.**
Insufficient # of Staff: No CNA or secretary assigned to floor. No one to answer telephones and call bells. Patients with trach and ventilators, wound care, pain management, glucose monitoring, complete care. **(repetitive and consistent response)**
Insufficient # of Staff & High Acuity: Patients on dobutamine drip, constant observation for active suicidal, multiple high fall risk patients who need constant redirection and reorientation, multiple wound care patients, three bariatric patients, BIPAP, multiple finger sticks, PICC lines, isolation patients, frequent pain management. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Mechanically vented patient with poor baseline status that was not transferred to ICU, has continuous fentanyl, levophed drip, titrated, and increased during shift. Patient is hyperglycemic, needing multiple insulin coverages. Patient's sodium level 168, see by nurse for seizure history, Neuro asking why patient wasn't in ICU. Patient's temp 100.5, PA ordering multiple labs.
Insufficient # of Staff, High Acuity: We have 6 hallway patients, including 2 day room patients, patients with vents and restraints, multiple constant observations with only one covered, BIPAP, patients with bradycardia, no unit secretary, no CNA.
Insufficient # of Staff, High Acuity: Entire staff wearing mas—quarantined unit, patient with C. diff, 5 droplet isolation, 1 trach, 16 complete care patients, two airborne isolation patients, 2 hallway patients, 3 very confused patients.
Insufficient # of Staff, High Acuity: 1 RN pulled to another floor. We have 2 admissions and 4 transfers to come, 1 patient awaiting discharge, 3 hallway patients (1 who is legally blind), 2 vent/trach patients requiring frequent suctioning, 10 complete care patients who require frequent turning, 10 confused patients, 5 with pressure ulcers, 3 isolations patients, 4 with PICC lines, 1 heparin drip, surgical patients who require frequent pain management.
Insufficient # of Staff in Violation of Negotiated Nurse to Patient Ratios of 1:6: *****Our patient census is 33 and we only have 5 RNs on duty today. *Each nurse is responsible for 12 patients today. We have 9 transfers, 5 admissions, 4 trach patients. *RN to patient ratio today is 1:7. Inadequate time for assessments and documentation * Our patient census is 20 and we only have 3 RNs on the floor and 2 of them are float nurses. * RN to patient ratios 1:7 for 3 RNs on unit. Unable to do hourly rounding or adequate evaluation of complex patient needs. No time for documentation * 1 RN with a patient ratio of 1:8 today who has 6 hallway patients
Volume of admissions and discharges: We are anticipating multiple admissions with 2 patients currently in the hallway. 2 patients have pressure ulcers, 1BIPAP, 1 CPAP, 3 on isolation, 2 PICC lines, 3 with Foleys, 1 heparin drip, 2 colostomies, 1 fecal management system awaiting a step down bed, 1 patient who is a deaf/mute requiring sign language, 14 complete care patients.
Insufficient # of Staff: Today there are no CNAs on the floor and each nurse is responsible for 12

patients during breaks and meals. We have several morbidly obese patients who require 4-5 nurses to turn/position the patient. We have multiple fall precaution patients and patients on bed alarms.
Insufficient # of Qualified Staff: Our census is 30 and we only have 5 RNs on duty today, 3 of them are new and 1 is a float.
Health and Safety, Insufficient # of Staff, High Acuity: Multiple patients requiring pain management, many with pressure ulcers requiring frequent repositioning, blood sugar assessments, foley care, wound care, respiration assessments for patients on BIPAP, contact isolations, call bells unable to be answered in a timely fashion. Only 1 CNA on floor. Patient fell during handoff.
Insufficient # of Qualified Staff: Charge RN has full complement of patients. New RN just off orientation needing guidance and assist with assignment. 1 patient on vent with multiple drips, 1 patient with multiple drains, transfused, 1 patient high acuity needing transfer to stepdown, 1 patient transfused with PRBC and having difficulty breathing even on hi flow oxygen, multiple patients on bed alarms due to confusion and fall risk.
Volume of Admission and Discharges, No Time for Documentation: 18 patients with 4 late discharges and 2 late admissions, and 4 more admissions scheduled, 1 patient on a vent, 3 patients on isolation, 1 enhanced observation due to seizure activity and hallucinations. No secretary, charge RN with full patient load, not enough time for documentation
Insufficient # of Qualified Staff: No CNA on the floor, 13 complete care patients, 2 vents, 2 trach collars, multiple fall risks, multiple wound care, sickle cell care patient, multiple patient assists.
Insufficient # of Staff: Once again we have a patient recording staff on his phone due to delayed staff responses to his issues and demands. Multiple 1:1 watches, we are supposed to have a sitter but non available as per nursing office. Multiple complete care and pain management patients. 3 PIBAPA, 1 vent, 1 trach, hallway patients, multiple would care patients.
Insfficient # of Staff & High Acuity: (multiple occurrences) multiple patients IV drips with insulin, levothyroxine, levophed, phenylephrine, socium bicarb, heparin, nitro,and vasopressin administration, and also complex, confused, complete care, respiratory distress, tube feeds, arterial lines, work up to facilitate organ donation, blood glucose monitoring every 2 hours, suicidal patients, continuous vital sign monitoring, hallway patients, isolation patients, patients with tracheostomies.
Insufficient # Qualified Staff, High Patient Acuity: RNs responsible for seven (7) or more level two patients, many are intubated on multiple drips, multiple blood transfusions, multiple total care patients, one patient missed dialysis five times due to staffing, multiple patients with continuous observation, only four (4) RNs on midnight shift, delayed administration of meds. **(repetitive and consistent response)**
Lack of Resources: No stretchers, no monitors, no space for beds, patient safety compromised, no free access to oxygen on wall due to rows of patient beds, no water on unit (both machines broken), pyxis is empty of meds, no monitors, no lines, no leads for cardiac monitors, no thermometers, inadequate ventilation, electronic equipment not functioning. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Patient Acuity, Lack of Resources: Patients remain in the ED for three to five (3 – 5) days. Nurses mixing meds, pharmacy not refilling orders, Vital sign machine not working, stretchers not available, no linen, no IV fluids. Multiple hallway patients, multiple patients on BIPAP, vent, drips.
Health and Safety: Insufficient space, hallway patients, patients stacked in rows, unable to access patients in a timely manner, temp in ED 76 degrees on west side, air conditioning not working on East side and area is **very hot** and uncomfortable, inadequate ventilation, unable to comply with appropriate infection control. Patients waiting days to get a bed and aggressive to staff. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, Violation of Staffing Regulations: Staff unable to take breaks or meals **(daily occurrences)** Census 50 patients in waiting room with wait time of 6 hours and 24 minutes; 85 patients, 6 RN and 5 ½ hours waiting to be triaged; 50 patients and 5 nurses resulting in inability to administer medications in a timely manner; census 80 and only 7 RNs; Only 2 nurses assigned to Blue Zone and each with 15 patients;

RNs covering 19+ patients resulting in no time to medicate or document in accord with policies
Insufficient # of Staff, High Patient Acuity: Red zone census with acuity ill patients, 4 complete care patients with decubitus ulcers and diarrhea, patients on levophed drip requiring close monitoring, one patient on IV cardene and IV protonix drip requiring 5 minute vital sign check, patients on enhanced observation for safety, 1 patient on multiple PRBC transfusions, IV antibiotics, and 1 patient on BIPAP.
Insufficient # of Qualified Staff: 37 patients waiting in triage and 55 patients waiting to be triaged with a 9 hour waiting time. 16 patients are waiting in waiting area with a 7 hour waiting time. 95 patients in ED right now, no tech on the floor to help out, 7 hour wait time to see an MD.
Insufficient # of Qualified Staff, High Patient Acuity: Acuity in **Red zone/Blue zone** very high with one nurse caring for patients including 8 intubated and IV levophed, BIPAP, telemetry, 1 stroke code requiring 95 minute vital sign check, 1 on suicidal watch who is unstable secondary to drug overdose, will be receiving new patients in the ED that are unstable, patient with chest pain
Insufficient # of Adequately Trained Staff: ED has 2 orientees, and 2 traveler nurses, no regular staff for 3 – 11 shift, staffing such that only one nurse in each zone during meal breaks, patients on insulin drips
Insufficient # of Qualified Staff: One RN covering 19 patients, 8 with blood transfusions, 8 unable to administer medication on time, no rooms for vented/BIPAP patients,
Lack of Resources: Unable to provide space/privacy for grieving families due to patient beds parked in front of bereavement room, unable to provide privacy due to environmental conditions (extreme overcrowding). **(repetitive and consistent response)**
Volume of Admissions: 160 patients in the ED at 7 p.m., multiple patients with extended length of stay waiting for beds on the floors, more than 30 patients waiting to be triaged, wait time to see an MD is 4 – 8 hours. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, Not Adequately Trained: 1 RN floated to L & D and she has never been oriented to the unit, and RN replaced 1 L & D RN who was floated to the OR. RN was floated from med/surg floor, and med/surg floor had to have an RN floated from another floor. **(repetitive and consistent response)**
Insufficient # of Qualified Staff: 2 Per Diems were cancelled and 1 overtime was cancelled and 2 RNs were floated to another floor today even though we had 6 laboring patients, 3 PACU patients, and 3 patients in triage, 2 scheduled c-sections, 1 acute patient with a cardiac condition.
Insufficient # of Qualified Staff, Acuity High, Case Load High: Census high, 8 patients in triage, 9 laboring patients, 1 + for Flu, 1 CHF patient, 2 patients on magnesium sulfate for high BP (Toxemia), 1 patient with vaginal bleeding, 6 RNs.
Health & Safety, Inadequate # of Qualified Staff: We are monitoring patients in L & D with flu, MRSA, pneumonia, morphine withdrawal complications, heparin drips, insulin drips, sickle cell crisis, eclampsia and hemorrhagic crisis, acute cardiac conditions, all needing transfers to other units with no beds available and/or 1:1 with no staff available to deliver safe care, no time for documentation, no ability to give our meds on time, no ability to properly assess patients. **(repetitive and consistent response)**
Insufficient # Staff Violation of Nurse to Patient Ratios: *I had 2 patients delivering at the same time, 1 patient in OR, and 1 patient delivering in the triage area *I had 3 inductions going on at the same time *I had 14 patients and I am overwhelmed *1Mother Fetal Assessment Center has a maximum capacity of 25 and there are 31 patients and 2 RNs.
Insufficient # of Staff, Case Load High: Only 4 nurses on the floor and several babies are on antibiotics. Our agency nurse was floated off of the floor. 4 babies need glucose monitoring.
Insufficient # of Staff, Case Load High: 7 laboring patients on the floor, 1 patient in OR, 3 patients in EU, patient in OR needed 2 RNs but only had 1 RN, EU patient needed 3 RNs, but only had 2 RN, PACU has 1

RN instead of 2 RNs, safety concerns.
Insufficient # of Staff, Case Load High: 1 RN with 11 patients, an admission and 3 babies on glucose monitoring every 3 hours, 2nd RN with twins on glucose monitoring and triple antibiotics, 3rd RN starting with 10 patients and getting an admission increasing patient load to 12, 4th RN in charge with 6 patients and getting an admission increasing patient load to 12, 1 nursery nurse with a boarder baby on Morpnine and showing withdrawal symptoms.
Insufficient # of Staff, Case Load High: only 1 RN in PACU, needs 2, 2 RNs in triage, needs 3, 2 labor and delivery rooms are closed, 7 patients are in active labor, 1 pre-term mother/baby with severe pre-eclampsia on magnesium sulfate, 3 patients in PACU, 1 on magnesium sulfate with severe pre-eclampsia, 1 with large EBL, 1 fresh post-op, there are 8 patients in triage, half of them are waiting to be seen, and we have 2 inductions waiting to come in.
Insufficient # of Staff, Case Load High: 2 patients were delivered in triage, there is 1 RN along in PACU with 2 patients on magnesium sulfate for pre-eclampsia and 1 patient with Von Wilderud's Disease. No breaks or meals for anyone. **(repetitive and consistent response)**
Health and Safety, Insufficient # of Staff, Acuity High: The MD is pushing Hydralazine on a patient with a severe range of BPs. I have 2 immediate post-op patients, and 3 of my patients are on magnesium sulfate for severe pre-eclampsia, 1 of my patients is receiving a blood transfusion. **I am the ONLY PACU RN on duty today.**
Insufficient # Qualified Staff, Inadequately Trained: I was **alone in triage** for the start of the shift until 8 p.m. I was then given a postpartum RN who was never oriented to triage and not adequately trained to care for labor patients. All charting of fetal heart strips had to be done by me because I did not have the time to orient when staffing was extremely unsafe.
Health & Safety; Insufficient # of Staff & High Acuity: Pediatric ED understaffed such that there is more than a 3.5 to 6 hour wait time to see a provider, more than 20 patients holding in triage area, no RN screener, patients pulling out IV and multiple attempts to bite, kick, scratch, and punch staff. Census 68, only 6 RNs.
High Acuity, Insufficient # of Qualified Staff: We have no CAN in the **PICU**. Management sent us only 1 CNA to cover for 2 constant observations and 3 extended observations. The 3 extended observations require GI feeds, oral foods, and constant care. No one to cover the 1:1 patients. We also have patients receiving IV drips, we have one suicidal patient, the charge nurse is taking a full patient assignment,
High Acuity, Insufficient # of Qualified Staff: We have patients in **PICU** on every 3 hour blood sugars with seizure precautions, patients with chemotherapy due, patients who are pre-op, patients with sickle cell disease and in pain (crisis), patients on PAP who need monitoring, and no CNA.
Lack of Resources, High Patient Acuity, Case Load High: We have no IV solution (DSW/NS) on the **PICU** unit and none in the hospital per central supply department, we have no screener. 2 PICU patients, 6 admissions with a 3 - 6 hour waiting time in waiting area with no RN screener. We have 20 patients in the waiting area for triage and 15 waiting to be called in. No coverage for breaks and meals **(repetitive and consistent response)**
High Patient Acuity, Insufficient # Qualified Staff: We had 3 staff call out in **PICU**- 2 RN and 1 CNA, and 1 nurse was floated out of the unit to the epilepsy unit. We have 3 close clinical watches, 1 constant observation and 2 enhanced observation, 2 discharges and 2 admissions. Manager states she has a call out a for RNs to come in. **(repetitive and consistent response)**
High Patient Acuity, Insufficient # Qualified Staff, Violation of Staffing Ratios: On **NICU**, we have 2 orientee RNs, and 2 CPAP baby, 4 CPAP babies with IV and ABTs, 3 babies with IV antibiotic and glucose checks every 3 hours. Our bed capacity is 35 and we are over with a census of 44. Only 3 RNs on duty. Parents need personal attention/education.
High Patient Acuity, Insufficient # Qualified Staff, Violation of Staffing Ratios: Our Census in the **NICU** is

42 with 4 RNs having patient assignment over contractual nurse to patient ratios. 1 RN has 2 babies on CPAP with a central line, 1 baby with PIV and a total of 8 babies, 2nd RN has 2 babies on CPAP, 2 babies with peripheral IVs, 1 baby with PICC line, and 1 baby on contact isolation. 3rd RN has 2 babies on CPAP with central lines, needs to administer 10 medications, feedings and is in charge until temporarily, 4th RN has 1 post-surgical baby who is intubated and 2 babies who are "NPO" with sepsis.
High Patient Acuity, Insufficient # Qualified Staff: Per Diem RN floated into **NICU,** never oriented to unit and required support, but she left at 11:15 a.m. for a family emergency. Charge Nurse has assignment with 1 CPAP baby. I am supporting another refresher orientation RN who has no orientation to NICU and is working between NICU and new born nursery.
High Patient Acuity, Insufficient # of Staff: The **CCU** has no CNA and most of the 13 - 17 patients on the unit need complete care. 7 patients on vents, 2 patients with trachs, patients with robotic CABG needing 1:1 coverage, 1 patient on BIPAP, patients on hypothermia, patients with open abdomen, patients receiving blood products, at times, 3 RNs required to care for 1 patient. **(repetitive and consistent response)**
High Patient Acuity, Case Load High, No Time Documentation, Health & Safety: I am protesting my personal assignment in the **CCU.** I have 1 patient on constant observation with agitated, combative, and violent behavior towards staff where patient continues multiple attempts to bite, kick, scratch, and punch staff. Patient behavior requires more than 1 staff member present to maintain safety of patient. Patient pulled out IV access and is detoxing. I have a patient who sustained a new skin tear in the midline coccyx area, 1 patient on contact and droplet precautions who is complete care and needs to be turned and positioned every 2 hours, 1 new admission who is a high fall risk (fell at home because of hypotension) who requires constant vitals and observation, 2 patients on every 4 hour glucose monitoring. Staff feeling overwhelmed by triple admission from ED and PACU, patients with delirium assigned to charge nurse, patient with active bleeding requiring transfusions of multiple blood products.
High Patient Acuity: Assignment given to RN in **CCU** presents an unsafe situation. Patient 1: 8 hours post-op open heart surgery with 4 vessel bypass, valve repair, and a rare cardiac myomectomy procedure. Patient is currently intubated with plans to do a bedside bronchoscopy and extubation during shift. As per manager, RN must be present at bedside at all times until extubation. Patient requiring continuous monitoring of vitals and constant titration of pressors and sedation. Patient 2 Post op open cholecystectomy complicated by bile leak and a fistula. Patient is also intubated and being weaned for extubation. Patient with mental status change post op and is scheduled for a CT scan of head today. According to policy T-4, patient requires level 1 care and must be accompanied by and RN. Patient also spiking fevers and required to be cultured. Unit consists of 15 critically ill patients, on other patient on hypothermia, another requiring peritoneal dialysis every 5 hours.
High Patient Acuity, Case Load High: CCU Unit consists of patients with multiple IVs requiring frequent blood draws, patients in atrial fibrillation with frequent ectopies, patients on ventilators, patients on multiple pressors, patients on hypothermia, and patients requiring hourly glucose monitoring.
High Patient Acuity, Insufficient # of Staff: ICU has 14 patients and 11 are vented, 9 with multiple drips, 2 of the RNs needed to triple up to care for one patient during the shift patient on post hypothermia, charge RN with 2 complete assignments.
High Patient Acuity, Insufficient # of Staff: SICU has 10 patients on vents, patients needing liver transplant, patients needing kidney/pancreas transplant, and one of our staff is an orientee, GI bleeder, patients needing frequent suctioning, patients on isolation, travel RNs are replacing SICU nurses who have been floated out of the unit **(repetitive and consistent response)**.
Patient Acuity High, Case Load High: Unit consists of 30 patients with 27 of them on telemetry requiring vital signs every 4 hours, 2 patients on BIPAP, 15 total care patients requiring turning and positioning every 2 hours, 9 patients with pressure ulcers requiring wound care and turning and positioning every 2

hours, 2 confused patients on extremely high risk for falls, 2 patients on vents, 1 on enhanced observation, 1 patient on levophed drip and insulin drip, 1 patient on Lasix drip, and 1 patient on remodulin drip requiring constant observation and assessment, 4 patients on isolation, **each RN has 6 or more patients,** 2 hallway patients and only 5 RNs and 2 CNAs on duty. **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Health & Safety, Not adequately trained: Unsafe situation, 1 critically unstable patient who requires 1:1 nursing care, patient is on multiple drips (insulin, levothyroxine, levophed, phenylephrine, sodium bicarb, vasopressin) and patient currently requires a higher level of care that a telemetry RN with 4 other patients can safely and adequately provide. Patient is ventedand an active organ donor, currently receiving transplant work-up to facilitate potential organ donation. Patient requiring continuously blood pressure monitoring to maintain a MAP of 60 for continuous organ effusion according to policy, RNs on this unit are not supposed to be administering the organ donation meds. An arterial line was placed at bedside and none of the RNs on this unit have been trained to care for an arterial line. Patient requires blood glucose monitoring every 2 hours as patient is on an insulin drip. No ICU beds are available. As per hospital policy, unable to triage the patient ahead of a living patient. 13 complete care patients on the unit that require turning and positioning every 2 hours, 1 suicidal patient that is on 1:1 constant observation, 8 patients with pressure ulcers that require turning and positioning every hour, 4 contact isolation patients, 8 patients with high fall risk (score > 65) and 11 congestive heart failure patients that require Montefiore's very extensive congestive heart failure patient teaching. Only 6 RNs on unit today. **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Volume of Admissions, Health & Safety: Extremely high acuity, 30 patients on unit, 26 on telemetry requiring vital signs every 4 hours, 8 total care patients requiring turning and positioning every 2 hours, 6 patients with wounds and pressure ulcers requiring turning and positioning every 1 hour, multiple admissions from ED, 11 Congestive heart failure patients on strict I & O and daily weights, 1 patient brought on unit from ED was unescorted by ED RN and not on telemetry monitoring, 2 patients on constant observation for safety for self-harm, 1 patient on enhanced constant observation for patient safety, 6 patient on contact and droplet isolation, 3 patients on heparin drips, 1 patient on nitro drip, 3 patients on Lasix drip, 1 patient on remodulin drip, 2 hallway patients, **only 6 RNs and no CNAs on the floor (repetitive and consistent response)**
Patient Acuity High: Case Load High: Extremely high acuity for 5 RNs and no CNA on meals and breaks. 3 admissions, 2 patients in the hallway, 12 total care patients, 1 patient on constant observation for suicidal ideation, 1 patient on enhanced observation, 4 patients on continuous Lasix, nitro, and heparin drips, 3 patients on contact/droplet isolation for RSV, 3 patients on droplet isolation for flu, 1 patient on contact isolation for C. Diff, 26 patients on continuous telemetry monitoring requiring vital signs every 4 hours, 2 patients post cardiac catheterization, 11 heart failure patients requiring reinforced heart failure education. **(repetitive and consistent response)**
Patient Acuity High, Case Load High: Unit consists of 31 patients, includes 2 hallway patients, multiple total care patients including confused patients on frequent reorientation plans, 7 enhanced observation patients, 6 contact and droplet precautions and our only CNA is sitting with the patient who needs constant supervision. Case load makes it impossible to give medications on time or deliver care on time.
Patient Acuity High, Case Load High, Not Honoring Contract Ratios: 2 vented stepdown patients, 1:4 ratio not honored, 2 hallway patients, privacy and safety impedes care and standards of excellence, 1 RN is assigned a 1:8 ratio, including 1 telemetry monitoring.
Patient Acuity High, Case Load High, Not Honoring Contract Ratios: I have 3 patients, with 1 hallway and 2 stepdown, 5 RNs have 6 patients and 1 RN has 7 patients, step down nurses with 6 patients each, 1 RN has an orientee and this staffing impedes patient safety and jeopardizes HCAP scores and patient experiences.

Patient Acuity High, Case Load High: Patient was brought up as a hallway patient and is in sickle cell crisis and is combative, mute, deaf, and uncooperative. Patient is currently projectile vomiting all over the hallway. Patient refuses to sit down due to crisis. ED should not have transferred this patient to a hallway as patient is not safe to travel. Patient is stripping her clothes and refusing clothes. Patient has menstrual cycle and has no bathroom (not in a room) and she is bleeding all over her legs and blood in her bed and her nails.
Patient Acuity High, Case Load High, Not Enough Qualified RNs: Census is 31. We have 1 graduate RN and 1 RN floated from another floor on the unit with limited step-down/telemetry patients. 4 step-down patients, 3 vents, 2 patients on levophed, 1 hallway patient, 2 trachs with 1 intubated. We need 2 more RNs to cover stepdown.
Patient Acuity High, Case Load High: Extremely high acuity, 3 BIPAP, 1 vent, 2 drips, 4 patients with wounds, 27 telemetry requiring vitals every 4 hours, 2 enhanced observations, 1 EOC, 1 CNA to watch continuous watch patient, congestive heart failure patients with daily I & O, 10 complete care patients, multiple confused patients, patients on fall risk plans, no breaks for any RNs, multiple patients needing to be turned and positioned every 2 hours, management has been aware for days that the floor is short staffed with only 4 RNs scheduled, and no help was arranged **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Not Enough Qualified RNs, Not Honoring Contract Ratios and High Volume Admissions: Multiple high fall risk patients, no secretary, high volume of admissions, RNs not specialty RN and cannot take the behavioral patients on step-down and telemetry. Nurse to patient ratio violates contract—RN ratio 1:6-7 for all RNs instead of contract 1:4.
Patient Acuity High, Not Honoring Contract Ratios, High Volume Admissions: Census 31, 4 RNs with **1:6 patient, 1 RN with 1:7 patients,** 2 vented patients 1 patient on BIPAP, 1 patient with restraints, 16 patients with complete care, 10 patients on fluid drips, nitro drips, other cardiac drips, 1 patient on blood transfusion who is also on enhanced observation, 5 patients in isolation, 11 hallway patients, 4 admissions, 1 discharge, patients on glucose monitoring every 4 hours **(repetitive and consistent response)**
Patient Acuity High, Insufficient No of Qualified Staff: Not enough RNs to care for patients on floor. We have 2 pre-lung transplant patients, patients on remodulin, patients on enhanced observation, patients on vents, levophed drips, calcium gluconate, and we had 1 CNA and 1 RN pulled from the floor. Unable to do hourly rounding. **(repetitive and consistent response)**
Health & Safety: We have a patient who is 450 pounds and is on a vent. Need more staff and equipment to turn and position this patient. 2 patients fell over the weekend due to low staffing.
Patient Acuity High, Not Honoring Contract Ratios: RN to patient ratio 1:5-6 in violation of contract. Patients on Amiderine (requires frequent re-assessment and vitals every 2 hours), patients on multi-dirps (Vassopressin, remodulin, levophed), patients on enhanced observation, patients on enhanced observation, patients on BIPAP, complete care patients, contact isolation patients; patients with chest tubes, only 1 CNA on the floor. **(repetitive and consistent response)**

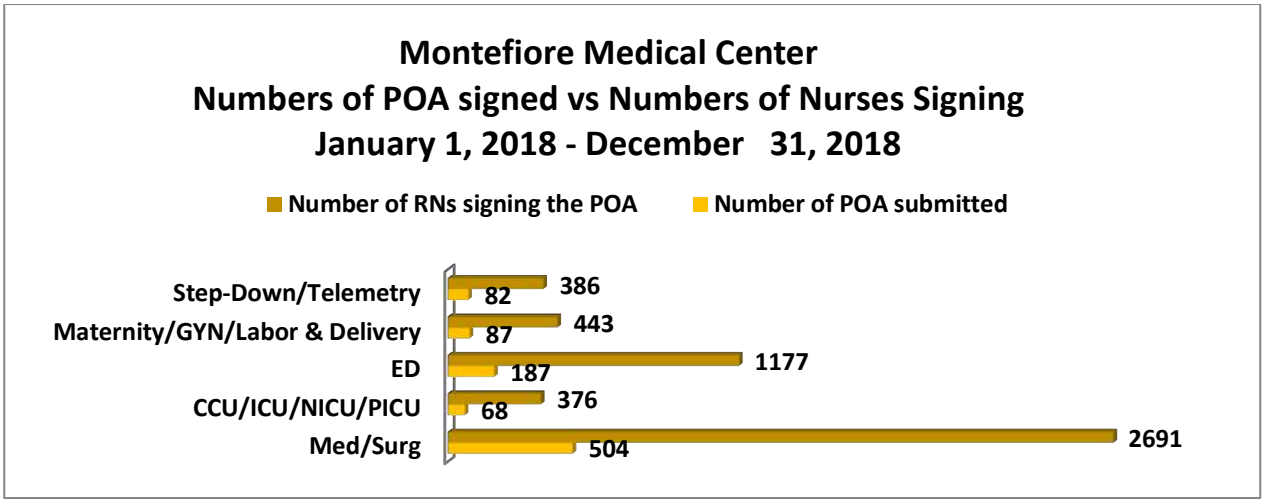
The 976 hospital wide POAs filed at Montefiore Medical Center January 1, 2018 through December 31, 2018 document a distribution by unit type, which is reflected in Table 2 below:

Table 2: Distribution of POAs by Unit Type

Unit	Number of POA submitted	Number of RNs signing the POA	Percent
CCU/ICU/NICU/PICU	68	242	7%
ER	187	1177	19%
Maternity	87	443	9%
Med-Surg	504	2691	51%
OR/Anesthesia	4	10	0
Peds	23	134	2%
Psychiatry	37	102	4%
Step Down	82	386	8%
Total	976	5405	

Medical Surgical Units generated the largest portion (44%) of the total Protest of Assignments. The Emergency Departments generated 2nd largest portion, 23% of the total Protest of Assignments. The FMCH units generated the third largest portion at 11%. The critical care units generated the fourth largest portion at 9% (CCU/ICU/NICU/PICU).

Figure 5: Numbers of POA vs Numbers of Nurses Signing POA by Unit Type



The 976 hospital-wide POAs filed at Montefiore Medical Center from January 1, 2018 - December 31, 2018 document a distribution by reason for filing the POA by unit type, which is reflected in the Table 3 below:

Table 3: Reason for Protest of Assignment by Unit Type

Specialty Unit TOTAL POA = 976	Number of Nurses Signing	Other	Inadequate No. Qualified Staff	Don't Have Resources Needed	Patient Acuity Too High	Case Load Too High	No Time for Documentation	Volume Admissions & Discharges High	Not Adequately Trained

CCU/ICU/ NICU/PICU	242	5	32	3	28	30	21	10	2
ER	1177	31	156	106	149	130	153	116	44
Maternity/ GYN	443	9	64	5	54	52	52	40	10
Med/Surg	2691	64	412	96	382	369	353	187	52
OR/Anesthesiology/ Recovery	10	1	2	2	1	3	1	1	1
Peds	134	1	11	5	14	14	15	7	1
Psychiatry	102	4	31	2	36	26	19	3	13
Step-Down/Telemetry	386	8	60	7	53	54	51	40	11
Other	24	1	2	1	2	3	1	0	0
Undetermined	196	12	28	10	25	19	23	16	4
Grand Total	**5405**	**136**	**798**	**237**	**754**	**700**	**689**	**410**	**138**

*In CCU / ICU / NICU / PICU, the ED, the Med-Surg. Units, the Psychiatric Units, and the Telemetry Units, the most common reasons for protest of assignments were lack of numbers of qualified staff, a caseload that impedes the delivery of safe care, high patient acuity, high volume of admissions and discharges, lack of resources and facility support, and an inadequate time for documentation. Other reasons were also identified in accordance with Table 1.

Nurse Staffing and Patient Care Quality and Safety

"Nursing is a critical factor in determining the quality of care in hospitals and the nature of patient outcomes" (Wunderlich, Sloan, and Davis, 1996). For several decades, health care researchers have reported associations between nurse staffing, safe practice environments, and positive patient

outcomes. Nevertheless, staffing levels, workplace environments, and availability of resources are set by administrators, not nurses, and are affected by forces that include budgetary considerations.

Other characteristics of the workplace environments include the physical environment, communications systems, collaboration, information systems, and support services. All of these factors ultimately influence the quantity of nursing time, as well as the quality of nursing care (Clarke and Donaldson, 2008).

Recognizing the importance of adequate staffing for the provision of quality patient care, the Montefiore Medical Center recognizes that there should be an appropriate number of staff on each unit. Thus, the Montefiore Medical Center has negotiated with the New York State Nurses Association the following language, which, when violated, can be submitted to arbitration:

“Staffing levels shall be based, in part, on an assessment of the patients on the unit, the unit’s average daily census/visits, and the competency of the personnel on the unit. Staffing patterns and staffing distribution are designed to meet the nursing care needs of groups of patients within the framework of pertinent institutional factors and resources. The parties agree that the determination of staffing needs is a constant, dynamic process influenced by a number of factors including: patient acuity, technology, unit and hospital census, standards of professional practices, resources, competency of staff, staff mix, productivity, vacancies (including leaves of absence, vacation, etc.), unplanned absences (including sick calls, emergencies, etc.), service specialty, nature of services, needs and acuity of both the Hospital and unit patient population, and applicable federal, state, local and JCAHO regulations. The Association and the Employer have agreed to implement the following Staffing Levels/Nurse-To-Patient Ratios (the “Ratios”) effective on March 1, 2012 at both the Henry and Lucy Moses Division and the Jack D Weiler Hospital of the Albert Einstein College of Medicine:

Chart 3: The Negotiated Nurse to Patient Ratios Montefiore Medical Center and NYSNA

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
CTICU (E)	ALL	1:2
7S (E) Medicine 9S (E) Medicine 9N (E) Medicine	ALL	1:6
10S (E) Medicine 10N (E) Surgery	ALL	1:6
8S (E)Telemetry	ALL	1:6 (Telemetry/Med-Surg.) 1:4 Stepdown
8N (E) Cardiology	ALL	1:6
11N (E) Ortho	ALL	1:3/1:4 Stepdown Levels 1:6 Med/Surg.
RAU CARDIAC CATH LAB (E)	D/N DAILY	2-3 RNs 5 RNs
RADIOLOGY (E)	DAILY	4 RNs
11S (E) Oncology	ALL	1:6
NICU (E)	ALL	1:2 Intensive Care Area 1:4 Intermediate Area
6S/5S/newborn nursery (E) Maternity	ALL	1:10 with 1-2 RNs in the Nursery
6N (E)L&D	ALL	11 RNs
Endoscopy (E)	Daily	7 RNs
AMB/SURG (E)	ALL	ASPAN Guidelines
PACU (E)	ALL	ASPAN Guidelines
MSICU (E)	ALL	1:2
2N (E)Rehab	ALL	1:6
DIALYSIS (E)		1:3
ADULT ED (E)	7A 11A 7P	6-7 RNs 3 RNs 6 RNs
Day Hospital (CHAM)	ALL	ASPAN Guidelines
Peds Dialysis	D E	2 RNs 2 RNs
CSICU (M)	ALL	1:2
N6A (M) ICCU N6B (M) ICCU	ALL ALL	1:5, 1:4 Stepdown 1:5; 1:4 Stepdown
CCU (M)	ALL	1:2
MICU (M)	ALL	1:2
SICU (M)	ALL	1:2
NW1 (M) Neuro	ALL	1:6
STROKE UNIT/NW1 (M) Adult Epi (M)	ALL	1:4
CHAM 10 EPI (M)	ALL	2 RNs & 1 LPN
CHAM 6 (M) Adolescent	ALL	1:5
PICCU (M)	ALL	1:2
CHAM 8 (M) Infants	ALL	1:5

Chart 3: The Negotiated Nurse to Patient Ratios Montefiore Medical Center and NYSNA

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
CHAM 9 (M) Child Oncology	ALL ALL	1:5 1:3
MIU	DAY EVE	4 RNs 2 RNs
RADIOLOGY (M)	DAY EVE	6-8 RNs 2-4 RNs
AMB/SURG (M)	ALL	ASPAN Guidelines
PACU (M)	ALL	ASPAN Guidelines
GIS (M)	DAILY	12 RNs 3 LPNs
N7AW (M) Ortho	ALL	1:6
N7AE (M) Vascular Transplant	ALL	1:6 – Med/Surg. 1:6 – Transplant 1:3 – Transplant 1st 24 hours Post op
N7B (M) Surgery	ALL	1:3/1:4 Stepdown 1:6 Med/Surg.
NW2 (M) Oncology	ALL	1:5
NW3	ALL	Med Surg: 1:6 Tele: 1:5
Same Day (M)	ALL	ASPAN Guidelines
K4-8	ALL	1:6
NW 4-8 (M)	ALL	Med Surg: 1:6
K2 (M)Psych	DAY NIGHT	3 RNs 2 RNs + 1 LPN
DIALYSIS (M)		1:3
CARDIAC CATH LAB (M)	Table of organization	18 RNs 11 Techs
PEDS ED (M)	7A 10A 12P 7P	4 RNs 1 RN 2 RNs 5 RNs
ADULT ED (M)	DAYS EVE NIGHTS	11 RNs 6 RNs +1 LPN Fast Track 11 RNs
POS (M)	ALL	1 RN + 1 Tech

Focused Analysis of POAs by Clinical Division

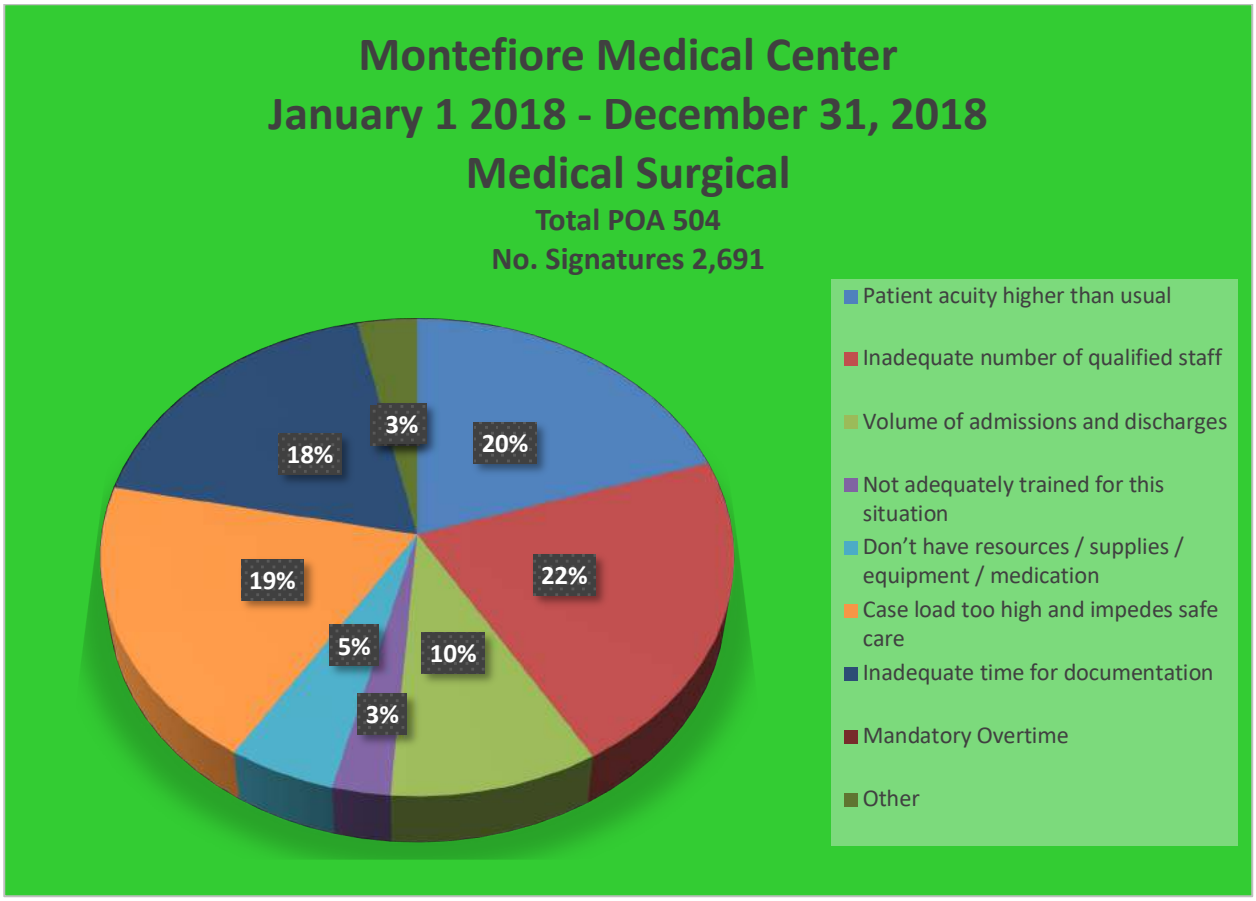
The following **focused analysis of POAs by clinical division** filed in the Montefiore Medical Center documents potential deficiencies in abiding by State and Federal law, negotiated nurse-to-patient ratios, and established standards of care as follows:

- The POAs document that requirements by State and Federal law and established standards of care have been repeatedly disregarded. This is evidenced by multiple POAs being inadequately addressed by management, management's failure to acknowledge RN concerns, and management's failure to provide a permanent solution to these staffing issues.
- The POAs document that ratios negotiated by the Montefiore Medical Center and the New York State Nurses Association in each of its nursing specialty units have been repeatedly disregarded. This is evidenced by multiple POAs being inadequately addressed by management, management's failure to acknowledge RN concerns, and management's failure to provide a permanent solution to these staffing issues.
- The POAs reveal the registered nurses have repeatedly and consistently documented an inadequate number of qualified staff to safely care for the volume of patients being admitted and discharged. The POAs also note instances of high case load, a lack of necessary management support and resources, and high acuity of patients causing delays in treatment. This has also necessitated the employer to request overtime work from its nursing staff. These factors increase the potential for episodes of failure to rescue and provision of quality nursing care. The POAs indicate that some nurses lack the training to provide exemplary care to this vulnerable patient population and have inappropriately been mandated to patient care units where they lack the necessary skills and training to appropriately provide nursing care. The POAs also repeatedly note a lack adequate time for documentation which impacts continuity of care, patient safety, and quality of care.
- The POAs provided examples of high volume of cases, extensive time required for rounds and high workload. They reflect several instances of high volume of admissions and discharges, high case load and high acuity of patients causing delays in treatment. These factors increase the potential for episodes of failure to rescue and render necessary care.
- The POAs document that there is a lack of supplies to meet immediate needs of patients and that there is computer systems that need to be addressed.

Chart 4: Montefiore Medical Center and the New York State Nurses Association Negotiated Nurse to Patient Ratios in Medical Surgical Units

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
CTICU (E)	ALL	1:2
7S (E) Medicine 9S (E) Medicine 9N (E) Medicine	ALL	1:6
10S (E) Medicine 10N (E) Surgery	ALL	1:6

Figure 6: Reason for POA in Medical – Surgical Nursing



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
20%	22%	10%	3%	5%	19%	18%	0%	3%

*The percentages noted in each categorical area reflect those POAs that document only one reason for the filing of the POA. However, the total number of POAs that delineate each categorical reason is calculated by the individual category + the "other" category.

The **five hundred and four (504) POAs, supported by two thousand six hundred and ninety one (2,691) signatures, POAs** filed in The Montefiore Medical Center between January 1, 2018 – December 31, 2018 indicates that there are consistent issues throughout the hospital in the Medical / Surgical Departments that include:

- Inadequate staffing for acuity, admission volume, discharges and caseloads.
- Lack of resources and training to adequately and safely meet the needs of the patient population.
- Inadequate time for patient care and documentation.
- Lack adequate numbers of qualified staff to address the needs of the patient population

Figure 7: Reason for POA by Frequency and Percentage

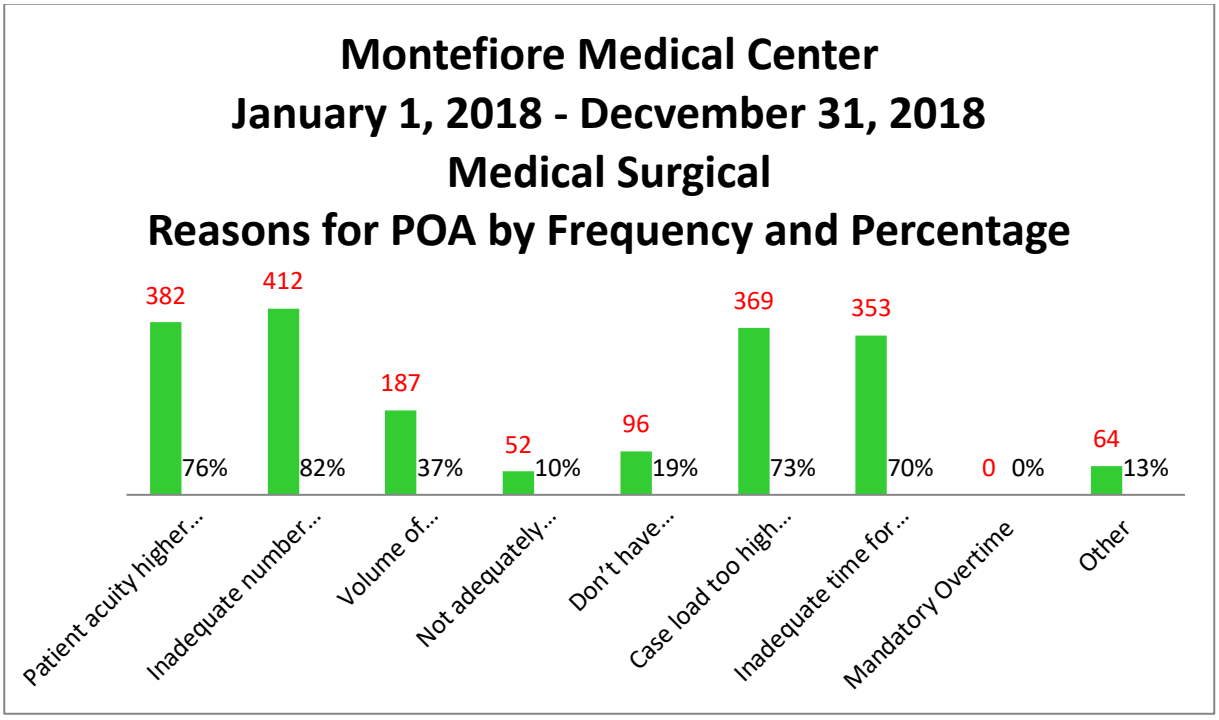


Figure 8: POAs/Signatures Medical – Surgical Nursing

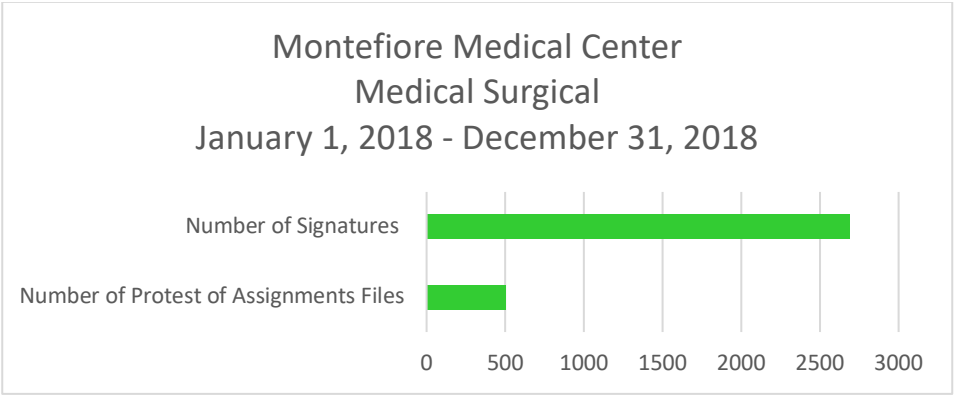


Table 4: Other Reasons for POAs in Med / Surgical

Medical/Surgical Units: A sampling of the Comments Written on the POAs
Insufficient # of Staff, High Acuity: Unable to meet organizational goals, unable to give medication on time, not enough time to teach patients, not enough time for documentation, call bells not answered in a timely manner, family members and patients dissatisfied with care, 99% of patients at high fall risk, multiple patients on wound care, multiple vented patients, multiple patients requiring enhanced observation and sitters, no CNA on floor, nurses doing everything. **(repetitive and consistent response)**
Health & Safety: MD on the unit is aggressive and combative toward staff
Insufficient # of Staff, High Acuity: Only 4 nurses on the unit. Multiple patients on BIPAP, 1 vented patient, 1 trach patient, patients on Levophed, 1 patient on constant observation for suicide attempts, multiple (3) hallway patients, multiple patients needing glucose monitoring every 4hours and complete care, several patients attempting to elope. **(repetitive and consistent response)**
Insufficient # of Staff and High Acuity: Multiple incontinent patients, multiple feed assistance patients, multiple pressure ulcers and multiple patients on isolation precautions, our CNAs have been pulled from the floor, leaving us with only 1 assistant. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Patients on insulin drips requiring glucose monitoring and VS monitoring every hour, patients with trachs, vents, tub feedings, incontinence, multiple patients on isolation. We only have one CNA and there is a patient on 1:1 constant observation. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Multiple GI bleeds, patients with trach care, patient waiting for liver transplant, patients on unit that belong in ICU and waiting for a bed that is currently not available, other patients on the unit inappropriately placed who below in stepdown, multiple BIPAPs, drips, blood transfusion.
Insufficient # of Staff: Unit currently with 28 patients, 2 admissions to come, 1 patient constantly climbing out of bed and trying to put his head between the bed rails, 9 complete care patients, charge nurse taking a full patient load, only 1 CNA on the floor.
Insufficient # of Staff and High Acuity: Monitoring a hallway patient with perianal bleeding, no privacy.
Not Adequately Trained: Staff on unit not trained to have patients on cardiac drips that require constant monitoring. No ACLS staff.
Insufficient # of Staff: Pulled nursing assistants to float to another unit **(repetitive and consistent response)**
Volume of Admissions and Discharges: High influx of admissions and transfers (8 admissions), RNs moving patients, CBI, trach, multiple isolation patients, BIPAP patients, multiple patient needing pain management, many complete care patients, 3 hallway patients, charge RN with full assignment.
Health & Safety: Impeding Safe Care: RN directed by administration to accept a patient with a diagnosis of thoracic aneyrysm with no monitoring of vitals via monitor. **NO MONITOR AVAILABLE, NO STEPDOWN BED AVAILABLE,** patient's blood pressure is increasing as time progresses 142/101, 157/94, now 172/100. Patient in need of telemonitoring.
Insufficient # of Staff, High Acuity: Unit census was 21 at start of shift with 2 admissions to be received. Now census is 26 with an additional 2 patients en route. A total of 11 admissions will be received on this shift. No CNAs on floor. 1 ventilated patient, 2 with trach, 1 on restraints, 3 isolations, multiple incontinent patients, 3 pressure ulcers, 1 blood transfusion, all call bells ringing but nurses are busy with admissions, over 20 patients on fall risk.

Insufficient # of Staff, High Acuity: 32 high acuity patients, patient population over bed census, hallway patients, multiple patients with EOC, ventilator, BIPAP, fall risk, wound care, complete care, frequent BP monitoring, pain management, post-op patients. Charge nurse with full assignment. No CNA on the floor.
Patient Acuity High: Patient acuity requiring more time to complete tasks. Multiple patients require complete care, on drips, in particular norepinephrine, which requires close monitoring and titration. Multiple patients with pressure ulcers who are incontinent and need frequent changes and would dressings due to soiled dressings, constant turning and positioning. Most patients are at risk for falls. **(repetitive and consistent response)**
Insufficient # of Staff: RN became ill and she was not replaced. We are expecting a 4th hallway patient and one **HALLWAY PATIENT ACTIVELY SEIZING.**
Insufficient # of Staff: No CNA or secretary assigned to floor. No one to answer telephones and call bells. Patients with trach and ventilators, wound care, pain management, glucose monitoring, complete care. **(repetitive and consistent response)**
Insufficient # of Staff & High Acuity: Patients on dobutamine drip, constant observation for active suicidal, multiple high fall risk patients who need constant redirection and reorientation, multiple wound care patients, three bariatric patients, BIPAP, multiple finger sticks, PICC lines, isolation patients, frequent pain management. **(repetitive and consistent response)**
Insufficient # of Staff, High Acuity: Mechanically vented patient with poor baseline status that was not transferred to ICU, has continuous fentanyl, levophed drip, titrated, and increased during shift. Patient is hyperglycemic, needing multiple insulin coverages. Patient's sodium level 168, see by nurse for seizure history, Neuro asking why patient wasn't in ICU. Patient's temp 100.5, PA ordering multiple labs.
Insufficient # of Staff, High Acuity: We have 6 hallway patients, including 2 day room patients, patients with vents and restraints, multiple constant observations with only one covered, BIPAP, patients with bradycardia, no unit secretary, no CNA.
Insufficient # of Staff, High Acuity: Entire staff wearing mas—quarantined unit, patient with C. diff, 5 droplet isolation, 1 trach, 16 complete care patients, two airborne isolation patients, 2 hallway patients, 3 very confused patients.
Insufficient # of Staff, High Acuity: 1 RN pulled to another floor. We have 2 admissions and 4 transfers to come, 1 patient awaiting discharge, 3 hallway patients (1 who is legally blind), 2 vent/trach patients requiring frequent suctioning, 10 complete care patients who require frequent turning, 10 confused patients, 5 with pressure ulcers, 3 isolations patients, 4 with PICC lines, 1 heparin drip, surgical patients who require frequent pain management.
Insufficient # of Staff in Violation of Negotiated Nurse to Patient Ratios of 1:6: *****Our patient census is 33 and we only have 5 RNs on duty today. *Each nurse is responsible for 12 patients today. We have 9 transfers, 5 admissions, 4 trach patients. *RN to patient ratio today is 1:7. Inadequate time for assessments and documentation * Our patient census is 20 and we only have 3 RNs on the floor and 2 of them are float nurses. * RN to patient ratios 1:7 for 3 RNs on unit. Unable to do hourly rounding or adequate evaluation of complex patient needs. No time for documentation * 1 RN with a patient ratio of 1:8 today who has 6 hallway patients
Volume of admissions and discharges: We are anticipating multiple admissions with 2 patients currently in the hallway. 2 patients have pressure ulcers, 1BIPAP, 1 CPAP, 3 on isolation, 2 PICC lines, 3 with Foleys, 1 heparin drip, 2 colostomies, 1 fecal management system awaiting a step down bed, 1 patient who is a deaf/mute requiring sign language, 14 complete care patients.
Insufficient # of Staff: Today there are no CNAs on the floor and each nurse is responsible for 12 patients during breaks and meals. We have several morbidly obese patients who require 4-5 nurses to

turn/position the patient. We have multiple fall precaution patients and patients on bed alarms.
Insufficient # of Qualified Staff: Our census is 30 and we only have 5 RNs on duty today, 3 of them are new and 1 is a float.
Health and Safety, Insufficient # of Staff, High Acuity: Multiple patients requiring pain management, many with pressure ulcers requiring frequent repositioning, blood sugar assessments, foley care, wound care, respiration assessments for patients on BIPAP, contact isolations, call bells unable to be answered in a timely fashion. Only 1 CNA on floor. Patient fell during handoff.
Insufficient # of Qualified Staff: Charge RN has full complement of patients. New RN just off orientation needing guidance and assist with assignment. 1 patient on vent with multiple drips, 1 patient with multiple drains, transfused, 1 patient high acuity needing transfer to stepdown, 1 patient transfused with PRBC and having difficulty breathing even on hi flow oxygen, multiple patients on bed alarms due to confusion and fall risk.
Volume of Admission and Discharges, No Time for Documentation: 18 patients with 4 late discharges and 2 late admissions, and 4 more admissions scheduled, 1 patient on a vent, 3 patients on isolation, 1 enhanced observation due to seizure activity and hallucinations. No secretary, charge RN with full patient load, not enough time for documentation
Insufficient # of Qualified Staff: No CNA on the floor, 13 complete care patients, 2 vents, 2 trach collars, multiple fall risks, multiple wound care, sickle cell care patient, multiple patient assists.
Insufficient # of Staff: Once again we have a patient recording staff on his phone due to delayed staff responses to his issues and demands. Multiple 1:1 watches, we are supposed to have a sitter but non available as per nursing office. Multiple complete care and pain management patients. 3 PIBAPA, 1 vent, 1 trach, hallway patients, multiple would care patients.
Insfficient # of Staff & High Acuity: (multiple occurrences) multiple patients IV drips with insulin, levothyroxine, levophed, phenylephrine, socium bicarb, heparin, nitro,and vasopressin administration, and also complex, confused, complete care, respiratory distress, tube feeds, arterial lines, work up to facilitate organ donation, blood glucose monitoring every 2 hours, suicidal patients, continuous vital sign monitoring, hallway patients, isolation patients, patients with tracheostomies.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Montefiore Medical Center

- The following State and Federal laws and regulations, standards of care, and accreditation requirements may have been left unaddressed in this situation:
    1) **State Regulations: New York Code of Rules and Regulations:**
    Care of Patients: Every patient of the hospital, whether an inpatient, emergency service patient, or outpatient, shall be provided care that meets generally acceptable standards of professional practice. **10 NYCRR 405.2(f) (1);**
    2) Hospitals shall have available at all times, personnel sufficient to meet patient care needs. **10NYCRR 405.2(f)(7);**
    3) Nursing Services: The Director of Nursing shall be responsible for the operation of the service including developing a plan to be approved by the hospital for determining the types and numbers of nursing personnel and staff necessary to provide nursing care to all areas of the hospital. **10 NYCRR 405.5(a)(1);**
    4) The hospital shall provide supervisory and staff personnel for each department or nursing unit to ensure, when needed in accordance with generally accepted standards of nursing practice, the immediate availability of a registered professional nurse (RN) for bedside care of any patient. **10 NYCRR 405.5(a)(2);**
    5) In addition, all facilities that accept Medicare patients are subject to the following **Federal regulations:**
    The nursing service must have adequate numbers of RNs, LPNs and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of an RN for bedside care of any patient. **42 CFR 482.23(b);**
    A registered nurse must supervise and evaluate the nursing care for each patient. **42 CFR 482.23(b)(3);**
    6) **The Academy of Medical-Surgical Nurses** mandates "providing a safe environment for both the patient and nurse [as] a paramount concern. The patient should receive resources according to need, and the medical-surgical nurse must be able to provide the resources based on his or her licensure, education, and role. Demand for staffing guidelines comes not only from the nursing profession, but also from consumers and policy makers seeking parameters for safe, quality patient care."
    7) **New York Code, Rules and Regulations, Title 10** Part 405 (Hospital Minimum Standards) requires "(2) The governing body, in order to achieve and maintain generally accepted standards of professional practice and patient care services in the hospital, shall establish, cause to implement, maintain and, as necessary, revise its practices, policies and procedures for the ongoing evaluation of the services operated or delivered by the hospital and for the identification, assessment and resolution of problems that may develop in the conduct of the hospital." **(405.2 (b) (2));**

8) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards)** states that "(1) The hospital shall comply with all applicable Federal, State and local laws, including the New York State Public Health Law, Mental Hygiene Law, and the Education Law," and "(2) The governing body shall take all appropriate and necessary actions to monitor and restore compliance when deficiencies in the hospital's compliance with statutory and/or regulatory requirements are identified, including but not limited to monitoring the chief executive officer's submission and implementation of all plans of correction." **(405.2(c));**
9) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards)** requires adequate number of staff to ensure "the immediate availability of a registered professional nurse for bedside care of any patient when needed". **(405.5 (a)(2));**
10) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21 "Condition of participation: Quality assessment and performance improvement program. (c)** ***Standard: Program activities*** (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care;"
11) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23** "**Condition of participation: Nursing services. (a)** ***Standard: Organization.*** The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital;
12) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23 "Condition of participation: Nursing services (b) Standard: Staffing and delivery of care.** The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed;"
13) **Joint Commission. (2013). Standard LD.04.03.11** The hospital manages the flow of patients throughout the hospital;
14) Joint Commission. (2013). LD.03.06.01, EP 3 Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services;
15) **Joint Commission. (2013). LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others;
16) Joint Commission Human Resources HR.01.01.01
"The hospital has the necessary staff to support the care, treatment, or services it provides" (The Joint Commission, 2012, HR -3);
HR. 01.02.01
"The organization defines staff qualifications" (The Joint Commission, 2012, HR -3). Elements of performance include defining staff qualifications specific to job duties. Includes infection prevention and control management;
HR.01.02.05

"The organization verifies staff qualifications" (The Joint Commission, 2012, HR -3). Elements of performance include ensuing that staff are licensed, certified or registered per State law; credentials are verified; education and experience is verified; a criminal background check and applicable health screening are completed;

HR.01.02.07

"The organization determines how staff functions within the organization" (The Joint Commission, 2012, HR -6);

Elements of performance include possessing the license, certification or registration in accordance with law and regulation; staff practice within the scope of their license; and that "staff oversee the supervision of students when they provide patient care, treatment or services as part of their training" (The Joint Commission, 2012, HR -5);

HR.01.04.01

"The organization provides orientation to staff" (The Joint Commission, 2012, HR -7). Elements of performance include key safety content determined by the organization to be included. Orientation must include and be documented- relevant policies and procedures; specific job duties, cultural diversity and patient rights. (The Joint Commission, 2013, HR- 7);

HR.01.05.03

"Staff participates in ongoing education and training" (The Joint Commission, CAMH, Update 2, October 2013, HR -7);

Elements of performance include participation and documentation of that participation by staff in ongoing education and training to maintain or increase competency; whenever staff responsibilities change; education that is specific to the needs of the population served and the need to report unanticipated adverse events and how to report these events.

17) (The Joint Commission, 2013, HR- 8);

HR.01.06.01

"Staff are competent to perform their responsibilities" (The Joint Commission, 2012, HR -9). Elements of performance include that the organization defines the competencies; reviews those competencies initially in orientation and once every three years or more and takes action when competency does not meet expectations. (The Joint Commission, 2012, HR-9);

HR.01.07.01

"The organization evaluates staff performance" (The Joint Commission, 2012, HR -9). Elements of performance include evaluation based on job responsibilities; and every three or more years.

18) **NYS Education Law Article 139** (Nurse Practice Act) and **Part 29** of the Rules of the Board of Regents require that licensees practice within the scope defined in law and within their personal scope of competence. If an RN is not competent to provide a service that they are legally allowed to provide, then they may not provide that service;
19) **New York Code, Rules and Regulations Title 10 Part 405 (Hospital Minimum Standards**) requires that a registered professional nurse shall plan, supervise, and evaluate the nursing care for each patient. A registered professional nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of such other nursing personnel **(405.5 (b)(2)(ii));**

20) **Center for Medicare and Medicaid Services (CMS)** - Competency is a requirement for nursing staff listed in the conditions of participation for hospitals to ensure that demonstration and documentation of competency is evident (Code of Federal Regulations, Title 42 ("Public Health") **§482.23(b)(5);§482.25(b)(2)(i));**
21) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21** "**Condition of participation: Quality assessment and performance improvement program. (e)** ***Standard: Executive responsibilities*** (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated. (3) That clear expectations for safety are established. (4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients;"
22) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23** "**Condition of participation: Nursing services. (a)** ***Standard: Organization.*** The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. **(b)** ***Standard: Staffing and delivery of care.*** There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient;
23) **Joint Commission. (2013) LD.04.04.05** The hospital has an organization wide, integrated patient safety program within its performance improvement activities. **LD.04.04.05, EP 1** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. **LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. **LD.03.01.01** Leaders create and maintain a culture of safety throughout the hospital. **LD.03.01.01, EP 1** Leaders regularly evaluates the culture of safety and quality using valid and reliable tools. **LD.03.06.01, EP 3** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. **EC.02.01.01, EP 1** The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.
24) **New York Code, Rules and Regulations Title 10 Part 405 (Hospital Minimum Standards**) requires timely medication and treatments in accordance with doctor's orders **(405.5 (c)(1-3));** and adequate and working equipment **(405.24 (c)(2) i-ii));**
25) **New York Code, Rules and Regulations Title 10 Part 405 (Infection Control)** "The hospital shall establish an effective infection control program for the prevention, control,

investigation and reporting of all communicable disease and increased incidence of infections, including nosocomial infections, consistent with current acceptable standards of professional practice." **(405.11);**

26) **Centers for Disease Prevention and Control** has provided guidelines for facilities describing control measures for preventing infections associated with air, water, or other elements of the environment (CDC, 2013);

27) Code of Federal Regulations, Title 42 ("Public Health") § 482.41 "**Condition of participation: Physical environment.** The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community **(c)** ***Standard: Facilities.*** The hospital must maintain adequate facilities for its services. (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality;"

28) Joint Commission (2013). LD.04.04.05 The hospital has an organization wide, integrated patient safety program within its performance improvement activities **LD.04.04.05, EP 1** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. **EC.02.01.01, EP 1** The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

29) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards**) requires an adequate number of staff to ensure immediate availability of a registered professional nurse for bedside care of any patient when needed **(405.5 (a)(2));** timely assessment and reassessment **(405.5 (b)(2-4));** timely medication and treatments **(405.5(c) (1-3));** adequate and working equipment **(405.24 (c)(2)(i-ii));** timely documentation **(405.5 (b) (2-4); 405.10(c)(1));**

30) An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**

31) Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

32) **Code of Federal Regulations, Title 42 ("Public Health") § 482.24** "**Conditions of Participation: Medical record services.** (c) Standard: Content of record. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures;"

33) The records kept by the nurses are required in order to ensure that continuity of care is provided to their patients. The American Nurses Association have established the Principles for Documentation which speak to who, what, where, when, why and how of documentation for the patients.

Need for Action

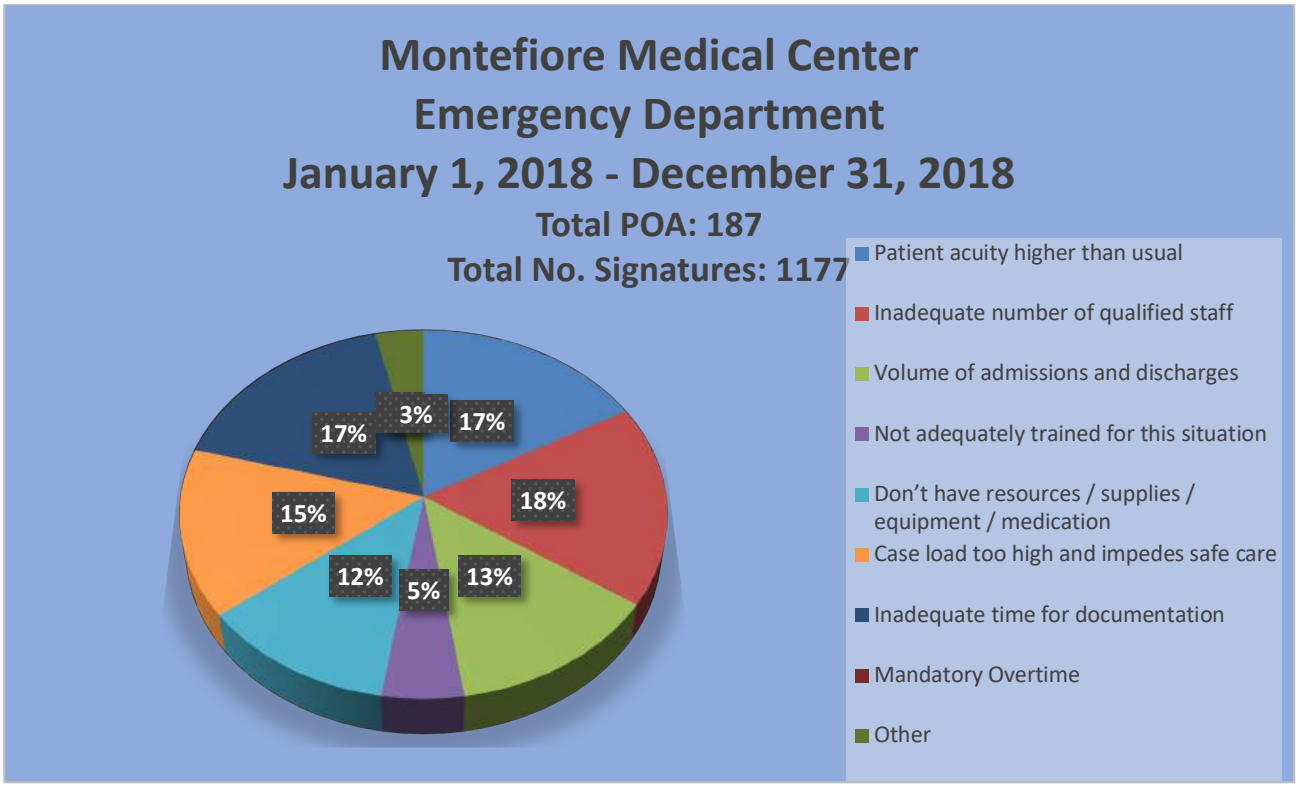
Nurses working in the Medical / Surgical Departments throughout Montefiore Medical Center are committed to improving delivery of care with the following recommendations:

- Increase medical-surgical care registered nurses, licensed practical nurses and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation and the Guidelines for Professional Registered Nurse Staffing for medical-surgical units and to provide for adequate time for documentation in accord with standards of practice;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of Montefiore Medical Center's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Medical / Surgical Care, while concomitantly meeting the individual needs of Montefiore Medical Center's patient population

Chart 5: Montefiore Medical Center and the New York State Nurses Association Negotiated Nurse to Patient Ratios in ED

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
ADULT ED (E)	7A 11A 7P	6-7 RNs 3 RNs 6 RNs

Figure 9: Reason for POA in Emergency Department



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
17%	18%	13%	5%	12%	15%	17%	0%	3%

*The percentages noted in each categorical area reflect those POAs that document only one reason for the filing of the POA. However, the approximate total number of POAs that delineate each categorical reason is calculated by the individual category + the "other" category. See Percentage Bar Graph below.

The **one hundred eighty seven (187) POAs, supported by one thousand one hundred seventy seven (1,177) signatures,** filed in Montefiore Medical Center between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the hospital in the ER Department that includes:

- Inadequate staffing of RN and ancillary staffing for acuity, admission volume, discharges and caseloads.
- Unsafe conditions caused by lack of resources, overcrowding, and boarding.
- Inadequate time for patient care and documentation.
- Lack adequate numbers of qualified staff to address the needs of the patient population.

Figure 10: Reason for POA by Frequency and Percentage

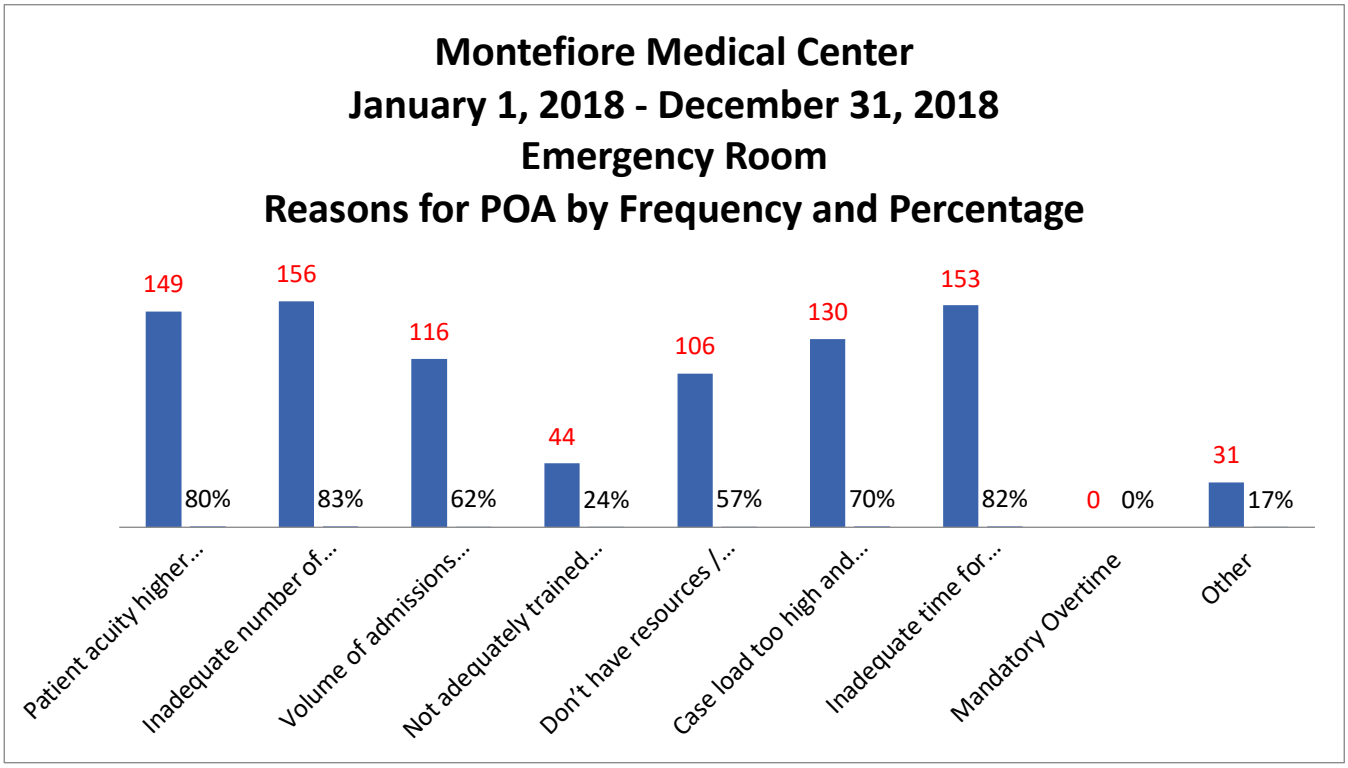


Figure 11: Number POA/Signatures in Emergency Department

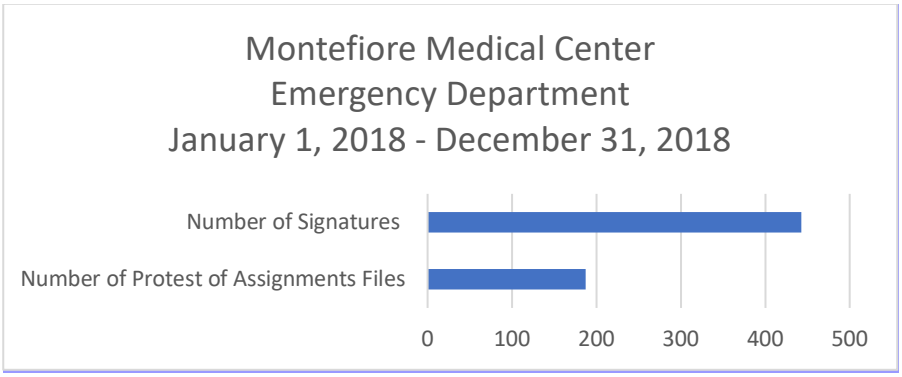


Table 5: Other Issues Specifically Identified in the ED POAs

ED Units: A sampling of the Comments Written on the POAs
Insufficient # Qualified Staff, High Patient Acuity: RNs responsible for seven (7) or more level two patients, many are intubated on multiple drips, multiple blood transfusions, multiple total care patients, one patient missed dialysis five times due to staffing, multiple patients with continuous observation, only four (4) RNs on midnight shift, delayed administration of meds. **(repetitive and consistent response)**
Lack of Resources: No stretchers, no monitors, no space for beds, patient safety compromised, no free access to oxygen on wall due to rows of patient beds, no water on unit (both machines broken), pyxis is empty of meds, no monitors, no lines, no leads for cardiac monitors, no thermometers, inadequate ventilation, electronic equipment not functioning. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Patient Acuity, Lack of Resources: Patients remain in the ED for three to five (3 – 5) days. Nurses mixing meds, pharmacy not refilling orders, Vital sign machine not working, stretchers not available, no linen, no IV fluids. Multiple hallway patients, multiple patients on BIPAP, vent, drips.
Health and Safety: Insufficient space, hallway patients, patients stacked in rows, unable to access patients in a timely manner, temp in ED 76 degrees on west side, air conditioning not working on East side and area is **very hot** and uncomfortable, inadequate ventilation, unable to comply with appropriate infection control. Patients waiting days to get a bed and aggressive to staff. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, Violation of Staffing Regulations: Staff unable to take breaks or meals **(daily occurrences)** Census 50 patients in waiting room with wait time of 6 hours and 24 minutes; 85 patients, 6 RN and 5 ½ hours waiting to be triaged; 50 patients and 5 nurses resulting in inability to administer medications in a timely manner; census 80 and only 7 RNs; Only 2 nurses assigned to Blue Zone and each with 15 patients; RNs covering 19+ patients resulting in no time to medicate or document in accord with policies
Insufficient # of Staff, High Patient Acuity: Red zone census with acuity ill patients, 4 complete care patients with decubitus ulcers and diarrhea, patients on levophed drip requiring close monitoring, one patient on IV cardene and IV protonix drip requiring 5 minute vital sign check, patients on enhanced observation for safety, 1 patient on multiple PRBC transfusions, IV antibiotics, and 1 patient on BIPAP.
Insufficient # of Qualified Staff: 37 patients waiting in triage and 55 patients waiting to be triaged with a 9 hour waiting time. 16 patients are waiting in waiting area with a 7 hour waiting time. 95 patients in ED right now, no tech on the floor to help out, 7 hour wait time to see an MD.
Insufficient # of Qualified Staff, High Patient Acuity: Acuity in **Red zone/Blue zone** very high with one nurse caring for patients including 8 intubated and IV levophed, BIPAP, telemetry, 1 stroke code requiring 95 minute vital sign check, 1 on suicidal watch who is unstable secondary to drug overdose, will be receiving new patients in the ED that are unstable, patient with chest pain
Insufficient # of Adequately Trained Staff: ED has 2 orientees, and 2 traveler nurses, no regular staff for 3 – 11 shift, staffing such that only one nurse in each zone during meal breaks, patients on insulin drips
Insufficient # of Qualified Staff: One RN covering 19 patients, 8 with blood transfusions, 8 unable to administer medication on time, no rooms for vented/BIPAP patients,
Lack of Resources: Unable to provide space/privacy for grieving families due to patient beds parked in front of bereavement room, unable to provide privacy due to environmental conditions (extreme overcrowding). **(repetitive and consistent response)**
Volume of Admissions: 160 patients in the ED at 7 p.m., multiple patients with extended length of stay waiting for beds on the floors, more than 30 patients waiting to be triaged, wait time to see an MD is 4 – 8 hours. **(repetitive and consistent response)**

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Montefiore Medical Center

- The following State and Federal laws and regulations, standards of care, and accreditation requirements may have been left unaddressed in this situation:
  1) **Public Health Law 2805-b** (1) Admission of patients and emergency treatment of non-admitted patients. **1.** Every general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed… ;
  2) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Governing body** -**Organization and Operation-405.2(b)(2)** hospitals must establish, implement, and maintain policies and procedures to insure the hospital is acting in accord with generally accepted standards of professional practice; **405.2(c)(1-2**) hospitals must operate in compliance with Federal, State and local laws; **405.2(f)(1)** every patient of the hospital shall be provided care that meets generally acceptable standards of professional practice; **405.2(f)(7)** hospitals shall have available at all times personnel sufficient to meet patient care needs;
     New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-**Nursing services 405.5(a)(2)** the hospital shall provide nursing staff for each department or nursing unit to ensure, in accordance with generally accepted standards of nursing practice, the ***immediate availability*** of a registered professional nurse for bedside care of any patient; **405.5 (b)(2-4)** timely assessment and reassessment of nursing care plans and evaluation of the adequacy and appropriateness of nursing care; **405.5(c)(1-3)** timely medication and treatments shall be provided; **405.10(c)(1)** there shall be timely documentation upon completion of provision of care;
     New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Quality assurance program 405.6(b)(1) shall involve all patient care activities and review care provided by all;
     New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Medical Records 405.10(c) requires timely documentation. This appears to be challenging given the number of POAs documenting an ***EMR system that crashes often***, leaving the RNs and other health care providers in the vulnerable position of not being able to adequately and safely communicate with one another. This endangers patient safety and care and violates the following standards of care;
     An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**
     Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)- **Emergency Services 405.19(d)(2)(iv)(a- b); 405.19(d)(3); 405.19(e)(2)** minimum number of nurses required are mandated;

3) **Emergency Nurses Association Scope and Standards of Practice r**equire that the RN advocate for the safety and welfare of healthcare consumers who are in "an emergency or significant phase of their illness or injury" (ENA, 2011, p. 2);
4) **Emergency Nurses Association Guidelines for ED Nurse Staffing (2003)** require a skill mix of 86% RN; 14% non-RN; two nurses 24 hours/day, 7 days/week for low volume ED's;
5) **American Academy of Emergency Medicine (2001):** Minimum nurse-to-patient ratio should be 1:3 or based on the rate of patient influx such that the rate of 1.23 patients per nurse per hour is not exceeded;
6) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21 "Condition of participation: Quality assessment and performance improvement program. (c) Standard: Program activities** (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care;"
   (e) Standard: Executive responsibilities address priorities for improved quality of care and patient safety**;**
7) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23 "Condition of participation: Nursing services (a)** ***Standard: Organization*** well-organized service with a plan of administrative authority and delineation of responsibilities for patient care **(b)** ***Standard: Staffing and delivery of care****.* The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed." There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. **(b)** ***Standard: Personnel****.* (1) The emergency services must be supervised by a qualified member of the medical staff. (2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility;"
8) **Code of Federal Regulations, Title 42 ("Public Health") § 482.41** "**Condition of participation: Physical environment.** The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community **(c)** ***Standard: Facilities.*** The hospital must maintain adequate facilities for its services. (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality"
   NOTE: the violation of this standard is particularly concerning in view of the documented malfunctioning ECG machines in SIUH's ER;
9) **Joint Commission. (2013). Leadership (LD) - LD.03.01.01** Leaders create and maintain a culture of safety throughout the hospital. **LD.03.01.01, EP 1** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools **LD.03.06.01, EP 3** Leaders provide for a

sufficient number and mix of individuals to support safe, quality care, treatment, and services **LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. **LD.04.03.11** The hospital manages the flow of patients throughout the hospital. **LD.04.04.05** The hospital has an organization wide, integrated patient safety program within its performance improvement activities. **LD.04.04.05, EP 1.** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events;

10) **Joint Commission. (2013). Environment of Care(EC)- EC.02.01.01, EP 1** The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment;
11) **Joint Commission. (2013). Life Safety (LS)-LS.02.01.20:** The hospital maintains the integrity of the means of egress.

Overcrowding

Since 1989, the New York State Department of Health (DOH) has repeatedly acknowledged the dangers of overcrowding. The emergency service regulations were amended limiting patient waiting in the emergency room to eight hours **(10 NYCRR 405.19(e)(2))**. This regulation was part of the impetus by the DOH to create accountability by hospitals to change the process and systems issues that continue to exist. An additional response to this and other unforeseen events, included the establishment of a data base HERDS (Hospital Emergency Response Data System) designed to allow the DOH and health care systems throughout the state to identify and monitor public health incidents as they occur (Barron, 1989).

The DOH reaffirmed the obligations and responsibilities of hospitals in 2000 to "develop meaningful solutions to address these issues." In the Dear Administrator Letter, the DOH strongly recommended hospitals begin to create and implement plans that would change this culture of overcrowding bulleting out 9 hospital obligations and responsibilities (New York State Department of Health, 2000).

In 2009, the DOH started using HERDS to identify hospitals to receive a survey to identify root causes, develop best practices and disseminate this information. No information is available on this initiative (NYSDOH, 2009).

1) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards)** "Care of patients. The governing body shall require that the following patient care practices are implemented, shall monitor the hospital's compliance with these patient care practices, and

shall take corrective action as necessary to attain compliance: (1) every patient of the hospital, whether an inpatient, emergency service patient, or outpatient, shall be provided care that meets generally acceptable standards of professional practice." **(405.2 (f) (1)).**

2) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards**) **Emergency Services** requires that: "if, on average:
(a) the volume of patients per eight-hour shift is under 25, an additional registered professional nurse shall be available as needed to assist the supervising registered professional nurse with delivery of direct patient care; or (b) the volume of patients per eight-hour shift is over 25, there shall be a minimum of two registered professional nurses per shift assigned to provide direct patient care. **As patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet patient care needs;**"
and further provides:
"(4) Support personnel. There shall be sufficient support personnel assigned to the emergency service to **perform the following duties on a timely basis: patient registration, reception, messenger service, acquisition of supplies, equipment, delivery and labeling of laboratory specimens, responsible for the timely retrieval of laboratory reports, obtaining records, patient transport and other services as required.**"
and still further provides:
(e) Patient care. (1) **The hospital shall assure** that all persons arriving at the emergency service for treatment receive emergency health care that meets generally **accepted standards of medical care**. (2) Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage[1] and transfer policies and protocols adopted by the emergency service and approved by the hospital. No later than **eight hours** after presenting in the emergency service, every person shall be admitted to the hospital, or assigned to an observation unit in accordance with subdivision (g) of this section." **(405.19(d)(2)(iv)(a- b); 405.19 (d)(3); 405.19 (e)(2));**

3) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21** "**Condition of participation: Quality assessment and performance improvement program. (e)** ***Standard: Executive responsibilities*** (2) That hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated. (3) That clear expectations for safety are established. (4) That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients;"

4) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23** "**Condition of participation: Nursing services. (a)** ***Standard: Organization.*** The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel

[1] "Triage" is an information collecting and decision making process. It is performed in order to sort injured and ill health care consumers into categories of acuity and prioritization based on the urgency of their medical or psychological needs (ENA, 2011. P. 47)

and staff necessary to provide nursing care for all areas of the hospital. **(b)** ***Standard: Staffing and delivery of care.*** There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. **(b)** ***Standard: Personnel.*** (1) The emergency services must be supervised by a qualified member of the medical staff. (2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility;"

5) **Joint Commission. (2013) LD.04.04.05** The hospital has an organization wide, integrated patient safety program within its performance improvement activities. **LD.04.04.05, EP 1.** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events. **LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. **LD.03.01.01** Leaders create and maintain a culture of safety throughout the hospital. **LD.03.01.01, EP 1** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. **LD.03.06.01, EP 3** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. **EC.02.01.01, EP 1** The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. **EC.02.03.01:** The [organization] manages fire risks. **LS.02.01.20:** The hospital maintains the integrity of the means of egress;
6) **Potential for unintended HIPAA violations –** While there have been substantial changes to the current HIPAA/HITECH, facilities are still required to ensure that there are appropriate safeguards in place and unintended disclosure is prevented. Allowing the emergency room to have stretchers touching one another, and not providing sufficient room for confidential discussion of health information, the facility is subject to potential violations of patient confidentiality (US Department of Health and Human Services, 2009).

Inadequate training for triage and ER nurses

The standard of practice for training triage and ER nurses has drastically changed over recent years. Nurses who have been employed as emergency room nurses recall triage training taking three or more months with a mentor ensuring competency in this critical area.

1) **New York State Code, Rules and Regulations Title 10 405.19(d)(2)(iii)** the RN shall have at least one year of clinical experience, successfully completed an emergency nursing orientation program and demonstrate skills and knowledge necessary to perform basic life support;

2) **Emergency Nurses Association (ENA) Scope and Standards of Practice** requires that "the emergency RN triages each health care consumer utilizing age, developmentally appropriate, and culturally sensitive practices to prioritize and optimize health care consumer flow, expediting those health care consumers who require immediate care." (Emergency Nurses Association [ENA], 2011, p. 16). The standards also note that "expert triage of the health care consumers seeking treatment in the overcrowded emergency department is crucial to assure timely treatment of health care consumers with emergency conditions. Emergency nurses must be competent in the use of evidenced-based triage systems and protocols. Rapid, efficient triage and judicious care contribute to optimal health care consumer outcomes." (ENA, 2011, p.12);
3) **The ENA position statement for triage qualifications** states that "general nursing education does not adequately prepare the emergency nurse for the complexities of the triage nurse role. Emergency nurses should complete a standardized triage education course that includes a didactic component and a clinical orientation with, a preceptor prior to being assigned triage duties". In addition the nurse should acquire additional education including but not limited to: CPR, ACLS, Emergency Nurse Pediatric Course, Trauma Nurse Core course and a Geriatric Emergency Nurse Education(ENA, 2011, p. 54);
4) **American Academy of Emergency Medicine (2001)** states that dedicated triage and charge nurses are necessary in higher volume ER departments.

These standards reaffirm the responsibilities of the RN to practice competently which are set out in the NYS Education Law and Title 10 of the New York Code, Rules and Regulations.

5) **NYS Education Law Article 139** (Nurse Practice Act) and **Part 29** of the Rules of the Board of Regents require that licensees practice within the scope defined in law and within their personal scope of competence. If an RN is not competent to provide a service that they are legally allowed to provide, then they may not provide that service;
6) **New York Code, Rules and Regulations Title 10 Part 405 (Hospital Minimum Standards**) requires that a registered professional nurse shall plan, supervise, and evaluate the nursing care for each patient. A registered professional nurse shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of such other nursing personnel **(405.5 (b)(2)(ii));**
7) **Center for Medicare and Medicaid Services (CMS)** - Competency is a requirement for nursing staff listed in the conditions of participation for hospitals to ensure that demonstration and documentation of competency is evident (Code of Federal Regulations, Title 42 ("Public Health") **§482.23(b)(5);§482.25(b)(2)(i)).**

The Joint Commission Addresses Overcrowding

The Joint Commission followed up in 2004 with new leadership standards and in 2009 updated life safety code standards for boarding of patients especially patients in the emergency department and in other temporary locations (The Governance Institute, 2009). These have been revised as of 2012 and are in effect in 2013.

In 2014, further Joint Commission revisions include leadership use of data and measures to identify, mitigate, and manage patient flow issues, management of ED throughput as a system wide issue, safety for boarded patients, and leadership communication with behavioral health providers so care of boarded patients is coordinated.

Need for Action

Nurses working in the Emergency Departments throughout the Montefiore Medical Center are committed to improving delivery of care with the following recommendations:

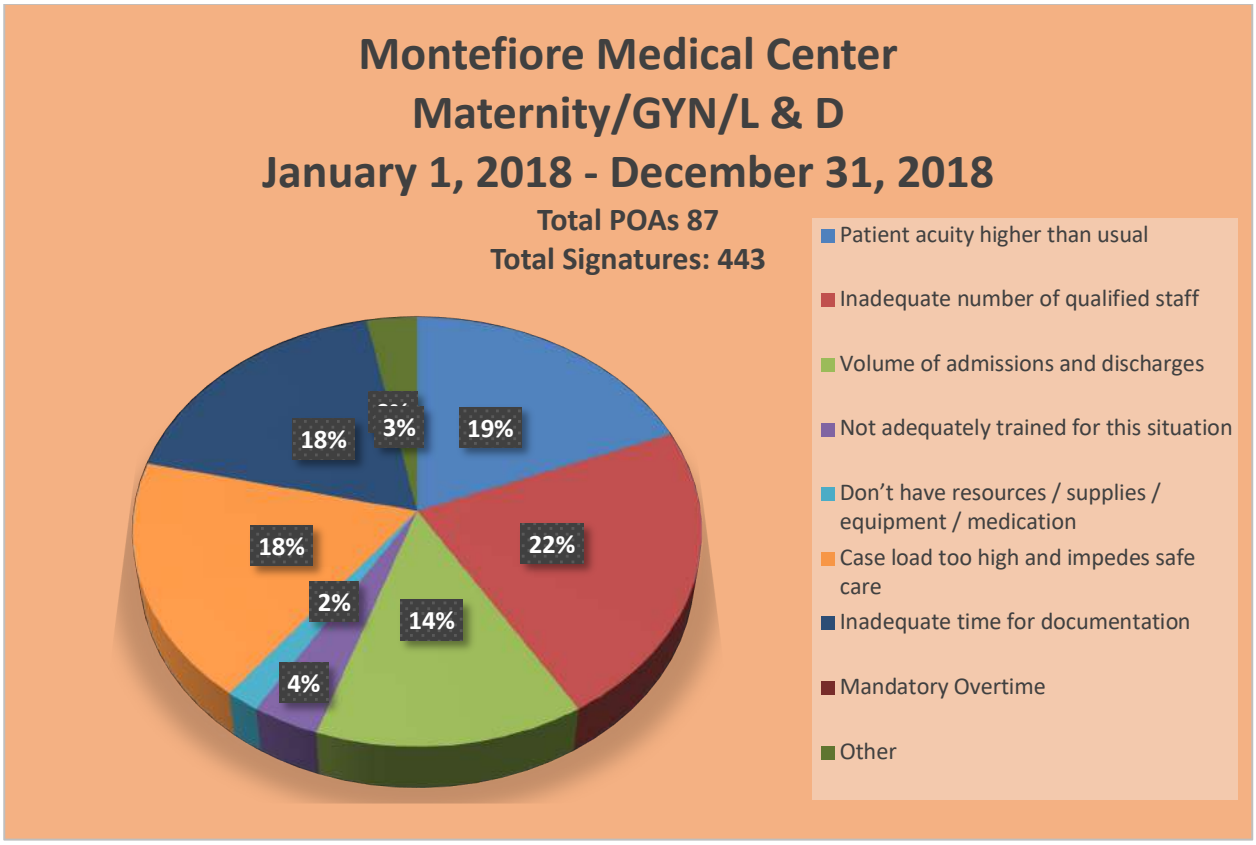
- Increase emergency room registered nurses, licensed practical nurses and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation and to provide for adequate time for documentation in accord with standards of practice;
- Open any closed beds/units to accommodate overflow patients that are normally sent to hallway beds;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix in accordance with the already agreed-to staffing guidelines and to meet the needs of Montefiore Medical Center's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Emergency Care, while concomitantly meeting the individual needs of Montefiore Medical Center's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to avoid the unnecessary and foreseeable use of floating, agency, and voluntary overtime;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of the Montefiore Medical Center's patient population in accord with specialty practice guidelines.

Chart 6: Montefiore Medical Center and the New York State Nurses Association Negotiated Nurse to Patient Ratios in Maternity/GYN/Labor & Delivery

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
6S/5S/newborn nursery (E) Maternity	ALL	1:10 with 1-2 RNs in the Nursery
6N (E)L&D	ALL	11 RNs

*** The 1:10 ratio denotes each RN has 5 couplets (mother / baby)**

Figure 12: Reason for POA Maternity/GYN/Labor and Delivery



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
19%	22%	14%	4%	2%	18%	18%	0%	3%

***The percentages noted in each categorical area reflect those POAs that document only one reason for the filing of the POA. However, the total number of POAs that delineate each categorical reason is calculated by the individual category + the "other" category.**

The **eighty seven (87) POAs, supported by four hundred and forty three (443) signatures,** filed at Montefiore Medical Center between January 1, 2018 to December 31, 2018 indicates that there are consistent issues throughout the hospital in the Maternity / GYN / L & D departments that include:

- Inadequate staffing for acuity, admission volume, discharges and caseloads.
- Unsafe conditions caused by acuity level of the patients, lack of resources, and lack of training.
- Inadequate time for patient care and documentation.

Figure 13: Reason for POA by Frequency and Percentage

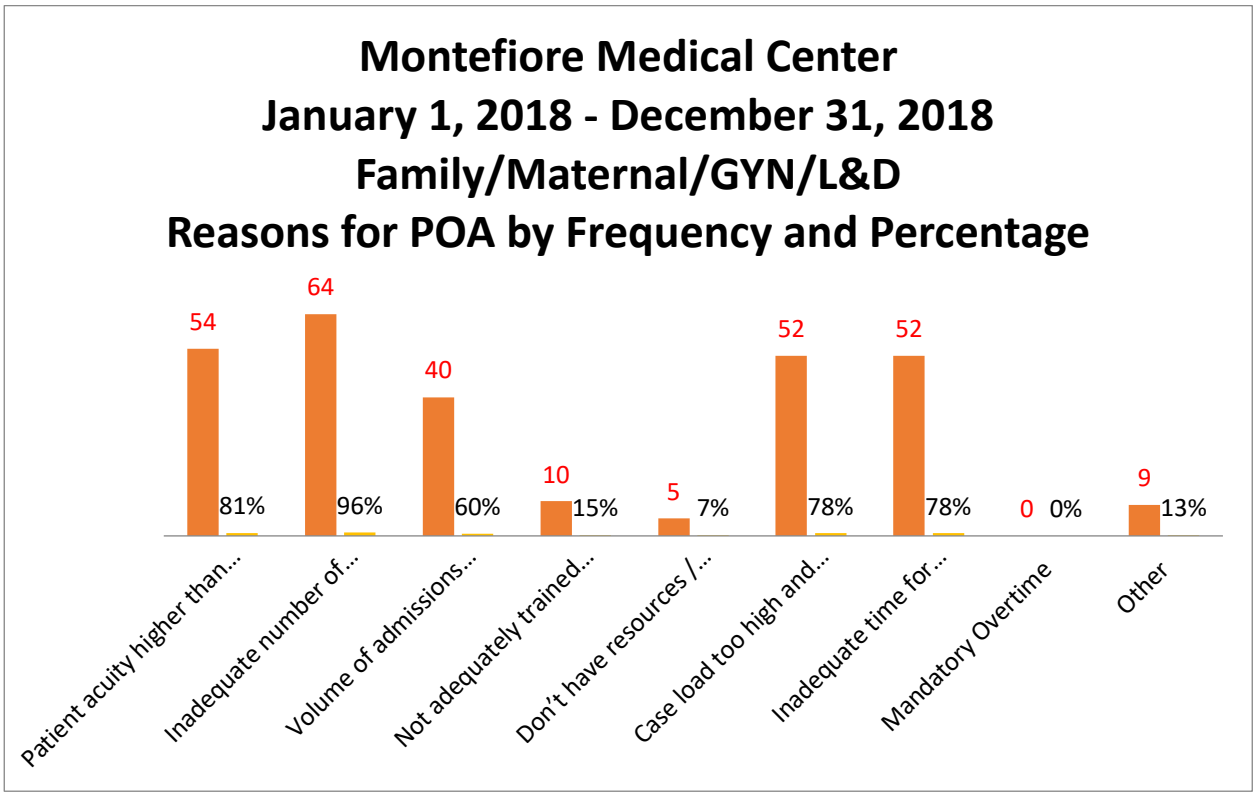


Figure 14: POAs/Signatures Maternity/GYN/Labor & Delivery

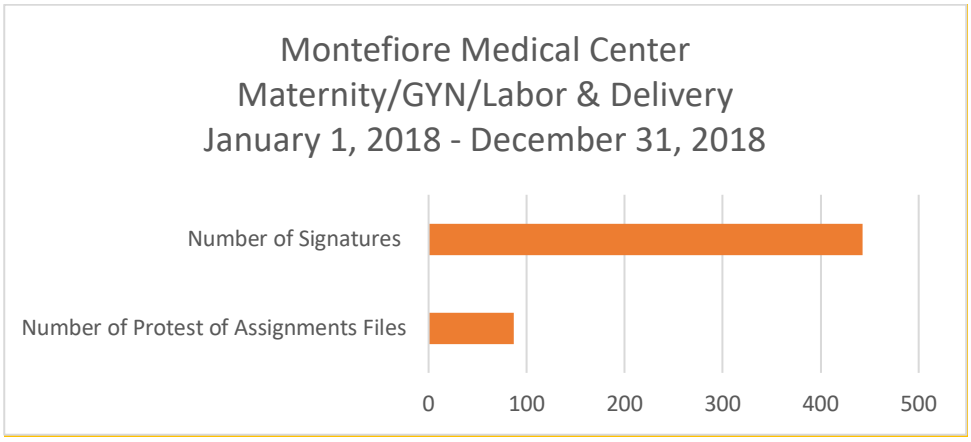


Table 6: Other Reason for POA in Maternity / GYN / Labor & Delivery

Maternal/GYN/Newborn/Labor & Delivery: A sampling of the Comments Written on the POAs
Insufficient # of Qualified Staff, Not Adequately Trained: 1 RN floated to L & D and she has never been oriented to the unit, and RN replaced 1 L & D RN who was floated to the OR. RN was floated from med/surg floor, and med/surg floor had to have an RN floated from another floor. **(repetitive and consistent response)**
Insufficient # of Qualified Staff: 2 Per Diems were cancelled and 1 overtime was cancelled and 2 RNs were floated to another floor today even though we had 6 laboring patients, 3 PACU patients, and 3 patients in triage, 2 scheduled c-sections, 1 acute patient with a cardiac condition.
Insufficient # of Qualified Staff, Acuity High, Case Load High: Census high, 8 patients in triage, 9 laboring patients, 1 + for Flu, 1 CHF patient, 2 patients on magnesium sulfate for high BP (Toxemia), 1 patient with vaginal bleeding, 6 RNs.
Health & Safety, Inadequate # of Qualified Staff: We are monitoring patients in L & D with flu, MRSA, pneumonia, morphine withdrawal complications, heparin drips, insulin drips, sickle cell crisis, eclampsia and hemorrhagic crisis, acute cardiac conditions, all needing transfers to other units with no beds available and/or 1:1 with no staff available to deliver safe care, no time for documentation, no ability to give our meds on time, no ability to properly assess patients. **(repetitive and consistent response)**
Insufficient # Staff Violation of Nurse to Patient Ratios: *I had 2 patients delivering at the same time, 1 patient in OR, and 1 patient delivering in the triage area *I had 3 inductions going on at the same time *I had 14 patients and I am overwhelmed *1Mother Fetal Assessment Center has a maximum capacity of 25 and there are 31 patients and 2 RNs.
Insufficient # of Staff, Case Load High: Only 4 nurses on the floor and several babies are on antibiotics. Our agency nurse was floated off of the floor. 4 babies need glucose monitoring.
Insufficient # of Staff, Case Load High: 7 laboring patients on the floor, 1 patient in OR, 3 patients in EU, patient in OR needed 2 RNs but only had 1 RN, EU patient needed 3 RNs, but only had 2 RN, PACU has 1 RN instead of 2 RNs, safety concerns.
Insufficient # of Staff, Case Load High: 1 RN with 11 patients, an admission and 3 babies on glucose monitoring every 3 hours, 2nd RN with twins on glucose monitoring and triple antibiotics, 3rd RN starting with 10 patients and getting an admission increasing patient load to 12, 4th RN in charge with 6 patients and getting an admission increasing patient load to 12, 1 nursery nurse with a boarder baby on Morpnine and showing withdrawal symptoms.
Insufficient # of Staff, Case Load High: only 1 RN in PACU, needs 2, 2 RNs in triage, needs 3, 2 labor and delivery rooms are closed, 7 patients are in active labor, 1 pre-term mother/baby with severe pre-eclampsia on magnesium sulfate, 3 patients in PACU, 1 on magnesium sulfate with severe pre-eclampsia, 1 with large EBL, 1 fresh post-op, there are 8 patients in triage, half of them are waiting to be seen, and we have 2 inductions waiting to come in.
Insufficient # of Staff, Case Load High: 2 patients were delivered in triage, there is 1 RN along in PACU with 2 patients on magnesium sulfate for pre-eclampsia and 1 patient with Von Wilderud's Disease. No breaks or meals for anyone. **(repetitive and consistent response)**
Health and Safety, Insufficient # of Staff, Acuity High: The MD is pushing Hydralazine on a patient with a severe range of BPs. I have 2 immediate post-op patients, and 3 of my patients are on magnesium sulfate for severe pre-eclampsia, 1 of my patients is receiving a blood transfusion. **I am**

the ONLY PACU RN on duty today.
Insufficient # Qualified Staff, Inadequately Trained: I was **alone in triage** for the start of the shift until 8 p.m. I was then given a postpartum RN who was never oriented to triage and not adequately trained to care for labor patients. All charting of fetal heart strips had to be done by me because I did not have the time to orient when staffing was extremely unsafe.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Montefiore Medical Center

- The following State and Federal laws and regulations, standards of care, and accreditation requirements may have been left unaddressed in this situation:

1) State Regulations: New York Code of Rules and Regulations

Each maternity patient, when present in a labor, delivery, birthing room or birth center shall be under the care of a registered professional nurse available in accordance with the patient's needs **10 NYCRR 405.21(e)(3)(iv);**

Level II, Level III and RPC perinatal care services shall maintain a nursing staff that is appropriately trained and adequate in size to provide specialized care to distressed mothers and infants. **10 NYCRR 405.21(d)(2)(iv);**

Post Partum / Mother Baby

Appropriate nursing care shall be available to the mother during the period of recovery after delivery. **10 NYCRR 405.21(d)(4)(v)(a)(8)(f)(2);**

Nursing personnel qualified to recognize postpartum emergencies and problems shall be immediately available. **10 NYCRR 405.21(d)(4)(v)(a)(8)(f)(2)(iv**);

Newborn Nursery

Immediate care of the newborn: At all times, the newborn shall be under the care of an RN. **10 NYCRR 405.21(d)(4)(v);**

2) An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**

3) Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

Labor and Delivery / Triage

4) Each maternity patient, when present in a labor, delivery, birthing room or birth center shall be under the care of a registered professional nurse available in accordance with the patient's needs **10 NYCRR 405.21(e)(3)(iv);**

5) Level II, Level III and RPC perinatal care services shall maintain a nursing staff that is appropriately trained and adequate in size to provide specialized care to distressed mothers and infants**. 10 NYCRR 405.21(d)(2)(iv);**

6) **AWHONN Guidelines for Professional RN Staffing for Perinatal Units: Triage** "Obstetrics triage is a process that occurs in the ED and/or on the perinatal unit….OB triage and ED triage differ in that in OB triage refers to an initial interview and assessment as well as care in the triage unit for several hours prior to disposition" **(2010, p. 7);**
7) **EMTALA:** EMTALA imposes specific obligations on healthcare providers who offer triage care to perform a medical screening examination to determine whether an emergency medical condition exists (including both the mother and the fetus), to provide necessary stabilizing treatment when an emergency medical condition exists, and to stabilize the patient, or, if the healthcare provider certifies that the benefits of transfer outweigh the risks, arrange for proper transfer to another hospital;
   Each maternity patient, when present in a labor, delivery, birthing room or birth center shall be under the care of a registered professional nurse available in accordance with the patient's needs **10 NYCRR 405.21(e)(3)(iv);**

   Level II, Level III and RPC perinatal care services shall maintain a nursing staff that is appropriately trained and adequate in size to provide specialized care to distressed mothers and infants. **10 NYCRR 405.21(d)(2)(iv);**

   Post Partum / Mother Baby
   Appropriate nursing care shall be available to the mother during the period of recovery after delivery. **10 NYCRR 405.21(d)(4)(v)(a)(8)(f)(2);**
   Nursing personnel qualified to recognize postpartum emergencies and problems shall be immediately available. **10 NYCRR 405.21(d)(4)(v)(a)(8)(f)(2)(iv**);

   Newborn Nursery
   Immediate care of the newborn: At all times, the newborn shall be under the care of an RN. **10 NYCRR 405.21(d)(4)(v);**
8) An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**
9) Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

10) **Federal Regulations**
   EMTALA imposes specific obligations on healthcare providers who offer triage care to perform a medical screening examination to determine whether an emergency medical condition exists (including both the mother and the fetus), to provide necessary stabilizing treatment when an emergency medical condition exists, and to stabilize the patient, or, if the healthcare provider certifies that the benefits of transfer outweigh the risks, arrange for proper transfer to another hospital;

11) **Joint Commission HR.01.02.05 "The organization verifies staff qualifications" (The Joint Commission, 2012, HR -3)**

Elements of performance include ensuing that staff are licensed, certified or registered per State law; credentials are verified; education and experience is verified; a criminal background check and applicable health screening are completed **(The Joint Commission, 2012, HR -3).**

HR.01.02.07 "The organization determines how staff functions within the organization" (The Joint Commission, 2012, HR -5).

Elements of performance include possessing the license, certification or registration in accordance with law and regulation; staff practice within the scope of their license; and that "staff oversee the supervision of students when they provide patient care, treatment or services as part of their training" **(The Joint Commission, 2012, HR -5).**

HR.01.04.01"The organization provides orientation to staff" (The Joint Commission, 2012, HR -6).

Elements of performance include key safety content determined by the organization to be included. Orientation must include and be documented- relevant policies and procedures; specific job duties, cultural diversity and patient rights **(The Joint Commission, 2012, HR -6).**

HR.01.05.03

"Staff participates in ongoing education and training" (The Joint Commission, 2012, HR -7).

Elements of performance include participation and documentation of that participation by staff in ongoing education and training to maintain or increase competency; whenever staff responsibilities change; education that is specific to the needs of the population served and the need to report unanticipated adverse events and how to report these events **(The Joint Commission, 2012, HR -7).**

HR.01.06.01

"Staff are competent to perform their responsibilities" (The Joint Commission, 2012, HR -8).

Elements of performance include that the organization defines the competencies; reviews those competencies initially in orientation and once every three years or more and takes action when competency does not meet expectations **(The Joint Commission, 2012, HR -8).**

HR.01.07.01 "The organization evaluates staff performance" (The Joint Commission, 2012, HR -9).

Elements of performance include evaluation based on job responsibilities; and every three or more years (The Joint Commission, 2012, HR -9).

Reference: Joint Commission (2012-2013) Human Resources, CAMAC: Comprehensive accreditation manual for ambulatory care, Update 2, September 2012 (HR-1 - HR-9) Oakbrook Terrace, IL: Joint Commission Resources;

12) **AWHONN Guidelines for Professional RN Staffing for Perinatal Units—Nurse to Patient Ratios**

2:1 Postpartum vaginal or caesarean birth (1 RN for mother and 1 or more for infant/s)

1:2 on the immediate postop day the woman is recovering from cesarean birth as part of the nurse to patient ratio of I nurse to 3 mother-baby couplets;

1:5-6 - postpartum patients without complications with no more than 2 to 3 women on the immediate postoperative day who are recovering from cesarean birth;

1:3 - postpartum patients with complications but in stable condition;
1:6-8-Newborns requiring only routine care;

Newborn Nursery

Immediate care of the newborn: At all times, the newborn shall be under the care of an RN. **10 NYCRR 405.21(d)(4)(v);**

13) An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**

14) Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

Labor and Delivery / Antepartum

1) (AWHONN Guidelines for Professional RN Staffing for Perinatal Units , 2010, p. 37)

- **1: 2-3** women during non-stress testing
- **1:2-3** after initial assessment in triage and in stable condition
- **1:3** women if in stable condition.
- **1:1** unstable antepartum
- **1:1** for IV magnesium sulfate in labor
- **1:2** Cervical ripening agents with electronic fetal monitoring and assessment every 30 minutes
- **1:2** for IV magnesium sulfate who are not in labor

Labor and Delivery / Intra-partum

2) AWHONN Guidelines for Professional RN Staffing for Perinatal Units: 1:1- (2010, p. 38):

- **1:1** Women in with medical or obstetric complications
- **1:1** 2nd stage of labor
- **1:1** Women receiving oxytocin
- **1:1** Women choosing no pain relief or medical interventions
- **1:1** Women whose fetus is being monitored via intermittent auscultation
- **1:1** Women using birthing balls or hydrotherapy
- **1:1** IV magnesium
- **1:1** Coverage for initiating epidural anesthesia
- **1:2** Women in labor without complications
- **2:1** Caesarean delivery (1 for mother; 1 or more for infant/s)
- **2:1** for vaginal births (1 for mother; 1 or more for infant/s);

Federal Regulations

EMTALA imposes specific obligations on healthcare providers who offer triage care to perform a medical screening examination to determine whether an emergency medical condition exists (including both the mother and the fetus), to provide necessary stabilizing treatment when an emergency medical condition exists, and to stabilize the patient, or, if the healthcare provider certifies that the benefits of transfer outweigh the risks, arrange for proper transfer to another hospital;

Joint Commission HR.01.02.05 "The organization verifies staff qualifications" (The Joint Commission, 2012, HR -3)

Elements of performance include ensuing that staff are licensed, certified or registered per State law; credentials are verified; education and experience is verified; a criminal background check and applicable health screening are completed **(The Joint Commission, 2012, HR -3).**

HR.01.02.07 "The organization determines how staff functions within the organization" (The Joint Commission, 2012, HR -5).

Elements of performance include possessing the license, certification or registration in accordance with law and regulation; staff practice within the scope of their license; and that "staff oversee the supervision of students when they provide patient care, treatment or services as part of their training" **(The Joint Commission, 2012, HR -5).**

HR.01.04.01"The organization provides orientation to staff" (The Joint Commission, 2012, HR -6).

Elements of performance include key safety content determined by the organization to be included. Orientation must include and be documented- relevant policies and procedures; specific job duties, cultural diversity and patient rights **(The Joint Commission, 2012, HR -6).**

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"Staff participates in ongoing education and training" (The Joint Commission, 2012, HR -7).

Elements of performance include participation and documentation of that participation by staff in ongoing education and training to maintain or increase competency; whenever staff responsibilities change; education that is specific to the needs of the population served and the need to report unanticipated adverse events and how to report these events **(The Joint Commission, 2012, HR -7).**

HR.01.06.01

"Staff are competent to perform their responsibilities" (The Joint Commission, 2012, HR -8).

Elements of performance include that the organization defines the competencies; reviews those competencies initially in orientation and once every three years or more and takes action when competency does not meet expectations **(The Joint Commission, 2012, HR -8).**

HR.01.07.01 "The organization evaluates staff performance" (The Joint Commission, 2012, HR -9).

Elements of performance include evaluation based on job responsibilities; and every three or more years (The Joint Commission, 2012, HR -9).

Reference: Joint Commission (2012-2013) Human Resources, CAMAC: Comprehensive accreditation manual for ambulatory care, Update 2, September 2012 (HR-1 - HR-9) Oakbrook Terrace, IL: Joint Commission Resources;

15) **National Association of Neonatal Nurses (NANN)** declares its position on nurse-to-patient ratios as follows "…at all times neonatal specialty care requires a minimum of two (2) registered nurses to four (4) intensive care neonatal patients with neonatal expertise and training., and two (2) registered nurses to six (6) intermediate neonatal patients." This follows the **American Academy of Pediatrics Guidelines for Perinatal Care (1997)** indicates a minimum staffing level of one (1) registered professional nurse for every two (2) to three (3) patients in intermediate care, and one (1) nurse for every one (1) to two (2) patients in intensive neonatal care. The Academy also declares "administrative pressure may exist to reduce professional staff to one (1) registered nurse [on duty] or replace them with unlicensed personnel. **NANN** does not believe such staffing patterns provide for safe or adequate nursing care based on the needs of physiologically at risk or compromised neonatal patients."

Need for Action

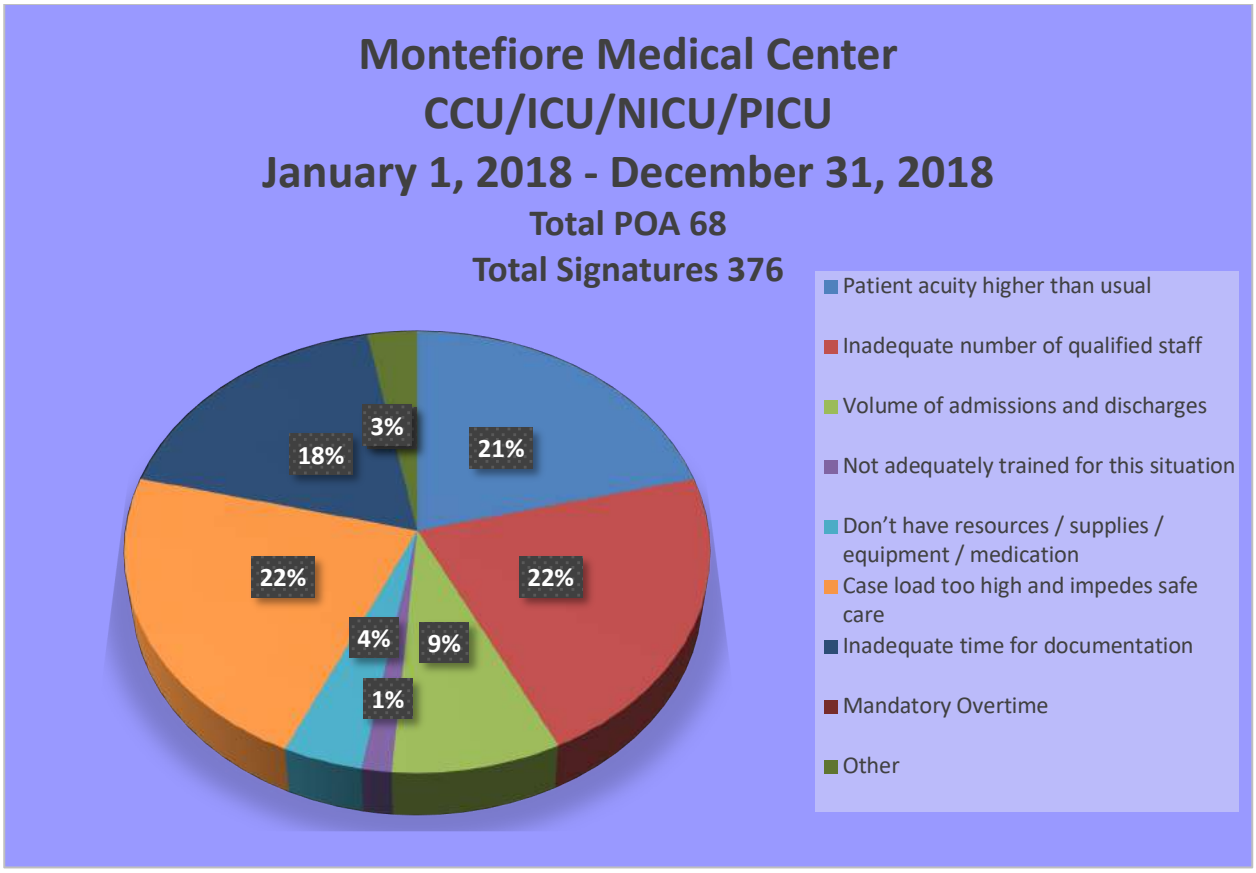
Nurses working in the Maternity / GYN / Newborn and Neonatal ICU Departments throughout SIUH are committed to improving delivery of care with the following recommendations:

- Increase maternity and newborn care and Neonatal registered nurses, licensed practical nurses and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation and the Guidelines for Professional Registered Nurse Staffing for Perinatal Units and NANN;
- Increase maternity and newborn and neonatal care registered nurses to provide for adequate time for documentation in accord with standards of practice;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of Montefiore Medical Center's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Maternity / Newborn Care / Neonatal Care, while concomitantly meeting the individual needs of Montefiore Medical Center's patient population;
- Provide adequate equipment to meet all patient care needs.

Chart 7: Montefiore Medical Center and the New York State Nurses Association Negotiated Nurse to Patient Ratios in CCU/ICU/NICU/PICU

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
CCU (M)	ALL	1:2
MICU (M)	ALL	1:2
SICU (M)	ALL	1:2
NICU (E)	ALL	1:2 Intensive Care Area 1:4 Intermediate Area
PICCU (M)	ALL	1:2

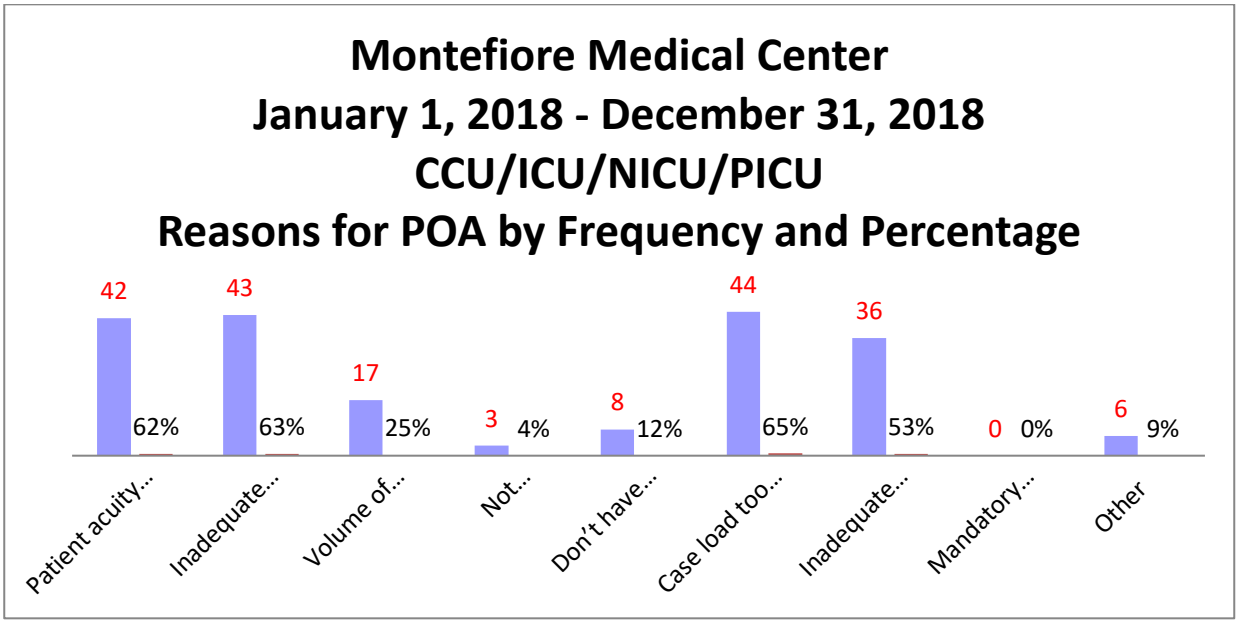
Figure 15: Reason for POA in CCU / ICU / NICU / PICU



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
21%*	22%*	9%*	1%*	4%*	22%*	18%*	0%	3%

*The percentages noted in each categorical area reflect those POAs that document only one reason for the filing of the POA. However, the total number of POAs that delineate each categorical reason is calculated by the individual category + the "other" category.

Figure 16: Reason for POA by Frequency and Percentage



The **sixty eight (68) POAs, supported by three hundred and seventy six (376) signatures,** filed at Montefiore Medical Center between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the hospital in the CCU / ICU / NICU / PICU departments that include:

- Inadequate staffing for acuity, and caseloads are too high.
- Insufficient numbers of qualified, adequately trained staff to meet the caseload and needs of this vulnerable population.
- Inadequate time for patient care and documentation.
- There is a lack of resources needed.

Figure 17: POAs/Signatures CCU/ICU/NICU/PICU

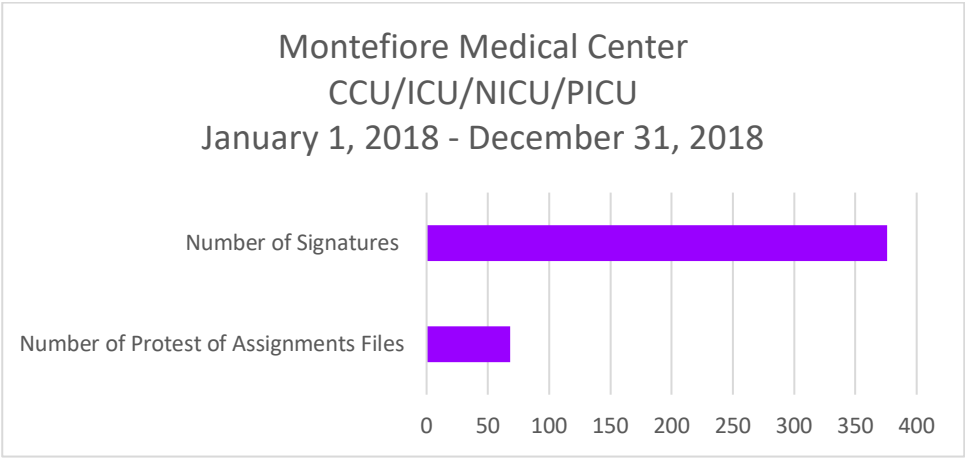


Table 7: Other issues specifically identified in the CCU/ICU/NICU/PICU

CCU/ICU/NICU/PICU Units: A sampling of the Comments Written on the POAs
Health & Safety; Insufficient # of Staff & High Acuity: Pediatric ED understaffed such that there is more than a 3.5 to 6 hour wait time to see a provider, more than 20 patients holding in triage area, no RN screener, patients pulling out IV and multiple attempts to bite, kick, scratch, and punch staff. Census 68, only 6 RNs.
High Acuity, Insufficient # of Qualified Staff: We have no CAN in the **PICU**. Management sent us only 1 CNA to cover for 2 constant observations and 3 extended observations. The 3 extended observations require GI feeds, oral foods, and constant care. No one to cover the 1:1 patients. We also have patients receiving IV drips, we have one suicidal patient, the charge nurse is taking a full patient assignment,
High Acuity, Insufficient # of Qualified Staff: We have patients in **PICU** on every 3 hour blood sugars with seizure precautions, patients with chemotherapy due, patients who are pre-op, patients with sickle cell disease and in pain (crisis), patients on PAP who need monitoring, and no CNA.
Lack of Resources, High Patient Acuity, Case Load High: We have no IV solution (DSW/NS) on the **PICU** unit and none in the hospital per central supply department, we have no screener. 2 PICU patients, 6 admissions with a 3 - 6 hour waiting time in waiting area with no RN screener. We have 20 patients in the waiting area for triage and 15 waiting to be called in. No coverage for breaks and meals **(repetitive and consistent response)**
High Patient Acuity, Insufficient # Qualified Staff: We had 3 staff call out in **PICU**- 2 RN and 1 CNA, and 1 nurse was floated out of the unit to the epilepsy unit. We have 3 close clinical watches, 1 constant observation and 2 enhanced observation, 2 discharges and 2 admissions. Manager states she has a call out a for RNs to come in. **(repetitive and consistent response)**
High Patient Acuity, Insufficient # Qualified Staff, Violation of Staffing Ratios: On **NICU**, we have 2 orientee RNs, and 2 CPAP baby, 4 CPAP babies with IV and ABTs, 3 babies with IV antibiotic and glucose checks every 3 hours. Our bed capacity is 35 and we are over with a census of 44. Only 3 RNs on duty. Parents need personal attention/education.
High Patient Acuity, Insufficient # Qualified Staff, Violation of Staffing Ratios: Our Census in the **NICU** is **42 with 4 RNs having patient assignment over contractual nurse to patient ratios**. 1 RN has 2 babies on CPAP with a central line, 1 baby with PIV and a total of 8 babies, 2nd RN has 2 babies on CPAP, 2 babies with peripheral IVs, 1 baby with PICC line, and 1 baby on contact isolation. 3rd RN has 2 babies on CPAP with central lines, needs to administer 10 medications, feedings and is in charge until temporarily, 4th RN has 1 post-surgical baby who is intubated and 2 babies who are "NPO" with sepsis.
High Patient Acuity, Insufficient # Qualified Staff: Per Diem RN floated into **NICU,** never oriented to unit and required support, but she left at 11:15 a.m. for a family emergency. Charge Nurse has assignment with 1 CPAP baby. I am supporting another refresher orientation RN who has no orientation to NICU and is working between NICU and new born nursery.
High Patient Acuity, Insufficient # of Staff: The **CCU** has no CNA and most of the 13 - 17 patients on the unit need complete care. 7 patients on vents, 2 patients with trachs, patients with robotic CABG needing 1:1 coverage, 1 patient on BIPAP, patients on hypothermia, patients with open abdomen, patients receiving blood products, at times, 3 RNs required to care for 1 patient. **(repetitive and consistent response)**
High Patient Acuity, Case Load High, No Time Documentation, Health & Safety: I am protesting my personal assignment in the **CCU.** I have 1 patient on constant observation with agitated, combative, and violent behavior towards staff where patient continues multiple attempts to bite, kick, scratch, and punch staff. Patient behavior requires more than 1 staff member present to maintain safety of

patient. Patient pulled out IV access and is detoxing. I have a patient who sustained a new skin tear in the midline coccyx area, 1 patient on contact and droplet precautions who is complete care and needs to be turned and positioned every 2 hours, 1 new admission who is a high fall risk (fell at home because of hypotension) who requires constant vitals and observation, 2 patients on every 4 hour glucose monitoring. Staff feeling overwhelmed by triple admission from ED and PACU, patients with delirium assigned to charge nurse, patient with active bleeding requiring transfusions of multiple blood products.
High Patient Acuity: Assignment given to RN in **CCU** presents an unsafe situation. Patient 1: 8 hours post-op open heart surgery with 4 vessel bypass, valve repair, and a rare cardiac myomectomy procedure. Patient is currently intubated with plans to do a bedside bronchoscopy and extubation during shift. As per manager, RN must be present at bedside at all times until extubation. Patient requiring continuous monitoring of vitals and constant titration of pressors and sedation. Patient 2 Post op open cholecystectomy complicated by bile leak and a fistula. Patient is also intubated and being weaned for extubation. Patient with mental status change post op and is scheduled for a CT scan of head today. According to policy T-4, patient requires level 1 care and must be accompanied by and RN. Patient also spiking fevers and required to be cultured. Unit consists of 15 critically ill patients, on other patient on hypothermia, another requiring peritoneal dialysis every 5 hours.
High Patient Acuity, Case Load High: CCU Unit consists of patients with multiple IVs requiring frequent blood draws, patients in atrial fibrillation with frequent ectopies, patients on ventilators, patients on multiple pressors, patients on hypothermia, and patients requiring hourly glucose monitoring.
High Patient Acuity, Insufficient # of Staff: ICU has 14 patients and 11 are vented, 9 with multiple drips, 2 of the RNs needed to triple up to care for one patient during the shift patient on post hypothermia, charge RN with 2 complete assignments.
High Patient Acuity, Insufficient # of Staff: SICU has 10 patients on vents, patients needing liver transplant, patients needing kidney/pancreas transplant, and one of our staff is an orientee, GI bleeder, patients needing frequent suctioning, patients on isolation, travel RNs are replacing SICU nurses who have been floated out of the unit **(repetitive and consistent response)**.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Montefiore Medical Center

- The following State and Federal laws and regulations, standards of care, and accreditation requirements may have been left unaddressed in this situation:
  1) **Public Health Law 2805-b (1)** Admission of patients and emergency treatment of non-admitted patients. 1. Every general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed…;
  2) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Governing body -Organization and Operation-405.2(b)(2)** hospitals must establish, implement, and maintain policies and procedures to insure the hospital is acting in accord with generally accepted standards of professional practice; **405.2(c)(1-2)** hospitals must operate in compliance with Federal, State and local laws; **405.2(f)(1)** every patient of the hospital shall be provided care that meets generally acceptable standards of professional practice; **405.2(f)(7)** hospitals shall have available at all times personnel sufficient to meet patient care needs;
  3) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Nursing services 405.5(a)(2)**the hospital shall provide nursing staff for each department or nursing unit to ensure, in accordance with generally accepted standards of nursing practice, the immediate availability of a registered professional nurse for bedside care of any patient; **405.5 (b) (2-4)** timely assessment and reassessment of nursing care plans and evaluation of the adequacy and appropriateness of nursing care**; 405.5(c)(1-3)** timely medication and treatments shall be provided; **405.10(c) (1)** there shall be timely documentation upon completion of provision of care;
  4) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Quality assurance program 405.6(b)(1)** shall involve all patient care activities and review care provided by all;
  5) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Medical Records 405.10(c)** requires timely documentation; An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;** Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**
  6) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Critical care and special care services** are those, which are organized and provided for patients requiring care on a concentrated or continuous basis to meet special health care needs. Each service shall be provided with a concentration of professional staff and supportive services that are appropriate to the scope of services provided. **10 NYCRR 405.22(a);**

Cardiac surgical center shall mean an inpatient care unit of a hospital which shall be approved as such by the department and shall be appropriately staffed and equipped to provide both diagnostic and surgical services **10 NYCRR 700.2(19).** Nursing personnel shall be certified in ACLS or meet acceptable equivalent training and experience and shall include: An RN, with 24-hour accountability, in charge of coordinating the care of post cardiac surgery patients and in charge of staffing levels for the unit; RNs, LPNs and nursing assistants ***in such ratios that are commensurate with the type and amount of nursing needs of the patients***. **10 NYCRR 405.29(d)(3)(ii)(a-b);**

Cardiac Catheterization Laboratory Center Criteria (Adult and Pediatric)-Staff must be available on a 24 hour/day basis **10 NYCRR 405.29(e)(1)(iv)(c).** Nurses with appropriate education and training shall be regularly assigned to the center **10 NYCRR 405.29(e)(1)(v)(b).**

Cardiac EP Laboratory Programs-In addition to the standards at paragraph **405.29(e)(1**), labs must be adequately staffed and equipped for providing intra-cardiac electrophysiology procedure**. 10 NYCRR 405.29(e)(5)(i)(a);**

Association of Peri-Operative Registered Nurses. (2012). Preoperative-The number of RNs and skill mix should be based on the # of patients, # of operating rooms, # of procedures, patient acuity, complexity of procedures, time required to perform tasks, age-specific needs, and average time for prep. **Intraoperative**-1:1 RN in the role of circulator. 1 scrub person per patient. Additional staff members with appropriate competencies for the following: (1) Moderate sedation 1 RN dedicated to monitoring and separate from circulator. (2) Local anesthesia 1 RN in addition to circulator depending upon nursing assessment (3) Additional RN staffing for complex surgical procedures and patients; technological demands and first assist requirements;

7) **American Association of Critical-Care Nurses- Critical Elements of Appropriate Staffing (2005):**
   - The healthcare organization has staffing policies in place that are solidly grounded in ethical principles and support the professional obligation of nurses to provide high quality care;
   - Nurses participate in all organizational phases of the staffing process from education and planning—including matching nurses' competencies with patients' assessed needs—through evaluation;
   - The healthcare organization has formal processes in place to evaluate the effect of staffing decisions on patient and system outcomes. This evaluation includes analysis of when patient needs and nurse competencies are mismatched and how often contingency plans are implemented;
   - The healthcare organization has a system in place that facilitates team members' use of staffing and outcomes data to develop more effective staffing models;
   - The healthcare organization provides support services at every level of activity to ensure nurses can optimally focus on the priorities and requirements of patient and family care;
   - The healthcare organization adopts technologies that increase the effectiveness of nursing care delivery. Nurses are engaged in the selection, adaptation, and evaluation of these technologies.

8) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21** "Condition of participation: Quality assessment and performance improvement program. (c) Standard: Program activities (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care;"
9) **(e) Standard:** Executive responsibilities address priorities for improved quality of care and patient safety;
10) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23** "Condition of participation: Nursing services (a) Standard: Organization well-organized service with a plan of administrative authority and delineation of responsibilities for patient care (b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed." There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient;
11) **Code of Federal Regulations, Title 42 ("Public Health") § 482.41** "Condition of participation: Physical environment. The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community (c) Standard: Facilities. The hospital must maintain adequate facilities for its services. (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality;"
12) **Joint Commission. (2013). Leadership (LD) - LD.03.01.01** Leaders create and maintain a culture of safety throughout the hospital. **LD.03.01.01, EP 1** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools **LD.03.06.01, EP 3** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services **LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. **LD.04.03.11** The hospital manages the flow of patients throughout the hospital. **LD.04.04.05** The hospital has an organization wide, integrated patient safety program within its performance improvement activities. **LD.04.04.05, EP 1** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events;
13) **Joint Commission. (2013).** Environment of Care(EC)- **EC.02.01.01, EP 1** The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

14) **Joint Commission. (2013). Life Safety (LS)-LS.02.01.20:** The hospital maintains the integrity of the means of egress;

Need for Action

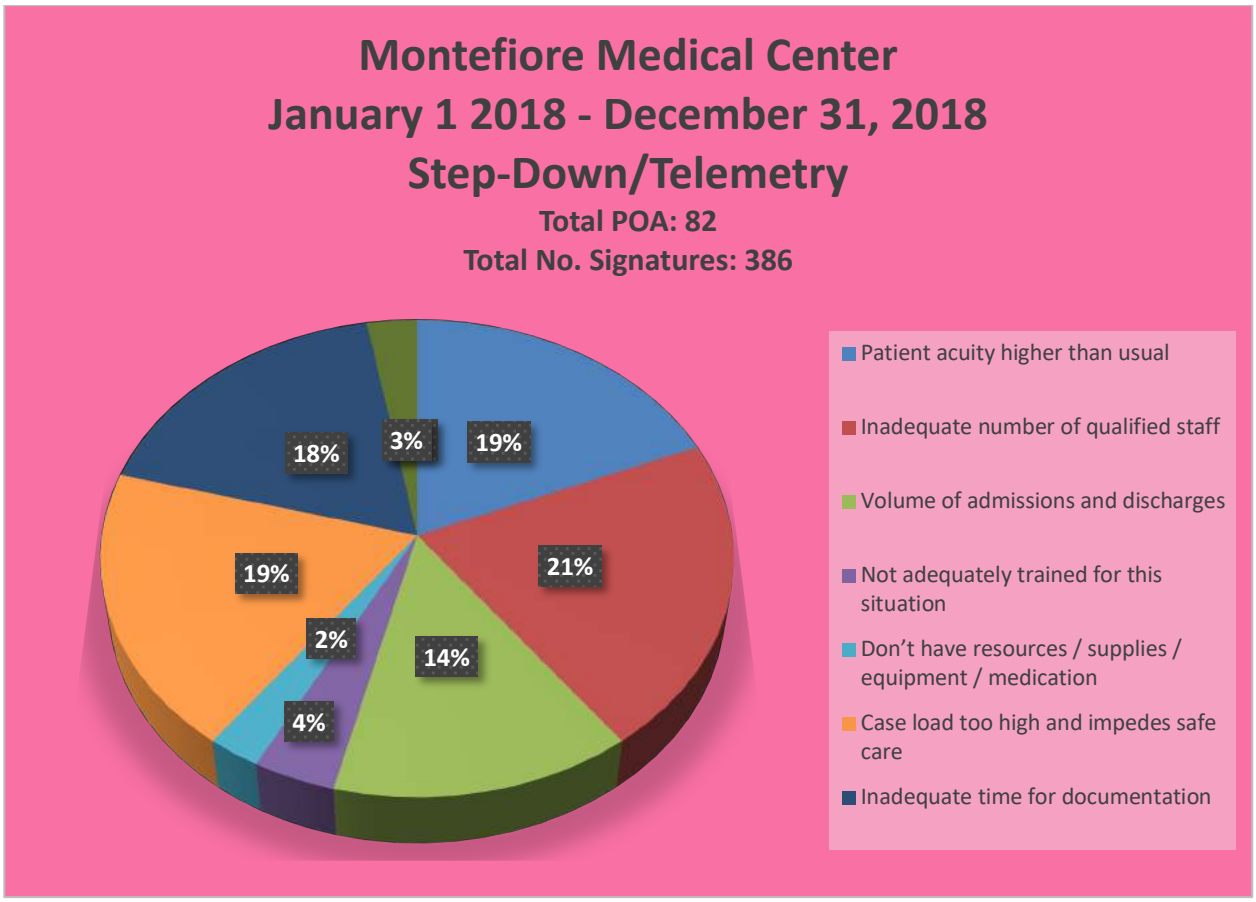
Nurses working in the Specialty Care / Intensive Care Units throughout Montefiore Medical Center are committed to improving delivery of care with the following recommendations:

- Increase specialty care registered nurses, and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation as well as the collective bargaining agreement language and to provide for adequate time for documentation in accord with standards of practice;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of Montefiore Medical Center's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Specialty Care / Intensive Care, while concomitantly meeting the individual needs of Montefiore Medical Center's SIUH's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of the Montefiore Medical Center's patient population.
- Provide resources/supplies to meet all of the immediate needs of patients.

Chart 8: Montefiore Medical Center and the New York State Nurses Association Negotiated Nurse to Patient Ratios in Step-Down / Telemetry

TYPE/UNIT	SHIFT	STAFFING LEVELS & REGISTERED NURSE-TO-PATIENT RATIOS
8S (E)Telemetry	ALL	1:6 (Telemetry/Med-Surg.) 1:4 Stepdown

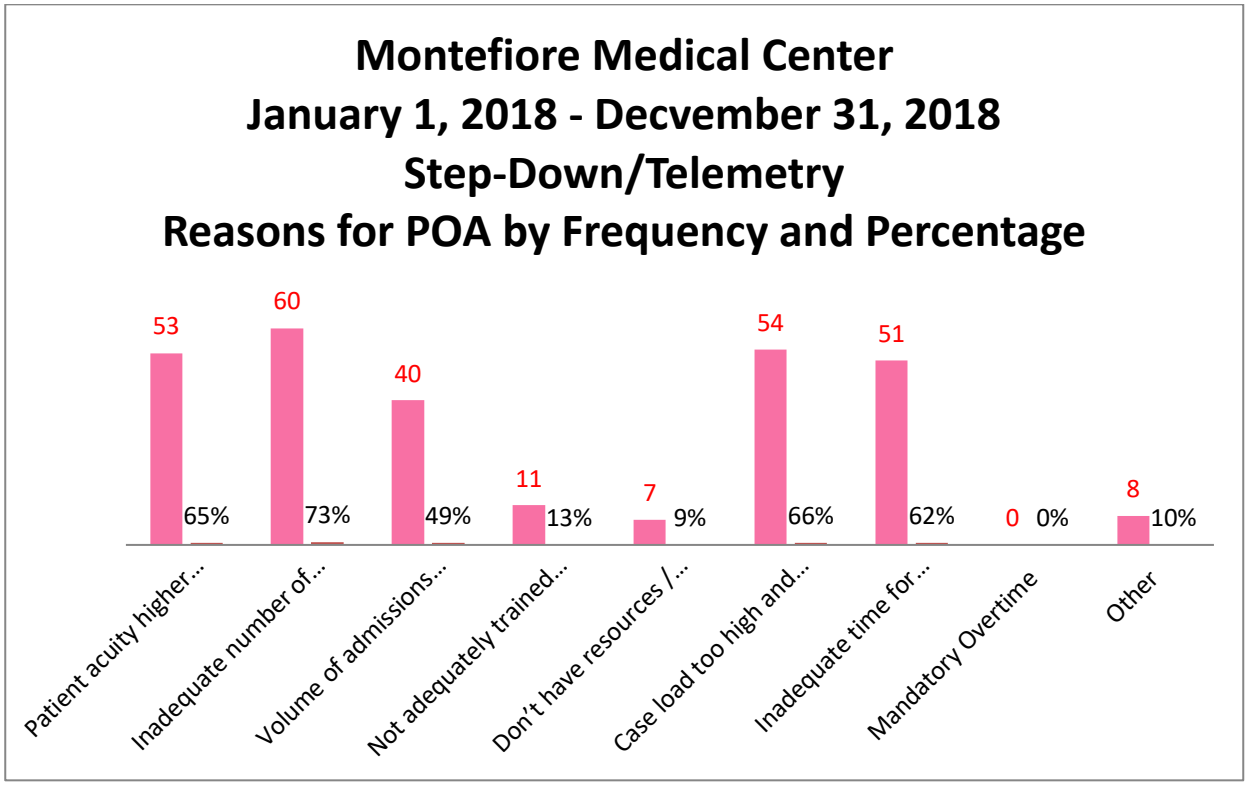
Figure 18: Reason for POA in Step-Down / Telemetry



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
19%	21%	14%	4%	2%	19%	18%	0%	3%

*The percentages noted in each categorical area reflect those POAs that document only one reason for the filing of the POA. However, the approximate total number of POAs that delineate each categorical reason is calculated by the individual category + the "other" category. See Percentage Bar Graph below.

Figure 19: Reason for POA by Frequency and Percentage



The **eighty two (82) POAs, supported by three hundred eighty six (386)** filed at Montefiore Medical Center between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the hospital in the Step-Down and Telemetry departments that include:

- Inadequate staffing of RN and ancillary staff for acuity, admission volume, discharges and caseloads.
- Potentially unsafe conditions caused by lack of resources and training.
- Inadequate time for patient care and documentation.
- Potentially unsafe conditions caused by lack adequate numbers of qualified RN and ancillary staff to address the needs of the patient population.

Figure 20: POAs/Signatures Step Down/Telemetry

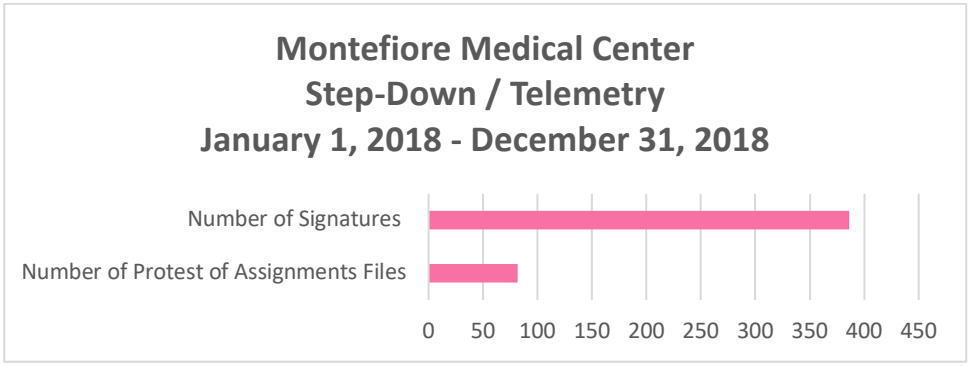


Table 8: Other Issues Specifically Identified in the Step Down / Telemetry POAs

Step-Down Telemetry Units: A Sampling of the Comments Written on the POAs
Patient Acuity High, Case Load High: Unit consists of 30 patients with 27 of them on telemetry requiring vital signs every 4 hours, 2 patients on BIPAP, 15 total care patients requiring turning and positioning every 2 hours, 9 patients with pressure ulcers requiring wound care and turning and positioning every 2 hours, 2 confused patients on extremely high risk for falls, 2 patients on vents, 1 on enhanced observation, 1 patient on levophed drip and insulin drip, 1 patient on Lasix drip, and 1 patient on remodulin drip requiring constant observation and assessment, 4 patients on isolation, **each RN has 6 or more patients,** 2 hallway patients and only 5 RNs and 2 CNAs on duty. **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Health & Safety, Not adequately trained: Unsafe situation, 1 critically unstable patient who requires 1:1 nursing care, patient is on multiple drips (insulin, levothyroxine, levophed, phenylephrine, sodium bicarb, vasopressin) and patient currently requires a higher level of care that a telemetry RN with 4 other patients can safely and adequately provide. Patient is ventedand an active organ donor, currently receiving transplant work-up to facilitate potential organ donation. Patient requiring continuously blood pressure monitoring to maintain a MAP of 60 for continuous organ effusion according to policy, RNs on this unit are not supposed to be administering the organ donation meds. An arterial line was placed at bedside and none of the RNs on this unit have been trained to care for an arterial line. Patient requires blood glucose monitoring every 2 hours as patient is on an insulin drip. No ICU beds are available. As per hospital policy, unable to triage the patient ahead of a living patient. 13 complete care patients on the unit that require turning and positioning every 2 hours, 1 suicidal patient that is on 1:1 constant observation, 8 patients with pressure ulcers that require turning and positioning every hour, 4 contact isolation patients, 8 patients with high fall risk (score > 65) and 11 congestive heart failure patients that require Montefiore's very extensive congestive heart failure patient teaching. Only 6 RNs on unit today. **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Volume of Admissions, Health & Safety: Extremely high acuity, 30 patients on unit, 26 on telemetry requiring vital signs every 4 hours, 8 total care patients requiring turning and positioning every 2 hours, 6 patients with wounds and pressure ulcers requiring turning and positioning every 1 hour, multiple admissions from ED, 11 Congestive heart failure patients on strict I & O and daily weights, 1 patient brought on unit from ED was unescorted by ED RN and not on telemetry monitoring, 2 patients on constant observation for safety for self-harm, 1 patient on enhanced constant observation for patient safety, 6 patient on contact and droplet isolation, 3 patients on heparin drips, 1 patient on nitro drip, 3 patients on Lasix drip, 1 patient on remodulin drip, 2 hallway patients, **only 6 RNs and no CNAs on the floor (repetitive and consistent response)**
Patient Acuity High: Case Load High: Extremely high acuity for 5 RNs and no CNA on meals and breaks. 3 admissions, 2 patients in the hallway, 12 total care patients, 1 patient on constant observation for suicidal ideation, 1 patient on enhanced observation, 4 patients on continuous Lasix, nitro, and heparin drips, 3 patients on contact/droplet isolation for RSV, 3 patients on droplet isolation for flu, 1 patient on contact isolation for C. Diff, 26 patients on continuous telemetry monitoring requiring vital signs every 4 hours, 2 patients post cardiac catheterization, 11 heart failure patients requiring reinforced heart failure education. **(repetitive and consistent response)**
Patient Acuity High, Case Load High: Unit consists of 31 patients, includes 2 hallway patients, multiple total care patients including confused patients on frequent reorientation plans, 7 enhanced observation patients, 6 contact and droplet precautions and our only CNA is sitting with the patient who needs constant supervision. Case load makes it impossible to give medications on time or deliver care on time.
Patient Acuity High, Case Load High, Not Honoring Contract Ratios: 2 vented stepdown patients, 1:4 ratio not honored, 2 hallway patients, privacy and safety impedes care and standards of excellence, 1 RN

is assigned a 1:8 ratio, including 1 telemetry monitoring.
Patient Acuity High, Case Load High, Not Honoring Contract Ratios: I have 3 patients, with 1 hallway and 2 stepdown, 5 RNs have 6 patients and 1 RN has 7 patients, step down nurses with 6 patients each, 1 RN has an orientee and this staffing impedes patient safety and jeopardizes HCAP scores and patient experiences.
Patient Acuity High, Case Load High: Patient was brought up as a hallway patient and is in sickle cell crisis and is combative, mute, deaf, and uncooperative. Patient is currently projectile vomiting all over the hallway. Patient refuses to sit down due to crisis. ED should not have transferred this patient to a hallway as patient is not safe to travel. Patient is stripping her clothes and refusing clothes. Patient has menstrual cycle and has no bathroom (not in a room) and she is bleeding all over her legs and blood in her bed and her nails.
Patient Acuity High, Case Load High, Not Enough Qualified RNs: Census is 31. We have 1 graduate RN and 1 RN floated from another floor on the unit with limited step-down/telemetry patients. 4 step-down patients, 3 vents, 2 patients on levophed, 1 hallway patient, 2 trachs with 1 intubated. We need 2 more RNs to cover stepdown.
Patient Acuity High, Case Load High: Extremely high acuity, 3 BIPAP, 1 vent, 2 drips, 4 patients with wounds, 27 telemetry requiring vitals every 4 hours, 2 enhanced observations, 1 EOC, 1 CNA to watch continuous watch patient, congestive heart failure patients with daily I & O, 10 complete care patients, multiple confused patients, patients on fall risk plans, no breaks for any RNs, multiple patients needing to be turned and positioned every 2 hours, management has been aware for days that the floor is short staffed with only 4 RNs scheduled, and no help was arranged **(repetitive and consistent response)**
Patient Acuity High, Case Load High, Not Enough Qualified RNs, Not Honoring Contract Ratios and High Volume Admissions: Multiple high fall risk patients, no secretary, high volume of admissions, RNs not specialty RN and cannot take the behavioral patients on step-down and telemetry. Nurse to patient ratio violates contract—RN ratio 1:6-7 for all RNs instead of contract 1:4.
Patient Acuity High, Not Honoring Contract Ratios, High Volume Admissions: Census 31, 4 RNs with **1:6 patient, 1 RN with 1:7 patients,** 2 vented patients 1 patient on BIPAP, 1 patient with restraints, 16 patients with complete care, 10 patients on fluid drips, nitro drips, other cardiac drips, 1 patient on blood transfusion who is also on enhanced observation, 5 patients in isolation, 11 hallway patients, 4 admissions, 1 discharge, patients on glucose monitoring every 4 hours **(repetitive and consistent response)**
Patient Acuity High, Insufficient No of Qualified Staff: Not enough RNs to care for patients on floor. We have 2 pre-lung transplant patients, patients on remodulin, patients on enhanced observation, patients on vents, levophed drips, calcium gluconate, and we had 1 CNA and 1 RN pulled from the floor. Unable to do hourly rounding. **(repetitive and consistent response)**
Health & Safety: We have a patient who is 450 pounds and is on a vent. Need more staff and equipment to turn and position this patient. 2 patients fell over the weekend due to low staffing.
Patient Acuity High, Not Honoring Contract Ratios: RN to patient ratio 1:5-6 in violation of contract. Patients on Amiderine (requires frequent re-assessment and vitals every 2 hours), patients on multi-dirps (Vassopressin, remodulin, levophed), patients on enhanced observation, patients on enhanced observation, patients on BIPAP, complete care patients, contact isolation patients; patients with chest tubes, only 1 CNA on the floor. **(repetitive and consistent response)**

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Montefiore Medical Center

- **The following contractual staffing has repeatedly and substantially been violated as evidenced by the monthly notice provided to Montefiore Medical Center's management by its RN employees. See: Tables 22–25**

- Management's resistance to address or acknowledge the RNs' concerns raised in the Step Down / Telemetry POAs or to provide a permanent solution to the staffing issues evidence a potential disregard for the following requirements of State and Federal law, and established standards of care:
    1) **Public Health Law 2803-c (3)(e**) Every patient shall have the right to receive adequate and appropriate medical care, … ;
    2) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-**Governing body -Organization and Operation-**405.2(b)(2);** Compliance with Federal, State and local laws -**405.2(c)(1-2);** Care of patients **405.2(f)(1); 405.2(f)(7)** sufficient staff;
    3) Administration **(405.3)** orientation of new employees to policy and procedures;
    4) Medical Staff **(405.4)** Standards of care, guidelines are adopted and monitored by the medical staff;
    5) Nursing services **(405.5(a)(2);** timely assessment and reassessment **(405.5 (b) (2-4));** timely medication and treatments **(405.5 (c)(1-3));** timely documentation **(405.5(b)(2-4); 405.10(c)(1));** basic orientation for duties and responsibilities **(405.5 (6));**
    6) Quality assurance program **405.6(b)(1)** shall involve all patient care activities and review care provided by all;
    7) Critical care and special care services are those which are organized and provided for patients requiring care on a concentrated or continuous basis to meet special health care needs. Each service shall be provided with a concentration of professional staff and supportive services that are appropriate to the scope of services provided. **10 NYCRR 405.22(a);**
    8) Medical Records **(405.10 (c))** requires timely documentation;
    9) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21** Condition of participation: Quality assessment and performance improvement program. (c) Standard: Program activities "(1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care " **42 CFR 482.21(c);**
    10) **42 CFR 482.21 (e)** Standard: Executive responsibilities address priorities for improved quality of care and patient safety;
    11) **Code of Federal Regulations, Title 42 § 482.23** Condition of participation: Nursing services (a) Standard: Organization "well-organized service with a plan of administrative authority and delineation of responsibilities for patient care" **42 CFR 482.23(a), (b)** Standard: Staffing

and delivery of care. “The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed.” **42 CFR 482.23,(b)** There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient; and a “registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available;”

12) **Industry standards for telemetry monitoring** require all telemetry unit patients be hemodynamically stable. Unstable patients and those with Acute Coronary Syndrome[1] should be managed in an intensive care or step-down unit. Industry standards also identify criteria for initiating telemetry monitoring on patients with various cardiac conditions, such as atrial fibrillation with rapid ventricular response[2];
13) **Industry standards for telemetry** require RNs on the unit to perform the following telemetry monitoring and documentation procedures:
    - Connect the patient to the telemetry monitor using a lead that best transmits the appropriate waveform;
    - Set alarm parameters according to the individual patient’s needs and/or the physician’s specifications, and ensure that the alarm volume is loud enough to be heard at all times;
    - Keep alarms on at all times;
    - Obtain and attach a representative sample of ECG strips to the hard copy medical record every shift and when necessary to document any abnormality and intervention instituted;
    - Report any abnormalities to the physician;
    - Review the alarms each hour;
    - Respond immediately to any patient care issue.
14) **Industry Standards for Telemetry Monitoring** provides for a continuous ECG reading of the heart’s electrical activity through external electrodes placed on the patient’s body. Segments of the ECG data are automatically transmitted to a remote surveillance location. As the patient’s electrical rhythms are transmitted, nurses need to continuously analyze the reading according to parameters programmed into the device. Some segments, such as rapid and slow heart rates or other symptomatic episodes, will automatically trigger an audible alarm;
15) **Industry Standards for Telemetry Monitoring** requires hospital staff who acknowledge the alarms and observe the telemetry data will be able to respond to the patient and provide immediate care should emergencies arise;
16) **Standards published by the American Heart Association (AHA)** advocate that each facility establish protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring, documentation of ECG changes, periodic documentation that alarms are set appropriately, and response to emergency and nonemergency cardiac events.
17) The **AHA** recommends that all staff assigned to telemetry units receive comprehensive training, including initial orientation followed by periodic competency evaluations, to ensure continued proficiency in critical elements of cardiac monitoring;

18) **AHA** also recommends periodic reviews of unit protocols, training curricula, and competency levels to determine if staff and patient needs continue to be met. This analysis should include reviews of staff performance, critical events, and patient outcomes;
19) The **AHA** recommends that staff assigned to telemetry units receive periodic refresher training on critical elements of cardiac monitoring;
20) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards)** requires an adequate number of staff to ensure immediate availability of a registered professional nurse for bedside care of any patient when needed **(405.5(a)(2));** timely assessment and reassessment **(405.5(b)(2-4));** timely medication and treatments **(405.5 (c) (1-3));** adequate and working equipment (405.24)(c)(2)(i-ii)); timely documentation **(405.5)(b)(2-4); 405.10(c)(1));**
21) An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;**
22) Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**
23) **Code of Federal Regulations, Title 42 ("Public Health") § 482.24** "**Conditions of Participation: Medical record services.** (c) Standard: Content of record. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures;"
24) The records kept by the nurses are required in order to ensure that continuity of care is provided to their patients. The American Nurses Association have established the Principles for Documentation which speak to who, what, where, when, why and how of documentation for the patients.

[1] Acute Coronary Syndrome is when the heart does not receive enough oxygen-rich blood, which can cause chest pain or a heart attack

.[2]Atrial fibrillation with rapid ventricular response is an irregular heart rate that can cause inadequate blood circulation through the heart, resulting in pooling of blood and eventual clots that can lead to stroke,

Need for Action

Nurses working at Montefiore Medical Center's in the Telemetry / Step Down Department are committed to improving delivery of care with the following recommendations:

- Increase telemetry / step-down registered nurses, and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation and the Guidelines for Professional Registered Nurse Staffing for telemetry / step-down units and to provide for adequate time for documentation in accord with standards of practice;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix in accordance with the already agreed-to staffing guidelines and to meet the needs of Montefiore Medical Center's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Step Down / Telemetry Care, while concomitantly meeting the individual needs of Montefiore Medical Center's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to avoid the unnecessary and foreseeable use of floating, agency, and voluntary overtime;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of the Montefiore Medical Center's patient population in accord with specialty practice guidelines.

Scientific Research Linking Safe RN Staffing to Patient Safety and Cost Effective Care

Effects of Nurse Staffing, Work Environments, and Education on Patient Mortality: An Observational Study
Eunhee Cho, Douglas Sloane, Eun-Young Kim, Sera Kim, Miyoung Choi, Il Young Yoo, Hye Sun Lee, Linda Aiken. (2015). International Journal of Nursing Studies. 52, 535-542.

To examine the effects of nurse staffing, work environment, and patient mortality, this study linked hospital facility data with staff nurse survey data and surgical patient discharge data from 14 high-technology teaching hospitals with 700 beds in Korea. Findings included a significant association between nurse staffing, nurse work environments, and patient mortality. Each additional patient per nurse was associated with a 5% increase in the odds of patient death within 30 days of admission, and the odds of patient mortality are 50% lower in hospitals with better nurse work environments.

The Impact of Hospital and ICU Organizational Factors on Outcome in Critically Ill Patients: Results from the Extended Prevalence of Infection in Intensive Care Study
Yasser Saker, et al. Journal of Critical Care Medicine, March 2015. 43(3), 519-526.

A high nurse-to-patient ratio was independently associated with a lower risk of in-hospital death.

Nurse Staffing, Medical Staffing, and Mortality in Intensive Care: An Observational Study
Elizabeth West, David N. Barron, et al. International Journal of Nursing Studies (2014). 51, 781 – 794.

To investigate whether the size of the nurse, MD, and support staff workforce has an impact on the survival chances of critically ill patients in the ICU, a cross-sectional, retrospective, observational study on 65 ICUs and 38,168 patients found that higher numbers of RNs per bed were associated with higher survival rates. Further exploration revealed that the number of nurses had the greatest impact on patients at high risk of death.

The impact of understaffed shifts on nurse-sensitive outcome.
Diane E. Twigg, Lucy Gelder, and Helen Myers. (January 2015). Journal of Advanced Nursing.

To explore the relationship between exposure to understaffed shifts and nurse-sensitive outcomes at the patient level, this study was conducted in 2014 and was a secondary analysis of administrative data from a large acute care hospital in Western Australia. The sample included 36,529 patient admissions over a two-year period from October 2004–November 2006. Results of the study showed strong associations between nurse staffing and surgical wound infection, urinary tract infection, pressure injury, pneumonia, deep vein thrombosis, upper gastrointestinal bleed, sepsis and physiological metabolic derangement.

The Association between Patient Safety Outcomes and Nurse/Healthcare Assistant Skill Mix and Staffing Levels & Factors that may Influence Staffing Requirements.
P. Griffitsh, J. Drennan, et al. (2014) Center for Innovation and Leadership in Health Sciences. Online article retrieved June 2, 2015 from http://eprints.soton.ac.uk/367526/1/Safe%20nurse%20staffing%20of%20adult%20wards%20in%20acute%20hospitals%20evidence%20review%201.pdf

Reviewers from the University of South Hampton in the United Kingdom were tasked by the National Institute of Clinical Effectiveness to determine which patient safety outcomes are associated with nurse and health care assistant staffing levels and skill mix in medical-surgical units of acute care hospitals. Screening 12,146 studies resulted in 35 eligible studies meeting inclusionary and exclusionary criteria and these studies were evaluated according to quality ratings. The strongest evidence came from two studies that investigated low nurse staffing and subsequent mortality, falls and drug administration errors.

Analysis of Nurse Staffing and Patient Outcomes using Comprehensive Nurse Staffing Characteristics in Acute Care Nursing Units.
Bae SH, Kelly M, Brewer CS, Spencer A. (Oct.-Dec. 2014). Journal of Nursing Care Quality; 29(4)318-26.

To analyze nurse staffing (RN, LPN, and UAP) and patient outcomes while using comprehensive nurse staffing characteristics (including RN turnover rate and temporary nurse staff) in acute care nursing units, this descriptive, cross-sectional correlational study using a convenience sample of 35 units within three NY hospitals found rates of patient falls and injury falls were greater with higher temporary RN staffing levels but decreased with greater levels of LPN hours per patient day (HPPD). Pressure ulcers were not related to any staffing characteristics.

Comparability of Nurse Staffing Measures in Examining the Relationship between RN Staffing and Unit-Acquired Pressure Ulcers: A Unit-Level Descriptive Correlational Study.
Choi J and Staggs VS. (Oct. 2014). International Journal of Nursing Studies; 51(10)1344-52.

To examine correlations among six staffing measures to compare explanatory power in relation to unit-acquired pressure ulcers (UAPU), this descriptive, cross-sectional correlational study using a convenience sample of five unit types: critical care, step-down, medical, surgical, & combined medical-surgical units in US hospitals contributing to the 2011 NDNQI surveys and database found RN-perceived staffing adequacy, RN skill mix, and unit tenure were significantly associated with UAPU.

The Relationship Between Nurse Staffing and Failure to Rescue: Where Does It Matter Most?
Talsma A, Jones K, Guo Y, Wilson D, Campbell DA. (Sep. 2014). Journal of Patient Safety; 10(3)133-9.

To examine the relationship between nurse staffing and failure to rescue: where does it matter most, this descriptive, cross-sectional correlational study using a convenience sample of units and nurses participating in NDNQI data collection from 6 hospitals ranging from 68 to 880 beds in general care and intensive care units found a low association between increased nurse staffing and failure to rescue.

Concurrent and Lagged Effects of Registered Nurse Turnover and Staffing on Unit-Acquired Pressure Ulcers.
Park SH, Boyle DK, Bergquist-Beringer S, Staggs VS, Dunton NE. (Aug. 2014). Health Services Research; 49(4):1205-25.

To examine the concurrent and lagged effects of RN turnover and staffing on UAPU, this longitudinal retrospective study using a convenience sample of units and nurses participating in 2008 – 2011 NDNQI data collection in four unit types: Stepdown, medical, surgical, and combined medical-surgical across US hospitals found higher RN staffing was associated with lower pressure ulcer rates.

Nurse Staffing and Education and Hospital Mortality in 9 European countries: A Retrospective Observational Study. (Abstract)
Linda H. Aiken, et al., May 2014, The Lancet, 383(9931), 1824-1830

Nurse staffing cuts to save money might adversely affect patient outcomes. An increase in a nurses' workload by 1 patient increased the likelihood of an inpatient dying within 30 days of admission by 7% and every 10% increase in BSN was associated with a decrease in this likelihood by 7%.

Night and day in the VA: associations between night shift staffing, nurse workforce characteristics, and length of stay.
de Cordova PB, Phibbs CS, Schmitt SK, Stone PW. (April 2014). Research in Nursing andHealth; 37(2):90-97.

To examine the association between night nurse staffing and workforce characteristics and the length of stay (LOS), this longitudinal retrospective study of medical, medical-surgical, surgical, step-down, and telemetry units using convenience sample of Veteran's Affairs (VA) hospitals from 2002 through 2006 found higher nurse staffing and a higher skill mix were associated with reduced LOS.

Structure, Process, and Annual ICU Mortality Across 69 Centers: United States Critical Illness and Injury Trials Group Critical Illness Outcomes Study.
Checkley W, Martin GS, Brown SM, Chang SY, et al. (Feb. 2014). Critical Care Medicine; 42(2):344-56.

In this study, 69 ICUs were surveyed about organization, size, volume, staffing, processes of care, use of protocols, and annual ICU mortality. Results showed a lower annual ICU mortality among ICUs that had a daily plan of care review and a lower bed-to-nurse ratio.

Associations between Rates of Unassisted Inpatient Falls and Levels of Registered and Non-Registered Nurse Staffing.
Staggs VA and Dunton N. (Feb. 2014). International Journal for Quality in Health Care; 26(1):87-92.

To understand how unassisted fall rates are associated with RN and non-RN staffing, this descriptive, cross-sectional correlational study using a convenience sample of units and nurses in US hospitals participating in 2011 NDNQI data collection in five unit types: stepdown, medical, medical-surgical, surgical, and rehabilitation found higher levels of non-RN staffing were generally associated with higher fall rates. Associations for RN staffing rates and fall rates varied by unit type.

Hospitals With Higher Nurse Staffing Had Lower Odds of Readmissions Penalties Than Hospitals with Lower Staffing.
Matthew D. McHugh, Julie Berez, Dylan Small, Health Affairs, 2013 October, 32(10), 1740-1747.

Hospitals with higher nurse staffing had 25% lower odds of being penalized under the ACAs Hospital Readmission Reduction Program compared to otherwise similar hospitals with lower staffing.

An observational study of nurse staffing ratios and hospital readmission among children admitted for common conditions
BMJ Quality and Safety in Healthcare online May 2013

Adding just one child to a hospital's average staffing ratio increased the likelihood of a medical pediatric patient's readmission within 30 days by 11%, while the odds of readmission for surgical pediatric patients rose by nearly 50%.

Florence Nightingale School of Nursing and Midwifery Research, Kings College, London Nurse Staffing Tied to Pediatric Readmissions
Safe Staffing Alliance Statement, May 2013

"A ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety which should be escalated by RNs for investigation."

Nurse Staffing and NICU Infection Rates
JAMA Pediatrics: Published online March 18, 2013

There are substantial shortfalls in nurse staffing in US neonatal intensive care units (NICUs) relative to national guidelines. These are associated with higher rates of nosocomial infections among infants with very low birth weights.

Hospital Nursing and 30-Day Readmissions Among Medicare Patients With Heart Failure, Acute Myocardial Infarction, and Pneumonia
McHugh, Matthew D. PhD, JD, MPH, RN; Ma, Chenjuan PhD, RN, Medical Care: January 2013

Improving nurses' work environments and staffing may be effective interventions for preventing readmissions. Each additional patient per nurse was associated with the risk of within 30 days of readmission for heart failure (7%), myocardial infarction (9%), and pneumonia (6%). "In all scenarios, the probability of patient readmission was reduced when nurse workloads were lower and nurse work environments were better."

State-Mandated Nurse Staffing Levels Lead to Lower Patient Mortality and Higher Nurse Satisfaction

Jill Furillo, RN, DeAnn McEwen, RN, AHRQ Health Care Innovations Exchange, September 26, 2012
Agency for Healthcare Research and Quality, September 26, 2012

The California safe staffing law has increased nurse staffing levels and created more reasonable workloads for nurses in California hospitals, leading to fewer patient deaths and higher levels of job satisfaction than in other states without mandated staffing ratios. Despite initial concerns from opponents, the skill mix of nurses used by California hospitals has not declined since implementation of the mandated ratios.

Nurse Staffing, Burnout, and Health Care Associated Infection
Jeannie P. Cimiotti, Linda H. Aiken, Douglas M. Sloane, Evan S. Wu. American Journal of Infection Control, Auguest 2012, 40(6), 486-490.

There is a significant association between patient to nurse ratio and urinary tract infection and surgical site infection.

Missed Nursing Care, Staffing and Patient Falls *Kalisch, Beatrice J. PhD, RN, FAAN; Tschannen, Dana PhD, RN; Lee, Kyung Hee MPH, RN* Journal of Nursing Care Quality: January/March 2012 - Volume 27 - Issue 1

The results of this study demonstrate that the level of nurse staffing predicted patient falls. This supports the findings of previous studies which have reported that higher staffing levels lead to fewer patient falls. It also reinforces earlier findings that staffing levels predict the amount and type of missed care.

Impact of Nurse Staffing Mandates on Safety-Net Hospitals: Lessons from California
Matthew D. McHugh, Margo BrooksCarthon, Douglas M. Sloane,. Evan Wu, Lesly Keyy, & Linda H. Aiken

One concern was that California's mandate would reduce skill mix. This study looked at safety-net and non-safety net hospitals. Results of this study revealed California's mandate improved staffing for all hospitals and improvements did not come at the cost of a reduced skill mix. A marginally higher proportion of RNs in non-safety net hospitals following the mandate, while the skill mix remained essentially unchanged for safety net hospitals.

Contradicting Fears, California's Nurse-To-Patient Mandate Did Not Reduce The Skill Level Of The Nursing Workforce In Hospitals

Matthew D. McHugh1, Lesly A. Kelly, Douglas M. Sloane and Linda H. Aiken Health Affairs, July 2011 vol. 30 no. 7

When California passed a law in 1999 establishing minimum nurse-to-patient staffing ratios for hospitals, it was feared that hospitals might respond by disproportionately hiring lower-skill licensed vocational nurses. This article examines nurse staffing ratios for California hospitals for the period 1997–2008. Results of the study revealed increased nursing skill mix and used more highly skilled RNs to meet the staffing mandates.

Quality and Cost Analysis of Nurse Staffing, Discharge Preparation, and Postdischarge Utilization

Marianne E. Weiss, Olga Yakusheva, and Kathleen L. Bobay Health Research and Educational Trust, April 2011

This study extends previous health services research on the impact of nurse staffing on patient outcomes of hospitalization by linking the unit-level nurse staffing directly to post-discharge readmission and indirectly through discharge teaching process to patient readiness for discharge and subsequent ED visits. Findings support recommendations to (1) monitor and manage unit-level nurse staffing to optimize impact on post-discharge outcomes, (2) implement assessment of quality of discharge teaching and discharge readiness as standard pre-discharge practices, and (3) realign payment structures to offset costs of increasing nurse staffing with costs avoided through improved post-discharge utilization.

Nurse Staffing and Inpatient Hospital Mortality

Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., V. Shane Pankratz, Ph.D., Cynthia L. Leibson, Ph.D., Susanna R. Stevens, M.S., and Marcelline Harris, Ph.D., R.N. New England Journal of Medicine, March 17, 2011

In this retrospective observational study, staffing of RNs below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care.

"Studies involving RN staffing have shown that when the nursing workload is high, nurses' surveillance of patients is impaired, and the risk of adverse events increases." "… We found that the risk of death increased with increasing exposure to shifts in which RN hours were 8 hours or more below target staffing levels or there was high turnover. We estimate that the risk of death increased by 2% for each below-target shift and 4% for each high-turnover shift to which a patient was exposed."

Implications of the California Nurse Staffing Mandate for Other States
Linda H. Aiken, Ph.D., et al., Health Services Research, August 2010

The researchers surveyed 22,336 RNs in California and two comparable states, Pennsylvania and New Jersey, with striking results, including: if they matched California ratios in medical and surgical units, New Jersey hospitals would have 13.9 percent fewer patient deaths and Pennsylvania 10.6 percent fewer deaths. “Because all hospitalized patients are likely to benefit from improved nurse staffing, not just general surgery patients, the potential number of lives that could be saved by improving nurse staffing in hospitals nationally is likely to be many thousands a year,” according to Linda Aiken, the study’s lead author. California RNs report having significantly more time to spend with patients, and their hospitals are far more likely to have enough RNs on staff to provide quality patient care. Fewer California RNs say their workload caused them to miss changes in patient conditions than New Jersey or Pennsylvania RNs. In California, where hospitals have better compliance with the staffing limits, RNs cite fewer complaints from patients and families and the nurses have more confidence that patients can manage their own care after discharge. California RNs are substantially more likely to stay in their jobs because of the staffing limits, and less likely to report burnout than nurses in New Jersey or Pennsylvania. Two years after implementation of the California staffing law—which mandates minimum staffing levels by hospital unit—“nurse workloads in California were significantly lower” than Pennsylvania and New Jersey. “Most California nurses, bedside nurses as well as managers, believe the ratio legislation achieved its goals of reducing nurse workloads, improving recruitment and retention of nurses, and having a favorable impact on quality of care,” the authors write.

Nurse Staffing and Patient Outcomes in Critical Care: A Concise Review *Aragon Penoyer, Daleen PhD, RN, CCRP, FCCM Critical Care Medicine: July 2010 - Volume 38 - Issue 7 - pp 1521-1528*

Findings from this review demonstrate an association of nurse staffing in the intensive care unit with patient outcomes and are consistent with findings in studies of the general acute care population. A better understanding of nurse staffing needs for intensive care unit patients is important to key stakeholders when making decisions about provision of nurse resources. Additional research is necessary to demonstrate the optimal nurse staffing ratios of intensive care units.

Overcrowding and Understaffing in Modern Health-care Systems: Key Determinants in Meticillin-resistant Staphylococcus Aureus Transmission

Archie Clements, et al, Lancet Infectious Disease, July 2008

This study finds that understaffing of nurses is a key factor in the spread of methicillin-resistant Staphylococcus aureus (MRSA), the most dangerous type of hospital-acquired infection. The authors note that common attempts to prevent or contain MRSA and other types of infections such as requirements for regular and repeated hand washing by nurses are compromised when nursing staff are overburdened with too many patients. They also note that hospitals now involve nurses in a "vicious cycle" where a call for nurses to increase their infection control procedures "are seldom accompanied by increases in staffing levels and thus represent an additional work burden on nursing staff" that leads to a greater spread of infections.

Nursing: A Key to Patient Satisfaction

Kutney-Lee, A, McHugh, M.D., Sloane, D.M., Cimiotti, J.P., Flynn, L., Felber Neff, D., and Aiken, L.H. (2009). Health Affairs 28 (4), 669-677.

Evidence suggests that improving nurse work environments in hospitals could result in improved patient outcomes, including better patient experiences and higher satisfaction ratings. Patient-to-nurse ratios in hospitals do affect patient satisfaction ratings and recommendation of the hospital to others.

The Impact of Medical Errors on 90-Day Costs and Outcomes: An Examination of Surgical Patients

William E. Encinosa and Fred J. Hellinger, Health Services Research, July 2008

A new study published in the journal Health Services Research found that the large difference in calculations for medical error expenses might mean that interventions to increase patient safety -- like adding more nursing staff -- could be more cost-effective than previously reported. The study found that insurers paid an additional $28,218 (52 percent more) and an additional $19,480 (48 percent more) for surgery patients who experienced acute respiratory failure or post-operative infections, respectively, compared with patients who did not experience either error. Preventing these and other preventable medical errors would reduce loss of life and could reduce healthcare costs by as much as 30 percent, the researchers said. "Many hospitals are struggling to survive financially," study co-author William Encinosa, senior economist at the Agency for Healthcare Research and Quality, said in a statement. "The point of our paper is that the cost savings from reducing medical errors are much larger than previously thought." Pointing to previous research that looked at the business case for improving RN staffing ratios, the researchers concluded: "It is quite possible that the post-discharger costs savings achieved by reducing adverse events might just be enough for the hospital to break-even on the investment in nursing."

Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations
Joanne Spetz, Ph.D, Policy, Politics & Nursing Practice, April 3, 2008

A statewide survey of nurses in California found that nurses perceived a significant improvement in their working conditions and were more satisfied with their jobs in the two years following implementation of the landmark California staffing law in 2004. According to the researchers, "Nurse satisfaction with many aspects of work increased significantly between 2004 and 2006. The largest changes in satisfaction, in percentage terms, were with adequacy of staff (a 12.95 % increase), providing patient education (+7.3%), clerical support (6.9%) and satisfaction with the job overall (5.9%)." The authors concluded: "A large body of research links job satisfaction, heavy workload, job stress, effective management and career development opportunities with turnover rates…It is possible that the improvements in RN satisfaction documented here will facilitate higher quality of care. High nurse turnover has a negative effect on the quality of care delivered to patients. If minimum staffing regulations improve nurse satisfaction, reduce job stress, and relieve workload, nurse turnover may indeed decline, further improving the quality of hospital care."

Survival From In-Hospital Cardiac Arrest During Nights and Weekends
Mary Ann Peberdy, MD, et al., JAMA, February 20, 2008

A national study on the rate of death from cardiac arrest in hospitals found that the risk of death from cardiac arrest in the hospital is nearly 20 percent higher on the night shift. The authors highlight understaffing during the night shift as a potential explanation for the death rate. "Most hospitals decrease their inpatient unit nurse-patient ratios at night… Lower nurse-patient ratios have been associated with an increased risk of shock and cardiac arrest," the authors stated.

Nurse Staffing and Patient, Nurse and Financial Outcomes
Lynn Unruh, PhD, RN, AJN, January 2008

This report provides a comprehensive literature review of more than 21 studies published since 2002 that, according to the author, "underscore the importance of hospitals acknowledging the effect nurse staffing has on patient safety, staff satisfaction, and institutions' financial performance." According to the report, "the evidence clearly shows that adequate staffing and balanced workloads are central to achieving good patient, nurse, and financial outcomes. Efforts to improve care, recruit and retain nurses, and enhance financial performance must address nurse staffing and workload. Indeed, nurses' workloads should be a prime consideration. If a proposed change would improve care and also reduce excessive (or maintain acceptable) workloads, it should be implemented. If not, it shouldn't be."

The Impact of Nurse Staffing on Hospital Costs and Patient Length of Stay: A Systematic Review
Petsunee Thungjaroenkul, RN, MS, Nursing Economics, Vol. 25, 2007

This study provides a comprehensive review of the research on the impact of RN staffing ratios on hospital costs and patient length of stay (LOS). It identified 17 studies published between 1990 and 2006 and concluded: "the evidence reflected that significant reductions in cost and LOS may be possible with higher ratios of nursing personnel in hospital settings. Sufficient numbers of RNs may prevent patient adverse events that cause patients to stay longer than necessary. Patient costs were also reduced with greater RN staffing as RNs have higher knowledge and skill levels to provide more effective nursing care as well as reduce patient resource consumption. Hospital administrators are encouraged to use higher ratios of RNs to non-licensed personnel to achieve their objectives of quality patient outcomes and cost containment."

Newly Licensed RNs' Characteristics, Work Attitudes, and Intentions to Work
Christine T. Kovner, PhD, RN,, et al, AJN, September, 2007

A national study on the work experience and attitudes of newly licensed nurses in America found that the majority of new grads had been given full patient assignments immediately following their orientation, with poor supervision and management, while more than 45 percent reported having recently been given more than 6 patients to care for at one time -- a patient load that the researchers said placed their patients at an increased risk of injury or death. More than 55 percent reported that they had to work too fast; 33 percent reported having little time to get things done and nearly a third of new grads reported they had too many patients to get their job done well, Not surprisingly, as a result of these conditions, more than 37% of the new nurses say they plan to leave their current job in the next two years, and more than 41% say they, if free to do so, would take another job immediately. The authors conclude: "The proportion of newly licensed RNs who expressed negative attitudes on individual survey items raises the concern that employers will not be able to retain them in the acute care settings where they start out."

Staffing Level: a Determinant of Late-Onset Ventilator-Associated Pneumonia
Stephanie Hugonnet, et al, Critical Care, July 19, 2007

Understaffing of registered nurses in hospital intensive care units increases the risk of serious infections for patients; specifically pneumonia, a preventable and potential deadly complication that can add thousands of dollars to the cost of care for hospital patients. This type of pneumonia is a leading cause of as many as 2,000 patient deaths in Mass. hospitals, costing as much as $400 million annually. Curtailing nurse staffing levels can lead to suboptimal care, which can raise costs far above the expense of employing more nurses.

Nurse Working Conditions and Patient Safety Outcomes

Patricia W. Stone, Ph.D., et al., Medical Care, 45(6): 571-578, June. 2007

A review of outcomes data for more than 15,000 patients in 51 U.S. hospital ICUs showed that those with higher nurse staffing levels had a lower incidence of infections, such as central line associated bloodstream infections (CLSBI), a common cause of mortality in intensive care settings. The study found that patients cared for in hospitals with higher staffing levels were 68 percent less likely to acquire an infection. Other measures such as ventilator-associated pneumonia and skin ulcers were also reduced in units with high staffing levels. Patients were also less likely to die within 30 days in these higher-staffed units. Increasing RN staffing could reduce costs and improve patient care by reducing unnecessary deaths and reducing days in the hospital.

Hospital Nurse Staffing and Quality of Patient Care

Evidence Report/Technology Assessment for Agency for Healthcare Research and Quality, May 2007

A comprehensive analysis of all the scientific evidence linking RN staffing to patient care outcomes found consistent evidence that an increase in RN-to-patient ratios was associated with a reduction in hospital-related mortality, failure to rescue, and other nurse sensitive outcomes, as well as reduced length of stay.

Hospital Workload and Adverse Events

Joel S. Weisman, Ph.D., et al, Medical Care, 45(5): 448-454, May. 2007

A study conducted by researchers at Brigham & Women's Hospital and Massachusetts General Hospital found that overcrowded and understaffed hospitals that are pushing too hard to streamline and cut costs are putting their patients at risk for medication errors, nerve injuries, infections and other preventable mistakes, A 10% increase in the number of patients assigned to a nurse leads to a 28% increase in adverse events such as infections, medication errors, and other injuries.

Nurse Staffing and Quality of Patient Care

Robert L. Kane, MD., et al, Evidence Report/Technology Assessment for Agency for Healthcare Research and Quality, AHRQ Publication No. 07-E005, May. 2007

A comprehensive analysis of all the scientific evidence linking RN staffing to patient care outcomes found consistent evidence that an increase in RN-to-patient ratios was associated with a reduction in hospital-related mortality, failure to rescue, and other nurse sensitive outcomes, as well as reduced length of stay. Every additional patient assigned to an RN is associated with a 7% increase in the risk of hospital-acquired pneumonia, a 53% increase in respiratory failure, and a 17% increase in medical complications.

Quality of Care for the Treatment of Acute Medical Conditions in U.S. Hospitals
Bruce E. Landon, MD, MBA., et al, Archives of Internal Medicine, 166: 2511-2517, Dec 11/25. 2006

A national study of the quality of care for patients hospitalized for heart attacks, congestive heart failure and pneumonia found that patients are more likely to receive high quality care in hospitals with higher registered nurse staffing ratios.

Impact of Hospital Nursing Care on 30-day Mortality for Acute Medical Patients
Ann E. Tourangeau, Ph.D., et al., Blackwell Publishing: 32-44, Aug. 2006

A study of 46,000 patients in 76 hospitals found the adequacy of nursing staffing and proportion of registered nurses is inversely related to the death rate of acute medical patients within 30 days of hospital admission. The study's authors recommend that "if hospitals have goals of minimizing unnecessary patient death for their acute medical patient population, they should maximize the proportion of Registered Nurses in providing direct care."

HeathGrades Quality Study: Third Annual Patient Safety in American Hospital Study
HealthGrades, Inc: April 2006

80,000 Medicare patients each year died between 2002 - 2004 in our nation's hospitals from preventable medical errors, with 63% of those deaths attributable to failure to rescue by a registered nurse or physician. Mass. Ranked 22nd in patient safety, with no improvement since the previous year's study.

Nurse Staffing in Hospitals: Is There a Business Case For Quality?
Jack Needleman, Ph.D., Peter Buerhaus, Ph.D., R.N., et al., Health Affairs, 25(1): 204-211, Jan.-Feb. 2006

Increasing the proportion of RNs without increasing total nursing hours per day could reduce costs and improve patient care by reducing unnecessary deaths and reducing days in the hospital.

Longitudinal Analysis of Nurse Staffing and Patient Outcomes - More About Failure to Rescue
Jean Seago, Ph.D., et al., JONA, 36(1): 13-21, Jan. 2006

Increasing RN staffing increased patient satisfaction with pain management and physical care; while "having more non-RN" care "is related to decreased ability to rescue patients from medication errors."

Correlation Between Annual Volume of Cystectomy, Professional Staffing, and Outcomes - A Statewide, Population-Based Study
Linda Elting, Ph.D., et al., Cancer, 104(5): 975-984, Sept. 2005

Patients undergoing common types of cancer surgery are safer in hospitals with higher RN-to-patient ratios. High RN-to-patient ratios were found to reduce the mortality rate by greater than 50% & smaller community hospitals that implement high RN ratios can provide a level of safety and quality of care for cancer patients on a par with much larger urban medical centers that specialize in performing similar types of surgery.

Improving Nurse-to-Patient Staffing Ratios as a Cost-Effective Safety Intervention
Michael Rothberg, et. al, Medical Care, 43(8): 785-791, Aug. 2005

Improving RN-to-patient ratios could save thousands of lives each year and is more cost effective than clot-busting medications for heart attacks and strokes, and cancer screenings.

Hospital Speedups and the Fiction of the Nursing Shortage
Gordon Lafer, Labor Studies Journal, 30(1): 27-45, Spring 2005

"There is no shortage of nurses in the United States. The number of licensed registered nurses in the country who are choosing not to work in the hospital industry due to stagnant wages and deteriorating working conditions is larger than the entire size of the imagined 'shortage.' Thus, there is no shortage of qualified personnel--there is simply a shortage of nurses willing to work under the current conditions created by hospital managers."

Nurses' Working Conditions: Implications for Infectious Disease
Patricia W. Stone, et al., Emerging Infectious Disease, 10(11): 1984-1989, Nov. 2004

Improving nurse staffing and working conditions "are likely to improve the quality of health care by decreasing incidence of many infectious diseases, and assisting in retaining qualified nurses."

The Working Hours of Hospital Staff Nurses and Patient Safety
Ann E. Rogers, et al., Health Affairs, 23(4): 202-212, July/Aug. 2004

Nurses working mandatory overtime are three times more likely to make a medical error. "Overtime, especially that associated with 12-hour shifts, should be eliminated."

Association Between Evening Admissions and Higher Mortality Rates in the Pediatric Intensive Care Unit
Yeseli Arias, M.D., et. al, Pediatrics, 113(6): e530-e534, June 2004

Children admitted to pediatric intensive care units at night are more likely to die in the first 48 hours of care; authors point to fatigue and lighter nurse staffing levels as contributing factors.

Consumer Perspectives: The Effect of Current Nurse Staffing Levels on Patient Care
National Consumers League Report, May 2004

National survey of recent patients in hospitals found that 45% believed their safety was compromised by understaffing of nurses; 12% believe their safety was extremely compromised. 78% of respondents support safe staffing legislation.

Nurse Staffing Levels and Quality of Care in Hospitals
Mark W. Stanton, M.A., AHRQ Research in Action, 14; March 2004

Poor hospital registered nurse staffing is associated with higher rates of urinary tract infections, post-operative infections, pneumonia, pressure ulcers and increased lengths of stay, while better nurse staffing is linked to improved patient outcomes.

Nurse Burnout and Patient Satisfaction
Doris C. Vahey, Ph.D., et al., Medical Care, 42(2): II-57-II-66, Feb. 2004

Improvements in nurse staffing in hospitals "simultaneously reduces nurses' high burnout and risk of turnover and increases patients' satisfaction with their care."

Is More Better? The Relationship Between Nurse Staffing and the Quality of Nursing Care in Hospital
Julie Sochalski, Medical Care, 42(2): II-67-II-73, Feb 2004

Survey of 8,000 RNs in Pennsylvania hospitals found workload and understaffing contributed to medical errors and patient falls and to a number of important nursing tasks left undone at the end of every shift.

Nurse Staffing and Mortality for Medicare Patients with Acute Myocardial Infarction
Sharina D. Peterson, Ph.D., et al., Medical Care, 42(1): 4-12, Jan. 2004

"Medicare patients with AMI (heart attack) who were treated in higher RN staffing environments had a significant in-hospital mortality advantage." Conversely, patients are more likely to die in hospitals with high LPN staffing environments. "The mortality difference we observed are related to differences in hospital staffing patterns and may derive from substitution of personnel with less training or experience."

The Shocking Cost of Turnover in Health Care
J. Deane Waldman, M.D., M.B.A., et al., Health Care Management Review, 29(1): 2-7, Jan. - March 2004

The cost for advertising, training and loss in productivity associated with recruiting new nurses to a facility is $37,000 per nurse at minimum and can add as much as 5% to a hospital's annual budget. Improving nurses' staffing conditions is a primary strategy for hospitals that can generate significant cost savings.

Keeping Patients Safe: Transforming the Work Environment of Nurses (Executive Summary)
Institute of Medicine, National Academy of Sciences, Nov. 2003

Following up on the 1999 report on patient safety, To Err is Human, the Institute for Medicine calls for improved nurse-to-patient ratios, limits on mandatory overtime, and nurse involvement on every level to protect patients.

The Relationship Between Nurse Staffing and Patient Outcomes (Abstract)
Sasichay-Akkadechanunt, T., Scalzi, C. C., Jawad, A. F., Journal of Nursing Administration (September 2003), 33(9), 478-35.

This study examined the association between in-hospital mortality and 4 nurse staffing variables—the ratio of total nursing staff to patients, the proportion of RNs to total nursing staff, the mean years of RN experience, and the percentage of nurses with BS in nursing degrees.

The findings of this study revealed that the ratio of total nurse staffing to patients was significantly related to in-hospital mortality in both partial and marginal analyses, controlling for patient characteristics. In addition the ratio of total nursing staff to patients was found to be the best predictor of in-hospital mortality among the 4 nurse staffing variables, controlling for patient characteristics.

The study did not find any significant relationship between in-hospital mortality and the other 3 nurse staffing variables.

Licensed Nurse Staffing and Adverse Events in Hospitals
Lynn Unruh, Ph.D., Medical Care, 41(1): 142-152, 2003

Hospitals with better licensed nurse staffing had a significantly lower incidence of adverse patient events, including bed sores, patient falls and pneumonia.

Nurse Staffing, Quality, and Hospital Financial Performance
Barbara Mark, Ph.D., et al., Journal of Health Care Finance, 29(4): 54-76, Summer 2003

Increased staffing of registered nurses does not significantly decrease a hospital's profit margin, even though it boosts the hospital's operating costs.

The Effects of Nurse Staffing on Adverse Events, Morbidity, Mortality, and Medical Costs
Sung Hyun Cho, Ph.D., et al., Nursing Research, 52(2): 71-79, March/April 2003

Increasing nurse staffing by just one hour per patient day resulted in a 10% reduction in the incidence of hospital-acquired pneumonia. The cost of treating hospital acquired pneumonia is $28,000 per patient. Patients who had pneumonia, wound infection or sepsis had a greater probability of death during hospitalization.

Patient-to-Nurse Staffing Ratios: Perspectives from Hospital Nurses
Peter D. Hart Research Corp., A Research Study for AFT Health Care, April 2003

Three in five nurses say they are responsible for too many patients and the problem is harming care. 82% of nurses support legislation setting limits on nurses' patient assignments.

Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction
Linda Aiken Ph.D., R.N., Journal of the American Medical Association, October 22, 2002

For each additional patient over four assigned to an RN, the risk of death increases by 7% for all patients. Patients in hospitals with a 1:8 nurse-to-patient ratio have a 31% greater risk of dying than patients in hospitals with 1:4 nurse-to-patient ratios. Legislation to regulate RN-to-patient ratios is a credible means of protecting patients and to ending the nursing shortage.

Strengthening Hospital Nursing
Jack Needleman, Ph.D., et al., Health Affairs, 21(5): 123-132, Sept./Oct. 2002

"The implications of doing nothing to improve nurse staffing levels in many low-staffed hospitals are that a large number of patients will suffer avoidable adverse outcomes and hospitals and patients will continue to incur higher costs than are necessary."

Nurse Staffing and Healthcare-associated Infections
Marguerite Jackson, Ph.D., R.N., et al., JONA, 32(6): 314-322, June 2002

"There is compelling evidence of a relationship between nurse staffing and adverse patient outcomes," including serious bloodstream infections in hospital patients.

Nurse-Staffing Levels and Quality of Care in Hospitals
Jack Needleman, Ph.D., et al., The New England Journal of Medicine, 346(22): 1715-1722, May 30, 2002

A higher proportion of RNs in the staff mix and a greater number of nursing hours per day are associated with better patient outcomes. Poor hospital registered nurse staffing is associated with higher rates of urinary tract infections, post-operative infections, pneumonia, pressure ulcers and increased lengths of stay, while better nurse staffing is linked to improved patient outcomes.

Health Policy Report - Nursing in the Crossfire
Robert Stimson, M.D., New England Journal of Medicine, 346(22): 1757-1766, May 30, 2002

Provides a review of the research underlying the current crisis in nursing with recommendations for policy, including legislation to regulate RN ratios and to recruit nurses into the profession.

Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis
Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 2002

JCAHO found that low staffing levels were a contributing factor in 24% of patient safety errors resulting in injuries or death since 1996. Recommends transforming the nursing workplace and giving hospitals an incentive to invest in high quality nursing care.

Intensive Care Unit Nurse Staffing and the Risk of Complications After Abdominal Aortic Surgery
Peter J. Pronovost, M.D., Ph.D., et al., Effective Clinical Practice, 4(25): 199-206, Sept./Oct. 2001

Patients treated in hospitals with fewer ICU nurses were more likely to have medical complications, respiratory failure or need a breathing tube inserted. The study also found the ICUs with fewer RNs incurred a 14% increase in costs.

Nurses' Reports on Hospital Care in Five Countries
Linda H. Aiken, Ph.D., R.N., et al., Health Affairs, 20(3): 43-53, May/June 2001

Study finds widespread job dissatisfaction among hospital nurses in the US due to understaffing and poor working conditions. Half of US nurses report the quality of care at their hospital has deteriorated in the last year; one in five nurses overall and one in three nurses under 30 plan on leaving bedside nursing.

The Nursing Crisis in Massachusetts
Report of the Legislative Special Commission on Nursing and Nursing Practice, May 2001

"It is the unanimous consensus of licensed nurses, health care personnel and administrators that the shortage of nursing care in the Commonwealth is endangering the quality of care that our nurses can provide to the patient." The Commission's top two recommendations to solve the crisis include legislation to ban mandatory overtime and to set RN-to-patient ratios.

ICU Nurse-to-Patient Ratio is Associated with Complications and Resource Use After Esophagectomy
Peter J. Pronovost, M.D., Ph.D., et al., Intensive Care Medicine, 26: 1857-1862, 2000

A nurse caring for more than two ICU patients at night increases the risk of several post-operative pulmonary and infectious complications and was associated with increased resource use. The study advocates a ratio of one RN to no more than two patients.

Organization and Outcomes of Inpatient AIDS Care
Linda H. Aiken, Ph.D., R.N., et al., LDI Issue Brief, 8(1): Sept. 1999

Higher nurse-to-patient ratios are strongly associated with a lower mortality for patients with AIDS in hospitals.

Nurse Staffing and Patient Outcomes
Mary A. Blegen, Ph.D., R.N., et al., Nursing Research, 47(1): 43-50, Jan./Feb.1998

Inpatient units with a higher proportion of RN care had fewer adverse patient outcomes, including fewer medication errors, bedsores and patient complaints. Conversely, when more care was delivered by non-RN team members, rates of bedsores, complaints and patient deaths increased.

Downsizing the Hospital Nurse Workforce

Linda H. Aiken, Ph.D., R.N., et al., Health Affairs, 15(4): 88-92, Winter 1996

Hospitals cut nurse staffing levels in the 90s by 7.3% nationally, while all other categories of hospital personnel increased, including a 46% increase in non-nurse administrative personnel and 50% increase in other direct care staff. Massachusetts cut its RN staffing by 27%, highest in the nation.

Moral Distress in Nursing

In health care environments that are driven by efficiency, cost containment pressures, and improving the bottom line (Tiedje, 2000), nurses have been noted to demonstrate a pattern of silencing themselves and will often sacrifice interpersonal confrontation and assertiveness to keep peace while not articulating what they need or feel directly (Demarco, Roberts, Norris & McCurry, 2007). Such self-silencing is often the direct result of the influence of organizational practices and business conditions on the ethical beliefs and clinical practices of nurses.

The institutional difficulty an individual nurse has in speaking up and out often leads to feelings of powerlessness, or moral distress. Moral distress, in contrast to an ethical dilemma, arises when a nurse knows the right thing to do, but whose judgment cannot be acted upon because the institution makes it impossible to act upon it. What results are feelings of frustration, anger, guilt, and a sense of moral responsibility accompanied by the knowledge that one cannot singularly change what is happening. Finally, and perhaps ironically, this situation often ultimately leads to the conclusion that only concerted collective action can adequately address deficiencies in the quality of patient care and the quality of working life (Andre, 1998; Tiedje, 2000).

Enhancing nurse staffing does not pose a significant cost for hospitals and in fact may result in cost savings:

- Lichtig, Knauf & Milholland (1999) suggested that by decreasing adverse outcomes (particularly those that are likely to result in increased length of stay), increased RN staffing could result in modestly decreased hospital costs.
- Earlier, Flood & Diers (1988) had similarly suggested an association between staffing levels and lower hospital costs resulting from decreased rates of nosocomial infections.
- Most recently, Needleman and his colleagues (2006) examined the data used in their 2002 study in order to determine the impact on hospital costs of different adjustments in nurse staffing. Under different potential staffing scenarios, they found that increasing overall hours of nursing care (irrespective of overall skill mix) would lead to a significant reduction in length of stay, patient deaths and other adverse outcomes, at net increase of hospital costs of 1.5% percent or

less. Increasing RN hours as a proportion of nursing hours without increasing overall nursing hours (i.e., increasing skill mix while holding nurse staffing hours steady) was associated with a small net reduction in costs.

- A study of patient mortality and length of stay data from two large hospital studies compared staffing ratios ranging from 8:1 to 4:1 and noted the cost-effectiveness of increased nurse staffing (Rothberg, Abraham, Lindenauer & Rose, 2005).

A mounting volume of evidence clearly demonstrates the strong relationship between RN staffing and patient outcomes of care—particularly in reducing complications and death:

- As early as 1988, researchers found associations between nurse staffing and development of hospital-acquired infections. (Flood & Diers 1988).
- In "one of the clearest demonstrations to date of the impact of nursing staffing on outcomes for both patients and nurses in acute care hospitals," (Clarke & Aiken 2003), a study in the Journal of the American Medical Association, analyzed data from 168 Pennsylvania hospitals. After adjusting for patient and hospital characteristics, each additional patient beyond four per nurse resulted in a 7% greater likelihood of dying within 30 days of admission and a 7% increase in the likelihood of failure to rescue. (Aiken, Clarke, Sloane, Sochalski & Silber, 2001).
- In a study published in the New England Journal of Medicine, data from 799 hospitals in 11 states, including 5,075,969 medical discharges and 1,104,659 surgical discharges revealed that among medical patients, a higher proportion of hours of nursing care per day provided by RNs and a greater total number of hours of nursing care per day provided by RNs were associated with a shorter length of stay, lower rates of urinary tract infections and upper gastrointestinal bleeding. A higher proportion of hours of care provided by RNs was also associated with lower rates of pneumonia, shock or cardiac arrest and failure to rescue. Among surgical patients, a higher proportion of nursing care provided by RNs was associated with lower rates of urinary tract infections. A greater number of RN hours of care per day was associated with lower rates of failure to rescue. The authors summarize their findings, in part, by noting their estimate that patients treated in whose staffing placed them in the upper quarter of hospitals studied)have lengths of stay 3-5% shorter and rates of complication 2-9% lower than those with RN staffing in the lower quarter of hospitals in the study. (Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, 2002a, 2002b).
- A study of 1609 hospital reports of sentinel events (unanticipated events that result in death, injury or permanent loss of function), found that 24% of such events were attributed to nurse staffing levels (Joint Commission on Accreditation of Healthcare Organizations, 2002).
- Discharge data from 589 acute-care hospitals in 10 states, finding a large and significant inverse relationship between full-time equivalent RNs per adjusted inpatient day (RNAPD) and two post-surgical complications—urinary tract infections and pneumonia. (Kovner & Green, 1988).
- Data from 42 units in a large university hospital found that a higher proportion of RN hours of care was associated with hospital unit rates of medication errors, pressure ulcers and patient

complaints. Total nursing hours of care were associated with lower rates of pressure ulcers, patient complaints and mortality. (Blegen, Goode & Reed, 1998).

- A study of 3763 U.S. hospitals found a decrease in mortality rates as staffing increased for registered nurses (Bond, Raehl, Petterle & Franke 1999).
- Hospital data from New York and California showed significant relationships between RNs per adjusted patient days and incidence of urinary tract infections, pneumonia, pressure ulcers and a weaker but significant relationship to thrombosis and pulmonary complications. (Lichtig, Knauf & Milholland, 1999)
- A study of 28 university hospitals that had undergone restructuring found an increase in the rate of patient falls as patient-to-nurse ratios increased. (Sovie and Jawad, 2001).
- Patients undergoing abdominal aortic surgery who were cared for in ICUs with nurse:patient ratios of 1:3 or more averaged 49% greater lengths of stay in the ICU.. (Pronovost, Jenckes, Dorman, Garrett, Breslow, Rosenfeld, et al.1999).
- Data for 118,940 patients hospitalized with acute myocardial infarction showed lower likelihood of in-hospital mortality for patients treated in hospitals with higher RN staffing levels. (Person, Allison, Kiefe, Weaver, Williams, Centor, et al., 2004).
- Data from hospitals in states participating in the National Inpatient Sample (NIS) maintained by the federal Agency for Healthcare Research and Quality showed that higher levels of nurse staffing were associated with lower rates of pneumonia. (Kovner, Jones, Zhan, Gergen & Basu (2002).
- An increase of 1 hour of RN care per patient day in California hospitals was associated with an 8.9% decrease in the odds of pneumonia. A 10% increase in proportion of RNs was associated with a 9.5% decrease in the odds of pneumonia. (Cho, Ketefian, Barkauskas & Smith 2003).
- Rates of bloodstream infections related to central venous catheter use in eight intensive care units were significantly associated with the use of “float” nurses (Alonso-Echanove, Edwards, Richards, Brennan, Venezia, Keen, et al., 2003).
- Data from 1751 units in hospitals participating in the National Database of Nursing Quality Indicators found that higher rates of patient falls were associated both with fewer nursing hours per patient day and a lower percentage of RNs. (Dunton, Gajewski, Taunton & Moore, 2004).
- In a study of 19 teaching hospitals in Ontario, Canada, a lower proportion of RNs employed on a hospital nursing unit was associated with higher numbers of medication errors and wound infections. (McGillis Hall, Doran & Pink 2004).
- A nurse-patient ratio of 1:2 was associated with a higher incidence of unplanned extubation relative to a nurse-to-patient ratio of 1:1. (Marcin, Rutan, Rapetti, Brown, Rahnamayi & Pretzlaff).
- Analyzing data from two large hospital studies compared nurse staffing levels ranging from four to eight patients per nurse, mortality among medical and surgical patients decreased as staffing increased. (Rothberg, Abraham, Lindenauer & Rose, 2005).

Safe Staffing Impacts Patient Safety and Quality of Care

- A study evaluating nurse staffing for every nursing shift in 43 hospital units at one hospital found that staffing of RNs below target levels was associated with increased mortality. High patient turnover -- admissions, discharges and transfers -- during a shift also was linked with greater risk of patient deaths.
    - Needleman, Jack, Buerhaus, Peter, Pankratz, V. Shane, Leibson, Cynthia L., Stevens, Susanna R., Harris, Marcelline (2011). Nurse Staffing and Inpatient Hospital Mortality. New England Journal of Medicine (364:11), 1037-1045.
- Evidence suggests that improving nurse work environments in hospitals could result in improved patient outcomes, including better patient experiences and higher satisfaction ratings. Patient-to-nurse ratios in hospitals do affect patient satisfaction ratings and recommendation of the hospital to others.
    - Kutney-Lee, A, McHugh, M.D., Sloane, D.M., Cimiotti, J.P., Flynn, L., Felber Neff, D., and Aiken, L.H. (2009). Nursing: A Key to Patient Satisfaction. Health Affairs 28 (4), 669-677.
- This systematic review and meta-analysis revealed consistent evidence that an increase in Registered Nurse (RN) to patient ratios was associated with a reduction in hospital-related mortality, failure to rescue, and other nurse-sensitive outcomes, as well as reduced length of stay. An increase in total nurse hours per patient day was associated with reduced hospital mortality, failure to rescue, and other adverse events.
    - Kane, R.L., Shamliyan, T., Mueller, C., Duval, S., and Wilt, T.J. (2007). Nurse Staffing and Quality of Patient Care. Agency for Healthcare Research and Quality. AHRQ Publication 07-E005.
- Research suggests that improved registered nurse staffing has a beneficial effect on patient outcomes. Conversely, research shows that the likelihood of both overall patient mortality (i.e., in-hospital death) and mortality following a complication (failure to rescue) increases by 7% for each additional patient added to the average registered nurse workload.
    - Aiken, L.H., Clark S.P., Sloan D.M., Sochalski J.& Silber J.H. (2002). Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction. Journal of the American Medical Association, 288(16), 1987-93.
- Results from a sample of Pennsylvania hospitals indicates that increased nurse staffing is associated with reductions in atelectasis (lung collapse), decubitus ulcers, falls, and urinary tract infections.
    - Unruh, L. (2003). Licensed Nurse Staffing and Adverse Events in Hospitals. Medical Care, 41(1), 142-52.
- Savings from shortened length of stay improve the cost-effectiveness of increased staffing, although the savings only offset half of the increased labor costs. Savings resulting from decreased length of stay would largely accrue to payers, such as health insurers, while hospitals would incur the costs of additional staffing.

- Rothberg, M.B., Abraham, I., Lindenauer, P.K.& Rose, D.N. (2005). Improving Nurse to Patient Staffing Ratios as a Cost Effective Safety Intervention. Medical Care, 43(8), 785-91.

Safe Staffing and Medical Errors

- Hospital nurses reporting higher workloads in a survey were more likely to report more frequent medical errors and patient falls occurring in their units.
  - Sochalski, J. (2004). Is More Better? The Relationship Between Hospital Staffing and the Quality of Nursing Care in Hospitals. Medical Care, 42(2 Suppl.) 1167-73.
- The number of hours worked by RNs is an important factor in the rate of medical errors. Odds of making an error during a shift of 12.5 hours or longer is over three times as great as during a shift of 8.5 hours or less.
  - Rogers, A.E., Hwang, W., Scott, L.D., Aiken, L.H., Dinges, D.F. (2004). The Working Hours of Hospital Staff Nurses and Patient Safety. Health Affairs, 23(4), 202-12.
- The Institute of Medicine, in a study of the nursing work environment, recommends that the length of nursing shifts be limited to 12 hours in any 24 hour period, whether mandatory or voluntary.
  - Institute of Medicine (2004) Keeping Patients Safe: Transforming the Work Environment of Nurses. Washington, D.C., National Academies Press, p.237.
- Evidence on Nurse Staffing and Patient Outcomes in four systematic reviews found low nurse staffing levels to be associated with higher patient mortality and failure to rescue (Griffiths et al., 2014, Kane et al., 2007, Penoyer, 2010, and Shekelle, 2013).
- Even studies with the most robust designs, which closely match time periods for nurse staffing levels to patient outcomes, found significant or nearly significant evidence for the association between nurse staffing volume and patient mortality (Needleman et al., 2011), as well as failure to rescue (Talsma et al., 2014).
- Griffiths et al., 2014 found evidence suggesting that low nurse staffing was associated with higher rates of patient falls in the hospital.
- Kane et al., 2007 and Shekelle, 2013 found research on this dynamic to be inconsistent, with some studies showing associations while other studies did not, but these systematic reviews included less robust study designs.
- Beyond patient health outcomes, there are patient process outcomes that have been found to be associated with lower nurse staffing levels. Griffiths et al., 2014 found evidence from several studies suggesting that higher rates of drug administration errors and missed nursing care were associated with lower nurse staffing levels.
- Three systematic reviews found evidence suggesting that lower nurse staffing levels were associated with longer patient stays in the hospital (Griffiths et al., 2014, Kane et al., 2007, and Shekelle, 2013).
- There is also evidence that higher nurse staffing levels were associated with a reduced length of stay (de Cordova et al., 2014).

- Other patient outcomes routinely used to measure patient safety such as pressure ulcers and hospital acquired infections have inconsistent or less strong evidence supporting an association with low nurse staffing levels (Griffiths et al., 2014; Choi and Staggs 2014; Park et al., 2014; Bae et al., 2014)

A Call to Action

Nursing remains at the front line of patient care, satisfaction and safety by identifying and addressing patient and health care system problems in a timely fashion. To maintain the ability of the profession to respond effectively to a dynamic healthcare system, the IOM's Future of Nursing (2010) indicated the need for nurses, among other things, to become full partners in the redesign of healthcare (p. 1). The report also calls for a reexamination of the effectiveness of the current healthcare workforce with methodology to determine areas requiring improvements (IOM, 2010).

There is no doubt that one such area requiring improvement is the staffing levels in all clinical divisions of patient care. This patient care chronicle reaffirms the nursing profession's responsibility to monitor staffing effectiveness to ensure the protection of the public from unsafe and ineffective nursing practice.

In examining trends in the labor shortage, the American Hospital Association Strategic Policy Planning Committee cite increased competition, changes in the attractiveness of healthcare careers, stressful work environments, and associated emotional risks/physical risks as altering an individual's decision about a career in health care (Joint Commission, 2007). All of these factors can and should be addressed by providing appropriate nurse-to-patient ratios in all patient care settings.

In its recent bill (H.R. 1907: Nurse Staffing Standards for Patient Safety and Quality Care Act of 2013 113th Congress, 2013–2015. Text as of May 09, 2013 (Introduced) (https://www.govtrack.us/congress/bills/113/hr1907/text), Congress has noted the importance of safe nurse-to-patient ratios in the healthcare arena and has proposed the following:

Congressional Findings:

(1)

The Federal Government has a substantial interest in promoting quality care and improving the delivery of health care services to patients in health care facilities in the United States.

(2)

Recent changes in health care delivery systems that have resulted in higher acuity levels among patients in health care facilities increase the need for improved quality measures in order to protect patient care and reduce the incidence of medical errors.

(3)

Inadequate and poorly monitored registered nurse staffing practices that result in too few registered nurses providing direct care jeopardize the delivery of quality health care services.

(4)

Numerous studies have shown that patient outcomes are directly correlated to direct care registered nurse staffing levels, including a 2002 Joint Commission on Accreditation of Healthcare Organizations report that concluded that the lack of direct care registered nurses contributed to nearly a quarter of the unanticipated problems that result in injury or death to hospital patients.

(5)

Requirements for direct care registered nurse staffing ratios will help address the registered nurse shortage in the United States by aiding in recruitment of new registered nurses and improving retention of registered nurses who are considering leaving direct patient care because of demands created by inadequate staffing.

(6)

Establishing adequate minimum direct care registered nurse-to-patient ratios that take into account patient acuity measures will improve the delivery of quality health care services and guarantee patient safety.

(7)

Establishing safe staffing standards for direct care registered nurses is a critical component of assuring that there is adequate hospital staffing at all levels to improve the delivery of quality care and protect patient safety.

(b) (1) Maintenance of records

Each hospital shall maintain accurate records of actual direct care registered nurse-to-patient ratios in each unit for each shift for no less than 3 years. Such records shall include—

(A)

the number of patients in each unit;

(B)

the identity and duty hours of each direct care registered nurse assigned to each patient in each unit in each shift; and

(C)

a copy of each notice posted under *subsection (a)*.

(2)

Availability of records

Each hospital shall make its records maintained under *paragraph (1)* available to—

(A)

the Secretary;

(B)

registered nurses and their collective bargaining representatives (if any); and

(C)

the public under regulations established by the Secretary, or in the case of a federally operated hospital, under section 552 of title 5, United States Code (commonly known as the *Freedom of Information Act*).

This bill makes clear that coordinated efforts in the healthcare arena to provide quality nursing care and to ensure an ample supply of nurses in the future will serve both the public and nursing's best interests. It is of utmost importance that HHC, professional and regulatory bodies, and the nursing professions consistently uphold existing professional and legal standards regardless of supply and demand issues and adopt as a contractual mandate the nurse-to-patient ratios in NYSNA's Proposed Acute Care Nurse-to-Patient Ratios in the Safe Staffing for Quality Care Act. Ethics and quality care principles mandate that we work together to improve the nurse's work environment and to increase registered nurse retention, while concomitantly providing for quality and safe patient care.

NYSNA Proposed Acute Care Nurse-to-Patient Ratios in the Safe Staffing for Quality Care Act

Trauma emergency	**1:1**
Operating room	**1:1**
All Intensive care	**1:2**
Emergency critical care	**1:2**
Post anesthesia care	**1:2**
Labor – 1st stage	**1:2**
Labor – 2nd & 3rd stage	**1:1**
Antepartum	**1:3**
Non-critical antepartum	**1:4**
Newborn nursery	**1:3**
Intermediate care nursery	**1:3**
Post-partum couplets	**1:3**
Post-partum mother-only	**1:4**
Well-baby nursery	**1:6**
Emergency department	**1:3**
Step-down & telemetry	**1:3**
Pediatrics	**1:3**
Medical-surgical	**1:4**
Acute care psychiatric	**1:4**
Rehabilitation & sub-acute	**1:5**

The Department of Health will establish ratios for any units not listed. All ratios are minimums to be adjusted based upon patient needs.

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