Mount Sinai St. Luke's and West Patient Care Chronicle

Presented by:

The Registered Professional Nurses at Mount Sinai St. Luke's and West

February, 2019

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Mount Sinai St. Luke's and West Protest of Assignment (POA) and

Patient Care Chronicle
January 1, 2018 through December 31, 2018

Executive Summary:

The **Mount Sinai St. Luke's and West hospitals** are affiliates of the **Mount Sinai Hospital Health System**. The **Mount Sinai Health System** combines the Icahn School of Medicine at Mount Sinai and eight hospital campuses throughout the New York metropolitan area. **Mount Sinai St. Luke's** describes itself as "the leading health care provider for West Harlem and Morningside Heights" in New York. (See: https://www.mountsinai.org/locations/st-lukes). Mount Sinai St. Luke's offers a level 2 trauma center and is a 495-bed institution with over 90,000 Emergency Room visits, over 10,000 Emergency Room admissions, over 97,000 days of patient care, 410,000 ambulatory visits to its Emergency Room per annum, and over 840 members of its nursing staff (See https://www.mountsinai.org/locations/st-lukes/about/stats). **Mount Sinai West** describes itself as a "full-service, 505-bed medical center, with a long history of clinical excellence, proudly serving patients from Midtown and the West Side of Manhattan, New York City, and beyond " (https://www.mountsinai.org/locations/west/about). Mount Sinai West (formally known as The Roosevelt Hospital) is a 505-bed medical center with over 69,000 Emergency Room visits, over 260,000 ambulatory visits to its Emergency Room per annum, and over 860 members of its nursing staff (See https://www.mountsinai.org/locations/west/about/stats).

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 one thousand five hundred (1588) registered professional nurses collectively at both the Mount Sinai St Luke's and West Hospitals*** for collective bargaining and nursing practice rights.

At the Mount Sinai St. Luke's and West campuses, during the time period of **January 1, 2018 to December 31, 2018, POA documentation** in nine (9) specialty unit areas revealed registered nurses had filed **individually and/or collectively** more than **four hundred and fifteen(416)** protests of assignment (POAs) supported by over **two thousand two hundred and ninety (2293)** signatures of registered professional nurses that raises questions regarding the St. Luke's hospital's promise and advertisement to provide world-class clinical care and research within the comfort of a neighborhood hospital known for compassion and sensitivity, and to be a leader in quality and safety, with a commitment to providing its patients with complete and accurate reporting on its quality and safety agenda and performance results[1] as well as Mount Sinai West's promise and advertisement to live up to its reputation as a renowned institution for multiple surgical specialties, its robust maternity service, and for delivering the highest quality, patient-centered care.[2]

These POAs also raise questions regarding Mount Sinai St. Luke and West's ability to adequately operationalize its guiding **vision** and **brand promise** that they "deliver the best patient care—from prevention to treatment of the most serious and complex human disease through unrivaled education, research, and outreach in the many diverse communities we serve."[3] 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 Mount Sinai St. Luke's and West campuses 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.[4] 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[5] and acuity[6] of the patients.

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[1]Retrieved from: https://www.mountsinai.org/locations/st-lukes/about.

[2]Retrieved from: https://www.mountsinai.org/locations/west/about

[3]Retrieved from: https://www.mountsinai.org/about/mission

[4] 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.

[5]"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

[6]"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 **416 POAs** filed at the Mount Sinai St. Luke's and West campuses document repetitive and consistent problems related to insufficient numbers of nursing staff throughout all hospital departments, but particularly in the Maternity/GYN/Labor & Delivery, and Med/Surg 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 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 a **total of 2 citations resulting from 1 of 2 inspections of Mount Sinai St. Luke's in 2017 for its deficiencies in patient care.** This report documents that Mount Sinai St. Luke's inspections resulted in a citation from the New York State Department of Health in **50% of the inspections.** A recent citation issued in March, 2017 appear below (New York State Department of Health, Health Profiles, Retrieved at https://profiles.health.ny.gov/hospital/view/102929#inspections (Chart 1)

Chart 1: NYS DOH Citations Mount Sinai St. Luke's 2017

March 13, 2017 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 28, 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

Care of patients

Complexity of facilities

The New York State Department of Health issued a **total of 2 citations resulting from 1 of 2 inspections of Mount Sinai West in 2017 for its deficiencies in patient care**. This report documents that Mount Sinai West's inspections resulted in a citation from the New York State Department of Health in **50% of the inspections**. A recent citation issued in March, 2017 appear below (New York State Department of Health, Health Profiles, Retrieved at https://profiles.health.ny.gov/hospital/view/102929#inspections (Chart 2)

Chart 2: NYS DOH Citations Mount Sinai West 2017

March 13, 2017 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 28, 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
Care of patients
Complexity of facilities

Overall complaints from the population to the New York State Department of Health from January 2, 2015 through December 31, 2017 regarding Mount Sinai St. Luke's and West appear in Chart 3.

Chart 3: Complaints to the NYS DOH Regarding Mount Sinai St Luke's and West 2

Overall Numbers of Complaints Received from January 1, 2015 through December 31, 2017 At Mount Sinai St. Luke's and West:

Measure	This Facility
Complaints received per 10,000 patient days	0.4
Complaints reviewed resulting in citations, per 10,000 patient days	0.1
Percentage of allegations made that were substantiated	10.5%

POAs are consistent with 2018 Leapfrog Report and 2018 New York State Health Profiles

The 2018 Leap Frog Report and the New York State Health Profiles aligns with the Registered Professional Nurses 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. The **Leapfrog Grade at both the Mount Sinai St. Luke's and West campuses is a C.** A sampling of the Leapfrog findings that are consistent with the more than **416 POAs** appears below:

* This Leapfrog Report aligns with the Mount Sinai St. Luke's and West's 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 practices

See https://www.hospitalsafetygrade.org/h/st-lukes-roosevelt-hospital-roosevelt-hospital-division/; https://www.hospitalsafetygrade.org/h/st-lukes-hospital-of-new-york.

Hip Replacement Surgery Infections Hip replacement surgery involves removing the damaged hip sections and completely or partially replacing with an artificial hip joint. Surgical Site Infections (SSIs) are infections that occur after surgery at the incision site or deeper within the body where the surgery took place. Some SSIs are minor and only involve the skin or superficial tissues; others may be deeper and more serious. All SSIs are measured as infections per 100 procedures.	▽ Poor Performer	Facility value of 3.81 per 100 instances; compares to state value of 0.77 per 100; Reporting period of 01/01/2016 to 12/31/2016

* This Leapfrog Report and New York State Health Profile aligns with the Mount Sinai St. Luke's and West's 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

See https://www.hospitalsafetygrade.org/h/st-lukes-roosevelt-hospital-roosevelt-hospital-division/; https://www.hospitalsafetygrade.org/h/st-lukes-hospital-of-new-york.

* This Leapfrog Report aligns with the Mount Sinai St. Luke's and West's 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 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 practices

See https://www.hospitalsafetygrade.org/h/st-lukes-roosevelt-hospital-roosevelt-hospital-division/; https://www.hospitalsafetygrade.org/h/st-lukes-hospital-of-new-york.

NYS Health Profiles: Mount Sinai St. Luke's and West Patient Satisfaction

Patient Satisfaction

Patient Satisfaction Composite score of an entity's HCAHPS satisfaction ratings (higher is better)	▽ Poor Performer; ranked 4043 of 4126 facilities	Facility value of 63.17%; Reporting period of 10/01/2016 to 09/30/2017
Doctors Always Communicated Well This measure is used to assess the percentage of respondents who reported their doctors always communicated well.	▽ Poor Performer; ranked 3830 of 4126 facilities	Facility value of 74.00%; compares to national value of 82.00%; Reporting period of 10/01/2016 to 09/30/2017
Nurses Always Communicated Well This measure is used to assess the percentage of respondents who reported their nurses always communicated well.	▽ Poor Performer; ranked 4006 of 4126 facilities	Facility value of 69.00%; compares to national value of 80.00%; Reporting period of 10/01/2016 to 09/30/2017
Pain Was Always Well Controlled This measure is used to assess the percentage of respondents who reported their pain was always well controlled.	▽ Poor Performer; ranked 5534 of 5888 facilities	Facility value of 63.00%; compares to national value of 71.00%; Reporting period of 07/01/2016 to 06/30/2017
Patient's Room Always Kept Quiet At Night This measure is used to assess the percentage of respondents who reported their room was always kept quiet at night.	▽ Poor Performer; ranked 3742 of 4126 facilities	Facility value of 48.00%; compares to national value of 62.00%; Reporting period of 10/01/2016 to 09/30/2017
Patient's Room and Bathroom Always Kept Clean This measure is used to assess the percentage of respondents who reported their room and bathroom were always kept clean.	○ Average Performer; ranked 2862 of 4126 facilities	Facility value of 70.00%; compares to national value of 75.00%; Reporting period of 10/01/2016 to 09/30/2017
Patients Always Received Help As Soon As They Wanted This measure is used to assess the percentage of respondents who reported that they always received help as soon as they wanted.	▽ Poor Performer; ranked 3985 of 4126 facilities	Facility value of 54.00%; compares to national value of 70.00%; Reporting period of 10/01/2016 to 09/30/2017
Patients Given Information About Recovery At Home This measure is used to assess the percentage of respondents who reported whether ("Yes" or "No") they were provided specific discharge information.	▽ Poor Performer; ranked 4050 of 4126 facilities	Facility value of 77.00%; compares to national value of 87.00%; Reporting period of 10/01/2016 to 09/30/2017
Patients Would Definitely Recommend This Hospital to Friends and Family This measure is used to assess the percentage of respondents who reported whether ("Definitely No," "Probably No," "Probably Yes," or "Definitely Yes") they were willing to recommend this hospital to their family and friends.	○ Average Performer; ranked 3033 of 4126 facilities	Facility value of 66.00%; compares to national value of 72.00%; Reporting period of 10/01/2016 to 09/30/2017
Percent of Patients Highly Satisfied This measure is used to assess adult inpatients' perception of their hospital. Patients rate their hospital on a scale from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible.	▽ Poor Performer; ranked 3783 of 4126 facilities	Facility value of 61.00%; compares to national value of 73.00%; Reporting period of 10/01/2016 to 09/30/2017
Staff Always Explained About Medicines This measure is used to assess the percentage of respondents who reported that the staff always explained about medicines.	▽ Poor Performer; ranked 3932 of 4126 facilities	Facility value of 55.00%; compares to national value of 66.00%; Reporting period of 10/01/2016 to 09/30/2017

* This NYS Health Profile Report aligns with the Mount Sinai St. Luke's and West's RNs POA complaints of insufficient numbers of qualified staff and acuity and case load too high resulting in:

- Inability to deliver nursing care in an environment conducive to the provision of patient satisfaction
- Inability to deliver nursing care 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 practices

See: https://profiles.health.ny.gov/hospital/printview/102929#quality.

Inspection: 1225235.015 - Mount Sinai Saint Luke'S

Inspection Information - Office: Manhattan

Nr: 1225235.015	Report ID: 0215000	Open Date: 04/17/2017		
Mount Sinai Saint Luke'S 1111 Amsterdam Avenue New York, NY 10025 SIC: NAICS: 622110/General Medical and Surgical Hospitals Mailing: 1111 Amsterdam Avenue, New York, NY 10025		Union Status: Union		
Inspection Type:	Complaint			
Scope:	Partial	Advanced Notice:	N	
Ownership:	Private			
Safety/Health:	Health	Close Conference:	04/17/2017	
		Close Case:	06/21/2017	
Related Activity:	Type	ID	Safety	Health
	Complaint	1202159		Yes

Case Status: CLOSED

Case Status: CLOSED

Inspection: 1225404.015 - Mount Sinai West

Inspection Information - Office: Manhattan

Nr: 1225404.015	Report ID: 0215000	Open Date: 04/17/2017		
Mount Sinai West 1000 10th Ave New York, NY 10019 SIC: NAICS: 622110/General Medical and Surgical Hospitals Mailing: 1000 10th Ave Administration First Floor, New York, NY 10019		Union Status: Union		
Inspection Type:	Complaint			
Scope:	Partial	Advanced Notice:	N	
Ownership:	Private			
Safety/Health:	Health	Close Conference:	04/17/2017	
		Close Case:	08/10/2017	
Related Activity:	Type	ID	Safety	Health
	Complaint	1201454		Yes

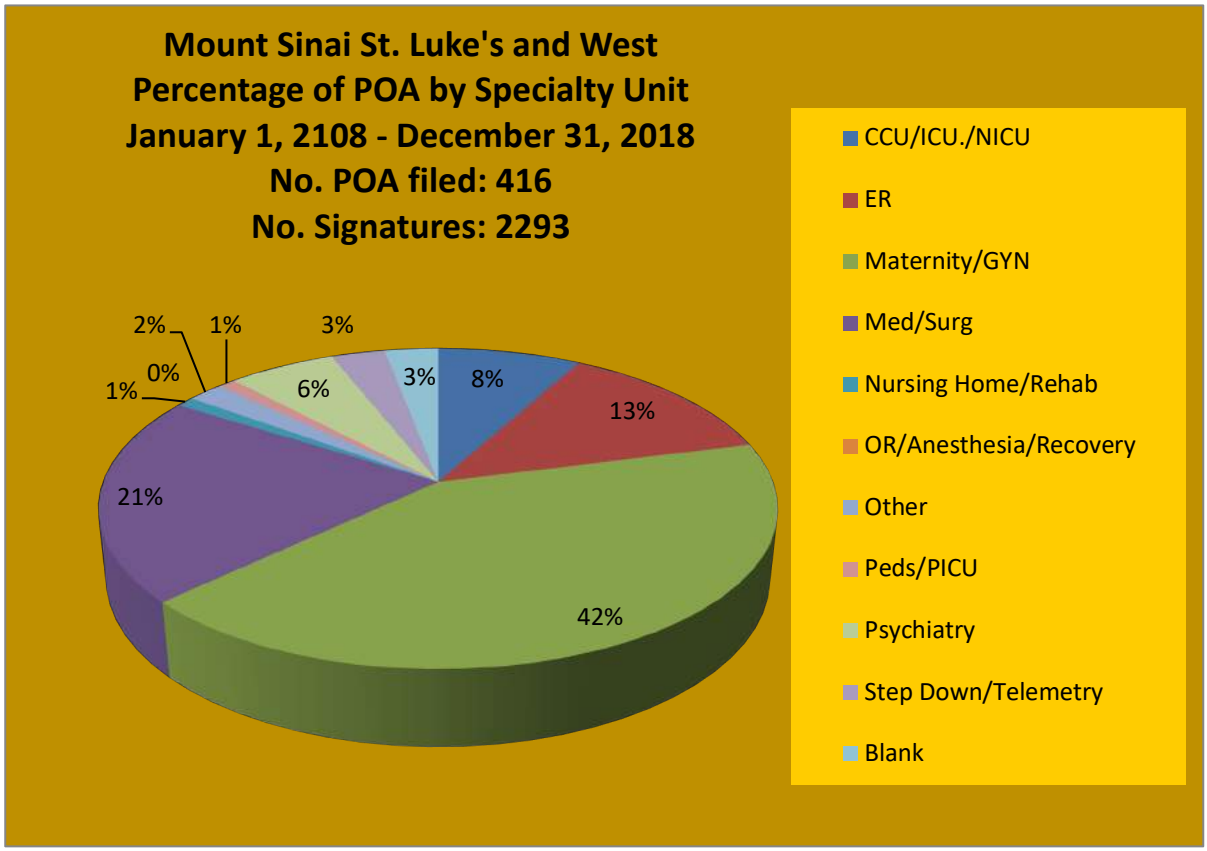
* This OSHA Complaint and Inspection Report aligns with the Mount Sinai St. Luke's and West's RNs POA complaints of insufficient numbers of qualified staff and acuity and case load too high resulting in:

- Inability to deliver nursing care in an environment conducive to the provision of patient satisfaction
- Inability to deliver nursing care in accordance with health and safety practices

See: https://www.osha.gov/pls/imis/establishment.inspection_detail?id=1225235.015&id=1225404.015.

Figure 1: Mount Sinai St. Luke's and West

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 four hundred and sixteen (416) protests of assignment (POAs) supported by over five thousand four hundred and five (5405) signatures filed in the specialty areas documented at the Mount Sinai St. Luke's and West 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

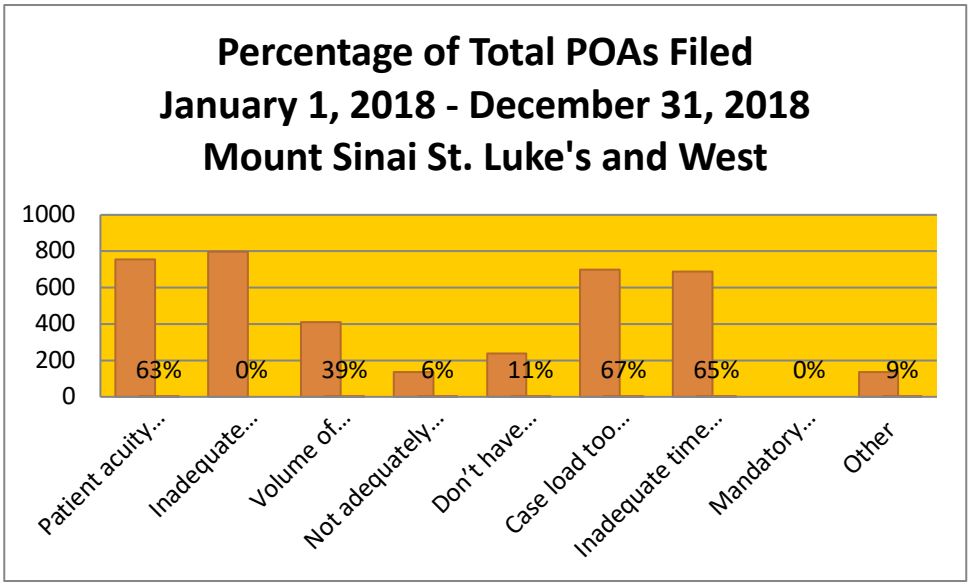
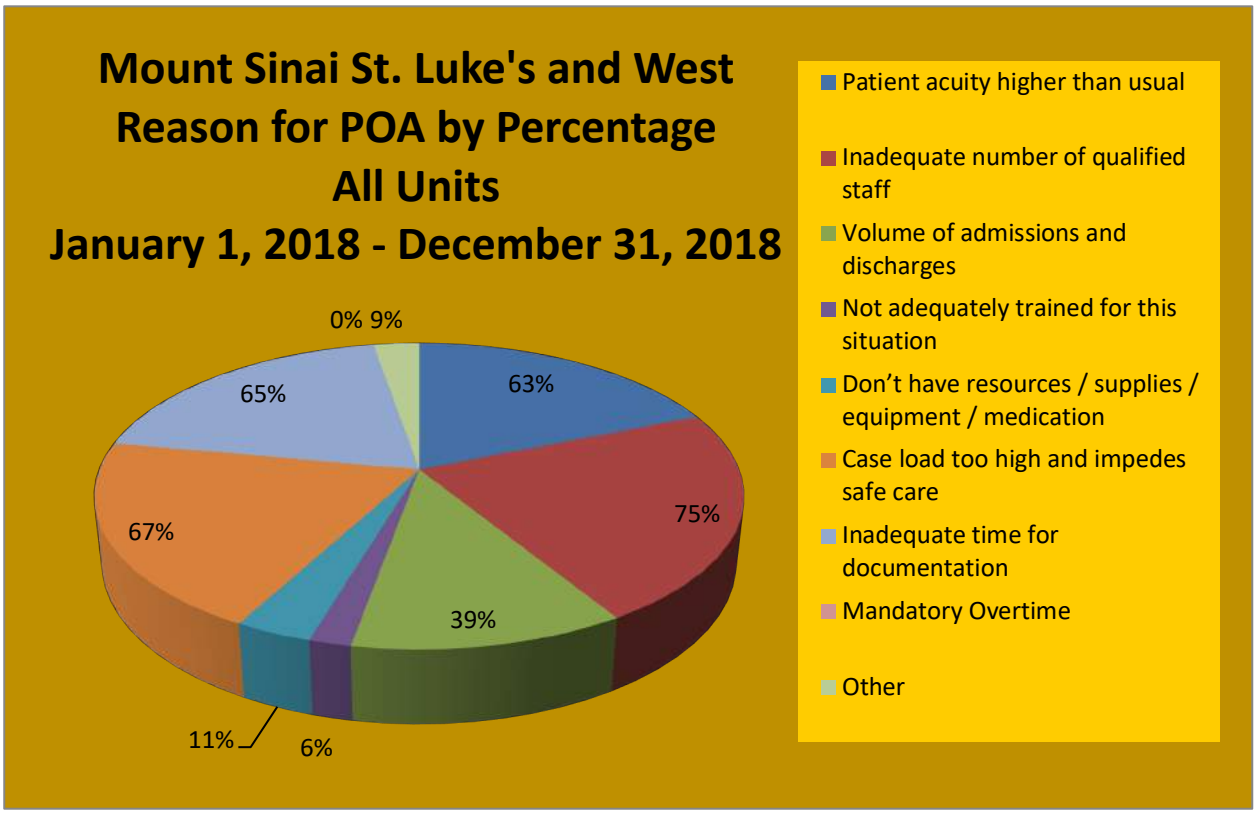


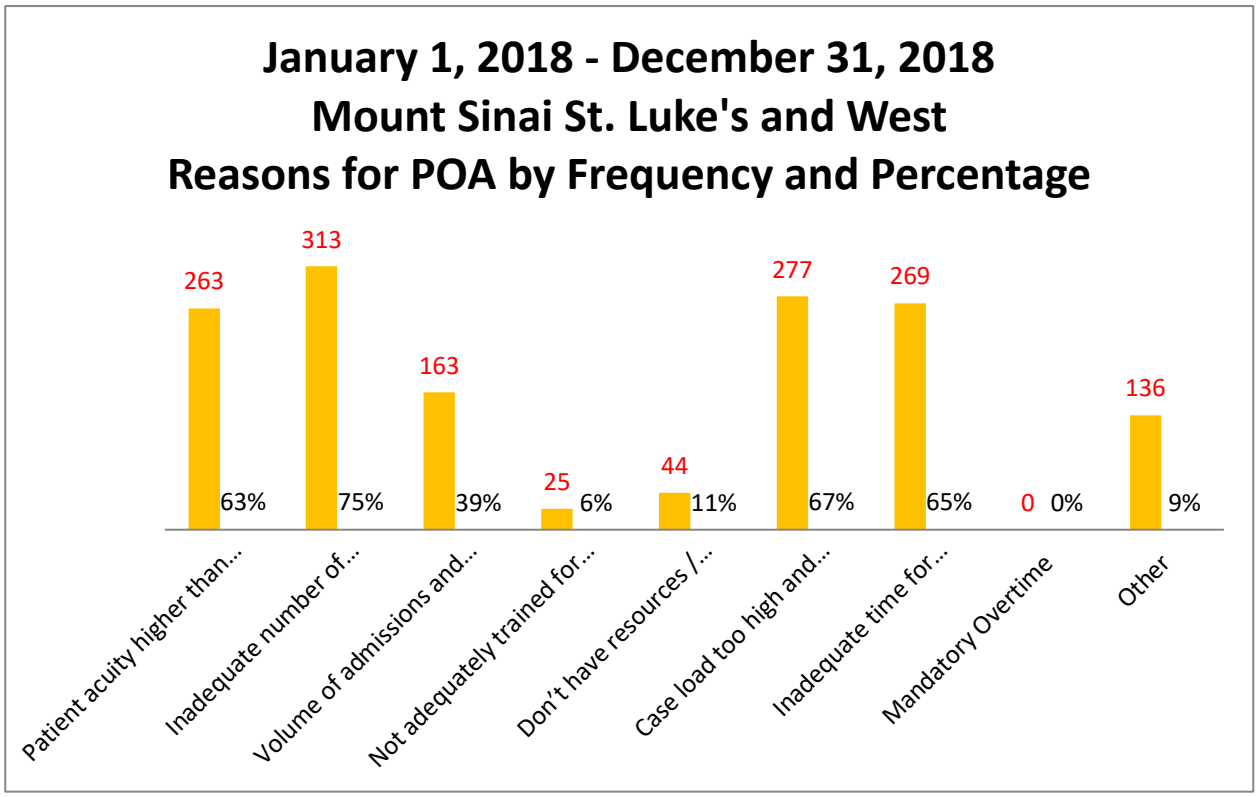
Figure 3: Most Frequent Reason for Protest of Assignment by Percentage



The 416 hospital-wide POAs filed at Mount Sinai St. Luke's and West Campuses 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 Percent



*The most common reason indicated for the Protest of Assignment was “inadequate numbers of qualified staff followed by “caseload too high to provide safe care” and “patient acuity higher than normal”. The second and third reasons logically follows the first. In addition to reflecting an inadequate number of trained and qualified RNs to provide care, inadequate numbers of ancillary staff also applied to situations where the absence of those 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, along with the inability to document care in accord with standards of practice in nursing.

The 416 hospital POAs in the specialty areas outlined filed at the Mount Sinai St. Luke's and West Campuses 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, Health & Safety, Violation of Contractual Nurse to Patient Ratio: (multiple occurrences) Telemetry unit at full capacity and we are over the bed capacity on telemetry unit and I have been assigned patients on telemetry monitors and I don't have any experience or training on monitors. The unit has been **without power** and the telemetry units are off. Nurses are assigned patients over the 1:4 contractual ratios. Multiple patients are at high risk for falls, multiple patients with decubitus ulcers needing wound care, many demanding patients who are high bell-callers, multiple total care patients.
Insufficient # of Staff, Insufficient # of Qualified Staff, & High Acuity, Volume of Admissions/Discharge: (multiple occurrences) Telemetry unit has 2 nurses that have been floated into the unit because acuity is high and staffing is low, but the **2 nurses are UNABLE TO READ TELEMETRY MONITORS**. 1 nurse is taking care of a patient on a vent with an additional 5 patients and 2 of the 5 patients are on a 1:1 watch and there is only 1 CNA on the floor. We have also had multiple transfers and admissions to the unit.
Insufficient # of Staff, Insufficient # of Qualified Staff, & High Acuity, Violation of Contractual Nurse to Patient Ratio: (multiple occurrences) Telemetry unit has multiple patients on the floor on BIPAP, many patients on a 1:1 watch, 2 patients have nephrostomy tubes, 1 patient on a heparin drip, 1 patient in restraints requiring q 30 minute assessment checks, several patients are diabetic requiring frequent FBS checks, 2 admissions on the floor, **nurse to patient ratio higher than the contractual 1:4.**
Insufficient # of Staff, Insufficient # of Qualified Staff, & High Acuity; Not Enough Resources, Mandatory Overtime: (multiple occurrences) Telemetry unit has nurse to patient ratio of 1:6 (contract calls for 1:4) and we are **orienting** 2 new nurses (we have **3 new nurses in the department).** Patients are severely ill requiring higher acuity of care than usual. We have patients on pacer pads, septic patients, hypertensive patients, 1:1 observation patients for suicide, isolation patients, intubated patients, and total care patients. We also have patients with trachs and fresh post-op patients needing pain management. We have had several admissions and discharges and our patient census is greater than our bed capacity. One nurse had to **stay an extra 6 hours** to care for critical patients. New nurses don't have experience with intubated patients. Had to **borrow ROA pump** from another floor.
Insufficient # of Qualified Staff, High Acuity, Case Load High: Addictions unit has many unpredictable behavior / high fall risk patients, detoxing patients requiring frequent monitoring, anticipated admissions, patients on 1:1 watch, high volume of narcotics being dispensed, and EPIC documentation RN is now expected to run groups for 45 minutes. The unit is staffed with only 2 RNs and medications are not being administered on time due to high case load. Insufficient numbers of staff impedes safe patient care. Not enough ancillary staff to comply with policy that staff must remain with patient while patient is in the bathroom.
Insufficient # of Qualified Staff, High Acuity, Case Load High, Health & Safety: Newborn nursery nurse is responsible for infant on isolation AT THE SAME TIME as caring for newborns that are in nursery and all admissions. Isolation infant on IV antibiotics.
Insufficient # of Qualified Staff, High Acuity, Case Load High: Rehab unit has 20 patients, 8 are diabetic requiring frequent BS monitoring, 10 CVA patients, 4 spine surgery patients, 3 confused patients, 1 1:1 watch patient, 2 decannulated trach patients, all 20 need assistance in and out of bed,

1 patient with PICC line and on IV drips, 1 patient with GT tube, **RN floated** to the unit not certified to do the documentation needed on these patients, no secretary. Unable to follow policy for hourly rounds
Insufficient # of Qualified Staff, High Acuity, Case Load High, Not Adequately Trained: PACU unit has an RN who was floated in to take a full assignment who was never trained to do EPIC in an ICU setting and no access to ICU EPIC page. **(multiple occurrences)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: PACU unit has 4 post-op patients, 1 needing a nerve block, patients who are vented, 1 patient waiting for anesthesia signed out due to long wait.
Insufficient # of Qualified Staff, High Acuity, Case Load High, Volume Admissions/Discharges, Violation of Contractual Nurse to Patient Ratio: ICU unit has patient census in excess of bed capacity with patients needing 1:1 care and charge RN requesting extra RN but nursing officer denied request. We have multiple vented patients, fresh open heart patients, complete care patients, patients on contact and droplet isolation, multiple patients with heavy wound care, 1 septic neuro patient, RNs working as preceptors who are not counted in as care givers, family members who are challenging, and multiple admissions and discharges. Frequently assigned nurse to patient ratio in excess of contractual 1:3. Most RNs working with 3 – 4 patients.
Insufficient # of Qualified Staff, High Acuity, Case Load High, High Volume Admissions/Discharges, Violation of Contractual Nurse to Patient Ratio: ICU Unit has high number of case load with only 5 RNs and no CNA. 4 patients needing blood transfusions, 2 patients with massive bleeding, 1 patient requiring 1:1 RN watch, 1 patient with hemaptosis, 1 admission that is status post code from the ED, patient acuity so high several patients need to have 3 nurses for the 1 patient.
Insufficient # of Qualified Staff, High Acuity, Case Load High, High Volume Admissions/Discharges, Violation of Contractual Nurse to Patient Ratio: ICU Unit has 7 vented patients, 2 BIPAP patients, 2 isolation patients, 2 trached patients, patients needing to be transported for CT scans, 12 patients on the unit and ONLY 4 RNs. Some patients need RN triple assignment. Some patients are agitated and require extended watch. No secretary and only 1 CNA. Management is responsible for putting us and our licenses at risk. This hole in the schedule has been known to administration for days. This **ratio violates our NYSNA contract. This is becoming the norm.**
Insufficient # of Qualified Staff, High Acuity, Case Load High, High Volume Admissions/Discharges; Infection Control: Cardiology Unit/ CCU has high admission / discharge / turnover rate. We have septic, febrile, hemodynamically unstable patients who have been inappropriately triaged, patients with the Varicella Zoster virus who are ICU level patients and need to be on droplet precautions, 1 RN caring for droplet isolation and neutropenic (low level of white blood cells) patient at the same time.
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Contractual Nurse to Patient Ratio: CCU unit has nurse to patient assignment in violation of the NYSNA contract. 4 open heart cases today requiring 1:1 RN care, all RNs have a 1:3 patient assignment. Other patients on the unit are on vents.
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Contractual Nurse to Patient Ratio, Health & Safety: Psych Unit has a nurse to **patient ratio of 1:8-10 in violation of contractual 1:7** ratios, with patients on a 1:1 observation for self-harm, and no CNA or agency nurse available, many patients who are detoxing and have violent and unpredictable behavior, court mandated admission violent patients, sexually pre-occupied patients, patients on fall and seizure precautions, several patients on hunger strikes with unstable glucose levels, patients with restraints, regular and per-diem RNs who are floated to the floor with no psych experience, pending 5 – 8 admissions, no breaks or meals for RNs, night nurse staying late to help with medication administration (high volume of narcotics to dispense and monitor responses), at times, RNs and CNAs

are pulled from floor to float out of the unit, charge nurse taking a full patient assignment. Nurses floated in are not properly oriented**. (multiple occurrences)**
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources, Nurse to Patient Ratio in Violation of Contract: Unable to provide a baby nurse in the OR and in the Delivery Room, Unable to give break on 1st shift at this time. There are 8 OB admissions, **IV pumps not working** and mothers in great pain, 7 possible discharges, **Nurse to Patient Ratio 1:10** in violation of contract **(repetitive and consistent response)**, L & D nurses who have not had their breaks are floated to other units, babies who are tachpneic with low blood sugars and low temps (a sign of impending seizure), multiple fresh c-sections.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Training: We have 3 patients on Magnesium for pre-eclampsia, 1 patient on insulin drip, 3 scheduled c-sections, 2 external rotations, 1 possible emergency c-section, **orientee unable to receive proper orientation** with current assignments. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Charge RN has 4 moms and 3 babies with language barrier (Arabic). Multiple patients on triple antibiotics, multiple patients needing blood, labs, ECG, glucose monitoring. We have no nursery RN and no unit secretary. Nurse to patient ratio is 1:9. **(repetitive and consistent response)** We had 3 sick calls unable to be replaced.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate training: I have been floated to post-partum unit and I am out of my scope of practice, **I have never trained/oriented in post-partum unit**. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: RNs are now assigned a new duty to wash delivery table and instruments. We say this is not a nursing duty.
Insufficient # Qualified Staff, High Patient Acuity, Case Load High: We have babies on phototherapy, 2 diabetic patients 2 fresh delivery patients, all patients needing breastfeeding help, 1 patient on antibiotics, 1 patient with extremely high BP, several patients with significant medical/OB history requiring additional care/attention, patients receiving 2 units of PRBCs, hypotensive patients, 1 patient receiving IV electrolytes, 1 patient with fecal drainage, 1 patient on isolation.
Insufficient # Qualified Staff, High Patient Acuity: We have 13 RNs with 3 on orientation. We are **short the baby nurse in all deliveries and no post partum RN. We only have 1 RN for triage and we have mothers waiting more than 4 hours in triage. Patients have multiple complaints.**
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources, Nurse to Patient Ratio in Violation of Contract: RNs have 10 patients / RN, and charge nurse has 8 patients. The L & D room cannot provide a baby nurse or a 2nd nurse in triage. RN who is on orientation is not receiving a proper orientation. Patients are waiting in triage for beds on the floor.
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources: We have no IV poles, no towels, no linens. We have no urine measuring supply. We cannot provide a baby nurse on the floor or in the OR. There is only 1 RN in triage with an orientee. No beds on unit to transfer patients from triage.
Insufficient # of Qualified Staff, High Acuity, Case Load High: Our bed capacity is 24, but we have 27 patients. 3 are scheduled for c-section, 1 emergency c-section, 4 scheduled induction admissions, 1 patient seriously sick in the recovery room after having her c-section, 2 babies are pre-term in the delivery room, 1 baby had to be sent to NICU. Patients need pain meds on time and 1 baby has unstable glucose issues. 1 baby has kidney issues. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: We have 5 RNs on orientation. We only have 1 RN in triage. We have 3 inductions, 1 patient waiting since yesterday. **(repetitive and consistent response)** We have patients who are hypertensive and patients needing blood transfusions. On our unit, we cannot provide a baby nurse in newborn nursery, we have 4 RNs on orientation, 1 RN in triage, and 1 RN doing a 1:1.

Insufficient # of Qualified Staff, High Acuity, Case Load High, Admission & Discharge High: Not enough RNs to admit and discharge patients at the same time. Unsafe nursing, RNs not able to check on patients every 1 – 2 hours and to check patients' charts. 1 DD C/S, 1 patient with epidural headache, patient on triple antibiotics and elevated BP, **nurse to patient ratio 1:10 with 1 RN has 1:11**. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: 1 patient on magnesium sulfate, 2 patients with unstable fetal monitoring tracings, 3 scheduled external rotations, 2 scheduled c-sections, 3 inductions with 1 patient waiting since yesterday, **bed capacity 24 with 28 patients.** No beds to put patients, causing backup in triage. No breaks, 4 patients waiting to be assessed in waiting area. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: Our bed capacity is 24. We have 31 patients. 3 patients on magnesium sulfate, 1 fetal breech presentation, 1 urgent c-section, 3 normal deliveries within 3 minutes of each other, **ALL THESE DELIVERIES REQUIRING A 1:1 RN PRESENCE.**
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Regulatory Requirements: Improper distribution of staff (we are being asked to cover another unit despite being short staffed in L & D. Only 1 RN in triage, and we are **unable to provide baby nurse for every delivery. (repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Regulatory Requirements: Staffing low, with multiple c-sections going on, **circulating RN had to scrub on same case, ANCC became circulating RN AND THE Baby RN between 2 ORs.** Nursery will have to close due to low staffing, with other RNs completing all newborn care and admissions. Unit Secretary working between 2 units.
Insufficient # of Staff, High Acuity, Nurse to Patient Ratio in Violation of Contract: RNs with 7 – 10 patients each on med/surg unit, charge RN taking an assignment of 6 patients, multiple patients with trach, i7 special observation patients, unit is not equipped. Patients are mostly total care, high fall risk. Patients have vents, multiple patients with 3 RN assists, multiple patients on pain management. We have patients pulling out their NGT, patients who are not compliant with Foley, 1 patient whose colonoscopy was not adequate and has to be redone. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have MRSA patients, only 1 CNA on the floor and patients who need 1:1 constant observation. No relief from nursing office. We have patients on contact isolation, multiple fall risk patients. We have patients on BIPAP and patients with chest tubes. 1 of our RNs was floated out of the unit and 1 is on orientation. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Nurse to Patient Ratio in Violation of Contract: Census is starting at 26, awaiting 5 patients for admission. Patients on police guard, 5 orthopedic post-op patients requiring 4 RNs to turn and assist, 4 post-op patients on trachs requiring 4 hour vitals, 9 total care patients, 1 special project assignment for bariatric surgery. On our geriatric units, staffing guidelines are not met. We are unable to reach patients in a timely manner. We have very agitated and aggressive patients, patients pulling out lines, confused patients, patients who are constantly screaming **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Start of shift with 34 patients, 9 total care patients, 1 patient on special observation for safety, 2 very confused patients requiring frequent checks, all patients requiring vital signs every 4 hours, all patients on strict I & O, 8 fresh post-op patients from PACU, 5 patient admissions.
Insufficient # Qualified Staff, High Patient Acuity; Health & Safety: Out of 30 patients, 26 are at risk for fall. We have 2 post-op patients, 2 critical patients, 1 sepsis patient, 1 hypoglycemic episode patient and 25 need assistance with hygiene care. Patients are confused, 6 patients are on observation for elopement risks, and some are combative toward staff. 1 patient is 508 pounds and needs multiple RN assistance with position changes. Our Census EXCEEDS our bed capacity.

Insufficient # Qualified Staff, High Patient Acuity, Nurse to Patient Ratio in Violation of Contract, Volume of Admissions/Discharges: We have 3 RNs with a greater than 1:7 ratio. 1 of our RNs is on orientation. We have had 8 admissions/transfers, 9 patients requiring complete care, 1 patient with NGT and rectal tube and trach, multiple patients on every 4 hours vital signs and I & O, no break relief, orthopedic patients that require a lot of time to bring to bathroom, patients requiring blood transfusions, patients who are incontinent and with bed sores. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have multiple patients on heparin drip, chest tubes, BCI, NGT, TPN, fresh post-op requiring lab testing every 4 hours, foley care, multiple pain meds, numerous PCA / blocks, and pre-op patients that need preparation.
Insufficient # Qualified Staff, High Patient Acuity, Not Enough Resources, Nurse to Patient Ratio Exceeds Contract: We have a pregnant woman on our floor and we are **unable to monitor fetus**, patients needing blood transfusions, patients with epidural PCAs, very sick and demanding patients, multiple admissions, confused patients getting in and out of bed, multiple total care, patients needing EKGs, bladder scanning, blood draws. Nurse to Patient Ratio exceeds contract.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Training: We have a mix of medical and surgical patients, patients transferring in from PACU, ED, and ICU. Multiple patients on PCAs, we have **5 RNs that have less than 6 months experience,** we have had a rapid response, patient requiring a septic code, patients that are withdrawing from drugs requiring frequent monitoring, patients who are confused, patients with chest tubes, patients on heparin drips, foley care, patients with acute pain, we have 3 patients requiring 1:1 constant watch. **Patient care, medication administration, and satisfaction is compromised.** We have 2 patients wh refuse to be discharged, and 4 elopement risk patient.
Insufficient # Qualified Staff, High Patient Acuity: We have 17 orthopedic patients requiring multiple RN to assist with care, transfer, mobility. We have 7 confused patients, 1 MRSA isolation, 1 airborne isolation, 1 orientee just off of orientation. We have 2 blood transfusions, 8 patients on blood PCA, 3 new post op patients, 4 patients with complete care, multiple patients with complex medications.
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Not Enough Resources: We have 28 patients on telemetry, 1 patient on bedside telemetry, 4 PIPAP, 1 vented patient requiring frequent suctioning, 24 patients requiring complete and total care because they are incontinent of bowel/bladder, needing frequent bed changes, multiple surgical patients requiring I & O monitoring, multiple patients on oxygen therapy and only 1 secretary covering 2 different units, multiple admissions/discharges. 1 patient is greater than **350 pounds. Supplies are limited.**
Insufficient # Qualified Staff, High Patient Acuity, Required Overtime, Inadequate Training: 3 of the 5 RNs on this unit are very new RNs. We have patients with trach requiring suctioning, chest tubes, PCA machines, 3 bypass patients, multiple patients needing 1:1 watch, confused patients, ortho patients needing assistance with mobility/ambulation, admissions from ED, and we had **1 nurse floated out of the unit,** and **1 night nurse who had to stay 5 hours past her regularly scheduled shift.**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: We have **2 morbidly obese patients,** multiple blood transfusions, most patients are fall risk patients, 2 contact isolation patients, multiple admissions, most patients need total care, multiple patients on IV drips, multiple patients on fall prevention programs, 1 patient on nerve block requiring vital signs every 2 hours and neuro checks every 2 hours, patients needing constant toileting. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Our bed capacity is 20. We have 25 patients and 3 RNs. All patients need assistance when getting out of bed to bathroom. 1 patient just got up by themselves and disconnected all of the monitoring devices. We have 3 laminectomy patients, 3 post bilateral knee surgeries, 9 – 12 patients who are incontinent and need frequent skin care and linen changes, 1 patient who is NPO with spinal stenosis and needs surgery but is refusing to go.
Insufficient # Qualified Staff, High Patient Acuity: We have had **2 patients just dropped onto the floor from the ER WITH NO REPORT GIVEN.** We have patients on telemetry who have atrial fibrillation, 1 patient who is rule out pulmonary embolism who was recently placed on telemetry, 1 transfer from neuro

ICU and 1 transfer from ED, 2 patients on contact isolation for C. Diff, 1 patient requiring turning and positioning every 2 hours. We have no secretary. We have 5 patients on heparin drip.
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: Staffing is so low patient care and patient satisfaction is compromised. We have patients on 1:1 constant watch that are verbally agitated. We have 7 very difficult patients, and a majority of our patients on high fall risk. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have patients with unstable FSGB's who are diabetic, patients on drips, 3 patients on 1:1 watch, patients with ostomy's, patients requiring pain medication administration, several patients who are total care requiring frequent turning and positioning, and only 4 RNs on the floor. We also have BIPAP patients on oxygen therapy, and multiple patients who have CHF and CORD. **We have had float nurses from nursery. They are not able to provide safe care for current patients on the floor (repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Inadequate Resources: 80% of our patients are on fall risk, 90% are complete care patients, our code cart monitors are broken, patients with trachs, 1 vented patient, 2 1:1 watch patients, 1 chemo patient, 2 patients with PCA pumps, 2 patient on heparin drips, 9 patients needing wound care, and 2 nurses who are precepting new RNs.
Insufficient # Qualified Staff, High Patient Acuity, Overcrowding: Holding 12 – 27 admitted patients in ED—no beds available, holding 1 MICU, 1 CCU, 2 telemetry, 10 med/surg admissions, multiple complete care patients, multiple extended observation patients, nurse to patient ratio is 1:14, 11 admissions at 7 a.m. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Overcrowding, Boarding: ED is dangerously overcrowded. No room to treat patients. No additional staff for boarders. 2 MICU patients, 23 admitted patients in ED but only 12 have bed assignments, 11 do not have assignments. RNs not able to take any breaks or meals. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Boarding: We are constantly short RNs (1 – 5 RNs). Only 1 triage RN, no trauma RN, only 1 evaluation RN. **We will have to close walk-in triage to take breaks/meals. Boarding 10** - 14 patients, no inpatient bed available. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Case Load High: RN in CPEP is in training. CPEP tech being pulled to do a 1:1 observation. Overnight tech had no break and is mandated to stay until management can find relief. Unsafe work environment: 2 adults admitted, 1 with policy, both are paranoid and unpredictable. 1 patient in 4 point restraints and we are unable to provide effective constant observation. 1 high elopement risk who is actively attempting to elope, 1 elderly patient who is a high fall risk and requires 1:1 constant watch. No time to do 15 minute rounds on CPEP. Only 2 RNs on staff. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Staff is so low there was a delay in procuring EKG from 1 patient, treatments and assessments from other patients, no CNA so late in assisting patients, no one available to pick up narcotics unless I leave 10 sick patient to go to pharmacy.
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: 50 patients eloping. Patients are walking out after waiting hours for meds, treatments, etc. This is very dangerous. Patients are getting very agitated. Patients are waiting for medications. Too many patients. Unable to do admissions. There is only 1 RN on a team. Patients are sick. 2 BIPAP, 1 post arrest, multiple with atrial fibrillation. **IT IS OVERWHELMING TO WORK HERE. (repetitive and consistent response)**
Insufficient Resources, Insufficient # Qualified Staff, High Patient Acuity, Not Adequate Training: EPIC slows us down, it is a new system, and not enough training. We have no supplies, no time to chart. **There are RNs names on schedule but they are not really working.** We have no tech, no coverage, very sick, heavy patients.
Insufficient # Qualified Staff, High Patient Acuity: Child sent to CPEP without COL, 1 unit nurse assigned to monitor the patient and sit as the patient's constant observation 1:1, no CPEP tech. This is an unsafe

environment and warrants secure staffing in place at all times. RNs should not be designated as a constant observation 1:1 but as essential personnel. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Resources, Health & Safety: Patient endangerment post cardiac arrest. Patient placed in reuse room, patient has high acuity due to IV drips and **WE DON'T HAVE THE PROPER IV TUBING** for this patient. RNs spent 3.5 hours with this patient and unable to care for other key patients.

The 416 hospital wide POAs filed at Mount Sinai St. Luke's and West Campuses 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

Specialty Unit	Number Signed	Percentage
CCU/ICU/NICU	194	8%
ER	288	13%
Maternity/Gyn	965	42%
Med-Surg	483	21%
Nursing Home/Rehab	20	1%
OR/Anesthesiology/Recovery	5	
Other	45	2%
Peds/PICU	23	1%
Psychiatry	130	6%
Stepdown/Telemetry	69	3%
(blank)	71	3%
Grand Total	2293	100%

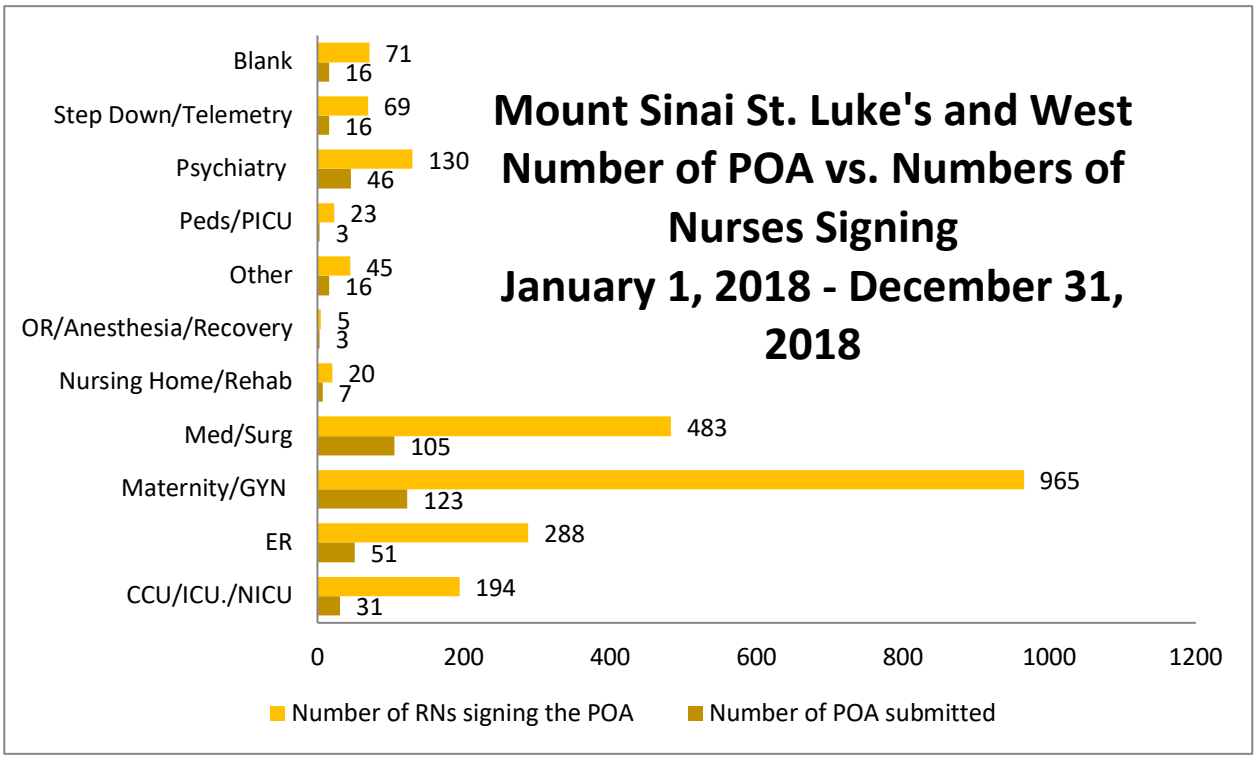
Maternity/GYN Units generated the largest portion (42%) of the total Protest of Assignments. The Medical Surgical Units generated 2nd largest portion, 21% of the total Protest of Assignments. The Emergency Room units generated the third largest portion at 13%. The critical care units generated the fourth largest portion at 8% (CCU/ICU/NICU).

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

Specialty Unit	Number of POA	Number Signed
CCU/ICU/NICU	31	194
ER	51	288
Maternity/Gyn	123	965
Med-Surg	105	483

Nursing Home/Rehab	7	20
OR/Anesthesiology/Recovery	3	5
Other	16	45
Peds/PICU	3	23
Psychiatry	46	130
Stepdown/Telemetry	16	69
(blank)	15	71
Grand Total	416	2293

Figure 6: Numbers of POA vs Numbers of Nurses Signing POA by Unit Type



The 416 hospital-wide POAs filed at Mount Sinai St. Luke's and West Campuses 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	Number Signed	Acuity Too High	Caseload Too High	No Time For Documentation	Don't Have Resources	Inadequate # Qualified RNs	Inadequate # of Staff	Not Adequately Trained	Volume Admissions	Other
CCU/ICU/NICU	194	20	20	14	4	0	26	1	11	1
ER	288	25	40	40	11	0	45	5	32	6
Maternity/Gyn	965	60	65	68	9	0	102	6	59	7
Med-Surg	483	87	77	81	15	0	72	8	43	10
Nursing Home/ Rehab	20	6	5	4	0	0	6	0	1	1
OR/Anesthesiology/	5	1	1	2	0	0	2	1	1	0

Recovery										
Other	45	8	12	11	3	0	8	0	5	4
Peds/PICU	23	3	3	3	0	0	2	1	1	1
Psychiatry	130	31	33	28	1	0	28	1	4	3
Stepdown/Telemetry	69	12	9	10	1	0	12	2	3	2
(blank)	71	10	12	8	0	0	10	0	3	1
Grand Total	**2293**	**263**	**277**	**269**	**44**	**0**	**313**	**25**	**163**	**36**

*In CCU / ICU / NICU / PICU, the ED, the Med-Surg. Units, the Psychiatric Units, the Maternity/GYN Units, and the Step-Down 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 Mount Sinai St. Luke's and West recognizes that there should be an appropriate number of staff on each unit. Thus, the **Mount Sinai St. Luke's and West** has negotiated with the New York State Nurses Association the following language, which, when violated, can be submitted to arbitration:

"Mutually agreed upon RN staffing guidelines are memorialized in Schedule B of this Agreement. The Hospital Center agrees to meet both the current and improved staffing guidelines through the use of filled positions, or in the case of vacancies, supplemental staffing , i.e.: voluntary overtime, per diem and agency nurses. The Association and the Employer have agreed to implement the following Staffing Levels/Nurse-To-Patient Ratios (the "Ratios") at both the Mount Sinai St. Luke's and West:

Chart 3: The Negotiated Nurse to Patient Ratios Mount Sinai St. Luke and West and NYSNA

C. Staffing

Mutually agreed upon RN staffing guidelines are memorialized in Schedule B of this Agreement. The Hospital Center agrees to meet both the current and improved staffing guidelines through the use of filled positions or, in the case of vacancies, supplemental staffing, i.e., voluntary overtime, per diem and agency nurses.

The Hospital Center acknowledges that patient care needs require an assessment of the adequacy of the RN table of organization. When the character of a unit has changed, Nursing Administration shall have the authority in consultation with the Association in the corporate Labor-Management Committee Forum, to modify unit-by-unit, shift-by-shift assignments. It may not reduce the total number of authorized RN positions during the term of this Agreement without consultation with the Association and the Executive Committee except under the conditions set forth below.

MOUNT SINAI ROOSEVELT Staffing Guidelines

UNIT	8B	9B	3G	10B	10A	9A	14B	7G
AVG OCCUPANCY (+/-15/20%)	20 (4)	35 (5)	20 (3)	32 8(close watch) (5)	27 (4)	32 (5)	8 (2)	35 (5)
D	4/2	6/2	4/2	6/2 2/1(close watch)	6/3	6/2	2/1	5/4
E	/2	/2	/1	/2	/2	/2	/1	
N	4/2	6/2	4/1	6/2 2/1(close watch)	6/2	5/2	2/1 (when 7 or more patients an additional RN will be provided)	3/2
UNIT	**CPEP**	**9G**	**11B/12B**	***BC***	**NICU**	**L&D**	**ICU**	**Neuro ICU (10acute,4SD)**
AVG OCCUPANCY (+/- 15/20%)		35 (5)	56 (8)	2	22	28 Stations	10	14
D	1/1	5/2	8/3	1/1	10/1	16/3	6/2	7/1
E	/1		/3	/1	/1	/2-3	/2	/1
N	1 (when 4 or more patients additional staff will be provided)	5/1	8/3	1/1	10/1	15/2	6/2	7/1
UNIT	**Peds ICU**	***ED***	**PACU**	**PACU**	**OR (inc. Cysto)**	**OR**	**Endo**	**Amb Surg**
AVG OCCUPANCY (+/- 15/20%)	4				(16 rooms)			
D	2	7:00a 8/3	8:00a 4/1 9:00a +2 10:00a +2; Noon +4	8:00a 1; Noon +1	21/20	1/1	5/1+1 MOA	13 (total day and eve)
E		10 /11a 16/3			3/3	1/1		
N	2	7:00p 17/3 10:30p 9/2	8:00p 2/1 M-F	8:00p 1 Sat-Sun	1/1 M-F	1/1 Sat-Sun	M-F	M-F
UNIT	**ASU North (Brodsky)**	**Endovascular**	**Hemo**	**AOPD**	**11G Outpatient Oncology**	**AIDS amb**	**14A Antepartum/postpartum**	
CENSUS							8	
D	2/2 (ORT)	7	2/1	3/4/1	4	2/0	2/1	
E	closed	closed				closed	/1	
N	closed M-F	closed M-F			M-F	closed M-F	2/1	

Chart 3: The Negotiated Nurse to Patient Ratios Mount Sinai St. Luke and West and NYSNA

MOUNT SINAI ST. LUKE'S Staffing Guidelines

UNIT	8E	9W	CL5	7W	6W	Sty 6
AVG OCCUPANCY (+/-15/20%)	32 (5)	29 (4)	10 (2)	32 (5)	28 (4)	12 (2)
D	7/2	6/2	2/1	5/1/2 5/2	5/2	3/1
E	/2	/2	/1	/2	/2	/1
N	7/2	6/2	2/1	5/2	5/2	2/1

UNIT	CL6	CL8	CL9	7E ICU	CCU/OHR	10E
AVG OCCUPANCY (+/-15/20%)	30 (5)	29 (4)	28 (4)	20	12	25 (4)
D	4/2	4/3	5/3	10/2	6/2	6/2
E	/2	/3	/3	/2	/2	/2
N	4/2	3/3	3/3	10/2	6/2 (1:1 openheart 1:1 IABP)	6/2

UNIT	HRT St. 9E	8W	Endo	HEMO	Pediatrics	Amb Surg	Amb Surg	CPEP
AVG OCCUPANCY (+/-15/20%)	30 (5)	14			10 (2)			
D	8 /2 + 1ET	3/1	10/3	4/1	3/1	8/1	1/1 Sat only	1/1
E	/2+ 1 ET	/1			/1	1/1	Closed	/1
N	8/2 + 1 ET	3/1			3/1	closed M-F	closed Sun	1 (when 4 or more patients additional staff will be provided)

UNIT	PACU	PACU	OR	OR
CENSUS				
D	8a 4/1; 10a +2; noon +2	8a 1/1; noon +1	12/9	2/2
E	/1	/1	3/3	2/2
N	8p 1/1 M-F	8p 1/1 Sat-Sun	2/2/1 M-F	2/2 Sat-Sun

UNIT	AOPD	Morningside Clinic	*ED*
CENSUS			
D	8/9/6/1	2/2	7a – 10 RNs (includes charge nurse), 4 ED techs M-F, 3 Sat-Sun 9a- 14 RNs (including charge nurse), 4 ED techs M-F, 3 Sat-Sun
E			11a – 20 RNs (includes charge nurse), 4 ED techs M-F, 3 Sat-Sun 1p- 23 RNs (including charge nurse), 4 ED techs M-F, 3 Sat-Sun
N			7p – 24 RNs (includes charge nurse), 4 ED techs M-F, 3 Sat-Sun

Focused Analysis of POAs by Clinical Division

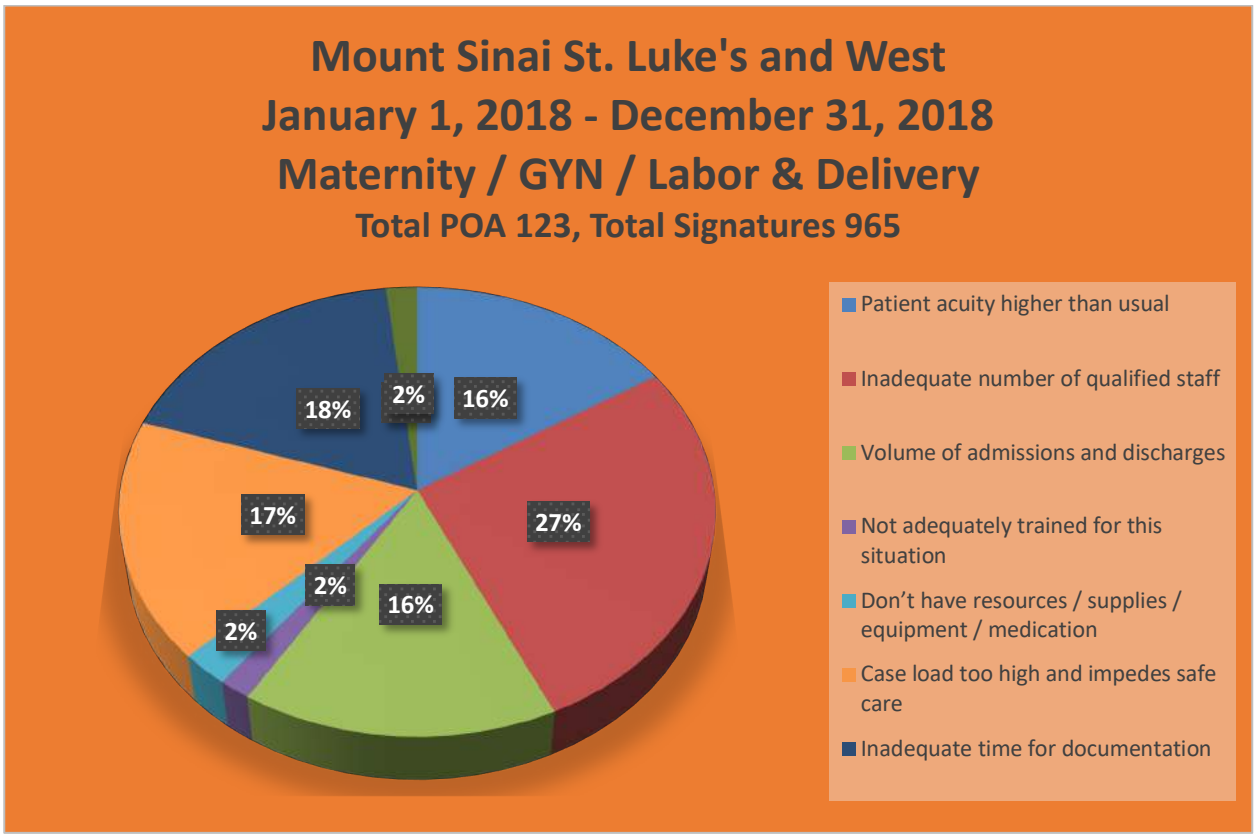
The following **focused analysis of POAs by clinical division** filed in the Mount Sinai St. Luke's and West documents potential deficiencies in abiding by State and Federal law, negotiated nurse-to-patient ratios, and established standards of care as follows:

- 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 Mount Sinai St. Luke's and West 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 are computer systems that need to be addressed.

Chart 6: Mount Sinai St. Luke's and West and the New York State Nurses Association Negotiated Nurse to Patient Ratios in Maternity/GYN (1:7 ratio) and Labor & Delivery (15 – 16 nurses)

11B/12B	BC	NICU	L&D
56 (8)	2	22	28 Stations
8/3	1/1	10/1	16/3
/3	/1	/1	/2-3
8/3	1/1	10/1	15/2

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)*
16%	27%	16%	2%	2%	17%	18%	0%	2%

*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 **one hundred twenty three (123) POAs, supported by nine hundred and sixty five (965) signatures,** filed at Mount Sinai St. Luke's and West between January 1, 2018 and 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

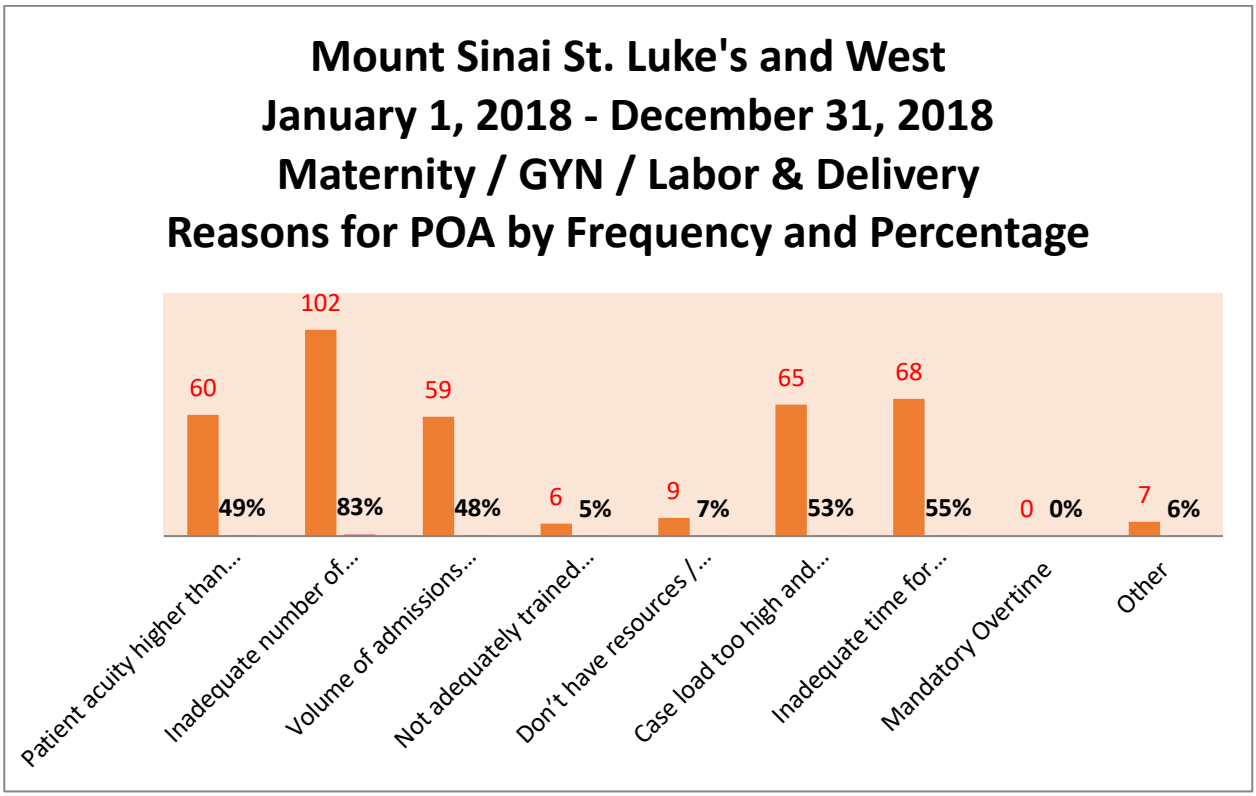


Figure 13: Percentage of Total POAs Filed by Reason

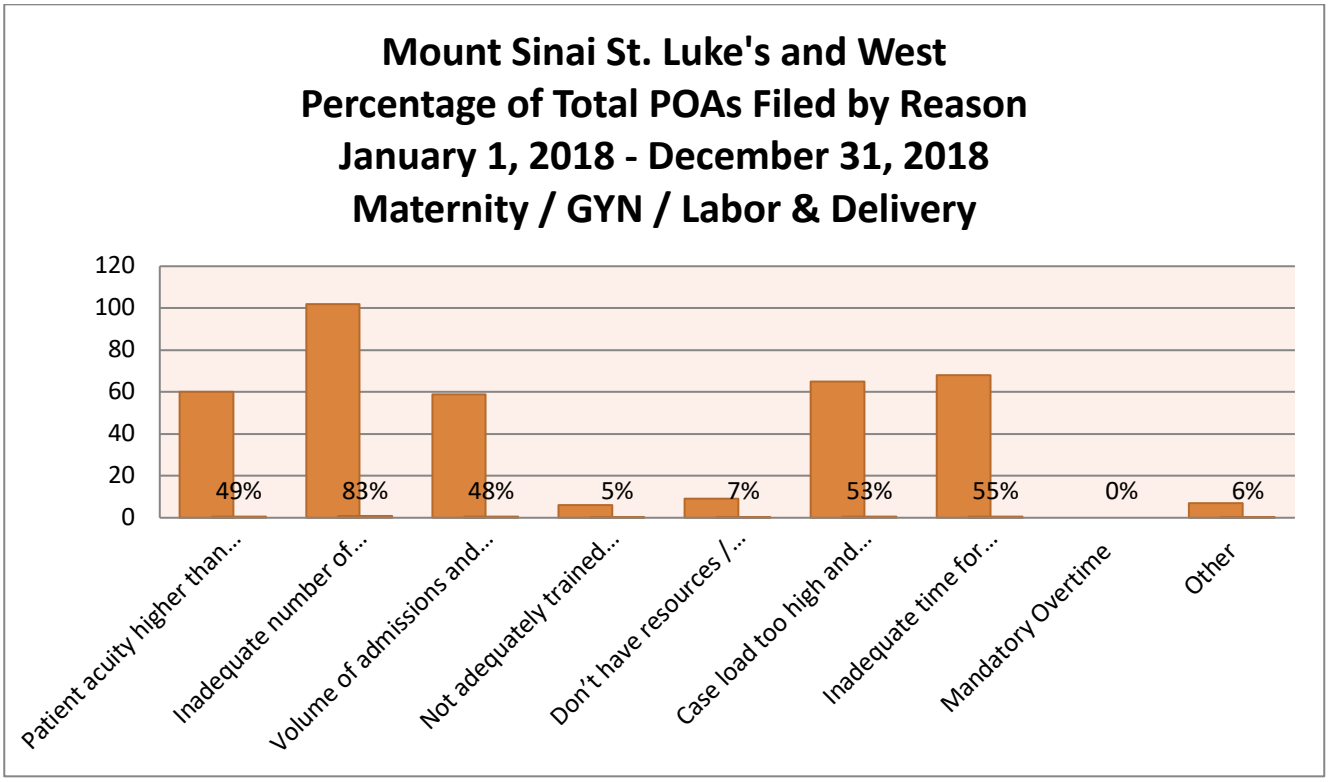


Figure 14: POAs/Signatures Maternity/GYN/Labor & Delivery

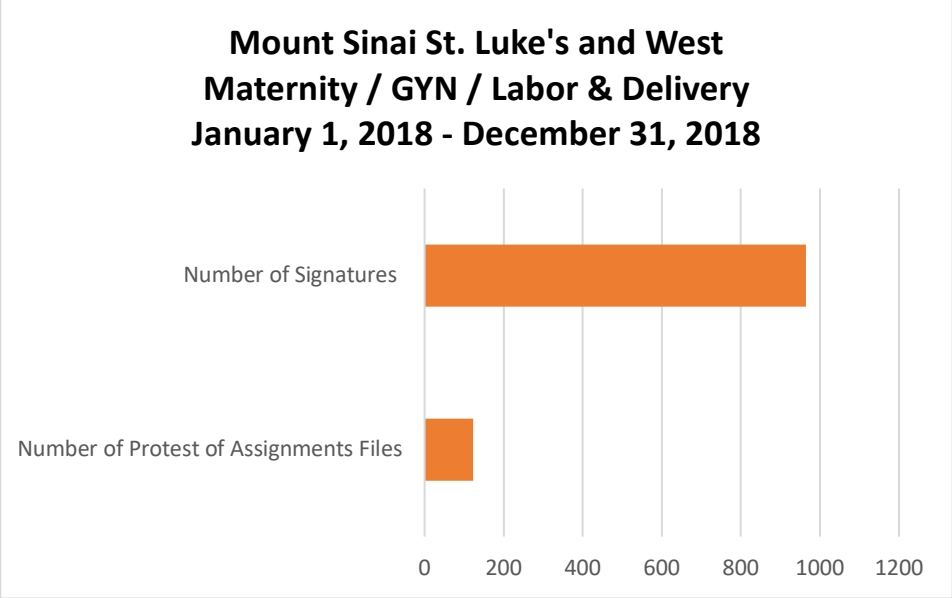


Table 6: Other Reason for POA in Maternity / GYN / Labor & Delivery

Maternal/GYN/Newborn/Labor & Delivery: A sampling of the Comments Written on the POAs
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources, Nurse to Patient Ratio in Violation of Contract: Unable to provide a baby nurse in the OR and in the Delivery Room, Unable to give break on 1st shift at this time. There are 8 OB admissions, **IV pumps not working** and mothers in great pain, 7 possible discharges, **Nurse to Patient Ratio 1:10** in violation of contract **(repetitive and consistent response)**, L & D nurses who have not had their breaks are floated to other units, babies who are tachpneic with low blood sugars and low temps (a sign of impending seizure), multiple fresh c-sections.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Training: We have 3 patients on Magnesium for pre-eclampsia, 1 patient on insulin drip, 3 scheduled c-sections, 2 external rotations, 1 possible emergency c-section, **orientee unable to receive proper orientation** with current assignments. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Charge RN has 4 moms and 3 babies with language barrier (Arabic). Multiple patients on triple antibiotics, multiple patients needing blood, labs, ECG, glucose monitoring. We have no nursery RN and no unit secretary. Nurse to patient ratio is 1:9. **(repetitive and consistent response)** We had 3 sick calls unable to be replaced.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate training: I have been floated to post-partum unit and I am out of my scope of practice, **I have never trained/oriented in post-partum unit**. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: RNs are now assigned a new duty to wash delivery table and instruments. We say this is not a nursing duty.
Insufficient # Qualified Staff, High Patient Acuity, Case Load High: We have babies on phototherapy, 2 diabetic patients 2 fresh delivery patients, all patients needing breastfeeding help, 1 patient on antibiotics, 1 patient with extremely high BP, several patients with significant medical/OB history requiring additional care/attention, patients receiving 2 units of PRBCs, hypotensive patients, 1 patient receiving IV electrolytes, 1 patient with fecal drainage, 1 patient on isolation.
Insufficient # Qualified Staff, High Patient Acuity: We have 13 RNs with 3 on orientation. We are **short the baby nurse in all deliveries and no post partum RN. We only have 1 RN for triage and we have mothers waiting more than 4 hours in triage. Patients have multiple complaints.**
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources, Nurse to Patient Ratio in Violation of Contract: RNs have 10 patients / RN, and charge nurse has 8 patients. The L & D room cannot provide a baby nurse or a 2nd nurse in triage. RN who is on orientation is not receiving a proper orientation. Patients are waiting in triage for beds on the floor
Insufficient # of Qualified Staff, High Acuity, Inadequate Resources: We have no IV poles, no towels, no linens. We have no urine measuring supply. We cannot provide a baby nurse on the floor or in the OR. There is only 1 RN in triage with an orientee. No beds on unit to transfer patients from triage.
Insufficient # of Qualified Staff, High Acuity, Case Load High: Our bed capacity is 24, but we have 27 patients. 3 are scheduled for c-section, 1 emergency c-section, 4 scheduled induction admissions, 1 patient seriously sick in the recovery room after having her c-section, 2 babies are pre-term in the delivery room, 1 baby had to be sent to NICU. Patients need pain meds on time and 1 baby has unstable glucose issues. 1 baby has kidney issues. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: We have 5 RNs on orientation. We only have 1 RN in triage. We have 3 inductions, 1 patient waiting since yesterday. **(repetitive and consistent response)** We have patients who are hypertensive and patients needing blood transfusions. On our unit, we cannot provide a baby nurse in newborn nursery, we have 4 RNs on orientation, 1 RN in triage, and 1 RN doing a 1:1.

Insufficient # of Qualified Staff, High Acuity, Case Load High, Admission & Discharge High: Not enough RNs to admit and discharge patients at the same time. Unsafe nursing, RNs not able to check on patients every 1 – 2 hours and to check patients' charts. 1 DD C/S, 1 patient with epidural headache, patient on triple antibiotics and elevated BP, **nurse to patient ratio 1:10 with 1 RN has 1:11**. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: 1 patient on magnesium sulfate, 2 patients with unstable fetal monitoring tracings, 3 scheduled external rotations, 2 scheduled c-sections, 3 inductions with 1 patient waiting since yesterday, **bed capacity 24 with 28 patients.** No beds to put patients, causing backup in triage. No breaks, 4 patients waiting to be assessed in waiting area. **(repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High: Our bed capacity is 24. We have 31 patients. 3 patients on magnesium sulfate, 1 fetal breech presentation, 1 urgent c-section, 3 normal deliveries within 3 minutes of each other, **ALL THESE DELIVERIES REQUIRING A 1:1 RN PRESENCE.**
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Regulatory Requirements: Improper distribution of staff (we are being asked to cover another unit despite being short staffed in L & D. Only 1 RN in triage, and we are **unable to provide baby nurse for every delivery. (repetitive and consistent response)**
Insufficient # of Qualified Staff, High Acuity, Case Load High, Violation of Regulatory Requirements: Staffing low, with multiple c-sections going on, **circulating RN had to scrub on same case, ANCC became circulating RN AND THE Baby RN between 2 ORs.** Nursery will have to close due to low staffing, with other RNs completing all newborn care and admissions. Unit Secretary working between 2 units.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Mount Sinai St. Luke's and West

- 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)

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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).**

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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).**

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"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).**

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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 Mount Sinai St. Luke's and West 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 Mount Sinai St. Luke's and West'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 Mount Sinai St. Luke's and West patient population;
- Provide adequate equipment to meet all patient care needs.

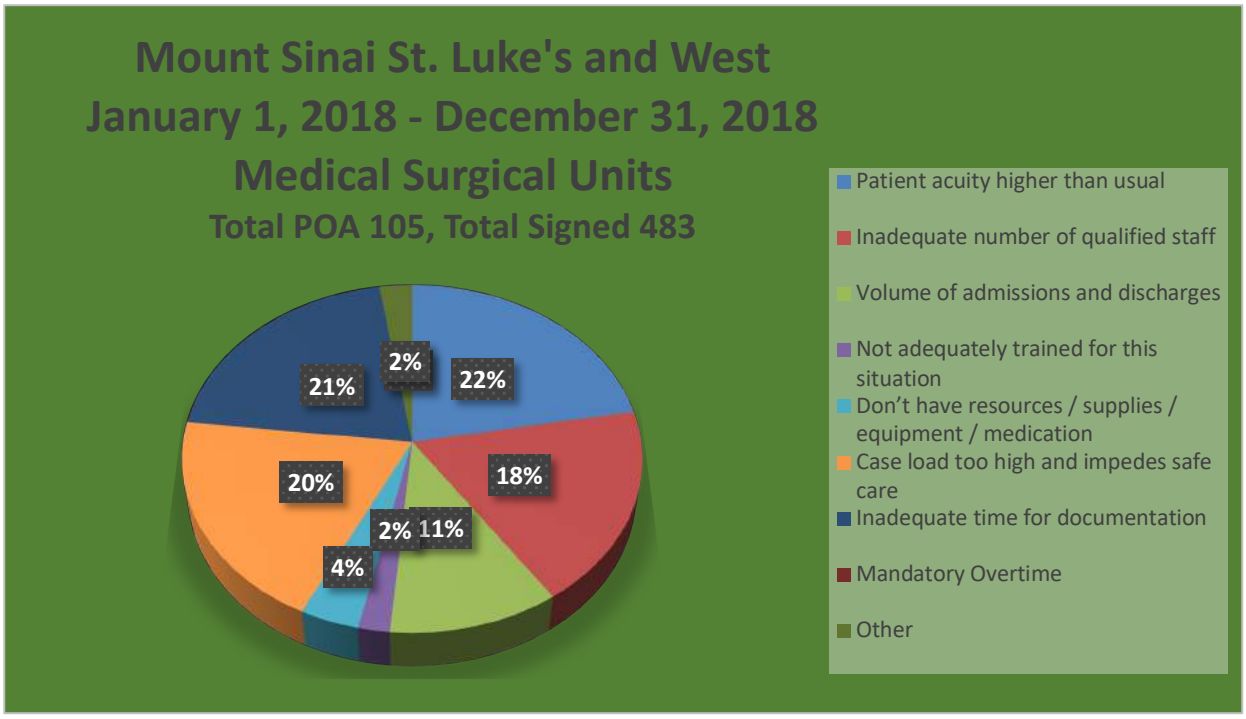
Chart 4: Mount Sinai St. Luke's and West and the New York State Nurses Association Negotiated Nurse to Patient Ratios in Medical Surgical Units 6W, 7W, 8W, 9W, 9A, 9B, 10A, 10B

Nurse to Patient Ratio: 1 : 5-6

9W	CL5	7W	6W
29 (4)	10 (2)	32 (5)	28 (4)
6/2	2/1	5/1/2 5/2	5/2
/2	/1	/2	/2
6/2	2/1	5/2	5/2

9B	3G	10B	10A	9A
35 (5)	20 (3)	32 8(close watch) (5)	27 (4)	32 (5)
6/2	4/2	6/2 2/1(close watch)	6/3	6/2
/2	/1	/2	/2	/2
6/2	4/1	6/2 2/1(close watch)	6/2	5/2

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)*
22%	18%	11%	2%	4%	20%	21%	0%	2%

*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 **one hundred and five (105) POAs, supported by four hundred and eighty three (483) signatures, POAs** filed in The Mount Sinai St. Luke's and West between January 1, 2018 and 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

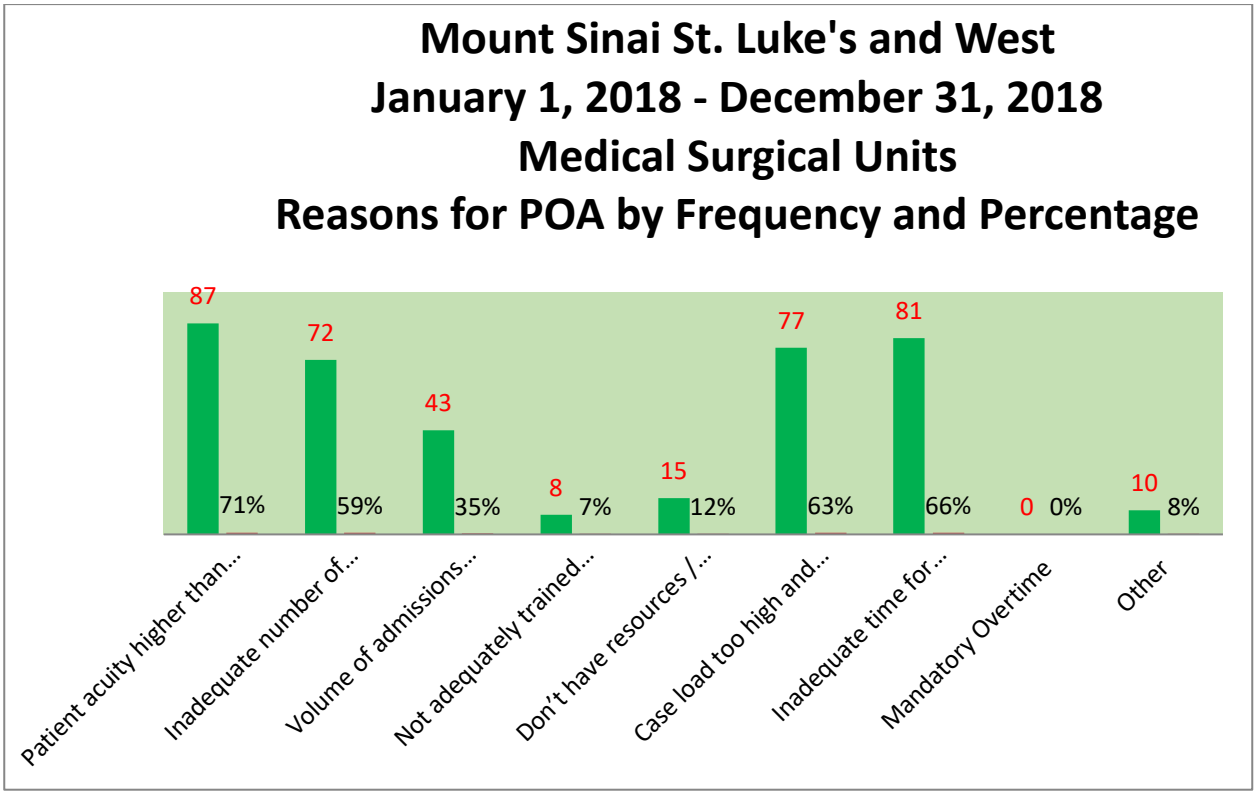
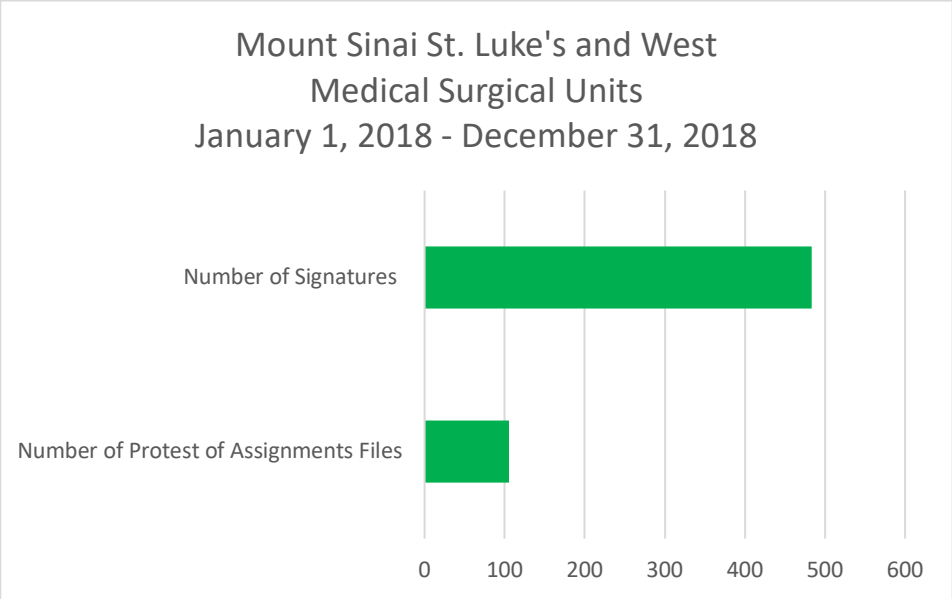


Figure 8: POAs/Signatures Medical – Surgical Nursing



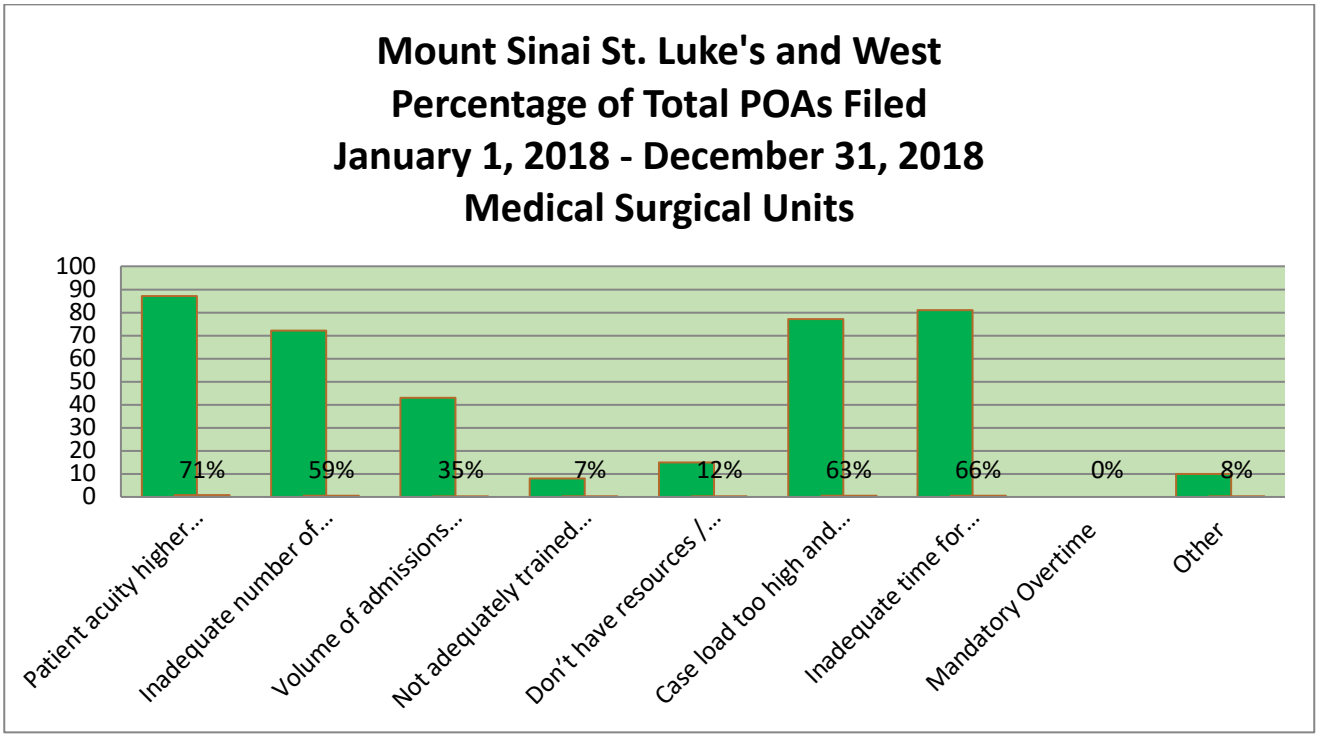


Table 4: Other Reasons for POAs in Med / Surgical

Medical/Surgical Units: A sampling of the Comments Written on the POAs
Insufficient # of Staff, High Acuity, Nurse to Patient Ratio in Violation of Contract: RNs with 7 – 10 patients each, charge RN taking an assignment of 6 patients, multiple patients with trach, i7 special observation patients, unit is not equipped. Patients are mostly total care, high fall risk. Patients have vents, multiple patients with 3 RN assists, multiple patients on pain management. We have patients pulling out their NGT, patients who are not compliant with Foley, 1 patient whose colonoscopy was not adequate and has to be redone. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have MRSA patients, only 1 CNA on the floor and patients who need 1:1 constant observation. No relief from nursing office. We have patients on contact isolation, multiple fall risk patients. We have patients on BIPAP and patients with chest tubes. 1 of our RNs was floated out of the unit and 1 is on orientation. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Nurse to Patient Ratio in Violation of Contract: Census is starting at 26, awaiting 5 patients for admission. Patients on police guard, 5 orthopedic post-op patients requiring 4 RNs to turn and assist, 4 post-op patients on trachs requiring 4 hour vitals, 9 total care patients, 1 special project assignment for bariatric surgery. On our geriatric units, staffing guidelines are not met. We are unable to reach patients in a timely manner. We have very agitated and aggressive patients, patients pulling out lines, confused patients, patients who are constantly screaming **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Start of shift with 34 patients, 9 total care patients, 1 patient on special observation for safety, 2 very confused patients requiring frequent checks, all patients requiring vital signs every 4 hours, all patients on strict I & O, 8 fresh post-op patients from PACU, 5 patient admissions.
Insufficient # Qualified Staff, High Patient Acuity; Health & Safety: Out of 30 patients, 26 are at risk for fall. We have 2 post-op patients, 2 critical patients, 1 sepsis patient, 1 hypoglycemic episode patient and 25 need assistance with hygiene care. Patients are confused, 6 patients are on observation for elopement risks, and some are combative toward staff. 1 patient is 508 pounds and needs multiple RN assistance with position changes. Our Census EXCEEDS our bed capacity.
Insufficient # Qualified Staff, High Patient Acuity, Nurse to Patient Ratio in Violation of Contract, Volume of Admissions/Discharges: We have 3 RNs with a greater than 1:7 ratio. 1 of our RNs is on orientation. We have had 8 admissions/transfers, 9 patients requiring complete care, 1 patient with NGT and rectal tube and trach, multiple patients on every 4 hours vital signs and I & O, no break relief, orthopedic patients that require a lot of time to bring to bathroom, patients requiring blood transfusions, patients who are incontinent and with bed sores. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have multiple patients on heparin drip, chest tubes, BCI, NGT, TPN, fresh post-op requiring lab testing every 4 hours, foley care, multiple pain meds, numerous PCA / blocks, and pre-op patients that need preparation.
Insufficient # Qualified Staff, High Patient Acuity, Not Enough Resources, Nurse to Patient Ratio Exceeds Contract: We have a pregnant woman on our floor and we are **unable to monitor fetus**, patients needing blood transfusions, patients with epidural PCAs, very sick and demanding patients, multiple admissions, confused patients getting in and out of bed, multiple total care, patients needing EKGs, bladder scanning, blood draws. Nurse to Patient Ratio exceeds contract.
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Training: We have a mix of medical and surgical patients, patients transferring in from PACU, ED, and ICU. Multiple patients on PCAs, we have **5 RNs that have less than 6 months experience**, we have had a rapid response, patient requiring a septic

code, patients that are withdrawing from drugs requiring frequent monitoring, patients who are confused, patients with chest tubes, patients on heparin drips, foley care, patients with acute pain, we have 3 patients requiring 1:1 constant watch. **Patient care, medication administration, and satisfaction is compromised.** We have 2 patients wh refuse to be discharged, and 4 elopement risk patient.
Insufficient # Qualified Staff, High Patient Acuity: We have 17 orthopedic patients requiring multiple RN to assist with care, transfer, mobility. We have 7 confused patients, 1 MRSA isolation, 1 airborne isolation, 1 orientee just off of orientation. We have 2 blood transfusions, 8 patients on blood PCA, 3 new post op patients, 4 patients with complete care, multiple patients with complex medications.
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Not Enough Resources: We have 28 patients on telemetry, 1 patient on bedside telemetry, 4 PIPAP, 1 vented patient requiring frequent suctioning, 24 patients requiring complete and total care because they are incontinent of bowel/bladder, needing frequent bed changes, multiple surgical patients requiring I & O monitoring, multiple patients on oxygen therapy and only 1 secretary covering 2 different units, multiple admissions/discharges. 1 patient is greater than **350 pounds. Supplies are limited.**
Insufficient # Qualified Staff, High Patient Acuity, Required Overtime, Inadequate Training: 3 of the 5 RNs on this unit are very new RNs. We have patients with trach requiring suctioning, chest tubes, PCA machines, 3 bypass patients, multiple patients needing 1:1 watch, confused patients, ortho patients needing assistance with mobility/ambulation, admissions from ED, and we had **1 nurse floated out of the unit,** and **1 night nurse who had to stay 5 hours past her regularly scheduled shift.**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: We have **2 morbidly obese patients,** multiple blood transfusions, most patients are fall risk patients, 2 contact isolation patients, multiple admissions, most patients need total care, multiple patients on IV drips, multiple patients on fall prevention programs, 1 patient on nerve block requiring vital signs every 2 hours and neuro checks every 2 hours, patients needing constant toileting. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Our bed capacity is 20. We have 25 patients and 3 RNs. All patients need assistance when getting out of bed to bathroom. 1 patient just got up by themselves and disconnected all of the monitoring devices. We have 3 laminectomy patients, 3 post bilateral knee surgeries, 9 – 12 patients who are incontinent and need frequent skin care and linen changes, 1 patient who is NPO with spinal stenosis and needs surgery but is refusing to go.
Insufficient # Qualified Staff, High Patient Acuity: We have had **2 patients just dropped onto the floor from the ER WITH NO REPORT GIVEN.** We have patients on telemetry who have atrial fibrillation, 1 patient who is rule out pulmonary embolism who was recently placed on telemetry, 1 transfer from neuro ICU and 1 transfer from ED, 2 patients on contact isolation for C. Diff, 1 patient requiring turning and positioning every 2 hours. We have no secretary. We have 5 patients on heparin drip.
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: Staffing is so low patient care and patient satisfaction is compromised. We have patients on 1:1 constant watch that are verbally agitated. We have 7 very difficult patients, and a majority of our patients on high fall risk. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: We have patients with unstable FSGB's who are diabetic, patients on drips, 3 patients on 1:1 watch, patients with ostomy's, patients requiring pain medication administration, several patients who are total care requiring frequent turning and positioning, and only 4 RNs on the floor. We also have BIPAP patients on oxygen therapy, and multiple patients who have CHF and CORD. **We have had float nurses from nursery. They are not able to provide safe care for current patients on the floor (repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Inadequate Resources: 80% of our patients are on fall risk, 90% are complete care patients, our code cart monitors are broken, patients with trachs, 1 vented patient, 2 1:1 watch patients, 1 chemo patient, 2 patients with PCA pumps, 2 patient on heparin drips, 9 patients needing wound care, and 2 nurses who are precepting new RNs.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Mount Sinai St. Luke's and West

- 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

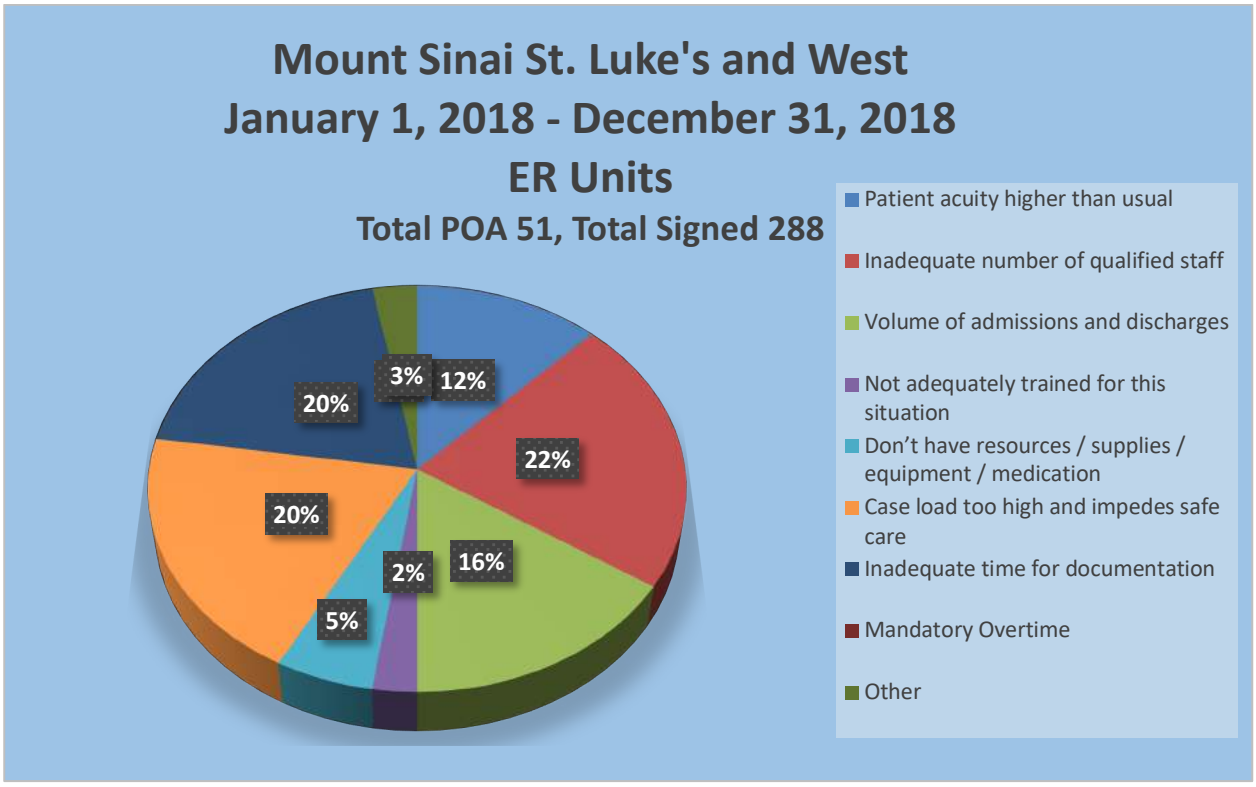
Nurses working in the Medical / Surgical Departments throughout Mount Sinai St. Luke's and West are committed to improving delivery of care with the following recommendations:

- 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 Mount Sinai St. Luke's and West 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 Mount Sinai St. Luke's and West patient population

Chart 5: Mount Sinai St. Luke's and West and the New York State Nurses Association Negotiated Nurse to Patient Ratios in ED (8 – 17 RNs)

UNIT	Peds ICU	*ED*
AVG OCCUPANCY (+/- 15/20%)	4	
D	2	7:00a 8/3
E		10 /11a 16/3
N	2	7:00p 17/3 10:30p 9/2

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)*
12%	22%	16%	2%	5%	20%	20%	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 **fifty one (51) POAs, supported by two hundred eighty eight (288) signatures,** filed in Mount Sinai St. Luke's and West 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

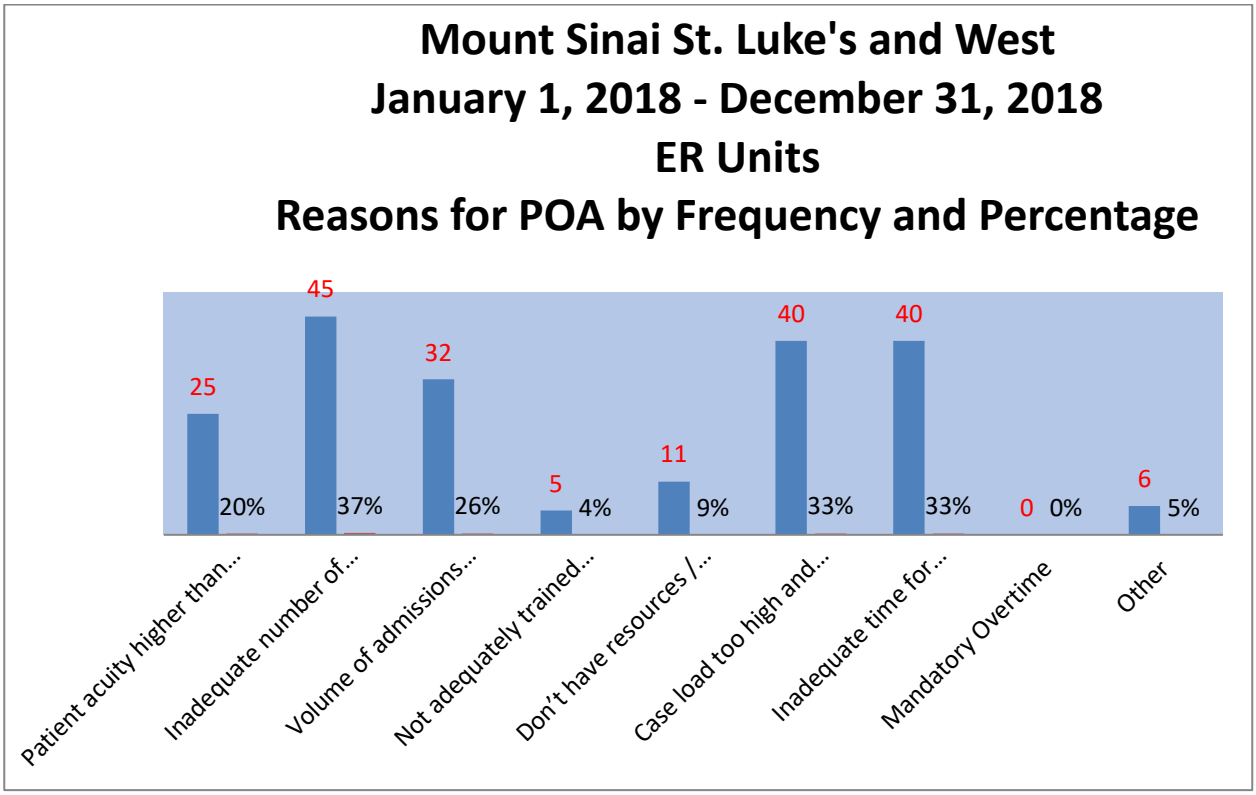


Figure XX ED Scores NYS Health Profile

Emergency Room Deficiencies and Re-admissions

Overcrowding and Boarding

Mount Sinai St. Luke's and West

Admit decision time to ED departure time for admitted patients Median time (in minutes) patients spent in the ED, after the doctor decided to admit them as an inpatient, before leaving the ED for their inpatient room.	▽ Poor Performer; ranked 128 of 153 facilities	Facility value of 251 mins; compares to state value of 156 mins; Reporting period of 10/01/2016 to 09/30/2017
Time from ED arrival to ED departure for admitted ED patients Median time, in minutes, patients spent in the ED before they were admitted to the hospital as an inpatient.	▽ Poor Performer; ranked 138 of 153 facilities	Facility value of 566 mins; compares to state value of 381 mins; Reporting period of 10/01/2016 to 09/30/2017

Readmissions Within 30 Days

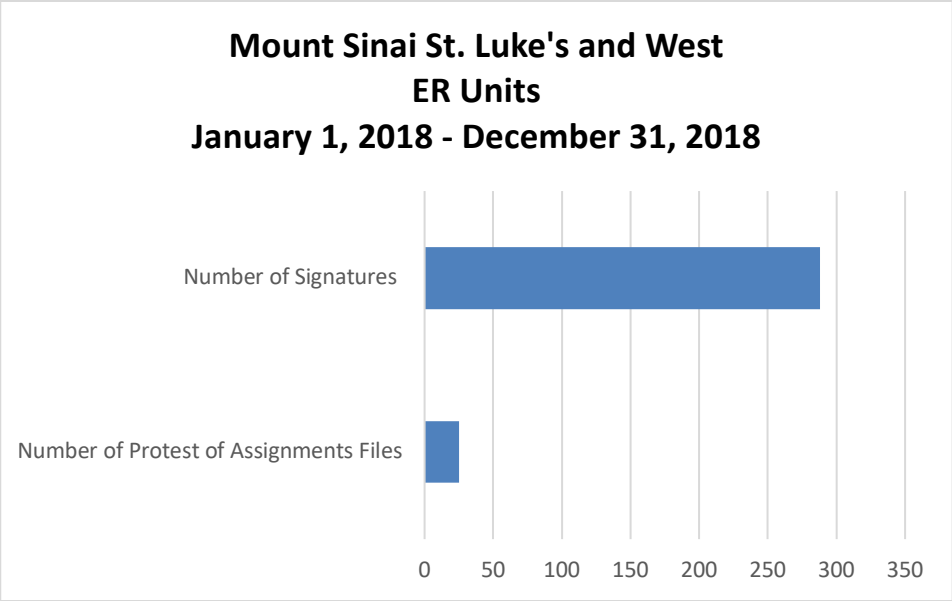
Readmissions Within 30 Days 30-day hospital-wide all- cause unplanned readmission (HWR) (lower is better)	▽ Poor Performer; ranked 4041 of 4417 facilities	Facility value of 16.40%; compares to national value of 15.30%; Reporting period of 07/01/2016 to 06/30/2017
Heart Attack Patients Readmitted to Hospital Within 30 Days This measure shows the all-cause 30-day readmission rate for patients discharged from a previous hospital stay for heart attack.	▽ Poor Performer; ranked 2124 of 2125 facilities	Facility value of 20.20%; compares to national value of 16.00%; Reporting period of 07/01/2014 to 06/30/2017
Heart Failure Patients Readmitted to Hospital Within 30 Days This measure shows the all-cause 30-day readmission rate for patients discharged from a previous hospital stay for heart failure.	▽ Poor Performer; ranked 3565 of 3618 facilities	Facility value of 25.60%; compares to national value of 21.70%; Reporting period of 07/01/2014 to 06/30/2017

* This NYS Health Profile Report aligns with the Mount Sinai St. Luke's and West's Emergency Room RNs POA complaints of insufficient numbers of qualified staff and acuity and case load too high resulting in:

- Inability to deliver nursing care in an environment conducive to the provision of patient satisfaction
- 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 practices
- Inability to deliver high quality nursing care particularly time for discharge planning and teaching

See: https://profiles.health.ny.gov/hospital/printview/102929#quality.

Figure 11: Number POA/Signatures in Emergency Department



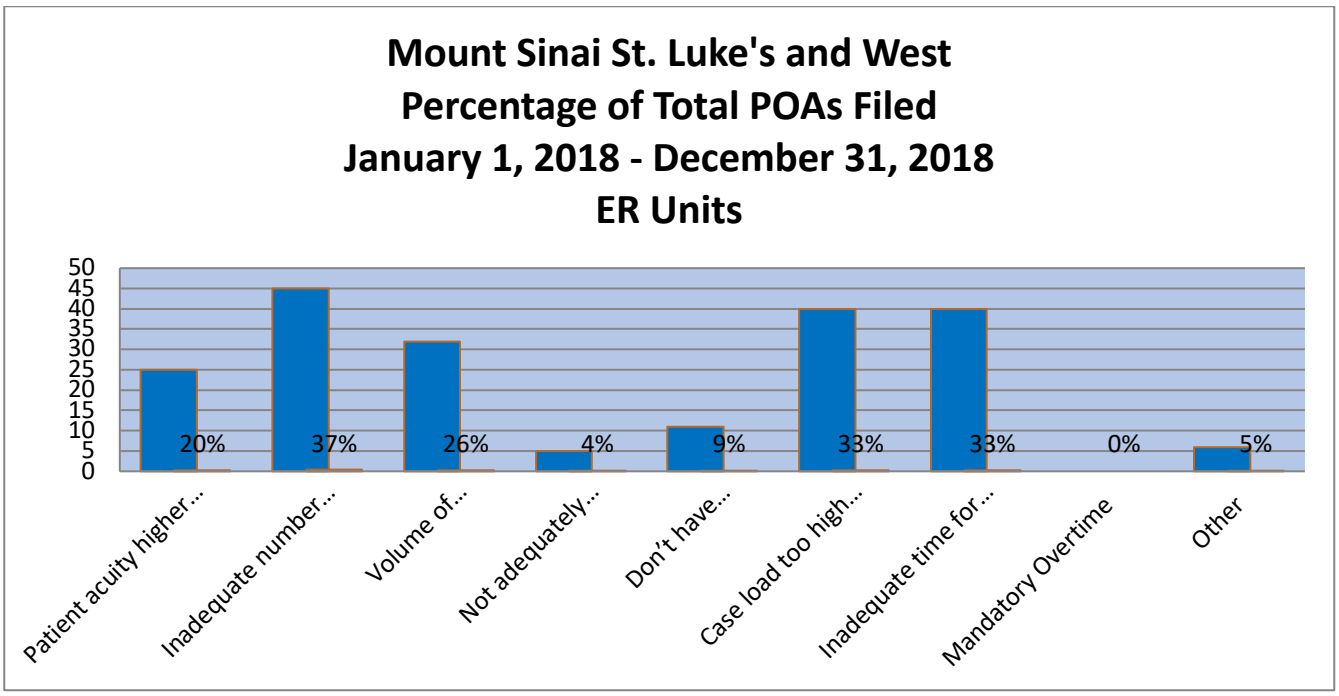


Table 5: Other Issues Specifically Identified in the ED POAs

ED Units: A sampling of the Comments Written on the POAs
Insufficient # Qualified Staff, High Patient Acuity, Overcrowding: Holding 12 – 27 admitted patients—no beds available, holding 1 MICU, 1 CCU, 2 telemetry, 10 med/surg admissions, multiple complete care patients, multiple extended observation patients, nurse to patient ratio is 1:14, 11 admissions at 7 a.m. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Overcrowding, Boarding: ED is dangerously overcrowded. No room to treat patients. No additional staff for boarders. 2 MICU patients, 23 admitted patients in ED but only 12 have bed assignments, 11 do not have assignments. RNs not able to take any breaks or meals. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Boarding: We are constantly short RNs (1 – 5 RNs). Only 1 triage RN, no trauma RN, only 1 evaluation RN. **We will have to close walk-in triage to take breaks/meals. Boarding 10** - 14 patients, no inpatient bed available. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Health & Safety, Case Load High: RN in CPEP is in training. CPEP tech being pulled to do a 1:1 observation. Overnight tech had no break and is mandated to stay until management can find relief. Unsafe work environment: 2 adults admitted, 1 with policy, both are paranoid and unpredictable. 1 patient in 4 point restraints and we are unable to provide effective constant observation. 1 high elopement risk who is actively attempting to elope, 1 elderly patient who is a high fall risk and requires 1:1 constant watch. No time to do 15 minute rounds on CPEP. Only 2 RNs on staff. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity: Staff is so low there was a delay in procuring EKG from 1 patient, treatments and assessments from other patients, no CNA so late in assisting patients, no one available to pick up narcotics unless I leave 10 sick patient to go to pharmacy.

Insufficient # Qualified Staff, High Patient Acuity, Health & Safety: 50 patients eloping. Patients are walking out after waiting hours for meds, treatments, etc. This is very dangerous. Patients are getting very agitated. Patients are waiting for medications. Too many patients. Unable to do admissions. There is only 1 RN on a team. Patients are sick. 2 BIPAP, 1 post arrest, multiple with atrial fibrillation. **IT IS OVERWHELMING TO WORK HERE.** **(repetitive and consistent response)**
Insufficient Resources, Insufficient # Qualified Staff, High Patient Acuity, Not Adequate Training: EPIC slows us down, it is a new system, and not enough training. We have no supplies, no time to chart. **There are RNs names on schedule but they are not really working.** We have no tech, no coverage, very sick, heavy patients.
Insufficient # Qualified Staff, High Patient Acuity: Child sent to CPEP without COL, 1 unit nurse assigned to monitor the patient and sit as the patient's constant observation 1:1, no CPEP tech. This is an unsafe environment and warrants secure staffing in place at all times. RNs should not be designated as a constant observation 1:1 but as essential personnel. **(repetitive and consistent response)**
Insufficient # Qualified Staff, High Patient Acuity, Inadequate Resources, Health & Safety: Patient endangerment post cardiac arrest. Patient placed in reuse room, patient has high acuity due to IV drips and **WE DON'T HAVE THE PROPER IV TUBING** for this patient. RNs spent 3.5 hours with this patient and unable to care for other key patients.

Federal and State Laws and Regulations, Standards of Care, Accreditation Requirements that have been Left Unaddressed by Mount Sinai St. Luke's and West

- 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 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

[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)

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 Mount Sinai St. Luke's and West 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 Mount Sinai St. Luke's and West 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 Mount Sinai St. Luke's and West 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 Mount Sinai St. Luke's and West 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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