New York Presbyterian Hospital Columbia University Medical Center Patient Care Chronicle

Presented by:

The Registered Professional Nurses at NY Presbyterian Hospital Medical Center

January, 2019

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New York Presbyterian Hospital Protest of Assignment (POA) and Patient Care Chronicle

January 1, 2018 through December 31, 2018

Executive Summary:

The **New York Presbyterian Hospital** (NYPH) is a member of the **NY-Presbyterian Healthcare System**. A non-profit 2,527 bedded private is a comprehensive, integrated academic health system servicing patients in the New York metropolitan area, nationally, and throughout the globe. NY-Presbyterian sees more than 2 million visits annually, including close to 15,000 infant deliveries. NY Presbyterian Hospital has more than 310,000 emergency department visits, about 50,000 of whom subsequently are admitted for inpatient care in to NY Presbyterian Hosptial (https://www.nyp.org/clinical-services/emergency-medicine). NY Presbyterian Hospital is a 738-bed medical center (https://www.nyp.org/about-us) and NY Presbyterian Allen Hospital is a 196-bed community hospital serving northern Manhattan, Riverdale, and other communities in the Bronx, Westchester, and Northern New Jersey (https://www.nyp.org/about-us).

The **New York State Nurses Association (NYSNA)** is a union of over 40,000 frontline nurses standing together for strength at work, our practice, safe staffing, and healthcare for all. NYSNA is New York's largest union and professional association for registered nurses, representing ***over 3,600 registered professional nurses at NYPH*** for collective bargaining and nursing practice rights.

At NYPH, during the time period of **January 1, 2018 to December 31, 2018, POA documentation** in six specialty areas revealed registered nurses had filed **individually and/or collectively** more than **one thousand and forty six (1,046)** protests of assignment (POAs) supported by over **four thousand four hundred and sixty nine (4,469)** signatures of registered professional nurses that raises questions regarding the hospital's promise and advertisement to adequately protect this patient population, as well as the public, even with New York Presbyterian **dedicated to** providing the highest quality, most compassionate care and services to patients in the NY metropolitan area, nationally, and throughout the globe[1].

These POAs also raise questions regarding NYPH's ability to adequately operationalize its guiding value that "Our governance and leadership structure is dedicated to the success of our mission: excellence in patient care, research and education.[1] Notably, the New York Code of Rules and Regulations, 405.2(b)(1) requires the hospital to have "…***a governing body legally responsible for directing the operation of the hospital in accordance with its mission."***

Protest of Assignment: Documentation of Practice Situations

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

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

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

For any single situation, multiple forms may be completed if there are multiple nurses who feel care is compromised. More frequently, however, due to time constraints, and is the case within NYPH, 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 NYPH indicate, among other issues, hospital-wide inadequacies in staffing, and a case load that is overwhelmingly high in both volume and acuity. This raises questions about whether there are sufficient resources to safely provide the quality of care that is mandated by the laws and regulations in NYS.[2] The 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 / Burn units, medical / surgical units, ventilation units, telemetry/stepdown units, rehabilitation units, neurology units, labor and delivery units, and maternal / child units where specialized orientation programs were utilized;
- Follow Joint Commission Standards for leadership;

- Support the staffing guidelines developed in accordance with standards of practice and Joint Commission reports, and to provide minimum staffing levels required to safely care for the volume[3] and acuity[4] of the patients.

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[1] https://www.nyp.org/about-us and https://www.nyp.org/about-us/governance-and-leadership (Retrieved January, 2019)

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

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

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

POAs are Consistent with Results of Published Industry Report Cards

The **1046 POAs** filed at the New York Presbyterian Hospital document repetitive and consistent problems related to insufficient numbers of nursing staff throughout all hospital departments, but particularly in the Medical/Surgical Units, Maternity/GYN/Labor & Delivery, the Emergency Department, and the Intensive Care Units. The POAs indicate that the numbers of RNs assigned to the units are consistently inadequate and this influences the inability of the nurse to meet the immediate and persistent needs of the patient population in direct violation of laws, standards of practice, and hospital policies. The POAs document the following correlating negative patient outcomes (See Table 1):

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

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

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

A total of 31 citations resulted from 11 inspections of this facility from October 1, 2014 through December 31, 2017. There were 21 inspections resulting in no citations. This hospital is part of a group that is authorized by the same operating certificate. Citations from some inspections, as noted below, apply to the group as a whole. Retrieved from https://profiles.health.ny.gov/hospital/view/106811#inspections (Chart 1)

Chart 1: NYS DOH Citations New York Presbyterian Hospital – Columbia Presbyterian Center

December 2, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on January 19, 2017. Plan of correction approved on March 16, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Data collection & analysis
Governing body
Maintenance of physical plant
Patient rights
Patient rights: care in safe setting
Physical environment
Qapi
Quality improvement activities

December 6, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 27, 2017. Plan of correction approved on April 20, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Medical staff
RN supervision of nursing care

September 23, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on May 10, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights: care in safe setting
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Staffing and delivery of care

April 28, 2016 **Recertification Survey**

Status: Statement of deficiencies issued on May 13, 2016. 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 planning during transplant period
Notification of removal to optn
Patient informed of donor risk factors
Patient informed of national/center outcomes

February 18, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 3, 2016. Plan of correction approved on March 16, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Data collection & analysis
Emergency services
Emergency services policies

April 8, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on April 21, 2016. Plan of correction approved on May 3, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Administration of drugs
Patient rights: restraint or seclusion

December 3, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on February 23, 2016. Plan of correction approved on March 11, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control
Infection control program

March 21, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 31, 2016. Plan of correction approved on April 26, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Maintenance of physical plant

November 24, 2015 **Complaint Investigation, State Licensure, Licensure Co Survey**

Status: Statement of deficiencies issued on December 14, 2015. Plan of correction approved on December 15, 2016.

Citations Issued

Medical staff. Medical staff accountability.

October 9, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on December 30, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Protecting patient records

August 24, 2015 **Complaint Investigation Survey**

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

Citations Issued

Maintenance of physical plant

Staffing and delivery of care

Chart 2: NYS DOH Citations New York Presbyterian Hospital – Allen Hospital

A total of **30 citations** resulted from 10 inspections of this facility from **October 1, 2014 through December 31, 2017.** There were 18 inspections resulting in no citations. This hospital is part of a group that is authorized by the same operating certificate. Citations from some inspections, as noted below, apply to the group as a whole. Retrieved from https://profiles.health.ny.gov/hospital/view/106810#inspections

December 2, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on January 19, 2017. Plan of correction approved on March 16, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Data collection & analysis
Governing body
Maintenance of physical plant
Patient rights
Patient rights: care in safe setting
Physical environment
Qapi
Quality improvement activities

December 6, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 27, 2017. Plan of correction approved on April 20, 2017. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Medical staff
Rn supervision of nursing care

September 23, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on May 10, 2017. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Patient rights: care in safe setting
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Patient rights: restraint or seclusion
Staffing and delivery of care

April 28, 2016 **Recertification Survey**

Status: Statement of deficiencies issued on May 13, 2016. 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 planning during transplant period
Notification of removal to optn
Patient informed of donor risk factors
Patient informed of national/center outcomes

February 18, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 3, 2016. Plan of correction approved on March 16, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Data collection & analysis
Emergency services
Emergency services policies

April 8, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on April 21, 2016. Plan of correction approved on May 3, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Administration of drugs
Patient rights: restraint or seclusion

December 3, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on February 23, 2016. Plan of correction approved on March 11, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Infection control

March 21, 2016 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on March 31, 2016. Plan of correction approved on April 26, 2016. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Maintenance of physical plant

October 9, 2015 **Complaint Investigation Survey**

Status: Statement of deficiencies issued on December 30, 2015. Plan of correction not approved or not required. The citations from this inspection apply to this hospital and to **the other members of the group**.

Citations Issued

Protecting patient records

August 24, 2015 **Complaint Investigation Survey**

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

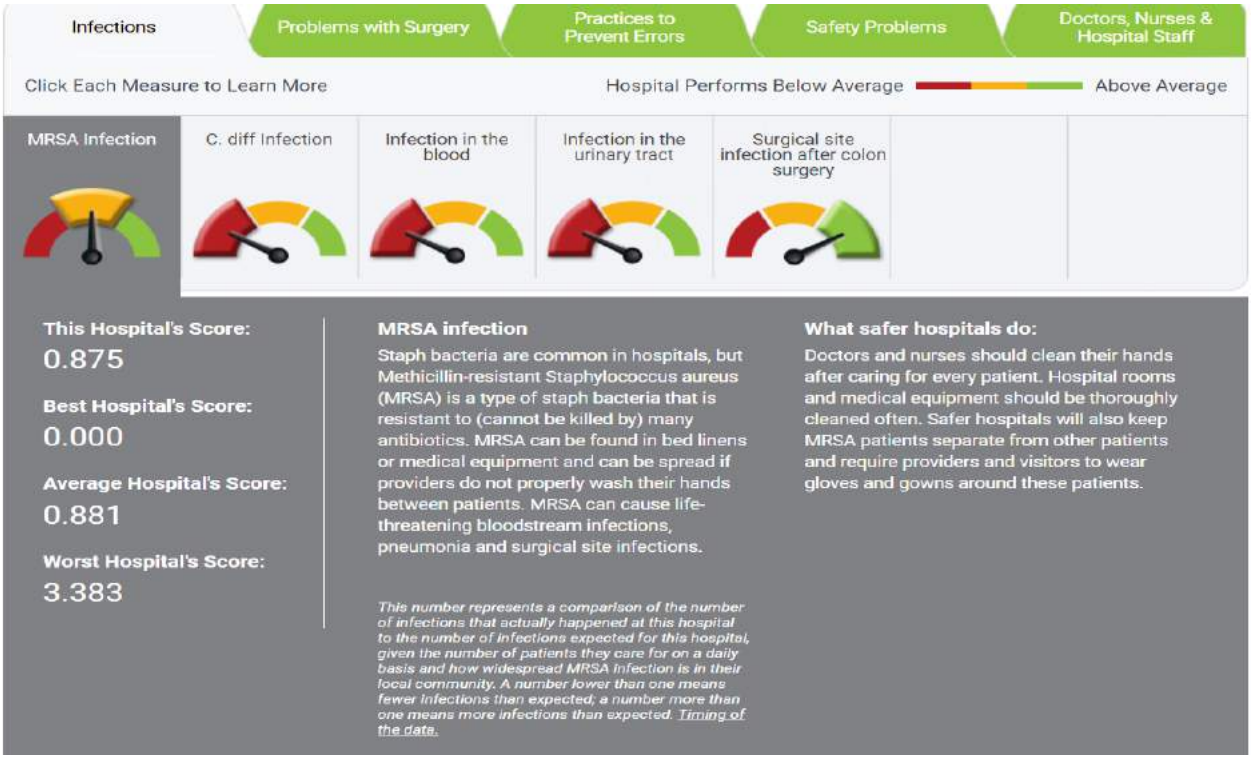
Citations Issued

Maintenance of physical plant

Staffing and delivery of care

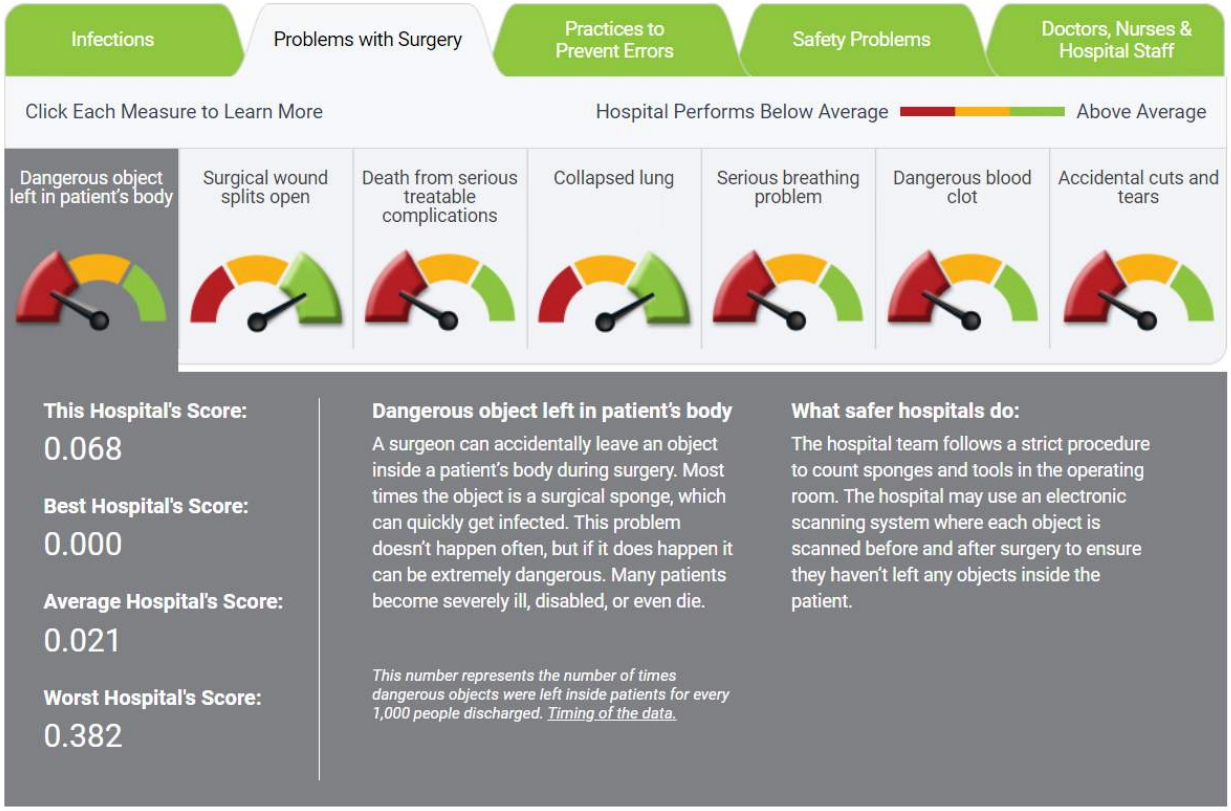
POAs are consistent with 2018 Leapfrog Report

The 2018 Leap Frog Report aligns with the POA complaints. Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) uses national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the American Hospital Association's Annual Survey and Health Information Technology Supplement. Taken together, those performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade includes 28 measures, all currently in use by national measurement and reporting programs. The Leapfrog Hospital Safety Grade methodology has been peer reviewed and published in the Journal of Patient Safety. The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system. The overall **Leapfrog Grade at NY Presbyterian Hospital –Columbia Presbyterian Hospital and Allen Hospital is a C.** A sampling of the Leapfrog findings that are consistent with the more than **1,046 POAs** appears below:



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

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



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

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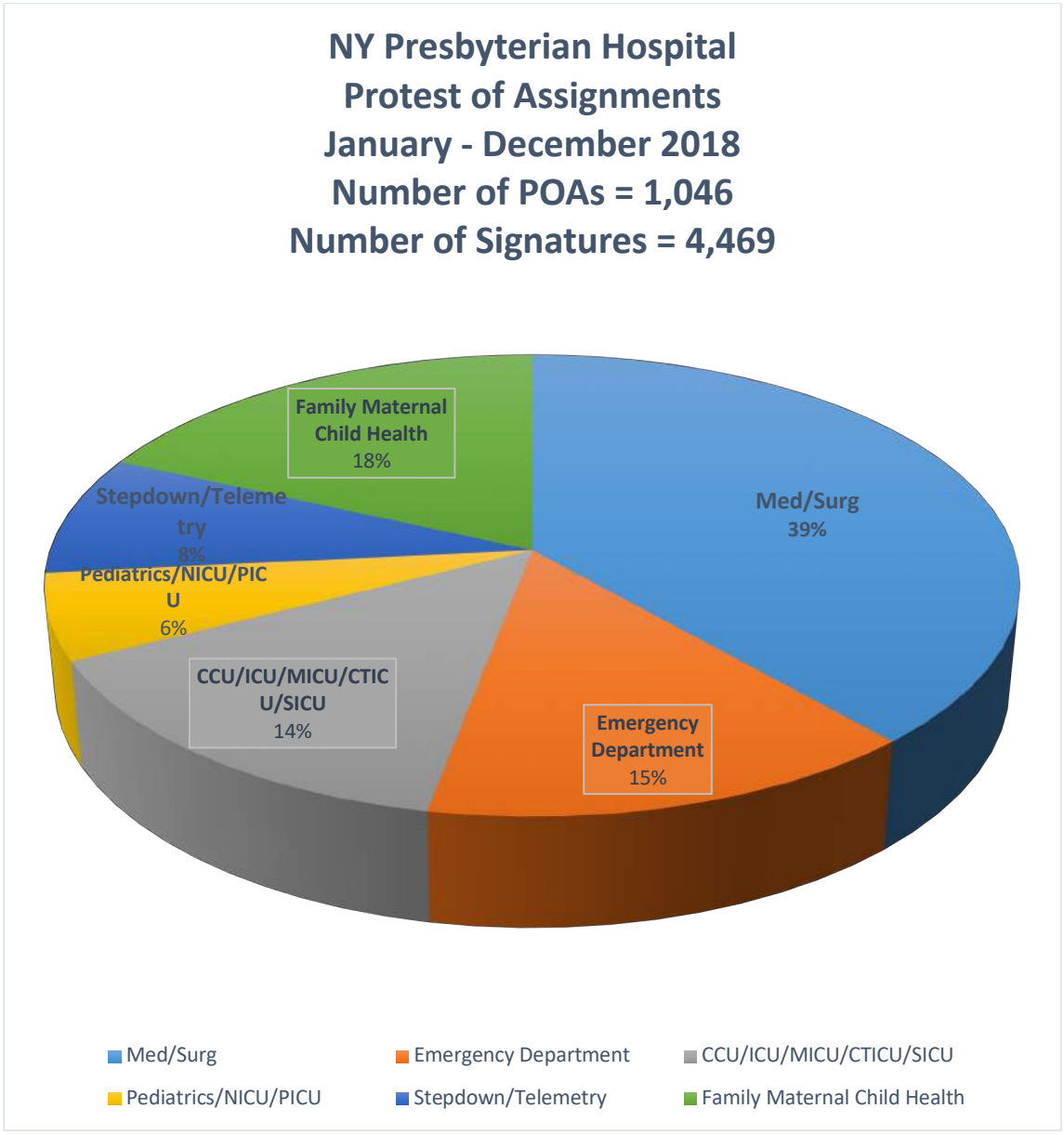
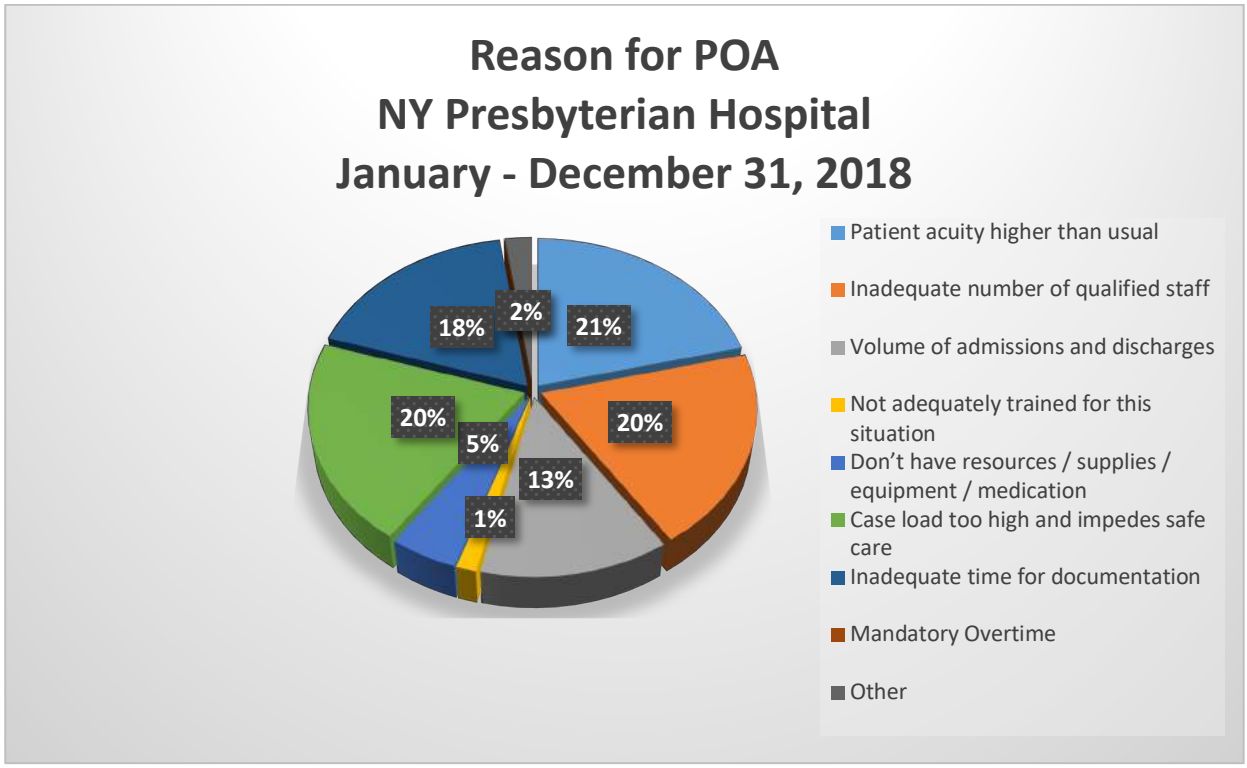

NY Presbyterian Hospital
Protest of Assignments
January - December 2018
Number of POAs = 1,046
Number of Signatures = 4,469
Family Maternal Child Health 18%
Stepdown/Telemetry 8%
Pediatrics/NICU/PICU 6%
CCU/ICU/MICU/CTICU/SICU 14%
Emergency Department 15%
Med/Surg 39%
Med/Surg
Emergency Department
CCU/ICU/MICU/CTICU/SICU
Pediatrics/NICU/PICU
Stepdown/Telemetry
Family Maternal Child Health

Protest of Assignment Report
New York Presbyterian Hospital
January 1, 2018 – December 31, 2018

The one thousand forty six (1,046) protests of assignment (POAs) supported by over four thousand four hundred and sixty nine (4,469) signatures filed in the specialty areas outlined at NYPH between January 1, 2018 through December 31, 2018 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

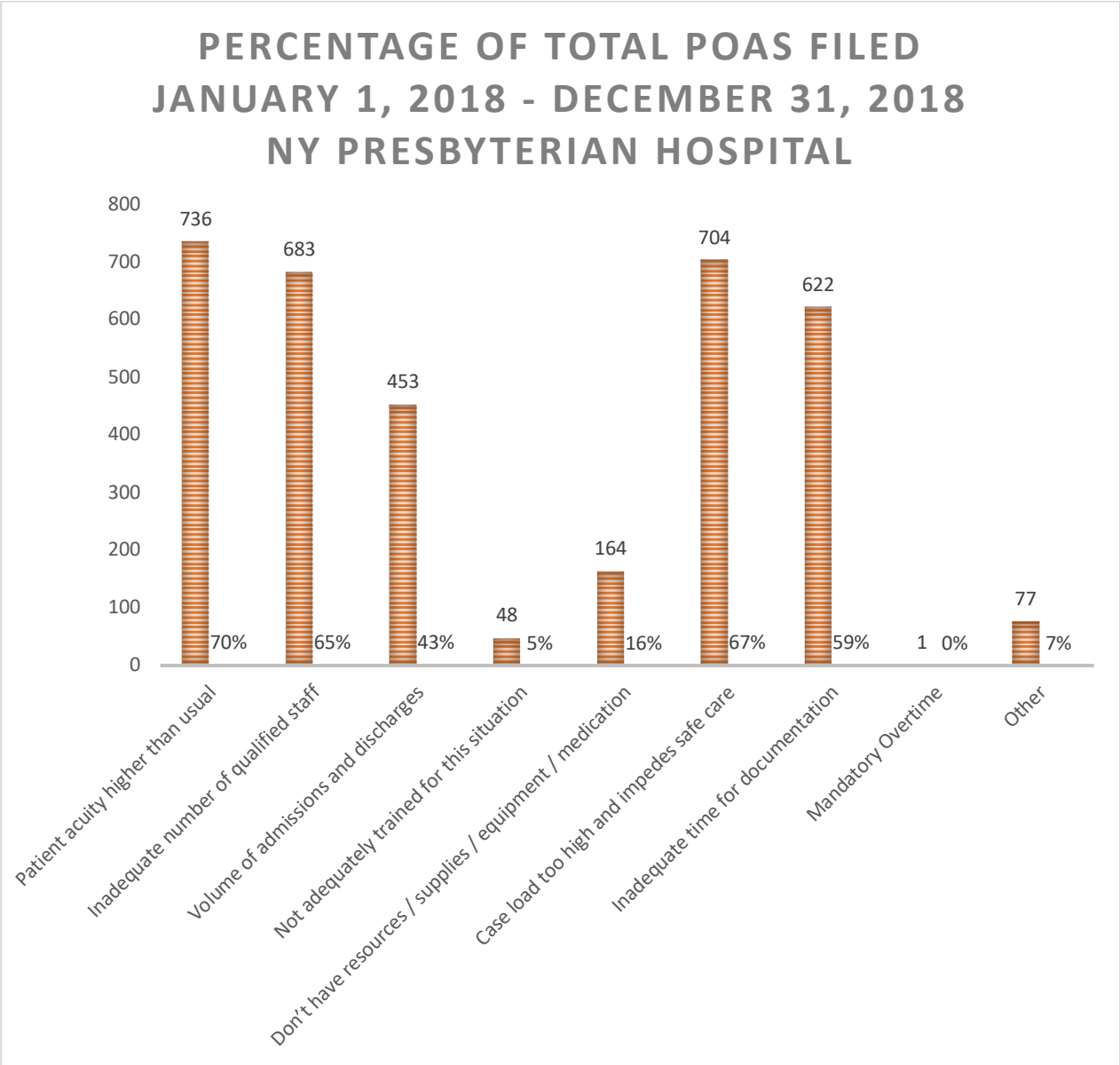
Figure 1: NY Presbyterian Hospital – Most Frequent Reasons for Protest of Assignment



The 1,046 hospital-wide POAs filed at NYPH between January 1, 2018 and December 31, 2018 documents the follow 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 70% 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 65% 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 (43% of the protests) and patient caseload (67% of the protests) leave them with inadequate time for documentation. Inadequate time for documentation comprises over 59% 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 7% of the protests filed throughout the hospital.

Figure 2: Reason for Protest of Assignment by Frequency and Percentage



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

The 1,046 hospital POAs in the specialty areas filed and utilized for this chronicle at NYPH January 1, 2018 and December 31, 2018 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:

Table 1: Most Common Other Reasons for POA Listed

Other:
Inadequate # Qualified Staff & High Acuity: Started with 8 patients, 3 RN's, 2 day shift RNs stayed till 11pm. 3 day RN came back 12 am – 7 am. 2 spine patient admissions, 2 vents, 1 BIPAP, 2 emergent hemodialysis during shift, 9 patients on isolation, 1 admission from ED requiring HD, intubation, 1 cardiac arrest during shift.
Inadequate # Qualified Staff & High Acuity: This POA is for Heart CCU. PCD notified of this POA as soon as the night RN left at 11:15 am. She worked from 7 pm last night until 11:15 am. Acuity includes 3 vents, 2 CVVH, 1 restraint.
Inadequate # of Qualified Staff & Acuity Higher than Usual: (Multiple occurrences) **Nurses have a 3 patient assignment with patients who have complex needs.**
Inadequate # of Qualified Staff & High Acuity: Inadequate supplies, 11 vents, 1 safety 1:1, charge RN with 2 patients, multiple patients with ICP crisis
Inadequate # of Qualified Staff & High Acuity: (Multiple occurrences) **Charge nurse with 2 patients** and many instances complex patients including patient on CVVHD and another complex patient.
Inadequate # of qualified Staff, High volume of admissions and discharges & High Acuity: Opening census 16 + 2 admissions to come. 2 transfers, + 2 extra admissions total of 4 admissions. 1 ECMO, 1 Impella, 9 vents, 4 CVVH, bedside procedures, 3 IABP
Inadequate # of Staff, High volume of admissions and discharges & High Acuity: We were staffed with 9 RNs but 2 stayed from day shift to help us out from 7:30 pm to 11 pm after which they had to go home. After 4 hours one came back to help us more till 7 am.
Inadequate # of Qualified Staff, High volume of admissions and discharges & High Acuity: Four new cases from the OR, four ECMO patients, one open chest, 4 patients on continuous dialysis, 3 VAD patients. Charge RN has a patient post chest washout and chest closure.
Inadequate # of Qualified Staff, acuity higher than usual: Started with 8 patients, expecting 1 ECMO from cathlab, got report, admitted this patient at 8:30 am, with ECMO, Impella, multiple pressors, TVP, pericardial drain, very unstable, and bleeding requiring multiple BT. At 12:15 pm admitted another patient from 5GS with endocarditis on CHB.
Insufficient # of Ancillary Staff: No unit assistant (7-3 shift) and nursing technicians (7-3 and 3-11 shifts) on duty. At 7:30 a, one patient went immediately to the procedure room for TVP insertion. Another patient was combative, tried to elope, and attempted to hit staff. Security personnel were requested to come up to help with this patient. Eventually, this patient was placed on 1:1 observation.
Inadequate # of Qualified Staff, high volume of admissions and discharges, not adequately trained for situation, inadequate time for documentation & High Acuity: Charge RN with 2 patients. 2 patients with multimodal monitoring. One patient 1:1 for suicidal ideations.

Inadequate # of Qualified Staff, high volume of admissions and discharges & High Acuity: Only 10 nurses, have 2 bundles, both are paired. Many CT scans and MRI's scheduled.
Inadequate # of Qualified Staff, inadequate time for documentation & High Acuity: RNs. (Multiple occurrences) Patient acuity very high, not enough staff, **requiring to pair patients such as VADs, fresh post ops, CVVHD with another patient.** Additionally at times no ancillary staff.
Inadequate # of qualified staff & acuity higher than usual: 1 ECMO, 1 Impella, 2 vents, 1 CVVH, no nursing technician working on the floor 7 am – 3pm. Admitted patient from the floor with 1:1 at 1pm. Again no nursing tech on the floor from 3 – 11 pm shift. Nursing tech was utilized for patient on 1:1. At 6 pm unit assistant floated to the floor.
Inadequate # of qualified staff, acuity higher than usual, high volume admissions & discharges, not adequately trained, don't have resources needed, caseload too high impedes safe care, inadequate time for documentation: 3 ECMO, 4 Impella, 1 CVVHD, 1 EKOS, started with 15 patients, admitted 1 with ECMO, intubated with Impella, and 1 patient with EKOS. Charge nurse took over 1 patient. No Nurse tech. 1 patient expired.
Inadequate # of qualified Staff, case load too high impedes safe care & High Acuity: (Multiple Occurrences) **Multiple patients on devices** such as ECMO, CVVHD, Impella, and EKOS, patients complex and inadequate # of staff.
Inadequate # of qualified staff, acuity higher than usual, high volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: shift starting with 15 patients, received 1 admission during the shift and no tech on floor from 7 pm – 7 am. 1 1:1 was covered for an hour and a half by RNs and the 1:1 was used to relieve another 1:1 coverage in the heart center CCU as well. Acuity includes, 2 impellas, 1 ECMO, 1 tandem heart RVAD, 1 patient on 1:1, 1 patients actively bleeding at impella site with fresh GI bleed. 3 patients watched over all night. There was a mass feeling of not being safe in the unit. Throughout the night the situation warranted at least 3-4 nurses in 1 patients who was decompensating actively.
Inadequate # of Qualified Staff & High Acuity: (multiple occurrences) **Inadequate number of support staff**
Inadequate # of Qualified Staff, caseload too high impedes safe care, inadequate time for documentation: The shift started with 9 patients and 1 possible admission. Charge nurse has 2 patients. No tech on the floor from 11 pm – 7 am. Acuity at this time involves 1 vented, 1 DNR/DNI, CVVH and multiple transfusion patient who is decompensating throughout needing intensive care. There are 3 isolations and 1 1:1 postop patient 11pm. In addition one of the nurses who went down for CT scan initially to the 3rd floor CT which was apparently malfunctioning and had to then go to the 8th floor CT leaving the unit for an hour with only 4 nurses on the floor. Nursing assignment had to be tripled as one nurse had to remain with the 1:1 patient at time and during RN break coverage.
Inadequate # of qualified Staff & Acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation, Mandatory OT: Patient vented, with impella and ECMO paired with another ICU patient. Unable to take break. Needed to assist with insertion of TVP of new admission from ED in the procedure room. Unsafe working conditions. Stayed late to document.
Acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Patient A: S/P TVR, labile BP on multiple pressors, though sedated has episodes of agitation with minimal stimulation, episodes of tachycardia up to 140s with PVCs and PACs, with HTN episode SBP 190. Patient B: Picked up patient in room around the corner from other patient. S/P NSTEMI, extubated day before and having IABP removed. Patient C: Asked to give up patient B and admit patient from ED. Patient was in CHB and immediately went to the

procedure room where received 2 units FFP. After a failed TVP insertion, patient was moved to room on opposite side of unit and was restless and agitated for over 1 hour pulling out IVs.
Acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: RN charge with 2 patients. Unable to assist with floor needs. Pt seizing and unstable. 2 Pts on ECMO and Impella. One patient unstable taken 2 times to CT scan and the other procedure room for IABP exchange.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care: One patient on high pressors levo 10, vaso 4. Very high inotropes Epi 4, dobut 5 mil .125. Weaning no. W VT plus new rapid afib with amio load. Malpositioned ETT w resp distress requiring repositioning. Fresh LVAD temp 39c, requiring new cooling blanket. Other patient with respiratory distress, recent trach, frequent mucus plugs, on and off vasopressors.
Inadequate # of qualified staff, acuity higher than usual, high volume admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Three patients. 1. CVVH that required blood transfusion and restarting CVVH x2 for circuit clotting. On insulin drip, precede and vasopressors. 2. New admission with HTN, BP 180/107 with unstable AAA. Requires nicardipine gtt and esmolol to maintain BP < 140. 3. Uncontrolled HTN BP 219/118, required multiple anti-hypertensive med interventions. S/P l thoracotomy + CT with changes in mental status. No break due to work load
Inadequate # of qualified staff: unit has 8 patients. 2 patients booked and coming. 1 pt requires a 1:1 for patient observation but there is no tech available from any cardiac unit that one is willing to cover. And no one from nursing office. Charge nurse has a full load of patients. Pt cannot be observed by nursing staff either due to inadequate staffing.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation, MOT: 3 CVVHD's, Code blue x 6, 2 1:1 observations, charge RN with an assignment, 9 restraints.
Inadequate # of qualified Staff, acuity higher than usual, case load too high impedes care, inadequate time for documentation: Start of shift with 4 RNs, 1 RN with 6 couplets and 3 RNs with 5 couplets. 9 discharges, 3 admissions. 7 c/s, 3 circumcisions, triple antibiotics. 1 pt on droplet isolation precautions.
Not adequately trained for situation: Pulled from normal unit (L & D) to work in TN due to staffing issues. Not trained for the TN. Only WBN.
Inadequate number of qualified staff: (Multiple occurrences) Only TN nurse in house tonight.
Inadequate # of qualified staff, volume of admissions and discharges, don't have resources needed, case load too high & impedes safe care, inadequate time for documentation: 7 RNs including charge RN and triage RN. 23 pts, 2 c/s, 6 NSVDs, 3 baby nurses, unsafe staffing ratios unable to meet AWHONN standards all day.
Inadequate # of qualified Staff, don't have resources needed, case load too high impedes safe care, volume of admissions and discharges, inadequate time for documentation: Against AWHONNs standards for safe nursing care. Only 4 RNs on unit including charge RN and triage RN. Unsafe staffing ratio.
Insufficient # of Staff: No RN available for newborn care.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, caseload too high impedes safe care, inadequate time for documentation: 2 RN on floor for 6 couplets each. 1 with blood transfusion and 1 fresh c/s. 1 on antibiotics, 1 hemorrhage. 1 baby with unstable blood glucose. 8 discharges, 5 admissions, 6 c/s, 1 WBN with orientee.

Inadequate # of qualified Staff: 5 nurses on unit. One of those nurses staying after 12.5 hour shift will go on break and we will be 4 nurses. PACU patient with tachycardia. Preterm patient in active labor. 2 units blood transfusion, triages.
Inadequate # of qualified Staff: (Multiple occurrences) Multiple RNs with at 6 – 8 couplets each and complex patients.
Inadequate # of qualified staff, case load too high and impedes safe care: We are 6 RNs currently on unit, including 1 Rn who is working 24 hours and will need to take a break after her 16 hours for a couple of hours. Another RN who is staying only until 1 pm. At this time we will be down to 4 until another nurse comes which brings us each up to 5 nurses. Multiple triages and admissions.
Inadequate # of qualified staff, patient acuity higher than usual, inadequate time for documentation, volume of admissions and discharges: 6 RNs for 12 patients with 2 patients in waiting area. 1 RN floated from postpartum unit with no L and D experience. 1 pt just delivered, 1 pt pushing, 5 patients in active labor, 1 post c/s, post USVD, multiple triages, 1 induction.
Inadequate # of qualified staff, not adequately trained, acuity higher than usual: I have been assigned a patient with critical level of care, and I am not adequately trained for these types of patients. The patient was assigned a CCOB-trained nurse who had to leave the unit at 5 pm, thereby requiring me to assume care of the patient for the remainder of the shift. I made it clear to both my charge nurse and my PCD that I do not feel comfortable taking care of this patient, and I was told that I have adequate support to take care of her so my assignment remained unchanged and I must assume care of the patient until the end of the shift.
Inadequate # of qualified staff: 4 admissions since 7 pm, only 1 nursing assistant 7 pm – 11 pm. No unit clerk 7 pm – 7 am. 1 nursing assistant pulled at 2 am. 1 patient on contact isolation, 1 on wound VAC, 1 on antibiotic, 14 mother 15 babies by 7 am.
Inadequate # of qualified staff, patient acuity higher than usual, case load too high impeding safe care, volume of admissions and discharges high: (Multiple occurrences) Inadequate number of L & D nurses for the number of patients. Many occurrences of nurses having 2 patients each and pt's complex
Inadequate # of qualified staff, not adequately trained for situation: 4 scheduled nurses with 1 nurse orienting. Day shift nurse staying to help with staffing. 1 nurse from postpartum also is not L and D trained.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: Received 7 patients. 1 pt to go to the OR that needs a baby nurse. 1 Pt in labor with high BP's magnesium to start. 1 Pt for trial of labor. 1 pt on magnesium. 2 Triages. 1 for admission.
Inadequate # of qualified staff, caseload to high impedes safe care, volume of admissions and discharges high, acuity higher than usual: 4 patients on Pitocin, 1 28 week prolonged monitoring for 24 hours status post fall, 1 induction of labor, 2 stat c-sections, 1 NSVD, 1 neonate to be transferred to NICU, 2 add on C/S, multiple triages.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 6 RNs, 7th RN for overtime in at 11pm. 10 patients, several triages, 1 emergent c/s. 1 add on c/s. 1 postpartum vaginal delivery. 3 NSVDs, 1 neonate to TN, charge nurse needed to be charge and triage.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 7 L & D nurses. 1 PP RN floated. 2 C/S simultaneously. Only 1 scrub tech so charge RN had to scrub. 2 babies required PPV, 1 NICU admission. 1 pt on MgSO4. Not enough staff to safely tend to bath pts in ORs and the rest of the floor

Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: Only 6 RNs, census 9. All patients on Pitocin, 1 on Mg, 1 R/O abruption, 1 to go to C/S, 2 NSVDs
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, inadequate time for documentation: 24 patients on unit, no additional beds available. 1 patient with NG tube, 2 patients with elevated BP, 13 scheduled discharges. WBN received 6 admits, mothers remain in labor room- no beds on 3 RW
Inadequate # of qualified staff, case load too high impedes safe care, inadequate time for documentation, MOT: (Multiple Occurrences) Midwifery. Scheduled alone. Delay in attending to all of the needs of patients. OR Triage L & D and phone Triage.
Patient acuity higher than usual, inadequate time for documentation: Assignment: 4 couplets and 1 set of twins (total of 9 individuals). Small for gestational age twins requiring care seat testing. One newborn onQ4 Finnegan Scale due to maternal history of polysubstance abuse.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: We are extremely short staffed with no EMTALA nurse, the nurse assigned a one to one patient is assigned to two patients. The charge nurse has been forced to take an assignment due to limited staffing, and we only have one nursing attendant.
Inadequate # of qualified staff, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: Delay in admitting, discharging and attending to the needs of all patients
Acuity higher than usual: 1 R/O PE, 2 fully dilated and pushing. 1 possible abruption, charge RN has 2 patients. Multiple triages, 1 Induced to still come.
Inadequate # of qualified staff, case load too high impeding safe care. Inadequate time for documentation: 7 RNs including charge RN and 1 triage RN. I have a new orientee (2nd) week and 2 labor patients. My orientee requires a great deal of attention and my time devoted to her as well as to my other patients is compromised
Inadequate # of qualified staff: 6 RNs, 1 RN to be scrub tech 7 pm – 11 pm for 2 cases. All other RNs with 2 patients already. Charge RN covering triage and Baby RN in OR
Inadequate # of qualified staff, case load too high impedes safe care, inadequate # of ancillary staff: Float NA sent and she covered lunch breaks for 1:1s, No EMTALA nurse. No RN for scheduled OR case due to C/S from 10 central
Unable to adhere to AWOHNN Standards (Multiple Occurrences)
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: I have an orientee in her 3rd week of orientation, I am assigned two patients. 1 is 9 cm and the other pt is having variables. I cannot devote adequate time to my orientee. So far the entire orientation has suffered due to inadequate staffing. Another RN has another orientee with multiple patients causing suboptimal precepting.
Inadequate # of qualified staff, patient acuity higher than usual, volume of admissions and discharges: 16 patients on labor floor. All nurses doubled up with patient assignments. Acuity of patients higher than usual. 3 CCOB pt. No meal breaks. 4 cesarean sections. 2 twin deliveries. 2 pt with blood transfusions. No postpartum beds.
Inadequate # of qualified staff: (Multiple occurrences) Charge nurse required to triage as well.
Not adequately trained for situation, patient acuity higher than usual, case load too high impeding safe care: I am not a designated Critical Care Obstetric (CCOB) nurse, and I have been assigned a CCOB patient with a list of critical medical problems, and she requires medications I am not at all

familiar with. The standard is to maintain a 1:1 CCOB nurse: patient ratio, and I am also assigned to take care of an antepartum patient while caring for CCOB patient.
Inadequate # of qualified staff, don't have resources needed, acuity higher than usual, case load too high impeding safe care, volume of admissions and discharges, inadequate time for documentation: No nursing attendants on duty. Nurse have to do assignments on Mom and Babies and do every 4 hour vitals. 10 c-sections of which 3 are new. 2 patients are on antibiotics, 6 admissions, 1 antepartum patient. No IV poles, and no IV Pumps. No more laundry linen for patients.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care. Each nursery should have at least 1 RN and 1 NA in each nursery. Tonight we have 1 RN in each nursery and no NA in either nursery. 5 C nursery has 1 photo baby and 1 high risk baby that requires frequent transferring for infant feeding. 6 c has 1 photo baby therapy
Inadequate # of qualified staff: (Multiple Occurrences) unsafe staffing in both nurseries. No NAs in both nurseries and acuity is high. Same situation on both 5th floor and 6th floor
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impeding safe care: A third nurse was send to assist with the delivery in triage however the third nurse rushed neonate to the transitional nursery to initiate resuscitation for the newborn, thereby leaving only two nurses in triage. One nurse remained to assist delivery and care for the fresh postpartum which requires 1:1 (placenta had not yet been delivered, patient had no IV access and there were two admissions including a patient with twin gestation, preterm, and advanced dilation, who was receiving a magnesium sulfate bolus, which requires 1:1 care, for a total of 5 patients in triage. We needed five nurses at that time.
Acuity higher than usual, volume of admissions and discharges, not adequately trained: 30 patients, started with 26. 2 patients discharged and 6 admissions, 3 of them unstable, 1 pt on hourly F/S-glucose. 1 patient actively bleeding, 1 patient with runs of vtach, s/p open. 1 patient admitted in withdrawal on CIWA, 2 1:1's 1 pt on 15 minute Vitals on telemetry. Unsafe situation
Inadequate # of qualified staff, acuity higher than usual, don't have resources needed, case load too high impeding safe care, inadequate time for documentation: 1 RN leaving prior to end of shift, 10 DNR, 8 tele patients, 3 PI, 3 MO, 2 pts with restraints (mittens), 1 foley, 1 urostomy, 2 NG tubes, 1 hospice, 2 PEGs, multiple complete cares, 32 high fall risk.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 30 patients on the unit, 2 Q 15 min, 2 1:1 PDA, 1 patient has behavioral problems and violent towards security and staff. 1 NA on the floor. 12 complete cares.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: As per NYSNA guidelines this census requires 7 RNs, 5 on duty. Telemetry patients, 4 DNR/DNI pts, 15 complete care, 15 in bed alarm, 5 on observation. 2 2:1, 2 1:1, 1 wound care, 5 patients foley catheter
Inadequate # of qualified staff: **(High number of occurrences)** Staffing guidelines not met
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: 29 patients, 5 RN's, 10 completes, 4 1:1's, broken blood pressure machine, 4 patients with wounds, patients going for tests off floor.
Inadequate # of qualified staff, don't have resources needed, inadequate time for documentation, acuity higher than usual: Guidelines for census of 31 requires 7 and only have 6 RNs. High acuity, multiple bed alarms, high risk for falls, 2 patients on q15 min check. Pt with security, 2 patients with 1:1 PDA, 2 patients on comfort care. 1 patient on EEG monitor, 1 patient on heparin drip, 1 patient on PCA, 11 complete care.

Acuity higher than usual, case load too high impedes safe care: Very high acuity. 1 patient placed on security watch, another placed on 1:1 for risk of elopement after 12midnight. 1 pt receiving blood products. 1 patients on max observation (had to relieve both N/A's and 1 N/A on the floor). 3 wound care, 6 telemetry, 1 patient in restraints, 1 patient on trach with frequent suctioning, 8 isolation, 4 on bed alarms.
Inadequate # of qualified staff, volume of admissions and discharges, care load too high impedes safe care, inadequate time for documentation, acuity higher than usual: Many discharges and admissions, several complete chemo plans. No time to chart. Only 1 NA. No supplies, no sheets, patients not happy.
Case load too high impeding safe care, acuity higher than usual, not adequately trained for situation: 28 patients, 5 patients on 1:1 observation, 1 patient needs to be on 2 R east but bed not available, 8 patients on isolation, 4 patients on telemetry, 3 patients with foley catheter, 5 patients requiring wound care, 2 patients on BIPAP, 2 patients on heparin drip, 1 patient on comfort care.
Case load too high impeding safe care, patient acuity higher than usual, volume of admissions and discharges: Many complete care and had to relieve 3 of the 5 1:1's leaving unit with no floor coverage at times. 6 1:1's on unit, needing break relief (3 done) 3 more to do. No unit assistance. 3 quick admissions. Starting census 25 now 31 with 1 patient in alcove.
Not adequately trained for the situation, don't have resources needed: At change of shift, day shift charge nurse informed me that there was a patient in the ED that needed an infusion of Rituximab, and that they were unable to administer the infusion in the clinic due to the agitation of the patient. The patient was placed on a security 1:1, and I was told that after discussion with Ms. Salabay and Marga Holland, that the patient would be going to the PICU to be sedated for the infusion. I then received a call from the neurology MD stating the patient was not aggressive, and was stable for a 2 bedded room. Our past experiences with patients with this condition has been that these patients can be intermittently aggressive and violent, and this presents physical threat to nursing staff as well as the other patient and family in the room. I adamantly expressed my concerns regarding the safety of the nurses and was told there was nowhere else for the patient to be placed. I explained that we were not able to sedate patients, nor are we able to apply any type of physical restraint, increasing risk of injury to any staff caring for the patient. My concerns for the safety of the nurses on the unit were disregarded.
Inadequate # of qualified staff for the acuity of patients: (Multiple occurrences) Complex patients or complete care patients
Inadequate # of qualified staff, acuity higher than usual, caseload too high impeding safe care, inadequate time for documentation: Inadequate staffing for census of 27 with 10 patients on telemetry, 1 trach patient, 7 isolations, 5 patients on 1:1 observation, 2 Q15 minutes, 4 patients with wound care.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed: Inadequate response to nurses request for assistance to threatening behavior by a patient. Continuous reinforcement needed by staff nurses to onsite supervisors to get situation safely resolved. Had 1:1 security, 5 falls risk, droplet contact, heparin drip, 4 aggressive patients.
Inadequate # of qualified staff, case load too high impeding safe care: Only 8 nurses, charge nurse with 3 patients. 4 Nurses called off unit to take a class. Charge nurse covering up to 6-8 patients for 2 hours. Many admits, no nurses.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: 3 vents, 2 stepdowns, 1

trach collar, 2 spinal drains, 3 restraints, 6 isolations, 10 telemetries, 3 EEG, 1:1 observation, 20 total cares, 1 chemo, 1 plex
Inadequate # of qualified staff, case load too high impeding safe care, don't have resources needed, inadequate time for documentation: Only one ICU tech on the floor for 27 patients. No ICU tech from 7 am – 8 am on the floor. No ICU tech on the floor from 1 pm – 3 pm as she needs to release 1:1 & take her own break.
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care, don't have the resources needed: 4 telemetry patients, 5 isolation patients, 1 patient suicidal, 1 patient on elopement, 6 patients DNR/DNI, 1 patient with PEG, 1 patient on Q15 min check, 3 patients on hemodialysis, 1 patient on TPN, 3 patients with PICC, 1 patient on CIWA.
No adequately trained for the situation, acuity higher than usual, volume of admissions and discharges: 24 patients, 1 transferred to ICU at 11 pm. Nurse with this patient from 7 pm until 11 pm rapid response @ 11:10 pm. Patient placed on BIPAP and continuous O2 sat monitor. High acuity, high activity, only 2 NA's on the floor. Unsafe assignment.
Inadequate number of ancillary staff, acuity higher than usual, volume of admissions and discharges: 5 patients on max observation 2 are suicidal and the other 3 for safety. Nursing attendants on the unit taking meal breaks and relieving 4 of the 5 for their break relief. Only 5 nurses high acuity on the floor and high activity.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, done have resources needed, case load too high and impedes safe care, inadequate time for documentation: 8 step down patients, 3 mechanical vent patients, 2 patients on HFNC, 2 patients on PCA, 1 patient on continuous BIPAP, 2 chest tubes, 2 patients on CIWA protocol, 2 patients on heparin, 3 patients on protonix drip, 1 patient on dopamine, 12 patients on telemetry, 2 patients discharged at change of shift, 6 admissions, 2 patients on close or maximum observation (8 nurses) (Similar scenario two days later)
Inadequate # of qualified staff, case load too high impedes safe care, acuity higher than usual: 10 telemetry patients on the floor with 1 broken, and none more available in the hospital as per tele, so one patient without. 2 agency nurses on the floor, 4 pressure ulcers, 1 PCA, 1 PICCS with blood draws to do. We have 5 1:1's with cluster requiring 6 reliefs from our 3, meaning each will be off the floor for 3 hours each. Not including cluster plus the 1:1's, we still have 11 totals on the floor. 1 patient receiving IVIG x 3 doses, receiving multiple rate changes. We had 2 admissions from the ER plus 1 tx. Needed 9 nurses for the census. 35 patients on the floor at beginning of shift.
Case load too high impedes safe care, acuity higher than usual, volume of admissions and discharges: Arrived to an emergency Patient on security watch who pulled oxygen off wall and attempted to charge at security. All patients on oxygen had to be given cylinder in the room-patient placed on 4 point restraints. 3 1:1s only 2 N/As on the floor to give breaks. No help from nursing office for break leaving the floor without an attendant for long periods of time. No N/A after 11 pm. Split with ICU
Inadequate # of qualified staff, acuity higher than usual, don't have resources needed, inadequate time for documentation: Patient admitted from ED with pediatric sized trach, requiring suctioning. Equipment to suction not available on unit. Extra trach not available on unit. Comfort care patient also requiring frequent oral suctioning.
Inadequate # of qualified staff, case load too high impeding safe care, inadequate time for documentation: (Multiple occurrences) during a shift multiple step down patients, multiple lung transplant patients, multiple trached patients, patients on drips, close observation patients, patient/s on ventilator

Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 5 patients going for invasive procedures, pts on PEG, SP cath, dobutamine, trach needs suctioning frequently. BIPAP, 3 foleys, 2 patients on restraints. 1 patient on 1:1 (restless and agitated). 10 central lines, 20 total drips including dobutamine, dopamine, heparin, Lasix, milrinone, IV fluids. 4 patients with pressure ulcers needs turning @2h, 33 patients on I and O's. 3 patients on telemetry, 9 isolations.
Inadequate time for documentation, acuity higher than usual, volume of admissions and discharges: (Multiple occurrences) Multiple drips, majority of patients on telemetry monitoring, high risk for fall.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impeding safe care: 28 patients plus admissions. Inadequate time for 4 orientees. 7 SD patients. 1 Vent, 6 hi flows. 1 chest tube.
Inadequate # of qualified staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Six admissions from PACU back to back. No NA/Tech after 11pm. 1 PCA pump, 1 Telemetry, 2 foley catheters, 1 blood transfusion, 4 total cares, 1 wound vac, 2 JPs. (2 nurses)
Inadequate # qualified staff, acuity higher than usual, case load too high impedes safe care: No Aides or Techs on floor 36 patients. (Multiple Occurrences)
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation: Staffing guidelines not met for 2 months. Multiple patients on telemetry, multiple total care patients, patients to feed.
Multiple patients high risk for fall and injury. No staff available for new maximum observation of patient. 11 admissions during our shift.
Inadequate # qualified staff, acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Four trach patients, one vent, three pressure ulcers, 3 heparin drips, one insulin drip, one chest tube, six step downs, two thymo infusions, one PRBC transfusion, two DNR/DNI requiring emotional support, one patient with restraints, one patient 1:1 observation.
Acuity higher than usual, case load too high impeding safe care: New admit to unit resulting in a fall after patient climbed out of bed. Patient placed on 1:1 leaving unit with no N/A on the unit placing all other high risk fall patients at higher risk.
Acuity higher than usual, volume admission and discharges, case load too high impeding safe care, don't have resources needed: 23 patients, 10 BMT, 12 oncology and off service. Day 0 Transplant and day 11 transplant. Multiple chemotherapy infusions with patients reacting to infusions. Multiple blood draws, blood product infusions. 2 total patients. Close monitoring patients. Close monitoring patients, multiple VS Q1/2 hour to 1 hour monitoring
Inadequate # of qualified staff, acuity higher than usual, not adequately trained. Just one NA on the floor. 17 complete patients, High CIWA, 1 security watch, 4 1:1 maximum observation, 2 vents/trach, 16 high risk for falls.
Inadequate # of qualified staff, acuity higher than usual, don't have resources: 37 patients on floor with only 8 nurses, per staffing grid we are to have 9 nurses. We have two patients on restraints. 9 patients on isolation, 7 on telemetry, 4 with PCA, 2 with central lines, 3 with foley, 4 on BIPAP. 14 total care patients on the floor. Supplies had to be ordered as IV fluids, IV kits, syringes not in stock on the floor. We had 1 unwitnessed fall (MD, and supervisor notified) who also wanted to call 911 because room is cold even though engineer has gone to room multiple times in the week. 1 Patient became agitated and security had to be called.

Don't have resources needed, inadequate # of qualified staff: Inventory was done in am but still missing 11 items required time off floor to find. 1 Patient at start of shift noted angry and agitated requiring multiple calls to team. Multiple bed moves being made. Floor acuity high. 1 patient with blood transfusion at start of shift ended up having a reaction. 2 patients on PCA. 1 transfer received requiring suctioning multiple times. Another admission came confused and anxious. 9 nurses needed only had 8.
Acuity higher than usual, volume admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Only 7 RNs, giving chemo on 11 central at start of shift over 2 hours. Though had a chemo spill had to go up and down to 11 central and 6 tower. Access port a cath on 6 tower. 2 discharges at start of shift. 4 admissions booked at 7:30am. BMT x 4, oncology x 7, Heme x 5, x1 OMFS, ortho x3, med x1, 1 total care. Multiple transfusions. Multiple line changes. Multiple lab draws. 1 reaction to cells. X2 runs of electrolytes. Change of staff.
Inadequate # of staff: (Multiple Occurrences) patients receiving multiple chemo 4 – 8 patients. Also Multiple Occurrences of multiple BMT patients of 3 up to 8, multiple oncology patients up to 10 and off service patients 10 – 11 with patients receiving chemotherapy and blood products.
Inadequate # of staff, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: Census at 7:30 pm 20 plus 1 admission, 1 transfer, 1 possible discharge. 2 BMT patients, 10 oncology patients, 8 off service patients. Multiple blood products ordered for patients, patients receiving chemo, unstable watcher patients x3. Low staff. Situation is unsafe.
Inadequate # of qualified staff, case load too high impedes safe care, inadequate time for documentation: 18 nurses scheduled. 22/23 needed. 1 co-charge (should have 2). 2 RNs in fast track should have 3. 3 Rns in A/B should have 4. 1 RN working in a pool by herself. No Sick calls. High patient volume. Inadequate coverage for lunch breaks. Situation unsafe. Staffing numbers inadequate for an infusion center caring for a high volume of patients many of whom require close observation and RN professional assistance.
Inadequate # of qualified staff, case load too high and impedes safe care, volume of admissions and discharges, acuity higher than usual, inadequate time for documentation: 9 discharges, 6 admissions, 7 total care patients requiring turning and positioning. 11 central lines, 8 patients with drains, 5 patients with ostomy. 3 heparin drips. 3 PCAs, 1 patient on bed alarm, 1 transfusion. 1 Fistula, 2 pleurx, 2 telemetry.
Acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 17 patients, 2 step down patients, 4 patients on tele monitoring, multiple patient's high risk of fall, confused patient on 1:1, multiple patients receiving blood products. New Transfer on ketamine drip. Chest tube and pain. Newly transplanted patient.
Patient acuity higher than usual: (Multiple Occurrences) Patient 1 – 3 on ketamine. OR patients getting Rituximab.
Inadequate # of qualified staff, case load too high impeding safe care, inadequate time for documentation: 25 patients, 4 RNs, 1 trach collar, multiple high risk for fall, multiple complete care, 5 BIPAPS, patients on restraints, 2 patients on 1:1 observation
Inadequate number of RN Staff and Support Staff: (multiple occurrences) Inadequate staff based on guidelines and census (multiple occurrences of only 5 RNs)
Inadequate number of RN Staff and Support Staff: 1 ventilator, 1 maximum observation, 11 isolation, 1 alcohol withdrawal, 3 BIPAPs, 1 trach collar

Inadequate number of RN Staff: 25 patients, 13 complete care, 1 at high O2, 14 patients on telemetry, stroke patients with 3 hour neuro checks, 1 patient on CIWAA protocol, 1 observation, multiple patients high risk for fall and multiple 2 hour repositioning, 1 hospice patient
Not adequately trained: Floated, not trained for stepdown level care
Inadequate # qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care: 14 patients on telemetry, 11 patients on isolation, one vent, 1 trach, 6 BIPAP, 2 to come from ER. Several high risk for fall patients. 15 complete care req. 20 reposition. Patient with multiple pressure injuries. One RN float unable to adm and can only have med/surg pt (non stepdown). RN still must answer phone and call bells. Address needs of family and visitors.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: Only 4 RNs for 21 patients. Most patients are bed bound, incontinent and high risk for falls. Multiple patients on neuro checks. 12 patients on isolation, 3 patients on maximum observation, 3 patients on BIPAP, 14 patients on telemetry
Inadequate # of qualified staff acuity higher than usual, inadequate time for documentation, volume of admissions and discharges: 22 patients and 1 admission to come with 5 RNs. 3 BIPAPs, 13 isolations, 14 telemetry patients. 15 complete care bed bound patients requiring Q2h turning and positioning. Patient on 1:1 observation. 1 patient on Q15 checks. 3 blood transfusions, 2 patients on amiodarone drips, 2 patients on protonix drips.
Inadequate # of qualified Staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: We have 8 stepdown patients, 2 telemetry patients, 19 contact isolations. 3 droplets, 3 traches (one on vent). 2 with rectal tubes, one on TPN, 2 PCA pumps, one on insulin drip, one on heparin drip. 5 on tube feeds, 4 with chest tubes. 2 on chemo, one on BIPAP, 2 with wound vacs, one patient transferred to stepdown on high flow oxygen. 5 patients going to procedures. 22 high risk for fall. 15 pick line draws. One transfer this am for SICU. This floor has too high of an acuity not to be fully staffed.
Inadequate # of RN Staff and acuity higher than usual: (Multiple occurrences) 4 RNs with 18-24 patient census and patients with high acuity.
Inadequate number of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 34 patients plus 1 admission. 17 Step down, 9 LVADS, 1 1:1, 3 trachs, only 10 RNs and 1 ICU tech on the floor.
Inadequate number of qualified staff, acuity higher than usual, don't have resources needed: Six step down patients, 2 1:1 observation of suicidal ideations. 1 pt watched closely for elopement 1 insulin drip. 1 heparin drip, 1 TPN, 1 RBC, 1 chest tube, 2 ileostomies, 1 thymoglobulin, 19 high risk for fall patients, 9 central lines, 2 pressure ulcers, 1 multi-visceral transplant patient
Inadequate # of RN Staff, acuity higher than usual, not adequately trained for the situation, case load too high impeding safe care: 9 nurses, 16 step downs, 1 vent, 8 trach, 11 LVADS
Inadequate # of RN Staff, acuity higher than usual, case load too high impedes safe care, volume of admissions and discharges, inadequate time for documentation: 21 patients, 5 RN's. 1 ventilated patient, 2 maximum observation patients, 1 with security officer. 12 complete care patients, 2 BIPAPs, 1 patient on mitten restraints. 3 tube feeds. Multiple high risk for fall patients. 15 telemetry patients. Admission with inadequate supplies.
Inadequate # qualified staff, acuity higher than usual, case load too high impedes safe care: 10 patients on telemetry. 7 isolation. One vent. One patient terminally removed from vent. 4 BIPAP. 4 patient on 1:1 active combative. Climbing out of bed two patients on CIWA. Several high risk for fall patients. One patient getting BID transfusion. 11 complete care patients needing repositioning. One patient on restraint. RN must still answer call bell with phone and address needs of visitor and families.

Inadequate number of Support staff, case load too high impedes safe care: Only 1 NA on the floor from 11:30 pm – 7:30 am. 12 total care patients. High fall risk patients. Seizure patient and heavy vent.
Inadequate number of qualified staff: 10 stepdown patients and 1 step down admission. 1 Vent. 8 VAD's and 1 VAD admission.
Inadequate number of RN Staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 1:1 NA float. 12 high risk fall patients. Cardiac arrest with post mortem care. RRT rapid response patient transferred to stepdown at 17:30. Admission received from 6th floor.
Inadequate number of qualified staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Six admissions from PACU back to back. No NA/Tech after 11 pm. 1 PCA pump, 1 telemetry, 2 foley catheters, 1 blood transfusion, four total cares. 1 wound vac. 2 JPs
Inadequate number of RN Staff and Support Staff: As per our grid should have 9 RNs only have 7. Have 11 total care patients. 33 patients on telemetry. 10 drips as well as 7 patients on multi-IV antibiotics.
Inadequate # of qualified staff, acuity higher than usual, case load high impedes safe care, inadequate time for documentation: I have patients on one to one watch. I have patient with chest pain, one on ventilator, one on CPAP, 1 on CIWA q4h, 2 patients out of control
Inadequate number of RN Staff, acuity higher than usual, not adequately trained for situation, case load too high impedes safe care: Inadequate # of ERT's, 1 NA sent from floor. Still did not make a dent based on work that needed to be done. Inadequate # RNs in the midafternoon where RNs on teams were covering 12 patients to 1 RN during mealtime. Failure to comply to ED 1200 documentation requirement. Delay in mediation administration. ER holds (for admissions) 8 hour and 19:30 hours (admissions) did not receive required standard of care. 1 core ICU patient tied up 3 RNs for over 1 hour.
Inadequate number of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Inadequate time to document as Ped ED states. Unable to monitor patients. A couple of nurses went the shift without any break due to acuity and # of patients. Had to cover break in infectious control guidelines. Patients were sandwiched together. Rooms were missing BP cuffs, inadequate number of ancillary staff help for the staff. Nursing mothers unsafe to pump breast.
Inadequate # of qualified staff, volume of admissions and discharges, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: 55 patients with 12 admitted patients with no beds available. Continuous walk-ins and ambulance patients.
Acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: (Multiple occurrences) 63 patients in ER, no space for patients to be examined, no equipment such as stretchers and monitors.
Inadequate # of qualified staff, acuity higher than normal, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: RN to patient ratio 1:8 too many patients. No room to be examined. Patients waiting in waiting room 4 to 6 hours.
Volume of admissions and discharges, acuity higher than usual, case load too high impedes safe care: (Multiple occurrences) No space to place patients with monitors. No room for patients to be examined. No monitors
Inadequate number of RN Staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation, acuity higher than usual: 1:11 Nurse to Patient Ratio

Inadequate number of qualified staff, acuity higher than usual, volume of admission and discharges, inadequate time for documentation: 1 RN out of 10 is on orientation. No room for patients to be examined. 3 ICU patients, no beds available, refused critical diversion by Dr. Trepp and Marsha.
Inadequate number of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: I had 2 step downs and 1 ETOH withdrawal patient. 1:10 ratio
Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Multiple admissions 2 ICU and 7 Step down. Tech pulled for 1:1 in ED. Nursing office states no one to pull, leaving 1 tech while breaks are covered including 1:1. No Monitors, asked for diversion and denied by Marsha, Nursing director of ED. 18 level 1 and 2's, No beds in house.
Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 12 admitted hold over patients, no ISO beds, No ICU or telemetry
Inadequate number of RN Staff, patient acuity higher than usual, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation, inadequate number of ancillary staff: 2 nurses in a main section of the ED with an orientee taken off and put on her own before her orientation was over.
Inadequate number of Qualified Staff: (Multiple occurrences) 1:10 nurse to patient ratio and 1:10-14 with ICU patients.
Inadequate number of RN Staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: census has been consistently high for weeks if not months and staff remains the same with 4 nurses taking care of all patients, admitted, walk-ins and ambulances. Bed capacity 25 Census 45
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high and impedes safe care, inadequate # of ancillary staff, volume of admissions and discharges: 41 with 3 nurses in area. Total 207 patients in ED
Inadequate number of RN Staff, case load too high impedes safe care, acuity higher than usual, inadequate time for documentation, inadequate # of ancillary staff, volume of admissions and discharges: I personally have 1:10 ratio, 2 stroke activations, 1 sepsis-hypotensive.
Inadequate number of RN Staff, case load too high impedes safe care, inadequate time for documentation: no direct coverage for breaks leaving 1 nurse to cover 18 patients. Multiple stroke patients this morning without adequate RNs to monitor and document on stroke patients.
Acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: I have a total of 6 patients, 2 ICU, 2 critical Finger Stick, 1 GI block
Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: (Multiple occurrences) precepting orientee- volume acuity and demands hindrance to proper education and orientation.
Patient acuity higher than usual, case load to high impedes safe care, inadequate time for documentation, inadequate number of ancillary staff: several critical care patients and cardiac arrest In the waiting room
Inadequate number of RN Staff and ancillary staff, acuity higher than usual, inadequate time for documentation, not adequately trained for situation, case load too high impedes safe care, MOT: there are 25 monitored beds in the ED at this time of this protest there are 18 level 2 patients, and 2 level 1 patients. Diversion was requested and granted by the medical admin on call but denied by administration. At present the situation is critically unsafe for patients and staff.

Acuity higher than usual, inadequate # of qualified staff, inadequate time for documentation: Acquired 8 patients upon shift change and severely acute patient from ambulance which then became an ICU patient. Lasted with patient from 10 am to 12:30 pm losing time with my other patients, giving them their medication, attention and documentation. Another nurse was assisting me with the ICU patient for more than 2 hours and she too lost time with her other patients, medications and her patient was seizing.
Inadequate # of qualified RNs, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation: unsafe working assignments, inadequate staffing assigned to area with 2 nurses and 19 patients, advised by leadership no coverage for breaks, leaving one nurse to care for entire team.
Inadequate # of qualified RNs and ancillary staff, acuity higher than usual, volume of admissions and discharges, done have resources needed, case load too high impedes safe care, inadequate time for documentation: 1 SBO patient, 1 BIPAP ICU patient, 1 chest tube patient, 1 hypotensive patient septic. Each RN has an ICU patient. Receiving leave 2 and 1 while with ICU patients. Unable to take proper break in 12 hour shift.
Inadequate # of qualified staff: 4 nurses scheduled, 1 orientee, 1 duty staff nurse stayed till 11 pm. With 3 post partum's, 1 triage preterm, transferred to CHONY. 1 admit – 1 triage
Inadequate # of RN and ancillary staff, acuity higher than usual, volumes of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: I was team captain in the area tasked with assigning patients and assisting other nurses in my area but I had 12 patients at a high acuity with many tasks to complete for myself. There was not enough staff in the area.
Inadequate RN and ancillary staff, acuity higher than usual, case load too high impedes safe care, volume of admissions and discharges: Personally am caring for 10 patients, 3 ICU patients, 2 on ventilators and 1 on levophed with unstable BP. Unable to properly chart and care for patients.
Inadequate # of RN and ancillary staff, acuity higher than usual, don't have resources needed, case load too high impedes safe care, volume of admissions and discharges: At 13:50 informed clinical coordinator the following: the census in Area B is 45 + and I was actively caring for 4 level 2 and 14 level 3 patients. Additionally, during above time period I was assigned 5 level 3 patients within minutes of each other by the pivot nurse who stated this is the new system. I told them but there is nothing I can do.
Inadequate # of RN and Ancillary staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care, volume of admissions and discharges: Personally cared for high acuity of patients including patient with pneumothorax requiring chest tube placement, pt requiring blood transfusion, pt with Afib with RVE, and a patient found unresponsive.
Inadequate # of qualified staff, acuity higher than usual: 1 Halo patient. 1 tracheostomy, 4 patients on CPAP/BIPAP, 3 transplants, 1 patient on peritoneal dialysis, Charge nurse full patient assignment, No nursing attendant on unit.
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care: Total IT breakdown. 7 BMT, 8 Onc, 7 o/s, total of 5 chemo patients. 8 total agents, Multiple patients on CA requiring other protocol. 2 off service CPAP. 2 prep liver biopsy getting warmed up.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: 10 BMT patients, 12 oncology. 1 Patient requires 1:1 nurse. 9 Chemo patients. 7 watcher patients.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for docuementation: 8 BMT, 5 off service patients. Multiple patients on PCA.

Febrile patient requiring line change. Blood transfusions. Families requiring support. Fresh transplant. 3 patients on CPAP. 3 Chemo patients
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care: High census and high acuity with 1 ECMO and multiple post-op patients with a pending admission and only 2 NP's staffed.
Acuity higher than usual, don't have resources needed, volume of admissions and discharges: Charge nurse with a patient assignment, post op bidirectional glenn with small bowel obstruction admitted at 05:00
Acuity higher than usual, case load too high impedes safe care: One patient intubated and other patient trach to vent. Intubated patient spontaneously wakes up and tries to self-extubate. I constantly have to be by patient's room to make sure this doesn't happen. We are not increasing sedation because PICU team/ENT plans for extubation today. However, patient is not ready to be extubated, requiring prns. Charge RN, Unit PCD, PICU team aware of patients' condition. Twice this AM, while giving care to my trach patient, my intubated patient woke up and tried to self-extubate. An RN was passing the room and was able to run in. I am unable to give adequate care and attention to my trach patient who requires hourly suction, because I am also needed in my other patient's room.
Inadequate number of qualified staff, acuity higher than usual, volume of admission and discharges, case load too high impedes safe care: 2 NPs on overnight, 7 patients each. 1 Pt on ECMO requiring chest opening and washout x2, circuit changed, hemodynamically unstable. 1 critical post op. 1 admission in TN. 1 transfer to another CHONY floor. Very critical unit.
Inadequate # of qualified staff and ancillary staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation, MOT: 3 NP's with 3 ECMO patients. 1 CVVH, 14 ICU patients
Case load too high impedes safe care: Only 2 NPs on when minimum staffing is 3. Assignment is too acute for safe care.
Inadequate # of qualified staff and ancillary staff, acuity higher than usual, case load too high impedes safe care: 6 mechanically ventilated patients. 1 DNR/DNI impending death, 4 BIPAP/CPAP. 2 potential respiratory decompensation, no floor nursing assistant. Charge nurse has an assignment.
Inadequate # of qualified staff and ancillary staff, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: 10 intubated patients. Unsafe assignments due to inadequate staffing. Missing equipment and supplies. No NA on floor for stocking. 2 patients on 1:1 observation, patients planned for procedures and test off and on the unit. 7 patients restrained. RN available for OT unconfirmed by administration.
Inadequate # of ancillary staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Not enough nurses on the unit as one nurse was called off this morning to leave us with 3 when we were supposed to have 4. Nursing assistant was floated to another unit so we did not have one. Lots of discharges and admissions, patients were also high acuity.
Inadequate ancillary staff, acuity higher than usual, volume of admissions and discharges: Floor typically staffed with 4 nurses, but 4th was cancelled by Nursing office for "low census" despite empty beds that will be booked and progressive-care level patients. No nursing assistant on the floor, both nursing assistants pulled to other floors.

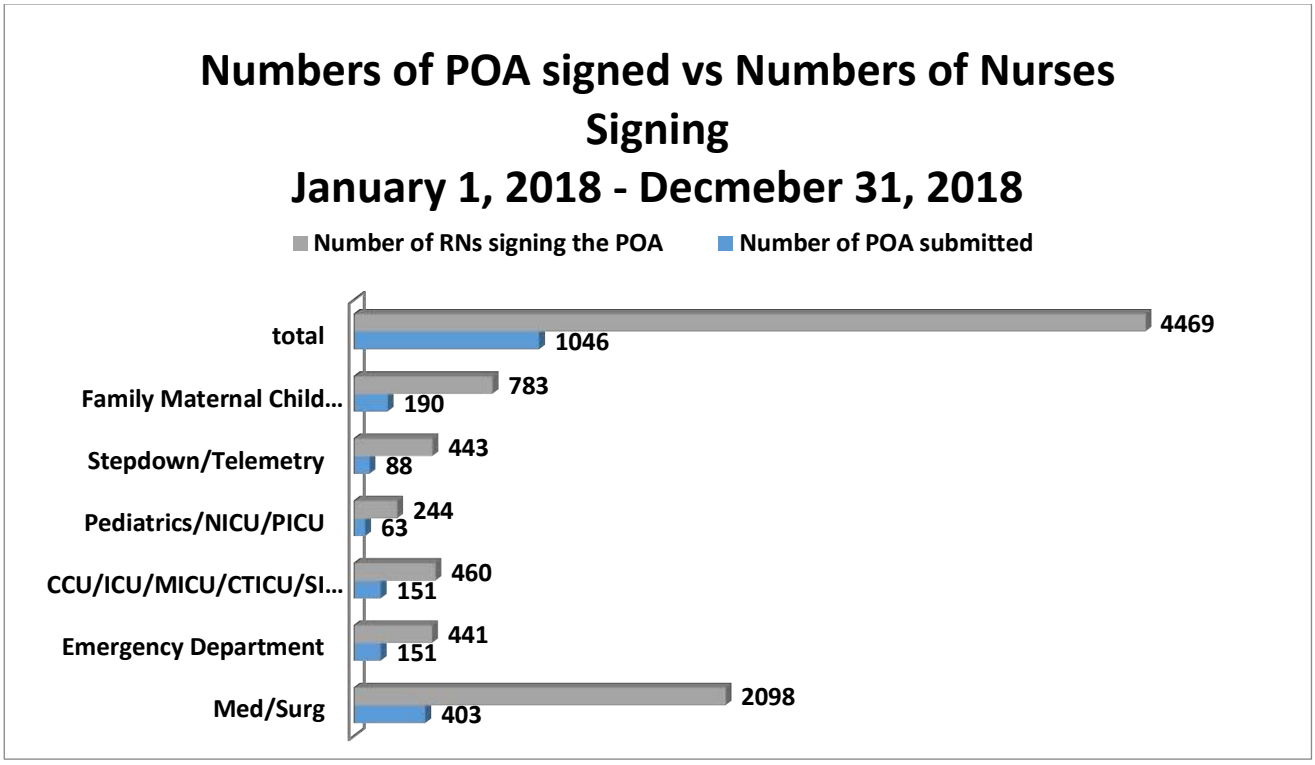
The 1,046 hospital wide POAs filed at NYPH in the specialty areas noted for this chronicle from January 1, 2018 and December 31, 2018 document a distribution by unit type, which is reflected in Table 2 below:

Table 2: Distribution of POAs by Unit Type

Unit	Number of POA submitted	Number of RNs signing the POA
Medical/Surgical	403	2098
Emergency Department	151	441
CCU/ICU/MICU/CTICU/SICU	151	460
Pediatrics/NICU/PICU	63	244
Stepdown/Telemetry	88	443
Family Maternal Child Health	190	783
Total	**1046**	**4469**

Medical/Surgical generated the largest portion, **39%** of the total Protest of Assignments. **Family Maternal Child Health** generated 2nd largest portion, **18%** of the total Protest of Assignments. The **Emergency Department** generated the third largest portion at **15%.** The **ICU units** generated the fourth largest portion at **14%**.

Figure 3: Numbers of POA vs Numbers of Nurses Signing POA by Unit Type



The 1,046 hospital-wide POAs filed at NYPH 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

Unit	Acuity Higher than usual	Inadequate # of Qualified Staff	Admis + Discharge	Not Adeq Trained	Don't Have Resources	Case Load Too High	Inadequate time for Documentation	Ma nd OT	Oth er	POA's	Signatures
Medical/ Surgical	317	318	165	4	85	272	225	0	35	403	2,098
Emergency Depart	116	47	86	7	32	121	119	0	7	151	441
CCU/ICU	105	64	39	11	18	90	69	0	6	151	460
Pediatrics/ NICU/PICU	47	41	31	10	13	50	38	1	15	63	244
Step Down/Tele metry	63	76	35	8	8	65	59	0	3	88	443
Family Maternal Child	88	137	97	8	8	106	112	0	11	190	783
Total	736	683	453	48	164	704	622	1	77	1046	4,469

* In Med/Surg, and Family Maternal Child Health, the most common reasons for protest of assignments were lack of numbers of qualified staff, acuity and caseload that impedes the delivery of safe care, 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

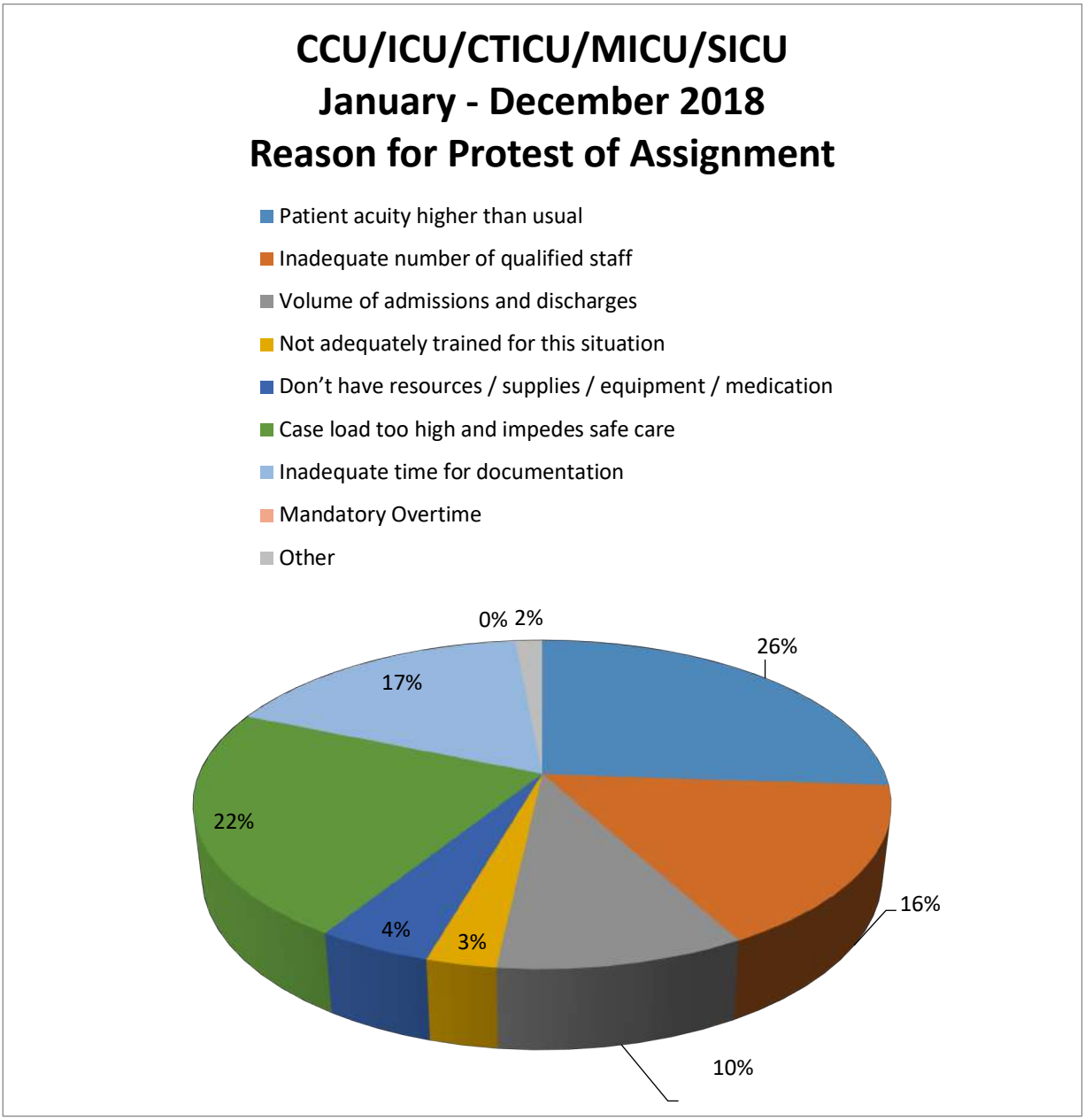
"Nursing is a critical factor in determining the quality of care in hospitals and the nature of patient outcomes" (Wunderlich, Sloan, and Davis, 1996). For several decades, health care researchers have reported associations between nurse staffing, safe practice environments, and positive patient outcomes.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

The following **focused analysis of POAs by clinical division** filed in NYPH document potential deficiencies in abiding by State and Federal law and established standards of care as follows:

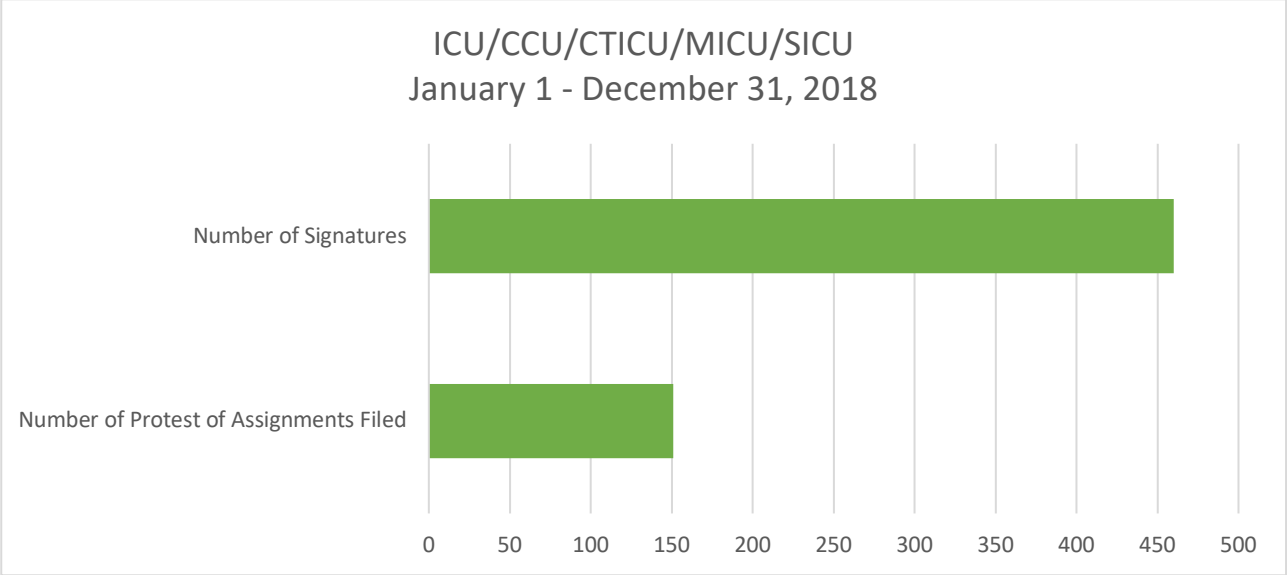
- The POAs document that requirements by State and Federal law and established standards of care have been repeatedly disregarded. This is evidenced by multiple POAs being inadequately addressed by management, management's failure to acknowledge RN concerns, and management's failure to provide a permanent solution to these staffing issues.
- The POAs reveal the registered nurses have repeatedly and consistently documented an inadequate number of qualified staff to safely care for the high acuity of patients and volume of patients being admitted and discharged. The POAs also note instances of high case load, a lack of necessary management support and resources, 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.

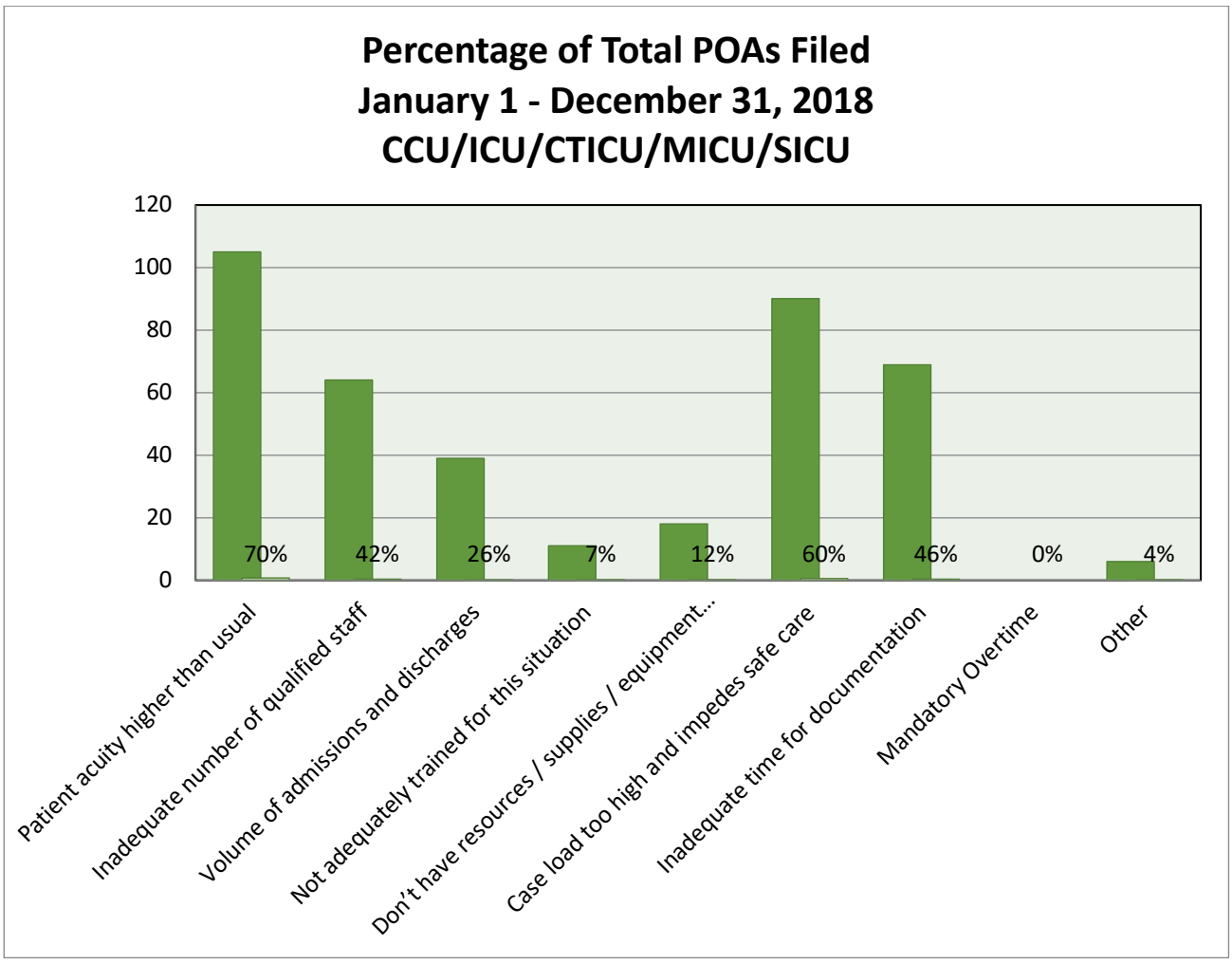
Figure 4: Reasons for POA in CCU/ICU/ MICU/CTICU/SICU



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)*
26%*	16%*	10%*	3%*	4%*	22%*	17%*	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 fifty one (151) POAs, supported by four hundred and sixty (460) signatures,** filed at NYPH between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the hospital in the CCU/ICU/MICU/CTICU/SICU departments that include:

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

Table 4: Other issues specifically identified in the CCU/ICU/MICU/CTICU/SICU:

ICU/CCU/MICU/CTICU/SICU Other:
Inadequate # Qualified Staff & High Acuity: Started with 8 patients, 3 RN's, 2 day shift RNs stayed till 11pm. 3 day RN came back 12 am – 7 am. 2 spine patient admissions, 2 vents, 1 BIPAP, 2 emergent hemodialysis during shift, 9 patients on isolation, 1 admission from ED requiring HD, intubation, 1 cardiac arrest during shift.
Inadequate # Qualified Staff & High Acuity: This POA is for Heart CCU. PCD notified of this POA as soon as the night RN left at 11:15 am. She worked from 7 pm last night until 11:15 am. Acuity includes 3 vents, 2 CVVH, 1 restraint.
Inadequate # of Qualified Staff & Acuity Higher than Usual: (Multiple occurrences) **Nurses have a 3 patient assignment with patients who have complex needs.**
Inadequate # of Qualified Staff & High Acuity: Inadequate supplies, 11 vents, 1 safety 1:1, charge RN with 2 patients, multiple patients with ICP crisis
Inadequate # of Qualified Staff & High Acuity: (Multiple occurrences) **Charge nurse with 2 patients** and many instances complex patients including patient on CVVHD and another complex patient.
Inadequate # of qualified Staff, High volume of admissions and discharges & High Acuity: Opening census 16 + 2 admissions to come. 2 transfers, + 2 extra admissions total of 4 admissions. 1 ECMO, 1 Impella, 9 vents, 4 CVVH, bedside procedures, 3 IABP
Inadequate # of Staff, High volume of admissions and discharges & High Acuity: We were staffed with 9 RNs but 2 stayed from day shift to help us out from 7:30 pm to 11 pm after which they had to go home. After 4 hours one came back to help us more till 7 am.
Inadequate # of Qualified Staff, High volume of admissions and discharges & High Acuity: Four new cases from the OR, four ECMO patients, one open chest, 4 patients on continuous dialysis, 3 VAD patients. Charge RN has a patient post chest washout and chest closure.
Inadequate # of Qualified Staff, acuity higher than usual: Started with 8 patients, expecting 1 ECMO from cathlab, got report, admitted this patient at 8:30 am, with ECMO, Impella, multiple pressors, TVP, pericardial drain, very unstable, and bleeding requiring multiple BT. At 12:15 pm admitted another patient from 5GS with endocarditis on CHB.
Insufficient # of Ancillary Staff: No unit assistant (7-3 shift) and nursing technicians (7-3 and 3-11 shifts) on duty. At 7:30 a, one patient went immediately to the procedure room for TVP insertion. Another patient was combative, tried to elope, and attempted to hit staff. Security personnel were requested to come up to help with this patient. Eventually, this patient was placed on 1:1 observation.
Inadequate # of Qualified Staff, high volume of admissions and discharges, not adequately trained for situation, inadequate time for documentation & High Acuity: Charge RN with 2 patients. 2 patients with multimodal monitoring. One patient 1:1 for suicidal ideations.
Inadequate # of Qualified Staff, high volume of admissions and discharges & High Acuity: Only 10 nurses, have 2 bundles, both are paired. Many CT scans and MRI's scheduled.
Inadequate # of Qualified Staff, inadequate time for documentation & High Acuity: RNs. (Multiple occurrences) Patient acuity very high, not enough staff, **requiring to pair patients such as VADs, fresh post ops, CVVHD with another patient.** Additionally at times no ancillary staff.
Inadequate # of qualified staff & acuity higher than usual: 1 ECMO, 1 Impella, 2 vents, 1 CVVH, no nursing technician working on the floor 7 am – 3pm. Admitted patient from the floor with 1:1 at 1pm. Again no nursing tech on the floor from 3 – 11 pm shift. Nursing tech was utilized for patient on 1:1. At 6 pm unit assistant floated to the floor.
Inadequate # of qualified staff, acuity higher than usual, high volume admissions & discharges, not adequately trained, don't have resources needed, caseload too high impedes safe care, inadequate time for documentation: 3 ECMO, 4 Impella, 1 CVVHD, 1 EKOS, started with 15 patients, admitted 1

with ECMO, intubated with Impella, and 1 patient with EKOS. Charge nurse took over 1 patient. No Nurse tech. 1 patient expired.
Inadequate # of qualified Staff, case load too high impedes safe care & High Acuity: (Multiple Occurrences) **Multiple patients on devices** such as ECMO, CVVHD, Impella, and EKOS, patients complex and inadequate # of staff.
Inadequate # of qualified staff, acuity higher than usual, high volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: shift starting with 15 patients, received 1 admission during the shift and no tech on floor from 7 pm – 7 am. 1 1:1 was covered for an hour and a half by RNs and the 1:1 was used to relieve another 1:1 coverage in the heart center CCU as well. Acuity includes, 2 impellas, 1 ECMO, 1 tandem heart RVAD, 1 patient on 1:1, 1 patients actively bleeding at impella site with fresh GI bleed. 3 patients watched over all night. There was a mass feeling of not being safe in the unit. Throughout the night the situation warranted at least 3-4 nurses in 1 patients who was decompensating actively.
Inadequate # of Qualified Staff & High Acuity: (multiple occurrences) **Inadequate number of support staff**
Inadequate # of Qualified Staff, caseload too high impedes safe care, inadequate time for documentation: The shift started with 9 patients and 1 possible admission. Charge nurse has 2 patients. No tech on the floor from 11 pm – 7 am. Acuity at this time involves 1 vented, 1 DNR/DNI, CVVH and multiple transfusion patient who is decompensating throughout needing intensive care. There are 3 isolations and 1 1:1 postop patient 11pm. In addition one of the nurses who went down for CT scan initially to the 3rd floor CT which was apparently malfunctioning and had to then go to the 8th floor CT leaving the unit for an hour with only 4 nurses on the floor. Nursing assignment had to be tripled as one nurse had to remain with the 1:1 patient at time and during RN break coverage.
Inadequate # of qualified Staff & Acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation, Mandatory OT: Patient vented, with impella and ECMO paired with another ICU patient. Unable to take break. Needed to assist with insertion of TVP of new admission from ED in the procedure room. Unsafe working conditions. Stayed late to document.
Acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Patient A: S/P TVR, labile BP on multiple pressors, though sedated has episodes of agitation with minimal stimulation, episodes of tachycardia up to 140s with PVCs and PACs, with HTN episode SBP 190. Patient B: Picked up patient in room around the corner from other patient. S/P NSTEMI, extubated day before and having IABP removed. Patient C: Asked to give up patient B and admit patient from ED. Patient was in CHB and immediately went to the procedure room where received 2 units FFP. After a failed TVP insertion, patient was moved to room on opposite side of unit and was restless and agitated for over 1 hour pulling out IVs.
Acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: RN charge with 2 patients. Unable to assist with floor needs. Pt seizing and unstable. 2 Pts on ECMO and Impella. One patient unstable taken 2 times to CT scan and the other procedure room for IABP exchange.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care: One patient on high pressors levo 10, vaso 4. Very high inotropes Epi 4, dobut 5 mil .125. Weaning no. W VT plus new rapid afib with amio load. Malpositioned ETT w resp distress requiring repositioning. Fresh LVAD temp 39c, requiring new cooling blanket. Other patient with respiratory distress, recent trach, frequent mucus plugs, on and off vasopressors.
Inadequate # of qualified staff, acuity higher than usual, high volume admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Three patients. 1. CVVH

that required blood transfusion and restarting CVVH x2 for circuit clotting. On insulin drip, precede and vasopressors. 2. New admission with HTN, BP 180/107 with unstable AAA. Requires nicardipine gtt and esmolol to maintain BP < 140. 3. Uncontrolled HTN BP 219/118, required multiple anti-hypertensive med interventions. S/P l thoracotomy + CT with changes in mental status. No break due to work load
Inadequate # of qualified staff: unit has 8 patients. 2 patients booked and coming. 1 pt requires a 1:1 for patient observation but there is no tech available from any cardiac unit that one is willing to cover. And no one from nursing office. Charge nurse has a full load of patients. Pt cannot be observed by nursing staff either due to inadequate staffing.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation, MOT: 3 CVVHD's, Code blue x 6, 2 1:1 observations, charge RN with an assignment, 9 restraints.

- The following State and Federal laws and regulations, standards of care, and accreditation requirements may have been left unaddressed in this situation:
  1) **Public Health Law 2805-b (1)** Admission of patients and emergency treatment of non-admitted patients. 1. Every general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed…;
  2) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Governing body -Organization and Operation-405.2(b)(2)** hospitals must establish, implement, and maintain policies and procedures to insure the hospital is acting in accord with generally accepted standards of professional practice; **405.2(c)(1-2)** hospitals must operate in compliance with Federal, State and local laws; **405.2(f)(1)** every patient of the hospital shall be provided care that meets generally acceptable standards of professional practice; **405.2(f)(7)** hospitals shall have available at all times personnel sufficient to meet patient care needs;
  3) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Nursing services 405.5(a)(2)**the hospital shall provide nursing staff for each department or nursing unit to ensure, in accordance with generally accepted standards of nursing practice, the immediate availability of a registered professional nurse for bedside care of any patient; **405.5 (b) (2-4)** timely assessment and reassessment of nursing care plans and evaluation of the adequacy and appropriateness of nursing care**; 405.5(c)(1-3)** timely medication and treatments shall be provided; **405.10(c) (1)** there shall be timely documentation upon completion of provision of care;
  4) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Quality assurance program 405.6(b)(1)** shall involve all patient care activities and review care provided by all;
  5) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)-Medical Records 405.10(c)** requires timely documentation; An accurate, clear, and comprehensive medical record shall be maintained for every person evaluated or treated as an inpatient, ambulatory patient, emergency patient or outpatient of the hospital. **10 NYCRR 405.10;** Medical records shall be legibly and accurately written, complete, properly filed,

retained and accessible in a manner that does not compromise the security and confidentiality of the records. **10 NYCRR 405.10(a)(1);**

6) **New York State Code, Rules and Regulations Title 10 (Part 405 Hospital Minimum Standards)- Critical care and special care services** are those, which are organized and provided for patients requiring care on a concentrated or continuous basis to meet special health care needs. Each service shall be provided with a concentration of professional staff and supportive services that are appropriate to the scope of services provided. **10 NYCRR 405.22(a);**

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

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

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

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

7) **American Association of Critical-Care Nurses- Critical Elements of Appropriate Staffing (2005):**
   - The healthcare organization has staffing policies in place that are solidly grounded in ethical principles and support the professional obligation of nurses to provide high quality care;
   - Nurses participate in all organizational phases of the staffing process from education and planning—including matching nurses' competencies with patients' assessed needs—through evaluation;
   - The healthcare organization has formal processes in place to evaluate the effect of staffing decisions on patient and system outcomes. This evaluation includes analysis of when patient

needs and nurse competencies are mismatched and how often contingency plans are implemented;
   - The healthcare organization has a system in place that facilitates team members' use of staffing and outcomes data to develop more effective staffing models;
   - The healthcare organization provides support services at every level of activity to ensure nurses can optimally focus on the priorities and requirements of patient and family care;
   - The healthcare organization adopts technologies that increase the effectiveness of nursing care delivery. Nurses are engaged in the selection, adaptation, and evaluation of these technologies.
8) **Code of Federal Regulations, Title 42 ("Public Health") § 482.21** "Condition of participation: Quality assessment and performance improvement program. (c) Standard: Program activities (1) The hospital must set priorities for its performance improvement activities that— (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care;"
9) **(e) Standard:** Executive responsibilities address priorities for improved quality of care and patient safety;
10) **Code of Federal Regulations, Title 42 ("Public Health") § 482.23** "Condition of participation: Nursing services (a) Standard: Organization well-organized service with a plan of administrative authority and delineation of responsibilities for patient care (b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed." There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient;
11) **Code of Federal Regulations, Title 42 ("Public Health") § 482.41** "Condition of participation: Physical environment. The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community (c) Standard: Facilities. The hospital must maintain adequate facilities for its services. (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality;"
12) **Joint Commission. (2013). Leadership (LD) - LD.03.01.01** Leaders create and maintain a culture of safety throughout the hospital. **LD.03.01.01, EP 1** Leaders regularly evaluate the culture of safety and quality using valid and reliable tools **LD.03.06.01, EP 3** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services **LD.04.04.03, EP 1** The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others. **LD.04.03.11** The hospital manages the flow of patients throughout the hospital. **LD.04.04.05** The hospital has an organization wide, integrated patient safety program within its performance improvement activities. **LD.04.04.05, EP 1** The leaders implement a hospital wide patient safety program. **LD.04.04.05, EP 3** The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes

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

Need for Action

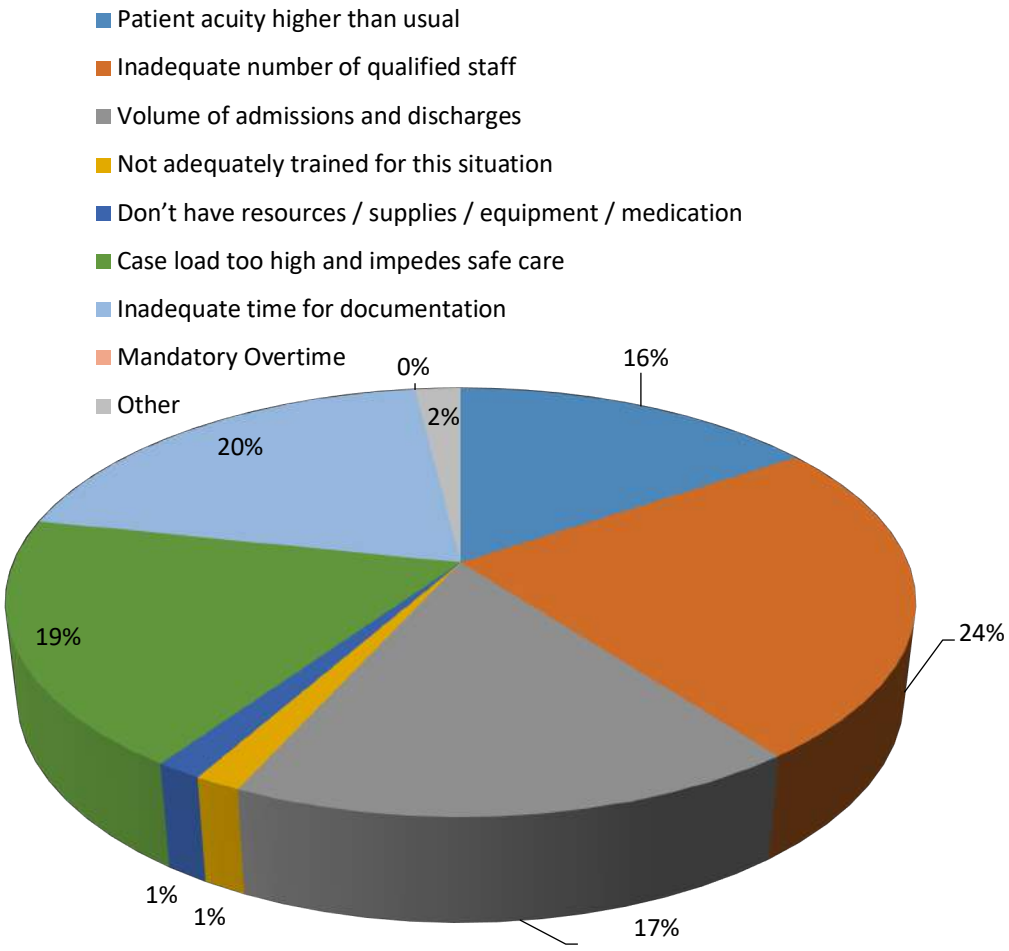
Nurses working in the Specialty Care / Intensive Care Units throughout NYPH are committed to improving delivery of care with the following recommendations:

- Increase specialty care registered nurses, and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation as well as the collective bargaining agreement language and to provide for adequate time for documentation in accord with standards of practice;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of NYPH's patients based on that organization's mission, values, and vision;

- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Specialty Care / Intensive Care, while concomitantly meeting the individual needs of NYPH's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix to meet the needs of the NYPH's patient population.
- Provide resources/supplies to meet all of the immediate needs of patients.

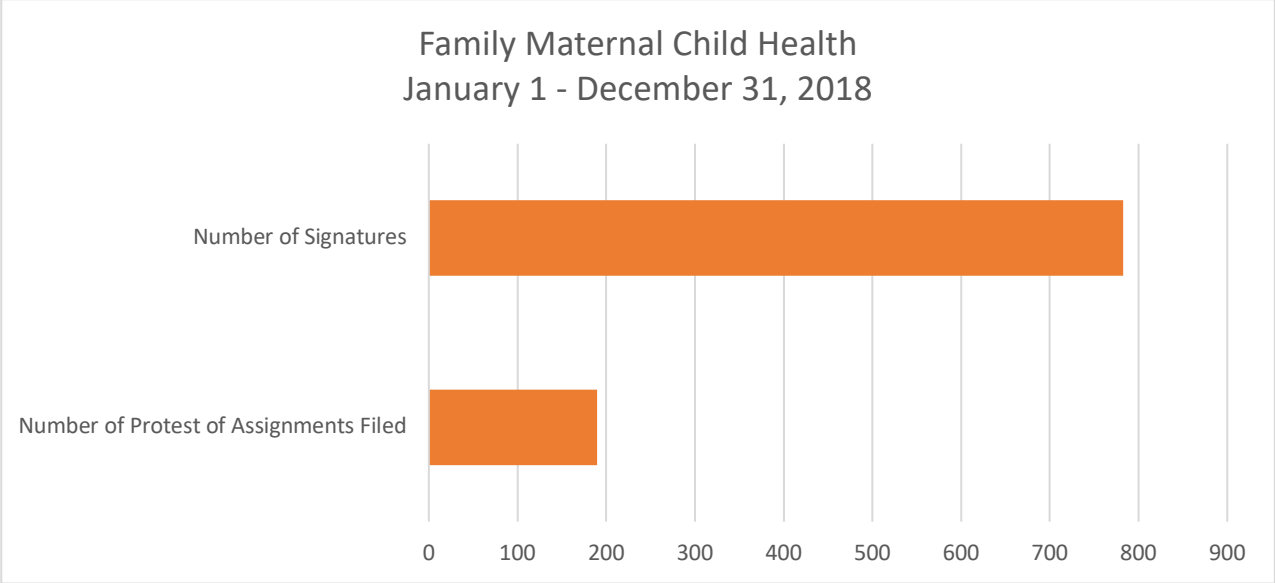
Figure 5: Reason for POA in Maternity / GYN / Newborn / Neonatal ICU:

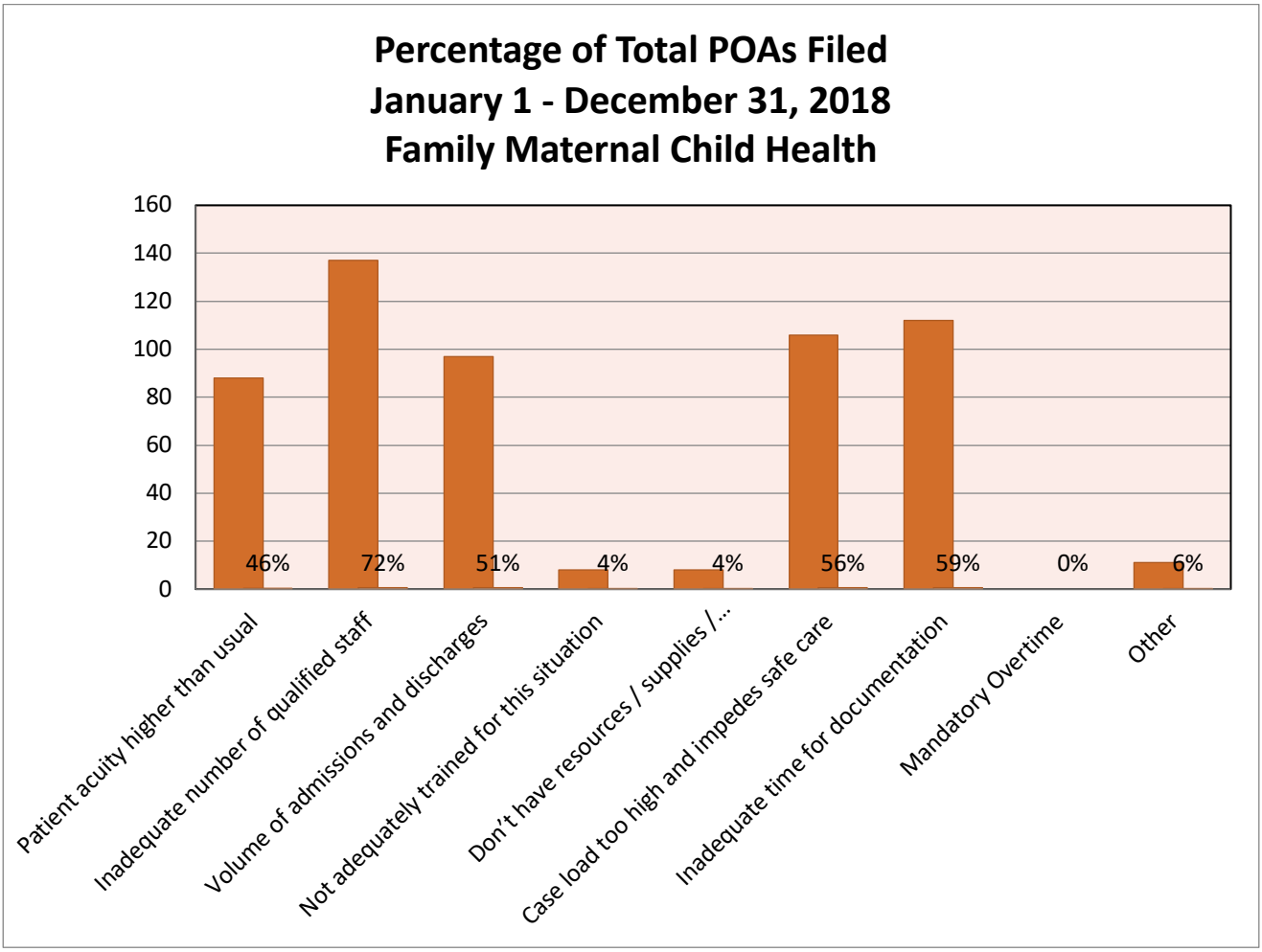
Family Maternal Child Health
January - December 2018
Reason for Protest of Assignment
POA's = 190
Signatures = 783



Patient Acuity	No. of Qualified Staff	Admissions and discharges	Not Adequately trained for situation	Lack of Resources	Case load too High	No time for Documentation	MOT	Other
18%	30%	10%	2%	7%	17%	10%	0%	6%

*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.


Family Maternal Child Health
January 1 - December 31, 2018
Number of Signatures
Number of Protest of Assignments Filed
0
100
200
300
400
500
600
700
800
900


Percentage of Total POAs Filed
January 1 - December 31, 2018
Family Maternal Child Health
160
140
120
100
80
60
40
20
0
46%
72%
51%
4%
4%
56%
59%
0%
6%
Patient acuity higher than usual
Inadequate number of qualified staff
Volume of admissions and discharges
Not adequately trained for this situation
Don't have resources / supplies /...
Case load too high and impedes safe care
Inadequate time for documentation
Mandatory Overtime
Other

The **one hundred and ninety (190) POAs, supported by seven hundred and eighty three (783) signatures,** filed at NYPH between January 1, 2018 to December 31, 2018 indicates that there are consistent issues throughout the hospital in the Maternity / GYN / Newborn departments that include::

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

Table 5: Other Reason for POA in Maternity / GYN / Newborn / Neonatal ICU

FMCH Other:
Inadequate # of qualified Staff, acuity higher than usual, case load too high impedes care, inadequate time for documentation: Start of shift with 4 RNs, 1 RN with 6 couplets and 3 RNs with 5 couplets. 9 discharges, 3 admissions. 7 c/s, 3 circumcisions, triple antibiotics. 1 pt on droplet isolation precautions.
Not adequately trained for situation: Pulled from normal unit (L & D) to work in TN due to staffing issues. Not trained for the TN. Only WBN.
Inadequate number of qualified staff: (Multiple occurrences) Only TN nurse in house tonight.
Inadequate # of qualified staff, volume of admissions and discharges, don't have resources needed, case load too high & impedes safe care, inadequate time for documentation: 7 RNs including charge RN and triage RN. 23 pts, 2 c/s, 6 NSVDs, 3 baby nurses, unsafe staffing ratios unable to meet AWHONN standards all day.
Inadequate # of qualified Staff, don't have resources needed, case load too high impedes safe care, volume of admissions and discharges, inadequate time for documentation: Against AWHONNs standards for safe nursing care. Only 4 RNs on unit including charge RN and triage RN. Unsafe staffing ratio.
Insufficient # of Staff: No RN available for newborn care.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, caseload too high impedes safe care, inadequate time for documentation: 2 RN on floor for 6 couplets each. 1 with blood transfusion and 1 fresh c/s. 1 on antibiotics, 1 hemorrhage. 1 baby with unstable blood glucose. 8 discharges, 5 admissions, 6 c/s, 1 WBN with orientee.
Inadequate # of qualified Staff: 5 nurses on unit. One of those nurses staying after 12.5 hour shift will go on break and we will be 4 nurses. PACU patient with tachycardia. Preterm patient in active labor. 2 units blood transfusion, triages.
Inadequate # of qualified Staff: (Multiple occurrences) Multiple RNs with at 6 – 8 couplets each and complex patients.

Inadequate # of qualified staff, case load too We are 6 RNs currently on high and impedes safe care: unit, including 1 Rn who is working 24 hours and will need to take a break after her 16 hours for a couple of hours. Another RN who is staying only until 1 pm. At this time we will be down to 4 until another nurse comes which brings us each up to 5 nurses. Multiple triages and admissions.
Inadequate # of qualified staff, patient acuity higher than usual, inadequate time for documentation, volume of admissions and discharges: 6 RNs for 12 patients with 2 patients in waiting area. 1 RN floated from postpartum unit with no L and D experience. 1 pt just delivered, 1 pt pushing, 5 patients in active labor, 1 post c/s, post USVD, multiple triages, 1 induction.
Inadequate # of qualified staff, not adequately trained, acuity higher than usual: I have been assigned a patient with critical level of care, and I am not adequately trained for these types of patients. The patient was assigned a CCOB-trained nurse who had to leave the unit at 5 pm, thereby requiring me to assume care of the patient for the remainder of the shift. I made it clear to both my charge nurse and my PCD that I do not feel comfortable taking care of this patient, and I was told that I have adequate support to take care of her so my assignment remained unchanged and I must assume care of the patient until the end of the shift.
Inadequate # of qualified staff: 4 admissions since 7 pm, only 1 nursing assistant 7 pm – 11 pm. No unit clerk 7 pm – 7 am. 1 nursing assistant pulled at 2 am. 1 patient on contact isolation, 1 on wound VAC, 1 on antibiotic, 14 mother 15 babies by 7 am.
Inadequate # of qualified staff, patient acuity higher than usual, case load too high impeding safe care, volume of admissions and discharges high: (Multiple occurrences) Inadequate number of L & D nurses for the number of patients. Many occurrences of nurses having 2 patients each and pt's complex
Inadequate # of qualified staff, not adequately trained for situation: 4 scheduled nurses with 1 nurse orienting. Day shift nurse staying to help with staffing. 1 nurse from postpartum also is not L and D trained.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: Received 7 patients. 1 pt to go to the OR that needs a baby nurse. 1 Pt in labor with high BP's magnesium to start. 1 Pt for trial of labor. 1 pt on magnesium. 2 Triages. 1 for admission.
Inadequate # of qualified staff, caseload to high impedes safe care, volume of admissions and discharges high, acuity higher than usual: 4 patients on Pitocin, 1 28 week prolonged monitoring for 24 hours status post fall, 1 induction of labor, 2 stat c-sections, 1 NSVD, 1 neonate to be transferred to NICU, 2 add on C/S, multiple triages.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 6 RNs, 7th RN for overtime in at 11pm. 10 patients, several triages, 1 emergent c/s. 1 add on c/s. 1 postpartum vaginal delivery. 3 NSVDs, 1 neonate to TN, charge nurse needed to be charge and triage.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 7 L & D nurses. 1 PP RN floated. 2 C/S simultaneously. Only 1 scrub tech so charge RN had to scrub. 2 babies required PPV, 1 NICU admission. 1 pt on MgSO4. Not enough staff to safely tend to bath pts in ORs and the rest of the floor
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: Only 6 RNs, census 9. All patients on Pitocin, 1 on Mg, 1 R/O abruption, 1 to go to C/S, 2 NSVDs
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, inadequate time for documentation: 24 patients on unit, no additional beds available. 1 patient with

NG tube, 2 patients with elevated BP, 13 scheduled discharges. WBN received 6 admits, mothers remain in labor room- no beds on 3 RW
Inadequate # of qualified staff, case load too high impedes safe care, inadequate time for documentation, MOT: (Multiple Occurrences) Midwifery. Scheduled alone. Delay in attending to all of the needs of patients. OR Triage L & D and phone Triage.
Patient acuity higher than usual, inadequate time for documentation: Assignment: 4 couplets and 1 set of twins (total of 9 individuals). Small for gestational age twins requiring care seat testing. One newborn onQ4 Finnegan Scale due to maternal history of polysubstance abuse.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: We are extremely short staffed with no EMTALA nurse, the nurse assigned a one to one patient is assigned to two patients. The charge nurse has been forced to take an assignment due to limited staffing, and we only have one nursing attendant.
Inadequate # of qualified staff, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: Delay in admitting, discharging and attending to the needs of all patients
Acuity higher than usual: 1 R/O PE, 2 fully dilated and pushing. 1 possible abruption, charge RN has 2 patients. Multiple triages, 1 Induced to still come.
Inadequate # of qualified staff, case load too high impeding safe care. Inadequate time for documentation: 7 RNs including charge RN and 1 triage RN. I have a new orientee (2nd) week and 2 labor patients. My orientee requires a great deal of attention and my time devoted to her as well as to my other patients is compromised
Inadequate # of qualified staff: 6 RNs, 1 RN to be scrub tech 7 pm – 11 pm for 2 cases. All other RNs with 2 patients already. Charge RN covering triage and Baby RN in OR
Inadequate # of qualified staff, case load too high impedes safe care, inadequate # of ancillary staff: Float NA sent and she covered lunch breaks for 1:1s, No EMTALA nurse. No RN for scheduled OR case due to C/S from 10 central
Unable to adhere to AWOHNN Standards (Multiple Occurrences)
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: I have an orientee in her 3rd week of orientation, I am assigned two patients. 1 is 9 cm and the other pt is having variables. I cannot devote adequate time to my orientee. So far the entire orientation has suffered due to inadequate staffing. Another RN has another orientee with multiple patients causing suboptimal precepting.
Inadequate # of qualified staff, patient acuity higher than usual, volume of admissions and discharges: 16 patients on labor floor. All nurses doubled up with patient assignments. Acuity of patients higher than usual. 3 CCOB pt. No meal breaks. 4 cesarean sections. 2 twin deliveries. 2 pt with blood transfusions. No postpartum beds.
Inadequate # of qualified staff: (Multiple occurrences) Charge nurse required to triage as well.
Not adequately trained for situation, patient acuity higher than usual, case load too high impeding safe care: I am not a designated Critical Care Obstetric (CCOB) nurse, and I have been assigned a CCOB patient with a list of critical medical problems, and she requires medications I am not at all familiar with. The standard is to maintain a 1:1 CCOB nurse: patient ratio, and I am also assigned to take care of an antepartum patient while caring for CCOB patient.
Inadequate # of qualified staff, don't have resources needed, acuity higher than usual, case load too high impeding safe care, volume of admissions and discharges, inadequate time for documentation: No nursing attendants on duty. Nurse have to do assignments on Mom and Babies and do every 4

hour vitals. 10 c-sections of which 3 are new. 2 patients are on antibiotics, 6 admissions, 1 antepartum patient. No IV poles, and no IV Pumps. No more laundry linen for patients.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care. Each nursery should have at least 1 RN and 1 NA in each nursery. Tonight we have 1 RN in each nursery and no NA in either nursery. 5 C nursery has 1 photo baby and 1 high risk baby that requires frequent transferring for infant feeding. 6 c has 1 photo baby therapy
Inadequate # of qualified staff: (Multiple Occurrences) unsafe staffing in both nurseries. No NAs in both nurseries and acuity is high. Same situation on both 5th floor and 6th floor
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impeding safe care: A third nurse was send to assist with the delivery in triage however the third nurse rushed neonate to the transitional nursery to initiate resuscitation for the newborn, thereby leaving only two nurses in triage. One nurse remained to assist delivery and care for the fresh postpartum which requires 1:1 (placenta had not yet been delivered, patient had no IV access and there were two admissions including a patient with twin gestation, preterm, and advanced dilation, who was receiving a magnesium sulfate bolus, which requires 1:1 care, for a total of 5 patients in triage. We needed five nurses at that time.

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

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

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

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

Post Partum / Mother Baby

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

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

Newborn Nursery

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

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

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

Labor and Delivery / Triage

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

5) Level II, Level III and RPC perinatal care services shall maintain a nursing staff that is appropriately trained and adequate in size to provide specialized care to distressed mothers and infants**. 10 NYCRR 405.21(d)(2)(iv);**
6) **AWHONN Guidelines for Professional RN Staffing for Perinatal Units: Triage** "Obstetrics triage is a process that occurs in the ED and/or on the perinatal unit….OB triage and ED triage differ in that in OB triage refers to an initial interview and assessment as well as care in the triage unit for several hours prior to disposition" **(2010, p. 7);**
7) **EMTALA:** EMTALA imposes specific obligations on healthcare providers who offer triage care to perform a medical screening examination to determine whether an emergency medical condition exists (including both the mother and the fetus), to provide necessary stabilizing treatment when an emergency medical condition exists, and to stabilize the patient, or, if the healthcare provider certifies that the benefits of transfer outweigh the risks, arrange for proper transfer to another hospital;
   Each maternity patient, when present in a labor, delivery, birthing room or birth center shall be under the care of a registered professional nurse available in accordance with the patient's needs **10 NYCRR 405.21(e)(3)(iv);**

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

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

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

10) **Federal Regulations**
   EMTALA imposes specific obligations on healthcare providers who offer triage care to perform a medical screening examination to determine whether an emergency medical condition exists (including both the mother and the fetus), to provide necessary stabilizing treatment when an emergency medical condition exists, and to stabilize the patient, or, if the healthcare provider

certifies that the benefits of transfer outweigh the risks, arrange for proper transfer to another hospital;

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

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

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

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

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

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

HR.01.05.03

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

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

HR.01.06.01

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

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

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

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

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

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

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

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

1:5-6 - postpartum patients without complications with no more than 2 to 3 women on the immediate postoperative day who are recovering from cesarean birth;
1:3 - postpartum patients with complications but in stable condition;
1:6-8-Newborns requiring only routine care;

Newborn Nursery

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

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

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

Labor and Delivery / Antepartum

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

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

Labor and Delivery / Intra-partum

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

- **1:1** Women in with medical or obstetric complications
- **1:1** 2nd stage of labor
- **1:1** Women receiving oxytocin
- **1:1** Women choosing no pain relief or medical interventions
- **1:1** Women whose fetus is being monitored via intermittent auscultation
- **1:1** Women using birthing balls or hydrotherapy
- **1:1** IV magnesium
- **1:1** Coverage for initiating epidural anesthesia
- **1:2** Women in labor without complications

- **2:1** Caesarean delivery (1 for mother; 1 or more for infant/s)
- **2:1** for vaginal births (1 for mother; 1 or more for infant/s);

Federal Regulations

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

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

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

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

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

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

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

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;

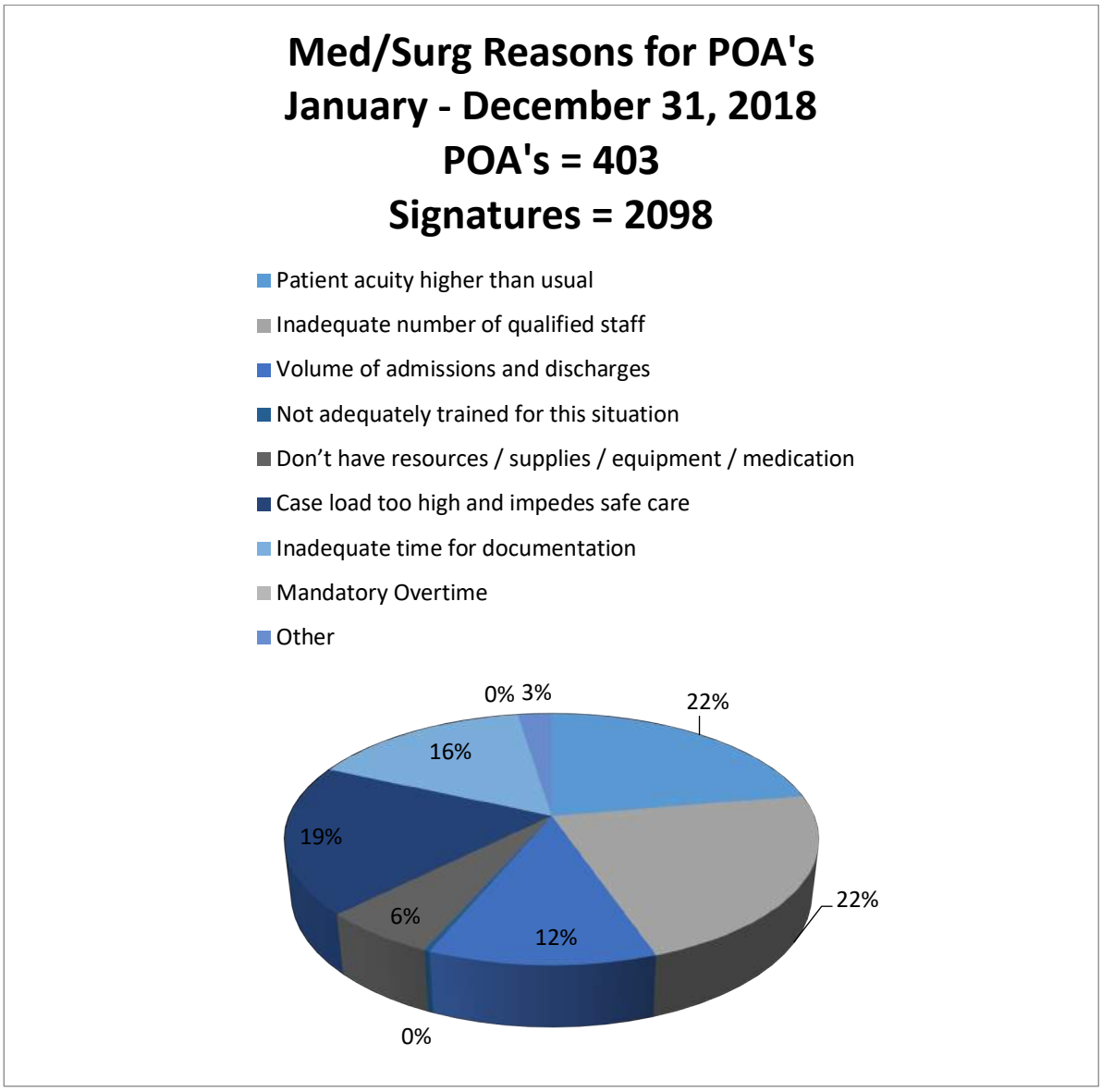
15) **National Association of Neonatal Nurses (NANN)** declares its position on nurse-to-patient ratios as follows "…at all times neonatal specialty care requires a minimum of two (2) registered nurses to four (4) intensive care neonatal patients with neonatal expertise and training., and two (2) registered 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 NYHPH are committed to improving delivery of care with the following recommendations:

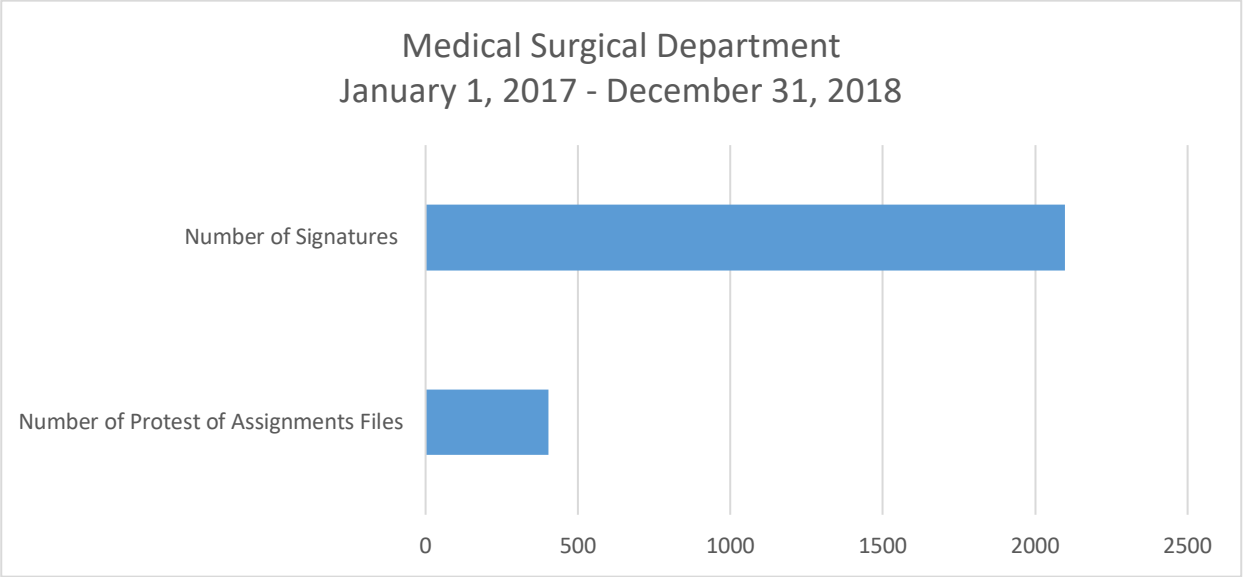
- Increase maternity and newborn care and Neonatal registered nurses, licensed practical nurses and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation, agreed upon staffing guidelines and the Guidelines for Professional Registered 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 NYPH'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 NYPH's patient population;
- Provide adequate equipment to meet all patient care needs.

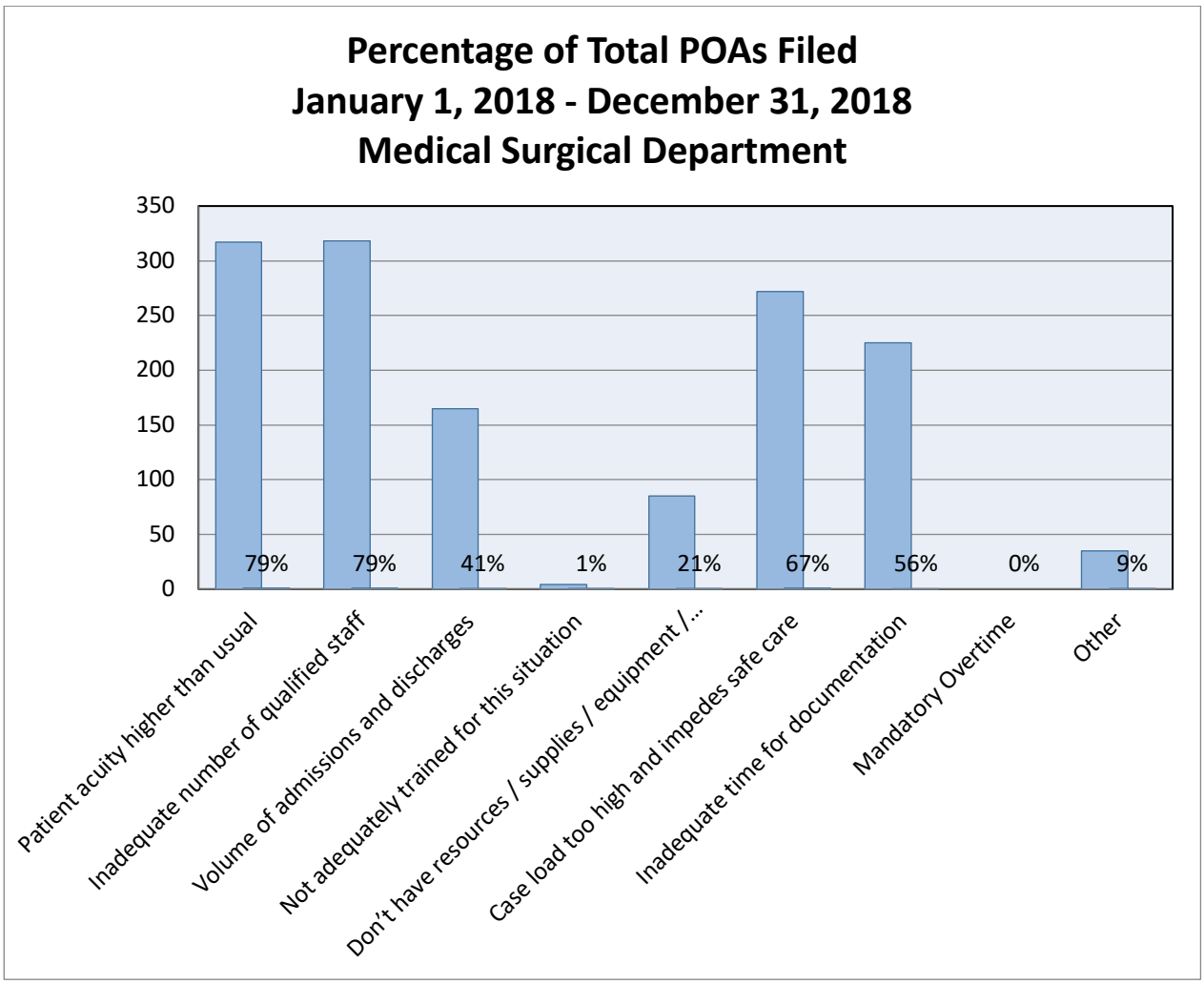
Figure 6: Reason for POA in Medical / Surgical



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%	22%	12%	0%	6%	19%	16%	0%	3%

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


Medical Surgical Department
January 1, 2017 - December 31, 2018
Number of Signatures
Number of Protest of Assignments Files
0
500
1000
1500
2000
2500



The **four hundred and three (403) POAs, supported by two thousand ninety eight (2,098) signatures, POAs** filed in NYPH between January 1, 2018 – December 31, 2018 indicates that there are consistent issues throughout the hospital in the Medical / Surgical / Oncology /Neurosurgery Departments that include:

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

Table 6: Other Reasons for POAs in Med / Surgical / Oncology / Neurosurgery

Other: Medical/Surgical
Acuity higher than usual, volume of admissions and discharges, not adequately trained: 30 patients, started with 26. 2 patients discharged and 6 admissions, 3 of them unstable, 1 pt on hourly F/S-glucose. 1 patient actively bleeding, 1 patient with runs of vtach, s/p open. 1 patient admitted in withdrawal on CIWA, 2 1:1's 1 pt on 15 minute Vitals on telemetry. Unsafe situation
Inadequate # of qualified staff, acuity higher than usual, don't have resources needed, case load too high impeding safe care, inadequate time for documentation: 1 RN leaving prior to end of shift, 10 DNR, 8 tele patients, 3 PI, 3 MO, 2 pts with restraints (mittens), 1 foley, 1 urostomy, 2 NG tubes, 1 hospice, 2 PEGs, multiple complete cares, 32 high fall risk.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 30 patients on the unit, 2 Q 15 min, 2 1:1 PDA, 1 patient has behavioral problems and violent towards security and staff. 1 NA on the floor. 12 complete cares.
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: As per NYSNA guidelines this census requires 7 RNs, 5 on duty. Telemetry patients, 4 DNR/DNI pts, 15 complete care, 15 in bed alarm, 5 on observation. 2 2:1, 2 1:1, 1 wound care, 5 patients foley catheter
Inadequate # of qualified staff: (High number of occurrences) Staffing guidelines not met
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: 29 patients, 5 RN's, 10 completes, 4 1:1's, broken blood pressure machine, 4 patients with wounds, patients going for tests off floor.
Inadequate # of qualified staff, don't have resources needed, inadequate time for documentation, acuity higher than usual: Guidelines for census of 31 requires 7 and only have 6 RNs. High acuity, multiple bed alarms, high risk for falls, 2 patients on q15 min check. Pt with security, 2 patients with 1:1 PDA, 2 patients on comfort care. 1 patient on EEG monitor, 1 patient on heparin drip, 1 patient on PCA, 11 complete care.
Acuity higher than usual, case load too high impedes safe care: Very high acuity. 1 patient placed on security watch, another placed on 1:1 for risk of elopement after 12midnight. 1 pt receiving blood products. 1 patients on max observation (had to relieve both N/A's and 1 N/A on the floor). 3 wound care, 6 telemetry, 1 patient in restraints, 1 patient on trach with frequent suctioning, 8 isolation, 4 on bed alarms.
Inadequate # of qualified staff, volume of admissions and discharges, care load too high impedes safe care, inadequate time for documentation, acuity higher than usual: Many discharges and admissions, several complete chemo plans. No time to chart. Only 1 NA. No supplies, no sheets, patients not happy.
Case load too high impeding safe care, acuity higher than usual, not adequately trained for situation: 28 patients, 5 patients on 1:1 observation, 1 patient needs to be on 2 R east but bed not available, 8 patients on isolation, 4 patients on telemetry, 3 patients with foley catheter, 5 patients requiring wound care, 2 patients on BIPAP, 2 patients on heparin drip, 1 patient on comfort care.
Case load too high impeding safe care, patient acuity higher than usual, volume of admissions and discharges: Many complete care and had to relieve 3 of the 5 1:1's leaving unit with no floor coverage at times. 6 1:1's on unit, needing break relief (3 done) 3 more to do. No unit assistance. 3 quick admissions. Starting census 25 now 31 with 1 patient in alcove.
Not adequately trained for the situation, don't have resources needed: At change of shift, day shift charge nurse informed me that there was a patient in the ED that needed an infusion of Rituximab,

and that they were unable to administer the infusion in the clinic due to the agitation of the patient. The patient was placed on a security 1:1, and I was told that after discussion with Ms. Salabay and Marga Holland, that the patient would be going to the PICU to be sedated for the infusion. I then received a call from the neurology MD stating the patient was not aggressive, and was stable for a 2 bedded room. Our past experiences with patients with this condition has been that these patients can be intermittently aggressive and violent, and this presents physical threat to nursing staff as well as the other patient and family in the room. I adamantly expressed my concerns regarding the safety of the nurses and was told there was nowhere else for the patient to be placed. I explained that we were not able to sedate patients, nor are we able to apply any type of physical restraint, increasing risk of injury to any staff caring for the patient. My concerns for the safety of the nurses on the unit were disregarded.
Inadequate # of qualified staff for the acuity of patients: (Multiple occurrences) Complex patients or complete care patients
Inadequate # of qualified staff, acuity higher than usual, caseload too high impeding safe care, inadequate time for documentation: Inadequate staffing for census of 27 with 10 patients on telemetry, 1 trach patient, 7 isolations, 5 patients on 1:1 observation, 2 Q15 minutes, 4 patients with wound care.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed: Inadequate response to nurses request for assistance to threatening behavior by a patient. Continuous reinforcement needed by staff nurses to onsite supervisors to get situation safely resolved. Had 1:1 security, 5 falls risk, droplet contact, heparin drip, 4 aggressive patients.
Inadequate # of qualified staff, case load too high impeding safe care: Only 8 nurses, charge nurse with 3 patients. 4 Nurses called off unit to take a class. Charge nurse covering up to 6-8 patients for 2 hours. Many admits, no nurses.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: 3 vents, 2 stepdowns, 1 trach collar, 2 spinal drains, 3 restraints, 6 isolations, 10 telemetries, 3 EEG, 1:1 observation, 20 total cares, 1 chemo, 1 plex
Inadequate # of qualified staff, case load too high impeding safe care, don't have resources needed, inadequate time for documentation: Only one ICU tech on the floor for 27 patients. No ICU tech from 7 am – 8 am on the floor. No ICU tech on the floor from 1 pm – 3 pm as she needs to release 1:1 & take her own break.
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care, don't have the resources needed: 4 telemetry patients, 5 isolation patients, 1 patient suicidal, 1 patient on elopement, 6 patients DNR/DNI, 1 patient with PEG, 1 patient on Q15 min check, 3 patients on hemodialysis, 1 patient on TPN, 3 patients with PICC, 1 patient on CIWA.
No adequately trained for the situation, acuity higher than usual, volume of admissions and discharges: 24 patients, 1 transferred to ICU at 11 pm. Nurse with this patient from 7 pm until 11 pm rapid response @ 11:10 pm. Patient placed on BIPAP and continuous O2 sat monitor. High acuity, high activity, only 2 NA's on the floor. Unsafe assignment.
Inadequate number of ancillary staff, acuity higher than usual, volume of admissions and discharges: 5 patients on max observation 2 are suicidal and the other 3 for safety. Nursing attendants on the unit taking meal breaks and relieving 4 of the 5 for their break relief. Only 5 nurses high acuity on the floor and high activity.

Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, done have resources needed, case load too high and impedes safe care, inadequate time for documentation: 8 step down patients, 3 mechanical vent patients, 2 patients on HFNC, 2 patients on PCA, 1 patient on continuous BIPAP, 2 chest tubes, 2 patients on CIWA protocol, 2 patients on heparin, 3 patients on protonix drip, 1 patient on dopamine, 12 patients on telemetry, 2 patients discharged at change of shift, 6 admissions, 2 patients on close or maximum observation (8 nurses) (Similar scenario two days later)
Inadequate # of qualified staff, case load too high impedes safe care, acuity higher than usual: 10 telemetry patients on the floor with 1 broken, and none more available in the hospital as per tele, so one patient without. 2 agency nurses on the floor, 4 pressure ulcers, 1 PCA, 1 PICCS with blood draws to do. We have 5 1:1's with cluster requiring 6 reliefs from our 3, meaning each will be off the floor for 3 hours each. Not including cluster plus the 1:1's, we still have 11 totals on the floor. 1 patient receiving IVIG x 3 doses, receiving multiple rate changes. We had 2 admissions from the ER plus 1 tx. Needed 9 nurses for the census. 35 patients on the floor at beginning of shift.
Case load too high impedes safe care, acuity higher than usual, volume of admissions and discharges: Arrived to an emergency Patient on security watch who pulled oxygen off wall and attempted to charge at security. All patients on oxygen had to be given cylinder in the room-patient placed on 4 point restraints. 3 1:1s only 2 N/As on the floor to give breaks. No help from nursing office for break leaving the floor without an attendant for long periods of time. No N/A after 11 pm. Split with ICU
Inadequate # of qualified staff, acuity higher than usual, don't have resources needed, inadequate time for documentation: Patient admitted from ED with pediatric sized trach, requiring suctioning. Equipment to suction not available on unit. Extra trach not available on unit. Comfort care patient also requiring frequent oral suctioning.
Inadequate # of qualified staff, case load too high impeding safe care, inadequate time for documentation: (Multiple occurrences) during a shift multiple step down patients, multiple lung transplant patients, multiple trached patients, patients on drips, close observation patients, patient/s on ventilator
Inadequate # of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 5 patients going for invasive procedures, pts on PEG, SP cath, dobutamine, trach needs suctioning frequently. BIPAP, 3 foleys, 2 patients on restraints. 1 patient on 1:1 (restless and agitated). 10 central lines, 20 total drips including dobutamine, dopamine, heparin, Lasix, milrinone, IV fluids. 4 patients with pressure ulcers needs turning @2h, 33 patients on I and O's. 3 patients on telemetry, 9 isolations.
Inadequate time for documentation, acuity higher than usual, volume of admissions and discharges: (Multiple occurrences) Multiple drips, majority of patients on telemetry monitoring, high risk for fall.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impeding safe care: 28 patients plus admissions. Inadequate time for 4 orientees. 7 SD patients. 1 Vent, 6 hi flows. 1 chest tube.
Inadequate # of qualified staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Six admissions from PACU back to back. No NA/Tech after 11pm. 1 PCA pump, 1 Telemetry, 2 foley catheters, 1 blood transfusion, 4 total cares, 1 wound vac, 2 JPs. (2 nurses)
Inadequate # qualified staff, acuity higher than usual, case load too high impedes safe care: No Aides or Techs on floor 36 patients. (Multiple Occurrences)

Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation: Staffing guidelines not met for 2 months. Multiple patients on telemetry, multiple total care patients, patients to feed.
Multiple patients high risk for fall and injury. No staff available for new maximum observation of patient. 11 admissions during our shift.
Inadequate # qualified staff, acuity higher than usual, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Four trach patients, one vent, three pressure ulcers, 3 heparin drips, one insulin drip, one chest tube, six step downs, two thymo infusions, one PRBC transfusion, two DNR/DNI requiring emotional support, one patient with restraints, one patient 1:1 observation.
Acuity higher than usual, case load too high impeding safe care: New admit to unit resulting in a fall after patient climbed out of bed. Patient placed on 1:1 leaving unit with no N/A on the unit placing all other high risk fall patients at higher risk.
Acuity higher than usual, volume admission and discharges, case load too high impeding safe care, don't have resources needed: 23 patients, 10 BMT, 12 oncology and off service. Day 0 Transplant and day 11 transplant. Multiple chemotherapy infusions with patients reacting to infusions. Multiple blood draws, blood product infusions. 2 total patients. Close monitoring patients. Close monitoring patients, multiple VS Q1/2 hour to 1 hour monitoring
Inadequate # of qualified staff, acuity higher than usual, not adequately trained. Just one NA on the floor. 17 complete patients, High CIWA, 1 security watch, 4 1:1 maximum observation, 2 vents/trach, 16 high risk for falls.
Inadequate # of qualified staff, acuity higher than usual, don't have resources: 37 patients on floor with only 8 nurses, per staffing grid we are to have 9 nurses. We have two patients on restraints. 9 patients on isolation, 7 on telemetry, 4 with PCA, 2 with central lines, 3 with foley, 4 on BIPAP. 14 total care patients on the floor. Supplies had to be ordered as IV fluids, IV kits, syringes not in stock on the floor. We had 1 unwitnessed fall (MD, and supervisor notified) who also wanted to call 911 because room is cold even though engineer has gone to room multiple times in the week. 1 Patient became agitated and security had to be called.
Don't have resources needed, inadequate # of qualified staff: Inventory was done in am but still missing 11 items required time off floor to find. 1 Patient at start of shift noted angry and agitated requiring multiple calls to team. Multiple bed moves being made. Floor acuity high. 1 patient with blood transfusion at start of shift ended up having a reaction. 2 patients on PCA. 1 transfer received requiring suctioning multiple times. Another admission came confused and anxious. 9 nurses needed only had 8.
Acuity higher than usual, volume admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Only 7 RNs, giving chemo on 11 central at start of shift over 2 hours. Though had a chemo spill had to go up and down to 11 central and 6 tower. Access port a cath on 6 tower. 2 discharges at start of shift. 4 admissions booked at 7:30am. BMT x 4, oncology x 7, Heme x 5, x1 OMFS, ortho x3, med x1, 1 total care. Multiple transfusions. Multiple line changes. Multiple lab draws. 1 reaction to cells. X2 runs of electrolytes. Change of staff.
Inadequate # of staff: (Multiple Occurrences) patients receiving multiple chemo 4 – 8 patients. Also Multiple Occurrences of multiple BMT patients of 3 up to 8, multiple oncology patients up to 10 and off service patients 10 – 11 with patients receiving chemotherapy and blood products.
Inadequate # of staff, volume of admissions and discharges, case load too high impeding safe care, inadequate time for documentation: Census at 7:30 pm 20 plus 1 admission, 1 transfer, 1 possible

discharge. 2 BMT patients, 10 oncology patients, 8 off service patients. Multiple blood products ordered for patients, patients receiving chemo, unstable watcher patients x3. Low staff. Situation is unsafe.
Inadequate # of qualified staff, case load too high impedes safe care, inadequate time for documentation: 18 nurses scheduled. 22/23 needed. 1 co-charge (should have 2). 2 RNs in fast track should have 3. 3 Rns in A/B should have 4. 1 RN working in a pool by herself. No Sick calls. High patient volume. Inadequate coverage for lunch breaks. Situation unsafe. Staffing numbers inadequate for an infusion center caring for a high volume of patients many of whom require close observation and RN professional assistance.
Inadequate # of qualified staff, case load too high and impedes safe care, volume of admissions and discharges, acuity higher than usual, inadequate time for documentation: 9 discharges, 6 admissions, 7 total care patients requiring turning and positioning. 11 central lines, 8 patients with drains, 5 patients with ostomy. 3 heparin drips. 3 PCAs, 1 patient on bed alarm, 1 transfusion. 1 Fistula, 2 pleurx, 2 telemetry.
Acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 17 patients, 2 step down patients, 4 patients on tele monitoring, multiple patient's high risk of fall, confused patient on 1:1, multiple patients receiving blood products. New Transfer on ketamine drip. Chest tube and pain. Newly transplanted patient.
Patient acuity higher than usual: (Multiple Occurrences) Patient 1 – 3 on ketamine. OR patients getting Rituximab.

- 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.

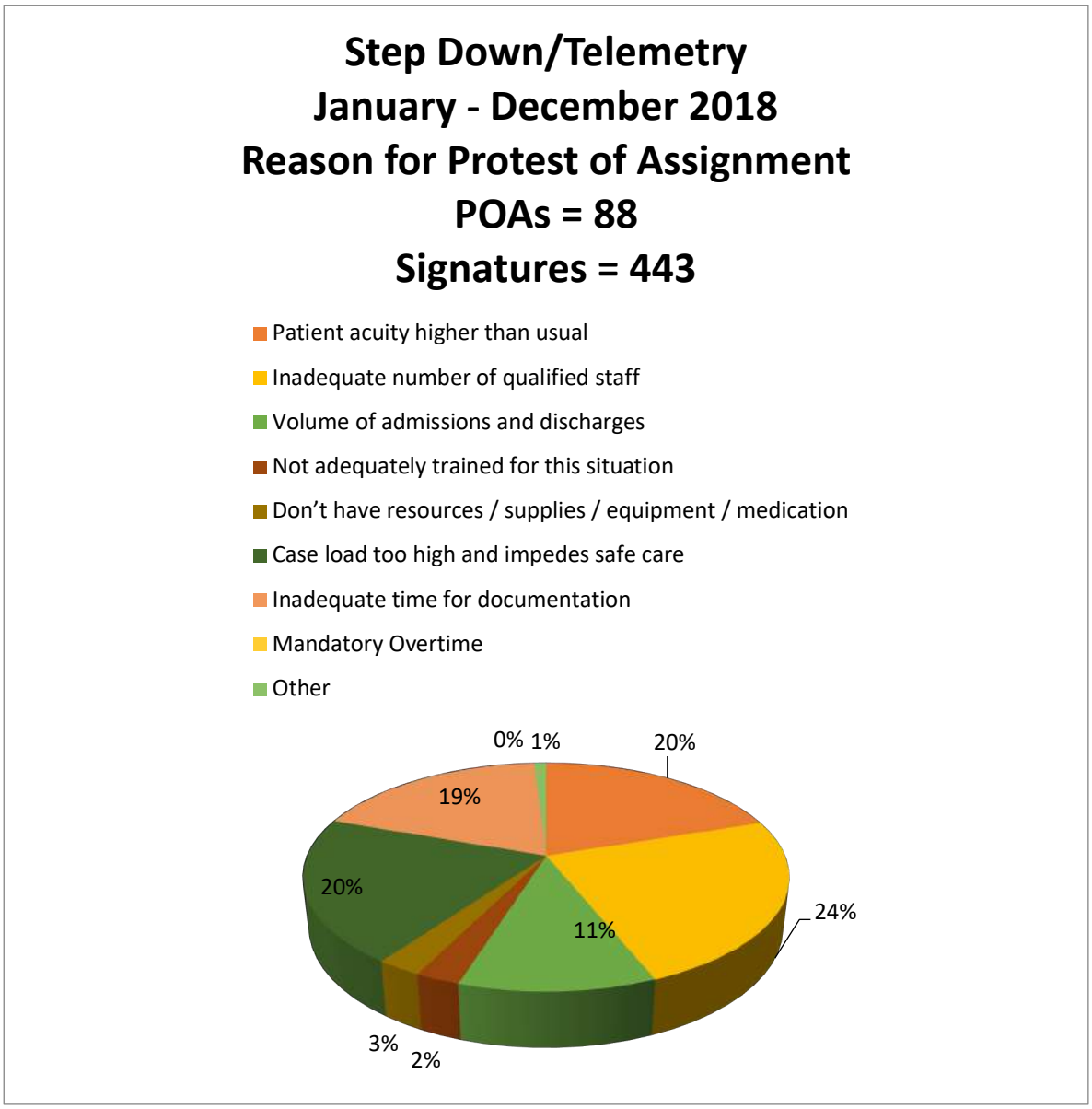
29) **New York Code, Rules and Regulations, Title 10 Part 405 (Hospital Minimum Standards**) requires an adequate number of staff to ensure immediate availability of a registered professional nurse for bedside care of any patient when needed **(405.5 (a)(2));** timely assessment and reassessment **(405.5 (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 NYPH are committed to improving delivery of care with the following recommendations:

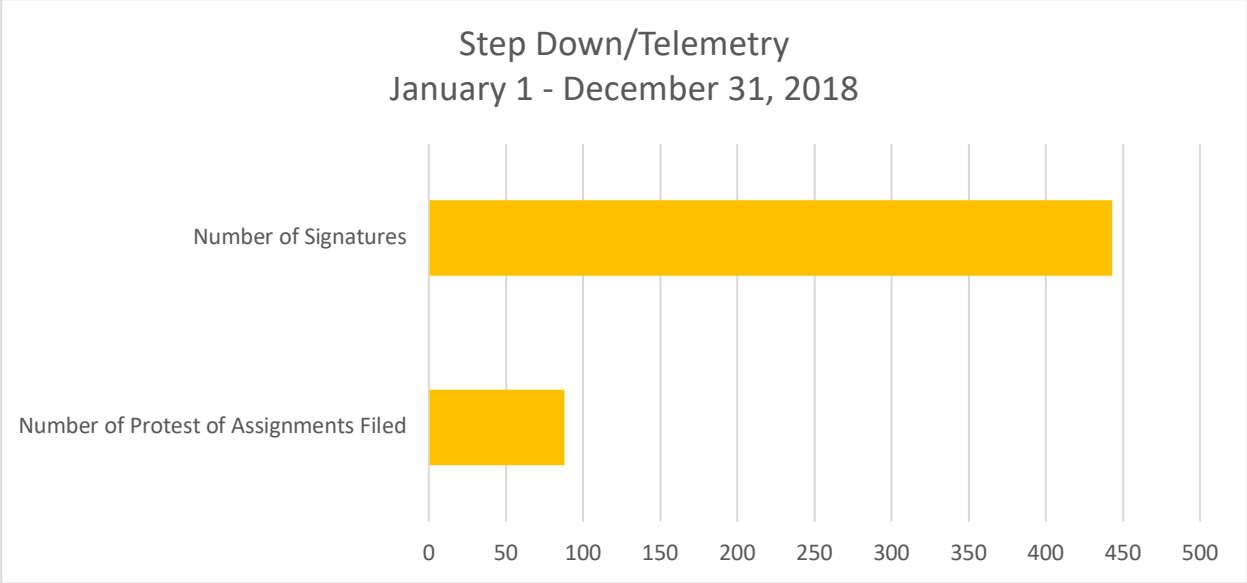
- Increase medical-surgical care registered nurses, licensed practical nurses and ancillary staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation, agreed up staffing guidelines and the Guidelines for Professional Registered Nurse Staffing 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 NYPH's patients based on that organization's mission, values, and vision;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Medical / Surgical Care, while concomitantly meeting the individual needs of NYPH's patient population

Figure 7: Reason for POA in Step Down/Telemetry

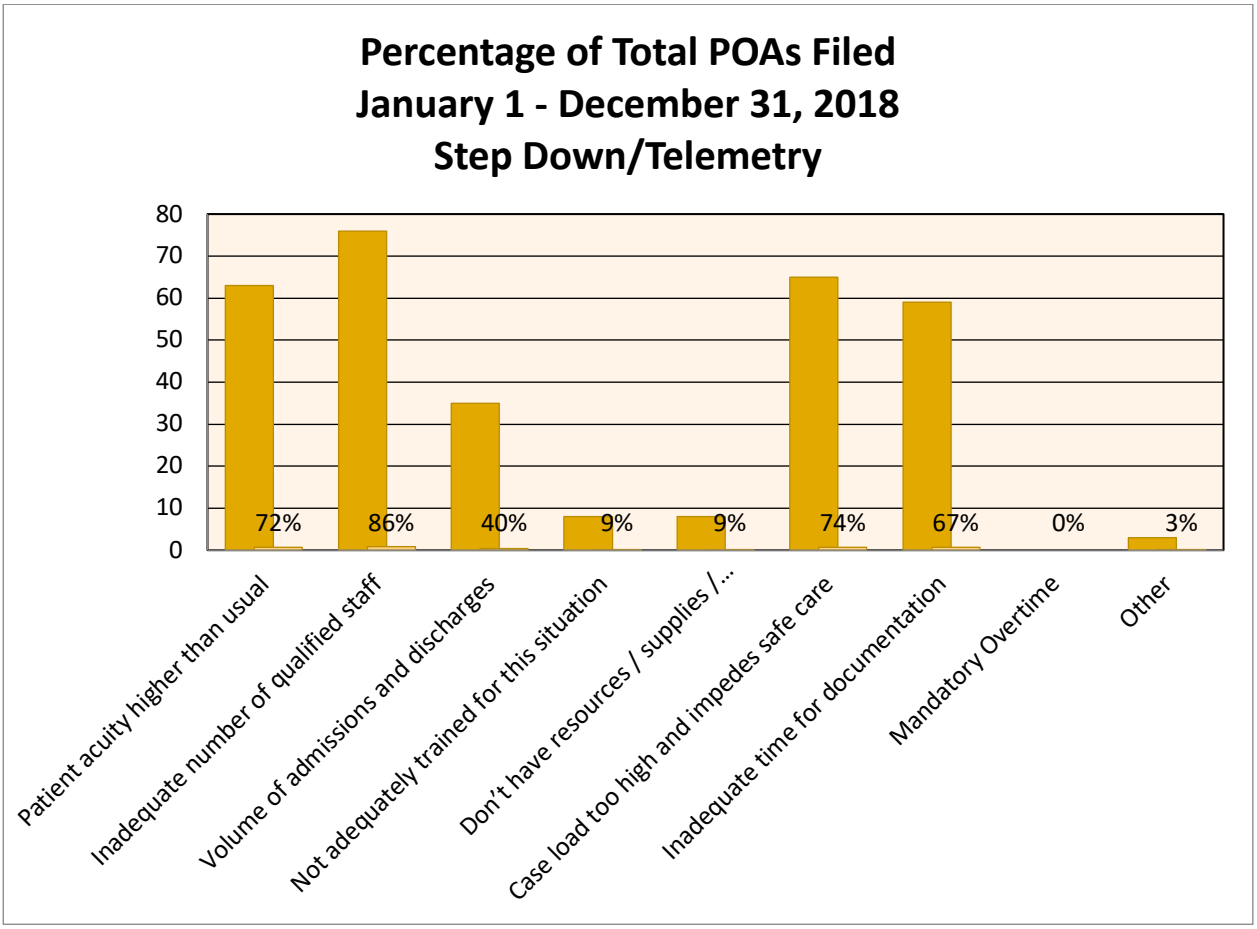


Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
20%	24%	11%	2%	3%	20%	19%	0%	1%

***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.**



Percentage of Protest of Assignments Filed for each categorical Reason in this specialty area



The **eighty eight (88) POAs, supported by four hundred and forty one (441) signatures,** filed in New York Presbyterian Hospital between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the hospital in the Step Down/ Telemetry Departments that include:

- Inadequate staffing for acuity, caseload of the patient population, as well as admission volume, discharges.
- Potentially unsafe conditions caused by lack adequate numbers of qualified staff to address the needs of the patient population.
- Inadequate time for patient care and documentation.

Table 7: Other Reasons for POAs in Step Down/ Telemetry Department

Reasons for POA: Step Down/ Telemetry
Inadequate # of qualified staff, case load too high impeding safe care, inadequate time for documentation: 25 patients, 4 RNs, 1 trach collar, multiple high risk for fall, multiple complete care, 5 BIPAPS, patients on restraints, 2 patients on 1:1 observation
Inadequate number of RN Staff and Support Staff: (multiple occurrences) Inadequate staff based on guidelines and census (multiple occurrences of only 5 RNs)
Inadequate number of RN Staff and Support Staff: 1 ventilator, 1 maximum observation, 11 isolation, 1 alcohol withdrawal, 3 BIPAPs, 1 trach collar
Inadequate number of RN Staff: 25 patients, 13 complete care, 1 at high O2, 14 patients on telemetry, stroke patients with 3 hour neuro checks, 1 patient on CIWAA protocol, 1 observation, multiple patients high risk for fall and multiple 2 hour repositioning, 1 hospice patient
Not adequately trained: Floated, not trained for stepdown level care
Inadequate # qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care: 14 patients on telemetry, 11 patients on isolation, one vent, 1 trach, 6 BIPAP, 2 to come from ER. Several high risk for fall patients. 15 complete care req. 20 reposition. Patient with multiple pressure injuries. One RN float unable to adm and can only have med/surg pt (non stepdown). RN still must answer phone and call bells. Address needs of family and visitors.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: Only 4 RNs for 21 patients. Most patients are bed bound, incontinent and high risk for falls. Multiple patients on neuro checks. 12 patients on isolation, 3 patients on maximum observation, 3 patients on BIPAP, 14 patients on telemetry
Inadequate # of qualified staff acuity higher than usual, inadequate time for documentation, volume of admissions and discharges: 22 patients and 1 admission to come with 5 RNs. 3 BIPAPs, 13 isolations, 14 telemetry patients. 15 complete care bed bound patients requiring Q2h turning and positioning. Patient on 1:1 observation. 1 patient on Q15 checks. 3 blood transfusions, 2 patients on amiodarone drips, 2 patients on protonix drips.
Inadequate # of qualified Staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: We have 8 stepdown patients, 2 telemetry patients, 19

contact isolations. 3 droplets, 3 traches (one on vent). 2 with rectal tubes, one on TPN, 2 PCA pumps, one on insulin drip, one on heparin drip. 5 on tube feeds, 4 with chest tubes. 2 on chemo, one on BIPAP, 2 with wound vacs, one patient transferred to stepdown on high flow oxygen. 5 patients going to procedures. 22 high risk for fall. 15 pick line draws. One transfer this am for SICU. This floor has too high of an acuity not to be fully staffed.
Inadequate # of RN Staff and acuity higher than usual: (Multiple occurrences) 4 RNs with 18-24 patient census and patients with high acuity.
Inadequate number of qualified staff, acuity higher than usual, case load too high impeding safe care, inadequate time for documentation: 34 patients plus 1 admission. 17 Step down, 9 LVADS, 1 1:1, 3 trachs, only 10 RNs and 1 ICU tech on the floor.
Inadequate number of qualified staff, acuity higher than usual, don't have resources needed: Six step down patients, 2 1:1 observation of suicidal ideations. 1 pt watched closely for elopement 1 insulin drip. 1 heparin drip, 1 TPN, 1 RBC, 1 chest tube, 2 ileostomies, 1 thymoglobulin, 19 high risk for fall patients, 9 central lines, 2 pressure ulcers, 1 multi-visceral transplant patient
Inadequate # of RN Staff, acuity higher than usual, not adequately trained for the situation, case load too high impeding safe care: 9 nurses, 16 step downs, 1 vent, 8 trach, 11 LVADS
Inadequate # of RN Staff, acuity higher than usual, case load too high impedes safe care, volume of admissions and discharges, inadequate time for documentation: 21 patients, 5 RN's. 1 ventilated patient, 2 maximum observation patients, 1 with security officer. 12 complete care patients, 2 BIPAPs, 1 patient on mitten restraints. 3 tube feeds. Multiple high risk for fall patients. 15 telemetry patients. Admission with inadequate supplies.
Inadequate # qualified staff, acuity higher than usual, case load too high impedes safe care: 10 patients on telemetry. 7 isolation. One vent. One patient terminally removed from vent. 4 BIPAP. 4 patient on 1:1 active combative. Climbing out of bed two patients on CIWA. Several high risk for fall patients. One patient getting BID transfusion. 11 complete care patients needing repositioning. One patient on restraint. RN must still answer call bell with phone and address needs of visitor and families.
Inadequate number of Support staff, case load too high impedes safe care: Only 1 NA on the floor from 11:30 pm – 7:30 am. 12 total care patients. High fall risk patients. Seizure patient and heavy vent.
Inadequate number of qualified staff: 10 stepdown patients and 1 step down admission. 1 Vent. 8 VAD's and 1 VAD admission.
Inadequate number of RN Staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 1:1 NA float. 12 high risk fall patients. Cardiac arrest with post mortem care. RRT rapid response patient transferred to stepdown at 17:30. Admission received from 6th floor.
Inadequate number of qualified staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Six admissions from PACU back to back. No NA/Tech after 11 pm. 1 PCA pump, 1 telemetry, 2 foley catheters, 1 blood transfusion, four total cares. 1 wound vac. 2 JPs
Inadequate number of RN Staff and Support Staff: As per our grid should have 9 RNs only have 7. Have 11 total care patients. 33 patients on telemetry. 10 drips as well as 7 patients on multi-IV antibiotics.
Inadequate # of qualified staff, acuity higher than usual, case load high impedes safe care, inadequate time for documentation: I have patients on one to one watch. I have patient with chest pain, one on ventilator, one on CPAP, 1 on CIWA q4h, 2 patients out of control

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

34) 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);**

35) Hospitals shall have available at all times, personnel sufficient to meet patient care needs. **10NYCRR 405.2(f)(7);**

36) 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);**

37) 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);**

38) 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);**

39) 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."

40) **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));**

41) **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));**

42) **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));**

43) **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;"

44) **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;

45) **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;"

46) **Joint Commission. (2013). Standard LD.04.03.11** The hospital manages the flow of patients throughout the hospital;

47) 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;

48) **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;

49) 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.

50) (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.

51) **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;

52) **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));**

53) **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));**

54) **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;"
55) **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;
56) **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.
57) **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));**
58) **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);**

59) **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);

60) 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;"

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62) **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));**

63) 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;**

64) 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);**

65) **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;"

66) 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.

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

staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient; and a "registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available;"

12) **Industry standards for telemetry monitoring** require all telemetry unit patients be hemodynamically stable. Unstable patients and those with Acute Coronary Syndrome[1] should be managed in an intensive care or step-down unit. Industry standards also identify criteria for initiating telemetry monitoring on patients with various cardiac conditions, such as atrial fibrillation with rapid ventricular response[2];
13) **Industry standards for telemetry** require RNs on the unit to perform the following telemetry monitoring and documentation procedures:
    - Connect the patient to the telemetry monitor using a lead that best transmits the appropriate waveform;
      Set alarm parameters according to the individual patient's needs and/or the physician's specifications, and ensure that the alarm volume is loud enough to be heard at all times;
    - Keep alarms on at all times;
    - Obtain and attach a representative sample of ECG strips to the hard copy medical record every shift and when necessary to document any abnormality and intervention instituted;
    - Report any abnormalities to the physician;
    - Review the alarms each hour;
    - Respond immediately to any patient care issue.

14) **Industry Standards for Telemetry Monitoring** provides for a continuous ECG reading of the heart's electrical activity through external electrodes placed on the patient's body. Segments of the ECG data are automatically transmitted to a remote surveillance location. As the patient's electrical rhythms are transmitted, nurses need to continuously analyze the reading according to parameters programmed into the device. Some segments, such as rapid and slow heart rates or other symptomatic episodes, will automatically trigger an audible alarm;
15) **Industry Standards for Telemetry Monitoring** requires hospital staff who acknowledge the alarms and observe the telemetry data will be able to respond to the patient and provide immediate care should emergencies arise;
16) **Standards published by the American Heart Association (AHA)** advocate that each facility establish protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring, documentation of ECG changes, periodic documentation that alarms are set appropriately, and response to emergency and nonemergency cardiac events.
17) The **AHA** recommends that all staff assigned to telemetry units receive comprehensive training, including initial orientation followed by periodic competency evaluations, to ensure continued proficiency in critical elements of cardiac monitoring;

18) **AHA** also recommends periodic reviews of unit protocols, training curricula, and competency levels to determine if staff and patient needs continue to be met. This analysis should include reviews of staff performance, critical events, and patient outcomes;
19) The **AHA** recommends that staff assigned to telemetry units receive periodic refresher training on critical elements of cardiac monitoring;

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

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

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

The AARC recommends that health care organizations undertake efforts to assure that:
* Professionals responsible for application, adjustment and monitoring of ventilators, alarm systems and

airways, possess relevant education, and have undergone validated competency testing.
* Systems are in place to check ventilator and monitoring system performance before and during clinical use.
* All devices and systems are maintained according to manufacturers' specification. This includes medical gas systems.
* A tracking system is in place to identify, analyze and remedy all ventilator-related incidents that lead to serious injury or death.
* Protocols for the application and discontinuance of mechanical ventilation are in place.
* A mechanism is in place to track outcomes of all ventilator patients.
* Organized, periodic, ventilator-related continuing education is accessible to those professionals responsible for the many components of care directed to ventilator patients.

The AARC recommendations are in-line with the following risk reduction strategies identified by JCAHO-accredited organizations that experienced a sentinel event related to ventilators:
1. Improve and expand staff orientation and training on ventilators.
2. Upgrade alarms and monitoring systems on ventilators.
3. Institute team training.
4. Establish new processes for alarm testing and verification of alarm settings.
5. Establish new or redesigned alarm response procedures.
6. Redesign rooms or units to improve observation of patient and ventilator.
7. Improve and expand preventive maintenance on ventilators.

Recommendations
JCAHO makes the following recommendations to help prevent ventilator-related deaths and injuries:

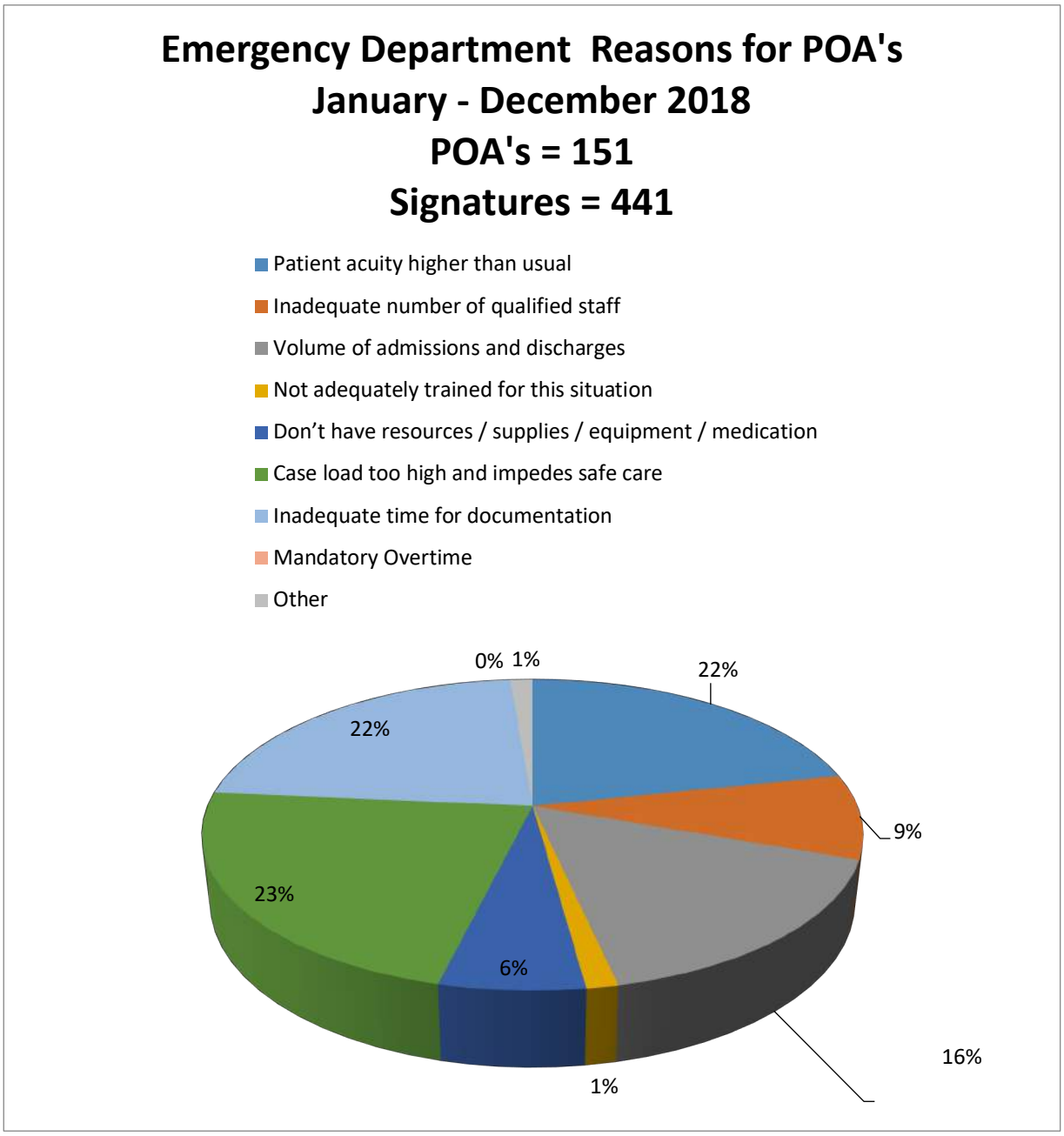
1. Review orientation and training programs for job-specific, ventilator safety-related content and include in competency assessment process.
2. Review staffing process to ensure effective staffing for ventilator patients at all times.
3. Implement regular preventive maintenance and testing of alarm systems.
4. Ensure that alarms are sufficiently audible with respect to distances and competing noise within the unit.
5. Initiate interdisciplinary team training for staff caring for ventilator patients.
6. Direct observation of ventilator-dependent patients is preferred in order to avoid over dependence on alarms.

Need for Action

Nurses working in the Step Down/ Telemetry Departments throughout NYPH are committed to improving delivery of care with the following recommendations:

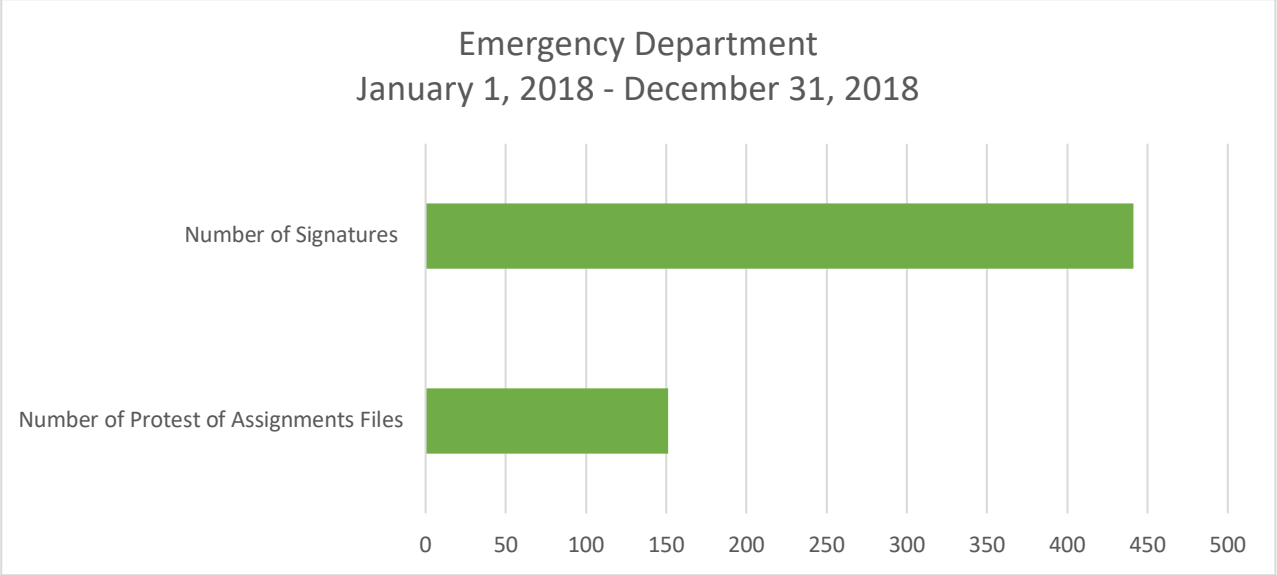
- Increase Step Down/ Telemetry registered nurses, and ancillary/support staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation. agreed upon staffing guidelines and the Guidelines for Professional Registered Nurse Staffing for Step Down/Telemetry units and to provide for adequate time for patient care, cover telemetry monitors and 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 NYPH's patients based on that organization's mission;
- Provide ongoing staff development to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Step Down/Telemetry Units, while concomitantly meeting the individual needs of NYPH's patient population.

Figure 8: Reasons for POA: ER

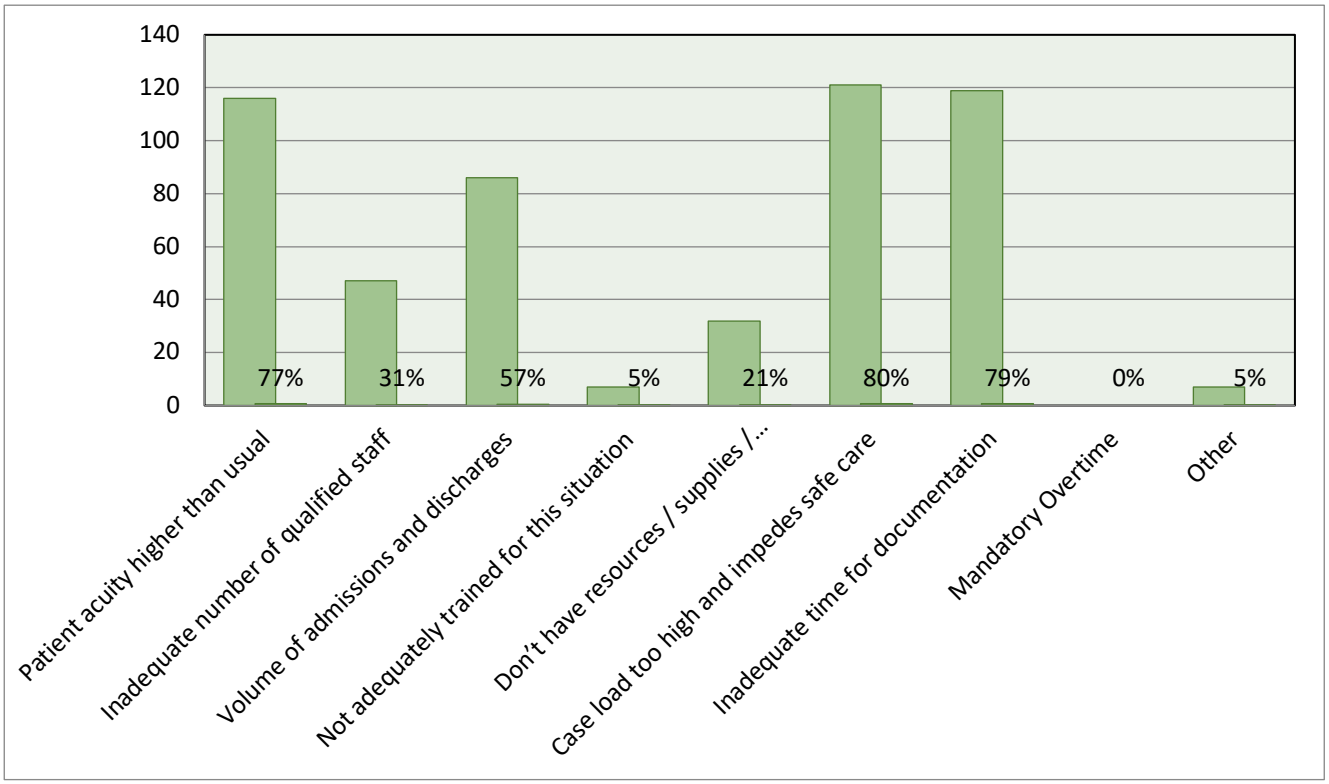


Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
22%	9%	16%	1%	65	23%	22%	0%	1%

***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.**


Emergency Department
January 1, 2018 - December 31, 2018
Number of Signatures
Number of Protest of Assignments Files
0
50
100
150
200
250
300
350
400
450
500

Percentage of Protest of Assignments Filed for each categorical Reason in this specialty area



The **one hundred and fifty one (151) POAs, supported by four hundred and forty one (441) signatures,** filed in NYP between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the system in the ER Departments that include:

- Inadequate 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.
- Not adequately trained for situation.

Table 8: Other Reasons for POA: ER

Other Reason for POA in ER
Inadequate number of RN Staff, acuity higher than usual, not adequately trained for situation, case load too high impedes safe care: Inadequate # of ERT's, 1 NA sent from floor. Still did not make a dent based on work that needed to be done. Inadequate # RNs in the midafternoon where RNs on teams were covering 12 patients to 1 RN during mealtime. Failure to comply to ED 1200 documentation requirement. Delay in mediation administration. ER holds (for admissions) 8 hour and 19:30 hours (admissions) did not receive required standard of care. 1 core ICU patient tied up 3 RNs for over 1 hour.
Inadequate number of qualified staff, acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: Inadequate time to document as Ped ED states. Unable to monitor patients. A couple of nurses went the shift without any break due to acuity and # of patients. Had to cover break in infectious control guidelines. Patients were sandwiched together. Rooms were missing BP cuffs, inadequate number of ancillary staff help for the staff. Nursing mothers unsafe to pump breast.
Inadequate # of qualified staff, volume of admissions and discharges, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: 55 patients with 12 admitted patients with no beds available. Continuous walk-ins and ambulance patients.
Acuity higher than usual, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: (Multiple occurrences) 63 patients in ER, no space for patients to be examined, no equipment such as stretchers and monitors.
Inadequate # of qualified staff, acuity higher than normal, volume of admissions and discharges, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: RN to patient ratio 1:8 too many patients. No room to be examined. Patients waiting in waiting room 4 to 6 hours.
Volume of admissions and discharges, acuity higher than usual, case load too high impedes safe care: (Multiple occurrences) No space to place patients with monitors. No room for patients to be examined. No monitors
Inadequate number of RN Staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation, acuity higher than usual: 1:11 Nurse to Patient Ratio
Inadequate number of qualified staff, acuity higher than usual, volume of admission and discharges, inadequate time for documentation: 1 RN out of 10 is on orientation. No room for patients to be examined. 3 ICU patients, no beds available, refused critical diversion by Dr. Trepp and Marsha.
Inadequate number of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: I had 2 step downs and 1 ETOH withdrawal patient. 1:10 ratio
Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Multiple admissions 2 ICU and 7 Step down. Tech pulled for 1:1 in ED. Nursing office states no one to pull, leaving 1 tech while breaks are covered including 1:1. No Monitors, asked for diversion and denied by Marsha, Nursing director of ED. 18 level 1 and 2's, No beds in house.

Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: 12 admitted hold over patients, no ISO beds, No ICU or telemetry
Inadequate number of RN Staff, patient acuity higher than usual, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation, inadequate number of ancillary staff: 2 nurses in a main section of the ED with an orientee taken off and put on her own before her orientation was over.
Inadequate number of Qualified Staff: (Multiple occurrences) 1:10 nurse to patient ratio and 1:10-14 with ICU patients.
Inadequate number of RN Staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: census has been consistently high for weeks if not months and staff remains the same with 4 nurses taking care of all patients, admitted, walk-ins and ambulances. Bed capacity 25 Census 45
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high and impedes safe care, inadequate # of ancillary staff, volume of admissions and discharges: 41 with 3 nurses in area. Total 207 patients in ED
Inadequate number of RN Staff, case load too high impedes safe care, acuity higher than usual, inadequate time for documentation, inadequate # of ancillary staff, volume of admissions and discharges: I personally have 1:10 ratio, 2 stroke activations, 1 sepsis-hypotensive.
Inadequate number of RN Staff, case load too high impedes safe care, inadequate time for documentation: no direct coverage for breaks leaving 1 nurse to cover 18 patients. Multiple stroke patients this morning without adequate RNs to monitor and document on stroke patients.
Acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: I have a total of 6 patients, 2 ICU, 2 critical Finger Stick, 1 GI block
Patient acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: (Multiple occurrences) precepting orientee- volume acuity and demands hindrance to proper education and orientation.
Patient acuity higher than usual, case load to high impedes safe care, inadequate time for documentation, inadequate number of ancillary staff: several critical care patients and cardiac arrest In the waiting room
Inadequate number of RN Staff and ancillary staff, acuity higher than usual, inadequate time for documentation, not adequately trained for situation, case load too high impedes safe care, MOT: there are 25 monitored beds in the ED at this time of this protest there are 18 level 2 patients, and 2 level 1 patients. Diversion was requested and granted by the medical admin on call but denied by administration. At present the situation is critically unsafe for patients and staff.
Acuity higher than usual, inadequate # of qualified staff, inadequate time for documentation: Acquired 8 patients upon shift change and severely acute patient from ambulance which then became an ICU patient. Lasted with patient from 10 am to 12:30 pm losing time with my other patients, giving them their medication, attention and documentation. Another nurse was assisting me with the ICU patient for more than 2 hours and she too lost time with her other patients, medications and her patient was seizing.
Inadequate # of qualified RNs, not adequately trained for situation, case load too high impedes safe care, inadequate time for documentation: unsafe working assignments, inadequate staffing assigned to area with 2 nurses and 19 patients, advised by leadership no coverage for breaks, leaving one nurse to care for entire team.
Inadequate # of qualified RNs and ancillary staff, acuity higher than usual, volume of admissions and discharges, done have resources needed, case load too high impedes safe care, inadequate time for documentation: 1 SBO patient, 1 BIPAP ICU patient, 1 chest tube patient, 1 hypotensive

patient septic. Each RN has an ICU patient. Receiving leave 2 and 1 while with ICU patients. Unable to take proper break in 12 hour shift.
Inadequate # of qualified staff: 4 nurses scheduled, 1 orientee, 1 duty staff nurse stayed till 11 pm. With 3 post partum's, 1 triage preterm, transferred to CHONY. 1 admit – 1 triage
Inadequate # of RN and ancillary staff, acuity higher than usual, volumes of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: I was team captain in the area tasked with assigning patients and assisting other nurses in my area but I had 12 patients at a high acuity with many tasks to complete for myself. There was not enough staff in the area.
Inadequate RN and ancillary staff, acuity higher than usual, case load too high impedes safe care, volume of admissions and discharges: Personally am caring for 10 patients, 3 ICU patients, 2 on ventilators and 1 on levophed with unstable BP. Unable to properly chart and care for patients.
Inadequate # of RN and ancillary staff, acuity higher than usual, don't have resources needed, case load too high impedes safe care, volume of admissions and discharges: At 13:50 informed clinical coordinator the following: the census in Area B is 45 + and I was actively caring for 4 level 2 and 14 level 3 patients. Additionally, during above time period I was assigned 5 level 3 patients within minutes of each other by the pivot nurse who stated this is the new system. I told them but there is nothing I can do.
Inadequate # of RN and Ancillary staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care, volume of admissions and discharges: Personally cared for high acuity of patients including patient with pneumothorax requiring chest tube placement, pt requiring blood transfusion, pt with Afib with RVE, and a patient found unresponsive.

- 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 inadequate time for documentation, 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"
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

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

and 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 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.

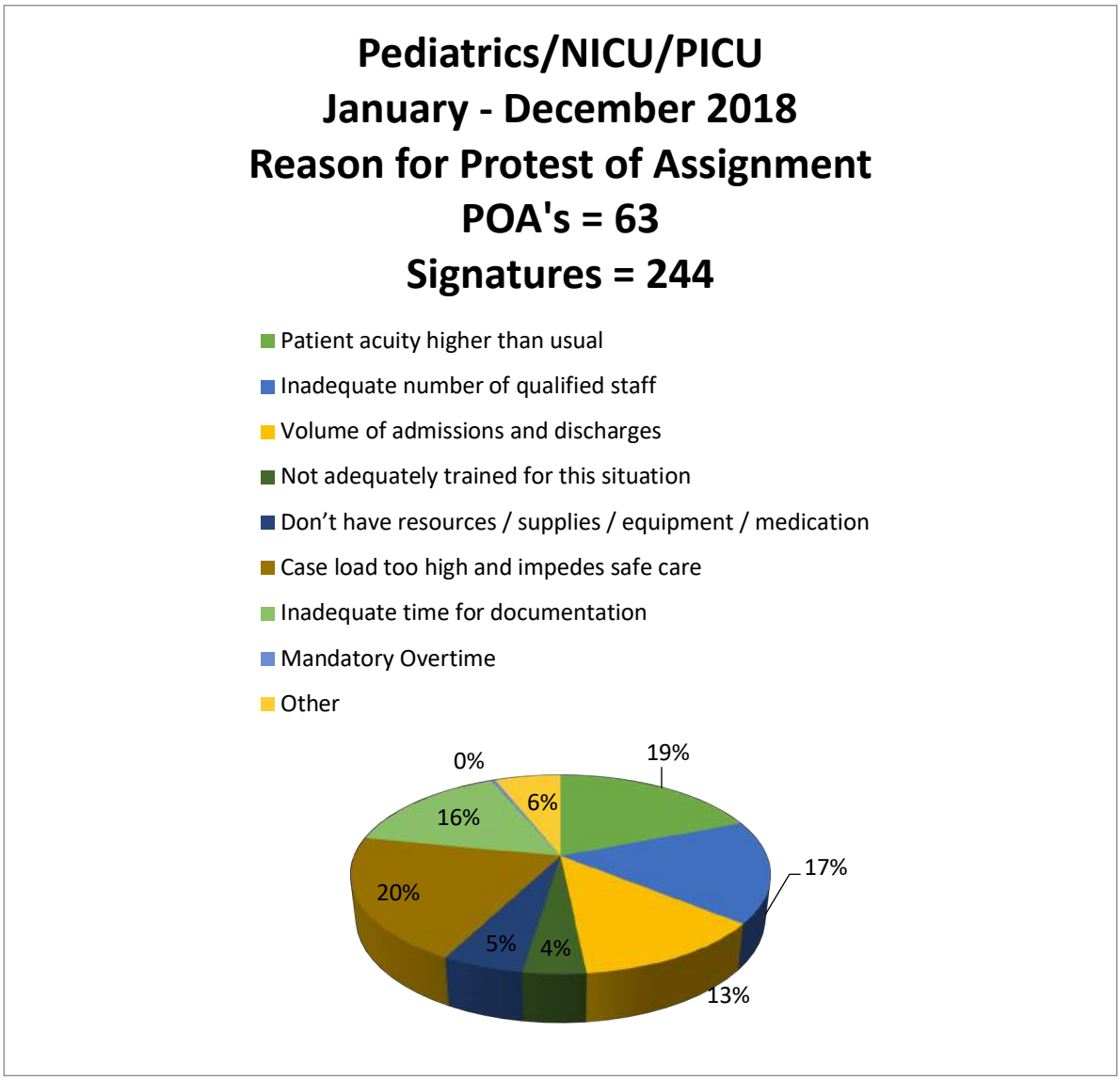
In 2014, further Joint Commission revisions include leadership use of data and measures to identify, mitigate, and manage patient flow issues, management of ED throughput as a system wide issue, safety for boarded patients, and leadership communication with behavioral health providers so care of boarded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

Need for Action

Nurses working in the Emergency Departments at NYPH are committed to improving delivery of care with the following recommendations:

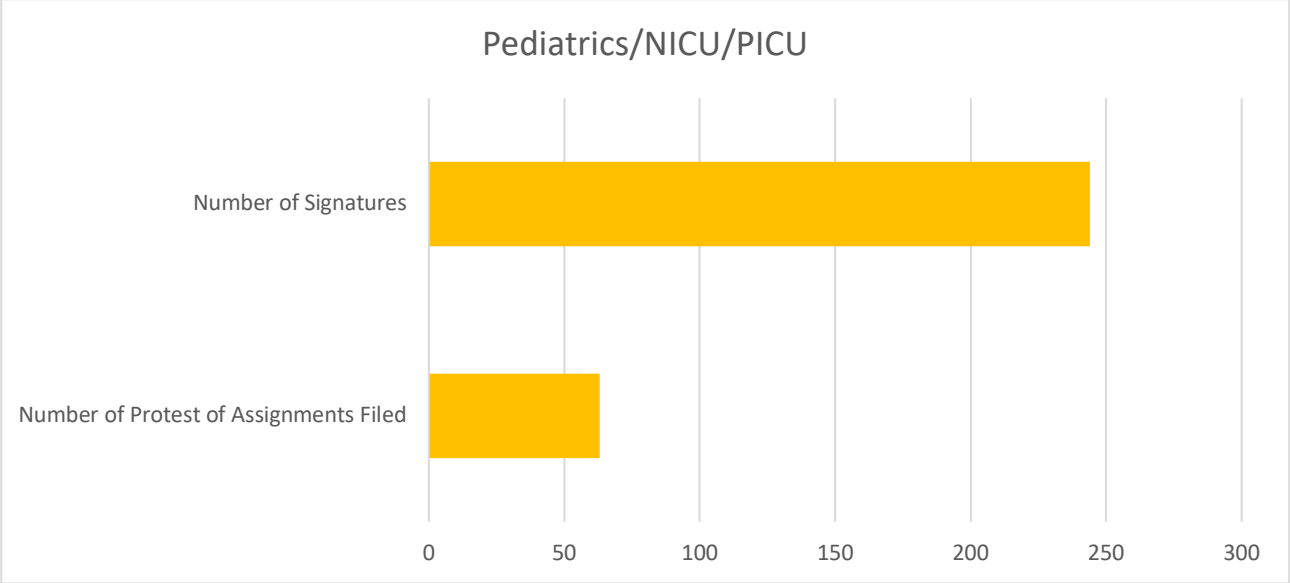
- Increase emergency room registered nurses, and ancillary/support staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation, agreed upon staffing guidelines and to provide for adequate time for patient care and documentation in accord with standards of practice;
- Open any closed beds/units to accommodate overflow patients that are normally kept in ED;
- 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 NYPH's patients based on that organization's mission;
- Provide ongoing and appropriate staff development and orientation 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 NYPH's patient population;
- Provide regular ongoing assessments of supplies in order to meet the individual needs of NYPH's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix.

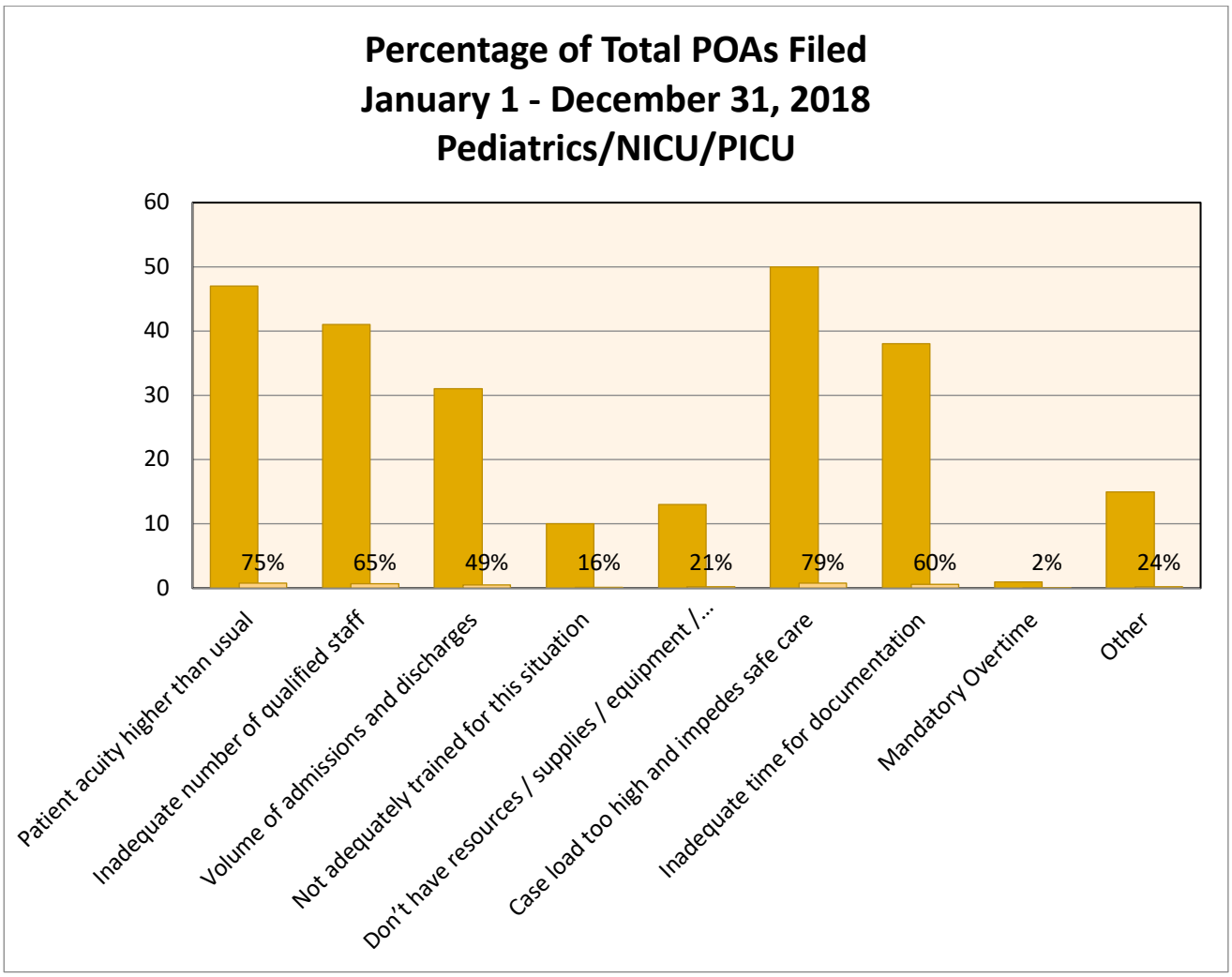
Figure 9: Reasons for POA: Pediatrics



Patient Acuity	No. of Qualified Staff	Admissions Discharges	Not Adequately Trained	Lack of Resources	Case Load Too High	No Time for Documentation	Mandatory Overtime	Other (in addition to all previously listed reasons)*
19%	17%	13%	4%	5%	20%	16%	0%	6%

***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.**


Pediatrics/NICU/PICU
Number of Signatures
Number of Protest of Assignments Filed
0
50
100
150
200
250
300



The **one hundred and fifty one (151) POAs, supported by four hundred and forty one (441) signatures,** filed in NYP between January 1, 2018 and December 31, 2018 indicates that there are consistent issues throughout the system in the Pediatric Departments that include:

- Inadequate staffing for acuity, caseloads and admission volume, discharges.
- Unsafe conditions caused by lack of resources and staffing.
- Inadequate time for patient care and documentation.
- Not adequately trained for situation.

Table 9: Other Reasons for POA: Pediatrics

Other Reason for POA in Pediatrics/NICU/PICU
Inadequate # of qualified staff, acuity higher than usual: 1 Halo patient. 1 tracheostomy, 4 patients on CPAP/BIPAP, 3 transplants, 1 patient on peritoneal dialysis, Charge nurse full patient assignment, No nursing attendant on unit.
Inadequate # of qualified staff, acuity higher than usual, inadequate time for documentation, case load too high impedes safe care: Total IT breakdown. 7 BMT, 8 Onc, 7 o/s, total of 5 chemo patients. 8 total agents, Multiple patients on CA requiring other protocol. 2 off service CPAP. 2 prep liver biopsy getting warmed up.
Inadequate # of qualified staff, acuity higher than usual, case load too high impedes safe care, inadequate time for documentation: 10 BMT patients, 12 oncology. 1 Patient requires 1:1 nurse. 9 Chemo patients. 7 watcher patients.
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, not adequately trained for situation, don't have resources needed, case load too high impedes safe care, inadequate time for docuementation: 8 BMT, 5 off service patients. Multiple patients on PCA. Febrile patient requiring line change. Blood transfusions. Families requiring support. Fresh transplant. 3 patients on CPAP. 3 Chemo patients
Inadequate # of qualified staff, acuity higher than usual, volume of admissions and discharges, case load too high impedes safe care: High census and high acuity with 1 ECMO and multiple post-op patients with a pending admission and only 2 NP's staffed.
Acuity higher than usual, don't have resources needed, volume of admissions and discharges: Charge nurse with a patient assignment, post op bidirectional glenn with small bowel obstruction admitted at 05:00
Acuity higher than usual, case load too high impedes safe care: One patient intubated and other patient trach to vent. Intubated patient spontaneously wakes up and tries to self-extubate. I constantly have to be by patient's room to make sure this doesn't happen. We are not increasing sedation because PICU team/ENT plans for extubation today. However, patient is not ready to be extubated, requiring prns. Charge RN, Unit PCD, PICU team aware of patients' condition. Twice this AM, while giving care to my trach patient, my intubated patient woke up and tried to self-extubate. An RN was passing the room and was able to run in. I am unable to give adequate care and attention to my trach patient who requires hourly suction, because I am also needed in my other patient's room.
Inadequate number of qualified staff, acuity higher than usual, volume of admission and discharges, case load too high impedes safe care: 2 NPs on overnight, 7 patients each. 1 Pt on ECMO requiring chest opening and washout x2, circuit changed, hemodynamically unstable. 1 critical post op. 1 admission in TN. 1 transfer to another CHONY floor. Very critical unit.
Inadequate # of qualified staff and ancillary staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation, MOT: 3 NP's with 3 ECMO patients. 1 CVVH, 14 ICU patients
Case load too high impedes safe care: Only 2 NPs on when minimum staffing is 3. Assignment is too acute for safe care.
Inadequate # of qualified staff and ancillary staff, acuity higher than usual, case load too high impedes safe care: 6 mechanically ventilated patients. 1 DNR/DNI impending death, 4 BIPAP/CPAP. 2 potential respiratory decompensation, no floor nursing assistant. Charge nurse has an assignment.

Inadequate # of qualified staff and ancillary staff, don't have resources needed, case load too high impedes safe care, inadequate time for documentation: 10 intubated patients. Unsafe assignments due to inadequate staffing. Missing equipment and supplies. No NA on floor for stocking. 2 patients on 1:1 observation, patients planned for procedures and test off and on the unit. 7 patients restrained. RN available for OT unconfirmed by administration.
Inadequate # of ancillary staff, volume of admissions and discharges, case load too high impedes safe care, inadequate time for documentation: Not enough nurses on the unit as one nurse was called off this morning to leave us with 3 when we were supposed to have 4. Nursing assistant was floated to another unit so we did not have one. Lots of discharges and admissions, patients were also high acuity.
Inadequate ancillary staff, acuity higher than usual, volume of admissions and discharges: Floor typically staffed with 4 nurses, but 4th was cancelled by Nursing office for "low census" despite empty beds that will be booked and progressive-care level patients. No nursing assistant on the floor, both nursing assistants pulled to other floors.

❖ 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);**
Hospitals shall have available at all times, personnel sufficient to meet patient care needs. **10NYCRR 405.2(f)(7);**

2) 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);**

3) 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);**

4) 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);**

5) **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."

6) **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));**

7) **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));**

8) **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));**
9) **New York Code, Rules and Regulations, Title 10 Part 405.6 Quality assurance program**. (b) The activities of the quality assurance committee shall involve all patient care services and shall include, as a minimum: (1) review of the care provided by the medical and nursing staff and by other health care practitioners employed by or associated with the hospital. Such review shall include a determination that the hospital is admitting only those patients for whom it has appropriate staff, resources, and equipment, and transferring those patients for whom the hospital does not have the capability to provide care, except under conditions of disasters and/or emergency surge that may require admissions to provide care to those patients;
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 Pediatric Departments at NYPH are committed to improving delivery of care with the following recommendations:

- Increase Pediatric registered nurses, and ancillary/support staffing by hiring more permanent registered nurses and other staff in accord with NYSNA's proposed staffing legislation, agreed upon staffing guidelines and to provide for adequate time for patient care and 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 NYPH's patients based on that organization's mission;
- Provide ongoing and appropriate staff development and orientation to insure an optimal number of competent personnel with the ability to provide exemplary care and meet the standards of practice in Pediatric/Critical Care, while concomitantly meeting the individual needs of NYPH's patient population;
- Provide regular ongoing assessments of supplies in order to meet the individual needs of NYPH's patient population;
- Provide ongoing assessments of scheduling deficiencies and make adjustments to provide the optimal number of competent personnel with the appropriate skill mix.

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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