STAFFING AT HEALTHEAST

THE TALE OF TWO HEALTHEASTS

It was the best of times, it was the worst of times…it was the spring of hope, it was the winter of despair… (*Tale of Two Cities*, Charles Dickens). The presentation and reception of MNA proposals related to staffing at HealthEast was reminiscent of Dickens' Tale of Two Cities. Management readily dismissed the Union's proposals as superfluous, as in the case of Unit Closure language which all other Metro hospitals have had in their contracts for years or an outrageous usurpation of management's authority, as in the case of the segment of the staffing proposal requiring arbitration of disagreements on staffing that cannot be amicably resolved.

TWO VIEWS ON HEALTHEAST STAFFING

- **MNA VIEW**
- Nurses are on the frontline of patient care at all three HE hospitals.
- Nurses know what is needed to deliver safe and appropriate patient care.
- Nurses need a true voice in how staffing is designed and delivered.
- The Contract needs to spell out the role of Nurse judgment.

- **Management View**
- Management works well with nurses to identify and assess staffing issues.
- There is no need for onerous language in the contract to specify how nurses can use their nurse judgement.

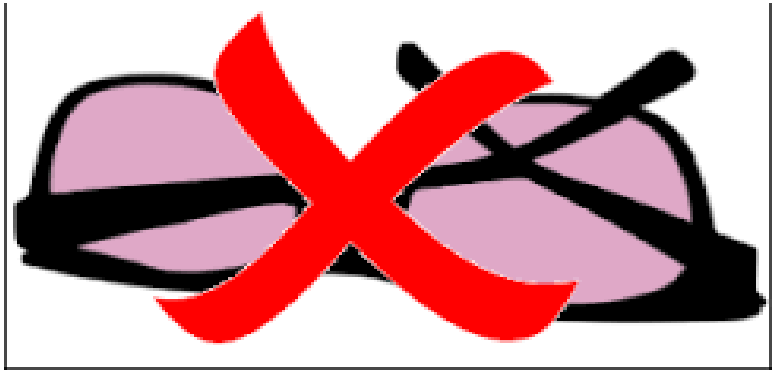
HOW CAN MNA AND MANAGEMENT SEE SUCH DIFFERENT THINGS WHEN LOOKING AT STAFFING?

- MNA NURSES ROLL UP THEIR SLEEVES EVERYDAY AND DEAL WITH SHORTAGES IN NURSE STAFFING AND OTHER RESOURCES BY DOING MORE WITH LESS, BY BURNING THEMSELVES OUT DOING THE JOB OF TWO PEOPLE, BY GETTING THROUGH SHIFTS BY THE SKIN OF THEIR TEETH, HOPING THAT THEIR PATIENTS WILL BE OKAY. THEN THEY COME BACK AND REPEAT THIS THE NEXT SHIFT!

- HEALTHEAST MANAGEMENT HIRES LEAN TEAMS, PUTS TOGETHER KIZAN PROJECTS AND CREATES SOLUTIONS WITHOUT SEEING THE PROBLEMS FIRSTHAND AS THEY PLAY OUT NEARLY EVERY DAY, MOSTLY EVERY SHIFT.
- MANAGEMENT BUYS AN EXPENSIVE COMPUTER PROGRAM THAT MAKES MANY ERRORS BUT TELLS THEM THAT THEY HAVE SOLVED THE STAFFING PROBLEM.

WHAT IS WRONG WITH THIS PICTURE?

- MNA NURSES ARE VIEWING THE STAFFING PROBLEMS IN 3D, IN REAL TIME.
- MNA NURSES BEAR THE WEIGHT OF THE TRUE STAFFING ISSUES.
- MNA NURSES FEEL THE PAIN OF NOT BEING ABLE TO PROVIDE THEIR PATIENTS WITH EVERYTHING TO WHICH THEY SHOULD BE ENTITLED.
- MANAGEMENT IS VIEWING THE STAFFING PROBLEMS AND SOLUTIONS THROUGH ROSE COLORED GLASSES!



WHAT CAN MANAGEMENT DO TO CREATE A TRUE COLLABORATIVE EFFORT WITH MNA TO UNDERSTAND AND PROPERLY ADDRESS STAFFING?

- CAREFULLY REVIEW THE UNION PROPOSALS
- The Unit Closure Proposal deserves a closer look. It is exactly the same language as reflected in the Fairview Contract.
- Unit Closure has not spelled doom for Fairview or any of the other Metro Hospitals.
- Understand that denying HE nurses contract rights already afforded all other Metro nurses is the equivalent of saying to them that management does not trust their nurse judgement.
- Nurses need to be able to exercise their nurse judgment. They have not and will not abuse it.

LISTEN TO THE NURSES!

- The MNA Nurses stories are many and varied.
- Perhaps because nurses tend to just keep moving forward no matter the circumstances, it's easy to think that everything is okay.
- Nurses put a positive spin on things and don't spend a lot of time complaining, but that doesn't mean there is nothing wrong.
- When the Charge Nurses ask for more resources, they want to be heard, the first time.
- Charge Nurses shouldn't have to beg and cajole. If they say there is no capacity to take another patient, that decision should not be overridden. If they say that they've exhausted all possibilities through staffing and the unit is still understaffed, then management needs to spring into action and get the floor staffed, even if they have to do it **temporarily** with managers.

HEALTHEAST NURSES HAVE SOMETHING TO SAY ABOUT STAFFING AND THEY NEED TO BE HEARD AND INCLUDED IN MEANINGFUL WAYS IN PLANS OF ACTION TO ADDRESS THE STAFFING CRISES

Healtheast nurses' shared stories with their Negotiation Team about staffing nightmares in the hospitals. The Negotiation Team passionately shared those stories with management as seen below. Management sat stoically while they listened. They then said "we hear you…" but repeatedly in their responses to the Nurses proposals on staffing, management said "We're not interested in adding this to the contract."

"One shift; 3 total care pts, 2 are confused and the other has a tracheostomy, sp cath, feeding tube, needs to be turned every 2 hours, frequent suctioning, explosive diarrhea, in precautions and no nursing assistant!"

"A mental health nurse who is chivvied into running a magnesium infusion on the mental health unit despite expressing concern repeatedly that it did not seem appropriate for the limited spectrum of medical issues/training on the unit"

"Violence on mental health ~ need more Techs. Unsafe."

"It's hard being stretched so thin in ICU. I no sooner have a patient transferred/discharged and another surgical/transfer waiting for me. The one that's gone is not charged yet. Sucks when the ICU is always open for business. Aides have been stretched thin as in 1 for a full ICU on occasion! This 1 resource nurse is bs as well. They recover

procedures all shift long sometimes, then when sh** hits the fan I have no help."

"When EVERYONE is a fall risk or a two person, Q2 turn, we NEED support staff and resources readily available. And for those people to not be burnt out to the core. I feel terrible, my aides work EXTREMELY hard (all of ours do)."

"We are getting that rolling 1 in as you roll 1 out all the time on the medical unit. We are getting pushed and questioned why they didn't leave sooner. It is getting to the point of not being able to keep up. Some days I feel like all I have time for is putting out fires and barely getting basics of meds and bare minimum charting. I am not able to keep track if what they are eating or drinking or peeing These little things are important. When you hear nurses asking at the end of the shift if these things happened. Not good care."

"ER sending up a suicide watch pt with no sitter at change of shift. Staffing unable to finding a sitter until 7pm Nurse and Aide took turns being the sitter plus doing their regular work. Than at 545pm same team was told we were getting another admit!"

"I feel most of the time when we are working short staffed it is due to not having enough aid help. The other day we started with 23 patients. 2 aids on the floor with holes for 3 admits. I told the ANS we could not fill ANY of our RN holes or we would then be down 2 aids. Our people are way too sick to work 2 people short. They did find us an RN to work as an aid at 9:30 so we could take our surgical."

"They hold to the grid for RNs most of the time but they don't care about the NA side of it. We all work together and one without the other it doesn't work. I know this is the Nurses contract but we can't do it without our aide as well."

“When I told them, I needed another aide also to take more patients. I was told aides don't matter in the ability to take patients. It just like working a nurse short. We are needing to do the task of the aides when we are short and busy.”

“When the RNs end up doing a lot of aide work, because there aren’t enough aides, they also end up missing breaks and staying late to catch up on their own work. And it’s stressful for the aides! They feel dumped on and undervalued! How many aides have we lost? And how much does it cost to hire and precept a new aide?! They are not disposable! AND patients notice when the unit is chaotic, so they’re not having the stellar experience administration is hoping for!”

“Violent patients who assaulted staff multiple times on a 1:1 and they won’t put a security guard with the patient. And all we have on the floor most of the time is women staff. I know we are strong women but really?”

“Why can’t the psych units have a security member on unit 24/7?”

“Even when we know the hospital is full, they keep doing elective surgeries instead of rescheduling and keep adding on to surgery schedule. I used to work in ICU and on tele floor, now working PACU. Nurses running their behinds off on the floors, PACU holding patients for hours, but they always preach “what’s best for the patient...”

“Unsafe staffing is opening a new unit and staffing it entirely with float pool staff, including charge RN and NA, because said unit didn't yet have enough core staff hired to meet staffing needs. Pt assault resulted with 2 RNs on the whole unit, NA was at break (1 RN in nsg station, 1 RN on the floor). Admin came back and said RNs needed more

education about where duress buttons were. How about staffing the unit appropriately to begin with!!”

“If ICU had 2 resources, I wouldn’t have to steal the med surg resource RN. I always feel that role is for all other units but not ICU. When I started 3 years ago at Joe’s we had 2 ICU resource nurses.”

“When I worked at Bethesda with the vented patients. I’d have 4 total care, vented patients, with al sorts of other tubes and lines. Also 500 meds a day. I could handle 3, but 4 meant a 5 min lunch.”

“When you have 4 admits planned, and the day shift charge said I can only take all 4 if there is a nurse variance for our bad grid number at 18 for the following day. It was promised and granted, then unable to be filled due to staffing. They could have known about this staffing need almost 24 hours in advance, yet because night shift is the only shift allowed to enter in the variance request, it is too short of notice to get anything filled.”

“I filled out an un-safe staffing event regarding RN’s who work 12 hour shifts and the ambiguity of floating mid-shift. I expressed that it is not safe for patient care being pulled mid shift “because it is your turn to float”. This negatively affects patient satisfaction, continuity of care, stress/burn out of nurses, and overtime in RN’s giving and receiving report. Being told by management (clinical manager) that it is the policy of the unit and “it’s just the way it is”. I asked to see the policy and the manager failed to provide it. There is no policy regarding floating guidelines. However, there are guidelines relating to staffing adequacy and the common goal to provide a safe, compassionate care experience, that is cost effective and high quality for all patients that the hospital services.”

“Working in ICU with 19 patients and 1 aide. Second time this week. Later in day another aide came and that helped a lot. Tele overflow and usually never have 2nd aide.”

“Management is so far up our rear ends about discontinuing 1:1’s it’s insane.”

“Management should never override professional judgement or advocacy for patients.”

“Management asks like every 3 hours if your patient can come off 1:1. Well, their delirium/dementia/encephalopathy has not changed so, no.”

“The other night i had 1 very busy multiple titrated gtts and blood ICU pt along with 2 tele that one was still weaning off pressers. the aids on the floor were floats and great but not really helpful with the ICU pts. and all three where line draws both tele where Q2 hr neuro checks. it’s a unsafe passively acceptation that’s become part of our culture. not good”

“I’m so rushed to downgrade ICU patients sometimes. Pressors off and an hour later let’s downgrade? Yeah not convinced pressures will stay good.”

“I’ve been at Joe’s 3 years now and I feel like a lot has changed in the last year especially. I think with the merge and new administration they are coming down hard on numbers and not people. There for managers are afraid of losing their jobs so they deliverer administrations ridiculous standards. We had a manager get phased out and I think it’s because she stood her ground for her employees.”

“Such high acuity for the tele patients with constant turn over. I especially think it’s nuts that icu nurses have to take tele patients in

addition to their icu patients. I honestly dread seeing that I'm assigned there. I love the staff there, but it always feels like pure chaos."

"It's never ok to fly by the seat of your pants!"

"I believe that management thinks that things are fine, that this is normal. It is not ok to be spinning around feeling that you do not have a handle on taking care of your patients. We need to band together and tell them that this is not OK. This is our nursing licenses."

"Asking for a variance, and the ANS says go ahead and put it in, but then realizes there is WOC help and LPN resource for the day, so they tell me to remove the request. yes, this might help a bit, but certainly does not mean that all help will be on our floor all shift, which is what we were asking for."

"I would love to experience the JOY of actually having time to sit with one of my mental health patients and listen to their concerns/struggle and to be able to offer them more than just bare-bones programming/services to get them back on their feet."

"My JOY comes from being able to give my patients the time and care they are entitled to. This is a rarity since we are so frequently understaffed."

"In the last 7 days I have gotten 33 texts from staffing begging people to stay for critical bonuses on all units. There is definitely an issue. 7 text today alone."

"I've gotten 9 texts just today alone asking for multiple RN's any skill (ob) with a critical bonus listed in each!"

"Hospice presents its own unique challenges..... our nurses are expected to meet unrealistic productivity goals with no breaks."

“Productivity goals and nursing should NEVER be spoken in the same sentence! These are HUMAN lives, with unique needs in EVERY person we care for. #wearenotmachines”

“Joy is having a shift where I can actually care for my patients as they deserve whilst caring for me too.”

“Joy is getting an email stating that you didn’t approve your time card! And why is that? Maybe I didn’t approve it because it’s WRONG! 3 outstanding TSAF forms, 1.5 critical shift bonuses taken away 16 hours of OT calculated at evening straight time when I’m a straight night shift worker!! Pure JOY I say...NOT!”

“Smart square making so many mistakes that often the next shift has nurses not show up who called in but smart square didn’t record it. Or a trade happens but smart square has both as working... or it can’t figure out who’s overtime or an extra shift because it’s not really all that smart!! A combo of a bad system and staffers that don’t know or try to use it.”

“What about being allowed to take an uninterrupted break? Most of us just eat when we can and answer call lights while still on break eating our suppers cold.”

‘Joy is being able to talk to my patients and their families about where they live, their work, their kids and grandkids. I feel like a robot most of the time.’

“Besides making a paycheck, the reason I go to work is because I enjoy my co-workers and caring for patients and families, despite the ridiculous computer issues, short staffing, piling up more and more expectations from management.”

“12 and 8 hour nurse scheduled an 8 hour shift, when we pick up overtime, we don’t get overtime because the computer thinks we work

all 12 hours. Not right! You have to do a TSAF to get your overtime, and hope they really do your TSAF."

"Seriously not having enough time to read about pt history on a transfer who came from an affiliate hospital. Was not able to personally take report on this patient. Additionally, with this same patient who had hx of multiple AMAs and Code 9's, transferring a patient off floor, discharging another (The discharged patient had papers at 15:00 when I came on at 3p but didn't want to leave until she had a BM... so laxative + suppository + disempacting = discharge at 22:30). I took over care of patient at 19:00 and was unable to see her until 22:00. Swat and colleagues helped. I did well with our pt with the AMA hx. Patients like this require additional time; building a positive rapport goes a long way. It's worth it, better for the patient and potentially preventing a code green. Lavender on a cotton ball doesn't come close to this...professional attentiveness requires time."

"They should maybe worry about the Joy of the oriented patients and family members that can count how how many times we are walking up and down the hall. That are concerned how busy we are and dont want to disturb us. Or all the interruptions from calls over the voceras that we need to take a phone call or a doctor is at the desk for us. OR the classic.... staffing mass calling us multiple times of the day... That makes our patients/families concerned how short staff we are and ask if it is always like that and how many nurse are doing doubles or long shifts. What would bring me.. Joy? Give us more aides on the floors."

"What makes it so complicated, for me, is that our most violent and abusive patients are not in their right minds. They are mentally ill, or demented, or delirious, or all of the above, and can't really be held accountable as a result. All of this makes it very challenging to care for them."

“We do have some antisocial patients that misuse the hospital resources and have an awareness of their abusive behavior toward staff. We, unfortunately, are not supported by providers who will not take the time/effort to have a forthright conversation in the ED with these patients, thus they're admitted repeatedly and we chase our tails in a cycle that demoralizes the staff and only serves to enable the patient.”

“Not too long ago I was working with a patient who was spitting at personnel, I walked in wearing a mask with a face shield and other PPE. The patient asked why I was wearing it and I told them it was because I didn’t want to be spit on. I was told then I shouldn’t be in healthcare because that’s part of the job.”

“A dollar is a dollar. True story. How about not spending so many dollars on pay for upper management and middleman that have zero idea what frontline healthcare workers deal with. Give me another nurse or nursing assistant instead of a new “process” and audit.”

“It would give me joy if Healtheast would support their employees.”

“Things that would give me joy working at Healtheast: Better insurance, good leadership, adequate staffing.”

“There have been several instances where a unit will be short aides and the nurses will have to take on the role.”

“The patient cares/needs are growing and day shift is next to impossible when you have 4 of them to feel like you are giving good enough care or it will be at the RN’s expense it not getting their break. The grid needs to change! Please! RN burn out is happening and this would be something to help correct that.”

“Sometimes we are too busy without a resource to call. Our grid needs to be reviewed to consider acuity and ratios.”

“I had 3 total care patients and no nursing assistance. 1 patient was a 1:1, 1 patient needed to be turned every 2 hours- along with frequent suctioning and my 3rd pt had dementia and was confused- turning on her call light every 5-10 minutes.”

“We need enough staff to ensure we are doing all we can to ensure patient safety and true patient-centered care. Stop asking me to use restraints because we don’t have enough staff for a 1:1!”

“Unit was short both RNs and CNAs and do not offer bonus until 6:55 for a 7:00 start time.”

“It gives me joy when I have enough staff to make sure my patients are safely cared for.”

“It would give me joy to not have to beg for appropriate staff.”

“A work environment that allows me to give quality care my patients deserve would be nice!”

“One morning we were short-staffed for NA. As the Charge nurse I worked to make the best out of a difficult situation. We never got any staffing help. I was asked if I had suggestions about who to call.”

“It would bring me joy to work for a hospital that has enough staff to provide quality patient care that is expected by management.”

“Staff frequently work doubles/bonus shifts. During Summer and late Fall/early Winter critical bonuses were being offered almost every weekend. In order to meet patients’ needs Charge Nurses are requesting variances for extra staff either for aides, RNs or 1:1s or resource nurse to break staff, assist with feeding patients, help with med pass and/or wound cares.”

“What would bring me joy: Appropriate staffing, safe nurse:patient ratios, being able to collaborate with other disciplines.”

“What will give me joy working for Healtheast: Enough staff to work safely, respect (management respecting staff, showing appreciation), having enough necessary supplies on every floor to work well, being kept on the same floor for my full shift as a float pool employee, getting differential for float pool staff.”

“What will give me joy working at Healtheast? When I get my unit staffed adequately to take my breaks and leave on time.”

“It would give me joy to have good staffing per patient acuity no just numbers. And to have good insurance.”

“Joy would be having a consistent schedule.”

“We need to clear up with staffing which shifts are not cancelable.”

“Many nights we are staffed per grid and staff are not able to get breaks. Just this weekend multiple staff did not get breaks, we were staffed per grid, had 2 NA 1:1s, 2 NA on floor. It was Epic Downtime also, only had 1 core staff on the floor. It was extremely busy and I did not get a break. I was Charge, thankfully did not have any patients. I ended up breaking the NAs and 1:1s. It’s very common for myself not to get a break, especially when I am Charge (if an admission comes I have to leave my break or deal with any crisis that are happening) it is worse when I have to take a patient assignment.”

“Sometimes when we don’t have enough staff to cover a shift, we try to adjust the different groups, so the pt’s needs can be met. Sometimes we can’t.”

“When we have patients on 1:1 sitter on our unit it becomes very challenging to take breaks.”

"Would love/appreciate being fully staffed at all times to ensure patient safety. Appropriate staffing ensures safety and prevents medication errors and safety event issues."

"Staffing on night shift (when I work) is usually fine except sometimes when C-side is low census. We only have 1 RN and high acuity patients…Then that solo RN is supposed to admit another high acuity patient? That doesn't make sense to me! Doesn't seem safe."

"Our manager has worked to change our grid, but the hospital is short of staff."

"I feel that the safety of unit 5500 would be greatly improved with the addition of a 3rd BT. In addition I feel we need a Behavioral Resource Nurse and a Resource BT on Day and Evening shifts. This Resource RN and BT could float between the behavioral units to help with admissions, relieve for breaks, cover 1:1s, etc."

"The grid doesn't take into account the acuity (either violent or medical). Sometimes can have 10 at night. The grid could be updated for staff safety."

"We had a severe incident where we were coming on to work short and staffing left the issue for the night supervisor to deal with instead of calling an agency. Once particular night, the night supervisor abruptly and rudely told me I had to float to another unit despite it not being my turn to float. Staffing had made an agreement with an evening RN that she could stay on our unit which would bump one of our core staff off the unit. Night supervisor told me she was going to write up the whole unit. Later in the shift, night supervisor pulled me into our report room and threatened to report me to my nursing manager. Her behavior was witnessed by evening charge, evening floor nurses and other staff. I had a talk with my manager who was supportive and said the incident

should never have happened. Another RN from our unit did submit a staffing concern to MNA."

"One day I was working on 6 West, I agreed to do a double so I asked staffing if I could stay on 6 West for my second shift if there was an opening for a float nurse. Staffing said they would try to keep me, when I checked smart square they were sending me to 3 West. As I was leaving another float nurse was coming into work 6 West and was given 2 out of the three patients I had. If I had stayed continuity of care would have been maintained."

"I answered "neutral" for most of the questions because the facility is not consistent with filling up the staffing grid. An example, the facility is expecting to have several admissions on that day so staffing should be proactive on filling up the staff grid. It is almost every day and every shift that our unit is short. The facility should hire agency staff to help but most of the time staffing will say that they couldn't find anybody so the unit was left with heavy workload and burnout staff. On top of that, the management is expecting us to provide quality patient care. I have known several staff who left or resigned due to heavy workload or much worse, is he/she got injured in their job."

"4/12/19 Started as Admit Nurse, pulled to a group at 1920 due to a 'miscommunication' in staffing. Frequently get pulled from 1 assignment to a different one, or get shuffled between 2-4 units before I actually get my patient assignment; which has caused me to clock in late. The core staff on the units are wonderful, but I feel that management frequently takes the Float Pool for granted. Rarely have continuity with patients, even over the weekend. Frequently pulled from unit to unit. I love my job, but I would LOVE to be core staff on a unit instead of in the float pool."

“Staffing frequently unaware of holes in coverage and scrambling to fill grid at the last minute instead of proactively seeking charge coverage when schedules are made (Wed Day Charge) requiring non-core staff to cover a challenging charge nurse position. Variance request granted the evening before but not filled for Day shift on 4/8 we had four admissions and ended up with a census of 19, which is our most challenging grid point on the day shift (3 groups of 4). Admissions are always challenging the first day with therapy and WOC visits, order reconciliation and multiple other variables. Groups of 4 should be avoided. Additionally, Tuesday is when Dr. Thao rounds so multiple wound vacs were scheduled to be changed. Not getting the variance from staffing was really upsetting.”

“As a float RN I understand it is my job to go where I am needed. I know how important float staff are to an efficient running hospital. A lot of extra responsibility comes with this position including flexibility and adaptation. Some challenges are having to work with unfamiliar staff and a constant new flow of patients. Sometimes I will be assigned to a unit and have half to a full report completed when staffing will call and move me to a different unit. This really sets me back on my workflow. It would be nice to have some consistency from shift to shift. I will have 4 days in a row and will be on a different unit every shift even thought I could have stayed on the unit I was on the day before for some reason they put a different float there.”

“I have been at Bethesda 5 years and there have only been a handful of times I am able to take more than my half hour lunch break. Our grid is awful on 3 South, we are staffed for numbers not acuity. When applying for a staffing variance, it may get granted, but 50% of the time we don’t have enough staff to fill it. The staff turnover is huge. Only a handful of those I started with 5 years ago are still here. Why stay if in STACHs you can have less patients and do less work?”

“Requests for vacation were taken and approved 6-8 months in advance of the requested time off. My schedule was approved for Tuesday, Wednesday, and Thursday including my 4 day weekends to each side. The last weekend was Easter which I was not scheduled to work. Once week prior to my vacation staffing changed my schedule to work Sat/Sun of Easter for SWAT and Charge need. They did not ask, they did not notify me by call or email. I informed them I no longer would be SWAT or Charge as a part of my float pool duties. Their response ‘You placed us in a very difficult position.’ My vacation was to fly to WASHINGTON STATE to be with my son and daughter-in-law.”

“Some days we leave work late because of patients’ heavy assignment with high acuity. No breaks for nurses. Most nurses on my unit take one 30-minute break and don’t claim break time pay.”

“Unit is staffed with 2 aides for census of 13 per grid on evening shift. This is not always meeting the needs of the patients depending on acuity level at the time or patient behaviors. Therefore, nurses are having to step in to do more hands-on cares that could be delegated to an aid. Which in turn results in overtime or missed breaks.”

“Staffing is not always able to find additional coverage for the unit. (i.e) Day nurse agrees to stay an extra 4 hours into the evening shift. No one comes to relieve the nurse who leaves at 7 pm. This causes the floor nurses to accept extra patients mid shift and/or the charge to take on patients.”

“I was floated to 4 South one evening to work as the aide for a one to one admission using mitts and non-violent restraints and padding on rails. The charge nurse told me that I would need to do the entire admission in addition to all of the cares. I refused because the patient was violently thrashing and repositioning in bed. He could easily rip off catheter and feeding tubes if not attended to. Eventually they gave the

admission work to another nurse but the original plan was unsafe given the computer was 6 feet away from the patient."

"On a day shift our unit was provided with one nursing assistant when our grid was 2. Half-way through the shift that nursing assistant had to go on a transport with one of our patients so the unit was left with no nursing assistants for 3 hours. This put extra responsibility on the nurses to ensure patients were repositioned, toileted, and for the therapies, etc."

"I have 4 patients who all eat. But 2 need to be fed, 2 need supervision. I tried to feed 2 patients at once. The other 2 ate in bed unsupervised. I did not like those unsupervised patients being alone during meals."

"I was working a 1:1 with a patient- actually a patient who needed a CAN 1;1 but no CNAs available. This was fine with me, but they did not assign a CAN to me. Since I could do both nursing and CAN tasks. Had another staff with patient to get meds- 5 minutes- but no help with cares, turning, no breaks. The floor was busy that day, but there was not another nurse or CAN available to help me at all. The patient's family helped to re-position the patient and clean patient up. Could not get to a bathroom break until 1400."

"Lots of unsafe staffing was filled out for this year. Many times we were working short and we cannot meet patient needs due to inadequate man-power and resources. But needs a contingency plan like planning ahead or using agency staff to cover staffing needs but till now its not happening. Patient safety is at stake when staffing is not well provided for our patients."

"There was a time I was forced to work without any NA on the floor and all the nurses were overwhelmed with all daily cares, meds, and treatment assignments. Unable to take any breaks and also unable to

do all the assignments as scheduled. Unsafe staffing was filed by the charge nurse at the time. ☹”

“It was difficult to get some vacation because we do not have enough replacement. Break times could be an issue on days when we have very sick patients.”

“For two days (Friday and Saturday) I was on 4 South, then Sunday they floated me to 5 South and put another float nurse on 4 South. When I questioned staffing about it I was told “you should talk to the nurse and see if she will switch” I had the same patients for two days and this switch interrupts continuity of care for our patients, especially important for patients on 4 South.”

“During breaks we rely on fellow staff working on the floor, wait for our turn for us to go on break. Not at all times grid/matrix meets our patient needs. Patients on that same group. We raise our concern but usually charge nurses are limited because they don’t have the choice but stick to the group. (Too many admissions at the same shift). Staffing always tries to fill holes/needs but is limited to availability of staff.”

“NARs often pulled for 1:1 and leaves short on floor, very difficult for all staff to get breaks when that happens.”

“Between admits and discharges, charting, checking orders, doing safety checks, and helping with room sweeps, shifts can get hectic and busy not allowing nurses to get adequate breaks. This past week we were short-staffed and didn’t have a charge nurse for several hours. We have been advocating for a third BT, but management has instead given nursing staff more responsibilities. At times, it can feel/be impossible to get everything done that is required of us while getting out of the unit on time.”

“Even when a grid looks good there are things that can make it hard to provide safe patient care.

Having what the grid says is the right number of nurses for the evening shift on my unit is not enough. We also need the right mix skills and resources.

“When there are not enough Aides to handle the number of patients, patients are put at risk.

When the Aides are pulled to do 1:1, patients are put at risk.

Why are patients at risk? Because the Aides are the ones who not only help us do things for the patients, but they also are our eyes and ears to alert RNs to serious situations that arise with our patients.

If the RN’s don’t have adequate Aide assistance, then the nurses have two jobs to do. It slows down the process and increases the likelihood that mistakes will be made.

All of this is made much worse if all of the nurses called for by the grid are not working that shift or even if they are working, the number of very acute patients we have is high.

The Charge nurse needs to be able to say, “We can’t take more patients”. But what usually happens is that the supervisor says you have to take the patients.

One example happened recently when we had nine admissions, one transfer and a night admission on my shift. This was an impossible situation.

Psych patients also present a big challenge and interfere with our ability to provide safe patient care.

We are not trained to take care of psych patients. We don't know how to approach these patients. Yet they get dumped on our unit because everybody else is avoiding taking them. We can't provide appropriate care for their medical needs because the behavior problems they show are too serious. We spend time calling Code Greens and this takes away from the care of all of our patients including the ones with the pysch problems.

I have heard that HealthEast has plans to open a new unit soon. All I can say is that before the unit opens, HE needs to make sure that it has enough properly trained nurses to staff the unit before it opens otherwise patients will be at risk.

The last thing I want to mention is something I don't really ever hear anybody in Management address—racism. I didn't come here hoping that you would solve social problems that have been around for a long time. I am raising the issue because the way it happens in the hospital poses a threat to the license of many nurses, especially African nurses who have an accent. What happens is that patients decide that they don't want nurses like me to be assigned to them—not because they know anything about my competency as a nurse but because they prejudge me and others. They cleverly complain to the charge nurse so that they can have another nurse assigned. Often their complaints are filled with lies, which if acted upon could cause me or other nurses to be hauled before the Board of Nursing. This is not okay!

What I would like to see happen in terms of staffing solutions is: Approve the Unit Closure proposal so that the Charge nurses can support the nurses on their units and prevent more patients than can be safely cared for from being pushed onto units. When the proper staffing is there then more patients can be accepted.

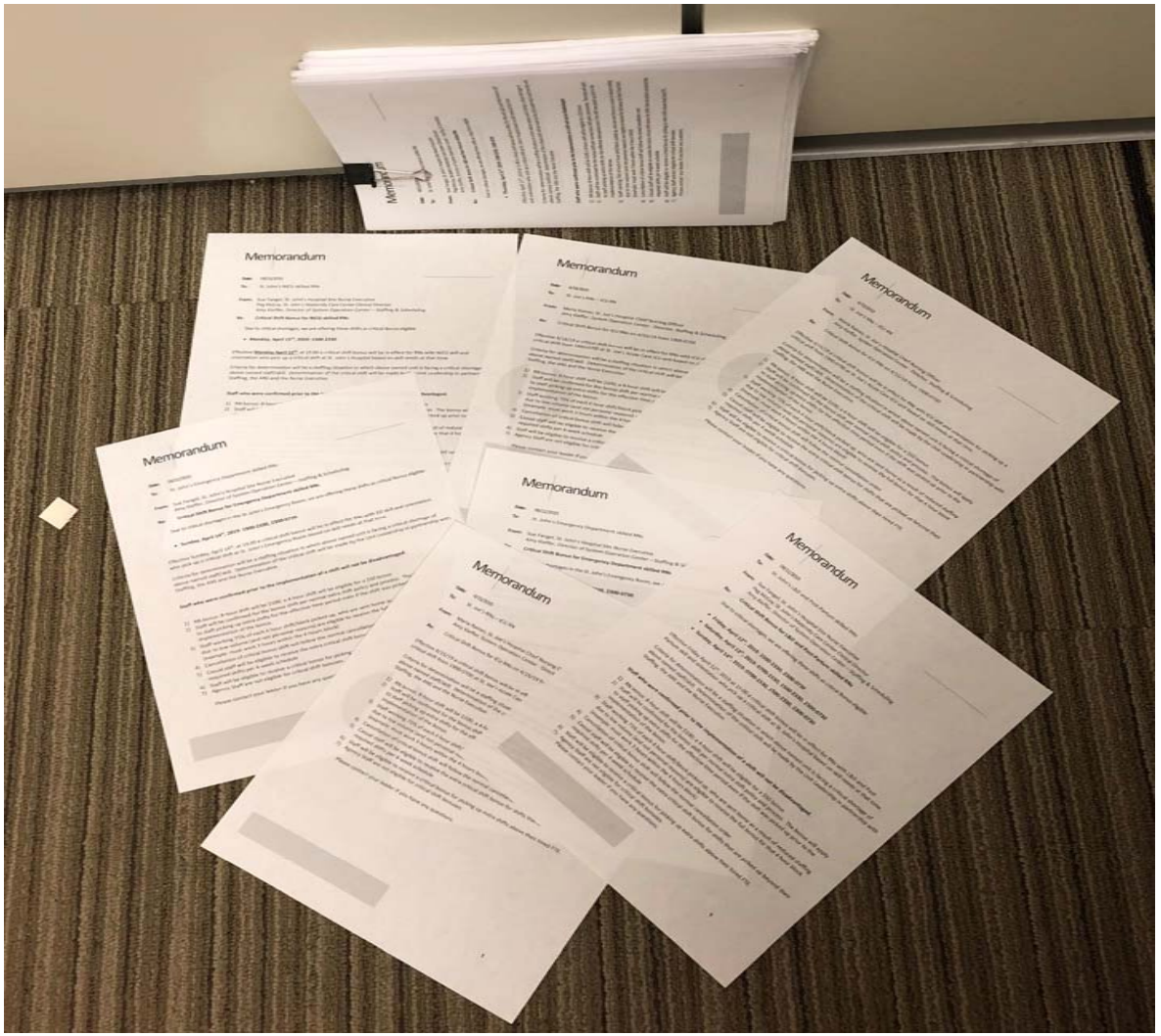
Approve processes that make sure that the right patients get placed on the right units.

Have back-up plans that nurses can immediately put in place while the staffing shortage is worked out.

Don't just go from staffing crisis to staffing crisis without putting in place a workable plan to fix the real problem. That is where the real teamwork between nurses and management become real. As nurses, we know what is going on. As nurses we know the things we need to fix the problems. If you put the framework in our contract, then it will be much easier for management and nurses to work together to make staffing what it ought to be for the safe care of our patients.

Thank you for listening. It really is important that nurses can know that their voices are heard."

IF YOU DON'T LISTEN TO NURSES ABOUT STAFFING NEEDS, DO YOU LISTEN TO YOUR OWN DATA?



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