

FOUNDATIONS OF CARE

Upholding the Legacy of Hopkins' Nurse Pioneers

Johns Hopkins Hospital Patient Care Report

December 2018



SECTION I

Summary

This Johns Hopkins Hospital Patient Care Report was based entirely on first-hand experience and observations of direct patient-care RNs employed by Johns Hopkins Hospital in Baltimore, Md. Initial and final drafts of this report were reviewed for accuracy by the reporting RNs. All incidents reported herein are believed to be not only accurate in their particulars, but also representative of common or typical assignments, practices, or policies. The report contains no personally identifiable patient information. All reporting is consistent with HIPAA guidelines.

Direct-care nurses who practice at Johns Hopkins Hospital, located in East Baltimore, Md. have written this report to bring attention to patient safety concerns that they and their patients face every day. As professionals and as members of the greater Baltimore community, nurses are uniquely positioned to speak authoritatively on issues of care and safety in a hospital setting. The nurses should be commended for their commitment to the safety of their patients and for upholding the duty placed upon them by the state nursing practice act to be patient advocates.

Key Findings

- Patient safety is compromised by high turnover among registered nurses and lack of experienced nurses. RN turnover is creating a patient care crisis.
- On many units, there are not enough registered nurses and support staff to meet individual patient care needs.
- Necessary supplies, equipment, and protective gear are often not available, creating delays in care that pose a risk to the safety of patients and nurses. Supply shortages are widespread throughout the hospital and vary from specialty unit to specialty unit.
- Systemic failure to plan for increases in patient population, acuity, and intensity creates conditions that leave patients vulnerable for missed care and care left undone.
- Poor working conditions: There is no system in place for break relief hospital-wide, creating conditions that cause fatigue, stress, and burnout.
- A dysfunctional organizational culture has created an atmosphere of fear and futility.

“We may have great and imposing buildings, the last word in hygienic and sanitary appliances, but that stricken human being lying there has many needs that none of these can satisfy.”

— Mary Adelaide Nutting

Nurses Heed the Call to Ethical Leadership

Described as an “extraordinary triumvirate of women,” Isabel Hampton Robb, Mary Nutting, and Lavinia Dock were early founders of nursing education and nursing practice at Johns Hopkins Hospital and “laid the foundation of leadership and innovation for all nurses who came after” (Johns Hopkins Hospital). During the late 1800s, these women were early nursing scholars and pioneers recognized not only for their academic prowess and clinical skills, but also for their commitment to social justice advocacy, which could be viewed as an extension of the profession’s core values. The women shared a commitment to the most challenging social issues of their time, such as women’s suffrage, the abolition of slavery, and improving living conditions for the poor. A deep understanding of the social determinants of health led them to be advocates far beyond the walls of the nursing school and the hospital. The three women joined with other nurses from around the nation to collectively organize and advocate for advancements in the profession of nursing, improve the working conditions of nurses, and to bring a collective voice to the social struggles of their time.

Isabel Hampton Robb, a close friend of Florence Nightingale, wrote the first book laying out ethical principles for nurses. These principles continue to guide nurses to this day. She went on to take the experience she gained at Johns Hopkins to Cleveland and helped to create the nursing program at Case Western Reserve’s Francis Payne Bolton School of Nursing.

Lavinia Dock oversaw the delivery of nursing care at Johns Hopkins Hospital in the very early days. She coauthored several authoritative textbooks on nursing with Mary Adelaide Nutting. Dock helped to found the *American Journal of Nursing*, which remains in publication nearly 120 years later.

Dock became a member of the Women’s Trade Union League and organized events for its members at nursing contemporary Lillian Wald’s Henry Street Settlement. She walked in the picket line of the 1909 shirtwaist strike in which 20,000 workers, most of them women, walked off their jobs. Dock told her nursing colleagues that “their status would be decided by the attitudes they took toward the needs and problems of the working class.” This ran counter to the belief of many nurses that they could define their professionalization by their very distance from “the ordinary worker” (Garofalo & Fee, 2015). Her commitment to advocacy for these causes, like that of many nurses in this time, was relentless.

Through their work and collaboration which began at Hopkins and continued for the rest of their lives, these early leaders eventually applied their “ideas of reform, progress, womanhood, justice and the public’s health into their construct of what nursing should be and wove it into a larger view of health” (Baer, 2012).

Johns Hopkins nurses seek to uphold this legacy as stated by Carol Gray, who served as the first Dean of the School of Nursing in 1984 when the school became a degree-granting division of Johns Hopkins University: “In the words of Isabel Hampton Robb, we seek to be looked to for what is best in nursing,” said Gray. “Our goal is to educate nurses who, in the Hopkins tradition, ask questions, are not satisfied with mediocrity or the status quo but are always striving to define better ways of caring for patients and of teaching the next generation of nurses” (Johns Hopkins Hospital).

Noble Beginnings

Many consider Johns Hopkins Hospital to be a world-class institution. It certainly aims to be with an institutionally declared mission statement “to improve the health of our community and the world by setting the standard of excellence in patient care.” This is clearly a lofty and noble aspiration fitting with the hospital’s foundation. The hospital’s beginning hails back to 1889, along with a medical school and a nursing school, commissioned by its benefactor, Johns Hopkins. Hopkins set forth this mission on his deathbed with instructions and funds to create a hospital to “treat the poor without charge” and to create both nursing and medical schools. Hopkins embraced this edict as both obligation and opportunity to provide aid to the poor and improve the social standards of his community in keeping with his family’s Quaker beliefs.

At the time, the institution was groundbreaking in providing care to the poor and, in particular, poor children of color. Combining patient care and research alongside formal nursing and medical education led to many benefits for the people of Baltimore as well as to the development of both the nursing and medical professions. These early beginnings and adherence to the ideals underlying the vision of Johns Hopkins, himself, are the basis upon which Johns Hopkins Hospital obtained its stellar reputation.

Reality Falls Short of Reputation

While there is no doubt that the groundbreaking research and innovation that has been accomplished through the scholarship and dedication of nurses and physicians alike has profoundly influenced patient care throughout the world; it is clear that in recent years these values at Johns Hopkins have eroded. The erosion of values coincides with the transformation of health care in the United States that has shifted the focus of care delivery away from core principles of service to public health and toward building an economic engine that fuels an industrial complex capitalizing upon the care and treatment of the sick. This change is a fall far afield from the noble vision of Johns Hopkins. Current JHH executives use the institution’s hard-earned reputation to further the interests of the business and create wealth for a small circle of influential individuals. The result is that, upon close examination of its marketing claims, both from the perspective of the registered nurses working at the bedside and the community immediately surrounding the hospital, the reality is falling short of Johns Hopkins’ reputation.

Patient Care Concerns

Nurses are drawn to employment at Johns Hopkins Hospital for the prestige and the opportunity to practice nursing at one of the largest academic hospitals on the East Coast. JHH provides nurses with the ability to practice in a high-skilled setting providing care to patients with a variety of complex and uncommon conditions. The hospital offers an incredible number of specializations that range from a variety of critical care, pediatric care, cancer, and emergency care units to specific units addressing patient populations with genetic disorders, as well as HIV and other pathological diseases.

Despite these benefits, the reality of working at Johns Hopkins Hospital is far removed from the picture described in marketing and recruitment materials. While the nurses who work at JHH are incredible at what they do, often accomplishing more with less, the hospital's outsized focus on making profit and funneling precious patient care dollars into marketing over delivering safe and quality patient care can take a toll on morale.

Nurses consistently experience barriers to providing the type of highly skilled and technical nursing care that all patients deserve — the kind of care that attracts patients to choose Johns Hopkins. Many of the barriers to care that nurses describe are aligned with the framework of factors that may contribute to a preventable adverse event (*see figure 1.*) These barriers include supply and equipment shortages; staffing levels that fail to meet patients' individualized needs; disrespectful working conditions; frequent exposure to workplace violence; and hostility from management when exercising their ethical mandate and legal right to advocate for patients.

Hopkins researchers suggest that medical errors are the third leading cause of death in the United States. The 250,000 deaths annually make errors more fatal than respiratory disease, and less deadly than only heart disease and cancer (Makary & Daniel, 2016). Considering the impact that nurses can have on preventing many of these errors, their concerns and experiences as frontline caregivers should be acted upon.

FIGURE 1.

Source: (Pronovost, Wu, Dorman, & Morlock, 2002)

Framework of Factors That May Contribute to a Preventable Adverse Event »

Patient Factors

- » Condition (complexity, seriousness, agitation)
- » Language or communication
- » Personality and social factors

Task Factors

- » Availability or use of protocols
- » Availability of test results
- » Accuracy of test results

Individual Provider Factors

- » Knowledge, skills, and competence
- » Fatigue
- » Failure to follow established protocol/procedure
- » Motivation and attitude
- » Physical and mental health

Team Factors

- » Verbal or written communication during hand off
- » Verbal or written communication during routine care
- » Verbal or written communication during crisis
- » Supervision and seeking help
- » Team structure and leadership

Working Conditions

- » Staffing levels
- » Skills mix
- » Workload
- » Availability or maintenance of equipment
- » Administrative and managerial support

Organization and Management

- » Financial resources
- » Time pressures
- » Physical environment (e.g., lack of space, noise level)

Ratings Unreliable

Hopkins' own researchers recognize that national ranking systems are flawed and fail to present an accurate portrayal of actual safety performance (Austin et al., 2015). Even though Hopkins-affiliated patient safety experts have expressed well-founded concerns over these types of ranking systems and have questioned their accuracy and value, they are prominently featured on various marketing materials and press releases (Johns Hopkins Hospital).

Publicly reported quality measures do provide a small glimpse into some of the problems nurses describe and emphasize the flaws in the national ranking systems. It is notable that there are no national ranking systems that report nursing satisfaction scores, which are demonstrated to be highly correlated with patient safety. Quality researchers discovered that a 25 percent increase in nurses' job satisfaction can yield significant benefits to patient outcomes (M. D. McHugh, Kelly, Sloane, & Aiken, 2011). Through nurses' own reports, one can see patient care and quality through the perspective of frontline caregivers who are the ones beside patients every hour of every day.

Turnover Crisis Indicates Systemic Dysfunction

Nurses in many patient care units throughout Johns Hopkins Hospital report that there is a serious problem with nursing turnover. When evaluating the ability of a nursing care unit to provide safe, competent, and therapeutic care, it is important to evaluate not only the level of education a nurse has completed but also the level of experience in clinical care. It takes several years to develop a competent level of skill in nursing practice and many more to achieve expert skill level. The advancement through the stages of novice to expert nurse is achieved only through clinical experience. Expert nurse status is not determined by level of education, status in an organizational hierarchy, or simply years logged as a nurse, but rather time spent providing hands-on care in an enriching clinical environment and the ability to take the time to analyze and process these experiences (Benner, 1982; Matthew D. McHugh & Lake, 2010).

The high level of turnover for nurses creates a vicious cycle where one group of nurses leave within their first two years at the hospital and new nurses come to replace them. New nurses see that charge nurses, supervisors, and preceptors are only a few years out of nursing school, and despite their best effort, cannot provide the necessary training that more experienced nurses can provide. This creates frustration, exasperation, and ultimately leads to a majority of nurses leaving within the first one to two years for positions at other hospitals in the area and around the country. On some units, the turnover rate is as high as 30 percent within the first six months of the year.

Some words from JHH RNs bring the impact of this revolving door into sharp clarity:

- » **Pediatric Intensive Care Unit (PICU):** "It is very difficult to retain nurses on PICU. It is common for an RN with one and a half years of experience to be the most experienced nurse on a shift. This collective lack of experience is dangerous for patients, and places nurses in difficult situations in which they have to take assignments they are not confident in performing."
- » **Surgical Oncology (W4CD):** "The hospital has made attempts to increase the unit staffing, but the retention issue in Weinberg 4CD is at a crisis

due to the workload. Over the last year, almost 50 percent of the nursing staff has left the floor, with most nurses leaving the hospital entirely. With a shortage of nurses, the workload has continued to mount and nurses rarely chart on time or take a lunch break.”

» **Pediatric Post-Anesthesia Care Unit**

(PACU): “Many of the RNs who worked in the Pediatric PACU had PICU experience. As a result of their PICU expertise, PICU patients have been sent to the PACU in the event of bed shortages. Many of these RNs are leaving the Peds PACU and taking that added experience with them. They are being replaced with RNs from medical-surgical units and new grads. The lack of PICU experience with the new hires presents a void as PICU patients are still being sent to the Peds PACU.”

» **Neuro Critical Care Unit (NCCU):** “Turnover is high in the NCCU. The reason for the high turnover is multifactorial, including uneven patient assignments, an unfair call-off system, mandatory overtime, broken promises around scheduling guidelines, lack of true self-scheduling, and an admitting process which does not properly take into account patient acuity. Nurses find that patient assignments are sometimes dangerous.”

What the nurses’ first-hand accounts describe are essentially entire patient care units that are devoid of expert nurses. Consider the stages of professional development as described by nursing theorist Patricia Benner: “Competency, typified by the nurse who has been on the job two to three years, develops when the nurse begins to see his or her actions in terms of long-range goals or plans.” She goes on to explain that for nurses in this stage of professional development, “the competent nurse lacks the speed and flexibility of the nurse who has reached the proficient level, but the competency stage is characterized by a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing. The competent nurse’s conscious, deliberate planning helps achieve a level of efficiency and organization” (Benner, 1982).

Failure to listen to frontline caregivers and resolve the turnover crisis creates patient safety risk.

Unfortunately, indications are that this problem will not resolve any time soon. In a recent interview, Kevin Sowers, the first nurse ever to serve as president of the Johns Hopkins Health System, acknowledged the mass exodus of nurses from the bedside and the profession as a problem, but placed blame on individual nurses and a lack of resilience.

“Sometimes people are dealing with really complex issues in their personal lives... at the system level, we should provide employees access to counselors — financial counselors, addiction counselors, grief counselors, whatever they need.” He went on to say that writing down “three good things they did each day, before they went to bed” fostered “resilience” (Gara, 2018).

Not only did President Sowers place blame on individuals’ so-called lack of resilience, but he also failed to acknowledge that the problem of burnout is impacting nurses at rates that are much higher than other healthcare professions: “The issue of burnout and resilience is a health care provider issue, it’s not just nurses” (Gara, 2018). This failure by JHH administration to accept responsibility for creating poor working conditions related to burnout, which leads to high turnover of registered nurses, specifically, is disappointing and indicative of a lack of willingness to address this crisis head on.

It’s a costly mistake. “The average cost of turnover for a bedside RN remained consistent at \$49,500 and ranges from \$38,000 to \$61,100 resulting in the average hospital losing \$5.7 million. RN turnover will cost a hospital from \$4.4 million – \$7.0 million. Each percent change in RN turnover will cost the average hospital an additional \$337,500. Shockingly, despite the tremendous expense of high turnover, 87 percent of hospitals are not tracking the cost of recruiting RNs lost to high turnover” (NSI Nursing Solutions, 2018).

Staffing Shortfalls

There is no substitute for nursing care. The primary commodity that hospitals “sell” is nursing care. If not for the need of skilled monitoring and constant surveillance by, and the expert knowledge of nurses, patients would be able to be at home. There now exists decades of research examining the impact of nurse staffing on patient safety and patient outcomes (Aiken, 2010). The body of literature is exhaustive and has confirmed the causal relationship between the two. The concept is relatively intuitive. “Missed nursing care, which is highly related to nurse staffing, is associated with increased odds of patients dying in hospital following common surgical procedures. The analyses support the hypothesis that missed nursing care mediates the relationship between registered nurse staffing and risk of patient mortality” (Ball et al., 2018).

Nurses’ reports, validated by studies, demonstrate that the prevalence of unfinished care is high. Hopkins nurses’ view, which is aligned with the experts, is that rationing of care is unethical and creates moral distress on frontline nurses. A 2018 report published in *Nursing Ethics* examining the impact of missed care on nurses explains that “there is evidence that the topic of missed care or unfinished care engenders feelings of guilt, a sense of lacking power to provide the care that patients need, and fear of victimization among nursing staff. There is a growing body of literature evidencing the reality of care rationing and its undermining effect on patient care and on the morale of nurses” (Scott et al., 2018).

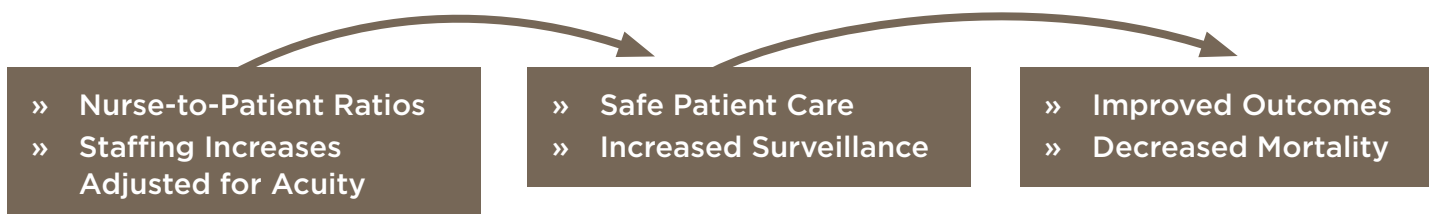
Examples Provided by Hopkins Nurses:

- » **General Psychiatry (Meyer 3):** “Nurse to patient ratios vary depending on time of day, from 1:4, up to 1:11. While patient care responsibilities are the same from 7:00 – 11:00 a.m. and 7:00 – 11:00 p.m. (assessments, milieu checks, passing medications), staffing is reduced in the evening hours.”
- » **Young Adult/Adult Inpatient Mood Eating Disorder (Meyer 4):** “The typical nurse-to-patient ratios are 1:4 or 1:5 during the day, and 1:11 at night... While rounding is taking place, the remaining nurses are caring for 22 inpatient patients, plus the day hospital patients.”
- » **Medical Intensive Care Unit (MICU):** “Staffing in the MICU was cut from 18 nurses per shift to 17 nurses per shift about a year ago, while the total number of patients on the floor on each shift stayed at 24. By cutting staffing by just one nurse each shift, two patients who should have been assigned to a single nurse each [for being very sick], are now with one nurse. Imagine a shift that should be running with 18 nurses, now running with 15 or 16 nurses. How many patients are receiving the individual attention their acuity demands? Not very many.”
- » **Surgical Oncology (Weinberg 4C/D):** “Due to the frequency of treatments and monitoring these patients require, the nurses on this unit have asked hospital administration to classify some beds as intermediate care (IMC) level beds,

JHH CURRENT STAFFING »



JHH NURSES’ STAFFING GOALS »



for those patients with a higher acuity and those that require frequent treatments and monitoring. If that were to happen, a nurse on this unit would be taking care of up to three patients at a time. Currently, the nurses are taking care of four or five patients during the day and six patients at night.”

- » **Bone Marrow Transplant Unit (Weinberg 5D):** “5D patients often require blood transfusions and close observation to manage side effects from treatment or disease...The nurse-to-patient ratio on 5D is 1:3. When a patient declines or becomes very ill, the unit does not have the ability to change the nurse’s patient assignment so that it’s one nurse [assigned to] one patient or a more appropriate ratio than the 1:3 normally assigned to nurses on this unit.”
- » **Medical Progressive Care Unit (MPCU):** The MPCU is an intermediate care unit with acutely ill patients, many of whom would be considered ICU-level patients in other hospitals. Because patients can become unstable very quickly, the unit has a high number of emergencies and codes. In the last year, nurses estimate that the unit experienced 120 rapid responses, meaning that there were 120 times when nurses have had to run a rapid response due to a decompensating patient. A rapid response is when nurses call providers and other hospital staff to evaluate any acute change in a patient’s status before there is a need to call a code. In comparison, the unit with the second-highest number of rapid responses in the hospital registered 30 rapid responses in the last year (unit undisclosed).

Acuity

Nurses report that there is little capacity to adapt staffing needs to match patients’ nursing care needs or the intensity of nursing care that is required in the unit overall. Due to the nature of patient care, patient conditions will predictably change and, therefore, must be a part of the overall plan to provide safe care for patients. Hopkins nurses observe that plans and processes for evaluating patient acuity do not accurately reflect the actual needs of the patient and, in some cases, are entirely absent. In other cases, when a patient condition changes there are system breakdowns that prevent transferring a patient to the correct level of care or decreasing the RN patient assignment to facilitate a higher level of vigilance.

Support Staff

As any nurse will acknowledge, it takes more than registered nurses to provide the best patient care. Nurses rely upon well-trained, experienced patient care support staff when they delegate the delivery of certain nursing care tasks to them. In order for nurses to be able to focus on assessment, care coordination, and other items that cannot be delegated, a complete team must be in place to provide this care.

- » **Adult ED:** “In the Emergency Acute Care Unit (1:5 nurse-to-patient ratio with 15 beds), there is no tech assigned. Often nurses are left to complete multiple patient care tasks which could be delegated to support staff. These additional tasks make it difficult to give each patient the time necessary to provide the best overall nursing care.”
- » **Endoscopy:** The procedures done in surgery are complicated and require many staff with different concentrations. When support staff call out sick, or otherwise are unavailable, the nurse must complete those duties along with their roles as a nurse.

Failure to Plan

- » **Adult ED:** Wait times [to receive care] are unsafe on most days, sometimes reaching up to 18 hours in the waiting room. Oncology patients, patients with chest pain, patients actively vomiting are just some of the patients left for many hours to wait. Nurses report that patients have had seizures in the waiting room, loss of consciousness from bleeding, and cardiac arrests while waiting for a treatment bed in the main area of the department.
- » **GI/General Medicine (M9):** When patients have high acuity and need to transfer to ICU (intensive care unit) or Critical Care Unit, there are often not enough beds so patients must be kept on a step-down unit. This means that nurses have to work with their colleagues to get help with their other patients while they take care of the high-acuity patient.
- » **Hematology (Weinberg 5A/4B):** “Over the past year, there have been two deaths on the unit that may have been preventable if the patients had been transferred to an ICU floor to receive adequate care. At the time, there was no bed availability in the ICU.”



Inadequate Supplies

Studies examining operational failures have found that nurses “experienced an average of 8.4 work system failures per eight-hour shift. The five most frequent types of failures, accounting for 6.4 of these obstacles, involved medications, orders, supplies, staffing, and equipment. Nurses waste up to an hour a shift searching for supplies” (Tucker & Spear, 2006).

Inadequate supplies create delays, disruption, and distraction and can contribute to errors that can result in patient harm (Pronovost et al., 2002). This problem can also create conflict and interfere with a therapeutic relationship when patients perceive these delays to be the fault of the nurse. Finally, the problem undermines the reputation of Johns Hopkins Hospital as a place where patients can expect to have access to specialized care that is facilitated by the availability of specialized equipment.

- » **Endoscopy:** During procedures, which can last up to five hours, nurses are required to move/shift patients without adequate lift equipment.
- » **Surgical Intensive Care Unit (SICU):** There is only one ultrasound machine on the unit. At times multiple patients have needed evaluation that requires the use of the ultrasound machine.
- » **Leukemia IMC (Weinberg 5B):** “C. Diff, a bacterium that impacts the colon, can be transmitted from patient to patient when the vital signs machines aren’t cleaned well enough. The unit has seen outbreaks of the C. Diff bacteria among patients, something that could be prevented if each room had its own vital signs machine.”
- » **Adult Emergency Department (ED):** Medication infusion pump shortages can cause delays in the administration of lifesaving medications and patient care. Registered nurses from the ED perform vital assessment and interventions that are often time sensitive. Searching for basic equipment creates unnecessary delays not only in the administration of medications but also contributes to a delay in the assessment and treatment of other patients.
- » **Surgical Intensive Care Unit (Weinberg 3A):** Infusion pumps that are used to administer pain medication via the Patient Controlled Analgesia (PCA) protocols are also in short supply. These PCA pumps offer a timely and safe delivery method that avoids overdose for administering potentially dangerous pain medications to patients needing frequent relief from extreme pain, such as that caused by sickle-cell crisis.

Working Conditions

Fatigue is an obvious contributor to mistakes that have the potential to cause patient harm.

Working long hours in a chaotic setting can take a toll. Nurses typically work 12.5-hour shifts that have the potential to go longer when patient care and documentation demands require.

Unfortunately, it is not uncommon for nurses to work these long hours without any period during the day when they are able to reset and refresh while completely free of patient care responsibilities. In cases where nurses are relieved of patient care responsibilities, nurses are actually leaving their patients in the hands of another nurse who is then responsible for additional patient care assignments. From the nurses' viewpoint, there is no amount of time that is acceptable for their patients to be left in the care of another nurse with an unsafe assignment. Yet, this is the circumstance under which nurses are "relieved" to take meal breaks, if at all.

Nurses Report »

- » **MICU:** "For our 12.5-hour shift, we get a one-hour lunch break, but since we do not have dedicated break relief nurses, we are covering each other's patients, meaning that one nurse has double the patient load. Having four ICU patients is dangerous."
- » **NCCU:** "Until recently, nurses did not get lunch breaks on the NCCU. Recently, nurses have begun to be allowed to take lunch breaks. However, because management does not staff break relief nurses, nurses on the unit must increase their ratio of nurses to patients from 1:1 or 1:2 to 1:3 for two hours out of the 12-hour shift."

SAFE AT HOPKINS?

A survey conducted earlier this year by Johns Hopkins nurses found »

» **37%**
of Hopkins nurses report that they have experienced workplace violence in the past year.

» **50.1%**
of nurses reported that their concern was ignored or nothing happened after reporting.

» **95%**
of Hopkins nurses replied that they feel at risk for injury at work at least sometimes.

Workplace Violence

In a survey conducted by nurses of nurses who work throughout Johns Hopkins Hospital, a shocking 37 percent of nurses reported that they have experienced workplace violence in the past year. Equally upsetting, 51 percent of nurses reported that their concern was either ignored or not acted upon after reporting.

A report published October 2018 in *Academic Medicine* describes exactly the types of cultural challenges that nurses are reporting (Dixon-Woods, 2018).

Researchers who performed the study at JHH

“found that some staff members said they didn’t know how to report their concerns, and others said that reporting processes were difficult to navigate. More generally, employees reported a culture of fear -- they worried about hostile or angry responses, retaliation, or being labeled a bad team player. Even when employees did speak up, they reported, nothing seemed to happen in response. A particular concern for many employees was a small number of senior staff members who engaged in poor conduct with apparent impunity. Quietly referred to by many as the ‘untouchables,’ their behavior was regarded as unacceptable, but they were so powerful that many felt that raising concerns would go nowhere.” (Dixon-Woods, 2018)

From nurses’ first-hand accounts, it is clear to see that a variety of organizational failures contribute to these incidents:

- » **Acute Inpatient Schizophrenia (Meyer 5):** “Failure to properly staff the unit leads to dangerous situations for nurses and patients. This month alone, we have had two instances of workplace violence involving an RN being kicked in the legs and a tech being scratched on the face so severely that she spent the rest of her night shift in the ER.”
- » **MICU:** “Workplace violence is also an issue on the unit, since many patients are confused, delirious, or experiencing withdrawals. Some equipment, like restraints, are available. Sitters are sometimes available when nurses request them, but often they are refused because it comes out of the unit budget... There are not enough sitters staffed in the hospital. RNs have to prioritize which patients receive a sitter. Many patients are confused or try to get out of bed. Patients have gotten hurt, which then increases their stay in the ICU. RNs also get hurt preventing patients from falling. RNs have had difficulty getting a sitter for patients with suicidal ideations.”

Seeking Solutions

Nurses have identified many potential solutions to the problems detailed in this report. First and foremost, management must respect nurses' right to "become involved and/or assume leadership positions in professional nursing organizations that have structures and mechanisms where [our] voices can be heard," which includes organizing to form a union and collectively advocate for patients (Rushton, 2017). There must also be an immediate halt to disruptive and hostile behavior toward nurses who are involved in efforts to form a union, behaviors for which JHH executives claim to have a policy of zero tolerance. In addition, nurses' recommended changes must be implemented to stop the turnover crisis, secure safe staffing throughout the hospital, reduce workplace injury, and guarantee that the supplies needed to care for patients and protect registered nurses are always available. Finally, while the vast majority of these issues have persisted long before nurses began to organize a union and continue to exist today, some of the issues identified here are, or may be, currently under review by management. These last minute measures to shore up problems with temporary measures, however, are not enough and require a long-term and sustainable solution that includes the voice of nurses at every step of the way.

The hospital's original values and quest for academic scholarship resulted in some of the country's most rigorous hospital safety standards. But it is clear to nurses that the current executive leaders of Johns Hopkins Hospital have lost sight of the early vision of its founder. The challenges that nurses face in advocating for their patients and obstacles to providing safe care are a result of conflicting values when making allocation resource priorities. It is clear that these compromises on the front lines are dictated by

executives, far removed from the realities of patient care, to save money and increase revenues. These executives rest on the laurels of a reputation earned long ago and no longer deserved.

JHH RNs seek to reinvigorate the values that formed the reputation that JHH is famous for and built its name upon. As Cynda Hylton Rushton, the Anne and George L. Bunting Professor of Clinical Ethics in the Johns Hopkins Berman Institute of Bioethics and the School of Nursing, recently advised,

"Organize colleagues to think about specific strategies and messages we can employ in a constructive way. What matters is that we pause to notice an opportunity, take the time, exert the effort, and not remain silent. Being involved in policy is not necessarily easy, but keeping the health and well-being of our patients at the forefront will make it worthwhile. Without our voice, the policy dialogue is incomplete. Small, courageous steps can make a difference!" (Rushton, 2017)

This is advice that nurses have taken to heart. It is advice that is consistent with the ethical principles set forth by nursing pioneers nearly 130 years ago. Much like the visionary nurses who, through their collaboration at JHH, created nursing as we know and understand it today... today's nurse leaders are ready to accept the challenges that lie ahead as they demand more than a mediocre status quo. As RN leaders who are leading the effort to make these vital improvements say, "We will never stop advocating for our patients." It is difficult to imagine that the "extraordinary triumvirate" of women who played such an important role in founding this prestigious institution would expect any less.

SECTION II » Unit Based Reports

EMERGENCY UNITS

Adult Emergency Department (Zayed 1)

The Adult Emergency Department (AED) is a high-acuity, fast-paced, Level I trauma center and designated stroke center which treats more than 60,000 patients annually. There are typically prolonged wait times. The workflow design, availability of properly working equipment, and overcrowding creates treatment delays for our patients.

Staffing Ratios

The nurse-to-patient ratio is 1:4 or 1:5, depending on the area assigned to the nurse. Within recent months, the largest reported area of complaint was staffing ratios. Nurses would be assigned to three patient rooms, but the AED has “psych overflow” rooms that hold up to five patients. This could result in the nurse caring for two high-acuity patients along with the five psychiatric patients who were waiting to be evaluated by the psychiatry team. The emergency room psychiatric area is constantly overflowing into the main area of the department, resulting in multiple rooms being used to hold “overflow” patients. Full-time RNs have been hired by the psychiatric department to manage the first overflow room, and fairly often, the overflow is contained to one room. There are occasions when overflow could be as many as three or more rooms, in which case the emergency department nurses will be assigned one of the overflow rooms to manage in addition to the other two patients.

Support Staff

There is a lack of support staff to assist nurses. There are often only one or two techs for the main pod, a grouping that consists of 25 beds. The techs are expected to assist with patient care, do vital signs, complete EKGs, draw labs, and place IVs, among other tasks. In addition to all of their assigned duties, they also respond to critical care patients. When there are multiple critical care patients, the techs may be out of their assignment for many hours at a time. Due to the shortage of techs, often nurses are left to

complete multiple patient care tasks (like vital signs, placing IVs, cleaning the patient, taking them to the restroom, etc.) which normally could be delegated to support staff. These additional tasks make it difficult to give each patient the time necessary to provide the best overall nursing care. In the emergency acute care unit (1:5 nurse-to-patient ratio with 15 beds), there is no tech assigned. In the South B pod, there is very rarely a tech assigned (1:4 nurse-to-patient ratio with nine treatment areas). Having support personnel to assist with tasks could greatly decrease the stress on nurses and allow time to provide safer patient care and better patient education.

Wait Times — Up-Front Process/Screening

The process by which patients are screened by a provider after being triaged is very inconsistent. The goal of the emergency department is for all patients to have a rapid medical screening by a provider (physician assistant, attending, or resident) within one hour of arriving to the emergency department. The patient is triaged by a nurse and acuity is determined using the ESI triage system. If the patient is determined to be stable (level 3, 4, or 5), he or she will then be screened by the screening provider. During this screening, acuity will again be assessed, medication can be ordered, labs are drawn, and radiology testing ordered. There is rarely an overnight provider, and patients can wait 10 hours without being seen by any provider on these occasions. When there is a provider and patients are promptly screened, the process is safer for our patients.

Waiting Room

There are long wait times on most days, sometimes reaching up to 18 hours in the waiting room, which creates risks for patients. There are several areas of the department that are not fully staffed overnight: South B (seven beds), South A (six beds), and the screening area. On the weekends, the South B area

does not become staffed until 1:00 p.m., and patients continue to wait in the waiting room due to staffing shortages of providers. Even when all of these areas are open and fully staffed, the wait times can still be many hours. Often high-acuity patients are left to wait because there are not any beds available for them to receive treatment. Oncology patients, patients with chest pain, and patients actively vomiting are just some of the patients who have been left for many hours to wait. Nurses report that patients have had seizures in the waiting room, loss of consciousness from bleeding, and cardiac arrests while waiting for a treatment bed in the main area of the department.

Boarding Admitted Patients

A significant contributing factor to the lack of available space and resources to treat patients in the waiting room is extended boarding time. AED boarding times were reported to be potentially more than 24 hours and even as long as 40-plus hours on occasions. One reported strategy to help improve AED patient flow and reduce boarding times was to designate providers from the inpatient unit into which the patient was anticipating admission as the primary treatment provider, while nurses in the ED continued to provide care for the patient. Thus, emergency department providers would no longer care for the patient unless the patient became critically unstable. This practice has been reported as a large cause of dissatisfaction for AED nurses because patients still require the same nursing care, but orders come from inpatient providers who would only see the patient maybe once in a 12-hour shift. Any needed orders or orders needing clarification now must be done by reaching out to the admitting team. This results in delays of inpatient care and decreased patient satisfaction and decreased nursing satisfaction.

Leadership Support

Nurses report that AED leadership has been in a state of flux for quite some time. There was an acting director of nursing while a new director was waiting to be hired. The new director splits her time between JHH and Bayview Medical Center and frequently is required to attend meetings when on site, and there-

fore has a limited presence in the AED. The assistant director of nursing has been filling her own position as well as acting nurse manager for several months. Between the dual duties, attending a large number of meetings, and attending conferences, her presence is also very limited. The staff feel unsupported due to the lack of presence in the clinical area by leadership. While the AED is short staffed on support personnel, residents, and attendings, there is no shortage of administration personnel in the department. Staff have expressed concerns and dissatisfaction over the money spent on administration and leadership personnel while nursing wages have remained stagnant and benefits have been cut.

Wilmer Eye Patients

The Wilmer Eye Center is a consulting service to the AED, but patients are referred to the AED daily when walk-in hours are not available. On the weekends, Wilmer is the only service to provide on-call ophthalmologist care in the area. There is only one ophthalmologist on call and the wait is extensive on most days to be evaluated and significantly worse on the weekends. Patients become very frustrated with the long waits, which are difficult for staff to explain.

Materials and Supplies

Supplies are consistently a problem at JHH. Items and supplies are “TOS” (temporarily out of stock) frequently. A lack of pumps and channels for the pumps has been a problem for several years and often a nurse could spend a significant amount of time each shift trying to secure a pump. Many nurses in the ED have experienced multiple occasions where the administration of lifesaving medications was delayed while a nurse searched for a pump to deliver the medication. Currently PCA pumps are on shortage, creating increased workload on nurses when treating patients with sickle cell crisis, who can require IV push pain medications every hour. These patients are almost always placed in the EACU (emergency acute care unit) and the nurses have a 1:5 nurse-to-patient ratio. There is also a shortage of wheelchairs. Several times a day, staff members find themselves searching for wheelchairs in order to transport their patients or to receive patients from paramedic stretchers in

triage. In addition, nurses reported being consistently out of items needed to provide the most basic emergency room care, such as blood pressure cuffs, pulse oximetry sensors, pulse oximetry cables, EKG leads, and EKG cables.

Safety and Security

Safety and security has been another reported issue. Staff members regularly experience verbal abuse and physical abuse. Many changes have occurred in the past six months, since nurses began organizing toward a union, that have greatly improved the safety and security of our environment in the AED. Security presence has been increased, behavior contracts and algorithms have been put into place with problematic patients, and “code green” has been instituted as a quick way to get help when there is a safety situation. Overall, our safety has been made a priority.

Scheduling

Self-scheduling is used in the ED. There has been an increase in complaints of scheduling difficulties such as schedules conflicting with school schedules, switching shifts with no regard to RN availability, and declining switch requests. Nurses are having difficulty making switches due to changes in department scheduling guidelines. Rules are put into place that will significantly impact the nurses’ ability to balance their schedules without any input from staff. As a result of these changes, there have been increased call-outs, resignations, and short staffing. RNs are still being required to do rotating shifts, which creates risks for the health and safety of nurses and patients alike. On-call is another subject that has caused dissatisfaction with the nurses in the department. Scheduling 12 hours of on-call in one period is required for all full-time staff members. While on-call is unpopular, the bigger issue is the difficulty with switching an on-call scheduled shift due to constantly changing rules about how switches can be made. The way holiday switches are handled has also been changed in recent years to make it very difficult to get switches completed. Changes have been made to the scheduling guidelines based upon behaviors of a small percentage of staff members.



Psychiatric Adult Emergency Department (Psych AED)

The psychiatric AED consists of 12 beds, with two being private rooms, two being seclusion rooms, and the remaining being double rooms. In addition to the 12 beds inside the psych AED, additional rooms can be converted to psych rooms to accommodate patients above the 12. Theoretically, overflow is unlimited. Two nurses are responsible for the care of the 12 patients in the psych AED. The charge nurse cares for up to five of the overflow patients, as well as assigning the treatment team to all psych patients, managing bed flow, and facilitating admissions and discharges. Outside of the psych AED, the shift coordinator and nurse supervisor are also responsible for tracking and managing movement of beds and workflow within the overall AED.

Patient Population

The psych AED provides care to adults arriving via court or police emergency petitions, patients who self-present with suicidal or homicidal ideation, substance use disorders, psychotic symptoms such as visual and/or auditory hallucinations, as well as those that are frequently re-admitted. Patients with medical problems and psychiatric problems are often sent to the psych AED without being adequately cleared medically. Medical supplies are not readily available in this department; therefore, the charge nurse must complete a second triage to determine if the patient would be better served on the medical side. If medical treatment is more urgent, psych AED charge will try to get them admitted to a medical floor.

It was reported that there is no standard or expected ratio, but the nurse-to-patient ratio was reported to rarely exceed 1:6.

Staffing

Staffing is generally inadequate. The psych AED is staffed by Meyer 3 nurses. Due to high staff turnover and a lack of experienced nurses trained to work in the ED, the psych AED is often understaffed. The

lack of full-time staff results in a reliance on ED nurses who are inexperienced in psychiatric care, and travel nurses. Also, on-call staff are often used to fill staffing deficits. Nurses from inside the hospital receive no training before the shift; travel nurses are oriented for just three days. Several travel nurses were hired around April 2018. While their presence has been helpful, they are only allowed to care for the less-acute patients, meaning no private or seclusion rooms and no overflow.

Scheduling

It has been reported that the schedule is a primary reason RNs leave. There is a list of RNs who want to be taken off rotating shifts. This is a first-come/first-served list. However, because not enough nurses are being trained to work in the psych AED, management has stopped following the seniority list to staff the psych AED. This highlights two issues: lack of respect for seniority and lack of adequate staff training.

Equipment and Supplies

As stated before, this unit is not set up for medical emergencies. There are limited medications available and only one IV pole. It is also difficult to find basic care supplies such as toothbrushes and toothpaste.

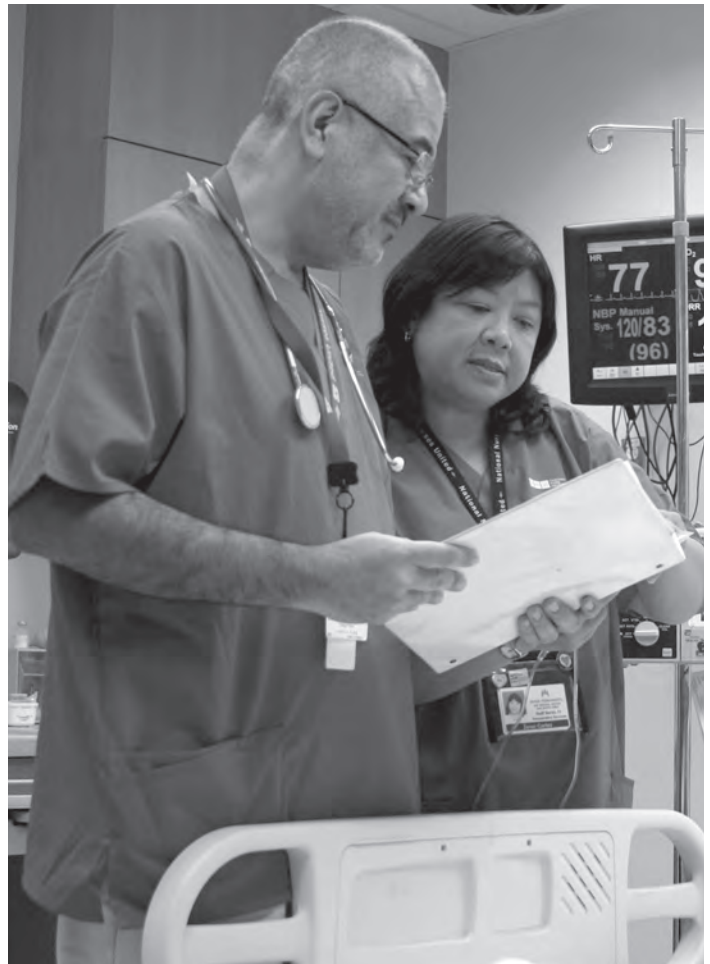
Patient Care

Patient wait times are a major problem in the psych AED. Patients routinely wait 50 hours or more, with many patients waiting 100 hours or more in the waiting room. There is a lack of resources in the psych AED to pass the time; in fact, it is commonly stated that the best thing patients can do is sleep. There is a shortage of beds both in the hospital and the surrounding area. Therefore, it is not unheard of for patients to be admitted to units that are not the best fit for their needs just to clear space in the psych AED.

Workplace Violence

Nurses and other patients are at risk of violence from psychotic and agitated patients. Not all nurses are trained in de-escalation, restraint, and emergency medication administration. Experienced psych nurses are often required to step in to manage aggressive events for non-unit nurses. There are not enough private rooms to place patients. On average, about two workplace violence incidents occur a month, regardless of whether they are reported. About a year and a half ago, a tech was taking a patient's blood pressure and got kicked in the head. The tech had to go on medical leave due to this incident.

Several months ago, a nurse was punched in the face by patient. In this situation, there were 13 patients in the psych AED instead of 12. The shift coordinator had insisted that a patient from overflow come back to the psych ED. The nurses had expressed that this was unsafe and that it was too acute in the psych area to move patients around. However, their voices were not heeded. The patient was moved to the back, and another patient had to sit in a chair. The patient in the chair ended up running and punching the nurse in the face. The nurse was encouraged by the hospital to press charges against the patient. The patient was restrained in the moment, but eventually discharged. The hospital placed the onus on the nurse who was assaulted to press charges against the patient.



INTENSIVE CARE UNITS

Cardiac Care Unit (Zayed 5W)

The cardiac care unit is a 12-bed medical intensive care unit specializing in cardiovascular diseases. The ratio on the unit is 1:2 or 1:1, depending on the patients' levels of acuity. We are located on Zayed 5 West, next to the cardiovascular surgical intensive care unit (CVSICU). Overall, our unit has a good mix of experienced and new nurses, and we pride ourselves on having a variety of staff from differing nursing backgrounds. Our patients come from the emergency department, operating room, and other units throughout the hospital, as well as from other hospitals in the area when patients are transferred to us for complex cardiac emergencies or life-threatening diseases. Additionally, we always try to have at least one open bed for any crashing or coding patient in the department of medicine, or any HAT (heart attack team) patients.

Our unit is unique in that we can accept any “overflow” ICU patient in the hospital; thus, our scope of practice is broad and we must maintain ICU skills from all specialties, not just cardiac. However, frequently accepting “overflow” patients from other ICUs in the hospital affects patient care because (1) it takes away beds from critically ill cardiac patients, and (2) does not allow us to deliver the highest-quality patient-centered care because our cardiac fellows and attendings are not assigned to take care of them. Despite the fact that we take care of complex ICU patients, the hospital administration does not formally consider our unit an ICU, and therefore, we are not provided with the same resources as other ICUs, especially the surgical ICUs. The lack of resources is

reflected in the substandard equipment and supplies our unit receives, including for example, ICU-specific beds and patient rooms. Night-shift nurses often state that they have low supplies overnight, and often do not have unit assistants to assist staff. The main justification we hear from management is that our unit doesn't bring in as much money as other ICUs, and thus cannot receive as much ICU support. Even our manager has had to stand up for us to hospital management to allow us to keep our staffing ratios safe for our critically ill patients.

In addition, we have problems keeping new nurses because there is an expectation that we cover shifts in the catheterization lab (CVIL). While some nurses are grateful to get experience working in CVIL, many coworkers find it frustrating that their schedules are not pre-set and they have varying shifts per schedule in the CCU and CVIL. Scheduling transparency and allowing nurses to be more involved in choosing when they work in the CCU versus the CVIL would greatly help with nurse morale and resiliency on our unit.

Lastly, poor hospital leadership has resulted in poor staff morale and retention. While a large majority of CCU staff are proud to be CCU nurses, many are unhappy about hospital leadership and the way nurses are treated at Johns Hopkins Hospital. We feel that taking care of critically ill patients and retaining nurses starts with putting nurses first and letting us have a voice.

Medical ICU (Zayed 10E)

In the MICU, we care for patients with pulmonary issues, liver failure, kidney failure, infections, sepsis, overdoses, drug withdrawals, and other illnesses. Most of our patient population is chronically ill with multisystem organ failure. Any hospital in the region, and even country, that feels it does not have the resources or expertise to care for certain patients may send these patients to the JHH MICU. We not only receive the sickest patients in the city, but also the state and Tri-State Area.

Staffing in the MICU was cut from 18 nurses per shift to 17 nurses per shift about a year ago, while the total number of patients on each shift stayed at 24. On every shift when it was 18 RNs, there were eight very high-acuity patients who required 1:1 care from a nurse. By cutting staffing by just one nurse each shift, two patients who should have gotten 1:1 assignments with a nurse now have to share a single nurse. Now with 17 nurses, only six 1:1 assignments can be made. Additionally, we held on to the rule from when we were staffed at 18 nurses per shift that there will be two call-outs before a nurse is called in. As a result, there are often only 16 nurses working per shift, with sometimes only 15 nurses working per shift. When this happens, only two high-acuity patients are assigned as 1:1 on the entire 24 bed MICU. Imagine a shift that should be running with 18 nurses, now running with 15 or 16 nurses. How many patients are receiving the individual attention their acuity demands? Not very many.

At the same time the staffing change was made, management also increased the number of continuous dialysis machines allowed on the unit at once. These machines are used to care for patients who are too critically ill to be safely dialyzed on regular machines. They are a form of life support. These machines run continuously and a lot can go wrong quickly, so they require more nursing attention. At most hospitals, the nurse-to-patient ratio for patients on the continuous veno-venous hemodialysis (CVVHD) machines is 1:1. Nurses need to be within earshot to hear the alarm from the CVVHD machines. Many alarms are so important that the machine automatically stops until the cause is troubleshooted and if the alarm source is not resolved within two minutes, blood will clot and cannot return to the patient. At JHH, the ratio for CVVHD patients can be 1:2. MICU nurses

often care for a patient on a CVVHD machine in addition to another patient. Since we have to care for the CVVHD patient and another complex patient, we are often in another room and are not able to get back to the patient in time. As a result, patients lose blood from the CVVHD machine regularly. The cut in staffing and increase in the number of machines allowed has delayed care for patients, which results in unnecessary blood transfusions.

For our 12.5-hour shift, we get a one-hour lunch break, but since we do not have dedicated break relief nurses, we are covering each other's patients, meaning that one nurse has double the patient load. Having four ICU patients is dangerous. Nurses on our unit go to lunch between 12:30 and 2:30, so only two to three nurses are working on each side of the unit during each lunch hour. More patients are less attended with fewer nurses on the floor. Although we do get our lunches, we don't want for a bad event to happen for us to get the proper staffing, which has happened before.

On the MICU, sometimes we get active oncology patients. These patients should be properly assigned to Weinberg ICU, where oncology ICU patients go. RNs in MICU get training on hazardous materials only once a year, so we are not used to giving chemotherapy and not accustomed to how to protect ourselves from the chemotherapy agent. MICU often becomes a catch-all unit with patients who should be on other units. For example, MICU also receives acute stroke patients. Although there is a neuro ICU unit at Hopkins, that unit is often full or will not accept certain neuro patients. When new MICU RNs are starting on the unit, they receive a four-hour crash course on neuro patients, but there isn't any training afterwards.

Workplace violence is also an issue on the unit, since many patients are confused, delirious, or experiencing withdrawals. These patients are not aware of what they are doing and are a danger to themselves and nurses. Some equipment, like restraints, are available. Sitters are sometimes available when nurses request them, but often they are refused because it comes out of the unit budget. However, the most helpful thing to prevent workplace violence is increased staffing, so nurses can devote more time to

those patients. Nurses being able to keep their eyes on confused patients minimizes the danger patients can inflict on themselves and nurses, and helps prevent patient falls. If the unit were better staffed, nurses would be able to monitor patients more effectively, ask for medication more appropriately and promptly, and have a better idea of what a patient needs. By having more nurses on the floor in general, we can help calm the patient down and provide the backup needed during violent episodes.

Patients who should have a sitter are denied a sitter because a sitter is not made available. There are

not enough sitters staffed in the hospital. RNs have to prioritize which patients receive a sitter. Many patients are confused or try to get out of bed. Patients have gotten hurt, which then lengthens their stay in the ICU. RNs also get hurt preventing patients from falling. RNs have had difficulty getting a sitter for patients with suicidal ideations. Restraints are sometimes used as an alternative to having a sitter, even in cases where a sitter is more appropriate. Hopkins policies say that sitters and other alternatives need to be tried before RNs restrain a patient, but this is not always possible given the lack of resources.



Cardiovascular Surgical ICU (Zayed 5E)

The cardiovascular surgical intensive care unit (CVSICU) is an 18-bed surgical ICU specializing in the care and resuscitation of patients in the immediate post-operative period following open heart surgeries, vascular surgeries in the chest, as well as patients who have undergone heart or lung transplantation. Patients on this unit have uniquely high and dynamic acuity, with many requiring invasive life-support devices requiring a vast array of special skills from nursing staff.

The typical RN on this unit has undergone up to six months of orientation in order to be deemed safe and competent enough to work independently. Currently, the unit is staffed for 14 of the 18 available beds, but sometimes is required to care for more than 14 patients, which increases stress on staff to accommodate patients recovering from invasive cardiac surgery.

Neuro Critical Care Unit (Zayed 3W)

The neurological critical care unit (NCCU) is a 24-bed intensive care unit where nurses care for the sickest neurological patients in the area. Patients with conditions such as ischemic and hemorrhagic stroke, status epilepticus, coma, traumatic brain injury, autonomic instability, and many other neurological illnesses rely on nurses to provide intensive care to survive. For example, patients on this unit require close monitoring including hourly neurological exams, invasive monitoring, and management of life-support equipment. Many patients require total care and/or are comatose and depend entirely on specially trained nurses for management of vasoactive drips, ventilators, surgical wound care, and neurological monitoring, as well as physically demanding basic needs such as turns, hygiene, and nutrition.

The nurses face many challenges to provide excellent care to their patients. One challenge is the inconsistent availability of medications and nutritional supplements in a timely fashion. Medications and nutritional supplements are often late and supplements can sometimes be out of stock for days. NCCU patients require supplements to aid the healing process, especially those patients who are recovering from brain and spinal surgery. Care is often delayed due to medications arriving late or requiring nurse intervention to be delivered to the unit at all. This delay results in nurses spending more time away from patient care and patients often not receiving medications on time.

Another danger to patient care is nurse burnout and fatigue. Until recently, nurses did not get lunch breaks on the NCCU. Recently, nurses have begun to be allowed to take lunch breaks, however, because management does not staff break relief nurses, nurses on the unit must increase their ratio of nurse

to patients from 1:1 or 1:2 to 1:3 for two hours out of the 12-hour shift. In addition, nurses are still responsible for the patients while on their “break”; they are required to answer their phones with the expectation that the nurse will return to the bedside if need be. This system means that nurses are required to take on a high patient load while also not getting a true break.

Turnover is high in the NCCU. The reason for the high turnover is multifactorial, including uneven patient assignments, an unfair call-off system, mandatory overtime, broken promises around scheduling guidelines, lack of true self-scheduling, and an admitting process which does not properly take into account patient acuity. Nurses report that patient assignments often fail to consider an individual nurse’s skill level and the overall complexity and intensity of an assignment. Nurses are required to take “on-call” shifts and when they are called in for an additional shift, end up working more than 40 hours in their work week. This overtime is mandatory. Weekend option nurses, who voluntarily work extra weekends for a pay differential to the benefit of the rest of the staff, were given a bait and switch around requirements to work Fridays. Management states that nurses have “self-scheduling.” However, nurses rarely get the shifts that they request. Patients are admitted into rooms based on the geography of the unit instead of the acuity of the patient assignment. This approach to admission assignments could mean that a very sick patient is assigned to an already busy nurse, putting that patient at risk. Nurses are also limited to taking less vacation than hours earned. On top of these issues, nurses are frequently required to stay late after their 12.5 hour shifts to complete charting tasks. This additional work time is not paid.

PSYCHIATRY UNITS

Adult Inpatient Behavioral Health Unit (Meyer 3)

Meyer 3 is a 22-bed psychiatric unit that treats patients with substance abuse disorders, with dual diagnosis (substance abuse disorder and other psychiatric diagnosis), and who are experiencing acute, major psychiatric episodes which require inpatient treatment. Many emergency room patients are admitted to Meyer 3.

Ratios

Nurse-to-patient ratios vary depending on time of day, from 1:4, up to 1:11. While patient care responsibilities are the same from 7:00 a.m. – 11:00 a.m. and 7:00 p.m. – 11:00 p.m. (assessments, milieu checks, passing medications), staffing is reduced in the evening hours. At night, from 11:00 p.m. – 7:00 a.m., there are two nurses, two clinical technicians, and sometimes a security guard to take care of 22 patients. These ratios can be incredibly dangerous for nurses, staff, and other patients. When disruptive incidents occur during nighttime hours, which happens regularly, nurses feel there is simply not enough staff to address the situation with the necessary care and safety required.

Staffing and Scheduling

Unit nurses feel we do not have enough full-time or part-time staff to make even minimal accommodations for our various scheduling needs. Those of us rotating between night and day shifts often have little time (sometimes less than 24 hours) to switch between these sleep schedules. Nurses are regularly scheduled until 11:30 p.m. the night before a 7:00 a.m. shift, leaving fewer than eight hours between shifts. Sometimes a nurse will be scheduled for an all-night on-call shift (11:00 p.m. – 7:00 a.m.) the night before a morning shift at 7:00 a.m. We are regularly scheduled for back-to-back eight-hour shifts resulting in 16-hour workdays. On-call shifts are not always used as intended. We are often called in for our on-call shifts not because of an unexpected situation, but because the shift was not adequately staffed in the first place. All of these practices feel not only disrespectful and frustrating, but also leave

nurses fatigued and stressed, preventing us from providing optimal patient care. We recently lost three experienced, valuable nurses from the unit who stated that the reason for their departure was because they could not continue to work on this unit and still have adequate time to spend with their families or complete school work.

Nurse Safety

The threat of violence is a constant concern of nurses on this unit. Many of our patients are placed under constant observation (CO) when they are a danger to themselves or others, yet we often feel the unit is understaffed and/or without adequate security to provide this necessary CO. When nurses are needed to provide CO, they are not available to other patients in their charge. Violence against nurses is a very real concern. With better staffing, fewer patient assignments, regularly available security, and more reliable COs, incidents of violence could be greatly reduced.

Recently, there were only three nurses on evening shift, when there are usually five. A patient quickly escalated from verbal to physical abuse, so security was called. It took 20 minutes for security to arrive, during which time several staff were elbowed and spat on. With better staffing, nurses may have been able to restrain the patient to administer emergency medication themselves, but the lack of adequate staff on the floor made it necessary for nurses to call and wait for security.

Equipment

The hospital recently purchased new beds which are not compatible with the restraints we use in psych units. The new restraint/bed combination makes it easy for patients to slip out of restraints, and also takes a considerably long time to administer. The EKG machine is decades old, batteries need to be regularly replaced, or do not work. Using these older EKGs, which we do with every admitted patient, takes much longer than with newer models, meaning nurses and techs are spending more time on the machines and less time on direct patient care.

Young Adult/Adult Inpatient Mood Eating Disorder (Meyer 4)

Meyer 4 is a 22-bed psychiatric unit that treats three patient populations: young adults, affective disorders, and eating disorders. Meyer 4 nurses are also responsible for staffing the electroconvulsive therapy (ECT) unit. The unit also includes a “day-hospital” for psychiatric patients, which is a partial hospitalization program for patients who are transitioning between the need for inpatient and outpatient care. As psych patients are not confined to individual rooms or beds as with most medical units, we have what is called “the milieu.” The milieu is the common area, which is where patients spend most of their time.

Staffing and Ratios

The typical nurse-to-patient ratios are 1:4 or 1:5 during the day and 1:11 at night. Inpatient and day hospital patients are included in these ratios. While these daytime ratios are usually followed on paper, the reality is that often other patient care responsibilities take nurses away from their patient assignments. These other responsibilities include rounding, constant observation duty, leading group therapy meetings, preparing patients for ECT, doing admissions and discharges, and milieu checks. Rounding,

in particular, can take up to four hours per shift, and staffing (of nurses or support staff) is not adjusted to compensate for those nurses not being available to patients. While rounding is taking place, the remaining nurses are caring for 22 inpatient patients, plus the day hospital patients. This is challenging and stressful for nurses and can make it difficult to provide adequate care.

Competency

Because the turnover rate is relatively low in this unit, we are not dependent on temporary nurses from a travel agency, interstaff, or high-needs shifts. Nurses are adequately oriented and trained on psych-specific safety techniques.

Patient Safety

A year and a half ago, a patient on Meyer 4 attempted suicide but was revived through CPR. Management’s response was to refurbish the unit with less dangerous fixtures and to be more restrictive and careful about what items are allowed on the unit. Milieu checks are emphasized as an essential part of patient safety.

Acute Inpatient Schizophrenia (Meyer 5)

Meyer 5 is a psychiatric unit specializing in schizophrenia and general psychiatry. The unit has 20 beds, nine for schizophrenia service and 11 for general psychiatric service. Nurse-to-patient ratios vary by time of day. We have five nurses on the floor from 7:00 a.m. – 7:00 p.m., four nurses from 7:00 p.m. – 11:00 p.m., and two from 11:00 p.m. – 7:00 a.m. The nurse-to-patient ratio varies between 1:4 and 1:10, depending on the shift worked.

Nurses on the unit recognize a recruitment and retention problem that is exacerbated by poor working conditions and insufficient pay.

Staffing and Ratios

Nurses feel our floor is not adequately staffed to properly care for our patients. Management’s solution to poor staffing thus far has been primarily to depend on interstaff (nurses hired by an agency) and

non-psychiatric nurses to temporarily fill in staffing shortages on the unit. Interstaff nurses are offered very high wages to pick up shifts. That money could be better spent hiring more full-time staff and training them fully and properly on the unit. Interstaff nurses are not familiar with our unit, and often are not adequately trained in techniques essential to the care of our patients, such as seclusion, restraint, de-escalation, and use of emergency medication. Nurses specialized and experienced in treating patients with schizophrenia can more quickly recognize signs of agitation and potential violence, and can act quickly to prevent escalation. Therefore, in addition to our own patient assignments, we are expected to train and take on patient care responsibilities of the outsourced nurses to ensure patient care outcomes are not compromised. If an interstaff nurse is one of the just two nurses on night shift, safety risks are especially pronounced.

Management's other solution is mandating that unit nurses stay on extra hours beyond their scheduled shift if there is not enough staff to cover the next shift, meaning nurses are regularly forced to work up to four hours of overtime. This practice adds additional danger to our patients and ourselves. Nurse fatigue creates conditions of decreased ability to focus or be aware of changes in our patients' conditions, creating a circumstance that is prone to error and injury.

While recommended nurse-to-patient ratios are always followed on paper, other responsibilities (such as rounding, constant observation duty, and "milieu" checks) often take us away from our patients for hours at a time. Instead of providing additional nurses during these times, management's solution is for nurses to "double up" on the patients they are responsible for. Frequently during day shift, there are hours during which only two floor nurses and one charge nurse are available to care for 20 patients.

Nurses cannot take breaks on night shift because there are only two nurses working overnight and a nurse cannot be left on the unit alone.

Workplace Violence

Failure to properly staff the unit can lead to dangerous situations for nurses and patients. In October 2018 alone, we have had two instances of workplace violence involving an RN being kicked in the legs and a tech being scratched on the face so severely that she spent the rest of her night shift in the ER. There was also an incident in which two patients got into a fistfight with each other when there were not enough available nurses to staff a meal period. Often, violent incidents

can be prevented through de-escalation techniques if 1) a nurse is available to witness the initial escalation and 2) that nurse is adequately trained and experienced enough to respond to the situation efficiently.

Retention

Working conditions which include forced overtime, poor staffing and ratios, and frequent workplace violence, in addition to a culture that does not encourage us to speak up on these issues, result in poor retention. Most nurses do not stay on the unit for more than two years, with many leaving before one year. In addition, the unit is losing nurses who have been on the unit for more than 10 years due to the decrease in the quality of patient care. This summer 2018, eight nurses left the unit. Nurses with less than a year of experience serve as charge nurses because there are no other more experienced staff to cover that position on every shift. This creates conflicts about authority and puts a strain on teamwork. In addition, younger, less-experienced nurses are assigned to night shift where they may be unable to handle the safety risks associated with understaffing.

Poor Leadership

Poor leadership affects the handling of admissions, particularly with acuity management and admissions from the ER. There are conflicts in seniority and authority. The unit culture does not permit a safe space to challenge administration. Decisions about patients are often made by managers and administrators, excluding the voices of nurses in important decisions about patients. We have to fight to be heard.

ONCOLOGY UNITS

Oncology Outpatient Clinic (OPD)

Oncology outpatient clinic (OPD) is currently housed in two areas, the Weinberg building second floor and the Viragh building ground floor, which is part of the Sidney Kimmel Cancer Center. The unit is divided into two areas. In the Weinberg building, OPD nurses take care of patients with blood cancers, multiple myeloma, leukemia, and lymphoma. In the Viragh building, nurses provide treatment to patients with solid cancerous tumors. Nurses are involved in the planning and administration of chemotherapy, blood products, blood transfusions, immunotherapy, biotherapies, and supportive care. A nurse's daily assignment is determined by a patient acuity point system. Depending on the acuity level of the patient, a nurse's ideal patient assignment should be around 16-18 points. Thus, a nurse is taking care of approximately four to six patients at one time.

Currently, an OPD nurse may work a shift with an acuity point range of 20 to 23 points. Over the last year and a half, nurses have regularly taken care of eight to nine patients at one time. This has led to more administration and protocol errors in the delivery of chemotherapy and blood products. There have also been delays in timed blood draws and EKGs. Delayed delivery of chemotherapy may impact whether patients receive their chemotherapy that day. Emerging biotherapies are tested and researched at the OPD clinic, and if these medications are being

administered late to patients, the issuers of these drugs will have a more difficult time determining the efficacy of their treatments. Increased patient load and acuity also mean less time spent with each patient, giving nurses less time to educate their patients.

OPD nurses attribute the high-acuity assignments to a lack of staff in both areas of the clinic. Over the summer, there have been several travelers and new nurses hired, but it is not enough. Charge nurses frequently take on patient assignments and nurses often stay several hours after their shift to help.

Due to a limited ability to prepare medications in the Viragh pharmacy, most chemotherapy drugs are prepared and delivered from the Weinberg building. This can create a longer transport time, which further extends the period of time it takes to prepare and deliver these drugs, further delaying patient care. The entire Weinberg unit is located in one of the older buildings and needs updating. The recliners that patients sit in are at least 10 years old. A few have been replaced, but more are needed. Hospital administration has said that they will remodel the unit, but no definitive date has been set.

Intermediate Care Oncology – Solid Tumor (Weinberg 4A)

Unsafe Admissions

Due to poor communication and pressure to quickly fill empty beds, the shift coordinator (a mediator between different units who is responsible for the safe transfer of patients from one unit to another) sometimes fails to provide 4A nurses with enough time needed to prepare for a new patient. Patients have appeared on the unit unexpectedly, without the receiving 4A nurse getting report, without the room being fully cleaned and ready, and without consideration of the existing patient load of the receiving 4A nurse. This places a heavy burden on 4A nurses and can compromise the safety of the new patient in addition to the nurses' other patients.

Chemical Spills

On our unit, there is no follow up from the facility about carcinogenic materials spilling on nurses. When this issue was reported, the nurse was told by management that there is no role for occupational health and therefore they should expect no follow up. This has happened to several nurses.

Unsafe Staffing

Nurses during the night shift are responsible for one more additional patient than day shift (four patients per nurse at night). There are infrequently clinical technicians at night, so RNs have to do all patient care with one less nurse. During the day, nurses might need to take three patients while there is only one clinical technician to assist and charge nurses are forced to take patient assignments on weekends and between 3:00 p.m. and 7:00 a.m. on weekdays.

Newer nurses are often assigned heavier patient loads that can prove unsafe. For example, experienced nurses are given two patients (when possible) and less-experienced nurses are always given three patients, particularly the total care patients.

Breaks

RNs in Weinberg 4A do not receive breaks during which RNs are relieved of patient care assignments. When nurses need to leave the floor, nurses give their phone numbers to the charge nurse and then must immediately return and pick up their patient

assignments when called. Usually this “break” is 10 minutes or less and only once per shift.

Rotating Shifts

All new hires, regardless of their experience level, are forced to rotate shifts. Typically, this means that they work two weeks of night shifts and four weeks of day shifts. Sometimes the transition between day and night shift is a week, but other times the transition is only one day. This practice is not a temporary measure. Management makes no effort to fill permanent day shifts with permanent day shift position nurses or vice versa with night shifts. Rather, they continue the practice of rotating shifts to maintain their own flexibility in a manner that can compromise safe patient care.

Support Staff

Since the summer of 2018, the number of CCSRs (clinical customer service representative or unit secretaries) has been inadequate to fill daytime shifts. RNs are expected to pick up these responsibilities on the weekends. Charge RNs are expected to fulfill these non-patient care responsibilities, including performing Medicare discharges, admitting and discharging patients from the census, and preparing new files for patients when they're admitted. The unit has never had a CCSR at night.

There is a fluctuating shortage of clinical technicians and there are many shifts (including day shifts) where the unit has one clinical technician for 18 patients. Sometimes there are no clinical technicians at all to assist in providing care. When there is a shortage of clinical technicians, nurses have to shoulder these additional duties, taking away from time that could be spent providing nursing care.

Supplies

The unit has specialized equipment needs, including pleural and abdominal catheter supplies and tracheotomy supplies. The unit runs out of these frequently. When this happens, nurses have to run to other units to find replacements, which can take up to 20 minutes. This not only diverts intermediate oncology nurses away from their patients, but also depletes other units of supplies. Nurses also need to

gather basic provisions for patients (such as juice and snacks) from other units and units throughout the entire hospital experience shortages. If a patient has a specific diet, nurses end up depleting these supplies across the units.

The unit requires daily care supplies such as wipes, pads for specialized beds, and diaper briefs – all of which typically run out of stock. When this happens, patients can wait hours for these supplies to come up from central storage. In the case that these more common supplies are unavailable, nurses often cannot easily procure these items from other units.

Management has provided new gloves, which are only marginally better than the previous white “oatmeal” gloves. These new gloves break and RNs, to avoid breaking them, will sometimes wear the next size or two sizes larger than what is appropriate to avoid ripping. Using the inappropriate size decreases RNs’ dexterity and increases the risk of error.

The unit also requires a bladder scanner, but RNs need to leave the unit and patients in order to retrieve a bladder scanner from other units. This can cause needless delays in care.

Workplace Violence

Hospital-acquired delirium is common in this unit (as it is among cancer patients generally with longer-term stays). The unit has difficulty managing violent patients. Without a specialized security team, the nurse is the one who subdues the patients and receives the brunt of the violence. When patients (and/or their families) have psycho-social issues, security is reticent to help. Further, despite visitor restrictions, visitors are in fact not restricted by security in the Weinberg building (though a recent change to this policy was announced in an Oct. 5, 2018 email).



Surgical Oncology (Weinberg 4CD)

Weinberg 4CD is a post-operative surgical unit that takes care of patients after surgery to remove cancer. The kinds of cancers nurses see on this floor are cancer of the liver, pancreas, and head and neck cancers. There are patients that have also had radical orthopedic surgeries with partial amputations, patients who have had plastic and reconstructive surgery due to their cancers, and gender-affirming surgeries.

Nurses on the unit take care of patients with fresh tracheotomies, providing hourly treatments for these patients. On a typical shift, the nurses on this unit are required to check on their patients on an hourly basis to clean and suction their patients' airways. Due to the frequency of treatments and monitoring these patients require, the nurses on this unit have asked hospital administration to classify some beds as intermediate care (IMC) level beds for those patients with a higher acuity and those that require frequent treatments and monitoring. If this request for reclassification were honored, a nurse on this unit would be taking care of up to three patients at a time.

Instead, Weinberg 4CD nurses are taking care of four or five patients during the day and six patients at night. The hospital has made attempts to increase the unit staffing, but the retention issue in Weinberg 4CD is at a crisis. Over the last year, almost 50 percent of the nursing staff has left the floor, with most nurses leaving the hospital entirely. With a shortage of nurses, the workload has continued to mount and nurses are rarely able to chart on time or take a lunch break.

The nurses have clinical technicians that help with checking a patient's vital signs and blood sugar

levels. Currently, there are days when one clinical technician is taking care of one entire side of the unit; two technicians might be responsible for 36 patients. A shortage of technicians adds to the nurses' work because they are not only struggling with their own nursing responsibilities but taking on the duties of the technician, which includes taking vital signs, bathing, walking with and assisting patients back and forth from the bathroom—all vital aspects of basic nursing care. Nurses feel that two clinical techs working on each side, at a minimum, on every shift, would be adequate to meet patients' needs (four techs total on all shifts).

During daily interdisciplinary rounds, which take 90 minutes, nurses are expected to stop their patient care and meet in the conference room to discuss their patients with the multidisciplinary team. Nurses give a five- to six-minute report per patient. However, rounds are not organized so that each nurse can report on all of her patients in one sitting. Instead, nurses must enter and exit the room multiple times, based on which surgical provider is presenting his/her patient. This leads to multiple interruptions in patient care for the nurses. Often, nurses have to wait while their colleagues report on their patients. The nurses of Weinberg 4CD have requested computer workstations in this conference room so that they can continue to chart while waiting to present on their patient to the team. Having access to computer workstations would allow nurses to, at least, use the time and interruption of care provision to chart on their patients.

Leukemia Intermediate Care Unit – Hematology (Weinberg 5A/4B)

Weinberg 5A is a 15-bed unit that predominantly provides care to leukemia patients. The nurses on Weinberg 5A also staff a six-bed hematology unit located on Weinberg 4B.

Support Staff Coverage

Clinical technicians (clin techs) that work on the unit staff both Weinberg 5A & 4B hematology. There is an unwritten rule that Weinberg 4B should be staffed first since there are only two nurses that work there at a time. This adversely impacts the nurses and patients on Weinberg 5A when there are not enough clin techs to adequately staff both units. When there are not enough clin techs working, nurses have to complete the duties that clin techs would ordinarily complete instead of focusing on nursing care.

Staffing of support staff has improved since nurses started organizing. This appears to be a way for management to dissuade nurses from continuing to organize.

Weinberg 4B is a hematology unit, which means that patients with various blood disorders including sickle cell and hemophilia receive treatment here. Nurses receive orientation on Weinberg 4B, however, there are no additional hematology trainings that are required.

Weinberg 4B is characterized as a medicine unit, however, the patients are sometimes categorized as being intermediate care (IMC) level patients. This means that they have higher acuity than standard medicine patients.

Inadequate Staffing

While the nurse-to-patient ratio of 1:3 is not bad on paper, there are factors that make it unsafe. Only two nurses work on Weinberg 4B at a time and one nurse is always charge nurse. When a nurse is running charge, they should not also be providing direct patient care. Additionally, nurses feel under supported because they are removed from the other nurses on Weinberg 5A who are trained in caring for this type of patient.

There is often not a clinical technician working overnight, meaning that it becomes the responsibility of the nurses to perform tasks that would have

otherwise been completed by clin techs. This takes away from the time that nurses spend providing nursing care.

Breaks

Nurses on Weinberg 4B are not able to have complete meal breaks where they leave the unit because there are only two nurses working here at a time. Leaving the unit would mean that one nurse would be in charge of watching up to six patients, which could result in extremely dangerous situations if a patient took a turn for the worse.

Escalating Care

When patients' situations deteriorate and they require a more intensive level of care, they have to be transferred to one of the intensive care units (ICUs) in another building or the ICU on Weinberg 5C. When transferred to these units, the patients must be transported to another floor or even another building, increasing the amount of time it takes for them to receive proper treatment.

Over the past year, there have been two deaths on the unit that may have been preventable if the patients had been transferred to an ICU floor to receive adequate care. At the time, there was no bed availability in the ICU.

Retention

Turnover is high on Weinberg 5A/4B hematology. The unsafe conditions that nurses and patients experience while on Weinberg 4B are a primary reason that nurses are unhappy with their jobs at JHH and ultimately leave. One solution would be to move Weinberg 4B up to the fifth floor; that way nurses would be able to ask for help from other nurses trained to work on the floor. Another possible solution is to reserve two beds on each of the units on the fifth floor for hematology patients so that nurses do not have to go down to the fourth floor to care for these patients and can have adequate support from other fifth-floor nurses. These would not be perfect solutions since hematology patients are categorized as medicine, not oncology, patients. Units that are specialized in medicine are housed in the Nelson building.

Oncology IMC – Leukemia (Weinberg 5B)

Mixed Patient Population

Weinberg 5B is a 16-bed unit that houses adult leukemia patients. Leukemia is a cancer that affects the blood. The primary services nurses provide on this unit are chemotherapy, blood transfusions, and administering IV antibiotics. Additionally, nurses on Weinberg 5B provide education on symptom management of medications including purposes, side effects, and intended effect.

Sometimes patients with different types of cancer like breast cancer, lung cancer, or brain cancer receive care here when the unit has empty beds. These types of patients require different types of care than leukemia patients. The medical team that provides care to these patients is often located elsewhere, leading to delays in care. The medical doctors can be difficult to reach, and slow to respond. If non-leukemia patients are going to receive care on Weinberg 5B, nurses need to be trained in how to best provide such care.

Lack of Sufficient Support Staff

In addition to nurses, unit assistants (UAs), clinical customer service representatives (CCSRs), and clinical technicians (clin techs) work on Weinberg 5B.

Inadequate staffing of clin techs means that nurses must spend nursing care time assuming clin tech duties such as cleaning patients, helping patients get to the bathroom, and recording vitals. Clin techs also cover breaks for sitters, who stay in a room to make sure patients do not hurt themselves or others. This means that nurses sometimes have to cover for sitters while they are on break, meaning that the nurse is unable to provide patient care for that period of time.

Weinberg 5B does not have access to the hospital transit system, so UAs transport patients if they need to be moved to get scans. On weekends and at night, when there are no UAs scheduled to work on the unit, RNs have to help transport patients. This means that if a patient needs to be transported, an RN has to leave the unit (and their patients) to do so. When UAs are not staffed, the unit's ability to properly care for patients is impacted by the insufficient amount of stocked supplies and impeded ability for labs to be walked down in the event that the tube system is inoperable.



Similarly, when there is not a CCSR on the unit, nurses are responsible for those duties which include answering phone calls, answering patient call bells, and printing admission paperwork.

In addition to not having access to the hospital transport team, Weinberg 5B also does not have access to the vascular access team (VAT). VAT nurses help place peripheral lines in patients, which means that without access to the VAT, Weinberg 5B nurses have to place these lines themselves. The unit does have access to a procedure team, but this requires massive coordination and timing. At times, such coordination is not possible. This can be dangerous when we have patients that require chemotherapy at specific time periods and they may lose access.

When there is a lack of support staff on Weinberg 5B, the duties that these workers would usually perform fall to the nurses. This means that nurses have less time to spend with their patients providing care. Time is precious when caring for our patients. When we have to dedicate our nursing time in performing support staff tasks, we are hindered in providing our best level of care to the patients.

Unsafe Charge Nurse Staffing

The patients in Weinberg 5B typically require intermediate care (IMC), with the safe staffing ratio being 1:3. During day shift the unit staffs safely, with two or three patients for every one nurse. However, during night shift nurses may care for up to four patients. The charge nurse, who should not be assigned patients, may also be assigned up to two patients.

Inexperienced nurses are pushed to start training as charge nurse with as little as one year of experience. The charge nurse is meant to be a resource on the unit for other nurses to turn to if they need help. If the charge nurse is also inexperienced, the unit may lack that resource.

Inadequate Equipment

One of the main services that patients receive on Weinberg 5B is blood transfusions. Every time a patient receives a blood transfusion, a nurse has to take vital signs 15 minutes later to ensure that the patient is not having an adverse reaction to the blood. As of this report's writing, the unit only has four vital signs machines, meaning that there may not be one readily available every time a patient needs vitals taken. These machines routinely break, often leaving the unit with even fewer vital signs machines available. Vital signs machines are used frequently and have to be cleaned thoroughly in between uses. When they are not cleaned well enough, infectious diseases can spread from patient to patient, such as C. Diff, a bacteria that impacts the colon. The unit has experienced outbreaks of the C. Diff bacteria among its patients, something that could likely have been prevented if each room had its own vital signs machine.

Medications

Often, scheduled medications from pharmacy need to be requested when they should be automatically delivered. The wait time for these medications can substantially delay patient care. This happens with both routine medications and in emergency situations.



Bone Marrow Transplants (Weinberg 5D)

Patients with cancer diagnoses are admitted to 5D for bone marrow transplants, chemotherapy, and complications related to treatment. 5D patients often require blood transfusions and close observation to manage side effects from treatment or disease. Common patient conditions include uncontrolled nausea/vomiting, fevers, acute kidney injury, respiratory distress, delirium, heart failure, and allergic reaction to treatments.

Most patients on 5D are severely immunocompromised, putting them at greater risk for infection and, if untreated, sepsis and septic shock. Immunocompromised patients decline rapidly and care often needs to be escalated to our oncology ICU, Weinberg 5C. 5D nurses are trained to care for intermediate level patients, people who are experiencing cardiac or breathing problems. These patients require close monitoring, frequent lab draws, and help with taking care of their basic needs. Nurses identify when a patient is becoming unstable and must be transferred to the ICU. The nurse-to-patient ratio on 5D is 1:3. When a patient declines or becomes very ill, the unit does not have the ability to adjust this ratio based on increased acuity.

Nurses are tasked with monitoring acute events, managing and coordinating treatment plans, administering chemotherapy, and educating patients on caring for themselves in the hospital and at home. Nurses teach patients and caregivers how to manage symptoms, administer IV antibiotics, and care for any tubes, drains, or central lines that they have. Patient education is crucial for patient survivorship and caregiver effectiveness. Current staffing ratios often make it difficult for nurses to closely review patients' discharge education and help plan their transition to the outpatient department.

Within the last two years, the upper limit age at which patients are eligible to receive bone marrow transplants has increased, making these patients more fragile. During this time the nurse-to-patient ratio increased to 1:3. Patients have more comorbidities, which puts them at greater risk for cardiac and respiratory complications. These patients are often bedbound following transplant and need rehabilitation, which is often not feasible when other patients need blood products, chemotherapy, and education. Decreased staffing and increased acuity makes it difficult for nurses to care for complex patients who have the potential of becoming very sick.

Oncology ICU (Weinberg 5C)

Weinberg 5C encompasses the bone marrow transplant unit and the oncology intensive care unit (ICU). There are six designated ICU beds, with one additional crash bed, on the 16-bed unit. At times, the unit can have up to seven critically ill patients. The ICU provides care to patients with hematological and oncological diseases requiring a higher level of care, including patients requiring mechanical ventilation, continuous veno-venous hemodialysis (CVVHD), multiple vasopressors, or other emergent therapies/treatments. These patients can come from any of the other oncology units at Hopkins, from the ED, or from outside hospitals when those other units/centers are unable to safely manage these patients. Nurses trained in critical care (those having completed the hospital's critical-care education) manage these patients and are directed by the pulmonary medical team. The nurse-to-patient ratio for critical care is typically 1:1 during the day for very ill patients, but can often be 1:2 at night when the unit is staffed with only eight RNs.

IMC-level patients (those requiring telemetry, or one pressor) are also often transferred to 5C for closer monitoring. Ratios are 1:2 for IMC-level RN management. Given the complexity and severity of illness for these critical-care patients, outcomes can often be poor. The remaining beds on the unit are filled with patients in the process of a bone marrow transplant or others being treated with chemotherapy for their cancer. Ratios for these patients are 1:2 or 1:3, depending on the unit staffing and the number of critical care patients on the unit. There are one to two CNEs working during most shifts.



PERIOPERATIVE UNITS

Post-Anesthesia Care Unit (Weinberg Building)

The Weinberg 3 Prep/PACU is a 28-bed post-anesthesia care unit (PACU). Nurse-to-patient ratios are 1:2 for stable cases and 1:1 for ICU cases. The ratio can be 1:3 for Phase II anesthesia recovery care. Nurses report a lack of adequate staffing, with travel and per diem nurses hired to cover busier days with additional OR cases, such as Tuesdays and Fridays. In addition, it was reported that nurses were required to cross-train in both PACU and in the pre-operative preparation area to meet staffing needs. In addition, staff report that the ideal number of nurses to properly care for our patients on the evening shift is eight to nine nurses, but typically we have seven to eight nurses, which can be an issue when there is a high volume of OR cases. Finally, staff have reported that nurses get prematurely trained to be charge nurses and that nurses without previous critical care or medical-surgical experience have been hired to meet staffing needs, posing a risk to patient safety. Typically, two years of acute-care experience is needed to successfully care for patients recovering from anesthesia.

Operating Room (Weinberg Building)

The Weinberg operating room (OR) has 16 rooms with a 1:1 nurse-to-patient ratio, staffing based upon Association of periOperative Registered Nurses (AORN) guidelines. There is one circulating nurse and one scrub tech or nurse per OR case, although sometimes additional nurses or techs are needed for more complex cases. Sometimes, an OR case may run late, especially in the evening. If not enough perioperative support staff volunteer to stay past the regularly scheduled time, some staff may be required to stay late. In addition, less frequently, staff have reported being asked to work on their days off, to meet staffing needs. Other issues reported include a lack of lead aprons for fluoroscopy cases. It was reported that other staff working in orthopedics and urology departments have enough gowns and aprons, but there are not enough in the Weinberg OR.

Post-Anesthesia Care Unit (Zayed 3)

The Zayed 3 PACU consists of 43 beds with four nursing stations: interventional radiology (IR) and neuro radiology prep, OR prep, interventional radiology PACU, and OR PACU. IR Prep and IR PACU have never had enough nurses to staff independently of each other. When there is a shortage of staff in one of the units, nurses are “borrowed” from the other side, which can create a disruption in the continuity of care. Both PACU units house patients who require continuous monitoring and specialized high-acuity nursing care.

The goal of perioperative nurses, whether in the OR or IR areas, is to always maintain the safety of our patients. However, our efforts can be severely compromised, especially when there is a lack of enough nurses. A shortage of staff — nursing and ancillary — means that nurses are often pulled away from the bedside to complete other tasks, such as answering phones, transporting patients, cleaning bays, and stocking carts. Charge nurses, who oversee the IR PACU and act as a resource nurse, must take patient assignments to relieve nurses for their lunch breaks because there are not enough dedicated break-relief nurses. The Zayed 3 OR PACU is the only PACU

scheduled with night shift nurses. They receive patients at night from Weinberg OR, Zayed 3 OR, and endoscopy. It is also common for critical patients to be downgraded from ICU to the PACU; these patients would fare better in an ICU setting. Also, anesthesia will want to bring patients to PACU that they promise to watch, but will invariably be called away for a Level 1 emergent case in the OR, leaving another critical patient for the minimally staffed night shift to care for. In addition, there are no techs at night so the nurse must leave the unit in order to transport patients. This leaves the unit understaffed and greatly compromises patient care. In addition, in many instances, the on-call central interventionist OR services physicians are unable to get to the Z3 PACU to support the RNs in patient care.

When staffing is stretched to its limits, there is also no ability to grow professionally. Time that should be used to advance up the clinical ladder or to participate in committees and unit-based councils cannot be spared because there are not enough nurses to cover the gap that one person’s absence would create. Without the opportunity and encouragement for professional growth, nurses feel stagnant and unsupported.

Operating Room (Zayed 3)

The Zayed 3 OR specializes in trauma, neuro, and ortho procedures. The hospital follows the ratio of 1:1. One nurse is assigned to duties of circulating nurse with a minimum of one scrub tech. The scrub tech can be a nurse. Nurses’ major concern is the scheduling of multiple cases simultaneously with only one surgeon on hand for more than one OR room. Having both rooms open at once creates an unsafe environment for the patient and delays care that is needed, especially within a critical setting. A patient may be under anesthesia without a surgeon in the room. At times cases may run late and generally nurses are asked to volunteer to stay overtime. If no nurses volunteer, the nurse scheduled for the case is mandated to stay. Having a pool of staff that already sign up to volunteer could alleviate this issue to relieve nurses from regular overtime shifts.

Turnover and retention is another concern. Many nurses come to the OR to gain critical experience and leave within a year, some coming from out of town to leave again. Our department does not have many experienced nurses to act as resources or help in cases.

On occasion, maybe twice a month, patients come down from the ICU due to post-surgery complications. They are considered a priority and must be accepted into the OR. The OR nurses must leave their current assignment to accommodate that patient, leaving possibly two OR rooms understaffed. This creates an unsafe environment for patients.

Interventional Radiology (Bloomberg Building)

Interventional radiology (IR) handles procedural cases. A nurse sedates the patient and records vital signs and the department complies with ratios of 1:1. Nurses have adequate non-interrupted breaks. All nurses have ICU step-down experience which is the minimum to work IR. The unit also has ready access to equipment needed and nurses feel they are able to vocalize any concerns and receive resolutions. When all cases have finished, nurses can be relieved earlier

than scheduled. If or when procedures run past operational hours, at least two nurses are expected to stay to safely handle the patient. However, in the past a nurse has been forced to stay until well after midnight. Additionally, the unit will routinely designate a nurse who was not assigned to a case transport a patient to the PACU, therefore possibly leaving out important information in her report.

Operating Room (Outpatient Center)

In the department, the hospital complies with the requirement of one registered nurse assigned to the duties of the circulating nurse and one scrub tech, who may also be a nurse. Cases are scheduled between the hours of 7:30 a.m. and 5:30 p.m. This is an older unit and supplies are not pulled ahead of time like they are in the other ORs. A nurse prepares the room for each case and at times, for the first morning case, may be required to come in before scheduled hours to properly prepare the room. This requires the nurse to start her shift early in order to ensure her first case starts on time. Each day four “stars” are selected and these can either be two techs and two nurses or four nurses. Those chosen to be a star must stay after operating hours to close down

the rooms. Stars are selected depending on overtime hours accumulated and those with the least are the designated stars for the day. This is a form of mandatory overtime.

The unit allows for three separate breaks during the shift: two 15-minute breaks (one in the morning and another in the evening) and one lunch break of 30-45 minutes. The 15-minute break in the morning is usually taken. Although a lunch break is never denied, lunch breaks in the unit are not guaranteed and may be interrupted to attend to a patient. If staffing allows, the 15-minute break in the evening is taken. However, if understaffed, a nurse may be working more than six hours without a break, thus tiring nurses out and decreasing quality of patient safety.

PACU (Outpatient Center)

In the recovery unit, nurses often have sufficient staff to safely handle patients and take meal breaks. At times more support staff is needed to allow nurses to spend more time with patients. When support staff is low, nurses can be pulled away from the bedside to answer phones and clean supplies. However, often nurses are able to address patient care concerns,

help with discharge, and provide patient education. Improvements to supplies such as gloves and masks would be beneficial. Due to the amount of space in the unit, it can be a risk for injury.

PROCEDURAL/INTERVENTIONAL CARE

Endoscopy (Zayed Main)

The endoscopy unit at Johns Hopkins Hospital performs an average of 50-60 procedures per day on a mixture of outpatients and inpatients. Procedures range from screening colonoscopies to treating gastrointestinal bleeds to more advanced procedures that involve treating advanced-stage gastrointestinal cancers. The length of procedures can range anywhere from five minutes to three to four hours and an endoscopist might have an average of 10 procedures a day with about 15 minutes turnover between procedures.

Endoscopy procedures require the support of multidisciplinary staff, including nurses, clinical techs, unit associates, transporters, physicians, gastrointestinal fellows, and anesthesia providers. The nurse's role varies day to day, from working in the prep area, to procedure rooms, to the post-anesthesia care unit (PACU). The nurse's role in the prep area is to prepare the patients for their procedures, which includes getting consent forms signed, IVs placed, and addressing any safety concerns. In the procedure room, the nurse works alongside certified registered nurse anesthetists (CRNA), clinical techs, physicians, and fellows and assists the physician during the procedure by repositioning the patient, getting supplies, or assisting in the actual procedure with the physician. In the PACU, the nurse's role is to recover and monitor two to three patients at a time after sedation, which includes treating nausea, pain, and any adverse outcome from the procedure. For outpatients, nurses also safely discharge them fast enough in order to get more patients into the recovery area.

Support Staff

The endoscopy unit is composed of a multidisciplinary team, of which each member has a vital role in ensuring patients receive their endoscopy procedure effectively and safely. The unit associates help with stocking supplies, cleaning bays after discharge, delivering specimens to the lab, and turning over the

procedure rooms in a timely fashion. Transporters help to deliver and return patients to their hospital rooms, as well as safely see outpatients to the entrance of the hospital. The clinical technicians are vital, especially during procedures, since they are the first to assist the physician in the procedure by handling equipment and supplies. It is a very demanding job, which requires constant focus and physical demands. When we are short of support staff, their various roles fall on the nurses. Often in the PACU, without support staff, nurses are left to clean and stock their own bays while simultaneously taking care of patients recovering from sedation. Nurses also retrieve family members and food and drinks for the patients and give a quick "report" to fellow nurses to watch over their patients while they are gone.

Equipment/Supplies

When the unit lacks basic supplies, like oxygen tank holders or cardiac lead cables, the nurse has to hunt to find extra, which takes away from patient care.

Nurse Safety

Nurses move patients during procedures while patients are sedated. Often, nurses must move patients who weigh more than 300 pounds without appropriate lift equipment. Many nurses have received injuries due to repetitive movements during lengthy procedures. Endoscopy staff performs 50 to 60 procedures per day, with only 15 to 20 minutes of turnover. Between the procedures, the nurse in the intra-op room is responsible for the room being clean and set up with the appropriate equipment and supplies, making sure the next patient is ready, and finding the necessary staff for the procedure. This often does not leave time for the nurse to have any breaks during the day other than our 45-minute lunch break.

Vascular Access Team (CMSC RM 210)

The vascular access team (VAT) is composed of RNs specializing in vascular access devices of all kinds. This team places all peripheral intravenous line (PIVs), midlines, and peripherally inserted central catheters (PICC), and is responsible for the entire East Baltimore Medical Campus of Johns Hopkins Hospital. We respond to all codes and rapid response teams (RRTs). VAT comprises several branches: all the inpatient units (divided into three “zones,” each zone is one-third of the whole hospital), the adult PICC team, pediatrics and the pediatric PICC team, as well as all “out of zone requests” which encompasses all the outpatient areas. Each nurse carries a zone phone, a Corus phone, and/or a charge phone, and/or a code pager. The average number of codes and RRTs for each shift is one to three.

There is one charge nurse, usually one of the zone 3 nurses (So that nurse does charge and zone 3). Zones 1 and 3 are supposed to be staffed with two RNs 7:00 a.m. – 7:00 p.m. Starting at 7:00 p.m. until 7:00 a.m., zone 1 only has one RN for the whole zone. From 11:00 p.m. – 7:00 a.m., zone 3 goes down to one RN for the whole zone plus charge duties. Zone 2 is only staffed with one RN 7:00 a.m. – 11:00 p.m. Then, from 11:00 p.m. – 7:00 a.m., the peds RN covers all of peds and zone 2. The charge RN is usually one of the zone 3 RNs, so this nurse fields all the charge issues, out-of-zone requests, resource questions, as well as the usual zone 3 responsibilities. Peds is staffed with one RN from 7:00 a.m. – 11:00 p.m. Peds PICCs is staffed with two RNs 7:00 a.m. – 3:00 p.m.

Adult PICCs are placed 7:00 a.m. – 7:00 p.m. Monday through Saturday. If there is only one PICC RN, or two PICC RNs and an extremely long PICC list, the PICC nurse pulls one of the zone nurses out of the zone to do the PICC assist, which usually takes 45 minutes to one hour. This leaves the remaining zone nurse alone in the zone. If two PICC nurses are pulling from the zone, that leaves each zone short.

The workload is not timed, scheduled, or divided. The work tasks appear on our work list as they are ordered in the computer by the various units 24 hours a day. We are required to address a request within 15 minutes. If the task cannot be done within 15 minutes, we are required to call the nurse/provider to let them know it will take longer than 15 minutes. We are expected to be “self directed” and to manage our own breaks. We almost never have an uninterrupted break.

Many of the patients at Johns Hopkins Hospital are very ill. Many, if not most, of the patients are difficult venipunctures and require the use of an ultrasound machine to gain venous access. We have one ultrasound machine per zone and they are often broken. We have been told that one new machine has been ordered for each of the adult and peds PICC teams. The old PICC machines are to be repurposed into zone ultrasound machines. These machines are old and obsolete.

Staffing patterns, hospital census, patient acuity, staff call outs, staff attrition, low morale, and lack of positive feedback impact workload on a daily basis. If there is a call out, one of the zones will be left short staffed. Night shift is often left with two RNs to staff the whole hospital when there is a night call out and no one wants overtime. New staff is being hired with no experience. Premature precepting and charge responsibilities are being thrust upon new hires just finishing orientation.

VAT deals with sharps, all types of isolations, and respiratory and skin irritants with almost every procedure we perform. Sometimes our patients are violent. We walk to every building on campus, averaging a total distance of three to eight miles per shift.

MEDICAL-SURGICAL, TELEMETRY, AND STEP-DOWN UNITS

Clinical Holding Unit (Osler 5)

Osler 5 is the clinical holding unit, also known as CHU. The patient population has a variety of diagnoses, including medical-surgical patients, gastrointestinal patients, and research patients. It is a short-stay holding unit with 14 beds. The nurse-to-patient ratio is 1:3 or 1:4 patients. There are usually two RNs working each shift. Prior to 2016, there were three RNs working each shift. As a result of fewer nurses, RNs are unable to leave the unit for breaks. There are many experienced RNs on CHU, but RNs from other units often pick up shifts there. The unit does not have a clinical customer service representative (CCSR), but there usually is a patient care technician (PCT).

Medical-Surgical Acute Care (Marburg 3-VIP)

Marburg 3 is a 14-bed unit, and is otherwise known as a post-surgical acute-care unit. Nurses take care of adult patients with varying complexities. Patients are either in pre- or post-surgery. The acuity of the patients is not as high as in other units, and patients are generally stable in their status. Sometimes, there are patients required to be on cardiac monitoring. The entire nursing staff is trained in telemetry monitoring.

The patients on this unit pay out of pocket for their care. They usually bring their own support staff to do the tasks clinical techs usually perform; the patients' own private staff will help them with walking, mobility, bathing, and other tasks reserved for techs. Sometimes, the patient will pay to close the entire unit, and will invite their friends and families for elective surgeries. Nurses provide primary care/total care to their patients. Since the patients hire their own support staff, nurses work in Marburg 3 without any techs.

Marburg 3 has a ratio of 1:3 during the day and 1:4 at night. Due to the acuity of telemetry patients and the role of nurses in primary care nursing, the ratio should be 1:3 at all times. An upcoming issue for the unit will be the upcoming unit remodeling. The hospital has promised Marburg 3 nurses a remodeling of the unit, and during the remodeling, the nurses will work in Zayed 11E orthopedic trauma. Nurses on the unit are concerned with having to care for higher-acuity patients with a higher nurse-to-patient ratio in 11E. Marburg 3 nurses have heard that in 11E, the ratio can be as high as 1:6. Hopefully, there will be adequate training and orientation for nurses moving onto 11E.

Inpatient Rehabilitation (Meyer 7)

Meyer 7 is an 18-bed acute inpatient rehabilitation unit. Patients are discharged from Johns Hopkins Hospital and readmitted immediately to acute rehabilitation. They have many speech, occupational, and physical therapy needs, and the goal of their stay is to rehabilitate them so they can return to their homes or get discharged to subacute facilities. The floor has a variety of surgical and medical patients. Because the patients are in rehab, they often are a two-person assist or at the least require supervision with activities of daily living. Patients are sometimes readmitted to the hospital due to acute changes in status.

Nurses in Meyer 7 experience significant burnout. This is due to a number of factors including staffing, complicated and short-notice vacation request approval, unclear disciplinary measures, and scheduling.

Meyer 7 is understaffed relative to patient need. The patient population often requires two-person assists but there are not enough techs or nurses available. At night, there are often no techs on the unit and only four nurses, including a charge nurse with a patient assignment, which is insufficient. Day shift sometimes has one or two techs, and generally has four nurses plus a charge nurse without patient assignments. There are frequently no clinical customer

service representatives (CCSRs) at night or on weekends, which means nursing staff has to cover their administrative duties in addition to direct patient care.

Management does not allow nurses an appropriate amount of time to plan for vacations and use paid time off (PTO). No more than two nurses can be off work at one time.

Discipline on Meyer 7 is completely at the whim of the nurse manager and there are no resources for staff.

At night, nurse-provider communication is mostly done via Corus to phone calls. No on-call doctor is present on site. If an emergency arises, they must come into the hospital from home.

Nurses who are on rotating schedules are often scheduled for both day and night shifts in the same week, sometimes with no days in between (e.g. 7:00 a.m. – 7:00 p.m. one day, then 7:00 p.m. – 7:00 a.m. the next). Nurses are also scheduled three or four nights/days in a row or work two in a row, off one day/night then back for three in a row.

Gastrointestinal – General Medicine (Meyer 9)

Meyer 9 is a gastrointestinal-general medicine unit with 22 beds. Patients seen on Meyer 9 are primarily liver failure and pre-/post-endoscopy procedures. The majority of patients admitted onto the floor are from the emergency department. Other patients are Hopkins Access Line (Hal-line) admissions or direct admissions onto the unit. Since the emergency department is in constant patient turnover, the information on the patient report are not as detailed as needed. When this happens, it's possible to call the nurse and ask questions about the patient's chart. When patients are admitted via Hal-line or directly onto the unit, access details in the charts are not as easy to clarify.

When patients are transported via Hal-line, they can be coming from a number of locations and facilities, so their reports are screened differently. Before admitting the patient, the facility that is transferring the patient to Johns Hopkins Hospital talks on the phone with the Meyer 9 - GI/general medicine charge nurse/primary nurse and shift or bed management personnel, so they may ask questions to make sure the patient is truly appropriate for the floor. Since the ride to Johns Hopkins Hospital may be hours long, it is not always clear what kind of state in which the patient will arrive. Patients admitted directly usually do not have information in their chart, therefore prompting an extensive evaluation of their past medical history and current state. This is not always feasible if they are not coherent enough to give us the correct information or if family is unavailable.

The nurse-to-patient ratio is usually one nurse to three or four patients. The charge nurse always has a patient load of about two patients. However, they usually have lower-acuity patients. When a patient needs to be upgraded based on acuity level, the main units they're typically upgraded to are MPCU, MICU,

or CCU. If those units do not have beds available on their units, the patients with high acuity are stuck on the Meyer 9 floor, and the charge nurse usually is able to help out during these times.

If a patient that is ICU-level acuity is on the floor and every nurse already has the maximum number of patient assignments, sometimes the clinical nurse III (NCIIIs) will come to the bedside to take care of patients. NCIIIs on the unit usually do not have patient assignments because they are working on administrative duties such as scheduling and ensuring everyone's competencies are up to date.

This shows only a few instances of the teamwork and collaboration on the unit. All staff help each other out throughout the shift because there is a common interest in giving good patient care.

Discharge is a procedure that often takes hours in order to ensure patients are going home with what they need. Most likely, a patient is not discharged before 11:00 a.m., even if they request and we ask to have their orders in by 8:30 a.m. This is because we have to make sure they go through all the discharge instructions before they leave, fill medications at the pharmacy which sometimes needs prior authorization from the insurance company (otherwise insurance will not cover the medication), and home health services needs to be set up and most times scheduled to be delivered at home around the time the patient arrives.

The insurance preauthorization causes issues because companies operate during regular business hours, while we continue to discharge patients seven days a week. This often means a patient cannot return home for another two days if a prior authorization has not been cleared by end of business day on Friday and cannot miss any doses of the medication prescribed.

General Medicine (Nelson 4)

Nelson 4, historically known as the Polk unit, is a medicine floor that specializes in the care of people with HIV/AIDS. As the numbers of HIV patients who require inpatient treatment has decreased, Nelson 4 has also become a frequent destination for patients with chronic pulmonary diseases such as cystic fibrosis and interstitial lung disease, and many are lung transplant recipients.

Some patients with HIV are admitted to Nelson 4 for a general medical issue and simply happen to have HIV, often well managed. Others have an acute issue related to HIV infection. The latter group often have complicated psycho-social needs and barriers to care, including active substance use disorder, unstable or no housing, psychiatric conditions, and poverty. So, in addition to coordinating travel to and from tests or procedures, medicating patients, and providing treatments and care, nurses work closely with case management (a role filled by one of three nurses who also work as staff nurses since our full-time nurse case manager retired), social work, and the Proactive Hospital Intervention for Psychiatric Service (PHIPPS) department to put together safe discharge plans for people who often don't have a safe place to go.

Often our patients have significant behavioral issues and struggle with adherence. Nurses must find the time to establish strong boundaries, behavior plans,

and negotiate participation in plans of care with patients who are oppositional and resistant.

Both infectious disease and pulmonary patients often require extended courses of intravenous antibiotics and unique maintenance medications. Nurses on Nelson 4 must have specific knowledge of antiretrovirals, immunosuppressives, antibiotics (in the context of active infection treatment and prophylaxis), antivirals, and gene therapy drugs. Our patients have a significantly higher number of central lines for long-term antibiotic treatment compared to other medicine floors. It is not uncommon for a nurse to have two or three patients with central lines, which means they often have to complete dressing changes or draw labs with a frequency not typically seen at this level of care with 1:4 nurse-to-patient ratios.

Nelson 4 nurses are often called to act as advocates for patients with active substance use disorders. These patients require medication to prevent withdrawal and require what can sometimes seem like excessive doses of narcotics to control their pain. Substance use disorder is heavily stigmatized and many physicians are inadequately prepared or reticent to provide necessary care for patients who are living with this condition. Nurses are often required to have lengthy, tense discussions with physicians to educate them and get patients the medications they need.

Medical Progressive Care Unit (Nelson 5)

The medical progressive care unit (MPCU) is the adult medical intensive care step-down unit, otherwise called an intermediate care unit. The typical patient population cared for in the MPCU is critically ill patients that do not necessarily warrant an ICU admission per JHH standards, but that have multiple complexities impacting their illnesses. The unit cares for patients from 11 different medical services, and is considered throughout the hospital as a “catchall” unit. The most common conditions nurses see are septic shock, respiratory failure, gastrointestinal bleeds, and multiple organ failure. Nurses also take care of patients with liver or kidney failure, diabetic ketoacidosis, interstitial lung disease, chronic obstructive pulmonary disease and asthma, hypertensive crises, heart failure and heart attacks, and even patients suffering with severe psychiatric comorbidities.

Due to the high acuity of the patients’ illnesses, every patient is continuously connected to cardiac and oxygen monitoring systems so that they can be monitored very closely. Vital signs are taken at least every four hours, but there are certain conditions that require a nurse to follow up with their patient’s vitals or labs every one or two hours. For example, a very hypertensive or unstable diabetic patient on certain medications may require follow-up every hour. MPCU nurses also take care of patients on breathing machines, including bilevel positive airway pressure/continuous positive airway pressure and ventilators, which may require frequent reassessing depending on how acute their respiratory issues are.

The MPCU is a 21-bed unit that staffs one nurse for every three patients. Even though the MPCU nurse-to-patient ratio of 1:3 reflects its status as an intermediary care unit (IMC-level unit), the nurses believe that in certain cases, an MPCU nurse should have an assignment of 1:2. This is due to the high acuity of certain patients. Sometimes, an unstable ICU-level patient stays on the MPCU due to the chronic lack of beds in other ICUs at the hospital. In these cases, the MPCU nurse should take care of two patients (ICU-level ratios) rather than three patients to ensure patient safety.

For example, an unstable patient on a ventilator often requires ICU-level nursing attention, and yet,

MPCU nurses care for these patients while also taking care of two other patients. Historically, the MPCU guidelines indicated that they can care for four, stable ventilated patients in the entire unit, meaning that a patient’s respiratory status is not decompensating and ventilator settings will not need to be adjusted. The guidelines indicated that if the ventilator settings needed adjustment, the patient requires an upgrade to the ICU for closer monitoring by nursing, respiratory therapy, and medical providers. Upgrading such patients to the ICU better ensures their safety because they are deteriorating and are at high risk of coding. These ventilator guidelines are now changing, and a deteriorating patient can now stay on the MPCU as long as only three changes to the vent are made in 24 hours.

Consequently, the MPCU will now provide care for unstable ventilated patients, so long as they meet these guidelines. On many occasions, MPCU nurses care for patients whose nursing needs are heavy enough to require ICU-levels of attention. In these kinds of cases, ICU-level nurse-to-patient ratios of 1:2 should be adhered to on the MPCU, ensuring proper monitoring and safety of patients on the unit.

Patients on the MPCU belong to 11 different medical teams with offices located throughout the medical buildings. This environment creates many obstacles that prevent effective communication between MPCU nurses and physicians, resulting in care delays for patients. Nurses are concerned that they do not have a unit-specific provider designated for the floor, especially with the high number of emergencies that occur on the unit. In a crisis situation like a rapid response or a code, or a critically decompensating patient, a provider could step in right away to assist nurses in responding. A mid-level provider on the floor, such as a nurse practitioner or physician assistant designated to the MPCU, would help provide a bridge between the nursing and the medical teams. These mid-level providers would have a crucial role in responding to emergencies and providing necessary interventions more quickly. They would also facilitate improved relationships among the nursing and medical staff.

Over the last few months, the hospital has taken measures to improve patient care issues on the MPCU. Improvements to staffing include the hiring

of additional clinical technicians (clin techs) and the addition of a mentor nurse. Clinical techs are important in assisting with checking vital signs and labs, patient mobility, and other treatments and care. Previously, many shifts would not have any clinical techs; nurses were required to complete the tech's job in addition to fulfilling their nursing responsibilities. Additionally, a mentor nurse has been added to daily staffing. The mentor is an experienced nurse without a patient load, who is a resource for other nurses and is available to transport patients, help with decompensating patients, and assist nurses with busy assignments. The hospital has also replaced many subpar supplies, including gloves that frequently ripped. However, the unit still has other equipment needs that have not been met. The hospital recently launched an initiative to increase patient mobility, but to do so safely on the MPCU, additional telemonitor boxes are necessary. The MPCU currently has three telemonitor boxes available for use among 21 patients, forcing nurses to decide between prioritizing patient safety or patient mobility. Also, more computers are necessary for staff to complete charting.

The MPCU is an intermediary care unit with acutely ill patients, many of whom would be considered

ICU-level patients in other hospitals. Because patients can become unstable very quickly, the unit has a high number of emergencies and codes. In the last year, nurses estimate that the unit experienced 120 rapid responses, meaning that there were 120 times when nurses have had to run a rapid response due to a decompensating patient. A rapid response is when nurses call providers and other hospital staff to evaluate any acute change in a patient's status before there is a need to call a code. The unit with the second-highest number of rapid responses in the hospital had 30 rapid responses in the last year (unit undisclosed). A nurse practitioner or physician assistant on the unit would help ensure a more timely response when a patient is quickly decompensating and nearing death. Improving the MPCU's ratios so that some nurses care for two patients, instead of three, means that patients would have improved monitoring, and some emergencies could potentially be avoided. Better ratios also means that additional nurses would be available to respond to emergencies. Another solution would be to include several nurses in the hospital-wide Rapid Response Team to help support nurses on units with a high number of codes.

Acute, Chronic Partial Inpatient, Telemetry (Nelson 7)

Nelson 7 is a medical-surgical unit with no particular specialty where patients are not requiring intermediate medical care or intensive care, but have frequently been downgraded from those settings. Typically, we see patients with heart failure exacerbations, volume overloads, asthma exacerbations, sickle cell crisis, chronic obstructive pulmonary disease (COPD) flares, skin issues, necrotic diabetic-related gangrene, severe or stable anemia, amputations, and transplant follow-up. Our patient population is very broad and diversified and many of our patients come from the Baltimore community.

Most patients are stable and medical acuity is typically low. Our patients do not require vents, continuous dialysis, or other care that requires monitoring every one to two hours. Our patients require monitoring every four hours, such as vitals. However, our patients may be behaviorally acute and require emotional and psychological support. Workplace violence is a major issue for medical units such as Nelson 7. The unit usually responds quickly to workplace violence from patients, and security is prompt to support RNs.

Nelson 7 used to have one of the highest turnover rates in the JHH department of medicine. Inadequate staffing and equipment were a driving force behind RNs leaving. When five Nelson 7 RNs quit at the same time one and a half years ago, Nelson 7 management started focusing on retention. By addressing staffing and equipment issues, Nelson 7 now has the lowest turnover rate in the department of medicine.

Nelson 7 has 24 patients per shift, and six to seven RNs work each shift. Each RN gets four patients on day shift and four to five patients on night shift. We have two patient care techs almost every shift. On day shift, charge RNs do not take patients. Charge RNs on night shift take up to three patients. RNs and

PCTs work well together and try to promote a positive and supportive environment. For example, it takes about 40 minutes and four staff in the patient room to do wound care, especially for behaviorally acute patients. Everyone is quick to help.

We currently have a resource nurse, who is not assigned patients that comes in to help with various aspects of patient care, including relieving nurses for breaks. When the unit is not as busy, nurses will hand their phones over to their buddies, give a quick report, and take their lunch. For that hour, the buddy will have double the patients.

We have an engaged, accessible, and transparent nurse manager who truly listens to staff concerns and follows through on addressing them in a timely manner. This level of support is also provided to other Nelson 7 support staff such as techs, unit associates, clinical customer service representatives and environmental services. The unit manager is passionate about promoting the culture and values of “teamwork, recognition, and respect” for the RNs and techs. The unit manager often offers to help with cleaning, turning, or checking vitals on patients when the unit is busy, further reinforcing the idea that Nelson 7 works as a collective, regardless of job title. Charge nurses are empowered and supported by the nurse manager to run the unit according to unit values.

Communication between RNs and physicians can be improved. Physicians communicate among themselves using the Corus app, which is a messenger app for healthcare professionals. RNs are not allowed to utilize this app because they are not able to use their personal phones. This forces physicians to call RNs directly on their ASCOM phones, even for low-acuity needs, making communication much less efficient.

General Medical Telemetry Unit (Nelson 8)

Nelson 8 is a general medicine unit (med-tele/med-surg) with 23 beds. Patients are admitted from the emergency department at all hours of the day. Transport workers are not trained in patient care, yet they have to bring patients into the unit. We have often received patients from the emergency department at change of shift. This is unsafe for patients because nurses are in report at that time. If there aren't any techs or nurses available to help transport, they will often leave the patient unattended. Report from the emergency department is now electronically done. We aren't really sure of the patient's condition until they get to our floor. If the patient cannot walk they can fall while unattended, which is unsafe.

Nurses on our floor and elsewhere will sometimes perform a procedure called a straight catheterization, during which a nurse inserts a tube into the patient's bladder to drain it of urine, then immediately removes the tube. Recently our straight catheter kits were replaced with inferior catheter kits. The previous kits were of better quality and contained all the necessary materials needed to safely and properly straight catheter a patient. The new catheters have a paper bowl that catches the urine once it's inserted. The urine can spill from the bowl. This has the potential to create a biohazard problem. The prior kits had a bag affixed to the catheter and spills were prevented. Compared to the prior kits, the new kits require more time to set up and are prone to spilling or leaking.



Brain Rescue Unit (Zayed 12 West)

Zayed 12 West is a neuroscience unit also known as “brain rescue” and is divided into three subsections: BRU, IMC, and floors. The unit is close to Z12 East, the epilepsy monitoring unit. A major issue within the unit is the placement of ICU-level patients in the neuro IMC, which is a step-down unit. Z12W nurses in the IMC are not given the six months of training required to work with ICU patients and this allows the hospital to bypass ICU ratios. In addition, nurses are not given adequate breaks and do not have a close relationship with their current manager, a situation that often denies the expertise of the nurses on the unit.

Progressive Cardiac Care Unit (Bloomberg 5S)

The progressive cardiac care unit (PCCU) is a heart monitoring unit, which specializes in taking care of patients with severe heart conditions. Those include heart failure and acute coronary syndrome, as well as all of the associated comorbidities, and problems of cardiac electrophysiology (dysrhythmia). This unit also takes care of any patients who are either awaiting a heart transplant or have a history of heart transplant. The PCCU is divided into two areas, an intermediate care area (IMC) and telemetry. Every patient on this floor needs to be on a cardiac monitor at all times which means that both sides of the unit take care of telemetry patients. No patients on the PCCU require mechanical ventilation. Both sides of the unit frequently transfer patients to/from the CCU (cardiac care unit, a critical care floor) or the cath labs where patients have minimally invasive procedures such as cardiac catheterizations and electrical procedure.

IMC patients are of a higher acuity than those in telemetry, but do not require critical care. IMC patients frequently require vasoactive drips and can have invasive monitoring, such as pulmonary artery catheters. Nurses take care of up to three IMC patients at one time and require specialized IMC training. Nurses are required to file two assessments per shift and these patients commonly require more frequent lab draws and vital signs. Directly after transcatheter aortic valve replacements (TAVR), patients will recover in either the IMC side of the PCCU or go to critical care, but never telemetry.

The patients on the telemetry side of PCCU may have just suffered a heart attack, suffer from chronic dysrhythmia (irregular heart rhythm), or are recovering from a same-day cardiac catheter procedure. The telemetry side of the unit also admits patients in need of frequent monitoring and drugs that must be consistently adjusted based upon ever-changing patient vital sign measures. Some of these drugs are designed to control patients' blood pressure and heart rate and must be monitored closely since too

much or too little medication can impact the patient's vital organ function. Nurses take care of four patients at one time during the day and five patients at night. Patients who just underwent cardiac catheterization recover on either the IMC or the telemetry side of the unit. These patients have had large catheters inserted into their groins and wrists, sometimes in the artery, leaving them at risk for bleeding and other complications. If a bleed develops after the procedure, it can be life threatening and require constant pressure to prevent catastrophic blood loss. All of these patients require frequent vital signs gathering, procedural site checks (to monitor for bleeding), and careful activity progression. Taking care of five patients at night makes it difficult for nurses to properly follow this post-procedure protocol.

Clinical techs are also needed on the floor to assist in checking vital signs and watching any patients who are fall risks. On the IMC side of the unit, nurses and techs draw labs, but not on the telemetry side, where phlebotomy is required to do draws. This helps to ease the burden on telemetry nurses. The unit has at least one clinical tech serving as a telemetry monitor watch and sometimes there are multiple other clinical techs working. Three techs on the floor are needed as a minimum: one as a monitor watch, one tech working the IMC side, and one working telemetry. But there are times where there is no tech working the IMC side of the unit. The ideal situation would be a minimum of four clinical techs working on the unit: two techs working on the IMC side, one to two techs working telemetry, and one as a monitor watch.

On this unit, PCCU nurses will see a number of patients with left ventricular assist devices (LVAD). These patients have hardware on the left side of their heart, helping them pump blood to the rest of the heart. When there are a large number of LVAD patients, the nurses do not have enough power base units (PBU) to monitor the function of the LVADs. PBUs are essential for ease of convenience in

monitoring LVAD flow and other important metrics, as well as being the interface through which doctors can change settings and view the device's recent history.

Each room has a computer workstation and there are rolling mobile workstations available as well. Medication scanners in patient rooms frequently malfunction, requiring the nurse to find a rolling workstation to scan the meds. When there are no

mobile workstations left, nurses have to consider the risks/benefits of giving a medication without first scanning it. On some computer workstations, the arms to move computer screens and keyboards up and down are broken. This leads to discomfort when nurses have to bend and crouch while they're charting on the computer. There are also computer screens in the hallways attached to walls, where nurses can work and chart on the computer.

Cardiovascular Progressive Care Unit (Zayed 10W)

The cardiovascular progressive care unit is a 32-bed unit located in the Zayed building on the west side of the 10th floor. Technically, though not strictly enforced, 12 of our 32 beds are reserved for intermediate care (IMC) patients. In addition to IMC-level care, the unit also provides care to telemetry and floor-level surgical patients from the operating room unit and from the cardiovascular intensive care unit. The majority of our patients have had cardiac surgery or vascular surgery. We also care for "off-service" patients requiring telemetry or IMC-level care. On day shift, the nurse-to-patient ratio is 1:3 and at night the ratio is 1:4.

All nurses on the unit are required to pick up one to two on-call shifts depending on the amount of hours they work. On-call shifts are meant to be used for emergency patient safety-related issues, not for normal day-to-day staffing, but since there are not enough nurses on the unit to achieve full staffing, on-call is used to cover this shortage.

There is no tech support at night when nurse-to-patient ratios are higher. This can have negative implications for various situations where support staff help is needed. Cardiac surgery patients have sternal precautions where they are not allowed to use their arms to help themselves get out of bed or to get on and off the toilet. This is when having a tech could be very valuable to help. Also medications like Lasix or bowel regimen are given to the patients, requiring staff to get patients to the toilet promptly. Patients

on our unit are high fall risks and, even with staff nurses, they struggle to get into the room and meet needs in a timely manner. Management responded by timing nurse/tech response to patient bathroom calls instead of hiring more support staff, which would help with response time.

There are certain situations in which CVSICU sends the "most stable patients" to CVPCU before the patient is ready to leave ICU because they still need ICU-level care. This is done so that planned surgeries in the operating room (OR) do not have to be canceled, which can be due to poor planning or overbooking of OR cases. However, these patients usually have needs that require them to be sent back to the ICU.

We accept "off-service patients" from other services requiring IMC care even though we don't always have providers easily available or prepared to handle their needs. More frequently, our unit has become a step-up unit from the floor levels. This means that instead of patients going to the ICU when their conditions deteriorate, they are sent to our unit. This is so that the ICU beds are left open and will give a temporary relief to those units.

Nurses do not get adequate breaks despite having a resource nurse. Nurses often have to cover each other's patients or take our phones with us when we are supposed to be on break.

Comprehensive Transplant Unit (Zayed 9W)

The comprehensive transplant unit (CTU) is a 32-bed unit located in Zayed 9 West. Six of the 32 beds are reserved for intermediate care (IMC) patients. The CTU provides three levels of care: intermediate care, telemetry, and general medical-surgical care. This means that the CTU treats all levels of care except ICU patients. Some of the patients on the CTU are fresh out of transplant surgery, while others may be experiencing chronic and/or acute medical issues even if they are not directly related to their transplant.

The maximum nurse-to-patient ratio for nurses working IMC is 1:3. The maximum nurse to patient ratio for non-IMC nurses working 7:00 a.m. - 7:00 p.m. and 7:00 p.m. - 11:00 p.m. is 1:5. However, nurses working from 11:00 p.m. - 7:00 a.m. are trained to care for a maximum ratio of 1:7. Management has proposed that if the nurse-to-patient ratio is at risk of going up to 1:7, then the on-call nurse should be called in. Nurses have proposed the better solution of increasing routine staffing so that the floor isn't at risk of having a 1:7 ratio and needing to call in nurses. Being consistently called in during your off hours instead of regularly staffing properly can result in nurse burnout and unsafe working conditions.

In order to try and have adequate nurse-to-patient ratios, the charge nurse may call in the nurse working on-call. A problem arises when there is not a nurse scheduled to work an on-call shift. In this case, a nurse from the previous shift will be required to stay and complete mandatory overtime from 7:00 a.m. - 11:00 a.m. or 7:00 p.m. - 11:00 p.m., meaning that nurse would work a 16-hour shift. The charge nurse may also care for patients so that other nurses do not have unreasonable ratios.

Other staff on the CTU includes clinical technicians (clin techs) and clinical customer service representatives (CCSRs). CCSRs help answer call bells from patients and other phone calls. The CTU lacks CCSR coverage on Saturday and Sunday nights as well as sometimes from 3:00 p.m. - 11:00 p.m. When the unit does not have adequate CCSR coverage, nurses and other staff have to help complete these tasks. This means that calls from patients might not be answered as quickly as they would if a CCSR were present.

Sometimes there is only one or no clin techs at night. When this happens, nurses are responsible for the additional care needed by the patients. When there is only one clin tech working, assigned to 16 patients, nurses have to decide which of their patients go without tech coverage and then absorb those assignments into their existing workload. Clin tech work includes getting vital signs, helping clean/bathe patients, turning a patient, and even small tasks like getting a patient a cup of water. When there is not sufficient clin tech staffing on the unit and nurses absorb these assignments, it takes away from crucial time that nurses could be spending on their nursing duties like giving medication or patient education.

There is a lack of sitters on the CTU. Sitters are employees or volunteers who sit with patients who are at risk to harm themselves or others, are confused and may pull out IV lines, are at risk of falling, or just need a companion. Because of the lack of sitter coverage, RNs must prioritize which patients need a sitter the most. There is a bed alarm that will alert RNs that a patient has gotten up, but by the time a nurse is able to make it to the room, the patient may have already fallen onto the floor. In July 2018, there were 10 falls on the unit because patients did not have enough sitters. When sitters are available, they require one-hour breaks. With short clin tech staffing, nurses have to relieve the sitter for breaks, taking them away from their other four to seven patients for an hour.

In order to take an uninterrupted lunch break, nurses must give their patient assignment to another nurse, meaning that a nurse may be caring for 10 patients during that time period. Because of this, if nurses go on break they keep their work phone and patient assignment because it is unsafe for another nurse to be responsible for the care of those additional patients. This means that if a patient needs care during that time and nurses receive a call on their phone, they will leave their break in order to take care of that patient. Uninterrupted breaks are important because if a nurse is not well rested, it is easier to make a mistake that impacts patient safety.

The supply closet, called the "Pyxis," is chronically out of supplies like Foley catheter kits. Nurses can go to the unit down the hall to find additional supplies,

but this takes away from time that nurses could be spending on patient care. Gloves on the unit are known to rip. Gloves that are sturdy are especially important on the CTU because they care for patients with different communicable diseases (e.g. HIV, hepatitis B, and hepatitis C) and patients who receive medications with hazardous handling precautions (e.g. anti-rejection medicines), and it is unsafe for nurses to be exposed to the blood and other bodily fluids of these patients.

The CTU only has one bladder scanner, which is an ultrasound machine for assessing a patient's bladder fullness. The machine is well used since the unit cares for patients with kidney transplants. As there is only one machine on the unit, nurses have to compete for who gets to use it first, resulting in a delay of patient care.

Urology, Thoracic (Zayed 11W)

Zayed 11W is a 32-bed unit that specializes in urology and thoracic medicine.

There are equipment issues that impact patient care on Z11W. Central stores does not deliver after 10:00 p.m. which means that nurses have to leave the floor in order to pick up adequate supplies for the unit.

Zayed 11W lacks enough pulse oximeters for every room.

The bladder scanner that the nurses use is too technical and is not user friendly. This can increase the amount of time that it requires for nurses to provide care to patients.

The Pyxis, which is similar to a supply closet, runs low on medication. Medications and other supplies

on the unit should not run low. When they do, it causes nurses to have to search for additional supplies which takes away from time that could be spent on patient care.

When nurses take breaks on the unit they have to partner up with another nurse, doubling that nurse's patient responsibility. A resource nurse, whose job is to help cover nurses during rest and meal breaks, is needed in order to ensure that nurses on break can still provide safe patient care. This nurse should not have patient assignments.

Ortho/Trauma (Zayed 11E)

11E is a high-acuity surgical unit that serves a wide variety of patients, from basic orthopedic injuries to gunshot wounds (GSWs). 11E is typically shortstaffed and regularly puts out requests for high-needs shifts, which incentivizes nurses from within and beyond 11E to pick up extra shifts. However, this presents some challenges, including staffing with nurses who are often already overworked as well as creating an influx of nurses who consistently need orientation to the unit.

Nurses on the unit typically take four patients on days and six patients on nights. The unit's nickname among nurses is "11E The Beast" as it is one of the most stressful units in which to work.

The stressful conditions often cause core staff to quit. It is typical for nurses who have less than two and a

half years of experience to be considered among the more senior nurses in the unit on a given shift.

Nurses on 11E rarely, if ever, get breaks. When nurses do have breaks, we need to give our patients to other nurses who themselves already have patient care assignments. Therefore, a nurse's assignment can be doubled, neglecting safe nurse-to-patient ratios.

Gloves consistently rip during normal use. Vital signs machines are often not available and when they are available, they are often not functional.

Workplace violence is common in this unit, including hostile patients and visitors. Nurses often bear the primary responsibility for de-escalating these situations

PEDIATRICS

Peds ED (Bloomberg 1)

The pediatric emergency department is a Level I trauma center and sees more than 25,000 patients every year. The nurse-to-patient ratio on the unit is usually 1:3 but the staffing isn't always adjusted appropriately when very sick kids are admitted. These are the most vulnerable.

Break Relief

The biggest complaints with staffing happen during lunch time when RNs are expected to cover their colleagues' patients while they have lunch. Although

the unit provides for a break relief nurse with trauma patients, it is not the norm for all patients. This results in nurses having to look after four to six patients at the same time while coworkers are out on lunch, even if three out of the four patients are high acuity. Another issue that negatively impacts staffing is the call out/sick call policy. If a nurse is sick or has sick family members and calls to cancel a shift, which happens often when working with very sick patients, then that nurse will get an occurrence, which is much like a negative attendance mark. This leads to nurses coming into work sick to avoid getting an occurrence.

Pediatric Operating Room (Zayed 4)

Issues for peds OR include lack of supplies, utilization of equipment, and patient and worker safety.

Peds OR has 1:1 ratios and performs a wide range of surgeries including ortho cases. A great hindrance during such procedures is the lack of properly stocked casts. During ortho surgeries, several casts may be needed to stabilize the patient's bone. Depending on the age and size of the child, up to three casts may be required to stabilize the limb. The "par" or standard for the OR supply cart is six casts per color or size. Often, the cart is under stocked. To further complicate matters, residents and nurses from ICU and ER use the peds OR supply cart as a resource. Suggestions and requests made to the department responsible for ordering supplies can take up to a year before being fulfilled.

Requests for specific instruments used during surgery are difficult to acquire. When a particular instrument is not available, nurses have to open kits that are furnished with numerous tools needed for surgical procedures in order to retrieve just one device. Consequently, the unused instruments have to go

through the process of being sterilized again and the cost of the entire kit is billed to the patient. Requests for individual instruments can take up to a year before being realized.

The unit also lacks adequate support staff. At night, surgical techs take on extra work in order to help RNs who have to leave the room in order to get supplies or equipment. There is one runner assigned to Bloomberg floors 3, 4, and 5. The runner is stationed on the third floor. Peds OR is on the fourth floor.

Peds OR has a new Bovie suction coagulator in each operating room. The machine suctions both liquids and smoke. This means that all individuals in OR could work in a smoke-free environment and not breath the toxic byproducts of cauterizations. (Some spinal surgeries can use up to three cauterization machines.) Carcinogenic surgical plumes could be eliminated and JHH surgical teams could avoid inhaling smoke that possibly contains viruses such as hep B during cauterizations. All that is needed is an extra attachment for the Bovie. The pencil adapters cost around \$267 for a case of 10. Tubing is included.

Peds PACU (Bloomberg 4N)

The 32-bed prep/PACU unit provides care for children younger than 22 years of age. The main issues for the unit include lack of equipment and staffing, clinical expertise, patient acuity, and patient care fulfillment.

Peds PACU patients are transported by doctors. During transport, patients are not monitored. These patients are just coming out of surgery and are at a crucial point of recovery from anesthesia. Without monitoring vital signs, doctors don't know if or when a critical change in the patient's condition occurs. Doctors have arrived at the PACU with patients in distress who had good vitals during surgery. In order to help prevent the risk of patients coding, doctors are purchasing their own monitors to use during transport.

Many of the RNs who work in the peds PACU had pediatric ICU (PICU) experience. As a result, PICU patients have been sent to the PACU in the event of bed shortages. Many of these RNs are leaving the

peds PACU and taking that added experience with them. They are being replaced with RNs without those skills and experiences. The lack of PICU experience among new hires presents a problem as PICU patients are still being sent to the peds PACU. To further complicate things, these new hires have no physical point of reference for the unit because there is no written orientation manual.

The peds PACU seems to have become a stop gap for the PICU, peds ED, and med-surg units. For example, patients with breathing problems, or "holds," from these units are sent to the peds PACU. The unit operates 24 hours a day. At night, there are two nurses on duty who take care of up to four patients. Depending on the patients' acuity, nurse-to-patient ratios could be a challenge. Peds PACU RNs have also experienced delays when requesting pain meds for their patients. When RNs from the unit ask doctors for meds for patients with acute pain, there seems to be an unusual delay before relief is made available.

School Age and Burn Care (Bloomberg 10s)

Bloomberg 10S is the school age and burn care unit. The patient population is children ages 5 to 13, and medical diagnoses include burns, renal failure, cystic fibrosis, asthma, and diabetes. The nurse-to-patient ratio is usually 1:3, sometimes 1:4. The unit often has sufficient staff to care for patients safely and has adequate supplies. RNs are also often able to take rest and meal breaks without any patient care responsibilities. Patient handling is well supported on this unit. RNs have access to functional lift equipment and more often than not, have additional staff to assist with multiple-person lifts. Workplace violence is not prevalent on 10S, and when it does occur, RNs are supported. Staffing can be improved, as the patient assignment has increased in the past two years. RNs have had less time to spend with their patients for discharge planning and teaching.

Pediatric Intensive Care Unit (PICU)

PICU is a 40-bed unit specializing in care of adolescents with intensive care needs, including acute trauma, organ transplant, and system failure.

Retention

It is very difficult to retain nurses on PICU. It is common for an RN with one and a half years of experience to be the most experienced nurse on a shift. This collective lack of experience is dangerous for patients, and places nurses in difficult situations where they have to take on assignments they are not confident handling. Many nurses stay only six months to a year on this floor before leaving Hopkins or moving on to another unit with better practices. A major factor in our retention problem is the culture of rampant favoritism and bullying on PICU. Favoritism determines what kind of assignments a nurse will get, if they will get help with patients when needed, if they will get yelled at for asking a question, what schedule they work, and if they are able to take their earned vacations. Management is responsible for this toxic culture that drives many nurses to leave the unit quickly.

Staffing, Bed Closures

Staffing is so inadequate on PICU that we recently had to close six beds (from 36 to 30) because there were not enough nurses on staff to cover all shifts and maintain ratios. That is six fewer beds that are available to very sick children in the community. While we technically have 40 beds on the unit, we have never been able to maintain enough staff to open all beds. The staffing problem is directly related to management's inability to retain nurses.

Ratios, Lack of Breaks

Ratios on our unit are 1:2 or 1:1. Staffing for each shift keeps us within these ratios, except for the periods of time when nurses need to take breaks. Without break relief nurses, we must double our patient assignments to 1:4 or 1:3 while a nurse is off the floor on break. This practice creates a culture that discourages nurses from taking breaks at all, due to the unsafe ratios that would result. When we do take breaks, it is expected that we take our phones with us, and return to the unit at a moment's notice. It is common for a nurse on a 12-hour shift to not get one break during that time.

Nurses Performing Care Without Proper Training

The high turnover also puts nurses in positions in which they are forced to take assignments for which they have not been adequately trained. To care for some patients with genetic heart defects, an RN is supposed to have two years of experience and have cardiac certification. However, if we are shortstaffed, those requirements are not met, and new nurses are thrown into situations for which they are unprepared. Acuity of patients is sometimes not taken into account when assignments are given. For example, one nurse may have one intubated patient and a trach/vented patient, both of which require a lot of additional care time.

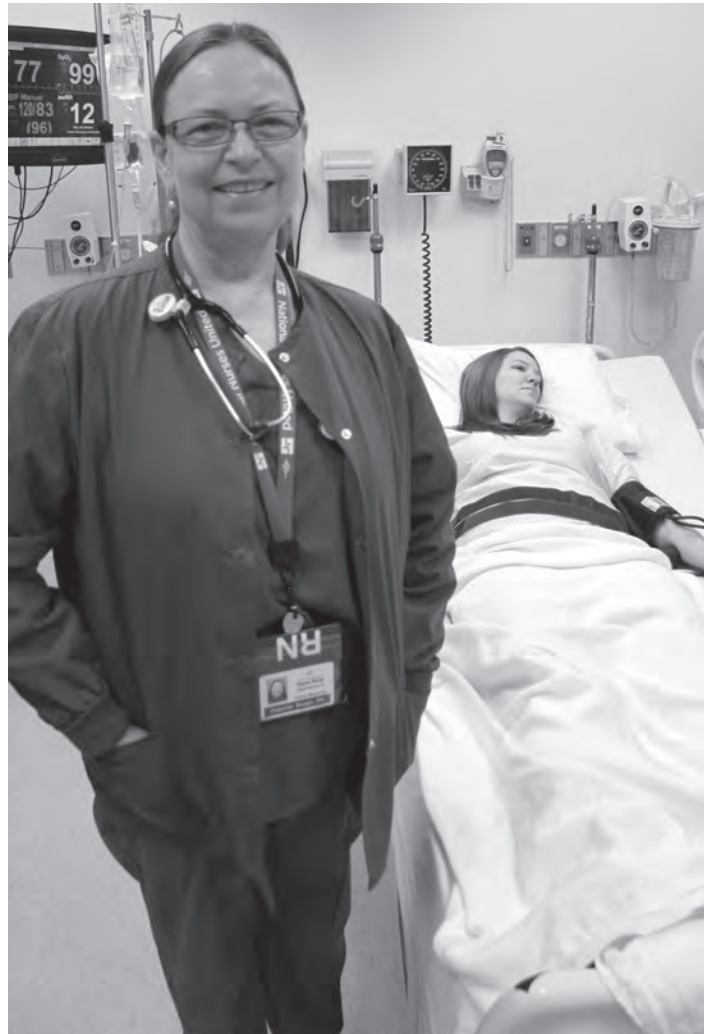
GYNECOLOGY AND OBSTETRICS UNITS

Gynecology, Obstetrics, Labor and Delivery (Zayed 8)

Nurses who staff gynecology, obstetrics, (GYN/OB) and labor and delivery (L&D) work both labor and delivery (Zayed 8E) and perinatal (Zayed 8W). When we arrive to work we see where we are assigned, except for two or three nurses who are permanently working perinatal or L&D. More than nine years ago, GYN/OB L&D adopted permanent day and night shifts, and this is still one of the only units at Johns Hopkins Hospital that has no rotating shift work.

There is no consistent break relief for night shift nurses, and only recently has management implemented a break relief nurse for day shift. This means that nurses who do not have break coverage must buddy up and ask another nurse to double her patient load while they go on break, or eat in the moments they are not directly giving patient care. Because nurses do not want to put their patients and their colleagues at risk, they typically forego their breaks. The nurse-to-patient ratio is 1:2 or 1:1 if the patient is in labor or high acuity.

RNs on the perinatal units do not have a consistent system of break coverage. Nurses who are pumping for their new babies at home are not supported by management to pump in a way that is most comfortable to them. Labor and delivery patients must be continually monitored so nurses cannot leave the floor to pump in the designated lactation room.



OUTPATIENT CLINICS

Outpatient Infectious Disease — John G. Bartlett Specialty Practice

Patient Population

The Bartlett Specialty Practice is a high-volume outpatient clinic providing HIV specialty and primary care as well as a wide variety of specialty infectious disease care (including viral hepatitis and blood-stream infections) to a majority low-income population. Many of our patients have low health literacy, and the majority of our patients are on forms of medical assistance such as Medicaid, Medicare, and/or Ryan White federal funding. The clinic is home to a variety of subspecialties (including HIV-focused psychiatry, gynecology, and neurology) and embraces and enacts the idea of multidisciplinary care amongst nurses, providers, pharmacists, social work, case managers, community health workers, and phlebotomy.

Exam Rooms

When our practice moved into the newly renovated clinic space in May 2017, the clinic was already full with its robust offering of subspecialties and high volume of patients. Among many other responsibilities, nurses also conduct billable appointments, counseling and testing encounters, and new patient intakes (including full medical, psychiatric, substance use, and sexual health histories) which require a private exam room. However, there are many clinic sessions in which nurses do not have a dedicated exam room to use, thereby forcing nurses to see patients for an hour-long new patient appointment in a treatment room bay separated from other patients by a curtain. When the treatment bays are already assigned to other staff or in use, nurses are told to use their offices for patient visits. However, given that the majority of nursing offices are shared, this may mean the patient must have a visit with another nurse present in the room behind a desk, and/or the other nurse cannot complete her or his work because phone calls can't be made with that patient in the room due to potential HIPAA violations. Furthermore, patients may not be forthcoming with important and relevant health information because others can hear their conversation.

Some clinical staff who see patients on a daily basis, such as members of the infectious disease psychiatry team, HIV providers, and viral hepatitis providers, do not have dedicated office space where they can complete work, store files, or safely store belongings in clinic without utilizing exam room space.

Equipment

The unit is in need of a second glucometer. Given the size of our clinic, patient care can be significantly delayed because there is only one glucometer available at one end of the clinic. The unit is also in need of a second stretcher for emergencies or routine visits with patients who are bedbound and transported to clinic appointments via ambulance.

There are no patient appointment label printers in the treatment room, leading to delays in care for immunizations or medication administrations. At worst, this could cause medication or specimen errors.

Wheelchairs are frequently unavailable when needed. Patients often need a wheelchair upon arrival. If there are none available, a staff member must be sent out of the clinic to find wheelchairs at other entrances to the hospital, which are, at a minimum, a one- to two-block walk away within the hospital. Patient transport can be called to request wheelchairs, but they may take more than an hour to respond to these requests. We have had numerous urgent situations in which patients needed to be transported by a nurse to the ED and care was delayed because staff had to go hunt in other areas of the hospital for a wheelchair.

Patient Safety During Rapid Response or Code Situations

The newly renovated clinic space is located in the former Johns Hopkins emergency department. Patients with no affiliation to our practice frequently walk in with acute medical emergencies. While we are not “supposed” to treat patients not scheduled for care at the Bartlett Clinic, we cannot and would not deny or ignore care to people who come in off the street

with a medical emergency (e.g. chest pain). In these situations, clinic nurses are called away from current patient care activities to see to these urgent needs, and we often have to call the department of medicine code team (for the hospital) to respond. These emergency situations are rarely an actual “code” (cardiac arrest, loss of airway) and we may be unwittingly pulling the code team away from other inpatient code situations.

Despite the fact that confusion over ER location has been an ongoing issue since our first week occupying the clinic, management’s only response has been to add a small sign to the brick wall in front of our clinic indicating that the emergency room is up toward Wolfe Street.

Furthermore, the code team often takes more than 10 minutes to respond in full to our clinic, as many team members are unaware of the clinic’s location and/or it is far away from other parts of the hospital. Despite the addition of signage within the hospital, this continues to be an ongoing problem that could cause a life-threatening delay in care.

The clinic waiting room is where codes or rapid response situations most commonly arise, yet it is the only space in our clinic without a code bell or pull cord for emergencies. If there is a medical emergency in which more staff are needed or should be simultaneously alerted about an emergency, there is no blanket alert sent out to ASCOM phones. ASCOM phones have lost service in the clinic on numerous occasions. Front desk and other clinical staff must go face to face or call individual phones to alert staff of an emergency and ask for help, greatly delaying the availability of medical resources for that patient. Similarly, there is no designated area at the front of the clinic to store a small emergency cart (e.g. gloves, bandages, oxygen tank, respiratory supplies) in event of emergency.

Workplace Safety

There is a security guard at our clinic entrance who is very skilled at managing patient flow and de-escalating waiting room tensions. However, he is not available to help patrol the back of the clinic, where patients, staff, or visitors may slip in from the hospital or the side door unnoticed. Although there is a swipe access-only door separating the waiting room from the clinic space and staff areas, patients and

visitors can very easily enter the back of clinic unsupervised. The swipe access-door has broken multiple times and taken upwards of a week for facilities to fix when broken. Even when working normally, the door sometimes slams shut and nearly injures people in its path if the door operator does not wait the full three seconds before trying to push it a second time.

Many of our patients struggle with behavioral health diagnoses and substance abuse that may impair their judgment and/or elevate drug-seeking behaviors. On occasion, these patients may engage in behaviors that are verbally or physically threatening to staff. Although all exam rooms and office spaces are equipped with a pull cord or panic button, the ease of access to staff offices and exam rooms and the lack of security personnel at the back of clinic has contributed to concerns about safety when these patients exhibit aggressive or violent behavior. Staff who open and close the clinic can be at greater risk as there are fewer staff present to help.

Communication

There are a variety of ways that clinical information, tasks, and requests requiring follow-up are communicated to nurses, including face-to-face, ASCOM phone, desk phone with voicemail, nursing station voicemail, personal cell phones, fax, Corus, email, Epic Inbasket messages (results, cc’d results, result notes, cc’d charts, staff messages), Epic Inbasket group pool messages (calls from central scheduling, results, refill requests, and patient advice requests that must be manually routed to correct nurse and/or provider), and stacks of records, documentation, or paperwork left on a nurse’s desk. There is significant provider variability regarding communication preferences. Nurses are expected to respond promptly to all of the listed forms of communication above and are the default responsible party for many patient paperwork, forms, and prior authorization requests.

Staffing and Care Coordination

While staffing has increased over the past two years, so have the staffing needs of the clinic as the practice continues to expand. Most notably, multiple practices were combined and housed in the newly renovated clinic space in May 2017. As the practice continues to grow, patients’ demands for services, especially walk-in and on-demand, increases. The clinic could use additional personnel, such as a walk-in/triage

nurse, walk-in/urgent psychologist, and walk-in/urgent social worker, along with additional certified medical assistants and administrative support staff. More specifically, patients struggling with substance abuse, behavioral health crises, and/or urgent medical needs frequently walk in requiring acute attention. Currently, staff who are often attending to other patients are called repeatedly and pulled from their scheduled duties to respond to a patient crisis in the waiting room. Having additional staff would greatly improve the functioning of the clinic, patient safety, and both patient and staff satisfaction.

At checkout there is no formal system for establishing a queue, which sometimes angers patients and providers when people are perceived to “jump” in line or don’t remember who sat down before or after them. Scheduling follow-up appointments generally takes five to 10 minutes. Both nursing and front desk staff are often prompted to follow up on administrative aspects of referrals while also managing the more immediate and pressing responsibilities of face-to-

face patient interactions in a high-volume clinic. Checkout staff are expected to simultaneously move patients through checkout quickly while also scheduling follow-up requests in real time because there are no dedicated referral coordinators in the clinic. Given the low health literacy of many of our patients and the complexity of navigating the healthcare system, referrals are often not scheduled and this detail may go unnoticed due to the lack of dedicated staff. A full-time referral coordinator is needed.

Though there is plenty of room for improvement in staffing and care coordination as noted above, striving for and achieving patient-centered care coordination is a hallmark of Bartlett Clinic nursing and staff at large. Nursing triage, education, and case management combined with the availability of on-site specialties such as HIV psychiatry, substance abuse, gynecology, pharmacy, and phlebotomy enables great collaboration to provide high-quality care to a medically complex and historically underserved patient population.

Ambulatory Clinics — Johns Hopkins Outpatient Center (JHOC)

The Johns Hopkins Outpatient Center (JHOC) services patients with varying needs in numerous outpatient clinics, from cardiology to GYN/OB.

Past Incidents of Workplace Harassment and Management Enablement

In certain units within the JHOC, it was not unusual for nurses to become the targets of verbal abuse by doctors in the clinic. In some cases, this was said to have been precipitated by a lack of sufficient training (which was common under previous management).

In cases where nurses and other staff were subjected to verbal abuse, management would not only refuse to hold offenders accountable, but also place blame on those reporting. This has since improved, but there exists no systematic response to this issue.

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