

We're speaking out: Protect care for moms and babies

Patients receive the safest care because of the judgment and experience of nurses. Patient needs for laboring mothers and their babies can change in a moment and that's why we're speaking out to stop proposed cuts to Labor and Delivery staffing. We delivered a petition signed by an overwhelming majority of Labor and Delivery nurses throughout the system to system-wide CNO Margo Bykonen and campus CNOs. Administration's proposed cuts to core staffing in Labor and Delivery goes against years of experience and what nurses know will create safe care.

Studies have reported that nurse staffing is connected to patient mortality: "Adequate [nurse] staffing is critical to providing safe nursing care to mother and babies. Staffing needs in perinatal units are dynamic, consistent with the various types of patients and clinical situations encountered in a perinatal service... Pooled results show that every additional FTE nurse per patient day was associated with a risk reduction in hospital-related mortality of 9% in ICU and 16% in surgical patients."¹

Swedish administration wants to limit when women in active labor will receive one on one care to only when there are medical complications. But this is not well defined and the ambiguity could mean that patients who present as non-complicated could become complicated in a moment without the right staffing plan in place.

AWHONN, the leading national professional organization on labor and delivery, calls for a standard that requires 1:1 care for nearly all women in active labor.

These cuts impact safety:



"Once a patient changes to high risk, if everyone has 1:2, who absorbs your patients? We get constant texts and calls now for help. I can't imagine what the OT budget will look like if Swedish makes this cut.

Nobody wants to say to their patient that we can't help them because our other patient has a prolapsed cord and we have to get to the OR and there isn't another nurse available. I have to make sure the mother gets through safely and make sure baby makes it out, too.

Whose definition of safety are we going to use? The last thing I want is to tell my patients I can't take care of you because we didn't meet budget."

Libbie Larson, RN, Labor and Delivery, First Hill

Staffing During the Active Labor portion of stage 1 labor, which has been 1:1 at Swedish	AWHONN Guidelines	Swedish Management
Woman laboring with minimal to no pain relief or medical interventions	1:1	1:2*
Woman receiving oxytocin during labor	1:1	1:2*
Continuous bedside nursing attendance during initiation of regional anesthesia until condition is stable (at least for the first 30 minutes after initial dose)	1:1	?
Woman whose fetus is being monitored via intermittent auscultation	1:1	?
Woman with medical (such as diabetes, pulmonary or cardiac disease, or morbid obesity) or obstetric (such as preeclampsia, multiple gestation, fetal demise, indeterminate or abnormal FHR pattern, women having a trial of labor attempting vaginal birth after cesarean birth) complications during labor.	1:1	1:1

*Management has said that moms without medical complications will have 1:2 care.

¹ AWHONN's 2010 Guidelines for Professional Registered Nurse Staffing for Perinatal Units

We have requested information to find out if administration believes that this fits a “medical complication” and therefore qualifies for 1:1 care.

Administration has announced 40 FTE cuts to meet a budget that matches this ratio change in Labor and Delivery. When the medical condition of laboring mothers and their newborn can change unpredictably and within minutes, it is irresponsible to reduce staffing to this level without certainty we can continue one on one care as a standard for our community. On top of this, the proposed cuts and closures to NICU and Special Care Nurseries feel like they increase the risk to the most vulnerable newborns that could impact the rest of their lives.

These cuts hurt Swedish



“My patients in med/surg often say ‘I love coming to Swedish because my daughter or my grandbaby was delivered here’. People remember a different Swedish. Swedish set the standard at one time and I think we need to stand up for those standards. Where is the quality? Where is the commitment to safe care? How long will people think of Swedish as a great

place to get care?”

Delores Prescott, RN, 3SW Short Stay, First Hill



Providence should prioritize patients over profits

Women giving birth are more than a number on a budget sheet and should be treated as such. We, the undersigned, see every day that safe care for mothers and newborns starts with adequate staffing. We believe that sustainable care models mean prioritizing the lives and care of women and children over corporate profits and we will not accept these cuts to care. We are united in demanding that you and Providence administration recommit to our mission and the standards of care that our families deserve.

We are calling on you to maintain safe nurse to patient ratios in Labor and Delivery and nurseries across the system.



“Every day I come to Swedish to give the best I have to my patients. It feels unethical for Swedish to make cuts without considering the impacts. Management should put every dollar toward quality care including cutting CEO pay.”

Sheron Ray, NAC, Surgical Telemetry, Cherry Hill

Standing up for patient care

Patient safety attendants

Patients need PSAs in a number of circumstances, including those with suicidal ideation, head injuries, or confusion or dementia.

When staff get pulled from the matrix to be 1:1 with a patient, other essential patient needs can be missed. That's why in 2015 we advocated and won in our contract that PSA staffing needs will come from outside of a unit's matrix. Now Swedish management has stated that they will not be staffing PSA needs as committed in the contract and will instead pull PSA from current staff on the floor. That's a violation of our contract and we're taking action.



"We've already had cuts, I don't know how we will go on with more to come. Last week, we had a patient on floor with a PSA and another patient that was trying to get out of bed so we needed additional help on the floor. Management was reluctant to do it because it would come out of the matrix and was going to affect their budget. I was the only CNA on the floor and I ended up having two people in one room and rounded on them every few minutes as time went by. I had to sit by the door and have my eyes on two patients and ear on for the call lights. Nurses were tied up and at that point everyone was tired. Our patients are not going to receive the care they need and don't even feel safe in that environment. I wish we looked at both sides — of course they want to make money but I think human life is more important at the end of the day. We should put extraordinary care and extraordinary caring first."

David Antwi, NAC, 8SW Medical Respiratory, First Hill

Our IV Team provides specialized care

Our IV teams bring specialized experience and care to ensure our patients have the safest and quickest outcomes for insertion and management of IV lines. Not only does this save money and even lives, it also means patients have a better experience while in our care. But management has announced that IV teams will become PICC teams and staff FTEs will be cut in half. This is an unacceptable cut and leaves nurses to take responsibility for specialized tasks with an unclear timeline and training.



"Where is the training for the 1500 RNs? Just last week one of my co-workers had to educate a doctor around safe practices regarding discontinuation around PICC lines. He wanted to pull a patient's PICC line with a huge clot, she informed him of the safety standards around anticoagulation. Had she not intervened serious complication could have occurred such as having the clot migrate further up into the central system.

This past week I experienced a patient's daughter recognizing me in the hallways as an IV RN and begging me to access her Mom's port because the ED staff could not. She endured multiple sticks in the ER and had received an ultrasound guided IV in the ER. They told the daughter that they could not get the IV in because they need a larger needle. The IV RN who is skilled in this area was able to access the patient's port without difficulty using a standard needle in less than 10 minutes.

Let's do things right! We should not be using community standards as a benchmark. Swedish needs to be the standard, in fact, leading the way above standards."

Kristi Hesla, IV RN, First Hill



"We usually don't have Flex on the house at night, so when ICU is super short and you have a code it's critical to have the right expertise in the room. No one is trained for that except our IV Team. Only IV Therapy can get access that saves patient lives."

Justin Penwell, RN, Float Pool, First Hill

Standing up for patient care

EVS are the frontline of infection protection

Without the vital work of our environmental services staff our patients would suffer. For our hospitals to be a place of healing every EVS department in our system must be fully staffed.



"Our EVS staff is the front line of infection control! That is why our department got together alongside members from around the Swedish system to demand that EVS be fully staffed and make real system changes that prevent discrimination and abuse in the workplace. Management made a commitment to meet our staffing committee to make improvements and now we are asking that they follow through. We need all EVS across our five campuses to be staffed appropriately so that patients are safe and get the care they need when they need it!"

Angel Sherbourne, EVS, Cherry Hill

Our cafeterias are patient and family areas — don't restrict access!

Friends and families need a place to gather and have warm food while supporting Swedish patients. For many, this can even mean processing and grieving. Our cafeterias offer this space.



"Every hospital has a cafeteria. Why would you not have a place for family members and staff to get a warm meal without having to leave their family member? Our community deserves better."

Then Thai, Nutrition Services Ballard campus

ICU patients need consistent staffing for safety

Our sickest patients need around the clock care to make sure they can heal. By cutting staff from this critical population, Swedish could be putting patients at risk.



"We measure patient care by good patient outcomes but management is making this very challenging with cuts that could be compromising patient care and safety. Last week we had a semi-coding patient. All hands on deck. Even nurses with 1:1 patients came to help. There were five nurses helping. A patient fell while one charge nurse was covering two floors. There was a Critical Care Response called and the charge left the semi-coding patient to assist. The IMCU nurse is new so I pulled the IMCU charge nurse twice to take patients at the beginning of the shift. We do what we do best which is to give extraordinary care to all our patients. To expect the same with less support is not ok. Management needs to find somewhere else to cut — never from the bedside!"

Lizette Vasquez, RN, ICU, First Hill, and Christina Gembinski, HUC, ICU, First Hill