

October 16, 2018

HMC ICU RNs voice concern in staffing practices



We know that in order to get management to hear our concerns we have to speak out and demand change. A super-majority in each ICU signed onto a petition that demands that management follow the agreed upon process laid out in our contract when making staffing decisions. Over 30 ICU RNs took the petition signatures to Executive Director Paul Hayes along with our stories and told him we expected to meet with the ICU administration. They agreed to a meeting to discuss our issues

Leaders from every ICU met with our Chief Nursing Officer, Darcy Jaffe, manager of MCICU and interim staffing office manager Marne Faber and labor relations addressing our four biggest areas of concern:

- Flexibility for admissions within the ICUs and the excessive use of standby to control cost at the expense of the patients.
- Floating of ICU RNs to acute care settings, including boarders and our staffing expectations in the boarder areas.
- The care of acute care patients within the ICUs using managements "adjustable matrix".
- Lack of transparency around all these issues by refusing discussion in our established nursing committees, RN Joint-Labor-Management and the now legally binding Nurse Staffing Committee.

We asked management for a written response to our concerns and proposed solutions within 14 days of our September 14 meeting. As of yet we have had no response, despite a follow up request for response. We are ready to take further action for our patients! Are you?



"We have 5,000 consultants in this hospital who actually do the work and experience the inefficiencies every day. If you want to solve the financial and patient care issues at HMC, then use the folks who know the work. Use our RN leaders in JLM and staffing committee, go to EVS for short staffing issues, go to UST for supply chain wastes — we

can help you find the answers."
Shanna Sierra, RN, 9EH, BPICU



"Our mission is our focus and purpose. Our environment should inspire us not expire us. We are exhausted and working under too much stress. We are in crisis without a crisis. We are depleted and finding it unsafe and unable to be in the moment to fully serve our patients. We would never prescribe this plan for our patients.

No matter what financial strains UW has, we still care for every patient. Support us to do our best. Patients first is not something we say, it needs to have meaning. We are the face of Harborview and the ones who have taken the brunt.

If we are boarding 60 patients then we need to cover it and if we can't then OT needs to happen. Come up with a functional responsible plan that puts nurses first because it is nurses that put patients first. As previous AACN president Chris Schulman stated in her outgoing speech, 'Nurses are an investment not an expense.'

Lori Davis, RN, MCICU, 37 years

ICU RNs voice concern about patient safety and staffing

If you are an RN who has worked at HMC for any length of time you’ve noticed a change in the ICU staffing. Our ICU charge nurses are taking patients instead of being available as a unit expert and resource. We see acute care patients being moved around the unit at 2AM to accommodate an ICU patient because of the new “adjustable matrix”. We are being called in as the 5th nurse on standby by 9:30 because they haven’t staffed for admits on our unit and we are being floated into other areas outside our area of expertise. The level one trauma center in a four state area is not staffing for ICU admissions. The excessive use of standby per contract language can inevitably lead to time and one half and that isn’t saving our hospital money. ICU nurse leaders are concerned about what we see as tighter staffing that is affecting patient care and morale in the units. We let management know in our meeting with them that the excessive use of standby to save money is not good for patients or the staff. They are scrambling when they don’t need to be. Our ICU leaders told devastating stories of shifts when they were staffed without room for acuity or admits.

We told them we need to staff for admissions. Stop putting everyone on standby and then calling them in within two hours after the shift start. We talked about the expertise of the charge nurse. If management states the matrix is only a guide then let the charge nurses make the call to staff to their acuity. Too often the Administrator on Call is making decisions about the staffing despite the recommendations of the unit charge nurses. The nurses at the bedside know what they need. Use our knowledge.

Match the right nurse to the right patient.

We know management has voiced a problem with acute care discharges in our safety net hospital. Patients are not always able to leave the hospital when ready because they have no safe plan for discharge to the community. We told management we see this problem overflowing into our ICUs. But staffing acute care patients in ICU like they are out on an acute care unit is not a safe option. We call on management to use the frontline ICU RNs expertise to help solve the ICU acute care patient problem and not change the matrix behind closed doors. Rely on our experienced charge nurses to determine the staffing they deem necessary whether patients are acute or ICU-level.

ICU nurses staffing acute care boarders is not a solution to the boarder problem

Many ICU RNs, in addition to our highly knowledgeable critical care float pool staff, are floating down to boarder units caring for acute care patients. We have had reports of 4 and 5 patient care loads in those units. In our meeting with management we called on them to answer:

Why are there no acute care float nurses to care for these patients? Why are ICU nurses caring for acute care patients? We told management our boarder area staffing needed to match the 1EH Boarder unit: 1:3 nurse to patient ratio on days, 1:4 on nights.

We also need to make sure our ICU certified nurses can meet their required numbers of care hours for recertification. It is our expectation that a critical care nurse get critical care nursing hours for recertification.



“As an ICU float nurse at HMC, I rarely float to the ICUs. Instead Critical Care Float Pool (CCFP) nurses staff all the boarder areas, which the majority of time are acute care patients. Where are all the acute care nurses? Many of the CCFP nurses have their Critical Care certification. Management needs to know that these nurses are required to work a certain number of hours in an ICU setting to maintain this certification. These CCFP nurses are required to have a very broad knowledge base at HMC — floating to boarder areas diminishes these skills. I call on management to solve the acute care boarder problem.”

Lisa Hansen, RN, ICU Float Pool



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