Massachusetts Nurses Association

June 23, 2023

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Re: Saint Vincent Hospital
123 Summer Street, Worcester, MA 01608

With increasing frequency over the past 12 months, the patients of Saint Vincent Hospital in Worcester, MA have been receiving substandard care due to chronic understaffing, compounded by inadequate training on a newly installed documentation system that is not universally implemented within the facility; insufficient workstations and communication with printers in some areas; and relevant to the ICU, blatant disregard for MGL 111 Section 231 placing ICU patients directly at risk and violating TJC standard LD.04.01.01 "The hospital complies with law and regulation."

The nurses have tried to protect patients from harm but are increasingly alarmed at the constant threat to patient care. The hospital continues to admit patients despite inadequate staff to appropriately meet the patients' needs, in violation of TJC standard PC.01.01.01 "The hospital accepts the patient for care, treatment and services based in its ability to meet the patient's needs." Nurses continue to witness the violation of *Patient Rights and Responsibilities*, but their concerns have gone unanswered. We ask for your investigation and intervention at the hospital to protect the patients of Worcester County.

The recently installed Cerner documentation system does not provide for safe handoff communication between the Emergency Department (ED) and the receiving (floor) nurse expecting an admitted patient, violating TJC standard IM.02.02.03, "The hospital retrieves, disseminates, and transmits health information in useful formats"; TJC standard LD.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital" and TJC standard LD.03.08.01 "New or modified services or processes are well designed" while simultaneously failing to meet the National Patient Safety Goal 2, "to improve the effectiveness of communication among caregivers." The Cerner system use began 5/9/2023. The admitting nurses were not oriented to the system or informed about a process to receive handoff from the ED nurse. Management has discouraged nurses from calling the ED for a patient handoff, and the new system does not, at a minimum, allow for easy access to the patient's past medical history, details of the emergency department visit, medication list or those administered inhouse,

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labs, testing completed in the ED. Nurses are not able to print a summary of the patient chart to bring into the room with them when they are initially assessing the patient and attempting to verify medications, allergies, etc. During the second week of Cerner 'go live', one manager posted instructions on how to use Cerner and noted "No SBAR"; nurses were given a three-page handout on the system. When a patient is admitted from the ED, the receiving floor is paged to alert them to an admission assigned to their unit and within ten minutes, that patient arrives to the floor. The admitting nurse has not been able to access information about the patient unless there is a previous admission in the EMR. There is no nurse-driven information shared with the accepting RN. Nursing assessment, medications administered, testing completed and pending, labs sent, and vital signs taken in the ED are not available to the receiving RN so there is no way to identify a change in status, including mental status, ensure the patient receives the appropriate dose of medications and no way to avoid an inappropriate repeat dose of a medication already administered.

As an example of the risks involved with the new documentation system and poor interdepartmental communication, please note that on 5/12/2023, the admitting floor nurse accepted a new admission from the ED at 2000h. The patient was an older gentleman with pancreatitis. The admitting nurse never received handoff communication. The admitting nurse found physician orders for antibiotics that had been written at 1630h in the ED. Without a way to verify that the patient had received the ordered dose, the nurse believed that the medications had been started in the ED. After much investigation and multiple calls to Pharmacy, the admitting nurse learned that the antibiotics, in fact, had not been started. Because of the lack of information sharing within the new documentation system, the patient received the first dose of antibiotics 11.5 hours after the order was written - a significant delay in treatment.

On 6/6/2023, a newly admitted patient with severe anemia, weakness, and Multiple Sclerosis arrived to the floor for admission. There was no clear communication between the ED and the admitting RN. The patient had received a unit of packed red blood cells in the ED but that was not communicated to the floor. Establishing intravenous access was problematic. The patient had a port-a-cath that was not accessed in the ED. The two saline locks that were established in the ED were no longer functional, and because there is no IV team in the hospital, the appropriate needle to be used to access the port-a-cath could not be located and the patient endured 8 attempts to establish IV access. The supervisor searched for the equipment needed to access the port-a-cath, including searching in the warehouse, but was unable to find the power Port Access Device. The hospital violated TJC standards LD.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital" and TJC standard LD 04.01.11 "The hospital makes space and equipment available as needed for the provision of care, treatment, and services."

Also on 6/6/2023, a newly admitted patient arrived to the floor at 1230h with diagnosed dysphagia. The receiving nurse received no handoff report and had no opportunity to scan the EMR for information. The patient arrived with no admitting orders. The floor's resource nurse spent over an hour contacting multiple physicians, trying to identify and communicate with the covering MD and obtain Admission Orders. The patient had no code status, no diet order, no

medication orders during the time it took to locate the admitting physician in violation of TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it..."

On 6/10/2023 a new admission from the ED was sent to the floor with diagnosed Opiate Withdrawal. Admitting orders included Richmond Agitation and Sedation Scale (RASS) protocols with methadone to be given on a sliding scale, based on the RASS score. A second new admission was admitted with heroin withdrawal and placed on the Clinical Opiate Withdrawal Scale (COWS) and Clinical Institute Withdrawal of Alcohol Assessment (CIWA) scales with phenobarbital to be administered on a sliding scale based on COWS and CIWA scores. The RASS, CIWA and COWS protocols could not be located in Cerner. The medications were included in the Electronic Medication Administration record (EMAR) but did not include dosing by scores on the scales. Therefore, nurses struggled to properly treat the patient and follow orders. Compounding the challenges of appropriately treating the patient, the hospital transitioned to a new dosing medication administration scale based on CIWA scores. There was no notification or alert to the nursing staff and no education or in-service provided on the new sliding scale that replaced the CIWA sliding scale that had been in use for decades. This lack of information sharing placed patients at risk for inappropriate medication doses. TJC standard LD.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital" and TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it..." was violated.

The DVT prophylaxis prompt is no longer part of the Adult Medical Admission documentation. The former system alerted staff if the admitting orders did not include some form of deep vein thrombosis (DVT) prophylaxis, such as venodyne boots or a pharmacological intervention when needed based on the internal algorithm. When prompted, nurses then obtained orders from the physician to protect the patient. That prompt is no longer in place, placing patients at risk for DVT. It is important to note that patients have been diagnosed with DVT after being in the hospital for a period of time without proper prophylaxis. The elimination of the DVT prompt contributes to increased risk for patients, violating TJC standard LD.03.08.01 "New or modified services or processes are well designed."

Pharmacy

There have been multiple serious pharmacy errors and have occurred with increasing frequency since the implementation of Cerner. Pharmacy currently adds heparin to IVF for heparin drips. Multiple bundles of IV bags had external labels identifying the bag as heparin added. The bundles were placed in heparin bins on multiple floors. There was no heparin in those bags. The error was not discovered immediately, and heparin drips were hung that contained only crystalloid and no anticoagulant.

In another patient who was being treated with comfort measures only, orders for a morphine drip were not correctly written by the provider. The pharmacy system did not flag that order when the bag was hung. Safety measures are not in place and because of burdensome assignments,

with no resource nurse and no mentorship and guidance for new nurses, the Morphine Sulfate drip was hung and the patient received an excessive morphine dose in a short period of time.

Emergency Department and Emergency Department Behavioral Health

Emergency Department staffing has left RNs with an excessive number of patients at one time. During the overnight shift of 4/14-4/15/2023, one RN was left alone in triage with 20 patients in the waiting room.

On 1/12/2023 a single nurse was assigned 5 patients - two of whom were ICU admissions- one required BiPap and vasopressors to maintain blood pressure and the other patient was critically ill with DKA and required blood glucose checks every 2 hours; this same nurse was also responsible for 3 additional patients on her assignment.

On the 5/2-5/3/2023 overnight shift, an inpatient behavioral health RN was floated to the ED behavioral health unit. That RN was alone in that section of the ED, leaving the patients unattended while the RN accepted an admission, administered medication, completed patient assessments and administered care to other patients. The ancillary staff assigned for a portion of the shift was pulled to another area of the ED due to staffing needs. Therefore, some behavioral health patients were essentially unmonitored while the sole RN was attending to any one patient.

Maternal Child Health

In the Labor and Delivery unit, the care relevant to the current delivery is documented in Centricity. The patient's past medical history is available in Centricity. For a vaginal delivery, all documentation is completed in Centricity. However, when the patient requires a c-section, the documentation is started in Centricity, but switched to Cerner in the OR for the delivery procedure details. Once the patient is transferred to the recovery area, documentation is then completed in Centricity. The patient is then transferred to the post-partum unit where documentation takes place in Cerner. The nursery also uses Cerner. It is difficult to have the full picture of the patient and the delivery because of the use of two different platforms.

On 5/3/2023, one of two scheduled RNs was ill and unable to complete the shift, leaving one RN working with a post-partum float to care for 3 special care nursery patients and 7 pending deliveries. Per hospital policy, one RN is required to attend each delivery and complete the initial assessment on the neonate leaving a post-partum float in the nursery with special care babies that require a skilled Level II nursery nurse.

On the overnight shift of 5/14-15/2023, the unit was staffed with four RNs which is two less RNs than the agreed upon minimum. The nurses were responsible for a "Code White" (baby in distress) with a delivery - there was no nursery nurse available to attend to the baby, violating hospital policy that requires a nursery nurse be in attendance and provide care for the baby in distress. During that same shift, a patient was receiving a post-partum magnesium drip and required hourly reflex assessment and neurological checks, fundal checks every 15 min x 2 hours, then hourly; vital signs every hour until stable and more frequently if not stable; assessment of pulmonary status every two hours. The nurses were also responsible for two patients in active labor and who each require 1:1 nursing; 2 Cervidil inductions requiring

assessment and documentation every 30 minutes; and one patient in triage who required labs and fetal monitoring, which requires 1:1 nursing for the first 20 minutes.

Operating Room

There is an inadequate number of computer workstations in the operating room suites and in outpatient. Therefore, nurses are handwriting their documentation of an OR case and then transcribing their notes into the Cerner system after the case has been completed. This risks transcription error and inaccurate documentation of times, counts, and case events. Pathology requisitions are completed using an online form, however, the online forms do not include all specimen (e.g. urine) types so some are completed using hard copy. Prior to Cerner, the surgeon would identify the sample and the circulator would include specimen, location, procedure. Now Cerner requires the nurse to document a verbal order for the specimen on a different screen. The surgeons no longer initial the specimen record and agreeing to the accuracy of the specimen site source and the label.

Outpatient Clinics

In Outpatient, nurses received none to minimal training to use the Cerner system. Their cases are handwritten and then transcribed at the end of the day as they have no workstations or laptops to document in real time. When the Advanced Practice Provider enters lab orders in the system, there is no communicating printer on the unit. Labels are printed at a printer located in a different unit that has yet to be identified.

In the Infusion Center, the RNs cannot register a patient and cannot adequately prepare for patient needs as they cannot visualize the patient list for a shift.

Intensive Care Unit

On 1/2/2023, a nurse assigned to a critically ill patient who required 1:1 staffing based on the nurse's acuity assessment – the patient required multiple blood transfusions, diuretics and frequent potassium boluses for electrolyte repletion. Because of the risk for cardiac dysrhythmias related to electrolyte imbalance, the patient required close cardiac monitoring. This nurse was assigned a second intubated patient with sepsis who required three vasopressors for hemodynamics in addition to repeat fluid boluses and frequent skin care due to incontinence of stool hourly. Both patients were high acuity and required the undivided attention of the RN. The doubled assignment directly violates MGL 111 Section 231. This violates TJC standard LD.04.01.01 "The hospital complies with law and regulation."

On 1/12/2023, one nurse was assigned a patient whose acuity indicated a need for 1:1 staffing yet the nurse was also expected to function in the role of charge nurse for the unit. The doubled assignment directly violates MGL 111 Section 231. This violates TJC standard LD.04.01.01 "The hospital complies with law and regulation."

On 1/11/2023, an ICU patient's hemodynamics were maintained on maximum doses of levophed, vasopressin and epinephrine drips; both day and night nurses were assigned a second

patient, violating MGL 111 Section 231. This violates TJC standard LD.04.01.01 "The hospital complies with law and regulation."

On 5/2/2023, the resource nurse was unable to respond to a Rapid Response at 2350h per hospital policy because of inadequate staffing and high acuity patients.

Gastroenterology Procedure Suite

In the Endoscopy Suite, documentation completed before and after the case is noted in Cerner, but intraprocedural notes are handwritten and then transcribed into the EMR due to an inadequate number of computer stations. Again, a significant risk of error in transcription exists. The GI nurses cannot access the patient's medication list and are unable to access the patient's past medical history before beginning a procedure. Specimen labels are printed with barcodes that are not translated for the RN who is adhering labels to the specimen jars. Therefore, the nurse notes the specimen site on a label and includes the barcodes in the specimen transport bag for the lab staff to appropriately adhere to the appropriate specimen.

Behavioral Health

The Behavioral Health Unit was left short staffed on 4/22/2023 and the overnight shifts of 4/16-4/17/2023; 4/20-21/2023; 4/22-4/23/2023; 4/28-29/2023; 4/30-5/1/2023 frequently because one of three RNs on duty are floated to the Behavioral Health Unit (BHU) in the ED due to staffing deficits there. That floated RN is frequently responsible for adolescent patients in the BHU of the ED, despite having no adolescent experience. The BHU at Saint Vincent Hospital is an adult unit and does not accept adolescents. Floating a BHU nurse to the ED gives that nurse an assignment of a patient population that is different from their usual patient population. This is in conflict with the hospital's responsibility to ensure that the staff have been properly oriented and are competent to care for their patients.

On 4/4/2023, one nurse was assigned six patients who were admitted on suicide precautions. After approximately 40 minutes, a sitter was sent to the unit, but no additional licensed personnel assisted in caring forsix patients at risk for self-harm. The hospital placed the responsibility for the safety of those six patients on the nurse who was unable to ensure their safety.

Medical Surgical Units

The Medical-Surgical Units universally note a delay in the delivery of nursing care due to staffing. Nurses are often responsible for six to seven total care patients at one time. In accordance with hospital policy, patients are assessed using the Braden Scale to determine their risk for development of pressure injury. It is not uncommon for patients whose Braden score indicates a need to turn and reposition the patient everytwo hours to be in one position for a longer period of time due to the inability of nurses or PCAs to reposition them as scheduled due to staffing. Call bells, bed alarms and bathroom alarms ring incessantly because staff are delayed in responding due to excessive patient assignments, placing unsteady patients at an increased risk for fall when they attempt to ambulate independently, violating TJC standard PC.01.02.08, 'The hospital assesses and manages the patient's risk for falls.". Bedbound patients wait extended periods of time to be changed and receive basic human care and cleansing when

incontinent. The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity.

Prior to the introduction of Cerner, nurses were able to use Teletracking to locate and follow the patient being admitted to their unit. The Teletracking system provided information about procedures, lab values and testing completed. The admitting nurse was able to evaluate the appropriateness of the patient assignment. That system is no longer available to the RN. One unit secretary who did have access noted that a patient booked for a semiprivate room tested positive for tuberculosis and appropriately notified the charge nurse before the patient arrived. Had that secretary not noted the respiratory precautions, the staff and patient already admitted to that room would have unnecessarily been exposed to TB.

36W- On 4/15/2023 and 4/16/2023, the hospital supervisor acknowledged short staffing and instructed the floor RNs to violate hospital policy for patient assignments because "the other floors are over guidelines…" This violates TJC standard LD.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital."

22S- On both 12-hour day and 12-hour night shifts of 4/22 and 4/23/2023, the unit had no secretary in addition to staffing with only two RNs (instead of three). Therefore, phones were not answered in a timely manner, communication with families was delayed, calls regarding critical lab results were not answered in a timely manner. The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed.

23S- The unit was consistently understaffed with RNs, PCAs and secretary on 4/3/2023; 4/9/2023; 4/152023; 5/8/2023; 5/30/2023. Therefore, the response to call bells, bed alarms, and bathroom alarms, and telephone calls was significantly delayed. Calls from the lab with critical results, family calls for a status on the patient, physician calls regarding patients are not answered in a timely manner. This violates TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it…" The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed.

24N- This unit is consistently understaffed. On 4/10/2023; 4/16/2023; 4/18/2023; 4/23/2023; 4/24/2023; 4/26/2023; 5/3/2023; 5/28/2023 the unit was staffed with at least two RNs a secretary and PCA shy of the agreed upon number for minimal staffing. As a result, patients were placed in dehumanizing situations. The response to call lights, bed alarms, chair alarms was delayed in addition to a delay in providing care to multiple incontinent patients, placing them at risk for skin breakdown. Orders to reposition patients every two hours could not be completed in a timely manner; vital signs could not be assessed every two hours as ordered; patients requesting pain medication waited extended periods of time. The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful

way and the right to personal dignity; and the right to a prompt response to all reasonable requests.

33S- On 4/21/2023The RN called Respiratory therapy (RT) to apply CPAP to a hypoxic patient. The Respiratory Therapist was unavailable to report to the floor and reported there were no other RT's available in the hospital to help. The unit manager was unable to assist the nurse and the nurse had not been trained and deemed competent to apply the device. The hospital standard of practice delegates application of CPAP and BiPAP to RT. This hypoxic patient was at risk for further hypoxemia and potential sequelae related to delay in oxygen delivery.

On 5/29/2023, the Cerner system was not functioning and the on-site administrator was unable to reach Cerner support help. The EMAR did not indicate when medications were due to be administered and nurses were unable to scan medications before administration. This bypass of the safety system placed patients at risk for inadvertent medication interactions, exposure to allergens, or additional doses of medications that could not be documented as given during the "downtime". This violates TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it..."

On 6/11/2023, a new admission was assigned to a partially occupied semiprivate room. Within five minutes of the floor being notified of the admission, the patient arrived to the floor, with no handoff communication. In violation of the hospital's own policy, the patient was inappropriately assigned to a semiprivate room that was already occupied by one patient, with the newly admitted patient being treated for an infectious process requiring contact precautions for *extended spectrum beta-lactamase* (ESBL). According to Saint Vincent Hospital policy, patients with ESBL are to be admitted to a private room. In the event that a private room is unavailable, the second bed in a semiprivate room is "blocked", prohibiting a second patient from being admitted to that room. The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to personal safety and a secure environment. The right to personal safety for the patient who was occupying the room was violated. In addition, TJC standards IC.01.03.01, "The hospital identifies risks for acquiring and transmitting infections" and IC.02.03.01 "The hospital works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff" were violated.

35N- This unit was understaffed on multiple days, typically having no secretary and only one PCA to provide assistance with patient care. This staffing scenario was repeated on the overnight shift on 5/13-14/2023. As a result, multiple vital signs and serum glucose levels were not assessed as ordered. The scenario was similar on 5/14-15/2023 when the unit had no secretary to answer calls, no PCA when the one PCA covered 1:1 sitters for breaks. On that shift a critically ill hypotensive patient required blood transfusions and transfer to the ICU. The logistics of obtaining cross matched blood from the blood bank and transferring the patient to the ICU includes multiple phone calls and coordination, yet there was no secretary to assist the RNs, taking the RN away from patient care to manage those calls. TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it..."

Sincerely,

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